

September 18, 2019

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: **CMS-1715-P**
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: File Code CMS-1715-P; CY 2020 Revisions to Payment Policies under the Physician Payment Schedule and Other Changes to Part B Payment Policies; (August 14, 2019)

Dear Administrator Verma:

The Society of Vascular Surgery (SVS) is a professional medical specialty society, composed primarily of vascular surgeons, that seek to advance excellence and innovation in vascular health through education, advocacy, research and public awareness. SVS, on behalf of its 5,900 members, appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services CY 2020 Revisions to Payment Policies under the Physician Payment Schedule and Other Changes to Part B Payment Policies.

Valuation of Specific Codes

SVS has significant concerns regarding the RUC recommendations rejected by CMS, particularly with the methodologies and rationale utilized for many codes. SVS believes the Agency is applying incorrect methodologies regarding time sources. CMS/Other codes have never been surveyed. The crosswalk or methodology used in the original valuation of such services is unknown and not resource-based, therefore it is invalid to compare the current time and work to the surveyed time and work. Very few Harvard codes were directly surveyed and most were surveyed only for intra-service work and the pre- and post-service work was computed by algorithm. In addition, for many diagnostic services, only total time is available from an undisclosed source. Therefore, comparing total time to intra-service only time from the modern RUC surveyed codes is not appropriate. In addition, the use of time ratio is not a valid methodology for valuation of physician services. CMS “time/ratio methodology” does not take into account intensity, which is a KEY component of evaluating services. For example, 15 minutes of treating a dissected aorta aneurysm is not the same as 15 minutes to trim nails. SVS believes the Agency’s inconsistent application of valuation methodologies is undermining the very nature of the relative value system. SVS urges CMS to adopt ALL the RUC recommendations forwarded for CY2020.

Intravascular Ultrasound (CPT Codes 37252 and 37253)

In CY 2014, the CPT Editorial Panel deleted CPT codes 37250 (*Ultrasound evaluation of blood vessel during diagnosis or treatment*) and 37251 (*Ultrasound evaluation of blood vessel during diagnosis or treatment*) and created new **bundled** codes 37252 (*Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; initial noncoronary vessel*) and 37253 (*Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel*) to describe intravascular ultrasound (IVUS).

CPT codes 37252 and 37253 were identified via the RUC Work Neutrality screen for re-review. Any code family that has an increase in work RVUs over 10% of what was estimated is reviewed by the RUC to determine what is occurring to impact claims. CPT codes 37252 and 37253 were reviewed at the January 2015 RUC meeting and assumed to be a savings. However, the codes had a 44% increase in work RVUs over the old codes from 2015 to 2016 and the utilization was double from that of the coding structure, not considering the radiological activities. Even though the specialties argued that the change in utilization was due to new policy to price the services in the office, the RUC recommended to resurvey these services to be certain that the time required (and work) had not changed with the addition of a new site of service.

CMS disagreed with the RUC recommendation to maintain the current work RVU of 1.80 for CPT code 37252, which was also the survey 25th percentile. CMS is proposing a work RVU of 1.55 based on a crosswalk to CPT code 19084 (*Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)*) (work RVU = 1.55 and 20 minutes intra-service time and 25 minutes of total time). In reviewing CPT code 37252, CMS notes, that in CY 2015 the specialty society stated that bundling this service would achieve savings. However, since 2015 observed utilization for CPT code 37252 has greatly exceeded proposed estimates, thus CMS is proposing to restore work neutrality to the intravascular ultrasound code family to achieve the initial estimated savings.

The RUC noted that while there was a reduction in work RVUs with the original bundling in 2014, there was an overall increase in utilization offsetting the projected work savings. The increase in utilization came from the concurrent CMS decision to price these services in the non-facility setting and to expand coverage to venous disease. The RUC agreed that the site of service changes (migrating into the office setting) for these services and change in patient population (venous disease) constitute compelling evidence to allow for the observed growth. The RUC noted that these services are performed approximately 35,000 in the Medicare 2017 estimated utilization data. Likewise, the *Physician and Other Supplier Data for CY 2016* indicates that 11% of the utilization for CPT code 37252 are performed by 10 individual providers and 18% of the utilization of CPT code 37253 are performed by 10 individual providers. The claims for these services in the office appear to be highly concentrated in relatively few offices. Due these reasons, the RUC determined there is compelling evidence explaining the growth of these

services. The specialty presented new survey data that support the current valuation of these services.

The RUC notes that increased utilization of 37252 and 37253 may be for a host of reasons, some of which include increased complexity of interventions being performed in the arterial, venous, and aortic spaces. As noted, a large proportion of the use is by a few physicians, something the stakeholder specialties have no control over. An attempt to enforce neutrality when a small group of physicians are at fault should be addressed at a local level. The specialties pointed out during the RUC presentation that if the Agency has concerns about possible overutilization or outlier users for CPT codes 37252 and 37253, they should use the Recovery Audit Contractor (RAC) process to review claims.

CPT Code 37252

SVS does not believe that CPT code 37252 requires the same physician work as CPT code 19084. The intra-service time of 20 minutes for CPT code 37252 is very different from that of 19084. IVUS assists in medical decision making during the intervention and by many physicians is used for problem solving and assessment of adequacy of the intervention, which could result in further intervention. This inherently is more complex than the 20-minute intra-service time of CPT code 19084 where a breast lesion biopsy and clip placement is performed using imaging guidance. The intra-service work for 19084 is a similar process in every patient. In addition, the physician performing 19084 is not the same physician that will provide definitive treatment at a later time. In contrast, the findings of IVUS, can help determine what is the best course of treatment for the patient during the same session by the same physician.

The RUC recommended work RVU of 1.80 for CPT code 37252 is supported by the survey key reference service chosen by physicians who perform this service, CPT code 92978 *Endoluminal imaging of coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel (List separately in addition to code for primary procedure)* (work RVU = 1.80 and intra-service time of 25 minutes). The bundling of two codes produced work savings at the code level as intended. The application of changes to the work RVU based on a change in utilization is misguided as this would be similar to the Agency changing the work RVU for every code every year based on whether the utilization increases or decreases. SVS urges CMS to accept a work RVU of 1.80 for CPT code 37252 based on no change in work and no change in time.

37253

For CPT code 37253, CMS disagreed with the RUC recommendation to maintain the work RVU of 1.44, which was also the survey 25th percentile. However, CMS notes the relative difference in work between CPT codes 37252 and 37253 is an interval of 0.36 RVUs. CMS is proposing a work RVU of 1.19 for CPT code 37253, based on the recommended interval of 0.36 fewer RVUs than the Agency's proposed work RVU of 1.55 for CPT code 37252.

The proposed recommendation is not valid because it is only a calculation and not based on survey data nor directly crosswalked to any service. SVS strongly discourages the use of valuing

the increment as these are not incremental codes (ie, not a base code and a family code with an increment of work). This inaccurately treats all components of the physician time as having identical intensity and is incorrect. CMS should carefully consider the clinical information justifying the difference in physician work intensity provided by the RUC.

CMS should rely on valid survey data and relative services such as CPT code 92978 *Endoluminal imaging of coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel (List separately in addition to code for primary procedure)* (work RVU = 1.80 and intra-service time of 25 minutes) and 92979 *Endoluminal imaging of coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; each additional vessel (List separately in addition to code for primary procedure)* (work RVU = 1.44 and 25 minutes intra-service time). The RUC noted that the intensity and complexity to perform these services are similar warranting a similar work RVU. The bundling of two codes produced work savings at the code level as intended. The application of changes to the work RVU based on a change in utilization is misguided as this would be similar to the Agency changing the work RVU for every code every year based on whether the utilization increases or decreases. SVS urges CMS to accept a work RVU of 1.44 for CPT code 37253 based on no change in work and no change in time.

Abdominal Aortography (CPT Codes 75625 and 75630)

In October 2017, the RAW requested that AMA staff compile a list of CMS/Other codes with Medicare utilization of 30,000 or more. In January 2018, the RUC recommended to survey these services for the October 2018 RUC meeting. Subsequently, the specialty society surveyed these codes.

CPT Code 75625

CMS disagrees with the RUC recommended work RVU of 1.75 and is proposing a work RVU of 1.44 for code 75625 (*Aortography, abdominal, by serialography, radiological supervision and interpretation*) based on an analysis to the top key reference service (KRS) 75710 (*Angiography, extremity, unilateral, radiological supervision and interpretation*) (work RVU = 1.75, 40 minutes intra-service time). CMS is proposing a work RVU reduction to 1.44 for CPT code 75625 based on an intra-service time and total-service time ratio with KRS code 75710. The Agency compares the intra-service time ratio between the survey time of 30 minutes and the KRS time of 40 minutes and found a ratio of 25 percent to calculate a work RVU of 1.31. Additionally, the Agency compares the total-service time ratio between the survey time of 60 minutes and the KRS time of 70 minutes and found a ratio of 14 percent to calculate a work RVU of 1.51. CMS believes an accurate value for CPT code 75625 would lie between the range of 1.31 and 1.51 RVUs. This is an invalid methodology to identify comparative work RVUs.

In addition, the Agency chooses code 38222 *Diagnostic bone marrow; biopsy(ies) and aspiration(s)* (work RVU = 1.44, 30 minutes intra-service time) as a crosswalk to support a proposed work RVU of 1.44 that fits within their range. We disagree with the use of code 38222

as a crosswalk because this code: 1) does not involve imaging and exposure to radiation, 2) does not require intra-arterial access or monitoring of hemodynamic parameters, 3) does not involve injection of intra-arterial iodinated contrast, 4) is a much lower risk procedure and 5) it is performed by physicians from a different specialty. The choice of code 38222 for a crosswalk is inappropriate because there is no clinical coherence between both codes. One is a vascular interpretive procedure while the other is a sampling diagnostic procedure.

SVS urges CMS to use valid survey data and review the actual relativity for all elements (physician work, time, intensity and complexity) when developing work values for services and not foster flawed methodologies that solely focus on time. SVS urges CMS to consider the clinical output of 54 physicians who perform this service and the RUC's collective review of the relativity of this service. SVS requests CMS accept a work RVU of 1.75 for CPT code 75625.

CPT Code 75630

The SVS appreciates that CMS recognizes that the RUC-recommended work RVU of 2.00 is the correct value for 75630 relative to other codes in the PFS.

Angiography (CPT Codes 75726 and 75774)

CMS is proposing the RUC-recommend work RVU for both codes in this family. They are proposing a work RVU of 2.05 for CPT code 75726 (Angiography, visceral, selective or supraseductive (with or without flush aortogram), radiological supervision and interpretation), a work RVU of 1.01 for CPT code 75774 (Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure). CMS is proposing the RUC-recommended direct PE inputs for all codes in the family. SVS appreciates CMS' proposal to accept the RUC recommendations for these services.

Stab Phlebectomy of Varicose Veins (CPT Codes 37765 and 37766)

These services were identified in February 2008 via the RUC High Volume Growth screen, for services with a total Medicare utilization of 1,000 or more that have increased by at least 100 percent from 2004 through 2006. The RUC subsequently recommended monitoring and reviewing changes in utilization over multiple years. In October 2017, the RUC recommended that this service be surveyed for April 2018. The stakeholder specialties requested a change in global period from 090 to 010, which is consistent with many families of codes that typically only require a single postoperative visit within 10 days to perform a wound check and remove sutures. As such, the RUC survey was conducted with a 010 day global period and subsequently the CMS proposed recommendations are in Addendum B as 010 day global services. CMS is proposing the RUC-recommended work RVUs of 4.80 for CPT code 37765 (Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions) and 6.00 for CPT code 37766 (Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions). SVS appreciates CMS' proposal to accept the RUC recommendations for these services.

Duplex Scan Arterial Inflow-Venous Outflow (CPT Codes 93X00 and 93X01)

In September 2018, the CPT Editorial Panel recommended replacing one HCPCS code (G0365) with two new CPT Category I codes to describe the duplex scan of arterial inflow and venous

outflow for preoperative vessel assessment prior to creation of hemodialysis access for complete bilateral and unilateral study.

CMS is proposing the RUC-recommended work RVU of 0.80 for CPT code 93X00 (*Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete bilateral study*), as well as the RUC-recommended work RVU of 0.50 for CPT code 93X01 (*Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete unilateral study*).

CMS is proposing to refine the clinical labor time for the “Prepare room, equipment and supplies” (CA013) activity from 4 minutes to 2 minutes for both codes in the family. Two minutes is the standard time for this clinical labor activity, and 2 minutes is also the time assigned for this activity in the reference code, CPT code 93990 (*Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow)*).

SVS supports the Agency’s proposal to accept the RUC recommendations.

Iliac Branched Endograft Placement (CPT Codes 34X00 and 34X01)

For CY 2018, the CPT Editorial Panel created a family of 20 new and revised codes that redefined coding for endovascular repair of the aorta and iliac arteries. The iliac branched endograft technology includes two new CPT codes to capture the work of iliac artery endovascular repair with an iliac branched endograft. These two new codes were surveyed and reviewed for the January 2019 RUC meeting.

CMS is proposing the RUC-recommended work RVU of 9.00 for CPT code 34X00 (*Endovascular repair of iliac artery at the time of aorto-iliac artery endograft placement 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 rupture or other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, penetrating ulcer, traumatic disruption), unilateral*) and the RUC-recommended work RVU of 24.00 for CPT code 34X01 (*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 preprocedure 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 (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, penetrating ulcer), unilateral*).

SVS supports the Agency’s proposal to accept the RUC recommendations.

Exploration of Artery (CPT Codes 35701, 35X01, and 35X01)

CPT code 35701 *Exploration not followed by surgical repair, artery; neck (eg, carotid, subclavian)* was identified via a RUC screen for services with a negative IWP/UT and Medicare utilization over 10,000 for all services or over 1,000 for Harvard valued and CMS/Other source codes. In September 2018, the CPT Editorial Panel revised one code, added two new codes, and deleted three existing codes in this family of major artery exploration procedures.

CMS is proposing the RUC-recommended work RVU for all three codes in this family. CMS is proposing a work RVU of 7.50 for CPT code 35701, a work RVU of 7.12 for CPT code 35X00 (*Exploration not followed by surgical repair, artery; upper extremity (eg, axillary, brachial, radial, ulnar)*), and a work RVU of 7.50 for CPT code 35X01 (*Exploration not followed by surgical repair, artery; lower extremity (eg, common femoral, deep femoral, superficial femoral, popliteal, tibial, peroneal)*). SVS supports the Agency’s proposal to accept the RUC recommendation for work RVUs and thanks the Agency for correcting the practice expense to reflect the number of office visits contained in the global period..

Payment for Evaluation and Management (E/M) Services

The SVS appreciates the Agency’s efforts to reduce the physician burden related to evaluation and management documentation. We also appreciate the Agency’s willingness to work with the medical community through the AMA CPT/RUC process. However, the anticipated vascular surgery cuts in reimbursement to offset the evaluation and management changes in RVUs for CY2021 are devastating. Vascular Surgery physicians and practices cannot withstand such drastic cuts particularly in addition to all the other payment cuts the specialty has suffered over the past several years. SVS urges the Agency to work with stakeholders, including the Administration to mitigate these negative impacts on the many specialties that are carrying the weight of these changes.

(A)	(B)	(C)	(D)	(E)	(F)
Specialty	Allowed Charges (mil)	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of MP RVU Changes	Combined Impact*
Total	\$92,979	0%	0%	0%	0%
Vascular Surgery	\$1,203	-2%	-3%	0%	-5%
General Surgery	\$2,031	-3%	-1%	0%	-4%

Proposed Add-On Code (GPCIX)

CMS is proposing an add-on code for the evaluation and management services and although, the codes descriptor implies that all physicians may report the code, only a subset of specialties are projected to receive payment for the service in the CMS published impact tables. This new add-on code is not necessary, given CMS’ proposal to adopt the new CPT framework for E/M code level selection which allows for selecting a higher level service when more complexity (or more time) is required. In the CY 2019 MPFS proposed rule, CMS stated the need for GPC1X and

GCG0X is justified in order to account for additional costs and resources not reflected in the proposed single payment rate for levels 2 through 5 visits. This add-on code is no longer justified and therefore not warranted because CMS is no longer proposing a single payment rate for levels 2 through 5 visits. In addition, SVS recommends any such code be discussed through the AMA's CPT/RUC workgroup PRIOR to being implemented in the fee schedule to allow for establishment of CPT guidelines, exclusionary parentheticals and correct assessment of work and practice expense.

Office Visits Included in Surgical Global Payment and RAND Reports

CMS is proposing not to apply the office visit increases to the office visits bundled into global surgery payment. CMS cites their continued efforts with RAND to collect information on global surgery codes as the reason for not applying the updates to the global surgical visits. SVS feels strongly that the RAND initiatives continues to have dramatic flaws in their methodology and reported findings. SVS has specific concerns about the definition of a practice, RANDS's "clean" procedure methodology and inclusion of non-reporters. It is inappropriate for the Agency to abandon the bedrock of the Medicare Fee Schedule, *relativity*, in this proposal. SVS strongly requests that CMS implement changes to the E/M work values and practice expense details to the post-operative office visits bundled visits.

Revised Impacts

SVS has concerns with the validity of the published impacts in Table 111. CMS must consider the public comments submitted in response to the proposed rule, revisit the assumptions for the use of the add-on code, as well as the additional anticipated updates to the underlying code level data and develop a revised impact table in the CY2020 Final Rule indicating the impacts by specialty.

Market-Based Supply and Equipment Pricing Update

In CY2019 CMS proposed to update pricing for over 2,000 supply and equipment items currently used as direct practice expense (PE) inputs based on their contract with StrategyGen. CMS proposed to update supply and equipment pricing over a 4-year phase-in. In the *Proposed Rule* for CY 2020 CMS received invoice submissions for approximately 30 supply and equipment codes from stakeholders as part of the second year of the market-based supply and equipment pricing update. CMS is proposing to update the prices of 36 supply and equipment items as listed in Table 9 of the *Proposed Rule* for CY 2020. SVS appreciates CMS' willingness to review updated pricing throughout this 4-year phase in.

Direct Practice Expense

SVS requests that CMS make available the components that make up all CMS kits/trays/packs. This will allow stakeholders (i.e. specialty societies, AMA RUC Practice Expense Committee, etc.) to assist the Agency and its contractors (i.e. StrategyGen) to develop accurate pricing information.

Medicare Coverage for Opioid Use Disorder Treatment Services Furnished by Opioid Treatment Programs

CMS is proposing to create bundled payments for opioid use disorder (OUD) treatment services which would include the medications approved by the Food & Drug Administration (FDA) for use in the treatment of OUD; the dispensing and administration of such medication, if applicable; substance use counseling; individual and group therapy; and toxicology testing. SVS commends the Agency for addressing opioid-related issues for its beneficiaries. SVS requests that the Agency publish the list of services that are covered within the outpatient treatment programs (OTPs) and guidance on reporting separate services (i.e. surgeons postoperative opioid care coordination) prior to implementation.

Comment Solicitation on Opportunities for Bundled Payments under the PFS

CMS is requesting information on opportunities to expand the concept of bundling to improve payment for services under the RBRVS. Specifically, CMS seeks to explore options for establishing MFS payment rates or adjustments for services that are furnished together. CMS notes options could include a per-beneficiary payment for multiple services or condition-specific episodes of care. CMS specifically notes that it believes the statute, while requiring CMS to pay for physicians' services based on the relative resources involved in furnishing the service, allows considerable flexibility for developing payments under the RBRVS.

SVS is very troubled by CMS' request to further expand 'bundled payments.' We remind CMS that any efforts to create bundled payments should consider implementation costs and historical outcomes. Specifically, we cite the Comprehensive Primary Care Plus Initiative (CPC+) that CMS established for 2017, where the Agency paid \$88,000-195,000 to practices on top of traditional fee-for-service payments. In the first annual report for CPC+, CMS indicates that the bundled payment model had minimal effects on beneficiary outcomes and cost 2 to 3 percent more than for comparison practices.¹ Other such CMS initiatives have had similar outcomes.

In a more limited scope of bundling, the specialties have been working with the AMA CPT/RUC, through the Relativity Assessment Workgroup (RAW) to bundle services based on billed-together thresholds (eg, services reported together greater than 75% of the time). This has resulted in significant payment adjustments for services that are furnished together. CMS has used these savings to implement new initiatives instead of applying the savings to overall Medicare cost. SVS interprets this request for opportunities to expand the concept of bundling as an additional way to inappropriately lower reimbursement for physician services without transparent criteria and possibly shift the savings to other initiatives or new benefits. SVS urges the Agency to work with the AMA CPT/RUC if they have concerns with a particular set of services.

Determination of Professional Liability Insurance Relative Value Units (PLI RVUs)

CMS is seeking comment on the proposed methodological improvements to the development of the professional liability insurance (PLI) premium data. For CY 2020, CMS uses a broader set of PLI filings, available online from the System for Electronic Rates & Forms Filing (SERFF) Filing Access Interface and largest market share insurers in each state, to obtain a more

¹ <https://innovation.cms.gov/Files/reports/cpcplus-fg-firstannrpt.pdf>

comprehensive data set. SVS appreciates the Agency's willingness to improve their PLI source data.

SVS does have concerns with some of the CMS proposals. For instance, CMS proposes to combine minor surgery and major surgery premiums to create the surgery service risk group, which it claims will yield a more representative surgical risk factor. SVS urges the Agency to work with the AMA to address inherent flaws in that methodology (i.e. the definition of "minor" vs. "major" surgery, variation in premium data and physician work RVU shares by service risk type).

Another area of concern is CMS' imputed methodology (based on the notion of trying to represent the rate that an insurer would charge a provider in a given specialty, if the insurer does not specifically list the specialty). For example, we are troubled by the crosswalking of the specialty Peripheral Vascular Disease (76) to Vascular Surgery (77). Peripheral vascular disease is a separately identified specialty that reflects (for the most part) physicians who are not surgeons (eg, internists, phlebologists) and who do not typically perform major surgical procedures with the inherent risk. If this were not the case, there would not be separate specialty designations. As such, the work RVUs and premium data for specialties 76 and 77 should not be combined or imputed to be the same.

Thank you for your consideration of our comments. Should you have any questions, please contact Trisha Crishock at trishacrishock@gmail.com.

Sincerely,

A handwritten signature in black ink, appearing to read "Kim J. Hodgson", with a long horizontal flourish extending to the right.

Kim Hodgson, MD
President, Society for Vascular Surgery (SVS)

cc: Kathy Bryant
Edith Hambrick, MD
Karen Nakano, MD
Michael Soracoe
Gift Tee
Marge Watchorn