

# TOA NEWSLETTER

Texas Ophthalmological Association

January 2019

## Editor's Message & Coding Update

By John M. Haley, MD

Chair, Liaison Committee to Third Party Payors

First of all, thank you to our friends at the AAO: President – George Williams, MD; Secretary for Federal Affairs – David Glasser, MD; Medical Director for Government Affairs – Michael Repka, MD, MBA; Manager, Quality/HIT Policy – Jessica Peterson, MD, MPH; Director, Health Policy – Cherrie McNett; Health Policy Specialist – Sarah Cartogena; members of the AAO Health Policy Committee, and CEO – David W. Parke II, MD. They are the principal sources of information for this newsletter.

There is never a dull moment for our American Healthcare System. Despite heavy congressional efforts to destroy the Affordable Care Act, it has endured and is being given credit for reducing the rapid rate of rise in our healthcare costs. Recently, a Texas federal judge ruled that the Affordable Care Act is unconstitutional now that Congress has eliminated a penalty for those who forgo health insurance. The ruling came under harsh attacks from legal analysts who predicted higher courts will reject the rationale as a tortured effort to rewrite not just the law but also congressional history. CMS Administrator Seema Verma has stated that the recent court decision is still moving through the courts, and that health insurance exchanges are still open for business and open enrollment will continue. Thank you, as I see many patients each week who cannot buy insurance anywhere else. The medical problems that existed before Obamacare was enacted are all still present. We continue to need a comprehensive US healthcare system that is more affordable and available as the President promised. Hopefully, our Congress can work to produce such a new system, whatever that may be. However, with federal deficits skyrocketing, there is increased pressure to make major cuts to our existing safety net programs of Medicare and Medicaid.

Several “Medicare for All” proposals have already been introduced in both the House and Senate, and a new caucus has been created to promote the policy. It has never been more important to stay very active politically with all the congressional-led changes coming to the healthcare system. Unfortunately, we are starting over in many cases with the changes in Congress from the mid-term elections. I urge you all to contribute something – anything – to our TOA EYE-PAC and the AAO’s OphthPAC so we can continue to be a player in the new healthcare negotiations. It is simply a cost of doing business if you want to have some input in the process.

### 2019 Coding Changes

**Deleted Code:** Electroretinography 92275 (\$150). This code has been deleted as of January 1, 2019. Changes are being made so that appropriate coding and tracking of the different types of ERG testing are now possible. This old ERG code was subdivided by the CPT panel due to differences in work and indications for the three types of ERG.

### New CPT Codes

**92273** - Electroretinography (ERG) with interpretation and report; full field (eg, ffERG, flash ERG, Ganzfeld ERG). The 2019 CMS proposed wRVU: 0.69; the RUC approved wRVU: 0.80. \$137.91 Dallas Medicare allowables.

**92274** - Electroretinography (ERG) with interpretation and report; multifocal (mfERG). The 2019 CMS proposed wRVU: 0.61; the RUC approved wRVU: 0.72. \$93.33.

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SAFE VISION  TEXAS

The Right Eyecare for All Texans

Check e-news soon  
for information on this  
new coalition

# C O D **Q**uest 2019

## *When & Where*

**San Marcos**  
Saturday, Jan. 26

**Lubbock**  
Friday, March 29

**Dallas**  
Saturday, March 30  
(plus fundamentals course)

**Houston**  
Saturday, April 6  
(plus fundamentals course)

## **Coding doesn't get easier. So professionals get better.**

Registration is now open for Codequest 2019. Registration fees have not increased.

The content is appropriate for your entire staff. In fact, the Houston and Dallas seminars will offer an optional Core Competencies/Fundamentals course in addition to the regular course. This will be perfect for those new to coding and those who need a refresher. Pick one or both courses if you're attending Houston or Dallas.

### **How You'll Benefit**

- Acquire valuable insights for protecting your practice
- Boost your coding performance
- Prepare for the inevitable audit scenario
- Learn to resolve claim denials

### **What You'll Cover in Four Hours**

Codequest's all-new 2019 program will help you understand:

- The most important updates of CPT, ICD-10, HCPCS, CCI, MUE, LCDs and payment changes for 2019
- Imminent changes to E/M codes and extended/subsequent ophthalmoscopy
- Up-to-date documentation rules for exams, tests, minor and major surgeries
- How to select the correct modifier for every situation. Learn how to avoid the common modifier mistakes that cause practices to lose thousands of dollars each year.
- How to resolve claim denials: identify the cause and implement solutions
- Informed recommendations for coding and billing success (e.g. prior authorization, MIGS coverage, vial drug administration and more)

Codequest is the only place you'll find these best-practice tips:

- 30+ recommendations from successful practices
- Prior authorization checklist – what is your form missing?
- How to code from an operative report
- MIGS: What's covered, what's not
- Calculations for multidose vial drug administration
- Exam and testing coverage and frequency for patients on high-risk medication
- Billing for two surgeons in the same operative session

### **Who Should Attend**

Ophthalmologists, practice administrators, coder and billers with an intermediate to advanced coding level. Optometrists employed by an ophthalmologist may attend.

***You Can't Afford to Miss Codequest!***



## Be a Lobbyist for a Day

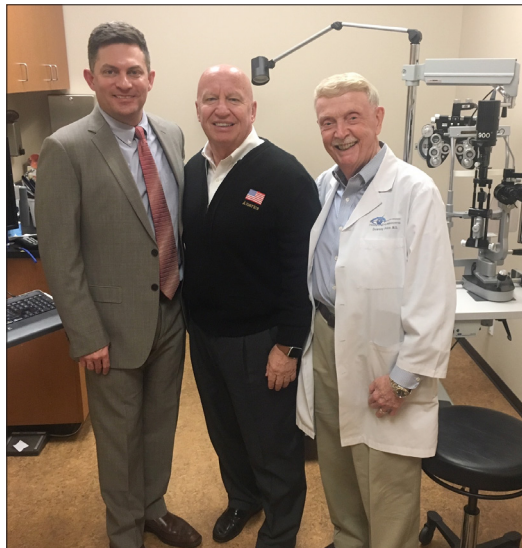
*Tuesday, Feb. 5*

Your patients are depending on you, whether they know it or not. Quality eye care will be under attack during the 2019 Texas legislative session. You can make a difference by joining the “white coat invasion” on Tuesday, Feb. 5 in Austin. Sign up today for TMA’s First Tuesday Lobby Day.

Contact Rachael Reed in the TOA office at (512) 370-1518 or [exec@Texaseyes.org](mailto:exec@Texaseyes.org) with any questions about how First Tuesday works.

As a bonus, you are invited to attend the TOA Executive Council meeting that afternoon in the TMA building. The Executive Council will conduct society business and present an award to a legislator.

Homework: Between now and February 5, take some time to get to know your own state representative and senator. Simply make an appointment in their district office and offer yourself as a resource. It will make your work on Feb. 5 even more meaningful if you have met before.



Drs. Aaron Miller and C. Downy Price invited US Congressman Kevin Brady (8th District-Texas) to tour their facility in Houston.

“The stakes are too high for government to be a spectator sport.”

– Rep. Barbara Jordan

Come to all  
First Tuesdays!

February 5<sup>th</sup>  
March 5<sup>th</sup>  
April 2<sup>nd</sup>  
May 7<sup>th</sup>

sign up at  
[www.texmed.org/Firsttuesdays](http://www.texmed.org/Firsttuesdays)



**FIRST  
TUESDAYS**

*Taking Medicine's Message to the Capitol*  
86TH LEGISLATIVE SESSION 2019

# TOA at Work

Follow us!



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[twitter.com/txoph](https://twitter.com/txoph)

## TOA Leaders at TMA Advocacy Retreat

**Drs. Michelle Berger, Keith Bourgeois, Jack Pierce, and Sanjiv Kumar** (TOA president) attended TMA's annual advocacy retreat in early December. The retreat was an opportunity for specialty society leaders to meet with TMA leadership on the eve of the 2019 Texas Legislative Session. Common themes among most specialties included scope of practice expansion concerns, funding for graduate medical education, Medicaid funding, opioid prescribing, and better access to mental health care.

Two physician lawmakers, state Reps. John Zerwas, MD (R-Richmond) and Tom Oliverson, MD (R-Cypress), both anesthesiologists, said many of the issues that medicine has long fought for will be up for debate again despite changes in the makeup of the House, including a new speaker. They also explained the unique perspective that physicians have as advocates: "Being a doctor, I think inherently makes you a good legislator because number one, you're a good listener ... and you're a good problem-solver," Representative Oliverson said. "I wish there were more physicians in the legislature because we are naturally gifted at problem solving, we are naturally gifted to be good legislators because it's how we were trained to think."

## TOA Members Halt ASC Rate Cuts

Thanks to your support, the Texas Health and Human Services Commission did not implement any of the fee cuts to ASC/HASC rates that had been proposed last fall during its biennial review.

As previously reported, these significant fee cuts to ASC reimbursements would have severely limited Texas Medicaid patients from accessing care in an ASC. Physicians would have been forced to refer patients to hospital outpatient departments (HOPD) where the surgeon's time is used less efficiently. These changes would have ultimately increased Texas Medicaid costs by driving procedures to the HOPD where there is a higher facility fee plus additional service fees such as preoperative laboratory and radiology work-ups, cardiology clearance, etc.

It is clear that our letters and advocacy made a difference in this process. Not all specialties fared as well. [From the TMHP site:](#)

*"Effective for dates of service on or after January 1, 2019, reimbursement rate changes and updates for some procedure codes, which were presented at a public rate hearing on November 13, 2018, will be implemented with the exception of Ambulatory Surgical Center/Hospital Ambulatory Surgical Center."*

Thank you to the TOA members who sent in comments, and special thank you to the four members who testified in person: **Megyn Busse, MD; Victor Gonzalez, MD; Jack Pierce, MD;** and president **Sanjiv Kumar, MD.**



# Members in the News

## AAO Honors TOA Members

Several TOA members received awards in conjunction with the AAO 2018 Annual Meeting in Chicago:

**Life Achievement Honor Award:** **Stephen C. Pflugfelder, MD**

Individuals earning 60 points and approved by the Awards Committee and the Board of Trustees receive the Life Achievement Honor Award.

**Senior Achievement Award:** **Aaron Miller, MD; Mitchell P. Weikert, MD;** and **Jess Thomas Whitson, MD, FACS**

Individuals earning 30 points and approved by the Awards Committee and the Board of Trustees receive the Senior Achievement Award.

**Secretariat Awards** - The following awards recognize individuals for their contributions and volunteer activities that support the AAO and the profession:

from the Secretary for Communications: **Jane C. Edmond, MD**

from the *Ophthalmology Retina* editor: **Charles C. Wykoff, MD**

from the Secretary for Member Services: **Jane C. Edmond, MD**

## TOA Members Recognized as Leaders

**American Academy of Ophthalmology:**

**Jane Edmond, MD**, completed her term on the AAO Board of Trustees last fall.



**Aaron Miller, MD** completed his second term as one of TOA's three AAO councilors, serving a total of six years. The AAO Council meets twice per year and is the advisory body to the AAO Board of Trustees. **Mark Mazow, MD** completed his first term as Councilor.

**Robert Gross, MD**, and **R. Galen Kemp, MD** also represent TOA on the Council. Dr. Miller will be succeeded by **Chevy Lee, MD** beginning in January, 2019.

**Aaron Miller, MD** will continue to serve ophthalmology on a national level - he has been appointed to serve as AAO Secretary for Member Services, effective January 2019.

**Sidney K. Gicheru, MD** has completed his term of service on the AAO's OPHTHPAC Committee. Dr. Gicheru continues his term as Regional Advisor, Secretariat of State Affairs. He also continues as TOA's alternate to the AAO Council.

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## TOA Annual Meeting – What's NEW in...

Mark your calendar for  
**May 17–18, Dallas**



This meeting is free to all TOA members. The program will bring new information to you on stem cell use, glaucoma, retina, pediatric neuro-ophthalmology, cataract, cornea, uveitis and more!

# Welcome New Members

## Provisional

**R. Wayne Bowman, MD**  
Dallas

**Jeremy Cefalu, MD**  
Tyler

**Roy E. Lehman, MD**  
Sherman

**Kyle Varvel, MD**  
Bryan

**William Waldrop, MD**  
Dallas

**Devin M. West, MD**  
Wichita Falls

## Fellow

**Mahdi Rostamizadeh, MD**  
McAllen

## Resident

**Grant Justin, MD**  
San Antonio

**Ravi H Patel, MD**  
Taylor

*Continued from page 5*

## Texas Medical Association:



**Michelle Berger, MD**, TOA past president, rotated off the TMA Interspecialty Society Committee on December 31. Dr. Berger served as TOA's alternate delegate to the TMA House of Delegates in this role for over 16 years. Luckily for us, Dr. Berger continues to represent medicine as TMA's treasurer. We thank Dr. Berger for her continued service.

Dr. Berger will be succeeded as our ISC alternate delegate by Austin member **Haumith Khan-Farooqi, MD**. Dr. Khan-Farooqi's two-year term begins January, 2019.

## 2018 Straatsma Awardee: **Preston Blomquist, MD**

Congratulations to Preston Blomquist, MD, the recipient of this year's Straatsma Award for Excellence in Resident Education, presented by the American Academy of Ophthalmology and the Association of University Professors of Ophthalmology. This award recognizes and celebrates Dr. Blomquist's achievements as a residency program director in ophthalmology.

Over his 16-year tenure as the residency program director for the Department of Ophthalmology at The University of Texas Southwestern Medical Center, Dr. Blomquist has directed 163 residents, thus far. He is described as a passionate advocate for resident rights and recognized for his support of comprehensive training for all graduating ophthalmology residents and for increasing the required surgical volumes for residents. He hopes his greatest success has been the development of the next generation of ophthalmologists and that he has been a positive influence for each of them as they "play it forward." He motivates his graduates to be successful from the start of their careers, to adapt to a changing world, and to be leaders of change. He strives to help each resident to reach their fullest potential.

Congratulations to Dr. Blomquist! The presentation of the Straatsma Award took place during the Program Director Forum of the 2018 AAO annual meeting in Chicago.

## American Medical Association:

**Lyle Thorstenson, MD** has been re-appointed to the board of directors of the AMA's Political Action Committee for a two-year term beginning Dec. 1. He, along with **Michelle Berger, MD**, also serves as a Texas delegate to the AMA House of Delegates.

## **AAO Leadership Development Program**

Since 1998, the Academy's Leadership Development Program has helped identify and develop future leaders of state, subspecialty and specialized interest societies. During the one-year program, class participants learn about leadership, advocacy and association governance.

Congratulations to **Gary Legault, MD** who graduated from the AAO Leadership Development Program in fall 2018. He was sponsored by the Society of Military Ophthalmologists. Each participant must complete a project; the title of Dr. Legault's project was "Society of Military Ophthalmology Website Design and Implementation."

Representing Texas now is **Jeremiah Brown, Jr., MS, MD** who was inducted into the Leadership Development Program Class of 2019. He is sponsored by OMIC.

## Texas' Own Making Strides with LDP in Africa



Sidney Gicheru, MD, TOA past president and a 2012 graduate of the AAO's Leadership Development Program (LDP), has been instrumental in the formation of an LDP within the African Ophthalmology Council (AOC). He is now the CEO of the AOC. Read his recent update:

The African Ophthalmology Council (AOC) is the supranational organization that represents ophthalmologists in Sub-Saharan Africa. We started a Leadership Development Program in August 2015.

I serve as Program Director for the joint Anglophone and Lusophone program and Mike Brennan (LDP Faculty) serves as Program Director for the Francophone program. The candidates come from a wide range of African countries. Our goal is to create better leaders so national ophthalmology societies of Africa can shepherd the use of scarce resources more effectively. On November 1, 2018, I was appointed the CEO of AOC. Our goal is to develop the organizational structure and overall performance of the AOC while enriching the member experience by expanding programming in addition to the AOC LDP.

The first Anglophone LDP class (AOC LDP I) started in August 2015 in Kenya, met in Tanzania in 2016 and graduated in Uganda in 2017. An AOC LDP 1 graduate is taking it a step further. Feyi Grace Adepoju (AOC LDP I) of Nigeria is the AOC representative in the Academy's LDP XXI, Class of 2019. Feyi is the first AAO LDP participant from Africa. We started Class 2 in Uganda and held our second session in Addis Ababa, Ethiopia on August 28-29, 2018. The Addis Ababa session was our best yet. Some of our AOC LDP I graduates are serving as faculty and will surely be future leaders of the AOC.

Following our meeting in Addis Ababa, our faculty and some members of AOC LDP I & II, flew to Cape Town, South Africa to run an Advocacy and Organizational Development course at the International Pediatric Ophthalmology and Strabismus Congress' ROP Africa meeting, on September 3-4, 2018.

This AOC LDP project has been a labor of love since 2015 and we are gaining traction. We would not be able to run this course without the help of International Council of Ophthalmology (ICO) and AAO doctors who have volunteered as faculty. I hope more global LDP participants have a chance to visit Africa and encourage those winterested to join me at the World Ophthalmology Congress (WOC) 2020 in Capetown, South Africa on June 26-29, 2019.



## Interested in LDP?

TOA may nominate an ophthalmologist to participate in next year's LDP class. This is a highly competitive program. The nomination includes a promise of financial support. Each class meets in person four times, twice in conjunction with the Academy annual meeting. Participants conclude their time in the program by completing a project in one of 10 key areas. If you are interested in being nominated, contact TOA president Sanjiv Kumar, MD at [president@TexasEyes.org](mailto:president@TexasEyes.org) by February 1.

### TOA graduates of the LDP include:

- **Dawn C Buckingham, MD**  
(TOA past president)
- **Garvin H Davis, MD**
- **Sidney K Gicheru, MD**  
(TOA past president)
- **Todd M Hovis, MD**
- **Gary L Legault, MD**
- **Helen Ka-Fun Li, MD**
- **Aaron M Miller, MD, MBA**
- **Ann Ranelle, DO**
- **John W Shore, MD**

# Legal Update

## Member Benefit:

Submit your questions  
regarding Texas  
Regulatory Laws &  
Practice Acts to  
[andrea@aschwablaw.com](mailto:andrea@aschwablaw.com)

### What is Fee Splitting and Why Should You Care?

By Andrea Schwab, JD, CPA, TOA General Counsel  
[andrea@aschwablaw.com](mailto:andrea@aschwablaw.com)

The *Merriam Webster Dictionary* defines fee splitting as “payment by a specialist (such as a doctor or a lawyer) of a part of his or her fee to the person who made the referral.” Although referral incentives are a common business practice in other industries, in medicine they erode the fiduciary relationship, potentially elevating a physician’s financial interests above the needs of the patient. The American Academy of Family Physicians defines fee-splitting as any division of fees without the full knowledge of the patient and with the intent of influencing the choice of physician, consultant, assistant, or treatment on any other basis than that of the greatest good of the patient.

Fee Splitting is often used interchangeably with the term “kickback” in reference to “anti-kickback/fee splitting,” which occurs when a licensed physician either pays, or is paid, for the referral of patients. It could also be in the form of sharing reimbursement fees for services or devices with any person or entity. This type of arrangement would potentially violate federal laws (Stark and federal anti-kickback law) and state laws, as well as medical ethics guidelines.

The federal Anti-Kickback Statute prohibits knowing and willful offers, payments, solicitations, or remunerations to induce referrals of services covered by Medicare, Medicaid, and other federally funded programs. Likewise, the Stark Law prohibits referring Medicare patients for designated health services to an entity with which the physician (or an immediate family member) has a financial relationship, unless an exception applies. See 42 U.S.C. §1320a-7b(b) and 42 U.S.C. §1395nn. The Anti-Kickback Statute is complex in large part because of its safe harbors. Although there was a point in which there was some protection for co-management arrangements (Medicare had implemented a global fee for cataract surgery in the early 1990s), the Office of the Inspector General (OIG) removed the safe harbor on co-management in November 1999. Such a global fee was inherently fee-splitting.

Therefore, any co-management arrangement should be carefully conducted as to not violate the federal Anti-Kickback Statute.

In addition to federal fee splitting laws, Texas law has an analogous criminal provision. This state law is often referred to as Texas’ Stark Law, as it regulates physician referrals at the state level. The Texas Patient Solicitation Act (TPSA) is a state law that is similar in wording to the federal anti-kickback statute. It states that a person commits an offense if the person knowingly offers to pay or agrees to accept, directly or indirectly, overtly or covertly any remuneration in cash or in kind to or from another for securing or soliciting a patient or patronage for or from a person licensed, certified, or registered by a state health care regulatory agency. Tex. Bus. & Occ. Code §102.001 et seq. Furthermore, section 102.051 makes soliciting patients an offense, as follows:



“A person commits an offense if the person: (1) practices the art of healing with or without the use of medicine; and (2) employs or agrees to employ, pays or promises to pay, or rewards or promises to reward another for soliciting or securing a patient or patronage.” Tex. Bus. & Occ. Code §102.051(a). “A person commits an offense if the person accepts or agrees to accept anything of value for soliciting or securing a patient or patronage for a person who practices the art of healing with or without the use of medicine... a person who practices the art of healing includes ... an optometrist.” Tex. Bus. & Occ. Code §102.051(b) and (d). Although section 102.051 does not apply to physicians, it applies to optometrists who accept anything of value for soliciting a patient.

In addition to potentially violating federal and state laws, sharing of fees or accepting or paying for referral of patients would violate medical ethics. The AMA Code of Medical Ethics Opinion 11.3.4 states that payment by or to a physician or health care institution solely for referral of a patient is fee splitting and is unethical. The Texas Medical Association’s Board of Councilors also condemns fee splitting: payment by or to a physician for the referral of a patient is fee splitting and is improper.

### What About Co-Management?

True co-management is not fee splitting. In a co-management scenario, the patient pays the physician for the physician’s services, and the patient pays any other provider such as an optometrist or physical therapist for those services. Co-management at its core is a series of referrals and stand-alone payment situations. Stand-alone payment situations without the sharing or reimbursement of payments is likely not “fee splitting.”

There is no circumstance where a physician should give payment directly to another provider for patient services. Any inducement for referrals or fee splitting would most likely be deemed an illegal and unethical act.

For instance, if co-management of cataract surgery with an optometrist is necessary due to the patient’s circumstance, the patient will pay the surgeon for the surgery and will pay the optometrist for their portion of post-surgical care. There is no need or justification for the optometrist to receive any payment for anything other than the optometrist’s care—the optometrist should not be receiving a portion of the physician’s surgery or any portion of the cost of surgery, such as the cost of a device or premium lens. This would most likely be considered a referral inducement, fee splitting, or a kickback.

*A full copy of the AAO’s Comprehensive Guidelines for the Co-Management of Ophthalmic Postoperative Care with citations can be found at [www.TexasEyes.org/guidelines-and-forms](http://www.TexasEyes.org/guidelines-and-forms). TOA was one of the many co-signatory organizations to these guidelines in 2016.*

In summary, due to these legal and ethical considerations, both parties are at risk when engaging in fee splitting and/or referral inducements. Referrals should be based on the needs of the patient alone.

Because federal and state anti-kickback laws carry heaving fines and penalties, any physicians involved in referral arrangements should seek the advice of their privately retained legal counsel.

## False Advertising in Your Community?

We occasionally hear from members who observe instances of false advertising or misrepresentation of health care providers in local publications. An example of this would be a mid-level provider listed as a physician or surgeon in a newspaper or phone book. While these listings might be accidental, it is important that members of the public see accurate information about the various providers in their community.

TOA can communicate with the involved parties so that you don’t have to. We will explain the law regarding professional identification, specifically the requirements of Chapter 104 Healing Art Practitioners, under Title 3 Health Professions of the Occupations Code, and the Texas Medical Act.

*Contact Rachael Reed in the executive office at [exec@TexasEyes.org](mailto:exec@TexasEyes.org) or at (512) 370-1518 for more information*

# Coding Update

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## *EYE-PAC Endorsement Results*

Your EYE-PAC scored well on election night last November, with 95% of its endorsed candidates winning. Sadly, some friends of medicine will not be returning to the Texas Legislature, but we have new opportunities to educate freshmen on quality eye care. If you have a relationship with any new legislators, please let us know as you could be a key contact.

## **New J Code J2787**

**Photrex** - Riboflavin for corneal crosslinking up to 3cc Riboflavin 5 – phosphate. Did any of you see the poster at AAO describing oral Riboflavin and exposure to natural sunlight 30 minutes/day for one month seemed to produce equal corneal results to expensive commercial crosslinking?

## **New Category III Codes**

**0509T** - Electroretinography (ERG) with interpretation and report, pattern (PERG). This has been created specifically for appropriate coding and tracking of this newer technology; there was inadequate literature support for Category 1. There are significant differences from the historical ERG code. The coverage and payment are determined by the Medicare Contractors. CMS proposed Active Status. The AAO proposal is a work value of 0.40, 10 min Intra Service Time, 12 minutes total time.

**0506T** – Macular pigment optical density measurement by heterochromatic flicker photometry, unilateral or bilateral, with interpretation and report.

**0507T** – Near infrared dual imaging (ie, simultaneous reflective and transilluminated light) of meibomian glands, unilateral or bilateral, with interpretation and report.

**0514T** – Intraoperative visual axis identification using patient fixation (List separately in addition to code for primary procedure).

## **Revalued CPT Codes.**

All of these CMS proposed values have been finalized except for RB Alcohol.\*

### **Removal of Foreign Body**

**65205** – Removal of foreign body, external eye; conjunctival superficial (\$36.97)

- CMS Proposed 2019 wRVU: 0.49
- RUC approved wRVU: 0.49
- Current wRVU: 0.71

**65210** – Removal of foreign body, external eye; conjunctival embedded (includes concretions), subconjunctival, or scleral non-perforating (\$58.07)

- CMS Proposed 2019 wRVU: 0.61
- RUC approved wRVU: 0.75
- Current wRVU: 0.84

### **Injections**

**67500** – Retrobulbar injection (\$62)

- CMS Proposed 2019 wRVU: 1.18
- RUC Recommended wRVU: 1.18
- Current wRVU: 1.44

**\*67505** – Retrobulbar injection with alcohol (\$86)

- CMS Proposed 2019 wRVU: 0.94
- RUC Recommended wRVU: 1.18 – **Accepted by CMS**
- Current wRVU: 1.27

**67515** – Injection into Tenon’s Capsule (\$74)

- Proposed 2019 wRVU: 0.75
- RUC Recommended wRVU: 0.84
- Current wRVU: 1.40

## Ophthalmic Ultrasound

**76514** – Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness) (\$13)

- Proposed 2019 wRVU: 0.14
- RUC recommended wRVU: 0.17
- Current wRVU: 0.17

## Medicare Regulatory Reform Agenda Continues

The American Academy of Ophthalmology launched a regulatory relief effort in 2016 in response to the election outcome. The immediate focus was on relief from 2018 performance penalties such as PQRS, EHR Meaningful Use, and Value-Based Modifier. In 2017 the Academy also began a campaign to reduce significant burdens of prior authorization within Medicare Advantage. These efforts brought simplification and eased the burden of MIPS for 2018. Specifically, it halted the application of the MIPS bonus and penalties to Part B drug payments to physicians. It also provided CMS flexibility to limit the cost component of MIPS to 10%-30% through the 2022 performance year, and it provided for CMS continued flexibility to set an incremental threshold to avoid a MIPS penalty through the 2022 performance year.

The relief was significant for small practices in 2018. Small practices enjoyed a 5-point bonus on their MIPS final score, they qualified for interoperability hardships, and they had a 3-point floor on quality measures.

The recently released Medicare Conditions of Participation proposed rule would give HOPDs and ASCs flexibility in determining pre-op H&P. If finalized, these policies will be determined by the facility medical staff.

Finally, the Academy won the repeal of the Independent Payment Advisory Board (IPAB).

## A New Threat: Medicare Advantage Step Therapy Guidance

In August, the US Department of Health and Human Services (HHS) announced without prior notice a new drug policy for Part B office-administered drugs for Medicare Advantage plans. The policy creates unequal access to Part B drugs for MA plan beneficiaries as compared to Original Medicare and restricts access in a way not permitted under Part B. It also rewards beneficiaries for a change in clinical treatment decisions that could be harmful to the patient. Several MA plans have already implemented step therapy for 2019 with insufficient notice to patients.

The Academy contends that this is a legally questionable policy with a potentially dangerous impact for eye care. Academy leaders have met with HHS Secretary Alex

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The Accreditation Council for Continuing Medical Education (ACCME®) and the American Board of Ophthalmology (ABO) have announced a new collaboration to expand opportunities for ABO-Certified ophthalmologists to earn Maintenance of Certification (MOC) credit for participating in accredited continuing medical education (CME) activities that meet ABO MOC requirements.

Azar more than once. They are working with a broad coalition of physicians, patients and other stakeholders, to conduct a legal analysis. This coalition of over 240 patient and medical groups sent a letter to Capitol Hill outlining concerns with step therapy policy. The coalition has also developed a Patient Education document for offices.

While I agree with the AAO's position, I realize that drugs simply are too expensive and something must be done as industry will not fix it. When two drugs' (Lucentis and Eylea) costs comprise 30% of the Medicare Part B budget and comes directly out of your pockets, we need a change. Fifty percent of retina docs never or rarely use Avastin with the excuse of sterility of compounded drugs (has not proven to be a concern) and silicone bubbles (it's a syringe selection problem not due to the compounded Avastin that also occurs in branded drugs).

## 2019 MIPS Regulatory Relief Requests

Our regulatory relief agenda continues with efforts to simplify the MACRA/MIPS scoring, increase credit for using the IRIS Registry and revise policies on the topped-out quality measures. Additionally, we are requesting to limit the number of excluded eligible professionals in order to expand the bonus pool. Ophthalmologists continue to receive the biggest portion of the MIPS bonuses.

## Overview of 2019 FINAL Medicare Policy Changes

### Medicare Payments for Ophthalmology 2019

CMS is holding the conversion factor nearly flat with a final rate of 36.04 versus 35.99 this year. This provides a +0.25% update with a .14% budget neutralizing adjustment. MACRA included a 0.5% update for years 2015 – 2019, but the 2018 Budget Act reduced this update to 0.25% for 2019 as an offset. There are no new misvalued codes identified for ophthalmology, but there are a few codes from earlier reviews still on the horizon for 2020, including those for Corneal Hysteresis, Extended Ophthalmoscopy, and Cataract/ECP.

Practice Expense Reduction will have a 1% impact on Ophthalmology's overall payments. This is due almost entirely to the New Practice Expense import prices for supplies and equipment. PE was last evaluated in 2004 -2005 and there is a four-year phase in for new values. That equals about 4% over four years.

### Ophthalmology's 2019 Fee Schedule Issues

As we predicted last year, the proposed changes to E/M coding and payment are a significant threat, as they will reduce payments for most advanced patient care, produce large reductions to procedures done with E/M visits, and propose inequitable add-on codes for limited specialties. There are also ongoing concerns for reimbursement. Two-thirds of RUC work values for eye codes are initially rejected and there are ongoing reviews of supplies and equipment for practice expense payments as well as post-operative global surgical payments.

The Academy strongly opposes the E/M Proposal. We met directly with CMS Administrator Seem Verma to express our concerns and signed onto an AMA-led letter that garnered support from over 100 national and state medical groups. In addition, we submitted detailed comments outlining the true impact on Ophthalmology and our patients. We are currently participating in a Joint CPT/RUC E/M Workgroup to find alternative solutions.

## CMS Proposed Changes to E/M Codes

In an effort to reduce burdens and simplify documentation, CMS put forward a proposal that would collapse the current system of 5 levels of coding to just 2 codes. New, single blended payment rates for levels 2 through 5 were proposed for both new and established E/M services. New patient payment would be \$134 and established patient payment would be \$92. A \$5 add-on code has been proposed for primary care as well as another \$12 add-on for certain specialties that see more complex patients. CMS proposed a very short list of eligible specialties and did not include Ophthalmology.

The Final Rule will begin in 2021 and will delay blended rates for 2 years. Providers will pay a single rate E/M Level 2-4 for established and new patients but will maintain Level 5. The Rule will allow for new add-on codes to reflect extra time needed with patients and will allow documentation for medical decision making, face-to-face time, or the current system. The required documentation of patients' history will change to focus only on the internal history since the previous visit. The requirements for physicians to re-document information that has already been documented by staff or patient and the need to justify providing a home visit instead of an office visit will be eliminated.

The Final Rule will extend MPPR concepts to office procedures billed the same day as an office visit (with the -25 modifier) by reducing payment by 50% for the less costly of the two codes. For Ophthalmology, this would mean an overall reduction of \$17 million dollars a year to physicians providing intravitreal injections on the same day as an office visit. It is important to note that CMS and the RUC have already reduced payment for intravitreal injections to account for duplication in time and resources when the two services are performed together. The Rule has also declined to move forward on MOD 25 office visit payment reduction.

The most harmful provision in the Final Rule is the blended rate for a portion of practice expense payments that otherwise varies based on specialty costs. The impact as provided in the Rule showed Ophthalmology reductions to be "minimal." However, Academy worked with a large coalition to perform a more thorough analysis. That work showed the impact would be -4%, resulting in a rate that will be significantly lower than what Ophthalmology currently receives. Groups like oncology and thoracic surgery would see double-digit cuts. CMS didn't account for the effect that the shifting of PE dollars would have on services and thus underestimated the impact of the proposal on all specialties. This evaluation exposed the Final Rule as a flawed proposal that attempts to mitigate reductions for some specialties created by the E/M proposal.

## CMS Review of Global Surgical Payments

In the NPRM, CMS proposes continued reporting of CPT 99024 for all post-operative visits associated with the most common 10- and 90-day procedures. Groups of 10+ providers in the states of Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon and Rhode Island should still report in 2019. Texas is still not included.

In late summer, CMS announced it was targeting 3 singular codes for a focused review by RAND, including cataract surgery. CMS emailed 1500 ophthalmology practices in states apart from the nine states reporting 99024, asking them to complete a survey of the time and resources involved in providing post-operative care for cataract surgery. In all, the practices were asked to report on 5 different post-operative encounters. Orthopedic hip procedures and deep wound repair were also on tap for review. Next year's fee schedule rule is likely to have additional CMS proposals regarding global surgical payments.

*Continued on page 14*

## TDI Proposes Rules Concerning Termination Notification

TOA, TMA and several other specialty societies have submitted comments to oppose rules that would strike the minimum 90 day notice requirement for HMO terminations. We await the outcome of this rule determination.

*Continued from page 13*

### **CMS Final Rule Change – November 2018 (2,378 pages)**

Site neutrality change will provide a level playing field (saving \$380M in 2019). 340B allowed hospital out-patient departments (HOPD) to pay 140% Medicare payment to owned out-patient clinics. Fees reduced to Medicare allowable over 2 years.

- 2019 – 70% of OPPS outpatient prospective payment system
- 2020 – Full implementation to regular medicine rates

This needed change will punish those hospitals that acquired clinical practices like primary care and specialty practices such as cardiology to take advantage of the much higher fee schedules for identical clinical work. Of course, the hospital takes a large piece of the revenue and will continue to do so even when they're back to Medicare allowables. Sounds like the old practice equity scheme to then pay the docs much less. Think they will?

### **Drug Handling Reduction When the Average Sales Price Isn't Available**

Apply only wholesale acquisition costs (WAC) based payments to the whole sale acquisition cost based on drug payment and add on reduced from 6% to 3% during the first quarter when the average sale price (ASP) is not available. This is subject to budget sequestration reduction. Normally, Part B drugs are reimbursed by 6% of ASP, minus budget sequestration.

### **ASC and Hospital OPD – Payment Update**

ASC payment rates will now be updated based on hospital marked basket rates rather than on consumer price index – urban rates for 2019 - 2023. This will promote site neutrality and encourage the migration of services from Hospital OPD to a lower cost ASC. It will ensure ASC payment for surgical procedures involving certain high cost devices parallels hospital OPD rates.

For 2019, CMS will adjust the ASC rate of \$45.575 using wage index budget neutrality, factor, and the hospital market basket update factor of 2.1%. This results in an ASC conversion factor of \$46.558 if quality reporting requirements are met. There will be a \$45.639 update if quality reporting is not met. ASC and Hospital OPD quality reporting – ACS – 11 Cataracts: improvement in patients' visual function within 90 days is retained but voluntary. CMS is still evaluating this measure.

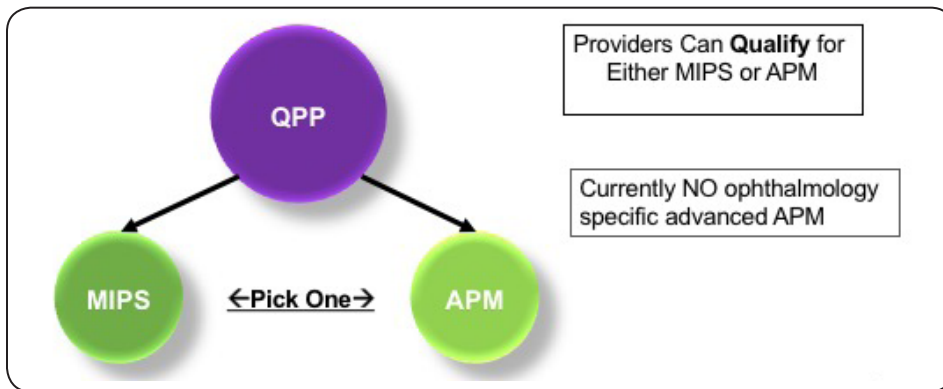
### **International Price Index**

The new CMS proposal begins the Spring of 2020 with a five year phase to 1) reduce the price Medicare pays for costly drugs closer to what other countries pay, 2) remove perverse incentives that encourage the prescribing of expensive drugs, and 3) reduce physician burden associated with "Buy and Bill" by enabling the private sector, allowing vendors to play a larger role in purchase and distribution. The handling fee would be a fixed dollar amount rather than a percentage. Based on 6% rather than 4.3% (with no sequester reduction) as drug prices fall, the ADD will fall. A CAP style vendor will be used for Lucentis and Eylea, but Avastin and Medicare Advantage will be excluded, which will complicate purchases. The cost savings is unclear; 30% savings is estimated. Initially there will be a demo in the larger spending states like Texas, New Jersey, California, Florida, and New York.

## Overview of the Merit-Based Incentive Payment System/ QPP3

The Quality Payment Program (QPP) Offers 2 Programs for Reimbursement under Medicare Part B:

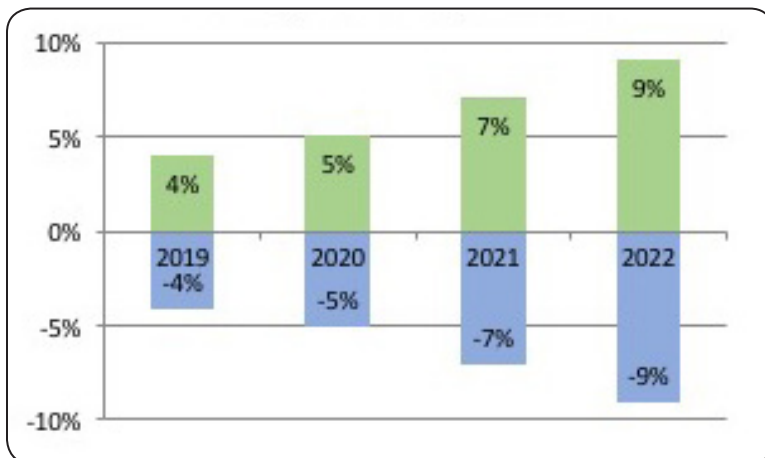
- 1) Merit-based Incentive Program System (MIPS)
- 2) Advanced Alternate Payment Model (APM)



### MIPS Payment Adjustments

The payment baseline for MIPS is the standard FFS payments and adjustments can be upward, neutral, or downward. Maximum adjustments are  $\pm 4\%$ ,  $\pm 5\%$ ,  $\pm 7\%$ ,  $\pm 9\%$ . These adjustments can be partial or full, depending on the Final Score, and are applied to services provided under Part B.

Exceptional performance pool: \$500M for 5 years (2019-2023)



### QPP Year 3: MIPS FINAL RULE 2019

Here are the exclusions for 2019:

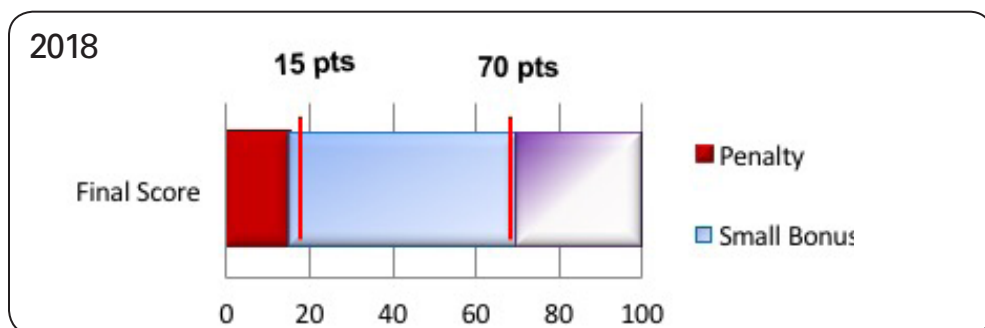
1. Low-Volume Threshold Increased: Clinician bills \$90,000 or less Part B covered service allowed charges AND/OR Clinician provides covered professional services to 200 or fewer Part B patients AND/OR Clinician provides 200 or fewer covered professional services to Part B patients. Clinicians can opt-in if they exceed at least one of the two criteria.

*Continued on page 16*

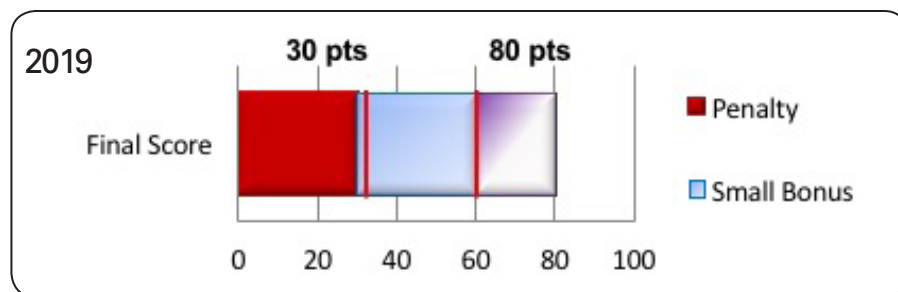
- 2. New Medicare Provider and APM Participation remain the same.

New classes of providers have been added: PT, OT, SW, Clin Psych, Speech path, Audiologists, Dieticians and Nutritional Professionals. If none of these exclusions applies, the MD/DO/OD is eligible to participate in MIPS. Exclusions reduce the patented bonus pool.

The 2018 MIPS Final Score is the sum of the weighted Category Scores. In 2018, you needed a final score of 15 points required to avoid a penalty. Between 15 points and 70 points, clinicians earned a small bonus, and the sum of these bonuses did not exceed the sum of penalties. At or above 70 points, clinicians earned an exceptional performance bonus.



For 2019, you will need a final score of 30 points to avoid a penalty. Between 30 points and 80 points, clinicians can earn a small bonus, but MIPS is budget-neutral, so the sum of these bonuses cannot exceed the sum of penalties. At or above 80 points, clinicians earn an exceptional performance bonus.



### Merit-based Incentive Payment System

The performance category weights will change. The law requires VBM (cost) to be at 30% by 2019.



## TOA Nominations

Nominate a colleague or yourself to serve in TOA Leadership by **Feb 5<sup>th</sup>**.

[www.TexasEyes.org/nominations](http://www.TexasEyes.org/nominations)



### Proposed Performance Category Weights

Legacy Program	New Category	Score Weight 2017	Score Weight 2018	Score Weight 2019
PQRS	Quality	60%	50%	45%
MU	Promoting Interoperability (PI) Formerly ACI	25%	25%	25%
(None)	Improvement Activities (IA)	15%	15%	15%
VBM	Cost	0%	10%	15%

There will be no changes in performance periods in 2019. Cost and Quality will remain at the full calendar year. PI and IA will remain at 90+ consecutive days.

## Changes in 2019

Small Practice Accommodations have changed. The program maintains 2018 Improvement Activity accommodations, where small practice clinicians/groups receive double credit for each Improvement Activity. There will be a reduction of Small Practice Bonus with the discontinuation of the application of 5-point bonus to MIPS Final Score. This will be replaced with a 6-point bonus to the quality category.

2018 ACI/Promoting Interoperability (PI) hardships will be maintained in 2019. Hardships include lack of availability of CEHRT, lack of internet, and extreme and uncontrolled circumstances. The 2018 ACI/PI Small Practice hardship will also be maintained.

PI EHR Requirements are changing. There will be a mandatory transition to 2015 certified EHR technology. New scoring methods will reduce clinician flexibility and eliminate the base, performance, and bonus scores. These changes will be an all-or-nothing conversion: the proposition will reduce available PI measures to 6, and all 6 measures must be completed with a numerator of at least 1 and will be scored on performance.

Only small practices will maintain the 3-point floor on quality measures. Larger practices can only receive 1 point on quality measures that do not meet data completeness. Data completeness will stay at 60%. There will be a suppression of measures impacted by clinical guideline changes during the performance period. There is a proposed one-year removal timeline for “extremely topped out” measures.

- Measure 12 – (POAG Optic Nerve Evaluation) – Retained
- Removal - #18 Diabetic Retinopathy – Presence or Absence of DME, severity
- #140 ARMD – use of antioxidant supplement

## Resource Use (Cost) Weighting In MIPS

Cost will increase to 15% of MIPS score in 2019 and will be up to 30% by 2022. This is based on a flawed Value-Based Modifier (VBM), flawed attribution, and flawed risk adjustment. Resource use metrics is derived solely from claims data with no reporting. Total per capita cost (TPCC) per beneficiary is mostly primary care and Medicare spending per beneficiary (MSPB) is mostly for inpatient care.

Cost Episode Groups are a coming attraction for 2019. These were developed by clinicians led by Acumen, LLC (consultant to CMS). The first wave of these groups will include:

- Elective Outpatient Percutaneous Coronary Intervention (PCI)

*Continued on page 18*

- Knee Arthroplasty
- Revascularization for Lower Extremity Chronic Critical Limb Ischemia
- Routine Cataract Removal with Intraocular Lens (IOL) Implantation
- Screening/Surveillance Colonoscopy
- Intracranial Hemorrhage or Cerebral Infarction
- Simple Pneumonia with Hospitalization
- ST-Elevation Myocardial Infarction (STEMI) with PCI

The first wave goes into effect in 2019 (with the payment year being 2021). CMS published details about Cost Effective Groups in the Final Rule. These should be more accurate and fairer than VBM, with scores based on costs under the physician's control, better attribution, and risk adjustment methodology. These will be a part of the cost score in MIPS, but their weight between groups, MSPB, and TPCC performance scores are unknown. Most ophthalmologists should not have MSPB, but some have TPCC scores. If physicians are ineligible for cost episode and have no MSPB or TPCC score, the group's weight will be shifted to quality.

Only code 66984, Routine cataract/IOL surgery, is eligible for the Cost Effective Group and nearly half of all these cases are excluded. All cases that would have been excluded in the two cataract PQRS measures (including the 120-day look-back period prior to date of surgery and any PQRS-excluded diagnosis listed anywhere on the claim form) are also excluded. This eliminates high-risk cases that would otherwise be difficult to risk-adjust. The minimum number of eligible cases necessary to generate a score is 10.

Pre-op costs occurring within 60 days prior to surgery are included in Cost Effective Groups. These include office visits and tests by any provider with cataract as a primary diagnosis and tests potentially considered part of cataract workup regardless of diagnosis (A-scan, optical biometry, topography, tear osmolality, OCT of macula, etc.). Costs associated with the procedure itself, such as the physician fee, facility fee, and anesthesia fee are also included. Post-op costs, including complications such as retained lens fragments, IOL repositioning/exchange, retinal detachment, and endophthalmitis occurring within 90 days after surgery may likewise be encompassed, but only costs billed to CMS (excluding routine postop visits in global period) are eligible.

### **Costs Not Under the Physician's Control**

There are aspects of patient care in which physicians do not have control over costs. Physicians may not have a choice as to where they perform surgery, and HOPD cases are costlier than ASC cases. Likewise, there is a price disparity between unilateral and bilateral cases as bilateral cases are inherently less costly because they involve only one pre-op H&P, A-scan/optical biometry/IOL calculation, etc. This not only includes same-day bilateral cases, but any bilateral cases done within 30 days of each other. Physicians also do not have complete cost control in co-managed cases, but no significant cost difference has been found in field testing.

The solution is Sub-grouping. Sub-grouping eliminates these inequities. Four subgroups were developed after field testing based on:

- HOPD vs. ASC
- Unilateral vs. Bilateral (within 30 days)

Subgrouping would exclusively compare similar cases and would assign subgroup scores based on costs within each subgroup. The final score would be calculated based on the weighted average of subgroup scores.

## Additional Risk-Adjustment Factors

In calculating risk-adjustment, a linear regression model is applied to control for beneficiary characteristics such as:

- Age
- Proctored resident cases
- New vs. established patients
- End stage renal disease (ESRD) status
- Institutionalized in a long-term care facility
- Hierarchical Condition Categories (HCC) data

The calculation shown is an example of Routine Cataract Removal with Intraocular Lens (IOL) Implantation Cost Measure:

**Calculation: Risk-Adjusted Cost Measure**

Routine Cataract Removal with Intraocular Lens (IOL) Implantation Cost Measure

	Unilateral ASC			Bilateral ASC		
	Episode 1	Episode 2	Episode 3	Episode 4	Episode 5	Episode 6
Obs.	\$3,300 /	\$4,890 /	\$4,020 /	\$5,270 /	\$6,850 /	\$5,460 /
Exp.	\$4,000 =	\$4,100 =	\$3,700 =	\$6,200 =	\$5,900 =	\$5,000 =
	0.825	+ 1.193	+ 1.086	+ 0.850	+ 1.161	+ 1.092
	= 6.207					
	6.207 / 6 episodes = 1.035					
	<b>\$5,325 = National Average Observed Episode Spending</b>					
	<b>1.035 * \$5,325 = \$5,508.88</b>					

## Implementation of Cost Episode Groups

The implementation of Cost Episode Groups begins in 2019, and scores will impact 2021 Medicare payments. No major changes are anticipated but are subject to change. Cost will account for 15% of MIPS score in 2019 and will increase to 30% no later than 2022 (previously set for 2020).

The weight of each episode group, MSPB (Medicare Spending/Benefits), and TPCC (Total Per Capita Cost) scores for the final cost score unknown. Most ophthalmologists will not have MSPB and only some will have TPCC scores, so episode groups will likely be the sole determinant of cost score for most. If a physician has no score in any of the three areas, the cost component of MIPS will be shifted to quality.

Cost episode scores can be found on CMS' QRUR website.

## MIPS and the IRIS® Registry

Benefits of IRIS® Registry participation include:

- Help in meeting quality reporting requirements
- MIPS success – 20% of general doctors were penalized 4%. No AAO Iris users were penalized.
- At least one outcome or high priority measure for most participants to report

*Continued on page 20*

## *We Will Win This Race to Quality!*

*Continued from page 19*

- Supports credit for improvement activities
- Facilitates promoting interoperability reporting by including a web entry portal

Physicians can earn bonus quality points via IRIS Registry participation for reporting multiple outcomes measures and for utilizing electronic reporting through the IRIS Registry-integrated EHR.

What are the results of this quality movement to measure performance and cost transparency?

- True values that are patient centered
- Positive care results measured by the impact on patients' lives
- Ophthalmology is best positioned to produce patient life quality
- All operations include life quality – Cataract 98% success
- We have the data with IRIS Registry

### **Telemedicine – Providing Clinical Healthcare**

Types of Telecare

- Ambulatory Care
- ED Acute Care
- In-Patient Care
- Transitional Care
- Remote Monitoring

Modes of Telemedicine:

- Synchronous – Face to face audio/video link in real time. This includes clinic-to-clinic video, home video visit, TeleConsult, urgent care video visit, and specialty care video visit.
- Asynchronous – Take photos or remote monitoring and send to reading room. This includes DR Screening, ROP screening, eConsult, and eVisit.
- Remote Patient Monitoring
  - AMD
  - Glaucoma

The tools of Telemedicine are employed by both patient and clinician. Patients use personal smart devices such as laptops, iPad, iPhone, and MyChart and may be provided remote monitoring devices like AMD and Glaucoma. Clinicians also utilize personal smart devices, but also use “black boxes” like AI and Decision Support.

Telemedicine is largely cost effective. Screening programs allow for the avoidance of costs associated with clinical care for advanced disease and societal costs for patients with severe vision loss. It also allows for increased access, efficiency, and patient satisfaction

The largest problem is reimbursement, which is currently received from hospital-based subsidies. State licensing, credentialing, and liability are also challenging.

## Telemed D R Eval:

By 2030, nearly 440 million individuals will have diabetes worldwide. It is unlikely that current eye care coverage will be able to keep pace with the increase in global rates of diabetes, and the task of detecting and evaluating diabetic retinopathy will become a considerable economic and resource burden on the healthcare system.

A solution to this growing problem is the Automated Retinal Image Analyzer. The analyzer would allow for automated grading vs decision support. This is a critical step in increasing the efficiency of image grading in an accurate and cost-effective manner. It allows for point of care delivery of findings. Several of these systems are approved in Europe (CE mark), but only one has FDA clearance in the United States. Although the analyzer is an automated tool, it is arguably no longer considered telemedicine.

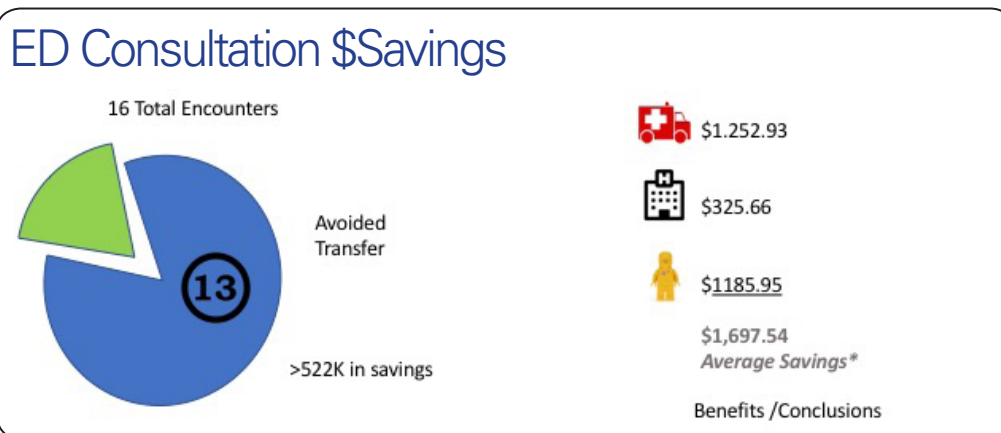
Another solution is the Tele-Diabetic Screen. The FDA has permitted the marketing of an artificial intelligence-based device, the IDx-DR, to detect certain diabetes related eye problems. The IDx-DR will be the first autonomous AI – based system to be marketed in United States and will be released soon.

Artificial Intelligence (AI) has been advanced by culture change. It can provide many benefits, such as limiting human error, helping with rare disorders, assisting with surgery, and predicting disease. But, are physicians and patients ready to trust what a machine “thinks” and “sees?”

## Emergency Department Ophthalmology Teleconsults = Savings

Traditionally, transfers from community hospitals to tertiary care result in additional costs of transportation and multiple visits. ED Consultations would remove the need for transfers, saving patients an average of \$1,697.54 in ambulance and patient care costs.

Johns Hopkins Experience:



Continued on page 22

## CMS Failed Rule Changes

CMS proposed rule changes to statutory restrictions in the Social Security Act to place limits on:

- Services CMS may cover as “Medicare telehealth services”
- Beneficiaries eligible to receive them.

CMS does not have the authority to change limitations relating to geography, patient setting, or type of furnishing practitioner for telehealth services.

## Old Telemedicine Codes

- **92227** - Remote imaging for detection of Retinal disease
  - Photo screening with analysis and report (\$15)
- **92228** – Remote imaging for monitoring and management of active retinal disease with physician review, interpretation and report (\$35)
- **99091** – Remote monitoring code \$58
- **92250** - Fundus Photography – NOT to be used for screening \$59

## New Virtual Telemedicine Care Codes

- G2012 – Virtual check in to decide whether an office visit or service is necessary (\$14.29)
- G2010 – Remote evaluation of recorded video or images submitted by an established patient to assess whether a visit is needed (\$9.40)
- Chronic Care Physiologic Monitoring:
  - **99453** (\$19.64)
  - **99454** (\$64.96)
  - **99457** (\$51.86)
- Interprofessional internet physician consults:
  - **99451** (\$37.51)
  - **99452** (\$37.51)
  - **99446** (\$18.43)
  - **99447** (\$36.50)
  - **99448** (\$54.94)
  - **99449** (\$73.01)

Detailed descriptions of these new codes are not yet available. Furthermore, at these low allowables, I cannot see how they will be of much use to ophthalmology.

## Recent Managed Care Hassles

### Risk Adjustment Audits by Medicare Advantage Plans

More complex diagnoses greatly increase MA plan reimbursement from Medicare. They request records, usually a large number, so they can mine the data for more complex diagnoses. Most contracts require that you comply to the audit but some say you cannot be compensated. This is a big time commitment even if they send over a person to use your computer, as you must assign a staff person to babysit the audit team. I suggest the

following: bill them \$25 per chart plus the cost of shipping and postage in advance, try negotiating a lower number of charts, and don't capitulate too early – just tell them you will comply but set the terms. Remember that third-party contractors are conducting these audits. They are pushy and they don't get paid without results.

## Aetna HMO

The PCP referral must contain procedure codes approved. Many PCP's leave the form blank and the claim will be denied. They must put 99499 on the pre-approval, and then all will be approved and claims paid. They must do this in advance of you seeing the patient except for an office visit only. 99499 is needed for any testing or surgery other than a routine office visit.

Aetna has a limit of two comprehensive eye exams per year. Additional comprehensive eye exams will be downcoded.

## United Healthcare

The PCP's choice by patient determines NTSP or Wellmed. When the patient changes PCP with an already-approved procedure from the former PCP, the claim will be denied. Plan changes and pre-approvals are a mess – they are non-pay claims. You must appeal. Plans handle refraction and copays differently.

NTSP – the refraction is only covered one time per year at 50%; for additional refractions, you must have a non-covered waiver on file and then bill the patient 100%.

There is much variation in how claims for bilateral procedures on the same day are filed:

- MA Plans: Intravitreal injections – 2 injections performed on the same day.
- Aetna MA Plans: 150% bilateral claim – must appear on two separate lines:
  - Line 1: The procedure – 100%
  - Line 2: Modifier 50 – 50%
- Regular Medicare: requires one line: Modifier 50, paid at 150%.

## Humana

There is great variation in how claims are processed this year. Your staff must check all claim remittance and fee schedule plan benefits. Question all claims and strongly appeal any denials if you are right.

## Coding Questions TOA Member Benefit

Members' coding and billing questions may be faxed to

**John Haley, MD** at  
(972) 276-5413 or

**Jeff Whitman, MD** at  
(214) 754-0079 or

may be submitted to  
[coding@TexasEyes.org](mailto:coding@TexasEyes.org).  
State the member's name.

Drs. Haley and Whitman volunteer their time to provide this valuable service. All they ask in return is that questions be submitted by physician members. It is important for physicians to get involved with coding.



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## Upcoming Events

**January 26, 2019**

Codequest  
*San Marcos*

**March 29, 2019**

Codequest  
*Lubbock*

**April 6, 2019**

Codequest  
*Houston*

**February 5, 2019**

TMA First Tuesday Advocacy Day  
& TOA Executive Council Meeting  
*Austin (any member may attend)*

**March 30, 2019**

Codequest  
*Dallas*

**April 10 – 13, 2019**

AAO Congressional Advocacy Day  
and Mid-Year Forum  
*Washington, DC*

**March 4, 2019**

TMA First Tuesday Advocacy Day  
*Austin*

**April 2, 2019**

TMA First Tuesday Advocacy Day  
*Austin*

**May 7, 2019**

TMA First Tuesday Advocacy Day  
*Austin*

**May 16 – 18, 2019**

TOA Annual Meeting & TexMed  
Dallas, TX

Go to [www.TexasEyes.org](http://www.TexasEyes.org) or contact TOA at 512-370-1504.