A New Direction for Maintenance of Certification

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A Breakdown of Changes to Health Care Reimbursement
Pro Tips for Determining Staffing Needs
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STAYING ON TOP OF YOUR GAME

Welcome to the second issue of Business Matters, a special section to Retina Today created with the business-savvy retina specialist in mind. As the cover indicates, the feature article in this issue focuses on maintenance of certification (MOC), a key component to staying on top of one's game in the practice of medicine. As with other avenues to this goal (eating healthy, staying current with literature, exercising, participating in research, etc.), American Board of Ophthalmology certification, and likewise MOC, is voluntary, but each offers an opportunity to help you put your best foot forward.

The American Board of Ophthalmology certifies physicians who demonstrate the knowledge, skills, and experience necessary to deliver high standards of patient care. To remain at our highest professional level, we must always be striving to enhance our knowledge and develop our skills, and that is where MOC comes in. The American Board of Ophthalmology is taking a new approach to MOC with an alternative examination program, which Andreas K. Lauer, MD, explains in depth starting on page 9.

The regular columns that make up the rest of the content in this supplement touch on topics related to health care reimbursement, common retina coding questions, and how to figure out staffing needs. If you missed the inaugural issue of Business Matters, which appeared with the March issue of Retina Today, it’s available online and can be viewed at bit.ly/BM0101. Keep an eye out for the next issue, available in September, which will offer a feature on teaching fellows about business topics.

GEORGE A. WILLIAMS, MD
SECTION EDITOR

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In 1992, Medicare transitioned from the historic charge-based payment system to the resource-based relative value scale (RBRVS). In the RBRVS system, payments for services are determined by the resource costs required to provide the respective service. These costs are allocated into three components: physician work, practice expense, and practice liability insurance.

Payments are calculated by multiplying combined costs, which are measured by relative value units (RVUs), by an annually updated conversion factor that is currently $35.9996. Payments are adjusted for geographic differences in resource cost. A fundamental tenet of the RBRVS is to be able to rank procedures in relation to other procedures using the concept of relativity. In other words, how do the resource-based costs of retinal services compare with services performed by other ophthalmologists and other physicians?

**BREAKING DOWN RELATIVE VALUE**

Relative value for a service is determined by a formula using the three previously mentioned cost components (physician work, practice expense, and practice liability insurance). These three components are not weighed equally.

**Physician Work**

The physician work component constitutes an average of 50.9% of the total relative value for each service. The factors used to determine physician work include the time it takes to perform the service, the technical skill and physical effort of a given procedure, the required mental effort and judgment needed for a particular service, and stress due to the potential risk to the patient. Many of these factors are subjective.

The American Medical Association/Specialty Society RVS Update Committee (RUC) uses a standardized survey system to assess these factors. The survey asks physicians to rank a service in relation to other services with established values, times, and intensity. A valid survey requires 30 to 100 respondents, depending on the volume of the service. Although the survey process is time-consuming, it is critical to generating accurate data.

**UNDERSTANDING RVUs IN RETINAL CARE**

Changes in health care reimbursement: it's all relative.

**BY GEORGE A. WILLIAMS, MD**
for valuation. Retina specialists who receive a survey request are strongly encouraged to participate.

**Practice Expense and Practice Liability Insurance**

The practice expense component varies significantly between procedures, but on average accounts for 44.8% of the total relative value for each service. The practice liability insurance component varies among specialties but on average accounts for 4.3% of the total relative value for each service. The current system measuring physician work, practice expense, and practice liability insurance has been operative since 2002 and is called the relative value scale (RVS).

**THE RUC**

In the law establishing the RVS, Congress recognized the dynamic and evolving nature of medical practice and required that the Centers for Medicare and Medicaid Services (CMS) establish a process for updating values. The majority of this updating process occurs through a committee of the American Medical Association and national specialty societies known as the RUC. The RUC represents the entire medical profession, with 21 of its 31 members appointed by major national medical specialty societies. The American Academy of Ophthalmology is a permanent voting member of the RUC.

Initially, Congress required that the RVS be updated every 5 years. Since 2012, the RUC has updated the RVS on an annual basis. Codes can be updated through multiple mechanisms. The primary mechanism is through the relativity assessment workgroup of the RUC. This subcommittee screens all of the nearly 10,000 CPT codes to identify which ones should be reviewed. Some of the common indicators that a CPT code should be reviewed include rapid growth in volume, services commonly performed together on the same day, high expenditure codes not recently reviewed, and codes with more than six postoperative visits in a global period. Also, CMS may request that the RUC review any code. Any new category 1 CPT code must also be reviewed by the RUC.

When CPT codes are reviewed by the RUC, it is done within the context of the CPT family of similar codes. For example, if one retinal detachment code is identified for review, the other associated retinal

**“SOME OF THE COMMON INDICATORS THAT A CPT CODE SHOULD BE REVIEWED INCLUDE RAPID GROWTH IN VOLUME, SERVICES COMMONLY PERFORMED TOGETHER ON THE SAME DAY, HIGH EXPENDITURE CODES NOT RECENTLY REVIEWED, AND CODES WITH MORE THAN SIX POSTOPERATIVE VISITS IN A GLOBAL PERIOD.”**

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**AT A GLANCE**

- In Medicare’s current resource-based relative value scale system, payments for services are determined by the resource costs required to provide those services.

- Relative value for a service is determined by a formula using three cost components: physician work, practice expense, and practice liability insurance.

- The relative value scale system is criticized for incentivizing volume over value. In response to this criticism, Medicare and other major payers have created systems to measure value defined as quality over cost.
detachment codes are also reviewed. If a new CPT code for a vitrectomy procedure is developed, it will be valued within the vitrectomy code family, requiring all the codes of the family to be reviewed.

What typically happens when a CPT code is reviewed by the RUC?
Since 2006, the RUC has reviewed nearly 2,100 CPT codes of potentially misvalued services. Of those, 41% had their reimbursement decreased, 28% underwent no change to reimbursement, 9% had their reimbursement increased, and 17% were deleted. Recent experience with retina codes associated with laser, vitrectomy, and ocular imaging has not followed the above ratio; all of their codes have been reduced.

Why have retina codes been cut?
The primary reason for retina codes being cut pertains to a decrease in the time of retina services. As noted above, physician work is measured primarily by time and intensity. The RUC measures intensity by a metric known as intraservice work per unit time (IWPUT), which provides a ratio of RVUs per minute. There are only 25 CPT codes in all of medicine with an IWPUT of greater than 0.20; of these, eight are in ophthalmology and four are in retina. Intravitreal injection (CPT code 67028) has the highest IWPUT of all codes performed, with a volume of more than 300,000 procedures.

The primary factor for high IWPUT is the continuing decrease in procedure time as measured by surveys. As expected with the advent of minimally invasive procedures such as sutureless vitrectomy, time spent per procedure has lessened. Because IWPUT is a ratio of value over time, if time decreases and value does not, the IWPUT increases. Because many retina procedures already have a relatively high IWPUT, the RUC uses this as an argument for decreasing value of certain procedures. More and more, time is the primary driver of valuation and intensity is a diminishing factor. In such a system, the reward for increased efficiency (decreased time) is decreased payment.

CRITICISMS
The RVS and the RUC have come under increased criticism over the past decade. A common complaint is that the RUC process favors specialists at the expense of primary care providers. A more fundamental critique is that the entire RVS system incentivizes volume over value.

As a result of such criticisms, Medicare and other major payers have created systems to measure value defined as quality over cost. The Quality Payment Program found in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is the first, but certainly not the last, step in this process. Within MACRA, the Quality Payment Program established the merit-based payment system (MIPS) and alternative payment models.

For most retina specialists, MIPS is the preferred pathway. MIPS measures and compares physicians in a new type of relativity across four categories: quality, advancing clinical information, practice improvement, and cost. High performers are eligible for a bonus and low performers face penalties. The process is designed to be revenue-neutral, so that (for the most part) the bonuses come from the penalties. In other words, if there are no losers (penalties), there are no winners (bonuses).

Unfortunately MIPS, as currently constructed, is unlikely to improve value for a host of reasons, including byzantine complexity, poor risk adjustment, and flawed patient attribution. I will discuss both MIPS and alternative payment models in greater detail in a future installment of Pennsylvania Avenue Updates.

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Billing and coding may not be enjoyable, but it’s a necessary evil of practicing medicine. Whether you oversee this process yourself or you have a dedicated staff member, it’s important to know certain rules and reasoning to get the most out of your time and effort. In this column I provide answers to some of the questions I’m asked most frequently.

QUESTION: In our rural community, primary care physicians sometimes ask us to provide the interpretation and report on photos taken in the primary care physician’s office for patients with known diabetic retinopathy in order to meet their Healthcare Effectiveness Data and Information Set requirements. Is this coded as 92250 Fundus photography, appended with modifier -26?

ANSWER: This is an example of telehealth. For patients with known retinopathy:

- 92228 -26, billed by the ophthalmologist $21.06
- 92228 -TC, billed by the PCP $13.78
- Do not report 92250 -26 for telemedicine $22.51

QUESTION: Suppose the doctor performs surgery with CPT language “one or more sessions” and must repeat the procedure during the 90-day global period. Is it possible to have the patient pay for the second procedure after having him or her sign an Advance Beneficiary Notice (ABN)?

ANSWER: Under no circumstance should you charge the patient as described. Medicare might interpret this as an attempt to commit fraud and as inappropriate use of an ABN. Medicare Part B payment is for the entire 90-day period no matter how many additional times the physician must perform the procedure.

QUESTION: In a group practice, the comprehensive ophthalmologist saw a patient for flashes and floaters, then referred the patient to the same group practice’s retina surgeon. Later that day, the retina specialist examined the patient, performed extended ophthalmoscopy, and surgically repaired a retinal detachment. What is billable in this scenario?

ANSWER: What was the comprehensive ophthalmologist’s diagnosis? If both physicians used the same diagnosis, only one of them can submit a claim. In 2013, the National Correct Coding Initiative bundled extended ophthalmoscopy with surgery when performed the same day. The practice should submit the appropriate level of Evaluation and Management or Eye visit code with...
modifier -57 to indicate that this was the office visit to determine the need for surgery and the surgery itself.

**QUESTION:** Can we unbundle CPT codes 67036 Pars plana vitrectomy and 67145 Prophylaxis of retinal detachment; photocoagulation with modifier -59 when performed simultaneously with or without tear?

**ANSWER:** CPT code 67145 has been bundled with 67036 since 1996. It is inappropriate to unbundle due to treatment of contiguous structures. Instead, bill CPT code 67036 Vitrectomy, mechanical, pars plana approach; with focal endolaser photocoagulation, as it has the higher allowable. If both codes are submitted, the payer has the option to accept the lower allowable code.

**QUESTION:** Our administrator told us to bill a sample medication as $0.01 along with the injection. Shouldn’t the charge be zero because we used a sample?

**ANSWER:** If your clearinghouse won’t accept a zero charge it’s best not to submit a claim for the sample medication at all.

**QUESTION:** Because payment for 92235 Fundus photography, 92240 ICG and 92242 Combined FA and ICG, is now bilateral instead of unilateral, should we append either modifier -RT or -LT, or modifier -52 to show reduced services?

**ANSWER:** Unless the specific payer states to do so in writing, the answer is no. No modifier is necessary. These codes have the same allowable whether one or both eyes are tested and include the language “unilateral or bilateral.”

**QUESTION:** We have a patient with bilateral wet age-related macular degeneration with active choroidal neovascularization. On a recent visit we injected only the patient’s left eye. Do we append the bilateral diagnosis to the injection?

**ANSWER:** No. This is cause for a denial with many payers. If the CPT code requires modifiers -RT or -LT, and the ICD-10 code has laterality, be sure bilateral is not reflected in the ICD-10 code selection. If the injection is in the left eye, use H35.3221 Exudative age-related macular degeneration, left eye, with active choroidal neovascularization.

(Continued on page 14)
The New Face of Board Certification

How the Quarterly Questions Program is changing maintenance of certification.

BY ANDREAS K. LAUER, MD

The new examination alternative program from the American Board of Ophthalmology (ABO), called Quarterly Questions, is changing the maintenance of certification (MOC) experience for board-certified ophthalmologists. The debut of this online, self-paced program marks the end of the era of high-stakes, once-a-decade testing for ophthalmologists in practice and allows the ABO and its diplomates to come together at the intersection of learning and assessment. Feedback from the program’s first year indicates that the activity is meaningful, valuable, and even enjoyable.

HOW WE GOT HERE

More than 100 years ago, ophthalmologists took a leap of faith by agreeing to trust one another to set professional standards for improving patient care and protecting the privilege of physician self-regulation. Today, the ABO honors this agreement through its mission to serve the public by certifying ophthalmologists through the verification of competencies. Under the guidance of 18 practicing ophthalmologists from around the country, the ABO approaches certification as a lifelong process that promotes excellence through continuous improvement. Programs such as MOC are designed by and for ophthalmologists and ophthalmic subspecialists to promote and recognize aspirational goals. Somewhere along the way, however, MOC began to struggle under the weight of its good intentions. Participants found the program burdensome and not as clinically relevant as they expected. Limitations that stemmed from the four-part MOC program framework developed by the American Board of Medical Specialties (the umbrella organization for the nation’s 24 medical specialty boards) didn’t help improve the experience, and the ABO found itself trying to design a modern program while still approaching high-stakes testing the same way it had more than a century ago. It was time to evolve to meet the needs of today’s practicing ophthalmologists.

THE TRANSFORMATION OF TESTING

For a fresh start, the ABO sought the advice of practicing ophthalmologists in various stages of their careers, working in different practice environments around the country. Through

AT A GLANCE

▶ The ABO is taking a new approach to maintenance of certification with an alternative examination program called Quarterly Questions.

▶ The program takes a longitudinal view of assessment rather than using a 1-day snapshot. It combines microlearning experiences with ongoing evaluation of general ophthalmologic knowledge.

▶ For participants whose certificates expire between now and 2020, meeting the passing standard on three annual sets of Quarterly Questions will satisfy the MOC Part III knowledge assessment requirement.
"THE QUARTERLY QUESTIONS PROGRAM IS AN INNOVATION IN ASSESSMENT, WITH THE GOAL OF HELPING TO MAKE MOC MORE RELEVANT TO INDIVIDUAL PRACTICE (AND, THEREFORE, MORE MEANINGFUL AND VALUABLE TO DIPLOMATES) WHILE CONTINUING TO OBJECTIVELY ASSESS PHYSICIANS’ KNOWLEDGE, JUDGMENT, AND SKILLS IN OPHTHALMOLOGY."

A collaborative codesign process, the ABO explored new ideas and opportunities with ophthalmologists and ophthalmologists-in-training, professional societies and subspecialty organizations, and even patients. A new vision took shape for a collaborative program that championed both learning and assessment at the same time.

Patterned after the American Board of Anesthesiology’s successful Maintenance of Certification in Anesthesiology Minute program, the ABO’s Quarterly Questions knowledge assessment component for MOC satisfies Part III of the American Board of Medical Specialties’ four-part MOC design. After 2018, the ABO will fully transition to Quarterly Questions and will no longer offer the Demonstration of Cognitive Knowledge Examination for Part III.

The Quarterly Questions program takes a longitudinal view of assessment rather than a 1-day snapshot. It combines microlearning experiences with the ongoing evaluation of everyday “walking-around knowledge” in ophthalmology. Inherent in the design of the Quarterly Questions program is the need to keep the content contemporary and relevant for the practicing ophthalmologist. Because medical knowledge grows quickly and practice patterns change, subject matter experts develop new questions annually to stay in step with the evolution of medical practice.

The Quarterly Questions program is an innovation in assessment, with the goal of helping to make MOC more relevant to individual practice (and, therefore, more meaningful and valuable to diplomates) while continuing to objectively assess physicians’ knowledge, judgment, and skills in ophthalmology (See “Anatomy of a Quarterly Question” below).

ANSWERING QUARTERLY QUESTIONS
Diplomates of the ABO can access up to 50 questions per year through Quarterly Questions, although annual...
Get Started With Quarterly Questions

To learn more about Quarterly Questions visit abop.org/qq or contact the ABO at 610-664-1175 or at info@abop.org.

Participants receive instant feedback after answering each question. The platform displays a key point (the main takeaway from the item) and a critique that explains the rationale for the correct answer and the reasons why the incorrect answers are not appropriate. References accompany each question as resources for those who wish to delve further into the topic. Along the way, diplomats can track their performance in relation to the aggregate score of the diplomate community. Research in the learning and assessment literature shows that this method of providing constructive, detailed feedback at the time of both correct and incorrect answers is effective for promoting learning and enhancing information retention.1,2,3

Scoring is based on meeting the annual passing standard a set number of times. The number is based on each diplomate’s certification date. For participants whose certificates expire between now and 2020, meeting the passing standard on three annual sets of Quarterly Questions will satisfy the MOC Part III knowledge assessment requirement. Diplomates whose certificates expire in 2021 or later should plan to meet the annual passing standard five times during the remainder of their 10-year cycle.

PROMISING RESULTS, POSITIVE FEEDBACK

Preliminary analysis of 2017 pilot year performance data confirms that the program is meeting its intended goals. With an average score of 76% on all knowledge-based questions, participants demonstrated that, although they’ve mastered most of the material, they still have the opportunity to learn something new regarding the questions they missed. Of those who answered a question incorrectly and then reviewed the question feedback, 98.2% of survey respondents found the key point to be helpful, 97.3% found the critique to be helpful, and 94.3% found the references to be helpful. Eighty-five percent of overall participants said they learned something useful that would help them provide better care to patients in the future.

Another measure for evaluating the success of Quarterly Questions is the participants’ relevance rating of the questions. In the pilot, all content was based on core knowledge, with no subspecialty options. Perhaps because of this, participants rated the content somewhere between slightly and moderately relevant, a mean 2.7 on a 4-point scale. In 2018, the ABO introduced subspecialty-specific sets of questions to improve relevance.

The program’s article-based questions serve a different purpose from the knowledge-based questions. Primarily formative (educational) in nature rather than summative (assessment), the article-based questions were designed to help participants learn new insights and best practices from reading the articles. In the program survey, 94% of diplomates agreed or strongly agreed that article-based questions were useful in learning new, emerging information.

Once sufficient program and performance data are available, the ABO intends to publish research about how the Quarterly Questions program promotes learning in ophthalmology. ■


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Financial disclosure: None
How many staff members does a practice with four MDs need? How many technicians does an established retina surgeon need? How many billing staff members do I need for my practice that generates $10 million in revenue?

As a practice management consultant working with many retina practices, these types of questions are among the most common that I receive from clients. This is not surprising, considering that staff salaries and benefits are the largest expense category that a practice incurs, often representing close to 30% of practice revenue.

Further, having the optimal number of staff members enables physicians to see a high volume of patients, which is important in maintaining profitability in a busy retina practice. Whether for front desk duties, technician work, prior authorization, or billing, finding the right balance of staff to provide great patient care while also maximizing financial efficiency is one of the greatest challenges leaders face in managing their health care practices.

The reality is that there is no simple, one-size-fits-all answer when determining employee needs is more involved than one might think.

BY ANDREW MALLER, MBA, COE

AT A GLANCE

- Figuring out a practice’s staffing needs takes a combination of subjective and objective analysis.
- Checking in with key players in the office on how things are running provides valuable information.
- The benchmarking process can be telling, but it’s not always straightforward. The goal is to stimulate discussion and to set goals to improve business efficiency and enable practice leaders to make better business decisions.
it comes to solving the staffing equation. Every retina practice is unique, and multiple factors must be addressed, including the number of physicians, number of locations, and overall business model. Finding the right solution for your practice includes a mix of subjective and objective analysis.

**THE SUBJECTIVE VIEW**

Subjective assessment requires input from the various stakeholders that play roles in your practice’s operations. Getting answers to the complex questions below should be your starting point in this assessment.

**Physicians:** Do the practice’s physicians feel they have the right number of technicians to manage a busy patient schedule?

**Front Desk/Phone Staff:** How long does new patient registration take? Can the staff keep up with the number of phone calls coming into the practice?

**Technicians:** Do technicians feel they are running around all day just to keep up? Are there bottlenecks that force the clinic to run behind schedule?

**Billers:** Does the billing staff feel it can keep up with the volume by posting and processing claims in a timely manner?

**Practice Administrator:** What is the overall morale of practice staff and physicians?

**Patients:** What do your patients say regarding wait times and overall experience?

**THE OBJECTIVE VIEW**

Benchmarking is the process of measuring one’s historic results against internal trends or industry benchmarks. It is a directional tool that will not necessarily give you an exact answer but rather will indicate potential areas of opportunity to improve overall business efficiency.

A number of metrics, described in the sidebar “Key Staffing Metrics,” are used to measure staffing volume and efficiency. The results should be tracked for the practice overall as a starting point and subsequently at the individual department level.

The retina practice benchmark ranges used in this article represent the 25th to 75th percentile of the

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<td><strong>Benchmark</strong></td>
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<tr>
<td><strong>Staff Payroll Ratio</strong></td>
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<td><strong>FTE Staff per FTE MD</strong></td>
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<td><strong>Net Collections per FTE Staff</strong></td>
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In the objective assessment of one’s practice, metrics such as those described below can be used to measure staff volume and efficiency.

**STAFF PAYROLL RATIO**

**Formula:** Annual staff salaries for nonphysician staff divided by net collected revenue (excluding injectable drug revenue)

**Retina Practice Benchmark Range:** 18% to 25% of net collected revenue

**Tips for Evaluating:** Extremely low percentages may indicate physician inefficiencies. Higher percentages may indicate overall practice inefficiencies or higher salary requirements in some geographic areas. To include employer payroll taxes and benefits in the calculation, add 6% to each side of the benchmark range.

**NUMBER OF FULL-TIME EQUIVALENT SUPPORT STAFF PER FULL-TIME MD**

**Formula:** Total number of full-time equivalent (FTE) staff members divided by number of full-time MDs

**Retina Practice Benchmark Range:** 6.0 to 9.0 staff members per 1.0 MD

**Tips for Evaluating:** Lower numbers may point to the need for additional staff. Higher numbers could represent inefficiencies in the use of staff. The results will fluctuate for many retina practices due to business model, number of locations, and increased demands for performing insurance verification and prior authorization.

**NET COLLECTED REVENUE PER FTE SUPPORT STAFF**

**Formula:** Total net collected revenue (excluding injectable drug revenue) divided by the number of FTE staff members

**Retina Practice Benchmark Range:** $150,000 to $225,000

**Tips for Evaluating:** Results lower than the benchmark range could indicate that the practice is overstaffed. Results on the high end of the range could indicate the need for additional staff. It is important to measure trends over time to see how changes in the business (new providers, locations, etc.) affect this metric.
BSM Consulting database, which was developed from a combination of several sources, including the American Academy of Ophthalmic Executives and American Society of Ophthalmic Administrators benchmark surveys, as well as our own client experience.

**DON’T BE LED ASTRAY**

One of the biggest mistakes practices make in using staffing benchmarks is looking at any result in isolation. The key to getting the most out of this exercise is to look at the results of the three metrics together to identify potential trends. For example, let’s assume the payroll ratio for a practice was 28% for a given period (Table). The natural reaction would be to assume that the practice is overstaffed. Before making that conclusion, however, what do the other two metrics indicate? In this case, the number of full-time equivalent (FTE) staff per FTE MD was 6.0, right in the middle of the benchmark range. The result for the net collections per FTE staff was $165,000, which, although within the benchmark range, is on the lower end.

Based on these three metrics, then, there are two indications that the practice could be overstaffed: payroll ratio and net collections per FTE. However, it is not totally clear. In this type of situation, additional analysis might be necessary. Because the payroll ratio and net collections per FTE both include net collections in their formulas, it is possible that, for this practice, the issue is not staffing volume but rather physician productivity. In addition, the high payroll ratio could be related to the geographic area of the practice. Regardless, performing this level of analysis leads to a problem-solving process based on objective analysis rather than gut feelings.

**TAKE A BALANCED APPROACH**

By marrying together the subjective and objective parts of the process described above, solving the staffing equation in your practice can become a more manageable exercise. The benchmarking process can be very telling, but, as illustrated in the example above, the answer is not always straightforward. Ultimately, the goal of using benchmarks is to stimulate discussion and set goals in order to improve business efficiency and enable practice leaders to make better business decisions.

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- Financial disclosure: None

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(Continued from page 8)

**QUESTION:** I performed bilateral repair of a retinal tear (CPT code 67145 Repair of retinal tear) on a Medicare patient on the same day. The first claim I submitted was 67145 -RT, 67145 -LT. When the payer denied it, I resubmitted 67145 -RT, 67145 -LT-51. The payer also denied the second claim. What is the best way to submit for reimbursement?

**ANSWER:** As of April 2013, Medicare Part B requires all bilateral surgical procedures to be submitted as a single line 67145-50 with a “1” in the unit field and double the charge. Medicare will pay 150% of the allowable. By not submitting the payment correctly, as you’ve experienced, you may be denied payment, or payment may be 100% of the allowable rather than the correct 150%. Commercial payers will vary in their requirements. Some may prefer two lines with -RT and -LT. No need to append modifier -51; most payers’ systems are sophisticated enough to recognize multiple procedures in the same setting.

**QUESTION:** What modifiers are required when performing both CPT code 67210 Destruction of localized lesion of retina (eg, macular edema, tumors), one or more sessions; photocoagulation, and CPT code 67028 Intravitreal injection in the same right eye?

**ANSWER:** As of April 1, there are no bundling edits with these two CPT codes. Submit 67210 -RT and 67028 -RT. Payment will be 100% for the first procedure, and the second procedure payment will be reduced by 50% due to multiple procedure guidelines.

**QUESTION:** Is there a postoperative period for laser therapy and treatment with injections? We have a patient who had laser on March 1 and then an injection on March 25.

**ANSWER:** All surgical procedures have a global period of either 0, 10, or 90 days of postoperative care. Medicaid payers also recognize a 60-day global period on many major procedures. When the injection is performed during the global period, append modifier -58 and the eye modifier to the injection code.

**Practice Makes Perfect**

Test your coding competency with the American Academy of Ophthalmology’s new 100-question Ophthalmic Coding Specialist Retina examination. Unique to retina, the test is available at aao.org/ocs.

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- Financial disclosure: None

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(Continued from page 9)
INDICATIONS AND USAGE

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13%
5%
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Fatal Events in Patients with DME and DR at baseline

WARNINGS AND PRECAUTIONS

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AMD-3) during the first year was 1.9% (17 of 874)

Diabetic Macular Edema (DME)

1-year

and Precautions (5.1)

and Patient Counseling Information (17)

studied in patients with DME and DR. In the full prescribing

In a pooled analysis of Studies D-1 and D-2, the rate of retinal

of both ischemic and hemorrhagic stroke) was 2.7% (13 of 484) in

0.5 mg LUCENTIS compared with 1.76% (11 of 629) in the control

of the following ATEs were ≥ 1% higher in patients who received

In the 2nd year, the rate of ATEs observed in the patients who

Thromboembolic Events

in Study D-2 is described in Table 7. The rate of ATEs in the treatment group

thromboembolic events (14.2 in the full prescribing information)

skeletal abnormalities including incomplete ossification of the thoracic vertebrae

Postmarketing Experience

AMD, and RVO Studies

64%

14%

13%

26%

26%

30%

10%

5%

2%

1%
INDICATIONS
LUCENTIS® (ranibizumab injection) is indicated for the treatment of patients with:
• Diabetic retinopathy (DR)
• Diabetic macular edema (DME)

IMPORTANT SAFETY INFORMATION
CONTRAINDICATIONS
• LUCENTIS is contraindicated in patients with ocular or pericocular infections or known hypersensitivity to ranibizumab or any of the excipients in LUCENTIS. Hypersensitivity reactions may manifest as severe intraocular inflammation.

WARNINGS AND PRECAUTIONS
• Intravitreal injections, including those with LUCENTIS, have been associated with endophthalmitis, retinal detachment, and iatrogenic traumatic cataract. Proper aseptic injection technique should always be utilized when administering LUCENTIS. Patients should be monitored following the injection to permit early treatment should an infection occur, and cough.
• Increases in intraocular pressure (IOP) have been noted both pre-injection and post-injection (at 60 minutes) with LUCENTIS. Monitor intraocular pressure prior to and following intravitreal injection with LUCENTIS and manage appropriately.
• Although there was a low rate of arterial thromboembolic events (ATEs) observed in the LUCENTIS clinical trials, there is a potential risk of ATEs following intravitreal use of VEGF inhibitors. ATEs are defined as nonfatal stroke, nonfatal myocardial infarction, or vascular death (including deaths of unknown cause).

In a pooled analysis of Studies DME-1 and DME-2, the ATE rate at 2 years was 7.2% (18 of 250) with 0.5 mg LUCENTIS, 5.6% (14 of 250) with 0.3 mg LUCENTIS, and 5.2% (13 of 250) with control. The stroke rate at 2 years was 3.2% (8 of 250) with 0.5 mg LUCENTIS, 1.2% (3 of 250) with 0.3 mg LUCENTIS, and 1.6% (4 of 250) with control. At 3 years, the ATE rate was 10.4% (26 of 249) with 0.5 mg LUCENTIS and 10.8% (27 of 250) with 0.3 mg LUCENTIS; the stroke rate was 4.8% (12 of 249) with 0.5 mg LUCENTIS and 2.8% (7 of 250) with 0.3 mg LUCENTIS.

• Fatal events occurred more frequently in patients with DME and DR at baseline treated monthly with LUCENTIS compared with control. A pooled analysis of Studies D-1 and D-2 showed that fatalities in the first 2 years occurred in 4.4% (11 of 250) of patients treated with 0.5 mg LUCENTIS, in 2.8% (7 of 250) of patients treated with 0.3 mg LUCENTIS, and in 1.2% (3 of 250) of control patients. Over 3 years, fatalities occurred in 6.6% (16 of 249) of patients treated with 0.5 mg LUCENTIS and in 4.4% (11 of 250) of patients treated with 0.3 mg LUCENTIS. Although the rate of fatal events was low and included causes of death typical of patients with advanced diabetic complications, a potential relationship between these events and intravitreal use of VEGF inhibitors cannot be excluded.

ADVERSE EVENTS
• Serious adverse events related to the injection procedure that occurred in <0.1% of patients included conjunctival hemorrhage, eye pain, vitreous floaters, and increased intraocular pressure. The most common non-ocular side effects included nasopharyngitis, rhinorrhea, and cough.
• As with all therapeutic proteins, there is the potential for an immune response to LUCENTIS. The clinical significance of immunoreactivity to LUCENTIS is unclear at this time.

Please see Brief Summary of LUCENTIS full Prescribing Information on following page.

The following clinical trials were conducted for the DR & DME indications:
RISE & RIDE—Two methodologically identical, randomized, double-masked, sham injection-controlled, Phase III pivotal trials (N=759) that studied the efficacy and safety of LUCENTIS 0.3 mg and 0.5 mg administered monthly to patients with DR and DME at baseline. The primary outcome was the proportion of patients gaining ≥15 letters at 2 years. Protocol S—A randomized, active-controlled study that evaluated LUCENTIS 0.5 mg vs. placebo photocoagulation in DR patients with and without DME. All eyes in the LUCENTIS group (n=191) received a baseline 0.5 mg intravitreal injection followed by 3 monthly injections. Further treatments were guided by prespecified retreatment criteria. FDA approval was based on an analysis of the LUCENTIS arm of Protocol S. The primary outcome was mean change in visual acuity from baseline to 2 years.1,2

LUCENTIS 0.3 mg is recommended to be administered as intravitreal injection once a month (approximately 28 days).1,2

DME, diabetic macular edema.

REFERENCES:

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