SVS Society for Vascular Surgery

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September 10, 2025

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1832-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: File Code CMS-1832-P; Medicare Program; 2026 Payment Policies under the Physician Payment Schedule and Other Changes to Part B Payment and Coverage Policies; (July 16, 2025)

Dear Administrator Oz:

The Society for Vascular Surgery (SVS) is a professional medical specialty society, composed primarily of vascular surgeons, that seeks to advance excellence and innovation in vascular health through education, advocacy, research, and public awareness. The SVS, on behalf of its approximately 6,400 members, offers comments on the Centers for Medicare and Medicaid Services (CMS) Notice of Proposed Rule Making on the revisions to Medicare payment policies under the Medicare Physician Payment Schedule (MPFS) for 2026, published in the July 16, 2025, *Federal Register (Vol. 90, No. 134 FR, pages 32352-33261)*.

SVS Comments re: CY2026 revisions to payment policies under the Medicare Physician Fee Schedule (MPFS)

Stabilizing Payment for Physicians

Vascular surgeons, like many specialists, face unique challenges in maintaining high standards of care amid rising costs and undervalued services. While recent legislative action, including a 2.5% increase to the MPFS conversion factor (CF) for CY2026, provides a short-term step in the right direction, policymakers with the Administration and Congress must establish a cohesive policy development and legislative process for the advancement of long-term reforms designed to ensure a physician payment system that is predictable, fair, and sustainable. The SVS is concerned that CMS' proposed policies included in the CY2026 MPFS continue to exacerbate the underlying problems within the broken Medicare physician payment system. Furthermore, these policies negatively impact the ability of physician practices to invest in quality improvement efforts that benefit Medicare patients, or transition to alternative payment models when appropriate.

Beginning in 2026, there will be two separate conversion factors for Qualifying APM Participants (QPs) and non-QP clinicians. The update to the qualifying APM conversion factor (which applies to PFS payments for QPs) for CY 2026 is 0.75 percent while the update to the nonqualifying APM conversion

factor (which applies to PFS payments for all other clinicians) for CY 2026 is 0.25 percent. The change to the PFS conversion factors for CY 2026 includes these updates as required by statute, a one-year increase of +2.50 percent for CY 2026 stipulated by statute, and an estimated 0.55 percent budget neutrality adjustment necessary to account for proposed changes in work RVUs. Thus, the CY 2026 qualifying APM conversion factor represents a projected increase of $1.24 (3.83%) from the current conversion factor of $32.35, for a total of $33.59. Similarly, the CY 2026 nonqualifying APM conversion factor represents a projected increase of $1.17 (3.62%) from the current conversion factor of $32.35, for a total of $33.42.

Additionally, the conversion factors are affected by a positive 0.55 percent budget neutrality adjustment resulting from proposed misvalued code changes and a -2.5 percent efficiency adjustment, which CMS proposes to apply to work RVUs and the corresponding intra-service portion of physician time of non-time-based services that CMS believes accrue gains in efficiency over time. This new efficiency adjustment impacts most surgical specialties, radiology, and pathology by reducing overall payment by one percent.

Preliminary SVS analysis, in addition to the impact charts provided in the proposed rule by CMS indicate that the combined impact for vascular surgeons for CY2026 is +5%. However, there is a significant underlying differential based on site of service and case mix. This is the first time in several years that payments for vascular surgeons (overall) are slated to increase. However, the impact for individual vascular surgeons will be determined by their practice setting and case mix.

TABLE 92: CY 2026 PFS Estimated Impact on Total Allowed Charges by Specialty						
(A)	(B)	(C)	(D)	(E)	(F)	(G)
Specialty	Allowed Charges Non-Facility/Facility	Allowed Charges (mil)	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of MP RVU Changes	Combined Impact*
VASCULAR SURGERY	**TOTAL**	**$929**	**0%**	**5%**	**0%**	**5%**
	Non-Facility	$656	0%	9%	0%	9%
	Facility	$273	0%	-6%	1%	-6%

Mandating deep cuts to certain physician services for no reason other than to increase payments for other physician services is an unfair and outdated policy. This pattern is repeated year after year via the constraints of budget neutrality—or more acutely in the CY2026 proposed rule—from seemingly arbitrary policy proposals that significantly impact the various inputs utilized to derive payments for various physician services. The proposed payment differential for vascular surgery based on site of service differential is a prime example of the impact of such policies. Policymakers must commit to modernizing our payment systems so that physicians are freed from the "zero-sum" methodology that has been relied on for so long, which ultimately hinders team-based, coordinated care.

SVS has concerns that these ongoing and repeated cuts by CMS will measurably reduce the ability for vascular surgeons to provide critical services to vulnerable populations. Systemic issues such as the negative impact of the Medicare physician fee schedule's budget neutrality requirements and the lack of an annual inflationary update will continue to generate significant instability for health care clinicians moving forward, threatening beneficiary access to essential health care services.

SVS believes that our policy makers, both within the Administration and in Congress, have a duty to ensure a stable physician payment environment that allows multiple physician practice models — independent private practice or hospital/health system employment — to thrive. Failure to do so will contribute to the ongoing, costly consolidations of the health care delivery system, hinder patient access to the physician of their choice, and hamper efforts to move toward safe, accountable, higher-quality care. A strong Medicare payment system should provide financial stability through a baseline positive annual update reflecting inflation in practice costs, and eliminate, replace, or revise budget neutrality requirements to allow for appropriate changes in spending growth.

SVS Recommendation: CMS must work with Congress and applicable stakeholders to identify and advance Medicare physician payment reform policies that will provide long-term stability for physicians serving patients within the Medicare program. We urge CMS to actively engage with both Congress and the physician community to introduce and advance legislation reflective of the following concepts:

- Establishing a permanent inflationary update to the MPFS.
- Eliminating or adjusting the budget neutrality requirements within the MPFS to help ensure payment stability for physicians providing care for Medicare beneficiaries.

Methodology for Establishing Work RVUs – Proposed Efficiency Adjustment

CMS is proposing a negative two and a half percent adjustment to over 7,000 non-time-based codes starting in 2026 and proposing that the efficiency adjustment be applied every three years. CMS stated in the proposed rule that they believe non-time-based procedures become more efficient as they become more common, professionals gain more experience, technology is improved, and other operational improvements are implemented. CMS also stated that when a code is reviewed by the RUC, 2 to 3 years usually pass between when the survey data was collected and its use by CMS in setting rates becomes effective. Finally, CMS is proposing a five year look back period for the initial application of the efficiency adjustment, thus the 2.5% figure was derived by tallying the last five years' private, non-farm, productivity adjustments in the Medicare Economic Index (MEI).

CMS is soliciting comments on the initial look-back period, the use of the MEI productivity adjustment percentages, whether adjustments should be made in future rulemaking to also adjust the direct practice expense (PE) inputs for clinical labor and equipment time that correspond with the physician time inputs.

Certain professions may experience increased efficiency over time due to technological advances and automation. Automation can replace some tasks previously performed by humans, reducing the demand for workers in certain roles (e.g., data entry clerks, manufacturing and production workers, bank tellers, postal service workers, bookkeepers, accountants, financial analysists, and customer service positions). Automation can also make it easier for companies to operate with fewer employees or relocate their operations to regions with lower labor costs. As a result, when tasks become easily automated, employers may have less incentive to negotiate higher wages or provide better benefits, diminishing workers' leverage. Surgery is NOT automated. Surgery is performed by human beings on human beings, and the last thing you want when a surgeon is operating on you is to think he/she is trying to "Beat the Clock."

In this proposal, CMS is equating efficiency with speed—then saying if a procedure is faster, it should be paid less. As a result, CMS is proposing that 8,960 services have gotten faster and should be paid less starting in 2026. *(CY 2026 PFS Proposed Rule Codes Subject to Efficiency Adjustment)* CMS states that it will exempt 389 codes, including time-based services, E/M, care management, maternity care, and services on the CMS telehealth list, from this efficiency adjustment.

Surgeries don't become more "efficient"/faster as they become more common. A recent study released in the Journal of the American College of Surgeons, found that the proposed efficiency adjustment is not supported by real world surgical time data. Intra-service time data (i.e., 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 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."[1]

Professions, like medicine, require critical thinking, complex problem-solving and creativity. These necessary attributes cannot be replaced by automation or artificial intelligence. Humans are at the heart of surgeries, not automatic processes or robots. Technology can play an important role in surgeries. However, it is not technology that, for instance, makes it easier to search our phones for pictures of our favorite pet or analyze our spending habits from prior months. Technology in medicine is different. Technology in medicine might:

- Allow a surgeon to perform an operation on a more complex patient;
- Provide some physical relief to the surgeon who is operating on a morbidly obese patient; or
- Allow a surgeon to perform a surgery for a new indication.

It is important to make this distinction to keep patients safe.

The "To Err is Human" report was a landmark publication by the Institute of Medicine (IOM) in 1999, focusing on patient safety and the need to address medical errors in the US healthcare system. It was a comprehensive report that highlighted the extent of preventable medical errors and their impact on patient safety, leading to a call for system-wide changes. The proposed efficiency adjustment—which reduces the value of surgeries and pushes surgeons to operate faster, not safer—will actually undermine other initiatives and advancements made to improve patient safety and will move patient care in the wrong direction.

MEI: Productivity Adjustment

CMS indicates in the proposed rule that they apply a productivity adjustment to inpatient and outpatient hospital payment. It is important to note that hospitals receive an annual MEI update to account for inflation. Physicians do not receive an MEI update, so penalizing them with a productivity adjustment is not comparable to hospital payment.

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[1] 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

Recently Valued Services

CMS proposes to also apply the efficiency adjustment to all recently reviewed services. They argued that when a code is reviewed by the RUC, two to three years usually pass between when the survey data was collected and its use by CMS in setting rates becomes effective.

However, and in this proposed rule, CMS is considering RUC recommendations for Baroreflex Activation Therapy (BAT), Thoracic Branch Endograft Services (TEVAR), and Lower Extremity Revascularization (LER), which represent three families of vascular services which were surveyed in November 2024. The effective date for these new/adjusted codes is January 2026, only 13 months from the survey date. This contradicts the CMS assumption about two-to-three-year lag time.

SVS Recommendation

In this proposed rule, CMS expresses concern regarding the frequency of CPT code reviews and the validity of the current survey process. As such, they are proposing a cut to most services in the fee schedule, starting 1/1/2026. The proposal is disruptive to the entire house of medicine and punitive to all non-primary care providers.

CMS estimates that codes are reviewed on average every 25.49 years (this includes 5382 out of 9970 codes which were never reviewed). When they exclude from the average those codes that have never been reviewed, the average is 17.69 years since the last review of a code by the RUC.

The figures CMS sites are entirely misleading. SVS directs CMS to the AMA comment letter which outlines in detail the number of codes that have been reviewed by the Relativity Assessment Workgroup (RAW) and the RUC over the past 20+ years. It is important to note that CMS did not volume weight their analysis. Virtually all CPT codes performed in Medicare patients more than 10,000 times per year have been reviewed by the RUC, oftentimes more than once. Only rarely performed procedures have not been reviewed.

It is also important to note that services are valued in the PFS based on a typical patient, not on the hardest cases, and the -22 modifier to request payment for extremely difficult cases is almost always denied. Finally, the "speed" at which a surgeon operates has a complex relationship to years of experience. New surgeons are cautious and operate slowly. Mid-career surgeons typically operate somewhat faster, but then as surgeons age, they slow down again. For reasons cited here, an efficiency adjustment is not justified, and is, in fact, totally inappropriate.

The SVS recommends:

- Not moving forward with the productivity adjustment for CY2026;
- ONLY considering a future productivity adjustment policy after CMS implements annual inflation-based update to the PFS;
- Not utilizing look-back periods;
- Not applying efficiency adjustments to direct practice expense inputs; and
- Establishing a process where codes/families of codes are identified through rule making for potential application of productivity adjustment.

Note: Source Files
The productivity adjustments for 2022 – 2026 are not listed in either of the CMS online tables related to the MEI or in information available from the U.S. Bureau of Labor Statistics (BLS). Although CMS states on page 32402 that these productivity figures reflect "historical data at the time of the CY update," for only two of the past four years shown in the table were we able to find any data source to validate the figures in Table 11. Failure to provide underlying data represents a violation of notice and comment provisions.

Updates to Practice Expense Methodology – Site of Service Payment Differential

For 2026, CMS proposes a significant change to the practice expense methodology. The proposal would reduce a key input for the indirect component of the facility PE RVU formula—the work RVU input—to 50 percent of the amount used for non-facility PE RVU computation. This is a substantial change as the work RVU in the PE formula serves as a proxy for how much time indirect resources are used when providing a service.

CMS noted that the purpose of this proposal is to address their concern for the potential for duplicative payment under the current PE methodology for allocating indirect costs for physicians practicing in the facility setting.

CMS' proposal reduces the indirect PE RVUs for hospital employed physicians as well as for private practice physicians performing procedures in a facility setting. The proposal does not differentiate physicians who incur indirect expenses verses those that do not incur expenses.

When private practice physicians perform a service in the facility setting, they incur indirect expenses, for example, coding and billing and scheduling. These administrative costs are paid for via the professional claim. It is important to note that when physicians are directly employed by the hospital, hospitals often 'charge' the physician-related costs (e.g., administrative, coding/billing, rent) to the department or unit.

SVS Recommendation

CMS should define "hospital employed physicians (HEP)," establish a new self-reported modifier to signify a HEP and apply an appropriate reduction to the indirect expenses in those instances only.

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

Endovascular repair of thoracic aortic aneurysms (TEVAR) received FDA approval in March 2005 following the pivotal trial utilizing the Gore Thoracic Endoprosthesis (TAG) device. This was approximately five years after the FDA approval of endovascular devices for abdominal aneurysm repair. A family of TEVAR codes was presented to the RUC in April 2005. At that time, TEVAR was typically performed by a team of physicians, including vascular surgeons, cardiothoracic surgeons, and interventional radiologists, and utilized component coding to account for various physicians and portions of the procedure performed. The TEVAR family of codes appeared in the 2006 MFS, and the values have not been reviewed since then. In May 2022, the FDA approved the use of thoracic branch endoprosthesis (TBE) during TEVAR procedures. This was the first new type of device to gain FDA approval within the TEVAR code family.

The new six-code family for TEVAR was developed to align with current clinical practices and CPT coding standards. It represents a complex set of operations that now include pre-planning, all radiologic supervision and interpretation, all routine catheterization, and all currently placed extensions at the

initial time of TEVAR. 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. Additionally, all radiographic S&I and selective catheter codes have now been bundled into the primary TEVAR codes. Deletion of the bypass codes at the time of TEVAR helps simplify coding by reducing the number of codes that describe the same work, which can lead to confusion and improper coding. The specialty societies surveying this code family requested modification to the 090-day survey tool to include language regarding pre-planning time, changes that were similar to those made to the endovascular aneurysm repair (EVAR) survey tool for the January 2017 RUC meeting and the Iliac Branched Endograft survey tool for the January 2019 RUC meeting. With these modifications, the survey tool provides survey respondents with the opportunity to account for this pre-planning time, which is extensive and often occurs more than 24 hours before the procedure due to surgical complexity. The two new codes and four revised codes in the TEVAR family were all surveyed for the January 2025 RUC meeting.

Work Neutrality and Utilization Assumptions

CPT codes 33880, 33881, 33883 and 33886 involve newly established bundling that affects work neutrality and utilization assumptions. In the CMS utilization crosswalk spreadsheet, there is an issue regarding the correct valuation of these revised services resulting from a mathematical error. This occurred because CMS double-counted the utilization for the new codes that had catheter placement, radiologic supervision/interpretation, and all proximal extensions performed at the time of TEVAR, which are now bundled into the main procedure. CMS may have misinterpreted the RUC's proposed utilization crosswalk recommendations, which inadvertently increased the utilization of revised CPT codes 33880, 33881, 33883 and 33886. For example, this misinterpretation may be attributable to the text saying, "Bundled into 33880" instead of "Savings (bundled into 33880)." There is a discrepancy of 25,176 work RVUs included in the CMS utilization assumptions compared to what the RUC originally submitted.

SVS Recommendation

SVS urges CMS to correct the mathematical error on which the current work RUVs for CPT codes 33880, 33881, 33883 and 33886 are based and accept the RUC recommended work RVUs of 30.00 for CPT code 33880, 26.75 for CPT code 33881, 24.25 for CPT code 33883, and 23.50 for CPT code 33886.

Code Family

CMS disagrees with the RUC recommended work RVUs for all six codes in this family. In their rationale, they note that the RUC recommended work RVUs for the existing codes in this family do not appear to fully account for the overall decreases in time based on the results of the RUC survey. Moreover, CMS states that the RUC recommended work RVUs for all six codes are higher in value relative to other codes with the same or similar times in the 090-day global period. CMS clarifies that changes in work time based on survey values do not have to reflect a one-to-one or linear change in the valuation of work RVUs and notes that decreases in the surveyed work time should typically be reflected in decreases to the work RVU.

SVS disagrees with CMS' proposed direct crosswalks and work RVU recommendations for all six of these codes. SVS agrees 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." (Proposed Rule pg. 32408); however, as is the case with TEVAR, the intensity has increased substantially, which results in less reduction in the work RVU. As was discussed and accepted at the RUC meeting, though the time for these procedures has decreased, the complexity has increased, and both conditions were supported by

a strong multispecialty survey. Notably, the patient population has changed in the last 20 years. With the improvement of device technology, a broader range of patients can be treated with TEVAR. The type and extent of aortic pathology that can be treated has also 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. The patients are typically frail, elderly, and have multiple comorbidities. They are generally unable to survive open surgical massive thoracic aorta operations and are at high risk for complications even during endovascular-procedures.

This is a unique procedure that has the real risk of permanent paralysis, anterior or posterior circulation strokes, retrograde type A aortic dissection necessitating sternotomy, aortic or iliac rupture, myocardial infarction, temporary or permanent dialysis, or even death. All the pre-operative, intra-operative, and post-operative care is meant to minimize these devastating complications. One of the most feared complications with TEVAR, which is different from other endovascular treatments of the aorta, is paralysis. There is an increased 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, with the largest being the artery of Adamkiewicz. To minimize the risk of spinal cord ischemia, a lumbar drain is placed prior to TEVAR. This must be managed in the ICU by the operating surgeon. Blood pressure and intraspinal pressure management, in conjunction with regular neurologic assessments, is critical to ensure spinal perfusion and minimize the risk of paralysis. Given the tenuous nature of these patients, this care is reserved for the operating surgeon.

The primary rationale in CMS' proposal for reducing the RUC recommended work RVUs rests on the overall decrease in surveyed work times. However, these times do not directly translate into linear changes in work RVU valuation. The intensity of physician work, including advanced procedural planning, imaging review, coordination with multidisciplinary teams, intraoperative decision-making, and critical post-operative management, has substantially increased with the complexity of modern TEVAR procedures. It is worth noting that the current typical use and subsequent management of spinal drains were not described in the original 2005 vignettes for CPT codes 33880, 33881, 33883, and 33886.

The RUC recommendations are based on robust survey data, detailed clinical vignettes, and a thorough understanding of modern endovascular aortic repair with significant intensity/complexity and risks that were not present when these codes were initially reviewed and valued. SVS disagrees with the CMS' proposed values for each code in this family as they do not accurately reflect the work and intensity of these codes and fundamentally place them improperly in a relative value-based payment schedule.

<u>33880</u>
For CPT code 33880, CMS disagrees with the RUC recommended work RVU of 30.00 and proposes a work RVU of 27.00, which is based on a direct crosswalk to CPT code 32672 *Thoracoscopy, surgical; with resection-plication for emphysematous lung (bullous or non-bullous) for lung volume reduction (LVRS), unilateral includes any pleural procedure, when performed* (work RVU = 27.00, 120 minutes intra-service time, 567 minutes total time). In their rationale, CMS states that the RUC recommended work RVU of 30.00 does not maintain relativity across other 90-day global period codes with the same intra-service time of 120 minutes and a similar total time of approximately 546 minutes. When compared to CMS' proposed direct crosswalk to CPT code 32672, CPT code 33880 requires an identical intra-service time of 120 minutes and requires a similar total time (546 minutes as compared with 567 minutes). Additionally, both CPT codes 33880 and 36672 require two post-operative office visits in the global period.

To support their direct crosswalk recommendation to CPT code 32672, CMS also compared CPT code 33880 to CPT code 43820 *Gastrojejunostomy; without vagotomy* (work RVU = 22.53, 120 minutes intra-service time, 545 minutes total time) and CPT code 34702 *Endovascular repair of infrarenal aorta by deployment of an aorto-aortic tube 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 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 (e.g., for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)* (work RVU = 36.00, 120 minutes intra-service time, 677 minutes total time). CMS asserts that together, these two 90-day global codes require the same amount of intra-service time as CPT code 33880 and bracket the code in terms of work RVU, and total time based on their proposed crosswalk recommendation to CPT code 32672.

SVS disagrees with the CMS-proposed direct crosswalk work RVU of 27.00 for this service and believes this direct crosswalk valuation relies too heavily on decreases of intra-service time and does not accurately account for the overall measured intensity required to perform this service. First, this procedure requires more than 100 minutes of pre-service evaluation time, which includes extensive imaging review and advanced 3D planning (60 minutes). Improper planning can be catastrophic for the patient, resulting in stroke, upper extremity ischemia, and paralysis. This type of pre-planning is not present in the primary comparator code used by CMS. Precise landing and length of the graft intra-operatively are paramount. Modern-day TEVAR patients have increasingly complex anatomy. The amount of proximal and distal aortic coverage is essential for optimal outcomes in these patients. Improper deployment and partial coverage of the left carotid can result in cerebral ischemia. Coverage of excess lumbar arteries can result in spinal cord ischemia. These risks are not present in any other surgery. All TEVAR procedures have a risk of spinal cord ischemia, and these patients are typically monitored in the ICU with a lumbar drain. Tight blood pressure monitoring and drain management are under the direction of the vascular surgeon, which can only happen in the ICU. The RUC recommendation reflects modern-day practice, was supported by a strong physician survey, and was accepted by the RUC. The intensity of pre-service, intra-service, and post-service work is reflected in the RUC recommended valuation.

The two key reference services used in the RUC recommendation, CPT code 34708 *Endovascular repair of iliac artery by deployment of an ilio-iliac tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally to the iliac bifurcation, and treatment zone angioplasty/stenting, when performed, unilateral; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (e.g., for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, traumatic disruption)* (work RVU = 36.50, 120 minutes intra-service time, 677 minutes total time) and CPT code 34705 *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 other than rupture (e.g., for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)* (work RVU = 29.58, 150 minutes intra-service time, 512 minutes total time), are appropriately compared to CPT code 33880 in terms of work RVU relativity and intensity. CPT code 33880 requires identical intra-service time compared to top key reference service 34708, but less total time and intensity to perform, thus justifying

a lesser work RVU. Notably, when physicians who perform this procedure were surveyed, 69 percent of those physicians who selected the top key reference code 34708 indicated that CPT code 33880 was a somewhat more or much more intense service to perform. The RUC recognized that the two reference services bracket the survey 25th percentile work RVU and total time, acknowledging that survey respondents used appropriate magnitude estimation and considered consistent intensity across this code family.

For CPT code 33880, SVS disagrees with the proposed CMS crosswalk to CPT code 32672, which has a work RVU of 27.00. The RUC recommended survey 25th percentile work RVU of 30.00 is commensurate with the overall physician work and time required to perform this service. Furthermore, the RUC recommendation maintains relativity within this code family and across other similar 90-day global period codes. **Therefore, SVS urges CMS to accept a work RVU of 30.00 for CPT code 33880.**

33881

For CPT code 33881, CMS disagrees with the RUC recommended work RVU of 26.75 and proposes a work RVU of 22.53, which is based on a direct crosswalk to CPT code 43820 *Gastrojejunostomy; without vagotomy* (work RVU = 22.53, 120 minutes intra-service time, 545 minutes total time). In their rationale, CMS states that the RUC recommended work RVU of 26.75 does not align with the decreases in time in the survey, specifically the drop from 200 to 110 minutes of intra-service time. When compared to CPT code 33881, CMS' proposed direct crosswalk CPT code 43820 requires slightly greater intra-service time (120 minutes as compared with 110 minutes) and a similar total time (545 minutes as compared with 506 minutes). Additionally, CPT code 43820 requires three post-operative office visits in the global period as compared to CPT code 33881, which requires two.

To support their direct crosswalk recommendation to CPT code 43820, CMS also compared CPT code 33881 to CPT code 34707 *Endovascular repair of iliac artery by deployment of an ilio-iliac tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally to the iliac bifurcation, and treatment zone angioplasty/stenting, when performed, unilateral; for other than rupture (e.g., for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation)* (work RVU = 22.28, 120 minutes intra-service time, 482 minutes total time) and CPT code 43880 *Closure of gastrocolic fistula* (work RVU = 27.18, 120 minutes intra-service time, 540 minutes total time). CMS asserts that together, these two 90-day global codes require the same intra-service time as CPT code 33881 and bracket the code in terms of work RVU based on their proposed crosswalk recommendation to CPT code 43820.

SVS disagrees with the proposed CMS direct crosswalk work RVU of 22.53 for this service and believes this direct crosswalk valuation relies too heavily on decreases of intra-service and total time and does not accurately account for the overall measured intensity required to perform this service. CMS' proposed direct crosswalk, CPT code 43820, by comparison, requires significant intensity to perform. It does not reflect the intensity of a procedure with risks of permanent paralysis, anterior or posterior circulation strokes, retrograde type A aortic dissection necessitating sternotomy, aortic or iliac rupture, myocardial infarction, temporary or permanent dialysis, or even death. The RUC recommendation reflects modern-day practice, was supported by a strong physician survey, and was accepted by the RUC. The intensity of pre-service, intra-service, and post-service work is reflected in the RUC recommended valuation.

The two key reference services used in the RUC recommendation, CPT code 34701 *Endovascular repair of infrarenal aorta by deployment of an aorto-aortic tube 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 aortic bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the aortic bifurcation; for other than rupture (e.g., for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)* (work RVU = 23.71, 120 minutes intra-service time, 482 minutes total time) and CPT code 34705 *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 other than rupture (e.g., for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)* (work RVU = 29.58, 150 minutes intra-service time, 512 minutes total time), are appropriately compared to CPT code 33881 in terms of work RVU relativity and intensity. The RUC recognized that the two key reference services chosen by survey respondents bracket the survey 25th percentile work RVU and total time. When physicians who perform this procedure were surveyed by the RUC, 78 percent of those physicians who selected top key reference code 3470 indicated that CPT code 33881 was a somewhat more or much more intense service to perform. Furthermore, the top key reference service 34701 requires similar intra-service time and is just slightly less intense/complex for the physician to perform than 33881, making it a strong point of comparison. The survey respondents used appropriate magnitude estimation and considered consistent intensity across this code family.

For CPT code 33881, SVS disagrees with the proposed CMS crosswalk to CPT code 43820, which has a work RVU of 22.53. The RUC recommended survey 25th percentile work RVU of 26.75 is commensurate with the overall physician work and time required to perform this service. Furthermore, the RUC recommendation maintains relativity within this code family and across other similar 90-day global period codes. **Therefore, SVS urges CMS to accept a work RVU of 26.75 for CPT code 33881.**

33883

For CPT code 33883, CMS disagrees with the RUC recommended work RVU of 24.25 and proposes a work RVU of 19.91, which is based on a direct crosswalk to CPT code 44320 *Colostomy or skin level cecostomy;* (work RVU = 19.91, 90 minutes intra-service time, 507 minutes total time). In their rationale, CMS states that the RUC recommended work RVU of 24.25 does not maintain relativity across other 90-day global period codes with the same intra-service time of 90 minutes and a similar total time of approximately 486 minutes. CMS notes that the RUC recommended work RVU of 24.25 does not align with the decreases in time in the survey, specifically the drop from 120 to 90 minutes of intra-service time. When compared to CMS' proposed direct crosswalk CPT code 44320, CPT code 33883 shares the same intra-service time of 90 minutes and requires a similar total time (507 minutes as compared with 486 minutes). Additionally, CPT code 44320 requires three post-operative office visits in the global period as compared to CPT code 33883, which requires two.

To support their direct crosswalk recommendation to CPT code 44320, CMS also compared CPT code 33883 to CPT code 33267 *Exclusion of left atrial appendage, open, any method (e.g., excision, isolation via stapling, oversewing, ligation, plication, clip)* (work RVU = 18.50, 90 minutes intra-service time, 401 minutes total time) and CPT code 43611 *Excision, local; malignant tumor of stomach* (work RVU = 20.38, 100 minutes intra-service time, 520 minutes total time). CMS asserts that together, these two 90-day global codes bracket CPT code 33883 in terms of work RVU and total time based on their proposed

crosswalk recommendation to CPT code 44320. SVS disagrees that the brackets recommended by CMS are reflective of the surgical procedure nor the intensity/complexity of endovascular aortic procedures.

SVS disagrees with the proposed CMS direct crosswalk of 24.25 for this service and believes this direct crosswalk valuation relies too heavily on decreases of intra-service and total time and does not accurately account for the overall measured intensity required to perform this service. While the intra-service time is the same between CMS' reference code and the surveyed code, CPT code 44320 has very low intensity/complexity comparatively. CPT code 33883 is an extension endograft, so the risk of spinal cord ischemia and coverage of the subclavian is similar or even more than CPT code 33881. The RUC recommendation reflects modern day practice, was supported by a strong physician survey, and was accepted by the RUC. The intensity of pre-service, intra-service, and post-service work is reflected in the RUC recommended valuation.

The two key reference services used in the RUC recommendation, CPT code 34701 *Endovascular repair of infrarenal aorta by deployment of an aorto-aortic tube 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 aortic bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the aortic bifurcation; for other than rupture (e.g., for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)* (work RVU = 23.71, 120 minutes intra-service time, 482 minutes total time) and CPT code 34708 *Endovascular repair of iliac artery by deployment of an ilio-iliac tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally to the iliac bifurcation, and treatment zone angioplasty/stenting, when performed, unilateral; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (e.g., for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, traumatic disruption)* (work RVU = 36.50, 120 minutes intra-service time, 677 minutes total time), are appropriately compared to CPT code 33883 in terms of work RVU relativity and intensity. The RUC recognized that the two key reference services chosen by survey respondents bracket the 25th percentile work RVU. The top key reference service 34701 requires nearly identical total time to perform, and the second key reference service 34708 requires more intra-service time and total time compared to 33883 and thus is valued higher. Notably, both key reference services are similarly intense/complex for the physician to perform as 33883, making both codes strong comparisons. Moreover, when physicians who perform this procedure were surveyed by the RUC, 80 percent of those physicians who selected top key reference code 34701 indicated the survey code was a somewhat more or much more intense service to perform. The survey respondents used appropriate magnitude estimation and considered consistent intensity across this code family.

For CPT code 33883, SVS disagrees with the proposed CMS crosswalk to CPT code 44320, which has a work RVU of 19.91. The RUC recommended survey 25th percentile work RVU of 24.25 is commensurate with the overall physician work and time required to perform this service. Furthermore, the RUC recommendation maintains relativity within this code family and across other similar 90-day global period codes. **Therefore, SVS urges CMS to accept a work RVU of 24.25 for CPT code 33883.**

<u>33886</u>

For CPT code 33886, CMS disagrees with the RUC recommended work RVU of 23.50 and proposes a work RVU of 19.91, which is based on a direct crosswalk to CPT code 44320 *Colostomy or skin level cecostomy;* (work RVU = 19.91, 90 minutes intra-service time, 507 minutes total time). In their rationale,

CMS states that the RUC recommended work RVU of 23.50 does not maintain relativity across other 90-day global period codes with the same intra-service time of 90 minutes and a similar total time of approximately 486 minutes. When compared to CMS' proposed direct crosswalk to 44320, CPT code 33886 shares the same intra-service time of 90 minutes and requires a similar total time (507 minutes as compared with 486 minutes). Additionally, CPT code 44320 requires three post-operative office visits in the global period as compared to CPT code 33886, which requires two.

To support their direct crosswalk recommendation of CPT code 44320, CMS also compared CPT code 33886 to CPT code 33267 *Exclusion of left atrial appendage, open, any method (e.g., excision, isolation via stapling, oversewing, ligation, plication, clip)* (work RVU = 18.50, 90 minutes intra-service time, 401 minutes total time) and CPT code 43611 *Excision, local; malignant tumor of stomach* (work RVU = 20.38, 100 minutes intra-service time, 520 minutes total time). CMS asserts that together, these two 90-day global codes bracket CPT code 33883 in terms of work RVU and total time based on their proposed crosswalk recommendation to CPT code 44320.

SVS disagrees with the proposed CMS direct crosswalk of 23.50 for this service and believes this direct crosswalk valuation relies too heavily on decreases of intra-service and total time and does not accurately account for the overall measured intensity required to perform this service. While the intra-service time is the same between CMS' reference code and the surveyed code, CPT code 44320 has very low intensity/complexity comparatively. CPT code 33886 is an extension endograft, so the risk of spinal cord ischemia and coverage of the artery of Adamkiewicz is highest here. Coverage of the celiac artery risks hepatic artery coverage, liver failure, and even intestinal ischemia based upon the other visceral artery anatomy. The RUC recommends that using a colostomy code as a comparator is inappropriate and notes that endovascular major aortic surgery should not be compared with straightforward intra-abdominal procedures. The RUC recommendation reflects modern-day practice, was supported by a strong physician survey, and was accepted by the RUC. The intensity of pre-service, intra-service, and post-service work is reflected in the RUC recommended valuation.

The two key reference services used in the RUC recommendation, CPT code 34701 *Endovascular repair of infrarenal aorta by deployment of an aorto-aortic tube 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 aortic bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the aortic bifurcation; for other than rupture (e.g., for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)* (work RVU = 23.71, 120 minutes intra-service time, 482 minutes total time) and CPT code 34718 *Endovascular repair of iliac artery, not associated with placement of an aorto-iliac artery endograft at the same session, by deployment of an iliac branched endograft, including pre-procedure sizing and device selection, all ipsilateral selective iliac artery catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally in the internal iliac, external iliac, and common femoral artery(ies), and treatment zone angioplasty/stenting, when performed, for other than rupture (e.g., for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, penetrating ulcer), unilateral* (work RVU = 24.00, 120 minutes intra-service time, 477 minutes total time) are appropriately compared to CPT code 33886 in terms of work RVU relativity and overall intensity/complexity. Overall, CPT code 33886 requires less intra-service time than the two selected key reference services, thus justifying it having a lower work RVU.

For CPT code 33886, SVS disagrees with the proposed CMS crosswalk to CPT code 44320, which has a work RVU of 19.91. The RUC recommended survey 25th percentile work RVU of 23.50 is commensurate with the overall physician work and time required to perform this service. Furthermore, the RUC recommendation maintains relativity within this code family and across other similar 90-day global period codes. **Therefore, SVS urges CMS to accept a work RVU of 23.50 for CPT code 33886.**

33XX2

For CPT code 33XX2, CMS disagrees with the RUC recommended work RVU of 39.00 and proposes a work RVU of 35.00, which is based on a direct crosswalk to CPT code 33390 *Valvuloplasty, aortic valve, open, with cardiopulmonary bypass; simple (i.e., valvotomy, debridement, debulking, and/or simple commissural resuspension)* (work RVU = 35.00, 180 minutes intra-service time, 622 minutes total time). In their rationale, CMS states that the RUC recommended work RVU of 39.00 does not maintain relativity across other 90-day global period codes with the same intra-service time of 180 minutes and a similar total time of approximately 621 minutes. When compared to CMS' proposed direct crosswalk CPT code 33390, CPT code 33XX2 shares the same intra-service time of 180 minutes and requires a very similar total time (621 minutes as compared with 622 minutes). Additionally, both CPT codes 33XX2 and 33390 require two post-operative office visits in the global period.

To support their direct crosswalk recommendation to CPT code 33390, CMS also compared CPT code 33XX2 to CPT code 33647 *Repair of atrial septal defect and ventricular septal defect, with direct or patch closure* (work RVU = 33.00, 180 minutes intra-service time and 614 minutes total time) and CPT code 35216 *Repair blood vessel, direct; intrathoracic, without bypass* (work RVU = 36.61, 180 minutes intra-service time, 658 minutes total time). CMS asserts that together, these two 90-day global codes require the same amount of intra-service time as CPT code 33XX2 and bracket the code in terms of work RVU and total time based on their proposed crosswalk recommendation to CPT code 33390.

SVS disagrees with the proposed CMS direct crosswalk work RVU of 35.00 for this service and believes this direct crosswalk valuation does not accurately account for the overall measured intensity required to perform this service. This is primarily a cardiopulmonary bypass code, as valvuloplasty is simple by comparison and a very small portion of the entire intra-service time. CPT code 33XX2 adds further intensity/complexity through fenestration alignment and selective catheterization of the subclavian artery. This code reflects both the technical sophistication and elevated risk of spinal cord ischemia requiring surgeon-led monitoring. The RUC recommendation reflects modern-day practice, was supported by a strong physician survey, and was accepted by the RUC. The intensity of pre-service, intra-service, and post-service work is reflected in the RUC recommended valuation.

The two key reference services used in the RUC recommendation, CPT 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 (e.g., for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)* (work RVU = 45.00, 178 minutes intra-service time, 735 minutes total time) and CPT code 34708 *Endovascular repair of iliac artery by deployment of an ilio-iliac tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally to the iliac*

bifurcation, and treatment zone angioplasty/stenting, when performed, unilateral; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (e.g., for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, traumatic disruption) (work RVU = 36.50, 120 minutes intra-service time, 677 minutes total time), are appropriately compared to CPT code 33XX2 in terms of work RVU relativity and intensity. The RUC recognized that the two key reference services chosen by survey respondents bracket the survey 25th percentile work RVU. Notably, the top key reference service 34706 requires nearly identical intra-service time and is just slightly less intense/complex for the physician to perform than 33XX2, making it a strong point of comparison. Moreover, when physicians who perform this procedure were surveyed by the RUC, 83 percent of those physicians who selected the top key reference code 34706 indicated the survey code was a somewhat more or much more intense service to perform. The survey respondents used appropriate magnitude estimation and considered consistent intensity across this code family.

For CPT code 33XX2, SVS disagrees with the proposed CMS crosswalk to CPT code 33390, which has a work RVU of 35.00. The RUC recommended survey 25th percentile work RVU of 39.00 is commensurate with the overall physician work and time required to perform this service. Furthermore, the RUC recommendation maintains relativity within this code family and across other similar 90-day global period codes. **Therefore, SVS urges CMS to accept a work RVU of 39.00 for CPT code 33XX2.**

35XX1

For CPT code 35XX1, CMS disagrees with the RUC recommended work RVU of 27.40 and proposes a work RVU of 23.53, which is based on a direct crosswalk to CPT code 32669 *Thoracoscopy, surgical; with removal of a single lung segment (segmentectomy)* (work RVU = 23.53, 150 minutes intra-service time, 502 minutes total time). In their rationale, CMS states that the RUC recommended work RVU of 27.40 does not maintain relativity across other 90-day global period codes with the same intra-service time of 150 minutes and a similar total time of approximately 486 minutes. When compared to CMS' proposed direct crosswalk to 32669, CPT code 35XX1 shares the same intra-service time and requires a similar total time (502 minutes as compared with 486 minutes). Additionally, both CPT codes 35XX1 and 32669 require two post-operative office visits in the global period.

To support their direct crosswalk recommendation to CPT code 32669, CMS also compared CPT code 35XX1 to CPT code 22612 *Arthrodesis, posterior or posterolateral technique, single interspace; lumbar (with lateral transverse technique, when performed)* (work RVU = 23.53, 150 minutes intra-service time, 482 minutes total time) and CPT code 35666 *Bypass graft, with other than vein; femoral-anterior tibial, posterior tibial, or peroneal artery* (work RVU = 23.66, 150 minutes intra-service time, 490 minutes total time). CMS asserts that together, these two 90-day global codes require the same amount of intra-service time as CPT code 35XX1 and bracket the code in terms of work RVU based on their proposed crosswalk recommendation to CPT code 32669.

SVS disagrees with the proposed CMS direct crosswalk of 27.40 for this service and believes this direct crosswalk valuation does not accurately account for the overall measured intensity required to perform this service. The RUC recommendation reflects modern-day practice, was supported by a strong physician survey, and was accepted by the RUC. The intensity of pre-service, intra-service, and post-service work is reflected in the RUC recommended valuation.

The two key reference services used in the RUC recommendation, CPT code 35601 *Bypass graft, with other than vein; common carotid-ipsilateral internal carotid* (work RVU = 27.09, 180 minutes intra-service

time, 484 minutes total time), and CPT code 35606 *Bypass graft, with other than vein; carotid-subclavian* (work RVU = 22.46, 145 minutes intra-service time, 414 minutes total time), are appropriately compared to CPT code 33XX2 in terms of work RVU relativity and intensity/complexity. The top key reference code 35601 requires nearly identical total time, but more intra-service time compared to CPT code 33886 and is less intense/complex for the physician to perform. The second key reference code 35606 requires nearly identical intra-service time but less total time than CPT code 33886 and is also less intense/complex to perform. Moreover, when physicians who perform this procedure were surveyed by the RUC, 63 percent of the physicians who selected the top key reference code 35601 indicated that CPT code 35XX1 was somewhat more or much more intense to perform. Together, the two key reference services chosen by RUC survey respondents bracket the 25th percentile work RVU due to appropriate differences in time, despite them both being less intense procedures overall. There are many clinical scenarios where this service would be applicable, not just in conjunction with TEVAR, resulting in a range of intensities.

For CPT code 35XX1, SVS disagrees with the proposed CMS crosswalk to CPT code 32669, which has a work RVU of 23.53. The RUC recommended survey 25th percentile work RVU of 27.40 is commensurate with the overall physician work and time required to perform this service. Furthermore, the RUC recommendation maintains relativity within this code family and across other similar 90-day global period codes. **Therefore, SVS urges CMS to accept a work RVU of 27.40 for CPT code 35XX1.**

Lower Extremity Revascularization (CPT codes 37XX1, 37X02, 37X03, 37X04, 37X05, 37X06, 37X07, 37X08, 37X09, 37X10, 37X11, 37X12, 37X13, 37X14, 37X15, 37X16, 37X17, 37X18, 37X19, 37X20, 37X21, 37X22, 37X23, 37X24, 37X25, 37X26, 37X27, 37X28, 37X29, 37X30, 37X31, 37X32, 37X33, 37X34, 37X35, 37X36, 37X37, 37X38, 37X39, 37X40, 37X41, 37X42, 37X43, 37X44, 37X45, and 37X46)

In October 2018, CPT codes 37225, 37227 and 37229 were identified by the RAW's PE High-Cost Supplies screen for services with non-facility Medicare utilization over 10,000, which were not reviewed in the last five years and include a supply item greater than $500. The specialty societies worked with the CPT Editorial Panel and submitted multiple code change applications over several years. In September 2024, the CPT Editorial Panel created four new subsections and 46 new codes to report LER services. The 16 existing codes (37220-37235) to report these services were deleted.

Sample Size/Survey Responses

CMS stated they had concerns about the LER survey data, specifically regarding the small sample size and large variations in responses. CMS appropriately summarizes in the Rule that a standard RUC survey was conducted on eleven codes (anchor codes) and the remaining 35 codes underwent an abbreviated survey. The eleven anchor codes represented every territory in the family, straightforward procedures, complex procedures, angioplasty only procedures, stent placement procedures, atherectomy procedures and add-on procedures. The 35 abbreviated survey codes were split into two groups and survey respondents only received one of those two groups along with the 11 core codes. There were two notable changes made to the abbreviated survey. CMS expressed concern in the Rule that this method could potentially introduce inaccuracies and bias in the survey outcomes.

In order to use the survey data, the survey respondent had to complete their entire survey, eleven anchor codes plus their set of additional codes. The specialty societies believe the response rate of over 100 surveys for the anchor codes is robust. The survey responses for the abbreviated surveys were 46-48,

which nicely aligns with the response rate of 100+ for the anchor codes because each of the two group had to respond to the anchor codes. This survey methodology was used to minimize the potential for inaccuracies and bias.

Practice Expense

CMS is proposing to accept the RUC's practice expense recommendations with quantity modifications for Drug-coated balloons (SD382) and Tibial Drug Eluting Stents (SD379). The Agency cites 'discrepancies' in the RUC recommendations for these two PE items. CMS is also seeking comments on whether they should use the Hospital Outpatient Prospective Payment System (OPPS) mean unit cost data (MUC) and/or high-cost supply G-Codes to price LER services.

SVS appreciates CMS request for comments regarding alternative ways to price high-cost supply items in the non-facility setting. SVS has long supported the concept of creating separately reportable HCPCS codes for high-cost disposable supplies priced more than $500, as the current practice expense methodology distorts the expenses associated with high-cost supplies.

CMS is proposing to use hospital outpatient data (cost data/relative weights) for some services in the CY2026 MFS PR. CMS requested comments on whether such an approach could work for LER services. SVS is open to reimagining how the direct practice expenses associated with lower extremity revascularization procedures performed in the non-facility setting are paid. As previously stated, the current practice expense methodology distorts the expenses associated with resource intense services. Also previously stated, using separately reportable HCPCS codes to report high-cost disposable supplies (greater than $500) could be a step in the right direction to more accurately reimburse for expensive disposable supplies.

The use of hospital outpatient cost data, which CMS believes to be reliable and updated routinely, is worth considering. However, SVS has concerns about how exactly the cost data would be used to establish PE RVUs. The services in the CY2026 MFS PR where CMS proposes to use OPPS cost data/APC relative weights vary extensively from LER services. For example, the radiation treatment delivery services and the remote monitoring services are practice expense only codes, with separate CPT codes to report physician work. The radiation oncology codes noted in this rule also have an "S" status indicator assigned to them (separately reportable). The 000-day LER services are assigned J1 status indicators (comprehensive APCs) in the HOPPS, making it challenging to align with the MFS because all ancillary services are packaged into J1 services. The LER APCs are also eligible for complexity adjustments, again, making it challenging to align with parallel CPT codes/PE RVUs in the MFS. In addition, add-on codes also play an important role in the LER family (for both work and PE), which complicates the relationship between the PFS and HOPPS, because add-on codes are packaged in the HOPPS and no separate payments are made. Finally, while CMS has taken steps over time to mitigate the problems caused by charge compression and inaccurate data for device-dependent APCs, charge compression remains a real problem for the LER procedures.

SVS believes the current CMS PE methodology does not appropriately account for the direct practice expenses incurred in the NF setting for resource intensive procedures. For example, the NF PE RVUs assigned to the new LER codes do not even cover the supply costs to perform the procedures. And the NF PE RVUs reimburse NF physicians for supplies, equipment AND clinical labor. This is a major problem with the PE methodology in the NF setting. SVS believes that improvements need to be made to

CMS' current methodology to appropriately reimburse physicians for resource intensive services they perform in the NF setting.

In future rule-making cycles, if CMS considers alternative solutions, it is critical that the Agency be transparent and detailed regarding potential methodology changes. For example, if CMS uses OPPS MUC to establish PE RVUs, in what step of the PE methodology will those costs be brought into the formula? Will they be subject to scaling factors? Operationalizing the use of hospital outpatient data to set PE RVUs in the PFS for such a complicated code family will be incredibly challenging. A detailed proposal will help stakeholders provide the necessary feedback to accurately establish reimbursement rates for these services. We thank the Agency for considering alternatives to the current PE methodology and are eager to engage in discussions with CMS on possible ways to improve the current system.

Specific LER PE Recommendations

The selection of individual inputs and the appropriate limitation of unnecessary inputs was the result of an exhaustive collaborative effort of several specialty societies over a period of several years. The details regarding the expected typical treatment algorithm, as determined by the multispecialty expert panel, were included in the practice expense summary of recommendation forms, which was submitted to the Agency by the AMA. Below, please find a detailed explanation of quantity selection for SD382 and SD379.

Drug-coated balloon (SD382)

First, regarding the drug-coated balloon (SD382), CMS stated that the RUC recommendations "show inconsistent quantity allocations across different code sets." The differences in quantity allocations do not represent an inconsistent strategy but rather an accurate depiction of a complex combination of additive or conjunctive treatments. This was described in some detail in the submitted PE SOR.

In the CMS comments, it was stated that "The RUC documentation specifies two units for the initial vessel and one unit for additional vessels in CPT codes 37X10 - 37X13 and 37X18 - 37X21. However, for CPT codes 37X14 - 37X15 and 37X22 - 37X23, only one unit is listed for the initial vessel." This is true, appropriate and defended in the SOR.

In CPT codes 37X10 - 37X13 which describe Femoropopliteal angioplasty and 37X18 - 37X21 which describe Femoropopliteal atherectomy and angioplasty, two balloons are required due to the length of disease typical in the superficial femoral and popliteal segments. In these CPT codes, no adjunct drug eluting stents or covered stents are being used and therefore the definite therapy is the drug coated balloon. These balloons are used in long segments of arterial disease in the superficial femoral/popliteal portion of the femoropopliteal region and two balloons is typical as a drug coated balloon can only deliver its therapeutic payload upon one area during a single inflation according to the FDA instructions for use (IFU).

For CPT codes CPT codes 37X14 - 37X15 and 37X22 - 37X23, only one unit is listed for the initial vessel as these codes describe femoropopliteal angioplasty or femoropopliteal atherectomy and angioplasty in an add-on vessel. As described in the SOR, the add-on vessel is most typically going to be used to describe treatment in the common femoral or profunda femoris segments of the femoropopliteal region which are much shorter vessels and therefore have shorter disease segments. Only one drug coated balloon is necessary most typically and therefore only one was included. This does not represent a "discrepancy" but rather the appropriate course of treatment of the typical scenario for the codes.

CMS also listed the discrepancy in the allocation of Drug Coated Balloons related to the absence of these balloons in CPT codes 37X16 and 37X17 (Femoropopliteal Angioplasty and Stent), 37X24 and 37X25 (Femoropopliteal Atherectomy, Angioplasty and Stent) and 37X26 (Femoropopliteal IVL add-on) as support for an inconsistent method of counting the number of required DCBs.

In 37X16, 37X17, 37X24 and 37X25 covered stents were felt to be typically used and therefore the use of DCBs would be unnecessary as the treated segments will be covered by a fabric coated stent.

In the CPT code 37X26 the PE inputs are limited to the added work of Intravascular Lithotripsy which is performed in addition to the base codes of the family. Additional DCBs would not be listed in this code as they are already listed in the appropriate base codes if, and only if, they are necessary in the completion of the appropriate course of therapies.

SVS requests that CMS accept the RUC recommended PE inputs for CPT codes 37X10, 37X12, 37X18, and 37X20 and restore the number of drug-coated balloon (SD382) to two per code.

Tibial Drug Eluting Stents (SD379)

In the proposed rule, CMS also commented that there were discrepancies in the number of tibial Drug Eluting Stents (SD379) throughout the code set.

The utilization of tibial stents has expanded due to an increase in the availability of advanced techniques, the improvement in the quality and availability of drug eluting stents and the expanding utilization of endovascular procedures in the treatment of limb threatening ischemia.

At the time that the Xpert stent was listed as the PE supply input for tibial stenting, it was the only product available with the sizes appropriate for tibial vessels. Since the time that the previous code set was valued, Xpert stents have been removed from the market and are no longer used.

It is inappropriate for CMS to use the prior number of supply inputs for a new expanded code set at the expense of the recommendations of numerous treating specialties and the RUC. The specialty societies and the RUC agree that 37X33 and 37X34 (which describe tibial angioplasty and stent placement in complex lesions) typically require the use of two Drug Eluting Stents due to the length of the lesions and the underlying heavy calcification commonly associated with this pathology.

The longest available Drug Eluting Stent FDA approved for the use in tibial vessels is 38 mm whereas the typical length of a tibial artery is 250-300mm. Similarly, the specialty societies and the RUC agree that 37X41 and 37X42 (which describe tibial atherectomy, angioplasty and stent placement in complex lesions) require the use of two Drug Eluting Stents for the same reasons.

It is important to note that these complex codes (37X33, 37X34, 37X41 and 37X42) are felt to represent the minority of tibial interventions and that it will be much more likely for tibial interventions to not require stent placement. Additionally, many more of the treatments will be simple stenoses and if stent placement is performed will only require a single drug eluting stent in most cases.

SVS requests that CMS accept the RUC-recommended PE inputs and restore the number of supply code SD379 (drug eluting stent, tibial) for four CPT codes in the tibial and peroneal vascular territory, CPT codes 37X33, 37X34, 37X41, and 37X42 to two each.

New Supply Pack for Angiography Services

SVS thanks CMS for creating a new supply pack for angiography services, SA142 *pack, angiography,* as requested, as part of the Lower Extremity Revascularization (LER) codes. However, in the Proposed Rule Table 26 and the public use file the pack is not assigned to the applicable codes. There are 22 new LER codes for which this pack could and should be used. The purchase price of $68.26 equates to the following individual components of the pack:

Angiography Supply Package (SA142) = $68.26

Angio Pack Contents	Supply Code	Corresponding Supply list components	Price Per Unit	Units	$ 68.26
10 cc syringe	SC051	syringe 10-12ml	0.21	4	$ 0.84
control syringe (lidocaine)	SC051	syringe 10-12ml	0.21	1	$ 0.21
Bowl, sterile	SJ079	basin, sterile 500cc	3.51	2	$ 7.02
gauze	SG055	gauze, sterile 4in x 4in	0.19	20	$ 3.80
marker, regular tip	SK075	skin marking pen, sterile (Skin Skribe)	1.62	1	$ 1.62
dome cover	SB008	drape, sterile, c-arm, fluoro	5.38	1	$ 5.38
blue towels	SB019	drape-towel, sterile 18in x 26in	0.47	4	$ 1.88
scalpel	SF007	blade, surgical (Bard-Parker)	0.68	1	$ 0.68
back table cover	SB014	drape, sterile, three-quarter sheet	3.46	1	$ 3.46
20cc syringe	SC053	syringe 20ml	0.83	4	$ 3.32
drape, femoral	SB009	drape, sterile, femoral	9.15	1	$ 9.15
medicine cup	SL157	cup, sterile, 8 oz	0.58	1	$ 0.58
label sheet	SL198	label, vial	0.02	9	$ 0.18
scissor	SA027	kit, scissors and clamp	0.82	1	$ 0.82
surgical gowns x 2	SB028	gown, surgical, sterile	5.13	2	$ 10.26
18 G needle	SC027	needle, 18-19g, filter	0.21	1	$ 0.21
25 G needle	SC028	needle, 18-26g 1.5-3.5in, spinal	9.96	1	$ 9.96
needle counter	SD120	styrofoam block, high density (3in-12in-12in)	1.86	1	$ 1.86
towel clamps (plastic disposable)	SD208	towel clamp, plastic	0.76	4	$ 3.04
Guidewire bowl	SD171	guidewire bowl w-lid, sterile	3.99	1	$ 3.99

SVS requests that SA142 be assigned to the following CPT codes: 37XX1, 37X03, 37X05, 37X07, 37X10, 37X12, 37X14, 37X16, 37X18, 37X20, 37X22, 37X24, 37X27, 37X29, 37X31, 37X33, 37X35, 37X37, 37X39, 37X41, 37X43, 37X45.

Baroreflex Activation Therapy (CPT codes 64XX5, 64XX6, 64XX7, 64XX8, 64XX9, 64X10, 93XX4, and 93XX5)

BAT treats heart failure symptoms and resistant hypertension by electrically stimulating carotid baroreceptors within the carotid artery. This triggers the autonomic nervous system to regulate heart, kidney, and vascular function through both sympathetic and parasympathetic pathways, reducing the heart's workload and helping it pump efficiently to relieve the often-debilitating symptoms of heart failure. The BAT modulation system received FDA approval in August 2019, and the CPT Editorial Panel approved conversion from a Category III code set to a Category I code set at the September 2024 CPT Panel meeting. This code family describes the implantation, replacement, revision, removal, and interrogation/programming of a BAT modulation system and was surveyed for the January 2025 RUC meeting. The specialties initially surveyed using both a targeted sample from a vendor list and a random sample of the specialty societies' membership. Ultimately, the entire specialty society membership was surveyed.

SVS appreciates CMS accepting the RUC recommended work RVU and direct practice expense recommendations for CPT codes 64XX5, 64XX6, 64XX7, 64XX8, 64XX9 and 64X10.

G2211 Utilization

In 2024, CMS implemented a new add-on code G2211, *Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (add-on code, list separately indication to office/outpatient evaluation and management visit, new or established).* Medicare claims data analysis indicates that the utilization of this code was greatly overestimated, dramatically impacting the Medicare conversion factor via a budget neutrality adjustment.

SVS Recommendation

SVS urges CMS to correct the utilization assumptions for G2211 and update the conversion factor (to account for the utilization error).

Strategies for Improving Global Surgery Payment Accuracy [FR section II.L.]

CMS continues to express concern about the accuracy of global surgery payment. Most recently, in the Final Rule for the CY2025 MFS, CMS finalized a proposal to require the use of the appropriate transfer of care modifier (modifier -54, -55, or -56) for all 90-day global surgical packages in any case when a physician plans to furnish only a portion of a global package both when there is a formal, documented transfer of care (current policy) and when there is an informal, non-documented but expected, transfer of care. Separately, CMS also created HCPCS code G0559 to capture the additional time and resources spent in providing follow-up post-operative care by a physician or other qualified health care professional who did not perform the surgical procedure and who has not been involved in a formal transfer of care agreement.

CMS is seeking comments on strategies to improve the accuracy of payment for global surgical packages, specifically related to the updated transfer of care policy. CMS also solicits comments on the best approach for utilizing this data going forward.

CPT Code 99024

Since July 1, 2017, Medicare physicians in 9 states have been required to report on the postoperative visits they furnish during the global period of specified high-volume procedures using CPT code 99024 *Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure*.

As part of the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015, Congress mandated that CMS gather information from physicians to assist in improving the accuracy of global surgery valuation, and that the Office of Inspector General (OIG) audit a sample of medical records to verify the accuracy of visits in the surgical global period. In June 2025, the OIG issued the report CMS Should Improve Its Methodology for Collecting Medicare Postoperative Visit Data on Global Surgeries. The OIG report identified several concerns about the validity of the 99024 Medicare data.

SVS urges CMS to:

- Adjust the work RVUs for the E/M visits included in the bundle to the existing E/M values;
- Modify the practice expense inputs for the inpatient hospital and observation care visits and office visits within the global periods;
- Publish the granular transfer of care data (modifier -54, -55, -56, G0559) when it becomes available; and
- Identify codes/families of codes they believe have inappropriate post operative visits assigned to them, as potentially misvalued services, through the rule making process.

Determination of Professional Liability Relative Value Units (PLI RVUs) [FR section II.M.]

For the 2026 MFS, CMS contracted with the Actuarial Research Corporation (ARC) to update the PLI premium data. SVS supports CMS' effort to improve their PLI data to ensure that as much specialty-specific data as possible is used to reflect the most accurate trends in professional liability premiums.

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

CMS policy of using expected specialty overrides for certain low volume services. The specialty assignments for these codes are intended to appropriately represent the professional liability risk that is inherent in the code itself and reflected in the professional liability risk of a single specialty. The purpose of assigning a specialty to these codes is to avoid the major adverse impact on professional liability insurance (PLI) and PE RVUs that result from errors in specialty utilization data magnified in representation by small sample size. The impact of these errors on the performing specialties can be severe due to the true overall code utilization being related to non-Medicare beneficiaries. In addition, the proposed specialty overrides are intended to appropriately represent the expected indirect practice expense for each service.

SVS appreciates the CMS policy of using expected specialty overrides for certain low volume services. SVS recommends the following low volume services be cross walked to vascular surgery:

34813	Femoral endovas graft add-on
35682	Composite byp grft 2 veins
35881	Revise graft w/vein
36474	Endovenous mchnchem add-on

Policies To Improve Care for Chronic Illness and Behavioral Health Needs:
REQUEST FOR INFORMATION: *Prevention and Management of Chronic Disease*

In the proposed rule, CMS states that six in ten Americans have at least one chronic disease, and four in ten have two or more chronic diseases. Many preventable chronic diseases are caused by a short list of risk behaviors, including smoking, poor nutrition, physical inactivity, and excessive alcohol use. The SVS recognizes that as per the Trump Administration's Executive Order, "Establishing the President's Make America Healthy Again Commission," CMS seeks to better understand and drastically lowering chronic disease rates, including considerations relating to the role of nutrition, physical activity, healthy lifestyles, over-reliance on medication and treatments, the effects of new technological habits, environmental impacts, and food and drug quality and safety. We also understand that CMS is exploring the availability of expanded treatment options and the flexibility for health insurance coverage to provide benefits to support beneficial lifestyle changes and disease prevention. As part of this process, CMS has outlined a "Request for Information" designed to solicit feedback regarding how the agency better understand how we could enhance our support management for prevention and management of chronic disease.

The SVS is pleased with the renewed focus on chronic disease management and its impact on not only the health of our nation's population, but also its effect on the healthcare delivery system overall. Vascular Surgeons are among the few *surgical* specialties that provide longitudinal care for patients, with a significant amount of the care provided (by vascular surgeons) dedicated to prevention, screening, and ongoing medication management of vascular diseases. This is critically important as vascular disease is more common than most people realize. It slows circulation and impacts the way the body functions in myriad ways. Up to 40 million Americans have a vascular disease, yet many have never heard of common conditions like peripheral artery disease (PAD), carotid artery disease (CAD), and abdominal aortic aneurysm. If left untreated, vascular disease can lead to serious or life-threatening complications including heart attack, stroke, amputation, and even death. This comes at a time when by 2030 more than 100 million people in the U.S. will be reaching an age associated with a high risk of vascular diseases, meaning more people than ever before may require care from a vascular surgeon. To help address these shortcomings, the SVS offers comments on the following:

- How could we better support prevention and management, including self-management, of chronic disease?
- Are there current services being performed that improve physical activity, where the time and resources to perform the services are not adequately captured by the current physician fee schedule code set? How should CMS consider provider assessment of physical activity, exercise prescription, supervised exercise programs, and referral, given the accelerating use of wearable devices and advances in remote monitoring technology?
- Should CMS consider creating separate coding and payment for intensive lifestyle interventions, where the time and resources to perform the services are not adequately captured by the current

physician fee schedule code set, and how should these interventions be prioritized? If so, what evidence has supported these services, and what do the services entail? How would additional coding and payment be substantively different from coding and payment for Intensive Behavioral Therapy?

- Are there technical solutions that would enhance the uptake of the annual wellness visit (AWV), or improve accessibility, impact, and usefulness of the AWV? How can CMS better support practitioners and beneficiaries related to the AWV? Should CMS consider moving some of the required components of the AWV to optional add-on codes of the AWV instead, with the intent of decreasing burden, improving uptake, and allowing practitioners to select additional AWV elements that may be more relevant to particular patients?

Peripheral artery disease (PAD) should be a central focus in the government's efforts to improve prevention and management of chronic disease. PAD is a progressive, chronic condition closely linked to diabetes, smoking, obesity, and poor nutrition—risk factors already emphasized in this administration's initiative. Its consequences are devastating: patients with PAD face a dramatically increased risk of heart attack, stroke, amputation, and death. Notably, PAD accounts for the majority of non-traumatic amputations in the U.S., a life-altering outcome that not only worsens disability but also significantly increases long-term healthcare costs through hospitalizations, prosthetics, rehabilitation, and loss of independence. By prioritizing PAD within chronic disease prevention, CMS would address a condition that embodies the intersection of multiple high-cost, high-burden chronic diseases.

Importantly, PAD management aligns with the Administration's goals of prevention, lifestyle intervention, and self-management. Evidence-based strategies such as supervised exercise therapy, smoking cessation, dietary interventions, and better diabetes control have proven efficacy in slowing PAD progression and preventing costly complications. Yet, the time and resources required for these interventions are often under-recognized and inadequately reimbursed under current payment structures. Expanding support for PAD-focused services—including supervised exercise programs, remote monitoring technologies, and intensive lifestyle interventions—would not only prevent amputations but also reduce Medicare spending on long-term disability and hospitalizations. Addressing PAD in this request for information would ensure that CMS meaningfully tackles one of the most preventable, yet most devastating, chronic conditions in America.

PAD fits squarely into the high-burden category outlined by CMS. >8.5 million Americans (and some estimates as high as 12 million) have PAD, yet it is often underdiagnosed and undertreated. Prevalence is especially high among Medicare beneficiaries (≈20% of those ≥65). PAD is strongly associated with reduced walking distance, loss of independence, frailty, and falls — outcomes CMS already prioritizes. Black Americans are nearly twice as likely as white patients to undergo major limb amputation, often without prior revascularization. This ties vascular health directly into CMS's health equity commitments. Major amputation carries a five-year mortality of ~70% and is associated with high readmissions, long-term nursing home placement, and prosthetic/rehabilitation costs. Preventing a single amputation can save Medicare upwards of $50,000–$100,000 in acute and post-acute costs. This figure does not include the long-term program costs for an amputee.

Supervised.Exercise.Therapy.as.Comprehensive.Lifestyle.Management
Supervised exercise therapy (SET) has been covered since 2017 for patients with PAD and is proven to improve walking ability and quality of life. However, SET for PAD requires specialized protocols distinct from cardiac rehabilitation, but current CPT codes don't differentiate between these fundamentally different interventions. Most programs lack integration with lifestyle modification components that are essential for optimal outcomes. Comprehensive SET programs achieve 200% improvement in walking distance plus significant improvements in cardiovascular risk factors, smoking cessation rates, and diabetes control. Evidence shows a 50% reduction in major adverse limb events with intensive lifestyle interventions. Yet national uptake remains below 5%. This is largely due to largely due to access barriers (location, staffing, scheduling, transportation). These structural barriers mean that many patients most in need of exercise interventions are effectively unable to access them, particularly those in rural and underserved communities.

Current coding doesn't capture the specialized nature of PAD exercise prescription or remote monitoring capabilities that could improve outcomes between supervised sessions. Wearable device integration in PAD management shows improved walking distances and better adherence to exercise programs, while remote monitoring reduces the need for in-person visits while maintaining outcomes. CMS should create a tiered coding structure that includes initial assessment with exercise stress testing, functional capacity evaluation, and walking distance measurement. This should be followed by supervised sessions three times weekly for 12 weeks with specialized claudication protocols, remote monitoring through wearable device integration for daily activity and symptom tracking, and objective outcome measurement of walking distance, pain-free time, and functional capacity.

Unsupervised but coached, counseled and monitored exercise therapy can be done under a physician's direction but there is no CPT code or reimbursement for this additional physician work. Developing a parallel CPT code for "unsupervised exercise therapy counseling" would mirror what CMS already does for tobacco cessation counseling and could be structured as a scalable, lower-cost preventive service. CMS should create PAD-specific SET codes that integrate medical optimization and medication titration during exercise sessions, nutritional counseling for diabetes and lipid management, smoking cessation programs tailored to vascular disease urgency, physical activity progression from supervised to independent maintenance, medication adherence support for antiplatelet, statin, diabetes medications, and technology integration through wearable device monitoring.

To address this gap, we encourage CMS to explore the creation of a **new CPT/HCPCS code for "unsupervised exercise therapy counseling" for PAD**. This service could parallel the existing structure of **tobacco cessation counseling codes (99406–99407)**, which recognize the physician/qualified provider time spent educating, counseling, and motivating patients toward behavior change outside of a supervised program. A comparable framework for PAD would:

- Support physician or qualified health professional time spent providing **individualized exercise counseling**, home-based walking prescriptions, and behavioral strategies to promote adherence.
- Enable integration with **remote monitoring and wearable device data**, enhancing accountability and tracking patient progress without requiring facility-based sessions.
- Lower access barriers by allowing patients to engage in lifestyle interventions in their own environment, thereby **expanding reach and equity of preventive vascular care**.

- Serve as a **cost-effective complement** to SET, reserving resource-intensive supervised programs for those who need close monitoring while still enabling all patients to benefit from structured exercise prescriptions.

Just as tobacco cessation counseling codes have proven successful in broadening access to preventive care, a code for unsupervised exercise therapy counseling would align with CMS's goals of promoting lifestyle interventions, improving self-management of chronic disease, and reducing long-term costs associated with vascular complications.

Additionally, IBT for Cardiovascular Disease (CVD Risk Reduction Counseling) covers only ONE face to face visit per year for 15 minutes. This is inadequate to support behavioral change and is much less than what is covered for obesity and STI. CMS should also explore a more robust payment structure for this service.

Enhanced.Payment.for.Complex.Vascular.Risk.Assessment

Comprehensive vascular risk assessment exceeds the typical E&M visit scope, and episodic care with predefined global periods doesn't reflect the ongoing complexity of PAD patient management. Vascular surgeons and specialists spend significant unreimbursed time on risk factor management, smoking cessation counseling, and care coordination that continues through and extends well beyond traditional global periods. The complexity of managing these patients with multiple comorbidities requires enhanced recognition through payment structures. CMS should create enhanced E&M codes for comprehensive vascular risk management available to all qualified PAD management providers, recognizing the time-intensive nature of optimal care.

Care.Coordination.for.Complex.Vascular.Patients

PAD patients average 4.2 specialists, which may lead to fragmented management and missed opportunities for comprehensive risk reduction. PAD screening identifies high cardiovascular risk patients at a lower cost than invasive testing, such as CT calcium scores, stress tests, and echocardiograms. Evidence demonstrates that care coordination reduces hospitalizations by 25% and improves medication adherence. CMS should consider the complexity of the care coordination and management of these patients when determining future payment programs that affect any qualified specialist, including vascular surgery, interventional cardiology, podiatry, and primary care, when managing patients with multiple vascular risk factors across specialties.

The Annual Wellness Visit is a proven but underutilized tool: even in 2022, only ~60% of beneficiaries completed one. To achieve near-universal participation, CMS should consider a **menu of beneficiary and provider incentives**, such as premium reductions for AWV completion, integration into Value Based Insurance Design benefits, supplemental benefit enhancements for MA enrollees, and provider-level performance rewards. These strategies would not only increase preventive care uptake but also generate downstream savings by enabling earlier detection and management of chronic disease.

Traditional cardiovascular risk models, such as Framingham and ASCVD, miss 40% of PAD patients who don't fit standard risk profiles, leading to late diagnosis and preventable complications. PAD affects over 200 million people worldwide and serves as a proxy for systemic cardiovascular disease. Patients with PAD have 2-3x higher risk of cardiovascular death, yet 75% remain undiagnosed until advanced stages. To address this, CMS should expand PAD screening integration into Annual Wellness Visits using inexpensive ankle-brachial index testing. Those who qualify for screening should include traditional criteria of diabetes, smoking, and age over 65, but should also consider family history of PAD or premature cardiovascular disease, geographic location in high-prevalence regions such as rural areas,

socioeconomic factors and limited access to preventive care, race and ethnicity, chronic kidney disease even with mild eGFR reduction, and any lower extremity symptoms or functional limitations.

This comprehensive approach transforms vascular health from a reactive specialty, where invasive procedures become the only treatment options left available to the patients, into a prevention-focused model that addresses the root causes identified in the Administration's "Make America Healthy Again" initiative. While working towards a PAD-free America, CMS needs to create a sustainable payment structure that supports evidence-based care across all qualified providers. By recognizing PAD as both a distinct disease and a proxy for cardiovascular risk, these recommendations create a framework that could serve as a template for chronic disease prevention across multiple specialties.

SVS Comments re: CY2025 Updates to the Medicare Shared Savings Program and the Quality Payment Program

The Society for Vascular Surgery (SVS) appreciates the opportunity to provide comments on CMS's updates to the Medicare Shared Savings Program and the Quality Payment Program. We share CMS's goals of improving quality reporting and aligning performance measurement with meaningful patient outcomes. At the same time, several elements of the proposal raise concerns, particularly given the early stage of MVP adoption. Below, we outline our feedback.

Core Elements for MVPs

CMS proposes requiring that all clinicians reporting on an MVP include at least one core MVP-specific measure. While standardized quality reporting could support better comparisons, this approach would significantly limit clinicians' ability to select measures that reflect their practice. Vascular Surgery practices are broad and heterogeneous, which will greatly limit the applicability of a single measure across all reporting providers. It is still very early in the MVP implementation process, and MVP adoption remains low. As a result, it is too soon to introduce requirements that narrow reporting flexibility. In addition, the SVS would be required to develop new measures to support this request, adding an increased burden at a time when the MVP program is still in its infancy.

Assigning Billing Codes to MVPs

CMS suggests assigning MVPs to clinicians based on their highest-billing procedures. The SVS is strongly against this proposal, as it removes the ability of providers to determine which measures best represent their practice. It will also create challenges in group settings where no single "dominant" procedure may exist. A more flexible approach to MVP reporting would better serve both providers and patients.

Vascular Surgery MVP

The SVS strongly supports the approval of the Vascular Surgery MVP. It reflects a comprehensive view of the care of patients with vascular disease and has relevance to providers outside vascular surgery, such as cardiologists.

We note, however, that CMS removed the patient-centered medical home measure and revised two improvement activities. While we support these specific changes, CMS also stratified the MVP to align measures with specific conditions without consulting the SVS. This stratification risks creating confusion among providers and may lead to misapplication of measures in clinical practice.

Cost Measures

The SVS supports CMS's proposal for a two-year "feedback-only" period for new cost measures. This is a thoughtful step that gives providers the chance to understand how these measures work and how their performance compares with peers, without penalty during the learning phase.

Improvement Activities

SVS supports CMS's proposal to replace the Achieving Health Equity category with Advancing Health and Wellness. The emphasis on prevention, nutrition, and wellness is appropriate and consistent with the evidence that these factors directly affect disease outcomes. That said, "well-being" is a concept that remains difficult to define and measure, and we encourage CMS to provide more clarity before incorporating it into formal requirements.

Data Completeness and Scoring

SVS supports CMS's decision to maintain the current thresholds for data completeness and the minimum score for a positive payment adjustment. These thresholds provide important stability as the QPP evolves and as clinicians move from traditional MIPS reporting toward MVPs.

Ambulatory Specialty Model

CMS proposes a new Ambulatory Specialty Model that relies heavily on patient-reported outcomes (PROs). While we agree that PROs have value, they are uniquely difficult to collect in vascular surgery populations. Even targeted efforts to gather PRO data have shown limited success. Making PROs the foundation of the Ambulatory Specialty Model will disadvantage vascular surgery providers and limit their ability to demonstrate the quality of their work.

Additionally, CMS proposes mandatory reporting on two Improvement Activities (IA) and Promoting Interoperability measures, with penalties for non-compliance. One required IA involves a collaborative care agreement with a primary care physician—something that does not reflect the practice structure of many vascular surgeons. The majority of vascular providers receive referrals from a variety of primary care physicians, rather than a single practice. This IA will need to be re-conceptualized to apply to vascular surgery providers.

Gaps in Knowledge and Infrastructure

There continues to be limited knowledge about quality reporting within vascular surgery, as well as limited infrastructure to support reporting. Without further development and testing, vascular providers will struggle to succeed under these requirements. We encourage CMS to allow more time for building out the necessary support before making reporting mandatory.

The Society for Vascular Surgery values CMS's efforts to strengthen quality reporting and align measures with patient outcomes. However, given the infancy of MVPs and the challenges noted above, we urge CMS to avoid significant changes at this stage. It is critical that CMS engage directly with specialty societies to ensure new requirements are both clinically meaningful and feasible.

We strongly support the approval of the Vascular Surgery MVP and encourage continued collaboration to refine the program. By working together, CMS and the SVS can ensure quality reporting supports better care for patients with vascular disease without creating undue burden for providers.

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The SVS appreciates the opportunity to provide comments and feedback regarding the policies included in the CY2026 Medicare Physician Fee Schedule Proposed Rule. However, and as is outlined in our comments, we remain deeply concerned with foundational instabilities within the MPFS and how these shortcomings are exacerbated by other ancillary policy updates introduced in the annual rulemaking process.

Nonetheless, the SVS reiterates its commitment to work with all relevant stakeholders to identify and advance reforms that will ensure the Medicare physician payment system remains on a more sustainable and efficient path.

If you have questions regarding these comments, please contact Megan Marcinko, SVS' Sr. Director of Advocacy & Public Affairs (mmarcinko@vascularsociety.org).

Sincerely,

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