Medicare Eye Q

A Membership Service of the

Wyoming Optometric Association

By

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Meaningful Use Hardship Exception

To avoid 2017 Medicare Electronic From the AOA

Health Record (EHR) Incentive Program penalties, AOA members who might not meet the 2015 meaningful use requirements should immediately apply for a hardship exception because there was no time to plan for the delayed program requirements.

Doctors—both attesting and not attesting to 2015 meaningful use—should consider applying for this exception in the event they fail attestation to avoid the 3 percent penalty on all Medicare medical eye care claims.

In October 2015, the Centers for Medicare & Medicaid Services (CMS) posted the Stage 2 Meaningful Use Program Final Rule after doctors began the presumed 90-day reporting period. This meant doctors had no time to prepare to meet the requirements for 90 days since the revised requirements weren't provided until fewer than 90 days remained in the year.

In frequently asked questions (FAQs) quietly posted last week, CMS clarified that the hardship exception for "extreme and uncontrollable circumstances" could be used for issues related to this delay to avoid the 2017 penalty.

Based on these changes and because applying for hardship exceptions does not adversely impact attestation for meaningful use, the AOA encourages members to apply for this hardship exception if they suspect they might not meet the meaningful use requirements, regardless of whether they attest for 2015 meaningful use.

"CMS issued the revised rule after we had to start meeting the meaningful use requirements, so this broad exemption is a blessing," says AOA President Steven A. Loomis, O.D. "Ensuring optometrists are not penalized in 2017 is the result of continued advocacy by AOA to improve the meaningful use program."

Members can apply for the "extreme and uncontrollable circumstances" hardship exception by selecting section 2.2d when completing the 2017 Medicare EHR Incentive Program Payment Adjustment Hardship Exception Application.

CMS must receive doctors' hardship exception applications by **July 1, 2016.**

UPDATE: Be wary of flawed hardship exception advice
Much like the mistaken reports that meaningful use was going to end, AOA has seen advice circulating to doctors of optometry that misconstrues the hardship exception. Members may want to read the CMS FAQs themselves—FAQ on final rule publication timing, and FAQ on the hardship exception documentation requirement—and should be aware that the AOA interpretation is shared by the American Medical Association (AMA). The AMA recently released a memo, *How to Avoid the 2017 Meaningful Use Penalty*, stating, **"The AMA is encouraging ALL physicians subject to the 2015 Medicare MU program to apply for the hardship."**

More on CMS guidance for documentation, delayed rulemaking

CMS guidance, released on Feb. 1, clarifies that these changes, directed by the Patient Access and Medicare Protection Act (PAMPA), will make it easier for doctors to apply for the above and other applicable hardship exceptions. Specifically, CMS updated FAQs related to the application's documentation requirements and delayed release of the final rule.

- **Documentation requirements for hardship exceptions**
  CMS specified that doctors are not required to submit documentation for the hardship category selected as the agency will no longer review applications on a case-by-case basis.

  "CMS will review the application to record the category selected and use the identifying information to approve the hardship exception for each provider listed on the application. Providers should retain documentation of their circumstances for their own records, but no such documentation is required for review by CMS," the CMS FAQ states.

  Although CMS indicates that documentation isn't necessary for certain hardship exceptions, the AOA recommends members fully document what they submit to CMS in the event that auditors may want some documentation.
- **Delayed 2015 final rule release**
  Additionally, the guidance goes on to clarify sub-category 2.2d (extreme and uncontrollable circumstances) of PAMPA, pertaining to EHR Certification/Vendor Issues (CEHRT Issues).

  According to the revised CMS FAQ: "If a provider is unable to meet the requirements of meaningful use for an EHR reporting period in 2015 for reasons related to the timing of the publication of the final rule, a provider may apply for a hardship exception."

Click here to find new applications and instructions for exemption from the 2017 payment adjustment.

CMS - Medicare Learning Network® Publications and Multimedia

Videos on Medicare Quality Reporting — New

Watch seven new MLN Connects videos on the Medicare Quality Reporting Programs, focusing on the requirements you need to meet in 2016:

- Introduction: Medicare Quality Reporting Programs: What Eligible Professionals Need to Know in 2016. Run time: 15 minutes.
- Module 1: Medicare Access and CHIP Reauthorization Act (MACRA) Preview. Run time: 6 minutes.
- Module 2: 2016 Incentive Payments and 2018 Payment Adjustments. Run time: 9 minutes.
- Module 3: 2016 Physician Quality Reporting System (PQRS) Updates. Run time: 20 minutes.
- Module 4: 2018 Value-Based Payment Modifier (VM) Policies. Run time: 17 minutes.
- Module 5: Physician Compare Updates in 2016. Run time: 6 minutes.
- Module 6: Meaningful Use of Certified Electronic Health Record Technology (CEHRT) in 2016. Run time: 16 minutes.

Visit MLN Connects Videos for a complete list of videos on the Medicare Quality Reporting Programs.

EHR: Learn More about Clinical Decision Support Interventions

Clinical Decision Support (CDS) is a key functionality of health IT that contributes to improved quality of care and enhanced outcomes by avoiding errors and adverse events, improving efficiencies, reducing costs, and enhancing provider and patient satisfaction.

For the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs in 2016, eligible professionals and eligible hospitals must meet the CDS objective by:

1. Implementing five CDS rules related to four or more clinical quality measures (CQMs) or related to a high-priority health condition for the EP, eligible hospital, or CAH's scope of practice or patient population

Enabling and implementing functionality for drug-drug and drug-allergy interaction checks.

CMS Guidance for CDS Interventions

The CDS objective gives providers flexibility in the types of CDS interventions they employ, as well as the timing of the CDS.

Providers can customize the implementation of the CDS to their own needs for their clinical practice and patient population. The CDS should be implemented at a “relevant point in patient care,” which refers to a relevant point in clinical workflows when the intervention can influence clinical decision-making before diagnostic or treatment action is taken in response to the intervention.

Additionally, providers are not limited to just “pop-up” alert CDS interventions. They can meet the objective by using other methods of CDS, including, but not limited to:

- Computerized alerts and reminders for providers and patients
- Information displays or links
- Clinical guidelines
- Condition specific order sets
- Focused patient data reports and summaries

- Documentation templates
- Diagnostic support
- Contextually relevant reference information

Note: These functionalities may be deployed on a variety of platforms (e.g., mobile, cloud-based, installed).

To Learn More
For more information on CDS, review the specification sheets for eligible professionals at https://www.cms.gov/regulations-and-guidance/legislation/EHRincentiveprograms/downloads/clinicaldecisionsupport_tipsheet-.pdf

AOA'S ASK THE CODING EXPERTS: COMPARATIVE BILLING REPORTS RAISE QUESTIONS ON GLAUCOMA PATIENT TREATMENT AND CODING

Ask the Coding Experts, by Doug Morrow, O.D., Harvey Richman, O.D., and Rebecca Wartman, O.D.
Abridged/adapted from the November/December 2015 edition of AOA Focus, pages 48-49.

In October 2015, CMS issued Comparative Billing Reports (CBRs) to 6,500 doctors of optometry who were selected for their billing patterns, particularly in regard to SCODI and visual fields. This data was intended to give these providers an opportunity to compare themselves to their peers, check their records against CMS' data and review Medicare guidelines to ensure compliance.

In part, the reports provided information on the percent of glaucoma patients who received visual fields CPT 92082-83 and scanning laser imaging codes (SCODI) CPT 92113-34 within 90 days. Based on the data provided by CMS, the national average for the percentage of glaucoma patients with both a visual field examination and SCODI study within 90 days was 37 percent from July 1, 2014, to June 30, 2015. The average by state during the same time period ranged from as low as 26 percent to as high as 65 percent
.
There is no national policy prohibiting the use of these two services within 90 days. However, doctors of optometry should be aware that there are certain Medicare contractors who have policies that speak directly to this issue.

- First Coast Service Options Inc. has a local coverage determination that indicates that with regard to glaucoma patients, "Patients with 'moderate damage' may be followed with scanning computerized ophthalmic diagnostic imaging and/or visual fields. One or two tests of either per year may be appropriate. If both scanning computerized ophthalmic diagnostic imaging and visual field tests are used, only one of each test would be considered medically necessary, as these tests provide duplicative information."

- CGS Administrators LLC, the Medicare contractor for Ohio, has a policy which indicates: In patients with moderate glaucomatous damage, alternating the use of SCODI and visual field tests within correct time intervals will be considered appropriate, and may increase the sensitivity of detecting glaucomatous damage. Performance of SCODI and visual field tests on the same day, or separated by a short period of time (within three months) is usually not considered medically necessary. However, there may be instances in which each test is needed to determine the patient's status and thus, treatment. The contractor expects use of both tests on the same day or during short intervals will be the exception rather than the rule.

  There are also non-Medicare payers who have specific policies regarding the performance of visual fields and SCODI.

- Health Net Inc. indicates that the health plan considers scanning computerized ophthalmic diagnostic imaging not medically necessary for patients with advanced glaucoma. The plan's policy indicates that for these patients, visual field is the preferred method of evaluation.

Many doctors of optometry see a benefit in providing SCODI and visual fields testing within three months of each other based on the patient's glaucoma status. As with all services billed, doctors should be aware of any payer reimbursement policies and be certain that clinical documentation fully supports the provision of any procedures or tests reported. I could find no active LCD that addresses time restrictions for Visual Field or SCODI LCDs.

Do you routinely perform both visual fields and SCODI within a 90 day time period? If so, your billing patterns could possibly flag you for future interest by CMS. Be sure your medical records document the need for such frequency.

Join Noridian Medicare E-mail lists

Be the first to receive Medicare news and information! Benefits of becoming a subscriber include having the following information delivered to you every Tuesday and Friday:

- Latest news and information from Noridian and CMS
- Up-to-date Medicare regulations
- Workshop and educational event notices
- Medical policy updates
- Payment and reimbursement updates
- Noridian hours of availability and related notifications

You can sign up for these emails at
https://naslists.noridian.com/list/subscribe.html?mContainer=2&mOwner=G30392x2n39372t36

Noridian Medicare Claim Denials

Have you received a Medicare claim denial for a claim that you have always submitted in the exact way the one denied was prepared and sent? The reason could be that the Medicare Carrier, Noridian Medicare has become strict on how claims are submitted and all required information must be present and accurate. The Noridian Medicare website has claim form completion instructions on their website under Education and Outreach, slide the cursor down to Event Materials and Tutorials and click on that. Next scroll down to Claim Submission and to the right you will find the CMS -1500 Claim form tutorial and CMS- 1500 claim form instructions. Or click on
https://med.noridianmedicare.com/web/jfb/education/event-materials

You also might want to check the Fees and News Section of the Part B website for Claims processing alerts to see if Noridian has had a problem with processing certain claims correctly. At times there have been errors in their claim denials. Make sure you always check your Medicare payments to know if they were processed correctly. They do make errors in processing claims.

Medicare questions? Contact Lana Jones, WOA Medicare consultant at 402-474-5717. Or email at ljones2@neb.rr.com. I am here to help you! Thank you for the opportunity to serve you!