CORRECT RECORD KEEPING
= CORRECT CODING (AND MORE)- PART II
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IMPORTANT NOTICE
INFORMATION IN THIS PRESENTATION IS CORRECT AT THE TIME IT WAS PRODUCED BUT IS SUBJECT TO CHANGE.

ANCILLARY TESTING
EXAMPLES
• EXTENDED OPHTHALMOSCOPY (92225,92226)
• RETINAL PHOTOS (92250)
• OCT (92132 ANT SEG, 92133 ONH, 92134 RETINA)
• VISUAL FIELDS (92081, 92082, 92083)
• GONIOSCOPY (92020)
• PACHYMETRY (78514 - ONLY ONCE)
• TEAR LAB TESTING (83861 QW)
WHAT'S REQUIRED FOR TESTING

1) WRITTEN ORDER IN CHART W/ DR. SIGNATURE
2) INTERPRETATION AND REPORT DONE BY DR. WITH DR. SIGNATURE

ARE YOU DOING PHOTOS AND SCREENING FIELDS DURING YOUR PRETESTING?

IF YOU FIND AN ABNORMALITY IN THESE TESTS ARE YOU THEN BILLING THEM TO MEDICARE OR MAJOR MEDICAL?

IF YOU ARE - WRONG!!!!!

YOU WILL FAIL AN AUDIT! WHY?

TESTING BILLED AS MEDICAL MUST HAVE AN ORDER

ORDER MUST BE DONE BEFORE THE TEST IS DONE

REMEMBER THAT EHR AND ELECTRONIC TESTING HAVE TIME STAMPS. IF AN AUDITOR CHECKS THAT, YOU FAILED AND MAY BE ACCUSED OF FRAUD
ORDERS

MUST SPECIFY THE TEST AND HAVE SIGNATURE

INTERPRETATION AND REPORT

- MUST BE IN A SEPARATE AREA OF EXAM RECORD
- BE DISTINCTLY LABELED “I & R” FOR EACH TEST
- MUST CONTAIN
  1. DIAGNOSIS (DON’T PUT “NORMAL”)
  2. COMPARATIVE DATA IF DONE PREVIOUSLY FOR THE SAME DIAGNOSIS
  3. CLINICAL MANAGEMENT DETAILS (PLAN)

ORDER EXAMPLE

SCHEDULE FOR VF AND GLAUCOMA OCT NEXT WEEK
T.R. CHEEZUM, O.D.

INTERPRETATION AND REPORT

VISUAL FIELDS

1) POAG - MODERATE STAGE - OS, MILD - OD
2) OD - VF FULL
   OS - SUPERIOR ARCUATE SCOTOMA. STABLE
3) CONTINUE PRESENT MEDICATION (CPM).
   REPEAT VF IN 6 MONTHS
HOW FREQUENTLY TO TEST?

OCT AND VF FOR GLAUCOMA PTS

MILD - ONCE PER YEAR FOR EACH
MODERATE - TWICE PER YEAR FOR EACH
SEVERE - DEPENDS ON LEVEL OF CONTROL
DON'T DO BOTH ON THE SAME DAY AFTER INITIAL DX IS MADE

COMMON MODIFIERS FOR ODs

RT - RIGHT EYE
LT - LEFT EYE
24 - UNRELATED E/M SERVICE DURING POSTOP PERIOD
25 - SEPARATELY IDENTIFIABLE E/M SERVICE ON SAME DAY AS ANOTHER E/M SERVICE
50 - BILATERAL PROCEDURE
52 - REDUCED SERVICES
55 - POSTOPERATIVE MANAGEMENT ONLY
79 - UNRELATED PROCEDURE OR SERVICE DURING POSTOPERATIVE PERIOD
26 - PROFESSIONAL COMPONENT
TC - TECHNICAL COMPONENT

ORDER OF MODIFIERS

MODIFIER AFFECTING PAYMENT SHOULD BE IN THE FIRST POSITION WHEN MULTIPLE MODIFIERS ARE REQUIRED FOR THE CLAIM

EXAMPLE
TEARLAB TESTING
83861 QW RT
QW AFFECTS PAYMENT BECAUSE IT REFERS TO THE TEST HAVING A CLIA WAIVER
**MODIFIER 25 EXAMPLE**

EST PT COMES W/ CC OF FB SENSATION IN OD

YOU DO EXAM TO FIND OUT WHAT IS CAUSING THE FB SENSATION AND FIND AN IMBEDDED CORNEAL FB

OV CODE 92012 - 25

PLUS CODE FOR FB REMOVAL W/ SL

65222 RT

IF YOU DON’T USE THE 25 MODIFIER, YOU MOST LIKELY WON’T BE PAID FOR THE OV CODE.

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**MODIFIERS FOR TESTING**

BILATERAL TESTS DON’T REQUIRE MODIFIERS - VF, PHOTOS, OCT, GONIO

IF YOU ONLY TEST ONE EYE FOR A BILATERAL TEST, YOU NEED **MODIFIER 52** (REDUCED SERVICE) + RT OR LT

MONOCULAR TESTS REQUIRE MODIFIERS TO SHOW EYE(S) TESTED - TEAR LAB, EXTENDED OPHTHALMOSCOPY

POSSIBLE MODIFIERS RT, LT, 50

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**EXTENDED OPHTHALMOSCOPY (EO)**

ONLY BILL IF YOU ARE EXAMINING A PATHOLOGY OR PATIENT HAS SYMPTOMS WHICH MAY SUGGEST A POSSIBLE PATHOLOGY

REQUIRES: 1) **DRAWING** OF AT LEAST 3 INCHES IN DIAMETER - CLEARLY LABELED (BLACK IS OK)
2) **INTERPRETATION AND REPORT** WHICH NOTES:
   - CLINICAL DIAGNOSIS
   - COMPARATIVE DATA (IF NOT A NEW PT)
   - CLINICAL MANAGEMENT

   **I&R SHOULD BE LABELED AND IN A SEPARATE POSITION IN THE RECORD**

3) EXAM MUST BE USED FOR THE MDM FOR THE PT
OTHER EO REQUIREMENTS
1) SHOULD RECORD TYPE OF EXAMINING LENS USED - BIO, CONTACT LENS, 78 D, 90 D ETC
2) RECORD WHETHER SCLERAL DEPRESSION WAS USED
3) REGULAR DILATED OPHTHALMOSCOPY FINDINGS MUST ALSO BE DONE AND RECORDED

EHR AND CLONED DRAWINGS

WON’T PASS AN AUDIT
EHR DRAWINGS - ONLY GOOD FOR SKETCHES AND DON’T MEET MEDICARE DETAIL REQUIREMENTS AND ARE DIFFICULT TO LABEL PROPERLY
CLONED DRAWINGS - CUT AND PASTE A DRAWING FROM A PRIOR VISIT IS CONSIDERED FRAUD

CODING FOR EXTENDED OPH.
92225 (INITIAL) AND 92226 (SUBSEQUENT)
MONOCULAR CODES
REQUIRE A MODIFIER FOR BILLING - RT, LT, 50. ONLY BILL FOR THE EYE WITH A PROBLEM
MAY BILL 92225 MORE THAN ONCE FOR THE SAME EYE IF A NEW DIAGNOSIS IS DETERMINED
DIAGNOSES YOU CAN BILL THEM FOR: MALIGNANT NEOPLASM, RD, RT, RH, SYMPTOMS SUGGESTIVE OF RD (FLASHES/FLOATER), DR, HR, PVD, HEMES, GLAUCOMA, HIGH RISK MEDICATION, AMD ETC.
IS IT WORTH IT? YOU DECIDE BUT DOCUMENT PROPERLY
**RETINAL PHOTOGRAPHY 92250**

Baseline photos of healthy eyes aren't covered by Medicare but may be covered by some independent insurers.

Repeat photos of a diseased eye which do not show progression or a new disease, aren't covered by insurance.

Medicare pts should sign a Notice of Exclusion from Medicare Benefits (NEMB) for screening or preventive medicine photos.

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**CODING FOR RETINAL PHOTOS**

Order and I&R required.

92250 is a binocular code.

92250-52 - (LT or RT) if you only photograph one eye.

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**ICD -10**

Effective 10/1/15.

Several code changes effective 10/1/16.
ICD-10 CODE CHANGES IN 2016/2017

ABOUT 2000 ICD-10 CM CODE CHANGES
APPROXIMATELY 125 NEW CODES FOR OPHTHALMOLOGY

LENIENCY FOR USING UNSPECIFIED CODES ENDED 1/1/2017

ICD - 10 FORMAT

###.#### 3-7 characters
First - letter for category (H00-H59 eye codes)
Second and third - anatomical site
Fourth thru seventh - for more specific description such as laterality, stage or occurrence
Fifth and/or sixth may be an "X" which acts as a "placeholder"
THE EYE CODES
CATEGORY "H" IN ICD-10 CODE BOOK
NOTE THAT THE H** CODES START AT THE FRONT OF THE EYE AND MOVE TO THE BACK OF THE EYE
H00 - EYELID CODES
H16 - CORNEA
H25-28 - LENS
H30-36 - CHOROID AND RETINA

THE "X" PLACEHOLDER
May be upper or lower case when filing
Used to assure that the letter or number after it is in the correct order. Code submitted without it is invalid
Allows for future code additions
H40.62X1 - Steroid induced glaucoma, mild, OS

MAJOR CONCEPTS OF ICD-10
- LATERALITY
- SPECIFICITY
- STAGES
- OCCURRENCE CODES
- ACTIVITY CODES
- LOCATION CODES
EYE SPECIFICS

"Laterality" Codes

##1 = OD
##2 = OS
##3 = OU
##9 = Unspecified (DO NOT USE)

Example: H25.011 = cortical age related cat, OD

Eyelid Codes

##1 = RUL
##2 = RLL
##3 = OD, Unspecified lid (DON'T USE)
##4 = LUL
##5 = LLL
##6 = OS, Unspecified lid (DON'T USE)
##9 = I don't know which eye or eyelid

STAGE CODES

- Unspecified
- Mild
- Moderate
- Severe
- Indeterminate
## GLAUCOMA STAGING CODES (7#)

.##0 = stage unspecified  
.##1 = mild stage  
.##2 = moderate stage  
.##3 = severe stage  
.##4 = indeterminate stage  

Example: H40.1123 = POAG, severe stage, OS

## GLAUCOMA STAGING DEFINITIONS

BASED UPON VF TEST RESULTS

1 = Mild - no VF loss w/ glaucomatous ONH  
2 = Moderate - VF loss only in one hemifield but not within 5 degrees of fixation w/ glaucomatous ONH  
3 = Severe - VF loss in two hemifields and/or within 5 degrees of fixation  
4 = Indeterminate - doctor can't determine nature of VF loss or patient hasn't been tested yet or patient performed poorly on VF test so doctor can't rely on results to arrive at diagnosis

## DIABETES STAGES

ARE DIFFERENT FROM GLAUCOMA STAGES

*1* = Unspecified diabetic retinopathy  
*2* = Mild NPDR  
*3* = Moderate NPDR  
*4* = Severe NPDR  
*5* = PDR
CODING ORDER FOR ACCIDENTS AND INJURIES

1) What - Occurrence
2) How - Activity
3) Where - Location

"Occurrence"/Encounter Codes: used only with S and T codes

.###A = Initial visit

.###D = Subsequent visit

.###S = Sequela - replaces the concept of "late effect" in ICD - 9. There isn't a time limit on sequela

Example: T15.02XA = Corneal FB, OS, Initial encounter

ACTIVITY CODES

Are only used for the initial encounter for treatment

T15.01xA would be appropriate time for this but not for a "D" or "S" visit

Y93 is the general category for activity codes

Others may be found in the "External Injury Index" in the ICD 10 code book.
PLACE OF OCCURRENCE

Are only used for the initial encounter for treatment.

Y92 is the general category for place of occurrence codes.

These are also listed in the External Injury Index of the code book under "Place of occurrence."

“Z” ICD-10 EYE CODES

Z01 "ENCOUNTER FOR OTHER SPECIAL EXAMINATION WITHOUT COMPLAINT, SUSPECTED OR REPORTED DIAGNOSIS INCLUDES: ROUTINE EXAMINATION OF SPECIFIC SYSTEM”

Z01.00 ENCOUNTER FOR EXAMINATION OF EYES AND VISION WITHOUT ABNORMAL FINDINGS

Z01.01 ENCOUNTER FOR EXAMINATION OF THE EYES AND VISION WITH ABNORMAL FINDINGS

LETS CODE SOME CASES
WHICH CPT CODE?

NEW PT
CC: BLURRED VISION OD
HX: COMPREHENSIVE
EXAM: COMPREHENSIVE
DX: DRY MACULAR DEGENERATION OD
PLAN: START AREDS, ORDER OCT, VF (10-2).

MDM IS MODERATE/HIGH - DUE TO NEW DIAGNOSIS
99204 OR 92004 DEPENDING ON HX AND EXAM ELEMENTS

WHICH CPT CODE?

ESTABLISHED PT
CC: BLURRED VA AND GLARE AT NIGHT OU
HX: COMPREHENSIVE
EXAM: COMPREHENSIVE
DX: MODERATE CORTICAL CATARACTS OU
PLAN: REFER FOR OU CATARACT SURGERY
MDM IS MODERATE - DUE TO SURGICAL REFERRAL
92014 CPT REFERRAL IS A TREATMENT PLAN
H25.013 - CORTICAL CATARCTS OU

WHICH CPT CODE?
ESTABLISHED PT SEEN FOR PRESSURE CHECK, VF AND OCT
CC: GLAUCOMA SUSPECT
HX: EXPANDED PROBLEM FOCUSED
EXAM: EXPANDED PROBLEM FOCUSED
DX: MODERATE OPEN ANGLE GLAUCOMA OU
PLAN: BEGIN TRIAL OF WITH TRAVATAN Z.
RECHECK IOP X 2 WEEKS

MDM - MODERATE
CPT 92012 (INITIATE TREATMENT)
92083 EXTENDED VF
92133 OCT OF ONH
H40.1132 MODERATE POAG OU
WHICH CPT CODE?

PT IN PREVIOUS CASE RETURNS FOR IOP CHECK
HX: PROBLEM FOCUSED
EXAM: PROBLEM FOCUSED
DX: MODERATE POAG W/ GOOD RESPONSE TO TRAVATAN Z
PLAN: WRITE RX FOR T-Z
RTC: X 3 MOS FOR IOP AND RETINAL PHOTOS

92012
CHANGE NOTED IN IOP (IMPROVED)
WRITING AN RX FOR THE T-Z NOW (INITIATING TREATMENT BASED ON FINDINGS)
WHEN SEEN IN 3 MOS, IF IOP IS STABLE AND NO CHANGES ARE MADE IN TREATMENT 99213 WOULD BE APPROPRIATE

IMPORTANT POINTS

1) HAVE MEDICAL NECESSITY TO BILL MEDICARE OR MAJOR MEDICAL
2) EXAM ELEMENTS MAY ALLOW YOU TO CHOOSE FROM MORE THAN ONE CPT CODE. PICK THE ONE THAT’S MOST APPROPRIATE
3) DON’T DO MORE “THINGS” JUST TO QUALIFY FOR A HIGHER CODE. JUST DO WHAT YOU HAVE TO DO TO ADDRESS THE MEDICAL PROBLEMS.
ICD-10 CODING EXAMPLES

CASE 1
CC: glaucoma suspect, check IOP and do VF testing
IOPs elevated OU
VF test results: OD shows moderate VF loss
OS shows severe VF loss
Dx: primary open angle glaucoma, severe OS (H40.1123)
      moderate OD (H40.1112)
Tx: Begin Travatan Z trial OU

CASE 2
CC: glaucoma suspect, check IOP and do VF testing
Significantly elevated IOP OU, C/D Asymmetry
VF testing unreliable OU
Dx: POAG
How would you stage this?
H40.1130 (UNSPECIFIED) or
H40.1134 (INDETERMINATE)?
CASE 3

Pt in for annual exam. He has Type 2 diabetes and is currently using insulin and oral hypoglycemics.

Dx: Type 2 DM without ocular manifestations

Tx: 1) letter to PCP
   2) Check x 1 year

E11.9 (TYPE 2 DM W/O COMPLICATIONS)
Z79.4 (INSULIN USE)
Z79.84 (ORAL HYPOGLYCEMICS)

CASE 4

Pt in for annual exam. Has Type 1 DM but reports no problems with vision or control of diabetes.

Findings/Dx: Mild NPDR OU w/o macular edema

Tx: 1) letter to PCP
   2) recheck 6-12 months

E10.3293
PEARL

If you don't know what type of diabetes a patient has, ICD guidelines say you code as if the patient has Type 2 diabetes. Remember to code for the insulin use if documented. (Z79.4)

If pt is using oral hypoglycemics for Type 2, now use Z79.84. If they are also using insulin, code Z79.4 as well.

Diabetes Coding Order (Complications)

First 4 Characters = Type w/ complications

E10.3 (Type 1 w/ complications)

5th Character = Stage

E11.33 (Type 2 w/ Moderate NPDR)

6th Character = w/ (1) or w/o (9) DME

E10.331 (Type 1 w/ Mod NPDR w/ DME)

7th Character = Laterality

E11.3312 (Type 2 Mod NPDR w/ DME OS)

CASE 5

CC: Pt has Lupus and is being treated with Plaquinil (hydroxychloroquine). Referred by rheumatologist for ocular exam.

Dx: Lupus without any evidence of retinal changes from current therapy.

Tx: 1) letter to referring doctor
2) recheck x 6-12 months

M32.9 (LUPUS)
Z79.899 (LONG TERM USE OF OTHER MEDS)
CASE 6

Same pt as in case 5 but they do have an adverse effect from the Plaquenil (hydroxychloroquine)

What do you need to add to your codes from Case 8?

How do you order the codes on your claim form?

M32.9 (LUPUS)
Z79.899 (LONG TERM DRUG USE)
T37.8X5A (ADVERSE EFFECT OF HYDROXYCHLOROQUINE)

IMPORTANT THINGS FOR ICD-10

1) TRY NOT TO USE "UNSPECIFIED" CODES
2) CODE TO THE HIGHEST LEVEL OF SPECIFICITY - EYE, LIDS, STAGE, TYPE (DRY VS WET, CATARACT)
3) CHECK THE CODE BOOK FOR ANY "CODE ALSO", "EXCLUDES" OR OTHER NOTES FOR COMPLETE CODING

WHAT’S COMING NEXT?
PROPOSAL TO END GLOBAL PERIODS

10 DAY PERIODS - 2017
90 DAY PERIODS - 2018

WHY? - CMS FOUND THAT THEY WERE PAYING FOR MORE VISITS IN THE POST OP FEE THAN WERE GENERALLY BEING FURNISHED

99024 - FOLLOW UP VISIT NORMALLY INCLUDED IN GLOBAL PERIOD

ALPHABET SOUP

PQRS
MU
eRX
VBPM
MACRA
MIPS
APM
HEDIS
HCC

NOW COMES MACRA

MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015

1) REPEALED SGR (SUSTAINABLE GROWTH RATE)

2) ESTABLISHED FRAMEWORK FOR REWARDING PHYSICIANS FOR VALUE VERSUS VOLUME

3) CONSOLIDATES EXISTING PROGRAMS - PQRS, MU VBPM INTO MIPS
WHAT HAPPENS TO PQRS PENALTIES

1) MACRA SUNSETS PRIOR PENALTIES FOR PQRS, MU AND eRX

2) CMS WILL NOT IMPOSE 2% PQRS PENALTIES IN 2018 BASED UPON 2016 PQRS REPORTING DUE TO PROBLEMS WITH ICD-10 CODE UPDATES

MIPS

MERIT-BASED INCENTIVE PAYMENT SYSTEM

APPLIES TO MOST ODs

1) CONSOLIDATES PQRS, MU AND VBPM

2) STARTS PROGRAM FOR PAYMENT BASED ON 4 PERFORMANCE CATEGORIES
   • QUALITY - 60% BASED ON REPORTING 6 QUALITY MEASURES INCLUDING 1 CROSSCUTTING AND 1 OUTCOME MEASURE
   • ADVANCING CARE INFORMATION (MU) - 25%
   • CLINICAL PRACTICE IMPROVEMENT -15% CHOOSE FROM 94 OPTIONS FOCUSED ON CARE COORDINATION, PATIENT SAFETY AND BENEFICIARY ENGAGEMENT
   • COST/RESOURCE USE - COMPARED PEERS IN REGARDS TO HEALTH CARE COSTS (NOT USED 2017)

MEASURES START 2017
PAYMENTS START 2019
WHO'S EXEMPT FROM MIPS IN 2017?

1) 2017 IS FIRST YEAR FILING MC CLAIMS
2) BILL LESS THAN $30K TO PART B MC
3) SEE FEWER THAN 100 PART B MC PATIENTS
4) PROVIDER FOR AN APM

2017 MIPS PARTICIPATION CHOICES

1) DON'T PARTICIPATE = 4% PENALTY IN 2019
2) SUBMIT SOMETHING - 1 QUALITY OR 1 IMPROVEMENT MEASURE = 0% PENALTY
3) PARTIAL FOR 90 DAYS - SUBMIT ALL MEASURES = 0% PENALTY OR PARTIAL FEE INCREASE
4) FULL REPORTING FOR ENTIRE YEAR = POSSIBLE 4% FEE INCREASE PLUS UP TO 10% BONUS

QUALITY MEASURE REQUIREMENTS

271 MEASURES TO SELECT FROM
REPORT 6 MEASURES, INCLUDING 1 OUTCOME MEASURE
REPORT THROUGH CLAIMS OR QCDR
EXAMPLES OF QUALITY MEASURES
1) AMD - ANTIOXIDANT COUNSELING
2) AMD - DILATED MACULAR EXAM
3) CLOSING THE LOOP - RECEIPT OF REPORT FROM SPECIALIST
4) DIABETES - DILATED EYE EXAM
5) DR - COMMUNICATE DR TO PCP
6) DR - DOCUMENT LEVEL OF DR AND WHETHER OR NOT THERE IS DME
7) DOCUMENT CURRENT MEDICATIONS

CPIA REQUIREMENTS
GROUPS WITH 15 OR MORE MEMBERS REPORT 4 MEASURES FOR 90 DAYS - ATTESTATION
GROUPS WITH LESS THAN 15 MEMBERS REPORT 2 MEASURES FOR 90 DAYS - ATTESTATION

EXAMPLES OF CPIAs
1) Annual registration in a state Prescription Drug Monitoring program (Opioid Monitoring in states)
2) Use of specialist reports back to referring clinician
3) Assess patient experience through surveys
4) Use of QCDR for various patient benefits
ADVANCING CARE REQUIREMENTS

USE EHR TECHNOLOGY THAT MEETS THE 2014 OR 2015 REQUIREMENTS OR THAT IS A COMBINATION OF THE TWO YEARS

EXAMPLES OF ADVANCING CARE INFO

BASE
1) DO SRA (HEALTHIT.GOV)
2) DO eRx FOR AT LEAST 1 PT
3) HAVE AT LEAST 1 PT VIEW OR TRANSMIT HEALTH INFO
4) CREATE AND ELECTRONICALLY TRANSMIT SUMMARY/TRANSITION OF CARE INFO FOR AT LEAST 1 PT

PERFORMANCE BASED ON HOW OFTEN YOU PERFORM 9 MEASURES (SEE AOA.ORG FOR SPECIFICS)

QPP.CMS.GOV
CHECK IF YOU HAVE TO PARTICIPATE IN MIPS
EXCELLENT RESOURCE AND WORKSHEET
WHAT ELSE IS BEING USED TO MONITOR QUALITY AND COST OF CARE?

COMPARATIVE BILLING REPORTS
COMPARE YOUR BILLING HABITS TO OTHER ODS ON A LOCAL AND NATIONAL BASIS
CURRENT CPT CODES USED
92XXX AND 99XXX
VISUAL FIELD CODES
OCT CODES

CBR WILL BE USED TO HELP DETERMINE QUALITY OF CARE FOR MIPS AND OTHER MEASURES USED TO DETERMINE REIMBURSEMENT FOR YOUR SERVICES
APM
ALTERNATIVE PAYMENT MODEL
TWO CURRENT EXAMPLES
ACO - ACCOUNTABLE CARE ORGANIZATION
MEDICARE ADVANTAGE PLAN

HOW CMS WILL USE APMs
2018 - 50% OF MEDICARE PAYMENTS WILL BE TRANSITIONED TO APMs
PARTICIPATING PHYSICIANS - RECEIVE 5% INCENTIVE PAYMENT EVERY YEAR 2019-2024
AFTER 2026, THE FEE SCHEDULE WILL BE HIGHER THAN FOR NON-APM PROVIDERS

WHAT HAPPENS IN 2019?
APM PROVIDERS - START RECEIVING ANNUAL 5% BONUS
NON-APM PROVIDERS - SUBJECT TO MIPS RULES
FEE SCHEDULE MAY CHANGE BASED ON HOW THEY HAVE DONE WITH MU, PQRS, VBM
HEDIS
HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET

ESTABLISHED BY NCQA:
NATIONAL COMMITTEE FOR QUALITY ASSURANCE

HEDIS IS A SERIES OF APPROXIMATELY 90 PERFORMANCE MEASURES USED TO MEASURE THE QUALITY OF CONSUMER HEALTH CARE PROVIDED BY HEALTH CARE PROVIDERS

HEDIS MEASURES FOR A SPECIFIC PT ARE DETERMINED BY THEIR DIAGNOSIS AND/OR AGE GROUP

DIABETES HEDIS MEASURES
1. HbA1c Testing
2. HbA1c Control (<8%)
3. Eye exam (retinal) performed
4. Medical attention to nephropathy
HOW DO ODs FIT INTO HEDIS?
EVERYTHING IN HEALTH CARE IS NOW BEING MEASURED FOR QUALITY BY INSURERS
PCPs NEED TO MEET THEIR HEDIS REQUIREMENTS OR RISK BEING REMOVED FROM PLANS - NCQA RATES INSURERS BASED UPON THEIR HEDIS SCORES
PCPs NEED ODs TO DO EXAMS AND SEND REPORTS FOR THEIR DIABETIC PATIENTS

HCC
HIERARCHICAL CONDITION CATEGORIES
EXAMPLES
DIABETES, COPD, BREAST CANCER, CHF, ANGINA
HCCs ADDED TO DETERMINE PT HEALTH RISK LEVEL
USED FOR MEDICARE ADVANTAGE PLANS TO DETERMINE FEES PAID TO THEM

 HOW DO ODs FIT INTO THIS SOUP?
• IF YOU DON'T PARTICIPATE, FEES ARE CUT
• ACOs AND MA PLANS NEED ODs TO MANAGE PATIENTS WHO HAVE DIABETES AND GLAUCOMA
• IF YOU DON'T PARTICIPATE, YOU MAY BE RELEGATED TO VCPs
DON'T GET LEFT OUT ACT NOW!!!!!!
ACOs AND MA PLANS MAY NOT HAVE TO ACCEPT ANY WILLING PROVIDER DON'T WAIT FOR THEM TO CONTACT YOU!

DON'T THINK THIS WILL AFFECT YOU?

REMEMBER

- MEDICAL EYE CARE IS BECOMING CRITICAL FOR A PRACTICE TO SURVIVE
- OUR AGING POPULATION WILL BRING MORE MEDICAL EYE CARE TO YOUR PRACTICE
- INSURANCE COMPANIES EVENTUALLY COPY WHAT MEDICARE IS DOING SO THIS WON'T BE ISOLATED TO ONLY MEDICARE AGED PATIENTS

DON'T BE LEFT OUT!

SOME CARRIERS ARE ALREADY SETTING ASIDE LARGE SUMS OF MONEY FOR BONUS PAYMENTS TO THE MOST EFFICIENT PROVIDERS
THANK YOU!