Hot-button Issues in ASC Reform

Government actions that ASC owners must know and understand

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Smarter, Better, Faster.¹
Advancing Every Femtosecond.

INTRODUCING THE NEW
LenSx® SoftFit™ Patient Interface

SMARTER
- Enhances patient comfort
- Minimizes corneal compression
- Fixates cornea for precise incisions

BETTER
- Free-floating capsulotomies in nearly every case
- Pristine capsulotomy edges
- Lower IOP rise of only 16 mmHg during the procedure
- Less energy required

FASTER
- Reduction in laser time with overall reduction in procedure time
- Simpler, easier docking process

¹ Multicenter prospective clinical study (n=137 eyes); Alcon data on file

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Caution:
United States Federal Law restricts this device to sale and use by or on the order of a physician or licensed eye care practitioner.

Indication:
The LenSx® Laser is indicated for use in patients undergoing cataract surgery for removal of the crystalline lens. Intended uses in cataract surgery include anterior capsulotomy, phacofragmentation, and the creation of single plane and multi-plane arc cuts/incisions in the cornea, each of which may be performed either individually or consecutively during the same procedure.

Restrictions:
- Patients must be able to lie flat and motionless in a supine position.
- Patient must be able to understand and give an informed consent.
- Patients must be able to tolerate local or topical anesthesia.
- Patients with elevated IOP should use topical steroids only under close medical supervision.

Contraindications:
- Corneal disease that precludes application of the cornea or transmission of laser light at 1010 nm wavelength
- Descemetocele with impending corneal rupture
- Presence of blood or other material in the anterior chamber
- Poorly dilating pupil, such that the iris is not peripheral to the intended diameter for the capsulotomy
- Conditions which would cause inadequate clearance between the intended capsulotomy depth and the endothelium (applicable to capsulotomy only)
- Previous corneal incisions that might provide a potential space into which the gas produced by the procedure can escape
- Corneal thickness requirements that are beyond the range of the system
- Corneal opacity that would interfere with the laser beam
- Hypotony or the presence of a corneal implant
- Recurrent, recurrent, active ocular or eyelid disease, including any corneal abnormality (for example, recurrent corneal erosion, severe basement membrane disease)
- History of lens or zonular instability
- Any contraindication to cataract or keratoplasty
- This device is not intended for use in pediatric surgery.

Warnings:
The LenSx® Laser System should only be operated by a physician trained in its use. The LenSx® Laser delivery system employs one sterile disposable LenSx® Laser Patient Interface consisting of an application lens and suction ring. The Patient Interface is intended for single use only. The disposables used in conjunction with Alcon® instruments products constitute a complete surgical system. Use of disposables other than those manufactured by Alcon may affect system performance and create potential hazards.
The physician should base patient selection criteria on professional experience, published literature, and educational courses. Adult patients should be scheduled to undergo cataract extraction.

Precautions:
- Do not use cell phones or pagers of any kind in the same room as the LenSx® Laser.
- Discard used patient interfaces as medical waste.

AEs/Complications:
- Capsulotomy, phacofragmentation, or cut in incision decenteration
- Incomplete or interrupted capsulotomy, fragmentation, or corneal incision procedure
- Capsular tear
- Corneal abrasion or defect
- Pain
- Infection
- Bleeding
- Damage to intraocular structures
- Anterior chamber fluid leakage, anterior chamber collapse
- Elevated pressure to the eye

Attention:
Refer to the LenSx® Laser Operator’s Manual for a complete listing of indications, warnings and precautions.
This November’s AAO meeting in New Orleans will mark my 30th anniversary serving as Washington Counsel and lobbyist to the Outpatient Ophthalmic Surgery Society (OOSS). When I was retained in 1983, there were approximately 150 ASCs in operation in the United States. Today, there are 5,300 (yes, more centers than hospitals), of which more than 900 are dedicated exclusively to the delivery of ophthalmic procedures. In the 80s, only a handful of eye services were eligible for payment in the ASC. Today, virtually every ophthalmic procedure resides on the ASC procedures list. Indeed, more than 40% of all Medicare services provided in surgery centers are ophthalmic and almost 50 cents of every dollar expended in ASCs by the government is allocable to treating patients requiring ophthalmic surgery.

In this article, I’ll focus on the many activities coming from the nation’s capital that have the potential to impact — in grand and small ways — the delivery of care by ophthalmic ASCs. What will ASCs be paid? How about hospitals? How will ASC quality and outcomes be measured? How will our centers be regulated? And what steps can the ASC surgeon and staff take to maximize our voice in Washington?

Federal policymakers are at last beginning to understand the consequences stemming from a reimbursement system that overpays hospitals and underpays ASCs for providing the same services. For the first time in the 30-plus year history of the ASC industry, about as many surgery centers are closing as are opening each year.

**ASC Payments in 2014**

In early July, CMS published its ASC payment proposal for 2014. This year’s update is based once again on the Consumer Price Update, or Urban (CPI-U), which the agency estimates to be 1.4%. However, most healthcare providers incur a “multifactorial productivity adjustment” that’s debited against their cost of living updates; CMS estimates that this adjustment will be 0.5%, which would result in a 2014 ASC payment rate update of 0.9%. (This compares with a 1.8% update for hospitals.) Because

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of statutorily imposed budget neutrality restrictions, base rates for ASC services didn’t change dramatically; some increased modestly and some declined.

The ASC and ophthalmology communities will again object to CMS’ use of the CPI-U as an inflator, urging instead that facilities be afforded the Hospital Market Basket, which is provided for hospital outpatient departments and is typically about a point higher. Because ASCs treat the same patients for the same conditions and consume comparable resources in delivering surgical care, there’s no justification for ASCs getting a lesser update. We’ll raise our continuing concerns regarding the impact of these cost-of-living differentials on the growing disparity in payment rates to ASCs and hospitals. And we’ll remind policymakers of the insidious and costly practice of hospitals acquiring ASCs and converting them to hospital outpatient departments (HOPDs), enabling them to bill for surgical services at the substantially higher hospital rates.

Finally, as a failsafe, the ASC community is garnering support for The ASC Quality and Access Act of 2013, which, among other components, would direct CMS to provide ASCs with the same annual update as hospitals. This bill would accomplish a number of other important objectives. It would:

• add an ASC voice to the Advisory Panel on Hospital Outpatient Payment (important since our rates are based on hospital payments)
• create a value-based purchasing program for ASCs; and
• require CMS to disclose the criteria it uses to determine which procedures may be performed in the ASC setting.

Cost Reporting for ASCs

For years, the Medicare Payment Advisory Commission (MedPAC) has recommended that Congress require ASCs to submit to some form of cost reporting as a condition for receiving an annual update. As part of the 2013 ASC payment regulation, CMS requested comments from the ASC and surgical communities on the desirability of, and means for collecting, cost or other data that might enable the agency to adopt or develop an appropriate ASC update factor. The ASC industry will continue to oppose any form of facility cost reporting. Why? The rates that ASCs are paid are based on payments to HOPDs; as such, ASC costs are irrelevant. Moreover, the administrative and financial burden on surgery centers would be substantial. We’re pleased that the 2014 ASC payment rule doesn’t include a cost-reporting mandate.

Leveling the Playing Field

The trend of surgical services migrating from HOPDs to ASCs has stalled. Moreover, hundreds of millions of Medicare dollars are being wasted as hospitals acquire ASCs and convert them to HOPD status in order to achieve higher reimbursements. To illustrate, the day after such a conversion, the new “hospital” entity (same patient, same location, same surgeons, same staff, same facility costs) receives $1,730 for a cataract procedure compared to the $971 it was paid the day before when it was an ASC.

In a quest to achieve budget savings and address myriad federal deficit issues, Congress is looking for new ideas to generate significant Medicare savings. With hospitals accounting for the lion’s share of program expenditures, Washington wonks are looking in places previously off limits. In its recently released Report to Congress, MedPAC delivered some far-reaching and unprecedented options to the budget scalpers on Capitol Hill. The Commission is acting under three principles: 1) patients should have access to all appropriate settings; 2) a prudent purchaser should not pay more for the same service in another setting; and, 3) Medicare should base its rates on the resources needed to treat patients in the lowest-cost, clinically appropriate setting.

How do these principles translate into policy and payments? MedPAC is advocating that HOPDs be paid at the ASC rates (which is about 40% lower than current hospital payments) for services: 1) that are furnished in ASCs more than half the time; 2) that are infrequently provided with an emergency room visit; and, 3) where patient severity in the HOPD is no greater than in the ASC. Most high-volume eye surgeries would meet these parameters. Will Congress take the plunge and adopt this proposal? Time will tell, but the approach is being seriously considered on the Hill.

Why should ASCs care about this development when our rates won’t be increased? There are a number of reasons for an enthusiastic embrace of such a proposal by the ASC community. First, services will undoubtedly migrate from the HOPD to our centers, because many hospitals are already less than enthusi-
astic about offering ophthalmic surgery and this concern would be heightened if payment rates are substantially reduced. Second, the wide disparity in payments to HOPDs and ASCs would be significantly narrowed. Third, the fact that ASCs and hospitals would be reimbursed at the same rate for many procedures solidifies our case that our centers should receive the same annual update. And, importantly, ASCs and hospitals would have identical interests in lobbying for higher payments, allowing surgery centers to ride the coattails of the gargantuan hospital lobbying forces. All in all, were Congress to adopt this MedPAC recommendation, the increase in revenues from expanded volume of cataract and other cases would likely be substantial. And that’s good news for ophthalmic ASCs.

Quality Reporting, Outcomes and Patient Satisfaction

For years, our industry has been touting ASC quality as equal or superior to that of hospitals. Over the next several years, surgery centers will have many opportunities to prove this claim. In what is the most significant change in the Medicare ASC program in decades, ASCs are required to submit quality data to CMS. We have been pleased that, to date, the agency adopted a number of the recommendations made by OOSS and the ASC community.

Reporting commenced on Oct. 1, 2012 on five process-based measures: patient burns; patient falls in the ASC; wrong site, wrong side, wrong patient, wrong procedure, wrong implant; hospital transfer/admission; and prophylactic IV antibiotic timing. Penalties of 2% are imposed on facilities that fail to comply with quality-reporting requirements. By almost every assessment (ASC claims by procedure, QDC rates by code, and QDC rate by specialty), participation by ASCs furnishing ophthalmic surgery has been impressive.

This year, facilities are required to report between July 1 and August 23 on two additional web-based measures: 2012 volume of specified procedures (including the most frequently performed ophthalmic services); and, affirmation that a safe surgery checklist was in use in 2012. Facilities are required to register on the CMS QualityNet website in order to report on these measures. If your ASC has not done so, it is imperative that the process be initiated to avoid penalties and a public display of non-reporting status.

In the new rule, CMS is also proposing that, commencing in 2014 for purposes of 2016 payment determinations, ASCs report on four new measures, two of which are ophthalmology-specific:

1. Complications Within 30 days Following Cataract Surgery Requiring Additional Surgical Procedures (NQF#0564); and, 2. Improvement in Patient’s Visual Function Within 90 days Following Cataract Surgery (NQF#1536). Facilities would provide aggregate data on these chart-abstracted measures via an online web-based tool on a CMS web page. OOSS will provide you with all of the tools to develop a relationship and convey an effective message.

Political Action. The Outpatient Ophthalmic Surgery Political Action Committee (OOSPAC) is the only PAC whose sole purpose is to advance the interests of surgeons who own and practice in ophthalmic ASCs. Please consider making a contribution.
ASC registry in existence.

In another development, CMS is in the process of designing and implementing a survey that will measure patient experience and outcomes with respect to care provided in both the HOPD and ASC. O OSS has provided extensive recommendations to the agency regarding this initiative, focusing on the need to minimize administrative burdens and select appropriate topics and questions for consumer responses. We’re proud of our results and relish the opportunity for patients to be able to ascertain the experiences of others in similarly located hospitals and ASCs.

**Regulation of ASCs**

No development in Washington has generated more confusion and aggravation for ophthalmic surgery centers over the past few years than the revised Medicare ASC Conditions for Coverage (CfC). The most arbitrary and irrational provision of the rules required patients to receive notice of their rights at least one day in advance of a surgical procedure, effectively prohibiting, except under narrow circumstances, a patient from receiving surgical care in an ASC on the same day the surgeon refers him to the facility. The rule had the onerous effect of precluding same-day diagnosis for, and performance of, Yag procedures, much to the inconvenience of beneficiaries and consternation of surgeons. After 2 years of intense opposition to the provision, the government repealed this regulation as one of many that were unnecessary, obsolete, or burdensome to hospitals and other healthcare providers. CMS has also clarified that notice of patient rights may be provided on the same day of surgery, if it’s provided prior to the start of the surgical procedure.

CMS also issued a final rule eliminating the specific list of emergency equipment ASCs must have on hand. Instead, facilities, in conjunction with medical staff and their governing bodies, can develop policies and procedures that specify emergency equipment appropriate to the services they provide. Despite these victories, there remain a plethora of CfC-related challenges as ophthalmic ASCs face new and sometimes ambiguous and inconsistently applied standards.

**What is the Facility Guidelines Institute?**

To be honest, until last fall, I’d never heard of the Facility Guidelines Institute (FGI). About a decade ago,
FGI assumed from the American Institute of Architects the responsibility for establishing minimum architectural standards for healthcare facilities. Comprised of hospital officials, nurses and regulators with little familiarity of the workings of an ASC, FGI revises architectural standards every 4 years. State health departments and other regulatory bodies then decide whether, or to what extent, they’ll adopt FGI’s recommendations for facilities within their jurisdictions.

The 2014 draft of the FGI’s Guidelines for Design and Construction of Hospitals and Outpatient Facilities caught our attention — like a two by four to the head! Among the proposed guidelines were these gems: a minimum operating room size of 360 square feet; wider doors and openings to and from ORs; and requirements for multi-position scrub sinks, recovery staff toilets, and multiple staff shower facilities that were costly and unnecessary. Why are we concerned? Although, technically, FGI standards apply on a prospective basis to “new” facilities, existing ASCs aren’t necessarily grandfathered in. For example, in many states, existing centers may be considered “new” when they seek regulatory approvals such as certificate of need or transfer ownership to another entity. More importantly, many of the standards simply make no sense. OOS and the Ambulatory Surgery Center Association conducted a survey of surgery centers throughout the country and confirmed that, for example, 40-60% of ophthalmic ASCs would not meet the proposed 360 square foot OR requirement. Given that FGI is charged with developing “minimum” (not optimal) standards, many of its draft provisions are irrational and unacceptable. Although final action on the FGI’s ASC architectural standards initiative won’t be taken until this fall, we’re optimistic that several of its most egregious elements will be revised.

The ASC product is an exceptional one, embodying the potential to reduce costs to patients and payer and expand access to millions of beneficiaries seeking high quality and patient-centered care. Like all providers, we will be regulated. However, by focusing on key issues, OOS, the ophthalmology and ASC communities, individual centers, and progressive ophthalmologists can ensure that such regulation is sane and sound.

Michael A. Romansky, JD, is Washington Counsel and Vice President of Corporate Development, Outpatient Ophthalmic Surgery Society (OOS), Washington, DC.
The Endo Optiks E2 system combines illumination, video imaging, and laser capability for expanded diagnostic and surgical applications in cataract, glaucoma, and retina with seemingly endless benefits for patients and practices.

I often use endoscopy to perform endoscopic cyclophotocoagulation (ECP) in combination with phacoemulsification. The endoscope is ideal for confirming proper lens and haptic placement, treating cases involving dislocated IOls, and identifying abnormalities of the capsule. Nate Kleinfeldt, MD (cataract surgeon)

The Endo Optiks E2 enables exceptional visualization and precise ECP for successful control of IOP. My glaucoma patients benefit from the surgery and the subsequent reduction in the need for meds. ECP is increasing as a treatment option for mild, moderate and advanced glaucoma and also when other filtering surgeries have failed. Brian Francis, MD (glaucoma specialist)

Call 800.756.3636 to learn how to experience the seemingly ENDless ENDoscopy benefits with the Endo Optiks E2 system.
New-technology IOLs

A look at today’s options and what’s in tomorrow’s pipeline.

Ophthalmologists have witnessed and delivered great changes in cataract surgery in the past decade, driven by better diagnostic technologies, new surgical techniques and an ever-improving range of IOLs. Factor declining reimbursements into these developments, and it’s easy to see how the opportunity to provide better post-operative vision than ever before is also an opportunity to generate additional revenue for your surgery center. For the right candidates, new-technology multifocal, toric and multifocal toric IOLs that go beyond the standard monofocal outcomes also go beyond Medicare reimbursement.

New-technology IOLs (NTIOLs) provide excellent results — patients are happy. Recently approved IOLs and those in the pipeline have the potential to make patients even happier — by correcting astigmatism and providing better near, middle and distance vision. They may even expand the scope of patients you consider to be good candidates for a certain type of lens. Here’s a look at some of the new-technology lenses available now and a glimpse of what’s to come.

Alcon: Flagship IOLs and New Deliveries

Today: Alcon offers several NTIOLs through its AcrySof IQ family of IOLs, a time-tested platform, which the company continues to grow.

“We develop lenses based on patients’ vision requirements such as distance or astigmatism correction, reduced dependence on reading glasses and a range of lifestyle enhancements,” says Rafael Chan, Global Director, IOLs at Alcon Laboratories, Inc. “Our philosophy is to offer surgeons and patients lens options that address a broad range of needs.”

The company’s AcrySof IQ ReSTOR multifocal lens has been available since 2007, and several multifocal toric lenses are in the pipeline. According to Global IOL Marketing Manager Paul Smith, unmet patient and surgeon needs drive the development of new IOLs.

“Much of our pipeline strategy is derived from our collaboration with eyecare professionals,” Smith says. “For many years, we’ve been reaching out to understand their needs and the challenges they face in daily patient care, and then we innovate new ways to fulfill those needs.”

At the same time, Alcon continues to develop products to support the insertion of their NTIOLs. Released in 2012, the automated Intrepid AutoSert IOL delivery system allows surgeons using the Infiniti Vision System to control the device with one hand and deliver the AcrySof IOL through a small incision using the system’s foot pedal, rather than pushing a plunger or turning a hand-piece screw.

Tomorrow: Alcon’s AcrySof IQ ReSTOR +2.5 D and +2.5 D Multifocal Toric lenses are in clinical trials in the United States and Japan after a year of successful use in other markets.

“Overall acceptance is positive. They provide excellent range of vision for patients who have more intermediate-to-distant dominant lifestyles,” Chan says. “The lenses compliment our existing products, broadening the IOL options to address patients’ needs. The ReSTOR +2.5 D and +2.5 D Toric IOLs are in clinical trial development in the U.S. and Japan.”

Alcon also added a new lens to the portfolio a few years ago with the launch of the AcrySof IQ ReSTOR +3 Multifocal Toric lens outside the United States. This aspheric lens corrects vision at all distances as well as low or high levels of astigmatism while reduc-
ing higher-order aberrations for better visual performance. The lens features Alcon’s Stableforce haptics, apodized diffractive optics, clean cylinder axis marks and fibronectin-binding AcrySof IOL material.

Alcon continues its dialog with physicians, even after a product like the AcrySof IQ Toric is released.

“Feedback from physicians around the world has been very positive for the AcrySof IQ Toric IOL, validating the clinical outcomes and high levels of patient satisfaction we experienced in our clinical studies,” Chan says. “In fact, one reason for our success is that after the lenses are released, physicians’ real-world outcomes mirror the study results.”

AMO: More Stable Torics, Preloaded IOLs

**Today:** Several of AMO’s NTIOLs have been available for years, including the Tecnis Multifocal IOL for patients with cataracts and presbyopia, the ReZoom multifocal IOL and the Verisyse Phakic IOL for moderate to high myopes. In April, the company received approval for its Tecnis Toric 1-Piece IOL, which shares the 1-piece approach to design with the Tecnis multifocal.

AMO’s Chief Medical Officer, David J. Tanzer, MD, points to the advantages of a one-piece design. “Like other one-piece lenses, the Tecnis Toric 1-Piece has greater long-term stability and resistance to rotation than three-piece designs. In fact, 94% of Tecnis Toric lenses implanted rotate 5% or less — a figure that exceeds the current standard.”

According to Dr. Tanzer, this stability leads to satisfied patients. He’s confident that patients are much less likely to return in a year or two with vision problems that didn’t exist immediately after surgery.

“Residual astigmatism after cataract surgery is a reason for patient dissatisfaction that we want to reduce. In AMO’s research, 97% of patients who received the Tecnis Toric 1-Piece would have it implanted again. That means we’re moving in the right direction,” explains Dr. Tanzer. “Patients also enjoy the benefits that Tecnis lenses have always offered, from the outstanding optical quality of the hydrophobic acrylic lens to the stability of the Tri-Fix 3-Point fixation design for stability in the capsular bag.”

**Tomorrow:** AMO anticipates its preloaded Tecnis lens will launch later this year in the United States after years of use overseas.

“It’s an exciting advance in technology that’s already used all over the world. Surgeons find the preloaded lens easy to use, and it reduces the steps surgical technicians must make for surgery, creating a higher level of efficiency in the OR,” Dr. Tanzer says. “We work closely with a very gifted advisory panel here and abroad, and we’re in constant receipt of perspectives from these physicians and our physician customers.”

Bausch + Lomb: Advanced Torics, No Glistenings and Microincision IOLs

**Today:** Recently, two unique approvals have expanded Bausch + Lomb’s list of IOLs. The first, approved in May, is the Trulign Toric lens. It not only corrects residual refractive cylinder in patients with or without presbyopia, but also provides improved uncorrected near, intermediate and distance vision, with increased spectacle independence. According to Calvin W. Roberts, MD, Executive Vice President and Chief Medical Officer at Bausch + Lomb, the large toric market and unique advantages of the Trulign Toric will guide the IOL’s success.

“This is the first time in the United States that patients can have both astigmatism correction and improved uncorrected near, intermediate and distance vision,” Dr. Roberts explains. “Many premium IOL patients are toric candidates, and every patient who would benefit from a toric IOL would have better vision, with increased spectacle independence, if they received a Trulign Toric lens rather than a standard toric. If a patient is going to pay for a premium toric lens, why wouldn’t every doctor give that patient a lens that delivers better vision and increased spectacle independence?”

**B+L’s Incise microincision IOL was introduced in Europe this year.**
Bausch + Lomb’s enVista IOL, approved last year, is the first IOL to demonstrate no glistenings, fluid-filled vacuoles that occur inside some hydrophobic acrylic IOLs, at any time point during the clinical trial. Eliminating glistenings represents a new technological advance that may represent the difference between a happy patient and an unhappy one, according to Dr. Roberts.

“In my experience as a cataract surgeon, there’s nothing worse than performing what you think is a perfect surgery with a patient who is happy postoperatively, only to have the patient come back a year later saying she doesn’t see as well as she did after surgery,” he says. “I can see glistenings in the lens, and I need to investigate if they’re affecting vision. Glistenings are a routine problem — a ubiquitous presence in many popular lenses. We avoid this problem with the enVista IOL by packaging the lens in fluid, so it doesn’t rehydrate in the eye and form glistenings.”

**Tomorrow:** To expand its range of products with no glistenings, Bausch + Lomb has initiated clinical trials in the U.S. for the enVista Toric IOL. This year, Bausch + Lomb also began distributing PhysIOL’s blue light-blocking FineVision trifocal and FineVision trifocal toric IOLs in some European, Asian and Middle Eastern markets. In May, Bausch + Lomb introduced the Incise microincision IOL in Europe as well.

“The Incise microincision IOL is the first approved IOL that goes into the capsular bag through a 1.8 mm incision or using a 1.4 mm wound-assist technique. Doctors have been reporting that they can easily insert the lens with the single-use Viscoject Bio injector without enlarging the wound,” Dr. Roberts says.

**Staar: Collamer Material and New Torics**

**Today:** Lens material is key when it comes to Staar Surgical’s NTIOLs because the company offers many of its lenses in both silicone and their proprietary collamer material. You have the option of choosing the Staar nanoFLEX Toric Lens, made of collamer, or the Staar Toric Silicone IOL. What’s the difference?

“Collamer is a unique flagship material for Staar,” states Rex Chandler, Staar’s Global Marketing Director. “The material has one of the lowest refractive indexes of any material on the market — 1.44, compared to 1.41 for silicone and 1.55 for acrylic. It’s extremely biocompatible, so the body is unaware of the lens being in the eye, and at a glance, doctors sometimes have a hard time seeing it in the eye. Collamer makes for a very clear, quiet lens in the eye without glare or reflection. The material has been the hallmark of Staar’s foundation and makes the Visian ICL what it is today. Staar is in somewhat of a renaissance period, and Collamer is part of a creative approach to serving the needs of patients and surgeons.”

**Themes for the Future**

The relative ease of getting approvals in Europe is a recurring theme in many areas of medicine, and ophthalmic surgery is no different. So, while it may take time to get your hands on new technologies, you also get to enjoy a window on the future. You know what’s coming and how well it has worked for others.

Manufacturers are working to deliver more bang for the patient’s buck by merging torics and multifocals, increasing stability, even eliminating glistenings and reducing blue light.

“You’re on the manufacturers’ radar as well. If you’re looking for reliable, easy IOL delivery methods like disposable preloaded injectors or automated systems, your choices are expanding. Microincision surgery is also on several manufacturers’ agendas. With all of these developments on the horizon, physicians can look forward to increasing satisfaction on the IOL front.

**References**

1. AcrySof IQ ReSTOR IOL (Model SN6AD1). Directions for Use.
Haag-Streit’s journey to perfect microscope optics began 155 years ago. Now that expertise is transforming ophthalmic surgical microscopes, including expanded depth-of-field and a patented, proven red reflex. Powered by Swiss optics, and German mechanics.

Before you buy, consider the new leader in the field, Haag-Streit Surgical.
A Shift Toward Disposable Instruments

Although surgeons still use reusable instruments in their ASCs, disposables are an increasingly common choice.

Do you use reusable or disposable surgical instruments in your ASC? Many surgeons are opting for disposables, pointing to safety and convenience as their primary motivations. This widespread change has been made possible by vast improvements in the quality of disposable instruments — quality that is now comparable to that of many reusable instruments.

Safety First

Choosing between reusable and disposable instruments often begins with a discussion about safety. When sterilized properly, the safety of reusable instruments is comparable to that of disposables. However, reusable cannulated instruments pose a particular challenge.

“In the past 10 years or so, most facilities have gotten away from reusable cannulas because of contamination concerns. In particular, with small-gauge cannulas, which can be as tiny as 30 gauge, it’s very difficult to be sure that you’re cleaning the inside of the cannula thoroughly,” says Chris Boore, Sales Manager at Oasis Medical, Inc.

“Cannulated products have more extensive cleaning and sterilization procedures, which require a large amount of distilled water and additional staff time for disassembly and reassembly,” adds Chuck Hess, Sr. Director of Sales and Marketing at Bausch & Lomb. “Disposable cannulas are more efficient, and eliminate the possibility of contamination.”

Yong Sun, Vice President of American Sales and Global Marketing at Beaver-Visitec, says simply, “There’s no argument that cannulas should be disposable. Sterilization can leave inflammation-causing sterile residuals or irrigating solution in the cannulas, and a single case of toxic anterior chamber segment syndrome could shut down a center for weeks. The risks and potential revenue losses outweigh the cost of disposables — it’s not worth it to save a dollar.”

Hess points to concerns with other reusable instruments. “We see movement to more and more micro-instrumentation, and those instruments are harder to clean and reuse. It requires great care to properly sterilize vitreoretinal instruments without damage, and that’s causing facilities to move toward single use,” he says. Reliability is another worry. “With reusable instruments, the thoroughness of the cleaning and sterilization cannot be standardized.”

Don Mikes, Vice President of Global Marketing at Moria, states, “Single-use instruments are the only way to guarantee 100% sterility for each patient. Instruments that have never been used on other patients have a lower risk of transmitting contaminants than those that have — regardless of the rigor of the decontamination process. Single-use instruments put ASCs in the best position to be compliant with increasingly more stringent regulatory requirements,” he says. “Plus, for every case, the surgeon has a new, precise instrument — one that has never been dropped and has no signs of wear.”

Pravin Dugel, MD, of Retinal Consultants of Arizona, Phoenix, says safety is the biggest reason he and his colleagues moved to disposable instruments. “I think most physicians look at safety first, and then at other deciding factors, such as efficacy and cost,” he says. “I don’t think anyone would say that reusable instruments are safer than disposables. We...”
Watch the video:

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Kerry Solomon, MD
know that autoclaving isn’t sufficient when cannulas are involved, so the safety discussion to me is no discussion — disposables are safer.”

Of course, the choice between reusables and disposables is only a choice if the instruments are of comparable quality. Dr. Dugel is confident that this is the case. “It used to be that although disposable instruments were safer, they weren’t as good as their reusable counterparts,” he explains. “That has changed a great deal. From my perspective, today’s disposables work every bit as well as the reusable instruments.”

Quality and Consistency

In comparing the quality of surgical instruments, two factors stand out: 1) quality out of the package and 2) the consistency of quality from patient to patient. So, how do reusables and disposables compare on first use?

“To me, there’s no difference in quality at the start. But the tips on disposable instruments are very consistent and accurate — they don’t show the effects of eight to 10 uses and cleanings a day,” says Sunil Gupta, MD, Founder of Retina Specialty Institute in Florida, Alabama, Mississippi and Louisiana. “We’ve been using all disposables for 4 or 5 years. As we shifted almost exclusively to the surgical center for our procedures, we found that because ophthalmic instruments are very fine, something like an intraocular forceps can be damaged easily. That means we wouldn’t have consistency with every surgery, and when we’re doing something such as grabbing the epiretinal membrane, we need the forceps tips to align perfectly. We can’t afford any variability. Rather than rack up the costs of sending the reusable instruments for repair, we negotiated a comparable price to use all disposables.”

Dr. Dugel has a similar perspective. “When I’m peeling the very thin, fine internal limiting membrane of the retina, I think the best forceps are disposable. I would use them even if cost weren’t an issue,” he says. “Microincision surgery is a factor in choosing instruments as well. We’ve gone from 20- to 25- to 27-gauge surgery. The instruments get smaller and more delicate. It becomes harder to sterilize and reuse them and trust that they will function consistently. Some companies make very delicate reusable instruments that are remarkably good, but just by definition, they become gradually less effective over time, even if they’re handled properly. Rather than spending money on labor that has to be performed by skilled, specialized staff, we choose to invest in disposables, knowing we’re going to get safety and consistency.”

Although these surgeons have moved to disposable instruments in their ASCs, there’s little dispute that the diamond blade still reigns supreme.

“The majority of knives in the marketplace are single use, and most reusable ones are diamond blade. Diamond is the gold standard of sharpness, but in the past 10 years, the margin between a diamond blade and a well-made single-use blade has become very small,” says Yong Sun. He explains that physicians are weighing that small difference against the potential consistency of the diamond blade’s quality over time. “A diamond knife is expensive. It’s serviced a few times a year, and that sharpening removes matter. The blade can also be damaged if it touches anything, which can occur even with careful handling by dedicated OR technicians. And the diamond blade is a fixed investment — one that doesn’t change, even as techniques evolve to ever-smaller incisions. I think surgeons who choose disposable blades are happy with the clean, self-healing incisions they can achieve. If they’ve accepted the quality of disposables, then cost is the main consideration.”

The Cost Difference

Disposable instruments generally cost more per case than reusable ones. In the ASC, where time and costs are crucial, surgeons who choose disposables must believe the added cost is justified by the advantages in safety and consistency. But how much more money are we talking about?

Dr. Dugel urges colleagues to make an accurate comparison with a true assessment of the total costs of reusables. “If a disposable instrument is $100 and you use it for every case, does the reusable version save you $100 per case? The cost of labor is very high in a surgery center, and we need highly trained staff to clean and wrap the instrument, put it through the autoclave, wait, take it out, rewrap it, and put it back into inventory. In the end, the reusable instrument may be cheaper, but possibly by only $10 or $20 per case,” he explains. “If you weigh the true cost difference against the added safety risk of reusable instruments, as well as their declining quality over time, is it really worthwhile to save $20?”

In Dr. Gupta’s practice, he’s found that disposable instruments actually reduce OR time. “One
thing people don’t consider is turnover time and duration of a case,” he says. “We want to use physician, staff and OR time efficiently. And when we compare safety and consider the reusables’ breakdown effect and replacement costs, we prefer disposables.”

“Very few places can tell us their costs for reusables,” says Don Mikes. “They often don’t know their sterilization costs, especially in large facilities where instruments are processed in a central department. Without those numbers, we can only tell them that disposables will be more expensive, but not dramatically so. The best way for a facility to ascertain the true difference is to set up a trial period to compare costs.”

In addition to conventional metal reusable and single-use instruments, Moria offers Composites, a new line of reusable instruments with tips of surgical steel and handles fabricated from a durable plastic polymer. “Composites provide equivalent performance to the best all-metal instruments but are priced at a level that allows them to be discarded and readily replaced from inventory if, for example, they’re dropped or damaged,” says Don Mikes. “Surgeons obviously don’t get a new instrument for every procedure as they would with single-use, but this is an affordable middle ground.”

In another interesting cost comparison, Hess considers the advantages of an all-disposable instrument pack. “The number of instruments used for a routine cataract case, for example, is only about four or five, so a single-use pack is fairly cost effective,” he says. “From an overall convenience perspective, single-use instruments can go right into a custom procedure pack, adding value for a facility because it can put the expense into the operational budget rather than the capital budget.”

“Oasis is always seeking new ways to help surgical facilities improve safety and compliance, use single-use instruments and manage their cost per case at the same time. One way we do this is by offering cannulated instruments and Premier Edge blades in bulk packaging instead of smaller boxes to save on the cost of packaging,” says Boore. “We’re working to develop new cost-effective alternative devices such as the single-use Oasis Iris Expander for managing small pupils and floppy iris syndrome.”

You can evaluate factors like sterilization costs and OR time individually, but it also pays to step back and take in the big picture. “The largest single cost of running our center is staffing, while the total cost of our disposables is always 20% or less of the total overhead,” Dr. Dugel says. “That tells me that we really ought to be doing what’s best for our patients’ safety and outcomes, rather than just choosing the least expensive option. We’re better off reducing costs by being more efficient with staff time.”

What’s Next?

So, what are manufacturers planning for the future? And what developments in disposable instruments do surgeons hope to see?

“Today, manufacturers assemble complex single-use instruments under a microscope, allowing us to provide designs that aren’t possible to assemble in the OR in a reusable form,” Hess says. “For example, our CapsuleGuard product has a silicone exterior to protect intraocular tissues. We couldn’t make a reusable version because technicians couldn’t consistently and reliably reassemble it. High-technology manufacturing practices will enable us to continue making new, advanced instruments in the future.”

Sun anticipates new advances in disposables as well. “We’ve developed a safety knife configured for the latest surgeries, and our Thermal Dot instrument marks the limbus for toric implants, eliminating problems with paint marks.”

“I’m looking forward to having the same excellent performance we have now, only with a smaller gauge. We’ll do the surgery moreatraumatically, and perform with greater access to tissue,” Dr. Dugel says. “I think we’ll see a steady progression to smaller gauge microincision procedures.”

Dr. Gupta hopes to see more instruments for delicate retina procedures. “I recently started using a heavier disposable forceps for proliferative vitreo-retinopathy cases, and this has been very helpful, but it would be nice to have a disposable lighted knife to allow efficient, bimanual dissection of preretinal fibrosis,” he says.

He sees room for the use of disposables to expand in the ASC as price becomes less of a factor. “Dollars in health care are shifting, and with less to spend per patient, some facilities continue to stick with reuse,” he says. “As more players enter the market, the greater number of available instruments should drive down costs, and those decreasing prices could be just the impetus to encourage a broader transition to using disposables.”
ASCs operate in a heavily regulated environment with increasing scrutiny and decreasing reimbursements. Keeping abreast of all the regulations that affect the operations of an ASC is a never-ending challenge.

Since the sweeping revision to the ASC Conditions for Coverage in 2009, CMS has issued a number of clarifications, proposals and changes. In this article, I’ll review the most recent revisions, which were published earlier this year. At that time, there were updates/revisions to the following:

• Emergency equipment
• Patient rights
• Physical environment
• Radiology
• Advance directives
• Infection control

Many of the changes are simply wording or reorganization and don’t carry significant operational implications. For the purposes of this discussion, I’ll limit my review to the substantive changes, which are italicized in the excerpts throughout this article.

Emergency Equipment Changes
A welcome change affords ASCs more latitude in selection of emergency supplies:

§416.44(c) Standard: Emergency Equipment
The ASC medical staff and governing body of the ASC coordinates, develops, and revises ASC policies and procedures to specify the types of emergency equipment required for use in the ASC’s operating room. The equipment must meet the following requirements:

(1) Be immediately available for use during emergency situations
(2) Be appropriate for the facility’s patient population
(3) Be maintained by appropriate personnel

Previous mandates were more specific and included a mechanical ventilator and tracheostomy set, among other things. The new standard allows flexibility for facilities to standardize their emergency supplies to suit their scope of care and patient population in conjunction with their medical staff and in accordance with acceptable standards of care in the ASC industry. Policies and procedures must specify the emergency supplies (including quantity), medications and equipment present in each OR and outside the ORs, including location, so all are readily available to the OR(s) in an emergency. They must also address how the emergency supplies and equipment will be maintained.

Having malignant hyperthermia (MH) emergency supplies is a standard of care if general anesthesia is included in the scope of care and/or if the ASC includes any MH triggering agents, such as succinylcholine, in its formulary.

It’s a requirement that ASC clinical staffing, specifically the number of RNs, be sufficient to handle an emergency that may arise without compromising patient safety. The revised interpretive guidelines are even more specific. Surveyors are directed to inquire as to how the ASC would handle concurrent emergencies happening simultaneously in different locations within the center.

Patient Rights Changes
The most significant changes are to the condition of Patient Rights.

§416.50 Condition for Coverage — Patient Rights
The ASC must inform the patient or the patient’s representative or surrogate of the patient’s rights and must protect and promote the exercise of these rights, as set forth in this section. The ASC must also post the written notice of patient rights in a place or places within the ASC likely to be noticed by patients waiting for treatment or by the

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patient’s representative or surrogate, if applicable.

A patient surrogate may be identified in writing through an advance directive, medical power of attorney or verbally. Some ASCs may need to consider posting more than one notice, depending on the size of the ASC and the physical layout. The critical point is ensuring that they’re posted in a manner and location in which patients and surrogates are likely to see it. Failure to post the written notice of patient rights in a single place (or places) within the ASC that are likely to be noticed by the patient or surrogate will result in a standard level citation.

§416.50(a) Standard: Notice of Rights
An ASC must, prior to the start of the surgical procedure, provide the patient, or the patient’s representative, or the patient’s surrogate with verbal and written notice of the patient’s rights in a language and manner that ensures the patient, the representative, or the surrogate understand all of the patient’s rights as set forth in this section. The ASC’s notice of rights must include the address and telephone number of the State agency to which patients may report complaints, as well as the Web site for the Office of the Medicare Beneficiary Ombudsman.

It’s recommended that ASCs provide all patients with a verbal and written notice of their rights as soon as possible after scheduling a procedure. Mail and email are acceptable methods of communication. It’s required that the notice be provided preoperatively and prior to administration of any medication that suppresses consciousness. If the ASC has a large number of non-English speaking patients, patient rights must be available in a language that the entire patient population will understand. If written notice is not available, the ASC must make translators available to provide a verbal notice of rights.

Ownership of an ASC
The interpretive guidelines for disclosure of physician financial interest or ownership have been revised to require written notice and include a list of physicians who have a proprietary interest in the ASC in writing. A generic statement of ownership isn’t acceptable.

Advance Directive Changes
A major revision is how ASCs handle patient advance directives as shown.

§416.50(c) Standard: Advance Directives
(1) Provide the patient or, as appropriate, the patient’s representative with written information concerning its policies on advance directives, including a description of applicable State health and safety laws and, if requested, official State advance directive forms.

Interpretive Guidelines: §416.50(c) Information on Advance Directives
Each ASC patient has the right to formulate an advance directive consistent with applicable State law and to have ASC staff implement and comply with the advance directive, subject to the ASC’s limitations on the basis of conscience. To the degree permitted by State law, and to the maximum extent practicable, the ASC must respect the patient’s wishes and follow that process.

An advance directive may be in the form of a living will or a medical power of attorney. Since this requirement was implemented 4 years ago, most ASCs have adopted a policy of informing patients that the ASC doesn’t honor advance directives, and in the event of a medical emergency, will implement resuscitative measures immediately while activating 911 for an emergency transfer. This policy is no longer acceptable. Under the current regulation, ASCs can refuse to implement specific provisions of an advance directive on the basis of conscience, to the extent permitted by state law. The ASC policy should include a statement of limitations, identify the state authority permitting a conscience objection, and describe the range of medical conditions affected by the conscience objection.

Written notice of the advance directive policy and information on advance directives, including the state approved form, must be made available to the patient, prior to the start of the surgical procedure. The revision further specifies that whether or not the patient has an executed advance directive must be documented for each visit. Staff must be educated on facility policies and procedures regarding advance directives and the patient’s right to make informed decisions regarding his health.

Other changes to the standards under the Patient Rights condition are largely aimed at inclusive language to extend the requirements to the patient’s surrogate or representative. The interpretive guidelines for 416.50(e) Standard: Exercise of rights and respect for property...
and person have been revised to mandate that the ASC must not engage in reprisals or discriminatory behavior in response to a patient exercising his rights. While this may be obvious and logical, the conditions for coverage require it to be codified in a policy and procedure.

**Infection Control Changes**

Significant changes to 416.51(b) Standard: Infection control program are to the interpretive guidelines. While the vast majority of ASCs have a formal program for tracking post-op infections, the revised guidelines specifically require a formal tracking investigation and reporting system. Of note to practice-owned ophthalmic ASCs is this: **ASCs may delegate portions of this follow-up responsibility to the physicians on the ASC’s staff who will see the patients in their office post-discharge only if the ASC’s process includes a mechanism for ensuring that the results of the follow-up are reported back to the ASC and documented in the patient’s medical record.**

ASCs are also obligated to comply with all applicable county, state and federal disease-reporting requirements. There are also changes to Exhibit 351, Infection Control Surveyor Worksheet.

**Updated AAAHC Standards**

In addition to CMS regulations, ASCs that obtained Medicare certification through a deemed status survey are accredited and must therefore comply with evolving accreditation standards. The national deemed status agencies include The Joint Commission, Health Facilities Accreditation Program, Accreditation Association for Ambulatory Health Care (AAAHC) and American Accreditation Association of Ambulatory Surgical Facilities. Since the majority of accredited ASCs are accredited by AAAHC, it’s worth mentioning many AAAHC standards, which have been edited or revised for 2013.

In the core standard, Quality of Care Provided, standard 4.E.4 has been edited to state **medication reconciliation is performed.** There has been discussion around this for years within the industry and accrediting bodies. The risk associated with inadvertent mismanagement of medication regimens in the acute care setting is well documented. The opportunity for unintended inconsistencies in medication management may occur at any point during transitions in care. Medication reconciliation is the process of reconciling medication regimens upon admission, transfer and discharge. Some have asserted this process is equally important in the outpatient setting, as some patients receive prescriptions from multiple outpatient providers. Unfortunately, in the ophthalmic ASC setting, this is rarely the case. Nonetheless, AAAHC now requires that a process of medication reconciliation be in place in ASCs.

In the core standard, Clinical Records and Health Information, standard 6.B.4 requires **a system for tracking access to medical records to block unauthorized access.** While most ASCs manage this process well, it may be wise to formalize the process you have in place to meet the standard. More burdensome for ophthalmic ASCs is standard 6.E, which requires a diagnostic summary for patients who have three or more admissions to the ASC. The concept of diagnostic summaries is not new and is a standard in clinic settings. However, it has not been standard in ASCs and in ophthalmic and pain management ASCs in particular, where patients often meet the three-admission threshold.

Finally, in the adjunct standards of Surgical and Related Services, 10.I.F is a new standard that requires **a written policy is in place for the risk assessment and avoidance practices related to deep vein thrombosis (DVT), when appropriate.** According to the Association of Perioperative Registered Nurses, in a December 2010 publication, Byron Burlingame notes that the patient population in the ambulatory setting is typically at low risk for developing DVT using the procedure-based risk stratification of the American College of Physicians. However, risk can exist in surgical patients when comorbidities and type and length of surgical procedures are considered.

CMS Conditions for Coverage and AAAHC accreditation standards are only two of the reference points dictating the operation of ASCs. OSHA, HIPAA, CDC guidelines, state licensing regulations, and many other local, state and federal regulations and guidelines also impose requirements upon ASC operators. It behooves owners and administrators to be “plugged in” to appropriate resources to ensure awareness of evolving standards and take appropriate action to ensure ongoing compliance.

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Regina Boore, RN, BSN, MS, CASC is President/CEO of Progressive Surgical Solutions, an ASC consulting firm, and Progressive eSupport, an online ASC management tool. Please Visit www.PSS4ASC.com to learn more about Progressive Surgical Solutions.
My favorite advice when teaching ASC surgical coding surgery is to remember that it’s like learning to drive on the left side of the road. You know how to drive — it’s just the rules are different than what you’re used to. We use modifiers, have procedures that are covered and not covered, suffer with compliance adherence and deal with operations that can be considered either cosmetic or functional, just as we do in physician coding — but the rules aren’t always the same. For those of you trained in physician surgical coding and reimbursement, the switch to ASC coding presents challenges. In this article, I’ll discuss some of these challenges.

My overview is based on Medicare guidelines and regulations and may not apply to other insurers. I urge you to check with each individual insurer. Some may have a national policy and others, such as the Blue Cross and Blue Shield organizations, do not, which means that each makes its own regulations.

Current Procedural Terminology (CPT) is the book used for code selection, as well as for determining the modifiers to apply and guidelines to follow for physician and ASC coding. This is the source of many dilemmas. A novice coder may erroneously believe that a modifier listed in the ASC/Hospital Outpatient appendix is mandatory to use. Medicare and CPT aren’t synonymous — just because a code or guideline appears in CPT doesn’t mean that Medicare, or any other payer, will necessarily reimburse for the procedure. So let’s tackle the first major problem — modifiers.

Modifier Problems
Appendix A in CPT contains various applications for modifiers including one titled “Modifiers” that’s generally used in physician coding followed by another called “Modifiers Approved for Ambulatory Surgery Center (ASC) Hospital Outpatient Use.” The latter was first developed in 1999 and as changes occurred in the “Modifiers” section, they were brought over to the ASC/Hospital Outpatient section.

Global Surgery. The first major issue to address is that many of the modifiers have a different use for Medicare than what is in the CPT description or they may not be applicable at all. As we go through the issues, it’s important to remember that ASC reimbursement is for the costs incurred by the facility and has no relationship to physician work. Thus, there is no basis for the modifiers based on the global surgery concepts (58, 78 and 79). Inclusion in the CPT ASC/Hospital Outpatient section of Appendix A doesn’t mean they should be used, even if they’re being used for coding the same case for the physician.

Uses Other than CPT listed ones. Some modifiers are used differently by Medicare for ASC coding. For example, modifier 76 is used by NHIC, Inc. for billing bilateral surgery, and there are varying instructions on whether or not to use modifier 50 for coding bilateral procedures. Modifier 53 indicates a discontinued procedure and is strictly used in physician coding. It’s not used for ASC discontinued procedures — instead use modifiers 73 and 74. We are well aware of the confusing nature of rules that are MAC (Medicare Administrative Contractor) specific, so it’s crucial to be cognizant of each insurer’s rules.

Discontinued Procedures. Two modifiers specific to ASC coding are 73 and 74. The 2013 CPT definitions read: “73 Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia”: Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient’s surgical preparation (including sedation when
provided, and being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia (local, regional block(s) or general). Under these circumstances, the intended service that is prepared for but cancelled can be reported by its usual procedure number and the addition of modifier 73. **Note:** The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.

WPS Medicare example of case eligible for payment: The patient developed uncontrolled bleeding and the procedure was terminated. Modifier 73 pays 50% of the allowed amount and modifier 74 pays 100%.

### Case Studies

**Q.** We have recently started implanting the iStent glaucoma device (Glaukos Corp.) as a secondary procedure during cataract surgery in our ASC. We had an instance where the surgeon decided to abort the iStent procedure after a failed attempt, but proceeded with completion of the cataract surgery. My billing department is familiar with how to code for an abort of the primary (cataract) case after administration of anesthesia, but is asking me if there’s a code for billing an aborted secondary procedure. Are there different codes for facility and surgeon in this instance?

**A.** The CPT codes are 0191T (Insertion of anterior segment drainage device without extraocular reservoir; internal approach, into the trabecular meshwork) and 66984 (cataract extraction with insertion of IOL). However, the iStent discontinued, so on the physician’s bill, modifier 53 would be applied and on the ASC bill, modifier 74 would be used. So, yes there are different codes for the facility and the surgeon.

Procedures should be listed in descending order of reimbursement. The iStent procedure is listed in the ASC fee schedule with an approximate reimbursement of $1535, whereas the cataract surgery allowance is approximately $892. Therefore, 0191T should be listed first, since it’s the highest paying procedure. The cataract/IOL surgery becomes the second procedure listed and no modifier is required except the RT or LT and modifier 51, if your contractor requires it.
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