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August 25, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, S.W.
Washington D.C. 20201

RE: Request for Information on Supplemental Episode Groupers (part II)

Dear Acting Administrator Slavitt:

On behalf of the American Academy of Ophthalmology, we appreciate the opportunity to comment on the Request for Information (RFI) on draft Episode Groupers as published by CMS. The American Academy of Ophthalmology is the largest association of eye physicians and surgeons in the United States. A nationwide community of nearly 20,000 medical doctors, we protect sight and empower lives by setting the standards for ophthalmic education and advocating for our patients and the public. We innovate to advance our profession and to ensure the delivery of the highest-quality eye care.

We appreciate CMS' work to develop episode groupers intended to improve resource use measurement under MACRA, and the Academy is committed to working with CMS to ensure their successful design and implementation. However, given the current flaws with the published episodes related to eye care, we encourage CMS not to advance their implementation until the existing issues can be resolved.

Any episode groupers implemented by CMS for payment or resource use measurement must accurately account for and attribute costs associated with providing care related to the episode, and not assign costs to a physician when such costs are outside of the physician's control or influence, and unrelated to the episode.

The Academy encourages CMS to work with the relevant medical specialties and other key stakeholders to 1) correct the existing flaws and improve these episode groupers, 2) test the episodes to ensure they are accurate and reliable, and 3) undertake significant efforts to educate the

physician community about the episodes and how they will be used prior to implementation.

CMS notes that draft episodes will be published in November. While it is not explicitly stated in the RFI, the Academy is concerned that the list of episode groupers published on CMS' website, including the Method A and B groupers, will be the basis of the episodes tied to the relationship codes. The Academy has significant concerns with Method A and Method B groupers related to eye care, as they contain serious flaws and methodological problems. In addition, not all of the ophthalmology-specific Method A groupers are limited to acute care services despite being indicated as such.

Our concerns involve every aspect of the proposed specifications of each grouper. For all of the proposed eye care groupers, the Academy opposes the lack of consideration of laterality, disease severity and staging, and sufficient risk adjustment to account for patient factors and variation in physicians' patient populations. Further, we have concerns with the proposed episode durations, that they are specified using ICD-9 codes rather than ICD-10, and with the significant errors and flaws in the episodes' specifications.

As examples of concerns about the episode duration, consider macular degeneration. That grouper appears to have a lifetime episode (episode closes when the patient leaves the analysis window, e.g. death or end of the analysis window). We have serious concerns that the groupers do not recognize laterality or stage of disease. How would you assign the grouper for a patient that was being actively treated for wet AMD in their right eye and the same patient has dry AMD being monitored in the left eye? Would the expenses of monitoring the disease in the left eye be added into the cost of treating the active disease in the right eye? That would not be accurate. We are also concerned that the episodes are not flexible enough to account for clinical judgement, and that they may incentivize providers to avoid sicker or higher risk patients.

Similarly, glaucoma disease can also be at different stages in each eye with dramatically different costs associated with them. Patients with any disease being considered for grouping may require expensive services for the same disease in each eye sequentially that would fall within the Closing Rule of treating the first eye. We are concerned that it will not be possible to differentiate or limit the episode to the eye receiving an acute treatment versus sequential procedures or ongoing treatment for chronic conditions. If it is not possible, these groupers would not be accurate or appropriate for implementation.

The episodes as currently written are not workable and would not fairly or appropriately attribute costs. The trigger codes listed for the major surgical procedures are not equivalent in efficacy/risk or indications, and it is unclear from the descriptions so far how the categories and

subcategories would be combined for analysis. If inappropriate combinations of procedures are used to compare surgeons to their peers, surgeons who perform appropriate procedures for their population may be found to have lower or higher costs simply due to their population of patients. Further, many of the trigger codes listed are used so infrequently that it will be unlikely that any surgeon will perform a statistically significant number of procedures on which to be measured unless CMS intends to combine procedures for measurement; a step that we would strongly oppose.

CMS released the specifications for the groupers with ICD-9 codes. However, ICD-9 codes are no longer used. These groupers must be transitioned over to ICD-10, and when they are, there will be more opportunities for errors and omissions. Further, opportunities to use ICD-10 codes that indicate laterality and stages to create better grouping rules will also be available. There must be the opportunity for additional review once the groupers are transitioned over to ICD-10 to ensure that the ICD-10 code inclusions are correct.

A glaring omission in the specifications is the lack of laterality modifiers or modifiers that indicate a service is provided in the global period that is unrelated to the surgery. CMS must ensure that patients who are operated on sequentially during the episode period be considered as two separate episodes and have mechanisms to exclude services that are unrelated to each surgery. Use of the modifiers provides these distinctions. These modifiers are available in the Medicare claims database, yet the groupers as currently written do not include them.

In developing the episodes, CMS must account for risk and complexity of patients under the physician's care, patient co-morbidities, factors outside of treating physicians' control including formularies, deductibles, patient factors, and method of attribution of costs prior to a patient referral to a specialist. CMS is also charged under MACRA with developing patient condition codes which are meant to address risk adjustment. The patient relationship and patient condition codes should not be developed in isolation so that a more complete understanding of how they would work in tandem with the episodes is available. These codes are relevant to the episodes under development and could help in accounting for patient risk factors. For example, adding a patient condition code that designates a patient as higher risk or as having associated co-morbidities, therefore excluding that patient from a grouper analysis, would be desirable.

If that is not available, then CMS must develop and test a mechanism to identify patients who are higher risk and either exclude or create another level of grouper to analyze those patients. Additionally, MACRA indicated that CMS should take into consideration how socioeconomic and demographic factors impact episodes of care, but neither is captured via

patient relationship or condition codes. We encourage CMS to incorporate improved risk adjustment methodologies to account for such factors.

The Ophthalmology Method A groupers have numerous errors and flaws in the lists of associated Relevant Services, Diagnoses, and Sequelae. It seems clear that the Episode Groupers were not reviewed by a clinician with current clinical expertise in ophthalmology. **The specifications as released so far serve to increase our concerns that the entire methodology is flawed and being rushed to implementation without adequate clinical review and without full understanding or demonstration of the Episode groupers in use.** A pilot program to analyze, evaluate the results, and with access to access the details of each patient claim assigned to a Grouper would be strongly recommended before implementing this program throughout the Medicare population. Otherwise, we fail to see how this grouper is improved over the earlier episode grouper methodologies that CMS has previously rejected.

The Academy has nominated three outstanding clinician members and was pleased that all three were accepted to serve on the Clinical Expert Panel being facilitated for CMS by Acumen. Given the significant problems that we see in the published groupers, we are not certain that two webinars will be sufficient to sort out all of the problems especially given the issues with bilateral disease that are both chronic and can result in surgical episodes. Furthermore, participants are being given insufficient time to review and provide their input in the first phase of the Acumen project. **We will provide summary comments on the most apparent clinical issues and problems but remain skeptical as to whether fixing these issues would still result in a grouper that would work as it should.**

<u>Appropriate Resource Use Aligned with Quality is Possible</u>

The initial vision of AQA, SQA and NQF was to tie resource use to specific quality measures. Resource use and quality must be linked in order to achieve the aim of improving health, increasing quality and lowering costs. For groupers, there should be quality measures and process measures to ensure the ability to quantify and improve quality measurement within a grouper.

Clinical data registries hold great potential to improve the accuracy of resource use data. There are numerous specialty society clinical data registries including more than a dozen of the major specialties that share a common vendor, FIGMD. This new breed of registry is EHR agnostic and uses a systems integrator to pull outcomes and measure performances from the electronic record. The Academy's registry, IRIS Registry-Intelligent Research In Sight, is based on such an infrastructure and also has access to the practice's administrative data base. We do believe common ophthalmological diseases and conditions could be appropriately measured for resource use within registry reported data.

Through IRIS Registry, many practice expenses, visits, procedures, testing pre-operative evaluations, lab results, and returns to the operating room are captured. Additionally, diagnoses and complications that may not be included on a claim form are also captured via the registry. For resources accrued outside the registry and/or office administrative data base, there are facility costs that can be normalized to regional costs. All registries have the ability to calculate resource use specific to a condition grouper, specific procedure or episode of care. CMS must acknowledge the utility and use of this manner of resource use measurement so that specialties can begin the process of analyzing the data and working with CMS to determine appropriate resource use.

Surgical Episodes of Care

The agency must keep foremost in its considerations regarding surgical care that incentives for physicians and payers to take shortcuts that would jeopardize high quality eye surgery are not created. There are several modifiers currently utilized in conjunction with surgical procedures that signify needed but unplanned services that that may be related or unrelated to the surgery being performed. Providers should not be penalized when providing these needed and unplanned services. The same would be true for unrelated evaluation and management services.

It is important that the use of such modifiers are tracked and excluded from the surgical episode. Ophthalmologists must not be punished because of the complications and complex issues that arise because of the disease process especially in advanced or complex diseases and patients with multiple ocular conditions that influence cost and outcomes.

Accountability for costs and quality that are within the physician's control is an important and achievable goal, but it cannot come at the expense of providing necessary, emergent or a different line of treatment when other options are failing. To this end, all applicable complications that are excluded from quality reporting measures, including relevant QCDR measures from the Academy's IRIS Registry, should also be excluded from associated episode grouper resource use measurement especially since CMS has not demonstrated any sufficient or reliable means for risk adjustment. Not including these exclusions will create an incentive for physicians to refer more complex/sicker patients to tertiary care centers. Physicians will need to be educated about including diagnosis codes that may follow the patient from their referring physician even if it is not directly related to the services being provided. Not doing so may leave off important factors that compound patient care.

New Ophthalmic Method A Groupers:

CMS published six additional ophthalmology groupers as Method A Episodes. Those include one broad grouper for "glaucoma surgery" which

includes a wide range of different surgeries, and three groupers for procedures related to retina conditions including age-related macular degeneration, diabetic retinopathy and diabetic macular edema as well as a two new cataract related groupers.

- *120-Day Length of Episode is not Appropriate for a Surgical Episode*

As we have previously commented, the Academy does not believe a 120-day episode (90 days after trigger and 30 days preceding) is appropriate. Extending the episode length beyond that of the global surgical period will no doubt capture services that are unrelated to the surgical procedure. This is especially true if CMS does not appropriately account for modifiers associated with diagnostic testing and evaluation and management services that would follow from the typical 90-day global period associated with all of these codes currently. The concern related to laterality within ophthalmology cannot be overemphasized and the correct matching of RT/LT modifiers and/or the appropriate diagnoses codes will be very important to ensure accurate episodes. If a 120-day global period is retained CMS must ensure that claims from other providers unrelated to the specific surgical procedure are not captured. **To work appropriately, any surgical Method A or Method B Episode should be 90 days.**

We also have concerns that diagnoses from unrelated procedures can be carried over on to claims. For instance, many times EHRs and or practices mistakenly carry over past diagnosis codes. In other cases, to avoid massive audits by MA plans related to a practice's diabetic patients, the diabetic diagnosis is often listed even when it is not the reason for the day's encounter.

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- **<u>Method A Glaucoma Surgery Episode</u> (Preceding discussion on lack of laterality, modifiers, duration of episode stage of disease, exclusions and ICD10 codes, all apply to this Episode also).**

The Academy recommends that CMS not move forward with this episode grouper given the complex nature of glaucoma, and the serious flaws included in the episode grouper's specifications. As an example of one concern which is not addressed in the current episode grouper: glaucoma surgery can be performed with and without other ocular surgery such as cataract or vitreoretinal or cornea. It is important that CMS separate out when glaucoma surgery is stand alone and when it is not. Patients with co-existing eye disease in addition to glaucoma are obviously more complex and more high risk. There will be many additional fees and related procedures when more than one procedure is performed, and it is the patient condition that dictates if additional procedures are required.

The Academy recommends that episodes that include cataract or vitreoretinal or cornea surgeries in addition to the glaucoma surgery be excluded from the grouper analysis-- these cases by definition will be more complex and more costly--and should not be compared against stand-alone surgical episodes.

Additionally, the Academy is concerned that the episode fails to address a number of factors which may influence costs for the episode, but are out of the physician's control, including patient compliance. As we have already indicated, these groupers have great potential to cause "cherry picking" of the healthiest patients. As constructed the glaucoma grouper could further create incentives for physicians to avoid expensive treatments or to avoid surgery even for patients who might benefit from it, because the episode only captures costs associated with surgery. Some treatment options, such as eye drops, may be less expensive in the short term than surgery, surgery may be less expensive in the long-term, but the episode does not account for that.

- Glaucoma Trigger Codes:

Only intraocular surgery should be considered trigger codes. Laser procedures such as iridotomy (CPT 65855) and iridectomy (CPT 66761) that are extraocular, have 10 day global periods, and confer much lower risk should be excluded. In our review of the 37 trigger codes listed, we find only 15 codes that would be appropriate triggers. The current list includes procedures that are rarely or never performed or are not FDA approved. CMS should limit triggers to the most commonly performed glaucoma procedures for more accuracy. In addition, it will be critical to explain how subcategories will be grouped and if they will be analyzed separately or combined. In order to be statistically valid, each subcategory must include an adequate number of cases (eyes), and if eventually combined with the other procedure subcategories must be compared to peers with a similar distribution of cases (eyes). Without doing so, CMS will inaccurately demonstrate cost variation. Improper grouping analysis will result in large variation in cost and resources simply because of the variation in reimbursement at the facility and surgeon level.

Even modified as we suggest, the listed trigger procedures are not equivalent in efficacy/risk or indications, so surgeons who perform appropriate procedures for their population may be found to have lower or higher costs simply due to their population of glaucoma patients. Costs for treating patients for a mild case should not be compared to those for treating patients with a severe case of glaucoma, as the costs associated with treatments would not be comparable. There must be away to account for variations in patient populations so as not to result in unfair comparisons; this one reason the Academy successfully implemented changes to ICD-9 codes several years ago that differentiate three stages of primary open angle glaucoma and those should be utilized for any grouper. It will also be unlikely that any surgeon performs a statistically significant number of procedures on which to be measured for the less common procedures and to avoid improper comparisons, we recommend that these trigger codes be removed.

Additionally, the list includes codes that are no longer relevant. Former CPT code 0192T has been converted to a CPT 66983. We also note that two codes that were added in 2014 are missing, CPT 66179 and CPT 66184. The attached spreadsheet provides details on the trigger codes as well on the other categories of codes provided.

- Relevant Services/Diagnosis Codes:

Many of the codes in these sections make no clinical sense or would indicate a very complex patient that should be excluded from analysis. The listed visual field codes would not typically be used by the operating glaucoma surgeon but rather used by a referring primary care physician or non-ophthalmologist. Another typical situation is that the patient is being referred from a primary care or neurologist and those costs would also be inappropriately included in the episode because those physicians use the diagnosis code on their claim even though they did not provide a service for the condition, just as we now see under current resource use reporting. The problems with these codes are discussed in the attached spreadsheet.

- Sequelae:

There is no apparent way that the sequelae are being separated from pre-existing, co-existing conditions. Additionally, the list includes congenital cataract that can in no way be a "sequelae". Complications of glaucoma surgery are patient specific and not related to surgeon quality or improper care. It is not clear if the episode is trying to account for complications or just expected sequelae or how they would be utilized within the grouper.

- Suggested Refinement—subcategories

In reviewing the glaucoma surgical grouper, refining the trigger codes into more appropriate subcategories is necessary in order to accurately make peer to peer comparisons given how broad this grouper is currently defined. There are lesser surgeries/procedures (some of which are currently 10-day global periods) and then major 90-day global surgeries, many of which may require medically necessary reoperations. As we have provided, at a minimum there should be at least 9 subcategories that include Trabeculotomy/canal procedures, Trabeculectomy, Aqueous shunt procedures, Aqueous shunt revisions, ab interno stent surgeries, laser trabeculoplasty, laser iridotomy, ab externo ciliary body destruction (extraocular), and ab interno ciliary body destruction (intraocular).

We strongly urge CMS to accept our revisions to the subcategories and preferably eliminate the 2 extraocular laser procedures with 10 day global periods. Once valid subcategories are developed, it is critical that each subcategory include enough cases to be statistically valid and compared to peers with the same volume of cases.

We also caution against subcategories being combined inappropriately and grouped together for comparison to peers without consideration of the distribution of patients under care, because then CMS will be comparing apples to oranges where physicians who provide a wide range of glaucoma services or who only take on the most complex glaucoma surgeries will be compared to physicians who only do maintenance or intermediary glaucoma services or who never do intraocular glaucoma surgeries.

Such a comparison will be so egregiously mismatched that physicians will have no confidence in the measurements. This will not only continue the ongoing resentment but it will also unfairly brand physicians taking care of the sickest patients as high resource utilizers. And under the new Quality Payment

Program, physicians and/or APMS will be penalized for taking on the care of patients with advanced disease.

- **Method A, Retina and Vitreous Procedures (Preceding discussion on duration of episode, lack of laterality, modifiers, stage of disease, exclusions and ICD-10 codes, all apply to this Episode also).**

The Academy has serious concerns with this proposed episode and encourages the agency not to move forward with implementation until a thorough review can be performed by clinical experts and their recommendations can be incorporated. The Academy has a number of questions regarding this episode grouper which requires significant review/revisions by a practicing ophthalmologists. For example, should E/M and Eye visit codes for examinations be included in the episode, and if so, how would CMS ensure that only E/M or Eye visit codes related to the retinal detachment are included in the grouper? In addition, we ask that this grouper, like the others, be tested prior to implementation to ensure it is accurate and valid.

- Trigger Codes:

As with the glaucoma episode, it will be critical to explain how subcategories will be grouped and if they will be analyzed separately or combined. In order to be statistically valid, each subcategory must include an adequate number of cases (eyes), and if eventually combined with the other procedure subcategories must be compared to peers with a similar distribution of cases (eyes). Not doing so will inaccurately demonstrate cost variation. Improper grouping analysis will result in large variation in cost and resources simply because of the variation in reimbursement at the facility and surgeon level. Additionally, there must be away to account for variations in patient populations so as not to result in unfair comparisons.

- Relevant Services/Diagnosis Codes:

Many of the codes in these sections make no clinical sense, and are in fact not relevant to this episode and should be removed from the list of relevant services and diagnoses. The inclusion of unrelated codes highlights our concerns that this grouper and the others proposed groupers need a more thorough review by clinical experts for refinement purposes prior to implementation. For example, 35475, Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel, is related to cardiology rather than ophthalmology and should not be included in this episode. Other incorrect codes included on the list of relevant services include 65750, 65770, 92136, E0471, J0178, J2778, J3300, J3490, J9035 and V2785.

CMS notes in the workbook that this episode should cover treatments for repairing a detached retina. However, some CPT codes used to diagnose and treat retinal detachments are not listed on list of relevant services. We believe these codes should be added, and include: 67040, 67112, 66852, 66984, 66985, 66986, 65093, 65103, 65105, 67110, 67101, 67105, 67113, 67108, and 67107.

Similarly, many of the ICD-9 diagnosis codes listed are not related to retinal detachment repair and should not be included. As explained in the workbook, these related diagnosis codes are intended to help steer claims to an episode, but because many of these codes are completely unrelated to the episode, we are concerned that the erroneous inclusion of these codes would result in an inappropriate assignment of costs to ophthalmologists when they are unrelated to the episode being evaluated. For example, 799.21, the diagnosis for nervousness, is unrelated to retinal detachment repair and should not be included in this grouper. Other incorrect codes include: 368.43, 368.45, 374.33, 379.91, 386.12, V43.89, V55.8, V70.8, V72.63, V72.81, V72.83, and V72.84. However, the spreadsheet should list all the ICD-9 / 10 codes for retinal detachments, which are not currently listed.

- Sequelae:

The Academy is concerned that there is no apparent way that the sequelae are being separated from pre-existing and/or co-existing conditions. Additionally, similar to the relevant services and diagnoses, the list of codes for the sequalae include codes unrelated to this episode which should be removed. For example, while CMS notes that the sequalae are the aftereffect or secondary results of care for the treatment episode, congenital cataract codes, which could not be the aftereffect of a retinal detachment procedure, are included on the list. By definition, the inclusion of these codes is incorrect, and again, this highlights the serious need for a review of these episodes by clinical experts prior to advancing them any further. The Academy recommends the following codes be removed from the list of sequelae: 276.50, 276.51, 276.52, 276.6, 276.61, 276.69 743.30, 743.31, 743.32, 743.33, and 743.34.

- Suggested Refinement—subcategories

As with the glaucoma surgical grouper, refining the trigger codes into more appropriate subcategories may be necessary in order to accurately make peer to peer comparisons given how broad this retinal detachment grouper is currently defined. Unfair and improper comparisons will lead to physicians having no confidence in the measurements, which could perpetuate the negative perception of resource use measurement by physicians, hurting the effectiveness of resource use measurement and the overall goals to increase value in healthcare.

- **<u>Method A, Macular Degeneration</u> (Preceding discussion lack of laterality, modifiers, duration of episode, stage of disease, exclusions and ICD-10 codes, all apply to this Episode also).**

As noted in comments above, the Academy has concerns with the duration proposed for this episode, which notes that the episode closes when the patient leaves the analysis window (eg. Death or end of analysis window.) However, it is unclear what is the length of the analysis; is it a year, or multi-years? In addition, each stage and the patient's visual acuity each play in important role in this chronic disease, and we underscore that each eye can be different. This underscores the importance of including modifiers to note

condition phases, as well as ICD-10 codes that denote stages, acuity, and laterality.

Furthermore, patients with co-existing eye diseases or other chronic conditions are obviously more complex and more high risk. There will be many additional fees and related procedures when more than one procedure is performed, and it is the patient condition that dictates if additional procedures are required.

- Trigger Codes:

CMS should update the trigger codes with current ICD-10 codes for the diagnosis of AMD, and include the codes which account for disease progression, staging and laterality to support more fair comparisons.

- Relevant Services/Diagnosis Codes:

Some of the codes included in these lists are in fact not relevant to this episode and should be removed from the list of relevant services. For example, the Academy asks that 67108 and 92060 be removed from the list of relevant services.

- Sequelae:

As stated previously, the Academy is concerned that there is no apparent way that the sequelae are being separated from pre-existing, co-existing conditions. In addition, there are numerous codes included a sequalae which are inappropriate and should be removed from this episode. For example, although there are a great number of all eye diseases that can be associated with AMD, it is incredulous to include retinoschisis as a sequela of treatment effect of AMD, and it should be eliminated form this list. In addition, we believe the following codes should be removed: 360.21, 367.0, 367.1, 367.31, 367.32, 367.51, 367.52, 367.53, 367.81, 367.89, 367.9, 361.10, 361.11, 361.12, 361.13, 361.14, 361.19, 377.16, 363.06 and 362.56.

- Suggested Refinement—subcategories

Given that AMD is a chronic eye disease, the disease's stage and acuity often dictate the resources used to treat the disease. In addition, for a patient with AMD, each eye can be different in terms of the disease progression. The Academy suggests that CMS refine the subcategories so that cases (eyes) with AMD of a certain stage and acuity are compared to cases (eyes) with the same staging and acuity. Updating the trigger codes and refining them into more appropriate subcategories is necessary in order to accurately make peer to peer comparisons given the nature of AMD. Failing to do so would penalize physicians that may only take on the most complex AMD cases. As stated in our comments on the glaucoma episode, such a comparison will be so egregiously mismatched that physicians will have no confidence in the measurements. This will not only continue the ongoing resentment but it will also unfairly brand physicians taking care of the sickest patients as high resource utilizers. And under the new Quality Payment Program, physicians and/or APMS will be penalized for taking on the care of patients with advanced disease.

- **Method A, Retina-Choroid Destructive Therapy (Preceding discussion lack of laterality, modifiers, stage of disease, exclusions and ICD-10 codes, all apply to this Episode also).**

    - **Trigger Codes:**

The Academy notes that the list of trigger codes is outdated. Not only is it described using ICD-9 codes (as is the case with the other episodes), but some of the codes listed are not used or do not exist. We encourage CMS to work with clinical experts including ophthalmologists to refine this episode, including to update the trigger codes.

    - **Relevant Services/Diagnosis Codes:**

The Academy has concerns with this episode as many of the related services and diagnoses are not related to the eye care provided. In fact, the Academy disagrees with every relevant diagnosis code listed with the exception of one: V58.71, aftercare following surgery of the sense organs. There are a number of related services listed that should also be eliminated form this list, including: 11042, 35475, 67121, 75710, 97597, A4221, C1300, J0881, J1570, J2778, J3490, J3590, J7312 and J9035. The Academy again underscores the important need for CMS to work with clinical experts to refine this and the other proposed groupers prior to advancing them any further.

    - **Sequelae:**

The Academy disagrees with all of the sequalae listed, as they are not the aftereffect or secondary results of care for an open condition or treatment episode.

    - **Suggested Refinement—subcategories**

In updating the trigger codes, they should be refined so that they fall under appropriate subcategories necessary to accurately make peer to peer comparisons.

- **Method A Cataract Surgery IOL (Preceding discussion on lack of laterality, modifiers, duration of episode, stage of disease, exclusions and ICD10 codes, all apply to this Episode also).**

In February and June of this year, the Academy submitted comments to CMS on the proposed Method B grouper related to cataract surgery. That grouper, though proposed as Method B, is similar to this Method A episode, and thus our concerns too are similar, including insufficient risk adjustment, potential adverse incentives for physicians to avoid complex cases, and the inclusion of incorrect codes in the episode. We again underscore the importance of involving clinical experts in the development of episodes, and to help modify the current proposed episodes to ensure they make clinical sense, and that the episodes also be tested prior to use to ensure accuracy and reliability.

- Trigger Codes:

The Academy recommends that CMS modify the proposed list of trigger codes for this episode grouper which includes codes unrelated to surgery, seldom used codes which would produce unreliable results if included in the episode, and codes for complex cataract surgery which should be removed. As one example of a code unrelated to cataract surgery, there is a Category III code, 0308T Insertion of ocular telescope prosthesis including removal of crystalline lens on the list of trigger codes. This code is inappropriate for any cataract grouper. This procedure is the implantation of a device which is quite sizeable within the eye. It includes significantly more resources because of the cost of the implant, and the extensive functional rehabilitation and training required for the patients receiving this implant. Most importantly the disease associated with this is not cataract, but rather age-related macular degeneration, and it should not be grouped with cataract procedures. Further the code descriptor was recently changed after further studies of the device showed that it could be successfully transplanted whether or not the patient still had their natural crystalline lens, and the same code is also now used for if the device is removed. The new descriptor states: Insertion of ocular telescope prosthesis including removal of crystalline lens or intraocular lens prosthesis.

Additionally, there are several codes included in the grouping that are done in rare circumstances and are unrelated to cataract removal procedures. The episode should only include the most common procedures related to cataract removal. If codes infrequently used codes are included, there will be a limited amount of patients to compare which will reduce the validity and reliability of the episode. The following codes should be removed: 66840, 66850, 66852, 66920, 66930, and 66940. Similarly, for any discission of secondary membranes after cataract that might be required, two codes were again listed that are rarely performed for this indication. CPT 66820 and 66830 should be removed.

- Relevant Services/Diagnosis Codes:

There are several codes included on this list of relevant services which are not relevant to cataract surgery and should be removed to avoid the inappropriate assignment of costs to physicians for this episode. For example, the Academy recommends that CMS remove J7682, Tobramycin, inhalation solution, because in ophthalmology, this drug would be administered by injection rather than inhalation. Similarly, the Academy recommends all the relevant diagnoses included in the episode be removed except for one, V58.71.

- Suggested Refinement—subcategories

❖ Method A Cataract Surgery Secondary Membranous (Preceding discussion on lack of laterality, modifiers, duration of episode, exclusions, stage of disease, and ICD10 codes, all apply to this Episode also).

The Academy notes that secondary membranous cataracts may form in some patients, though not all, and should not be considered a complication of cataract surgery.

- Trigger Codes:

The Academy believes that the codes listed as trigger codes are used so infrequently that they would not produce reliable data in support of resource use measurement or payment.

- Relevant Services/Diagnosis Codes:

The Academy disagrees with all of the listed relevant services and all of the relevant diagnoses listed other than one, V58.71. The flawed nature of this episode again underscores the significant need for CMS to work with clinical experts to help define appropriate episodes for ophthalmology that would enable accurate measurement of resource use.

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We appreciate the opportunity to provide our input into this important request. For more information or questions regarding this comment, please contact Ms. Cherie McNett, AAO Health Policy Director at cmcnett@aaodc.org or via phone at 202-737-6662.

Sincerely,

Michael X. Repka, M.D.
AAO Medical Director for Government Affairs