


The Independent Practice In The Era Of Health Care Reform

The World Has Changed.
Are You Keeping Up With It?

John Rumpakis, OD, MBA

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John Rumpakis, OD, MBA
Management - Consulting - Practice Appraisal
Medical Audit Representation - Education Programs &
SaaS Based Software Services

Dr. Rumpakis is currently President & CEO of Practice Resource Management, Inc., a firm that specializes in providing a full array of consulting, appraisal, and management services for healthcare professionals and industry partners. He has developed some of the leading Internet-based software applications for the medical/eye care field such as CodeSAFEPLUS.com® (www.CodeSAFEPLUS.com), the industry leading cloud-based CPT & ICD Code Data and Information Service, and offers personal medical coding consultation through JustAskJohn (www.JustAskJohn.net). He is also the founder of Opt-ED® Professional Continuing Education (www.Opt-ED.com) which creates and delivers top tier continuing education around the country as well as Opt-IN® which provides optometric marketing and promotional services.

Named the Chief Medical Coding Editor for Review of Optometry, Primary Care Optometry News, Optometry Today, and past Editor for Optometric Management, he has been extensively published on the topics of third party coding & billing, strategy development and execution, practice management, team building, maximizing effectiveness and profitability, including the textbook “Business Aspects of Optometry”. Dr. Rumpakis is a popular lecturer both nationally and internationally. In addition to having had a successful solo practice, Dr. Rumpakis developed the practice management curriculum at Pacific University College of Optometry and taught optometric & medical economics there for over a decade. He was also named a Benedict Professor for the University of Houston College Of Optometry.

A 1984 graduate of Pacific University College of Optometry, he served as a volunteer for the AOA for near 17 years and currently sits on numerous advisory boards, and board of directors for companies both in and out of the ophthalmic industry.

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I Am A Project Based Consultant & Have Received Honoraria From:
(Partial Listing)

Alcon Laboratories	Allergan	RevolutionEHR	ArcticDX	Eye-Tel Imaging
Carl Zeiss Meditec	Beaver-Visitec	VisionWeb	Modernizing Medicine	Bausch & Lomb
Optos	OfficeMate	Opticare - Envolv	Annidis	Essilor of America
Vistakon	Maximeyes	United Health Care	Kowa Optimed	Wal-Mart
CooperVision	Luxottica	Vision Source	HeartSmart	Macuscope
Maculogix	MacuRisk	Bio-Tissue	Diopsys	Topcon
EMRLogic	Davis Vision	ECRVault	Nicox	CyclopsEMR
TearLab	Paragon	OptoVue	TearScience	GuidePoint
Freedom-Meditech	Synergeyes	Harbinger Health LLC	Uprise	Lineage Capital
SightScience	Quidel	Oculo	IDOC	
OysterPoint Pharma	Medical Optometry America		Acuity Eyecare Group	
Osmotica			Notal Vision	
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Chief Medical Clinical Coding Editor – Primary Care Optometric News, Ocular Surface
News - Optometry Times - Review Of Cornea &
Contact Lens

Prior Engagements – Review of Optometry – 18 years, Optometric Management – 11 Years

Ownership Interests

JustAskJohn – Personalized Medical Coding Consultation (www.JustAskJohn.net)
CodeSAFEPLUS® (www.CodeSAFEPLUS.com)
Founder – Opt-ED®, Professional Optometric Continuing Education
Founder – Opt-IN®, Optometric Marketing & Promotions
WhatsMyPracticeWorth.com® - Online Practice Appraisals

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Disclosures

- Any fees represented within this presentation are the 2023 National Average Medicare Maximum Allowable Reimbursements for each procedure listed as of June 10, 2023.
- All information regarding policies, procedures, guidelines and definitions is current as of June 10, 2023
- Each viewer is responsible to be current in their own geographical jurisdiction interpretation of legalities, ethical requirements, policies, procedures, guidelines and definitions prior to implementation within their own practice.

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Questions
About This
Lecture?

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And Now... Today's Feature Presentation

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THE FOLLOWING **PRESENTATION** HAS BEEN APPROVED FOR
ALL AUDIENCES
BY THE RUMPAKIS SCHOOL OF ETHICS & COMPLIANCE

THIS PRESENTATION HAS BEEN RATED

R

SEVERE DOSE OF REALITY

THIS PRESENTATION IS NOT FOR THE FAINT OF HEART OR FOR INDIVIDUALS WHO AVOID SITUATIONS THAT ARE ACTUALLY HAPPENING RIGHT IN FRONT OF THEM AND ARE AFRAID TO DEAL WITH THEM. CURRENT MARKET CONDITIONS AND GRAPHIC DEPICTIONS OF THE HEALTHCARE ENVIRONMENT ARE CONTAINED THROUGHOUT.

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THE FOLLOWING PRESENTATION CONTAINS

FA

FACTUAL ANALYSIS OF HEALTH CARE DELIVERY SYSTEM
WITH CHALLENGES & OPPORTUNITIES

GE

GRAPHIC SCENES OF ETHICS & COMPLIANCE
REQUIREMENTS & ECONOMIC ANALYSIS

AP

ACTION PLAN TO OVERCOME & CORRECT BEHAVIOR THAT
VIOLATES ETHICAL/LEGAL STANDARDS & CREATES A COMPLIANT
PRACTICE ENVIRONMENT THAT CREATES PROFITABILITY

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Who Are The Care Providers?

Ophthalmologist

Optometrist

Physician's Assistant

Optician

IBM Watson

Google DeepMind

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Facts As We Know Them

- 77% of all new patient encounters occur in an optometric practice
- 66% of all enduring care stays in an optometric practice
- Optometrists provide 85% of all comprehensive eye exams
- 17.6% of all optometric office visits are reported as being related to medical issues as reported by the AOA
- Eyewear sales capture rate is 73%
- Contact lens usage is flat at 16.1% - Drop Out is also 16%
- Medical eye care growth is not as fast as data suggests it should be

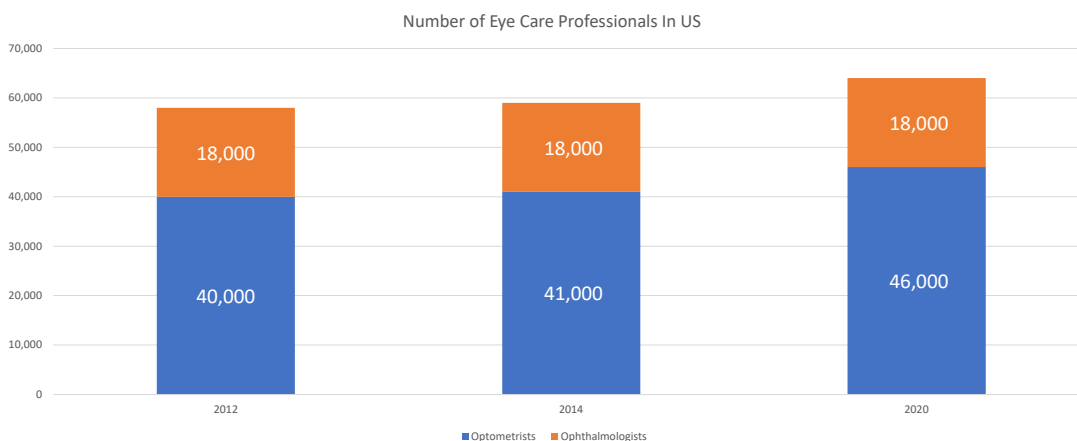
American Optometric Association. State of the Optometric Profession: 2013. June 2013.
Available at: www.aoa.org/Documents/news/state_of_optometry.pdf

Rumpakis J. New data on contact lens dropouts: An international perspective. Rev Optom. 2010 Jan;147(1):37-42
Available at: www.revoptom.com/content/d/contact_lenses_and_solutions/c/18929

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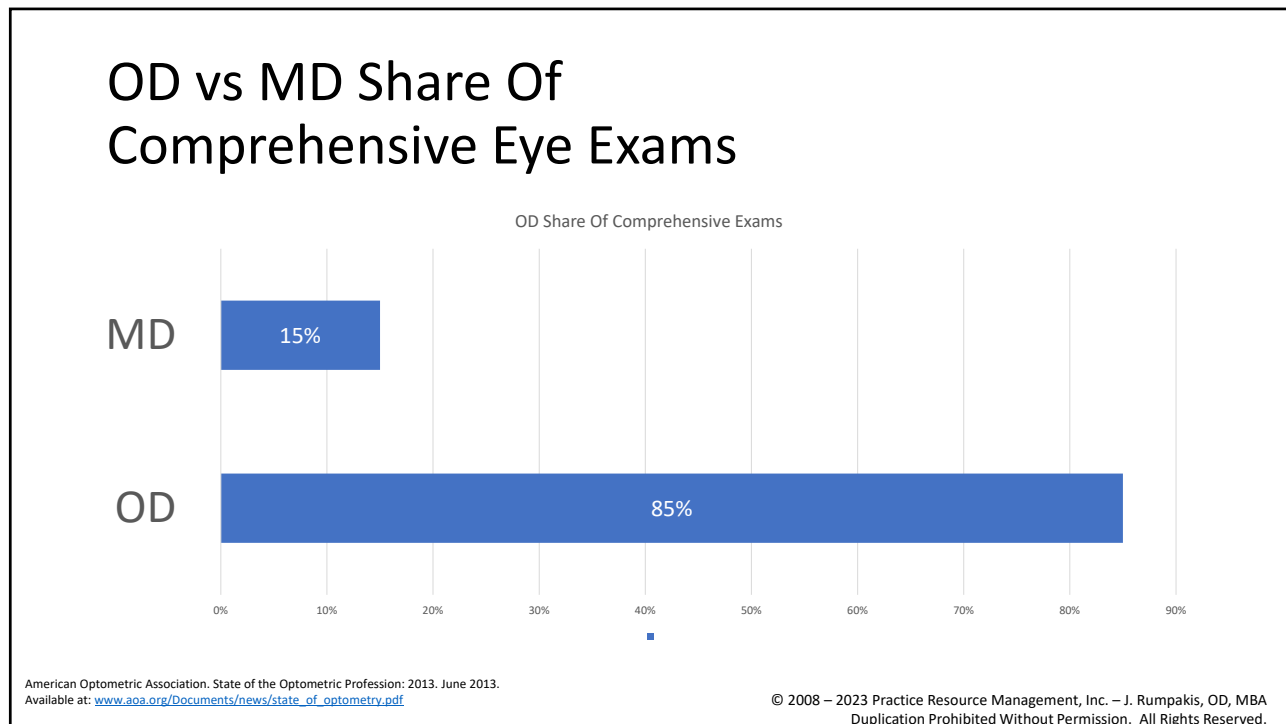
Let's See Some Data



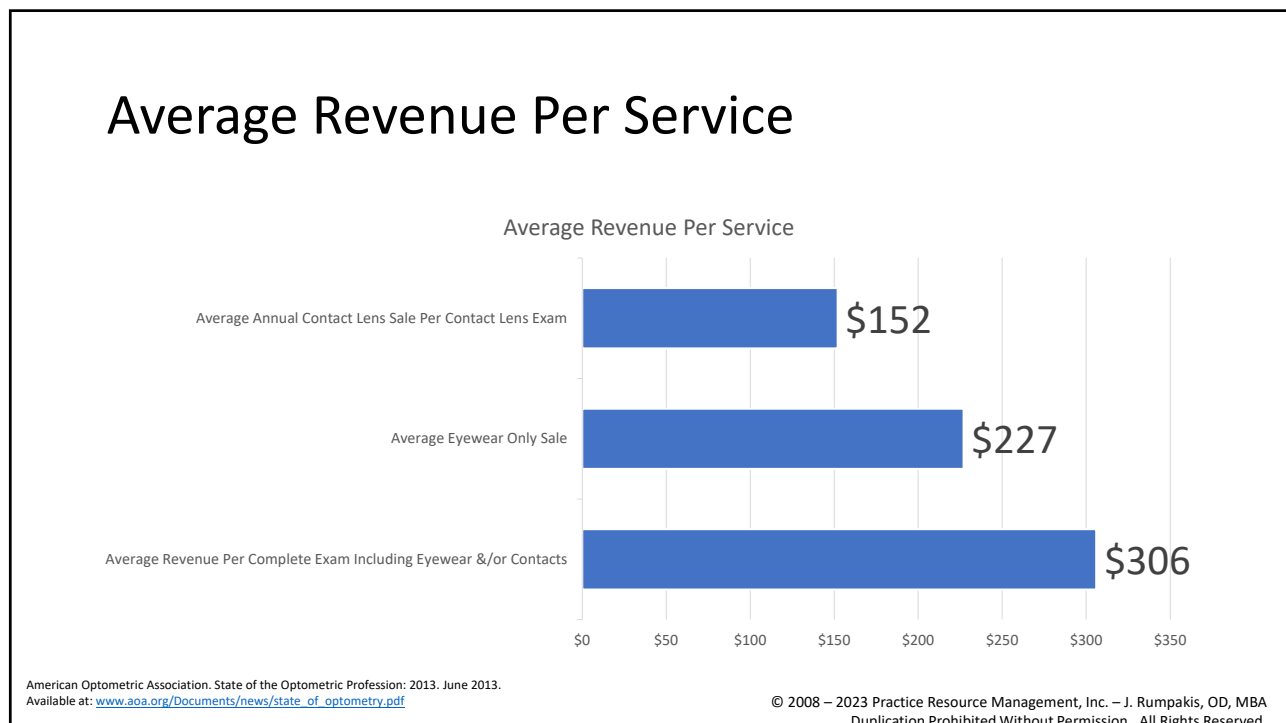
American Optometric Association. State of the Optometric Profession: 2013. June 2013.
Available at: www.aoa.org/Documents/news/state_of_optometry.pdf

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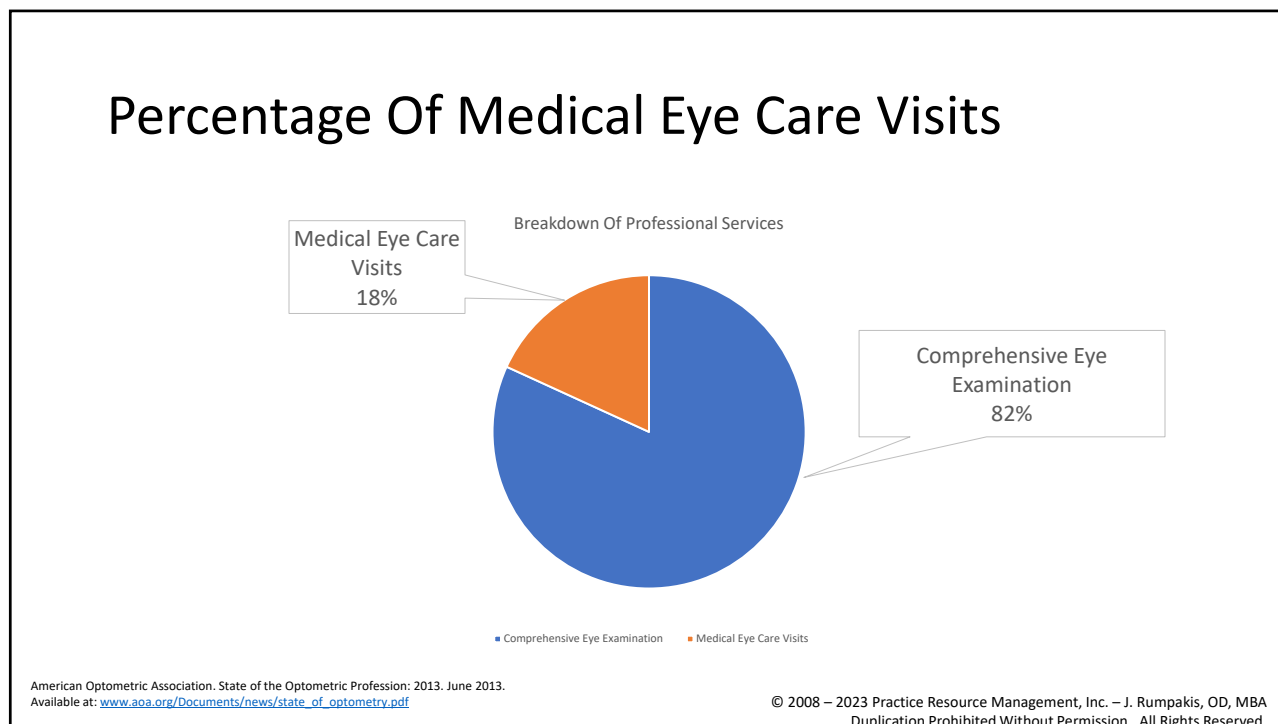
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Some Numbers To Consider

Revenue, Earnings, Debt, Challenges & Opportunities

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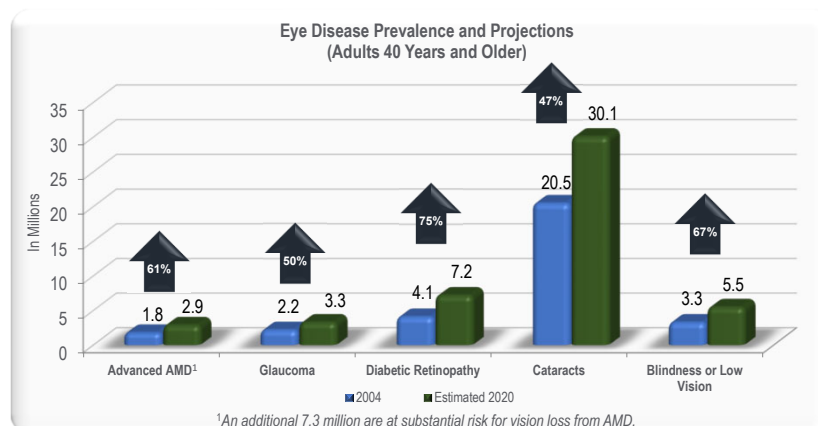
Trends Affecting Practices

- Downward pressure on refractive reimbursements
- Increasing costs for practice owners
- Increasing demand for care (baby boomers)
- Contracting supply of ophthalmologists
- More patient pay (deductibles, diagnostics, treatments)
- More savvy patients – more online transactions
- EMR and other technology – telehealth?
- Need for better-trained staff – remote care delivery?
- Practice consolidation, PE acquisitions, closures
- Healthcare reform – whatever this means???
- Impact of AI

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Incidence Rates in Americans - Age 40+

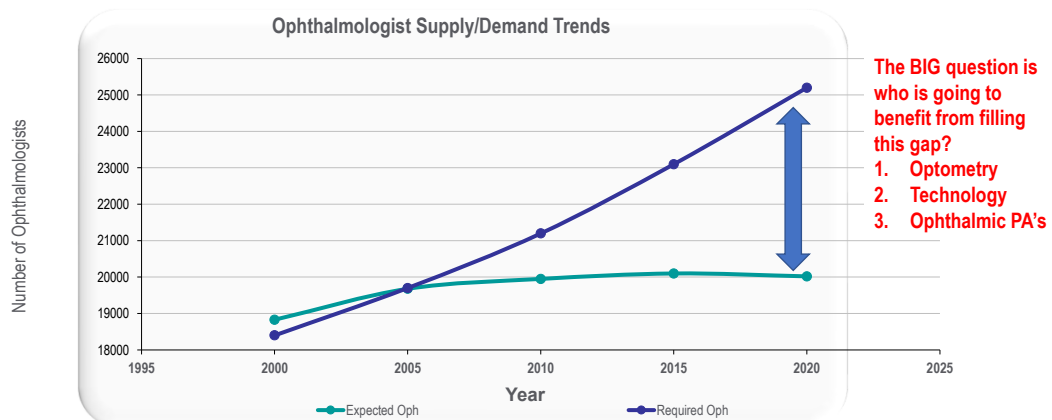


Source: National Eye Institute, 2004 Study. The study examined primarily advanced AMD, glaucoma, diabetic retinopathy, and cataracts, noting these as the four most common eye diseases in Americans age 40 years and older.

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Eye Care Provider Trends



Source: DHHS Physician Supply and Demand Projections to 2020.

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Today Our Thoughts &
Actions Are Driven By:

Fear
Safety
Finance
Fear



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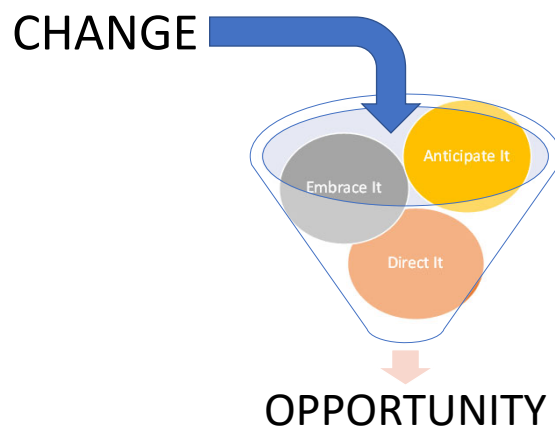
Having The Right Frame Of Mind Is Critical

And having the foundation, resources, network and confidence to succeed

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We Have To CHANGE The Change Cycle!



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Past – Present - Future



Past

We accepted all insurance plans (MVC & Medical) indiscriminately
We made up for poor reimbursement with sufficient volume
We were (overly) generous with our time
We were complacent with profitability
TeleHealth, although available, never used



Present

Psychological burden for patients, staff, and self is high
Disruption creates GREAT opportunity for change
Volume is significantly reduced
Profitability significantly impacted
Time & how to use it most effectively has finally risen to the top of our list
Everyone excited about TeleHealth

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Past – Present - Future



Future

We will be much more analytical about practice
We will have to be less dependent on managed vision care plans
We will manage our service & retail businesses separately
Profitability will be calculated, not just happenstance
Our services will be a mix of virtual & in person
Hybrid exam including online refraction will be common
Much more of a focus on proper business metrics

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“I’m All For Progress,
It’s Just Change I Don’t Like”
~Mark Twain

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The Landscape

What Is Going On In The Broader Health Care Marketplace?

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The “Affordable” Care Act

The Patient Protection and Affordable Care Act was signed into law by former President Obama in March 2010. Its major provisions went into effect in Jan. 1, 2014, although significant changes went into effect before that date and will continue in years to come.

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What Are The Pillars Of The ACA?

Essential Health Benefits	Employers Must Offer Health Coverage <small>Never Implemented!</small>	Individuals Must Obtain Coverage <small>No Longer Required!</small>	
<small>Increased Deductibles!</small>	Cost Shifting	Reduce Utilization	Outcome Based Care

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"So you've got this crazy system where all of a sudden 25 million more people have health care and then the people who are out there busting it, sometimes 60 hours a week, wind up with their premiums doubled and their coverage cut in half. It's the craziest thing in the world,"

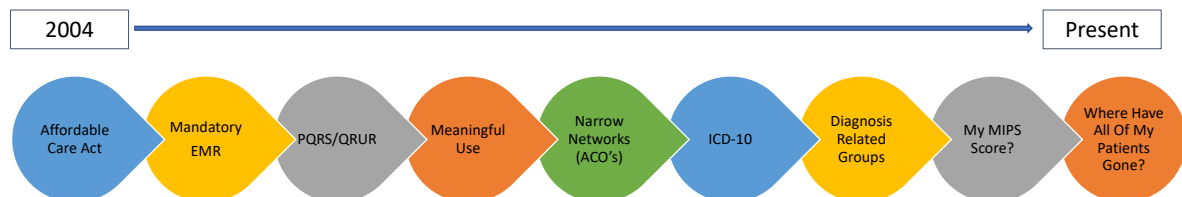
Former President Bill Clinton

October 5, 2016

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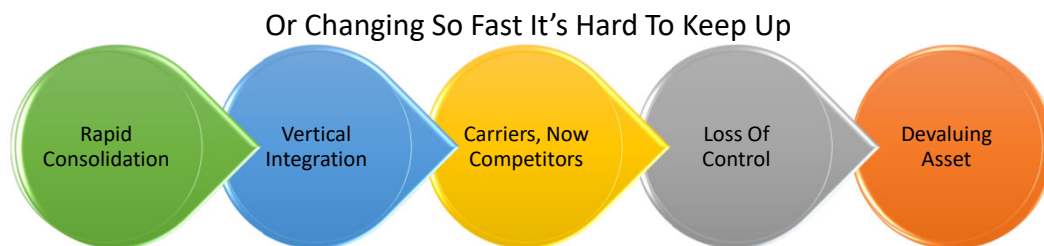
Let's Talk About The Total Patient Care Model In An Outcome Based World



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In A Marketplace That Is Less & Less Familiar



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What Do You Think Is Happening In Health Care?

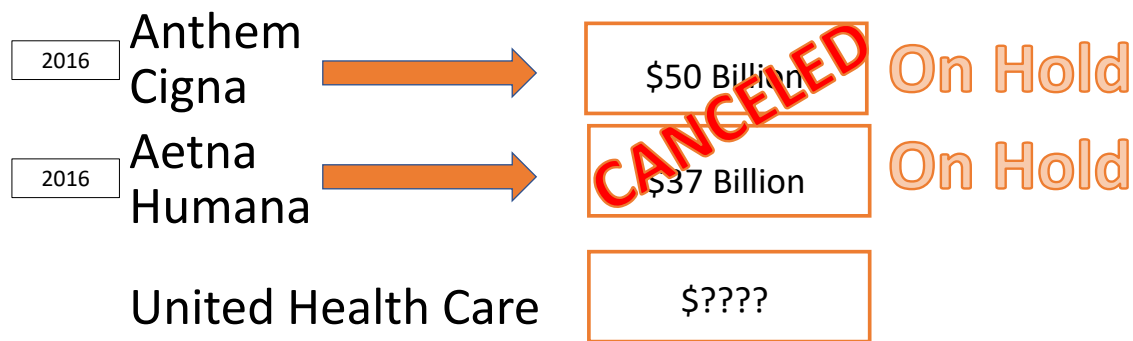
And how is it affecting the independent eye care professional?

Changes In Practice Landscape Drive Changes In Behavior

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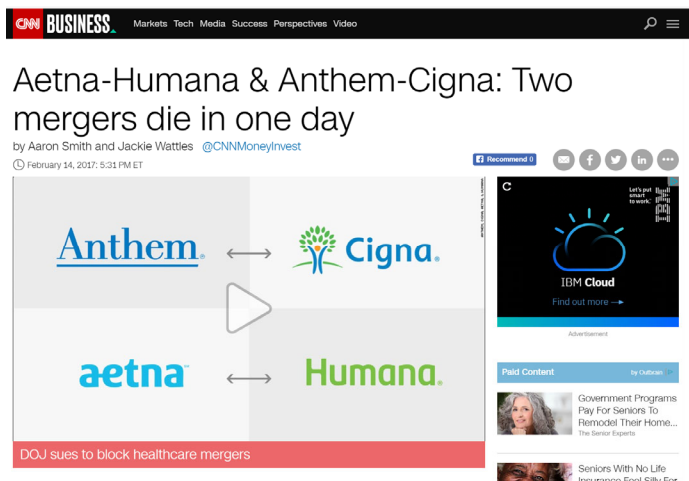
The Big Five Are Now The Big Three



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And Then The
Government
Had It's Say



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Reviews
Optometric Business

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Q f t i n

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NEWS BRIEF'S ARCHIVE

MetLife to Acquire Versant Health for \$1.7 Billion

f t in

Print Friendly

Sept. 23, 2020

MetLife Inc. has entered into a definitive agreement to acquire Versant Health from an investor group led by Centerbridge Partners and including FFL Partners for approximately \$1.675 billion in an all-cash transaction, according to a recent announcement reported on by Vision Monday. Versant Health owns the well-established marketplace brands Davis Vision and Superior Vision.

Following the acquisition, MetLife will gain access to Versant Health's roughly 35 million members, and MetLife's existing customers will gain access to Versant Health's extensive provider network, which is one of the largest in the industry.

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Top Ways to Generate Referrals from Other Healthcare Practices

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The Sterilization Technology My Practice Has Added

FINANCES
How to Make a PE Deal that Includes a "Second Bite" of Profitability

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Wonkblog

UnitedHealth Group to exit Obamacare exchanges in all but a 'handful' of states

A

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Save for Later

Reading List

By Carolyn Y. Johnson April 19 at 9:46 AM

[Follow @carolynjohnson](#)

UnitedHealth Group Inc. signage stands in front of the company headquarters in Minnetonka, Minnesota. (Mike Bradley/Bloomberg)

UnitedHealth Group, the nation's largest health insurer, said that in 2017 it will exit most of the 34 states where it offers plans on the Affordable Care Act insurance exchanges in an earnings call.

THE WALL STREET JOURNAL.

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Insurance Options Dwindle in Some Rural Regions

Some health insurers quit unprofitable markets; ACA exchanges in some areas will have one insurer

Insurance Options Dwindle in Some Rural Regions

Some health insurers quit unprofitable markets; ACA exchanges in some areas will have one insurer

By ANNA WILDE MATTHEWS and STEPHANIE ARMOUR
April 19, 2016, 7:42 p.m. ET

Health-insurance customers in a growing number of mostly rural regions will have just one insurer's plans to choose from on the Affordable Care Act's exchanges next year, as some companies pull out of unprofitable markets.

"Highest in Customer Satisfaction Among Traditional Carriers in North America," Nine Years in a Row

Alaska AIRLINES

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Latest News

MyEyeDr Acquires Doctors Vision Center

By Staff
Thursday, January 2, 2020 1:11 PM



VIENNA, Va.—MyEyeDr, the regional eyecare group based here, today acquired Doctors Vision Center (DVC), including the brand and the corporate-owned locations of the group, one of the leading retail retailers in North Carolina. The purchase price was undisclosed.

With this acquisition along with those in other states as well as four European locations and seven other one- or two-office practices in North Carolina over the past year, the MyEyeDr group now has 62 locations with \$123 million in revenue, executives said today. They added that this exceeds its previously stated goal of 60 locations with \$100 million in revenue by the end of 2019, a target they announced after an infusion of private equity capital from Horizon Capital Partners in December 2012, as reported by VMEI March 13, 2013.

MyEyeDr now has 500 employees, which has grown from the 500 it had when the announcement was made in March 2013. Founded in 2001 by Robert Samit, OD, and president Sue Davies, MyEyeDr generated revenue of \$75 million from 42 locations in 2013, according to Vision Monday's ranking of the Top 50 U.S. Optical Retailers. Doctors Vision Center generated revenue of \$43.5 million from 42 locations in 2013, according to Vision Monday's Top 50 report.

MyEyeDr continues actively pursuing other acquisitions with more to be announced shortly that will bring the company closer to 100 locations, Davies said.

Latest News

MyEyeDr's Fast-Paced Expansion Grows at a Rate of One Location Per Week

By John Sauer
Tuesday, September 23, 2014 2:00 PM



VIENNA, Va.—Following its goal of 60 locations and \$100 million in revenue by the end of 2013, MyEyeDr's expansion drive continues unabated. Thanks to an infusion of an undisclosed amount of private equity capital from Horizon Capital Partners, Capital Partners in December 2012, MyEyeDr has grown to 62 locations in North Carolina, located here to 2013 and from 42 to 62 locations at the end of 2013 to 62 locations in the end of 2013. The company now operates 62 locations in Maryland, Va., Virginia, Maryland, North Carolina, South Carolina and Georgia with about 500 staff.

Not only has private equity enabled MyEyeDr to afford the purchase price of its acquisitions, but it has also helped MyEyeDr and its acquisition teams, said Robert Samit, CEO and president. He said the company operates three locations in each state and has a strong presence in each state.

Latest News

MyEyeDr Acquires Eye Care Associates in North Carolina

By Staff
Monday, November 10, 2014 10:00 AM




VIENNA, Va.—MyEyeDr announced today the acquisition of Eye Care Associates, a group of 12 optometric practices in North Carolina. The acquisition is part of MyEyeDr's expansion drive to grow its footprint in the Southeast. The acquisition is expected to be completed by the end of the year. MyEyeDr has a strong presence in each state and has a strong presence in each state.

Latest News

MyEyeDr Expands Into Florida Market With Acquisition of The Hour Glass/South East Eye Specialists

By Staff
Monday, May 11, 2015 10:30 PM



VIENNA, Va.—MyEyeDr today closed on the acquisition of The Hour Glass and South East Eye Specialists with seven locations in Tallahassee, Fla., and in Southern Georgia. The deal represents MyEyeDr's initial expansion into the Florida market. Terms of the transaction were not disclosed.

Founded by James A. Stephens, OD, 30 years ago, The Hour Glass currently operates five locations based in Tallahassee and surrounding areas and two locations based in Tallahassee, Georgia and Albany, Georgia. Dr. Stephens, who grew up in the area, attended Florida State University, is a past Florida Optometric Association Optometrist of the Year and past president of the Florida Optometric Association. In addition, the 12 ODs of The Hour Glass/South East Eye Specialists, will be a strong addition to MyEyeDr's portfolio of doctor driven practices. The company said today, MyEyeDr has been pursuing a major expansion plan, acquiring both large groups and individual practices. In December 2014, the group acquired Eye Care Associates in North Carolina, as previously reported.

The only practice in the group that MyEyeDr is not purchasing is John D. Bell Optometry. Dr. Stephens and Dr. Bell will continue to own and operate that office separately, said David Steffen, executive vice president, MyEyeDr.

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Monday, June 3, 2019

BUSINESS | EYECARE | TECHNOLOGY | STYLE | PEOPLE | SCENE + HEARD | INSIGHT

Latest News

Goldman Sachs Division to Acquire Capital Vision Services, Manager of MyEyeDr. Group, from Altas Partners and CDPQ

By Staff
Monday, June 3, 2019 9:30 AM



NEW YORK & VIENNA, Va. and TORONTO & QUEBEC CITY, Québec-- West Street Capital Partners VII, a fund managed by the Merchant Banking Division of Goldman Sachs (GS MBD), Altas Partners and Caisse de dépôt et placement du Québec (CDPQ) announced today their entry into a definitive agreement under which GS MBD will acquire Capital Vision Services, LP (CVS) from Altas and CDPQ. Capital Vision Services provides management services to MyEyeDr. The terms of the deal, which is expected to be closed in the third quarter, according to the announcement, were undisclosed. However the Wall Street Journal earlier this morning in its own report, valued deal as \$2.7 billion, including debt.

MyEyeDr supports affiliated independent MyEyeDr. optometrists and their practices with a complete array of financial, marketing, human resources, and accounting services, along with managed care credentialing and claims processing. MyEyeDr. practices offer patients personalized and essential eyecare services, a selection of prescription eyeglasses and sunglasses, and standard and specialty contact lenses to meet their unique vision, health and wellness needs, the company said.



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Latest News

FFL Partners Makes Growth Investment in Clarkson Eyecare

By Staff
Monday, April 6, 2015 8:00 AM

Latest News

Warby Parker Raises \$100M, Now Valued at \$1B

By Staff
Thursday, April 30, 2015

Latest News

Clarkson Eyecare Acquires

By Staff
Wednesday, July 1, 2015 12:30 AM

Latest News

Warby Parker Partners Online

By Staff
Monday, August 10, 2015 12:24 AM

Latest News

Global Investment Firm Partners Group to Acquire a Majority Stake in EyeCare Partners from FFL Partners

By Staff
Monday, December 16, 2019 11:08 AM





Latest News

EyeCenter of the Carolinas

one of the largest eyecare groups in the strategic investment in EyeCenter (ECC), ce across North Carolina and South Carolina. ed as financial advisor to ECC, and Golub ir the transaction. Details of the transaction

Latest News

EyeCare Partners

DENVER and BAAR-ZUG, Switzerland—Partners Group, a global private markets investment manager, announced this morning that it has agreed to make "a significant equity investment" in EyeCare Partners LLC (ECP), a leading vertically integrated medical vision services provider in the U.S. Partners Group will become the majority shareholder, while ECP's management team and physician partners will continue to maintain a substantial equity stake in the 450-location practice group, according to the announcement. The transaction with FFL Partners selling its stake in ECP, is expected to close in the first quarter of 2020. The terms of the deal were not disclosed.


Latest News

EyeCare Partners

Both sur Parker spokesperson told VMail, "Cu Warby Parker associate, while all ot said. "Nordstrom's approach to customer When Olivia asked us to team up, w Dave Gilboa, about Olivia Kim, the c high/low price range to match each new theme.

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Wednesday, June 5, 2019

BUSINESS | EYECARE | TECHNOLOGY | STYLE | PEOPLE | SCENE + HEARD | INSIGHT

Latest News

Acuity Eyecare Group Acquires Two Pittsburgh-Area Optometry Practices in Separate Transactions

By Staff
Wednesday, June 5, 2019 12:24 PM




July 02, 2019

www.visionmonday.com

NEWS NOW

Acuity Eyecare Group Continues Acquisition Momentum With Deal for Pediatric & Adult Vision Care

DALLAS—Acuity Eyecare Group (AEG) will be portfolio company Acuity Eyecare Group (AEG), an owner and operator of leading North American vision groups and optometry practices. The deal is expected to close in the first quarter of 2020.




July 31, 2019

www.visionmonday.com

NEWS NOW

Acuity Eyecare Group Enters Texas Market With Two Multi-Location Acquisitions

DALLAS—Acuity Eyecare Group (AEG) announced Tuesday that it has acquired two multi-location optometry practices in Texas. The practices are located in Dallas and Houston, Texas. The practices are expected to close in the first quarter of 2020.



September 04, 2019

www.visionmonday.com

NEWS NOW

Acuity Eyecare Group Continues Texas Growth With Acquisition of Eight Practice Locations

DALLAS—Acuity Eyecare Group (AEG), an owner and operator of leading North American vision groups and optometry practices, has announced an additional eight optometry practice locations. The deal is expected to close in the first quarter of 2020.

And For PE, Just Business As Usual But At A Different Cost

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Latest News

Warby Parker on Track to Open 25 More Locations by Year's End

By Staff
Wednesday, July 19, 2017 12:24 AM

NEW YORK—As it moves ahead toward its goal of establishing 25 new brick-and-mortar locations in 2017, Warby Parker is opening two new stores in the July 8 to 22 timeframe, including its first store in Colorado. If the retailer, which launched as an online-only business, hits its target of 25 openings this year, it will close 2017 with more than 70 showroom locations.

The first Colorado store opened in the east end of Boulder during the weekend of July 8 to 9. Another new Warby Parker location is expected to debut Saturday (July 22) in Plano, Texas, a spokeswoman confirmed to VMail. In addition, a new Warby Parker location is expected to open in nearby Fort Worth before the end of the year.

The two openings mark the 53rd and 54th locations that Warby Parker has opened since its debut in 2010. Warby Parker finished 2016 with 46 retail/showroom locations and ranked No. 11 on the Vision Monday Top 50 U.S. Optical Retailers list.

"Our first store in the state [of Colorado], in the heart of downtown Boulder on historic Pearl Street, is the home base we've been eager to build for years—and it has the best mountain view of any Warby Parker store in existence," co-founder and co-chief executive officer Dave Gilboa said in a statement announcing the Boulder opening.

Texas is becoming one of the company's key markets in terms of brick-and-mortar showrooms, also. Warby Parker previously opened two stores in Austin and two stores in the Dallas market, and is preparing to open its first location in Houston before the end of the year. Warby Parker expects to open single locations in Los Angeles and Milwaukee, Wis., later this year, according to its website.

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ReviewOptometric Business

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Warby Parker to Accept Vision Insurance in 2018

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Latest News

Warby Parker Now Available to People Enrolled in UnitedHealthcare Medicare Advantage Plans

By Staff
Wednesday, November 21, 2018 12:18 AM

WARBY PARKER

UnitedHealthcare

MINNETONKA, Minn.—Warby Parker's prescription eyewear is now available to approximately two million people enrolled in UnitedHealthcare Medicare Advantage plans, either online at WarbyParker.com or at more than 80 Warby Parker stores nationwide. This marks the first time Warby Parker is accepting Medicare insurance. People enrolled in Medicare Advantage plans that include eyewear benefits through UnitedHealthcare Vision can purchase prescription eyewear from Warby Parker for little or no out-of-pocket cost, often for less than \$50.

The expansion builds on an existing network relationship that provides people with employer-sponsored and individual UnitedHealthcare plans access to Warby Parker's eyewear for only a copayment. UnitedHealthcare became the first insurance plan accepted by Warby Parker in 2017, as [VMAZL reported](#) and UnitedHealthcare anticipated the expansion of the program to UnitedHealthcare's vision members nationally this year.

During the open-enrollment season for 2019 health benefits, UnitedHealthcare is enhancing its vision benefits for people enrolled in employer-sponsored and individual plans, the company said.

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January 12, 2015 4:52 pm

GrandVision NV
Retail
10,001+ employees

Dutch Optician Group Raises

Latest News

GrandVision NV Reports 4.1 Percent Comparable Growth for the Full Year and Q4 2015

By Staff
Friday, December 4, 2015 12:18 AM

GrandVision

FOR EYES

SCHIPOL, The Netherlands—GrandVision NV (EURONEXT: GVINV), has reported that the Group's overall comparable sales growth was 4.1 percent, based on constant exchange rates, for the full year and fourth quarter 2015. This includes a 4.1 percent growth in the G4 segment, 3.2 percent throughout what it calls "Other Europe" and 6.6 percent in the Americas and Asia.

In Q4 fiscal 2015, comparable growth reached 2.2 percent following growth of 6.2 percent in the prior year's Q4. The G4 segment achieved 3.0 percent comparable growth with a consistent performance across all markets. Other Europe recorded a decline of 0.7 percent, mainly due to a slowdown in Italy and Northern Europe, the company said. In the Americas & Asia segment, comparable growth was 5.6 percent as high single digit growth in Latin America was partially reduced by a mid-single digit decline in Russia.

The figures are unaudited. GrandVision will report the its full year and Q4 results on March 16. The company noted that the Americas & Asia segment includes the U.S. as of Dec. 1, 2015. Comparable growth for the U.S. will be included after its first full calendar year of consolidation.

GrandVision operates leading optical retail banners and operations, doing business in over 6,000 stores in 44 countries across Europe, the Americas, the Middle East and Asia.

As [VMail](#) has previously reported, GrandVision completed its acquisition of the [For Eyes Optical](#) retail chain in the U.S. in December.

GVNV), the major global acquisition of 100 percent of the proposed deal was the U.S. market, as [VMail](#)

00 people and operates revenue in 2014 of

and Asia business

ture operation or those S. market.

tries across Europe, Latin Optik in Germany, Pearle ile d'Optique and Opticas Lux and Masvisión

GrandVision a market val investment firm said in a trading commenced in Amsterdam.

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BUSINESS | EYECARE | TECHNOLOGY | STYLE | PEOPLE | SCENE + HEARD | INSIGHTS

Latest News

GrandVision Says Revenue Rose 7.5 Percent in Q1 as Company Prepares to Strengthen 'Digital' Capabilities

By Staff
Monday, April 29, 2019 12:21 AM

f t in t e



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Saturday, July 27, 2019

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Latest News

HAL in Talks With EssilorLuxottica About Possible Sale of GrandVision

By Staff
Wednesday, July 17, 2019 12:40 PM

ESSILORLUXOTTICA

GrandVision

GrandVision is a global optical retailer that operates over 7,200 stores and has more than 37,000 employees. The company, based in Schiphol, The Netherlands, offers a wide range of services as well as prescription glasses, contact lenses and contact lens care products, and sunglasses both plain and with prescription lenses. These products are offered through leading optical brands or banners which operate in more than 40 countries across Europe, the Americas, the Middle East and Asia.

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ESSILORLUXOTTICA

GrandVision

CHARENTON-LE-PONT, France—EssilorLuxottica announced today that it will significantly expand its retail footprint through an agreement with Hal Optical Investments B.V., a wholly-owned subsidiary of HAL.



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Saturday, February 8, 2020

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Latest News

GrandVision Reports Sales Growth of 8.6 Percent in FY19 and Says Work Continues on Regulatory Approvals of EssilorLuxottica Deal

By Staff
Friday, January 24, 2020 12:24 AM

GrandVision

GrandVision is a global optical retailer that operates over 7,200 stores and has more than 37,000 employees. The company, based in Schiphol, The Netherlands, offers a wide range of services as well as prescription glasses, contact lenses and contact lens care products, and sunglasses both plain and with prescription lenses. These products are offered through leading optical brands or banners which operate in more than 40 countries across Europe, the Americas, the Middle East and Asia.


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Wednesday, March 13, 2019

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Latest News

VSP Global to Expand Retail Strategy, Open Eyeconic Stores and Launch VSP Ventures


By Staff
Wednesday, March 13, 2019 12:27 AM

RANCHO CORDOVA, Calif.—VSP Global is announcing today an expanded retail strategy which includes its intent to open three brick-and-mortar Eyeconic locations as well as the launch of VSP Ventures, a new business unit designed to offer a care-focused choice for doctors looking to transition their practices. "Benefits managers are demanding more substantial retail options and doctors have been asking VSP to create a doctor-centric alternative to private equity. It's critical for VSP to ensure this evolving landscape serves both our members and VSP network doctors in mutually beneficial ways," said Michael Guyette, president and CEO of VSP Global.

"A well-defined network strategy, which includes retail, allows us to provide a variety of options for doctors at every career stage and in every kind of practice setting—from privately owned, to dispensary-managed, to VSP-owned and operated." A VSP spokesperson defined "dispensary-managed" as "a model that allows for either co-ownership of the dispensary (frames, lenses, etc.) or one where the practice agrees to deploy technologically advanced tools that enhance the consumer experience and that drive value and profitability to the doctor."



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Soccer Star Alecko Eskandarian Will Speak at Neuro-Optometric Rehabilitation Association Conference

Pan-Oceanic Eyewear Partners With ESE International to Distribute Children's Brand Frames

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BUSINESS | EYECARE | TECHNOLOGY | STYLE | PEOPLE | SCENE + HEARD | INSIGHT

Latest News

VSP Ventures and Rosin Eyecare Form JV to Acquire Two Eyecare Practices in Tennessee

By Staff
Wednesday, June 5, 2019 12:27 AM











Steve Baker (l), VSP Ventures and Jonathan Rosin, MD, of Rosin Eyecare.

RANCHO CORDOVA, Calif.—VSP Ventures and Rosin Eyecare have established a joint venture through which the organizations have acquired two practices in Tennessee, Shanks Family Eye Care and Coley and Coley Family Eye Care. Both practices are in the Nashville, Tennessee market and will continue to operate under their respective brands, executives said. “We’re pleased to partner with an organization of the caliber of Rosin Eyecare, leveraging their expertise to ensure seamless transitions for practices,” said Steve Baker, president of VSP Ventures. “Our first two acquisitions enable the founding doctors to continue their passion for delivering exceptional patient care.”

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Friday, June 28, 2019



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Latest News

VSP Global Opens Its First Two Eyeconic Brick-and-Mortar Stores in Chicago

By Staff
Wednesday, June 26, 2019 12:27 AM











a differentiated eyecare and eyewear experience. Transparent prices and seamless digital and physical retail access are the cornerstones of our brand. And in partnership with a doctor of optometry, we now offer comprehensive eye exams using state-of-the-art technology to ensure eye health and wellness remains the focal point of our customer journey.”

RANCHO CORDOVA, Calif.—VSP Global enters brick-and-mortar retailing today with the opening of the company’s first two Eyeconic stores in the country, located in the Chicago market. The Bucktown location has had a soft opening since mid-June and will have a grand opening on June 29, while the second will be in Fulton Market opening on July 13, the company said. In an interview with VMAIL, Bill Vaughan, president of VSP Retail, described some of the thinking and planning that went into creating the digital and merchandising features of the new locations, noting that the stores “will serve as an extension of VSP’s e-commerce Eyeconic site, connecting products, services and a VSP network doctor to retail minded consumers who are looking for experiences that bridge the divide between digital and physical.”

VSP originally announced its intentions to expand Eyeconic via brick-and-mortar stores back in March, as VMAIL reported. Vaughan said, “We are thrilled to bring the very first Eyeconic stores to Chicago and offer customers



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Alpine Investors Makes Strategic Growth Investments in Ohio Eyecare Practices

Dr. Alan R. Morse Will Retire As President and CEO of Lighthouse Guild

NuSight Granted U.S. Patent Covering the NuLids System for Treating Dry Eye Disease

Lighthouse Awards 18 College Scholarships to Students With Vision Loss

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Physician Practice Sales to Private Equity Doubled in 3 Years

Alicia Ault
February 18, 2020

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Private investor purchases of medical practices more than doubled between 2013 and 2016, a new study shows. When analyzed by specialty, the authors found that anesthesiology has accounted for the most sales to such entities, but acquisitions occurred across a host of specialties.

The study, [published online](#) today in the *Journal of the American Medical Association*, documents an accelerating trend that has been causing consternation in some quarters and celebration among some physicians who have been glad to get a cash infusion to support their practices or to help finance their retirement.

During the 3-year study, 355 physician practices were purchased by private

What will artificial intelligence mean for medicine?

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PODCAST

Eric Topol, MD
Editor-in-Chief
Medscape

Abraham Verghese, MD

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Forbes

Billionaires Innovation Leadership Money Consumer Industry Lifestyle

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4,056 views | Apr 8, 2019, 08:30am

Big Blue Cross Plans To Open Primary Care Clinics In Texas And Beyond

Bruce Japsen Senior Contributor @Healthcare
I write about healthcare business and policy

CHICAGO – JULY 09: Blue Cross Blue Shield Tower on July 09, 2014 in Chicago, Illinois. (Photo By Raymond Boyd/Getty Images) 2014 SHOOTING.COM

The venture capital arm of five Blue Cross and Blue Shield plans has partnered with global primary care provider Sanitas USA to open medical centers in Texas as a precursor to a U.S. multi-state rollout.

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THE WALL STREET JOURNAL

Essilor, Luxottica to combine, creating eyewear giant worth \$49 billion

Published: Jan 16, 2017 3:33 a.m. ET


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Luxottica's chairman L




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Essilor/Luxottica Merger Corners Half Of The World's Sunglasses

SGB Media · 3 days ago



In focus: Essilor and Luxottica unite

Optician Online · 19 hours ago



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The Economist · 10 hours ago

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Thursday, March 28, 2019

BUSINESS | EYECARE | TECHNOLOGY | STYLE | PEOPLE | SCENE + HEARD | INSIGHTS | JOBS

Latest News

Differences Emerge Around Management and Governance of EssilorLuxottica

By Staff
Friday, March 22, 2019 12:33 AM

CHARENTON-LE-PONT, France and LUXEMBOURG—The Essilor and Luxottica merger was formally completed and closed last October. However, differing views about future management and governance of the combined company, EssilorLuxottica (ESLXPA), emerged in Europe mid-week, as Leonardo Del Vecchio, executive chairman of EssilorLuxottica and chief of Luxottica and Hubert Sagnieres, executive vice chairman of EssilorLuxottica and head of Essilor, each issued separate statements raising questions about how the leadership transition and control of the combined companies will move forward.

ESSILORLUXOTTICA

Agreement between Essilor and Delfin is, in Delfin's opinion, a clear violation of the Combination Agreement and of the company's governance rules."



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RUN THE DIAMOND

MORE ON: LATEST NEWS

Delfin Calls for Arbitration on EssilorLuxottica Merger

NPS College Bowl Student Optician Event Sponsored by Hoya Vision Care Debuts at Vision Expo East

Essilor's Sagnieres Seeks to Reassure Staff That Governance Issues Will Not Derail Merger with Luxottica

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Delfin Calls for Arbitration on EssilorLuxottica Merger

LUXEMBOURG—The war of words between [Luxottica](#) founder Leonardo Del Vecchio and [Essilor](#) chairman Hubert Sagnieres over issues involving the governance of the newly merged [EssilorLuxottica](#) [Read More](#)

ESSILORLUXOTTICA

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POLITICO Magazine Trump Presidency

Generics Drive Savings, Not Costs

Humana becomes first major insurer to quit Obamacare exchanges

The company said it doesn't see any signs that the law's marketplaces are getting healthier.

By ADAM CANCRYN | 02/14/17 07:22 AM EST | Updated 02/14/17 06:48 PM EST

Health insurance giant Humana on Tuesday said it will quit Obamacare's insurance markets altogether, announcing it will stop selling individual coverage in 2018.

Aetna becomes latest insurer to flee ACA exchanges

By TOM MURPHY, AP HEALTH WRITER
May 11, 2017, 8:13 AM ET

HEALTH CARE BACKLASH

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THE WALL STREET JOURNAL

Home World U.S. Politics Economy **Business** Tech Markets Opinion Life & Arts Real Estate WSJ Magazine

CVS to Buy Aetna for \$69 Billion, Combining Major Health-Care Players

Deal is latest and most dramatic sign of how the lines between traditional segments in health care are blurring

CVS pharmacy

Pedestrians walk past a CVS store in Chicago. PHOTO: CHRISTOPHER DILTS/BLOOMBERG NEWS

By Sharon Terlep, Anna Wilde Mathews and Dana Cimilluca
Updated Dec. 3, 2017 9:09 p.m. ET

CVS Health Corp. **CVS** -1.93% agreed to buy **Aetna** 0.63% Inc. for about \$69 billion in cash and stock in a move to transform the pharmacy company and capture more of what consumers spend on health care.

83 COMMENTS

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CVS to offer nationwide telemedicine service through smartphone video

Nathan Bomey, USA TODAY Published 12:01 a.m. ET Aug. 8, 2018 | Updated 12:07 a.m. ET Aug. 8, 2018



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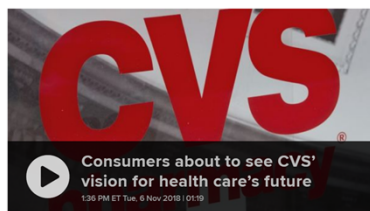
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CVS to test stores with added health services early next year after Aetna deal closes

- CVS expects its roughly \$69 billion acquisition of health insurer Aetna to close before Thanksgiving.
- CVS plans to open its first concept stores early next year, CEO Larry Merlo said Tuesday.
- Merlo outlined areas CVS will focus on to reduce medical costs once the deal closes.

Angelica LaVita | @angelicalavita
Published 9:31 AM ET Tue, 6 Nov 2018 | Updated 1:40 PM ET Tue, 6 Nov 2018
CNBC



Consumers will soon start to see CVS Health's vision for the future of health care.

CVS expects its roughly \$69 billion acquisition of health insurer Aetna to close before Thanksgiving, the company said Tuesday when announcing third-quarter financial results. The combined company has pledged to improve health services and outcomes and lower costs.

CVS plans to open its first concept stores early next year, CEO Larry Merlo told Wall Street analysts Tuesday. Merlo outlined areas CVS will focus on to reduce medical costs for the combined company once the deal closes.

Four examples Merlo outlined Tuesday include:

- Managing five common chronic conditions — diabetes, cardiovascular disease, hypertension, asthma and behavioral health.
- Optimizing and extending primary care, including to expand the scope of services available at CVS' MinuteClinics to help identify and manage chronic diseases.
- Reducing avoidable hospital readmissions by combining Aetna's clinical programs with CVS' stores to guide patients when they're discharged.
- Managing complex chronic diseases, such as kidney disease.

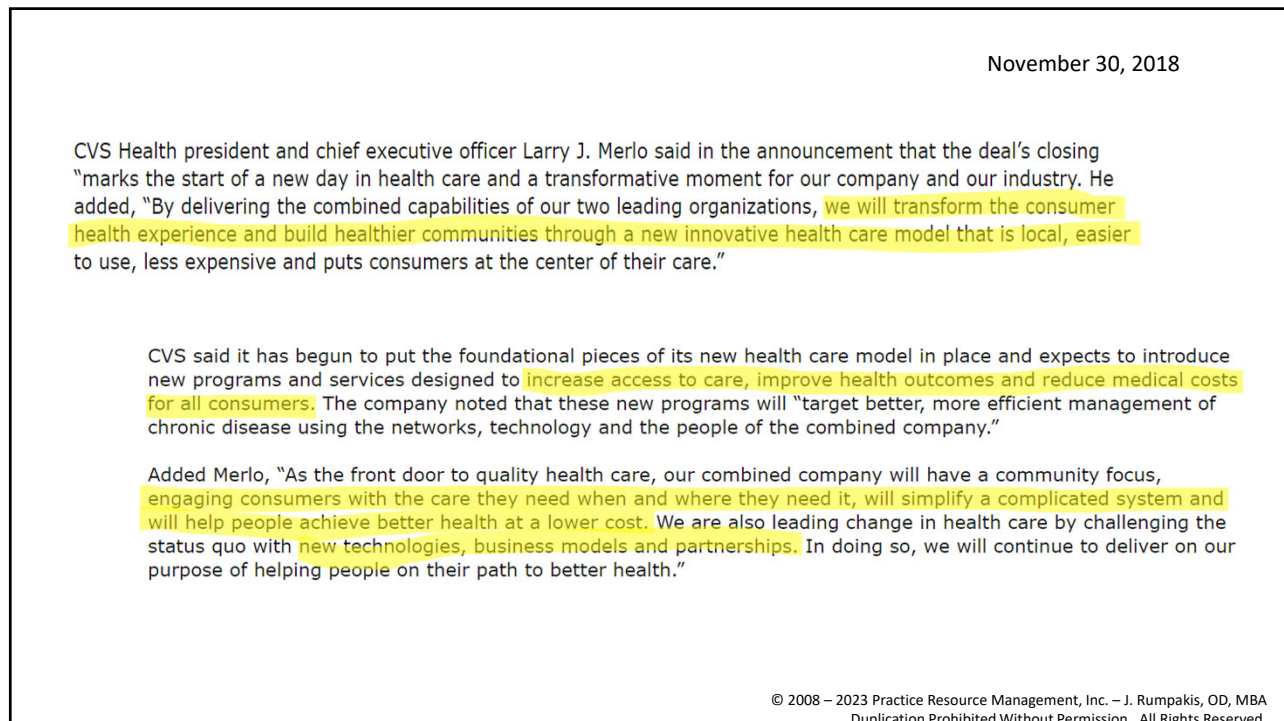
Merlo said CVS will pilot these programs at the concept stores to learn which programs are most effective and able to be scaled across CVS' locations. The company currently operates about 10,000 stores and 1,100 MinuteClinics.

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The screenshot shows a WSJ article from April 5, 2019. The headline is "Federal Judge to Hold Hearings on Decision to Allow CVS-Aetna Merger". The sub-headline states: "U.S. Judge Richard Leon will hear from witnesses including the American Medical Association in live testimony on the deal in May". The author is "By Brent Kendall" and it was "Updated April 5, 2019 6:32 p.m. ET". A blue arrow points to the author's name. The article begins with "WASHINGTON—A federal judge on Friday said he wants to hear in court from witnesses who object to the Justice Department's decision". There are also advertisements for "18X THE NATIONAL AVERAGE" and "2.10% APY" at the top, and a "Does your wealth manager" ad on the right.

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Insights

“Our customers love the new format. And by creating a unique health care experience that meets consumers where they are and helps them achieve their best health at a lower cost, we’ve set the stage for our company to compete and win in an industry that is rapidly transforming.”

CVS Pharmacy president Kevin Hourican, in a [statement](#) earlier this month in which the drugstore retailer noted its plan to expand its HealthHub format stores to Boston, Dallas/Fort Worth, Maryland, North Carolina, Ohio and Virginia. According to CVS, HealthHUB is a first-of-its-kind community-based store concept focused on helping customers by offering a broader range of health care services.

Insights

“A lot of this is not rocket science; it’s giving people simple, direct access to care when and where they need it.”

CVS Health chief digital officer Firdaus Bhatthana, speaking at the Digital Health Impact conference in Boston earlier this month, as reported by [Fierce Healthcare](#). Bhatthana noted that CVS Health is working to connect the physical and digital experience to expand consumers’ access to care, CVS is renovating 1,500 stores into a HealthHUB format to focus on health services.

CVS expands \$59 telehealth video visits to Arkansas

by Talk Business & Politics | Thursday, July 11th 2019

CVS Health has rolled out its virtual visit offering in eight additional states, including Arkansas. (Photo: TBF/ign/ig)

LITTLE ROCK (KATV) — CVS Health, the largest pharmacy health care provider in the United States, announced Wednesday that [MinuteClinic](#), the company’s retail medical clinic, has rolled out its virtual visit offering in eight additional states, including Arkansas.

The service makes healthcare professionals available 24 hours a day through the CVS Pharmacy app and online. CVS said the service is now available in 26 states with the recent additions of Arkansas, Connecticut, Hawaii, Indiana, Minnesota, Missouri, Oklahoma, and Texas.

77

Insights

“CVS Health isn’t just any old pharmacy. The chain is quietly and efficiently replacing your doctor. CVS has been running its walk-in MinuteClinics for years. ... And its HealthHUB concept is pushing CVS deeper into health care, providing patients with full primary-care services, dietitians and even weight-loss programs. This is a smart move. Retail may not be ‘dead,’ per se, but CVS and other retail pharmacies face unrelenting pressure from Amazon.com and other online services rather than just commoditized pills, & relevant in the decade ahead.”

A report by the personal finance publisher

Insights

“The CVS HealthHUB is a neighborhood health care destination that will bring easier access at a lower cost. These centers also will have a concierge who will be responsible for customer engagement, there to educate people about new services and new events. Most customers welcome this service.”

Longtime retail analyst Walter Loeb, writing recently on [Forbes.com](#) about how CVS Health is bringing about significant changes in the way consumers access health care.

Insights

“A majority of patients even expressed that such a convenient location of the eye doctor near a place of shopping may improve their likelihood of pursuing eyecare. The combination of convenience through a community-based retail eye clinic and tertiary level care provided by telemedicine is a novel approach to improve eyecare utilization.”

Lindsay A. Rhodes, MD, an assistant professor in UAB’s Department of Ophthalmology and Visual Sciences, and colleagues in an analysis of their EQUALITY telehealth study, as reported recently by [mHealth Intelligence](#). Rhodes has received a \$3.5 million grant to study telehealth solutions for primary open angle glaucoma, according to a [UAB announcement](#).

Chief digital officer Firdaus Bhatena, speaking at a recent health impact conference in Boston, as reported by [Fierce](#). Bhatena noted that CVS Health is investing heavily in its digital infrastructure and wants to leverage the differentiated CVS and recently acquired Aetna to move forward with innovation.

Insights

“We are delivering real change to the health care system. Through HealthHUBs, consumers are at the center of an unmatched retail health experience. The HealthHUB products and services are designed specifically with the consumer’s health needs, challenges and goals in mind, so that they can easily receive coordinated, personalized care in a familiar, neighborhood location.”

Alan Lohvin, MD, chief transformation officer for CVS Health, in a statement last week in which the retailer announced the debut of 16 HealthHUB locations in Atlanta, its first in this market.

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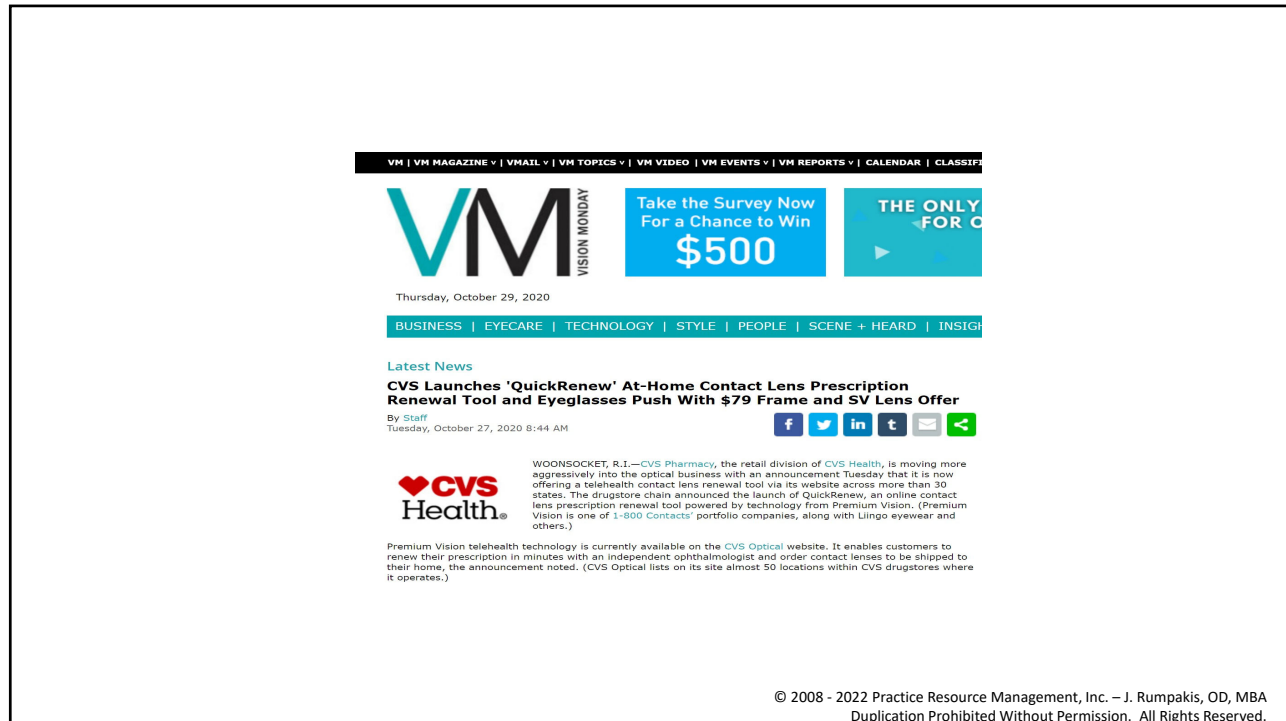
BUSINESS // BIZFEED

Aetna's new Houston insurance offering aimed at bringing consumers into its CVS stores

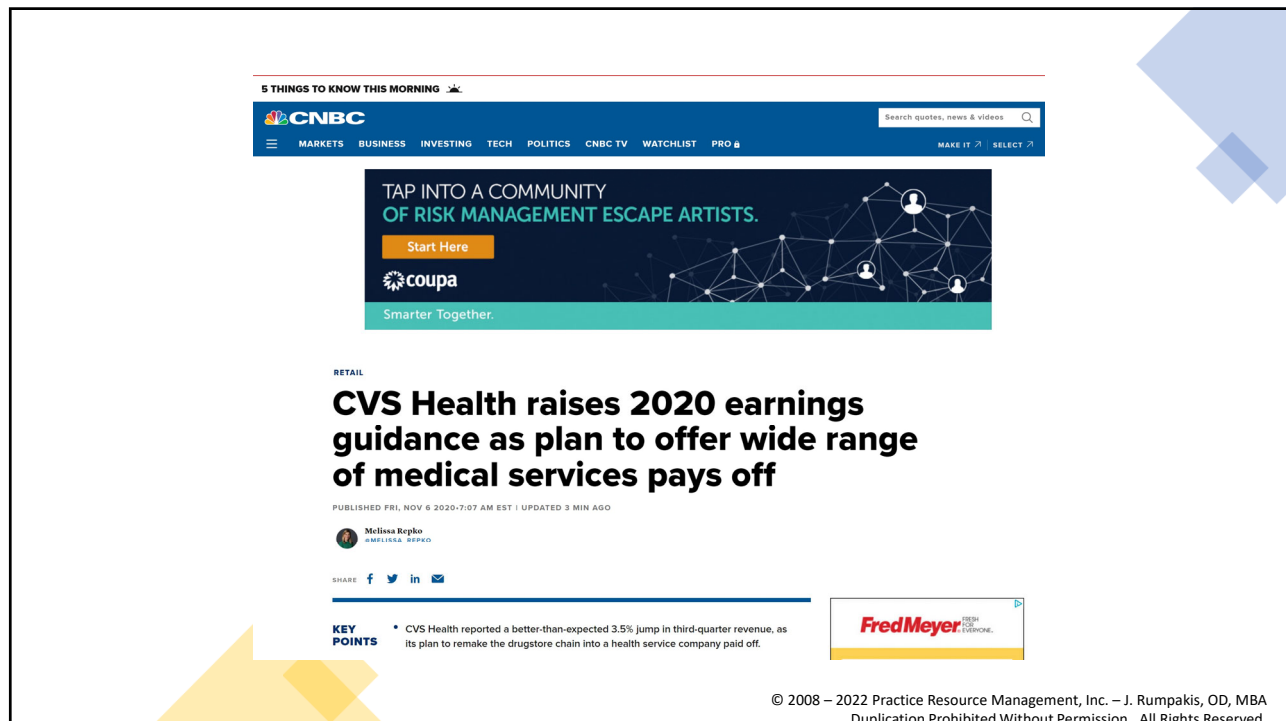
Gwendolyn Wu | Nov. 11, 2020 | Updated: Nov. 11, 2020 5:25 p.m.

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BREAKING Stocks making the biggest moves premarket: CVS, Hormel, RH, GameStop and others

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RETAIL

CVS says it expects sales to accelerate as it expands its range of health-care services

PUBLISHED THU, DEC 9 2021-6:42 AM EST | UPDATED 35 MIN AGO

 **Melissa Repko**
@MELISSA_REPKO

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KEY POINTS

- CVS Health said sales will accelerate in the year ahead, as it launches new health-care services and combines its drugstores and insurance businesses.
- The drugstore chain and health insurer projected that adjusted earnings per share will be between \$8.10 to \$8.30 on total revenues of between \$304 billion to \$309 billion in fiscal 2022.
- The company will hold an investor day on Thursday.


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9:00 AM ET 



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BREAKING The confusing job market: Tech and finance brace for the worst, travel can't hire fast enough


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RETAIL

CVS says it plans to get into primary care by year-end



PUBLISHED WED, AUG 3 2022-10:17 AM EDT | UPDATED 2 HOURS AGO


 **Melissa Repko**
@MELISSA_REPKO

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KEY POINTS

- CVS said Wednesday that it plans to acquire or take a stake in a primary-care company by the end of the year.
- The company already has touchpoints across the health-care industry, including insurer Aetna, pharmacy benefits manager Caremark and its urgent-care locations, MinuteClinics.
- Other players have made moves in primary care, too, with Amazon recently announcing it will acquire boutique health-care company One Medical.

 **WATCH LIVE**
UP NEXT | **Closing Bell** 03:00 pm ET 



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THE WALL STREET JOURNAL


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John Rumpakis

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Walgreens, Humana Are in Preliminary Talks to Take Stakes in Each Other

Wide-ranging talks include possibility of expanding clinic partnership



For Walgreens, a closer connection with Humana could replicate expected benefits of the CVS-Rite aid deal at a much lower cost than a takeover. PHOTO: MOHAMMAD KHURSEED/REUTERS

By **Dana Mattioli**, **Michael Siconolfi** and **Dana Ginniflice**
Updated Nov 25, 2019 4:08 p.m. ET

Druggstore owner **Walgreens Boots Alliance Inc.** (NYSE:WBA) and health insurer **Humana Inc.** (NYSE:HUM) are in preliminary discussions to take equity stakes in each other, according to people familiar with the matter, as health industry players scramble for tie-ups that will help them compete in a rapidly evolving environment.

4 COMMENTS

VISION MONDAY

Tuesday, November 26, 2019

BUSINESS | EYECARE | TECHNOLOGY | STYLE | PEOPLE | SCENE | HEARD | INSIGHT

Latest News

UnitedHealthcare to Open Member Medicare Services Centers in Select Walgreens Stores

By Staff
Tuesday, November 26, 2019 12:24 AM

MINNETONKA, Minn. & DEERFIELD, Ill.—UnitedHealthcare, the health benefits business of UnitedHealth Group (NYSE:UHG), and Walgreens will open 24 UnitedHealthcare Medicare services centers within Walgreens stores in five metropolitan areas as part of a multi-year agreement, the companies announced yesterday. “We are expanding access to UnitedHealthcare Medicare resources to better serve our members, providing them with all the valuable benefits they have come to expect from their UnitedHealthcare Medicare Advantage plans plus delivering the customer service and information they desire locally within Walgreens,” said Mike Anderson, CEO of the Medicare Part D business at UnitedHealthcare.

The UnitedHealthcare Medicare services centers will begin to open in January 2020 at Walgreens stores in the Las Vegas, Phoenix, Cleveland, Denver and Memphis markets. Through these centers, Walgreens customers can learn more about Medicare, meet with service advocates to discuss their UnitedHealthcare plan benefits and even enroll in plans. UnitedHealthcare Medicare Advantage members can also make an appointment for an in-store annual wellness visit at the Medicare service center in Walgreens through UnitedHealthcare’s HouseCalls program, helping make it easier to get needed care, tests and treatment.

“Walgreens collaboration with UnitedHealthcare helps people navigate their healthcare options and provides convenient access to affordable care,” said Rick Gides, senior vice president, pharmacy and healthcare at Walgreens. “Through strategic partnerships like this, Walgreens store locations can offer comprehensive services tailored to the specific needs of the communities we serve that are conveniently accessible alongside our pharmacy services.”

Together, the two companies are also collaborating on the new **AARP Medicare Advantage Walgreens** plans from UnitedHealthcare to deliver lower prescription drug costs and convenient access to medication. Expanding upon UnitedHealthcare’s 2020 Medicare Advantage offerings, the new AARP Medicare Advantage Walgreens plans with Medicare Part D prescription drug coverage will deliver lower prescription drug costs and convenient access to medications through Walgreens, the plan’s preferred retail pharmacy. Many of the plans will feature \$0 premiums and \$0 co-pays on primary care visits, preventive care and many common generic drugs, offering another way for plan members to save. The new plans will feature benefits available through most UnitedHealthcare Medicare Advantage plans including a broad health care network, dental and vision coverage, and access to Renew Active, UnitedHealthcare’s Medicare fitness program for mind and body.

AARP Medicare Advantage Walgreens plan members are not limited to using Walgreens and may continue to fill prescriptions at most retail pharmacies or through mail-order from OptumRx. At Walgreens, plan members will enjoy lower in-store drug prices, access to additional in-store value, enhanced discounts through the Walgreens Balance Rewards program and simple to use digital tools through Walgreens. The 45 plans will be available across 24 states where 18.2 million people eligible for Medicare reside. Enrollment can begin during the Medicare Annual Enrollment from October 15 through December 7 when people eligible for Medicare can choose their coverage.

Serving more than 12 million Medicare beneficiaries, UnitedHealthcare’s UnitedHealthcare Medicare plans offer programs that help people stay active, improve health and manage complex care needs. The only company to offer Medicare plans with the AARP name, UnitedHealthcare serves one in five people in the Medicare program through its portfolio of plans.

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RETAIL

Walgreens strikes deal with primary-care company to open doctor offices in hundreds of drugstores

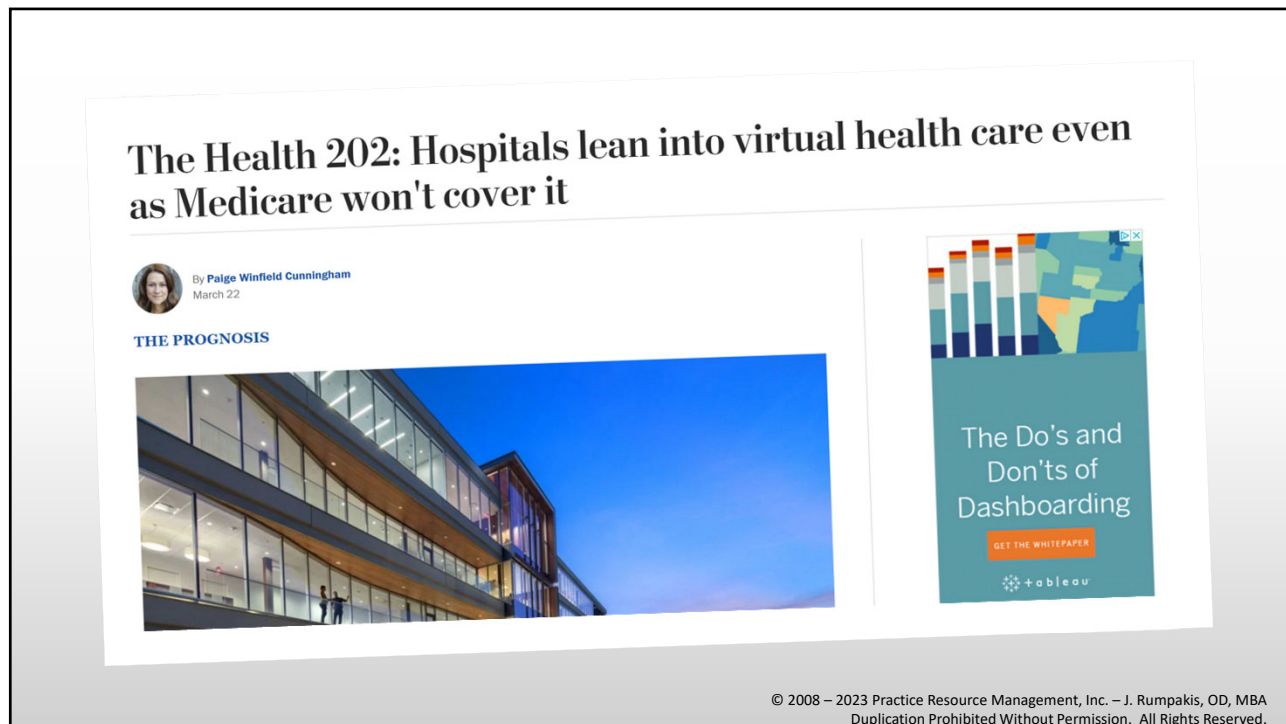
PUBLISHED WED, JUL 8 2020 8:00 AM EDT | UPDATED 30 MIN AGO

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Reality Strikes



Key Obamacare premiums to jump 25 percent next year

By RACHANA PRADHAN | 10/24/16 05:24 PM EDT | Updated 10/24/16 06:16 PM EDT

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Premiums for a crucial category of Obamacare plans on HealthCare.gov will rise by 25 percent on average next year, more than three times larger than this year's price increases, the Obama administration said Monday.

Arizona Obamacare Plan To Jump By 116 Percent When Premiums Go Up Next Year

October 25, 2016 7:56 PM

Filed Under: Arizona, Health Care, Obamacare, President Obama



NEW YORK (CBSNewYork/AP) — Arizona will be hit the hardest when Obamacare premiums go up next year.

The Department of Health and Human Services revealed Monday that premiums for a midlevel benchmark plan will increase an average of 25 percent across the 39 states served by the federally run online market, and that about 1 in 5 consumers will have plans only from a single insurer to pick from, after major national carriers such as UnitedHealth Group, Humana and Aetna scaled back their roles.

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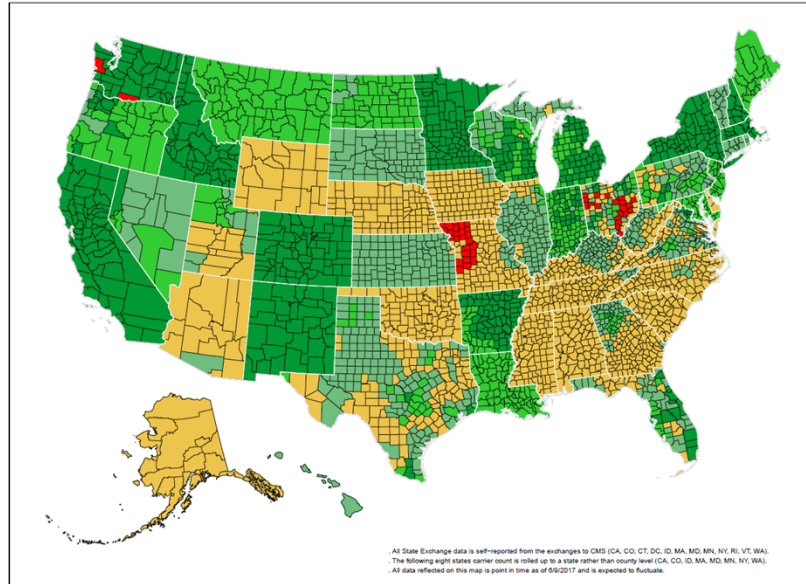
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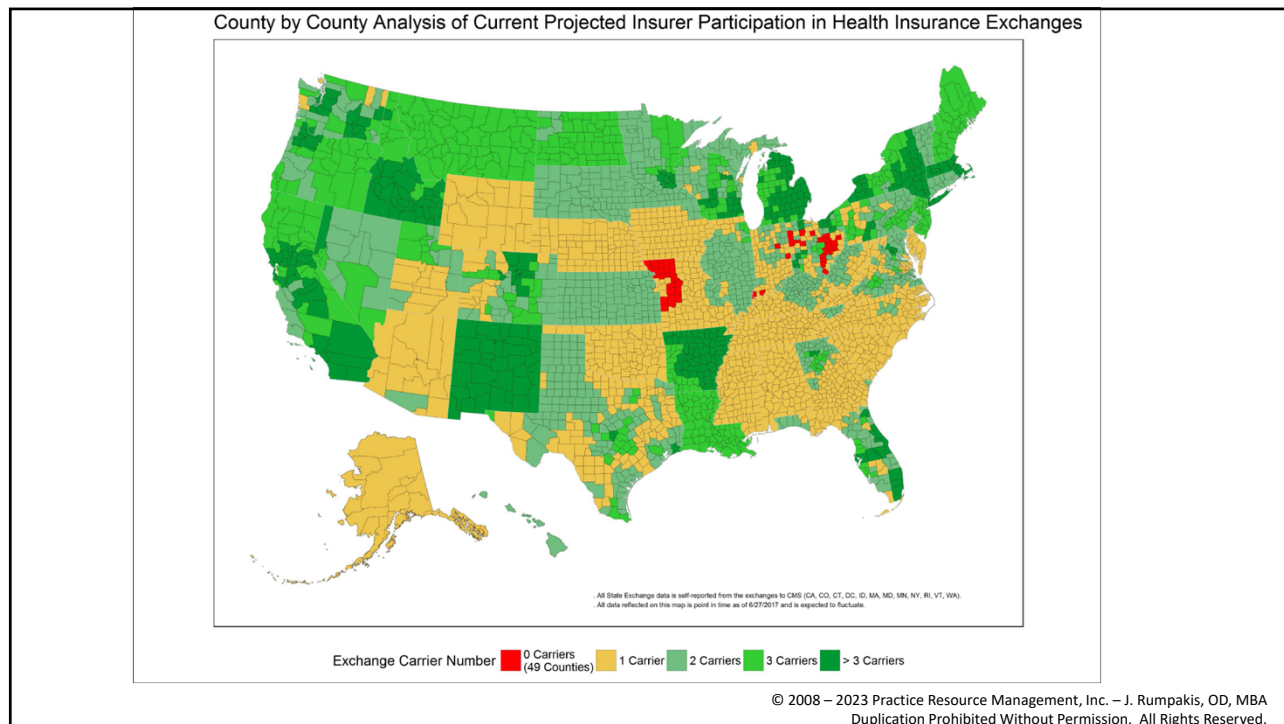
County by County Analysis of Current Projected Insurer Participation in Health Insurance Exchanges



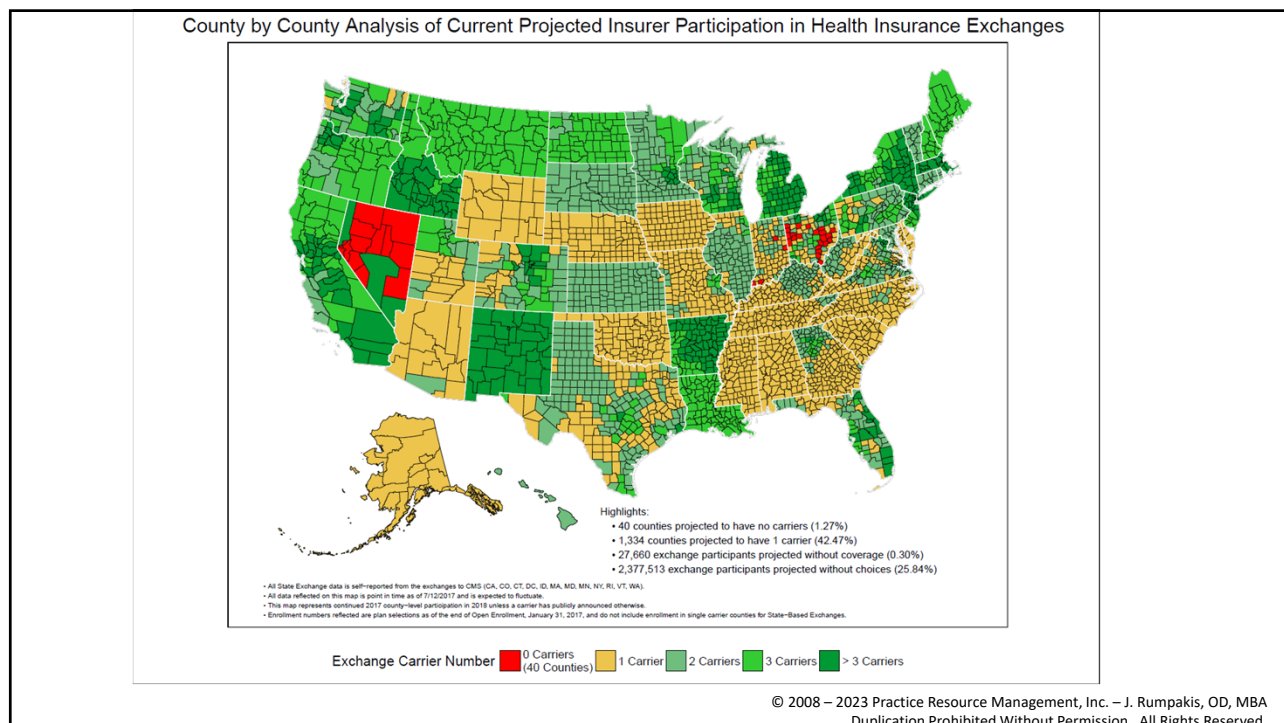
Exchange Carrier Number 0 Carriers (47 Counties) 1 Carrier 2 Carriers 3 Carriers > 3 Carriers

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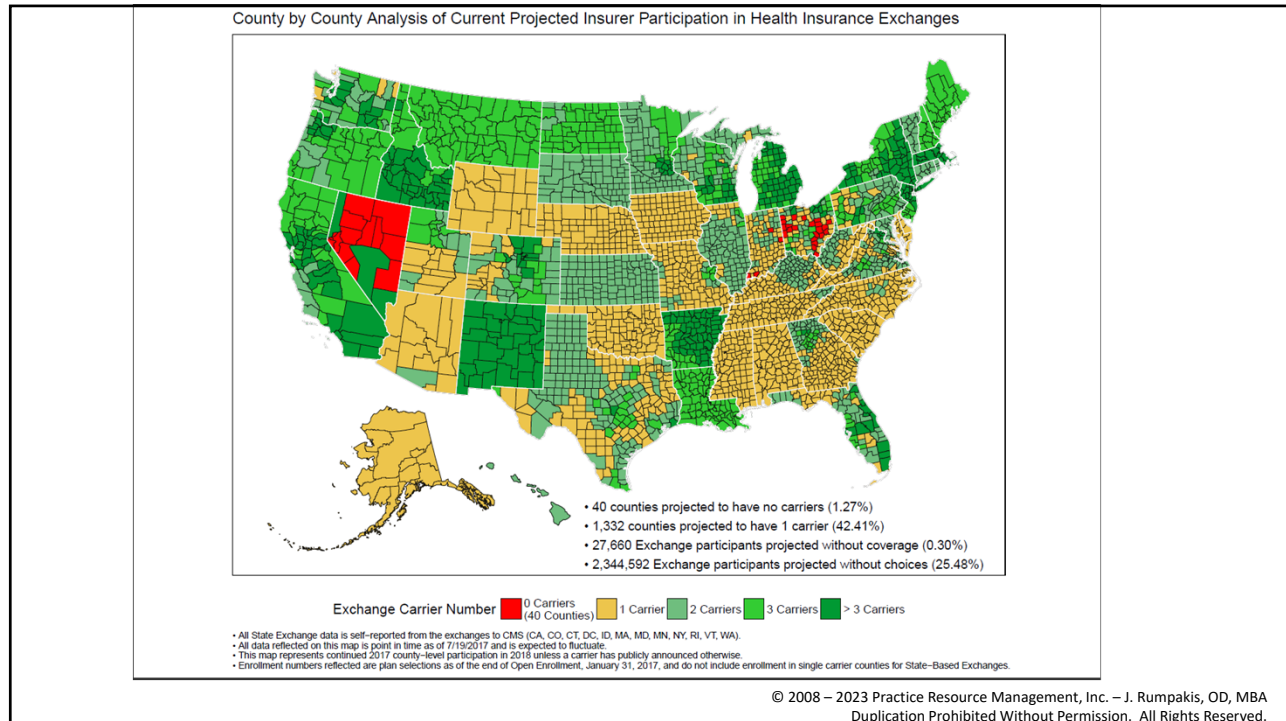
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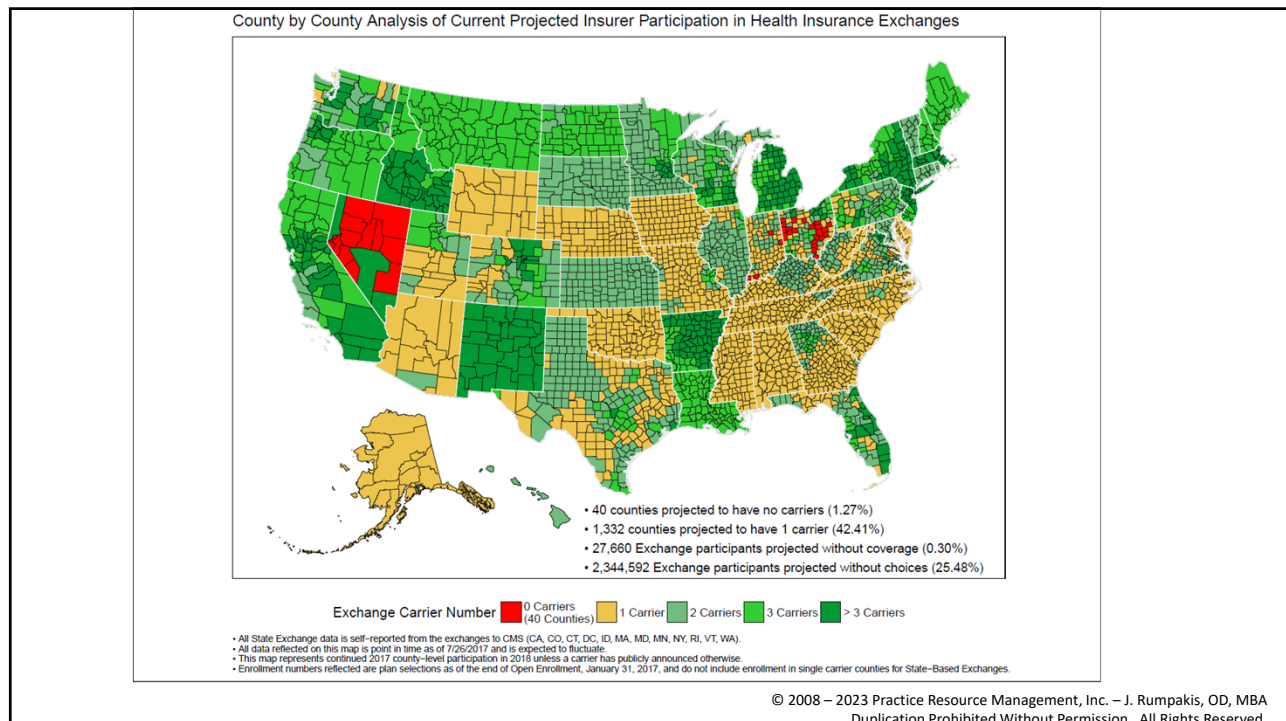
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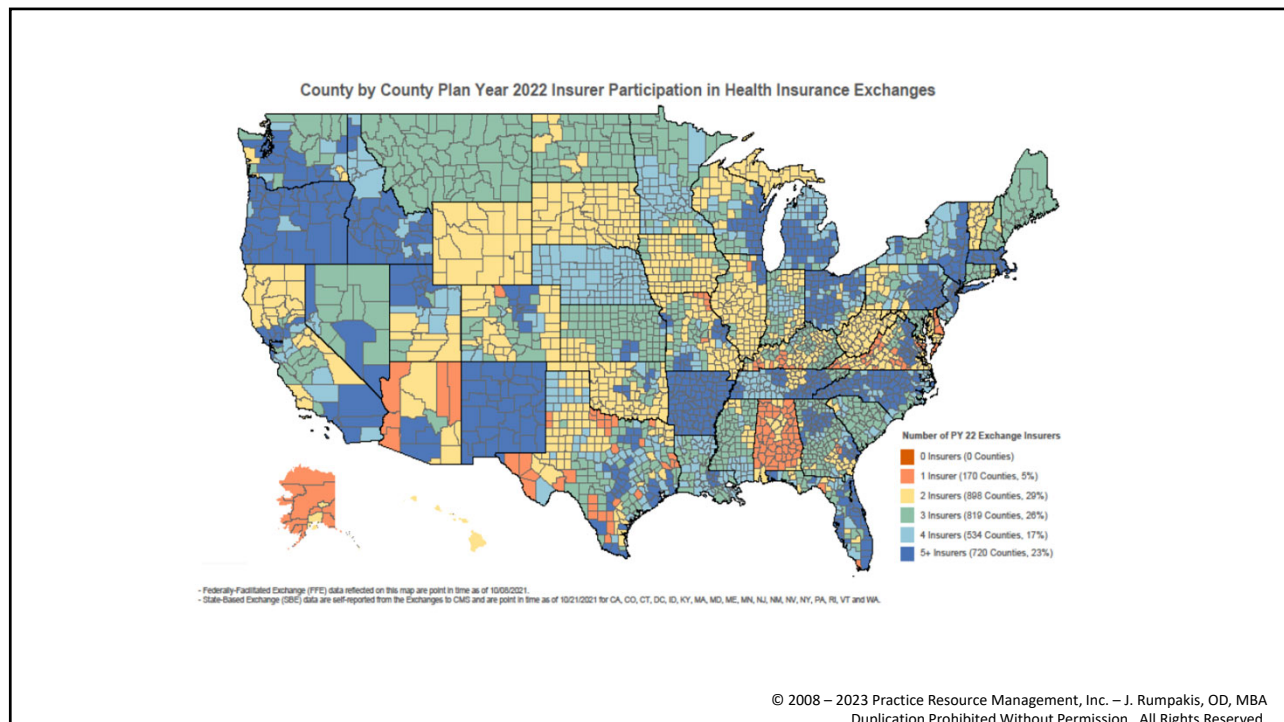
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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

CMS NEWS

FOR IMMEDIATE RELEASE
July 10, 2017

Contact: CMS Media Relations
(202) 690-6145 | [CMS Media Inquiries](#)

Fewer issuers apply to participate in Health Insurance Exchanges for 2018 *Less choice for consumers as issuer health plan applications drop 38 percent from last year*

The Centers for Medicare & Medicaid Services (CMS) today announced 141 individual market qualified health plan

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[Congress](#) [Obamacare](#)

JULY 18, 2017, 10:25 A.M.
REPORTING FROM WASHINGTON

McConnell's latest Obamacare repeal plan also collapsing amid more Republican defections

Noam N. Levey and Lisa Mascaro



(J. Scott Applewhite / Associated Press)

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The New York Times

Trump Retreats on Health Care After McConnell Warns It Won't Happen




President Trump on Monday in the White House. He said late Monday that a Republican plan to replace Obamacare would be voted on after the 2020 election. Sarah Silbiger/The New York Times

By Robert Pear and Maggie Haberman

April 2, 2019

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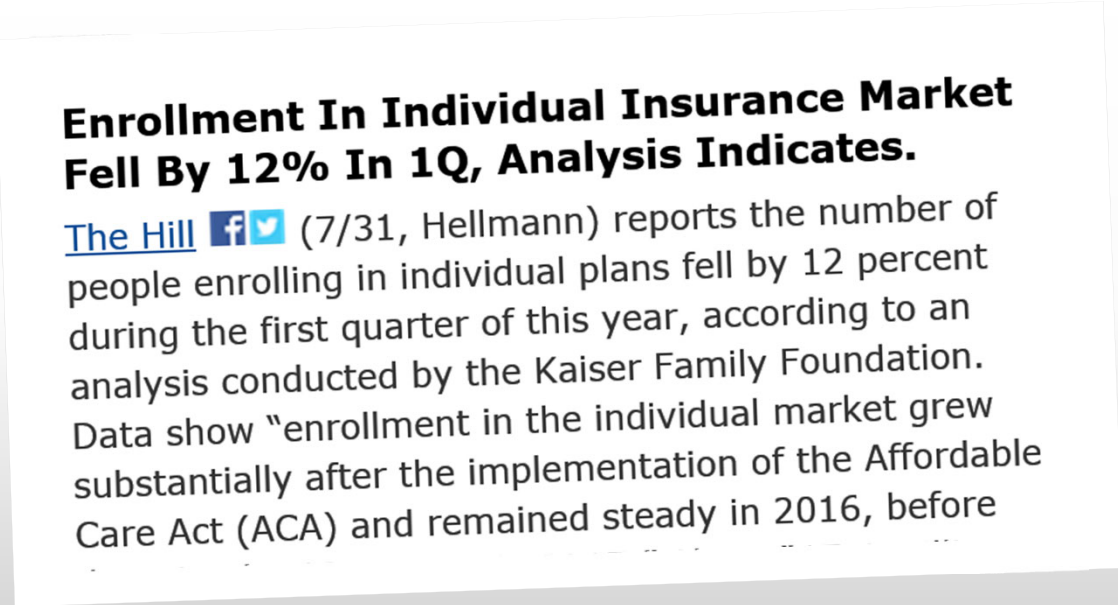
The screenshot shows the New York Times homepage. The main headline is "Without the Insurance Mandate, Health Care's Future May Be in Doubt" by Robert Pear, dated Dec. 18, 2017. Below the headline is a photo of two people at a computer. To the right of the photo is a list of related articles under the heading "The Republican Tax Plan".

Without the Insurance Mandate, Health Care's Future May Be in Doubt
By ROBERT PEAR DEC. 18, 2017

The Republican Tax Plan
Complete coverage of the Republican Party's sweeping plan to cut federal taxes.

- After a Chaotic Start, Congress Has Made a Conservative Mark. DEC 24
- U.S. Tax Bill May Inspire Cuts Globally, While Fueling Trade Tensions. DEC 22
- In Signing Sweeping Tax Bill, Trump Questions Whether He Is Getting Enough Credit. DEC 22
- If You Want to Know How the New Tax Code Affects You, Read This First. DEC 22
- Right and Left React to the Passage of the G.O.P. DEC 21

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The screenshot shows a quote from The Hill. The quote states that enrollment in the individual insurance market fell by 12% in the first quarter of this year, according to an analysis conducted by the Kaiser Family Foundation. The quote also mentions that enrollment in the individual market grew substantially after the implementation of the Affordable Care Act (ACA) and remained steady in 2016, before

Enrollment In Individual Insurance Market Fell By 12% In 1Q, Analysis Indicates.

[The Hill](#) (7/31, Hellmann) reports the number of people enrolling in individual plans fell by 12 percent during the first quarter of this year, according to an analysis conducted by the Kaiser Family Foundation. Data show "enrollment in the individual market grew substantially after the implementation of the Affordable Care Act (ACA) and remained steady in 2016, before

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THE WALL STREET JOURNAL

News Alert

Some Insurers Seek ACA Premium Increases of 30% and Higher

Major health insurers in some states are seeking increases as high as 30% or more for premiums on 2018 Affordable Care Act plans, according to new federal data that provide the broadest view so far of the turmoil across exchanges as companies try to anticipate Trump administration policies.


Big insurers in Idaho, West Virginia, South Carolina, Iowa and Wyoming are seeking to raise premiums by averages close to 30% or more, according to preliminary rate requests published by the U.S. Department of Health and Human Services. Insurers face a mid-August deadline for completing their rates. The companies have until late September to sign federal agreements to offer plans in 2018.

[See More Coverage »](#)

August 2, 2018

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Insurers prepare for double-digit rate hikes (again)


By DAN DIAMOND (ddiamond@politico.com; @ddiamond) | 03/27/2018 10:00 AM EDT

INSURERS PREPARE FOR DOUBLE-DIGIT RATE HIKES (AGAIN) — The spending package enacted last week by Congress was likely the last chance to do something to mitigate another year of expected double-digit rate hikes for Obamacare plans. That's because insurers are already starting the process of developing products and pricing for 2019, and there's little appetite on Capitol Hill to revisit the issue after months of failing to achieve consensus, POLITICO's Paul Demko reports.


"The fact that it fell apart is just so disheartening," said John Baackes, CEO of L.A. Care Health Plan.

We Live For This

Even when wildfires threatened their community, Tracy and her team coordinated with nearby dialysis centers to make treating patients their priority.




— The biggest driver of premiums increases for next year is expected to be the repeal of the individual mandate. The CBO has said that alone will drive up premiums 10 percent, but



We Live For This

Even when wildfires threatened their community, Tracy and her team coordinated with nearby dialysis centers to make treating patients their priority.

LEARN MORE



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John@PRMI.com www.PRMI.com – www.CodeSAFEPLUS.com – www.JustAskJohn.net

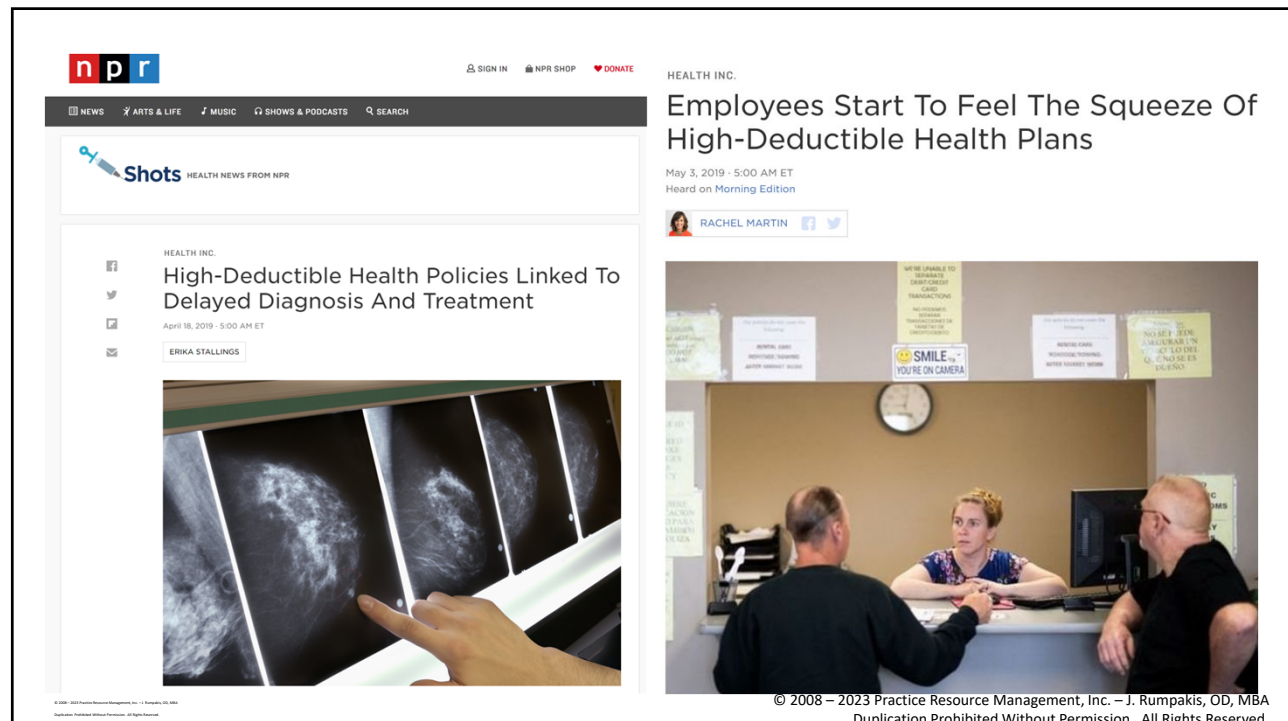
LEADING THE NEWS

Poll: Under 35 More Likely To Defer Healthcare Because Of Cost.

[NPR](#) [f](#) [t](#) (12/7, Hensley) reported an NPR-IBM Watson Health Poll of more than 3,000 households nationwide conducted in July found that about one in five people "had postponed, delayed or canceled some kind of health care service...because of cost in the preceding three months." About a third of people under 35 said "it had been a problem compared with only 8 percent of people 65 and older." A quarter of respondents said they or members of their household "had difficulty paying for some kind health care service in the preceding three months," with "41 percent of people under 35 saying they had experienced difficulty while only 11 percent of people 65 and older had."

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The screenshot displays the NPR website interface. At the top, the NPR logo is visible alongside navigation links for NEWS, ARTS & LIFE, MUSIC, SHOWS & PODCASTS, and a SEARCH bar. Below the navigation bar, there are two main article teasers. The left teaser, titled 'High-Deductible Health Policies Linked To Delayed Diagnosis And Treatment' by Erika Stallings, dated April 18, 2019, features an image of a hand pointing to a mammogram. The right teaser, titled 'Employees Start To Feel The Squeeze Of High-Deductible Health Plans' by Rachel Martin, dated May 3, 2019, features an image of three people in an office setting. The right article also includes a 'SMILE - YOU'RE ON CAMERA' sign on the wall. At the bottom of the screenshot, a copyright notice reads: '© 2008 – 2023 Practice Resource Management, Inc. – J. Rumpakis, OD, MBA Duplication Prohibited Without Permission. All Rights Reserved.'

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Dealing with Unexpected Expenses

Four in 10 adults in 2017 would either borrow, sell something, or not be able pay if faced with a \$400 emergency expense. While still disconcertingly large, the share of families who would struggle with such an expense has decreased over the past five years. In 2013, half of adults could not easily cover such an expense. Even with the improvement, financial challenges remain for many families. One in five adults cannot cover their current month's bills, and one in four skipped a medical treatment in the past year due to an inability to pay.

Small, Unexpected Expenses

Relatively small, unexpected expenses, such as a car repair or replacing a broken appliance, can be a hardship for many families without savings. When faced with a hypothetical expense of only \$400, 59 percent of adults in 2017 say they could easily cover it, using entirely cash, savings, or a credit card paid off at the next statement (referred to, altogether, as "cash or its equivalent"). Over the past five years, as the economy has recovered, the fraction of families able to easily cover this emergency expense has increased by about 9 percentage points (figure 11).

Figure 11. Would cover a \$400 emergency expense using cash or its equivalent (by survey year)

Year	Percent
2013	50
2014	53
2015	54
2016	56
2017	59

Among the remaining 4 in 10 adults who would have more difficulty covering such an expense, the most common approaches include carrying a balance on credit cards and borrowing from friends or family (figure 12). Far fewer people would turn to higher-cost options, such as a payday loan, deposit advance, or bank overdraft in these situations.

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Analysis: Employer-Based Health Coverage Is Increasingly Unaffordable With Average Premium Exceeding \$20,000

The [New York Times](#) (9/25, Abelson) reports rising premiums and deductibles are making employer-based health coverage increasingly unaffordable, according to a new analysis from the Kaiser Family Foundation based on a survey. The article says that "the average premium paid by the employer and the employee for a family plan now tops \$20,000 a year, with the worker contributing about \$6,000, according to the survey." In addition, "more than a quarter of all covered workers and nearly half of those working for small businesses face an annual deductible of \$2,000 or more."

ACCESS TO HEALTHCARE

Some Employers Offer More Traditional Health Plans Without High Deductibles To Recruit Employees

[Kaiser Health News](#) (10/29, Andrews) reports that some employers are offering more traditional health plans without high deductibles to attract employees. The article says that "in a tight labor market, offering a more generous plan with a deductible that's less than four figures can be an attractive recruitment tool," and "a more traditional plan may appeal to workers who want more predictable out-of-pocket costs, even if the premium is a bit higher."

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THE HILL

Survey: 20 million Americans have crowdfunded to help pay medical bills

BY JESSIE HELLMANN - 02/19/20 01:20 PM EST

331 COMMENTS

Just In...

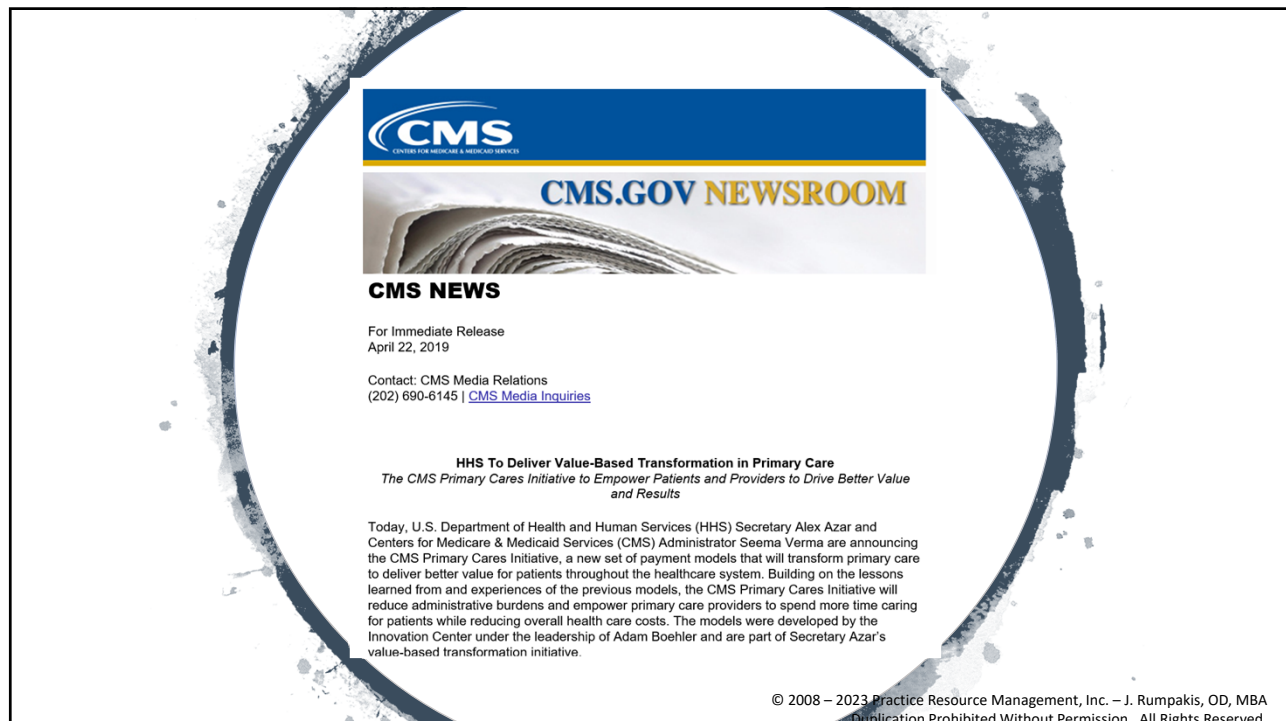
China's coronavirus economic impact

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CMS NEWS

For Immediate Release
April 22, 2019

Contact: CMS Media Relations
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HHS To Deliver Value-Based Transformation in Primary Care


The CMS Primary Cares Initiative to Empower Patients and Providers to Drive Better Value and Results

Today, U.S. Department of Health and Human Services (HHS) Secretary Alex Azar and Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma are announcing the CMS Primary Cares Initiative, a new set of payment models that will transform primary care to deliver better value for patients throughout the healthcare system. Building on the lessons learned from and experiences of the previous models, the CMS Primary Cares Initiative will reduce administrative burdens and empower primary care providers to spend more time caring for patients while reducing overall health care costs. The models were developed by the Innovation Center under the leadership of Adam Boehler and are part of Secretary Azar's value-based transformation initiative.

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Latest in Science



EPA could lock in emissions rules before Trump takes office


2h ago

The Tinkerer



12 gifts for tireless tinkers


4h ago



NASA's Antarctica balloons will study cosmic rays and

In IBM's future, Watson will be your doctor

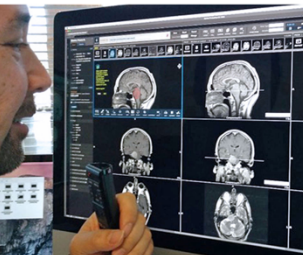
The supercomputer will crunch your medical images and your records to work out what's wrong with you.



Daniel Cooper, @danielwcooper
6h ago in [Medicine](#)

8 Comments

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IBM Watson Health

One of the systems that IBM is developing is a "physician support tool," that seems to take much of the mental leg-work away from doctors. If a patient is diagnosed with a tumor, Watson will pull together data from various sources to develop a personalized health care plan. Another system will help emergency rooms detect a brain bleed by cross-checking scan data with their historical records to spot patterns. Although there's always a worry that Google -- via its [DeepMind AI](#) -- may have won the hearts and minds of clinicians across the world.

November 30 - 2016

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nature > articles > article

nature

Article | Published: 01 January 2020

International evaluation of an AI system for breast cancer screening

Scott Mayer McKinney, Marcin Sieniek, [...] Shrivaya Shetty

Nature 577, 89–94(2020) | Cite this article

1168 Altmetric | Metrics

Abstract

Screening mammography aims to identify breast cancer at earlier stages of the disease, when treatment can be more successful¹. Despite the existence of screening programmes worldwide, the interpretation of mammograms is affected by high rates of false positives and false negatives². Here we present an artificial intelligence (AI) system that is capable of surpassing human experts in breast cancer prediction. To assess its performance in the clinical setting, we curated a large representative dataset from the UK and a large enriched dataset from the USA. We show an absolute reduction of 5.7% and 1.2% (USA and UK) in false positives and 9.4% and 2.7% in false negatives. We provide evidence of the ability of the system to generalize from the UK to the USA. In an independent study of six radiologists, the AI system outperformed all of the human readers: the area under the receiver operating characteristic

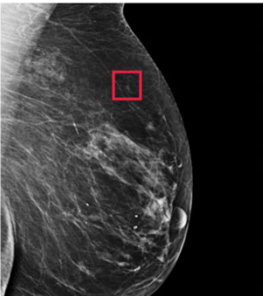
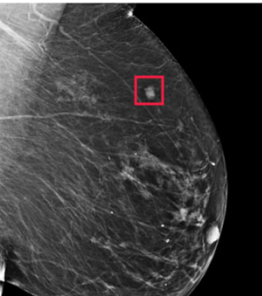
News & Analysis

This MIT AI Predicts Breast Cancer Risk Up to 5 Years in Advance

MIT CSAIL scientists partnered with Massachusetts General Hospital to develop a deep-learning model that was trained on 90,000 full-resolution mammogram scans from 60,000 patients who were scanned over the course of several years with various outcomes.

By Ben Dickson May 23, 2019 8:44AM EST

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HOW IT REALLY HAPPENED with Neil Patrick Harris

HLN NEW EPISODES FRIDAYS 9P ET/PT

January 26 - 2017

'Automated dermatologist' detects skin cancer with expert accuracy

By Susan Scotti, CNN
Updated 6:37 PM ET, Thu January 26, 2017

What causes melanoma? 01:22

Story highlights

- (CNN) — Even though the phrase "image recognition technologies" conjures visions of high-tech surveillance, these tools may soon be used in medicine more than in spycraft.
- A team of Stanford researchers trained a computer to identify images of skin cancer moles and lesions as accurately as a dermatologist, according to a new paper published in the journal Nature.
- In the future, this new research suggests, a simple cell phone app may help patients diagnose a skin cancer -- the most common of all cancers in the United States -- for themselves.

"Our objective is to bring the expertise of top-level dermatologists to places where the dermatologist is not available," said [Sebastian Thrun](#), senior author of the new study, founder of research and development lab Google X and an adjunct professor at Stanford University. He added that those who live in developing countries do not have the same level of care as can be found in the US and other industrialized nations.

Story highlights

- Stanford researchers trained a computer to identify images of skin cancer moles and lesions
- The research could lead to a simple cell phone app to help patients diagnose skin cancer

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- The Morning After: Apple's New Mac Pro made a surprise appearance
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Microsoft AI helps diagnose cervical cancer faster

It might just be crucial to overloaded doctors in India.

Joe Foweraker, @foweraker 1h ago in Medicine

0 Comments 131 Shares

Chiroprapping via Getty Images

In some cases, AI-assisted cancer detection might be more than a convenience -- it could be the key to getting a diagnosis in the first place. Microsoft and IBM Diagnostics have developed an AI tool that helps detect cervical cancer, freeing doctors in India and other countries where the sheer volume of patients could prove overwhelming. The team trained an AI to spot signs of the cancer by feeding it "thousands" of annotated cervical smear images to help it spot abnormalities (including pre-

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IBM's Watson is really good at creating cancer treatment plans

Clinicians continue to add to the system's cancer-assessing repertoire.

Mallory Locklear, @mallorylocklear
8h ago in Medicine

6 Comments 551 Shares




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Jeopardy-winning Watson is getting better and better at designing cancer treatments. New data presented this week at the American Society of Clinical Oncology's annual meeting show that IBM's Watson for Oncology

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GOOGLE'S AI EYE DOCTOR GETS READY TO GO TO WORK IN INDIA



Lily Peng speaks with WIRED's Sarah Follen. © COLLE WILSON FOR WIRED

Google is poised to begin a grand experiment in using machine learning to widen access to healthcare. If it is successful, it could see the company help protect millions of people with diabetes from an eye disease that leads to blindness.

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MEETING NEWS **2020**

Association for Research in Vision and Ophthalmology

VIDEO: AI-based diabetic retinopathy screening device shows 'exceptional results'

Nov 28, 2019

ADD TOPIC TO EMAIL ALERTS



VANCOUVER, British Columbia — Kaushal Solanki, PhD, founder and CEO of Eyenuk Inc., discusses study results of the Eyekit AI Screening System for autonomous detection of diabetic retinopathy at the Association for Research in Vision and Ophthalmology meeting.

The prospective, multicenter, pivotal clinical trial found "exceptional results," according to Solanki.

VM VISION MONDAY


Saturday, February 8, 2020

BUSINESS | EYECARE | TECHNOLOGY | STYLE | PEOPLE | SCENE + HEARD | INSIGHT

Latest News

Eyenuk Receives NIH Grant to Expand AI Eye Screening Platform for Neurodegenerative Disease Detection

By Staff
Monday, October 21, 2019 12:27 AM



LOS ANGELES—Eyenuk has been awarded a grant to develop a fully automated retinal image artificial intelligence (AI) solution for detection of biomarkers for neurodegenerative disorders. The grant is supported by the National Institute of Neurological Disorders and Stroke (NINDS) and the National Institutes of Health (NIH). It supports a collaboration between Eyenuk and Cedars-Sinai Medical Center, one of the nation's leading academic medical centers, to conduct research with the goal of developing ophthalmic screening tools for early detection of neurodegenerative disorders.

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MD Login Register All Specialties

Fully Automated Analysis of Retinal Images by Deep Learning Holds Promise

JANUARY 18, 2018
Armanda Warren

Interest in the promise of deep learning to assist in the analysis of optical coherence tomography (OCT) scans led Thomas Schlegel, MD, with the Christian Doppler Laboratory for Optic Nerve Image Analysis at the Medical University Vienna, in Austria, and colleagues to develop and validate a fully automated method of detecting and quantifying macular fluid in OCT imaging.

The research group developed an accurate automated method of detecting and quantifying intraretinal cystoid fluid (IC) and subretinal fluid (SRF) in 3 macular pathologies: neovascular age-related macular degeneration (AMD), diabetic macular edema (DME), and retinal vein occlusion (RVO). Testing their system against expert manual analysis of OCT scans, the researchers determined that the automatic diagnostic method was both reliable and accurate, providing a "promising horizon" for clinical ophthalmology diagnosis and treatment.

Most Popular

Google's AI Uses Retinal Images to Reveal Cardiovascular Risk Factors

Ricki Lewis, PhD
February 28, 2018

Deep machine learning can extract and quantify several risk factors for cardiovascular disease (CVD) from photographs of the retinal fundus, according to findings published online February 19 in *Nature Biomedical Engineering*.

Traditional risk factors for CVD include age, sex, smoking status, blood pressure, body mass index, and blood glucose and cholesterol levels. However, a major limitation in considering these risk factors is that many people do not know all of their values, particularly serum cholesterol, for which body mass index is sometimes used as a substitute.

TECHNOLOGY

Google's DeepMind Develops AI Diagnostic For Eye Diseases.

The [Financial Times](#) (2/4, Ram, Subscription Publication) reports that Google's DeepMind has developed a method to use artificial intelligence to diagnose eye diseases by evaluating medical images.

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Google's DeepMind now showing human-like characteristics

The AI has learned to play chess in ways hitherto seen by grandmasters

One of DeepMind's projects, AlphaZero, has broken new ground once again by learning to play chess like a human. It can now develop its own tactics, understand positioning, and has amazed one of the greatest players of all time.

See related :

- [This AI can spot Alzheimer's disease six years before doctors](#)
- [The ethical implications of conversational AI](#)
- [Can AI really be emotionally intelligent?](#)

DeepMind's AlphaZero AI is the most advanced of its kind, and [works by thinking like a human brain](#). Known as a neural network, where the AI keeps information to hand when making decisions, AlphaZero is able to remember previous outcomes or results, and use those to influence decision making for similar problems in the future.

Its creators used this to play chess, starting it out with only the game's basic rules. AlphaZero then played against itself millions of times, learning and remembering as it went. Within an incredibly short period of time, a matter of hours in fact, it was playing at a world-class level.

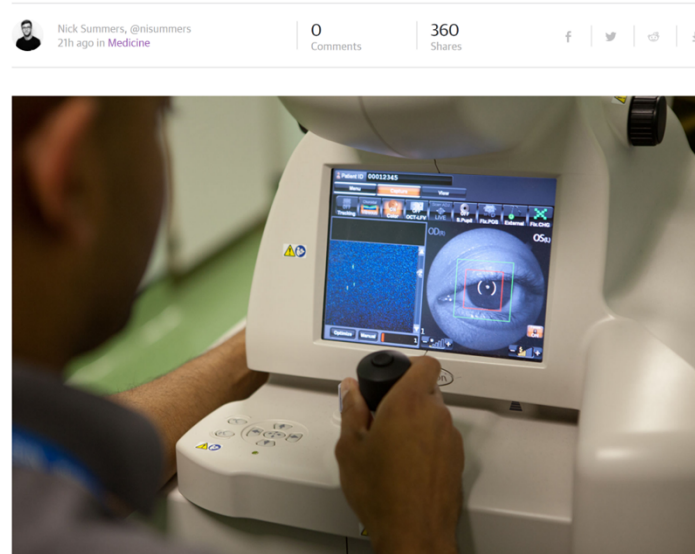
After just a few hours of mental sparring, AlphaZero was set against the world's most powerful chess machine, Stockfish, which is able to calculate 60 million moves a second. AlphaZero came out comfortably victorious. In a 1,000-game match, AlphaZero bested Stockfish 155 times, losing only six games and drawing the remaining fixtures.

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DeepMind AI matches health experts at spotting eye diseases

The tool searches OCT scans for over 50 eye diseases including macular degeneration.



Moorfields Eye Hospital

DeepMind has successfully developed a system that can analyze retinal scans and spot symptoms of sight-threatening eye diseases. Today, the AI division -- owned by Google's parent company Alphabet -- published "early results" of a research project with the UK's Moorfields Eye Hospital. They show that the company's algorithms can quickly examine optical coherence tomography (OCT) scans and make diagnoses with the same accuracy as human clinicians. In addition, the system can show its workings, allowing eye care professionals to scrutinize the final assessment.

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C'mon John... Technology Will Never Replace What We Do...

So Of Course, You Think I'm Making This Up...

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The screenshot shows a website for Vision Monday (VMM) dated Thursday, June 20, 2019. The navigation bar includes links for BUSINESS, EYECARE, TECHNOLOGY, STYLE, PEOPLE, SCENE + HEARD, INSIGHTS, and JOBS. The main article is titled "GlobeChek Rolls Out Comprehensive Eye Screening Kiosk" by Staff, dated Monday, June 17, 2019. The article features a photo of two men standing next to a large, globe-shaped eye screening kiosk. The text describes the ESG 1200 Eye Screening Globe, a unique kiosk equipped with diagnostic instruments for comprehensive eye screenings. It mentions that GlobeChek is a global telehealth corporation founded by two ophthalmologists, William Mallon, MD and Adam Katz, MD. The kiosk is designed to be placed in various locations like malls, airports, hospitals, and retail chain stores, operated by on-site technicians. A quote from the GlobeChek website states: "The goal of GlobeChek is to remove the barriers to eye exams, detect...". There are also social media sharing icons and a "click for sound" button. At the bottom right, there is a "PREMIER PROGRAM" badge and a link to "REWARDS AND SAVINGS FOR YOUR PRACTICE".

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The average consumer
could very easily
perceive this
“screening” as a
comprehensive eye
examination

GlobeCheck
What we see may save your sight™

Name: Nancy Normal DOB: 01/01/1984 Scan ID: 1001 Address: 2001 N. ... 32900 Date: 10/10/2016 Age: 32 E-Mail: 2020va@globecheck.com Cell No: 772 638 2020

Distance VA Near VA
Vision without glasses: Right Eye 20/20 J1 Left Eye 20/20 J2

Auto Refraction: Right Eye -1.00 +0.40 x 180 Left Eye -0.00 +0.50 x 35 * Not valid for eye glasses prescription

Eye Pressure: Right Eye 16 Left Eye 17

External Photo: [Image] Retina and Optic Nerve Photos: Right Eye [Image] Left Eye [Image]

Dermatochallack: [Image] Macula (OCT): Right Eye [Image] Left Eye [Image] Optic Nerve (OCT): Right Eye [Image] Left Eye [Image]

Normal Normal Normal Normal Normal Normal

SUMMARY and RECOMMENDATIONS

1. Based on above screening:
Normal findings

2. Recommended Follow-Up:
Baseline Follow-Up: All adults should have a baseline eye exam by age 40 or when early signs of eye disease or vision changes start to occur. If you have any abnormal eye exam or any risk factors for developing eye disease, you should see an Ophthalmologist or Optometrist, even if you are younger than 40.

GlobeCheck™ Doctors for Follow-Up:
Jayne Desrosiers, OD <http://www.visionfirstva.com> 634 21st St, Vero Beach, FL 32900
Muhammad Rafiey, OD <http://www.charlesrefine.com> 1432 Kimbrough RD Germantown, TN 38138

Optometrist Optometrist

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In The Eyes Of The Health Care
System, There Is No Such Thing
As The Medical Model Of Eye Care,
Only The Eye Care Model Of Eye Care

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What Is Outcome Based Care?

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Humana's shift from fee-for-service medicine to value-based payments for physicians continues to reduce costs and improve quality of care for seniors enrolled in Medicare Advantage plans, the insurer says, citing a new internal study.

Medical costs were nearly 16% lower for seniors enrolled in Humana Medicare Advantage plans that paid physicians via value-based models in 2017 compared to costs of those in traditional fee-for-service Medicare, the Louisville-based insurer's study, released Tuesday showed. Medicare Advantage plans contract with the federal government to provide extra benefits and services to seniors, such as disease management and nurse help hotlines, with some even providing vision and dental care and wellness programs.

"Humana MA value-based physicians had better results than their peers in fee-for-service," Humana corporate medical director of medical market clinical integration Dr. Kathryn Lueken wrote in the report. "The goal of taking costs out of the system and creating more value for the care received is showing results. Thus, value-based care is achieving the goal of creating higher quality medical care for lower cost."

Medicare Costs Drop As Humana Shifts Doctors To Value-Based Models



Bruce Japsen Senior Contributor
Healthcare
I write about healthcare business and policy

TWEET THIS

- "Humana MA value-based physicians had better results than their peers in fee-for-service," Humana
- The number of Medicare Advantage plan choices is increasing nearly 20% to 3,700 in 2019

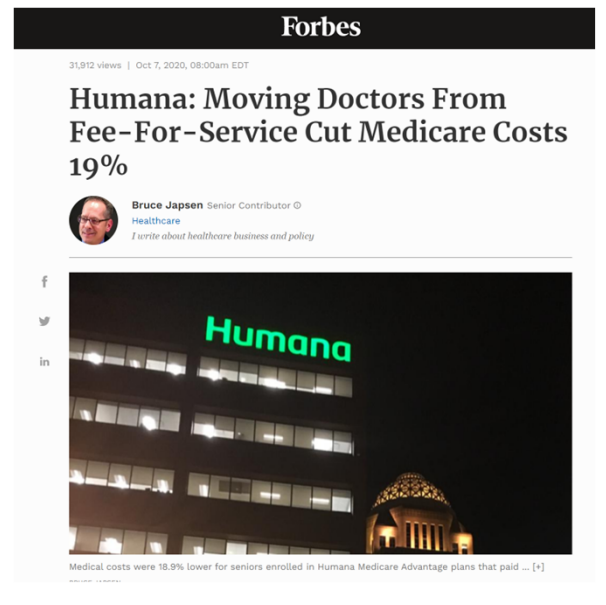
Value & Quality More Than Quantity

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And The Trend Continues



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CMS NEWS

FOR IMMEDIATE RELEASE
December 6, 2016

Contact: CMS Media Relations
(202) 690-6145 | [CMS Media Inquiries](#)

CMS Office of the Actuary Releases 2017 National Health Expenditures

Overall national health spending grew at a rate of 3.9 percent in 2017, almost 1.0 percentage point slower than growth in 2016, according to a study conducted by the Office of the Actuary at the Centers for Medicare & Medicaid Services (CMS) and published today as a Web First by *Health Affairs*. Medicare spending grew at about the same rate in 2017 as in 2016, while Medicaid spending grew at a slower rate in 2017 than in 2016.


According to the report, overall healthcare spending growth slowed in 2017 for the three largest goods and service categories – hospital care, physician and clinical services, and retail prescription drugs. Details from the slower spending growth in these three largest goods and service categories are:

- **Hospital spending** (33 percent of total healthcare spending) decelerated in 2017, growing 4.6 percent to \$1.1 trillion compared to 5.6 percent growth in 2016. The slower growth for 2017 reflected slower growth in the use and intensity of services, as growth in outpatient visits slowed while growth in inpatient days increased at about the same rate in both 2016 and 2017.
- **Physician and clinical services spending** (20 percent of total healthcare spending) increased 4.2 percent to \$694.3 billion in 2017. This increase followed more rapid growth of 5.6 percent in 2016 and 6.0 percent in 2015. Less growth in total spending for physician and clinical services in 2017 was a result of a deceleration in growth in the use and intensity of physician and clinical services.
- **Retail prescription drug spending** (10 percent of total healthcare spending) slowed in 2017, increasing 0.4 percent to \$333.4 billion. This slower rate of growth followed 2.3 percent growth in 2016, which was much slower than in 2014, when spending grew 12.4 percent, and in 2015, when spending grew 8.9 percent. These higher rates of growth in 2014 and 2015 were primarily the result of the introduction of new, innovative medicines and faster growth in prices for existing brand-name drugs. Retail prescription drug spending growth slowed in 2017 primarily due to slower growth in the number of prescriptions dispensed, a continued shift to lower-cost generic drugs, slower growth in the volume of some high-cost drugs, declines in generic drug prices, and lower price increases for existing brand-name drugs.

CMS Spending Stats Reflects Shift To Value

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CMS.GOV NEWSROOM

CMS NEWS

FOR IMMEDIATE RELEASE
March 27, 2019

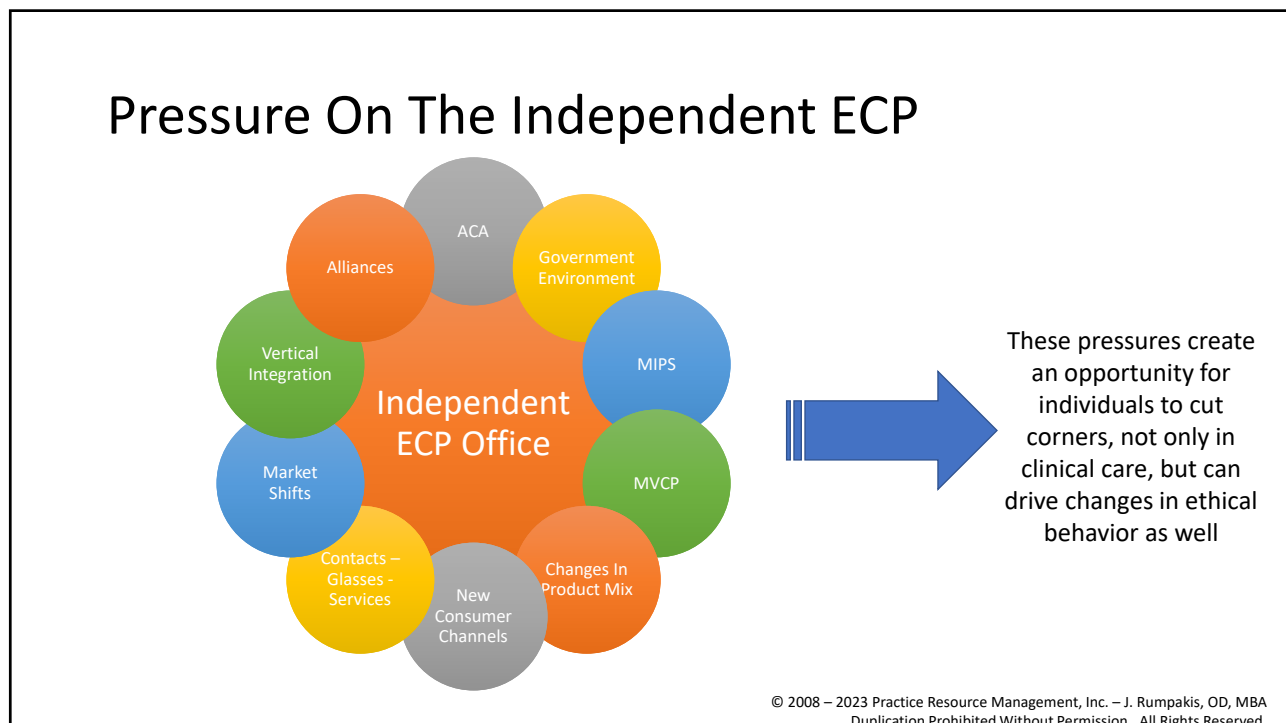
Contact: CMS Media Relations
(202) 690-6145 | [CMS Media Inquiries](#)

CMS launches Artificial Intelligence Health Outcomes Challenge
New competition seeks innovative solutions to better predict healthcare outcomes


Today, the Centers for Medicare & Medicaid Services (CMS) announced a new competition that aims to accelerate innovative solutions to better predict health outcomes and improve the quality of care for patients. Following President Trump's executive order to prioritize research and development of America's artificial intelligence capabilities, the CMS Artificial Intelligence Health Outcomes Challenge will unleash innovative solutions as CMS continues to move the healthcare system towards value.

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These Pressures Create Challenges

And Regulatory
Demands Add Angst
& Confusion

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Reviewing The Basics

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Some Primers

- Audits Are Increasing
 - Medical & Refractive Carriers
- Intense Scrutiny On Medical Necessity For Testing
- 92004/92014 Under Attack
 - Routine exams are going to be more prevalent Increased MVCP Competition For Covered Lives
 - Changing product mix will lead to decreased reimbursements
 - Increased bundling of services – Asking us to do more – for less
- Dictums From Carriers On How To Practice
- Automation Is A Driving Force & Will Continue To Challenge The Traditional Practice Model As Carriers Move To Adopt & Cover It

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The Big Three Things – The ONLY Three Things



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Why Do I Have To Pay Attention To All Three?

Failure To Follow Rules, Regulations, & Contract Provisions Can Have Serious Ramifications

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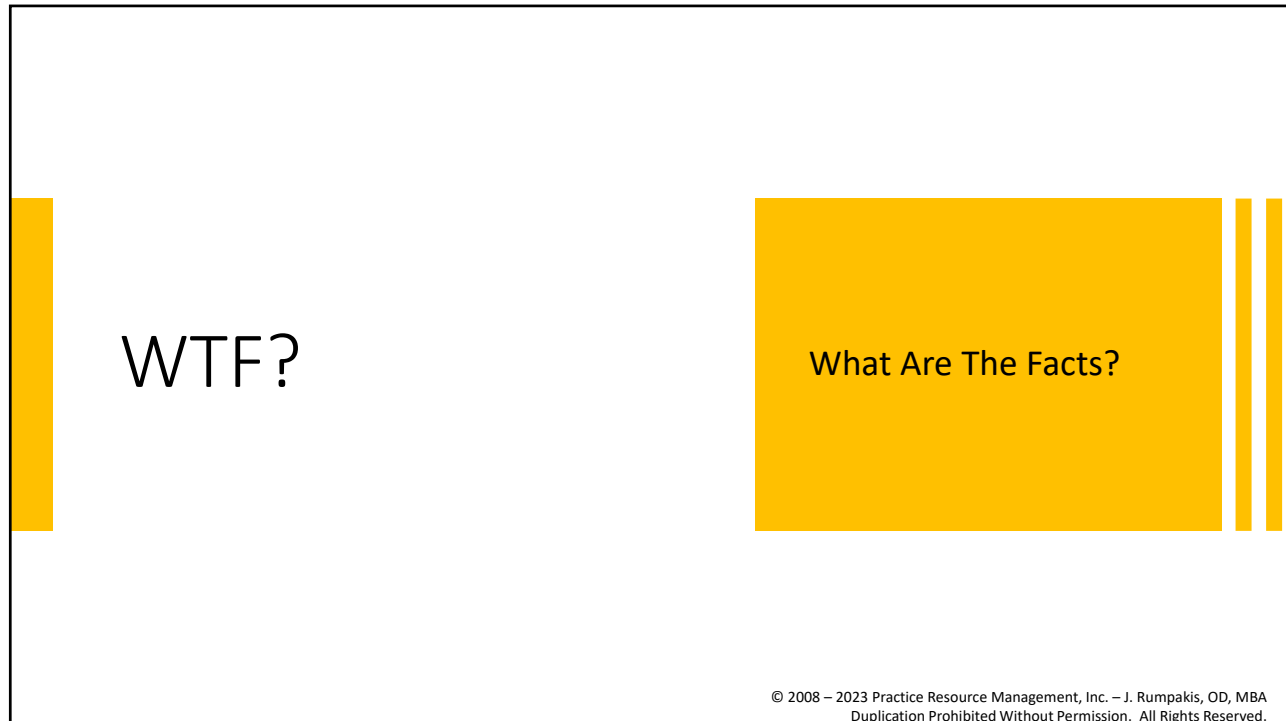


So What, John?

This stuff doesn't affect me at all

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WTF?

What Are The Facts?

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What Are We Using As Our Barometer?

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What Is Managed Vision Care?

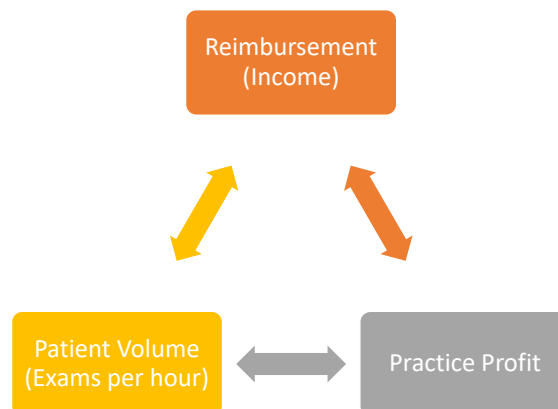
Managed Vision Care = Managed Competition

Where an unaffected third party controls your supply, your demand, and ultimately your profitability, through mechanisms of controlled distribution and contractual limitations.

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Avoiding The Race To Zero...

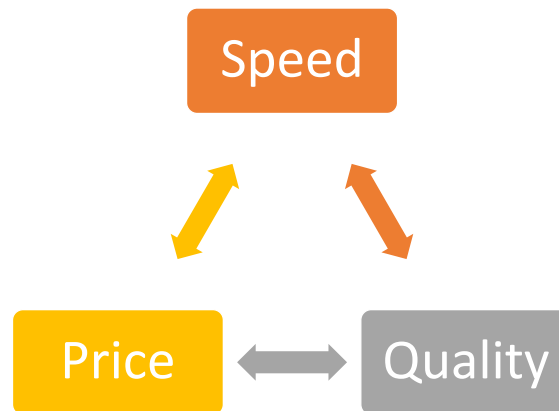


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Another Classic Business Principle

When applied to other industries, you can generally deliver only two out of three



Changes in the healthcare system of the future will require that we deliver three out of three

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So, Let's Show You How To Get There

By Knowing The Standards Of Coding Compliance & Ethics

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But John, I Get So Confused...

These rules change so fast, and there are so many different people who say so many different things...

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TRANSPARENCY

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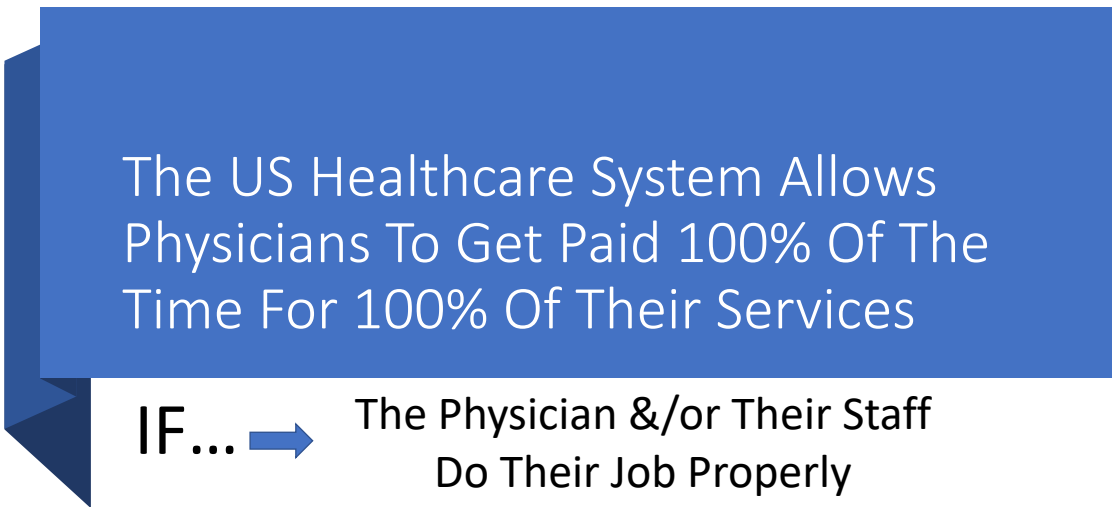
Do I Have To
Follow The
Rules???

Circumstances Drive Behavior –
Reinforced Behavior Can Be A
Further Driver Of Non-
Compliance...

And Lead To Dire Ramifications

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The US Healthcare System Allows
Physicians To Get Paid 100% Of The
Time For 100% Of Their Services

IF... → The Physician &/or Their Staff
Do Their Job Properly

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If You Just Take Care Of The Patient The Code Will Take Care Of Itself!



The patient's condition determines everything that you do.

History that was required understand the patient's complaint
Exam that was required to properly diagnose the condition
Assessment of the condition(s)
Plan to provide the best outcome in the most efficient way that is concurrent with local standard of care



What you do with the patient determines what you write down in the medical record.



What you have written down determines the codes you use to describe the care required.

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Bottom Line The Law Says That...

The individual patient presentation or what you have them returning for determines everything that you do with them, and therefore determines the services performed and the subsequent coding of those services.

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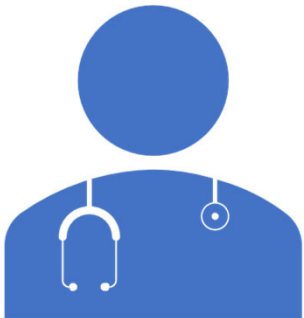
What We Have To Do Is
STOP Making Clinical
Decisions Based Upon
Patient Coverage

Doing Things In The WRONG Order
Complicates Your Life By Creating Bad
Decision Making & Puts You At RISK



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What
Information Do
I Need?

Fully Communicate Expectations
To The Patient

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My Question Checklist

Why Do You Need To See The Dr?

- New Patient
- Established Patient

Patient Demographics

Allow Time For Paperwork

- On website
- Email in advance

Capture Insurance cards – coverage established for services

- Medical Always
- Refractive If They Have It

Clearly Communicate Credit Policy

- Deductible established
- Co-pay collected prior to patient seeing physician

ABN completed

Non-Medically Necessary Procedures

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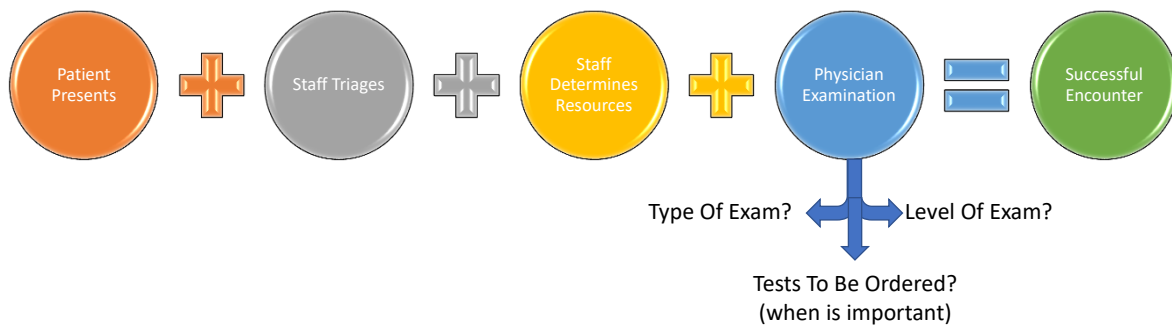
The Most
Important
Question Asked
At Each & Every
Encounter

Why Does The Patient
Need To See The Doctor?
or
Why Are You Bringing
The Patient Back?

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All Patient Encounters Should Start & End The Same Way



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Ethics & Legalities
Related To Compliance

The Medical Record

And the penalties associated
with failing to follow the
laws, rules, and guidelines
that govern how we create it



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The U.S. False Claims Act

- A person does not violate the False Claims Act by submitting a false claim to the government;
- To violate the FCA a person must have submitted, or caused the submission of, the false claim (or made a false statement or record) with knowledge of the falsity. In § 3729(b)(1), knowledge of false information is defined as being (1) actual knowledge, (2) deliberate ignorance of the truth or falsity of the information, or (3) reckless disregard of the truth or falsity of the information.

Reference: http://www.justice.gov/sites/default/files/civil/legacy/2011/04/22/C-FRAUDS_FCA_Primer.pdf

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Fraud, Waste & Abuse

Fraud

is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program, or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.

For the definitions of fraud, waste, and abuse, refer to Chapter 21, Section 20 of the “Medicare Managed Care Manual” and Chapter 9 of the “Prescription Drug Benefit Manual” on the Centers for Medicare & Medicaid Services (CMS) website.

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Waste

includes overusing services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare Program. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.

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Waste

includes overusing services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare Program. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.

Abuse

includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program. Abuse involves payment for items or services when there is not legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

For the definitions of fraud, waste, and abuse, refer to Chapter 21, Section 20 of the “Medicare Managed Care Manual” and Chapter 9 of the “Prescription Drug Benefit Manual” on the Centers for Medicare & Medicaid Services (CMS) website.

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Provider Relationships The Basics of Professional Ethics

- Other than the doctor/patient relationship (the most important relationship), ethical behavior of providers is organized around:
 - Relationships with payers
 - Relationships with fellow providers
 - Relationships with vendors

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Relationships With Payers

- Relationships with patients are increasingly dominated by a third party – the payer
- Components of the provider/payer relationship include:
 - Accurate coding and billing
 - Accurate medical records documentation
 - Prescription authority
 - Assignment within the Medicare system

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Relationship With Payers Accurate Coding and Billing

The main issues involved in billing for rendered services include:

Billing Only For:


- medically necessary care
- services actually performed

Not Billing For:

- services with no benefit or beneficial outcome
- services provided by improperly trained or improperly supervised care
- services provided by a provider included in the Exclusion Statute

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A large orange circle with the text "Special Note!" in white. A small blue circle is at the bottom left of the orange circle. To the right of the orange circle is a list of bullet points. Above the list is a yellow dashed arc.

- The OIG is VERY serious about “worthless” services – patient services that provide no real diagnostic or therapeutic benefit to the patient. The last three convictions in 2014 all resulted in CRIMINAL convictions with federal prison sentences up to 10 years

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“Worthless Services” – Per CMS

- is not accepted as safe and effective by the medical community
- is not supported in peer-reviewed medical literature
- is experimental or investigational
- is not medically necessary in a specific case or specific medical Dx
- is furnished at a level, duration, dosage or frequency not appropriate for a specific patient or clinical condition
- is not furnished in a manner consistent with standards of care
- is not furnished in a setting (place of service) consistent with the patient's medical needs and condition
- is furnished in a manner for patient or provider convenience
- is a device is not approved by the FDA
- is a test or service now considered obsolete


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Relationship With Payers Medical Records Documentation

 By contract with the payer, providers attest that the patient's medical records are:

 Accurate

 Complete


 Show justification of medical necessity

 Have you ever read the back of your CMS-1500 form?

 It is a **LEGAL CONTRACT** assuring the necessity and truthfulness of your services.

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In submitting this claim for payment from Federal Funds, I certify that:

- The information on this form is true, accurate and complete
- I have familiarized myself with all laws, regulations and program instructions available from the Medicare contractor
- I have provided or can provide sufficient information required to allow the government to make an informed eligibility and payment decision
- This claim complies with all Medicare program instructions

The Contract Signed By You 20-40x Per Day
(and have never read...)

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It's All About
Ethics and
Jurisprudence

"My signature is to certify that the foregoing information is true and accurate. I understand that any false claims or statements or concealment of a material fact may be prosecuted under applicable Federal and Stark laws."

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Who Is The OIG?

The Office Of Inspector General

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The OIG & Their Mission

- The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452 (as amended), is to protect the integrity of Department of Health and Human Services (HHS) programs, as well as the health and welfare of the beneficiaries of those programs.

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The OIG & Their Mission

- OIG has a responsibility to report both to the Secretary and to the Congress program and management problems and recommendations to correct them. OIG's duties are carried out through a nationwide network of audits, investigations, inspections and other mission-related functions performed by OIG components.

<http://oig.hhs.gov/>

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The OIG Work Plan

- The OIG Work Plan sets forth various projects to be addressed during the fiscal year by the Office of Audit Services, Office of Evaluation and Inspections, Office of Investigations, and Office of Counsel to the Inspector General. The Work Plan includes projects planned in each of the Department's major entities: the Centers for Medicare & Medicaid Services; the public health agencies; and the Administrations for Children, Families, and Aging.
- Information is also provided on projects related to issues that cut across departmental programs, including State and local government use of Federal funds, as well as the functional areas of the Office of the Secretary. Some of the projects described in the Work Plan are statutorily required, such as the audit of the Department's financial statements, which is mandated by the Government Management Reform Act.

<https://oig.hhs.gov/reports-and-publications/workplan/index.asp>

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What Is The Current Audit Environment?

Understanding The Carrier Environment
Is Critical To Everything

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The Government Recovery Is Hitting Records!

The screenshot shows the HHS.gov website with a blue header. The navigation bar includes links for About HHS, Programs & Services, Grants & Contracts, and Laws & Regulations. A search bar is on the left, and a 'Text Resize' tool is on the right. The main content area features a news release dated March 19, 2015, titled 'FOR IMMEDIATE RELEASE'. The headline reads: 'Departments of Justice and Health and Human Services announce over \$27.8 billion in returns from joint efforts to combat health care fraud'. The sub-headline states: 'Administration recovers \$7.70 for every dollar spent to fight health care-related fraud and abuse; third-highest on record'. The body text explains that more than \$27.8 billion has been returned to the Medicare Trust Fund over the life of the Health Care Fraud and Abuse Control (HCFAC) Program, and that the government's health care fraud prevention and enforcement efforts recovered \$3.3 billion in taxpayer dollars in Fiscal Year (FY) 2014 from individuals and companies that attempted to defraud federal health programs.

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24 Charged in \$1.2 Billion Medicare Scheme, U.S. Says



The F.B.I. and the Department of Health and Human Services, pictured an alleged Medicare scheme that involved hundreds of thousands of...
Radharc Images/Alamy

By Niraj Chokshi and Julia Jacobs

April 9, 2019

Technology Is Aiding In The Ability To Identity Fraud

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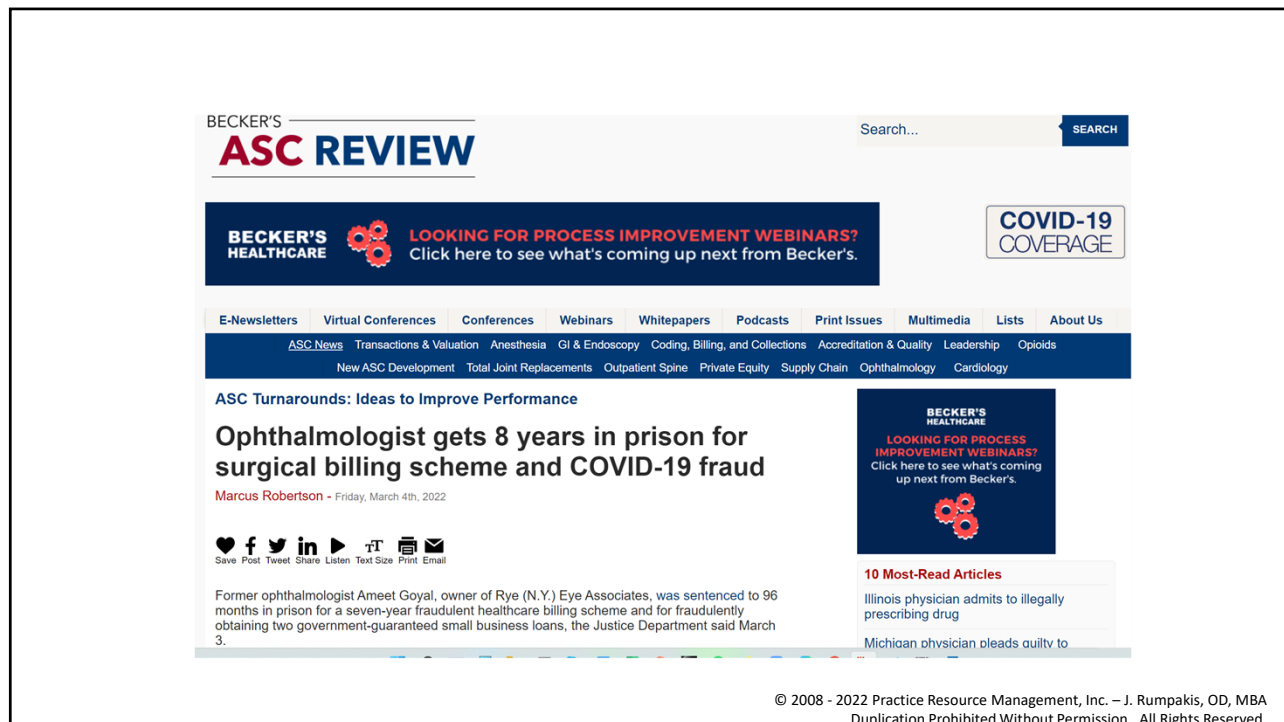
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ASC REVIEW

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New ASC Development Total Joint Replacements Outpatient Spine Private Equity Supply Chain Ophthalmology Cardiology

ASC Turnarounds: Ideas to Improve Performance

Ophthalmologist gets 8 years in prison for surgical billing scheme and COVID-19 fraud

Marcus Robertson - Friday, March 4th, 2022

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Former ophthalmologist Ameet Goyal, owner of Rye (N.Y.) Eye Associates, was sentenced to 96 months in prison for a seven-year fraudulent healthcare billing scheme and for fraudulently obtaining two government-guaranteed small business loans, the Justice Department said March 3.

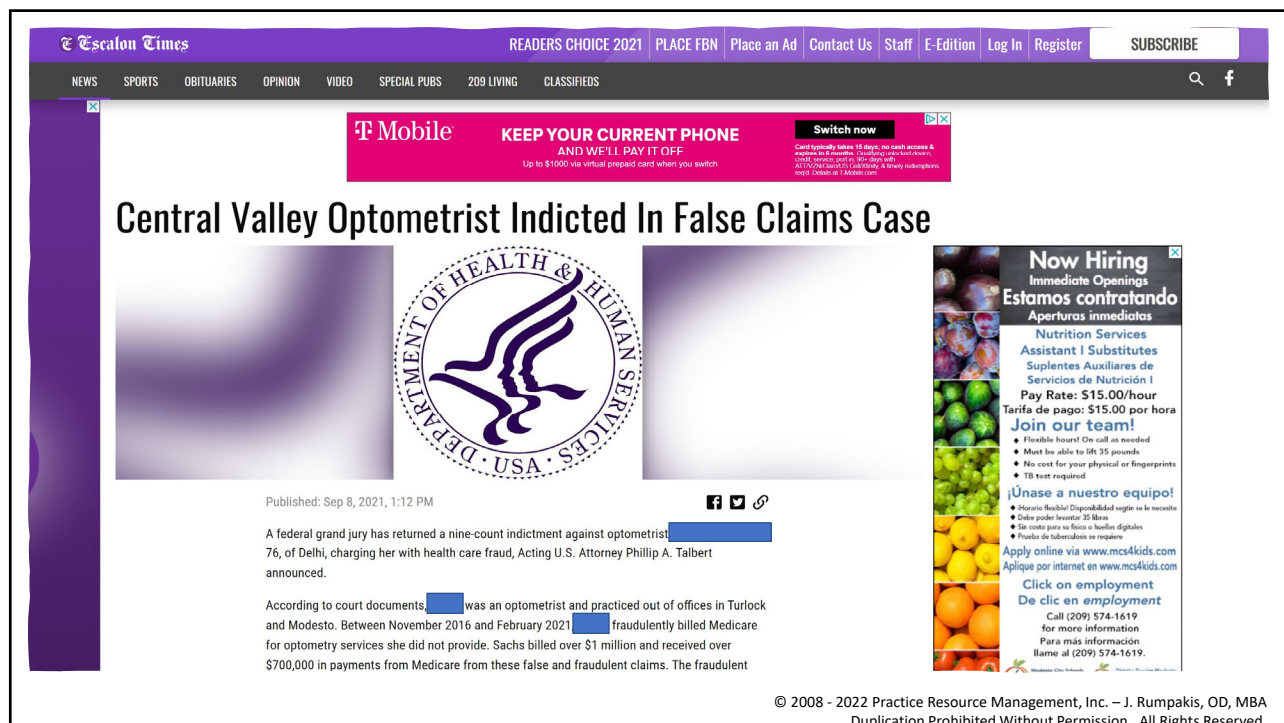
10 Most-Read Articles

Illinois physician admits to illegally prescribing drug

Michigan physician pleads guilty to

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Escalante Times

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NEWS SPORTS OBITUARIES OPINION VIDEO SPECIAL PUBLS 209 LIVING CLASSIFIEDS

T-Mobile **KEEP YOUR CURRENT PHONE**
AND WE'LL PAY IT OFF
Up to \$1000 via virtual prepaid card when you switch

Switch now
Card typically takes 10 days. No cash access & requires 4 months. (See store for restrictions. Offer requires 100% activation. See store for restrictions. Limit 1 device. Limit 1 account.)

Central Valley Optometrist Indicted In False Claims Case

Published: Sep 8, 2021, 1:12 PM

A federal grand jury has returned a nine-count indictment against optometrist [REDACTED], 76, of Delhi, charging her with health care fraud, Acting U.S. Attorney Phillip A. Talbert announced.

According to court documents, [REDACTED] was an optometrist and practiced out of offices in Turlock and Modesto. Between November 2016 and February 2021 [REDACTED] fraudulently billed Medicare for optometry services she did not provide. Sachs billed over \$1 million and received over \$700,000 in payments from Medicare from these false and fraudulent claims. The fraudulent

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Assistant / Substitutes
Suplentes Auxiliares de
Servicios de Nutrición I
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Tarifa de pago: \$15.00 por hora

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- Horario flexible! Disponibilidad según se le necesite
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Technology Is Driving Monetary Recoveries...

...And At A Blistering Pace

Using "Big Data" analysis returned an increase from 2014 to 11.6 to 1 return on investment in 2015!

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Everyone Is Looking To Be Rewarded!

Whistleblowers Have Been Awarded Over \$5.2 Billion.
Possible cash award for reporting fraud over \$1 million.
[Report fraud against the government here.](#)

Choosing the Right Whistleblower Attorney is the Most Important Step

STOP Medicare Fraud
U.S. Department of Health & Human Services and U.S. Department of Justice

Prevent Fraud
Common Scams and Identity Theft
Senior Medicare Patrol

About the Senior Medicare Patrol
The Senior Medicare Patrol (SMP) is a group of highly trained volunteers who teach others about health care fraud. SMP volunteers show Medicare and Medicaid recipients how to protect against, detect, and report fraud.

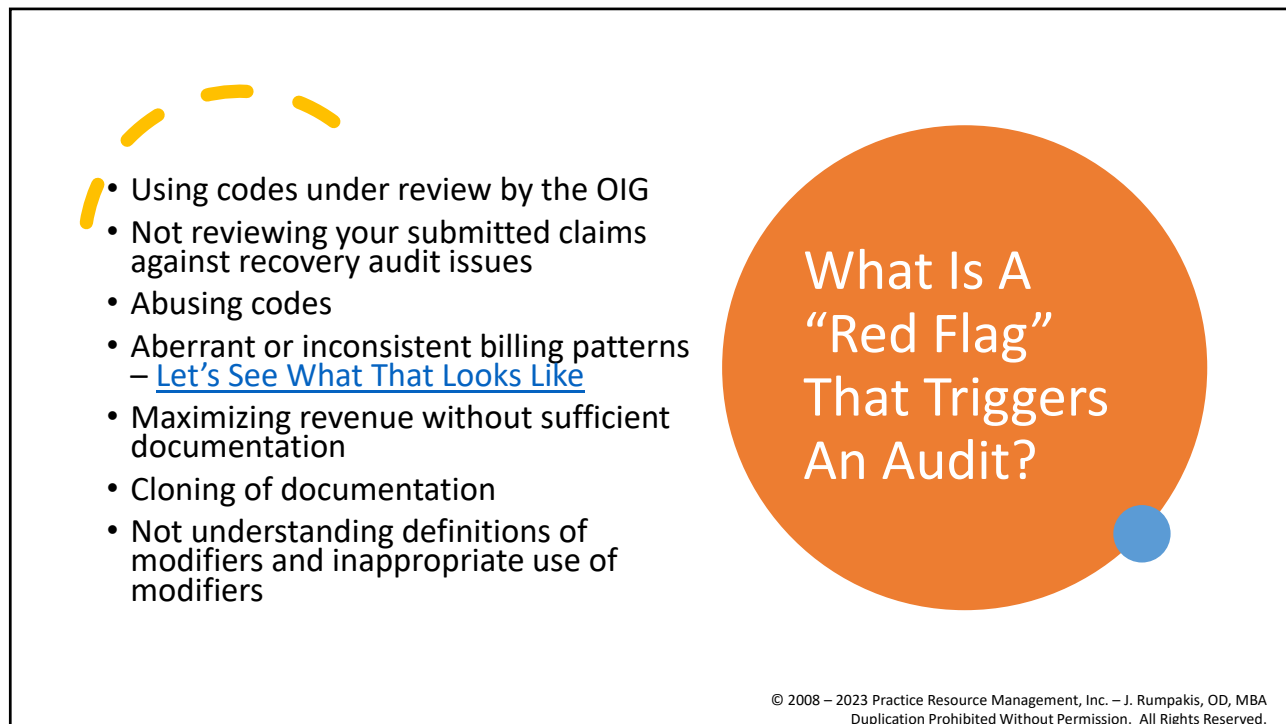
We believe that working with healthcare users to prevent fraud will:

- Protect our citizens' health
- Protect their health benefits
- Strengthen Medicare and Medicaid

Report Medicare Fraud Now
Office of Inspector General
Call: 800-447-5477
TTY: 800-377-4950
Online: [Report Fraud](#)
Centers for Medicare and Medicaid
Call: 800-633-4227 / TTY 877-486-2048
[More >](#)

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- Using codes under review by the OIG
- Not reviewing your submitted claims against recovery audit issues
- Abusing codes
- Aberrant or inconsistent billing patterns – [Let's See What That Looks Like](#)
- Maximizing revenue without sufficient documentation
- Cloning of documentation
- Not understanding definitions of modifiers and inappropriate use of modifiers

What Is A
“Red Flag”
That Triggers
An Audit?

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The Top Three Issues For Audit Failure

- Lack of Medical Necessity noted in record
 - For level of visit
 - For special ophthalmic procedures
- Improper coding of office visits
 - Overuse of 920X4 codes
 - Improper use of 92012 codes
 - Improper coding of 992XX codes – approximating the level rather than actually coding correctly
- Improper use of modifiers -25 and -59
 - Not meeting clinical use of or fulfilling definition of the modifier

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Fundamental Principles Are At The Heart Of Ethics & Legal Obligations To The System

- What Do You Do?
(hint... think evidence based medicine)
- What Does This Patient Need?
(hint... not what do you want to do)
- What Is In The Patient's Best Interest?

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The Five Pillars Of Compliance



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Things Are Changing So Fast

Knowledge and
Compliance Are
Absolutely Required

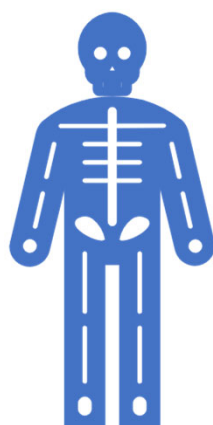
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Let's Review Some Basics

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Each CPT Code Is Unique

Every CPT code has a very specific
definition and set of characteristics
and usage guidelines that
determine how it is used

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Understanding Code Differences

Within the HCPCS system each code subset has its own implicit purpose - and its own format

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Key Concepts

Term	Definition	Code Format	Ownership
HCPCS I	CPT-4; Current Procedural Terminology, 4th Edition (HCPCS Level I Codes)	12345 Always Five Digits	AMA ¹
HCPCS II	Healthcare Procedural Coding System Level II Codes	A-V1234 Always Alphanumeric	AMA ¹
HCPCS III	Healthcare Procedural Coding System Level III Codes (Emerging Technology)	1234T Always Alphanumeric	AMA ¹
ICD-10-CM	International Classification of Disease, 10 th Edition	A123.45XX Generally Seven Characters	WHO ²

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1: <http://www.ama-assn.org/ama/pub/category/3884.html>
2: <http://www.who.int/classifications/icd/en/>

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Health Care Procedural Coding System (HCPCS)

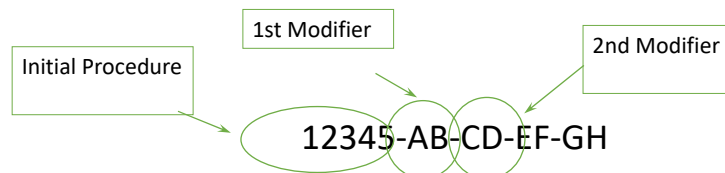
- Level One HCPCS → • CPT Procedural Codes
- Level Two HCPCS → • Non-CPT Codes for Materials, Services & PQRS
- Level Three HCPCS → • Emerging Technology & Temporary Use Codes

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Health Care Procedural Coding System (HCPCS)

- Level One HCPCS Are The CPT®-4
 - Current Procedural Terminology – 4th Edition
- CPT Codes Are Always...
 - One Five Digit Code Plus Up To Four, 2 Digit Modifiers



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Health Care Procedural Coding System (HCPCS)

- Level Two - National Codes for Materials, Services & PQRS
- Level Two Codes: 5 Digit Alpha-Numeric

Level II Designation

A-V1234

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Health Care Procedural Coding System (HCPCS)

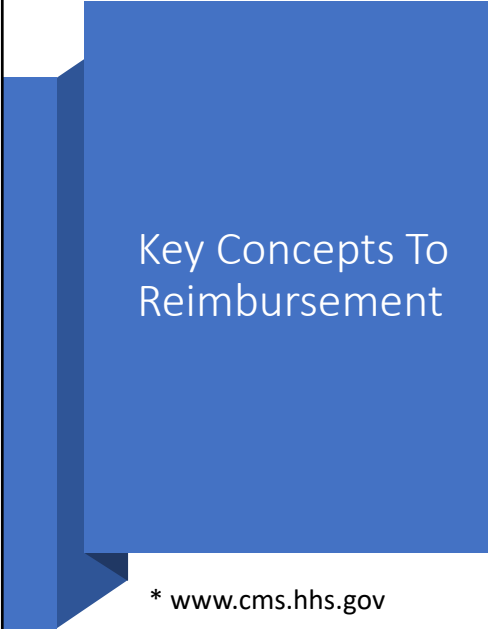
- Level Three - Emerging Technology & Temporary Use Codes
- Level Three Codes: Category III codes are temporary codes for emerging technology, services, and procedures. Category III codes consist of four numbers followed by the letter "T."

Category III Designation

→ 1234T

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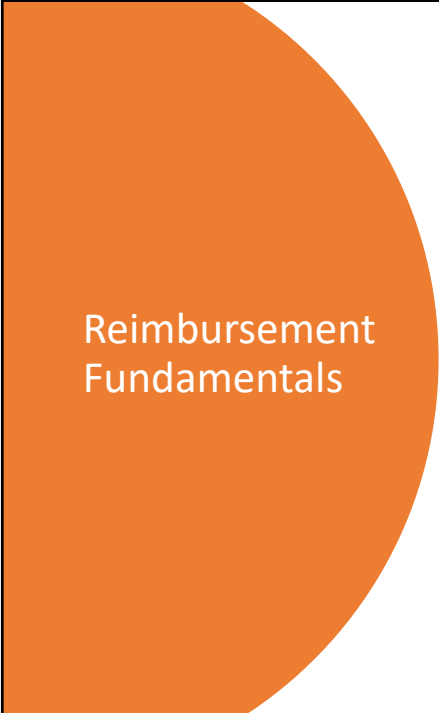
Key Concepts To Reimbursement

Term	Definition	Resource
RBRVS	Resource Based Relative Value System	CMS*
RVU	Relative Value Unit	CMS*
GPCI	Geographic Practice Cost Index	CMS*
Conversion Factor	A “Dollar” Multiplier In The Reimbursement Calculation	CMS*
Maximum Allowable Reimbursement	Geographically Adjusted RVU’s X The Conversion Factor	CMS*

* www.cms.hhs.gov

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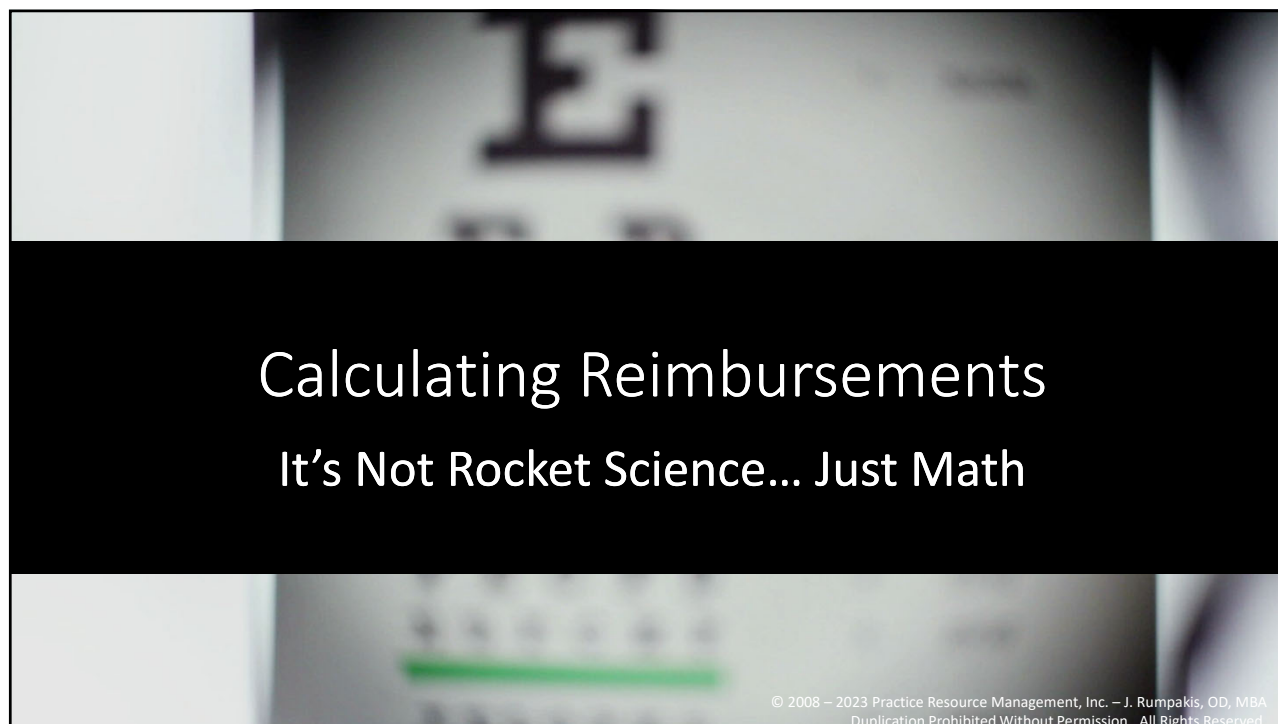


Reimbursement Fundamentals

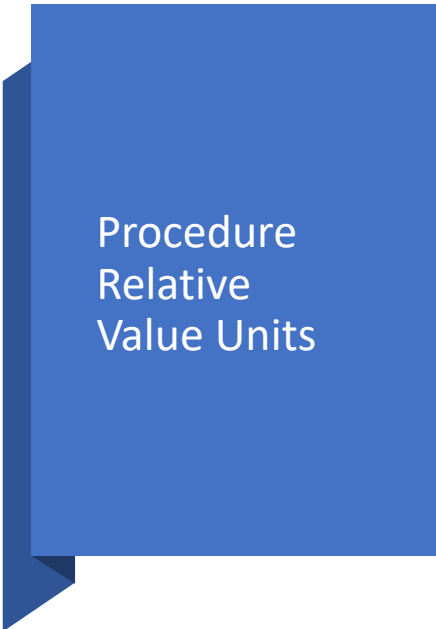
- RBRVS
- Determines the Maximum Allowable Fee
 - For Every Procedure
 - For Every Carrier
- Relative Value Units Are Based On:
 - Amount Of Work Associated With Procedure
 - Practice Overhead Expenses Associated With Procedure
 - Malpractice & Professional Liability Costs Associated With Procedure
 - Geographic Location Adjustments
 - GPCI – Geographic Practice Cost Indices

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 <p>Procedure Relative Value Units</p>	CPT	Code Descriptions	Work	Practice Expense	Malpractice
	92014	Eye exam & treatment	1.1	1.41	0.03
	92015	Refraction	0.38	1.49	0.01
	92020	Special eye evaluation	0.37	0.34	0.01
	92070	Fitting of contact lens	0.7	1.07	0.02
	92083	Visual field examination (s)	0.5	1.43	0.02

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Geographic Practice Cost Index (GPCI's)

Locality Name	Work GPCI	PE GPCI	MP GPCI
Alabama	1	0.846	0.752
Alaska	1.017	1.103	1.029
Arizona	1	0.992	1.069
Arkansas	1	0.831	0.438
San Francisco, CA	1.06	1.543	0.651
Oakland/Berkley, CA	1.054	1.371	0.651
Santa Clara, CA	1.083	1.54	0.604
Los Angeles, CA	1.041	1.156	0.954
Anaheim/Santa Ana, CA	1.034	1.236	0.954

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The Conversion Factor

A Conversion Factor is nothing more than a “Dollar Multiplier” in determining the Maximum Allowable Reimbursement for each CPT code

Total Geographically Adjusted RVU's
X The Conversion Factor

= The Maximum Allowable Reimbursement

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Changes From 2021 To 2022 To 2023

- Conversion Factor In 2021 was \$34.89
- Conversion Factor In 2022 was \$33.59, then moved to \$34.6062, 2023 is now \$33.8872
- Was decrease of 3.7%, then decrease of just 1%, now 2.1%
- This is due in part to the expiration of the 3.75% payment increase provided for in CY 2022 by the Consolidated Appropriations Act of 2022

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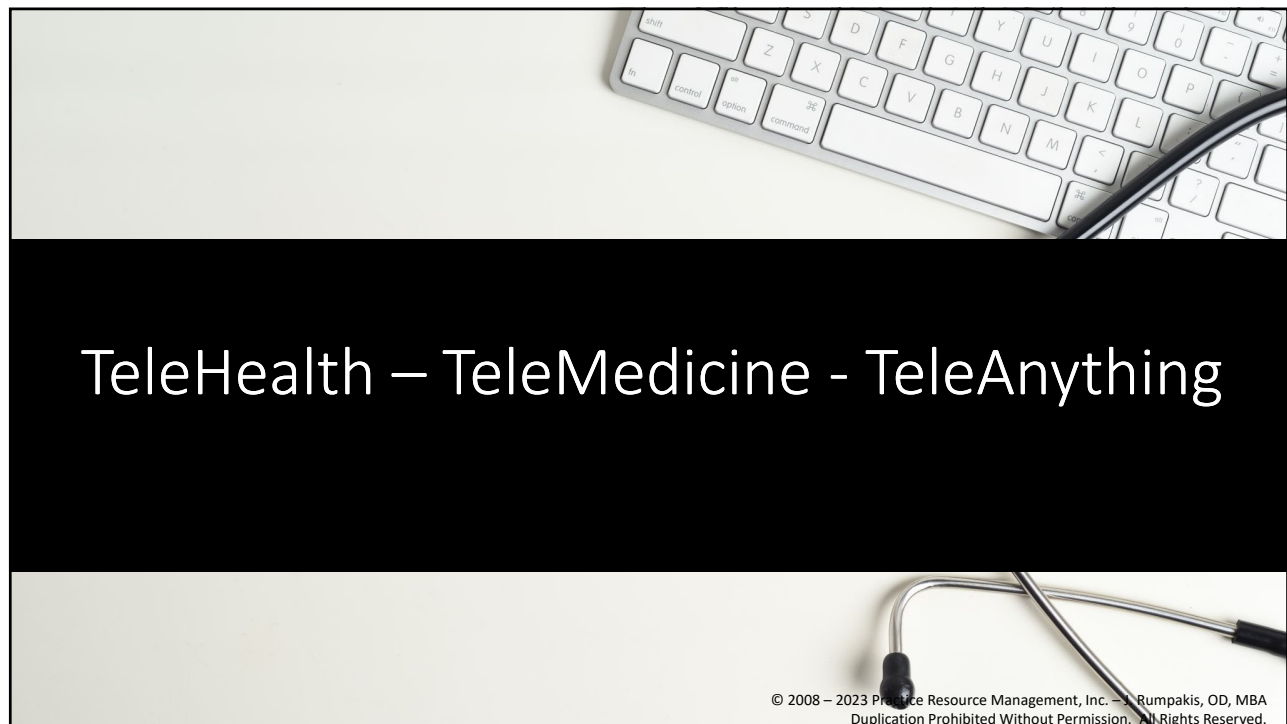
EOB Issue To Note

CO-223 Claim Reduction
Designator Due To
SEQUESTER

CO-253 Sequestration -
Reduction in Federal
Spending
(Effective September 5, 2013)

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Traditional Definition Of Telehealth Services

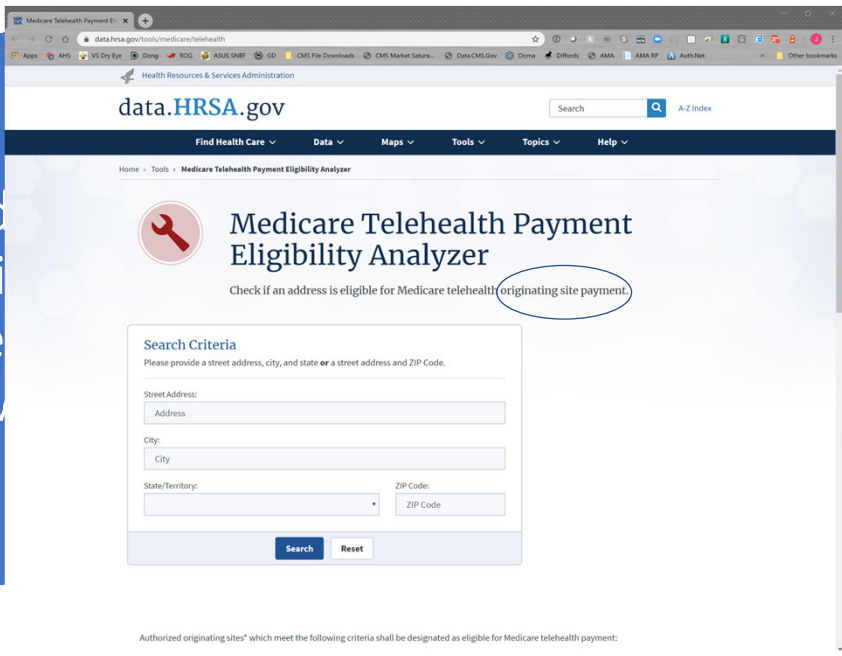
Definitions

- Originating Site – Generally defined as the location of the patient. Traditionally – Must be in the county outside of a Metropolitan Statistical Area (MSA) or in a rural Health Professional Shortage Area (HPSA) in a rural census tract.
 - You can find patient originating site status at <https://data.hrsa.gov/tools/medicare/telehealth>
- Distant Site – Generally defined as location of provider

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Trad
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the location
n the county
ea (MSA) or
Area (HPSA)

[re/telehealth](#)

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Who Are The Qualified Providers?



- Physicians
- Nurse practitioners (NP's)
- Physician assistants (PA's)
- Nurse-midwives
- Clinical nurse specialists (CNS's)
- Certified registered nurse anesthetists
- Clinical psychologists (CP's) and clinical social workers (CSW's)
- Registered dietitians or nutrition professional

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Traditional Definition Of Telehealth Services



Telehealth Services Consist Of:

- Office visits
- Psychotherapy
- Consultations (interprofessional)
- Certain other medical or health services

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Telehealth Services – Two Types

**These Services
REQUIRE a HIPAA
compliant secure email
and/or video portal**

Synchronous Communication Services

The American Telemedicine Association (ATA) defines synchronous telemedicine as "Interactive video connections that transmit information in both directions during the same time period."

Asynchronous Communication Services

The American Telemedicine Association (ATA) defines asynchronous telemedicine as "Term describing store-and-forward transmission of medical images and/or data because the data transfer takes place over a period of time, and typically in separate time frames. The transmission typically does not take place simultaneously."

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Traditional Telehealth Services Covered ONLY IF

- Patient is at a remote doctor's office
- Patient is at a hospital
- Patient is at a critical access hospital
- Patient is at a rural health clinic
- Patient is at a federally qualified healthcare facility
- Patient is at a hospital based dialysis facility
- Patient is at a skilled nursing facility
- Patient is at a community mental health center
- Patient is at their home IF End Stage Renal Disease (ESRD)
- Patient is at a mobile stroke unit



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CMS ALERT! – What Changed?

Under the Coronavirus Preparedness and Response Supplemental Appropriations Act and Section 1135 waiver authority, the Centers for Medicare & Medicaid Services (CMS) broadened access to Medicare telehealth services, **so beneficiaries can get a wider range of services from their doctors and other clinicians without traveling to a health care facility.** On March 6, 2020, Medicare began temporarily paying clinicians to furnish beneficiary telehealth services residing across the entire country.

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What Happened?

- March 6, 2020 – Legislation provides DHHS with the authority to remove the restrictions with traditional Telehealth Services
- March 17, 2020 – CMS takes action to relax Telehealth rules under a 1153 Waiver for the duration of the COVID-19 Health Emergency and made their action retroactive to March 6, 2020
- HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

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CMS ALERT! – Services Prior To March 6th

Before this announcement, Medicare could only pay clinicians for telehealth services, such as routine visits in certain circumstances. For example, the beneficiary getting the services must live in a rural area and travel to a local medical facility to get telehealth services from a doctor in a remote location. **In addition, the beneficiary generally could not get telehealth services in their home.**

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CMS ALERT! – Services After March 6

- Under this Section 1135 waiver expansion, a range of providers, such as doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers, can offer a specific set of telehealth services.
- The specific set of services beneficiaries can get include evaluation and management visits (common office visits), mental health counseling, and preventive health screenings. **Beneficiaries can get telehealth services in any health care facility including a physician's office, hospital, nursing home or rural health clinic, as well as from their homes.**
- This change broadens telehealth flexibility without regard to the beneficiary's diagnosis, because at this critical point it is important to ensure beneficiaries follow CDC guidance including practicing social distancing to reduce the risk of COVID-19 transmission. This change will help prevent vulnerable beneficiaries from unnecessarily entering a health care facility when clinicians can meet their needs remotely.

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CMS ALERT! – COVID-19 Emergency Summary

The March 2020 emergency action allows:

- For telehealth services to be provided outside of specifically designated areas such as MSA or HPSA areas
- For telehealth services to be provided when the patient is in their home
- For telehealth services to be provided using “everyday communications technologies” such as FaceTime or Skype rather than the requirement of a HIPAA secure portal
- OIG not pursuing auditable actions due to waiver of copay or deductible

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Unfortunately – Not All Of This Will Stick

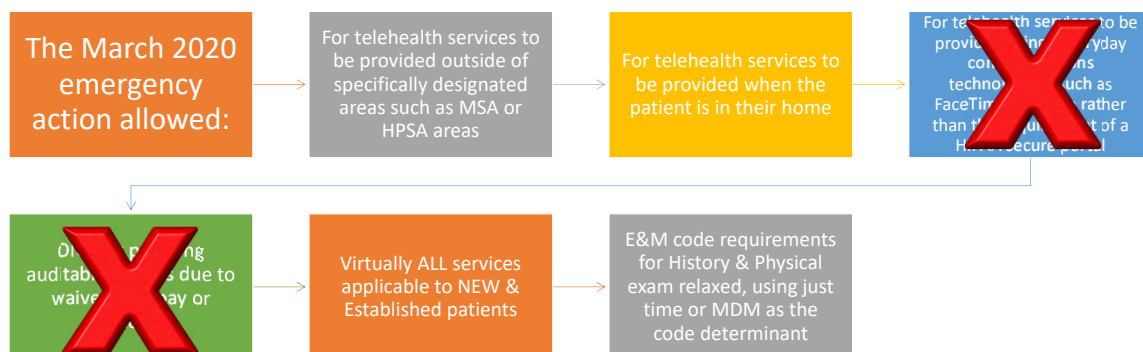
2023 Rules Will Bring Some Revisions Back To Original Posture

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CMS TeleHealth ALERT! COVID-19 Emergency Summary

What Do I Think Is
Going To Happen?




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CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

mlnconnects
Official CMS news from the Medicare Learning Network®



Special Edition – Thursday, October 15, 2020

Trump Administration Drives Telehealth Services in Medicaid and Medicare

On October 14, CMS expanded the list of telehealth services that Medicare Fee-for-Service will pay for during the COVID-19 Public Health Emergency (PHE). CMS is also providing additional support to state Medicaid and Children's Health Insurance Program (CHIP) agencies in their efforts to expand access to telehealth. The actions reinforce President Trump's Executive Order on Improving Rural Health and Telehealth Access to improve the health of all Americans by increasing access to better care.

"Responding to President Trump's Executive Order, CMS is taking action to increase telehealth adoption across the country," said CMS Administrator Seema Verma. "Medicaid patients should not be forgotten, and today's announcement promotes telehealth for them as well. This revolutionary method of improving access to care is transforming health care delivery in America. President Trump will not let the genie go back into the bottle."

Expanding Medicare Telehealth Services:

For the first time using a new expedited process, CMS added 11 new services to the Medicare telehealth services list since the publication of the May 1 COVID-19 Interim Final Rule with comment period (IFC).

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TeleHealth
Within CMS Is
Expanding,
But...

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TeleHealth Future?

ACCESS TO HEALTHCARE

Some Private Insurers To Stop Fully Paying For Virtual Visits Today [STAT](#) (9/29, Robbins, Brodwin) reported that beginning today, some private insurers, including UnitedHealthcare and Anthem, "will no longer fully pay for virtual visits under certain circumstances." As a result, people will face out-of-pocket costs again for "the virtual care that has been heralded as a lifeline at a time when Covid-19 is still killing more than 700 Americans each day."

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Living In The World Of Telehealth Now

It's Here To Stay, So Understand The Rules Well

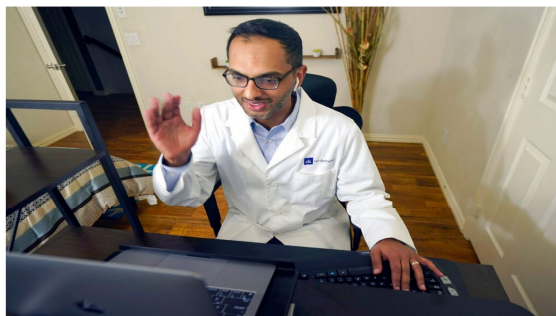
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News

Medicare's telehealth experiment could be here to stay

Updated: Dec. 11, 2021, 11:35 a.m. | Published: Dec. 11, 2021, 11:35 a.m.



FILE - In this April 23, 2021, file photo, medical director of Doctor on Demand Dr. Vibin Roy waves good-bye to a patient at the conclusion of an online primary care visit conducted from his home in Keller, Texas. (AP Photo/LM Otero, File) AP

Advertisement



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What Are The Code Sets Applicable To Telehealth?

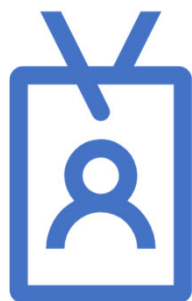
- Evaluation & Management Codes – CPT Range 99201-99215
 - Typically performed through the HIPAA compliant secure portal
- Virtual Check In & Image Review – HCPCS II G2012/G2010
- Medicare On-Line Digital Evaluations – CPT Range 99421 – 99423
 - Typically performed through the HIPAA compliant secure portal
- Telephone Services – CPT Range 99441 – 99443
- Interprofessional Consults – CPT Codes 99446-99449, 99451, 99452

- **ALL Ophthalmic Visit Codes ARE NOT ALLOWED**



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Virtual Check In Services

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Virtual Check In Services

Require Patient Verbal Consent



If Image Quality Not Sufficient For
Clinical Purposes – Can't Bill

G2010 - \$12.20 - \$12.80

- Remote Evaluation Of Recorded Video And/OR Images Submitted By **An Established Patient** (E.G., Store And Forward), Including Interpretation With Follow-up With The Patient Within 24 Business Hours, Not Originating From A Related E/M Service Provided Within The Previous 7 Days Nor Leading To An E/M Service Or Procedure Within The Next 24 Hours Or Soonest Available Urgent Appointment

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Virtual Check In Services

Require Patient Verbal Consent



G2012 - \$14.64 - \$15.78

- Brief Communication Technology-based Service, E.G. Virtual Check-in, By A Physician Or Other Qualified Health Care Professional Who Can Report Evaluation And Management Services, **Provided To An Established Patient**, Not Originating From A Related E/M Service Provided Within The Previous 7 Days Nor Leading To An E/M Service Or Procedure Within The Next 24 Hours Or Soonest Available Appointment; 5-10 Minutes Of Medical Discussion

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Virtual Check In Services Summary

- Provided to ONLY established patients (now NP & EP)
- At least on an annual basis, the patient must verbally consent to services and this consent must be documented before services are provided
- Provided “in lieu” of office visit
- Medicare coinsurance and deductible apply to these services

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On Line Digital Evaluations

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On Line Digital Evaluations - Physicians



- CPT 99421 - Online Digital Evaluation And Management Service, For An Established Patient, For Up To 7 Days, Cumulative Time During The 7 Days; 5-10 Minutes - \$14.99 - \$16.49
- CPT 99422 - Online Digital Evaluation And Management Service, For An Established Patient, For Up To 7 Days, Cumulative Time During The 7 Days; 11-20 Minutes - \$29.98 - \$32.27
- CPT 99423 - Online Digital Evaluation And Management Service, For An Established Patient, For Up To 7 Days, Cumulative Time During The 7 Days; 21 Or More Minutes - \$47.41 - \$52.82

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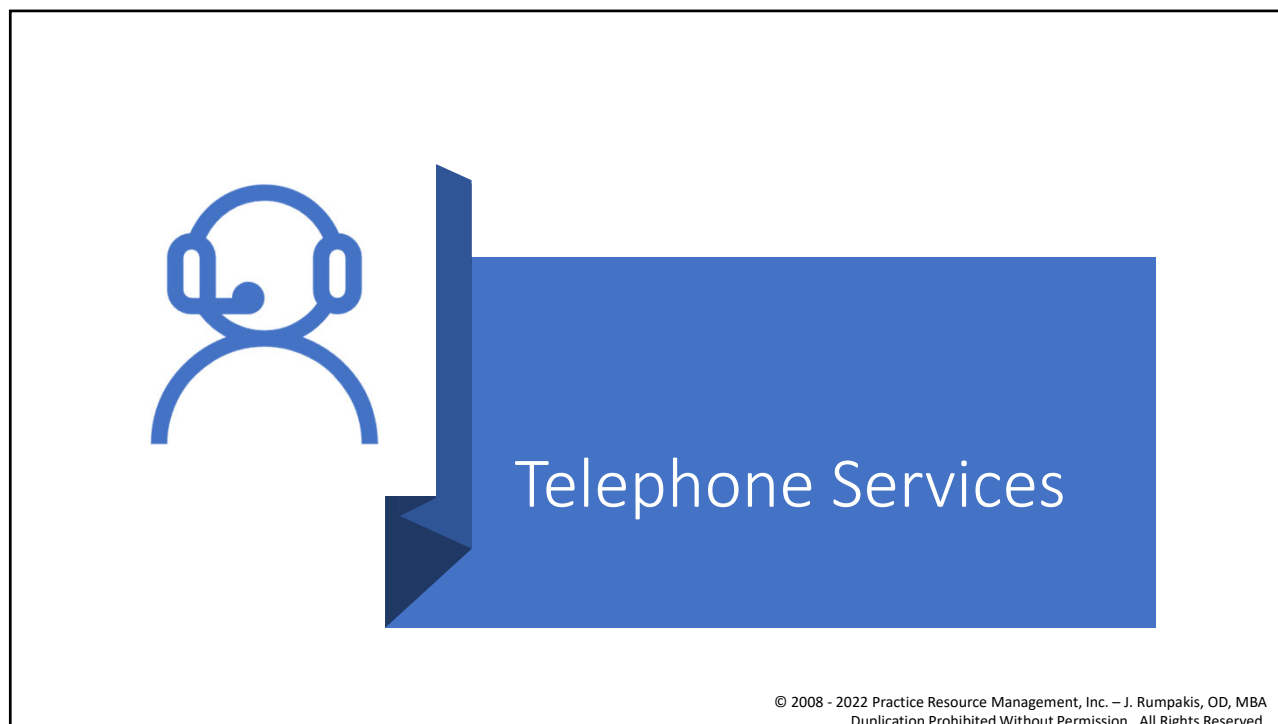
On Line Digital Evaluation Summary

- Communication with patient without an office visit using an on-line patient portal
- Must be initiated by the patient (patient must be established by CPT definition)
 - Now NP & EP
- Communication may occur over a 7-day period of time (calendar days)
- Not related to any medical visit in previous 7 days, and does not lead to medical visit in next 24 hours
- Medicare coinsurance and deductible apply (can be waived during crisis only)

Normal requirement is to store communication and ensure HIPAA compliance for all patient communications – this is not enforced during this COVID-19 emergency period and providers are allowed to use common technology such as FaceTime and Skype


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Telephone Services Defined



- These are specifically non face-to-face E&M services provided using the telephone to report episodes of patient care initiated by **an established patient**

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Telephone Services – Now Covered (April 2, 2020) To Be Discontinued at End of Emergency Period



- 99441 - Telephone Evaluation And Management Service Provided By A Physician To An Established Patient, Parent, Or Guardian Not Originating From A Related E/M Service Provided Within The Previous 7 Days Nor Leading To An E/M Service Or Procedure Within The Next 24 Hours Or Soonest Available Appointment; 5-10 Minutes Of Medical Discussion, **\$56.84 – Now \$60.28**
- 99442 - Telephone Evaluation And Management Service Provided By A Physician To An Established Patient, Parent, Or Guardian Not Originating From A Related E/M Service Provided Within The Previous 7 Days Nor Leading To An E/M Service Or Procedure Within The Next 24 Hours Or Soonest Available Appointment; 11-20 Minutes Of Medical Discussion, **\$92.73 – Now \$97.78**
- 99443 - Telephone Evaluation And Management Service Provided By A Physician To An Established Patient, Parent, Or Guardian Not Originating From A Related E/M Service Provided Within The Previous 7 Days Nor Leading To An E/M Service Or Procedure Within The Next 24 Hours Or Soonest Available Appointment; 21-30 Minutes Of Medical Discussion, **\$131.43 – Now \$137.90**

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Telephone Services Summary



- Currently NOT COVERED by CMS or Medicaid
 - ALERT, Now covered as of April 2, 2020
- DO NOT USE TELEPHONE SERVICES IF:
 - Call results in decision to see patient within next 24 hour or next available visit
 - Call refers to E&M service billed by provider within previous seven days whether requested by provider or not
 - Reported any telephone-based service by same provider for same problem in the previous seven days
- Policy can differ by commercial carrier – should verify with individual carrier prior to providing services

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Interprofessional Consults

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CPT Updates – InterProfessional Consults



- **Billing Practitioner.** Billing for interprofessional services is limited to those practitioners that can independently bill Medicare for E/M services.
- **Consent.** Verbal patient consent must be documented in the patient's medical record for each consultation. The patient's consent must include assurance that the patient is aware of applicable cost-sharing.
- **Cost Sharing.** Providers must collect the requisite copayment from the patient for each service billed, as with all Medicare Part B services.
- **Benefit of the Patient.** The consultation must be undertaken for the benefit of the patient. Because the patient is going to be responsible for cost-sharing, CMS is concerned about distinguishing these Interprofessional Internet Consultations from those undertaken for the edification of the practitioner, such as information shared as a professional courtesy or as continuing education.

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CPT Updates – InterProfessional Consults Billed By Consulting Physician

- CPT 99446 - Interprofessional Telephone/Internet/Electronic Health Record Assessment And Management Service Provided By A Consultative Physician, Including **A Verbal And Written Report** To The Patient's Treating/Requesting Physician Or Other Qualified Health Care Professional; 5-10 Minutes Of Medical Consultative Discussion And Review - \$18.81 - \$21.06
- CPT 99447 - Interprofessional Telephone/Internet/Electronic Health Record Assessment And Management Service Provided By A Consultative Physician, Including **A Verbal And Written Report** To The Patient's Treating/Requesting Physician Or Other Qualified Health Care Professional; 11-20 Minutes Of Medical Consultative Discussion And Review - \$33.80 - \$40.86
- CPT 99448 - Interprofessional Telephone/Internet/Electronic Health Record Assessment And Management Service Provided By A Consultative Physician, Including **A Verbal And Written Report** To The Patient's Treating/Requesting Physician Or Other Qualified Health Care Professional; 21-30 Minutes Of Medical Consultative Discussion And Review - \$53.66 - \$60.46
- CPT 99449 - Interprofessional Telephone/Internet/Electronic Health Record Assessment And Management Service Provided By A Consultative Physician, Including **A Verbal And Written Report** To The Patient's Treating/Requesting Physician Or Other Qualified Health Care Professional; 31 Minutes Or More Of Medical Consultative Discussion And Review - \$73.19 - \$80.41

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CPT Updates – InterProfessional Consults

- 99451 - Interprofessional Telephone/Internet/Electronic Health Record Assessment And Management Service Provided By A Consultative Physician, Including **A Written Report** To The Patient's Treating/Requesting Physician Or Other Qualified Health Care Professional, 5 Minutes Or More Of Medical Consultative Time - \$36.25 - \$39.39 – Billed By Consulting Physician
- 99452 - Interprofessional Telephone/Internet/Electronic Health Record Referral Service(s) Provided By A Treating/Requesting Physician Or Other Qualified Health Care Professional, 30 Minutes - \$36.60 - \$41.21 – Billed By Requesting Physician

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Modifiers & Place Of Service Codes

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Modifiers

GT – Service was rendered via Interactive Audio And Video Telecommunication Systems (ELIMINATED January 1st 2018)



Elimination of the GT Modifier for Telehealth Services

MLN Matters Number: MM10152 Related Change Request (CR) Number: 10152
Related CR Release Date: November 29, 2017 Effective Date: January 1, 2018
Related CR Transmittal Number: R3629CP Implementation Date: January 2, 2018

PROVIDER TYPES AFFECTED

This MLN Matters® Article is intended for providers who submit claims to Medicare Administrative Contractors (MACs) for telehealth services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10152 eliminates the requirement to use the GT modifier (via interactive audio and video telecommunications systems) on professional claims for telehealth services. Use of the telehealth Place of Service (POS) Code 02 certifies that the service meets the telehealth requirements.

BACKGROUND

CR10152 revises the previous guidance that instructed practitioners to submit claims for telehealth services using the appropriate CPT or HCPCS code for the professional service along with the telehealth modifier GT (via interactive audio and video telecommunications systems). The GT modifier is still required when applicable. As a result of the CY 2017 Physician Fee Schedule (PFS) final rule, CR9726 implemented payment policies regarding Medicare's use of a new POS Code 02 to describe services furnished via telehealth. The new POS code became effective January 1, 2017. Use of the telehealth POS code certifies that the service meets the telehealth requirements.

Note that for distant site services billed under Critical Access Hospital (CAH) method II on institutional claims, the GT modifier will still be required.

MACs will apply the "one every three days" frequency edit logic for telehealth services when codes 99231, 99232, and 99233 are billed with POS 02 for claims with dates of service January 1, 2018, and after. This frequency editing also applies when these services are span-dated on the claim (that is, the "from" date and the "to" date of service are not equal, and the "units" field is greater than one).

MACs will apply the existing "one every 30 days" frequency edit logic for telehealth services when codes 99307, 99308, 99309, and 99310 are billed with POS 02 for claims with dates of

Page 1 of 2



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Modifiers

GT – Service was rendered via Interactive Audio And Video Telecommunication Systems (ELIMINATED January 1st 2018)

95 - Synchronous Telemedicine Service Rendered Via A Real-time Interactive Audio And Video Telecommunications System

ONLY use -95 modifier when a service description is not otherwise designated as a Telemedicine service

Good reference for other codes that can be used with modifier -95 is Appendix P of the CPT book.

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Place Of Service Codes

- POS codes represent where the physician is when providing services.
- 11 – Designator – Office
 - Location, Other Than A Hospital, Skilled Nursing Facility (Snf), Military Treatment Facility, Community Health Center, State Or Local Public Health Clinic, Or Intermediate Care Facility (Icf), Where The Health Professional Routinely Provides Health Examinations, Diagnosis, And Treatment Of Illness Or Injury On An Ambulatory Basis.
- 02 – Designator – Telehealth
 - The Location Where Health Services And Health Related Services Are Provided Or Received, Through A Telecommunication System.
- **Always use POS 02 when providing telehealth services**
 - **ALERT - Some carriers have reversed policy and now want POS 11**

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Service Type	Description	Code Sets	Patient Relationship	Covered By CMS
Telemedicine Visits	A visit that uses telecommunication systems that require realtime audio/video	99201 – 99215	New Or Established	Yes
Virtual Check In	A 5-10 min check in with physician via telephone or other telecommunication device to decide whether an office visit or other service is needed	G2012	New Or Established	Yes
Online Digital Evaluations	A communication between a patient and physician through an online patient portal or secure email (now FT & Skype)	99421 – 99423	New Or Established	Yes
Telephone Services	Telephone service more than 7 days after a visit and more than 24 hours prior to a visit	99441 - 99443	New Or Established	Yes
Video or Image Evaluation	Review of previously recorded video or image taken by patient	G2010	New Or Established	Yes
Office Visits	Intermediate Ophthalmic Codes	920X2	New Or Established	Yes

<https://www.aao.org/practice-management/news-detail/coding-phone-calls-internet-telehealth-consult>

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Telehealth Code Summary During The Public Health Emergency

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CPT Code	Time	Modifier	POS
Evaluation & Management Visits			
99201	10min	95	11
99202	20min	95	11
99203	30min	95	11
99204	45min	95	11
99205	60min	95	11
99211	5min	95	11
99212	10min	95	11
99213	15min	95	11
99214	25min	95	11
99215	40min	95	11

<https://www.aao.org/practice-management/news-detail/coding-phone-calls-internet-telehealth-consult>

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Telehealth Code Summary With Time & Modifier Requirements

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CPT Code	Time	Modifier	POS
Ophthalmic Office Visits			
92002	NA	95	11
92012	NA	95	11
Evaluation Of Static or Video Images			
G2010	NA	NA	11
Online Digital Evaluations			
99446	5-10min	NA	11 Or 22 (outpatient hospital)
99447	11-20min	NA	11 or 22
99448	21-30min	NA	11 or 22

<https://www.aao.org/practice-management/news-detail/coding-phone-calls-internet-telehealth-consult>

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Telehealth Code Summary With Time & Modifier Requirements

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CPT Code	Time	Modifier	POS
Physician & Patient Telephone Calls			
99421	5-10min	NA	11
99422	11-20min	NA	11
99423	21 or more	NA	11
99421	5-10min	NA	11
Inter-Professional Consultations			
99446	5-10min	NA	11 Or 22
99447	11-20min	NA	11 or 22
99448	21-30min	NA	11 Or 22
99449	31 or more	NA	11 or 22
99451	5 min or more	NA	11 Or 22
99452	30min	NA	11 or 22

<https://www.aao.org/practice-management/news-detail/coding-phone-calls-internet-telehealth-consult>

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Telehealth Code Summary With Time & Modifier Requirements

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May 11, 2023 End Of The Public Health Emergency Period


So, What Does That Mean To Us?

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Telehealth Coverage POST - PHE




Virtual check-in codes (G2012, G2010, G2252) and remote patient monitoring codes will only be allowed for established patients after the PHE ends.




Medicare will continue to pay for audio-only telephone services billed with CPT® codes 99441-99443 through Dec. 31, 2024, when appropriate and all required elements in the code descriptions are met. The payment parity to CPT® codes 99212-99214 is also extended through Dec. 31, 2024.




Behavioral and mental health services (CPT® 90785-90840) are now permanently added to the Medicare Telehealth Services List and may be provided using audio-only equipment through Dec. 31, 2024.



All other services on the Medicare Telehealth Services list, unless otherwise indicated, require audio-video equipment permitting two-way, real-time interactive communication. CMS will update the list for 2024 using standard protocols.



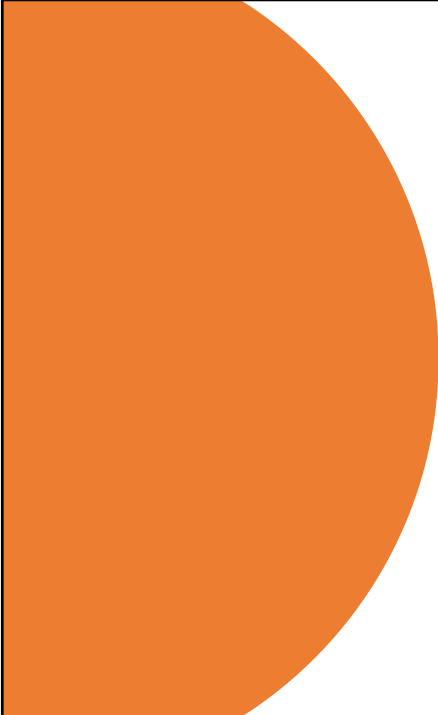
Incident-to services via virtual supervision will no longer be allowed after Dec. 31, 2023.



When the PHE ends, CMS will continue to allow for a total deferral to state law regarding licensure requirements for billing Medicare for services provided outside of their state of enrollment. State laws may override this freedom, however.

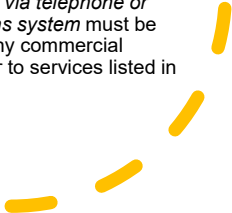
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- Practitioners must resume reporting their home address on the Medicare enrollment beginning Jan. 1, 2024.
- All telehealth platforms must be HIPAA compliant starting the day after the end of the PHE (May 12). Smart phone video options such as FaceTime and Skype will no longer be an option for telehealth after the PHE ends, per the Office of Civil Rights.
- Place of service (POS) codes will continue to be used based on where the patient would have been seen had they been seen in person. However, POS 02 *Patient not in their home when telehealth services are rendered* or POS 10 *Patient in their home when telehealth services are rendered* may be reported, as appropriate. Reporting these specific POS codes will result in facility reimbursement.
- Modifier 95 *Synchronous telemedicine service rendered via real-time interactive audio and video telecommunications system* will continue to be used for audio and video services for Medicare telehealth through 2024.
- Modifier 93 *Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system* must be used, as of Jan. 1, 2023, for all audio-only services. Many commercial payers have instructed providers to append this modifier to services listed in Appendix T of CPT® 2023.

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Per a CMS Feb. 27, 2023, fact sheet:

- “The Consolidated Appropriations Act, 2023, extended many telehealth flexibilities through December 31, 2024, such as:
- People with Medicare can access telehealth services in any geographic area in the United States, rather than only those in rural areas.
- People with Medicare can stay in their homes for telehealth visits that Medicare pays for rather than traveling to a health care facility.
- Certain telehealth visits can be delivered audio-only (such as a telephone) if someone is unable to use both audio and video, such as a smartphone or computer.”


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Office Visits

Defining The Physician/Patient Encounter
(The #1 Audit Trigger)



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Overview Eye Examinations – Office Visits

Code Set	Code Group Class	Relative Value Units	Level Of Reimbursement	Level Of Documentation	Billed To Medical Insurance?	Acceptance By Medical Insurance?	Role In Medical Eye Care?
920XX Codes	HCPCS Level I (CPT)	Yes	Higher 92004 = \$150.46	Lower	Yes	Varied	Varied
992XX Codes	HCPCS Level I (CPT)	Yes	Lower 99203 = \$112.84	Higher	Yes	Always	High
S Codes	HCPCS Level II	No	Market Value	Lower	No	None	None

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Why Is It Important To Use The Right Code?

Compliance – Code must match service required & provided

Economics – even small differences in reimbursement are significant

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Evaluation & Management Code Differences

CPT Code	Reimbursement	Fee Relationship	% Delta
99205	\$220.94	100%	
99204	\$167.40	76%	24%
99203	\$112.84	51%	25%
99202	\$72.86	33%	18%
99201	No Longer Valid		
99215	\$179.94	100%	
99214	\$128.43	71%	29%
99213	\$90.82	50%	21%
99212	\$56.93	32%	19%

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Evaluation & Management Code Differences

CPT Code	2020 Reimbursement	2021 Reimbursement	2022 Reimbursement
99205	\$211.12	\$224.11	\$224.25
99204	\$167.09	\$167.74	\$169.57
99203	\$109.35	\$113.63	\$113.85
99202	\$77.23	\$73.90	\$74.06
99201	\$46.56	No Longer A Valid Code	No Longer A Valid Code
99215	\$148.33	\$183.02	\$183.07
99214	\$110.43	\$131.09	\$129.77
99213	\$76.15	\$92.39	\$92.05
99212	\$46.19	\$56.84	\$57.45
99211	\$23.46	\$23.02	\$23.53

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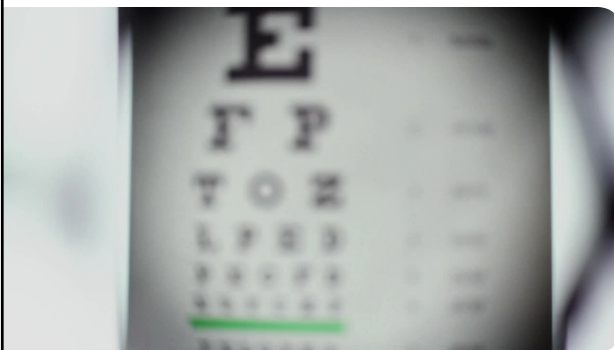
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Ophthalmic Code Differences

CPT Code	Reimbursement	Fee Relationship	% Delta
92004	\$150.46	100%	
92014	\$127.08	84%	16%
92002	\$86.07	57%	27%
92012	\$90.48	60%	-3%


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The Routine Eye Examination

So, What Does “Routine” Really Mean?



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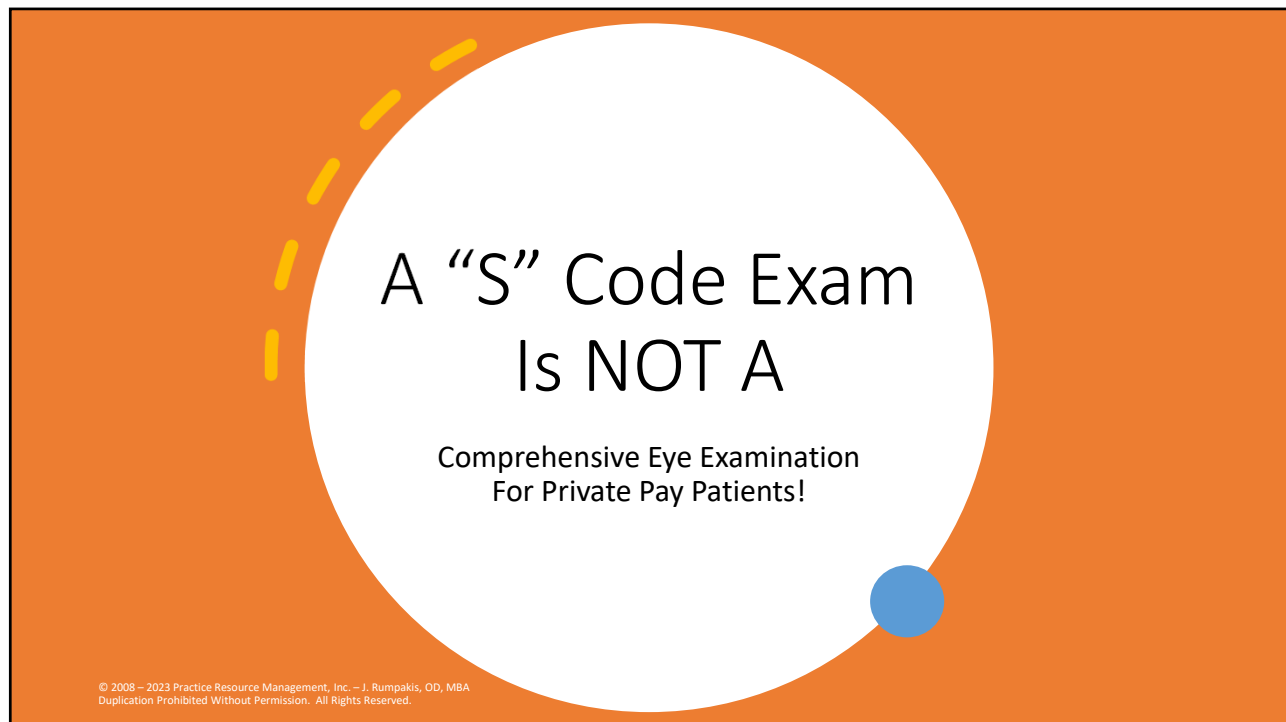
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The “S” Codes

- Although Medicare and other federal payers don't recognize the "S" codes, they can be useful for claims to some private insurers and other parties...
 - S0620 (for new patients)
 - S0621 (for established patients)
- Specifically describe routine well patient vision exams, including refraction.
- By performing a different level of service, you are required to use a different code, therefore are able to charge a separate fee.

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A “S” Code Generally Consists Of:

- Visual acuities
- Visual fields by confrontation
- Ocular alignment and motility
- Refraction
- Pupillary function
- Slit-lamp biomicroscopy examination
- Intraocular pressure measurement
- Fundus examination

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The Ophthalmic Office Visits

The Comprehensive Exam & The Intermediate Exam

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920x4 – Comprehensive Service

CPT 2023 Definition:

“... describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session.”

- The service includes:
 - History
 - General medical observation
 - External examination
 - Ophthalmological examinations
 - Gross visual fields
 - Basic sensorimotor examination
- It often includes, as indicated:
 - Biomicroscopy
 - Examination with cycloplegia or mydriasis
 - Tonometry

It always includes initiation of diagnostic and treatment programs.”

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920x2 – Intermediate Service

CPT 2023 Definition:

“... describes an evaluation of a new (condition) or an existing condition complicated with a new diagnostic or management problem not necessarily related to the primary diagnosis

- The service includes:
 - History
 - General medical observation
 - External examination
 - Adnexal examination
 - other diagnostic procedures as indicated
- It often includes, as indicated:
 - Biomicroscopy
 - And may include the use of mydriasis for ophthalmoscopy

It always includes initiation of diagnostic and treatment programs.”

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The Evaluation & Management Codes - 2020

The Standard In Medicine
A Historical Perspective



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Evaluation & Management Coding System

New Patient

- 99201
- 99202
- 99203
- 99204
- 99205

Established Patient

- 99211
- 99212
- 99213
- 99214
- 99215

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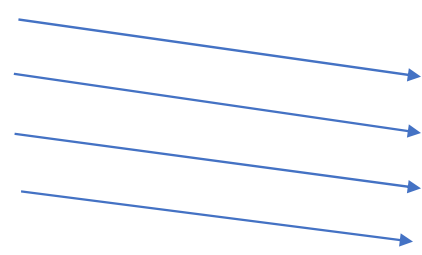
Evaluation & Management Coding System

New Patient

- 99201
- 99202
- 99203
- 99204
- 99205

Established Patient

- 99211
- 99212
- 99213
- 99214
- 99215



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Evaluation & Management Coding System

New Patient

- 99201
- 99202
- 99203
- ~~99204~~
- ~~99205~~

The use of 99204 & 99205 require a comprehensive history which is difficult for us to provide

Established Patient

- ~~99211~~
- 99212
- 99213
- 99214
- ~~99215~~

Use CPT 99211, physician presence is not required, but he/she must have initiated the service as part of a continuing plan and must at least be in the office suite when each service is provided.

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The Big Three Medical Record Elements

History

- Four levels of history

Physical Examination

- We are single system subspecialists
- Four levels of physical examination

Medical Decision Making

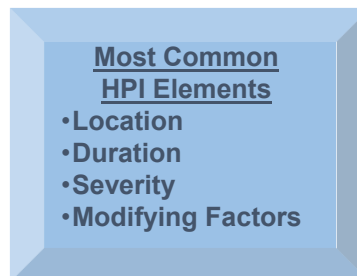
- Four levels of medical decision making

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Documentation of History

- Problem Focused
 - Chief Complaint
 - 1 to 3 elements of History of Present Illness (HPI)
- Expanded Problem-Focused
 - Chief Complaint
 - 1 to 3 elements of HPI
 - Ocular review of systems
- Detailed
 - Chief Complaint
 - 4 elements of HPI
 - Ocular review of systems + 1 other system
 - 1 specific item from past, family, or social history
- Comprehensive
 - Chief Complaint
 - 4 elements of HPI
 - Ocular review of systems
 - Review of at least 9 additional systems
 - 2-3 specific item from past, family, and social history (est. vs. new)



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Scoring A History - HPI

- History of Present Illness (HPI)
 - Location
 - Quality
 - Severity
 - Duration
 - Timing
 - Context
 - Modifying Factors
 - Associated Signs & Symptoms
- Brief
 - - 1-3 elements
 - Extended
 - - 4-8 elements or at least 3 chronic or inactive conditions

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Scoring A History – Review Of Systems

- Constitutional
- Eyes
- Ears, Nose, Mouth & Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

How Are You Going To Get To 10?

Problem Pertinent is 1 system Extended is 2-9 systems Complete is 10-14 systems

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Documentation of History

- Problem Focused
 - Chief Complaint
 - 1 to 3 elements of History of Present Illness (HPI)
- Expanded Problem-Focused
 - Chief Complaint
 - 1 to 3 elements of HPI
 - Ocular review of systems
- Detailed
 - Chief Complaint
 - 4 elements of HPI
 - Ocular review of systems + 1 other system
 - 1 specific item from past, family, or social history
- Comprehensive
 - Chief Complaint
 - 4 elements of HPI
 - Ocular review of systems
 - Review of at least 9 additional systems
 - 2-3 specific item from past, family, and social history (est. vs. new)

Most Common HPI Elements

- Location
- Duration
- Severity
- Modifying Factors

Must be pertinent &
germane to the CC or
reason for visit

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Reference:
1997 CMS Evaluation &
Management Guidelines

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Scoring A History - PFSH

Past, Family & Social History

- Patient's Past History
- Family History
- Social/Occupational History
- Problem Pertinent
 - 1 question
- Complete
 - 2 areas for Est Pt
 - 3 areas for New Pt

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Scoring A History Putting The Pieces Together

	Level 1	Level 2	Level 3	Level 4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
HPI	Brief 1-3	Brief 1-3	Extended 4-8	Extended 4-8
ROS	N/A	Problem Pertinent 1 area	Extended 2-9 areas	Complete 10-14 areas
PFSH	N/A	N/A	Problem Pertinent 1 area	Complete 2 areas est 3 areas new

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Documentation of Physical Exam

- Problem Focused
 - Limited exam of the affected body area or organ systems
 - 1 to 5 elements of the eye exam documented
- Expanded Problem-Focused
 - Limited exam of the affected body area or organ system and other symptomatic or related organ systems
 - 6 elements of the eye exam documented
- Detailed
 - Extended exam of the affected body area and other symptomatic or related organ systems
 - 9 elements of the eye exam documented (can include M/S)
- Comprehensive
 - Complete single system specialty exam
 - All elements of the eye exam plus mental status documented

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Documentation of Physical Exam

- Problem Focused
 - Limited exam of the affected body area or organ systems
 - 1 to 5 elements of the eye exam documented
- Expanded Problem-Focused
 - Limited exam of the affected body area or organ system and other symptomatic or related organ systems
 - 6 elements of the eye exam documented
- Detailed
 - Extended exam of the affected body area and other symptomatic or related organ systems
 - 9 elements of the eye exam documented (can include M/S)
- Comprehensive
 - Complete single system specialty exam
 - All elements of the eye exam plus mental status documented

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Levels Of Physical Exam

- Remember The Key Numbers of 5, 6, 9, or Everything
- Any 5 elements or less = Level 1
- Any 6 – 8 elements = Level 2
- Any 9 – 13 elements = Level 3 (including mental status)
- All elements = Level 4 (including mental status)

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Medical Decision Making Diagnostic & Treatment Options

- | | |
|--------------------------------|-------------------|
| • Number of Diagnoses | • 1 is Minimal |
| | • 2-3 is Limited |
| • Number of Management Options | • 4-5 is Multiple |
| | • 6+ is Extensive |

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Medical Decision Making Complexity of Data

- Diagnostic service ordered, planned, scheduled, or performed
- Review of diagnostic tests
- Decision to obtain old records, or take additional history
- Relevant finding from old records or additional history taken
- Discussion with other physician
- Independent interpretation of previously taken images, or studies

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Medical Decision Making Risk Of Complications/Morbidity

- Minimal - One self limited or minor problem
- Low - Two or more self limited or minor illnesses; One stable or chronic illness; One acute illness or injury; Uncomplicated injury or illness. Use of OTC medication.
- Moderate - One chronic illness with mild complications; Two stable chronic illnesses; An undiagnosed new problem (uncertain prognosis); Acute illness with systemic symptoms; Acute complicated injury. Prescription medication management.
- High - One or more chronic illness with severe complications, Acute or chronic illnesses or injuries posing a threat to life, or an abrupt change in neurological status

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Medical Decision Making

	Level 1	Level 2	Level 3	Level 4
	Straightforward	Low Complexity	Moderate Complexity	High Complexity
Number of Diagnostic & Treatment Options	Minimal (1)	Limited (2-3)	Multiple (4-5)	Extensive (6+)
Amount & Complexity of Data	Minimal or None (1)	Limited (2-3)	Moderate (4-5)	Extensive (6+)
Risk of Complications &/or Morbidity	Minimal 1 self limited	Low 2 SL, 1 C, 1A, OTC	Moderate 1CwC, 2 C, New, Rx	High 1C w/high comp, threat to life

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Medical Decision Making

	Level 1	Level 2	Level 3	Level 4
	Straightforward	Low Complexity	Moderate Complexity	High Complexity
Number of Diagnostic & Treatment Options	Minimal (1)	Limited (2-3)	Multiple (4-5)	Extensive (6+)
Amount & Complexity of Data	Minimal or None (1)	Limited (2-3)	Moderate (4-5)	Extensive (6+)
Risk of Complications &/or Morbidity	Minimal 1 self limited	Low 2 SL, 1 C, 1A, OTC	Moderate 1CwC, 2 C, New, Rx	High 1C w/high comp, threat to life

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Medical Decision Making

	Level 1	Level 2	Level 3	Level 4
	Straightforward	Low Complexity	Moderate Complexity	High Complexity
Number of Diagnostic & Treatment Options	Minimal (1)	Limited (2-3)	Multiple (4-5)	Extensive (6+)
Amount & Complexity of Data	Minimal or None (1)	Limited (2-3)	Moderate (4-5)	Extensive (6+)
Risk of Complications &/or Morbidity	Minimal 1 self limited	Low 2 SL, 1 C, 1A, OTC	Moderate 1CwC, 2 C, New, Rx	High 1C w/high comp, threat to life

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Medical Decision Making

	Level 1	Level 2	Level 3	Level 4
	Straightforward	Low Complexity	Moderate Complexity	High Complexity
Number of Diagnostic & Treatment Options	Minimal (1)	Limited (2-3)	Multiple (4-5)	Extensive (6+)
Amount & Complexity of Data	Minimal or None (1)	Limited (2-3)	Moderate (4-5)	Extensive (6+)
Risk of Complications &/or Morbidity	Minimal 1 self limited	Low 2 SL, 1 C, 1A, OTC	Moderate 1CwC, 2 C, New, Rx	High 1C w/high comp, threat to life

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Medical Decision Making

	Level 1	Level 2		Level 4
	Straightforward	Low Complexity	Moderate Complexity	High Complexity
Number of Diagnostic & Treatment Options	Minimal (1)	Limited (2-3)	Multiple (4-5)	Extensive (6+)
Amount & Complexity of Data	Minimal or None (1)	Limited (2-3)	Moderate (4-5)	Extensive (6+)
Risk of Complications &/or Morbidity	Minimal 1 self limited	Low 2 SL, 1 C, 1A, OTC	Moderate 1CwC, 2 C, New, Rx	High 1C w/high comp, threat to life

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Identifying Level of Service - New

- New Patient – Must meet or exceed 3 of 3 to qualify for that code level
- (Grade To Lowest Of Three)

	99201	99202	99203	99204	99205
History	1	2	3	4	4
Exam	1	2	3	4	4
Decision Making	1	2	2	3	4

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Identifying Level of Service - Established

- Established Patient – Must meet or exceed 2 of 3 to qualify for code
- (Grade To Middle Of Three)

	99211	99212	99213	99214	99215
History	0	1	2	3	4
Exam	0	1	2	3	4
Decision Making	0	1	2	3	4

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Big Changes Came In 2021

These New Changes Uncomplicate Coding!

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2021 E/M Update

Time Has Been Redefined

What Counts?

A shared or split visit is defined as a visit in which a physician and other qualified healthcare professional(s) jointly provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of a service for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and or other qualified health care professional(s) assessing and managing the patient on the date of the encounter **is summed to define total time.**

- Preparing To See The Patient (Eg, Review Of Tests)
- Obtaining And/Or Reviewing Separately Obtained History
- Performing A Medically Appropriate Examination And/Or 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)
- Documenting Clinical Information In The Electronic Or Other Health Record
- Independently Interpreting Results (Not Separately Reported) And Communicating Results To The Patient/Family/Caregiver
- Care Coordination (Not Separately Reported)

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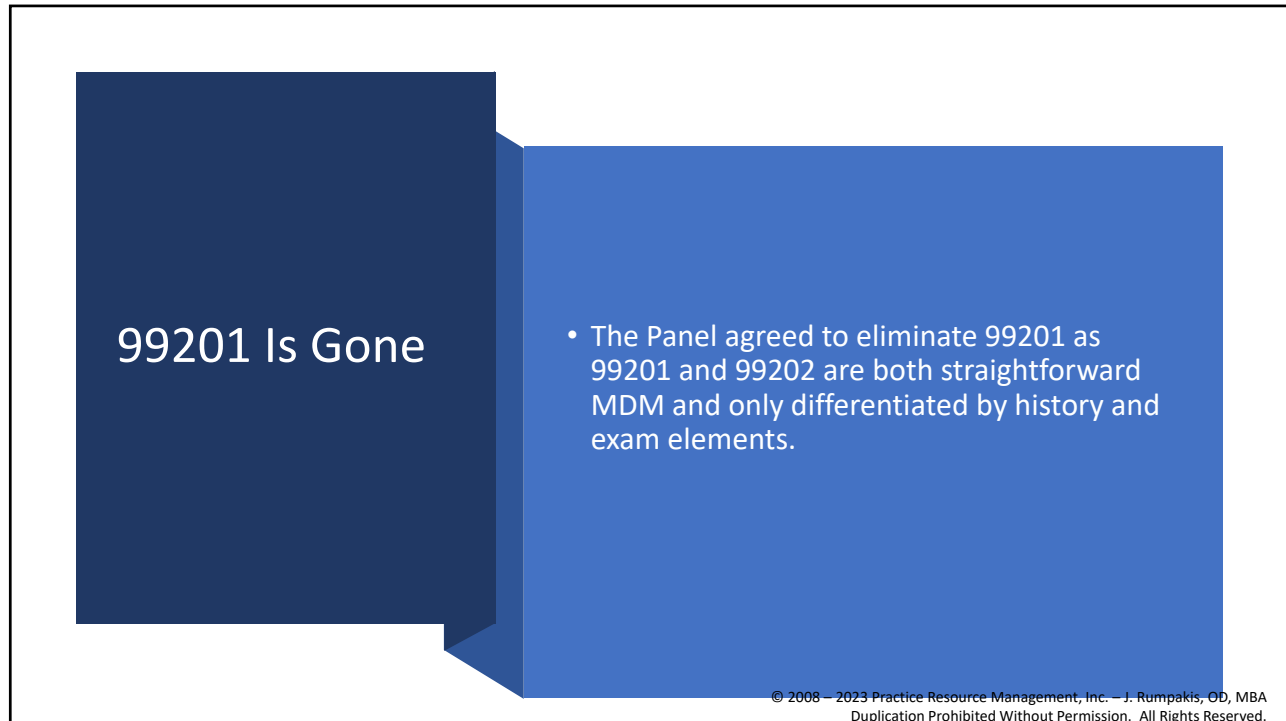
333

History & Physical Exam No Longer A Factor

- While the physician's work in capturing the patient's pertinent history and performing a relevant physical exam contributes to both the time and medical decision making, these elements alone should not determine the appropriate code level. The Workgroup revised the code descriptors to state providers should perform a "**medically appropriate history and/or examination**"

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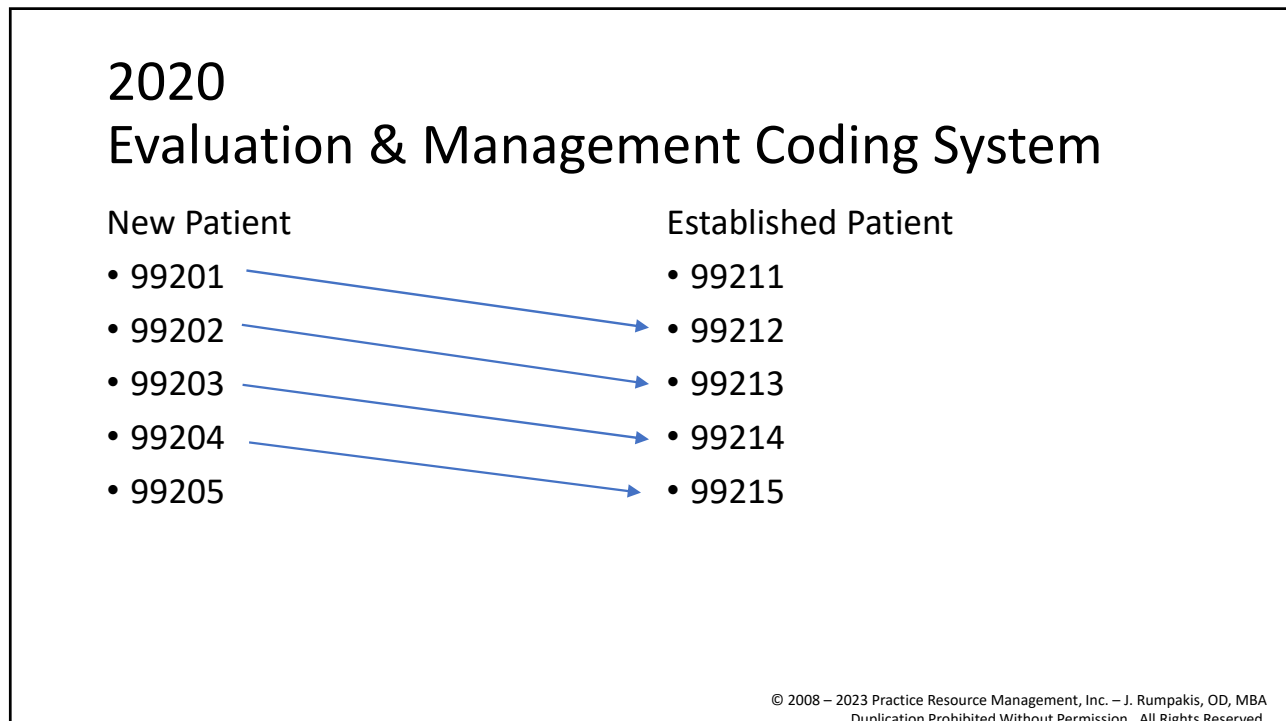


99201 Is Gone

- The Panel agreed to eliminate 99201 as 99201 and 99202 are both straightforward MDM and only differentiated by history and exam elements.

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**2020
Evaluation & Management Coding System**

New Patient		Established Patient
• 99201	→	• 99211
• 99202	→	• 99212
• 99203	→	• 99213
• 99204	→	• 99214
• 99205	→	• 99215

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2021 Evaluation & Management Coding System

New Patient

~~• 99201~~

- 99202 →
- 99203 →
- 99204 →
- 99205 →

Established Patient

- 99211
- 99212
- 99213
- 99214
- 99215

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New E&M Definitions

- 99202 - Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and STRAIGHTFORWARD medical decision making.
- 99203 - Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and LOW LEVEL of medical decision making
- 99204 - Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and MODERATE level of medical decision making.
- 99205 - Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and HIGH LEVEL of medical decision making.

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New E&M Definitions

- 99211 - Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.
- 99212 - Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and **STRAIGHTFORWARD** medical decision making.
- 99213 - Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and **LOW** level of medical decision making.
- 99214 - Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and **MODERATE** level of medical decision making.
- 99215 - Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and **HIGH** level of medical decision making.

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Choose Time OR Medical Decision Making

- **MDM:** The Workgroup did not materially change the three current MDM sub-components, but did provide extensive edits to the elements for code selection and revised/created numerous clarifying definitions in the E/M guidelines.
- **Time:** The definition of time is minimum time, not typical time, and represents total physician/qualified health care professional (QHP) time on the date of service. The use of date-of-service time builds on the movement over the last several years by Medicare to better recognize the work involved in non-face-to-face services like care coordination. These definitions only apply when code selection is primarily based on time and not MDM.

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Wait...
How Do I
Calculate My
Time Again?
(Doctor Time Only)

- Preparing To See The Patient
- Taking Additional Or Reviewing Previously Taken History
- Performing Your Medically Appropriate Exam
- Counseling/Educating Patient, Family, Caregiver
- Ordering Medication, Tests, or Procedures
- Referring & Communicating With Other Health Care Providers
- Documenting The Medical Record
- Independently Interpreting Test Results & Communicating Them
- Coordination Of Care

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Record Each Time Segment, Then Total It

Preparing To See The Patient	2 Minutes
Taking Additional Or Reviewing Previously Taken History	4 Minutes
Performing Your Medically Appropriate Exam	12 Minutes
Counseling/Educating Patient, Family, Caregiver	7 Minutes
Ordering Medication, Tests, or Procedures	2 Minutes
Referring & Communicating With Other Health Care Providers	0 Minutes
Documenting The Medical Record	6 Minutes
Independently Interpreting Test Results & Communicating Them	0 Minutes
Coordination Of Care	0 Minutes

**Total Time For
Coding Purposes Is
33 Minutes Of
Physician Time**

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New Coding System – By Time (Total Time)

New Patient

99202 15-29 minutes

99203 30-44 minutes

99204 45-59 minutes

99205 60-74 minutes

Established Patient

99211 NA

99212 10-19 minutes

99213 20-29 minutes

99214 30-39 minutes

99215 40-54 minutes

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Record Each Time Segment, Then Total It

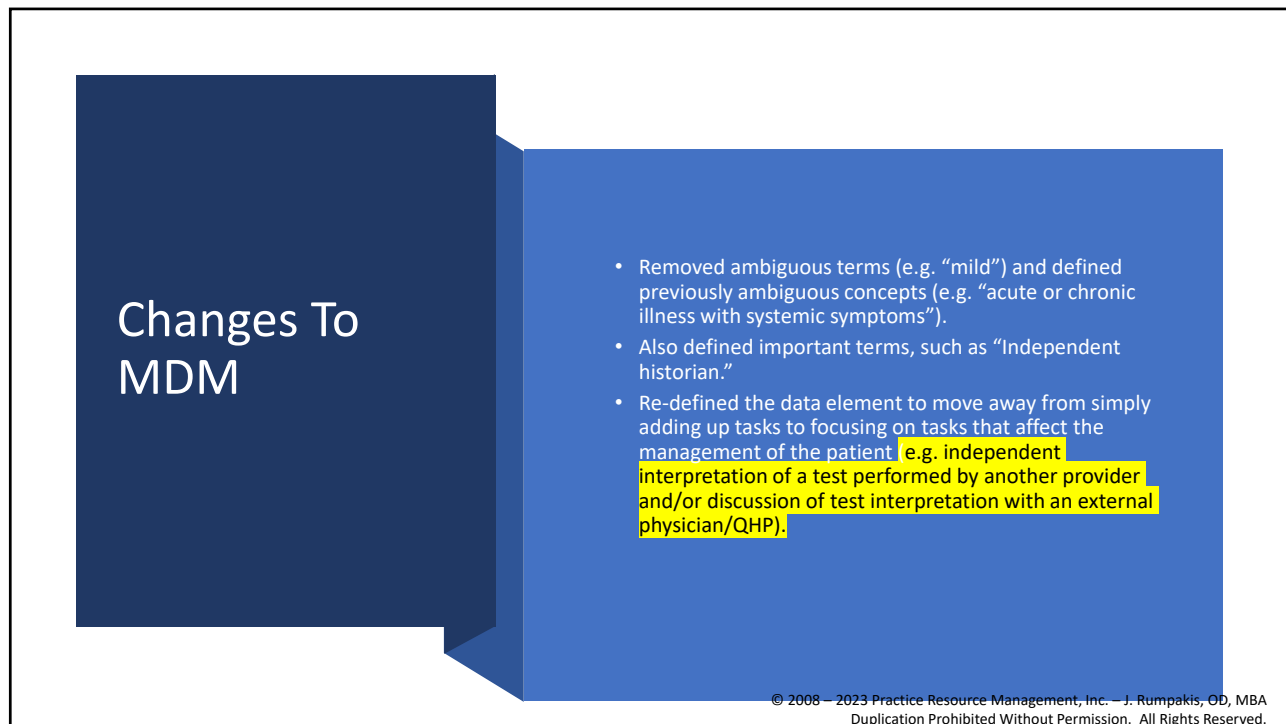
Preparing To See The Patient	2 Minutes
Taking Additional Or Reviewing Previously Taken History	4 Minutes
Performing Your Medically Appropriate Exam	12 Minutes
Counseling/Educating Patient, Family, Caregiver	7 Minutes
Ordering Medication, Tests, or Procedures	2 Minutes
Referring & Communicating With Other Health Care Providers	0 Minutes
Documenting The Medical Record	6 Minutes
Independently Interpreting Test Results & Communicating Them	0 Minutes
Coordination Of Care	0 Minutes

Total Time For
Coding Purposes Is
33 Minutes

Which is going to
be either a
99203 or a 99214

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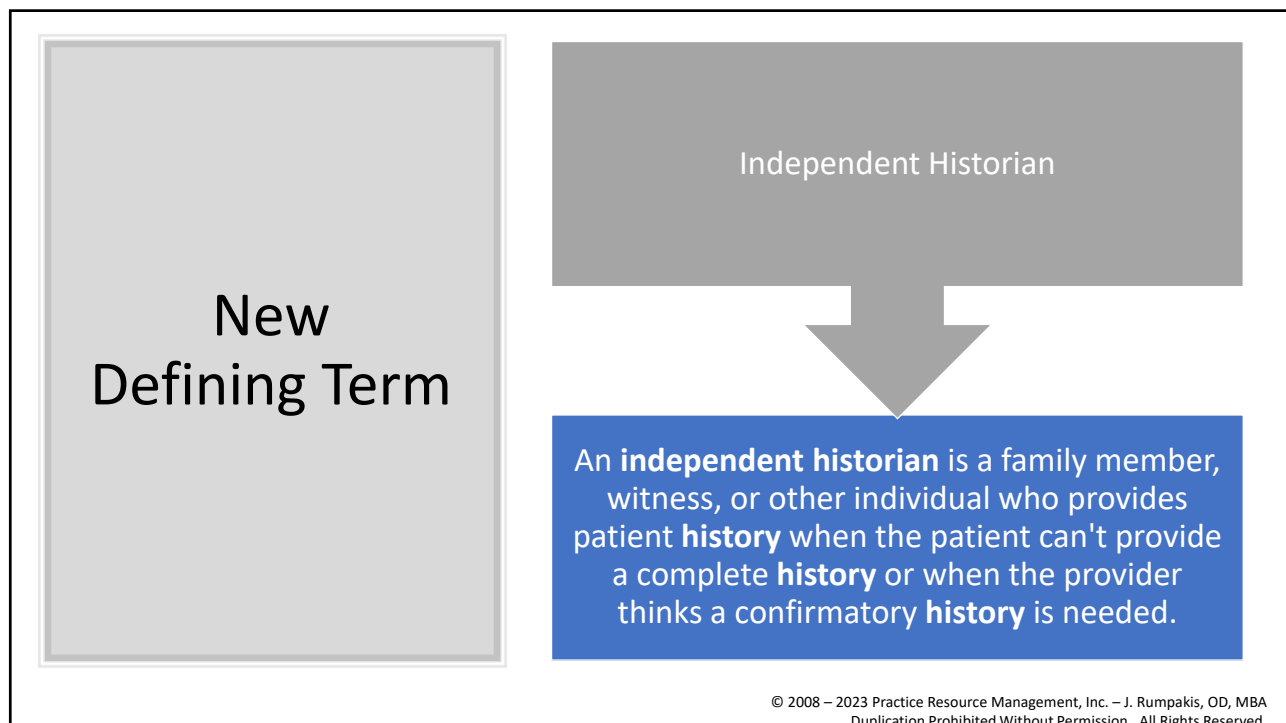


Changes To MDM

- Removed ambiguous terms (e.g. “mild”) and defined previously ambiguous concepts (e.g. “acute or chronic illness with systemic symptoms”).
- Also defined important terms, such as “Independent historian.”
- Re-defined the data element to move away from simply adding up tasks to focusing on tasks that affect the management of the patient [e.g. independent interpretation of a test performed by another provider and/or discussion of test interpretation with an external physician/QHP].

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New Defining Term

Independent Historian

An **independent historian** is a family member, witness, or other individual who provides patient **history** when the patient can't provide a complete **history** or when the provider thinks a confirmatory **history** is needed.

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By Medical Decision Making

CPT Code	Level Of MDM (2 out of 3)	Number & Complexity Of Problems Addressed	Amount &/or Complexity of Data To Reviewed & Analyzed	Risk Of Complications &/or Morbidity
99211	NA	NA	NA	NA
99202/12	Straightforward	Minimal • 1 self-limited or minor problem	Minimal or None	Minimal risk of morbidity from additional diagnostic testing or treatment

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By Medical Decision Making

CPT Code	Level Of MDM (2 out of 3)	Number & Complexity Of Problems Addressed	Amount &/or Complexity of Data To Reviewed & Analyzed	Risk Of Complications &/or Morbidity
99203/99213	Low	Low • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury	Limited <i>(Must meet the requirements of at least 1 of the 2 categories)</i> Category 1: Tests and documents • Any combination of 2 from the following: • Review of prior external note(s) from each unique source*; • review of the result(s) of each unique test*; • ordering of each unique test* or Category 2: Assessment requiring an independent historian(s) <i>(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)</i>	Low risk of morbidity from additional diagnostic testing or treatment

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By Medical Decision Making

CPT Code	Level Of MDM (2 out of 3)	Number & Complexity Of Problems Addressed	Amount &/or Complexity of Data To Reviewed & Analyzed	Risk Of Complications &/or Morbidity
99204/99214	Moderate	Moderate <ul style="list-style-type: none"> • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or <ul style="list-style-type: none"> • 2 or more stable chronic illnesses; or <ul style="list-style-type: none"> • 1 undiagnosed new problem with uncertain prognosis; or <ul style="list-style-type: none"> • 1 acute illness with systemic symptoms; or <ul style="list-style-type: none"> • 1 acute complicated injury 	Moderate <i>(Must meet the requirements of at least 1 out of 3 categories)</i> Category 1: Tests, documents, or independent historian(s) <ul style="list-style-type: none"> • Any combination of 3 from the following: <ul style="list-style-type: none"> • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) or Category 2: Independent interpretation of tests <ul style="list-style-type: none"> • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or Category 3: Discussion of management or test interpretation <ul style="list-style-type: none"> • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported) 	Moderate risk of morbidity from additional diagnostic testing or treatment <i>Examples only:</i> <ul style="list-style-type: none"> • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health

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By Medical Decision Making

CPT Code	Level Of MDM (2 out of 3)	Number & Complexity Of Problems Addressed	Amount &/or Complexity of Data To Reviewed & Analyzed	Risk Of Complications &/or Morbidity
99205/99215	High	High <ul style="list-style-type: none"> • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or <ul style="list-style-type: none"> • 1 acute or chronic illness or injury that poses a threat to life or bodily function 	Extensive <i>(Must meet the requirements of at least 2 out of 3 categories)</i> Category 1: Tests, documents, or independent historian(s) <ul style="list-style-type: none"> • Any combination of 3 from the following: <ul style="list-style-type: none"> • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) or Category 2: Independent interpretation of tests <ul style="list-style-type: none"> • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or Category 3: Discussion of management or test interpretation <ul style="list-style-type: none"> • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported) 	High risk of morbidity from additional diagnostic testing or treatment <i>Examples only:</i> <ul style="list-style-type: none"> • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis

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More Applicable Definition Of Prolonged Services

- **Creation of a shorter Prolonged Services code:** The Panel created a shorter prolonged services code that would capture physician/QHP time in 15-minute increments. This code would only be reported with 99205 and 99215 and be used when time was the primary basis for code selection.

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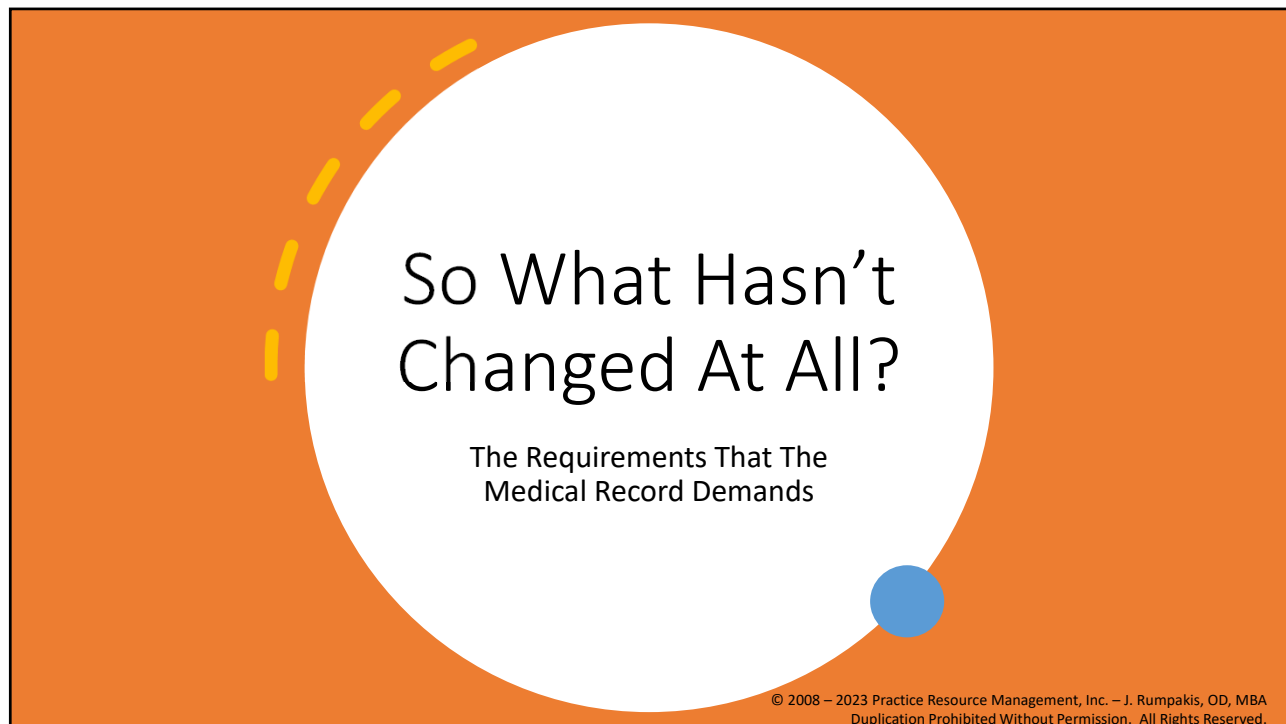
351

Summary Of E/M Coding Revisions

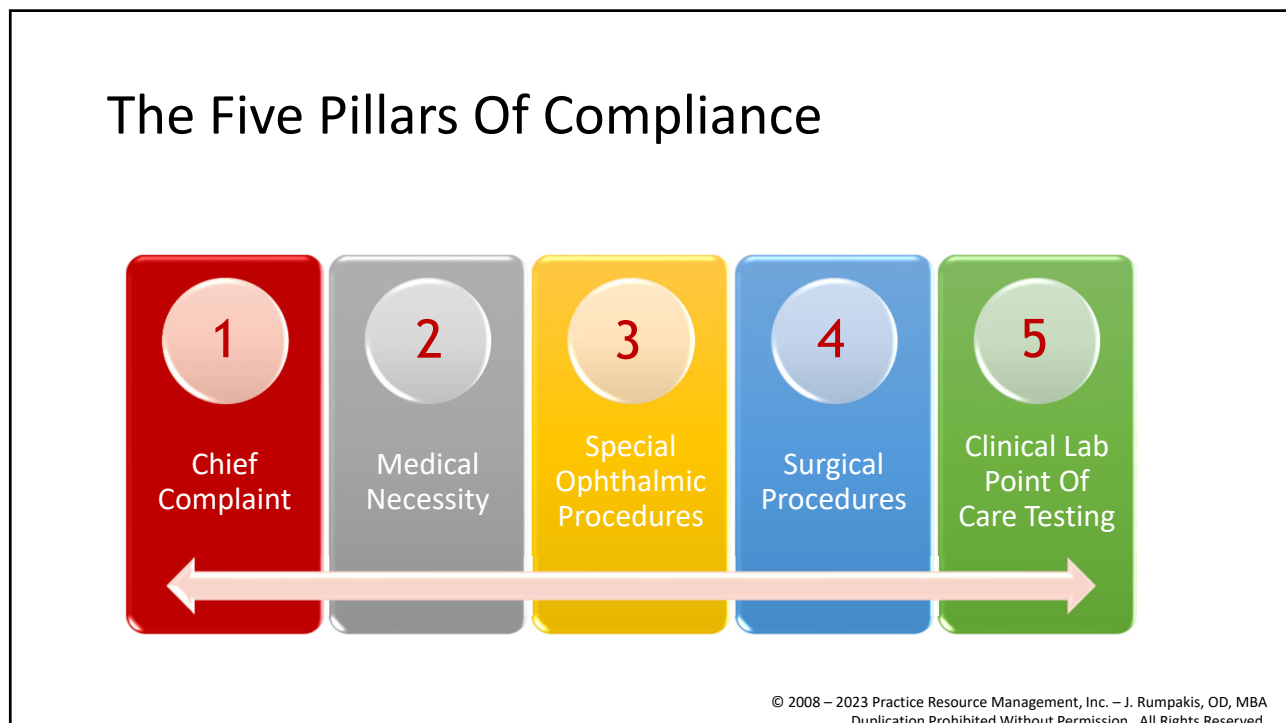
1. **Deletion Of CPT Code 99201**
2. **Eliminate History And Physical As Elements For Code Section**
3. **Allow Physicians To Choose Whether Their Documentation Is Based On Medical Decision Making (MDM) Or Total Time**
4. **Modifications To The Criteria For MDM**
5. **Creation Of A Shorter Prolonged Services Code – 99417 (15 Minute Increments)**

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Pillar #1

Chief Complaint

→

The Medicare Carriers Manual, Part 3 §2320 reads:

"The coverage of services rendered by a physician is dependent on the purpose of the examination rather than on the ultimate diagnosis of the patient's condition. When a beneficiary goes to a physician with a complaint or symptoms of an eye disease or injury, the physician's services (except for eye refractions) are covered regardless of the fact that only eyeglasses were prescribed. However, when a beneficiary goes to his/her physician for an eye examination with no specific complaint, the expenses for the examination are not covered even though as a result of such examination the doctor discovered a pathologic condition."

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Patients Are Not Expected To Be The Expert – WE ARE!

Why? - Think Of The Three E's
Education, Expertise, & Experience

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Why Is The Patient In Your Office?

There are only THREE ways that the patient ends up in your practice.

1. They initiate the appointment by phone call, email, online booking.
2. You initiate the appointment by telling them to return to the office for a specific reason.
3. Other Physician initiates the appointment by telling them to make an appointment for a specific reason.

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There Are TWO Ways A Chief Complaint Requirement Is Met

Why Are You
Bringing Them Back
To The Office?
(reason for return visit)

Patient Directed
Complaint

(why did the patient
request to see the doctor?)

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Pillar #1



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Pillar #1



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Plan Stated In Last Record...

Examples:

1. Patient to RTC 1 month or PRN for further evaluation of IOP, assessment of optic nerve, and efficacy of new meds.
2. Order fundus photography (OD, OS, OU) secondary to presence of A/V crossing anomalies noted today.
3. Order OCT of optic nerve OU secondary to change in vertical optic nerve rim tissue noted today.
4. Patient to RTC 1 year or PRN for further diagnostic evaluation of nuclear sclerotic cataracts OU, noted today.

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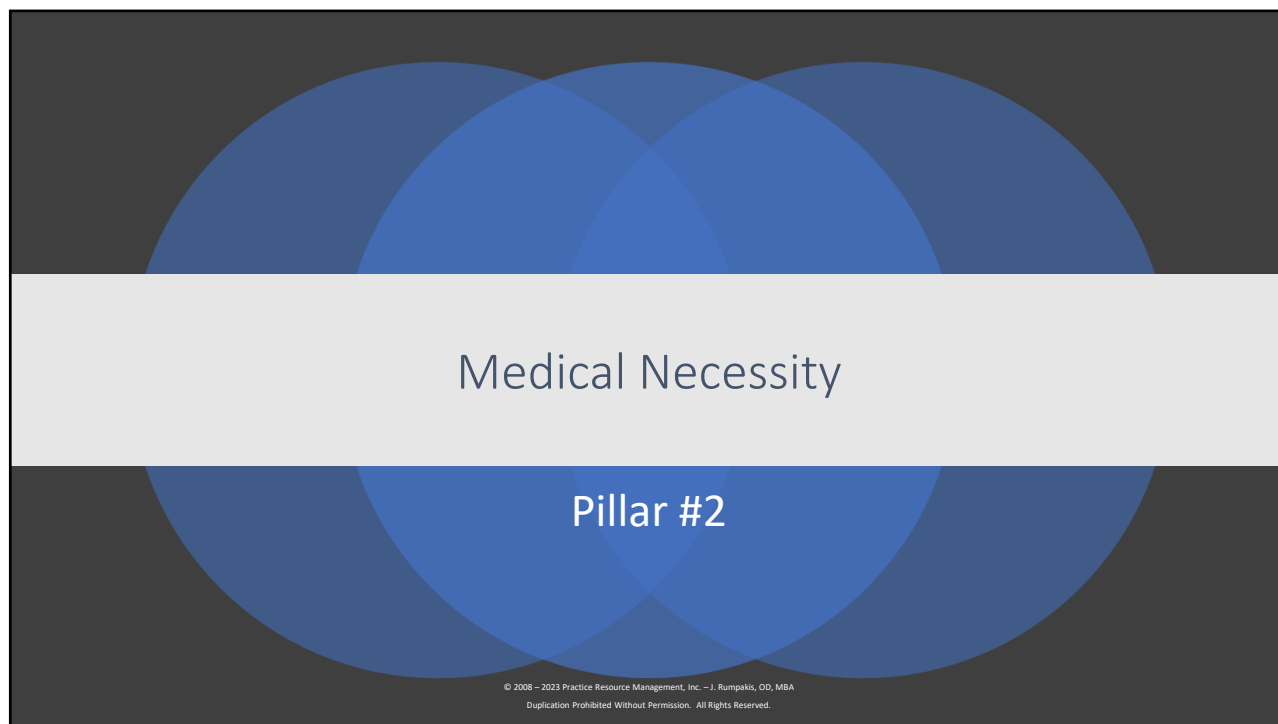
...Becomes The Chief Complaint For The Subsequent Visit or Encounter

Examples:

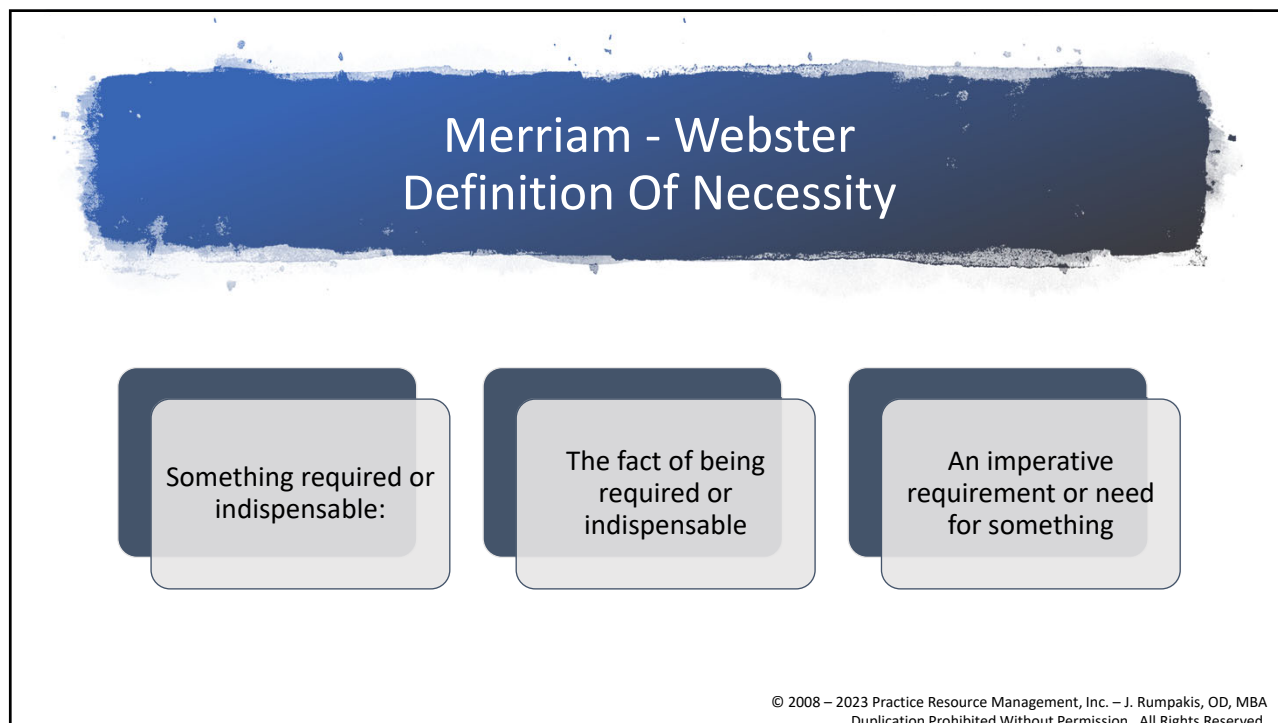
1. Patient returning per doctor directed orders for further evaluation of IOP, assessment of optic nerve, and efficacy of new meds.
2. Patient returning per doctor directed orders for fundus photography (OD, OS, OU) secondary to presence of A/V crossing anomalies noted today.
3. Patient returning per doctor directed order for OCT of optic nerve OU secondary to change in vertical optic nerve rim tissue noted today.
4. Patient returning per doctor directed orders for further diagnostic evaluation of nuclear sclerotic cataracts OU, noted today.

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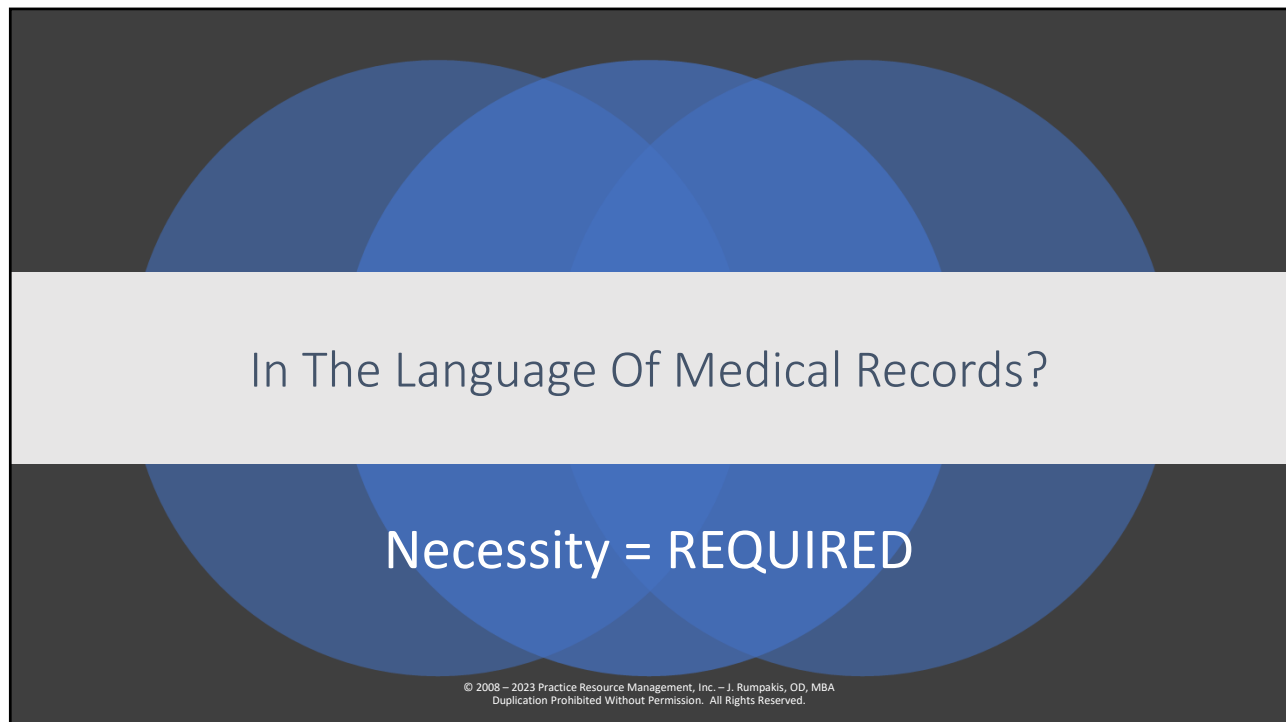
365



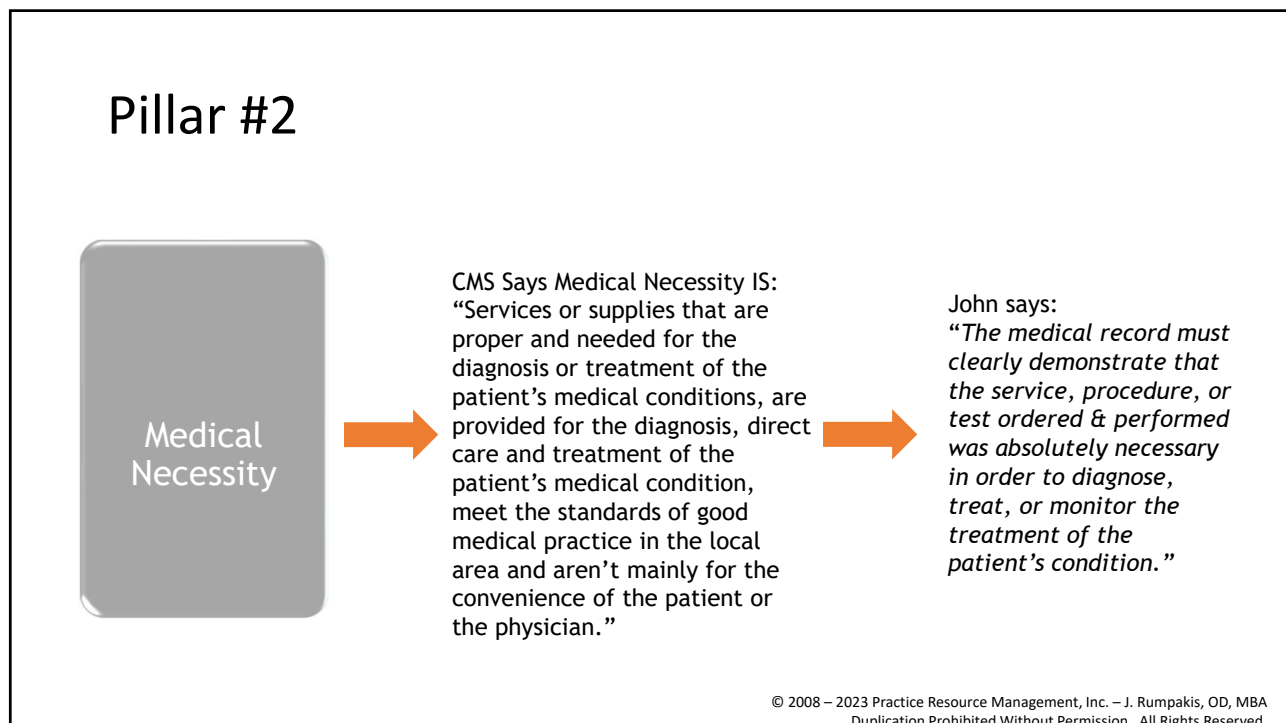
366



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Pillar #2



Medical Necessity of E&M Services

Section 1862(a)(1)(A) of the SSA, "Exclusions From Coverage and Medicare as Secondary Payer" does not include expenses acquired for items and services which are not deemed necessary for the diagnosis or treatment of illness or injury. This applies to all services.

CMS IOS Publication 100-04, Chapter 12, Section 30.6.1 states:

"Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported. The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record."

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Pillar #2 Medical Necessity – Take Home

What ever you are doing with a patient, ALWAYS tell the record WHAT you are going to do, WHEN you are going to do it, and WHY you are doing it.

ALWAYS INCLUDE THE WHAT, THE WHEN & THE WHY

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Medical Carriers & Medical Necessity

These Are Drivers For Ethical & Legal Requirements When Providing Clinical Care

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What Is A NCD? National Coverage Decision

- An NCD sets forth the extent to which Medicare will cover specific services, procedures, or technologies on a national basis. Medicare contractors are required to follow NCDs.
- If an NCD does not specifically exclude/limit an indication or circumstance, or if the item or service is not mentioned at all in an NCD or in a Medicare manual, it is up to the Medicare contractor to make the coverage decision (see LMRP).
- Prior to an NCD taking effect, CMS must first issue a Manual Transmittal, CMS ruling, or Federal Register Notice giving specific directions to our claims-processing contractors. That issuance, which includes an effective date and implementation date, is the NCD.

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What Is A LCD? Local Coverage Determination

- An LCD, as established by Section 522 of the Benefits Improvement and Protection Act, is a decision by a fiscal intermediary or carrier whether to cover a particular service on an intermediary-wide or carrier-wide basis in accordance with Section 1862(a)(1)(A) of the Social Security Act (i.e., a determination as to whether the service is reasonable and necessary).
- The difference between LMRP's and LCD's is that LCDs consist only of "reasonable and necessary" information, while LMRP's may also contain category or statutory provisions.

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What Happens If The Carrier Doesn't Have A Policy?

- But, sometime carriers will not have a specific policy regarding the indications of medical necessity, nor a list of covered diagnoses or utilization guidelines that you can refer to.
- When this is the case, then the prevailing CPT definition and guidelines in combination WITH YOUR MEDICAL EXPERTISE become the defensible rule.

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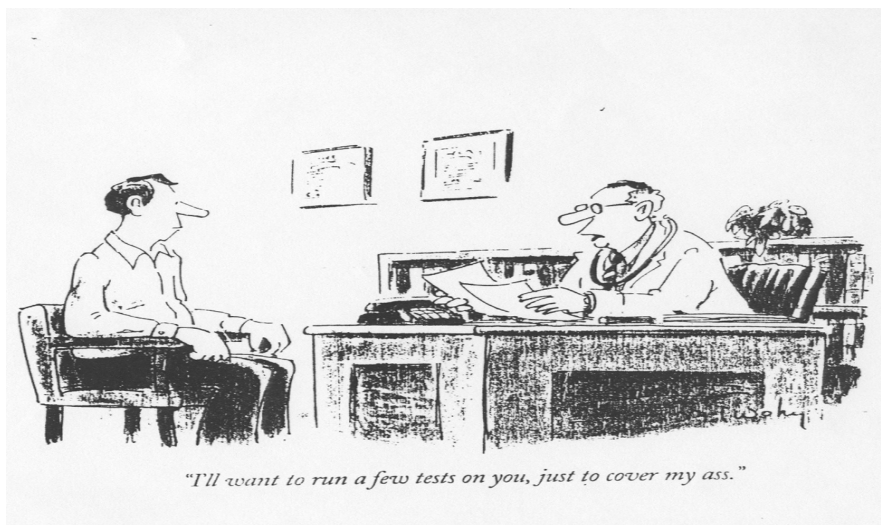
375

Or What Happens If The Patient Is Paying?

- If the patient is paying out of pocket and it is a separate distinct financial transaction where the carrier is NOT involved (i.e. balance billing), then you are free to do what you and the patient agree to.

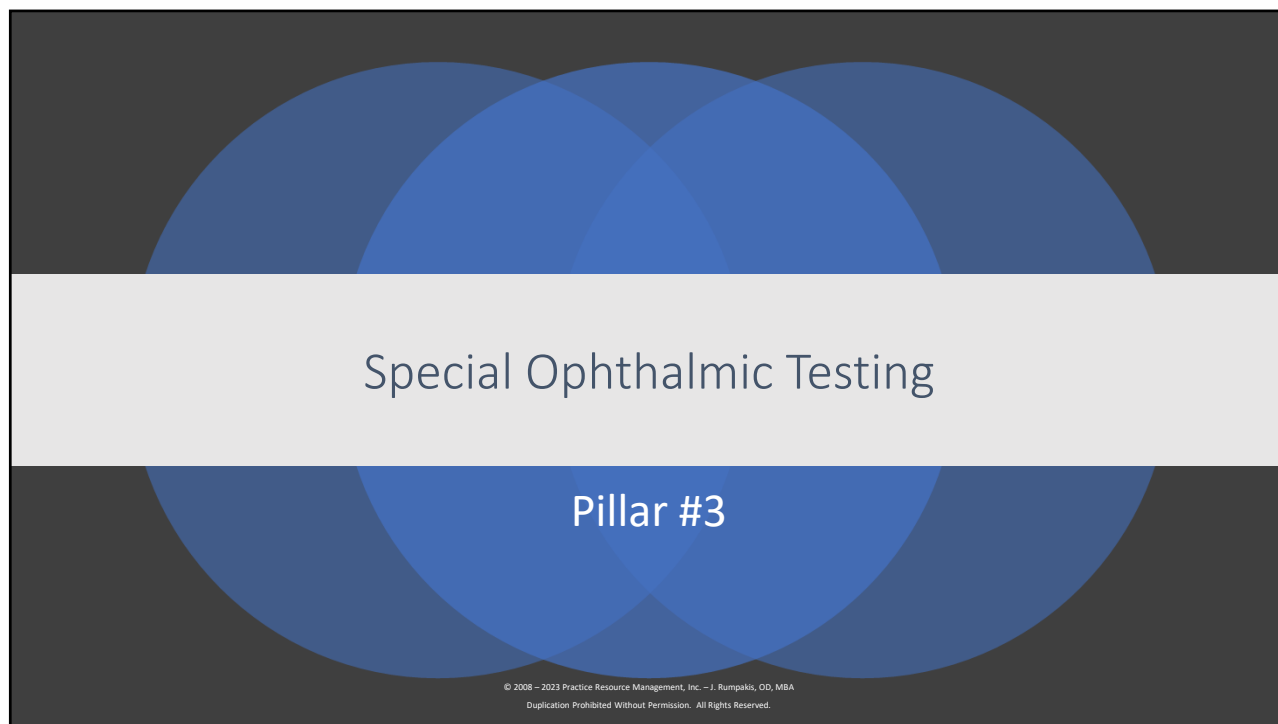
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The CMS 1500 Form

- Your LEGAL document submission
 - You are attesting under penalties of perjury that everything is true and accurate as stated earlier
- Standard format accepted by all carriers for submitting claims
- Understanding this form is essential to getting properly reimbursed and for following rules in claims submissions.
- [Let's Take A Look](#)

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CMS-1500 Form Detail

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)				15. OTHER DATE			
MM	DD	YY	QUAL.	QUAL.	MM	DD	YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a.			
				17b. NPI			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)							
A.		B.		C.		D.	
E.		F.		G.		H.	
I.		J.		K.		L.	

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CMS-1500 Form Instructions

Additional instructions for CMS-1500 claim form (02/12): Enter one of the following qualifiers as appropriate to identify the role that this physician or NPP is performing:

For Paper claims

Enter the qualifier to the left of the dotted vertical line on Item 17.

Qualifier	Provider Role
DN	Referring physician
DK	Ordering physician
DQ	Supervising physician

For electronic claims

Loop: 2420E - Segment: NM108

Qualifier	Provider Role
DN	Referring physician
DK	Ordering physician
DQ	Supervising physician

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CMS-1500 Form Detail

The image shows a portion of the CMS-1500 form. Three red circles with numbers are overlaid on the form:

- Circle 1:** Surrounds the field '17. NAME OF REFERRING PROVIDER OR OTHER SOURCE'.
- Circle 2:** Surrounds the 'NPI' field under '17b'.
- Circle 3:** Surrounds the field '21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY'.

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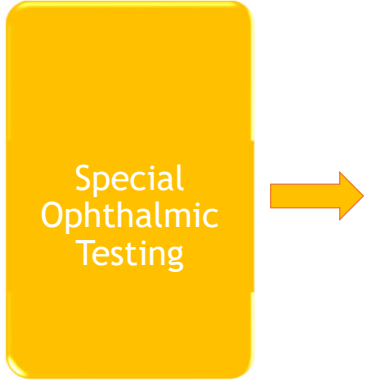
How You Handle These Situations Is Critical!

- When can I do a special ophthalmic test?
 - You can perform a special ophthalmic test on the same day as any office visit.
 - They are a distinct and separate procedure and are not bundled into any examination services
- Can I do the tests when the doctor is not in the office?
 - Yes – but you do have to pay attention to Supervision Status
- Can I bill the test on the same day?
 - May have to use a modifier for some carriers
- Do I have to collect two co-pays?
- Can I order tests way ahead of time?

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Pillar #3



Special Ophthalmic Testing

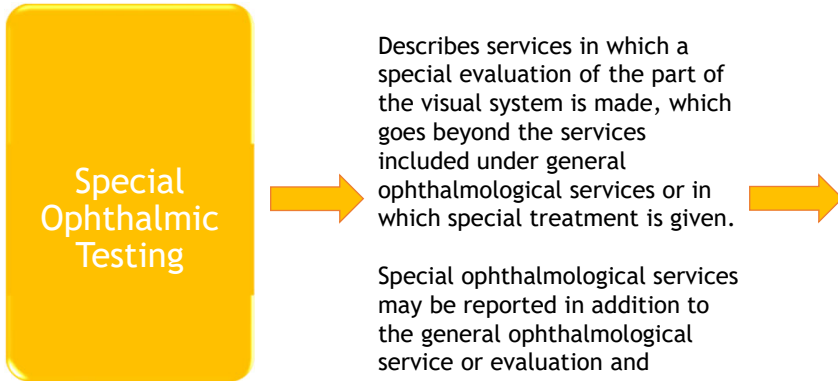
Describes services in which a special evaluation of the part of the visual system is made, which goes beyond the services included under general ophthalmological services or in which special treatment is given.

Special ophthalmological services may be reported in addition to the general ophthalmological service or evaluation and management services.

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Pillar #3



Special Ophthalmic Testing

Describes services in which a special evaluation of the part of the visual system is made, which goes beyond the services included under general ophthalmological services or in which special treatment is given.

Special ophthalmological services may be reported in addition to the general ophthalmological service or evaluation and management services.

John says:
That means you can do whatever you want to do whenever you want to do it, IF:

- *You have medical necessity noted for the specific test*
- *You have communicated with the patient regarding coverage*
- *You have obtained an ABN, if required*

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How A Code Is Broken Down

- Example
- 92134 – Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral, retina.
- What Coding with modifiers means
 - 92134-TC, means you only performed the technical component
 - 92134-26, means you only performed the professional component

CPT: Professional Edition, 2021. Pg. 715

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How A Code Is Broken Down

Definitions – Modifiers -26 & -TC

- -26 Professional Component, Certain procedures are a combination of the a physician professional component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier -26

-
- -TC Technical Component, The technical component is the equipment and technician performing the test. This is identified by adding modifier “TC” to the procedure code identified for the technical component charge.

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Performing Additional Tests

Routine Procedures VS. Ordered Procedures

- The chronology of your medical record is imperative
- Routine testing = standing orders
 - Never billable
- Ordered testing
 - Based upon medical necessity
 - Bill with office visit
 - Use modifier when appropriate
 - Be aware of specific code requirements & definitions
 - Generally require an Interpretive Report

What Are The Ethical
& Legal Considerations
In Coding Something
That Is Different Than
Its Defined Value?

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Example – Fundus Photography (92250)

- Active Code
- Bilateral By Definition
- Global Period Definition (XXX)
- Traditional Bilateral Use – 92250
- Unilateral Use – 92250 – 52 - (RT or LT)

Base Reduced Laterality
Code Services Indicator

Be sure to make the
laterality of the
procedure matches
the laterality of the
ICD-10 diagnosis
code you are using.

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You Be The Auditor

1. Order fundus photo secondary to change in appearance of optic nerve
Acceptable or Not Acceptable?
2. Order fundus photograph OU, secondary to appearance of background diabetic retinopathy OU noted today
Acceptable or Not Acceptable?
3. Order fundus photograph due to diabetes
Acceptable or Not Acceptable?

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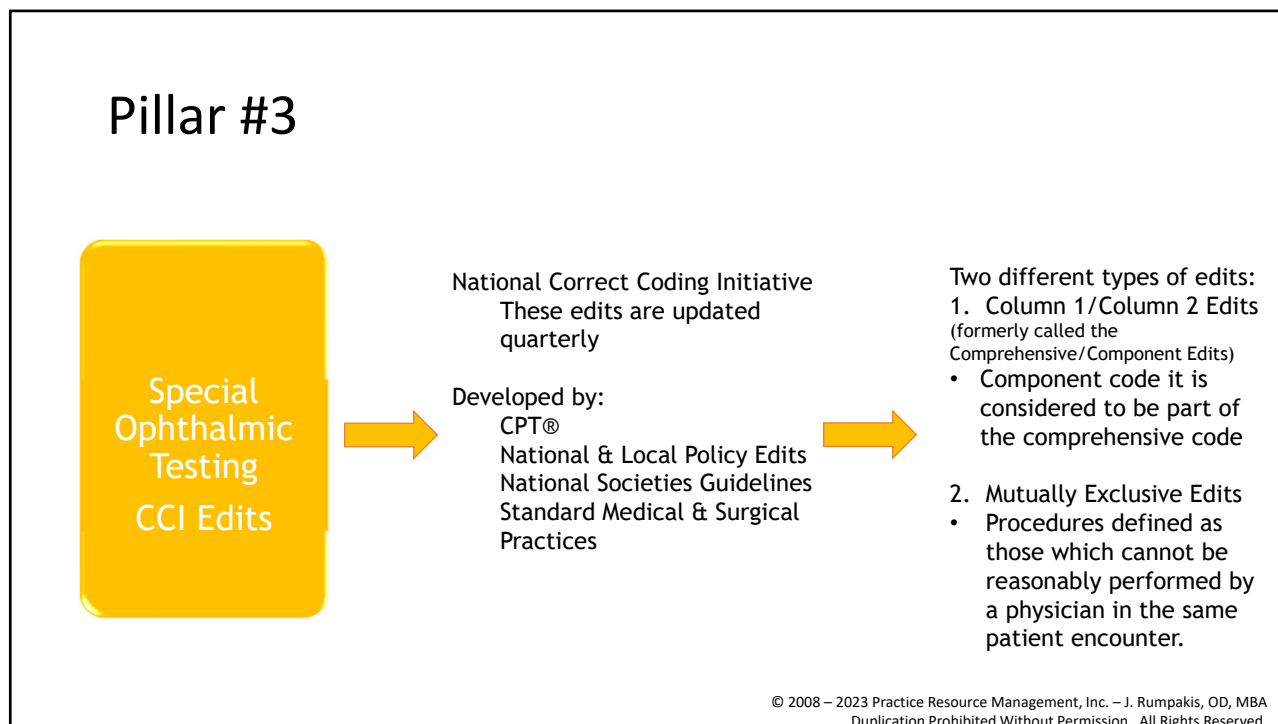
390

Learn To Write The Order Correctly

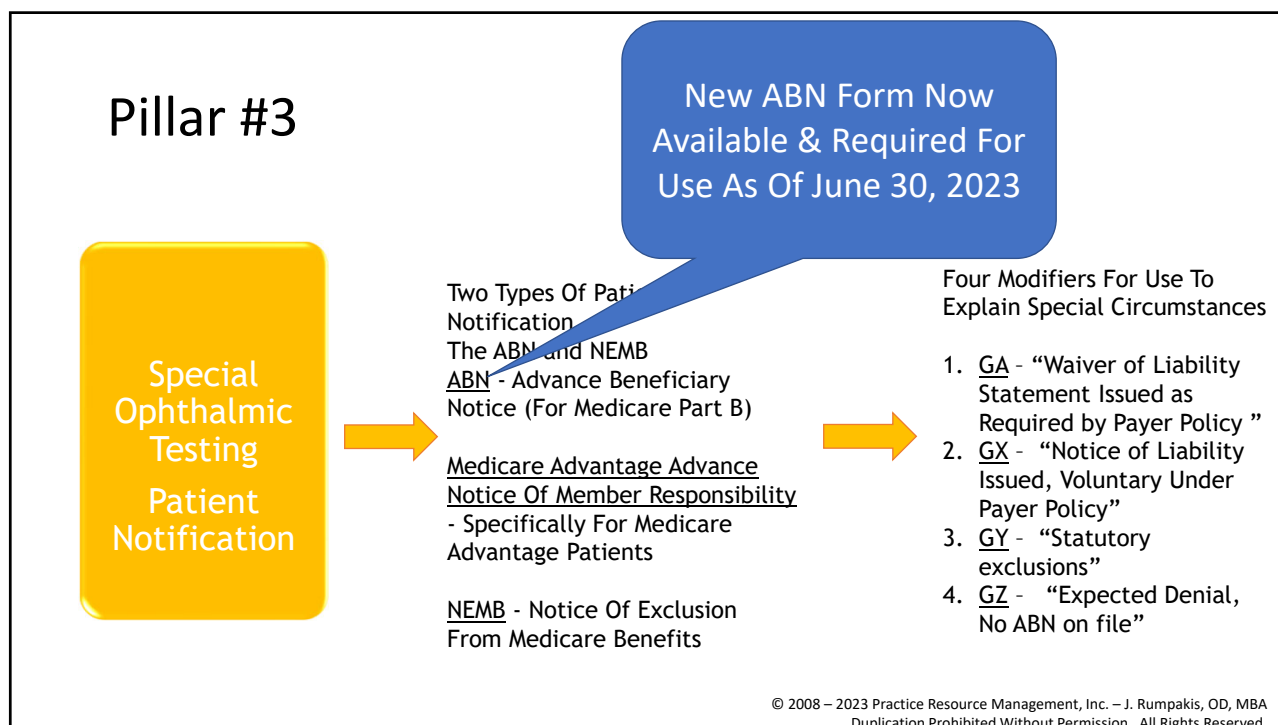
1. Order fundus photo secondary to change in appearance of optic nerve
2. Order fundus photograph OU, secondary to appearance of background diabetic retinopathy OU noted today
3. Order fundus photograph due to diabetes

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Protect Yourself Through Great Charting

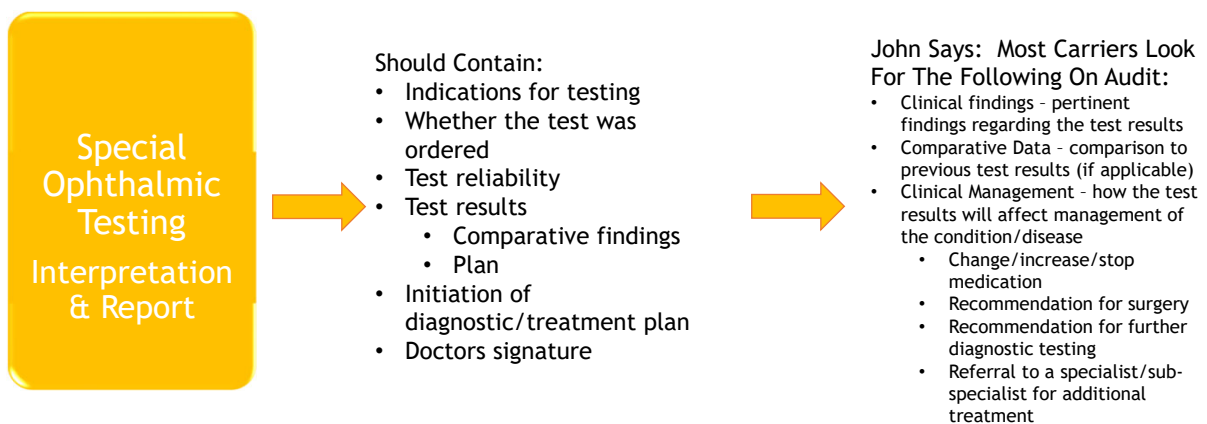
- Interpretation and report by the physician is an integral part of the special ophthalmological services where indicated.
- Technical procedures (which may or may not be performed personally) are often part of the service, but should not be mistaken to constitute the service itself.

CPT: Professional Edition, 2021. Pg. 714

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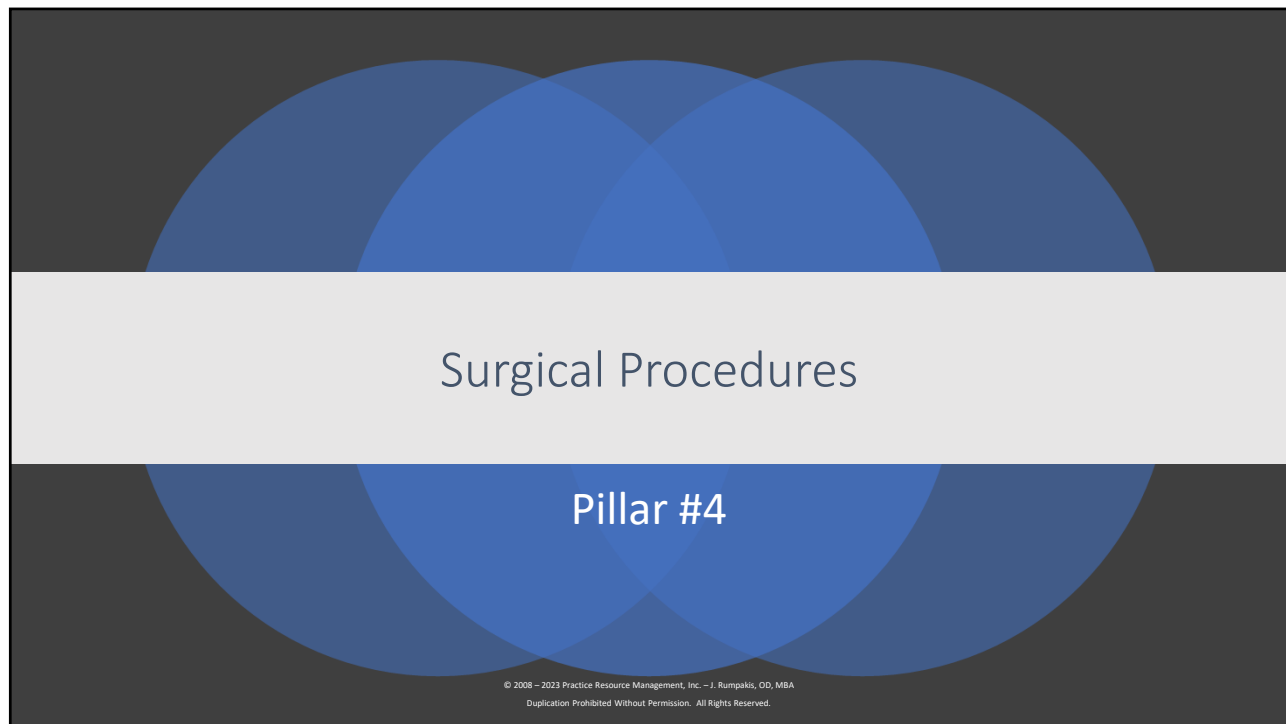
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Pillar #3

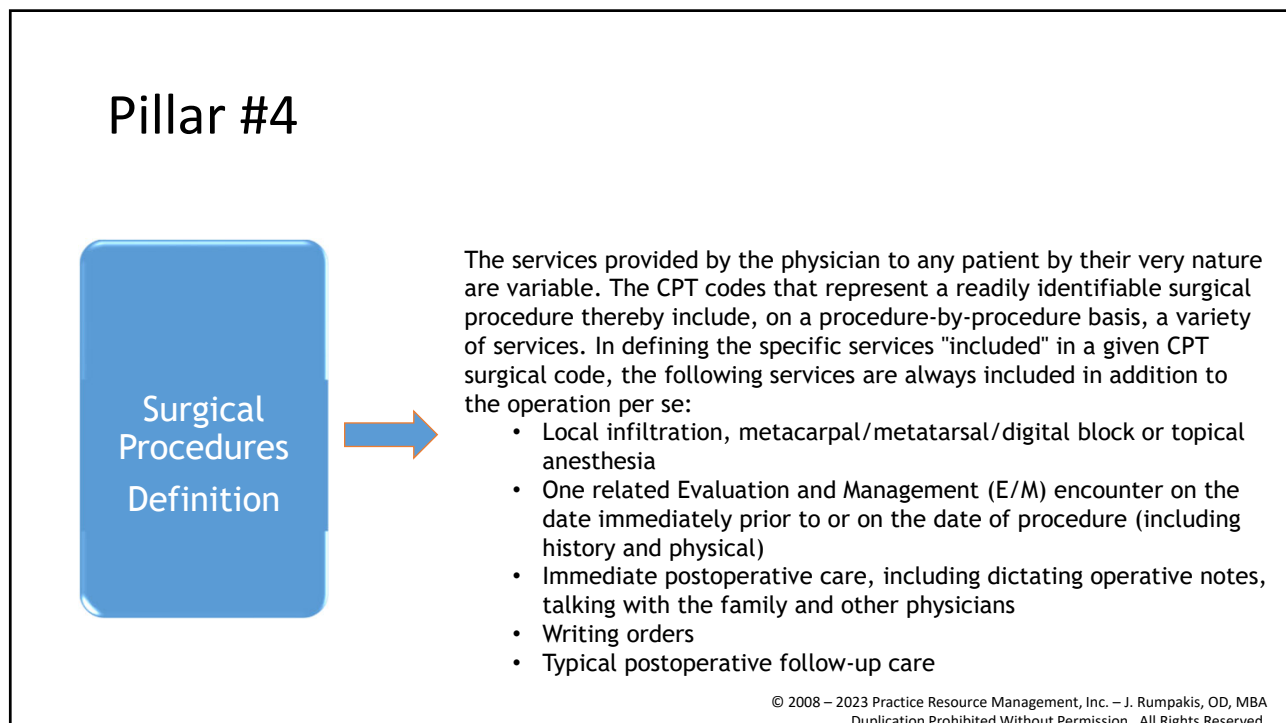


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Pillar #4



Key Statement: One related Evaluation and Management (E/M) encounter on the date immediately prior to or on the date of procedure (including history and physical)

- In general E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure.
- **The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service.**
- The E&M service and minor surgical procedure do not require different diagnoses.
- If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is “new” to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure.

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Global Periods

- A Global Period is that period of time for which the follow-up care related to the surgical procedure, for that specific interval, is compensated for in the “Global” payment for the surgical procedure

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Major vs. Minor Surgery

- Minor Surgery
 - Any surgical procedure performed on someone else
- Major Surgery
 - Any surgical procedure performed on you

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Major vs. Minor Surgery

- Minor Surgery
 - Any surgical procedure that has a global period of **LESS THAN 90 days**
- Major Surgery
 - Any surgical procedure that has a global period of **EQUAL TO or GREATER THAN 90 days**

I Thought These Were Going Away?

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Pillar #4



- 24 Unrelated E/M Service, Same Physician, During Post-Operative Global Period
- 25 Separate Service, Same Physician, Same Day
- 50 Bilateral Procedure
- 51 Multiple Procedures
- 54 Surgical Care Only
- 55 Post-Operative Care Only
- 57 Decision To Perform Major Surgery
- 58 Staged or Related Procedure or Service by the Same Physician
- 67 Repeat Procedure or Service, Same Physician
- 79 Unrelated Procedure, Same Physician, During Post-Operative Global Period
- RT/LT Right, Left
- E1 – E4 Punctal/Lid Identifiers

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Modifier -25

- Significant, Separately Identifiable E/M service
- “The patient’s medical record documentation is expected to clearly evidence that the evaluation and management service performed and billed was **“above and beyond”** the usual pre-operative and post-operative care associated with the procedure performed on that same day.”



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Modifier -25

So What's Right?

- Be sure the record is clear regarding the patient complaint, circumstance, finding, result of diagnostic testing, complication, etc... that supports the need for a SECOND evaluation and management service.

- Reference: [CMS Rule](#)

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Pillar #4



When using modifiers it is critical to understand:

1. The definition of the modifier
2. Making sure that the clinical procedures being performed don't violate a CCI edit and allow a modifier
3. Making sure that the clinical procedures involved meet medical necessity rules
4. Making sure you are not violating modifier rules just to embellish the medical record

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The Operative Report

- Just as we do an Interpretation & Report after a special ophthalmic procedure, an **Operative report** is a **report** written in a patient's medical record to document the details of a surgery after the surgery has been completed.

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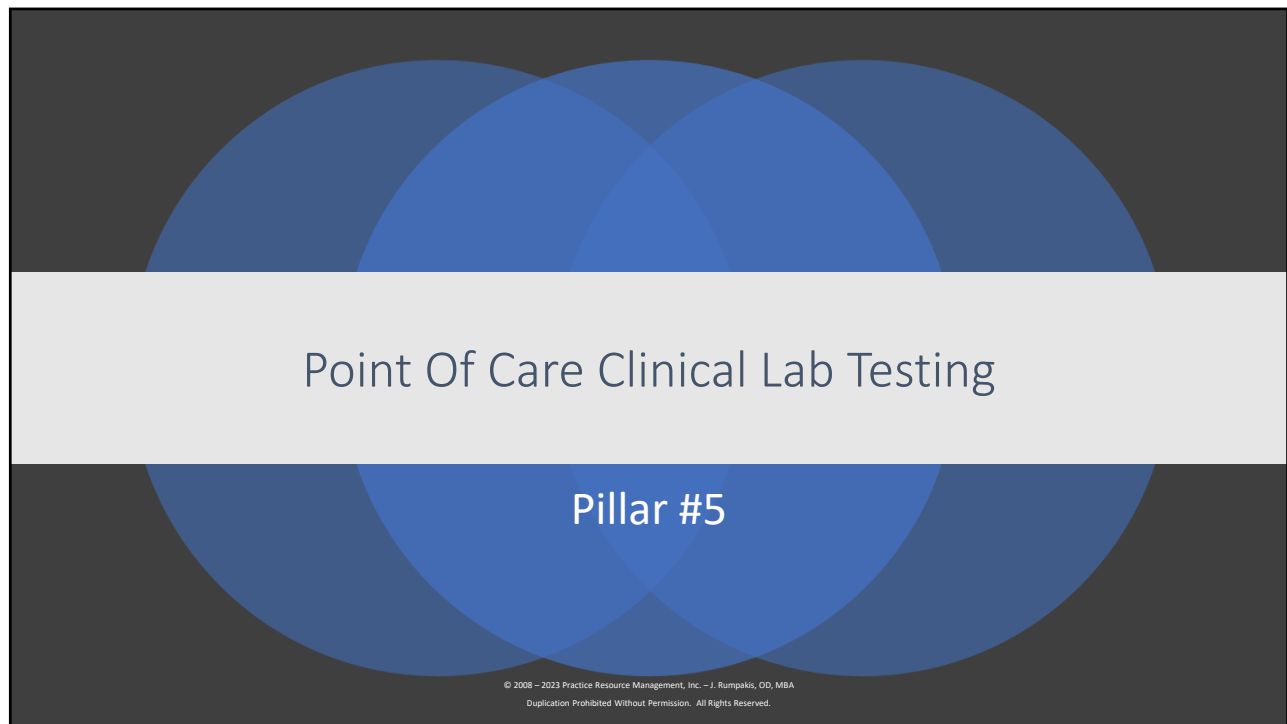
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Typical Components Of An Operative Report

- Patient's name
- Date
- Preoperative Diagnosis
- Postoperative Diagnosis
- Surgeon's Name
- Assistant Surgeon/Co-Surgeon (N/A to us)
- Procedure
- Indications for Surgery
- Findings at Surgery
- Details

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OK, So What Is CLIA?

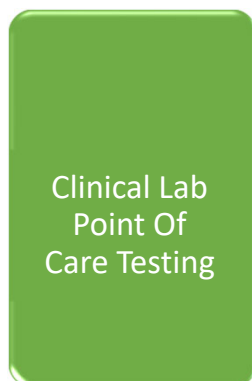
- Definition:
 - Clinical
 - Lab
 - Improvement
 - Amendment(s)
- Congress passed the Clinical Laboratory Improvement Amendments (CLIA) in 1988 establishing quality standards for all laboratory testing to ensure the accuracy, reliability and timeliness of patient test results regardless of where the test was performed.

[So, where can you get additional information on Federal CLIA Registration?](#)

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Pillar #5



- Overview

- Found on the Laboratory Fee Schedule (Not the Physician Fee Schedule)
- Requires doctor office to be a certified laboratory (CLIA Regulations)
- For Medicare - no patient co-pay nor co-insurance

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Pillar #5



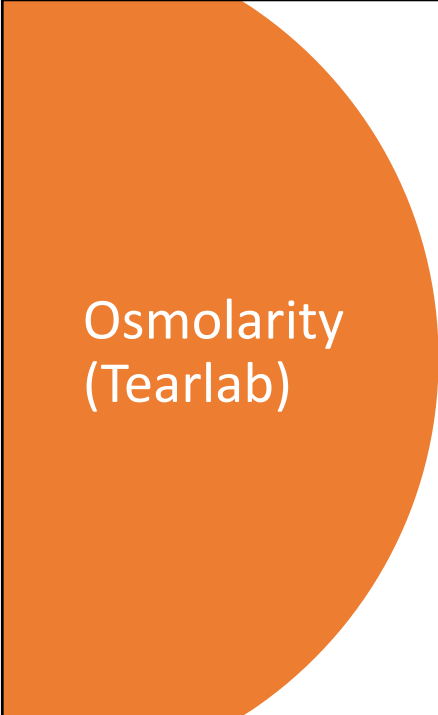
The ABN's For Lab Tests

Advance Beneficiary Notice
(For Medicare Part B):
ABN - Specifically For Lab Tests
ABN For Commercial Carriers

Four Modifiers For Use To
Explain Special Circumstances

1. GA - "Waiver of Liability Statement Issued as Required by Payer Policy"
2. GX - "Notice of Liability Issued, Voluntary Under Payer Policy"
3. GY - "Statutory exclusions"
4. GZ - "Expected Denial, No ABN on file"

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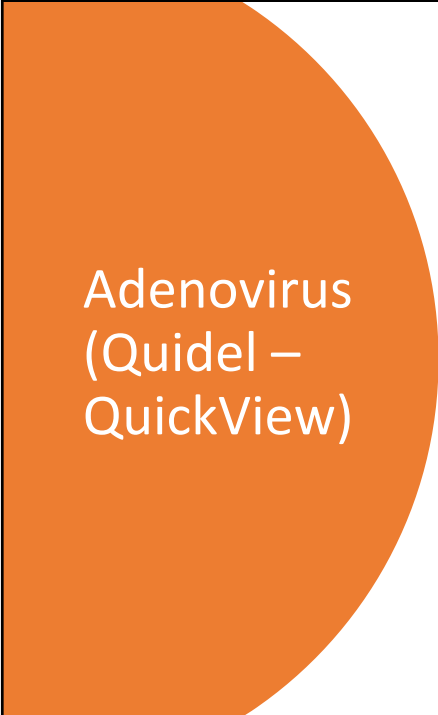


Osmolarity (Tearlab)

- CPT Code
 - 83861 Description: Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolarity
- Test both eyes; Code both eyes
 - 83861-QW-RT
 - 83861-QW-LT
 - (Do NOT use modifier -59)
 - Adhere to the policy as recommended by your carrier or billing specialist.
- 2020 Reimbursement
 - \$22.48 per test

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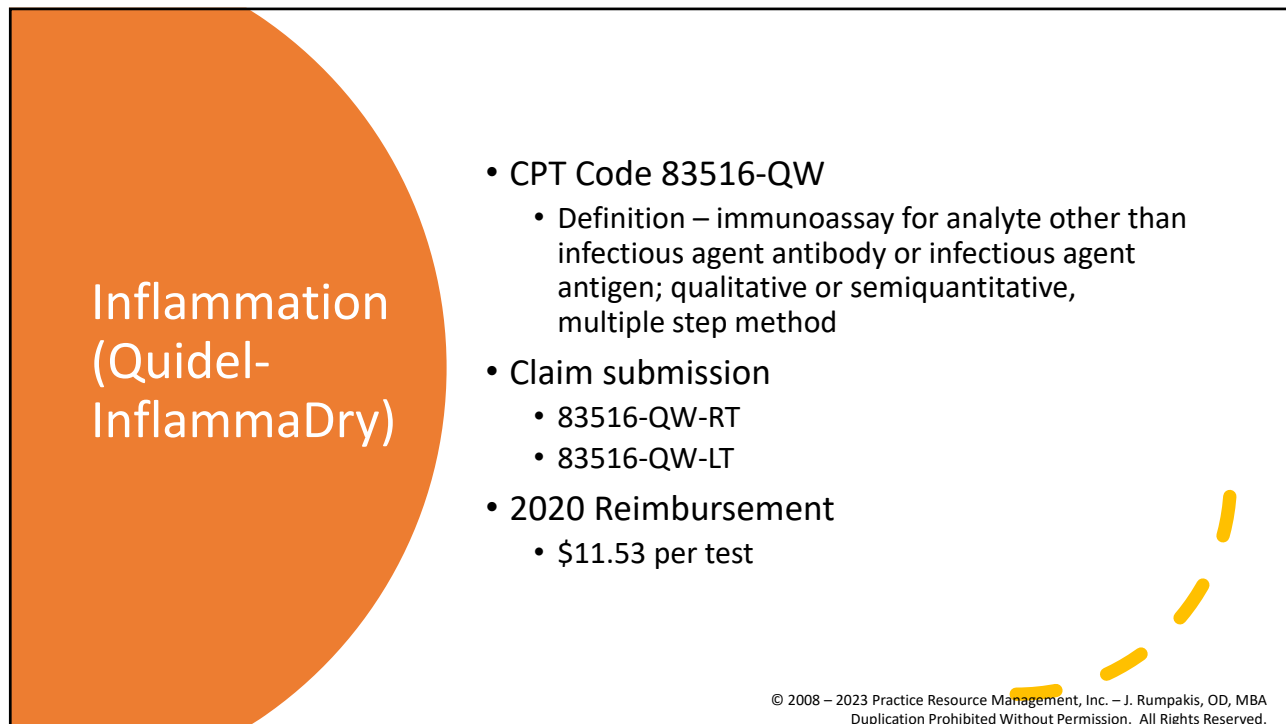


Adenovirus (Quidel – QuickView)

- CPT Code 87809-QW
 - Definition – Infectious agent antigen detection by immunoassay with direct optical observation; adenovirus
- Claim submission
 - 87809-QW-RT
 - 87809-QW-LT
- 2019 Reimbursement
 - \$21.76 per test

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Inflammation
(Quidel-InflammaDry)

- CPT Code 83516-QW
 - Definition – immunoassay for analyte other than infectious agent antibody or infectious agent antigen; qualitative or semiquantitative, multiple step method
- Claim submission
 - 83516-QW-RT
 - 83516-QW-LT
- 2020 Reimbursement
 - \$11.53 per test

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The Five (Necessary) Steps To Success

- 1 Note Sign or Symptom
- 2 Specifically Identify Test
- 3 Record Results & Indicate Normal vs Abnormal
- 4 Determine Proper Management Plan
- 5 Documentation & Physician Signature

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Ethical & Legal Patient Care Requires Compliance That Revolves Around The Five Pillars



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A graphic with a dark gray background featuring large, overlapping semi-circles in orange, yellow, and blue. The blue semi-circle on the right contains the title and a bulleted list.

Following The Rules Isn't Optional

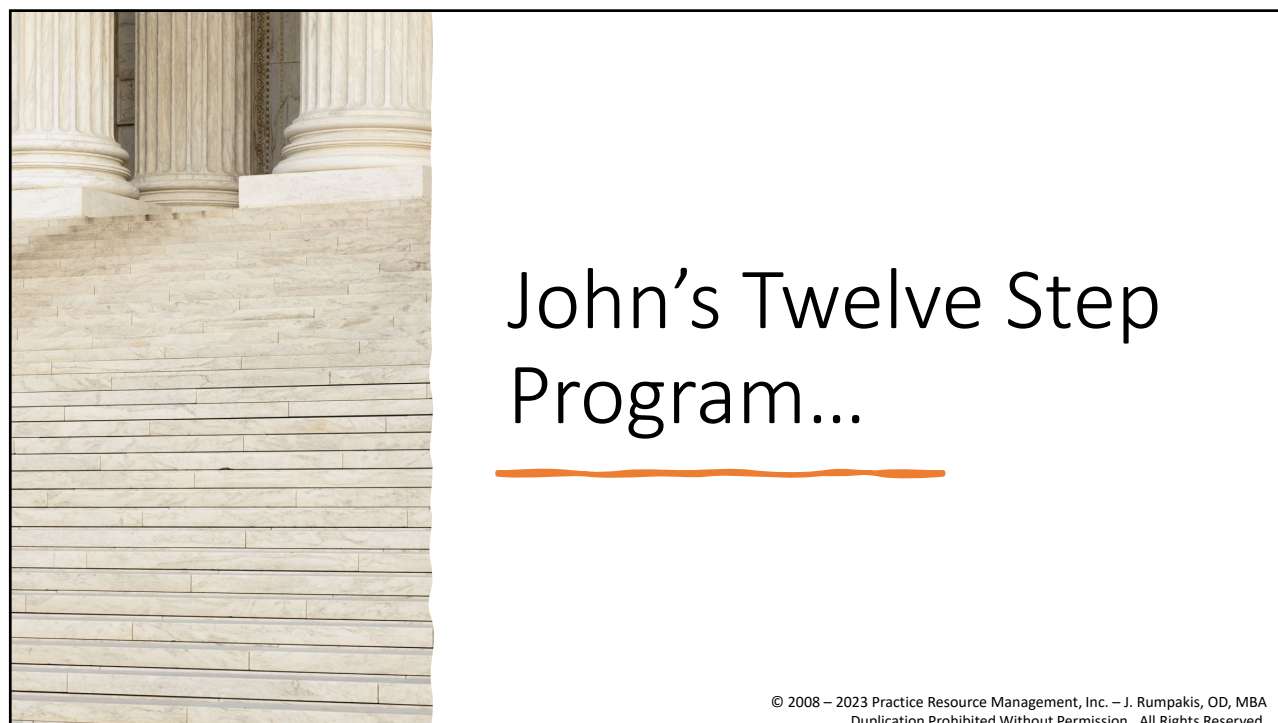
- What you do, how you do it, and how you document it is all about Ethics
- What you do, how you do it, and how you document it is all about Jurisprudence
- HIPAA Is The Law That **REQUIRES** you to follow the CPT & ICD Rules

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John's 12-Step Program



Identify carriers with whom you want to be on their plan – it's a business decision!



Establish "Needs Assessment" for your situation

Obtain resource material that you need



Create disease protocols for your office

Review the findings regarding the health and vision of each patient
Correspond with the patients PCP regarding your care and the patient's condition
Develop system for appointing the patients next visit before they leave the office
Put the process in flow chart format

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John's 12-Step Program



Everyone in the office must be educated about the protocol and the process

All staff must be onboard with providing the highest level of care

- Diagnosis
- Treatment
- Selection of Medication



Market your ability to provide primary care to your patient base

Set Goals, Objectives, Strategies, and Tactics for what you want to achieve

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John's 12-Step Program



Always perform the standard of care as your baseline



Document the medical record with your thoughts and impressions



Be vigilant about proper coding

Perform internal audits on a regular basis
Use a grading sheet on a regular basis
Keep up with change in coding protocols
Develop office strategy for change mgmt

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John's 12-Step Program



Develop office strategy for change
management

Rules & requirements change frequently



Be audit proof – a perfect medical record that accurately reflects the care provided
and outcomes attained is priceless



Never be complacent!

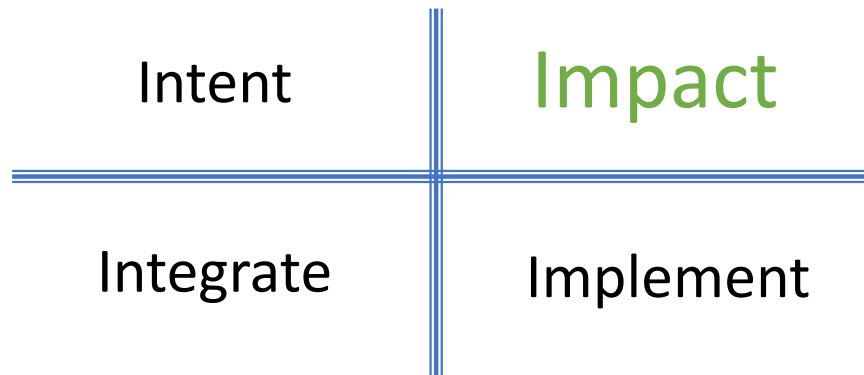


Keep up on your continuing education and remember that your medical record and
subsequent coding of your services is a legal requirement – it's not an option!

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The Power Of I to the 4th Power



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The Independent Practice In The Era Of Health Care Reform

The World Has Changed.
Are You Keeping Up With It?

John Rumpakis, OD, MBA

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