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Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: CMS-1676-P; Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program

Dear Administrator Verma,

On behalf of the 7,400 members of The Society of Thoracic Surgeons (STS), I am writing to provide comments on the Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program as published in the *Federal Register* on July 21, 2017. STS appreciates the opportunity to comment on the physician fee schedule for the 2018 calendar year.

Founded in 1964, STS is an international not-for-profit organization representing more than 7,400 cardiothoracic surgeons, researchers, and allied health care professionals in 90 countries who are dedicated to ensuring the best surgical care for patients with diseases of the heart, lungs, and other organs in the chest. The mission of the Society is to enhance the ability of cardiothoracic surgeons to provide the highest quality patient care through education, research, and advocacy.

General Comments on Global Payments

STS continues to have strenuous concerns with the methodology employed by CMS to collect data on glocal surgical payments. We have very little faith that mandatory reporting of a single code (99024) for every postoperative visit performed by surgeons in nine states and a broader survey of surgeons across the United States will provide CMS with valid and actionable information. We also fear surgeons were not adequately educated and prepared for the mandatory submission of 99024 codes for postoperative visits. Without the time needed to effectively educate providers on the data collection and without CMS's communication regarding logistics, submission, and analysis of the data, we fear that CMS will not accurately capture the data needed for a comprehensive view of postoperative care. Without an accurate picture of postoperative care, the potential re-valuation of global surgical services may be seriously flawed.

We ask that CMS halt implementation of data collection until the data collection methodology can be validated. Further, we encourage CMS to provide more education to providers on this data collection effort to ensure a more complete picture of the postoperative services of cardiothoracic surgeons.

I. Provisions of the Proposed Rule for Physician Fee Schedule

Determiniation of Practice Expense Relative Value Units (PE RVUs)
Changes to Direct PE Inputs for Specific Services: Standardization of Clinical Labor Tasks (Preservice Clinical Labor for 0-Day and 10-Day Global Service

Proposed Change:
CMS is seeking comment on the value and appropriate application of the standard in our review of RUC recommendations in future rulemaking. In reviewing the inputs included in the direct PE inputs database, CMS found that for the 1,142 total 0-day global codes, 741 of them had preservice clinical labor of some kind (65 percent). CMS is seeking comment specifically on whether the standard preservice clinical labor time of 0 minutes should be consistently applied for 0-day and 10-day global codes in future rulemaking.

STS disagrees with the proposal to consistently apply a standard preservice clinical labor time of 0 minutes for 0-day and 10-day global codes in future rulemaking. Rather than move forward, STS recommends that CMS work with the Relative Value Scale Update Committee (RUC) and specialty societies to 1) identify specific 0- and 10-day global services that currently have clinical staff time that do not meet the current criteria for compelling evidence, 2) identify specific circumstances where deviations from the standard for clinical staff time associated with 0- and 10-day global services would be appropriate, and 3) extrapolate clear definitions and criteria that support compelling reasons for clinical staff time for 0- and 10- day global procedures.

A number of complex cardiothoracic surgery procedures have recently been valued and implemented as 0-day global procedures, however in the past, these would have been valued as 90-day global services. Revaluing these procedures to 0-day global services allowed clinicians on the care team the flexibility to provide needed care to the patient during extended hospital stays or extensive postoperative care for procedures such as transcatheter aortic valve replacement (TAVR) and extracorporeal membrane oxygenation (ECMO). Additionally, there are many 0-day global services, such as diagnostic thoracoscopy, that are performed in a hospital inpatient setting under general anesthesia where the patients will have a multi-day hospital stay. For these types of procedures, the typical clinical staff activities are the same as they would be if the procedure had a 90-day global. They are complex procedures involving the coordination of multiple clinicians, complex scheduling for operating rooms, specialized personnel and equipment, and obtaining consent, among other activities. **STS agrees that the standard time of "0" minutes is appropriate for many 0- and 10-day global procedures but not all. STS disagrees with CMS' proposal to consistently apply a standard preservice clinical labor time of 0 minutes for 0-day and 10-day global codes in future rulemaking.**

Changes to Direct PE Inputs for Specific Services: Standardization of Clinical Labor Tasks (Obtain Vital Signs Clinical Labor)

Proposed Change:
CMS is proposing to assign 5 minutes of clinical labor time for all codes that include the "Obtain vital signs" task, regardless of the date of last review. CMS is proposing to assign this 5 minutes of clinical labor time for all codes that include at least 1 minute previously assigned to this task. CMS is also proposing to update the equipment times of the codes with this clinical labor task accordingly to match the changes in clinical labor time. For codes that were not recently reviewed and for which CMS lacked a

breakdown of how the equipment time was derived from the clinical labor tasks, CMS could not determine if the equipment time included time assigned for the "Obtain vital signs" task. In these cases, CMS is proposing to adjust the equipment time of any equipment item that matched the clinical labor time of the full service period to match the change in the "Obtain vital signs" clinical labor time. The proposed list of all codes affected by these proposed vital signs changes to direct PE inputs is available on the CMS website under downloads for the CY 2018 PFS proposed rule.

STS disagrees with the CMS proposals to assign 5 minutes of clinical labor time for all codes that include the "obtain vital signs" task, include at least 1 minute previously assigned to this task, or update the equipment times of the codes with this clinical labor task accordingly to match the changes in clinical labor time. STS encourages CMS to work with the RUC to evaluate each CPT code independently based on what is typical for that service, rather than unilaterally increasing or decreasing direct PE inputs without physician input.

The RUC PE Subcommittee's current practice expense standard for obtaining vital signs is divided into three levels of service with the following times:

- Level 0 (no vital signs taken) = 0 minutes
- Level 1 (1-3 vitals) = 3 minutes
- Level 2 (4-6 vitals) = 5 minutes

STS agrees that the RUC standard times identified above are accurate and the best way to make sure that individual codes are allocated the correct amount of time for the clinical staff work performed for each CPT code. The amount of clinical staff work performed varies on an individual code basis and the inputs for each code are reviewed and discussed by the RUC PE Subcommittee when time associated with any clinical labor task is increased. This ensures that the correct inputs are assigned to each code based on the clinical work performed.

Determination of Malpractice Relative Value Units (MP RVUs)

MP Premium Data

Proposed Change:
CMS proposes to use the most recent data for MP RVUs for 2018 and to align the update of MP premium data and MP GPCIs to once every 3 years. CMS is also seeking comment on methodologies and sources it might use to improve the next update of the MP premium data.

Although STS continues to believe that if CMS has access to updated data for the PLI Premium Update, it is imprudent for the Agency not to use it. However, STS has serious concerns with the Agency's proposal to update the MP RVUs for CY 2018. Specifically, STS has concerns with respect to changes to the methodology and data collection processes.

For the CY 2015 MP RVU update, the CMS contractor, Acumen, collected MP premium data to calculate a national average for each specialty. Acumen examined the differences among four calculation options for comparison and validation purposes, including:

- Option 1: Sum all county-level price adjustment premiums, weighted by share of total population

- Option 2: Sum all county-level price adjustment premiums, weighted by the share of work and PE RVUs
- Option 3: Sum all county-level price adjustement premiums, weighted by the share of total RVUs
- Option 4: Sum the ratio of each total RVU weighted specialty premium to each MP RVU-weighted MP GPCI

Based on Acumen's determination that there were generally no substantial differences in national average premiums when comparing each option, CMS incorporated population estimates from the American Community Survey as weights for calculating specialty premiums. Option 1, which weights national average premiums with population estimates, was utlitzed to calculate MP RVUs. Thus, the American Community Survey data replaced the use of total RVU and MP RVUs to weight specialty premiums. **We disagree with the assumption that the differences between the options were not substantial with and feel that Option 1 (population weighting) is different than Options 2-4 (RVU weighting).** We are concerned that using the population weight option is an incorrect methodology and will negatively affect clinicians. This methodology does not reflect differences in risk-of-service in different areas of the country. **Geographic premium rate differences are based on risk and paid claims, not on how many people live in a geographic area**. Premiums should be normalized using surgical and non-surgical work RVUs for each geographic area. Recognizing risk-of-service provides a more accurate reflection of how services may differ and will better inform professional medical liability policies. Taking into account the time, intensity, and difficulty of the service is imperative to understanding malpractice risk. Currently, the work RVUs reflect differences in time, intensity, and difficulty among procedures. STS believes that these work RVUs currently provide the most accurate substitution for weighting geographic differences to calculate national average premiums. **We urge CMS to use work RVUs rather than population to weight geographic differences in the national average premiums calculations.**

For a number of specialties there was a wide variation in whether premium classes were reported and which categories were reported (including surgical versus non-surgical). Acumen blended the available rate information into one general premium rate using a weighted average "blended" premium at the national level, according to the percentage of work RVUs correlated with the premium classes within each specialty. For specialties where there was not premium data for at least 35 states, and for specialties for which there were not distinct premium data in the rate filings, Acumen crosswalked the specialty to what it though was a "similar" specialty, either conceptually or by available premium data. Nearly 40 percent of the specialties were crosswalked because of insufficient data, which raises concern regarding the validity of the premium data. **We do not believe that a single premium that blends whatever data are available for surgical, non-surgical, and unspecified premium accurately and fairly contributes to the final calculation of MP RVUs.** For example, for cardiology, the CMS contractor collected data regarding major surgery premiums for cardiologists in 41 states in 2015. In 2018, CMS's contractor was only able to collect data in 12 states for "major surgery." It is doubtful that this is due to a decrease in the number of interventional cardiologists performing procedures. It is more likely due to a difference in the data collection process and/or a change in practice from individual to group or employment status or changes in states' catagorization of cardiologists as interventional cardiologists, which would make it more difficult to obtain premium data. As currently proposed, the surgical MP factor for cardiology is reduced by about 73%, from 6.98 to 1.90, ignoring a surgical surgical risk factor for invasive cardiology procedures performed in and on the heart. CMS has consistently applied a surgical risk factor to invasive cardiology procedures that fall within the surgical HCPCS code range and

to identified HCPCS codes outside the surgical HCPCS code range, stating "we continue to believe that the malpractice risk for cardiac catheterization and angioplasty services are more similar to the risk of surgical procedures than to most nonsurgical service codes." **We urge CMS to continue to recognize a surgical risk factor for invasive cardiology procedures because a significant difference exists for these services that must be incorporated into a relativity-based payment system.**

Furthermore, STS urges CMS to make a more concerted effort to obtain broad surgical premium data and recommends that CMS use the previous surgical premiums until more data can be obtained instead of using blended premiums for MP RVU calculations. If CMS uses the proposed methodology, we recommend that CMS apply a crosswalk from the cardiac surgery risk factor of 6.87 to the cardiology surgical risk factor.

Methodolgy for Proposed Revision of Resource-Based Malpractice RVUs
Low Volume Service Codes

Proposed Change:
CMS requests comment on the proposal to use the service-level overrides to determine specialty mix for low volume services and the list of overrides.

STS supports the proposal to use service-level overrides to determine specialty mix for low volume service using the specialty for both Practice Expense (PE) and Professional Liability Insurance components. STS strongly encourages CMS to ensure that the correct override specialty is assigned to the low volume services as recommended by the specialty societies and the RUC. Additionally, we urge CMS to implement processes that will ensure that these overrides are consistently and accurately implemented each year.

STS appreciates that CMS is correcting the majority of the malpractice (PLI) RVU errors for the low volume thoracic surgery and congenital heart surgery codes that STS identified in previous comments. However, we remain concerned with certain codes within the low volume service code set. First, there are codes that CMS has not correctly identified as cardiac surgery or thoracic surgery services for the low volume specific malpractice (PLI) RVU. Second, some codes have been identified as the correct specialty for a low volume service; however, CMS did not initially apply the correct MP risk factor to the service. Third, there are several codes that were not included in CY2018 NPRM low volume override list.

Many of these low volume services are performed by congenital cardiac surgeons in the Medicaid population. For several years, the RUC and specialties with low volume services, including STS, have asserted that CMS should use an "expected/anticipated" specialty assignment, rather than claims data, to assign a professional liability risk factor to low volume codes. Flawed claims data for a low volume code may significantly distort the PLI RVU and may have a negative effect on the cardiothoracic surgery specialty, particularly for those services performed in non-Medicare populations such as congenital cardiac surgery.

STS reviewed the CMS file titled *Anticipated Specialty Assignment for Low Volume Services*, that was provided as a supporting file document to the *CY 2018 Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018 Proposed Rule for the Medicare Shared Savings*

Program Requirements; and Medicare Diabetes Prevention Program. STS has concerns with the final override list. These concerns are addressed below:

First, several codes were not included in the proposed CY2018 low volume override list. Therefore, **STS recommends that the following specialties be assigned to the indicated low volume procedures for the override list: Cardiology: 33477; Cardiac surgery: 33238, 33514, 33548, 33951, 33953, 33955, 33957, 33958, 33959, 33962, 33963, 33964, 33965, 33969, 33973, 33985, 33987, 33988, 33989, 33991, 35271; General Surgery: 35251, 43325; Thoracic Surgery: 32672, 33025, 33215, 43135**.

Second, despite identifiying the dominate specialty as cardiac surgery in the CMS low volume specialty override list the MP RVUs in the originally published addendum B of the proposed rule did not reflect that cardiac surgery was applied as the override specialty for the following codes: 33470, 33471, 33610, 33676, 33677, 33684, 33690, 33710, 33737, 33750, 33755, 33762, 33764, 33768, 33775, 33776, 33777, 33779, 33780, 33781, 33782, 33803, 33813, 33822 and 33925. After the American Medical Association (AMA) notified CMS of this error, a corrected file was released.

While STS appreciates that this error was promptly corrected, we are concerned that processess are not in place to ensure that the low volume service overrides are consistently applied on a yearly basis. STS has submitted a number of codes to CMS in previous years and has asked that they be assigned to the low volume override code set. Appendix B provides the full list of the cardiothoracic low volume codes and the recommened dominate specialty assignment.

STS strongly encourages CMS to implement a process that provides consistency in implementing this override each year.

Lastly, the CMS specialty code assignments included in the override list is not representative of the dominate specialty that performs the procedures. **STS recommends the following changes to the indicated codes on the low volume override list:**

- **Codes 33363 and 33364 - change the override specialty from cardiology to cardiac surgery**
- **Codes 33516, 33976 and 35812- change the override specialty from thoracic surgery to cardiac surgery**
- **Codes 35311 and 35526- change the override specialty from vascular surgery to cardiac surgery**
- **Codes 38382, 43108, 43118, 43123, 43360, 43405 and 43425- change the override specialty from general surgery to thoracic surgery.**

Medicare Telehealth Services

Adding Services to the List of Medicare Teleheatlh Services G0296 (Counseling visit to discuss need for lung cancer screening using low dose ct scan (LDCT)

Proposed Change:
In response to a request that this code be added, CMS believes that the service described by this code is sufficiently similar to office visits currently on the telehealth list and that all components of the service can be furnished via interactive telecommunications technology. Therefore, CMS proposed to add G0296 to the list of Medicare telehealth service under Category 1.

STS appreciates that CMS has identified the need for counseling patients on the need for lung cancer screenings using LDCT. Therefore, we agree with the proposed addition of G0296 to the list of Medicare telehealth services as a Category 1.

Lung cancer is the leading cancer killer in both men and women in the United States with over half of people with lung cancer dying within one year of being diagnosed. This is predominately because lung cancer is not usually detected in the early stages.

Sadly, due to the lack of early diagnosis, lung cancer causes more deaths than the next three most common cancers combined (colon, breast and pancreatic). By adding the counseling visit to discuss the need for lung cancer screenings will increase the number of patients who will benefit from a LDCT lung cancer screening and decrease the number of late stage lung cancer diagnosis.

Proposed Valuation of Specific Codes

Tracheostomy (CPT codes 31600, 31601, 31603, 31605, and 31610)

Proposed change
CPT code 31600 was identified as part of a screen of high expenditure services with Medicare allowed charges of $10 million or more that had not been recently reviewed. CPT codes 31601, 31603, 31605, and 31610 were reviewed as part of the code family.

STS agrees with the CMS proposal to accept the RUC-recommended work RVUs for all five codes in the tracheostomy family. CMS proposes a work RVU of 5.56 for CPT code 31600, a work RVU of 8.00 for CPT code 31601, a work RVU of 6.00 for CPT code 31603, a work RVU of 6.45 for CPT code 31605, and a work RVU of 12.00 for CPT code 31610.
CMS considered a work RVU of 6.50 for CPT code 31601 and is seeking comment on the effect that this alternative value would have on relativity compared to other PFS services, especially since the survey data does not suggest an increase in the time required to perform the procedure.

Compelling evidence that the current work value for CPT code 31601 was based on flawed methodology was approved by the RUC. CMS should not compare recommend work RVU and physician time to the current value and physician time. In their consideration of an alternate value, CMS does not provide any crosswalks or reference to how they arrived at the alternate work RVU. **STS recommends that CMS rely on valid survey data accepting the RUC recommended work RVU of 8.00 for CPT code 31601 as proposed.**

For CPT code 31605 CMS considered a work RVU of 4.77, based on the survey 25th percentile from the combined survey total and an intra-service work time of 15 minutes using the median intra-service work time from the combined survey total for CPT code 31605. CMS indicated they had concerns with the low number of survey respondents and the available 0-day global codes for crosswalk with similar RVUS and intra-service time. As with 31601, the RUC-approved compelling evidence for this code based on flawed methodology, and CMS should not compare the recommend work RVU and physician time to the current value and physician time. A rank order anomaly within this family of services will be created if CMS uses the 25th percentile combination of survey data between those who perform this service and those who have not, resulting in a lower work RVU for this intense emergency tracheostomy compared

to a planned tracheostomy, CPT code 31600, and others in the family. As with other procedures, CMS should consider the physician work for the service as a whole, including time and intensity, and not just focusing on the time. **STS recommends CMS finalize the RUC recommended work RVU of 6.45 for CPT code 31605 as proposed.**

CMS considered a work RVU of 6.50 for CPT code 31610 based on a direct crosswalk to CPT code 31601 indicating concerns about the negative derived intensity and the significant amount of time included in the postoperative visits compared to the amount of intra-service time. CMS also considered if a 0-day global period should be assigned to CPT code 31610. Using a crosswalk to the alternative work RVU of 31601 is arbitrary and, as outlined above in 31610, CMS provided no rationale or crosswalk supporting the considered value for 31601. Pursuing this type of methodology will perpetuate the flawed methodology in valuing these services. Assigning a work RVU based solely on them having the same intra-service time, once again disregards the variation in physician work and intensity for the procedures. CPT code 31610 is a major surgery and is appropriately classified as a 90-day global period, changing the procedure to a 0-day global period would also negatively impact the associated direct practice expenses in the post-operative period. The RUC reviewed each post-operative visit and the levels identifying the work performed at each encounter and agreed that they were appropriate for the associated post-operative care. **STS recommends that CMS finalize the RUC recommended work RVU of 12.00 and maintain the 090-day global period assignment for CPT code 31610 as prosed.**

<u>Artificial Heart System Procedures (CPT codes 339X1, 339X2, and 339X3)</u>

Proposed Change:
For CY 2018, the CPT Editorial Panel deleted Category III CPT Codes 0051T through 0053T and created CPT codes 339X1, 339X2, and 339X3 to report artificial heart system procedures. CMS is proposing the RUC-recommended work RVU of 49.00 for CPT code 339X1, and proposing to assign contractor-priced status to CPT codes 339X2 and 339X3 as recommended by the RUC.

CMS considered assigning contractor-priced status for CPT code 339X1. CMS has concerns regarding the accuracy of the RUC-recommended work valuation for CPT code 339X1, due to its low utilization and the resulting difficulties in finding enough practitioners with direct experience of the procedure for the specialty societies to survey. CMS seeks comment on the sufficiency of the survey data, especially since new technologies and those with lower utilization are typically contractor-priced. For CY 2018, CMS is proposing the RUC-recommended work RVUs for CPT code 339X1. CMS is seeking comment on alternative pricing for this CPT code 339X1.

CMS is not proposing any direct PE inputs, as CMS did not receive RUC-recommended PE information for CPT codes 339X1, 339X2, and 339X3. These three codes will be placed on the RUC's new technology list and will be re-reviewed by the RUC in 3 years.

STS agrees with the proposal to accept the RUC-recommended work RVU of 49.00 for CPT code 339X1, and to assign contractor-priced status to CPT codes 339X2 and 339X3. We do not agree with CMS's rationale in their consideration of assigning contractor pricing for CPT code 339X1. Code 339X1, although a low volume procedure, will be performed at a frequency of 100 procedures per year and it is anticipated that this number will increase. There were a sufficient number of survey respondents for this low volume procedure. Further, a majority (18/24) of the respondants had a median experience of 2

cases. The experienced respondents were able to make reasonable intensity, work, and time estimates compared to good reference code, 33983 - *Replacement of a VAD pump(s), single ventricle with cardiopulmonary bypass*. As discussed during the RUC presentation, there are 76 centers in the US currently certified to perform these procedures. Only those hospitals that are certified transplant centers, working on becoming a transplant center, use MCS devices, or Joint Commission-certified DT LVAD center may perform the procedures. Certain exceptions may apply such as some children's centers may only have had experience with the Berlin Heart. Currently there is only one total artificial heart (TAH) available in the US market. The specialty societies used a RUC Research Subcommittee approved targeted list from the company that included 128 individuals who are considered implanting surgeons, explanting surgeons or assistants. The insertion of the total artificial heart (339X1) is considered a life-saving procedure. These services will be provided by a limited number of physicians who practice at designated heart centers around the country and will likely do a reasonable number of these over time. Even though 339X1 represents a low volume procedure, it can be valued compared to other cardiac services and services within the fee schedule and should be assigned RVUs so that physicians who provide the service have an expectation regarding the level of reimbursement they will receive for providing the service.

<u>Endovascular Repair Procedures (CPT codes 34X01, 34X02, 34X03, 34X04, 34X05, 34X06, 34X07,34X08,34X09,34X10, 34X11, 34X12, 34X13, 34812, 34X15, 34820, 34833, 34834, 34X19, and 34X20)</u>

Proposed Change:
The CPT/RUC joint workgroup on codes recommended in October 2015 to bundle endovascular abdominal aortic aneurysm repair (EVAR) codes together with radiologic supervision and interpretation codes, since these codes were typically reported together at least 50 percent of the time. The CPT Editorial Panel bundled these services together in September 2016, creating 16 new codes, revising four existing codes, and deleting 14 other codes related to endovascular repair procedures.

CMS is proposing the RUC-recommended work RVUs for all 20 codes in this family. CMS is proposing a work RVU of 23.71 for CPT code 34X01, a work RVU of 36.00 for CPT code 34X02, a work RVU of 26.52 for CPT code 34X03, a work RVU of 45.00 for CPT code 34X04, a work RVU of 29.58 for CPT code 34X05, a work RVU of 45.00 for CPT code 34X06, a work RVU of 22.28 for CPT code 34X07, a work RVU of 36.50 for CPT code 34X08, a work RVU of 6.50 for CPT code 34X09, a work RVU of 15.00 for CPT code 34X10, a work RVU of 6.00 for CPT code 34X11, a work RVU of 12.00 for CPT code 34X12, a work RVU of 2.50 for CPT code 34X13, a work RVU of 4.13 for CPT code 34812, a work RVU of 5.25 for CPT code 34X15, a work RVU of 7.00 for CPT code 34820, a work RVU of 8.16 for CPT code 34833, a work RVU of 2.65 for CPT code 34834, a work RVU of 6.00 for CPT code 34X19, and a work RVU of 7.19 for CPT code 34X20.

STS agrees with the CMS proposal to accept the RUC-recommended work RVUs and the RUC-recommended direct PE inputs without refinement for all 20 codes in the endovascular abdominal aortic aneurysm repair (EVAR) family. We support the RUC recommended values as follows for these codes:

- **a work RVU of 23.71 for CPT code 34X01,**
- **a work RVU of 36.00 for CPT code 34X02,**
- **a work RVU of 26.52 for CPT code 34X03,**
- **a work RVU of 45.00 for CPT code 34X04,**

- **a work RVU of 29.58 for CPT code 34X05,**
- **a work RVU of 45.00 for CPT code 34X06,**
- **a work RVU of 22.28 for CPT code 34X07,**
- **a work RVU of 36.50 for CPT code 34X08,**
- **a work RVU of 6.50 for CPT code 34X09,**
- **a work RVU of 15.00 for CPT code 34X10,**
- **a work RVU of 6.00 for CPT code 34X11,**
- **a work RVU of 12.00 for CPT code 34X12,**
- **a work RVU of 2.50 for CPT code 34X13,**
- **a work RVU of 4.13 for CPT code 34812,**
- **a work RVU of 5.25 for CPT code 34X15,**
- **a work RVU of 7.00 for CPT code 34820,**
- **a work RVU of 8.16 for CPT code 34833,**
- **a work RVU of 2.65 for CPT code 34834,**
- **a work RVU of 6.00 for CPT code 34X19, and**
- **a work RVU of 7.19 for CPT code 34X20.**

STS disagrees with the alternative work RVUs and rationales that were considered by CMS. Responses to the alternative values and rationales considered by CMS follow:

The endovascular abdominal aortic aneurysm repair (EVAR) codes were revised based on the CPT/RUC joint workgroup recommendation to bundle the codes with the radiologic supervision and interpretation codes, since these codes were reported together at least 50 percent of the time. The current EVAR code set was originally developed to report elective endovascular aneurysm repairs because it was not technically feasible to repair a repair a ruptured aortic aneurysm using endovascular techniques. Over time, physicians developed the appropriate skill and the procedures have now evolved so that endovascular repair of a ruptured aortic aneurysm is now possible. As with other aneurysm repair codes, the new code set includes codes for elective endovascular repairs (34X01, 34X03, 34X05, 34X07) which represent approximately 85% of reported services, and codes for ruptured aneurysm repairs (34X02, 34X04, 34X06, 34X08) which represent approximately 15% of total reported services.
In the proposed rule, CMS states that a net reduction in work RVUs for the combined elective and ruptured aneurysm repair codes was considered, even as RUC-recommended work RVUs for the newly bundled elective codes are significantly lower than the current values of the component services and RUC-recommended work RVUs for the newly bundled ruptured aneurysm repair codes are higher. This net reduction occurs despite the addition of new work associated with the complexity of ruptured aortic and iliac aneurysm repairs.

As is often the case, the changes considered by CMS only for this family of codes address the time associated with the procedure. CMS appears to be overlooking the intensity component and its role in valuation of the procedures. A ruptured aortic aneurysm has a mortality rate as high as 90%. The work associated with a ruptured aortic aneurysm repair is significantly different work compared to that of an elective aneurysm repair. The complexity of the patient increases and additional work is required, including intraoperative hemodynamic stability management and longer, more complex post-operative care.

STS encourages CMS to consider evaluating the intraoperative work intensity for this family of codes relative to other highly intense services in the fee schedule rather then just considering the intra-service and total times. As STS has pointed out with other procedures, the creation of increments of RVUs between code pairs to try and create streamline implied relationshiops is not substantiated. The current fee scheduled is based on magnitude estimation and there are subtle differences in each procedure that can lead to variations in how they are valued.

Proposed Change:
CMS requests comments on assignment of a 0-day global period to codes +34X13, +34812, +34X15, +34820, +34833, +34834, +34X19, +34X20, instead of the specialty societies and RUC-recommended add-on (ZZZ) global period proposing to add back the preservice and immediate post service work time, and increase the work RVU of each code accordingly using a building block methodology. CMS also notes their concern that as add-on procedures, these eight codes would not be subject to the multiple procedure payment discount and as a result the total payment for these services will be increasing in the aggregate based on changes in coding that alter MPPR adjustments despite the information in the surveys that reflects a decrease in the intraservice time required to perform the procedures, and a decrease in their overall intensity as compared to the current values.

STS refers CMS to the multispecialty CPT proposal submitted in February 2016, which proposed these eight codes as add-on services because they never would be performed independent of another procedure. The subsequent review and revisions by the CPT Editorial Panel, which includes CMS and other third party payer representatives, never questioned the proposed add-on code assignment. In addition, add-on code assignment was confirmed as appropriate by CMS in October 2016 prior to the societies conducting a RUC survey. The assignment of the 0-day global period and using a building block methodology to add-in pre-and post-service time would result in these services being consistently under-reimbursed for the work performed. For example, the RUC-recommended work RVU for add on code +34X19 is 6.00. CMS is proposing a 0-day global work RVU of 8.35, which, with the 50% reduction, would result in a work RVU of 4.18. Since the code would never be reported alone, the procedure would always be paid at a work RVU of 4.18, which is substantially lower than the add-on code work RVU of 6.00, which appropriately considers the time and intensity of the additional non-overlapping work associated with the service. Additionally, in a few years, the codes would hit a screen for being reported together more than 75% of the time, since they will always be reported with another procedure. The intent of add-on codes is to capture the additional, non-overlapping intraoperative work of a service that may be done with multiple procedures and to allow flexibility within a family of procedures as to how various aspects of the work are performed depending on the patient. These eight codes represent work associated with not only the EVAR codes, but other CPT codes where the work associated with the type of approach used is not built into the code. This allows the physician the flexibility to adapt the procedure to the patient based on their circumstances without creating numerous codes for every possible combination of services and capture the associated additional work across multiple procedures and specialties.

STS recommends that CMS retain the ZZZ global period and the RUC reviewed and recommended work RVUs of 2.50 for CPT code 34X13, 4.13 for CPT code 34812, 5.25 for CPT code 34X15, 7.00 for CPT code 34820, 8.16 for CPT code 34833, 2.65 for CPT code 34834, 6.00 for CPT code 34X19, 7.19 for CPT code 34X20.

Esophagectomy (CPT codes 43107, 43112, 43117, 432X5, 432X6, and 432X7)

Proposed Change:
CPT codes 432X5, 432X6, and 432X7 were created by the CPT Editorial Panel to report esophagectomy via laparoscopic and thoracoscopic approaches. CPT codes 43107, 43112, and 43117 were also reviewed as part of the family with the three new codes. CPT code 43112 was revised to clarify the nature of the service being performed. CMS is proposing the RUC-recommended work RVUs and work times for all six codes in the family as follows: a work RVU of 52.05 for CPT code 43107, a work RVU of 62.00 for CPT code 43112, a work RVU of 57.50 for CPT code 43117, a work RVU of 55.00 for CPT code 432X5, a work RVU of 63.00 for CPT code 432X6, and a work RVU of 66.42 for CPT code 432X7.

CMS is also proposing the RUC-recommended work times for all six codes in this family. CMS considered removing 20 minutes from the preservice evaluation work time from all six of the codes in this family. CMS has concerns as to whether this additional evaluation time should be included for surgical procedures, due to the lack of evidence indicating that it takes longer to review outside imaging and lab reports for surgical services than for non-surgical services. CMS also considered refining the preservice positioning work time and the immediate postservice work time for all six of the codes in this family consistent with standard preservice and postservice work times allocated to other PFS services.

CMS is seeking comment regarding the changes in the valuation between the two surveys, the preservice and immediate postservice work times, and the RN staffing type employed for routine preservice clinical labor.

STS agrees with the proposal to accept the RUC-recommended work RVUs, work times and the RUC-recommended direct PE inputs without refinement for all six codes in the esophagectomy family. STS supports the RUC recommended Work RVUS as follows:

- **a work RVU of 52.05 for CPT code 43107,**
- **a work RVU of 62.00 for CPT code 43112,**
- **a work RVU of 57.50 for CPT code 43117,**
- **a work RVU of 55.00 for CPT code 432X5,**
- **a work RVU of 63.00 for CPT code 432X6, and**
- **a work RVU of 66.42 for CPT code 432X7.**

STS strongly disagrees with the alternative work RVUs and rationales that were considered by CMS. Following is a detailed response to the alternative values and rationales considered by CMS.

Proposed Change:
Preoperative evaluation time
CMS has expressed concerns as to whether additional evaluation time should be included for surgical procedures, due to the lack of evidence indicating that it takes longer to review outside imaging and lab reports for surgical services than for non-surgical services.

During the presentation to the RUC and CMS representatives at the RUC meeting, the specialties indicated that the preoperative evaluation time for these six esophagectomy codes was atypical. These are low volume procedures and long complex operations involving surgery in at least two or three separate body cavities: the abdomen, mediastinum, and chest and/or neck. There is no same day E/M

reported with these procedures. Evaluation of these procedures includes extensive data review including CT scans of the neck, chest, and abdomen; PET scans; endoscopy; and medical and radiation oncology reports. These reports come from many sources and different specialties, each providing their own unique service. To ensure resection of the esophagus and proximal stomach with appropriate surgical margins, the type of esophagogastrectomy procedure is individualized to the patient, and depends on the location of the patients' cancer and the extent of the tumor. Assessment of the abdomen, heart, lungs and neck is also necessary given the location of the esophageal resection and the physiologic impact to those organs. This extensive data review is not typical for most surgical procedures. In addition to extensive data, the evaluation component of preoperative time also includes coordination and planning for the multi-incisional approach with, the anesthesia providers whose various tubes and lines cannot interfere with the multiple operative incisions, the assistant surgeon, and scrub nurses who will assist. This extensive preoperative team planning is not typical for the majority of surgical procedures. For these long complex procedures, the extensive data review and pre-operative team planning is critical due to the involvement of more than one surgical specialist separate from the assistant surgeon, the high-risk nature of the procedure and complexity involved with the multiple incision approaches and multi-body cavity involvement.

The additional time recommended by the RUC is consistent with other major procedures requiring multiple specialties. We acknowledge that a majority of procedures are well represented by the standard 40 minutes for preoperative evaluation. However, in some instances, such as emergent procedures, the time for preoperative evaluation will be less, and in some instances especially where multiple surgeons are involved and extensive data and preoperative planning is included, the time for preoperative evaluation will be greater. The additional time requested is consistent with many other cardiothoracic surgical procedures in the physician fee schedule.

STS believes that the RUC recommended preoperative evaluation time of 60 minutes is more than justified for the complex, atypical work required on the day before and the day of the operation for 43107, 43112, 43117, 432X5, 432X6, 432X7.

Proposed Change:
Preoperative positioning time

CMS also considers refining the preservice positioning time for all six of the codes in this family to be consistent with standard preservice times allocated to other PFS services. The standard "base" preoperative time for positioning is three minutes.

The standard three minutes represents positioning the patient supine with no additional positioning work. As indicated during the presentation to the RUC and CMS representatives at the RUC meeting, the typical positioning for patients undergoing these procedures includes additional work to account for padding the patient for a five to seven-hour operation that includes securing the patient to a table that will be adjusted (e.g., reverse Trendelenburg, roll, etc.) several times during the operation. These multi-body cavity esophageal resection procedures will also require undraping, re-positioning, and re-padding for neck, chest, and abdominal incisions and accommodation of double lumen endotracheal tube, and lines near the operative field as the patient is moved and repositioned throughout the procedure. This repositioning must be accomplished while maintaining the sterility of all surgical instrumentation.

These codes all involve at least two or more of the following approaches laparoscopic, thoracoscopic, laparotomy, thoracotomy or neck. It is well established in the fee schedule that the work of positioning for laparoscopic, thoracoscopic, and thoracotomy procedures includes additional positioning time. There are multiple examples of RUC-recommended and CMS-approved procedures throughout the fee schedule where this can be found (e.g., lung resections via thoracotomy**,** laparoscopic fundoplication, thoracoscopy wedge resection).

STS believes the RUC recommended preoperative positioning time of 20 minutes for 43107 and 432X5 and for 30 minutes for 43112, 43117, 432X6, and 432X7 is justified for the atypical work required and is supported by the survey results. Additionally, the pre-service time is representative of other similar services that have been previously reviewed and approved by CMS throughout the fee schedule.

Proposed Change:
RN clinical labor type
CMS also considered changing the preservice clinical labor type for all six codes from an RN (L051) to an RN/LPN/MTA blend (L037D) due to concerns about whether the use of RN clinical labor would be typical for filling out referral forms or for scheduling space and equipment in the facility.

The typical providers for these services are cardiothoracic surgeons. It is typical for cardiothoracic surgeons to employ PAs and NPs as their clinical staff due to their complex patient population. Since CMS does not recognize PAs and NPs as clinical staff for practice expense and cardiothoracic surgeons typically employ PAs and NPs, it was established many years ago that the clinical staff type of RN would be typical for cardiothoracic surgeons. The majority of the cardiothoracic surgery procedures have an RN staff type, including the existing codes 43107, 43112 and 43117, it would create rank order anomalies in practice expense and would not be representative of the level of employee employed by cardiothoracic surgeons to assign a clinical blend for these services.

STS believes the RUC recommended RN clinical labor type is justified and consistent with the majority of cardiothoracic surgical procedures in the PFS.

Proposed Change:
Immediate postoperative time
CMS also considered refining the immediate postoperative time for all six of the codes in this family to be consistent with standard postoperative times allocated to other PFS services.

The additional time recommended by the RUC accounts for multiple site dressings; reversing excessive padding prior to transfer off table; extensive post-operative notes from a five to seven-hour procedure; extensive post-operative orders for multiple drains, tubes and other devices; and review of postoperative labs and films before transferring the patient to the ICU.

Additionally, for the open codes, the patient's anesthesia level is reduced after the fascia is closed and while the skin is closed and dressings applied. However, for the laparoscopic and thoracoscopic codes, anesthesia needs to be maintained at full level and deep until the last laparoscope/thoracoscope is pulled, intraperitoneal gas is allowed to escape and the fascia and skin is closed. This results in a longer time to monitor these patients prior to extubation and moving the patient to recovery.

All of the work described above and at the RUC meeting is in addition to the typical work for more straightforward operations where a standard postoperative time would apply.

STS believes the RUC recommended immediate postoperative time of 45 minutes for 43107, 43112, 43117 and for 60 minutes for 432X5, 432X6, 432X7 prior to discharge to the ICU is justified for the atypical work required for these patients and was supported by the surveys.

CMS has expressed concerns about the results of two separate surveys that were conducted for the three new codes 432X5, 432X6, and 432X7. CMS indicates that they do not understand how the survey median intraservice time could increase so significantly from the first survey to the second survey for CPT code 432X7, or how the surveyed times for CPT code 432X5 could be decreasing while the work RVU was simultaneously increasing by 15.00 work RVUs. CMS indicates that based on their analysis, the results varied based on the reference service lists that were used for the surveys. CMS further believes that the values in the first survey are more accurate and as a result considered a variety of alternative methods to establish alternative values for the family of codes.

We disagree with CMS that the results of the first survey for codes 432X5, 432X6, 432X7 are more accurate than the second survey. Not only did we receive more responses from the second survey, but the respondents were more experienced. This would indicate that the second survey was more robust and had greater validity. Additionally, the respondents in the second survey were considering the work of all the codes in relation to each other rather than the work of the new codes compared to the old codes which at their current values represent rank order anomalies within the fee schedule.
STS is perplexed that CMS believes that the results of the first survey are more accurate. During the RUC meeting and at a subsequent conference call with CMS staff (March 27, 2017), the specialties presented a rationale for conducting a second survey and explaining the results and differences in the results between the two surveys. The specialties articulated that a second survey was necessary in order to more correctly describe the typical patient for each new code (as originally requested by the specialty societies), and adding codes 43107, 43112, and 43117 to the survey as a family of codes. The specialties presented a series of facts, which the RUC accepted, about an invalid survey in 2000 that resulted in flawed values for 43107, 43112, and 43117. Additionally, to survey the new laparoscopic and thoracoscopic services, independent of the current open codes, would have resulted in significant rank order anomalies within the code families and across the fee schedule. Adding codes 43107, 43112, and 43117 to the second survey resulted in the need to create a revised Reference Services List (RSL) because codes 43107 and 43112 were removed.

In the proposed rule, CMS expresses concern that the codes on the initial RSL had a median work RVU of 44.18, while the codes on the second RSL had a median work RVU of 59.64. STS acknowledges this fact. However, we would point out that the codes on the second RSL represented a better continuum of work RVUs that condensed the RVW scale and eliminated large gaps between values. Specifically, for these operations with intra-times between five to seven hours, it made no sense to include codes for procedures that require one-third the time. The survey respondents and the RUC cannot easily compare the relative work for such disparate procedures. Therefore, the 3 lowest RVW codes were removed from the 2nd RSL. Additionally, the highest RVW code was also removed from the RSL. The end result was a RSL with an RVW range between 26.10 and at 83.12. In addition, two of the open codes (43107 and 43112) were removed from the 2nd RSL since they were being surveyed and gaps within the RSL were

filled. For example, in the first RSL, there was a large gap between 51.43 and 67.07. The second RSL added two codes between 51.43 and 67.07.

STS believes the RSL used to survey all six codes, which removed codes from both the low end and the high end of the work RVU range and added codes to decrease large gaps across the range, provided a more comparable list of reference for the survey respondents.

STS disagrees with CMS's considerations on the calculation of work RVUs for 43107, 43112, and 43117 using the intraoperative ratio of time with the new codes 432X5, 432X6, and 432X7. The RUC and the specialties have repeatedly indicated that physician work includes more than time, it includes complexity and intensity. It also includes variability in preoperative and postoperative time and visits. The only commonality that the open esophagectomy codes and the laparoscopic/thoracoscopic esophagectomy codes share is that the esophagus is resected. Otherwise these are dramatically different procedures, done with different equipment and requiring a considerably different skill set. There is no evidence supporting that a time ratio would differentiate the nuances and complexities of work represented by open esophagectomy codes (43107, 43112, and 43117) and the laparoscopic/thoracoscopic esophagectomy codes (432X5, 432X6, and 432X7).

We disagree with CMS regarding their consideration and rationale for using the values from the first survey and employing an intraservice time ratio between the new codes and the open codes.

As previously outlined, the first survey, which only included the new codes, did not accurately describe the typical patient as argued by the specialties and agreed upon by the RUC, which would naturally result in misrepresentative values for the procedures. There is no validity to the idea of discreetly utilizing intraservice time ratios as the primary difference between the new codes and the open codes. Furthermore, CMS admits that they would in fact be creating a rank order anomaly. To correct that rank order anomaly, CMS proposes a direct crosswalk of code 46744 (repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, sacroperineal approach) to code 43112 at 58.94 work RVUs. Code 46744 is not a valid comparator. This rarely performed procedure was reviewed almost 20 years ago at a time when the fee schedule still did not recognize the value of codes that included significant work for major complex operations that took 5 to 7 hours and after which patients were in the hospital for weeks. In 2000, when code 46744 was reviewed, there were only 8 codes valued greater than the RUC recommendation for 46744, including heart/lung transplant which was valued at 60.96 at that time. Instead, we point CMS to the list of codes in the the appendix for comparable major operations with a 90-day global period. The RUC valuations for all six codes are supported by the surveys and comparable to more recently reviewed services. The RUC recommended values do not create rank order anomalies and they provide a logical relationship to similar codes without the need for a crosswalk.

Valuing a family of low volume "all inclusive" codes such as these is difficult because there is variability in the patients requiring variability in the surgical approach and work and time. The alternative values that CMS considers would create rank order anomalies, not only with other esophagectomy codes, but with other codes that have high intraoperative time and extensive preoperative and postoperative work.

In summary, we believe the RUC recommended work RVUs and time and visits are appropriate as shown in Table 1 (in Appendix A) that was previously submitted to CMS. This table clearly shows that

the RUC recommendations are aligned correctly and are appropriately bracketed by the key reference codes and many other high work codes.

Evaluation & Management (E/M) Guidelines

CMS seeks input on the specific changes CMS should undertake to reform the guidelines, reduce the associated burden, and better align E/M coding and documentation with the current practice of medicine. CMS specifically seeks comment on how it might focus on initial changes to the guidelines for the history and physical exam, including whether it would be appropriate to remove its documentation requirements for the history and physical exam for all E/M visits at all levels. CMS also seeks comment on how such reforms may differentially affect physicians and practitioners of different specialties, including primary care clinicians, and how CMS could or should account for such effects as it examines this issue. There may still be clinical or legal reasons for individual practitioners to document an extended history or physical exam. CMS seeks comment on whether it should leave it largely to the discretion of individual practitioners to what degree they should perform and document the history and physical exam. CMS also welcomes comments on specific ideas that stakeholders may have on how to update medical decision-making guidelines to foster appropriate documentation for patient care commensurate with the level of patient complexity, while avoiding burdensome documentation requirements and/or inappropriate upcoding.

STS appreciates the CMS proposal to consider changes to the evaluation and management (E/M) guidelines specific to the history and physical exam. We believe that there are aspects of the history and physical exam that should be re-evaluated and potentially revised to reflect the current practice of medicine and decrease the burden of documentation. STS recommends that CMS work with the AMA CPT Editorial Panel, the RUC, and interested stakeholders to identify and eliminate unnecessary components, identify those aspects of the E/M documentation that are relevant to current practices across specialties, and evaluate the impact on the fee schedule prior to making any changes.
The criteria for documenting the review of systems (ROS) for the history and the requirements required for the physical exam (PE) portion of the E/M codes are not reflective of current practice and particularly burdensome to physicians.

The current guidelines that require ROS are unnecessary and excessive. The physician should be able to obtain information from the patient that is relevant to the reason the patient is being seen. For example, it is unnecessary to collect information on many of the systems if the patient is seeing the physician for assessment of lung cancer. Elimination of this requirement will allow physicians to focus on those aspects of the visit necessary to evaluate and provide appropriate care for the patient. However, STS agrees that it is still important for physicians to capture the history of present illness and the past medical, family and social history as these specifically contribute to the evaluation of the patient and facilitates communication with other clinicians regarding the patients care.

The need for a physical exam and the specific components necessary for a physical exam vary widely for each patient as well as across and within specialties. Having specific criteria regarding the physical exam is unnecessary and often burdensome for physicians and the current criteria are not reflective of current practice since this information is often available to the physician already in the patient's shared electronic health record (EHR).

CMS has clearly indicated that medical decision-making (MDM) and time should be considered the most important factors in distinguishing visit levels. However, STS believes the current guidelines for medical decision-making should also be reviewed. There is inadequate guidance on how to apply the measured aspect of the components which include quantifying diagnoses and management options, data, and risk. Reviewing these guidelines and criteria along with the history and physical exam guidelines and finding solutions that streamline the information with specific criteria that is easily understood by providers and auditors would help reduce the documentation burden on practitioners and ensure that there are still measures that can differentiate levels of care. With respect to CMS's specific emphasis on time as a major determinating factor of visit level, STS points out that current times are outdated and not necessarily representative of current practice. As with the other E/M documentation criteria, time should be evaluated and potentially re-aligned to reflect changes in practice that have occurred with EHRs.

STS feels that it is important that E/M documentation include the information that is communicated to the patient at each visit and provide sufficient information to facilitate the care of the patient by other medical professionals. The current documentation guidelines result in the capture of unnecessary data and often complicate communications with the patient and other professionals because irrelevant data is included only to meet reimbursement or compliance criteria. Documentation should capture the reason the patient is being seen, considerations that are relevant to the physician's decision-making related to the visit, information that is communicated to the patient at each visit, and information that is relevant for communication and coordination of care with other healthcare professionals, as well as any decisions that are made during the visit. The degree and documentation of the history and physical exam should be left to the discretion of the individual practitioner allowing them to adapt each visit to address the needs of the patient. However there should be some criteria that ensure that relevant data are being captured and communicated as necessary to other healthcare professionals. This approach should apply to all levels and categories of E/M for all specialties. Revison of the documention guidelines could have significant impact on the fee schedule, as such, it is important that any revsions are carefully considered and evaluated.

II. Other Provisions of the Proposed Rule

Appropriate Use Criteria for Advanced Diagnostic Imaging Services

Proposed Change
The Protecting Access to Medicare Act (PAMA) of 2014 requires that CMS establish a program to promote the appropriate use of advanced diagnostic imaging (including MRI, CT, PET and nuclear cardiology, but not x-ray, ultrasound, and fluoroscopy) in applicable settings (physician offices, hospital outpatient departments and ambulatory surgical centers, but not inpatient or emergency settings). The program will require professionals ordering an advanced diagnostic imaging service to consult established Appropriate Use Criteria (AUC) using a federally approved clinical decision support mechanism (CDSM) for all applicable Medicare patients and for the furnishing professional to report this consultation to CMS in order to get paid for the service. This program was expected to go into effect on January 1, 2017, but has been delayed due to implementation challenges. Per statute, starting January 1, 2020, ordering professionals identified as "outliers" in regards to AUC adherence to a subset of priority clinical areas will be required to obtain prior authorization from CMS before advanced imaging orders can be furnished.

In this rule, CMS proposes that reporting of AUC consultations must begin on January 1, 2019. CMS also proposes to make this first year an educational "testing period." CMS notes that during the "testing period," ordering professionals would consult AUC and furnishing professionals would report AUC consultation information on the claim, but CMS would continue to pay claims whether or not they correctly include such information. CMS does not expect to continue this testing period beyond the first year of the AUC program. In conjunction with this rule, CMS also identified an initial list of qualified CDSMs.

CMS also proposes to offer a voluntary reporting period to be available ahead of January 1, 2019, which is anticipated to begin July 2018 depending on CMS's readiness. This would be separate from the proposed testing period beginning January 1, 2019. During the voluntary reporting period, AUC consultation and reporting would not be required.

Additionally, CMS proposes to establish a series of HCPCS level 3 codes to facilitate the reporting of data under this program. These G-codes would indicate:

- *Which qualified CDSM was consulted by the ordering professional;*
- *Whether the service ordered would adhere to specified applicable AUC, would not adhere to specified applicable AUC, or whether specified applicable AUC were not applicable to the service ordered; and*
- *Circumstances where a qualified CDSM was not consulted by the ordering professional (e.g., situations where an exception applies, such as imaging service was ordered for a patient with an emergency medical condition)*

Although STS is a strong proponent of efforts to minimize inappropriate use of imaging, we are concerned about the regulatory burden that this program could impose on clinicians and question whether it is the most effective strategy for promoting more appropriate use of imaging. As currently proposed, the program seems like it will greatly add to the reporting burden of clinicians without doing much to actually improve quality. For example, impacted professionals are required to consult AUC using federally qualified CDSMs for every applicable diagnostic imaging order. However, CDSMs must only make available, at a minimum, AUC that reasonably address each of the *priority* clinical areas. This means that there will be many instances where relevant AUC are not available to a specialist. In these situations, the specialist must communicate this to the furnishing professional, who then must report to CMS that no applicable AUC is available related to the service ordered. This time-consuming process takes time away from direct patient care at a time when clinicians are already distracted by multiple federal mandates and adds little to the overall quality of patient care.

We also believe that a 2019 start date is premature since CMS is only first publishing a list of qualified CDSMs in conjunction with this rule. This rule will not be finalized until late 2017, which means that clinicians will only have a year to identify and invest in the most appropriate CDSM, ensure that it integrates seamlessly into their practice, and modify their EHR and billing systems to ensure they can sufficiently communicate details about the AUC consultation to other furnishing clinicians. These are significant practice changes to make at a time when clinicians are also trying to ready their practices for new reporting requirements under the Merit-Based Incentive Payment System (MIPS).

As such, STS requests that CMS attempt to delay this program beyond the proposed mandatory start date of January 1, 2019. At the very least, CMS should make the initial year voluntary. Although CMS

refers to 2019 as a "test year," the proposal suggests that clinicians would have to at least report *something* in 2019 in order to get paid (even if it's not accurate). We request that CMS clarify this point and ensure that the first year of implementation is truly voluntary where CMS would pay claims for advanced diagnostic imaging services regardless of whether they even contain information on the required AUC consultation. We suggest that CMS delay implementation of this program until it has had a chance to carefully test the feasibility of the program and to evaluate alternative, and potentially better and more efficient ways, to promote more appropriate use of imaging under MIPS.

Physician Quality Reporting System (PQRS) Criteria for Satisfactory Reporting for Individual EPs and Group Practices for the 2018 PQRS Payment Adjustment

Proposed Change
CMS proposes multiple changes to limit the number of clinicians who will be penalized under the PQRS in 2018. These include:

- *Revising the previously finalized satisfactory reporting criteria for the 2016 reporting period to lower the requirement from 9 measures across 3 NQS domains, where applicable, to only 6 measures with no domain requirement.*
- *No longer requiring a cross-cutting measure of reporting via claims of qualified registry and no longer requiring an outcome or other high priority measure is reporting via QCDR.*
- *No longer requiring larger group practices to administer the CAHPS for PQRS survey.*

STS appreciates and supports these proposals, which minimize the complexity of the 2016 PQRS and help clinicians transition to MIPS. Further, we urge CMS to not penalize a clinician who reports at least one measure within the PQRS program in 2016. This will better align with the Merit-Based Incentive Payment System (MIPS) Pick Your Pace option for the 2017 performance period.

Physician Compare Downloadable Database - Addition of Value Modifier (VM) Data

Proposed Change
In this rule, CMS proposes not to rescind its earlier decision to publicly report data related to the 2018 VM (based on 2016 performance data) via the Physician Compare downloadable file in late 2017. **STS supports this proposal.** Posting such data would only serve to confuse the public since VM data would only be available for one year prior to the VM transitioning to MIPS. This proposal also recognizes the fact that the VM data might not accurately reflect a clinician's actual performance given other proposed changes in this rule.

Clinical Quality Measurement for Eligible Professionals Participating in the EHR Incentive Program for 2016

Proposed Change
To align with other proposals related to the PQRS, CMS also proposes to change the reporting criteria from 9 clinical quality measures (CQMs) covering at least 3 NQS domains to 6 CQMs with no domain requirement for EPs and groups who, in 2016, chose to electronically report CQMs through the PQRS Portal for purposes of the Medicare EHR Incentive Program. Clinicians or groups who satisfy the proposed reporting criteria may qualify for the 2016 incentive and may avoid the downward payment adjustment in 2017 and/or 2018, depending on the applicable EHR reporting period. Again, **we support**

this proposal since aligns with other changes being proposed in this rule.

Value-Based Payment Modifier and Physician Feedback Program

Proposed Change
CMS proposes multiple changes to Value Modifier (VM) policies that would impact 2018 payment adjustments period. These include reducing the magnitude of penalties automatically assessed on clinicians who fail to satisfy PQRS requirements in 2016 and holding clinicians subject to quality-tiering harmless from downward performance-based payment adjustments in 2018. Since the VM is a budget neutral program, these changes also mean that CMS must reduce the magnitude of upward payment adjustments for those with high performance.

Similar to our other comments, **we very much appreciate these accommodations, which will allow clinicians to focus more of their time and resources on MIPS and result in a smoother transition to this new program.** It also recognizes the fact that performance assessments under the VM might not be completely accurate as a result of the proposed changes in this rule related to the PQRS.

Patient Relationships Categories and Codes

Proposed Change
The Medicare Access and CHIP Reauthorization Act (MACRA) requires CMS to develop classification codes to identify patient relationship categories that define and distinguish the relationship and responsibility of a clinician with a patient at the time of furnishing an item or service. In accordance with MACRA, the final Operational List of Categories and Codes must be published in April 2017, and clinicians must begin reporting these codes on all Medicare claims, beginning January 1, 2018. These codes are part of a multi-pronged effort to improve methodologies for measuring the cost of physician care and are intended to be implemented in conjunction with newly developed episode-based cost measures.

Based on feedback collected throughout 2016 and early 2017, CMS posted the following operational list of patient relationship categories in May 2017:

- *Continuous/Broad Services*
- *Continuous/Focused Services*
- *Episodic/Broad services*
- *Episodic/Focused Services*
- *Only as Ordered by Another Clinician*

In this rule, CMS proposes that Medicare claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2018, should include applicable HCPCS modifiers reflecting the categories listed above, as well as the NPI of the ordering physician or applicable practitioner if different from the billing physician or applicable practitioner. To allow clinicians time to gain familiarity with using these modifiers, CMS proposes that, at least for an initial period, clinicians may voluntarily report these codes on claims.

Overall, STS is supportive of efforts to more clearly define a clinician's role in treating a patient for purposes of cost measurement. As we have expressed in the past, the current set of measures used to evaluate cost under the Value Modifier and MIPS are largely irrelevant to many physicians—either

because no patients are attributed to them or because the physicians have little to no opportunity to influence the costs that are attributed to them. Additionally, under the VM and MIPS, CMS currently uses a plurality approach, which holds the clinician or group practice responsible for the totality of inpatient resource utilization, including costs related to a range of other professionals who might contribute to the cost of treating a patient in different, but important ways (e.g., testing, procedures, imaging and per diem charges using E&M codes). We remind CMS of the critical need for more properly designed cost of care measures, including measures that are tied to more discrete episodes of care and that better reflect the patient-physician relationship throughout the episode of care, as well as the clinical and socio-demographic characteristics of patients that might impact their need for healthcare services. Our members continue to work closely with CMS and its contractors to develop more refined measures. It is our hope that these measures will not only improve the relevance, reliability and applicability of cost measurement, but also will result in more actionable clinician feedback.

In regards to CMS's proposal to implement the reporting of patient relationship codes, STS appreciates that CMS specifies that the selection of the modifiers would not be a condition of payment and claims would be paid regardless of *whether* and how the modifiers are included. As such, we view this a true test year where no clinician would be required to report this information to CMS in order to get paid. We also appreciate that CMS will work with clinicians to educate them about the proper use of the modifiers.

Nevertheless, we continue to have concerns about the specific manner in which these codes will be reported and used. CMS has not yet articulated many important details related to this program and without such details, we question whether it is even appropriate to begin a test year in 2018. Listed below are some overarching concerns and principles that STS believes CMS should adhere to as it further refines patient relationship categories and codes:

- **Balancing Administrative Simplicity with Clinical Accuracy**. Finding the sweet spot between a classification system that is clear and simple to administer, but also granular enough to capture critical clinical distinctions will be challenging. The categories must be discrete enough to distinguish between the different responsibilities clinicians have with a patient at the time of furnishing a service, as well as the changing relationship that might evolve throughout the span of the episode. CMS has not yet specified how it would capture or treat this evolving relationship. At the same time, CMS cannot ignore the mounting regulatory requirements facing clinicians. Just as the patient relationship reporting mandate is being rolled out, clinicians will be in the midst of learning how to comply with a plethora of new and complex requirements under MIPS and other programs. Most clinicians simply do not have the infrastructure (i.e., information technology, coding staff, etc.) to comply with these new requirements. At best, only the largest systems with the most resources might be able to keep up with these mandates. To avoid the most dangerous situation where clinicians devote more time to regulatory compliance than direct patient care and to minimize burnout, CMS must prioritize these new mandates, implement them one at a time, and evaluate how it can meet its goals in the most efficient and least duplicative manner.

- **Gradual Implementation.** Similarly, we request that CMS implement this new policy gradually and thoughtfully. It is challenging to provide meaningful feedback on patient relationship categories when CMS has not yet finalized a set of initial clinical episodes. Without that context,

it is difficult to assess the adequacy of the proposed relationship categories. In fact, as CMS continues its refinement of the episode groups, it might find that it needs to adopt different strategies for categorizing patient-physician relationships across different episodes rather than adopting a uniform approach. Only once a set of episode-based cost measures has been developed that captures a diverse range of specialties can the patient relationship categories and codes be properly piloted. Initially, CMS should provide clinicians with the opportunity to confidentially review the resulting data before using them to evaluate cost performance under MIPS. Clinicians should also have the opportunity to to review, question and correct inappropriately attributed resources. It is not clear from the proposal whether CMS expects clinicians to append a patient relationship code to every single claim they submit to Medicare, but in the initial years of implementing this new policy, we advise against imposing such an adminstrtively burdensome requirement.

- **Transparency**. Similar to concerns we raised in previous comment letters about the proposed clinical episode groups and logic, we remind CMS of the importance of ensuring that these categories and codes are developed and refined based on the ongoing input of practicing clinicians and that this process take place in a fully transparent manner**.** Posting information on the CMS website is insufficient. We request that CMS hold listening sessions with a variety of specialties and stakeholders to generate more specific feedback on these proposals.

- **Categories and Codes Must Reflect the Realities of Clinical Practice**. The current proposal still does not address how to capture a clinician's relationship with a patient who has multiple concurrent acute care episodes, all of which might occur in the context of an underlying chronic episode or disease process. Similarly, what is the timeline for a given relationship category? Is it dictated by the role of the clinician at the onset of an episode or can it change throughout? And if it can change, how frequently would clinicians have the opportunity to adjust their role (e.g., daily, annually, per claim, per episode)?

- **Arbitrating Role Assignment.** CMS also has not yet discussed how it would address situations where multiple clinicians claim the same role in treating the patient or where no clinician claims a role. While STS supports care coordination and more team-based approaches to care, it is unreasonable to adopt a national coding policy that hinges on clinicians coordinating their responses to decide who should claim which role. As CMS refines this reporting mandate, we urge it to develop a thoughtful strategy for adjudicating or otherwise addressing these conflicting or overlapping interpretations.

- **Additional Adjustments Will Be Necessary.** While patient relationship codes may help to improve attribution, they are insufficient in isolation CMS must simultaneously develop better risk-adjustment methodologies that take into account the health and socio-demographic status of the patient, the clinical setting (e.g., geographic location, teaching vs. non-teaching hospital), and the physician specialty.

The ability to attribute patients to clinicians, in whole or in part, based on clinician reporting of the different relationships they have with their patients is a promising opportunity. However, to achieve the goal of more accurate cost measurement, it is absolutely critical that CMS implement this policy gradually, with relevant and transparent clinical input, and in a manner that minimizes the

administrative burden on clinicians who are already struggling to make the patient a priority in the face of multiple, competing regulatory demands.

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The Society of Thoracic Surgeons appreciates the opportunity to provide our comments on proposed changes to the Calendar Year 2018 MPFS and look forward to working with CMS as it continues to implement these policies. Please contact Courtney Yohe, Director of Government Relations at: cyohe@sts.org or 202-787-1230 should you need additional information or clarification.

Sincerely,

Richard Prager, MD
President

Appendix A: Esophagectomy PFS Rank Order Comparison Table Handout

CPT	Long Descriptor	RVW	IWPUT	minutes				visits			
				Total	PRE	INTRA	POST	ICU	INPT	DCHG	OV
43117	IVOR LEWIS - OPEN CURRENT	43.65	0.0480	1077	60	410	60	1	10	-39	3
43107	TRANSHIATAL - OPEN CURRENT	44.18	0.0571	987	90	300	45	2	8	-39	4
33468	Tricuspid valve repositioning and plication for Ebstein anomaly	45.13	0.095	806	63	240	60	2	5	-38	1
33410	Replacement, aortic valve, with cardiopulmonary bypass; with stentless tissue valve	46.41	0.113	800	95	229	40	1	6	-38	2
43112	McKeown - OPEN CURRENT	47.48	0.0398	1243	103	415	118	2	9	-39	4
33516	Coronary artery bypass, vein only; 6 or more coronary venous grafts	49.76	0.105	883	95	264	40	1	7	-38	2
61700	Surgery of simple intracranial aneurysm, intracranial approach; carotid circulation	50.62	0.112	949	105	240	40	0	12	-38	3
33875	Descending thoracic aorta graft, with or without bypass	50.72	0.083	993	100	240	60	3	6	-39	2
33430	Replacement, mitral valve, with cardiopulmonary bypass	50.93	0.105	913	95	232	40	2	6	-39	3
KEY REF 43121	Partial esophagectomy, distal two-thirds, with thoracotomy only, with or without proximal gastrectomy, with thoracic esophagogastrostomy, with or without pyloroplasty	51.43	0.106	962	95	240	40	1	8	-39	4
43107	TRANSHIATAL – OPEN REC	52.05	0.091	977	95	270	45	2	7	-39	4
47765	Anastomosis, of intrahepatic ducts and gastrointestinal tract	52.19	0.105	882	75	290	53	1	8	-38	3
33406	Replacement, aortic valve, with cardiopulmonary bypass; with allograft valve (freehand)	52.68	0.114	853	95	282	40	1	6	-38	2
48153	Pancreatectomy, proximal subtotal with near-total duodenectomy, choledochoenterostomy and duodenojejunostomy (pylorus-sparing, Whipple-type procedure); with pancreatojejunostomy	52.79	0.073	1,078	90	315	45	2	10	-38	4
47125	Hepatectomy, resection of liver; total left lobectomy	53.04	0.124	855	75	225	45	2	7	-38	3
61526	Craniectomy, bone flap craniotomy, transtemporal (mastoid) for excision of cerebellopontine angle tumor;	54.08	0.112	789	120	360	45	0	6	-38	3
61692	Surgery of intracranial arteriovenous malformation; dural, complex	54.59	0.109	896	115	340	68	0	8	-38	2
432X5	TRANSHIATAL – Laparoscopic REC	55.00	0.106	957	100	300	60	1	7	-39	4

CPT	Long Descriptor	RVW	IWPUT	minutes				visits			
				Total	PRE	INTRA	POST	ICU	INPT	DCHG	OV
47785	Anastomosis, Roux-en-Y, of intrahepatic biliary ducts and gastrointestinal tract	**56.19**	0.097	**939**	75	**360**	40	1	8	-38	3
32442	Removal of lung, pneumonectomy; with resection of segment of trachea followed by broncho-tracheal anastomosis (sleeve pneumonectomy)	**56.47**	0.111	**1,035**	95	**286**	60	0	11	-38	2
33545	Repair of postinfarction ventricular septal defect, with or without myocardial resection	**57.06**	0.121	**939**	95	**236**	40	3	6	-39	2
33463	Valvuloplasty, tricuspid valve; without ring insertion	**57.08**	0.100	**1,127**	95	**231**	40	2	12	-38	2
61520	Craniectomy for excision of brain tumor, infratentorial or posterior fossa; cerebellopontine angle tumor	**57.09**	0.117	**815**	120	**360**	45	0	7	-38	4
47130	Hepatectomy, resection of liver; total right lobectomy	**57.19**	0.134	**870**	75	**240**	45	2	7	-38	3
43117	**IVOR LEWIS – OPEN REC**	**57.50**	**0.088**	**1,067**	105	**330**	**45**	2	8	-39	4
33863	Ascending aorta graft, with cardiopulmonary bypass, with aortic root replacement using valved conduit and coronary reconstruction (eg, Bentall)	**58.79**	0.121	**905**	95	**287**	40	2	6	-38	1
33412	Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)	**59.00**	0.122	**866**	63	**300**	60	2	5	-38	1
47140	Donor hepatectomy (including cold preservation), from living donor; left lateral segment only (segments II and III)	**59.40**	0.101	**1,073**	120	**355**	60	0	10	-38	4
33860	Ascending aorta graft, with cardiopulmonary bypass, includes valve suspension, when performed	**59.46**	0.114	**931**	80	**305**	40	2	6	-38	2
47122	Hepatectomy, resection of liver; trisegmentectomy	**59.48**	0.100	**1,000**	75	**300**	45	3	7	-38	3
32851	Lung transplant, single; without cardiopulmonary bypass	**59.64**	0.095	**1,165**	140	**240**	90	4	7	-39	2
33413	Replacement, aortic valve; by translocation of autologous pulmonary valve with allograft replacement of pulmonary valve (Ross procedure)	**59.87**	0.122	**898**	95	**297**	40	2	5	-38	2
61702	Surgery of simple intracranial aneurysm, intracranial approach; vertebrobasilar circulation	**60.04**	0.111	**1,144**	115	**280**	50	0	15	-38	3

CPT	Long Descriptor	RVW	IWPUT	minutes				visits			
				Total	PRE	INTRA	POST	ICU	INPT	DCHG	OV
33864	Ascending aorta graft, with cardiopulmonary bypass with valve suspension, with coronary reconstruction and valve-sparing aortic root remodeling (eg, David Procedure, Yacoub Procedure)	**60.08**	0.130	**853**	120	**300**	60	2	4	-38	1
43112	**MCKEOWN – OPEN REC**	**62.00**	**0.093**	**1,097**	105	**360**	**45**	2	8	-39	4
33411	Replacement, aortic valve; with aortic annulus enlargement, noncoronary sinus	**62.07**	0.114	**1,059**	95	**283**	40	2	9	-38	2
432X6	**IVOR LEWIS Laparoscopic, Thoracoscopic REC**	**63.00**	**0.097**	**1,097**	110	**360**	**60**	2	7	-39	4
61697	Surgery of complex intracranial aneurysm, intracranial approach; carotid circulation	**63.40**	0.111	**1,194**	105	**300**	50	0	16	-38	3
61682	Surgery of intracranial arteriovenous malformation; supratentorial, complex	**63.41**	0.116	**874**	120	**420**	50	0	9	-38	2
32445	Removal of lung, pneumonectomy; extrapleural	**63.84**	0.105	**1,182**	95	**310**	40	1	11	-38	4
33622	Reconstruction of complex cardiac anomaly (eg, single ventricle or hypoplastic left heart) with palliation of single ventricle with aortic outflow obstruction and aortic arch hypoplasia, creation of cavopulmonary anastomosis, and removal of right and left	**64.00**	0.123	**986**	63	**300**	60	2	11	-38	1
33783	Aortic root translocation with ventricular septal defect and pulmonary stenosis repair (ie, Nikaidoh procedure); with reimplantation of 1 or both coronary ostia	**65.08**	0.119	**926**	63	**360**	60	2	5	-38	1
432X7	**MCKEOWN Thoracoscopic, Laparoscopic, Open cervical incision REC**	**66.42**	**0.091**	**1,157**	110	**420**	**60**	2	7	-39	4
KEY REF 43118	Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)	**67.07**	0.111	**1,184**	95	**327**	40	1	11	-39	4
61686	Surgery of intracranial arteriovenous malformation; infratentorial, complex	**67.50**	0.110	**1,019**	135	**420**	55	1	8	-38	3

CPT	Long Descriptor	RVW	IWPUT	minutes				visits			
				Total	PRE	INTRA	POST	ICU	INPT	DCHG	OV
33877	Repair of thoracoabdominal aortic aneurysm with graft, with or without cardiopulmonary bypass	**69.03**	0.114	**1,110**	110	**324**	60	3	6	-39	3
KEY REF 43124	Total or partial esophagectomy, without reconstruction (any approach), with cervical esophagostomy	**69.09**	0.097	**1,398**	95	**243**	40	3	14	-39	5
61698	Surgery of complex intracranial aneurysm, intracranial approach; vertebrobasilar circulation	**69.63**	0.115	**1,209**	115	**360**	50	0	15	-38	3
47141	Donor hepatectomy (including cold preservation), from living donor; total left lobectomy (segments II, III and IV)	**71.50**	0.117	**1,101**	135	**420**	60	0	9	-38	5
33305	Repair of cardiac wound; with cardiopulmonary bypass	**76.93**	0.100	**1,251**	37	**296**	40	8	7	-38	1
33916	Pulmonary endarterectomy, with or without embolectomy, with cardiopulmonary bypass	**78.00**	0.112	**1,259**	63	**360**	60	4	10	-38	2
47142	Donor hepatectomy (including cold preservation), from living donor; total right lobectomy (segments V, VI, VII and VIII)	**79.44**	0.115	**1,221**	135	**480**	60	0	11	-38	5
Other REF 43113	Total or near total esophagectomy, with thoracotomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)	**80.06**	0.111	**1,358**	95	**391**	40	2	12	-39	4
Other REF 43108	Total or near total esophagectomy, without thoracotomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation and anastomosis(es)	**82.87**	0.110	**1,358**	95	**461**	40	1	12	-39	4
Other REF 43123	Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es)	**83.12**	0.109	**1,419**	95	**442**	40	1	14	-39	4
32853	Lung transplant, double (bilateral sequential or en bloc); without cardiopulmonary bypass	**84.48**	0.113	**1,440**	130	**375**	90	4	10	-39	2
33945	Heart transplant, with or without recipient cardiectomy	**89.50**	0.117	**1,716**	272	**325**	85	4	12	-39	6

CPT	Long Descriptor	RVW	IWPUT	minutes				visits			
				Total	PRE	INTRA	POST	ICU	INPT	DCHG	OV
32854	Lung transplant, double (bilateral sequential or en bloc); with cardiopulmonary bypass	**90.00**	0.108	**1,600**	130	**400**	90	4	13	-39	2

Appendix B: The Society of Thoracic Surgery Comments on CMS Anticipated Specialty Assignment for Low Volume Services

CPT Code	Anticipated Specialty	Specialty Recommendation for CY2018 NPRM Comment	Comments
32035		STS recommends THORACIC SURGERY	Not included in 2018 NPRM
32215		STS recommends THORACIC SURGERY	Not included in 2018 NPRM
32672		STS recommends THORACIC SURGERY	Not included in 2018 NPRM
33238		STS recommends CARDIAC SURGERY	Not included in 2018 NPRM
33363	CARDIOLOGY	STS recommends CARDIAC SURGERY	
33364	CARDIOLOGY	STS recommends CARDIAC SURGERY	
33477		STS recommends CARDIOLOGY	Not included in 2018 NPRM
33514		STS recommends CARDIAC SURGERY	Not included in 2018 NPRM
33516	THORACIC SURGERY	STS recommends CARDIAC SURGERY	
33548		STS recommends CARDIAC SURGERY	Not included in 2018 NPRM
33951		STS recommends CARDIAC SURGERY	Not included in 2018 NPRM
33953		STS recommends CARDIAC SURGERY	Not included in 2018 NPRM
33955		STS recommends CARDIAC SURGERY	Not included in 2018 NPRM
33957		STS recommends CARDIAC SURGERY	Not included in 2018 NPRM
33958		STS recommends CARDIAC SURGERY	Not included in 2018 NPRM
33959		STS recommends CARDIAC SURGERY	Not included in 2018 NPRM
33962		STS recommends CARDIAC SURGERY	Not included in 2018 NPRM
33963		STS recommends CARDIAC SURGERY	Not included in 2018 NPRM
33964		STS recommends CARDIAC SURGERY	Not included in 2018 NPRM
33965		STS recommends CARDIAC SURGERY	Not included in 2018 NPRM
33969		STS recommends CARDIAC SURGERY	Not included in 2018 NPRM
33973		STS recommends CARDIAC SURGERY	Not included in 2018 NPRM
33976	THORACIC SURGERY	STS recommends CARDIAC SURGERY	

33985		STS recommends CARDIAC SURGERY	Not included in 2018 NPRM
33987		STS recommends CARDIAC SURGERY	Not included in 2018 NPRM
33988		STS recommends CARDIAC SURGERY	Not included in 2018 NPRM
33989		STS recommends CARDIAC SURGERY	Not included in 2018 NPRM
33991		STS recommends CARDIAC SURGERY	Not included in 2018 NPRM
35182	THORACIC SURGERY	STS recommends CARDIAC SURGERY	
35251		STS recommends GENERAL SURGERY	Not included in 2018 NPRM
35271		STS recommends CARDIAC SURGERY	Not included in 2018 NPRM
35311	VASCULAR SURGERY	STS recommends CARDIAC SURGERY	
35526	VASCULAR SURGERY	STS recommends CARDIAC SURGERY	
38382	GENERAL SURGERY	STS recommends THORACIC SURGERY	
43108	GENERAL SURGERY	STS recommends THORACIC SURGERY	
43118	GENERAL SURGERY	STS recommends THORACIC SURGERY	
43123	GENERAL SURGERY	STS recommends THORACIC SURGERY	
43135		STS recommends THORACIC SURGERY	Not included in 2018 NPRM
43325		STS recommends GENERAL SURGERY	Not included in 2018 NPRM
43360	GENERAL SURGERY	STS recommends THORACIC SURGERY	
43405	GENERAL SURGERY	STS recommends THORACIC SURGERY	
43425	GENERAL SURGERY	STS recommends THORACIC SURGERY	