[GKOS, SGHT] Eyeing Up Rate Reductions & Competitive Catalysts

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We think CMS is unlikely to reverse the 20% rate reduction for **Sight Sciences (SGHT)** canaloplasty procedures [CPT 66174] proposed in the CY23 Physician Fee Schedule (PFS) last week, which should also imply incremental benefits for **Glaukos (GKOS)**. Separately, SGHT is unlikely to secure mitigation as part of the Medicare hospital outpatient / Ambulatory Surgery Center (ASC) payment rule due out in the coming days, where we suspect CMS will once again reject requests for improved ASC reimbursement by classifying canaloplasty as a "device intensive procedure." While some questions remain about GKOS's ability to capitalize on newer product offerings (e.g., iPrime, iAccess) by combining services / payments with legacy iStent procedures, it is less likely that Medicare will formally preclude the "stacking" of these claims. Though GKOS *also* intends to bill iPrime under canaloplasty code 66174, the net effect of its potential combination with other codes is likely to marginally *expand* the company's reimbursement advantage to SGHT, and payment policy for such services should remain beneficial – if not improve materially in some settings – over the next 2-3 years. Also benefitting GKOS is what we expect will be accommodative reimbursement for pipeline products like iStent Infinite (~2H22) and iDose (~Mid-2023).

SGHT PHYSICIAN CUTS: PROSPECTIVE MISTAKE OR RETROACTIVE FIX?

With the market caught off guard by the 20% cut in physician payments for canaloplasty procedures – and SGHT trading off ~25% since last week – we largely reject speculation by some that this was either a mistake on the part off CMS or the byproduct of the service's nomination as a "potentially misvalued code" by an "interested party" outlined in the rule itself. While this line of thinking would imply an agency reevaluation of the code's underlying value that SGHT could pressure CMS to abandon during the public comment period, we think the cut is much more likely to be the deliberate follow up to the reweighting started in *last year's* rulemaking, as part of a two-year phase-in that CMS previously indicated it would employ in cases of large reductions.

CANALOPLASTY RELATIVE VALUE UNITS (RVUs) – CY20 to CY23

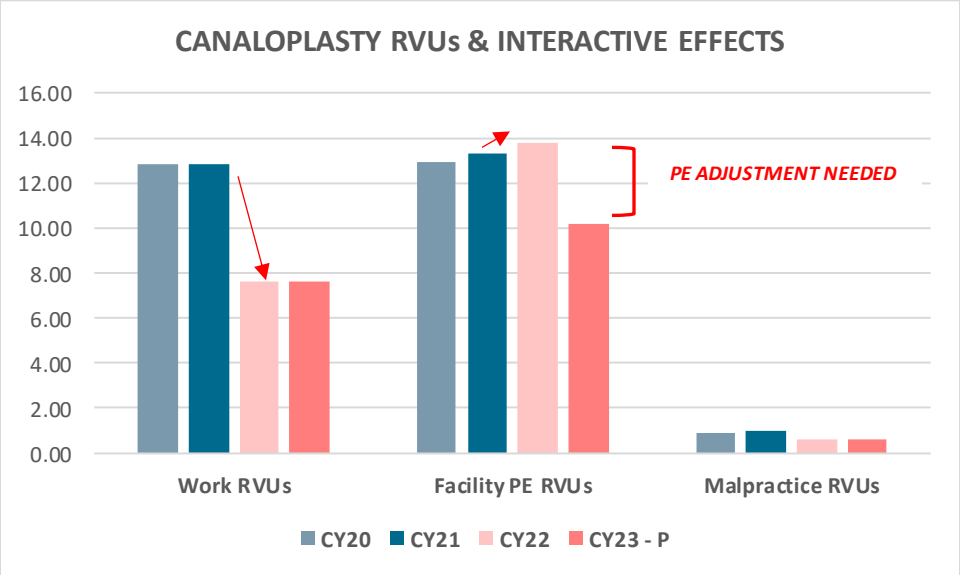
CPT 66174: CANALOPLASTY	CY20	CY21	%Δ YoY	CY22	%Δ YoY	CY23 - P	%Δ YoY
Work RVUs	12.85	12.85	*0.0%*	7.62	*-40.7%*	7.62	*0.0%*
Facility PE RVUs	12.97	13.35	*2.9%*	13.77	*3.1%*	10.18	*-26.1%*
Malpractice RVUs	0.95	0.96	*1.1%*	0.60	*-37.5%*	0.63	*5.0%*
TOTAL	**26.77**	**27.16**	***1.5%***	**21.99**	***-19.0%***	**18.43**	***-16.2%***
Conversion Factor	*$36.0896*	*$34.8931*	*-3.3%*	*$34.6062*	*-0.8%*	*$33.0775*	*-4.4%*
PAYMENT RATE	**$966.12**	**$947.70**	***-1.9%***	**$760.99**	***-19.7%***	**$609.62**	***-19.9%***

More specifically, in our view this downward revision likely stems from: (A) the interactive effects of last year's significant reduction in Work Relative Value Units (RVUs) for the canaloplasty code, prompted by recommendations from the American Medical Association (AMA) Relative Value Scale Update Committee (RUC); and (B) carryover effects related to established CMS policy that "if the total RVUs for a service would otherwise be decreased by an

estimated 20% or more as compared to the total RVUs for the previous year, the applicable adjustments….shall be phased in over a 2-year period….[and] we consider a 19% reduction as the maximum 1-year reduction for any service not described by a new or revised code."

Investors will recall that, in February 2021, the AMA RUC recommended that the Work RVU component of canaloplasty reimbursement – capturing physician procedure time – be cut by roughly 34%, from CY21's 12.85 to 8.53. This was based on physician surveys showing a median intraservice time of just 20 minutes, rather than the prior assumption of one hour, "related to increasing familiarity with the procedure and significant improvements in the instrumentation used." CMS nevertheless finalized a still greater reduction in Work RVUs in the CY22 rule, finding that 7.62 – not 8.52 – "more accurately reflects both the surveyed physician time and relative relationship among these codes and other services of similar time values."

This resulted in a YoY RVU reduction of exactly 19.0% that, coupled with a concomitant decline in the broader PFS conversion factor, triggered a 19.7% cut in overall payments. Importantly, however, the code's *Practice Expense (PE)* RVUs were left unchanged in the final rule, despite the fact that, given the indirect cost allocation associated with physician work time, this too should have been subject to a downward adjustment. This would likely have been the case were it not for the agency's cap on YoY RVU cuts exceeding 19.0%.



In short, indirect PE allocations are intrinsically associated with the Work RVUs of any given code, implying that as one goes down, so should the other. Though CMS neglected to specifically cite code 66174 in the CY22 rule text itself as being subject to this rebalancing, or even the possibility of a two-year phased-in RVU adjustment following the previously established 19.0% cut, the agency's supporting data tables ***do*** explicitly refer to canaloplasty as falling under this policy, as shown below from the source document entitled "Codes Subject to Phase-In."

HCPCS	Short Descriptor	Modifier	Facility	PE RVU Without Phase-In	PE RVU With Phase-In
66174	Translum dil eye canal		Y	9.87	13.77
66175	Trnslum dil eye canal w/stnt		Y	10.96	13.02
67311	Revise eye muscle		Y	6.82	7.61
67314	Revise eye muscle		Y	6.82	9.63
67320	Revise eye muscle(s) add-on		Y	1.83	4.16
67331	Eye surgery follow-up add-on		Y	1.23	4.85
67332	Rerevise eye muscles add-on		Y	2.15	3.86
67334	Revise eye muscle w/suture		Y	1.26	4.69

With CMS estimates showing that the CY22 PFS would have resulted in a canaloplasty PE RVU allocation of 9.87 – 3% *lower* than was actually proposed for CY23 – we think it doubtful that the reweighting will be reversed in the final rule. Though this rate reduction would naturally apply to procedures involving the GKOS iPrime transluminal dilation device as well, that device's potential *combination* use with legacy iStent procedures would actually see the company's net reimbursement advantage to SGHT *increase* YoY for such cases. In order to capitalize on this, the challenge for GKOS will be to more directly emphasize the utility of stacking these devices in medically appropriate patients.

CANALOPLASTY PROCEDURES	CY22	CY23P	$Δ YoY	%Δ YoY
Sight Sciences Omni + Cataract Removal	$1,033	$875	-$158	-15.3%
Glaukos iPrime + iStent	$1,103	$971	-$131	-11.9%
GLAUKOS DOLLAR ADVANTAGE	***$69***	***$96***	***$27***	***38.7%***
GLAUKOS PERCENTAGE ADVANTAGE	***6.7%***	***11.0%***		

Notably, this may be more easily accomplished for the iAccess micro-goniotomy device billing under code 65820, which *also* competes with the SGHT Omni in such patients, as CMS claims data (CY20) suggests that, even prior to the product's release, iStent + goniotomy combinations were more frequent than iStent + canaloplasty. While goniotomy / canaloplasty procedures are most commonly performed with a traditional cataract removal [CPT 66984], they *are* also being performed with iStent, the incremental reimbursement for which is sufficient to maintain the company's physician rate advantage.

CODE #1	CODE #2	COMBO AS % OF SERVICES
Goniotomy - 65820	66984	84%
Canaloplasty - 66174	66984	51%
iStent - 0191T	65820	1.3%
	66174	0.9%

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GONIOTOMY PROCEDURES	CY22	CY23P	$Δ YoY	%Δ YoY
Sight Sciences Omni + Cataract Removal	$1,111	$1,077	-$34	-3.1%
Glaukos iAccess + iStent	$1,180	$1,144	-$36	-3.0%
GLAUKOS DOLLAR ADVANTAGE	***$69***	***$68***	***-$2***	***-2.3%***
GLAUKOS PERCENTAGE ADVANTAGE	***6.2%***	***6.3%***		

We therefore see the biggest potential threat to this opportunity as payer pushback to either of these devices fitting the code-specific definitions of either canaloplasty or goniotomy following the AMA's plans to revise the description of the former and ophthalmology stakeholder criticisms of iAccess use under the latter. While we would be marginally more concerned for iAccess / goniotomy than for iPrime / canaloplasty, we would also be surprised to see widespread claim denials in either case.

BEYOND DOC DOLLARS: WHERE WILL FACILITY FEES LAND

We do *not* think the RVU dynamic outlined above is likely to be repeated in the CY23 ASC / hospital outpatient payment rules due for release in the coming days, where: (A) GKOS maintains a still more significant reimbursement advantage; (2) SGHT efforts to secure improved ASC rates appear unlikely to succeed; and (3) longer-term (CY24-CY25), GKOS combination procedures are well positioned to secure still broader rate advantages for the ~15% of volumes that currently flow through hospital outpatient departments.

Facility reimbursement is calculated using a fundamentally different methodology to the RVU approach within the PFS, based instead on hospital cost reports that are adjusted for individual facility mark-ups and scaling factors to

apply hospital payment rates to the lower-cost ASC setting. It is therefore unlikely that a similar payment erosion awaits investors as part of the CY23 proposal, and we would expect reimbursement to remain relatively stable YoY, as it has in previous rulemakings.

ASC PROCEDURES	CODE	CY20	CY21	%Δ YoY	CY22	%Δ YoY
Cataract Removal	66984	$1,013	$1,045	*3.2%*	$1,063	*1.8%*
Canaloplasty	66174	$1,836	$1,882	*2.5%*	$1,919	*1.9%*
Goniotomy	65820	$1,836	$1,882	*2.5%*	$1,919	*1.9%*
iStent + Cataract	66991	$3,224	$3,353	*4.0%*	$3,246	*-3.2%*

What *is* similar to physician payment rules, however, is the mechanism for compensating facilities that perform multiple procedures / claims within one operative session, whereby ASCs will receive 100% of the established payment amount for the "primary" (read: highest paying) procedure and 50% of the CMS-set rate for subsequent services. We also note that, with both canaloplasty and goniotomy codes assigned to the same Ambulatory Payment Classification (APC) group in the hospital outpatient setting, forming the basis of their ASC payments, the delta for their combination with either standard cataract removal [i.e. SGHT] or iStent [i.e. GKOS] remains the same. Though GKOS of course lost some ground in last year's rulemaking cycle as part of its iStent coding transition, it nevertheless maintains a significant rate advantage of ~$1,750.

ASC GONIOTOMY / CANALOPLASTY	CY21	CY22	$Δ YoY	%Δ YoY
Sight Sciences Omni + Cataract Removal	$2,404	$2,450	$46	1.9%
Glaukos iAccess / iPrime + iStent	$4,294	$4,205	-$89	-2.1%
GLAUKOS DOLLAR ADVANTAGE	***$1,890***	***$1,755***	***-$135***	***-7.1%***
GLAUKOS PERCENTAGE ADVANTAGE	***78.6%***	***71.6%***		

For both standalone and combination procedures set in the hospital outpatient department, facilities are paid a fixed amount based on the APC assignment of whatever "primary" service is selected, with all additional code lines incorporated into a single standardized amount. In other words, for ***most*** cases, hospitals receive the same payment whether they perform a standalone procedure or "stack" several billing codes together, with numerous codes all grouped together.

STANDALONE HOSPITAL PROCEDURES

HOSPITAL OUTPATIENT	APC	CY20	CY21	%Δ YoY	CY22	%Δ YoY
Cataract Removal	5491	$2,022	$2,079	*2.8%*	$2,121	*2.0%*
Canaloplasty	5492	$3,818	$3,918	*2.6%*	$4,000	*2.1%*
Goniotomy	5492	$3,818	$3,918	*2.6%*	$4,000	*2.1%*
iStent + Cataract	5492 / 1526	$3,818	$3,918	*2.6%*	$4,251	*8.5%*

COMBINATION PROCEDURES

HOSPITAL GONIOTOMY / CANALOPLASTY	CY21	CY22	$Δ YoY	%Δ YoY
Sight Sciences Omni + Cataract Removal	$3,918	$4,000	$82	2.1%
Glaukos iAccess / iPrime + iStent	$3,918	$4,251	$333	8.5%
GLAUKOS DOLLAR ADVANTAGE	***$0***	***$251***	***$251***	--------
GLAUKOS PERCENTAGE ADVANTAGE	***0%***	***6.3%***		

Where this rule does ***not*** apply, however, is when the costs of two frequently combined procedures are sufficiently high to trigger a "Complexity Adjustment," whereby payments automatically increase to those for the next highest paying APC group. In the case of billing codes currently assigned to APC 5492 [e.g., canaloplasty, goniotomy], paying

$4,000 for CY22, this is highly significant given that APC 5493 rates are set at $7,494, representing an 87% premium over the status quo. Importantly, iStent procedures had *also* been assigned to APC 5492 prior to last year's deletion of its legacy Category III code (0191T) and its replacement with the permanent Category I code 66991, which has received *temporary* assignment to the New Technology APC 1526, currently paying $4,251.

While the New Technology APC assignment means that GKOS iStent services are not currently eligible for a Complexity Adjustment, we would expect it to once again be assigned to its historic APC group once CMS has collected sufficient claims data to support permanent assignment, likely by CY24. Although this would bring standalone GKOS / SGHT hospital payments back into parity, it also presents a significant opportunity for *combination* procedures.

CMS cost data demonstrate that, while SGHT cases do not have sufficient expenses to be lifted into the next highest paying APC, those involving iStent + either goniotomy (i.e., iAccess) or canaloplasty (i.e., iPrime) do, and we would expect that dynamic to continue. This would take the current 6% rate advantage for GKOS procedures to 87%, while also representing a 75% increase in payments relative to the CY22 status quo under New Technology APC 1526. In fact, of the 852 code combinations that CMS evaluates within this legacy APC group, just seven qualify for a complexity adjustment, and of these, two are directly applicable to GKOS: (1) iStent + canaloplasty; and (2) iStent + goniotomy.

HCPCS #1	APC #1	HCPCS #2	APC #2	COMPLEXITY ADJUSTED APC	COMBINATION GEOMEAN COST	ADJUSTMENT COST THRESHOLD	COMPLEXITY ADJUSTMENT	ADJUSTED PAYMENT RATE
0191T	5492	65820	5492	5493	$8,845	$5,384	Y	$7,494
67113	5492	66984	5491	5493	$6,048	$5,384	Y	$7,494
0191T	5492	66174	5492	5493	$6,396	$5,384	Y	$7,494
66180	5492	67036	5492	5493	$6,296	$5,384	Y	$7,494
67108	5492	66984	5491	5493	$5,982	$5,384	Y	$7,494
65730	5492	66982	5491	5493	$6,141	$5,384	Y	$7,494
65756	5492	67010	5491	5493	$5,398	$5,384	Y	$7,494

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CAN SGHT DO ANYTHING TO COUNTER THIS POSSIBILITY?

Unlikely, and we suspect that available options would have only incremental effects, while also being more applicable to ASC-based services.

In the previous two years, SGHT has sought CMS designation of canaloplasty code 66174 as a "device intensive procedure," and has been subsequently denied, though we suspect that a recent meeting with the agency was intended to reassert that request. This status is reserved for services whose device component – known as the device offset amount – represents ≥ 30% of a procedure's mean cost, which can then be carried over to the ASC setting to improve reimbursement.

In short, when hospital-based procedures are performed in the ASC, payment weights for both the device and service components are scaled down to reflect the reduced overhead costs borne by the facility. In the case of device intensive procedures, however, ASCs retain the *hospital-based* device portion of the payment, with only the service portion being negatively adjusted, thereby increasing facility payments relative to alternative options and making them incrementally more attractive.

Historically, GKOS iStent procedures have had a device offset percentage of ~55%, while those for goniotomy and canaloplasty have been consistently calculated by CMS at less than 20%.

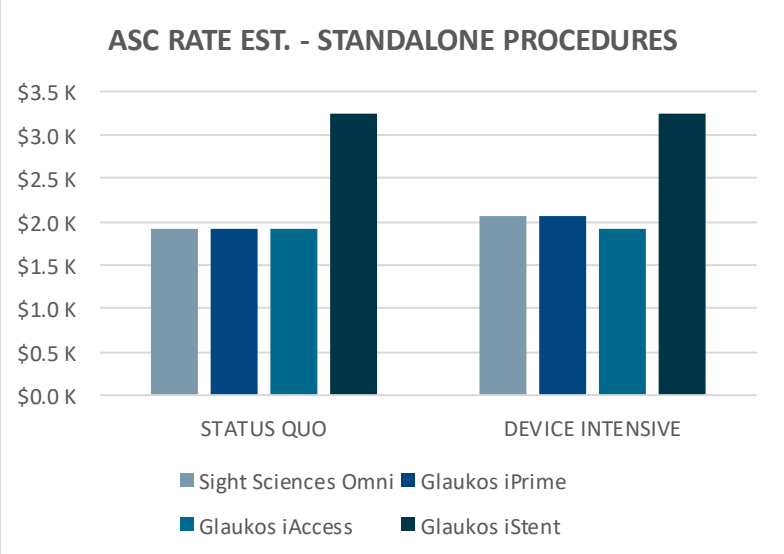
	CY20		CY21		CY22	
PROCEDURE	OFFSET %	SHORTFALL	OFFSET %	SHORTFALL	OFFSET %	SHORTFALL
iStent	55%	$958	55%	$962	55%	$1,044
Canaloplasty	8%	-$854	18%	-$456	18%	-$466
Goniotomy	10%	-$754	10%	-$767	10%	-$783
Cataract Removal	13%	-$335	13%	-$356	13%	-$364

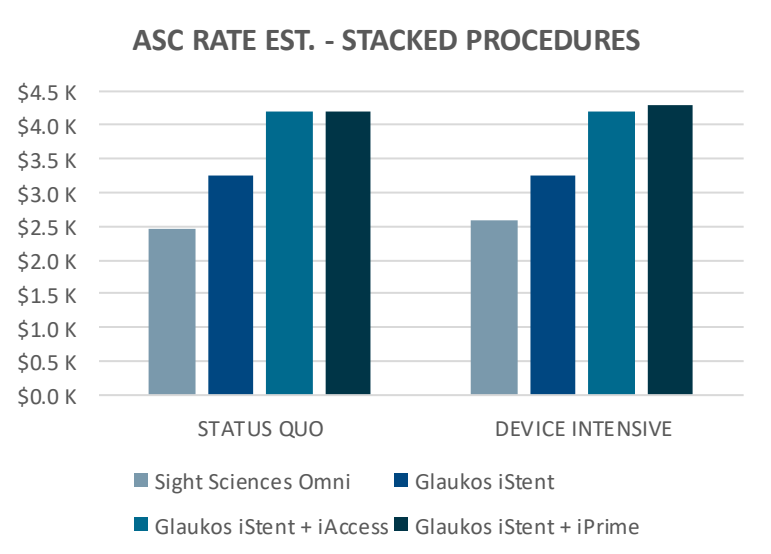
As shown in the table above, this would appear to leave such services well short of the necessary threshold for "device-intensive" status. We nevertheless suspect that the manufacturer will argue that these data are premised on incorrect hospital cost reporting, and that the agency should use its discretion to at least temporarily base code-specific device offset amounts on company-supplied invoices.

While CMS *has* adopted such an approach in the past, it also repeatedly reminds applicants that this is only suitable in rare instances, and that "it would be inappropriate to apply a higher device offset percentage or increase the payment rate in the ASC setting simply because a device's invoice price is greater than the procedure's device offset amount." In other words, SGHT will likely have a difficult time persuading CMS to see things its way.

If we are wrong in that assessment, our recreation of CMS methodologies suggests that, after scaling the service component and applying the ASC-specific conversion factor, meeting the 30% threshold would likely result in YoY reimbursement improvements of just 5% to 12%. It should also be remembered that any such increase would apply equally to GKOS iPrime procedures billing under code 66174 as well, including both standalone and combination services. While such a change *would* cut into GKOS's net payment advantage, the likely magnitude strikes us as insufficient to meaningfully facilitate SGHT market share gains or price increases to bolster margins.

CANALOPLASTY PROCEDURES	PAYMENT RATE	%Δ
STATUS QUO	**$1,919**	-
Low Estimate	$2,020	5.3%
Median Estimate	$2,074	8.1%
High Estimate	$2,148	12.0%





EYEING UP PIPELINE PRODUCT PAYMENTS: iSTENT INFINITE

With GKOS still targeting FDA approval of its standalone aqueous drainage device iStent Infinite (i.e., without concomitant cataract removal) for use in refractory glaucoma patients, we are cautiously optimistic on the rollout from a Medicare reimbursement standpoint, noting that CMS has already established *facility* rates for the relevant billing code [CPT 0671T], paying ASCs $1,601 and hospital outpatient departments $2,121.

PRODUCT	ASC RATE	ASC DEVICE OFFSET	HOSPITAL	HOSPITAL DEVICE OFFSET
iStent Inject	$3,246	$2,212	$4,251	$2,319
iPrime	$1,919	$472	$4,000	$734
iAccess	$1,919	$140	$4,000	$417
iStent Infinite	$1,601	$1,091	$2,121	$1,157

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The more difficult question remains how the individual Medicare Administrative Contractors (MACs) will price *physician* reimbursement for this Category III procedure, though there too we see reason to expect rates to support adoption.

To date, just one MAC – First Coast, facilitating claims in the state of Florida – has a published a fee schedule amount for 0671T, paying an average of ***$1,059***, or a ***nearly 2x premium*** to what it had paid for the legacy iStent Inject code 0191T (~$360). Though First Coast has been responsible for just ~10% of those services, we note that it operates under the same parent company as MAC Novitas [TX, PA, NJ, MD, DC, CO, LA, OK, AR, MS, NM], which processed 26% of 0191T procedures in the last available claims year (CY20), and the two often coordinate on reimbursement / coverage considerations. It is therefore reasonable to assume that Novitas may adopt a similarly generous payment level that would allow GKOS to rapidly scale in those regions.

While this figure likely implies significant upside to investor expectations, we think it prudent to adopt a more conservative approach for other localities, and would look for rates to come in closer to the volume-weighted average of 0191T MAC payments, or $400-$500. Tempering our expectations is the fact that, following publication of the iStent Inject *national* codes for CY22 – whereby physicians performing device procedures *inclusive* of cataract removal [CPT 66991] are paid $683 – CMS's implied marginal valuation of the device-only component is just $139, reached by reducing this rate by the current cataract-only reimbursement amount of $545 [CPT 66984].

Though we struggle to understand why First Coast would pay such a significant premium to combination device + cataract procedure, given that iStent Infinite's value proposition is use case on a standalone basis, we do not think that merely excising the cataract input from the existing code is an appropriate methodology for expectations. There are presumably other procedural work requirements for iStent Infinite implants that would not be captured by such a simplified exercise, and MACs have a history of accommodative pricing for temporary Category III codes like 0671T.

By the same token, it is impossible to validate the $1,000+ rate endorsed by First Coast in the *absence* of currently unavailable procedural information, but a cursory RVU buildup suggests that a middle ground between these two extremes is likely reasonable. The below incorporates the pre-and post-service work currently included in the iStent Infinite code for physician payment, while also assuming an intraservice time for standalone procedures that is five minutes shorter than traditional cataract removal. It next includes the same PE RVU contribution as iStent Infinite and an identical malpractice risk premium, resulting in an estimated payment rate of $576.

0671T RVU BUILD ESTIMATE	RVUs
Work RVUs	6.50
PE RVUs	10.19
Malpractice RVUs	0.73
Total RVUs	*17.42*
IMPLIED RATE	**$576**

iDOSE: LITTLE VISIBILITY, BUT REASON FOR OPTIMISM

Despite investor enthusiasm, there is even less information to inform a reasonable reimbursement expectation for the iDose drug-eluting stent, with the company targeting FDA approval in 1H23 for refractory glaucoma and ocular hypertension, using a proprietary formulation of travoprost. We nevertheless think it unlikely that physician reimbursement would represent a material headwind for adoption.

CMS has already endorsed procedure codes for both implantation (0660T) and removal / replacement (0661T), and though they are currently excluded from Medicare payment, the most significant reimbursement component will likely stem from a product-specific J-Code (or temporary Q-Code) paid at 106% of travoprost's Average Sales Price (ASP), as has been the case for other drug / device combinations. At the very least, this implies that GKOS will maintain significant pricing discretion, and that implanting providers will receive – on average – a 6% margin on product acquisitions.

A review of CMS's ASP Pricing Files do not offer up much in the way of useful datapoints (i.e., other products inclusive of travoprost), but the means by which J-Codes / Q-Codes are assigned suggests that GKOS should receive this necessary marketing element within just 1-3 quarters of FDA approval. Assuming agency endorsement by mid-2023, this would suggest that Medicare claims processing / reimbursement could begin by 4Q23.

CMS DRUG CODE REVIEW CYCLES

REVIEW CYCLE	APPLICATION DEADLINE	CMS DECISION	CODE EFFECTIVE
CYCLE ONE	JANUARY 1	APRIL	JULY 1
CYCLE TWO	APRIL 1	JULY	OCTOBER 1
CYCLE THREE	JULY 1	OCTOBER	JANUARY 1
CYCLE FOUR	OCTOBER 1	JANUARY	APRIL 1

APPENDIX

PHYSICIAN PAY FOR GKOS & SGHT OPTHALMOLOGY CODES

CPT 66174: CANALOPLASTY	CY20	CY21	%Δ YoY	CY22	%Δ YoY	CY23 - P	%Δ YoY
Work RVUs	12.85	12.85	*0.0%*	7.62	*-40.7%*	7.62	*0.0%*
Facility PE RVUs	12.97	13.35	*2.9%*	13.77	*3.1%*	10.18	*-26.1%*
Malpractice RVUs	0.95	0.96	*1.1%*	0.60	*-37.5%*	0.63	*5.0%*
TOTAL	**26.77**	**27.16**	***1.5%***	**21.99**	***-19.0%***	**18.43**	***-16.2%***
Conversion Factor	*$36.0896*	*$34.8931*	*-3.3%*	*$34.6062*	*-0.8%*	*$33.0775*	*-4.4%*
PAYMENT RATE	**$966.12**	**$947.70**	***-1.9%***	**$760.99**	***-19.7%***	**$609.62**	***-19.9%***

CPT 65820: GONIOTOMY	CY20	CY21	%Δ YoY	CY22	%Δ YoY	CY23 - P	%Δ YoY
Work RVUs	8.91	8.91	*0.0%*	8.91	*0.0%*	8.91	*0.0%*
Facility PE RVUs	12.66	14.07	*11.1%*	14.63	*4.0%*	14.88	*1.7%*
Malpractice RVUs	0.64	0.66	*3.1%*	0.68	*3.0%*	0.73	*7.4%*
TOTAL	**22.21**	**23.64**	***6.4%***	**24.22**	***2.5%***	**24.52**	***1.2%***
Conversion Factor	*$36.0896*	*$34.8931*	*-3.3%*	*$34.6062*	*-0.8%*	*$33.0775*	*-4.4%*
PAYMENT RATE	**$801.55**	**$824.87**	***2.9%***	**$838.16**	***1.6%***	**$811.06**	***-3.2%***

CPT 66984: CATARACT REMOVAL	CY20	CY21	%Δ YoY	CY22	%Δ YoY	CY23 - P	%Δ YoY
Work RVUs	7.35	7.35	*0.0%*	7.35	*0.0%*	7.35	*0.0%*
Facility PE RVUs	7.57	7.83	*3.4%*	7.83	*0.0%*	8.11	*3.6%*
Malpractice RVUs	0.53	0.53	*0.0%*	0.56	*5.7%*	0.59	*5.4%*
TOTAL	**15.45**	**15.71**	***1.7%***	**15.74**	***0.2%***	**16.05**	***2.0%***
Conversion Factor	*$36.0896*	*$34.8931*	*-3.3%*	*$34.6062*	*-0.8%*	*$33.0775*	*-4.4%*
PAYMENT RATE	**$557.58**	**$548.17**	***-1.7%***	**$544.70**	***-0.6%***	**$530.89**	***-2.5%***

CPT 66991: DRAINAGE DEVICE + CATARACT REMOVAL	CY20	CY21	%Δ YoY	CY22	%Δ YoY	CY23 - P	%Δ YoY
Work RVUs	-	-	-	9.23	-	9.23	*0.0%*
Facility PE RVUs	-	-	-	9.84	-	10.19	*3.6%*
Malpractice RVUs	-	-	-	0.68	-	0.73	*7.4%*
TOTAL	**-**	**-**	**-**	**19.75**	**-**	**20.15**	***2.0%***
Conversion Factor	*$36.0896*	*$34.8931*	-	*$34.6062*	*-0.8%*	*$33.0775*	*-4.4%*
PAYMENT RATE	**-**	**-**	**-**	**$683.47**	**-**	**$666.51**	***-2.5%***

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