

[FAQs : Medicare Reimbursement Changes 2011](#)

- **What happened to Iridotomy 66761?**
  - Iridotomy now has a 10-day global period, instead of a 90-day global, meaning you can bill for all medically-necessary office visits performed beginning 11 days after the procedure.
  - The payment for 66761 has been reduced accordingly. See chart below.
  - You can continue to bill for any procedure on the fellow eye during the 10-day global by coding modifier “-79 - Procedure during postoperative period, unrelated” and the R/L modifier.
- **What happened to Anterior Segment OCT?**
  - The Category 3 code, 0187T, for anterior segment OCT has been deleted.
  - There is a new Category 1 CPT code: 92132, unilateral or bilateral, with interpretation and report.
  - It has RVUs assigned by CMS and will be paid at a rate similar to anterior segment photography.
  - Private payers and Medicare Carriers may still not cover the test.
- **What happened to Scanning Computerized Imaging, Posterior Segment?**
  - 92135 has been deleted. Two new codes have been created:
    - 92134 for retinal diagnoses, and
    - 92133 for optic nerve diagnoses.
  - This occurred at the insistence of CMS because they detected large volume increases in the past few years. These were mainly due to the increase in use for AMD and diabetic retinopathy, but the regulations require revaluation.
  - 92133 and 92134 cannot be billed on the same date of service, even if there is a different diagnosis for each code. This limitation is stipulated in CPT.
  - We expect most carriers will continue to restrict claims with 92250, fundus photography, so that neither 92133 or 92134 can be billed on same date of service as 92250 unless there are 2 separate diagnoses and medical necessity. Even then the claim may be vigorously scrutinized and rejected.
  - Only one unit of 92133 or 92134 is billed whether one or both eyes are imaged, or if you image on more than one device.
  - Regional Medicare carriers and private payers may have policies outlining the annual allowed frequency of testing.
  - The RVUs for 92133/92134 have been reduced by CMS.
    - The key change was a reduction in the Practice Expense calculations because the time to conduct the test and acquire scans is shorter with current machines.
    - The cost of these instruments is amortized in such a way that it has very contribution to the final reimbursement.
    - Physician effort for the interpretation and report of 92133/92134 was determined by surveys of ophthalmologists and was typically described as equivalent to the effort and time to interpret and report 92083 Visual Fields. This value was accepted by CMS.
    - The technician time and room use are longer for the visual field codes than for 92133/92134 which is why the payments for 92083 is higher.
- **What happened to Canaloplasty?**
  - Canaloplasty now has category 2 CPT codes replacing category 3 codes:
    - 66174 Transluminal dilation of aqueous outflow channel; without retention stent or device
    - 66175 with retention of device or stent
  - The RVUs for the physician professional fee are now assigned nationally by CMS and not by individual carriers.
  - The hospital outpatient and ASC fees are unchanged.
  - Some payers may still not cover the procedure considering it investigational.
  - RVUs for all procedures including canaloplasty are determined with random surveys of physicians (did include glaucoma specialists) and take into account information on:
    - time for procedure
    - intensity and risk of procedure
    - number and level of postoperative visits (currently postoperative visits are generally valued as Level 2 E/M)
    - comparable procedures for physician work
  - A major impact on the discussion at the Relative Value Update Committee included patient information from company websites that touted procedure as “non-invasive,” safer than traditional filtration surgery, and requiring fewer postoperative visits.
- **What happened to our office visit and procedure codes?**

- Office visits and our frequently used procedure codes have received increases in payments.
- Some of the increases are coming from updates to the Practice Expense values assigned to Ophthalmology from surveys in 2008.
- Some are beneficiaries of the legislative goal to increase values to Primary Care codes.
- Procedure code payments include postoperative visits (see above) during the global period, and because they have gone up, the total payment for the procedures have increased.
- See **Chart** below for examples.

Codes	Description	2011 Total RVUs	2011 Physician Payment*	2010 Total RVUs	2010 Physician Payment*	% Increase
99213	Estab E/M Level 3	2.03	\$68.97	1.81	\$66.74	3.3%
99204	New E/M Level 4	4.66	\$158.33	4.21	\$155.23	2.0%
92002	New Intermed Eye	2.22	\$75.43	1.96	\$72.27	4.4%
92004	New Compr Eye	4.12	\$139.98	3.67	\$135.32	3.4%
92012	Estab Intermed Eye	2.35	\$79.84	2.06	\$75.96	5.1%
92014	Estab Compr Eye	3.41	\$115.86	3.01	\$110.99	4.4%
92083	Visual Field, unilat/bilat	2.48	\$84.26	2.11	\$77.80	8.3%
92133	2011 ON Imaging, unilat/bilat	1.31	\$44.51			
65855	Laser Trabeculoplasty, office	9.67	\$328.55	8.5	\$313.42	4.8%
65855	Laser Trabeculoplasty, ASC/hospital	8.55	\$290.50	7.55	\$278.39	4.3%
66761	Laser iridotomy, office**	9.27	\$314.96	11.23	\$414.08	NA
66761	Laser iridotomy, ASC/hospital**	7.89	\$268.07	10.29	\$379.42	NA
66170	Trabeculectomy	33.65	\$1,143.31	29.6	\$1,091.44	4.8%
66172	Trabeculectomy, scarring	42.4	\$1,440.60	37.27	\$1,374.25	4.8%
66180	Glaucoma drainage device	33.03	\$1,122.24	29.28	\$1,079.64	3.9%
67255	Scleral reinforcement w/ patch graft	24.36	\$827.66	21.36	\$767.60	7.8%
66174	Canaloplasty, no stent	28.91	\$982.26	Carrier-based		
66175	Canaloplasty, with stent #	30.78	\$1045.79			
66984	Cataract/IOL	21.85	\$742.38	19.36	\$713.86	4.0%
66982	Complex Cataract/IOL	30.36	\$1,031.52	26.93	\$992.99	3.9%

\*Payment values are based on Conversion Factors only and do not reflect geographic multipliers, etc., so your actual payments will likely differ than these amounts.

The 2010 Payment values are based on October 2010 Conversion Factor.

\*\*Iridotomy has 10 day global, beginning 2011.

# approximate RVU, with estimated correction of an error in Malpractice RVUs in original release.

#### Appendix: The AMA Relative Value Update Committee process for physician payments.

1. Codes for valuation are selected by several criteria. The goal is to re-value all CPT codes every 5 years, but this has evolved into prioritizing codes that a) are new category 1 CPT codes, b) overutilized codes identified by CMS, and c) codes that have never been valued by the current RUC protocols.
2. Specialty societies (the AAO) are told about the targeted codes and sometimes can dissuade revaluation based on arguments or explanations for what has been happening with utilization and why. For example, the AAO was successful in delaying the revaluation of 92135 for several years by explaining why the utilization increased so dramatically. Finally, the RUC and CMS demanded separate codes and valuation and denied billing per eye.
3. The Specialty Society (AAO) is charged with performing a survey of physicians who perform the targeted procedure. The survey is done, with all costs borne by the society. The Health Policy committee, working with the relevant sub-specialty society, is involved with creating a) a clinical vignette that describes the typical patient who requires the

- service, and b) creating an appropriate comparison list of RUC-approved CPT procedures to which the surveyed procedure will be compared, and c) compiling and analyzing the data from the survey and creating a Statement that summarizes and explains the results and suggests the proper interpretation for the RVU committee to consider.
4. A survey of various practices and clinical workflow analysis is also performed to determine inputs for the Practice Expense portion of the RVU valuation. For an office procedure this may include the time it takes to have a patient check-in, technician time, undergo positioning, have a consent performed and documented, perform the actual procedure, the cost of the equipment involved, the number of clinic lanes used and the time they are occupied, etc. For many of the inputs there are standard times and costs assigned. The method of amortization of expensive equipment results in a very small contribution to the Practice Expense RVU.
  5. The survey for physician time and effort is sent by email to physicians. Physicians who have received more than \$5000 from an entity connected to the procedure must recuse themselves and are not allowed to participate in the survey, and surgeons are asked at the beginning of the survey how many procedures they typically perform. Physicians comment during the survey on a) whether the clinical vignette is an accurate description of the typical patient, b) the time involved in performing the procedure, c) the number of postop visits during the assigned global period, d) the intensity and risk involved in performing the procedure, and e) asked to select the most comparable code from the list of comparison codes with their work RVUs. A valid number of survey results must be returned and if not, the survey goes out to more physicians. The results are tallied and then evaluated by the Health Policy committee members.
  6. The interpretation of the survey data is sent to the RUC, which assigns the review to 3 voting members of the RUC for in-depth evaluation of the valuation suggested by the survey data and the specialty society. The RUC voting members are made up of representatives from all Medical specialty societies. The AAO has one voting member, and there are 25 other societies represented. Those Reviewers will interview colleagues that they know in their hospitals, visit the websites of companies who market the devices involved, and research the comparable procedures in their own specialty. There are representatives from CMS at the full meetings to watch the proceedings and comment if necessary. Keep in mind that there is one pool of money for all of physician payments that has to be portioned out according to this process (also known as budget neutrality.) Money not apportioned to one specialty's codes is then available for the entire pool.
  7. An experienced RUC Advisor for the AAO (not the AAO RUC member) formally presents the survey results to the full RUC committee, and is usually accompanied by a clinician who is familiar with the procedure to answer any clinical questions about the procedure. (This year I accompanied the liaison for the 92133/92132 and 66761 codes, and a surgeon who performs canaloplasty was present for that code presentation. There were very few clinical questions asked of us by the RUC members.) The RUC committee members discuss the valuation, make comments, or accept the 3 RUC member Reviewer recommendations about the valuation. The Specialty Society has very little input, because the survey data is paramount, and much stake is put in them by the RUC.
  8. The RUC valuation is for physician payment or work RVUs only. The Practice Expense RVU formula results are arrived at through a separate committee that also has AAO representation. Malpractice expense formulas are calculated by the AMA using a formula worked out with CMS and added too. Then a total RVU is determined and published in the Federal Register. There is a limited comment period after publication, and a very limited appeal process that can only be initiated for cause or errors in the process. Most groups have had little success in appealing codes that have been felt to be mis-valued by RUC or CMS in the past.
  9. Ultimately the assigned RVUs are multiplied by the "Conversion Factor" that is determined by CMS yearly or more often depending on what money Congress allows us to have. The Conversion factor is influenced by budget neutrality and the total pool of money to be divided. Besides the CF, there are additional multipliers based on regional variations in cost of business, geographical need in rural areas, etc. Your regional Medicare carrier posts the final payment values on their websites.