TOA NEWSLETTER

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Despite all the gloom out there, 2010 was a good ophthalmology practice year. Practice liability RVUs were up 2%, practice expense RVUs were up 3% and budget neutrality turned the consultation code deletion into a 4% gain. And if you did what we have been recommending and worked on the PQRI and eRx bonuses, you really had a good year, with PQRI and eRx bonuses in the neighborhood of $25-35k each for a small group practice. (Even my SMU ponies began a comeback and TCU, wow. But, no noise from the orange bloods; except their new $300 million TV network, not a bad year indeed.)

What has happened to the Medicare fee schedule? As you know, again everything hung on fixing the SGR mandated fee cuts and again a last minute bill was passed that fixed the cuts for another one year period. Why can't they just fix the flawed SGR system? In a word, money. It will cost $330 billion (new figure takes into account all the most recent band-aids) to fix and there is no where to get it in these recessionary times. I see more multiple part-time fixes in the near future and no permanent fixes until and unless Healthcare reform reduces cost of care ("bending the healthcare curve") or at least slows down the rate of growth in expenses. A permanent SGR fix was never part of the congressional agenda but neither party wants major fee cuts. The feds cannot afford to lose physicians during transition. Both sides of the aisle are focused on keeping the current system long enough to implement their changes, whether it be the PPACA, ACOs, etc. or some yet unidentified tweak/replacement of that.

In actuality, 2011 is also shaping up to be a good year.
3% increase practice expense RVU
1% increase from rebasing the Medicare economic index

But an 8% reduction in the Medicare conversion factor? What, an 8% cut in the MCF? How can that be good when the MCF gets cut from the current $36.87 to $33.97? Now, I would need two accounting degrees and a PhD in medical economics to really understand that move but here is what I do know. The conversion factor is lower for 2011 because CMS is rebasing the Medicare Economic Index (MEI), an inflation index for physician practice costs that is used as part of the formula to calculate the Medicare physician fee schedule rates. (The costs of inputs used to produce physician services by changing data sources, lost categories or price proxies used in the input price index). To offset the increased practice expense and malpractice relative value units created by MEI rebasing, CMS reduced the MCF by 8% to achieve budget neutrality as required by law. Last time the MEI was rebased, the work RVUs were changed and that created a mess with the other carrier fee schedules based on the MFSs. Ophthalmology was lucky and all this funny business had little effect on our codes, but still got the 3% increase in many of our practice expenses. I am very glad I am writing this ophthalmological newsletter rather than those of Cardiology, Radiology and Oncology as they did not fare well.

There were some work reductions due to RUC/CMS reviews (not Obamacare – the IPAB won't go to work for a couple more years):

67028	Intravitreal injections down 36%
66761	Laser Iridectomy down 26%, but now a 10 day GF
15283	Blepharoplasty down 10%
92135	SCODI (deleted and replaced with three new codes that are no longer paid per eye but are for both eyes) down 55%
92285	External Ocular Photography down 32%

As you recall the RUC is continually re-evaluating all our codes and these were just in their opinion simply overvalued. The AAO repeatedly protested 67028, but to date the changes are law.

But most other surgical codes have slight increases due to the practice expense increase in the embedded office visits post op visits:

66170	Trabeculoplasty up 2%
66984	Cataract/IOL up 2%
67036	Pars Plana Vit up 2%

Also, there are gains in some office visit codes:

92004	New Patient Complete up 5%
92012	Established Patient Intermediate Up 5%
92014	Established Patient Complete up 4%
99203	New Patient EM up 1%
99214	Established Patient EM up 0%

FUTURE SOCIOECONOMIC TRENDS IN SURGICAL FEES

Still nervous that our surgical fees will continue to be ground into dust? Actually the RBRVS and RUC process has worked as originally designed and brought down all surgical fees

40-45% over the last ten years and now all surgeons feel the same pain and we look to see the surgical fee cuts at an end.

What do they see as overvalued now? Diagnostic testing and all scanning codes. That is why you hear so much howling coming from Cardiology, Radiology and Oncology. It's also why we're seeing reductions in 92135. (67028, meanwhile, is a victim of its own popularity as seen in high utilization).

PQRS

Physician Quality Reporting System (PQRS) (formerly PQRI, pay-for-performance) is not going away. Though PQRS has been around for a few years, the Patient Protection and Affordable Care Act of 2010 (aka Obamacare) extends PQRS incentive payments through 2014. The incentives change to penalties in 2015. It is all part of a gradual transition to being paid for quality of care provided not volume of care provided.

Payment Reform

Payment reform is being initiated through the use of patient centered medical homes, then will move to accountable care organizations from fee for service to pay for episodic care, and finally on to total cost of care. Who knows how successful this transition will ever be, but we must be alert to be on top of the trends and influence them the best we can. In 2015 a value-based modifier will be introduced that can increase reimbursement up to 10% for good outcome and resource use.

PQRS Registries

Use of a registry (AAO has a collaborative agreement with Outcome Sciences) rather than claims reporting has achieved a 95% success over the 60% success compared with claims reporting. However, registry reporting requires double entry and more paperwork. After using the registry for one year in my own practice to bail us out of a mistake, we have gone back to claims reporting; we plan to revisit our registry after implementing EMR in the next few months. (There are some Practice Management and EMR software packages that will report to Outcome Sciences directly. There are also some other efficiencies that are gained such as not having to check and recheck every claim.)

Where is PQRS headed? To data integration software with Cloud Computing. Then the doctors can be compared after data is entered automatically from EMR. Thus, the push to EMR.

Requirements for 2011

- Choose from 9 ophthalmic measures plus #130 (document current meds) and #226 (smoking preventative care)
- 3 measures reported if possible
- Bar lowered from 80% to 50% on claims reporting, registry stays at 80%
- Positive incentive of 1% plus 0.5% if meet maintenance of certification (currently there is no MOC measure for ophthalmology)
- Future incentives: 2012 to 2014 — 0.5% bonus; 2015 — 1.5% penalty; 2016 onward — 2.0% penalty

Physician Compare Website & 2011 PQRS Data

Public access to Medicare data on individual physicians will expand in stages:

- Eventually will report performance data
- Options to get interim feedback information
- Informal review process
- Claims-based, registry and EHR reporting is currently accepted but claims-based will be limited in the future
- Requires an IACS account (see below) which is now easier to get
- www.medicare.gov/physiciancompare

IACS Accounts

An Individuals Authorized Access to CMS Computer Services (IACS) account is needed to access feedback reports for 2009 eRx and PQRI information. On November 15, 2010 IACS was upgraded to a new more user-friendly system. There is now a help desk available to help you register, access or change your IACS account: 1-866-288-8912 or qnetsupport@SDPS.org.

PQRS measures (formerly PQRI)

Measure	Definition	Claim/ Regis
12	Primary Open Angle Glaucoma (POAG) Optic Nerve Evaluation	C, R
14	Age-Related Macular Degeneration (ARMD): Dilated Macular Examination	C, R
18	Diabetic Retinopathy: Documentation of Presence or Absence	C, R
19	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	C, R
117	Diabetes mellitus: Dilated Eye Exam in Diabetic Patient	C, R
130	Documentation and Verification of Current Medications in the Medical Record	C, R
140	Age-Related Macular Degeneration (ARMD): Counseling on Antioxidants Supplement	C, R
141	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care	C, R
191	Cataracts: 20/40 or better visual acuity within 90 days following cataract surgery (REGISTRY REPORTING ONLY)	R
192	Cataracts: Complications with 30 days following cataract surgery requiring additional surgical procedures (REGISTRY REPORTING ONLY)	R
226	Tobacco Use: Screening and Cessation Intervention	C, R

My approach to PQRS

- Pick the three diabetic codes (measures 18, 19, 117)
- Put aside all Medicare (not Medicare Advantage) Diabetic diagnoses
- Billing staff adds PQRS code before filing electronically

E-PRESCRIBING – eRx

Like PQRS, ePrescribing is not going away. 2011 is much the same as last year, but with a 1% incentive payment.

- Use on at least 25 claims
- Must be linked to Eye or EM codes
- Cannot get both eRx and EHR meaningful use bonuses
- Future Incentives:

	Bonus	Penalty
2011	1%	
2012	1%	-1.0 %
2013	0.5%	-1.5 %
2014		-2%

An important caveat: The bonuses are paid in the following year as the PQRI/PQRS bonuses have been. **But the penalties are taken out of your Medicare settlements and the penalties for 2012 and 2013 are based on 2011.** So if you don't participate this year, you will not only not get a 1% bonus, you'll also be penalized by 1% in 2012 for the same year of inaction.

Most importantly, to avoid the penalty in 2012, at least 10 of the required 25 ePrescriptions must be submitted by July 1, 2011. Did you get that? The eRx payment penalty that goes into effect 2012 is based on physician reporting of G8553 on the required claims between January 1 and June 30, 2011. 1% penalty next year in 2012 if you do not report eRx now.

In 2013, a 1.5% penalty will be assessed. Right now the 2013 payment penalty will be based on the entire 2011 reporting period January – December (at least 25 claims). But CMS may change this.

What is the most common error by far in ePrescribing? Not realizing that G8553 is the only HCPCS code to report when ePrescribing for 2010 as well as 2011.

Don't have ePrescribing in your office yet? Allscripts offers a free web-based basic eRx system as the technical basis for the National ePrescribing Patients Safety Initiative (NEPSI) coalition at www.nationalerx.com. (Allscripts also has a pay-based system). It's easy money – once you enter 25 patients, you've hit the 1% incentive.

ICD-10

The implementation deadline is still 2013 for the new diagnostic system to replace ICD-9. The AAO has completed crosswalks from ICD-9 to ICD-10 but the bad news is that there are so many more codes that it will be impossible to do on a simple super bill, another argument in favor of EMR.

2011 MEDICARE – Medicare is a bargain for beneficiaries (including this author). When one finally is allowed to sign up for Medicare, one gets very interested in his new personal benefits. Allow me review them for you.

- Part A (hospital coverage): deductible $1,132
  The premium is paid in full if enrollee or spouse worked 40 quarters of a Medicare-covered employment (99% of enrollees meet this standard; tiered premiums for <40 qtrs.)
- Part B (outpatient, ASC, doctors): deductible $162 plus 20% copays
  - Standard premium - $115/month but means tested to $369/month
  - Supplement policy – good quality type F TX BCBS $200/month pays all copays, deductibles and other extra for Part A and B
- Part D (Drugs) TX BCBS Value Plan
  $60/month
  Has graduated copays like most commercial policies

So, for $629.00 a month, I have essentially 100% coverage plus drug copays – heck of a deal. Our office pays much more for much less coverage and very high deductibles for our staff.

ELECTRONIC HEALTH RECORDS

What does it take to get to meaningful use? That's the $44,000 ($64,000 for Medicaid) question?

First and foremost, the requirements can be found online at www.healthkit.hhs.gov

Meaningful Use

Meaningful use-certified software is currently certified by one of three organizationsorganization

1. CCHIT (Chicago)
2. Drummond (Austin)
3. Infoguard Lab (San Luis Obispo)

Two other certifying agencies were scheduled to come online at the end of 2010. There are now over 200 certified products and more being added all the time. You can find the link to CMS and lots of important information on the EHR Central page of the AAO website. Here's a shortcut: http://macu.la/ehr

Below is a bulleted summary of Meaningful Use:

Stage 1 Criteria

- Core set of 15 meaningful use objectives
- Additional menu set of objectives at the discretion of the physician report 5/10, once population and public health objective
- Core Clinical quality measures
- 3 additional quality measures chosen from the 38 quality measures

Exclusions

- If meaningful use objectives are not applicable to a providers clinical practice, the physician would not have any eligible patients or actions for the measure denominator and would be excluded from having to meet that particular measure
- Example – Immunizations, vital signs

So entering ZERO will not disqualify incentive eligibility

Stage 2 & 3 Criteria

- NOT YET DEFINED
- Complexity will increase; currently in comment period

Reporting

- Attestation Methodology – used to report meaningful use in 2011 (i.e. you swear to CMS that you are meeting the objectives)
- May require EHR reporting technology starting in 2012
  - 1st payment year – report for 90 continuous days
  - 2nd and subsequent years – report full years data

Program Registration

- Register between January 2011 to February 29, 2012 to participate in incentive payment for 2011.
- Physicians must be enrolled in PECOS and have an NPI number

Incentive Payment Schedule for EHR and eRx

These payments are in addition to bonus payments under PQRS:

Payment Begins	% Medicare Bonus for eRx	*or**	Payments for Medicare Meaningful EHR use
2009	+2%		
2010	+2%		
2011	+1%	*or**	$44,000 over 5 yrs
2012	+1%	*or**	$44,000 over 5 yrs
2013	+0.5%	*or**	$39,000 over 4 yrs
2014			$24,000 over 3 yrs

*If a physician is receiving ***Medicare*** EHR incentive payments, cannot concurrently receive the e-prescribing bonus as well. Physicians claiming the ***Medicaid*** EHR can receive both Medicaid EHR and Medicare e-prescribing incentive.

Penalties for not adopting e-prescribing and EHRs

Penalty Begins	% Medicare Penalty for not eRx	%Medicare Penalty for not EHR
2012	-1%	
2013	-1.5%	
2014	-2%	
2015		-1%
2016		-2%
2017		-3%
2018 and beyond		Could be increased up to 5%

How does Meaningful Use change the landscape?

Meaningful use coupled with large financial incentives, may signal the beginning of the end of healthcare as a cottage industry. Congress and administrative forces have made it plain that the practice of Medicine must change. A payment system that rewards quality and efficiency is required. The AMA news recently reported that EMR use rose 50% in 2010, more than double the adoption rate in 2005. Peer pressure is moving from fighting EHRs to embracing them. We are in an electronic age. You either go with it or you're in the dark ages. As older physicians retire and more freshly minted doctors join the work force, the resistance to EMR lessens. The fear factor is dissipating. For the first time EMR use passes 50% as incentives outweigh resistance.

PPACA, AKA OBAMACARE

Now that the Republicans have gotten past their politically necessary but practically pointless repeal vote in the House, we're likely to see some ideas come from them on the "replace" side of their "repeal and replace" mantra. Many will be met by the same stone wall in the Senate and looming veto pen as the repeal vote has been, but it does provide an opportunity for any bipartisan tweaks to get a hearing.

Meanwhile, AAO, other national specialty groups, and the insurance companies are now focusing much of their attention and time on the regulations that have yet to be written. Texas BCBS has two law firms to interpret the new rules and they often have different opinions. Those opinions only stand to differ further as we get into the process.

Opportunities and Dangers:

- 90-95% of the regulations have not been written
- "The Secretary Shall" need new regs to clean up the law
- Secretaries of Labor & Treasury in addition to HHS
- End of the beginning, not the beginning of the end

Despite some of the doom and gloom that accompanies Obamacare, Medicare age folks are those that pay our bills as ophthalmologists. Branching out is difficult, and I [Dr. Haley] am not aware of any general ophthalmologists or subspecialists that have been able to pull off dumping Medicare. I know of some LASIK doctors and oculoplastic doctors that have tried but the recession has made that focus on elective medicine difficult. Also, I think the screws being put to commercial carriers under Obamacare will force most of the few remaining rich commercial contracts downward, making the split from Medicare that much more difficult.

NEW FOR 2011 – PART 1: NEW CATEGORY I CODES

Glaucoma

Glaucoma gets 2 new codes to represent canaloplasty:

66174 Transluminal dilation of aqueous outflow canal; *without* retention of device or stent		**66175** Transluminal dilation of aqueous outflow canal; *with* retention of device or stent	
W-rvu	12.85	W-rvu	13.60
PE-rvu	13.79	PE-rvu	14.31
MP-rvu	2.27	MP-rvu	4.87
Fee (Dallas)	$ 984.26	Fee	$ 1113.26

Amniotic Membrane Placement

Amniotic membrane placement also gets two new codes: 65778 and 65779. If use tissue glue, must use unlisted code. You can thank a certain famous coding consultant for this hickey – the AAO knows better – so you must put a few suture in if you use tissue glue.

65778 Placement of amniotic membrane on the ocular surface for wound healing; self-retaining (ProKera)		**65779** Placement of amniotic membrane on the ocular surface for wound healing; simple layer, sutured	
W-rvu	1.19	W-rvu	3.92
PE-rvu	35.56/0.84	PE-rvu	28.93/4.07
MP-rvu	0.18	MP-rvu	0.56
Fee	$1256.13/75.29	Fee	$1136.75/291.25

For the physician payment only, office reimbursement is higher to include the AMT material. 65780 – Ocular surface reconstruction – is the existing more extensive AMT code for major reconstruction.

Diabetic Retinopathy Remote Screening

The good news is that these codes eliminate the improper use of 92250 Fundus Photos used by many in the past for photo screening. It effectively eliminates photo screening except for all but large populations since the $11 will never pay for the technology involved (Again no physician work RVUs).

92227 remote imaging for detection of retinal disease (e.g., retinopathy in a patient with diabetes) supervision, unilateral or bilateral		**92228** Remote imaging for monitoring and management of active retinal disease (e.g., diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral	
W-rvu	0.00	W-rvu	0.30
PE-rvu	0.33	PE-rvu	0.56
MP-rvu	0.01	MP-rvu	0.02
Fee	$ 11.55	Fee	$ 29.99

SCODI/OCT

The 92135 SCODI/OCT code is being deleted for 2011. Its 2010 fee was about $45 per eye ($90/2 eyes). (92135 Scanning computerized ophthalmic diagnostic imaging, posterior segment, (e.g., scanning laser) with interpretation and report, unilateral). It is being replaced by three new codes:

92132 (*Visante*) Scanning computerized ophthalmic diagnostic imaging, *anterior segment*, with interpretation and report, *unilateral or bilateral*	
W-rvu	0.35
PE-rvu	0.68
MP-rvu	0.04
Fee	$ 36.44

92133 Scanning computerized ophthalmic diagnostic imaging, *posterior segment*, with interpretation and report, *unilateral or bilateral*; *optic nerve*		**92134** Scanning computerized ophthalmic diagnostic imaging, *posterior segment*, with interpretation and report, *unilateral or bilateral*; *retina*	
W-rvu	0.50	W-rvu	0.50
PE-rvu	0.77	PE-rvu	0.77
MP-rvu	0.04	MP-rvu	0.04
Fee	$ 44.65	Fee	$ 44.65

Note the reason these SCODI codes took such a hit (>50%): When the RUC evaluates new codes (Zeiss aggressively has been pursuing a category 1 code for Visante and they got it and much more, not to their liking), they consider the context. The RUC evaluated the whole family of SCODI codes because of dramatically increasing volume and decided to break the codes into the three new ones and eliminate the old 92135 for which we got very favorable terms years ago.

All scanning codes are under great scrutiny and only pay for physician work and how much physician work is in the scanning codes? 0.35 to .50 work RVUs.

And the practice expense RVU which is the real killer; when you pay $65 to $110K for these machines, the Medicare PE does not reflect our true costs. Why? Because CMS has designed their equipment depreciation schedules that determine the amount paid to us on practice expenses to assumes a utilization of 50%. No one uses anything close to that number so none of these expensive gadgets can pay for themselves unless you keep them very busy. It is to the point that it takes a group of doctors to afford the technology.

CMS admits that the PE payment only covers 70% of costs. Also, the change from unilateral to bilateral code is huge but that is the way the RUC treats all new or revised codes. See why we are in no push to evaluate any code to gain a few dollars? The risk of losing is too high. As Mike Repka says "The Medicare system pays primarily for physician work, and technology in general does not involve as much physician work as older techniques. It increases the physician's efficiency, but the decreasing work will lead to lower payments." Thus, doctors find themselves in an ironic predicament: as it becomes possible to provide quicker, better outcomes for patients, their financial reward decreases.

Another factor is the CCI which now bundles all three of these SCODI codes on the same day. Further CCI bundles 92033 and 92034 with 92227 and 92228, the photo scanning codes and 92250 Fundus Photos.

Tear Osmolarity

The new 83861 Tear Osmolarity, (per eye) code, in the pathology section (TearLab microfluidic analysis) provides for reimbursement only in a CLIA lab. It's moderately complex to get a CLIA designation. $9,000 for machine plus a click fee per eye (originally rumored at $15). Allowable is $14.32/eye. Not sure about how the math works on that one.

NEW FOR 2011 – PART 2: CATEGORY I CHANGES

There's not much good news here. RUC/CMS reduced work values (W-rvu) for the following codes by approximately 1 W-rvu or less.

- 66761 Iridotomy/iridectomy by laser surgery
- 67028 Intravitreal injection
- 15823 Blepharoplasty
- 92081/82 Visual Fields
- 92285 External Photos

Here are the details:

Iridotomy

66761 was changed from a 90-Day to a 10-Day global. Previous W-rvu of 5.0 represented multiple sessions and now new value will represent single session. You will be able to bill separately for any visits after 10 days.

66761 Iridotomy/iridectomy by laser surgery (e.g., for glaucoma) (per session)	
W-rvu	3.00
PE-rvu	5.82
MP-rvu	0.45
Fee	$ 315.60

Intravitreal Injection

67028 Intravitreal injection of a pharmacologic agent	
W-rvu	1.44
PE-rvu	2.14
MP-rvu	0.20
Fee	$ 128.73

Why the big decrease (it was $197 in 2010)? First with the massive increase in utilization, 67028 was a clear target. Second look at the work RVUs: the new 1.44 mark is down from the previous 2.52.

Blepharoplasty

Was $662/$613 in 2010

15823 Revision of upper eyelid	
W-rvu	6.81
PE-rvu	9.75/8.16
MP-rvu	1.27
Fee	$606.88/551.78

Visual Fields

Were $52 and $69, respectively, in 2010.

92081		92082	
W-rvu	0.30	W-rvu	0.40
PE-rvu	1.09	PE-rvu	1.54
MP-rvu	0.04	MP-rvu	0.05
Fee (Dallas)	$ 48.67	Fee	$ 67.74

External Ocular Photography

Was $41 in 2010.

92285	
W-rvu	0.05
PE-rvu	0.75
MP-rvu	0.02
Fee	$ 27.88

NEW FOR 2011 – PART 3: CATEGORY III (EMERGING TECHNOLOGY CODES) CHANGES

Category III Deletions: 0016T and 0017T

- Category III codes 0016T, 0017T have been deleted Rationale – New technologies that did not take hold
- Code 0016T, which previously described destruction of localized lesion of choroid transpupillary thermotherapy, should be reported with unlisted code 37299
- Code 0017T, which previously described destruction of macular drusen, photocoagulation, should be reported with unlisted code 67299.

Category III Deletion: 0187T becomes 92132

- 0187T scanning computerized ophthalmic diagnostic imaging; anterior segment has been deleted. To report, use new Cat I CPT Code 92132
- Rational - To support the addition of Category I code 92132, Category III code 0187T that previously described this service has been deleted, with the addition of a cross-reference to direct the user to the new code.

Category III Revisions

- 0191T Insertion of anterior segment aqueous drainage device, without extraocular reservoir; internal approach, into the trabecular meshwork
- Remains the same: 0192T external approach

New Category III Additions

- 0253T Insertion of anterior segment aqueous drainage device, without extraocular reservoir; internal approach, into the suprachoroidal space

NEW TECHNOLOGY IOLS INCENTIVE ENDS FEBRUARY 26, 2011

The new technology IOL classification began in 1994 in which the CMS recognizes significant new technology intraocular lenses for an additional $50 payment (Q1001). To qualify, CMS requires that manufacturers prove that use of the new IOL technology results in measurable, clinically meaningful

improved outcomes in comparison with use of current available IOLs.

At this time, only the aspheric (spherical aberration reducing lenses by various manufacturers qualify for the NTIOL designation. AMO Technis was the first followed by aspherics by Alcon, Bausch & Lomb, Staar, Hoya and Lenstar.

The new technology status will expire in February 2011. These aspheric lenses have become very popular and now command a 70% market share of all implanted IOLs.

The ASC's will take an immediate $50 hit/case in February so negotiations with the manufacturers are now hot and heavy as to repricing or rebates.

NEW TIME LIMIT ON FILING MEDICARE CLAIMS

Beginning January 1, 2011, providers only have one year from date of service to file Medicare claims.

CONGRESS EXEMPTS DOCTORS FROM "RED FLAGS" RULE

It has been a two year battle to pass legislation to exempt physicians from the FTC imposed credit rules called the Red Flags rule. The President has signed the legislation, but the AMA filed lawsuit will remain in place until the FTC officially backs down.

The Red Flags rule is the result of the FTC's interpretation of the Fair and Accurate Transaction Act of 2003, which was created to tighten security of financial data held by banks and credit card companies. The FTC said physicians were covered under the rule because they bill people for services after they are provided and because they allow payment plans.

DR. HALEY'S QUESTIONS AND ANSWERS

PTK at the Laser Center

Q: I want to perform a PTK on a Medicare patient in my Lasik Center. Will Medicare pay for the facility fee.

A: Not unless the laser is located in a Medicare certified ASC, otherwise, it is non-covered.

Wrong IOL

Q: By mistake, I put in a wrong IOL power but discovered the error and brought the patient back to the OR for a single IOL exchange on the same day. Because it was handled very smoothly, the patient had an excellent outcome and was very happy. Can I bill Medicare for any of the IOL exchange?

A: This is a very serious mistake. You know that Medicare is now trying to reduce medical mistakes and will not pay for any wrong site surgery. An incorrect lens put in a patient (patient identity confusion not a faulty calculation) is now considered a wrong site surgery and not only requires special reporting, but also Medicare will not pay for the original surgery or any re-ops to correct the problem.

No Diagnosis on Crossed Eye Complaint

Q: A mother brought her 6 month old to be seen today with complaints of crossing eyes. There was no alignment problems and the exam was normal. How can I get paid for the exam? Is there a code for pseudo strabismus?

A: I always tell the mom there is good news and bad news. First, your child is normal and that is very good, but the bad news is there is no code for pseudo strabismus and the insurance will probably not pay. (Thanks Sue V)

CPT for Custom Intralase

Q: What would be the appropriate CPT code for custom intra lase Lasik?

A: I presume you are using the intralase for host graft prep and recipient beds for PKP. Currently, there is no code. At present most carriers consider that the intra lase preparation of the host or graft is part of the work already paid for in the PKP code. This is evolving technology and if it works out, a mechanism for payment will be determined.

Aetna & B-scans for Mature Cataract

Q: Aetna is refusing to pay for a B scan for a mature cataract saying it is experimental despite the fact I sent them the retired LCD from Trailblazer.

A: Unfortunately, the private carriers can do what they want in regards to fees and payment policy. The good news is this is an unusual situation that a B scan is needed. This is a good example of an instrument that would be very difficult to justify economically. A normal general ophthalmology practice (except an extremely busy Retina practice) would not approach 50% utilization. From reading Aetna's medical policy, they will pay for other tests before cataract surgery only if another diagnosis is present. You might try writing a good letter to the carrier saying Medicare and most other carriers pay for this service (B scans for opaque media) and Avastin for whatever and include literature to support the claim that it is standard of care. I have no relationship with most private carriers except TX BCBS, Medicare and Medicaid. Most medical directors are not located in Dallas and will not return my phone calls.

Modifier 25

Q: I was at the annual ASRS in Vancouver last week and we were told we could not use the modifier 25 when we charged an office visit and any injection such as Avastin. They stated that the OIG is looking closely at the use of the 25 modifier. My billing department stated that at your coding meeting in Houston in March of this year, you stated that we are allowed to use the 25 modifier at subsequent office visit when the patient returns for possible additional injections. Our chart should state return for re-evaluation and possible injections. This is what we have been doing. Please let me know if we must change our current system of billing.

A: Modifier 25 has always been under strict review by the carriers and the OIG so that is why we stress at all TOA

CODEquest meetings and TOA newsletters the importance of learning and complying with the rules. You are coding correctly. If the purpose of the visit is to evaluate the retina to determine the necessity of another Avastin injection and then the injection was made, then properly use OD modifier 25 and the IVI. If one routinely gives the IVI regardless of the OV evaluation, then the office visit and modifier 25 are inappropriate and only the IVI is billed.

Billing Refraction Differently by Payor

Q: Is it legal to charge for a refraction (or any service) to Medicare patients, and write off this fee for cash paying patients? Are we required to charge all patients exactly the same, regardless of insurance status?

A: Refraction for Medicare and most carriers is a non-covered service and one is not required to bill for it. However, a refraction is one of the most difficult time consuming parts of an eye examination. In these austere times, one is a fool to give this service away. I recommend a standard fee for all which can be discounted in hardship cases or for those that pay cash.

Ptosis & Entropian

Q: I have a patient with Bilateral Ptosis and Bilateral Senile Entropion of the lower lids. I performed procedures 67904 (Levator Resection) on the upper lids and 67923 (Tarsal Wedge) on the lower lids. Medicare bundles these procedures, but would it be appropriate to add modifier 59 to unbundled since they were performed on different lids?

A: No, the only way around the bundle is to perform it at a second surgery. As you know, this smacks of cosmetic surgery and that is the reason for the bundle.

Q: We have received a denial from one of the Medicare Advantage plans on ICD-9 Code V43.1 (Pseudophakia) because we used it as a primary diagnosis and the code book shows it to be a secondary diagnosis code. We have not had any denials from Trailblazer, but I was wondering if Trailblazer is going to start denying it as a primary code.

A: Not that I know of. No reason they should change. MA plans got raked over the coals by the PPACA and will be more problematic in the future as they seek additional savings.

Bilateral Entriopian Paperwork

Q: When doing an entropian repair for trichiasis do the ASC rules require separate paperwork for each eye or can you create one report for both eyes?

A: You must describe what you did for each eye if billing for each eye, but that can be in one op note. Don't forget that you need supporting external photos for all blephs, entropion, ectropion and ptosis codes.

Yag Iridolysis?

Q: I recently saw a patient who presented 6 months status post routine phaco with IOL. I noticed he had an oval shaped pupil, which was not seen before post operatively. On further exam, I noted he had several stromal iris strands captured within the internal lip of the phaco wound, causing the traction. After discussing the options with the patient, we opted to Yag the iris strands from the sound and reduce the iris traction (while restoring the shape of the pupil). I billed 67031 (Yag Vitreolysis) since this seemed to me to be the closest procedure describing what I actually did with the Yag. However, vitreous was not involved. I called it an Iridolysis in the laser report, with a diagnosis of iris adhesion (367.74) per the "coding coach manual." Is this OK or should I use a different code for the laser procedure? I thought Iridoplasty (66762) might work, but it's an Argon Laser, not a Yag.

A: There is no exact code for laser lysis of anterior synechiae 65865 is incisional technique to lyse anterior synechiae. And as you state the 67031 is Yag Vitreolysis. Iridoplasty and Iridectomy does not seem appropriate, so the best option is to use the 66999 unlisted procedures anterior segment code.

Removal of Post-Cataract Cortex

Q: For that (luckily rare) little piece of unnoticed cortex that two weeks post op swells into the pupil and requires wash out or removal. How do you code it?

A: Use diagnosis code 366.52 other after cataract, not obscuring vision or 366.53 after cataract obscuring vision and use one of these procedure codes:

- 66840 – Removal of lens material, aspiration technique or
- 66850 – Phacofragmentation with aspiration (if phaco also required)

Medicaid Funds & Medical Services Bundling

Q: We are denied all ophthalmic medical services (92002-92014) when done at the same time as fundus photos (92250) when billing Medicaid. As we move forward we want to make sure that Medicare does not limit the number of diagnostic testing done on the same day as an Eye code. The diagnostic testing of concern includes: Fundus photos (92250), Visual Field (92083), GDX Scanning (92135), and Pachymetry (76514).

A: Medicaid has its own set of rules that are spelled out in the Medicaid manual. Texas Medicaid is broke and unable to pay like Medicare and other payors. We have been unable to influence this process in the past. I suppose however, that the low Medicaid rates and medical policy inconsistent with Medicare is better than no insurance at all. I look at accepting Medicaid as part of my internal public service obligation. Having said that I find the Managed Care Medicaid programs to be too big a hassle. Who knows what will happen when Obamacare produces 30% more Medicaid patients in our care and the state cuts Medicaid rates 10%. One lesson is to keep your practice well diversified, not dependent on any one payor. This is really important in regards to Medicaid and Medicare Advantage plans.

Diabetic Photos

Q: One of my OD's mentioned that he heard that in some states, Medicare will pay for a photo to be done yearly on all diabetics for documentation. Can we do it in Texas?

A: No, photo screening has not been allowed in the past. We do have the new photo screening codes to be used in lieu of a proper fundus exam but they only pay about $11.00. If pathology is present, that requires Fundus Photos to help make treatment decisions then the Fundus Photo code 92250 may be used.

Debridement by Irrigation

Q: I performed a debridement of a corneal wound by irrigation with BSS. No scraping or suturing was done. What CPT code can I use?

A: There is no code for corneal irrigation. I expect it is included in the office visit code. If a foreign body was removed or superficial keratectomy was performed, one can bill for same.

Modifiers 54 and 55

Q: There is an out of town optometrist who refers patients to me for cataract surgery. Some of these patients choose to receive their postoperative care from their local doctor. He has indicated he does not want to bill Medicare for this postoperative care. Even though we know he will not be billing Medicare, should we still be adding the 54 modifier to our surgery charge since we will not be providing the postoperative care?

A: No, do not use the 54, 55 modifiers unless you comanage and want to divide the fee. As long as the OD does not bill Medicare, you do not need to divide the fee through the use of 54, 55 modifiers.

Q: A patient presented to our clinic for a second opinion for cataract surgery evaluation after being signed up for PCIOL surgery with another surgeon. The patient had all the appropriate pre-surgical testing on 20/20 cataracts performed by the other surgeon and billed to Medicare, as this is the patient's primary insurer. The other surgeon charged the patient $5,000 per eye for PCIOL surgery. Upon cancellation, the office retained $1,000 per eye for an administrative fee. Does Medicare have a position on administration fees charged for cancelled cataract surgery?

A: As it appears the Medicare criteria for cataract surgery was not met – 20/20 visual acuity – unless I don't know the whole story, none of the pre-op testing is a covered service. I think all the patient needs to do is write a letter to Medicare, specifically the program integrity unit at Trailblazer Health, and explain the facts and the $1,000 charge plus the illegal tests and heads will roll. I really hate to hear that this still goes on.

Documenting IOL Power Calculation

Q: Is the IOL calculation print out acceptable as the interpretation and report or is other documentation required.

A: I would circle the IOL power selected and initial it. If other factors enter into the calculation such as change of effective corneal power after refractive surgery, your thought processes and calculations should be included in the report sheet.

Presbyopic/Toric IOLs

Q: We have noticed that some payors are covering 66999 Presbyopic Correcting and Toric IOLs even if we attach a GY modifier, but they are underpaying. For example Blue Cross paid $637.50 for a Restor when our charge was $1,200 Tricare paid $375.00 for the Restor. Can we balance bill the patients for the difference, or do we have to accept what they paid?

A: Texas Blue Cross Medical Director answers:

"Our medical policy doesn't allow these lenses – they're considered 'Not Medical Necessary' because the standard IOL is considered a medically acceptable device following cataract extraction."

"That being said, it's possible that any specific claim might get paid because either the nature of the IOL wasn't appreciated or a self-insured plan had its own customized benefit language."

"Our standard contract language has exclusion for

- *Treatment of myopia and other errors of refraction, including refractive surgery or;*
- *Orthoptics or visual training; or*
- *Eyeglasses or contact lenses, provided that intraocular lenses shall be specific exceptions to this exclusion."*

"However, that language about intraocular lenses being exceptions to the exclusion doesn't mean we ignore application of Medical Necessity to the specific type of lens being provided."

"I think it's fair to say that an in-network ophthalmologist can bill a patient for the unallowed amount on a special IOL, but we strongly recommend that the physician obtain a signed procedure-specific waiver from the patient, acknowledging they will be responsible for payment of the non-covered items if the plan denies coverage. However, if the plan does cover the lens it would not be appropriate to balance bill the member beyond that allowable."

OIG LAUNCHES INQUIRY INTO COST OF AVASTIN

The OIG has launched an inquiry into the actual cost of Avastin for retina specialists. This, for all we know, is the data is gathered from an online study which CMS had done previously.

With the results of the CATT study comparing Lucentis and Avastin due out soon, perhaps they are getting data to set a price for compounded Avastin.

Also, the OIG is making inquiries on the use of rebates in Lucentis purchase. Genentech paid large rebates to those practices that use large volumes of Lucentis. The rebate

program has been reviewed by comparing consults and is said to be legal. We also hear that it has been a hot topic of conversation for the AAO Ethics Committee, so look for more about that in an upcoming issue of EyeNet.

MEDICARE COMPETITIVE BIDDING PROGRAM

January 1, 2011, Medicare began a new competitive bidding process for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). The program is designed to get quality equipment at a better price. Only selected contract suppliers will be allowed to participate and they cannot charge more than the contract amount.

The program will be phased in with only certain equipment included in nine geographic areas – DFW is the only area in Texas at present. The good news it only includes equipment that we as ophthalmologists never prescribe – oxygen, wheelchairs, diabetic supplies, CPAP, hospital beds, walkers, etc.

CODEquest 2011

The TOA/AAO CODEquest has continued to grow over the years, continually testing the capacity of the hotels and conference centers around the state.

This year we've added a third meeting to the calendar, so we've got one in Central Texas, one in the Metroplex and one in Houston:

March 12	Embassy Suites (Exit 201; near Outlet Mall) San Marcos
March 19	UT Southwestern Gooch Auditorium Dallas
April 2	Norris Conference Center @ CityCentre Houston

The San Marcos and Houston courses are both intermediate level coding courses running 8:30 to 12:30. To add an introductory component that does not conflict with the intermediate course, the Dallas course has been split into two courses. The morning course (8:30-11:30) is an introductory level course and the afternoon course (12:30-3:40) is an intermediate level course.

Be sure to go to www.TexasEyes.org for all of your coding seminar information *including directions*. These places are a lot easier to find when you use the custom made Google maps.

TOA ANNUAL MEETING - MAY 13-14, HOUSTON

TOA Annual Meeting is coming up on May 13 and 14 in Houston. We are delighted to once again be partnering with the Texas Medical Association's TexMed conference. Information on the meeting is being updated at TexasEyes.org. Registration is already open, as is housing (Hyatt Regency Houston – $149/night – 713-654-1234 – ask for TMA rate), so log on and sign up!

This year's meeting will include the following topics:

- Angle Closure Glaucoma
- Cornea
- Refractive IOLs
- Orbital Cellulitis
- Pediatric Ophthalmology
- Post-Traumatic Neuro-Oph
- Intraocular Tumors
- Retina
- Laser Refractive Surgery
- Resident Presentations
- Ethics
- Risk Management
- Electronic Health Records

The TMA is also putting on their full program, including a practice management for office managers, and a general session talk by health industry analyst Jeff Goldsmith on how health care professionals can prosper under the recently passed healthcare reform bill.

In addition, we have expanded exhibits in the Ophthalmology Pavilion, which this year will be a specialty-specific section of the TMA exhibit hall. Exhibitors signed up as of press time are as follows:

- Dougherty's Pharmacy
- DavLong Medflow
- NIDEK
- Iridex
- Bayou Ophthalmic Instruments
- New World Medical, Inc.
- Heidelberg Engineering
- Ellman International

If you speak to a rep from a company listed above, be sure to thank them for their support. And if you have a close relationship with a rep from another ophthalmic company, please be sure to mention the meeting to them (send them to www.TexasEyes.org for more information under "Meetings"). Exhibitors are a large reason why we can continue to put on our annual meeting with no registration cost for members.

JCAHPO TECH MEETING - MAY 13, HOUSTON

The TOA/TMA meeting is not the only attraction at the George R. Brown Convention Center on Friday May 13. Parallel to day 1 of the TOA meeting, JCAHPO is hosting a meeting for clinical staff. 6.75 Group A JCAHPO CE credits are available, with such topics as:

- Pharmacology
- Pathology
- Laser Technology
- Cornea
- Ocular Trauma
- Optic Neuropathies
- Refraction

The JCAHPO meeting is being held separately from, but in close cooperation with, the TOA Annual Meeting. They are also getting some logistical assistance from TMA; the housing for JCAHPO is the same as for the TOA Annual Meeting (Hyatt Regency Houston – $149/night – 713-654-1234 – ask for TMA rate).

Complete JCAHPO meeting information is available at www.JCAHPO.org under "CE Opportunities" or use the link from the TOA Meetings page at www.TexasEyes.org.

LEGISLATIVE OUTLOOK

The Texas Legislature has reconvened in Austin and they have a full plate. You've no doubt heard about some of the issues staring down lawmakers: the State Budget, Redistricting, Voter ID, etc. There will be a good many other issues considered as well, some with big impacts on you and your patients.

The Makeup

Texas saw the same Republican sweeps in 2010 as the rest of the country, and, after a pair of party switches, the House now stands at 101-49 Republican. The new 2/3s majority in the House will give the Republicans opportunities they did not have previously if they can agree as a caucus.

At the same time, it will cause problems during redistricting as every expert believes that there are simply not 101 Republican districts out there to pass around. Estimates put the actual number somewhere in the 87-91 range. This means some Republicans are going to be paired together and the process is sure to get messy.

The House Public Health Committee was just announced right before press time and has both familiar faces and some new ones:

Lois Kolkhorst (Brenham) , Chair
Elliot Naishtat (Austin), Vice Chair

Garnet Coleman (Houston) | Veronica Gonzalez (McAllen)
Jodie Laubenberg (Parker) | Vicki Truitt (Keller)
Carol Alvarado* (Houston) | Sarah Davis* (Houston)
Susan King (Abilene) | John Zerwas (Richmond)
Charles Schwertner* (Georgetown)

** indicates new to the committee.*

The Senate stands at its previous 19-12 balance, though it did gain two new members (one each from safe R and D seats) replacing retiring Senators.

The Senate Health and Human Services Committee has a very familiar look to it, with the only change being that retiring Senator Eliot Shapleigh has been replaced by Jose Rodriguez who won Shapleigh's seat:

Jane Nelson (Lewisville), Chair
Bob Deuell (Greenville), Vice Chair

Joan Huffman (Houston) | Robert Nichols (Jacksonville)
Dan Patrick (Houston) | Jose R. Rodriguez (El Paso)
Carlos Uresti (San Antonio) | Royce West (Dallas)
Judith Zaffirini (Laredo)

The Budget

As you know, Texas staved off the recession as long as it could, but the times have caught up with us. For the next two year budget, Texas is anticipated to see a 16% decrease in actual revenue and a 26% decrease in the revenue that would be needed to maintain the current level of state services.

That means there will be some deep cuts out there. The baseline budget released by the House – the starting point for the Appropriations Committee – calls for 25% cuts in Health and Human Services. And that figure is from actual dollar amounts, not from what would be needed to sustain current service levels given our changing population. For physicians, that proposal contains a 10% cut in Medicaid reimbursements.

With the pressure to cut Medicaid weighing heavy under the granite dome, the TMA has created a document you can use to help dispel the most common misconceptions about the program. It is downloadable at http://macu.la/ZY

Scope of Practice

It's a ritual as old as medicine – under-qualified practitioners who lack sufficient medical training come to the legislature each year in an attempt to gain the plenary license of a physician by legislative fiat rather than by training.

The filing deadline for bills is not until mid-March, but already there are aggressive bills filed to expand the scope of advanced practice nursing (completely independent care) and physical therapists (no diagnosis/referral required; board to define future scope of practice).

While no bill has been filed as of press time, you can bet that optometry will again be out in full force pushing an expansion of their scope. Into what? We can't say for sure until we see their bill. Scalpel and/or laser surgery? Intravitreal injections? Use of general anesthesia? Unlimited medical formulary? Authority to expand their own scope in the future? These were all in the bill filed for optometry last session, so be ready for every bit of that and more.

What can you do to stop this? Funny you should ask...

FIRST TUESDAYS AT THE CAPITOL

TOA is once again working with TMA, TMA Alliance, and TEXPAC to bring ophthalmologists to Austin for "First Tuesdays at the Capitol." Come be a part of the White Coat Invasion.

We've already had one great group on February 1, **but we need *you***. No one can make the case for your patients better than you. **Plan to attend March 1, April 5, and May 3.**

It's easy. The day starts with breakfast tacos and a quick orientation and issue briefing. Then it's off to the capitol with your fellow physicians of all stripes to discuss the current issues facing medicine.

Registration and additional information is available at www.texmed.org/firsttuesdays or call 800-880-1300 ext. 1361.

FIRST TUESDAYS

AT THE CAPITOL

82ND LEGISLATIVE SESSION — 2011

FEBRUARY 2011

MARCH 2011

APRIL 2011

MAY 2011

Your patients need YOU to be a lobbyist for a day! Come to Austin for *First Tuesdays at the Capitol* and make a difference for your patients and your practice.

For up-to-date information, check out the First Tuesdays Web site www.texmed.org/firsttuesdays, or call (800) 880-1300 ext. 1361 for more information.

Physicians Caring for Texans