Corcoran Consulting Group

What's New in 2018?

Corcoran Consulting Group

Executive Summary

- Payment issues
- New codes / coding issues
- Regulatory matters
- Administrative changes
- Utilization changes

2018 Medicare Physician Fee Schedule (MPFS)

- MACRA +0.5% update
- Budget neutrality adjustment of -0.10%
- Misvalued code reduction target adjustment of -0.09%
- Geographic practice cost index (GPCI) floor of 1.0 expired on 12/31/17 for nearly all regions
  - Fully reinstated on 2/9/18 and extended through 2020
- CY 2018 Conversion factor = $35.9996
  - Up 0.28%

Source: CMS, ASCRS 11/03/17

2018 MPFS

CPT	Description	2017	2018
92014	Comprehensive eye exam established	$125.25	$128.52
99204	E/M new patient level 4 exam	$166.16	$167.40
66984	Cataract surgery with IOL	$651.02	$656.27
66821	YAG laser capsulotomy (within facility)	$316.18	$338.40
67028	Intravitreal injection	$103.72	$104.40

Source: CMS 1676-F

Medicare Payments for Ophthalmic Imaging

CPT	Description	2017	2018
92235	Fluorescein angiography*	$87	$88
92240	ICG angiography*	$211	$214
92242	FA & ICG*	$230	$233
92250	Fundus photography	$67	$58
92132	SCODI, anterior	$32	$32
92133	SCODI, optic nerve	$38	$39
92134	SCODI, retina	$42	$42

**In 2017, these procedures were changed to bilateral services*

2018 MPFS Changes

• VEP except glaucoma (95930)	-46%
• Epilation (67820)	-19%
• B-scan (76512)	-19%
• Fundus photography (92250)	-13%
• Optical coherence biometry (92136)	-12%
• Implant corneal ring segments (65785)	+20%

Percentage change from 2017

2018 ASC Payment

- For those meeting the 2016 quality reporting requirements:
  - Wage adjustment for budget neutrality (1.0007%)
  - Multi-factor productivity adjustment (1.2%)
  - 2018 ASC conversion factor = $45.575 (+1.9%)
- ASCs not meeting the quality reporting requirements in 2016 are paid based on a conversion factor of $44.674

Source: CMS-1678-CN , ASCRS Regulatory Alert 7/14/17

Finalized ASC Rules for 2018

- Eliminated 3 ASC Quality measures for 2018 reporting:
  - ASC-5: Prophylactic Intravenous Antibiotic Timing
  - ASC-6: Safe Surgery Checklist Use
  - ASC-7: ASC Facility Volume Data
- Delays 2018 implementation of the CAHPS Survey
- TASS measure (ASC-16) was not included

Source: CMS, ASCRS Regulatory Alert 11/01/17

ASC Quality Reporting Program

- Updated ASC Quality Reporting Specifications Manual, Version 7.0a is available on the QualityNet website describing ASC 2018 data collection and reporting

Source: QualityNet website. http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FSpecsManualTemplate&cid=1228776140694

ASC Payment Rates

CPT	Procedure	2016	2017	2018
66984	ECCE w IOL	$976	$977	$992
66821	YAG Capsulotomy	$246	$254	$254
66180	Aqueous Shunt	$1,794	$1,747	$1,773
15823	Blepharoplasty	$789	$771	$817

Source: 2018 rates – CMS Addendum AA, Transmittal 1678-FC

ASC Payment Rates – Large ↓ Change

CPT	Procedure	2017	2018	%
15821	Bleph LL, w/ ext. fat pad	$1,354	$817	-66%
0449T	GDD, int. approach, w/o reservoir, subconj. space	$2,360	$1,773	-33%
0100T	Retinal prosthesis	$146,086	$117,502	-24%
0253T	GDD, int. approach, w/o res., suprachor. space	$2,155	$1,773	-22%

Source: CMS 2017 & 2018 ASC payment rates

ASC Payment Rates – Large ↑ Change

CPT	Procedure	2017	2018	%
12051	Intermed. repair, face/lids, ≤ 2.5 cm	$83	$162	+49%
0402T	Corneal CXL	$418	$809	+48%
65770	Keratoprothesis	$6,297	$6,935	+6%

Source: CMS 2017 & 2018 ASC payment rates

Executive Summary

- Payment issues
- New codes / coding issues

New CPT Codes

- *15733 - Muscle, myocutaneous, or facsiocutaneous flap; head and neck with named vascular pedicle (eg buccinators, genioglossus, temporalis, masseter, sternocleidomastoid, levator scapulae)*
- *(For forehead flap with preservation of vascular pedicle, use 15731)*
- ► *(For anterior pericranial flap on named vascular pedicle, for repair of extracranial defect, use 15731)* ◄

Source: AMA CPT 2018

Deleted CPT Codes

- *15732 - ~~Muscle, myocutaneous, or facsiocutaneous flap; head and neck (eg temporalis, masseter muscle, sternocleidomastoid, levator scapulae)~~*

- *~~(For forehead flap with preservation of vascular pedicle, use 15731)~~*

*SOOF lift may be best coded with 14xxx series codes

Source: AMA CPT 2018

New CPT Codes

- *15730 - Midface flap (ie, zygomaticofacial flap) with preservation of vascular pedicle*

Source: AMA CPT 2018

Clarification on CPT Code

- *15731 – Forehead flap with preservation of vascular pedicle (eg axial pattern flap, paramedian forehead flap) …*
- *► (For repair of head and neck defects using non-axial pattern advancement flaps [including lesion] and / or repair by adjacent tissue transfer or rearrangement [eg Z-plasty, W-plasty, V-Y plasty, rotation flap, random island flap, advancement flap] see 14040, 14041, 14060, 14061, 14301, 14302) ◄*

Source: AMA CPT 2018, ASOPRS

New CPT Codes

- *31253 - Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including frontal sinus exploration, with removal of tissue from frontal sinus, when performed*

- *► (Do not report 31253 in conjunction with 31254, 31255, 31257, 31259, 0406T, 0407T when performed on the ipsilateral side) ◄*

Source: AMA CPT 2018

Revised CPT Codes

- *31254 - Nasal/sinus endoscopy, surgical with ethmoidectomy; ~~with ethmoidectomy~~ partial*

- *► (Do not report 31254 in conjunction with 31253, 31255, 31257, 31259, 0406T, 0407T when performed on the ipsilateral side) ◄*

Source: AMA CPT 2018

Revised CPT Codes

- *31255 - Nasal/sinus endoscopy, surgical with ethmoidectomy; ~~with ethmoidectomy~~ total (anterior and posterior)*

- *► (Do not report 31255 in conjunction with 31253, 31254, 31257, 31259, 0406T, 0407T when performed on the ipsilateral side) ◄*

Source: AMA CPT 2018

New CPT Codes

- *31257 - Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy*

- *► (Do not report 31257 in conjunction with 31253, 31254, 31255, 31259, 0406T, 0407T when performed on the ipsilateral side) ◄*

Source: AMA CPT 2018

New CPT Codes

- *31259 - Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy, with removal of tissue from sphenoid sinus*

- *► (Do not report 31259 in conjunction with 31253, 31254, 31255, 31257, 0406T, 0407T when performed on the ipsilateral side) ◄*

Source: AMA CPT 2018

Revised CPT Codes

- *95930 - Visual evoked potential (VEP) checkerboard or flash testing, central nervous system except glaucoma, ~~checkerboard or flash,~~ with interpretation and report*

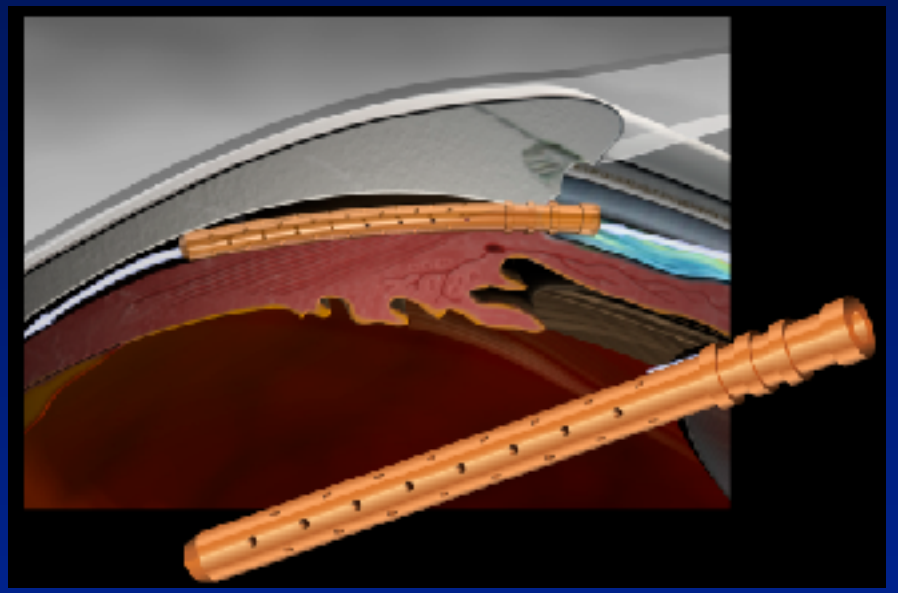
- *► (For visual evoked potential testing for glaucoma, use 0464T) ◄*
- *(For visual screening of visual acuity using automated visual evoked potential devices, use 0333T)*

Source: AMA CPT 2018

New Category III Code

- *0474T Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space*

- Effective: July 1, 2017
- Sunset: January 2023



Source: AMA Website, CPT 2018

HCPCS Payment Status Changes

- C9447 (*phenylephrine and ketorolac, injection*)
  - Granted pass-through status for Medicare payment 1/01/15 through 12/31/17 (K2 payment indicator)
    - K2 = Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate
  - Payment indicator changed to N1 for DOS 1/01/18 and later
    - N1 = Packaged service/item; no separate payment made
    - Cannot shift payment to patient by using an ABN to circumvent coverage

Source: CMS. Addendum BB, ASC fee schedule 2018

HCPCS J-code Denied

- Omidria (phenylephrine and ketorolac, injection)
  - *"**Final Decision**: A national program operating need to establish a code for Omidria was not identified by Medicare, Medicaid or the Private Insurance Sector. For coding guidance, contact the entity in whose jurisdiction a claim would be filed. For Medicaid, contact the Medicaid Agency in the state in which a claim would be filed. For private insurance, contact the individual insurance contractor. For Medicare, contact the Medicare contractor."*

Source: CMS. 2017-05-17 HCPCS Application Summary

Pass-through Extension

- (G) PASS-THROUGH EXTENSION FOR CERTAIN DRUGS AND BIOLOGICALS
  - In the case of a drug or biological whose period of pass-through status under this paragraph ended on December 31, 2017, and for which payment under this subsection was packaged into a payment for a covered OPD service (or group of 3 services) furnished beginning January 1, 2018, such pass-through status shall be extended for a 2-year period **beginning on October 1, 2018**.

Source: Consolidated Appropriations bill. Title XIII. Section 1301. Signed by President March 2018. Link: http://docs.house.gov/billsthisweek/20180319/BILLS-115SAHR1625-RCP115-66.pdf. See page 2029.

Pass-through Extension

- (H) TEMPORARY PAYMENT RULE FOR CERTAIN DRUGS AND BIOLOGICALS
  - In the case of a drug or biological whose period of pass-through status under this paragraph ended on December 31, 2017 … was packaged into a payment for a covered OPD service … beginning January 1, 2018, the payment amount … shall be the greater of:
    - (i) the payment amount that would otherwise apply under … for such drug or biological during such [other] period; or
    - (ii) the payment amount that applied … [as of] December 31, 2017

Source: Consolidated Appropriations bill. Title XIII. Section 1301. Signed by President March 2018. Link: http://docs.house.gov/billsthisweek/20180319/BILLS-115SAHR1625-RCP115-66.pdf. See page 2029.

Pass-through Extension

- The pass-through provision of OPPS was extended for two years by the 2018 Consolidated Appropriation Act effective 10/01/18. For any dates of service from 1/1/18 through 9/30/18, Medicare Administrative Contractors will not pay claims for Omidria.
- An ABN cannot be used to shift responsibility to the patient. Only the facility should purchase it.
- Payment will resume on 10/01/2018.
  - Payment level will be the *greater* of any amount in effect as of 12/31/17 or any new level set by CMS.
    - 20% co-payment for patient in a facility will apply in an ASC but not in an HOPD.
    - No extra payment for the surgeon.

Source: Consolidated Appropriations bill. Title XIII. Section 1301. Signed by President March 2018. Link: http://docs.house.gov/billsthisweek/20180319/BILLS-115SAHR1625-RCP115-66.pdf. See page 2029.

HCPCS Changes

- "*Fee-for-time compensation arrangement*" nomenclature replaces "*locum tenens*"
  - Modifiers Q5 and Q6

Source: *CMS. 2018 HCPCS code changes.*

MM10090. Fee-for-Time Compensation Arrangements. Eff. 6/13/17

HCPCS J-code Denied

- Photrexa (riboflavin)
  - *"**Final Decision:** This request to establish a new Level II HCPCS code to separately identify Photrexa has not been approved, because this product is an integral part of a procedure and payment for that service includes payment for Photrexa, if it is used."*
- Use only 0402T (*collagen cross-linking of cornea*)

Source: CMS. 2017-05-17 HCPCS Application Summary

CPT Assistant

- **Question:** At what point after the initial fitting of a keratoconus lens (92072) is a new lens (not a replacement) billable with code 92072 due to the fact that the lens no longer fits the patient's need?
- **Answer:** Code 92072, Fitting of contact lens for management of keratoconus, initial fitting, is reported for initial fittings only … Lens designs can include corneal, scleral, hybrid, or piggyback systems … If the lens need to be changed because it no longer fits the patient's needs, the fitting of new lens is considered an initial fitting and should include all of the services noted above.

Source: AMA CPT Assistant - September 2017 Issue

CPT Assistant (cont.)

- **Answer:** Subsequent fittings should be reported with the appropriate level of evaluation and management (E/M) code or … ophthalmological services code (92002-92014). The service described by code 92072 is not an inherent component of any surgical corneal procedure … it should be additionally reported when performed. The supply of lens may be additionally reported with either code 99070 … or the appropriate … (HCPCS) supply code

Source: AMA CPT Assistant - September 2017 Issue

April 2018 NCCI edit changes

- April 1, 2018, edits now bundle the following codes
  - 14061 – adjacent tissue transfer or rearrangement, 10 to 30 sq cm
  - 14301 – adj tissue transfer or rearrangement, add'l 30 to 60 sq cm
  - +14302 – adj tissue transfer or rearrangement, each add'l 30 sq cm
  - Indicator "0" means never unbundle
  - Indicator "1" means unbundling is OK - if the situation meets mod 59/X

Column 1	Short Descriptor	Column 2	Indicator
67961	Exc/Repair of eyelid, up to ¼ of lid margin	14061 14301 14302	1
67966	Exc/Repair of eyelid, over ¼ of lid margin	14061 14301 14302	1
67971	Reconstruction of eyelid, full thickness, with tarsoconjunctival flap from opposing lid, up to 2/3 of lid, first stage	14061 14301 14302	1

Source: CMS. NCCI Edits effective 4/01/18

2018 ICD-10 Updates

- If insulin and oral hypoglycemics are both used, code Z79.4 for "*Long-term (current) Insulin Use*"
- If only current or long-term oral hypoglycemic, code Z79.84
- S04.0 - Injuries to ON and pathways – descriptor changed from "eye" to "side"

Source: CMS, CDC

2018 ICD-10 Updates

- Chapter 7 – Eye and Adnexa (H00 – H59)
  - H02.0- “Trichiasis without entropiAN”
    - Spelling changed to “entropiON”
  - H42 Glaucoma in diseases specified elsewhere
    - Changed the “Excludes2” notation to a “Code first”
    - Payers may implement “code order” requirements
    - Glaucoma (in) diabetes mellitus (E08.39, E09.39, E10.39, E11.39, E13.39)

Source: CMS, CDC

2018 ICD-10 Updates

- Chapter 7 – Eye and Adnexa (H00 – H59)
  - H44.2- Degenerative Myopia
    - H44.2A- Degenerative myopia w/ choroidal neovascularization
    - H44.2B- Degenerative myopia w/ macular hole
    - H44.2C- Degenerative myopia w/ retinal detachment
    - H44.2D- Degenerative myopia w/ foveoschisis
    - H44.2E- Degenerative myopia w/ other maculopathy

Source: CMS, CDC

2018 ICD-10 Updates

- Chapter 7 – Eye and Adnexa (H00 – H59)
  - H54.- Blindness and Low Vision
    - Watch which eye(s) blind and which has low vision

Source: CMS, CDC

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2018 Part B Annual Deductible

- Medicare Part B deductible $183
- No change from 2017 deductible
- Effective date 1/1/18

Source: FR Vol. 82, No. 223. 11/21/17

Medicare Advantage (Part C) Update

- Average Part C monthly premium decreases $1.91 (-6%)
  - From $31.91 to $30
  - 99% of beneficiaries will have access to at least one MA plan
  - 85% will have access to >10 MA plans
  - Number of plans increased from 2,700 to 3,100
- 77% enrollees will have same or lower monthly premium
- Medicare Advantage enrollment is projected to increase to 20.4 million in 2018 [9% increase over 2017]
- 34% of all Medicare enrollees are projected to be in a [MA] plan in 2018.

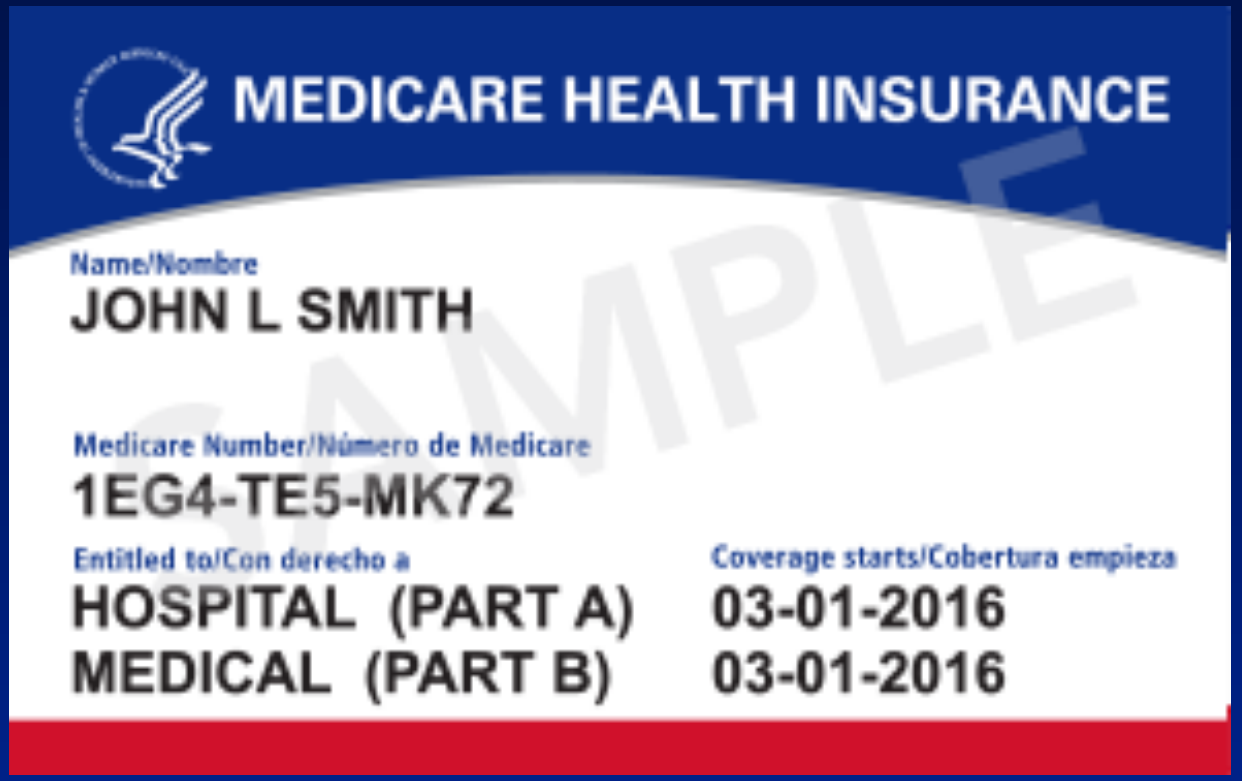
Source: CMS Press Release 09/29/17

Medicare Part D Update

- 100% of Medicare beneficiaries have access
- Average basic premium for 2018 projected to decline for the first time since 2012
  - 2017: $34.79
  - 2018: $33.50

Source: CMS Press Release 09/29/17

New Medicare Card



Source: CMS. New Medicare Cards. 10/23/17

New Medicare Card

- MACRA requires no SSN# on Medicare cards by April 2019
- Card re-design with new number to fight identity theft
  - Medicare Beneficiary Identifier (MBI) – 11 random numbers and uppercase letters (no special characters)
  - CMS notes to regard the MBI as confidential and protect it as before
- New cards get mailed beginning in April 2018
  - Random distribution mailing by geographic location
  - During transition period, either old or new MBI number will work (4/01/18 – 12/31/19)
  - Transition period ends 1/01/2020 – then use only the new MBI
- Appeals inquiries can use either number until the transition period ends

Source: CMS. New Medicare Cards. 10/23/17

Discussion on Revising E/M Coding

- *We continue to agree with stakeholders that the E/M documentation guidelines should be substantially revised.*
- *We believe that a comprehensive reform of E/M documentation guidelines would require a multi-year, collaborative effort among stakeholders. We believe that revised guidelines could both reduce clinical burden and improve documentation in a way that would be more effective in clinical workflows and care coordination.*
- *Although we believed that MDM guidelines may also need to be updated, we stated our belief that in the near term, it may be possible to eliminate the current focus on details of history and physical exam, and allow MDM and/or time to serve as the key determinant of E/M visit level.*

Source: Federal Register. MPFS Final Rule. 11/15/17

Provider Enrollment Validation – Cycle 2

- Began May 31, 2016
- MAC sends notifications within 2-3 months of revalidation date
- Use Medicare Provider Enrollment, Chain, and Ownership System (PECOS)
- Check status: https://data.cms.gov/revalidation
- Failure to revalidate could result in a hold on your Medicare payments or deactivation of billing privileges

Source: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html

CMS Policy Changes to Blepharoplasty With Covered Ptosis Surgery - 10/01/17

- Effective October 1, 2017
- Cosmetic Bleph (CPT 15823) allowed with functional blepharoptosis (67901-67908)

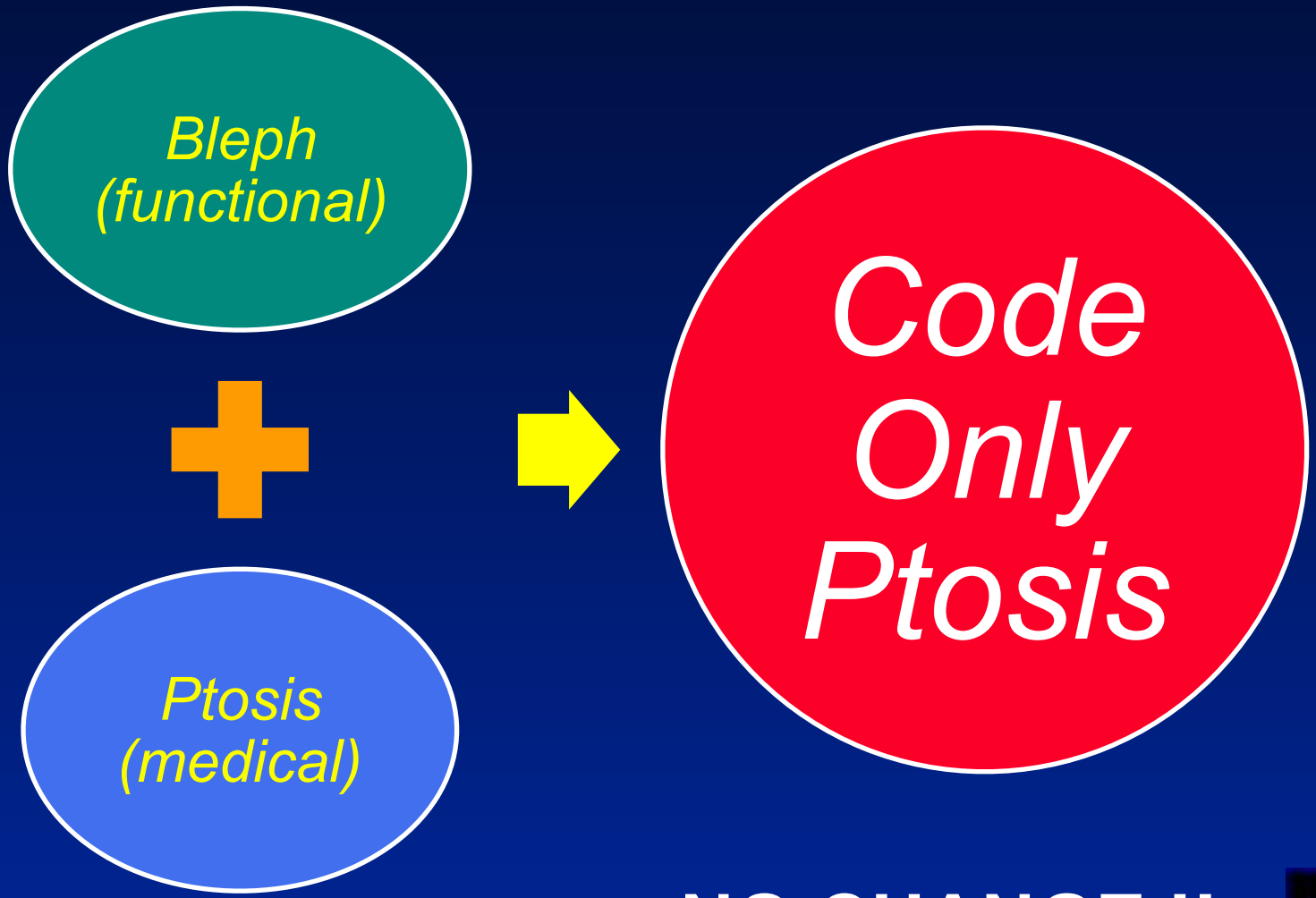
Source: MM 10236. Oct 2017 Update of the Hospital Outpatient Prospective Payment System. Effective 10/01/2017

CMS Policy Changes on 10/01/17

- MM 10236 notes:
- *" … effective October 1, 2017, CMS is revising this policy to allow either cosmetic or medically necessary blepharoplasty to be performed in conjunction with a medically necessary upper eyelid blepharoptosis surgery. Specifically, physicians may receive payment for a medically necessary upper eyelid blepharoptosis from Medicare even when performed with (non-covered) cosmetic blepharoplasty on the same eye during the same visit …"*

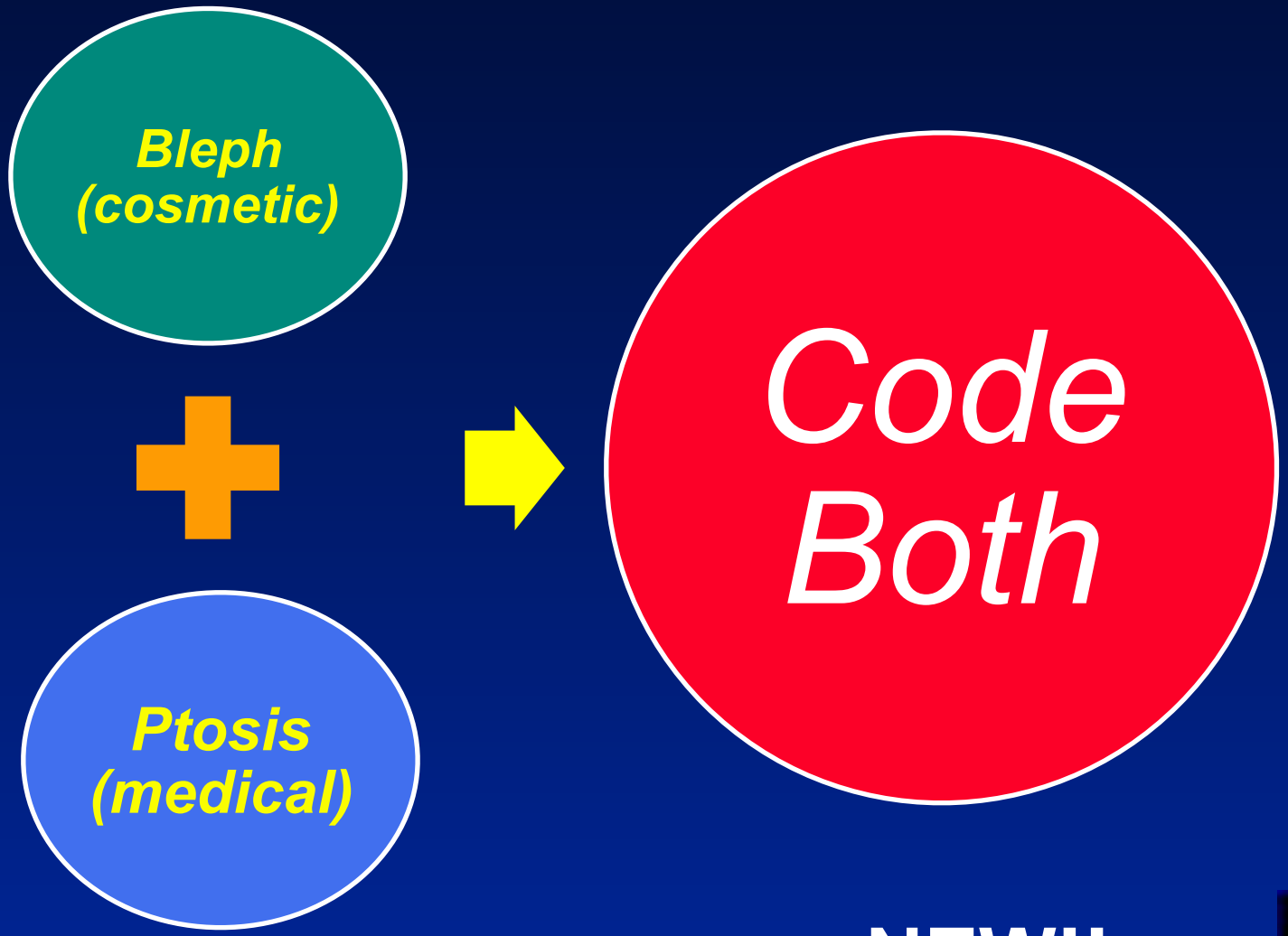
Source: MM 10236. Oct 2017 Update of the Hospital Outpatient Prospective Payment System. Effective 10/01/2017

Cosmetic vs Incidental – on 10/01/17



NO CHANGE !!

Cosmetic vs Incidental – on 10/01/17



NEW!!

Refunding Overpayments

- ACA §6402(a) provided that knowingly retaining an overpayment creates liability under the False Claims Act
- Final regulations published February 11, 2016 explains that a provider has 60 days to refund under the broad definition of an "identified" overpayment

Source: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-11.html

Refunding Overpayments

- Regulation states that a provider has an obligation to conduct “reasonable diligence” once the provider has credible information of a potential overpayment, and that barring exceptional circumstances, that inquiry should take no more than 6 months
- 60 day refund clock begins once the overpayment amount has been calculated
- Lookback period is within 6 years of the date the overpayment was received

Source: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-11.html

Health Care Programs Fraud and Abuse

- Bipartisan Budget Act of 2018
  - Became law on February 9, 2018
  - Section 50412 of the Act replaced the Anti-Kickback Statute (AKS) fines and sentences
  - Civil and Criminal monetary penalties and sentences were doubled. Even minimums were raised.
    - Maximum fine is now $100,000 (Civil and Criminal)
    - Criminal sentences for felony convictions now have a 10 year maximum

Source: https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.pdf (This section starts on page 157)

2018 OIG Work Plan

- June 2017 - OIG changed to “continuously updated” website from the prior annual work plan
- Items on the list:
  - Medicare Payments for Telehealth Services
  - Security of CEHRT under Meaningful Use
  - Manufacturer Rebates – Federal Share of Rebates
  - Part C Payments for DOS after Date of Death
  - Drug Waste of Single - Use Vial Drugs
  - Risk Adjustment Data – Supporting Documentation

Source: HHS OIG Work Plan October 2018

Focus by CMS: "Ophthalmology Services"

- Ophthalmology Services: Questionable Billing and Improper Payments
- *The Office of the Inspector General (OIG) reports that Medicare is vulnerable to fraud, waste, and abuse for*
  - *wet Age-related Macular Degeneration (wet AMD) and cataracts:*
    - *Administration of Lucentis injections for wet AMD more than once every 28 days (based on* [LCDs])
    - *Billing for a second cataract surgery on the same eye*
    - *Submitting disproportionately more claims for complex than standard cataract surgery*
- As a result, Providers may see more data-driven chart requests by Medicare Administrative Contractors (MACs)

Source: CMS MLN Connects Newsletter, 4/19/18. All MAC websites

Targeted Probe and Educate (TPE) Reviews

- Pilot program began in 2014 in only one MAC
- Pilot *"… combined a review of a sample of claims with education to help reduce errors in the claims submission process. CMS called this medical review strategy, Probe and Educate. CMS believes results of this program have been favorable, based on the decrease in the number of claim errors after providers received education*."
- July 2017, it expanded to three more MACs and expands to all MACs by the end of 2017

Source: CMS. Targeted Probe and Educate (TPE).

Targeted Probe and Educate (TPE) Reviews

- CMS "*will select claims for items/services that pose the greatest financial risk to the Medicare trust fund and/or those that have a high national error rate.*"
- MACs *"will focus only on providers/suppliers who have the highest claim error rates or billing practices that vary significantly out from their peers. These providers/ suppliers and specific items/services are identified … through data analysis*."

Source: CMS. Targeted Probe and Educate (TPE).

Targeted Probe and Educate (TPE) Reviews

- There are 3 possible rounds or "probe"
  - 20-40 charts per provider, per item or service, per round
  - "*After each round, providers are offered individualized education based on the results of their reviews … helping the provider to avoid additional similar errors later in the process*."
    - Education is via 1:1 sessions with the MAC's outreach and education staff
  - If you do well on early rounds, might skip subsequent rounds
  - Grades based on CMS-defined error rates:
    - Low, Moderate, High

Targeted Probe and Educate (TPE) Reviews

- After round 3 …
- *"continued high error rates … may be referred … for additional action, which may include 100% prepay review, extrapolation, referral to a Recovery Auditor, or other action."*

Source: CMS. Targeted Probe and Educate (TPE).

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Changes to Practice Patterns
Ophthalmology (18) Tests / Increases

Description	Code	2015	2016	Difference	% Chg
Immunoassay	83516	36,324	79,205	42,881	118%
UBM	76513	15,797	28,309	12,512	79%
Pachymetry	76514	353,036	599,294	246,258	70%
B-scan	76512	167,439	279,198	111,759	67%
A-scan	76510	14,979	20,924	5,945	40%
A-scan	76519	321,763	444,357	122,594	38%
ERG	92275	58,376	76,131	17,755	30%
OCT - Ant Seg	92132	29,054	35,284	6,230	21%
CT	92025	143,092	163,938	20,846	15%
OCT-Retina	92134	5,294,803	5,766,010	471,207	9%
CCB	92136	1,448,173	1,549,931	101,758	7%

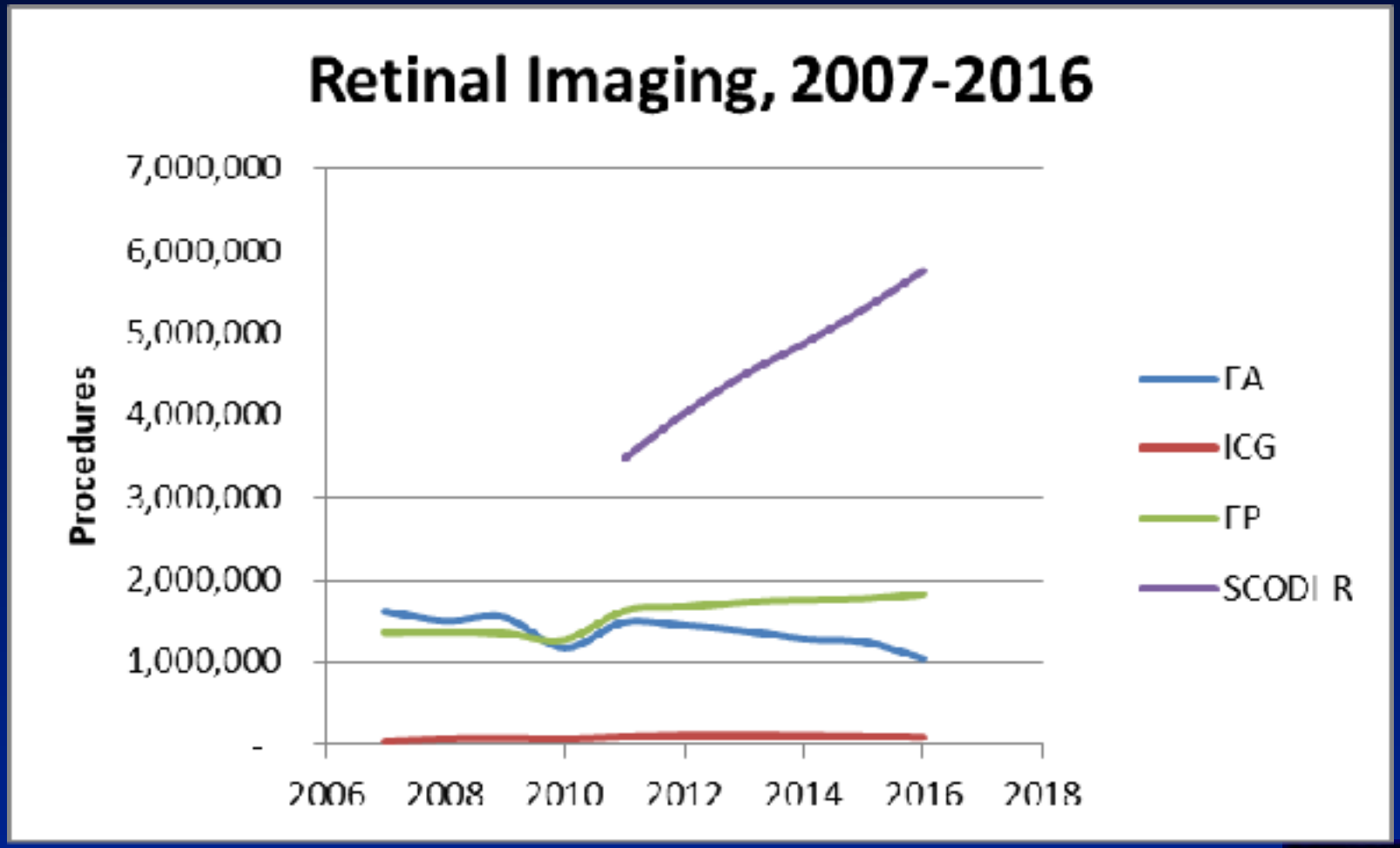
Source: CMS data 2015 vs. 2016, 18 – Ophthalmology

Changes to Practice Patterns
Ophthalmology (18) Services / Decreases

Description	Code	2015	2016	Difference	% Chg
Allergy	95165	12,432	7,618	(4,814)	-39%
Nursing home	99305	11,028	7,133	(3,895)	-35%
Nursing home	99308	13,419	9,000	(4,419)	-33%
Allergy	95004	638,135	487,020	(151,115)	-24%
Ext O'scopy	92226	2,567,376	2,116,828	(450,548)	-18%
Fluorescein	92235	1,251,945	1,046,851	(205,094)	-16%
VF-intermed	92082	82,777	74,511	(8,266)	-10%

Source: CMS data 2015 vs. 2016, 18 – Ophthalmology

Trends for Ophthalmic Imaging (18)

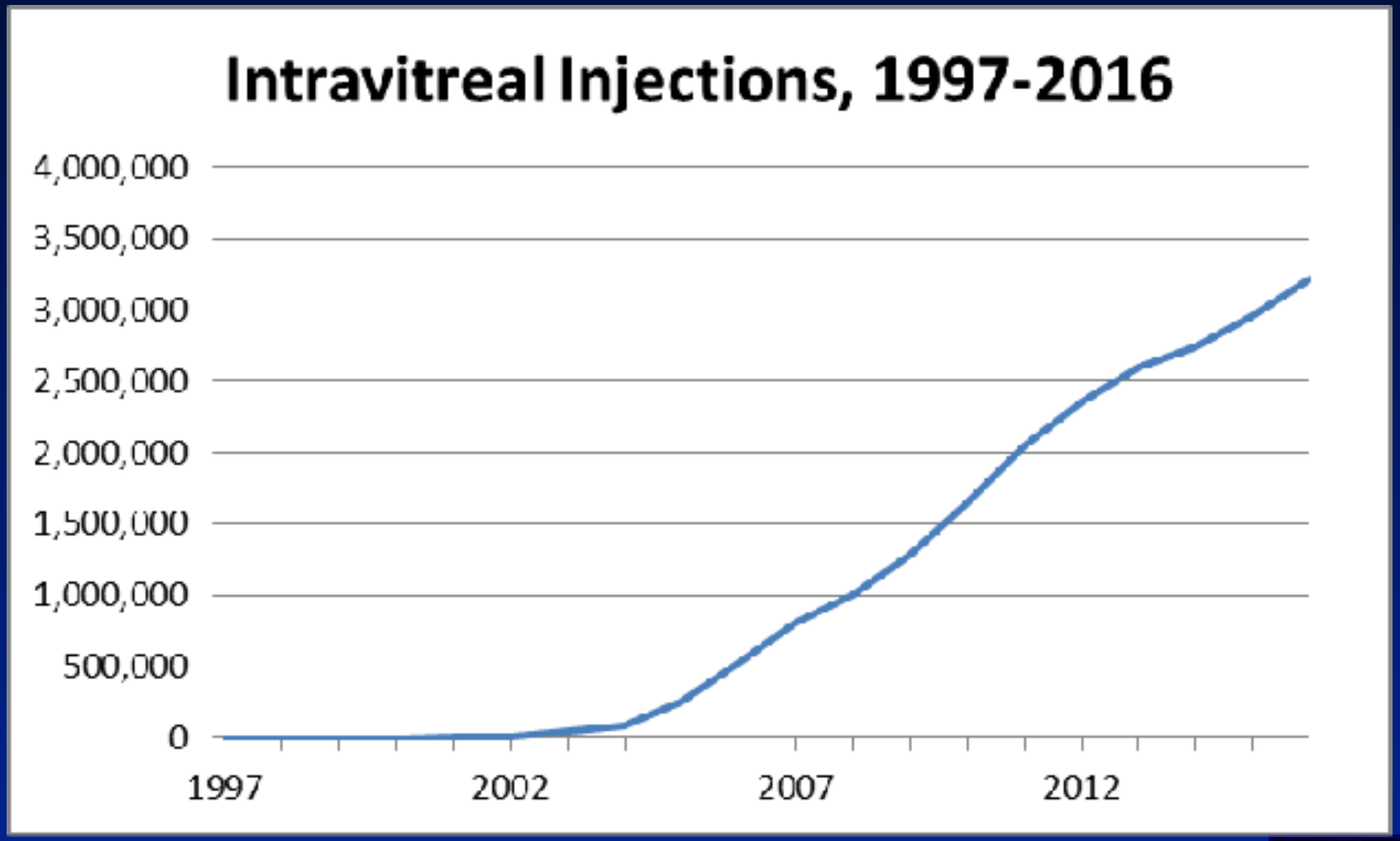


Changes to Practice Patterns
Ophthalmology (18) Surgery (+/-)

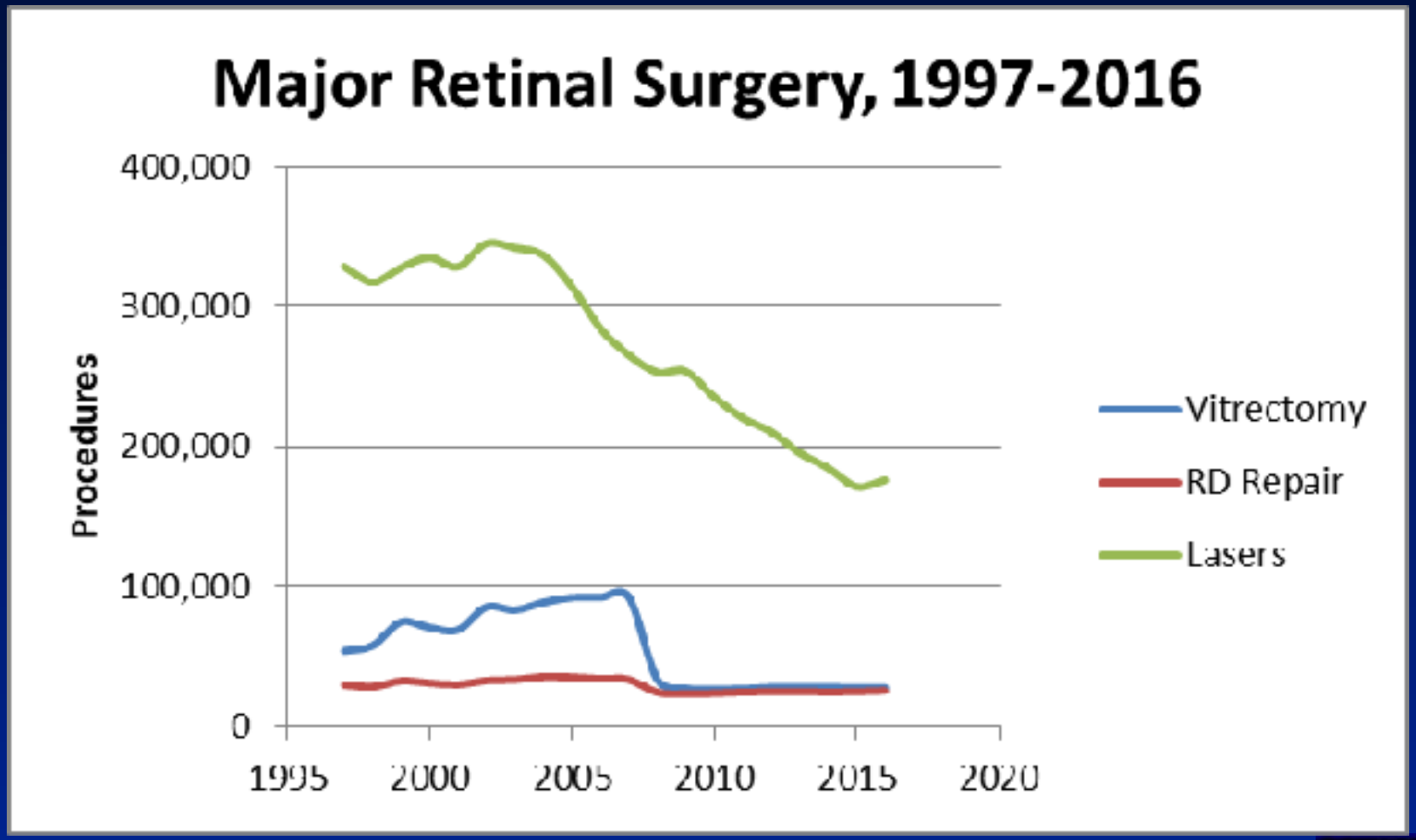
Description	Code	2015	2016	Difference	% Chg
iStent	0191T	28,768	42,266	13,498	47%
Temp AM	65778	11,137	16,037	4,900	44%
Intravit Inj	67028	2,959,021	3,215,435	256,414	9%
Paracentesis	65800	37,547	27,607	(9,940)	-26%
Subconj Inj	68200	18,363	9,857	(8,506)	-46%

Source: CMS data 2015 vs. 2016, 18 – Ophthalmology

Trends for Intravitreal Injections



Trends for Retinal Surgery



Changes to Practice Patterns
Ophthalmology (18) Supplies (+/-)

Description	Code	2015	2016	Difference	% Chg
Dysport	J0586	12,277	17,389	5,112	42%
Xeomin	J0588	170,164	212,067	41,903	25%
Eylea	J0178	1,765,543	2,152,831	387,288	22%
Ozurdex	J7312	156,174	190,205	34,031	22%
Triamcinolone	J3301	80,178	91,887	11,709	15%
Lucentis	J2778	2,864,867	2,663,875	(200,992)	-7%
Misc Biologic	J3590	365,557	222,548	(143,009)	-39%
Misc Drug	J3490	71,618	35,751	(35,867)	-50%

Source: CMS data 2015 vs. 2016, 18 – Ophthalmology

Executive Summary

- Payment issues
- New codes / coding issues
- Regulatory matters
- Administrative changes
- Utilization changes
- Quality Payment Program

Retroactive PQRS & VBPM Penalty Relief

- Retroactive relief for some providers and practices
- 2016 PQRS required 9 measures across 3 National Quality Strategy (NQS) domains with 1 cross-cutting measure
  - Failure to achieve this meant providers got both a 2% PQRS 2018 MPFS penalty and a 2% - 4% VBPM penalty (VBPM penalty based on practice size)
- Only 6 PQRS measures required in 1 NQS domain

Source: ASCRS 7/13/17

Retroactive PQRS & VBPM Penalty Relief

- If you were close to success, you get relief for 2018
  - Example: Practice did 6-8 PQRS & 3 NQS domains (2016)
  - Example: Practice did 9 PQRS but <3 NQS domains (2016)
- Before, if 1-9 providers then a 4% penalty in 2018
    - 2% from PQRS and 2% from VBPM
  - 2018 rule eliminates 2018 PQRS penalty & makes VBPM = 1%
- Before, if 10+ providers, a 6% penalty in 2018
    - 2% from PQRS and 4% from VBPM
  - 2018 rule eliminates 2018 PQRS penalty & makes VBPM = 2%

Source: CMS, ASCRS 11/03/17

Next Steps

- Add new CPT codes to your professional fee schedule
- Note code descriptor and modifier changes
- Stop using deleted CPT codes 1/1/18
- Add ICD-10 codes for dates of service after 10/01/17
- Speed up overpayment refunds (6 yrs, 6 mos, 60 days)
- Prepare for more audits and new types (TPE)
- Review your utilization patterns

Additional Assistance

(800) 399-6565

Website: www.CorcoranCCG.com

Mobile application: Corcoran 24/7