2014 Medicare Update

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Practice Management Program
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Financial Interest

E. Ann Rose is President of Rose & Associates and acknowledges a financial interest in this subject matter.

Physician Fee Schedule

• 2014 Physician Fee Schedule Final Rule
  – Called for 24.1% reduction in physician fees
    • Included a 4% budget-neutrality adjustment
  – 3-month “patch” implemented through March 31, 2014
    • Temporarily halted 24% cut
      – Conversion Factor for 2014 is $35.8228
      – Anesthesia Conversion Factor is $17.2283
Physician Fee Schedule

- Congress passed another “patch” on March 31, 2014
  - Continues the 0.5% update through 12/31/14
  - Implements a 0% stop gap update from January 1 through April 1, 2015
  - Extends the 1.0 work GPCI floor another year
  - Creates process for identifying “misvalued codes” in future physician fee schedule updates
  - Delays ICD-10 implementation at least another year until October 1, 2015

Physician Fee Schedule

- Other provisions of 2014 final rule remain
  - Sequestration (Medicare spending) cuts extended another 2 years through 2023
    - Remittance Advice (RA) will include denial message “223 – Sequestration reduction in federal spending”
  - Permanent Geographic Practice Cost Index (GPCI) floor of 1.000% created for frontier states
    - NV, SD, ND, ID, WY, MT

Physician Fee Schedule

- Multiple Procedure Payment Reduction (MPPR) Continued
  - Technical component (-TC modifier) of second and subsequent tests performed on same patient, same day is reduced by 20%
    - CMS expects physicians to continue treating patients under same medical standards
    - Will monitor practice patterns to ensure MPPR not being bypassed
**Physician Fee Schedule**

- **Physician Value-Based Payment Modifier**
  - Payment Modifier
    - Will allow differential payment to physicians based on quality of care compared to cost of care during a specific period
    - Modifier to be used beginning in 2015
      - Will apply to all physicians by January 1, 2017

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**Physician Fee Schedule**

- 2014 final rule lowers threshold to groups of 10 or more eligible professionals in 2016
  - Originally included groups of 100 or more
- Groups of 10-99 not subject to downward adjustment, only an upward adjustment
- Groups of 100 or more are subject to upward, downward or neutral adjustments

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**Physician Fee Schedule**

- Groups of 10 or more physicians that do not participate in PQRS
  - Will be subject to automatic -2% adjustment in payment
Physician Fee Schedule

• Physician Compare Website
  – Allows beneficiaries to find and choose physicians/other providers enrolled in Medicare
  • Created to help patients make informed choices about healthcare they receive through Medicare
  • Can compare group practices
  • Will be able to compare individual doctors/other providers in the future

Physician Fee Schedule

– CMS to expand quality measures posted on Physician Compare Website
  • Will report on all measures collected through:
    – Group Practice Reporting Option (GPRO) web interface
    – Groups of all sizes participating in 2014 under PQRS GPRO
    – Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Program
  • Will post 2014 data in 2015 on CMS Physician Compare Website

Physician Fee Schedule

• PQRS
  – No reductions in 2014
  – Physicians who didn’t successfully report in 2013
    • Will receive 1.5% decrease in their Medicare payments in 2015
  – To avoid 2.0% penalty in 2016
    • Must report on 3 individual measures on 50% or more of eligible Medicare patients
    • Not subject to MAV review
Physician Fee Schedule

• To qualify for 0.5% bonus in 2014 and avoid MAV review
  – Must report 9 measures covering 3 NQS (National Quality Strategy) domains
    • If you report on only 1-8 measures, will be subject to MAV review
  – MAV review applies only to providers who are reporting for the bonus
    • Doesn’t apply if you only want to avoid penalty

Physician Fee Schedule

• What is MAV?
  – Measure-Applicability Validation Process
    • Allows CMS to determine if there were more measures that could have been reported by eligible professional
    • If they find this to be the case, could say EP doesn’t meet requirements to receive incentive bonus

PQRS

• Measures to consider reporting include:
  – Measure 12
    • Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation
  – Measure 14
    • Age-Related Macular Degeneration (AMD): Dilated Macular Examination
PQRS

- Measure 18
  - Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy

- Measure 19
  - Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

- Measure 117
  - Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient

PQRS

- Measure 140
  - Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement

- Measure 141
  - Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care

PQRS

- Can also report the following general measures to meet the 9 required
  - Measure 130
    - Documentation of Current Medications in Medical Record
  - Measure 226
    - Preventative Care and Screening: Tobacco Use Screening and Cessation Intervention
PQRS

• Registry ONLY Cataract Measure Group
  – Measure 191
    • Cataracts: 20/40 or Better Visual Acuity Within 90 Days Following Cataract Surgery
  – Measure 303
    • Cataracts: Improvement in Patient’s Visual Function Within 90 Days Following Cataract Surgery

PQRS

– Measure 192
  • Cataracts: Complications Within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures
– Measure 304
  • Patient Satisfaction Within 90 Days Following Cataract Surgery
– Only have to report 20 patients (11 of whom have to be Medicare patients)

Physician Fee Schedule

– To avoid 2.0% penalty in 2016
  • Only need to report on 3 individual measures on 50% or more of eligible Medicare patients
  • Must be at least in 1 NQS Domain
  • Not subject to MAV review
Physician Fee Schedule

• NQS Domains
  – 1. Patient Safety (2 Ophthalmic Measures)
    • Cataract complications within 30 days following cataract surgery requiring additional surgical procedures (Registry and EHR reporting only)
    • Documentation of current medication in the medical record

– 2. Communication and Care Coordination (3 Ophthalmic Measures)
  • Biopsy follow-up (registry only)
  • Primary open angle glaucoma: reduction of IOP by 15% or documenting a plan of care
  • Melanoma: Coordination of care (registry only)

– 3. Efficiency (1 Ophthalmic Measure)
  • Melanoma: Overutilization of imaging studies (registry only)

– 4. Population Health (1 Ophthalmic Measure)
  • Preventative care and screening: tobacco use screening and cessation intervention
Physician Fee Schedule

5. Clinical Process and Effectiveness: (8 Ophthalmic Measures)
   - Primary open angle glaucoma, optic nerve evaluation
   - ARMD – dilated macular exam
   - Diabetic Retinopathy – documentation of presence or absence of macular edema & level of severity of retinopathy
   - ARMD – Counseling on antioxidant supplement

6. Patient and Family Experience:
   - None that are specific to ophthalmology

Physician Fee Schedule

- Diabetic retinopathy – communication with the managing physician
- Melanoma – continuity of care, recall system (registry only)
- Cataracts 20/40 or better VA within 90 days after surgery (registry and EHR reporting only)

6. Patient and Family Experience:
   - None that are specific to ophthalmology

Physician Fee Schedule

- E-Prescribing Incentive Program
  - Program has now ended
    - There are no more incentive payments
  - No longer need to report code G8553
    - Will need to attest to e-prescribing in Meaningful Use in 2015
    - But won’t need to report “G” code
**Physician Fee Schedule**

- EPs and group practices who did not successfully e-prescribe in 2012 or 2013 will receive a 2.0% reduction in 2014
  - Medicare payment will be 98% of allowed charges
  - An informal review may be requested if EP or group practice believes they did meet requirements
    - Can submit informal review request to: eRxInformalReview@cms.hhs.gov

**Physician Fee Schedule**

- Incident to Services
  - Individuals performing “incident to” services in physician’s office must now meet “state” requirements including licensing
    - Will enable CMS to recover funds paid if services are not furnished in accordance with the law
      - Need to make sure any RNs, PAs, NPs, etc., that require licensing now meet any required state laws

**EHR Meaningful Use**

- Meaningful Use Timeline
  - Stage 2 which started January, 2014, will be extended through 2016
    - Does not delay start of Stage 2 Meaningful Use
    - Does not affect current reporting periods and deadlines for 2014 participation
  - Stage 3 will begin in 2017
    - For providers who have completed at least two years of Meaningful Use in Stage 2
EHR Meaningful Use

– In 2014 providers will attest for 90 days regardless of whether they are attesting for Stage 1 or Stage 2
  • EPs who are beginning the EHR program in 2014 must attest Stage 1 no later than October 1, 2014
  • EPs who are in the second year of Stage 1 or Stage 2 attestation have until December 31, 2014, to attest

EHR Meaningful Use

– If you have completed one year of Stage 1 of Meaningful Use
  • Must demonstrate a second year of Stage 1 in 2014 for a 3-month reporting period (calendar quarter) for Medicare
    – It’s any 90 days for Medicaid
  • Must demonstrate Stage 2 for two years (2015 and 2016)
  • Must begin Stage 3 in 2017

EHR Meaningful Use

– If you have completed two or more years of Stage 1 of Meaningful Use
  • Will need to demonstrate Stage 2 in 2014 for a 3-month (calendar) quarter for Medicare (any 90 days for Medicaid)
  • Will need to demonstrate Stage 2 for 3 years (2014, 2015, 2016)
  • Must begin Stage 3 in 2017
  – CMS to propose legislation for Stage 3 in the Fall of 2014
ASC Fee Schedule

• 2014 ASC Fee Schedule includes the following provisions:
  – ASCs that met the quality reporting requirements
    • Payment will increase by 1.2%
    • Resulting in ASC conversion factor of $43.471
  – ASCs that did not meet the quality reporting requirements
    • Conversion factor is $42.612 resulting in lower ASC payments

ASC Fee Schedule

<table>
<thead>
<tr>
<th>Procedure</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keratoplasty</td>
<td>$1,665</td>
<td>$1,703</td>
</tr>
<tr>
<td>Trabeculectomy</td>
<td>$ 941</td>
<td>$ 966</td>
</tr>
<tr>
<td>Express shunt</td>
<td>-</td>
<td>$1,678</td>
</tr>
<tr>
<td>YAG laser</td>
<td>$ 231</td>
<td>$ 237</td>
</tr>
<tr>
<td>Complex cataract</td>
<td>$ 971</td>
<td>$ 976</td>
</tr>
<tr>
<td>Cataract with IOL</td>
<td>$ 971</td>
<td>$ 976</td>
</tr>
<tr>
<td>Intravitreal Injection</td>
<td>$ 49</td>
<td>$ 48</td>
</tr>
<tr>
<td>Vitrectomy</td>
<td>$1,635</td>
<td>$1,691</td>
</tr>
<tr>
<td>Retina Detach</td>
<td>$1,635</td>
<td>$1,691</td>
</tr>
<tr>
<td>Retina Repair</td>
<td>$1,635</td>
<td>$1,691</td>
</tr>
</tbody>
</table>

ASC Fee Schedule

• ASC Quality Reporting (ASCQR) Program
  – Required to report on up to 5 measures
    • From October 1, 2012 – December 31, 2012
     – Had to report on 50% of claims
    • Reporting was required to avoid a 2% payment penalty in 2014
  – Effective January 1, 2013, ASCs were required to report the G-codes on claims for both Medicare primary and secondary
ASC Fee Schedule

• Added three new measures including two for ophthalmology
  • Measure for Complications within 30 days
    – Was withdrawn in final rule
  • ASC 11 - Cataracts: Improvement in patient’s visual function within 90 days following cataract surgery (NQF #1536)
    – CMS originally delayed implementation of ASC-11 until April 1, 2014

ASC Fee Schedule

– ASC-11 now delayed indefinitely
  • Do not have to report in 2014 at all
  • CMS will revisit in 2015 OPPS/ASC payment rule

– In order to support medical necessity for ASC to perform surgery in their center, ASC still needs to obtain:
  • Copy of clinic chart notes supporting medical necessity for surgery
  • Copy of patient lifestyle impairment questionnaire

ASC Fee Schedule

• ASC Supplies
  – Code V2785, Processing, preserving and transporting corneal tissue only billable supply
    • All other supplies included in ASC facility fee payment
  – Pass-through Drugs
    • Some drugs are considered pass-through drugs and payable separately to the ASC
    • Make sure staff is aware of this and bills Medicare accordingly
### ASC Fee Schedule

#### Most Common Ophthalmology ASC Pass-Through Drugs

<table>
<thead>
<tr>
<th>Code</th>
<th>Drug</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9257</td>
<td>Bevacizumab (Avastin – 0.25 mg), compounded</td>
<td>$1.64</td>
</tr>
<tr>
<td>J0178</td>
<td>Methylene (EYLEA) injection, 1 mg – 2 units</td>
<td>$902.50</td>
</tr>
<tr>
<td>J0585</td>
<td>Botox</td>
<td>$5.44</td>
</tr>
<tr>
<td>J0900</td>
<td>EDTA</td>
<td>$201.40</td>
</tr>
<tr>
<td>J0901</td>
<td>Cyamemazine</td>
<td>$1,013.57</td>
</tr>
<tr>
<td>J0902</td>
<td>Mitoxantrone</td>
<td>$1,026.97</td>
</tr>
<tr>
<td>J0978</td>
<td>Ranibizumab (Lucentis)</td>
<td>$397.20</td>
</tr>
<tr>
<td>J0979</td>
<td>Achiase (TPA)</td>
<td>$19.62</td>
</tr>
<tr>
<td>J3350</td>
<td>Triamcinolone – preservative free</td>
<td>$3.19</td>
</tr>
</tbody>
</table>

**Effective 1/1/14 - Payments updated quarterly**

### ASC Fee Schedule

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<th>Code</th>
<th>Drug</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>J3396</td>
<td>Verteporfin – lat 100 units</td>
<td>$10.83</td>
</tr>
<tr>
<td>J3710</td>
<td>Ganciclovir implant</td>
<td>$16,960.00</td>
</tr>
<tr>
<td>J3711</td>
<td>Fluorouracil acetate (Retin) implant</td>
<td>$19,345.00</td>
</tr>
<tr>
<td>J3712</td>
<td>Dextran – 7 units</td>
<td>$ 195.87</td>
</tr>
<tr>
<td>J3715</td>
<td>Mitomycin, 9.2mg (Moxa) – 1 unit</td>
<td>$379.47</td>
</tr>
<tr>
<td>J3716</td>
<td>Doxplatin (RETICA) injection, 8.125 mg – 4 units</td>
<td>$1,046.75</td>
</tr>
<tr>
<td>J0935</td>
<td>Bevacizumab (Avastin – 10 mg)</td>
<td>$65.96</td>
</tr>
<tr>
<td>J0290</td>
<td>Mitomycin – 5 mg</td>
<td>$23.86</td>
</tr>
</tbody>
</table>

**Effective 1/1/14 - Payments updated quarterly**

### CPT Code Changes

Several new CPT Codes for 2014 affecting Ophthalmology.
### CPT Codes

**Revised Codes**

- **Code 65778**, Placement of amniotic membrane on the ocular surface; without sutures
  - Codes were revised to omit the phrase “for wound healing” and to substitute the term “self-retaining” to “without sutures.”
  - Helps differentiate between the two techniques, non-sutured/sutured or self-retaining
  - The term “for wound healing” restricted the use of the codes which was not the original intent

### CPT Codes

- **Code 66780**, Ocular surface reconstruction; amniotic membrane transplantation, multiple layers
  - Revised parenthetical phrase to indicate:
    - (For placement of amniotic membrane without reconstruction using no sutures or single layer suture technique, see 65778, 65779)
- **Code 13150**, Repair, complex, eyelids, nose, ears and/or lips was deleted
  - Now must use simple or intermediate wound repairs

### CPT Codes

- **Code 13151**, Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm
- **Code 13152**, 2.6 cm to 7.5 cm
- **Code +13153** each additional 5 cm or less (list separately in addition to code for primary procedure)
  - Code 13151 was switched to a parent code due to deletion of code 13150
CPT Codes

- **New Codes**
  - **Code 66183**, Insertion of anterior segment aqueous drainage device without extraocular reservoir, external approach
    - Relieves intraocular pressure associated with glaucoma not responding to medical therapy or surgical intervention
    - Requires conjunctival incision and creation of partial-thickness scleral flap in which to secure the aqueous drainage device

CPT Codes

- **Code 0329T**, Monitoring of intraocular pressure for 24 hours or longer, unilateral or bilateral, with interpretation and report
  - Device measures circumferential change at the corneoscleral junction of eye every 5 minutes over a 24-hour period
  - Data is interpreted and converted to a 24-hour profile of patient's IOP

CPT Codes

- **Code 0330T**, Tear film imaging, unilateral or bilateral, with interpretation and report
  - Reports digital interferometry to access the quality and thickness of the lipid layer of the tear film
    - If inadequate, can cause dry eyes
  - Operates on a white light interferometry and provides color assessment of tear film
  - Interpreted by doctor to see if patient has a lipid deficiency
CPT Codes

– Code 0333T, Visual evoked potential; screening of visual acuity, automated
  • Use to report a limited screening of visual acuity using an automated visual evoked potential instrument-based algorithm with a pass/fail result
  • Will most likely be considered screening test billable only to the patient
– As a reminder, CMS does not apply RVUs to Category III codes
  • Payment is left up to carrier discretion

CPT Codes

• Extended Category III Code
  – Code 0191T, Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach into the trabecular meshwork
    • iStent® Trabecular MicroBypass
    • Received extension through 2019
      • Was due to sunset in 2014

CPT Codes

• Deleted Codes
  – Code 0192T, Insertion of aqueous shunt, external approach
    • Should now bill new code 66183
  – Code 0124T, Conjunctival incision with posterior extrascleral placement of pharmacological agent
    • Deleted for lack of use
2014 OIG Work Plan

Includes new and ongoing issues affecting Ophthalmology

New Issues

- **Physician Compare Website**
  - OIG to review Physician Compare Website to make sure it contains accurate information
    - CMS required by law to create website so patients could make informed choices about their healthcare
    - Uses PECOS system for provider information
    - OIG found provider information often inaccurate or incomplete
  - This is “new start” for 2015

New Issues

- Mainly looking at Medicare contractors for their efforts
- **Provider action:**
  - When revalidating or entering new provider enrollment make sure it’s accurate
  - Errors or inaccurate information could result in OIG looking at provider as well
On-Going Issues

• **Billing patterns for nursing home stays**
  – OIG will continue to identify questionable billing patterns during stays not paid under Part A
    • Stays where benefits are exhausted, for example
    • Not sure if ophthalmology services were on list
  – **Provider action:**
    • If you have ODs routinely seeing patients in nursing homes, make sure billing is correct

On-Going Issues

• **Inappropriate payments for E&M Services**
  – OIG will continue to determine to what extent certain E&M services were inappropriate
    • Will also review multiple E&M services associated with same providers for documentation errors
  – CMS has noticed increase in identical documentation across services

On-Going Issues

– This could be result of increased “cloned” documentation in EHR charts
  • Data being pulled forward each visit
  • CMS has even released guidance in their newsletters regarding “cloned documentation”
  – **Provider action:**
    • Conduct frequent internal and external chart audits to make sure the documentation in both paper charts and EHR meets the level of service billed
On-Going Issues

• Questionable Billing and Payments to Ophthalmologists
  – OIG reviewing claims for 2012
  – Will identify certain geographic locations for providers exhibiting questionable billing
    • In 2012 CMS allowed over $6.8 billion for services provided by ophthalmologists
  – Action item:
    • Ensure services are always accurately billed as documented in chart/op report

• Assignment Rule Violations
  – OIG looking at 2012 claims to see if beneficiaries were inappropriately billed in excess of Medicare allowed amounts
    • Participating physicians agree to accept payment on assignment for all services billed
      – Requires written agreement between beneficiaries and providers allowing provider to request direct payment from Medicare
      – Provider, in return, agrees to accept the Medicare allowed amount as indicated by Medicare
  – Action Item:
    • Make sure staff is not over-collecting on Medicare assigned claims
      – Can only collect coinsurance and deductible and not difference between Medicare’s allowed amount and your actual charge
    • Make sure patient assignment agreement is in order
      – Does it contain Medicare language?
On-Going Issues

- **Place of Service Coding Errors**
  - Still looking at ASC and HOPD claims to see if correct place of service used
    - Some claims show “office” when place of service should have been HOPD or ASC
  - Medicare pays physician higher amount when services performed in office vs. HOPD or ASC
  - **Action item:**
    - Make sure billers are accurately coding place of service

Questions