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

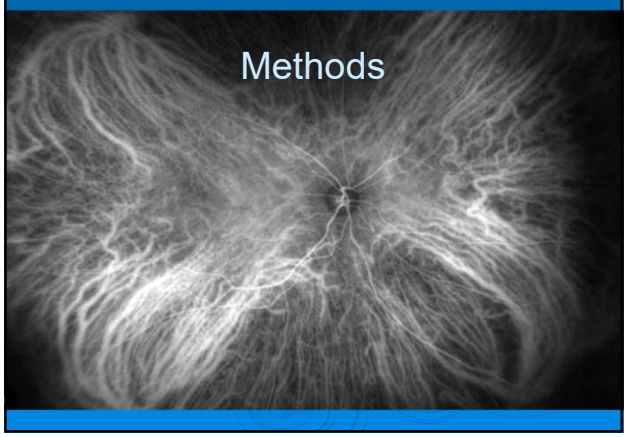
Sunday 09 | Financial Planning Strategies for the Small Retina Practice

Sunday 10 | Coding Update

Christian T. Jurs

Special Agent
U.S. Department of Health and Human Services
Office of Inspector General
Office of Investigations

Methods



Peer Comparison: Diagnosis

Provider	Year	Percent of beneficiaries diagnosed with 362.52
All others	2005	2.87%
Pon	2005	49.80%
All others	2006	3.22%
Pon	2006	59.08%
All others	2007	3.56%
Pon	2007	69.73%
All others	2008	3.89%
Pon	2008	91.19%
All others	2009	4.11%
Pon	2009	96.22%
All others	2010	4.35%
Pon	2010	97.46%
All others	2011	5.87%
Pon	2011	98.03%

Peer Comparison: ICG

Provider	Year	Units of 92240 billed per beneficiary	Percent of beneficiaries who got 92240	Units of 92240 billed per beneficiary who got that service
All others	2005	0.0045	0.14%	3.1700
Pon	2005	6.3900	43.20%	14.7917
All others	2006	0.0041	0.13%	3.2105
Pon	2006	7.8603	58.68%	13.3946
All others	2007	0.0032	0.09%	3.6038
Pon	2007	9.5448	70.18%	13.6006
All others	2008	0.0053	0.14%	3.8137
Pon	2008	12.0238	90.95%	13.2199
All others	2009	0.0059	0.16%	3.5880
Pon	2009	12.0236	95.51%	12.5891
All others	2010	0.0057	0.18%	3.2096
Pon	2010	12.0636	95.67%	12.6090
All others	2011	0.0046	0.20%	2.3467
Pon	2011	5.9738	95.74%	6.2397

Peer Comparison: Laser

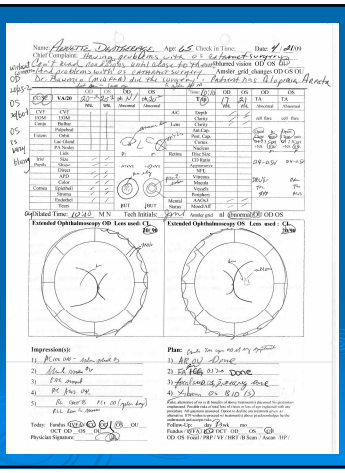
Provider	Year	Units of 67220 billed per beneficiary	Percent of beneficiaries who got 67220	Units of 67220 billed per beneficiary who got that service
All others	2005	0.0023	0.18%	1.2734
Pon	2005	1.2180	31.60%	3.8544
All others	2006	0.0016	0.13%	1.2680
Pon	2006	1.6627	50.30%	3.3056
All others	2007	0.0012	0.09%	1.2803
Pon	2007	2.4417	65.70%	3.7167
All others	2008	0.0011	0.08%	1.3364
Pon	2008	3.6357	86.43%	4.2066
All others	2009	0.0011	0.08%	1.3955
Pon	2009	3.9007	92.43%	4.2199
All others	2010	0.0009	0.07%	1.3626
Pon	2010	3.8931	92.62%	4.2033
All others	2011	0.0007	0.05%	1.2472
Pon	2011	0.9803	62.62%	1.5654

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

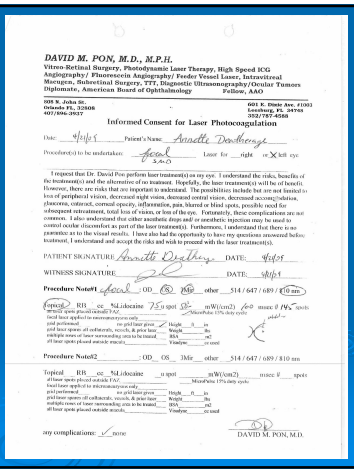
Initial Visit

- Exam note
- Shows drawing of macular disease in left eye and laser treatment is advised



Initial Visit

- Laser form



DAVID M. PON, M.D., M.P.H.
Vitreo-Retinal Surgery, Photodynamic Laser Therapy, High Speed ICG Angiography/ Fluorescein Angiography/ Feeder Vessel Laser, Intravitreal Macugen, Subretinal Surgery, TTT, Diagnostic Ultrasonography/Ocular Tumors
Diplomate, American Board of Ophthalmology — Fellow, AAO

909 N. Johs St.
Orlando FL, 32808
407/896-2027

601 E. Dixie Ave. #1003
Leesburg, FL 34748
352/787-6500

Informed Consent for Laser Photocoagulation

Date: 4/15/09 Patient's Name: Annette Deatherage

Procedure(s) to be undertaken: Focal Laser for right or X left eye.

I request that Dr. David Pon perform laser treatment(s) on my eye. I understand the risks, benefits of the treatment(s) and the alternative of no treatment. Hopefully, the laser treatment(s) will be of benefit. However, there are risks that are important to understand. The possibilities include but are not limited to loss of peripheral vision, decreased night vision, decreased central vision, decreased accomodation, glaucoma, cataract, corneal opacity, inflammation, pain, blurred or blind spots, possible need for subsequent retreatment, total loss of vision, or loss of the eye. Fortunately, these complications are not common. I also understand that either anesthetic drops and/ or anesthetic injection may be used to control ocular discomfort as part of the laser treatment(s). Furthermore, I understand that there is no guarantee as to the visual results. I have also had the opportunity to have my questions answered before treatment. I understand and accept the risks and wish to proceed with the laser treatment(s).

PATIENT SIGNATURE: Annette Deatherage DATE: 4/15/09

WITNESS SIGNATURE: DATE: 4/15/09

Procedure Note#1 focal OD OS other 514 / 647 / 689 / 810 nm

Topical RR cc %Lidocaine 75 spot 50 mW/(cm2) 60 msec # 145 spots

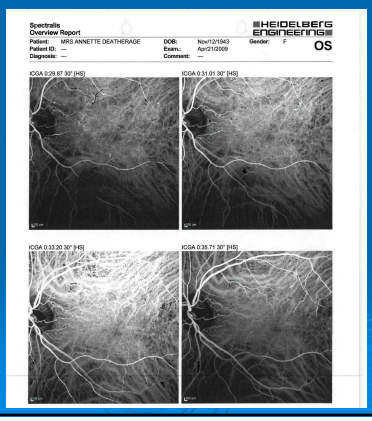
Procedure Note#2 OD OS other 514 / 647 / 689 / 810 nm

Topical RR cc %Lidocaine u spot mW/(cm2) msec # spots

any complications: ✓ none

DAVID M. PON, M.D.

Initial Visit



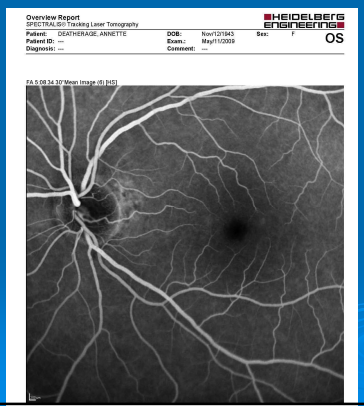
Spectralis
Overview Report

HEIDELBERG ENGINEERING

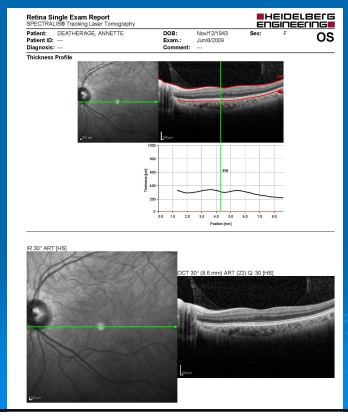
Patient: MRS ANNETTE DEATHERAGE
Patient ID: ---
Diagnosis: ---
DOB: Nov/12/1943
Exam.: Apr/21/2009
Comment: ---
Gender: F
OS

ICGA 0:29.87 30° [HS]
ICGA 0:31.01 30° [HS]
ICGA 0:33.20 30° [HS]
ICGA 0:35.71 30° [HS]

One Month Visit

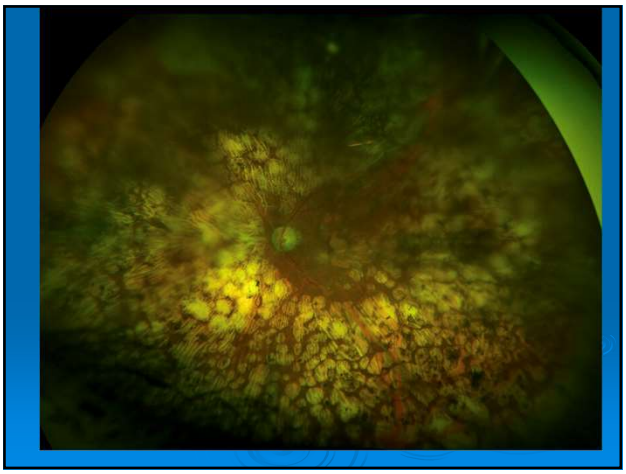


Two Month Visit



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

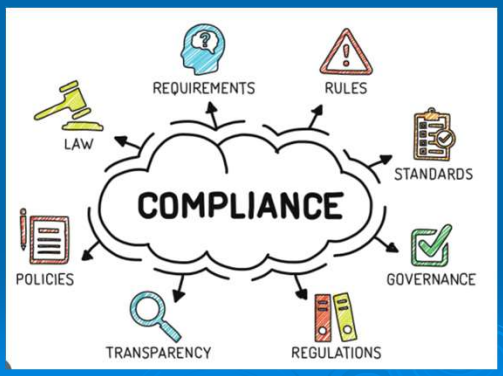
- "Telemedicine" companies
- Stem cell Tx/Regenerative Medicine
- Stark/Kickbacks
- Amniotic membrane treatment w/o prior Tx
- Most of the ophthalmologist we see - cataract or glaucoma
  - Falsify cloudiness or ocular pressures
  - Unnecessary lens replacement
  - Easy to maintain good pressures when 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%

Modifier 25

- 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



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COLORADO RETINA RETINA

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

2

Genesis of Our Lean Journey:
Finding Problems, Fixing Processes

#1 Pt c/o ~ Wait Times

#1 Burnout ~ Admin Tasks

3

Sharing Our Experience With Lean to De-Risk Your Journey
2017-2024…

Prepare!
- AAOE, MGMA, ASRS
- Data Infrastructure
- Site Visits
- Mentorship
- Leadership
- Change Management

4

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

Eliminating Waste in US Health Care
Donald M. Berwick, MD, MPP
Andrew D. Hackbarth, MPhil
JAMA.2012;307(14):doi:10.1001/jama.2012.362

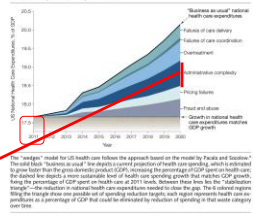
"The need is urgent to bring US health care costs into a sustainable range for both public and private payers.

Commonly, programs to contain costs use cuts, such as reductions in payment levels, benefit structures, and eligibility. A less harmful strategy would reduce waste, not value-added care. The opportunity is immense.

In just 6 categories of waste—overtreatment, failures of care coordination, failures in execution of care processes, administrative complexity, pricing failures, and fraud and abuse—the sum of the lowest available estimates exceeds 20% of total health care expenditures."

Administrative Complexity

Figure. Proposed "Wedges" Model for US Health Care, With Theoretical Spending Reduction Targets for 6 Categories of Waste



5

JAMA | Special Communication

Waste in the US Health Care System
Estimated Costs and Potential for Savings

William H. Shrank, MD, MSHS; Teresa L. Rogstad, MPH; Natasha Parekh, MD, MS

~ 25-30% of Spending is Waste!

~ $256B Waste from Administrative Complexity

Table 2. Cost Estimates by Waste Domain

Domain	Costs, $US Billion Annual Estimates	Total Range
Failure of Care Delivery		
Hospital-acquired conditions and adverse events[39–41]	5.7-44.6	
Clinician-related inefficiency (variability in care, inefficient use of high-cost physicians)[42,43]	8.0	102.4-161.7
Lack of adoption of preventive care practices (obesity, vaccines, diabetes, hypertension)[44–50]	80.6-111.1	
Failure of Care Coordination		
Unnecessary admissions and avoidable complications[46,48]	5.9-58.3	27.2-76.2
Readmissions[49,50]	21.25-21.93	
Overtreatment or Low-Value Care		
Low-value medication use[47,49,50]	16.6-29.1	
Low-value screening, testing, or procedures[39,49,51]	17.2-27.9	75.7-101.2
Overuse of end-of-life care[52]	48.1	
Pricing Failure		
Medication pricing failure[8]	169.7	
Payer-based health services pricing failure[28,53]	31.4-41.2	238.7-248.5
Laboratory and ambulatory pricing[28]	29.7	
Fraud and Abuse		
Fraud and abuse in Medicare[49,54]	50.5-83.9	50.5-83.9
Administrative Complexity		
Billing and collecting activity[55]	248	260.8
Physician time spent reporting on quality measures[56]	17.6	

Administrative Complexity

"[W]aste that comes when government, accreditation agencies, payers, and others create inefficient or misguided rules. For example, payers may fail to standardize forms, thereby consuming limited physician time in needlessly complex billing procedures."

Commitment to Continuous Improvement From Top-to-Bottom

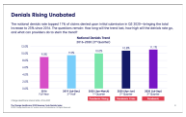
Setting the revenue cycle up for success in automation and AI. McKinsey, July 2023

- *"**Health system leaders** can capture value by being nimble and failing fast when required, adjusting rapidly and pursuing opportunities for value as they shift, and investing for the long-term by setting the technology foundation to enable automation, analytics, and – when it's ready – gen AI."*
- *"…**Leaders from within the revenue cycle function** …a willingness to seek out 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 Bear the Burden Alone!
    - RCM Staff
    - Scribe-MD's "structured" documentation
    - Pre-Visit Prep, Call Center & Front Desk
    - Payor Contracting Teams
- *Ultimately leading to improved Stakeholder collaboration? + AI tools on the horizon to avoid them (predictive analytics)*

The "Current State" of Denied Claims

Revenue Cycle



Lean Works for Health Care

- **Conceptual Leap: Assembly Line → Healthcare Delivery → RCM**
  - **Lean Make Workflows Efficient by Eliminating Waste**
- **Lean Tools Make Clinical Processes More Efficient.**
  - **Value-Stream Mapping (VSM):** Find & 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."

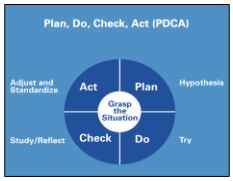
-- *attributed to Albert Einstein*

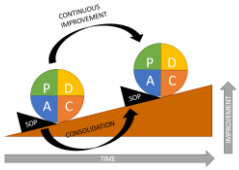
"WAIT!!!
Gimme a second."

Making the Case for Structured Problem-Solving

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

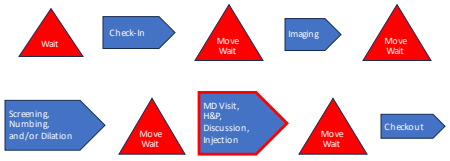
Structured Problem-Solving of Lean:





PDCA Cycles, SOPs Consolidate Gains

Value-Stream Mapping of Retina Clinic



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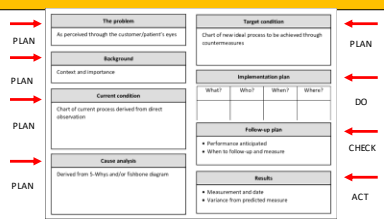
A3 Template +
Plan-Do-Check-Act Cycle Embedded Within



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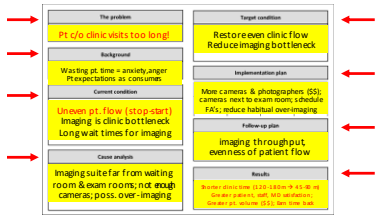
A3 Template:
Retina Clinic Bottleneck



Patient-Centricity = Major Health Policy Meme

15

Summary

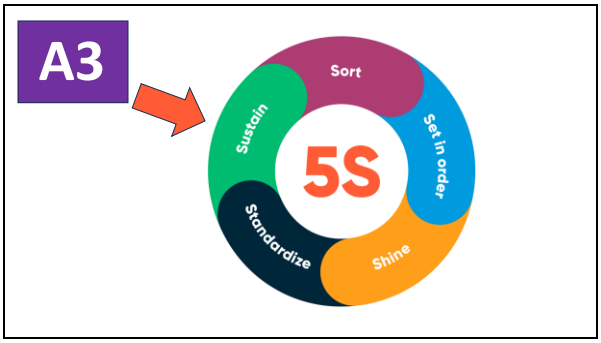
- **Reframe: Visualize a String of Process Steps**
- **Lean's Structured Problem-Solving Tools**
  - A3 Template + PDCA Cycle + SOPs
  - Collaboration Improves Creativity
  - Discipline Prevents You From Leaping to the First Solution
- **Lean Culture: Lean Thinking is Invisible**
  - Are You Allowed 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…**

16

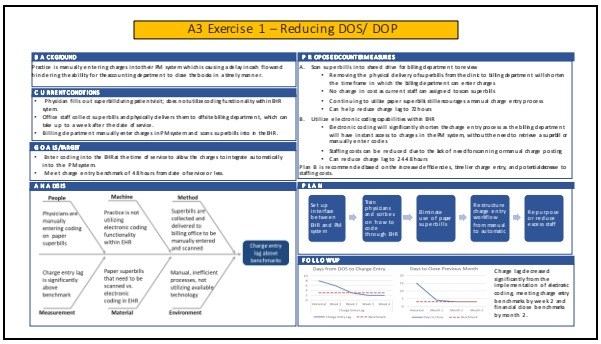
17

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
Sort
Set in order
Shine
Standardize
Sustain
5S


5S: SUSTAIN
Make 5S a way of life by forming the habit of always following the first four S's.
Sort
Set in order
Shine
Standardize
Sustain
5S


A3 Exercise 1 – Reducing DOS/ DOP
BACKGROUND
Practice is manually entering charges into their PM system which is causing a delay in cash flow and hindering the ability for the accounting department to close the books in a timely manner.
CURRENT CONDITIONS
Physician fills out superbill during patient visit; does not utilize coding functionality within EHR system.
Office staff collect superbills and physically delivers them to offsite billing department, which can take up to a week after the date of service.
Billing department manually enter charges in PM system and scans superbills into in the EHR.
GOAL/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 from date of service or less.
PROPOSED COUNTERMEASURES
A. Scan superbills into shared drive for billing department to review
Removing the physical delivery of superbills from the clinic to billing department will shorten the timeframe in which the billing department can enter charges
No change in cost as current staff can assigned to scan superbills
Continuing to utilize paper superbills still encourages a manual charge entry process
Can help reduce charge lag to 72 hours
B. 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 to retrieve a superbill or manually enter codes
Staffing costs can be reduced due to the lack of need for scanning or manual charge posting
Can reduce charge lag to 24-48 hours
Plan B is recommended based on the increased efficiencies, timelier charge entry, and potential decrease to staffing costs.
ANALYSIS
People
Machine
Method
Physicians are manually entering coding on paper superbills
Practice is not utilizing electronic coding functionality within EHR
Superbills are collected and delivered to billing office to be manually entered and scanned
Charge entry lag above benchmarks
Charge entry lag is significantly above benchmark
Paper superbills that need to be scanned vs. electronic coding in EHR
Manual, inefficient processes, not utilizing available technology
Measurement
Material
Environment
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
Days from DOS to Charge Entry
Days to Close Previous Month
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 a delay in cash flow and hindering the ability for the accounting department to close the books in a timely manner.

CURRENT CONDITIONS

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

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 from date of service or less.

A3 Exercise 1 – Reducing DOS/ DOP

ANALYSIS

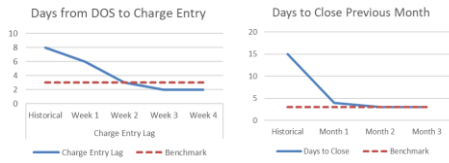
PROPOSED COUNTERMEASURES

- 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 to retrieve a superbill or manually enter codes
  - Staffing costs can be reduced due to the lack of need for scanning or manual charge posting
  - Can reduce charge lag to 24-48 hours

PLAN

A3 Exercise 1 – Reducing DOS/ DOP

FOLLOWUP



- Charge lag decreased significantly from the implementation of electronic coding, meeting charge entry benchmarks by 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.

A3 Exercise 2 – Reducing % of AR > 90 Days

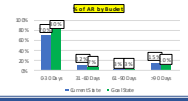
BACKGROUND

•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

CURRENT CONDITIONS

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

GOAL/TARGET



ANALYSIS

Billing Specialist	Completed	In Progress	Not Started	Grand Total	% Completed/ In Progress
Biller 1	3248	397	469	4114	89%
Biller 2	3105	72	1459	4636	69%
Biller 3	3924	190	789	4903	84%
PT Assistance Specialist	1529	800	691	3020	77%
Billing Lead	2663	80	517	3260	84%
Billing Supervisor	1896	128	768	2792	72%
Grand Total	16365	1667	4693	22725	79%

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

PLAN

- 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 later lead to increase in AR >90 Days
- Billers – required to work a certain number of tasks per week

FOLLOWUP

- Create monthly physician productivity reports, including top 10-15 high dollar accounts > XX 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

A3 Exercise 2 – Reducing % of AR > 90 Days

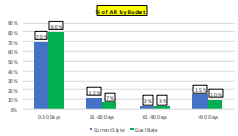
BACKGROUND

•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

CURRENT CONDITIONS

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

GOAL/TARGET



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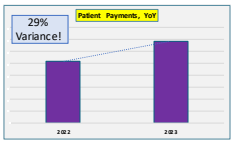
RCM – POST LEAN

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 an automated payment module 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

50 Anniversary Associated Retina Consultants

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)

	Cost	Medicare	Gross	Margin
Eylea (J0178)	$ 1,616.90	$ 1,724.56	$ 107.66	6.7%
Lucentis 0.3 (J2778)	$ 521.82	$ 562.65	$ 40.83	6.7%
Cimerli 0.3 (Q5128)	$ 689.40	$ 786.24	$ 96.84	14.0%
Lucentis 0.5 (J2778)	$ 869.70	$ 937.75	$ 68.05	7.9%
Cimerli 0.5 (Q5128)	$ 1,149.00	$ 1,310.40	$ 68.05	14.0%
Ozurdex (J7312)	$ 1,373.00	$ 1,439.27	$ 66.27	4.8%
Iluvien (J7313)	$ 8,800.00	$ 9,328.05	$ 528.05	6.0%
Yutiq (J7314)	$ 8,996.00	$ 9,522.00	$ 526.00	5.8%
Vabysmo (J2777)	$ 2,034.51	$ 2,166.00	$ 131.49	6.5%
Beovu (J0179)	$ 1,880.76	$ 1,951.44	$ 70.68	3.8%
Syfovre (J2781)	$ 2,146.20	$ 2,271.90	$ 125.70	5.9%
Eylea HD (J3590)	$ 2,579.06	$ 2,782.50	$ 203.44	7.9%

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." If $5 to $7.50 (50% markup).
  - **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

Augustus Gloop

Sources for additional information

- RETNET
- ASRS
- AAO –Codequest
- Advocacy
  - AAO Midyear Forum Apr 17-20, 2024

ASRS American Society of Retina Specialists

Washington Update

Michael M. Lai, MD, PhD, FASRS
Chairman
ASRS Federal Affairs Committee

ASRS

Financial Disclosure

- No relevant financial relationships to disclose.

ASRS

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.

ASRS

Physician Payment: What Happened this Week

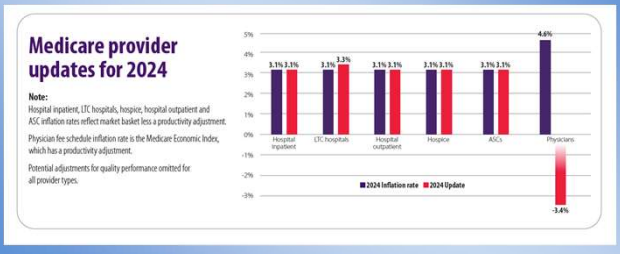
- **ASRS advocated for immediate relief from the full 3.4% Medicare payment cuts that went into effect January 1, 2024.**
- Advocacy efforts from all across medicine, including **660** ASRS members and practice staff sending **2327** messages to legislators, resulted in partial relief restoring approximately 50% of the cut.
- But Congress failed to fix the full cut
- The final result – a **2.04%** cut from 2023 payment levels.

ASRS

Physician Payments – Two Decades Behind Inflation

ASRS

Only Physicians Got Cut in 2024



ASRS

Retina Codes Adjusted for Inflation

	ESTABLISHED EXAM 92012	ESTABLISHED EXAM 92014	NEW EXAM 99204	OCT 92134	FA 92235	FP 92250	RETINOPEXY 67145	INJECTION 67028	PPV 67036	PPV/PRP 67040	PPV/LM 67042	RD REPAIR 67108
2014	87.41	126.8	166.64	46.4	111.31*	79.66	548.42	106.65	1,004.12	1,486.10	1,588.92	1,662.62
2024	90.48	127.6	167.48	48.91	166.66	37.54	245.11	113.26	891.84	1,027.89	1,132.22	1,177.84
Adjusted Inflation*	115.21	166.92	219.71	61.18	146.76*2	105.03	723.09	140.62	1322.93	1959.41	2094.98	2218.82
Adjusted 2024%	78.58%	76.44%	76.23%	66.87%	56.78%	31.83%	33.89%	80.54%	67.36%	52.46%	54.04%	53.09%

bls.gov*

Bilat as of '17

ASRS

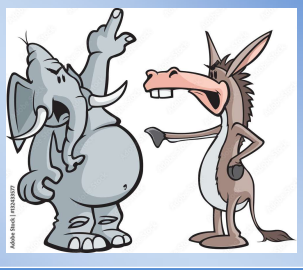
Physician Payment: What We Want

- 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.

ASRS

So what are we likely to get?

The political situation complicates our prospects.



ASRS

Administration Priorities

1. Get re-elected.
2. Get re-elected.
3. Maintain positive economic growth/soft landing.
4. Contain border/migrant issues.
5. Prevent further escalation of foreign conflicts.

ASRS

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.

ASRS

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.

ASRS

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.

ASRS

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

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

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.

ASRS

ASRS

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

MDs/DOs

Practice Staff

ASRS

THANK YOU & QUESTIONS?

ASRS American Society of Retina Specialists

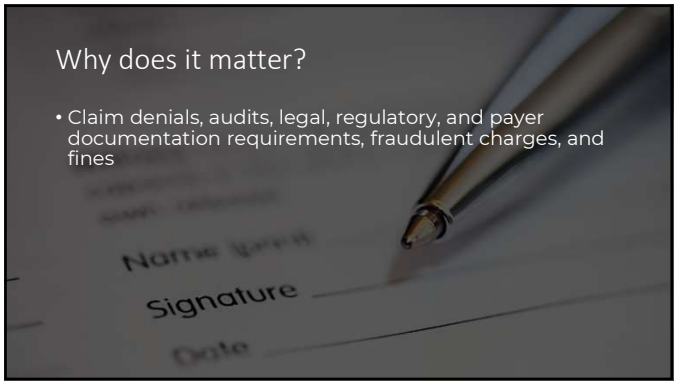
TEXAS RETINA ASSOCIATES

Documentation Compliance
Training Scribes and Staff

Niki Kothari, MD

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

Image credit: https://medtigo.com/blog/how-virtual-scribes-transform-physician-productivity/

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

Training a scribe

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

https://www.aao.org/Assets/076ecf7c-d748-4a79-92ba-da0100d8374f/638212240529670000/eye-visit-code-cl-pdf?inline=1

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 patients 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 compliant 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

Biggest pitfalls

- Use of modifiers
  - If you exclude the decision to inject, would your note warrant billing an exam? If so, then a modifier 25 with the exam is appropriate

How to avoid pitfalls

Document during or immediately after the visit

Be careful when copying forward

Be specific when talking to scribes

"Please add punctate 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)

So you want to build a Retina ASC

Joel Pearlman, MD, PhD
VRMG, Inc
Retina Consultants of America

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

MEDICARE/MEDICAID

STATE

LOCAL

PHARMACY

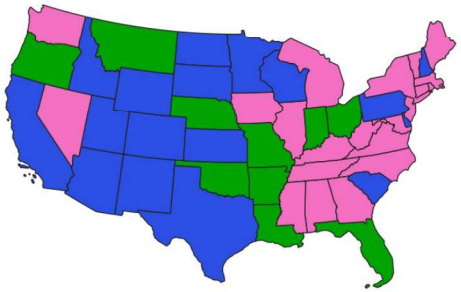
INSURANCE PANELS

Certificates of Need

CON

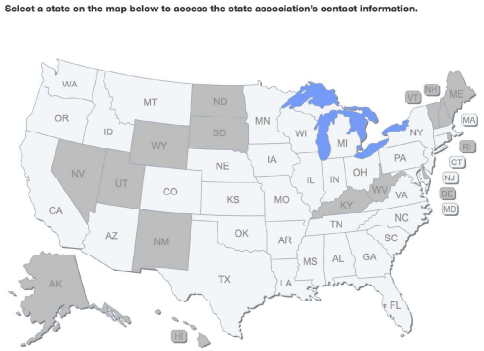
No CON

No CON Law



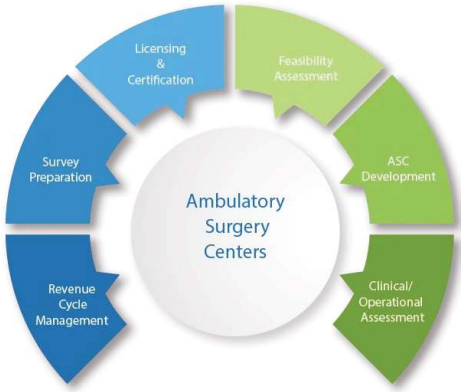
State ASC Associations

- https://www.ascassociation.org/asca/asc-operations/state-resources/find-a-state-association#CA



Consultants

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



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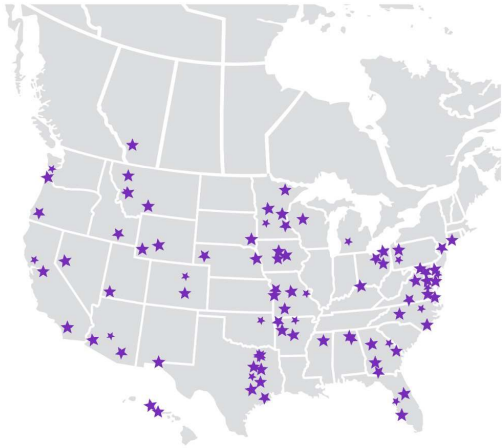


Staffing

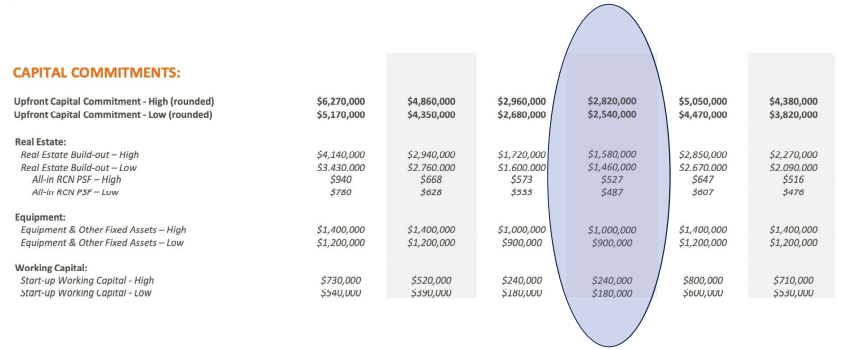
Common Code Facility Fees (CMS)

HCPCS Code	Short Description	Facility Price
67036	Removal of inner eye fluid	$939.30
67039	Laser treatment of retina	$1,003.30
67040	Laser treatment of retina	$1,080.75
67041	Vit for macular pucker	$1,189.57
67042	Vit for macular hole	$1,189.57
67043	Vit for membrane dissect	$1,253.38
67101	Repair detached retina crtx	$301.36
67105	Repair detached retina pc	$290.64
67107	Repair detached retina	$1,169.90
67108	Repair detached retina	$1,237.06
67110	Repair detached retina	$858.33
67113	Repair retinal detach cplx	$1,383.56

Common Surgical Costs/Pass-Throughs

Pack	$400-600
Drape Pack	$50
Forceps	$100-150
Laser Probe	$100-150
Other Disposable Instuments	$100-200
Disposable Wide-Angle Viewing	$200
PFO	$500
Silicone Oil	$400

Finances



CAPITAL COMMITMENTS:

Upfront Capital Commitment - High (rounded)	**$6,270,000**	**$4,860,000**	**$2,960,000**	**$2,820,000**	**$5,050,000**	**$4,380,000**
Upfront Capital Commitment - Low (rounded)	**$5,170,000**	**$4,350,000**	**$2,680,000**	**$2,540,000**	**$4,470,000**	**$3,820,000**
Real Estate:						
Real Estate Build-out – High	*$4,140,000*	*$2,940,000*	*$1,720,000*	*$1,580,000*	*$2,850,000*	*$2,270,000*
Real Estate Build-out – Low	*$3,430,000*	*$2,760,000*	*$1,600,000*	*$1,460,000*	*$2,670,000*	*$2,090,000*
All-in RCN PSF – High	*$940*	*$668*	*$573*	*$527*	*$647*	*$516*
All-in RCN PSF – Low	*$780*	*$628*	*$533*	*$487*	*$607*	*$476*
Equipment:						
Equipment & Other Fixed Assets – High	*$1,400,000*	*$1,400,000*	*$1,000,000*	*$1,000,000*	*$1,400,000*	*$1,400,000*
Equipment & Other Fixed Assets – Low	*$1,200,000*	*$1,200,000*	*$900,000*	*$900,000*	*$1,200,000*	*$1,200,000*
Working Capital:						
Start-up Working Capital - High	*$730,000*	*$520,000*	*$240,000*	*$240,000*	*$800,000*	*$710,000*
Start-up Working Capital - Low	*$540,000*	*$390,000*	*$180,000*	*$180,000*	*$600,000*	*$530,000*

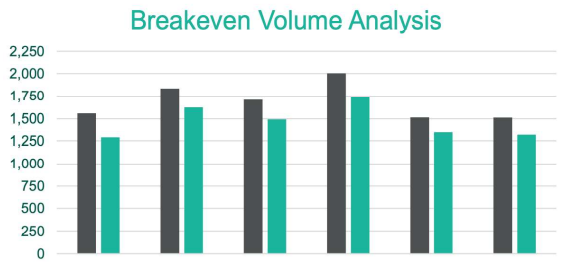
Feasibility Analysis P&L

SUMMARY P&L:						
Total Net Operating Revenue ('000's)	**$3,617.9**	**$2,357.5**	**$975.3**	**$924.7**	**$3,944.1**	**$3,378.8**
Operating Expenses ('000's)						
Employee Payroll Costs	$763.7	$428.6	$235.4	$189.7	$595.6	$492.6
Medical Supplies	$1,212.4	$984.5	$412	$422.5	$1,509.2	$1,379.4
Other Operating Costs	$230.2	$181.5	$87.3	$112.1	$326.4	$283.5
Total Operating Expense ('000's)	**$2,206.3**	**$1,594.6**	**$734.8**	**$724.3**	**$2,431.2**	**$2,155.5**
EBITDA ('000's)	**$1,411.6**	**$762.9**	**$240.4**	**$200.4**	**$1512.9**	**$1,223.4**
SUMMARY COMMON - SIZE P&L:						
Total Net Operating Revenue	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Operating Expenses						
Employee Payroll Costs	21.1%	18.2%	24.1%	20.5%	15.1%	14.6%
Medical Supplies	33.5%	41.8%	42.3%	45.7%	38.3%	40.8%
Other Operating Costs	6.4%	7.7%	9.0%	12.1%	8.3%	8.4%
Total Operating Expense	**61.0%**	**67.6%**	**75.3%**	**78.3%**	**61.6%**	**63.8%**
EBITDA	**39.0%**	**32.4%**	**24.7%**	**21.7%**	**38.4%**	**36.2%**

ROI Analysis

RETURN ON INVESTMENT ANALYSIS						
Discretionary Cash Flow (High Capital Commitment)	$1,321,563	$672,904	$170,449	$130,412	$1,422,846	$1,133,392
Discretionary Cash Flow (Low Capital Commitment)	$1,331,563	$682,904	$180,449	$140,412	$1,432,846	$1,143,392
Annual Return (Cash Flow / High Capital Commitment)	21.1%	13.8%	5.8%	4.6%	28.2%	25.9%
Annual Return (Cash Flow / Low Capital Commitment)	25.8%	15.7%	6.7%	5.5%	32.1%	29.9%
Payback Period (High Capital Equipment)	4.7 years	7.2 years	17.4 years	21.6 years	3.5 years	3.9 years
Payback Period (Low Capital Equipment)	3.9 years	6.4 years	14.9 years	18.1 years	3.1 years	3.3 years

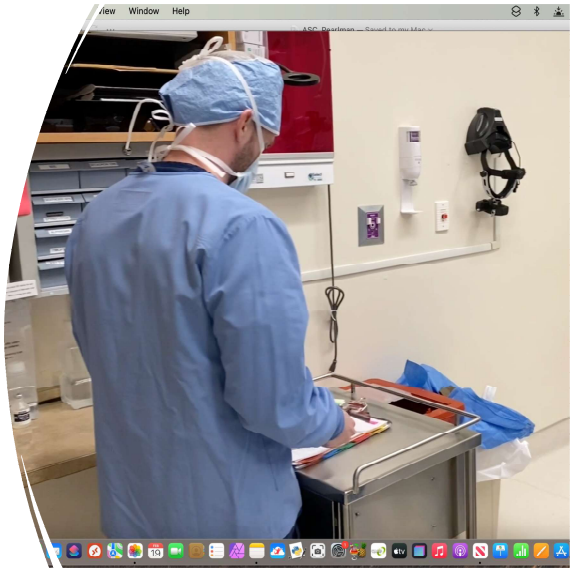
Breakeven Analysis (by Cases)

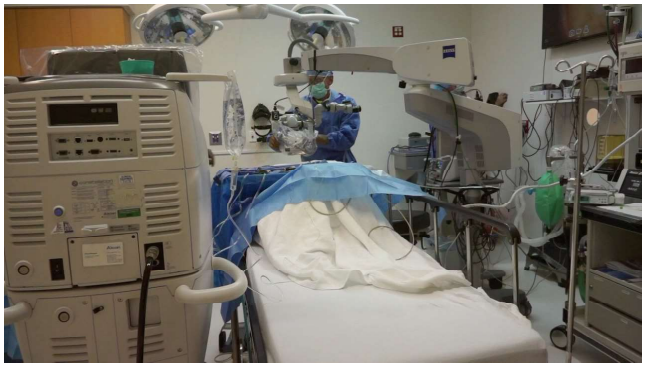


Keys to Success

- 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
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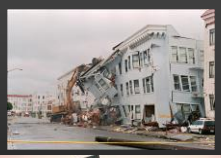
West Coast Retina

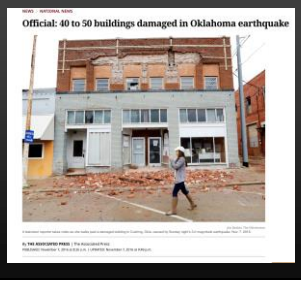
Disasters

- 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

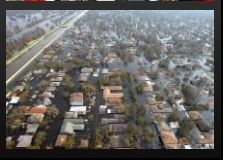
San Francisco-1989

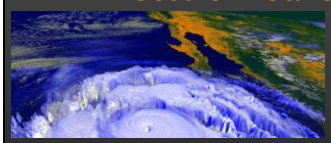
Oklahoma City -2016



New Orleans - 2005



Southern California - 2023



Santa Rosa - 2017

Hundreds of Sonoma County doctors displaced by fires

More than 200 local doctors are looking for temporary or permanent housing, representing 1 in every 6 Santa Rosa physicians.

The New York Times

March 9, 2024

Cyberattack Paralyzes the Largest U.S. Health Care Payment System

The hacking shut down the nation's biggest health care payment system, causing financial chaos that affected a broad spectrum ranging from large hospitals to single-doctor practices.

JAMA Health Forum.

Original Investigation

Trends in Ransomware Attacks on US Hospitals, Clinics, and Other Health Care Delivery Organizations, 2016-2021

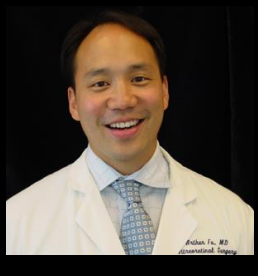
STAT+

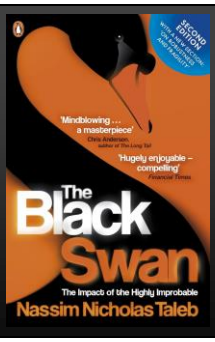
Change Healthcare cyberattack outage could persist for weeks, UnitedHealth Group executive suggests

The outage caused by the Change Healthcare cyberattack could last weeks, a top UnitedHealth executive suggested in a Tuesday conference call with hospital cybersecurity officers, according to a recording obtained by STAT.

UnitedHealth Group Chief Operating Officer Dirk McMahon said the company is setting up a loan program to help providers who can't submit insurance claims while Change is offline. He said that program will last "for the next couple of weeks as this continues to go on."

Arthur D. Fu, MD 1971-2020





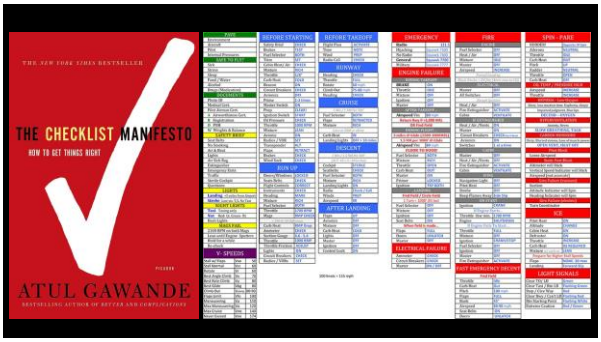
Priority Areas to Address

- 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.
- Maintain emergency contact information for employees.
- Have a policy in place that requires staff to report to the office to receive triage directions and possible placement at satellite offices.

Curi *Disaster Panning for the Medical Office* 2020.
https://curi.com/wp-content/uploads/2020/03/Disaster-Planning-2020_LFK-edited-1.pdf

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.

Curi *Disaster Panning for the Medical Office* 2020.
https://curi.com/wp-content/uploads/2020/03/Disaster-Planning-2020_LFK-edited-1.pdf

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.

https://www.hhs.gov/hipaa/for-professionals/faq/960/can-health-care-information-be-shared-in-a-severe-disaster/index.html

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 the call 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., your satellite office or other temporary location). In extreme circumstances, you may have to refer the patient to another practice or send 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 in order to schedule patients efficiently.
- Maintain an off-site list of all phone and cell numbers to which your practice may need access.
- If 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.

Management of Hospital/OR Communication
During and After a Disaster

- Designate one staff member to stay in touch with each physician. Consider having a back-up physician on-site 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

- Know your area resources
- Identify a contact name and phone number for all local resources named above.
- Develop a vendor contact list. For example, who would you call for fallen trees that obstruct the path to your office?
- Consider speaking with other professionals who may have experienced the same types of disaster your office may face one day.
- Contact restoration companies who specialize in fire, water, or storm damage to find out what type of services are available in your area.
- Be prepared to set up a temporary office in another location.
- Have a plan for funneling supplies and staff if you have to set up the office in a temporary location.
- Keep a disaster box. Use a box that is on rollers for easy portability. Consider including some or all of the following items in the box:
- Keep an up-to-date 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.

Management of the Facility
During and After a Disaster

- Consider using area hotels as a temporary resource. They often have internet access.
- Provide for equipment and electrical safety. Unplug all electrical appliances.
- Have a containment area available.
- Adjust your level of service depending on the type of disaster.
- Use the local media. It can be a resource for patients and staff regarding shelters, medical care, safety, emergency refills, and transportation. Know in advance how to reach such resources and keep that information off-site.
- Consider developing an employee relief fund or soliciting donations to help those in need.
- If you anticipate flooding:
  - Cover all computers and other equipment with plastic to prevent water damage.
  - Elevate all equipment off the floor if possible.
  - Utilize sandbags for low-level or basement doors. In most areas, you can purchase premade 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 if the water is off. The same advice applies to a re-circulating pump.

Management of Business Operations
Before a Disaster

- Review insurance policies for current coverage. Make this an annual review. Pay special attention to loss of business (revenue) 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 the review of any non-waiver agreements or reservation of rights. Be aware of any exclusions to your policy.
- 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 rolodex cards and keep off-site. Alternatively, have information in electronic format (for example, a spreadsheet or electronic handheld device).
- Keep copies of insurance policies, contacts, business licenses, and any associated documents in a easily accessible place in case you need to get out of the office quickly. Use a file folder system so that the folder can be removed from the office if the need to leave becomes immediate.
- Develop a back-up 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 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

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Disaster Planning
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Implementing DISC to Drive Organizational Culture

Scott Westhouse, DO
ASRS Business of Retina 2024

Retina Specialists of Michigan

Disclosures

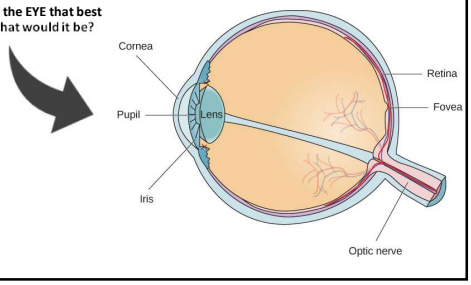
- No disclosures related to topic

- Regeneron – S, I
- Apellis – A
- Genentech – A, I
- Lumata Health - C
- Aviceda - I
- EyePoint Pharmaceuticals - I
- Janssen - I
- Alkeus Pharmaceuticals - I
- Kodiak - I

S – Speakers Bureau, A – Advisory Board, I – Investigator, C- Consultant

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

4

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

Retina Specialists of Michigan

- Other Options:
  - Enneagram
  - Kolbe Index
  - Clifton Strengths
  - Myers-Briggs

Three Type of Conflicts

Me – Me

Me – You

Me – Job

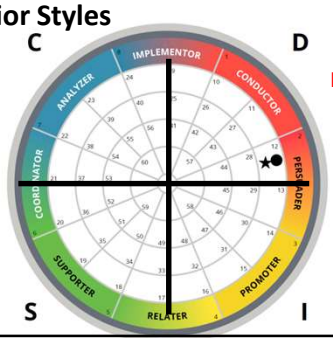
ME – ME
DISC Behavior Styles

Compliance

Dominance

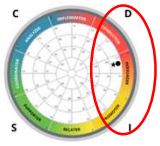
Steadiness

Influence



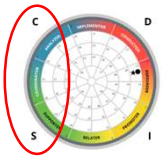
ME – ME
DISC Behavior Styles

- 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



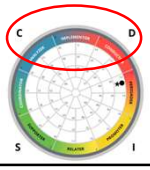
ME – ME
DISC Behavior Styles

- If someone has **INTERNAL style**, they will be at the left of the grid.
- Identifiable characteristics include :
  - Structured
  - Cautious
  - Moderately paced
  - Guarded behavior



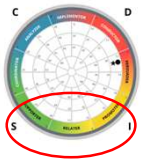
ME – ME
DISC Behavior Styles

- 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"



ME – ME
DISC Behavior Styles

- 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



Task-oriented
Questioning
Logic-focused
Skeptical
Challenging

Compliance **Dominance**

Indirect
Moderate-paced
Calm
Methodical
Cautious

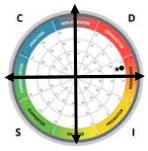
Direct
Fast-paced
Assertive
Dynamic
Bold

Steadiness **Influence**

Relationally-oriented
Accepting
People-focused
Empathetic
Agreeable

Compliance

Dominance

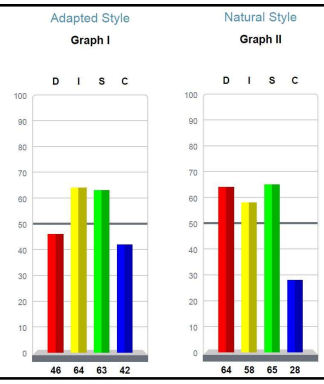


Steadiness

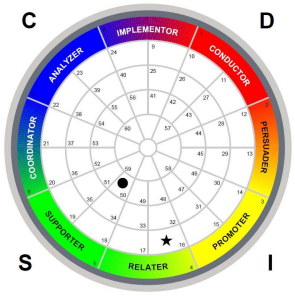
Influence

DISC Report

- Natural Style S-D-I
- Adapted Style I-S
- Low C

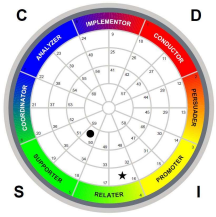


Success Insights Wheel



Leadership Styles

- Superpowers
- Kryptonite



Comparison with Direct Reports

Checklist for Communicating

Most people are aware of and sensitive to the ways in which they prefer to be communicated to but may not understand the styles of others. Most find this section to be extremely accurate and important for enhanced interpersonal communication. This page provides a list of things the other should DO when communicating with the other. Read each statement and highlight the 3 or 4 statements which are most important to each person.

Ways to Communicate with Scott

- Use a motivating approach, when appropriate.
- Understand his defiant nature.
- Present your case softly, non-threateningly, with a sincere tone of voice.
- Clearly define (preferably in writing) individual contributions.
- Start, however briefly, with a personal comment. Break the ice.
- Use a balanced, objective and emotional approach.
- Provide solutions—not opinions.
- Flatter his ego.

Ways to Communicate with Heather

- Be isolated from interruptions.
- Use her jargon.
- Put projects in writing with deadlines.
- Provide time for fun and relaxing.
- Come prepared with all requirements, objectives and support material in a well-organized "package."
- Verify that the message was heard.
- Understand her sporadic listening skills.
- Be specific and leave nothing to chance.

Comparison with Direct Reports

Checklist for Communicating

Continued

This section of the report is a list of things NOT to do while communicating with either Scott and Heather. Review each statement and highlight those that cause frustration. By sharing this information, both parties can negotiate a communication system that is mutually agreeable.

Ways NOT to Communicate with Scott

- Ramble.
- Keep deciding for him, or he'll lose initiative. Don't leave him without backup support.
- Give him your opinion unless asked.
- Be paternalistic.
- Patronize or demean him by using subtlety or incentive.
- Let him overpower you with verbiage.
- Be abrupt and rapid.
- Muffle or overcontrol.

Ways NOT to Communicate with Heather

- Direct or order.
- Talk too slowly or dwell on details to excess.
- Leave loopholes or cloudy issues if you don't want to be zapped.
- Forget or lose things, be disorganized or messy, confuse or distract her mind from business.
- Use a paternalistic approach.
- Let her change the topic until you are finished.
- Speculate wildly or offer guarantees and assurances where there is a risk in meeting them.
- Try to convince by "personal" means.

Comparison with Direct Reports

Value to the Organization

This section of the report identifies the specific talents and behavior Scott and Heather each bring to the job. These statements showcase the value each person brings to the organization. This can be used to develop a system to capitalize on the particular value each person contributes.

Scott's Value:

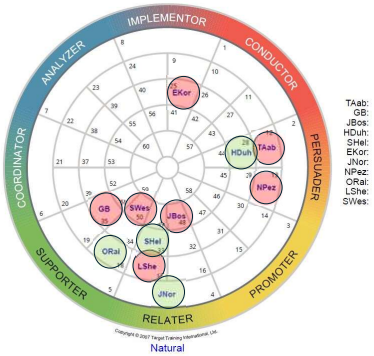
- Has the confidence to do the difficult assignments.
- Can support or oppose strongly.
- Creative approach to problem solving.
- Builds good relationships.
- Service-oriented.
- People-oriented.
- Big thinker.
- Dedicated to his own ideas.

Heather's Value:

- Challenge-oriented.
- Usually makes decisions with the bottom line in mind.
- Thinks big.
- Change agent—looks for faster and better ways.
- Creative in her approach to solving problems.
- Sense of urgency.
- Spontaneity.
- Will join organizations to represent the company.

Our Leadership Team

- Doctors
- Directors
  - Executive
  - Clinic
  - Operations
  - Imaging



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

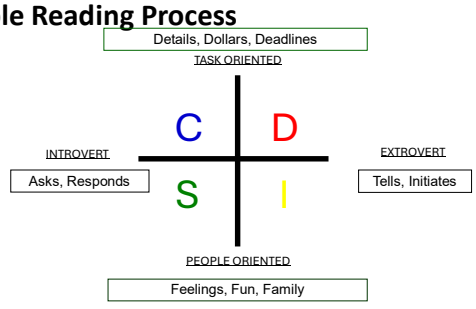
Source: Bolton, Robert and Bolton, Dorothy. (2009). *People Styles at Work and Beyond*. Second Edition. New York, NY: American Management Association.

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

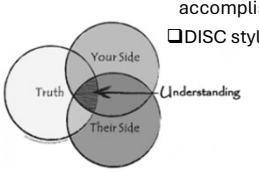
ME – YOU
People Reading Process

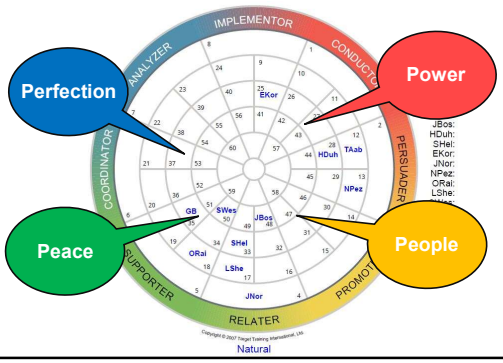


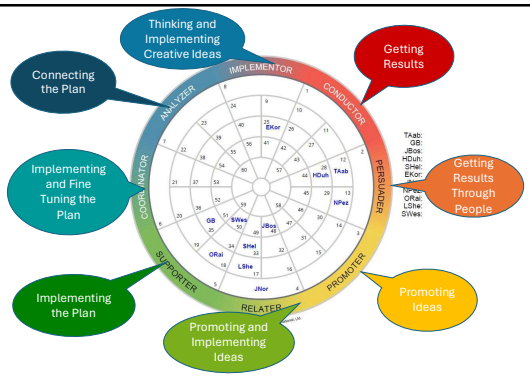
24

ME – YOU
People Are Different

- ❑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

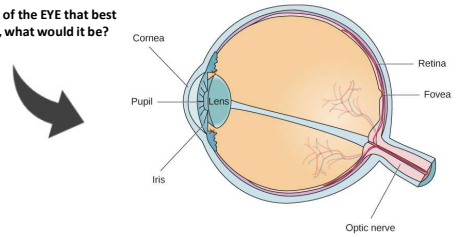






What Value Do You Add to Your Organization?

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



28

ME – ORGANIZATION Putting It Together

- 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?

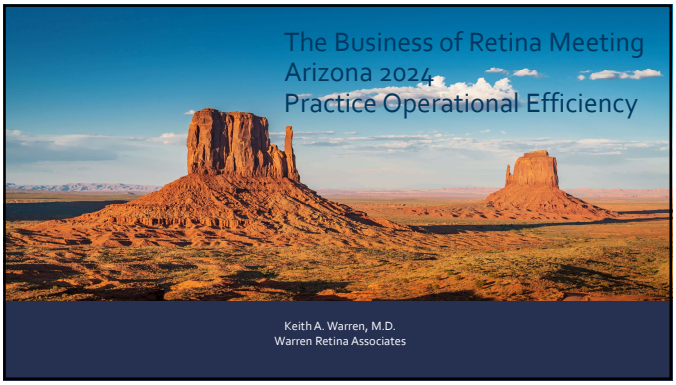
My Personal Action Steps…

- **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.ttisi.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



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 emphasis

Float

- During down time float should be in the surgery scheduling office working on secondary tasks **i.e. phone calls (medical records / RX refills), confirm next weeks sx times, scanning, surgery paper work**
- Stock the Diagnostic rooms at the ***beginning of each day***
- Alerts doctor when patient is seated in the room by calling or texting him
- Perform diagnostic testing, fundus, IVFA, OCT, A's & K's, HVF, and ultrasound
- Consent patient for surgeries
- Set up laser and pneumatic retinopexy
- Lead the laser and pneumatic patients to the appropriate areas
- Leads patients to the check out desk
- Brings surgery request over to check-out
- Relays messages to the doctor regarding incoming calls, contacts outside physicians at scribe/doctor's request
- Cleans equipment between each patients
- Cleans & archive images the testing rooms at the ***end of each day***

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

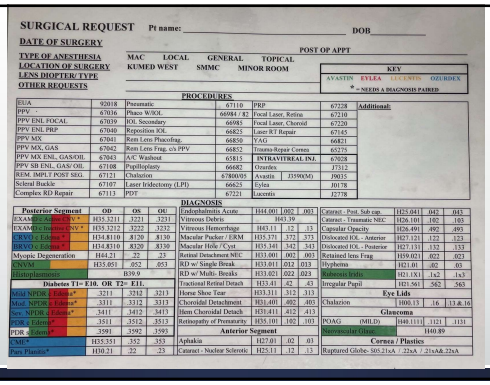
Patient encounter

Understand visit type (New, routine, Injection only)

Billing staff

Pre- certification, Prior authorization

Patient financial responsibility (No Surprise)



SURGICAL REQUEST Pt name: _____ DOB_____

DATE OF SURGERY

POST OP APPT

TYPE OF ANESTHESIA — MAC LOCAL GENERAL TOPICAL

LOCATION OF SURGERY — KUMED WEST SMMC MINOR ROOM

LENS DIOPTER/ TYPE

OTHER REQUESTS

KEY: AVASTIN EYLEA LUCENTIS OZURDEX

* = NEEDS A DIAGNOSIS PAIRED

PROCEDURES

EUA	92018	Pneumatic	67110	PRP	67228	Additional:	
PPV -	67036	Phaco W/IOL	66984 / 82	Focal Laser, Retina	67210		
PPV ENL FOCAL	67039	IOL Secondary	66985	Focal Laser, Choroid	67220		
PPV ENL PRP	67040	Reposition IOL	66825	Laser IKT Repair	67145		
PPV MX	67041	Rem Lens Phacofrag.	66850	YAG	66821		
PPV MX, GAS	67042	Rem Lens Frag. c/s PPV	66852	Trauma Repair Cornea	65275		
PPV MX ENL, GAS/OIL	67043	A/C Washout	65815	INTRAVITREAL INJ.	67028		
PPV SB ENL, GAS/OIL	67108	Pupilloplasty	66682	Ozurdex	J7312		
REM. IMPLT POST SEG.	67121	Chalazion	67800/05	Avastin J3590(M)	J9035		
Scleral Buckle	67107	Laser Iridectomy (LPI)	66625	Eylea	J0178		
Complex RD Repair	67113	PDT	67221	Lucentis	J2778		

DIAGNOSIS

Posterior Segment	OD	OS	OU
EXAM-Est. Acute CNV *	H35.3211	.3211	.3231
EXAM-Est. Chronic CNV *	H35.3212	.3222	.3232
CNVM - c Edema *	H34.8110	.8120	.8130
DRVO - Edema *	H34.8310	.8320	.8330
Myopic Degeneration	H44.21	.22	.23
CSR/M	H35.051	.052	.053
Histoplasmosis *	B39.9		
Diabetes T1= E10. OR T2= E11.			
Mod. NPDR - Edema*	.3211	.3212	.3213
Mod. NPDR - Edema*	.3311	.3312	.3313
Sev. NPDR - Edema*	.3411	.3412	.3413
PDR - Edema*	.3511	.3512	.3513
PDR - Edema*	.3591	.3592	.3593
CME*	H35.351	.352	.353
Prev Plasties*	H30.21	.22	.23

Endophalmitis Acute	H44.001	.002	.003
Vitreous Debris		H43.39	
Vitreous Hemorrhage	H43.11	.12	.13
Macular Pucker / ERM	H35.371	.372	.373
Macular Hole / Cyst	H35.341	.342	.343
Retinal Detachment NEC	H33.001	.002	.003
RD w/ Single Break	H33.011	.012	.013
RD w/ Multi- Breaks	H33.021	.022	.023
Tractional Retinal Detach	H33.41	.42	.43
Horse Shoe Tear	H33.311	.312	.313
Choroidal Detachment	H31.401	.402	.403
Hem Choroidal Detach	H31.411	.412	.413
Retinopathy of Prematurity	H35.101	.102	.103
Anterior Segment			
Aphakia	H27.01	.02	.03
Cataract - Nuclear Sclerotic	H25.11	.12	.13

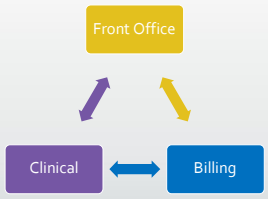
Cataract - Post. Sub cap.	H25.041	.042	.043
Cataract - Traumatic NEC	H26.101	.102	.103
Capsular Opacity	H26.491	.492	.493
Dislocated IOL - Anterior	H27.121	.122	.123
Dislocated IOL - Posterior	H27.131	.132	.133
Retained lens Frag	H59.021	.022	.023
Hyphema	H21.01	.02	.03
Adhesion Iritis	H21.1X1	1x2	1x3
Irregular Pupil	H21.561	.562	.563
Eye Lids			
Chalazion	H00.13	.16	13 & 16
Glaucoma			
POAG (MILD)	H40.1111	.1121	.1131
Neovascular Glauc	H40.89		
Cornea / Plasties			
Ruptured Globe- S05.21xA / .22xA / .21xA& 22xA			

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



Dx	Orders	Comments	Injections
EXAMD OD	FUNDUS OU	FUV 6 MO	E H35.3211
VEIN OCCLUSION OD	FULL	NP BRILL	A H34.8110 H34.8310
S/P COMPLEX CAT & DM TRD OD	OCT OD	FOV 2 WKS	A E10.3511/2
S/P DM TRD OD	OCT OU	FOV 3 WKS	E E11.3511 E11.3512
NEVUS OS & AMD OU	FUNDUS & A/B SCAN OS	FUV 3-4 WKS	
CRVO OD	OCT OU	FUV 6-7 WKS	E H34.8110
EXAMD OD	OCT & FUNDUS OU	FUV INJ A OD	A H35.3211
EXAMD OU	OCT OU	FUV 10 WKS	E H35.3211/2
EXAMD OD	FUNDUS OU	FUV INJ L OD	L H35.3210
DME OU	OCT OU	FUV 5-6 WKS	A E11.3511/2
EXAMD OU	OCT OU	FUV INJ E OU	E H35.3231
EXAMD OU	OCT OU	FUV 2-3 MO	E H35.3211
EXAMD OU	OCT OU	FUV INJ A OS	A H35.3221
S/P MAC HOLE OS	OCT OS	FOV 3 WKS	
EXAMD OU	OCT OU	FUV INJ E OS	E H35.3221
EXAMD OS	OCT OU	FUV 2 MO	E H35.3221
NEVUS OD	FUNDUS OD	FUV 4 MOS	
EXAMD OD	OCT OU	FUV INJ E OD	E H35.3211
CSR OS>OD	TVPA OS=OD	FUV FOCAL LASER CHOROID OS	
PDR OU	NONE	FUV PRP OD	E10.3511
CRVO OD	OCT OD	FUV OZURDEX OD	O H34.8110

New patient flow

Front Office

→ Clinical Staff

→ Insurance Verification

↵

→ Appointment

New patient flow

Appointment
Work-up

→

Diagnostic Testing
Float

↓

Exam
Scribe

↓

(Ins. Ver)
Treatment
Float

Injection Only

Appointment
Work-up
Ins. Ver.

Diagnostic Testing
Float

Inj. Prep
Scribe

(Ins. Ver)
Treatment
Float

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

Strong Healthcare Company
2023 Summary of Operations

	Total Strong Healthcare
Net Revenues	
Professional Fees	9,000,000
Net Drug Recoveries	7,500,000
Net Research Revenue	5,000,000
Other Revenue	100,000
Total Net Revenue	21,600,000
Operating Expenses	
Partner Physician Comp	4,500,000
Employed Physician Comp	1,500,000
Other Compensation	7,000,000
Rent Expense	2,000,000
Medical Supplies Expense	1,000,000
Other Operating Expenses	3,000,000
Total Operating Expenses	19,000,000
Operating Income	2,600,000
Operating Income %	12%
EBITDA	2,600,000
Partner Physician Comp	4,500,000
EBITDAP	7,100,000

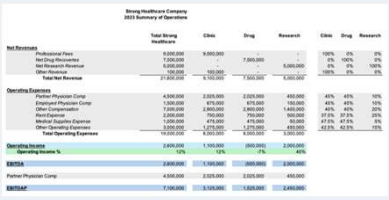
3PL—After Re-Organization

Strong Healthcare Company
2023 Summary of Operations

	Total Strong Healthcare	Clinic	Drug	Research
Net Revenues				
Professional Fees	9,000,000	9,000,000	-	-
Net Drug Recoveries	7,500,000	-	7,500,000	-
Net Research Revenue	5,000,000	-	-	5,000,000
Other Revenue	100,000	100,000	-	-
Total Net Revenue	21,600,000	9,100,000	7,500,000	5,000,000
Operating Expenses				
Partner Physician Comp	4,500,000	2,025,000	2,025,000	450,000
Employed Physician Comp	1,500,000	675,000	675,000	150,000
Other Compensation	7,000,000	2,800,000	2,800,000	1,400,000
Rent Expense	2,000,000	750,000	750,000	500,000
Medical Supplies Expense	1,000,000	475,000	475,000	50,000
Other Operating Expenses	3,000,000	1,275,000	1,275,000	450,000
Total Operating Expenses	19,000,000	8,000,000	8,000,000	3,000,000
Operating Income	2,600,000	1,100,000	(500,000)	2,000,000
Operating Income %	12%	12%	-7%	40%
EBITDA	2,600,000	1,100,000	(500,000)	2,000,000
Partner Physician Comp	4,500,000	2,025,000	2,025,000	450,000
EBITDAP	7,100,000	3,125,000	1,525,000	2,450,000

3PL—Expense Allocations

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



Strong Healthcare Company
2023 Summary of Operations

	Total Strong Healthcare	Clinic	Drug	Research	Clinic	Drug	Research
Net Revenues							
Professional Fees	9,000,000	9,000,000	-	-	100%	0%	0%
Net Drug Recoveries	7,500,000	-	7,500,000	-	0%	100%	0%
Net Research Revenue	5,000,000	-	-	5,000,000	0%	0%	100%
Other Revenue	100,000	100,000	-	-	100%	0%	0%
Total Net Revenue	21,600,000	9,100,000	7,500,000	5,000,000			
Operating Expenses							
Partner Physician Comp	4,500,000	2,025,000	2,025,000	450,000	45%	45%	10%
Employed Physician Comp	1,500,000	675,000	675,000	150,000	45%	45%	10%
Other Compensation	7,000,000	2,800,000	2,800,000	1,400,000	40%	40%	20%
Rent Expense	2,000,000	750,000	750,000	500,000	37.5%	37.5%	25%
Medical Supplies Expense	1,000,000	475,000	475,000	50,000	47.5%	47.5%	5%
Other Operating Expenses	3,000,000	1,275,000	1,275,000	450,000	42.5%	42.5%	15%
Total Operating Expenses	19,000,000	8,000,000	8,000,000	3,000,000			
Operating Income	2,600,000	1,100,000	(500,000)	2,000,000			
Operating Income %	12%	12%	-7%	40%			
EBITDA	2,600,000	1,100,000	(500,000)	2,000,000			
Partner Physician Comp	4,500,000	2,025,000	2,025,000	450,000			
EBITDAP	7,100,000	3,125,000	1,525,000	2,450,000			

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…

HOW THE PATIENTS SEE US

OUR REALITY

- 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

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

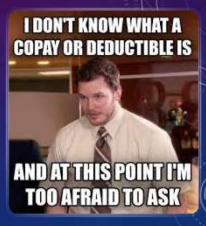
OFFICE VISIT COPAY

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 responsibility. 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. Office policy should be visible and communicated wherever necessary. 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

ANNUAL DEDUCTIBLES AND CO-INSURANCE RESTS EVERY YEAR, AND FOR COMMERCIAL PATIENTS, THAT IS NOT ALWAYS JANUARY 1.

THERE ARE MANY TOOLS FOR COST ESTIMATES THAT ARE IN YOUR PM SYSTEM, OR CAN BE SUPPLEMENTED, BASED ON YOUR PRACTICE'S FEE SCHEDULE..

COLLECTING PAYMENT IN FULL AT TIME OF SERVICE IS THE IDEAL BEST PRACTICE.

PATIENT STATEMENTS

- Healthy Patient Revenue comes from carefully constructed billing infrastructure.
- Send out statements regularly.
- Do patients have easy payment access and resources for billing questions?
- Make past due balances very clear.
- Check balances at check in, even notifying patients before their visit that their copay and balance will be due.

PAYMENT PLANS

- Will your practice accept them?
- Is it be 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 agreement?
- How do you monitor adherence?

EXTERNAL COLLECTIONS

- Shop around for a good plan and low collections ratio.
- 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 that means no longer seeing the patient.
- Offering a limited time payment in full discount before collections has been successful in our practice.

HOW CAN PEOPLE STILL GET CARE ?

- Provide discounted services for self-pay patents.
- 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

1

Financial Disclosures:

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

2

First Things First:

Huge thank you to Jeff Brockette and Michael Sullivan

3

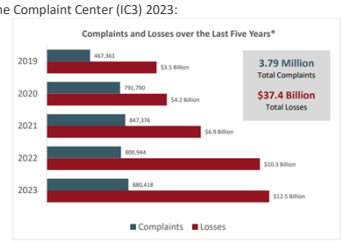
First Things First

- Change Healthcare / UnitedHealth
  - Fluid situation, new information coming in constantly
  - https://www.unitedhealthgroup.com/ns/changehealthcare.html
  - AlphV and Blackcat have claimed responsibility, exfiltrating 6TB of data
  - According to reports, $22MM was paid in bitcoin
    - https://www.crn.com/news/security/2024/unitedhealth-pays-22-million-to-ransomware-group-behind-change-healthcare-cyber-attack?itc=refresh

4

How Bad Is It?

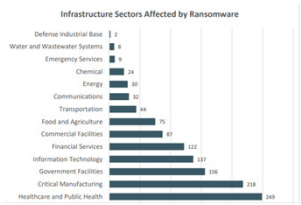
FBI Internet Crime Complaint Center (IC3) 2023:



5

How Bad Is It?

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



6

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

7

April 2019

```
---=    GANDCRAB V5.2    =---

**********************UNDER NO CIRCUMSTANCES DO NOT DELETE THIS FILE, UNTIL ALL
YOUR DATA IS RECOVERED**********************

        *****FAILING TO DO SO, WILL RESULT IN YOUR SYSTEM CORRUPTION, IF THERE ARE
DECRYPTION ERRORS*****

Attention!

All your files, documents, photos, databases and other important files are encrypted
and have the extension: .WNMYGNJIV

The only method of recovering files is to purchase an unique private key. Only we
can give you this key and only we can recover your files.


The server with your key is in a closed network TOR. You can get there by the
following ways:
```

8

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

9

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

10

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

11

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

12

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

13

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

14

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

15

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

16

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

17

New Policy and Procedure Changes

- 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

18

New Policy and Procedure Changes

- Use multifactor authentication whenever possible
- Administrator password restricted
  - IT company and CIO have this password
  - Minimum 25 characters (ex., gaFDz5$Myn&x7!EHWHBNSYDBF)
  - 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

19

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.

20

Four Years Later…

- The HHS / Office for Civil Rights (OCR) can contact your practice

> My name is and I'm an Investigator with the U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR). This message is regarding OCR Transaction No. (Talley Medical Surgical Eyecare Associates, PC), which was recently reassigned to me. I'd like to follow up and discuss this matter with you further. Please let me know your availability for a brief call at your earliest convenience. 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

21

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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
  - Academy Director of Coding and Reimbursement

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

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Course Agenda

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

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E/M and Eye Visit Codes

Choose with confidence

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E/M and Eye visit codes

- Different documentation guidelines
- 99214 does not automatically equal 92014

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

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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 1 level lower from highest level.

COMPONENT	STRAIGHT-FORWARD	LOW	MODERATE	HIGH
Number and/ or Complexity of Problems Addressed at the Encounter	**Minimal** 1 self-limited or minor problem	**Low** 2 or more self-limited or minor problems; ***Or*** 1 stable chronic illness; ***Or*** 1 acute, uncomplicated illness or injury *Or* 1 stable, acute illness *Or* 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	**Moderate** 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; ***Or*** 2 or more stable chronic illnesses; ***Or*** 1 undiagnosed new problem with uncertain prognosis; ***Or*** 1 acute illness with systemic symptoms; ***Or*** 1 acute complicated injury	**High** 1 or more chronic illnesses with severe exacerbation, progression or side effects of treatment; ***Or*** 1 acute or chronic illness or injury that pose a threat to life/body function
Amount and/ or Complexity of Data to be Reviewed and Analyzed	**Minimal or none**	**Limited** 1 of 2 Categories must be met Category 1: Tests and documents any combination of 2 from the following: • Review of prior external note(s) from each unique source; • Review of the results(s) of each unique test; • Ordering of each unique test; ***Or*** Category 2: Assessment requiring an independent historian(s)	**Moderate** At least 1 of 3 Categories must be met Category 1: Tests, documents, or independent historian(s). Any combination of 3 from the following: • Review of prior external note(s) from each unique source; • Review of the result(s) of each unique test; • Ordering of each unique test; • Assessment requiring an independent historian(s) ***Or*** Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/QHP (not separately reported); ***Or*** Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/QHP/appropriate source (not separately reported)	**Extensive** 2 of 3 Categories must be met Category 1: Tests, documents, or independent historian(s). Any combination of 3 from the following: • Review of prior external note(s) from each unique source • Review of the result(s) of each unique test • Ordering of each unique test • Assessment requiring an independent historian(s) ***Or*** Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/QHP (not separately reported) ***Or*** Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/QHP/appropriate source (not separately reported)
Risk of Complications and/or Morbidity or Mortality of Patient Management	**Minimal** Minimal risk of morbidity from additional diagnostic testing and treatment	**Low** Low risk of morbidity from additional diagnostic testing or treatment	**Moderate** Moderate risk of morbidity from additional testing or treatment. Examples only: • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health	**High** High risk of morbidity from additional diagnostic testing or treatment. Examples only: • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Parenteral controlled substances
Final Determination	**99202** **99212**	**99203** **99213**	**99204** **99214**	**99205** **99215**

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Hospital: 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 1 level lower from highest level.

COMPONENT	STRAIGHT-FORWARD	LOW	MODERATE	HIGH
Number and/ or Complexity of Problems Addressed at the Encounter	**Minimal** 1 self-limited or minor problem	**Low** 2 or more self-limited or minor problems; ***Or*** 1 stable chronic illness; ***Or*** 1 acute, uncomplicated illness or injury Or 1 stable, acute illness Or 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	**Moderate** 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; ***Or*** 2 or more stable chronic illnesses; ***Or*** 1 undiagnosed new problem with uncertain prognosis; ***Or*** 1 acute illness with systemic symptoms; ***Or*** 1 acute complicated injury	**High** 1 or more chronic illnesses with severe exacerbation, progression or side effects of treatment; ***Or*** 1 acute or chronic illness or injury that pose a threat to life/body function
Amount and/ or Complexity of Data to be Reviewed and Analyzed	**Minimal or none**	**Limited** 1 of 2 Categories must be met Category 1: Tests and documents any combination of 2 from the following: • Review of prior external note(s) from each unique source; • Review of the results(s) of each unique test; • Ordering of each unique test; ***Or*** Category 2: Assessment requiring an independent historian(s)	**Moderate** At least 1 of 3 Categories must be met Category 1: Tests, documents, or independent historian(s). Any combination of 3 from the following: • Review of prior external note(s) from each unique source; • Review of the result(s) of each unique test; • Ordering of each unique test; • Assessment requiring an independent historian(s) ***Or*** Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/QHP (not separately reported); ***Or*** Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/QHP/appropriate source (not separately reported)	**Extensive** 2 of 3 Categories must be met Category 1: Tests, documents, or independent historian(s). Any combination of 3 from the following: • Review of prior external note(s) from each unique source • Review of the result(s) of each unique test • Ordering of each unique test • Assessment requiring an independent historian(s) ***Or*** Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/QHP (not separately reported) ***Or*** Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/QHP/appropriate source (not separately reported)
Risk of Complications and/or Morbidity or Mortality of Patient Management	**Minimal** Minimal risk of morbidity from additional diagnostic testing and treatment	**Low** Low risk of morbidity from additional diagnostic testing or treatment	**Moderate** Moderate risk of morbidity from additional testing or treatment. Examples only: • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health	**High** High risk of morbidity from additional testing or treatment. Examples only: • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Parenteral controlled substances
Initial Hospital Inpatient	**99221**	**99221**	**99222**	**99223**
Subsequent Hospital Inpatient	**99231**	**99231**	**99232**	**99233**
Emergency Department	**99282**	**99283**	**99284**	**99285**

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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
- ☐ Extraocular motility
- ☐ Conjunctiva
- ☐ Ocular adnexa
- ☐ Pupil and iris
- ☐ Cornea
- ☐ Anterior chamber
- ☐ Lens
- ☐ Intraocular pressure
- ☐ Optic nerve discs
- ☐ Retina and vessels
- ☐ Dilation: As medically necessary.

Comprehensive Exam Codes 92004/92014

HISTORY

- ☐ Chief complaint
- ☐ History
- ☐ General medical observation

EXAMINATION

All 12 elements of the exam medically necessary to perform unless unable due to age of patient or trauma.

- ☐ Visual acuity
- ☐ Gross or confrontation visual fields
- ☐ Extraocular motility
- ☐ Conjunctiva
- ☐ Ocular adnexa
- ☐ Pupil and iris
- ☐ Cornea
- ☐ Anterior chamber
- ☐ Lens
- ☐ Intraocular pressure
- ☐ Optic nerve discs
- ☐ Retina and vessels
- ☐ Dilation: As medically necessary. If not dilated, document why.

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EYE VISIT CODE CHECKLIST

Intermediate Exam Codes 92002/92012	Comprehensive Exam Codes 92004/92014
INITIATION OF DIAGNOSTIC AND TREATMENT PROGRAM	INITIATION OF DIAGNOSTIC AND TREATMENT PROGRAM
Includes, but is not limited to:	Includes, but is not limited to:
☐ Prescription of medication, glasses or contact lenses	☐ Prescription of medication, glasses or contact lenses
☐ Arranging for special ophthalmological diagnostic or treatment services	☐ Arranging for special ophthalmological diagnostic or treatment services
☐ Consultations	☐ Consultations
☐ Laboratory procedures	☐ Laboratory procedures
☐ Radiological services	☐ Radiological services
☐ Recommendation or decision for or scheduling or performance of a major or minor (000, 010, or 090 day global) surgical procedure.	☐ Recommendation or decision for or scheduling or performance of a major or minor (000, 010, or 090 day global) surgical procedure.
☐ Scheduling necessary follow-up of a medical problem	☐ Scheduling necessary follow-up of a medical problem
☐ Other_____	☐ Other_____

Need 1 or more from this list to meet the definition

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E/M vs Eye Visit Codes

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

E/M	
99203	$ 109.69
Eye	
92004	$ 146.04 ✓

2. New patient: medically relevant history, comprehensive exam, **moderate** MDM

E/M	
99204	$ 164.38 ✓
Eye	
92004	$ 146.04

For all payers: over $18 difference

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

E/M	
99213	$ 89.39
Eye	
92014	$ 123.45 ✓

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

E/M	
99214	$ 126.07 ✓
Eye	
92012	$ 87.43

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Lasers & Surgeries

What is the Diagnosis?

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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 Focal macular laser, grid	**67145** Repair retinal tear	**67228** PRP	**67220** Destruction of localized lesion of choroid	**67105** Repair retinal detachment, photocoagulation

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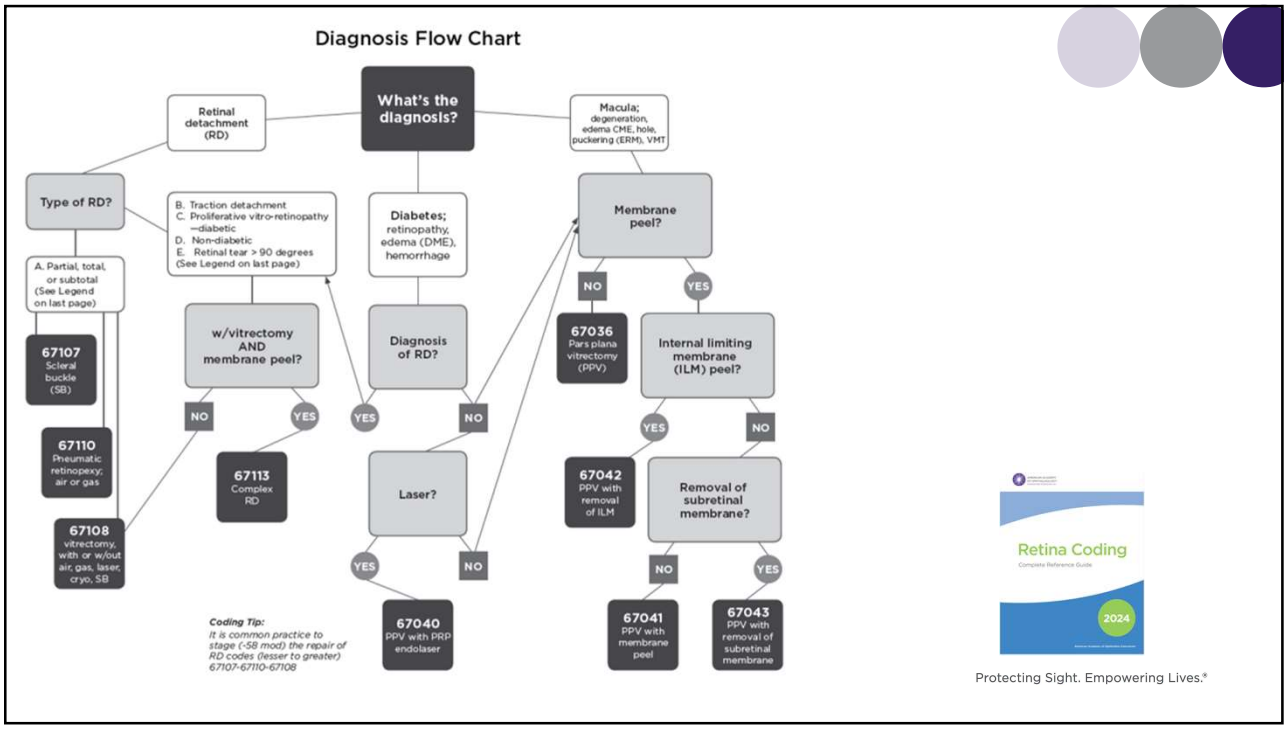
Diagnosis Flow Chart
What's the diagnosis?
Retinal detachment (RD)
Macula; degeneration, edema CME, hole, puckering (ERM), VMT
Type of RD?
B. Traction detachment
C. Proliferative vitro-retinopathy –diabetic
D. Non-diabetic
E. Retinal tear > 90 degrees (See Legend on last page)
Diabetes; retinopathy, edema (DME), hemorrhage
Membrane peel?
A. Partial, total, or subtotal (See Legend on last page)
w/vitrectomy AND membrane peel?
Diagnosis of RD?
NO
YES
67036 Pars plana vitrectomy (PPV)
Internal limiting membrane (ILM) peel?
67107 Scleral buckle (SB)
67110 Pneumatic retinopexy; air or gas
67113 Complex RD
Laser?
67042 PPV with removal of ILM
Removal of subretinal membrane?
67108 vitrectomy, with or w/out air, gas, laser, cryo, SB
67040 PPV with PRP endolaser
67041 PPV with membrane peel
67043 PPV with removal of subretinal membrane
Coding Tip:
It is common practice to stage (-58 mod) the repair of RD codes (lesser to greater)
67107-67110-67108
Retina Coding
Complete Reference Guide
2024
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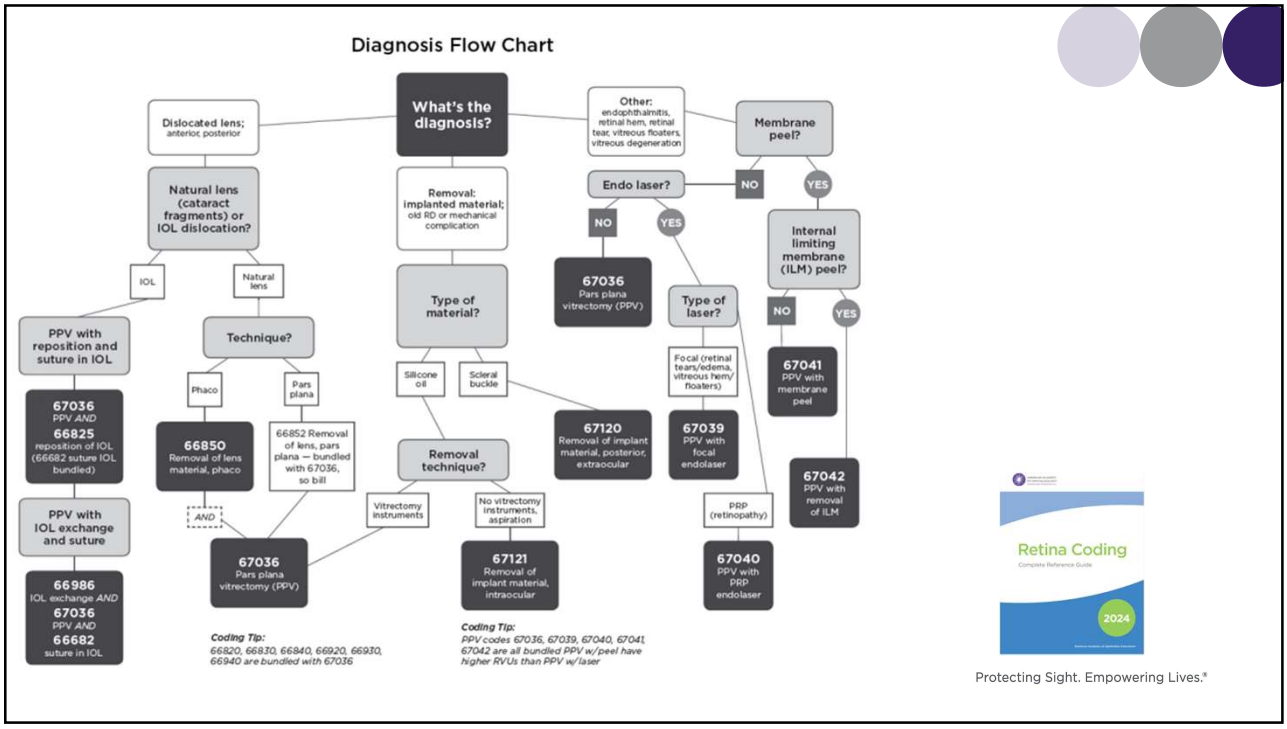
Diagnosis Flow Chart
What's the diagnosis?
Dislocated lens; anterior, posterior
Other: endophthalmitis, retinal hem, retinal tear, vitreous floaters, vitreous degeneration
Membrane peel?
Natural lens (cataract fragments) or IOL dislocation?
Removal: implanted material; old RD or mechanical complication
Endo laser?
NO
YES
Internal limiting membrane (ILM) peel?
IOL
Natural lens
Type of material?
67036 Pars plana vitrectomy (PPV)
Type of laser?
PPV with reposition and suture in IOL
Technique?
Silicone oil
Scleral buckle
Focal (retinal tears/edema, vitreous hem/ floaters)
67041 PPV with membrane peel
Phaco
Pars plana
67036 PPV AND 66825 reposition of IOL (66682 suture IOL bundled)
66850 Removal of lens material, phaco
66852 Removal of lens, pars plana – bundled with 67036, so bill
67120 Removal of implant material, posterior, extraocular
67039 PPV with focal endolaser
Removal technique?
AND
PPV with IOL exchange and suture
Vitrectomy instruments
No vitrectomy instruments, aspiration
PRP (retinopathy)
67042 PPV with removal of ILM
66986 IOL exchange AND 67036 PPV AND 66682 suture in IOL
67036 Pars plana vitrectomy (PPV)
67121 Removal of implant material, intraocular
67040 PPV with PRP endolaser
Coding Tip:
66820, 66830, 66840, 66920, 66930, 66940 are bundled with 67036
Coding Tip:
PPV codes 67036, 67039, 67040, 67041, 67042 are all bundled PPV w/peel have higher RVUs than PPV w/ laser
Retina Coding
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Modifiers

Office Visits & Surgeries

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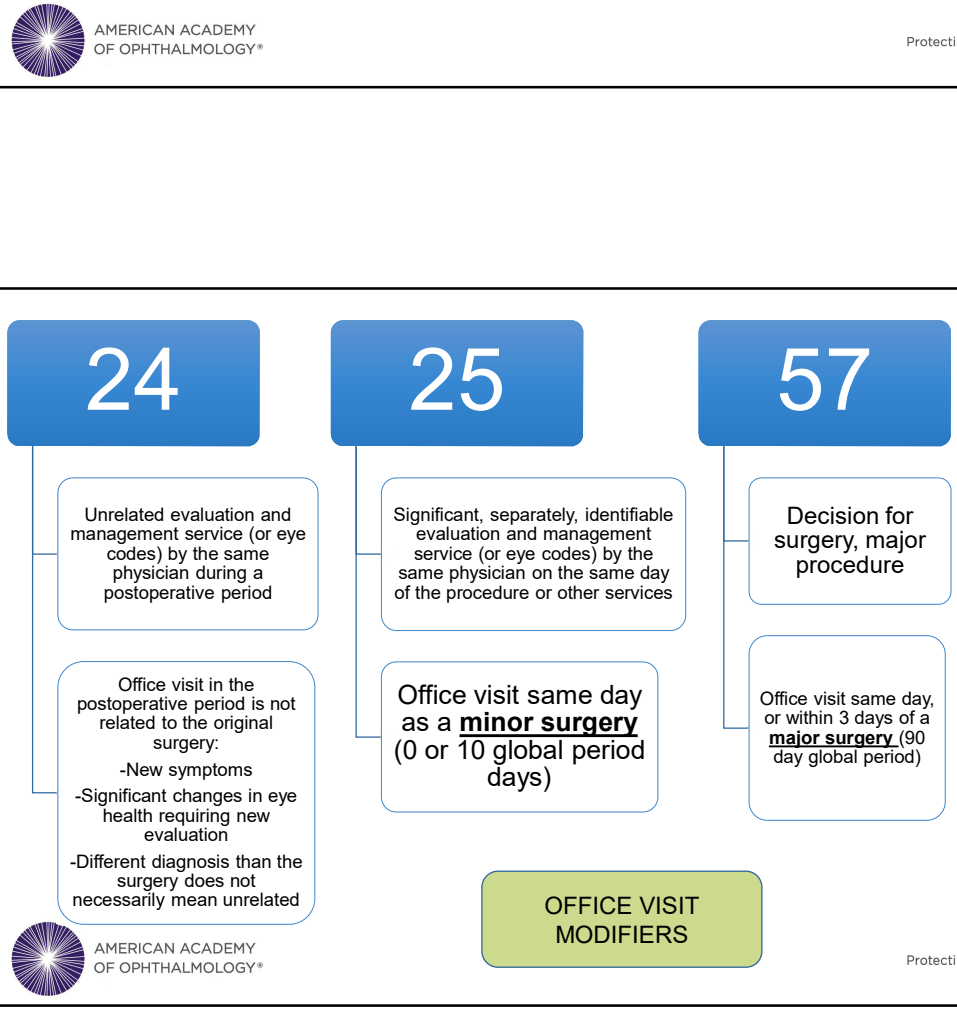

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Retina Laser Global Periods

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

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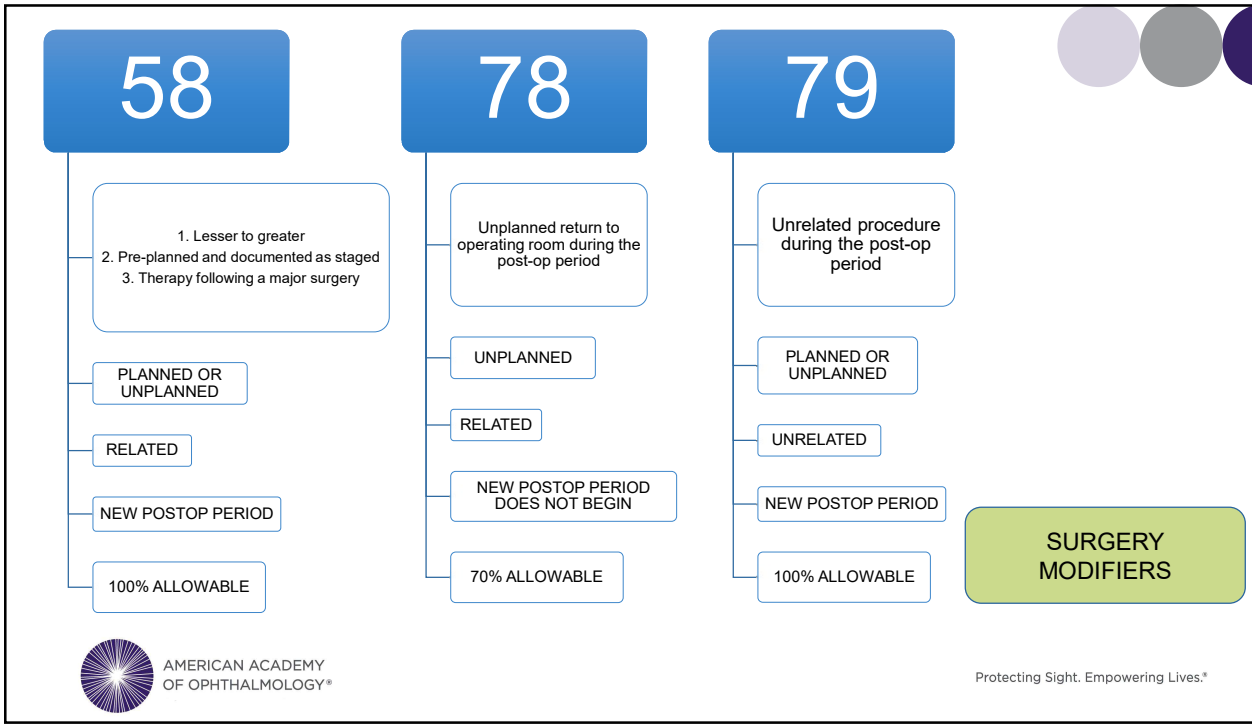

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NCCI Edits

Quick Reference Guides

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NCCI Edits

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

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Retina Testing Services NCCI 30.0 Effective 1/1/24	EO peripheral retinal disease 92201	EO posterior pole 92202	FA 92235	ICG 92240	FA/ICG 92242	FP 92250	Posterior Segment OCT 92134	Optic Nerve OCT 92133
EO peripheral retinal disease 92201		Mutually Exclusive	Billable same day	Billable same day	Billable same day	Mutually Exclusive	Billable same day	Billable same day
EO posterior pole 92202	Mutually Exclusive		Billable same day	Billable same day	Billable same day	Mutually Exclusive	Billable same day	Billable same day
FA 92235	Billable same day	Billable same day		Mutually Exclusive	Mutually Exclusive	Billable same day	Billable same day	Billable same day
ICG 92240	Billable same day	Billable same day	Mutually Exclusive		Mutually Exclusive	Bundled	Billable same day	Billable same day
FA/ICG 92242	Billable same day	Billable same day	Mutually Exclusive	Mutually Exclusive		Bundled	Billable same day	Billable same day
FP 92250	Mutually Exclusive	Mutually Exclusive	Billable same day	Bundled	Bundled		Bundled	Bundled
Posterior Segment OCT 92134	Billable same day	Billable same day	Billable same day	Billable same day	Billable same day	Bundled		Mutually Exclusive
Optic Nerve OCT 92133	Billable same day	Billable same day	Billable same day	Billable same day	Billable same day	Bundled	Mutually Exclusive	

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Retina Testing Services, CCI bundles, January 1, 2024, Version 30.0

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2024 Retina Coding: Complete Reference Guide

Lens/Vitrectomy NCCI 30.0 Effective 1/1/24	67036-67043 Vitrectomy	66682 Suture lens	66825 Reposition of IOL	66850 Lensectomy, phaco	66852 Lensectomy, pars plana	66982 Cataract removal, complex	66984 Cataract removal	66985 Secondary implant	66986 Exchange of intraocular lens
67036-67043 Vitrectomy (VX codes and 67121 bundled)		Billable same day	Billable same day	Billable same day	Bundled	Billable same day	Billable same day	Billable same day	Billable same day
66682 Suture lens	Billable same day		Bundled	Billable same day	Billable same day	Billable same day	Billable same day	Billable same day	Billable same day
66825 Reposition of IOL	Billable same day	Bundled		Bundled	Bundled	Bundled	Bundled	Bundled	Bundled
66850 Lensectomy, phaco	Billable same day	Billable same day	Bundled		Bundled	Bundled	Bundled	Bundled	Billable same day
66852 Lensectomy, pars plana	Bundled	Billable same day	Bundled	Bundled		Bundled	Bundled	Billable same day	Billable same day
66982 Cataract removal, complex	Billable same day	Billable same day	Bundled	Bundled	Bundled		Bundled	Bundled	Bundled
66984 Cataract removal	Billable same day	Billable same day	Bundled	Bundled	Bundled	Bundled		Bundled	Billable same day
66985 Secondary implant	Billable same day	Billable same day	Bundled	Bundled	Billable same day	Bundled	Bundled		Bundled
66986 Exchange of intraocular lens	Billable same day	Billable same day	Bundled	Billable same day	Billable same day	Bundled	Billable same day	Bundled	

Intravitreal Injection

Master the Basics

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Protecting Sight. Empowering Lives.®

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

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Calculate Units: Lucentis

HCPCS Descriptor

- J2778 Injection, ranibizumab, 0.1 mg

Dose Injected

- 0.5 mg

Total Units to Bill

- 5 units

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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)

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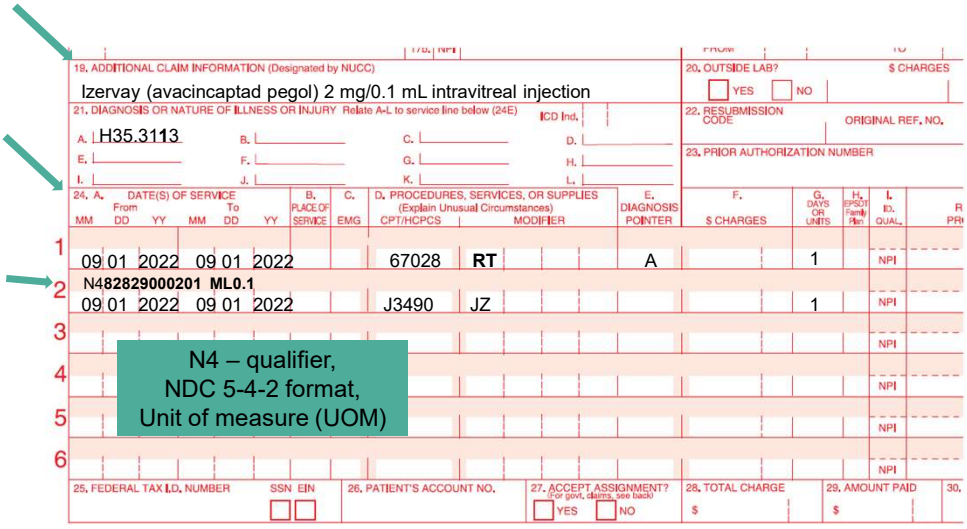
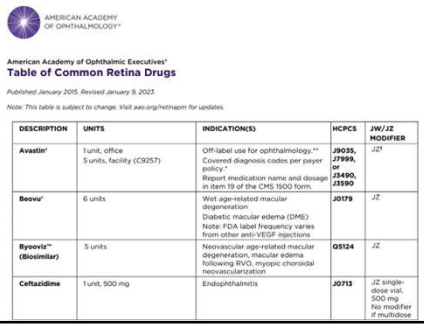
What is my injection claim denied?

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



Retina Practice Management & Coding

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



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American Academy of Ophthalmic Executives®

Table of Common Retina Drugs

Published January 2015. Revised January 9, 2023.

Note: This table is subject to change. Visit aao.org/retinapm for updates.

DESCRIPTION	UNITS	INDICATION(S)	HCPCS	JW/JZ MODIFIER
Avastin®	1 unit, office 5 units, facility (C9257)	Off-label use for ophthalmology.** Covered diagnosis codes per payer policy.* Report medication name and dosage in item 19 of the CMS 1500 form.	J9035, J7999, or J3490, J3590	JZ*
Beovu®	6 units	Wet age-related macular degeneration Diabetic macular edema (DME) Note: FDA label frequency varies from other anti-VEGF injections	J0179	JZ
Byooviz™ (Biosimilar)	5 units	Neovascular age-related macular degeneration, macular edema following RVO, myopic choroidal neovascularization	Q5124	JZ
Ceftazidime	1 unit, 500 mg	Endophthalmitis	J0713	JZ single-dose vial, 500 mg No modifier if multidose

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Questions?

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Academy Resources

aao.org/retinapm

aao.org/audits

aao.org/coding

aao.org/em

aao.org/lcds

aao.org/consulting

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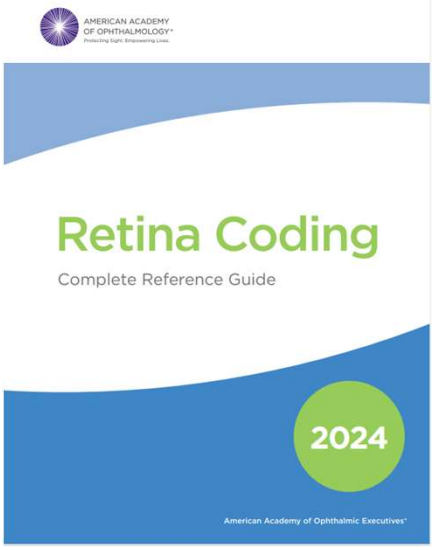

aao.org/store

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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

ASRS Business of Retina Meeting
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Department of Health and Human Services
OFFICE OF INSPECTOR GENERAL

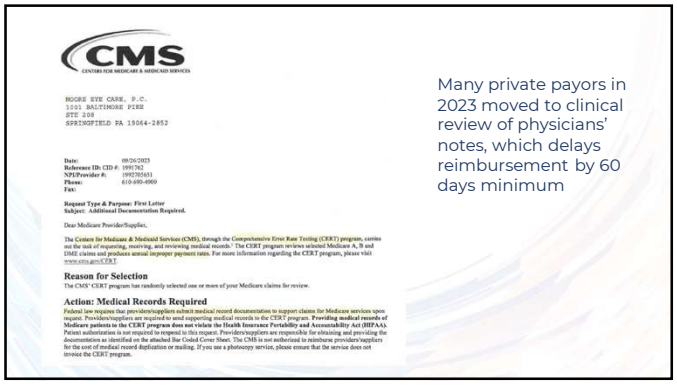
QUESTIONABLE BILLING FOR MEDICARE OPHTHALMOLOGY SERVICES

We did this study to determine the extent ophthalmology services are vulnerable to fraud, waste, and/or abuse.

Lucentis injection more often than 28 days per eye, 209 providers were paid $68 million

Alerts for treatments outside standard practice patterns

Retina	Glaucoma	Comprehensive			
		Procedure			
Date	OD	OS	Prov/Loc	E/M	
04/06/2017		Eylea (94)	LHG/Sph		
03/31/2017	Lucentis 0.5 (56)		LHG/Sph		
03/13/2017			LHG/Sph	92012	
02/03/2017	Eylea (1)		LHG/Sph		
02/02/2017	Lucentis 0.5 (52)		LHG/Sph		
01/02/2017		Eylea (54)	LHG/Sph		



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

MOORE EYE CARE, P.C.
1001 BALTIMORE PIKE
STE 209
SPRINGFIELD PA 19064-2852

Date: 09/26/2023
Reference ID: CID #: 1991782
NPI/Provider #: 1992705651
Phone: 610-690-4900
Fax:

Request Type & Purpose: First Letter
Subject: Additional Documentation Required.

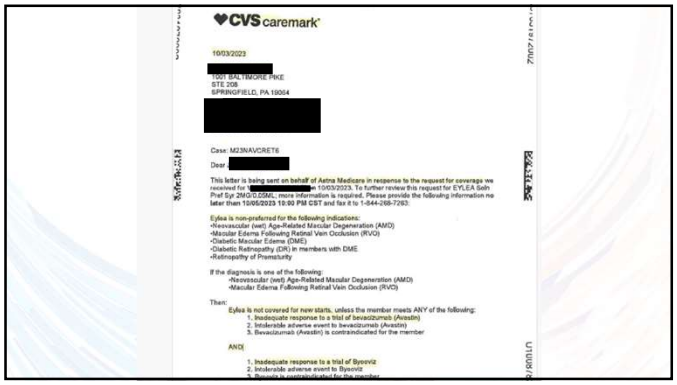
Dear Medicare Provider/Supplier,

The Centers for Medicare & Medicaid Services (CMS), through the Comprehensive Error Rate Testing (CERT) program, carries out the task of requesting, receiving, and reviewing medical records.[1] The CERT program reviews selected Medicare A, B and DME claims and produces annual improper payment rates. For more information regarding the CERT program, please visit www.cms.gov/CERT.

Reason for Selection
The CMS' CERT program has randomly selected one or more of your Medicare claims for review.

Action: Medical Records Required
Federal law requires that providers/suppliers submit medical record documentation to support claims for Medicare services upon request. Providers/suppliers are required to send supporting medical records to the CERT program. **Providing medical records of Medicare patients to the CERT program does not violate the Health Insurance Portability and Accountability Act (HIPAA).** Patient authorization is not required to respond to this request. Providers/suppliers are responsible for obtaining and providing the documentation as identified on the attached Bar Coded Cover Sheet. The CMS is not authorized to reimburse providers/suppliers for the cost of medical record duplication or mailing. If you use a photocopy service, please ensure that the service does not invoice the CERT program.

Many private payors in 2023 moved to clinical review of physicians' notes, which delays reimbursement by 60 days minimum



CVS caremark

10/03/2023
[redacted]
1001 BALTIMORE PIKE
STE 208
SPRINGFIELD, PA 19064
[redacted]

Case: M23NAVCRET6
Dear [redacted]

This letter is being sent on behalf of Aetna Medicare in response to the request for coverage we received for [redacted] on 10/03/2023. To further review this request for EYLEA Soln Pref Syr 2MG/0.05ML, more information is required. Please provide the following information no later than **10/06/2023 10:00 PM CST** and fax it to 1-844-268-7283:

Eylea is non-preferred for the following indications:
•Neovascular (wet) Age-Related Macular Degeneration (AMD)
•Macular Edema Following Retinal Vein Occlusion (RVO)
•Diabetic Macular Edema (DME)
•Diabetic Retinopathy (DR) in members with DME
•Retinopathy of Prematurity

If the diagnosis is one of the following:
•Neovascular (wet) Age-Related Macular Degeneration (AMD)
•Macular Edema Following Retinal Vein Occlusion (RVO)

Then:
Eylea is not covered for new starts, unless the member meets ANY of the following:
1. Inadequate response to a trial of bevacizumab (Avastin)
2. Intolerable adverse event to bevacizumab (Avastin)
3. Bevacizumab (Avastin) is contraindicated for the member

AND

1. Inadequate response to a trial of Byooviz
2. Intolerable adverse event to Byooviz
3. Byooviz is contraindicated for the member

It Used To Be So Simple: Three Choices

New Medications and Brand vs. Generic Requirements

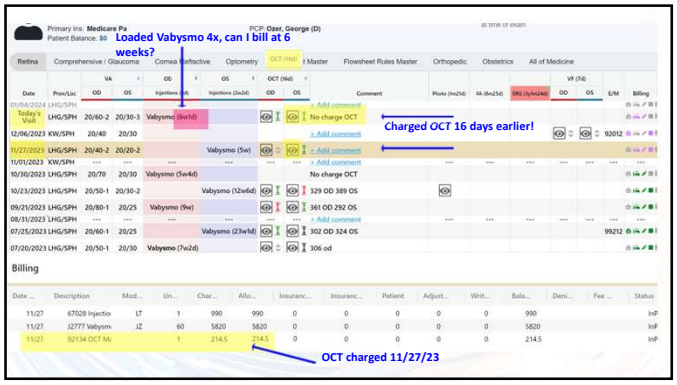
- Indications
- Payor rules
- Frequencies
- Cost and reimbursement

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 does more frequently than Q 7 weeks?
- What documentation is needed?
- What insurances cover it?



DRUG	DX	First Step	Dose extension recommendations	Criteria
Vabysmo	DME	4 Doses every 4 weeks	up to 4 week extensions or up to 8 week reductions	Based on CST & VA eval through week 52
Vabysmo	DME	6 Doses every 4 weeks	8 weeks Q8W for the following 28 weeks	
Vabysmo	nAMD	4 Doses every 4 weeks	1. Weeks 28 and 44 Q16W	Based on OCT & VA eval @ 8 and 12 weeks
			2. Weeks 24, 36, & 48 Q12W	
			3. Weeks 20,28, 36, & 44 Q8W	
EyleaHD	DME	3 Doses every 4 weeks	Q8W-Q16W	Based on OCT & VA eval @ initial dosing
	nAMD	3 Doses every 4 weeks	Q8W-Q16W	
	DR	3 Doses every 4 weeks	Q8W-Q12W	

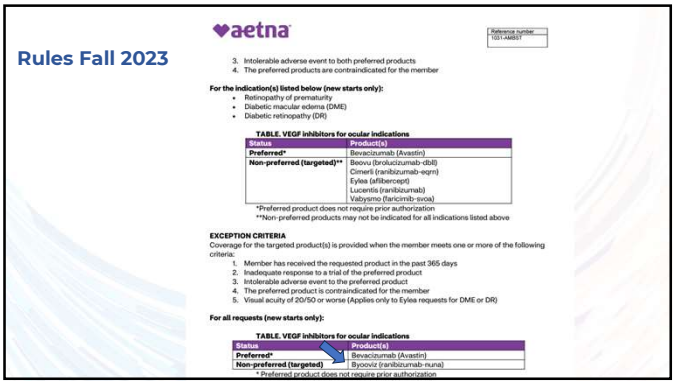
Potential errors

INVENTORY LOG	CHART DOCUMENTATION	MEDICATION CODING	ERROR
Eylea vial dispensed	Avastin injection	Avastin injection	@ $1850 potential loss, incorrect coding & documentation
Lucentis 0.3 mg dispensed	Lucentis 0.3 mg inj., DME	Lucentis 0.5 mg, 5 units	incorrect coding, overbilled $746.72 0.5 mg off label use for DME
Eylea vial dispensed, Patient – John Smith	Eylea injection – Jane Smith	Eylea injection – Jane Smith	Inventory log has incorrect patient assignment for vial
Lucentis 0.5 mg – OD	Lucentis 0.5mg – OS	Lucentis 0.5mg, 5 units, left eye	Inventory log was correct, chart was incorrect and coding 67028-LT, should be -RT
Triesence 40 mg vial	Triesence 2 mg injected, 38 wasted	Triesence 4 mg injected, 36 wasted	incorrect coding medication injected and wasted, neglected to check the chart

Figure 9

THE PROFITABLE RETINA PRACTICE
Medication Inventory Management

Rules Fall 2023



aetna

Reference number: 1021-AMBST

3. Intolerable adverse event to both preferred products
4. The preferred products are contraindicated for the member

For the indication(s) listed below (new starts only):

- Retinopathy of prematurity
- Diabetic macular edema (DME)
- Diabetic retinopathy (DR)

TABLE. VEGF inhibitors for ocular indications

Status	Product(s)
Preferred*	Bevacizumab (Avastin)
Non-preferred (targeted)**	Beovu (brolucizumab-dbll) Cimerli (ranibizumab-eqrn) Eylea (aflibercept) Lucentis (ranibizumab) Vabysmo (faricimb-svoa)

*Preferred product does not require prior authorization
**Non-preferred products may not be indicated for all indications listed above

EXCEPTION CRITERIA

Coverage for the targeted product(s) is provided when the member meets one or more of the following criteria:

1. Member has received the requested product in the past 365 days
2. Inadequate response to a trial of the preferred product
3. Intolerable adverse event to the preferred product
4. The preferred product is contraindicated for the member
5. Visual acuity of 20/50 or worse (Applies only to Eylea requests for DME or DR)

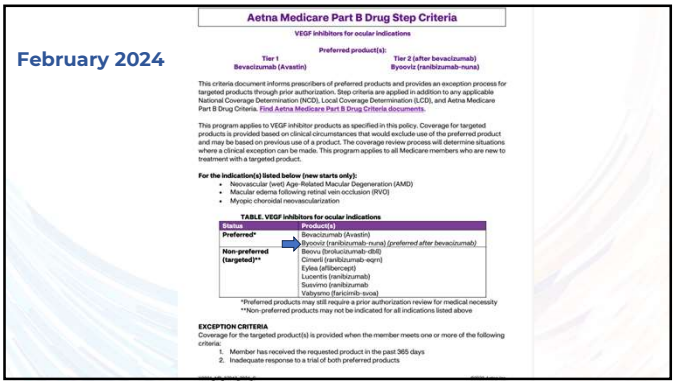
For all requests (new starts only):

TABLE. VEGF inhibitors for ocular indications

Status	Product(s)
Preferred*	Bevacizumab (Avastin)
Non-preferred (targeted)	Byooviz (ranibizumab-nuna)

* Preferred product does not require prior authorization

February 2024



Aetna Medicare Part B Drug Step Criteria

VEGF inhibitors for ocular indications

Preferred product(s):

Tier 1
Bevacizumab (Avastin)

Tier 2 (after bevacizumab)
Byooviz (ranibizumab-nuna)

This criteria document informs prescribers of preferred products and provides an exception process for targeted products through prior authorization. Step criteria are applied in addition to any applicable National Coverage Determination (NCD), Local Coverage Determination (LCD), and Aetna Medicare Part B Drug Criteria. Find Aetna Medicare Part B Drug Criteria documents.

This program applies to VEGF inhibitor products as specified in this policy. Coverage for targeted products is provided based on clinical circumstances that would exclude use of the preferred product and may be based on previous use of a product. The coverage review process will determine situations where a clinical exception can be made. This program applies to all Medicare members who are new to treatment with a targeted product.

For the indication(s) listed below (new starts only):

- Neovascular (wet) Age-Related Macular Degeneration (AMD)
- Macular edema following retinal vein occlusion (RVO)
- Myopic choroidal neovascularization

TABLE. VEGF inhibitors for ocular indications

Status	Product(s)
Preferred*	Bevacizumab (Avastin) Byooviz (ranibizumab-nuna) *(preferred after bevacizumab)*
Non-preferred (targeted)**	Beovu (brolucizumab-dbll) Cimerli (ranibizumab-eqrn) Eylea (aflibercept) Lucentis (ranibizumab) Susvimo (ranibizumab Vabysmo (faricimb-svoa)

*Preferred products may still require a prior authorization review for medical necessity
**Non-preferred products may not be indicated for all indications listed above

EXCEPTION CRITERIA

Coverage for the targeted product(s) is provided when the member meets one or more of the following criteria:

1. Member has received the requested product in the past 365 days
2. Inadequate response to a trial of both preferred products

United Health Care Requirements

Intravitreal Vascular Endothelial Growth Factor (VEGF) Inhibitors – Neovascular (wet) Age Related Macular Degeneration (Compounded Avastin, Beovu, Byooviz, Eylea, Lucentis, Susvimo, Vabysmo)

Preferred Drug(s)/Product(s)	Non-Preferred Drug(s)/Product(s)
Compounded Avastin, then Eylea	Beovu, Byooviz, Cimerli, Lucentis, Susvimo, Vabysmo

Step Therapy Criteria

Eylea

Eylea, when prescribed for Neovascular (wet) Age Related Macular Degeneration, may be covered when any of the criteria listed below are satisfied:

- History of a trial of at least 3 doses, resulting in minimal clinical response to compounded Avastin (bevacizumab); or
- History of contraindication or adverse event(s) to compounded Avastin (bevacizumab); or
- Continuation of prior therapy within the past 365 days.

Beovu, Byooviz, Cimerli, Lucentis, Susvimo, Vabysmo

Beovu, Byooviz, Cimerli, Lucentis, Susvimo, or Vabysmo, when prescribed for Neovascular (wet) Age Related Macular Degeneration, may be covered when any of the criteria listed below are satisfied:

- Both of the following:
  - Trial of at least 3 doses, resulting in minimal clinical response to compounded Avastin (bevacizumab); and
  - History of use of Eylea, resulting in minimal clinical response to therapy

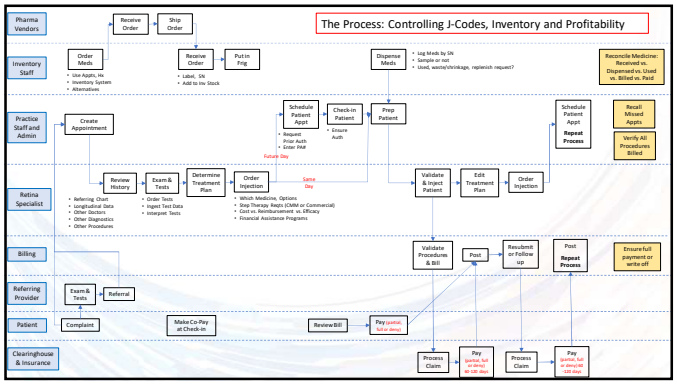
  or
- History of contraindication, intolerance, or adverse event(s) to compounded Avastin (bevacizumab) and Eylea; or
- Continuation of prior therapy within the past 365 days.

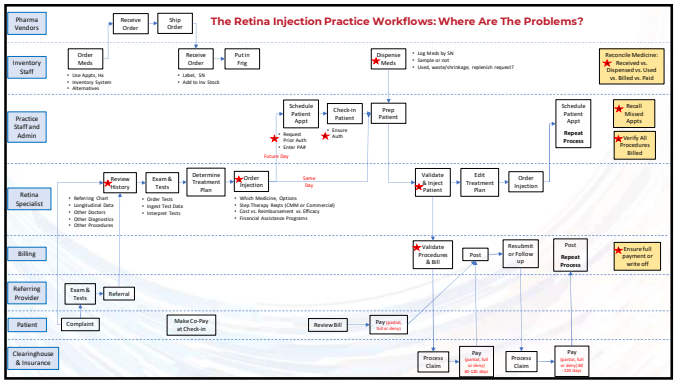
Financial Loss of a J Code Denial

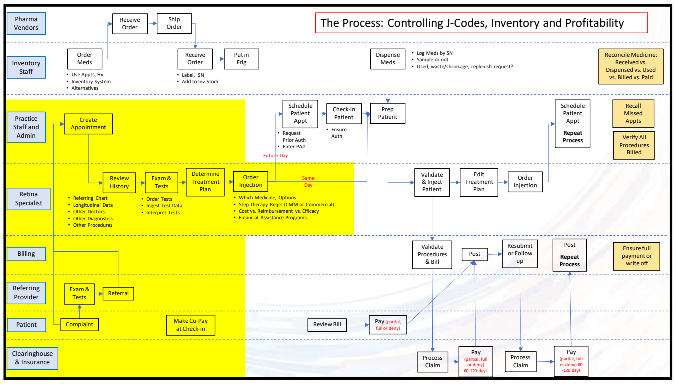
Manufacturer	Drug	Dose (MG)	J Code	Drug Cost per Injection	Medicare Reimbursement for Drug (80%)	Secondary Reimbursement (20%)	Total Reimbursement	Net Revenue	# of Additional Injections Required to Break Even after One Drug Denial
Samsung Bioepis	Byvoviz	0.5	Q5124	$979.71	$1,050.06	$262.51	$1,312.57	$332.86	2.54
Genentech (Roche)	Lucentis	0.5	J2778	$918.45	$946.34	$236.58	$1,182.92	$264.47	3.47
Coherus	CIMERLI	0.5	J3490	$1,149.00	$1,048.28	$262.07	$1,310.35	$161.35	7.12
Regeneron	Eylea HD	8	J3590	$2,579.06	$2,163.00	$540.75	$2,703.75	$124.69	20.68
Astellas	IZERVAY	2	J3490	$2,058.00	$1,730.40	$432.60	$2,163.00	$105.00	19.60
Coherus	CIMERLI	0.3	J3490	$689.40	$628.97	$157.24	$786.21	$96.81	7.12
Genentech (Roche)	Vabysmo	6	J2777	$2,034.51	$1,704.70	$426.17	$2,130.87	$96.36	21.11
Regeneron	Eylea	2	J0178	$1,616.90	$1,357.58	$339.39	$1,696.97	$80.07	20.19
Apellis	Syfovre	15	J2781	$2,146.20	$1,775.69	$443.92	$2,219.61	$73.41	29.24
Novartis	Beovu	6	J0179	$1,880.76	$1,561.15	$390.29	$1,951.44	$70.68	26.61
Clearside Biomedical	XIPERE	4	J3299	$1,683.00	$1,399.10	$349.78	$1,748.88	$65.88	25.55
Genentech (Roche)	Lucentis	0.3	J2778	$521.82	$442.93	$110.73	$553.66	$31.84	16.39
Genentech (Roche)	Avastin	1.25	J9035	$42.46	$53.31	$13.33	$66.64	$24.18	1.76
AbbVie	Ozurdex	0.7	J7312	$1,428.47	$1,143.50	$285.87	$1,429.37	$0.90	1,587.19

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 $2,579.06.
On average, it takes nearly 16 injections to break even from the loss.






The Process: Controlling J-Codes, Inventory and Profitability
Pharma Vendors
Receive Order
Ship Order
Inventory Staff
Order Meds
• Use Appts, Hx
• Inventory System
• Alternatives
Receive Order
• Label, SN
• Add to Inv Stock
Put in Frig
Dispense Meds
• Log Meds by SN
• Sample or not
• Used, waste/shrinkage, replenish request?
Reconcile Medicine: Received vs. Dispensed vs. Used vs. Billed vs. Paid
Practice Staff and Admin
Create Appointment
Schedule Patient Appt
• Request Prior Auth
• Enter PA#
Check-in Patient
• Ensure Auth
Prep Patient
Schedule Patient Appt
Repeat Process
Recall Missed Appts
Verify All Procedures Billed
Future Day
Retina Specialist
Review History
• Referring Chart
• Longitudinal Data
• Other Doctors
• Other Diagnostics
• Other Procedures
Exam & Tests
• Order Tests
• Ingest Test Data
• Interpret Tests
Determine Treatment Plan
Order Injection
• Which Medicine, Options
• Step Therapy Reqts (CMM or Commercial)
• Cost vs. Reimbursement vs. Efficacy
• Financial Assistance Programs
Same Day
Validate & Inject Patient
Edit Treatment Plan
Order Injection
Billing
Validate Procedures & Bill
Post
Resubmit or Follow up
Post
Repeat Process
Ensure full payment or write off
Referring Provider
Exam & Tests
Referral
Patient
Complaint
Make Co-Pay at Check-in
Review Bill
Pay (partial, full or deny)
Clearinghouse & Insurance
Process Claim
Pay (partial, full or deny) 60-120 days
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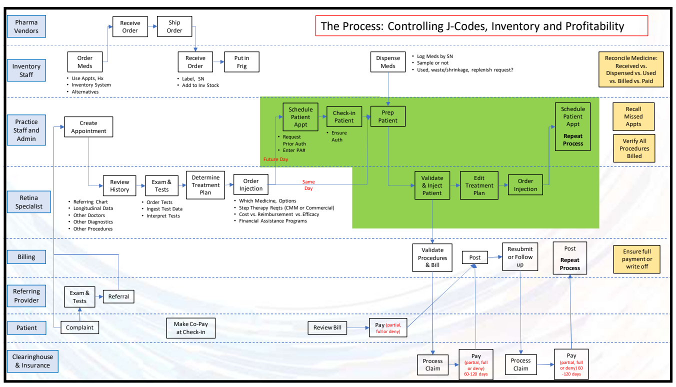
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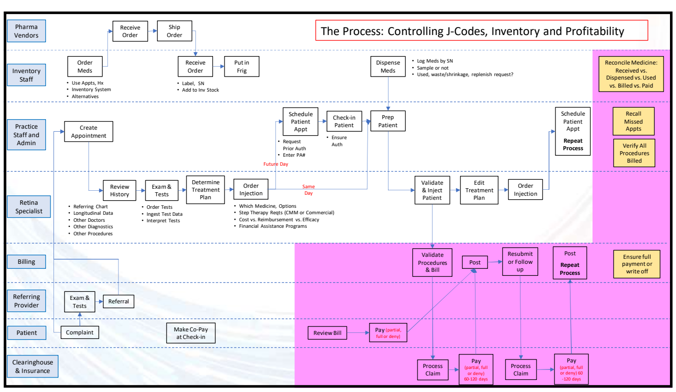
Practice Staff and Admin
Create Appointment
Schedule Patient Appt
• Request Prior Auth
• Enter PA#
Check-in Patient
• Ensure Auth
Prep Patient
Schedule Patient Appt
Repeat Process
Recall Missed Appts
Verify All Procedures Billed
Future Day
Retina Specialist
Review History
• Referring Chart
• Longitudinal Data
• Other Doctors
• Other Diagnostics
• Other Procedures
Exam & Tests
• Order Tests
• Ingest Test Data
• Interpret Tests
Determine Treatment Plan
Order Injection
• Which Medicine, Options
• Step Therapy Reqts (CMM or Commercial)
• Cost vs. Reimbursement vs. Efficacy
• Financial Assistance Programs
Same Day
Validate & Inject Patient
Edit Treatment Plan
Order Injection
Billing
Validate Procedures & Bill
Post
Resubmit or Follow up
Post
Repeat Process
Ensure full payment or write off
Referring Provider
Exam & Tests
Referral
Patient
Complaint
Make Co-Pay at Check-in
Review Bill
Pay (partial, full or deny)
Clearinghouse & Insurance
Process Claim
Pay (partial, full or deny) 60-120 days
Process Claim
Pay (partial, full or deny) 60 -120 days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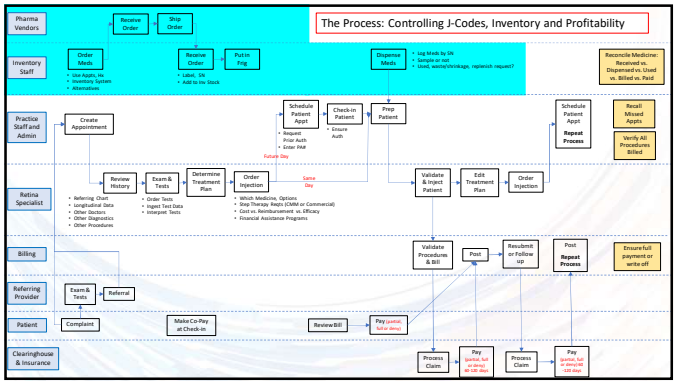
• Sample or not
• Used, waste/shrinkage, replenish request?
Reconcile Medicine: Received vs. Dispensed vs. Used vs. Billed vs. Paid
Practice Staff and Admin
Create Appointment
Schedule Patient Appt
• Request Prior Auth
• Enter PA#
Check-in Patient
• Ensure Auth
Prep Patient
Schedule Patient Appt
Repeat Process
Recall Missed Appts
Verify All Procedures Billed
Future Day
Retina Specialist
Review History
• Referring Chart
• Longitudinal Data
• Other Doctors
• Other Diagnostics
• Other Procedures
Exam & Tests
• Order Tests
• Ingest Test Data
• Interpret Tests
Determine Treatment Plan
Order Injection
• Which Medicine, Options
• Step Therapy Reqts (CMM or Commercial)
• Cost vs. Reimbursement vs. Efficacy
• Financial Assistance Programs
Same Day
Validate & Inject Patient
Edit Treatment Plan
Order Injection
Billing
Validate Procedures & Bill
Post
Resubmit or Follow up
Post
Repeat Process
Ensure full payment or write off
Referring Provider
Exam & Tests
Referral
Patient
Complaint
Make Co-Pay at Check-in
Review Bill
Pay (partial, full or deny)
Clearinghouse & Insurance
Process Claim
Pay (partial, full or deny) 60-120 days
Process Claim
Pay (partial, full or deny) 60 -120 days


The Process: Controlling J-Codes, Inventory and Profitability
Pharma Vendors
Receive Order
Ship Order
Inventory Staff
Order Meds
Receive Order
Put in Frig
Dispense Meds
Reconcile Medicine: Received vs. Dispensed vs. Used vs. Billed vs. Paid
Practice Staff and Admin
Create Appointment
Schedule Patient Appt
Check-in Patient
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Post
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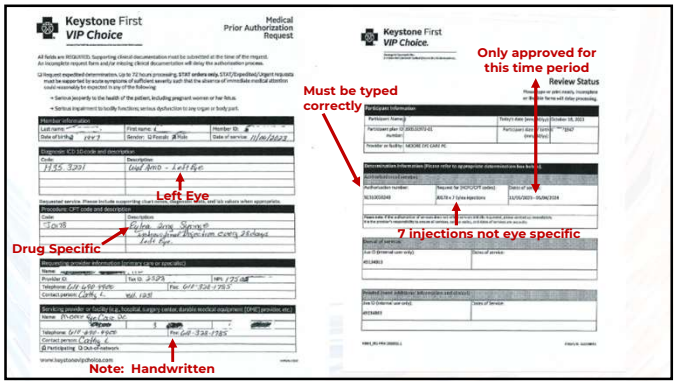
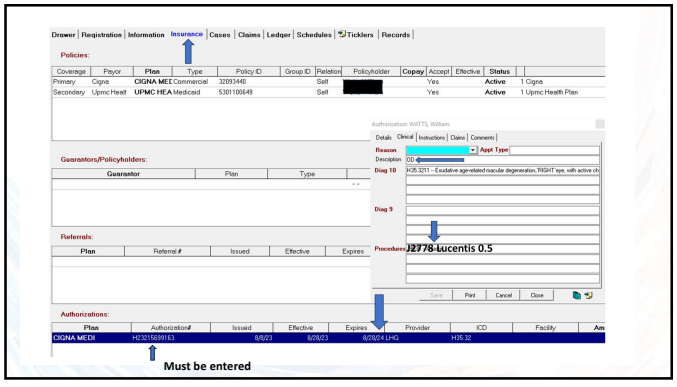
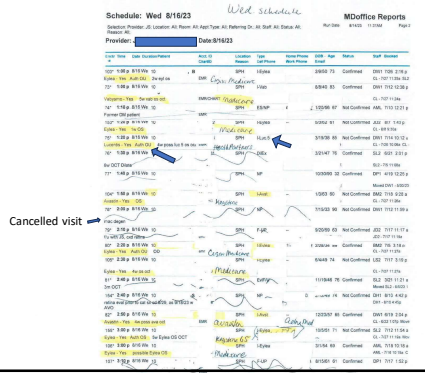
Referral
Patient
Complaint
Make Co-Pay at Check-in
Review Bill
Pay
Clearinghouse & Insurance
Process Claim
Pay
Process Claim
Pay

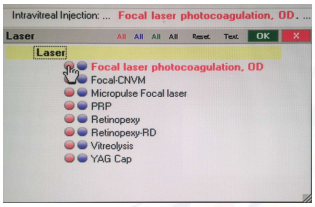

Keystone First
VIP Choice
Medical
Prior Authorization
Request
Left Eye
Drug Specific
Note: Handwritten
Must be typed correctly
Only approved for this time period
Review Status
7 injections not eye specific

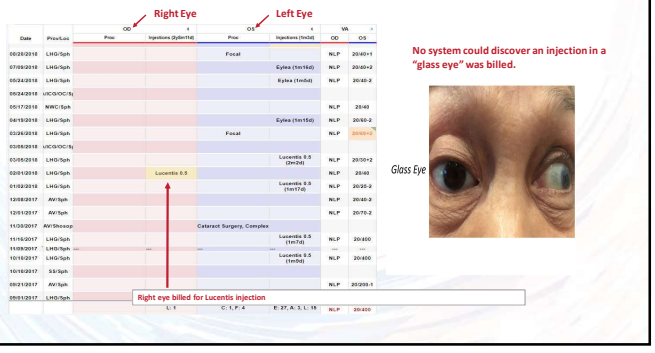

Drawer
Registration
Information
Insurance
Cases
Claims
Ledger
Schedules
Ticklers
Records
Policies:
Coverage
Payor
Plan
Type
Policy ID
Group ID
Relation
Policyholder
Copay
Accept
Effective
Status
Primary
Cigna
CIGNA MEC
Commercial
32093440
Self
Yes
Active
1 Cigna
Secondary
Upmc Healt
UPMC HEA
Medicaid
5301100649
Self
Yes
Active
1 Upmc Health Plan
Guarantors/Policyholders:
Guarantor
Plan
Type
Referrals:
Plan
Referral #
Issued
Effective
Expires
Authorizations:
Plan
Authorization#
Issued
Effective
Expires
Provider
ICD
Facility
CIGNA MEDI
H23156691 63
8/8/23
8/28/23
8/28/24 LHG
H35.32
Authorization: WATTS, William
Details
Clinical
Instructions
Claims
Comments
Reason
Appt Type
Description
Diag 10
H35.3211 – Exudative age-related macular degeneration, RIGHT eye, with active ch
Diag 9
Procedures
J2778-Lucentis 0.5
Save
Print
Cancel
Close
Must be entered



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.

Number Key	Description
1	Physician failing to see history of treatments and procedures/global period/lack of modifier
2	Physician failing to follow step therapy or ins requirements
3	No prior authorization on file
4	Diagnosis billed is not same as prior authorization dx codes
5	Wrong medication dispensed (sample vs. billed)
6	Physician injecting the wrong eye
7	Physician billing error/no CPT code selected/incorrect CPT
8	Physician forgot to bill procedure
9	Patient changed insurance/did not notify practice
10	Patient's ins did not change but ID number changed and prior auth no longer valid
11	Appealed too late for timely- billing error
12	Incorrect CPT selected for avastin
13	Specialty Pharmacy Only
14	Physician Non-Par with Insurance
15	No referral
16	Services not covered by patient's ins plan
17	Billing error- no pre auth but schedule said Yes for medication
18	Still outstanding/current appeals in process

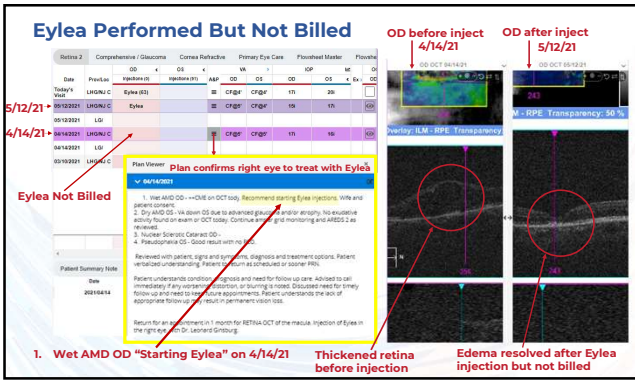
2021	
$ 55,868.44	#17 Billing error- no pre auth but schedule said Yes for medication
$ 29,120.00	#13 Specialty Pharmacy Only
$ 23,840.00	#3 No prior authorization on file
$ 4,230.00	#9 Patient changed insurance/did not notify practice
$ 3,640.00	#11 Appealed too late for timely- billing error
$ 2,115.00	#8 Physician forgot to bill procedure*
$ 2,065.00	#18 Still outstanding/current appeals in process
$ 550.00	#4 Diagnosis billed is not same as prior authorization dx codes
$ 121,428.44	

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

2022	
$ 53,510.00	#3 No prior authorization on file
$ 33,940.00	#9 Patient changed insurance/did not notify practice
$ 14,135.00	#5 Wrong medication dispensed (sample vs. billed)
$ 6,000.00	#2 Physician failing to follow step therapy or ins requirements
$ 3,640.00	#13 Specialty Pharmacy Only
$ 1,550.00	#15 No Referral
$ 500.00	#12 Incorrect CPT selected for avastin
$113,275.00	

2023	
$ 77,152.50	#17 Billing error- no pre auth but schedule said Yes for medication
$ 60,370.00	#3 No prior authorization on file
$ 41,515.00	#9 Patient changed insurance/did not notify practice
$ 5,115.00	#15 No Referral
$ 3,640.00	#13 Specialty Pharmacy Only
$ 187,792.50	

Eylea Performed But Not Billed



Specialty Pharmacy Drugs
Patient Specific

- Drop Ship programs for Part B Healthcare provider administered drugs
- Health Care 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 patients
- Health Care 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

JW Modifier Example: The following is for sites other than hospital outpatient departments that use the CMS-1500 form.

- A patient uses only 0.3 mg from a 0.5 mg vial, so the provider discards 0.2 mg
- The provider lists the product on 2 lines of the claim; both lines start with the Q-code
- The first line represents the 0.3 mg that was administered to the patient, so 3 units are recorded
- The second line represents the 0.2 mg that was discarded, so those 2 units are recorded, and the Q-code is followed by the initials "JW," known as the JW modifier

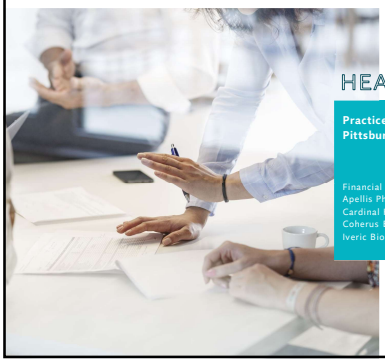
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS
Q5124				3
Q5124	JW			2
67028				1

Tools Offered by the Distributors

COMPANY	SOFTWARE
Amerisource Bergen	CubixxMD Inventory Management for Retina
Amerisource Bergen	Podis Plus Inventory Management
Cardinal Health	RxID Select Inventory Management and Analytics
CuraScript SD	Mainbridge Inventory Management
McKesson	Glide- Billing Scrubber/CCI Edits/Reporting
McKesson	Lynx Inventory Management
SamaCare	Preauthorization Tool for Submission to Insurance

CONSIDERATIONS FOR ONBOARDING NEW RETINA DRUGS

HEATHER THOMAS, OCSR



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

2

MAKE A PLAN

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

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

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

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

BILLING
Know the requirements for submitting a clean claim:
- Drug Administration
- NOC vs permanent J-code
- Correct NDC
- Modifiers
- Units
- Correct ICD-10

3

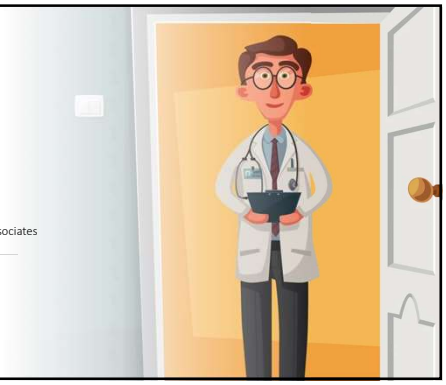
THANK YOU

Heather Thomas, OCSR

ASRS BOR 2024

Onboarding a New Physician

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



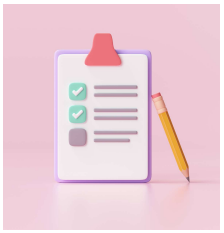
Financial Disclosures

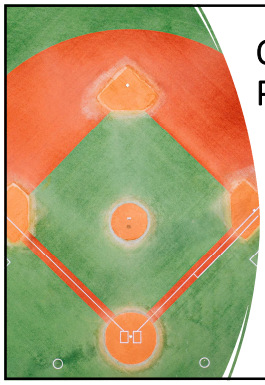
I, Aamer Hayat, have no relevant financial relationships in the products or services described, reviewed, evaluated or compared in this presentation.

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 IPA's 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

Advanced – Ensuring success!

- 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 ophthalmologist and optometrist- use it 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?

New Patients	Months												
Physician/Year	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	Grand Total
Dr 1 Year 1	59	53	52	33	33	38	52	61	45	51	58	53	589
Dr 2 Year 1	46	76	117	83	88	84	34	103	65	89	76	78	939
% Difference	-22%	43%	125%	159%	175%	115%	-35%	63%	44%	75%	52%	42%	61%

New Patients	Months													
Physician/Year	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	Grand Total	Year Over Year
Dr 1 Year 2	41	49	27	20	8	18	13	31	28	38	21	2	343	-41%
Dr 2 Year 2	83	73	81	67	50	86	66	82	85	105	72	76	910	-3%
% Difference	102%	49%	200%	235%	525%	126%	253%	148%	189%	250%	188%	159%	165%	

All Appt	Months												
Physician/Year	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	Grand Total
Dr 1 Year 1	142	178	221	206	333	322	353	423	304	419	386	382	3677
Dr 2 Year 1	202	227	390	368	374	442	245	444	368	433	391	414	4311
% Difference	42%	27%	76%	79%	10%	35%	-32%	5%	23%	3%	1%	14%	17%

All Appt	Months													
Physician/Year	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	Grand Total	Year over Year
Dr 1 Year 2	360	362	267	245	245	359	341	332	333	339	273	351	3,977	5%
Dr 2 Year 2	425	408	469	483	425	458	386	528	481	537	519	494	5601	30%
% Difference	18%	13%	76%	96%	73%	15%	11%	57%	44%	58%	85%	37%	45%	

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
- HIPPA 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

Nadeem N. Vaidya, M.D.

Moderator

- President, Retina Orange County, Inc.
- Also, Handyman, Bookkeeper, IT Support Staff
- Established in 2012
- No relevant disclosures

Robert C. Wang, M.D.

Panelist

- 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?

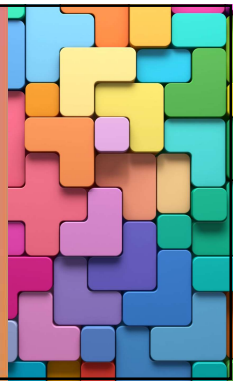
What do you see as the future of RCM? Can better software or AI mitigate some of the need to outsource?

Questions?

Fundamentals of the Drug Approval Process

Ashley Nahrwold, COA
Revenue Cycle Director
The Retina Institute of St. Louis

2024 ASRS Business of Retina Meeting



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.

COURSE OBJECTIVES

- Optimize practice workflows for the drug approval process
- Identify reimbursement concerns prior to injection
- Reduce injectable drug denials
- Reduce patient out of pocket costs
- Promote collaboration amongst Clinic, Front Desk, and Revenue Cycle teams

Prior Authorization - Is it enough?

Example 1:

Drug Name	Drug Code	Authorization Status
Injection, aflibercept, 1 mg	J0178	Approved

The authorization provided is not a guarantee of payment to the provider. Payment is based on the patient's benefit plan and eligibility when the services are received.

Example 2:

Aetna Medicare Gold Advantage (HMO) got your request to review the following drug(s). We are pleased to tell you that we approved the following drug(s).

LUCENTIS Soln Pref Syr 0.5MG/0.05ML

If this 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

Practice	Payer	Patient	Pharma
Payer Contracts	Payer Coverage Policies	Insurance Eligibility	FDA Approved "On Label" Diagnoses
Credentialing and Billing - Group vs. Individual MD	Prior Authorization Requirements	Plan Specific Drug Benefit Coverage	Dosing frequency
Drug Acquisition, Cost and Margins	Step Therapy Requirements	Specialty Pharmacy Requirements	Copay Assistance Options
Inventory Management	Specialty Pharmacy Requirements	Out of Pocket Cost	CPT Billing Code
Communication	PCP Referral Requirements	Severity of Disease / Urgency to Treat	New Indications

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.

The method of communicating the drug approved back to the physician is called the Injection Status.

Getting Started

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

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 providers 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
- 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
- Physician 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 cost to your Medicare allowed amount each quarter

Sample Medicare Drug Fee Schedule Cost Comparison

Code	Units Billed	Medicare Allowed Amount (Current Quarter - Q2)	80% Reimbursed By Medicare (when primary)	Medicare 2% Sequestration Adjusted from Payment	Reimbursement Received From Medicare (when primary)	20% Patient Responsibility if no Secondary Insurance or Patient Assistance	WAC	Drug Cost	Cost Discount Amount	Cost Discount Percentage	Margin per Drug (From Expected Reimbursement Excluding Rebates)
J9035	1	$71.35	$57.08	$1.14	$55.94	$14.27	$27.00	$27.00	$0.00	0%	$43.21
J0179	6	$1,889.13	$1,511.30	$30.23	$1,481.08	$377.83	$1,850.00	$1,807.73	$42.27	2%	$51.17
J0178	2	$1,787.10	$1,429.68	$28.59	$1,401.09	$357.42	$1,850.00	$1,592.85	$257.15	14%	$165.66
J2778	5	$1,238.27	$990.61	$19.81	$970.80	$247.65	$1,950.00	$1,109.55	$840.45	43%	$108.90
J2778	3	$742.96	$594.37	$11.89	$582.48	$148.59	$1,150.00	$665.73	$484.27	42%	$63.34
J2777	60	$2,245.32	$1,796.26	$35.93	$1,760.33	$449.06	$2,190.00	$2,124.30	$65.70	3%	$85.09

1. Return to clinic plans should indicate which drug has been selected to treat the patient
2. Determine how drug requested will be communicated to the staff obtaining prior authorization
3. Consider drug specific appointment scheduling events to identify, report and generate tasks for upcoming planned injections
4. Determine how staff will communicate back to the clinic when a drug is approved – Injection Status
5. Develop protocols for how often drug approvals are re-verified to ensure reimbursement continues for the during of treatment

COMMUNICATION

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)
- Obtain a list of payers seen at your practice
- Create guides for each payer product and each payer driven fundamental
- Payer 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 a lower out of pocket cost.
- 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.

Drug Approval Workflow

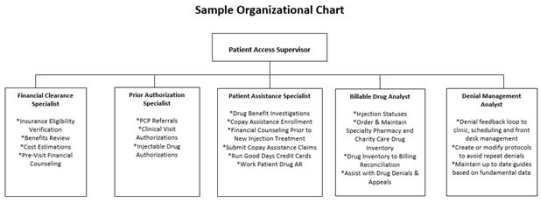
Prior to next visit (injection visit):

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.

Who Provides the Injection Status

- 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

The Patient Access Team



FINANCIAL CLEARANCE FUNCTIONS

- 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 scenario.

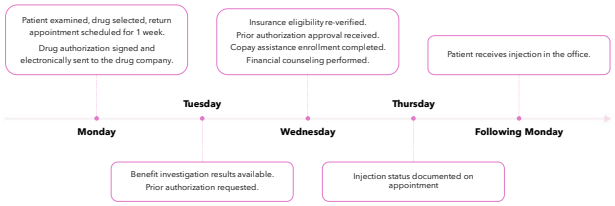
INJECTION STATUS GRANTED

"Based on the knowledge of the fundamentals, the Patient Access Team believes if this drug is injected the practice 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 attached to the appointment in a field that will be communicated to the clinic on the day of service.

Example Injection Status: IVE OD for AMD H35.3211

FIRST INJECTION APPROVAL TIME



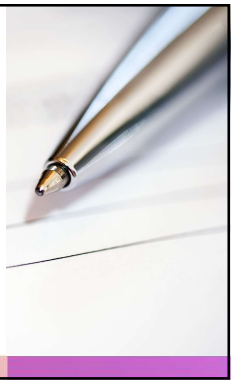
SAME DAY INJECTIONS

- 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



MANAGING CHANGES

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

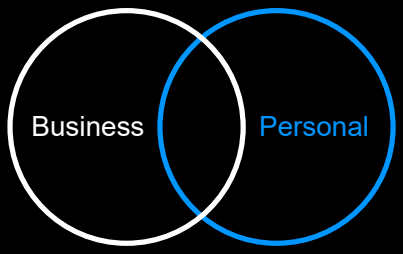
Question:

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

Future

$200,000

Risk Reward

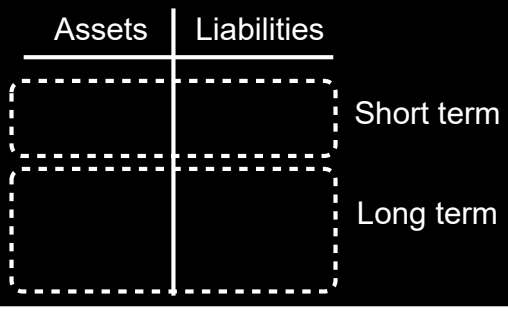
Risk-free

1. Cash in FDIC insured account → ?
2. US Government Treasuries
3. Paying off debt

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

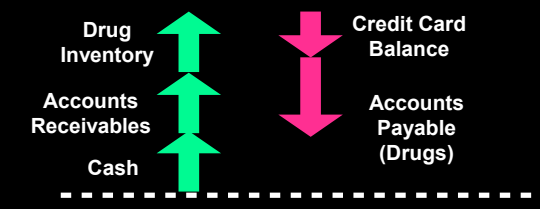


Working Capital =

Short Term Asset - Short Term Liabilities

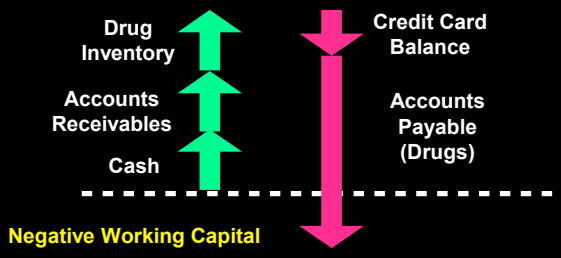
Working Capital =

Short Term Asset - Short Term Liabilities



Positive Working Capital

Working Capital =
Short Term Asset - Short Term Liabilities



Is negative working capital risky?

Yes

Is negative working capital bad?

It Depends on Risk vs Benefit

Negative Working Capital

- Same as a short term interest free loan.

Negative Working Capital

- How robust is your practice?

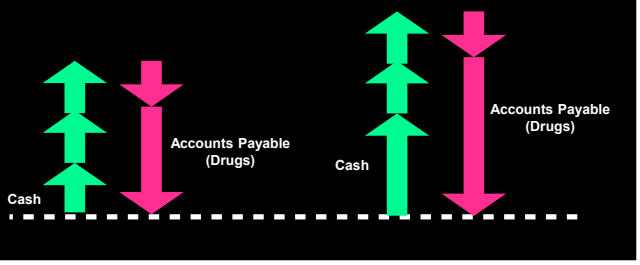
Large Accounts Payables

Making Choices

- Managing a practice is about making choices.

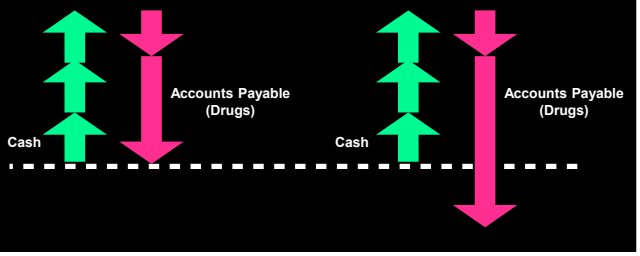
Example 1

Pay off payables vs Savings Account



Example 2

Pay off payables vs Buy an OCT



Example 2

Pay off payables vs Buy an OCT

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

NADEEM N. VAIDYA, M.D.
RETINA ORANGE COUNTY, INC.
IRVINE, CALIFORNIA

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

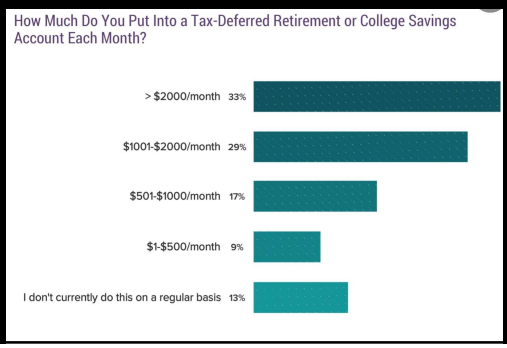
- no relevant disclosures

THE IMPORTANCE OF FINANCIAL PLANNING

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

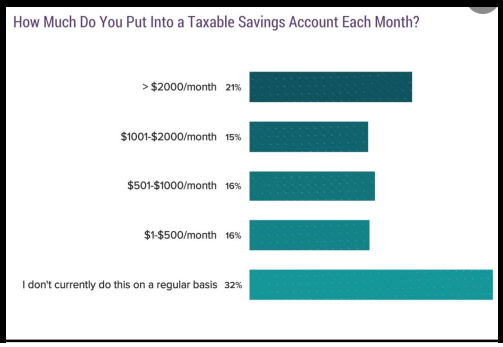
TAX DEFERRED

HOW MUCH ARE WE SAVING?



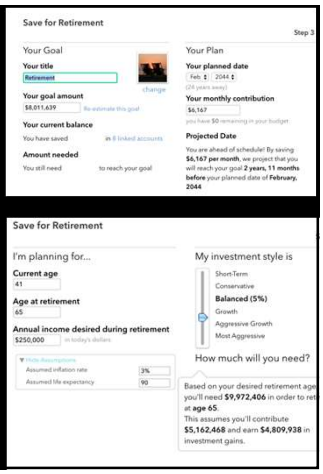
POST TAX

HOW MUCH ARE WE SAVING?



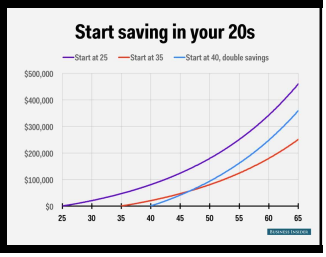
HOW MUCH DO I NEED?

- 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



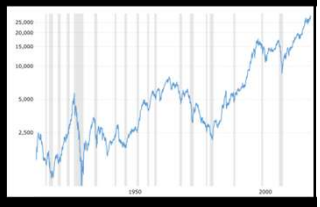
IS THIS DIFFICULT?

- 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?

	Small plan 401(k)	Individual 401(k)	SEP-IRA	SIMPLE IRA
Benefits	• Best option if you're looking to offer your employees all the tax, savings, and retirement benefits of a typical 401(k) plan.	• Excellent method to maximize tax deferral. Can contribute as employer and employee. Vanguard is one of the few investment companies to offer a Roth 401(k) option.	• Works well for business owners who prefer to provide a retirement benefit to all employees (including themselves) by making solely employer contributions.	• Great starter plan that encourages contributions from employees.
Participants	• All eligible employees.	• Sole proprietors or partners with no common-law employees.	• Anyone.	• Business owners with 100 or fewer employees.
Employer contribution limit	• For 2019, employer plus employee contribution limit is $56,000 ($62,000 if the employee is age 50 or older). • Contributions are deductible as a business expense and are not required every year.	• For 2019, employer plus employee contribution limit is $56,000 ($62,000 if the employee is age 50 or older). • Contributions are deductible as a business expense and are not required every year.	• For 2019, up to 25% of the employee's compensation or $56,000, whichever is less. • Contributions are deductible as a business expense and are not required every year.	• Option 1: Match up to 3% of each employee's compensation or $13,000 for 2019, whichever is less. • Option 2: Contribute 2% of each eligible employee's compensation up to $5,600 for 2019. • Contributions are deductible as a business expense.

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

A DIFFERENCE OF 3 MILLION

PROFIT SHARING 401K

STARTING LATER?

PENSION PLAN

LOWER COST, SMALLER BENEFIT

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 years 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

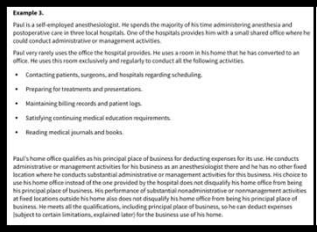
- we’ve all heard about section 179
- hummer loophole - section 168
  - GVWR > 6000lbs
  - bonus depreciation in year 1
    - 100% of the cost of the vehicle
    - Prior to the TCJA it was 25% in the first year
  - only when bought
  - only when “new to you”

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



Example 3.

Paul is a self-employed anesthesiologist. He spends the majority of his time administering anesthesia and postoperative care in three local hospitals. One of the hospitals provides him with a small shared office where he could conduct administrative or management activities.

Paul very rarely uses the office the hospital provides. He uses a room in his home that he has converted to an office. He uses this room exclusively and regularly to conduct all the following activities.

- Contacting patients, surgeons, and hospitals regarding scheduling.
- Preparing for treatments and presentations.
- Maintaining billing records and patient logs.
- Satisfying continuing medical education requirements.
- Reading medical journals and books.

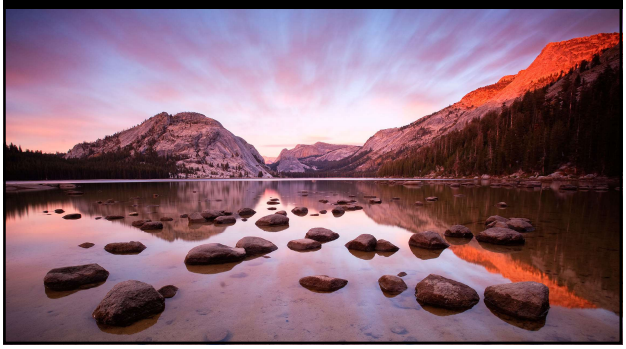
Paul's home office qualifies as his principal place of business for deducting expenses for its use. He conducts administrative or management activities for his business as an anesthesiologist there and he has no other fixed location where he conducts substantial administrative or management activities for this business. His choice to use his home office instead of the one provided by the hospital does not disqualify his home office from being his principal place of business. His performance of substantial nonadministrative or nonmanagement activities at fixed locations outside his home also does not disqualify his home office from being his principal place of business. He meets all the qualifications, including principal place of business, so he can deduct expenses (subject to certain limitations, explained later) for the business use of his home.

https://www.irs.gov/publications/p587

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

THANK YOU



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Protecting Sight. Empowering Lives.®

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.

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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

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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

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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)◀

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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

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6

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

G2211 RVUs	2024 CF	G2211 Allowable Payment	Patient Copay (20% of Allowable)
0.49	$32.74	$16.04	$3.21

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2024 ICD-10-CM

Effective October 1, 2023 housekeeping changes

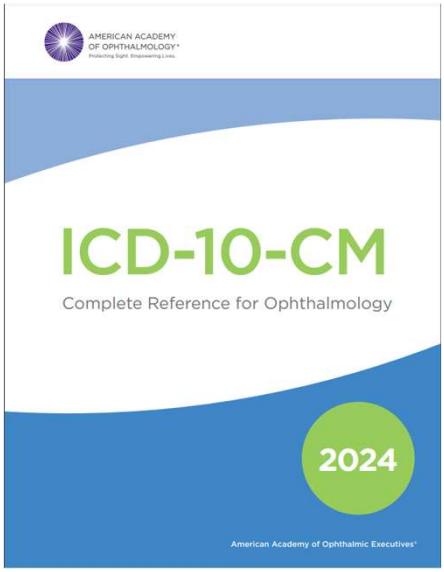
Expanded codes that represent social determinants of health
- Z62.23 Child in custody of non-parental relative

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)



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Evolving World of Retina Drugs

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Evolving World of Retina Drugs

Modifier -JZ	• Medicare required July 1, 2023
Geographic Atrophy Treatment	• 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
Eylea HD, 8 mg	• Office - report with NOC code until permanent code assigned • Facility – C9161, 8 units effective 1/1/24
Download the current resources: Table of Common Retina Drugs, Fact Sheets, Checklists	• Bookmark: aao.org/retinapm

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New FDA-Approved Drugs and CPT codes

Drug	HCPCS	NDC 5-4-2 Format Report in item 24a	CPT code	Indication(s)
Eylea HD (aflibercept) 8 mg/0.07 mL	**C9161-JZ (facility), 8 units eff 1/1/24** J3490 or J3590- JZ, 1 unit	61755-0050-01 61755-0050-**51(sample)**	67028	Neovascular age-related macular degeneration, diabetic macular edema, diabetic retinopathy
Izervay (avacincaptad pegol) 2 mg/0.1 mL	**C9162-JZ (facility), 20 units eff 1/1/24** J3490 or J3590- JZ, 1 unit	82829-0002-01	67028	Geographic atrophy (GA) secondary to age-related macular degeneration
SYFOVRE (pegcetacoplan) 15 mg/0.1 mL	**J2781, 15 units eff 10/1/23** C9151 deleted 10/1/23	73606-0020-01	67028	Geographic atrophy (GA) secondary to age-related macular degeneration
XIPERE (triamcinolone acetonide injectable suspension) 0.9 mL (40 mg/mL) **Suprachoroidal use**	J3299, 4 units J3299-JW, 32 units	71565-0040-01	**Eff 1/1/24 67516** 0465T deleted 12/31/23	Macular edema associated with uveitis **Procedure note should include dose and wastage**: 4 mg/0.1 mL was injected, and 32 mg/0.8 mL was wasted from the single-dose vial labeled as 0.9 mL (40mg/ml) of medication from one tray included in the Xipere carton.

Visit aao.org/retinapm for updates.

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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

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

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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!

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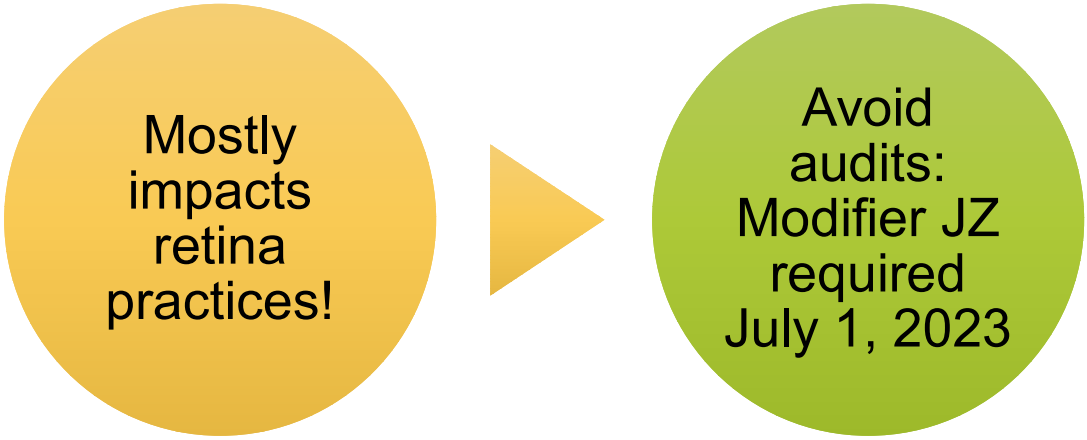
Hot Topic: JW and JZ Modifiers



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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

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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

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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

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JW Modifier

- Incorrect ✗

D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES
J3396			Charge $$
J3396	JW		Zero Charge

No charge second line

D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS
J3396	JW		Charge $$	150

Total units billed one line

- Correct ✓

D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS
J3396			Charge $$	130
J3396	JW		Charge $$	20

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JZ Modifier

- Incorrect ✗

D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES
J0178			Charge $$
J0178	JZ		Zero Charge

Billed on two lines

- Correct ✓

D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS
J0178	JZ		Charge $$	2

Billed on one line with modifier JZ, 2 units

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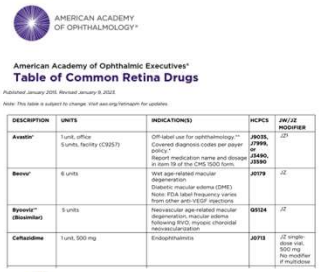
JW or JZ?

Table of Common Retina Drugs

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



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American Academy of Ophthalmic Executives®

Table of Common Retina Drugs

Published January 2015. Revised January 9, 2023.

Note: This table is subject to change. Visit aao.org/retinapm for updates.

DESCRIPTION	UNITS	INDICATION(S)	HCPCS	JW/JZ MODIFIER
Avastin®	1 unit, office 5 units, facility (C9257)	Off-label use for ophthalmology.** Covered diagnosis codes per payer policy.* Report medication name and dosage in item 19 of the CMS 1500 form.	**J9035, J7999, C9257, J3490, J3590**	JZ†
Beovu®	6 units	Wet age-related macular degeneration Diabetic macular edema (DME) Note: FDA label frequency varies from other anti-VEGF injections	**J0179**	JZ
Byooviz™ (Biosimilar)	5 units	Neovascular age-related macular degeneration, macular edema following RVO, myopic choroidal neovascularization	**Q5124**	JZ
Ceftazidime	1 unit, 500 mg	Endophthalmitis	**J0713**	JZ single-dose vial, 500 mg No modifier if multidose

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Audit Update

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Audit Realities

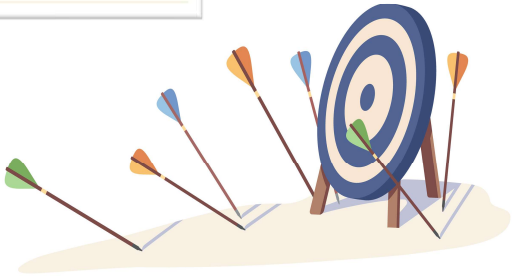
Yes, we failed

- How?
- What can we expect?
  - Increased scrutiny
- What should we do now?

SMRC Audits

INTRAVITREAL INJECTIONS

•29% FAILURE



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Pop Quiz #2

- Which of the following statements are <u>not</u> 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.

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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?

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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

https://www.aao.org/practice-management/multimedia-detail/how-to-document-specific-intravitreal-injection

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10 Steps for Retinal Surgery Coding

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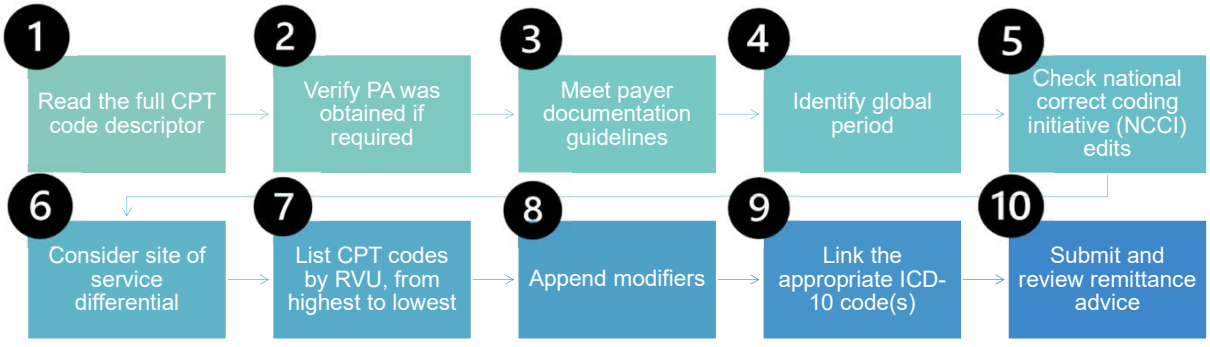
10 Steps to Surgical Coding



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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.

Description of Procedure: Courtesy of Austin Retina

Step #1 Read the Full CPT Descriptor

CPT code	Description
67036	Vitrectomy, mechanical, pars plana approach
67039	Vitrectomy, mechanical, pars plana approach; with focal endolaser photocoagulation
67040	Vitrectomy, mechanical, pars plana approach; with endolaser panretinal photocoagulation
67041	Vitrectomy, mechanical, pars plana approach; with removal of preretinal cellular membrane (eg, macular pucker)
67042	Vitrectomy, mechanical, pars plana approach; with removal of internal limiting membrane of retina (eg, for repair of macular hole, diabetic macular edema), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil)
67043	Vitrectomy, mechanical, pars plana approach; with removal of subretinal membrane (eg, choroidal neovascularization), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil) and laser photocoagulation

Step #1 Read the Full CPT Descriptor

CPT code	Description
67020	Injection, anterior chamber of eye (separate procedure); air or liquid
68200	Subconjunctival injection

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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

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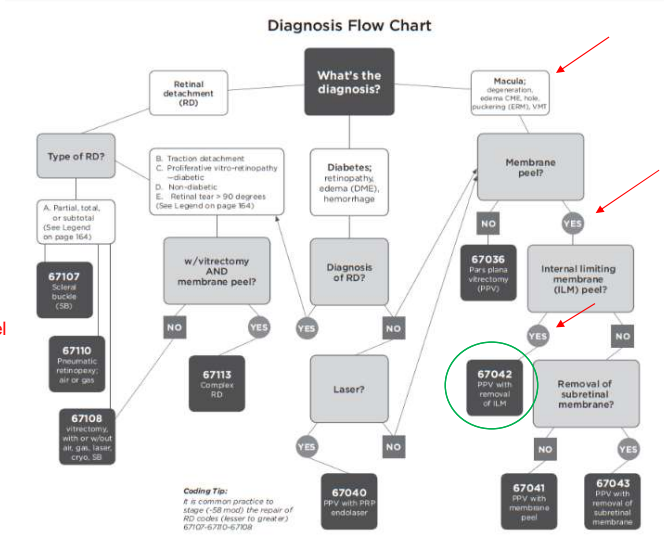
Pre-Operative Diagnosis:
Macular hole, right eye

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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Step #1 Read the Full CPT Descriptor

CPT code	Description
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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. . .

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

SURGERY MODIFIERS

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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 imitative (NCCI) edits
- 67042 is bundled with 67039
- Bill 67042 (higher RVU)

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CPT code	Description
67036	Vitrectomy, mechanical, pars plana approach
67039	Vitrectomy, mechanical, pars plana approach; with focal endolaser photocoagulation
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67043	Vitrectomy, mechanical, pars plana approach; with removal of subretinal membrane (eg, choroidal neovascularization), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil) and laser photocoagulation

Steps #8, #9, and #10

Step #8
- Append Modifiers
- Anatomical modifier

67042 -RT

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

H35.341

Step #10
- Submit and review remittance advice

Confirm Payment is appropriate for 67042

E/M: Decipher the Definitions

Retina Case Studies

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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

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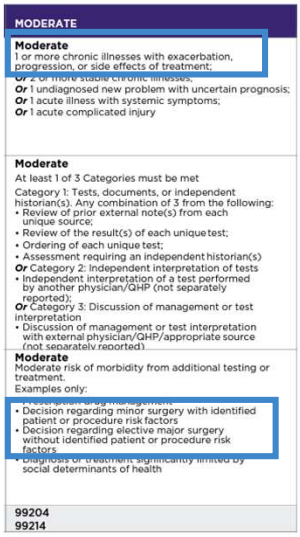
Decipher the Definitions

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"



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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

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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

LOW	MODERATE	HIGH
Low 2 self-limited or minor problems; **Or** 1 stable chronic illness; **Or** 1 acute, uncomplicated illness or injury Or 1 stable, acute illness Or 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	**Moderate** 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; **Or** 2 or more stable chronic illnesses; **Or** 1 undiagnosed new problem with uncertain prognosis; **Or** 1 acute illness with systemic symptoms; **Or** 1 acute complicated injury	**High** 1 or more chronic illnesses with severe exacerbation, progression or side effects of treatment; **Or** 1 acute or chronic illness or injury that pose a threat to life/body function
Limited 1 of 2 Categories must be met Category 1: Tests and documents any combination of 2 from the following: • Review of prior external note(s) from each unique source; • Review of the results(s) of each unique test; • Ordering of each unique test; **Or** Category 2: Assessment requiring an independent historian(s)	**Moderate** At least 1 of 3 Categories must be met Category 1: Tests, documents, or independent historian(s). Any combination of 3 from the following: • Review of prior external note(s) from each unique source; • Review of the result(s) of each unique test; • Ordering of each unique test; • Assessment requiring an independent historian(s) **Or** Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/QHP (not separately reported); **Or** Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/QHP/appropriate source (not separately reported)	**Extensive** 2 of 3 Categories must be met Category 1: Tests, documents, or independent historian(s). Any combination of 3 from the following: • Review of prior external note(s) from each unique source • Review of the result(s) of each unique test • Ordering of each unique test • Assessment requiring an independent historian(s) **Or** Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/QHP (not separately reported) **Or** Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/QHP/appropriate source (not separately reported)
Low Low risk of morbidity from additional diagnostic testing or treatment	**Moderate** Moderate risk of morbidity from additional testing or treatment. Examples only: • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health	**High** High risk of morbidity from additional diagnostic testing or treatment. Examples only: • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Parenteral controlled substances
99203 99213	99204 99214	99205 99215

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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

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Decipher the Definitions

Category 1: Tests, documents, or independent historian

- Does not include tests that are separately billable
- Does include - External tests (eg, 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

Amount and/ or Complexity of Data to be Reviewed and Analyzed	Minimal or none	Limited 1 of 2 Categories must be met Category 1: Tests and documents any combination of 2 from the following: • Review of prior external note(s) from each unique source; • Review of the results(s) of each unique test; • Ordering of each unique test; **Or** Category 2: Assessment requiring an independent historian(s)	Moderate At least 1 of 3 Categories must be met Category 1: Tests, documents, or independent historian(s). Any combination of 3 from the following: • Review of prior external note(s) from each unique source; • Review of the result(s) of each unique test; • Ordering of each unique test; • Assessment requiring an independent historian(s) **Or** Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/QHP (not separately reported); **Or** Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/QHP/appropriate source (not separately reported)	Extensive 2 of 3 Categories must be met Category 1: Tests, documents, or independent historian(s). Any combination of 3 from the following: • Review of prior external note(s) from each unique source • Review of the result(s) of each unique test • Ordering of each unique test • Assessment requiring an independent historian(s) **Or** Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/QHP (not separately reported) **Or** Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/QHP/appropriate source (not separately reported)

E/M #4

- Determine the level of complexity for a new **problem;** acute posterior vitreous detachment:

A. Low – 1 acute, uncomplicated illness

B. Low – 1 acute, uncomplicated illness, requiring hospital inpatient or observation level of care

C. Moderate – 1 undiagnosed new problem with uncertain prognosis

D. Moderate – 1 acute illness with systemic symptoms

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

LOW	MODERATE
Low 2 self-limited or minor problems; **Or** 1 stable chronic illness; **Or** 1 acute, uncomplicated illness or injury Or 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	**Moderate** 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; **Or** 2 or more stable chronic illnesses; **Or** 1 undiagnosed new problem with uncertain prognosis; **Or** 1 acute illness with systemic symptoms; **Or** 1 acute complicated injury
Limited 1 of 2 Categories must be met Category 1: Tests and documents any combination of 2 from the following: • Review of prior external note(s) from each unique source; • Review of the results(s) of each unique test; • Ordering of each unique test; **Or** Category 2: Assessment requiring an independent historian(s)	**Moderate** At least 1 of 3 Categories must be met Category 1: Tests, documents, or independent historian(s). Any combination of 3 from the following: • Review of prior external note(s) from each unique source; • Review of the result(s) of each unique test; • Ordering of each unique test; • Assessment requiring an independent historian(s) **Or** Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/QHP (not separately reported); **Or** Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/QHP/appropriate source
Low Low risk of morbidity from additional diagnostic testing or treatment	**Moderate** Moderate risk of morbidity from additional testing or treatment. Examples only: • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health
99203 **99213**	**99204** **99214**

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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

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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

CPT 2024	Meet or exceed
99202	15
99203	30
99204	45
99205	60
99212	10
99213	20
99214	30
99215	40

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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

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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

MODERATE	HIGH
Moderate 1 or more chronic illnesses with exacerbation, **Or** 2 or more stable chronic illnesses; **Or** 1 undiagnosed new problem with uncertain prognosis; **Or** 1 acute illness with systemic symptoms; **Or** 1 acute complicated injury	**High** 1 or more chronic illnesses with severe exacerbation, progression or side effects of treatment; **Or** 1 acute or chronic illness or injury that pose a threat to life/body function
Moderate At least 1 of 3 Categories must be met Category 1: Tests, documents, or independent historian(s). Any combination of 3 from the following: • Review of prior external note(s) from each unique source; • Review of the result(s) of each unique test; • Ordering of each unique test; • Assessment requiring an independent historian(s) **Or** Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/QHP (not separately reported); **Or** Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/QHP/appropriate source (not separately reported)	**Extensive** 2 of 3 Categories must be met Category 1: Tests, documents, or independent historian(s). Any combination of 3 from the following: • Review of prior external note(s) from each unique source • Review of the result(s) of each unique test • Ordering of each unique test • Assessment requiring an independent historian(s) **Or** Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/QHP (not separately reported) **Or** Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/QHP/appropriate source (not separately reported)
Moderate Moderate risk of morbidity from additional testing or treatment. Examples only: • Prescription drug management • Decision regarding minor surgery with identified • Decision regarding elective major surgery without identified patient or procedure risk • Diagnosis or treatment significantly limited by social determinants of health	**High** High risk of morbidity from additional diagnostic testing or treatment. Examples only: • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Parenteral controlled substances
99204 99214	99205 99215

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Questions?

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Academy Resources

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aao.org/lcds

aao.org/consulting

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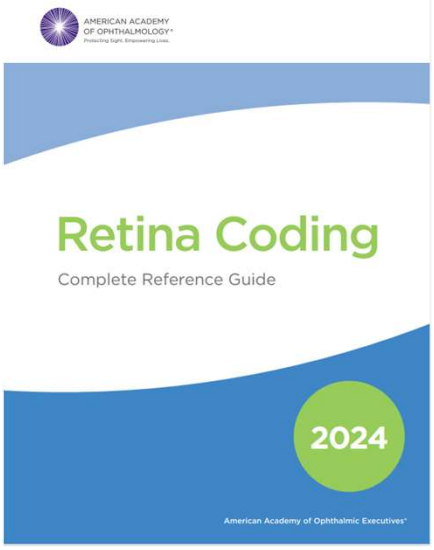

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