Survival Strategies

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Financial Disclosure

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Headlines

- How Doctors Are Experimenting With Cutting Health-Care Costs
- Huge insurance mergers inch toward approval
- Final 2016 Obamacare sign-up tally hits 12.7M
- Processing quality measures costs $40K per physician per year
- Private accountable care organizations are growing; More than half including downside risk

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Survival of the Fittest

- Diverse practice with large market share and a strong bargaining position
- Ability to manage cost but not compromise quality or customer service
- Infrastructure to respond to change

Positives and Challenges

- Positives for growth
  - Aging population
  - New technology
- Challenges to growth
  - Increased oversight
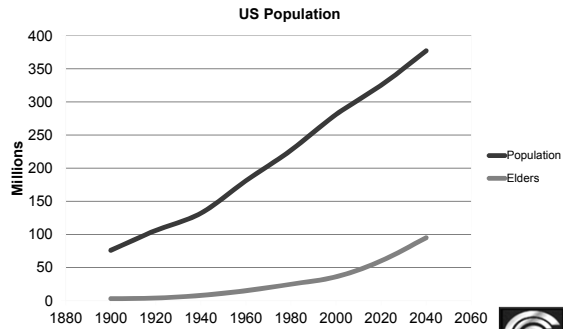 - Declining workforce
  - Reduced reimbursements

Aging Population

- 55 million Medicare beneficiaries (2015)
- 75 million baby boomers (1946 to 1964)
  - In 2010, 13% of US population will be ≥65 y/o
  - In 2030, 20% of US population will be ≥65 y/o
- Longer life expectancy
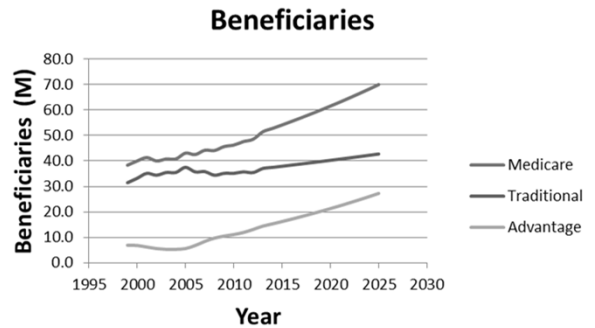- Approximately 32 million gained health insurance

Sources: US Census Data, CMS enrollments

US Population Growth

US Population

Millions (y-axis: 0, 50, 100, 150, 200, 250, 300, 350, 400)
x-axis: 1880 1900 1920 1940 1960 1980 2000 2020 2040 2060

Population
Elders

Medicare Enrollment

Beneficiaries

Beneficiaries (M) (y-axis: 0.0, 10.0, 20.0, 30.0, 40.0, 50.0, 60.0, 70.0, 80.0)
Year (x-axis: 1995 2000 2005 2010 2015 2020 2025 2030)

Medicare
Traditional
Advantage

Advances in Technology

- Premium IOLs
- Microinvasive glaucoma surgery (MIGS)
- Corneal cross-linking
- Femtosecond laser
- Corneal hysteresis
- iSTENT®
- Tear osmolarity testing
- Wavefront aberrometry

List is not exhaustive of all new technologies

Increased Oversight

"Is this your first Medicare audit?"

Who's watching?

- Office of Inspector General (OIG)
- Comprehensive Error Rate Testing (CERT)
- Recovery Audit Contractors (RAC)
- Zone Program Integrity Contractors (ZPIC)
- Medicare Part C Plans
    - Risk adjustment audits

OIG Report: Questionable Billing for Medicare Ophthalmology Services

- Reviewed claims from CY2012 related to:
    - AMD
    - Cataract
- Study to determine the extent to which ophthalmology services are vulnerable to fraud, waste, and/or abuse.

Source: OIG Report September 2015 OEI-04-12-00280

Comparative Billing Reports – MD

- CBRs sent to ophthalmologists in April 2015
- eGlobalTech
- Medicare Part B: July 1, 2013 through June 30, 2014
- Analyzed services:
  - General ophthalmological services (920xx)
  - Evaluation and management services (E/M)
  - Cataract surgery (66982, 66984)

Compliance Programs

- Formal compliance plans become mandatory
- Condition of enrollment in federally funded programs
- Secretary to determine timeline of core elements and implementation date

Source: Patient Protection & Affordable Care Act (PPACA) Section 6401

Physician Supply Projections

- Growth and aging of US population will cause a surge in demand for physician services
- Requirements for physicians will increase 21% – 22% from 2005 to 2020
- Requirements for ophthalmologists will increase 28% from 2005 to 2020

Source: DHHS Physician Supply and Demand Projections to 2020
http://bhpr.hrsa.gov/healthworkforce/reports/physiciansupplydemand/

Characteristics of New Residents

- More are sub-specializing; fewer generalists
- Fewer pediatric and neuro specialists
- Lifestyle is an important consideration
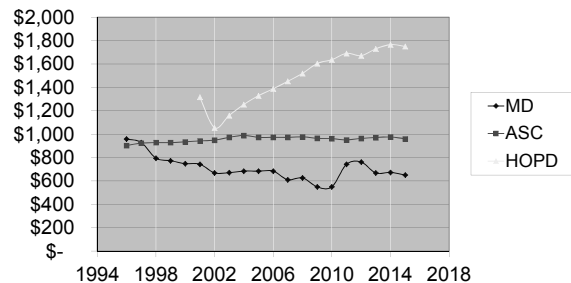 - Less time devoted to patient care

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10 Year Manpower Shortage

- FTE Ophthalmologists remains unchanged, however in 10 years, 45% more seniors need them
- FTE Optometrists grows 8%, however in 10 years, 35% more seniors need them

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Medicare Payments for Cataract Surgery

Strategic Planning

- Keep it simple
- Involve others in the process
- Monitor and adjust as needed

One Page Strategic Plan

1. Vision: A clear picture of your destination
2. Mission: Driving purpose of your practice
3. Values: Guide used for decision making and treating others
4. Objectives: Numbers you track
5. Strategies: Paths you've decided to take
6. Priorities: Work to do and who does it

Source: You Can't Send a Duck to Eagle School (author Mac Anderson)

Survival Kit / Tool Box

- Coding expertise
- Utilization statistics
- Current fee schedules
- Expansion of non-covered services
- CMS' Quality Programs
- Office efficiencies

Accurate Coding

- Proper level of service for exams
- Favor eye codes
- Select ICD-10 codes carefully
- Use modifiers appropriately
- Claim supported by chart documentation
- Coding and chart review

Auditing and Monitoring

- Review standards and procedures
- Claims submission audit
  - Are bills accurately coded?
  - Is documentation complete?
  - Are services reasonable and necessary?
  - Any incentives for unnecessary services?
- Baseline audit within 3 mos of initial training, and thereafter on an annual basis
  - 5-10 records per physician

Source: Federal Register Vol 65, No 194, October 5, 2000

Complete Charge Capture

- Exam to determine the need for surgery (-57)
- Exam on the day of a minor procedure that meets definition of separately identifiable (-25)
- Diagnostic tests
- Additional surgical procedures
- Drugs
- Refractions

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Utility of Practice Patterns

- Target opportunities for increased revenue
- Forecasting future financial performance
- Validate practice appraisal
- Assess capital equipment purchase
- Identify red flags for probable Medicare audit
- Caution statistics can mislead

Top 10 Ophthalmic Procedures
Medicare Utilization Patterns Ophthalmology (18)

Rank	CPT	Procedure	Rank	CPT	Procedure
1	67028	Intravitreal Injection	6	66982	Complex Cataract
2	66984	Cataract w/IOL	7	65855	Lx Trabeculoplasty
3	66821	YAG Capsulotomy	8	15823	Blepharoplasty
4	68761	Punctum plug	9	66761	Laser PI
5	67820	Epilation	10	67210	Focal Laser

Source: CMS data 2014, 18 - Ophthalmology

Office Visits
Medicare Utilization Patterns Ophthalmology (18)

CPT	New Patients	λ	CPT	Established Patients	λ
99205	Level 5 E/M	2%	99215	Level 5 E/M	1%
99204	Level 4 E/M	29%	99214 92014	Level 4 E/M Comprehensive Eye	54%*
99203 92004	Level 3 E/M Comprehensive Eye	62%*	99213 92012	Level 3 E/M Intermediate Eye	42%*
99202 92002	Level 2 E/M Intermediate Eye	6%*	99212	Level 2 E/M	3%
99201	Level 1 E/M	<1%	99211	Level 1 E/M	<1%

*Combined utilization of E/M and eye codes

Source: CMS data 2014, 18 - Ophthalmology

Common Ophthalmic Tests
Medicare Utilization Patterns (18 - Ophthalmology)

CPT	Procedure	λ	CPT	Procedure	λ
92134	Scanning Laser (retina)	23%	92250	Fundus Photo	8%
9222x	Ext Ophthalmoscopy	16%	92235	Fluorescein	6%
9208x	Perimetry	11%	92020	Gonioscopy	3%
---	Biometry (A or OCB)	8%	95004	Allergy testing	2%
92133	Scanning Laser (glauc)	8%	76514	Pachymetry	2%

Frequency is per 100 office visits (%) on Medicare beneficiaries
Source: CMS data (2014), 18 – Ophthalmology

Compliance – Standards of Care

- Develop the practice's standards
- Consider AAO's Preferred Practice Patterns as a guide
    - Indications and Frequency
- Educate physician's and staff
- Hold them accountable

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Reasonable Fee Schedule

- Reasonable fees
  - Near rates promulgated by most third party payers
  - Consider local market rates
  - Weighted for largest payers
- Solitary fee schedule for specialty and locality
  - Universal
  - Only one charge per procedure

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Medicare Statutory Exclusions

- Not reasonable and necessary
- No legal obligation to pay
- Related to military service
- Personal comfort items
- Routine care (e.g., check-ups, glasses)
- Cosmetic surgery (e.g., LASIK)
- Drugs used at home
- Worker's compensation

Source: Social Security Act

Strengthen Optical

- Review Optician goals
- Evaluate presentation of optical goods
- Revisit costs
- Assess claims and collections

Consider Dispensing Medications

- Vitamins
- Tears and ointments
- Other OTC remedies
- Explore turn-key in-office pharmacy opportunities

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CMS Quality Programs

- Physician's Quality Reporting System (PQRS)
- Value-based Payment Modifier (VM)
- Health Information Technology (HIT) Incentives
- Merit-Based Incentive Payment (MIPS)

New Health Care Payment Models

- Category 1 – fee for service with no link of payment to quality
- Category 2 – fee-for-service with a link of payment to quality
- Category 3 – alternative payment models built on fee-for-service architecture
- Category 4 – population-based payment

PQRS

- PPACA made PQRS mandatory by 2015
- Punitive if not participating in 2015
- -2.0% reduction in Medicare reimbursement in 2016 and beyond
- On 9/11/15, CMS notified eligible professionals who would be penalized in 2016 for failure to be successful PQRS reporters in 2014

Value-based Payment Modifier

- Provides for differential payment to a physician or group under the MPFS based upon the quality of care furnished compared to cost during a performance period.
- Program in effect for groups of >10 in 2016; based on 2014 performance
- Program in effect for all providers in 2017; based on 2015 performance
- Based on participation in PQRS program
- Applied at the Tax Identification Number (TIN) level

2014 VBM Results

- Applied to groups of 10 or more eligible professionals
- Results affect 2016 reimbursements
- 97.8% - 8,208 groups have had <u>no</u> change in Medicare reimbursement in 2016
- 0.7% - 59 groups have a downward adjustment of either 1% or 2%
- 1.5% - 128 groups have an upward adjustment of either 15.92% or 31.84%

Merit-Based Incentive Payment System (MIPS)

- Combines and builds on 3 existing incentive programs
  - PQRS, VBM, MU
- Adds a new category – Clinical Practice Improvement Activities
- Score of 0-100 given based on performance in each of the 4 categories
- Composite score compared with performance threshold to determine bonus vs. penalty

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## Physician Compare Initiative

- ACA required establishment of the Physician Compare website
- Launched December 30, 2010
- Redesigned to improve accuracy in 2013
- Basic provider information (*i.e.,* demographics, board specialties)
- Quality program participation indicators (PQRS, EHR, e-RX)

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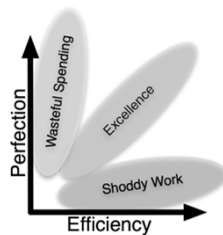
Do the math…

- 2 patients per session (session = half day) or 4 patients per day.
- 4 days/week in clinic (1 day in OR)
- 46 weeks/year
- Average encounter $110
- 16 pts/week x 46 weeks x $110/encounter
- ~ $81,000

Speed up collections

- Daily closing and reconciliation
- Attack resubmissions and denials
- Pursue outstanding claims
- Accelerate secondary claims

Analyze Revenue

- Compare End of Month Reports to prior months
  - Charges, Payments and Adjustments
  - Accounts Receivable Aging
- Benchmarks
  - Days in AR
  - Aging Buckets
- Compare expected collections to actual collections
- Review outstanding claim's report

Internal Auditing of Billing Office

- Track staff's accuracy
- Identify denial causes
- Identify denial trends
- Determine if appeal is warranted
- Monitor electronic remittances closely

Inhibit Embezzlement

- Screen and inform employees
- Diversify duties
- Outsource payroll function
- Proper cash handling
- Prompt banking
- Efficient software
- Patient billing documentation
- Careful inventory tracking
- Professional advisors
- Knowledgeable physician partners

Expenses – Case Studies

- Paid out physician bonuses *before* backing out drug reimbursement
- Two different internet providers
- Fax line that no longer exists
- Service contracts for equipment no longer owned

Managing Customer Service

- Spot check phone etiquette
- Ask patient about the service they received from staff
  - At time of visit
  - Survey after the visit
- Educate staff on customer service

Measure Results

- What gets measured gets improved -- *Peter Drucker*

Survival Strategies

- Assess your practice today
- Develop a plan for tomorrow
- Implement the plan
- Monitor the progress
- Adjust as needed

Additional Assistance

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