Reimbursement Challenges in an ASC

Nikki Hurley, RN, BSN, MBA, COE
Key-Whitman Eye Center

Kevin J. Corcoran, COE, CPC, CPMA, FNAO
President, Corcoran Consulting Group

Financial Disclosure

Nikki Hurley, RN
• 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.

Summary

• ASC Payment Rates
• ASC Quality Reporting
• Revenue Cycle
• Compliance
• Coding
• Growing Revenue

ASC Payment 2016

• For those meeting the quality reporting requirements
• Wage adjustment for budget neutrality (0.9997)
• Multi-factor productivity adjustment (0.3%)
• 2016 ASC conversion factor = $44.177 (+0.27%)

Source: ASCRS Regulatory Alert 10/30/15

ASC Payment Rates – Small Change

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>66984</td>
<td>ECCE w IOL</td>
<td>$976</td>
<td>$960</td>
<td>$976</td>
</tr>
<tr>
<td>66821</td>
<td>YAG Capsulotomy</td>
<td>$237</td>
<td>$243</td>
<td>$246</td>
</tr>
<tr>
<td>66180</td>
<td>Aqueous Shunt</td>
<td>$1,678</td>
<td>$1,711</td>
<td>$1,794</td>
</tr>
<tr>
<td>15823</td>
<td>Blepharoplasty</td>
<td>$757</td>
<td>$771</td>
<td>$789</td>
</tr>
</tbody>
</table>

Source: 2016 rates – CMS Addendum AA

ASC Payment Rates – Large Change

<table>
<thead>
<tr>
<th>CPT</th>
<th>Procedure</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>65770</td>
<td>Keratoprosthesis</td>
<td>$6,885</td>
<td>$2,262</td>
</tr>
<tr>
<td>65280</td>
<td>Repair perforated cornea</td>
<td>$960</td>
<td>$1,794</td>
</tr>
<tr>
<td>66174</td>
<td>Canaloplasty w/o stent</td>
<td>$1,711</td>
<td>$976</td>
</tr>
<tr>
<td>66940</td>
<td>ECCE w/o IOL</td>
<td>$412</td>
<td>$976</td>
</tr>
<tr>
<td>67027</td>
<td>Intravitreal drug implant device</td>
<td>$1,711</td>
<td>$2,262</td>
</tr>
<tr>
<td>67036</td>
<td>Pars plana vitrectomy</td>
<td>$1,711</td>
<td>$976</td>
</tr>
<tr>
<td>67041</td>
<td>Macular pucker surgery</td>
<td>$1,711</td>
<td>$976</td>
</tr>
</tbody>
</table>

Source: CMS 2015 & 2016 ASC payment rates – CMS Addendum AA
Corneal Tissue Reimbursement

- CMS limits separate payment for corneal tissue processing (V2785) to corneal transplant procedures
- Corneal tissue used as patch graft in glaucoma shunt surgery is bundled and not separately paid

Source: ASCRS Regulatory Alert 10/30/15

OPPS Pass-Through Regulation

- Outpatient Prospective Payment System
  - Medicare’s payment system for HOPD and ASC
  - Pre-set fee schedule for cataract
  - Generally includes all supplies
  - Exception for pass-through drugs and devices
  - CMS determined the cost of the drug or biological is not insignificant in relation to the amount payable for the applicable APC

OPPS Pass-Through Regulation

- Pass-through for Omidria (phenylephrine/ketorolac)
  - C9447 – a single-use-vial (4 ml)
  - Separate reimbursement through 12/31/17
  - Copayment applies in ASC setting (20%)

Mitosol Reimbursement

- Expiration of pass-through for Mitosol
- J7315 assigned status indicator "N" on 1/1/16
- Drugs that function as supplies when used in a surgical procedure
- Mitosol is “for use as an adjunct to ab externo glaucoma surgery”
- CFR §419.2(b)(16) – OPPS basis of payment


Bilateral Cataract Surgery – MAC LCD

"Immediate, sequential, bilateral surgery has advantages and disadvantages that must be carefully weighed and discussed by the surgeon and patient. Foremost is the risk of potentially blinding complications in both eyes. For this reason the second eye should be treated like the eye of a different patient using separate povidone iodine prepping, draping, instrumentation, and supplies such as irrigating solutions, OVD, and medications."

Source: NGS LCD L33558

In-office Cataract Surgery

- CMS requesting comment on in-office cataract surgery
- CMS exploring development of non-facility practice expense RVUs for cataract surgery

Source: The Ophthalmic ASC – 10/2015; CMS-1631-FC
Executive Summary

- ASC Payment Rates
- ASC Quality Reporting

ASC Quality Reporting Program

- No new measures
- Updated ASC Quality Reporting Specifications Manual, Version 5.0 is available on the QualityNet website

Source: ASCRS Regulatory Alert 10/30/15;

2016 ASC Reporting

- Anticipate additions in the future
- Proposed rule for anterior vitrectomies during cataract surgery
- Remember to 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, 2014 through March 31, 2016)

2016 ASC 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 prophylactic antibiotics

2016 ASC Reporting

- ASC-11 Cataracts: Improvement in patient’s visual function within 90 days following cataract surgery
  Continues to be VOLUNTARY

Executive Summary

- ASC Payment Rates
- ASC Quality Reporting
- Revenue Cycle
ASC Preauthorizations

- NEW: Many payers now requiring preauthorizations that did not in the past
- Some payer policies being developed with narrow networks requiring preauthorizations
  - Timeliness of acquiring preauthorizations
  - Some will not provide until procedure is scheduled
  - Some are provided with 12 month expirations while others have very narrow windows (causing issues with second eye cataract procedures)
- Preauths required for YAGs and SLTs in the ASC

MA 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
- Payments come 60 or more days later or the process of asking for more items is repeated
  - Example: UHC and iStent

Veterans Administration

- Claims never paid under 45 days
- No information is requested
- 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 Impact

- A/R
- Billing personnel productivity
- Staffing
  - Labor expenses for overtime/additional hires
- General cash flow

Plan: Strengthen Billing Team

- Billing processes and systems
- Certified coders
- A/R benchmarking

Plan: Revenue Cycle Management

Source: Google – Revenue Cycle Management
Executive Summary

- ASC Payment Rates
- ASC Quality Reporting
- Revenue Cycle
- Compliance

Medicare Advantage Organizations

- Do not use an ABN
- Notice of denial of coverage issued by MAO (similar to a preauthorization)
- Pre-service organization determination from the MAO
  - Patient requested
  - Provider requested
- Check with MAO plans on process


Medicare Advantage Organizations

Key considerations:
- May require itemized list of services with CPT codes and ICD-10 codes
- May require submission of codes for noncovered services on claim with modifiers GA and GY on same claim with covered services
- Without denial notification prior to surgery, MAO could require physician to refund patient for noncovered items / services

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."

Kickback

Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program...

Source: Social Security Act §1128B

Potential Kickback

- ASC pays surgeons for FS laser
  - Arrangement does not fall within safe harbor
  - A safe harbor is a provision of a statute or regulation that specifies certain conduct will be deemed not to violate a given rule.
Potential Kickback

- ASC pays dividends to surgeon-owners based on volume of cases performed

Medicare Reimbursement for Medically Necessary Cataract Surgery

- Well-defined coverage and payment parameters for surgery (66984, 66982)
- Medically necessary cataract surgery is covered
- Cataract surgery includes:
  - Making an opening in the eye to permit entrance of surgical instruments
  - Capsulorrhexis of the anterior capsule
  - Fragmentation of the lens nucleus

Ancillary Noncovered Items and Services with Cataract Surgery

- May bill the patient for non-covered services such as:
  - Cataract surgery that does not qualify as a covered procedure
  - Astigmatism assessment and treatment, including toric IOL
  - Presbyopia assessment and treatment, including presbyopia-correcting IOL
  - Cannot bill the patient extra for anything that is a part of the covered service

Professional Societies Advisory

- AAO and ASCRS publish joint guidelines in November 2012
- Limits when charges to patient for FS laser to:
  - Refractive lens exchange
  - Refractive astigmatic keratometry
- Encourage transparency of patient-shared pricing

Laser-Assisted Cataract Surgery

- CMS guidance published November 16, 2012

  "Medicare coverage and payment for cataract surgery is the same irrespective of whether the surgery is performed using conventional surgical techniques or a bladeless, computer controlled laser."

  "Medicare patients may be charged a fee for performing astigmatic keratotomy, assuming that they were informed about, and consented to, the non-covered charges in advance."

Medicare’s Coverage Policy

Refractive Keratoplasty

"...keratoplasty for the purpose of refractive error compensation is considered a substitute or alternative to eye glasses or contact lenses, which are specifically excluded...keratoplasty to treat refractive defects are not covered."

Source: NCD 80.7 Medicare Policy Keratoplasty
Advance Beneficiary Notice of Noncoverage (ABN)

- Option 1. I want the _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment...I can appeal to Medicare...
- Option 2. I want the _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal to Medicare...
- Option 3. I don't want the _____ listed above. I understand with this choice I am not responsible for payment...I cannot appeal to Medicare...

Key Points

- Anything included in cataract surgery was already covered and paid
- Refractive testing and surgery is non-covered
- Use ABN or financial waiver forms

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

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. Any patient who requests laser-assisted cataract surgery, with or without refractive surgery, is asked to pay the ASC an out-of-pocket laser fee of $900. Is this a good policy?

1) Yes
2) No
**FS Laser Fee  Yes or No?**

Your ASC bought a FS laser. Any patient who requests laser-assisted cataract surgery, with or without refractive surgery, is asked to pay the ASC an out-of-pocket laser fee of $900. Is this a good policy?

No – ASCs must accept assignment. Balance billing for a covered service (cataract surgery) is prohibited.

---

**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**

- Dropless 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**

- Dropless 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

---

**Dropless Cataract Surgery**

“Injections are a part of the ocular surgery and are included as a part of the ocular surgery and the HCPCS code used to report the surgical procedure.”

“Although these drugs are a covered part of the ocular surgery, no separate payment will be made.”

Source: CMS Transmittal 3150 12/12/14
### Dropless 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

### Potential Violations of CfC

- Reusing “single use” vials and/or devices
- Requiring patients to bring medications to ASC for use during surgery

### 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

### OIG Strategic Plan 2014 - 2018

- **Goals**
  1. Fight Fraud, Waste, and Abuse
  2. Promote Quality, Safety, and Value
  3. Secure the Future
  4. Advance Excellence and Innovation
- Each goal has a list of 3 to 4 priorities
- Health Care Fraud and Abuse Control program returned $7 for every $1 invested


### Targets for Scrutiny 2016 OIG Work Plan

- Payments for drugs
- Ambulatory Surgical Centers – Payment System
- Anesthesia services
- Noncompliance with assignment rules and excessive billing of beneficiaries

### Medicare FFS Improper Payments

- **CY 2014**
  - Cataract procedures: 4.1% error rate
  - Ophthalmology: 3.5% error rate
  - ASC: 1.5% error rate
- **Compare to:**
  - All providers: 12.1% error rate

Source: DHHS: Medicare FFS 2014 Improper Payments Report
**HIPAA Privacy Rule**

Reporting of breach:
1. Individual notice to the patient(s) within 60 days following the discovery
2. If > 500 patients, notify media outlets in the area within 60 days of discovery
3. Notify secretary of DHHS with breach reporting form on HHS website. If > 500 patients report “without reasonable delay”, no later than 60 days. If < 500 report on an annual basis.

Source: http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/breachnotificationrule.html

---

**Next Steps**

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

---

**Executive Summary**

- ASC Payment Rates
- ASC Quality Reporting
- Revenue Cycle
- Compliance
- Coding

---

**New Category I CPT Code**

- Intrastromal Corneal Ring Implantation
- 65785 replaces 0099T
- Implantation of intrastromal corneal ring segments


---

**CPT Code Revisions**

- 65855 Trabeculoplasty by laser surgery
- 67227 Destruction of extensive or progressive retinopathy (eg, diabetic retinopathy), cryotherapy, diathermy
- 67228 Treatment of extensive or progressive retinopathy (eg, diabetic retinopathy), photocoagulation
- One or more sessions verbiage removed

Source: AMA CPT 2016

---

**CPT Code Revisions**

- 67101 Repair of retinal detachment, 1 or more sessions; cryotherapy or diathermy with or without including drainage of subretinal fluid when performed
- 67105 photocoagulation with or without including drainage of subretinal fluid, when performed

Source: AMA CPT 2016
CPT Code Revisions

• 67107 Repair of retinal detachment; scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), with or without including, when performed, implant, with or without cryotherapy, photocoagulation, and drainage of subretinal fluid

• 67108 with vitrectomy, any method, with or without including, when performed, air or gas . . .

Source: AMA CPT 2016

CPT Code Revisions

• 67113 Repair of complex retinal detachment . . . with vitrectomy and membrane peeling including, may include when performed, air, gas, or silicone oil . . .

Source: AMA CPT 2016

Deleted CPT Code – RD Repair

• 67112 by scleral buckling or vitrectomy on patient having previous ipsilateral retinal detachment repair(s) using scleral buckling or vitrectomy techniques

Source: AMA CPT 2016

New Category III Code

• 0402T Collagen cross-linking of cornea (including removal of the corneal epithelium and intraoperative pachymetry when performed)

(Do not report 0402T in conjunction with 65435, 69990, 76514)

• Released July 1, 2015; effective January 1, 2016

Source: AMA Website

Revised Category III Code

• 0308T Insertion of ocular telescope prosthesis including removal of crystalline lens or intraocular lens prosthesis

Source: CPT 2016

New HCPCS Code – Iluvien

• J7313 – Injection, fluocinolone acetonide intravitreal implant, 0.01 mg

• Implant is fixed dose containing 0.19 mg

• Requires 19 units on claim

• FDA approved indication: “DME in patients who have been previously treated with a course of corticosteroids and did not have a clinically significant rise in IOP”

• Intravitreal injection (67028)

Source: CMS Transmittal R3225; HCPCS 2016
**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

---

**Executive Summary**

- ASC Payment Rates  
- ASC Quality Reporting  
- Revenue Cycle  
- Compliance  
- Coding  
- Growing Revenue

---

**Plan: Grow Procedure Volume**

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

---

**Plan: Grow Procedure Volume**

- Review most profitable, compliant surgeons and engage clinic to discover ways to boost volume  
- 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  
- Research other specialties that could be a good fit for your ophthalmic surgery center (ensuring your license allows for multi-specialties)

---

**Expansion Complications**

- 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
- MIGS procedures
- Cornea – small investment, corneal tissue problems
- Oculoplastics

Plan: Add New Products

- When considering new products, do your homework!

Questions Or Concerns?

Nikki Hurley, RN
can be reached at:

Nikki.Hurley@KeyWhitman.com
or
(866) 605-4455

Additional Assistance

(800) 399-6565
Website: www.CorcoranCCG.com
Mobile application: Corcoran 24/7