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
Founder, Corcoran Compliance Connection

Educational Objectives
- Identify challenges for ASCs:
  - Quality measures
  - Lower and slower reimbursement
  - Compliance issues
  - Recognize potential trouble – how to handle it
  - Formulate best practices for ASCs

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

ASC Payment 2015
- Wage adjustment for budget neutrality (0.9998)
- Multi-factor productivity adjustment (1.4%)
- 2014 Conversion factor ($43.471)
- 2015 Conversion factor ($44.071)
- For those meeting the quality reporting requirements

ASC Medicare Payment Rates

<table>
<thead>
<tr>
<th>CPT</th>
<th>Procedure</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>66984</td>
<td>ECCE w IOL</td>
<td>$971</td>
<td>$976</td>
<td>$961</td>
</tr>
<tr>
<td>66821</td>
<td>YAG Capsulotomy</td>
<td>$231</td>
<td>$237</td>
<td>$243</td>
</tr>
<tr>
<td>66170</td>
<td>Trabeculectomy</td>
<td>$941</td>
<td>$966</td>
<td>$961</td>
</tr>
<tr>
<td>15823</td>
<td>Blepharoplasty</td>
<td>$847</td>
<td>$757</td>
<td>$771</td>
</tr>
</tbody>
</table>

Source: ASCRS Regulatory Alert 10/31/14; CMS Fact sheet 10/31/14

Source: CMS

Financial Disclosure
Nikki Hurley, RN
- No financial interests or relationships to disclose.

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

- ASC Payment Rates
- ASC Quality Reporting

ASC Quality Measures

- ASC quality measure reporting began 10/1/12
- 98.9% of ASCs successfully reported - avoiding 2% reduction to facility reimbursement in 2015

Source: https://www.qualitynet.org/dcs/ContentServer?c=Page&pageName=QnetPublic%2FPage%2FQnetTier3&cid=1228773657692

2015 ASC Reporting

ASCs will be assessed penalties unless the following is provided.

- ASC measures 1-5, reported on claims, continually
  - ASC-1: Patient burn
  - ASC-2: Patient fall
  - ASC-3: Wrong site, wrong side, wrong patient, wrong procedure, wrong implant
  - ASC-4: Hospital Transfer/Admission
  - ASC-5: Prophylactic IV antibiotic timing

2015 ASC Reporting

Remember, ASC-5 must always be reported 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
- G8907 is added for no order for prophylactic antibiotics

2015 ASC Reporting

NEW for 2015, added measure ASC-12 must also be reported on claims for any multispecialty ASC

- ASC-12, reported on claims
  Facility 7 day risk standardized hospital visit rate after outpatient colonoscopy

2015 ASC Reporting

The following measures must be reported using QNET by August 15, 2015
- ASC-6: Safe surgery checklist use
- ASC-7: ASC facility volume data on selected ASC surgical procedures
- ASC-9 and 10: Endoscopy related. Currently not allowed to report because "0" not recognized. QNET will resolve and notify you.
2015 ASC Reporting

The following measure must be reported through the CDC's National Health Safety Network by August 15, 2015

• ASC-8 Influenza vaccination coverage among healthcare personnel (anyone working in the facility October 1, 2014 through March 31, 2015)

2015 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 Payment – Slow-Mo Games

• United Healthcare and Medicare Advantage Plans

• Claims are submitted
• 30 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
• Another 30 days before payment arrives, unless further clarification is needed

ASC Payment – Slow-Mo Games

• BCBS denying claims based on the fact that the claim is a duplicate
• Appeal process/phone calls/submitted data to support that the claim is indeed an “original”
• Timing for denials, appeals, follow up, and payment ranges from 30-60 days

ASC Payment – No-Mo Games

• CMS started new protocols for corneal tissue payments in efforts to seemingly delete corneal tissue reimbursement
• CMS 1500 line 19 must have PWK*M1 recorded
• Ensure inbound file loop 2300 and outbound loop 2300 PWK indicator is attached
• Within 7 days fax the corneal tissue invoice
• Denials common
• Must call representative and insist they track it down and pay
**ASC Payment – Don’t-Owe Games**

United Healthcare

- History of denying based on capitation plans and instructs facility to send to secondary payer
- UHC is responsible for the claim
- Appeals/calls/follow-up

**ASC Payment Impact**

- A/R
- Billing personnel productivity
- Staffing
- 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

**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.”
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

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

- 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

---

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

---

Next Steps

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

---

Targets for Scrutiny

2015 OIG Work Plan

- Place of Service Errors
- Payments for drugs
- Ambulatory Surgical Centers – Payment System
- Ophthalmological Services – Questionable billing
- Noncompliance with assignment rules and excessive billing of beneficiaries
New Targets for Scrutiny
2015 OIG Work Plan

- Anesthesia services – Payments for personally performed services
- Payment for compounded drugs under Medicare Part B
- Security of Electronic Health Records

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

Executive Summary

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

New / Revised CPT Codes

- 66179  Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft (new)
- 66180  with graft (revised)
  (Do not report 66180 in conjunction with 67255)

CPT Code Deletion

- 66165  Fistulization of sclera for glaucoma; iridencleisis or iridotasis

New / Revised CPT Codes

- 66184  Revision of aqueous shunt to extraocular equatorial plate reservoir; without graft (new)
- 66185  with graft (revised)
  (Do not report 66185 in conjunction with 67255)

Source: AMA CPT 2015
New / Revised Category III CPT Codes

- 0191T Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into trabecular meshwork; initial insertion (revised)
- + 0376T each additional device insertion (List separately in addition to code for primary procedure) (new)
- No additional facility reimbursement for 0376T

Source: AMA CPT 2015; CMS ASC and HOPD addenda

Revised Category III CPT Code

- 0253T Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the suprachoroidal space

Source: AMA CPT 2015

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
- Investigational research
- Increase offering of noncovered services
  - Refractive surgery
  - Cosmetic surgery
Medicare Part B ASC Volume (000's)

<table>
<thead>
<tr>
<th>Procedure</th>
<th>CPT</th>
<th>CY 2012</th>
<th>CY 2013</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Eye Cases</td>
<td>1,881</td>
<td>1,930.5</td>
<td>3%</td>
<td></td>
</tr>
<tr>
<td>Phaco w/ IOL</td>
<td>66984</td>
<td>1,157.9</td>
<td>1,186.0</td>
<td>2%</td>
</tr>
<tr>
<td>YAG</td>
<td>66821</td>
<td>264.1</td>
<td>276.6</td>
<td>5%</td>
</tr>
<tr>
<td>Cpx Phaco w/ IOL</td>
<td>66982</td>
<td>92.3</td>
<td>97.5</td>
<td>6%</td>
</tr>
<tr>
<td>SLT, ALT</td>
<td>85855</td>
<td>33.4</td>
<td>34.6</td>
<td>4%</td>
</tr>
<tr>
<td>Phake repair</td>
<td>67904</td>
<td>33.0</td>
<td>32.8</td>
<td>7%</td>
</tr>
<tr>
<td>Laser PI</td>
<td>66761</td>
<td>22.3</td>
<td>22.2</td>
<td>0%</td>
</tr>
<tr>
<td>Intravit Inj</td>
<td>67028</td>
<td>21.9</td>
<td>19.3</td>
<td>-12%</td>
</tr>
<tr>
<td>Ectropion repair</td>
<td>67917</td>
<td>16.7</td>
<td>17.3</td>
<td>4%</td>
</tr>
<tr>
<td>Brow lift</td>
<td>67900</td>
<td>11.9</td>
<td>12.3</td>
<td>3%</td>
</tr>
<tr>
<td>PPV ILM</td>
<td>67042</td>
<td>11.0</td>
<td>12.5</td>
<td>7%</td>
</tr>
</tbody>
</table>

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!
  - Medications

OPPS Pass-Through Regulation

- Outpatient Prospective Payment System
  - Medicare’s payment system for HOPD and ASC
  - Pre-set fee schedule for cataract (APC 246)
  - 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
  - Effective January 1, 2015
  - C9447 – a single-use-vial (4 ml)
  - APC 1663
  - Wholesale Average Cost + 6%
    - Q1, Q2 2015 ($492.90)
  - Average Selling Price + 6% beginning in Q3 2015
  - Separate reimbursement through December 31, 2017

Copayment

- Copayment for Omidria
  - HOPD – no copayment
  - ASC – 20% copayment

Plan: Add New Products

- Cataracts represent highest volume in most ophthalmic ASCs
  - Consider products that can boost profitability
    - Lenses
    - Astigmatism correction
    - FS laser-assisted cataract surgery

Premium IOL Utilization

Sources: Corcoran Consulting Group, Market Scope

Challenge: Refractive Surgery

- Legal jeopardy (e.g., kickback)
- Segregation of funds (i.e., ASC and surgeon)
- Purchasing arrangements (i.e., IOLs, equipment)

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
  - Refraction
  - Non-covered ancillary diagnostic tests (e.g., screening OCT)
  - Astigmatism assessment and treatment, including toric IOL
  - Presbyopia assessment and treatment, including presbyopia-correcting IOL
  - Routine eye care beyond the global surgery period
- 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

---

**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

---

**Premium IOLs**

**Yes or No?**

You are the director of an ASC that uses premium IOLs. One of your surgeons wants to provide these IOLs from his own office consignment. 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?

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?

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?

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

Questions Or Concerns?

Nikki Hurley, RN
can be reached at:

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

More help...

For additional assistance or confidential consultation, please contact Kevin Corcoran at:

(800) 399-6565
or
www.CorcoranCCG.com