



OUTPATIENT OPHTHALMIC  
SURGERY SOCIETY

September 10, 2018

Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

**Re: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program**

Dear Ms. Verma:

The American Society of Cataract and Refractive Surgery (ASCRS) is a medical specialty society representing nearly 9,000 ophthalmologists in the United States and abroad who share a particular interest in cataract and refractive surgical care. We appreciate the opportunity to provide comments on this proposed rule.

The Outpatient Ophthalmic Surgery Society (OOSS) is a professional medical association of more than 1,100 ophthalmologists, nurses, and administrators who specialize in providing high-quality ophthalmic surgical procedures performed in cost-effective outpatient environments, including ambulatory surgical centers (ASCs).

**We appreciate that CMS continues to listen to physicians and take a measured and flexible approach to implementing the Quality Payment Program (QPP) that seeks to limit burdens on clinical and administrative staff. We support the proposals related to an extended MIPS transition period and keeping the Cost category at a low weight, as authorized by the Bipartisan Budget Act of 2018. Further, we appreciate the efforts to reduce burden and eliminate measures based on patient action in the Promoting Interoperability category of MIPS. We recommend CMS continue to simplify the reporting requirements and scoring methodology throughout the MIPS program.**

**In addition to the proposals CMS is making for 2019 performance, ASCRS and OOSS also appreciate and thank CMS for its continued efforts to incorporate physician and stakeholder input since the program's inception to ensure that MIPS is successful and available to physicians long-term.** Ophthalmologists have made serious efforts to understand and implement MIPS in their practices. Consequently, ophthalmology had the highest performance of any specialty in MIPS for the first performance year. This is a result of the groundwork laid in past years through measure development and adoption of the IRIS Registry. Following that, ASCRS worked with its members to educate them on MIPS by developing resources, such as in-depth guides, in-person training, and web-based tools. ASCRS and its members are committed to making MIPS a successful program long-term. Given that ophthalmologists do not typically coordinate care with other specialties, and solely practice in outpatient facilities in Part B, there are very few opportunities to participate in APMs, which are generally primary care-

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based and do not measure ophthalmic care. MIPS is the best option for ophthalmologists to demonstrate the quality and value of care they provide to Medicare beneficiaries. **We continue to urge CMS to maintain MIPS, and a viable fee-for-service option, in Medicare Part B.**

**While we appreciate CMS' efforts related to the QPP, we oppose the proposals related to evaluation and management (E/M) services. CMS' proposals may reduce some documentation burden; however, we believe that the proposals related to payment may impact physician reimbursement to a greater degree than CMS has estimated. Further, this change is out of step with the process of valuing physician services and will have unintended impacts on the current resource-based physician fee schedule. We recommend CMS not finalize these proposals and work with the medical community to identify strategies for reducing the administrative burden of documentation and refining the codes as necessary.**

ASCRS and OOSS will provide detailed comments on the following proposals included in the proposed rule:

### *E/M Services*

- **ASCRS and OOSS oppose the collapse of E/M code levels two through five, as it will have a negative impact on the relativity of the physician fee schedule. We are concerned that this proposal ignores the current resource-based method of valuing physician services.** We continue to support the resource-based relative value scale (RBRVS) system and the Relative-Value Update Committee's (RUC) system of valuing physician services. CMS' E/M proposal does not seem to have been developed with this in mind and has potentially far-reaching impacts across the fee schedule.
- **ASCRS and OOSS oppose the proposal to reduce by 50% the lower-value code when a procedure is furnished in conjunction with an E/M service.** The RUC has recently spent considerable time identifying and revaluing procedure codes, including ophthalmology codes, that are frequently performed in conjunction with an E/M service. This proposal is an additional cut to the reimbursement for these services.
- **ASCRS and OOSS oppose the proposal to arbitrarily create add-on codes with additional reimbursement for primary care and for some non-procedure-based specialty care, as the codes are not resource-based and would further impact the relativity of the physician fee schedule.**
- **ASCRS and OOSS support the efforts of the AMA's CPT and RUC workgroup to review E/M services, which allows for input from the physician community.** We believe this process will allow for full consideration of possible changes to documentation requirements to ease burdens while maintaining a resource-based method for valuing the codes.
- **ASCRS and OOSS support the proposals to allow physicians to review documentation provided by ancillary staff and to allow for multiple physicians in the same practice to bill E/M codes for the same patient on the same day.** These proposals would significantly reduce administrative burden and ensure that all physicians treating the same patient on one day are reimbursed for their services.

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**Quality Payment Program**

- **Support for maintaining a low MIPS threshold, and not using the previous year's mean or median to set the threshold.** ASCRS supported the MACRA technical corrections in the Bipartisan Budget Act of 2018, and we believe this continued transition will allow physicians and practices additional time to implement the MIPS program.
- **Support for keeping the Cost category weight at a level below 30%.** The 15% weight allows physicians additional time to understand how their scores may be impacted by the cost measures and to familiarize themselves with the new episode-based measures, including for cataract surgery. However, we remain opposed to the continued flawed attribution methodology of the population health measures retained in this category.
- **Support for the 90-day performance period for the Promoting Interoperability (PI) and Improvement Activities categories.** We recommend CMS also shorten the Quality category performance period to a minimum of 90 days.
- **We appreciate the recognition that some physicians, including ophthalmologists practicing in areas with high penetration of Medicare Advantage plans, do not have a high volume of Part B patients and should have the option to participate in or be excluded from MIPS.**
- **We appreciate CMS' efforts to simplify and streamline the PI category requirements and scoring by removing the confusing base and performance score methodology and eliminating measures that rely on patient actions.** We remain concerned about the "all-or-nothing" requirement of the category and recommend additional exceptions for the opioid-related measures and the health information exchange measures.
- **We recommend maintaining the small practice bonus on the MIPS final score, rather than moving it to the Quality category.** Keeping the bonus on the final score assures that it will be applied equally to all physicians in small practices.
- **We recommend maintaining the claims reporting option for all physicians, regardless of practice size.** Some practices have decided that claims reporting is the best option for the physicians in their group. This option should not be eliminated without additional lead time to allow these groups to explore other options for quality reporting.
- **We continue to oppose CMS' methodology for identifying and scoring "topped-out" measures and continue to support giving full credit to physicians who maintain high quality.** Ophthalmologists have a high level of participation in quality reporting programs, and successful procedures, such as cataract surgery, have very little opportunity for improvement. Ophthalmologists should not be disadvantaged in the program or be forced to report on measures not relevant to their specialty because the measures are deemed to be "topped out."
- **We recommend CMS maintain the three ophthalmology measures proposed for removal in 2019,** so that physicians who report via claims will have six ophthalmology-related measures available in the measure set. While we do not support the four-year topped-out measure process mentioned above, the

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proposal to remove these measures does not even comply with this process to determine whether they should be removed or not, and none of the measures are topped out across all submission mechanisms.

- **We continue to oppose the inclusion of the two pre-existing cost measures, Medicare Spending per Beneficiary and Total per Capita Cost of Care, as they are primary care-based, and the flawed attribution methodology potentially holds physicians responsible for care they did not provide. We continue to recommend they be removed from the program or not calculated for specialists. We support the proposal to include a cataract surgery episode-based measure.**

#### ***Global Surgery Data Collection***

- **While we appreciate that CMS scaled back its initial data collection proposal on post-operative care in the global period, we continue to question the reliability and relevancy of the data currently being collected.**

#### ***Medicare Physician Fee Schedule***

- **Opposition to CMS' valuation of CPT code 65210, Removal of Foreign Body, due to Work RVU adjustments that ignore intensity of the procedure. We do not recommend further refinements to this code's direct practice expense (PE), as the RUC-approved value rightly includes the use of the screening lane for the duration of the entire procedure.**
- **Opposition to CMS' valuation of CPT codes 67505, 67515, Injection—Eye, and CPT code 76514, Echo Exam of Eye Thickness, due to similar adjustments to WRVUs that ignore the intensity of the procedures.**

#### ***Telemedicine***

- **ASCRS and OOSS appreciate CMS' efforts to expand coverage of telemedicine. We support the creation of a virtual "check-in" without existing originating site requirements. This proposal will reduce physician burden and increase beneficiaries' access to care.**

Full comments on the proposed rule are included below.

#### **E/M CODE PROPOSAL**

**ASCRS and OOSS oppose the proposals related to E/M services included in this proposed rule. CMS' proposals are not resource-based and will have a negative impact on the relativity of the entire physician fee schedule. While we believe some elements of the proposal, such as reduced documentation requirements, will ease physician burden, the overall changes are too significant to make without full input from the medical community. We recommend CMS not finalize this proposal and allow the AMA's CPT and RUC committees to review and propose modifications to E/M services as needed.**

- **While we appreciate CMS' efforts to reduce administrative burden through reducing documentation requirements, we are concerned that the payment proposals for E/M visits could pose a significant risk to Medicare physician reimbursement and the relativity of the physician fee schedule, and,**

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**therefore, we recommend that CMS not finalize them.** ASCRS and OOSS continue to support the resource-based valuation methodology for physician services. When a physician sees a patient with a more complex disease, or diseases, requiring greater time and intensity, then he or she should be reimbursed at a higher level than for a patient with less complex medical needs. Collapsing levels two through five E/M visits ignores that foundational principle of the physician fee schedule. In addition, arbitrarily changing the RVUs associated with a particular code without significant analysis of the overall impact on the relativity of the fee schedule risks far-reaching unintended consequences for the value of other physician services. **We continue to support RBRVS and recommend CMS wait to modify the value of E/M codes until after the CPT and RUC have completed their review of the codes.**

- **We are particularly concerned about the effect this proposal will have on indirect practice expense (PE).** To reflect the single blended payment for E/M visits, CMS proposes a new average PE value per hour by creating a separate Indirect Practice Cost Index (IPCI) for E/M. This change would create a Designated Medical Specialty for E/M visits and remove the indirect practice costs associated with those visits when calculating IPCIs for all other specialties. AMA's RUC estimates that creating the separate IPCI for E/M visits would have significant impacts to the indirect PE for other specialties that are not based on any changes in the cost of inputs. For ophthalmology, RUC estimates that total indirect PE allowed charges for all services excluding E/M visits would be reduced by at least \$50 million. **Therefore, we continue to recommend CMS not implement this proposal until the full impacts on the fee schedule are understood and addressed.**
- **ASCRS and OOSS oppose the proposal to implement a multiple procedure reduction on the lesser of two codes when a procedure is performed on the same day as an E/M visit because it is duplicative of recent RUC efforts to revalue codes that are frequently performed in conjunction with E/M services.** In recent years, the RUC has sought to identify those services that are routinely performed with an office visit and, consequently, has reduced the value of hundreds of these codes. **We recommend CMS not implement a multiple procedure reduction in conjunction with E/M codes, as it would further reduce reimbursement for services that already have been revalued to address the issue.**
- **The proposed add-on codes for primary care and non-procedure-based specialty care are further examples that the overall E/M proposal is not resource-based and is arbitrary.** In proposing these codes, it is apparent that CMS realized that the proposal to collapse the E/M code levels would have a greater negative impact on reimbursement for some specialties and, therefore, determined the add-on codes were necessary. While we recognize that CMS was attempting to ensure that certain specialties were not significantly impacted by the code collapse, the proposed remedy of the add-on codes was an arbitrary solution that continued to ignore resource-based code valuation methodology. In addition, the attempt to account for potential reduced reimbursements was applied across specialties arbitrarily, since it appears from CMS' analysis that even though primary care was not estimated to experience as great a cut as some other specialties, they are eligible to use the add-on code for additional reimbursement. **We are concerned that these add-on codes will have a further negative impact on the relativity of the physician fee schedule and continue to recommend any changes to E/M code values originate from the CPT and RUC processes to ensure that they remain resource-based.**
- **While we are encouraged by the documentation proposals CMS includes in the proposed rule, we believe that any changes to E/M services should be developed through the CPT and RUC process, as it will allow for physician input, and any changes to the codes or their values would be resource-based.** Currently, there is little consensus about what is required to document to higher E/M levels and, in

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effect, this causes physicians to document more than is warranted when a patient's condition requires more intense care. In addition, there are ambiguities in the current documentation guidelines related to the history and physical exam and medical decision-making. Despite agreement that documentation guidelines should be simplified and updated, there are varying viewpoints across medicine about how to achieve that simplification. The CPT and RUC processes offer the appropriate method for considering those viewpoints and making recommendations that do not have an undue impact on any one specialty. Furthermore, this process will be resource-based and will specifically seek not to have a negative impact on the relativity of the physician fee schedule. **We welcome efforts to clarify documentation guidelines to reduce burdens and believe the CPT and RUC process is the appropriate means to achieve those goals.**

- **Despite the promise of reduced burden that the documentation proposal may provide, we continue to caution that any documentation requirements not overvalue time, as it is not a proxy for complexity or intensity.** Ophthalmologists manage patients with complex eye disease, which requires both intensity from medical decision-making and time spent with the patient. Time is not an accurate representation of physician work without the intensity factored into medical decision-making. However, time should not be ignored as a key element in ensuring complex conditions are adequately addressed. **We continue to believe the history and physical exam, medical decision-making, and time are all integral to the delivery of ophthalmic care and should be accounted for in the description and value of E/M codes.**

**To reiterate, ASCRS and OOSS oppose CMS' proposals related to E/M visits and recommend they are not finalized. We support AMA's CPT and RUC processes to review the codes and make any necessary modifications. This process will adhere to the established RBRVS and maintain the relativity of the physician fee schedule. In addition, it will allow for input from physicians across medicine to ensure significant impacts are not unintentionally focused on just a few specialties and will ensure beneficiaries continue to have access to care.**

### **THE QUALITY PAYMENT PROGRAM**

#### ***Extended MIPS Transition Period***

- **ASCRS and OOSS support extending the MIPS transition period into the 2019 performance period, as required by the MACRA technical corrections included in the Bipartisan Budget Act of 2018.** As we have noted in previous comments on the first two years of the program, MIPS is a complex program that requires each practice to evaluate how to implement it. After years of the disparate legacy reporting programs that required all-or-nothing participation, physicians and practice administrators are still becoming familiar with the scoring and budget-neutral structure of MIPS payment adjustments. It is only since the beginning of July that physicians received feedback on their performance in the first year of MIPS, so they are just now considering whether they need to make further changes to participate in the 2018 performance year or in 2019 and beyond. **Continuing the transition flexibility into the third year alleviates the burden on practices still trying to implement the program. We recommend CMS use its full authority granted by Congress to extend the transition period to the full five years to provide predictability for physicians.**

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- **ASCRS and OOSS support setting the MIPS performance threshold at 30 points for 2019 performance and 2021 payment.** While this is a 100% increase over the 2018 performance threshold of 15 points, it is still achievable by practices, especially small practices. **In addition, we support raising the exceptional performance threshold to 80 points.**
  - In the proposed rule, CMS asks whether it would be helpful to set the performance threshold prospectively for the next two years before the transition period authority is gone, and CMS must move the mean or median standard to give physicians more predictability. We believe that this could be a helpful option if more information about physician performance in the first year of the program was available. While we understand that 91% of eligible clinicians participated in the first year of MIPS, we do not know to what extent they participated. It would be helpful to know what percentage chose “pick your pace” options and just submitted minimal data, versus how many chose to participate fully and even achieved the exceptional performance threshold. **Additional data on physician performance in MIPS to date would help determine at what level the MIPS performance threshold should be set in the next few years.**
  - **We also appreciate CMS’ proposal to keep the Cost category weight at a level below the previously statutorily required level of 30% in 2019.** As we will focus on in our comments on the Cost category later in this letter, ASCRS and OOSS still have significant concerns about the existing primary care-based measures in the category, and physicians are still becoming familiar with how they will be scored. While the addition of episode-based measures, including cataract surgery, is encouraging, physicians will still need time to understand those measures, as well. **Keeping the Cost category weight at a lower level, such as 15%, ensures that physicians have additional time to evaluate how this category will impact their overall MIPS scores.**

### ***MIPS Program Simplification***

- **We appreciate the efforts CMS has made in this proposed rule to streamline and simplify the scoring of the MIPS program, such as through the overhaul of the PI category, and we encourage CMS to take further steps to simplify the program as a whole.** As we have noted in previous comments, we believe MIPS is complex and the scoring methodology can be confusing for clinicians. CMS has rightfully recognized that the previous scoring methodology in the PI, the former Advancing Care Information, category was difficult to understand and proposes to modify the category. We also recommend CMS explore how it can simplify the scoring in other categories. A key strategy to accomplish that would be to follow the proposal submitted by the medical community earlier this year that would align the available points in each category with its weight in the final score. For example, the Quality category is proposed to be weighed at 45% of the final score, and in the category, physicians and groups could work toward earning a total possible 45 points. In addition, we recommend identifying measures or activities that will count for scoring in all, or multiple, categories, such as a practice focusing on patient-reported outcomes through a qualified clinical data registry, which would accrue points in the Quality, PI, and Improvement Activities categories. **We urge CMS to continue to work to refine and streamline the program to reduce the burden on physicians.**

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### ***Performance Period***

- **ASCRS and OOSS support a 90-day performance period for the PI and Improvement Activities categories, and we continue to support a minimum of 90-day performance period for the Quality category.** A 90-day performance period for the PI and Improvement Activities categories is a key factor in reducing the regulatory burden on physician practices. We recommend CMS further ease that burden and reduce the Quality category performance period to a minimum of 90 days as well, rather than requiring all physicians to report for a full year. While many physicians may choose to report Quality data for a full year, the flexibility of a minimum of 90-day performance period gives physicians options and the ability to focus on the measures that are most relevant to their practices. For instance, outcome and other high-priority measures provide the most relevant feedback on a physician's performance but can be labor-intensive and burdensome to report on 60% of all patients for a full year. **If CMS wants to incentivize physicians to report outcomes measures, a reduced performance period could spur practices to take on those more challenging measures.**

### ***Low-Volume Threshold***

- **ASCRS appreciates that CMS continues to recognize that some physicians may not see a high volume of Part B patients and should be excluded from MIPS.** While most ophthalmologists see a high volume of Medicare patients and are MIPS-eligible, some may unexpectedly not meet the low-volume threshold. Low-volume ophthalmologists tend to be those that practice in areas with a high penetration of Medicare Advantage, or who have experienced disruptive events, such as changing practices or extended leave due to health issues, that happened during the determination period.

### ***MIPS Terminology***

- **ASCRS and OOSS caution CMS against making too many changes to the terminology related to the MIPS program, as it potentially adds confusion to an already complex program.** While we appreciate that CMS is attempting to be more specific in its wording for certain aspects of the program, such as terms related to quality measure collection and submission and the PI category and its measures, we are concerned that the re-naming may have the opposite effect and cause physicians confusion when attempting to participate in MIPS. Physicians spend the majority of their time taking care of patients and, therefore, should not have to spend additional time learning new terms for what are essentially the same program elements. **In general, we continue to encourage CMS to identify ways to simplify the program rather than add to its complexity. We recommend CMS carefully evaluate whether terminology changes have a meaningful impact or may cause unintended confusion.**

### ***Small Practice Bonus***

- **We recommend retaining the 5-point bonus on the MIPS final score for small practices rather than moving the bonus to the Quality category.** Maintaining the small practice bonus on the final score ensures that it impacts all physicians in small practices equally. If physicians or groups are not able to report quality measures, they will not be able to receive the bonus. Conversely, if a small group is performing well in the Quality category and scoring at or close to the total number of points, it will similarly not receive the small practice bonus. Finally, if a practice has had another category re-weighted to the Quality category, then the 3-point bonus takes on a greater weight than it would if the Quality



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category weight was 45% for that physician. **ASCRS and OOSS recommend CMS move the small practice bonus back to the final MIPS score.**

### Quality Category

#### *Quality Category Scoring*

- **As noted above, we recommend CMS modify MIPS scoring to reduce complexity, including in the Quality category.** The Quality category score continues to be based on a total of 60 or 70 points and then weighted at 45% of the clinician's final MIPS score. It would be easier for clinicians to monitor and predict their performance in this category if the total points available were aligned to the weight of the category. For example, in year one of the MIPS program, the Quality category was worth 60% of the final MIPS score, and there were a potential 60 points in the category for small practices. This allowed clinicians to track their performance throughout the year and determine whether they were meeting their goals, such as the exceptional performance threshold. The proposed weight and requirements for this category do not allow them to monitor in the same way without doing additional calculations. **Scoring simplification, such as aligning the points available with the weight of the category, would reduce the burden on physicians participating in MIPS.**
- **In terms of keeping the program simple and easy for physicians to predict their scores, we are concerned with CMS' consideration of a new scoring methodology that ranks the importance of various measures, such as through "gold, silver, or bronze" designations.** While complex, the current program does allow physicians to choose whichever measures are most meaningful to their practices. Apart from choosing one outcome, or high-priority measure if no outcome is available, physicians do not have to consider additional factors. Creating an alternate methodology that parses out whether one measure is more important than another could add complexity to the program and be confusing for clinicians. **Before moving forward with a new structure for the Quality category, we recommend CMS consult with the medical community and explore through testing how a change will impact clinicians who are already participating in and familiar with the program.**

#### *Reinstatement of the Quality Measures Group Option*

- **As an alternative to creating a rank order of measures, ASCRS and OOSS recommend CMS reinstate the measures group option previously available under PQRS to incentivize clinicians to report on outcome and high-priority measures and reduce burden.** Many of our members used the Cataracts Measures Group or the Diabetic Retinopathy Measures Group, which required the reporting of 8 measures on 20 patients, 50% of whom had to be Medicare Part B patients, to successfully meet the PQRS reporting requirement. The reinstated availability of the measures groups would continue the important work of evaluating the quality of care for particular conditions or related to specific procedures.
- **We believe these measures groups meet the goals of the meaningful measures initiative to identify the measures most relevant to a clinician's practice and incorporate outcome and high-priority measures.** The Cataracts Measures Group featured six outcomes measures that focus on surgical complication rates, clinical outcomes, patient-reported outcomes, and patient satisfaction. We believe

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these highly relevant measures are more in line with CMS' stated goals than other measures, many of them process, not grouped to address particular conditions or procedures.

- **Reinstating the measure group option would allow ophthalmologists to report meaningful patient-reported outcome measures.** CMS encourages MIPS participants to report patient experience measures, but most ophthalmologists are not able to because they do not practice in large enough groups to use the CAHPS for MIPS survey, and the IRIS Registry no longer offers measures 303 and 304, which measured patient outcomes following cataract surgery. Since cataract surgeons may perform thousands of surgeries per year, the category's data completeness threshold of 60% of all patients makes analyzing patient responses to the surveys unmanageable and, therefore, prevents any clinician from reporting the measure. **Reinstating the cataract measure group would allow clinicians to continue to report these valuable patient experience measures on a limited, but still significant, set of patients.**

### *Scoring for Measures with High Success Rates and Topped-Out Measures*

- **ASCRS and OOSS continue to oppose the methodology for scoring and removing topped-out measures.** Cataract surgery is the number-one Medicare-reimbursed procedure and is performed on millions of beneficiaries, contributing not only to increased visual function but secondary benefits, such as increased independence, and reduced risk of other health conditions, including falls or depression. Given that importance, measures relating to cataract surgery that have high performance rates should be carefully considered before being considered "topped out," and physicians should have the ability to receive full credit for maintaining high quality.
- **CMS' proposed methodology for identifying topped-out measures relies solely on arbitrary quantitative results and does not take into account qualitative aspects that may ensure highly relevant measures are retained and receive full points.** We recommend CMS develop a more transparent methodology for assessing the continued relevance of individual quality measures that incorporates feedback from the medical community and measure stewards. Quality measures undergo regular maintenance by their owners with input from physicians who use the measures to ensure they reflect the most recent clinical practices and guidelines. This regular maintenance should not be overlooked by CMS, and therefore, measures should not be removed without a request that they be withdrawn by the measure owner or going through a transparent process allowing for comments from stakeholders.
- **For measures related to high-volume services, such as cataract surgery, CMS should consider the overall effect of removing or devaluing the measure on the overall percentage of Medicare beneficiaries and expenditures covered by MIPS measures.** Cataract surgery is the number-one Medicare-reimbursed procedure and, as such, should have a quality measure component. Current outcome measures for cataract surgery are nearing designation as topped-out measures. **CMS must provide a level of oversight to ensure that the topped-out measure methodology does not arbitrarily remove clinically relevant measures related to high-volume procedures, such as cataract surgery.**
- **Furthermore, we oppose capped scoring for topped-out measures, and recommend CMS continue to award full credit to physicians maintaining high quality.** As noted above, cataract surgery is overwhelmingly successful, and as a result, our members tend to score highly on measures pertaining to the procedure. Much of the success of the procedure is due to the attention cataract surgeons pay to

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ensuring high-quality care with positive outcomes. Cataract surgery measures serve as a useful monitor to maintain that high quality. In addition, many of the measures are outcomes measures and must be reported via registry or QCDR. Sustained reporting of these measures contributes to continued research and efforts to maintain high quality. **If these measures are only eligible for capped scores, or are not retained in MIPS, our members have fewer incentives to participate in the program.**

### ***Opposition to Removing Ophthalmology Measures***

- **Despite our continued opposition to CMS' topped out measures methodology, we are disappointed that CMS is proposing to remove three ophthalmology measures from the MIPS program for 2019 reporting without using any of the steps outlined in the topped-out measures methodology. The topped-out measure methodology is flawed, but at minimum it allows for a phased approach to removing the measures. For 2019, CMS is proposing an immediate elimination of the measures that does not give physicians time to select and implement new measures.**
- These three measures continue to measure key aspects of ophthalmic care:
  - #12, Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation;
  - #18, Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy; and
  - #140, Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement.

According to CMS' 2018 benchmarking chart, none of these measures are topped out for all reporting options, and measure 18, which is only available for EHR reporting, is not topped out at all. **These measures should not be removed from MIPS until there is an analysis of their relevance and effectiveness and a clear indication that they are topped out across all submission options.**

- **Removing these measures limits the ability of ophthalmologists reporting via claims to report solely ophthalmology-based measures.** If these measures are removed for 2019, ophthalmologists reporting through claims would have only five ophthalmology-specific measures available in the ophthalmology measure set. In addition to the five relevant measures, ophthalmologists would have to choose a primary care-focused cross-cutting measure, such as tobacco cessation, to meet the full requirements of the category. While cross-cutting measures may evaluate important care for beneficiaries, they do not focus on ocular conditions. It is important that ophthalmologists focus on measures related to ophthalmic care since ocular co-morbidities, such as diabetic retinopathy or glaucoma, generally have a greater impact on surgical outcomes, such as cataract surgery, than do systemic conditions. **We recommend CMS maintain these three measures for 2019 so claims reporters will be able to focus their quality reporting on relevant conditions.**

### ***Claims Reporting***

- **In addition to maintaining the three ophthalmic measures proposed for removal, we recommend CMS maintain claims reporting for all MIPS-eligible clinicians, regardless of practice size, and not eliminate the ability of large practices to report via claims.** While most ophthalmology practices, of any size, choose to report quality measures through other submission mechanisms than claims, some of our members still report through claims. Generally, these practices have determined that implementing EHR is not appropriate for their group and are able to care for their patients without it. Ophthalmic practices

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have access to the IRIS Registry, but without an EHR, the data completeness threshold of 60% of all patients makes it too labor-intensive to enter the data manually. Therefore, the only option these practices have is to report via claims. Without this option, many of these practices may conclude that the cost and disruption to the practice of implementing a new system is more than the potential negative payment adjustment and choose not to engage in any quality reporting, or the MIPS program, at all. **We recommend CMS maintain the claims reporting option for practices of all sizes.**

### ***Bonus Points***

- **ASCRS and OOSS support maintaining the Quality category bonuses for additional outcome and high-priority measures and for electronic end-to-end reporting and recommend maintaining them in the program for future years.** As noted above, the data collection and reporting can be onerous and labor-intensive for some outcome and high-priority measures. To incentivize clinicians to continue to report measures that CMS has deemed to be more meaningful, it should maintain bonus points for reporting additional outcome or high-priority measures beyond the required one measure. In addition, the electronic end-to-end bonus points help incentivize clinicians and groups to move beyond claims reporting and adopt EHRs or clinical registries. **Maintaining the bonus points in the Quality category ensures that clinicians will strive for advanced participation in MIPS.**

### ***All-Cause Hospital Readmission Measure***

- **We continue to oppose the inclusion of the all-cause hospital readmission measure in the Quality category. We appreciate that CMS proposes to continue scoring the measure for practices of 16 or more providers who have 200 attributed patients, but we continue to oppose the attribution methodology and urge CMS to remove it from the MIPS program completely.** As we have stated before, and will again in our comments on Cost, the all-cause hospital readmission measure potentially holds providers, especially such specialists as ophthalmologists, responsible for care they did not provide, regardless of the practice size. Ophthalmologists do not provide treatment in inpatient settings and, therefore, have no control over readmission rates. They should not be scored on this measure because they have no ability to impact their performance on it.
- The attribution process is problematic since CMS will first assign beneficiaries who have had a plurality of primary care services rendered by primary care physicians, and second, for beneficiaries who remain unassigned, will assign beneficiaries who have received a plurality of primary care services (billed as E/M services) rendered by non-primary care physicians in the TIN. CMS changed this attribution model for ACOs and, at the time, noted the possible negative effects it could have on specialists. These same issues arose with the VBPM—and will likely with the all-cause hospital readmission measures—and may have the effect of holding specialists, such as ophthalmologists, accountable for the cost and quality of care they did not actually provide. **CMS should remove the additional measures completely and evaluate the Quality category only on the six measures physicians choose to report.**

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**Cost Category*****Cost Measures Do Not Apply to Our Specialty***

- **ASCRS and OOSS continue to have major concerns with attribution and risk adjustment for the Medicare Spending per Beneficiary and Total per Capita Cost of Care, which are primary care-focused and do not apply to our specialty.** CMS proposes to continue the use of these two measures, originally from the VBPM. These measures potentially attribute high costs of treatment for non-ophthalmic conditions to ophthalmologists, simply due to the flawed attribution process based on E/M billing. Currently, these measures use the flawed two-step attribution methodology as we described previously, by first attributing a patient, and all the costs of his or her care, to a primary care physician. If the patient did not see a primary care physician during the year, he or she is attributed to whichever physician billed the plurality of E/M codes. This arbitrary method can hold specialists, such as ophthalmologists, responsible for the cost of care they did not provide. Specialists have no way of predicting what patients they will be attributed and no meaningful way to take action or impact their scores on this measure in future years. **We continue to assert that it is impossible for CMS to evaluate specialists based on their cost data using these measures since none of the measures apply to specialty providers, such as ophthalmologists.**
- **ASCRS and OOSS recommend CMS continue to work with its contractor to refine these measures to improve risk adjustment and attribution.** As part of one ASCRS member's ongoing service on a technical expert panel (TEP) charged with overseeing development of episode-based measures, we are aware that CMS has charged Acumen with updating the existing cost measures, and we have provided input. We believe that Acumen understands the issues that both specialists and primary care physicians have expressed about the lack of risk adjustment and physicians being measured on the cost of care they did not provide—or had any ability to influence. It is apparent from the initial discussions of the TEP that it will require a painstaking process to rethink and refine the measures. As such, they may not be ready to be used in 2019. **We recommend CMS suspend use of these measures until they are updated, and if they cannot be sufficiently refined to correct current attribution and risk-adjustment problems, they should be removed from the program completely.**

***Episode-Based Measures***

- **ASCRS and OOSS thank CMS for following the recommendations of the Ophthalmology Subcommittee of the Episode-Based Cost Measure TEP in proposing the new cataract surgery episode-based cost measure.** As noted above, ASCRS had a physician serve on both the overarching TEP and the clinical subcommittee. Throughout the development of the measure, the members of the committee grappled with all the relevant costs associated with cataract surgery and designed the measure to account for only elements that are within the cataract surgeon's ability to influence. They excluded patients with significant ocular co-morbidities that often impact the cost and outcome of cataract surgery through no fault of the surgeon. In addition, they accounted for differences in payment based on CMS' own policies, such as whether the surgery was performed in an ambulatory surgery center (ASC) or hospital outpatient department (HOPD) and whether one or both eyes were operated on within the episode window. **We believe the specifications of the measure accurately reflect the costs of cataract surgery and will provide actionable data to surgeons seeking to contain costs.**

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- **While we support the inclusion of the cataract episode measure for the 2019 performance year, we continue to have some concern about the scoring and feedback for the episode measures.** Throughout the field test conducted on the draft measure, we expressed frustration with CMS' insistence on comparing the clinician's cost to a standardized national average figure. While we realize that the clinician's final average cost was adjusted to account for such factors as site of service, geographic payment differences, and other risk adjustment, the clinician is not given the information to see how that adjustment impacted the final average cost. Given the four different episode sub-groups for site of service and laterality, the final average figure may not be close to any of the observed costs. Only by looking at the drill-down tables is the physician able to determine where he or she may be more or less costly. **We continue to recommend CMS use an alternative metric than national average as the final comparison for the cataract episode cost measure. We believe physicians would better understand the report and be able to take action in response if they were shown how their average observed cost compared to their average expected cost.**

#### ***Exclude Part B Drugs***

- **ASCRS and OOSS continue to recommend CMS exclude the cost of Part B drugs from future cost calculations. The price of certain drugs administered in the office is rarely within the physician's control, and other options may not be available.** As noted previously, physicians do not control the cost of the drugs administered in their offices. Ophthalmologists, both in general practice and retina subspecialties, frequently use intravitreal injections to treat age-related macular degeneration (AMD) and diabetic retinopathy. Injectable drugs for these chronic diseases may cost in the tens of thousands of dollars over the course of the treatment, and lower-cost repackaged versions may not be available. **Including the cost of Part B drugs potentially significantly overstates a physician's cost of caring for patients. To accurately assess the cost of care a physician provides, these drugs should be excluded from cost attribution.**

#### ***Scoring Cost Improvement***

- **In accordance with the MACRA technical corrections included in the Bipartisan Budget Act of 2018, we support CMS' delay of incorporating improvement into the Cost category score.** As mentioned above, ophthalmologists have no ability to influence their scores on the current total per capita and MSPB cost measures used in the 2017 and 2018 performance years. We continue to oppose the inclusion of these measures and believe that scoring improvement on these measures that arbitrarily attribute patients and their cost of care to ophthalmologists and other specialists will not provide any relevant or actionable data. **CMS should not only continue to delay but should eliminate scoring improvement for these measures that specialists, such as ophthalmologists, have no ability to impact.**

#### ***Promoting Interoperability Category***

- **ASCRS and OOSS appreciate and thank CMS for listening to both our recommendations, and those of the medical community, and proposing to overhaul the PI category. The original scoring methodology was cumbersome and difficult for physicians to understand, and physician's scores depended too heavily on the actions of other physicians or patients. We believe the proposals for the category overhaul will reduce burden and allow physicians to focus on measures most relevant to their practices. Despite these major improvements, there are still some issues CMS should address, such as**

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the continued “all-or-nothing” structure of the category, streamlining reweighting measures, and the need for additional exclusions for opioid measures and health information exchange.

- **In addition, we continue to recommend that physicians who use QCDRs that integrate with their EHR be awarded full credit in the PI category.**

#### *Promoting Interoperability Scoring*

- **We continue to recommend CMS award full credit in the PI category to any physician or group who participates in end-to-end electronic reporting through a QCDR.** Ophthalmologists have access to the IRIS Registry, a QCDR that integrates seamlessly with most EHR systems and provides them with full reporting capabilities for MIPS. The use of the QCDR is a clinically relevant tool to provide a full picture of the physician’s performance. PI measures are process related and generally primary care-based. They do not provide useful information to specialists, such as ophthalmologists.
- **Physicians using a QCDR are participating at a higher, and more meaningful, level in MIPS and should be given full credit in the PI category, so they can concentrate on clinically relevant measures.**
- **As mentioned above, CMS’ proposed overhaul of this category retains the troublesome “all-or-nothing” scoring methodology that began first under Meaningful Use and continued through the first two years of MIPS.** For any credit in the category, clinicians must report on each of the measures included in the category. Participants receive no partial credit for reporting on some, but not all, of the required measures. The other categories of MIPS provide some credit for reporting some data, and the PI category should be modified accordingly. If clinicians know they will not be able to complete all the required measures, they do not have any incentive to work toward meeting any of the others. **We recommend CMS remove the “all-or-nothing” scoring methodology and award partial credit for physicians who attempt to report on some of the PI measures.**
- **To simplify the PI category scoring in future years, beginning with the 2020 performance period, CMS should consider requiring physicians and groups to attest a “yes” or “no” for each measure, which would indicate whether or not they had at least one patient in the numerator. The clinician would be awarded ten points for each “yes,” rather than be scored on each measure’s performance. In addition, the clinician should only be scored at the objective level by being required to report one measure from the objective and receive bonus points for any additional measures reported.** This methodology would allow the clinician to focus on the measures that are the most relevant to his or her practice. For example, most ophthalmologists report to the IRIS registry and would therefore want to report the clinical data registry measure, but cannot report any of the other registry measures, because they do not administer immunizations and syndromic surveillance and electronic case registries do not accept ophthalmic data. By attesting to the clinical data registry measure, which is the most relevant to ophthalmology, the clinician would satisfy the Public Health/Clinical Data exchange objective. CMS has already recognized that not every physician can report to all the public health registries—or report on several of the measures in other objectives—and therefore, must offer exclusions. An approach that allows physicians to report on the most relevant measures would eliminate the need for any exclusions in the category. In addition, we suggest CMS explore options for EHR vendors to report the functionality of CEHRT products they offer, and the physicians’ use of those functions, rather than rely solely on physicians to report. **We encourage CMS to consider this alternatives that will reduce burden and**

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**increase flexibility and allow clinicians to report on the measures that are most relevant to their specialty and practice.**

- **If CMS does not remove the all-or-nothing score, we recommend that the proposals related to re-weighting measures when a physician takes an exclusion be modified because they are confusing.** In its descriptions of each of the included measures that have exclusions, such as e-prescribing and health information exchange measures, CMS includes a lengthy procedure for determining how the measure's weight will be redistributed if the physician claims the exclusion. None of the conditions are the same for two measures, which will likely lead to substantial confusion for clinicians attempting to participate in the category. In the Quality or Cost categories, if it is determined that the clinician does not have enough measures available, the points are removed from the denominator, rather than distributed elsewhere. **We recommend CMS use a similar formula as in the Cost and Quality categories to score clinicians who take exclusions on PI measures.**
- **We recommend reinstating the PI bonus for improvement activities accomplished using CEHRT.** CMS is seeking comments on strategies for streamlining the MIPS program and providing credit across categories. The bonus for using CERHT in improvement activities provided ophthalmologists with an incentive to participate fully in both categories, such as providing 24-hour electronic access to patient records. Furthermore, for the 2019 performance year, ophthalmologists, who don't typically prescribe opioids, will not have any options in the category to earn bonus points. **The bonus for using CEHRT in improvement activities should continue to be an option for MIPS participants.**

### ***Promoting Interoperability Measures***

- **ASCRS and OOSS support removing the measures that relied on patient action and modifying the measures relying on the actions of other physicians.** Ophthalmologists have repeatedly cited these types of measures in the previous program and the first two years of MIPS as some of the most challenging requirements. Ophthalmologists treat an older cohort of Medicare beneficiaries—many of whom have very poor eyesight—who may not be interested in or able to engage with their physicians electronically. Furthermore, many ophthalmologists may receive the majority of their referrals from optometrists, who may not be eligible for MIPS and have no incentive to exchange information electronically. CMS' proposed modification of the "receive a summary of care" measure will improve performance on this measure by basing ophthalmologists' scores solely on whether they complete the clinical data reconciliation when they receive an electronic summary of care. Currently, the "receive a summary of care" measure scores the physician on the percentage of electronic summaries of care he or she receives from other practitioners, of all referrals he or she receives. The current measure is entirely based on the actions of other physicians, and we thank CMS for proposing to modify the measure so physicians are able to influence their own scores. **We appreciate CMS' proposals to remove the patient action measures and modify the "receive a summary of care" measure, and we request that they be finalized.**
- **Despite our support for the modified measures in the category, we request exclusions be included for the opioid measures and the health information exchange measures.** ASCRS and OOSS appreciate the efforts CMS is making to combat the opioid abuse crisis and support including the measures in the program. However, ophthalmologists almost never prescribe controlled substances, if at all. While we recognize these measures are optional for 2019, we recommend CMS provide an exclusion for each of



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these opioid measures, as they are not applicable to ophthalmologists. In addition, we recommend maintaining exclusions for the health information exchange measures, as some practices do not refer many patients from their practices or may not receive referrals from physicians with EHR. In addition, interoperability between EHRs is still lacking in some cases, making it difficult to exchange electronic data seamlessly. **We recommend CMS include these exclusions for the 2019 performance year.**

- **ASCRS supports the proposed changes to the data registry measures and recommends CMS keeps them in the future.** Ophthalmologists have access to the IRIS Registry to report ophthalmic data; however, they do not administer immunizations, and most public health registries do not accept ophthalmic data. Therefore, we support the proposed exclusions for this measure if the clinician is unable to report to two registries. In addition, we recommend CMS make claiming the exclusions user-friendly. Under the final years of the Meaningful Use program, clinicians attesting had to work through a cumbersome process to take the exclusions in this measure. **Finally, we support maintaining this measure in PI as it will continue to encourage physicians to report to qualified clinical data registries.**
- **CMS seeks comment on a potential measure related to health information exchange with non-MIPS-eligible clinicians.** We believe this measure would be duplicative of the current health information exchange measures because nowhere in the description of either current measure does it mention that the referring physician be MIPS-eligible or not. It is not clear from the proposed rule which clinicians CMS intends to include in this measure. If CMS is defining a non-MIPS eligible clinician as a clinician who does not meet the low-volume threshold, or who is a qualifying participant (QP) in an APM, it would be difficult for the ophthalmologist to know if the other clinician is low volume or a QP. If CMS is only referring to clinicians practicing in such facilities as long-term care that are not eligible for MIPS, then ophthalmologists would likely not have enough patients referred for the measure. **We recommend CMS maintain the current health information exchange measures, which do not require the physician to determine whether the other clinicians they are exchanging information with are eligible for MIPS or not.**

### ***2015 EHR Certification***

- **While many ophthalmologists with EHR have already upgraded to 2015 technology, or are planning to in the near future, we continue to recommend CMS not require upgrading to 2015 technology.** The costs associated with upgrading can be significant for small practices, and some vendors are not ready to provide the updated technology. Furthermore, ASCRS and OOSS do not agree that maintaining 2014 technology and transitional measures is a burden on EHR vendors. As noted above, physicians' primary responsibility is patient care, and complying with MIPS is a secondary concern. EHR vendors, however, are in the sole business of developing and servicing software. Responding to the needs and preferences of their customers, in this case physicians, should never be considered a regulatory burden for a business. In attempting to reduce vendors' supposed "burden" associated with maintaining 2014 technology, CMS is falsely equating them with the real regulatory burdens our physicians face while still providing sight-saving care to patients. **We urge CMS to reject the so-called burden on EHR vendors and allow for physicians to continue using 2014 technology if that is their preference.**

### ***Improvement Activities***

- **ASCRS and OOSS support the proposed new improvement activity "Comprehensive Eye Exams" for the 2019 performance year.** There are currently no ophthalmology-specific improvement activities

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available, and most activities are primary care-focused. This new improvement activity allows physicians providing eye care to highlight the importance of regular exams, which can detect and mitigate chronic disease, such as glaucoma, earlier. In addition, a comprehensive eye exam will screen beneficiaries for cataracts. Cataract surgery has been proven to improve and extend seniors' independence and quality of life and reduces the risk of falls and accidents. **We recommend CMS finalize this proposed activity, as it will have positive clinical impacts on Medicare beneficiaries.**

- **ASCRS and OOSS support providing an automatic high weighting for activities that involve CEHRT.** As noted above in the PI section, we recommend CMS reinstate the bonus in the PI category for using CEHRT to accomplish improvement activities. Physicians who are incorporating CEHRT into their practices, such as through integration with a QCDR, are already participating in MIPS at a higher level. CMS should recognize those efforts and designate those improvement activities that use CEHRT as high-weighted.
- **In this proposed rule, CMS notes that it plans an overhaul of the Improvement Activities category in next year's rulemaking.** While we encourage CMS to refine and simplify scoring in the MIPS program overall, we are opposed to scoring improvement in this category and caution against making too many changes to this category as a whole. In general, ophthalmologists are able to participate fully in this category, and ASCRS supports the current structure and scoring. Furthermore, CMS has no statutory authority to measure year-to-year improvement in this category and should not be contemplating policies related to improvement. **We urge CMS to concentrate its efforts to reduce burden by simplifying overall scoring in MIPS, and in the Quality category, rather than in Improvement Activities.**

### **Alternative Payment Models**

- **ASCRS and OOSS continue to have concerns that despite CMS' efforts to encourage physicians to move away from traditional fee-for-service, there are very few options for ophthalmologists to participate in alternative payment models (APMs) at either the advanced or MIPS APM levels.** Most current models are primary care-focused, and none are ophthalmology specific. Ophthalmologists are solely focused on eye care and do not coordinate care with physicians treating other parts of the body. Like many specialists, when ophthalmologists can participate in APMs, they are not generally involved in the management of the APM and often do not have any day-to-day involvement in the APM. In addition, the measures APMs, such as ACOs, do not focus on ophthalmology or other specialty care but are targeted at primary care. ACOs do not report on any measures related to common procedures performed by ophthalmologists, such as cataract surgery, or medical care for chronic diseases, such as glaucoma and macular degeneration. Furthermore, ophthalmologists practicing in traditional fee-for-service have already taken steps to make care more cost-efficient, such as migrating all ophthalmic procedures to lower-cost hospital outpatient departments and ASCs. MIPS is the only program available that allows ophthalmologists to report on and demonstrate the quality performance and value of the ophthalmic care they provide. **CMS must maintain a viable fee-for-service option in Medicare so that ophthalmologists can continue to provide specialized and efficient care to beneficiaries.**
- **To encourage the limited opportunities that ophthalmologists have in APMs, ASCRS and OOSS recommend reinstating the diabetic eye exam measure to the web interface collection type.** When ophthalmologists are asked to join ACOs, it is generally because the ACO is focusing on diabetes care and wants to report Measure 117, Diabetes: Eye Exam, which requires a full retinal or dilated exam by

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an eye care professional. The inclusion of this measure is vital to ensure diabetic patients receive early intervention to prevent vision loss or total blindness. By removing it from the web interface measure set, which most ACOs use to report quality data, they do not have as great an incentive to include ophthalmologists in their participant list. **We ask CMS to make Measure 117 available for web interface reporting in 2019.**

### **GLOBAL SURGERY DATA COLLECTION**

- **As we have stated in previous comments and correspondence related to this issue, ASCRS and OOSS do not believe simply collecting data on the number of post-operative visits furnished during a global period is an accurate representation of the level of post-operative care surgeons, especially ophthalmologists, provide.** For example, ophthalmic post-operative care may typically include services, such as visual acuity testing, manifest refractions, or intraocular pressure checks, that not only require specialized equipment but contribute to the higher work RVUs of the global service because they include a higher level of intensity than traditional E/M codes. **The current policy requiring physicians to report 99024 does not take these differences in intensity and practice expense into account.**
- **It is clear from CMS' commentary in the proposed rule that it is not receiving accurate or usable data.** CMS notes that participation in this data collection effort varies widely depending on specialty. ASCRS, our affiliated group, the American Society of Ophthalmic Administrators (ASOA), and other ophthalmic groups have undertaken significant efforts to educate members who are subject to this policy about the data reporting requirements. This effort is borne out by CMS' own data in the proposed rule that shows a high rate of participation by ophthalmology. **We encourage CMS to reach out to those specialties that are not reporting at such a high rate, so all data is available before CMS draws conclusions about post-operative care in general.**
- **We are concerned that CMS is already making assumptions that physicians are not performing post-operative care associated with procedures that have a 10-day global period without providing data to support that conclusion.** CMS notes that procedures with 10-day globals are the least likely to have reported post-operative visits, and even those practices that are "robust" reporters are only reporting a low number of post-operative visits on the 10-day global procedures. CMS assumes that the post-operative visits are not being performed but makes no comment on what specific 10-day procedures are the least likely to have post-op care reported and by what specialty. As CMS notes, there are differences in the level of reporting across specialties. It is possible that the 10-day global procedures in question are clustered in one or several specialties that have a low overall rate of reporting. Without complete information, it is impossible to draw a conclusion. **We urge CMS to release additional information on the specific codes not being reported and perform additional validation on the number of post-operative visits furnished during 10-day global periods.**
- **We do not recommend CMS add to surgeons' burden by requiring they report the 54 modifier for surgical care only, even if they do not anticipate a formal transition of care to another physician for post-operative care.** Ophthalmologists frequently co-manage post-operative care with other ophthalmologists or optometrists, usually for the convenience of the patient. Physicians who do this routinely are aware of the billing requirements and are using the 54 and 55 modifiers as necessary. If the modifiers are not being used, then it is unlikely anyone but the surgeon or another physician in his or her practice is providing the post-operative care. If CMS is losing track of post-operative visits when they

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are performed by another physician, it may be that the physician providing post-op care is not in the cohort of physicians required to report, such as those in groups of 9 or fewer practitioners or an excluded state. **We continue to encourage CMS to identify additional methods of validating the data collected without additional onerous reporting requirements.**

- **As we have stated above, we believe the current RUC values accurately represent post-operative work in incorporating both the type and number of post-operative visits.** The RUC process ensures that the unique type of post-operative care required following ophthalmic procedures is accurately valued relative to the specific post-operative requirements of other specialties. **As we noted above, CMS has taken the RUC-recommended values for the majority of proposed values in this proposed rule. We encourage CMS to maintain that policy when surgical codes are revalued in the future.**

### **MEDICARE PHYSICIAN FEE SCHEDULE**

- **ASCRS and OOSS continue to support the AMA's Relative Value Update Committee (RUC) process as the most appropriate means of valuing physician services.** The process, which is well understood by physicians, ensures that every code is carefully evaluated, accounting for the time and intensity, as well as pre- and post-operative care and the practice expense (PE) units, which, in the case of ophthalmology, are unique to our specialty. In addition, the RUC process ensures the resource-based relative value of the codes is maintained. **ASCRS and OOSS recommend CMS accept the RUC-recommended values for all codes in 2019.**
- **We are concerned that CMS is again ignoring the intensity of certain procedures in assigning Work RVUs and making further arbitrary and inaccurate refinements to RUC-approved values—many of which were approved by the committee unanimously.** For all the ophthalmology codes that CMS has proposed additional refinements to for 2019, CMS makes further reductions to WRVUs primarily on the basis of the reduced survey time reported. WRVUs must be based on both time and intensity of the procedure, and the RUC has adjusted for instances when time associated with a procedure dropped, but not the intensity, by shifting the intensity per minute to the remaining time associated with the procedure. **CMS' proposals ignore RUC's adjustment to account for intensity and reduce the values of the WRVUs arbitrarily.**

### ***CPT Code 65210, Removal of Foreign Body—Eye***

- **ASCRS and OOSS oppose the CMS-proposed devaluation of the WRVUs for 65210, Removal of Foreign Body, External Eye; Conjunctival Embedded (Includes Concretions), Subconjunctival, r Scleral Nonperforating, to 0.61 in 2019.** During its consideration of this code, the RUC noted that the code had never been surveyed and the time was based on flawed Harvard data. The RUC determined that the survey showed the current time value based on Harvard data was inaccurate, but that the work associated with the procedure was fundamentally the same and valued the code accordingly. However, CMS notes that the RUC did not adequately account for the reduction in the overall time of the procedure and reduced it further, without taking into account the unchanged intensity of the procedure. **ASCRS and OOSS recommend CMS accept the unanimously approved RUC work RVU of 0.75 for 65210.**

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- **ASCRS and OOSS appreciate that CMS is not making any refinements to direct PE for 65210 or the other code in the family, 65210, and recommend no further refinements because the screening lane (EL006) is in use for the entire procedure.** In ophthalmology, the screening lane functions as the exam room for patients. It is in use for the entirety of ophthalmic care, including pre- intra-, and post-service. This direct input cannot be used for another patient at all during the procedure. **We recommend CMS accept RUC's recommendation to include the use of the screening lane in the direct PE for the entirety of the procedure.**

#### *CPT Codes 67505, 67515, Injection—Eye*

- **ASCRS and OOSS oppose the CMS-proposed devaluation of the WRVUs for 67505, Retrobulbar Injection; Alcohol, from 1.27 in 2018 to 0.94 in 2019.** CMS states that previously, this code had a lower WRVU than the related code 67500, whose RUC-recommended value CMS has accepted and, therefore, should continue to have a lower WRVU. However, the most recent survey data finds that while 67505 has a lower time value than 67500, it is a more intense procedure **due to the risk of death if the absolute alcohol is accidentally injected into the optic nerve sheath.** CMS again discounts the intensity of the procedure by proposing a lower WRVU. **We recommend CMS accept the RUC's recommended value of 1.18 WRVU for 67505.**
- **ASCRS and OOSS oppose the CMS-proposed devaluation of the WRVUs for 67515, Injection of Medication or Other Substance into Tenon's Capsule, from 1.40 in 2018 to 0.75 in 2019.** Similar to the above codes, this service is a highly intense procedure that requires injecting medication in an area next to the eye that the physician cannot see, and risks impacting the patient's vision if not done correctly. CMS is inappropriately proposing to reduce the value further by crosswalking to a less intense code, 64450. **Therefore, we recommend CMS increase the work RVUs for 67515 to 0.84 to align with the RUC recommendation.**

#### *CPT Code 76514, Echo Exam of Eye Thickness*

- **ASCRS and OOSS oppose the CMS-proposed devaluation of the work RVUs for 76514, Ophthalmic Ultrasound, Diagnostic; Corneal Pachymetry, Unilateral or Bilateral (Determination of Corneal Thickness), from 0.17 in 2018 to 0.14 in 2019.** While time associated with this procedure decreased significantly, and newer, hand-held pachymeters can be operated by technicians, the work for this procedure is fundamentally unchanged since the physician must still interpret the measurements, which has a higher level of intensity. The RUC appropriately maintained the WRVU based on the unchanged work by reducing the inter-service time but increasing the intensity of those intra-service minutes to reflect the physician's interpretation of the measurements. Further, the RUC questioned the validity of the survey time data since the survey was conducted prior to a change in the instructions that inform respondents not to round up time values. **Therefore, we recommend CMS increase the work RVUs for 76515 to 0.17 to align with the RUC recommendation.**

#### TELEMEDICINE

- **ASCRS and OOSS appreciate CMS' efforts to extend telemedicine services to Medicare beneficiaries. We support the creation of a new virtual check-in code.** This code will alleviate some of the need for

beneficiaries to travel to the physician's office when no care, or no immediate care, is necessary. Some ophthalmologists have already integrated telemedicine into their practices and note that the type of check-in CMS is proposing is a key tool used for non-Medicare patients—and they are eager to extend the service to Medicare beneficiaries. For example, ASCRS members report they have assessed patients who are traveling overseas through designated apps and been able to determine that the patient would not need to curtail travel and return home to see the ophthalmologist in person. In addition, we appreciate that CMS has removed the originating site requirements for these virtual check-ins, so any beneficiary who chooses to may use this service. **We recommend CMS finalize the proposal for virtual check-ins.**

- **In addition, we recommend CMS identify additional telemedicine options for Medicare beneficiaries.** The requirements that beneficiaries be in a rural or healthcare provider shortage area and be physically present in a healthcare facility to receive care via telemedicine limits the availability and usability of this service. As telemedicine applications become more robust, and beneficiaries who are familiar with them age into the Medicare program, there will be greater demand for these types of services. **We encourage CMS to meet this growing demand in future years.**

## CONCLUSION

**ASCRS and OOSS appreciate the proposals CMS has made that seek to reduce the administrative and regulatory burden on physicians, but oppose the proposals related to E/M visits because they will result in reduced physician reimbursement and negatively affect the relativity of the physician fee schedule. We believe CMS' proposals are not resource-based and are arbitrarily valued. We recommend they not be finalized and to allow physician input in their review through the CPT and RUC process.** Conversely, we believe the continued MIPS transition period will give physicians and practices additional time to implement the program. In addition, the new reporting requirements and scoring methodology in the Promoting Interoperability category will improve ophthalmologists' ability to participate in the category. We are encouraged by the effort to simplify and streamline the Promoting Interoperability category and encourage CMS to make similar simplifications to the MIPS program as a whole.

Thank you for providing our organizations with the opportunity to present our comments on the proposed rule. Should you have any questions regarding our comments, please do not hesitate to contact Allison Madson, ASCRS manager of regulatory affairs, at [amadson@ascrs.org](mailto:amadson@ascrs.org) or 703-591-2220, or Michael Romansky, OOSS Washington counsel, at [mromansky@ooss.org](mailto:mromansky@ooss.org) or 301-332-6474.

Sincerely,



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