



# TOA NEWSLETTER

Texas Ophthalmological Association

February 2021

## Coding Update Inside

## President's Message

By *Mark L. Mazow, MD*  
president@TexasEyes.org

The 87th Texas Legislative Session is well under way. Amidst protests and a pandemic, our State Legislators are undertaking the business of the State of Texas. What form this session will ultimately take is still not known. It is also unclear whether legislative business will be limited to budgetary matters alone or whether other matters will come before the Legislature. In any case the TOA staff and Executive Council are monitoring events in Austin and are ready to let our voice be heard on matters relating to protecting quality eye care for the citizens of the State of Texas.

While access to the Capitol complex will be limited and hearings will be a hybrid of in-person and virtual formats, there will be opportunities for you to advocate for patients. First Tuesdays are being organized by the TMA, albeit in a virtual and somewhat truncated format. Sign up today for at least one First Tuesday – February 2, March 2, April 6 and May 4. Registration is free, briefings will start at noon and last only about an hour. Go to <https://www.texmed.org/FirstTuesdays/> to register.

If you have any personal relationships with our state legislators, now is the time for you to reach out to them and educate them on quality eye care. Offer yourself as a resource should they have any questions regarding medicine. It is easy to do this with the “take action” tool provided at [www.safevisiontexas.org/](http://www.safevisiontexas.org/). JOIN Safe Vision Texas while you are at it.

While there have been no inappropriate scope of practice expansion bills filed yet, the session has just begun. Watch your e-news, especially for any legislative alerts. If we ask you to call your representative, this means that we very much need you to reach out. This is very important.

### Annual Meeting Update

In an abundance of caution, the Education Committee and the Executive Council have voted to not hold traditional CME meetings at TexMed this year. We felt that the virtual platform would not allow us to best honor our speakers or bring you the high-quality interaction to which we have become accustomed. We will again hold elections electronically. The CME portion of our annual meeting along with awards and our business meeting will be back strong at TexMed in Houston, April 29-30, 2022.

TOA will bring you Codequest and valuable OMIC, pain management, and human trafficking CME courses this year. Additionally, we encourage everyone to take advantage of the plentiful CME offerings that will be part of TexMed 2021, which will be held May 14-15. TOA members who are not TMA members will still attend free as a TOA member benefit.

### Keep the Faith

This is a very difficult year both from a medical standpoint and with the rising political, social and cultural tensions in the nation. I know we will get through this. While things may seem dark now and may get worse before they get better, they will get better. Keep the faith...

401 W. 15th St.,  
Suite 825  
Austin, Texas  
78701-1667

(512) 370-1504

[toa@TexasEyes.org](mailto:toa@TexasEyes.org)

[www.TexasEyes.org](http://www.TexasEyes.org)

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# Editor's Message

## Coding & Reimbursement Update

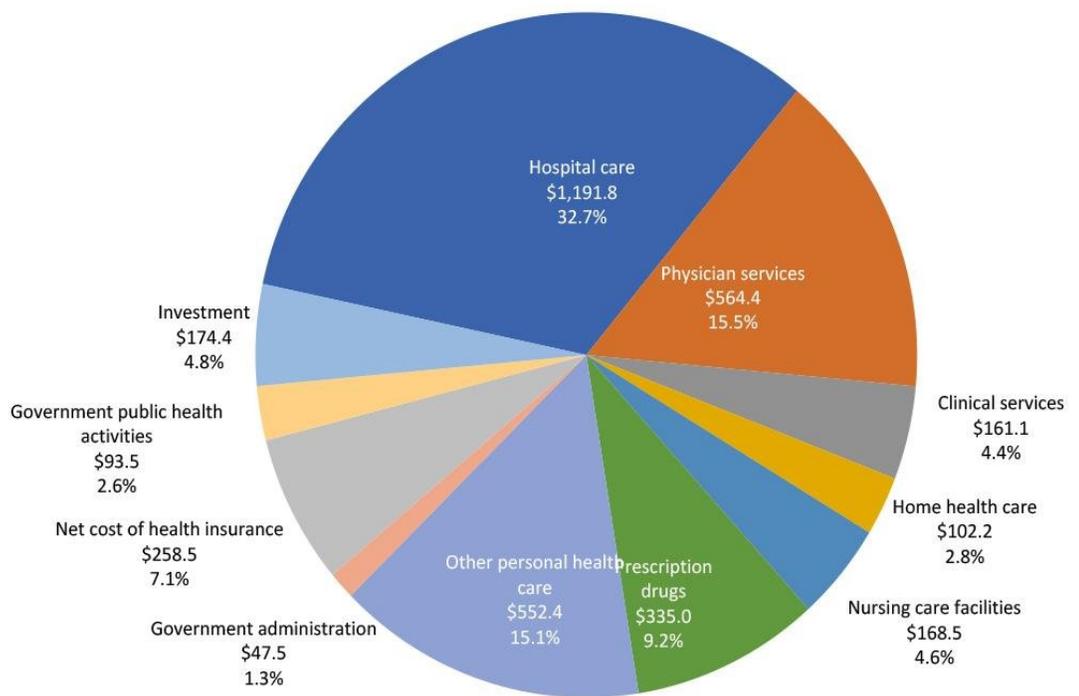
By John M. Haley, MD, OCS, AAO Health Policy Committee, Novitas Medicare CAC, TOA 3rd Party Liaison Chair, TOA Newsletter Editor

[coding@TexasEyes.org](mailto:coding@TexasEyes.org)

At year's end 2020, Congress and the US Senate passed the Consolidated Appropriations Act of 2021, a 6,000-page legislative package to run our government for 2021. It will have great implications on our Medicare Fee Schedule (MFS) and downstream to all our other fee schedules. Before we discuss the specific changes, I want to review how we got here.

### Annual US Healthcare Spending

All Spending: \$3,649 Billion



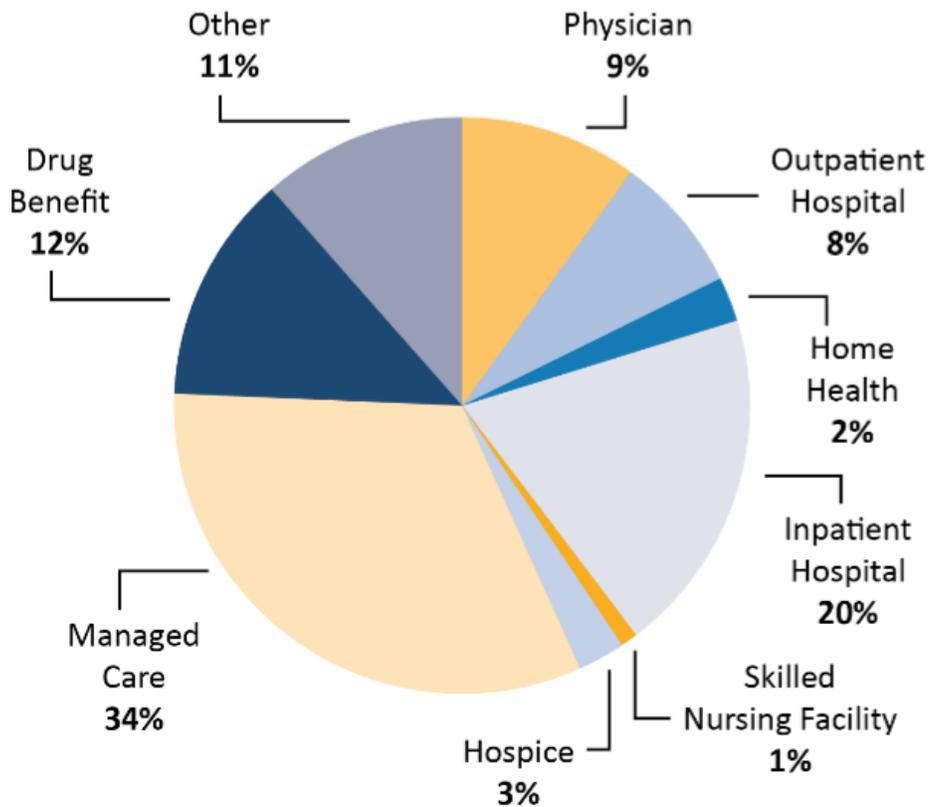
**VIRTUAL**  
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**2021**

March 27th, 2021

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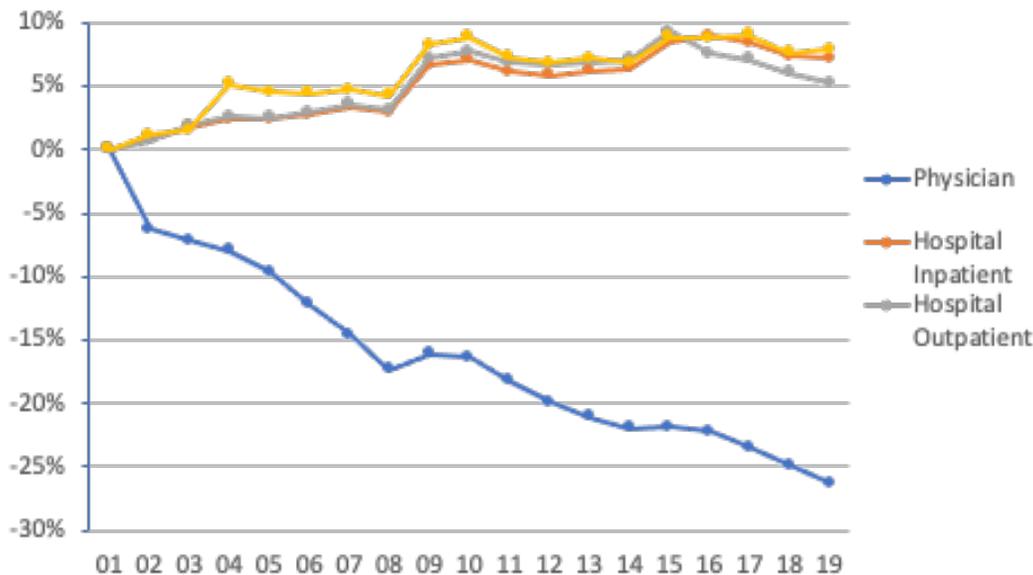
## Medicare Spending: \$842 Billion



Note that the healthcare Medicare spending pie is fixed, and physicians receive only 9%. As services, devices or drugs increase, the pie slice for physicians gets smaller.

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

## Inflation-Adjusted Medicare Payment Updates



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**SAFE VISION TEXAS**

**Access to Quality  
Patient Eyecare for  
All Texans**

**SafeVisionTexas.org**

As you can see, physicians have received negative payment updates in the last 20 years as opposed to all other providers such as hospitals, inpatient and outpatient and skilled nursing facilities.

## **Common Theme: Give More \$ to Primary Care.**

The assumptions are three-fold. One assumption is that there are too few PCPs and too many proceduralists. But healthcare workforce predictions since 1910 share one characteristic: all have been wrong. A second assumption is that PCP management is the answer to out-of-control spending. This has not been demonstrated outside of capitated or salaried systems. A third assumption is that having more PCPs will improve access to care. The reality is that lack of insurance and high deductibles/copays are the primary barriers to access to care.

It is a zero-sum game where payments to primary care must be shifted away from specialty and surgical care. In the last 10 years, primary care reimbursement has increased 14-18% whereas specialty reimbursement has decreased 1-20% (81% IDTF). This formula is politically driven and based on multiple flawed assumptions. Increased payments for “cognitive” care will attract more PCPs, in fact PCP payments have already increased.

To reward and encourage primary care physicians, the Centers for Medicare and Medicaid Services (CMS) greatly increased the values of many of the E/M codes (the eye codes were not included in the increase.)

The increase in E/M codes and the new add-on inherently complex E/M visit (G2211) must be paid for somehow as the Medicare payment is limited within this zero-sum game. Therefore, the Medicare Conversion Factor (CF) was to be reduced by 10.2% across the board for all CPT codes.

## **A Proposed 10.2% Reduction in the Medicare CF – Why?**

Budget neutrality decreases payments for all services via reducing the CF. This CF reduction was triggered by anticipated expenditure increases greater than \$20 million. There was a \$10.2 billion increase in spending targeting primary care as follows:

- \$5.6 billion: RUC-recommended increased payments for E/M services
- \$3.3 billion: New CMS-created add-on complexity code for E/M services
- \$1.3 billion: Other CMS-approved increases

Under this scenario, cataract surgery 66982, 66984 would have undergone a 9% decrease and all surgical codes would have received cuts.

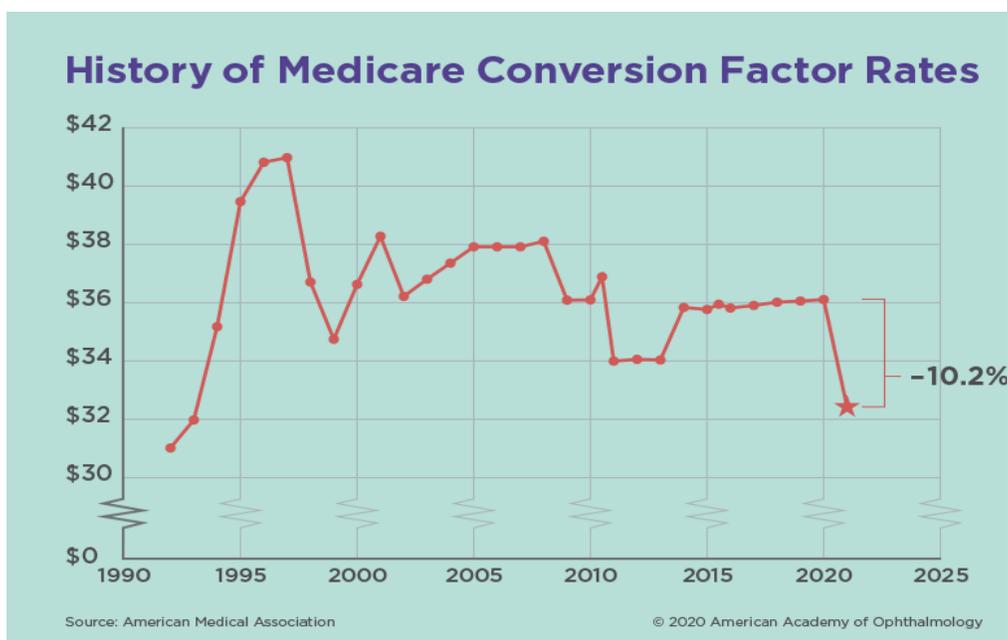
## Payment Based on Relative Value Since 1992

The RVS Update Committee (RUC) votes on values and makes recommendations to CMS.

- **Physician work: WRVUs**
  - Based on *time* and *intensity* of work on date of service and postop visits
  - Survey-derived data compared *relative* to other procedures
- **Practice expense: PERVUs**
  - Based on clinical staff time, equipment costs and time used, supplies
- **Professional liability insurance cost: PLIRVUs**
  - Based on national trends for malpractice premiums
- **Total Value = (WRVU + PERVU + PLIRVU) x CF (2021 = \$32.4085)**

## Steep Drop in Payment in 2021 – We Dodged This Bullet for One Year Only

The relative value units (RVUs) are multiplied by a conversion factor set by CMS to convert the RVUs into payment rates. The 2021 conversion factor finalized by CMS was \$32.41, a decrease of \$3.68 (-10.2%) from the 2020 rate of \$36.09. This would have resulted in the lowest since 1993. Thanks to the 2021 Appropriations Act, the CF has been changed to \$34.89 for 2021, one year only.



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## E/M Code Changes in Effect January 2021

- Eliminates the level 1 new patient code (99201)
- Introduces *prolonged service* and *complexity* add-on codes
- **Substantial increases** in payment for level 2-5 office visits
- E&M increases not applied to value of
  - Postop visits: \$115 million increase in Medicare payments to ophthalmology
  - Eye codes (92002-92014): \$267 million increase in Medicare payments

January 2021 – The largest change to E/M codes since incorporation 1992 and single specialty definition 1997.

Office based (11) or OUT patient Facility (22)

- E/M code allowable will be greatly INCREASED

### NOT THE EYE CODES!

The purpose was to reduce the administrative burden, reduce note bloat and unnecessary information, to decrease third-party audits. The level depends on MDM or TOTAL TIME.

### **New Patient**

- 99201 – DELETED
- 99202 – Medically appropriate history and/or exam straight forward MDM or 15-29 MINIMUM TOTAL TIME
- 99203 – Medically appropriate history and/or exam Low level complexity/MDM or 30-45 minutes TOTAL TIME
- 99204 – Medically appropriate history and/or exam moderate complexity MDM or 45 – 59 minutes TOTAL TIME
- 99205 - Medically appropriate history and/or exam HIGH level MDM or 75 or greater TOTAL TIME

### **Established Patient**

- 99211 – many not require doctor – tech code, minimal presenting problem
- 99212 – medically appropriate history and/or exam straight forward MDM or 10-19 TOTAL TIME
- 99213 – medically appropriate history and/or exam low level MDM or 20-29 minutes TOTAL TIME
- 99214 – medically appropriate history and/or moderate MDM or 30-39 minutes or longer TOTAL TIME
- 99215 – medically appropriate history and/or exam HIGH MDM or 55 minutes or longer TOTAL TIME

### **Using Time – On the Day of Encounter Only**

- Physician face to face time
- Physician non face to face responsibility – review data, order tests, meds, etc.
- Assistant or tech time DOES NOT COUNT
- Make sure TOTAL exam time claimed does NOT exceed actual clinic hours.

## The Bottom Line

- MDM or TIME determines level of visit
- NO MORE counting unnecessary exam or history elements
- NO MORE reviewing numerous irrelevant systems
- Obtain only relevant history and exam
- Dilation – physician’s choice
- Can we still use EYE or E/M codes – YES!
  - In past use eye codes unless you get to E/M 99204, 99205 or 99215. New Payor E/M allowables will dictate change.
- New or Established patients same documentation requirements, different TOTAL TIMES
- CMS table of risk – easier to understand

## Medical Decision Making (MDM) – 3 Factors

### 1) Number + Complexity of problems addressed at the encounter

99202 99212	99203 99213	99204 99214	99205 99215
Minimal	Low	Moderate	High
<ul style="list-style-type: none"> <li>• 1 self-limited or minor problem</li> </ul>	<ul style="list-style-type: none"> <li>• 2 or more self-limited or minor problems; or</li> <li>• 1 stable chronic illness; or</li> <li>• 1 acute, uncomplicated illness or injury</li> </ul>	<ul style="list-style-type: none"> <li>• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or</li> <li>• 2 or more stable chronic illnesses; or</li> <li>• 1 undiagnosed new problem with uncertain prognosis; or</li> <li>• 1 acute illness with systemic symptoms; or</li> <li>• 1 acute complicated injury</li> </ul>	<ul style="list-style-type: none"> <li>• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or</li> <li>• 1 acute or chronic illnesses or injury that poses a threat to life or bodily function</li> </ul>

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## 2) Amount and/or Complexity of Data to be Reviewed and Analyzed

99202 99212	99203 99213	99204 99214	99205 99215
Minimal	Limited 1 of 2 categories	Moderate 1 of 3 categories	High 2 of 3 categories
Minimal or none	<p><b>Category 1:</b> Tests and documents 2 from the following:</p> <ul style="list-style-type: none"> <li>Review of prior external note(s) from each unique source;</li> <li>Review of the result(s) of each unique test;</li> <li>Ordering of each unique test; or</li> </ul> <p><b>Category 2:</b></p> <ul style="list-style-type: none"> <li>Assessment requiring an independent historian(s)</li> </ul>	<p><b>Category 1:</b> Tests and documents or independent historian(s) 3 from the following:</p> <ul style="list-style-type: none"> <li>Review of prior external note(s) from each unique source;</li> <li>Review of the result(s) of each unique test;</li> <li>Ordering of each unique test;</li> <li>Assessment requiring an independent historian(s), or</li> </ul> <p><b>Category 2:</b> Independent interpretation of tests</p> <ul style="list-style-type: none"> <li>Independent interpretation of test performed by another physician/other QHP (not separately reported): or</li> </ul> <p><b>Category 3:</b> Discussion of management or test interpretation with external physician/other QHP (not separately reported)</p>	<p><b>Category 1:</b> Tests and documents, or independent historian(s) 3 from the following:</p> <ul style="list-style-type: none"> <li>Review of prior external note(s) from each unique source;</li> <li>Review of the result(s) of each unique test;</li> <li>Ordering of each unique test;</li> <li>Assessment requiring an independent historian(s), or</li> </ul> <p><b>Category 2:</b> Independent interpretation of tests</p> <ul style="list-style-type: none"> <li>Independent interpretation of a test performed by another physician/other QHP (not separately reported): or</li> </ul> <p><b>Category 3:</b> Discussion of management or test interpretation</p> <ul style="list-style-type: none"> <li>Discussion of management or test interpretation with external physician/other QHP (not separately reported)</li> </ul>

## 2) Risk of complications and/or morbidity or mortality of patient management

99202 99212	99203 99213	99204 99214	99205 99215
Minimal	Limited	Moderate	High
<ul style="list-style-type: none"> <li>Minimal risk of morbidity from additional diagnostic testing and treatment</li> </ul>	<ul style="list-style-type: none"> <li>Low risk of morbidity from additional diagnostic testing or treatment</li> </ul>	<ul style="list-style-type: none"> <li>Moderate risk of morbidity from additional testing or treatment</li> <li>Examples</li> <li>Prescription drug management</li> <li>Decision regarding minor surgery with identified patient or procedure risk factors,</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>Elective major surgery without identified patient or procedure risk factors</li> <li>Diagnosis or treatment significantly limited by social determinants of health</li> </ul>	<ul style="list-style-type: none"> <li>High risk of morbidity from additional diagnostic testing or treatment</li> <li>Examples:</li> <li>Drug therapy requiring intensive monitoring for toxicity</li> <li>Decision regarding elective major surgery with identified patient or procedure risk factors</li> <li>Decision regarding emergency major surgery</li> <li>Decision regarding hospitalization</li> <li>Decision not to resuscitate or to de-escalate care because of poor prognosis</li> </ul>

## MDM Table: Final Determination

	99202 99212	99203 99213	99204 99214	99205 99215
Level of MDM	Straightforward	Low	Moderate	High
Number and/or Complexity of problems addressed at the encounter	Minimal <i>1 self-limited or minor</i>	Low <i>2 self-limited or minor, or 1 stable chronic, or 1 acute</i>	Moderate <i>1 chronic w/ progression, or 2 chronic stable, or 1 new, or 1 acute</i>	High <i>1 chronic severe progression, or 1 acute or chronic w/<b>immediate</b> threat to life/body function</i>
Amount or/ or Complexity of Data to be Reviewed and Analyzed	Minimal or none	Limited <i>1 of 2 categories</i>	Moderate <i>1 of 3 categories</i>	High <i>2 of 3 categories</i>
Risk of Complications and/or Morbidity or mortality or Patient Management	Minimal	Low	Moderate	High

**2 of 3 levels of MDM must be met or exceeded**

1) (Number amount or risk)  
2) Must have same level of complexity (straight forward, low moderate or high) otherwise select 1 level lower from highest level

2021	
NEW PATIENT	ESTABLISHED PATIENT
<b>99201</b> – DELETED	<b>99211</b> – many not require doctor – tech code, minimal presenting problem
<b>99202</b> – Medically appropriate history and/or exam <u>STRAIGHTFORWARD</u> MDM or 15-29 MINIMUM TOTAL TIME	<b>99212</b> – medically appropriate history and/or exam <u>STRAIGHTFORWARD</u> MDM or 10-19 TOTAL TIME
<b>99203</b> – Medically appropriate history and/or exam <u>LOW LEVEL COMPLEXITY</u> /MDM or 30-45 minutes TOTAL TIME	<b>99213</b> – medically appropriate history and/or exam <u>LOW LEVEL</u> MDM or 20-29 minutes TOTAL TIME
<b>99204</b> – Medically appropriate history and/or exam <u>MODERATE COMPLEXITY</u> /MDM or 45 – 59 minutes TOTAL TIME	<b>99214</b> – medically appropriate history and/or <u>MODERATE</u> MDM or 30-39 minutes or longer TOTAL TIME
<b>99205</b> - Medically appropriate history and/or exam <u>HIGH LEVEL</u> MDM or 75 or greater TOTAL TIME	<b>99215</b> – medically appropriate history and/or exam <u>HIGH LEVEL</u> MDM or 55 minutes or longer TOTAL TIME

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***“Do not forget:  
you must use  
your 1997 E/M  
guidelines for  
visits outside  
the office such  
as hospital  
and outpatient  
department.”***

## **Prolonged Services**

The E/M workgroup identified the need for prolonged service code to capture services for a patient that required longer time on the date of the encounter

### **99417**

- Only when using time > LEVEL 5
- 15 minute increments x 3
- Neurophthalmology, low vision, uveitis

## **G-codes: G2211 and G2212**

*The new law delays implementation for three years, but you should know that these are coming.*

### **G2211**

- Visit complexity inherent to evaluation and management associated with medical care services
- (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established) (in place of 99417)
- Was GPC1X in proposed rule
- CMS is not establishing any policies that prohibit reporting the add-on code by any specialties, so ophthalmologists can use it
- CMS does not expect G2211 to be used when E/M service is reported with a modifier (explicit prohibition TBD) (like modifier 25)
- Can be reported for both new and established patients

### **G2212**

- This code replaces CPT code 99417, prolonged office/outpatient E/M visits.
- (List separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services)
- Medicare requires G2212 but other payors may recognize the code published in the CPT book 99417
- Was 99XXX in proposed rule

**Do not forget: you must use your 1997 E/M guidelines for visits outside the office such as hospital and outpatient department.**

The new E/M code requirements and fee values apply to only office place of service 11 or Facility 22 (HOPD).

In contrast, all of the below places of service use the old 1997 coding system:

**ALL visits not office POS 11 or Facility 22  
Emergency Dept (POS – 23)  
5 levels – 99281, 99282, 99283, 99284, 99285  
New or Established**

**Inpatient Hospital Exam (POS – 21)**

3 levels 99211, 99222, 99223  
A) Initial  
B) Subsequent – 99231, 99232, 99233

**Nursing Facility**

Assisted living (POS – 13)  
Skilled Nursing (POS – 31)  
Nursing Facility (POS – 32)  
Initial – 99304, 99305, 99306  
Subsequent – 99307, 99308, 99309

**Proposed fee changes that were averted:**

These are the fees that were slated to go into effect January 1, 2021 before the new appropriations bill was passed. As you can see, the large increases were in the Established Patient E/M exams. Also, the eye codes were slated to take a large hit. Further, the E/M codes imbedded in the GF period for all surgical codes were not to be increased.

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

CPT Code	2020 Office Pay	2021 Office Pay (proposed but averted)	Percent Change
99201	\$46.56	Deleted	N/A
99202	\$77.23	\$69.03	-10.6%
99203	\$109.35	\$106.30	-2.8%
99204	\$167.09	\$159.77	-4.4%
99205	\$211.12	\$210.98	-0.1%
<b><u>Eye codes</u></b>			
92002	\$85.53	\$81.35	-4.9
92004	\$152.68	\$141.95	-7.0

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

CPT Code	2020 Office Pay	2021 Office Pay (proposed but averted)	Percent Change
<b>99211</b>	\$23.46	\$22.04	-6.1%
<b>99212</b>	\$46.19	\$54.12	17.2%
<b>99213</b>	\$76.15	\$86.85	14.1%
<b>99214</b>	\$110.43	\$123.48	11.8%
<b>99215</b>	\$148.33	\$172.74	16.5%
<b>Eye codes</b>			
<b>92012</b>	\$89.86	\$84.59	-5.9%
<b>92014</b>	\$128.12	\$119.59	-6.7%

So now that we understand the new E/M charges, how exactly did the Consolidated Appropriations Act of 2021 passed in late December actually affect the Medicare Fee Schedule?

- 3.75% increase in MFS
- The add-on complexity code G2211 was delayed for three years saving us another 3% on MFS.

Both of these changes reduce the required budget neutrality conversion factor adjustment. The Medicare conversion factor was set to be cut 10% on the final CMS rule but the Appropriations Act greatly reduced this hit. The new 2021 Medicare Conversion Factor will be \$34.89 (a 3.3% reduction from the 2020 CF of \$36.09 but up from the proposed \$32.408.) Additionally, the Medicare 2% Sequestration Cut is suspended until March 31, 2021.

Most facility-based surgical codes are reduced 1-2% because the post-op E/M visits were not given the increase in E/M payments for primary care.

Cataract /IOL	66984	\$548.17	-1.7%
Complex Cataract	66982	\$750	-1.9%
PPV	67036	\$903	-1.6%
Trabeculectomy	66170	\$1,101	-1.3%

However, office visits are generally increased E/M more than eye codes.

## Heads Up! – Here is What You Need to Know NOW

### 2021 MFS Office Visits: New Adjusted Values of Average National Values

New Patient	MDM	Time(min.)	Allowable	% Change from 2020
99202	Straight forward	15-29	\$73.97	-4.2%
99203	Low	30-44	\$113.17	+4.0%
99204	Moderate	45-59	\$169.93	+1.7%
99205	High	60-74	\$224.36	+6.3%
92002			\$87.58	+2.4%
92004			\$152.48	-0.1%
Established Patient	MDM	Time(min.)	Allowable	% Change from 2020
99212	Straight forward	10-19	\$56.88	+23.1%
99213	Low	20-29	\$92.47	+21.4%
99214	Moderate	30-39	\$131.20	+18.8%
99215	High	40-54	\$183.19	+23.5%
92012			\$91.07	+1.3%
92014			\$128.41	+0.2%

So, you can see that the E/M codes pay more in many circumstances relative to the Eye Codes but you must relearn the definitions of Medical Decision Making to use these codes. There is no longer a requirement for more extensive documentation so why not make like a primary care doc and use the E/M codes when you find it advantageous? That is the path for survival.

Remember the current 3.6% fee increase is only in effect for one year and then the fees go down again unless we are able to intervene politically on every level. Please, please support our [AMA](#), [AAO](#) and [TOA](#) political action committees so we can remain strong for our patients.

*Continued on page 14*

C O D **Q**uest  
2021

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Registration insert

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**Houston**  
**Saturday, October 2**

# Coding Changes for 2021

## Revised Codes

### Cat III Trabeculostomy Ab Interno

- 0622T was established to report use of ophthalmic endoscope when used with trabeculostomy described in 0621T
- Addition of an exclusionary parenthetical note following 0622T

● 0621T      Trabeculostomy ab interno by laser;

● 0622T      with use of ophthalmic endoscope

▶ (Do not report 0621T, 0622T in conjunction with 92020) ◀

### Ophthalmic US Anterior Segment (76513)

- 76513 was revised to reflect unilateral or bilateral service

*76510 Ophthalmic ultrasound, diagnostic; B-scan and quantitative A-scan performed during the same patient encounter*

▲ 76513      anterior segment ultrasound, immersion (water bath) B-scan or high resolution biomicroscopy, unilateral or bilateral

*(For scanning computerized ophthalmic diagnostic imaging of the anterior and posterior segments using technology other than ultrasound, see 92132, 92133, 92134)*

### Remote retinal imaging (92227, 92228, 92229)

- 92227 was revised to become a parent to 92228
- 92227 and 92228 were revised to include imaging of retina for detection or monitoring
- 92227 was revised to specify use by remote clinical staff and 92228 to specify use by remote physicians/QHP
- 92229 (9225x in proposed rule) was added for retinal imaging with automated point-of-care

### IDXR artificial intelligence evaluation of diabetic retinopathy

★▲ 92227    Imaging of retina for detection or monitoring of disease; with remote clinical staff review and report, unilateral or bilateral)

▶ (Do not report 92227 in conjunction with 92133, 92134, 92228, 92229, 92250) ◀

★▲ 92228    with remote physician or qualified health professional review and report, unilateral or bilateral

▶ (Do not report 92228 in conjunction with 92133, 92134, 92227, 92229, 92250) ◀

#● 92229    point-of-care automated analysis and report, unilateral or                      bilateral

▶ (Do not report 92229 in conjunction with 92133, 92134, 92227, 92228, 92250) ◀

## **IDxDR – Artificial Intelligence Evaluation of Diabetic Retinopathy (92229)**

- CMS changed the assigned APC for CPT code 92229 to APC 5733 (Level 3 Minor Procedures) rather than APC 5732 (Level 2 Minor Procedures).
- CMS is also finalizing a change to the status indicator, assigning CPT code 92229 to APC 5733 with status indicator “S.” The Academy has urged CMS to assign the code to a more appropriate APC, this reassignment will ensure Medicare payment for this innovative service accurately reflects the cost of providing this technological advance to patients.

## **Revalued Codes**

### **Ophthalmic US Anterior Segment (76513)**

- 76513 was revised to reflect unilateral or bilateral service

*76510 Ophthalmic ultrasound, diagnostic; B-scan and quantitative A-scan performed during the same patient encounter*

- ▲ 76513 anterior segment ultrasound, immersion (water bath) B-scan or high resolution biomicroscopy, unilateral or bilateral

(For scanning computerized ophthalmic diagnostic imaging of the anterior and posterior segments using technology other than ultrasound, see 92132, 92133, 92134)

### **Imaging of Retina Using AI (92229)**

- CPT 92229 Imaging of retina for detection or monitoring of disease; with point-of-care automated analysis with diagnostic report; unilateral or bilateral
- Can be used at a primary care practice site and the artificial intelligence technology interprets the test instead of a remotely located ophthalmologist
- CMS acknowledges AI applications are not well accounted for in their PE methodology, but still eliminated the \$25.00 RUC-recommended analysis fee
- CMS finalized payment based on contractor pricing, where each individual MAC sets their own pricing for each locality
  - The Academy will work with the MACs to advocate for the RUC-recommended values, just as we did for ECP codes in 2020

### **Intravitreal Injection (67028) Revaluation**

- 67028 was identified by the RUC’s Relativity Assessment Workgroup (RAW) as a code where the original valuation was based on a crosswalk code that had since been revalued
- CMS accepted the RUC-recommended work value of 1.44, but refined the direct PE inputs
  - CA024 “Clean room/equipment by clinical staff” (CA024) was reduced from the RUC-recommended 5 minutes to 3 minutes
  - Equipment times were refined to match the change in clinical labor time

## New Valuations After New Appropriations Bill Changes

### Revaluation in Dollars

CPT Code	2020 Pay	2021 Pay	Change in Pay 2020-2021	% Change in Pay 2020-2021
67028 (office)	\$103.22	\$116.15	\$12.93	12.52%
67028 (facility)	\$100.69	\$93.04	-\$7.65	-7.59%
76513	\$101.41	\$81.58	-\$19.83	-19.55%
92227	\$13.71	\$16.30	\$2.59	18.89%
92228	\$34.65	\$31.49	-\$3.16	-9.11%

### New Codes

#### **Remote Retinal Optical Coherence Tomography (0604T-0606T)**

- 0604T Optical coherence tomography (OCT) of retina, remote, patient-initiated image capture and transmission to a remote surveillance center, unilateral or bilateral; initial device provision, set-up and patient education on use of equipment
- 0605T Remote surveillance center technical support, data analyses and reports, with a minimum of 8 daily recordings, each 30 days
- 0606T review, interpretation and report by the prescribing physician or other qualified health care professional of remote surveillance center data analyses, each 30 days

▶ (Do not report 0604T, 0605T, 0606T in conjunction with 99457, 99458) ◀

#### **Iris Prosthesis Procedures (0616T-0618T)**

- 0616T Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed; without removal of crystalline lens or intraocular lens, without insertion of intraocular lens
- 0617T with removal of crystalline lens and insertion of intraocular lens

▶ (Do not report 0617T in conjunction with 66982, 66983, 66984) ◀

- 0618T with secondary intraocular lens placement or intraocular lens exchange

▶ (Do not report 0618T in conjunction with 66985, 66986) ◀

▶ (Do not report 0616T, 0617T, 0618T in conjunction with 66600, 66680, 66682) ◀

### **PPE supplies during COVID-19 (99072)**

- *Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health emergency, as defined by law, due to respiratory-transmitted infectious disease*
- Finalized as a bundled service on an interim basis

## **Other Changes for 2021**

### **Telehealth Provisions – Public Health Emergency**

CMS finalized making certain telemedicine services permanent after the public health emergency ends with a focus on improving rural telehealth access. The Academy requested that any services permanently added to the list of Medicare covered telehealth services should be paid fairly relative to other covered services. Telehealth services covered now under the federally declared PHE, and those made permanent, will only apply to rural areas after the PHE, barring congressional action.

### **CMS Finalizes ASC Changes for CY 2021**

- Takes effect January 1, 2021
- Payments increased by 2.4% for ASCs
- Expanding the list of services requiring prior authorization (PA) when performed in HOPDs, which already includes blepharoplasty and botulinum toxin
- The elimination of the inpatient-only list over a three-year transitional period with the list completely phased out by calendar year 2024.
- CMS approved the application for device pass-through payment for the *Customflex Artificial Iris* starting in 2021.
- CMS is not planning to extend the pass-through status for products due to the public health emergency.
  - Will consider an extension in future rulemaking

### **Insertion of drug-eluting implant (0356T)**

- CMS did not change the assigned APC or status indicator for CPT code 0356T, insertion of drug-eluting implant (including punctal dilation and implant removal when performed) into lacrimal canaliculus, each).
  - CMS finalized their proposed policy without modification to assign CPT code 0356T to APC 5692 (Level 2 Drug Administration) with OPPS status indicator “Q1” in the CY 2021 OPPS. Based on those assignments, CMS also finalized an ASC payment indicator for CPT code 0356T of “N1” under the CY 2021 ASC payment system.
- The drug itself, *Dexamethasone ophthalmic insert 0.1 mg* (HCPCS code J1096) is currently on pass-through status (assigned to APC 9308) and does receive separate payment.

## Omidria and Non-Opioid Pain Management

- CMS will continue to apply separate payment for non-opioid pain management drugs that function as surgical supplies when furnished in the ASC setting for CY 2021.
- CMS agreed that Omidria meets this definition and does qualify as a non-opioid pain management drug that functions as a surgical supply. CMS is excluding Omidria from bundling under the ASC payment system beginning Oct. 1, 2020 and in 2021.

## ASC Quality Reporting Changes for CY 2021

- CMS finalized continuing its policy of voluntary reporting for measure ASC-11: Cataracts — Improvement in Patient’s Visual Function within 90 Days Following Cataract Surgery.
- CMS finalized continuing the delay of implementation for measure ASC-15a-e Consumer Assessment of Healthcare Providers and Systems Outpatient and Ambulatory Surgery (OAS CAHPS) Survey.
- CMS finalized its proposal to give ASCs the opportunity to review and correct data on measures submitted to CMS via a CMS online tool. The review and corrections period will run concurrently with the data submission period.

## 2021 MIPS Eligibility

- **Three Exclusions**
  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
    - 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!**

# MIPS Is Getting Harder

## 2020 & 2021 MIPS Proposed Scoring

Threshold	2020	2021	2022 (Proposed)
<b>Threshold to Avoid a Penalty</b>	45 points	60 points	74.01 points
<b>Exceptional Performance Threshold</b>	85 points	85 points	85 points

## MIPS Proposed Performance Category Weights

MIPS Category	Score Weight 2017	Score Weight 2018	Score Weight 2019	Score Weight 2020	Score Weight 2021	Score Weight 2022+ proposed
<b>Quality</b>	60%	50%	45%	45%	40%	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%	20%	30%

## MIPS 2021: What's in Store?

### MIPS APMs

- MIPS APMs can report through MIPS or a new APM Performance Pathway (APP)
- The APP includes a fixed set of measures for each performance category

### MIPS Eligibility

- Unchanged

### Quality

- CMS Web Interface collection type extended until 2022

### Cost

- Scoring weight change by 5%

### Promoting Interoperability

- Unchanged

*Continued on page 20*

### Improvement Activities

- Unchanged

### Small Practices

- PI Hardship Maintained
- 6-Point Small Practice Bonus in Quality Category Maintained
- Double Credit for Each IA Maintained

### **MIPS and the IRIS® Registry**

Benefits of IRIS® Registry participation include:

- Helps meet quality reporting requirements;
- Provides at least one outcome or high priority measure for most participants to report;
- Supports credit for improvement activities;
- Facilitates promoting interoperability reporting and counts towards the clinical data registry reporting measure for integrated practices.

#### *Bonus quality points via IRIS Registry participation*

- For reporting multiple outcomes measures
- For electronic reporting through IRIS Registry-integrated EHR

### **MIPS Extreme Circumstances Hardship**

- Physicians who experience an extreme and uncontrollable circumstance that is outside of their control can apply for an extreme and uncontrollable circumstances hardship exception for each individual category of the Merit-Based Incentive Payment System
- Extreme and uncontrollable circumstances hardship exceptions require you to apply for a hardship exception by Feb. 1, 2021 at 8 p.m. ET.
  - CMS has not yet declared and automatic extreme and uncontrollable circumstance exceptions

## **Most Favored Nations (MFN) Final Rule (not yet implemented)**

This rule creates a new, mandatory, 7-year drug price payment demonstration that changes how CMS pays providers for a set of 50 drugs reimbursed under Medicare Part B, including three anti-VEGF drugs. During the mandatory drug-price demonstration, which starts Jan. 1, CMS will switch to a payment model based on the lowest international price. So instead of reimbursing for the average sales price plus 6 percent, CMS will pay providers the lowest price plus a flat fee that will be adjusted quarterly for inflation.

The effective dates are Jan. 1, 2021, to Dec. 30, 2027. Under the new calculation, reimbursement is the lowest international price plus a flat fee. The countries used in calculation are the members of the Organisation for Economic Co-operation and Development that have at least 60 percent of the U.S. gross domestic product per capita (GDP). The flat fee is \$148.73 for the first quarter of 2021.

Participation is mandatory. The drugs affected include the top 50 most costly drugs reimbursed by Medicare. This includes Eylea and Lucentis. Exceptions include compounded drugs, which should exclude Avastin for ophthalmic use.

The American Academy of Ophthalmology has responded to MFN vigorously via letters to HHS, press releases, grassroots advocacy, public comment and the formation of coalitions.

I certainly agree that we must do something quickly in our society to control drug costs. When 2 Anti-VEGF drugs Eylea and Lucentis became 30% of the Medicare Part B budget, I get real concerned as all these expensive drugs and devices greatly lower the physician Medicare Part B ophthalmology pie that determines our fees. This has greatly contributed to our negative fee updates in the last 20 years. What we need is Congressional action. The Trump-mandated Most Favored Nation rule is a good idea in my view, but already it has been blocked by judicial rulings so its future is uncertain. The drug companies claim drug innovation will completely stop if fees are controlled but our doc fees have been controlled for 40 years and medical innovation has continued. The drug companies will adapt as have the docs and innovation will continue.

Speaking of drug companies, the Lown Institute think tank gives out its annual Shkreli Awards to shame healthcare profiteers. (Recall that Martin Shkreli was the drug lord who purchased Daraprim used for ocular Toxo and cornered the market and raised its price 56X - he was not convicted but sent to jail for tax evasion.) This year, the second-place award went to vaccine maker Moderna, which received nearly \$1 billion in federal funds to develop its mRNA COVID-19 preventive. It set a price between \$32 - \$37 per dose, more than the US agreed to pay for other COVID-19 vaccines. Although the US has placed an order for \$1.5 billion worth of doses at a discount, a price of \$15 per dose, given the upfront investment by the US government, we are essentially paying twice. Also, the Bill Gates Foundation gave Moderna \$100 million several years ago to develop the mRNA process.

Many thanks to the excellent AAO Washington DC staff David B. Glasser, MD, Secretary for Federal Affairs; Michael X. Repka, MD, MBA, Medical Director for Governmental Affairs; Kayla L. Amodio, PhD, Director, Health Policy and Sue Vicchilli, Director, Coding & Reimbursement.

**John Haley, MD  
and William  
Plauche, MD  
answer coding and  
reimbursement  
questions from  
TOA members at  
coding@texaseyes.  
org. They volunteer  
their time to  
provide this  
valuable service.**

## PMP – What Ophthalmologists Need to Know

**QUESTION: Do I need to check the new Prescription Monitoring Program (PMP) before giving a patient a sedative in my office before a procedure?**

As of January 1, 2021, state and federal laws mandate that all controlled substances must be prescribed electronically. Read the Texas Medical Board update here: <http://www.tmb.state.tx.us/page/renewal-prescribing-updates>

*Ophthalmologists need to be aware* that whether you prescribe or dispense in your office for the patient to take at home, the Prescription Monitoring Program (PMP) must be checked.

In an instance where a physician administers the controlled substance to a patient in the office (for instance, valium before a surgery), this administration of medication would most likely not require that the PMP be checked. However, safeguards should be in place that this medication is actually being administered, i.e, the medication is being injected or orally taken by the patient in the presence of staff; otherwise, it could fall under the definition of “dispense.” See the definitions below from the Texas Health and Safety Code.

Texas Health and Safety Code, Section 481.0764 requires a prescriber to check the PMP as follows (emphasis added):

Duties of Prescribers, Pharmacists, and Related Health Care Practitioners

- a. A person authorized to receive information under Section 481.076 (Official Prescription Information; Duties of Texas State Board of Pharmacy) (a)(5), other than a veterinarian, **shall access that information with respect to the patient before prescribing or dispensing opioids, benzodiazepines, barbiturates, or carisoprodol.**

- b. A person authorized to receive information under Section 481.076 (Official Prescription Information; Duties of Texas State Board of Pharmacy) (a)(5) may access that information with respect to the patient before prescribing or dispensing any controlled substance.
- c. A veterinarian authorized to access information under Subsection (b) regarding a controlled substance may access the information for prescriptions dispensed only for the animals of an owner and may not consider the personal prescription history of the owner.
- d. A violation of Subsection (a) is grounds for disciplinary action by the regulatory agency that issued a license, certification, or registration to the person who committed the violation.
- e. This section does not grant a person the authority to issue prescriptions for or dispense controlled substances.
- f. A prescriber or dispenser whose practice includes the prescription or dispensation of opioids shall annually attend at least one hour of continuing education covering best practices, alternative treatment options, and multi-modal approaches to pain management that may include physical therapy, psychotherapy, and other treatments. The board shall adopt rules to establish the content of continuing education described by this subsection. The board may collaborate with private and public institutions of higher education and hospitals in establishing the content of the continuing education. This subsection expires August 31, 2023.

The requirement does not use the word “administering.” Pursuant to section 481.002 of the Texas Health and Safety Code, the definitions of “administer,” “dispense” and “prescribe” are as follows:

- (1) “**Administer**” means to directly apply a controlled substance by injection, inhalation, ingestion, or other means to the body of a patient or research subject by:

- A. a practitioner or an agent of the practitioner in the presence of the practitioner; or
- B. the patient or research subject at the direction and in the presence of a practitioner.

(12) **“Dispense”** means the delivery of a controlled substance in the course of professional practice or research, by a practitioner or person acting under the lawful order of a practitioner, to an ultimate user or research subject. The term includes the prescribing, administering, packaging, labeling, or compounding necessary to prepare the substance for delivery.

(40) **“Prescribe”** means the act of a practitioner to authorize a controlled substance to be dispensed to an ultimate user.

## After-hours Answering Services

### QUESTION: Must an after-hours answering service be manned by a live person?

There is no Texas law that specifically requires physicians to have an after-hours answering service, but physicians must ensure they have a reliable process in place for immediately directing patients to alternative after hours care as based on the patient’s urgency of patient’s medical need. Some health plans require after-hours access, such as a recorded message directing a patient to call the answering service (with number provided), a recorded message that directs the patient to call or page the physician or an on call physician (with number provided), or the use of an answering service. You should review Texas Medical Board Chapter 190 Disciplinary Guidelines - and specifically Chapter 190.8 Violation Guidelines with regard to availability/developing an after-hours/on-call policy. Excerpts with some relevant bullet points are below (emphasis added):

#### §190.8. Violation Guidelines.

When substantiated by credible evidence, the following acts, practices, and conduct are considered to be violations of the Act. The following shall not be considered an exhaustive or exclusive listing.

(1) Practice Inconsistent with Public Health and Welfare. Failure to practice in an acceptable professional manner consistent with public health and welfare within the meaning of the Act includes, but is not limited to:

**(F) failure to timely respond in person when on-call or when requested by emergency room or hospital staff;**

**(J) termination of patient care without providing reasonable notice to the patient;**

(L) prescription of any dangerous drug or controlled substance without first establishing a proper professional relationship with the patient.

(i) A proper relationship, at a minimum requires:

**(IV) ensuring the availability of the licensee or coverage of the patient for appropriate follow-up care.**

(2) Unprofessional and Dishonorable Conduct. Unprofessional and dishonorable conduct that is likely to deceive, defraud, or injure the public within the meaning of the Act includes, but is not limited to:

**(L) failing to timely respond to communications from a patient;**

You should contact your liability insurance and/or speak with your own legal counsel on setting this up for your practice.

You should also review your payer contracts to verify if there are any specific requirements regarding after-hours coverage/answering service.

*As an association, TOA cannot provide specific legal advice, but can provide members with general legal information. The information provided herein is general information and should not be taken as legal advice. For specific legal advice, physicians should seek advice from their own retained counsel. Send your question regarding Texas practice acts or regulatory acts to [exec@texaseyes.org](mailto:exec@texaseyes.org). No malpractice, reimbursement, or practice management questions please.*

## Members in the News

During the 2020 elections, TOA past president **Dawn Buckingham, MD** (R - Lakeway) kept her District 24 Senate seat, impressively winning with 70% of her voting constituency. Congratulations Senator Dr. Buckingham!

**Sidney K. Gicheru, MD's** term as Deputy Section Leader of the State Section of the AAO Council began January 2021. Dr. Gicheru continues his service on the AAO's Committee for State Organizational Development which is part of the Secretariat for State Affairs. Dr. Gicheru is a TOA past president.

TOA president-elect **Lindsey Harris, MD** was recently elected to the Texas Medical Liability Trust's Board of Governors. TMLT is a self-insured medical liability trust established by the Texas Medical Association and led by a Board of Governors. Dr. Harris is one of nine board members, elected by TLMT policyholders.

Last December 1, several TOA leaders spent their Saturday morning meeting with leaders of TMA and other state specialty societies to discuss legislative priorities for 2021. The hot topics were meaningful health care coverage expansion, scope of practice encroachment concerns, telemedicine and prior authorization relief. Thank you to Drs. **Mark Mazow**, TOA president, **Michelle Berger**, **Victor Gonzalez**, **Robert Gross**, **Jerry Hunsaker** and **Jack Pierce** for attending and representing ophthalmology.

## Welcome New Provisional Members!

Jamie Alexander, MD, Dallas  
Larry Alexander, MD, Pasadena  
Peter Bealka, MD, Waco  
William Burkes, MD, San Angelo  
Kai Chu, MD, Houston  
M. Dolores Diaz, MD, Houston  
Kourtney Dwyer, MD, Lewisville  
Yasser Elshatory, MD, PhD, Plano  
Allan H. Fradkin, MD, Galveston  
Matthew Goldman, MD, San Angelo  
Carlos A. Gonzales, MD, Houston  
Timmy A. Koor, MD, Houston  
James P. Lai, MD, Houston  
Megan X. Law, MD, Houston

Philip Lieu, MD, Dallas  
Kathryn H. Musgrove, MD, Houston  
Luke B. Potts, MD, PhD, Dallas  
Jacob Reynolds, MD, Cedar Park  
William Riggs, MD, Bryan  
Caroline M. Schmidt, MD, Houston  
Adeel H. Shaikh, MD, Houston  
Krishna P. Shanmugam, MD, Bryan  
Philip Storey, MD, Austin  
Tom H. Sun, MD, Tomball  
Colleen Yard, MD, Round Rock  
Ryan C. Young, MD, Austin  
Joshua Zaffos, MD, Dallas



### 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/job-board](http://www.texaseyes.org/job-board)

## Pediatric Updates

### TOA at Work – ROP Exams for Premature Infants Restored

Last fall, TOA's Medicaid Workgroup members alerted Texas Health and Human Services to a glitch that was limiting the number of extended ophthalmoscopies for premature babies to two per year and imposing prior authorization requirements. These barriers were creating an access to care crisis and putting babies suffering from ROP at risk for blindness and visual impairment.

Our members successfully explained the need to make medical policy consistent with the evidence-based research and guidelines. The good news is that in January 2021, HHSC proposed a new medical benefit policy allowing up to 12 extended ophthalmoscopies for preterm babies. The new policy states, in part, "Repeat extended ophthalmoscopy is medically necessary when there is a change in signs, symptoms or specific condition. The frequency for providing extended ophthalmoscopy depends upon the medical necessity in each client which relates to the diagnosis. While most clients will require up to two services per year, in some cases, additional services may be reimbursed up to 12 services per year."

The TOA Medicaid Workgroup reviews benefit notices and advises staff when intervention is necessary. The current members are Drs **Charlotte Akor, John Bishop, Megyn Busse, David Coats, Victor Gonzalez, Michael Hunt, Aaron Miller, Jacob Moore, Alan Norman** and **Eric Packwood**. If you would like to be added to this group, simply email Rachael Reed at [exec@texaseyes.org](mailto:exec@texaseyes.org).

### Vision Screening Rules During COVID-19

Health and Safety Code, Chapter 36 and 25 Texas Administrative Code Chapter 37 require Public, Private, Parochial, and Denominational Schools (Schools) and Department of Family and Protective Services (DFPS) Licensed Child Care Centers and Licensed Child Care Homes (Child Cares) to screen children for vision, hearing and spinal problems.

Although screening is still required for this school year, the Texas Department of State Health Services (DSHS) understands the need for flexibility during the pandemic and is advising schools and school districts to assess their capacity to safely conduct screenings. Schools and childcare centers with the capacity to screen should notify parents and follow best practices previously developed by the DSHS. Parents who choose not to participate at this time may decline screenings.

DSHS is recommending that schools notify the parents of children who have missed or will miss a screening. This notification should inform parents of the missed screening and encourage them to ask for screenings at their child's next well-child appointment with their medical provider.

Sample letters to parents and best practices documents are available at [www.dshs.texas.gov/vhs](http://www.dshs.texas.gov/vhs). Questions should be sent to the Vision, Hearing and Spinal Screening Program at [vhssprogram@dshs.texas.gov](mailto:vhssprogram@dshs.texas.gov).



## ***EYE-PAC Backs Winners Again***

EYE-PAC, TOA's political action committee, continued its impressive record of backing winning candidates in the Texas Legislature. During the November elections, EYE-PAC endorsed 14 candidates in the Texas Senate and all 14 won.

In the Texas House, EYE-PAC weighed in on 116 races and 98% of those endorsed candidates won.

When you contribute to EYE-PAC, 100% of your money goes toward educating lawmakers and candidates about quality eye care.

## **Mark your calendar for the return of Codequest:**

C O D **Q**uest  
**2021**

**Saturday, March 27, 2021, 8 am - Noon.**  
This will be a VIRTUAL course conducted in real time. Take the course from the comfort of your home.

**Saturday, October 2, 2021, 8 am - Noon in Houston.**  
This will be the return of our live, in-person Codequest course!

Join the most knowledgeable coding experts in ophthalmology for four hours of professional coding education vital to your success as we emerge from the pandemic. We'll map out the latest coding updates, review key competencies, test your knowledge of new E/M requirements (the first changes in 25 years), and steer you towards successful solutions for preventing claim denials.

Developed by the American Academy of Ophthalmology and presented in partnership with TOA, Codequest™ provides unparalleled instruction for practices of every size.

**Register today at [TexasEyes.org](https://www.texaseyes.org)  
Attend with your Team.**

## **Member Benefit: Pain Management/Ethics CME**

The 2019 Texas Legislature passed three different laws that require physicians to complete two hours of CME in during each two-year licensing period. The mandate applies to the renewal of a license on or after September 1, 2020.

TOA is providing members with the two hours with an online course free. The on-demand course will result in:

- Two CME hours.
- Two ethics hours.
- Two hours to fulfill the state's opioid prescribing mandate.

Simply go to [www.texaseyes.org/opioidcme](https://www.texaseyes.org/opioidcme) for instructions.

Once you complete the videos and fill out your evaluation form, TOA will e-mail the CME certificate to you several days later.

*Contact Rachael Reed at [exec@texaseyes.org](mailto:exec@texaseyes.org) with any questions or if you have not received your CME certificate.*

# Proud to be an Eye Physician

## TOA's oldest living member is 99 years old – and he still gives to EYE-PAC



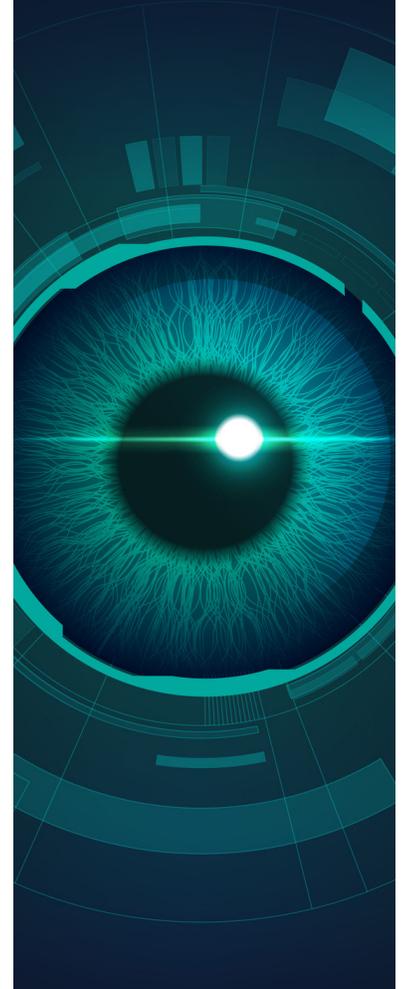
**Thomas J. Tredici, MD, Col, USAF, MC FS (Ret)** began his US Air Force career in his early 20's as a B-17 pilot (457th BG 8th AF) in World War II, deployed to Great Britain. Dr. Tredici and his crew regularly flew between 30,000 and 35,000 feet without pressurization. He recalls that the most common injuries were frostbite and ocular trauma if the aircraft came under fire. In total, he flew 18 combat missions over Germany between November 1944 and June 1945.

After the War, Dr. Tredici attended college and then medical school at the University of Pittsburgh, graduating in 1952. He served in the Korean Conflict as a USAF medical officer from 1952-1953. He returned to the University of Pittsburgh and completed his ophthalmology residency in 1956, followed by duty at Scott AFB in Illinois and Clark AFB in the Philippines, as Chief of Ophthalmology. After completion of a fellowship in ophthalmic pathology in 1964, he was assigned to the USAF School of Aerospace Medicine performing aero-medical research and he became a USAF flight surgeon. Dr. Tredici then served as an eye surgeon in Vietnam from 1965-1966. After his Vietnam service, he became Chief of the Aerospace Ophthalmology Branch at the USAF School of Aerospace Medicine at Brooks AFB in San Antonio.

After two recalls to active duty, and after 39 years of active military service, Thomas Tredici retired from the Air Force at age 65. He continued to serve the Air Force as a Senior Scientist at the USAF School of Aerospace Medicine until his final retirement in 2011, after a total of 70 years of military service. He is now a USAF Emeritus Scientist.

Dr. Tredici has lived an incredible life, with much of it in service to his country and to his patients. He has held the distinctions of being both the top ophthalmologist in the US Air Force and the last WWII pilot to retire from Air Force active duty.

He has been a member of TOA since 1991 and he contributes to the TOA Foundation and EYE-PAC to this day. We are honored to have Thomas Tredici, MD as a TOA Emeritus member.



**Thomas J. Tredici, MD**



**Texas Ophthalmological Association**  
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## Upcoming Events

**March 2, 2021**

First Tuesdays  
*Virtual*

**March 27, 2021**

Codequest  
*Virtual via Zoom*

**December 4 – 5, 2021**

TMA Advocacy Retreat  
*Austin, TX*

**April 6, 2021**

First Tuesdays  
*Virtual*

**May 14-15, 2021**

TexMed 2021  
*Austin, TX*

**TOA Annual Meeting  
& TexMed 2022**

April 29-30, 2022  
*Houston, TX*

**May 4, 2021**

First Tuesdays  
*Virtual*

**October 2, 2021**

Codequest – Live!  
*Norris Conference Center  
Houston, TX*

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