Coding, Compliance & MIPS for 2019

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Goals for Today's Program

CPT basics review & Updates for 2019
Documentation guidelines
99xxx E/M Codes & 92xxx Eye Codes
Supplemental testing guidelines
Modifiers
Compliance & Audit Risk Reduction
ICD-10 Updates for 2019
Changes in Coding Concepts for 2021

Billing, Coding The Basics

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2019 Government Changes to Fees

- Medicare Deductible – part B is $185.00 for 2019
  - $2.00 increase over 2018
- Medicare Part B standard monthly premium is $135.50 ($1.50 increase)
  - Filers with <$85,000/individual, $170,000/joint income
- Medicare Part B monthly premium is $187.50
  - Filers with $85,000-107,000/indiv, $170-214,000/joint
- Medicare Part B monthly premium is $267.90
  - Filers with $107-133,500/indiv, $214-267,000/joint
  - Social Security Administration announced a COLA of $39 for 2019 for an annual increase of $468/year

New CPT Codes for 2019

- CPT 92273 – ERG, w I&R, Full field (ffERG)
- CPT 92274 – ERG, w I&R, Multifocal (mfERG)
- CPT 92275 – ERG, w I&R, Pattern (pERG)
  - an old code that has been deleted in 2019
  - For pattern ERG use CPT 0509T

Medicare – Just Give Me The Numbers

- Longevity Revolution
  - Third year of Baby Boomers hitting 65 years of age
  - 10,000/day turn 65 years of age
  - An individual turns 60 years of age every 8 seconds
  - If you live until age 65, average life expectancy is age 84
- 59, 672,971 Medicare beneficiaries in US
  - 15% of total population
- Cataract surgery is the most common surgical procedure in US in Medicare beneficiaries
  - Also boasts best outcomes
  - Lowest complication rate

Medicare – Distribution by Age (2004)

- 65-69 23.2 %
- 70-74 19.9 %
- 75-79 17.3 %
- 80-84 12.9 %
- 85+ 11.0 %

JAM

Medicare To Issue New Cards

- MACRA 2015 requires CMS to remove SSNs from all Medicare Cards by April 2019
- New Medicare beneficiary Identifier (MBI) will replace the SSN-based Health Insurance Claim Number (HICN)
  - Will assign a new MBI
    - 11 characters in length, only numbers and upper case letters
  - CMS will Mail new Medicare Cards beginning April 2018
  - Will phase in new cards by geographic location
- Transition period will allow use of either card to exchange data
- Goal – to protect HPI & financial information

E/M GUIDELINES

- New/Established Patient
- Chief Complaint
- History of Present Illness
- Family History
- Past History
- Social History
  - New additions level of education, sexual history, marital status/living arrangements
- Review of Systems
- Time

JAM

Social History Changes

- ***Age appropriate review of past & current activities***
- Marital status
- Current employment
- Occupational history
- Military history
- Use of drugs, alcohol, tobacco
- Level of education
- Sexual history
- ***Other relevant social factors***

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E/M DESCRIPTORS

- History *
- Examination*
- Medical Decision Making*
- Counseling
- Coordination of Care
- Nature of the Presenting Problem
- Time

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CATEGORIES OF SERVICE

- Office Visits (E/M Codes)
  - New 99201-99205
  - Estab 99211-99215
- Office Visits (Eye Codes)
  - New 92002-92004
  - Estab 92012-92014
- Consultations (E/M Codes)
  - ELIMINATED for Medicare, Medicaid, Tricare and Medicare Advantage HMOs and when any of these are secondary payors
  - Can still be used for other commercial plans

SELECTING AN E/M LEVEL

- Identify Category of Service
- Identify Extent of **History** Taking
- Identify Extent of **Examination**
- Identify Complexity of **Medical Decision Making**
- Review E/M Descriptors

JAM

E/M CODING - OFFICE VISITS

- New Patient (3 of 3)
  - 99201 - PFH / PFE / SDM / 10
  - 99202 - EFH / DFE / SDM / 20
  - 99203 - DH / DE / LDM / 30
  - 99204 - CH / CE / MDM / 45
  - 99205 - CD /CE / HDM / 60

JAM

E/M Coding - Office Visits

- Established Patient (2 of 3)
  - 99211 - Minimal / 5
  - 99212 - PFH / PFE / SDM / 10
  - 99213 - EFH / EFE / LDM / 15
  - 99214 - DH / DE / MDM / 25
  - 99215 - CH / CE / HDM / 40

JAM

DOCUMENTATION OF HISTORY

- Problem Focused History (PFH)
  - CC / 1-3 HPI **(NEVER USE)**
- Expanded Problem Focused History (EPF)
  - CC / 1-3 HPI / Ocular ROS **(QUICK VISIT)**
- Detailed History (DH)
  - CC / 4 HPI / Ocular ROS / ROS-2 / 1 OF 3 PFSH
  - **(RETURN PATIENT, BIG EXAM)**
- Comprehensive History (CH) – **(ALL NEW PATIENTS)**
  - CC / 4 HPI / Ocular ROS / ROS-10 / 3 OF 3 PFSH (NEW) OR 2 OF 3 PFSH (ESTAB)

JAM

Eye Examination Documentation

- VA / CVF / Pupils & Iris / Adnexa
- Bulbar & Palp Conjunctiva
- EOM
- SLE: Cornea / Lens /AC
- IOP / Optic Nerve / Posterior Segment
- Neurologic: Orientation (Time / Place / Person)
- Psychiatric: Mood & Affect (Depression /Anxiety /Agitation)

JAM

DOCUMENTATION OF EXAMINATION

- Problem Focused Exam (PFE)
  - Limited Exam / 1 - 5 Elements
- Expanded Problem Focused Exam (EPF)
  - Limited Exam / 6 Elements
- Detailed Exam (DE)
  - Extended Exam / 9 Elements
- Comprehensive Exam (CE)
  - Complete Single System Exam
  - All 14 Elements

JAM

Medical Decision Making

- Straightforward (SF) – **(NEVER USE)**
  - # Dx / Rx Options - Min / Data - Min / Risk - Min
- Low Complexity (LC) – **(OPTOMETRY)**
  - # Dx / Rx Options - Lim / Data - Lim / Risk - Low
- Moderate Complexity (MC)
  - # Dx / Rx Options - Mult / Data - Mod / Risk –Mod
  - **(START Rx, CHANGE Rx, SURGERY, REFER)**
- High Complexity (HC) – **(WHEELS OFF BUS)**
  - # Dx / Rx Options - Ext / Data - Ext / Risk - High

JAM

Comprehensive Ophthalmological Service 92004 / 92014

- Complete system evaluation,
- Need not be performed at one session
- Integrated services where med decision making cannot be separated from examination methods
- Itemization of service components, such as slit lamp examination, keratometry, routine ophthalmoscopy retinoscopy, tonometry, or motor evaluation is not applicable

Comprehensive Ophthalmological Service 92004 / 92014

- ***Includes*** history, medical observation, external & ophthalmoscopic examinations, gross visual fields, sensorimotor examination
- ***Often*** includes, ***as indicated***: biomicroscopy, examination with cycloplegia or mydriasis and tonometry
- ***Always*** includes initiation of diagnostic and treatment programs

Comprehensive Ophthalmological Service 92004/92014

- Always includes initiation of diagnosis and treatment programs
  - includes the prescription of medication, and arranging for special ophthalmological diagnostic or treatment services, consultations, laboratory procedures and radiological services

JAM

Intermediate Ophthalmological Service 92002 / 92012

- Evaluation of new or existing condition, complicated with a new diagnostic or management problem not necessarily relating to the primary diagnosis
- Integrated services where med decision making cannot be separated from examination methods
- Includes history, medical observation, external & adnexal, & other diagnostic procedures ***as indicated; may include*** use of mydriasis for ophthalmoscopy

JAM

2004 New HCPCS Codes

- "S" codes are useful for some private insurers
- Medicare and other federal payers ***do not*** recognize them
- They are useful when CPT does not have a code to accurately describe the service (i.e. LASIK, PTK, PRK, corneal topography) or for invoicing self-pay patients.
- ***They specifically describe "routine exams" including refractions*** and permit a different charge

JAM

HCPCS "S" Codes

- S0620 Routine ophthalmologic exam including refraction; new patient
- S0621 Routine ophthalmologic exam including refraction; established patient
- S0625 Digital screening retina

JAM

Ophthalmological Services - 92xxx

- Prescription of lenses, when required, is included in 92015
  - Not factored into 92xxx code selection
- It includes specification of lens type, power, axis, prism,
- Absorptive factors,
- impact resistance,
- and other factors

JAM

2019 Medicare Fee Schedule

99201	$ 45.46	99211	$ 22.42
99202	$ 75.95	99212	$ 44.74
99203	$ 107.99	99213	$ 73.90
99204	$ 164.32	99214	$ 108.31
99205	$ 206.75	99215	$ 145.33
92002	$ 83.31	92012	$ 87.55
92004	$ 150.16	92014	$125.69

JAM

Refraction 92015

- Non-covered service
- Can be billed to beneficiary
  - failure to do so results in lost revenues
- Reminders
  - Charge only for "Rx-able" refractions
  - Do not forget to charge for the final refraction when changing spectacles in a post-operative cataract patient

JAM

Gonioscopy 92020

- Bilateral
- Requires documentation
  - describe visible angle structures
- No limitations to diagnostic groups in most states
- Fee $ 27.54

JAM

Visual Field 9208x

- Bilateral
- Requires Interpretation & report
  - narrative in body of medical record, on date of service
  - Must be signed
- Fee (-81) / $ 33.69 Screening
- Fee (-82) / $ 47.32 Screening, threshold related
- Fee (-83) / $ 63.36 Full threshold

JAM

Extended Ophthalmoscopy 92225 / 92226

- Unilateral
- Initial (-225) vs. Subsequent (-226)
- Implies detailed, extra ophthalmoscopy
  - document fundus lenses used
- Modifiers RT /LT
- Requires retinal drawings & interpretation
  - sizes, colors and dimensions carrier specific
- Fee 92225 ($ 27.55) 92226 ($ 25.41)

JAM

Fundus Photography 92250

- Bilateral
- Not Bundled
- Requires Interpretation & Report
- Fee $ 50.08

JAM

External Ocular Photography 92285

- Report for documentation of medical progress
  - Ex.: close-up photography, slit lamp photography, goniophotography, stereo-photography
- Bilateral
- Not Bundled
- Requires Interpretation and report
- Fee $ 21.22

JAM

Special Anterior Segment Photography 92286

- With specular endothelial microscopy and cell count
  - Ex: Konan specular microscope
- Bilateral
- Not Bundled
- Requires Interpretation and report
- Fee $ 38.68

JAM

Tear Osmolarity Testing 83861

- Unilateral
  - Paired or cross walked to code 84081
- Applies to TearLab's Osmolarity Device
  - Novel "Lab-on-a-chip"
  - Point of care, 50nl sample of tear fluid
  - Sample-to-answer in less than 30sec
  - CLIA waiver granted
- Requires Interpretation & report
- Fee: $22.48

JAM

InflammaDry Testing 83516

- Unilateral, modifiers –RT, -LT
- CMS requires modifier –QW for CLIA waived
- Immunoassay for analyte other than infectious agent antigen; qualitative or semi-quantitative method
- Many diagnosis codes associated with dry eye payable
- Applies to InflammaDry Device (Quidel)
  - CLIA waiver granted
- Requires Interpretation & report
- Fee $15.82

JAM

Amniotic Membrane 65778

- Description – placement of amniotic membrane on ocular surface for wound healing; self retaining
  - Dry eye, RCE, chemical burns, large abrasions, HSV, SJS, EBMD, ulcers, keratitis (bacterial, neurotrophic, filamentary, viral), bullous keratopathy
- Global period – 0 days (was 10 days in 2016)
- Cost of goods – $800-950 depending on volume for cryopreserved and much less for dehydrated
- Fee: $1,440 (varies widely geographically)

Computerized Corneal Topography 92025

- Bilateral or unilateral
- Requires interpretation & report
- No limitations to diagnostic groups in most states
- Fee $ 37.57

JAM

Scanning Computerized Ophthalmic Diagnostic Imaging 92132

- Unilateral or bilateral
- Applies to anterior segment evaluations
  - Carl Zeiss / Optical Coherence Tomography (Cirrus)
  - Optovue / (RTVue, iVue)
- Requires Interpretation & report
- Fee $ 31.27

JAM

Fitting CL for Ocular Surface Disease 92071

- Unilateral; Use –RT/-LT or -50
- Do not report 92071 in conjunction with 92072
- Report supply of lens separately with 99070 or appropriate supply code
- Fee $37.95

JAM

Fitting CL for Management Keratoconus 92072

- Initial fitting
  - For subsequent fittings, report E/M services or general ophthalmological services
- Do not report 92072 in conjunction with 92071
- Report supply of lens separately with 99070 or appropriate supply code
- Unilateral payment; Use –RT/-LT or -50
- Fee $131.72

JAM

Serial Tonometry
92100

- Bilateral
- Requires Interpretation & Report
  - Example: Angle closure glaucoma
  - multiple measurements over time
- Fee $ 81.15

JAM

Corneal Hysteresis
92145

- Unilateral or Bilateral
- Corneal hysteresis determination by air impulse stimulation
- Requires Interpretation & Report
- Fee $ 17.25

JAM

Pachymetry
76514

- Bilateral
- Measurement of central corneal thickness (CCT) proven by Ocular Hypertension Treatment Study (OHTS) to be standard of care in diagnosis and management of glaucoma, glaucoma suspect and ocular hypertension
- Also billable for keratoconus, corneal transplants, cataracts with corneal dystrophies, guttata, edema
- Requires Interpretation & Report
- Fee $ 12.72

JAM

Scanning Computerized Ophthalmic Diagnostic Imaging
92133

- Unilateral or bilateral
- Applies to glaucoma or optic nerve evaluations
  - Heidelberg / Heidelberg Retinal Topography (HRT, Spectralis)
  - Carl Zeiss / Optical Coherence Tomography (GDX, Stratus, Cirrus)
  - Optovue / (RTVue, iVue)
  - Marco / Retinal Thickness Analyzer (RTA)
- Requires Interpretation & report
- Fee $ 36.95

JAM

Scanning Computerized Ophthalmic Diagnostic Imaging
92134

- Unilateral or bilateral
- Applies to vitreo-retinal evaluations
  - Heidelberg / Heidelberg Retinal Topography (HRT, Spectralis)
  - Carl Zeiss / Optical Coherence Tomography (GDX, Stratus, Cirrus)
  - Optovue / (RTVue, iVue)
  - Marco / Retinal Thickness Analyzer (RTA)
- Requires Interpretation & report
- Fee $ 40.82

JAM

Visual Evoked Potential (VEP)
95930

- Unilateral or bilateral
- Visual evoked potential testing central nervous system, checkboard or flash testing, central nervous system EXCEPT glaucoma
- Brain's electrical response to visual stimulus indicate lesion in visual pathway, including optic nerve
  - MS, Fam Hx MS, monitor dz progression in MS, assess response to Rx
- VEP for glaucoma – requires category III code 0464T
- Requires Interpretation & report
- Fee $ 67.63

JAM

Electroretinogram (ERG) 92273

- Unilateral or bilateral
- Full field electroretinogram – global response of photoreceptors
  - Full field electroretinogram (ffERG),
  - Flash electroretinogram
  - Ganzfeld electroretinogram
- Brain's electrical response to visual stimulus indicate lesion in visual pathway, with emphasis on retinal disease states
  - AMD, High risk drugs like HCQ, Diabetic retinopathy, CRVO, media opacitites
- Requires Interpretation & report
- Fee $ 131.73

JAM

Electroretinogram (ERG) 92274

- Unilateral or bilateral
- Multifocal electroretinogram (mfERG) – response of photoreceptors in multiple, separate locations in the retina including the macula
- Brain's electrical response to visual stimulus indicate lesion in visual pathway, with emphasis on retinal disease states
  - AMD, High risk drugs like HCQ, Diabetic retinopathy, CRVO, media opacitites
- Requires Interpretation & report
- Fee $ 89.45

JAM

Electroretinogram (ERG) 92275 *DELETED*

- Unilateral or bilateral
- Multifocal pattern electroretinogram
- Brain's electrical response to visual stimulus indicate lesion in visual pathway, with emphasis on retinal disease states
  - AMD
  - High risk drugs like HCQ
- Requires Interpretation & report
- Report Pattern ERG in 2019 using 0509T (a temporary CPT)
- Fee $ 85.00

JAM

Correction Trichiasis 67820*

- Epilation
- By forceps
- ICD-9
  - Trichiasis without entropion
  - Senile entropion
- Global days - 000
- Fee $ 32.68

JAM

Removal of Foreign Body 65205*

- External Eye, Conjunctiva
  - superficial
  - scleral, non-perforating
- ICD-9
  - FB in cul-de-sac
- Global days - 000
- Fee $ 46.10

JAM

Removal of Foreign Body 65210*

- External Eye, Conjunctiva
  - embedded (includes concretions)
  - subconjunctival
  - scleral, non-perforating
- ICD-9
  - FB in other sites or combined sites
- Global days - 000
- Fee $ 56.34

JAM

Removal of Foreign Body 65222*

-

- External Eye, Corneal
  - with Slit Lamp
- ICD-9
  - FB in cornea
- Global days - 000
- Fee $ 68.11

JAM

Sensorimotor Examination 92060

- Quantitative measurement of ocular deviation
  - document all major fields of gaze
- Bilateral
- Requires interpretation and report
- Fee $64.32
- 92065 – Orthoptic and / or pleoptic training, with continuing medical direction and evaluation
- Fee $ 63.99

JAM

Dilation of Lacrimal Puncta 68801*

- With or Without Irrigation
- ICD-9
  - Epiphora, insufficiency of drainage
  - Chronic Dacryocystitis
  - Stenosis, Lacrimal Punctum
  - Nasolacrimal Duct Obstruction
- Fee $ 90.20

JAM

Punctal Occlusion By Plug 68761

- Temporary (collagen) or Permanent (Silicone)
- Payment is per puncta (modifiers required)
  - E1=left upper E3=right upper
  - E2=left lower E4=right lower
- Global period - 10 days
- Supply code-included in procedure code, not separately billable
- Fee $148.24

JAM

Modifiers

- 79 Inside post-operative global period
- 50 Bilateral Procedure
- 24 Unrelated Service / Same Doctor
- 79 Inside Global Period
- 25 Separate Service / Same Doctor / Same Day
- 52 Reduced Service / Informational / Not Reduced Fee
- 54 Surgical Care Only
- 55 Post-Op Care Only
- 51 Multiple Procedures
- RT / LT Right / Left
- E 1- E4 Identifies Puncta or lids
- 52 Reduced service

IOL Master Biometry for Cataracts 92136

- Measurement of axial length and corneal keratometry
- For calculation of IOL power
- Unilateral
- Fee: $69.30

JAM

A-scan Biometry for Cataracts 76519

- Measurement of axial length
- For calculation of IOL power
- Unilateral
- Fee: $65.50

JAM

Co-Management of Surgery 66984

- CPT code same as surgery code = 66984
- ICD-10 code same as surgery offices' diagnostic code
- Date of service – same as date of surgery
- Global Periods - 90 days
- Value - up to 20%
- MD name and NPI
- Modifiers (-54 on MD claim, -55 on OD claim and RT/LT)
- Range Dates – from transfer date to end of 90 day global
- Rules - Medicare Transfer Agreement in MD record
- Correspondence / Legal / Political / Inter-professional Issues
- Fee $642.26

JAM

Complicated Cataract Surgery 66982

- CPT code added in 2001
- Extracapsular cataract extraction with insertion of IOL, complex, requiring devices or techniques not generally used in routine cataract surgery
  - 2-3% of all cataract surgeries involve extraordinary work
    - iris expansion devices, suture support for IOL, posterior capsulorrhexis, small pupil, subluxed lens, Pseudoexfoliation, trauma, Marfan's, glaucoma, uveitis
    - pediatric population
    - Advanced, white, hard cataract
- Fee $798.76

JAM

Reduction in Diagnostic Testing

- CMS will decrease payment by 20% of technical component of second and subsequent diagnostic tests furnished by same physician (or physicians in same group) to same patient on same day
  - Originally set at 25%
  - A diagnostic service refers to any diagnostic test that has a technical & professional component
- CMS indicated they will closely monitor practice changes to bypass multiple payment reductions

Reduction in Diagnostic Testing

76510	92060	92228	92285
76511	92081	92235	92286
76512	92082	92240	92145 - hyteresis
76513	92083	92250	92265 – eom eval
76514	92132	92270	
76516	92133	92275	
76519	92134	92283	
92125	92136	92284	

Place of Service Updates for 2019

01 = Pharmacy	16 = Temporary Lodging
03 = School	17 = Walk-in retail health clinic
04 = Homeless shel	18 = Place of employmt
05 = IHS-freeStand	19 = Off campus outpt hosp
06 = IHS=-provBas	20 = Urgent care
07 = Tribal-freeSt	21 = Inpt Hosp
08 = Tribal-provbas	22 = On campus outpt hosp
09 = Prison	23 = Emergency room
11 = Office	24 = ASC
12 = Home	25 = Birthing Center
13 = Assisted living	26 = Military facility
14 = Group home	31 = Skilled Nursing facility
15 = Mobile Unit	32 = Nursing facility

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Distinct Procedural Service (-59)

- Documentation should support a different session, different procedure or surgery, different site or organ, separate lesion, separate injury
- Use only when another modifier is not available
- HCPCS Modifiers for selective identification of **subsets** of Distinct procedural service (-59)
  - XE – Separate encounter
  - XS – Separate structure
  - XP – Separate practitioner
  - XU – Unusual non overlapping service

Distinct Procedural Service (-59)

- CMS – most widely used modifier
- Correct usage is when a procedure or service includes 2 or more CPT codes that are bundled under MC's CCI edits, yet circumstance support separate charges. This is not common in eyecare.
  - Contiguous structures within same organ is not considered different anatomic site
- Documentation should support a different session, different procedure or surgery, different site or organ, separate lesion, separate injury
- Use only when another modifier is not available

Distinct Procedural Service (-59)

- HCPCS Modifiers for selective identification of **subsets** of Distinct procedural service (-59)
  - XE – Separate encounter
  - XS – Separate structure
  - XP – Separate practitioner
  - XU – Unusual non overlapping service
- On MC claims these four modifiers should be used instead of modifier -59
- Ex: exam and extended ophthalmoscopy on patient w RD in office in morning, then RD repair at hospital later same day. RD repair & 92225 bundled so append –XE (or -59) to claim for 92225

Modifier Reminders

- Anatomical modifiers are still required; even though ICD-10 codes identify anatomy and laterality!!
- ICD coding does not impact reporting CPT or HCPCS
- -RT
- -LT
- -E1
- -E2
- -E3
- -E4

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20 Conditions Account for 95% Costs

MI	Endometrial CA
AD	Glaucoma
Afib	Hip Frx
BrCA	CAD
Cataract	Lung CA
CHF	Depression
CKD	Osteoporosis
ColonRecCA	ProstateCA
COPD	RA/OA
DM	CVA

OIG Audits / Work Plan

- Ophthalmological services – 92xxx codes
  - Reviewing claims during 2014
  - Focus on 92004/92014, other 92- included
- E/M Services: OIG report 5/29/14
  - Improper payments for E/M codes cost Medicare 6.7 billion in 2010; 42% of claims incorrectly coded
  - Modifiers -25
    - Significant, separately identifiable service above & beyond pre & post operative work of the procedure
    - July 1 2013 policy statement warning not to use -25 for same day surgery, exception being NEW patients
    - Bilateral intravitreal injections
  - Prolonged services – reasonableness of services

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Big Changes for E/M Documentation!

- Documentation guidelines are challenging for any provider
- Idea of a simplified, lesser tiered, approach to both documentation and payment is being launched in 2021
  - Proposed consolidating the E/M coding levels from 5 to 2
  - Final rule compromised and created 3 levels of codes
- On July 12, 2019 the ***Proposed Policy, Payment, and Quality Provision Changes to Medicare Physician Fee Schedule for Calendar Year 2019*** was released.
  - The final rule was released on November 1, 2018
  - CMS confirms these changes will not affect 92xxx Codes
  - Only for Medicare fee-for-service patients

Streamlining E/M Payment & Burden

- For CY 2019 and CY 2020, CMS will continue the current coding & payment structure for E/M visits
- Providers should continue to use 1997 E/M documentation guidelines to document outpatient office visits billed to Medicare
- Eliminates the requirement to document medical necessity of a home visit in lieu of an office visit
- For established patient office visits, when relevant information is already contained in the medical record, practitioners may choose to focus documentation on what has changed since last visit or on pertinent items that have not changed, and need not re-record the defined list of required elements if evidence of review

Streamlining E/M Payment & Burden

- Practitioners should still review prior data, update as needed, and indicate in medical record that they have done so
- For new & established patients for visits, practitioners need not re-enter in medical record information on patient's chief complaint and history that has been entered in record by ancillary staff or beneficiary
  - May simply indicate that information has been reviewed and verified
- Removal of duplicative requirements for notations in records that may have been previously included by residents or other members of care team for E/M visits furnished by teaching physicians

CY 2021 E/M Payment Reforms

- Reduction in payment variation for E/M office visit levels by paying a single rate for E/M office visit levels 2 through 4 for new & established patients
- Maintains payment rate for E/M level 5
- Permits practitioners to choose to document E/M office levels 2-5 using Medical Decision Making (MDM) or Time instead of applying the current 1997 E/M documentation guidelines
  - Alternatively you could continue using current framework
- Beginning in CY 2021 for E/M visits level 2-5, CMS allows flexibility in how visits are documented – specifically a choice to use current framework, MDM, or Time

CY 2021 E/M Payment Reforms

- When using MDM or current framework to document visits, CMS will apply a minimum supporting documentation standard associated with level 2 visits
  - Requires information to support history / exam / medical decision making for level 2 visit code
- When Time is used to document, practitioners will document medical necessity of the visit and that the billing practitioner personally spent the required time face-to-face with the beneficiary
- Implementation of "add-on" codes that describe the additional resources inherent in visits for primary care and particular kinds of non-procedural specialized medical care, but not restricted by specialty

Add- On Codes

- Additional or supplemental procedures
- Designated as add-on codes with the symbol "+"
- Listed in Appendix D of the CPT book
- Applies only to add-on procedures by the same physician
- Describe additional intra-service work associated with the primary procedure
- Performed in addition to primary procedure and are never stand-alone codes
- Exempt from multiple procedure concept

Add-On Codes

- Add-on codes included in policy proposal, varies by locality
- Not limited by specialty, reflecting only care provided
  - Primary care: $5.00
  - Visit complexity: $14.00
  - Prolonged service: $67.00

JAM

CY 2021 E/M Payment Reforms

- Add-on codes only reportable with E/M office visit codes level 2 through 4
- Their use generally would not impose new per-visit documentation requirements
- Adoption of a new "extended visit" add-on code for use only with E/M office visit level 2-4 to account for the additional resources required when practitioners need to spend extended time with the patient
- CMS believes these policies allow greater flexibility to exercise clinical judgment in documentation, so they can focus on what is clinically relevant and medically necessary
  - Agrees to further refine these policies for CY 2021

New & Revised ICD-10 Codes for 2019

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New ICD-10 Codes for 2019

- This year's code update focus mostly on eyelids, brows, conjunctiva and meibomian gland anatomic areas
  - Adds new categories
- Adds more detail for oculo-plastics subspecialty
- Effective date for ICD-10 implementation is October 1, 2019
- Be sure to update PMS software to incorporate these additions
- When a new diagnostic code exists one must use the most specificity possible

JAM

Chapter 2: Neoplasms

- C43.111 Malignant melanoma, RU, inc canthus
- C43.112 Malignant melanoma, RL, inc canthus
- C43.121 Malignant melanoma, LU, inc canthus
- C43.122 Malignant melanoma, LL, inc canthus
- C4A.- Merkle cell
- C44.11- Basal cell
- C44.12 Squamous cell
- C44.13 Sebaceous cell
- D03.1- Melanoma in situ
- D22.1- Melanocytic nevi

JAM

Chapter 7: Eye

- Changes here allow for **both lids** on **one side** to be selected; 2018 only permitted one eye coding options
  - H01.00A Unspec Blepharitis right eye, upper & lower
  - H01.00B Unspec Blepharitis left eye, upper & lower
- Similar changes for other blepharitis codes as well:
  - Ulcerative blepharitis (H01.01A and H01.01B)
  - Squamous blepharitis (H01.02A and H01.02B)
- For lagophthalmos there are more options inc "all 4 lids"
  - H02.20A Unspec Lagophth right eye, upper & lower
  - H02.20B Unspec Lagophth left eye, upper & lower
  - H02.20C Unspec Lagophth bilateral, upper & lower

JAM

Chapter 7: Eye

- Cicatricial lagophthalmos has more options
  - H02.21A Cicatricial lagophthalmos right, upper & lower lid
  - H02.21B Cicatricial lagophthalmos left, upper & lower
  - H02.21C Cicatricial lagophthalmos bilateral, upper & lower
- Mechanical lagophthalmos has more options
  - H02.22A Cicatricial lagophthalmos right, upper & lower lid
  - H02.22B Cicatricial lagophthalmos left, upper & lower
  - H02.22C Cicatricial lagophthalmos bilateral, upper & lower

JAM

Chapter 7: Eye

- Paralytic ectropion is a new ICD code with multiple options
  - H02.151 Paralytic ectropion right upper lid
  - H02.152 Paralytic ectropion right lower lid
  - H02.153 Paralytic ectropion right unspec lid
  - H02.154 Paralytic ectropion left upper lid
  - H02.155 Paralytic ectropion left lower lid
  - H02.156 Paralytic ectropion left unspec lid
  - H02.159 Paralytic ectropion unspec eye, unspec lid
- Note: caution in using unspecified codes (-3, -6, -9)

JAM

Chapter 7: Eye

- Meibomian gland dysfunction increases specificity
  - H02.881 Meibomian Gland Dysfunction right upper lid
  - H02.882 MGD right lower lid
  - H02.883 MGD right unspec lid
  - H02.884 MGD left upper lid
  - H02.885 MGD left lower lid
  - H02.886 MGD left unspec lid
  - H02.889 MGD unspec eye, unspec lid
  - H02.88A MGD right upper & lower lids
  - H02.88B MGD left upper & lower lids

JAM

Chapter 7: Eye

- New code(s) for Brow ptosis (H57.81)
  - H02.811 Brow ptosis right
  - H02.812 Brow ptosis left
  - H57.813 Brow ptosis bilateral
  - H57.819 Brow ptosis unspec
- New code(s) for conjunctivitis
  - H10.821 Rosacea conjunctivitis right
  - H10.822 Rosacea conjunctivitis left
  - H10.823 Rosacea conjunctivitis bilateral
  - H10.829 Rosacea conjunctivitis unspec

JAM

Understanding MACRA-MIPS for 2019

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CMS Incentive Programs

- Physician Quality Reporting System (PQRS)
- Health Information Technology (HIT/EHR)
- Value-Based Payment Modifiers (VM)
  - Aoa.org/vbm-fact-sheet
- Merit-Based Incentive Payment System (MIPS)
  - Starting in 2019, MIPS will combine VBM, PQRS, & EHR/MU
  - Begin rating doctors based on a 100 point scale reflecting performance on quality, resource use, clinical practice improvement activities & MU of EHR

JAM

MIPS Payment Adjustments

- Quality Payment Program final policy released October 14, 2016
- Your performance in 2019 and beyond affects your bonus or penalty in 2021 for Medicare Part B
- MIPS payment adjustment
  - 2016-18 = 0
  - 2019 = +/-4%
  - 2020 = +/-5%
  - 2021 = +/-7%
  - 2022 = +/-9%

JAM

MIPS Eligible Providers

- Physicians – participate as individuals, groups or "virtual groups"
  - Virtual groups composed of solo practitioner or groups of 10 or fewer clinicians, who come together "virtually" with at least 1 other such solo practitioner (2 or more TINs) or group to participate for a performance year (requirements are the same)
- Physician Assistants ((PA)
- Nurse Practitioners (NP) / Clinical Nurse Specialists (CNS)
- Certified Registered Nurse Anesthetists (CRNA)
- Groups that include such clinicians

JAM

MIPS Virtual Group Identifiers

- Created a "Virtual group participant identifier"
- Identifier would be combination of three identifiers
  - Virtual group identifier
  - TIN (9 numeric characters)
  - NPI (10 numeric characters)
- 2019 NEW clinician types includes
  - Physical therapy
  - Occupational therapy
  - Clinical social workers
  - Clinical psychologists

JAM

MIPS Eligible Providers

- Next generation ACOs
- Comprehensive Primary Care Plus
- Medicare Shared Savings Program (MSSP)
- Oncology Care Model with two sided risk
- Comprehensive End Stage Renal Disease Care
  - for larger dialysis organizations
- CMS created https://qpp.cms.gov/participation-lookup for providers to enter their NPI number to assess their MIPS eligibility status

JAM

10 Things to Know About MACRA 2019

1. Pick-your-pace transition plan continues in 2019
2. Use of 2015 certified EHR is now required in 2019
3. CMS maintains the low volume threshold exclusion, and 63% of all Medicare clinicians will be exempt from MIPS in 2019
4. Cost (formerly VBM) will be 15% of the overall MIPS score in 2019
5. Providers can participate in MIPS as individuals, groups or virtual groups

JAM

10 Things to Know About MACRA 2019

6. CMS will allow multiple submission mechanisms within the PI, quality & improvement activities categories
7. CMS will offer small practices "significant hardship" exceptions to opt out of MIPS PI continuing in 2019
8. CMS made only minor changes to the Advanced APM regulations, requires use of certified EHR
9. Bonus points to final MIPS score for Small Practices moved to the Quality category score
10. 2018 Rule includes several wins (small practices) as Trump Admin makes efforts to reduce regulation

JAM

MIPS Final Scores & Penalties

- CMS continues to allow flexibility in 2019 reporting
  - Allows providers to avoid penalties for 2021
- MIPS Options for Transition Year
  - Do Nothing = 7% penalty in 2021 (0-7.5 pts)
  - Submit "some" data = less than 7% penalty (7.51-29.99 pts)
  - Submit "more" date = Neutral (30 pts)
  - Partially participate = eligible for small bonus (30.1-74.99 pts)
  - Fully participate = eligible for small bonus plus exceptional performance bonus (75-100 pts)
- Payment adjustment will depend on how much data you submit & your quality results

JAM

MIPS Transition Flexibility

- MIPS is budget neutral
- If few providers receive penalties the bonuses would be lower to maintain neutrality with maximum of 4%
- Positive payment adjustments multiplied by scaling factor to ensure budget neutrality
- Exceptional performance – bar is raised in 2019
  - Providers who fully participate
  - Earn a MIPS score of 75 or higher (was 70 in year 1 and 2)
  - Qualifies for additional bonus of 0.5% or higher
    - Capped at 10%
  - Funded by $500 million authorized by law

JAM

Can You Be Excluded from MIPS ?

- If you see 200 or fewer Medicare part B patients per year or
- If you have $90,000. or less in Part B allowed charges per year OR
- If you are newly enrolled in Medicare during the reporting year OR
- NEW: provide 200 or fewer covered professional services under the Physicians Fee Schedule (PFS)
- Determination period – October 1, 2018-September 30, 2019 (no claims run out)

JAM

Modified Category Weights for Scoring

- Quality Measures (PQRS/QP) = 45% (60%-'17, 50%-'18)
- Promoting Interoperability (MU/ACI/PI) = 25%
- Clinical Practice Improvement Activities = 15%
- Cost (Resource Use) = 15% (10%-'18, 0%-'17)
- MIPS Final Score of 100
  - Final score of 30 will avoid negative payment adjustment
  - Final score of >30 and <74.99 eligible for small bonus
  - Final score of >75 eligible for bonus of at least 0.5% (capped at 10%) from funds for "exceptional performance"

JAM

Restructuring Promoting Interoperability Category (PI)

- 2019 CMS overhauls former ACI category
- Base, performance & bonus scores would be eliminated
- Replaced with new scoring methodology based solely on performance (ALL OR NONE)
- Four objectives must be met (one measure per objective)
  - e-prescribing
  - Health Information Exchange
  - Provider-to-Patient Exchange
  - Public Health & Clinical Data Exchange
- Fall short with even 1 measure and PI score is zero! JAM

EHR and MU Changes in MIPS in 2018

- In 2018 providers ***not required*** to upgrade to the 2015 edition of certified EHR technology as directed in 2017
  - Allows use of 2014 or 2015 Edition CEHRT in 2018
- In 2019 providers ***must use*** 2015 Edition CEHRT
- Hardship exemptions continue in MIPS 2019
  - PI Category re-weighted to zero
  - Points shifted to Quality score (re-weighted to 70%)
  - Change the deadline for exception application submission for 2019 and future years to December 31 of performance year

JAM

PI Requirements at a Glance

- Security Risk Analysis – conduct a SRA, implement updates, MUST be done during 2019, then attest
- Electronic prescribing – at least 1Rx
- Health Information Exchange – send a summary of care or request a summary of care
- Provider-to-patient exchange – provide patients electronic access to their health information
- Public Health & Clinical Data Exchange – report 2 measures from any of these 4 registries
  - Immunization / Electronic Health Registry / Clinical Data / Syndrome Surveillance

JAM

PI Requirements at a Glance

- Report these measures to
  - Attest yes to Prevention of Information Blocking
  - Submit yes to ONC Direct Review attestation
- No longer need these measures
  - Patient generated health data – eliminated for 2019
  - View, download, transmit – eliminated for 2019
  - Patient Specific Education – eliminated for 2019
  - Secure Messaging – eliminated for 2019
  - Health Information Exchange – eliminated for 2019

JAM

QP "Topped Out" Quality Measures

- CMS is capping the total possible points per measure at 7 points instead of the usual 10 points per measure
- Means that overall performance on these measures are consistently high
- It is likely that these measures will be removed from the MIPS program in 2020

JAM

QP "Topped Out" Quality Measures

- #12 POAG: Optic nerve evaluation
- #14 AMD: Dilated exam
- #19 Diabetic retinopathy: Communication w PCP
- #117 Diabetes: Eye exam
- #130 Documentation of current medications in med record
- #141 POAG: reduction of IOP by 15% or documentation of plan of care

JAM

Quality Program in MIPS

- Report Quality measures at any point during the year
- Can report using Registry, EHR, or Claims
- As little as ***30 pts*** avoids penalty!
- Eligible to earn Small Bonus – successfully report more than 6 measures during the entire performance period
- To Maximize Quality Score
  - Report ***on at least 60%*** of applicable patients
    - Medicare only for claims reporting
    - All payers for Registry & EHR reporting
  - 1 measure must be an "Outcome" or "High Priority Measure"
- 3 Point bonus to Quality score for Small Practices

JAM

Quality Program Scoring in MIPS

- Quality Scoring is 45% of MIPS
  - Each of the 6 measures is worth from 3-10 points depending upon your success on each measure
  - Each measure reported will earn a minimum of 3 points
    - Even if not reported for 90 days
    - Even if not reported on 60% of eligible patients
- Outcomes Measures – 2 bonus points per measure awarded for additional outcomes measures when more than one outcomes measure reported
- EHR or Registry-EHR integration – 1 bonus point awarded for electronically reporting quality measures

JAM

Quality Program Measures Update

- New & revised ICD-10 codes now required
- No longer required to report from specific quality domains
- Required to report from at least one measure that is
  - Outcome or High priority
- Data submission requirement by method
  - Claims reporting – processed within 60 days of end of performance period (March 1, 2018)
- Manual registry reporting – submitted by March 31, 2018
- EHR reporting – submitted by March 31, 2018
- https://qpp.cms.gov/mips/quality-measures

JAM

Relevant MIPS Measures - 2019

- Measure #130 (G8427) – Documentation of current medications in medical record
  - Domain – Patient safety
  - Report via claims, registry, EHR
- Measure #110 (G8482) Influenza immunization: Not w 92xxx
  - Domain – Community & population health
  - Report via claims, registry, EHR
- Measure #111 (4040F) – Pneumococcal vaccination status in >65yo: Not w 92xxx
  - Domain – Community & population health
  - Report via claims, registry, EHR

Relevant MIPS Measures - 2019

- Measure #226 Tobacco Use: screening & cessation intervention
  - CPT 4004F – screened for tobacco, received counseling (user)
  - CPT 1036F – screened for tobacco, not user
  - Domain – Community & population health
  - Report via claims, registry, EHR, CMG
- Measure #236 – Controlling HTN
  - Domain – Effective clinical care
  - Report via claims, registry, EHR
- Measure #1 Diabetes: HA1c Poor Control (>9)
  - Report via claims

Relevant MIPS Measures - 2019

- Measure #402 Tobacco Use & help w Quitting among Adolescents
  - Domain – Community & population health
  - Report via EHR
- Measure #128 Preventive Care & Screening BMI
  - Domain - Population Health & Community Health
  - Not w 92xxx
  - CPT 3016F – BMI documented within normal parameters, no f/u

QP Measures AOA Recommends

Measure #130 (G8427) – Current medications with name, dose, frequency, route documented, Rx, OTC, Herbals, Multivitamins

- Or G8428 Current medications NOT documented

- Measure #131 (G8730) – Pain Assessment & Follow Up
  - Must use standardized pain assessment tool
  - Must include pharmacologic or educational intervention
  - Or G8509 Not Documented

QP Measures AOA Recommends

- Measure #226 (4004F) – Preventive Screening Tobacco Use: Screen and Cessation intervention
  - Report only ONCE per reporting period (24 months)
  - Or 1036 Current Tobacco Non-User
- Measure #317 (G8783) – Preventive Care & screening for High Blood Pressure
  - Must perform BP screening at each visit & document F/U plan
    - Lifestyle modification, Wt Loss, DASH, Less salt, mod EtOH, exercise
  - 2nd HTN reading >140 or >90 w/in 12 months requires Rx, labs, ECG and referral to PCP
  - Or G8950 Pre-HTN or HTN Not Documented

JAM

MIPS Measures AOA Recommends

- Measure #317 – Preventive Care & screening for High Blood Pressure
  - G8783 – Normal BP documented
  - G8950 - Pre-HTN or HTN Not Documented
  - G8784 – BP Not documented
  - G8951 – Pre-HTN or HTN documented, F/U not documented, patient not eligible
  - G8785 – BP Not documented, reason not given
  - G8952 – Pre-HTN or HTN documented, F/U Not documented, reason not given

MIPS Measures 2019

- Measure #130 – Documentation of current medications in medical record (High priority)
  - Domain – Patient safety
  - Report via claims, registry, EHR
- Measure #110 – Influenza immunization
  - Domain – Community & population health
  - Report via claims, registry, EHR
- Measure #111 – Pneumococcal vaccination status in >65yo
  - Domain – Community & population health
  - Report via claims, registry, EHR

PQRS Cross Cutting Measures 2016

- Measure #226 Tobacco Use: screening & cessation intervention
  - Domain – Community & population health
  - Report via claims, registry, EHR, CMG
- Measure #236 – Controlling HTN
  - Domain – Effective clinical care
  - Report via claims, registry, EHR
- Measure #374 – Closing the Referral Loop
  - Domain – Communication & Care coordination
  - Report via EHR

Measure 12: POAG Optic N. Evaluation

- CPT category II Code: 2027F
- Diagnosis codes

  Open angle glaucoma
  - Open angle glaucoma
  - Low tension glaucoma
  - Residual stage of open angle glaucoma
- Documentation tips – ON can be documented with a drawing, description, photograph or scan
- Modifiers -1P, -8P
- Reporting – Claims, registry, EHR (Effective clin care)

Measure 141: POAG Reduction of IOP by 15% or Documentation of Plan of Care

- IOP reduced by 15% from pre-intervention
  - CPT category II Code: 3284F (*High Priority)
- IOP reduced less than 15% from pre-intervention
  - CPT category II Code: 3285F plus
  - CPT category II Code: 0517F to document plan of care
    - Recheck IOP, Rx change, additional testing, referral, plan to recheck
- Once per reporting period
- CPT Codes: 92002, 92004, 92014, 92012, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

Measure 14: AMD Dilated Exam

- CPT category II Code: 2019F
- Pts 50yrs+ with diagnosis AMD having DFE with documentation of presence or absence of macular thickening or hemorrhage AND level of severity (mild, moderate, severe) of AMD during one or more office visits w/in 12 mos, minimum of once per reporting period
- Diagnosis codes
  - Macular degeneration, (wet/dry)
- Modifiers -1P, -2P, -8P

Measure 140: AMD Counseling on Antioxidant Supplement

- Patients aged 50 and older with a diagnosis of AMD and/or their caregiver(s) who were counseled within 12 months on the benefits and/or risks of the AREDS formulation for preventing progression of AMD
- CPT category II Code: 4177F
- Diagnosis codes – any applicable atrophic or exudative AMD
- Modifiers -8P
- Note: If already receiving AREDS supplements, assumption is counseling has already been performed

Measure 117: Diabetes Mellitus Dilated Exam

- CPT category II Code:
  - 2022F: dilated retinal exam by OD/OMD with interpretation documented and reviewed
  - 2024F: 7 standard field stereophotos with interpretation documented and reviewed
  - 2026F: eye imaging validated to match diagnosis from 7 standard field stereophotos with results documented and reviewed
  - 3072F: low risk for retinopathy (no evidence of retinopathy in prior year)
- Modifiers -8P

Measure 18: DM Documentation of Presence of ME & Level of Severity of Retinopathy

- CPT category II Code: 2021F
- Pts 18yrs+ with diagnosis of Diabetic Retinopathy with DFE
- Documentation must include
  - Level of severity of retinopathy (background, non-proliferative (mild, moderate, severe etc), proliferative)
  - If macular edema is present or absent
- Diagnosis codes
  - Background diabetic retinopathy
  - Proliferative diabetic retinopathy
  - Nonproliferative retinopathy, NOS
  - Mild nonproliferative diabetic retinopathy
  - Moderate nonproliferative diabetic retinopathy
  - Severe nonproliferative diabetic retinopathy
- Modifiers -1P, -2P, -8P

Measure 19: Diabetic Retinopathy Communication with Physician Managing Diabetes Care

- CPT category II Code: 5010F (Findings of exam communicated) & G8397 (DFE performed documenting presence or absence of macular edema & level of severity of retinopathy) both required
  - G8398 dilated macular exam not performed
- Patients 18 years+ diagnosed w DR and DFE, at least once per reporting period, documented verbally or by letter
- Diagnosis codes
  - Background diabetic retinopathy
  - Proliferative diabetic retinopathy
  - Nonproliferative retinopathy, NOS
  - Mild nonproliferative diabetic retinopathy
  - Moderate nonproliferative diabetic retinopathy
  - Severe nonproliferative diabetic retinopathy
- Modifiers - -1P added for 2011, all others fine
- HIGH PRIORITY

Improvement Activities in MIPS

- IA Scoring is 15% of MIPS Score
- Avoid Penalties – attest to completing at least 1 IA activity from list of 112 possible activity choices
- Earn Small Bonus – attest to completing more than 1 IA activity
- Earn Full Bonus – attest to completing enough IA activities for a 90 day period to reach 40 points

JAM

Clinical Practice Improvement in MIPS

- CPI activities are weighted as High or Medium
- High activities – 20 points
- Medium activities – 10 points
- Report on two high, four medium, or a combination to reach 40 points
- For Small practices
  - Points are doubled for practices with less than 15 or fewer eligible clinicians
  - Report on just one high activity to get 40 points or two medium activities

JAM

Improvement Activities in MIPS

- **New for 2019 an eye specific improvement activity**
  - **Comprehensive eye exam** – medium weighted, participants must promote the importance of a comprehensive eye exam
    - Accomplished by providing literature, or facilitating conversation about the topic using materials created by the AOA or AAO
- Must attest to completion of CPIA
- Attestations can be submitted by
  - Using CMS Attestation website
  - Using Registry
  - Using your EHR if offered by your vendor

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Clinical Practice Improvement in MIPS

- High Activities (20 Points)
  - Provision of same or next day care for urgent care needs
  - Provide 24/7 access to physicians for care advise about urgent or emergent care
  - Seeing new or f/u Medicaid patients in timely manner
  - Use of qualified clinical data registry to generate regular feedback reports that summarize practice patterns & treatment outcomes

JAM

Clinical Practice Improvement in MIPS

- Medium Activities (10 Points)
  - Use of qualified clinical dat registry data for ongoing practice assessment and improvements in patient safety
  - Participation in registry and use of registry data for quality improvement
  - Provide regular specialist reports back to referring providers
  - Provide self-management materials to an appropriate literacy level and in appropriate language

JAM

Cost (Resource Use) in MIPS

- Weighted as 0% in 2017, 10% in 2018, 15% in 2019
- Will not impact 2017 MIPS Score or 2019 Payment adjustments, will impact 2021 payments
- No reporting by doctors required
- Calculated by CMS using administrative claims
- Physicians measured and feedback reports will be provided based on
  - Total per capita cost
  - Medicare spending per beneficiary
  - New episode-based measure: lens and cataract episodes

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Performance Periods for 2019

- Quality Program – 12 months
- Cost – 12 months
- Promoting Interoperability – 90 days
- Improvement Activities – 90 days

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Thank you

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