2016 CODING & BILLING UPDATE

Zachary S. McCarty, OD
taop.thirdpartycenter@gmail.com
@TAOP_TPC

2016 MEDICARE DEDUCTIBLE

<table>
<thead>
<tr>
<th>PART</th>
<th>CATEGORY</th>
<th>MONTHLY</th>
<th>DEDUCTIBLE</th>
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<tbody>
<tr>
<td>A</td>
<td>HOSPITAL</td>
<td>$411</td>
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<tr>
<td>C</td>
<td>MEDICARE ADVANTAGE</td>
<td>VARIES</td>
<td>VARIES</td>
</tr>
<tr>
<td>D</td>
<td>MEDICARE PRESCRIPTION DRUG COVERAGE</td>
<td>VARIES</td>
<td>VARIES</td>
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MACRA - MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015

MACRA
• Repeals Medicare's Sustainable Growth Rate (SGR) formula
• Prevents 21% fee reduction from Medicare
• Increases reimbursement by 0.5% starting in July 2015 and annually through 2019
• Introduces Merit-based Incentive Payment Systems (MIPS)
• 2019-2022 - could receive 12% to 27% bonus (or penalty)
MIPS

- Streamlines three distinct incentive programs:
  - Physician Quality Reporting System (PQRS)
  - Value-Based Modifier (VBM)
  - Meaningful Use of EHRs (EHR MU)
- Adds other elements to the calculation

MIPS

- Four (4) Categories:
  - Quality
    - PQRS, VBM, EHR MU
  - Resource Use
  - Meaningful Use
  - Clinical Practice Improvement Activities
    - Patient/Consumer Satisfaction surveys, Maintenance of Certification (MOC), Board Certification, Qualified Clinical Data Registry

UPDATE - JUST ANNOUNCED

- CMS is recognizing ABO Board Certification for:
  - MIPS
  - Reporting on Physician Compare website

MIPS

- Composite performance score of 0-100
- Compare each physician composite score to a performance threshold
- Performance threshold will be the mean or median of the composite performance score for all MIPS eligible professionals
- Will know before period starts the composite score required to obtain incentive payments and avoid penalties

MIPS

- Starting in 2019
  - Negative adjustments capped at 4%
  - Zero adjustments
  - Positive adjustments
    - higher above threshold, the higher the positive payment adjustment (percentile and standard deviations)
OVERLOOKED PORTION OF MACRA

• Starting in 2015, HHS Secretary must publish:
  • Utilization and payment data for physicians
  • Emphasis on services most commonly furnishes including:
    • number of services
    • submitted charges
    • payments
  • Searchable by: name, location, and services furnished

OTHER POINTS IN MACRA

• Requires that EHRs be interoperable by 2018
• Prohibits providers from deliberately blocking information sharing with other EHR vendor products
• GAO to report on barriers to expanding telemedicine and remote patient monitoring
• You WILL need access to a Registry

CPT CODE UPDATES

NEW CPT CODES IN 2016

• Revised Codes/Definitions
  • 99354 - prolonged services or psychotherapy (first hour)
  • 99355 - prolonged services or psychotherapy (each additional 30 minutes beyond first hour)

NEW CPT CODES IN 2016

• 99415 - prolonged clinical STAFF service (the service BEYOND the typical service time) during evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (must list separately the E&M service code) [45-74 minutes]
• 99416 - each additional 30 minutes [75-104 minutes]
  • Use multiples for each additional 30 minutes beyond 105 minutes
• Examples:
  • IOP lowering
  • Breaking synechiae

NEW CPT CODES IN 2016

• 65785 - implantation of intrastromal corneal segments
  • 0099T was deleted
  • 67101, 67105, 67107, 67108, 67113, 67227, 67228
  • Retinal surgery codes
• 0123T - DELETED - fistulation of sclera for glaucoma through ciliary body
• 0308T - insertion of ocular telescope prosthesis including removal of crystalline lens or intraocular lens prosthesis
• 0402T - Collagen Cross-linking of the cornea (includes epi-on and epi-off - includes introperative pachymetry)
92000 VS 99000 CODE CHOICES

• No MANDATED use of one code set over the other
• Some speakers have lectured that without a new problem, cannot use 92012 code
  • UNTRUE!
• No audit results to back this claim
• CPT did not design this to be difficult or tricky

GENERAL OPHTHALMOLOGIC CODES
(92000)

• Definitions:
  • 92012 - ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient
  • 92014 - same as above; comprehensive, established patient, 1 or more visits
• NOTE: Current Procedural Terminology (© American Medical Association) is the ONLY accepted source of definitions for these services

WHAT’S CAUSING THE CONFUSION?

• CPT is the only official definition for codes
• CPT code wording is the ONLY official definition for codes
• CPT code introductions are NOT official definitions - only further explain code use
• Introduction to Code Wording - established patients
• Evaluation of new/existing condition complicated by new diagnostic/management problem not necessarily related to primary diagnosis

OVER ALL ELSE...

• Medicare Claims Manual, Ch 12: Physicians / Nonphysician Practitioners, 30.6.1 Selection of Level of E&M

• “Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of E/M service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported. The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record…”

NCCI - NATIONAL CORRECT CODING INITIATIVE

The CMS developed its coding policies based on:
• coding conventions defined in the AMA’s CPT Manual
• national and local policies and edits
• coding guidelines developed by national societies
• analysis of standard medical and surgical practices
• review of current coding practices

Updated annually and published on CMS website
http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
WE’RE EXCLUSIVE

• Optic Nerve scan (92133) and the retinal scan (92134) are BUNDLED into one another
  - Cannot bill both of these on the same date of service
  - Cannot use a modifier to bill these on the same date of service
• Also bundled with 99211 and 92250 (fundus photography)
  - Medically necessary documentation is required
• 92133 (and 92134) mutually exclusive 92250

MODIFIER -59

BEWARE THE IDES OF -59

• Per CMS publication, “For the NCCI its primary purpose is to indicate that two or more procedures are performed at different anatomic sites or different patient encounters.”
• Therefore cannot use -59 modifier to simply by-pass a NCCI edit
• OIG has indicated this will be an area on investigation and increased risk of audit for practices that over-utilize this modifier

UPDATE ON -59 MODIFIER

• -XE Separate Encounter: A service that is distinct because it occurred during a separate encounter
• -XS Separate Structure: A service that is distinct because it was performed on a separate organ/structure
• -XP Separate Practitioner: A service that is distinct because it was performed by a different practitioner
• -XU Unusual Nonoverlapping Service: The use of a service that is distinct because it does not overlap usual components of the main service
  NOTE: Does NOT include treatment of contiguous segments of same organ - CMS considers posterior segment structures of the eye a SINGLE anatomical site

UPDATE ON -59 MODIFIER

• -X codes only used by CMS
• NOT used WITH -59 Modifier
• Use INSTEAD of -59 Modifier

MODIFIER -25
E/M MODIFIERS

• -25: Separately identifiable Evaluation and Management service done on the same date as a procedure. Used when patient comes in for exam and you end up doing a Procedure (e.g. Punctal Plugs or Trichiasis procedure) Generally CC is separately identifying (USED ON E/M CODE)

• Cannot be used for FB eval and removal

• -24: Unrelated Evaluation and Management service by the same physician performed during the post-operative period. Used when a patient requires an office visit during their post-operative cataract surgery global period (or any surgical global period) for problems that have nothing to do with their surgical procedure (USED ON E/M CODE)

DOCUMENTATION GUIDELINES

AUDITING

OIG INVESTIGATIONS

PQRS

• If you did NOT report PQRS measures in 2013, you WILL receive a payment reduction of -1.5% in Medicare payments in 2015

• If you did NOT report PQRS measures in 2014, you WILL receive a payment reduction of -2.0% in Medicare payments in 2016

• If you do NOT report PQRS measures in 2015, you WILL receive a payment reduction of -2.0% in Medicare payments in 2017
PQRS

- Bonus paid for reporting performance measures aka Quality Data Codes (QDC)
  - Example: POAG-Reduction of intraocular pressures by 15% or documentation of treatment plan
- Reported by:
  - Claims based on CMS-1500 electronic-based filing (most typical for ODs)
  - Qualified Clinical Data Registry reporting (registries specific for eye care in development)
  - Measures group reporting (none for ODs)
- EHR (CEHRT) Reporting - ask your EHR vendor

PQRS FOR ODS—THE GOOD NEWS?
IS THIS AN INDICATOR FOR MIPS?

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2016 PQRS CLAIMS-BASED REPORTING

- To satisfactorily report for 2016 (avoid penalty in 2018):
  - Report on at least 9 measures from 3 different National Quality Strategy (NQS) domains, 50% of the time for each measure and 1 cross cutting measure
  - Not 9 measures on every claim
  - Submit PQRS measures for all reportable cases
  - Frequent reporting will aid in meeting 50% goal and not penalize for over reporting

PQRS FOR ODS—THE BAD NEWS!

- 21,052 ODs getting a pay cut by Medicare
  - Because you didn’t submit PQRS in 2013
    - 62% of all ODs are currently not ready for Medicare’s new payment system that starts in 2019!!
- OMDs
  - 28% receiving pay cut in 2015
- Not just CMS!

2016 PQRS CLAIMS-BASED REPORTING

- Cross Cutting Measures
  - Tobacco Use and counseling (#226)
  - Hypertension and follow-up (#317)
  - Medication listing (#130)

PQRS

- Registry and/or EHR reporting will likely be mandatory
- PQRS measures reported with CPT II Codes
- CPT II Codes are submitted on CMS-1500 Form
  - Use $0.00 or $0.01 charge
  - Submitted with a CPT I Code on the same claim and linked to diagnosis
  - Will be denied with N365: procedure code is not payable and measure sent to National Claims History (NCH) for PQRS analysis
- Must report at least 3 measures 50% of the time for bonus
- Can NOT re-bill a claim just to add a CPT II (PQRS) code

Example: POAG-Reduction of intraocular pressures by 15% or documentation of treatment plan

Because you didn’t submit PQRS in 2013

2016 PQRS CLAIMS-BASED REPORTING

- Cross Cutting Measures
  - Tobacco Use and counseling (#226)
  - Hypertension and follow-up (#317)
  - Medication listing (#130)
2016 PQRS MEASURES
• 284 Total Quality Measures
  • 110 measures for claims/group reporting
  • 201 registry only measures
  • 64 EHR reporting measures
  • 25 groups for Measures group reporting (none for Optometry)
  • 45 measures retired for 2014

2016 PQRS - NQS
• National Quality Strategy (NQS) Domains:
  • Patient Safety
  • Person and Caregiver-Centered Experience and Outcomes
  • Communication and Care Coordination
  • Effective Clinical Care
  • Community/Population Health
  • Efficiency and Cost Reduction

2016 PQRS MEASURES
• 10 Quality Measures Related to Eye Care
  • 6 pertain to Optometry
  • 4 are registry only codes not meant for Optometry (cataract surgery)
    • 191 & 192 - cataract codes - registry only
    • 303 & 304 - cataract outcomes - registry only
  • Other general codes that ODs may use:
    • 8 others that could be used to meet the 9 total measures and additional domain needed

2016 PQRS MEASURES - EYE
• #12 - POAG: Optic nerve eval (Eff. Clinical care)
• #14 - AMD: Dilated macula exam (Eff. Clinical care)
• [RETIRED for individual measure reporting] #18 - DR: Doc. +/- ME and level of Ret. (Eff. Clinical care)
• #19 - DR: Comm. with Physician managing (Eff. Clinical care)
• #117 - DM: DFEx in Diabetic patient (Eff. Clinical care)
• #140 - AMD: Counseling on anti-oxidant (Eff. Clinical care)
• #141 - POAG: ↓ IOP by 15% or plan of care (Comm/Care Coord)

2016 PQRS MEASURES - OTHER
• With 92000 codes
  • #130 - Doc. of current meds in MR (Pt Safety)
  • #226 - Preventative care and screen: Tobacco Use with cessation counseling (Comm/Pop Health)
  • #317 - Preventative care and screen: Hypertension with follow-up documented (Comm/Pop Health)
  • #131 - Pain Assessment and follow-up

2016 PQRS MEASURES - OTHER
• CANNOT use with 92000 codes
  • #110 - Preventative care and screen: Influenza Immunization (Comm/Pop Health)
  • #111 - Pneumonia Vaccination status for older adults (Comm/Pop Health)
  • #128 - Preventative care and screen: BMI screening and F/U (Comm/Pop Health)
  • #173 - Preventative care and screen: Unhealthy alcohol use - screening (Comm/Pop Health) Retired for 2016
3 Diseases to consider for eye care:

- Age-related macular degeneration (AMD)
- Glaucoma - Primary open angle (POAG)
- Diabetes - insulin or non-insulin dependent

Medicare Office Visit

- 99201-99205, 99212-99215
- 92004, 92014, 92002, 92012
- Can also use nursing home and rest home visit codes

PQRS

"...the actual action described in the measure only has to be performed one time during the reporting period or during the 12-month period. However, the provider needs to report the QDC on EACH and every claim submitted for a particular patient with the appropriate diagnosis and visit code."

### 2016 PQRS MEASURES

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<tr>
<th>MEASURE</th>
<th>CPT II CODE</th>
<th>DESCRIPTION</th>
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<tr>
<td>12</td>
<td>2027F</td>
<td>POAG, OPTIC NERVE EVALUATION</td>
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<tr>
<td>14</td>
<td>2019F</td>
<td>AMD, DILATED MACULAR EXAM</td>
</tr>
<tr>
<td>19</td>
<td>5010F WITH G8397 (DFE) OR G8398 (NO DFE)</td>
<td>OR COMMUNICATION WITH PHYSICIAN MANAGING ONGOING DIABETES CARE</td>
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<tr>
<td>117</td>
<td>2022F</td>
<td>DM, DILATED EYE EXAM WITH INTERPRETATION 7 FIELD PHOTOS WITH INTERPRETATION BY OD/OMD FOR DM</td>
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<tr>
<td></td>
<td>2024F</td>
<td>EYE IMAGING VALIDATED TO MATCH DIAGNOSIS FROM 7 FIELD PHOTOS</td>
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<tr>
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<td>2026F</td>
<td>LOW RISK RETINOPATHY FOR DM (NO RETINOPATHY IN PRIOR YEAR)</td>
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<tr>
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<td>3072F</td>
<td>DR: COMMUNICATION WITH PHYSICIAN MANAGING ONGOING DIABETES CARE</td>
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<tr>
<td>140</td>
<td>4177F</td>
<td>COUNSELING ON ANTIOXIDANT SUPPLEMENTS</td>
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<tr>
<td>141</td>
<td>5284F OR 0517F AND 3285F</td>
<td>IOP REDUCED &lt;15% FROM PRE-INTERVENTION LEVEL</td>
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**WHY PARTICIPATE IN PQRS?**

- For 2014 PQRS CMS will post on it’s Participating Physician Directory (www.Medicare.gov), names of providers who:
  - Submit data on 2014 PQRS quality measures
  - Meet one of the proposed satisfactory reporting criteria for individual measures
  - Qualify to earn a PQRS incentive payment for covered professional services furnished during the 2011 or 2012 reporting period
- Eventually, CMS will report performance information

**WHAT IS AOA MORE?**

- Database
- Systematic collection of data
- Captures data that can be analyzed
  - Analyze to improve care and outcomes
- Cancer registry...
**HOW AOA MORE HELPS YOU**

- Streamline PQRS
  - Eliminates the need for adding codes to your billing
  - Automatically correlated to your exam findings and diagnostic procedures (eCQMs)
    - CMS requirements to be "qualified"
- Satisfies Meaningful Use requirements
- Modified Stage 2 and Proposed Stage 3
- Clinical practice improvement

**NEWS FLASH!!!**

- CMS eliminates 1 year waiting period for Registries to report
- What does this mean………?
- AOA MORE may be able to report 2016 PQRS data (in 2017)

**HOW AOA MORE HELPS YOU**

- Clinical practice improvement
  - Glaucoma/Glaucoma Suspect (VF, OCT)
  - Laser outcomes
  - PQRS satisfied
  - Medication Rx’s
  - ICD’s
  - Constantly evolving
- Benchmarks compared to all ODs

**HOW AOA MORE HELPS YOU**

- Answering Optometry’s Questions:
  - Kids under 5?
  - Most common K ulcer?
  - Diabetics?
  - Myopia progression?
- Optometry advocating for Optometry!!

**How Does AOA MORE work?**

- Integrates with your Electronic Medical Record
- Cost?
  - $0 to AOA members
    - Registries cost upwards of $100 per month per doctor in other professions and optometry
  - $1800/year (non-members)

For more information and/or to sign up go to: WWW.AOA.ORG/MORE

CODING RESOURCES

- Coding manuals
- AOA/ Third Party Center
- State Associations
- Medicare newsletters
- Local Carrier newsletters
- ICD-9/ICD-10 manuals
- CPT manuals
- HCPCS manuals

ONLINE RESOURCES

- CMS website (http://www.cms.gov/Medicare/Medicare.html)
  - Whole sections on Billing and coding
- CMS website dedicated to ICD-10
- AOA Eyelearn - live and recorded webinars (AOA members)
- AOA resource center (for AOA members) - AOA excelOD
  - http://www.excelod.com/
- AOA Coding Today (for AOA members only)
  - http://aoacodingtoday.prsnetwork.com

AOA CODING TODAY