



The Society of Thoracic Surgeons

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December 29, 2014

Honorable Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1512-FC
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1612-FC: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015.

Dear Ms. Tavenner:

On behalf of The Society of Thoracic Surgeons (STS), the largest organization representing cardiothoracic surgeons in the United States and the world, I write to provide comments on the Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015 final rule with comment period that was published in the Federal Register on November 13, 2014.

Founded in 1964, STS is an international, not-for-profit organization representing more than 6,800 surgeons, researchers, and allied health care professionals in 90 countries who are dedicated to providing patient-centered high quality care to patients with chest and cardiovascular diseases, including heart, lung, esophagus, transplantation, and critical care. 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.

Comments

Professional Liability Insurance Relative Value Units

STS has three general recommendations regarding CMS's approach to revaluing professional liability insurance (PLI) relative value units (RVUs). Although STS pointed out significant errors that were published in the physician fee schedule proposed rule, and CMS has validated our concerns, the errors remain. These errors will have a significant negative payment impact on these high value, high risk procedures and will also be significant for the very small number of surgeons whose entire practices are related to procedures that are described by these codes.

In the final rule, in response to the STS comments on the physician fee schedule notice of proposed rulemaking, CMS stated:

We recognize that anomalies in the claims data can occur that would affect the dominant specialty for low volume services, and therefore resulting in the need for a subjective review of some services in place of a complete reliance on claims data. To that end, we reviewed the commenter's recommendations for overriding the dominant specialty from our claims data with a recommended specialty. After careful consideration of the comments, we will override the dominant specialty from Medicare claims data when the dominant specialty from our claims data is inconsistent with a specialty that could be reasonably expected to furnish the service. For example, our claims data indicates that pulmonary disease is the dominant specialty for HCPCS code 33622 (Reconstruction of complex cardiac anomaly), however as the commenter mentioned, this service is furnished by heart surgeons. A complete listing of low volume services for which we will override the claims based dominant specialty with the recommended specialty to assign a service level risk factor is illustrated in Table 12.

The errors we highlight below were identified by a rudimentary screen of the proposed Addendum B Excel file upon its release in July. In the attached chart (Appendix A) STS added the 2014 PLI values matched to each CPT code, and added a column with formulae showing the percent change in PLI for each code from 2014 to 2015. The data set was then sorted by percent change and all the codes identified below were instantly revealed. The magnitude of the changes we observed suggested that this was not due to any change in PLI resource based cost. This has proved to be the case upon examination of the individual codes characteristics and utilization data. In the future, we recommend that CMS perform these types of screens before publishing the proposed rule.

Second, we would ask that CMS provide an avenue to address these types of concerns before the fee schedule is finalized. As described above, we communicated our concerns in comments to the proposed rule. Separately, STS also reached out to the CMS staff person listed in the physician fee schedule final rule with comment period as being responsible for PLI issues. After a discussion by phone, the staff member agreed to accept further correspondence, review our public comments, and bring this to the attention of his superiors in the agency. We provided such correspondence (Appendix B). However, at the time of this writing, we have received no response.

Finally, it is very clear that current CMS policy to provide payment for procedures regardless of specialty designation (i.e., CPT codes are available for use by any physician) has great potential for fraud and abuse. There are a large number of questionable payments for surgical procedures claimed to have been performed by non-surgical specialties throughout the PFS in addition to those identified in this correspondence. Some instances of allowed charges may be related to surgical assistance by non-surgeons, and some may be due to faulty specialty designation by providers. However, we do not believe that this is sufficient to explain all instances. Therefore, we recommend that CMS develop a mechanism to improve its utilization database, and to

carefully scrutinize claims where a major surgical procedure is billed for primary payment by a non-surgeon specialist.

In reviewing Table 12, we note that CMS overrode the claims based dominant specialty for only 3 of the 34 codes submitted for consideration by STS, even though the rationale acknowledged by CMS in the final rule applies to all of those submitted by STS. Additionally, the published finalized PLI values for the 3 codes in Table 12 appear to be the same erroneous values calculated based on the incorrect dominant specialty assignment.

Appendix A shows the PLI history, the proposed PLI value, the finalized PLI value, the arithmetic relationship of the PLI value to the work value, and the percent reduction in PLI value as finalized compared to the 2014 value. We also describe our concerns below.

The following codes are congenital heart surgery codes that have PLI reductions of nearly 70% as compared to 2014 and 2013 values. This is far more than can be accounted for by changes in PLI premium direct inputs. There have been no changes in the vast majority of these procedures in decades, and as already submitted and agreed to by CMS, they can only be performed by congenital cardiac surgeons. These codes, described below, are found in rows 2-29 of Appendix A. **STS recommends that the finalized PLI values for these codes be changed to reflect the malpractice risk factor of CARDIAC SURGERY.**

CPT Code	Long Descriptor
33471	Valvotomy, pulmonary valve, closed heart; via pulmonary artery
33606	Anastomosis of pulmonary artery to aorta (Damus-Kaye-Stansel procedure)
33611	Repair of double outlet right ventricle with intraventricular tunnel repair;
33619	Repair of single ventricle with aortic outflow obstruction and aortic arch hypoplasia (hypoplastic left heart syndrome) (eg, Norwood procedure)
33676	Closure of multiple ventricular septal defects; with pulmonary valvotomy or infundibular resection (acyanotic)
33677	Closure of multiple ventricular septal defects; with removal of pulmonary artery band, with or without gusset
33692	Complete repair tetralogy of Fallot without pulmonary atresia;
33737	Atrial septectomy or septostomy; open heart, with inflow occlusion
33755	Shunt; ascending aorta to pulmonary artery (Waterston type operation)
33762	Shunt; descending aorta to pulmonary artery (Potts-Smith type operation)
33764	Shunt; central, with prosthetic graft

CPT Code	Long Descriptor
33768	Anastomosis, cavopulmonary, second superior vena cava (List separately in addition to primary procedure)
33770	Repair of transposition of the great arteries with ventricular septal defect and subpulmonary stenosis; without surgical enlargement of ventricular septal defect
33771	Repair of transposition of the great arteries with ventricular septal defect and subpulmonary stenosis; with surgical enlargement of ventricular septal defect
33775	Repair of transposition of the great arteries, atrial baffle procedure (eg, Mustard or Senning type) with cardiopulmonary bypass; with removal of pulmonary band
33776	Repair of transposition of the great arteries, atrial baffle procedure (eg, Mustard or Senning type) with cardiopulmonary bypass; with closure of ventricular septal defect
33777	Repair of transposition of the great arteries, atrial baffle procedure (eg, Mustard or Senning type) with cardiopulmonary bypass; with repair of subpulmonic obstruction
33778	Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type);
33779	Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type); with removal of pulmonary band
33780	Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type); with closure of ventricular septal defect
33781	Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type); with repair of subpulmonic obstruction
33783	Aortic root translocation with ventricular septal defect and pulmonary stenosis repair (i.e., Nikaidoh procedure); with reimplantation of 1 or both coronary ostia
33786	Total repair, truncus arteriosus (Rastelli type operation)
33803	Division of aberrant vessel (vascular ring); with reanastomosis
33813	Obliteration of aortopulmonary septal defect; without cardiopulmonary bypass
33822	Repair of patent ductus arteriosus; by division, younger than 18 years
33840	Excision of coarctation of aorta, with or without associated patent ductus arteriosus; with direct anastomosis
33851	Excision of coarctation of aorta, with or without associated patent ductus arteriosus; repair using either left subclavian artery or prosthetic material as gusset for enlargement

Next, there are three CPT codes that are performed by thoracic surgeons where again the PLI values have been finalized with a 67-70% reduction compared to 2013 and 2014. These are represented in rows 31-33 in Appendix A. **STS recommends that the finalized PLI values for these codes be changed to reflect the malpractice risk factor of THORACIC SURGERY.**

CPT Code	Long Descriptor
31766	Carinal reconstruction
31775	Bronchoplasty; excision stenosis and anastomosis
43313	Esophagoplasty for congenital defect (plastic repair or reconstruction), thoracic approach; without repair of congenital tracheoesophageal fistula

Regarding 31766, carinal reconstruction, there are several features of this code’s utilization pattern that deserve mention: Carinal reconstruction is a low volume procedure with only 5 performed in the 2013 Medicare Utilization file. Two of the cases listed were billed by thoracic surgeons, two were billed by cardiac surgeons and one was billed by pulmonary medicine (which must be a flawed claim, as this code describes a major thoracic surgical procedure). STS represents the specialty of thoracic surgery, which encompasses adult and congenital cardiac surgery, and what we refer to as general thoracic surgery which is surgery on the chest wall, lungs, esophagus and tumors of the mediastinum that do not involve the heart. There is only one certification by the American Board of Thoracic Surgery, and it is very common for thoracic surgeons thus defined to perform both cardiac and general thoracic surgery. However, each surgeon has a designation of either CARDIAC SURGERY or THORACIC SURGERY in the utilization file and, as your survey indicates, the malpractice risk factor for each is naturally very similar. Thus many obvious cardiac procedures, and many obvious general thoracic procedures, have a percentage performed by both “specialty designations.” Since the risk factors are similar, a blend of the two is certainly appropriate. It becomes problematic, though, when as in this case there is no dominant specialty even when 80% of the procedures (40% CARDIAC SURGERY, 40% THORACIC SURGERY) are performed by surgeons of the same specialty. In this case, the two specialty designations responsible for performing the procedure actually represent the same specialty. In this case, using the risk factor for either specialty or even a blend of both would be appropriate.

The next two CPT codes in Appendix A (rows 35 and 36) demonstrate where faulty utilization data are a major factor in leading to abnormally low PLI:

CPT Code	Long Descriptor
33420	Valvotomy, mitral valve; closed heart
32654	Thoracoscopy, surgical; with control of traumatic hemorrhage

These codes are major cardiac surgical and major general thoracic procedures, respectively.

Code 33420, valvotomy, mitral valve; closed heart, is a low volume surgical procedure. During this procedure, a dilatation device is directly inserted into the beating heart through a pursestring suture and the surgeon’s finger is inserted through another pursestring suture. The surgeon manipulates the device across the mitral valve by “feel” and the device opens the fused valve to relieve mitral stenosis. Incidentally, this was actually the first cardiac procedure ever performed, in the 1930’s. This is a low volume code with, 37.5% of the procedures performed by CARDIAC SURGERY, 37.5% of the procedures by THORACIC SURGERY and inexplicably the remaining 25% by GENERAL PRACTICE. Similar to the example above, the dominant specialty is actually our specialty performing the procedure 75% of the time. With the remainder erroneously billed. In this instance, it would be appropriate for the malpractice risk factor to be CARDIAC SURGERY in keeping with the type of procedure.

32654, thoracoscopy, surgical; with control of traumatic hemorrhage, is a major general thoracic procedure involving a thoracoscopic approach for bleeding due to trauma. The PLI here has been degraded from 22% of the relative value of work (RVW) to 18% of RVW due to utilization by PULMONARY DISEASE at the 22.95% level along with a potpourri of other specialties including CARDIOLOGY, CRITICAL CARE and INTERNAL MEDICINE. This is not a low volume code by CMS criteria (2013 Utilization 244), but ours is the dominant specialty again split with 43.44% THORACIC SURGERY and 18.85% CARDIAC SURGERY for a total of 62.3%. This utilization pattern is consistent with inaccurate coding as this code clearly describes and is valued for a major surgical procedure but is being performed in significant volume by non-surgical specialties. **STS recommends that the finalized PLI values for these codes be changed to reflect the malpractice risk factor of CARDIAC SURGERY for 33420 and THORACIC SURGERY for 32654.**

Next are two codes that are represented in Table 12 of the final rule (Rows 38 and 39 of Appendix A), where CMS agreed that the PLI should be adjusted to reflect the fact that they can only be performed by congenital cardiac surgeons:

CPT Code	Long Descriptor
33620	Application of right and left pulmonary artery bands (eg, hybrid approach stage 1)
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 pulmonary bands (eg, hybrid approach stage 2, Norwood, bidirectional Glenn, pulmonary artery debanding)

Despite this, the finalized PLI values have changed insignificantly from those proposed and remain reduced by 72% and 70% as compared to 2013 and 2014 values. **STS recommends that the finalized PLI values for these codes be changed to reflect the malpractice risk factor of CARDIAC SURGERY.**

Improving the Valuation and Coding of the Global Service Package

The STS is very concerned with CMS' decision to finalize its proposal to transition away from the 010-day and 090-day global surgical periods without modification. As we and others commented on the proposed rule, there is little, if any, legitimacy in the proposed approach in relation to the stated CMS concerns. Additionally, we, and others, lack any confidence in CMS's ability to make such wholesale changes in the fee schedule in an accurate or fair manner, even if it were to heed the advice provided by the RUC or other commenters on its actions. Finally, the proposed time schedule is unrealistic and will result in many, hugely detrimental errors. If CMS proceeds, we request CMS to at a minimum demonstrate that it is capable of fairly evaluating and responding to commenters in a timely fashion, and to provide a mechanism for retroactive claims adjudication as a remedy for erroneous actions.

Specifically, CMS proposes to remove evaluation and management (EM) value from 4,264 010 and 090 global CPT codes that describe surgical procedures, and convert them to 0 day global codes. This would permit physicians to bill for EM services as they are provided, rather than receiving payment for the typical patient under a global payment.

The primary flaw in the CMS proposal is the undefined mechanism to determine the appropriate reduction. We are concerned that CMS will assume that the value of the EM services currently included in the global payment and the value of performing the actual procedure were determined independently in the valuation process. If this were true, removing the value of the EM services would be legitimate. However, for the vast majority of CPT codes, the total value of the global code was the only adjudicated value. The value of performing the procedure and the value of the associated EM services were not separately adjudicated and then summed as "building blocks" to create the total value. Thus, it is not legitimate to simply subtract the EM "building block" to arrive at a new value. In fact, this process, if implemented, would "undo" the 20-year history of refinement of the relativity of the resource-based relative value scale.

To this point, we would call CMS's attention to a simple exercise that we performed to analyze the impact of the proposed conversion of all 4,264 CPT codes. To simplify the analysis, we calculated the payment rate for these codes using the proposed conversion factor and expressed it in dollars per hour. As demonstrated in Appendix C, first we restructured the payment for the evaluable 010 and 090 global codes by removing the value and time of all inpatient and outpatient visits, and adding back the value and time of the single highest valued inpatient visit. This assumes that CMS will agree that an inpatient visit occurring on the same day after the procedure is completed should be included in the 000 global. We also made a similar code value restructuring, assuming that no inpatient visit value will be allowed by CMS on the day of surgery, even though such visits occur and will not be independently billable for CPT codes with a 000 global assignment.

We compared our results to CPT code 99213, *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; **Medical***

decision making of low complexity. Under this code, counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. ***Usually, the presenting problem(s) are of low to moderate severity.*** Typically, 15 minutes are spent face-to-face with the patient and/or family (emphasis added). For 99213, the overall payment rate for total physician work is \$90.65 per hour. For the face-to-face sub-component, which is equivalent to the intraservice component of a procedure, the payment rate is \$113.31 per hour.

We found that, if the revised and revalued 000 global codes contain a single inpatient visit (if present in the current RUC database), 26/4246 codes will have negative payment rates. This is due to the fact that the value of the EM component of the code in the CMS/RUC database exceeds the total current value of the code. This means that, using this methodology, surgeon would be required to pay CMS in order to provide these procedures. In addition 2600/4246 surgical procedures will have payment rates less than the rate of \$113.31 per hour that we calculated for 99213. If a same day inpatient visit is not allowed in the restructured codes, 61/4246 will have negative payment rates, and 2596/4246 will have payment rates less than 99213.

In examining the intraservice payment rate (operative skin-to-skin work vs face-to-face time 99213) we find that 2016/4246 000 global codes have payment rates less than that of 99213. Negative intraservice payment for current 010 and 090 global codes will occur in 167 codes. The vast majority of the 4,246 codes that will be affected are invasive surgical procedures. We conclude, and we think reasonably, that 99213 (described as having decision making of low complexity) would represent an absolute minimum payment rate for these codes, and perhaps applicable to only the most simple surgical procedural code.

This evaluation demonstrates that a systematic change in the code values based upon current RUC data will result in major payment inequities. Leaving aside the question of what the relationship of all these codes to 99213 should be, this information clearly demonstrates that the majority of the CPT codes subject to conversion will need to be individually evaluated to establish new work values. The magnitude of the work involved clearly exceeds that which will be available in the timeline finalized by CMS.

In addition to these concerns, we reiterate our previously expressed concerns regarding the need to correct for other consequences of the conversion that will result in under-reimbursement for PLI, indirect practice expense (PE) and direct PE for surgical specialties and surgical procedures. In this regard, we would support the more detailed comments of the RUC and ask that CMS review the STS comments on the proposed rule.

STS suggests an alternative proposal that would appear to respond to CMS's stated rationale for the conversion, which consists of evidence that outpatient visits that can be documented vary from the number of visits embedded in the global payment for certain codes and that disparities in payment occur for these outpatient visits when they occur in the facility setting but are reimbursed in the global period as non-facility visits.

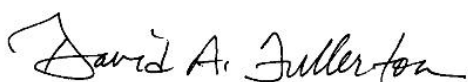
STS suggests that CMS retain the current global periods, but work with the RUC to remove the value of office visits from the total code value. Office visits that are provided would then be billed separately, using a modifier to indicate that the visit is occurring within a global period. STS suggests that a new modifier be developed to report these visits and that it be required to be associated with the global period code or codes that have created the global period. In this way, CMS can attach the proper malpractice risk factor for the EM visit PLI and capture the direct and indirect expenses associated with the visit from the global code(s). This would require that the office visit inputs would need to be retained in the 090 or 010 global code, even though the value will have been removed. This mechanism would resolve many of the concerns raised in comments by STS and others, and permit CMS to directly determine the site of service of the outpatient visit.

Further, STS would suggest that the process of removing outpatient visits be considered by the RUC to ensure that decisions related to individual codes are reviewed systematically. Many codes with only 1 or 2 low level visits will be relatively non-controversial, but there are undoubtedly many codes where there are multiple outpatient visits that are not evidence-based and actually reflect payment for the procedure itself, as outlined above.

The process outlined here would leave intact the inpatient visit patterns embedded in the global periods, and will be far less likely to cause disruptions in the established relativity of the fee schedule. STS would encourage CMS to study billing patterns for 010 and 090 inpatient visits by providers other than the billing surgeon, performing risk adjustment to identify situations where it is typical for comprehensive inpatient management to be provided by other physicians. This would provide an evidence-based rationale for any further action to convert to 000 globals for selected codes. We would be grateful for the opportunity to work with CMS on this revised approach to the revaluation of global surgical procedures. We urge CMS not to implement its current approach.

On behalf of the Society, thank you for the opportunity to provide these comments. If you have any questions, please contact Courtney Yohe, STS Director of Government Relations, at 202-787-1222 or cyohe@sts.org.

Sincerely,

A handwritten signature in black ink that reads "David A. Fullerton". The signature is written in a cursive, flowing style.

David A. Fullerton, MD
President

Appendix A

Appendix A

CMS Final Rule Table	CPT Code	Long Descriptor	2013 Medicare Frequency	2013 PLI	PLI 2014	PLI 2015 Proposed	PLI 2015 Final	2013 PLI %	2014 PLI %	2015 Proposed PLI %	2015 Final PLI %	Percent PLI Change from 2014
2	No	33471	Valvotomy, pulmonary valve, closed heart, via pulmonary artery	5.76	5.51	1.49	1.53	25%	24%	6%	7%	-72%
3	No	33606	Anastomosis of pulmonary artery to aorta (Damus-Kaye-Stansel procedure)	6.72	6.43	2.05	2.10	21%	20%	7%	7%	-67%
4	No	33611	Repair of double outlet right ventricle with intraventricular tunnel repair;	8.90	8.51	2.31	2.37	25%	24%	6%	7%	-72%
5	No	33619	Repair of single ventricle with aortic outflow obstruction and aortic arch hypoplasia (hypoplastic left heart syndrome) (eg, Norwood procedure)	11.42	10.92	3.18	3.24	23%	22%	7%	7%	-70%
6	No	33676	Closure of multiple ventricular septal defects; with pulmonary valvotomy or infundibular resection (acyanotic)	9.36	8.95	2.40	2.45	25%	24%	6%	7%	-73%
7	No	33677	Closure of multiple ventricular septal defects; with removal of pulmonary artery band, with or without gusset	9.75	9.32	2.51	2.57	25%	24%	7%	7%	-72%
8	No	33692	Complete repair; tetralogy of Fallot without pulmonary atresia;	9.11	8.71	2.35	2.40	25%	24%	7%	7%	-72%
9	No	33737	Atrial septectomy or septostomy; open heart, with inflow occlusion	5.27	5.04	1.46	1.50	23%	22%	6%	7%	-70%
10	No	33755	Shunt; ascending aorta to pulmonary artery (Waterston type operation)	4.94	4.72	1.47	1.51	22%	21%	7%	7%	-68%
11	No	33762	Shunt; descending aorta to pulmonary artery (Potts-Smith type operation)	5.73	5.48	1.47	1.51	25%	24%	7%	7%	-72%
12	No	33764	Shunt; central, with prosthetic graft	4.83	4.62	1.47	1.51	21%	20%	7%	7%	-67%
13	No	33768	Anastomosis, cavopulmonary, second superior vena cava (list separately in addition to primary procedure)	1.99	1.9	0.52	0.53	25%	24%	7%	7%	-72%
14	No	33770	Repair of transposition of the great arteries with ventricular septal defect and subpulmonary stenosis; without surgical enlargement of ventricular septal defect	9.16	8.76	2.55	2.60	23%	22%	7%	7%	-70%

Appendix A

	CMS Final Rule Table	CPT Code	Long Descriptor	2013 Medicare Frequency	2013 PLI	PLI 2014	PLI 2015 Proposed	PLI 2015 Final	2013 PLI %	2014 PLI %	2015 Proposed PLI %	2015 Final PLI %	Percent PLI Change from 2014
15	No	33771	Repair of transposition of the great arteries with ventricular septal defect and subpulmonary stenosis; with surgical enlargement of ventricular septal defect	-	10.32	9.87	2.65	2.70	25%	24%	7%	7%	-73%
16	No	33775	Repair of transposition of the great arteries, atrial baffle procedure (eg, Mustard or Senning type) with cardiopulmonary bypass; with removal of pulmonary band	-	8.29	7.93	2.15	2.19	25%	24%	7%	7%	-72%
17	No	33776	Repair of transposition of the great arteries, atrial baffle procedure (eg, Mustard or Senning type) with cardiopulmonary bypass; with closure of ventricular septal defect	1	8.72	8.34	2.27	2.32	25%	24%	7%	7%	-72%
18	No	33777	Repair of transposition of the great arteries, atrial baffle procedure (eg, Mustard or Senning type) with cardiopulmonary bypass; with repair of subpulmonic obstruction	-	8.61	8.23	2.23	2.28	25%	24%	7%	7%	-72%
19	No	33778	Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type);	-	10.85	10.38	2.78	2.85	25%	24%	7%	7%	-73%
20	No	33779	Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type); with removal of pulmonary band	1	10.99	10.51	2.81	2.88	25%	24%	7%	7%	-73%
21	No	33780	Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type); with closure of ventricular septal defect	-	11.14	10.65	2.87	2.92	25%	24%	7%	7%	-73%
22	No	33781	Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type); with repair of subpulmonic obstruction	-	10.99	10.51	2.81	2.88	25%	24%	7%	7%	-73%

Appendix A

CMS Final Rule Table	CPT Code	Long Descriptor	2013 Medicare Frequency	2013 PLI	PLI 2014	PLI 2015 Proposed	PLI 2015 Final	2013 PLI %	2014 PLI %	2015 Proposed PLI %	2015 Final PLI %	Percent PLI Change from 2014	
23	No	33783	Aortic root translocation with ventricular septal defect and pulmonary stenosis repair (ie, Nikaidoh procedure); with reimplantation of 1 or both coronary ostia	-	15.24	14.57	4.25	4.33	23%	22%	7%	7%	-70%
24	No	33786	Total repair, truncus arteriosus (Rastelli type operation)	3	10.60	10.14	2.73	2.79	25%	24%	7%	7%	-72%
25	No	33803	Division of aberrant vessel (vascular ring); with reanastomosis	-	5.08	4.86	1.32	1.36	25%	24%	6%	7%	-72%
26	No	33813	Obiteration of aortopulmonary septal defect; without cardiopulmonary bypass	2	5.01	4.79	1.39	1.41	23%	22%	7%	7%	-71%
27	No	33822	Repair of patent ductus arteriosus; by division, younger than 18 years	1	4.45	4.26	1.15	1.18	25%	24%	6%	7%	-72%
28	No	33840	Excision of coarctation of aorta, with or without associated patent ductus arteriosus; with direct anastomosis	-	5.34	5.11	1.39	1.41	25%	24%	7%	7%	-72%
29	No	33851	Excision of coarctation of aorta, with or without associated patent ductus arteriosus; repair using either left subclavian artery or prosthetic material as gusset for enlargement	-	5.48	5.24	1.43	1.46	25%	24%	7%	7%	-72%
31	No	31766	Carinal reconstruction	5	7.40	7.08	2.06	2.11	23%	22%	7%	7%	-70%
32	No	31775	Bronchoplasty; excision stenosis and anastomosis	8	5.76	5.51	1.77	1.81	23%	22%	7%	7%	-67%
33	No	43313	Esophagoplasty for congenital defect (plastic repair or reconstruction), thoracic approach; without repair of congenital tracheoesophageal fistula	-	11.35	10.85	3.15	3.22	23%	22%	7%	7%	-70%
35	No	33420	Valvotomy, mitral valve; closed heart	8	3.54	3.39	3.28	3.32	14%	13%	13%	13%	-2%
36	No	32654	Thoracoscopy, surgical; with control of traumatic hemorrhage	244	4.65	4.45	3.67	3.76	23%	22%	18%	18%	-16%

Appendix A

	CMS Final Rule Table	CPT Code	Long Descriptor	2013 Medicare Frequency	2013 PLI	PLI 2014	PLI 2015 Proposed	PLI 2015 Final	2013 PLI %	2014 PLI %	2015 Proposed PLI %	2015 Final PLI %	Percent PLI Change from 2014
38	Yes	33620	Application of right and left pulmonary artery bands (eg, hybrid approach stage 1)	46	7.50	7.17	2.25	1.99	25%	24%	8%	7%	-72%
39	Yes	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 pulmonary bands (eg, hybrid approach stage 2, Norwood, bidirectional Glenn, pulmonary artery debanding)	2	14.98	14.33	4.62	4.25	23%	22%	7%	7%	-70%

Appendix B

THE SOCIETY OF THORACIC SURGEONS

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December 8, 2014

COPY SENT VIA EMAIL

Mr. Craig Dobyski
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244-8013

Dear Mr. Dobyski,

Thank you for speaking recently with Dr. Peter Smith, Chair of the Society's Workforce on Coding and Reimbursement, about CMS's decisions regarding professional liability insurance (PLI) Relative Value Unit (RVU) values assigned to 40 individual CPT codes that were finalized in the October 31 Physician Fee Schedule final rule. I am writing to request that CMS correct its decision, which we believe was made in error.

During the Calendar Year 2015 Physician Fee Schedule public comment period, The Society of Thoracic Surgeons submitted comments regarding 34 CPT codes for which the proposed PLI RVU was drastically and incorrectly reduced. These codes describe complex and highly invasive cardiac surgical procedures that can only be performed by cardiac surgeons. The PLI RVU assigned, however, was more consistent with performance by non-surgeons or the blend assigned to 99213. Additionally, the PLI RVUs were markedly reduced from both 2014 and 2013 values (ranging from 22-24% of relative value work (RVW) to 7% of RVW), with no change in the procedural RVW and no change in clinical practice.

In the Final Rule, CMS agreed with our assessment as follows:

After careful consideration of the comments, we will override the dominant specialty from Medicare claims data when the dominant specialty for our claims data is inconsistent with a specialty that could be reasonably expected to furnish the service."

However, in the complete listing of codes, where CMS committed to an override of the claims data dominant specialty, only 6 of 40 relevant CPT codes that are performed predominantly by

thoracic or cardiac surgeons are listed: 33620, 33621, 33622, 33697, 33766 and 43341 (79 Fed Reg 67594):

- 33620 and 33622 (the latter of which was specifically used as the example in the CMS response text) were submitted as anomalous by STS in our September 2, 2014 comment letter. However, the finalized PLI RVUs of 1.99 and 4.25, respectively, do not reflect any change in the specialty risk factor, despite the policy stated in the final rule. As finalized, the PLI RVU values for these codes represent ~7% of the RVW for each code, a value not consistent with a cardiac surgery risk factor.
- STS did not submit 33621 as anomalous since its PLI RVU was proposed at 3.56 RVU or 22% of RVW, which indicated to us that the assigned risk factor was already correct. The finalized PLI RVU of 3.70 or 23% of RVW seems to reflect the minor changes made overall to PLI that occurred for reasons other than specialty risk factor designation.
- STS also did not submit 33697, 33766 or 43341 as anomalous, because the proposed PLI RVUs for these codes were also consistent with the application of a correct risk factor for cardiac or thoracic surgery. Although CMS stated it would change these risk factor assignments, the finalized values have not changed significantly. They are, however, appropriate.

In summary, CMS has accepted the rationale for assigning a dominant specialty risk factor, other than the one derived by its methodology, for only 2 of the 34 codes submitted by STS, and for those 2 has actually not implemented the change it sought to finalize. Further, CMS has not responded to the other 32 examples that meet the same criteria for override as accepted for 33620 and 33620.

We have attached an excel spreadsheet named "Attachment2-STs PLI Anomalies" that includes the long descriptors of all the codes submitted for change, including an additional two codes that were submitted by the RUC for similar reasons. This file contains 36 codes that should have PLI RVUs adjusted to reflect the specialty designation risk factor in the column "Recommended Specialty for PLI." The file also shows the basis for our concern, which is a precipitous reduction in PLI RVU that is not consistent with the minor changes due to the new resource basing of malpractice risk factors.

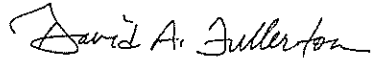
Also attached is an excerpt from our public comment on the proposed rule, which provides additional detail on most of CPT codes that are now re-submitted.

This would seem to be a straightforward request. We are writing to request that this request be honored to be in effect as of January 1, 2015. I understand that, in your conversation with Dr. Smith, you agreed to discuss this situation with others in your department. We would expect that clinical review of the long descriptors would reassure them that correction is justified.

Craig Dobyski
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Thank you for your early consideration of this request.

Sincerely,

A handwritten signature in cursive script that reads "David A. Fullerton".

David A. Fullerton, MD
President

Enclosures

cc: Robert A. Wynbrandt
William F. Seward
Courtney Yohe
Peter K. Smith

Appendix C (see attached)