ASCs NEXT LEVEL
Symposium 2022
CHICAGO • SATURDAY, OCTOBER 1ST @ 11:30AM
Agenda

• **OOSS Welcome** by David George MD, OOSS President
  • **Strategic Priorities and Initiatives for 2023-2026** by Diane Blanck, OOSS Executive Director
• **Alcon Address** by Jim Di Filippo, US General Manager, Alcon Surgical
• **Washington Update** by Mike Romansky JD, OOSS General Counsel
• **Ophthalmic Industry Consolidation**
  • **State and Trends of the Industry** by Andrew Maller MBA, COE, Principal and Consultant, BSM Consulting
  • **Panel of Physicians and Industry Executives Representing 3 Different ASC Ownership Models:**
    • Miranda Bishara MD (National management company partner)
    • Michael Patterson DO (Independent)
    • William Wiley MD (Private Equity)
  
  Kelvin Liang, Director, Corporate Accounts, US Surgical, Alcon
• **10 Current Issues in Reimbursement for Eyecare** by Kevin Corcoran of Corcoran Consulting Group
Welcome

OOSS has been successfully representing the interests of Ophthalmic ASCs for 40 years:

Advocacy · Education · Analytics

Ophthalmic ASCs are the proven best solution:

✓ WIN for patients  ✓ WIN for physicians  ✓ WIN for payers

✓ WIN for staff  ✓ WIN for industry
OOSS is healthy and growing

- Membership is growing
- Industry partnerships are growing
- Board of directors is evolving and engaged
- OOSS is the only US ophthalmic ASC-driven organization focused on advocacy, education and analytics to optimize the business of exceptional patient care.
OOSS Board of Directors

Directors ending term

Victor Gonzalez MD

Tom Harvey MD
OOSS Board of Directors

Retiring Associate Directors

John Grant, Amsurg

Joshua Stites, VP of Operations, Surgery Partners

New Associate Directors

Tesha Simpson, COO, Amsurg

John Blanck, Surgery Partners
New Partners and Sponsors

Genentech
A Member of the Roche Group

SURGLOGS

CoFi
Alcon and OOSS

40 years of working together to help people See Brilliantly
Our 40-year Partnership
Focus on **Efficiency and Sustainability**

Providing *digital solutions that drive efficiencies* and help transform inventory management and patient flow

**Sustainability efforts** to help reduce waste and decrease carbon footprint
Transforming Inventory Management with MyAlcon 360 Inventory Manager App

- Works with our RFID scanner
- Quickly organize, track, and manage Alcon IOL inventory
- On-demand visibility to inventory status
- Easily manage your inventory ordering needs

“What used to take me hours, now takes me minutes with the MyAlcon 360 app... I would highly recommend the MyAlcon 360 app for other surgery centers.”

- Pilot user, RN, BSN

COMING SOON! Early 2023
Alcon Vision Suite

SMARTCataract
ARGOS® in Clinic

SMARTCataract
SMARTCataract is a cloud-based platform designed to connect your Alcon devices from the clinic to the OR

Digital Marker LenSx (DML)

Digital Marker Microscope (DMM)

ORA with AnalyzOR

NGENUITY (Coming Soon)

Time savings per patient²

78%
FOR ASIOMATIC PATIENTS

75%
FOR POST-REFRACTIVE PATIENTS

57%
FOR CONVENTIONAL PATIENTS
Alcon Sustainability Plan

**Sustainable Products**
- Embed sustainable design principles in product design
- Packaging reduction & recycled materials

**Energy Efficiency & GHG Reduction**
- Carbon neutral for Scope 1 and 2 GHG emissions
- Scope 3 GHG Emission Inventory refinement
- Continuous improvement energy efficiency projects

**Waste Reduction**
- Zero waste to landfill at manufacturing & distribution sites
- Continuous improvement waste reduction & recycle projects

**Water Stewardship**
- MTO Site Water Conservation & Efficiency Plan
2021 Environmental Sustainability Highlights

- 41 energy-saving projects completed resulting in an estimated **42,700 gigajoules (GJ)** of energy saved.
- **~76%** of operational waste recycled.
- **7%** decrease in energy intensity compared to our 2019 baseline.
- **108** metric tons of devices and equipment reused, recycled or donated.
- **~8,400** metric tons of carbon dioxide equivalent (tCO2e) greenhouse gases avoided thanks to energy-saving projects.
Bringing sustainability to the ASC

- **Trayless Cassette for Centurion® Fluid Management System in a Custom Pak®**
  - Deleted machine cassette pak tray and Tyvek lid
  - Reduces plastic and CO2 footprint
  - Reduces Waste

- **Green Cell Foam for Ophthalmic Viscosurgical Devices**
  - Replaced Styrofoam for an environmentally friendly foam*
  - Total Styrofoam eliminated annually: 106,835 lbs

  Reference: Data on File. Styrofoam Elimination. *Project currently implemented in the U.S. only

- **Electronic DFUs**
  - Removed printed DFU in IOL Packaging*
  - Reduces CO2 footprint
  - Total reduction in packaging weight: 53%

  Reference: Data on File. Weight Reduction Study DFU Elimination Report
  *With exceptions for markets with local regulations, which do not permit the exclusion of DFU booklets from their boxes

Thank You!
Alcon
SEE BRILLIANTLY
Scan QR code to send Questions/Comments to Presenters and Panel

Or Text: (816) 701-9370
Strategic Priorities - Background

• 2022 Insight Survey: Your voice, your input

• BOD Triennial Strategic Strategic Retreat
2023-2026 Strategic Priorities

- Advocacy to ensure fair payment and appropriate regulatory environment for ASCs.
- Fight OBS market penetration – patient safety and business model viability
2023-2026 Strategic Priorities

• Grow and nurture memberships and partnerships.
  • Private equity membership initiatives

• Tell the OOSS story –
  • O-ASCs: THE solution today and tomorrow.
  • OOSS value: advocacy, education, analytics
2023-2026 Strategic Priorities

- Support building succession plans for successful ASCs long term.
2023-2026 Strategic Priorities

• Provide support and knowledge on recruitment and retention and training of ASC staff.

• Provide support for anesthesia staffing resources, and business models.
2023-2026 Strategic Priorities

• Education regarding optimization of the ASC, segmented to audience: physician-owners, young physicians, staff, allied professionals
  • EyeProGPO
  • Progressive Surgical Solutions education partnership
has partnered with PROGRESSIVE SURGICAL SOLUTIONS, a division of BSM Consulting, to bring exceptional training and development opportunities to ophthalmic surgery center LEADERS.
FREE monthly educational webinars for busy ASC professionals.

**OCTOBER 28**
Revenue Cycle Management: Improving The Bottom Line

**NOVEMBER 28**
Annual Survey Watch Report

**DECEMBER 16**

RN, CASC and CAIP CE credit offered for select sessions*

WWW.PROGRESSIVESURGICALSOLUTIONS.COM/PSS-WEBINARS

*Progressive Surgical Solutions, division of BSM Consulting is approved by the California Board of Registered Nurses, Provider #17435 and BASC, Provider #1016.
Progressive Surgical eSupport

The leading online regulatory, compliance & training membership for ASC managers.

**COMPLIANCE**
- Comprehensive compliance calendar
- Customizable templates

**COMMUNITY**
- Answers from experts and feedback from peers in active member-only Forum

**TRAINING**
- 29 CE Courses that meet ASC annual training requirements for your entire staff
- Contact Hours for RNs

& **CLINICAL DIRECTOR TRAINING FOR THE ASC**
- 10 online modules (additional fee applies)

WWW.PROGRESSIVESURGICALSOLUTIONS.COM/ESUPPORT/

$200 O OSS Member Discount
WASHINGTON UPDATE:
THE 2022-2023 OOSS AGENDA

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

• 2022 Survey Results:
  • 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!
### Proposed 2023 ASC Payment Rates for Ophthalmic Services

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
<th>2022</th>
<th>2023 Proposed</th>
</tr>
</thead>
<tbody>
<tr>
<td>66984</td>
<td>Cataract</td>
<td>$1,063</td>
<td>$1,080.23</td>
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<tr>
<td>66821</td>
<td>Yag</td>
<td>261</td>
<td>270.71</td>
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<tr>
<td>67904</td>
<td>Repair Eyelid</td>
<td>874</td>
<td>884.15</td>
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<tr>
<td>66170</td>
<td>Glaucoma Surgery</td>
<td>1,063</td>
<td>1,080.23</td>
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<tr>
<td>67040</td>
<td>Laser, Retina</td>
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<td>1,928.33</td>
</tr>
<tr>
<td>65755</td>
<td>Corneal Transplant</td>
<td>1,919</td>
<td>1,928.33</td>
</tr>
<tr>
<td>67036</td>
<td>Vitrectomy</td>
<td>1,919</td>
<td>1,928.33</td>
</tr>
</tbody>
</table>
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
  • Great news!! Deferred through Covid PHE

• 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
Session Agenda

1. Private Equity’s Impact on Ophthalmic Practices and ASCs
2. Recapitalization Activity in 2021 and 2022
3. Perceived Impact from Economic Uncertainty
4. Future Trends in Ophthalmology Consolidation
Market Trends
*Consolidation Activity Map may not include all ophthalmic consolidation deals, but instead gives an overview of major private equity activity in recent years. Location markers indicate presence in a given city but may not represent number of physical locations in that city.
Consolidation Activity Map may not include all ophthalmic consolidation deals, but instead gives an overview of major private equity activity in recent years. Location markers indicate presence in a given city but may not represent number of physical locations in that city.
Scale of Ophthalmology Consolidation

- Transactions have occurred in approximately 48 states
- Practice acquisitions\(^1\):
  - 30+ Ophthalmology Management Company Platforms
  - 430+ Tuck-in practices
  - 120+ ASCs
  - 1,900+ Locations
- Providers included in acquisitions\(^1\):
  - Over 1,900 MDs/DOs
  - Over 2,000 ODs
- Status of Current Pipeline:
  - Estimate of 200-300 active transactions in play
  - Continued interest from non-affiliated practices

Footnote: 1) Figures are not exact but provide an estimate of the number of acquisitions and providers involved.
Recapitalization Activity
What is the typical life cycle of a private equity backed MSO?

A typical private equity fund has a lifespan and ability to call for capital of a period of around 10 years. Generally, the fund will invest its capital within 3 to 5 years and then has another 5 years or so to liquidate or sell its holdings.

In essence, an MSO typically will have a time horizon of 5-7 years with their original capital partner.
Recapitalization Activity / “Second Bite of the Apple”

Recent Recapitalization Events

• EyeCare Partners (Partners Group Holdings, December 2019)
• CEI Vision Partners (EyeCare Partners, Nov 2021)
• American Vision Partners (HIG Capital, Early 2022)
• Vision Innovation Partners (Gryphon Investors, April 2022)
• EyeSouth Partners (Olympus Partners, Fall 2022)
2021 and 2022 Trends

2021 Deal Activity

- Record setting year in terms of deal volume, particularly the 2nd half of 2021
  - Threat of tax law change
  - COVID Catch-Up?

2022 Deal Activity

- 1st half of 2022 was on par with high 2021 volume
- 2nd half showing indications of a return to pre-COVID deal volume
Perceived Economic Impact
Economic Uncertainty

- Stock Market Impact on Private Equity
- Rising Interest Rates/Increasing Cost of Capital
- Inflation Impact on EBITDA Margins
- Slow COVID Recovery for Sellers
Future Trends
What does the future hold?

- Continued deal activity, but likely at a slower pace in late 2022 into 2023
- Look for additional platforms to have recapitalization events
- Continued impact from current economic conditions
- Impact on remaining independent practices and ASCs
Thanks

Andrew Maller,
amaller@bsmconsulting.com
Industry Consolidation
Panel of Experts

- Miranda Bishara MD
- Michael Patterson DO
- William Wiley MD
- Kelvin Liang, Director, Corporate Accounts, US Surgical, Alcon

QR Code for questions:

(816) 701-9370
10 Current Issues in Reimbursement for Eyecare

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

- Medical necessity
- Pre-op testing
- Cataract premium services
- Laser surgery
- Operative report
- Co-management
- Intravitreal injections
- Cosmetic lid procedures
- Bundles and unbundling
- Missing C-code on UB-04
Medical Necessity Questioned

- OIG assessments of unnecessary cataract surgery
- MAC findings of unsupported second eye surgery
- SMRC claims review of cataract surgery

Source: OIG, CERT, MACs, Noridian SMRC
Medical Necessity - Cataract

1. Cataract causing symptomatic (i.e., causing the patient to seek medical attention) impairment of visual function not correctable with a tolerable change in glasses or contact lenses resulting in the patient's inability to function satisfactorily while performing Activities of Daily Life including, but not limited to reading, viewing television, driving, or meeting vocational or recreational needs.

2. Concomitant intraocular disease (e.g., diabetic retinopathy or intraocular tumor) requiring monitoring or treatment that is prevented by the presence of cataract.

Source: Noridian LCD 34203
Medical Necessity - Cataract

3. Lens-induced disease threatening vision or ocular health (including, but not limited to, phacomorphic or phacolytic glaucoma).

4. High probability of accelerating cataract development as a result of a concomitant or subsequent procedure (e.g., pars plana vitrectomy, iridocyclectomy, procedure for ocular trauma) and treatments such as external beam irradiation.

5. Cataract interfering with the performance of vitreoretinal surgery.

Source: Noridian LCD 34203
6. Intolerable anisometropia or aniseikonia uncorrectable with glasses or contact lenses that exists as a result of lens extraction in the first eye (despite satisfactorily corrected monocular visual acuity.)

Source: Noridian LCD 34203
Medical Necessity - Documentation

1. Patient’s inability to function satisfactorily (ADLs)
2. BCVA by careful refraction
3. Degree of lens opacity
4. Physician attestation glasses/CLs won’t help
5. With other comorbidities, cataract is significantly contributing to visual impairment
6. Patient desires surgery and surgeon expects it to improve visual and functional status

Source: Noridian LCD 34203
Medical Necessity - Cataract

Physician’s Attestation:

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 cataract(s) significantly contribute to the patient’s visual impairment even when other ocular disease(s) or condition(s), if any, also affect visual function. The risks, benefits, and alternatives of cataract surgery have been explained, and (check only one)

- there is a reasonable expectation that lens surgery will significantly improve both the visual and functional status of this patient.
- cataract surgery is medically necessary to permit the evaluation and management of a 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

Noridian
Medical Necessity - Cataract

Patient’s Attestation:

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
“When patients note improved visual function after first-eye surgery, it is common to desire second-eye surgery, which brings additional significant improvement in visual function. The indication for second-eye surgery is the same as for the first eye, i.e., when the cataract-impaired vision no longer meets the patient's needs and the anticipated benefits of surgery exceed the risks. The patient and ophthalmologist should discuss the benefit, risk, and timing of second-eye surgery when they have had the opportunity to evaluate the results of surgery on the first eye.”

Source: AAO Preferred Practice Pattern, Cataract in the Adult Eye
Timing of 2\textsuperscript{nd} Cataract Surgery

1. The patient's visual needs
2. The patient's preferences
3. Visual function in the second eye
4. The medical and refractive stability of the first eye
5. The need to restore binocular vision and resolve anisometropia,
6. An adequate interval of time has elapsed to evaluate and treat early postoperative complications in first eye, such as endophthalmitis; and/or
7. Logistical and travel considerations of the patient.

Source: Noridian LCD 34203
“Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique, complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; without endoscopic cyclophotocoagulation”

Source: CPT 2022
Medical Necessity – YAG Capsulotomy

- Visual loss and/or symptom of glare (VA 20/30 or worse under Snellen conditions, using contrast sensitivity or simulated glare testing)
- Symptoms of decreased contrast
- Amount of posterior capsular opacification or other possible causes of decreased vision following cataract surgery

Source: Noridian LCD 34203
Medical Necessity – YAG Capsulotomy

• Generally no less than 90 days following cataract extraction

• When a series of procedures is performed ... it will be covered as a single procedure (i.e., 1 or more stages)

Source: CGS
Outline

• Medical necessity
• Pre-op testing
“In most cases, a comprehensive eye exam (ocular history and ocular examination) and a single scan to determine the appropriate pseudophakic power of the IOL are sufficient. In most cases involving a simple cataract, a diagnostic ultrasound A-scan is used. For patients with dense cataract, an ultrasound B-scan may be used.”

Source: NCD §10.1
“Accordingly, where the only diagnosis is cataract(s), Medicare does not routinely cover testing other than one comprehensive eye exam (or a combination of a brief/intermediate examination not to exceed the charge of a comprehensive examination) and an A-scan, or if medically justified, a B-scan. Claims for additional diagnostic tests are denied as not reasonable and necessary unless there is an additional diagnosis and the medical need for the tests is fully documented.”

Source: NCD §10.1
<table>
<thead>
<tr>
<th>Non-covered Pre-operative Tests</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Aberrometry</td>
</tr>
<tr>
<td>• OCT-Anterior segment</td>
</tr>
<tr>
<td>• Corneal topography</td>
</tr>
<tr>
<td>• OCT-retina/macula</td>
</tr>
<tr>
<td>• Tear osmolarity</td>
</tr>
<tr>
<td>• HOA</td>
</tr>
<tr>
<td>• Cornea, ACA</td>
</tr>
<tr>
<td>• Astigmatism, keratoconus</td>
</tr>
<tr>
<td>• Macular degeneration</td>
</tr>
<tr>
<td>• Dry eye</td>
</tr>
</tbody>
</table>
Non-covered Pre-operative Tests

- Aberrometry
- OCT-AS
- CT
- OCT-retina
- Tear osmolarity

- Refractive test
- Screening
- Refractive, screening
- Screening
- Screening
Financial Waivers

- Consent: beneficiary accepts financial responsibility
- Respect patient’s wishes
  - No – patient declines to proceed
  - Yes – patient understands and wishes to proceed
- Timing: prior to providing service
  - Advance Beneficiary Notice of Noncoverage (Part B Medicare but not Part C Medicare)
  - Notice of Exclusion from Healthcare Benefits
- Claims: use appropriate modifier (i.e., GA, GX, GY)
Financial Waivers

• CMS prohibits ABN for MA Plans
  • Predetermination of benefits for Medicare Advantage
Outline

• Medical necessity
• Pre-op testing
• Cataract premium services
<table>
<thead>
<tr>
<th>Cataract Premium Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine</strong></td>
</tr>
<tr>
<td>• Eye exam</td>
</tr>
<tr>
<td>• Biometry</td>
</tr>
<tr>
<td>• Cell count (occasional)</td>
</tr>
<tr>
<td>• B-scan (occasional)</td>
</tr>
<tr>
<td>• Postop care</td>
</tr>
<tr>
<td>• Return to OR for AE</td>
</tr>
<tr>
<td>• FF: ASC/HOPD/IOL</td>
</tr>
<tr>
<td>• Anesthesia</td>
</tr>
<tr>
<td><strong>Premium</strong></td>
</tr>
<tr>
<td>• Astigmatism correction</td>
</tr>
<tr>
<td>• CRI/LRI</td>
</tr>
<tr>
<td>• Toric IOL</td>
</tr>
<tr>
<td>• Presbyopia correction</td>
</tr>
<tr>
<td>• Part of IOL (not routine)</td>
</tr>
<tr>
<td>• Additional facility fee</td>
</tr>
<tr>
<td>• Enhancements</td>
</tr>
<tr>
<td>• Extended postop care</td>
</tr>
</tbody>
</table>
Medicare’s Policy  
Presbyopia-Correcting IOLs

• “…the facility and physician may take into account any additional work and resources required for insertion, fitting, vision acuity testing, and monitoring of the presbyopia-correcting IOL that exceeds the work and resources attributable to insertion of a conventional IOL”

• “…the beneficiary requests this service”

• “The physician and the facility may not require the beneficiary to request a presbyopia-correcting IOL as a condition of performing a cataract extraction with IOL insertion”

Source: Transmittal 636
Medicare’s Coverage Policy
Astigmatism-Correcting IOLs

“…the physician may take into account the additional physician work and resources required for insertion, fitting, visual acuity testing of the astigmatism-correcting IOL compared to insertion of a conventional IOL”

Source: CMS-1536-R
Patient Understanding

While payment for non-covered services is the beneficiary’s responsibility, Medicare Law (§1879) contains a provision that waives that liability if the beneficiary is not likely to know and did not have a reason to know that the services would not be covered.
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 and ASCRS
ASC Buys IOLs

• Best practices entail ASC purchases IOLs from manufacturer
• Avoid giving the appearance of payment for referral between ASC and surgeon
• 2014, Memorial Hospital, Ohio – substantial fine when “an ophthalmologist purchased IOLs and then resold them to Memorial at inflated prices”
Outline

• Medical necessity
• Pre-op testing
• Cataract premium services
• Laser surgery
FS Laser Guidance

• January 2012 ASCRS/AAO joint guidance
• Providers may not “balance bill” a Medicare patient or his or her secondary insurer for any additional fees to perform covered components of cataract surgery with an FS laser.
• The patient must be informed about, and consent to, the additional out-of-pocket-costs in advance.
• A refractive lens exchange is not medically necessary and therefore is not covered

Source: ASCRS/AAO Guidance
FS Laser Guidance

• A surgeon may use the FS laser for the cataract surgery, but neither the surgeon nor the facility may obtain additional reimbursement from either Medicare or the patient over and above the Medicare-allowable amount.

• Neither the surgeon nor the facility should use the differential charge allowed for implantation of a premium refractive IOL to recover all or a portion of the costs of using the FS laser for cataract surgical steps.

Source: ASCRS/AAO Guidance
FS Laser Guidance

- Patient-shared pricing with one cost for a premium IOL, and a higher cost for the additional use of the FS laser to perform the cataract surgical steps, should not be offered.

- 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.

Source: ASCRS/AAO Guidance
Because astigmatic keratotomy for refractive indications is a non-covered service, a higher fee can be charged for performing it using the FS laser, instead of with a metal or diamond blade.

While most astigmatism treatment is not covered, Medicare does cover the treatment of large degrees of astigmatism that were the result of previous ocular surgery. Local coverage determinations may apply.

Source: ASCRS/AAO Guidance
Laser-Assisted Cataract Surgery

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. Under either method, Medicare will cover and pay for the cataract removal and insertion of a conventional intraocular lens. If the bladeless, computer controlled laser cataract surgery includes implantation of a PC-IOL or AC-IOL, only charges for those non-covered services specified above may be charged to the beneficiary.

Source: CMS Guidance Nov 16, 2012
Laser-Assisted Cataract Surgery

These charges could possibly include charges for additional services, such as imaging, necessary to implant a PC-IOL or an AC-IOL but that are not performed when a conventional IOL is implanted. Performance of such additional services by a physician on a limited and non-routine basis in conventional IOL cataract surgery would not disqualify such services as non-covered services. This guidance does not apply to the use of technology for refractive keratoplasty.

Source: CMS Guidance Nov 16, 2012
Approaches to CMS Guidance

• BEST: Charge patients for use of the FS laser for arcuate incisions to correct clinically significant pre-existing regular astigmatism, which is not covered, for any type of IOL.

• INSUFFICIENT: Charge patients for use of the imaging element of FS laser

• TROUBLESOME: Charge patients with a conventional IOL without astigmatism for use of the FS laser for prophylactic arcuate corneal incisions “just in case” they might later develop astigmatism.

• AVOID: Patient charges without a rational basis that are not defensible or may be misleading.
Outline

- Medical necessity
- Pre-op testing
- Cataract premium services
- Laser surgery
- Operative report
Operative Report

- Heading with location, date, patient name, ID number
- Pre-op and post-op diagnoses
- Surgeon, assistant, co-surgeon
- Procedure(s) performed
- Indication(s)
- Complexity
- Description of procedure(s)
- Discharge instructions
- Notes on time, intensity, and comparable procedures
Outline

• Medical necessity
• Pre-op testing
• Cataract premium services
• Laser surgery
• Operative report
• Co-management
Co-management Guidelines

• The patient requests and makes an informed decision in writing to be seen by the non-operating practitioner for postoperative care.

• The operating ophthalmologist determines that the operative eye is sufficiently stable for transfer of care or co-management.

• The operating ophthalmologist determines that the transfer of care or co-management arrangement is clinically appropriate.

• The non-operating practitioner is willing to accept the care of the patient.

Source: Comprehensive Guidelines 9/7/16
Co-management Guidelines

• State law permits the non-operating practitioner to provide postoperative care and the non-operating practitioner is otherwise qualified to do so.

• The operating ophthalmologist is familiar with the non-operating practitioner and is confident that the practitioner has the adequate training, skills and experience to accurately diagnose and treat the conditions that are likely to be presented as well as the willingness of the non-operating practitioner to seek advice from operating ophthalmologists whenever necessary.

Source: Comprehensive Guidelines 9/7/16
Co-management Guidelines

• There is no agreement between the operating ophthalmologist and a referring non-operating practitioner to automatically send patients back to non-operating practitioner.

• The arrangement complies with all applicable federal and state laws and regulations, including the federal anti-kickback and Stark laws and state laws concerning fee splitting and patient brokering.

Source: Comprehensive Guidelines 9/7/16
Co-management Guidelines

• The operating ophthalmologist or an appropriately trained ophthalmologist is available upon request from either the patient or non-operating practitioner to provide medically necessary care related to the surgical procedure directly or indirectly to the patient.

Source: Comprehensive Guidelines 9/7/16
Co-management Guidelines

• The non-operating practitioner’s co-management fees should be commensurate with the service(s) actually provided, and should be separately billed by the non-operating practitioner.

• For Medicare/Medicaid patients, the co-management arrangement should be consistent with all Medicare/Medicaid billing and coding rules and should not result in higher charges to Medicare/Medicaid than would occur without co-management.

Source: Comprehensive Guidelines 9/7/16
Co-management Guidelines

• The patient should be informed of any additional fees that the non-operating practitioner may charge beyond those covered by Medicare/Medicaid or other third party payors.

• For services that are not covered by Medicare or Medicaid, other fee structures may be appropriate, though they should also be commensurate with the services provided and otherwise comply with all applicable federal and state laws and regulations.

Source: Comprehensive Guidelines 9/7/16
Co-management Guidelines

• Transfer of care or co-management is documented in the medical record as required by carrier policy.
• All relevant clinical information is exchanged between the operating ophthalmologist and the non-operating practitioner.

Source: Comprehensive Guidelines 9/7/16
Co-management Guidelines

• The operating ophthalmologist should consult with qualified legal counsel and other consultants to ensure that his/her co-management practices are consistent with federal and state law and best legal practices.

• … Above all, patients’ interests must never be compromised as a result of co-management.

Source: Comprehensive Guidelines 9/7/16
Co-management Best Practices

- Proper motivation consistent with professionalism
- Surgeon decides suitability for surgery
- Surgeon and patient discuss post-op care options
- Co-management depends on what is best for patient
- Document patient’s choice
- Adhere to Medicare instructions
- Follow other third-party payers’ policies
- Ensure fair market value for services performed
- Transparent billing so patient knows amount paid to each provider
OIG Advisory Opinion: Co-management

- OIG publishes opinion on co-management involving non-covered services associated with premium IOLs
- Tightly worded favorable opinion with caveats
- No written or unwritten agreements to co-manage w/OD
- Surgeon informs patient that OD may charge for non-covered services associated with premium IOL
- Charges are for non-covered services - not increasing charges to Medicare
- Patient is returned to OD at the patient’s request

Source: OIG Advisory Opinion No. 11-14
OIG Advisory Opinion: CE Programs

• OIG publishes advisory opinion on continuing education programs for optometrists
• OIG criticized or questioned the arrangements citing AKS

Source: OIG Advisory Opinion No. 22-14
Outline

- Medical necessity
- Pre-op testing
- Cataract premium services
- Laser surgery
- Operative report
- Co-management
- Intravitreal injections
Chart Documentation

• Operative report
  • Indication for procedure
  • Description of procedure
  • Identify substance injected, lot number, and dose
  • Specific statement that leftover agent was discarded
Outline

- Medical necessity
- Pre-op testing
- Cataract premium services
- Laser surgery
- Operative report
- Co-management
- Intravitreal injections
- Cosmetic lid procedures
Lid Procedures

Functional Blepharoptosis

• Chart documentation supports all requirements and links to covered ICD-10 code(s) in MAC’s LCD.

• Submit bilateral surgeries as one-line item with modifier -50 and a “1” in the unit field as required for Medically Unlikely Edits.
Lid Procedures

Cosmetic Blepharoplasty

• Cosmetic surgery excluded: SSA §1862(10)
• Inform patient; obtain consent; use voluntary financial waiver
• Statutorily excluded items/services don’t require a claim; some beneficiaries may request it anyway (-GY)
• Follow CMS guidelines for combined functional and cosmetic eyelid surgery
• National Correct Coding Initiative edits have a mutually exclusive bundle with functional blepharoptosis and blepharoplasty procedures
Outline

• Medical necessity
• Pre-op testing
• Cataract premium services
• Laser surgery
• Operative report
• Co-management
• Intravitreal injections
• Cosmetic lid procedures
• Bundles and unbundling
Modifier -59 and the OIG

- 40% of code pairs billed with modifier -59 in 2003 did not meet program requirements - $59M overpayment
- Excessive use of modifier -59 garners (unwanted) attention
- OIG asked CMS to scrutinize use of modifier -59

Source: OIG Report, Nov. 2005, OEI-03-02-00771
“Some of the procedures or services listed in the CPT codebook that are commonly carried out as an integral component of a total service or procedure have been identified by the inclusion of the term ‘separate procedure’. The codes designated as ‘separate procedure’ should not be reported in addition to the code for the total procedure or service of which it is considered an integral component.”

Source: AMA, CPT Surgery Guidelines
Distinct Procedure

When a designated ‘separate procedure’ is carried out independently or considered to be unrelated or distinct from other procedures/services provided at that time, it may be reported by itself, or in addition to other procedures/services by appending modifier -59…

Source: AMA, CPT Surgery Guidelines
Distinct procedure service, same day

Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances.

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 2022
<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>XE</td>
<td>Separate Encounter</td>
</tr>
<tr>
<td>XS</td>
<td>Separate Structure</td>
</tr>
<tr>
<td>XP</td>
<td>Separate Practitioner</td>
</tr>
<tr>
<td>XU</td>
<td>Unusual Non-Overlapping Service</td>
</tr>
</tbody>
</table>

**Source:** CMS Introduced X-modifiers in 2015
Outline

• Medical necessity
• Pre-op testing
• Cataract premium services
• Laser surgery
• Operative report
• Co-management
• Intravitreal injections
• Cosmetic lid procedures
• Bundles and unbundling
• Missing C-code on UB-04
Device Code on UB-04

- The HCPCS Level II code set includes a section specific to outpatient hospital reporting. Medicare created C-codes for use by Outpatient Prospective Payment System (OPPS) hospitals.
- OPPS hospitals use these codes to report drugs, biologicals, devices, and new technology procedures that do not have other specific HCPCS Level II codes that apply.
- CMS analyzes claims with C-codes to set payment rates
Device Code on UB-04

- C1780 – Intraocular lens (new technology)
- C1783 – ocular implant, aqueous drainage assist device
- C1784 – Ocular device, intraoperative, detached retina
- C1818 – Integrated keratoprosthesis
- C1839 – Iris prosthesis
- C1840 – Lens intraocular (telescopic)
- C1841 – Retinal prosthesis includes internal and external components
• C1889 – implantable, insertable device, NOC
• C9034 – injection of dexamethasone 9%, intraocular 1mcg
• C9257 – injection bevacizumab 0.25mg
• C9770 – Vitrectomy, mechanical pars plana approach with subretinal injection of pharmacologic biologic agent
Conclusion

- Provide support for each cataract surgery in the exam and the operative report
- Separate covered and noncovered pre-cataract testing
- Attend to guidance for premium cataract surgery and use of femtosecond laser
- Follow co-management guidelines
- Document drug, dose, and discarded intravitreal substance
- Separate functional and cosmetic eyelid surgery
- Assess claims that unbundle CPT codes
- Don’t forget C-codes on UB-04
More help…

For additional assistance or confidential consultation, please contact us at:

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