Reimbursement Changes for 2011

BY GEORGE A. WILLIAMS, MD

On Jan. 1, 2011, the Centers for Medicare and Medicaid Services (CMS) implemented major changes in reimbursement for important vitreoretinal codes and began payment for some new imaging codes. These changes are the culmination of a several-year process that will have significant financial implications for all vitreoretinal practices. This article discusses the history and processes behind the new numbers and codes.

INTRAVITREAL INJECTION CODE

The biggest cut in payment for 2011 is for code 67028, intravitreal injection of a pharmacologic agent (separate procedure). Payment has been reduced from approximately $200 to $125. This cut is the result of more than 2 years of review of this service. In 2007, at the request of CMS and the Medicare Payment Advisory Commission (MedPAC), the American Medical Association (AMA) Specialty Society Relative Value Update Committee (RUC) created a workgroup to evaluate potentially misvalued codes on an ongoing basis. This was in response to increasing criticism that the RUC has been too generous to some specialties.[1] The workgroup created screens to identify codes that needed review. As of May 2010, the RUC identified 853 services for review and has completed review of 622 codes. The remaining codes are scheduled for review over the next year. One of the first screens used by the workgroup was high-volume Current Procedural Terminology (CPT) codes with a 15% increase in utilization since 2006. The underlying assumptions are that if volume increases, there may be anomalous economic incentives or that physicians have become more efficient in the provision of the service. In a resource-based reimbursement system in which time is the primary resource, efficiency means less time per procedure, which means less payment. Not surprisingly, code 67028 was at the top of the list. Since 2000, utilization of 67028 in Medicare fee for service has increased from approximately 4,000 per year to a projected 1,000,000 in 2010. The American Academy of Ophthalmology (AAO) presented compelling scientific evidence that the increase in volume was attributable to the advances in retinal pharmacologic therapy, and the RUC agreed that the code should be removed from the review list. However, in the proposed 2009 Medicare Physician Fee Schedule published in July 2008, CMS demanded review of all codes with utilization over 100,000 that had not been previously reviewed by the RUC. Because code 67028 had not been reviewed by the RUC, the RUC directed the AAO to conduct a formal survey of code 67028 for presentation and valuation at the October 2009 RUC meeting.

The prior valuation of code 67028 had a physician work relative value unit (RVU) of 2.52, which was based on times from the initial Resource-based Relative Value Scale (RBRVS) process in 1992. These times totaled 44 minutes, allocated as 14 minutes for pre-service time, 16 minutes for intra-service time and 14 minutes for post-service. The new survey of 118 retina specialists who were experienced in providing the service demonstrated a total mean time of 15 minutes, with 5 minutes each for the pre-, intra- and post-service times. The AAO presented a detailed argument about the value of 67028, which considered the intensity and complexity of the procedure and the relative value compared to other similar codes. The RUC rejected the AAO recommendation and assigned a work value of 1.44 RVU. The AAO strongly disagreed with this value, believing it did not reflect the intensity and complexity of an intravitreal injection. Therefore, the AAO appealed to the RUC's Administrative Committee on the basis of inconsistencies in the RUC process. The appeal was denied, and the AAO then appealed directly to CMS through a formal presentation. Julia Haller, MD, joined the AAO team at that CMS appeal. Unfortunately, this appeal was denied. The AAO continues to believe that the new valuation of 67028 is inconsistent with previous RUC policies and valuations and creates rank order anomalies with other ocular injection codes.

In the new value, the RUC assumed that the typical patient receiving an intravitreal injection will also receive an evaluation and management (E/M) service on the same day. This assumption was based on recent Medicare analysis of codes billed on the same day as 67028. This decision

eliminates most pre-service and post-service time from the valuation of the procedure. Therefore, retina specialists may bill an E/M service on the same day as an intravitreal injection, assuming appropriate medical necessity and documentation.[2] Other medically necessary diagnostic imaging and testing services also remain billable separately. The value for 2011 is an interim value, and the AAO, in conjunction with the American Society of Retina Specialists, is considering further appeal options.

POSTERIOR-SEGMENT IMAGING

The other major change involves codes for posterior segment imaging. Code 92135 no longer exists, and it has been replaced by two new codes, 92133 and 92134: Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; 92133 optic nerve; 92134 retina. Code 92135 was identified on the previously discussed screen for volume. The utilization for 92135 in the Medicare fee for service database increased from approximately 150,000 in 1999 to over 8,000,000 in 2008. Again, this growth was due to the development of new and effective drugs for retinal disease as well as improved technology. The AAO effectively argued that the growth was appropriate, but the previous valuation was based on use in glaucoma. It was apparent that 92135 was no longer an accurate descriptor of the service. The RUC referred code 92135 back to the CPT Editorial Panel, which determined that two new codes were needed for posterior segment imaging to describe the different work for glaucoma and retinal disease. The CPT Editorial Panel also decided that these codes should be unilateral or bilateral as with fundus photography, code 92250. Once these new codes were developed, the RUC required the AAO to survey both codes. Based on the survey results, the RUC assigned and CMS accepted a work value of 0.5 RVU, which is more than the previous unilateral code (92135) value of 0.35, but obviously less than the bilateral value. Keeping in mind that the key word in RBRVS is "relative," a chest X-ray has a work RVU of 0.18.

In 2011, there are two new codes for remote retinal imaging. These codes were developed at the request of industry with the support of the AAO through the CPT process. The first is code 92227: Remote imaging for detection of retinal disease (eg, retinopathy in a patient with diabetes) with analysis and report under physician supervision, unilateral or bilateral. This code has no physician work and is intended for use by nonphysician readers. The only payment is for practice expenses. The second code is 92228, remote imaging for monitoring and management of active retinal disease (eg, diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral. This code for physicians who perform remote imaging has a work RVU of 0.30. This code should not be used unless a physician performs the service for each patient. Physician supervision of nonphysician readers is not adequate for this code. The physician must interpret and write a report on each study.

DEVALUING PHYSICIAN SERVICES

The process of valuing physician services is under intense scrutiny from both within and outside medicine. In particular, the RUC process continues to be criticized.[3] Many retina specialists are frustrated by the continuing decline in reimbursement for our services. The current RBRVS process is increasingly being driven by physician time, while intensity and complexity are becoming less important. For those who may wish there was a different system, be careful what you ask for. The 2010 Patient Protection and Affordable Care Act creates a potential alternative to the RUC called the Independent Payment Advisory Board (IPAB) which is charged with limiting growth in Medicare expenditures. The IPAB will consist of 15 individuals nominated by the President and confirmed by the Senate. In 2014, the IPAB will submit legislation to Congress to reduce the per capita rate of growth in Medicare expenditures if spending exceeds a target growth rate, which is determined by the consumer price indices. This legislation must be voted up or down without input from Congress. Interestingly, the IPAB is precluded from cutting hospital, hospice or clinical lab payments until 2019. Also, IPAB cannot ration care, increase taxes, or change benefits or copayments. If you are thinking that does not leave much to cut except physician payments, you are right. CMS estimates that the IPAB will result in a $24 billion savings between 2014 and 2019, and nearly all of that will come from physician payments. ■

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