

ASC Reimbursement Challenges

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Financial Disclosure

Nikki Hurley, RN, MBA, COE

- No financial interests or relationships to disclose.

Kevin J. Corcoran is President of Corcoran Consulting Group and acknowledges a financial interest in the subject matter of this presentation.

Outline

- Conditions for Coverage
- Growing Revenue
- ASC Quality Reporting
- Revenue Cycle Management
- Payment Rates
- Coding
- Compliance



Shared Eye Drop Bottles

- (1998) ISMP – “Shared Eye Drop Bottles: Danger In Making Every Drop Count”
- (2016) CDC – FAQ regarding safe practices for medical injections. *“Multi-dose vials should be dedicated to a single patient whenever possible.”*
- (2012) AORN – “...procure and store only single-dose vials in the OR and post-anesthesia unit.”
- (2013) ASORN – “Medications labeled as multi-dose may be used for more than one patient if, and only if, sterile technique, safe injection practices, and standard precautions are followed.”

Shared Eye Drop Bottles

- (2015) ASCRS - “Some members reported that surveyors have arbitrarily proscribed these well established and common practices, without any evidence that they pose greater risk”
- “Another well-established practice is the use of multidose eye drops on multiple patients as part of the preoperative surgical protocol (i.e. dilating drops, NSAID etc.). The safety and cost effectiveness of multidose bottles are well recognized in the clinic and in the surgery setting. Safety guidelines have been established for the safe use of these products including: expiration 28 days after initial use, proper dispensing technique, and discarding of any bottle with suspected tip contamination. The ASCRS Cataract Clinical Committee strongly supports the current established practice of utilizing multidose eye drops on multiple patients, when proper protocols are followed.”

Shared Eye Drop Bottles

- Survey of a Morgantown, WV ASC
- Successful rebuttal to surveyor’s criticism of eye drop use
- Powell, SR, Corcoran, KJ, Multi-use Eye Drops in the ASC, The Ophthalmic ASC, Feb 2017
- <http://www.ophtalmologymanagement.com/supplements/2017/february-2017/current-trends-in-surgical-microscopes/multi-use-eye-drops-in-the-asc>

Outline

- Conditions for Coverage
- Growing Revenue



Plan: Grow Procedure Volume

- Expand volume with additional providers
- Additional surgical days
- Consider new procedures or products
- Investigational research
- Increase offering of noncovered services
 - Refractive surgery
 - Cosmetic surgery

Top 10 Ophthalmic Procedures Medicare Utilization Patterns Ophthalmology (18)

Rank	CPT	Procedure	Rank	CPT	Procedure
1	67028	Intravitreal Injection	6	66982	Complex Cataract
2	66984	Cataract w/IOL	7	65855	Lx Trabeculoplasty
3	66821	YAG Capsulotomy	8	15823	Blepharoplasty
4	68761	Punctum plug	9	66761	Laser PI
5	67820	Epilation	10	67210	Focal Laser

Source: CMS data 2015, 18 - Ophthalmology

Plan: Grow Procedure Volume

- Review most profitable, compliant surgeons and engage clinic to discover ways to increase volume of procedures
- Add surgical days – if already full capacity 5 days a week, consider Saturdays
- Consider adding OR space
- Add sub-specialties such as retina, glaucoma, or cornea
- Where licensure permits, research other specialties that could be a good fit for your ophthalmic ASC

Expansion Impediments

- Larger cities experiencing hospitals purchasing physician practices and directing that all patients are brought to their HOPD for treatment
- Referral sources can be affected by ACOs, narrow networks, directing patients to eye surgeons within the network
- ASC may be at capacity and need to consider larger space for additional providers

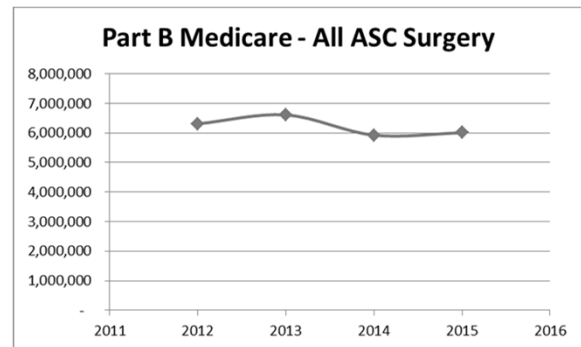
Plan: Add New Procedures

- Retina – steep capital investment
- Minimally invasive glaucoma surgery (MIGS) procedures
- Cornea – small investment, corneal tissue problems
- Oculoplastics – subtle coding and billing

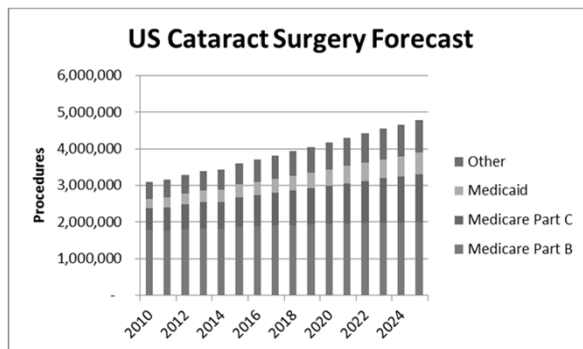
Plan: Add New Products

- Cataracts constitute highest volume in ophthalmic ASCs
- Consider products that improve profitability
 - Premium IOLs (presbyopia, astigmatism)
 - Astigmatism correction

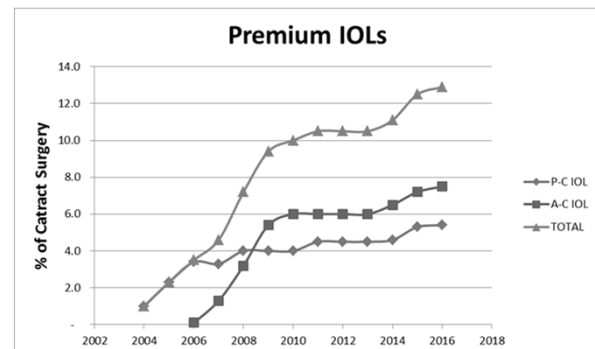
Part B Medicare ASC Procedures



US Cataract Surgery



Premium IOL Utilization



Sources: Corcoran Consulting Group, Market Scope

Outline

- Conditions for Coverage
- Growing Revenue
- ASC Quality Reporting



2017 ASC Quality Reporting

ASC-5 must always be reported on claims for complete claims compliance

EXAMPLE:

- G8907 is used on most claims to denote no documented fall, burn, wrong site/side/pt or procedure, or hospital admissions
- G8918 is added for no order for IV prophylactic antibiotics (most ophthalmic cases)

2017 ASC Quality Reporting

The following measures must be reported using QNET by August 15, 2017

- ASC-6 Safe surgery checklist use
- ASC-7 Facility volume data on selected ASC surgical procedures
- ASC – 9 & 10 Endoscopy related. Enter 0 for these measures, but must enter it – DO NOT LEAVE BLANK

2017 ASC Quality Reporting

Input data to NHSN for flu vaccinations by May 15

ASC-8 Influenza vaccination coverage among healthcare personnel (anyone working in the facility October 1, 2016 through March 31, 2017)

2017 ASC Quality Reporting

ASC-11 Cataracts: Improvement in patient's visual function within 90 days following cataract surgery

Continues to be VOLUNTARY

2020 ASC Quality Reporting

No additional measures added for this year's reporting cycle, but CMS finalized the addition of 7 measures for payment year 2020

(Proposed) ASC-13 Normothermia outcome, which assesses the percentage of patients having surgical procedures under general or neuraxial anesthesia of 60 minutes or more in duration who are normothermic within 15 minutes of arrival in the post-anesthesia unit.

Will apply to some ophthalmic ASCs for longer retina cases or possibly longer plastics procedures under general anesthesia

2020 ASC Quality Reporting

(Proposed) ASC-14 Unplanned Anterior Vitrectomy, which assesses the percentage of cataract surgery patients who have an unplanned anterior vitrectomy (removal of the vitreous present in the anterior chamber of the eye).

Well-known physicians acquire referrals for difficult cases from other sources, making their overall percentage of difficult cases higher than those physicians referring

Only if the physician notes in the clinical chart and warns the ASC in writing of a potential vitrectomy due to a difficult case, then it is a planned event – do not report

2020 ASC Quality Reporting

(Proposed) ASC-15 (a-e) Five finalized measures that are collected using the Outpatient and Ambulatory Surgical Center Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) survey, a patient experience or care survey that assesses patients' access to care, interactions with facility staff, and overall experience at the facility.



How To Prepare

- Start now
- Train staff to provide superior service – online and consulting tools
- Focus on the patient throughout the process
- Address any issues of concern before the patient leaves the facility
- Choose your third party vendor and begin at some point this year to have well established practices
- Jan 1, 2018 – required for payment decisions in 2020

Outline

- Conditions for Coverage
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- ASC Quality Reporting
- Revenue Cycle Management



ASC Preauthorizations

- More frequent preauthorizations; becoming common
- Some require the exact date of service, but may only be good for short period of time (patient cancellation issues)
- Some provide 12 month expirations while others have very narrow windows (causing issues with second eye cataract procedures)
- Even for straightforward laser surgery (YAG, SLT, PI)
- Some refuse laser surgery in ASC – only in-office

ASC Payment Issues

United Healthcare - Medicare Advantage Plans

- Claims are submitted
- 30 - 45 days later, when payment should be expected, an audit letter comes with records request of clinical charts proving medical necessity as well as operative reports
- Items are submitted
- Status checked- nothing received
- Entire process begins again
- Payments come when they feel like it



ASC Payment Issues

Veterans Administration

- Claims never paid under 45 days, and can be over 60 days
- No information is requested and on hold times for status checks are extensive
- Constant follow up is required to simply receive payment for services rendered to patients that were sent for surgery due to not having access at the VA



ASC Payment Issues

Exchange plans, such as Molina Marketplace and Ambetter

- Will not authorize cataract surgery based on glare complaints or glare VA – must be appealed
- Will not give authorization for both eyes – must submit postop VA of first eye
- Will not give authorization for YAGs within 12 months of cataract surgery



ASC Payment Issues

iStent surgery

- UHC and BCBS requiring all clinical chart data prior to payment consideration
- State they have submitted to their experts and are waiting on decision



ASC Payment Impact

- A/R
 - Days outstanding for some payers over 120 days!
- Billing personnel productivity
 - Time consuming – multitasking
- Staffing
 - Labor expenses for overtime/additional hires
- General cash flow
 - A/R increases, need cash paying procedures to offset slow insurance payments



Plan: Strengthen Billing Team

- Billing processes and systems
- Certified coders
- A/R benchmarking
- Constant consistency in tracking payments
- Immediate communication
- Provide feedback – appreciation



Revenue Cycle Management

- Hire enough staff to process claims and to follow up
- Train billing staff to keep communication lines open to determine where help is needed
- Discuss weekly to determine best courses of action for payment
- Motivate staff with team building experiences and/or bonus structures
- Encourage certification process to become certified coders
- Seek help from consultants, congressmen, or state departments/bureaus of insurance

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ASC Payment 2017

- For those meeting the quality reporting requirements
- Wage adjustment for budget neutrality (0.9996)
- Multi-factor productivity adjustment (1.9%)
- 2017 ASC conversion factor = \$45.030 (+2%)



Source: ASCRS Regulatory Alert 11/4/16

ASC Payment Rates

CPT	Procedure	2015	2016	2017
66984	ECCE w IOL	\$960	\$976	\$977
66821	YAG Capsulotomy	\$243	\$246	\$254
66180	Aqueous Shunt	\$1,711	\$1,794	\$1,747
15823	Blepharoplasty	\$771	\$789	\$771

Source: 2017 rates – CMS Addendum AA

ASC Payment Rates – Large Change

CPT	Procedure	2016	2017	%
67101	Repair RD, cryo	\$457	\$198	-57%
67027	Implant intravitreal drug system	\$2,262	\$1,563	-31%
67105	Repair RD, laser	\$246	\$171	-31%
65855	Trabeculoplasty	\$175	\$133	-24%
0308T	Ocular telescope prosthesis	\$17,629	\$15,824	-10%

Source: CMS 2016 & 2017 ASC payment rates

ASC Payment Rates – Large Change

CPT	Procedure	2016	2017	%
0100T	Retinal prosthesis	\$7,667	\$146,086	1,805%
65770	Keratoprosthesis	\$2,262	\$6,297	178%
67115	Release buckle	\$976	\$1,747	79%
67041	Macular pucker surgery	\$976	\$1,747	79%
67036	PPV	\$976	\$1,747	79%
66600	Iridectomy	\$976	\$1,747	79%
66225	Repair staphyloma w graft	\$976	\$1,747	79%
66174	Canaloplasty w/o stent	\$976	\$1,747	79%

Source: CMS 2016 & 2017 ASC payment rates

ASC Payment Rates – Large Change

CPT	Procedure	2016	2017	%
66155	Fistulization, cautery	\$976	\$1,747	79%
65880	Sever cornealvitreal adhesions	\$976	\$1,747	79%
0191T	GDD internal approach TM	\$1,794	\$2,538	42%
0253T	GDD internal approach SCS	\$1,794	\$2,432	36%

Source: CMS 2016 & 2017 ASC payment rates

Corneal Tissue

- V2785 (processing, preserving, and transporting corneal tissue)
- Eligible corneal transplant procedures
 - 65710 – Anterior lamellar keratoplasty
 - 65730 – PKP
 - 65750 – PKP in aphakia
 - 65755 – PKP in pseudophakia
 - 65756 – Endothelial corneal transplant
 - 65765 – Keratophakia
 - 65767 – Epikeratoplasty

Source: CY 2016 OPPS/ASC Final Rule, 80 FR 70472

Corneal Tissue

- Status indicator “F” – “not paid under OPPS; paid at reasonable cost”
- Only for eligible transplant procedures
- In all other procedures, cornea tissue is incidental, bundled

Source: MCPM Chapter 4, §200.1 Billing for corneal tissue

Pass-through Expiration

- C9447 – injection, phenylephrine and ketorolac, 4 ml vial
- APC 1663
- Expires 12/31/17

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CPT Code Revisions

- 67101 *Repair of retinal detachment, ~~4 or more sessions; cryotherapy or diathermy~~ including drainage of subretinal fluid when performed; cryotherapy*
- 67105 *photocoagulation ~~including drainage of subretinal fluid, when performed~~*
- Post-op period changed to 10 days

Source: AMA CPT 2017

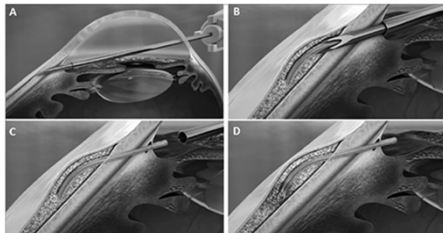
New Category III Code

- 0465T *Suprachoroidal injection of a pharmacologic agent (does not include supply of medication)*
- Effective January 1, 2017

Source: AMA Website

New Category III CPT Codes

- 0449T – *Insertion of anterior segment drainage device, without extraocular reservoir; internal approach, into the subconjunctival space*
- +0450T – *each additional device*

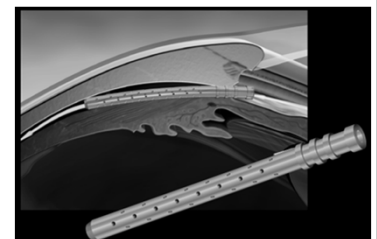


Source: AMA CPT 2017

New Category III Code

- 0474T *Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space*

- Effective July 1, 2017



Source: AMA Website

Coding for MIGS with GDD

- CyPass 0474T (effective 7/1/17)
- ExPRESS 66183
- InnFocus 66183
- iStent 0191T +0253T
- iStent Supra 0253T
- iStent Inject 0191T +0376T
- SOLX 66183
- XEN 0449T +0450T

Source: Corcoran, KJ. Glaucoma Physician, March 2017

Coding for MIGS without GDD

- Kahook Dual Blade 65820
- Trab 360 65820
- Trabectome variable
- ABiC, Visco 360 66174

Source: Corcoran, KJ. Glaucoma Physician, March 2017

Modifier 59 Distinct Procedural Service

... Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision / excision, separate lesion, or separate injury . . .

... When another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

Source: AMA CPT 2015

Level II (HCPCS / National) Modifiers

HCPCS modifiers for selective identification of subsets of Distinct Procedural Services (-59 modifier)

- XE Separate Encounter
- XS Separate Structure
- XP Separate Practitioner
- XU Unusual Non-Overlapping Service

Source: AMA CPT 2015

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Threats to Health Care Data Security

- Lost and stolen computers and mobile devices
- Hacker attacks
- Malicious insiders
- Cloud computing risks
- Potential HIPAA Privacy Rule violation

Unbundling – Potential Overpayment

- *“Unbundling is the use of multiple CPT/HCPCS codes to report a procedure when a single code adequately describes the service or supply.”*
- Examples of possible unbundling
 - Fragmenting into component parts
 - Reporting separately integral services
 - Using modifier 59 inappropriately to break NCCI edits
 - Exploratory procedures followed by definitive procedure
 - Separate procedures
 - Using unlisted codes for “incident to”

Unbundling – Potential Overpayment

- Examples of possible unbundling
 - Blepharoplasty and ptosis surgery
 - Separate charge for fat removal during bleph
 - Serial procedures (same day) billed separately
 - Separate charge for 2nd glaucoma drainage device

Unbundling – Potential Overpayment

- Dropleless cataract surgery – beneficiary asked to pay for TriMoxi or TriMoxiVanc (Imprimis Pharmaceuticals) out-of-pocket
- CMS Transmittal 1759 (June 19, 2009) *“Unless otherwise specified in the long description, HCPCS descriptions refer to the non-compounded, FDA-approved final product. If a product is compounded and a specific HCPCS code does not exist for the compounded product, the ASC should include the charge for the compounded product in the charge for the surgical procedure performed.”*

Unbundling – Potential Overpayment

- Dropleless cataract surgery – beneficiary asked to pay for TriMoxi or TriMoxiVanc (Imprimis Pharmaceuticals) out-of-pocket
- Incorrect billing: J3300 – Triamcinolone acetonide, preservative free (Triesence®)
- 67028 – “*separate procedure*”
- Prophylactic antibiotic and anti-inflammatory agents, incidental to cataract surgery

Dropleless Cataract Surgery

“... physicians or facilities should not give Advance Beneficiary Notices (ABNs) to beneficiaries for either these drugs or for injection of these drugs because they are fully covered by Medicare. Physicians or facilities are not permitted to charge the patient an extra amount (beyond the standard copayment for the surgical procedure) for these injections or the drugs used in these injections because they are a covered part of the surgical procedure. Also, physicians or facilities cannot circumvent packaged payment in the HOPD or ASC for these drugs by instructing beneficiaries to purchase and bring these drugs to the facility for administration.”

Source: CMS Transmittal 3150 12/12/14

Miscoding

- Sources of confusion and miscoding
 - Misunderstanding CPT terminology
 - Incomplete description in operative report
 - Picking a code that's “close”
- Areas to watch
 - Oculoplastics
 - Complex cataract surgery

Targets for Scrutiny 2017 OIG Work Plan

- Drug Waste of Single Vial Drugs (*new*)
- Management Review: CMS' Implementation of the Quality Payment Program (*new*)
- ASC – Quality Oversight
- Anesthesia services – Payments for personally performed services

Source: HHS OIG FY 2017 Work Plan

Surgeon Buys IOLs Yes or No?

You are the director of an ASC with several cataract surgeons who favor different IOLs. To save space, ordering headaches, and time, a surgeon proposes that IOL consignments be moved to each surgeon's office. Do you approve?

No – Under CfC, ASC must provide the IOL

Potential Kickback

- ASC buys IOLs from surgeon
- May 13, 2014 - Department of Justice Announcement
- Memorial Hospital, Fremont, Ohio
- Pays \$8.5M to settle False Claims Act Allegations
- *"...an arrangement under which an ophthalmologist purchased intraocular lenses and then resold them to Memorial at inflated prices...violated statutory requirements."*

Surgeon Dividends Yes or No?

You are the director of an ASC with several surgeon owners. One of your busy surgeons wants to receive a larger percentage of the ASC profit as a dividend to correspond to the volume of cases. Do you approve?

No – ASC dividends to owners are based on equity ownership and not procedure volume

Refractive Surgery Best Practices

- **Transparency** – clearly inform patients of financial responsibility: for what, how much, why, and when
- **Documentation** – use a financial waiver, ABN or similar instrument to document financial responsibility
- **Separation** – segregate professional and facility fees and monies
- **Compliance** – follow CMS guidelines, and recommendations of AAO & ASCRS

Source: Hovanesian (editor) *Refractive Cataract Surgery, Best Practices and Advanced Technology*, 2nd edition (2017) SLACK

Premium IOL Yes or No?

You are the director of an ASC. A visiting surgeon asked you to let him handle all the financial arrangements for refractive cataract surgery – "it's simpler that way". Do you approve?

- 1) Yes
- 2) No

Premium IOL Yes or No?

You are the director of an ASC. A visiting surgeon asked you to let him handle all the financial arrangements for refractive cataract surgery – “it’s simpler that way”. Do you approve?

No – Separate professional and facility fees.

Premium IOLs Yes or No?

An ASC purchases a toric IOL for \$495 and bills the surgeon \$505.50 for it including a small handling fee to cover shipping. The surgeon bills the patient \$550 for the IOL. As the director of the ASC, do you approve?

- 1) Yes
- 2) No

Premium IOLs Yes or No?

An ASC purchases a toric IOL for \$495 and bills the surgeon \$505.50 for it including a small handling fee to cover shipping. The surgeon bills the patient \$550 for the IOL. As the director of the ASC, do you approve?

No – The surgeon’s profit of \$44.50 is a problem

FS Laser Fee Yes or No?

Your ASC bought a FS laser. You were advised by another ASC director to establish a policy that any surgeon who uses the laser must pay a “use fee”. Do you approve?

- 1) Yes
- 2) No

FS Laser Fee Yes or No?

Your ASC bought a FS laser. You were advised by another ASC director to establish a policy that any surgeon who uses the laser must pay a “use fee”. Do you approve?

No – Use of the FS laser in cataract surgery is solely the ASC’s financial responsibility – not the surgeon’s. Use of the FS laser in refractive surgery is the patient’s financial responsibility.

Next Steps

- Review any payments to surgeons
- Review coding of operative reports
- Review claims for NCCI and MUE edits
- Strengthen Compliance Plan

Questions Or Concerns?

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