Agenda

11:30 am  **OOSS Welcome** by President, David George, MD and Immediate Past President, Cathleen McCabe MD

11:35 am  **Johnson & Johnson Vision Address** by Sandor Palfi, the VP of the Americas, J&J Vision

11:40 am  **Washington Update** by Mike Romansky, JD, OOSS Washington Counsel

11:50 pm  **Keeping it Straight with the Feds and State** - Allison Shuran, JD and Kevin Corcoran, COE, CPC, CPMA, FNAO, President of Corcoran Consulting Group

12:35 pm  **Operational Innovation** by Brandon Coombs, VP Business Development, SurgLogs

12:40 pm  **Innovation that makes sense (and dollars) Panel** - Todd Albertz, Director, Healthcare Solutions, Eckert Wordell, Mark King, Administrator of Tyson Eye, Cape Coral, FL, Albert Castillo, OOSS Director of Member Services and CEO of San Antonio Eye.

1:00 pm  **Close**
State of OOSS

- Financially healthy
- Welcomed new members
- Welcomed new strategic and marketing partners
- Solid foundation with long-standing members and partners
- Launching new programs and initiatives
People, Programs and Initiatives

- William Wiley, MD, elected OOSS Vice President
- Private Equity Collaboration
- Eyepro GPO
- Sustainability
Sustainability Initiatives

OOSS initiatives over the last 4 years – joint association collaboration:

• OICS instrument sterilization taskforce
• OR Waste Perception global research
• Pre and post med use and reuse survey
Eye Sustain

• Led by ASCRS, AAO and ESCRS
• Over 24 global societies participating, including OOSS
• New website, app and exhibit
• Leadership and attendees
OOSS engagement and initiatives

- Call to action!

• Facility pledge
  • Agreement to promote sustainability of quality eye surgery through education and collaboration.
  • 7 points

• OR Recycling Initiative
  • Instruments and solutions – working with industry, i.e., Hasa Optix
  • Survey on current practices, barriers and key opportunities
  • Form a committee of volunteers
OUR CREDO

WE BELIEVE OUR FIRST RESPONSIBILITY IS TO THE PATIENTS, DOCTORS AND NURSES, TO MOTHERS AND FATHERS AND ALL OTHERS WHO USE OUR PRODUCTS AND SERVICES. IN MEETING THEIR NEEDS EVERYTHING WE DO MUST BE OF HIGH QUALITY. WE MUST CONSTANTLY STRIVE TO PROVIDE VALUE, REDUCE OUR COSTS AND MAINTAIN REASONABLE PRICES. CUSTOMERS' ORDERS MUST BE SERVICED PROMPTLY AND ACCURATELY. OUR BUSINESS PARTNERS MUST HAVE AN OPPORTUNITY TO MAKE A FAIR PROFIT.

WE ARE RESPONSIBLE TO OUR EMPLOYEES WHO WORK WITH US THROUGHOUT THE WORLD. WE MUST PROVIDE AN INCLUSIVE WORK ENVIRONMENT. EVERY PERSON MUST BE CONSIDERED AS AN INDIVIDUAL AND EQUALLY TREATED.

SANDOR PALFI
THE VP OF THE AMERICAS

Johnson & Johnson VISION
WASHINGTON UPDATE:
THE 2023 OOSS AGENDA

Michael A. Romansky, JD
Washington Counsel, OOSS
mromansky@OOSS.org
Which Issues Are of Concern to Ophthalmic ASCs?

Survey Results, 2022:

- Reasonable and equitable facility payments – 99%
- Ameliorating unreasonable infection control and other regulatory requirements – 97%
- Leveling playing field in HOPD/ASC rates – 96%
- Fighting office-based cataract surgery – 78%
- Preserving physician ownership of ASCs – 92%
- Reasonable and meaningful quality reporting requirements – 94%
- Payment for intracameral drugs – 87%

WHAT UNANTICIPATED CHALLENGES?
WHAT ARE OUR ISSUES?

Goal – No payment for office cataract surgery

Strategy:
• Survey of facilities to ascertain comorbidities and document lack of “routine” cases
• Comprehensive analysis of Medicare ASC conditions for coverage to determine which should apply to offices
• Submission of comprehensive comments to CMS
• Meetings with CMS
• Cultivated allies for the effort and mitigated non-supportive ophthalmology community views
• Refuted “studies” that supported office surgery
• Articles, presentations

Status – 2022 MFS rule; 2025/2027 RUC review
I am frequently wrong, but never in doubt. That said, I offer the following thoughts on the future of OBS under Medicare Part B.

- No Medicare OBS before 2027 at very earliest
- No Medicare OBS until peer-reviewed literature supports safety and efficacy
- No Medicare OBS until the major ophthalmology organizations support it
- No Medicare OBS without appropriate standards
- No Medicare OBS at rates that are anywhere near our payment rates
- OBS only accounts for less than 1/3 of one percent of cataracts; without payment, growth will be marginal

Advocacy Strategy – Remain Vigilant
ASC PAYMENT RULE:
Higher Annual Inflation Update

• **Primary Objective** – Change annual update factor from the CPI-U to the Hospital Market Basket
  - Same patients, resources, costs as HOPDs
  - Different inflators exacerbates gap in payment rates to HOPDs and ASCs
  - Gap in rates is adversely impacting growth in ASC industry

**CMS:** ASCs will receive hospital market basket for ASCs through 2023
  – **GOAL:** Make it PERMANENT!
PAYMENT ISSUES

- Annual update from CPI-U to Hospital Market Basket – accomplished, but only through 2023
- Eliminate secondary rescaler from ASC payment calculation
- Payment for intracameral drugs
- Standalone MIGS
- No ASC cost reporting
- Higher device and drug reimbursement
- NTIOL
- Leveling playing field between ASC and HOPD
ASC Quality Reporting Program

ASC 11, Cataracts: Improvement in Patient Visual Function within 90 days of Cataract Surgery

• Reporting in 2025 for payment determination in 2027
• Deferred through Covid PHE, which is ending May 11
• Met with CMS and will continue battle to have ASC-11 permanently withdrawn

Ridiculous!

• Not related to episode of care in ASC
• Data not available in ASC records
• Won’t produce data actionable in ASC
... AND THAT AIN’T ALL!

- Eliminate arbitrary budget neutrality adjustments that unfairly compress ASC rates
- Sterilization of ophthalmic instruments
- Elimination of unnecessary and burdensome policies
- “Leveling the playing field” between ASC and HOPD rates
- Aetna
Without 40 Years of ASC Reforms, Where Would We Be NOW?

- Could surgeons own ASCs?
- Would our facility payments have increased 300% or would they have dropped like professional fees?
- Would we be able to perform virtually every ophthalmic procedure in the ASC?
- Would Medicare facility regulations be more burdensome? Would we have been regulated out of business?
How Can You Help?

• OOSS’ track record
• Need to build relationships with legislators
• Grassroots: New Advocacy Center (www.ooss.org/advocacy)
  • Follow our current issues – exclusively ASC
  • CONTACT ELECTED OFFICIALS WITH A FEW KEYBOARD STROKES
  • Next year – Enact ASC Quality Act of 2023

• Contribute to OOSSPAC
KEEPING IT STRAIGHT WITH THE FEDS AND THE STATE

Allison W. Shuren, MSN, JD
Partner, Arnold & Porter

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

Allison Shuren is a Partner, Arnold & Porter.

Kevin J. Corcoran is President of Corcoran Consulting Group and acknowledges a financial interest in the subject matter of this presentation.
This information is not an official source, except where specific citations are given, nor is it a complete guide on all matters pertaining to reimbursement. Attendees are strongly encouraged to review official instructions promulgated by the Centers for Medicare and Medicaid Services. Local variations between carriers may occur which are not described here. In addition, you should check with payers for specific payment policies and coding instructions. Finally, this information can and does change over time, and may be incorrect at any time following the presentation.
OUTLINE

· Anesthesia
  · Premium IOLs
  · Femtosecond laser
  · Co-management
  · Office-based surgery
  · Claims submission
  · Medical necessity
Your anesthesia provider informs the ASC there is a new administrative fee in 2023 to schedule him for all cases, and that it is not due from the patient – the ASC must pay $200/case or the ASC will be refused anesthesia services.

How do you respond?

What if there are no anesthesia alternatives?
Assuming the anesthesia provider is submitting a claim to Medicare for the service furnished is there a concern that the collection of additional fees is in tension with assignment?

Similar question if anesthesia is billing for their own services to commercial contracts.

Is there an argument that the anesthesia provider may not submit a claims because the provider has already been paid?

CRNA as an alternative
OUTLINE

- Anesthesia
- **Premium IOLs**
- Femtosecond laser
- Co-management
- Office-based surgery
- Claims submission
- Medical necessity
COMPLIANCE DILEMMA

- Your ASC bills surgeons for the full cost of any premium IOLs (P-C or A-C) ordered for cataract surgery. An administrative fee is added to the cost. Your practice administrator asks you about this policy.

- How should you respond?
Implicit in this scenario is that the surgeon will bundle the IOL into the practice charge to the patient for a premium IOL case.

ASC submits a claim and is paid by Medicare for the IOL. Has the physician paid for the IOL again?

Has the ASC given something of value to a referral source?

Profit from the IOL
- ASC purchases IOL for $1,000
- ASC sells to surgeon $1,000 + $50 administration fee
- Sells to patient for $1,150
- Surgeon sells to patient for $1,400
One of the surgeons who uses your ASC insists on purchasing his own IOLs to use in his cataract cases. He intends to bring them to the OR and submit invoices to the ASC for these IOLs. The ASC administrator asks you if this is OK.

How should you respond?
COMPLIANCE DILEMMA

- Is the physician a medical device distributor under state law that requires licensure or registration?
- Same AKS situation
  - What is the physician selling?
  - The “covered aspect” of the IOL, the non-covered aspect?
  - Has the ASC given something of value to the surgeon, a referral source?
  - Profit from the IOL?

A mistake repeated more than once is a decision.
OUTLINE

- Anesthesia
- Premium IOLs
  - Femtosecond laser
- Co-management
- Office-based surgery
- Claims submission
- Medical necessity
ASC management proposes a new policy that all patients must pay a fee before any procedure that uses a femtosecond laser. Your practice administrator asks you if this is OK.

How should you respond?
If we assume “any procedures” means cataract surgery without a premium IOL and without a separate asigmatism-correction procedure, then the response should be “not so fast.”


- Non-covered imaging associated with the FSL may be separately charged to patients receiving a premium-IOL.
- Use of the FSL to perform a non-covered procedures such as an LRI may be billed to a patient.
- Neither the imaging or use of the FSL may be billed to a patient who has not selected a premium-IOL or an astigmatism-correcting surgical procedure.
OUTLINE

- Anesthesia
- Premium IOLs
- Femtosecond laser
- **Co-management**
- Office-based surgery
- Claims submission
- Medical necessity
COMPLIANCE DILEMMA

- Your partner is a cataract surgeon who receives a lot of referrals from optometrists in the community. He wants to discuss with you increasing the co-management fee the practice pays to optometrists for refractive cataract surgery to include a portion of the value of the P-C or A-C IOL. Several referring ODs have advised they are receiving more lucrative fees from competitor practices.

- How should you respond?
CO-MANAGEMENT

- Our practice does not pay co-managers to furnish post-operative care. Either the third-party payor or the patient receiving the services pays for the services.

- Let’s consider what the Texas settlement says regarding some of the concerns of the government regarding co-management of premium IOLs.

The Press Release stated that the Practice:

1) “... provided remuneration to referring optometrists when it paid referring optometrists money untethered to actual non-Medicare and non-Medicaid covered services for referring cataract patients who received premium intraocular lenses ...” So, the government contends that payments made to optometrists for co-managing premium IOL patients did not reflect the value of the services performed by the optometrists.
The Press Release stated that the Practice:

2) “... guaranteed the automatic return of patients referred. . .”

3) “... provided optometrists free continuing education courses.”

4) “... rewarded top referring optometrists with expensive dinners, and invited optometrists, their family, and staff to Texas Rangers stadium games at the company suite.”

5) Paid fees to referring optometrists for patients who received premium lenses or laser-assisted cataract surgery that “were . . . not tied to or commensurate with actual post-operative services specifically attributed to premium IOLs or laser-assisted cataract surgery rendered.”
You use dexamethasone ophthalmic insert at the conclusion of cataract surgery in the ASC. Your referring optometrists ask you to stop so that they can implant the intracanalicular dexamethasone insert when the patient is comanaged.

How should you respond?
We will do what is in the best interest of the patient – clinically and financially.

Is administration of dexamethasone ophthalmic insert in the co-manager’s scope of practice?

Is there a patient benefit to have the drug administered in the office versus the OR?

Are you providing something of value to the optometrist (the opportunity to bill) in return for referrals?
• Anesthesia
• Premium IOLs
• Femtosecond laser
• Co-management
• **Office-based surgery**
• Claims submission
• Medical necessity
OFFICE-BASED SURGERY

- No facility fee like an ASC or HOPD
- No surgery tray (A4550)
- No surgeon site of service differential for 66982, 66984
- No separate charge for incident to items or services
- No ABN for covered items
- No payment for anesthesia by the surgeon
- Assignment rules apply for participating physicians
- No separate payment for certain drugs
- No overhead fee
OFFICE-BASED SURGERY

- IOL paid separately ($135)
- Refractive surgery (astigmatism, presbyopia)
- Premium IOL
- Carve outs and special contracts (non-Medicare)
- Medicare Advantage contracting
- Uninsured patients pay cash
CMS Response

“…we have concerns about these services being furnished in non-facility settings...CMS will continue to evaluate whether these service are being furnished in non-facility settings and will consider establishing non-facility values for these services at that time.”

In short: “Not now”

Source: Fed Register 11/18/22
## MEDICARE SITE OF SERVICE DIFFERENTIAL

### Reimbursement in Office

<table>
<thead>
<tr>
<th>CPT</th>
<th>Short Descriptor</th>
<th>Office</th>
<th>Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>66982</td>
<td>Complex cataract/IOL</td>
<td>$742</td>
<td>$742</td>
</tr>
<tr>
<td>66984</td>
<td>Cataract/IOL</td>
<td>$542</td>
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</tbody>
</table>

Source: 2023 CMS Physician Fee Schedule
OUTLINE

- Anesthesia
- Premium IOLs
- Femtosecond laser
- Co-management
- Office-based surgery
- **Claims submission**
- Medical necessity
A new surgeon recently joined your group. As yet she is not credentialed with any payer. The administrator of the practice asks if claims can be filed in your name on behalf of the new surgeon during the administrative interlude.

How should you respond?

No
San Diego Eye Doctors Pay $950,000 to Settle Medicare Billing Fraud Allegations

Assistant U.S. Attorney Joseph P. Price, Jr. (619) 546-7642

NEWS RELEASE SUMMARY – January 2, 2020

SAN DIEGO – Mark D. Smith and Fane Robinson, two San Diego-area physicians, have paid the United States $948,768.18 to resolve allegations that they violated the federal False Claims Act by knowingly submitting false claims to Medicare.

Dr. Smith and Dr. Robinson are medical doctors specializing in ophthalmology. They maintain a medical practice in San Diego known as San Diego Retina Associates and are participating providers in federally-funded health care programs including Medicare.
· Anesthesia
· Premium IOLs
· Femtosecond laser
· Co-management
· Office-based surgery
· Claims submission
· Medical necessity
A payor audit concludes that your documentation fails to support medical necessity for cataract surgery on numerous patients.

How should you respond?
MEDICAL NECESSITY

- Check your chart documentation for these elements:
  - Adequate chief complaint
  - Questionnaire about activities of daily living
  - Physician attestation
  - Patient attestation
  - Measurement of BCVA
  - (With glare complaint) BAT model no., light settings
  - Slit lamp exam of the crystalline lens; grade opacity
MEDICAL NECESSITY

- Adequate physician’s assessment
  - Stratify all relevant diagnoses starting with cataract
- Adequate physician’s plan
  - Orders for biometry and other indicated tests
  - Discussion of postop care
I certify that this patient’s symptoms, physical findings, and impairment of visual function are
not correctable with a tolerable change in glasses or contact lenses. This patient’s cataracts
significantly contribute to the patient’s visual impairment even when other ocular disease(s)
or condition(s), if any, also affect visual function.

SELECT/OMIT? There is a reasonable expectation that lens surgery will significantly improve
both the visual and functional status of this patient.

SELECT/OMIT? Cataract surgery is medically necessary to permit the evaluation and
management of comorbid ophthalmic disease, such as glaucoma or retinal disease, and
improvement of visual and functional status is NOT the primary purpose for the procedure.

Signature ______________________  Date _______________
Cataract surgery can almost always be safely postponed until you feel you need better vision. If stronger glasses won’t improve your vision any more, and if the only way to help you see better is cataract surgery, do you feel your vision problem is bad enough to consider cataract surgery now?

☐ YES ☐ NO

The risks, benefits, and alternatives of cataract surgery have been explained to me, and my questions about the surgery answered, and I wish to proceed.

☐ YES ☐ NO  Signature _______________________  Date ___________________
MEDICARE ERROR RATE (1996 – 2022)

Source: 2022 Medicare Fee-for-Service Supplemental Improper Payment Data
MEDICARE FFS IMPROPER PAYMENTS

- Ophthalmology 1.9% error rate
- Compare to:
  - All specialties 8.5% error rate
  - Optometry 6.4% error rate

Source: CMS. 2021 Medicare Fee-for-Service Supplemental Improper Payment Data. Table I-1
MEDICARE FFS IMPROPER PAYMENTS

- Cataract surgery w/ IOL (66984) 12.7%
- DMEPOS post-cataract lenses 74.8%

Source: CMS. 2021 Medicare Fee-for-Service Supplemental Improper Payment Data. Table D1, Table I2. Also Tables G-2, L-1 and I-2
QUESTIONS?

Scan QR code to send QUESTIONS/COMMENTS to presenters and panel:

Or Text:
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Phone: 202-942-6525
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Regulatory Best Practices with Modern Technology
The Basics of Compliance Documentation
Documentation Goals

- Follows Standards
- Easy
- Quick
- Retrievable
Documentation Methods

**Physical:**
Traditional Pen and Paper Checklists

**Digital:**
Cloud solution and Local Solution

**Physical/Digital:**
Pen/Paper Checklists, Uploaded & Stored Digitally
Goals:

- Accessible
- Secure
- Acceptable Duration (7-10 years)
Storage Options

**Physical**
- ✓ Onsite
- ✓ Offsite Vendor

**Digital**
- ✓ Onsite
- ✓ Offsite Vendor
- ✓ Cloud
Survey Time

• Preparing
  • Gathering Documentation
  • Ensuring Compliance
  • Mock survey education
• Reviewing Documentation with Surveyor
• Walk Through Facility
• Interviews with Techs
  • Process Oriented
  • Where are resources
• Survey recap and follow up
<table>
<thead>
<tr>
<th>Paper</th>
<th>Digital</th>
<th>Combined</th>
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<tr>
<td><strong>Pros:</strong></td>
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<td>→ Quick</td>
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<td>→ Short Build Time</td>
<td>→ Data Aggregation</td>
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<td>→ Cheap to Start</td>
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<td>→ Accountability</td>
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<td>→ Low Storage Costs</td>
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<td><strong>Cons:</strong></td>
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<tr>
<td>→ Fallible</td>
<td>→ Requires Training</td>
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<tr>
<td>→ Accessibility</td>
<td>→ Requires Technology</td>
<td>Training</td>
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<tr>
<td>→ Easy to forget</td>
<td>→ Double Work</td>
<td></td>
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<tr>
<td>→ Hard to Modify</td>
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<td>(Document/Upload)</td>
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<tr>
<td>→ Hard to use Data</td>
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<tr>
<td>→ High Storage Costs</td>
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</tr>
<tr>
<td></td>
<td>→ Long Build Time</td>
<td>→ Upload Time</td>
</tr>
</tbody>
</table>
Thank You

Brandon Coombs
VP, Business Development

e-mail brandon@surglogs.com

cell 442.515.2355
Innovation that makes sense (and dollars)

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

Mark King
Administrator of Tyson Eye,
Cape Coral, FL

Todd Albertz
Director
Healthcare Solutions, Eckert Wordell

Facilitator: Albert Castillo
OOSS Director of Member Services
and CEO of San Antonio Eye
Innovation that makes sense (and dollars)

- Bilateral sequential cataract surgery
- Light adjustable lens
- Efficiency pearls
Scan QR code to send QUESTIONS/COMMENTS to presenters and panel:

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(913) 608-9199
THANK YOU FOR PARTICIPATING IN PERSPECTIVE 2023