# The Independent Practice In The Era Of Health Care Reform

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

John Rumpakis, OD, MBA



1

John Rumpakis, OD, MBA

PRMI

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.



2


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# Financial Disclosures – John Rumpakis, OD, MBA

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

- Alcon Laboratories
- Carl Zeiss Meditec
- Optos
- Vistakon
- CooperVision
- Maculogix
- EMRLogic
- TearLab
- Freedom-Meditech
- SightScience
- OysterPoint Pharma
- Osmotica
- Heru
- Allergan
- Beaver-Visitec
- OfficeMate
- Maximeyes
- Luxottica
- MacuRisk
- Davis Vision
- Paragon
- Synergeyes
- Quidel
- Medical Optometry America
- RevolutionEHR
- VisionWeb
- Opticare - Envolve
- United Health Care
- Vision Source
- Bio-Tissue
- ECRVault
- OptoVue
- Harbinger Health LLC
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- Modernizing Medicine
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- Kowa Optimed
- HeartSmart
- Diopsys
- Nicox
- TearScience
- Uprise
- IDOC
- Acuity Eyecare Group
- Notal Vision
- Eye-Tel Imaging
- Bausch & Lomb
- Essilor of America
- Wal-Mart
- Macuscope
- Topcon
- CyclopsEMR
- GuidePoint
- Lineage Capital



3

# Financial Disclosures – John Rumpakis, OD, MBA

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

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Founder – Opt-IN®, Optometric Marketing & Promotions
WhatsMyPracticeWorth.com® - Online Practice Appraisals



4


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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.



5

## Questions About This Lecture?

John@PRMI.com



6

# And Now…
# Today's Feature Presentation

10

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.

11


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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

12

## Who Are The Care Providers?

- Ophthalmologist
- Optometrist
- Physician's Assistant
- Optician
- IBM Watson
- Google DeepMind



13

# 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

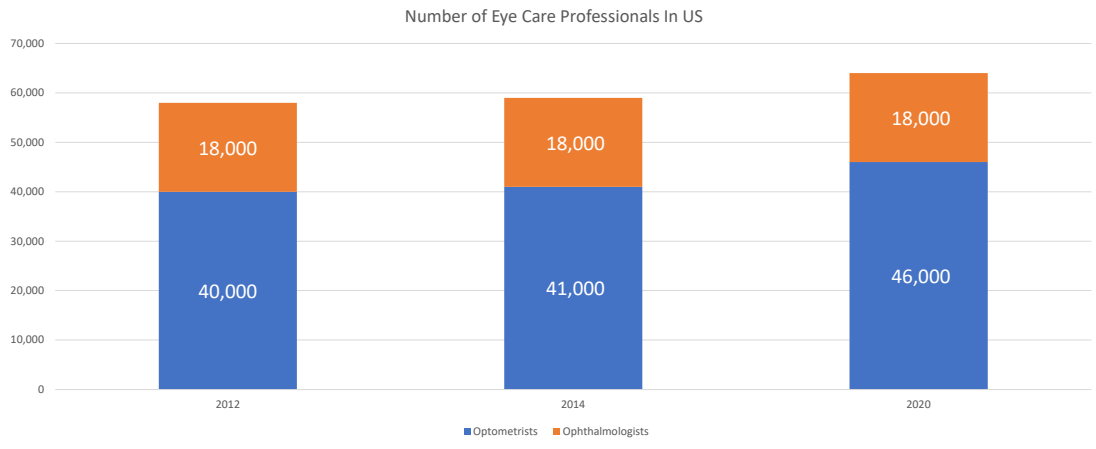
American Optometric Association. State of the Optometric Profession: 2013. June 2013.
Available at: www.aoa.org/Documents/news/state_of_optometry.pdf

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



14

# Let's See Some Data

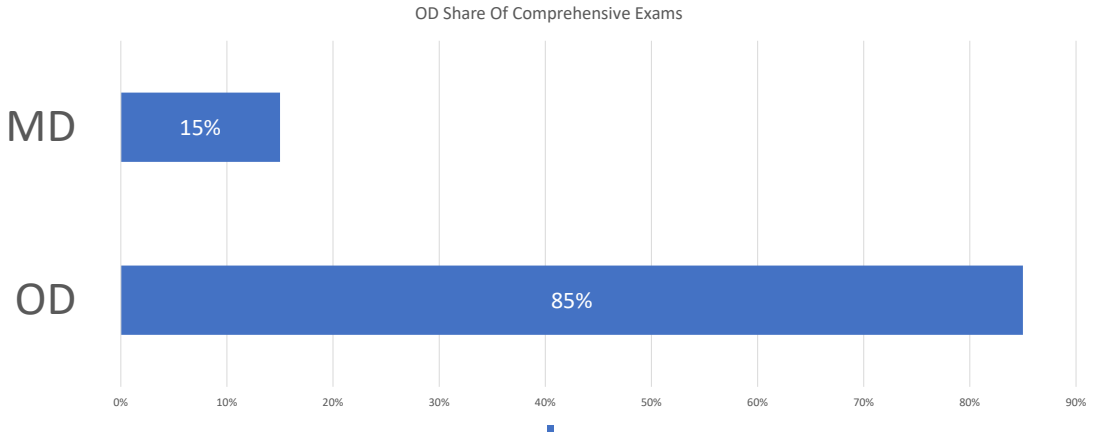



American Optometric Association. State of the Optometric Profession: 2013. June 2013.
Available at: www.aoa.org/Documents/news/state_of_optometry.pdf



15

# OD vs MD Share Of Comprehensive Eye Exams




American Optometric Association. State of the Optometric Profession: 2013. June 2013.
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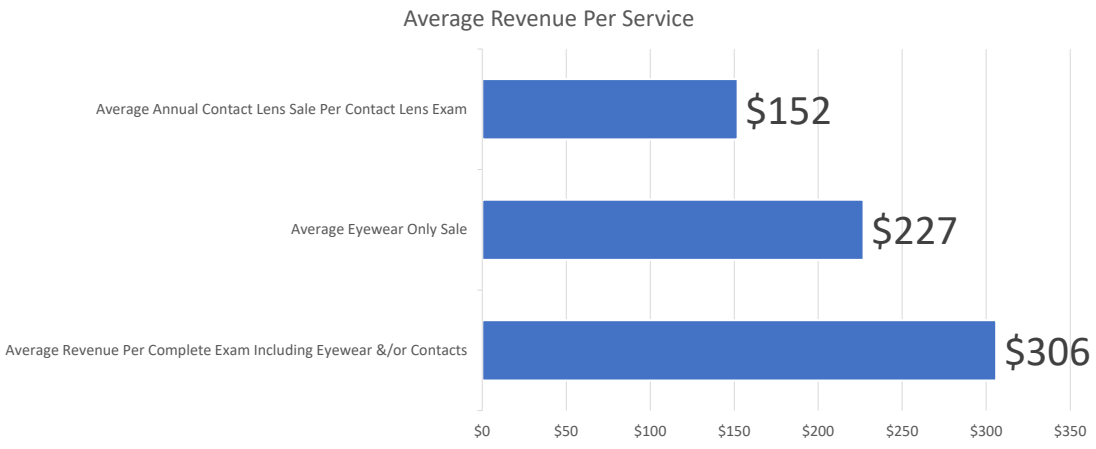
16

# Average Revenue Per Service




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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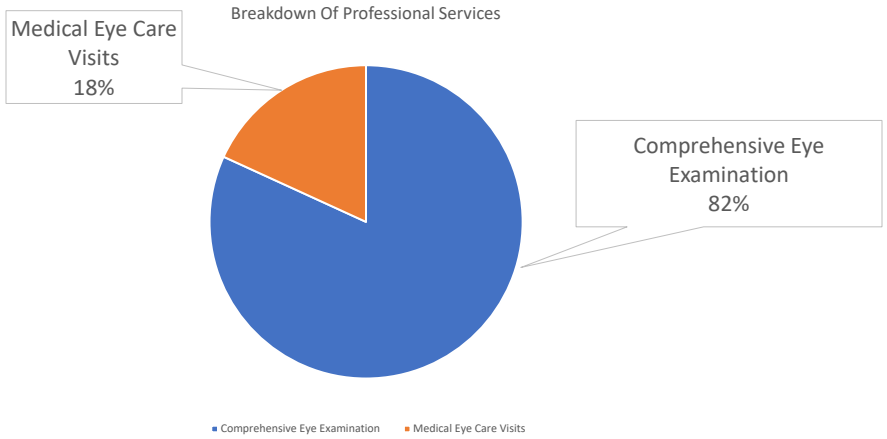
# Percentage Of Medical Eye Care Visits




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



18

# Some Numbers To Consider

Revenue, Earnings, Debt, Challenges & Opportunities



19

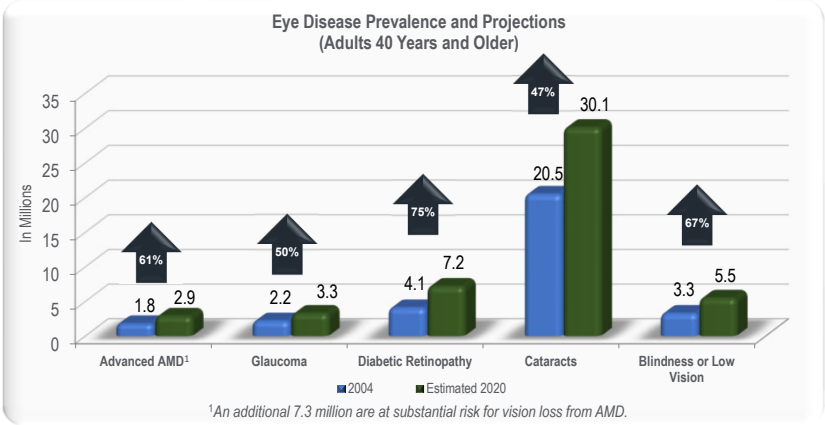
# Trends Affecting Practices

- 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



22

# Incidence Rates in Americans - Age 40+

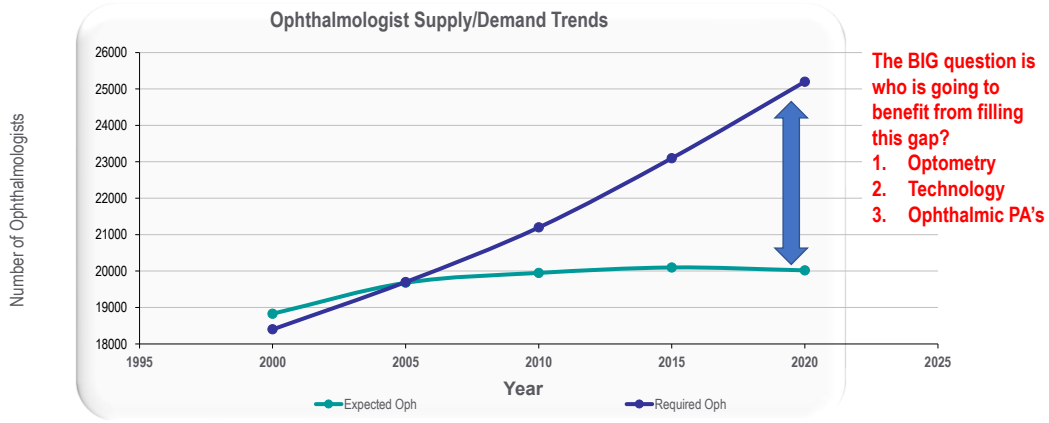



Source:National Eye Institute, 2004 Study. The study examined primarily advanced AMD, glaucoma, diabetic retinopathy, and cataracts, noting these as the four most common eye diseases in Americans age 40 years and older.



27

# Eye Care Provider Trends




**The BIG question is who is going to benefit from filling this gap?**

1. **Optometry**
2. **Technology**
3. **Ophthalmic PA's**

Source: DHHS Physician Supply and Demand Projections to 2020.



28

# Today Our Thoughts & Actions Are Driven By:

Fear
Safety
Finance
Fear



30

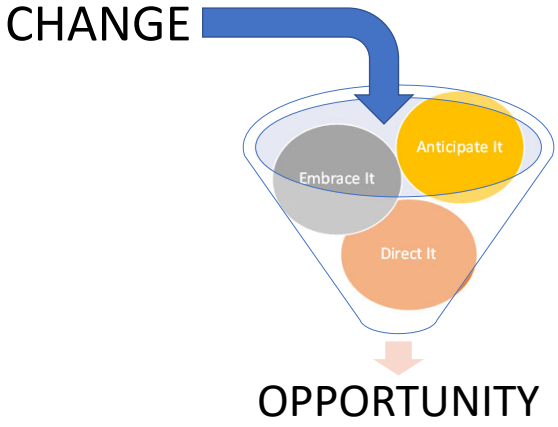
# Having The Right Frame Of Mind Is Critical

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



32

# We Have To CHANGE The Change Cycle!






33

## 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



35

## 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



36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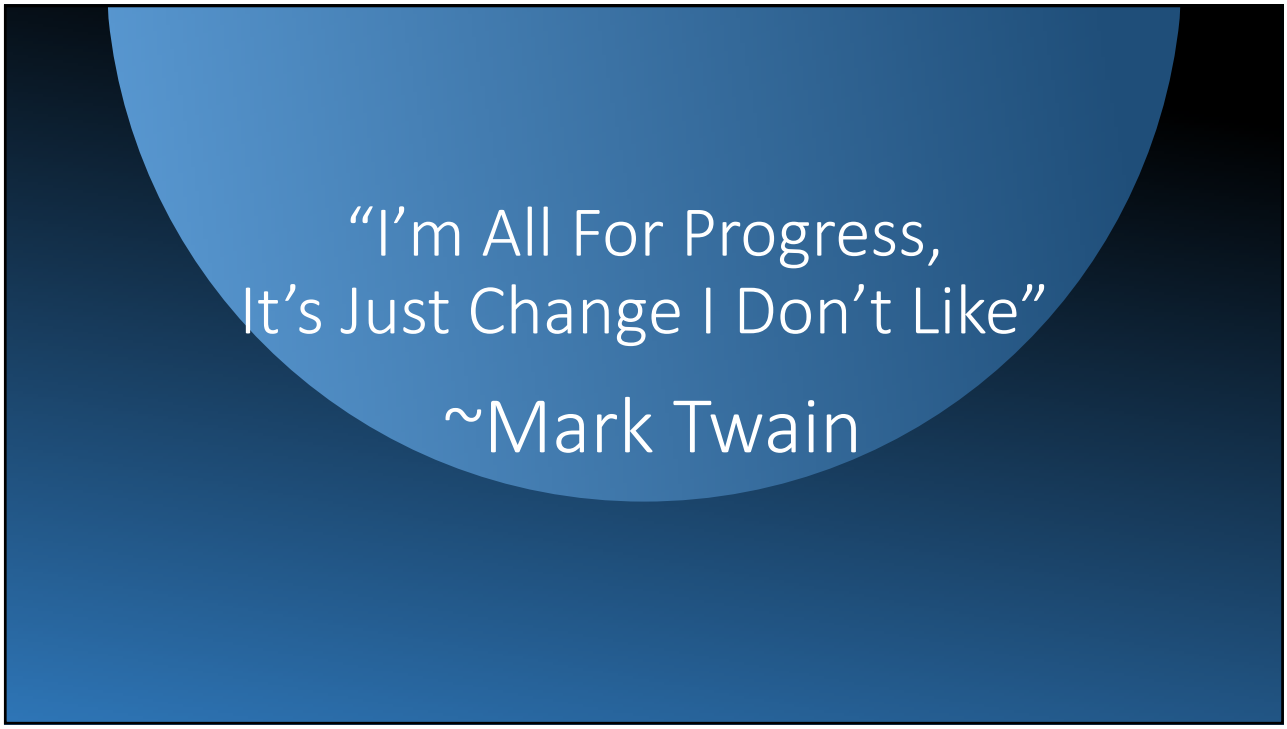



37

# The Landscape

What Is Going On In The Broader Health Care Marketplace?



38

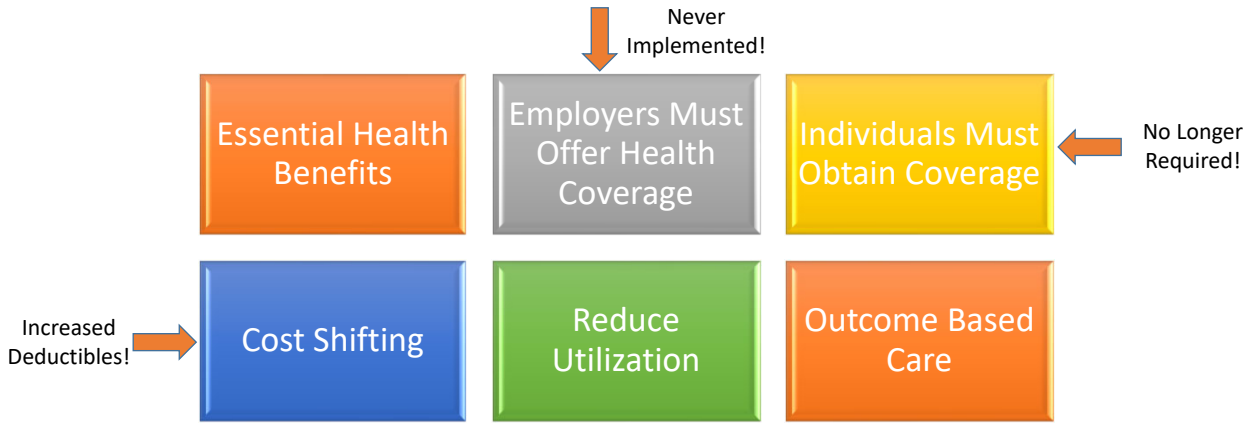
# The "Affordable" Care Act

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.



39

# What Are The Pillars Of The ACA?



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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,"

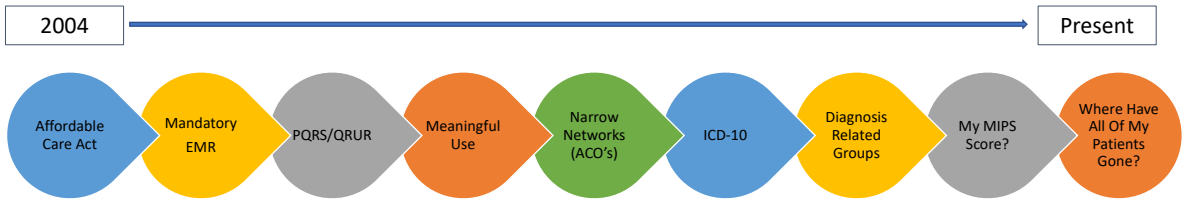
Former President Bill Clinton

October 5, 2016



41

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






42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## In A Marketplace That Is Less & Less Familiar

Or Changing So Fast It's Hard To Keep Up




43

## 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



44

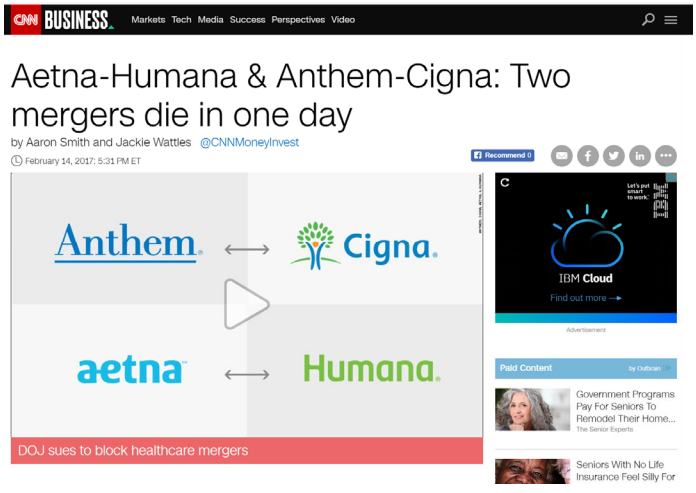
## The Big Five Are Now The Big Three

| | | | |
|---|---|---|---|
| 2016 | Anthem Cigna | $50 Billion CANCELED | On Hold |
| 2016 | Aetna Humana | $37 Billion | On Hold |
| | United Health Care | $???? | |



45

## And Then The Government Had It's Say



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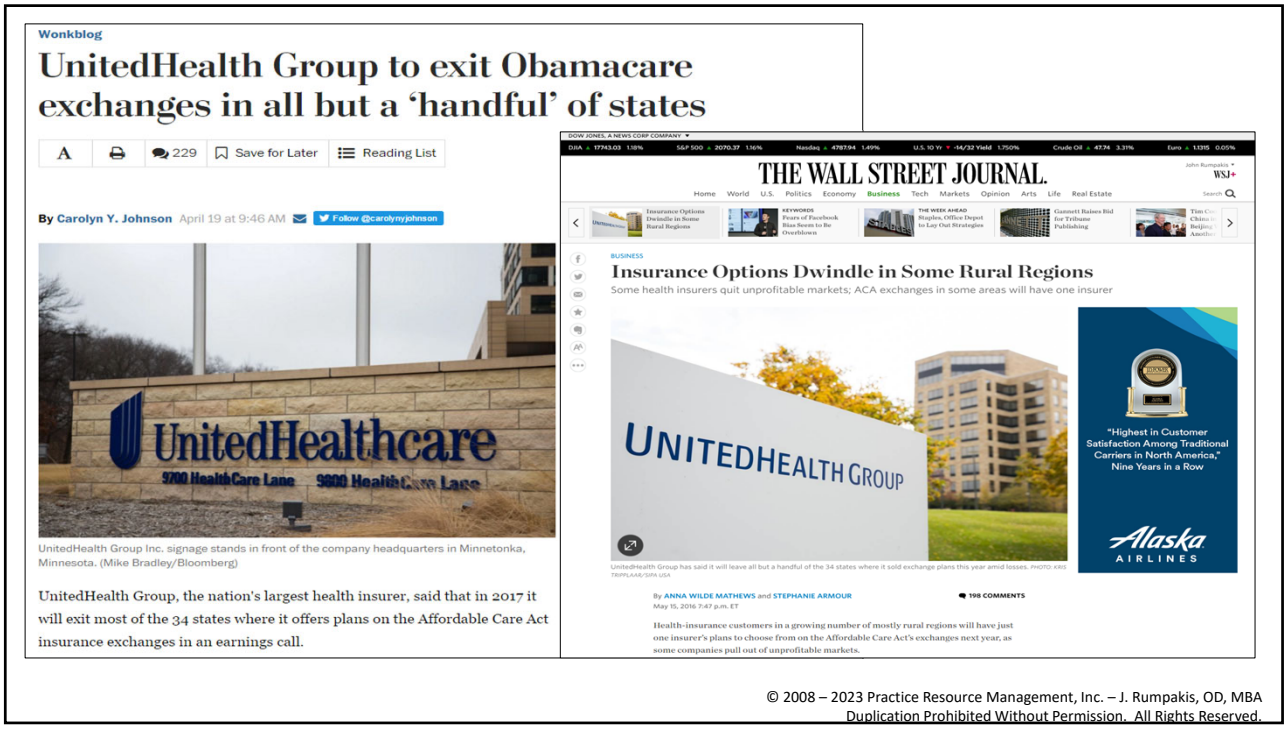




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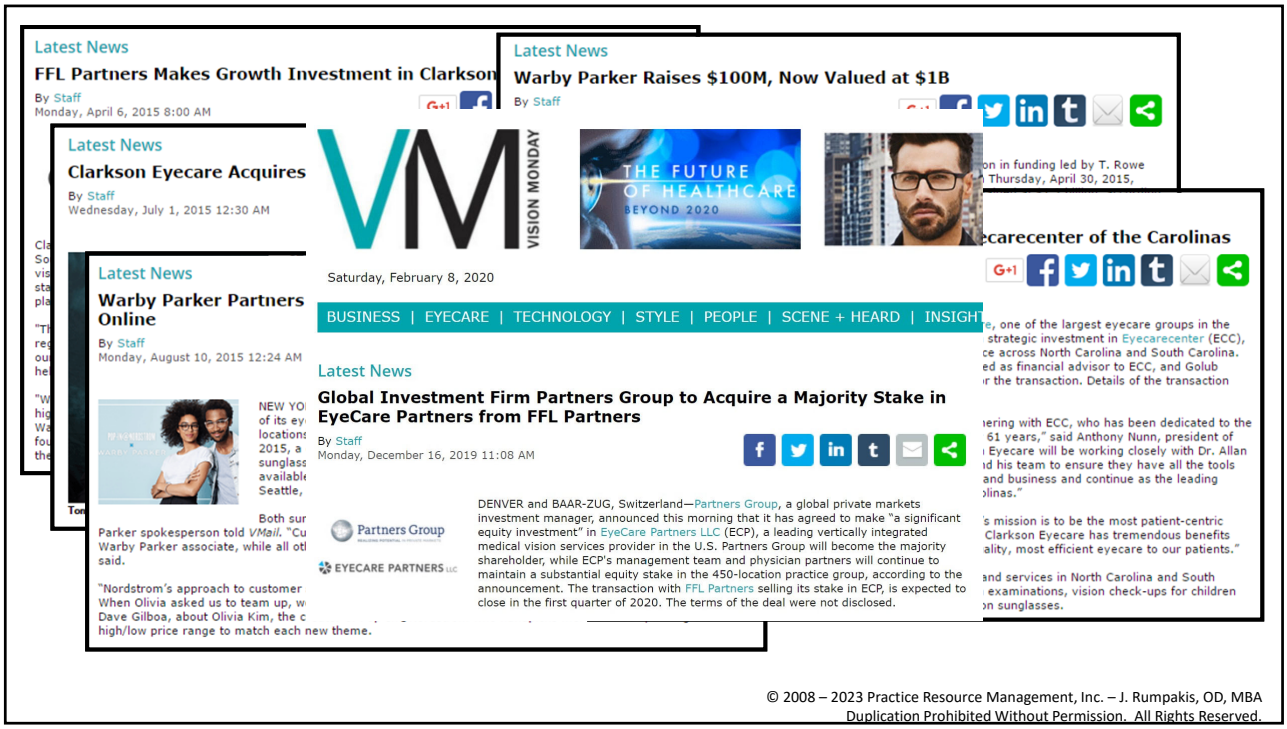




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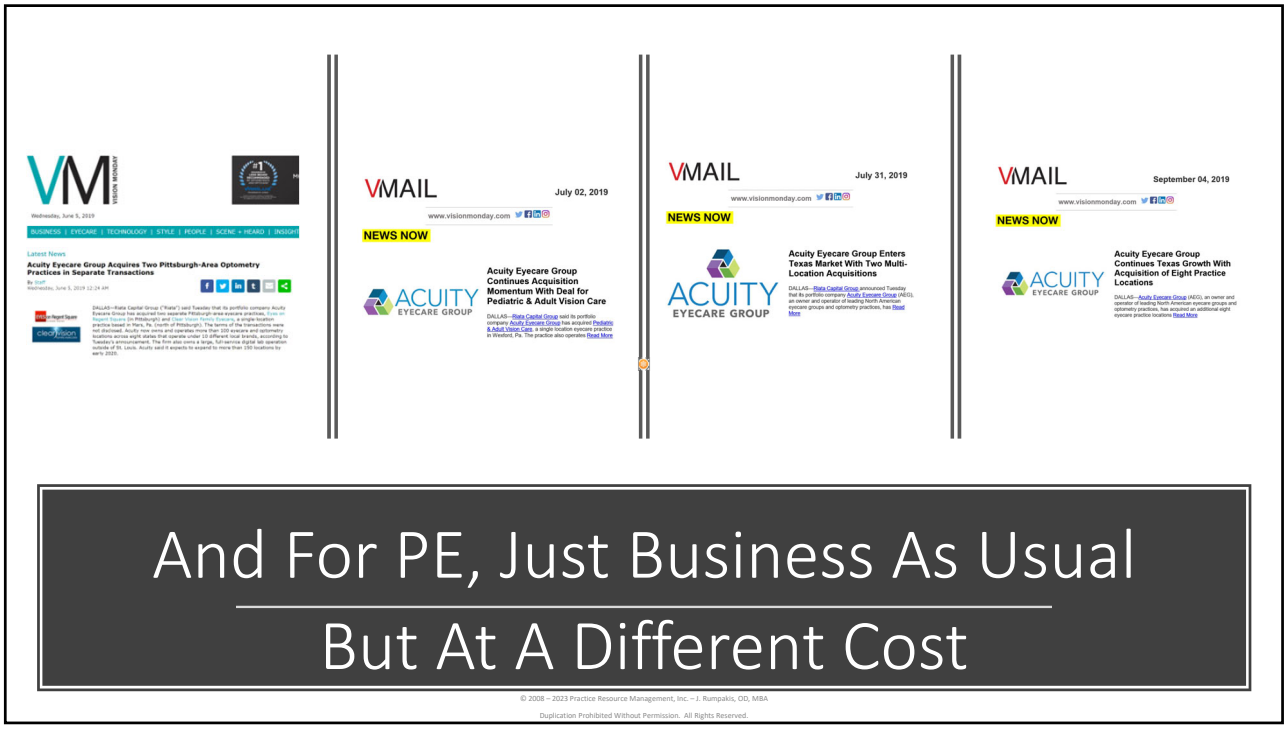


And For PE, Just Business As Usual

But At A Different Cost



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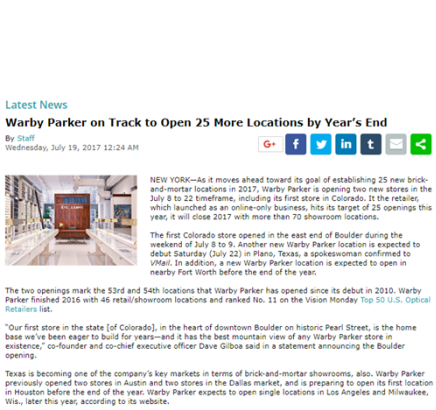

Latest News

**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. It 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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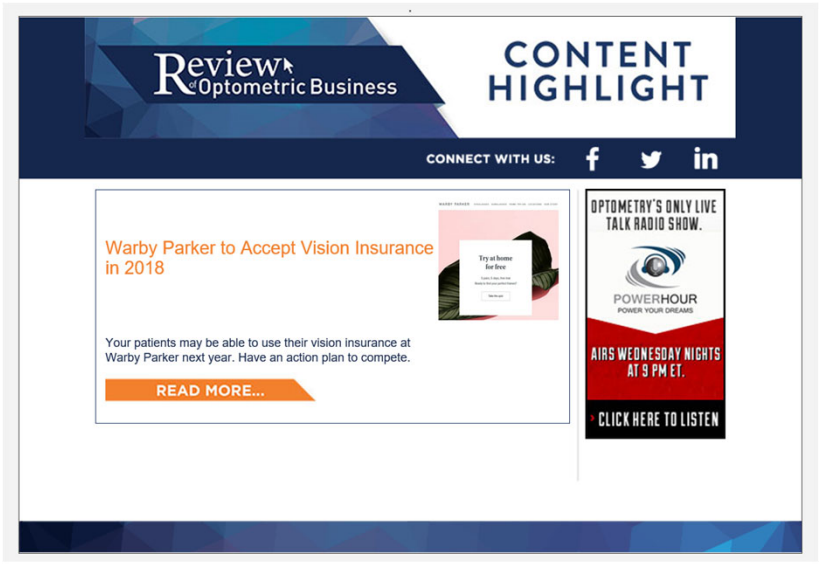




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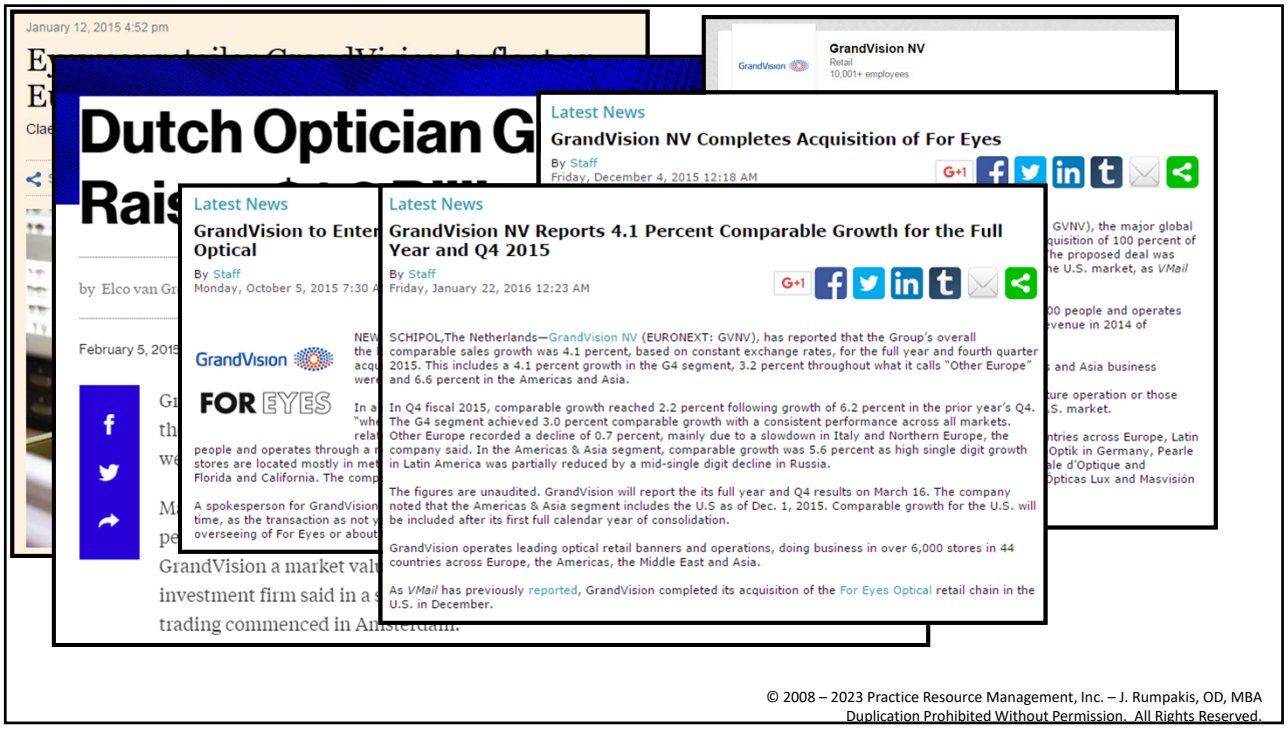




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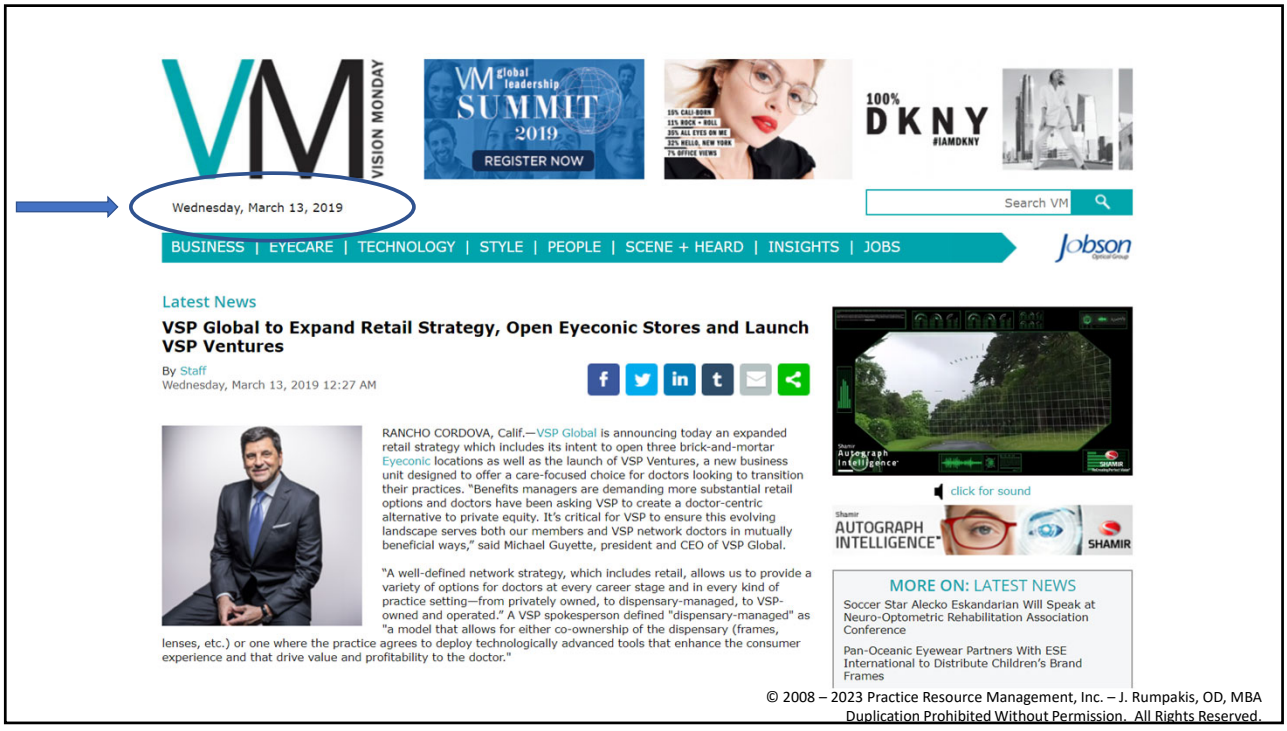
59






60

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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."



61

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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

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 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."

click for sound

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MORE ON: LATEST NEWS

- 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



62

Latest News

**VSP Global Enters Into Definitive Agreement to Acquire Visionworks**

By Staff
Thursday, June 27, 2019 10:15 AM

RANCHO CORDOVA, Calif.—VSP Global announced today that it has entered into a definitive agreement to acquire San Antonio, Texas-based Visionworks, subject to completion of regulatory approval. With a footprint of more than 700 stores in nearly 40 states, the Visionworks acquisition will be the single largest VSP network investment in the company's 65-year history, the company said. "This transaction is highly complementary to our business and marks a significant leap forward in continuing to fulfill our vision to provide access to affordable, high-quality eyecare and eyewear to more people," said Michael Guyette, president and CEO of VSP Global. "With expanded nationwide access, we'll provide our clients and members with an option for a more substantial, consistent and sustainable retail experience, further enhanced by the professional care of VSP network doctors."

Michael Guyette (l) and Pete Bridgman.

"We are aligned with VSP's values and our shared commitment to help people see," said Visionworks CEO, Pete Bridgman. "Grounded in our passion to deliver affordable quality eyecare in a simple way, and strengthened by our new partnership with VSP, we will focus on advancing patient care and accessibility."

"The Visionworks acquisition, once closed, will position VSP to meet expectations of our clients and to grow membership," said Gordon Jennings, OD, VSP Global board chair. "Together, we will be able to provide greater access for our members."

click for sound

PREMIER PROGRAM REWARDS AND SAVINGS FOR YOUR PRACTICE LEARN MORE

MORE ON: LATEST NEWS

- NuSight Granted U.S. Patent Covering the NuLids System for Treating Dry Eye Disease
- Prevent Blindness to Hold 14th Annual 'Eyes on Capitol Hill' Advocacy Event
- Lighthouse Awards 18 College Scholarships to Students With Vision Loss
- The Vision Council Hosts Congressional Briefing in Recognition of National Sunglasses Day
- Versant Health Names Mark Weibel as Regional



63

VISION MONDAY

Saturday, February 8, 2020

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Latest News

**VSP Ventures Acquires Redhawk Vision Center of Southern California**

By Staff
Friday, October 25, 2019 12:27 AM

RANCHO CORDOVA, Calif.—VSP Ventures said Thursday that it has acquired Redhawk Vision Center in Temecula, Calif. The practice was founded in 1999 by the husband-and-wife team of Donny Broyles, OD, and Sonya Hooks-Broyles, OD. The terms of the transaction were not disclosed. Redhawk Vision Center will continue to operate under its existing name, and all doctors and practice staff will remain in their roles, the VSP Ventures announcement noted. Earlier this month, VSP Ventures (a division of VSP Global) announced the acquisition of University Optometry, a boutique optometry practice based in Palo Alto, Calif, as VMAIL reported.

VMAIL

August 22, 2019

www.visionmonday.com

NEWS NOW

**VSP Ventures Acquires EyeZone's Six Optometry Practices**

RANCHO CORDOVA, Calif.—VSP Ventures has announced the acquisition of EyeZone, a six location optometry practice in Nevada. Founded in 2004 by Daniel Rowan, Read More

VISION MONDAY

Thursday, January 2, 2020

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Latest News

**VSP Ventures Acquires Stockton's Largest Optometric Practice, Brookside Optometric Group**

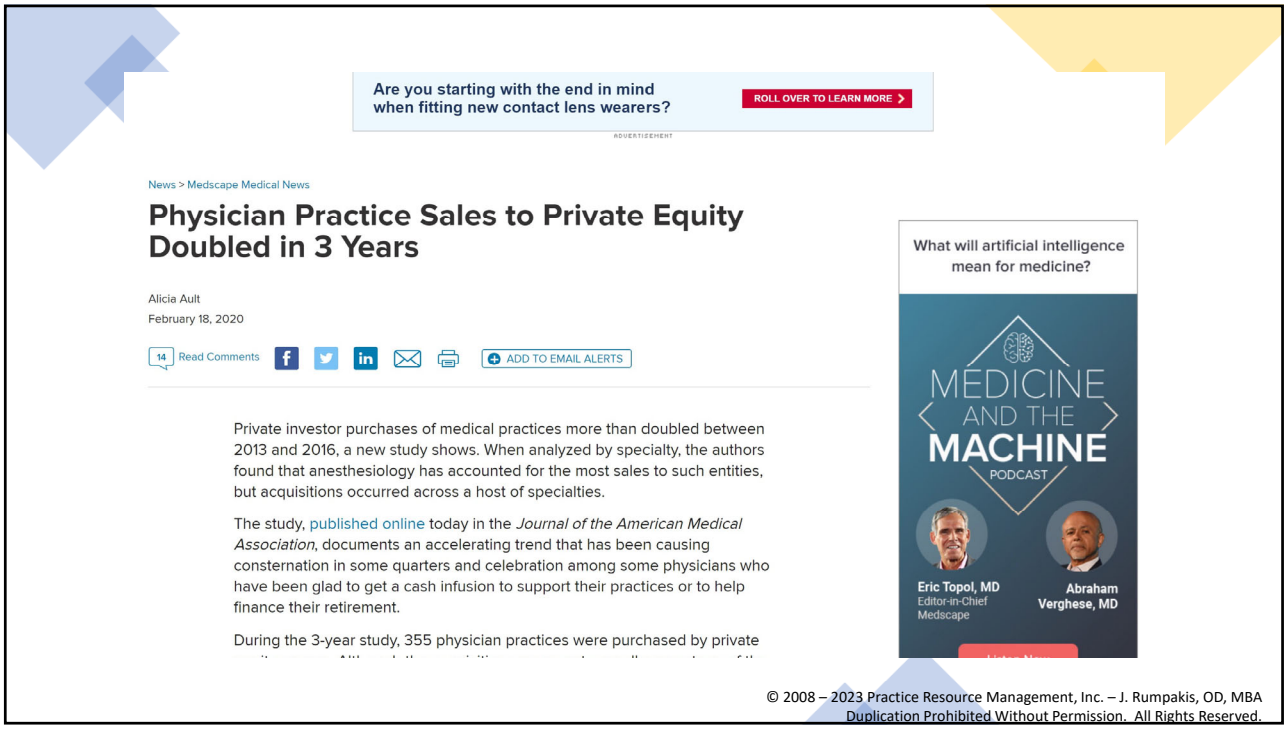
By Staff
Friday, December 27, 2019 12:30 AM

RANCHO CORDOVA, Calif.—VSP Ventures, a care-focused practice transition partner and a business unit of VSP Global, announced Thursday the acquisition of Brookside Optometric Group in Stockton, Calif. Founded in 1998 by the late Craig Hisaka, OD, Brookside Optometric Group was established after the five largest optometric practices in Stockton merged together, according to the announcement. The terms of the deal were not disclosed. VSP Ventures was launched in March 2019 as part of VSP Global's expanded retail strategy, as VMAIL reported.

Brookside Optometric Group will continue to operate under its existing name and all doctors and practice staff will remain in their roles.



64



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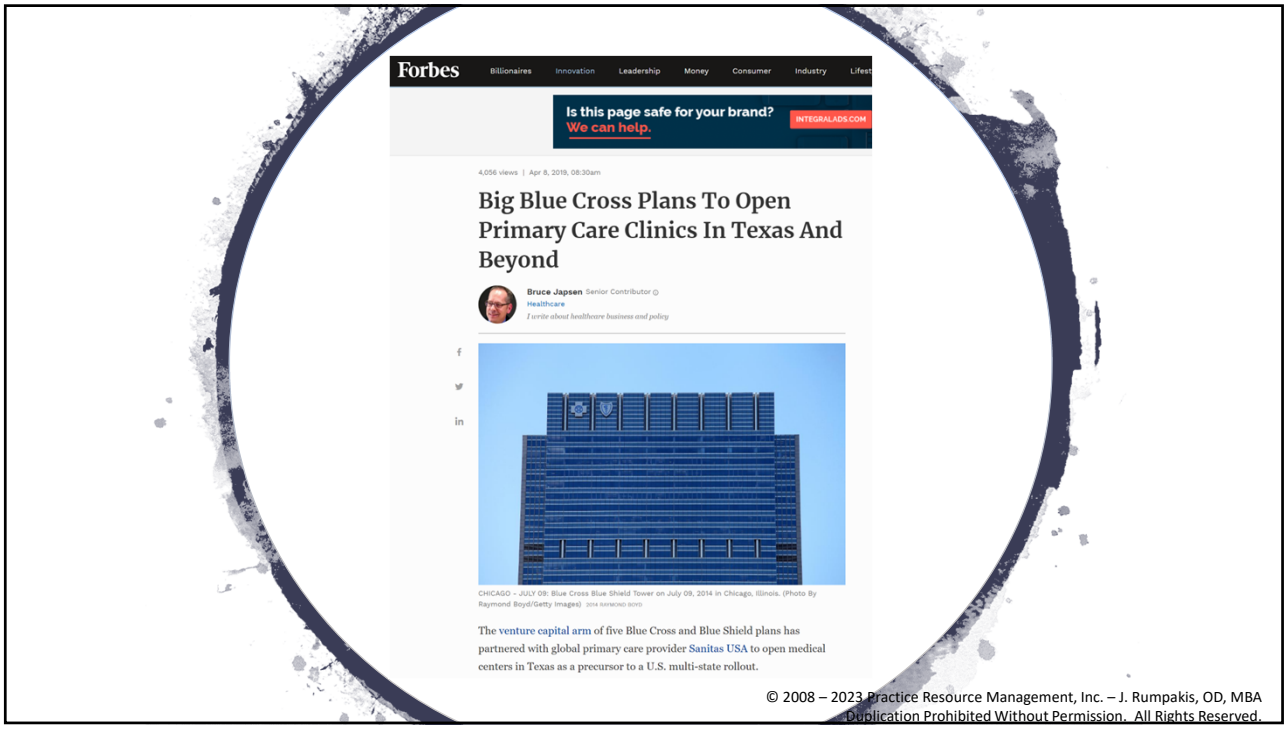




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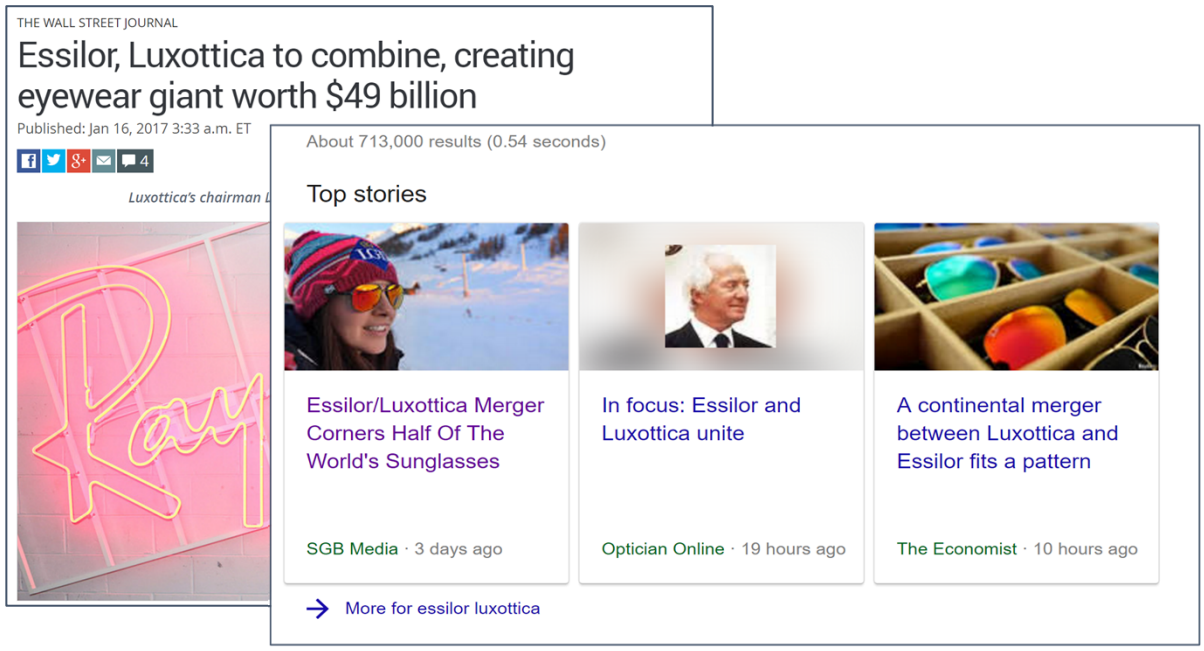




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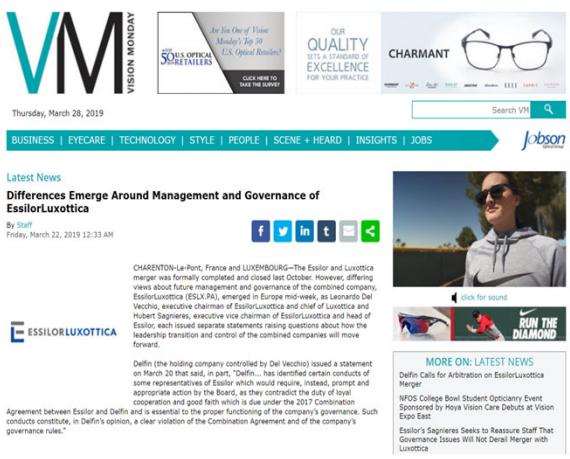


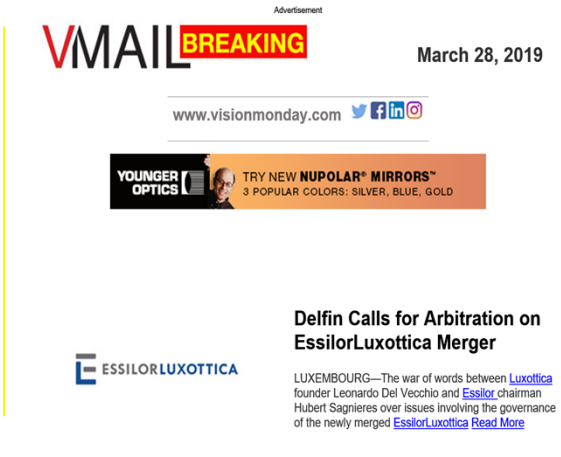




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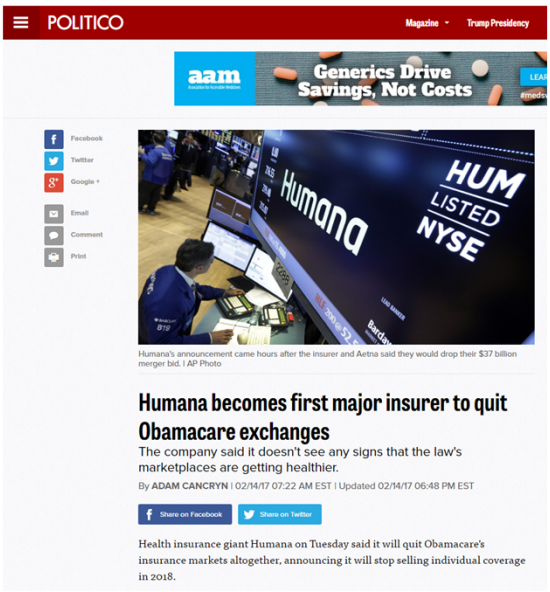





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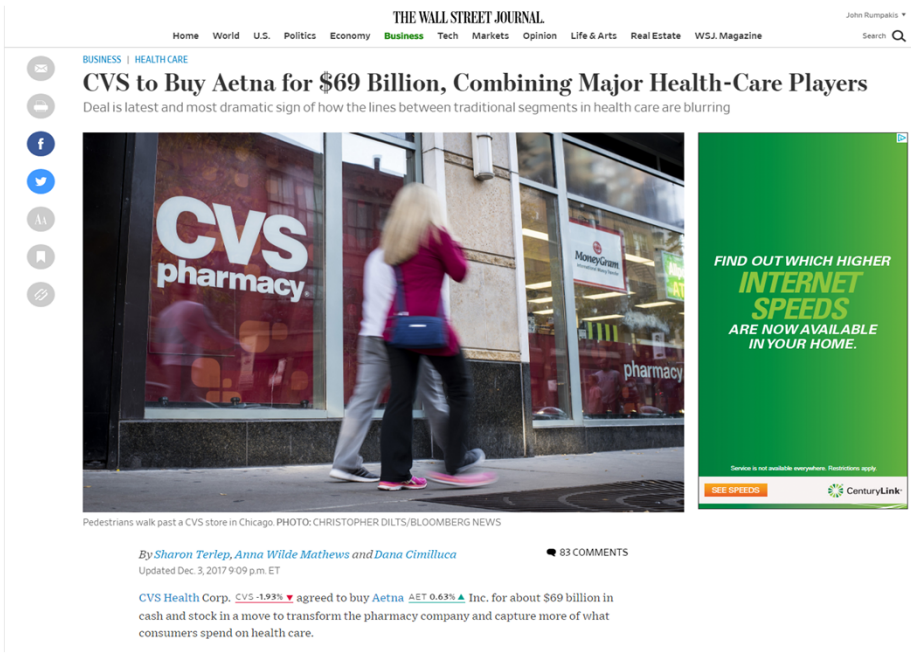




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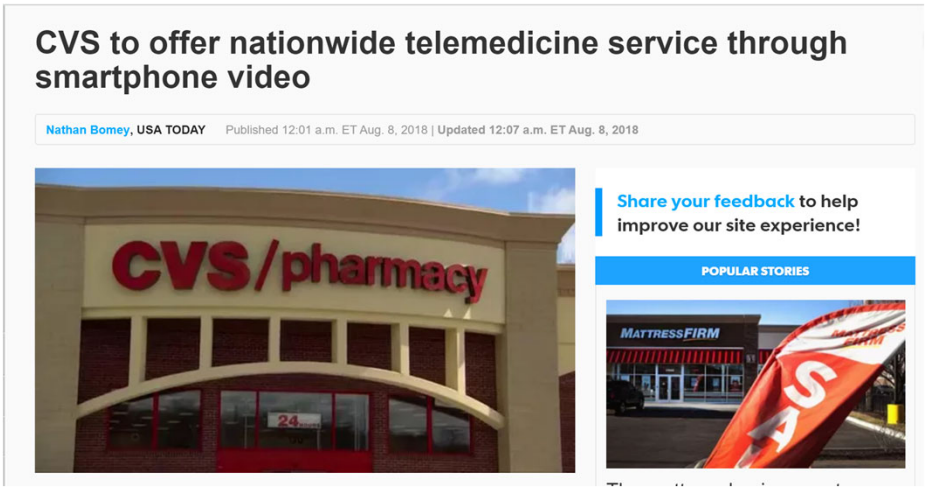

CVS to offer nationwide telemedicine service through smartphone video

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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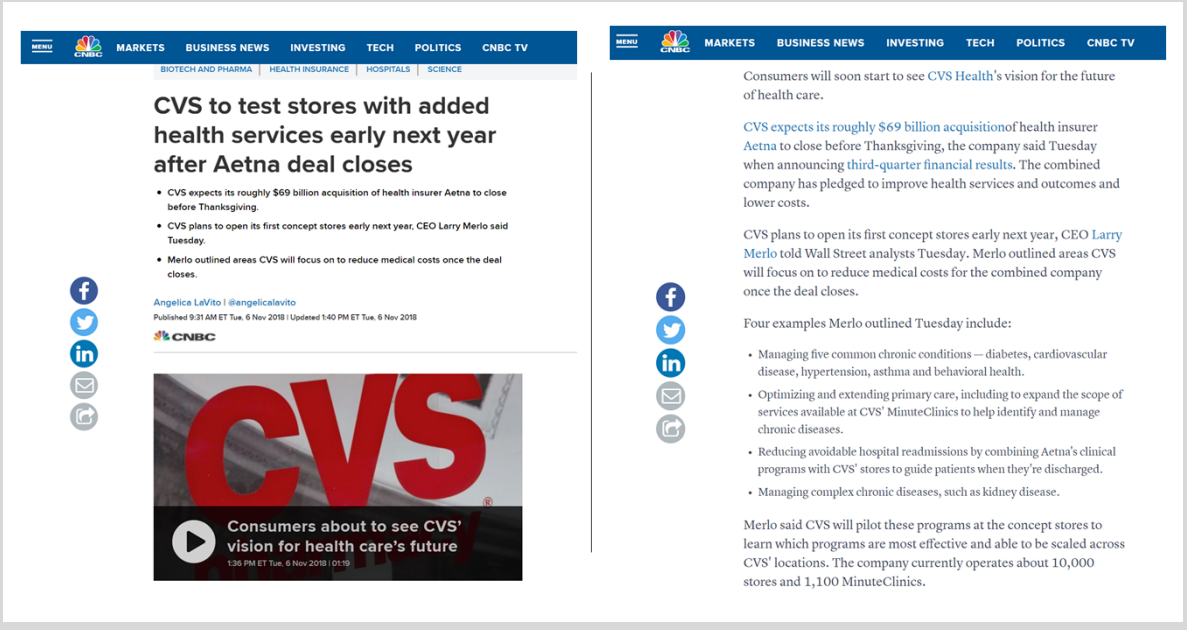

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CVS to test stores with added health services early next year after Aetna deal closes

- 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 LaVito | @angelicalavito

Published 9:31 AM ET Tue, 6 Nov 2018 | Updated 1:40 PM ET Tue, 6 Nov 2018

CNBC



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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.



72




73

November 30, 2018

CVS Health president and chief executive officer Larry J. Merlo said in the announcement that the deal's closing "marks the start of a new day in health care and a transformative moment for our company and our industry. He added, "By delivering the combined capabilities of our two leading organizations, we will transform the consumer health experience and build healthier communities through a new innovative health care model that is local, easier to use, less expensive and puts consumers at the center of their care."

CVS said it has begun to put the foundational pieces of its new health care model in place and expects to introduce new programs and services designed to increase access to care, improve health outcomes and reduce medical costs for all consumers. The company noted that these new programs will "target better, more efficient management of chronic disease using the networks, technology and the people of the combined company."

Added Merlo, "As the front door to quality health care, our combined company will have a community focus, engaging consumers with the care they need when and where they need it, will simplify a complicated system and will help people achieve better health at a lower cost. We are also leading change in health care by challenging the status quo with new technologies, business models and partnerships. In doing so, we will continue to deliver on our purpose of helping people on their path to better health."



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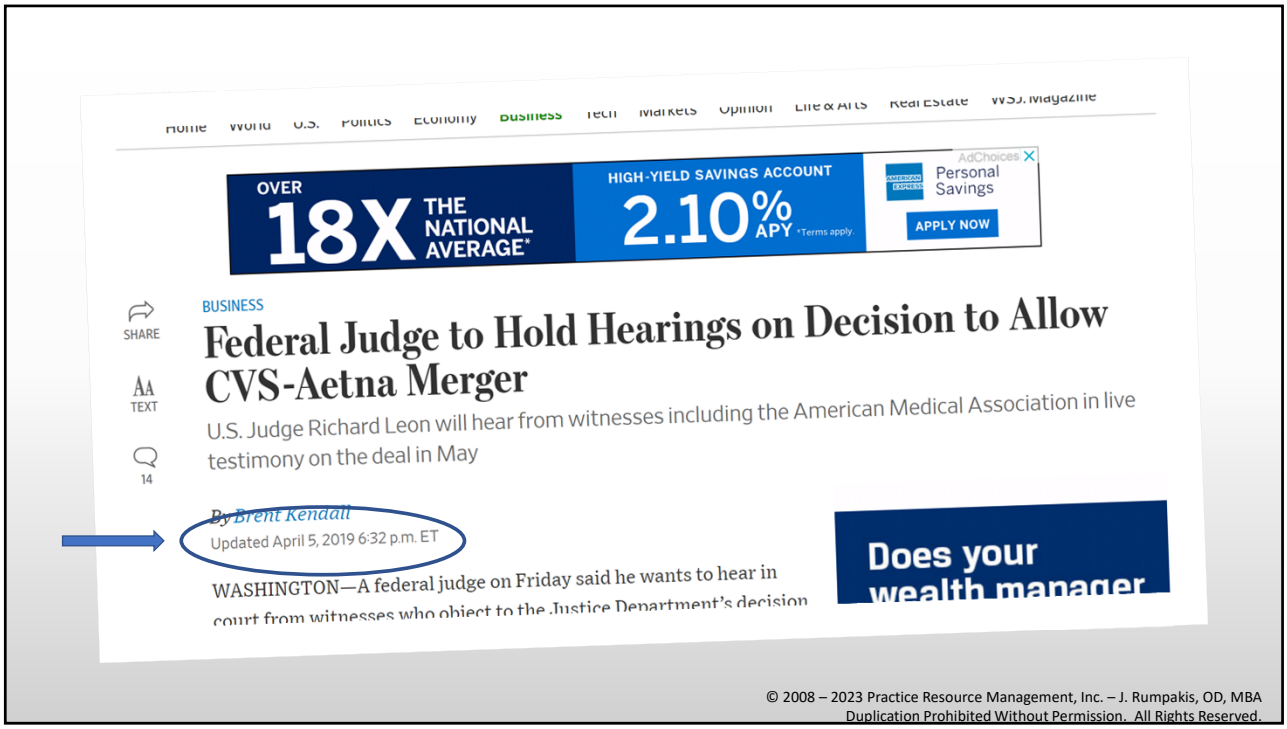




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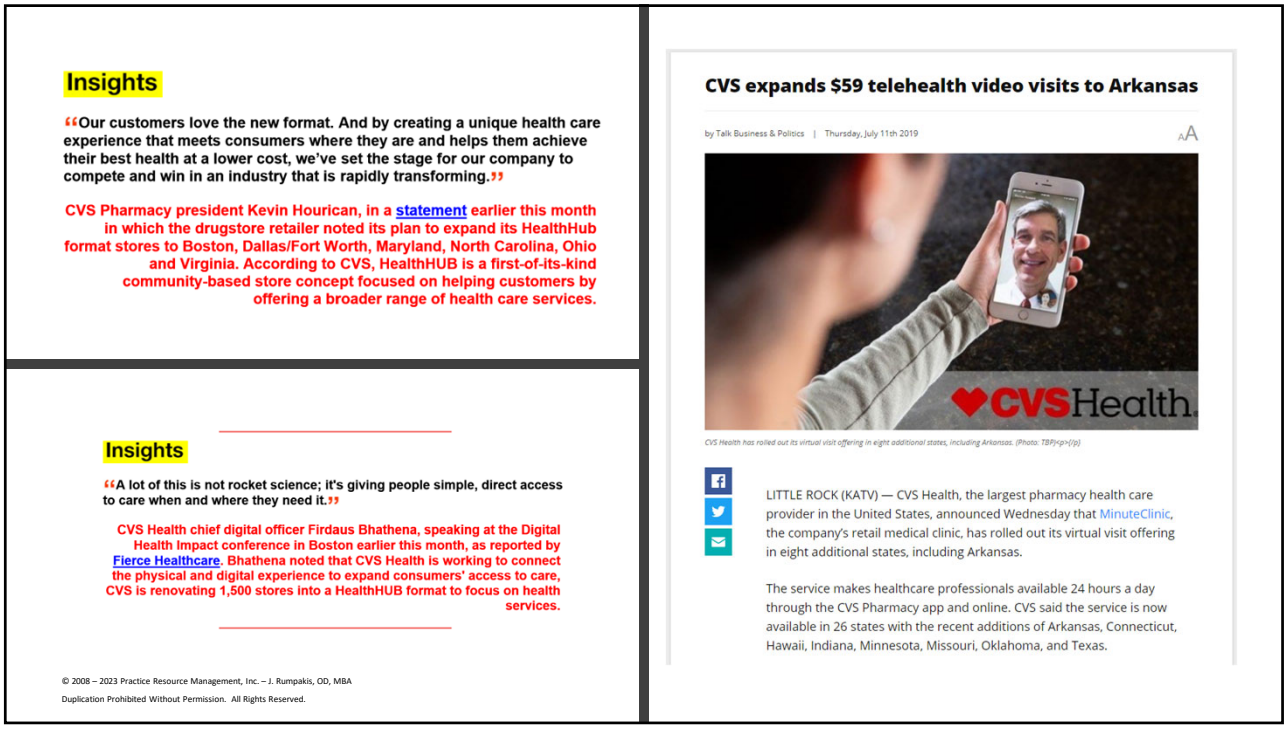



77

**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 [illegible] services rather than just commoditized pills, [illegible] 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.

to invent every connected device and we're not going to [illegible]y breakthrough. But we do have a direct connection to [illegible]ners and want to leverage that and bring value and bring [illegible]."

[illegible]hief digital officer Firdaus Bhathena, speaking at a recent [illegible]ealth Impact conference in Boston, as reported by Fierce [illegible]Bhathena noted that CVS Health is investing heavily in its [illegible]gy infrastructure and wants to leverage the differentiated [illegible]e 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 Lotvin, 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.



78

BUSINESS // BIZFEED

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

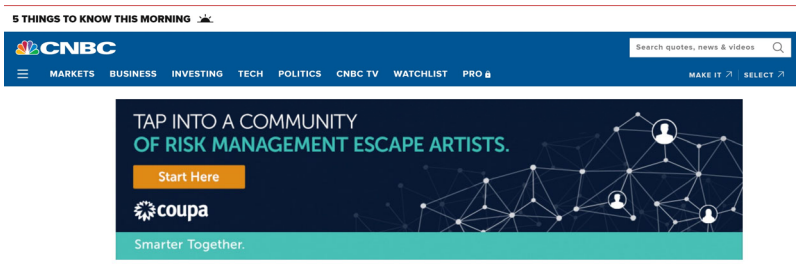
Gwendolyn Wu | Nov. 11, 2020 | Updated: Nov. 11, 2020 5:25 p.m.




79




80



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82




83

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BUSINESS

**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-Aetna deal at a much lower cost than a takeover. PHOTO: MOHAMMAD KHURSHEED/REUTERS

By Dana Mattioli, Michael Siconolfi and Dana Cimilluca 4 COMMENTS

Updated Nov. 20, 2018 4:08 p.m. ET

Drugstore owner Walgreens Boots Alliance Inc. WBA +1.57% ▲ and health insurer Humana Inc. HUM 0.51% ▲ 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.

VM VISION MONDAY

Tuesday, November 26, 2019

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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: UNH), and Walgreens will open 14 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 services 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 Gates, 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 medications. 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 co-pays for drugs, access to additional in-store value, enhanced discounts through the Walgreens Balance Rewards program and simple to use digital tools through Walgreens. The 46 plans will be available across 24 states where 16.2 million people eligible for Medicare reside. Consumers can enroll 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's Medicare plans offer programs that help people stay active, improve health and navigate 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.



84

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

Melissa Repko
@MELISSA_REPKO

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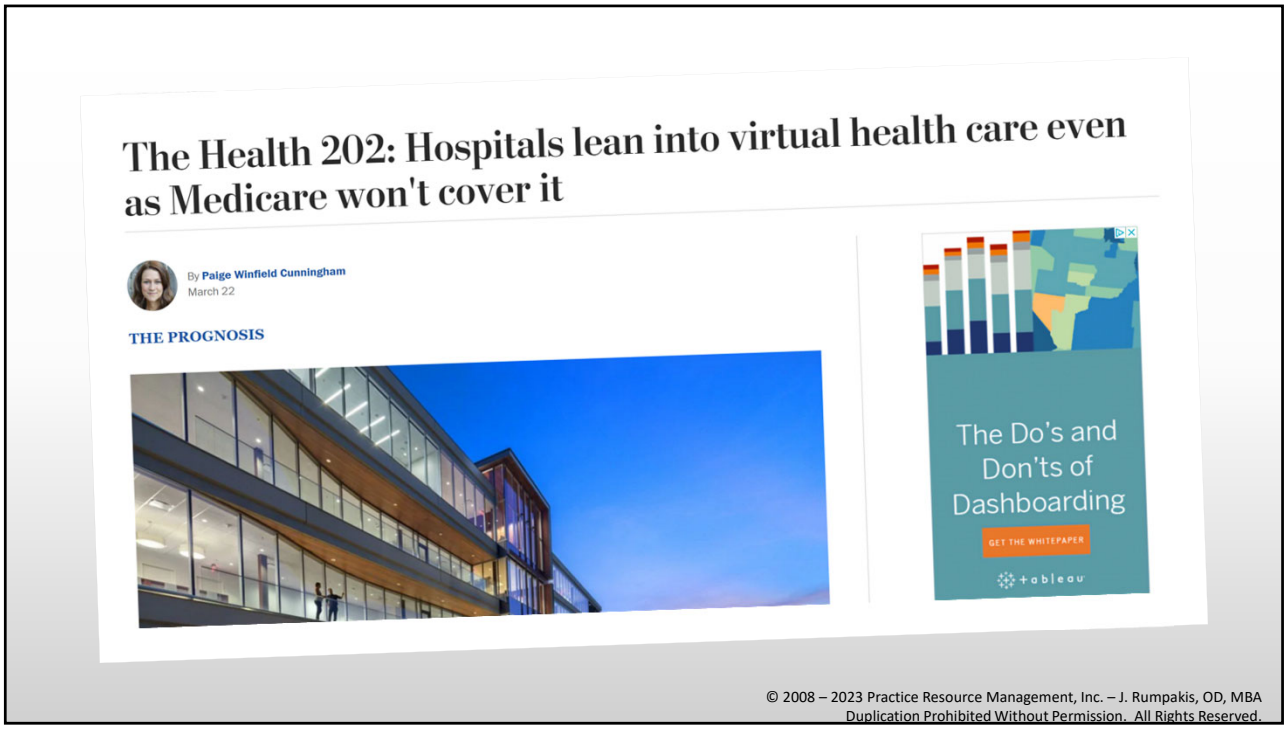




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# Reality Strikes





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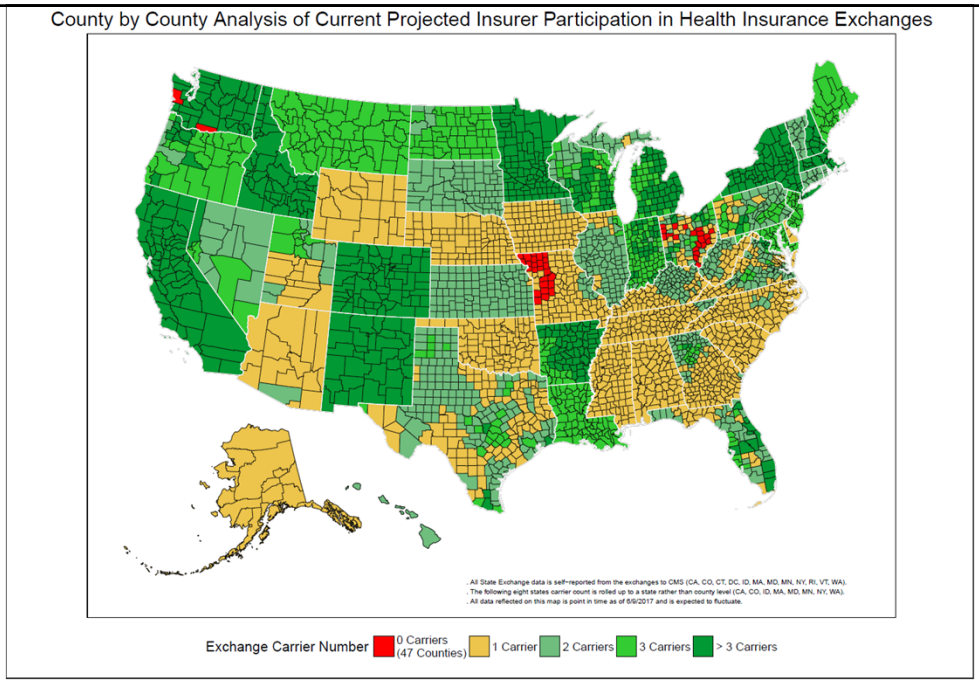




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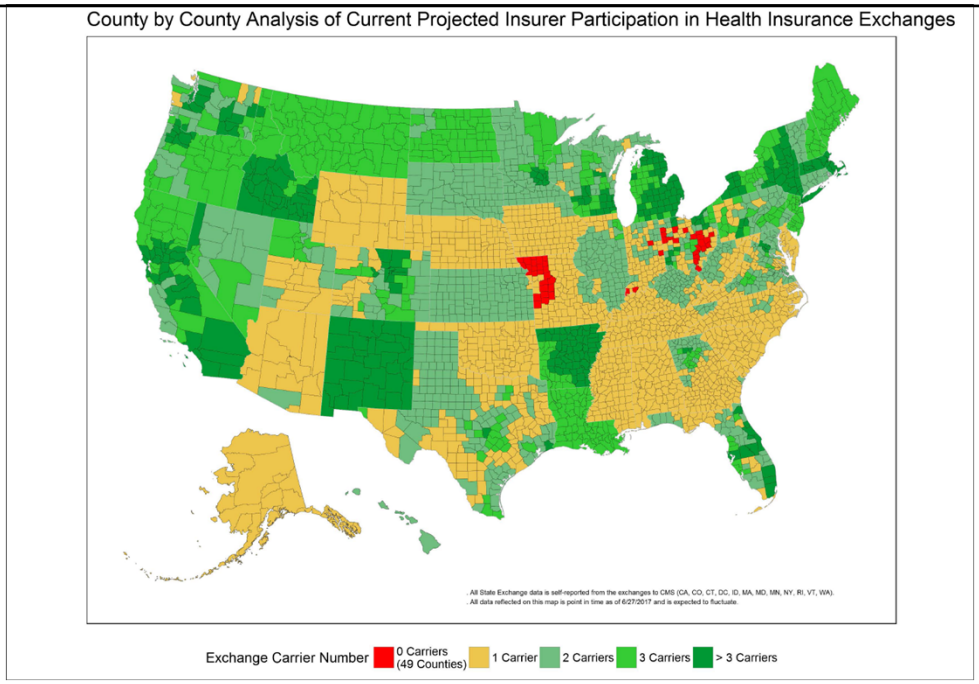




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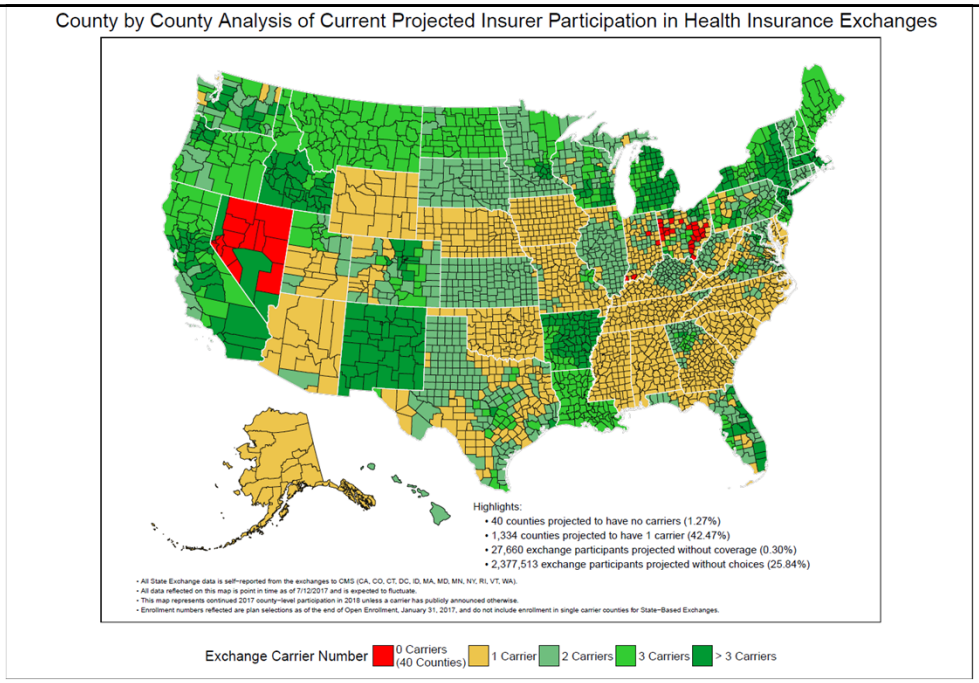




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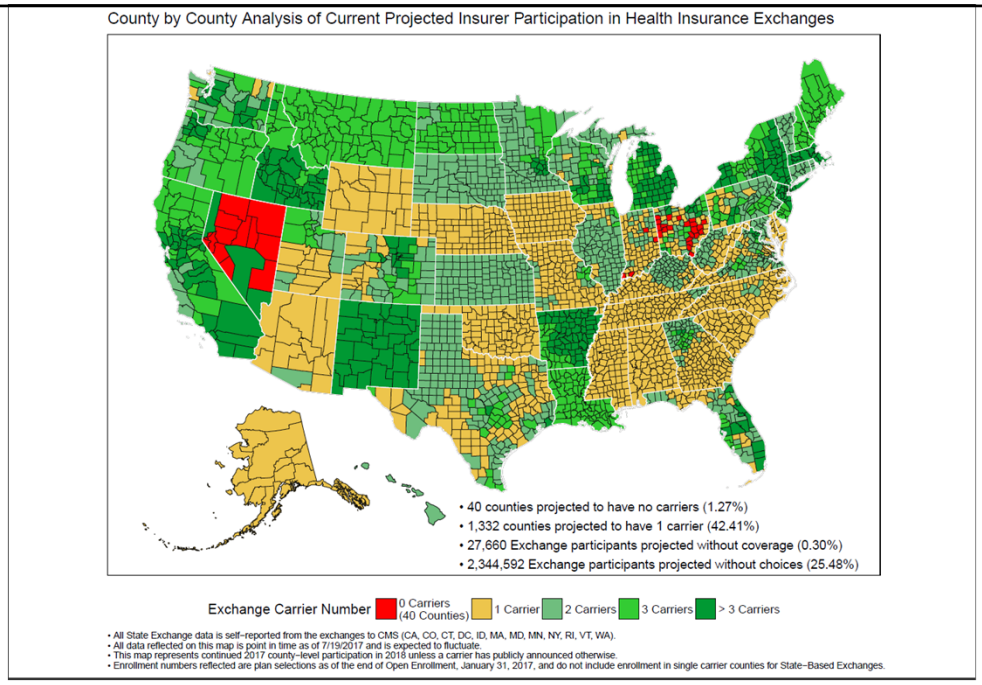




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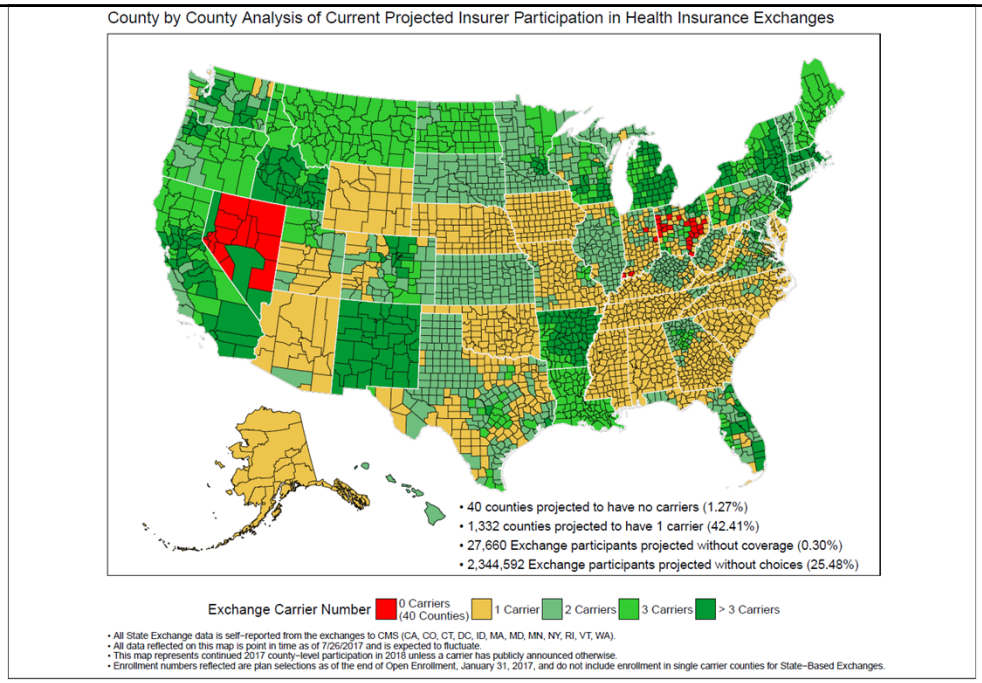




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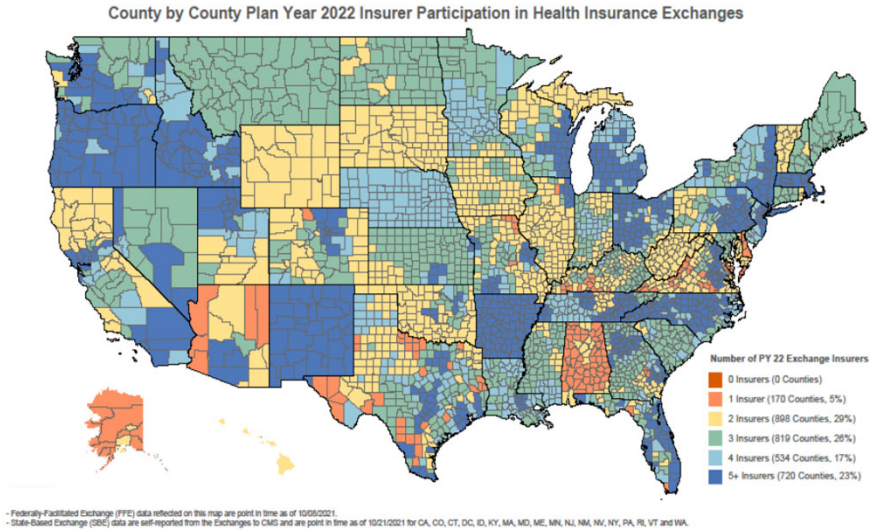




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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

## 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



96

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)



97

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



98




99

**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



100

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.

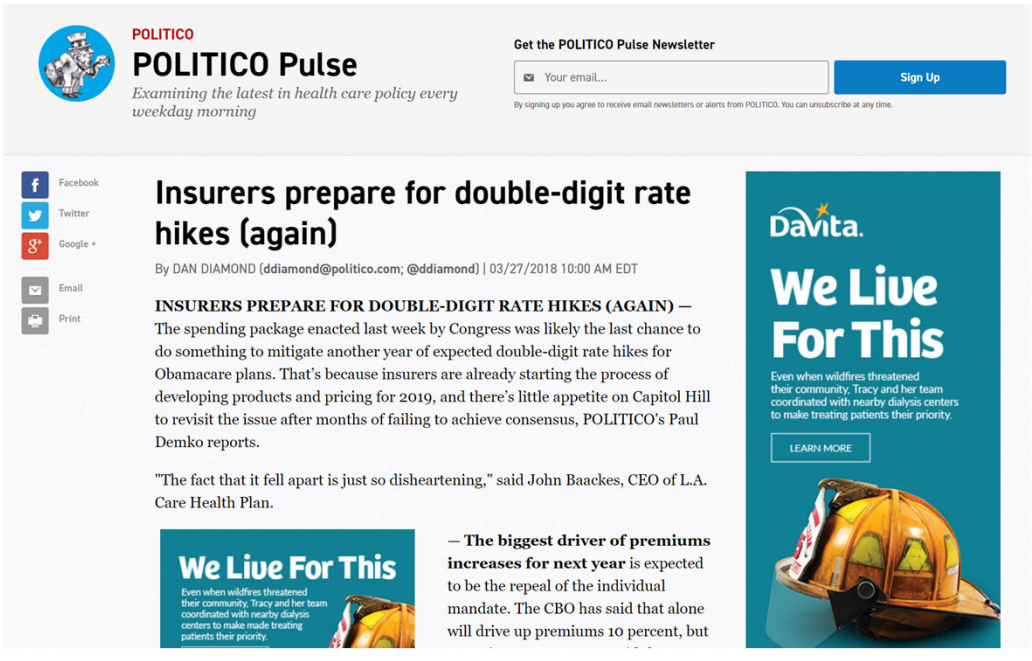
Big insurers in Idaho, West Virginia, South Carolina, Iowa and Wyoming are seeking to raise premiums by averages close to 30% or more, according to preliminary rate requests published by the U.S. Department of Health and Human Services. Insurers face a mid-August deadline for completing their rates.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

**See More Coverage »**

August 2, 2018



101



POLITICO

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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.



**— 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





102

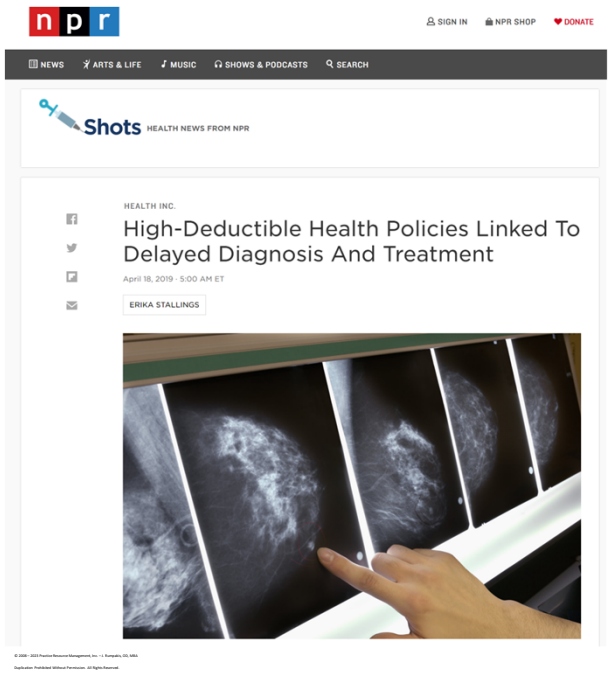
## LEADING THE NEWS

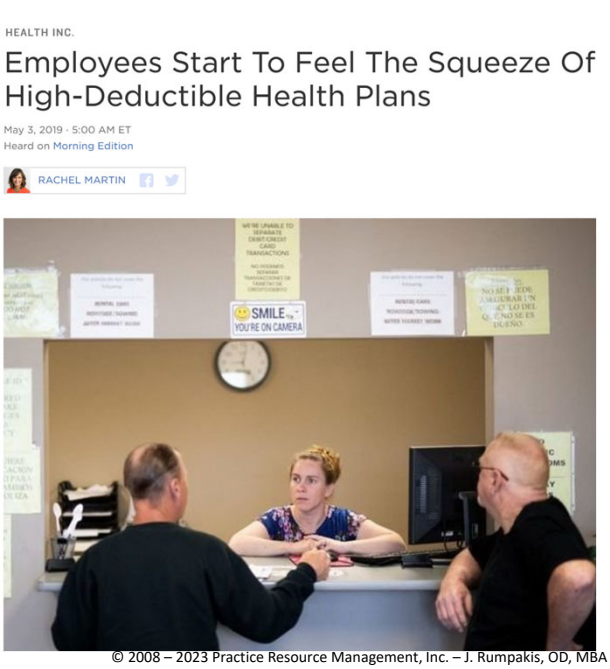
**Poll: Under 35 More Likely To Defer Healthcare Because Of Cost.**

NPR (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."



103






104

29 / 66

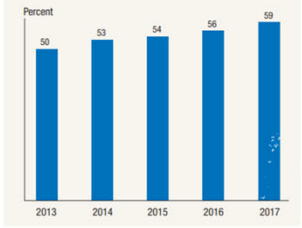
## Dealing with Unexpected Expenses

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)**




Among the remaining 4 in 10 adults who would ha more difficulty covering such an expense, the m common approaches include carrying a balan credit cards and borrowing from friends or f (figure 12). Far fewer people would turn options, such as a payday loan, deposit bank overdraft in these situations.



105

**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**

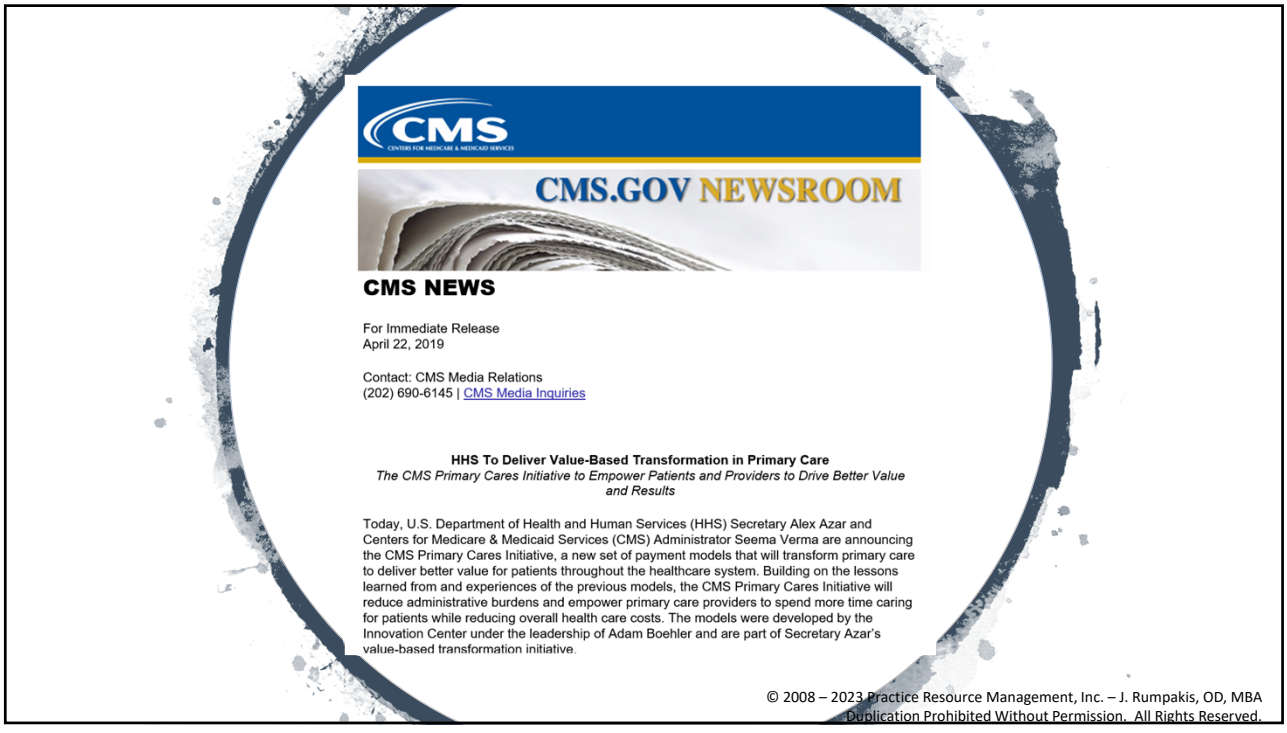
Kaiser Health News (10/29, Andrews) reports that some employers are offering more traditional health plans without high deductibles to attract employees. The article says that "in a tight labor market, offering a more generous plan with a deductible that's less than four figures can be an attractive 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."



106




107






108

Latest in Science

EPA could lock in emissions rules before Trump takes office

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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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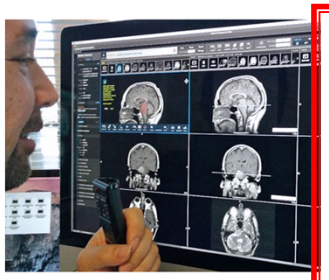


IBM Watson Health

November 30 - 2016

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.



115

nature > articles > article

nature

Article | Published: 01 January 2020

## International evaluation of an AI system for breast cancer screening

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

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

**1168** Altmetric | Metrics

### Abstract

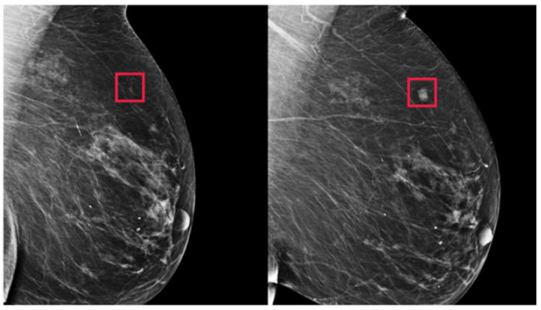
Screening mammography aims to identify breast cancer at earlier stages of the disease, when treatment can be more successful[1]. Despite the existence of screening programmes worldwide, the interpretation of mammograms is affected by high rates of false positives and false negatives[2]. Here we present 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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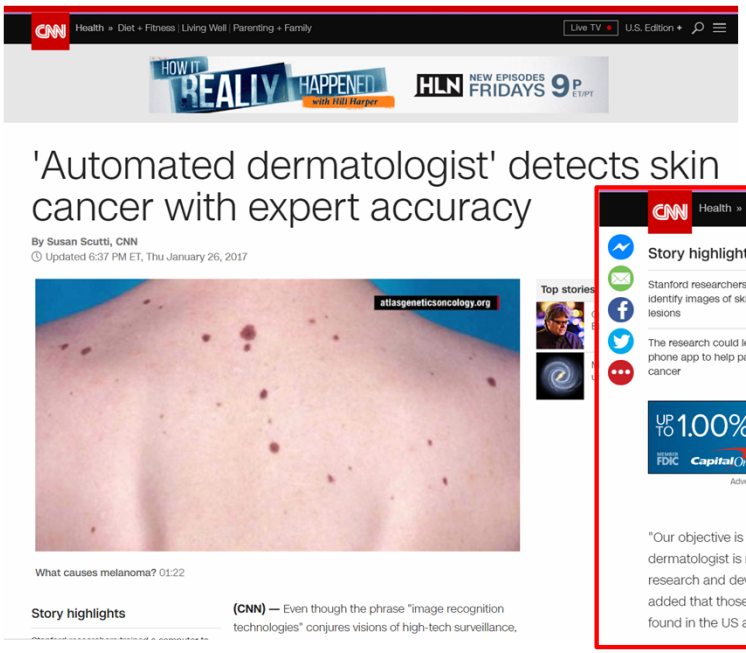


January 26 - 2017



117




118

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

Shutterstock / Maksym Dykha

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

SHARE

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

Lily Peng speaks with WIRED's Sarah Fallon.

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.

MOST POPULAR



119

Healio OCULAR SURGERY NEWS

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Association for Research in Vision and Ophthalmology

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

ADD TOPIC TO EMAIL ALERTS

VANCOUVER, British Columbia — **Kaushal Solanki, PhD**, founder and CEO of Eyenuk Inc., discusses study results of the EyeArt 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

THE FUTURE OF HEALTHCARE BEYOND 2020

Saturday, February 8, 2020

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

Latest News

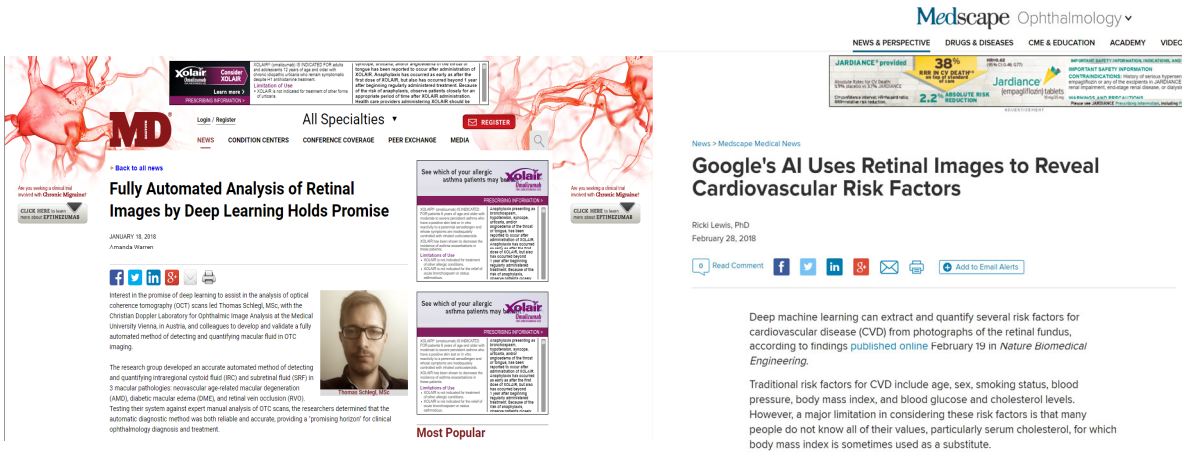
**Eyenuk Receives NIH Grant to Expand AI Eye Screening Platform for Neurodegenerative Disease Detection**

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.



120



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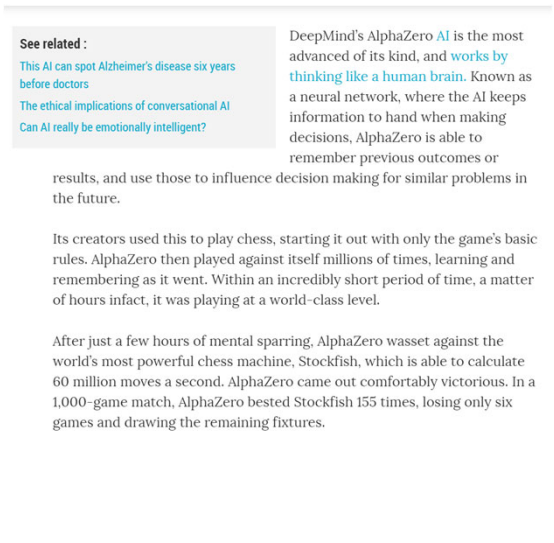





122

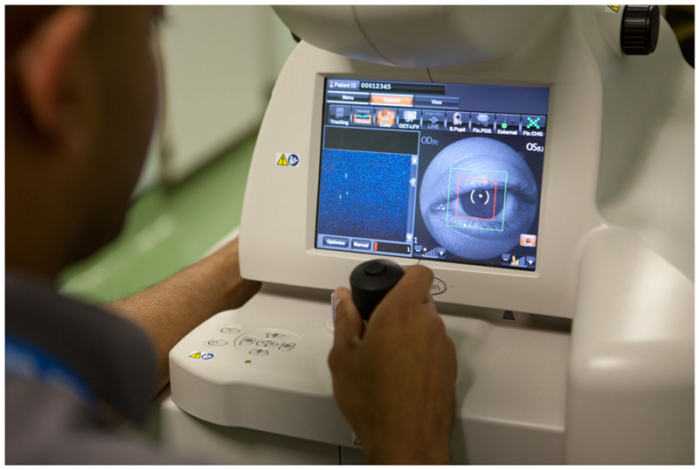
## DeepMind AI matches health experts at spotting eye diseases

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

Nick Summers, @nisummers
21h ago in Medicine

0 Comments

360 Shares



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.



123



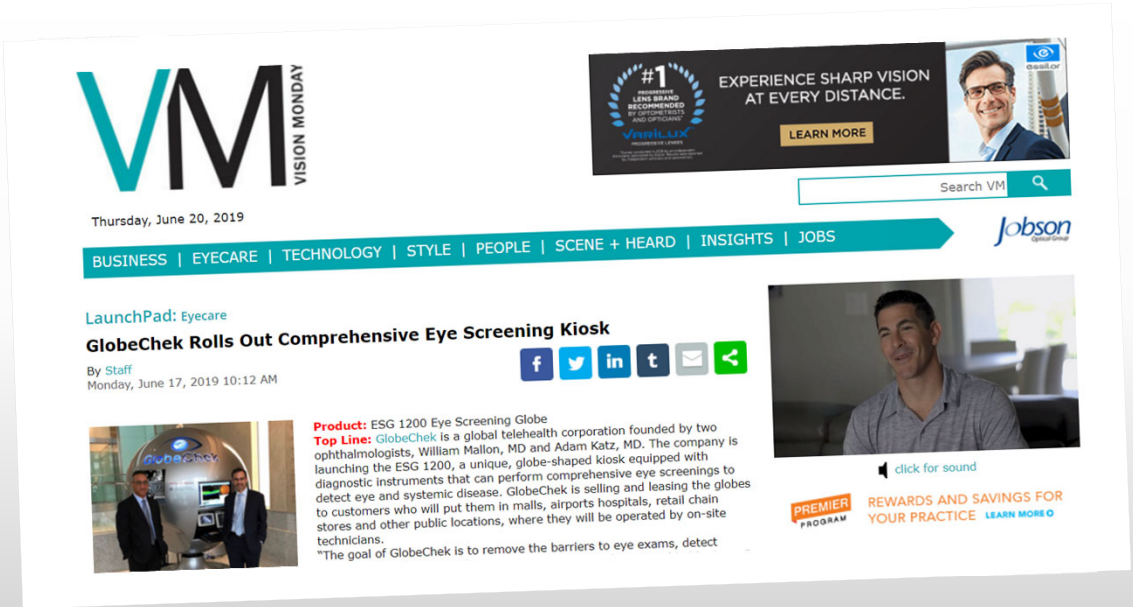

124

# C'mon John… Technology Will Never Replace What We Do…

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



125



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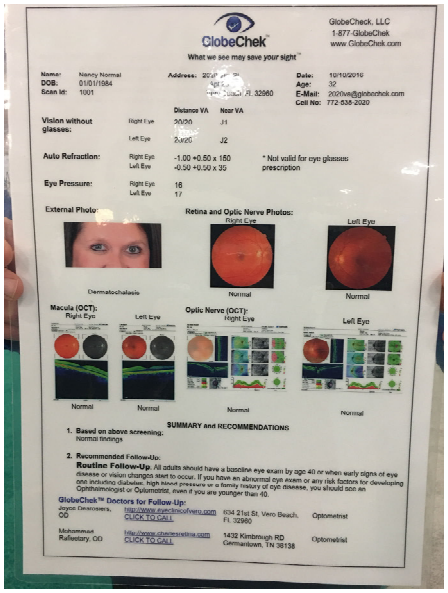
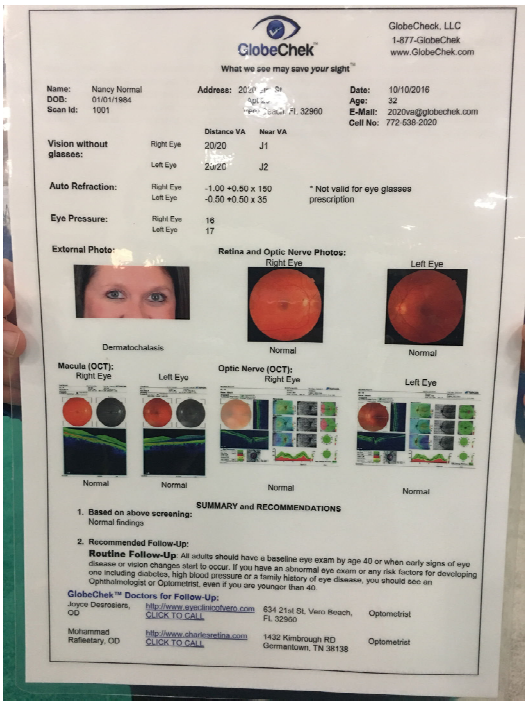
128




129

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






130

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



132

# What Is Outcome Based Care?



133

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



134

# And The Trend Continues

Forbes

31,912 views | Oct 7, 2020, 08:00am EDT

## Humana: Moving Doctors From Fee-For-Service Cut Medicare Costs 19%

**Bruce Japsen** Senior Contributor

Healthcare

*I write about healthcare business and policy*


Medical costs were 18.9% lower for seniors enrolled in Humana Medicare Advantage plans that paid ... [+]



135

CMS

CMS.GOV NEWSROOM

**CMS NEWS**

FOR IMMEDIATE RELEASE
December 6, 2018

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



136

CMS.GOV NEWSROOM

**CMS NEWS**

FOR IMMEDIATE RELEASE
March 27, 2019

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

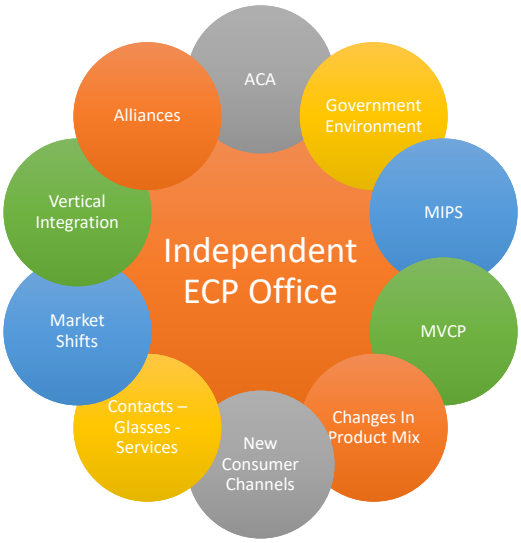
**CMS launches Artificial Intelligence Health Outcomes Challenge**
*New competition seeks innovative solutions to better predict healthcare outcomes*

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.



137

# Pressure On The Independent ECP




These pressures create an opportunity for individuals to cut corners, not only in clinical care, but can drive changes in ethical behavior as well



138

# These Pressures Create Challenges

And Regulatory Demands Add Angst & Confusion



139

## Reviewing The Basics



141

# 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



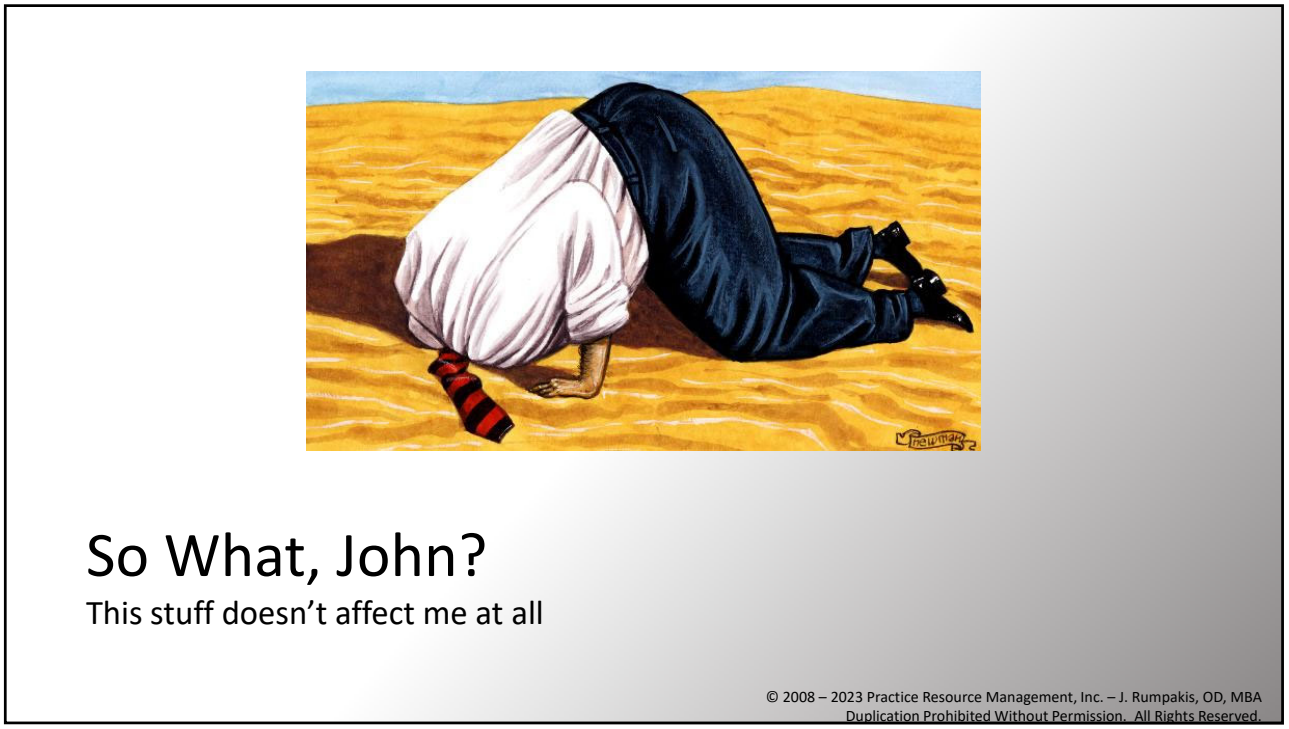
142

# The Big Three Things – The ONLY Three Things




143


144




145

# WTF?

What Are The Facts?



146

What Are We Using As Our Barometer?



147

## What Is Managed Vision Care?

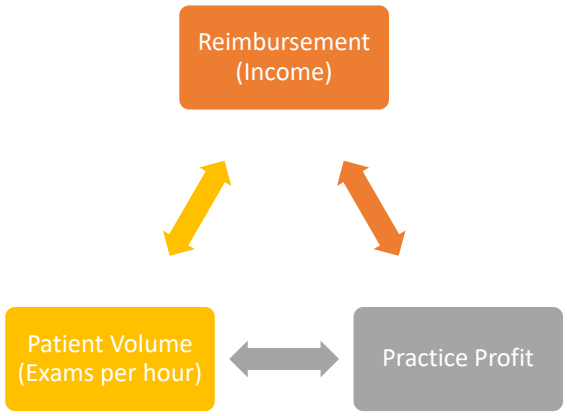
Managed Vision Care = Managed Competition

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



148

## Avoiding The Race To Zero…

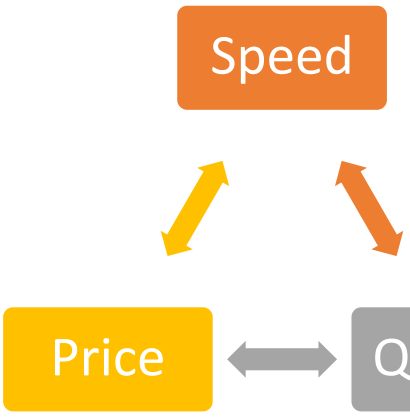





149

## 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



150

## So, Let's Show You How To Get There

By Knowing The Standards Of Coding Compliance & Ethics



153

# But John, I Get So Confused…

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



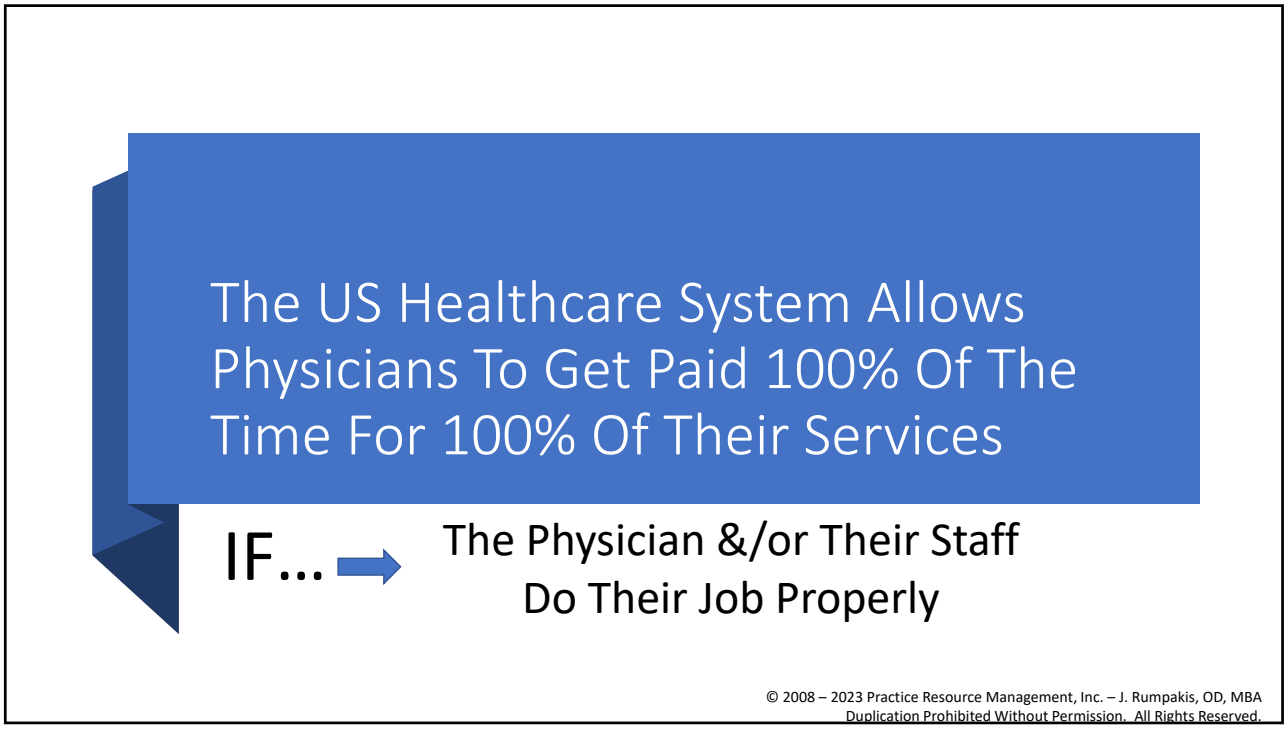
154

# TRANSPARENCY



157


158




159

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

The patient's condition determines everything that you do.

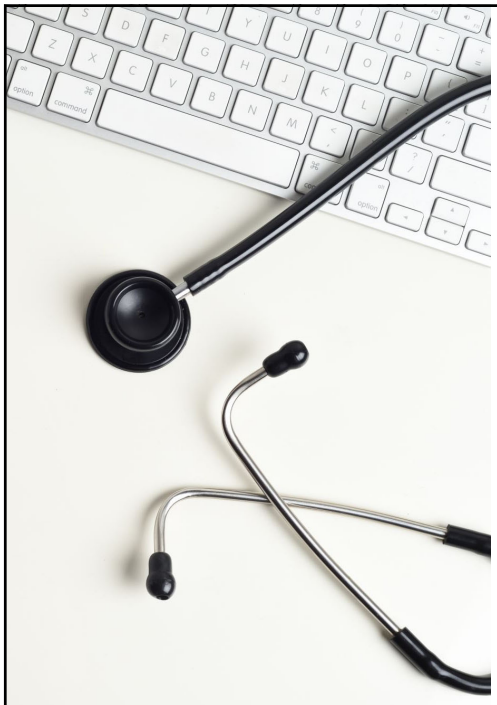
- History that was required understand the patient's complaint
- Exam that was required to properly diagnose the condition
- Assessment of the condition(s)
- Plan to provide the best outcome in the most efficient way that is concurrent with local standard of care

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.



163



## 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.*



164

## 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




165

## What Information Do I Need?

Fully Communicate Expectations To The Patient



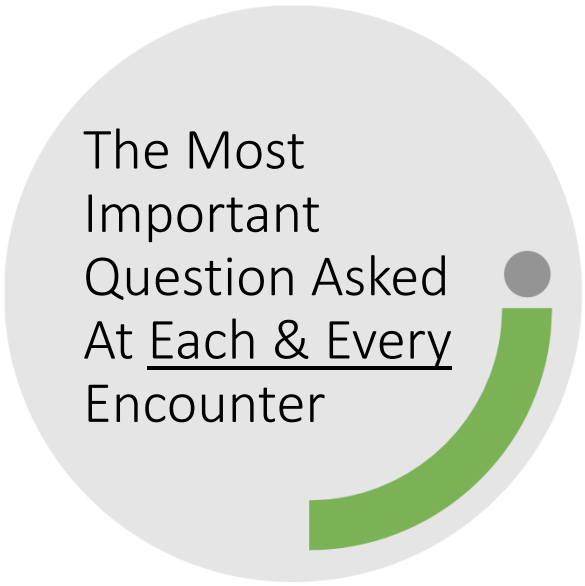
166

# 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



167




Why Does The Patient Need To See The Doctor?

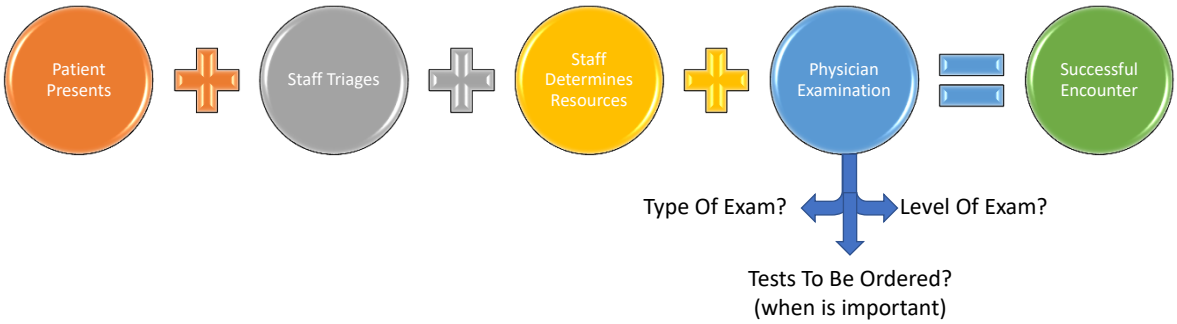
or

Why Are You Bringing The Patient Back?



168

## All Patient Encounters Should Start & End The Same Way






169

## 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



170

## 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



171

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



172

# 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.



173

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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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174

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**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.



175

## 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



176

## 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



177

## Relationship With Payers Accurate Coding and Billing

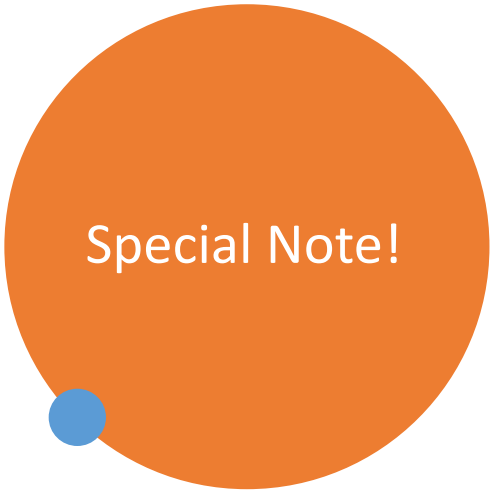
The main issues involved in billing for rendered services include:

**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



178




- 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



179

# "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



180

## 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.



181

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…)



182

## 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."



183

## Who Is The OIG?

The Office Of Inspector General



184

## 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.



185

## 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/



186

# 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



187

# What Is The Current Audit Environment?

Understanding The Carrier Environment Is Critical To Everything



188

# The Government Recovery Is Hitting Records!

HHS.gov — U.S. Department of Health & Human Services

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**FOR IMMEDIATE RELEASE**
**March 19, 2015**

**Contact: HHS Press Office**
**202-690-6343**

## Departments of Justice and Health and Human Services announce over $27.8 billion in returns from joint efforts to combat health care fraud

*Administration recovers $7.70 for every dollar spent to fight health care-related fraud and abuse; third-highest on record*

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, Attorney General Eric Holder and HHS Secretary Sylvia M. Burwell announced today. 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, including programs serving seniors, persons with disabilities or those with low incomes. For every dollar spent on health care-related fraud and abuse investigations in the last three years, the administration recovered $7.70. This is about $2 higher than the average return on investment in the HCFAC program since it was created in 1997. It is also the third-highest return on investment in the life of the program.



189

***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



190

## Dr. Salomon Melgen gets 17 years for defrauding Medicare at least $73M: 5 insights

*Written by Shayna Korol* | February 23, 2018 | Print | Email

South Fla.-based ophthalmologist Salomon Melgen, MD, received a 17-year sentence Feb. 22 for stealing at least $73 million from Medicare, the *SunSentinel* reports.

Here are five things to know:

1. Dr. Melgen was previously convicted of 67 crimes, including healthcare fraud, submitting false claims and falsifying records in patients' files. He has been in custody since his April 28, 2017 conviction.

2. According to the prosecution, he became the highest-paid Medicare physician in the U.S. between 2008 and 2013 by giving elderly patients unnecessary tests and treatments they did not need.

3. Prosecutors argued while any physician could make occasional billing mistakes, Dr. Melgen made too many to be honest. Among other things, he frequently billed Medicare for tests and treatment on the nonexistent eyes of one-eyed patients, and split single-use vials of an expensive eye drug into four doses when there was enough extra medicine in each, billing Medicare separately for each injection.

4. Melgen was ordered to pay $42.6 million in restitution to Medicare; he could be ordered to pay more in the future.



191

United States Department of Justice — Offices of the United States Attorneys

THE UNITED STATES ATTORNEY'S OFFICE
SOUTHERN DISTRICT of TEXAS

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**Department of Justice**
U.S. Attorney's Office
Southern District of Texas

SHARE

FOR IMMEDIATE RELEASE — Tuesday, September 29, 2020

### Laredo eye doctor pays over $3M to resolve fraud claims

LAREDO, Texas - A South Texas doctor has agreed to pay $3,234,900.50 to resolve allegations he fraudulently submitted claims to the Medicare program for medically unnecessary tests and procedures, announced U.S. Attorney Ryan K. Patrick.

Dr. David Mora is an optometrist who owns the Mora Eye Clinic in Laredo.

The U.S. Attorney's Office (USAO) conducted a proactive analysis of claims data and determined Mora to be one of the most significant statistical outliers in the nation for certain categories of claims.

From Jan. 1, 2013, to June 14, 2019, Mora billed Medicare for medically unnecessary punctal plug insertion, sensorimotor testing, vision therapy/orthoptics and amniotic membrane placement. Medical need did not appear to support many of the claims. The patient's condition did not warrant the service or test or many treatments were repeated on the same patient more often than what would be medically reasonable or necessary.

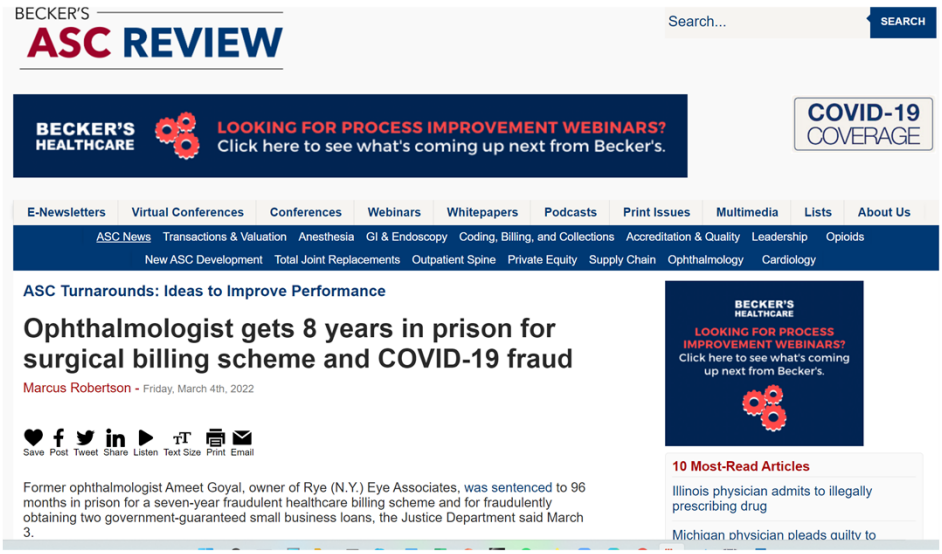
REPORT COVID-19 CRIME
Contact the National Center for Disaster Fraud Hotline: 866-720-5721 or Justice.gov/DisasterComplaintForm

JUSTICE 101

VWA VICTIM WITNESS ASSISTANCE
LEARN MORE



192



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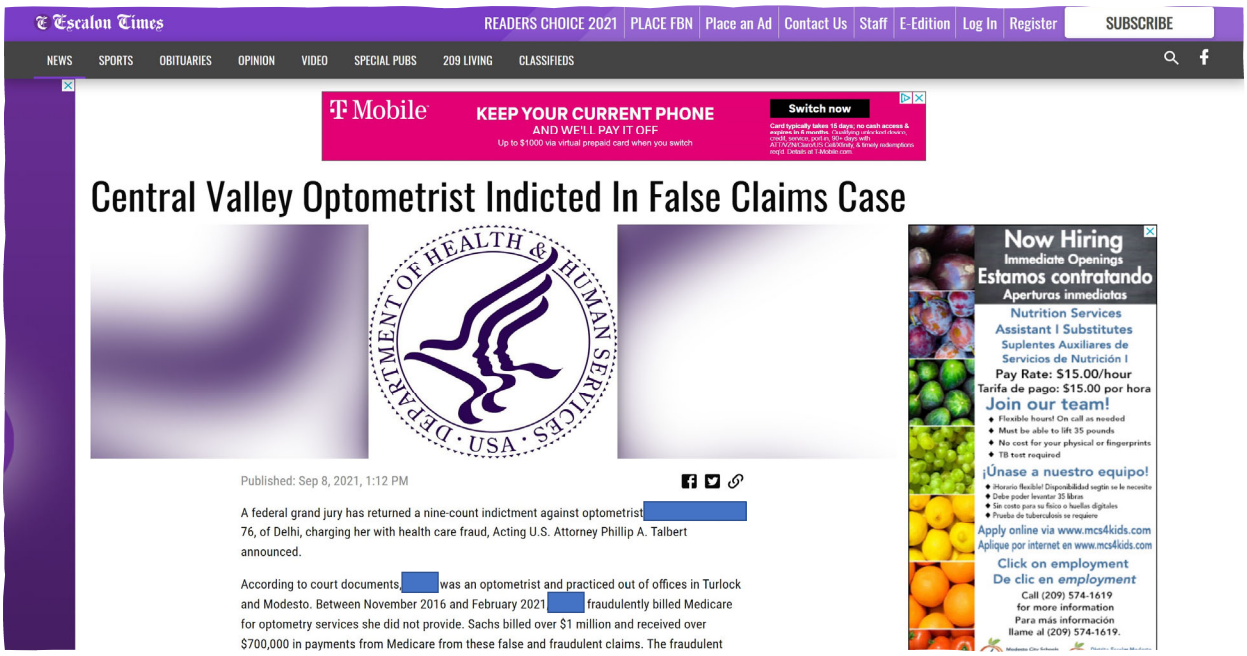
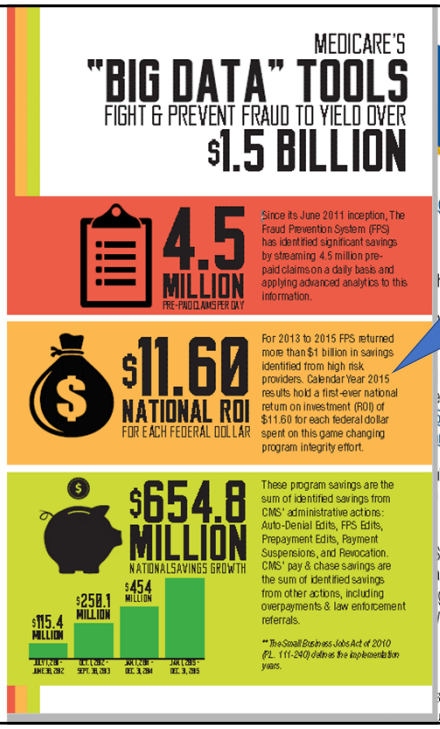





194

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!



195

# Everyone Is Looking To Be Rewarded!




196

## What Is A "Red Flag" That Triggers An Audit?

- 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



197

## 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



198

## 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?



202

There Are Legal Implications Of How You Record Your Encounter

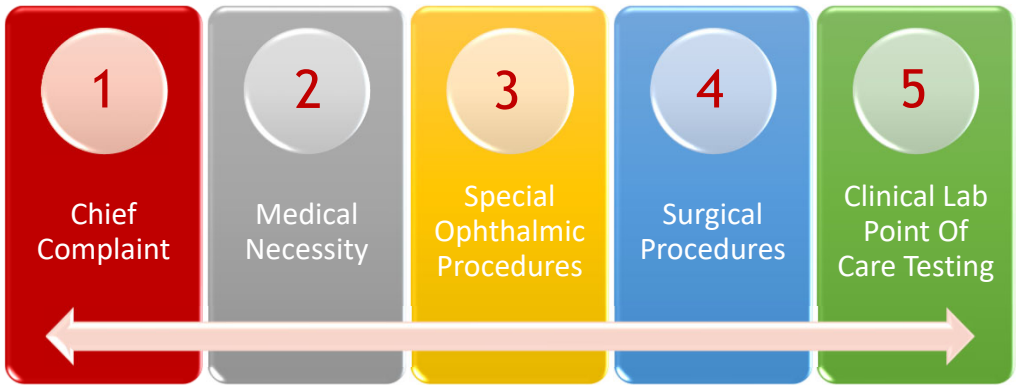
## How You Create Your Medical Record Matters!

What You Write & How You Write It Matters!



203

## The Five Pillars Of Compliance






222

## Things Are Changing So Fast

Knowledge and Compliance Are Absolutely Required

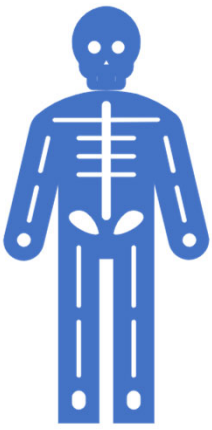


224

# Let's Review Some Basics



225



# 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



226

# Understanding Code Differences

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



227

# 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, 10th Edition | A123.45XX Generally Seven Characters | WHO[2] |



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

228

# Health Care Procedural Coding System (HCPCS)

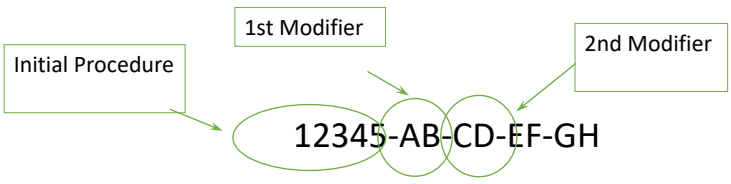
- Level One HCPCS → CPT Procedural Codes
- Level Two HCPCS → Non-CPT Codes for Materials, Services & PQRS
- Level Three HCPCS → Emerging Technology & Temporary Use Codes



229

# 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






230

## Health Care Procedural Coding System (HCPCS)

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




231

## 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."




232

## 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



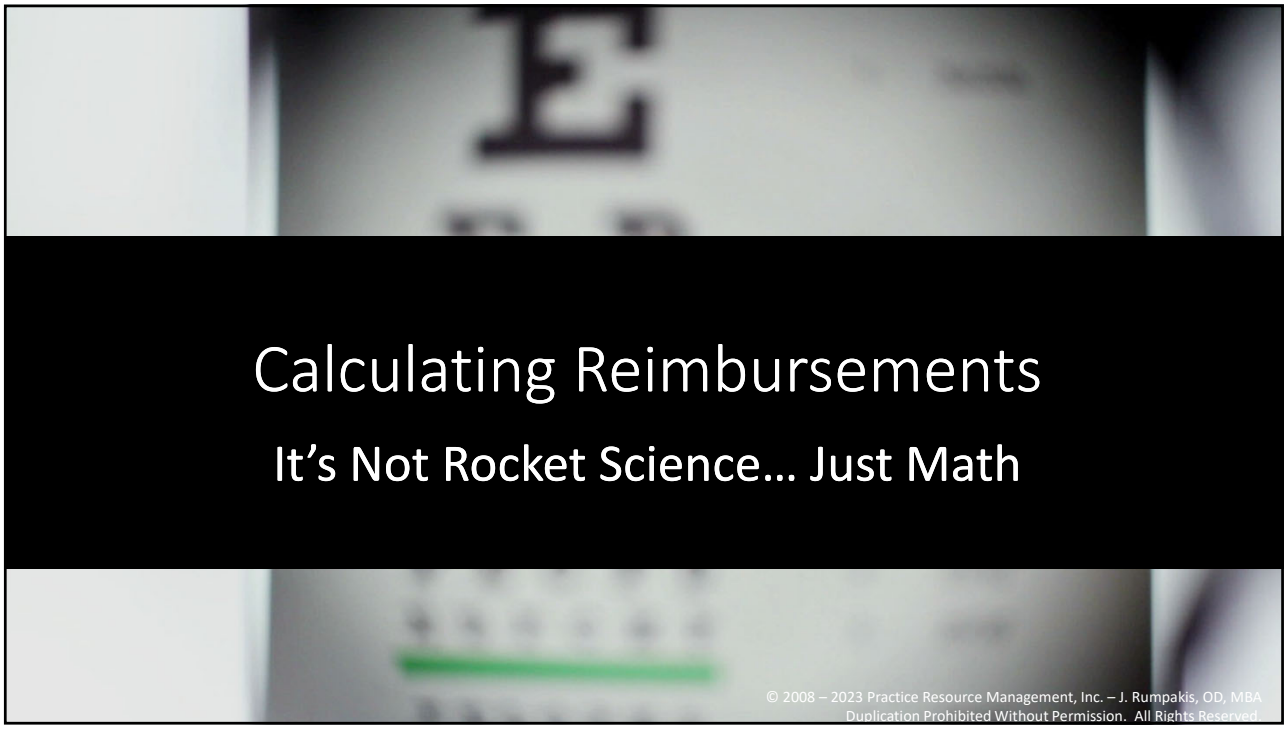
233

## 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



234




235

Procedure Relative Value Units

| 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 |



236

## 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 |



237

## 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



238

# 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



239

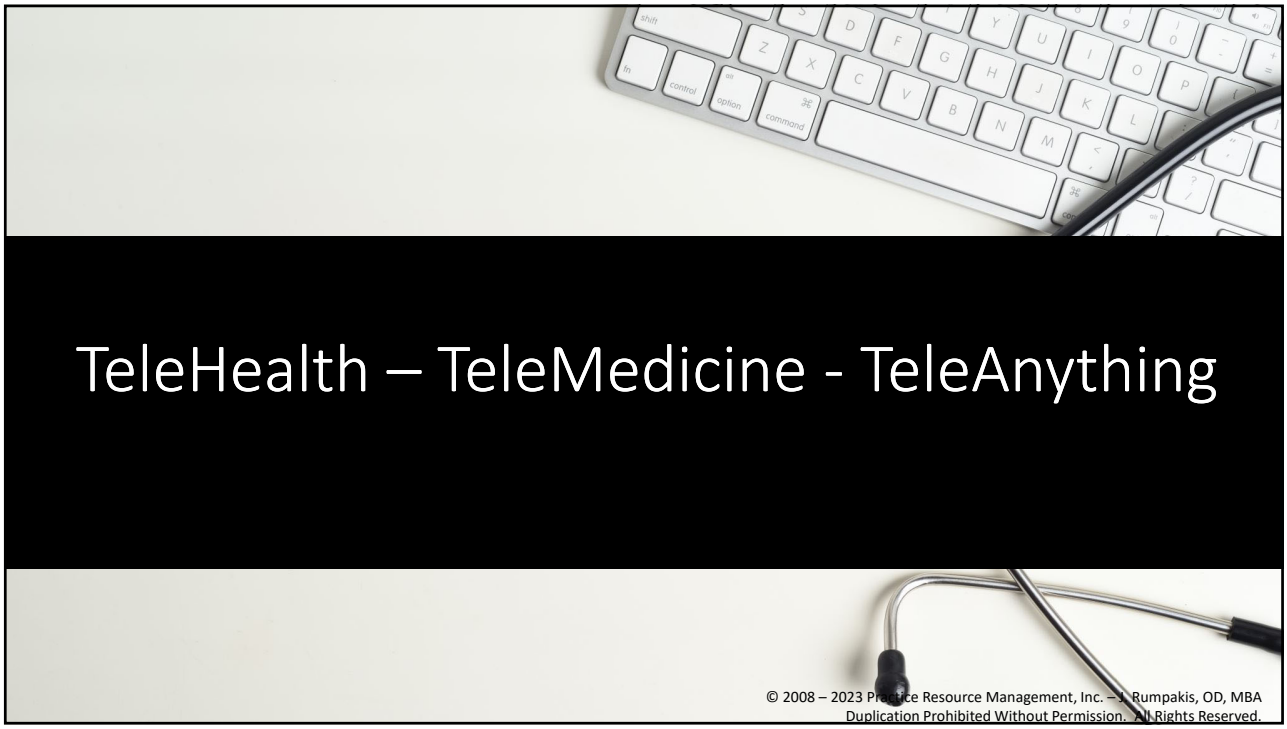
# EOB Issue To Note

CO-223 Claim Reduction Designator Due To SEQUESTER

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



247




248

## Traditional Definition Of Telehealth Services

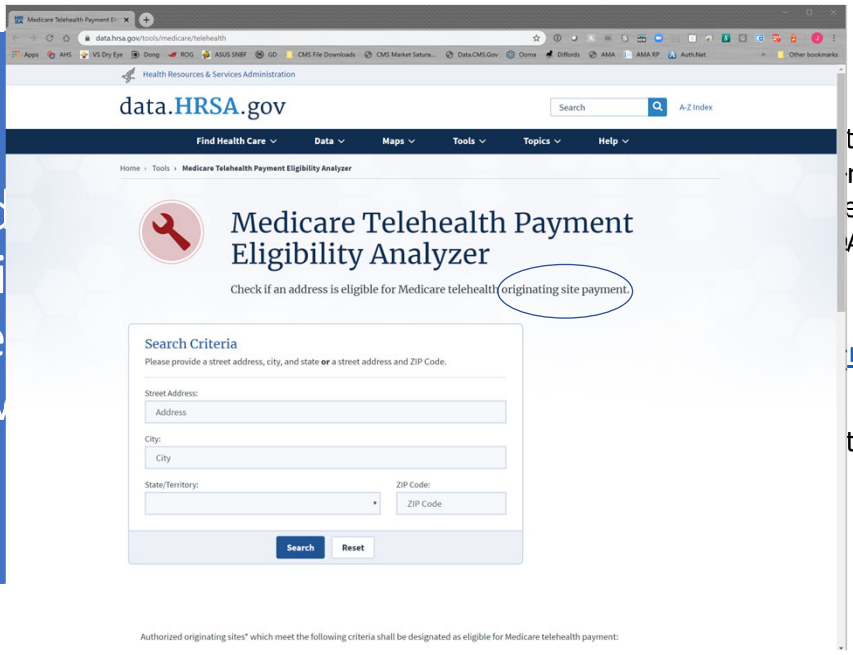
Definitions

- 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



249

## Trad… Defi… Tele… Serv…




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

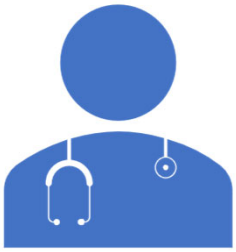
…re/telehealth

…tion of



250

## 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



251

## Traditional Definition Of Telehealth Services

Telehealth Services Consist Of:

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



252

## 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."



253

## 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



254

## 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.



255

## 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.



256

## 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.***



257

## 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.



258

## 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



259

# Unfortunately – Not All Of This Will Stick

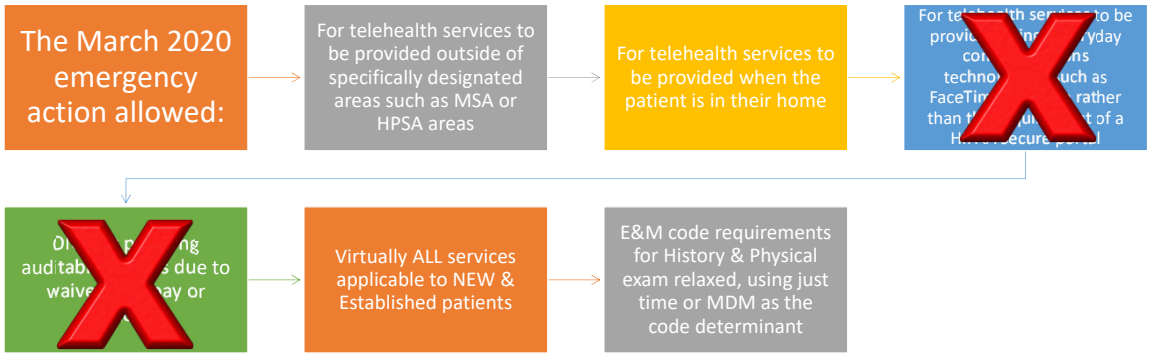
2023 Rules Will Bring Some Revisions Back To Original Posture



261

## CMS TeleHealth ALERT! COVID-19 Emergency Summary

**What Do I Think Is Going To Happen?**



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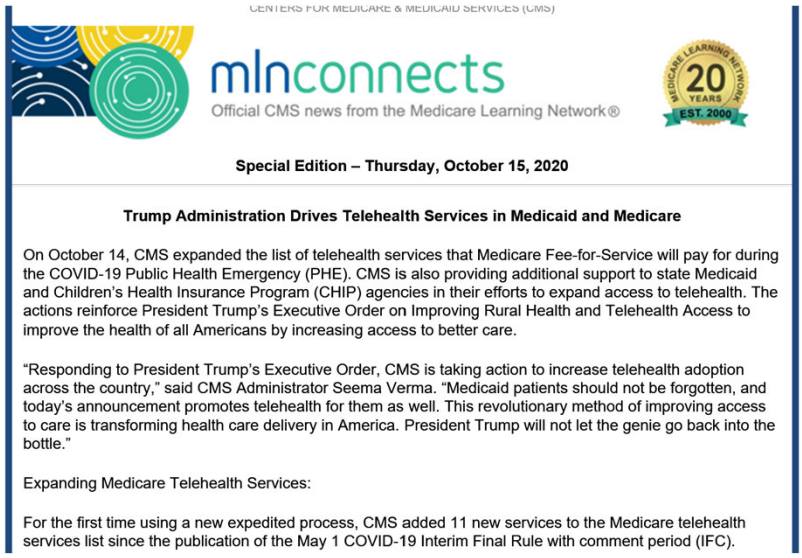


CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

mlnconnects

Official CMS news from the Medicare Learning Network®

20 YEARS EST. 2000

**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).

## TeleHealth Within CMS Is Expanding, But…



263

## 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."



264

# Living In The World Of Telehealth Now

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

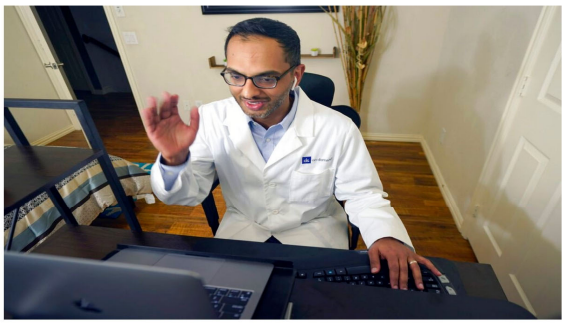


265

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






266

## 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**




267

## Virtual Check In Services



268

## 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



269

## 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



270

## 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



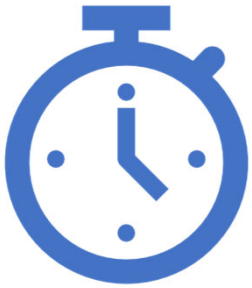
271

## On Line Digital Evaluations



272

## 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



273

## 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*



274

## Telephone Services



275

## 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***



276

## 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



277

## 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



278

# Interprofessional Consults



279

## 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.



280

## 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



281

## 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



282

# Modifiers & Place Of Service Codes



283

## Modifiers

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

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**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: R3929CP — 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 GQ 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

CMS Medicare Learning Network



284

# 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.



285

# 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***



286

| 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

## Telehealth Code Summary During The Public Health Emergency



287

| 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

## Telehealth Code Summary With Time & Modifier Requirements



288

| 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

## Telehealth Code Summary With Time & Modifier Requirements



289

| 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

## Telehealth Code Summary With Time & Modifier Requirements



290

# May 11, 2023 End Of The Public Health Emergency Period

So, What Does That Mean To Us?



291

# 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.

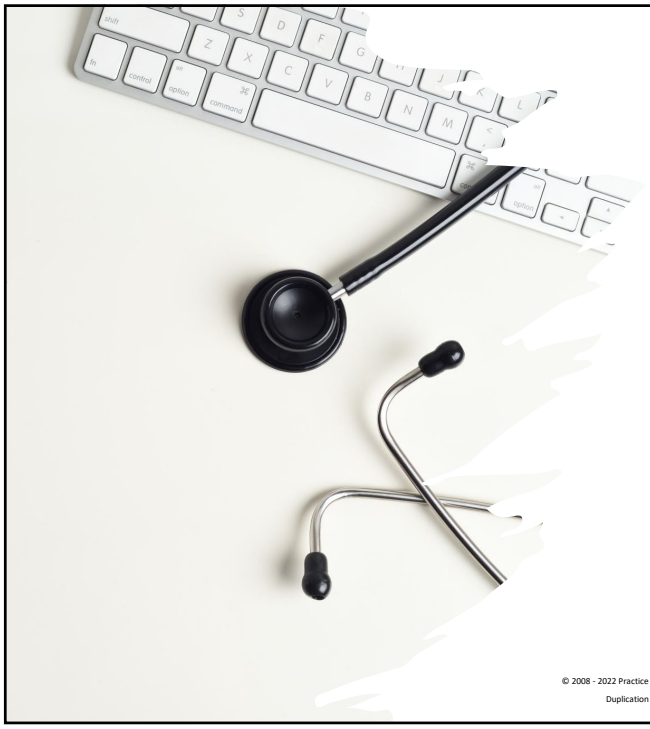


292

- 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.



293



# 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."



294

# Office Visits

Defining The Physician/Patient Encounter

(The #1 Audit Trigger)



295

# 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 |



296

# Why Is It Important To Use The Right Code?

Compliance – Code must match service required & provided

Economics – even small differences in reimbursement are significant



297

# 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% |



298

## 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 |



299

## 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% |



300

# The Routine Eye Examination

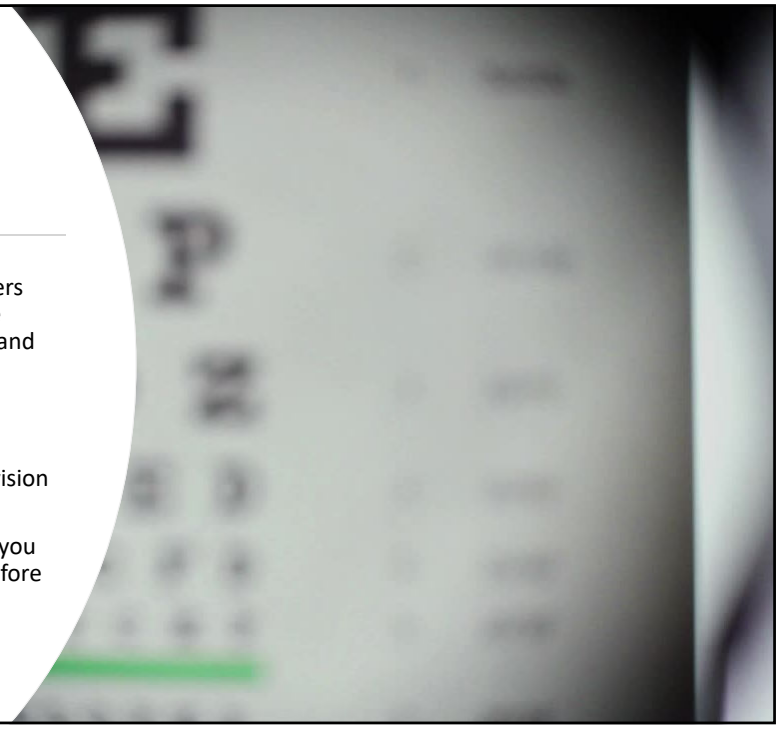
So, What Does "Routine" Really Mean?



301

## 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.



302

# A "S" Code Exam Is NOT A

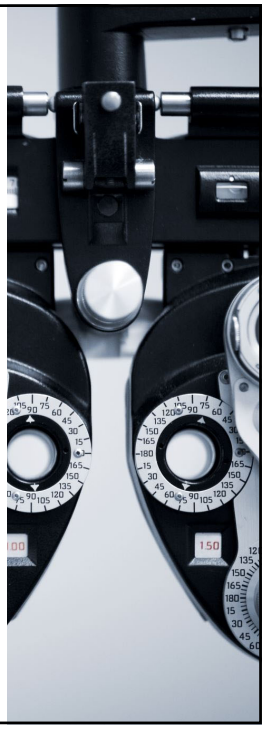
Comprehensive Eye Examination
For Private Pay Patients!



303

## 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





304

# The Ophthalmic Office Visits

## The Comprehensive Exam & The Intermediate Exam



305

## 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."



306

## 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."



307

## The Evaluation & Management Codes - 2020

The Standard In Medicine

A Historical Perspective



308

## Evaluation & Management Coding System

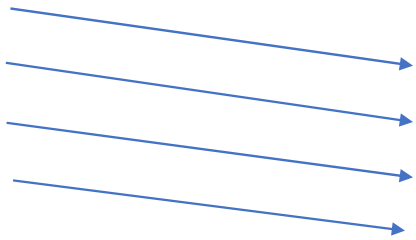
| New Patient | Established Patient |
|---|---|
| • 99201 | • 99211 |
| • 99202 | • 99212 |
| • 99203 | • 99213 |
| • 99204 | • 99214 |
| • 99205 | • 99215 |



309

## Evaluation & Management Coding System

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





310

# 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.



311

# The Big Three Medical Record Elements

| | |
|---|---|
| History | • Four levels of history |
| Physical Examination | • We are single system subspecialists<br>• Four levels of physical examination |
| Medical Decision Making | • Four levels of medical decision making |



312

# 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**



313

# 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



314

# 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



315

# 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

Reference:
1997 CMS Evaluation & Management Guidelines



316

# Scoring A History - PFSH

## Past, Family & Social History

- Patient's Past History
- Family History
- Social/Occupational History

- Problem Pertinent
  - l question
- Complete
  - 2 areas for Est Pt
  - 3 areas for New Pt



317

# 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 |



318

# 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



319

# 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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320

## 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)



321

## Medical Decision Making
## Diagnostic & Treatment Options

- Number of Diagnoses
- Number of Management Options

- 1 is Minimal
- 2-3 is Limited
- 4-5 is Multiple
- 6+ is Extensive



322

## 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



323

## 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



324

# 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 |



325

# 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 |



326

# 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 |



327

# 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 |



328

# 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 |



329

# 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 |



330

## 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 |



331

# Big Changes Came In 2021

These New Changes Uncomplicate Coding!



332

## 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)



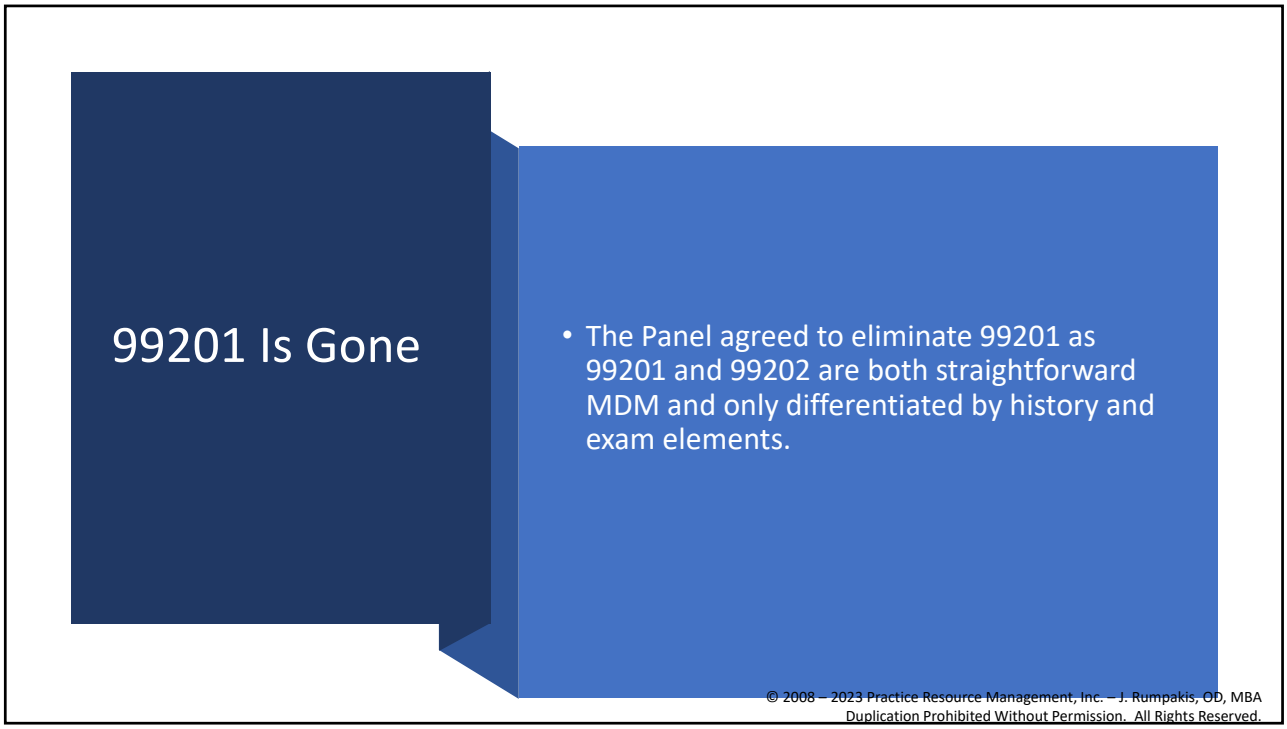
333

## History & Physical Exam No Longer A Factor

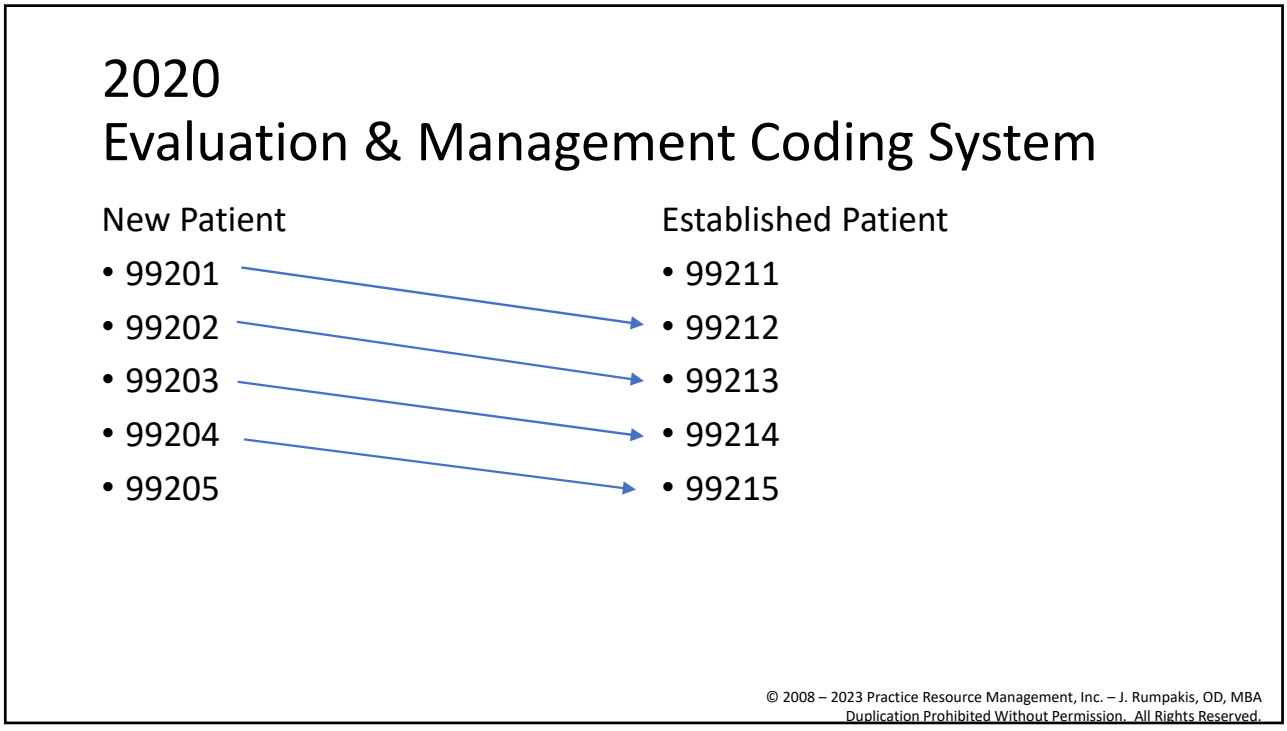
- While the physician's work in capturing the patient's pertinent history and performing a relevant physical exam contributes to both the time and medical decision making, these elements alone should not determine the appropriate code level. The Workgroup revised the code descriptors to state providers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



334




335




336

# 2021
# Evaluation & Management Coding System

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



337

# 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.



338

# 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.



339

# 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.



340

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



341

## 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



342

## New Coding System – By Time (Total Time)

| New Patient | | Established Patient | |
|---|---|---|---|
| 99202 | 15-29 minutes | 99211 | NA |
| 99203 | 30-44 minutes | 99212 | 10-19 minutes |
| 99204 | 45-59 minutes | 99213 | 20-29 minutes |
| 99205 | 60-74 minutes | 99214 | 30-39 minutes |
| | | 99215 | 40-54 minutes |



343

## 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 | O Minutes |

Total Time For Coding Purposes Is 33 Minutes

Which is going to be either a 99203 or a 99214



344

## 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).



345

## 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.



346

# 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**<br>• **1** self-limited or minor problem | Minimal or None | Minimal risk of morbidity from additional diagnostic testing or treatment |



347

# 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**<br>• **2** or more self-limited or minor problems;<br><br>or<br>• 1 stable chronic illness;<br><br>or<br>• **1** acute, uncomplicated illness or injury | **Limited**<br>*(Must meet the requirements of at least 1 of the 2 categories)*<br>**Category 1: Tests and documents**<br>• Any combination of 2 from the following: • Review of prior external note(s) from each unique source*;<br>• review of the result(s) of each unique test*;<br>• ordering of each unique test*<br><br>**or**<br>**Category 2: Assessment requiring an independent historian(s)**<br>*(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)* | **Low risk of morbidity from additional diagnostic testing or treatment** |



348

## 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**<br>• **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment;<br>**or**<br>• 2 or more stable chronic illnesses;<br>**or**<br>• **1** undiagnosed new problem with uncertain prognosis;<br>**or**<br>• **1** acute illness with systemic symptoms;<br>**or**<br>• 1 acute complicated injury | **Moderate**<br>*(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)**<br>• Any combination of 3 from the following:<br>• Review of prior external note(s) from each unique source*;<br>• Review of the result(s) of each unique test*;<br>• Ordering of each unique test*;<br>• Assessment requiring an independent historian(s)<br>**or**<br>**Category 2: Independent interpretation of tests**<br>• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);<br>**or**<br>**Category 3: Discussion of management or test interpretation**<br>• 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**<br>Examples only:<br>• Prescription drug management<br>• Decision regarding minor surgery with identified patient or procedure risk factors<br>• Decision regarding elective major surgery without identified patient or procedure risk factors<br>• Diagnosis or treatment significantly limited by social determinants of health |



349

## 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**<br>• **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;<br>**or**<br>• 1 acute or chronic illness or injury that poses a threat to life or bodily function | **Extensive**<br>*(Must meet the requirements of at least 2 out of 3 categories)*<br>**Category 1: Tests, documents, or independent historian(s)**<br>• Any combination of 3 from the following: • Review of prior external note(s) from each unique source*;<br>• Review of the result(s) of each unique test*;<br>• Ordering of each unique test*;<br>• Assessment requiring an independent historian(s)<br>**or**<br>**Category 2: Independent interpretation of tests**<br>**• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);**<br>**or**<br>**Category 3: Discussion of management or test interpretation**<br>• 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**<br>*Examples only:*<br>• Drug therapy requiring intensive monitoring for toxicity<br>• Decision regarding elective major surgery with identified patient or procedure risk factors<br>• Decision regarding emergency major surgery<br>• Decision regarding hospitalization<br>• Decision not to resuscitate or to de-escalate care because of poor prognosis |



350

## 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.



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)**



352

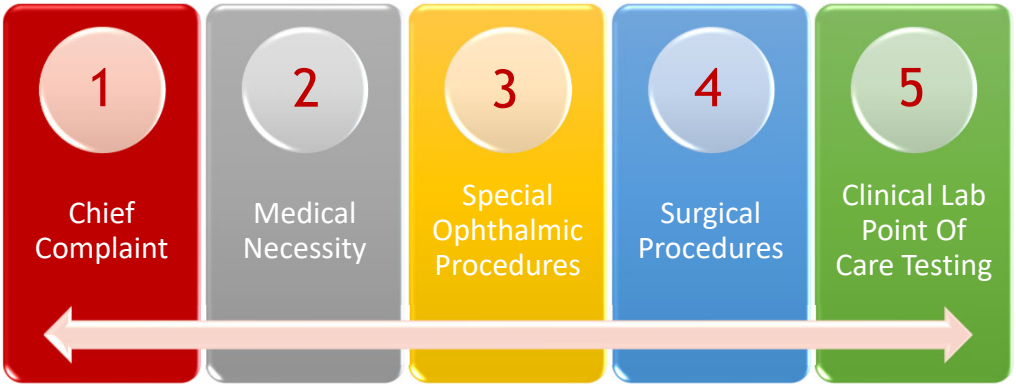
# So What Hasn't Changed At All?

The Requirements That The Medical Record Demands



354

## The Five Pillars Of Compliance



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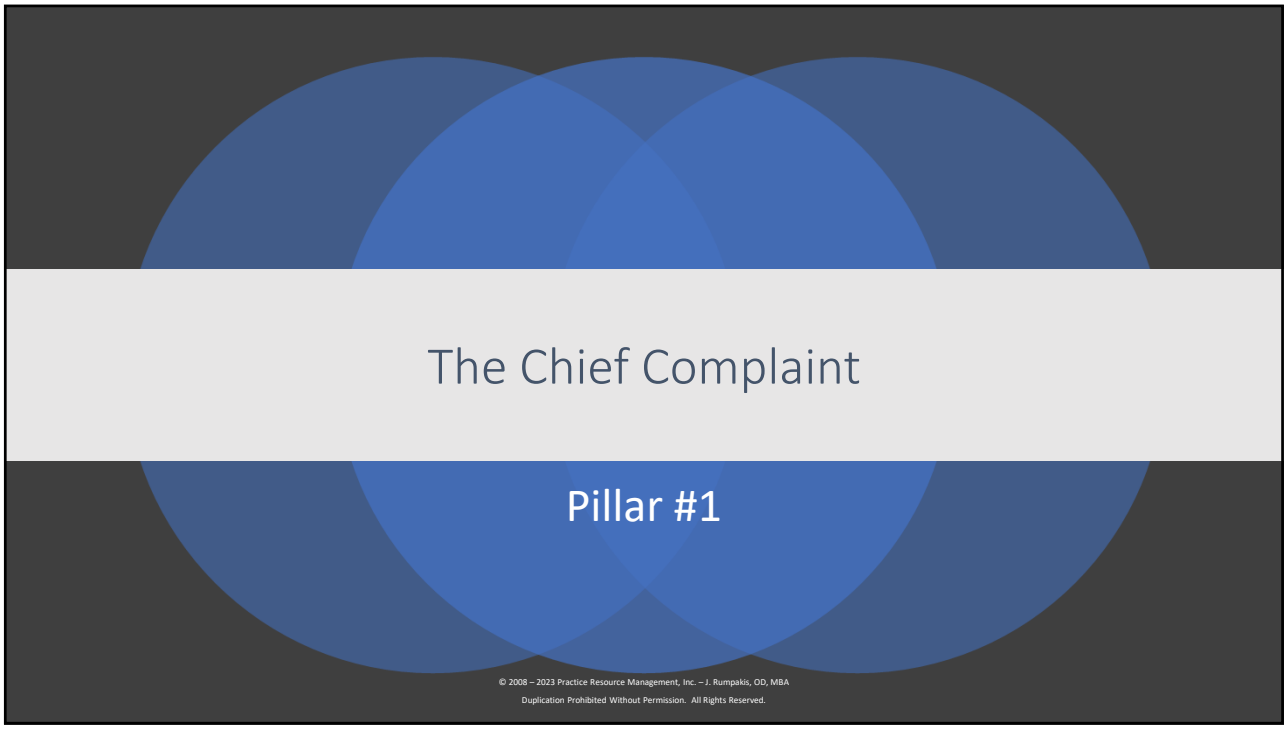



356

## 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."



357

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

Why? - Think Of The Three E's

Education, Expertise, & Experience



358

# 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.



359

## 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?) |
|---|---|



360

## Pillar #1

Chief Complaint →

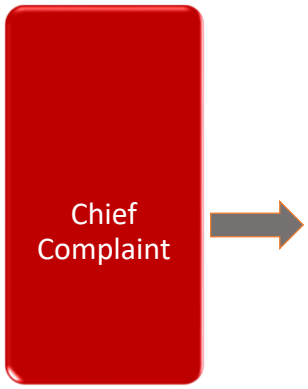
The Medicare Carriers Manual, Part 3 §2320 reads:

"**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."



361

## Pillar #1

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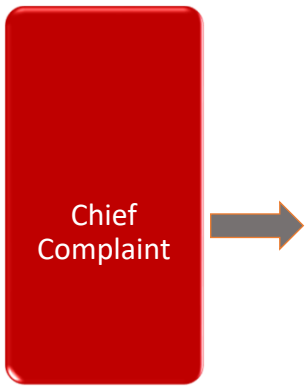
362

## Pillar #1

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363

## 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.



364

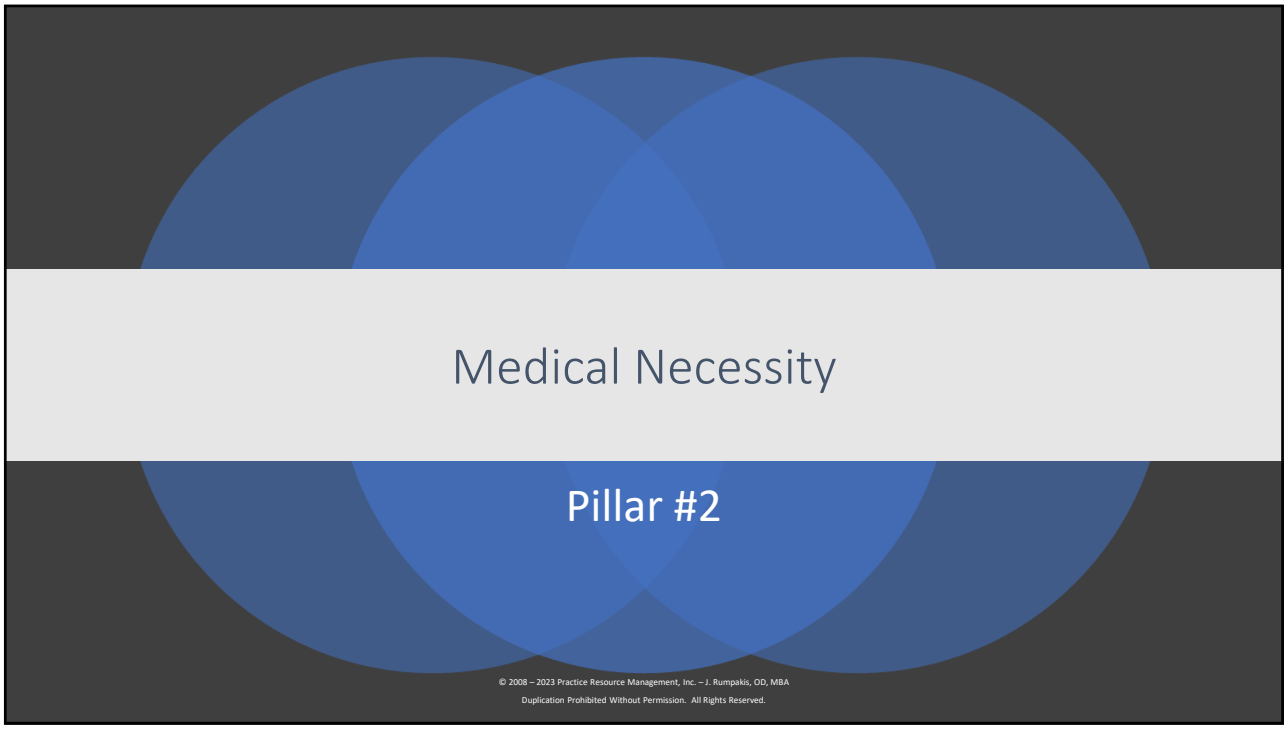
## …Becomes The Chief Complaint For The Subsequent Visit or Encounter

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.



365

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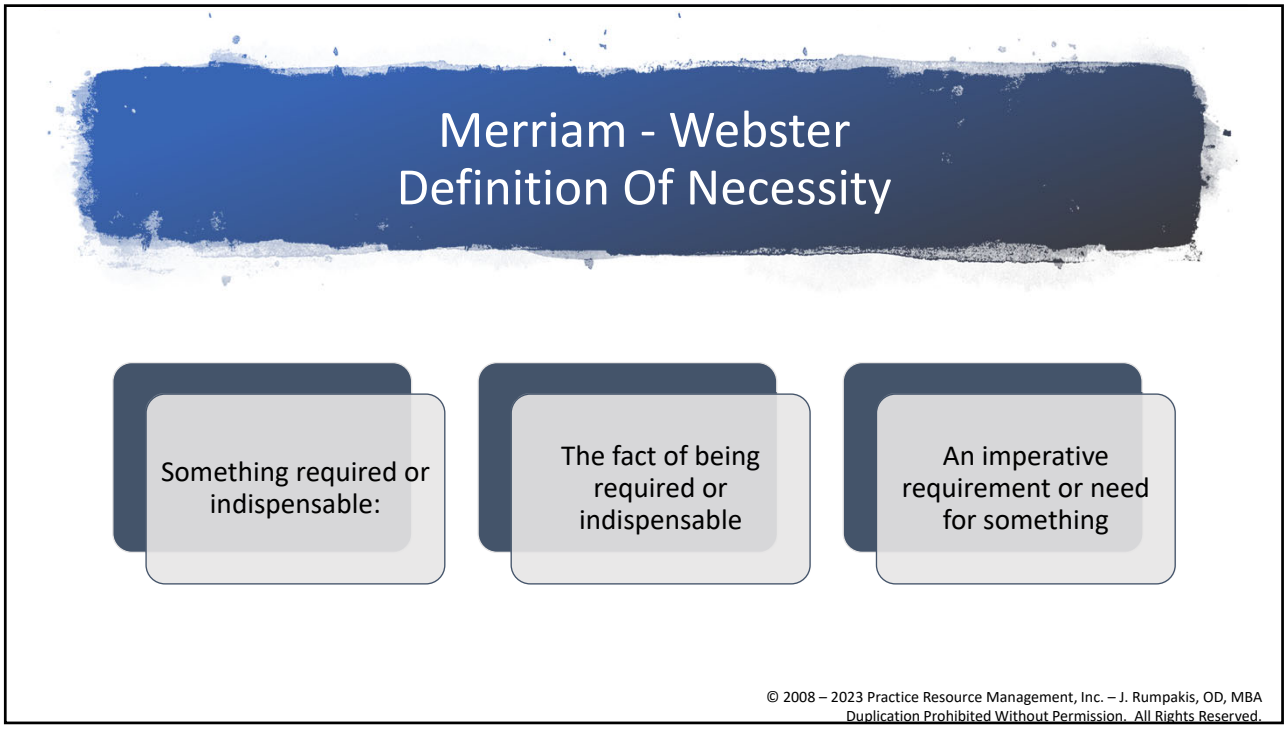



367


368

## Pillar #2

Medical Necessity

CMS Says Medical Necessity IS:
"Services or supplies that are proper and needed for the diagnosis or treatment of the patient's medical conditions, are provided for the diagnosis, direct care and treatment of the patient's medical condition, meet the standards of good medical practice in the local area and aren't mainly for the convenience of the patient or the physician."

John says:
"*The medical record must clearly demonstrate that the service, procedure, or test ordered & performed was absolutely necessary in order to diagnose, treat, or monitor the treatment of the patient's condition.*"



369

## Pillar #2

Medical Necessity

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."



370

## 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



371

# Medical Carriers & Medical Necessity

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



372

## 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.



373

## 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.



374

## 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.



375

## Or What Happens If The Patient Is Paying?

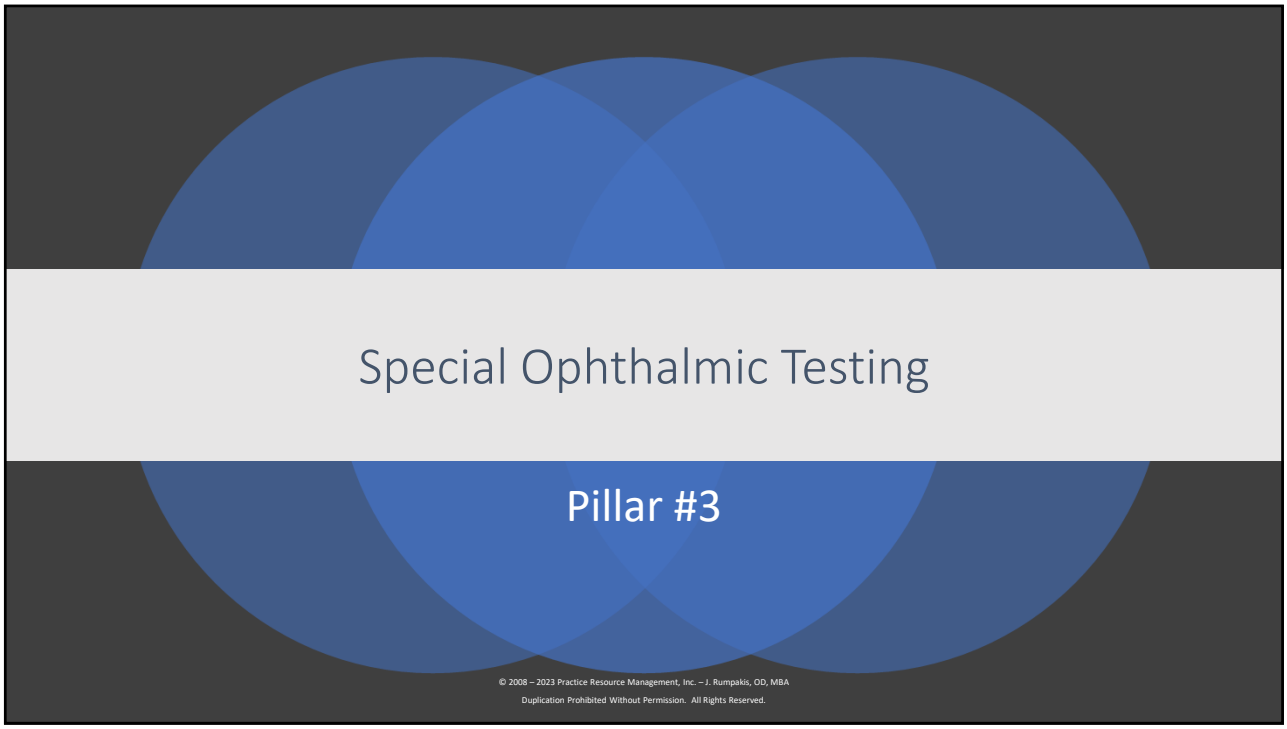
- If the patient is paying out of pocket and it is a separate distinct financial transaction where the carrier is NOT involved (i.e. balance billing), then you are free to do what you and the patient agree to.



376




377




378

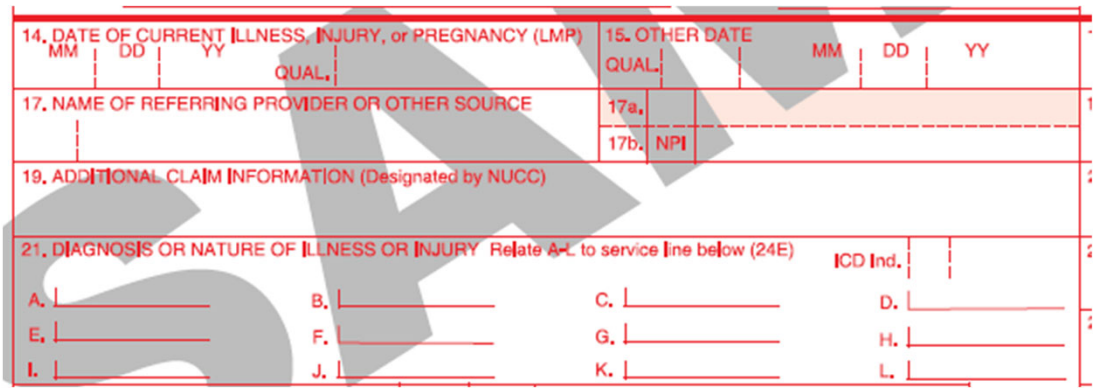
## The CMS 1500 Form

- 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



379

# CMS-1500 Form Detail






380

# 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**

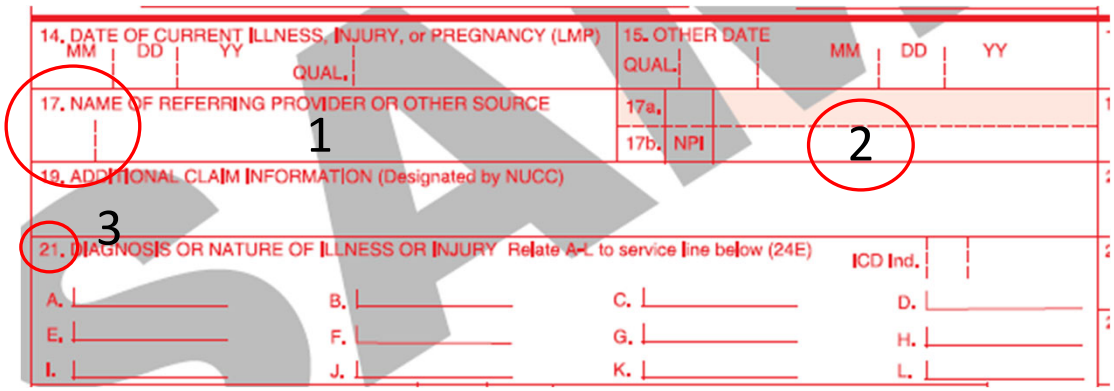
Loop: 2420E - Segment: NM108

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



381

# CMS-1500 Form Detail






382

# 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?



383

## 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.



384

## 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*



385

## 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



386

## 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.



387

# 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?



388

# 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 Code | Reduced Services | Laterality Indicator

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



389

## 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?



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



391

## Pillar #3

**Special Ophthalmic Testing**

**CCI Edits**

National Correct Coding Initiative
These edits are updated quarterly

Developed by:
CPT®
National & Local Policy Edits
National Societies Guidelines
Standard Medical & Surgical Practices

Two different types of edits:
1. Column 1/Column 2 Edits
(formerly called the Comprehensive/Component Edits)
- Component code it is considered to be part of the comprehensive code

2. Mutually Exclusive Edits
- Procedures defined as those which cannot be reasonably performed by a physician in the same patient encounter.



392

## Pillar #3

New ABN Form Now Available & Required For Use As Of June 30, 2023

**Special Ophthalmic Testing**

**Patient Notification**

Two Types Of Pati
Notification
The ABN and NEMB
ABN - Advance Beneficiary Notice (For Medicare Part B)

Medicare Advantage Advance Notice Of Member Responsibility - Specifically For Medicare Advantage Patients

NEMB - Notice Of Exclusion From Medicare Benefits

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"



393

## 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



394

## Pillar #3

Special Ophthalmic Testing

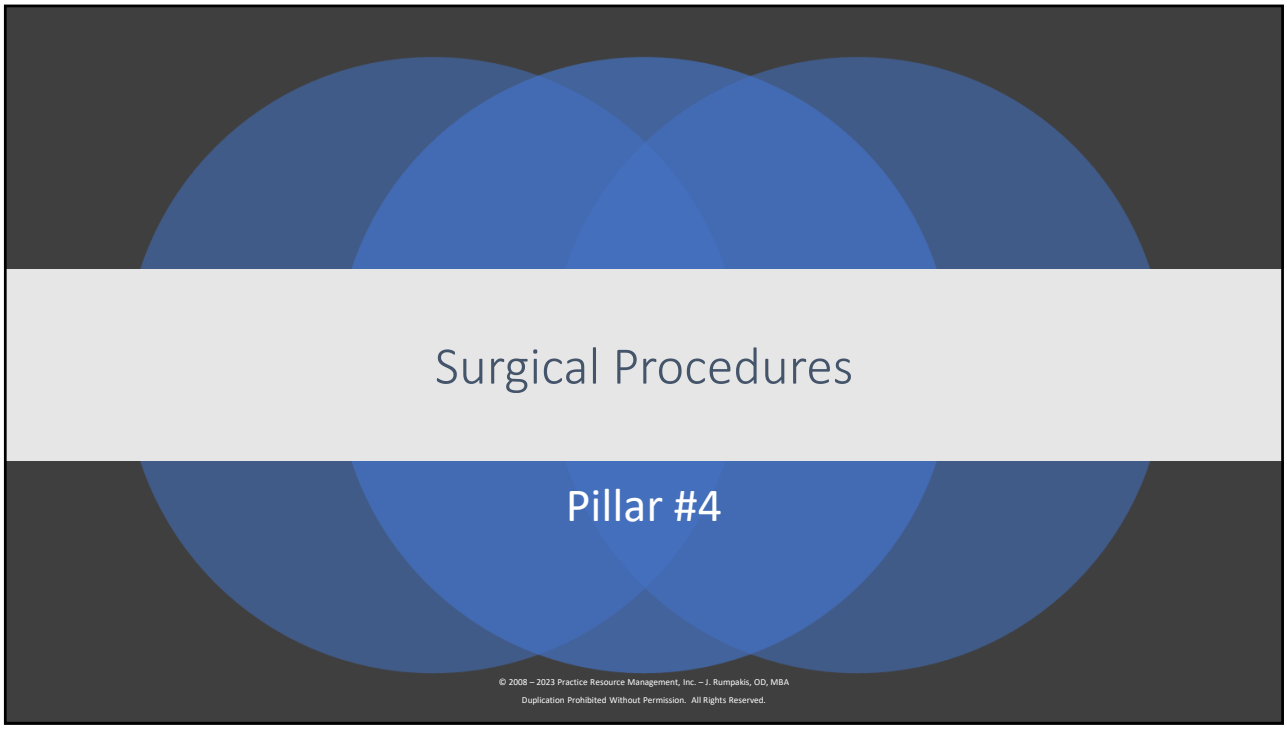
Interpretation & Report

Should Contain:
- Indications for testing
- Whether the test was ordered
- Test reliability
- Test results
  - Comparative findings
  - Plan
- Initiation of diagnostic/treatment plan
- Doctors signature

John Says: Most Carriers Look For The Following On Audit:
- Clinical findings - pertinent findings regarding the test results
- Comparative Data - comparison to previous test results (if applicable)
- Clinical Management - how the test results will affect management of the condition/disease
  - Change/increase/stop medication
  - Recommendation for surgery
  - Recommendation for further diagnostic testing
  - Referral to a specialist/sub-specialist for additional treatment



395




396

## Pillar #4

Surgical Procedures Definition

The services provided by the physician to any patient by their very nature are variable. The CPT codes that represent a readily identifiable surgical procedure thereby include, on a procedure-by-procedure basis, a variety of services. In defining the specific services "included" in a given CPT surgical code, the following services are always included in addition to the operation per se:

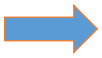
- Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia
- One related Evaluation and Management (E/M) encounter on the date immediately prior to or on the date of procedure (including history and physical)
- Immediate postoperative care, including dictating operative notes, talking with the family and other physicians
- Writing orders
- Typical postoperative follow-up care



397

# Pillar #4

Surgical Procedures Definition



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.



398

# 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



399

## Major vs. Minor Surgery

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



400

## Major vs. Minor Surgery

- Minor Surgery
  - Any surgical procedure that has a global pe… …AN 90 days
- Major Surgery
  - Any surgical procedure t… …al period of EQUAL TO or GREATER THAN 90 days

I Thought These Were Going Away?



401

# Pillar #4

**Surgical Procedures Definition**

-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



402

# 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."



403

# 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



405

# Pillar #4

Surgical Procedures Definition

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



406

## 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.



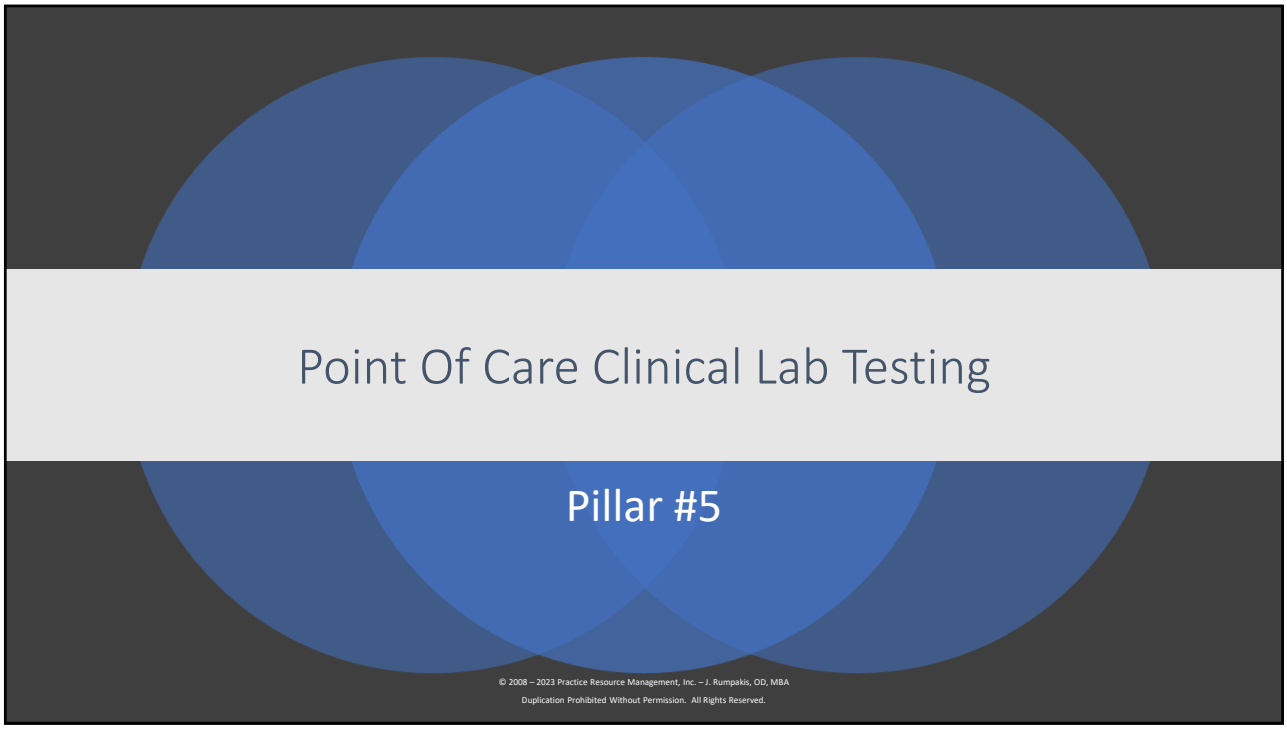
407

## 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



408




411

## 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?



412

# Pillar #5

Clinical Lab Point Of Care Testing

- 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



413

# Pillar #5

Clinical Lab Point Of Care Testing

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"

414

## 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



415

## 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



416

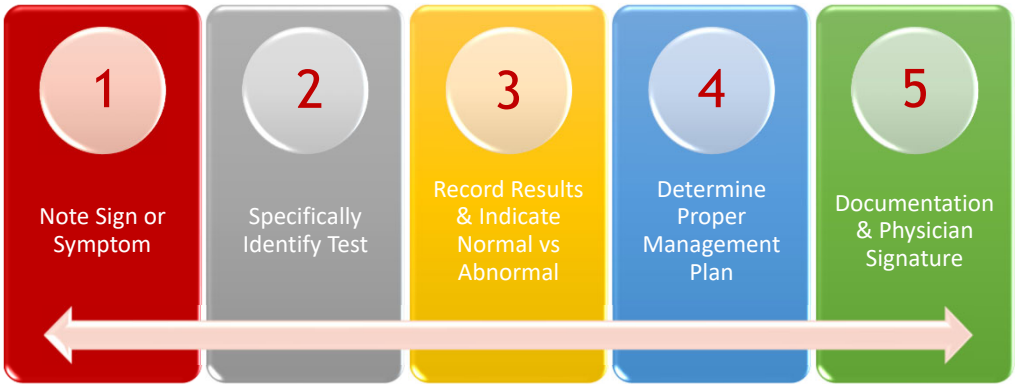
## Inflammation (Quidel-InflammaDry)

- 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



417

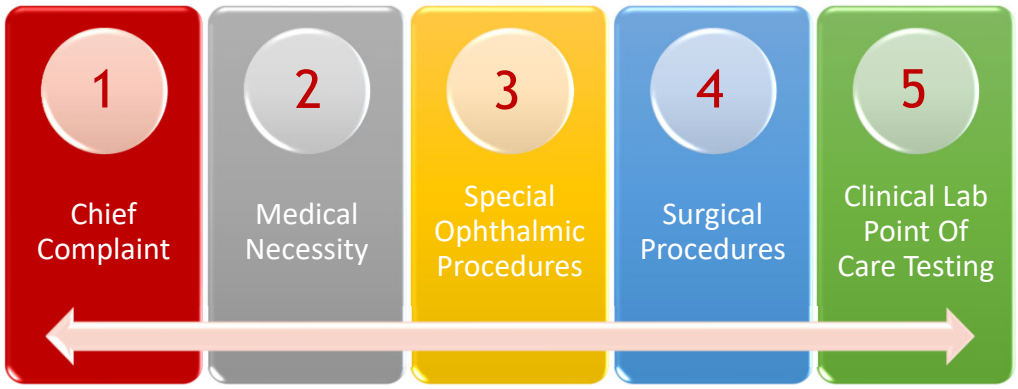
## The Five (Necessary) Steps To Success






418

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





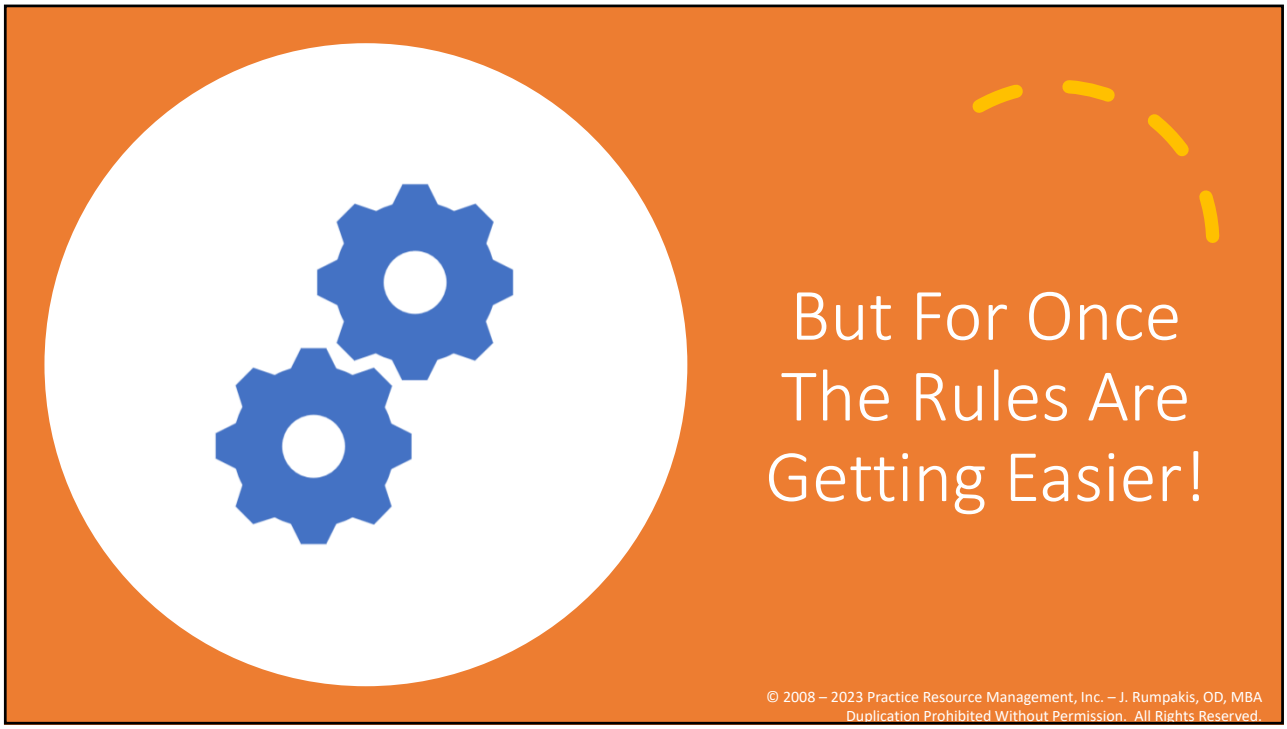

419

## 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



420

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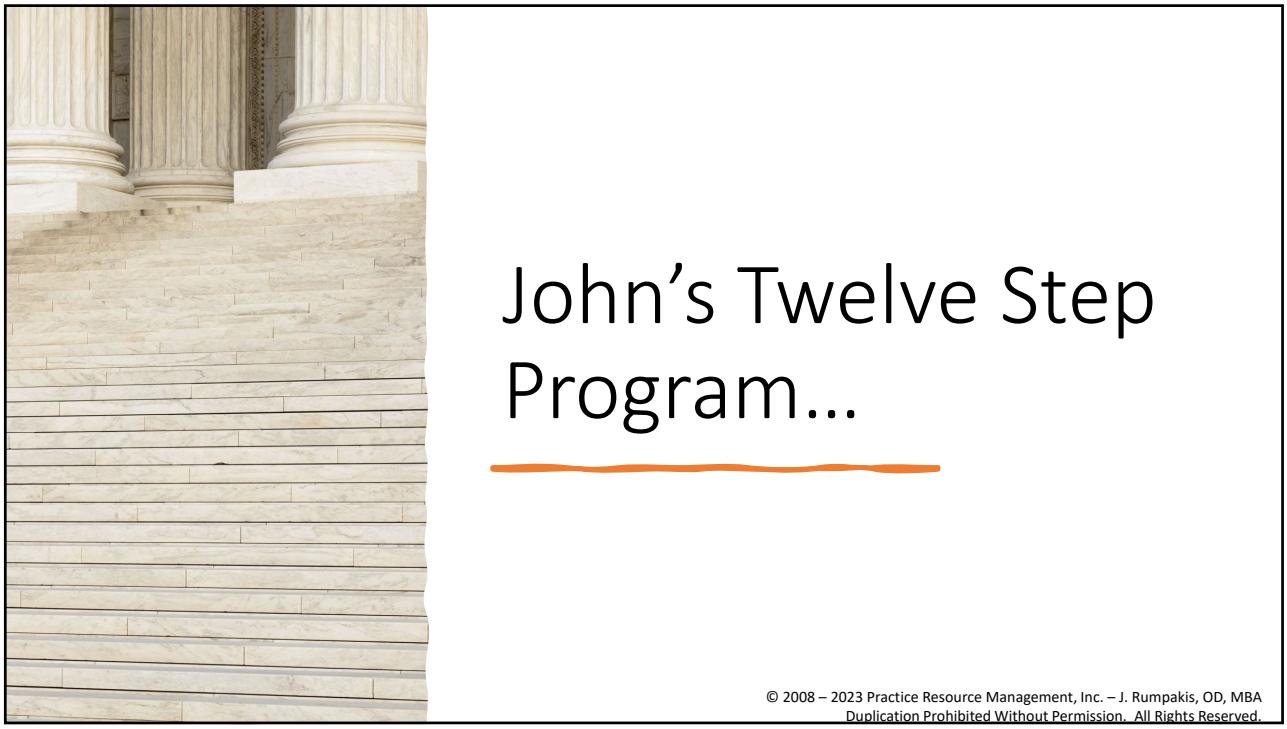



736

## 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



737

## 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



738

## 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



739

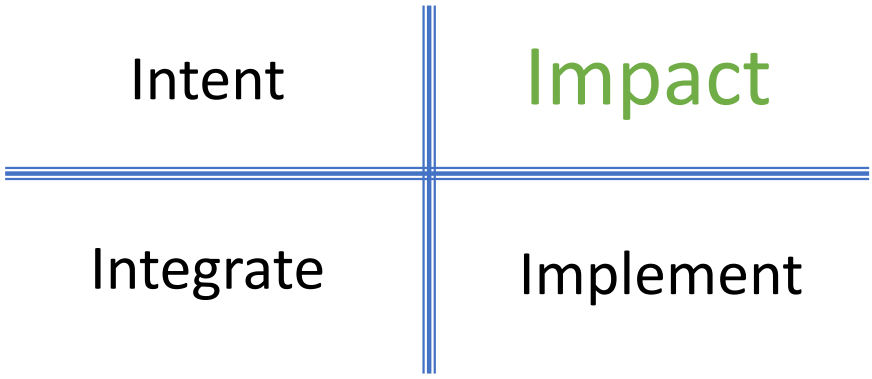
## John's 12-Step Program

- 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!



740

## The Power Of I to the 4th Power






842

## The Independent Practice In The Era Of Health Care Reform

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

John Rumpakis, OD, MBA



844