WEST VIRGINIA ACADEMY OF EYE PHYSICIANS & SURGEONS

Presents:

Charting for the 2021 E/M Guidelines & What's New in 2021?

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SEMINAR: Charting for the 2021 E/M Guidelines & What's New in 2021?

by

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Objective*: This program is a general discussion of billing, coding, and reimbursement for evaluation and management codes using the 2021 CPT guidelines. It also includes a review of the requirements for general ophthalmological services. This information is not an official source, except where specific citations are given, nor is it a complete guide on all matters pertaining to reimbursement. Attendees are strongly encouraged to review official instructions promulgated by the Centers for Medicare and Medicaid Services. Local variations between carriers may occur which are not described here. In addition, you should check with payers for specific payment policies and coding instructions. Finally, this information can and does change over time, and may be incorrect at any time following the presentation.*

Disclaimer: *The reader is reminded that this information can and does change over time, and may be incorrect at any time following publication.*

CHARTING FOR THE 2021 E/M GUIDELINES

Charting for the 2021 E/M Guidelines

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Outline

- Medicare error rates
- Motivation for revising E/M guidelines
- Physician time spent
- History
- Problems
- Data
- Management
- Exam
- E/M codes vs Eye codes

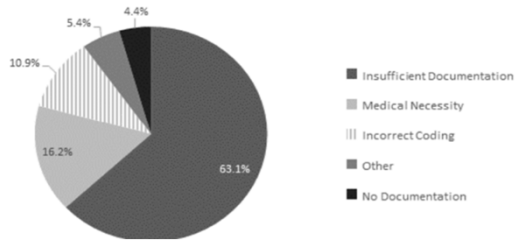
Medicare FFS Improper Payments

- Ophthalmology 2.3% error rate

- Compare to:
- All specialties 6.3% error rate
- Optometry 6.9% error rate

Source: CMS. 2020 Medicare Fee-for-Service Supplemental Improper Payment Data.

Medicare Error Rate



Source: CMS. Comprehensive Error Rate Testing (CERT) 11/16/20

Proper Documentation

- Describes what the physician did and where performed
- Identifies indications for treatment
- Demonstrates informed consent for treatment
- Shows adherence to clinical standards
- Supports medical necessity for a claim

Proper Documentation

- Protects payment programs: ensures the Federal healthcare programs pay the right amount to the right people
- Protects your patients: promotes safety and quality of care and can help ensure that patients get the right are at the right time
- Protects the providers: can help avoid liability or concerns of fraud and abuse

Source: OIG Podcast Transcript (Importance of Documentation) 2011

The Value of Good Charting

"The best prophylactic against a malpractice claim is good rapport. The best defense, once a claim is filed, is good documentation."

Source: Argus, October 1991 (www.omic.com)

Outline

- Medicare error rates
- Motivation for revising E/M guidelines

CMS' Motivation

- CMS' view that office and outpatient E/M were outdated and needed revision
  - CMS' Proposal Patients Over Paperwork stated, *"To alleviate the effects and mitigate the burden associated with continued use of the outdated CPT code set, we are proposing to simplify the office-based and outpatient E/M payment rates and documentation requirements"* July 2018
- Note bloat within EMR as a result of misplaced emphasis on checking boxes

AMA's Guiding Principles

- Decrease administrative burden of charting and coding so there is more available time for patient care
- Decrease chart audits for office E/M services

Caveats

- AMA's E/M guidelines are challenging at first glance
- Some terminology is defined loosely or only in subjective terms
- There are no illustrative cases to help explain them
- Ophthalmic concepts (like lenses) are omitted
- Eye codes are ignored – not integrated
- Professional society instruction restates AMA without further clarification
- Third party payers are largely silent – so far

Outline

- Medicare error rates
- Motivation for revising the E/M guidelines
- Physician time spent

Coding Based on Physician Time

Includes:	Does not include:
Reviewing notes	Registration, technician time
Conversing with providers	Waiting or dilating time
Ordering tests/services	Testing by technician
Coordinating care	Surgical procedures
Examining the patient	Activities that do not require
Educating patient/family	a physician or QHP
Documenting	

Charting Physician Time Spent

- Notes about physician time must be:
  - Accurate
  - Credible
  - Evidentiary
- Avoid vague descriptions that appear to describe check-in to check-out time and inflate time spent

Charting Physician Time Spent

Dot phrase "*CPT based on physician time spent. I spent __##__ minutes with this patient today, reviewing charts from outside physician, doing a medical evaluation, discussing with family members, coordinating care with an outside physician, ordering diagnostic tests from other facilities, and/or documenting in the electronic medical record.*"

Uncontrolled Glaucoma (Weak)

An established patient returns for an IOP check as directed for their COAG, OU. History is otherwise healthy, they are compliant with drops. The exam is VA, SLE, and the IOP exceeds the target pressure. HVF is performed. They are given prescription for a different anti-glaucoma medication and told to return in 1 month. CPT code chosen based on time. Patient spent a total of 40 minutes in the office today.

Physician Time Spent - Example

- Patient dilating in the waiting room 15 min
- Examine patient 10 min
- Performing visual field 10 min
- Discussion with family members 5 min
- Total time spent 40 min

- Established patient: 99215 (40-54 minutes)

Physician Time Spent - Example

- ~~Patient dilating in the waiting room 15 min~~
- Examine patient 10 min
- ~~Performing visual field 10 min~~
- Discussion with family members 5 min
- Total physician time spent 15 min
- Instead of 40 minutes

- Established patient: 99212 (10-19 minutes)

Cataract Evaluation (Better)

An ophthalmologist sees a 66 y/o new patient referred for evaluation and management of decreased vision and inability to read or drive at night. Age-related cataracts are found; informed consent given; surgery scheduled OS. Biometry is performed. CPT code selection based on physician time spent. Physician spent 15 minutes including patient examination, discussing surgical risks and benefits and documenting in medical record.

Physician Time Spent - Example

- Examine patient 10 min
- Discussion with family members 5 min
- Total physician time spent 15 min

- New patient: 99202 (15-29 minutes)

Idiopathic Loss of Vision

A neuro-ophthalmologist sees a 45 y/o new patient referred for evaluation and management of slow loss of vision with unexplained etiology. The patient brings a copy of the complete medical record from the referring physician and ophthalmologist reviewed today. Exam performed and findings discussed with patient. 90 minutes spent with patient, reviewing records from outside physician, performing exam, and documenting in medical record.

Physician Time Spent - Example

- Reviewing patient records today 15 min
- Examine patient 45 min
- Discussion with family members 10 min
- Documenting in patient's record 20 min
- Total physician time spent 90 min

- New patient: 99205 + 99417 x 2 (90-104 minutes)
- Alternate: 99205 + G2212 x 1 (89-103 minutes)

CPT: NP Prolonged Services

Duration of NP Office Visit	Code(s) Use with 99205
<75 mins	Not reported separately
75-89 mins	99205 and 99417 X 1
90-104 mins	99205 and 99417 X 2
≥105 mins	99205 and 99417 X 3 or more for each added 15 mins

Do not report 99417 for any time unit less than 15 minutes

CMS: NP Prolonged Services

Duration of NP Office Visit	Code(s) Use with 99205
≤ 88 mins	Only 99205
89 - 103 mins	99205 and G2212 X 1
104 - 118 mins	99205 and G2212 X 2
119 - 133 mins	99205 and G2212 X 3

Do not report G2212 for any time unit less than 15 minutes

Outline

- Medicare error rates
- Motivation for revising E/M guidelines
- Physician time spent
- History

Prior Guidelines for History

	CPT CODE	HISTORY AND EXAM ELEMENTS PRIOR TO 2021	HISTORY AND EXAM ELEMENTS EFFECTIVE JANUARY 1, 2021
NEW PATIENT	99202	Expanded problem focused history/examination	Medically appropriate history and/or examination
	99203	Detailed history/examination	Physician discretion
	99204	Comprehensive history/examination	Physician discretion
	99205	Comprehensive history/examination	Physician discretion
ESTABLISHED PATIENT	99212	Problem focused history/examination	Physician discretion
	99213	Expanded problem focused history/examination	Physician discretion
	99214	Detailed history/examination	Physician discretion
	99215	Comprehensive history/examination	Physician discretion

Medically Appropriate History

- Reason for the visit (chief complaint)
- Pertinent history of present illness (HPI)
  - When, what, where, why, how?
- Medical observations that address current health status and any contributory systemic diseases (ROS, PFSH)

Diabetes, Floaters

- **CC**: Floaters
- **HPI**: A 63-year-old woman presents for DM recheck and reports an increase in floaters x 3 days
- **Hx**: DM x 7 years

Diabetes, Floaters

- **CC**: Floaters
- **HPI**: A 63-year-old woman presents for DM recheck and reports an increase in floaters OS x 3 days
- **Hx**: DM x 7 years, Humulin, last HbA1c 7.0

Foreign Body

CC: Pain OD

HPI: 35 y/o established patient returns complaining of FBS, redness and tearing OD x 1 day. He notes symptoms started while he was grinding metal at work without protective eyewear.

ROS completed in full

PFSH completed in full

Foreign Body

CC: Pain OD

HPI: 35 y/o established patient returns complaining of FBS, redness and tearing OD x 1 day. He notes symptoms started while he was grinding metal at work without protective eyewear.

ROS no change since last visit

PFSH no change since last visit

Cataract

CC: Annual eye exam

Hx: DM x 20 yrs, well controlled with insulin

Exam: VA 20/400 CC, No improvement with PH or manifest. 2+ NS OU, 1+ PSC OU.

Test: IOL Master performed

Dx: NS cataracts OU, PSC OU

Tx: Scheduled surgery OS

Cataract

CC: Poor vision OU

HPI: 65 y/o, complaining of decreased vision OU x 1 yr, glare while driving at night

Hx: DM x 20 yrs, well controlled with insulin

Exam: VA 20/400 CC, No improvement with PH or manifest. 2+ NS OU, 1+ PSC OU.

Test: IOL Master performed

Dx: NS cataracts OU, PSC OU

Tx: R/B/A discussed, consent signed, scheduled surgery OS

Outline

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MDM: Assessing Problems

MINIMAL	LOW	MODERATE	HIGH
1 self-limited or minor illness/injury	2/more self-limited or minor illness/injury **OR** 1 stable/chronic illness injury **OR** 1 acute uncomplicated illness/injury	1/more chronic illness/injury w/ exacerbation **OR** 2+ stable chronic illness/injury **OR** 1 new illness/injury w/ uncertain prognosis **OR** 1 acute illness/injury, but w/ systemic symptoms **OR** 1 acute complicated injury/illness	1/more chronic illness or injury w/ severe side effect or severe exacerbation **OR** 1 acute or chronic illness/injury which poses imminent threat to life or sight

E/M Documentation: Problems

- Number of problems addressed
- Newly diagnosed?
- Duration: acute vs chronic
- Severity: mild, moderate, severe, urgent, emergent
- Vision threatening, long term damage
- Stability: progressing, worsening, recurring, stable, improving, resolving

E/M Documentation: Problems

- Identify all pertinent problems in assessment
- Describe whether problems are new, worsening, emergent, stable, or improving, and severity
- Indicate which problems were addressed in plan
- Describe if recommended treatment was accepted, deferred, or declined

Blepharitis

CC/HPI: Patient is seen in office complaining of redness, itching and irritation OU x 6 months that is worse in the am. Patient notes crusting upon waking.

Hx: Dry AMD OU

Exam: VA, SLE and includes adnexa finds crusting on the lashes and 1+ conjunctival injection

Dx: 1) Blepharitis OU – new, 2) Dry AMD OU

Tx: Warm compresses twice a day and return in 4 months for dilated exam

Problem level chosen = Moderate

Blepharitis

CC/HPI: Patient is seen in office complaining of redness, itching and irritation OU x 6 months that is worse in the am. Patient notes crusting upon waking.

Hx: Dry AMD OU

Dx: 1) Blepharitis OU – new, 2) Dry AMD OU

Problem level chosen = Moderate

Correct level = Low

Glaucoma

CC/HPI: Here for dilated glaucoma f/u. Compliant with Latanoprost OU and no side effects. Complains of gradual decrease in vision OU x 6 months, but no decrease in activities of daily living.

Exam: CE and DFE, IOP meets target pressure. Slightly worsening 1-2+ NS OU, refraction worse (-4.00D)

Dx: COAG OU – stable

Tx: Refill Latanoprost Rx. RTO in 4 mos for IOP check.

Just 1 problem in assessment / plan - COAG

Glaucoma

CC/HPI: Here for dilated glaucoma f/u. Compliant with Latanoprost OU and no side effects. Complains of gradual decrease in vision OU x 6 months, but no decrease in activities of daily living.

Exam: CE and DFE, IOP meets target pressure. Slightly worsening 1-2+ NS OU, refraction worse (-4.00D)

Dx: COAG OU – stable, age-related cataract OU, myopia

Tx: Refill Latanoprost Rx. Rx new eyeglasses, monitor cataract progression. RTO in 4 mos for IOP check.

3 problems evident

Vitreous Hemorrhage

CC/HPI: A 63 y/o woman reports a sudden loss of vision x3 days affecting her left eye. New floaters OU 3-4 days

Hx: DM x 7 years, using Humalog 4-6 units before meals and Humulin 15 units at bedtime. Last HbA1c was 7.0

Exam: CE and DFE

Tests: B-scan OD, IVFA OS today, IVFA OD when vitreous clears

Dx: Floaters OU, vitreous hemorrhage OD, PDR OU, IDDM poorly controlled

Tx: RTO in 1 week, discussed better BS control, VH resolution, consider PRP

Vitreous Hemorrhage

CC/HPI: A 63 y/o woman reports a sudden loss of vision x3 days affecting her left eye. New floaters OU 3-4 days

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Tests: B-scan OD, IVFA OS today, IVFA OD when vitreous clears

Dx: Floaters OU, vitreous hemorrhage OD, PDR OU, IDDM poorly controlled

Tx: RTO in 1 week, discussed better BS control, VH resolution, consider PRP

3 problems evident: floaters, VH, PDR

Outline

- Medicare error rates
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- History
- Problems
- Data

MDM: Assessing Data

MINIMAL	LOW	MODERATE	HIGH
NONE	Meet one: Cat 1 (need 2) **OR** Cat 2 (need 1)	Meet one: Cat 1 (need 3) **OR** Cat 2 (need 1) **OR** Cat 3 (need 1)	Meet any two: Cat 1 (need 3) **OR** Cat 2 (need 1) **OR** Cat 3 (need 1)

E/M Documentation: Data

- Document review (not simply receipt)
  - External notes
  - External tests
- Provider orders for tests from other sources
- Essential comments by independent historian
- Provider discussion with an outside physician
- Interpretation of tests ordered/performed outside

E/M Documentation: Data

Often Seen Notes	**Preferred Documentation**
• Patient brought records from referring physician	• Reviewed notes from referring physician today

E/M Documentation: Data

Often Seen Notes	**Preferred Documentation**
• Patient brought tests from referring physician	• Reviewed OCT and HVF from referring physician today

E/M Documentation: Data

Often Seen Notes	Preferred Documentation
• Patient to have VEP, ERG tests	Ordered VEP, ERG at the University Hospital

AMD

A new patient is referred by Dr. Cataract for reduced vision following uneventful cataract surgery with possible CME OS. The patient notes VA decreased OS x 1 week. History shows hypertension on medical management and dry AMD for which they use antioxidants. The last exam note and OCT from Dr. Cataract are brought and reviewed in office today. IVFA OU, extended ophthalmoscopy, and FP are performed. The exam reveals CME OS, dry AMD OU, PVD, floaters OU, and lattice degeneration OU. A sub-tenon's Kenalog injection is given OS and patient to return in 2 weeks for dilated fundus exam and OCT.

Documentation Considerations Data - Historian

Often Seen Notes	Preferred Documentation
• Down's syndrome accompanied by mother	• Down's syndrome patient seen in office today. Mother states that patient has decreased vision OU x3 days.

Refractive Error

A 13 y/o new patient for evaluation of blurry vision referred by their pediatrician. Accompanied by mother. Patient notes vision is blurry mostly at distance, mostly while at school, with difficulty reading the Promethean Board.

CE and DFE with refraction performed in office today. Dx: myopia OU. Glasses Rx is given and patient to return in 1 year.

Refractive Error

A 13 y/o new patient for evaluation of blurry vision referred by their pediatrician. Mother states patient's vision is blurry at distance, mostly while at school, with difficulty reading the Promethean Board.

CE and DFE with refraction performed in office today. Dx: myopia OU. Glasses Rx is given and patient to return in 1 year.

Documentation Considerations Data - Discussion

Often Seen Notes	Preferred Documentation
• Refer patient to retinal specialist	• Called and spoke to retina specialist - discussed patient for referral

Documentation Considerations Data - Interpretation

Often Seen Notes	Preferred Documentation
• MRI reviewed	• Interpretation of MRI today shows blow-out fracture involving the orbital floor and medial orbital wall

Outline

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- Management

MDM: Assessing Management

Examples:	Examples:	Examples:	Examples:
- No treatment - Watchful waiting - Rest	- OTC meds or readers - Glass, CL Rx f/u ≥1 yr - Consideration/Decision for minor surgery - Self-care (eg, warm compresses)	- RX med/optical, f/u weekly, monthly, quarterly - Consideration/Decision minor surgery with identified risk factors - Consideration/Decision for major surgery - Unknown treatment plan	- Drug therapy requiring intensive monitoring of toxicity (eg, IV steroid) - Consideration/Decision for major surgery with identified risk factors - Consideration/Decision for emergency major surgery - Hospitalization

Management

Patient management decisions, made at the visit associated with the patient's problem(s), are graded based on the risk of complications, morbidity, and/or mortality. This includes possible management options selected and those considered but not selected after discussion with the patient and/or family.

Management

- Does the physician …
  - Identify treatment options?
  - Explain all options?
  - Give informed consent?

MDM: Assessing Management

- Note timing (*e.g.,* urgent, emergent)
- Note identified risk factors

Cataract

- **Exam:** CE and DFE finds worsening cataracts 2+ NS OU, BCVA 20/40 OU
- **Dx:** NS OU
- **Tx:** Recommend cataract surgery OS, risks, benefits and alternatives discussed. Patient would like to wait for now. Recommend wearing UV protective eyewear.

- Management Level chosen based on eyewear = Low

Cataract

- **Exam:** CE and DFE finds worsening cataracts 2+ NS OU, BCVA 20/40 OU
- **Dx:** NS OU
- **Tx:** Recommend cataract surgery OS, risks, benefits and alternatives discussed. Patient would like to wait for now. Recommend wearing UV protective eyewear.

- Management Level chosen based on recommended major surgery = Moderate

Hyphema

Dx: Hyphema following trauma OD and elevated IOP OD

Tx: Bed rest; PF OD qid, homatropine 5% OD tid, Trusopt OD tid

Management Level chosen based on prescription medications given = Moderate

Hyphema

Dx: Hyphema following trauma OD and elevated IOP OD

Tx: Bed rest; PF OD qid, homatropine 5% OD tid, Trusopt OD tid. RTO tomorrow for IOP check.

Management Level chosen based on prescription medications given and close f/u = High

Congenital Cataract

CC/HPI: Cataract chk in 8 m/o. Mom describes decreased vision in last 3 mos.

Hx: Down's syndrome, heart abnormalities

Exam: CE and DFE

Tests: B-scan OU

Dx: Congenital cataracts

Tx: Lens removal w/o IOL, OS. Get surgical clearance due to anesthesia risk related to heart abnormalities

Management Level chosen based on recommended major surgery = Moderate

Congenital Cataract

CC/HPI: Cataract chk in 8 m/o. Mom describes decreased vision in last 3 mos.

Hx: Down's syndrome, heart abnormalities

Exam: CE and DFE

Tests: B-scan OU

Dx: Congenital cataracts

Tx: Lens removal w/o IOL, OS. Get surgical clearance due to anesthesia risk related to heart abnormalities

Management Level chosen based on identified risk factors = High

Outline

- Medicare error rates
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- Exam

Exam

- The LOS for E/M does not depend on eye exam elements
- Physician discretion
- The LOS for eye codes does depend on exam elements

EMR Revisions

- Reduced requirements for history and exam
- Reduced need for scribes to chart everything
- No benefit to copy forward
- No merit in duplicative notes
- No value in nonessential or extraneous notes
- No justification for repeating exam elements that do not change or don't contribute to the assessment and plan
- ONLY essential history and exam required

Exam

- **CC/HPI** Established glaucoma patient returns for 3 mos IOP check. CE/DFE done on prior visit.
- Is motility necessary?

Exam

- **CC/HPI** Established wet AMD patient returns for 8 week check. CE/DFE done on prior visit.
- Are confrontation fields necessary?

Exam

- **CC/HPI** Established subconjunctival hemorrhage patient returns for 4 week check. CE/DFE done on prior visit.
- Is IOP necessary?

Outline

- Medicare error rates
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- Exam
- E/M codes vs Eye codes

Comprehensive Eye Exam (920x4)

- Required elements:
- Evaluate complete visual system
- Initiation or continuation of diagnostic and treatment programs
- History
- General medical observation
- Gross visual fields
- Basic sensorimotor exam
- External exam
- Ophthalmoscopy

Source CPT

Intermediate Eye Exam (920x2)

- Required elements:
- Evaluation of a new or existing condition complicated with a new diagnostic or management problem not necessarily relating to the primary diagnosis
- Other diagnostic programs *as indicated*
- Initiation or continuation of treatment
- History
- General medical observation
- External ocular and adnexal exam

Source: CPT

Arcus Senilis

CC: Established patient with white line/circle OU. No change in VA. No pain. No trauma.
Exam: VA, SLE
Tests: None
Dx: Arcus senilis OU
Tx: Reassure

Arcus Senilis

CC: Established patient with white line/circle OU. No change in VA. No pain. No trauma.
Exam: VA, SLE
Tests: None
Dx: Arcus senilis OU
Tx: Reassure

92012 cannot be used.
No initiation or continuation of treatment

Ocular Hypertension

CC: New patient advised to see eye doctor to check IOP
Exam: CE, DFE, IOP = 21 mmHg
Tests: Corneal pachymetry
Dx: Ocular hypertension
Tx: Monitor. RTO 6 mos; VF. No Rx at this time

Ocular Hypertension

CC: New patient advised to see eye doctor to check IOP
Exam: CE, DFE, IOP = 21 mmHg
Tests: Corneal pachymetry
Dx: Ocular hypertension
Tx: Monitor. RTO 6 mos; VF. No Rx at this time

92004 cannot be used.
No initiation or continuation of treatment

Controlled Glaucoma

CC: Established patient returns for IOP check
Exam: VA, SLE, IOP meets target pressure
Tests: OCT and VF
Dx: Stable moderate COAG OU
Tx: Continue anti-glaucoma meds; RTO 4 mos

Controlled Glaucoma

CC: Established patient returns for IOP check
Exam: VA, SLE, IOP meets target pressure
Tests: OCT and VF
Dx: Stable moderate COAG OU
Tx: Continue anti-glaucoma meds; RTO 4 mos

92012 cannot be used.
No evaluation of a new or existing condition complicated with a new diagnostic or management problem not necessarily relating to the primary diagnosis.

Herpes Keratitis

CC: 2 wk recheck dendritic lesion OS as directed
Exam: VA, SLE, CF, IOP
Tests: None
Dx: Herpes keratitis OS, improved significantly
Tx: Continue meds; RTO 2 wks

Herpes Keratitis

CC: 2 wk recheck dendritic lesion OS as directed
Exam: VA, SLE, CF, IOP
Tests: None
Dx: Herpes keratitis OS, improved significantly
Tx: Continue meds; RTO 2 wks

92012 cannot be used.
No evaluation of a new or existing condition complicated with a new diagnostic or management problem not necessarily relating to the primary diagnosis.

Conclusion

- E/M level of service is gauged based on problems, data, management – careful notations are vital
- Physician time spent is rarely the best approach for coding exams, and requires careful description
- Within E/M, history and exam are only what's medically appropriate in the physician's determination
- Payers' requirements supporting medical necessity for services are a significant consideration in charting

Conclusion

- Avoid inefficient, duplicative charting
- Time saved on charting can be used for patient care
- Eye code requirements remain unchanged, yet eye codes cannot be used universally

More help…

For additional assistance or confidential consultation, please contact us at:

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WHAT'S NEW IN 2021?

What's New in 2021?
Documentation and Coding Update

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Outline

- Payment issues
- New and revised codes
  - 2021 E/M exam changes
- CMS regulatory matters
- Quality Payment Program – 5th year

2021 Medicare Physician Fee Schedule (MPFS)

- MACRA +0.00% update
- CY 2021 Conversion factor = $34.8931
  - Down $1.20 (-3.3%)
- Consolidate Appropriations Act of 2021
  - $3 Billion for MPFS
  - 3.75% increase on $800 Billion spend for Part B Medicare

Source: CMS-1734-FC, BBA of 2018, CCA 2021

Economic Impact of 2021 MPFS

- Ophthalmology -6%
- Optometry -4%
- CCA 2021 erased the proposed deficit

Source: FR 2020-26815, Public comment 12/02/20 TABLE 106: CY 2021 MPFS Estimated Impact on Total Allowed Charges by Specialty

Recent Congressional Action

- Delay G2211 (complexity add-on) for 3 years
- Extension of work GPCI floor to 1/1/2024

Source: Consolidated Appropriations Act, 2021

2021 MPFS

CPT	Description	2020	2021
92014	Comprehensive eye exam established	$128	$128
99204	E/M new patient level 4 exam	$167	$170
92012	Intermediate eye exam, established	$89	$91
99214	E/M established patient level 4 exam	$110	$131
66984	Cataract surgery with IOL	$557	$548

Source: CMS-1734-P

2021 ASC Payment Update

- 2021 ASC conversion factor = $48.952 (+2.4%)
- **QualityNet:** *"ASCs that do not meet program requirements … may receive a two percent reduction ..."*
- **CMS:** 100% of ASCs will get the full payment in 2021 due to COVID-19 in 2020

Source: CMS-1736-F, QualityNet, ASCRS Regulatory Alert 12/03/20

2021 ASC Payment Rates

CPT	Procedure	2019	2020	2021
66984	ECCE w IOL	$977	$1,013	$1,045
66821	YAG Capsulotomy	$256	$256	$256
66761	Laser PI	$190	$190	$181
67036	Vitrectomy, PP	$1,772	$1,836	$1,882
15823	Blepharoplasty	$798	$820	$871
0191T	GDD, internal	$2,680	$2,717	$2,831

Source: CMS 2019, 2020 and 2021 NFRM ASC Addenda

2021 ASC Quality Reporting Program

- New 2021 ASC Quality Reporting Specifications Manual now available (Version 10.0)
  - Applies for ASC services with dates of service from 1/1/2021 thru 12/31/2021
  - For 2020 dates of service, Version 9.0 applies

QualityNet

Source: CMS QualityNet website.

2021 ASC Quality Reporting Program

- "Fewer Than 240 Rule" (Begun in 2020)

CMS determined that some ASCs have relatively small numbers of Medicare claims and instituted a claims threshold for ASCs with fewer than 240 Medicare claims (primary plus secondary payer) per year. For example, an ASC with fewer than 240 Medicare claims in CY 2019 (for the CY 2021 payment determination year) would not be required to participate in the ASCQR Program in CY 2020 (for the CY 2022 payment determination year).

- If true, your ASC avoids the 2021 penalty
- You did not have to participate in 2020
- You avoid the 2022 penalty also

QualityNet

Source: CMS QualityNet website. ASC Specifications Manual Ver. 10.0

ASC Quality for 2021

- Quality Measures ASC 1 thru ASC-4 have no 2021 changes in reporting while CMS continues to revise measures
  - ASC-1: Patient Burn
  - ASC-2: Patient Fall
  - ASC-3: Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant
  - ASC-4: All-Cause Hospital Transfer/Admission
- Important: There is no requirement for ASC reporting of G8907 for 2021 (same as 2020)

Source: CMS, OOSS, ASCRS Regulatory Alert

ASC Quality for 2021

- Kept Quality Measure ASC-11
  - ASC-11 Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery
  - Reporting remains voluntary, but any reported data will be public
  - Report via CMS Web-based tool after end of reporting year
  - New: Claims w/ modifier 55 and 56 are excluded
- Kept Quality Measure ASC-14
  - ASC-14 Unplanned Anterior Vitrectomy
    - Relevant CPT codes: 66982, 66983, and 66984
    - Data sources for this according to CMS are *"ASC medical records, incident/occurrence reports and variance reports"*
  - Report via CMS Web-based tool

Source: CMS FR 2020-26815 Public Commnet, QualityNet, OOSS, ASCRS

HOPD Payment 2021

- Various adjustments result in an update to HOPD payment rates of 2.4%

Source: CMS-1736-FC

2021 HOPD Medicare Payment Rates

CPT	Procedure	2019	2020	2021
66984	ECCE w IOL	$1,917	$2,022	$2,078
66821	YAG Capsulotomy	$496	$507	$504
15823	Blepharoplasty	$1,549	$1,623	$1,715
0191T	GDD, internal	$3,640	$3,818	$3,918

Source: CMS 2021 NFRM *Addendum B*

Prior Authorization in HOPD Continues

- CMS implemented a prior authorization process for certain procedures done in the HOPD in mid-2020
  - It continues in 2021
  - It includes blepharoplasty (15820-15823)
  - Other codes affected:
    - Blepharoptosis: 67900-67908; eyelid retraction: 67911
    - Botox injection (64612, 64615), botulinum drugs (J0585-J0588)
  - Prior authorization is <u>not needed</u> in an ASC setting

Source: *FR Vol. 84, No. 218, Table 65. 11/12/19, FR Vol. 85, 1/03/20 CMS-1717-FC*

Outline

- Payment issues
- New and revised codes
  - 2021 E/M exam changes

New CPT Code

- 99072 Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency as defined by law, due to respiratory-transmitted infectious disease
- Code released on 9/08/20; not in printed CPT manual
- Only a few private payers recognize it – most don't pay
  - UHC on 11/18/20 said they will not recognize it
- Only for use in the office setting
- Medicare treats PPE as incidental (bundled)

Source: AMA CPT Assistant Special Edition: September Update; UHC Provider Bulletin 11/18/20.

New CPT Code

- 92229 Imaging of retina for detection or monitoring of disease; point-of-care automated analysis and report, unilateral or bilateral

- ►Do not report 92229 in conjunction with 92133, 92134, 92227, 92228, 92250 ◄

Source: AMA CPT Manual 2021

Revised CPT Codes

- 92227 ~~Remote~~ Imaging <u>of retina</u> for detection ~~of retinal disease (eg, retinopathy in a patient with diabetes)~~ or monitoring of disease; ~~with analysis and report~~ <u>remote clinical staff review and report</u>, unilateral or bilateral
- ► (Do not report 92227 in conjunction with 92133, 92134, 92228, 92229, 92250)◄
- 92228 with remote physician or other qualified health care professional interpretation and report, unilateral or bilateral
- ► (Do not report 92228 in conjunction with 92133, 92134, 92227, 92229, 92250) ◄
- Effective January 1, 2021

Source: AMA CPT Manual 2021

New CPT Code

- 0604T Optical coherence tomography (OCT) of retina, remote, patient-initiated image capture and transmission to a remote surveillance center, unilateral or bilateral; initial device provision, set-up and patient education on use of equipment
- 0605T …remote surveillance center technical support, data analyses and reports, with a minimum of 8 daily recordings, each 30 days
- Effective: July 1, 2020

Source: AMA CPT Manual 2021

New CPT Code

- 0606T …review, interpretation and report by the prescribing physician or other QHP of remote surveillance center data analyses, each 30 days
- Effective: July 1, 2020

Source: AMA CPT Manual 2021

New Category III Code

- 0615T Eye-movement analysis without spatial calibration, with interpretation and report
- ►(Do not report 0615T in conjunction with 92540, 92541. 92542, 92544, 92545, 92546, 92547)◄
- Effective July 1, 2020

Source: AMA CPT Manual 2021

New CPT Code

- 0616T Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed; without removal of crystalline lens or intraocular lens, without insertion of intraocular lens
- 0617T …with removal of crystalline lens and insertion of intraocular lens
- 0618T …with secondary intraocular lens placement or intraocular lens exchange
- Effective: July 1, 2020

Source: AMA CPT Manual 2021

Reminder: 2020 HCPCS C-code

- C1839 *Iris implant*
- Product Name: CUSTOM*FLEX*® ARTIFICIAL*IRIS*
- Cost ~$8,000
  - FDA approval June 2018
- Effective 1/1/2020

Source: CMS;
Image courtesy of VEO Ophthalmics

New CPT Code

- 0621T Trabeculostomy ab interno by laser;
- 0622T Trabeculostomy ab interno by laser; with use of ophthalmic endoscope

(Do not report in conjunction with 92020)

Source: AMA CPT Manual 2021

Revised CPT Code

- 76513 Ophthalmic ultrasound, diagnostic; anterior segment ultrasound, immersion (water bath) B-scan or high resolution biomicroscopy, unilateral or bilateral
- (For scanning computerized ophthalmic diagnostic imaging of the anterior and posterior segments using technology other than ultrasound, see 92132, 92133, 92134)
- Effective January 1, 2021

Source: AMA CPT Manual 2021

New Add-on CPT Code

- +99417
- Prolonged office or other outpatient E/M service(s) beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes of total time
  - ►List separate in addition to 99205, 99215◄
  - ►Do not report 99417 for any time unit less than 15 mins◄
- Effective January 1, 2021
- Note: CMS guidance at odds w/ CPT

Source: AMA CPT Manual 2021

New HCPCS Code

- G2212
- Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (List separately in addition to CPT codes 99205 or 99215 for office or other outpatient E/M services)
- For Part B, this new code works like +99417 but time begins at the high end of the time span for 99205, 99215
- Effective January 1, 2021

Revised Add-on CPT Codes

- +99415 Prolonged clinical staff service (the service beyond the highest time in the range of total ~~typical service~~ time of the service) during an evaluation and management in the office or outpatient setting, direct patient contact with physician supervision; first hour (List separately in addition to code for ~~office or other~~ outpatient **Evaluation and Management** service)
- +99416 each additional 30 minutes (List separately in addition to code for prolonged service)
- Effective January 1, 2021

Source: AMA CPT Manual 2021

Revised Add-on CPT Code

- +99356 Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (List separately in addition to code for inpatient or observation **Evaluation and Management** service)
- Effective January 1, 2021

Source: AMA CPT Manual 2021

New HCPCS J-code

- **J7351** Injection, bimatoprost, intracameral implant, 1 microgram
- DURYSTA® (bimatoprost implant) 10 mcg
  10 units on claim (Effective 10/1/20)
- Single Use only
  - Indicated for open angle glaucoma or ocular hypertension
  - Directions for use include warnings and precautions and *"…should be limited to a single implant per eye"*

Source: CMS. https://www.cms.gov/files/document/2020-hcpcs-application-summary-quarter-2-2020-drugs-and-biologicals-updated-07312020.pdf

Continued Payment for Omidria

- **J1097** phenylephrine 10.16 mg/ml and ketorolac 2.88 mg/ml ophthalmic irrigating solution, 1 ml
- Omidria
- Qualifies for separate payment in ASCs under the CMS policy for non-opioid pain management surgical drugs
- Effective October 1, 2020

Source: CMS-1736-FC

2021 Revising E/M Coding

- Office or other outpatient services (99202-99215)
  - 99201 deleted
- Revise E/M code definitions
  - Coding LOS based on time or medical decision making
  - History and exam as medically appropriate
- No changes to general ophthalmological services (920xx)

Source: AMA CPT Manual 2021

Old vs New E/M Guidelines

- Prior E/M coding relies on CPT and HCFA's 1995 General or 1997 Specialty guidelines
- Prior to 2021, there are significant coding differences between new and established patients
- Inpatient codes will change later, but not in 2021
- History is not a critical determinant of level of service
- Exam is not a critical determinant of level of service
- Physician time spent on the encounter is critical
- Medical decision making is critical

Physician Time Spent

- Preparing to see the patient (e.g., review of tests)
- Reviewing separately obtained history
- Performing a medically appropriate evaluation
- Counseling and educating the patient/family/caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other health care professionals (when not separately reported on a claim)
- Documenting clinical information in the electronic or other health record

Physician Time Spent

- Independently interpreting results (not separately reported on a claim) and communicating results to the patient/family/caregiver
- Care coordination (not separately reported on a claim)
- Do not count time for separately reported tests ordered or performed and interpreted by the physician (e.g., angiography, extended ophthalmoscopy)

Physician Time Spent

- For coding purposes, time for these services is the total physician time on the date of the encounter.
- It includes both the face-to-face and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter
- It includes time in activities that require the physician or other qualified health care professional and does not include time in activities normally performed by clinical staff

Physician Time Spent - Example

- Review chart notes from outside physician 12 min
- Examine patient 15 min
- Discussion with family members 6 min
- Telephone call with outside physician 9 min
- Orders written for lab work and X-ray 8 min
- Total physician time spent 50 min

- New patient: **99204**
- Established patient: **99215**

2021 E/M Level of Service

Code	Description	Time
99202	NP, E/M SF MDM	15-29 min
99203	NP, E/M Low MDM	30-44 min
99204	NP, E/M Moderate MDM	45-59 min
99205	NP, E/M High MDM	60-74 min

2021 E/M Level of Service

Code	Description	Time
99211	EP, E/M minimal	N/A
99212	EP, E/M SF MDM	10-19 min
99213	EP, E/M Low MDM	20-29 min
99214	EP, E/M Moderate MDM	30-39 min
99215	EP, E/M High MDM	40-54 min

2021 E/M Coding: Problems

- "The number and complexity of problem(s) that are addressed during the encounter."
- A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter
- A problem is addressed or managed when it is evaluated OR treated during the encounter by the physician
- A problem that is not addressed, such as one outside of the scope of the physician's practice, is not counted for E/M

Source: AMA CPT E/M Office Revisions

E/M Problem Differentiation

Code	Level	Problem(s)
992x5	High	1 acute or chronic illness or injury that poses a threat to life or function
	High	1 or more chronic illnesses with severe exacerbation, progression
992x4	Mod	1 acute complicated injury
	Mod	1 acute illness with systemic symptoms
	Mod	1 undiagnosed new problem with uncertain prognosis
	Mod	2 or more stable chronic illnesses
	Mod	1 or more chronic illnesses with exacerbation, progression

Source: AMA, Table 2 – CPT E/M Office Revisions

E/M Problem Differentiation

Code	Level	Problem(s)
992x3	Low	1 acute uncomplicated illness or injury
	Low	1 stable chronic illness
	Low	2 or more self-limited or minor problems
992x2	SF	1 self-limited or minor problem
99211	N/A	N/A

Source: AMA, Table 2 – CPT E/M Office Revisions

2021 E/M Coding: Data

- "... amount and/or complexity of data to be reviewed and analyzed … for the encounter."
- Data includes:
  - Notes from an outside provider/facility
  - Tests from an outside provider/facility
  - Orders for tests to be performed/billed elsewhere
  - Historian (*e.g.,* parent, spouse, caregiver)
  - Discussion of management or test with another physician
  - Interpretation of a test performed elsewhere

2021 E/M Coding: Management

- "The risk of complications, morbidity, and/or mortality of patient management decisions made at the visit, associated with the patient's problem(s), the diagnostic procedure(s), treatment (s). This includes the possible management options selected and those considered, but not selected, after shared MDM with the patient and/or family."

2 of 3 Rule

Problems	Data	Management	EM Level
High	Extensive	High	5
Moderate	Moderate	Moderate	4
Low	Limited	Low	3
Minimal	Min/None	Minimal	2

CMS MPFS Changes for 2021

CPT	New Patients	%	CPT	Established Patients	%
99205	Level 5 E/M	**6.3%**	99215	Level 5 E/M	**23.5%**
99204	Level 4 E/M	**1.7%**	99214	Level 4 E/M	**18.8%**
99203	Level 3 E/M	**4.0%**	99213	Level 3 E/M	**21.4%**
99202	Level 2 E/M	**-4.2%**	99212	Level 2 E/M	**23.1%**
99201	Level 1 E/M	**-100.0%**	99211	Level 1 E/M	**-1.8%**
92004	Comp Eye	**-0.1%**	92014	Comp Eye	**0.2%**
92002	Intermed Eye	**2.4%**	92012	Intermed Eye	**1.3%**

Source: CMS-1734-FC MPFS for 2021 as revised by CAA 2021

Current Coding Pattern

CPT	New Patients	λ	CPT	Established Patients	λ
99205	Level 5 E/M	**1.8%**	99215	Level 5 E/M	**0.7%**
99204	Level 4 E/M	**31.8%**	99214	Level 4 E/M	**8.0%**
99203	Level 3 E/M	**8.1%**	99213	Level 3 E/M	**11.4%**
99202	Level 2 E/M	**1.0%**	99212	Level 2 E/M	**2.2%**
99201	Level 1 E/M	**0.1%**	99211	Level 1 E/M	**0.2%**
92004	Comp Eye	**52.0%**	92014	Comp Eye	**48.2%**
92002	Intermed Eye	**5.2%**	92012	Intermed Eye	**29.4%**

Source: 2018 CMS utilization data – Specialty 18, Ophthalmology

Estimated Future Coding Pattern

CPT	New Patients	λ	CPT	Established Patients	λ
99205	Level 5 E/M	**3.0%**	99215	Level 5 E/M	**2.0%**
99204	Level 4 E/M	**67.0%**	99214	Level 4 E/M	**48.0%**
99203	Level 3 E/M	**8.0%**	99213	Level 3 E/M	**32.9%**
99202	Level 2 E/M	**5.0%**	99212	Level 2 E/M	**2.0%**
99201	Level 1 E/M	**0.0%**	99211	Level 1 E/M	**0.1%**
92004	Comp Eye	**16.0%**	92014	Comp Eye	**8.0%**
92002	Intermed Eye	**1.0%**	92012	Intermed Eye	**7.0%**

ICD-10 Updates

- New chapter
- Chapter 22 - Codes for Special Purposes (U00 – U85)
- Only 2 codes in the chapter for now:

- U07.0 Vaping-related disorders
- U07.1 COVID-19
  - More specific than existing code B34.2, coronavirus infection

Source: CMS – ICD-10 Revisions effective 10/1/20

ICD-10 Updates

- New guidance on insulin and diabetes drugs
- *If the patient is treated with both insulin and an injectable non-insulin antidiabetic drug, assign codes Z79.4, Long-term (current) use of insulin, and Z79.899, Other long term (current) drug therapy.*
- *If the patient is treated with both oral hypoglycemic drugs and an injectable non-insulin antidiabetic drug, assign codes Z79.84, Long-term (current) use of oral hypoglycemic drugs, and Z79.899, Other long-term (current) drug therapy.*

Source: CMS – ICD-10 Revisions effective 10/1/20

ICD-10 Updates

- Chapter 7 – Diseases of the Eye and Adnexa (H00-H59)
- New codes
- H55.8 Deficient smooth pursuit eye movements
  - No laterality
  - Only 4 characters
- Revised codes
- H18.5- Hereditary Corneal Dystrophies
  - All the existing codes in this area gained laterality

Source: CMS – ICD-10 Revisions effective 10/1/20

ICD-10 Updates

- Chapter 3 – Diseases of the Blood and Blood-Forming Organs and Certain Disorders Involving the Immune Mechanism (D50-D89)
- D57.- Sickle-cell
  - Increased specificity

- Chapter18 – Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified
- R51.- Headache
  - No longer a 3-character code
  - Increased specificity

Source: CMS – ICD-10 Revisions effective 10/1/20

ICD-10 Updates

- Chapter 19 – Injury, Poisoning And Certain Other Consequences of External Causes (S00-T88)

- T86.84- Corneal Transplant
  - Gained 7th character for laterality

Source: CMS – ICD-10 Revisions effective 10/1/20

ICD-10 Updates

- Chapter 20 – External Causes of Morbidity (V00-Y99)
- New codes
- Y77.11 Adverse incidents with contact lenses
- Y77.19 Adverse incidents with other ophthalmic devices

Source: CMS – ICD-10 Revisions effective 10/1/20

ICD-10 Updates

- Chapter 21 – Factors influencing health status and contact with health services (Z00-Z99)
- New:
- Z03.82- Encounter for observation for suspected inserted (injected) foreign body ruled out
  - Has laterality
- Revised:
- Z88.- Allergy status
  - Minor changes in wording

Source: CMS – ICD-10 Revisions effective 10/1/20

CPT Assistant – February 2020

- **Question:** What code should be reported for a medial or spindle procedure for a diagnosis of punctal eversion? If it is performed at the same time as a tarsal strip procedure and the surgeon specifically notes that it was done through a separate incision, may both codes be reported?
- **Answer:** It would be appropriate to report both codes 68705, *Correction of everted punctum*, for the spindle and code 67917, *Repair of ectropion; extensive (eg, tarsal strip operations)*, for the tarsal strip procedure because each is performed in separate locations … [but in] cases when the tarsal strip procedure alone causes the punctum to rotate into the correct postion … it would not be appropriate
- **Note:** NCCI edits bundle 68705 with 67917

Source: AMA. CPT Assistant – February 2020 Volume 30 Issue 2

CPT Assistant – March 2020

- **Question:** Is it appropriate to append HCPCS modifier TC to codes 99453 and 99454 for the technical component associated with the service(s) described by these codes?
- **Answer:** No, it is not … [these remote physiologic monitoring codes] describe physician services that may not be split into technical and professional components.

Source: AMA. CPT Assistant – March 2020 Volume 30 Issue 3

CPT Assistant – March 2020

- **Question:** The patient has an eyelid defect following a Mohs procedure and had the deficit closed/repaired using a lateral tarsal strip procedure with an advancement flap. What codes are reported … when there is no ectropion or entropion?
- **Answer:** The advancement flap reconstruction would be reported using code 14060, Adjacent tissue transfer … eyelids, nose ... Defect 10 sq cm or less … In addition, if the development of the flap will [then] cause an ectropion requiring a tarsal strip procedure [67917] …would additionally be reported ... [since] the … flap alone may pull the lower eyelid away from the globe, causing an ectropion
- Note: NCCI edits don't bundle 14060 and 67917

Source: AMA. CPT Assistant – March 2020 Volume 30 Issue 3

CPT Assistant – May 2020

- **Question:** A [procedure biopsy is performed] via the tangential technique (shave, scoop, saucerize, or curette). After the biopsy is performed, it is noted that the depth of the biopsy reached the subcutaneous fat … Which is the most appropriate CPT biopsy code to report …?
- **Answer:** A tangential biopsy performed … that inadvertently penetrates the subcutaneous space does not fully rise to the level of incisional biopsy … 11102 … and … 11103 [still apply]

Source: AMA CPT Assistant – May 2020 Volume 30 Issue 5

CPT Assistant – May 2020

- **Question:** Over the years, CPT has listed different time frames when modifier 22 is appended … Is the assignment of modifier 22 based on the specific type of procedure … or is a documentation standard required to append this modifier?
- **Answer:** The use of modifier 22, Increased Procedural Services, depends on several factors as indicated in Appendix A of the CPT code set … When the work required is substantially greater … Documentation must support the substantial additional work and the reason

Source: AMA CPT Assistant – May 2020 Volume 30 Issue 5

CPT Assistant – June 2020

- **Question:** A stent designed to lower the high pressure of open-angle glaucoma in a patient's eye was surgically implanted in the subconjunctival space utilizing an external approach. What code would be reported for this procedure?
- **Answer:** Code 66183, Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach, should be reported … because the stent drains aqueous fluid from the eye … this code was valued by [CMS] for a typical device insertion under a scleral flap with a conjunctival bleb. New techniques may require the use of modifier 52 … and 22… depending on the difference in physician work

Source: AMA CPT Assistant – June 2020 Volume 30 Issue 6

CPT Assistant – November 2020

- **Question:** Does the word "device" in the code descriptors of Category III codes 0191T and +0376T mean a "stent"?
- **Answer:** Yes, the term "device" could be a single stent left in the eye. Category III code 0191T … is used to report the initial device … insertion, while add-on code +0376T is used for each additional device or stent placed at the same encounter.

Source: AMA CPT Assistant – October 2020 Volume 30 Issue 11

Outline

- Payment issues
- New and revised codes
  - 2021 E/M exam changes
- CMS regulatory matters

Sequestration

- Sequestration was scheduled to resume January 1, 2021
- Congress initially extended the moratorium on sequestration for 3 months through March 31, 2021
- 05/15/2021 AMA announced an extension on the moratorium through rest of 2021

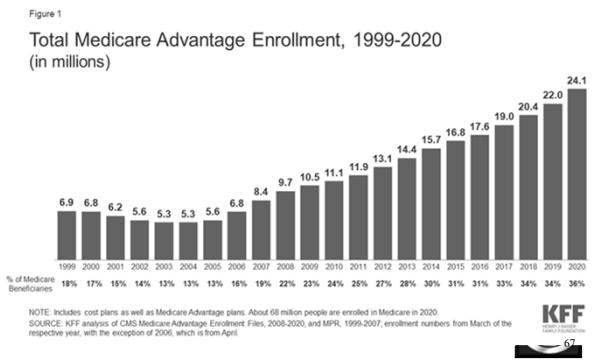
Source: Consolidated Appropriations Act, 2021

2021 Part B Annual Deductible

- Medicare Part B deductible $203
- Up $5 from 2020 deductible
- Effective date 1/1/21

Source: Federal Register Vol. 85, No. 219 11/12/20

Medicare Advantage



Drug Payments – MFN Model

- Most Favored Nation Model: The top 50 drugs in terms of Medicare Part B payments – excluding COVID-19 treatments - will be governed differently as of 1/01/20. All states and all Part B providers are affected.
- CMS: "*The Most Favored Nation (MFN) Model tests an innovative way to lower prescription drug costs by paying no more for high-cost Medicare Part B drugs and biologicals than the lowest price that drug manufacturers receive in other similar countries …*"
  - Eylea, Lucentis, and Botox are on the list
- Formula:
  - Year 1-4: 75% based on ASP and 25% on MFN pricing
  - Year 5-7: 100% MFN pricing

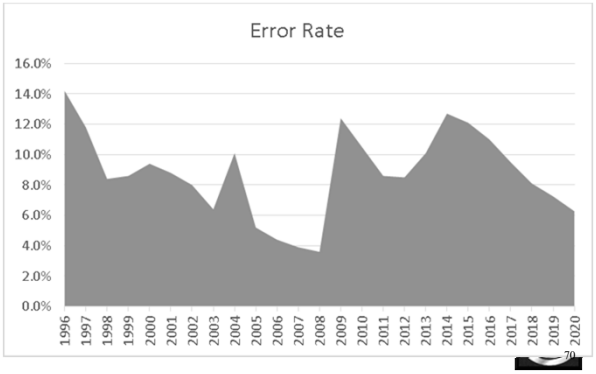
Source: CMS. Newsroom. FACT SHEET: Most Favored Nation Model for Medicare Part B Drugs and Biologicals Interim Final Rule with Comment Period. 11/20/20. CMS. MFN Model. 11/30/20.

Telemedicine in 2021

- Telemedicine (TM) during the pandemic expanded
  - Broader coverage
  - Payment of some codes not normally covered by CMS
  - Raised payments for some services
- CMS wrote special rules for TM that remain in place during the public health emergency (PHE)
- CMS approved a list of services, known as "Category 3", that will remain approved for telemedicine use for the remainder of the year in which the PHE ends
- Congressional action required for further expansion

Source: CMS

Medicare Error Rate (1996 – 2020)

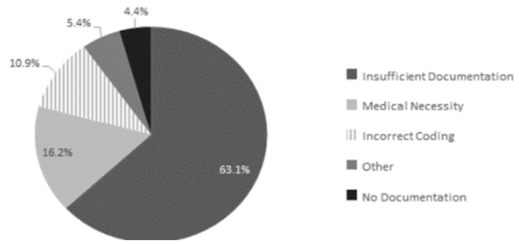


Medicare FFS Improper Payments

- Ophthalmology 2.3% error rate
- Compare to:
- All specialties 6.3% error rate
- Optometry 6.9% error rate

Source: CMS. 2020 Medicare Fee-for-Service Supplemental Improper Payment Data.

Medicare Error Rate



Source: CMS. Comprehensive Error Rate Testing (CERT) 11/16/20

Provider Enrollment Validation – Cycle 2

- Began May 31, 2016
- MACs send notifications to providers and designates 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
- Deactivation of providers is temporarily on hold during the PHE declaration but providers can still revalidate even though the site will not reflect it
- Deactivation resumes once the PHE ends

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

FTC Amends Contact Lens Rule

- The Federal Trade Commission (FTC) announced 6/23/20 approval of the new Contact Lens Rule (effective 10/16/20)
- FTC: You are exempt from the new rule if you lack a financial interest in the sale of contact lenses. There are 4 ways to comply:

1) Request pt sign separate acknowledgement of receipt for CL Rx
2) Pt can sign the prescriber-retained copy of CL Rx which contains a statement confirming receipt
3) Pt can sign the prescriber-retained copy of the sales receipt for the exam that contains statement confirming receipt of CL Rx
4) Give pt a digital copy of the CL Rx, but retain evidence that it was sent, received, or made accessible, downloadable, and printable.

Source: FTC. Final Amendments to the Agency's Contact Lens Rule 6/23/20

Outline

- Payment issues
- New and revised codes
  - 2021 E/M exam changes
- CMS regulatory matters
- Quality Payment Program – 5th year

Quality Payment Program - 2020

- New: May 20, 2021
- CMS announced all Cost Scoring for 2020 reporting would be re-weighted from 15% to 0%
  - 10% goes to Quality and 5% goes to Program Interoperability
- All eligible providers in MIPS, APMs, Groups, and Virtual Groups are included.
- New weights for 2020 with this reduction:
  - Quality: 55%
  - Cost: 0%
  - Program Interoperability: 30%
  - Improvement Activities: 15%

Quality Payment Program - 2021

- Year 5 Changes
  - Quality
  - Improvement Activities
  - Promoting Interoperability
  - Resource Use
- MIPS Value Pathways (MVP)
  - Placed on hold for now

Merit-based Incentive Payment System

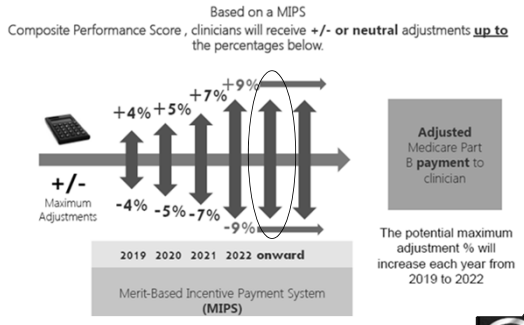
- Composite score (0-100)
- CY 2019 performance used for 2021 adjustment
- CY 2020 performance used for 2022 adjustment
- CY 2021 performance used for 2023 adjustment

Shifting MIPS Scoring

MIPS Category (Reporting Yr)	2017	2018	2019	2020	2021	2022
Quality	60%	50%	45%	45%	40%	30%
Program Interoperability	25%	25%	25%	25%	25%	25%
Improvement Activities	15%	15%	15%	15%	15%	15%
Resource Use	0%	10%	15%	15%	20%	30%

Source: CMS. Public Comment FR2020-26815. 12/02/20.

MIPS Payment Adjustment



MIPS Comparison – Penalty Avoidance

- CY2017 – threshold to avoid penalty was 3 points
- CY2018 – 15 points
- CY2019 – 30 points
- CY2020 – 45 points
- CY2021 – 60 points

- Requires 2015 editions of CEHRT

Source: CMS. FR/2020-26815. Public Comment 12/02/20. Table 50

Exceptional Performance Bonus

- Clinicians who achieve a final composite score in 2021 of 85 points or higher will be eligible for the exceptional performance adjustment
  - Same as 2020

CMS Report on 2019 QPP Results

- Clinicians participating in MIPS as individuals or small practice groups (and not through an APM) received a mean score of 68.99 points
- More than 97% of eligible clinicians participated
  - 538,323 as individuals or groups
  - 416,281 eligible clinicians through APMs
- Those making the Exceptional Performance bonus in 2019 get up to 1.79% extra in 2021
  - This is over their "standard" MIPS scoring bonus

Source: CMS Blog. 2019 Quality Payment Program (QPP) Performance Results. CMS Administrator Seema Verma. 10/27/20

Quality Reporting

- Quality reporting (all methods) are for a full year
- Choose 6 measures; 1 or more must be an "outcome" or "high priority" measure
- Meet the data completeness standard
- CMS noted they will continue with "Historical" Benchmarking for scoring

Resource Use (Cost) Reporting

- Resource Use (Cost) is for a full year
- Routine Cataract Surgery measure continues for a second year
- If re-weighting happens due to not having a Cost score, then the result is no longer "all to Quality" as in the past.
  - 15% to Quality
  - 5% to PI

Promoting Interoperability

- Some practices qualify for a hardship exemption for the entire PI category
  - Score would be ZERO for PI but the 25% is then moved in full to Quality
- Re-weighting of PI means that the Quality category is increased from 40% to 65%

2021 Hardship

- Hardship exceptions exist in the following categories:
- Lack of Infrastructure (i.e., w/o sufficient Internet access)
- Extreme and Uncontrollable Circumstances (i.e., natural disaster)
  - Hurricanes, Fires, Floods
  - COVID-19 (2020 Reporting year)

Hardship (cont.)

- EHR Vendor Issues: EHR vendor was unable to obtain certification or the eligible professional switched vendors
- Patient Interaction:
  - Lack of face-to-face or telemedicine interaction with patient
  - Lack of follow-up need with patients
- Practice at Multiple Locations: Lack of control over availability of CEHRT for more than 50% of patient encounters

Improvement Activities – Year 5

- Improvement Activities (IA) - "*any period of 90 or more days*" during the reporting year
- Choose from 90+ measures in 8 categories
- No substantive changes from 2020

Factors Affecting 2020 IA Reporting

- Size of your practice
- Electronic medical records
- Qualified Clinical Data Registry (QCDR) reporting
- Group reporting:
  - CMS finalized in 2020 (continued for 2021) that 50% or more of the group's clinicians must participate in any measure for the all the group's members to receive credit toward the category score.
  - Any 90 days for IA - do not have to run concurrently for each clinician

IRIS Registry

- Use the IRIS Registry in 2 different ways:
  - Data extraction by IRIS – equivalent to direct EHR
  - Upload to IRIS – characterized as Registry/QCDR
- Examples of 2019 scoring for Measure 12 (Primary Open Angle Glaucoma / Eval of Optic Nerve):
  - Direct EHR – Not topped out, 10 pt max
  - QCDR – Topped out, 7 pt max
- In 2021, this work shifts to Verana Health

Quality Payment Program – Year 5

- Budget neutrality provisions limit *"available positive adjustments"*
- So, there may be more penalties due to the higher minimum scoring but COVID may end up exempting a lot of providers
- Complex patient bonus is kept but maximum rises if applicable (due to COVID)
  - Based on Hierarchical Condition Category (HCC) used in Part C and VBPM risk adjustment calculations

Next Steps

- Educate physicians and staff on E/M for 2021
  - Expand use of E/M codes; constrict use of eye codes
- Revise your fee schedules for 2021
  - Particular attention to eye exams
- Analyze payer mix
  - Attend to Part C Medicare
- Update your Compliance Plan
  - Perform annual chart audit and staff training

Next Steps

- Check utilization patterns
  - Find opportunities in underutilized services (*e.g.,* VF)
  - Identify risks in overutilized services
- Re-check MIPS measures and reporting
- Evaluate your 2020 MIPS Resource Use; plan for 2021
  - Cost of cataract surgery is a focus

More help…

For additional assistance or confidential consultation, please contact us at:

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Email: mpjohnson@corcoranccg.com
Mobile App: Corcoran 24/7

Corcoran Consulting Group

2021 E/M Exam Coding – Audit Sheet

	MINIMAL	LOW	MODERATE	HIGH
PROBLEMS	1 self-limited or minor illness/injury Examples: - Allergic conjunctivitis - Arcus - Old retinal scar - Pinguecula - Subconjunctival hemorrhage - Xanthelasma	≥2 self-limited or minor illness/injury **OR** 1 stable/chronic illness/injury **OR** 1 acute uncomplicated illness/injury Examples: *Controlled Chronic:* - Dry AMD - Glaucoma - Diabetic retinopathy - Blepharitis - Dry eye syndrome - Trace cataract *Acute Uncomplicated:* - Corneal abrasion/FB - Recurrent iritis	≥2 chronic illness/injury with exacerbation **OR** ≥2 stable chronic illness/injury **OR** 1 new illness/injury with uncertain prognosis **OR** 1 acute illness/injury with systemic symptoms **OR** 1 acute complicated injury/illness Examples: *Worsening Chronic* - AMD with decreased VA - Glaucoma uncontrolled *Acute Complicated* - Central corneal ulcer - Corneal FB with infection *Uncertain Prognosis* - Undetected organic pathology - Unexplained loss of vision - Idiopathic condition or no apparent physical cause	≥1 chronic illness or injury with severe side effect or severe exacerbation **OR** 1 acute or chronic illness/injury which poses imminent threat to life or sight Examples: - New macula-on RD - New endophthalmitis - Ruptured globe - New retinal tear - Acute optic neuritis - New very high IOP (eg, 50)
*DATA (see page 2)	NONE	Meet one: Cat 1 (need 2) **OR** Cat 2 (need 1)	Meet one: Cat 1 (need 3) **OR** Cat 2 (need 1) **OR** Cat 3 (need 1)	Meet any two: Cat 1 (need 3) **OR** Cat 2 (need 1) **OR** Cat 3 (need 1)
MANAGEMENT	Examples: - No treatment - Watchful waiting - Rest	Examples: - OTC meds or readers - Glass, CL Rx f/u ≥1 yr - Consideration/Decision for minor surgery - Self-care (eg, warm compresses)	Examples: - RX med/optical, f/u weekly, monthly, quarterly - Consideration/Decision minor surgery with identified risk factors - Consideration/Decision for major surgery - Unknown treatment plan	Examples: - Drug therapy requiring intensive monitoring of toxicity (eg, IV steroid) - Consideration/Decision for major surgery with identified risk factors - Consideration/Decision for emergency major surgery - Hospitalization
Instructions: Circle the appropriate level for each area: Problem, Data, Management. Ignore lowest level of 3 (the one furthest to the left). Select the lesser of two remaining levels.				
CPT®	99202 99212	99203 99213	99204 99214	99205 99215

2021 E/M Exam Coding – Audit Sheet

Scoring of External Tests and Data from Unique Sources

- All materials from a single unique source counts as 1 data element.
  - Example: Multiple tests and visits come from one outside doctor's office.
- If the reviewed tests have the same unique CPT code and source, they are defined as a "series" and count once.
  - Example: VF 02/01/19, VF 03/02/20, VF 01/03/21, same source, counts as 1 data element.
- A unique test from two different unique sources is counted once for each source. They are not a series.
  - Example: 1 refraction from Practice A, and 1 refraction from Practice B, counts as 2 data elements.

***DATA LEVELS – Be careful when material**

Minimal or None

None or only 1 of external test, note or order

Limited – need to meet either category "1" or "2"

Category 1 (need 2 in this category):

- Review of prior external notes from each unique source
- Review of results from each unique external test
- Ordering of each unique test (performed/billed outside the practice, not separately reported)

Category 2:

Assessment requiring an independent historian

- History from someone other than patient (eg, parent, guardian, spouse, caregiver). Not a paid translator.

Moderate – Meet a single category: "1" or "2" or "3"

Category 1 (Requires any 3 of the below; a single bullet may count repeatedly, eg, source or test):

- Review of prior external notes from each unique source
- Review of results from each unique external test when not "a series"
- Ordering of each unique test (performed/billed outside the practice, not separately reported)
- Assessment requiring an independent historian

Category 2:

Independent interpretation of external tests performed by another physician or QHP (not separately reported)

Category 3:

Discussion with external physician or other QHP (not separately reported; two-way communication)

High – Met by any of the following category combinations: "1 and 2", "1 and 3", or "2 and 3"

Category 1 (Requires any 3 of the below; a single bullet may count repeatedly, eg, source or test):

- Review of prior external notes from each unique source
- Review of results from each unique external test when not "a series"
- Ordering of each unique test (performed/billed outside the practice, not separately reported)
- Assessment requiring an independent historian

Category 2:

Independent interpretation of external tests performed by another physician or QHP (not separately reported)

Category 3:

Discussion with external physician or other QHP (not separately reported; two-way communication)