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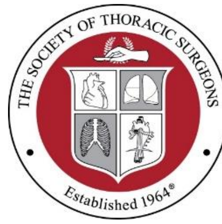

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September 11, 2023

Chiquita Brooks-LaSure, MPP
Administrator
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program [CMS-1784-P]

Dear Administrator Brooks-LaSure,

On behalf of The Society of Thoracic Surgeons (STS), I write to provide comments on Calendar Year (CY) 2024 Medicare Physician Fee Schedule (PFS). Founded in 1964, STS is a not-for-profit organization representing more than 7,900 surgeons, researchers, and allied healthcare professionals worldwide who are dedicated to ensuring the best possible outcomes for surgeries of the heart, lungs, and esophagus, as well as other surgical procedures within the chest.

General Comments – Sustainability of Medicare Reimbursement

CMS estimates the CY 2024 PFS CF to be $32.7476, which reflects a budget neutrality adjustment of -2.17 percent, the 0.0 percent update adjustment factor required under the Medicare Access and CHIP Reauthorization Act (MACRA), and a +1.25 percent payment update provided under the Consolidation Appropriations Act, 2023 (CAA, 2023).

STS is profoundly disappointed that this proposed rule continues the longstanding trend of systematically devaluing Medicare reimbursements. While the operational and overhead costs for medical practices continue to rise significantly, especially during the wake of the COVID-19 pandemic, Medicare reimbursements have been on a declining trend for several decades. This widening gap not only puts undue financial strain on medical professionals, but also threatens the sustainability of practices that countless patients rely upon for their healthcare needs. It's imperative to recognize that when reimbursements do not keep pace with escalating costs, the viability and quality of patient care are potentially at risk.

According to the American Medical Association (AMA), Medicare physician payments have lagged 26% behind the rate of inflation growth since 2001. This is in stark contrast to other healthcare sectors who regulatory receive inflation-based updates. Reductions to physician reimbursements are multifactorial and continue to compound. In addition to facing negative conversion factor adjustments each year triggered by budget neutrality requirements, physicians face ongoing sequestration reductions, the threat of

PAYGO, the loss of alternative payment model (APM) bonus payments, up to 9% penalties as part of the Quality Payment Program (QPP), and more. In just this year, cardiothoracic surgeons are facing a reduction exceeding 3%, which surpasses the amount specified in CMS' impact table 104 from the proposed rule, due to the termination of the 1.25% relief previously granted by Congress. These levels of reductions are not sustainable, especially for a specialty like cardiothoracic surgery which Health Resources and Services Administration (HRSA) recently projected will have the largest projected shortfall of any physician specialty evaluated by 2035, with an 69% adequate supply of physicians within the specialty.[1]

While STS recognizes that many of these factors are outside of CMS' control and would require congressional intervention to fully address, these challenges serve as an important backdrop that we believe should inform CMS' approach to the physician fee schedule. Further, we urge CMS to work with Congress to provide a positive update to the Medicare conversion factor in 2024 and all future years.

Payment Provisions of the Proposed Rule for the Physician Fee Schedule (PFS)

Determination of Practice Expense Relative Value Units (PE RVUs)

PE Methodology and Professional Liability Insurance (PLI) RVUs – Expected Specialty Overrides for Low Volume Service Codes

STS appreciates CMS' continued policy of using expected specialty overrides for certain low volume services. We agree with the codes included in the *Anticipated Specialty Assignment for Low Volume Services* list provided as part of the supporting documentation in the Proposed Rule. It appears all of the codes STS and the AMA RVS Update Committee (RUC) have requested in the past are included in the list and the overrides have been applied to the malpractice and PE RVUs for the codes in Addenda B of the Proposed Rule.

The CMS list also includes a column specifying if a service that previously had an anticipated specialty override continues to meet the criteria for the override to be applied for CY 2024. There are several codes for cardiac surgery or thoracic surgery where the 3-year average is less than 100 but the "Override Applied?" column (Column C) is blank. **Our understanding is that cardiac surgery or thoracic surgery will be the specialty assigned to these codes, but STS would like to verify that cardiac surgery or thoracic surgery, depending on which is the dominant specialty, will in fact be used for the PE and PLI calculation for these codes.** As part of the list, CMS indicates "We note that the specialty override is unneeded for some codes as all utilization is already from the anticipated specialty." For some of the codes where Column C is blank, cardiac surgery or thoracic surgery account for all the utilization for the code. However, some of the blanks in Column C represent codes where either there is no utilization data for the code or cardiac surgery and/or thoracic surgery are not the only specialties that provide the service, but cardiac surgery or thoracic surgery is still the specialty that accounts for the highest utilization for the code. The codes in question include the following:

- 33238 (2019 - 89, 2020 - 88, 2021 - 84; Thoracic Surgery - 22.6%, Cardiac Surgery - 64.3%)
- 33254 (2019 - 79, 2020 - 66, 2021 - 89; Thoracic Surgery - 50.6%, Cardiac Surgery - 47.2%)
- 33475 (2019 - 103, 2020 - 96, 2021 - 85; Thoracic Surgery - 44.7%, Cardiac Surgery - 50.6%)
- 33507 (2019 - 74, 2020 - 56, 2021 - 63; Thoracic Surgery - 57.1%, Cardiac Surgery - 39.7%)
- 33600 (2019 - 8, 2020 - 5, 2021 - 4; Thoracic Surgery - 75.0%)

[1] https://data.hrsa.gov/topics//health-workforce/workforce-projections

- 33602 (2019 - 2, 2020 - 4, 2021 - 5; Thoracic Surgery - 80.0%)
- 33619 (2019, 2020, 2021 - No data)
- 33710 (2019 - 3, 2020 and 2021 - No data)
- 33778 (2019, 2020, 2021 - No data)
- 43045 (2019 - 5, 2020 - 4, 2021 - 5; Thoracic Surgery - 60.0%)
- 43312 (2019 - 103, 2020 - 90, 2021 - 62; Thoracic Surgery - 67.7%, Cardiac Surgery - 3.2%)

STS also agrees with the analysis performed by the RUC to identify all codes that meet the criteria to receive a specialty override under this CMS policy and recommends that CMS add the following codes with the indicated low volume specialty override to the list for CY 2024:

- 32310 - THORACIC SURGERY (2021 - 81; Thoracic Surgery - 82.7%, Cardiac Surgery - 8.6%)
- 32815 - THORACIC SURGERY (2021 - 69; Thoracic Surgery - 71.0%, Cardiac Surgery - 10.1%)
- 33141 - THORACIC SURGERY (2021 - 4; Thoracic Surgery - 100.0%)

Adding these codes to the *Specialty Assignment for Low Volume Services* list ensures that the risk for the appropriate specialty is reflected in the professional liability for the code. Assigning the correct specialty to these codes avoids the major adverse impact on PLI RVUs that result from errors in specialty utilization data magnified in representation (percentage) by small sample sizes. In addition, the proposed specialty overrides also ensure appropriate application of the expected indirect practice expense for each service.

As in previous years, CMS has applied the expected specialty override to services with fewer than 100 Medicare claims in a three-year average without adjusting the utilization to interpret any Current Procedural Terminology (CPT) modifiers. STS agrees that the usage of a three-year average continues to be appropriate.

Adjusting RVUs To Match PE Share of the Medicare Economic Index (MEI)

CMS is proposing to not incorporate the 2017-based MEI in PFS ratesetting for CY 2024. CMS continues to monitor other data sources and will propose any changes to the MEI in future rulemaking, as appropriate.

In the nearly 50 years since the initial establishment of the MEI in 1975, the AMA has collected data about physicians' earnings and practice costs which has served as the standard and a consistent source of information. Data from 2006 obtained from the AMA's last Physician Practice Information (PPI) Survey serve as the basis for the current MEI weights that CMS uses in rate setting.

In the CY 2023 Final Rule, CMS rebased and revised the MEI to reflect more current market conditions faced by physicians in furnishing physicians' services. CMS finalized but postponed implementation of the updated MEI weights for the different cost components of the MEI using a new methodology based primarily on a subset of data from the 2017 US Census Bureau's Service Annual Survey (SAS). The proposed and postponed MEI weights from CMS using the new methodology from 2023 changed the physician work from 50.9% to 47.3%, the practice expense from 44.8% to 51.33% and the PLI from 4.3% to 1.4%. Due to the significant impact to physician payments, the implementation of the proposed MEI changes was postponed until time uncertain allowing for continued public comment.

In the CY 2024 proposed rule, CMS announced that they will not incorporate the 2017-based MEI in PFS ratesetting for CY 2024. CMS indicated that given the impact of the changes in methodology, the change in data sources would have on payments, and that the AMA intends to collect certain practice expense

data that could be used, they will continue to monitor other data sources and will propose any changes to the MEI in future rulemaking, as appropriate.

STS supports CMS' decision to continue to postpone the implementation of the rebased and revised MEI using the SAS data and wait to review the data from the AMA PPI Survey that was launched in July 2023.

Valuation of Specific Codes

Proposed Valuation of Specific Codes for CY 2024

<u>Intraoperative Ultrasound Services (CPT codes 76998, 7X000, 7X001, 7X002, and 7X003)</u>

CPT code 76998 was identified as a potentially misvalued code as part of the Relativity Assessment Workgroup (RAW) screen for CMS/Other codes with Medicare utilization of 20,000 or more in October 2018. There were several specialties including cardiothoracic surgery, general surgery, breast surgery, urology, interventional cardiology, interventional radiology and vascular surgery that were represented in the Medicare claims data, and these specialties submitted a joint action plan that the RAW reviewed in October 2019. The action plan noted that there was significant variability in how intraoperative ultrasound is utilized for each specialty with differences in the typical patient and physician work. To account for these differences, each society would submit applications for new code(s) as needed to carve out the work currently reported with 76998 until the code was no longer needed or until it was clear what the final dominant use of 76998 was so that a survey could be conducted.

The RUC referred this issue to the CPT Editorial Panel in October 2019 to clarify correct coding and accurately differentiate the physician work provided by multiple specialties under CPT code 76998. The Panel addressed several areas of reporting for code 76998 in 2020 and 2021, including: addition of instructional parentheticals that restrict the use of imaging guidance with vein ablation procedures, addition of new codes that bundled imaging guidance for urological procedures; and a Panel determination about correct coding for intraoperative intra-abdominal diagnostic ultrasound. The CPT Editorial Panel created four new codes to report intraoperative cardiac ultrasound services in May 2022 which carved out most of the prior reporting of code 76998 by cardiothoracic surgeons and cardiologists.

STS surveyed new CPT codes 7X000, 7X001, 7X002, 7X003 for the September 2022 RUC meeting. CMS is proposing the RUC recommended work RVU for only one of the four cardiac Intraoperative Ultrasound Services codes, CPT code 7X000.

<u>7X000</u>

We agree with the CMS recommendation to accept the RUC recommended work RVU of 0.60 and the RUC recommended times from the survey of 5 mins pre-services, 10 mins intra-service and 3 mins post-service with a total time of 18 minutes for the thoracic aorta ultrasound (epiaortic) code 7X000.

<u>7X001-7X003</u>

CMS states that the Summary of Recommendations for 7X001 through 7X003 state that these intraoperative ultrasound services are expected to be very rare, as intraoperative transesophageal echocardiography (TEE) is considered the gold standard and can be performed for most patients instead, which could be reported using CPT codes 93315 through 93317. Because CPT codes 7X001 through 7X003 are an alternative to CPT codes 93315 through 93317 for congenital cardiac anomalies when intraoperative TEE is contraindicated, we believe we should maintain consistency and propose a work

RVU for CPT code 7X001 that equals the combined work RVUs of CPT codes 7X002 and 7X003. CMS disagrees with the RUC recommendations, and they propose alternative work RVUs of 1.62, 1.08, and 0.54 for CPT codes 7X001, 7X002, and 7X003, respectively.

STS would like to point out that it is not unusual to have a time savings when different aspects of a procedure are combined, which is why so many codes have been bundled when performed together greater than 75% of the time. While there are circumstances where the sum of the different components of work will be the same as the combined work, it was clearly demonstrated to the RUC that this was not the case for the intraoperative congenital echocardiography codes.

In this case, even though the service is similar to TEE, there are significant differences which include: the rarity of the service, the fact that 7X001 -7X002 are performed directly on the beating heart while having to maintain absolute sterility, and for 7X002 – 7X003, the way the cardiologist and the cardiothoracic surgeon interact during the procedure resulting in a different total amount of work than if the cardiothoracic surgeon performs the entire procedure alone. If the cardiothoracic surgeon provides the service alone, there is some time-savings involved which is clearly reflected in the survey results for these procedures.

Unlike the congenital TEE codes, where the intraservice time for the combined code (93315) is 40 minutes equaling the sum of the component codes (93316 and 93317) which each have 20 minutes of intraservice time, the intraoperative time for the combined congenital cardiac echocardiography code (7X001) is the same as the intraservice time of the component codes (7X002, 7X003) with all three codes having an intra-service time of 20 minutes (if the RUC recommended intraservice time for 7X003 is used) or 20 minutes of intraservice time for 7X001 and 7X002 and 15 minutes of intraservice time for 7X003 if the median intraservice time is used.

Regardless, the intraservice time of the combined code is in essence the same as that of the component codes unlike the TEE codes where the intraservice time of the combined code actually adds up to that of the component codes. Similarly, the total time (65 mins) for the combined TEE code (99315), while not equal to the sum of the total time (75 mins) for the component codes (99316 and 99317), it is still significantly greater than the total times for each of the component codes (65 mins vs 35 mins) and (65 mins vs 40 mins) respectively.

As with the intraservice times, the total time for the combined intraoperative congenital cardiac echocardiography code (7X001) is only 5 mins greater (40 mins vs 35 mins) than the total times of the component codes (7X002 and 7X003) if the RUC recommended times are used or 10 mins greater for 7X003 if the median intraservice time is used (40 mins vs 30 mins of total time). This further supports the concept that that the work involved in the component codes, while the same is not equivalent to that of the combined code. **For CMS to force consistency into a situation where there are clearly differences in how the work of the component codes occurs compared to the work of the combined code is nonsensical and unnecessary.** Because the code structure is similar doesn't mean that the work is the same.

Codes 7X001 represents the work of one physician, typically the cardiothoracic surgeon. Codes 7X002 and 7X003 represent separate work provided by two physicians, in different specialties providing distinct, work. While the time spent by the physicians to accomplish the work of 7X002 and 7X003 overlaps, the work that each physician provides does not overlap and is not duplicative. The code structure allows each physician to report and get reimbursed for the work they provide. **STS requests that CMS reconsider the survey data and the differences in the work as depicted in the following comparison tables and reconsider their recommendation to try and make the sum of the component codes (7X002, 7X003)**

equal that of the combined code (7X001) for the intraoperative congenital cardiac echocardiography codes 7X001 -7X003.

Comparison and summary of work involved for each procedure							
Code	**Specialty providing service**	**Pre-time**	**Pre-Service Activities**	**Intra-time**	**Intra-Service Activities**	**Immed Post time**	**Immed Post Activities**
7X001	Cardiac surgeon	10 mins	Performed by the cardiothoracic surgeon. Includes work of securing the ultrasound equipment, supplies, entering the settings and the intraoperative pre-service work of preparing the heart for the ultrasound by removing packing, positioning the heart and infusing fluid if necessary. This is all done twice – once intraoperatively before cardiac repair and once intraoperatively at the end of cardiac repair.	20 mins	Performed by the cardiothoracic surgeon. Performed twice per operation. Pre- and post-procedural placement and manipulation of the transducer probe on beating heart. Obtain multiple images of different structures of the heart and interpret intraoperatively. Acquire images for final archival storage.	10 mins	Performed by the cardiothoracic surgeon. Store final images as appropriate and generate report on findings from multiple images from different structures of the heart from both pre- and post-surgical images.
7X002	Cardiac surgeon	10 mins	The same as the pre-service work performed by the cardiothoracic surgeon in 7X001.	20 mins	Performed by the cardiothoracic surgeon. Performed twice per operation. Pre- and post-procedural placement and manipulation of the transducer probe on beating heart. Obtain multiple images of different structures of the heart at the direction of the cardiologist. Discuss the cardiologist's findings intraoperatively.	5 mins	Performed by the cardiothoracic surgeon. Generate report on findings from multiple images from different structures of the heart from both pre- and post-surgical images. Difference in work from 7X001 is the cardiothoracic surgeon does not store the final images.
7X003	Cardiologist	5 mins	Performed by the cardiologist. Reviews the procedure with the cardiac surgeon and reviews previous imaging for the patient.	20 mins (RUC Rec)	Performed by the cardiologist. In the OR at the same time as the cardiothoracic surgeon, at the beginning and again at the end of the procedure, actively directing them on probe manipulation and the images that need to be obtained ensuring adequate images are captured. Applying color doppler to assess valves and any stenoses. Interpret pre- and post-procedural images in the OR during the procedure and discuss the findings with the cardiothoracic surgeon. Acquire images for final archival storage.	10 mins	Performed by the cardiologist. Store final images as appropriate and generate report on findings from intraoperative interpretation and discussion of multiple images from different structures of the heart from both pre- and post-surgical images. Similar to work done in 7X001 by cardiothoracic surgeon

7X001

For CPT code 7X001, CMS disagrees with the RUC recommended work RVU of 1.90 and proposes a work RVU of 1.62 based on a direct work RVU crosswalk to two separate codes with identical work RVUs and times, CPT code 73219 Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; with contrast material(s) (work RVU of 1.62, intra-service time of 20 minutes, total time of 40 minutes) and CPT code 78452 Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection (work RVU of 1.62, intra-service time of 20 minutes, total time of 40 minutes).

CMS does not specifically state why they disagree with the RUC recommended value of 1.90, they simply recommend a crosswalk to a lower valued code. CPT code 73219 was last reviewed by the RUC and CMS over 20 years ago and is a less intense service that is not intraoperative and only involves the physician performing the interpretation and report. CPT code 78452 describes cardiac imaging performed on a patient before and after the patient exercises. It is not a sterile intraoperative service, and a technologist typically handles the image acquisition. Neither code CMS proposed to use for direct work value crosswalks are appropriate comparators for 7X001.

CPT code 7X001 describes ultrasound image acquisition performed in the operating room through an open chest where the ultrasound probe is placed directly on the patient's beating heart. Sterility must be maintained throughout. The physician work involved in placing and manipulating the echo probe directly on a beating heart both before surgical repair and after repair with various suture lines is dramatically different from the manipulation of a transesophageal probe which is residing in the non-operated esophagus and not in direct contact with the heart (TEE). Additionally, for epicardial echocardiography, the operated heart needs to be manually carefully manipulated and repositioned in order to obtain certain images. A distinct difference from TEE. The normal external landmarks for probe positioning are not present. During the RUC presentation, the congenital cardiac surgeons noted that this was an intense service due to its rare nature. CMS proposal inappropriately puts 7X001's intensity on par with the proposed value of 76998, even though it is a more intense service to perform. CMS proposed value assigns an inappropriately low intensity to a service that is intense and complex. Furthermore, the typical patient for this service is an infant who is only a few months old with a complete atrioventricular septal defect or another significant congenital heart defect, which CMS proposal does not reference or sufficiently account for.

The relativity of 7X001 with a work RVU of 1.90 is also supported by comparing the intensity and WPUT of codes 7X001 (combined intraoperative congenital cardiac echocardiography) and 93317 (component code for the image acquisition, interpretation, and report only of the congenital TEE codes). Codes 7X001 and 93317 both have 20 minutes of intraservice time and 40 minutes of total time. It would make sense that the intensity and WPUT for code 7X001 would be greater than that of a 93317 based on the increased work and complexity associated with 7X001. With work RVUs of 1.90 for 7X001 and 1.84 for 93317 with the same intraservice and total times the result is a slightly higher intensity (0.73 for 7X001 vs 0.70 for 93317) and WPUT (0.048 for 7X001 and 0.046 for 93317) for the work associated with the combined code over that of the component code. As pointed out earlier in our comments, the work of the intraoperative congenital cardiac echocardiography codes is different than that associated with the congenital TEE codes as clearly demonstrated by the survey data and the presentation to the RUC. Although one procedure (intraoperative congenital cardiac echocardiography) may be used when

the other cannot (TEE), it does not mean that that the work or values are interchangeable or directly comparable.

The RUC recommendation was based on the median work RVU from robust survey results and favorable comparison to reference code 78431 (*Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan)* which was valued in 2019 with a work RVU of 1.90 an intraservice time of 21 mins and a total time of 39 mins, which is almost equivalent to the intraservice and total time for 7X001 (20 mins and 40 mins respectively). **STS urges CMS to accept a work RVU of 1.90 for CPT code 7X001.**

7X002

For CPT code 7X002, CMS disagrees with the RUC recommended work RVU of 1.20 and proposes a work RVU of 1.08 based on reducing CMS proposal for 7X001 by 1/3rd. CMS did not agree with the RUC's recommendation to assign work RVUs for CPT codes 7X002 and 7X003 that sum to more than the aggregate work RVU for CPT code 7X001.

STS would like to provide some additional context for the RUC recommendation. CMS proposed value assigns an inappropriately low intensity to a service that is intense and complex. CPT code 7X002 describes ultrasound image acquisition performed in the operating room through an open chest in a sterile operative field where the ultrasound probe is placed directly on the patient's beating heart. For the congenital cardiac epicardial echocardiography code 7X002, the cardiothoracic surgeon does the work of the probe placement, manipulation and acquires the images, the cardiologist can provide guidance to the cardiothoracic surgeon to ensure capture of certain views (that work by the cardiologist is captured in 7X003). The physician work involved in placing and manipulating the echo probe both before surgical repair and after repair with various suture lines requires careful manual manipulation and positioning by the cardiothoracic surgeon in order to obtain certain views. Due to the abnormal structure of the infant heart and the surgical repair, the normal external landmarks for probe positioning are not present, adding increased complexity to the procedure. Furthermore, the typical patient for this service is an infant who is only a few months old with a complete atrioventricular septal defect or another significant congenital heart defect, which CMS proposal does not reference or sufficiently account for.

CMS' initial interpretation that the combination of 7X002 and 7X003 should equal the value for 7X001 is flawed and inconsistent with how the Agency pays for most services that are performed by multiple providers. For a large majority of CPT and other Healthcare Common Procedure Coding System (HCPCS) codes that are performed by multiple surgeons, CMS provides payment that is greater than 100% to the two surgeons. When there are co-surgeons (modifier 62), CMS' payment of 125% is split between the two surgeons. Similarly, when there is an assistant at surgery (modifier 80), CMS pays the primary surgeon 100% and the assistant at surgery 16%. While it would not be appropriate to use the 62 modifier for codes 7X002 and 7X003, the analogy to the payment policy modifier 62 that recognizes distinct work performed by providers in different specialties to accomplish a procedure equals more than the base value of the procedure and is therefore paid at the higher rate is germane.

The work of 7X002 is performed by the cardiothoracic surgeon both before and after the cardiac repair. The cardiac surgeon places the probe on the beating heart carefully manipulating the probe to capture images of multiple heart structures and their function. Typically, while the cardiac surgeon is performing the probe manipulation and image acquisition (i.e. the work of 7X002), the cardiologist is present and interacting with the cardiac surgeon. The intraservice work for CPT 7X003 by the cardiologist includes

giving the cardiac surgeon direction on probe manipulation to best visualize the heart as well as the echo interpretation and report creation. The cardiothoracic surgeon discusses and makes decisions with the cardiologist about the surgical plan prior to and after to determine if additional repairs are needed. The time spent by the cardiothoracic surgeon performing the probe manipulation and acquiring the images and discussing the findings real-time both before and after the cardiac repair in 7X002 is 20 minutes. The cumulative time of the cardiologist and the cardiothoracic surgeon is therefore higher than the overall procedure time.

There is relativity within the fee schedule that clearly supports the code values as recommended by the RUC. The RUC recommended work RVU of 1.20 for code 7X002 with an intraservice time of 20 minutes and a total time of 35 minutes is clearly supported by the following codes which were recently valued in 2016, have a work RVU of 1.20 and have intraservice and total times that bracket that of 7X002 and include the following codes: 70554 (*Magnetic resonance angiography, head; without contrast material(s)*) with a work RVU of 1.20 an intraservice time of 12 minutes and a total time of 22 minutes; 88333 (*Pathology consultation during surgery; cytologic examination (e.g., touch prep, squash prep), initial sit*) with an work RVU of 1.20 an intraservice time of 25 minutes and a total time of 25 minutes and 93284 (*Programming device evaluation (in-person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified healthcare professional; multiple lead transvenous implantable defibrillator system*) with an RVU of 1.20 an intraservice time of 18 minutes and a total time of 37 minutes.

The RUC recommendation was based on the 25th percentile work RVU from robust survey results and favorable comparison to reference codes 70490 *Computed tomography, soft tissue neck; without contrast material* (work RVU= 1.28, intra-service time of 15 minutes, total time of 25 minutes) and Medical Provider Component (MPC) code 99213: *Office or other outpatient visit for the evaluation and management of an established patient*, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter (work RVU= 1.30, total time of 30 minutes). **STS urges CMS to accept a work RVU of 1.20 for CPT code 7X002.**

7X003

For CPT code 7X003, CMS disagrees with the RUC recommended work RVU of 1.55 and proposes a work RVU of 0.54 based on CMS proposal for 7X001 reduced by 2/3^{rds}. CMS rationale was that "*Because CPT code 7X003 represents one of the three service parts performed by a cardiologist, we allotted 1/3rd of the aggregated work RVU for CPT code 7X001, equaling 0.54 (1.62 * 1/3 = 0.54).*" *CMS also proposed to reject the RUC-recommended intra-service time of 20 minutes, and instead proposed an intra-service time of 15 minutes.*

As the RUC discussed and the specialty societies agreed, it is likely the physicians (typically, pediatric cardiologists) completing the survey underestimated the amount of time they spent in the operating room (OR) (15 mins instead of 20 mins) and the 75th percentile intraservice time of 20 minutes is more appropriate. The cardiologist must be in the operating room before the cardiothoracic surgeon places the probe on the heart and begins manipulation of the probe (reported with code 7X002) under the real-time direction from the cardiologist and they remain in the OR through the entire image acquisition process until the findings are discussed and decisions on next steps are made. The RUC agreed that this coupled with the nature of the service where the cardiologist is not in the OR during the entire procedure but rather in the OR prior to the repair(s), leaves and then comes back at the completion of the repair(s) could

have resulted in the survey respondent's underestimation of time. The intraservice work per unit time (IWPUT) that CMS proposed value and times would assign 7X003 is only 0.014, which is only slightly more than half the assigned intensity of a 99211 nurses visit, a value that is already inappropriately low for physician work for a major surgery typically performed in an infant with a congenital heart defect where the cardiologist is directing the cardiothoracic surgeon on manipulation of the probe on the beating heart to capture the images (reported separately with 7X002), providing real-time interpretation of the images and discussing those findings with the surgeon to determine the course of the procedure and or next steps and documents the final echo report.

The RUC recommended 7X003 to be valued higher than 7X002; however, CMS is recommending the inverse. The CMS proposed value is only a third of the RUC recommendation. For code 7X003, during the intraoperative image acquisition portion before and after the cardiac repair(s), the cardiologist is in the operating room providing real-time guidance to the cardiothoracic surgeon on probe placement and manipulation (the work of the cardiothoracic surgeon is reported with code 7X002) to ensure adequate image acquisition. The cardiologist is also interpreting the images real-time and discussing the findings with the cardiothoracic surgeon, helping the cardiothoracic surgeon determine if the surgical plan needs to be altered before the cardiac repair, and if the repair is adequate or additional procedures are needed after the cardiac repair is completed. With 7X003, the cardiologist completes the echo report.

CMS initial interpretation that the combination of 7X002 and 7X003 should equal the value for 7X001 is flawed and inconsistent with how the Agency pays for most services that are performed by multiple providers. Just as there are often time-savings when a single physician performs multiple procedures in the same session, there are also numerous circumstances where CMS recognizes there is additional work when two physicians are involved in a procedure or perform multiple procedures during the same session. For a large majority of CPT and other HCPCS codes that are performed by multiple surgeons, CMS provides payment that is greater than 100% to the two surgeons. When there are co-surgeons (modifier 62), CMS' payment of 125% is split between the two surgeons. Similarly, when there is an assistant at surgery (modifier 80), CMS pays the primary surgeon 100% and the assistant at surgery 16%. While it would not be appropriate to use the 62 modifier for codes 7X002 and 7X003, the analogy to the payment policy modifier 62 that recognizes distinct work performed by providers in different specialties to accomplish a procedure equals more than the base value of the procedure and is therefore paid at the higher rate is germane.

CPT code 7X003 describes real-time direction of ultrasound image acquisition, interpretation and report performed in the operating room by the cardiologist. The procedure requires two separate physicians performing distinct work in the operating room at the same time during the entire duration of image acquisitions prior to the cardiac repair and again after the cardiac repair has been completed. The cardiologist is in the operating room with the cardiothoracic surgeon from the time the probe is placed on the heart and guides the surgeon on placement and manipulation of the probe on the beating heart providing real-time interpretation. This is done twice during the procedure, once before the cardiac repair, the cardiologist then leaves the OR and comes back again after the cardiac repair(s) is completed. With both 7X002 and 7X003 there is discussion between the cardiothoracic surgeon and cardiologist to determine if the surgical plan needs to be altered or additional repairs are required. Furthermore, the typical patient for this service is an infant who is only a few months old with a complete atrioventricular septal defect or another significant congenital heart defect, which CMS proposal does not reference or sufficiently account for regarding physician work.

The RUC recommendation was based on the 25th percentile work RVU from robust survey results and favorable comparison to reference codes CPT code 78491 *Myocardial imaging, PET, perfusion study*

(including ventricular wall motion[s] and/or ejection fraction[s], when performed); single study, at rest or stress (exercise or pharmacologic) (work RVU= 1.56, intra-service of 15 minutes, total 30 minutes) and CPT code 78492 *Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exercise or pharmacologic)* (work RVU= 1.80, intra-service time of 20 minutes, total time of 38 minutes). **STS urges CMS to accept a work RVU of 1.55 for CPT code 7X003.**

Evaluation and Management (E/M) Visits

Office & Outpatient E/M Visit "Complexity" Add-on Code

CMS proposes implementing HCPCS add-on code G2211 for separate payment for office/outpatient E/M visits starting January 1, 2024. CMS reiterated that, to the extent that the Agency adopted the RUC-recommended values for E/M visits beginning in CY 2023, CMS does not believe that the RUC-recommended relative values for E/M visits fully reflected appropriate relative values given that separate payment was not yet made for G2211. CMS refined the G2211 policy in two ways: (1) CMS proposes that G2211 will not be payable when the office/outpatient E/M visit is reported with payment modifier-25; and (2) CMS revised its utilization assumption of G2211 to be billed with 38 percent of all office/outpatient E/M visits initially, and billed with 54 percent of all office/outpatient E/M visits when fully adopted after several years. CMS states that approximately 90 percent of the budget neutrality adjustment in the CY 2024 Medicare PFS proposed rule is attributable to the implementation of G2211, with all other proposed valuation changes making up the other 10 percent.

STS reiterates its position that CMS should not implement G2211, as outlined in comments submitted on July 26, 2023, by 19 surgical organizations led by the American College of Surgeons.

- There is no longer a valid justification for G2211 because under the new office or outpatient E/M coding structure, physicians, and qualified healthcare professionals (QHPs) have the flexibility to bill a higher-level E/M code to account for increased medical decision-making or total time of the encounter.

- Numerous reportable and resource-based validated codes are available for documenting work and time across various complexity levels and continuing care, making G2211 duplicative of work already represented by existing codes.

- If implemented, this code will inappropriately result in overpayments to those using it while at the same time penalizing all physicians due to a reduction in the Medicare conversion factor that will be required to maintain budget neutrality under the PFS.

- Implementing G2211 is expected to introduce disruptions to the RVUs of E/M services under the PFS.

G2211 is No Longer Justified

STS maintains its opposition to the implementation of G2211 and emphasizes that there is no longer a valid justification for its existence. The original rationale for the add-on code was based on CMS' policy for a single payment rate for office/outpatient E/M visit levels 2 through 5, which has since been rescinded. CMS argued that primary care and certain specialty services often involve significant non-face-to-face work, and there were no coding options in the 2019 CPT E/M code set or the single payment rate to account for this additional non-face-to-face time and work— this is no longer true. Additionally, CMS

believed that the proposed G2211 add-on code would address potential payment instability resulting from the adoption of a single payment rate for office/outpatient E/M code levels 2 through 5 — particularly for providers who typically billed level 4 or level 5 E/M visit codes based on Medicare billing patterns. This is also no longer true because there is no payment instability with the new E/M visit code set.

The current code set no longer supports the justification for G2211, as CMS has retained the various office/outpatient E/M levels and accepted the revised coding structure that incorporates both face-to-face and non-face-to-face work and time of physicians and/or QHPs. This revised structure now includes work and time for three days prior to and seven days after the encounter date. **Consequently, payment for HCPCS code G2211 is not justified because under the new coding structure, physicians and QHPs have the flexibility to bill a higher-level E/M code to account for increased patient complexity or a higher-level code based on total time, which includes non-face-to-face time, even if the encounter itself was not complex.**

G2211 is Duplicative of Separately Reportable Work and Results in "Double-Dipping"

CMS maintains that the payment for add-on code G2211 is necessary because the Agency believes the revised office/outpatient E/M visit code set fails to adequately describe or encompass the resources involved in primary care and certain specialty visits for ongoing care management of patients with chronic conditions. However, CMS has not provided details regarding the specific resources required. For instance, it remains unclear what additional resources beyond the already accounted 10 days of time and work are typically involved and not covered by the revised office/outpatient E/M codes, other non-face-to-face care management codes, and/or other new digital medicine codes. **Any additional resources, if required, are already reportable using other newly developed codes for ongoing care as an added payment to a single office visit, making payment for G2211 duplicative.** Examples of some of these codes are described below.

- **Principal Care Management (PCM).** In the CY 2022 Medicare PFS, CMS accepted new CPT codes for PCM services, which describe ongoing care management services for one single chronic condition. CMS stated that — especially for specialties that use office/outpatient E/Ms to report most of their services — there could be significant resources involved in ongoing care management for a single high-risk disease or complex condition that is not well accounted for in existing coding.

- **Chronic Care Management (CCM).** In the CY 2022 Medicare PFS, CMS also accepted new CPT codes for CCM, which describe ongoing care management services for two or more chronic conditions. CMS stated that physicians and nonphysician practitioners who furnish ongoing care to patients with multiple chronic conditions require greater resources than those needed to support patient care in a typical E/M service.

- **Complex Care Management (Complex CCM).** These codes were added in the CY 2017 Medicare PFS and are similar to the CCM codes but are also separately reportable for ongoing non-face-to-face patient care.

- **Transitional Care Management (TCM).** The TCM codes were added in the CY 2012 Medicare PFS and provide additional reimbursement for care management and care coordination services beginning when a physician discharges a Medicare patient from an inpatient stay and continuing for the next 29 days.

- **Prolonged Services Code.** In the CY 2020 Medicare PFS, CMS added a new HCPCS add-on code for 15 minutes of prolonged office/outpatient E/M services that require additional time beyond the maximum time for the highest-level codes. The AMA's CPT/RUC Workgroup on E/M specifically included this add-on code to account for more time and resources in response to the earlier CMS proposals.

- **Remote Physiologic Monitoring.** CMS accepted new CPT codes in CYs 2019 and 2020 to account and pay for additional provider non-face-to-face time and practice expense resources related to ongoing patient care management of a chronic condition.

- **Remote Therapeutic Monitoring (RTM).** In the CY 2022 Medicare PFS, CMS finalized the RTM codes for managing patients who use medical devices to collect non- physiological data such as medication adherence, medication response, and pain levels.

Numerous reportable and resource-based validated codes are available for documenting work and time across various complexity levels and continuing care, making the arbitrary, poorly defined add-on code G2211 duplicative of work already represented by existing codes. If implemented, this code will inappropriately result in overpayments to those using it while at the same time penalizing all physicians with the reduced conversion factor required to maintain budget neutrality.

G2211 is Not Resource-Based

CMS has faced challenges in providing a clear and validated description of the additional resources associated with G2211. The assignment of work RVUs and time to the code was confusing and primarily driven by considerations of budget neutrality and the mitigation of potential payment instability for particular physicians resulting from adopting a single payment rate for office/outpatient E/M visit levels 2 through 5. In other words, the resources allocated to G2211 were primarily based on redistributing available work RVUs due to changes in documentation and payment policies rather than being firmly grounded in resource-based criteria. **Given that the proposal to collapse E/M visit levels 2 through 5 into a single payment was rescinded and the new office/outpatient E/M structure based on MDM (complexity) or time was accepted, it can no longer be asserted that code G2211 describes any additional and unaccounted for resources.**

That said, if the resources that CMS may be contemplating were for extraordinary circumstances, the chronic/complex care management codes for longitudinal patient-centered care would be appropriate instead of G2211. At the other extreme, it is difficult to justify adding G2211 to a level 2 E/M visit involving a patient with a self-limited or minor problem, minimal or no need for data to be reviewed, and/or minimal risk of morbidity because this visit would not require additional resources to integrate the treatment/management of the illness or injury or to coordinate specialty care in a longitudinal care model. The other visits in between the complex and minor cases would be covered by the current office/outpatient E/M coding structure or other newly available codes and not require add-on code G2211. This argument is even more compelling when code level selection is based on time because if additional time is needed, a higher-level code could be reported even if the visit was not complex. Furthermore, there is no limit when reporting using time because the prolonged services add-on code G2212 (or CPT code 99417) may be billed for each additional 15 minutes required. **Therefore, time can never be considered a resource cost for G2211.**

Consequences Of Implementing G2211

There are significant consequences for physician practices if G2211 is implemented. For example:

- **Implementing G2211 is expected to result in payment reductions for many physicians due to its expected impact on the Medicare conversion factor.** In the CY 2024 Medicare PFS proposed rule, CMS somewhat mitigated the cut's impact on the conversion factor by estimating lower utilization assumptions for implementing G2211. However, CMS also states in the rule that approximately 90 percent of the budget neutrality adjustment for CY 2024 is attributable to G2211, with all other proposed valuation changes making up the other 10 percent.[2] This reduction would still create concerning implications for physician practices and their ability to provide patient care services, especially in today's high inflationary period. This could particularly affect physicians, including primary care physicians, practicing in rural and underserved areas who perform minor procedures and other services, such as imaging, that will see reductions in reimbursement to pay for G2211.

- **Implementing G2211 is also expected to introduce disruptions to the resource based RVUs of E/M services.** Implementing G2211 would lead to varying payments for E/M services based on the specialty of the provider delivering the service, as CMS has made assumptions regarding which providers will likely report this non-resource-based code at the expected billing rate. bonus without a specific validated resource that can be clearly defined or audited. In contrast, every code within the Medicare PFS has a well-defined and validated work definition, allowing for audit. Unfortunately, code G2211 fails to meet these criteria, and approving payment for this code would disrupt the relative resource based RVUs of E/M services and the integrity of the entire Medicare PFS. Per Medicare statute, CMS is prohibited from paying physicians differently for the same work, and the "Secretary may not vary the . . . number of relative value units for a physician's service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician."[3]

Given these serious problems, we strongly urge CMS not to implement G2211. The policy basis for this code no longer exists. It is disingenuous for CMS to continue to put forth unconvincing rationales in its rulemaking over the years to account for why G2211 — a code that is not resource-based, is not validated, and is duplicative of other services — should be implemented. G2211 was a stop-gap measure to make certain specialties whole when first proposed in 2018. It is no longer justified given the many other codes that have been revised and/or newly established that provide additional validated resource-based reimbursement for ongoing patient care. Finally, the consequences of implementing this code are grim — many physician practices would be harmed, thereby serving as a potential detriment to their ability to deliver timely, affordable, high-quality care to their patients.

Split (or Shared) E/M Visits

CMS states it has been policy when a service has been furnished by both a physician and a non-physician practitioner (NPP) that the physician can submit the claim for the service if the physician delivered the "substantive portion" of the service. CMS previously finalized that "substantive portion" would be defined as "more than half of total time" but delayed implementation until CY 2024. CMS acknowledged it continues to hear concerns about the implementation of the "more than half the total time" substantive portion policy. Considering these concerns, CMS proposes to again delay the effective date of the "substantive portion" policy through at least December 31, 2024.

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[2] Centers for Medicare & Medicaid Services. Medicare and Medicaid Programs: CY 2024 Physician Fee Schedule Proposed Rule. July 13, 2023. https://www.federalregister.gov/public-inspection/2023-14624/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other.

[3] Medicare Physician Fee Schedule, 42 U.S. Code §1395w-4(c)(6) (2022).

STS supports CMS decision to further delay implementation of their split or shared visit policy allowing physicians to continue to bill split or shared visits based on the current definition of substantive portion as one of the following: history, or exam, or medical decision-making, or more than half of total time through calendar year 2024. We agree CMS should review the revised CPT guidelines in the 2024 CPT book and encourage CMS to develop their policy to mirror that of the AMA.

Payment for Medicare Telehealth Services Under Section 1834(m) of the Act

Changes to the Medicare Telehealth Services List

CMS states it received several requests to permanently add various services to the Medicare Telehealth Services List effective for CY 2024. CMS found that none of the requests met the Category 1 or Category 2 criteria.

STS agrees with CMS that there are circumstances where the hospital and emergency department services codes (CPT 99221-3, 99234-6, 99238-9, 99281-3) may be furnished safely via two-way, audio-video communication technology. However, we also have concerns that there are times when it would not be appropriate for these codes to be furnished using telehealth and as such, more information is needed to determine the circumstances under which it would be appropriate for these services to be furnished using telehealth versus when they should be furnished in-person. Therefore, STS agrees with CMS that these services should not be added to the permanent telehealth services at this time and it would be appropriate to include them on the Medicare Telehealth Services List through CY 2024 while additional information is obtained.

CMS seeks to clarify and modify its process for making changes to the Medicare Telehealth Services List and return to a simple binary system that existed with Category 1 and 2, without disregarding the flexibility of Category 3. CMS proposes to assign either "permanent" or "provisional" status to a service, and to implement a process for changing the status of a service.

STS agrees with CMS' that clarifications and modifications to the process for reviewing requests for additions to the Medicare Telehealth List are needed. The approach that CMS has outlined seems like a reasonable approach that will simplify the list with just two designations, permanent or provisional for the codes approved for telehealth. The 5-step proposal as outlined for analysis of services under consideration for addition, or removal, or a change in status to the Medicare Telehealth Services List also looks reasonable and provides a clear methodology and pathway that requestors can use to guide their submissions for the changes to the telehealth services list.

CMS proposes to consolidate Categories 1, 2, and 3 for all services that are currently on the Medicare Telehealth Services List. For CY 2024, CMS proposes to redesignate any services that are currently on the Medicare Telehealth Services List on a Category 1 or 2 basis and would be on the list for CY 2024 to the proposed new "permanent," category while any services currently added on a "temporary Category 2" or Category 3 basis would be assigned to the "provisional" category

STS supports CMS' proposal to consolidate the services that are currently on the Medicare Telehealth Services list from the current Category 1, 2 and 3 classifications and redesignating them as "permanent" or "provisional" for CY 2024.

The CAA, 2023 extended several telehealth flexibilities, which had previously been extended for 151 days after the COVID-19 Public Health Emergency (PHE), through December 31, 2024. These include:

- *Temporary expansion of the scope of telehealth originating sites for services furnished via telehealth to include any site in the United States where the beneficiary is located at the time of the telehealth service, including an individual's home;*
- *Expansion of the definition of eligible telehealth practitioners to include qualified occupational therapists, qualified physical therapists, qualified speech-language pathologists, and qualified audiologists;*
- *Continued payment for telehealth services furnished by FQHCs and RHCs using the methodology established for those telehealth services during the PHE;*
- *Delaying the requirement for an in-person visit with the physician or practitioner within 6 months prior to initiating mental health telehealth services, and again at subsequent intervals as the Secretary determines appropriate, as well as similar requirements for RHCs and FQHCs; and*
- *Continued coverage and payment of audio-only telehealth services included on the Medicare Telehealth services List as of March 15, 2020.*

CMS states its intent to implement the above provisions, but also notes that its proposals do not alter payment amounts or billing rules that are in effect as of January 1, 2023.

STS appreciates CMS extension of the telehealth flexibilities implemented during the COVID-19 PHE through December 2024. We encourage CMS to further retain telehealth flexibilities beyond 2024. The PHE illustrated how valuable a tool telehealth can be in increasing access to healthcare for all communities, including those in rural or underserved communities. Data collected during COVID-19 demonstrates the positive impact telehealth has had on both patient clinical outcomes and patient experiences. A 2020 study by the National Institutes of Health (NIH) found the benefits of telemedicine in both acute care and chronic disease management and suggests that it is equivalent to in-person care for health outcomes in certain conditions and may also decrease short-term hospital and emergency department utilization. Additionally, research shows that the use of telehealth provides access to care despite geographic barriers, reduces burden on medical infrastructure, and lessens exposure to infectious diseases for all participants.[4] Advances in technology and the advent of more sophisticated equipment has increased the extent of patient monitoring via telemedicine and has resulted in increased physician and patient satisfaction.

In administering payment and billing policies for Medicare services provided via telehealth, CMS previously finalized a policy to make payment at the rate for a service had the service been furnished in-person (by use of telehealth Modifier ~95). This payment rate is at the non-facility practice expense rate. Beginning in CY 2024, CMS would revise this policy to replace the use of Modifier ~95 and instead require telehealth services to be billed with either:

- *Place of Service (POS) 02 (Telehealth Provided Other than in Patient's Home); or*
- *POS 10 (Telehealth Provided in Patient's Home)*

For CY 2024, CMS proposes that claims billed with POS 10 (Telehealth Provided in Patient's Home) be paid at the higher non-facility practice expense rate, while claims billed with POS 02 (Telehealth Provided Other than in Patient's Home) will be paid at the lower facility practice expense rate.

STS is concerned that this policy does not adequately recognize the resources needed to deliver telehealth services and inaccurately values practice expense by attempting to assign values for the service based on the location of the patient, when that has no bearing on the costs incurred by the provider. Because of

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[4] Shaver J. (2022). The State of Telehealth Before and After the COVID-19 Pandemic. Primary care, 49(4), 517–530. https://doi.org/10.1016/j.pop.2022.04.002

this, and as we continue to transition from the PHE polices, STS encourages CMS to maintain the current telehealth Modifier ~95 and practice expense policies through CY 2024 and delay any additional changes until a more thoughtful approach can be implemented in CY 2025 that better and more accurately accounts for the practice expense associated with delivery of a service via telehealth.

Other Non-Face-to-Face Services Involving Communications Technology under the PFS

Recognizing concerns about potential barriers to access that a return to pre-PHE rules would present, CMS proposes to continue to define direct supervision to permit the presence and "immediate availability" of the supervising practitioner through real-time audio and visual interactive telecommunications through December 31, 2024. This would align the timeframe of this policy with many of the previously discussed telehealth policies that were extended under the CAA, 2023. CMS solicits comment on whether it should consider extending the definition of direct supervision to permit virtual presence beyond December 31, 2024.

STS strongly supports the decision by CMS in previous rulemaking to allow the statutory provision regarding direct supervision of cardiac and pulmonary rehabilitation programs to be met through virtual presence via real-time, two-way audio/visual telecommunications technology. Additionally, we strongly recommend CMS make permanent direct supervision through virtual presence via real-time, audio-visual telecommunications technology beyond CY 2024 so Medicare beneficiaries can continue to receive cardiac and pulmonary rehabilitation services that can improve their lives. STS has signed on to a letter lead by the American Association of Cardiovascular and Pulmonary Rehabilitation with more detailed comments on this proposal.

Proposals on Medicare Parts A and B Payment for Dental Services Inextricably Linked to Specific Covered Medical Services

Proposed Additions to Current Policies Permitting Payment for Dental Services Inextricably Linked to Other Covered Services

CMS proposes to identify more scenarios where dental services are inextricably linked to other covered services such that they do not fall within the statutory payment exclusion. CMS seeks comment on several aspects of its dental policy, including additional cardiac interventions where the risk of infection posed to beneficiaries is similar to that associated with cardiac valve replacement or valvuloplasty and several implementation issues, including billing, coding, and care coordination.

STS supports the CMS proposal to include coverage for dental services as part of a comprehensive workup for the services proposed as well as other covered medical services that are linked to and produce better outcomes from dental services. It is well established that untreated oral microbial infections are closely linked to a wide range of costly chronic conditions, including diabetes, heart disease, dementia, and stroke. In addition, oral diseases have been documented by researchers and medical specialty societies as precluding, delaying, and even jeopardizing medical treatments such as organ and stem cell transplantation, heart valve repair or replacement, cancer chemotherapies, placement of orthopedic prostheses, and management of autoimmune diseases.

Despite these factors, most Medicare beneficiaries do not currently receive oral/dental care even when medically necessary for the treatment of Medicare-covered diseases. In fact, Medicare coverage extends to the treatment of all microbial infections except for those relating to the teeth and periodontium. Moreover, the lack of medically necessary oral/dental care heightens the risk of costly medical complications, increasing the financial burden on Medicare, beneficiaries, and taxpayers. For example, when a patient presents with very poor dentition, the cardiothoracic surgeon frequently requests a dental

consult to help ensure that the patient has the best possible outcome for any cardiac or general thoracic surgical procedure. Poor oral hygiene increases the risk of infection in a newly implanted heart valve. In addition, cardiothoracic surgeons often find that their patients have primary bacterial endocarditis or, worse, prosthetic valve endocarditis secondary to neglected dental health and chronic dental abscesses. These are life-threatening situations that could be prevented if Medicare would cover medically necessary oral/dental health therapies.

Although STS supports Medicare coverage for dental services when medically necessary, we would like to note that some organizations in the medical community have reservations about the limited resources available and how this proposal may cause further reduction in the resources their providers receive. We understand this concern and would like to point out to CMS that budget neutrality continues to force providers to make difficult choices between the best options for patients and the value of services provided.

Other Provisions of the Proposed Rule

Appropriate Use Criteria for Advanced Diagnostic Imaging

While STS recognizes the importance of appropriate use criteria (AUC) for advanced diagnostic imaging services to ensure the most appropriate imaging study is selected to improve health outcomes for patients based on their individual context, we agree with CMS that the AUC program is not the correct mechanism to accomplish this goal. We agree that the program as currently operationalized is not practical and does not fit into the workflow for most clinicians and we support CMS' decision to pause the program indefinitely. We believe that most physicians understand the value of clinical decision support and will continue to implement many of the concepts to improve the quality safety, efficiency and effectiveness of healthcare.

Quality Payment Program

Medicare Shared Savings Program

Request for Information (RFI) on MIPS Value Pathway (MVP) Reporting for Specialists in Shared Savings Program Accountable Care Organizations (ACOs)

Since CMS decided to require ACOs to be assessed on an APM Performance Pathway (APP) for Shared Savings Program ACOs measure set, it has heard concerns about the challenges and applicability of the APP measures to specialists that are part of their ACOs. CMS is considering bonus points for specialists in an ACO who report quality measures through an MVP. These points would be added to the ACO's quality performance score, which would still be based on the APP quality measure set. CMS is seeking feedback on the following questions:

- *To highlight specialty clinical practice within ACOs, how should CMS encourage specialist reporting of MVPs?*
- *How should it encourage the reporting of MVPs to collect quality data that is comparable to data reported by other specialty providers in quality MVPs and to address clinician concerns over measure appropriateness?*
- *What concerns and considerations should CMS be aware of when assessing ACOs for quality performance based on reporting quality measures within MVPs?*

- *How long should CMS have bonus points in place to incentivize MVP reporting? CMS does not intend to establish bonus points as a permanent policy as it is simply meant to encourage reporting of MVPs.*

STS continues to have concerns about whether there will be adequate MVPs for specialists and ensuring that the measures included in MVPs are meaningful to providers. CMS developed MVPs to serve as a bridge from MIPS to APM participation and will complement APP reporting such that it will enhance performance measurement and available information while minimizing additional burden.

While we support CMS' effort to reduce clinician burden and offer a pathway for more clinicians to transition to alternative payment arrangements, we have strong concerns that the MVP framework lacks the specificity and applicability to truly affect change. By attempting to fit the MVP model into the current MIPS framework, CMS fails to provide a meaningful and less burdensome participation pathway for specialists or to provide a practical glide path to APMs. It is critical that CMS recognize multi-category measures that simultaneously address two or three MIPS performance categories, such as quality measures reported to clinician-led data registries that may also earn a clinician credit for the Improvement Activities or Promoting Interoperability categories. If the MVP framework too closely resembles the MIPS program, there is limited incentive for specialist participation, especially given the limited number of specialist MVPs currently available. Transitioning to MVPs should provide more actionable data and information that prepares providers for more advanced models. One concept cannot be overstated: CMS should engage specialty societies directly in the development of new MVPs to capitalize on their knowledge and experience with data collection and quality improvement.

There is currently no thoracic surgery MVP and the development of a thoracic surgery MVP could take years before it is feasible to report. Special consideration for specialist scoring and bonus points should be given to providers who do not have access to a meaningful and relevant MVP. Instead of a fixed timeline for specialists reporting an MVP, CMS should attach the bonus points to the MVP itself. Specialists reporting on a new MVP during its first two years in the program would receive bonus points. For example, if a thoracic surgery MVP is created and available for reporting in the APP program, any thoracic surgeon reporting that MVP will receive bonus points for the first two years of reporting.

Updates to the Quality Payment Program (QPP)

Transforming the Quality Payment Programs

CMS seeks comment on how it can modify its policies under the QPP to foster clinicians' continuous performance improvement and positively impact care outcomes for Medicare beneficiaries. Such modifications for MIPS may include requiring more rigorous performance standards, emphasizing year-to-year improvement in the performance categories, or requiring that MIPS eligible clinicians report on different measures or activities once they have demonstrated consistently high performance on certain measures and activities.

STS warns against continuing to set the goal posts further back for providers. Many practices are already investing significant staff and monetary resources into quality improvement. While the motives behind this proposal are laudable, continuing to demand significant improvements each year is arbitrarily unrealistic, and will not lead to improved patient care. Requiring even more rigorous performance standards requires additional resources, detracting from the time and attention needed for exceptional patient care.

Additionally, if this policy is finalized, providers will have a harder time earning an incentive on their MIPS performance score, leading to as much as a 9% reimbursement reduction. **Along with continual physician cuts to reimbursement and no adjustment for inflation to the Medicare Economic Index, providers will already be facing drastic reductions in their reimbursements.** These challenges could ultimately discourage participation in quality improvement programs or the difficult decision to stop treating Medicare beneficiaries.

MIPS Value Pathways (MVP) Development, Maintenance, and Scoring

Complex Patient Bonus for Subgroups

In the CY 2022 PFS Final Rule, CMS intended to apply the complex patient bonus based on the patient population of the subgroup. Since then, however, CMS has identified issues with using claims data associated with the clinicians in a subgroup that prevents it from calculating the complex patient bonus at the subgroup level. CMS proposes that for subgroups, beginning with the CY 2023 performance period/2025 MIPS payment year, the affiliated group's complex patient bonus will be added to their final score.

STS supports and encourages CMS to finalize the proposed approach for applying the complex patient bonus to a subgroup. We believe it is essential that providers be rewarded for and encouraged to continue to treat patients with complex conditions. Policies such as this can help to reduce access to care issues and advance health equity by recognizing physicians who meet the challenge of treating more complex patients.

MIPS Performance Category Measures and Activities

Data Completeness Criteria

In this rule, CMS proposes to maintain the data completeness criteria threshold to at least 75% for the CY 2026 performance period/2028 MIPS payment year for MIPS eligible clinicians, groups, virtual groups, subgroups, and APM Entities submitting quality measures data on Part B claims, QCDR measures, MIPS clinical quality measures (CQMs), or eCQMs, and to increase the data completeness criteria threshold to at least 80% for the CY 2027 performance period/2029 MIPS payment year.

While CMS may not consider a 5% increase in data completeness to be consequential, the proposal to update the threshold to 80% for CY 2027 increases provider burden in an already highly burdensome program. The increase in data completeness does not consider providers who work between multiple sites and have a more difficult time calculating the correct percentage of patients and submitting data. Not all sites within the same National Provider Identifier and Taxpayer Identification Number participate in MIPS or use the same registry or EHR for MIPS reporting. This makes combining and calculating MIPS data difficult.

Additionally, STS does not believe that the increased percentage of data CMS receives is enough to make a meaningful difference in quality improvement. While we appreciate the stability of the data completeness threshold until CY 2026, the forthcoming increase will negatively impact provider burden without any benefit to CMS. **STS opposes the proposed increased data completeness threshold. No further actions should be taken to increase the data threshold until an improved interoperability landscape emerges, allowing data to seamlessly flow across settings and providers.**

Selection of MIPS Quality Measures

For the CY 2024 performance period, CMS proposes 14 new MIPS quality measures including the Preventive Care and Wellness composite measure. CMS also proposes to remove the Tobacco Use and Help with Quitting Among Adolescents and Body Mass Index (BMI) Screening measures, which instead will be collected within the new composite measure. Additionally, CMS is proposing to add the new Connection to Community Service Provider measure to the Thoracic Surgery Measure Set.

STS has concerns over the new Preventative Care and Wellness composite measure proposed. **We urge CMS to provide clarification on how the measure will be implemented.** As it is written, it is unclear whether a provider will need to report on all parts of the measure to satisfy the requirements, or if they can report on only the parts that are relevant to their practice. For example, while thoracic surgeons do tobacco screenings, they do not perform breast and colorectal screenings and would not be eligible to report those processes. If the Preventative Care and Wellness measure relies on complete measure reporting to be satisfied, then we would not support the removal of the Tobacco Use and Help with Quitting Amongst Adolescents measure as it is an important measure for our providers and patients.

Additionally, we support the inclusion of the new health equity focused measures in the Thoracic Surgery Measure Set, again, as long as providers continue to be able to choose the measures relevant to their practice.

Promoting Interoperability Performance Category

Promoting Interoperability (PI) Performance Category Performance Period

CMS proposes to require a continuous 180-day performance period for the PI performance category beginning with the CY 2024 performance period/2026 MIPS payment year, rather than the current 90-day requirement.

STS does not support expanding the PI performance period to a continuous 180 days. As we stated previously about other MIPS category proposals, this change also increases provider burden in already highly burdensome program. Additionally, we do not believe this increase would further prove that providers are utilizing their EHR systems to ensure meaningful use of CEHRT and information exchange. It does not account for issues with technology, vendors or other variables that may be impacting why a provider is unable to utilize their EHR to its full capacity for 180 days. CMS continues to bring forth proposals that move the goal posts arbitrarily, making it more difficult for providers to comply with the requirements to avoid a penalty. STS encourages CMS to keep the PI category requirements stable and maintain the 90-day performance period.

MIPS Payment Adjustments

Performance Threshold for the CY 2024 Performance Period/2026 MIPS Payment Year

CMS proposes to revise its policy for identifying the "prior period" by which it will establish the performance threshold beginning with the CY 2024 performance period/2026 MIPS payment year as three performance periods, instead of a single prior performance period. To determine the performance threshold for the CY 2024 performance period/2026 MIPS payment year, CMS proposes to use the CY 2017/2019 MIPS payment year through CY 2019 performance period/2021 MIPS payment year as the prior period.

CMS proposes to use the CY 2017 through CY 2019 performance periods/2019 through 2021 MIPS payment years as the prior period for the purpose of establishing the performance threshold for the CY 2024 performance period/2026, which produces a mean of 82 points (rounded down from 82.06 points).

STS has significant concerns with the CMS' proposal to change the interpretation of "prior period" this far along in the MIPS program. CMS has the flexibility to continue to define the "prior period" as a single performance year as it has been since MIPS was implemented. As CMS stated, this proposal is a change in perspective from the CY 2022 PFS final rule, which concluded that choosing the mean or median from a "prior period" does not allow it to "balance scores from multiple years." If CMS were to follow the intention made clear in the 2022 final rule and keep the definition of "prior period" stable, the performance threshold could remain at 75 points (based on the 2017 mean) for the CY 2024 performance period. By choosing to change the definition, CMS would be increasing the threshold to 82 points. This action will introduce yet another hurdle for providers, making it more challenging to avoid a payment penalty in 2026.

In determining the performance threshold for CY 2024 performance period, CMS is not considering the means of the final scores for certain prior periods because of issues with the underlying data. For example, the CY 2020 through 2021 performance periods/2022 through 2023 MIPS payment years are not being considered because CMS extensively applied its extreme and uncontrollable circumstances (EUC) policies to MIPS eligible clinicians nationwide due to the COVID-19 PHE. STS understands this reasoning and believes that similar flexibility should be applied to providers whose focus was on treating patients during the pandemic, and not submitting MIPS data. Many providers will need time to adjust and reintegrate back into the program and may have a harder time reaching the higher 82-point threshold. **CMS should maintain the performance threshold at 75 points and maintain the interpretation of the "prior period" as one year as it was originally implemented.**

Overview of QP Determinations and the APM Incentive

APM Incentive Payment

As required by statute, beginning with 2024/2026, the 5% APM incentive payment for Qualifying Participants (QPs) will end. Beginning for the 2026 payment year, which relates to the 2024 QP Performance Period, there will be two separate PFS conversion factors, one for items and services furnished by a QP, and the other for other items and services (the non-qualifying APM conversion factor). Each conversion factor will be equal to the conversion factor for the previous year multiplied by the applicable update. The update specified for the conversion factor for QPs will be 0.75 percent, while the update for all others will be 0.25 percent.

If CMS' goal is to encourage providers to prioritize value-based care by participating in APMs instead of the traditional MIPS program, then the agency needs to work with Congress to reauthorize the APM Incentive Payment at its original 5% level. Participation in an APM requires additional investment such as significant transition costs, updated certified EHR technology, staffing, and more, that many providers need the bonus money to be able to afford. For example, practices may need staff to provide enhanced care management prior to receiving a potential bonus. Practices may also have a harder time recruiting physicians into risk-based models and may need the incentive payment for negotiations. **A higher Medicare PFS conversion factor will not adequately make up for the loss of the 5% bonus payment given that even with a higher conversion factor, physician payment is consistently decreasing.** Without that additional incentive, providers may not be able to take on downside risk and will be forced to continue reporting through MIPS. Additionally, without the incentive payment, providers may stand to earn more through MIPS reporting than through APM participation, which contradicts CMS' goal.

Since the Advanced APM pathway was introduced, it has been primarily geared towards primary care with limited participation options for specialists. The bonus payments will expire before APMs targeted towards specialist participation have been introduced for use in the QPP, meaning specialists have not had an opportunity to earn the bonus. Continuing to adequately incentivize participation in Advanced APMs will allow specialists to have the same incentives as primary care providers, which may encourage more specialists to take on down-side risk and prioritize value-based care**. To ensure specialist participation in Advanced APMs, the full 5% bonus payment needs to be reinstated by Congress and CMS. Additionally, the Center for Medicare and Medicaid Innovation (CMMI) need to test and approve Advanced APMs endorsed by the Physician-Focused Payment Model Technical Advisory Committee (PTAC), so that specialists can more rapidly shift to value based payment arrangements.**

Thank you for the opportunity to provide these comments. Please contact Molly Peltzman, Associate Director of Health Policy, at mpeltzman@sts.org or Derek Brandt, Vice President of Government Relations at dbrandt@sts.org should you need additional information or clarification.

Sincerely,

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President