Important information for AIR OPTIX® NIGHT & DAY® AQUA contact lenses:

Indicated for vision correction for daily wear (worn only while awake) or extended wear (worn while awake and asleep) for up to 30 nights.

Relevant Warnings:
A corneal ulcer may develop rapidly and cause eye pain, redness or blurry vision as it progresses. If left untreated, a scar, and in rare cases loss of vision, may result. The risk of serious problems is greater for extended wear vs. daily wear and smoking increases this risk. A one-year post-market study found 0.18% (18 out of 10,000) of wearers developed a severe corneal infection, with 0.04% (4 out of 10,000) of wearers experiencing a permanent reduction in vision by two or more rows of letters on an eye chart. Relevant Precautions: Not everyone can wear for 30 nights. Approximately 80% of wearers can wear the lenses for extended wear. About two-thirds of wearers achieve the full 30 nights continuous wear. Side Effects: In clinical trials, approximately 3-5% of wearers experience at least one episode of infiltrative keratitis, a localized inflammation of the cornea which may be accompanied by mild to severe pain and may require the use of antibiotic eye drops for up to one week. Other less serious side effects were conjunctivitis, lid irritation or lens discomfort including dryness, mild burning or stinging. Contraindications: Contact lenses should not be worn if you have: eye infection or inflammation (redness and/or swelling); eye disease, injury or dryness that interferes with contact lens wear; systemic disease that may be affected by or impact lens wear; certain allergic conditions or using certain medications (ex. some eye medications).

Additional Information:
Lenses should be replaced every month. If removed before then, lenses should be cleaned and disinfected before wearing again. Always follow the eye care professional’s recommended lens wear, care and replacement schedule. Consult package insert for complete information, available without charge by calling (800) 241-5999 or go to myalcon.com.


See product instructions for complete wear, care, and safety information.

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Learn more about the lens approved for up to 30 nights of continuous wear at myalcon.com
It’s not always this obvious

47% of lens sleepers aren’t telling you how often they sleep in their lenses

Talk to your patients about AIR OPTIX® NIGHT & DAY® AQUA contact lenses.

- FDA-approved for up to 30 days and nights of continuous wear
- #1 eye care practitioner-recommended lens for sleepers

AIR OPTIX® NIGHT & DAY® AQUA Contact Lenses

Learn more about the lens approved for up to 30 nights of continuous wear at myalcon.com

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1. In a survey of 284 daily and extended wear contact lens patients. Alcon data on file, 2012.
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Your Health Care Reform Resource

Optometry poised for health care’s new era

The American health care system is in an historic period of change. New Year’s Day 2014 will be a “red-letter date” on which major provisions of the Affordable Care Act (ACA) take effect. The health care system is also feeling the impact of many other major health care laws – such as the Medical Improvements for Physicians and Patients Act (MIPAA), Health Insurance Portability and Accountability Act (HIPAA), and Medicare Modernization Act. In addition, nongovernmental forces including economics, technology, and clinical advances are reshaping the practice of health care.

“No one in the White House, any federal or state agency, Congress, think tanks, academia, industry, or the provider community can claim to know the full impact these changes will together have,” said Roger L. Jordan, O.D., chair of the AOA Federal Relations Committee. “The only certainty is that change is upon us – and optometry is ready, thanks to important legislative, regulatory, and third party advocacy victories by the AOA Advocacy Group and ongoing AOA membership benefit programs to help optometry.”

Medicare now offers incentives up to $12,000 plus 1% in 2014

Medicare’s three incentive programs – the Medicare Electronic Health Records (EHR) Incentive Program, Medicare Physician Quality Reporting System (PQRS), and Medicare e-Prescribing (e-Rx) Incentive Program – are changing. Maximum bonuses offered for successful participation in the incentive programs are rapidly being reduced, and penalties for those who do not participate are increasing.

Medicare incentive programs could still offer optometrists the opportunity to earn $12,000 plus 1 percent of their total allowed charges during 2014, depending on when they began participating. Practitioners who do not participate in the incentive programs during 2014 could see their Medicare reimbursements reduced up to 4 percent in 2016.

EHR incentive program

The Medicare EHR Incentive Program during 2014 offers up to $12,000 for those in their first or second year of participation, up to $8,000 for those in their third year, and up to $4,000 for those in their fourth year. Optometrists who participate in the Medicare EHR Incentive Program are eligible to receive a bonus of up to $12,000 for successful participation, depending on the stage of the program in which they participate.

See Incentives, page 8

Key dates

Deadlines for the Affordable Care Act, PQRS, EHR incentive programs, ICD-10 and health plan identifiers are set in stone.

The next-generation AOA newsmagazine debuts 2014.
New pediatric vision benefit ensures brighter future for children

Pediatric eye and vision care is included in a package of “essential health care benefits” that must be covered by all insurance plans operating within new health insurance marketplaces created under the Affordable Care Act (ACA) and those sold outside these new insurance exchanges. “That is a significant legislative and regulatory victory for the AOA,” said Stephen Montaquila, O.D., chair of the AOA Third Party Center Executive Committee. “It will mean new access to comprehensive eye care services for millions of American children.”

The AOA was the only national eye health organization Congress and the U.S. Department of Health & Human Services needed when developing the new requirement, according to Dr. Montaquila. He believes the requirement, according to Dr. Montaquila, O.D., chair of the AOA Third Party Center Executive Committee. “It will mean new access to comprehensive eye care services for millions of American children.”

“comprehensive eye care services for millions of American children.”

Those efforts center around four major themes:

**Comprehensive eye exam** — The federal government requires states to define the new benefit as coverage for regular comprehensive eye exams, including all follow-up care and, in almost every case when needed, eye glasses and contact lenses. This coverage will be included in all health insurance plans sold in health insurance marketplaces, as well as most new and renewed plans sold outside of the marketplaces. Concerned parents covered by a health plan delaying a move toward this new standard can join the AOA in urging their employer and plan to make children’s eye health care a priority now.

**Coverage through at least age 18** — Consistent with the AOA’s recommendations, families may use the new coverage for children beginning in infancy and continuing through age 18. A comprehensive eye examination provided by a doctor of optometry, unlike a vision screening, is designed to consistently identify every eye health and vision issue that can affect a child’s overall development and achievement.

**Included within the health plan** — Unlike limited stand-alone plans offered as add-ons to coverage but not required, the new optometric care essential pediatric health benefit will be included as a core benefit and embedded within the overall health plan. The approach provides the seamless primary eye health and vision care that children need.

**Direct access to optometrists** — Parents can directly access eye care for their children through their local doctor of optometry, both for comprehensive eye exams and needed treatment. When a health plan does not include the family’s favorite optometrist in their network, concerned parents can join the AOA in urging insurers to modernize their provider panel by including more optometrists.

The AOA Third Party Center encourages practicing optometrists to join in efforts to facilitate widespread public understanding of the new children’s vision benefit.

The multidisciplinary National Commission on Vision and Health (wwwVISIONANDHEALTH.ORG) produced a fact sheet covering the new optometric care essential health benefit.

For more information on the new children’s optometric care essential health benefit, visit www.AOA.ORG.

Congress eyes landmark Medicare payment reform

Landmark Medicare payment reform legislation, designed to implement a system of value-based reimbursement — and in the process eliminate the threat of massive Medicare physician fee cuts — is pending in Congress as this special edition of AOA News goes to press. Final congressional approval anticipated in during the first quarter of 2014.

“The AOA has launched a ‘massive grassroots advocacy mobilization’ to ensure the legislation preserves the status of optometrists as physicians under Medicare as well as fully recognized partners in developing and participating in physician-level initiatives such as quality measures and meaningful use,” said Mitchell T. Munson, O.D., AOA president.

Competing measures to reform Medicare payment were approved separately by the Senate Finance Committee and House Ways and Means Committee Dec. 12.

Both bills would:

- Freeze or marginally increase Medicare physician payments over the next five years.
- Implement a new Medicare Physician Quality Reporting Program, beginning in 2017, under which physicians could receive either a percentage bonus or a payment reduction based on personal performance in meeting clinical practice improvement targets.
- Eliminate the widely criticized sustainable growth rate (SGR) from the formula used to set Medicare physician reimbursement levels. The SGR has prompted Medicare to propose substantial decreases in physician reimbursement over each of the past dozen years — including a 24 percent cut slated to take effect Jan. 1, 2014.

However, the Senate Finance Committee version of the legislation, at the AOA’s urging, was specifically amended, during the recent hearing to clearly affirm that ODs will be fully eligible participants in the new quality care incentive program. Participation in the new incentive program will be critical to ensuring adequate reimbursement under Medicare, the AOA Advocacy Group notes.

The House Ways and Means Committee’s proposal, despite input from AOA, was not similarly amended. It is now moving forward, but with “flawed” provisions that could exclude optometrists from the new incentive program, according to the AOA Advocacy Group.

Similar Medicare payment reform legislation was approved by a key House committee earlier this year. At the urging of AOA, that legislation included protections for optometrists, similar to those in this month’s Senate committee bill.

The AOA Advocacy Group is calling on association members to join efforts to ensure optometrists are specifically defined as full participants in the new Medicare incentive program when the House and Senate consider final action on the reform legislation early next year.

In addition to the comprehensive Medicare payment reform bill, “pay patch” legislation is pending in Congress to spare physicians the 24 percent Medicare reimbursement currently scheduled to take effect in 2014. The AOA Advocacy Group urges practitioners to watch for updates regarding both the comprehensive reform and pay patch bills at www.AOA.ORG/news.
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The New World... of Health Care

As we bid farewell to the AOA News, a publication that has served our profession and our members for well over 50 years, I am reminded how much the world of communication has changed and how the challenge of sharing information with our members has become more complex than ever.

To that end, the AOA is excited about our plan to improve our reach to members.

Specifically, news and information will be coordinated across all of our vehicles: website, email and print with a complete redesign of the News into our fresh and contemporary newsmagazine publication: AOA Focus.

So it is with pride that we dedicate this, the final edition of AOA News, to doing what we have done better than anyone — providing the best and most reliable information about the new health care law as well as strategies to help our profession, our practices and our patients thrive and succeed.

Not since 1986, when the AOA convinced Congress and President Ronald Reagan to grant full recognition to ODs as physicians in Medicare, has our profession been so engaged in the national debate over the future of health care.

That’s why no matter how any of us feels about the Affordable Care Act, we can all be rightfully proud that — by uniting in our advocacy efforts and outworking the many powerful interests that seek to put barriers between us and our patients — the law recognizes what we do is essential and as a national health care priority.

That we are specifically entrusted in new legislation and regulation with providing our full scope of care to millions more Americans signals that whatever lies ahead in health care, our profession has a seat at the table whenever and wherever health care policy decisions are made.

All types of health care providers are facing their share of uncertainty under the new law, and optometry is no different. However, the specific gains secured by the AOA in Washington, D.C., established for us a firm foundation for optometry’s future others can only envy.

And so our efforts will continue. Our highly respected Washington office staff will continue to work with members of Congress as will our mem-

Not since 1986, when the AOA convened Congress and President Ronald Reagan to grant full recognition to ODs as physicians in Medicare, has our profession been so engaged in the national debate over the future of health care.

Sincerely,

Mitchell T. Munson, O.D.,
AOA president

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The U.S. Department of Health & Human Services (HHS) announced several changes to its Stage 1 Electronic Health Records (EHR) Meaningful Use program for 2014. Participants should prepare for software and other recording procedure updates, according to David Jaco, O.D., AOAExcel™ EHR consultant.

**Software update**

The HHS now requires all EHR systems to meet both Stage 1 and Stage 2 meaningful use requirements in order to be certified for use in government incentive programs. All health care practitioners attempting to meet Stage 1 meaningful use criteria must have EHR systems meeting Stage 2 criteria. Practitioners who already have EHR systems should check with vendors to determine when system updates will be available, Dr. Jaco said.

**Online health information**

Stage 1 meaningful use objectives now require participants to provide patients timely access to their health information online. Until now, Stage 1 practitioners were allowed to use CDs or similar media to meet meaningful use requirements for providing health care information electronically.

Stage 2-certified EHR systems will provide functionality to make patient information available securely online. However, practitioners must learn how to use it and make patients aware of the feature.

**Vital signs**

Beginning in 2014, Stage 1 meaningful use participants are required to record in their EHRs:
- Blood pressure for patients age 3 and older
- Height and weight for all patients.

Recording such data was optional in 2013. Practitioners may be granted an exclusion from recording height and weight, blood pressure, or all three of those vital signs if they feel those statistics are not relevant to their practice. Practitioners who see only patients 3 years and younger can be excluded from recording blood pressure. However, from a “menu.” However, practitioners will now only be allowed to count “exclusions” in that total when they cannot find a total of five menu objectives relevant to their practices. Optometrists, in most cases, should find five menu objectives relevant to their practices, Dr. Jaco noted.

**Clinical quality measures**

Beginning in 2014, all providers regardless of their stage of meaningful use will report on clinical quality measures (CQMs) using the same set of ambulatory clinical quality measures. For additional information, including the complete list of updated Stage 1 core and menu meaningful use objectives, visit www.excelod.com/ehr.
Medicare EHR incentive program enters Stage 2

The U.S. Department of Health & Human Services (HHS) electronic health records (EHRs) incentive program officially enters Stage 2 in 2014.

Health care practitioners who have participated in the Medicare or Medicaid EHR incentive program for more than a year will now have to meet the department’s Stage 2 meaningful use standards in order to continue earning payment bonuses.

Stage 2 EHR meaningful use centers largely around using EHR “interconnectivity” functions that allow health care practitioners to exchange health information as well as electronically provide health care information to patients.

To meet Stage 2 meaningful use standards, practitioners must also use features such as computerized physician order entry (CPOE), patient follow-ups and answer patient questions electronically.

Online clinical decision support, adverse drug interaction warnings for specified numbers or percentages of patients, and e-prescribing.

They must provide patients with access to their health information on demand through secure practice websites and email, as well as conduct patient follow-ups and answer patient questions electronically.

EHR systems certified for use in federal incentive programs must provide all functions required for meaningful use.

During 2014 only, practitioners beyond their first year of demonstrating meaningful use will have a three-month reporting period.

For additional information on the Medicare EHR Incentive program, visit www.cms.gov/EHRIncentivePrograms or www.aoa.org/EHR.

Practitioners can attest 2013 EHR MU compliance until Feb. 28

Optometrists participating in the Medicare Electronic Health Record (EHR) Incentive Program can still receive incentive payments for compliance for 2013 by filing attestations by Feb. 28, 2014.

The reporting year ends Dec. 31, 2013, for eligible health care professionals (EIs) who participated in the Medicare EHR Incentive Program during 2013. That means practitioners must have completed their 90-day reporting period by the end of 2013 in order to qualify for payments. However, they have until Feb. 28, 2014, to actually register and attest to meeting meaningful use standards to receive an incentive payment for calendar year 2013 through the Medicare & Medicaid EHR Incentive Program Registration and Attestation System (https://ehrincentives.cms.gov/hitech/login.action).

Determining total allowed charges

Feb. 28 is also the submission deadline for calendar year 2013 Medicare claims used under the Medicare EHR Incentive Program to determine a program participant’s Medicare total allowed charges for the year – and the participant’s EHR incentive payment.

Medicare EHR incentive payments to are based on 33 percent of the Part B allowed charges for covered professional services furnished by a practitioner during the entire payment year, up to a cap of $24,000.

The U.S. Centers for Medicare & Medicaid Services (CMS) will allow 60 days after the end of 2013 – or until the last day of February – for all pending claims to be processed.

Health care practitioners could qualify for up to $8,000 in Medicare EHR incentives during 2013 if they reached the total Medicare allowable charges cap of $24,000.

Medicare EHR incentive payments for 2013 are expected to be issued no later than April 2014.

Medicaid EHR incentives will be paid by state Medicaid agencies, and the timing of payments will vary by state. Practitioners should contact their state Medicaid Agencies for more details about payment.

Optometrists can now participate in Medicaid EHR incentive programs in eight states thanks to AOA and affiliate advocacy.

For additional information on the Medicare EHR Incentive program, visit www.cms.gov/EHRIncentivePrograms or www.aoa.org/EHR.

During 2014 only, practitioners beyond their first year of demonstrating meaningful use will have a three-month reporting period. The HHS generally requires practitioners to report compliance for an entire calendar year to qualify for EHR incentive payments. The change is intended to allow practitioners up to an additional nine months to upgrade EHR systems to Stage 2 standards.

Most EHR vendors either have Stage 2 updates ready or “core” and “menu” objectives. Practitioners must achieve all core objectives to earn incentive bonuses. The HHS incentive programs have a three-stage EHR implementation process.

Stage 1 sets the basic functionalities EHRs must include such as capturing data electronically and providing patients with electronic copies of health information.

Stage 2 increases health information exchange between providers and promotes patient engagement by giving patients secure online access to their health information.

Stage 3 will continue to expand meaningful use objectives to improve health care outcomes. The agency has not yet indicated when it might release rules for the third stage of the program.

A fact sheet on CMS final rule is available at http://tinyurl.com/Stage2factsheet. More information on the Stage 2 rule can be found at www.cms.gov/EHRIncentivePrograms.

News updates

The News page of the AOA website and a new email service will feature updates on issues relevant to optometry. AOA Focus, the new AOA newsmagazine, will feature in-depth coverage on changes in the health care system beginning in February. AOAnewstips@aoa.org
metric practices understand and prepare for a changing health care system.”

Four unprecedented eye and vision care provisions are included in the ACA reforms:
- Recognizing in law children’s vision as an essential benefit in health plans
- Defining the pediatric essential vision care benefit as an annual comprehensive eye exam, with treatment and materials (a definition confirmed in the regulations of 48 states and the District of Columbia)
- Requiring the children’s optometric essential benefit be embedded in new health plan coverage rather than as an optional “stand-alone” benefit
- Barring, for the first time under federal law, discrimination against optometrists by health plans, including the self-funded, Federal Employee Retirement Income Security Act (ERISA)-regulated employer health plans.

The Children’s Vision Benefit and the Harkin Amendment prohibition on provider discrimination represent hard-won victories, addressing longstanding issues that have faced optometrists and their patients for decades,” Dr. Jordan said. “Going forward, the AOA will continue working to reinforce the value of these new provisions to policymakers while fending off increasing attacks on these wins by anti-optometry forces.”

The children’s eye care benefit will be included in all health plans made available through the new network of health insurance exchanges (HIEs), or marketplaces, established under the ACA on Jan. 1, as well as through other health insurance plans sold outside of the exchanges. The Harkin Amendment will apply to all nearly all public and private health insurance plans.

The AOA’s success in establishing pediatric eye care as an essential benefit under the ACA benefit package is especially clear when contrasted with the pediatric oral care benefit included in the package, Dr. Jordan contends. Originally marked as essential, pediatric dental care is now optional. A special-interest provision separated dental care for children from comprehensive coverage and any type of subsidy.

“As a result, there is no requirement on the newly insured to purchase pediatric dental coverage, and it is now widely recognized by health policy experts as the ‘lost’ essential benefit,” said Dr. Jordan.

Beyond ACA

The ACA will be just one source of opportunity for optometrists and challenges during 2014.

Private-sector health plans are developing alternative health care reimbursement systems, such as “pay for performance” programs, and new coordinated care service models, such as the medical home. Accountable care organizations (ACOs) do both, combining alternative payment methodologies with coordinated care.


Among the major trends optometrists will likely see emerging in 2014 are:
- Payment reform – Public and private health plans are expected to transition from traditional fee-for-service payment to consumer-directed reimbursement systems.
- Collaborative care – Medicare is fostering a nationwide system of ACOs to help patients receive high-quality outcomes in a cost-effective manner. Private, state and local health plans are establishing medical homes.
- Interconnectivity – Both collaborative care and reform systems will require electronic patient recordkeeping with secure interconnectivity.
- Patient involvement – While government plans are on hold for all Americans to have personal health records, patients increasingly will have direct access to their health information through other means (including practitioner websites).
- New legislative, regulatory, economic, technological and clinical developments are expected to further change the health care system over the coming year.

The AOA will continue working to reinforce the value of these new provisions to policymakers while fending off increasing attacks on these wins by anti-optometry forces.

New era, from page 1

The AOA will continue working to reinforce the value of these new provisions to policymakers while fending off increasing attacks on these wins by anti-optometry forces.
ODs may earn 0.5 percent maintenance of certification bonus

Medicare’s Physician Quality Reporting System (PQRS) will continue to offer a 0.5 percent maintenance of certification (MOC) bonus during 2014. This applies to optometrists maintaining certification through the American Board of Optometry (ABO).

Under the program, practitioners who satisfactorily report PQRS quality measures over a 12-month period and earn a PQRS bonus can earn an additional half-percent incentive payment when they exceed minimum participation levels for a maintenance of certification and practice assessment program recognized by the U.S. Centers for Medicare & Medicaid Services (CMS).

Optometry remains one of only a dozen health care disciplines that can earn Medicare PQRS certification bonuses.

To earn certification, practitioners must document ongoing efforts after graduating from optometry school to update their knowledge and professional skill.

To earn the Medicare bonus, practitioners must then maintain that certification through a recognized MOC program.

The CMS began offering MOC bonuses for Medicare practitioners under the PQRS program in 2011.

Some value-based third party reimbursement programs have proposed board certification as a requirement, along with some emerging care coordination systems such as accountable care organizations (ACOs) and patient-centered medical homes (PCMH).

The ABO was the first and remains the only entity to offer CMS-recognized maintenance of certification program for optometrists.

For additional information on the ABO, visit www.americanboardofoptometry.org.

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**2014 Medicare incentive programs at a glance**

The Medicare Physician Quality Reporting System (PQRS), formerly known as the Physician Quality Reporting Initiative (PQRI), in 2014 will offer a 0.5 percent bonus for practitioners who report performing specified quality measures. Health care practitioners who do not participate in the PQRS program in 2014 will see Medicare payments reduced 2 percent in 2016. Practitioners must report PQRS quality measures for specified percentages of applicable patients to earn bonuses.

The Medicare PQRS Maintenance of Certification (MOC) offers an additional 0.5 percent bonus for practitioners who successfully participate in the PQRS program over a 12-month period as well as participate in a qualified maintenance of certification program such as the American Board of Optometry (ABO) certification initiative. To qualify for incentive payments, practitioners must exceed the minimum participation levels for the certification program. For additional information, visit www.americanboardofoptometry.org.

The Medicare ePrescribing Incentive Program no longer offers bonuses, and optometrists are exempt from penalties imposed under the program on health care practitioners. For additional information, visit www.aoa.org/documents/E prescribingFactSheet.pdf.

The Medicare EHR Incentive Program in 2014 will offer bonuses of up to $4,000 for both new and continuing participants. That means practitioners who entered the program early (2011 or 2012) could still be on track to earn a total of $44,000 ($48,000 in federally designated health profession shortage areas) over the life of the incentive program. Practitioners who enter the program next year could still earn a total of $6,000.

For additional information, visit www.aoa.org/EHR.

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**MEDICARE INCENTIVE PROGRAMS**

Applicable to optometrists during performance year 2014

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- Bonuses based on percentage of allowed charges for 2014
- Penalties assessed as reduction in payments during 2016
New federal law bans provider discrimination

Harkin amendment means greater access to care Jan. 1

The Harkin Amendment, a first-of-its-kind federal law prohibiting discrimination against health care providers by insurance plans, could mean new access to eye care for thousands of Americans when it takes effect Jan. 1, 2014, according to the AOA Third Party Center.

However, the landmark federal health care access provision is not yet well understood by either insurance plan administrators or the general public, warns Stephen Montaquila, O.D., chair of the AOA Third Party Executive Committee.

Federal enforcement of the new law is expected to be lax.

Through its “rethink eyecare” campaign, the AOA Third Party Center is working to inform health plan executives of the new provider nondiscrimination law and the benefits of using optometrists as providers of medical eye care.

The AOA Third Party Center encourages optometrists to review the Harkin amendment and conduct outreach efforts to local health insurers using materials and an action plan available at www.rethinkeyecare.com.

Sponsored by Sen. Tom Harkin (D-Iowa) and enacted as part of the federal Affordable Care Act, the Harkin amendment specifies any insurer offering group or individual coverage “shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider’s license or certification under applicable state law.”

Similar in many respects to the provider nondiscrimination laws already enacted in many states, the Harkin amendment will effectively prevent private health care plans from banning optometrists from their medical eye care provider panels. That includes employer-based health insurance programs regulated under the federal Employee Retirement Income Security Act (ERISA), which have commonly refused to cover eye care services provided by optometrists, reasoning that their plans are exempt from state regulation.

Medicare and other federally sponsored health insurance programs are already prohibited from discriminating against entire classes of health care providers.

“The Harkin amendment represents a major legislative victory for the AOA and its state optometric associations,” said Dr. Montaquila. “The AOA’s goal was to extend the scope of the debate to the more than 70 million individuals with coverage through ERISA plans that have discriminated against optometry for 55 years. Jan. 1, 2014, is truly a red-letter day in the history of American health care and particularly in American eye care. It will effectively open access to a necessary eye exam for thousands of Americans by preventing insurance plans from restricting the providers of care.”

Federal enforcement of the new law is expected to be lax.

ODs again exempt from e-Rx penalty

The 2013 AOA Apollo Award honored Sen. Tom Harkin for distinguished service to the visual welfare of the public.

The 2013 AOA Apollo Award honored Sen. Tom Harkin for distinguished service to the visual welfare of the public.

The AOA works with the e-Rx industry to ensure all optometrists have e-Rx capabilities. Virtually all e-Rx in the United States today is accomplished through the SureScripts network, the nation’s consolidated e-prescribing system (http://surescripts.com). The network can be accessed using any electronic health record (EHR) system certified for use in the Medicare EHR Incentive Program or many stand-alone e-Rx software programs.

The CMS announced in 2011 that optometrists were among a handful of health care professionals who would qualify for e-Rx bonuses but would not be subject to e-Rx penalties.

The CMS is now in the midst of a three-year effort to encourage e-Rx by imposing payment penalties. Most non-e-prescribing practitioners were subject to payment penalties of 1 percent in 2012 and 1.5 percent in 2013, with a 2 percent penalty planned for 2014.

The CMS announced in 2011 that optometrists were among a handful of health care professionals who would qualify for e-Rx bonuses but would not be subject to e-Rx penalties.

The AOA Federal Relations Committee worries the e-Rx penalty exemption could represent a threat to optometrists’ status as physicians under Medicare. Physician status ensures optometrists equal pay with ophthalmologists for eye care services under Medicare and generally enhances optometrists’ access to patients under the government health plan.

Government incentive programs aside, e-Rx is a good way for optometrists to help maintain their place as an integral part of the nation’s health care system, the AOA Federal Relations Committee notes.

For that reason, the AOA works with the e-Rx industry to ensure all optometrists have e-Rx capabilities. Virtually all e-Rx in the United States today is accomplished through the SureScripts network, the nation’s consolidated e-prescribing system (http://surescripts.com).

The network can be accessed using any electronic health record (EHR) system certified for use in the Medicare EHR Incentive Program or many stand-alone e-Rx software programs.

Practitioners can register to get free e-Rx software at www.nationalerx.com.

Additional e-Rx resources, including an interactive Electronic Prescribing Readiness Assessment and information on software, can be found under the “e-Prescribing” tab on www.aoa.org/EHR.
New year brings changes to Medicare EHR quality measure reporting

Clinical quality measure (CQM) reporting will still be required to demonstrate meaningful use under the Medicare and Medicaid electronic health records (EHRs) incentive programs in 2014.

The Centers for Medicare & Medicaid Services (CMS) meaningful use criteria no longer lists CQM reporting as an objective because the agency now considers quality measure reporting an inherent part of meaningful EHR use.

All practitioners in both the Medicare and Medicaid programs will now report on the same set of quality measures. Those measures will apply to both Stage 1 and Stage 2 meaningful use.

Practitioners must report on nine of the government’s 64 approved CQMs for both adults and children (http://tinyurl.com/nhqD7ore).

Selected CQMs must cover at least three of the U.S. Department of Health & Human Services’ National Quality Strategy priority areas or “domains.” Beginning in 2014, all Medicare-eligible providers beyond their first year of demonstrating meaningful use must report their CQM data to the CMS electronically.

Stage 1 EHR users must still provide aggregate numerator, denominator, and exclusions through attestation to meet meaningful use criteria (or be part of the CMS’ PQRS Electronic Reporting Pilot).

For additional information, see:
- AOAExcel™ EHR (www.excelod.com/EHR)
- CMS 2014 CQM (http://tinyurl.com/b5jhaqjv)
- CMS CMQ Tip Sheet (http://tinyurl.com/aqzw6x3)

CPT adds new codes for emerging technologies, services

Recognizing growth in telemedicine and Internet consultations among health care practitioners, the American Medical Association (AMA) added four new codes for remote consultation to its Current Procedural Terminology® (CPT) code set for 2014.

The revised code set takes effect Jan. 1, 2014.

The four new electronic consultation codes are:
- 99446 – Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient’s treating/requesting physician or other qualified health care professional; five to 10 minutes of medical consultative discussion and review
- 99448 – Consultation as described above with 11 to 20 minutes of medical consultative discussion and review
- 99449 – Consultation as described above with 21 to 30 minutes of medical consultative discussion and review
- 99449 – Consultation as described above with 31 minutes or more of medical consultative discussion and review

However, the introduction of CPT codes for telemedicine services does not necessarily mean Medicare or other health insurance plans will begin covering such services.

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New Category III codes

Also added to the CPT code set for 2014 are several new Category III temporary (T) codes for emerging technologies, services, and procedures.

- New category III code 0330T for digital interferometry of the lipid layer of the tear film of the eye to detect lipid layer deficiency to aid in the diagnosis of dry eye syndrome
- 0330T – Tear film imaging, unilateral or bilateral, with interpretation and report
- 0333T – Visual evoked potential, screening of visual acuity
- 0329T – Monitoring of intraocular pressure for 24 hours or longer, unilateral or bilateral with interpretation and report

Parenteral notes regarding the above-mentioned codes have been added after:
- CPT 92285 (External ocular photography), instructing practitioners to use code 0330T to report tear film imaging.
- CPT 99330 (Visual evoked potential (VEP) testing central nervous system, checker board or flash), instructing practitioners to use 0333T to report screening of visual acuity using automated visual evoked potentials.

See CPT, page 14

Adult Recommended Core Ambulatory CQMs

- Controlling High Blood Pressure
- Use of High-Risk Medications in the Elderly
- Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- Use of Imaging Studies for Low Back Pain
- Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
- Documentation of Current Medications in the Medical Record
- Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
- Closing the Referral Loop: Receipt of Specialist Report
- Functional Status Assessment for Complex Chronic Conditions

Pediatric Recommended Core Ambulatory CQMs

- Appropriate Testing for Children with Pharyngitis
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
- Chlamydia Screening for Women
- Use of Appropriate Medications for Asthma
- Childhood Immunization Status
- Appropriate Treatment for Children with Upper Respiratory Infection (URI)
- ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication
- Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
- Children Who Have Dental Decay or Cavities

6 key health care policy domains

1. Patient and Family Engagement
2. Patient Safety
3. Care Coordination
4. Population and Public Health
5. Efficient Use of Health Care Resources
6. Clinical Processes/Effectiveness
ODs must begin using ICD-10 codes Oct. 1, 2014


Effective that date, optometrists and all other health care practitioners will be required to report all diagnoses using the ICD-10-CM coding.

While hospitals and other health care institutions will be required to use ICD-10-PCS codes to report health care procedures starting in October, health care practitioners will continue to report services with the Current Procedure Terminology (CPT) codes currently in use for several more years.

ICD-10-CM codes will be required by all public and private health insurance plans, not just federal programs such as Medicare and Medicaid.

The Oct. 1 deadline will not be further postponed, and health care providers will not be provided any grace periods, according to the U.S. Centers for Medicare & Medicaid Services (CMS).

Initially set to launch in the U.S. Oct. 1, 2013, the CMS delayed implementation of ICD-10s by a year to give health care practitioners more time to understand the pending change, determine how it will affect their practices, and decide how to implement the new code set in their offices.

The CMS also extended the deadline for implementation of HIPAA 5010 software, designed to accommodate ICD-10 codes, in 2012.

Use of the codes is technically required under federal law for electronically filed claims, but while ICD-10 codes are currently used, including: authorizations, pre-certifications, physician orders, medical records, party payers, claims filing services, and other business associates to assure a smooth transition to ICD-10.

The CMS emphasizes that while ICD-10 codes are technically required under federal law for electronically filed claims, they will be the accepted standard for paper claims as well.

Preparing for ICD-10

AOAExcel™ medical & records consultants Walt Whitley, O.D., Jason Miller, O.D., and Chuck Brownlow, O.D., offer the following tips for optometrists and paraoptometrics preparing for conversion to ICD-10.

Use AOA and CMS ICD-10 resources: The AOA offers a variety of resources to help optometric practices implement ICD-10 coding.

CMS website ICD-10 page (http://tinyurl.com/n6n3247) offers extensive information on the coding system, access to listserves and webinars, and links to providerspecific provider information.

The AOA’s Codes for Optometry 2014 includes a flashcards kind ICD-10 Coding Primer for Optometrists.

AOA’s EyeLearn™ offers a dozen ICD-10 tutorials and articles (http://tinyurl.com/ExcelICD10).

Evaluate current documentation practices: Take a look at the practice’s current records to see whether the clinical documentation is sufficient to support ICD-10 coding. The purpose of ICD-10 is to more accurately describe each patient’s condition. Practitioners should consider whether their patient history is comprehensive enough to fully describe the encounter and support findings. Practice and improve everyday documentation for each clinical condition to allow practitioners and coders enough information for ICD-10 classification.

Determine who will be affected: Evaluate all aspects of the practice where ICD-9 is currently used, including: authorizations, pre-certifications, physician orders, medical records, superbills, EHR systems, coding manuals and public health reports. For staff who will use ICD-10, establish a training timeline to allow every affected individual ample time to understand these changes while providing the necessary training.

Know your top codes: Convert the ICD-9 codes most commonly used in the practice to ICD-10 to get a feel for the new coding system. There are several programs, websites and services available to help navigate the new ICD-10 codes and allow a comparison to ICD-9. (Visit www.excelod.com/coding.)

Steps for practices to take

Health care practitioners should begin making plans for the implementation of the ICD-10 codes in their practices now.

The CMS recommends health care practitioners use a three-step strategy to implement ICD-10-CM coding in their practices.

1. Hold initial staff meetings on ICD-10 and provide information on the coding system immediately.

2. Take formal resource courses on the ICD-10 and provide such course for their office staffs roughly six to nine months prior to the implementation deadline.

3. Practice using ICD-10 codes daily in the office prior to the implementation date (beginning in April). Electronic health records (EHR) systems can assist in the proper selection of ICD-10-CM codes. Genera l equivalents for ICD-9 codes, are available through the agency.

Ultimately, however, health care practitioners and key staff will have to personally be proficient in use of the ICD-10 system to file claims.

While the Department of Health & Human Services (HHS) has required practices to have HIPAA 1500 compliant software since early 2012, practitioners should continue to test the software for application in filing claims with ICD-10 codes.

Practitioners should also continue to work with third-party payers, claims filing services, and other business associates to assure a smooth transition to ICD-10.

How is ICD-10 different?

The ICD-10 CM code set, with some 69,000 codes, is much larger than the ICD-9 CM currently in use – which has 14,300 – and provides for more anatomically specific and detailed reporting of conditions as well as new diagnoses not covered under the older coding set.

The new ICD-10 codes also will be somewhat longer and more complex.

ICD-10-CM diagnosis codes will be three to seven characters in length, with the first character a letter of the alphabet, the second a number, and digits three through seven either letters (not case sensitive) or numbers with a decimal point after the third digit.

The larger ICD-10-CM coding system allows the practitioner to use combination codes for certain conditions and common associated symptoms and manifestations. (For example: E11.341 – Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema.)

It also allows practitioners to report laterality (left, right, bilateral). (For example: H16.013 – Central corneal ulcer, bilateral.)

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The CMS emphasizes that while ICD-10 codes are technically required under federal law for electronically filed claims, they will be the accepted standard for paper claims as well.
ODs should begin using newly released code for pupillometry

For the first time, the American Medicare Association (AMA) released a Current Procedural Terminology (CPT) code for pupillometry: 0341T – Quantitative pupillometry with interpretation and report, unilateral or bilateral.

Eye care practitioners can begin using the new Category III temporary CPT code to report the procedure on insurance claims beginning Jan. 1, 2014.

Once considered esoteric, pupillometry – the measurement of pupil size – is being used more widely in eye care practices for assessment of laser refractive correction patients.

Recent studies demonstrate the relationship between pupil responses and early signs of Parkinson’s, Alzheimer’s, autism, cardiovascular disease and other systemic rheumatologies.

Although pupillometry is not now covered by most medical or vision insurance plans, reporting the procedure on claims with the new temporary code will be an important step in eventually securing third-party reimbursement for the procedure, according to Doug Morrow, O.D., of the AOA Third Party Center Executive Committee.

Optometrists and billing staff should note that while the new temporary code does not appear in the AMA’s official CPT code book for 2014, it is valid and accepted for use in reporting on insurance claims as of Jan. 1, 2014.

The AMA generally issues Category III temporary CPT codes, designated with a “T,” as the first step in the development of a permanent code for a new health care procedure.

Data collected through reporting of the procedure on claims with the temporary code will be used to determine if a permanent code should be developed.

The AOA Third Party Center encourages all optometrists to report pupillometry by using the new 0341T code on claims.

Pre-order 2014 coding books through the AOA Marketplace at 800-262-2210.

Recent studies demonstrate the relationship between pupil responses and early signs of Parkinson’s, Alzheimer’s, autism, cardiovascular disease and other systemic rheumatologies.

Medicare to accept revised CMS 1500 claim form starting in January

The U.S. Centers for Medicare & Medicaid Services (CMS) revised the CMS-1500 Claim Form is to more adequately support the use of the ICD-10 diagnosis code set. The revised form, identified as version 02/12, will replace the current form, known as version 08/05.

Medicare will begin accepting the revised form Jan. 6, 2014. Starting April 1, 2014, Medicare will accept only the revised version of the form.

The revised form will give providers the ability to indicate whether they are using ICD-9 or ICD-10 diagnosis codes. This is important for the scheduled Oct. 1, 2014, ICD transition.

ICD-9 codes must be used for services provided before Oct. 1, 2014, while ICD-10 codes should be used for services provided on or after Oct. 1, 2014. The revised form also allows for additional diagnosis codes, expanding from four possible codes to 12.

Only providers who qualify for exemptions from electronic submission may submit the paper CMS-1500 Claim Form to Medicare. The CMS encourages providers who use service vendors to determine when they will switch to the new form.

For additional information, visit http://tinyurl.com/6vxcn6w.

PREORDER NEW 2014 ICD-9 Coding Books NOW WITH A SPECIAL ICD-10 Primer!

The two-books included are:
1) The AMA 2014 CPT Standard Edition
2) The 2014 ICD-9 Codes for Optometry Book featuring a new section which demonstrates the ICD-10 conversion process, using the calculators that will be available before October 1, 2014.

Pre-order the two books: ODE13 - $155 for Members

Call 800-262-2210 Today!
The AOA Third Party Center’s new online Accountable Care Organization (ACO) Resource Toolkit provides convenient access to a complete range of resources optometrists can use to develop a thorough understanding of ACOs, identify and approach ACO networks and provide a full scope of optometric eye and vision care to ACO patients.

When health care historians look back on the year 2014, it may well be remembered as the year coordinated care had its first growth spurt. Medicare quickly moved to care had its first growth spurt.

The CMS is attempting to encourage the development of ACOs for Medicare through three initiatives:

- The Medicare Shared Savings Program (MSSP) — which helps Medicare fee-for-service program providers establish ACOs and earn performance incentive bonuses.
- The Advance Payment ACO Program — a supplementary incentive program for selected participants in the MSSP.
- The Pioneer ACO Program — an early Medicare coordinated care pilot project.

In part because of those programs, the number of ACOs in the U.S. grew rapidly over recent years. Some 488 ACOs were serving patients around the nation as of July 2013 — more than double the number in operation a year earlier, according to a recent report by the CMS.

A little over half are providing care to Medicare patients through either the MSSP or Pioneer program. ACOs generally fall into one of four categories, organized by:

- Small physician groups
- Large hospitals
- Multiple hospitals/physician groups
- State agencies for Medicaid populations.

The AOA has long advocated for optometrists to be part of ACOs. Congress agreed with the AOA, and made ACOs accountable for all care covered for patients under Medicare Part A and B, including eye care. In the regulatory process, the CMS confirmed any individual or entity, including optometrists, opticians, ophthalmologists, and surgery centers, may join ACOs.

While optometrists are not be required on Medicare ACO provider panels, the strong emphasis placed on providing a range of well-coordinated, accessible health care services effectively encourages utilization of optometrists, the AOA Advocacy Group notes.

The AOA has made the elimination of barriers to OD participation in accountable care organizations a top priority.

“The AOA Optometrists’ Guide for ACO Participation” and the “Accountable Care Guide,” both of which are part of the AOA’s online ACO Resource Toolkit.

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Government and private sector efforts to encourage coordinated care models are expected to grow over coming years, according to Dr. Montaquila. For that reason, now would be a good time for optometrists to “get in on the ground floor” of a growing health care movement.

Tools for ACO participation

“The AOA Optometrists’ Guide for ACO Participation” is a practical implementation and execution guide for optometrists who are interested in participating in ACOs or other types of integrated health systems,” said Dr. Montaquila.

The guide outlines the basic structure and function of ACOs, the role optometrists can play, and a strategy for securing participation in the new health care networks.

The toolkit includes:

- Selected articles to provide necessary background on ACOs and other value-oriented health systems
- Direct links to the websites of major ACO-related organizations
- Direct links to major ACO industry publications and other ACO resource materials
- A complete list of existing Medicare-sanctioned ACOs (with key contact persons when available)
- Examples of “best practice” ACO models that include and properly utilize optometrists
- Video and PowerPoint presentation slides for use in presentations to ACO administrators
- Information on AOAExcel’s Ochub, now under development to provide optometrists the electronic health records (EHR) connectivity required for participation in integrated care networks, and
- Information on a new AOA Third Party Center Access and Integration Team, now being established to assist optometrists with participation in integrated health networks.

“The AOA has made the elimination of barriers to OD participation in accountable care organizations a top priority,” said Dr. Montaquila. “I urge all AOA members to review the new guide and then consider approaching and joining these emerging care systems,” Dr. Montaquila said. AOA members can access the association’s ACO Resource Toolkit, including its Optometrists’ Guide for ACO Participation, at www.aoa.org/x16106.xml (member sign in required).

For more information, contact TPC@aoa.org.
 evolved potential devices.  

- CPT 92100 [Serial tonometry (separate procedures)] with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day), instructing practitioners to use 0329T to report the monitoring of intraocular pressure for 24 hours or longer.

The AMA added a parenthetical note after CPT 68040 (Expression of conjunctival follicles), instructing practitioners to use 0207T to report automated evacuation of Meibomian glands.

The new, temporary Class III codes do not appear in the AMA’s official CPT code list for 2014, but are approved for use on claims, the AOA Third Party Center emphasizes.

Other new codes
Other CPT codes changes relevant to eye and vision care include new codes for anterior segment procedures include:

- 65778 – Placement of amniotic membrane on the ocular surface; without sutures
- 65779 – Placement of amniotic membrane on the ocular surface; single layer, sutured

The new CPT 65778, 65779 codes cannot be used in conjunction with cornea removal or destruction codes 65430, 65435, 65780.

Placement of amniotic membrane using tissue glue should be reported on claims using CPT 66999 (Unlisted procedure, anterior segment of eye).

Code changes for 2014 also include a new code for insertion of an aqueous shunt:
- 66183 – Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach.

Deleted codes
The AMA deleted several Category III temporary (T) codes used for emerging technologies, services, and procedures:

- 0124T – Conjunctival incision with posterior extracapsular placement of pharmacologic agent (does not include supply of medication);
- 0186T – Suprachoroidal delivery of pharmacologic agent (does not include supply of medication);
- 0192T – Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach.

Commonly used special ophthalmologic service codes, which may be important to proper reporting of services. Most are related to the use of Category III T codes that may be more appropriate than special ophthalmologic service codes.

For example, the new edition of the codes notes temporary code CPT 0329T (monitoring of intraocular pressure for 24 hours or longer) should be used when a monitoring device is fitted to the patient for continuous monitoring over a full day, instead of special ophthalmologic service code 92100 (Serial tonometry with multiple measurements of intraocular pressure over an extended time period).

“Proper use of CPT codes on claims has always been critical to ensuring prompt reimbursement and avoiding unnecessary claim denials or rejections,” said Dr. Morrow. “With Medicare and other third-party payers now conducting unprecedented audits programs, it has become more important than ever.”

Special ophthalmologic codes
The 2014 edition of the CPT codes includes several new parenthetical notes for commonly used special ophthalmologic service codes, which may be important to proper reporting of services. Most are related to the use of Category III T codes that may be more appropriate than special ophthalmologic service codes.

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“Proper use of CPT codes on claims has always been critical to ensuring prompt reimbursement and avoiding unnecessary claim denials or rejections,” said Dr. Morrow. “With Medicare and other third-party payers now conducting unprecedented audits programs, it has become more important than ever.”

Resources
To ensure optometrists and their billing staffs have up-to-date code sets and coding instructions, the AOA annually updates Codes for Optometry – the only comprehensive coding directory developed specifically for optometric practices. AOAExcel™ offers a variety of online resources on its Medicare Records and Coding page, including an online coding directory and advice from nationally recognized coding experts (http://tinyurl.com/ExcelODcoding).
PQRS expands reporting requirements

Earning Medicare Physician Quality Report System (PQRS) payment bonuses will require a bit more of health care practitioners in 2014. Practitioners generally will be required to report on nine quality measures — up from just three quality measures in past years. If fewer than nine PQRS measures apply to a practice, a health care practitioner can still earn a bonus by reporting on all of the PQRS measures that do apply.

To ensure successful PQRS participation, the AOA Advocacy Group recommends AOA members review detailed information at http://tinyurl.com/AOAEyeLearnPQRS.

The 2014 PQRS rules are somewhat more complex than in the past and not without their ambiguities, the AOA Washington office notes.

Practitioners who report on fewer than nine measures on Medicare claims will be subject to a Measures Applicability Validation (MAV) process, through which the U.S. Centers for Medicare & Medicaid Services (CMS) will determine whether the practitioner should have reported quality data codes for additional measures.

The reported measures must cover at least three of the federal National Quality Strategy (NQS) domains, established by the U.S. Department of Health & Human Services (HHS) (see box).

The CMS never officially indicated which PQRS quality measures are applicable to optometric practice. However, the center has identified at least 14 measures — including seven specific to eye care — that appear to be appropriate for reporting by an optometrist.

“If an optometrist reports on the seven eye care measures and selects two of the ‘extra’ measures to report, bringing the total to nine measures reported, the optometrist has the potential to earn a bonus and avoid the penalties that will be applied under the PQRS in future years,” said Rebecca Wartman, O.D., of the AOA Third Party Center Executive Committee.

Practitioners are required to report on PQRS quality measures for 50 percent of applicable patients in order to earn bonuses.

### 2014 PQRS Quality Measures applicable to optometry

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<td>12 (NQF 0086)</td>
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<td>AMD: Dilated Macular Examination</td>
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<td>Community/Population Health</td>
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MEETINGS

January

MARSHALL B. KETCHUM UNIVERSITY/SCCO
DRY EYE / EXTERNAL DISEASE
January 3, 2014
Las Vegas, NV
714/449-7495
FAX: 714/992-7855
cel@ketchum.edu
www.ketchum.edu/ce

SOUTH-WEST CONGRESS OF OPTOMETRY
January 10-12, 2014
Dury Inn Riverwalk, San Antonio, TX

PACIFIC UNIVERSITY COLLEGE OF OPTOMETRY
2014 GLAUCOMA SYMPOSIUM
January 11, 2014
Williams Lodge, Woodinville, WA
www.pacificu.edu/optometry/ce

EYECARE ASSOCIATES CONTINUING EDUCATION PROGRAM
January 11-12, 2014
Williamsburg Hotel & Conference Center, Williamsburg, VA
Linda Cavares, ECA Meeting Planner
804/356-5165

MARSHALL B. KETCHUM UNIVERSITY/SCCO
ANTERIOR & POSTERIOR SEGMENT
January 12, 2014
Marshall B. Ketchum University/SCCO, Fullerton, CA
714/449-7495
FAX: 714/992-7855
cel@ketchum.edu
www.ketchum.edu/ce

MARSHALL B. KETCHUM UNIVERSITY/SCCO
MACULAR DISEASE
January 15, 2014
Sepulveda VA, Sepulveda, CA
714/449-7495
FAX: 714/992-7855
cel@ketchum.edu

59TH ANNUAL KRASKIN INVITATIONAL SKEPPINGTON SYMPOSIUM ON VISION OPTOMETRIC EXTENSION PROGRAM FOUNDATION (CEPFI)
January 18-20, 2014
Hyatt Regency Bethesda, Bethesda, MD
Jefrey Kraskin
202/363-4450
jkraskin@cepfi.com
www.skifittingssymposium.org

TROPICAL CE
January 18-25, 2014
Costa Rica
281/900-8493
Fax: 281/274-9338

UNIVERSITY OF CALIFORNIA, BERKELEY SCHOOL OF OPTOMETRY
BERKELEY PRACTICUM - 25TH ANNUAL
January 18-20, 2014
Doubletree Hotel, Berkeley Marina, Berkeley, CA
UCBSC Continuing Education Program
Office: 510/642-5447
Fax: 510/642-0279
optics@berkeley.edu
http://optometry.berkeley.edu/cb/berkeleypracticum

PACIFIC UNIVERSITY COLLEGE OF OPTOMETRY
2014 ISLAND EYES CONFERENCE
January 18-20, 2014
Willows Lodge, Woodinville, WA
www.pacificu.edu/optometry/ce

SOS CE MEETING
SACRAMENTO VALLEY OPTOMETRIC SOCIETY
January 21, 2014
Woodlake Hotel, Sacramento, CA
Jerry Sue Hooper
jenyse@bvsc.info

MARSHALL B. KETCHUM UNIVERSITY/SCCO
DERMATOLOGY: GENERAL & NEOPLASTIC DISEASE
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February 16-23, 2014
Panama Canal CRUISE SEMINAR
February 18, 2014
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jenyse@bvsc.info

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Salem Conference Center/Grand Hotel, Salem, OR
Jeny Sue Hooper
jenyse@bvsc.info

NORTHWEST OPTOMETRIC CONGRESS
February 22-23, 2014
Pacific University College of Optometry, Forest Grove, OR
Eric Husey, O.D.
spaceagga@cs.comcast.net

TROPICAL CE
February 22March 1, 2014
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February 27March 1, 2014
Big Sky, MT
Sue Weininger
406/443-1160
Fax: 406/443-4614

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SVE CE MEETING
BERKELEY, SCHOOL OF OPTOMETRY
February 21-22, 2014
Salem Conference Center/Grand Hotel, Salem, OR
Jeny Sue Hooper
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Fax: 406/443-4614
University of Alabama at Birmingham  
School of Optometry

RESIDENCY POSITIONS AVAILABLE

Positions are available in each of our in-house residency programs in Cornea and Contact Lenses, Family Practice Optometry, and Pediatric Optometry to commence June 2014. Salary for each position is $40,644.00. Applicants must possess an O.D. degree from an accredited professional optometric program and must have passed Parts I, II, and III of the NBEO.

Additional residency positions are available at our affiliated programs: Ocular Disease at Omni Eye Services of Atlanta; Ocular Disease at Vision America of Birmingham; Hospital-Based / Primary Care Optometry at the Tuscaloosa, AL VAMC; and Geriatric and Low Vision Rehabilitation Optometry at the Birmingham VAMC.

Deadline for ORMatch application (www.natmatch.com/ormatch) is February 15, 2014. Program website may be found at www.uab.edu/optometryresident. Requests for additional information should be addressed to: Lisa L. Schiffanella, O.D., M.S. School of Optometry University of Alabama at Birmingham Birmingham, Alabama 35234-0010 lschiff@uab.edu Equal Opportunities in Education and Employment

NOVA Southeastern University

College of Optometry
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Primary Care with emphasis in Pediatrics and Binocular Vision
Primary Care with emphasis in Geriatrics and Low Vision
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Opportunity to participate in service activities

Visit our website for more information:
http://optometry.nova.edu/residency/internal/index.html

Lori Vollmer, OD, FAAO
Director of Residency Programs
lvollmer@nova.edu
954-262-1452

SCHOOL OF OPTOMETRY
INDIANA UNIVERSITY
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Residency Programs 2014 - 2015

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Department of VAMC Illiana Health Care System Danville, IL
Lexington VAMC Lexington, KY
Virginia Commonwealth University Department of Ophthalmology Richmond, VA

For application and information on each residency program, please visit: www.optometry.iu.edu/academics/residencies/index.shtml
Application deadline for all programs is February 1st, 2014

Indiana University School of Optometry
744 E. Third Street, Bloomington, IN 47405-3680
Phone: (812) 855-1964 Fax: (812) 855-4389
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Indiana University is an Affirmative Action/Equal Opportunity Employer committed to excellence through diversity. The University actively encourages applications from women, minorities, and persons with disabilities.

DEAN, PENNSYLVANIA COLLEGE OF OPTOMETRY
Elkins Park, PA

Salus University invites nominations and expressions of interest for the position of Dean of the College of Optometry.

Founded in 1919 as Pennsylvania College of Optometry (PCO), Salus is the only university to be founded by a college of optometry and offers a broad and dynamic collection of high-quality health science, education and rehabilitation programs. PCO is the largest of four colleges, enrolls 614 students, maintains an on-campus and off-campus residents program, and houses 57 faculty members. For 94 years, PCO has held a reputation for challenging accepted practices and setting new standards.

The Dean is the Chief Academic and Administrative Officer of PCO and reports to the Provost and Vice President for Academic Affairs (PVPA). The Dean is responsible for providing leadership in the College to promote new levels of academic excellence in curriculum, assessment methods, research and scholarship. As the University expands academic programs, the new Dean should encourage collaboration across the University and identify opportunities for interprofessional education. The Dean represents PCO internally to the University and externally to various stakeholders. Applicants with a Doctor of Optometry Degree (OD) and an outstanding record as an accomplished educator are invited to apply. Ten (10) years of experience in optometric education preferred.

Review of applications will begin immediately and continue until the position is filled. Nominations, inquiries and applications, including letter of interest and CV, should be forwarded to jayblonsky@armitongeotruiting.com.

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