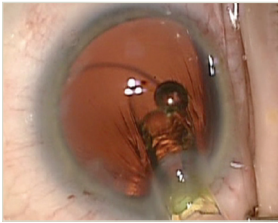


## OSN EXCLUSIVES

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**Warming viscoelastics, lens implants can be beneficial**



The practice of cooling these materials to subphysiologic temperatures hampers their functional characteristics. **37**

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## SPOTLIGHT ON ANTERIOR SEGMENT DIAGNOSTIC &amp; TEST INSTRUMENTATION

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See Uday Devgan, MD, FACS's latest blog entitled "Looking through a corneal scar" at [OSNSuperSite.com/blog/devgan.aspx](http://OSNSuperSite.com/blog/devgan.aspx)

## COVER STORY

## Medical practices prepare to weather regulatory challenges

As a plethora of federal initiatives aimed at rooting out Medicare overpayment and fraud begin to take hold across medicine, ophthalmologists may soon find themselves burdened by more administrative functions.

Coding and compliance experts have suggested that physicians may need to adopt a more proactive, team-based approach to coding and billing in order to deal with the mounting pressures that physician offices may soon face. As well, tapping available educational resources may become vital to ensuring compliance with Medicare regulations.

Whereas antifraud and anti-overpayment efforts previously focused mainly on durable medical equipment and institutions, newer initiatives may cast the spotlight on practitioners in medical specialties such as ophthalmology. Some experts believe that all Medicare providers are susceptible to audits, reviews and investigations by Medicare contractors such as Recovery Audit Contractors (RACs).

Regulation is not a recent phenomenon. Regulatory burdens have grown steadily more onerous over the years, and they now may represent a new threat

*Cover story continues on page 10*



Image: Bruce Berg Photography

**To prepare for an unannounced, Medicare-initiated inspection, Mark Packer, MD, hired a consulting firm to perform a mock inspection of his practice.**

## Intravitreal anti-VEGF therapy shows efficacy in treating retinal angiomatous proliferation

PARIS — Intravitreal anti-VEGF injection is a feasible treatment option in patients with retinal angiomatous proliferation. Ranibizumab is more effective than bevacizumab in advanced stages of the disease involving pigment epithelium detachment, according to a study.

Retinal angiomatous proliferation is a distinct form of neovascular age-related macular degeneration with high vasogenic potential

and unknown origins.

"It might originate from a retinal or choroidal lesion, or from both sites at the same time. Whatever the origin, the most important feature is the formation of type 3 retinal and choroidal new vessels. The prognosis is poor. Bilateral involvement approaches 100% within 3 years," **Francesco Bandello, MD, FEBO**, said at the meeting of the French Society of Ophthalmology.

A total of 50 patients were enrolled; 26 were randomized to receive intravitreal injection of bevacizumab, and 24 received ranibizumab.

"A significant improvement of visual acuity was observed at all stages of the follow-up," Dr. Bandello said. Five patients lost one line in visual acuity in the bevacizumab group, compared with two patients in the ranibizumab group.

*For more on this story see page 14.*

**Descemet's membrane endothelial keratoplasty a useful technique for selective tissue corneal transplantation**

The technique allows for faster visual recovery and better final visual acuity compared to DSAEK. **4**



## COVER STORY

# Complex compliance regulations may hinder physicians' ability to practice medicine

*continued from cover*

to a practice's economic livelihood, OSN Practice Management Section Editor **John B. Pinto**, said.

"This isn't just an abrupt first-time turning of the screw," he said. "This is sort of a continuation of the regulatory hoops that continue to be held higher and higher for folks to jump through, and more of them."

In the long run, increasing regulatory pressure may likely diminish the joy and satisfaction of working in ophthalmology, Mr. Pinto said.

"I think that this tightening of the screw is going to be, at the end of the day, not changing that many behaviors," he said. "But I think it's going to change a lot of attitudes ... and it's going to lead many in the profession, whether they are administrators or doctors, who felt pretty great about working in this industry to give it some second thought."

## New pressures

There is concern in some circles that increasing documentation requirements may soon start to eat into clinical time. Physicians are being increasingly pressured to ensure thorough documentation in the interest of complying with tougher billing and compliance standards. Additionally, the need to participate in Physician Quality Reporting Initiatives (PQRI) now appears mandatory in the face of newer regulations that would punish physicians who do not participate.

According to **Robert J. Noecker, MD, MBA**, the PQRI and new compliance regulations go hand in hand with the government's bigger-picture goal of instituting a pay-for-performance model of medicine. In some respects, physicians will already be documenting the things necessary for Medicare compliance in the interest of PQRI. However, how burdensome new documentation requirements become on the practice of medicine may ultimately hinge on how the regulations are enforced.

"You can argue that these initiatives are well-intentioned. It will all come down to how they are executed, whether

they are executed in a punishment kind of way vs. what is truly best for the patient. I think we all want to do what is best for the patient, but to be penalized if we don't fill out a line on our bill — to



**"There is always concern about overbilling, but when you look at it, there is probably a fair amount of underbilling that goes on too."**

— **ROBERT J. NOECKER, MD, MBA**

throw out the whole bill, for example — little things like that, that's a concern and a fear," Dr. Noecker said.

The new regulatory standards have been touted as a mechanism to close funding gaps within the Medicare system, but some remain skeptical that simply going after overpayments and/or fraud and abuse will have the intended effect. Neither is there abundant confidence in the field that the new regulations are, in fact, necessary to practicing good medicine.

"I don't know if patient care has improved," **Mark Packer, MD**, said. "It's not like a lot of these regulations are based on strong evidence that this is a better way to do things. It's kind of just the way things are written up and documented."

Dr. Packer explained that his surgical center recently underwent an unannounced, Medicare-initiated inspection. A new set of regulations were drawn up for surgical center compliance, and stimulus money funded

contract inspectors that "want to see everything you do — infection control, all your documentation, quality improvement programs, down to the last time you threw away the sponge in your kitchen," Dr. Packer said.

While the actual inspection was unannounced — Dr. Packer said that the inspector showed up at the front desk and announced that he would be reviewing the center for the next 2 days — all surgical centers were put on notice that an inspection would occur when the new regulations went into effect. His practice had the forethought to hire a consulting firm to perform a mock inspection, which Dr. Packer described as "money well spent." The center's administrator handled the inspector, so that when the inspection did occur, it was not a complete shock to regular operations.

"We actually had no findings on our inspection, and I really think it's because we put a lot of work into it," he said.

Anecdotally, however, Dr. Packer said he knows of fellow physicians who have not been as fortunate.

"I have colleagues who definitely did not have that experience, who to my mind — I've visited their facilities, I think they run perfectly great surgery centers and have great results — but nevertheless, they had a list of stuff that were deficiencies that they had 10 days to fix, with the threat that 'if you don't fix this, you're going to get shut down,'" he said.

## Does practice size matter?

At his own institution, Dr. Noecker said that the perception exists that clinic time is not necessarily suffering from new compliance regulations, but that physicians are spending more time after hours dealing with paperwork.

"I think our big fear is that we're going to be paid less for doing more work," Dr. Noecker said.

At the University of Pittsburgh, Dr. Noecker said that electronic health records have helped facilitate better documentation. Physicians may spend more clinical time learning new practices during the EHR implementation phase, but in the long run, digitized records can prompt physicians to complete needed documentation. But there is concern that the regulations are so complex, and the fear of missing required information so dire, that practicing physicians may



**"The way we have to code is similar to an accounting formula rather than really based on the doctor's perception of what is a brief visit, intermediate visit or comprehensive visit."**

— LAURIE K. BROWN, COMT, COE, OSA, OCS

find themselves writing down everything possible, regardless of its inherent clinical value.

"The other part of that is that people just sort of copy in the information, and at some level it becomes somewhat meaningless, in terms of clinical utility, but you need to do it to get paid," Dr. Noecker said.

Large academic institutions that have access to compliance officers who conduct intermittent audits to ensure best practices with Medicare compliance, a regular practice at Dr. Noecker's center, would seemingly have an advantage because of the access to specified experts. Additionally, because large institutional practices constitute a larger chunk of Medicare spending, they would seem more likely to be targeted by regulators.

Yet, regulatory burdens may not be different at smaller practices. The increasing digitization of medical records facilitates easier screening audits, regardless of practice size. And although a smaller practice may have electronic records and perform quarterly sample audits to self-detect coding errors, regulatory bodies that are incentivized by fiduciary return on invested time, such as RACs, will assuredly be thorough enough to at least recoup expenses or even generate profit from their activity.

"I don't, by any means, feel like I am protected in any way or under the radar. I feel pretty exposed, actually," Dr. Packer said.

As a result, physicians who make simple coding errors — an increasing likelihood, given evolving, complex compliance measures — may get punished. The threat of compliance watchdogs looking into medicine at least adds stress on an already taxed profession.

"It's a distraction," Dr. Packer said. "This isn't just Medicare. We have all the commercial insurers to deal with too."

#### Data-driven process

Some ophthalmic business experts believe that small practices will bear a disproportionately heavy administrative burden. Unlike highly specialized staff in large, multimillion-dollar practices, managers of smaller solo and two-physician practices need to wear many hats simultaneously, Mr. Pinto said.

"Most administrators are time-poor and are really drinking from a fire hose," Mr. Pinto said. "They've got so much else going on, and ultimately, if they're at all diligent, they're having to go to more meetings, they're having to read up more, they're having to just become more aware of the broad issues."

**Laurie K. Brown, COMT, COE, OSA, OCS**, practice administrator for Drs. Fine, Hoffman and Packer in Eugene, Ore., attributed increasing paperwork to a shift in ophthalmic coding from an intuitive function to a more data-driven activity.

"The way we have to code is similar to an accounting formula rather than really based on the doctor's perception of what is a brief visit, intermediate visit or comprehensive visit," Ms. Brown said. "It's not intuitive anymore, so we have continuing education to try to help people to think this way."

When facing an audit, a practice should seek advice from a qualified coding consultant, OSN Practice Management Board Member **Riva Lee Asbell** said.

"I think the really smart thing to do, the first time you get an audit, is to contact a coding consultant and get instructions on how to handle it," she said. "I have found those who take it seriously from the beginning do very well. The auditors go away and often don't come back. ... Handle it right from the beginning."

Cover story continues on page 12

#### POINT / COUNTER

### As regulatory pressure on practices mounts, would more performance incentives and a more stable physician payment system induce physicians to continue serving Medicare patients?

#### POINT

##### Permanent Medicare physician pay cut not likely

Despite the combined efforts of physicians of all specialties, Congress was unable to replace the sustainable growth rate, deciding to pass yet another temporary fix that will last until November 30, 2010. At that time, physicians caring for Medicare patients will owe the U.S. Treasury in excess of \$220 billion, and we will once again be at risk for 21% or greater cuts during the lame-duck Congress. It seems unlikely that Congress would let a permanent reduction happen, given the likely access issues that would quickly develop among beneficiaries.

In addition to fixing payment instability, it is time that Congress recognizes that physician payments have fallen well behind the rate of medical supply inflation and solve the sustainable growth rate problem. Medicine should be involved in determining this fix. A repeat of 2010 is not a sound financial model for health care. Unfortunately, the sustainable growth rate solution will likely come with new responsibilities, reforms and penalties for participating providers, such as limits on new technology, comparative effectiveness benchmarks and quality outcome measures. Stakeholders will need to carefully evaluate these limits to determine the best balance between payment stability and payment reform allowing their continuing participation in the program.

**Michael X. Repka, MD**, is the American Academy of Ophthalmology's secretary for federal affairs. He practices at the Wilmer Eye Institute, Johns Hopkins University School of Medicine, Baltimore, Md.



Michael X. Repka

#### COUNTER

##### Pay cuts will force physicians to drop Medicare

As the sustainable growth rate debacle continues with no permanent fix, doctors are becoming more and more disenchanted with participation in the Medicare program because of poor reimbursement that does not keep up with the ever-increasing expenses of running a practice.

Some ophthalmologists with large Medicare patient populations are opting out of Medicare. In December 2010, physicians who participate in Medicare will be facing a 23% cut in reimbursement for professional fees. This translates into a 46% cut in physician take-home pay! (This assumes 100% of practice revenue comes from Medicare.) This is totally untenable for physicians who are running a practice with payroll and other fixed costs. Therefore, physicians need a permanent fix to the sustainable growth rate to create a stable practice environment so they can continue to care for Medicare patients. If this happens, it will help to slow the defection by physicians from Medicare and preserve Medicare patient access to physicians.

Concomitant with stagnation of physician fees over the past 10 years, performance incentives such as the Physician Quality Reporting Initiative have been a failure because of the amount of work involved for the minimal increase in payment. A high percentage of physicians who participated in the Physician Quality Reporting Initiative in 2009 did not receive the promised reimbursement. Also, the Obama health insurance reform, the Patient Protection and Affordable Care Act, makes the Physician Quality Reporting Initiative punitive, so that physicians who do not participate will start receiving punitive cuts in reimbursement starting in 2015.

In my opinion, Medicare is very important for our elderly, but it is a defined benefit plan that is oversubscribed and underfunded. It needs to be changed to a defined contribution plan, with patients able to upgrade their level of benefit by contributing their own capital. This will make patients better health care consumers and will also help to reduce government spending on Medicare.

**Brock K. Bakewell, MD, FACS**, is chairman of the American Society of Cataract and Refractive Surgery's Government Relations Committee, co-director of Fishkind, Bakewell & Maltzman Eye Care and Surgery Center in Tucson, Ariz., and is assistant clinical professor of ophthalmology at the University of Utah.



Brock K. Bakewell

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Knowledge gap

As regulatory requirements mount and government scrutiny intensifies, ophthalmology has a wide knowledge gap regarding current Medicare billing and coding regulations. The gap can be attributed to a lack of time and insufficient training in ophthalmology-specific coding. Coding is singularly more complex in ophthalmology than in other medical specialties, Ms. Brown said.

“We are such a different animal from any other specialty in medicine,” she said.

The knowledge gulf can be bridged with due diligence and full use of available resources, Ms. Asbell said.

“There is a wealth of information out there that providers don’t take advantage of because they are either too busy or unaware of its existence. The same applies to their staff,” she said. “But it’s really important because once it’s published as public information,

you are held to any laws or regulations that Medicare has issued.”

For example, the Centers for Medicare and Medicaid Services offer various resources on their website, [www.cms.hhs.gov](http://www.cms.hhs.gov). The Medicare Learning Network is an online source of educational materials, manuals, videos, notices and toll-free call centers for providers.

Medicare providers can sign up with their Medicare contractor to get e-mail alerts and other updated information,

according to Ms. Asbell. Contractors are required to pass information to providers, she said.

“When CMS transmits to the contractors, then they are obliged to contact and give that information to providers,” she said. “They do it through the Internet. That’s available for everyone.”

Contractors also offer informational meeting and online seminars for providers and staff, Ms. Asbell said.

To get current ophthalmology-specific coding regulations, practice managers may wish to attend coding courses sponsored by the American Academy of Ophthalmology, American Society of Cataract and Refractive Surgery, state and local societies, smaller ophthalmic societies, and academic centers such as Wills Eye Institute in Philadelphia, Ms. Asbell said.

Mr. Pinto and Ms. Brown advised practice managers to rely on multiple advisors and consultants to get a complete picture of regulatory requirements.

Physician and staff involvement

According to Ms. Asbell, less than 10% of practicing ophthalmologists are well-trained in coding.

“They all sort of hobble by, but very few really understand it and expend the time to take an all-day course such as the annual course given at Wills Eye Institute in Philadelphia,” she said.

A team approach to practice management is the best way to maximize the accuracy of Medicare claims, Ms. Brown said.

“We educate our entire billing and clinical practice staff on quarterly chart reviews. At staff meetings we bring up coding issues to make sure people are informed,” she said. “When we get new information from our many societies and newsletters, we share that information. You’ve got to keep talking about it every day and trying to make sure you’re not missing something and that you’re staying up-to-date with coding information, again, on a daily basis.”

Physicians’ lack of involvement in billing can doom a practice, Mr. Pinto said.

“When practices go belly-up, it’s almost always first due to a doctor’s just not being involved with billing at all, not knowing how to optimize reimbursement,” he said. “It would be like running a restaurant and not checking to see

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whether the waitresses know how much to charge for the steak and eggs.”

The physician, by virtue of being the most cognizant of the nature of an office visit, is best qualified to fill out a fee slip, Mr. Pinto said. The second best option is for the physician to call out codes to a scribe. The third option is for a scribe or technician present to report services performed, and for the physician to review the record.

“The worst approach is that the front desk takes a look at what was written in the chart and fills out the fee slip,” Mr. Pinto said.

Physician perspective on coding

Most experts agree that the days when administrative tasks could be safely delegated to administrative personnel have passed. Physicians at least need to be aware of the compliance issues or, ideally, heavily involved in ensuring that a practice runs smoothly and according to the rules.

Although there is much concern about overbilling within medical practices, there is incentive in dissecting a practice’s billing patterns. Regulators may be harping on recouping excessive payments, but at the same time, physicians may sometimes underbill a patient

encounter, either in error or due to an overly cautious approach.

“There is always concern about overbilling, but when you look at it, there is probably a fair amount of underbilling that goes on too,” Dr. Noecker said.

Electronic records are beneficial, and there are ample financial incentives available to underwrite implementation; yet, paper records can achieve the same level of thoroughness with the use of templates, checklists, reminders and cues for documenting required information.

Some practices employ scribes to document patient encounters, whereas physicians fill out codes in other practices. The growing sense among practitioners, however, is that each practice will practice uniquely. The trick seems to be finding a system that works and customizing it to meet specific needs.

“You can have it a lot of different ways, because we’re dealing with people here. Certain doctors are comfortable with a certain way of documentation, and that’s what works best for them, whereas for the next guy, it will be a different style,” Dr. Noecker said.

Ms. Brown noted that in her practice, the General Electric Centricity EMR

system helps office personnel streamline coding and billing functions, ultimately boosting accuracy and compliance.

“We have tools developed where if you pick the code or the doctors pick the code and the scribe isn’t sure it’s accurate or the doctor and the scribe aren’t sure, we have a way in our EMR to flag the code for the biller, so that at the end of the day they can all come together and look at the coding book and figure it out,” Ms. Brown said.

In addition, the EMR helped her practice prepare for a recent diagnostic audit performed by a carrier. Personnel simply had to call up records, copy them to PDF files and e-mail them to the carrier.

The EMR also allows billing staff to focus on maintaining accurate records as opposed to data input, Ms. Brown said.

“Since we’ve moved to the electronic world — and charges don’t necessarily have to be input because they’re imported from EMR to the practice management side — our billing personnel function a lot more as auditors now to make sure things are accurate than actually inputting, which is a very good change,” she said. – by Bryan Bechtel and Matt Hasson

References:

Medicare Learning Network. Centers for Medicare and Medicaid Services website. <http://www.cms.gov/MLNGenInfo/>. Accessed July 21, 2010.

Practice Management Information Corporation. *Medicare Compliance Manual 2011*. Los Angeles, CA: PMIC. In press.

Recovery Audit Contractor Overview. Centers for Medicare and Medicaid Services website. <http://www.cms.gov/RAC/>. Accessed July 21, 2010.

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