ASRS American Society of Retina Specialists

September 6, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

RE: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017 (CMS-1654-P)

Dear Acting Administrator Slavitt:

The American Society of Retina Specialists (ASRS) appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services' (CMS) proposed rule (CMS-1654-P), published on July 15, 2016 in the *Federal Register*, regarding the proposed policy revisions to the 2017 Medicare physician fee schedule (PFS). ASRS is the largest retinal organization in the world, representing more than 2900 members in every state, the District of Columbia, Puerto Rico, and 59 countries.

There are a number of provisions in the proposed rule that impact retina specialists and the Medicare beneficiaries they treat. ASRS offers comments in the following areas:

- Proposed CY 2017 Work RVUs for New, Revised and Potentially Misvalued Codes
- Improving Payment Accuracy for Primary Care, Care Management, and Patient-Centered Services
- Collecting Data on Resources Used in Furnishing Global Services

PROPOSED CY 2017 WORK RVUS FOR NEW, REVISED AND POTENTIALLY MISVALUED CODES

CY 2017 Proposed Codes - Retinal Detachment Repair (CPT codes 67107, 67108 and 67110)

In the interim final Medicare Physician Fee Schedule for 2016, CMS imposed significant cuts to the following retinal detachment repair procedures CPT codes: 67107, 67108, and 67110. At the request of ASRS and the RUC, CMS agreed to refer these codes to the CY 2016 multi-specialty refinement panel. The refinement panel supported the original RUC RVUs for 67107, 67018, and 67110 of 16.00, 17.13, and 10.25, respectively. Based upon the comments and the results of the refinement panel, CMS reversed its original stance and proposes instead the RUC recommended

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work RVUs. **We appreciate this decision as we believe the RUC process resulted in fair work values and we thank CMS for its reevaluation.**

Technical Correction Needed

We note, however, that although the preamble indicates that CMS proposes these work RVUs for CY 2017, Addendum B still includes the interim final work RVUs that were initially proposed last year. As this contradicts the decision CMS notes in the preamble, to accept the 2016 refinement panel recommended work RVU, we anticipate this modification will be implemented as technical corrections in CMS files to be ready for both the CY2017 MFS Final Rule and January 1, 2017 payments. Moreover, as these errors would have impacted the formula CMS uses to derive PE RVUs, the PE RVUs should be corrected as well.

CY 2017 Proposed Codes - Retinal Detachment Repair (CPT codes 67101 and 67105)

For CPT code 67101, CMS proposes the RUC recommendation of 3.50 work RVUs, which was based on the 25th percentile of the survey. We appreciate this proposal.

For CPT code 67105, the RUC recommended a work RVU of 3.84 based on the 25th percentile of the survey. The RUC also stated that CPT code 67105 was a more intense procedure, and therefore, should have a higher work RVU than CPT code 67101. CMS disagrees, noting that currently, CPT code 67101 has a higher work RVU than CPT code 67105 and according to the surveys the intraservice and total times remain higher for CPT code 67101. CMS believes the claim regarding greater intensity of this code was not clearly explained and it does not understand why the RUC believes that CPT code 67105 is more work than CPT code 67101. Therefore it is not proposing the RUC-recommended work value of 3.50 for CPT code 67105 and proposes a new value of 3.39 for CPT code 67105.

Since CMS did not find sufficient evidence to support the claim that 67105 has greater intensity, we would like to provide a more detailed explanation comparing the work related to the use of cryopexy (67101) and laser (67105). When cryopexy is placed for repair of a retinal detachment, the surgeon typically places 8-12 freezes to the retina to surround the retinal detachment. In contrast, when laser is placed, it typically requires anywhere from 200 - 800 burns to surround the retinal detachment. It takes significantly fewer cryopexy freezes because they cover a much larger area of retina than laser. The use of laser is more difficult and time consuming to treat retinal detachment because each of the 200 - 800 laser burns must be placed individually and precisely. While cryopexy is easier, laser is the preferred treatment since patients recover more rapidly and the seal around the retinal detachment starts within 24 hours compared to 2+ weeks for cryopexy. Since the goal is to create a barrier around the retinal detachment, it is advantageous to have an instantaneous barrier rather than one that forms over 2 or more weeks.

Given the above explanation of relative complexity, ASRS agrees with the RUC recommendations and urges CMS to accept its recommendation of 3.84 based upon changes in the services that now make 67105 more intense than 67101.

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CMS should accept the original RUC recommendation of 3.84 work RVUs for CPT code 67105.

CMS REQUEST FOR COMMENTS ON WORK VALUE METHODOLOGY

We appreciate that CMS acknowledges that physician work intensity per minute is typically not linear and that making reductions in RVUs in strict proportion to changes in time is inappropriate. We also appreciate its acknowledgement that the usage of time ratios to reduce work RVUs is not necessarily appropriate, as often a change in physician time coincides with a change in the physician work intensity per minute.

ASRS supports the RUC position and the long-standing position of the AMA and medical specialties that all adjustments to work relative values should be solely based on the resources involved in performing each procedure or service. All adjustments to work RVUs should either be work neutral to the family or result in budget neutral adjustment to the conversion factor. Broadly redistributing work RVUs would distort the relative value system and create unintended consequence (i.e. misaligning physician productivity measurement systems and adding complexity to the ongoing valuation process).

We oppose any potential methodology that would use a "reverse building block" methodology to reduce a work RVUs for services. A reverse building block methodology is highly inappropriate, due to the fact that magnitude estimation was used to establish work RVUs for services in the RBRVS. As CMS itself notes, it has not applied such an approach specifically because it agrees that the per-minute intensity of work is not necessarily static over time or even necessarily during the course of a procedure.

The ASRS agrees with the longstanding position of both the RUC and CMS that treating all components of physician time (pre-service, intra-service, post-service and post-operative visits) as having identical intensity is incorrect and inconsistently applying it to only certain services under review creates inherent payment disparities in a payment system which is based on relative valuation. When physician times are updated in the Medicare payment schedule, the ratio of intra-service time to total time, the number and level of bundled post-operative visits, the length of pre-service and length of immediate post-service time may all potentially change for the same service. These changing components of physician time result in the physician work intensity per minute often changing when physician time also changes. CMS should always account for these nuanced variables.

We understand that all RUC recommendations now explicitly state when physician time has changed and address whether and to what magnitude these changes in time impact the work involved. Specific rationales justifying changes in physician work intensity, when applicable, often with supporting clinical information, is also provided. CMS should carefully consider this information when determining proposed and final work values.

PHASE-IN OF SIGNIFICANT RVU REDUCTIONS

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CMS proposes to finalize a proposal that all existing codes (not new or revised) undergoing a reduction in value equal to or greater than 20 percent, have a maximum reduction of 19 percent in total RVUs per year until the total reduction is achieved.

The ASRS recommends that CMS finalize its proposal to set a 19 percent reduction ceiling on all existing codes.

ESTABLISHING A HCPCS G-CODE TO IMPROVE PAYMENT ACCURACY FOR CARE OF PEOPLE WITH MOBILITY-RELATED DISABILITIES

Proposal

To improve payment accuracy and help ameliorate potential disparity in access and quality for beneficiaries with mobility-related disabilities, CMS proposes to create a new add-on G-code, effective for CY 2017, to list separately in addition to the primary procedure that would describe the additional services furnished in conjunction with E/M services to beneficiaries with disabilities that impair their mobility:

> GDDD1: Resource-intensive services for patients for whom the use of specialized mobility-assistive technology (such as adjustable height chairs or tables, patient lifts, and adjustable padded leg supports) is medically necessary and used during the provision of an office/outpatient evaluation and management visit.

Comments

ASRS appreciates CMS' desire to improve access to health care for patients with disabilities, but we do not believe it is appropriate to fund these services with an overall cut in physician payment rates. While the intent is laudable, we believe there may be some unintended consequences that need to be considered. The first of which is increased copayments for individuals with mobility-related disabilities. Based on the proposed $44 add-on payment for physicians, patients with mobility-related disabilities will have an additional $9 copayment each time special equipment is required during a physician visit. Second, the proposal does not clearly define what constitutes a sufficient mobility problem to justify the $44 add-on payment. Rushing to implement this proposal without adequate guidelines will create unnecessary confusion and chaos. Finally, we believe CMS should evaluate whether some of the costs physicians incur to provide care for such patients have already been at least partially reimbursed in the practice expense portion of physician payment or through tax credits offered under the Americans with Disability Act.

Prior to finalizing this proposal, CMS should consider input from stakeholders and assess whether a broader array of patients that face mobility barriers may benefit. Otherwise, it may create unequal coverage for care of disabled patients with impaired mobility and anomalies in the relative value scale. ASRS recommends that CMS work with the CPT Editorial Panel and the RUC to develop a policy to address the issues and concerns outlined above that would not negatively impact patients with mobility-related disabilities.

The ASRS opposes CMS' plan to eliminate the 2017 physician payment increase Congress provided in MACRA in order to fund an add-on payment for services provided to patients with mobility-related disabilities.

If CMS proceeds with this new G code, it should broaden application to a wider array of patients that face mobility barriers, such as those with vision impairment.

COLLECTING DATA ON RESOURCES USED IN FURNISHING GLOBAL SERVICES

Background

In the CY 2015 final rule, CMS finalized a policy to transform all 10- and 90-day global codes to 0-day global codes, beginning in CY 2018. Under this policy, CMS would have valued the surgery or procedure to include all services furnished on the day of surgery and paid separately for visits and services furnished after the day of the procedure. Subsequently, Congress enacted Section 523 of the Medicare Access and CHIP Reauthorization Act (MACRA) in 2015 prohibiting CMS from implementing this policy. Instead, Congress required the agency to develop a process to gather information needed to value surgical services from a representative sample of physicians, and requires that the data collection shall begin no later than January 1, 2017. The collected information must include the number and level of medical visits furnished during the global period and other items and services related to the surgery.

CMS Proposal

In the proposed rule, CMS proposes a massive data collection strategy that would collect data on the frequency of, and inputs involved in furnishing, global services including the procedure and the pre-operative visits, postoperative visits, and other services for which payment is included in the global surgical payment. It proposes:

- A comprehensive claims-based reporting about the number and level of pre- and postoperative visits furnished for 010- and 090-day global services.
- A survey of a representative sample of practitioners about the activities involved in and the resources used in providing a number of pre- and post-operative visits during a specified, recent period of time, such as two weeks.
- A more in-depth study, including direct observation of the pre- and post-operative care delivered in a small number of sites, including some ACOs.

Beginning in January, 2017, all physicians providing 10- and 90-day global surgery services to Medicare patients would be required to report a whole new set of HCPCS level II G codes to document the type, level and number of pre- and post-operative visits furnished during the global period for every global surgery procedure provided to Medicare beneficiaries. Physicians would be required to report on each 10-minute increment of services provided. **ASRS is opposed to this initiative because it is too broad, overly burdensome and inconsistent with Congressional intent.**

Congress called for CMS to gather data from a "representative sample" of physicians. As proposed, however, the data collection requirement would place a new coding burden on all

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physicians providing global surgery services. Practice management software or electronic health records could not be updated in time to include these new codes in 2017. It would be a major challenge for physicians to learn the new codes, which are markedly different from the Level 1-5 E/M codes or the eye codes with which physicians are familiar. Adapting to new definitions would require a significant learning curve. In reality, data collected would be unreliable, inaccurate and inconsistent given the likely confusion, steep learning curve and inherent bias to forget or underreport. Physicians are not used to tracking time on patient care, let alone on a 10 minute basis, while multitasking throughout the day providing simultaneous care to multiple patients.

If finalized, the proposal would further direct provider resources towards greater reporting compliance and away from patient care, requiring compliance with a new set of regulations on top of the substantial changes in reporting requirements that will begin in 2017 under MIPS, the most significant payment system changes in the last 25 years. It is simply not feasible to add on new rules that would redefine E/M services performed in the post-operative period, with insufficient time to educate physicians, and also require the collection of time per patient, at the minute level, for every task that the physician and their clinical staff perform throughout the day.

ASRS recommends that CMS revise its approach. Per MACRA, CMS must begin to collect data by January 1, 2017, but it is not required to implement all phases of data collection at that time. **CMS should start with a survey and potentially observation, and from that, gather data to better derive a representative sample from which it can collect data.** CMS should work with physician stakeholders to develop the representative sample and the best mechanisms to gather the data. A smaller sample of physicians could be adequately trained to reduce the potential for inaccurate data.

We support the recommendations of the RUC that CMS select a representative sample from surgical services using the following criteria:

- Medicare volume of at least 10,000
- And/Or $10 million in allowed charges
- At least 100 separate physicians perform the procedure

The RUC recommends that CMS limit its data collection to services within this set of 235 codes. As the recent RUC data is based on responses from 76 physicians, on average, it would make little sense to collect data on CPT codes via the claims process for service performed by fewer than 100 physicians in the U.S. In addition, CMS should select a representative sample of physicians, based off the pool of services defined above. The sample should include medium and small practices, not just large hospital-based practices that often represent modified practice patterns than practicing physicians in suburban and rural areas.

Collection of data via CPT code 99024

ASRS also supports the RUC recommendation for the use of CPT code 99024 Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and

management service was performed during a postoperative period for a reason(s) related to the original procedure once per visit to identify the number of postoperative visits associated with a surgical procedure.

We agree with the RUC that although available data suggests that there is relatively little to gain from collecting the level of postoperative visits performed in conjunction with surgical procedures, CMS has a mandate to collect this information. We concur with the RUC that a new system of coding does not need to be established solely to track post-operative visits. CMS should instead collect the level of visit data as part of the broad survey of practitioners that the Agency describes in the proposed rule. From the list of procedures that meet the criteria of services in the above recommendation, CMS should have physicians indicate their typical level of E/M visits throughout the post-operative period. Additionally, the RUC has suggested a separate, secure portal created specifically to collect postoperative visit data. CMS could create a separate reporting pathway that would be separate from the survey process, and allow the data to be easily integrated among multiple reporting sites.

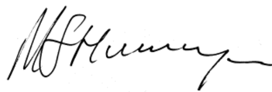
These recommended actions if implemented would allow CMS to focus limited resources on high volume services, while also giving the Agency valuable data on the reliability of surgical package valuation and limit the administrative burden on physicians, which also increases the likelihood of compliance by busy practicing physicians.

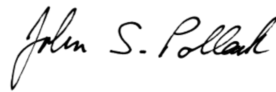
As CMS was provided a large amount of latitude by Congress to conduct a data collection methodology, ASRS urges CMS to revise its approach. CMS should begin to collect data by January 1, 2017, starting with a survey and/or observation, and from that data, derive a representative sample from which it can collect further data. CMS should follow the RUC recommendations to collect the level of visits for specifically identified, high volume, broadly performed surgical procedures by a process separate from claims reporting via the potential avenues that the RUC proposes, such as the proposed survey of practitioners and/or the creation of a secure portal.

CONCLUSION

ASRS appreciates the opportunity to provide comments on the 2017 physician fee schedule proposed rule. If we may provide any additional information, please contact Jill Blim, ASRS Executive Vice President at jill.blim@asrs.org.

Sincerely,





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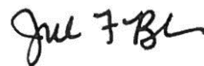

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