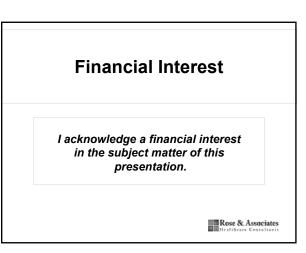
2015 Medicare Update

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

Presented by: E. Ann Rose

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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 reconvene 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

National Fee Schedule Payments Th	nrough Mar	ch 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 that	n 99214 est.	pt. exam
99204 - Comp, New Patient	\$166	\$165
99205 - Comp, New Patient	\$207	\$208

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		

1,214 1,090	\$1,150 \$1,041
700	0.054
793	\$ 854
342 325	\$ 333 \$ 314
838	\$ 804

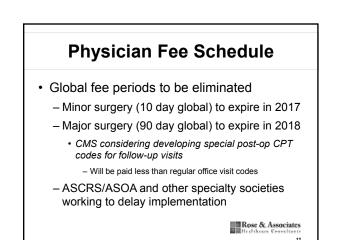
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National Fee Schedule Payments Through March 31, 2015

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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National Fee Schedule Payments	s 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



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

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

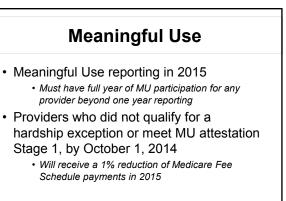
Code	Drug	Payment
C1841	Retinal Prosthesis (includes int/ext components)*	Contractor Priced
C9447	Omidria - Phenylephrine & ketorolac - 4 ml	\$ 418.70
J0178	Afilbercept (EYLEA) Injection, 1mg - 2 units	\$ 980.50
J0585	Botox	\$ 5.58
J0600	EDTA	\$3,063.72
J0850	Cytomegalovirus	\$1,013.87
J2503	Macugen	\$ 1,035.10
J2778	Ranibizumab (Lucentis)	\$ 396.05
J2997	Activase (TPA)	\$ 68.19
* Effectiv	ve 1/1/15 - Payments updated quarterly	Rose & Associa

I	Most Common Ophthalmology ASC Pass-Through	h Dru	gs
Code	Drug	Р	ayment
J3300	Triamcinolone – preservative free	\$	3.74
J3396	Verteporfin – bill 150 units	\$	10.75
J7310	Ganciclovir Implant	\$1	6,960.00
17311	Fluocinolone acetonide (Retisert implant)	\$1	9,725.67
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	1,046.75
19280	Mitomycin – 5 mg	\$	39.86



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*

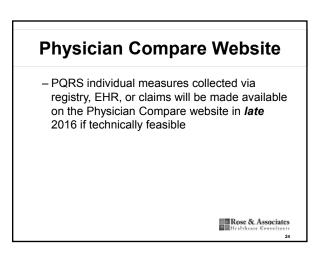
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Physician Compare Website

- 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



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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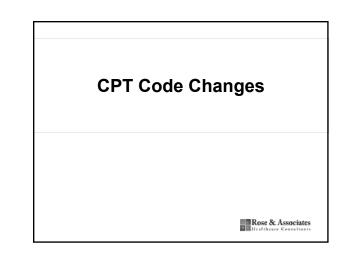
Value Based Payment Modifier

- 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



		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

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		

		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			

C	odes Impler	nented 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
is by	contractor dis	not assign RVUs to Category III codes. Payment scretion. should be billed in order to develop billing e conversion to CPT permanent codes.

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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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

Aqueous Shunts

		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)

		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)

Category III Code Changes

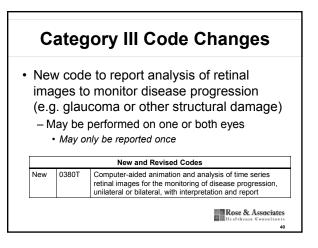
- New Category III codes created to report visual field assessment up to 30 days
- Assessment
 - Patient transmits daily test-data to monitoring center (IDTF) for input into secured database
 - Technician with physician (or other qualified healthcare professional) analyzes the data and prepares report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

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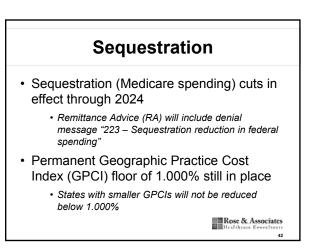
Category III Code Changes

- 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

		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 othe qualified health care professional			



		odes Implemented July 1, 2014 uded 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)

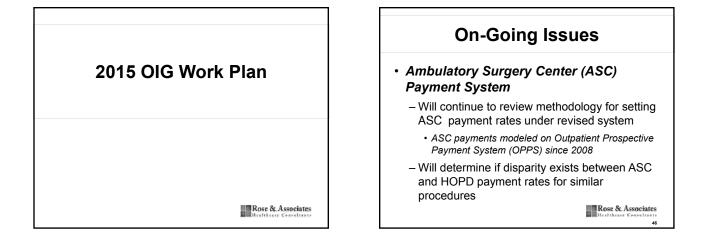


MPPR

- 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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		N	ИРР	ľ		
				Diagnost Iultiple P		
92285	92270	92228	92132	92060	76514	76510
92286	92275	92235	92133	92081	76516	76511
	92283	92240	92134	92082	76519	76512
	92284	92250	92136	92083	92025	76513



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

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

