Medicare Reimbursement Challenges

ASCRS-ASOA Symposium & Congress
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Financial Interest

I acknowledge a financial interest in the subject matter of this presentation.

Overpayments

• CMS Released New Rules
• Definition of a Medicare overpayment
  – Payment received in excess of amounts properly payable under Medicare statutes and regulations
    • Once Medicare identifies an overpayment, that amount becomes a debt the provider owes the Federal government
    • Federal law requires CMS to try to recover all identified overpayments

Overpayments

• In Medicare, overpayments commonly occur due to:
  – Duplicate submission of the same service or claim
  – Furnishing and billing for excessive or non-covered services
  – Payment for excluded or medically unnecessary service
  – Payment to the incorrect payee

Overpayments

• When Medicare discovers an overpayment of $25 or more, MAC initiates an initial demand letter requesting repayment
  – If you receive a Demand Letter, you have several options
    • Make an immediate payment
    • Request immediate recoupment
    • Request standard recoupment (automatic offset/withholding)
Overpayments

- Medicare also requires Medicare Part A and Part B providers and suppliers to:
  - Report and return overpayments identified by the provider by the later of:
    - The date that is 60 days after the date an overpayment was identified, or
    - The due date of any corresponding cost report, if applicable

- Clarification of Identification
  - The person has identified an overpayment when the person has or should have diligently determined that an overpayment was received and the amount of overpayment

- Lookback Period
  - Overpayments must be reported and returned only if a person identifies the overpayment within six years of the date the overpayment was received

- Reporting and Returning Overpayments
  - Providers and suppliers must use an applicable claims adjustment, credit balance, self reported refund, or another appropriate process to satisfy the obligation and return overpayments
  - ASCRS and other specialty societies will continue to monitor the issue and keep it's members updated

Co-Management

- ASCRS/AAO developed new joint position paper
  - Added three instances that justify co-management
    - Patient unable to return to surgeon’s office
    - Unavailability of surgeon to provide post-op care
    - Patient prerogative
Co-Management

– Patient inability to return to surgeon’s office
  • Unable to travel due to distance or due to another illness
  • Has no one that can bring patient back to surgeon’s office
– Surgeon unavailable to perform post-op care
  • Surgeon will be unable due to travel, leave
  • Itinerant surgery in rural area

Co-Management

• Surgery performed in ophthalmologist shortage area
• Retirement
• Illness
– Patient Prerogative
  • Patient requests and/or consents to transfer of care to minimize cost of travel
  • Loss of time spent travelling
  • Patient inconvenience

Co-Management

– Change in post-operative course
  • Development of a complication
  • Development of intercurrent disease
    – (Occurring during the progress of another disease)
– List of criteria in Position Paper that should be followed when ophthalmologists enters into a co-management arrangement or transfers care of patient
  • Patient requests, or is given the option to receive post-op care for another provider

Co-Management

• Operating surgeon determines operative eye is sufficiently stable for transfer of care or co-management is clinically appropriate
• Co-manager (non-operating practitioner) willing to accept care of patient
• State law permits co-manager to provide post-operative care and is qualified to do so
• No agreement between operating surgeon and referring practitioner to automatically send patients back to non-operating practitioner

Co-Management

• Arrangement complies with all applicable federal and state laws, including federal anti-kickback and Stark laws and state fee splitting laws
• Operating ophthalmologist or other appropriate trained ophthalmologist is available upon request to provide care directly or indirectly to patient
• Patient should be informed of any additional fees co-manager may charge beyond those covered by Medicare/Medicaid
  – Additional fees for premium IOL co-management beyond Medicare covered services

Co-Management

– Financial compensation
  • Should review Position Paper for specific instructions
– Medicare requires that the transfer of care is documented in both the surgeon’s chart and the co-manager’s chart
  • Fax or mail a copy of patient-signed Transfer of Care form to co-manager
– All relevant clinical information should be exchanged between surgeon and co-manager
<table>
<thead>
<tr>
<th>Enrollment Screening</th>
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</thead>
<tbody>
<tr>
<td>• CMS implementing fingerprint-based background check</td>
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<tr>
<td>– Individuals with a 5% or greater ownership interest in a provider or supplier that falls under a high risk category</td>
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<tr>
<td>• Applies to providers and suppliers who are newly enrolling DME suppliers</td>
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<tr>
<td>• Also applies to providers and suppliers who have been elevated to the high risk category</td>
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<td>– Screening level increased by CMS for following reasons:</td>
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<tr>
<td>• Imposed a payment suspension for last 10 years</td>
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<td>• Been excluded from Medicare by the OIG</td>
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<td>• Has had billing privileges revoked within previous 10 years</td>
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<tr>
<td>• Has been excluded from any Federal Health Care program</td>
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<tr>
<td>• Has been subject to any final adverse action, in the previous 10 years</td>
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<td>• Has been terminated or otherwise precluded from billing Medicaid</td>
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<tr>
<td>• CMS lifts a temporary moratorium on a provider or supplier and that provider or supplier applies for enrollment in Medicare within 6 months from the date the moratorium was lifted</td>
</tr>
<tr>
<td>– Fingerprint-based background checks will be used to detect persons attempting to enroll in Medicare and remove those currently enrolled</td>
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<tr>
<td>– Affected providers and suppliers will receive notification of fingerprint requirements from their MAC</td>
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<tr>
<td>• Generally an individual will be required to be fingerprinted only once</td>
</tr>
<tr>
<td>– Providers or suppliers will have 30 days from date of notification to be fingerprinted</td>
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<tr>
<td>– If provider or supplier finds a discrepancy in ownership listing</td>
</tr>
<tr>
<td>• Should contact MAC immediately to correctly reflect ownership information</td>
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| Miscellaneous Issues |
Blepharoplasty Audits

- AAO continues to challenge rash of blepharoplasty audits
  - CMS has agreed to provide several exemptions for ophthalmologists from future audits
    - Physicians who have already had 40 or more claims reviewed in a RAC audit
    - Physicians meeting low claims denial rate threshold

Glaucoma/Retina Cuts

- ASCRS and other societies working with Congress to convince CMS to revise drastic fee cuts for glaucoma and retina codes
  - 66170 – Trabeculectomy
  - 66172 – Trabeculectomy with scarring
  - 67107 – Retinal detachment with scleral buckle
  - 67108 – Retinal detachment with vitrectomy
  - 67110 – Retinal detachment by injection

ALT/SLT

- CPT Code 65855
  - Has a bilateral payment indicator of "2" in the 2016 physician fee schedule
    - Means paid only once regardless if one or both eyes are treated
  - Other surgeries (except lids) have payment indicator of "1"
    - Procedure paid "per eye"
  - Some MACs even applied to lasers performed outside 10-day global fee period

ALT/SLT

- When performed bilaterally
  - Modifiers -50 and -RT/-LT not being recognized by Medicare contractors
  - Caused major denials
- CMS has been made aware of problem
  - Not sure when (or if) CMS will make change

Amniotic Membrane Tissue

- AMT used in pterygium surgery, CPT codes 65420 and 65426
  - AMT (codes 65778 and 65779) no longer payable separately by Medicare
  - Considered incident to pterygium removal
    - Modifier -59 or -X modifiers not an option
      - Unless performed at different session
    - Would be inappropriate to bill patient for cost of tissue

Corneal Tissue

- Corneal tissue now paid only when used in corneal transplant procedures
  - 65710, Keratoplasty; anterior lamellar
  - 65730, Keratoplasty; penetrating (except in aphakia or pseudophakia)
  - 65750, Keratoplasty; penetrating (in aphakia or pseudophakia)
  - 65755, Keratoplasty; penetrating (in pseudophakia)
  - 65756, Keratoplasty; endothelial (DSAEK, etc.)
- Code V2785 can no longer be billed in any other circumstance
Corneal Tissue

- Corneal allograft
  - Patch grafts used in glaucoma shunt surgery
    - Now included in ASC facility fee payment
    - No longer billable separately

Surgery Issues

Laser-Assisted Cataract Sx

- Refractive imaging component of femtosecond (FS) laser performed on premium AC-IOL and PC-IOL cataract patients before surgery has begun is a non-covered service
  - Can bill premium IOL patients for OCT imaging
  - Fee usually included in premium IOL charge
  - Cannot charge fee for use of femtosecond laser used intraoperatively for:
    - Phaco incision, capsulotomy, lens fragmentation

Laser-Assisted Cataract Sx

- Cannot bill patient femtosecond OCT imaging performed on conventional IOL patients
  - CMS expects FS laser on these patients to be rare
  - Even if not charged
  - Will negate argument that only premium IOL patients need this special imaging
- LRI/CRI performed with FS laser at same time as conventional IOL surgery
  - Still billable to patient as a non-covered service
  - When performed on premium IOL patients fee included in premium IOL charge

Dropless Cataract Surgery

- Use of intraocular or periocular injections of anti-inflammatory drugs and antibiotics at time of cataract surgery has increased considerably such as:
  - Triamcinolone and moxifloxacin with or without vancomycin
  - Referred to as "dropless cataract surgery"
- Eliminates need for post-operative antibiotic eye drops

Dropless Cataract Surgery

- According to CCI:
  - Injection of drugs during a cataract extraction or other ophthalmic procedure is not separately billable
  - Injections are part of ocular surgery and included as part of code used to report the surgical procedure
Dropless Cataract Surgery

- What about the medications?
  - Compounded drugs must now be billed with code J7999, Unclassified compounded drug
  - ASCs do not get paid separately for unclassified drugs or biologicals
  - Packaged as part of ASC facility fee
  - ASC cannot report J7999 or C9399

Diagnostic Tests

Order for Test

- Test must be ordered by treating physician before test can be performed
  - Order can be in Plan of previous visit
    - “Return 6 month glaucoma check and visual field”
    - Chart must be clear as to who ordered the test and who performed the service
  - Medical necessity must be clearly noted or evident in the chart

Interpretation & Report

- Most diagnostic tests require separate Interpretation & Report
  - Should address the findings, relevant clinical issues, and comparative data (when available)
    - What was seen or not seen but anticipated
      - Glaucoma
    - What findings suggest as to status of illness
      - Stable, worsening, improving
    - What impact the test results have on treatment
      - Continue present meds, surgery as indicated, see Plan

Interpretation & Report

- Interpretation and Report
  - Can be a separate document, included in body of chart, or on test printout
- Interpretation and Report
  - If paper chart, I&R must be signed and dated by doctor
  - If EMR, may have statement “interpreted by”
    - Log out signature also confirms who documented chart and test results

Test Results

- All test results must be readily available
  - In some instances, photos and results of tests may not be in the paper chart or the EMR
    - Sometimes stored digitally
  - The medical record must document the location of the diagnostic test in this case
    - Disc C, dated 4/1/13, etc., or
    - Notation as to where test result can be found
Standing Orders

- Appears to be a growing issue
  - Medicare will not recognize any order that is not first documented in chart
    - Patient’s medical status
    - Illness or injury
    - Medical necessity for test
  - Medicare does not accept standing orders for any tests
    - Including A-scans/IOLMasters

Per Eye Tests

- Ophthalmology has several tests billable for both the right eye and the left eye

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<tr>
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<tbody>
<tr>
<td>76512 B-Scan</td>
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<tr>
<td>92225 Extended ophthalmoscopy, initial</td>
</tr>
<tr>
<td>92226 Extended ophthalmoscopy, subsequent</td>
</tr>
<tr>
<td>92230 Fluorescein angiography</td>
</tr>
<tr>
<td>92235 Fluorescein angiography</td>
</tr>
<tr>
<td>92240 Indocyanine-Green (ICG)</td>
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Bill on two line items using the -RT and -LT modifiers

ICD-10

- CMS issued ICD-10 Grace Period
  - Effective until October 1, 2016
    - Grace period implemented to help providers get ready for ICD-10
    - Prevents punitive damages for reporting incorrect codes during the transition period
    - CMS will not deny claims solely on the specificity of diagnosis code as long as provider uses a valid code from the right “family” of codes

ICD-10 Grace Period

- Only 5 months left to make sure your ICD-10 diagnosis codes are in order
  - Most practices have been coding to the highest level of specificity regardless of the grace period
  - Denials were mainly on the part of CMS
    - New LCDs did not contain all the diagnoses that were in the ICD-9 LCDs
  - EMR systems should be coding properly by now

ICD-10 Toolkit

- CMS released ICD-10 Toolkit
  - Offers tips and resources for:
    - Assessing ICD-10 progress to identify issues that could affect productivity or cash flow
    - Addresses opportunities for improvement
      - Troubleshooting issues identified during assessment
      - System enhancements and targeted staff training
    - Maintaining progress and keeping up-to-date on ICD-10
      - Helps resolve issues with payers
ICD-10 Toolkit

- Maintaining your progress
  - ICD-10 updates take place annually on October 1 of each year
    - Review your coding guidelines on a regular basis and make updates annually
  - For access to ICD-10 toolkit and other ICD-10 resources visit CMS website at:
    - www.cms.gov/ICD10

ICD-10 Changes

- ICD-10 2017 Release
  - Will include over 5,000 new codes that were not added last year due to the freeze on codes prior to the October 1, 2016 implementation of ICD-10
    - 1,900 new codes for physicians
    - 3,600 or so are hospital codes
  - A large portion of the updates includes the H54, Blindness and Low Vision code set

ICD-Changes

- New low vision codes to allow more differentiation of categories for visual impairment

<table>
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<tbody>
<tr>
<td>H54.0 Blindness, both eyes</td>
</tr>
<tr>
<td>H54.11 Blindness, right eye, low vision left eye</td>
</tr>
<tr>
<td>H54.12 Blindness, left eye, low vision right eye</td>
</tr>
<tr>
<td>H54.2 Low vision, both eyes</td>
</tr>
<tr>
<td>H54.41 Blindness, right eye, normal vision left eye</td>
</tr>
<tr>
<td>H54.42 Blindness, left eye, normal vision right eye</td>
</tr>
<tr>
<td>H54.51 Low vision, right eye, normal vision left eye</td>
</tr>
<tr>
<td>H54.52 Low vision, left eye, normal vision right eye</td>
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ICD-10 Changes

- Diabetes codes
  - Categories E10, E11 and E13 changed to include which eye
    - Central retinal vein occlusion (CRVO) and branch retinal vein occlusion (BRVO)
      - Updated to include:
        - “With macular edema”
        - “With retinal neovascularization”
        - “Stable”

ICD-10 Changes

- Age Related Macular Degeneration (AMD)
  - H35 series of codes updated
    - Includes more disease detail and which eye
  - Postprocedural hemorrhage and hematoma following ophthalmic procedure
    - H59 series of codes updated
      - Separated codes into two categories now
      - Codes now for just hematoma
      - Codes now for just hemorrhage

ICD-10 Coding Manuals

- Coding Manuals
  - Practices should purchase new 2017 ICD-10 Coding Manual now
    - Will give you time to make changes to computers and/or encounter forms
  - Not purchasing new manuals each year could result in denials….or worse, lost income
  - The same applies to other coding manuals
    - CPT manual
    - HCPCS manual