2015 Medicare Update

ASCRS-ASOA Symposium & Congress
Practice Management Program
San Diego, California
April 17-21, 2015

Presented by: E. Ann Rose

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Financial Interest

I acknowledge a financial interest in the subject matter of this presentation.

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Physician Fee Schedule

- 2015 Physician Fee Schedule Final Rule
  - Called for 21.2% reduction in physician fees
    - *Included a -0.06% budget-neutrality adjustment and ending conversion factor of $28.2239*
- Protecting Access to Medicare Act (PAMA)
  - Preserved 0% update for January 1 though March 31, 2015
    - *Malpractice RVU corrections and other RVU technical changes resulted in final conversion factor of $35.7547*

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Physician Fee Schedule

- Legislation passed by House of Representatives in March
  - Fully repeals SGR (flawed method of calculating physician fees)
  - A 0.5% update to fee schedule for 5 years
  - Preserves fee-for-service option

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Physician Fee Schedule

- Consolidates quality reporting programs and repeals penalties for:
  - *PQRS, Meaningful Use, Value Based Payment Modifier*
- Creates new consolidated Merit-Based Improvement System (MIPS) in 2019
  - *Establishes quality-improvement thresholds*

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Physician Fee Schedule

- Senate opted to delay voting on legislation until after Spring Break
  - Expected to pass legislation when they re-convene in April
- CMS also reversed decision to eliminate global fee surgical periods
  - Will collect data on global fees in 2017
    - *Will determine accuracy of payment rates*

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Physician Fee Schedule

National Fee Schedule Payments Through March 31, 2015

CPT Code	2014	2015
92004 - Comp, New patient	$151	$149
92012 - Interm, Est. Patient	$ 87	$ 85
92014 - Comp, Est. Patient	**$126**	**$124**
99203 - Detailed, New Patient	$108	$109
99213 - Exp. Prob. Focused, Est. Patient	$ 73	$72
99214 - Detailed, Est. Patient	**$108**	**$108**
99215 - Comp, Est. Patient	**$144**	**$146**
**92014 est. pt. still pays more than 99214 est. pt. exam*		
99204 - Comp, New Patient	**$166**	**$165**
99205 - Comp, New Patient	**$207**	**$208**

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Physician Fee Schedule

National Fee Schedule Payments Through March 31, 2015

CPT Code	2014	2015
92083 - Visual field	$ 65	$ 64
92133 - OCT, optic nerve	$ 45	$ 44
92134 - OCT, retina	$ 46	$ 45
92225 - Extended Ophthalmoscopy, Initial	$ 28	$ 27
92226 - Extended Ophthalmoscopy, Subsequent	$ 25	$ 25
92250 - Fundus Photo	$ 79	$ 79
92235 - Fluorescein angiography	$111	$110
92285 - External ocular photography	$ 21	$ 20

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Physician Fee Schedule

National Fee Schedule Payments Through March 31, 2015

CPT Code	2014	2015
15823 - Blepharoplasty	$ 638	$ 613
65756 - DSAEK	$1,201	$1,198
66170 - Trabeculectomy	$1,244	$1,213
66180 - Aqueous Shunt	$1,214	$1,150
66183 - Express shunt	$1,090	$1,041
66185 - Revise Aqueous shunt/graft	$ 793	$ 854
66821 - YAG – Office 66821 - YAG - Facility	$ 342 $ 325	$ 333 $ 314
66982 - Complex Ct w/IOL	$ 838	$ 804

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Physician Fee Schedule

National Fee Schedule Payments Through March 31, 2015

CPT Code	2014	2015
66984 - Cataract w/IOL	$ 673	$ 647
67028 - Intravitreal Injection	$ 106	$ 102
67036 - Vitrectomy	$1,002	$ 911
67039 - Laser treatment of retina	$1,310	$ 976
67040 - Laser treatment of retina	$1,482	$1,055
67041 - Vitrectomy – macular pucker	$1,386	$1,166
67042 - Vitrectomy – macular hole	$1,386	$1,166
67043 - Vitrectomy – Membrane dissect	$1,585	$1,231

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Physician Fee Schedule

National Fee Schedule Payments Through March 31, 2015

CPT Code	2014	2015
67108 - Repair Detach. Retina	$1,679	$1,622
67113 - Complex Retina Repair	$1,827	$1,764
68761 - Punctum Plug Insertion	$ 153	$ 149

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Physician Fee Schedule

- Global fee periods to be eliminated
  - Minor surgery (10 day global) to expire in 2017
  - Major surgery (90 day global) to expire in 2018
    - *CMS considering developing special post-op CPT codes for follow-up visits*
      - Will be paid less than regular office visit codes
  - ASCRS/ASOA and other specialty societies working to delay implementation

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ASC Fee Schedule

- 2015 ASC Fee Schedule
  - Conversion factor for ASCs increased to 1.4% for facilities meeting quality reporting requirements
    - *Results in small increases in ASC facility fee payments*
- HOPD 2015 Reimbursement
  - Rates increase about 2.3% in 2015

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ASC Fee Schedule

National ASC Fee Schedule Payment Amounts

		2014	2015
65755	Keratoplasty	$1,783	$1,711
66170	Trabeculectomy	$ 966	$ 960
66183	Express shunt	$1,678	$1,711
66821	YAG laser	$ 237	$ 243
66982	Complex cataract	$ 976	$ 960
66984	Cataract with IOL	$ 976	$ 960
67028	Intravitreal Injection	$ 48	$ 47
67036	Retina (Codes 67036 - 67043)	$1,691	$1,711
67108	Retina Detach	$1,691	$1,711

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ASC Fee Schedule

- ASC Quality Measure Reporting
  - ASCs that satisfactorily report on quality measures:
    - *2015 ASC Conversion Factor is $44.071*
  - ASCs that failed to meet ASC quality reporting:
    - *Will be paid on a lower ASC Conversion Factor in 2015 of $43.202*

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ASC Fee Schedule

- Cataract ASC-11 Reporting Measure
  - ASCs were going to initially be required to report on pre- and post-operative patient visual function
    - *ASCRS, ASOA and other ophthalmology societies strongly advocated that this was not an appropriate measure for the ASC setting*
  - CMS has now determined that ASC-11 is now a *voluntary* reporting measure

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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*

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ASC Fee Schedule

Most Common Ophthalmology ASC Pass-Through Drugs

Code	Drug	Payment
C1841	Retinal Prosthesis (includes int/ext components)*	Contractor Priced
C9447	Omidria - Phenylephrine & ketorolac - 4 ml	$ 418.70
J0178	Afilbercept (EYLEA) Injection, 1mg - 2 units	$ 980.50
J0585	Botox	$ 5.58
J0600	EDTA	$3,063.72
J0850	Cytomegalovirus	$1,013.87
J2503	Macugen	$ 1,035.10
J2778	Ranibizumab (Lucentis)	$ 396.05
J2997	Activase (TPA)	$ 68.19

** Effective 1/1/15 - Payments updated quarterly

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ASC Fee Schedule

Most Common Ophthalmology ASC Pass-Through Drugs

Code	Drug	Payment
J3300	Triamcinolone – preservative free	$ 3.74
J3396	Verteporfin – bill 150 units	$ 10.75
J7310	Ganciclovir Implant	$16,960.00
J7311	Fluocinolone acetonide (Retisert implant)	$19,725.67
J7312	Ozurdex – 7 units	$ 201.25
J7315	Mitomycin, 9.2mg (Mitosol) – 1 unit	$ 372.80
J7316	Ocriplasmin (JETREA) Injection, 0.125 mg – 4 units	$ 1,046.75
J9280	Mitomycin – 5 mg	$ 39.86

** Effective 1/1/15 - Payments updated quarterly

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Quality Reporting

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PQRS

- PQRS is mandatory for 2015
  - *No bonus payments in 2015*
  - Providers who did not successfully report PQRS in 2013
    - *Will receive 1.5% reduction in Medicare Fee Schedule payments in 2015*
  - Providers who did not successfully report PQRS in 2014
    - *Will receive 2% reduction in Medicare Fee Schedule payments in 2016*

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Meaningful Use

- Meaningful Use reporting in 2015
  - *Must have full year of MU participation for any provider beyond one year reporting*
- Providers who did not qualify for a hardship exception or meet MU attestation Stage 1, by October 1, 2014
  - *Will receive a 1% reduction of Medicare Fee Schedule payments in 2015*

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Physician Compare Website

- CMS expanding public reporting via Physician Compare Website
  - Group level measures for public reporting on the Physician Compare website will be expanded in 2016 to include:
    - *2015 PQRS GPRO web interface, registry and EHR measures for group practices of 2 or more eligible professionals and Accountability Care Organizations*

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Physician Compare Website

- PQRS individual measures collected via registry, EHR, or claims will be made available on the Physician Compare website in ***late*** 2016 if technically feasible

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Value Based Payment Modifier

- CMS will continue to phase in the VBPM
  - Adjusts traditional Medicare payments based on quality and cost of care
  - Providers who deliver higher quality care at a better value will receive upward adjustments in payments
    - *Providers who underperform may be subject to a payment reduction*

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Value Based Payment Modifier

- Solo practitioners and physician practices with fewer than 10 providers including optometrists who successfully report PQRS in 2015
  - *Will be exempt from any negative payment adjustments under the VBPM*
- Practices with fewer than 10 providers and solo practitioners who do not successfully participate in PQRS in 2015
  - *Will receive automatic payment reductions of 2% in 2017*

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Value Based Payment Modifier

- Practitioners with 10 or more providers who do not successfully report PQRS in 2015
  - *Will receive payment reductions of 4% in 2017*

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CPT Code Changes

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2015 CPT Changes

New and Revised Codes		
New	66179	Aqueous shunt to extra-ocular equatorial plate reservoir, external approach; without graft
Revised	66180	Aqueous shunt to extra-ocular equatorial plate reservoir, external approach; with graft (Cannot report 66180 with 67255 – scleral reinforcement w/graft)
New	66184	Revision of aqueous shunt to extra-ocular equatorial plate reservoir; without graft
Revised	66185	Revision of aqueous shunt to extra-ocular equatorial plate reservoir; with graft
Deleted	66165	Fistulization of sclera for glaucoma, iridencleisis or iridotasis

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2015 CPT Changes

New and Revised Codes		
New	92145	Corneal hysteresis determination, by air impulse stimulation, unilateral or bilateral, with interpretation and report (replaces 0181T)
Revised	0191T	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the trabecular meshwork; initial insertion
New	+0376T	……each additional device insertion (List separately in addition to code for primary procedure)
Revised	0253T	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the suprachoroidal space

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2015 CPT Changes

New and Revised Codes		
New	0378T	Visual field assessment, with concurrent real time data analysis and accessible data storage with patient initiated data transmitted to a remove surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional
New	0379T	……technical support and patient instructions, surveillance, analysis, and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional
New	0380T	Computer-aided animation and analysis of time series retinal images for the monitoring of disease progression, unilateral or bilateral, with interpretation and report

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2015 CPT Changes

Codes Implemented July 1, 2014 - Included in 2015 CPT		
New	0341T	Quantitative pupillometry with interpretation and report, unilateral and bilateral
New	0356T	Insertion of drug-eluting implant (including punctal dilation and implant removal when performed) into lacrimal canaliculus, each

Note: CMS does not assign RVUs to Category III codes. Payment is by contractor discretion.

Category III codes should be billed in order to develop billing history for possible conversion to CPT permanent codes.

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Aqueous Shunts

- AMA and RUC
  - Determined that frequency of use of grafts in aqueous shunt procedures warranted new code structure
    - *Codes 66180 and 67255 reported together 73% of the time*
    - *Revised codes 66180 and 66185 to include graft*
    - *Created new codes for the non-graft procedures*

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Aqueous Shunts

New and Revised Codes		
New	66179	Aqueous shunt to extra-ocular equatorial plate reservoir, external approach; without graft
Revised	66180	Aqueous shunt to extra-ocular equatorial plate reservoir, external approach; with graft (Can no longer report 66180 in conjunction with scleral reinforcement w/graft, code 67255)
New	66184	Revision of aqueous shunt to extra-ocular equatorial plate reservoir; without graft
Revised	66185	Revision of aqueous shunt to extra-ocular equatorial plate reservoir; with graft
Deleted	66165	Fistulization of sclera for glaucoma, iridencleisis or iridotasis

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Corneal Hysteresis

New and Revised Codes		
New	92145	Corneal hysteresis determination, by air impulse stimulation, unilateral or bilateral, with interpretation and report
		Replaces Category III code 0181T due to increase in usage
		Corneal hysteresis (CH) is **defined** as the difference in intraocular pressure recorded during inward and outward applanation.
		New code now describes a test performed on a single or both eyes (e.g., unilateral or bilateral)

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Category III Code Changes

New and Revised Codes		
Revised	0191T	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the trabecular meshwork; **initial insertion**
New	+0376T	……**each additional** device insertion (Can use to report each additional stent beyond the first implanted stent) (List separately in addition to code for primary procedure)
Revised	0253T	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the suprachoroidal space (Now a stand alone code)

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Category III Code Changes

- New Category III codes created to report visual field assessment up to 30 days
- Assessment
  - Patient transmits daily test-data to monitoring center (IDTF) for input into secured database
    - *Technician with physician (or other qualified healthcare professional) analyzes the data and prepares report*
      - Results are then interpreted by physician

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Category III Code Changes

- The professional component of the physician (or other qualified health care professional) is billed to insurance
- Can also bill separately for the technical component of the device set-up and patient instructions for daily testing and transmission with technical staff report

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Category III Code Changes

New and Revised Codes		
New	0378T	Visual field assessment, with concurrent real time data analysis and accessible data storage with patient initiated data transmitted to a remove surveillance center for up to 30 days; **review and interpretation with report by a physician or other qualified health care professional**
New	0379T	……..**technical support and patient instructions,** surveillance, analysis, and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional

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Category III Code Changes

- New code to report analysis of retinal images to monitor disease progression (e.g. glaucoma or other structural damage)
  - May be performed on one or both eyes
    - *May only be reported once*

New and Revised Codes		
New	0380T	Computer-aided animation and analysis of time series retinal images for the monitoring of disease progression, unilateral or bilateral, with interpretation and report

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Category III Code Changes

Codes Implemented July 1, 2014 Included in 2015 CPT Coding Manual		
New	0341T	Quantitative pupillometry with interpretation and report, unilateral and bilateral
New	0356T	Insertion of drug-eluting implant (including punctal dilation and implant removal when performed) into lacrimal canaliculus, each
		(Included parenthetical notes following punctum plug and probing codes to report 0356T for drug-eluting implants)

Reminder: Since CMS does not assign RVUs to Category III codes, payment is made by contractor discretion.
Billing Category III codes will help develop billing history for possible conversion to CPT permanent codes.

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Sequestration

- Sequestration (Medicare spending) cuts in effect through 2024
  - *Remittance Advice (RA) will include denial message "223 – Sequestration reduction in federal spending"*
- Permanent Geographic Practice Cost Index (GPCI) floor of 1.000% still in place
  - *States with smaller GPCIs will not be reduced below 1.000%*

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MPPR

- Multiple Procedure Payment Reduction (MPPR) Continues
  - 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*

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MPPR

Diagnostic Tests Subject to Multiple Procedure Reduction						
76510	76514	92060	92132	92228	92270	92285
76511	76516	92081	92133	92235	92275	92286
76512	76519	92082	92134	92240	92283	
76513	92025	92083	92136	92250	92284	

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2015 OIG Work Plan

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On-Going Issues

- ***Ambulatory Surgery Center (ASC) Payment System***
  - Will continue to review methodology for setting ASC payment rates under revised system
    - *ASC payments modeled on Outpatient Prospective Payment System (OPPS) since 2008*
  - Will determine if disparity exists between ASC and HOPD payment rates for similar procedures

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On-Going Issues

- ***Payments for Personally Performed Anesthesia Services***
  - Will review claims to determine whether personally performed anesthesia services were billed correctly
    - *Must be reported with "AA" modifier*
  - Reporting incorrect modifier as though the service was personally performed when it was not results in higher (incorrect) payments

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On-Going Issues

- ***Imaging Services***
  - Will review Medicare payments to determine if they accurately reflect expenses incurred and that utilization rates reflect industry practices
    - *Will continue to focus on Practice Expense component including equipment utilization rates*

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On-Going Issues

- ***Questionable Billing and Payments to Ophthalmologists***
  - OIG still 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*

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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*

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On-Going Issues

- Security of certified EHR records under Meaningful Use

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New Issue

- Provider Eligibility
  - Enhanced enrollment screening for Medicare Providers
    - *Stepping up effort to prevent fraud, waste, and abuse resulting from vulnerabilities in Medicare enrollment process*
    - *Implementing new authorities that will include:*
      - Site visits, fingerprinting, background checks, and automated provider screening process

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Questions

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