STS Headquarters
633 N Saint Clair St, Suite 2100
Chicago, IL 60611-3658
(312) 202-5800
sts@sts.org

Washington Office
20 F St NW, Suite 310 C
Washington, DC 20001-6702
advocacy@sts.org

September 12, 2025

Mehmet Oz, MD
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 2026 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program [CMS-1832-P]

On behalf of The Society of Thoracic Surgeons (STS), I write to provide comments on the Calendar Year (CY) 2026 Medicare Physician Fee Schedule (PFS) Proposed Rule. Founded in 1964, STS is a not-for-profit organization representing more than 7,800 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.

Payment Provisions of the Proposed Rule for the Physician Fee Schedule

Proposed CY 2026 Conversion Factors

Consistent with requirements established in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), CMS proposes the following two conversion factors (CFs) for 2026:

- *$33.5875 for items and services furnished by Qualifying APM Participants, which reflects a 3.84 percent increase relative to the 2025 CF*
- *$33.4209 for other items and services, which reflects a 3.32 percent increase relative to the 2025 CF*

The conversion factors reflect a budget neutrality adjustment (+0.55 percent) and the 2.5 percent temporary increase for CY 2026 provided under the One Big Beautiful Bill Act.

STS commends CMS for proposing an increase in the CY 2026 conversion factor. In an environment of growing financial pressure and uncertainty for physician practices, this increase is a much-needed first step toward restoring stability and predictability in Medicare reimbursement. By bolstering the conversion factor, CMS helps ensure that physicians and their teams continue providing high-quality, specialized care to beneficiaries. A stable payment system is essential for sustaining the infrastructure of clinical practices, supporting innovation, and maintaining access to care for patients who rely on thoracic surgeons for life-saving procedures.

While we are encouraged by the increase in the conversion factor, we must emphasize our serious concerns with other proposed policies in this proposed rule. Specifically, we are concerned about the efficiency adjustment and modifications to indirect practice expense (PE) calculations which if implemented as proposed may have a largely negative effect on reimbursement for cardiothoracic surgeons. The efficiency adjustment, designed to promote cost containment, risks penalizing specialties like thoracic surgery that already operate with high levels of efficiency and resource stewardship.

Similarly, revisions to the indirect PE methodology lack data to justify an arbitrary 50 percent cut and does not account for the complex variability and realities of physician employment arrangements. CMS' one-size-fits-all approach will unfairly penalize both employed and non-employed physicians in facility settings, potentially harming patient access and care.

Above all, STS is concerned that downward pressure on reimbursement from efficiency adjustments and PE changes will yet again undermine our ability to treat patients effectively. Adequate reimbursement is crucial for maintaining the skilled workforce and technical capacity required to deliver optimal outcomes. We urge CMS to carefully consider the cumulative effects of these policies and to avoid payment cuts that would jeopardize patient access to specialized surgical care.

Determination of PE Relative Value Units (RVUs)

Practice Expense RVU Methodology and Professional Liability Insurance RVUs - Expected Specialty Overrides for Low Volume Service Codes

Resource-based malpractice (MP) RVUs were calculated for each CPT/HCPCS code that has work or PE RVUs. In the CY 2018 PFS, CMS finalized a proposal to apply the list of expected specialties instead of the claims-based specialty mix for low volume services to address stakeholder concerns about the year-to-year variability in PE and MP RVUs for low volume services. These are defined as codes that have 100 allowed services or fewer per year. For CY 2026, CMS is soliciting public comment on the list of expected specialties.

STS appreciates CMS' continued policy of using expected specialty overrides for certain low volume services. Adding these codes to the Specialty Assignment for Low Volume Services list ensures that the risk for the appropriate specialty is reflected in the practice expense and professional liability for the code. STS supports the continued use of a three-year average without utilization adjustment for Current Procedural Terminology (CPT®) modifiers to identify services with fewer than 100 Medicare claims per year for the expected specialty override codes.

STS reviewed and agreed with the cardiothoracic codes included in the Anticipated Specialty Assignment for Low Volume Services list provided as part of the supporting documentation in the proposed rule. All codes previously requested by STS and the American Medical Association (AMA) RVS Update Committee (RUC) are included in the list and the overrides have been applied to the MP and PE RVUs for the codes in Addenda B of the CY 2026 rule.

Additionally, the AMA RUC performed an analysis to identify newly eligible codes that meet the criteria to receive a specialty override for CY 2026 and identified three thoracic surgery codes that qualify. STS recommends that CMS add the following codes with the indicated specialty to the Anticipated Specialty Assignment for Low Volume Services list for CY 2026:

CPT Code	Long Descriptor	Global	3-year Average	Recommended Low Volume Specialty Override
32096	Thoracotomy, with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilateral	090	87	THORACIC SURGERY
32141	Thoracotomy; with resection-plication of bullae, includes any pleural procedure when performed	090	88	THORACIC SURGERY
33875	Descending thoracic aorta graft, with or without bypass	090	99	THORACIC SURGERY

There are four cardiothoracic surgery codes in the Anticipated Specialty Assignment for Low Volume Services list for CY 2026 that do not contain a "Yes" in column C "*2026 Override Applied?"* for the code. In reviewing the past 3 years of data from the Utilization Data Crosswalked files from the CY 2024 and CY 2025 PFS final rules and the CY 2026 PFS proposed rule, it appears that they should still meet the low volume code criteria. Per the table below using the column E "*undiscounted allowed services*" data from the tables, the codes still meet the low volume criteria for the three-year average in two ways:

1. If the utilization is calculated using the number of services with no modifier
2. If the utilization is calculated using services with modifiers 22, 52 or 53, which would represent services provided to a single patient.

However, if the utilization is calculated using data for all services, including modifiers 80, 82, 62 or AS, then the codes do not qualify for the three-year average. STS would like to verify that the anticipated specialty override will be applied to those codes in CY 2026. If the override is not applied, we request clarification on which services CMS includes to determine the codes that qualify for applying the low volume override. Additionally, if CMS does use those services that include modifiers 80, 82, 62 or AS, STS recommends CMS reconsider as this would effectively be double counting the service. Those modifiers represent a second provider involved in providing a single service to a patient as opposed to two separate services being provided to a single patient.

			CY 2024 FR 2022 Utilization Data Crosswalked		CY 2025 FR 2023Utilization Data Crosswalked		CY 2026 PR 2024 Utilization Data Crosswalked		3-yr Average Utilization	
CPT Code	**Anticipated Specialty**	**Override Applied?**	**Utilization with Modifiers 22,52,53**	**Utilization with All Modifiers**	**Utilization with Modifiers 22,52,53**	**Utilization with All Modifiers**	**Utilization with Modifiers 22,52,53**	**Utilization with All Modifiers**	**Utilization with Modifiers 22,52,53**	**Utilization with All Modifiers**
33254	CARDIAC SURGERY		78	130	113	191	98	158	**96**	160
33415	THORACIC SURGERY		65	104	84	125	71	109	**73**	113
33475	CARDIAC SURGERY		69	108	76	102	78	107	**74**	106
33507	THORACIC SURGERY		69	103	93	139	94	116	**85**	119

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

CMS proposes maintaining the current PE per Hour (PE/HR) and 2006-based MEI cost shares for CY 2026 PFS ratesetting. CMS indicates that they received and reviewed the data from the AMA Physician Practice Information (PPI) and Clinician Practice Information (CPI) Surveys to consider for the PE/HR data and cost shares in PFS ratesetting for CY 2026. However, due to substantive concerns about the accuracy and suitability of the PPI and CPI Survey data as an immediate replacement for the current PE/HR data and cost shares for use in CY 2026 PFS ratesetting, CMS is not proposing to implement the PE/HR or cost shares from the AMA's survey data currently.

STS supports maintaining the current PE/HR and 2006-based MEI cost shares for CY 2026 PFS ratesetting as proposed for CY 2026. While we agree with CMS that it is important to balance payment stability and predictability by incorporating new data through more routine updates, we feel that it is important to identify the best data sources available for physician services' input expenses and establishing the MEI cost shares. We encourage CMS to continue to work with the AMA to determine the validity of the 2024 AMA PPI and CPI survey data and how it can be used in future rulemaking and work with stakeholders to identify other viable data sources that can be used to update the PE/HR and MEI cost shares.

Supply Pack Pricing Update

For CY 2026, CMS is proposing to continue implementation of updating the supply pack pricing for 15 supply packs with three moving directly to final prices for CY 2026 and the remaining 12 phased in using the same multiyear transition established in CY 2025.

STS supports CMS' proposal to update the fifteen supply packs identified in the rule and incorporating the twelve packs with higher costs into the multiyear supply pack pricing transition established for the CY 2025 supply packs. STS also supports CMS' proposal to fold the updates for the twelve higher priced supply packs

identified for CY 2026 into the previous pricing transition using the same methodology with the new direct PE prices for all updated supply packs fully implemented for CY 2028. Due to the high number of services that make use of these very common supply items, this approach simplifies the transition process and minimizes potential disruptive effects that could be caused by other sudden shifts in RVUs during the transition period.

Updates to Practice Expense Methodology – Site of Service Payment Differential

CMS proposes significant refinement to their PE methodology which would reduce the portion of the facility PE RVUs allocated based on work RVUs by 50 percent of the amount allocated to non-facility PE RVUS for CY 2026. The proposed indirect practice expense adjustment would result in a reduction to the PE RVUs used in physician payment for services performed in the facility (e.g., hospitals, ambulatory surgical centers, etc.) setting.

CMS believes allocating the same amount of indirect PE based on work RVUs in both facility and non-facility settings may overstate the range of indirect costs incurred by facility-based physicians, particularly if they are less likely to maintain an office-based practice separate from their facility practice. CMS alleges that the proposed changes to the indirect cost allocation methodology is intended to better recognize the relative resources involved in furnishing services paid under the PFS in facility and non-facility settings.

The AMA estimates that under this proposed change, physician payment for services performed in a facility will decrease overall by 7 percent and non-facility-based payments will increase by 4 percent. STS strongly opposes this proposal which reduces physician payments for all services furnished in a facility setting, regardless of whether the physician is employed. CMS should address differences in practice expense costs incurred by employed and non-employed physicians by targeting specific problematic policies and not implement an across-the-board reduction that targets all procedures performed in the facility setting.

This proposal fails to take into consideration the myriads of relationships between hospitals and employed physicians or account for the indirect PEs such as coding, billing, and scheduling that are still incurred by most physicians, even when employed. There are different types of employment arrangements covering a wide range of scenarios. Some employed physicians are based fully in the hospital while others, even though employed, are set up as independent practices that pay rent and administrative staff to handle scheduling, coding and billing and other associated expenses, similar to office-based physicians. It is also common that employed physicians are required to reimburse the hospital for expenses or pay for a portion of the indirect PE.

The one-size-fits-all policy as proposed by CMS, will have a non-uniform and detrimental effect on physicians and may be further impacted negatively by the arrangement that employed and non-employed physicians have with the hospitals. The proposal unfairly penalizes non-hospital-employed physicians for services provided in a facility setting and results in unequal enforcement of the law by CMS. STS has major concerns about the significant unintended and unsustainable impacts on employed and non-employed physicians which will negatively impact patient access and care.

Additionally, the amount by which CMS is proposing to reduce the facility indirect PE, 50 percent, is arbitrary and CMS does not offer any data or rationale supporting this percent reduction. Instead, CMS indicates that they are “seeking comments on whether there are additional data sources that might help identify a more precise site of service difference in the allocation of indirect PE RVUs.” It would be prudent for CMS to first identify data sources that could be used to allocate indirect PE RUVs and use that data to inform their decision

making for policy changes to ensure that physicians in all circumstances are fairly compensated for their indirect PE expenses.

CMS should explore other solutions to address the specific issue they are targeting. Examples include targeting a narrower application of the payment adjustment that encompasses only employed physician services instead of all facility-based services or using data to determine the evidence-based percentage reduction. While STS is supportive of ensuring that patients are fairly charged and physicians fairly compensated for the services provided by employed and non-employed physicians, we strongly disagree with the approach proposed by CMS. We encourage CMS to delay this proposal and work with the AMA, national specialty societies and other stakeholders to identify the specific circumstances where cost differences apply, what those cost differences entail and then determine the best method to account for those differentials.

High-Cost Disposable Supplies

As part of its consideration of the Lower Extremity Revascularization codes, CMS indicates that they "are seeking comments on whether we should create G-codes to describe the use of high-cost supplies".

Historically the RUC has recommended that CMS create Healthcare Common Procedure Coding System (HCPCS) supply codes (e.g., G-codes) that can be separately reported to identify and pay for high-cost disposable supplies (those priced more than $500). Per the RUC, the 2026 PFS Proposed Rule includes 94 medical supply items currently embedded in codes with a purchase price of more than $500. High-cost disposable supplies significantly impact the current PE methodology which allocates a large amount of the indirect PE for procedures that include these supplies in addition to the direct PE for the supplies. As a result, a large portion of indirect PE is allocated to the practices performing the service with the high-cost supplies, which is subsidized by the broader specialty and other physicians and qualified healthcare professionals.

Paying separately for high-cost supplies using HCPCS codes would address this issue by ensuring that the excess indirect practice expense currently assigned to these services is more evenly distributed throughout the specialty PE pool. This change would lead to a fairer allocation of PE among all services. Pricing of the supplies should be accomplished on a regular basis utilizing a transparent process to ensure pricing and payment accuracy for Medicare services.

Potentially Misvalued Services Under the PFS

Cryoablation Therapy to Treat Postoperative Pain

Based on a request, CMS is seeking public comments on whether a new G-code is needed to account for the additional intraoperative time required to perform cryoablation therapy, including service elements and valuation of work and practice expense, including potential crosswalk codes.

STS has repeatedly fielded questions on the correct coding for intercostal cryoablation nerve therapy performed intra-operatively for post-operative pain management. While we agree that the procedure requires additional intra-operative time that is not valued into the primary procedure (e.g., procedures requiring thoracotomy or thoracoscopy), it is not clear whether CMS considers this work to be included in the global package. Per the Medicare Claims Processing Manual, "Postsurgical Pain Management - By the surgeon" is listed as an included component of the global package.[1] Based on this, STS and other specialty societies have

[1] Chapter 12 - *Physicians/Nonphysician Practitioners,* Section 40.1- *Definition of a Global Surgical Package*

concluded that intraoperative cryoablation in anticipation of postop pain management is part of the global surgical package and have recommended it should not be separately billed to Medicare. However, coverage for commercial/non-government payors varies and as such, some may reimburse cryoablation therapy for postoperative pain management under CPT code 64699 *Unlisted procedure, nervous system*.

Due to ongoing confusion about this provision in the Medicare Carrier's Manual, STS requests that CMS clarify whether intra-operative procedures that require additional time for post-operative pain management, such as intercostal cryoablation nerve therapy, are considered part of the global surgical package or may be billed separately when the extra time is not already valued in the primary procedure.

If CMS decides that the additional work for intraoperative cryoablation nerve therapy is not part of the global surgical package and can be billed separately, STS recommends that CMS create a temporary G-code for this purpose. This code would allow proper billing for the extra intra-operative effort until a permanent CPT code is established and appropriately valued. The new G-code should be created as an add-on code to account for the additional 25-30 minutes of intra-service time to perform the procedure.

Additionally, other post-operative pain management procedures require additional intra-operative time, such as insertion of a pain pump that CMS may consider in the creation of a new code. Instead of a code specific to cryoablation therapy, it could be a time-based code for post-operative pain management not inherent to the procedure with a parenthetical that provides examples such as cryoablation nerve therapy, insertion of pain pumps, and others. There would be no associated clinical staff time or PE associated with the procedure, which would typically be performed in a facility setting if created and valued as an add-on code.

However, if an add-on G-code was created specific to cryoablation nerve therapy for post-operative pain management or a generic post-operative pain management code, STS suggests valuing the code using a crosswalk to an add-on (ZZZ Global) code with 20-35 minutes of intra-service time such as:

- 33268 - Exclusion of left atrial appendage, open, performed at the time of other sternotomy or thoracotomy procedure(s), any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip) (List separately in addition to code for primary procedure) - intra-service time of 20 minutes with a wRVU of 2.50
- 32667 – Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure) - intra-service time of 25 minutes with a wRVU of 3.00
- 32507 - Thoracotomy; with diagnostic wedge resection followed by anatomic lung resection (List separately in addition to code for primary procedure) - intra-service time of 30 minutes with a wRVU of 3.00
- 33509 - Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure, endoscopic – intra-service time of 35 minutes with a wRVU of 3.34
- 64643 - Chemodenervation of one extremity; each additional extremity, 1-4 muscle(s) (List separately in addition to code for primary procedure) – intra-service time of 20 minutes with a wRVU of 1.22
- 64645 - Chemodenervation of one extremity; each additional extremity, 5 or more muscles (List separately in addition to code for primary procedure) – intra-service time 25 minutes with a wRVU of 1.39
- 64913 - Nerve repair; with nerve allograft, each additional strand (List separately in addition to code for primary procedure) – intraservice time 30 minutes with a wRVU of 3.00

To establish efficacy of the procedure and ensure appropriate valuation based on physician work, STS

recommends that a G-code be done as a temporary solution until a new Category I CPT code can be established. Societies would likely be willing to bring forward codes to fill these gaps in physician work once CMS clarifies the question of whether the work is considered part of the global surgical package.

Payment for Medicare Telehealth Services

Proposal to Modify the Medicare Telehealth Services List and Review Process

CMS proposes revising their annual review process for changes to the telehealth services list to focus its review on whether the service can be furnished using an interactive telecommunications system. Under this proposal, services on the Medicare Telehealth Services List would no longer be designated "permanent" or "provisional", instead, all services listed or added would be included on a permanent basis. CMS would still reserve the right to remove services included on the Medicare Telehealth Services List based on internal review or feedback received from interested parties in accordance with its statutory authority.

STS supports CMS' proposal to simplify the Medicare Telehealth Services list to only include a list of covered telehealth services. As all the telehealth services on the list are covered regardless of their status, it makes sense to just have one all-inclusive list. We also agree with simplifying the review criteria by eliminating steps 4 and 5 which added unnecessary complexity to the process.

Frequency Limitations on Medicare Telehealth Subsequent Care Services in Inpatient and Nursing Facility Settings, and Critical Care Consultations

CMS proposes to permanently remove the frequency limitations for the subsequent hospital care services (CPT 99231-99233), subsequent nursing facility visits (CPT 99307-99310), and critical care consultations (G0508 and G0509) furnished via telehealth. These frequency restrictions were originally suspended in response to the public health emergency for COVID-19 and remained suspended through CY 2025.

STS is supportive of permanently eliminating the frequency limitations for the subsequent hospital care, subsequent nursing facility and critical care services. Removing the frequency limitations ensures that physicians and other practitioners can use their professional judgement to determine the type and number of visits and the type of treatment for the patient considering their circumstances and access to care.

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

Direct Supervision via Use of Two-way Audio/Video Communications Technology

CMS proposes permanently allowing certain services to be furnished under direct supervision that allows the immediate availability of the supervising practitioner using audio/video real-time communications technology (excluding audio-only). This would apply to all services provided incident-to a physician services, except for services with a global surgery indicator of 010 or 090. The agency proposes to apply this definition to the applicable cardiac, pulmonary, and intensive cardiac rehabilitation services. As part of this proposal, CMS is also seeking feedback on whether 000 global indicator procedures should be excluded due to patient safety concerns.

As with other provisions in this policy, STS has concerns with CMS applying blanket policies such as this to the code set. Services and the risks they entail for the patient should be the basis on which this policy is applied. If a HCPCS code is identified as being safe to provide in an incident-to manner under direct supervision, the global period for the procedure should not impact that. Varying the policy based on the associated global

period results in different levels of care for procedures that are deemed to be similar, which could result in unsafe care for patients. As we have commented previously, we encourage CMS to consider the clinical circumstances, supervisee experience level, and type of supervisee as factors that should influence the extent to which virtual supervision is appropriate.

Proposed Changes to Teaching Physicians' Billing for Services Involving Residents with Virtual Presence

CMS proposes to discontinue the current policy that allows teaching physicians to have a virtual presence for services furnished virtually. This would be reverting the pre-Public Health Emergency (PHE) policy which requires teaching physicians to provide appropriate oversight and personal involvement in resident-furnished services for which Medicare payment is sought. For services provided within metropolitan statistical areas (MSAs), physicians must maintain physical presence during critical portions of all resident-furnished services to qualify for Medicare payment, not just in-person services, ensuring consistent oversight standards. However, the rural exception for services provided outside MSAs, which was in place before the PHE, and allows teaching physicians in rural areas to utilize audio/video real-time communications technology to fulfill the presence requirement will remain in place. CMS clarifies that this proposal does not impact teaching physicians' ability to provide virtual supervision of residents for educational purposes.

While we agree with CMS that it is important to ensure consistent oversight standards for teaching physicians, we do not agree with their proposal to revert to the pre-PHE policy requiring teaching physicians in MSAs to maintain physical presence during critical portions of services furnished virtually. Many cardiothoracic surgery services, especially those provided to congenital cardiac patients, are in more populated areas. Patients often travel to receive their surgical services and once released from the hospital, return to their homes, facing transportation and other access challenges even when located within an MSA. In those circumstances, it is beneficial to the patient to allow the teaching physician to provide virtual oversight since the visit is already occurring via telehealth.

Valuation of Specific Codes

Proposed Efficiency Adjustment

CMS is proposing to implement an efficiency adjustment to the work RVUs and intraservice physician time inputs for non-time-based services under the PFS. This proposal assumes that physician time and work intensity decrease as practitioners gain expertise and technology improves. CMS cites longstanding concerns about the reliability of AMA RUC survey data, including low response rates, small samples, potential biases, conflicts of interest, and delays in updating valuations, which have led to many services remaining overvalued for long periods. By introducing this adjustment, CMS aims to address perceived distortions in the valuation of services and better reflect efficiency gains over time, with the potential for future updates to practice expense inputs.

STS has significant concerns about CMS' proposal to apply an efficiency adjustment to all non-time-based codes beginning in CY 2026 and again every three years if finalized. STS utilized data from the STS National Database to value adult cardiac and general thoracic procedures during the 5-year reviews that took place in 2005 and 2010. STS National Database data was used again in April 2012 when single arterial coronary artery bypass graft (CABG) (33533), aortic valve replacement (33405) and mitral valve replacement (33430) were reviewed as part of a CMS High Expenditure Procedural Codes screen. In that review, data from the STS National Database showed small but significant increases in intraservice time for CABG (151 to 158 minutes) and mitral valve replacement (223 to 232 minutes) and just a 1-minute decrease in time for aortic valve replacement (198 to 197 minutes).

For single arterial CABG procedures in 2012, data also showed increases in the incidences of diabetes, heart failure, cerebrovascular disease and peripheral vascular disease. The data supported that most of the composite variables that predict increased morbidity increased and the use of preoperative beta-blockers had increased. STS was able to provide information supporting that the patient population undergoing surgical myocardial revascularization changed dramatically due to two factors from 2005-2012 when the CABG codes were reviewed.

First, the drug eluting coronary stent was introduced in 2002-2003 and became prevalent at the very end of the 2000-2004 period used in establishing the current work values. This device led to dramatic shifts in the surgical population from patients having severe and diffuse coronary artery disease (and those with diabetes) toward percutaneous intervention.

The second major change in the patient population was the prevalence of dual antiplatelet drug therapy that occurred in 2004 when the FDA panel recommended at least 12 months of such therapy to minimize the occurrence of fatal drug eluting stent thrombosis. This increased the prevalence of dual antiplatelet therapy, and the introduction of other agents such as direct thrombin inhibitors and irreversible fractionated heparin products increased complexity and intensity of obtaining hemostasis during cardiac surgery. Those changes were further compounded by the withdrawal of aprotinin from the marketplace in 2006, which at that time was the only effective hemostatic agent in this anti-platelet drug environment, and was in widespread use during the 2000-2004 index period. While the RUC did not recognize the same methodology that was used in the 2005 and 2010 5-year reviews to determine a value, it did recommend an increase in value for 33533 in April 2012 based on the increased intra-service time and intensity caused by the changes in the patient population.

Instead of the previous methodology used to value codes with the STS National Database, the RUC used magnitude estimation using a direct crosswalk to CPT code 33510, Coronary artery bypass, vein only; single coronary venous graft and recommended a work RVU of 34.98. CMS did not accept the RUC recommended value and instead maintained the existing work RVU of 33.75 but increased the intra-service time to reflect the 2012 STS National Database time of 158 minutes. STS did not seek an increase to mitral valve replacement in the April 2012 review, despite a slight increase in intra-service time because the data did not support significant changes in the patient population at that time. CMS accepted the valuations for the procedures using the STS National Database time data in 2005 and 2010 despite hesitation due to concerns of fairness for other specialties without database data.

STS recently obtained updated data on the CABG codes (33510-33523 and 33533-33536) from the STS National Database, showing that the intra-service CABG times have increased since the codes were last reviewed by the RUC and CMS in 2005 and 2012. The recent data compiled from 1,448,393 procedures shows that the times for arterial or venous CABG codes have substantially increased by 12%, not decreased since the codes were last valued by the RUC and CMS.

In addition, a recent study in the Journal of the American College of Surgeons was released showing the intra-service time data (eg, skin-to-skin operative time) from 2019 and 2023 were compared for 1.7 million surgeries across 249 CPT codes and 11 surgical specialties from the National Surgical Quality Program (NSQIP) registry. The study concluded that “overall, operative times increased by 3.1% (CI 3.0-3.3%, $p<0.001$) in 2023 compared to 2019, or 0.8%/year (CI 0.7-0.8%/year, $p<0.001$). At the procedure level, 90% of CPT codes had longer or

similar operative times in 2023 compared to 2019."[2] This along with the data from the STS National Database provides empirical proof that counters CMS' presumption that intra-service physician time is overstated for all physician services.

While technological advances can have an impact on procedures and gaining experience with new technologies can improve over time, not all procedures involve significant technological shifts. Procedures such as CABG have not seen significant technological improvements. The surgical technique has not changed significantly since the codes were last valued. However, like primary care physicians caring for patients with multiple and chronic diseases, patients undergoing surgery have many added conditions and complications, which adds increased complexity to the procedures being performed. Patients undergoing surgical procedures have often had prior less invasive interventions which further increase the complexity of the surgery.

For CMS to treat all non-time-based procedures equally and assume that all procedure times decrease due to gains in efficiency over time is a severely flawed approach. Applying an efficiency reduction to all non-time based wRVUS and decreasing the intra-service times is detrimental to physicians and puts patient access and quality of care at risk. This proposal also discounts the very nature of the RBRVS system where procedures have been valued on their individual merits over the years, accounting for the time and intensity required to provide the service.

Additionally, CMS' proposal results in unequal treatment of physicians and other providers. Penalizing new physicians before they have even begun their practices and discounting the expertise of experienced physicians. Since new physicians are continually entering the system and experienced physicians retiring, there will always be a range of experience at any given time. CMS' proposal penalizes every procedural-based physician regardless of where they are in their experience. The expertise gained by physicians ensures that they can continue to safely and effectively treat a constantly changing and increasingly complex patient population. To assume that payment should go down because the length of procedures reduce is short-sighted and shows an inherent bias of CMS towards non-procedure-based services. There is no other profession that gets penalized for their experience and expertise. To impose this type of penalty on physicians and healthcare providers who have spent numerous years in training is an insult to the practice of medicine.

As part of the proposal, CMS also includes applying the efficiency adjustment to procedures that have been reviewed by the RUC within the past 5 years. This includes procedures for which CMS did not accept the RUC recommended value and already applied a downward adjustment and those procedures where values were decreased by the RUC based on time and other factors. To apply another downward adjustment to codes where reductions have already occurred results in additional undue decreases.

STS strongly urges CMS to abandon this ill-conceived idea and continue to work with the AMA RUC, specialty societies and other stakeholders to maintain the integrity of the RBRVS system by continuing to individually review and value services based on the time, intensity and individual merits associated with each procedure. If the goal of CMS is to shift money to primary care, then they should do so in an open and transparent process

[2] Childers, Christopher P MD, PhD; Foe, Lauren M MPH; Mujumdar, Vinita JD; Mabry, Charles D. MD, FACS; Selzer, Don J MD, MS, FACS; Senkowski, Christopher K MD, FACS; Ko, Clifford Y MD, MS, MSHS, FACS, FASCRS; Tsai, Thomas C MD, MPH, FACS. Longitudinal Trends in Efficiency and Complexity of Surgical Procedures: Analysis of 1.7 Million Operations Between 2019 and 2023. Journal of the American College of Surgeons ():10.1097/XCS.0000000000001588, August 13, 2025. | DOI: 10.1097/XCS.0000000000001588

that does not undermine and disadvantage procedure-based physicians and the integrity of the RBRVS. The valuation applied to services provided by all physicians should be thoughtfully and fairly evaluated to ensure continued access and quality of care for all patients, especially for physicians caring for an aging population and more complex patients.

Valuation of Specific Codes for CY 2026

Thoracic Branch Endograft Services (CPT codes 33880, 33881, 33883, 33886, 33XX2, and 35XX1)

CMS denied the RUC recommended values for all six of the Thoracic Endovascular Aortic Repair (TEVAR) codes, which includes four revised and two new services. CMS states "although we do not believe that changes in work time as reflected in survey values must equate to a one-to-one or linear change in the valuation of work RVUs, we believe that since the two components of work are time and intensity, decreases in the surveyed work time should typically be reflected in decreases to the work RVU." CMS found the RUC recommended work RVUs for the codes to be high, relative to other codes with the same or similar times. CMS recommended:

- *wRVUs of 27 instead of 30.00 for code 33880*
- *wRVU of 22.53 instead of 26.75 for code 33881*
- *wRVU of 35.00 instead of 39.00 for code 33XX2*
- *wRVU of 19.91 instead of 24.25 for code 33833*
- *wRVU of 19.91 instead of 23.50 for code 33886*
- *wRVU of 25.53 instead of 27.40 for code 35XX1.*

STS implores CMS to accept the RUC recommended wRVUs for these codes. The TEVAR code set was revised to include all radiographic supervision and interpretation (S&I), selective catheterizations and account for new technology to more accurately describe the current clinical practices and CPT coding standards. These procedures incorporate significant pre-service planning, intraoperative complexity, and extensive post-operative care that were not fully captured in the original code set or existing comparators. While the time for these procedures has decreased (supported by a strong multispecialty survey), the complexity increased substantially (also supported by a strong multispecialty survey) which was reflected in the smaller reduction in wRVUs as recommended by the RUC.

Increased intensity for TEVAR procedures comes in the form of a change in the patient population since the devices were first introduced 20 years ago. With the improvement of device technology, a broader range of patients are treated with TEVAR. The type and extent of aortic pathology which can be treated has increased dramatically since the initial valuation of these codes in 2005. Previously these were short lesions, now the lesions are typically longer, more tortuous, and more complex.

TEVAR patients are typically frail, elderly, with multiple co-morbidities, and unable to tolerate open surgical intervention. Additionally, these patients are at high risk for complications during and after the procedures which carry the real risk of permanent paralysis, anterior or posterior circulation strokes, retrograde type A Aortic Dissection necessitating sternotomy, aortic or iliac rupture, MI, temporary or permanent dialysis, or even death. All pre-operative, intra-operative, and post-operative care is meant to minimize these devasting complications. The procedures have an increasing risk of spinal cord ischemia as more of the thoracic aorta is covered. Spinal cord blood supply is directly from lumbar arteries in the thoracic aorta and a lumbar drain is placed prior to TEVAR to help minimize the risk of spinal cord ischemia. The operating surgeon manages these risks by managing blood pressure and intra-spinal pressure in conjunction with regular neurologic assessments, which is critical to ensure spinal perfusion and minimizing the risk of paralysis.

As indicated, CMS' primary rationale for reducing the RUC-recommended RVUs appears to rest on overall decreases in the work times surveyed. However, these times do not directly translate into linear changes in RVU valuation. The intensity of physician work, including advanced procedural planning, imaging review, coordination with multi-disciplinary teams, intraoperative decision-making, and critical post-op management, has substantially increased with the complexity of current TEVAR procedures.

The RUC recommended wRVU of 30.00 for code 33880 represents a 15.2% reduction from the prior valuation of 34.58. CMS decreases this valuation even further to 27.00. In their rationale, CMS notes that the RUC proposed work valuation is "nearly" higher than other 90-day global codes with similar times and proposes a crosswalk to code 32672 (thoracoscopy, surgical; with resection-plication for emphysematous lung ((bullous or non-bullous)) for lung volume reduction, unilateral includes any pleural procedure, when performed). To value 33880 at the same wRVU as 32672 based only on time similarities, discounts the intensity of the procedure, which includes extensive pre-operative planning and critical care during the global period. The RUC recommended value for the code, although at the higher end of the range for the intra-service time is still within an acceptable range and maintains relatively with other codes using the CMS proposed brackets [with a lower bracket of CPT code 43820 (gastrojejunostomy; without vagotomy) at a work RVU of 22.53 and an upper bracket of CPT code 34702 (endovascular repair of infrarenal aorta by deployment of an aorto-aortic tube endograft including preprocedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the aortic bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the aortic bifurcation; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (for example, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)) with a work RVU of 36.00. We appreciate CMS acknowledging the range of RVU includes the RUC recommended value.

The RUC recommended wRVU of 26.75 for code 33881 represents a 10.6% reduction from the prior valuation of 29.58. CMS again uses crosswalk methodology for a comparator code with very low intensity code, 43820 (Gastrojejunostomy; without vagotomy). As with code 33880, the complexity of the comparator crosswalk code does not reflect the intensity and risks associated with 33881. The RUC proposed value of 26.75 is still within an acceptable range and sits relatively within the CMS proposed brackets.

For code 33XX2, the CMS proposed value of 35.00 is based on a crosswalk to CPT code 33390 (valvuloplasty, aortic valve, open, with cardiopulmonary bypass; simple ((eg, valvotomy, debridement, debulking, and/or simple commissural resuspension)) instead of the RUC recommended value of 39.00. Code 33XX2 is a new code that involves endografting that can extend into the transverse aortic arch. Cardiothoracic surgeons perform both procedures and while the times are similar, the complexity and intensity of code 33XX2 is greater than that associated with 33390. While both codes treat complex patient populations, code 33390 tends to represent a less intense procedure accomplished via an open approach with cardiopulmonary bypass. The TEVAR code requires increased technical skill and has a higher risk of injury due to the nature of the treatment and the complexity of disease process which is reflected in the higher intensity associated with the RUC recommended value. This increased intensity is supported through the survey where 83% of physicians who perform this procedure selected code 34706 (Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for rupture including temporary aortic and/or iliac

balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)) as the top key reference service and indicating that the survey code was a somewhat more or much more intense service to perform than a ruptured infra-renal abdominal aortic aneurysm.

The RUC recommended wRVU of 24.25 for code 33883 represents an 11.3% reduction from the prior valuation of 27.00. As with the other codes in this family, CMS proposes a value of 19.91 based on a crosswalk to CPT code 44320 *(Colostomy or skin level cecostomy).* While the intraservice time is the same as the comparator, code 44320 has very low complexity relative to the proposed code. The intensity remains high for code 33883 which is an extension endograft that still carries the risk of spinal cord ischemia and coverage of the subclavian is similar or even more than 33881. When physicians who perform this procedure were surveyed by the RUC, 80% of the physicians that selected top key reference code 34701 indicated the survey code was somewhat more or much more intense service to perform. The brackets recommended by CMS are not reflective of a knowledge of the surgical procedure nor the complexity of endovascular aortic procedures.

As with the other codes in this family, CMS disagreed with the RUC-recommended value of 27.40 for code 35XX2, instead using a crosswalk to CPT code *32669* (Thoracoscopy, surgical; with removal of a single lung segment (segmentectomy)) to recommend a value of 23.53. There are several CPT codes with intra-service times of 120-150 minutes and similar total times with wRVUS that are in the 26-29 range (e.g., 32672, 34703, 34705) that support the RUC recommended value for code 35XX2. Of the physicians who perform this procedure, 63% selected code 35601 as the top key reference code and indicated the survey code was somewhat more intense or more intense service to perform. Total time for physician survey first reference code is nearly identical to the proposed code and the RUC approved RVU value is similar.

STS urges CMS to reconsider the proposed reductions and adopt the RUC-recommended work RVUs for the new TEVAR code family. Yet again, STS continues to be concerned with CMS' inability and unwillingness to appropriately account for the intensity in valuing complex procedures such as these. We encounter this bias almost every time codes are revalued. Although CMS repeatedly states that they account for intensity in their valuations and not just time, their constant downward adjustments and rationales based on time alone do not reflect this practice. The RUC recommendations for the TEVAR family of codes are based on robust survey data, detailed clinical vignettes, and a thorough understanding of modern endovascular aortic repair with significant complexity and risks that were not present when these codes were initially valued. CMS' proposed values do not reflect the work and intensity of these codes and place them improperly in a relative value-based fee schedule. The RUC recommendations maintain relativity within the code family and across other similar 90-day global period codes and the fee schedule.

Strategies for Improving Global Surgery Payment Accuracy

<u>Strategies to Address Global Package Valuation</u>

CMS continues to express concerns about the accuracy of the global surgery payment. In the CY 2025 PFS final rule, CMS formalized their proposal requiring the use of modifier -54 (surgical care only) for formal or informal transfers of care for procedures with a 90-day global period, that is for all cases where the physician plans to furnish only a portion of the procedure. Data collected from this initiative has not been shared by CMS yet. For CY 2026, CMS is seeking comments related to the updated transfer of care policy on strategies to improve the payment accuracy for global surgical packages. CMS indicates that there are currently about 5,500 that are 0-, 10-, or 90-day globals and clarifies that the global packages apply to the practitioner performing the procedure, and in the case of a group practice, to the entire group practice.

CMS is considering approaches to establishing the payment allocations for portions of the global package when the transfer of care modifiers are used. The current methodology for payment when modifier 54 is reported with a global code indicates that Medicare pays a "fixed share" of globals valuation and that the "procedure shares" are based on "long-standing assumption and are clustered at certain values." However, CMS indicates that "currently, there is no clear basis for the current procedure shares" and that they are once again seeking public comments on what the procedure shares should be based on for the 90-day global packages as well as comments on current practice standards and division of work between surgeons and providers of post-operative care.

As part of their proposal, CMS outlines three alternatives "to the status quo" for establishing the "procedure shares" asserting that based on input from the RAND Corporation, "current procedure shares do not reflect the real-world division of work between surgeons and providers of post-operative care". The proposals include the following:

1. *Approach B: CMS calculates work RVUS "by subtracting work RVUs assigned to each post-operative visit listed in the Physician Time File for a global procedure HCPCS code from the total valuation of the global surgical package" expressing concerns that the "procedure shares" under this approach could only be updated when a global is revalued and relies on the visit count that CMS believes is too high.*
2. *Approach C: CMS calculates work RVUs by subtracting the work RVUs for post-operative visits by multiplying the number of post-op visits "typically" provided for the global procedure, which CMS is defining as "the median count of post-operative visits reported to CMS using no-pay code 99024" by the average by the average valuation per post-operative visit calculated for the number and level of post-op visits as listed in the physician time file. CMS states that it focuses more heavily on this approach because it "reflects real-world, observed patterns of post-operative care" and it "allows for routine, transparent updated of procedure shares over time".*
3. *Approach D: CMS calculates work RVUs as the product of the code's total time physician time in the Physician Time File and the ratio of physician time assigned to post-op visits in the Physician Time File to total physician time ([Total Physician Time]*[Post-Op Physician Time/Total Physician Time]). CMS expresses concerns that under this proposal, the "procedure shares" could only be updated when a global is revalued and relies on the visit count that CMS believes is too high.*

The table below shows the resulting "procedure shares" for the current or "status quo" (Approach A) and other proposed methodologies for some of the signature cardiothoracic procedures.

STS continues to support CMS' goal to ensure that payments to practitioners and the relative values assigned to global surgical packages are accurate and represent real-world objective and updateable information regarding the relative resources involved in furnishing the services. However, STS has significant concerns with CMS relying on any of these proposed methodologies to update the "procedure shares" for the global packages.

The proposed options do not offer appropriate or viable alternatives to the status quo legacy procedure share ratios used in the transfer of care policy, because at the very core of their proposals they would be using flawed data. CMS still has not addressed the mis-valuation of the bundled post office visits relative to analogous stand-alone E/M visits by passing along the increased work values and practice expense inputs of the inpatient hospital and observation care visits (99231-99233, 99238 and 99239), and office visits (99202-99215) to the E/M services included in the global package. Because of this, any consideration of the currently valued global packages will be based on inaccurate values. Failure to adjust for the increase in post-operative

visits in the global period continues to fracture relativity in the fee schedule and impedes accurate comparison among services.

In addition, STS continues to have substantial concerns with the RAND reports and maintains that CMS cannot make informed decisions about the future of global surgical payments based on these flawed studies. As detailed in our CY 2023 comment letter, we do not believe that Medicare claims data for 99024 accurately captures and in fact, tends to underrepresent, the number of visits furnished in global surgical procedures. Given the difficulty CMS and RAND researchers have encountered in aligning CPT code 99024 with specific CPT codes and the limited participation of eligible physicians, 99024 should not be used to determine the accuracy of surgical global payment.

STS urges CMS to correct the currently flawed global package valuations by applying the full increase of work and physician time for the inpatient hospital and observation care visits (99231-99233, 99238 and 99239), and office visits (99202-99215) to the global surgical package before trying to assess "procedure share" values to ensure that any changes are based on accurate values.

Determination of Malpractice Relative Value Units (RVUs)

Methodology for the Proposed Revision of Resource-based Malpractice RVUs

CMS proposes to update MP RVUs using updated premium data obtained from state insurance rate filings. CMS notes that in setting MP RVUs, it relies on specialty-level risk values which are derived from:

- *Data on specialty-specific MP premiums incurred by practitioners;*
- *Service-level risk values derived from Medicare claims data of the weighted average risk values of the specialties that furnish each service; and*
- *Intensity/complexity of service adjustment to the service level risk value based on either the higher of the work value or the clinical labor portion of the direct PE RVU.*

For 2026, CMS does not propose any major methodological refinements to the process for collecting professional liability insurance premium data or determining PLI RVUs.

STS appreciates CMS' efforts and their commitment to continue to improve their data collection efforts to ensure that accurate, updated, specialty-specific data is used to reflect the most accurate trends in professional liability premiums. The proposed CY 2026 risk index for thoracic surgery (33) is 2.90 compared to 2.81 in 2025 and the proposed risk index for cardiac surgery (78) is 2.75 compared to 2.63 in 2025. STS agrees with the proposed MP RVU updates for CY 2026 and as indicated above, we continue to support CMS' use of expected specialty overrides for low volume service codes as noted in our comments above.

Updates to the Quality Payment Program

Transforming the Quality Payment Program

Subgroup Reporting

CMS finalized that, beginning with the CY 2026 performance period/2028 MIPS payment year, an MVP Participant means an individual MIPS eligible clinician, single-specialty group, subgroup, or APM Entity that is assessed on an MVP for all MIPS performance categories. CMS excluded "multispecialty group" from the MVP participant definition beginning with the CY 2026 performance period/2028 MIPS payment year and replaced

the term with "subgroup" to account for the requirement for multispecialty groups to divide into subgroups if they choose to report MVPs.

Mandating subgroup reporting for MVPs starting in CY 2026 is premature, as many specialties currently lack clinically relevant measures within the available MVP options. For instance, the present suite of MVPs does not include any measures applicable to general thoracic surgeons, leaving these clinicians without meaningful pathways for participation. Moving forward with mandatory subgroup reporting before the measure set is sufficiently robust for all specialties may inadvertently disadvantage those for whom appropriate metrics do not exist, ultimately undermining the intent of the program to foster meaningful quality improvement across the healthcare spectrum.

While in previous years, CMS has cited less MVP options due to concerns over an abundance of measure choice, STS believes this goes against the administration's current goals. Providing more measure options for providers is a significant step towards deregulation and reducing the administrative burden on physicians. By allowing them to report on measures that are already integrated into their daily workflow, it eliminates the need for extra work to report on measures that fall outside their regular scope of practice. This approach not only streamlines the reporting process but also enhances the efficiency and effectiveness of healthcare delivery, as physicians can focus more on patient care rather than administrative tasks.

Core Elements Request for Information (RFI)

CMS is considering proposing a Core Elements policy in the CY 2027 PFS proposed rule and proposing the policy for implementation prior to the sunset of traditional MIPS. Specifically, CMS is considering a policy to require an MVP Participant to select one quality measure from a subset of quality measures in each MVP, referred to as "Core Elements." MVP Participants would select the other three required quality measures and would still have to meet existing MVP reporting requirements.

STS has some concerns about the use of the core element measures that would be selected in each MVP. Currently, cardiothoracic surgeons are only able to report on measures within the Surgical Care MVP candidate which lumps multiple surgical subspecialties into a general surgical framework. The Surgical Care MVP lacks the specificity and applicability to impact the providers reporting it. By attempting to fit general surgery, cardiothoracic surgery, gastroenterology, neurosurgery, and orthopedic surgery measures into one MVP model, CMS fails to provide a meaningful pathway for specialists to be measured. The measures included in the model are not "limited, connected, or complementary" as emphasized by the current MVP Guiding Principles. The MVP is muddied by including measures across distinct populations without consideration of how these populations are treated in practice and does not allow for significant comparison or quality improvement. Therefore, including a core element measure that all surgical specialists report on makes little clinical sense. If CMS does go forward with this proposal, it would be pivotal for the CABG measures to be moved to the Advancing Care for Heart Disease MVP which would be more representative of team-based care.

Traditional MIPS

Cost Category Scoring

CMS proposes that, beginning with the CY 2026 performance period/2028 MIPS payment year, it would score all new cost measures for the first 2 years after the measure is initially finalized for informational only purposes; CMS would not incorporate any informational-only scores on cost measures into MIPS eligible clinicians' cost performance category score or MIPS final score.

STS supports CMS' proposal to score all new cost measures for the first two years after they are initially finalized for informational purposes only. We believe that equipping providers with information and transparency on cost data is essential before incorporating these scores into the MIPS final score. This approach will allow providers to understand and adapt to the new measures, ensuring a smoother transition and more accurate performance evaluations in the future.

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

Sincerely,

Joseph F. Sabik III, MD
President