



TOA NEWSLETTER

Texas Ophthalmological Association

February 2015

President's Message

By Sidney Gicheru, MD

I just returned from a weeklong mission trip in Haiti. My church has supported an eye clinic in Petit Goaves (a small village 2 hours away from Port Au Prince) for over 30 years. We were highly productive and saw over 1,000 patients and did about 40 cataract cases. The trip was gratifying, but I also learned a lot. After some introspection, I came to understand that some of the lessons apply to the TOA:

Lesson 1: SCOPE OF PRACTICE MATTERS

On this trip, we did not have access to Phacoemulsification and had to rely on MSICS (manual small incision cataract surgery). I think of myself as a skilled Phaco surgeon. But, it had been about 14 years since my last Extracap. I had taken an MSICS course in Fort Worth a few weeks before the trip. I quickly learned that I could easily perform MSICS on most of the patients. But, the dense brown cataracts were truly humbling.

I am typing this message at DFW airport as I get ready to board a plane for Austin to attend a TMA First Tuesday Lobby Day. This is a program that allows regular doctors to meet our state leaders in Austin to discuss our healthcare issues. The sessions occur on the first Tuesday of February to May when the Texas Legislature is in session (every two years). These days when we step out of our worlds and into theirs are rewarding and educational – for both physicians and their legislators. I hope that you'll join me in March, April and May for First Tuesdays.

We are gearing up for a busy session and expect the Optometrists to ask for expanded scope of practice. As in Louisiana and California, they might argue that they should be permitted to do surgery. At a minimum, the optometric association is seeking to remove any physician input in the treatment of glaucoma patients they see in their practices. With the growing number of problem patients we see with preventable vision loss, we need to tighten this relationship and not just set patients on a “buyer beware” journey for appropriate care. But an important question needs to be asked: How can a professional who has not attended medical school perform eye surgery or even ask for expanded scope? As a highly trained Ophthalmologist with 14 years experience in practice, I was able to recognize that I had some limitations with MSCIS. How can a person with no training ask to perform eyelid lesion excisions, laser procedures or even cataract surgery? I urge every Ophthalmologist in Texas to attend First Tuesdays this year and let our legislators hear that surgery in Texas will be performed only after completion of medical school and a residency. No healthcare providers should be permitted to practice beyond their education, training and experience. We need to fight for the safety of Texas patients, including those we will never see in our offices.

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TexansForSafeSurgery.org

The Race to the Bottom in Eye Care Safety and Quality is Underway and the Patients Will Have no Clue or Chance without You Getting Involved for Them.

And They're Off!! Legislative Alert

By David G. Shulman, MD, Chair, Committee on Legislative Activities & Jay Propes, Legislative Consultant

The Race to the Bottom in Eye Care Safety and Quality is Underway and the Patients Will Have no Clue or Chance without You Getting Involved for Them.

Though this was certainly expected, we now (as of February 15) have three bills designed to lower the standard of training for providers of medical and surgical eye care in Texas. These bills were ironically filed on Friday the 13th, and glaucoma patients and others without knowledge of the training and educational differences between ophthalmologists and optometrists should be feeling full-on *triskaidekaphobia*.

[House Bill 1413](#) by Representative Craig Goldman of Fort Worth allows for several surgeries including laser surgeries to be performed by optometrists; it also eliminates any physician input in the management of glaucoma of any kind when these patients are seen by an optometrist and therapeutic optometrist. [House Bill 1420](#) by Representative J.M. Lozano and [Senate Bill 577](#) by Senator Charles Perry of Lubbock are *companion bills*, meaning they were identical, as filed. These bills are even more wide open and eliminate any restrictions on the formulary prescription of antibiotics or antivirals, allow for the prescription of hydrocodone (even though it is now classified as scheduled to by the FDA as a Class II agent) and a three-day supply of any controlled substance in schedules III, IV, or V, for analgesic use. The bill also allows for subconjunctival injections and for surgical procedures that are limited only by the enumeration of those that are prohibited.

This would be a good time to reacquaint yourself with your state representatives and senators and to commit to coming to First Tuesday Lobby Days on March 3 and April 7. There are a lot of members of the legislature who weren't around when the last discussion of optometric scope of practice occurred. Many of them do not even know the difference in training between optometrists and ophthalmologists and need to be so informed – quickly. Please go to <http://www.fyi.legis.state.tx.us> to determine who represents you in the Texas House and Senate. If you view the content of the bills filed and referenced above (www.capitol.state.tx.us), you will see that this is a real threat to Texas *patients* and they need your help right now. If you are comfortable contacting your representatives, please do so and let them know of your concern about these bills and what they might mean to your patients *and* to patients in Texas you will never even meet.

We will keep you informed as these bills go through the legislative process, but know that our work has to begin right now. It starts with letting the legislators know that you care enough to share your background and information with them so that they can make a solid decision in the safe and intelligent oversight of healthcare in this state.

Lesson 2: POLITICAL INVOLVEMENT MATTERS

When we landed in Port au Prince, our medical team of 30 had our medical equipment, supplies and medications confiscated. Haitian customs said we were missing a letter from the Haitian Ministry of Health. Without this letter, we were going to have to pay “customs duty.” They would not readily tell us the tax rate, and clearly any monies paid were not going to the Haitian Treasury. After 4 hours of negotiations, we left the airport dejected.

I decided to call my congressman, US Representative Pete Sessions. I woke up the next morning to see 10 messages from my wife. Apparently, Representative Sessions had called the State Department to help and they had been trying to reach me all night. I called back and they put me in touch with the US embassy in Haiti. By 11 am, most of our supplies were released by customs. Granted, a lot of other people made efforts, but I like to think that Pete’s intervention is what saved our mission.

I bring this up because having good relationships with our members of Congress can have some unexpected benefits. At the TOA, we are adopting a new online tool called RAP Index to help us determine which TOA members have strong relationships with which legislators. Your friends and family have key relationships as well – we want to know about them: Go to the links listed or use the QR codes to the right. Please complete it. It is straightforward and I was able to do it in less than 3 minutes. Or use the abbreviated form in this newsletter.

Lesson 3: OPENNESS MATTERS

In Haiti, we practiced “community” medicine. That means we saw patients in large rooms filled with loads of other patients. Sometimes waiting patients would help you translate for your current patient. Unfortunately, this meant patient privacy went out of the window. But with limited clinical space and hordes of patients, it was the only way to operate. Openness can be a good thing. In our case, it actually helped with efficiency.

The TOA Executive Council has regular meetings and the meetings have always been open to any TOA member. We want to be more open and inclusive. Going forward, we will be inviting a few TOA members and non-members to our Executive Council meetings. This is a good way to see the Executive Council at work and witness the many issues we grapple with. If you are interested in attending, please reach out to our Executive Director, Rachael Reed, at Exec@Texaseyes.org. The next Executive Council meeting will be April 30 in Austin.

TOA Member Survey:
<http://re.spon.se/NqrdOx>



**Friends & Family complete
this key contact survey:**
<http://re.spon.se/1FEly3>



Save the Date!

TexMed 2015 & TOA Annual Meeting
May 1-2

Austin



Plan on attending the 2015 Annual Meeting in Austin, May 1-2. It will again be held in conjunction with Texas Medical Association's TexMed Conference. Look for registration materials soon.

Halsey Settle, III, MD is the program director for this TOA meeting.

Editor's Message and Coding Updates

By John Haley, MD, Chair, Liaison Committee to Third Party Payors

Well, it is starting to happen...only much sooner than we had anticipated. The Centers for Medicare & Medicaid Services (CMS) just announced an accelerated transition to value-based payments for providers and hospitals. Somehow, they plan to tie fees to whether patients get healthier. Policy makers widely agree that our US healthcare system needs to move away from rewarding providers for volume and focus on rewarding the value of care being provided. Providers currently are paid set fees for every procedure performed, regardless of patient outcome. The CMS goal is to deliver better healthcare and spend healthcare dollars wisely. Its interim target is to have 30% of reimbursements value-based by 2016 and 50% by 2018.

These are interesting words. But what do they mean to us? Other than ACO's (which still run on a fee-for-service backbone) and some hospital readmission programs, I do not see a quick fix. Perhaps this means more tough negotiations with the hospital systems to reduce cost shifting. The only way I see that CMS can quickly apply value-based payments to ophthalmology is to implement our PQRS and value-based modifier programs at a faster pace. More later.

So, with that note of cheer, I hope you have been paying attention to the tsunami of regulatory penalties that may cut doctor pay by up to 13%. That is here now: paste the table below to your morning shaving mirror and bathroom wall so you can study it. Note the severe penalties that will occur already over the next six years beginning in January.

CMS Incentives and Penalties with Current Law

Year	Deficit Reduction Sequester	Electronic Prescribing	Meaningful use (HIT)	PQRS/MOC	Value Based Modifier (group size)	TOTAL RISK
2014	(-2%)	(-2%)	\$4 - 12K	1.5% - 1%		(-4%)
2015	(-2%)		(-1%)/\$2-8K	(-1.5%)	(-1%);>100	(-5.5%)
2016	(-2%)		(-2%)/\$2-4K	(-2%)	(-2%);>10	(-8%)
2017	(-2%)		(-3%)	(-2%)	(-4%) groups of 10 or more (-2%) groups of <10 or more	(-11%)
2018	(-2%)		(-4%)	(-2%)	2018	(-12%)
2019	(-2%)		(-5%)	(-2%)	2019	(-13%)

The penalties are increased by the ongoing deficit reduction sequester, Meaningful Use of EHR, PQRS/MOC and the value-based modifier. Note these penalties go from up to 4% this year to 13% over the next six years. That doesn't seem worth the effort to comply, feedback continue to hear on a daily basis. What does a 13% Medicare allowable cut really mean?

What does 13% Medicare Payment Mean?	
If Gross Medicare Payments – \$ 1,000,000 with 60% overhead \$ -600,000 (overhead) <hr/> \$ 400,000 NET	With a 13% Cut GROSS Medicare Payments – \$ 870,000 \$ -600,000 (overhead) <hr/> \$ 270,000 NET
32% cut to the bottom line, if all Medicare	

A 32% cut to your bottom line is unsustainable and that's without the other cuts that are coming.

The SGR

The Sustainable Growth Rate (SGR) is the formula Medicare uses to calculate payments to physicians. The SGR is based on the gross domestic product, not actual healthcare costs. The SGR was intended to be a budgetary restraint on Medicare's total expenditures, effectively lowering reimbursement per service performed if the utilization of physician services increases above an arbitrary target.

Without Congressional repeal, the SGR will continue to threaten steep cuts to physician payments because practice costs continue to rise. Congress has delayed the enforcement of the SGR for the past several years with legislation commonly called "Doc Fixes." On March 31, 2014, Congress passed the most recent "Doc Fix," the Protecting Access to Medicare Act, delaying the implementation of the conversion factor until March 31, 2015.

Without permanent reform, practices face a 21% cut come April 1, 2015. The American Academy of Ophthalmology (AAO) believes that physicians need fair and stable updates similar to other providers; delays and short term fixes are fiscally irresponsible; and repeal of SGR is necessary to permanently reform Medicare physician payment.

The Protecting Access to Medicare Act (HR 4302) last year was another short-term patch, providing a 0.5% update for the remainder of 2014; a 0.0% update for January – March of 2015; and the delay of ICD-10 implementation until October 1, 2015. Medicine opposed the ongoing and increased review of "mis-valued codes" as the bill's funding mechanism or "pay for." Momentum is now building for a permanent repeal.

So what is wrong with the "mis-valued code" pay-for? The "mis-valued code" targets specialists/surgeons and sets an unrealistic four-year target of 0.5% in annual savings. There have already been \$4 billion total in cuts, with \$2.5 billion already cut from specialists/surgeons. And recently revalued codes are not exempt from review. There will be across-the-board fee schedule cuts if targets are not met.

Congress needs to get back to bipartisan, bicameral efforts to find offsets to take advantage of the reduced SGR repeal cost estimate. Another \$20 billion patch will get us no closer to repeal and it increases the costs. Immediate relief from current penalties in Medicare quality improvement programs is needed. They must reverse the "mis-valued codes" pay for. The 17 temporary fixes have cost \$169.5 billion.

There are payment problems overall. In April, 2015, a 20+% SGR cut is scheduled. The CBO cost of repeal remains the lowest it has been at \$116 billion over 10 years. (I just heard the CBO now projects \$177 billion for

(Continued on page 16)

Member Spotlight



Jane Edmond, MD has been a TOA member for over 15 years. She serves on the AAO Board of Trustees and always helps guide the residents at Congressional Advocacy Day in DC.

TOA: Give us a summary of your training and career in ophthalmology.

I received a BA in biology from the University of Texas, Austin and my medical degree from Baylor College of Medicine in 1985. Subsequently, one of the happiest moments in my life was when I received my match results for ophthalmology residency. Over the next four years at Baylor, I did an internship in internal medicine and completed my ophthalmology residency. Between Ben Taub, the VA and the outstanding faculty, it was an incredible learning experience, but it was very intense.

Following my residency in 1990, I began my fellowship in pediatric ophthalmology and strabismus at the University of Iowa. At the end of my fellowship, I got a page from Danny Jones. I was certain that it was going to be bad news, maybe that I was being sued. To my relief, surprise, delight and honor, DBJ invited me to return to Houston and join the ophthalmology department at BCM and Texas Children's Hospital. Gunter and Paul Steinkuller were my colleagues. Gunter von Noorden taught me so much about strabismus that it was like an extended fellowship. Paul Steinkuller and I spent most of our time together laughing!

In 1997, I moved to Philadelphia and took a position at Children's Hospital of Philadelphia (academic appointment at Sheie Eye Institute) and ran a weekly resident clinic at Wills Eye Hospital. I met many amazing and inspiring physicians at those institutions.

In 2003, I returned to the BCM department of ophthalmology and Texas Children's Hospital. I did a second fellowship in neuro-ophthalmology at BCM in 2006 with Rod Foroozan. It was a much appreciated sabbatical and Rod was an excellent mentor. I worked as any other fellow, getting histories, performing intraocular pressure readings and dilating all the patients. At least the adult patients didn't kick and cry like my pediatric population!

Currently, I am an associate professor of ophthalmology and practice pediatric ophthalmology, pediatric and adult strabismus, and pediatric neuro-ophthalmology.

My primary interests are strabismus secondary to thyroid eye disease and the ophthalmic impact of pediatric brain tumors and craniofacial disorders.

TOA: What do you do in your free time?

In the past few years, I've sort of run out of free time, unfortunately! This problem has not stopped me from making thorough use of the Neiman Marcus app on my phone, however. Hopefully in the near future, I can re-discover my love of oil painting, gardening, and cooking. I would also like to visit my family ranch near Wimberley, Texas more frequently.

TOA: Explain the TOA in two sentences like you're telling someone about it for the first time.

"Would you be comfortable if your mother received an eye surgery from a doctor who took a weekend course to learn the surgical technique? The Texas Ophthalmological Association, via its excellent relationship with the Texas legislators and their 800+

ophthalmologist members, ensures that eye surgery in Texas is performed by ophthalmologists — the Eye MDs.”

TOA: You serve on the AAO Board of Trustees. Why did you decide to get involved nationally?

Over the past twenty-five years, I have served on more committees with the AAO and AAPOS than I can count! Two years ago, I was nominated to the position of Trustee-at-Large by the AAO Board of Trustees, and voted in by the membership. It is a great honor to serve in this position. We have an incredibly valuable Academy, with more than 90% of US ophthalmologists serving as members. David Parke is an engaged, invested and visionary EVP. It’s a great experience!

TOA: It feels as if “advocacy season” is upon us with First Tuesdays at the Texas Legislature and AAO’s Congressional Advocacy Day coming up. It’s a sacrifice to shut down the office to come visit lawmakers, but what will happen if ophthalmologists stop getting engaged?

All Texans, like my mom, would be at risk of receiving eye surgery from an eye doctor who took a weekend course to learn the surgical technique. We, as ophthalmologists, must advocate for our patients, and to do this we must form relationships with our legislators and support our primary advocacy organization, the TOA.

TOA: If you could, what advice would you go back and give your 25-year-old self about practicing medicine?

I would tell myself to not stress about my suboptimal academic productivity during the 10 years I would work part-time to be with my young kids. I would tell myself that getting involved in advocacy and my state ophthalmological organization is NOT about protecting our turf as ophthalmologists. I would advise myself to always make time for hobbies and friends! Lastly, I would tell myself to take computer proficiency classes, because in the future my paper chart would tragically be replaced by an unfriendly EHR!

Welcome New Members

The Executive Council voted in the following new members in February, 2015:

Provisional Members

Rehan Ahmed, MD – San Antonio
Richard Bond, MD – Corpus Christi
C. Brad Bowman, MD – Dallas
Monica L. Bratton, MD – Irving
Richard Chun-Hsien Chu, DO – Fort Worth
Elena Geraymovych, MD – San Antonio
Sandhya Iyer, MD – Dallas
Joseph T. Kavanagh, MD – Seguin
Megan Liu, MD – Dallas
Emma Loucks, MD – Galveston
Lori Murphy, MD – Austin
William H. Quayle, MD – Houston
Vivek Raizada, MD – Beaumont
David Schuller Risner Jr., MD – Longview
Caleb Sawyer, MD – Weatherford
Susan L. Swanson, MD – Dallas
Misha F. Syed, MD – Galveston
Elaine Thung, MD – Houston
Louis E. Verstringhe III, MD – Shenandoah
Allen T. Wang, MD – Duncanville

Resident Members

Shazia Ali, MD – Houston
Lucas Groves, MD – San Antonio
Mohamed Guenena – Dallas
Aaron Hager, MD – San Antonio
George Joseph, MD – Lubbock
Aimee Lam, MD – San Antonio
Vlad Matei, MD – Dallas
Sagar Yatin Patel, MD – Dallas
Megan Scott, MD – Houston
Julie Soto, MD – Dallas

Fellow Members

Richard Moore, MD – Irving
Jeffrey Peterson, MD, PhD – Houston
Deepak Sobti, MD – Dallas

Collaborative Management of Glaucoma

The ophthalmologist will confirm the diagnosis within 30 days of the diagnosis of glaucoma made by the optometrist.

The following article was published in the December, 2014 issue of the Texas Medical Board Bulletin. It is a good reminder of the responsibilities involved in co-management.

In 1999, the Texas Legislature passed HB 1051, addressing the issue of untreated glaucoma by authorizing therapeutic optometrists to diagnose and treat patients with glaucoma under a limited set of circumstances with a co-managing ophthalmologist. Subsequent to the law taking effect, both the Texas Optometry Board and the Texas Medical Board adopted rules to implement the provisions of collaborative management of glaucoma. The relevant statutory and rule sections are cited below:

- Texas Optometry Act, Section 351.3581, Occupations Code.
- TMB Rule 193.19. “Collaborative Management of Glaucoma,” (under Chapter 193 “Standing Delegation Orders).

TMB Rule 193.19 outlines minimum standards for collaborative management of glaucoma for the treating ophthalmologist. There are 10 basic guidelines listed as follows:

- 1) The ophthalmologist will confirm the diagnosis within 30 days of the diagnosis of glaucoma made by the optometrist. While the ophthalmologist may, in his or her discretion, require that the patient visit the ophthalmologist for a face-to-face visit, such a face-to-face visit is not mandated. The ophthalmologist may, at the ophthalmologist’s discretion, rely upon the results of diagnostic tests performed originally by the optometrist, unless reaffirmation is needed.
- 2) The ophthalmologist must communicate in written form the confirmation of the diagnosis within 30 days, as well as the refinement of the treatment plan as recommended by the optometrist.
- 3) A proper medical record must be generated for each patient by the ophthalmologist and shall include all correspondence and testing results. The medical record must also include a written note made in the record by the ophthalmologist or a copy of the written informed consent demonstrating that the patient understands that he or she is participating in a co-management of primary open angle glaucoma.
- 4) The necessity for follow-up visits will be at the discretion of the ophthalmologist based on the communication of the patient’s progress by the optometrist.
- 5) The ophthalmologist must report any irregular behavior of the optometrist to the Texas Medical Board for referral to the Texas Optometry Board.

- 6) The ophthalmologist must enter into the patient's written medical records that the ophthalmologist has elected to enter into a co-management agreement with an optometrist.
- 7) It is at the discretion of the ophthalmologist to complete a clinical skills assessment with each optometrist in which a co-management arrangement exists. The ophthalmologist will, however, receive written confirmation and documentation that the co-managing optometrist has completed all of the requirements of the Optometric Health Care Advisory Committee to obtain the designation of "optometric glaucoma specialist."
- 8) A physician may charge a reasonable consultation fee for a consultation given when a patient is referred with a diagnosis of primary open angle glaucoma.
- 9) When a physician examines a patient involved in a co-management consultation with a therapeutic optometrist for treatment of primary open angle glaucoma, the physician shall forward to the therapeutic optometrist, not later than the 30th day following the examination, a written report on the results of the examination. A physician who, for a medically appropriate reason, does not return a patient to the therapeutic optometrist, shall state in the physician's report to the therapeutic optometrist the specific medical reason for failing to return the patient.
- 10) In order to enter into a co-management agreement with an optometrist, there must be an agreement between the two professionals that, following each visit, specified information, previously agreed upon by both the ophthalmologist and the optometrist, about the patient examined will be forwarded to the other practitioner.

RESOURCES

- Texas Medical Board Rules
<http://www.tmb.state.tx.us/page/board-rules>
- Texas Optometry Act
<http://www.statutes.legis.state.tx.us/Docs/OC/htm/OC.351.htm>

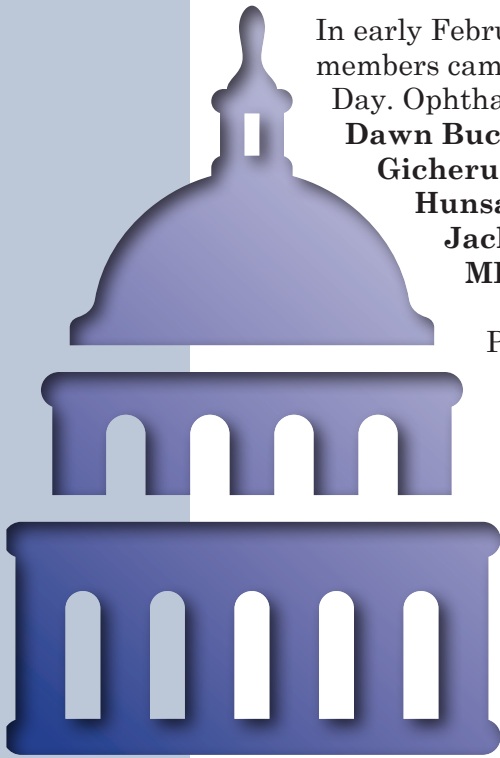
Editor's Note:

The preceding article is intended for general guidance only and does not replace the text of applicable Board rules and laws or ensure compliance.



Be sure to "like" the
TOA on Facebook
www.Facebook.com/txoph

TOA Legislative Update: Scope, Medicaid and More



In early February, over 300 physicians, medical students and alliance members came to Austin to participate in TMA's First Tuesday Lobby Day. Ophthalmology was represented by: **Michelle Berger, MD; Dawn Buckingham, MD; Amber Dobler-Dixon, MD; Sidney Gicheru, MD; Victor Gonzalez, MD; David Holck, MD; Jerry Hunsaker, MD; R. Galen Kemp, MD; Jacob Moore, MD; Jack Pierce, MD; H. Miller Richert, MD; Halsey Settle, MD; David Shulman, MD; and Stephen Whiteside, MD.**

Physicians from many specialties took this opportunity to educate lawmakers, especially newly-elected lawmakers, about the dangers of scope of practice expansion. TOA will continue to work with the TMA and the Coalition for Patient Safety to stop any efforts to expand scope of practice beyond that safely permitted by non-physician practitioners' education, training and skills.

Another top legislative agenda item for both TMA and TOA is to make improvements to Medicaid and specifically to restore funding for Medicaid-Medicare "dual-eligible" patients. Last fall, TOA signed onto a letter to the Legislative Budget Board urging the board members to fix the utterly inadequate physician payment rates in Texas Medicaid, which ultimately impact access to care. Specifically, the requests were as follows:

- Maintain Medicare parity in the 2016 to 2017 budget for primary care physicians currently receiving the higher rates.
- Extend the parity payments for primary care to services provided to CHIP.
- Establish competitive Medicaid and CHIP payment rates for physician specialties who are not included in the Medicaid to Medicare parity increase.
- Reverse the eight percent payment reduction for Physician Assistants (PAs) and Advanced Practice Registered Nurses (APRNs) practicing under physician supervision. The cut, which will take effect in early 2015, will undermine Texas' efforts to promote team-based models of care, an essential element of reforming the Medicaid delivery system.

Victor Gonzalez, MD (TOA officer) of McAllen is a member of the Border Health Caucus, which comprises physicians from the Texas-Mexico border region. During the February First Tuesday at the state Capitol, Dr. Gonzalez along with Sidney Gicheru, MD, participated in a news conference focusing on improving payments for physicians who see Medicaid patients, with particular focus on dual-eligible funding.

During the 82nd Texas Legislature, lawmakers made several funding cuts without knowing their complete impact, creating a medical emergency for thousands of

“dual-eligible” Texans (those who qualify for both Medicare and Medicaid) and the physicians who care for them. Texas has about 465,000 dual-eligible patients, who are among the sickest and most vulnerable people in our state.

Beginning Jan. 1, 2012, Texas Medicaid quit covering the Medicare deductible. It also decided to pay physicians and providers no more than the amount Medicaid pays for the same service, which, in most instances, eliminated payment of a patient’s coinsurance. The Texas Legislature in 2012 subsequently reinstated full payment of the annual deductible for dual-eligible patients. Yet, the patients’ physicians still face a cut of 20 percent for the coinsurance amount.

Along with his colleagues, Dr. Gonzalez urged lawmakers to make necessary improvements to Medicaid. He said he is concerned about physicians retiring and not being replaced. “I know many doctors who are close to retiring and for some, these Medicaid cuts are the straw that has broken the camel’s back. Many are deciding to retire or move away. It is very difficult to recruit a young physician with a big educational debt in such an uncertain economic situation. We will not be replacing those doctors that retire so access to care will continue to decrease in our community.”

Texas Medical Association’s First Tuesday lobby days are the perfect place for you to apply your advocacy skills on behalf of your patients. It’s very simple – come to Austin and tell legislators what you see in your office every day.

Register now to come to Austin March 3, April 7 or May 5 to tell your story. Go to www.texmed.org/firsttuesdays.


Health Committees

As this 84th Texas Legislative Session progresses, TOA will ask you to contact your senator or representative regarding pieces of legislation that impact ophthalmology and/or the House of Medicine. Some of our key legislators are:

2015 House Public Health Committee:

Rep. Myra Crownover, Chair (R-Denton)
Rep. Elliott Naishtat, Vice Chair (D-Austin)
Rep. César Blanco (D-El Paso)
Rep. Garnet Coleman (D-Houston)
Rep. Nicole Collier (D-Fort Worth)
Rep. Sarah Davis (R-West University Place)
Rep. R. D. "Bobby" Guerra (D-Mission)
Rep. Rick Miller (R-Sugar Land)
Rep. J. D. Sheffield (R-Gatesville)
Rep. Bill Zedler (R-Arlington)
Rep. John Zerwas (R-Richmond)

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Be a Lobbyist
for a Day: No
Experience
Necessary

March 3
April 7
May 5

Texmed.org/FirstTuesdays



2015 Senate Health & Human Services Committee

Sen. Charles Schwertner, Chair (R-Georgetown)
Sen. Lois W. Kolkhorst, Vice Chair (R-Brenham)
Sen. Donna Campbell (R-New Braunfels)
Sen. Craig Estes (R-Wichita Falls)
Sen. Charles Perry (R-Lubbock)
Sen. José R. Rodríguez (D-El Paso)
Sen. Van Taylor (R-Plano)
Sen. Carlos Uresti (D-San Antonio)
Sen. Judith Zaffirini (D-Laredo)

It will help TOA tremendously to know about relationships you or your friends and family have with lawmakers. Please complete the survey at <http://re.spon.se/NqrdOx> (it will pull up your legislators based upon your home address) or use the enclosed form.

Your friends, family, employees – they may have key contacts as well. They should use this abbreviated online survey <http://re.spon.se/lFEly3> or the same enclosed form.

2015-2016 Slate of Officers

Presented by the TOA Nominating Committee:

David K. Coats, MD, Chair; Rajiv Rugwani, MD; H. Miller Richert, MD; and Mark J. Gallardo, MD

Office	2015-2016 Office Holder	Notes
President	Halsey M. Settle, III, MD, Austin	Automatic Progression
President-Elect	Victor Gonzalez, MD, McAllen	NEW
Secretary	Aaron Miller, MD, Houston	NEW
Treasurer	Stephen Whiteside, MD, Austin	Continuing
Councilor	Jacob J. Moore, MD, Corpus Christi	Continuing
Councilor	Douglas Kappelman, MD, San Angelo	Continuing
Councilor	Amber Dobler-Dixon, MD, Amarillo	Continuing
Councilor	Arvind Neelakantan, MD, Dallas	Continuing
Councilor	Barbara Smythe, MD, Grapevine	NEW
Councilor	Open	Open
Councilor	Rajiv Rugwani, MD, Waxahachie	Continuing
Councilor	H. Miller Richert, MD, Abilene	Continuing
Councilor	Mark J. Gallardo, MD, El Paso	Continuing
AAO Councilor	R. Galen Kemp, MD, Waxahachie	Continuing
AAO Councilor	Aaron Miller, MD, Houston	Continuing
AAO Councilor	Sidney Gicheru, MD, Irving	NEW
AAO Alt Councilor	Dawn Buckingham, MD, Austin	Continuing
AAO Alt Councilor	Roberto Diaz-Rohena, MD, McAllen	Continuing
AAO Alt Councilor	Sanjiv R. Kumar, MD, Uvalde	Continuing

The 2015 business meeting will be held on Saturday, May 2 at the TOA Annual Meeting, in conjunction with TexMed 2015 in Austin.

Upon conclusion of the business meeting, elected officers will begin their terms. David K. Coats, MD, past president, will rotate off of the Executive Council after twelve years of service. We thank him for his years of leadership.

In Memory: Robert (Bob) Allen Neely, MD

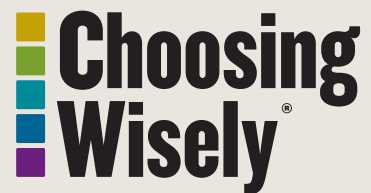
Born March 1, 1921, in Temple, Texas, Robert “Dr. Bob” Allen Neely, MD knew great love when he passed away peacefully in his home of Bellville on Monday, November 24, 2014. He was 93 years old and a member of TOA since 1987.

Dr. Neely served the Bellville community for nearly 50 years. He was a decorated veteran whose service during World War II earned him the American Campaign Medal. He also served during the Korean Conflict as a Senior Medical Corps Officer, for which he received the National Defense Service Medal. Dr. Neely was a proud veteran and Life Member of the Veterans of Foreign Wars.

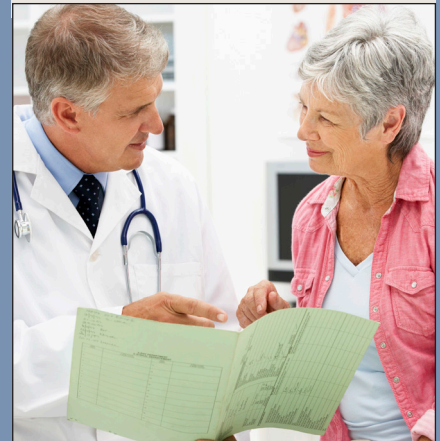
Dr. Neely graduated from UT - Austin in 1942 with his Bachelor of Science, and from the UT Medical Branch at Galveston in 1944, with a degree of Doctor of Medicine. He completed his post-graduate training in Ophthalmology at Washington University in St. Louis, Missouri, and later interned and completed his Ophthalmology residency at Hermann Hospital in Houston, Texas. He was certified by the American Board of Ophthalmology as a specialist in the field in 1957.

Dr. Neely maintained his medical practice in Bellville for the entirety of his medical career. He retired from the active practice of medicine on December 31, 1992 at the age of 71. He was active in both the local and national medical communities. He was a former trustee and staff member of the Bellville General Hospital, and the former President of Mid-Tex Nursing Homes. He was a member and former President of both the Austin-Grimes-Waller Counties Medical Society and the Ninth District Medical Society. Dr. Neely was particularly engaged with the Texas Medical Association. He served in the Texas Medical Association’s House of Delegates, and as a member of the Board of Directors of its Political Action Committee. Additionally, he was a member of the American Medical Association, the American Academy of Ophthalmology, and the American Medical Society of Vienna.

Our heartfelt condolences go out to Dr. Neely’s family and friends as we honor his many accomplishments within the medical community and particularly his service to the ophthalmological community.

**Choosing
Wisely**[®]

An initiative of the ABIM Foundation



The Texas Medical Association is advancing the *Choosing Wisely*[®] campaign, an initiative to help physicians and patients talk about avoiding unnecessary care.

Through the *Choosing Wisely*[®] campaign, TMA is helping Texas physicians spur conversation around evidence-based recommendations created by your medical specialty societies.

One-third of all physicians acquiesce to patient requests for tests and procedures — even when they know they’re not necessary.

For more information about *Choosing Wisely*[®], visit www.texmed.org/ChoosingWisely/.



Physicians Caring for Texans

TOA at Work

Drs. **Michelle Berger**, **Keith Bourgeois**, **Dawn Buckingham**, **Sidney Gicheru**, **Jerry Hunsaker** and **Jack Pierce** represented ophthalmology at the Texas Medical Association's 2014 Advocacy Retreat in December. The House of Medicine met to discuss priorities for the 2015 Texas Legislative Session.

Drs. **Sidney Gicheru** and **Mujahid Hines** invited new Texas State Representative **Matt Rinaldi** (R-Irving) to observe a cataract surgery in December. They explained the complexity involved in all surgical procedures. If you are interested in inviting your representative or senator to your surgical center, contact TOA for information.



Dr. Sidney Gicheru
Representative
Matt Rinaldi
Dr. Mujahid Hines

In mid-November, the AAO alerted TOA to a new iteration of a congressional bill, the "Protecting the Integrity of Medicare Act" (PIMA). The bill contained language requiring prior authorization of ophthalmic upper and lower eyelid procedures. Establishing a prior authorization requirement in statute for eyelid (blepharoplasty) and eyebrow procedures would have been unprecedented. No other Part B Medicare surgical procedure has a similar prior authorization requirement in statute. Drs. **Sidney Gicheru** (Irving) and **Mark Mazow** (Dallas) flew to Washington DC with a mere two days' notice to join AAO staff in a meeting with Representative Kevin Brady, Chair of the Health Subcommittee, Committee on Ways and Means. Drs. Gicheru and Mazow explained to Chairman Brady that, while everyone supports efforts to root out health care fraud, this provision would ultimately, and unintentionally, jeopardize patient access to care. The next day, Dr. **David Shulman** and our legislative consultant **Jay Propes** met with Chairman Brady in the Woodlands, his home district, to underscore the reasons for removing the pre-authorization provision and to thank him for his years of friendship and accessibility. While the eye lid savings

provision was not included in the final bipartisan PIMA legislation introduced by House Ways and Means leaders in December, the bill did not see action on the House floor before the 113th Congress ended. We do expect that this legislation will be a priority in the 114th Congress but AAO and TOA will continue to monitor it.

Michelle Berger, MD and her husband otolaryngologist David Tobey, MD, have been named as co-chairs for the 22nd annual TMA Foundation gala. The TMA Foundation is the philanthropic arm of the Texas Medical Association. Its gala will take place on May 1, 2015 in conjunction with the TexMed and with the TOA Annual Meeting in Austin.

During the 2014 American Academy of Ophthalmology Annual Meeting, the AAO Secretariat for State Affairs awarded TOA Executive Director **Rachael Reed, CAE**, with its “Outstanding Executive Director for Organizational Development” award. Ms. Reed has been with the TOA since July 2012 and also serves as executive director for the Oklahoma Academy of Ophthalmology.

TOA’s Member Services Coordinator **Skye Downing** has been selected for the 2015 class of Leadership TSAE. The Texas Society of Association Executives chose only fifteen young professionals from around the state to participate in this nine-month program, which is designed to help association professionals develop well-rounded skills and a broader knowledge base in association management.



Rachael Reed, CAE

Congratulations to the eight recipients of TOA travel scholarships to attend the AAO’s Congressional Advocacy Day and Mid-Year Forum in DC, April 15-18. These young ophthalmologists will represent Texas inside the US Capitol building. Thank you to the programs for nominating them and allowing for time off:

- **Soheil Daftarian, MD** - Texas Tech University HSC
- **Lena Dixit, MD** - Baylor College of Medicine
- **Robert Garoon, MD** - Baylor College of Medicine
- **Aimee Lam, MD** - UTHSC San Antonio
- **Sean Lutmer, DO** - The San Antonio Uniformed Services Health Education Consortium
- **Tahira Mathen, MD** - University of Texas Southwestern
- **Jeffrey Peterson, MD** - University of Texas Houston Medical School
- **Severin Pouly, MD, MHA** - University of Texas Southwestern

There is still time for any AAO member to attend Congressional Advocacy Day. Go to www.aao.org/meetings.

Send your appointments/accomplishments/awards to exec@TexasEyes.org for inclusion in the next newsletter.

this fix). Since 2001, practice costs have risen 26% and Medicare payments have increased only <4%. The 2% sequestration cut has been extended to 2024 as part of the debt limit bill.

Medicare Payment Basics

Resource Based Relative Value Scale (RBRVS) means CMS assigns a relative value to each CPT code based on the combination of three factors: physician work value (Wrvu), practice expense value (PErvu), and professional liability insurance value (PLIrvu). National payment for each service is determined by Medicare as follows: $Wrvu + PErvu + PLIrvu \times \text{Conversion Factor}$. The local payment is determined as follows: $(Wrvu \times GPCI) + (PErvu \times GPCI) + (PLIrvu \times GPCI) \times CF = \text{local payment amount}$. GPCI is the geographic practice cost index that is determined by CMS for every county/metropolitan statistical area in the US. The conversion factor will fall from the current \$38.8013 to \$28.2239 if the SGR is not fixed.

Payment Update for 2015

The final Medicare payment rule was released in November. There are extensive impacts for ophthalmology – including a projected -2% to our overall Medicare revenues. This doesn't include Final Values from CMS/RUC mis-valued code process. The CMS made an error in calculating malpractice values for ophthalmology services in 2010. Every specialty has a risk factor that is determined by state premium data. In the 2010 review of liability RVU's, CMS omitted the ophthalmology risk factor; instead, other higher specialty risk factors (neuro, ob/gyn) ended up in our data.

The reductions to the PLIrvu only impact 2-8% of any individual payment, but are dramatic overall. The biggest impact is on our high volume codes:

- 66982 proposed to decrease -2%
- 66984 proposed to decrease -4%
- 67028 proposed to decrease -3%.

CMS also proposes to eliminate the global surgical periods: end 10-day global periods by 2017 and end 90-day global periods by 2018. Most significantly, CMS would not allow the use of office visit or eye visit codes for post-op care, but rather some yet-to-be-determined payment for post-op visits, and they will most likely pay less than present.

The Academy strongly opposes finalizing this proposal without further review and input. It leaves payments for post-operative visits completely uncertain. It puts patients on the hook for adverse events, unforeseen consequences, costs of in-office drugs such as bacitracin, Afrin, etc. and additional co-payments. Patients may have to cut post-op care and monitoring short because of the added costs. The Academy and 40 other medical groups signed onto an AMA letter opposing this change. Thirty-seven members of Congress sent a letter to CMS also opposed to finalizing the proposal. The AMA Relative-value Update Committee (RUC) is comprised of 31 volunteer physicians who make recommendations to CMS about payment updates; ophthalmology has only one vote. CMS is charged with identifying and updating mis-valued CPT codes. The specialty societies make recommendations and the RUC reviews them. Much of the Academy's reimbursement work this year came from the ongoing CMS/RUC review of potentially mis-valued services. The Academy surveyed members for glaucoma, plastics and retina procedures that were presented to the RUC in 2013 and 2014.

Glaucoma

The RUC requested review of two glaucoma codes as possibly mis-valued. The Academy has now presented data for CPT 66180 Aqueous shunt and 66185 Revision of Aqueous shunt to the RUC. CMS data showed shunt codes were performed 76% of the time with 67255 Scleral patch graft. CMS requested new codes for shunts inserted with and without graft. Importantly, our surveys showed that the intra-service time and post-op visits of the existing shunt codes were consistent with current values. However, the RUC viewed the work of the graft as not adding significantly to the base codes. The combined shunt and graft code had 400 minutes of MD time built into

them. The new bundled code has 277 minutes. These new bundled codes will be paid much less than when 66180 and 67255 were billed together. The revision code when combined with the graft will also pay significantly less in 2015 – A 30% reduction.

Solutions?

The SGR patch legislation passed earlier this year has a provision that allows for a 2-year phase in of any payment cut of 20% or more. Although not effective until 2017, the Academy will push to have reductions for any of our codes that meet these criteria spread out. This is unlikely to be effective.

Retina

CMS identified the following as mis-valued in 2013: CPT 67036 Vitrectomy, mechanical, pars plana approach. The Academy and the ASRS presented six codes in the family for the October 2013 RUC meeting. RUC accepted the AAO survey values. There were very robust surveys with over 100 responses for each code:

- 67036 Vitrectomy
- 67039 focal endolaser
- 67040 panretinal endolaser
- 67041 macular pucker
- 67042 macular hole
- 67043 with removal of subretinal membrane

The surveys showed that all but one of these services required less time than is currently built into their work and PE values. Reductions in time varied from 20 minutes to over 100 minutes.

Vitrectomy Time

CPT Code	Current Total Time	New Survey Time	Time Set by RUC*
67036	276.50	288.00	257.00
67039	351.00	303.00	267.00
67040	387.50	316.00	280.00
67041	249.00	303.00	267.00
67042	269.00	303.00	267.00
67043	302.00	323.00	282.00

We know based on the RUC review that the total payments for these services will see lower work, PE and PLI values in 2015. The total reductions range from 7 – 25%.

CPT Coding Basics

There are two main categories of CPT codes:

Category I codes are the full 5-digit numeric codes that we are all familiar with such as CPT 66984 Cataract.

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Transition to ICD-10 almost certain for October 1.

Congressional leaders indicate they are unlikely to support further delays.

*Attend
CODEquest.*

*No matter
what your
level of coding
experience,
it's where you
need to be.*

(Continued from page 17)

Category III codes are for new procedures that don't meet the full requirements for a Category I code. Many are not covered, such as 0100T insertion of retinal prosthesis.

New Codes for 2015

There are two new codes for aqueous shunt procedures without scleral graft for 2015:

- 66179 Aqueous shunts to extraocular equatorial plate reservoir, external approach; without graft
- 66184 Revision of aqueous shunt to extraocular equatorial plate reservoir; without graft

Revised Codes for 2015

There are two revised codes for shunt surgeries with scleral graft for 2015:

- 66180 Aqueous shunt to extraocular equatorial plate reservoir, external approach; with graft (do not report 66180 in conjunction with 67255)
- 66185 Revision of aqueous shunt to extraocular equatorial plate reservoir; with graft (do not report 66185 in conjunction with 67255)

More New Codes for 2015

- New Category I Code: CPT 92141 Corneal Hysteresis. This was formerly a Category III code 0181T; 0181T will be deleted for 2015.
- Recommended value for CPT 92141: Corneal Hysteresis was presented to the RUC last April. A very low payment is expected based on the recommended work value, like pachymetry.
- 0383T Insertion of aqueous drainage device without extraocular reservoir, internal approach to the trabecular meshwork; each additional device insertion iStent. This is for when more than one iStent device (0191T) is utilized for glaucoma surgery. As a Category III code, the payment rate will be determined by each carrier and many will not cover this.
- 0341T Quantitative pupillometry with interpretation and report, unilateral or bilateral. This will also be carrier priced.
- 0356T Insertion of drug-eluting implant (including punctal dilation and implant removal when performed) into lacrimal canaliculus, each. Also carrier priced.
- 0378T Visual field assessment with concurrent data analysis and patient-initiated data transmission for up to 30 days; review and interpretation with report.
- 0379T Technical support and patient instructions, surveillance, analysis and transmission of daily and emergent data reports.
- 0378T is for the remote AMD monitoring device known as ForeSee Home Monitoring.
- 0379T is for the patient education and training done by staff (primarily practice expenses valuation).

- 380T Computer-aided analysis of time series fundus photographs for the monitoring of disease progression; unilateral or bilateral; interpretation and reporting. This is for the service known as Matched Flicker. As a Category III tracking code, it will also be carrier priced.

Medicare Quality Reporting / HIT Programs

There are incentives and penalties for 2015 in three categories: Meaningful Use of EHRs, Physician Quality Reporting System (PQRS) and Value-based Modifier.

Incentives and Penalties for Meaningful Use of EHR:

Meaningful Use of electronic health records comes from the Health Information Technology for Economic and Clinical Health Act (HITECH Act), which was enacted as part of the American Recovery and Reinvestment Act of 2009, to promote the adoption and meaningful use of health information technology. The intent was to stimulate the adoption of EHRs by providing financial incentives to physicians who demonstrate “meaningful use” of an EHR. The maximum incentive under the Medicare incentive program was \$44,000, spread out over five years. The incentives become smaller the later you adopt EHR technology.

Physicians who are not using electronic medical records and who fail to meet the federal “meaningful use” regulations will see their Medicare physician payments cut. These penalties are substantial: 1% in 2015, 2% in 2016 and 3% in 2017. Fifty percent of eligible professionals will receive a Meaningful Use penalty for 2015 – about 60% in ophthalmology.

The Academy and other physician groups worked with Representative Diane Black (R-TN) to introduce HR1331 – the Electronic Health Records Improvement Act – last spring. There are now 25 co-sponsors of the bill. The Academy continues to push for passage or inclusion in the next SGR bill. HR1331 would create three-year exemptions for solo physicians and those near retirement, tailoring the requirements to meet the needs of specialists. It would establish an appeals process before penalties are applied, and it would allow for an alternative pathway to Meaningful Use quality measures for participation in a qualified registry.

To date, 7,900 ophthalmologists have attested to Meaningful Use – less than half of all US ophthalmologists. Less than 5% have attested to Meaningful Use 2. Ophthalmology has received over \$187 million in Meaningful Use incentive payments since the start of the program.

CMS just released a new proposal to make MU less difficult. The only thing I have seen so far is to require MU for only 3 months out of a year so we will see.

PQRS Bonus Money

Ophthalmology is a success story here for some. In 2012, ophthalmologists received \$16 million in incentive payments as follows:

- E-prescribing – 2012
 - o \$39.37 million paid to ophthalmology
 - o 66% participation
- PQRS – 2012
 - o \$16 million paid to ophthalmology
 - o 55% participation
 - o The average bonus to Eye MD’s was \$1,728
 - o Over 9,000 ophthalmologists are getting money here.

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The PQRS program for 2015 eliminates the bonus. To avoid the 2% penalty in 2017, you must:

- Report 9 measures from 3 domains for 50% of patients
- Including 2 “cross cutting” (non eye-care) measures such as medication reconciliation or smoking cessation

CMS also decided not to eliminate claims reporting for eye-care measures. So the available PQRS measures for 2015 are:

- 14 – ARMD, dilated macular exam
- 140 – ARMD, counseling on antioxidant supplement
- 12 – Primary Open Angle Glaucoma, optic nerve evaluation
- 19- Diabetic Retinopathy, communication with the physician managing ongoing diabetes care
- 117-Diabetic eye exam
- 141 – Primary Open Angle Glaucoma, reduction of intraocular pressure by 15% or documented plan of care

Measures removed by CMS: Measure 18 – Diabetic Retinopathy: Documentation of presence or absence of macular edema and level of severity of retinopathy.

In the 2015 PQRS proposals, the cataract measures group is still an option:

- 20 patients is still the threshold
- Increases from 4 measures to 8 measures to be reported, including 2 cross cutting measures, a surgical risk assessment measure, and two new cataract surgery measures.

The eye-care measure proposals are as follows:

4 new measures proposed (not by AAO):

- Cataract surgery with intra-operative complications (unplanned rupture of posterior capsule requiring unplanned vitrectomy)
- Cataract surgery: difference between planned and final refraction % of the 1D target refraction
- Adult primary rhegmatogenous retinal detachment reoperation rate
- Adult primary rhegmatogeneous retinal detachment surgery success rate – flat retina 6 months

Two measures remain:

- AMD: Counseling on antioxidant supplement
- AMD: dilated macular examination

Physician Payment Reform

The shift from volume to value accelerated in 2009. The penalties for existing programs (PQRS, Meaningful Use, and Value-based Modifier) will reach 8-10% by 2018.

Qualified Clinical Data Registry (QCDR)

In 2012, Congress provided for QCDRs to ease reporting burdens. The QCDR enables specialties to design, implement and report quality measures that are more meaningful to their patient populations. The IRIS Registry was designated by QCDR in May, 2014. It is currently developing sub-specialty outcomes measures to report in 2016. Physicians participating in QCDR must report nine quality measures across three domains for 50% of patients. They must report three outcomes measures. If fewer than three are available, report two and one efficiency or patient satisfaction measure. This is a big increase from the current requirement of one outcome measure.

CMS has agreed to delay the public reporting of individual physician or practice level data on the first year of QCDR measures until measures are reported for one year.

Value-based Modifier

The Affordable Care Act requires CMS to make differential payments to physicians and others based on quality of care compared to cost. The statute requires the Value-base Modifier (VBM) to promote systems-based care (group reporting and ACOs). The penalties and bonuses apply to all MDs by 2017. It is a budget-neutral program, meaning the size of the bonus depends on the money collected from penalties. The VBM uses two year old cost/quality data; the first adjustments will begin in 2015 for groups of 100 or more EPs based on 2013 data. It is a two-step process: 1) Participate in PQRS or ACO to avoid the penalty; 2) Enter tiering competition: high quality/low cost yields the maximum bonus and low quality/high cost yields the maximum penalty.

Lubbock
March 6

San Marcos
March 7

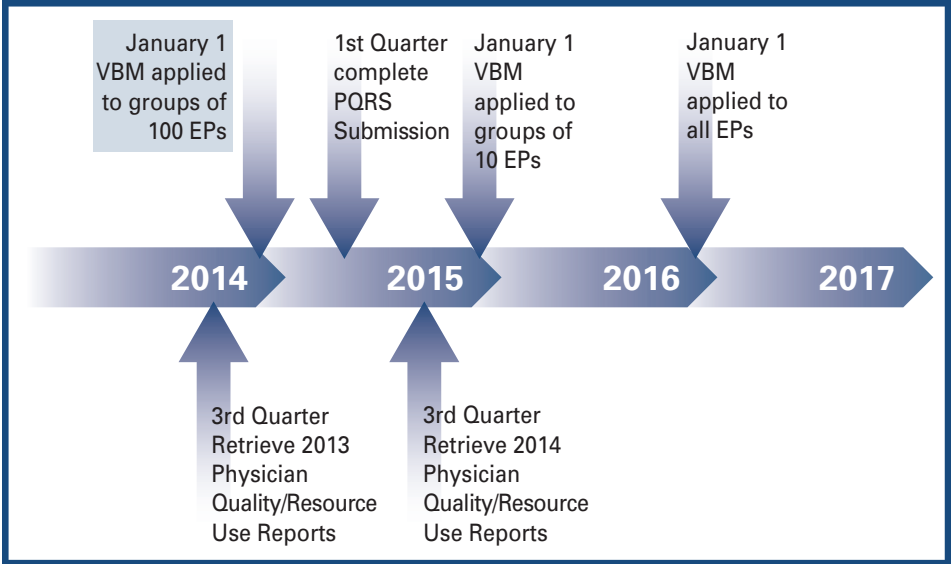
Houston
March 14

Dallas
March 28

Value-Based Care Measures

VBM Components	2015 Finalized Policies	2016 Finalized Policies	2017 Proposed Policies
Cost Measures	Total per capita-cost measure (annual Part A & Part B cost with risk adjustment)	Same as 2015; plus Medicare spending per Beneficiary including pre and post inpatient hospitalization costs	Same as 2016 (with minor modifications to Beneficiary exclusions)
Benchmarks	Group Comparison	Specialty adjusted group cost	Same as 2016

Timeline for VBM Heading Into 2017



Value-Based Modifier Proposals

- Penalty increases to 4% in 2017 for 10 or more EP.
- 2% penalty for fewer than 10 or solo practitioner (bonus also possible)
- Now applies to physician practices of all sizes in 2017, based on 2015 data

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- Expanded to cover non-physician EPs in 2017, including ODs, but NOT nurse practitioners or PAs.
- Based on PQRS performance, those not participating in 2015 will get an automatic 4% VBM penalty in 2017 on top of the 2% PQRS penalty.
- Successful 2015 PQRS participation exempts solo practitioners and group with fewer than 10 EPs from the 2017 penalty
 - o Solo practitioners and groups with 2-9 EPs are only subject to positive or neutral VBM payment in 2017 if successfully participating in 2015 PQRS.

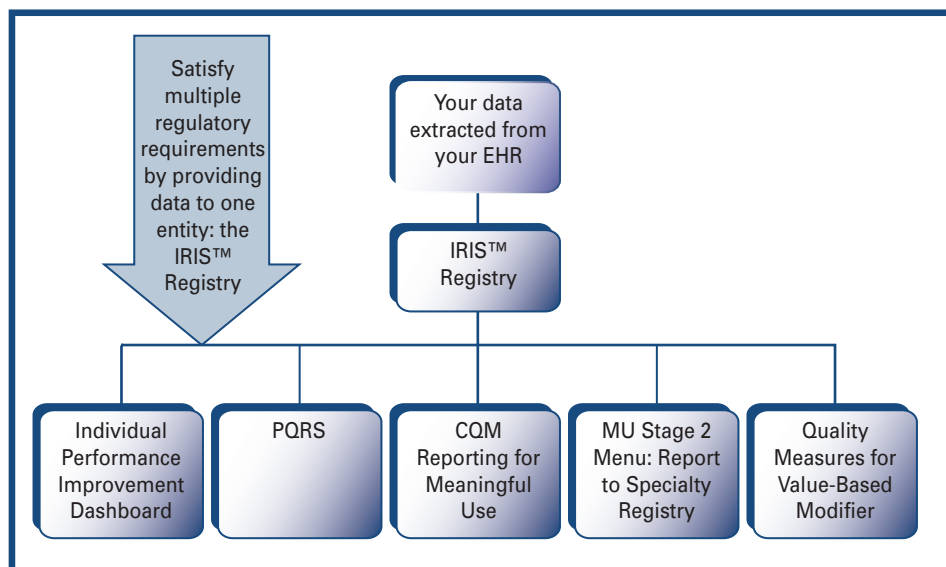
I truly believe that the AAO and the creation of the IRIS™ Registry will save our bacon and allow us to compete in this new world of value-based care.

Academy Solution: IRIS™ Registry

The IRIS™ Registry (Intelligent Research in Sight) is the first comprehensive eye disease clinical registry. It enables ophthalmologists to use clinical data to improve care delivery and patient outcomes and helps practices meet the requirement of PQRS. It collects data directly from EHR systems while being HIPAA compliant.

In 2012, the American Taxpayer Relief Act required CMS to establish a pathway for physicians who participate in a “qualified clinical data registry” to receive credit for PQRS. The law required transparency, submission of data from multiple payers, timely performance reports and support for quality improvement initiatives. In 2014, 5038 ophthalmologists contracted with the IRIS™ Registry for reporting. 10.14 million patient visits and 3.94 million unique patients have been recorded to date. 2503 ophthalmologists with EHRs have successfully mapped, with 23 different types of EHRs. Over 7,000 ophthalmologists have inquired for future year reporting.

The Value of IRIS™ Registry



The more data collected, the more effective IRIS™ Registry will be. You can participate by emailing irisregistry@aao.org for information.

I truly believe that the AAO and the creation of the IRIS™ Registry will save our bacon and allow us to compete in this new world of value-based care. If

you have looked ahead and made the transition to EHR, while many still badmouth it as cost prohibitive and a waste of time, you will now be rewarded if you join the IRIS™ Registry. Then you can easily, painlessly participate in the value-base payment future. Currently, the only information the feds can evaluate is PQRS measures. For now, the PQRS measures will determine the Value-based Modifier performance.

As word of all these penalties and future value-based payments starts to leak out to the docs on the street, they ask, “How can I possibly do this as a simple practitioner?” my answer is you must get out and learn from those who have made the effort and succeeded. Go visit several practices, go to a meeting, get out of your closet before it is too late or plan an early retirement. If you note all the mid- to large-sized ophthalmology groups made the transition years ago. As to IRIS, our practice was among the first in the country to map our computer and interface with IRIS, not a difficult task and now they are doing all our PQRS reporting. Does all of this take time from your golf game? Most certainly, but one must spend considerable time to get all of this going or plan for an early retirement. A 32% cut to your bottom line is not sustainable.

ASC Payment Increases

Ambulatory surgical centers that satisfactorily report on quality measures in 2015 have the conversion factor of \$44.071 (up from \$43.202). Failure to have met quality reporting will reduce the conversion factor to \$43.202. In 2014, ninety-six percent of ASC successfully avoided the penalty.

ASC Measure 11 – Cataracts – Improvement in patients’ visual function reporting has been voluntary. Failure to report does not cause an ASC payment reduction, so no need to do this at present.

ICD-10

The transition is scheduled for October 1, 2015. Most people I know feel that it will occur this time. So we all need to prepare again. We will have four AAO/TOA CodeQuest courses in Texas this year and will review ICD-10.

Other Changes for 2015

Modifier 59 Change: Modifier 59 is used to invalidate the CCI bundles. They are to be rarely used in ophthalmology unless there is a separate encounter, separate structure, separate practitioner or unusual non-overlapping service. To get your attention, CMS has established four different X-modifiers to discourage their use:

- XE – separate encounter
- XS – separate structure
- XP – separate practitioner
- XU – unusual non-overlapping service

Modifier 59 or the X modifier can be used, but not used together. Use of these modifiers will continue to trigger audits in the future so be very careful if you use these modifiers.

Omidria

This drug combination has been released with a pass through designation in the ASC/Hospital OPD. So it is paid in addition to the ASC/Hospital OPD prospective payment system. It is a combination of phenylephrine and NSAID to be put in the phaco irrigating solution at the time of cataract surgery. It has an allowable of \$458. What? It’s \$458. I can see \$45-\$50 and we might consider its use, but not at \$458.

CMS will continue to pay the average sales price plus 6% (minus 2% for sequestration) for both pass through and non-pass through drugs, biologics are paid separately under the hospital Outpatient Prospective Payment System (OPPS) that cost more than \$95. Drugs costing less than \$95/day are bundled into the visit or treatment payment and are not separately reimbursable.

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By now, you all have seen the CMS' opinion on billing patients directly for injectables at surgery such as Trimoxivanc, the new technique of transzonule drug delivery to limit the use of post-op drops. No charge can be billed to the patient for any service or drug performed at the time of the covered cataract surgery. Medicare also bundles any injectables into the fee. So you or the ASC/Hospital OPP will eat the cost of the Trimoxivanc

Be sure to read the whole Blepharoplasty LCD if you perform Blepharoplasty or ptosis repair.

Meaningful Use and Requirement for Scribes

There have been a lot of rumors from various sources that CMS limits the use of scribes in EMR entry for MU purposes. That has finally been clarified. To use a data entry scribe for EMR to enter medication, laboratory or radiology orders, CMS now allows use of a certified ophthalmic medical scribe, certified technician or certified medical assistants. The certified medical scribe is a faster training approach, but we recommend that most such office assistants become certified ophthalmic assistants/techs, which offers a better range of knowledge for the long haul.

Corneal Tissue Payment in ASC or Hospital OPD

In the last year, we have heard of many mistakes in billing for corneal tissue. CMS has clarified that corneal tissue is paid in both the ASC and HOPD on an invoice specific cost basis and not under the OPFS. Facilities should bill separately using HCPCS code V2785 and provide a copy of the invoice.

Blepharoplasty LCD

As you remember, Novitas introduced a new Blepharoplasty/Ptosis LCD last year that eliminated the visual field requirement and substituted a very strict photography documentation requirement that we must supply good quality frontal photos that clearly show the pathology claimed and demonstrate an MRD-1 of 2 mm or less – that's the mm distance between the central corneal reflex and the upper eyelid or pseudoptosis. There has been much discussion across the country on this new policy and Noridian has adopted a similar LCD. I do not know if the 2.0 mm requirement is too strict or too lenient but time will tell and we will change it if necessary. Some want to return to using fields as a standard but as an auditor, it is very difficult to audit these when the photo does not support the claimed visual loss, and that occurs frequently. I would strongly support that you tape a small mm ruler to the patient's face or use a new device developed by John Shore, MD in Austin to take the photo that allows easier caliper measurement of the MRD-1 or do you really want to enjoy more RAC audits? Mark Mazow, MD and John Shore, MD will talk on this subject during the upcoming TOA Annual Meeting in Austin, May 1-2. Be sure to read the whole Blepharoplasty LCD if you perform Blepharoplasty or ptosis repair.

Bill Hutton, a longtime member of Texas Retina in Dallas, has retired and as former CEO of Med Synergies is one of the most informed doctors in this part of the country in trends in medicine. That was his business in Med Synergies. He interviewed many high performing practices and managers for the following report on "The Ophthalmic Practice: Where Do We Go from Here?" I asked if we could share his presentation with you. Thanks, Bill. It is reproduced on the TOA website and well worth the read.

QUESTIONS AND ANSWERS

QUESTION: We are considering terminating our contract with Medicaid next year but will continue to provide care for our Medicare patients. There are some patients who are dual-eligible with Medicare and Medicaid. What are my options regarding the Medicare guidelines about seeing these patients? Am I obligated to see them and receive no payments from Medicaid or can I refuse to accept patients with this plan? What about patients who are on a Medicare replacement plan and Medicaid?

ANSWER: You can refuse to see patients with Medicare/Medicaid dual-eligible plans or you can see them and just accept what Medicare pays, but you cannot bill the patient for the Medicaid portion. Same for the MA/Medicaid patient.

QUESTION: Is code 65778 reimbursed for the clinic/office setting and in a hospital setting?

ANSWER: Yes, however reimbursement will not cover the cost of the device if it is placed on a patient in an ASC setting. So, Prokera or Prokera Slim can be utilized for a multitude of surface related issues in an office/clinic setting and will be completely reimbursed. If a patient is admitted to a hospital, ie a burn unit, Prokera and Prokera Slim are completely reimbursed as well.

One addition to code 65778 is that Prokera and Prokera Slim can be used in conjunction with surgery postoperatively. For example, if you were to perform a high risk PKP and wanted to reduce inflammation and minimize scarring as much as possible, you can place a Prokera Slim on that eye one day post-op in the clinic and it will be reimbursed 100%. All that needs to be done is mention in the pre-op notes that you will be using a Prokera Slim post-operatively and add a 58 modifier to the claim.

The office fee for 65778 includes fitting and supply of Prokera Rings which is the reason the fee is so high. In the ASC, the ProKera Ring is included in the ASC payment with no additional pass through. Hospital and Hospital OPD include the Prokera in the payment group or may get a pass through for additional revenue.

QUESTION: I take care of many Medicaid patients with keratoconus and failed grafts from all around North Texas including Fort Worth. Frequently, they are Parkland refugees and I am the only cornea specialist accepting Medicaid and managed Medicaid. What can be done to get this reimbursed?

ANSWER: Nothing at present. Medicaid is broke and you know the attitude of the Texas Legislature on expanding Medicaid or improving payment. Until all refuse to accept Medicaid patients, this will not change. Pediatricians and Pedi-ophthalmologists have made this work and are paid more presently.

QUESTION: can a 92014 be billed more than one a year assuming the patient has a new chief complaint with is being addressed, and has been dilated and all the elements for 92014 are documented?

ANSWER: for Medicare, there is no limit on medical exams as long as they are medically necessary. On an audit. if a comprehensive exam medically necessary? If so, it can be billed. Be sure you have the medical documentation to back up your claim.

(Continued on page 26)

QUESTION: My parents visited me this weekend and I examined them both. My mother needs cataract surgery and has Medicare. May I bill Medicare for their exams and for her upcoming cataract surgery?

ANSWER: No, you cannot bill family members on Medicare – you can treat them but not get paid. Your partner may see them and get paid.

QUESTION: I am told that Novitas has changed its LCD for cataract surgery to be broader only expecting that the patient have a complaint that the surgeon feels would be helped by cataract surgery and the patient agrees. If this is true, it must be a new standard as at our CodeQuest training in February, the long standing 20/40 guideline was still what was printed in the materials.

ANSWER: At CodeQuest, we discussed that it was changing. Look up the LCD on Novitas.com so you will be up to date and in compliance. The burden of proof is on you and your medical record to meet the LCD requirements. There is no longer a VA standard but the requirements remain for complaints and interference with lifestyle and use of a standardized measure of visual performance.

QUESTION: In the past, my understanding was that all other insurance companies went along with whatever the Medicare standard was. True?

ANSWER: All insurance companies make their own rules but many use Medicare rules as a starting guideline. Most take Medicare rules into account when they write their own.

QUESTION: Is the new Novitas standard one we can now safely use on cataract surgery patients with private insurance?

ANSWER: No. You must research each different insurance company to determine the guidelines for when you can proceed with cataract surgery.

QUESTION: My office is experiencing an issue with the refraction fee with Silverback/NTSP and AARP Medicare Complete (Secure Horizons). It appears that these replacement Medicare plans are now following traditional Medicare guidelines and not allowing refractions. Can we bill the patient for the refraction in addition to collecting their copay if they have signed an ABN?

ANSWER: Yes, you can bill the patient for the non-covered service but good luck if you have not warned them before the refraction and given them a choice of yes or no.

Coding
Questions —
TOA Member
Benefit

Members' coding and billing questions may be:

- faxed to John Haley, MD (972) 276-5413 or
- faxed to Jeff Whitman, MD (214) 754-0079 or
- submitted online at www.TexasEyes.org (member log in required).

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



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* Savvy Practice™ Content (Dallas and Houston only):

Make a day of it! We are offering practice management symposia for you and your staff at the Houston and Dallas sites immediately after CODEquest. Topics covered:

- EHR and meaningful use.
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CME, JCAHPO, AAPC and COE credits are pending.

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Your feedback is very important. Please complete online at <http://re.spon.se/NgrdOx>
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Which statewide advocacy issue is the most important to you?

- Preserving high quality of medical/surgical patient care by opposing non-physician scope of practice efforts
- Tort reform defense
- Medical Education Funding (workforce)
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- Medicaid/dual-eligible funding
- Truth in Advertising
- Public perception of ophthalmology
- Other, please specify:

Which TOA benefit is the most important to you?

- Affordable CME
- Advocacy in the Texas Legislature
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- Coding education
- OMIC discount
- TMLT discount
- Information about laws and regulations
- Eye care safety awareness for the public
- Representation in TMA and AAO
- Other, please specify:

It is extremely helpful for us to know about relationships you have with leaders in government.

	I know personally	Is a patient	A friend of mine knows personally	I am willing to contact
Gov. Greg Abbott				
Lt Gov. Dan Patrick				
Attorney General Ken Paxton				
US Senator: (name)				
US Rep: (name)				
State Senator: (name)				
State Rep: (name)				
Others: (name)				
Others: (name)				

How can TOA improve the value of your membership?