Ophthalmology Takes Major Hits in 2015 Proposed Rule on Medicare Physician Fee Schedule


This analysis shows Ophthalmologists taking major hits nationally in regard to many facets of the rule.

The following is a brief review of some of the more important provisions. The Display version of the rule is posted at the link here and a more detailed analysis from the AAO will be forthcoming.


The proposed rule will be posted on July 11, 2014 with a comment period ending on September 2, 2014.

CMS Asserts Ophthalmology Overpaid for Malpractice Values for Five Years; Proposed Recalculation to Decrease Ophthalmology Payment by 2 Percent in 2015

The Centers for Medicare and Medicaid Services today released its proposed 2015 Medicare Physician Fee Schedule. The proposed rule shows a decrease to overall payments to ophthalmology of -2 percent due to an error that CMS made five years ago in calculating revised malpractice relative value units. CMS proposes to correct the error and recalculate the rates of ophthalmology and optometry.

Because of the error correction, several high-volume eye procedures, including CPT 66984 cataract are proposed for a 4 percent reduction in 2015. The Academy objects to this proposal and will have the data independently reviewed. At a minimum, The Academy will recommend that any change is phased in.

Value-based Modifier Penalty Doubles to 4 Percent for 2015 Reporting

CMS is required by Congress to adjust payments to all physicians based on their quality and resource use by 2017. The adjustment, called the value-based modifier, is phased-in over three years based on size of the physician practice. The VBM will first apply to practices with 100 or more providers in 2015, based on cost and quality data collected in 2013. It will subsequently apply to practices with 10 or more providers in 2016, calculated from data collected this year.
For this rule, CMS proposes that maximum negative adjustments would increase from 2 percent to 4 percent of payments for all physicians and non-physician eligible professionals in 2017. All physicians and non-physician eligible professionals who participate in fee-for-service Medicare, including solo practitioners, will be subject to the VBM payment adjustment in 2017, resulting from cost and quality data collected in 2015. Implementation of the VBM is based on participation in the Physician Quality Reporting System.

Successful participation in PQRS in 2015 will exempt physician practices with fewer than 10 providers from the proposed 4 percent downward VBM payment adjustment in 2017. Physicians who do not successfully participate in PQRS in 2015 will automatically receive downward adjustments. Because the value-based modifier is directly tied to PQRS, CMS is proposing to establish a corrections process to allow physicians a 90-day window after receiving their PQRS feedback reports to make corrections to their PQRS data. However, this process would only be available to providers using a data submission vendor or registry to participate in PQRS.

**Proposed Rule Offers No Guidance on 2015 SGR Reduction**

The proposed rule was silent on what the SGR reduction will be next year. Congress failed once again last fall to pass a permanent repeal of the Sustainable Growth Rate formula that determines the annual payment rate for physicians. It instead passed another one-year patch earlier this year. The 2015 conversion factor that is scheduled to go into effect on April 1, 2015 will not be addressed until the final rule is released in November. The Academy is continuing to work with lawmakers on Medicare payment reforms that would permanently repeal the SGR formula.

**CMS proposes to eliminate global surgery periods**

CMS is proposing to eliminate 10- and 90-day global surgical packages and instead make all surgical codes 000-day global periods over the next several years. Beginning in 2017, CMS would eliminate post-op visits from 10-day global codes and then 90-day global codes in 2018. New work values will be established based on data that CMS gathers regarding the particular services, as well as associated post-operative office visits.

**More Ophthalmology codes targeted as potentially misvalued**

Several ophthalmic services were proposed for review as potentially misvalued by CMS. In particular, it is targeting codes with more than $10 million in annual allowed charges that have not been RUC reviewed since 2009. Ophthalmology has several codes that meet this criterion including 66821 YAG laser, 65855 Trabeculoplasty, 67228 retinal photocoagulation, 68761 punctal plug closure, 92136 biometry and 92250 fundus photography.
Public Comment on Proposed New/Revised Payment Values to begin

CMS is proposing a new process for establishing physician-fee-schedule payment rates that will be more transparent and allow for greater public input prior to setting them. Under the new process, payment changes will go through notice and comment rule making, before being adopted starting in 2016. Under the current process, CMS doesn’t publish its acceptance or rejection of values as submitted by the AMA Specialty Society Relative-value Update Committee (RUC) until the final rule. Comments are submitted after the new payments are implemented beginning in January.

CMS to begin closer review of practice expense payments

CMS is not renewing its previous proposal that would have capped payment rates for practice expense payments, regardless of whether the service is performed in the physician office or the outpatient facility setting. It continues to believe, however, that practice expense payment differences may point to errors or other problems. CMS will explore options for gathering and reviewing new sources of data and seek input from the public for fairly valuing these services.

PQRS requirements to avoid penalty to be greater in 2015

Beginning in 2015, successful participation in PQRS will only enable providers to avoid penalties. CMS is proposing to raise the threshold necessary for physicians to avoid the PQRS penalty. In 2014, physicians must report three PQRS measures to avoid the 2016 penalty. Under this proposal, CMS is increasing the number of measures that physicians must report in 2015 from three to nine in order to avoid the 2 percent penalty in 2017. The proposal also includes two new proposed ophthalmology cataract related measures for unplanned vitrectomy, and one that measures the difference between planned and final refraction.

The agency also calls for the elimination of two ophthalmology measures, including the Age-Related Macular Degeneration (AMD): Dilated Macular Examination measure, and the AMD: Counseling on Antioxidant Supplement.

Additionally, CMS would eliminate the claims reporting option for select PQRS measures, including several for ophthalmology. The Academy opposes this proposal and intends to advocate for maintaining this important reporting option for all possible measures. Additionally, CMS is proposing to increase the minimum number of measures in a measures group, such as the cataract measures group, from four measures to six.
Under this proposal, physicians continue to have the option to participate in PQRS through qualified registry reporting, direct electronic health record (EHR) submission, or through participation in a qualified clinical data registry (QCDR) such as the Academy’s IRIS™ Registry. Congress established the QCDR designation as a mechanism to allow specialists to participate and lead quality measurement.

As a QCDR, the IRIS Registry allows the Academy to design, implement and report non-PQRS quality measures that are more meaningful to ophthalmic practices and their specific patient populations. In addition, participation in a QCDR would also allow providers to meet some requirements of the Medicare Electronic Health Record Incentive Program.

The CMS website includes a fact sheet about the 2015 proposed physician fee schedule.

**Ambulatory Surgery Center Payments Proposed to Increase Slightly in 2015**

In the proposed Ambulatory Surgery Center (ASC) rule also released this afternoon, CMS indicates that ASCs that satisfactorily report on quality measures will see a 2015 Conversion Factor of 43.918, up from 43.321. Payments to ASCs that fail to meet quality reporting program requirements will be decreased to 43.050.

Heeding the Academy’s opposition to this measure, CMS proposes that submission for the problematic cataract ASC-11 measure be voluntary, and clarifies that ASCs would not be subject to a payment adjustment for failing to report this measure.

The Academy asserts that this measure, which requires facilities to report pre- and post-operative patient visual function, is not appropriate for the ASC setting. The Academy, in collaboration with the American Society of Cataract and Refractive Surgery and the Outpatient Ophthalmic Surgery Society, is working to propose an alternative and more appropriate measure(s) for the program to be included in the final rule.