



## The Society of Thoracic Surgeons

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September 2, 2014

Honorable Marilyn B. Tavenner  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1599-P  
Room 445-G, Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

Re: CMS-1612-P – 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 proposed rule that was published in the Federal Register on Friday, July 11, 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

#### **II. B. Potentially Misvalued Services Under the Physician Fee Schedule 4. Improving the Valuation and Coding of the Global Package**

In the proposed rule, CMS asserts that the providers of 090 and 010 day globals do not provide the number and level of visits that are notionally part of the global period payment as embodied in its work-time files for the typical patient. It acknowledges that its evidence for this is incomplete, in large part due to the fact that there are no documentation requirements and no requirements that a global provider submit a non-billable CPT code for any evaluation and management (E&M) service. CMS cites two reports from the

Health and Human Services Office of the Inspector General that focus on the delivery of outpatient services which show that some patients receive more and some fewer E&M services of unknown level and unknown medical necessity. Without supporting evidence, CMS concludes that, since other physicians are providing billable services during the same period of time, it must be true that the global service provider is providing fewer services than are accounted for in the global payment. Thus CMS proposes to reduce the payment for 010 and 090 global codes to account only for the physician work, practice expense (PE) and malpractice expense on the day of surgery (i.e. conversion to a 000 global) by 2017 and 2018 respectively. CMS goes on to state a variety of reasons that this cannot be accomplished with both efficiency and accuracy due to the limitations inherent in the methods used to establish the current values for these codes.

STS is committed to the concept that postoperative evaluation and management by the surgeon is critically important to the care and overall well being of our patients. STS would support CMS in identifying services that are not performed, or not performed at the level of payment, and taking steps to eliminate those payments. However, STS does not agree that these concerns should be applied exclusively to 090 and 010 global period codes, or that CMS should generalize its concerns about the provision of surgical care based on a small sample of observations of specific procedures and specialties.

STS is deeply concerned, with CMS's analysis, underlying assumptions and proposed methodologies. We would remind CMS that the global period was created to prevent two clearly unethical behaviors, itinerant surgery and fee-splitting. The term "fee-splitting" refers to an agreement that a surgeon would not bill for post-operative hospital and outpatient visits (E&M services), but rather engage the referring physician to perform and bill these services in return for the referral itself, rather than basing the referral on what was best for the patient. Itinerant surgery is the practice of providing the operation only, and then abandoning the patient to the care of others, a practice that is facilitated by fee-splitting. Both practices are inconsistent with the professional credo of surgeons, who are committed to responsibility and accountability for their patients before, during and until complete recovery from their surgery.

The existence of the 90 day global service period for major surgical procedures was created to discourage these unethical practices. Further, we feel professionally bound to the fundamental principle that it is medically necessary and indeed a patient expectation that their surgeon evaluate them on a daily basis while in hospital, and from time-to-time as an outpatient, until recovery is assured.

#### *Unintended Consequences*

CMS is proposing to re-value over 4,000 CPT codes in 2 years, with little code-specific or specialty-specific information. The current values of these codes have evolved over a 20 year period of extraordinary multidisciplinary work that cannot be replicated in the proposed timeline. As will be detailed below, STS suggests that this proposal is likely to reduce the quality of care for beneficiaries and result in no cost-savings for CMS. The postoperative global period provides for a bundled payment for postoperative visits and other services by the provider. When this single payment and co-payment is made, the patient is generally treated by the surgeon for

all surgery-related problems without additional billing. The unbundling of these services, with individual billing for them, will likely have a number of important consequences:

1. *Patient Care:* We are concerned that this policy will have a devastating effect on continuity of care. One of the principal reasons for the surgeon to perform post-operative care is his/her specialized knowledge of the course of normal recovery after an operation. Neither patients nor alternate providers are as qualified to determine whether or not a postoperative visit by the surgeon is necessary. An increase in the incidence of adverse outcomes, as well as delay and non-standard management of common complications is likely to occur as a result of this proposed change.
2. *Cost of Care – Beneficiary:* The global period (especially the 90 day global period) is, in part, a 90 day insurance policy. The patient pays a flat rate and receives all necessary services. With the conversion to 000 globals, patients will be exposed to risk that recovery will be long, arduous and with multiple adverse events. Currently, most issues that are related to surgery are resolved within 90 days and there is little financial consequence for patients requiring more and higher level services than is typical since it is all covered by the initial global payment. As below (#3), this is more likely to affect Medicare beneficiaries, who are generally older and sicker than the non-Medicare population, than other patients. Further, out of a desire to save money, patients may fail to return to see their surgeons for follow-up care or seek care from an alternate, less expensive provider. For example, patients, who currently bear some cost-sharing burden, would now be responsible for co-pays after each outpatient visit. Even if the net expense is equivalent to that under the surgical global, the perceived expense may dissuade some from seeking necessary follow-up care.
3. *Cost of Care - Medicare:* The overall cost to Medicare is likely to rise substantially. The current global period payment is based on the typical patient, which contains both Medicare and non-Medicare patients. It is probable that Medicare patients, who are older and have more co-morbidities, on average will have longer lengths of hospital stay, more complications, and more significant complications than non-Medicare patients. Thus, CMS and Medicare beneficiaries enjoy a substantial payment discount for most global procedures to the extent that the global period visits, under current reimbursement methodology, reflect the mix of both older Medicare and healthier non-Medicare populations, thus resulting in visit reimbursements that are fewer and of less intensity than what is experienced by the Medicare population alone. When the visits become unbundled we expect that the number and level of medically necessary visits for Medicare beneficiaries will be greater when billed separately than exist in current, accurate bundles. Put another way, in using the typical patient to determine payment, Medicare is shifting cost to other insurers and non-Medicare patients who have fewer complications, shorter hospital lengths of stay, and faster less complicated recoveries. We expect that other, third-party payors would ultimately adopt CMS's proposal, since they are likely to experience a reduction in cost for the non-Medicare population.

4. *Registry data:* If patients elect to forgo follow-up treatment or decide to seek it from other physicians or health care providers, the proposed policy will obstruct the collection of patient outcomes information, effectively stifling the utility of clinical registries, including those that have been approved to participate in the Qualified Clinical Data Registry program. In so doing, this proposal not only has the potential to destroy one of the earliest examples of care coordination in Medicare, but also cannibalize future reform efforts.
5. *Administrative Burden:* Under this proposal, each pre- and post-operative service will have to be coded and billed separately – increasing the administrative burden to surgeons and the cost to CMS for processing all of these additional claims. The American Medical Association estimates that the elimination of the global period will result in 63 million additional claims filed to account for post-surgical evaluation and management services. Even if physicians could accommodate this enormous increase in volume, it is not clear that CMS would have the ability to process the information it is requesting.

#### *Duplicative Services*

The Relative Value Update Committee (RUC) collects data on surgeon-provided E&M services through survey and multispecialty review. Per the survey instructions, these data represent the surgeons' work, and not the work by other providers. In the proposed rule, CMS suggests that other providers are also billing for services during the global period, and that this is duplicative of services provided by the surgeon being paid under the global. We agree with CMS that, in the 15 years since RBRVS was instituted, the in-hospital care delivery model has changed with the development of critical care specialists, hospitalists and a team approach to patient care.

However, much if not all of this change has been driven by two simultaneous developments. First there has been a change in the patient population which is now older and sicker, changes which have been well documented in our clinical registry. In addition, there has been a growing movement by patient safety advocates to provide round the clock coverage and appropriate non surgical specialty care for this increasingly frail patient population. Put in another way, there is now more care given because there is simply more care required to achieve the high quality results demanded by private and governmental regulatory entities. We differ from CMS in that we believe that the combined cognitive input from different members of the multi-disciplinary team (including surgeons, critical care specialists, and various subspecialists when appropriate) is medically necessary and fundamental to the team approach that improves outcomes, decreases complications and cost, and improves quality. In summary, care delivered by non-surgical providers during a global period is medically necessary and not duplicative of the work of the surgeon. This view has been stated unequivocally and repeatedly by the RUC.

STS is very concerned that the proposal to require separate billing for post-operative surgical care provides the substrate for the eventual denial of payment to one or more of the post-operative care providers, based on the notion that care provided by other specialties is duplicative of or replacing care provided by the surgeon. We believe that multiple providers with differing expertise and training are essential to achieve optimal patient outcomes and that this proposal will provide disincentive to optimal patient care.

*Timeline of proposed conversion to 000 globals*

STS is also concerned with the unwarranted urgency with which CMS plans to proceed with this proposal, knowingly sacrificing accuracy for “efficiency.” In fact, CMS openly discusses the many problems that will make accuracy virtually impossible within the time-frame it proposes. STS emphatically disagrees that CMS must identify a payment reduction methodology that can be broadly applied to all relevant codes or code families in order to meet its self-imposed deadline. Such methods will be assured to result in the misvaluation of many individual codes and it may take years to correct these errors. The process used to establish the current value of these CPT codes has been exacting and demanding. There are many codes that were Harvard valued, or valued before 2000, where the importance of accuracy regarding the visits was less well understood. Nonetheless, the total value is felt to be accurate making many such codes difficult to revalue as CMS proposes to do.

CMS notes in its overview that the impact of errors in individual code valuation is magnified by the degree to which each code is billed, and has employed this as a primary justification for its proposed change to the global payment structure. In objecting to this change, STS would point out that due to the inaccuracies which CMS itself recognizes, the proposed methodology will almost certainly cause hundreds of misvaluation errors by applying a uniform process strategy for all CPT codes. This will profoundly and adversely effect legitimate physician payment and has the potential to have catastrophic financial effects for individual physicians and the patients to whom they provide care.

*Practice Expense and Malpractice Expense Considerations*

STS is also very concerned about the many assumptions that CMS is making regarding PE and professional liability insurance (PLI), expense. Although, in the proposed rule, CMS states its obligation to provide resource based payment for physician services, it goes on to state that it will not do so for these two components which account for approximately 50% of the total payment. Rather, CMS proposes to move the PE and PLI relative value unit (RVU) value attributed to the specialties performing these services into the blend of PE and PLI inputs for all E&M services. Since the 090 and 010 global periods apply to surgical procedures generally associated with higher PE inputs (including supplies, labor type, and indirect PE rates) and higher professional liability risk factors, the effect will be to dramatically reduce the total value of these two components when billed separately. For example, examine an existing procedure that all agree is perfectly valued for the operation itself, contains an accurate number and level of postoperative visits, and then has the value of these visits removed for conversion to a 000 day global. If the surgeon were to then perform and bill for exactly the the same visits that have been removed, there would be a payment shortfall that would vary in direct proportion to the degree of professional liability risk and the components of PE outlined above.

In reviewing the 2012 utilization data, allowable charges for physicians designated as CARDIAC SURGERY or THORACIC SURGERY were identified for 773 individual 090 global CPT codes. There were 231,902 medium intensity 99213 office visits included within the global period of these allowed charges, accounting for 46,498 PLI RVUs determined by the professional liability risk factor for each code. If these same visits were independently billed instead, using the blended 99213 Risk Factor, 16,233 PLI RVUs would be reimbursed, a 65%

reduction. The result is similar for all other E&M services that will be differentially reimbursed under this proposal. Unless this is accounted for, PLI reimbursement will be substantially and selectively underfunded for providers of current 090 and 010 global period procedures.

The CMS proposal will also similarly reduce the indirect PE allocation associated with the shift to blending of E&M indirect cost rates, which are generally higher for surgical specialties. This will worsen the existing systematic underfunding of practice expense and selectively allocate this contribution to budget neutrality to a subset of providers. This is contrary to the the objectives of RBRVS, and is particularly objectionable because the indirect cost expenses are known at the specialty designation level but will be intentionally unaccounted for. We agree with the RUC response to the proposed rule regarding the loss of resource based direct PE inputs that will occur unless the global period conversion methodology is substantially changed. Further we call on CMS to consider the long list of equipment and supply direct inputs (to be supplied in detail by the RUC) that will no longer be accounted for in the PE calculation for converted global codes.

We also have a specific concern about the CMS plan to discard the differential labor cost component of direct PE that exists between many current 090 and 010 global codes. CMS notes that staff blend listed as “RN/LPN/MTA” (L037D) and priced at \$0.37 per minute is utilized for 99211-99215 when billed independently, whereas some codes with post-operative outpatient visits at the same level include the staff type “RN” (L051A) priced at a higher rate of \$0.51 per minute. CMS notes

*For these codes, the higher resource cost may accurately reflect the typical resource costs associated with those particular visits. However, the different direct PE inputs may drive unwarranted payment disparities among specialties who report global surgery codes with post-operative periods and those that do not. The only way to correct these potential discrepancies under the current system, which result from the specialty-based differences in resource costs, would be to include standard direct PE inputs for these services regardless of whether or not the standard inputs are typical for the specialties furnishing the services.*

We agree with CMS that the additional resource costs of direct labor payment rate are actual, because they have been laboriously determined by survey, adjudicated and confirmed by the RUC Practice Expense Subcommittee at the individual code level, and have already been approved and accepted by CMS. We strongly disagree that these are “*unwarranted payment disparities*” and that the “*only way to correct these potential discrepancies... would be to include standard direct PE inputs*” regardless of whether or not they are typical. The payment disparities that exist are better characterized as reimbursement for experienced cost and are not “*unwarranted*” but actual, resource-based differences. Thus, STS strongly urges CMS to develop a mechanism of PE payment to retain correct, resource based reimbursement for these labor costs as defined in its current database.

One method would be to determine the difference in payment for PE and PLI for each E&M service removed from the global code and its corresponding E&M service when billed separately. This difference, which would usually be positive as outlined above, would then be added to the PE and PLI of the affected CPT procedure code components as calculated as revised

to a 000 global. Of course, this method will only be effective for CPT procedure codes where the E&M visits that are removed, accurately describe the typical visit pattern conducted. This will not be the case for many procedures, as CMS notes, and thus the accuracy of this method would be determined by the accuracy of any new CMS method used to estimate the typical number and level of visits for each code.

An alternative, and perhaps preferable, method would be for CMS to determine the PE and MP RVUs according to the billing provider's specialty designation. This would permit accurate reimbursement of expenses incurred, and acknowledge that the E&M services provided in association with a high-risk procedure should contain reimbursement for the risk and complexity of that procedure. This would leave only the direct supply inputs and perhaps the direct labor inputs to be retained in the value of the 000 modified procedure codes. Currently, practice expense and malpractice expense inputs reflect the specialty designation and the types of services that are performed. A major obstacle to "passing through" accurate reimbursement (not "payment") for these expenses is the utilization of blending at the CPT code level according to specialty-specific utilization data. This has the effect of over- and under-reimbursement for many specialties, which is compounded by CMS's acknowledgement that its pool of available funds is inadequate to fulfill its total resource-based obligation.

There are many additional benefits to this alternative approach. For example, CMS could utilize this approach to avoid overpayment for assistants at surgery who currently assume the blended PLI and PE payment rates of the primary surgeon in the ratio of 84:16 for the -80 modifier, because the utilization blend is determined by allowed total charges rather than allowed charges without the assistant modifier. STS maintains that the assistants' PLI and PE determinants are already included in that specialties resource inputs. Further, this approach would markedly strengthen both CMS's analytic file and identification of abuse by establishing the reality of aberrant billing practices. For example, STS notes that CPT code 33620 (Application of right and left pulmonary artery bands [eg, hybrid approach stage 1]) has a specialty utilization for Thoracic or Cardiac Surgery of only 34.8% of allowed charges, even though this procedure can only be performed within those specialty designations. As will be mentioned elsewhere in this response, this is one of many CPT codes where (aside from assistant charges) there are a severely limited number of specialties that can legitimately bill for the service. Another example is CPT code 33420 (Valvotomy, mitral valve; closed heart) where 25% of allowed charges are attributed to General Practice, again for a code that cannot be performed by this specialty. The current effect of this has been to reduce the PE and PLI inputs for this code inappropriately.

#### *Multiple Procedure Reductions*

We call CMS's attention to the fact that the entire process of reduction calculation for multiple procedures performed at the same setting will need to be revisited as a result of the migration and revaluation of 090 global codes to 000 global codes. This is due to the fact that the 50% reduction applied to second and later 090 globals is to account for overlap in postoperative care included in the value of these codes. Since this value will be largely removed, the reduction must be lessened by methods that have not been developed at this time. We would suggest that a secondary CPT code should have its value reduced by removing some (but not all) pre and post time based work, and perhaps adjusted using the same day visit value that remains in the 000

global. Additionally, if a procedure is performed using the same incision and exposure, the intensity of this work is much lower than the intensity of the procedure if it was performed and billed by itself. Thus, any time-based adjustment utilizing the intensity of the second code and its total time must take into account that the component to be considered for payment in the multiple procedure setting will have more intensity than embodied in the code when billed separately. This will obviously also change considerably if an additional incision is required for a secondary procedure, where the time and intensity will be similar to that same procedure when performed alone.

This problem will be of significant concern during implementation, where it will be unlikely that a fair methodology of conversion of 000 globals will appropriately affect the value of all codes likely to be performed together.

### II. C. Malpractice Relative Value Units (RVUs)

The Society of Thoracic Surgeons has specific concerns about the proposed MP RVUs for codes where our specialty and subspecialties provide the majority of services. The majority of these issues are in low volume services in the files that Medicare uses to calculate a blended malpractice risk factor, particularly for congenital heart surgery that is rarely performed for Medicare beneficiaries but frequently performed for Medicaid patients or children with other types of medical insurance.

The following is a list of specific codes that represent congenital heart operations, where the MP risk factor and consequently the MP RVU are erroneously low:

CPT Code	Long Descriptor	PLI RVU 2014	PLI 2015 Prop	Delta PLI	2014 PLI pct of RVW	2015 PLI pct of RVW
33471	Valvotomy, pulmonary valve, closed heart; via pulmonary artery	5.51	1.49	-4.02	24%	6%
33472	Valvotomy, pulmonary valve, open heart; with inflow occlusion	5.55	1.51	-4.04	24%	7%
33606	Anastomosis of pulmonary artery to aorta (Damus-Kaye-Stansel procedure)	6.43	2.05	-4.38	20%	7%
33611	Repair of double outlet right ventricle with intraventricular tunnel repair;	8.51	2.31	-6.20	24%	6%
33619	Repair of single ventricle with aortic outflow obstruction and aortic arch hypoplasia (hypoplastic left heart syndrome) (eg, Norwood procedure)	10.92	3.18	-7.74	22%	7%
33620	Application of right and left pulmonary artery bands (eg, hybrid approach stage 1)	7.17	2.25	-4.92	24%	8%



<b>CPT Code</b>	<b>Long Descriptor</b>	<b>PLI RVU 2014</b>	<b>PLI 2015 Prop</b>	<b>Delta PLI</b>	<b>2014 PLI pct of RVW</b>	<b>2015 PLI pct of RVW</b>
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)	14.33	4.62	-9.71	22%	7%
33676	Closure of multiple ventricular septal defects; with pulmonary valvotomy or infundibular resection (acyanotic)	8.95	2.40	-6.55	24%	6%
33677	Closure of multiple ventricular septal defects; with removal of pulmonary artery band, with or without gusset	9.32	2.51	-6.81	24%	7%
33692	Complete repair tetralogy of Fallot without pulmonary atresia;	8.71	2.35	-6.36	24%	7%
33737	Atrial septectomy or septostomy; open heart, with inflow occlusion	5.04	1.46	-3.58	22%	6%
33755	Shunt; ascending aorta to pulmonary artery (Waterston type operation)	4.72	1.47	-3.25	21%	7%
33762	Shunt; descending aorta to pulmonary artery (Potts-Smith type operation)	5.48	1.47	-4.01	24%	7%
33764	Shunt; central, with prosthetic graft	4.62	1.47	-3.15	20%	7%
33770	Repair of transposition of the great arteries with ventricular septal defect and subpulmonary stenosis; without surgical enlargement of ventricular septal defect	8.76	2.55	-6.21	22%	7%
33771	Repair of transposition of the great arteries with ventricular septal defect and subpulmonary stenosis; with surgical enlargement of ventricular septal defect	9.87	2.65	-7.22	24%	7%
33775	Repair of transposition of the great arteries, atrial baffle procedure (eg, Mustard or Senning type) with cardiopulmonary bypass; with removal of pulmonary band	7.93	2.15	-5.78	24%	7%

<b>CPT Code</b>	<b>Long Descriptor</b>	<b>PLI RVU 2014</b>	<b>PLI 2015 Prop</b>	<b>Delta PLI</b>	<b>2014 PLI pct of RVW</b>	<b>2015 PLI pct of RVW</b>
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	8.34	2.27	-6.07	24%	7%
33777	Repair of transposition of the great arteries, atrial baffle procedure (eg, Mustard or Senning type) with cardiopulmonary bypass; with repair of subpulmonic obstruction	8.23	2.23	-6.00	24%	7%
33778	Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type);	10.38	2.78	-7.60	24%	7%
33779	Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type); with removal of pulmonary band	10.51	2.81	-7.70	24%	7%
33780	Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type); with closure of ventricular septal defect	10.65	2.87	-7.78	24%	7%
33781	Repair of transposition of the great arteries, aortic pulmonary artery reconstruction (eg, Jatene type); with repair of subpulmonic obstruction	10.51	2.81	-7.70	24%	7%
33783	Aortic root translocation with ventricular septal defect and pulmonary stenosis repair (ie, Nikaidoh procedure); with reimplantation of 1 or both coronary ostia	14.57	4.25	-10.32	22%	7%
33786	Total repair, truncus arteriosus (Rastelli type operation)	10.14	2.73	-7.41	24%	7%
33813	Obliteration of aortopulmonary septal defect; without cardiopulmonary bypass	4.79	1.39	-3.40	22%	7%
33822	Repair of patent ductus arteriosus; by division, younger than 18 years	4.26	1.15	-3.11	24%	6%
33840	Excision of coarctation of aorta, with or without associated patent ductus arteriosus; with direct anastomosis	5.11	1.39	-3.72	24%	7%

CPT Code	Long Descriptor	PLI RVU 2014	PLI 2015 Prop	Delta PLI	2014 PLI pct of RVW	2015 PLI pct of RVW
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	5.24	1.43	-3.81	24%	7%

Without exception, the procedures described by these codes **can only be performed by cardiac surgeons**. The available utilization data are as follows:

CPT Code	Medicare Util 2013	Specialty 1	Specialty 1 Percent	Specialty 2	Specialty 2 Percent	Specialty 3	Specialty 3 Percent
33471	0	NA					
33472	0	NA					
33606	1	Thoracic Surgery	100%				
33611	1	Cardiac Surgery	100%				
33619	0	NA					
33620	46	Anesthesiology	37%	Cardiac Surgery	17%	Thoracic Surgery	17%
33622	2	Pulmonary	100%				
33676	0	NA					
33677	0	NA					
33692	0	NA					
33737	0	NA					
33755	0	NA					
33762	0	NA					
33764	1	Thoracic Surgery	100%				
33770	0	NA					
33771	0	NA					
33775	0	NA					
33776	1	Cardiac Surgery	100%				
33777	0	NA					
33778	0	NA					
33779	1	Vascular Surgery	100%				

CPT Code	Medicare Util 2013	Specialty 1	Specialty 1 Percent	Specialty 2	Specialty 2 Percent	Specialty 3	Specialty 3 Percent
33780	0	NA					
33781	0	NA					
33783	0	NA					
33786	3	Thoracic Surgery	67%	Cardiac Surgery	33%		
33813	2	Thoracic Surgery	50%	Cardiac Surgery	50%		
33822	1	Thoracic Surgery	100%				
33840	0	NA					
33851	0	NA					

STS can find no satisfactory explanation for the Malpractice Risk Factors selected for these codes, particularly those where the utilization data suggest dominance by Cardiac Surgery. CMS should be aware that our specialists are categorized as either Thoracic Surgery (33) or Cardiac Surgery (78) possibly depending on whether or not a cardiac surgeon also performs general thoracic surgery. Our specialty has only one board certification (Thoracic Surgery) which encompasses all aspects of adult cardiac surgery, general thoracic surgery and congenital heart surgery. The two Medicare designations have similar malpractice risk factors, consistent with the scope of practice of our overall specialty.

In the ACUMEN Draft Report describing the methodology used for the proposed update of the MP RVUs, we note the statement “If the allowed services count for a procedure is less than 100, the risk factor of the dominant specialty is utilized.” We would submit that, for the determination of dominant specialty when both Cardiac Surgery and Thoracic Surgery are providers, the sum of the utilization of these two designations be used, and a weighted average of their separate risk factors be calculated as the MP risk factor for the code. This does not pertain to any of the codes identified above, but has occurred in the past. Also in this regard, we would ask CMS to provide ACUMEN with the work product of the RUC PLI subcommittee, which reviewed all low volume codes with specialty society input to determine a consensus opinion as to the identity of the dominant provider for each code.

Also within the above lists, it is important to note that there are clear flaws where specialties such as pulmonary disease and anesthesiology are generating allowed charges for surgical procedures that they are incapable of providing. STS notes that a large number of the listed procedures (33471-33851) are performed in the pediatric age group, and therefore, any Medicare data will be not be representative of the patient population who receive these services. STS also wishes to remind CMS that similar errors in the methodology to assign Malpractice RVU’s for pediatric cardiac procedure codes were made within the last five years which CMS ultimately corrected when made aware of these errors. However, the result was a one year significant economic impact on congenital heart surgeons across the US as the majority of private payors

base fee schedules on the Medicare Fee Schedule. It is difficult for STS to understand the mechanisms by which the same errors have occurred with this particular group of codes that are performed almost exclusively by congenital heart surgeons for pediatric patients. **For all of the above codes, STS requests that CMS reconsider its proposed MP RVU values, and assign the malpractice risk factor for Cardiac Surgery to recalculate a new MP RVU.**

The following codes also have anomalously low proposed MP RVUs:

CPT Code	Long Descriptor	PLI RVU 2014	PLI 2015 Prop	Delta PLI	2014 PLI pct of RVW	2015 PLI pct of RVW
31766	Carinal reconstruction	7.08	2.06	-5.02	22%	7%
31775	Bronchoplasty; excision stenosis and anastomosis	5.51	1.77	-3.74	22%	7%
32654	Thoracoscopy, surgical; with control of traumatic hemorrhage	4.45	3.67	-0.78	22%	18%
33420	Valvotomy, mitral valve; closed heart	3.39	3.28	-0.11	13%	13%
33803	Division of aberrant vessel (vascular ring); with reanastomosis	4.86	1.32	-3.54	24%	6%

CPT Code	Medicare Util 2013	Specialty 1	Specialty 1 Percent	Specialty 2	Specialty 2 Percent	Specialty 3	Specialty 3 Percent
31766	5	Cardiac Surgery	40%	Thoracic Surgery	40%	Pulmonary Disease	20%
31775	8	Pulmonary Disease	75%	Cardiology	13%	Thoracic Surgery	13%
32654	244	Thoracic Surgery	43%	Pulmonary Disease	23%	Cardiac Surgery	19%
33420	8	Cardiac Surgery	38%	Thoracic Surgery	38%	General Practice	25%
33803	0	NA					

The malpractice risk factor has changed for 31766, 31755, and 32654 which are highly specialized thoracic surgery procedures where it is unlikely that any other specialty would be legitimately involved. Thus, we are surprised to see that the allowed charges include Pulmonary Disease and Cardiology. It appears that their inclusion is possibly accounting for the MP reduction that is proposed. For unknown reasons, the MP RVU for 31775 also appears to be currently misvalued. 33803 is a major procedure involving surgery on the great vessels, and is typically performed by cardiac surgeons although it is possible that vascular surgeons or pediatric general surgeons could perform it in practice. A simpler form of the procedure is 33802 (Division of aberrant vessel (vascular ring);) where the MP RVU is correctly assigned to cardiac surgery both currently and in the proposed rule. **For these codes, STS requests that CMS reconsider its proposed MP RVU values, and assign the malpractice risk factor for Cardiac**

**Surgery to 33420 and 33803, and a malpractice risk factor for Thoracic Surgery for 31766, 31775 and 32654.**

STS is concerned about the method of blending malpractice risk factors at the CPT code level, as described by ACUMEN here:

The average risk factor reflects the relative malpractice liability associated with that procedure, based on the specialties of the physicians who perform the service. Specifically, under the current methodology, the average risk factor is a weighted average of the risk factors for each specialty that performs the procedure, weighted by the share of the allowed services count provided by that specialty:

$$\text{avg}RF_{CPT/MOD} = \frac{\sum_s (RF_s \times MTUS_{CPT/MOD,S})}{\sum_s MTUS_{CPT/MOD,S}}$$

where the weights  $MTUS_{CPT/MOD,S}$  are the sum of the number of services performed per specialty per procedure (Miles/Times/Units/Service), as reported in the 2015 Discounted Utilization File provided by CMS. If the allowed services count for a procedure is less than 100, the risk factor of the dominant specialty is utilized.

Here, ACUMEN states that the average risk factor for a procedure is the weighted average of the risk factors for *each specialty that performs the procedure* weighted by the share of the allowed services count provided by that specialty, emphasis ours. In review of the file “CMS-1612-P\_2014 2013 Utilization Data Crosswalk to 2015” it appears that this may include the allowed services for surgical assistance, possibly discounted to reflect the assistant role under payment policy. Specialties who assist at the procedure do not perform it, and the assistant’s associated malpractice risk factor has no bearing on the malpractice cost for the surgeon.

*Malpractice RVU GPCI calculations*

STS has had the opportunity to review the ACUMEN report upon which the new malpractice RVUs are based. We were surprised to note that Virginia is not listed as a state with a malpractice surcharge, and wonder if this oversight is a unique event or a process issue that could effect the GPSI calculations.

We refer to the existence of the Virginia Birth Fund that currently is financed by a medical license surcharge of \$300 for every physician, and \$6,200 for each physician who will deliver babies. This payment for each physician regardless of involvement in birth related injuries and any causal effect between the delivering physician and birth injury is in effect a global malpractice premium. For those who deliver babies, it results in protection from malpractice litigation for participants (excepting gross negligence) and undoubtedly reduces malpractice premiums that ACUMEN has used in its calculations. This is clearly a resource based cost of malpractice insurance for Virginia physicians and should be considered as such by CMS in these and future calculations. Information regarding the expense, funding sources, and intent of this fund can be found at: <http://www.vabirthinjury.com/>

## **II. F. Valuing New, Revised and Potentially Misvalued Codes**

Although we appreciate CMS's effort to establish more transparency in the valuation of physician and other healthcare professional services, we support the alternative proffered by the American Medical Association (AMA) to expedite the review processes for new, revised and potentially misvalued services.

### *Refinement Process/Appeals Process*

CMS proposes to eliminate the Refinement Panel process currently utilized by the Agency to consider comments on interim relative values. Although we regret that the refinement panel process has largely become an exercise in futility for specialties appealing erroneous determinations by CMS, we do not agree with the proposal to eliminate them. STS has devoted considerable resources to this process resulting in the Refinement Panels overruling CMS proposed work values in 29 instances over the past 4 years. Unfortunately, CMS accepted the Refinement Panel recommendations (which were the same as the RUC recommendations) for only 2 of the 29 recommendations (7%). CMS did not provide a rationale for rejecting the other 27 recommendations. With the current proposal, CMS plans to decimate any semblance of responsiveness to multidisciplinary physician input.

As CMS proposes elsewhere in the proposed rule, and as we have described above, we anticipate a continuance of the departure from the principles of RBRVS and an indiscriminate revaluation of thousands of CPT code values over the next 3 years. Through this action, the public and its elected representatives will have no alternate source of information to confirm or deny the validity of final rule making on code values. The fact that CMS regularly disregards the input of these Panels, despite their control of Panel composition, suggests that additional measures of oversight and appeal are needed rather than the removal of the only duly constituted, formal advisory mechanism for its physician payment activities. STS agrees with the RUC, which recommends that CMS consider these issues and create a fair, objective, and consistently applied appeals process that would be open to any commenting organization.

## **III. E. Access to Identifiable Data for the Center for Medicare and Medicaid Models**

Although we appreciate that CMS needs to measure the relative benefit of emerging, alternative methods of payment, we oppose the submission of patient-identifiable and/or raw data, and support the submission of performance rates, patient outcomes, and/or composite scores for participating providers. Appropriately risk-adjusted and audited (verified) clinical and administrative data should be used to facilitate public reporting, comparative effectiveness and clinical research, and quality improvement. On the other hand, raw or unadjusted data have little or no value to the public at large as they are easily misinterpreted and misused.

As new payment models emerge, many will rely on clinical registries to demonstrate their utility. The primary purpose of many registries is to track quality of care for targeted medical or surgical procedures, to provide medical groups and hospitals with invaluable data for analyzing and reporting their performance—including the generation of risk-adjusted national and local benchmarks—and to ultimately improve patient outcomes. As a result, data collected is

expansive and therefore extremely expensive and burdensome to sort and prepare for use. We do not think that CMS should be granted access to the proprietary information collected by registries, or otherwise provided access to information that registries and medical specialty boards collaborate on for purposes of maintenance of certification (MOC). We believe that a robust validation strategy and transparent auditing guidance will be sufficient in lieu of submitting patient-level data with identifiers and/or raw data.

It is important to note that registries cannot fulfill the promise of facilitating the development of alternative payment models unless they are able to access both administrative claims information from CMS and other payors as well as death information from the Social Security Administration. Research based on this information helps physicians to provide information to today's patients and families to help them with shared decision making. Outcomes data give patients confidence in their medical interventions and demonstrate to patients and their families the durability and long-term benefits of medical procedures. Importantly, STS, through its contracts with the Duke Clinical Research Institute, maintains the patient identifier data separately from the actual clinical and other demographic data, and the only patient level identified information that ever leaves the database is simply that the patient has a record in the database. When the follow-up information is returned from external entities, such as the Social Security Death Master File, it can be linked back to the records in the de-identified database, but the flow of information is only in this direction. The externally derived data are used to supplement the data in the individual record, but these data never leaves the database except in de-identified form.

### **III. I. Reports of Payments or Other Transfers of Value to Covered Recipients**

CMS has proposed revoking the existing Sunshine Act reporting exclusion for continuing medical education (CME) activities, due in large part to requests from other accrediting bodies that they be added to the list of exempt organizations covered by the exclusion. Instead, the proposal would exempt third party transfers to Continuing Education (CE) only where an industry donor is unaware of the recipients/beneficiaries before and after the funds are transferred. STS believes that this raises concerns as industry could learn the identities of speakers/faculty and potentially participants through brochures, programs, and other publications, or through their physician-employees' participation in CE activities (either as speakers/faculty or attendees). This unintended reporting may drive physicians away from beneficial CE opportunities, despite the fact that there is no influence on the educational material.

We strongly recommend that CMS modify the proposal to clarify that the exemption applies under section 403.904(g)(1)(i) when an applicable manufacturer provides funding or in-kind support to a CME/CE provider but does not select or pay the covered recipient speaker/faculty/attendee directly, or provide the CME/CE provider with a list in any format of individuals to be considered as faculty/speakers/attendees for the activity. We suggest that CMS provide guidance that the above mentioned is achieved if the commercial supporter is unaware of the speakers/faculty/specific attendee names before signing an agreement to commit to providing the commercial support for a specific activity. Further, this guidance should clarify that if a



commercial supporter becomes aware of the names of speaker/faculty/attendees after the commitment to support the activity was made, the activity would remain exempt. Otherwise, it is our contention that the revised language would negate rather than expand the current exemption that is in place for accredited and certified CME. To allow CE providers time to ensure that their processes comply with the modified exemption, we urge CMS make this change effective no sooner than six months after the final rule is issued.

### **III. J. Physician Compare Website**

In general, we are concerned that CMS plans to create its own composite scores and benchmarks for the physician compare program. We are concerned that the proposed composite scores and benchmarks will not accurately represent a fair comparison of performance among physicians because

- they will not be risk-adjusted,
- the proposed sample size will not be adequate (confidence intervals would likely not be accurate with small denominators (20 cases), and
- the proposed statistical model to develop composite score is questionable.

We believe that CMS should work with measure stewards to develop and test composites prior to publishing scores on Physician Compare. For example, STS has already developed the STS Coronary Artery Bypass Graft (CABG) composite score and rating, one of the most sophisticated and widely regarded overall measures of quality in health care. We have also developed the STS AVR composite score and most recently the STS Aortic Valve Replacement (AVR) + CABG composite score, and further composite measures for general thoracic surgery are currently being developed. We also believe that CMS should work with consumers to determine how to best display composite scores on Physician Compare such as through a chart, graphical depiction (e.g. spidergraph), or another form of representation. STS has worked with Consumer Reports, drawing on their expertise to publish our composite scores in a way that is accessible to the public.

CMS seeks comments on expanding public reporting to possibly include specialty-society approved and vetted measures on Physician Compare. CMS is also considering the option to include linking to specialty society Web sites so that public can view non-PQRS measures. We appreciate CMS's willingness to include measures from approved and vetted specialty societies and welcome future opportunities to work with CMS. We request that CMS include a disclaimer on Physician Compare that these measures reported by specialty societies have been determined to be more relevant by clinicians in that field.

CMS also proposes to include 2015 Qualified Clinical Data Registry (QCDR) measures on the Physician Compare Web site by either posting measure information on the QCDR's own Web site and allowing Physician Compare to link to it or providing the data for CMS to post on Physician Compare. We do not support this proposal because this timeline is too aggressive to ensure that data will be valid and reliable and in a format which consumers can understand. The QCDR program is in its infancy and we believe it would be a serious mistake to rush the public reporting of QCDR data. Posting data before it is proven valid and reliable could result in the

misclassification of care, which will misinform the public. Instead, for CY 2015, we recommend that CMS post whether an eligible professional (EP) is participating in a QCDR with a clear explanation of why participation in a QCDR may be more relevant and meaningful for the EP.

We recommend that CMS implement a gradual approach to the requirement to publicly report QCDR data. We believe it would be more feasible and appropriate to report after a measure is fully tested for validity and reliability and after benchmarks are established. This will allow entities to gain experience in collecting and reporting data to CMS and resolving any inaccuracies in the data. We believe this course of action will build provider trust by ensuring data reported on providers does not misclassify the care they provide and allow QCDR participants to improve prior to public disclosure of QCDR data. Additionally, only after QCDR data is proven to be reliable and valid, QCDR entities should have the option to choose the most meaningful public reporting strategy, whether it is posted on the Physician Care Website, the QCDR Website, or another appropriate location.

### III. K. Physician Payment, Efficiency, and Quality Improvements – Physician Quality Reporting System

#### *Discontinued Measures*

STS opposes the discontinuation of the following measures:

Measure	Rationale
<b>PQRS Measure # 233: Thoracic Surgery: Recording of Performance Status Prior to Lung or Esophageal Cancer Resection.</b>	This is one of the few measures available to General Thoracic Surgeons.
<b>PQRS Measure # 234: Thoracic Surgery: Pulmonary Function Tests Before Major Anatomic Lung Resection (Pneumonectomy, Lobectomy, or Formal Segmentectomy)</b>	This is one of the few measures available to General Thoracic Surgeons.
<b>PQRS Measure # 168: Coronary Artery Bypass Graft (CABG) Surgical Re-Exploration</b>	The CABG measures (168 – 171) are part of the STS CABG composite measures and therefore are important to collect
<b>PQRS Measure # 169: Coronary Artery Bypass Graft (CABG) Antiplatelet Medications at Discharge</b>	The CABG measures (168 – 171) are part of the STS CABG composite measures and therefore are important to collect
<b>PQRS Measure # 170: Coronary Artery Bypass Graft (CABG) Beta-Blockers Administered at Discharge</b>	The CABG measures (168 – 171) are part of the STS CABG composite measures and therefore are important to collect
<b>PQRS Measure # 171: Coronary Artery Bypass Graft (CABG) Anti Lipid Treatment at Discharge</b>	The CABG measures (168 – 171) are part of the STS CABG composite measures and therefore are important to collect
<b>PQRS Measure # 157: Thoracic Surgery: Recording of Clinical Stage Prior to Lung Cancer or Esophageal Cancer Resection</b>	This is one of the few measures available to General Thoracic Surgeons.

Measure	Rationale
<b>PQRS Measure # 0023: Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis</b>	This is one of the few measures available to General Thoracic Surgeons.

We also agree with the comments provided by the American College of Surgeons in support of the following measures:

- PQRS #21: Perioperative care: selection of prophylactic antibiotic-first or second generation cephalosporin
- PQRS #22: Perioperative care: discontinuation of prophylactic parenteral antibiotics
- PQRS #23: Perioperative care: venous thromboembolism prophylaxis when indicated in all patients

We do not believe that these measures should be discontinued.

#### *Qualified Clinical Data Registries*

The Society of Thoracic Surgeons maintains the STS National Database which is a Qualified Clinical Data Registry (QCDR). We are interested in continuing to improve the capability and utility of the clinical quality measures currently being captured by the STS National Database through the PQRS QCDR reporting option. We believe measures from specialty registries can be more relevant, clinically appropriate, and actionable for surgeons when compared to the measures currently available under other PQRS reporting options. Below, we provide comments on the proposed changes to the QCDR program:

- CMS proposes to increase the maximum number of non-PQRS measures that can be reported on behalf of an EP from the current 20 measures to 30 measures. STS supports this proposal as it will allow for a better and more complete picture of quality of care. It will also provide additional measure options for EPs thereby increasing a QCDR's ability to meet the needs of a broader range of specialties and subspecialties.
- CMS proposes to extend the deadline for QCDRs to submit quality measures data to CMS to March 31st following the end of the applicable reporting period (for example, March 31, 2016 for 2015 reporting periods). We thank CMS for acknowledging the need for an extension.
- CMS also proposes to allow for more frequent submission of data, such as quarterly or year-round submissions, rather than having only one opportunity to submit quality measure data. We do not necessarily believe that providing more frequent submissions will provide CMS with valuable information. We want to emphasize the importance of being able to run reports or performance analyses over longer periods of time (e.g., 3-years of data). We contend that shorter periods of time will yield results that are not meaningful. Less commonly performed procedures, such as AVR, will have a more valid quality score if CMS allows us to collect several years of data.
- CMS proposes to require that, at a minimum, QCDRs must publically report the title and description of the measures that a QCDR reports to the Physician Quality Reporting

System (PQRS), as well as the performance results for each measure the QCDR reports. As stated above, we remain concerned with this proposal because individual providers' performance results may be based on small sample sizes and will not be risk-adjusted. This will provide skewed results to the PQRS program and could have negative implications for participating providers.

- CMS also proposes that 15 days following CMS approval of measure specifications, the QCDR must publically post the measures specifications using any public format it prefers. We feel that 15 days is not enough time to have the measure specifications published. We suggest that CMS allow QCDRs 30 days instead.

### **III. L. Electronic Health Record (EHR) Incentive Program**

The high cost of EHR remains a burden for private practitioners, particularly as the PQRS program no longer includes any incentive payments for reporting. A study in the March 2011 edition of Health Affairs estimated that the total first-year cost of EHR implementation for a five-physician practice to be \$233,297, with average per-physician cost of \$46,659 – a large expense for any small business to incur. We ask CMS to keep in mind the combination of the extremely high cost burden of EHR implementation with the multiple reporting penalties physicians are facing.

### **III. N. Value-Based Payment Modifier and Physician Feedback Program**

The Affordable Care Act requires the VBPM to be phased in over a three-year period beginning in 2015 and ending in 2017, when it would apply to all physicians. CMS is basing the adjustments in any given year on a “performance year” two years earlier, which means that any requirements attached to the 2016 payment adjustment have a two year “look-back” to 2014; we find this time lag very problematic.

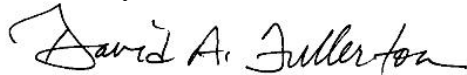
Under the current proposal, successful PQRS participants could be subject to a “quality tiering” step where groups would be compared nationally on quality and cost and have the potential to earn an unspecified bonus or penalty of up to two percent. As we have previously articulated, STS opposes using a methodology that creates the same benchmark for all physicians. We believe this proposal is a flawed concept. This would only be fair if physicians are compared to their peers by allowing cardiothoracic surgeons to select measures that have been developed by STS and endorsed by the NQF process. Because of our concerns, STS will be working with Congress and other physician groups to repeal the VBPM or at least slow its expansion, limit potential penalties and eliminate the two-year lag between performance and adjustment years.

STS does, however, support Physician Feedback Reports. Known as Quality and Resource Use Reports (QRUR), we believe these will be useful since they will compare quality and resource use among physicians and will provide a preview of how affected groups might fare under the VBPM on a risk-adjusted basis using three factors: patient health status, demographics and beneficiary type. We support CMS providing these reports to physicians in all groups and solo practices within a year and physicians having the ability to access additional data, including

patient identity. However, as the program moves forward we also have some concerns that we feel CMS should address. Given the number of changes to programs such as the VBPM and PQRS in the last few years, the feedback a physician will receive in their QRUR could be based on quality and performance for less measures than are required in the current reporting year, or even for measures that are no longer included in the PQRS program due to the large number of measures CMS has chosen to remove. STS supports feedback to physicians, but worries that, given program changes, the usefulness of that feedback may be diminished. We urge CMS to work to reduce the amount of drastic change in the programs from year to year, and the yearly removal of large numbers of measures that physicians may have previously reported on or find useful in order to meet the reporting requirements.

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](mailto: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