Medicare Updates for 2011

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Medicare Physician Fee Schedule – 12 Month Reprieve
Once again, Congress steps in at the 11th hour to prevent a significant decrease in the Medicare physician fee schedule. At least this time, we have a fee schedule that should last for 12 months (all of 2011). Hopefully, Congress will stop kicking the can down the road and come up with a long-term solution for the sustainable growth rate formula (SGR) used to establish Medicare's physician fee schedule. Since 2002, the use of the SGR formula has resulted in negative updates, While Congress has intervened to prevent reductions in the conversion factor, our Congressional representatives have not resolved the core problems with the formula.

On December 9, the House of Representatives followed the Senate's action and passed the Medicare and Medicaid Extenders Act. President Obama is expected to quickly sign the legislation. This Act extends the 2010 conversion factor of $36.8729 for all 2011 dates of service. This latest legislation (the 5th change noted during 2010) averts the 30 percent decrease that was scheduled to take effect January 1.

This does not mean the fees applicable in 2010 will continue in 2011. Due to changes in relative value units there will be some differences between the two fee schedules; however, the financial impact is miniscule in comparison to the decrease that would have occurred if this action had not taken place.

The Centers for Medicare & Medicaid Services (CMS) will recalculate and provide Medicare Contractors with revised 2011 Medicare physician fee schedules. Once received and tested, Medicare Contractors will post the revised fee schedules on their websites. The information should be available on or before January 1, 2011.

Part B Medicare Deductibles and Co-insurance
CMS announced the 2011 Part B Medicare deductible and coinsurance amounts. Once again, the Part B deductible has been increased. For 2011, the deductible is $162 up from $155 in 2010. Coinsurance remains at 20 percent of the Medicare approved amount once the patient's deductible has been satisfied.

Electronic Prescribing Incentives
The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 included incentive payments for electronic prescribing from 2009 through 2013.

- 2009 and 2010 incentive 2.0 percent
- 2011 and 2012 incentive 1.0 percent
- 2013 incentive 0.5 percent

MIPPA also included payment penalties to be applied to physicians/nonphysician practitioners for not successfully reporting the e-Rx measure:

- 2012 payment reduction 1 percent (payment based on 99 percent of the Medicare Physician Fee Schedule)

- 2013 payment reduction 1.5 percent (payment based on 98.5 percent of the Medicare Physician Fee Schedule)
- 2014 and each subsequent year, payment reduction 2 percent (payment based on 98 percent of the Medicare Physician Fee Schedule)

2010 Electronic Prescribing (e-Rx) Incentives

Depending on the number of prescriptions you e-Rx, it may not be too late to earn the 2 percent electronic prescribing (e-Rx) incentive for 2010. All eligible professionals successfully submitting 25 individual e-Rx measures on or before December 31, 2010 are entitled to the 2010 incentive which will be paid in the 3rd or 4th quarter of 2011. The incentive payment is based on 2.0 percent of the eligible professional's total estimated allowed charges for their 2010 professional services.

The measure is applicable if at least one (1) prescription is submitted electronically during the patient's visit. Report code G8553 to indicate an e-Rx was submitted during a patient encounter described by one of the following visit codes:

- 92002-92014 (Eye codes)
- 99201-99215 (Office/outpatient E/M)
- 99304-99316 (Nursing facility)
- 99324-99337 (Domiciliary visits)
- 99341-99350 (Home visits)

2011 Electronic Prescribing Incentives – Changes Abound!!!

- The EHR Incentive Program begins in calendar year 2011. Electronic prescribing bonuses will not be paid to eligible professionals receiving an EHR incentive payment for the same year – no double dipping!

- In 2011, physicians and nonphysician practitioners will continue to report G8553 when at least one electronic prescription is created during the encounter. To be counted towards the minimum number of times needed to obtain the e-Rx incentive, the claim must include one of the visit codes noted above.
- To be eligible for the incentive payment, electronic prescribers must report a minimum of 25 e-Rx measures during 2011 (payment made during the 3rd or 4th quarter 2012.)
- If the eligible professional is not a successful electronic prescriber for the 2011 reporting period, Medicare's 2012 fee schedule amount for the provider's covered professional services will be reduced by 1 percent.

  This means if the 2012 fee schedule allowance for code 12345 is $1000, an unsuccessful electronic prescribers' fee schedule allowance will be reduced to $990. Then Medicare processes the claim, applies any remaining deductible, and pays 80 percent.

  - Successful electronic proscribers - patient has already met their deductible, the 2012 Medicare payment for code 12345 is $800 and the patient is financially responsible for $200.
  - Unsuccessful electronic prescribers – patient has already met their deductible, the 2012 Medicare payment for code 12345 is reduced to $792 and the patient is responsible for $198 – a loss of $10.

- To avoid the 2012 payment reduction, at least 10 individual electronic prescribing measures must be included on the same claim as an acceptable visit code and submitted for payment between January 1, 2011 and June 30, 2011.

- Effective with dates of service on or after January 1, 2011, CMS established two "hardship codes" that can be reported on claims with visit codes if an eligible professional needs to request an exemption to the e-Rx Incentive Program and 2012 payment adjustments. A hardship exception, can be granted when one of the following situations apply:

  - G8642 The eligible professional practices in a rural area without sufficient high speed internet access and requests a hardship exemption from the application of the payment adjustment under §1848(a)(5)(A) of the Social Security Act. – This means high-speed internet access is not available in the area; the code should not be used when the physician/nonphysician practitioner decides not to establish internet access.
  - G8643 The eligible professional practices in an area without sufficient available pharmacies for electronic prescribing and requests a hardship exemption from the application of the payment adjustment under §1848(a)(5)(A) of the Social Security Act. – Do not assume the pharmacies in your area do not have e-Rx capabilities, you must confirm the pharmacies' electronic status.

- Eligible professionals not having prescribing privileges should report G8644 in 2011 to prevent being subjected to a payment adjustment in 2012.

2010 PQRI – Still Not Too Late To Collect Incentive!!!

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) made the Physician Quality Reporting Initiative (PQRI) a permanent program, but only authorized incentive payments through 2010. Eligible professionals who meet the criteria for satisfactory submission of quality measures data for services rendered during the 2010 reporting periods will receive an incentive payment of 2.0 percent of their total estimated allowed charges for their 2010 professional services. Historically CMS has authorized the Medicare Contractors to send incentive payments in the 3rd quarter of the following year. Thus, 2010 incentive payments probably will be sent the 3rd quarter of 2011.

Professional services are identified by *CPT/HCPCS* codes included on the Medicare Physician Fee Schedule. Incentive payments do not apply to other services, e.g., medications, eyeglasses, contact lenses, etc.

CMS set two (2) PQRI reporting periods for 2010. Physicians could select either a 12- or 6-month reporting period.

- 12-month reporting period – January 1 through December 31, 2010 (bonus calculated on 12 months of Medicare approved charges)
- 6 month reporting period – July 1 through December 31, 2010 (bonus calculated on 6 months of Medicare approved charges)

For 2010, there were two (2) reporting options

- Claims-based reporting
- Registry-based reporting

In addition to the claims-based reporting mechanism and the registry-based reporting mechanism, CMS began testing electronic health record (EHR) data submission, in cooperation with EHR vendors. Unfortunately ophthalmology measures were not selected for EHR reporting in 2010. (This omission continues in 2011.)

In a June 2010 article, NCI reemphasized the importance of reporting PQRI measures and provided the following examples:

You chose to report the diabetes mellitus and diabetic retinopathy measures. You see 10 diabetic patients during the reporting period and 4 of these patients have diabetic retinopathy. You must report the following to be successful

- Dilated Eye Exam in Diabetic Patient within 12 months
  - Eligible patients – 10
  - Must report on 8 patients

- Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care within 12 months
  - Eligible patients – 4
  - Must report on all 4 patients to meet the 80% requirement

- Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy within 12 months
  - Eligible patients – 4
  - Must report on all 4 patients to meet the 80% requirement

Continuing with the same example, if the physician successfully reports the entire calendar year, he/she will be entitled to a two (2) percent bonus on the Medicare approved amounts for all of his/her services that are paid on the Medicare Physician Fee Schedule for all of 2010. (Excludes drugs and optical items)

Let's say the total amount for your Medicare approved amounts for eligible services is $750,000 for 2010. You successfully report the entire year (paid claims with dates of service January 1 through December 31, 2010), your bonus will be $15,000. This bonus will be paid during the 3rd quarter of 2011.

Physicians successfully reporting during the second reporting period, July 1 through December 31, 2010, will have their bonus percentage based on the paid claims for these dates of service. Continuing with our previous example, your Medicare approved amounts for eligible services from January 1 through December 31, 2010 is $750,000 of which $400,000 is for claims with dates of service July 1 through December 31, 2010. Your bonus will be $8,000. This bonus will be paid during the 3rd quarter of 2011.

Registry Reporting

That article also included information on how to report 2010 quality measures using the American Academy of Ophthalmology (AAO) sponsored PQRI Registry. The Ophthalmic Patient Outcome Database (Outcome Sciences) can still be used to participate in 2010 PQRI reporting. Using a registry means that you did not need to submit data on your Medicare claims. The information can be submitted any time during the reporting period and, to be considered, must be reported to the registry no later than January 31, 2011. Outcome Sciences submits your data directly to CMS. This gives you the opportunity to still receive the 2 percent bonus for the entire year of eligible Medicare claims.

According to the article included in the May 2010 issue of *EyeNet Magazine*, Outcome Sciences charges a fee of approximately $600 per physician per year. The AAO believes being able to use a registry will greatly reduce physician and staff time required to participate in PQRI.

Currently, there is no method to determine whether you have been successful this year (2010) with your claims-based reporting; however, if you were successful in the past, you have reason to believe claims-

based reporting is working well for you and you may not want to change now. If, however, you have reported in the past and haven't received any bonus or you are reporting this year, but wonder if you have captured all the necessary data, registry reporting may just be the tool you have been looking for.

Eligibility for registry-based reporting works the same way. The physician must report on a minimum of three (3) measures and each of these measures must be reported on at least 80 percent of eligible patients. What makes registry reporting so cool is that you can batch report! You choose when to report the data.

Plus, this really is a neat option for ophthalmologists performing cataract surgery. If you report through the registry, for 2010 there are three (3) cataract measures. Two (2) of these measures are only applicable for the registry reporting option.

Measure # 139	Cataracts: Comprehensive Preoperative Assessment for Cataract Surgery with Intraocular Lens (IOL) Placement
Measure # 191	Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery
Measure # 192	Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures

You can easily upload or enter the data on the patients having cataract surgery during 2010 all at one time by January 31, 2011 and be a successful reporter for all of 2010!

See http://outcome.com/pqri.htm for more information. NCI encourage you to sign up for one of their webinars covering how to report PQRI measures through the registry.

- Wednesday, December 15, 2010 - 12:00 PM - 1:00 PM EST
  https://www1.gotomeeting.com/register/917138585

- Wednesday, December 22, 2010 - 12:00 PM - 1:00 PM EST
  https://www1.gotomeeting.com/register/915214153

- Wednesday, December 29, 2010 - 12:00 PM - 1:00 PM EST
  https://www1.gotomeeting.com/register/297994225

PQRI Changes to PQRS for 2011

The Affordable Care Act (ACA) included several changes to the Physician Quality Reporting Initiative. Not the least of which was to change the name to the Physician Quality Reporting System (PQRS). It also authorizes incentive payments through 2014 and beginning in 2015, it imposes a penalty for eligible professionals who do not satisfactorily report quality measures.

- For 2011, eligible professionals who meet the criteria for satisfactory submission of quality measures data will qualify for an incentive payment of 1.0 percent of their total estimated allowed charges for their 2011 professional services.
- For 2012 through 2014, eligible professionals may earn an incentive payment of 0.5 percent of their total estimated allowed charges for covered professional services furnished during the respective reporting periods.

Beginning in 2015, eligible professionals who do not satisfactorily report PQRS measures may be subject to a payment adjustment (penalty). Specifically, if an eligible professional does not satisfactorily report during the reporting period for the year, the Medicare Physician Fee Schedule for covered professional services furnished by this professional during the following year will be less than the PFS amount that would otherwise apply.

- For 2015, Medicare fee schedule allowances will be reduced by 1.5 percent if the professional does not satisfactorily report quality measures in 2014. For example, if the Medicare fee schedule for code 12345 is $100, this professional's fee schedule allowance will be $98.50.
- For 2016 and each subsequent year, Medicare fee schedule allowances for professional services will be reduced by 2.0 percent if the professional does not satisfactorily report quality measures during the previous year.

The ACA also authorizes an additional 0.5 percent incentive for 2011 through 2014 for eligible professionals who satisfactorily report and also participates in a Maintenance of Certification (MOC) Program in and successfully completes a qualified Maintenance of Certification Program practice assessment during the same year. The practice assessment of a qualified Maintenance of Certified Program requires more frequent assessments than those required to qualify for, or maintain, board certification status. For additional information on the MOC, see the American Board of Ophthalmology's website http://www.abop.org/maintain/req.asp

NCI expects CMS will publish additional information on how to report participation in a qualified MOC sometime in 2011.

2011 PQRS Ophthalmology Specific Measures

C = Claims Based Reporting
R = Registry Based Reporting

Measure Number	Description	Reporting Methods
12	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation	C, R
14	Age-Related Macular Degeneration (AMD): Dilated Macular Examination	C, R
18	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	C, R
19	Diabetic Retinopathy: Communication with the Physician Managing On-going Diabetes Care	C, R
117	Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient	C, R
140	Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement	C, R
141	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care	C, R
191	Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery	R
192	Cataracts: Complications within 30 days Following Cataract Surgery Requiring Additional Surgical Procedures	R

See the CMS website at http://www.cms.gov/PQRI/15_MeasuresCodes.asp#TopOfPage. Scroll down and select "2011 Physician Quality Reporting System Measure Specifications and Release Notes" for detailed information on each measure.

If you still haven't "seen the light" and already realize that reporting PQRS isn't really optional anymore, pay close attention to the next reason to participate:

Public Disclosure of e-Rx and PQRS Successful Providers

Beginning 2011, CMS will post the names of physicians and other eligible professionals who successfully reported quality data under the Physician Quality Reporting System (PQRS, formerly

PQRI), on its website. The names of eligible professionals (or group practices) who are successful electronic prescribers will also be posted.

While the current system gives credit for the physician's ability to capture data, because the title of the program includes the word "quality," it stands to reason that some patients may perceive this to mean if your name isn't on the list, you do not provide "quality care." As I have always reminded my staff, a person's perception is their reality.

To help you with claims-based reporting, NCI updated the PQRS cheat sheet for 2011 measures. It is included at the end of this article.

Most Physicians Exempted from Red Flag Rules
And you thought Congress wasn't getting anything done!

In a separate piece of legislation, the House followed the Senate's lead and passed the Red Flag Program Clarification Act of 2010. President Obama is expected to sign this legislation shortly. This Act narrows the definition of 'creditor' in the Fair and Accurate Credit Transaction Act that includes the Red Flags Rule.

Once signed by the President, a creditor is defined as an individual or entity that regularly, and in the ordinary course of business,

- obtains or uses consumer reports, directly or indirectly, in connection with a credit transaction;
- furnishes information to certain consumer reporting agencies in connection with a credit transaction; or
- advances funds to or on behalf of a person, based on the person's obligation to repay the funds or on repayment from specific property pledged by them or on their behalf.

The third criterion does not include funds advanced on behalf of a person for expenses incidental to a service provided by the creditor to that person.

Medicare Provider Enrollment Chain of Ownership Systems – Automatic Denials Delayed
During 2009 and 2010, NCI advised all physicians and nonphysician providers to verify they were in Medicare's Provider Enrollment Chain Ownership System (PECOS). Although there had been multiple delays, CMS planned to begin denying claims on January 1, 2011 for all services ordered by physicians and nonphysician providers who were not enrolled in PECOS. Ordering ophthalmologists not enrolled in PECOS would have created denials for the provider/supplier's claims for testing services, e.g., visual fields, OCT, etc. and Medicare covered eyeglasses and contact lenses.

Due to the backlog some Medicare contractors are experiencing with CMS-855 applications, this week CMS once-again decided to temporarily delay turning on the denial edit. This does not mean physicians and nonphysician practitioners do not have to be concerned about PECOS!

If you have not already done so, NCI strongly recommends reviewing the CMS list (available on the CMS website) to confirm you are in PECOS. If you are not on the list of providers and you have not submitted a CMS-855I application, you need complete and submit the application. The CMS PECOS list is available at http://www.cms.gov/MedicareProviderSupEnroll/Downloads/OrderingReferringReport.pdf

Physicians/providers can revalidate their enrollment via internet-based PECOS or they can fill out the appropriate paper CMS-855I and, if needed, the CMS-855R Medicare provider enrollment forms and mail them to the appropriate enrollment contractor.

Instructions on Internet-based PECOS can be found on the CMS website at http://www.cms.hhs.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp#TopOfPage

2011 PQRS Measures **Patient Name: _____ Date of Service: _____**

Primary Open-Angle Glaucoma: Optic Nerve Evaluation within 12 months (Measure #12)
Visit codes Office/Outpatient 99201-99205, 99212-99215, 92002-92014; Nursing home visits: 99304-99310; Domiciliary/Assisted Living 99324-99337 and diagnosis codes 365.10, 365.11, 365.12, 365.15

____ Optic nerve head evaluation performed (2027F)
____ Optic nerve head evaluation NOT performed for documented medical reasons, e.g., not indicated absence organ (2027F-1P)
____ Optic nerve evaluation NOT performed, reason not specified (2027F-8P)

Primary Open-Angel Glaucoma (POAG): Reduction of IOP by 15% OR Documentation of a Plan of Care (Measure #141)
Visit codes Office/Outpatient 99201-99205, 99212-99215, 92002-92014; Nursing home visits: 99307-99310; Domiciliary/Assisted Living 99324-99337 and diagnosis codes 365.10, 365.11, 365.12, 365.15
Documentation: Most recent IOP < or ≥ 15% from pre-intervention level and plan of care

_____ IOP reduced by a value of ≥ 15% from the pre-intervention level (3284F)
_____ IOP reduced < 15% from pre-intervention level AND glaucoma plan of care documented (0517F AND 3285F)
_____ IOP reduced <15% from pre-intervention level AND glaucoma plan of care NOT documented, reason not specified (0517F-8P AND 3285F)
_____ IOP measurement NOT documented AND glaucoma plan of care NOT documented, reason not specified (0517F-8P AND 3284F-8P)

Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement (Measure #140)
Visit codes Office/Outpatient 99201-99205, 99212-99215, 92002-92014; Nursing home visits: 99307-99310; Domiciliary/Assisted Living 99324-99337 and diagnosis codes 362.50, 362.51 362.52
Documentation: Discussion with all PTs with AMD including those who do not meet the criteria for the AREDS formulation, PTs who smoke

_____ Counseling about benefits and/or risks of AREDS (4177F)
_____ Counseling NOT performed, reason(s) not specified (4177F-8P)

Age-Related Macular Degeneration: Dilated Macular Examination within 12 months (Measure #14)
Visit codes Office/Outpatient 99201-99205, 99212-99215, 92002-92014; Nursing home visits: 99304-99310; Domiciliary/Assisted Living 99324-99337 and diagnosis codes 362.50, 362.51, 362.52
Documentation requires – presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity

____ Dilated macular exam performed (2019F)
____ Dilated macular examination NOT performed for medical reasons, e.g., dilation medically contraindicated (2019F-1P)
____ Dilated macular examination NOT performed for patient reasons, e.g., patient refused dilation (2019F-2P)
____ Dilated macular examination NOT performed, reason not specified (2019F-8P)

Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy within 12 months (Measure # 18) Visit codes Office/Outpatient 99201-99205, 99212-99215, 92002-92014; Nursing home visits: 99304-99310; Domiciliary/Assisted Living 99324-99337 and diagnosis codes 362.01, 362.02, 362.03, 362.04, 362.05, 362.06
Documentation requires dilation, level of severity of retinopathy (e.g., background diabetic retinopathy, proliferative diabetic retinopathy, nonproliferative diabetic retinopathy) AND documentation of whether macular edema was present or absent

____ Macular or fundus exam performed (2021F)
____ Macular or fundus exam NOT performed for medical reasons, e.g., dilation medically contraindicated (2021F-1P)
____ Macular or fundus exam NOT performed for patient reasons, e.g., patient refused dilation (2021F-2P)
____ Dilated macular or fundus exam NOT performed, reason not specified (2021F-8P)

Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care within 12 months (Measure #19)
Visit codes Office/Outpatient 99201-99205, 99212-99215, 92002-92014; Nursing home visits: 99304-99310; Domiciliary/Assisted Living 99324-99337 and diagnosis codes 362.01, 362.02, 362.03, 362.04, 362.05, 362.06
Documentation: findings of the dilated macular or fundus exam were communicated with the clinician managing the patient's diabetic care OR a copy of a letter in the medical record to the clinician managing the patient's diabetic care outlining the findings of the dilated macular or fundus exam.

____ Dilated macular or fundus exam findings communicated (5010F AND G8397)
____ Dilated macular or fundus exam performed but findings NOT communicated for medical reasons (5010F-1P AND G8397)
____ Dilated macular or fundus exam performed but findings NOT communicated for patient reasons, e.g., patient instruction not to communicate with other physician (5010F-2P AND G8397)
____ Dilated exam performed, but findings NOT communicated, reason not specified (5010F-8P AND G8397)
____ Patient not dilated (G8398)

Dilated Eye Exam in Diabetic Patient within 12 months (Measure #117)
Visit codes Office/Outpatient 99201-99205, 99212-99215, 92002-92014; Nursing home visits: 99304-99310; Domiciliary/Assisted Living 99324-99337 and diagnosis codes 250.00-250.93, 357.2, 362.01-362.07, 366.41, 648.00-648.04
Documentation: dilated comprehensive exam OR stereoscopic fundus photography OR eye imaging matching seven standard field stereoscopic photos

____ Dilated retinal eye examination performed (2022F)
____ Dilated eye exam, low risk for retinopathy (No evidence of retinopathy in the prior year) (3072F)
____ Seven standard field stereoscopic photos with interpretation (2024F)
____ Eye imaging matching seven standard field stereoscopic photos with interpretation (2026F)
____ NOT dilated/no photos or imaging, reason not specified (2022F-8P)