The Ophthalmic Practice Administrators Program has been approved for 6.25 COE Category “A” credits by the National Board for the Certification of Ophthalmic Executives.
Saturday, June 27

7:00–8:00 AM  
**Registration/Breakfast with Exhibitors**  
*South Ballroom Foyer/Ponce de Leon IV-VI*

8:00–8:15 AM  
**Welcome and Introductions**  
Steven R. Robinson, FASOA, COE

8:15–9:15 AM  
**2015 Medicare Update**  
E. Ann Rose

9:15–10:15 AM  
**Legislative and Regulatory Issues Impacting Ophthalmology**  
Nancey K. McCann, BA

10:15–10:45 AM  
**Break with Exhibitors**  
*Ponce de Leon IV-VI*

10:45–11:45 AM  
**Identifying and Developing Trainers**  
Elizabeth Holloway, COE, CPSS, SHRM-CP

11:45 AM–12:15 PM  
**Obtaining a Clearer Vision for Marketing Your Practice in 2015**  
Shawn Davis, BS, CRMC

12:15–1:00 PM  
**Lunch**  
*Magnolia Room*

1:00–1:45 PM  
**Identify and Manage Unhappy Patients**  
Anne M. Menke, RN, PhD

1:45–2:45 PM  
**The Big 10: Key Performance Indicators You Should Be Tracking**  
Elizabeth Holloway, COE, CPSS, SHRM-CP

2:45–3:45 PM  
**My Employees: A Team or a Mob?**  
Steven R. Robinson, FASOA, COE

3:45–4:00 PM  
**Questions and Answers**

4:00 PM  
**Adjourn**

**Accreditation**
*The Ophthalmic Practice Administrators Program has been approved for 6.25 COE Category “A” credits by the National Board for the Certification of Ophthalmic Executives.*
FACULTY

Shawn Davis, BS, CRMC
President
IMPACT MD
Orlando, FL

Elizabeth Holloway, COE, CPSS, SHRM-CP
Senior Consultant
BSM Consulting
Trinity, FL

Nancey K. McCann, BA
Director of Government Relations
American Society of Cataract and Refractive Surgery
American Society of Ophthalmic Administrators
Fairfax, VA

Anne M. Menke, RN, PhD
Risk Manager
Ophthalmic Mutual Insurance Company
San Francisco, CA

Steven R. Robinson, FASOA, COE*
Senior Consultant
S&R Consulting
Chattanooga, TN

E. Ann Rose
Owner/President
Rose and Associates
Duncanville, TX

*2015 Office Administrator Program Chair
E. Ann Rose
8:15–9:15 AM
E. Ann Rose

Ann Rose is owner and president of Rose & Associates, a Medicare reimbursement and compliance consultant who has been associated with the health care industry for over 40 years. Rose & Associates specializes in Medicare coding and billing with medical record auditing being their main focus.

Ann is a member of the American Society of Ophthalmic Administrators (ASOA), the Medical Group Management Association, and the American Academy of Professional Coders. She is also editor and publisher of The Messenger, a newsletter written and developed specifically for the specialty of ophthalmology, a regular contributor to ASOA’s Administrative Eyecare magazine, and serves on the editorial board of the reimbursement section of Ocular Surgery News.
2015 Medicare Update
Masters in Ophthalmology 2015
Administrator Program
Palm Beach, Florida
June 27, 2015
Presented by: E. Ann Rose

Financial Interest
I acknowledge a financial interest in the subject matter of this presentation.

Physician Fee Schedule
• On April 14, 2015, new legislation was passed that:
  – Fully repealed flawed SGR used to calculate physician fees
    • Averted 21% cut in physician fees
  – Guarantees annual increases of 0.5% starting in July, 2015 – December, 2019

Physician Fee Schedule
National Fee Schedule Payments July 1, 2015 – December 31, 2015
CPT Code | 6/31/15 | 7/1/15
---|---|---
92004 - Comp, New patient | $149 | $149
92012 - Intern, Est. Patient | $ 85 | $ 86
92014 - Comp, Est. Patient | $124 | $124
92030 - Detailed, New Patient | $109 | $110
92125 - Exp. Prob. Focused, Est. Patient | $72 | $73
9214 - Detailed, Est. Patient | $108 | $109
9215 - Comp, Est. Patient | $146 | $147
99204 - Comp, New Patient | $165 | $167
99205 - Comp, New Patient | $208 | $210

*92014 est. pt. still pays more than 99214 est. pt. exam

Physician Fee Schedule
National Fee Schedule Payments July 1, 2015 – December 31, 2015
CPT Code | 6/31/15 | 7/1/15
---|---|---
92083 - Visual field | $ 64 | $ 65
92133 - OCT, optic nerve | $ 44 | $ 45
92134 - OCT, retina | $ 45 | $ 46
92225 - Extended Ophthalmoscopy, Initial | $ 27 | $ 27
92226 - Extended Ophthalmoscopy, Subsequent | $ 25 | $ 25
92250 - Fundus Photo | $ 79 | $ 80
92256 - Fluorescein angiography | $110 | $111
92258 - External ocular photography | $ 20 | $ 21

Physician Fee Schedule
National Fee Schedule Payments July 1, 2015 – December 31, 2015
CPT Code | 6/31/15 | 7/1/15
---|---|---
15823 - Blepharoplasty | $ 613 | $ 617
65756 - DSAEK | $1,198 | $1,205
66170 - Trabeculectomy | $1,213 | $1,220
66180 - Aqueous Shunt | $1,150 | $1,156
66183 - Express shunt | $1,041 | $1,047
66185 - Revise Aqueous shunt/graft | $ 854 | $ 859
66821 - YAG – Office | $ 333 | $ 335
66821 - YAG – Facility | $ 314 | $ 316
66982 - Complex Cl w/OL | $ 804 | $ 808
Physician Fee Schedule

National Fee Schedule Payments July 1, 2015 – December 31, 2015

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>6/31/15</th>
<th>7/1/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>66984 - Cataract w/IOL</td>
<td>$ 647</td>
<td>$ 650</td>
</tr>
<tr>
<td>67028 - Intravitreal Injection</td>
<td>$ 102</td>
<td>$ 103</td>
</tr>
<tr>
<td>67036 - Vitrectomy</td>
<td>$ 911</td>
<td>$ 916</td>
</tr>
<tr>
<td>67039 - Laser treatment of retina</td>
<td>$ 976</td>
<td>$ 981</td>
</tr>
<tr>
<td>67040 - Laser treatment of retina</td>
<td>$1,055</td>
<td>$1,060</td>
</tr>
<tr>
<td>67041 - Vitrectomy – macular pucker</td>
<td>$1,166</td>
<td>$1,173</td>
</tr>
<tr>
<td>67042 - Vitrectomy – macular hole</td>
<td>$1,166</td>
<td>$1,173</td>
</tr>
<tr>
<td>67043 - Vitrectomy – Membrane dissect</td>
<td>$1,231</td>
<td>$1,237</td>
</tr>
</tbody>
</table>

Physician Fee Schedule

- CMS’s decision to eliminate global fee periods has been reversed
  - CMS plans to take a look at this again in 2017
    - May start collecting data to make decision at that time
  - Will still need to pay close attention to use of global fee modifiers for compliance
    - Particularly -25 modifier which is under scrutiny

Sequestration

- Sequestration (Medicare spending) cuts still in effect through 2024
  - Remittance Advice (RA) will include denial message “223 – Sequestration reduction in federal spending”
  - Permanent Geographic Practice Cost Index (GPCI) floor of 1.000% still in place
    - States with smaller GPCIs will not be reduced below 1.000%

MPPR

- Multiple Procedure Payment Reduction (MPPR) Continues
  - Technical component (-TC modifier) of second and subsequent tests performed on same patient, same day is reduced by 20%
    - CMS will monitor practice patterns to ensure MPPR not being bypassed
      - Expects physicians to continue treating patients under same medical standards

MPPR

<table>
<thead>
<tr>
<th>Diagnostic Tests Subject to Multiple Procedure Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>76510 76514 92060 92132 92228 92270 92285</td>
</tr>
<tr>
<td>76511 76516 92081 92133 92235 92275 92286</td>
</tr>
<tr>
<td>76512 76519 92082 92134 92240 92283</td>
</tr>
<tr>
<td>76513 92025 92083 92136 92250 92284</td>
</tr>
</tbody>
</table>
ASC Fee Schedule

• 2015 ASC Fee Schedule
  – Conversion factor for ASCs increased to 1.4% for facilities meeting quality reporting requirements
    • Results in small increases in ASC facility fee payments
  – HOPD 2015 Reimbursement
    – Rates increase about 2.3% in 2015

ASC Fee Schedule

• ASC Quality Measure Reporting
  – ASCs that satisfactorily report on quality measures in 2015:
    • ASC Conversion Factor is $44.071
  – ASCs that failed to meet ASC quality reporting:
    • Are paid a lower ASC Conversion Factor of $43.202

ASC Fee Schedule

• ASC supplies billable separately
  – Corneal tissue - Processing, preserving and transporting
    • Report Code V2785
  – Corneal allograft - Used with aqueous shunt codes 66180 and 66185 (Effective 4/1/15)
    • Must also report Code V2785
  – These are the only two supplies billable separately for ophthalmology
    • Will need to fax copy of invoice when electronic claim filed

ASC Fee Schedule

2015 National ASC Fee Schedule Payment Amounts

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>65755</td>
<td>Keratoplasty</td>
<td>$1,783</td>
<td>$1,711</td>
</tr>
<tr>
<td>66170</td>
<td>Trabeculectomy</td>
<td>$ 966</td>
<td>$ 960</td>
</tr>
<tr>
<td>66183</td>
<td>Express shunt</td>
<td>$1,678</td>
<td>$1,711</td>
</tr>
<tr>
<td>66821</td>
<td>YAG laser</td>
<td>$ 237</td>
<td>$ 243</td>
</tr>
<tr>
<td>66982</td>
<td>Complex cataract</td>
<td>$ 976</td>
<td>$ 960</td>
</tr>
<tr>
<td>66984</td>
<td>Cataract with IOL</td>
<td>$ 976</td>
<td>$ 960</td>
</tr>
<tr>
<td>67028</td>
<td>Intravitreal injection</td>
<td>$  48</td>
<td>$  47</td>
</tr>
<tr>
<td>67036</td>
<td>Retina (Codes 67036 - 67043)</td>
<td>$1,691</td>
<td>$1,711</td>
</tr>
<tr>
<td>67108</td>
<td>Retina Detach</td>
<td>$1,691</td>
<td>$1,711</td>
</tr>
</tbody>
</table>

ASC Fee Schedule

• Cataract ASC-11 Reporting Measure
  – ASCs were going to initially be required to report on pre- and post-operative patient visual function
    • ASCRS, ASOA and other ophthalmology societies strongly advocated that this was not an appropriate measure for the ASC setting
  – CMS has now determined that ASC-11 is a voluntary reporting measure

ASC Fee Schedule

• ASC pass-through drugs
  – Certain drugs are considered pass-through drugs and payable separately to the ASC
    • These are identified in the ASC Fee Schedule with a “K2” payment indicator
  – The drug codes should be billed on the same claim form as the related surgical service
    • If not the claim could be returned as unprocessable
  – The OPPS drug payments are updated quarterly
### ASC Fee Schedule

**Most Common Ophthalmology ASC Pass-Through Drugs**

<table>
<thead>
<tr>
<th>Code</th>
<th>Drug</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1841</td>
<td>Retinal Prosthesis (includes int/ext components)*</td>
<td>Contractor Priced</td>
</tr>
<tr>
<td>C9447</td>
<td>Osmotica - Phemephrine &amp; ketorolac - 4 ml</td>
<td>$492.90</td>
</tr>
<tr>
<td>J0178</td>
<td>Alfalof (EYLEA) Injection, 1mg - 2 units</td>
<td>$980.50</td>
</tr>
<tr>
<td>J0585</td>
<td>Botox</td>
<td>$5.57</td>
</tr>
<tr>
<td>J0600</td>
<td>EDTA</td>
<td>$4,430.35</td>
</tr>
<tr>
<td>J0850</td>
<td>Cytomogalovirus</td>
<td>$1,013.87</td>
</tr>
<tr>
<td>J2503</td>
<td>Macugen</td>
<td>$1,040.51</td>
</tr>
<tr>
<td>J2778</td>
<td>Ranibizumab (Lucentis)</td>
<td>$355.54</td>
</tr>
<tr>
<td>J2997</td>
<td>Activase (TF)</td>
<td>$68.44</td>
</tr>
</tbody>
</table>

**Effective 4/1/15 - Payments updated quarterly**

### CPT Code Changes

**Aqueous Shunts**

- **AMA and RUC**
  - Determined that frequency of use of grafts in aqueous shunt procedures warranted new code structure
  - Codes 66180 and 67255 reported together 73% of the time
  - Revised codes 66180 and 66185 to include graft
  - Created new codes for the non-graft procedures

**New and Revised Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>New</td>
<td>66179 Aqueous shunt to extra-ocular equatorial plate reservoir, external approach; without graft</td>
</tr>
<tr>
<td>Revised</td>
<td>66180 Aqueous shunt to extra-ocular equatorial plate reservoir, external approach; with graft (Can no longer report 66180 in conjunction with scleral reinforcement w/graft, code 67255)</td>
</tr>
<tr>
<td>New</td>
<td>66184 Revision of aqueous shunt to extra-ocular equatorial plate reservoir; without graft</td>
</tr>
<tr>
<td>Revised</td>
<td>66185 Revision of aqueous shunt to extra-ocular equatorial plate reservoir; with graft</td>
</tr>
<tr>
<td>Deleted</td>
<td>66165 Fistulization of sclera for glaucoma, iridencleisis or iridotaxis</td>
</tr>
</tbody>
</table>

**Corneal Hysteresis**

- **New and Revised Codes**
  - **New** 92145 Corneal hysteresis determination, by air impulse stimulation, unilateral or bilateral, with interpretation and report
  - Corneal hysteresis (CH) is defined as the difference in intraocular pressure recorded during inward and outward applanation.
  - New code now describes a test performed on a single or both eyes (e.g., unilateral or bilateral)
  - Replaces Category III code 0181T due to increase in usage
Category III Code Changes

New and Revised Codes

| Revised 0191T | Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the trabecular meshwork; initial insertion |
| Revised +0376T | Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the trabecular meshwork; initial insertion. (Can use to report each additional stent beyond the first implanted stent). (List separately in addition to code for primary procedure) |

- NEW and Revised Codes

CATALOG III CODE CHANGES

Visual Field Assessment

- New code created to report visual field assessment up to 30 days

- Assessment
  - Patient transmits daily test data to monitoring center (IDTF) for input into secured database
  - Technician with physician analyzes the data and prepares report
  - Results are then interpreted by physician

Professional Component

- Physician bills service to Medicare or other insurance

Technical Component

- Can also bill separately for technical component of device set-up and patient instructions for daily testing and transmission with technical staff report

New and Revised Codes

| New 0378T | Visual field assessment, with concurrent real time data analysis and accessible data storage with patient initiated data transmitted to a removal surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional |
| New 0379T | Technical support and patient instructions, surveillance, analysis, and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional |

Category III Code Changes

- New code to report analysis of retinal images to monitor disease progression (e.g., glaucoma, other structural damage)
  - May be performed on one or both eyes
  - May only be reported once

New and Revised Codes

| New 0380T | Computer-aided animation and analysis of time series retinal images for the monitoring of disease progression, unilateral or bilateral, with interpretation and report |

Codes Implemented July 1, 2014

Included in 2015 CPT Coding Manual

| New 0341T | Quantitative pupillometry with interpretation and report, unilateral and bilateral |
| New 0356T | Insertion of drug-eluting implant (including punctal dilation and implant removal when performed) into lacrimal canaliculus, each |

Reminder: Since CMS does not assign RVUs to Category III codes, payment is made by contractor discretion. Billing Category III codes will help develop billing history for possible conversion to CPT permanent codes.
### On-Going Issues

#### 2015 OIG Work Plan

- **Ambulatory Surgery Center (ASC) Payment System**
  - Will continue to review methodology for setting ASC payment rates under revised system
  - ASC payments modeled on Outpatient Prospective Payment System (OPPS) since 2008
  - Will determine if disparity exists between ASC and HOPD payment rates for similar procedures

#### On-Going Issues

- **Payments for Personally Performed Anesthesia Services**
  - Will review claims to determine whether personally performed anesthesia services were billed correctly
    - Must be reported with “AA” modifier
  - Reporting incorrect modifier as though the service was personally performed when it was not results in higher (incorrect) payments

- **Imaging Services**
  - Will review Medicare payments to determine if they accurately reflect expenses incurred and that utilization rates reflect industry practices
  - Will continue to focus on Practice Expense component including equipment utilization rates

- **Questionable Billing and Payments to Ophthalmologists**
  - OIG still reviewing claims for 2012
  - Will identify certain geographic locations for providers exhibiting questionable billing
    - In 2012 CMS allowed over $6.8 billion for services provided by ophthalmologists

- **Place of Service Coding Errors**
  - Still looking at ASC and HOPD claims to see if correct place of service used
  - Some claims show “office” when place of service should have been HOPD or ASC
  - Medicare pays physician higher amount when services performed in office vs. HOPD or ASC

- **On-Going Issues**

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On-Going Issues

• Security of certified EHR records under Meaningful Use
  – Will most likely be ongoing issue for quite some time
    • Nothing provider needs to do

New Issue

• Provider Eligibility
  – Enhanced enrollment screening for Medicare Providers
    • Stepping up effort to prevent fraud, waste, and abuse resulting from vulnerabilities in Medicare enrollment process
    • Implementing new authorities that will include:
      – Site visits, fingerprinting, background checks, and automated provider screening process

New Issue

• Before hiring any employee
  • Physician, administrator, coder, biller, accounting clerk, etc.
    – Need to check out OIG’s “Excluded Individuals” database
      • http://exclusions.oig.hhs.gov/
    – It’s a simple name search that can prevent you from hiring the employees that can put your practice at risk

Other Issues

New CCI “X” Modifiers

• New “X” modifiers developed to assist providers in correct use of unbundling codes under the CCI edits
  • Effective for dates of service on or after January 1, 2015
  – Modifier -XE: Separate Encounter
    • A service that is distinct because it occurred during a separate encounter

New CCI “X” Modifiers

– Modifier -XS: Separate Structure
  • A service that is distinct because it was performed on a separate organ/structure
– Modifier -XP: Separate Practitioner
  • A service that is distinct because it was performed by a different practitioner
– Modifier -XU: Unusual Non-Overlapping Service
  • The use of a service that is distinct because it does not overlap usual components of the main service
New CCI “X” Modifiers

• CMS will continue to recognize -59 modifier for now
  – Should not be used when more appropriate modifier exists, however
    • CMS may begin to identify code pairs as only payable with the “X” modifiers
    • Would result in denials if “X” modifier not used
  – CMS encourages providers to use “X” modifiers when appropriate

Dropless Cataract Surgery

• Use of intraocular or periorcular injections of anti-inflammatory drugs and antibiotics at time of cataract surgery has increased
  – For example: triamcinolone and moxifloxacin with or without vancomycin
    • Referred to as “dropless cataract surgery”
  • Eliminates need for post-operative antibiotic eye drops

Dropless Cataract Surgery

• According to CCI:
  – Injection of drugs during a cataract extraction or other ophthalmic procedure is not billable separately
  • Injections are considered part of ocular surgery and included in code used to report the surgical procedure

Dropless Cataract Surgery

• What about the medications?
  – Compounded drugs must be billed with code J3490 (unclassified drugs), regardless of the site of service
  – ASCs do not get paid separately for NOC drugs or supplies
    • Packaged as part of ASC facility fee
    • Cannot report J3490 or C9399

Femtosecond Revisited

• Refractive imaging component of FS laser performed on premium AC-IOL and PC-IOL cataract patients before surgery has begun is a non-covered service
  – Can bill premium IOL patients for OCT imaging
  – Fee usually included in premium IOL charge
  – Cannot charge fee for Femtosecond laser used intraoperatively (during surgery) such as:
    – Phaco incision, capsulotomy, lens fragmentation

Femtosecond Revisited

– Billing patient for FS laser OCT imaging performed on conventional IOL patients
  • CMS expects FS laser on these patients to be rare
    – Even if not charged
  • Will negate argument that only premium IOL patients need this special imaging
– LRI/CRI performed with FS laser at same time as conventional IOL surgery
  • Still billable to patient separately
    – When performed on premium IOL patients fee usually included in premium IOL charge
Medically Unlikely Edits

• Medically Unlikely Edit (MUE)
  – This is a unit of service claim edit applied to Medicare claims against a procedure code rendered by one provider to one patient on the same day
• Why did CMS develop MUEs?
  – To reduce the paid claims error rate for Part B claims
  • Implemented January 1, 2007

Medically Unlikely Edits

• How MUEs affect billing
  – The edits are based on:
    • Anatomic considerations (-LT or -RT)
    • HCPCS/CPT code descriptors
    • CPT instructions
    • CMS policies
    • Nature of service/procedure
    • Nature of equipment
    • Clinical judgment

Medically Unlikely Edits

– When procedures or services are performed on both eyes at the same session physicians should:
  • Append the -50 modifier on one line only
  • Bill “1” unit and increase your charge
  • Can no longer submit –RT or –LT modifiers to Medicare for bilateral surgeries
– ASCs still required to bill bilateral services on two lines
  • Must use the -RT and -LT modifiers

New Patient Definition

• CMS previously edited new patient exams based solely on Tax ID # of practice
  – CMS now edits new patient exams by NPI number not just Tax ID #
  • Exam will be denied if provider saw that patient anywhere during the past 3 years regardless of where he/she worked

New Patient Definition

– If new physician joins practice and sees old patients in new practice
  • Cannot bill as a new patient exam
– Patient sent to practice for test because referring doctor does not have equipment
  • No exam conducted - just I&R of test
  • If patient returns for exam within 3 years of the test, can bill as new patient since no exam or other face-to-face service was performed by the doctor

ICD-10 Implementation

• October 1, 2015
  • New target go live date for ICD-10
• Don’t be caught off guard you only have a few months left
  • Understanding the ICD-10 differences and training needs are critical
• Having a good transition plan is critical
  • Will make your job much easier
ICD-10 Implementation

- Identify how ICD-10 will affect your practice
  - Arm yourself with information for smooth transition
    - Review differences in ICD-9 and ICD-10 with staff
    - Understand how differences will impact your practice
    - How they will impact ASC and Optical if applicable
    - Think about how to budget for implementation
  - This needs to be a team effort

ICD-10 Implementation

- Take a cursory look at ICD-10 coding manual
  - Introduction and General Conventions
  - Even if you aren’t a coder, you will be surprised what you will learn
    - Make this mandatory for your coders
  - Review Chapter 7: Diseases of Eye and Adnexa
    - Diagnosis codes H00-H59
  - A little knowledge will go a long way with all staff

ICD-10 Implementation

- Determine your top 80% of ICD-9 codes and devise ICD-10 crosswalk
  - Share with doctors, technicians, coders and billers
  - Will give them a chance to become familiar with the differences in the codes
  - Consider investing in other tools to help with coding if not on EMR

ICD-10 Training

- Training should begin NOW!
  - Look for ophthalmology specific training
  - After training:
    - Create sample charts for testing throughout the next few months
    - Retrain coding staff that don’t appear to be grasping new ICD-10 codes
      - Or doctors/technicians who aren’t improving documentation

ICD-10 Training

- Types of training available
  - Regional seminars
  - Web based courses
  - On-Site training for entire staff
    - Book in advance – classes will fill up fast

ICD-10 Training

- Physicians/nurses/technicians should get training at same time
  - Helps ensure they will be on board with same information
- Documentation for some conditions will need to improve
  - Physician input may be key to proper documentation
    - This will be coder’s biggest task
ICD-10 Training

• May want non-certified staff to take refresher on-line anatomy course
  – Eye anatomy becomes important in ICD-10
    • Knowing anatomy not required in ICD-9
• Understanding the differences between ICD-9 and ICD-10 will also be key
  • And the impact it will have on the practice
Nancy K. McCann, BA
9:15–10:15 AM
Nancey K. McCann, BA

Nancey McCann is Director of Government Relations for the American Society of Cataract and Refractive Surgery (ASCRS), an international educational and scientific organization whose over 9,000 member ophthalmologists specialize in cataract and refractive surgery. Ms. McCann is responsible for the development, implementation and coordination of the ASCRS government relations program. She has served in that capacity since 1993.
2015 Legislative/Regulatory Update

Nancy K. McCann, BA
Director of Government Relations
ASCRS/ASOA

June 2015

Priority Issues for Ophthalmology

- Passage of H.R. 2, the Medicare Access and CHIP reauthorization Act of 2015 (SGR repeal and 10 and 90 day global issue resolved)
- 21st Century Cures Initiative
- Repeal IPAB
- Private Contracting/Patient Shared Responsibility
- Drug Compounding
- Immediate Use Steam Sterilization
- Medicare Advantage Plans
- ASC Quality Reporting
- Accountable Care Organizations – exclusivity issue
- Quality Reporting Programs

Nancy K. McCann

No Relevant Financial Relationships with Commercial Interests

Working Together for a Change?

What’s the opposite of progress?
**Common Theme**

*** All proposals (Bi-partisan) aimed at moving Medicare payment into a system based on outcomes, quality, and efficiencies

- In January 2015, HHS set a goal of tying 30 percent of fee-for-service Medicare payments to quality or value through alternative payment models, such as ACOs or bundled payments, by the end of 2016
- Goal of tying 30% of traditional or fee-for-service Medicare payments to “quality or value” through alternative payment models (ACOs or bundled payment models) by the end of 2016; 50% of payments to these models by the end of 2018.

**Medicare Access and CHIP Reauthorization Act (MACRA) Overview**

- Developed in bipartisan, bicameral process over 2+ years
- Several previous versions not supported by ASCRS and medical community
- Worked with committees of jurisdiction to develop compromise that included positive updates, flexible pay for performance metrics, non-budget neutral provisions
- Supported by over 750 national and state-based physician organizations
- Passed House of Representatives March 26, 2015- 392-37
- Passed Senate April 14, 2015 – 92-8
- Permanently eliminates the SGR, which has been producing Medicare physician payment cuts annually since 2002

**MACRA Overview (cont.)**

- Global Surgical Codes Protected
  - CMS Policy would have transitioned all 10- and 90-day global codes to 0-day
  - Analysis showed that ophthalmology would have been the hardest hit specialty
- Standard of Care Protection Act
- Indefinite Opt-Out for Private Contracting
- EHR’s required to be “interoperable” by 2017

**MACRA Improvements vs. Prior Law**

<table>
<thead>
<tr>
<th>Then</th>
<th>Now</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative Updates for the foreseeable future</td>
<td>Modest, but positive updates for 5 years, and then again in 2026 and beyond</td>
</tr>
<tr>
<td>Multiple overlapping, rigid, and sometimes contradictory reporting and penalty programs</td>
<td>Consolidated Merit Based Incentive Payment System (MIPS) with more flexibility, potential for significant bonuses, lower maximum penalties</td>
</tr>
<tr>
<td>Limited support for new payment and delivery models through Centers for Medicare and Medicaid Services Innovation</td>
<td>Enhanced technical and financial support for small practices, transitional payments for new models, funding for quality measures, more timely physician access to performance data</td>
</tr>
</tbody>
</table>

**Physicians Have Choices**

<table>
<thead>
<tr>
<th>FFS</th>
<th>APMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Physicians role in creating new models specified</td>
<td>• Physicians role in creating new models specified</td>
</tr>
<tr>
<td>• 5% update bonuses for 5 years aids transition to new 2-sided risk models</td>
<td>• 5% update bonuses for 5 years aids transition to new 2-sided risk models</td>
</tr>
<tr>
<td>• Demonstrated savings will produce higher payments</td>
<td>• Demonstrated savings will produce higher payments</td>
</tr>
<tr>
<td>• Participants exempt from MIPS</td>
<td>• Participants exempt from MIPS</td>
</tr>
</tbody>
</table>

**2019 Penalties Compared**

<table>
<thead>
<tr>
<th>MPS Factors</th>
<th>2019 scoring*</th>
</tr>
</thead>
<tbody>
<tr>
<td>PQRS</td>
<td>30% of score</td>
</tr>
<tr>
<td>MU</td>
<td>25% of score</td>
</tr>
<tr>
<td>VBM</td>
<td>less than 30% of score</td>
</tr>
<tr>
<td>Clincial practice improvement activities</td>
<td>15% of score</td>
</tr>
<tr>
<td>Total Penalty Risk Capped at 4%</td>
<td>As high as 4% with the potential to earn as much as 3 times that amount, in addition to a potential 10% for exceptional performers</td>
</tr>
</tbody>
</table>

*Scoring weights can be flexible, to accommodate specialties with insufficient measures, other factors

Courtesy of the American Medical Association
Fee-for-Service Penalties, Bonuses, & Updates
2014-2021 Compared

<table>
<thead>
<tr>
<th>Year</th>
<th>Current Law</th>
<th>H.R. 2 (PL 114-10)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Max Penalties</td>
<td>Max Bonuses</td>
</tr>
<tr>
<td>2014-2016</td>
<td>2%</td>
<td>1.5%</td>
</tr>
<tr>
<td>2016-2017</td>
<td>4% or more</td>
<td>VBM</td>
</tr>
<tr>
<td>2016-2018</td>
<td>10% or more</td>
<td>VBM</td>
</tr>
<tr>
<td>2016-2019</td>
<td>15% or more</td>
<td>VBM</td>
</tr>
<tr>
<td>2016-2020</td>
<td>20% or more</td>
<td>VBM</td>
</tr>
<tr>
<td>2016-2021</td>
<td>25% or more</td>
<td>VBM</td>
</tr>
<tr>
<td>2016-2022</td>
<td>30% or more</td>
<td>VBM</td>
</tr>
</tbody>
</table>

*with the potential to scale up to as much as 3 times that amount in addition to a 10% bonus for exceptional performances

Moving Forward: More Work Ahead

- MACRA is not the law we would have written ourselves
- MACRA is a complicated law, many details to be determined through rulemaking
- Requirements for MU and other programs still too onerous
- ASCRS will seek regulatory and legislative solutions
- Securing policy changes and additional updates will be simpler starting from a positive baseline, rather than making up for steep SGR cuts.

Other Provisions

- Work GPCI floor extended through 2017
- Children’s Health Insurance Program (CHIP) extended through 2017
- Funds for Community Health Centers and the National Health Service Corps and the Teaching Health Center GME Payment Program extended through 2017
- Therapy caps exceptions process extended through 2017
- Qualifying Individual (QI) program – provides Part B premium support for low-income Medicare beneficiaries extended permanently
- Transitional Medical Assistance (TMA) program – allows Medicaid recipients to maintain coverage for a year as they transition from welfare to work.

Other Provisions continued

- Medigap plan coverage limited to costs above the amount of the Part B deductible – for new enrollees beginning in 2020.
- Income-related premiums for Medicare Part B and D under current law readjusted
  - Incomes between $133,501 and $160,000 increase from 50% to 65%
  - Incomes at $160,001 and above increase from 65% to 80%

Transition of 10 and 90-Day Global Packages – included in 2015 Final Rule rescedined!

- CMS finalized policy to refine bundles by transitioning over several years all 10 and 90-day global codes to 0-day global codes.
- The post-operative visits would be eliminated from 10-day global codes in CY 2017 and from the current 90-day global codes in CY 2018.
- This proposal would have affected more than 4,200 codes, and CMS had not developed a methodology for making the transition to 0-day codes.

Transition of 10 and 90-Day Global Packages – included in 2015 Final Rule

- CMS indicated they would most likely create new postoperative visit codes, which would have been reimbursed at a lesser amount than the current E/M or eye codes and it is highly likely they would have limited the number of post-operative visits
- ASCRS worked with AMA and surgical coalition to stop implementation. (Report language included in Cromnibus bill and provision to stop implementation included in H.R. 2)
Medicare Patient Empowerment Act
H.R. 1650 – Congressman Tom Price (R-GA) – March 26, 2015

→ Allows docs and patients to privately contract on case-by-case basis
→ No Medicare opt-out
→ Hospital - other fees still paid
→ 26 co-sponsors

www.MyMedicare-MyChoice.org

Repeal the Independent Payment Advisory Board (IPAB)

• What is the IPAB?
  – 15 member, government board
  – Sole purpose: cut Medicare
  – Limited Congressional oversight
  – No judicial review
  – Hospitals exempt from cuts until 2020
  – Cuts on top of SGR and other Medicare cuts

• Sen. John Cornyn (R-TX)/Rep. Phil Roe, MD reintroduced legislation to repeal IPAB (S. 141/H.R. 1190)
• House version has 232 co-sponsors (more than half the House); Senate version has 40 co-sponsors.
• Could be considered as part of bi-partisan efforts to amend ACA.

Drug Compounding Law

• S. 959, the Pharmaceutical Compounding Quality and Accountability Act – passed Senate HELP Committee
• ASCRS, AAO, AMA successfully lobbied for changes to the bill.
• Compromise legislation- H.R. 3204, the Drug Quality and Security Act, (totally different bill) passed House under unanimous consent and was signed into law (P.L. 113-54).
• ASCRS and the ophthalmic community raised concerns with the bill contending it would limit access to certain drugs commonly used in ophthalmology because it did not include office-use and repacking in the definition of compounding. Oversight of these issues was left to the FDA.
  – The sponsors of the legislation made statements indicating it was not their intention to regulate compounded drugs for office use or limit repackaged drugs.

Drug Compounding Law

• FDA recently released draft guidance on repackaging of biologics that will allow traditional compounding pharmacies and outsourcing facilities to repackage Avastin for ophthalmic use.
• ASCRS and other ophthalmology stakeholder groups have concerns with the short Beyond Use Dates (BUDs) the draft guidance lays out.
  – There are concerns that the 5-day expiration date will severely limit the use of Avastin.
• ASCRS has testified before the FDA regarding the issues surrounding these short BUD timeframes, and asked they be extended in the final guidance document.
• Following advocacy from ASCRS, and other ophthalmology groups, Dear Colleague letters from the House and Senate were sent to the FDA recommending it abandon the one-size-fits-all approach to compounded and repackaged biological products and, where the evidence shows the products can be safely compounded or repackaged outside the proposed parameters, allow those products to be compounded or repackaged within parameters appropriate for that particular drug.

21st Century Cures Initiative

• Bipartisan effort by the House Energy and Commerce Committee to speed access to new drugs and devices.
• H.R. 6, the 21st Century Cures Act, passed Energy and Commerce Committee unanimously on May 21, 2015.
• Year-long study of current state of medical innovation. Testimony from FDA, NIH, Industry, patient advocacy groups.
• ASCRS worked with the committee and has provided input

21st Century Cures Act

• H.R. 6 Includes:
  – Increased funding for FDA and NIH
  – Streamlining and modernizing clinical trials and approval process
  – EHR interoperability
  – Enhanced valid scientific evidence
  – Medicare Pharmaceutical and Technology Ombudsman
  – Enhanced combination products review
  – Improvements to the FDA Advisory Committee Process
  – Off-label communications
• ASCRS Recommends:
  – Changes to off-label provisions
  – Rapid appeals process
PQRS, EHR, Value-Based Payment Modifier - Quality Programs

• Medicare's Quality Programs for MDs
  – Physician Quality Reporting System (PQRS)
  – Electronic Prescribing (eRx) – ended
  – Electronic Health Records (EHR)
  – Value-Based Payment Modifier (VBPM)

• Penalties for Non-Compliance only; No more incentive payments
• Penalties for these programs sunset in 2018, new Merit-Based Incentive Program (MIPS) payments begin in 2019

Quality Reporting Program Penalties

<table>
<thead>
<tr>
<th>Quality Reporting Program</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>eRx</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>PQRS</td>
<td>1.5%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Meaningful Use</td>
<td>1%</td>
<td>2%</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>VBPM</td>
<td>1%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Meaningful Use

- Applies only to practices of 100 or more
- Applies only to practices of 10 or more
- Depending on practice size

Penalties for these programs sunset in 2018, new Merit-Based Incentive Program (MIPS) payments begin in 2019

PQRS 2015

• PQRS:
  – Eligible professionals must report nine PQRS measures – and must cover at least three of the National Quality Strategy domains for 50% of the Medicare Part B fee-for-service patients they see during the reporting period to avoid a 2% PQRS Penalty.
  – There is no longer a PQRS incentive payment

PQRS 2015 Continued

• Of the measures reported, if an EP sees at least 1 Medicare patient in a face-to-face encounter, the EP must report on at least 1 broadly applicable measure contained in the cross-cutting measure set as 1 of their 9 measures.

PQRS 2015 Continued

• If less than 9 measures apply to the provider, they can report as many measures as apply (1-8) for 50% of the Medicare Part B fee-for-service patients seen during the applicable reporting period.
• If a provider reports less than 9 measures, they will be subject to the Measure Applicability Validation (MAV) process – which will evaluate whether there are additional measures that apply that they did not report.

PQRS 2015 Continued

For Ophthalmology

To successfully report for 2015 PQRS providers have a choice of reporting EITHER

1. The Cataract Measures Group via registry OR
2. 9 individual measures from the relevant ophthalmology and general care measures in 3 NQS domains.

If you are reporting the Cataract Measures Group, you must report 8 measures (increased from 4 measures in 2014) via registry for 20 patients, 50% (or 11) of which must be Medicare Part B patients.
For Ophthalmology

If providers have less than 9 PQRS measures that apply to them, they should report general measures, such as:

- **Measure 130**: Documentation of Current Medications in the Medicare Record or Preventative Care Screening: Tobacco Use: Screening and Cessation Intervention

**PQRS Qualified Clinical Data Registries**

- New clinical data registry option permitting physicians to report quality measures used by the clinical data registry instead of the PQRS measure list.
- Registry must capture at least nine measures covering at least three of the National Quality Strategy domains.
- A list of Qualified Registry Vendors that have been approved by CMS is available on CMS’ ‘Registry Reporting’ webpage

**Valued-Based Payment Modifier (VBPM)**

- The Value-Based Payment Modifier program provides incentives and levies penalties based on the quality of care and cost of care that groups of eligible professionals provide under the Medicare Physician Fee Schedule.
- Adjustment is based on participation in the Physician Quality Reporting System (PQRS).
- The VBPM will apply to all physicians in CY 2017 based on 2015 PQRS reporting.
- Group practices or solo practitioners who do not successfully report for PQRS in 2015 will receive an additional VBPM (penalty) of 2-4% depending on group size.

**VBPM continued**

- Successful PQRS participants (including group practices where more than 50% of the group successfully participated in PQRS) will be subject to a second “quality tiering” step where groups are compared nationally on quality and cost measures and have the potential to earn a bonus or penalty.
- In 2015, groups of 10 or more are no longer able to opt out of quality tiering.

**VBM 2015 Changes**

- **10 or More Eligible Professionals**
  - 4% penalty for all groups of 10 or more eligible professionals that do not successfully report for PQRS in 2017
  - Quality Tiering
    - Maximum upward or downward adjustment +/- 4 times adjustment factor in 2017
    - -2 times adjustment factor for low quality/average cost or average quality/high cost
    - +2 times adjustment factor for average quality/low cost or high quality/average cost
    - Adjustment factor determined at the end of CY2015 based on the aggregate amount of downward payment adjustments

- **Groups of 2-9 EPs and Solo Practitioners**
  - 2% penalty for all groups of 2-9 or solo practitioners that do not successfully report for PQRS in 2017
  - Quality Tiering
    - The maximum upward adjustment for groups of 2 or more EPs or solo practitioners is +2 times the adjustment factor.
    - They will not be subject to negative adjustments under quality tiering in 2017.
VBM 2015 Changes

• CMS will apply the VBM to groups of 2 or more non-physician eligible professionals in 2017 and to non-physician solo practitioners in 2018.

Physician Feedback Reports

• All eligible professionals have access to a confidential feedback report based on 2013 data for Medicare patients – Quality and Resource Use Reports (QRURs)
• Reports compare quality and resource use and provide a “preview” of how affected groups might fare under the VBM.

Physician Compare

• Group level measures will be expanded to make all 2015 PQRS GPRO web interface, registry and EHR measures for practices of 2 or more EPs and ACOs available for public reporting in 2016.
• All 2015 PQRS individual measures collected via registry, EHR, or claims will be made available for public reporting in late 2016, if technically feasible.

Meaningful Use

• Eligible Professionals must attest to Meaningful Use for a full calendar year in 2015 - regardless of their Stage of Meaningful Use.

Stage 1 Meaningful Use

• 2014 was the final year to begin EHR Meaningful Use and qualify for incentive payments.
• CMS changed the reporting requirements for Meaningful Use Stage 1. Beginning in 2014, all eligible professionals, regardless of their stage of meaningful use, had to report on CQMs in the same way.
• Ophthalmologists must report for 2015:
  – All 13 of the Core Set Objectives and Measures
  – 5 out of 9 of the Menu Set Objectives and Measures (including 1 public health measure)
  – 9 Clinical Quality Measures (CQM) that are relevant to your practice from a list of 64.
    ▪ Selected CQMs must cover at least 3 of the National Quality Strategy domains.

Stage 2 Meaningful Use

• Same number of EHR objectives
  – 17 core objectives
  – 3 of 6 menu objectives
  – Retains the scope of practice exclusion: all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice. Can report on blood pressure and exclude height and weight.
Stage 2 Meaningful Use

There are two Meaningful Use measures that require patients to take action.

- **Patient Electronic Access**: Provide patients with an electronic copy of their health information (including diagnostic test results, problem lists, medication lists, allergies).
  - This measure requires that 50% of patients have access to their information and that 5% of patients have used the capability to access and download their information.
  - Suggestions are to have patients log in while in the office. Some EHR’s require email address collection for this measure but that is a requirement of a specific EHR vendor, not CMS.
- **Secure Electronic Messaging**: Use secure electronic messaging to communicate with patients on relevant health information.
  - Patients are offered secure messaging online and at least 5% (of unique patients or their authorized representatives) have sent secure messages online.
  - A secure message is any electronic communication between a provider and patient that ensures only those parties can access the communication. Please note, this does not have to be an email, nor does it have to be through your patient portal.
  - Secure messaging can be used to promote care coordination between visits, handle routine health issues, address patient questions and concerns, monitor patient condition(s), and help patients better manage their conditions. Secure messaging can be used for handling routine nonclinical tasks, such as medication refills and referrals.

Meaningful Use Proposed Flexibility Rule

- CMS released proposed flexibility rule that contains major changes to both Stage 1 and Stage 2 Meaningful Use.
- For 2015 only, CMS proposes to allow all EPs, regardless of their prior participation in Meaningful Use, to attest to an EHR reporting period of any calendar year quarter.
- For 2015 and 2016, new participants in EHR reporting program can attest for any continuous 90-day reporting period.
  - Returning participants in 2016 and 2017 would attest for a full year.

Meaningful Use Proposed Flexibility Rule

- CMS is proposing to eliminate the distinction between menu and core measures and require all eligible professionals to report on 9 objectives and one consolidated public health reporting objective for both Stage 1 and Stage 2 of Meaningful Use.

Meaningful Use- Scribe Certification

- ASCRS and ASOA always took the position certified scribes could enter CPOE information based on FAQ, issued by CMS after Meaningful Use Stage 2 2012 Final Rule.
- Conflicting information was circulated that scribes were in fact not able to enter CPOE data for EHR Meaningful Use, however, ASCRS continued conversations with CMS.
- CMS requested a crosswalk between the duties, functions and educational areas of a medical assistant versus an ophthalmic scribe.
- As a result of this crosswalk, CMS stated that ophthalmic certified scribes will qualify to enter CPOE data under FAQ 9085.

Stage 3 Meaningful Use

- Stage 3 Meaningful Use Proposed Rule released on March 25, 2015
  - Proposes following an optional Stage 3 year in 2017, all providers move to Stage 3 regardless of their prior Meaningful Use participation in 2018.
  - Lays out eight program objectives, with 16 associated measures, eligible professionals must meet to successfully attest to Stage 3 Meaningful Use such as:
    - Protect electronic protected health information (ePHI) - Generate and transmit permissible prescriptions electronically
    - Implement clinical decision support (CDS) interventions
    - Use CPOE for medication, laboratory, and diagnostic imaging orders
    - Provide access for patients to view online, download, and transmit health information, or retrieve health information
    - Provide summary of care record when transitioning or referring patient to another setting of care
  - Maintains the reporting of CQMs in Stage 3
  - ASCRS submitted comments regarding our concerns with the Stage 3 proposed rule including increased measure thresholds and a full-year reporting requirement
**Merit-Based Incentive Payment System (MIPS)**

- MIPS streamlines existing PQRS, VPBM and EHR Meaningful Use programs
  - Existing penalties sunset at the end of 2018
- MIPS will assess the performance of EPs based on 4 categories:
  - Quality: Current quality performance measures and new measures through rulemaking
  - EPs select which measures to report
  - Resource Use: Current VBPM program measures
  - Meaningful Use: Current MU requirements
  - Clinical Practice Improvement Activities

- EPs will receive a composite performance score (0-100) based on their performance in the 4 categories.
- Composite score will be compared to a performance threshold.
  - Mean or median of all composite performance scores for all MIPS EPs during prior period

- Positive, negative or neutral adjustment based on composite score.
- Negative adjustment: capped at 4% in 2019, 5% in 2020, 7% in 2021 and 9% in 2022.
  - EPs between 0 and ¼ of threshold get maximum negative penalty
  - EPs closer to threshold score get small negative payment adjustments

- If EP’s composite score is at the threshold - will not receive a MIPS payment adjustment
- Positive adjustment: higher performance scores receive proportionally larger incentive payments up to 3 times the annual cap for negative payment adjustments.
  - Additional incentive payment for exceptional performance (above 25th percentile)

**Encouraging Advanced Payment Model (APM) participation**

- EPs who receive significant share of revenues (25% in 2019) through an APM that involves risk of financial loss and quality measure component receive 5% bonus each year from 2019-2024.
- Excluded from MIPS and most EHR Meaningful Use requirements

*Further details will be determined through rulemaking*

**Sunshine Act**

- Requires manufacturers of drugs, devices, biologicals or medical supplies covered by Medicare, Medicaid or the Children’s Health Insurance Program to report to CMS any payments or transfers of value of more than $10 to physicians
- Open Payments data went live on September 30, 2014.
- Physicians can still register for Open Payments to review data before future data releases.
- Manufacturers and GPOs had a March 31, 2015 deadline for 2014 data submission. The data review period for physicians to review 2014 payments attributed to them began on April 6 and will last for 45 days before the data becomes public.
2015 ASC payment & quality reporting

- Conversion Factor $44.071
- Update still based on CPI-U with budget neutrality and productivity adjustment = 1.4%
- Previously, ASC-11: Cataracts: Improvement in Patient’s Visual Function within 90 Days Following Cataract Surgery was required for all ASCs
- 2015 ASC Final Rule: CMS changes ASC-11 from mandatory to voluntary for 2015

Accountable Care Organizations

- Previous Exclusivity Policy - Precluded any practice that performs E&M from full-fledged participation in more than one ACO – regardless of specialty.
- ASCRS, worked with the AMA, led an effort to address the exclusivity issue.
- Proposed regulation released on Dec 1 – revises exclusivity issue – CMS is proposing to exclude services provided by certain specialties from being limited to full participation in one ACO, including ophthalmology.

Going Forward

- Provide input into rulemaking for MIPS program and advocate for changes to the newly enacted law as needed.
- 21st Century Cures Initiative
- Advocate for private contracting and repeal of IPAB.
- Monitor Medicare Advantage Plans
- Immediate Use Steam Sterilization
- Continue to work with relevant stakeholders to ensure continued access to compounded drugs.
- Work to finalize ACO changes

What Can You Do?

- Join physicians/administrators to advocate for our priorities.
  - Visits, phone calls and emails made a difference in the development of the SGR repeal and replacement.
  - Your legislators need to hear from you
    - Legislators care what people living and working in their districts think.
    - Illustrate the impact on patient care.
    - Respond to Grassroots Alerts.
    - Meet with your Representative and Senators
      - Back home or in Washington D.C.
    - ascrgeneral.org

Thank you!

Questions?

nmccann@ascrs.org
amcgloine@ascrs.org
Elizabeth Holloway, COE, CPSS, SHRM-CP
10:45–11:45 AM
Elizabeth Holloway, COE, CPSS, SHRM-CP

Elizabeth Holloway is a senior consultant for BSM Consulting and is based in Trinity, Fla. Ms. Holloway provides support to BSM and corporate clients in all aspects of clinical operations, staff training and development, and human resources.

Prior to joining BSM, Ms. Holloway served as the chief operations officer (COO) for a large multispecialty ophthalmic practice in Florida. Her responsibilities included clinic flow and efficiency, compliance, financial benchmarking and budgeting, and staff/leadership development. Additionally, Ms. Holloway supervised the practice’s human resources activity, contract negotiations for managed care and accountable care organizations (ACOs), implementation and attestation of electronic health records, and integration of ophthalmology and optometry.

Ms. Holloway is the author of numerous BSM Connection® distance learning courses and is a regular columnist for Ophthalmic Professional. She has appeared as a guest speaker at the American Society of Ophthalmic Administrator (ASOA) National Congress and the Hawaiian Eye Conference and served on ASOA’s Education Committee.

During her tenure as a COO, Ms. Holloway helped pilot the Certified Patient Service Specialist (CPSS) program, the nation’s only certification curriculum for nonclinical medical staff. Her involvement ultimately helped earn her practice the BSM Center of Excellence Award. Additionally, Ms. Holloway is a Gallup Institute Certified Strengths Coach and implemented the StrengthsFinder program into the practice in 2008.

Ms. Holloway is a Certified Ophthalmic Executive (COE), a Certified Patient Service Specialist (CPSS), and is certified as in Human Resources. She is a member of the Society of Human Resources Management. Her education includes a Bachelor of Arts degree from Florida Southern College (Lakeland, Fla.) and a Master of Arts degree from Rice University (Houston, Texas).
Identifying and Developing Trainers

Elizabeth Holloway
Senior Consultant, BSM Consulting
Masters in Ophthalmology

Course Objectives

Administrators and managers will be able to identify:
- Successful training programs and trainers.
- Successful training environments.
- Adult learning styles.
- A teaching process to facilitate learning.
- Tips and resources to provide trainers.

Successful Training Programs

Successful training programs:
- View training as part of the practice’s overall success.
- Develop unique training plans to meet individual needs.
- Develop training pathways for career development.

Successful Training Programs

- Provide training resources for trainers.
- Quantify learning objectives for team.
- Outline the timeframe available for training.
- Help eliminate interruptions during early training!

Who Are Your Successful Trainers?

Successful trainers are:
- Top-performers
- Possess knowledge and skill
- Supervisors

Qualities of Successful Trainers

Successful trainers have the ability to:
- Present information in clear, concise terms.
- Present information in a chronological sequence.
- Present information for adult learners in a variety of learning styles and mediums.
- Monitor comprehension and recognize success.
Identifying and Developing Trainers

Set the Stage: Available Resources
Identify resources the practice provides for training:
- Training guides
- Updated handouts
- Policies and Procedures Manual
- Updated protocols

Set the Stage: Learning Objectives
Quantify the learning objectives for each training session.
- Discuss objectives with the trainer.
- Set realistic expectations and time goals.

Set the Stage: Training Timeframes
Work team needs
- Adequate training time
- Ability to readjust
- Realistic expectations

Set the Stage: No Interruptions!
- Eliminate interruptions during early training.
- Work with trainers and staff to help prevent interruptions.

Provide Training Encouragement
Develop and implement a meaningful incentive program to recognize and reward trainers and trainees for educational success.

Adult Learning – The Do’s
- Start with basic skill sets.
- Focus on one area at a time.
- Present information sequentially.
- Provide appropriate time.
- Encourage questions.
Identifying and Developing Trainers

**Adult Learning – The Don’ts**
- Don’t overwhelm.
- Don’t discourage.
- Don’t train in front of patients.

**Adult Learning Styles (V.A.K.)**
- **Visual**
- **Auditory**
- **Kinesthetic**

**The Visual Learner**
- Prefers the use of seen or observed things.
- Prefers reading directions.
- Learns best when information is presented in:
  - Diagrams
  - Displays
  - Flip charts
  - Video
  - Handouts

**The Auditory Learner**
- Prefers listening to absorb information.
- Learns best when information is presented in:
  - Lectures
  - Sounds
  - Noises
  - Explanations
  - Discussions

**The Kinesthetic Learner**
- Prefers to learn through physical movements.
- Learns best when information is presented in a way that allows:
  - Touching
  - Holding
  - Doing
  - Having “hands-on” experiences
  - Following instincts
  - Experiencing trial and error

**V.A.K. Training**
- Use Visual, Auditory, and Kinesthetic to produce faster training and better retention.
V.A.K. Training (continued)

- Use Learning Style Questionnaire
- Identify preferred learning style
- Adapt training plan to match learning style

Trainer Development – The Process

- Explain (Auditory)
- Observe (Visual)
- Perform (Kinesthetic)
- Repeat
- Teach

Staff Training Plans

- Administrators-Managers
- Business Office Personnel
- Front Office Personnel
- New Employee Orientation
- Opticians
- Technicians

Continuation of Training

- Continue training, even after “done”
- Identify mentor/go-to-person
- Establish guidelines

Training Tips

- Be protective of the trainee.
- “Too many cooks in the kitchen can spoil the broth.”

Training Tips (continued)

- Limit training time.
- Set debrief schedule.
- Conduct reviews.
Schedule Senior Management Updates

Develop progress reports to management:

- Establish daily/weekly reporting
- Keep team informed of trainee’s progress.

Big Responsibility

When it isn’t working …

- Why is the trainee failing?
- Is the trainee a wrong fit for position or practice?

Conclusion

- Effective training does not happen by accident.
- Having a well-executed training plan can mean the success or failure of a new staff member.
- Training focused on learning styles will lead to better retention.
- A competent, well-trained staff leads to better patient care!

Thank you for attending!

Elizabeth Holloway
Senior Consultant

eholloway@bsmconsulting.com

Any questions?
Shawn Davis, BS, CRMC
11:45 AM–12:15 PM
Shawn Davis, BS, CRMC

Shawn Davis, BS, CRMC, is a graduate of the University of South Carolina where he majored in Broadcasting and Marketing. His career in healthcare sales and marketing has included working for companies such as Johnson & Johnson, Allergan, and Clear Channel Radio.
Obtaining A Clearer Vision For Marketing Your Practice in 2015

By
Shawn Davis, BA, CRMC
President

About Us..
Over 35 years of Healthcare Sales and Marketing Experience

Our Services
Physician Liaison
Strategic Planning
Research Analysis
Coordinate Marketing Efforts
Customer Service and Physician Liaison Training

Myths About Marketing:
Marketing is Not Simply...

- Advertising.
- Having a great website.
- Having a Facebook, Twitter or LinkedIn account.
- Word of mouth.

Top 5 Mistakes Made In Marketing

- 1. Lack of research and testing
- 2. Improper focus and positioning
- 3. Marketing without a unique selling proposition
- 4. Failing to capture repeat customers/referring physicians
- 5. Lack of focus on current and potential customer’s needs

Source: About Money, www.marketing.about.com

Are You Strategically Marketing Your Practice?

- Have you created a strategic marketing plan for your practice?
- “Build it and they will come” is just a line from a Hollywood Movie.
- A referral is NEVER assumed.
- Are the operations of your practice willing or able to change?
- Do you know what your patients/referring physicians are saying about your practice?

Two Reasons Why You Should Market Your Practice:

1. Patients have choices in today’s healthcare.
2. If you’re not marketing, then your competition is!
Balancing the Marketing Checklist

- Other specialists in your market are promoting their practice (Cardiology, Orthopedic, Osteo, ENT, Pain Mgmt, Imaging)
- Can you easily track your referrals on a monthly basis? Who are your top referrals?
- Who are your patients? (demographics)
- What is the long term marketing plan for your practice?
- Are you planning a fall reaim to discuss your 2016 goals?
- Is your website current with easy access for patients?
- Are you over spending in advertising? Do you have a marketing budget?
- Have you considered direct mail for seasonal awareness campaigns?
- Are you interacting with the community through speaking events, etc?
- Is your practice running smoothly on the operational side to make changes if needed?
- How is your patient relation? Do you provide customer service training for your staff?
- Do you have the time as an administrator to effectively market your practice?
- Do you have a physician liaison? If not, why? If yes, do they present themselves as just another vendor with goodie baskets or are they marketing your practice strategically?

Rationale On Why Practices Do Not Have A Physician Liaison

- We’ve been in practice since 1985 and everyone knows who we are.
- We cover all the bases from cataracts to plastics to retina. It’s a small community and we’ll attain the business by word of mouth.
- We have all the latest technology... All the OD’s know who we are and what amazing technology we have so they will refer to us.
- The competition is weak. We’ve heard complaints from their former patients so we’re going to attain business by default.
- We are very busy and have all the business that we can handle right now.
- The doctors make sales calls during their spare time.
- The doctors are old school and do not believe in marketing.
- We do not have any time. We are busy with staff training and EMR.
- Doctors will refer to an Ophthalmologist versus an OD, we have no threat.
- As the administrator, I’ll get out there and make sales calls when I have spare time.

Let’s Take a Look at the PCP Opportunity

Revenue Potential Case Study with PCPs. This patient segment must have an annual eye exam.

Diabetic patient (Diabetic eye exam, fundus photos & refraction). The lowest payment would be $125 (gross revenue per patient, estimate).

PCPs see an average of 20 patients a day, which is around 4800 patients a year per PCP. The percentage of patients who PCPs see in their practice that are diabetic are between 18% – 28%.

One PCP’s annual referral worth is between $108,000 – $168,000.

$108,000

18% of 4800 = 864 patients x 125 = $108,000

$168,000

28% of 4800 = 1344 patients x 125 = $168,000

Being focused on 100 PCPs just for their diabetic patient referrals alone is worth an annual Gross Revenue Potential between $10,800,000 and $16,800,000.

1344 patients x 100 PCPs x $125 = $16,800,000

864 patients x 100 PCPs x $125 = $10,800,000

Note: NP’s and PA’s see just as many patients or more as the M.D.

How much share of the market is your practice capturing?

Getting the Job Done.

- Physician to Physician Marketing: By directly calling an PCPs in your market, promoting the services, features and benefits of your practice.
- Strategic Planning: Apply the 80:20 rule. 80% of your business comes from the top 20% of your customers. Your goals are to try to increase your current business and uncover any new business opportunities. A strategic plan in your campaign is success in Physician to Physician Marketing efforts.
- Research Analysis: Analyze your current business practices and competition. Every competitor has a weakness. Learn what makes you strong. You must have an in-depth understanding of your competition to be the market leader.
- Qualitative ( EMR / FAX / Desktop ) Who do you have to be your eyes and ears on the streets? How are you receiving any feedback from referring physicians?
- Develop and Maintain Marketing Budget. Are you reviewing your marketing plan to ensure your efforts are meeting the best ROI. Advertising is fixed and track and quantify. Unless you’re a Hospital I would limit Radio, TV, Newspaper etc.
- Coordination Marketing Efforts: This includes production of any marketing collateral. If you’re going to spend time and resources to help increase the market share of your practice, the business events are coordinate and marketing collateral you should make sense and be an effective tool that will help increase your business.
- Referring Physicians are bombarded each day my multiple messages and their time is valuable.
- Marketing collateral you use should make sense and be an effective tool that will help increase your business.
- By directly calling on PCPs in your market, promoting the services, features and benefits of your practice.
- You must have an in-depth understanding of your competition to be the market leader.
- Who do you have to be your eyes and ears on the streets? How are you receiving any feedback from referring physicians?
- Advertising is fixed and track and quantify. Unless you’re a Hospital I would limit Radio, TV, Newspaper etc.
- If you’re going to spend time and resources to help increase the market share of your practice, the business events are coordinate and marketing collateral you should make sense and be an effective tool that will help increase your business.
- All the OD’s know who we are and what amazing technology we have so they will refer to us.
- They are a partner with your referral source network to enhance the experience between their patients (referring MD/OD) and your practice.
- I recommend your Physician Liaison has additional training.
- No matter how long you’ve been in sales, there’s always something you can learn. (Integrity Selling—AIDINC)
What You’ll Need To Get Started
Come Monday Morning...

1. Take a look at the past 2 years of referral history data. Maintain, grow and regain business.
2. Choose the top 20% referrals, focus on 125-150 targets max.
3. Create Marketing Collateral that is clear and concise.
4. Make it easy for your referral sources to refer. How’s the access to your office?
5. Schedule CS training with your phone/call center and front desk staff.
6. Schedule field time with your doctors to meet and THANK their current referral sources. This is a critical component. This will make or break your growth.
7. Treat everyone in the referring office like Gold. Develop strong relationships with everyone from front desk, office manager and MD/OD.
8. Create a 90 day strategic plan and adjust as needed for Q2, Q3 and Q4.
9. Be willing to change any areas of internal development ASAP. Perception is reality.
10. If you currently have a Physician Liaison, do you have MBO’s in place and have they been observed in the field? Schedule additional training.
11. Always do the right thing. There are no secrets in Healthcare. If the competition is cutting corners, that’s on them. Compliance, compliance, compliance.
12. Network with other Physician Liaisons from other practices. (Ortho, Cardio etc.)

Questions?

Shawn Davis
Phone: (205) 790-4663
Email: shawn@impactmd.com
www.IMPACTMDLLC.COM
Anne M. Menke, RN, PhD
1:00–1:45 PM
Anne M. Menke, RN, PhD

Anne M. Menke, RN, PhD, received her diploma in registered nursing from Christ Hospital School of Nursing, her B.A. from San Francisco State University, and her MA and PhD from Harvard University. Dr. Menke draws upon nine years of clinical nursing, fifteen years in academics, and eighteen years in healthcare risk management. She provides confidential risk management consultations to ophthalmologists; conducts research and writes articles on ophthalmic clinical and risk management topics; directs the content of the OMIC Digest and writes the Hotline column and lead articles; and presents risk management seminars at national, state, and subspecialty ophthalmic conferences, as well as American Society of Ophthalmic Registered Nurses (ASORN), American Academy of Ophthalmic Executives (AAOE), and the Joint Commission on Allied Health Personnel Ophthalmology (JCAHPO) meetings.
Identify and Manage Unhappy Patients
Anne M. Menke, RN, PhD
Ophthalmic Office Administrators
June 27, 2015

Disclosures
• Anne Menke, RN, PhD, has no financial disclosures.

Why This Topic?
• Volume of calls to our Hotline but growing sense that physicians and staff:
  – Aren’t identifying unhappy patients soon enough
  – Aren’t managing obviously unhappy patients as well as possible
  – Are continuing efforts when unlikely to be helpful

Case #1
• Patient referred with a macula-on retinal detachment (RD)
• Told could have surgery right away in office or wait to be scheduled for surgery
• Pneumatic retinopexy in office, then needed two vitrectomies for recurring RDs
• Final outcome light perception (LP)

Why This Topic?
• Patient very discouraged about poor outcome despite 3 surgeries
• Reviewed circumstances of her care and became very angry
• Sued the physician and the group practice
• Sent letter listing grievances as part of litigation process
Case #1

- Physician told her he "was just working her in" on first day
- "Tone and expression gave impression taking too long to decide"
- Pain so severe she cracked two teeth
- Staff in festive attire, joking, laughing

Case #1

- Admitted to ASC for 2\textsuperscript{nd} surgery
- Schedule changed, waited for hours
- Nurse asked if she had had the surgery before, and patient said yes
- Nurse said couldn’t have had this surgery in the office, only in OR

Case #1

- Patient alleges she overheard physician saying that had had surgery in office and that “these people don’t realize how much it costs to do surgery in the hospital”
  – “I was not a charity case!”

Case #1

- Needed 3\textsuperscript{rd} surgery so once again asked for authorization
- Letter lost under other paperwork on surgeon’s desk, so surgery delayed for months

Case #1

- "If the first surgery had been done under proper procedures in the hospital, I would have had favorable results."

Case #1

- Patient could not find expert to criticize care
- Judge granted motion for summary judgment
- Case closed without payment
Risk Management

• What was missing in this physician/patient encounter?
• What did this patient really want?
• How did the physician and practice respond?
• What might have worked better?

Risk Management

• PATIENT
• Physicians want patients to know they are qualified, but patients assume physicians are qualified
• Patients want to know their doctor cares about them
• This patient believed that neither MD nor staff cared (party, comments, delays)

Risk Management

• PHYSICIAN
  – Did not anticipate any unhappiness and was surprised by lawsuit
  – Felt care appropriate
  – Defended his communication style and content

Risk Management

• Crucial Conversations
  • People who do not feel safe enough to communicate use ancient parts of the brain and respond with “fight or flight” or “violence” or “silence”
  • This patient retreated into silence for quite some time, then “violence”

Risk Management

• Crucial Conversations
  • When we feel unsafe, we tell ourselves stories
    – Victim (“horrible things are happening to me”)
    – Villain (“you are doing horrible things to me”)
    – Helplessness (“there is nothing I can do to change this”)
  • Watch for the patient’s story and your own story in response
Risk Management

• Examples of events that lead to “silence”
  – Complications
  – Need for additional care (surgery, medication, referral to another doctor)
  – Delays and waits
• Behaviors
  – No show
  – Refusal of care

Risk Management

• What story did the patient tell herself?
  – Victim and helpless during care, then villain
• What was missing in this physician/patient encounter?
  – Knowledge of unhappiness
  – Empathy once unhappiness known

Risk Management

• Invite Input: Problems Noticed
  – I see that you experienced a complication. How has this affected your recovery from the surgery?
  – You missed your appointment today. Are there any concerns you would like us to know about?
  – I see that you need to see another doctor. Do you have any questions about why?

Risk Management

• Invite Input Each Encounter
  – Do you have any questions?
  – Is there anything you need from us?

Case #2

• Patient presented for LASIK
• Preoperative evaluation done by optometrist (OD)
• Surgeon met patient on the day of surgery

Case #2

• Immediately had a buttonhole complication, so procedure was stopped
• Ophthalmologist explained complication to patient and his wife, asked him to return next day
• Patient angry, stated he would not return to eye MD, only to OD
Case #2

- Developed corneal abrasion
- Later developed 2nd complication, Sands of Sahara, again refused to see eye MD
- Eye eventually healed without loss of vision or scar

Case #2

- Obtained medical records
- Found Operative Note (dictated before procedure) that stated good outcome with no complications
- Attorney agreed to take on case

Risk Management

- MD Deposition: explained did not get a chance to replace pre-dictated note or include handwritten operative note
- Physician refused settlement (known complications)
- Plaintiff eventually dismissed case

Risk Management

- WHAT IS GOING ON WITH THIS PATIENT?
  - Patients who meet their surgeon on the day of surgery may have difficulty trusting the physician
  - Patients who experience more than one complication often lose faith in their physician
  - Patients whose expectations are not met may equate maloccurrence with malpractice
  - Patients who pay cash feel “invested” in outcome

Risk Management

- PHYSICIAN
  - Physician explained complication and prognosis and asked patient to come see him next day
  - When patient refused, he stressed the importance of follow up to monitor the healing of the cornea
Risk Management

- What story did the patient tell?
  - Villain
- What was missing in this physician/patient encounter?
  - Acknowledgement of patient’s feelings about stopped procedure
  - Discussion of financial impact

Risk Management

- Patients with “Violent” or “Fight” Response
  - High, unmet expectations
  - Cash investment
- Behaviors
  - Crowd front desk
  - Demand special attention
  - Expect quick response
  - Loud voice, use of profanity

Risk Management

- Recode “silence” and “violence” as signs the patient is feeling unsafe
  - 1. Step away from the content
  - 2. Build safety
  - 3. BE CURIOUS: “Why would a reasonable, rational, and decent person do what this person is doing?”

Risk Management

- Make it right financially if can’t “deliver”
  - “I will refund your fees since you did not have the LASIK surgery you paid for.”
  - “I could not place a premium IOL, so I will refund the extra money you paid for it.”

Risk Management

- Notice the unhappiness
  - “You must be really unhappy with me if you don’t want to come back again.” Give the patient time to talk.
- Ask for input
  - “Do you have any questions for me? Is there something I can do to help?”
- Clarify available if patient changes his mind, and what care is needed.
Case 3

- A new patient on Medicare and secondary insurance presented for an exam with a chief complaint of blurry vision
- The ophthalmologist performed a comprehensive exam, including refraction

Case 3

- Practice collected at the time of service what they expected CMS would allow $(104.97)$ and $45$ for the refraction
- Patient paid by credit card
- Cancelled payment when got EOB from CMS

Case 3

- Allegations of overcharging Medicare (charged $245 but quoted me $149), which would net the fraudulent doctors some $23,000 per year if saw 1000 patients
- “Forced prepayment” at time of visit so could collect both from patient and from insurance company

Case 3

- Sent letter to credit card company, state director of aging and adult services, state attorney general, head of federal HHS, and President Obama
- Threatened to contact state medical board

Case 3

- Practice learned secondary insurance would cover visit (patient only needed to pay refraction)
- Practice wrote to insurance company, asking them to help explain to the patient about the change in the allowable amount

Case 3

- MD later got involved and apologized for confusion
  - Explained to patient that once learned insurance covered, would have issued refund, and explained billing process
- Physician never heard from patient again
Risk Management

• BE CURIOUS: “Why would a reasonable, rational, and decent person do what this person is doing?”
  • What did this patient really want?
  • How did the physician and practice respond?
  • What might have worked better?

Risk Management

• PATIENT
  • Wanted to understand fees and not pay for what his insurance company would cover
  • Felt they should:
    – Not “force payment” at the time of service
    – Post a notice in the lobby if they were going to “force payment”
  • Quickly moved to anger and suspicion

Risk Management

• PRACTICE
  • Focused on the content (billing confusion)
  • Wanted to help patient understand

Risk Management

• What story did the patient tell?
  – (Super)villain: you’re doing horrible things to me and you meant to gain from them
• What was missing in this physician/patient encounter?
  – Acknowledgement of anger and sense of injustice

Risk Management

• “You seem very angry and I can understand why: you think we aren’t being honest with you and the insurance company about the fees.”
  – Keeps a professional tone
  – Shows patient it is okay to question bill, even if done quite forcefully

Risk Management

• If patient seems able to hear your empathy, move back to content
  – “I’d like to answer your questions about the bill and explain our billing process. Would that be okay?”
• If patient again seems upset, acknowledge that
  – “You are still upset with us. What can I do to help?”
Handling Ongoing Anger

- Notice the patient’s anger and stop trying to “do your job”
  - This patient will not be able to hear anything you say until the feelings are handled
  - Say to yourself:
    • This patient is upset. My job is to listen.

Handling Ongoing Anger

- STAY CALM
- Anger is hard to handle so watch for your own reaction
- Stay calm
- Take deep breaths
- Relax your muscles
- Give the patient the gift of your attention

Handling Ongoing Anger

- DON’T TAKE IT PERSONALLY
- Chances are, you have never met this person or spoken to him/her before
- You had nothing to do with what has upset the patient
- Tell yourself: “This person does not feel safe. I need to create safety.”

Handling Ongoing Anger

- LET THE PATIENT VENT
- Allow the patient to tell his or her story without interrupting
- This uninterrupted time may give the patient the time/space to calm down
- Acknowledge what you are hearing: “I see..”, “Go on…”

Handling Ongoing Anger

- BE PATIENT
- The longer the patient talks and vents, the more time the patient has to calm down.
- It may take the patient a while to get his/her story out and be able to have a conversation

Handling Ongoing Anger

- GET HELP
- Let your manager, the physician, or other leader know what is going on
- Recognize when your efforts aren’t working or you don’t have the solution to the patients’ problem
Handling Ongoing Anger

• CONSIDER ENDING THE CONTACT
• “You seem very upset. Would you prefer to continue this conversation via email?”
• “I’m sorry you’re so upset. Would you like us to call you back when you are calmer?”
• “I apologize, but if you continue to use that language, I will have to end the call.”

Case 4

• Longstanding patient
• Regularly calls to report “urgent” problems and wants to be seen immediately
• Shows up hours early for his appointment
• While waiting, loudly and repeatedly tells other patients that he has an emergency but the doctor won’t see him

Case 4

• Has vague complaints of “my eyes don’t feel right”
• Denies pain, infection, trauma
• No measurable visual change

Case 4

• Staff offers refreshment while waiting
• Staff try to calm him down
• “The drama in the waiting room happens every time”

Risk Management

• BE CURIOUS: “Why would a reasonable, rational, and decent person do what this person is doing?”
• What did this patient really want?
• How did the physician and practice respond?
• What might have worked better?

Risk Management

• PATIENT
• What does this patient want???
• Does not appear to have eye condition
• Seems to be more than miscommunication
• Behavior suggests possible anxiety disorder (in other patients, may be cognitive impairment, substance abuse, etc.)
Risk Management

- PRACTICE
  - Good effort to handle patient’s anxiety each time
  - Responsive to patient concerns
  - But staff members feels helpless

- What story? Helpless, victim
- What is missing in this physician/patient encounter?
  - Action to address issues and set limits

- ADDRESS ANXIETY
  - “You seem to become anxious while you wait for your appointment. What can we do to help?”
  - Solution might be first appointment in the morning or after lunch
  - That won’t solve the repeat calls.

- ADDRESS REPEAT BEHAVIOR
  - “I know it feels like something is wrong with your eye but just like the last three visits, I was not able to find anything to explain what is happening. And when you tell other patients we won’t see you, it is upsetting to them and to us.”

- DISCUSS EXPECTED BEHAVIOR
  - “We will try to schedule you first in the morning but when that is not possible, we expect you to wait quietly until you are called for your appointment.”

- ADVISE OF CONSEQUENCES
  - If doesn’t meet expectations, advise of possible consequences: “You told other patients today three times that we won’t see you. If this happens again, we may need to discharge you from the practice.”
**Risk Management**

- **CONSIDER REFERRAL**
  - If problem seems to be possible psychiatric condition or cognitive impairment, consider referring patient to PCP or other physician for evaluation
  - These are all medical conditions so treat patient with compassion and respect

- **KNOW WHEN TO STOP**
  - Recognize when patient needs more than you can provide or won’t be satisfied and needs to be discharged from practice
  - Repeat problem behaviors despite sincere effort to hear concerns and address them
  - Escalating behavior
  - Disruptive to practice and other patients

- **AVOID ABANDONMENT**
  - Give written notice of discharge with 30-day period to find another physician
  - Exception: violent patients
  - Protocol and sample letters at www.omic.com

- **Outcome**
  - Physician recognized need to allay patient’s anxiety to the extent possible
  - Offered frequent, regularly scheduled appointments to occur before anxiety started to climb
  - Patient agreed, and solution has worked well so far

**Questions?**

- **FOLLOW-UP QUESTIONS**
  - amenke@omic.com
  - 800.562-6642, extension 651
Elizabeth Holloway, COE, CPSS, SHRM-CP
1:45–2:45 PM
Elizabeth Holloway, COE, CPSS, SHRM-CP

Elizabeth Holloway is a senior consultant for BSM Consulting and is based in Trinity, Fla. Ms. Holloway provides support to BSM and corporate clients in all aspects of clinical operations, staff training and development, and human resources.

Prior to joining BSM, Ms. Holloway served as the chief operations officer (COO) for a large multispecialty ophthalmic practice in Florida. Her responsibilities included clinic flow and efficiency, compliance, financial benchmarking and budgeting, and staff/leadership development. Additionally, Ms. Holloway supervised the practice’s human resources activity, contract negotiations for managed care and accountable care organizations (ACOs), implementation and attestation of electronic health records, and integration of ophthalmology and optometry.

Ms. Holloway is the author of numerous BSM Connection® distance learning courses and is a regular columnist for Ophthalmic Professional. She has appeared as a guest speaker at the American Society of Ophthalmic Administrator (ASOA) National Congress and the Hawaiian Eye Conference and served on ASOA’s Education Committee.

During her tenure as a COO, Ms. Holloway helped pilot the Certified Patient Service Specialist (CPSS) program, the nation’s only certification curriculum for nonclinical medical staff. Her involvement ultimately helped earn her practice the BSM Center of Excellence Award. Additionally, Ms. Holloway is a Gallup Institute Certified Strengths Coach and implemented the StrengthsFinder program into the practice in 2008.

Ms. Holloway is a Certified Ophthalmic Executive (COE), a Certified Patient Service Specialist (CPSS), and is certified as in Human Resources. She is a member of the Society of Human Resources Management. Her education includes a Bachelor of Arts degree from Florida Southern College (Lakeland, Fla.) and a Master of Arts degree from Rice University (Houston, Texas).
Objectives

- Determine the metrics most important in measuring the financial health of the practice.
- Integrate the metrics and tools provided in the course in the practice.
- Interpret the results of each metric to identify tangible areas of opportunity for improvement.

What is a Key Performance Indicator (KPI)?

- Type of performance measurement that is essential to the practice reaching its goals.
- An objective to be targeted that will add the most value to the business.
- Should be understandable, meaningful, and measurable.

The truth is, if you are not tracking KPIs...

- You won’t know where you are or where you are going.
- You will have no sense of how performance compares to prior year or budget.
- You will find it challenging to lead or manage the practice.
- You will tend to make poor business decisions.

What are the most important KPIs to track in your practice?

Balance Sheet
**Balance Sheet Introduction**

- **Assets**
  - Current Assets
  - Tangible Assets
  - Non-Current Assets
- **Liabilities**
  - Current Liabilities
  - Non-Current Liabilities
- **Shareholders’ Equity**
  - Paid in Capital
  - Retained Earnings
  - Net Income

**Balance Sheet Ratios**

- **Current Ratio**
  - Ratio: Current Assets divided by Current Liabilities
  - Used For: Measure of a practice’s ability to use current assets to cover current liabilities
  - Goal: Goal should be greater than 1.0, but 2.0 or higher is preferred

- **Debt-to-Equity Ratio**
  - Ratio: Total Liabilities divided by Total Equity
  - Used For: Measure of a practice’s borrowing power or leverage
  - Goal: Goal should be less than 3 to 1

**Physician Productivity**

- **Are Our Physicians Productive?**
  - **Net Collections per FTE Physician**
    - Data: Net collections (gross collections minus refunds)
    - Formula: Net collections divided by the number of FTE Physicians
    - Used For: Assessment of provider productivity; track year over year trends, as well as inter-doctor variances
    - Tips: Look at the ratio over an extended period of time (monthly variances are quite common); low collections may indicate collection difficulties or provider inefficiencies
    - MD Benchmark Range: $800,000–$1,300,000
    - OD Benchmark Range: $200,000–$400,000
### Net Collections Per Encounter

**Data:** Net collections (gross collections minus refunds) / Total patient encounters

**Formula:** Net collections divided by total patient encounters.

**Used For:** Practice efficiency assessment tool; Useful tool to build revenue model in budgeting plan

**Tips:** Understand your practice and the types of patients you see.

Helps you project provider revenue

**MD Benchmark Range:** $175 - $250

**OD Benchmark Range:** $80 - $125

### Are we getting paid in a timely manner?

**Net Collection Ratio**

**Data:** Monthly Collection Total (net of patient refunds) / Monthly Adjusted Charges (gross charges less contractual agreements)

**Formula:** Net collections divided by adjusted charges.

**Used For:** Identification of a practice's ability to collect that which it can legally collect (net charges).

**Tips:** Look at the ratio over an extended period of time (monthly variances are quite common); low percentages may indicate billing problems, collection difficulties, payer delays.

**Benchmark Range:** 95% - 99%

### Billing Metrics: Accounts Receivable Aging

**Data:** Monthly Accounts Receivable Summary Aging Reports

**Used For:** Identifying collection trends in the practice.

**Tips:** High ratios could be caused by billing problems, difficulties, or payer delays; track trends over time; if problems are apparent, complete a detailed payer analysis and re-assess department policies and procedures.

<table>
<thead>
<tr>
<th>A/R Aging Category</th>
<th>Percent of A/R Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-30 days</td>
<td>55% - 75%</td>
</tr>
<tr>
<td>31-60 days</td>
<td>8% - 14%</td>
</tr>
<tr>
<td>61-90 days</td>
<td>3% - 6%</td>
</tr>
<tr>
<td>91-120 days</td>
<td>2% - 4%</td>
</tr>
<tr>
<td>Over 120 days</td>
<td>0% - 1%</td>
</tr>
</tbody>
</table>

**Benchmark Range:**

### Billing Metrics: Days Sales Outstanding

**Ratio:** Days Sales Outstanding = Adjusted accounts receivable / Average daily collections

**Used For:** Measure of how quickly receivables turn over in the practice.

**Tips:**

- Adjusted Accounts Receivable Balance
  - (Current A/R balance + gross collection ratio [net collections/gross charges])

- Average Daily Collections
  - (Net collections/number of days in the time period)
Operating Efficiency

Are my expenses too high?

Operating Expense Ratio

Data: Operating Expense Less MD/OD Compensation and Benefits
Net Collections (monthly gross collections less refunds)

Formula: Total operating expenses divided by net collections.

Used For: Illustration of practice efficiency converting revenue into professional compensation.

Tips: Statistic not absolute: correlate with other indices; evaluate over time to observe trends.

Benchmark Range: 50%–70%

Staffing

Do I have the right number of staff?

Net Collections per FTE Staff

Data: Net collections (gross collections minus refunds)
Number of FTE Staff

Formula: Net collections divided by the number of FTE’s.

Used For: Assessment of staff efficiency and productivity

Tips: Compare trends over several years; be sure to compare with other like kind practices; performance less than healthy range may indicate overstaffing problem.

Benchmark Range: $140,000–$200,000
**Payroll Ratio**

**Data:** Gross non-physician payroll.
Net collections (gross collections less refunds)

**Formula:** Gross non-physician payroll divided by net collections.

**Used For:** Efficient use of non-professional personnel

**Tips:** Extremely low percentages may indicate physician inefficiency; High percentages generally indicate overall practice inefficiencies.

**Benchmark Range:** 20%–26%

**Case Study: Do I have the right number of staff?**

- **Low Payroll Ratio: 18%**
  Over Stressed Staff

- **High Payroll Ratio: 36%**
  Inefficient Office

**Monthly Benchmarking**

**Dashboard Reports**

**Key Calculations**

- **FTE Staff:** Total hours employees worked ÷ 2080
- **Patient Encounters:**
  - Eye codes (92004, 92014, 92002, 92012)
  - E/M codes (99201 – 99205 and 99211 – 99215)
  - No charge visits (99024)
  - Encounters for free LASIK screenings or surgical consults
- **MD / OD Net Collections:** Only includes professional fees

**Presenting Numbers to Physicians**

- Set monthly deadlines
- Be accurate
- Be on time!
- Condense data
- Prepare back-up documentation
Summary

- KPI's: The Big 10
- Understand performance
- Understand trends
- Make informed business decisions

Thank you for attending!

Elizabeth Holloway
BSM Consulting
eholloway@bsmconsulting.com
Steven R. Robinson, FASOA, COE
2:45–3:45 PM
Steven R. Robinson, COE, FASOA

Steve is the principal consultant with S & R Consulting of Chattanooga Tennessee. He works with physicians’ offices, clinics and optical operations in the capacity of a business consultant for human resources, finance and operations management. Steve was previously vice president and chief operations officer of Professional Eye Associates of Dalton Georgia where he served in his capacity for 18 years. He received his education from The University of Tennessee at Chattanooga in Business Management. He holds a Certified Ophthalmic Executive credential (COE). Steve is a past president of American Society of Ophthalmic Administrators (ASOA), and one of only six fellows of that society. He is a contributing writer for Administrative Eyecare and is a national speaker on current topics of interest to the medical management community.
Disclosure:
Steve Robinson is a paid consultant who works for physicians in the area of practice management and operations. He has a financial interest in the material presented herewith. He accepts honoraria for these presentations, and fees for services to physicians offices that may arise from a consultation in relation to this presentation.

Steve Robinson, FASOA, COE
Senior Practice Management Consultant

Cell 423-316-3934
steve@srr2.com

My Employees, A Team...or a mob?

The Workplace Team.... Myth or Reality?

WHAT DO YOU SEE?
An Exercise for your Next Practice Staff Meeting

Give this set of instructions…..
Line up around the room in order of your birth date
Rules
1. You cannot speak to each other
2. You cannot write anything down for each other
3. The last person in the line is to yell “Done” very loudly!

Do NOT give them any more instruction than just that
Now, just tell them to GO!

Go around the room telling everyone to hurry up!

Evaluate
Could this have been done better?
How ??
Was there a time limitation?
Why did I go around telling everyone to hurry?

Evaluate
Did I help or hurt?
How well did we communicate?
What could we have done to communicate better?

If this is about teamwork…..?
There are basically 2 types of organizations in the workplace:

1. Work Groups
2. Highly Motivated Teams

**Workgroup** - a group of people who are employed by an organization that has a stated purpose.

**TEAMS**… Motivated Group, working In Concert With Each Other

Many differences between a work group and a highly functioning team

**Workgroup**

Autocratic Approach
Use Their Own Time Table
No Interaction With Others Except…..

**Workgroup**

No Desire To Excel
Workgroup
Maintain The Status Quo
Perform To Protect Position

Little Risk With Membership In A Workgroup

Can you think of an organization that fits this description ????

Motivated Group Working In Concert

TEAMS
Utilizing Strengths Of Individuals To Accomplish Clearly Defined Goal

Both Risks And Rewards Are Present With Teams
Accomplishments Are Greater Than The Sum Of Their Parts

Synergy Within…

For thousands of years, we were a hunter/gatherer society

Payoff

If you got kicked off the team…..

Thus, the birth of individual merchant!

Industrial Revolution
When you go into a business that is run by a group who is not... can you tell?

TEAMS ......
1. Highly communicative
2. Different backgrounds, skills and abilities
3. Have a shared sense of mission...a common purpose
4. Have clearly identified goals

QUESTION...
when you go into a business that is run by a group that is happy to be there.... can you tell?
Comes from the TOP…down!

OK…
So how do we do this?

Share the vision
Keep the people informed
Give them a sense of purpose

Ensure that all the elements of the practice are included
Celebrate the accomplishments

It’s All About Expectations!

Collective Training
State the overall goal for the practice

Have Smart Goals

Specific, measurable, attainable, realistic, imeliness

Mission Statement

Delegate ..... 

Managers... Then the next level
Hold People Accountable

Celebrate!
Even the smallest victories

What is the most important Position in your practice?

Recognize Positive Behavior

Cross Train
Cross Train
Cross Train

Reward all newfound team effort
“A GREAT PLACE TO WORK” by Robert Levering

Research showed these attributes:

1. When you can trust those for whom you work (they listen and delegate)

2. Where you can be proud of what you do

3. Where you can enjoy who you work with (it is ok to have fun)

Pride, Trust and Enjoyment are three attributes of a great place to work

$$$

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Key to teamwork

Giving people goals and the reasons why they should achieve those goals

Standards

1. Set them High

Standards

2. Don’t deviate

Standards

3. Everyone knows the performance standards

Standards

4. Continually measure performance
Standards

5. Publish the results

What Happens?

All of you will become cheerleaders

Patients will benefit

Employees will benefit

Doctors will benefit
Predictable pitfalls

Not everyone will get on board

One of two things will happen
They will leave you…. or you will leave them!

And….. When you replace them, remember this …..

You can’t send a duck to eagle school!
Hard Work

Remember… you have a choice!

Steve Robinson, FASOA, COE
Senior Practice Management Consultant
Cell 423-316-3934
steve@srr2.com