25th Annual Business of Retina Meeting Handout
Booklet

Saturday 01 | HHS OIG Update
Saturday 02 | Lean Techniques for RCM
Saturday 03 | Evaluation of Injectables
Saturday 04 | Washington Update
Saturday 05 | Data-Driven Advocacy
Saturday 06 | Documentation Compliance: Training Scribes and Staff
Saturday 07 | So You Want to Build a Retina ASC
Saturday 08 | What Retina Fellows Look for in a Practice
Saturday 09 | Disaster Planning
Saturday 10 | Implementing DISC to Drive Culture
Saturday 11 | Practice Operational Efficiency
Saturday 12 | Analysis by 3PL
Saturday 13 | Challenges in Patient Billing
Saturday 14 | Cybersecurity: Recovery After a Ransomware Attack
Sunday 01 | Retina Coding for Beginners
Sunday 02 | Revenue Cycle Administrative Burdens
Sunday 03 | Onboarding New Drugs
Sunday 04 | Onboarding New Physicians
Sunday 05 | Synchronous vs. Asynchronous Scribes
Sunday 06 | Internal vs. Outsourced Billing
Sunday 07 | Fundamentals of the Drug Approval Process
Sunday 08 | Working Capital Management in a Retina Practice
Sunday 09 | Financial Planning Strategies for the Small Retina Practice
Sunday 10 | Coding Update
Methods

Peer Comparison: Diagnosis

<table>
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<tr>
<th>Provider</th>
<th>Year</th>
<th>Percent of Beneficiaries Diagnosed with 362.52</th>
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Peer Comparison: ICG

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Peer Comparison: Laser

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Case Example: Annete Deatherage

- 1st visit: 4/21/2009
- Immediately given bilateral FA and ICG
- Immediately diagnosed with wet AMD
- Laser photocoagulation at 1st visit
Exam note
Shows drawing of macular disease in left eye and laser treatment is advised

Initial Visit
Laser form
One Month Visit

- Examined by three other ophthalmologists and expert witness
- One – just before Dr. Pon: 20/25 and 20/30 vision and “one drusen”
- One: July 2009: No wet AMD, no scars
- One: Nov. 2009: No wet AMD; no scars
- Expert: “No laser, no CNV, No wet AMD on any image”
- Patient: Scared; never told wet AMD by Pon – Secretary told on phone when examine file

Two Month Visit

Same Patient

- Examined by three other ophthalmologists and expert witness
- One – just before Dr. Pon: 20/25 and 20/30 vision and “one drusen”
- One: July 2009: No wet AMD, no scars
- One: Nov. 2009: No wet AMD; no scars
- Expert: “No laser, no CNV, No wet AMD on any image”
- Patient: Scared; never told wet AMD by Pon – Secretary told on phone when examine file
Pitfalls

- You are everyone’s first line of defense
  - Red flag diagnoses
  - Failure/resistance to provide medical records
  - Inconsistent info
  - Outdated procedures/Impossible procedures
  - Aberrant Dx testing regimen
  - Exaggerate severity – esp. with diabetes
  - Excessive lasers in a time of Anti-VEGF
  - Unapproved anti-VEGF drugs from overseas

- Most of the time – stand alone single MD practice – no checks and balances

Pitfalls

- “Telemedicine” companies
- Stem cell Tx/Regenerative Medicine
- Stark/Kickbacks
- Amniotic membrane treatment w/o prior Tx
- Most of the ophthalmologist we see - cataract or glaucoma
  - Falsify cloudiness or ocular pressures
  - Unnecessary lens replacement
  - Easy to maintain good pressures when no disease
Modifier 25

- Has to be (1) Significant and separately identifiable, and; (2) More complex than 99211
- Since surgical proc. – global periods – 67028
  - Global period = 0 days
- Since surgical code – pre and post-op Tx related to 67028 not applicable – only intra
- Often means a different dx, although esp. in ophthalmology not 100%

Questions to honestly ask oneself:
- New Dx or just management of existing one?
- Is the surgical code (67028) already scheduled or is exam necessary to est. if needed
- Can the tx with the -25 modifier be separated out from re and post-op of surgical code with reasonable ease?
- Just like law – reasonableness and articulation
- Different levels of scrutiny – audit v. civil v. criminal
Lean Techniques for Revenue Cycle Management (RCM)

Alan Kimura, MD, MPH - Past President, Colorado Retina, Retina Consultants of America
Daniel Maher - Director of Payor Strategy & Population Health, Retina Consultants of America
Nicole Smith - Director of Operations and Integration, Retina Consultants of America

March 9, 2024

Financial Disclosures

- RetinAI – Consultant
- Johnson & Johnson – Consultant

Genesis of Our Lean Journey:
Finding Problems, Fixing Processes

#1 Pt c/o ~ Wait Times  #1 Burnout ~ Admin Tasks
Sharing Our Experience With Lean to De-Risk Your Journey 2017-2024…

Lean = Eliminate Waste!
6 Domains of Waste in US Healthcare

Administer complexity

~ 25-30% of Spending is Waste!
~ $256B Waste from Administrative Complexity
Commitment to Continuous Improvement
From Top-to-Bottom

- Health system leaders can capture value by being nimble and failing fast when required, adjusting rapidly and pursuing opportunities as they arise.----and drawing for the long term by building the technology foundation to enable automation, analytics, and---when it’s ready---gen AI.

- Leaders from within the revenue cycle function at will to spot opportunities, and a mindset of iteration and continuous improvement in rapid feedback cycles.

- Success = Opportunities to Improve + Redesign of Processes
  - Opportunity = Rejected Claims
  - Process in Need of Redesign = Revenue Cycle

- However, a Departure from Default Position!
  - Short-term thinking of “Managing” Denials instead of Preventing them
  - Long-term Thinking --- Identify Root Causes

- Pareto Principle (80/20 Rule)
  - Requires Coordination Across the Organization
  - RCM Cannot Continue to Be a Siloed Activity
  - Standards
  - "Structured" Documentation
  - Pre-Visit Prep, Call Center & Front Desk
  - Paper Contracting Teams

- Ultimately leading to improved Stakerholder Collaboration + Predictive Analytics

Revenue Cycle

The "Current State" of Denied Claims

Lean Works for Health Care

- Conceptual Leap: Assembly Line → Healthcare Delivery → RCM
- Lean Tools Make Clinical Processes More Efficient
- Value-Stream Mapping (VSM): Red & Eliminate waste
- A3 Template & Plan-Do-Check-Act (PDCA): Structured Problem Solving
- Standard Operating Procedures (SOPs) = Output from PDCA Cycle
- Investments in Lean Pay for Itself + "Life Gets Better"!
- Less Stressed! Patients, Staff, and MDs
- Gain Time Back: Reboot & Reconnect (Reduce Burnout)
- Quality & Safety: Reduce Medical Errors & Patient Harm
- Pays for Itself! See More Patients, Every Day Thereafter…!
“I Don’t Have Time For This!”
“Change is Hard and Scary!”
“Where Would I Even Start?”

“Problems cannot be solved at the same level of awareness that created them.”
**attributed to Albert Einstein**

“WAIT!!!
Gimme a second.”

Making the Case for Structured Problem-Solving

Structured Problem-Solving: S.O.A.P. Charting

Structured Problem-Solving of Lean:

PDCA Cycles, SOPs Consolidate Gains
Value-Stream Mapping of Retina Clinic

Check in

MD Visit, MD/NA conversation, function

Check out

A3 Template + Plan-Do-Check-Act Cycle Embedded Within

A3 Template: Retina Clinic Bottleneck

Patient-Centricity = Major Health Policy Meme
Summary

- Reframe: Visualize a String of Process Steps
- Lean’s Structured Problem-Solving Tools
- A3 Template + PDCA Cycle + SOPs
- Collaboration Improves Creativity
- Discipline Prevents You From Leaping to the First Solution

Lean Culture: Lean Thinking is Invisible
- Are You Allowed to Even Name the Problem?
- “Mistakes” Occur in Any Creative Process, But Continuous Learning Improves the Organization
- Inertia of Status Quo → Continuous Improvement
- Lean is Fungible → Apply to Revenue Cycle Management...

Examples of Waste - RCM

- Time
  - Manual spreadsheets vs. automated tasks
  - Failure to identify root cause issues
    - Example: consolidate and categorize all denial codes
- Money
  - Failure to utilize system functionality you are paying for
  - Postage in lieu of automated payment notifications
  - Processing virtual credit card payments instead of EFT
    - Example: Credit card fees and time
- Duplicative work
- Multiple people touching the same claims
A3: Exercise 1

Reducing DOS/DOP

Setup

- Interface between EHR and PM system
- Training physicians and scribes on how to code through EHR
- Eliminating use of paper superbills
- Reconstruct charge entry workflow from manual to automatic
- Repurpose or reduce excess staff

Charge lag decreased significantly from the implementation of electronic coding, meeting charge entry benchmarks by week 2 and financial close benchmarks by month 2.
A3 Exercise 1 – Reducing DOS/DOP

**BACKGROUND**

Practice is manually entering charges into their PM system which is causing delays in cash flow and hindering the ability to close books in a timely manner.

**CHALLENGE**

- Physician fills out superbill during patient visit; does not utilize coding functionality within EHR.
- Office staff collect superbills and physically delivers them to offshore billing department which can take up to a week after the date of visit.
- Billing department manually enter charges in PM system and scans superbills into EHR.

**CURRENT CONDITIONS**

- Charges entered electronically at date of service
- Automatic integration from EHR to PM system
- Charge entry at benchmark of 48 hours or less

**GOALS/TARGET**

- Enter coding into the EHR at the time of service to allow the charges to integrate automatically into the PM system.
- Meet charge entry benchmark of 48 hours or less.

**ANALYSIS**

**PROPOSED CONTINGENCY**

- Utilize electronic coding capabilities within EHR
  - Electronic coding will significantly shorten the charge entry process as the billing department will have instant access to charges in the PM system without the need of super bills scanned or manual entry.
  - Staffing costs can be reduced due to the lack of need for scanning or manual charge posting.
  - Can respond to new patients in a timely fashion.

**PLAN**

- Set up interface between EHR and PM system
- Train physicians and scribes on how to code through EHR
- Eliminate use of paper superbills
- Restructure charge entry workflow from manual to automatic
- Repurpose or reduce excess staff

**FOLLOW UP**

- Charge lag decreased significantly from the implementation of electronic coding, meeting charge entry benchmarks in week 2 and financial close benchmarks by month 2.
- Close monitoring of charge lag and days to close should be maintained to ensure benchmarks are met continuously.
After value stream mapping and 5S exercises, which led us to move our manual process to a task-based system, our AR > 90 was reduced by 5%, but there is still a threat that we may lose money to timely filing if we can’t reduce further.

**BACKGROUND**

- AR > 90 days is still 5% above benchmark.
- Tasks not evenly distributed, some duplicated.
- Uneven employee productivity.

**CURRENT CONDITIONS**

**GOALS/TARGET**

**ANALYSIS**

**PROPOSED COUNTERMEASURES**

- Remove duplicate tasks
- Identify root cause of denial and AR issues
- Direct the work – highest to lowest dollar balance sorted by oldest to newest
- Mass appeal payor specific issues
- RCM Director/Manager
  - Revisit tasks – work with vendor to ensure all duplicate task triggers have been removed
- Analyze denials and AR to identify bulk payor issues and appeal

**BILLING SUPERVISOR**

- Address biller with productivity issues – ensure he/she is properly trained and possibly put on a PIP

**PLANNING**

- RCM Director/Manager
  - Revisit tasks – work with vendor to ensure all duplicate task triggers have been removed
- Analyze denials and AR to identify bulk payor issues and appeal

- Billing Supervisor
  - Address biller with productivity issues – ensure he/she is properly trained and possibly put on a PIP

- Ensure cross communication with denial and AR specialists to quickly identify potential issues that could lead to increase in AR > 90 Days

- Billers – required to work certain number of tasks per week
• Create monthly physician productivity reports, including top 10-15 high dollar accounts > 36 days—HOLD YOURSELVES ACCOUNTABLE!
  • Sometimes a handful of patients with recurring month-over-month issues encompass a large percentage of AR.
  • By looking at the account level, you’re much more likely to figure out what the issue is, and prevent it going forward.
  • We all remember finding a patient with a 5-figure balance, only to learn we were billing the wrong payor.

What issues can be anticipated?
• Employees out sick – is there a plan for coverage?  
• Payor issues – these can’t be prevented, but with excellent team communication and weekly denial reviews, they can be caught early.

RCM – POST LEAN

LEAN provides you with one of the world’s most precious commodities: TIME!
• Renegotiate your payor contracts / bring contracting back in-house
• Continue to fine-tune your processes, track additional KPIs
• Utilize even more tools/automate as much as possible
  • One group that moved to automated payment modules saw a 29% increase in patient payments, YoY, and saved tens of thousands of dollars on postage.

Revenue Cycle Department – POST LEAN

What would you focus on with more time?
Evaluation of Injectables

HENRY M KWONG JR, MD

Evaluation of Injectables

- Objective: Participants will be able to evaluate the logistical and financial aspects of adding new injectables.

- Description: The decision to add additional injectables to a retina practice is more complex than simple reimbursement/margin. Factors that need to be considered include time of reimbursement, authorization, claim resubmittal, J-codes, CPT codes, and ordering/storage.
### Disclosures
- Regeneron Ad Board Participant
- PI/Sub I on Multiple Studies (Including Genentech/Roche, Regeneron)

### Initial Cost Basis (J Code)

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Through the Looking Glass...

- Mark up for small businesses
  - **Keystone Markup (50%)**: A common rule of thumb is to use a 50% markup, also known as “keystone.”
  - **Industry Standards**: Consider industry-specific norms. Here are some examples:
    - **Grocery Retail**: Typically applies around a 15% markup.
    - **Restaurants (Food)**: Use around a 60% markup, but it can reach 500% for beverages.
    - **Jewelry**: Typically employs a 50% markup.
    - **Clothing**: Relies on markups between 150% and 250%, depending on the brand.

Rebate/Discount Programs

- Have ranged from "cash rebate" to credit or discounted price on future purchases
- Question of potential IRS or "Stark-like" violation
- Ethical Dilemma
  - Prescribing for maximum profit
  - Prescribing for patient benefit
- Vegas rules – The House ALWAYS wins.
Procedure reimbursement (CPT)

- Standard Intravitreal injection – 67028 ($108.33)
- Suprachoroidal injections – 67516 ($115.07)
- PDS implant – 67027 ($808.16)
- PDS refill – 67028 ($108.33)

Tempus Fugit

- Prior authorization vs step therapy
- Chair time
- Tech time
- Explanation to patient
  - Biosimilars/off label
  - Direct to Consumer Marketing
- Procedural time
- Resubmittals/Appeals
Payment cycle

- Date of purchase
- Date of use
- Date of reimbursement
- Date of Payment
  - Variable terms of 30-180 days depending on vendor and manufacturer
  - Credit Cards vs Cash flow

Average payment times for a “clean” claim:

- Medicare – 27 days
- BCBS – 21 days
- UHC – 28 days
- Cigna Medicare – 25 days
- VA Triwest – 30 days
- Humana – 20 days
- AHCCCS – 25 days
- Medicare advantage plans – 35 days
The Walmart/Buckee’s Paradox

• You can’t always get what you want vs. Everything, Everywhere, All at once (Lean Six Sigma vs Augustus Gloop)

• Cost cycle exposure
  • Delayed reimbursement
  • Change in payment terms
  • Damaged/expired/contaminated stock

• Physical storage
  • Refrigeration
  • Inventory Management
Sources for additional information

- RETNET
- ASRS
- AAO – Codequest
- Advocacy
  - AAO Midyear Forum Apr 17-20, 2024
Washington Update
Michael M. Lai, MD, PhD, FASRS
Chairman
ASRS Federal Affairs Committee

Financial Disclosure
• No relevant financial relationships to disclose.

ASRS Priority Issues
• Ensuring adequate Medicare physician payment.

• Protecting patient access to Part B drugs and preserving physician autonomy to provide appropriate treatment.

• Curbing plans’ use of prior authorization and step therapy.
Physician Payment: What Happened this Week

• ASRS advocated for immediate relief from the full 3.4% Medicare payment cuts that went into effect January 1, 2024.

• Advocacy efforts from all across medicine, including 660 ASRS members and practice staff sending 2327 messages to legislators, resulted in partial relief restoring approximately 50% of the cut.

• But Congress failed to fix the full cut

• The final result – a 2.04% cut from 2023 payment levels.

Physician Payments – Two Decades Behind Inflation

Physician Payments – Only Physicians Got Cut in 2024
Retina Codes Adjusted for Inflation

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<th>Code</th>
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<td>150.00</td>
<td>150.00</td>
<td>150.00</td>
</tr>
</tbody>
</table>

Physician Payment: What We Want

- Regular, inflation-based updates to the conversion factor.
- Modify budget neutrality in the fee schedule.
  - Recent annual cuts are due to budget neutrality.
  - Increase the threshold to trigger neutrality adjustments
  - Waive neutrality on new services – E/M add-on code, remote monitoring/AI
- Replace MIPS with a more clinically-meaningful and less burdensome alternative.
- Increase APM opportunities for specialists.

So what are we likely to get?

The political situation complicates our prospects.
Administration Priorities

1. Get re-elected.
2. Get re-elected.
5. Prevent further escalation of foreign conflicts.

Congressional Priorities Are Competing

Senate – Dem Control
- Help Biden get re-elected
- Full-year funding agreement
- Comprehensive immigration reform
- Foreign aid

House – GOP Control
- Prevent Biden from getting re-elected
- Mike Johnson wants to keep his job
- Move past current government funding crisis
- Manage competing factions/slim majority

Payment Advocacy – the rest of 2024

- ASRS and physician groups are focused on securing long-term reform.
  - First step: H.R. 2474 would tie physician payment to the Medical Economic Index (MEI) that measures healthcare inflation.
- Target the post-Election lame duck session for action on reform.
Utilization Management

• Prior authorization reform lost steam in the last Congress due to unexpectedly high score from the Congressional Budget Office (CBO).

• CMS is implementing key provisions of the bill through the regulatory process.

• If CBO decides CMS reforms reduce the cost of the bill, it will likely pass quickly.

More Work Needed on Prior Auth/Step Therapy

• CMS excluded all drugs from MA electronic prior authorization regulations.
  – Acknowledged pushback from ASRS and other organizations in the final rule.
  – May address this in the future.

• CMS hasn’t taken any action to reign in MA step therapy.
  – Even though it says plans can’t have stricter requirements for medical necessity.

ASRS Advocacy Makes a Difference!

- CMS prior authorization regs implement important patient-protections and oversight of plans.

- ASRS was instrumental in securing changes to the MIPS Diabetes Cost measure to exempt retina specialists.
ASRS Advocacy Makes a Difference!

✓ ASRS successfully developed and CMS is implementing three new MIPS quality measures.

✓ ASRS successfully advocated for major changes to the Part B drug wastage policy to prevent under-dosing.

Help Support Inflation-Based Payment Updates
Contact Congress RIGHT NOW!

MDs/DOs     Practice Staff
THANK YOU & QUESTIONS?
Why does it matter?

- Claim denials, audits, legal, regulatory, and payer documentation requirements, fraudulent charges, and fines

Scribe Models

- Virtual scribes + assistant for drugs
- In person scribes
Training a scribe

01
SCRIBES GET TRAINED BY ONE OF THE OFFICE MANAGERS

02
SCRIBES THEN ENTER THE CLINIC WITH AN OVERSEEING SENIOR SCRIBE OR OFFICE MANAGER

03
ONCE INDEPENDENT, THEIR NOTES ARE CHECKED FOR ACCURACY BY THE OFFICE MANAGER

04
FEEDBACK IS GIVEN TO THE OFFICE MANAGER FROM THE PHYSICIAN AND THEN TO THE SCRIBE

Scribes and technicians should understand the difference in exam codes and inform you if any items are missing or incomplete.

Training and retraining

RETINA IS CONSTANTLY CHANGING

AS NEW TREATMENTS ARISE WE (AS PHYSICIANS) NEED TO STAY UP TO DATE TO TRAIN THE SCRIBES APPROPRIATELY
Biggest pitfalls

- Clone documentation:
  - Exam looks identical to the previous visit for a patient coming for injections
  1. Is the exam, imaging, and assessment/plan consistent?
     - For example, if ERM is worsening in A/P, is this consistent in the exam and imaging sections?

Biggest pitfalls

- Incorrect documentation
  - Patient had cataract surgery done appropriately documented in A/P however the exam says "2+ NS"

Biggest pitfalls

- Chief complaint is not addressed in exam or A/P
  - "Patient complains of irritation and tearing"
  - Per note, this complaint was not addressed during the visit
Biggest pitfalls

- Interpretations of imaging
- Writing 'positive,' 'normal,' or 'no change' is unacceptable

How to avoid pitfalls

- Document during or immediately after the visit
- Be careful when copying forward
- Be specific when talking to scribes

"Please add punctuate epithelial erosions to the exam, dry eyes to the assessment, and use artificial tears in the plan!"
How to avoid pitfalls

• Correct mistakes made by scribes immediately
• Even with a great office manager, communication directly between the physician and scribe is critical
• Create an environment in which asking questions (at the appropriate time) is welcome

How to avoid pitfalls

• Conduct audits
  • At Texas Retina Associates, we obtain an annual chart audit along with physician feedback
  • Prepares you if you do get audited
  • Impacts billing error and omissions insurance (renewal and premium)

Thank you

Jodi Crockett and Jeff Benschette
So you want to build a Retina ASC

Joel Pearlman, MD, PhD
VRMG, Inc
Retina Consultants of America
Visiting the Center

Benefits

- Control of Schedules
- Focus on Retina
- Concentrated Expertise
- New Revenue Streams
  - Facility
  - Building Partnership
Headwinds

- Capital Expenditures
- Staffing Issues
- Anesthesia
- Regulatory Issues
- Fee Cuts
- Rising Cost of Goods & Services

Regulatory Issues and Agencies

- Conditions for Coverage 42 CFR 416
  - Deemed Status
- The Joint Commission on Accreditation of Healthcare Organizations
  - https://www.jointcommission.org/
- Accreditation Association of Ambulatory Health Care
  - https://www.aaahc.org/
- Accreditation Commission for Health Care
  - https://www.achc.org/
Legalities

- LLCs
- Stark Law/Safe Harbors
- AKS (and Safe Harbors)
- Other Issues
  - CPOM
  - ASC Licensing Acts (TX)
  - CMS Reporting
  - OSHPOD (CA)

Licensing
**Certificates of Need**

- **CON**
- **No CON**
- **No CON Law**

**State ASC Associations**

- [https://www.ascassociatio
n.org/asc-operations/state-
resources/find-a-state-
association#CA](https://www.ascassociatio
n.org/asc-operations/state-
resources/find-a-state-
association#CA)
Consultants

- https://sullivanhealthcareconsulting.com/
- https://www.medcgroup.com/
### Staffing

### Common Code Facility Fees (CMS)

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Description</th>
<th>Facility Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0302</td>
<td>Removal of inner eye fluid</td>
<td>$939.30</td>
</tr>
<tr>
<td>97039</td>
<td>Laser treatment of retina</td>
<td>$1,033.30</td>
</tr>
<tr>
<td>97040</td>
<td>Laser treatment of retina</td>
<td>$1,080.75</td>
</tr>
<tr>
<td>97041</td>
<td>Vit for macular pucker</td>
<td>$1,189.57</td>
</tr>
<tr>
<td>97042</td>
<td>Vit for macular hole</td>
<td>$1,189.57</td>
</tr>
<tr>
<td>97043</td>
<td>Vit for membrane dissection</td>
<td>$1,253.36</td>
</tr>
<tr>
<td>97101</td>
<td>Repair detached retina crx</td>
<td>$301.36</td>
</tr>
<tr>
<td>97109</td>
<td>Repair detached retina pc</td>
<td>$290.64</td>
</tr>
<tr>
<td>97107</td>
<td>Repair detached retina</td>
<td>$1,189.90</td>
</tr>
<tr>
<td>97108</td>
<td>Repair detached retina</td>
<td>$1,237.06</td>
</tr>
<tr>
<td>97110</td>
<td>Repair detached retina</td>
<td>$868.33</td>
</tr>
<tr>
<td>97113</td>
<td>Repair retinal detach cpix</td>
<td>$1,383.56</td>
</tr>
</tbody>
</table>
### Common Surgical Costs/Pass-Throughs

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pack</td>
<td>$400-600</td>
</tr>
<tr>
<td>Drape Pack</td>
<td>$50</td>
</tr>
<tr>
<td>Forceps</td>
<td>$100-150</td>
</tr>
<tr>
<td>Laser Probe</td>
<td>$100-150</td>
</tr>
<tr>
<td>Other Disposable Instruments</td>
<td>$100-200</td>
</tr>
<tr>
<td>Disposable Wide-Angle Viewing</td>
<td>$200</td>
</tr>
<tr>
<td>PFQ</td>
<td>$500</td>
</tr>
<tr>
<td>Silicone Oil</td>
<td>$400</td>
</tr>
</tbody>
</table>

### Finances

**CAPITAL COMMITMENTS:**

- **Upfront Capital Commitment - High (rounded):**
  - $6,270,000
  - $4,400,000
  - $2,200,000
  - $1,050,000
  - $490,000

- **Upfront Capital Commitment - Low (rounded):**
  - $1,050,000
  - $490,000
  - $1,050,000
  - $490,000

- **Real Estate:**
  - Office space lease - High: $4,400,000
  - Office space lease - Low: $1,050,000
  - Office space lease - Low: $490,000

- **Equipment:**
  - Equipment & Other Fixed Assets - High: $6,400,000
  - Equipment & Other Fixed Assets - Low: $1,050,000
  - Equipment & Other Fixed Assets - Low: $490,000

- **Working Capital:**
  - Start-up Working Capital - High: $730,000
  - Start-up Working Capital - Low: $140,000
## Feasibility Analysis P&L

<table>
<thead>
<tr>
<th></th>
<th>$3,017.9</th>
<th>$2,357.3</th>
<th>$975.3</th>
<th>$963.9</th>
<th>$944.1</th>
<th>$5,378.8</th>
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</thead>
<tbody>
<tr>
<td>Operating Expense (EBITDA)</td>
<td>$792.7</td>
<td>$626.6</td>
<td>$525.6</td>
<td>$389.7</td>
<td>$305.4</td>
<td>$492.6</td>
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<tr>
<td>Medical Supplies</td>
<td>$1,873.4</td>
<td>$1,616.3</td>
<td>$532</td>
<td>$342.5</td>
<td>$310.2</td>
<td>$1,559.4</td>
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<tr>
<td>Other Operating Costs</td>
<td>$1,099.2</td>
<td>$1,014.3</td>
<td>$871.9</td>
<td>$512.2</td>
<td>$406.4</td>
<td>$1,159.9</td>
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<tr>
<td>Total Operating Expense</td>
<td>$3,026.5</td>
<td>$2,386.2</td>
<td>$1,019.9</td>
<td>$650.6</td>
<td>$621.7</td>
<td>$2,122.7</td>
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<tr>
<td>EBITDA Margin</td>
<td>30.0%</td>
<td>22.4%</td>
<td>30.7%</td>
<td>45.1%</td>
<td>41.1%</td>
<td>30.2%</td>
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</tbody>
</table>

## SUMMARY COMMON - SIZE P&L

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<thead>
<tr>
<th></th>
<th>100.0%</th>
<th>100.0%</th>
<th>100.0%</th>
<th>100.0%</th>
<th>100.0%</th>
<th>100.0%</th>
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</thead>
<tbody>
<tr>
<td>Operating Expenses</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Employee Payroll Costs</td>
<td>32.2%</td>
<td>32.2%</td>
<td>32.2%</td>
<td>32.2%</td>
<td>32.2%</td>
<td>32.2%</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>35.3%</td>
<td>35.3%</td>
<td>35.3%</td>
<td>35.3%</td>
<td>35.3%</td>
<td>35.3%</td>
</tr>
<tr>
<td>Other Operating Costs</td>
<td>32.6%</td>
<td>32.6%</td>
<td>32.6%</td>
<td>32.6%</td>
<td>32.6%</td>
<td>32.6%</td>
</tr>
<tr>
<td>Total Operating Expenses</td>
<td>61.3%</td>
<td>61.3%</td>
<td>61.3%</td>
<td>61.3%</td>
<td>61.3%</td>
<td>61.3%</td>
</tr>
<tr>
<td>EBITDA</td>
<td>30.0%</td>
<td>22.4%</td>
<td>30.7%</td>
<td>45.1%</td>
<td>41.1%</td>
<td>30.2%</td>
</tr>
</tbody>
</table>

## ROI Analysis

<table>
<thead>
<tr>
<th></th>
<th>21,356,769</th>
<th>24,752,804</th>
<th>21,704,990</th>
<th>$135,812</th>
<th>7,402,469</th>
<th>7,312,386</th>
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</thead>
<tbody>
<tr>
<td>Discretionary Cash Flow (NI)</td>
<td>21,356,769</td>
<td>24,752,804</td>
<td>21,704,990</td>
<td>$135,812</td>
<td>7,402,469</td>
<td>7,312,386</td>
</tr>
<tr>
<td>Free Cash Flow (NI + Capital Expenditures)</td>
<td>17,955,575</td>
<td>21,673,160</td>
<td>18,494,975</td>
<td>$128,387</td>
<td>5,736,871</td>
<td>5,306,775</td>
</tr>
<tr>
<td>Return on Investment (ROI)</td>
<td>41.6%</td>
<td>13.8%</td>
<td>5.4%</td>
<td>0.6%</td>
<td>28.4%</td>
<td>25.4%</td>
</tr>
<tr>
<td>Average Return</td>
<td>12.0%</td>
<td>8.0%</td>
<td>6.0%</td>
<td>5.0%</td>
<td>15.0%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Payback Period (NI + Capital Expenditures)</td>
<td>6 years</td>
<td>5 years</td>
<td>7 years</td>
<td>21.6 years</td>
<td>3.2 years</td>
<td>5 years</td>
</tr>
<tr>
<td>Payback Period (NI + Capital Expenditures)</td>
<td>3.8 years</td>
<td>6.4 years</td>
<td>5.9 years</td>
<td>18.1 years</td>
<td>3.2 years</td>
<td>3.8 years</td>
</tr>
</tbody>
</table>
Breakeven Analysis (by Cases)

Keys to Success

- Patience
- Patients
- Some Efficiencies
- Management
- Buy-in from surgeons
- Flexibility
- Excellence in Care
Ready for a Time Out?
Disaster Planning
Kristin Yockus
Senior VP of Operations and Integration
Retina Consultants of America
J. Michael Jumper, MD
West Coast Retina

Disasters
• Those we can expect (not necessarily prepared for)
  – Natural
  – Man-made
  – Hybrid – tsunami causes a nuclear power plant meltdown
  – Small medical practice specific
• "Black swan" events

San Francisco-1989
Black Swan Event
1. Unpredictable
2. Severe and widespread consequences
3. Hindsight bias

Priority Areas to Address
• Fostering a culture of preparedness
• Building workforce capacity and resilience
• Strengthening cross-sector partnerships

Helena Bonfitto, Benjamin C. Wise. AHA News; Dec 15, 2022.
Disaster Plan Objective

1. Management of Staff Communication
2. Management of Patient Communication
3. Management of Hospital Communication
4. Management of Documents
5. Management of the Facility/Satellites
6. Management of Business Operations

Disaster Preparedness Checklist

- Backup and recovery methods for electronic data
- An inventory with photographs of tangible assets
- Copies of important legal documents
- A list of important telephone contacts and email addresses
- A full-circle call tree for staff
- Instructions for setting up instant messaging technology
- Instructions for securing the records of patients undergoing diagnostic testing/procedures
Management of Staff Communication

Before a Disaster

- Educate staff on how they will be contacted and establish written communication protocols.
- Distribute an official written chain of command so everyone knows their role and line of communication.
- Maintain a list of all employee phone numbers off-site & electronically.
- Have a policy in place that requires staff to report to the office to receive triage directions and possible placement at satellite offices.

Management of Staff Communication

During and After a Disaster

- Give instructions to your answering service on how to answer calls.
- Leave an informative message on the practice’s answering machine for both employees and patients.
- Ensure staff and patient safety. Determine if the situation will allow the practice to remain operational, and under which circumstances you will have to close.
- Utilize public radio, social media, and local media to contact staff if necessary. Know in advance how to post such messages.
- Offer staff transportation if necessary.
- Hold a debriefing after the disaster with all management staff. Discuss what went well and what could be improved. Communicate findings with physicians and document the improvement process.

Management of Patient Communication

Before a Disaster

- Have a plan for handling high-risk patient populations.
- If the disaster is foreseeable, have an employee take the next day’s patient list home in order to expedite appointment scheduling. If you do this, be sure to keep the information secure in order to protect patient confidentiality.

Curi: Disaster Planning for the Medical Office 2020.

Curi: Disaster Planning for the Medical Office 2020.

Management of Patient Communication

**During and After a Disaster**

- Email your patients, if possible.
- Place notices on office doors.
- Utilize phone system (if operational) and cell phones where needed.
- Contact your local phone carrier. They may be able to insert a message giving instructions to patients and staff. The message can also redirect calls to the answering service if needed.
- Make appointments available immediately for high-risk patients or those with urgent needs. If your office is closed or damaged, utilize other locations (i.e., patient’s office or another nearby location). In rare circumstances, you may have to refer the patient to another practice or admit them to the hospital.
- Designate personnel responsible for off-site management of patients.
- Dedicate a staff member to work with patients and vendors to ensure maintenance of medications.
- Maintain communication with hospitals and other physician groups to better schedule patients efficiently.
- Maintain a list of all phone and cell numbers to which your practice may need access.
- If the disaster/recovery lasts more than 2-3 days, employ the media (newspaper, television, radio, or social media) to tell patients how they should contact your office. Know in advance how to post such messages.

Management of Hospital/OR Communication

**Before a Disaster**

- Have a plan for office coverage based on physician/staff proximity.
- Have a policy in place for cross-training issues.
- Develop a plan on how you will handle elective surgery and patient communication. The OR and physicians should work together on cancellations and rescheduling.
- Encourage physicians and other staff to purchase cell phone chargers that can be used in the car. If electricity is lost, it may be the only method available to charge the phone.

**During and After a Disaster**

- Designate one staff member to stay in touch with each physician. Consider having a back-up physician onsite at the hospital if necessary.
- Use the hospital pharmacy to store drugs (for any perishable drugs if you do not have a generator). Discuss your options with your hospital so you know what to do when the need to store arises.
- Work with your hospital admissions department. In the event of a disaster, your physician may have to see patients in the emergency room versus a direct hospital admission.
- Give a list of staff cell phone numbers to major hospital departments (e.g., Operating Room, Emergency Room).
- Stress testing the back-up systems frequently. They also recommend testing the competency of personnel who will be called during a power failure.
Management of Documents

- Have a plan for handling high-risk patient populations
- If the disaster is foreseeable, have an employee take the next day’s patient list home in order to expedite appointment scheduling. If you do this, be sure to keep the information secure in order to protect patient confidentiality.

Management of the Facility

Before a Disaster

- Review your insurance.
- Identify a contact name and a number from local resource names.
- Develop a vendor list. For example, who would you call to clean or move the office?
- Consider being part of the professional organizations to receive advice from group leaders.
- Create a list of specialists: fire, water, or storm damage. Find out what services are available in your area.
- Be prepared to set up a temporary office in another location.
- Have a plan for handling high-risk patient populations.
- If the disaster is foreseeable, have an employee take the next day’s patient list home in order to expedite appointment scheduling. If you do this, be sure to keep the information secure in order to protect patient confidentiality.
- Make sure you have a list of local resources.
- Create a list of vendors and contact information.
- Consider speaking with other professionals who may have experienced a similar type of disaster.
- Contact restoration companies about fire, water, or storm damage. Find out what services are available in your area.
- Be prepared to set up a temporary office in another location.
- Keep a disaster box. Use a box that is on wheels for easy portability. Consider including some or all of the following items in the box:
  - A current inventory list of all supplies in your office. If your building is destroyed or damaged, having this list will allow you to itemize your losses and replace needed items.
  - A disaster plan.
  - A list of local resources.
  - A list of vendors and contact information.
  - A plan for handling high-risk patient populations.
  - If the disaster is foreseeable, have an employee take the next day’s patient list home in order to expedite appointment scheduling. If you do this, be sure to keep the information secure in order to protect patient confidentiality.

During and After a Disaster

- Consider using area hotels as temporary resources. They often have internet access.
- Provide for equipment and electrical safety. Unplug all electrical appliances.
- Have a secure and secure environment.
- Adjust your level of services depending on the type of disaster.
- Use the list of local resources to secure and electrical safety, water, or storm damage. Find out what services are available in your area.
- Consider developing an employee relief fund and sending donations to help those in need.
- If you supplied flooding:
  - Cover all computers and other equipment with plastic to prevent water damage.
  - Elevate all equipment, if possible.
  - Utilize sandbags for low-level or basement doors. In most areas, you can purchase pre-made sandbags.
- Consider the length of time without electricity. You may need to provide for an alternative source of heating or cooling.
- Turn the hot water heater off. There are additional places to a recirculating pump.
Management of Business Operations

**Before a Disaster**

- Review insurance policies for current coverage. Make this a regular annual review. Pay special attention to loss of business coverage due to the inability to operate normally. You should also become familiar with the details of your insurance coverage before you need it. How much would it cost to move health information, run your facility in another location, or recover damaged equipment?

- Other coverage issues to consider include insured or excluded or terminated rights. Be aware of any exclusions to your policy.

- Consider financial issues that may be more severe and differ significantly from one type of disaster to another.

- Consider the cost of replacing lost information systems and other equipment. Do you have a backup plan for your important medical information?

- Consider how failure to protect your property from further loss could influence a potential claim.

- Don’t hesitate to obtain second and third estimates to repair and/or replace damaged equipment. Ask your carrier if there are any restrictions that would limit you if you decide to make some of your own repairs without their approval.

- Re-evaluate your current deductible to determine if it needs to be modified or adjusted.

- Consider all types of disasters and how your practice would respond. This includes fire, explosion, tornado, hurricane, flood, severe storm, bioterrorism, extended power outage, and public health crises.

- Consider if flood insurance is worthwhile for your practice. Coverage is typically offered for the structure only, not equipment. FEMA (Federal Emergency Management Agency) sells a flood insurance product.

- Copy phone rotaled cards and keep offsite. Alternatively, keep information in electronic form. Make sure your computer is backed up and additional hard drives are on hand. Make sure your computer is backed up for at least 1 month in case of the failure of key equipment or software. Be sure backups are part of your routine practices. Backups should be updated at least every month. Note that a possible charge may apply.

- Develop a backup billing system in case of computer malfunction. Having an Internet-based system will allow you to access the information from any location.

Management of Business Operations

**During and After a Disaster**

- Notify your property insurance carrier. When reporting a claim, the description of the event is essential in order to determine coverage. There have been insurance disputes over simple definitions such as “storm surge” versus “flood.”

- Notify the postal service to hold all mail.

- Call the phone company. They may be able to do a back-up for missed calls and voicemails. Note that a possible charge may apply.

Disaster Protection - Insurance

- Business disruption insurance
- Cyber insurance
- Key man insurance
- Disability
Implementing a Disaster Plan

• Quarterly practice disaster test
• Pick different scenarios (flood, cyber attack)
• Drill with all staff members
• Meet afterward to discuss
• Refine your disaster plan accordingly

Conclusion

• You can’t be disaster-proof but you can be disaster-ready
• Mitigate known risks
  - Appropriate insurance
  - Back-ups
  - Cyber attack protections
• Create a culture of preparedness
  - Plans
  - Checklists
  - Drills

References

5. Disaster Preparedness for Your Office Practice.pdf
8. Hundreds of Sonoma County doctors displaced by fires.pdf
13. preprint_2022_o_200807_09965907_20271.pdf
14. Main Types of Disasters and Associated Trends.html
Implementing DISC to Drive Organizational Culture

Scott Westhouse, DO
ARIS Business of Retina 2024

Disclosures

- No disclosures related to topic
- Regeneron – S, I
- Apellis – A
- Genentech – A, I
- Lumata Health - C
- Aviceda - I
- EyePoint Pharmaceuticals - I
- Janssen - I
- Alkex Pharmaceuticals - I
- Kodiak - I

What Value Do You Add to Your Organization?

If you could pick a part of the EYE that best represents your style, what would it be?
Today’s Goal

Objectives:
- Why is DISC Important
- Overview of the DISC Model
- Identify and Adjust to Others
- Apply it to your Organization

Keys to Success:
Understanding Self & Others

- Achievers throughout history have had one thing in common... they know themselves.
- Achievers care about others and learn to modify/adjust to get the best out of themselves and others.
- Achievers adapt to thrive rather than survive by developing plans to overcome their shortcomings and take advantage of their strengths.

"Your success in life is largely determined by how well you interact with others.”

– William Marston

Why DISC?

- My Story
- Other Options:
  - Enneagram
  - Kolbe Index
  - Clifton Strengths
  - Myers-Briggs
Three Type of Conflicts

- Me – Me
- Me – You
- Me – Job

ME – ME
DISC Behavior Styles

- If someone has an EXTERNAL style, they will be at the right of the grid.
- Identifiable characteristics include:
  - Assertiveness
  - Fast paced
  - Dynamic
  - Shaping people or situations to meet their needs
If someone has INTERNAL style, they will be at the left of the grid.
Identifiable characteristics include:
- Structured
- Cautious
- Moderately paced
- Guarded behavior

If someone is TASK ORIENTED, they will be at the top of the grid.
Identifiable characteristics include:
- A need to control
- Logic based
- Skepticism
- Perceives things to be "negative"

If someone is RELATIONALLY ORIENTED, they will be at the bottom of the grid.
Identifiable characteristics include:
- Accepting
- Agreeable
- Receptive
- Perceives things to be favorable
**Disc Report**

- Natural Style: S-D-I
- Adapted Style: I-S
- Low C
Success Insights Wheel

Leadership Styles
- Superpowers
- Kryptonite

Comparison with Direct Reports
Checklist for Communicating

Ways to Communicate with Scott
- Use a motivating approach, when appropriate.
- Endorse the other's manager.
- Present project status, name the strategy, with a specific approach.
- Clearly define deadlines, in writing, individual commitments.
- Suggest, however briefly, with a personal concern.
- Offer to help.
- Use a balanced, objective, and emotional approach.
- Provide solutions, not opinions.
- Foster the spirit.

Ways to Communicate with Heather
- Be succinct, from the perspective.
- Use her language.
- Paraphrase or write with clarity.
- Provide time for fair and equal roles.
- Come prepared with all requirements, objectives, and present materials in a well-organized format.
- Verify that the message was heard.
- Understand her specific learning style.
- Be specific, and leave nothing to chance.
### Comparison with Direct Reports

#### Checklist for Communicating

**Continued**

The section of the report is in the spirit of NOT to do, as outlined here. Do not do any of these things. If you find yourself in a situation where you feel you must, please contact the appropriate person for advice and guidance.

<table>
<thead>
<tr>
<th>Ways NOT to Communicate with Scott</th>
<th>Ways NOT to Communicate with Heather</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Keep it to yourself.</td>
<td>• Talk too loudly or shout in their ear.</td>
</tr>
<tr>
<td>• Give them a task when they asked.</td>
<td>• Ignore them or close them out.</td>
</tr>
<tr>
<td>• Be dismissive.</td>
<td>• Force them to agree with you.</td>
</tr>
<tr>
<td>• Control them by using authority or silence.</td>
<td>• Use a threatening approach.</td>
</tr>
<tr>
<td>• Let them overpower you with words.</td>
<td>• Let them know you are finished.</td>
</tr>
<tr>
<td>• Be authoritarian and rigid.</td>
<td>• Operate by unspoken rules and expectations.</td>
</tr>
<tr>
<td>• Waffle or procrastinate.</td>
<td>• Don’t come back to them if they ask.</td>
</tr>
</tbody>
</table>

### Comparison with Direct Reports

#### Value to the Organization

Scott's Value:
- • Use the confidence to do the difficult assignments.
- • Can support or oppose strongly.
- • Creative approach to problem solving.
- • Multi-great relationships.
- • Share leadership.
- • People-oriented.
- • BIG thinker.
- • Dedicated to his own ideas.

Heather's Value:
- • Challenge-oriented.
- • Usually makes decisions with the button line in mind.
- • Thinks big.
- • Open to new ideas and learning.
- • Creative in their approach to solving problems.
- • Sense of urgency.
- • Sponsoring.
- • Will join organizations to represent the company.

### Our Leadership Team

- **Doctors**
  - Executive
  - Clinic
  - Operations
  - Imaging

- **Directors**
ME – YOU
People Are Different

3 out of 4 people important to your success...
• Think differently
• Decide differently
• Use time differently
• Handle emotions differently
• Manage stress differently
• Communicate differently
• Deal with conflict differently


ME – YOU
Adapt/Adjust Your Style for Maximum Results

“It’s not what style you are; it’s what you do with what you are and how you adapt to another’s style.”
- Richard S. George

ME – YOU
People Reading Process

<table>
<thead>
<tr>
<th>Details, Outliers, Deadlines</th>
<th>Introvert</th>
</tr>
</thead>
<tbody>
<tr>
<td>TASK ORIENTED</td>
<td></td>
</tr>
</tbody>
</table>

Details, Outliers, Deadlines
S
C
D
<table>
<thead>
<tr>
<th>Introvert</th>
<th>Extrovert</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specify, Responds</td>
<td>Tell, Initiates</td>
</tr>
</tbody>
</table>

@Person 12 ads

<table>
<thead>
<tr>
<th>People Oriented</th>
<th>Feelings, Fun, Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>TASK ORIENTED</td>
<td></td>
</tr>
</tbody>
</table>

Each type has both strengths and development areas.

DISC styles don’t limit a person’s ability to accomplish.

DISC styles show how we tend to do things.

ME – YOU
People Are Different

- Perfection
- Power
- Peace
- People
What Value Do You Add to Your Organization?

If you could pick a part of the EYE that best represents your style, what would it be?

• What are your strengths?
• What are your weaknesses?
• How do you leverage strengths?
• How do you mitigate weaknesses?

• What skillset does this job require?
• Am I a good fit for the job?
• How might different styles perform this job well?

ME – ORGANIZATION Putting It Together

Communication
• How do you naturally communicate?
• How do you adjust to better communicate to the individuals on your team?
• How can you help teammates better communicate with you?

Motivation
• What are some examples of things that motivate you?
• How do you think other individuals on your team are motivated?
• What specific things can you do to get the most out of individuals on your team?
• What are examples of things that may be motivating to a large number of people on your team?
My Personal Action Steps...

• Take a DISC Assessment
• Start Looking For DISC Styles in People around YOU
• Practice Adjusting
• Make a Plan to Implement in your Organization

Resources

• Positive Personality Profiles – by Robert Rohm
• TTI Success Insights - www.ttiis.com/
• Crystal Knows - www.crystalknows.com/

• Other Related Topics:
  • The Ideal Team Player – by Patrick Lencioni
  • Emotional Intelligence 2.0 – by Travis Bradberry and Jean Greaves
The Business of Retina Meeting
Arizona 2024
Practice Operational Efficiency

Keith A. Warren, M.D.
Warren Retina Associates

Financial Disclosure

I have no financial conflicts to disclose related to this presentation

Objectives

The purpose of this lecture is to examine and streamline the processes involved in scheduling, obtaining diagnostic testing and optimizing patient flow through a retina practice.
Objectives

At the conclusion of the lecture the attendees should be:

1. Able to have their staff schedule an appointment, appropriate testing and calculate the estimated cost PRIOR to the patient visit
2. Able to have staff appropriately prep the patient for their appointment type (INJ ONLY, NEW, F/U)
3. Able to maintain efficient clinic flow with a reduced staff
4. Identify areas for improving efficiency in their individual practices
Operational Efficiency

- **Organization**
  - The appropriate structure and personnel to complete tasks required
- **Preparation**
  - The completion of tasks, information and the inventory in anticipation of the clinical workload
- **Cooperation (Teamwork)**
  - Processes (Communication) that allow for the coordination of all aspects of patient care services

Organization

- Well defined job tasks and responsibility
  - Clinical Team - Work-up, Scribe and Float
  - Administrative team – Intake, Checkout, Insurance Verification, Billing Services
- Uniformed orientation and training
  - Single trainer
  - Consistent terminology and implementation
  - Routine review and renewal (reinforcement)
- Clearly defined flow
  - Established protocol
  - “Zone” concept emphasized

Float

- During down time that should be in the surgery scheduling office working on
  - External tasks like, house calls (medical records, RX refill), confirm test
  - Works on time keeping surgery paper work
- Stand the Diagnostic room at the beginning of each day
- Alert the diagnostic room at the beginning of each day
- Perform diagnostic testing, fundus, IVFA, OCT, A’s & K’s, IVF, and ultrasound
- Cares for patient in recovery room
- Set up laser and pneumatic orinoptic
- Lead the laser and pneumatic patients to the appropriate areas
- Leads patients to the check out desk
- Brings surgery report over to check out
- Relays messages to the doctor regarding incoming calls, contacts outside physicians at appropriate’s request
- Checks equipment between each patient
- Checks & archives images for working room at the end of each day

- [Blank]
Preparation

- Completion of the tasks required to perform key elements of a comprehensive patient care experience.

- Front office
  - Accurate medical records, insurance data
  - Understanding of visit type (New, Routine, Injection only)

Clinical Staff
Patient encounter
Understand visit type (New, routine, Injection only)

Billing staff
Pre-certification, Prior authorization
Patient financial responsibility (No Surprise)

Cooperation (Teamwork)

- The coordination of all service areas for the most efficient delivery of patient care.

Dependent upon:
- Processes - Allow for the accurate transfer of patient information (Clinical and financial)
- A system of checks and balances to ensure implementation
New patient flow

Front Office ➞ Clinical Staff ➞ Insurance Verification ➞ Appointment

New patient flow

Appointment ➞ Diagnostic Testing ➞ Float

Float ➞ Exam ➞ Scribe

Scribe ➞ One-Pod

One-Pod ➞ Treatment ➞ Float
Injection Only

Cooperation (Teamwork)

- Frequent meetings and updates to processes
- Each staff member understanding their role in the big picture
- Cross Training – Keeps flow with staffing changes
- Checks and balances- Coding, Testing, Billing, Procedures

TEAM BUILDING!!

Team Building
Summary

- Practice Operational efficiency requires:
  - Organization – organizational design, structure and staffing to achieved desired goal
  - Preparation - Understanding and execution of tasks to allow for the efficient delivery of patient care services
  - Teamwork – Employees who understand their role (Feel supported) and have the processes in place to provide the best patient care

Thank You!!!!
3PL—What is it?

- 3PL represents "Three Product Lines"
- Clinic ➔ Drug ➔ Research
- All 3PLs are complex and strategies are different for each
- 3PL organization is simple—Any bookkeeper can manage

3PL—Clinic/Professional Fees

- Impacted by "Visits" or how much activity each physician produces
- Impacted by complexity of patient mix (Oncology/Uveitis)
- Coding accuracy
3PL—Drug/Treatments

• Impacted by “Distribution Agreement”
• Payor Contracted rates (Commercial v. Medicare)
• Payor mandated step therapies
• Specialty Rx “Brown Bagging”
• ASP fluctuations
• Physician treatment plans/choice
• Drug mfr discounts and dynamics

3PL—Research

• Participation in trials
• Sponsor budgets
• Success in recruiting for trials
• New patient volume
• Operational capacity

3PL—Traditional P&L
3PL—After Re-Organization

<table>
<thead>
<tr>
<th>Description</th>
<th>Clinic</th>
<th>Drug</th>
<th>3PL</th>
<th>VA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Labor</td>
<td>$500,000</td>
<td>$500,000</td>
<td>$500,000</td>
<td>$500,000</td>
</tr>
<tr>
<td>Non-Professional</td>
<td>$300,000</td>
<td>$300,000</td>
<td>$300,000</td>
<td>$300,000</td>
</tr>
<tr>
<td>Total</td>
<td>$800,000</td>
<td>$800,000</td>
<td>$800,000</td>
<td>$800,000</td>
</tr>
</tbody>
</table>

3PL—Expense Allocations

- Start somewhere—Meant to be directional
- See below image of allocations:

3PL—The End
CHALLENGES IN PATIENT BILLING

CLAIRE M. MURPHY

CEO, PIEDMONT RETINA SPECIALISTS, PA

CLAIRE M. MURPHY

• 5-Physician Practice in the central Piedmont Triad area of North Carolina
• 14 Years Experience that began as a single biller with 1 Physician
• 4 Surgeons, 1 Medical Retina, 2 Locations
• 60 on staff including billing, administration, business office, technicians and scribes

FINANCIAL DISCLOSURES

• Speaker Bureaus: Regeneron, Apellis
• Advisory Boards and Panels: Outlook, Apellis, Iveric Bio, Engage Education, Deerfield Research
• Consulting: Samacare, PX Technology, Iveric Bio
WHEN I ASK A PATIENT TO PAY THEIR BILL...

• Staff Compensation
• Healthcare Costs
• Accounts Receivable
• Wait Times
• Supply Inflation
• Reduced Reimbursement
• Comp Formulas
• Rent
• Patient Demand
• Increased Deductibles
• Facility Expenses

• Office Supplies
• Physician Recruitment
• Staffing Shortages
• IT Cost
• Back Orders
• Meeting Cost
• Overhead
• Insurance
• Competitive Pay
• Drug Cost
• Bonuses

HOW THE PATIENTS SEE US

OUR REALITY
PATIENT COLLECTIONS AND BILLING: HOW DO WE BALANCE GETTING PAID WITH PROVIDING CARE TO THOSE WHO NEED IT?

OFFICE VISIT COPAY

THE EASIEST AND HARDEST PAYMENT TO COLLECT.

DUE AT TIME OF SERVICE PER THE CONTRACT BETWEEN THE INSURANCE COMPANY AND THE PATIENT.

TIPS ON COPAY COLLECTION

• Patients tend to have a lack of understanding regarding their insurance terms and responsibilities. Educating your front desk staff is imperative to collection at the time of service. A patient who understands their copay or balance is much more likely to pay their bill.

• Create clear and consistent office policy based on your practice needs. Policy should be visible and communicated throughout your practice. Staff should be knowledgeable and patients informed.

• Approach & respond with kindness. We don’t know what someone is going through, especially those on a fixed or lower income.

• Have a plan of what you want done if a patient cannot pay at the time of service and be consistent.

• Because it is a violation of the patient/insurance contract, you can turn a patient away if they cannot pay their copay at the time of service.
ESTIMATES... AND NOT JUST FOR SURGERY

THERE ARE MANY TOOLS FOR ESTIMATING THAT ARE INSIDE YOUR PM SYSTEM OR CAN BE SUPPLEMENTED BASED ON YOUR PRACTICE'S FEES.

COLLECT PAYMENT AT TIME OF SERVICE IN THE PRACTICE

PATIENT STATEMENTS

• Healthy patient revenue comes from carefully constructed billing infrastructure.
• Send out statements regularly.
• Do patients have easy payment tools and resources for billing questions?
• Make past due balances very clear:
• Check balances at check in, even notifying patients before their visit that their copays and balances will be due.

PAYMENT PLANS

• Will your practice accept them?
• Is it easy to enroll the patient and keep their financial information secure?
• Take into consideration: minimum payment, term of payoff, will you charge a finance fee and what happens when a regular patient is non-compliant with the agreements?
• How do you monitor adherence?
EXTERNAL COLLECTIONS

- Shop around for a good plan and low collections rates.
- Consider a flat fee for small balances or keep those accounts internal.
- Make sure to track these patients and make a plan for their medical care, even if you no longer see the patient.
- Offering a limited time payment plan before collections has been successful in our practice.

HOW CAN PEOPLE STILL GET CARE?

- Provide discounted services for self-pay patients.
- Refer patients to local community or government programs that could provide help.
- University settings can also be a better fit for an indigent patient, especially if they do not get regular medical care.
- Kindness and a supportive attitude can make a big difference.
- A patient will usually be able to get emergency care at an Emergency Department.
- Also, hospital call patients may be treated differently. Make sure to know if your hospital has any rules about patient collections.

QUESTIONS?
THANK YOU!
Cybersecurity: Recovery After a Ransomware Attack

Bill James, MHA, COE
Talley Eye Institute
Evansville, Indiana

Financial Disclosures:
- None
- Will not disclose companies that our practice used in our ransomware attack

First Things First:
Huge thank you to Jeff Brockett and Michael Sullivan
First Things First

- Change Healthcare / UnitedHealth
  - Fluid situation, new information coming in constantly
  - Fluid situation, new information coming in constantly
  - ALphV and Blackcat have claimed responsibility, exfiltrating 6TB of data
  - According to reports, $22MM was paid in bitcoin

How Bad Is It?

FBI Internet Crime Complaint Center (IC3) 2023:

"Healthcare is the hardest hit industry sector."
- David Scott, Deputy Assistant Director, FBI Cyber Division
April 2019

What happened:
- Our practice was hacked with Gandcrab V5.2 ransomware by Russian hackers
  - All servers and several workstations were involved
  - All affected files were encrypted with the extension .WNMYGNJIV
  - EHR, Email, and other files affected; all backups failed
  - Each affected folder had a .txt file, describing what needed to be done to recover our data

April 2019

What we did, Day 1:
- Contacted our health law attorney
- Contacted the FBI
  - Their recommendation was that we not pay the hackers, but
  - They understood if we made the decision to pay the ransom
- Searched for companies who have experience with decryption of files
- Determined that we felt more comfortable paying a reputable company that could decrypt instead of paying the hackers
April 2019

What we did, Day 1:
- Continued to see patients through this mess
  - Our retina staff pulled previous injections through the medication inventory system
  - Our anterior segment physicians are referral-based, and most patients were new patients
- Follow up patients and post-ops:
  - Utilized prior OCTs, Optos images, visual fields, and other diagnostic testing for historical data
  - Contacted the ASCs to get op reports for post-op patients

April 2019

What we did, Day 2:
- Informed staff of what has happened and what we were doing to recover data
- Informed staff to tell the patients (at that time) that our servers had crashed
- Begin decryption process of data
  - All servers
    - Which affected PCs needed to be decrypted vs. wiped and rebuilt

Two Weeks Later...

Terabytes of data finally decrypted
- Day-to-day operations back to "normal"
  - Entered data from paper charts into the EHR into the system
- Determine if PHI had been compromised
  - Difficult to determine
  - Companies can do a "deep dive" of your data to determine:
    - How information was exfiltrated
    - If PHI had been exposed
Six Weeks Later – What We Learned

- An old account that was no longer used had been compromised
- A brute force attack was launched on this account to gain access
- Malware was uploaded to our RDP server
  - 16 executables were launched in a span of 20 minutes
- The executables allowed hacking of the Administrator account
- Ransomware installed on devices, but
- PHI had not been compromised

Six Weeks Later – Disclosure

- Report information to:
  - Health and Human Services / Office of the Inspector General (HHS/OIG)
  - State Attorneys General (in our case, Indiana, Illinois, and Kentucky)
  - Media
  - Referring Doctors
  - Patients
- Send a Letter Detailing Events of the Attack
  - What information was involved
  - Steps patients could take to protect themselves
  - Contact information for the practice if they have questions

Six Weeks Later – Disclosure

- HHS and AG reports
  - Work with your attorney to provide this information, which should include:
    - HIPAA policies and procedures
    - Password management policies
    - Notice of Privacy Practices
    - Previous Risk Assessments and Penetration Test Reports
    - How your practice has responded to these reports
    - A description of the incident
    - What security steps have been taken since the attack
Expenses Incurred

- Our IT company acknowledged blame for the backup failure
  - Did not charge us for their work
- Payment for data recovery: $167,000
  - This included stronger antivirus protection from the recovery company
  - Also included email protection tools
- "Deep Dive" to confirm no exfiltration of data: $20,000
- Legal fees: $35,000
- All covered and repaid through our cybersecurity insurance policy
- No fines or penalties assessed by the HHS/OIG and Attorneys General

New Policy and Procedure Changes

- Backups done every hour
  - All servers and PCs with crucial data
  - Loaded to a local appliance and moved offsite
  - Backup data is tested and encrypted
  - Air-gapped (no connection between the backup and our network)
  - Continue to obtain appropriate penetration tests, vulnerability tests, and risk assessments
  - Discuss the results of these in board meetings
  - Document the observations and recommendations in the board meeting minutes
  - Designate these items as fixed, working on, or known and acceptable risks

- All staff undergo annual HIPAA training, regular cybersecurity awareness testing
- Use phishing emails to see if staff are paying attention
- Discuss cybersecurity regularly in staff meetings
  - Document this in the staff meeting minutes
- Check all accounts (Windows, EHR, SonicWall, etc.) to ensure all former employees are deactivated
  - Ensure password complexity and enforce changing at least every 90 days
New Policy and Procedure Changes

- Use multifactor authentication whenever possible
- Administrator password restricted
  - IT company and CIO have this password
  - Minimum 25 characters (ex., gaFDu$5Myw&x?7EWH8NSYDBF)
  - Changed regularly
- Make sure that your cybersecurity insurance policy is up to date
- Include cybersecurity in your disaster recovery plan and incident response plan
- Cybersecurity policy coverage is $1MM

Ongoing expenses

- Annual vulnerability testing, penetration testing, etc. for MACRA and MIPS compliance: $18,000
- Cybersecurity insurance premium: $17,000
- Estimated IT support for cybersecurity: $13,000
  - Includes offsite backup management, cybersecurity awareness training, etc.

Four Years Later...

- The HHS / Office for Civil Rights (OCR) can contact your practice
  - My name is [redacted] and I’m an investigator with the U.S. Department of Health and Human Services’ Office for Civil Rights (OCR). The message is regarding OCR Investigation No. [redacted] which has now been resolved to my satisfaction. Thank you.
- The OCR wants to know if:
  - You have continued your risk assessments, penetration tests, etc.
  - You have continued to respond to these accordingly
  - You have continued to provide training to staff all appropriate training
Retina Coding for Beginners

Presented by:
Joy Woodke, COE, OCS, OCSR

ASRS Business of Retina
Sunday, March 10, 2024

Speaker Financial Disclosure

• Joy Woodke, COE, OCS, OCSR
  o Academy Director of Coding and Reimbursement

• Speaker has no financial relationships to disclose.
• All relevant financial relationships have been mitigated.
Course Agenda

- E/M and Eye Visit Codes
- Lasers & Surgeries
- Office Visit & Surgical Modifiers
- NCCI Edits
- Intravitreal Injections
- Academy Resources

E/M and Eye Visit Codes
Choose with confidence
### Documentation Guidelines

- **E/M** – medically relevant history and exam, determine level of E/M from MDM or total physician time
- **Eye Visit Codes** – meet history, exam elements and initiation of diagnostic & treatment program

### Consider both family of codes

- Confirm the level of E/M and Eye Visit Code
- Avoid 9 scenarios when not to use an Eye Visit Code
- Maximize reimbursement

---

### American Academy of Ophthalmology’s Final Determination Table for Medical Decision Making

<table>
<thead>
<tr>
<th>Component</th>
<th>Straightforward</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number and/or Complexity of Data to be Collected and Analyzed</td>
<td>Minimal or None</td>
<td>Low Risk</td>
<td>Moderate</td>
<td>High Risk</td>
</tr>
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<td>Amount and/or Complexity of Data to be Collected and Analyzed</td>
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<td>Moderate</td>
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</tr>
<tr>
<td>Risk of Complications and/or Morbidity of Patient Management</td>
<td>Minimal</td>
<td>Low Risk</td>
<td>Moderate</td>
<td>High Risk</td>
</tr>
<tr>
<td>Final Determination</td>
<td>99302/99</td>
<td>99317</td>
<td>99324</td>
<td>99324</td>
</tr>
</tbody>
</table>

---

**Notes:**
- Different documentation guidelines
- 99214 does not automatically equal 92014
- Consider both family of codes
- Confirm the level of E/M and Eye Visit Code
- Avoid 9 scenarios when not to use an Eye Visit Code
- Maximize reimbursement

---

**American Academy of Ophthalmology’s Final Determination Table for Medical Decision Making**

To arrive at the final determination for the level of exam, 2 of 3 components (problems, data and risk) must have the same level of complexity (straightforward, low, moderate or high). Otherwise, select the level lower from highest level.

<table>
<thead>
<tr>
<th>Component</th>
<th>Straightforward</th>
<th>Low Risk</th>
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**Notes:**
- Different documentation guidelines
- 99214 does not automatically equal 92014
- Consider both family of codes
- Confirm the level of E/M and Eye Visit Code
- Avoid 9 scenarios when not to use an Eye Visit Code
- Maximize reimbursement
### Hospital: Final Determination Table for Medical Decision Making

<table>
<thead>
<tr>
<th>COMPONENT</th>
<th>STRATEGIC</th>
<th>LOW</th>
<th>MODERATE</th>
<th>HIGH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number and/or Components of Additional or New Diagnoses and/or Procedures</td>
<td>Minimal</td>
<td>Low: 1 new diagnosis or procedure</td>
<td>Moderate: 2 or more diagnoses or procedures</td>
<td>High: ≥3 or ≥4 new diagnoses or procedures</td>
</tr>
<tr>
<td>Amount and/or Complexity of Data to be Analyzed</td>
<td>Limited</td>
<td>Low: ≤1 criteria must be met</td>
<td>Moderate: ≥2 criteria must be met</td>
<td>High: ≥3 criteria must be met</td>
</tr>
<tr>
<td>Risk of Complications or Mortality or Morbidity of Patient Management</td>
<td>Minimal</td>
<td>Low: 1 new diagnosis or procedure</td>
<td>Moderate: ≥2 criteria must be met</td>
<td>High: ≥3 criteria must be met</td>
</tr>
</tbody>
</table>

- Initial Hospital Inpatient: 05/23/21
- Subsequent Hospital Inpatient: 05/23/21
- Emergency Department: 06/26/21

### EYE VISIT CODE CHECKLIST

**Intermediate Exam Codes 92002/92012**

- History
  - Chief complaint
  - History
  - General medical observation

- Examination
  - Three or more, but less than 12 elements of the exam medically necessary to perform
  - Visual acuity
  - Gross or confrontation visual fields
  - Extrapapillary motility
  - Conjunctiva
  - Ocular adnexa
  - Pupil and iris
  - Cornea
  - Anterior chamber
  - Lens
  - Intraocular pressure
  - Optic nerve disc
  - Retina and vessels
  - Dilation: As medically necessary.

**Comprehensive Exam Codes 92004/92014**

- History
  - Chief complaint
  - History
  - General medical observation

- Examination
  - All 11 elements of the exam medically necessary to perform unless unable to perform due to age of patient or trauma
  - Visual acuity
  - Gross or confrontation visual fields
  - Extrapapillary motility
  - Conjunctiva
  - Ocular adnexa
  - Pupil and iris
  - Cornea
  - Anterior chamber
  - Lens
  - Intraocular pressure
  - Optic nerve disc
  - Retina and vessels
  - Dilation: As medically necessary, if not dilated, document why.
## E/M vs Eye Visit Codes

1. **New patient:** medically relevant history, comprehensive exam, low MDM

<table>
<thead>
<tr>
<th>E/M</th>
<th>Price</th>
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</thead>
<tbody>
<tr>
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<tr>
<td>Eye 92004</td>
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2. **New patient:** medically relevant history, comprehensive exam, moderate MDM

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<td>Eye 92004</td>
<td>$146.04</td>
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   For all payers: over $18 difference

3. **Est patient:** medically relevant history, comprehensive exam, low MDM

<table>
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4. **Est patient:** medically relevant history, problem-focused exam, moderate MDM

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Lasers & Surgeries

What is the Diagnosis?

Diode Lasers

What's the diagnosis?

- DME, CME, retinal edema
- Prophylaxis or RD, retinal break or tear, lattice degeneration
- Proliferative retinopathy
- Choroidal neovascularization
- Retinal detachment

67210 Final photocoagulation laser, grid
67145 Repair retinal laser
67228 PEP
67220 Destruction of localized laser of choroid
67105 Repair retinal detachment, photocoagulation
Modifiers
Office Visits & Surgeries

24
Unrelated evaluation and management service (or eye codes) by the same physician during a postoperative period
Office visit in the postoperative period is not related to the original surgery:
- New symptoms
- Significant changes in eye health requiring new evaluation
- Different diagnosis than the surgery does not necessarily mean unrelated

25
Significant, separately identifiable evaluation and management service (or eye codes) by the same physician on the same day of the procedure or other services
Office visit same day as a minor surgery (0 or 10 global period days)

57
Decision for surgery, major procedure
Office visit same day, or within 3 days of a major surgery (90 day global period)

OFFICE VISIT MODIFIERS

AMERICAN ACADEMY OF OPHTHALMOLOGY®
### Retina Laser Global Periods

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Description</th>
<th>Medicare global period</th>
<th>Same day exam modifier</th>
<th>Other payers may vary</th>
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<tr>
<td>67105</td>
<td>Laser to repair retinal detachment</td>
<td>10 days</td>
<td>-25</td>
<td>10 or 90-day global</td>
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<tr>
<td>67145</td>
<td>Prophylaxis laser for retinal tear, lattice degeneration</td>
<td>10 days</td>
<td>-25</td>
<td>10 or 90-day global</td>
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<tr>
<td>67210</td>
<td>Diode focal laser</td>
<td>90 days</td>
<td>-57</td>
<td>90-day global</td>
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<tr>
<td>67220</td>
<td>Destruction of localized lesion of choroid, photocoag</td>
<td>90 days</td>
<td>-57</td>
<td>90-day global</td>
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<tr>
<td>67228</td>
<td>Panretinal photocoagulation (PRP) laser</td>
<td>10 days</td>
<td>-25</td>
<td>10 or 90-day global</td>
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</tbody>
</table>

### Surgery Modifiers

- **58**
  - 1. Lesser to greater
  - 2. Pre-planned and documented as staged
  - 3. Therapy following a major surgery
  - Planned or unplanned
  - Related
  - New postop period
  - 100% allowable

- **78**
  - Unplanned return to operating room during the post-op period
  - Unplanned
  - Related
  - New postop period does not begin
  - 70% allowable

- **79**
  - Unrelated procedure during the post-op period
  - Planned or unplanned
  - Unrelated
  - New postop period
  - 100% allowable
NCCI Edits

Quick Reference Guides

NCCI Edits:

- “0” indicator—mutually exclusive
- “1” indicator—can unbundle when appropriate

When is it appropriate to unbundle with modifier -59?

- Separate structure, opposite eye
- When the payer states in published policies
<table>
<thead>
<tr>
<th>Retina Testing Services</th>
<th>EO peripheral retinal disease 92201</th>
<th>EO posterior pole 92202</th>
<th>FA 92235</th>
<th>ICG 92240</th>
<th>FA/ICG 92242</th>
<th>FP 92250</th>
<th>Posterior Segment OCT 92134</th>
<th>Optic Nerve OCT 92133</th>
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<tbody>
<tr>
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<td>Billable same day</td>
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<tr>
<td>EO peripheral retinal disease 92201</td>
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<td>Billable same day</td>
<td>Mutually Exclusive</td>
<td>Billable same day</td>
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<tr>
<td>EO posterior pole 92202</td>
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<td>FA 92235</td>
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<tr>
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**Lens/Vitrectomy**

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<thead>
<tr>
<th>NCCI 30.0 Effective 1/1/24</th>
<th>67036-67043 Vitrectomy</th>
<th>66682 Suture lens</th>
<th>66825 Reposition of IOL</th>
<th>66850 Lensectomy, phaco</th>
<th>66852 Lensectomy, pars plana</th>
<th>66982 Cataract removal, complex</th>
<th>66984 Cataract removal</th>
<th>66985 Secondary implant</th>
<th>66986 Exchange of intraocular lens</th>
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<tbody>
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<td>67036-67043 Vitrectomy</td>
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<td>66682 Suture lens</td>
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<td>66825 Reposition of IOL</td>
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<td>Bundled</td>
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</tr>
<tr>
<td>66850 Lensectomy, phaco</td>
<td>Billable same day</td>
<td>Billable same day</td>
<td>Bundled</td>
<td>Bundled</td>
<td>Bundled</td>
<td>Bundled</td>
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<tr>
<td>66852 Lensectomy, pars plana</td>
<td>Bundled</td>
<td>Billable same day</td>
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<tr>
<td>66982 Cataract removal, complex</td>
<td>Billable same day</td>
<td>Billable same day</td>
<td>Bundled</td>
<td>Bundled</td>
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<td>66984 Cataract removal</td>
<td>Billable same day</td>
<td>Billable same day</td>
<td>Bundled</td>
<td>Bundled</td>
<td>Bundled</td>
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<td>66985 Secondary implant</td>
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<td>Billable same day</td>
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<tr>
<td>66986 Exchange of intraocular lens</td>
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</table>
Intravitreal Injection

Master the Basics

Medication Coding: Back to Basics

When assigned, medications have a permanent HCPCS code used for coding

- J codes are common in ophthalmology

The HCPCS code descriptor:

- Description
- Dosage = 1 unit
- Route of administration, i.e., IV

Example:

- J0178 Injection, aflibercept, 1 mg
Calculate Units: Lucentis

HCPCS Descriptor
• J2778 Injection, ranibizumab, 0.1 mg

Dose Injected
• 0.5 mg

Total Units to Bill
• 5 units

What is my injection claim denied?

1 - Incorrect ICD-10 code link
2 - NDC reported incorrect format and box on claim
3 - Unit of measure missing
4 - Wrong HCPCS code (e.g., Avastin, NOC)
5 - Incorrect units
6 - Frequency (e.g., 28-day rule or FDA label)
What is my injection claim denied?

7 – Measurable wastage not reported
   • -JW modifier

8 – Modifier mishap
   • Missing JZ or surgical modifier

9 – Lack of prior authorization

10 – Step therapy policy not followed

11 – Unique payer policy

12 – Patient eligibility

N4 – qualifier, NDC 5-4-2 format, Unit of measure (UOM)

Izervay (avacincaptad pegol) 2 mg/0.1 mL intravitreal injection
Retina Practice Management & Coding

• Resources
  o Documentation checklists
  o JW/JZ fact sheet
  o Table of common retina drugs
  o And more!

<table>
<thead>
<tr>
<th>Description</th>
<th>Units</th>
<th>Indications</th>
<th>Units</th>
<th>Uses</th>
<th>Dose</th>
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<tr>
<td>Acetazolamide</td>
<td>Drug</td>
<td>Off-label use for ophthalmology</td>
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<td>Boric Acid</td>
<td>Drops</td>
<td>Irritant</td>
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<td>Asus</td>
<td>Drops</td>
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<td>Sodium Hypochlorite</td>
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</table>

Questions?
Academy Resources

aao.org/retinapm
aao.org/audits
aao.org/coding
aao.org/em
aao.org/lcds
aao.org/consulting

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Revenue Cycle Administrative Burdens
The Retina Injectables

Leonard H. Ginsburg, MD
Chairman, Moore Eye Institute
Chairman, Ophthalmology Residency Program, PCOM

ASRS Business of Retina Meeting
March 10, 2024
8:00-8:15 am
Phoenix, AZ

Financial Disclosure

• DHRpro, LLC
  • Founder & Chief Medical Officer
  • Equity

Alerts for treatments outside standard practice patterns

<table>
<thead>
<tr>
<th>Date</th>
<th>Provider</th>
<th>Procedure</th>
<th>ICD-10 Code</th>
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</thead>
<tbody>
<tr>
<td>02/24/2017</td>
<td>Experian</td>
<td>0001</td>
<td>0101</td>
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</table>

Scleritis injection more often than 28 days per eye; 209 providers were paid $6 million
Many private payors in 2023 moved to clinical review of physicians’ notes, which delays reimbursement by 60 days minimum.

New Medications and Brand vs. Generic Requirements

- Indications
- Payor rules
- Frequencies
- Cost and reimbursement

Vabysmo:
- Can I inject sooner than Q 7-8 weeks after four loading doses?

Eylea HD:
- Is it approved for CRVO?
- Can I inject after three loading doses more frequently than Q 7 weeks?
- What documentation is needed?
- What insurances cover it?

It Used To Be So Simple: Three Choices

New Medications and Brand vs. Generic Requirements
<table>
<thead>
<tr>
<th>DRUG</th>
<th>DR</th>
<th>First Step</th>
<th>Dose extension recommendations</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vabysmo</td>
<td>DME</td>
<td>4 Doses every 4 weeks</td>
<td>Up to 4 week extensions or up to 8 week reductions</td>
<td>OCT charged 11/27/23</td>
</tr>
<tr>
<td>Vabysmo</td>
<td>DME</td>
<td>6 Doses every 4 weeks</td>
<td>3 weeks QBW for the following 28 weeks</td>
<td>OCT charged 11/27/23</td>
</tr>
<tr>
<td>Eylea HD</td>
<td>DME</td>
<td>3 Doses every 4 weeks</td>
<td>Based on OCT &amp; VA and @ 8 and 12 weeks</td>
<td>OCT charged 11/27/23</td>
</tr>
<tr>
<td>nAMD</td>
<td>3 Doses every 4 weeks</td>
<td>Q8W-Q16W</td>
<td>OCT charged 11/27/23</td>
<td></td>
</tr>
<tr>
<td>DR</td>
<td>3 Doses every 4 weeks</td>
<td>Q8W-Q12W</td>
<td>OCT charged 11/27/23</td>
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</table>

Potential errors

<table>
<thead>
<tr>
<th>INVENTORY LOG</th>
<th>CHART DOCUMENTATION</th>
<th>MEDICATION CODING</th>
<th>ERROR</th>
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<tbody>
<tr>
<td>Kyros 0.25 mg disp</td>
<td>Kyros 0.25 mg disp</td>
<td>Kyros 0.25 mg disp</td>
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<td>Lucentis 0.6 mg disp</td>
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<td>Lucentis 0.6 mg disp</td>
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<td>Kyros 0.25 mg, 0.5 mg</td>
<td>Kyros 0.25 mg, 0.5 mg</td>
<td>Kyros 0.25 mg, 0.5 mg</td>
<td>Kyros 0.25 mg, 0.5 mg</td>
</tr>
</tbody>
</table>

Figure 8
Financial Loss of a J Code Denial

<table>
<thead>
<tr>
<th>Manufacturer</th>
<th>Drug</th>
<th>J Code</th>
<th>Drug Cost per Injection</th>
<th>Medicare Reimbursement for Drug (MS)</th>
<th>Secondary Reimbursement (MS)</th>
<th>Total Reimbursement</th>
<th>Net Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genentech (Roche)</td>
<td>Vabysmo</td>
<td>J3490</td>
<td>$1,428.47</td>
<td>$1,143.50</td>
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<tr>
<td>Apellis</td>
<td>Ozurdex</td>
<td>J2777</td>
<td>$1,683.00</td>
<td>$1,399.10</td>
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<td>$1,05.07</td>
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<td>$2,130.87</td>
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<td>$1,540.75</td>
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<td>$76.15</td>
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Note: Costs and reimbursements reflected were current as of 2/23/2024 for a practice in southeastern Pennsylvania. Rates vary by MIPS score, state, and region and are subject to change on a quarterly basis.

A single J code denial could cost a practice as much as $2,379.06. On average, it takes roughly 14 injections to break even from the loss.

The Process: Controlling J-Codes, Inventory and Profitability

The Retina Injection Practice Workflows: Where Are The Problems?
Can we make mistakes and order/bill the wrong eye?

- **Mis-clicks**: Wrong button, wrong date, etc.
- **Bilaterality**: Wrong side (my left is your right)
- Lack of - or wrong documentation
- Doctors can and do change the planned care
- Scribes

No system could discover an injection in a "glass eye" was billed.
Three Year Study of Injectable Medication Losses

Factors for rejections were investigated for this study.

Matching up IMS against billing not performed

Key indicators for root cause reflected.

<table>
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<th>Description</th>
<th>Amount</th>
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<tr>
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<td>Physician failing to see history of treatments and procedures/global period/lack of modifier</td>
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</tr>
<tr>
<td>2</td>
<td>Physician failing to follow step therapy or ins requirements</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>No prior authorization on file</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Diagnosis billed is not same as prior authorization dx codes</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Wrong medication dispensed (sample vs. billed)</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Physician failing to bill procedure</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Physician not following CPT code selected/billed CPT</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Physician forgot to bill procedure</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Patient changed insurance/did not notify practice</td>
<td>$5,420</td>
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<tr>
<td>10</td>
<td>Patient’s ins did not change but ID number changed and prior auth no longer valid</td>
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</tr>
<tr>
<td>11</td>
<td>Appeals too late (timely billing error)</td>
<td>$3,450</td>
</tr>
<tr>
<td>12</td>
<td>Incorrect CPT selected for avastin</td>
<td>$500</td>
</tr>
<tr>
<td>13</td>
<td>Specialty Pharmacy Only</td>
<td>$29,120</td>
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<tr>
<td>14</td>
<td>Physician Non-Par with insurance</td>
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</tr>
<tr>
<td>15</td>
<td>No referral</td>
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</tr>
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<td>16</td>
<td>Services not covered by patient's ins</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Billing error - no pre auth but schedule said yes for medication</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Still outstanding/current appeals in process</td>
<td>$2,050</td>
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<td>$55,808.44</td>
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<td></td>
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<tr>
<td>$29,120.00</td>
<td>#13 Specialty Pharmacy Only</td>
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<td>$23,840.00</td>
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<td>$4,210.00</td>
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<tr>
<td>$3,450.00</td>
<td>#11 Appeals too late (timely billing error)</td>
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</tr>
<tr>
<td>$2,135.00</td>
<td>#8 Physician forgot to bill procedure*</td>
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<td>$2,050.00</td>
<td>#18 Still outstanding/current appeals in process</td>
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<tr>
<td>$550.00</td>
<td>#4 Diagnosis billed is not same as prior authorization dx codes</td>
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<tr>
<td>$121,428.44</td>
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</table>

*Artificially low as Physicians in practice visualizer what is billed and can correct issue
**2022**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Amount</th>
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<td>#3</td>
<td>No prior authorization on file</td>
<td>$53,510.00</td>
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<tr>
<td>#9</td>
<td>Patient changed insurance/did not notify practice</td>
<td>$33,940.00</td>
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<tr>
<td>#5</td>
<td>Wrong medication dispensed (sample vs. billed)</td>
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<tr>
<td>#2</td>
<td>Physician failing to follow step therapy or ins</td>
<td>$ 6,000.00</td>
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<td>#13</td>
<td>Specialty Pharmacy Only</td>
<td>$ 3,640.00</td>
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<tr>
<td>#15</td>
<td>No Referral</td>
<td>$ 1,550.00</td>
</tr>
<tr>
<td>#12</td>
<td>Incorrect CPT selected for avastin</td>
<td>$ 500.00</td>
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<td>Total</td>
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<td>$113,275.00</td>
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**2023**

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<td>No prior authorization on file</td>
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<tr>
<td>Total</td>
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<td>$187,792.50</td>
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</table>

**Eylea Performed But Not Billed**

1. Wet AMD OD "Starting Eylea" on 4/14/21
2. Eylea Not Billed
3. OD before inject 4/14/21
4. OD after inject 5/12/21
5. OD before injection
6. OD after injection but not billed
7. Edema resolved after Eylea injection but not billed
8. Thickened retina before injection
Specialty Pharmacy Drugs

**Patient Specific**

- Drop Ship programs for Part B Healthcare provider administered drugs
- Healthcare provider sends a prescription to health plans designated pharmacy
- These drugs may still be subject to prior authorization requirements
- Typically the pharmacy MUST confirm with the patient that the drug will be used; which provides complication if the patient does not answer or return their call to confirm delivery
- Specialty pharmacy ships the drug to healthcare provider where it will be administered in the office
- Specialty pharmacy submits for drug reimbursement to the payer and it will fall under the patient's
- Healthcare provider ONLY bills for the administration of the drug i.e., 67028. NOT the cost of the drug (J code)

Patient Specific May Become the New Norm

---

**Use of JW Modifiers**

For Drugs Discarded Or Not Administered

- Healthcare providers are required to report the JW modifier on claims for discarded drugs and biologics.
- The discarded amount is defined as what remains from a single use vial or other single use packaging after administering a dose or quantity to the patient.
- The JW modifier indicates the amount of drug discarded that is eligible for payment under the discarded drug policy. This policy and its requirements are for Part B drug claims and most commercial plans.

---

**Billing Drugs With Wastage**

Sample Billing of Byooviz Using JW Modifier
### Tools Offered by the Distributors

<table>
<thead>
<tr>
<th>COMPANY</th>
<th>SOFTWARE</th>
</tr>
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<tbody>
<tr>
<td>Amerisource Bergen</td>
<td>CubixxMD Inventory Management for Retina</td>
</tr>
<tr>
<td>Amerisource Bergen</td>
<td>Podis Plus Inventory Management</td>
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<tr>
<td>Cardinal Health</td>
<td>RxID Select Inventory Management and Analytics</td>
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<tr>
<td>CuraScript SD</td>
<td>Mainbridge Inventory Management</td>
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<tr>
<td>McKesson</td>
<td>Glide- Billing Scrubber/CCI Edits/Reporting</td>
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<tr>
<td>McKesson</td>
<td>Lynx Inventory Management</td>
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<tr>
<td>SamaCare</td>
<td>Preauthorization Tool for Submission to Insurance</td>
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</table>
CONSIDERATIONS FOR ONBOARDING NEW RETINA DRUGS
HEATHER THOMAS, OCSR

Practice Administrator at Retina Vitreous Consultants
Pittsburgh, PA

Financial Disclosures:
Apellis Pharmaceuticals: Advisory Board, Speaker
Cardinal Health: Speaker
Coherus BioSciences: Advisory Board
Iveric Bio: Advisory Board

EDUCATION
Educate staff on disease state, drug treatments available, dosing & delivery, etc.
• Create a new drug chart that identifies key steps & staff

ACQUIRING DRUG
Know your resources to order:
• Medicare FFS (Buy & Bill)
• MA or Commercial: Do they require Specialty Pharmacy?
• Consider an inventory tracking system

NEED
Identify patient population, disease burden, etc.
• Consider prioritizing patients with traditional Medicare & a Supplement before moving on to MA or Commercial plans

DOCUMENTATION
Identify payer requirements and consider what the company policy will be.
• Disease state
• Imaging
• Clinical notes
• Who will update EMR system?

PAYER LANDSCAPE
Research payer policies:
• Benefits Investigator (BI)
• Prior Authorizations (PA)
• Step Edits
• Create a tracking system and assign necessary staff

BILLING
Know the requirements for submitting a clean claim:
• Drug Administration
• NDC vs permanent J-code
• Correct NDC
• Batchers
• BARS
• Correct ICD-10
Onboarding a New Physician

ASRS Business of Retina 2024
Aamer Hayat
CAO
Northern California Retina Vitreous Associates

Financial Disclosures

I, Aamer Hayat, have no relevant financial relationships in the products or services described, reviewed, evaluated or compared in this presentation.

Onboarding a New Physician

The Basics:
- Key to successful onboarding is being well-organized (hint - use a checklist if done in-house; review vendor checklist if outsourced)
- ASRS has a well-developed list to use: ASRS New Physician Checklist
- Start the credentialing process as soon as possible
- Medicare allows credentialing 60 calendar days before the start of practice
  - Process can take 15-60 days
- Most commercial plans are similar
- Medicare Advantage/HMO plans can take longer - check with PAs on their credentialing schedule
- Checklist should include an answer to: “What does the physician need to have a successful day 1?”
Onboarding a New Physician

---

Successful onboarding isn't a field of dreams.

Leverage a marketing strategy to quickly build volume.

Onboarding a new physician is a great opportunity to visit referring ophthalmologists and optometrists and to re-introduce the practice and introduce new physician.

Identify the top referring providers to the office(s) new physician will be located. Also identify nearby potential referrals sources for an introduction.

Reach out to referring office, offer to introduce new physician over lunch for the office.

Use the lunch to address any concerns referring office might have, make one-on-one connection between referring doctor and new physician, office staff and management.

Track new referrals, send a "thank-you" gift after the first 5-10 referrals. Continue to follow up.

Make sure new physician remains available as scheduled (even if they aren't seeing patients, use the time to build the physician's "brand").

Tie bonus to growth!

---

Onboarding a New Physician

---

How did it work for NCRVA?

<table>
<thead>
<tr>
<th>Months</th>
<th>New Patients</th>
<th>Grand Total</th>
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<tr>
<td></td>
<td>JANUARY</td>
<td>3652</td>
</tr>
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</table>
Synchronous vs. Asynchronous Scribes
Srinivas Kondapalli, MD

Telescribe
- A scribe who is not physically with the physician during the patient encounter.

Telescribe Benefits
- Retain well-trained staff
- Work-life balance opportunity
- Efficiency/space limitations in examination room
- Only able to scribe—not getting pulled
Telescribe Drawbacks

- Changes in workflow
- Unable to fill in gaps in office staff
- Scribe burnout/lack of advancement opportunities

Technical Requirements

- VPN/secured internet connection
- HIPAA Compliant messaging/call system (Teams, Skype for Business)
- Strong WIFI
- Limited external electronics (Bluetooth interference)
- Bluetooth enabled earbud

Synchronous vs Asynchronous Scribing

- Synchronous
  - Scribe at same time as patient encounter
- Asynchronous
  - Scribe before/after patient encounter
Synchronous

- New patients
- Follow up examinations
- Real-time scribing: follow up

Asynchronous

- Injection-only type visits
- Record voice note
- Send instant message (via TEAMS) with results and follow up
- Allows downtime to be used more efficiently

Cases
Internal vs. Outsourced Billing
ASRS Business of Retina 2024

Nadeem N. Vaidya, M.D., Retina Orange County, Inc., Irvine, California
Robert C. Wang, M.D., Texas Retina Associates, Dallas, Texas

Moderator
Nadeem N. Vaidya, M.D.
- President, Retina Orange County, Inc.
- Also, Handyman, Bookkeeper, IT Support Staff
- Established in 2012
- No relevant disclosures

Panelist
Robert C. Wang, M.D.
- Partner, Texas Retina Associates
- Current President
- Also part-time mountaineer, marathoner, race car driver and informal CTO
- No relevant disclosures
What precipitated your move to outsource billing?

At what point do you think the transition saved you money?

At what juncture do you advise other practices, small, medium, or large, to consider outsourcing?
What do you see as the future of RCM? Can better software or AI mitigate some of the need to outsource?

Questions?
Financial Disclosure

• Ashley Nahrwold, COA is the Revenue Cycle Director for The Retina Institute in St. Louis. She acknowledges no financial interest in the subject matter of this presentation.
Prior Authorization - Is it enough?

Example 1:

Example 2:

Additional Medicare Gold Advantage (HMO) will do our request to review the following drug(s). We are pleased to tell you that we approved the following drug(s):

LUCENTIS Solo Pref Price: $200/40ML.

If the drug will be given in your provider’s office, please check to see if your provider is in-network. Coverage for out-of-network services may be limited if you are enrolled in an HMO plan. If you are enrolled in a PPO plan, your out-of-pocket costs may be higher if you receive services out-of-network.

DRUG APPROVAL PROCESS

A strong drug approval process needs to expand across multiple departments and functions within your practice and account for all variables that could prevent or delay receiving full reimbursement for every drug injected.

These variables are the fundamentals of the drug approval process.

Fundamentals

<table>
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<tr>
<th>Practice</th>
<th>Payer</th>
<th>Patient</th>
<th>Pharma</th>
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<td>Payer Contracts</td>
<td>Payer Coverage Policies</td>
<td>Insurance Eligibility</td>
<td>FDA-Approved &quot;On Label&quot; Diagnoses</td>
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<td>Credentialing and Billing - Groups vs. Individual MD</td>
<td>Prior Authorization Requirements</td>
<td>Plan Specific Drug Benefit Coverage</td>
<td>Dosing frequency</td>
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<tr>
<td>Drug Acquisition, Cost and Margins</td>
<td>Step Therapy Requirements</td>
<td>Specialty Pharmacy Requirements</td>
<td>Copay Assistance Options</td>
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<tr>
<td>Inventory Management</td>
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<td>Out of Pocket Cost</td>
<td>OPT Billing Code</td>
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<tr>
<td>Communication</td>
<td>PCP Referral Requirements</td>
<td>Severity of Disease / Urgency to Treat</td>
<td>New Indications</td>
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</tbody>
</table>
The method of communicating the drug approved back to the physician is called the Injection Status.

The goal of the drug approval process should be to take all these fundamentals and guarantee that each billable drug will be reimbursed in full prior to the injection occurring in the clinic.

**Injection Status**

- Assign a project leader or task force
- Gather data
- Develop practice protocols
- Reach out to industry reimbursement specialists for help

**Getting Started**

**PAYER CONTRACTS**

- Do you have a copy of all your payer contracts?
- Are they outdated? Have they been renegotiated in the past 1 year, 2 years, 5 years?
- What is the fee schedule? Are you being reimbursed appropriately for drugs?
- How is the language within the contract related to new drug reimbursement? Reimbursement for billing a new drug with a miscellaneous J code or Q code for biosimilar drugs may be problematic with older contracts.
- If you are in a group practice, are your contracts under the group Tax ID or does each physician have a separate contract? If so, do the physician contracts vary in regard to this information?
- No payer contract could mean your practice is out of network with that payer.
CREDENTIALING & BILLING

Payer credentialing is the process that links the individual provider with the payer contract.

Payer contracting, credentialing, obtaining prior authorization and billing should be synchronized to use the same provider identifiers (NPI and Tax ID).

Payer contracts with individual physicians and/or credentialing of individual physicians with no group practice linkage means prior authorizations will be linked to that individual physician and not to the group.

Practice best to credential the group NPI and tax ID to the payer contract then link all the individual providers to the group.

This method will allow coverage for drug authorizations under the group practice in the event the patient needs to be treated by another physician within the same practice.

Physicians not credentialing or linked to the group practice could leave the individual provider in an out of network status with that payer.

Best practice is to credential the group NPI and tax ID to the payer contract then link all the individual providers to the group.

This method will allow coverage for drug authorizations under the group practice in the event the patient needs to be treated by another physician within the same practice.

Physicians not credentialed or linked to the group practice could leave the individual provider in an out of network status with that payer.

Drug Cost & Inventory

Determine which drugs you will stock in inventory versus which drugs will be ordered as needed or approved.

Compare your drug costs to your Medicare allowed amount each quarter.

Sample Medicare Drug Fee Schedule Cost Comparison

<table>
<thead>
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<th>Everett</th>
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</tbody>
</table>

1. Determine which drugs you will stock in inventory versus which drugs will be ordered as needed or approved.

2. Compare your drug costs to your Medicare allowed amount each quarter.

3. Return to clinic plans should indicate which drug has been selected to treat the patient.

4. Determine how drug requested will be communicated to the staff obtaining prior authorization.

5. Consider drug specific appointment scheduling events to identify, report and generate tasks for upcoming planned injections.

6. Determine how staff will communicate back to the clinic when a drug is approved or denied.

7. Develop protocols for how often drug approvals are re-verified to ensure reimbursement continues for the duration of treatment.

COMMUNICATION

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**PAYERS**

Insurance payers can vary based on geography and market. Medicare jurisdictions vary by state and policies are not universal. Payers often have multiple products and plan types that may have varying authorization and coverage policies (Commercial, Medicare Advantage, Medicaid, etc.).

- Obtain a list of payers seen at your practice
- Create guides for each payer product and each payer driven fundamental
- Payor policies change from time to time
- Develop a system for identifying changes and keeping your guides current

**PATIENTS**

- Insurance eligibility verification confirms if a patient’s insurance plan is active
- Most automated electronic eligibility returns the patient’s status as of the date eligibility was ran, not by a future appointment date
- Most employer-sponsored plans will be active until the end of the calendar month even if the plan is terminated
- State Medicaid and Managed Medicaid plans are renewed monthly based on patient’s eligibility. Some states will change the patient’s Managed Medicaid plan throughout the year
- Many patients do not know what insurance plan they have, their covered benefits or their cost share (copay, deductible and coinsurance)
- Develop a practice protocol for who will be responsible for insurance eligibility verification, when the verification will occur and when it will be rechecked on each patient

**TRADITIONAL MEDICARE**

Patients with traditional Medicare Part B only (no secondary payer) will have a 20% coinsurance for all services including drug.

For branded anti-VEGF drugs, this can be around $200-500 out of pocket per injection.

For patients receiving monthly bilateral treatment and relying on a Good Days grant to cover their out-of-pocket cost, there may not be enough funds to cover them for a full year.
Medicare Advantage Plans

Medicare eligible patients that have elected to have a Part C replacement policy (Medicare Advantage Plan) usually have lower out of pocket costs. These patients will retain their original Medicare card. Insurance eligibility will still run active under the Traditional Medicare ID number even though the patient will now be covered under an advantage plan. Most Medicare Advantage Plans require prior authorization for branded anti-VEGF drugs. Some Medicare Advantage Plans require step therapy or double step therapy.

Pharma

FDA approved diagnoses are not universal across all branded anti-VEGF drugs. Traditional Medicare will cover all FDA approved diagnoses. Commercial payers may develop their own coverage policies that may not be inclusive of all FDA approved diagnoses. If an established drug receives FDA approval for a new indication, verify payers update their coverage policies to include the indication. Create a guide of Copay Assistance options available by payer type, drug and diagnosis, include eligibility criteria.

New Drugs

New drugs to market will be billed using a miscellaneous J-code until a permanent CPT is established (typically two quarters). Payers usually release coverage policies closely following FDA approval. This does not mean reimbursement will cover the cost of drug. Reimbursement for miscellaneous J-code under commercial payers is directly tied to your contract language. Prior authorization is usually required for the drug even with miscellaneous J-code. Once the permanent CPT code is established, make sure to update your prior authorizations with the payer.
COMBINING THE DATA

Combine all fundamental data gathered for the practice, payers, and pharma to create a master Insurance Drug Coverage Guide that will be utilized in clinic to select a covered drug at decision to treat.

This does not approve a same day injection. Best practice is to have the patient return for injection unless clinically urgent. The Insurance Drug Coverage Guide is a tool to avoid requesting a drug that will not be approved. Example: Request for branded drug for a payer that has strict step therapy requirements.

Drug Approval Workflow

This workflow is based upon all patients being checked in with correct and verified insurance attached to their chart. This workflow also assumes PCP Referrals are on file for required plans.

1. Patient is seen in clinic and needs anti-VEGF injections.
2. Physician should utilize the Insurance Drug Coverage Guide to determine which drug choice is appropriate for the patient’s diagnosis and primary insurance payer.
3. Chart notes are typically required to be sent with prior authorization requests. The exam impression should clearly state the diagnosis and medical need for injection treatment. The return to clinic plan should specify the drug selected by the physician.
4. Patient should sign the corresponding authorization form to run a detailed insurance benefit investigation through the drug company’s provided service.
5. Check out staff should schedule the patient’s return appointment using the appropriate drug specific appointment event.

Prior to next visit (injection visit):

6. Obtain prior authorization from the patient’s insurance for the drug requested.
7. Run the benefits investigation through the drug company portal.
8. Enroll the patient in copay assistance if applicable and eligible.
9. Complete Financial Counseling with the patient for out-of-pocket cost. Prepare the patient to pay at check in of the injection visit.
10. Three business days prior to the return visit, re-verify the patient’s insurance to confirm it is still active.
11. Two business days prior to the return visit, confirm patient’s payer/diagnosis/drug combination clears all check points and provide the appropriate Injection Status for this appointment.
Staff members responsible for each function within the drug approval process may vary from practice to practice.

Determine the workflow that works best for your practice.

In my practice, this work is completed within the Revenue Cycle Department.

Our Revenue Cycle Department is divided between the Patient Access Team and the Billing Team.

Number of FTEs needed will vary by provider count, patient volume, and automated technology.

Who Provides the Injection Status

- Insurance eligibility verification – primary and secondary insurance verified 3 business days prior to appointment for every patient before every visit
- Confirm practice and provider are in network with patient’s insurance plan
- Benefit review – complete once annually for all plans and update as needed
- Cost estimations – complete as needed based on patient’s insurance plan benefits and planned services
- Pre-visit financial counseling – complete each visit when patient’s out of pocket cost exceeds their office visit copay. Prepare patient to pay at check in for planned services
PRIOR AUTHORIZATION FUNCTIONS

- PCP referrals & visit authorizations: review payer specific report of appointments scheduled the previous day and obtain referral or authorization prior to each visit based on payer requirements.
- Injectable drug authorizations: review report of appointments scheduled the previous day for drug specific events and obtain authorization for drug requested. Note: CPT 67028 for administration may also need prior authorization.

PATIENT ASSISTANCE PRE-VISIT FUNCTIONS

- Drug benefit investigations: review report of upcoming appointments scheduled for drug specific events and review the detailed benefit investigation returned from the drug company.
- Copay assistance enrollment: the benefit investigation results will include the patient’s drug benefits (if deductible applies and percent cost share of coinsurance). Enroll patients as needed based on their individual scenarios.

INJECTION STATUS GRANTED

- Example Injection Status: IVE OD for AMD H35.3211

“Based on the knowledge of the fundamentals, the Patient Access Team believes this drug will be reimbursed 100%.”

2 business days prior to appointment, the Billable Drug Analyst reviews a report of appointments scheduled for drug specific events and assigns an Injection Status based on the confirmation of data gathered by the team. The Injection Status is communicated to the clinic on the day of service.
**FIRST INJECTION APPROVAL TIME**

- **Monday**: Patient examined, drug selected, return appointment scheduled for 1 week.
- **Tuesday**: Drug authorization signed and electronically sent to the drug company.
- **Wednesday**: Benefit investigation results available. Prior authorization requested.
- **Thursday**: Insurance eligibility re-verified. Prior authorization approval received. Copay assistance enrollment completed. Financial counseling performed.
- **Following Monday**: Patient receives injection in the office.

**SAME DAY INJECTIONS**

- There will be times where the patient clinically cannot return in 1 week for injection and will need to be treated same day.
- We call this a Verbal Injection Status.
- During certain scenarios patients will be approved for a one time buy and bill drug based on the knowledge we have of that payer's fundamentals.

**SUBSEQUENT INJECTIONS**

Functions that should be repeated every visit for appointments scheduled with drug-specific events:
- Review report of expiring prior authorizations and/or remaining visits/units
- Insurance eligibility verification for primary and secondary payers
- Review patient's accounts receivable / confirm reimbursement for previous injections
- Copay assistance grant balance
- Confirm no change with drug / diagnosis code combination compared to prior authorization approval
- Injection Status approved and attached to appointment for subsequent injection visit
If any of the following elements change, the drug approval process should be restarted:

- Payer fundamentals – coverage policy, prior authorization requirements, step therapy requirements
- Patient’s insurance payer or plan benefits
- Patient’s eligibility or need for copay assistance
- Drug change requested by physician
- Diagnosis change – slight changes in diagnosis or disease stage may require a new or amended prior authorization

**OPTIMIZING THE WORKFLOW**

- Keep data organized
- Maintain current guides for the fundamentals
- Provide clear protocols and guidelines to staff
- Review denials, identify reimbursement problems and adjust protocols accordingly
- Leverage technology for automation
- Be creative to implement new workflow or utilize existing technology in new ways
- Ongoing staff training

**THANK YOU**
Working Capital Management in a Retina Practice

Sharam Danesh MD, MBA (2024)
Phoenix Retina Associates

Disclosures
1. No financial disclosures
2. Not tax Advice
3. Not financial advice

Question:
Can your practice survive in the event of a sudden liquidity crisis?
Outline:
1. Risk
2. What is working capital?
3. Examples of choices

Business vs Personal

Risk:
Definition:
Today $$$$$
Future $
Risk:

Today
$200,000

Future

Risk:

Risk-free
1. Cash in FDIC insured account
2. US Government Treasuries
3. Paying off debt

Reward

Working Capital:

1. The ability to cover short term obligations and expenses
2. Measure of financial health
3. Measure of “Liquidity”
Working Capital: Balance Sheet

<table>
<thead>
<tr>
<th>Assets</th>
<th>Liabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short term</td>
<td></td>
</tr>
<tr>
<td>Long term</td>
<td></td>
</tr>
</tbody>
</table>

Working Capital =
Short Term Asset - Short Term Liabilities

Positive Working Capital
Negative Working Capital

• Same as a short term interest free loan.

Reward

Risk

Is negative working capital risky?
Yes

Is negative working capital bad?
It Depends on Risk vs Benefit

Working Capital = Short Term Asset - Short Term Liabilities

Drug Inventory
Accounts Receivables
Cash

Credit Card Balance
Accounts Payable (Drugs)

Negative Working Capital
Negative Working Capital

• How robust is your practice?

Large Accounts Payables

Making Choices

• Managing a practice is about making choices.
Example 1
Pay off payables vs Savings Account

Cash
Accounts Payable (Drugs)

Cash
Accounts Payable (Drugs)

Example 2
Pay off payables vs Buy an OCT

Cash
Accounts Payable (Drugs)

Cash
Accounts Payable (Drugs)

Example 2

Risk

Reward

Short term liquidity risk

• Interest Free Loan
• Compare to Leasing
Conclusion:

- Working Capital is a tool
- Provides choices
- Always remember risk/reward for all decision

Thank You
FINANCIAL PLANNING STRATEGIES FOR THE SMALL RETINA PRACTICE:

amERICAN SOCIETY OF RETINA SPECIALISTS -
BUSINESS OF RETINA 2024

OR (HOW TO BUY A TESLA MODEL X FOR 50% OFF)

FINANCIAL DISCLOSURES

• no relevant disclosures
The Importance of Financial Planning

- average lifespan ~85y/o
- retirement age ~65y/o
- pre-tax income in retirement: ???

How much are we saving?

Tax Deferred

Post Tax
**HOW MUCH DO I NEED?**

- if you haven’t already, sign up for a financial planning app/service
- holistic view of your accounts
- estimate your needs based on the income you desire

**IS THIS DIFFICULT?**

- excessive debt burden from student loans
- lost time from medical school and training for compounding interest
- delayed gratification when we finally get an income stream

**NOT IMPOSSIBLE**

- practice ownership allows for tax efficient and large contributions to retirement funds at relatively low cost
  - 401k
  - SEP-IRA
  - Simple IRA
  - Defined Benefit Plan
WHAT ARE THE DIFFERENCES?

<table>
<thead>
<tr>
<th>SEP-IRA</th>
<th>Defined Benefit Plans</th>
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<tbody>
<tr>
<td>Benefits:</td>
<td>Benefit types:</td>
</tr>
<tr>
<td>Description of what the plan offers, such as profit sharing or retirement savings.</td>
<td>Description of what the benefits are, such as health insurance or retirement savings.</td>
</tr>
<tr>
<td>Good starter plan for practices with 2 or fewer employees.</td>
<td>aka pension plan</td>
</tr>
<tr>
<td>Limits are the same as profit sharing plans.</td>
<td>higher limit - 230k</td>
</tr>
<tr>
<td>Eligible employees all match at the same percentage.</td>
<td>increased cost due to increased employer contributions.</td>
</tr>
</tbody>
</table>

**SEP-IRA**

- Good starter plan < 2y in practice, or with just a few employees, or part-time employees.
- Limits are the same as profit sharing plans.
- Eligible employee all match at the same percentage.

**Defined Benefit Plans**

- Aka pension plan
- Higher limit - 230k
- Increased cost due to increased employer contributions.
- Excellent choice for aging practice owners who need to catch up for retirement.
401K

- relatively low cost
- administration
- profit sharing
  - new comparability testing
  - key or highly compensated employees
  - safe harbor for “regular” employees

Profit Sharing

- maximum at 25% of income
- up to 69k total with all employee contributions and safe harbor
- percentage calculated only on the first 345k of income

Cost Savings - New Comparability

- compliance
  - 3% safe harbor match requirement for all employees
- restrictions
  - work hours
  - vesting period
  - cost share for maintenance
  - longevity
- a smaller proportion of HCE/key employee percentage for profit share
NOT BAD

TYPICAL 401K

<table>
<thead>
<tr>
<th>End Amount</th>
<th>Additional Contributions</th>
<th>Return Rate</th>
<th>Starting Amount</th>
<th>Investment Length</th>
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<tbody>
<tr>
<td>$3</td>
<td>$3</td>
<td>7%</td>
<td>$900,000</td>
<td></td>
</tr>
<tr>
<td>$30</td>
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<tr>
<td>$150,000</td>
<td>$150,000</td>
<td>7%</td>
<td>$900,000</td>
<td></td>
</tr>
</tbody>
</table>

Balance Accumulation Graph

Results

- End Balance: $1,341,624.63
- Total Contributions: $900,000.00
- Total Interest: $441,624.63

A DIFFERENCE OF 3 MILLION

PROFIT SHARING 401K

<table>
<thead>
<tr>
<th>End Amount</th>
<th>Additional Contributions</th>
<th>Return Rate</th>
<th>Starting Amount</th>
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<td>$150,000</td>
<td>$150,000</td>
<td>7%</td>
<td>$900,000</td>
<td></td>
</tr>
</tbody>
</table>

Balance Accumulation Graph

Results

- End Balance: $4,593,716.61
- Total Contributions: $900,000.00
- Total Interest: $3,693,716.61

STARTING LATER?

PENSION PLAN

<table>
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<tr>
<th>End Amount</th>
<th>Additional Contributions</th>
<th>Return Rate</th>
<th>Starting Amount</th>
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<tbody>
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<tr>
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<td>7%</td>
<td>$900,000</td>
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</table>

Balance Accumulation Graph

Results

- End Balance: $3,001,624.63
- Total Contributions: $900,000.00
- Total Interest: $2,101,624.63

- End Balance: $1,341,624.63
- Total Contributions: $900,000.00
- Total Interest: $441,624.63

- End Balance: $4,593,716.61
- Total Contributions: $900,000.00
- Total Interest: $3,693,716.61

- End Balance: $3,001,624.63
- Total Contributions: $900,000.00
- Total Interest: $2,101,624.63
**SIMPLE IRA**

**HEALTH INSURANCE**

- qsehra plans
- tax credit for employer contributions
  - minimum contribution of 50%
  - maximum = 100%
- hsa plans
- triple tax protected

**MINIMIZE CORP TAXES**

- pass through corporations pay tax on profit at the regular income tax level of the owners (excluding Medicare and Social Security)
- whether or not it is actually distributed
WEAPONIZE YOUR DRUG FLOAT

- Aim “profit” for close to zero except section 179 deductions
- Prepay next year’s drug float in current tax year (December 31st)
- Save ~37% of profit by not paying taxes on said profit

BE CAREFUL

- Threading through two loopholes
- I’m not a CPA
- Use at your own risk

SECTION 168 AND 179

- We’ve all heard about section 179
- Hummer loophole - section 168
  - GVWR > 6000lbs
  - Bonus depreciation in year 1
  - 100% of the cost of the vehicle
  - Prior to the TCJA it was 25% in the first year
- Only when bought
- Only when “new to you”
BUSINESS USE?

• pre-tax business expense for eligible business travel
• commuting is not business travel
  • unless

HOME OFFICE LOOPHOLE

• multiple locations/jobs
• conducts certain activities exclusively in home office
• business to business travel may be deductible

RESOURCES

• soloeyedocs/soloretinadocs - email forum - email me at drvaidya@retinaoc.com
• requires $500 donation to surgical scope fund or ophthPAC or other organized ophthalmology group
• young retina forum - telegram - contact Hemang Pandya
Retina Coding Update

Presented by:
Joy Woodke, COE, OCS, OCSR

ASRS Business of Retina
Sunday, March 10, 2024

Speaker Financial Disclosure

- Joy Woodke, COE, OCS, OCSR
  - Academy Director of Coding and Reimbursement

- Speaker has no financial relationships to disclose.
- All relevant financial relationships have been mitigated.
Course Agenda

What’s New for 2024?
• CPT and Category III codes

Evolving World of Retina Drugs

Audit Update

Code This OP Report
• 10 Steps for Surgical Coding

E/M MDM: Decipher the Definitions
• Retina case studies

CPT and Category III Codes

CPT Codes Implemented January 1 each year
Category III Codes Assigned July 1 and January 1
For a link to NCCI edits, visit aao.org/coding-topics
after January 1, 2024
Deletion: Suprachoroidal Injection (0465T)

Category III Codes

0465T  Suprachoroidal injection of a pharmacologic agent (does not include supply of medication)

(To report intravitreal injection/implantation, see 67025, 67027, 67028)

►(0465T has been deleted)►

►(For suprachoroidal injection of a pharmacologic agent, use 67516)►

New CPT: Suprachoroidal Injection (67516)

Surgery/Eye and Ocular Adnexa/Ocular Adnexa/Orbit/Other Procedures

67516 Suprachoroidal space injection of pharmacologic agent (separate procedure)

►(Report medication separately)►

67550  Orbital implant (implant outside muscle cone); insertion

67560  removal or revision

(For ocular implant (implant inside muscle cone), see 65093-65105, 65130-65175)

(For treatment of fractures of malar area, orbit, see 21355 et seq)

Valuation: 1.53 work RVUs, non-fac $117.22, fac $93.98
New: Subretinal Drug Delivery Injection (0810T)

Category III Codes

0810T Subretinal injection of a pharmacologic agent, including vitrectomy and 1 or more retinotomies

► (Report medication separately)
► (Do not report 0810T in conjunction with 67036, 67039, 67040, 67041, 67042, 67043)

New HCPCS Code: G2211

• E/M office visit add-on code
• Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient’s single, serious condition or a complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)
HCPCS Code: G2211 Billing and Payment

- CMS has so far produced insufficient billing/coding guidance in the rollout of G2211
  - CMS has confirmed do not report G2211 when modifier –25 is appended to an E/M
  - Do not report with Eye visit codes

**Fact Sheet: Coding for G2211 – Visit Complexity Add on Code**

<table>
<thead>
<tr>
<th>G2211 RVUs</th>
<th>2024 CF</th>
<th>G2211 Allowable Payment</th>
<th>Patient Copay (20% of Allowable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.49</td>
<td>$32.74</td>
<td>$16.04</td>
<td>$3.21</td>
</tr>
</tbody>
</table>

**2024 ICD-10-CM**

- Effective October 1, 2023 housekeeping changes
- Expanded codes that represent social determinants of health
  - Z62.23 Child in custody of non-parental relative
- H36.8- nonproliferative and proliferative sickle-cell retinopathy
- H50.6- Muscle entrapment
- G43.E- Chronic migraine with aura, intractable w or w/out status migrainosus
- H57.8A- Foreign body sensation eye (ocular)
Evolving World of Retina Drugs

- **Modifier -JZ**
  - Medicare required July 1, 2023

- **Syfovre, permanent HCPCS code J2781 effective 10/1/23**
- **Izervay, FDA approved, office - report with NOC code, facility C9162, 20 units**
- **EyeNet Savvy Coder, Nov 2023**

- **Geographic Atrophy Treatment**
  - Office - report with NOC code until permanent code assigned
  - Facility – C9161, 8 units effective 1/1/24

- **Eylea HD, 8 mg**
  - Bookmark: aao.org/retinapm

**Download the current resources:**
- **Table of Common Retina Drugs, Fact Sheets, Checklists**
  - Bookmark: aao.org/retinapm
New FDA-Approved Drugs and CPT codes

<table>
<thead>
<tr>
<th>Drug</th>
<th>HCPCS</th>
<th>NDC 5-4-2 Format Report in item 24a</th>
<th>CPT code</th>
<th>Indication(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eylea HD (afiblercept)</td>
<td>C9161-JZ (facility), 8 units eff 1/1/24 J3490 or J3590-JZ, 1 unit</td>
<td>61755-0050-01</td>
<td>67028</td>
<td>Neovascular age-related macular degeneration, diabetic macular edema, diabetic retinopathy</td>
</tr>
<tr>
<td>Izervay (avacincaptad pegol)</td>
<td>C9162-JZ (facility), 20 units eff 1/1/24 J3490 or J3590-JZ, 1 unit</td>
<td>82829-0002-01</td>
<td>67028</td>
<td>Geographic atrophy (GA) secondary to age-related macular degeneration</td>
</tr>
<tr>
<td>SYFOVRE (pegcetacoplan)</td>
<td>J2781, 15 units eff 10/1/23 C9151 deleted 10/1/23</td>
<td>73606-0020-01</td>
<td>67028</td>
<td>Geographic atrophy (GA) secondary to age-related macular degeneration</td>
</tr>
<tr>
<td>XIPERE (triamcinolone acetonide injectable suspension)</td>
<td>J3299, 4 units J3299-JW, 32 units</td>
<td>71565-0040-01</td>
<td>Eff 1/1/24 67516 0465T deleted 12/31/23</td>
<td>Macular edema associated with uveitis</td>
</tr>
</tbody>
</table>

Visit aao.org/retinapm for updates.

New Drug Treatment Checklist

**Review**
- Review FDA label for indications and frequency

**Identify**
- Identify any published payer policies

**Report**
- Report with NOC HCPCS code, (J3490 or J3590) until assigned a permanent code

**Include**
- Include on CMS-1500:
  - Item 19: medication name, dosage in mg/mL
  - Item 24a: NDC in 5-4-2 format and unit of measurement (UOM) (e.g. ML0.05)

**Monitor**
- Monitor remittance advices for appropriate payment

Appendix - Practice Perfect: How to Add a New Retina Drug to Your Practice

Protecting Sight. Empowering Lives."
New Drug Considerations

Payer challenges
- Unique policies and/or PA, step policies
- Delayed implementation of permanent HCPCS codes

NOC HCPCS codes
- Clean claims, ready to appeal

New indications
- GA diagnosis, Eylea HD does not include ME following RVO or ROP

Variance to "28-day rule"
- Eylea HD initial every 28 days +/- 7 days
- Syfovre every 25-60 days
- Izervay every 28 days +/- 7 days

Academy / ASRS
- On our radar:
  - Noridian Eylea TPE audits
  - Blue Cross step therapy policy effective 10/1/23
  - BCBS NC, GA step therapy
  - Aetna limiting covered diagnosis codes for OCT due to misinterpreting LCA
  - UHC reimbursement issues: GA, dual coverage
    - Check your contracts!
Hot Topic: JW and JZ Modifiers

Mostly impacts retina practices!

Avoid audits: Modifier JZ required July 1, 2023

JW Modifier

Effective January 1, 2017
Single-dose containers
Report on all claims that bill for unused and discarded drugs
Documentation must include amount of drug injected and wasted
Units reported must match chart note
JZ Modifier

Required July 1, 2023

Single-dose vials, containers and packages

Report when no discarded amount of drug or when less than 1 unit

Pop Quiz #1

- Do not report JW or JZ modifier for:
  A. Multi-dose vials or containers
  B. Sample drugs
  C. Specialty pharmacy drugs
  D. All of the above
**JW Modifier**

- **Incorrect**
  
  ![Incorrect JW Modifier Example]

- **Correct**
  
  ![Correct JW Modifier Example]

**JZ Modifier**

- **Incorrect**
  
  ![Incorrect JZ Modifier Example]

- **Correct**
  
  ![Correct JZ Modifier Example]
JW or JZ?

Table of Common Retina Drugs

- JW and JZ Fact Sheet
- aao.org/retinapm

Audit Update
Audit Realities

Yes, we failed

How?

What can we expect?
- Increased scrutiny

What should we do now?

Pop Quiz #2

- Which of the following statements are not included in Palmetto A53387 for Eylea:

A. It is not reasonable and necessary to injection more than one anti-VEGF in the same eye, same session.

B. If different medications are injected, the rationale must be documented, and RT/LT appended to the HCPCS code

C. Treatment for macular edema sooner than 28 days will not be covered

D. Alternating drugs every 2 weeks will be covered.
Audit Lessons to Learn

- Physician not aware of failure, until recoupments from MAC
- Auditor finding coding mistakes
- Documentation deficiencies limiting appeal options
- Trusting EHR systems
- Signature requirements
- When did the policy change?

Intravitreal Injection Documentation

Medical necessity
- Treatment plan, why the specific medication was chosen, changed or continued
- Video: How to Document Why a Specific Drug is Chosen*
- Diagnosis per FDA label and/or payer policy
- Physician order

Procedure note
- Diagnosis
- Site of injection, route of administration, eye(s)
- Dosage in mg and mL, document wastage

Inventory log
- Medication used linked to patient, date of encounter
- Available in the event of an audit

10 Steps for Retinal Surgery Coding

1. Read the full CPT code descriptor
2. Verify PA was obtained if required
3. Meet payer documentation guidelines
4. Identify global period
5. Check national correct coding initiative (NCCI) edits
6. Consider site of service differential
7. List CPT codes by RVU, from highest to lowest
8. Append modifiers
9. Link the appropriate ICD-10 code(s)
10. Submit and review remittance advice

10 Steps to Surgical Coding

Protecting Sight. Empowering Lives®
Case Study #1

Pre-Operative Diagnosis:

- Macular hole, right eye

*Procedures on the right eye:

- PPV
- Macular hole repair
- Internal limiting membrane peel
- Endolaser
- C3F8
- *Always review the detailed description of the surgical procedure in the operative report*

Case #1 Op Report Description

DESCRIPTION OF PROCEDURE: After informed consent was signed and placed on the chart, the patient was brought back to the operating room and placed on the operating room table. Cardiopulmonary monitoring equipment was placed to the patient per Anesthesia. Please see Anesthesia notes for further details. After the operative eye was prepped and draped in the usual sterile fashion, the operating microscope was brought into position. A lid speculum was placed to the eye. Peribulbar block of lidocaine and Marcaine was given. Infusion cannula was placed and verified to be in appropriate position before being turned on. Two further trocar/cannula assemblies were placed superonasally and superotemporally. A core vitrectomy was undertaken at this time followed by peripheral vitrectomy. ICG was used to stain the ILM and the ILM was peeled. Air-fluid exchange was undertaken followed by prophylactic laser. C3F8 16% gas was placed. Cannulas were removed and pressure was held to the globe. There was no evidence of any leaks. Subconjunctival injection of antibiotic and dexamethasone were placed. One drop of Neo-Poly-Dex and atropine were placed to the eye.
### Step #1 Read the Full CPT Descriptor

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Description</th>
</tr>
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<tbody>
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<td>67036</td>
<td>Vitrectomy, mechanical, pars plana approach</td>
</tr>
<tr>
<td>67039</td>
<td>Vitrectomy, mechanical, pars plana approach; with focal endolaser photocoagulation</td>
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<tr>
<td>67043</td>
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<td>67020</td>
<td>Injection, anterior chamber of eye (separate procedure); air or liquid</td>
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<tr>
<td>68200</td>
<td>Subconjunctival injection</td>
</tr>
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</table>
**Case #1: Poll the Audience**

Which vitrectomy CPT code(s) describe* the procedures?

A. 67036  
B. 67039 and 67042  
C. 67040 and 67041  
D. 67039 and 67041  
E. 67043

*not necessarily the final codes to bill

---

Pre-Operative Diagnosis:  
Macular hole, right eye

Procedures on the right eye:  
PPV  
Macular hole repair  
Internal limiting membrane peel  
Endolaser  
C3F8

---

Source: Academy  
2023 Retina Coding – Complete Reference Guide
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Steps #2, #3, and #4

Step #2
- Verify Prior Authorization was obtained if required
  - Who is the payer?
  - Obtain PA for all possible codes?

Step #3
- Meet payer documentation guidelines

Step #4 – Identify global
- Modifier...
Steps #5, #6, and #7

Step #5
- Order CPT codes highest to lowest, per RVU

Step #6
- Consider site of service differential
- N/A – RVU Facility only

Step #7
- Check national correct coding initiative (NCCI) edits
- 67042 is bundled with 67039
- Bill 67042 (higher RVU)
Steps #8, #9, and #10

**Step #8**
- Append Modifiers
- Anatomical modifier

**Step #9**
- Link appropriate ICD-10 code(s)

**Step #10**
- Submit and review remittance advice

**CPT code** | **Description**
--- | ---
67036 | Vitrectomy, mechanical, pars plana approach
67039 | Vitrectomy, mechanical, pars plana approach; with focal endolaser photocoagulation
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E/M: Decipher the Definitions

Retina Case Studies

E/M #1

• A new patient comprehensive exam is performed with a decision to perform laser to repair retinal tear (CPT code 67145), right eye. PVD, left eye.

• Code this office visit:
  A. E/M level 2, 99202
  B. E/M level 3, 99203
  C. E/M level 4, 99204
  D. Eye visit, comprehensive, 92004
Decipher the Definitions

Decision regarding elective major surgery

- E/M definition - major vs minor surgery (not based on global period)
- Without identified patient or procedure risk factors

Pitfalls to avoid:
- “We always use Eye visit codes”

E/M #2

- Determine the level of complexity for an assessed problem; exudative age-related macular degeneration with active CNV and subretinal hemorrhage:

A. Low – 1 stable chronic illness
B. Moderate – 1 or more chronic illnesses with exacerbation, progression
C. Moderate – 1 acute illness with systemic symptoms
D. High – 1 or more chronic illnesses with severe exacerbation, progression
Decipher the Definitions

1 or more chronic illnesses with exacerbation, progression

- Severe – high
- AMA: Significant risk of morbidity and may require hospital level of care

Pitfalls to avoid:

- Although the problem is "severe", must meet the E/M definition
- Not considering risk in final determination

E/M #3

- Determine the level of complexity in the data category when sending a letter to the referring physician, ordering and reviewing an OCT, FA and B-scan.

A. Minimal or none
B. Limited – 2 review/order tests
C. Moderate – 3 review/order tests
D. High – 3 review/order tests, discussion of management with external provider
Decipher the Definitions

Category 1: Tests, documents, or independent historian

- Does not include tests that are separately billable
- Does include - External tests (e.g., lab, CT scan, MRI)

Category 3: Discussion of management

- Letter to referring physician does not count
- Two-way discussion for patient management

Pitfalls to avoid:

- Not documenting eligible MDM data components

<table>
<thead>
<tr>
<th>E/M #4</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Determine the level of complexity for a new problem; acute posterior vitreous detachment:</td>
</tr>
<tr>
<td>A. Low – 1 acute, uncomplicated illness</td>
</tr>
<tr>
<td>B. Low – 1 acute, uncomplicated illness, requiring hospital inpatient or observation level of care</td>
</tr>
<tr>
<td>C. Moderate – 1 undiagnosed new problem with uncertain prognosis</td>
</tr>
<tr>
<td>D. Moderate – 1 acute illness with systemic symptoms</td>
</tr>
</tbody>
</table>
Decipher the Definitions

1 acute uncomplicated illness (low) vs:
- Undiagnosed new problem with uncertain prognosis (moderate) is defined as a problem in the differential diagnosis that represents a condition likely with high risk of morbidity without treatment

Pitfalls to avoid:
- New problems are not all uncertain prognosis
- Even if PVD chronic and stable, low
- Systemic symptoms are not fever, fatigue from a minor illness
- Consider risk, meet or exceed 2/3
- Not considering an Eye visit code

E/M #5
- The chart documentation states the patient checked in at 9:05 am and checked out at 10:02 am. The physician had previously ordered OCT/FA/FP, exam of the fellow eye and scheduled injection.
- How would you code this case?
  A. 99215, 40 minutes total time
  B. 99215 + 99417, 40 minutes + prolonged services
  C. Retina visits are always an E/M level 4
  D. Additional documentation required to code
Decipher the Definitions

Total physician time on the date of the encounter

- Includes – face-to-face encounter and non-face-to-activities; reviewing chart notes, ordering lab coordinating care, documenting in EHR
- Does not include - wait time, technician work-up, performing diagnostic tests, non-medical discussions with patient

Pitfalls to avoid:

- Missing documentation of physician activities on the date of encounter
- Prolonged services should only billed with level 5 with additional 15-minute intervals
- "Our physician spends more time with patients"
- Excessive high levels linked to specific diagnosis codes may prompt payer scrutiny

<table>
<thead>
<tr>
<th>CPT 2024</th>
<th>Meet or exceed</th>
</tr>
</thead>
<tbody>
<tr>
<td>99202</td>
<td>15</td>
</tr>
<tr>
<td>99203</td>
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<td>99204</td>
<td>45</td>
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<tr>
<td>99214</td>
<td>30</td>
</tr>
<tr>
<td>99215</td>
<td>40</td>
</tr>
</tbody>
</table>

E/M #6

- An established patient with a worsening chronic retinal detachment and surgery is discussed, patient consents and to be scheduled, next available.

- Determine the level of E/M:

  A. 99212, E/M level 2
  B. 99213, E/M level 3
  C. 99214, E/M level 4
  D. 99215, E/M level 5
Decipher the Definitions

1 chronic illness with progression
- For, 1 chronic illness that pose a threat to body function, requires:
  - Requiring treatment in the near term (eg 24 hrs.) or the patient will go blind or have significant visual loss

Decision for elective major surgery
- High risk would be emergency major surgery

Pitfalls to avoid:
- "An office visit to schedule RD surgery is always a level 5"
- Consider problem definition
- Urgent vs emergent

Questions?