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Health Policy Department

December 29, 2015

The Honorable Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1631-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: File Code-CMS-1631-FC; Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016 Final Rule; (November 16, 2015).

Dear Acting Administrator Slavitt:

The American Academy of Ophthalmology, the Academy, appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) Final Rule on the revisions to Medicare payment policies under the Physician Payment Schedule for calendar year 2016, published in the November 16, 2015 *Federal Register (Vol. 80, No. 220 FR, pages 70886-71386, November 16, 2015)*.

The Final Rule includes a number of policy and payment modifications within the Resource-Based Relative Value Scale (RBRVS) impacting ophthalmology. In particular, CMS has introduced a methodology of determining physician work that has never been discussed or tested to ensure that payments adequately reflect the physician work and resources needed to provide quality patient care. This new method appears to disregard the congressional and legislative intent of the Resource-based relative Value System (RBRVS) and appears to undermine relativity that is fundamental to RBRVS.

- **AAO is not opposed to refinements in wRVUs --even refinements that reduce payments to ophthalmologists -- but those refinements should be consistent with the implementation of RBRVS and affirm fairness in the fee schedule.**
- **CMS interim values at issue are not consistent with RBRVS methodology and raise both policy and process concerns.**
- **We oppose CMS phasing in alternate values developed using an intraservice time ratio methodology discounting work estimates and ignoring work intensity and complexity.**
- **We strongly recommend that CMS not move forward with interim final values and instead adopt the work RVUs recommended by the RUC to maintain the integrity of RBRVS.**
- **CMS should then have a discussion with the RUC at its April meeting regarding this significant change in methodology and impact on the fee schedule.**

The existing physician payment statute at Sec. 1848. [42 U.S.C. 1395w–4] (a) (i) clearly states that the Secretary shall determine the work relative value units for a service based on the relative resources incorporating physician time and intensity required in furnishing the service. **The Academy requests that CMS provide transparency by sharing its legal review of a solely time based approach and sharing the statutory authority that demonstrates that such a significant change in methodology is appropriate.** Using an intraservice time ratio with the base or denominator value for time represented by more than 20-year old-estimates is unfair, as these times were guesses and long understood to not be accurate. Recent valuations of other codes have not used this system, and thus not been impacted to the same degree, leading to loss of relativity.

The Academy developed recommendations based on very robust surveys for the RUC-review process that well exceeded required response rates for the services considered in this final rule. Based on those recommendations the AMA RUC conducted an extremely thorough analysis of these codes and recommended appropriate work values which were reductions from the Academy's recommendations.

- CMS ignored this effort and set interim final values based on inconsistent methods that were significantly lower than the RUC's already reduced RVUs by assuming that the change in physician work should directly correspond to the alleged change in service time.
- Equating time to work undermines the basis for the RBRVS:
    - For every physician service, the intensity of work varies substantially for each component of that service
    - Each service has its own intensity
    - As time gets shorter for intraservice work, intensity may very well go up.

Applying such methodologies disrupts relativity across the fee schedule. The RBRVS is based on measures of the relative physician work/resources involved in provision of a service. Medicare and the RUC define the physician work component as reflecting:

- The time it takes to perform the service
- Technical skill and physical effort
- Mental effort and judgement
- The stress associated with the physician's concern about iatrogenic risk.

In addition to considerable concerns about the inconsistent and unproven valuation methods, **CMS applied this formula to codes that are not subject to proposed value reviews and for which physicians have little time to prepare for such draconian cuts. This is unprecedented and very unfair to ophthalmologists and the entire physician community in general.**

- **Because of this significant departure in methodology and due to the unfair timeline for implementation of these values, CMS should not move forward with these reductions for January 2016.**
- **If CMS moves forward with revaluation, the Academy requests that the agency accept the RUC recommendations for CPT code 65780, 65855, 66170, 66172, 67107, 67108 and 67110.**

- **Finally, the Academy requests Refinement Panel consideration for these services if the CMS recommendations are implemented as interim final values for 2016.**

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Code Specific Discussion:

The Academy supports the data and analysis of the CMS methodology put forward in the comments of the AMA Specialty Society Relative Value Update Committee (RUC) for hose codes.

A. Ocular Reconstruction Transplant (CPT Code 65780)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
65780	Ocular surface reconstruction; amniotic membrane transplantation, multiple layers	8.80	8.00	Disagree

CMS derived the interim-final work RVU for CPT code 65780 by simply multiplying the current work RVU by the ratio between the RUC recommended total time and the existing total time from 2003 (8.00 RVUs= 10.73 RVUs X (230 minutes /316 minutes). The Agency's crude calculation distills the valuation of this service into a basic formula with the only variable being the new total physician time which as has been reiterated above is inappropriate. This methodology is based on the incorrect assumption that the per minute physician work intensity established is permanent regardless of when the service was last valued (2003 in this case) or has ever been RUC surveyed.

B. Trabeculoplasty by Laser Surgery (CPT code 65855)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
65855	Trabeculoplasty by laser surgery	3.00	2.66	Disagree

CMS selected a ratio calculation that discounts the relative resources incorporating physician time and intensity required in furnishing the service. Taking one element that

changed and applying an overall ratio reduction based on changes to intra-service time renders the value no longer resource-based. The significant RUC recommended reduction clearly accounted for the reduction in physician intra-service time and post-operative visit.

CMS' recommended work RVU lacks relativity to other similar services including the reference service 66761 chosen by the majority of survey responders. The two services correlate very closely with the same work RVU, intra-service time (10 minutes) and similar total time (66 minutes for 66761 and 61 minutes for 65855). The RUC-approved value of 3.00 a fair and appropriate value for 65855.

C. Trabeculectomy surgery (CPT Codes 66170 and 66172)

CPT Code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
66170	Fistulization of sclera for glaucoma; trabeculectomy ab externo in absence of previous surgery	13.94	11.27	Disagree
66172	Fistulization of sclera for glaucoma; trabeculectomy ab externo with scarring from previous ocular surgery or trauma (includes injection of antifibrotic agents)	14.81	12.57	Disagree

CMS cannot take one element of the services that changed and apply an overall ratio for reduction based on changes to intra-service time; this renders the value no longer resource-based. CMS again selected a ratio calculation that discounts the relative resources incorporating physician time and intensity required in furnishing the service. CMS' recommended work RVU lacks relativity to other similar services. The two services referenced (44900 and 59100) are not comparable to 66170 and 66172. The referenced services do not require the same intensity and complexity and only account for half of the post-operative services required with 66170 and 66172 to avoid permanent vision loss for the patient.

CMS points to 44900 and 59100 as reference for their work valuation. These services are not identified on the Multi-Specialty Points of Comparison List used to help establish relativity across services nor would their low volume or the length of time since previous RUC review qualify them as appropriate reference services.

The RUC provided five reference codes for both 66170 and 66172, including MPC codes, to support the survey 25th percentile results. Codes 66180 (work RVU = 15.00), 66183 (work RVU = 13.20), 53445 (work RVU = 13.00), 52649 (work RVU = 14.560 and 52601 (work RVU = 15.26).

CMS should use the data surveyed from 88 and 74 physicians, respectively, and supported by the extensive review of the RUC. **This is a case where CMS should accept the survey 25th percentile work RVU of 13.94 for 66170 and 14.81 for 66172.**

D. Retinal Detachment Repair (CPT Codes 67107, 67108, 67110, and 67113)

CPT code	Descriptor	RUC Rec RVU	CMS Proposed RVU	CMS Work RVU Decision
67107	Repair of retinal detachment; scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), including, when performed, implant, including, when performed, cryotherapy, photocoagulation, and drainage of subretinal fluid	16.00	14.06	Disagree
67108	Repair of retinal detachment; with vitrectomy, any method, including, when performed, air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique	17.13	15.19	Disagree
67110	Repair of retinal detachment; by injection of air or other gas (e.g., pneumatic retinopexy)	10.25	8.31	Disagree
67113	Repair of complex retinal detachment (e.g., proliferative vitreoretinopathy, stage C-1 or greater, diabetic traction retinal detachment, retinopathy of prematurity, retinal tear of greater than 90 degrees), with vitrectomy and membrane peeling, including, when performed, air, gas, or silicone oil tamponade, cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling, and/or removal of lens	19.00	19.00	Agree

CMS added an even more illogical methodology to reject RUC recommendations for these very complex retinal detachment repair services. For these codes CMS attempts to determine magnitude estimation between services with a method that is considerably flawed. The estimation employed is completely removed from any true standard of measuring physician work. CMS multiplied the current work RVU by the ratio between the RUC recommended intra-service time and the existing intra-service time from Harvard surveys. Then for completely unrelated services it subtracted the increment between between CPT code 67107 and 67110, from the CMS derived work RVU of 67107. This makes no sense since the first code is a major facility based open procedure

while the second code is done primarily in the office and is a laser based closed treatment.

CMS' reliance on existing time to derive new proposed work values for these potentially misvalued service is misguided, as the existing physician times were last determined by the Harvard study over 20 years ago. These reductions appear arbitrary and punitive. By accepting some increments and rejecting others, CMS has not only established inconsistencies within the family of codes, but potentially opened up anomalies across a wide range of services.

In addition, the new IWPUT values for these three services are inappropriately low with the most egregious being 0.064 for CPT code 67110, putting the physician work intensity of that service in the same range as mid-level office visits. Furthermore, if the RVUs for the CMS-accepted post-operative visits were backed out of the interim-final work RVU for 67110, that would only leave 2.49 RVUs for the 58 minutes of very intense surgical work.

When the appropriate method of magnitude estimation is utilized then the RUC approved values are fair and appropriate**. The Academy requests that CMS reconsider its decision and accept the RUC recommendation as listed above for CPT code 67107, 67108 and 67110 similar to its acceptance of the RUC value for the last and most complex code in this family, 67113.**

Summary

The issue of fairness maintaining relativity is an important one within the MPFS and RBRVS implementation. In addition to the aspect of the time required to perform a service, another key factor is the intensity of such services. Intensity is defined as the technical skill and physical effort, mental effort and judgment as well as the psychological stress associated with the iatrogenic risk to the patient. The work component of the Medicare physician fee schedule is based on a list of physician services and procedures ranked according to the amount of physician work and expressed in terms of relative value units (RVUs). The values are not absolute, but arranged in rank order *relative* to one another, thus the term: *relative* value units.

While we agree that intensity is not the only or even primary driver of payment, it should and is an important factor. The original Hsiao project on which the Resource-based Relative Value System is based produced direct estimates of intra-service work using magnitude estimation methodology and assigned intensity values to the various aspects of pre- and post-service work. **Both the original Hsiao study and a subsequent American College of Surgeons project using magnitude estimation combined with Rasch analysis for confirmation showed that the intensity of the intra-service work was consistently about twice that of the pre- or post-service work associated with the same service. The use of both time and intensity to measure the spectrum of physician work relative to other specialties is absolutely necessary to maintain relativity.** These actions by CMS to rely solely on time for procedural and surgical payment determinations with little or no consideration of intensity are creating significant distortions or loss of relativity in the fee schedule. Doing so not only threatens relativity, but also the value of all physician services, whether surgical or medical.

Whatever method CMS uses to measure the value of physician work, and however that method is implemented, the results must make clinical sense. An outside observer, masked to how data were generated, should feel comfortable that the results are sensible and consistent with clinical experience. A result that indicated that the singular session of work of removing a splinter from a finger during an office visit was more intense than the entire 90-day global period that accompanies performing a total hip replacement or repairing a significant retinal detachment or saving vision for a patient with significant optic nerve damage from glaucoma suggests methodological issues that need to be corrected. **Intensity matters.**

Conclusion

We appreciate the opportunity to comment on the Interim Final Rule for the 2016 Medicare Physician Fee Schedule. If you have questions or need any additional information regarding any portion of these comments, please contact Ms. Cherie McNett, AAO Health Policy Director at or via phone at 202-737-6662.

Sincerely,

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