You're a Cataract Surgeon? Here's How Coding Impacts Your MIPS Cost Score

The Merit-Based Incentive Payment System (MIPS) involves four performance categories—cost, quality, improvement activities, and the EHR-based promoting interoperability. If you are scored on all four of those, the cost performance category would contribute up to 30 points to your MIPS final score.

Which cost measures apply to ophthalmology? During the 2023 performance year, only two of the cost measures are likely to apply to ophthalmologists. Cataract specialists and comprehensive ophthalmologists might be scored on the cost measure for routine cataract surgery, and the melanoma cost measure may apply to some oculofacial subspecialists.

Not everybody will be scored on cost. If you are reporting MIPS as an individual and none of the cost measures are relevant to you, you won't receive a cost score and the 30 points that are associated with cost would be distributed to one or more other performance categories. The same would be true if you were reporting as part of a group and none of the cost measures were relevant to anybody in the group.

You must be a MIPS eligible clinician. You won't be scored on any of the MIPS performance categories unless you are a MIPS eligible clinician. Ophthalmologists and optometrists who bill for Medicare patients are likely to be MIPS eligible clinicians, though some may be excluded from the program if, for example, they are new to Medicare or fall below the low-volume threshold. To learn more about MIPS eligibility, see "Who Does (and Doesn't) Take Part in MIPS" at aao.org/eyenet/mips-manual-2023.

An Overview of the Routine Cataract Surgery Measure

As with all cost measures, the Routine Cataract Removal With IOL Implantation measure does not involve any additional reporting on your part. Instead, CMS reviews information that is submitted as a matter of course when providers bill for Medicare patients. It uses this data to 1) attribute relevant surgeries to you and 2) track costs that are clinically associated with those procedures.

Which surgeries are attributed to you? In general, an episode of routine cataract surgery will be attributed to the MIPS eligible clinician who performed the procedure that "triggers" the episode. That procedure is known as the "trigger service," and the day on which it takes place is the "trigger day."

CPT code 66984 triggers an episode of care. Unless an exclusion applies, an episode of routine cataract surgery will be attributed to you if you bill CPT code 66984 *Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification); without endoscopic cyclophotocoagulation.* (Note: CPT code 66982 for complex cataract surgery would not trigger an episode.)

Exclusions may apply. When determining your score for the cataract cost measure, CMS will exclude surgeries involving significant ocular conditions, such as retinal detachment, that might impact the complication rate or the visual outcome.

Hundreds of ICD-10 codes may prompt an exclusion. In looking for ICD-10 codes that might prompt an exclusion, CMS will review Medicare Part B physician claims, inpatient claims, and outpatient claims with dates of service up to 120 days before the cataract surgery. For the cataract cost measure, there are hundreds of ICD-10 codes that would result in an episode of care being excluded. These include codes for the following diagnoses:

- Type 1 or 2 diabetes mellitus with ophthalmic complications (E10.3-, E11.3-)
- Central corneal ulcer (H16.01-) or opacity (H17.1-)
- Keratoconus (H18.6-)
- Open-angle glaucoma (H40.1-)
- Nonexudative and exudative macular degeneration (H35.3-)
- Chorioretinal inflammation (H30-)
  Note: dry eye syndrome (H04.12-)

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and keratoconjunctivitis (H16.22-) are not excluded diagnoses. For the full list of codes that would prompt an exclusion (including a few CPT codes), download the CMS measure specifications (see "More on Cost").

A 10-episode case minimum. The cataract measure will only contribute to your cost score if at least 10 episodes of care are attributed to you or, if you are reporting as part of a group, to your group during 2023.

What costs are included? The cataract measure's specifications include a list of CPT and HCPCS codes whose costs could be assigned to an episode of care (see "Examples of Assignable Costs"). CMS reviews the patient's Medicare claims over a five-month period to see if any of those codes have been billed. This review period includes a "pre-trigger window," which is the 60 days prior to the day of surgery (the trigger day) and a 90-day "post-trigger window."

CMS tries to account for costs that are beyond your control. Your costs for the measure will undergo standardization and risk adjustment. This is intended to account for cost variations that are beyond your control, such as geographic variations in practice expenses or patient characteristics that could lead to increased costs, such as patient age or comorbidities.

CMS uses subgroups to compare apples to apples. CMS recognizes that costs can vary depending on whether surgery was done in an ambulatory surgery center (ASC) or a hospital outpatient department (HOPD), and that costs can also vary depending on whether the cataract surgery is unilateral or bilateral (which it defines as the second surgery being done within 30 days of the first). Consequently, CMS divides episodes of routine cataract surgery into four subgroups and will only compare an episode's costs against the cost of episodes within the same subgroup. The subgroups for the routine cataract surgery measure are:

- Unilateral surgery in an ASC
- Bilateral surgery in an ASC
- Unilateral surgery in a HOPD
- Bilateral surgery in a HOPD

(Note: the 10-episode case minimum requirement applies to the measure as a whole, not to individual subgroups.)

CMS calculates your score. If your routine cataract surgeries fall within more than one of the subgroups, a weighted average of your subgroup scores will be used to determine your score for the cataract cost measure. Each subgroup score will be based on how your performance compares with that of others within that subgroup.

Examples of Assignable Costs

For the routine cataract surgery measures, which costs can be assigned to the episode of care? For a full list, download the measures specifications (see "More on Cost"), but here are a few examples:

Complications during the global period. Suppose complications of surgery result in additional costs being incurred. For example, a patient who has endophthalmitis (ICD-10 code H44.00-) may need a vitreous tap (CPT code 67015), an intravitreal injection of vancomycin (HCPCS code J3370), or even a pars plana vitrectomy (CPT code 67036). If these costs are incurred during the 90 day–post-trigger window, they would be assigned to the total cost for that episode of care.

Similarly, if cataract lens fragments are in the eye following cataract surgery (ICD-10 code H59.02-), the cost of removing them (CPT code 67036, 66850, or 66852)—which could be done by any ophthalmologist—would be assigned to your episode of care. A Nd:YAG laser capsulotomy (CPT code 66821) is another example of a service that could be assigned to your episode of care.

Intraoperative miosis. To prevent intraoperative miosis and to reduce postoperative pain, phenylephrine and ketorolac intraocular solution (Omidria, HCPCS code J1097) may be used, often as a separately payable drug in the ASC, and would be included in the cost of your episode of care. However, when the patient is diagnosed with miosis during the pre-trigger window and this is reported with ICD-10 code H57.03, the cost would not be included.

Punctal plug insertion. The cost of closing a lacrimal punctum using a punctal plug (CPT code 68761) is assigned, surprisingly, to the episode of care, regardless of whether it takes place in the pre- or post-trigger window. Under the CMS Medically Unlikely Edit (MUE) program, CPT code 68761 has a MUE of 4, which means it can be billed up to four times (for four eyelids), which can increase costs.

For a More Accurate Score, Follow Best Coding Practices

When CMS scores you on an episode-based cost measure, such as the routine cataract surgery measure, the agency uses the Medicare billing history to account for factors that might unfairly skew your score. However, the agency can take those factors into account and calculate costs fairly only if services are coded correctly. You should therefore review your use of CPT codes, Category III codes, HCPCS codes, ICD-10 codes, modifiers, and place of service codes—and, if appropriate, educate other providers on correct coding.

If a cataract evaluation determines that surgery is needed, report *all* relevant ICD-10 codes. Reporting the diagnoses that pertain to a patient encounter is a basic ICD-10 coding principle. By adhering to that, you can ensure that episodes of care are excluded appropriately. For example, if a patient has primary open-angle glaucoma and diabetic retinopathy and these problems were assessed at the cataract evaluation, make sure you report the ICD-10 codes for all of those diagnoses, not just the code for the cataract diagnosis.

Use laterality modifiers. Another coding rule is to always append the appropriate laterality modifier (–RT, –LT, or –50) to surgical CPT codes. For example, when billing for routine cataract surgery in the right eye, report 66984–RT. If you aren't using the

laterality modifiers, and you perform cataract surgery on the left eye within 90 days of that first surgery, the cost for both eyes will count toward both episodes, essentially doubling the calculation.

And beyond MIPS, the absence of the laterality modifier can cause claim denials or prompt a payer review to confirm that you aren't billing twice for cataract surgery in the same eye.

Use the correct place of service (POS) code. When calculating costs for a cataract surgery, CMS will include facility costs. Those can vary greatly between the ASC and the HOPD, so make sure the surgery is allocated to the appropriate subgroup by reporting the correct POS code:

- 19 for off campus HOPD
- 22 for on campus HOPD
- 24 for ASC

Billing for evaluations can impact an episode's costs. ASCs and hospitals often require a history and physical (H+P) before cataract surgery, but billing for that will increase the costs associated with the procedure. If a limited examination is necessary, the surgeon may provide the H+P as a part of a nonbillable preoperative visit or during the cataract evaluation.

Watch out for how other specialists bill for consults. Suppose the patient's primary care provider orders a consultation for a nonophthalmic condition, such as chronic obstructive pulmonary disease (COPD). If the consulting physician bills for the visit using the cataract ICD-10 code in addition to the COPD ICD-10 code, the costs of that consultation and subsequent workups and tests will count toward your episode of care if they fall within the five months of Medicare billings reviewed by CMS. Without the cataract ICD-10 code on the claim, the costs won't be included.

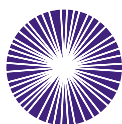
In summary. Although not all costs associated with routine cataract surgery can be controlled, you can impact your score by adhering to fundamental coding principles and reviewing the cataract measure specifications to see which services might be assigned to your episode of care.

MORE ON COST

For more information on the cost performance category, visit aao.org/medicare/cost.

To get the CMS measures specifications for the routine cataract surgery cost measure and the melanoma resection cost measure, go to qpp.cms.gov/resources/resource-library, scroll down to "Full Resource Library," select the appropriate performance year and then select "MIPS" as the QPP reporting track, "Cost" as the performance category, and "Measure Specifications" as the resource type, and download the 2023 MIPS Cost Information Forms zip file.

Note: Each MIPS performance year, make sure you download an updated version of the measure specifications.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