Medicare Eye Q

A Membership Service of the
Wyoming Optometric Association
By
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NEW! EHR Attestation by March 13th

CMS is extending the submission deadline for 2016 Quality Reporting Document Architecture (QRDA) data submission for the EHR reporting mechanism. Individual eligible professionals (EPs), PQRS group practices, qualified clinical data registries (QCDRs), and qualified EHR data submission vendors (DSVs) now have until March 13, 2017 to submit 2016 EHR data via QRDA. The original submission deadline was February 28, 2017.

The Centers for Medicare & Medicaid Services Registration and Attestation System is now open. Providers participating in the Medicare EHR Incentive Program must attest to the 2016 program requirements by MARCH 13 in order to avoid a 2018 payment adjustment. The EHR reporting period was any continuous 90 days between January 1 and December 31, 2016. If you are eligible to participate in both the Medicare and Medicaid EHR Incentive Programs, you MUST demonstrate meaningful use to avoid the Medicare payment adjustment. You may demonstrate meaningful use under either Medicare or Medicaid.

Reminder: Remember to visit the registration tab in the Registration and Attestation System to ensure your personal information is accurate. For more information on registration, visit the Registration & Attestation page of the EHR Incentive Programs website.

Payment Adjustments and Hardship Exceptions

In January 2018, CMS will begin to apply payment adjustments for providers that did not successfully demonstrate meaningful use of EHR technology or apply for and receive a hardship exception for the 2016 program year. CMS will send a separate announcement with more information on the hardship exception application process, once available.

Attestation Resources

Eligible Professional (EP) Attestation Worksheets
EP Attestation User Guides
EP Registration User Guides
Attestation Batch Upload Webpage

For More Information

For questions about the Registration and Attestation System, contact the EHR Information Center at 1-888-734-6433 (press option 1). The EHR Information Center is open Monday through Friday from 6:30 a.m. to

5:30 p.m. ET, except federal holidays.

Find more information regarding Meaningful Use requirements and attestation at AOA's Meaningful Use Webpage and CMS' Registration & Attestation Webpage. Need more information? Contact Jensen Jose at jjose@aoa.org

NEW! HCC CODING TO A VOID MIPS PENALTY

A NEW CODING WRINKLE TO INSURE CORRECT MIPS CREDIT FOR "VALUE"

Hierarchical Condition Category (HCC) coding is a method used by CMS to compare the cost of your patient care to the cost of care provided by other ODs. HCC coding enables more accurate comparisons between providers treating patients with varying clinical complexity. **The results of HCC coding will affect your MIPS score and Medicare reimbursement in the future.**

How does this affect your coding? **At least once a year you should code all of a patient's eye related diagnoses, at their most specific level, even if that visit points to only one of those diagnoses.**

Hierarchical Condition Category (HCC) coding is a CMS risk adjustment payment model that identifies patients with serious or chronic illness, and assigns them a risk factor score based upon their ICD –10 diagnoses. There are more than 9000 ICD-10 codes that map to 79 HCC codes in the Risk Adjustment model, including **diabetes and macular degeneration.**

The goal of risk adjustment is to enable more accurate comparisons across TINs that treat beneficiaries of varying clinical complexity, by removing differences in health risk factors that impact measured outcomes but are not under the TIN's control.

In the absence of risk adjustment, TINs treating many beneficiaries with multiple chronic conditions, for example, could perform worse on certain quality and cost measures than TINs with relatively healthy beneficiaries due, at least in part, to differences in their beneficiary populations. Risk adjustment facilitates more accurate comparisons by accounting for differences in the clinical complexity of beneficiaries across TINs.

To assure that the patient continues to have any chronic/severe diagnoses, HCC coding requires the OD to code all of the patient's specific eye related diagnoses at least once a year, even if the visit points to only one of those diagnoses. And documentation is required to support the diagnosis, assessment, and plan.
Source

Attesting to Objective 8 Measures: Health Information Exchange

I get this question often: Does the 2015 and 2016 patient access to electronic records measure (objective 8) require a practice to have 50% of patients actually log on to the portal or does just one patient have to do that? The 2016 guide on this measure is confusing to most.

I believe the requirements can be deciphered by concentrating on the underlined phases below.

- There needs to be access for at least 50% of patients, and
- at least one patient needs to have used that access.

Please see below.

Objective: **Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.**

Note: EPs must satisfy both measures in order to meet the objective.

Measure 1: More than 50 percent of all unique patients seen by the EP during the EHR reporting period **are provided timely access to view online**, download, and transmit to a third party their health information subject to the EP's discretion to withhold certain information.

Exclusion for Measure 1: Any EP who neither orders nor creates any of the information listed for inclusion as part of the measures except for "Patient Name" and "Provider's name and office contact infomation."

Measure 2: **At least one patient** seen by the EP during the EHR reporting period (or patient Authorized representative) **views, downloads, or transmits** his or her health information to a third party during the EHR reporting period.

Exclusion 1 (for Measure 2): Any EP who neither orders nor creates any of the information listed for inclusion as part of the measures except for "Patient Name" and "Provider's name and office contact information," or

Exclusion 2 (for Measure 2): Any EP who conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.

I hope the above helps understand the measure a bit more.

AOA Webinars Give Doctors an Edge on 2017

2016 has drawn to a close, and the AOA would like to help doctors best prepare for 2017. AOA invites doctors to review the following webinars that cover important Medicare program changes, information on AOA's Qualified Clinical Data Registry, AOA MORE (Measures and Outcomes Registry for Eyecare), and important coding updates.

Doctors can access pertinent AOA webinars, including:

- Medicare Merit-Based Incentive Payment System (MIPS).This webinar provides information regarding the new Medicare payment program that begins in 2017. For more information on MIPS, review the AOA's MIPS Roadmap to Success.

- AOA MORE. This webinar provides information regarding the purpose of registries, how AOA MORE operates and information on the use of AOA MORE to meet Medicare program requirements.

- 2017 ICD-10 Code Changes. This webinar provides information on the diagnosis code changes that went into effect on Oct. 1, 2016.

- ICD-10 Ten Part Series. This webinar series provides information on the ICD-10 codes thatfirst went into effect on Oct. 1, 2015.

If you have suggestions for additional educational materials that would be helpful to your practice, please contact Kara Webb at kcwebb@aoa.org

This has been updated! **2017 MIPS Reporting for ODs**

The size of your payment adjustment will depend both on how much data you submit and your quality result

This table has been revised based on CMS updates	**TEST ONLY REPORTING** If you submit a minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity on one patient), you can avoid the 2019 downward payment adjustment	**PARTIAL REPORTING** If you submit 90 days of 2017 data you may earn a neutral or small positive payment adjustment	**FULL REPORTING** If you submit a full year of 2017 quality data, plus 90 days of both Improvement Activities and Advancing Care Information, you may earn a moderate positive payment adjustment.
	REPORT USING:EHR* OR AOA MORE Registry** OR Individually report Claims-based Quality Measures as done with PQRS in 2016	**REPORT USING EHR* OR AOA MORE** Registry** (Can use Claims-based reporting for the Quality portion of reporting only)	**REPORT USING: EHR* O AOA MORE** Registry** (Can use Claims-based reporting for the Quality portion of reporting only)
QUALITY 60% of score in 2017	**REPORT ONE of THESE** One **Quality Measure**, reported on just one patient via claims or EHR prevents a negative adjustment. OR Attest to one Improvement Activity on one patient prevents a negative adjustment.	**MUST REPORT, for 90 days**, at least six quality measures on 50% of all patients using EHR, or on 50% of Medicare patients using Claims-based reporting. Include one outcome measure, or one high-priority measure if outcome measure is not available to you. Choose measures with a minimum of 20 patients to report per measure. Reporting more measures improves score.	**MUST REPORT, for the year**, at least six quality measures on 50% of all patients using EHR, or on 50% of Medicare patients using Claims-based reporting. Include one outcome measure, or one high-priority measure if outcome measure is not available to you. Choose measures with a minimum of 20 patients to report per measure. Reporting more measures improves score.
ADVANCING CARE INFORMATION 25% of score in 2017		**MUST REPORT** Fulfill the required measures for a minimum of 90 days: Base score: • Security Risk Analysis • e-Prescribing • Provide Patient Access • Send Summary of Care • Request/Accept Summary of Care Performance score (added to base score) • Choose to submit up to 9 measures for a minimum of 90 days for additional credit. List of measures available from CMS. • Performance scoring is available HERE. •Choices must be compatible with your certified EHR	**MUST REPORT** Fulfill the required measures for a minimum of 90 days: Base score: • Security Risk Analysis • e-Prescribing • Provide Patient Access • Send Summary of Care • Request/Accept Summary of Care Performance score (added to base score) • Choose to submit up to 9 measures for a minimum of 90 days for additional credit. List of measures available from CMS. • Performance scoring is available HERE . • Choices must be compatible with your certified EHR
IMPROVEMENT ACTIVITIES 15% of score 2017		**MUST REPORT** Unless you are part of a group of 16 or more, you simply attest that you completed up to 2 activities for a minimum of 90 days. Chose activities compatible with your EHR from this CMS website . Large groups have more stringent requirements.	**MUST REPORT** Unless you are part of a group of 16 or more, you simply attest that you completed up to 2 activities for a minimum of 90 days. Chose activities compatible with your EHR from this CMS website . Large groups have more stringent requirements.
COST/Value Of your care compared to other ODs (see HCC article in this issue.) 0% of score 2017	No Action Required. Computed by CMS. See the article on HCC article In this issue	No Action Required. Computed by CMS. Seethe article on HCC in this article	No Action Required. Computed by CMS. See the article on HCC coding in this issue.

* **Your must report measures compatible with your certified EHR technology. Ask you vendor which measures your software is designed to report, and ask how you must configure your software to report correctly on every appropriate patient.**

** **Your EHR software must be compatible with AOA's registry MORE, and you must have** enrolled with AOA's MORE**. Check with the AOA and your EHR** vendor.

*** **Examples of Quality measures for ODs**. High Priority measures: DM letter to PCP; Document meds; Close referral loop. **Outcomes Measure: POAG 15%** reduction in IOP; **Other measures: DM eye exam; DM retinopathy; POAG; AMD exam; AREDS counseling; BMI measure; BP screening; Tobacco screening**

**** **Check with your vendor as to which certified EHR technology is used by your system.**

GW Modifier Reminder

On occasion an optometrist will provide services to a patient in hospice care. **Don't forget to add the GW modifier on the codes for the services provided that are NOT related to the terminal conditions for which the patient is receiving hospice.**

From the CMS manual: "*Any covered Medicare services not related to the treatment of the terminal conditions for which hospice care was elected and which are furnished during a hospice election period may be billed by the rendering provider using professional or institutional claims for non-hospice Medicare payment. On professional claims, these services are coded with the GW modifier "Service not related to the hospice patient's terminal condition."*

Claim Re-openings Webinar - March 28, 2017

The Noridian Provider Outreach and Education (POE) staff is hosting a Re-openings webinar on March 28, 2017 at 2 p.m. Central Time. This presentation will review covers an overview of the re-openings process, types of claim errors that can be reopened and which need to be submitted as a redetermination, instruction on the various ways a reopening can be completed and helpful resources.

To sign up for this webinar or other webinars of interest, visit the Noridian Schedule of Events.

Revalidation Enrollment on Demand Tutorials

February 28, 2017 is the next Due Date for Cycle 2 Revalidation. When revalidation applications are late, Noridian places a "Pend Status" on the account, meaning payments are held. Failure to revalidate leads to deactivation and a lapse in coverage.

- **Finding Revalidation Due Dates:** Use these Revalidation Tools to find out if a Revalidation application is needed
- **Revalidate Electronically:** Internet-based PECOS is the most efficient way to submit a revalidation application. Providers are able to see the current enrollment information listed in PECOS and are able to easily update the information.
- **Tutorials Showing Revalidation Steps:** Enrollment on Demand Tutorials (EoD) offer step-by-step instructions on submitting revalidation applications using either PECOS or paper forms.

View the Revalidation webpage for additional resources regarding Cycle 2 Revalidation.

For Medicare billing, coding, policy questions, contact Lana Jones, WOA Medicare Consultant

402-474-5717, ljones2@neb.rr.com It is always a pleasure to assist the WOA members!