



OUTPATIENT OPHTHALMIC  
SURGERY SOCIETY

September 11, 2017

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 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program**

Dear Ms. Verma:

The American Society of Cataract and Refractive Surgery (ASCRS) is a medical specialty society representing nearly 10,000 ophthalmologists in the United States and abroad who share a particular interest in cataract and refractive surgical care.

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).

Thank you for the opportunity to provide comments on the 2018 Medicare Physician Fee Schedule proposed rule. We especially appreciate the focus CMS has put on proposing ways to reduce the regulatory burden on physicians in this proposed rule, **such as eased 2016 requirements for the legacy reporting programs to impact 2018 payments and accommodations for small practices participating in the 2018 QPP. Reducing the regulatory and administrative burden on physicians and practices has long been the foundation of both ASCRS' and OOSS' advocacy efforts, and therefore, CMS should consider our comments in their entirety as recommendations to reduce regulatory burden.** We believe reducing the regulatory burden will ensure physicians can devote the maximum time to patient care and maintain a strong doctor-patient relationship.

**We thank CMS for seeking to reduce the burden from the legacy quality reporting programs, and urge CMS to provide further regulatory relief by modifying the requirements to ensure physicians who attempted to report any data for 2016 will not be penalized in 2018. Specifically:**

- **PQRS – We recommend that CMS reduce the reporting requirements for this program so that any physician who sat least attempted to report any PQRS data in 2016 would avoid the 2% penalty in 2018.** Physicians who did not submit any data in 2016 would be subject to the penalty.
- **VBPM – We recommend CMS continue the current policy that any physician who avoided the PQRS penalty in 2018, including by attempting to report any quality data as requested above, would be**

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**exempt from any automatic VBPM penalties. We support CMS' proposal to decrease the maximum downward adjustment from 2% to 1%.**

- **Meaningful Use – We recommend CMS establish a new “Administrative Burden” category of hardship exemption for the 2016 MU performance year.**

In addition, ASCRS and OOSS are offering comments on the following proposals and requests for comments in the proposed rule:

- **Support for CMS' decision to re-value updated codes at the RUC-recommended values; however, we oppose the RUC-recommended value for 65820, correction of trichiasis.**
- **Continued support for improving cost measure attribution through the use of patient relationship modifiers; and continued request for additional information for how these modifiers will be used to measure and score cost.**
- **Support for making some clarifications to Evaluation and Management (E/M) Codes documentation guidelines; however, we do not believe the codes should be modified to be based solely on medical decision-making and time.**
- **Support for further regulatory relief for surgical practices, including related to the global surgery data collection. We recommend CMS set an end date to the global surgery data collection requirement and provide additional details on the data already collected and how it will be used.**

#### **Further Relief from Legacy Reporting Programs**

**ASCRS and OOSS appreciate CMS' proposals to modify 2016 reporting requirements for the legacy reporting programs, since they will help to ensure more physicians and practices avoid penalties in 2018. However, we recommend CMS provide further relief in the final rule.** Since its enactment in 2015, ophthalmologists and ophthalmic practices have been focusing on the implementation of the Medicare Access and CHIP Reauthorization Act (MACRA). MACRA represents the biggest change to physician Medicare payment in decades, and its implementation has placed a significant burden on physicians and practices transitioning to the new system. **In order to create a smooth transition to MACRA, CMS could provide additional relief to physicians participating in the legacy programs.**

**To achieve this, we recommend CMS better align the requirements of the previous programs with the 2017 requirements of their replacement, the Merit-Based Incentive Payment System (MIPS).** Congress created MIPS as a streamlined program to address many of the criticisms of the legacy programs, such as that they were overly punitive, relied on “all-or-nothing” scoring structures, and were oftentimes redundant or not clinically relevant—especially for specialists, such as ophthalmologists. Recognizing the need for a more moderate transition to the new program, CMS offered options for the first year of the program, such as “Pick Your Pace,” and reduced the Cost category weight to 0% of the first year's score to allow physicians time to understand and implement the new program in their practices without facing penalties. **Therefore, while CMS is proposing welcome relief from the legacy programs, we believe the proposals related to 2016 PQRS, VBPM, and Meaningful Use to impact 2018 payments should be further modified to align with the policies finalized for the first transition year of MIPS.**

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**PQRS**

- **We appreciate CMS' proposal to reduce the required number of measures reported in 2016 to six, down from nine, with no requirement for a cross-cutting measure, as well as no required number of domains to avoid the 2018 penalty. While this will reduce regulatory burden on our members considerably, some specialists, such as ophthalmologists, may still struggle to report on six clinically relevant measures. To ensure as many physicians be held harmless from 2018 penalties as possible, we recommend CMS allow any physician who attempted to report any data in 2016 to avoid the negative payment adjustment.** CMS has finalized for 2017 that any physician or group reporting six measures, with at least one being an outcome measure, for at least 90 days would be considered a full participant in the Quality category of MIPS and eligible to receive a bonus. However, any physician or group who reports just one measure on one patient in 2017 would be able to avoid the entire MIPS penalty. **Given that the 2017 minimum requirements for MIPS is to report just one measure and not have to reach any data completeness threshold, physicians who reported any amount of data in 2016 should be considered successful PQRS reporters for 2018 payment.**
- **Reporting the proposed six measures, with full data completeness requirements in 2016, may still mean that some ophthalmologists, particularly sub-specialists, will not be successful in PQRS and avoid the penalty.** Since increasing the PQRS requirements to nine measures, we have heard from many practices that have had difficulty meeting PQRS. While there are ample ophthalmology measures to meet nine in total, individual sub-specialty ophthalmologists, such as corneal, retina, or oculoplastics, may not see a wide enough variety of patients to be able to report on nine measures, especially in different domains. In addition, the previous Measures Applicability Validation (MAV) process often identified measures, such as body mass index, that are not relevant to ophthalmology as available, and penalized physicians who did not report the full number of measures. Under MIPS for 2017, sub-specialists can avoid the penalty with one measure or participate fully as a group.
- Finally, the "all-or-nothing" scoring of PQRS means that simple coding errors cause practices who think they are participating fully in PQRS to receive penalties. Oftentimes, EHR or practice management software upgrades temporarily override settings to report PQRS measures, and practices are unaware, causing them to miss data completeness thresholds. In essence, these practices who attempt to participate fully and miss meeting PQRS by narrow margins are penalized the same as practices that did nothing at all. **MIPS has removed the majority of the "all-or-nothing" scoring, and therefore, CMS should align the last year of PQRS with that in mind. Physicians should satisfy the PQRS requirements by attempting to report any amount of quality data in 2016.**

**VBPM**

- **ASCRS and OOSS thank CMS and support the proposal to modify the program requirements for the 2016 VBPM to hold any practice that participated in PQRS in 2016 harmless from downward payment adjustments under quality tiering. However, we urge CMS to finalize our recommendation that a physician who attempted to submit any quality data in 2016 would satisfy the PQRS requirement and, therefore, not be subject to the automatic VBPM penalty. In addition, we support CMS' proposal to reduce the maximum downward adjustment from 2% to 1% for any practice that did not submit any quality data and recommend CMS finalize both proposals.**

- **We believe holding physicians who submit any data for PQRS harmless from the VBPM downward adjustments from quality tiering would be consistent with the policy CMS has finalized regarding the Cost category of MIPS. Specifically, the Cost category will not be weighted as part of the 2017 final score—as well as the proposed 2018 final score. In addition, physicians should not be penalized using the flawed measures that continue to be included in the VBPM and the Cost category under MIPS.** ASCRS has consistently opposed the cost measures used in the VBPM—and held over into MIPS—due to the flawed attribution methodology and lack of risk adjustment. The measures are primary care-based, and specialists, such as ophthalmologists, have little ability to impact their own scores on VBPM measures or receive any relevant clinical information from their QRUR feedback reports. CMS has agreed with our recommendations to re-weight the Cost category for MIPS in 2017 and proposes to do so in 2018 as well. CMS is in the process of creating more clinically relevant episode-based cost measures, and ASCRS is participating in multiple technical expert panels to provide feedback on the measures as they are developed. We have urged CMS not to use the current cost measures to score clinicians until they can improve attribution methodology and incorporate risk adjustment. **To ensure physicians are not subject to these flawed measures for the 2016 VBPM, we urge CMS to modify its proposal further for 2016 PQRS to consider a physician who attempts to report any quality data also a successful participant in the Value Based Payment Modifier program.**

### *Meaningful Use*

- **While we appreciate that CMS proposes to lower the required number of electronic clinical quality measures to be consistent with its proposals related to PQRS, we urge CMS to lower the requirement further to align with our recommendations that physicians who attempt to report any data be held harmless from a penalty. ASCRS and OOSS were disappointed that CMS did not offer any proposals related to Meaningful Use hardship exemptions, as this program continues to be challenging for our members and a significant source of regulatory burden. Therefore, we recommend CMS create a new “Administrative Burden” category for hardship exemptions to relieve the burden on practices who cannot meet Meaningful Use requirements.**
- **Many ophthalmology practices are burdened by the cost of implementing EHR systems or find meeting the program requirements difficult since they are not clinically relevant or rely on the actions of other providers or patients.** In many cases, ophthalmology practices are composed of one or a few practitioners, and operate as a small business. Implementing an EHR system can be very costly in terms of the actual cost of the system and the disruption to the practice. Many practices have analyzed the cost and benefits of the systems and determined that any potential incentives that were available under Meaningful Use, or may be under MIPS, did not make up for the time spent away from patient care, the burden of implementing the system, and the difficulty of meeting Meaningful Use measures that are not clinically relevant, and therefore, have opted not to implement EHR.
- Despite these disincentives to implement the program, many ophthalmology practices have implemented EHR and attempted to meet the Meaningful Use requirements in good faith, but due to the “all-or-nothing” requirements of the program, they were not successful. Measures related to Health Information Exchange, Patient Electronic Access, and Secure Messaging objectives rely on the action of other providers or patients, and are outside the direct control of the physician. **Specialists, such as**

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**ophthalmologists, have consistently questioned the overall relevance of the Meaningful Use program to their practices due to the burden of implementing an EHR, lack of clinically relevant measures, and the inclusion of measures outside the physician's control. Therefore, to provide additional relief for physicians, CMS should offer a new hardship exemption for administrative burden in this last year of the meaningful use program.**

#### **Revaluation of Codes Under the Physician Fee Schedule**

- **ASCRS and OOSS support CMS' proposal to revalue codes for 2018 at the original RUC-recommended values in most cases. ASCRS and OOSS support the AMA's Relative Value Update Committee (RUC) process as the appropriate methodology for ensuring services are accurately valued.** 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. In the past, we have had concerns with CMS' process, which may not have adequately factored both time and intensity into its proposed work values for certain services, including several ophthalmic procedures. **We encourage CMS to continue basing the majority of its revaluation proposals on the RUC-recommended values.**
- **Specifically, we support CMS' proposal to accept the RUC-recommended value for several ophthalmic biometry codes, including 76516, 76519, and 92136. The RUC-recommended values for 76519 and 92136 include time for physicians to discuss lens implantation options with the patient. Since the codes were last surveyed, new lens options have become available, which increases the time necessary to ensure the patient is fully aware of his or her available choices.**
- **Despite our support for the RUC process, we oppose the RUC-recommended, and CMS-proposed, devaluation of the work RVUs for 67820, correction of trichiasis, from 0.71 in 2017 to 0.32 in 2018.** Following the survey of this code in early 2016, the ophthalmic community recommended reducing the work RVUs to 0.40. This service is typically furnished during an E/M visit, and thus, the ophthalmic community recommended decreases in both the pre- and post-service times to account for this. The submitted RVUs are below the survey's 25th percentile. The RUC further reduced the pre- and post-service time, but did not fully account for the additional work required beyond what was already furnished as part of the office visit. Therefore, **we recommend CMS increase the work RVUs for 67820 to 0.40, to align with the specialty recommendations.**

#### ***Practice Expense Equipment Utilization Time Request for Comment***

- ASCRS and OOSS are considering CMS' request for comment regarding setting a more accurate equipment utilization rate for some equipment, rather than the standard 50% for equipment other than expensive diagnostic imaging equipment. Gathering robust and actionable data will take time, and we therefore will work with the ophthalmic community to develop specific recommendations at a later date.

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## **Patient Relationship Codes**

ASCRS and OOSS support the creation of new patient relationship modifiers to assist in accurately attributing the cost of care. While we support CMS' proposal that reporting the codes in 2018 be voluntary, we continue to seek additional information from CMS regarding how these modifiers will be incorporated into the methodology for calculating a physician's cost scores under MIPS or other programs, and encourage CMS to provide clarification as soon as possible. Therefore, we recommend reporting by physicians remain voluntary, or delay the implementation, until additional information is available.

- **Patient relationship categories and modifiers have the potential to more accurately identify which physician is responsible for a patient's care.** ASCRS has long opposed CMS' existing policies for attributing patients for resource use measures—first as part of the Value-Based Payment Modifier (VBPM) and now to continue in the MIPS program—because the measures are primary care-based and potentially hold certain physicians, particularly specialists, such as ophthalmologists, responsible for care they did not provide. The current methodology attributes a patient in a two-step process: first, if the patient sees a primary care doctor during the year, he is attributed to the primary care physician; second, if he does not see a primary care physician, he is attributed to whichever physician provides the plurality of E/M visits. Since ophthalmologists bill a high volume of E/M, they may be attributed patients—and held responsible for the cost of caring for those beneficiaries—even if they did not provide it. **Since the current methodology for determining cost is not effective, it is imperative that CMS ensure these modifiers are incorporated into a new methodology in a way that accurately holds physicians, particularly specialists, such as ophthalmologists, accountable for the cost of the care they provide and control.**
- **While we appreciate CMS has listened to our recommendations and those of the medical community and is formally proposing to use modifiers to represent patient relationships, we continue to question how CMS will incorporate these modifiers into the cost measure methodology.** Without a clear proposal, it is difficult to comment on how effective the modifiers will be in attributing the cost of care. **We continue to urge CMS to provide additional details, so we can analyze the potential effectiveness. Reporting of these codes should remain voluntary, or be delayed, until CMS provides additional details.**
- **We recommend CMS work with the current technical expert panels (TEPs) who are developing new episode-based cost measures, including for cataract surgery, so that the patient relationship modifiers are incorporated in the attribution methodology.** ASCRS has been participating in the TEPs, and while there has been some discussion of the patient relationship modifiers, to this point there has been no effort to incorporate them into the measures. **We believe including the patient relationship modifiers in the attribution methodology will allow physicians to pro-actively signal which episodes are within their direct control, and therefore, be attributed.**

### ***Factors to Consider When Incorporating Patient Relationship Modifiers into Cost Methodology***

- **When designing a framework for how patient relationship modifiers will be used to determine a physician's cost, ASCRS and OOSS urge CMS to develop a proposal that does not hold physicians who report a specific patient relationship accountable for the costs of care they did not provide and cannot control.** Similar to the current cost attribution method, it is possible that an ophthalmologist might be

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the only physician a patient sees in a particular year or performance period who claims a relationship of leading the management of care for a chronic disease or acute episode. However, if a patient is treated for another disease or acute episode unrelated to the care the ophthalmologist provides, and no other physician claims to have the overall management of that unrelated care, the ophthalmologist should not be attributed the cost for all of the care provided to the patient—which is out of an ophthalmologist's control.

- **CMS must clearly define how costs will be attributed to specific physicians based on the relationship they report. We urge CMS to provide additional information regarding how these patient relationship categories and modifiers will be used in relation to episode groups.** Physicians should know in advance what costs they are responsible for based on the type of relationship they are claiming. In addition, physicians claiming to have the ultimate responsibility for the patient should know what costs will be included in the episode, and have the opportunity to indicate what costs within the episode are within their control, so they are not held accountable for the cost of care unrelated to the disease or acute episode or from other providers. Physicians also should not be attributed the extra costs for particular treatments required due to other care the patient is receiving from other physicians. For example, if a cataract patient is prescribed Tamsulosin by a primary care physician, that patient will likely require the use of iris retractors, leading to the use of the complex cataract surgery code 66982, reimbursed at a higher value than cataract surgery, 66984. **Only costs within the control of the physician attributed the episode should be included.**
- **The framework for including patient relationship modifiers in cost measures use should also take into account the severity of the patient's disease, which impacts the type and cost of care a physician may provide.** Treating patients with diabetic retinopathy, for example, may involve several different courses depending on severity. Patients with well-controlled blood sugar may not have a severe case of diabetic retinopathy and not require more than annual exams. However, patients with severe cases may require extensive intravitreal injections to curb the progression of the disease. If the injections are not sufficient to curb the progression of the disease, laser treatment or surgery may be required to prevent the patient from losing his or her sight completely. Treating the more severe case would become much more expensive than a mild or moderate case. In addition, the presence of certain co-morbidities may impact the complexity of cataract surgery, and may lead to complications during surgery. **Physicians may report the same modifier for all patients with the same chronic disease or who underwent the same procedure, but without a way to indicate the severity of the disease, the relationship modifier may not accurately represent the cost of treating that patient.**

**Physicians should not be held accountable for care they, or other physicians, are required to provide due to issues, such as patient compliance or socioeconomic factors, that are beyond their control.** For instance, glaucoma patients will never fully regain their vision, but preventing further progression of the disease generally depends on the patient's use of prescribed topical treatment of eye drops, if surgery is not warranted, or is opted against, and following up with the ophthalmologist's office for regular eye pressure checks and other glaucoma-related testing. Patient compliance can have an impact on the progression of the disease and, ultimately, the cost of care. If a patient cannot make his or her regularly scheduled appointments, or does not regularly use prescribed eye drops, it may require costlier treatment, such as surgical intervention. In addition, older patients with glaucoma may have difficulty withstanding visual field testing in both eyes in one visit and may require additional visits. Patients with severe diabetic retinopathy must come to the physician's office for regular intravitreal injections. If a

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patient misses several appointments, the treatment cannot simply be restarted, and may require surgery.

- **The ophthalmologist treating this type of patient should not be penalized for having to provide the more expensive care when the patient could not comply with the original course of treatment depending on severity.** There are also a variety of socioeconomic factors that impact overall care for certain patients. For example, lower income patients or patients in rural areas may have difficulty making regularly scheduled appointments if they do not have access to reliable transportation or must travel longer distances. In general, ophthalmologists tend to treat older Medicare patients, who may not have the manual dexterity required to administer their drops. In addition, older patients have mobility issues and rely on other caregivers to bring them to the physician's office. **All of these factors can impact their ability to receive regular care or the ultimate cost of the care.**
- **Furthermore, if a physician and patient decide a costlier treatment is a better option because it will lead to a better clinical outcome or cost savings in the future, physicians should not be penalized for the increased cost of the care.** For example, some glaucoma patients may be well managed using drops but would benefit from surgery. While the surgery may increase the cost of the treatment in the immediate term, maintaining the patient's regimen of drops for the chronic disease would be far costlier to Medicare in the long term. For example, a 2012 study found that the savings of performing laser trabeculoplasty (LTP) as opposed to continuing a course of generic topical prostaglandin analogs (PGAs) are realized in 13.1 months.<sup>1</sup> Another 2012 study estimated LTP provided a cost saving of \$2,645 per quality adjusted life year compared to PGAs.<sup>2</sup> **The savings to Medicare, as well as the potential for improved quality of life for the patient, are significant. However, if cost measures only compare the cost of treating all beneficiaries with the same patient relationship modifier and do not take a holistic view, especially when considering the ongoing costs of caring for chronic disease over time, physicians could ultimately be penalized for providing care that may cost more in the immediate term, but have lasting savings over the long term.**
- **We also recommend CMS provide additional guidance related to reporting these modifiers, such as how physicians are expected to report when multiple types of relationships exist with a single patient, how to indicate that a relationship with a patient has changed, and what will happen if no physician claims a relationship with a particular patient.** These questions still need to be answered but could have an impact on the physician's cost score. For example, ophthalmologists treat both chronic disease and perform surgery. It is not unusual for a patient with a chronic disease, such as glaucoma, to require cataract surgery. Should the physician report both modifiers related to chronic care management and episodic surgical care? Furthermore, if, in the example above, a physician performs a surgical intervention on a glaucoma patient, the patient may need less regular care by the ophthalmologist and be able to discontinue the use of eye drops—both of which create a long-term cost savings—but the patient will never fully recover and will still have glaucoma. The physician is still providing chronic care, but at a different level. Finally, if no physician claims a relationship with a patient, how are the costs of that beneficiary's care attributed? In that case, CMS should not revert to the current attribution methodology based on primary care services mentioned above. **We believe CMS must consider these**

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<sup>1</sup> Seider MI, Keenan JD, Han Y. Cost of Selective Laser Trabeculoplasty vs Topical Medications for Glaucoma. Arch Ophthalmol. 2012;130(4):529-530. doi:10.1001/archophthalmol.2012.355.

<sup>2</sup> Stein JD, Kim DD, Peck WW, et al. Cost-effectiveness of medications compared with laser trabeculoplasty in patients with newly diagnosed open-angle glaucoma. Arch Ophthalmol. 2012; 130:497-505.



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points when factoring patient relationship modifiers into cost scores, and provide additional guidance to physicians on how to address multiple relationships or when a relationship with a patient changes.

**As noted above, we appreciate that CMS has made reporting of patient relationship modifiers voluntary in 2018, and we urge that it at least remain voluntary, if not delayed, until CMS can provide additional details for how the modifiers will be factored into physician cost scores.**

### **E/M Codes Request for Information**

ASCRS and OOSS appreciate CMS' focus on providing regulatory relief throughout this proposed rule, and other recent rulemaking and requests for information. While there may be an opportunity to update or clarify some of the documentation requirements for E/M codes, we do not believe a full re-evaluation of the codes is necessary to provide regulatory relief for our members. Specifically, we would oppose any proposal that removed the requirements for history and physical exam and based the code level only on medical decision-making and/or time. Since the codes are well established, changing requirements could lead to more burden if physicians and practices had to learn a new system.

### ***Possible Updates to E/M Code Documentation Guidelines***

- **While ophthalmologists, who bill a high volume of E/M codes, are familiar with the current documentation guidelines, some ambiguities exist, causing many practitioners to feel they need to provide more detail than is necessary to support billing a specific level of E/M code.** For example, the 1997 guidelines with specialty specific exam elements including for the eye, identify 12 elements of the exam related specifically to the eye and a 13th element for the patient's mental status. All 12 plus the 13th element must be documented to meet the guidelines for a comprehensive exam. However, it isn't clear if the mental status can only be element #13 and not, for example, #6. Additionally, there is no confirmation that a negative response from the patient in the History of Present Illness (HPI) would count as an element. For example, a patient presents in the ophthalmologist's office with floaters, but responds he or she is not experiencing flashes when the physician inquires. Both floaters and flashes could be symptoms of a vitreous detachment, and therefore, ophthalmologists should ask patients whether they are experiencing either or both symptoms. The absence of "flashes" is a pertinent negative in regard to the patient's condition, but it is unclear whether it counts in the elements of the HPI? Further, there may be cases where a patient is experiencing multiple symptoms that may be categorized under the same element in the HPI. For example, a patient presents with complaints of a red eye (Quality). On inquiry, the patient also notes discharge (associated sign or symptom) **and** burning (associated sign or symptom). What is not clear is whether two "associated signs or symptoms" can be counted as two under the elements of the HPI or is it just one? **These are common occurrences in ophthalmology practices, and should be addressed to reduce ambiguity.**
- **CMS should also seek to clarify what type of practitioner is able to perform certain elements of the history of present illness.** Ophthalmology relies heavily on the assistance of allied health professionals, especially certified ophthalmic technicians. In certain areas of the documentation guidelines, CMS notes some tasks can be performed by registered nurses, but makes no mention of other types of professionals.

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- **We urge CMS to reduce burden by working with the medical community to update and clarify documentation guidelines to address frequent questions raised by physicians and other health professionals.** In addition, we recommend CMS provide additional training, including in-depth “train the trainer” sessions, to ensure physicians and practices clearly understand the requirements.

#### ***Concern with Removing Documentation Requirements for History and Physical Exam from E/M Visit Codes***

- **While we believe that medical decision-making and time are integral elements, they should not be the only determinants in the level of E/M visit code—either solely or together.** 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 determination of the level of E/M service and should be maintained.**

In general, we urge CMS to seek full input from the medical community before moving ahead with any changes to E/M codes, including the suggested clarifications noted above. Ophthalmologists bill a high volume of E/M codes, and even minor changes to the codes or their documentation would require physicians and practices a great deal of time to understand and implement.

#### **Relief from Global Surgery Data Collection Requirements**

ASCRS and OOSS appreciate that CMS scaled back its original proposal related to the global surgery data collection to limit the collection only to practices of 10 or more in certain states, and only for high-volume codes. However, we believe this program is a considerable regulatory burden and continue to question its usefulness. We encourage CMS to provide additional details on how much longer practices should report this data, how it is being validated, and how it will be used in the future.

- **As we have stated in previous comments and correspondence related to this issue, ASCRS does 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, which 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.**
- **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.**

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- **To reduce the regulatory and administrative burden on surgical practices, we recommend CMS announce an end date to the collection requirement. We recommend discontinuing the requirement at the end of CY 2017.**
  - **We request CMS provide timely feedback on the data collection to ensure the validity of the data.** In previous letters to CMS prior to the implementation of this program on July 1, 2017, we asked for clarification on several issues related to the logistics of reporting the data. While CMS provided that information, it did not answer questions related to the validity of the data and how it will be used. We are concerned that CMS has not put into place proper safeguards to ensure the data is reliable. For example, what steps is CMS taking to ensure incomplete data, such as practices who did not properly code each post-operative visit, is not interpreted as a visit or visits not occurring? Furthermore, what methods is CMS using to analyze the data, and how will it be incorporated into future code valuations? **We are concerned that this program has gone forward without complete consideration of its impact, and urge CMS to provide an immediate update on its data collection efforts to date.**

### Conclusion

**ASCRS and OOSS reiterate our support for CMS's initiatives to reduce the regulatory burden on physicians and practices. We continue to believe that further modifications to the 2016 reporting requirements for the legacy programs will provide the most relief to practices already struggling to implement the new MACRA program.**

In addition, we reiterate our support for CMS' decision to accept most RUC recommendations for revaluing codes in 2018. We continue to urge CMS to provide additional information on how new patient relationship modifiers will factor into physicians' cost scores in future years. In addition, we recommend some clarifications be made to E/M documentation guidelines to increase clarity, but we do not believe that a complete re-evaluation of these codes would ease regulatory burden. Finally, we urge CMS to discontinue the global surgery data collection effort and provide additional information on the data collected and analyzed to date.

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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, manager of regulatory affairs, ASCRS, at [amadson@ascrs.org](mailto:amadson@ascrs.org) or 703-591-2220; or Michael Romansky, Washington counsel, OOSS, at [mromansky@ooss.org](mailto:mromansky@ooss.org) or 301-332-6474.

Sincerely,



Bonnie An Henderson, MD  
President, ASCRS



Jeffrey Whitman, MD  
President, OOSS