



January 27, 2014

SUBMITTED VIA ELECTRONIC FILING AND REGULAR MAIL

Marilyn Tavenner, RN
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1600-FC
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014

Dear Administrator Tavenner:

On behalf of the American Academy of Otolaryngology—Head and Neck Surgery (AAO-HNS), I am pleased to submit the following comments on the “Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014” published in the *Federal Register* as a final notice on November 27, 2013. Our comments will address the following issues, in the order in which they appear in the proposed rule: (1) Sustainable Growth Rate (SGR); (2) Establishing Relative Value Units (RVUs) for CY 2014; (3) Other Otolaryngology Payment Issues within the 2014 MPFS; (4) Physician Compare Website; (5) Quality Reporting Initiatives; and (6) Value Based Payment Modifier and Physician Feedback Program.

I. MEDICARE SUSTAINABLE GROWTH RATE (SGR)

Over the past decade, the AAO-HNS and others in the physician community have repeatedly advocated for the reform and full repeal of the unstable and unsustainable Medicare physician payment formula. The failure to enact permanent reform has created an instability and uncertainty that undermines the ability of physicians to plan for the future, to provide for their employees, and to make investments to improve the quality and efficiency of the care they provide. After release of the final rule, Congress and the Administration took action to implement a three month “patch” which provided a .5% update to Medicare payments through March 31, 2014. Since the passage of that legislation, the Centers for Medicare & Medicaid Services (CMS) have reissued their payment files for CY 2014, to reflect the .5% update. While we appreciate this short term update, the Academy continues to be concerned that these short term patches are not real solutions to the broader problem the flawed SGR formula presents.

As such, the Academy continues to advocate for permanent repeal of the SGR, and has submitted numerous comments to the U.S. House of Representatives’ Energy & Commerce and Ways & Means Committees, as well as the Senate Committee on Finance, regarding their draft repeal legislation and proposals. To access the Academy’s comments on SGR repeal visit: <http://www.entnet.org/Practice/members/Advocacy.cfm>. We appreciate, and are encouraged by, the efforts of lawmakers and CMS in this regard over recent months and welcome efforts by CMS to work with Congress to achieve full repeal of the SGR formula prior to the March 31, 2014 deadline.

II. ESTABLISHING RELATIVE VALUE UNITS (RVUS) FOR CY 2014

Within this section of the final rule, CMS first addresses comments received on the 2013 final MPFS and the outcome of refinement panels convened during 2013 related to these comments. CMS then goes on to discuss their proposed interim values for CY 2014 for services which were reviewed by the AMA RUC. Our comments on both sections are outlined below.

A. CMS' Response to Comments on CY 2013 Interim RVUs

i. 2013 Refinement Panel for EMG Codes for 2014

The Academy greatly appreciates CMS' decision to revise the physician work RVUs for CPT 95886 and 95887 *EMG extremity add-on and EMG non-extremity add-on* from the 2013 interim work RVUs of 0.70 and 0.47, respectively, to 0.86 and 0.71 for CY 2014. While the 2014 approved values are still lower than the RUC and refinement panel recommended values, they are more consistent with the input provided by the Academy and other participating "related specialties" in the refinement panel convened for these codes. ***Thus, we support CMS' decision to implement these modifications in the final rule.***

ii. Modifications to Physician Work RVUs for 2014

The Academy greatly appreciates CMS' decision to revise the physician work RVU for CPT 13152 *Repair, complex, eyelids, nose, ears, and/or lips; 2.5 cm to 7.5 cm* from the 2013 interim work RVU of 4.90 to the RUC recommended work RVU of 5.34 for CY 2014. This is consistent with the both the RUC and specialty society recommendations regarding appropriate valuation for this service, and we support CMS' decision to implement this modification in the final rule.

In contrast, we are disappointed CMS did not accept our recommendations to increase the work values to match the AMA RUC recommended values for the pediatric polysomnography codes. We continue to believe the RUC recommendations of 3.00 and 3.20 physician work RVUs respectively were appropriate given the difficulty of performing sleep studies on children. Specifically, we believe children require significantly more effort than adults in order to obtain an accurate polysomnogram. They frequently pull leads off, require more attention, and may even require mild sedation. Additionally, they are even more complex to titrate due to their resistance to accepting the CPAP mask. Therefore, the minimal increase in work value over the adult polysomnography codes which are finalized by CMS for CY 2014 does not accurately capture the additional work required when conducting these studies on children. ***Thus, we believe the RUC values for physician work for CPT 95782 and 95783 are more appropriate and urge CMS to reconsider the valuation for these new codes in future rulemaking.***

iii. Modifications to Practice Expense RVUs

We are also pleased that CMS agreed with many of our comments related to the direct practice expense inputs for CPT 31231 *Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)*. Specifically, we greatly appreciate CMS' modification to include the second endoscope required for this procedure. We also appreciate CMS' agreement with our comments that the times assigned to equipment was in all cases too low and to accordingly increase the minutes assigned to the equipment which increased the PE RVUs for this code.

B. Proposed Interim RVUs for RUC Reviewed Codes in CY 2014

Within the final rule, CMS comments directly on several of the services presented to the AMA RUC by AAO-HNS, we will address those comments in turn below, however, ***we would like to begin by thanking CMS for finalizing the AMA RUC recommended physician work values for 10 CPT codes surveyed or commented on by***



the Academy (CPT 31237, 31283, 31239, 31240, 43220, 43226, 43450, 43453, 92521, and 92522) within the AMA RUC cycle.

i. Practice Expense for Nasal Endoscopy Codes (31237 & 31238)

The Academy is perplexed at CMS' decision to modify the practice expense for CPT codes 31237 and 31238 within the 2014 final rule. Specifically, CMS chose to reduce the clinical staff time when performed in the office setting, for checking tubes, monitors, and drains from the PEAC standard 15 minutes for 000 global services, to 5 minutes. CMS stated that this was based on their "clinical review". The Academy respectfully disagrees with this modification by the Agency, and urges CMS to retain the 15 minutes for clinical staff monitoring to maintain consistency in the direct practice expense inputs for services across the RBRVS. Additionally, and as was noted during presentation to the AMA RUC in April 2013, time for monitoring the patient post procedure is particularly key for CPT 31238 *Nasal sinus endoscopy, surgical; with control of nasal hemorrhage* where the risk for recurrent bleeding is greater and patients often become lightheaded due to vaso-vagal reaction. ***Thus, we feel the 15 minutes of post procedure monitoring by a clinical staff person are vital to ensure quality care for patients undergoing this procedure, and urge CMS to consider modification of the direct PE for this code to include 15 minutes of monitoring time in accordance with the PEAC standard.***

ii. Rigid Transoral Esophagoscopy Codes (43191-43196)

Regarding the physician work RVUs for the six new rigid, transoral esophagoscopy codes (43191-43196), the Academy is extremely disappointed with CMS' decision to reduce the AMA RUC recommended RVUs for these codes. In their comments on this family of services within the final rule, CMS notes that the RUC recommendations reflected a "significant overall reduction in time associated with furnishing these services" and that "in the absence of information supporting an increase in intensity, CMS would expect that the work RVUs would decrease if there are reductions in time." While we understand this rationale provided by CMS, and at a basic level would agree that where time is reduced, intensity arguments must be made to justify the retention of RVUs, we are perplexed by this statement as it relates to the six new rigid esophagoscopy codes. Specifically, because the Academy presented detailed arguments regarding the intensity of the six new rigid procedures, all were uniformly accepted and understood by the RUC panel.

We respectfully point out that compelling evidence was presented for these codes to rationalize an increase in work RVU from the existing combination flexible/rigid codes, which the RUC approved. ***Compelling evidence was based on the fact that three of the previous codes (43200, 43202, 43226) were Harvard-valued and input was only provided by Gastroenterologists, who do not use rigid scopes and would not have evaluated the value of these services with a rigid scope in mind, when the values were assigned.*** Further, two of the former codes 43220 and 43226 which were surveyed in 1993, were surveyed using vignettes that explicitly described a flexible scope, so again, the use of the rigid endoscopes and the associated work were not appropriately valued by the providers who actually perform the services. For 43201, surveyed in 2002, only Gastroenterologists participated in the RUC survey, so similar arguments exist since Otolaryngologists were not part of the surveyed providers and thus, the procedure in mind would not have included the rigid esophagoscope, or the general anesthesia, typically used for rigid esophagocopy procedures.

These factors, coupled with the fact that the typical patients described by the vignettes for 43191-43196 are most commonly more complex than the patient who would receive the corresponding flexible transoral procedure, support increased work values reflected in the RUC approved RVUs. This is true in the case of the first three codes (43191-43193) as they represent cancer patients, and in all cases, these patients are more complex due to age, co-morbidity, and prior treatment including radiation to the area being examined. Further, these procedures are all done in the facility setting under general anesthesia, as compared to the flexible transoral procedures which can be done in either the facility or office setting under moderate sedation. ***We believe, based on these arguments, the intensity concerns expressed by CMS were adequately addressed by our specialty during the***

presentation of these codes to the AMA RUC and that the RUC approved RVUs for these services more accurately reflect the work and intensity involved in these procedures.

We also respectfully disagree with CMS' rationale in regards to comments that the times were reduced based on survey responses. For codes 43191, 43193, 43195, and 43196, the intraservice times reported by respondents exceeded the intraservice time for the code previously used to report the service. Additionally, in all cases, for codes 43191-43196, the total physician work time far exceeded that of the current codes used to report the service given the change in site of service and type of anesthesia used (i.e. rigid scope done under general anesthesia in the facility setting) which greatly increases the necessary pre-service time required for the procedure. ***Based on this, we believe CMS' comments were instead directed at the survey responses for the flexible transoral codes (43200-43232) and are not appropriately applied in the case of the rigid esophagoscopy codes CPT 43191-43196.***

In addition to these concerns, we are concerned by the methodology that CMS utilized to lower the RUC recommended work RVUs. In devising a methodology to revalue these services, CMS states:

We considered the AMA RUC-recommended intraservice times and found that the surveys showed that half of the rigid transoral esophagoscopy codes had 30 minutes of intraservice time and a work RVU survey low of 3.00, a ratio of 1 RVU per 10 minutes (1 work RVU/10 minutes).

The RUC has been, and continues to be, deeply critical of the use of the survey low to make primary work RVU recommendations for physician services. To take the response of one individual to value a service performed across the U.S. is not logical and negates the large amount of resources the RUC and specialty societies expend to accurately value services based upon their resource costs and surveyed times from practicing physicians. Furthermore, the Agency takes this policy one step further and applies a ratio based off the survey low and intraservice time from half of the codes and applies them to the entire family. This methodology incorrectly assumes that the intensity of physician work is identical across the family of services, thus there is no account taken for the intricacies of each procedure.

Additionally, the methodology defies all sound statistical logic as an anomalous outlier is being used as the primary mechanism for valuation. CMS's use of this methodology is further weakened by the fact that the agency provides only one code (CPT code 43200) to support their recommendation without even considering the physician work differences or providing additional codes to support each value. Given that the RUC and the specialty societies provided robust evidence of the increase in physician work intensity for these services (discussed above), along with providing statistically sound recommendations based on the survey's 25th percentile, ***the Academy requests CMS finalize the following RUC recommended values for CY 2015: a work RVU of 2.78 for CPT code 43191, a work RVU of 3.21 for CPT code 43192, a work RVU of 3.36 for CPT code 43193, a work RVU of 3.99 for CPT code 43194, and work RVU of 3.21 for CPT code 43195 and a work RVU of 3.36 for CPT code 43196. In addition, we request that all these codes be referred to the Refinement Panel for reconsideration.***

iii. Flexible Transnasal Esophagoscopy Codes (43197-43198)

a. Physician Work

The Academy is similarly concerned regarding CMS' modifications to physician work RVUs for new flexible transnasal codes 43197-43198. CMS justifies a reduction in RUC recommended work RVUs for these codes based on the fact that they are not furnished with moderate sedation like the flexible transoral codes, and thus, should not be valued the same. Based on this, CMS removed 2 minutes of pre time for scrub, dress, and wait and assigned the values of 1.48 and 1.78 accordingly to the codes. The Academy disputes this reduction in physician



work time as it is not consistent with the precedent historically used by the RUC to assign pre-service time. Historically, pre-service package 6 (Procedure with anesthesia care performed in the non-facility setting) to procedures using local anesthesia and 5 minutes allotted for a) the administration of local/topical anesthesia, and b) the necessary time for it to take effect. Accordingly, due to the total time necessary to administer and allow the topical/local anesthesia to work, pre-service package 6 was correctly assigned to these codes by the RUC. In contrast, the RUC approved the use of pre-service package 1B (Procedures performed in the facility which are straightforward patient / straightforward procedures (with sedation/anesthesia care)) for the flexible transoral procedures. We note that it is actually more work to administer topical anesthesia than to inject moderate sedation and more time should be allotted for codes which include local/topical anesthesia than those in which moderate sedation is used.

Additionally, we believe CMS' methodology as it relates to these codes is flawed given that there is increased difficulty in performing these procedures on patients who are unsedated and often anxious and moving during the procedure. Patients typically experience gagging and other discomfort, such as bloating, that adds to the intensity of the procedure as the physician must work to keep the patient calm and in the necessary position throughout the entire procedure. Since the transnasal esophagoscope only has one wheel to allow maneuvering of the endoscope, a great deal of endoscope rotation is usually required to perform a complete esophagoscopy which also adds to the complexity of the procedure. Further, these services were not valued using the building block methodology; therefore, arbitrarily removing 2 minutes of pre-service scrub, dress and wait time does not mean there is less work being performed. The RUC considered the appropriate relativity, for both codes, factoring in all the factors of physician work time, intensity and comparisons with other codes to arrive at reasonable recommendations for CPT codes 43197 and 43198. In fact, the RUC recommendations (the current work RVUs for 43197 and 43198) were substantially less than the surveyed 25th percentiles and thus provided validity that the physician work has not changed. *Therefore, we request a refinement panel be convened to review the assigned value for these codes, as we believe the difference in assigned pre-service packages approved by the RUC appropriately captured the difference in type of sedation/anesthesia utilized, and differing sites of service. Further, we respectfully request that CMS rescind their modification to pre-service time for CPT codes 43197 and 43198, and instead, finalize the RUC approved pre-service times and physician work values for these codes.*

b. Practice Expense

Regarding CMS' revisions to the practice expense RVUs for these codes, we appreciate CMS' decision to increase equipment time for 7 pieces of equipment. For the scope, however, we disagree with CMS' decision to remove time for cleaning the instrument pack. CMS states correctly, that no instrument pack was listed for either 43197 or 43198; however, it is incorrect to infer that this means that no time for cleaning instruments is required given that we supplied invoices for specific instruments that were required for this procedure. Those instruments included a nasal speculum, bayonette forceps, and biopsy forceps – all of which are non-disposable pieces of equipment which must be cleaned after the procedure. *Thus, it is inappropriate not to include any clinical staff time for cleaning these instruments. In addition, we disagree with CMS' decision to delete the biopsy forceps for CPT 43198, as the CPT descriptor for this code clearly states that a biopsy is performed as part of this service. Thus, for this code to be appropriately used by the surgeon, and for the work of removing to be completed, biopsy forceps are mandatory to properly perform the procedure and should be retained in the direct practice expense for CPT 43198.*

iv. Removal Impacted Cerumen (69210)

Similarly, the Academy is concerned regarding CMS' revisions to coding guidance and interpretation of CPT 69210 for CY 2014. Within the final rule CMS correctly notes that this CPT code was modified via the CPT Editorial Panel to clarify that the procedure was "unilateral". However, CMS states in the final rule that they disagree with the assumption by the RUC that this procedure will be furnished in both ears only 10 percent of the

time, as they feel the physiologic processes that create cerumen impaction likely will affect both ears. **Thus, CMS states they will only allow one unit of CPT 69210 to be billed when furnished bilaterally.**

The Academy, and the associated societies that perform this function, fundamentally disagree with CMS' assertions related to the procedure for two reasons. First, CMS states that during the presentation to the AMA RUC that the specialty societies stated there was no information to determine how often the service was unilaterally performed. In fact, during our presentation to the RUC, and also in our Summary of Recommendation form, the Academy explained that our expert panel felt that the estimate of 10% bilateral utilization was appropriate based on the fact that 81% of our 312 survey respondents indicated that the service was typically (more than 50% of the time) provided unilaterally (or on only one ear). Given that this information was clearly stated in our presentation to the AMA RUC, during which CMS representatives were present, we are perplexed by CMS' comment that no rationale was provided for the projection that 10% of procedures would be performed bilaterally. ***Thus, we respectfully request that CMS amend their policy within the 2015 final rule which would not allow CPT 69210 to be billed bilaterally (or using a -50 modifier when performed on both ears), and urge the Agency rescind this policy of only allowing CPT 69210 to be billed once, even in cases where it is performed bilaterally.***

Our second area of concern stems from CMS' assertion that the "physiologic processes that create cerumen impaction likely would affect both ears". We do not believe there is clinical evidence to support that just because a patient presents with wax in one ear, they must have it in the other. There are many causes of cerumen that can frequently be unilateral, for example hearing aids (which are often worn unilaterally), one ear canal may be narrower than the other, and most commonly patient manipulation of the external auditory canal which is not symmetrical. ***Thus, we believe this assumption by CMS is flawed and request additional clinical rationale, and/or literature to support CMS' comment that "the physiologic processes that create cerumen impaction likely would affect both ears".***

Additionally, it is not clear how CMS intends to operationalize their policy of only allowing this service to be billed once. We presume this means that CMS will put a Medically Unlikely Edit (MUE) in place of "1", however, we are concerned that given the change to the CPT code descriptor to specify "unilateral" this will cause inordinate confusion among the provider community. ***Therefore, in the event CMS does not modify their policy recommendations, we seek guidance from CMS as to whether this code should be sent back to CPT to clarify that the service may only be reported once, or if CMS intends to provide practices with further education on this coding policy.***

v. Speech Evaluation Codes (92521-92524)

Regarding CMS' modifications to valuations for the new speech evaluation codes (CPT 92521-92524), we respectfully disagree and request reconsideration of the reduction CMS made in the work RVUs for 2 new evaluation codes used primarily by speech-language pathologists. CPT code 92523 (Evaluation of speech sound production with evaluation of language comprehension and expression) was reduced from a HCPAC recommended 3.36 to 3.0 and CPT code 92524 (Behavioral and qualitative analysis of voice and resonance) was reduced from a HCPAC recommended 1.75 to 1.50. Regarding 92523, CMS stated that the "affected specialty society stated that its survey results were faulty for this CPT code because survey respondents did not consider all the work necessary to perform the service." In actuality, the presenting specialty society stated, and the HCPAC agreed, that the survey respondents did appropriately take time and effort into account, but had difficulty using a time-based reference code to calculate the RVU for 92523, an untimed code. Additionally, the RUC HCPAC acknowledged that, for 92523, the work for the second hour of evaluation of language expression and comprehension is more intense than the first hour of evaluation of speech sound production.

CMS also fails to recognize the significantly more difficult aspects of performing CPT code 92524 as opposed to CPT code 92522 and based its reduction exclusively upon the intraservice time. CMS’ reduction ignores the very different aspects of conducting an evaluation of speech sound production (92522) and the more challenging aspects of performing a behavioral and qualitative analysis of voice and resonance (92524). Upon presentation before the HCPAC, the clinical differences between the codes were made clear and the expert panel determined the work value for CPT code 92524 to be 0.25 higher than 92522. The reduction of value is arbitrary and based exclusively upon time rather than the full components of the HCPAC recommended valuation. It is worthwhile to note that CMS officials were not present while these codes were being presented to the RUC HCPAC and may not have had the benefit of the thorough discussion on these relative values. *Therefore, we urge CMS to accept the HCPAC recommended work RVU of 3.36 for CPT code 92523 and work RVU of 1.75 for CPT code 92524 and request refinement panel review of these services.*

C. CMS Modifications to Recommended Malpractice Crosswalks

Finally, within the discussion of interim values for CY 2014, CMS discusses their recommended malpractice (PLI) crosswalks for CPT codes reviewed by the AMA RUC. Upon review of the proposed crosswalks, the Academy noted that CMS did not accept several of our recommended PLI crosswalks. Specifically, for the new rigid esophagoscopy codes 43191-43196 we recommended that CMS use various Bronchoscopy, Rigid or Flexible, codes as the PLI crosswalks and instead, CMS elected to use CPT 31575 Diagnostic Laryngoscopy as the crosswalk to represent similar malpractice risk.

The Academy respectfully disagrees that diagnostic laryngoscopy reflects similar malpractice risk to a rigid, transoral esophagoscopy procedure. In fact, we feel they are quite distinct due to the life threatening risk of esophageal perforation which is present when the rigid endoscope is used. Many of these patients have had chemotherapy radiation which increases the risk of perforation. In contrast, there is no risk of perforation when a diagnostic laryngoscopy is performed. Further, the site of service and mode of anesthesia is different for these procedures where the rigid esophagoscopy procedures will be performed only in the facility setting under general anesthesia. In contrast, diagnostic laryngoscopy is performed predominantly in the physician office (86% of the time per the 2013 RUC database) and is done under local/topical anesthesia. *Thus, we encourage CMS to reconsider diagnostic laryngoscopy as the PLI crosswalk for the new rigid, transoral esophagoscopy codes, and instead, utilize the specialty-suggested bronchoscopy codes (see chart below) which are more clinically similar and represent similar risk of malpractice.*

CY 2014 New, Revised, or Potentially Misvalued Code		Malpractice Risk Factor Crosswalk Code		AAO-HNS Recommended Crosswalk	
43191	Esophagoscopy Rigid trnso dx	31575	Diagnostic laryngoscopy	31622	Bronchoscopy, rigid or flexible, including fluoroscopic guidance,
43192	Esophagoscopy Rigid trnso inject	31575	Diagnostic laryngoscopy	31625	Bronchoscopy, rigid or flexible, w/ biopsy
43193	Esophagoscopy Rigid trnso biopsy	31575	Diagnostic laryngoscopy	31625	Bronchoscopy, rigid or flexible, w/ biopsy
43194	Esophagoscopy Rigid trnso removal fb	31575	Diagnostic laryngoscopy	31638	Bronchoscopy, rigid or flexible, with revision of tracheal or bronchial stent
43195	Esophagoscopy Rigid trnso balloon	31575	Diagnostic laryngoscopy	31625	Bronchoscopy, rigid or flexible, w/ biopsy
43196	Esophagoscopy Rigid trnso guide wire dilation	31575	Diagnostic laryngoscopy	31638	Bronchoscopy, rigid or flexible, with revision of tracheal or bronchial stent

III. OTHER OTOLARYNGOLOGY PAYMENT ISSUES WITHIN THE 2014 MPFS

i. Retraction of OPSS Cap Proposed Policy

The Academy is pleased that CMS chose to rescind this proposed policy within the final 2014 MPFS. We agree with its assessment that given the wealth of thoughtful comments and concerns expressed by stakeholders in response to the proposed rule, that it is prudent to delay any action related to this proposed policy until CMS has had sufficient time to fully review and vet comments received on the proposed rule. Despite this, we understand that CMS intends to revisit this policy in future rulemaking and does not feel that the AMA RUC practice expense review process is sufficient to address CMS' concerns that the practice expense for these 211 codes is inaccurate. *While the Academy understands CMS' rationale for their concerns related to this list of codes, we respectfully disagree that the AMA RUC Practice Expense process is fundamentally flawed.*

Rather than implement a new policy which would arbitrarily assign payment rates to these procedures, when provided in the office, based on hospital outpatient payment rates; the Academy suggests that CMS consider recommending changes to the RUC process, such as requiring societies to submit several invoices from different companies to reflect a more broad view of the market costs for pieces of medical equipment. CMS could also implement a new misvalued codes screen for the 2015 MPFS NPRM and identify codes which are paid more in the physician office setting so that specialty societies and other public stakeholders have the opportunity to provide CMS feedback and rationale (where appropriate) for why those codes may be appropriately paid at a higher rate, or in the alternative, to allow specialty societies notice that the codes will be required to go through the AMA RUC review process for the coming year. CMS could also revisit a concept voiced several years ago, and supported by the RUC, to implement a rolling 5 year review of practice expense in lieu of this proposed policy. *Again, we thank CMS for taking the time to thoughtfully consider next steps related to this area of policy making. We look forward to further collaboration and discussion with CMS on this issue via future rulemaking. Further, to the extent this policy would have impacted Otolaryngology services, the Academy has agreed to review the practice expense direct inputs for the 13 codes on the OPSS PE Cap proposed list which are dominantly provided by our specialty for the April 2014 RUC meeting in hopes that it will address CMS' concerns regarding valuation for these Otolaryngology services when performed in the physician office.*

ii. Nomination of Potentially Misvalued Codes for RUC/CMS Review

Within the 2014 final rule, CMS reiterates the ability for public stakeholders to nominate codes that they believe are potentially misvalued and should be considered for review. For CY 2015 rulemaking, the Academy would like to nominate CPT 41530 *Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session* **for review of the direct practice expense (PE) inputs within the code.** This request is consistent with a letter sent to CMS by the Academy on November 15, 2013, however, we are taking the opportunity to reiterate our desire to review the direct practice expense inputs for this code within our comments on the final rule, as we believe this is consistent with CMS' requested process for evaluating requests to review potentially misvalued codes.

CPT 41530 was RUC surveyed in 2007, at which time both the physician work and direct PE inputs were valued by the RUC, and the recommended values were then approved by CMS within the following year's final MPFS rule. *Since that time, we believe the practice expense for two of the direct PE items have decreased substantially, and therefore, the current practice expense is overvalued and should be adjusted. Specifically, we believe the cost of supply code SD109 probe, radiofrequency, 3 array (StarBurstSDE) should be adjusted to reflect a more typically used probe, not currently reflected by the CMS supply list, which would be much lower in cost than the current input. The same concern is present for the equipment code EQ214 radiofrequency generator (NEURO), which we would propose revising to a more applicable input based on current invoices for the types of generators used for these procedures.*

Therefore, we respectfully request permission to review the direct practice expense for this service at the April 2014 RUC meeting in Chicago, IL, should the Agency agree and should this comport with the AMA RUC staff's schedule for that meeting. We also note that this code was captured in the list of 211 codes which are paid more in the office setting than the hospital outpatient under the OPPOS Cap policy considered by CMS in the NPRM. Given this, we believe review of this service is even timelier, and appreciate CMS' consideration of this request.

iii. Improving Valuation of the Global Surgical Package

The Academy appreciates CMS' decision to correct the post-operative evaluation and management visit information for 117 codes within the 2014 final rule. We agree that these codes, identified by the AMA RUC, were inadvertently altered and appreciate CMS correcting this issue and consequently, increasing the post time for these services.

iv. Liability for Overpayments to Individuals

The Academy is extremely concerned regarding CMS' decision to expand the "look back period" for purposes of evaluating liability for overpayments made to individuals under the Medicare program from the prior 3 year period to a new 5 year period. Under this provision, CMS can go back and take monies for overpayment unless the provider is deemed "without fault" or it would be "against equity and good conscience" to do so. While we are supportive of efforts to ensure proper payments are made under the Medicare system, we are concerned that this extended period of liability for providers, particularly those in rural and/or small private practices, is too onerous. Specifically, we are concerned that such a long look back period may result in ongoing financial liability for small practices that simply do not have the ongoing cash flow to sustain such audits so far removed from the date a claim was paid (i.e. 5 years after payment is rendered). We are also concerned that as physicians seek to comply more fully with the requirements of the Affordable Care Act (ACA) we will see changes in practice type and location, or increases in retirement, which further heightens this risk. . *As such, we urge CMS to reconsider this policy in future rulemaking so as not to overly burden small practices which are integral to the provision of services, particularly in rural and underserved areas, within the Medicare program.*

III. PHYSICIAN COMPARE WEBSITE

While the Academy supports providing patients and beneficiaries with information that allows them to make the best decision possible regarding their clinical care, we have continued concerns regarding CMS' proposals related to Physician Compare. Specifically, in regards to future reporting of patient experience measures, which CMS plans to do in 2014 for group practices of 100 or more, those participating in the MSSP ACOs, and for group practices of 25 or more professionals who report CG-CAHPS data via a certified CAHPS vendor; *the Academy reiterates our concern that the CG-CAHPS survey does not appropriately capture patient experience associated with surgical procedures. Instead, we encourage CMS to allow surgeons to utilize the AHRQ approved Consumer Assessment of Healthcare Providers and Systems Surgical Care Survey (S-CAHPS) survey to evaluate the patient experience associated with surgical care for purposes of posting this information on the Physician Compare website. We believe use of the S-CAHPS survey will further CMS' goal to obtain more accurate and meaningful quality data to share with Beneficiaries.*

Similarly, while we appreciate the desire to provide patients with information on provider's quality performance to aid them in selecting a physician, we reiterate that CMS should be mindful as to what provider information is necessary and meaningful to patients, and avoid over-saturating them with too much information. For instance, it is unclear how information on PQRS quality measures (for groups of 100 or more in 2014 and for smaller groups and individuals in future years) will be used by patients who likely do not know what the PQRS program is. *In addition, we believe that it is too early for CMS to begin posting PQRS GPRO measure data and CG-CAHPS data for large groups and ACOs in 2014. As noted above, we are concerned that for surgical specialists, the CG-CAHPS survey is not applicable to their patients and may not accurately reflect the quality of care*

received. As such, we urge CMS to allow surgical specialties to use the S-CAHPS survey for patients over 18 in the hospital setting in lieu of the CG-CAHPS, to better reflect the quality of surgical services provided.

Further, despite the recent revisions and re-launch to the website, there remain many problems with the Physician Compare Website. For example, upon review of several of our physician leader’s information following the website re-launch, we noted that many physicians are listed as affiliated with hospitals they’ve never worked in, or have languages listed which they don’t speak. In fact, our members reported that when they attempted to correct their information listed on the website, they were asked for PECOS login information which many times is not immediately available, and were told that it would take up to 6 months for the information to be corrected. *Therefore, while we believe CMS has made major strides in improving the usability of the Physician Compare website, we remain concerned about the accuracy of information posted on the website and urge CMS not only to improve the accuracy of physician information, but also to streamline the process by which providers can correct their information and shorten the time within which corrections are posted.*

V. QUALITY REPORTING INITIATIVES

A. Physician Quality Reporting System

The Academy appreciates CMS’ continued willingness to enhance the Physician Quality Reporting System (PQRS). We are also pleased with CMS’ efforts to streamline the reporting periods and requirements across the PQRS, Value Based Payment Modifier, and Electronic Health Reporting (EHR) programs for CY 2014 reporting. With respect to CMS’ stated goal of improving participation within PQRS for future years, the Academy has several comments below which address questions and issues in the final rule.

i. Changes to PQRS Measures in CY 2014

a) Adult Sinusitis Measures for 2014 Reporting

The Academy is pleased to see that CMS has finalized 56 new measures and 3 new measure groups for CY 2014. *Specifically, we are thrilled that CMS has finalized inclusion of four of our nine recommended Adult Sinusitis Measures created through the Physician Consortium for Performance Improvement (PCPI) process and endorsed by the Academy.* The four measures included for 2014 were:

<u>Measure Title</u>	<u>CMS Reporting Method</u>	<u>PCPI Recommended Data Source</u>
Adult Sinusitis: Computerized Tomography for Acute Sinusitis (overuse)	Registry	Claims, EHR or Registry
Adult Sinusitis: More than 1 Computerized Tomography (CT) Scan Within 90 Days for Chronic Sinusitis (Overuse)	Registry	EHR or Registry
Adult Sinusitis: Antibiotic Prescribed for Acute Sinusitis (Appropriate Use)	Registry	EHR or Registry
Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use)	Registry	EHR or Registry

While we greatly appreciate CMS’ decision to include these four measures for CY 2014 reporting, *we would reiterate our comments provided to CMS at two in-person meetings during 2013 (April and November) urging CMS to work with our specialty and the AMA PCPI to expeditiously finalize testing of the remaining five adult*

sinusitis measures below and consider them for inclusion in the PQRS program for 2015 reporting. Additionally, we would welcome the opportunity to collaborate with CMS moving forward to create an Otolaryngology-specific measures group utilizing existing measures, which could incorporate the adult sinusitis measures, for use by Otolaryngologists in CY 2015 PQRS reporting.

<u>Measure Title</u>	<u>PCPI Recommended Data Source</u>	<u>Specifications included in call for Measures</u>
Adult Sinusitis: Accurate Diagnosis of Acute Sinusitis: Distinguishing Viral vs. Bacterial Sinusitis	Claims, EHR or Registry	Claims/registry specifications; Data requirements table for EHR
Adult Sinusitis: Plain Film Radiography for Acute Sinusitis (overuse)	Claims, EHR or Registry	Claims/registry specifications, Data requirements table submitted for EHR consideration
Adult Sinusitis: Appropriate Diagnostic Testing for Chronic Sinusitis (underuse)	Claims, EHR or Registry	Claims/registry specifications, Data requirements table for EHR
Adult Sinusitis: Watchful Waiting for Acute Bacterial Sinusitis: Initial Observation Without Antibiotics for Patients With Mild Illness (Appropriate Use)	EHR or Registry	Data requirements table for EHR/ Registry
Adult Sinusitis: Premature Changing of Initial Antibiotic for Acute Bacterial Sinusitis (Overuse)	EHR or Registry	Data requirements table for EHR/ Registry

b) Changes to other Individual Measures for CY 2014

For CY 2014, we understand that CMS chose to eliminate and modify the reporting methods for several measures which may have been reported by Otolaryngologists (eight functional communication measures, two hypertension measures, and a smoking and tobacco use cessation measure) due to the low frequency with which they were reported. While we understand CMS' need to balance relevancy of measures and the workload associated with maintenance of existing measures, we are concerned that due to the limited number of measures available for specialists such as Otolaryngologists to report, elimination of any measures makes it increasingly difficult for specialists to participate in CMS quality reporting programs. This is especially true for specialties that do not treat prioritized conditions for which there are many endorsed measures and support for review and maintenance.

Some examples of changes to reporting methods which may impact Otolaryngologist's ability to successfully participate in PQRS include the following:

53	0047	Asthma: Pharmacologic Therapy for Persistent Asthma - Ambulatory Care Setting	Claims Removed
64	0001	Asthma: Assessment of Asthma Control – Ambulatory Care Setting	Claims Removed, EHR Removed
66	0002	Appropriate Testing for Children with Pharyngitis	Claims Removed
130	0419	Documentation of Current Medications in the Medical Record	EHR Added
143	0384	Oncology: Medical and Radiation – Pain Intensity Quantified	EHR Added

Thus, we are disappointed that CMS has chosen to eliminate these measures for CY 2014, particularly in light of the increased number of measures required for successful reporting from 3 to 9 in 2014 (see further discussion on

this issue below). *Even in light of the four sinusitis measures proposed for inclusion in the 2014 PQRS program, specialties such as Otolaryngology, with a large number of subspecialties, remain limited in terms of measures they are able to report. In addition, given that CMS elects to delete 45 measures for CY 2014, any elimination of useable measures increases the difficulty of participation for our specialty.*

c) New Patient-Centered Surgical Risk Assessment and Communication Measure for 2014 Reporting

The Academy appreciates CMS' decision to finalize the Patient-Centered Surgical Risk Assessment and Communication measure for registry reporting as part of the new general surgery measures group. We are supportive of having such a measure available to all surgeons. However, we have some questions and concerns we'd like to pose for the Agency's consideration in future rulemaking.

Specifically, the tool seems to be somewhat onerous upon initial testing and the calculator used is general and not specialty specific. This may result in the tool not being valid for many specialized procedures, such as those provided by Otolaryngology – Head and Neck Surgeons. For example the tool doesn't ask about prior radiation therapy which would impact many of the morbidities Otolaryngologists see in head and neck cancer patients. Likewise, it doesn't ask about prior surgery in the site being operated upon which could be significant for wound breakdown in head and neck, plastics, or otologic procedures. *In light of these concerns, we would pose the following questions for CMS' consideration in future rulemaking:*

At this point in time, it is unclear whether otolaryngologists will be able to meaningfully participate in this measure or be able to adapt it into part of their routine practice. Given this, we believe the tool used within this measure requires further refinement to ensure meaningful surgical specialty participation in the measure for future PQRS reporting.

ii. Changes to Individual Reporting Requirements to Avoid the 2016 Penalty Adjustment

The Academy is extremely concerned with CMS' decision to increase the number of measures required for satisfactory individual reporting from 3 (required in 2013) to 9 for CY 2014. As outlined above, given the limited number of measures reportable by Otolaryngologists, increasing the requirements for reporting from 3 measures to 9 will make it extremely difficult for members of our specialty to successfully report. This is true even in light of the four new sinusitis measures CMS has finalized for CY 2014.

While we are appreciative of CMS' exception to the 9 measure reporting requirement, which allows EPs who report via claims on 3 measures to avoid the 2016 payment penalty, *we continue to be concerned that specialties which are as subspecialized as Otolaryngology may have difficulty meeting this reduced reporting requirement, and thus, avoiding the 2016 payment penalty.*

Further, we are concerned that providers who do not meet the 9 measure reporting requirement will be automatically subject to the Measure Applicability Validation (MAV) process, which may determine that providers could, or should, have reported on measures which may not be readily apparent to participating providers. For Otolaryngology practices that are highly sub-specialized, the MAV process may interpret measures as relevant when in actuality they are not. *As such, we encourage CMS to increase the development of public guidance documents aimed at educating specialties and specialty societies on which measures are applicable to them for PQRS reporting. Development of additional guidance, in conjunction with the help desk services already provided, would ensure that providers are not routinely penalized based on the outcomes of the MAV process which may instruct that they should have reported on measures they never would have considered as applicable to their specialty.*

Finally, we are appreciative that CMS has decided to reduce the reporting threshold for individuals reporting via registry from the previous 80% of Medicare Part B beneficiaries to 50% within the final rule. We applaud this decision by CMS and believe this lowered threshold is much more realistic and attainable for participating providers reporting via registry.

i. New Qualified Clinical Data Registry Reporting Option (QCDR)

The Academy is pleased with CMS' decision to introduce the new qualified clinical data registry reporting option for CY 2014. We believe this new reporting option will provide much needed flexibility to the PQRS program and will allow the implementation and utilization of new and meaningful quality measures to be utilized by specialties given that QCDR's are not required to have their measures endorsed by PQRS or the National Quality Forum (NQF). *Therefore, the Academy applauds CMS for finalizing this new reporting option for CY 2014. Specifically, we applaud CMS' decision to allow QCDRs to utilize non PQRS and NQF measures as we believe this allows more flexibility in reporting and will enable CMS to gather more meaningful quality data.*

We do, however, have some concerns regarding the requirements and timeline for this new reporting option. Specifically, groups must self-nominate by January 31 to report under this method. While we understand that groups may dually identify as a registry and a QCDR, we are skeptical that any existing registry will be adjusted and ready for reporting based on the proposed QCDR requirements, by the January 2014 nomination deadline. CMS is also requiring descriptions for the measures that the QCDR will report by March 31, 2014, which may not be feasible. *To that end, we request that CMS provide further clarification on what the process will be for groups who dual identify as a registry and a QCDR for CY 2014 reporting, but do not end up meeting the requirements for the QCDR by the March 31, 2014 deadline for descriptions of measures which the QCDR will report.*

ii. Reporting Mechanisms for Group Practices

CMS maintains their policy that all group practices of 100+ professionals report via the GPRO web-interface for satisfactory reporting to avoid the 2016 payment adjustment. Due to the limited number of quality measures applicable to Otolaryngology in the two outlined reporting mechanisms, *the Academy urges CMS to expand the available reporting mechanisms for group practices of 100+ professionals to include claims, registry, qualified clinical data registry (QCDR), and EHR based reporting.* Allowing large group practices to report via these additional methods will improve our specialty's participation and ability to satisfactorily report in PQRS.

CMS will also allow groups of 25+ to report on CG-CAHPS to meet 3 of their 9 measure requirements for satisfactory reporting for CY 2014. These groups would then have to also report 6 measures covering at least 2 National Quality Strategy domains using registry, EHR, or GPRO web interface reporting (depending on their size). *The Academy appreciates CMS providing this new option to groups of 25+ to satisfy some of their reporting requirements via the CG-CAHPS survey measures, however, we continue to have concerns that these surveys are not particularly applicable to specialists. While we encourage CMS to continue all efforts to expand flexibility for groups to meet PQRS reporting requirements, we want to ensure that the data reported is meaningful for specialties and groups reporting. Thus, we reiterate our recommendation from 2013 for CMS to allow both the CG-CAHPS and S-CAHPS survey tools in order for surgical specialty groups reporting under PQRS to meet 3 of their 9 measures requirements in CY 2015.*

iii. Changes to Measure Groups in 2014

For CY 2014 CMS has finalized a new General Surgery Measures Group which includes the following measures: Anastomotic Leak Intervention; Unplanned Reoperation within the 30 Day Postoperative Period; Unplanned Hospital Readmission within 30 Days of Principal Procedure Surgical Site Infection (SSI); Patient-Centered Surgical Risk Assessment and Communication.



While the Academy appreciates CMS' efforts to expand the number of measures groups for use by surgical specialties reporting on the PQRS program, we are concerned that as currently structured, the new General Surgery Measures Group would not be reportable by Otolaryngology, or several other surgical specialties. Specifically, because Otolaryngologist – Head and Neck Surgeons mostly operate in a “clean infected” or “infected” space (e.g. oral, nasal, alimentary, and respiratory tracts) with a few exceptions (thyroid, parathyroid, and neck masses not communicating with mucosa, etc.). *Despite this, we are hopeful that we may be able to work with the CMS moving forward to utilize the individual measures within the set which are applicable (e.g. “clean” surgical site infection measure and the unplanned admissions and the counseling measure) or to incorporate them as part of a new measures group that could be made up of existing PQRS measures, which would be reportable by Otolaryngologists.*

iv. PQRS Reporting Periods in 2014

The Academy is pleased with CMS' decision to finalize the additional six month reporting period (July 1-December 31) for the reporting of measure groups via registry for 2014. Additional reporting periods are extremely helpful in allowing EPs to successfully report quality measures to avoid payment reductions in 2016 and we appreciate CMS' inclusion of this new reporting period for 2016. We also appreciate CMS' decision to align the reporting periods for all other reporting options (including a secondary option for EPs reporting via registry) to a 12 month reporting period. We believe unified reporting periods across all reporting methods avoids confusion for participating EPs and group practices.

v. Aligning National Quality Forum and CMS Measure Review Timelines

While we understand that the operational function of the National Quality Forum (NQF) is outside the control of CMS, we would like to provide positive feedback to the Agency related to recent changes made by NQF to their measure review, testing, and endorsement processes which will positively impact measure development, and in turn, will enhance provider's ability to meaningfully participate in the PQRS program. Specifically, we are pleased that NQF has heeded the advice of many specialty societies, including the Academy, to streamline their timeline and processes to more closely align with the CMS timeframe for proposed new quality measures which have been tested and/or endorsed by the NQF. The NQF's new rolling review process will allow heightened flexibility for public involvement in the development, testing, and validating of new quality measures for use in quality incentive payment programs, such as PQRS. *As such, the Academy is fully supportive of these procedural changes for CY 2014 and we encourage CMS to actively engage the NQF in the measure endorsement process and work toward continued alignment to allow meaningful clinical quality measures to be developed in the future.*

VII. VALUE-BASED PAYMENT MODIFIER (VBM) AND PHYSICIAN FEEDBACK PROGRAM

A. New Cost Measure for CY 2014

For CY 2014, CMS finalized a new cost measure as part of the VBM program. Specifically, CMS proposes to add a cost measure for Medicare spending per beneficiary (3 days prior and 30 days after an inpatient hospitalization) attributed to all groups providing a Part B service during hospitalization.

The Academy continues to be concerned with this new cost measure as implemented by CMS. Specifically, we are concerned with appropriate attribution of patients and their care to the surgeon. Under the structure of this cost measure, excessive costs may be applied to our specialty without any way to individually attribute patient care and costs that may or may not be within the purview or control of the surgeon. Further, we are concerned that costs could erroneously be attributed under this cost measure and would like to request further information from CMS as to how patients will be attributed under this new cost measure via CMS provider calls or future rulemaking.

B. Cost Benchmarking in CY 2014

CMS creates a cost composite for each group of physicians by calculating a standardized score for each cost measure and then places the measures into one of two equally weighted domains: (1) the total per capita costs for all attributed beneficiaries domain and (2) the total per capita costs for attributed beneficiaries with specific conditions domain. To calculate the standardized score for each cost measure, CMS compares the performance for each group's cost measure to the benchmark (national mean of the performance rate among all the groups of physicians) of other groups subject to the payment modifier (peer group) for the same performance year.

For CY 2014 reporting, CMS finalizes that they will use the same methodology used for the Medicare Shared Savings Program (MSSP) Accountable Care Organization (ACO) program to assign beneficiaries to groups for purposes of the VBM. That is, they will assign beneficiaries based on the delivery of primary care services. For groups that do not provide primary care services, or who have fewer than 20 beneficiaries attributed to them, CMS will assign their cost composite as “average” cost as a default cost score.

CMS also finalizes their proposed policy from the NPRM to account for specialty mix using a “specialty adjustment” method as it relates to calculating a group's standardized score for each cost measure and benchmarking against other groups for that performance year. The new specialty adjustment will entail the following:

1. Creating a national specialty-specific expected cost to use as a benchmark
2. Calculating a specialty-adjusted expected cost for each group of physicians by weighting the national specialty specific expected costs by the group's specialty composition of Part B payments; and
3. Calculating a specialty-adjusted total per capita cost.

CMS will identify the specialty for each EP based on the specialty they have listed on the largest share of their Part B claims. CMS states that the “specialty adjustment” method accounts for the specialty composition of the group of physicians when making peer group comparisons and creates standardized scores for each cost measure. They also believe this methodology allows the payment modifier to apply to smaller size groups and solo practitioners. CMS states that although the calculations are very detailed, they are transparent and they can provide each group of physicians' information on how their costs were benchmarked. CMS believes that the “comparability peer group” method would be less transparent. CMS does not believe it is necessary to delay implementation and will monitor the impact of the specialty adjustment method on physician groups.

i. Specialty Adjustment Method

While the Academy favored the specialty adjustment method in our comments on the NPRM; we remain concerned that under this method CMS will identify a provider's specialty based on specialty listed on the majority of the individual's claims. Using this method to assign a specialty could be fraught with error in cases where the PECOS designated specialty is incorrect for a provider or in cases where their specialty mix is spread across several specialties, but one designation is associated with higher cost services than another. ***Rather, we encourage CMS to assign specialty designations for cost benchmarking purposes under the VBM program based on a claims analysis to identify the services most typically provided by the individual (i.e. the top 15 services the provider renders based on submitted claims) and assign their specialty based on the care they are most frequently providing.***

C. Physician Feedback Program / QRUR Reports

As part of the value based modifier program, CMS began issuing Physician Feedback reports (or Quality Resource Use Reports (QRURs)) to physicians in fall of 2011 (sent to groups of physicians who participated in the PQRS GPRO) and again in March of 2012 (sent to all physicians in four states). These reports were intended to provide confidential reports to physicians that measure the resources and quality of care involved when

furnishing care to Medicare beneficiaries. CMS has stated they intend to continue distribution of these reports to physicians and will distribute reports this fall on September 16 to groups with 25 or more EPs (this does not include non-physician health care providers) which will be based on 2012 PQRS quality data.

While the Academy appreciates CMS's tremendous work in this complex area, we remain concerned with the aggressive timeline for roll-out of this program. We recognize that statute requires the value based payment modifier (VBM) to apply to all physicians enrolled in the Medicare program by January 1, 2017, however, we fear that physicians are just beginning to understand the incentive/penalty structure for other quality programs, such as Meaningful Use of EHRs, eRx incentives, and PQRS, which have been in place for several years now. To add an additional quality program, which is even more complex in nature, is certain to cause increased difficulty in preparing our members to meet the requirements of these programs. Further, SGR repeal proposals, which are currently being evaluated by Congress, contain language that would alter, modify, or combine several of these quality reporting programs. This only adds to the complexity and uncertainty of how these programs will impact physicians in 2014 and in the future.

In addition, we feel there is much to learn from the prior distribution of these feedback reports to physicians in 2010, 2011 and 2012; particularly given that CMS has acknowledged that physicians receiving the reports would most likely be penalized by the program if it were applicable today. ***Based on this, we encourage CMS to continue refining the way information is relayed to physicians to ensure that it is timely and frequent enough to allow physicians and groups for which the VBM will apply, to adjust their practice patterns, if needed based on feedback from these reports, to avoid the VBM penalty.*** We understand that CMS has taken large strides to improve the clarity and usability of the QRUR reports to present cost and quality performance in a meaningful and clear way to providers, and to that end we appreciate CMS' efforts with stakeholders. ***We urge the Agency to continue these efforts and recommend that it reconvene the stakeholder workgroup they previously worked with to continue the enhancement of these feedback reports for 2014 and future years.***

D. Value-based Payment Modifier (VBM): Expanding to groups of 10+ for CY 2014

The Academy recognizes CMS' urgency to begin expanding the VBM program to meet the 2017 statutory deadline for phasing in all physicians enrolled in Medicare; however, we have concerns regarding CMS' expansion of the VBM program to all groups of 10+ for CY 2014. Specifically, we are concerned that under previous rulemaking, CMS elected to send QRURs to all groups in September of this year. That data was based on a group's performance in PQRS in CY 2012. Thus, this prior policy decision now creates a gap in information for groups of 10-24 EPs who will not receive any feedback on their 2012 PQRS performance related to cost and quality, but will be subject to the VBM in CY 2014. ***As such, we strongly urge CMS to find a method to convey feedback, prior to Q3/Q4 of 2014, on performance for groups of 10-24 prior to applying the VBM for 2014 reporting in order to allow them to prepare and modify practice patterns, where necessary to avoid VBM payment penalties in CY 2016. We understand that CMS selected the 10+ size groups for 2014 as a way to integrate 60% of Medicare providers at the half-way point of the VBM program rollout, however, we believe this disadvantages groups of 10-24 who do not have performance metrics or feedback reports to work off of to prepare for participation in the VBM program in CY 2014.***

E. New Reporting Mechanism for CY 2014: 50% of EPs Reporting Individually

The Academy is pleased with CMS' decision to provide an additional method of reporting for groups under the VBM program for CY 2014 reporting. Specifically, we appreciate the flexibility in meeting reporting requirements by in allowing them to report on PQRS measures as individuals so long as 50% of the EPs in the practice report successfully. ***We applaud CMS for providing this additional reporting option, and urge them to conduct additional provider education around this option, as it has the potential to be confusing for practices and groups in the first year of applicability. We are also appreciative of CMS' decision in the final rule to reduce the percentage threshold from the proposed 70% to 50% for successful reporting under this option for***

CY 2014. This was consistent with the requests made by the Academy in our comments on the 2014 NPRM, and we greatly appreciate CMS' modification in this regard.

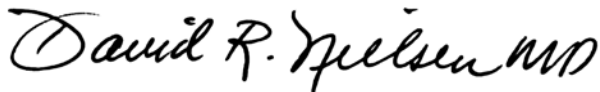
F. Mandatory Quality Tiering in CY 2014

The Academy understands that based on feedback in 2013 rulemaking, providing group practices with the option to elect quality tiering was unlikely to be an effective method to incentivize group participation in this portion of the VBM program. To that end, we can appreciate CMS' decision to mandate quality tiering for all groups under the 2014 reporting year for VBM program. We also applaud CMS for incorporating a "hold harmless" provision of sorts, which will allow groups of 10+ to avoid a VBM payment penalty in 2016 so long as they participate in PQRS for CY 2014 reporting. Despite this provision, however, we remain concerned that groups of 100+ will not know that they are automatically subject to quality tiering and will potentially be subject to a 2016 payment penalty if they perform poorly as compared to their peers on quality and cost metrics. ***To that end, we urge CMS to conduct large scale educational efforts, including provider calls, MLN Matters articles, webinars, etc., and to collaborate with specialty societies to provide materials they can share with their members, to prepare groups of 100+ for this policy change in CY 2014.***

Conclusion

The American Academy of Otolaryngology—Head and Neck Surgery appreciates the opportunity to provide comment and recommendations regarding these important policies on behalf of our members. If you have any questions or require further information, please contact Jenna Minton, Esq., Senior Manager of Health Policy at jminton@entnet.org or 703-535-3725. Thank you.

Sincerely,



David R. Nielsen, MD, FACS
Executive Vice President and CEO

cc: Edith Hambrick, MD
Steve Phurrough, MD
Kathy Bryant