2017 Medicare Update

ASCRS-ASOA Symposium & Congress
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Financial Interest

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

Physician Fee Schedule

- 2017 Medicare Physician Fee Schedule rule released on November 2, 2016
  - Budget-neutrality adjustment and 0.5% update adjustment factor resulted in increase in conversion factor used to set fees
    - Conversion Factor is $35.8887
    - Anesthesia Conversion Factor is $22.0454

- Retina and glaucoma cuts
  - Drastically reduced in 2016
    - Flawed payment methodology
    - CMS has now valued certain procedures based on intensity not just time
      - Will be phased-in based on RUC-reduced values
      - Big win for ophthalmology

- Retina diagnostic tests
  - Fluoresceins (92235) and ICG (92240)
    - Now paid as bilateral tests
    - Should report only once to Medicare regardless if both eyes are tested
    - Maybe different for commercial payers
  - CMS eliminated cost of certain supplies and decreased the time used in how long it takes to perform these tests

- Global fee period changes
  - 67101 - Repair detached retina
  - 67105 - Repair detached retina
    - Global fee period changed to 10 days
    - Resulted in decreased payment
    - Exam same day must now meet modifier -25 requirements in order to bill office visit
Physician Fee Schedule

• Sequestration
  – 2% sequestration reduction on Medicare Part B claims will continue until further notice
    • Also applies to drugs administered by physicians
    • 2% affects 80% of allowable
    • Beneficiary copayments and deductibles do not change
  – Non-participating physicians
    • 2% applies to payment made to patient

• Post-operative data collection
  – CMS agreed to modify proposal for collecting data on the valuation of global surgical codes
    • Original proposal was to require all physicians to report post-operative services when a 10- or 90-day global service is performed
    • 10-minute increments on claims beginning January 1, 2017

• Provider and supplier enrollment
  – CMS finalized rules requiring providers and suppliers to be screened and enrolled in Medicare in order to provide services to beneficiaries enrolled in Medicare Advantage (Part C) plans
    • May get request to be fingerprinted, etc.

• MIPS
  – Big challenge for ophthalmology
    • All existing quality reporting programs now under one umbrella for calculating performance
      – Providers may receive a bonus or a penalty
      – Or, may just stay neutral
    – There are four categories
      • Quality – replaces Physician Quality Reporting System
        – Weight 60 percent
**Physician Fee Schedule**

- **Resource Use** – Replaces Value-Based modifier program
  - 2017 Weight: 0 percent but CMS may assign a higher weight in the future
- **Advancing Care Information** – Replaces EHR Meaningful Use
  - 2017 Weight: 15 percent
- **Clinical Practice Improvement Activity** – New program
  - 2017 Weight: 15 percent

**Physician Fee Schedule**

- Fee Schedule errors
  - Codes 76519-26 and 92136-26
    - Technical components of A-scan and IOLMaster had wrong payment indicator
    - Prevented payment of second IOL calculation
  - CMS has now corrected payment indicator retroactive to January 1, 2017
  - Any denied claims or outstanding claims should be billed to Medicare payment for payment

**Physician Fee Schedule**

- Code 65855, Trabeculoplasty by laser
  - CMS had wrong payment indicator of “1” instead of “2”
  - Prevented payment of bilateral procedure
  - May be July before it is corrected
  - Just hold claims
  - Check MAC website for additional information

**ASC Fee Schedule**

- 2017 ASC Conversion Factor
  - $45.030
  - For ASCs meeting quality reporting requirements
    - $44.330
  - For ASCs not meeting quality reporting requirements
    - There were some decreases and some increases

**ASC Fee Schedule**

<table>
<thead>
<tr>
<th>2017 National ASC Fee Schedule Payment Amounts</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>65755 Keratoplasty</td>
<td>$1,794</td>
<td>$1,747</td>
</tr>
<tr>
<td>66170 Trabeceulectomy</td>
<td>$976</td>
<td>$977</td>
</tr>
<tr>
<td>66183 Express shunt</td>
<td>$1,794</td>
<td>$1,747</td>
</tr>
<tr>
<td>66821 YAG laser</td>
<td>$246</td>
<td>$254</td>
</tr>
<tr>
<td>66882 Complex cataract</td>
<td>$976</td>
<td>$977</td>
</tr>
<tr>
<td>66884 Cataract with IOL</td>
<td>$976</td>
<td>$977</td>
</tr>
<tr>
<td>67028 Intravitreal Injection</td>
<td>$48</td>
<td>$48</td>
</tr>
<tr>
<td>67036 Retina (Codes 67036 &amp; 67043)</td>
<td>$976</td>
<td>$1,747</td>
</tr>
<tr>
<td>67039 Retina (Codes 67039 &amp; 67040)</td>
<td>$1,794</td>
<td>$1,747</td>
</tr>
<tr>
<td>67108 Retina Detach</td>
<td>$1,794</td>
<td>$1,747</td>
</tr>
</tbody>
</table>

**ASC Fee Schedule**

- Meaningful Use
  - CMS shortened the 2016 reporting period for physicians
  - Enabled eligible professionals to avoid penalties in 2018 by reporting a single continuous 90-day period
    - Between January 1, 2016 and December 31, 2016
  - New participants who have not successfully demonstrated Meaningful Use
    - Must attest to Modified Stage 2 by October 1, 2017
ASC Fee Schedule

- Returning EPs will be reporting through new MIPS program in 2017 and will be unaffected
- CMS also finalized that certain EPs can apply for a significant hardship exception from the 2018 payment adjustment by July 1, 2017
  - Have not demonstrated MU in a prior year,
  - Intend to attest to MU for an EHR in 2017, and
  - Intend to transition to MIPS and report on measures specified for the advancing care information category of MIPS as finalized for 2017

ASC Fee Schedule

- As part of MU, Stage 2 changes, Computerized Provider Order Entry (CPOE) requirements have been eliminated in 2017:
  - This previously required certification of scribes who document orders in patient’s medical record
- Corneal tissue
  - CMS will continue to limit separate payment in the ASC to only corneal tissue (V2785) used in corneal transplant procedures

ASC Fee Schedule

- Quality Reporting Measures
  - For 2018, CMS will add new quality measures for Normothermia outcome and unplanned vitrectomy
  - Five additional survey-based measures will be added:
    - ASC-15a: OAS CAHPS - About Facilities and Staff
    - ASC-15b: OAS CAHPS - Communication About Procedure
    - ASC-15c: OAS CAHPS - Preparation for Discharge and Recovery
    - ASC-15d: OAS CAHPS - Overall Rating of Facility
    - ASC-15e: OAS CAHPS - Recommendation of Facility

ASC Fee Schedule

- ASC 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 Description</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9252</td>
<td>Bevacizumab (Avastin) - Bill 5 units</td>
<td>$1.84</td>
</tr>
<tr>
<td>C9447</td>
<td>Omidria - 4 ml - Will be packaged in 2018 when pass-through status expires</td>
<td>$478.86</td>
</tr>
<tr>
<td>J0378</td>
<td>Afibcept (EYLEA) injection, 1mg - Bill 2 units</td>
<td>$90.14</td>
</tr>
<tr>
<td>J0585</td>
<td>Botox</td>
<td>$5.94</td>
</tr>
<tr>
<td>J0600</td>
<td>ZIVRA</td>
<td>$5,504.42</td>
</tr>
<tr>
<td>J0850</td>
<td>Cytoptogallovirus</td>
<td>$1,127.74</td>
</tr>
<tr>
<td>J2503</td>
<td>Maxugen - bill number of units needed</td>
<td>$1,054.70</td>
</tr>
<tr>
<td>J2778</td>
<td>Ranibizumab (Lucentis) - Bill 5 units</td>
<td>$375.21</td>
</tr>
</tbody>
</table>

** Effective 4/1/17 - Payments updated quarterly
ASC Fee Schedule

<table>
<thead>
<tr>
<th>Code</th>
<th>Drug</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>J2997</td>
<td>Activase (TPA)</td>
<td>$81.35</td>
</tr>
<tr>
<td>J3300</td>
<td>Triamcinolone - preservative free – Bill 40 units</td>
<td>$3.74</td>
</tr>
<tr>
<td>J3396</td>
<td>Valtrexin - Bill 150 units</td>
<td>$10.78</td>
</tr>
<tr>
<td>J3399</td>
<td>Sandocnikoval - Bill 40 units</td>
<td>$51.71</td>
</tr>
<tr>
<td>J7310</td>
<td>Fluocinolone acetate (Retisert implant)</td>
<td>$20,110.39</td>
</tr>
<tr>
<td>J7312</td>
<td>Ocrsbex - Bill 7 units</td>
<td>$292.78</td>
</tr>
<tr>
<td>J7313</td>
<td>Fluocinolone acetate intravitreal implant – ILUVIEN, 0.01mg; Bill 19 units</td>
<td>$490.95</td>
</tr>
<tr>
<td>J7315</td>
<td>Mitomycin, 0.02 mg - Now included in ASC fee</td>
<td>-</td>
</tr>
<tr>
<td>J7316</td>
<td>Ocriplasmin (JETREA) Injection, 0.125 mg - Bill 4 units</td>
<td>$1,046.75</td>
</tr>
</tbody>
</table>

** Effective 4/1/17. Payments updated quarterly

CPT Code Changes

Several new CPT Codes for 2017 affecting Ophthalmology

CPT Codes

- **Revised Codes**
  - 67101 - Repair of retinal detachment, including drainage of subretinal fluid when performed; cryotherapy
    - **Removed the phrase “1 or more sessions” and “cryotherapy or diathermy.”**
  - 67105 …………..photocoagulation
    - **Removed the phrase “including drainage of subretinal fluid, when performed.”**

CPT Codes

- 92235 - Fluorescein angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral
  - **Now includes phrase “unilateral or bilateral.”**
- 92240 - Indocyanine-green angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral
  - **Now includes phrase “unilateral or bilateral.”**

Note: Will be paid only once by Medicare regardless if one or both eyes are tested

CPT Codes

- **Deleted CPT Code**
  - 92140 - Provocative tests for glaucoma, with interpretation and report without tonography
    - **Code was deleted for lack of use**
    - **If your doctor still performs this test, will have to report with NOC code 92499, Unlisted ophthalmological service or procedure**
      - Be sure to include definition of test in Item 19 (or EMC equivalent) of CMS-1500 claim form
CPT Category III Codes

• New Category III codes
  – 0333T – Visual evoked potential, screening of visual acuity, automated with report
    • For visual evoked potential testing for glaucoma, use 0464T
    – Effective January 1, 2017
    • For publication in 2018 CPT coding manual

CPT Category III Codes

• 0444T - Initial placement of a drug-eluting ocular insert under one or more eyelids, including fitting, training, and insertion, unilateral or bilateral
  – Effective January 1, 2017
  • For publication in 2018 CPT coding manual

CPT Category III Codes

• Used to report delivery system for administration of intraocular pressure
  – Placed under eyelid and does not require surgical incision
    • Unilateral or bilateral
      – Should be reported only once regardless if service is performed on one or both eyes
    – Effective January 1, 2017
    • Is included in 2017 CPT coding manual

CPT Category III Codes

• 0464T – Visual evoked potential, testing for glaucoma, with interpretation and report
  • For visual evoked potential screening for visual acuity, use 0333T
  – Effective January 1, 2017
  • For publication in 2018 CPT coding manual

CPT Category III Codes

• 0465T – Suprachoroidal injection of a pharmacologic agent (does not include supply of medication
  • To report intravitreal injection/implantation, see 67025, 67027, or 67028
  – Effective January 1, 2017
  • For publication in 2018 CPT coding manual

CPT Category III Codes

• 0445T - Subsequent placement of a drug-eluting ocular insert under one or more eyelids, including re-training, and removal of existing insert, unilateral or bilateral
CPT Category III Codes

- 0469T – Retinal polarization scan, ocular screening with on-site automated results, bilateral
  • Do not report 0469T in conjunction with 92002 – 92014
  • For ocular photoscreening, see 99174, 99177
- Effective July 1, 2017
  • For publication in the 2018 CPT coding manual

CPT Category III Codes

- 0474T - Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space
  • CyPass® Micro-Stent
    • For use in conjunction with cataract surgery for reduction of IOP in adult patients with mild to moderate primary open-angle glaucoma (POAG)
    • Any other use would be considered off-label use
- Effective July 1, 2017

CPT Category III Codes

- Do not report code 0253T in the interim
  • Code 0253T is for insertion of device in suprachoroidal space
  • Code 0474T is for insertion of device in supraciliary space
- According to AMA can report code 66999, Unlisted procedure, anterior segment of eye, until July 1, 2017 effective date of code 0474T

Other Issues for 2017

Taxonomy Codes

- New subspecialty codes were created
  - Glaucoma
  - Oculoplastics
  - Retina
  - Uveitis
  • Providers need to update subspecialty code (if applicable) in their provider enrollment files with CMS
    • PECOS best way

Taxonomy Codes

- Will be important in MIPS
  - CMS will evaluate subspecialists among their peers
    • In the past, subspecialists were evaluated among all Ophthalmologists
  - If a retina specialist only sees retina patients, for example
    • List that as their subspecialty
  - If a doctor sees retina and other patients
    • List ophthalmology as their specialty
Premium IOLs

- Physicians and facilities are allowed to bill patient for extra work involved in implanting premium IOLs
  - Important to pay attention to current list of premium IOLs
  - PC IOLs
    - **Abbott Medical Optics**
      - TECNIS® Symfony (model ZXR00)
      - TECNIS Multifocal 1-Piece (models ZKB00, ZLB00, and ZMB00)

Premier IOLs

- Abbreviations
  - PC IOLs
    - **Abbott Medical Optics**
      - TECNIS Multifocal Acrylic (model ZMA00)
      - TECNIS Multifocal Silicone (model ZMB00)
      - ReZoom®
        - Acrysof® IQ ReSTOR® (models SN6AD1, SN6AD3, MN6AD1, and SV2ST0)
    - **Alcon**
      - Acrysof® IQ Toric (models SN6AT3 through SN6AT9; collectively referred to as SN6ATT)
    - **Bausch + Lomb**
      - Trulign™ Toric (models AT50T, BL1AT, and BL1UT)
    - **STAAR Surgical**
      - Silicone 1-Piece Toric (models AA4203TF and AA4203TL)

- AC IOLs
  - **Abbott Medical Optics**
    - TECNIS Toric 1-Piece (models ZCT150, ZCT225, ZCT300, and ZCT400)
  - **Alcon**
    - Acrysof IQ Toric (models SN6AT3 through SN6AT9; collectively referred to as SN6ATT)
  - **Bausch + Lomb**
    - Trulign™ Toric (models AT50T, BL1AT, and BL1UT)
  - **STAAR Surgical**
    - Silicone 1-Piece Toric (models AA4203TF and AA4203TL)

- PC/AC IOLs
  - **Abbott Medical Optics**
    - TECNIS Symfony (models ZXT150, ZXT225, ZXT300, and ZXT375)
  - **Alcon**
    - Acrysof® IQ ReSTOR® (models SND1T3, SND1T4, SND1T5, and SNF1T6)

- If the IOL to be implanted is not on this list, the patient cannot be charged for any extra work involved in implanting the IOL

Complex Cataract

- CPT code 66982
  - Requires special technique or device in order to bill complex cataract
  - Practices have been billing code 66982 when dye (e.g., Trypan Blue, ICG) is used to stain the capsule when removing a dense/mature cataract
    - Some LCDs still permit the use of dye to justify code 66982
    - Others have removed this from their LCDs

- In the March, 2016, issue of CPT Assistant, the following was given in response to a Q&A
  - “…the additional work of instilling and removing Trypan Blue dye from the anterior segment though an additional surgical step does not reach the threshold of physician time, work, or intensity necessary to report the complex cataract code.”

- Unless your MAC has an LCD stating otherwise, code 66982 should not be billed when dye is used during cataract surgery
### Drug Wastage

**Use of -JW modifier for drug wastage**
- Effective January 1, 2017, providers must include modifier -JW on Medicare claims
  - Applies to any discarded Part B drugs and biologicals from a single-use vial
  - Patient chart must document any unused amount of drug
    - First line of CMS-1500 must include amount injected
    - Second line item must include amount wasted plus -JW modifier

**Example**

- **J3300 Injection, triamcinolone acetonide, preservative free, 1 mg**
  - Patient received 4 units from a 40-unit vial
  - Wastage = 36 units
  - **Bill:**
    - J3300 = 4 units
    - J3300-JW = 36 units

**Example**

- **Lucentis code J2778, 0.5 mg or 0.3 mg does not contain any billable discarded drug**
  - Do not report -JW modifier for overfill of any drug
- **Eylea (afibercept, 1 mg)**
  - HCPCS code identifies as code J1787 – 1 mg
  - Dosage is always 2 units
  - Wastage more than 2 mg would not require -JW modifier
  - 1 unit is billed per 1 mg used – which for Eylea is 2 mg and 2 units

### CCI Edits

**Reminder**
- When billing multiple services, CCI edits should be checked prior to billing
  - Be sure to check all code combinations
  - For example:
    - OCT, code 92134 is not bundled into fundus photos, code 92250
    - Code 92250, however, is bundled with code 92134

### Ophthalmology Issues

**2017 OIG Work Plan**
- ASC Quality Oversight
  - OIG found spans of 5 or more years between certification surveys for some ASCs
  - OIG trying to get surveys back on track
  - ASC audits already started
  - Make sure your ASC documents are pristine
    - Need medical necessity for each eye prior to cataract surgery including lifestyle impairment
    - Make sure your ASC is meeting all the requirements for Conditions for Coverage (CICs)
Ophthalmology Issues

- Drug Wastage of Single-Use Vials
  - OIG suggest manufacturers should market smaller vials at lower prices
    - Policy on use of -JW modifier was created
- MACRA/MIPS
  - OIG will identify the key challenges and potential vulnerabilities CMS is facing during implementation

Ophthalmology Issues

- Medicare Advantage Risk Adjustment
  - OIG has identified medical record documentation does not support diagnoses submitted to CMS by MA plans
    - Looks like Risk Adjustment audits are not going away anytime soon
- Provider Self-Disclosure
  - Gives providers opportunity to minimize potential costs/disruption if full-scale OIG audit or investigation if fraud is uncovered

Ophthalmology Issues

- Self-disclosure also enables provider to negotiate fair monetary settlement and potentially avoid being excluded from participation in CMS federal programs
  - OIG would investigate the reported results of the provider to determine appropriate course of action
  - Before proceeding with any self-disclosure, be sure to seek the assistance of a healthcare attorney

Compliance

- Compliance is still very important to OIG and CMS
  - Audit billing practices regularly
    - Internal audits on a regular basis
    - External audits at least every 1-2 years
    - Review LCDs regularly for changes
  - Modify habits if needed to maintain compliance
    - Develop internal policies to effect changes

Questions