

# TOA NEWSLETTER

Texas Ophthalmological Association

February 2020

## Bylaws Changes Inside

### President's Message

By Mark Gallardo, MD  
[president@TexasEyes.org](mailto:president@TexasEyes.org)

As 2019 has come to an end, we usher in our goals for the upcoming year, goals both personal and professional. The beginning of 2019 was very active on a legislative side and the end of 2020 will no doubt bring challenges to organized medicine throughout the country, through scope of practice battles, reimbursement cuts, abuse of prior authorizations from Medicare Advantage Plans and more.

#### *TOA Bylaws Changes – Including Name Change*

For years, our staff and consultants have apprised us of the difficulty that lawmakers and the public have distinguishing between the two arms of eye care.

When our members meet with lawmakers and their staff, time is very short and precious. We introduce ourselves as ophthalmologists – and we often see immediate confusion on the other side of that handshake. Even our TOA acronym is the same as that of the Texas Optometric Association. Imagine trying to differentiate between “Hi, I’m Dr. Eyecare from TOA and we support House Bill X,” and “Hi, I’m Dr. Eyecare from TOA and we oppose House Bill X” multiple times per day. It is understandably confusing.

At the May 2019 Executive Council meeting in Dallas, a motion passed to propose changing the name of Texas Ophthalmological Association to **Texas Society of Eye Physicians and Surgeons**. Because each of us has been trained as a physician and surgeon, this name leaves no doubt about who we are and what we do. In order to make the change, we need to amend our bylaws. The proposed bylaws changes as presented by the Executive Council are found in this newsletter. There are additional proposed changes besides the name change. We will discuss the issue and have a vote during the Annual Business Meeting on Friday, May 1, 2020 in Fort Worth. Voting members include Provisional and Regular members only.

We hope to see you all there and welcome your input.

I want to congratulate you all on a successful 2019 and wish you a 2020 filled with warmth, compassion, love and success.

*P.S. See the summary of significant bylaws changes on page 19.*

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# Editor's Message

## Coding & Reimbursement Update

By John Haley, MD, Chair, TOA Liaison Committee to Third Party Payors and Peer Review Agencies  
coding@TexasEyes.org

As 2020 begins, we are enduring the presidential impeachment trial and more legal threats to the Affordable Care Act as well as more Democratic presidential debates. But our world of Medicare payment policy must go on. Medicare payment policy continues to change, and I want to bring you up to date.

First, some background on valuation. Since 1992, the Centers for Medicare and Medicaid Services (CMS) and most other payers have made payments based on relative value. The RVS Update Committee (RUC) of the American Medical Association (AMA) factors in components from three areas before voting on values. The RUC then makes its annual relative value recommendations to CMS.

Payments are determined by the resource costs needed to provide them, with each service divided into three components:

**wRVU:** This is the physician work component. The physician work component accounts for an average of 51% of the total relative value for each service. The physician work is based on *time* and *intensity* of work on the date of service and post-op visits. Survey-derived data are compared *relative* to other procedures.

**PERVU:** This practice expense component accounts for an average of 45% of the total relative value for each service. It is based on clinical staff time, equipment costs plus time used, and supplies.

**PLIRVU:** This professional liability insurance component accounts for an average of 4% of the total relative value for each service. It is based on national trends for malpractice premiums.

**Total Value = (WRVU + PERVU + PLIRVU) x CF (2020 = \$36.0896)**

### Specialty Impacts Since 2009

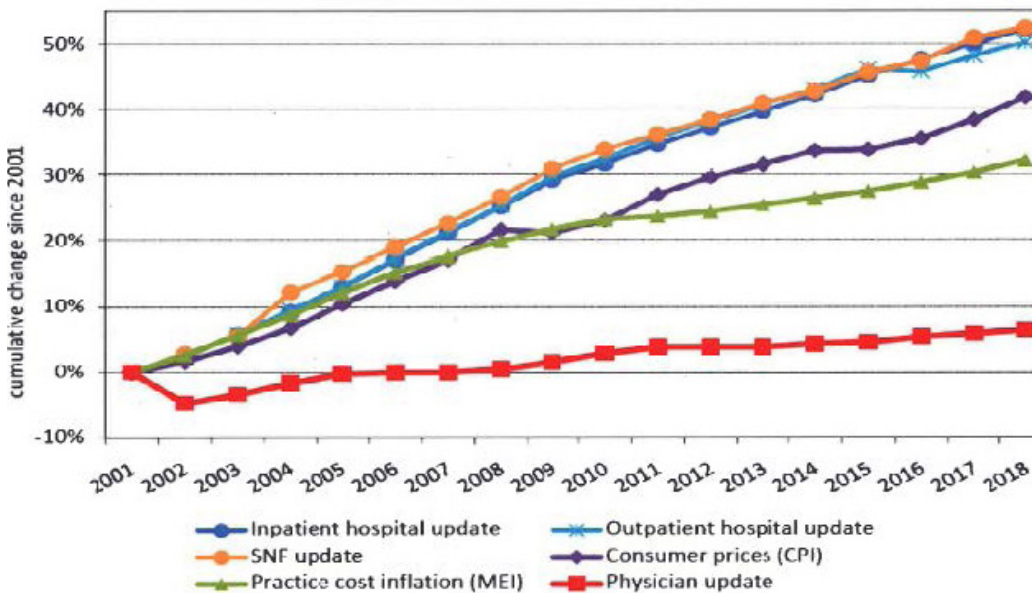
| Specialty       | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | Total |
|-----------------|------|------|------|------|------|------|------|------|------|------|------|-------|
| Ophthalmology   | 0%   | 5%   | 0%   | 1%   | -3%  | 0%   | -2%  | -1%  | 0%   | 0%   | -1%  | -1%   |
| Cardiology      | -2%  | -8%  | -2%  | -2%  | -2%  | 1%   | 1%   | 0%   | 1%   | 1%   | -1%  | -13%  |
| Neurology       | 1%   | -2%  | 2%   | 1%   | -7%  | -1%  | -1%  | -1%  | 0%   | 0%   | -2%  | -10%  |
| Neurosurgery    | 0%   | -1%  | -1%  | -1%  | 0%   | 0%   | 1%   | -1%  | 0%   | 0%   | 1%   | -2%   |
| Otolaryngology  | -1%  | -2%  | 3%   | 1%   | 0%   | -2%  | 0%   | 0%   | -2%  | -2%  | -1%  | -6%   |
| IDTF (e.g. Rad) | -6%  | -17% | -25% | -6%  | -10% | -13% | 0%   | 0%   | 0%   | 0%   | -4%  | -81%  |
| Rad Oncology    | -3%  | -1%  | -1%  | -6%  | -7%  | 1%   | 0%   | -2%  | 1%   | 1%   | -2%  | -19%  |
| Urology         | 0%   | -4%  | -3%  | -2%  | -1%  | -1%  | 0%   | 0%   | -1%  | -1%  | 3%   | -10%  |
| Vascular Surg   | 1%   | -2%  | -2%  | -2%  | -2%  | -2%  | 0%   | -1%  | -1%  | -1%  | -1%  | -13%  |
| Family Practice | 2%   | 4%   | 2%   | 1%   | 7%   | 0%   | 1%   | 0%   | 0%   | 0%   | 1%   | +18%  |
| Geriatrics      | 3%   | 3%   | 1%   | 1%   | 5%   | 1%   | 1%   | 0%   | 0%   | 0%   | -1%  | +14%  |

Note that ophthalmology has done relatively well with just an overall decrease of 1% whereas most other procedural specialties have had double digit decreases and primary care cognitive specialties have had double digit increases.

## The Ugly

Ophthalmology will have a 4% payment decrease for 2020. Note the increase in payment to other providers over the years: in-patient hospital, skilled nursing facility update, practice cost inflation, out-patient hospital update and consumer price index.

### Medicare Updates Compared to Inflation (2001-2018)



Your coding questions can be sent to [coding@texaseyes.org](mailto:coding@texaseyes.org)

## Ophthalmic Procedures Revalued for 2020

- Cataract (66984), Complex Cataract (66982)
- Endocyclophotocoagulation (ECP) (66711)
- Combined Cataract/ECP (two new codes: 66987, 66988)
- Extended Ophthalmoscopy (two new/redefined codes)
- Corneal Hysteresis

### Cyclophotocoagulation

This is performed to reduce intraocular pressure. 66711 was identified as being regularly performed with cataract surgery. The RUC recommended the establishment of new codes. 66987 and 66988 describe when an endoscopic cyclophotocoagulation is performed at same encounter as extracapsular cataract removal with intraocular lens insertion. **Per below, Codes 66711, 66982, 66984 were revised to clarify the reporting of endoscopic cyclophotocoagulation when performed at the same time as cataract surgery.**

#### *Cyclophotocoagulation (66711) - Revision*

▲ 66711 Ciliary body destruction; cyclophotocoagulation, endoscopic, without concomitant removal of crystalline lens

*Continued on page 4*



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► (For endoscopic cyclophotocoagulation performed at same encounter as extracapsular cataract removal with intraocular lens insertion, see 66987, 66988) ◀

### ***Complex Cataract without Cyclophotocoagulation (66982)***

▲ 66982 Extracapsular cataract removal with insertion of intraocular lens prosthesis (1- stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex; without endoscopic cyclophotocoagulation

► (For complex extracapsular cataract removal with concomitant endoscopic cyclophotocoagulation, use 66987) ◀

(For insertion of ocular telescope prosthesis including removal of crystalline lens, use 0308T)

### ***Complex Cataract with Cyclophotocoagulation (66987)***

**66987** with endoscopic cyclophotocoagulation

► (For complex extracapsular cataract removal without endoscopic cyclophoto coagulation, use 66982) ◀

### ***Cataract without Cyclophotocoagulation (66983-66984)***

**66983** Intracapsular cataract extraction with insertion of intraocular lens prosthesis (1 stage procedure)

▲ **66984** Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); without endoscopic cyclophotocoagulation

(For complex extracapsular cataract removal, use 66982)

► (For extracapsular cataract removal with concomitant endoscopic cyclophotocoagulation, use 66988) ◀

### ***Cataract without Cyclophotocoagulation (66983-66984)***

**66983** Intracapsular cataract extraction with insertion of intraocular lens prosthesis (1 stage procedure)

▲ **66984** Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); without endoscopic cyclophotocoagulation

(For complex extracapsular cataract removal, use 66982)

► (For extracapsular cataract removal with concomitant endoscopic cyclophotocoagulation, use 66988) ◀

## Cataract with Cyclophotocoagulation (66988)

66988 with endoscopic cyclophotocoagulation

▶ (For extracapsular cataract removal without endoscopic cyclophotocoagulation, use 66984) ◀

▶ (For complex extracapsular cataract removal with endoscopic cyclophotocoagulation, use 66987) ◀

### RUC Recommendations 2020: Cyclophotocoagulation w/wo Cataract

| CPT Code | Current Work RVU | RUC Rec. Work RVU | Proposed CMS RVU |
|----------|------------------|-------------------|------------------|
| 66711    | 7.3              | 6.36              | 5.62             |
| 66982    | 11.08            | 10.25             | 10.25            |
| 66983*   | 10.44            | Carrier Priced    | Carrier Priced   |
| 66984    | 8.52             | 7.35              | 7.35             |
| 66987    | N/A              | 13.15             | Carrier Priced   |
| 66988    | N/A              | 10.25             | Carrier Priced   |

*“One of the penalties for refusing to participate in politics is that you end up being governed by your inferiors.”*

*– Plato*

*Vote in the March primary elections!*

### Combined Cataract/ECP Codes

CMS rejected the RUC recommendation and proposed carrier pricing for the combined cataract/ECP codes. CMS was unable to formulate a rationale to set a price, stating a lack of crosswalks. The problem with using carrier pricing is that it is inconsistent with precedent. The RUC did present a rationale for the recommended price, supported by survey data. CMS did not present an alternative.

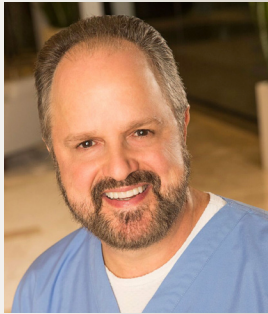
The AAO supplied MACS with RUC pricing and I think that Novitas will adopt these values:

|                                  |       | <u>Total RVU</u> |
|----------------------------------|-------|------------------|
| 66987 Complex Cat 66982 with ECP | \$865 | 23.99            |
| 66988 Cat IOL 66984 with ECP     | \$706 | 19.58            |

This new pricing disenfranchises two long-standing covered procedures. It increases the burden, work and confusion for physicians and carriers because prices must be negotiated by each Medicare Administrative Contractor (MAC) and the MACs have no more expertise than CMS does in developing rational pricing. Additionally, different payments are confusing for practices with patients from more than one MAC.

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*Jeffrey Whitman, MD of Dallas completed his service as our alternate representative to Novitas' Contractor Advisory Committee.*

*Dr. Whitman spoke up for eyecare patients as a volunteer on this committee for many years.*

### Cataract (66984), Complex Cataract (66982)

|                         | 2019     | 2020 (est) | Decrease (%)  |
|-------------------------|----------|------------|---------------|
| Cataract: 66984         | \$654.47 | \$557.58   | \$96.89 (15%) |
| Complex Cataract: 66982 | \$813.04 | \$765.82   | \$47.22 (6%)  |

CMS accepted the RUC recommendations here. The decrease for 66984 primarily reflects one less post-op visit (three vs. four). The reduction in 66982 is related to the 10% reduction in intraoperative time. Cataract remains one of the most highly valued 90-day global procedures on a time base. Minute for minute, it is valued higher than thoracotomy, carotid endarterectomy, CABG and craniotomy.

### **Extended Ophthalmoscopy (EO)**

CPT eliminated initial and subsequent codes for EO. There are new codes for drawing of:

- Peripheral retina, with scleral depression: 5% increase in value over deleted initial EO;
- Optic nerve or macula: 32% decrease compared to deleted initial EO.

Extended ophthalmoscopy is changed from unilateral to bilateral, which amounts to an additional 50% cut when both eyes are drawn.

Extended ophthalmoscopy was identified by the RUC as high utilization. The rationale for these changes is that codes 92225 and 92226 differed only by initial or subsequent evaluation. These codes have been deleted because it was determined that the initial and subsequent exams involved the same physician work, but there were distinct differences between posterior pole and peripheral exam work.

### **Ophthalmoscopy (92201-92202)**

- ~~92225 Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report; initial~~
- ~~92226 subsequent~~
- 92201 Ophthalmoscopy, extended; with retinal drawing and scleral depression of peripheral retinal disease (eg, for retinal tear, retinal detachment, retinal tumor) with interpretation and report, unilateral or bilateral
- 92202 with drawing of optic nerve or macula (eg, for glaucoma, macular pathology, tumor) with interpretation and report, unilateral or bilateral
- ► Do not report 92201, 92202 in conjunction with 92250 ◀

## RUC Recommendations 2020: Ophthalmoscopy

| CPT Code | Current Work RVU | RUC Rec. Work RVU | Proposed CMS RVU |
|----------|------------------|-------------------|------------------|
| 92201    | N/A              | 0.40              | 0.40             |
| 92202    | N/A              | 0.26              | 0.26             |

High volume, Low Reimbursement

- 92201 \$23.45 (\$28.11 – 2019)
- 92202 \$15.15 (\$28.11 – 2019)

But bilateral code now.

## RUC Recommendations 2020: Corneal Hysteresis

This is identified by the New Technology/New Services screen. It is used as a glaucoma screen. It will be a very low allowable.

| CPT Code | Current Work RVU | RUC rec. Work RVU | Proposed CMS RVU |
|----------|------------------|-------------------|------------------|
| 92145    | 0.17             | 0.10              | 0.10             |

## Category III Codes

### Category III Revision: Collagen cross-linking of Cornea

▲ **0402T** Collagen cross-linking of cornea, (including removal of the corneal epithelium and intraoperative pachymetry, when performed (Report medication separately) (Do not report 0402T in conjunction with 65435, 69990, 76514).

The revised language included in code 0402T now addresses the FDA-approved drug utilized during the procedure. The descriptor clarifies the medication is not included in the CPT descriptor, and is to be reported separately.

### New Category III Code

**0563T** Evacuation of meibomian glands, using heat delivered through wearable, open-eye eyelid treatment devices and manual gland expression, bilateral

- (For evacuation of meibomian gland using manual gland expression only, use the appropriate evaluation and management code) ◀

Not to be confused with existing code:

*Ophthalmology's new alternate representative to the CAC is William Plauche, MD of Sherman.*

**0207T** Evacuation of meibomian glands, automated, using heat and intermittent pressure, unilateral ► (For evacuation of meibomian glands using heat delivered through wearable, open-eye eyelid treatment devices and manual gland expression, use 0563T.

## Evaluation & Management Code Proposals

These proposals are scheduled to go into effect January 2021. The level 1 new patient code would be eliminated. The proposal introduces prolonged service and complexity add-on codes. It calls for substantial increases in payment for level 2-5 office visits. The AAO's goal here is to apply E&M increases to the value of:

- Postop visits: \$115 million increase in Medicare payments to ophthalmology
- Eye codes (92002-92014): \$267 million increase in Medicare payments
- If post op visit codes are not included in increase, could be 2x worse overall than this year's cataract cut

### New Patient E&M Work Values (2021)

| CPT Code | Current wRVU | Proposed wRVU | Increase |
|----------|--------------|---------------|----------|
| 99201    | .48          | Code deletion | NA       |
| 99202    | .93          | .93           | 0%       |
| 99203    | 1.42         | 1.60          | 13%      |
| 99204    | 2.38         | 2.60          | 9%       |
| 99205    | 3.17         | 3.50          | 10%      |

### Established Patient E&M Work Values (2021)

| CPT Code | Current wRVU | Proposed wRVU | Increase |
|----------|--------------|---------------|----------|
| 99211    | .18          | .18           | 0%       |
| 99212    | .48          | .70           | 46%      |
| 99213    | .97          | 1.30          | 34%      |
| 99214    | 1.50         | 1.92          | 28%      |
| 99215    | 2.11         | 2.80          | 33%      |

The common theme here is to increase payment to primary care. It's a zero-sum game where payments are being shifted away from specialty/surgical care. Over the past ten years, primary care has seen 14-18% increases while specialties have seen 1-20% decreases (81%

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IDTF). This is politically driven and based on multiple flawed assumptions, such as the theory that increased payments for “cognitive” care will attract more PCPs. There are too few PCPs and too many proceduralists. There is one characteristic common to all of the healthcare workforce prediction since 1910: all have been wrong.

PCP management is the answer to out-of-control spending, but this has not been demonstrated outside of capitated or salaried systems. Having more PCPs will improve access to care, but lack of insurance and high deductibles/copays will remain the primary barriers to access.

This is all good unless you are a surgeon. Currently, EM post-op visit codes will not be increased in the 10-90 day GF periods and will mean an 8% overall cut to us next year. This flagrant change fails to maintain the relativity in the Medicare Fee Schedule and it is being strongly protested by the AAO and ASCRS. The law requires that physicians receive the same payment for the same services regardless of specialty. But we have a year to try to correct this injustice.

## ASC Changes

CMS has finalized a change effective November 29, 2019 aimed at reducing regulatory burdens for ASCs.

The new health and physical requirement replaces the requirement that the assessment be completed by a physician not more than 30 days before the scheduled surgery with the maintenance by the ASC of a policy that identifies those patients who require a medical history and physical examination prior to surgery.

Regarding ASC payments, the ASC conversion factor for 2020 is \$47.747 which is a 2.6% increase from 2019. Now ASCs and hospital OPDs get the same adjusted market basket update:

- For those facilities that meet reporting requirements \$45.795 (\$46.532 - 2019) for those that do not
- 66984 \$1,012.72 (2019 - \$976.84)

The facility’s policy must include:

- Timeframe for the H&P to be completed prior to surgery,
- Patient age, diagnosis, the type and number of procedures scheduled to be performed on the same surgery date,
- Known comorbidities and the planned anesthesia level.

Upon admission, each patient must have a pre-surgical assessment completed by a physician or other qualified practitioner, in accordance with **applicable state health and safety laws** where surgery is performed. The ASC is no longer required to have a written transfer agreement with a hospital, and physicians no longer need to have admitting privileges in hospital.

There is a push to equalize hospital OPD rates with ASC rates. Of course, OPD rates will decrease to ASC rates, and ASC volume will increase.

## For 2020

The MF’s conversion factor is \$36.0896 (\$36.091 – 2019). Almost flat.

- 14% budget neutrality adjustment
- Update as established in MACRA – 6 year pay freeze
- Only fee increase will be APM or MIPS

*Continued on page 10*

# Medicare Value-Based Payment Overview and 2020 Update

The Quality Payment Program (QPP) offers two programs for reimbursement under Medicare Part B:

1. Merit-based Incentive Program System (MIPS)
2. Advanced Alternate Payment Model (APM)

APMs are generally not available to ophthalmology so we must use MIPS or suffer the penalty.

## MIPS Payment Adjustments

The payment baseline is standard FFS payments. The adjustment is partial or full based on the final score. MIPS payment adjustments are applied to services provided under Part B. This system is budget neutral – there must be winners and losers. The exceptional performance pool is \$500M for five years (2019-2023).

## 2018 MIPS Performance: Ophthalmology vs. the Rest of the Field

100% of ophthalmology avoided the 5% penalty; this avoidance is worth on average \$20,086 per ophthalmologist. 99.9% ophthalmologists reporting qualified for a bonus, and 81.85% qualified for an exceptional bonus. Those 6.11% who had a perfect score will see a 1.68% bonus. These numbers are based upon numbers from the IRIS Registry®.

Compare those numbers to MIPS participants overall. 96.8% avoided the penalty and 96.12% qualified for a bonus.

## 2019 MIPS Eligibility

There are three exclusions for eligibility:

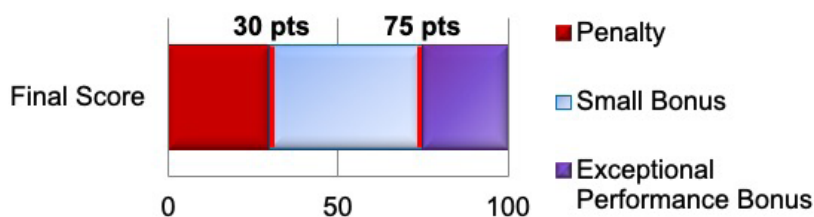
1. New Medicare Provider: Enrolled in Medicare for the first time during performance year
2. Low-Volume Threshold:
  - Clinician bills Medicare Part B no more than \$90,000 OR
  - Clinician sees 200 or fewer Medicare Part B patients
  - *\*NEW\** Clinician provides *200 or fewer covered professional services* to Part B patients.
3. APM Participation: Clinician is a qualified participant in an Advanced APM

If none of these exclusions applies, the MD/DO/OD is eligible to participate in MIPS. Note that exclusions reduce the potential bonus pool.

## MIPS Final Score

As explained, the MIPS final score is the sum of the weighted category scores:

- Score of 30 points required to avoid a penalty
- Between 30 points and 75 points, clinicians can earn a small bonus
  - MIPS is budget-neutral, so the sum of these bonuses cannot exceed the sum of penalties
- At or above 75 points, clinicians earn an exceptional performance bonus



## QPP Year 4: Performance Year 2020

MIPS is getting harder. Here is the 2020 and 2021 proposed scoring:

| Threshold                                | 2019      | 2020      | 2021 (Proposed) |
|--|-----------|-----------|-----------------|
| <b>Threshold to Avoid a Penalty</b>      | 30 points | 45 points | 60 points       |
| <b>Exceptional Performance Threshold</b> | 75 points | 85 points | 85 points       |

Here are the MIPS proposed performance category weights:

| MIPS Category                          | Score Weight 2017 | Score Weight 2018 | Score Weight 2019 | Score Weight 2020 | Score Weight 2021 (proposed) | Score Weight 2022+ (proposed) |
|--|-------------------|-------------------|-------------------|-------------------|------------------------------|-------------------------------|
| <b>Quality</b>                         | 60%               | 50%               | 45%               | 45%               | 35%                          | 30%                           |
| <b>Promoting Interoperability (PI)</b> | 25%               | 25%               | 25%               | 25%               | 25%                          | 25%                           |
| <b>Improvement Activities (IA)</b>     | 15%               | 15%               | 15%               | 15%               | 15%                          | 15%                           |
| <b>Cost</b>                            | 0%                | 10%               | 15%               | 15%               | 25%                          | 30%                           |

### MIPS 2020

For MIPS 2020, eligibility is unchanged. For cost, ophthalmology is specifically excluded from the total per capita cost measure. The weighting for this category will move to quality. And for quality, the data completeness threshold increases to 70% from the 60% in 2019. Only small practices will maintain the three-point floor on quality measures (larger practices will receive 0 points on quality measures that do not meet data completeness.)

There are no significant changes for 2020 for promoting interoperability.

For improvement activities, the group reporting requirement is that 50% of NPIs in a TIN must perform the IA for the same 90+ consecutive day period (only one clinician was required in 2019.)

For small practices, the PI hardship is maintained. The 6-point small practice bonus in the quality category is maintained. The double credit for each IA is maintained.

### **Two Quality Measures Removed**

The following two quality measures will be removed in 2020:

- Measure 192 – Cataracts – complications within 30 days following cataract surgery requiring additional surgical procedures
- Measure 388 – Cataract surgery with Intraoperative Complications – unplanned rupture requiring vitrectomy

Many providers feel that MIPS is not worth the effort due to the time and resources required. The

*Continued on page 12*

## ***New TOA Job Board***

*The new TOA job board  
is the perfect place to  
look for ophthalmic  
personnel or partners,  
and sell/buy equipment,  
and more.*

***[www.texaseyes.org/  
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exceptional performance bonus is 1.68%. Yes, the program is budget neutral and rewards require new resources. Gains are minimal. But non-participation can cost you a 7% penalty in 2021 from 2019 participation.

### **The IRIS Registry® is a No Brainer**

The AAO's IRIS Registry has tracked 250 million patient visits from 60 million patients. The benefits are many. It helps meet quality reporting requirements thus making MIPS compliance a non-issue. It provides at least one outcome or high priority measure for most participants to report. It supports credit for improvement activities. IRIS facilitates promoting interoperability reporting by including a web entry portal. For bonus quality points, IRIS Registry participation allows for reporting multiple outcomes measures and electronic reporting through IRIS Registry-integrated EHR.

### **How Can Ophthalmology Survive?**

The AMA is the only organization that represents all of medicine – but only 20% of docs are members. The AAO & ASCRS represent our profession, amounting to 3% of all docs. And within the AAO, ASCRS and AMA – less than 18% of our members contribute anything to our political action committees (PACs). In contrast, the hospital lobby spends 50x more than medicine combined. Physician compensation is still at the high end of the American job market. The Washington reality is that Washington runs on political contributions. In order to impact and improve healthcare, we must have good political relationships, good medical data, sound policy and a large increase on PAC contributions – IT'S THE COST OF DOING BUSINESS.

## **Medicare Advantage**

Medicare originated in 1966. Private managed Medicare Advantage (MA) Plans have been around since the early 1980s. They promised to reduce costs by more efficiently competing with regular Medicare. They were also intended to improve patient choice and enhance quality. Risk-based plans were to assume liability for beneficiary health expenses by capitation.

These promises were not fully realized. Today, Medicare Advantage enrollment is now 35% of the Medicare base. The plans are still paid more than regular Medicare. Sick patients are forced back to regular medicine for more complete and unobstructed care. There is increased choice for some, but it's impossible to truly compare plans until one uses them. Quality has not improved – this is very difficult to measure, and these plans are not required to use MIPS. The MA plans are paid more for greater risk scores due to increased coding intensity. MA is only good for patients if they don't get sick. For a patient who is enrolled

in an MA and then returns to regular Medicare, the supplemental plans are not required to take them or they can rate their premiums on illness severity.

So why does MA still exist if the original goals have NOT been met after 40 years? Conservatives fear “socialized” single payor Medicare. The conservative thinking is that private companies can manage care more efficiently than government-run regular Medicare. Additionally, medical complaints to Congress can be answered with “now you have multiple choices so just change plans” rather than requiring Congressional action to fix regular Medicare.

Medicare Advantage is our **largest** clinical problem today. It demands step therapy, prior authorization, and risk adjustment audits. Communication is very difficult. Try to get anyone to fix a mistake – good luck. You must contact your regional CMS office as they have oversight, not Novitas.

### “Protecting and Improving Medicare for our Nation’s Seniors”

The Administrative Executive Order on October 3, 2019 directs the secretary of HHS to submit a report to the President on ways to transition FFS Medicare to payments to more closely reflect the prices paid for services in Medicare Advantage Plans and Commercial Insurance Market. Read between the lines. If you accept below Medicare rates, that might be your new Medicare fee profile.

## New Glaucoma Device LCD

The MACS are carving out the billing and coding information from the LCDs and putting it in articles so now you must look at both the LCD and the article.

MIGS – CGS, Novartis and FCSO came out the same day. They are collaborating policy – good.

- LCD Micro Invasive Glaucoma Surgery (L38225)
- Article – Billing + Coding Surgery (A56633)

*Single insertion per eye of anterior segment drainage device without extraocular revision, via internal approach into the trabecular meshwork or with creation of intraocular revision into supraciliary space in conjunction with cataract surgery for mild or moderate glaucoma.*

- 019T – iStent, Hydrus, iStent Inject
- 449T – Additional Stent

*A single insertion per eye of an aqueous drainage device without extraocular reservoir via internal approach into the subconjunctival space.*

C O D **Q**uest  
2020

**Register today at**  
**[www.TexasEyes.org](http://www.TexasEyes.org)**  
**or call TOA at**  
**(512) 370-1504.**

Registration on page 21

**Lubbock**  
**Friday, March 27**

**Dallas**  
**Saturday, March 28**

**Houston**  
**Saturday, April 4**



***“You must  
now use  
J7999 for  
all Avastin.”***

Stand alone for refractory Glaucoma, after failed filter or cilioablative technique, or MAX tolerated medical therapy (4 classes of topical meds or fewer if intolerated or ineffective.

### **XENGelstent – 0449T**

#### **NO Diagnosis limitation**

65820 – Goniotomy

65850 – Trabeculotomy

66170 – Trabeculectomy

66172 – Trabeculectomy with scarring

#### **NON COVERED**

0253T – iStent Superior

0376T – Additional iStent or iStent Inject

0450T – Additional Cypass

0474T – Cypass

#### **Limitations – NOT COVERED**

1. Non FDA approved or recalled devices (Cypass)
2. Devices used outside of FDA approval
3. Insertion of anterior segment drain device via internal approach into suprachoroidal space (Cypass)
4. Additional insertion of anterior segment aqueous drain device via internal approach into trabecular meshwork
5. Insertion of device into trabecular meshwork or supracilliary space NOT performed with cataract surgery
6. Goniotomy performed in conjunction with the insertion of a glaucoma drain device – may trigger for a Medical review
7. Insertion of glaucoma drain device (one or two microstents) into the meshwork or supracilliary space, limited to one inserter per eye with cataract surgery. Additional inserter not medically necessary.
8. Insertion of glaucoma drainage devices into the subconjunctival space is limited to one device per eye per day. Additional devices are NOT medically necessary.

#### **Provider Qualifications**

- Device insertion allowed only by Board Certified Ophthalmologist.
- Must have training in a residency, fellowship or extensive CME by courses sponsored by an US Academic Institution or specialty/subspecialty society with AMA category 1 credit.

## Other 2020 News

CMS will adopt prior authorization for 2020 for blepharoplasty if performed in HOPD (not ASC).

Medicare Premiums and Deductibles:

- Part B Premium ↑ 7% to \$144.60/month
  - Deductible ↑ \$13 to \$198
- Part A Deductible ↑ \$44.00 to \$1,408
  - Social Security Cost of Living ↑ \$24/month

## Avastin & New FDA Regulation

There are three 503B Compounding Pharmacies: Avella, Pine and Leiter's.

Last summer the FDA implemented a new Avastin compounding regulation to regulate the number and size of particles delivered in intravitreal Avastin. Silicon particles have become a big problem and some lawsuits have been filed. Apparently, the cause is silicone particles from TBC syringes lubricated with silicone. The new regulation requires more extensive milipore filtering of Avastin and use of silicone-free syringes, currently Normject. Avella was the first compounding pharmacy to make the switch and supply was in havoc for several months. Furthermore, Normject syringes use 2 times more Avastin than the TBC syringes so it costs more. Also, more Avastin is wasted in filtering. Many providers have not made the switch to the safer Normject syringes so there are different acquisition costs.

Meanwhile, Novitas received complaints about too low an affordable for Avastin J9035 and decided to find out why by requiring all to begin using the unlisted J7999 to fill Avastin and submit invoices for payment. It was a disaster as invoices rained all over the place and payment was spotty and variable (never high). There has been much confusion but I think the problem has been solved.

**You must now use J7999 for all Avastin. If you continue to use J9035, you will be subject to possible recoupment.** Remember that the physician or practice is the only group who will be billing for the individual use of the compounded drug. There is no separate facility billing, part A. Done in a hospital or facility, it would not be provider expense.

IRIS Registry shows us that only 45% of anti-VEGF use is Avastin and more expensive branded drugs are 55% and make up 30% of the Part B ophthalmology Medicare benefit. The two branded drugs are preventing us from fee increases due to budget neutrality. Good drugs but their greed is killing ophthalmology. Further, I hate to see the MACs do anything to discourage use of Avastin when possible but when the hassle becomes severe and payment is low and spotty, I can see why some turn to the branded drugs. Terrible for society and Medicare.

## Other important topics:

**MIPS** – There is a long-term glitch with NextGen that will not allow direct messaging so one cannot close the referral loop and are penalized in MIPS patients. Why can NextGen not fix this?

**Know Your Payors** – Be sure to make sure your payors pay what the contract states and stick to their fee schedules as many times they do not. Recent mistakes we have seen: Humana – pays \$23 or a contract \$43 for OCT RNFL. Wellmed – copays incorrect, dual checks sent, no collection of 2% sequestration for last 8 months They have? Initiated a fix but it still goes on.

**PCP referrals** – we continue to see wrong DX, wrong documentation, wrong location, wrong service authorization. If any are not correct, payment will not be made. You must go to the website to see if the referral is valid.

*Continued on page 16*

**Durezol Ophthalmic** – I rarely if ever push a commercial product but this is special. Strong performance by Novartis. With the patent on Durezol running out soon, rather than discontinuing the product and allowing a generic product to take the market, Novartis did a very smart thing – surprise – they are lowering the cash price to \$60, effective November, 2019. You just send an eRX to Script Hero Pharmacy in your EMR or call 1-866-747-4276 along with patient contact information and they do the rest. What are the alternatives? As we all know, you can get generic prednisolone acetate for \$100 or more and everything else goes up from there. I believe the case for Durezol is that it is very potent and according to the AAO Retinal Technology Group at the AMA annual meeting prevents CME with no added benefit of using NSAIDS. So if you use Durezol, you no longer need expensive NSAIDS and all for \$60. It may be even cheaper if your drug insurance covers it. There are some good stories out there regarding drug companies.

**HHSC Restores OCT Policy** – New Medicaid Coding Rules for OCT Testing as of January 1, 2020. Jack Pierce, MD and Rachael Reed met with the medical director of HHSC last year and the TOA wrote letters urging HHSC to reconsider its unreasonable limit of two OCT exams per year. The policy is now up to 12 per year but prior authorization will be required over 2 per year. This to me will be an improvement but might further discourage anyone wanting to participate in the fee schedule which is about 60% Medicare rates and then one must waste time with prior authorization? Details:

**121.** Procedure code 92134 does not require prior authorization for the first two services performed in a calendar year. Providers may request additional services with prior authorization for a total of 12 services per calendar year.

**122.** Prior authorization requests must be submitted on a SMPA Request Form and must include documentation of medical necessity for the following circumstances: 122.1. Monitoring patients with conditions affecting the optic nerve (e.g. optic neuropathy) or retinal disease (e.g., macular degeneration, diabetic retinopathy) and in the evaluation and treatment of certain macular abnormalities (e.g. macular edema, atrophy associated with degenerative retinal diseases) including: 122.1.1. Patients being treated with bevacizumab, aflibercept, pegaptanib sodium, dexamethasone, or ranibizumab for either diabetic retinopathy or macular degeneration.



Dr. Haley and his wife live as sustainably as they can, tending to urban chickens and beehives in Dallas.

## Final Thoughts

Finally, be very alert in the upcoming year regarding healthcare reform which certainly will be a major issue in the next election. Seventy percent of Americans support Medicare for All or at least a Medicare option for all. But no one really understands what that really means or how that will impact our current private system. I have regular Medicare personally with a Type F supplement and I am 100% covered and I love how it works and am very confident in the coverage. As before, I am very leery of the Medicare Advantage plans. Last week one of my smartest and best-informed ophthalmology leaders told me that if we did have Medicare for All, it would certainly be run by the Medicare Advantage companies. Now that is a deal breaker for me as it does not work for the patients or the docs unless you are not sick. So be alert – the devil is in the details and I have no idea where we will finally end up, but they cannot do it without us, the docs, as stakeholders. Only we can take care of the medical problems.

## Questions from the TOA Herd

**Question:** When I place a toric IOL, I use the new millascope mounted keratoscope to align the toric axis. I am billing 0514T and Medicare will not allow payment.

**Answer:** Let's reason this together. The device that determines the visual axis using patient fixation to make toric alignment 0514T is a Category 3 emerging technology code and most payers do not cover Category 3 codes. Further, these devices are used for premium IOL toric lens placement which is not covered so the device to place it is also not covered.

**Question:** We have always used eye codes for reimbursement. Our newer associate is considering using an E&M 4 level code instead of a comprehensive eye exam code, since it pays a little more. Are offices using that code now and can it be justified with a comprehensive visit that is fairly routine? We don't want to trigger a Medicare audit or anything of that nature.

**Answer:** You must meet the more rigorous medical decision making criteria for level 4-5 codes; only a small percentage of office visits meet those criteria. It's worth the effort for NP 4-5th level codes and established patient 5th level codes.

**Question:** My billing team has mentioned the inconsistent payments from payers when billing out a 92134 for the usage of long-term medication. They have paid in the past, but when we bill it the same way, it is now denied. We normally bill the condition (disease) first and the high-risk medication code as a second ICD-10. Suggestions?

**Answer:** Medicare pays for high-risk medications DX but many private carriers do not. You must code the medical DX like Lymes or RA and some just do not pay for the scan but they are rare.

**Question:** I am bringing an optometrist to my practice to work part time for just six to seven months. Can this optometrist see patients and bill under my Medicare provider number, even if that means a reduced rate? The process of him obtaining his own number could last as long as his time working here.

**Answer:** No. Because optometrists are considered physicians under Medicare, he must obtain his own Medicare provider number. The only advice is to start the process with Medicare well in advance of the optometrist's start date.

**Question:** We would like to determine the legality of selling compounded eyedrops to patients directly from our office. For example, if the drops cost \$35 and we charge the patient \$40 (cost plus a \$5 handling fee), is this legal?

**Answer:** A reminder to members that the Texas Administrative Code indicates that only in exceptional circumstances may a physician supply drugs to patients other than to meet their immediate needs. And even in these exceptional circumstances, it is a violation of the Code to profit (i.e. handling or delivery fee) from the delivery of the drug. The rule doesn't make any distinction or exception for compounded drugs.

*The Annual Meeting is free for TOA members.*

# TOA Annual Meeting

**May 1-2 in Fort Worth**

These three invited guest speakers will again make our meeting one of the best state meetings in the country. Mark your calendar. The 2020 business meeting will include the presentation of the Distinguished Service Award and voting on significant bylaws changes.

## **Teprotumumab and its Use in Thyroid Eye Disease**

Raymond Douglas, MD, PhD  
Director of the Orbital and Thyroid Eye Disease Program  
Cedars-Sinai Medical Center  
Los Angeles, CA

## **John H. and Anna Marie Fish Memorial Lecture: The Eye in Alzheimer's Disease**

Alfredo Sadun, MD, PhD  
Flora L. Thornton Chair, Doheny  
Vice-Chair of Ophthalmology, UCLA  
Los Angeles, CA

## **The Bright Future for Cataract Surgery**

Douglas D. Koch, MD  
Professor and Allen, Mosbacher, and Law Chair in Ophthalmology  
Department of Ophthalmology  
Baylor College of Medicine  
Houston, TX





# Summary of Proposed Bylaws Changes

Below is a summary of the most significant proposed changes, with the full amendments on the enclosed pages.

Per policy, members must be notified of any proposed bylaws changes 30 days before voting occurs.

The mission statement, bylaws and principles of professional conduct may be amended at the Annual Business Meeting on Friday, May 1, 2020 in Fort Worth by a two-thirds vote. Voting members include Provisional and Regular members only.

## **PROPOSED AMENDMENT: TOA Name Change**

**Explanation:** The proposed change from Texas Ophthalmological Association to Texas Society of Eye Physicians and Surgeons will help the public better understand that ophthalmologists have completed medical school and are trained as physicians and surgeons.

## **PROPOSED AMENDMENTS: Membership**

Article I. MEMBERSHIP, Section 1. A: Provisional Membership.

**Explanation:** Requiring completion of a three-year ophthalmology residency training period for provisional membership for our future members indicates a high standard of care for patients. Current members will not be subject to this change.

Article I. MEMBERSHIP, Section 1. C: Senior Associate Membership.

**Explanation:** This category will be eliminated so that those practicing part time will remain voting members with full benefits. Current senior associate members may remain in the category for five years. By May 1, 2025, remaining senior associate members will move to another membership category.

Article I. MEMBERSHIP, Section 1. F: Emeritus Membership.

**Explanation:** This will change to Lifetime Membership. These fully retired members may opt to pay one-quarter of Regular dues to retain the right to vote and receive mailings.

## **PROPOSED AMENDMENT: Executive Council Voting Privileges**

Article II. OFFICERS, Section 4.

**Explanation:** AAO Councilors and Alternate Councilors will be able to vote on matters before the Executive Council.

## **PROPOSED AMENDMENT: Annual Meeting**

Article III. ANNUAL MEETING, Section 2.

**Explanation:** Removing the mandate that our annual scientific and business meetings be held in conjunction with Texas Medical Association's annual meeting simply allows flexibility for future meetings.

## **PROPOSED AMENDMENT: Dues**

Article VIII. DUES, Section 1.

**Explanation:** It is important for the leadership of any membership organization to have the authority to set dues to ensure the financial wellbeing of the organization. It should be noted that TOA dues have not increased in over 18 years and there are no current plans to raise them.

## **PROPOSED AMENDMENT: Committees**

Article IX. STANDING COMMITTEES

**Explanation:** Some committees have become obsolete.

## **PROPOSED AMENDMENT: Principles of Professional Conduct**

II. RULES OF PROFESSIONAL CONDUCT, a. Competence.

**Explanation:** The residency requirement reflects the change made to provisional membership.

## **PROPOSED AMENDMENT: Principles of Professional Conduct**

II. RULES OF PROFESSIONAL CONDUCT, h. Postoperative Care.

**Explanation:** The wording "eye care professional" acknowledges the surgeon's judgment and ability to co-manage with non-physicians when appropriate.

## Welcome New Members

**Kristen S. Held, MD, San Antonio**  
**Christopher R. Henry, MD, Houston**  
**Leslie Pfeiffer, MD, Dallas**  
**Mark Phelan, MD, Abilene**  
**Ashvini K Reddy, MD, San Antonio**  
**Mark Suggs, MD, Wichita Falls**  
**Keven Wells, MD, Bryan**

## In Memorium

**Charles R. DeHaven, MD** of Tyler died October 2019.  
**Frank Grady, MD** of Lake Jackson died January 2020.  
**William Lee Phelps, MD** of Dallas died November 2019.  
**James Allan Stoeckel, MD** of Brookeland, died May 2019.

## TOA at Your Lions Club Meeting

Recently, **Marie Bui, MD** spoke to the Austin Founders Lions Club on diabetic retinopathy; **Mark Trevino, MD** spoke to the San Antonio Founder Lions Club about cataract surgery. At both meetings, Rachael Reed, executive director, gave a brief presentation on the history and mission of TOA.

If you know of an opportunity to present at your local Lions Club meeting or would like TOA to reach out on your behalf, contact Rachael Reed at [exec@TexasEyes.org](mailto:exec@TexasEyes.org).



*TOA executive director  
**Rachael Reed**  
was inducted as a  
member of the Austin  
Founder Lions Club in  
December, 2019.*





# Texas Ophthalmological Association

## 2020 Codequest Lubbock/Dallas/Houston

*In conjunction with the American Academy of Ophthalmic Executives*

### Which course?

**Lubbock, March 27** (early bird March 16)  **Dallas, March 28** (early bird March 16)  **Houston, April 4** (early bird March 23)

### 1: Registration & Fees (check one registrant category):

|                          |  | By early bird date | After early bird date | Total |
|--------------------------|--|--------------------|-----------------------|-------|
| <input type="checkbox"/> | <b>TOA Member and/or Staff</b>                 | \$295 x ____       | \$350 x ____          | \$    |
| <input type="checkbox"/> | <b>Resident or Fellow</b>                      | Free!              | Free!                 | \$    |
| <input type="checkbox"/> | <b>Non-Member Ophthalmologist and/or Staff</b> | \$395 x ____       | \$450 x ____          | \$    |

### 2: Name of Ophthalmologist associated with this registration: \_\_\_\_\_

### 3: Registrant Listing (please complete all lines for each registrant for continuing ed. purposes; copy page for additional names):

Full Name & Credentials: \_\_\_\_\_  
 Job Title: \_\_\_\_\_ Clinic: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Full Name & Credentials: \_\_\_\_\_  
 Job Title: \_\_\_\_\_ Clinic: \_\_\_\_\_  
 Mailing Address (if different from above): \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

**ADA:**  check here if you need any auxiliary services identified with the Americans with Disabilities Act.

### 4: Payment

Method:  **check payable to TOA**     **VISA**     **MC**     **AMX**

Card Number: \_\_\_\_\_  
 Expiration Date: \_\_\_\_\_ CVV #: \_\_\_\_\_  
 Name on Card: \_\_\_\_\_  
 Complete Billing Address: \_\_\_\_\_

**Return this form to:** Mail: Texas Ophthalmological Association, 401 w. 15<sup>th</sup> St., Ste. 825, Austin, TX 78701  
 Fax: (512) 370-1637; Online: [www.TexasEyes.org](http://www.TexasEyes.org); Email to [toa@TexasEyes.org](mailto:toa@TexasEyes.org), or call (512) 370-1504.

# Congressional Advocacy Day 2020 – Scholarships Announced

Congratulations to these young ophthalmologists who will represent Texas inside the US Capitol during AAO's Congressional Advocacy Day and Mid-Year Forum in Washington DC in April. Thank you to the program directors for nominating them and allowing for time off:

*Any AAO member  
may attend  
Congressional  
Advocacy Day,  
April 22-25.*

*Go to [www.aao.org/meetings](http://www.aao.org/meetings).*

**The San Antonio Uniformed Services Health Education Consortium**  
Marshall Hill, DO  
Gregory “Bryant” Giles, DO

**Baylor Scott & White Eye Institute**  
Timothy Sipos, MD

**UT Health Science Center Houston**  
Colleen Yard, MD

**Baylor College of Medicine**  
Mohamed “Mo” Mohamed, MD

**University of Texas Medical Branch**  
Eric Niespodzany, MD  
Karima Khimani, MD

**UT Southwestern Medical Center**  
David Seamont, MD  
Zachary Keenum, MD  
David Fell, MD  
Isabella Herrera, MD  
Parsha Forouzan, MD

**Texas Tech University HSC**  
Peter Clark, MD  
Madison McMenemy, MD

**UT Health San Antonio**  
Effe Rahman, MD  
Alexander Foster, MD



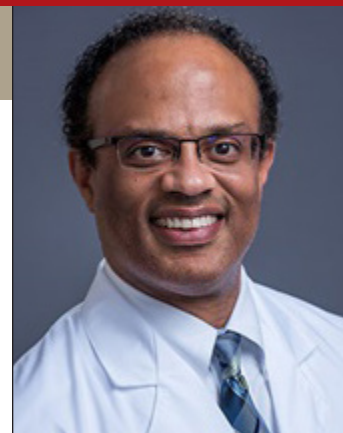


# Proud to be an Eye Physician

*Ophthalmology is one of the very best specialties in medicine. Our eye physicians and surgeons tend to be leaders in their communities and life-long learners.*

## **An interview with Jeremiah Brown, Jr., MD**

*Dr. Brown is a retina specialist practicing in Schertz, Texas.*



### **Why did you choose retina as your subspecialty? Would you choose it again?**

As an ophthalmology resident, I was fascinated by the complexity and seemingly miraculous function that the retina performs. I was amazed to see that nearly every systemic disease process has a manifestation in the retina. My mentor Ed Stone at the University of Iowa kindled my interest in the genetics of retinal diseases and the exciting future that lies ahead in the next 10-20 years. Now, during my day in the clinic, I may walk from one room with a 40-year-old patient struggling with retinitis pigmentosa, then a 20-year-old with VKH uveitis, then a hard-working 30-year-old diabetic patient who is going blind from a traction retinal detachment and never took the time out to get an eye exam. The challenges and success stories are what keep me going every day. I would definitely choose this field again.

### **You have been an active leader with several ophthalmic organizations including the FDA's Ophthalmic Devices Committee. What was that experience like?**

I had the privilege to serve on the FDA Ophthalmic Devices Advisory Panel for several years. I developed a deep appreciation of what it takes to bring a new device to market. I had to confront the challenges of balancing public safety with the desire to bring new devices to patients who may have no other hope for a cure. It was a very valuable experience.

### **What inspired you to get involved in OMIC leadership?**

In 2017 I began working with Ophthalmic Mutual Insurance Company (OMIC), serving on two committees. Years earlier I had attended an OMIC forum at the AAO Annual Meeting, being delivered by Anne Menke, PhD. I was struck by her thoughtfulness and very detailed analysis of the behaviors that can lead to medical lawsuits. When I was given the opportunity to work with OMIC, I jumped at the offer.

### **What are your leadership aspirations?**

I hope to continue to work with OMIC and serve on its Board or Directors. I am also passionate about keeping what we do on the minds of the public. At the present time, much of how medicine is delivered is being directed to us by nonphysicians. We see time-consuming elements being required within our EMR notes that have nothing to do with the care of the patient or the patient's outcome. More and more often, the value of the care that we deliver is being lowered despite the outstanding advances in care that we are making for our patients. When we argue against a reimbursement cut, we need to argue from the standpoint of what VALUE this care gives to the patient. We should not be arguing about whether a particular ophthalmic procedure should be paid more or less than a particular orthopedic procedure. People value vision. We need to communicate this better to the public and our legislators.

### **How can your colleagues lead?**

I strongly encourage all ophthalmologists to reach out at least once a year to a legislator. This can be at your local state representative's office or nationally in Washington D.C. This is invaluable. While attending the AAO Mid-Year Forum last April, we visited several members of Congress. It was striking that at one of our meetings the representative said, "Now tell me more about this prior authorization issue. I didn't realize that it even was an issue for you." If we are not there, they will not understand any of our issues. Furthermore, the message is taken much more seriously when coming from a constituent, rather than from a lobbyist.

### **What do you enjoy doing when you're not at work?**

When I'm not working, I enjoy running, traveling, and visiting the ocean. Life has been busy recently having three kids in high school and two just out of college. Lots of band concerts, basketball games, football games and performances. It's all good!!!





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## Upcoming Events

**February 1, 2020**

Codequest  
*San Marcos*

**March 27, 2020**

Codequest  
*Lubbock*

**March 28, 2020**

Codequest  
*Dallas*

**April 4, 2020**

Codequest  
*Houston*

**April 23-25, 2020**

AAO Congressional Advocacy Day  
and Mid-Year Forum  
*Washington, DC*

**April 30, 2020**

TOA Executive Council Meeting  
4 pm  
*Any TOA member may attend*  
*Fort Worth*

**May 1-2, 2020**

TOA Annual Meeting  
& TexMed  
*Fort Worth*

**December 4 – 5, 2020**

TMA Advocacy Retreat  
*Austin, TX*

Go to [www.TexasEyes.org](http://www.TexasEyes.org) or contact TOA at 512-370-1504.