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Why Have Procedures Been Devalued? A CMS Payment Primer

Over the past year, ophthalmologists have been painfully surprised by payment cuts to a number of important CPT codes. Many members have called and emailed to ask: How did this happen? Why now? Why us? And what can we do about it?

Recent changes in the Relative Value Scale Update Committee (RUC)/CMS payment process are not targeted to any one subspecialty in ophthalmology—or even to ophthalmology. Several trends have brought about specific code changes.

The first trend is the political/policy objective of shifting money to primary care physicians (PCPs) from non-PCPs. This impacts both the RUC recommendations and the ultimate CMS decision in the Medicare Fee Schedule Final Rule. Payments to PCPs are up significantly since 2008—and because the process is intended to be budget neutral, the increases have generally been offset by cuts to procedural specialties. Changes have been unevenly distributed year to year by specialty, depending on which codes are up for review, the economic impact of the codes, etc.

The second trend is a shift from a "time plus intensity" formula to determine the work component of payment to one that is *very* heavily time-weighted. (Intensity includes technical skill, mental effort and judgment, and risk-associated stress). What this means, simplistically, is that if something takes 10 minutes—whether it is neurosurgery or toenail clipping—it is paid similarly. Ophthalmology procedures, on average, have been ranked among the highest in terms of intensity of service.

The third trend is the mandated misvalued code initiative, by which CMS will take $1 billion from physician payments annually for 3 years by reducing the payment for "misvalued codes." As you can imagine, in this scenario, "misvalued" has to equal "overvalued." CMS uses a number of "screens" to determine which CPT codes to survey for revaluation. These include aggregate cost, cost per code, changes in code volume, time since last surveyed, and (yes) politics.

Once a code is targeted, specialty societies are then obligated to survey their members to assess all the factors (including time) that go into the CPT code and to "value" it relative to other procedures—in and out of the specialty. (Some ask why specialty societies participate in this process. If they don't, their codes are at the mercy of other societies and of CMS. The Academy actively involves subspecialty societies to ensure that this complex and costly survey process is accurate.) After the ophthalmology team presents our findings, the RUC—which consists of representatives from across the medical community—develops its final recommendation. CMS then considers the RUC recommendation and decides whether to accept it or change it.

Here is where things have changed: Historically, CMS accepted about 95% of RUC recommendations. Now, CMS is increasingly ignoring the RUC recommendations.

Statistically, it is "our turn" to feel the pain of the code spotlight. Over the past 6 years, we have fared better than all other specialties except primary care in the aggregate economic impact of these cuts. Some specialties have seen a blended impact of a more than 50% cut in all their codes! We have been essentially flat over this period. While this is no cause for celebration, it is clear that we have not been singled out.

In appealing this, there are 2 approaches. The first is to go after specific codes: "Your final decision, CMS, is unfair in that it does not take into account the following facts about the work component of this code, and you need to amend your final recommendation." The second is to take a more general approach: "Your final decision, CMS, in not weighting the intensity component of the procedure actually violates the congressionally mandated process for code valuation, and you need to correct your whole process."

The first approach is almost always unsuccessful. The core problem is that the CMS process (in our opinion) has changed and is unfair—and perhaps illegal.

Therefore, the Academy (in partnership with several subspecialty societies) is challenging the CMS methodology. This way, it is not just one specialty whining over one code or family of codes. We can point to potentially violated congressional mandates. Although this involves many subspecialties, we are highlighting glaucoma and retina because our case is stronger with some of those codes. If we are successful, any changes will have an impact across all ophthalmology codes.

Much has already gone into this fight: money, trips to CMS and Capitol Hill, staff time, and volunteer efforts. I honestly can't predict the outcome, but we all agree it is critical.