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September 11, 2023

SUBMITTED VIA ELECTRONIC MAILING

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, D.C. 20201

[Submitted online at: <https://www.regulations.gov/>]

Re: CMS-1784-P; Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies

Dear Administrator Brooks-LaSure:

On behalf of the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS)¹, I write in response to the calendar year (CY) 2024 Medicare Physician Fee Schedule (MPFS) and Quality Payment Program (QPP) proposed rule, as published in the August 7 version of the *Federal Register*.

The 2024 MPFS continues to create concerns related to payment for physician work and practice expenses. The overall result of CMS' proposals fails to recognize that the proposed conversion factor for 2024 is considerably less than in the 1990s. This is despite practice overhead doubling during the same period. This comes at a time when other Medicare care providers are receiving significant increases in their payments.

CMS projects that otolaryngology would receive a zero percent update from the MPFS valuation in 2024. However, this calculation does not include the 1.25% cut all clinicians are subject to as prescribed in the Consolidated Appropriations Act, 2023 (CAA, 2023). In addition, the continued degradation of valuation for procedure-based services will create obstacles for surgeons to maintain and offer state-of-the-art technology and care to their patients. The combination of these factors could lead to necessary prioritization of non-Medicare patients in order to continue practice operations, delaying access which result in less than optimal

¹ The AAO-HNS is the world's largest organization representing specialists who treat the ears, nose, throat, and related structures of the head and neck. The Academy represents approximately 12,000 otolaryngologists-head and neck surgeons who diagnose and treat disorders of those areas.

situations for Medicare beneficiaries including worse health outcomes. Eventually, continued reductions will lead to physicians opting out of the Medicare program.

The AAO-HNS wishes to provide detailed comments on several specific proposals contained in the proposed rule. Our comments will address the following proposals within the rule: the 2024 conversion factor, practice expense, rebasing the MEI, evaluation and management services, value of otolaryngology services, telehealth, and Quality Payment Program updates for CY 2024.

Physician Fee Schedule

A. Proposed CY 2024 Conversion Factor

The AAO-HNS joins our colleagues across the house of medicine in expressing our strong concerns and opposition to the proposed conversion factor of \$32.75 for CY 2024. This change results in a decrease of \$1.14, or 3.36%, from calendar year 2023 and represents a reduction of over 50% below the 1994 conversion factor level, which would be approximately \$67.75 in current dollars today. When adjusted for inflation, Medicare physician payment has effectively declined 26% from 2021 to 2023. The proposed conversion factor reduction further increases the gap between physician practice expenses and Medicare reimbursement rates. While costs are constantly increasing, inflation and the drop in the conversion factor have methodically eroded the effective reimbursement rate for all physicians, particularly surgeons.

These proposed payment reductions come at a time when physician practices, hospitals that employ physicians, and other healthcare stakeholders, are facing rising costs due to inflation, prevalent and persistent staffing shortages, and disruptive challenges posed by regulatory burdens including prior authorization, fallacious “No Surprises Act” regulations, interoperability requirements, and participating in quality programs through Medicare such as MIPS. These obstacles to the practice of medicine could generate significant problems in access to care for Medicare beneficiaries, especially for those receiving care in the physician office, the most cost-effective setting for providing medical care.

B. Practice Expense RVUs

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

The Medicare Economic Index (MEI), first implemented in 1975, has long served as a measure of practice cost inflation and a mechanism to determine the proportion of payments attributed to physician earnings and practice costs. In the nearly 50 years since the initial establishment of the MEI, data collected by the AMA has served as

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the standard and a consistent source of information about physicians’ earnings and practice costs. The MEI weights that are the basis for current CMS rate setting were based on data obtained from the AMA’s Physician Practice Information (PPI) Survey. This survey was last conducted in 2007/2008 and collected 2006 data.

In last year’s final rule, CMS finalized updated MEI weights for the different cost components of the MEI for CY 2023 using a new methodology based primarily on a subset of data from the 2017 U.S. Census Bureau’s Service Annual Survey (SAS). However, CMS also noted that they postponed implementation of the proposed MEI changes until time uncertain, referencing the need for continued public comment due to the significant impact to physician payments.

MEI History

	1975-1992	1993	Currently Used	Updated MEI Weights (Postponed)
Physician Work	60%	54.2%	50.9%	47.3%
Practice Expense	40%	41.0%	44.8%	51.3%
Professional Liability Insurance	(included with PE)	4.8%	4.3%	1.4%

The persistent inversion of the relationship between physician work and practice expense clearly acts as an “indirect marker” of the unending administrative requirements to practice medicine that continues to plague medical practice today. It should be noted that none of these administrative barriers have shown to improve patient outcomes to date. In the CY 2024 proposed rule, CMS announced that they will continue to postpone implementation of the updated MEI weights, referencing the AMA’s national study to collect representative data on physician practice expenses, the AMA PPI Survey. **The Academy applauds CMS for recognizing the PPI Survey effort and postponing implementation of the updated MEI weights.**

“In light of the AMA’s intended data collection efforts in the near future and because the methodological and data source changes to the MEI finalized in the CY 2023 PFS final rule would have significant impacts on PFS payments, we continue to believe that delaying the implementation of the finalized 2017-based MEI cost weights for the RVUs is consistent with our efforts to balance payment stability and predictability with incorporating new data through more routine updates. Therefore, we are not proposing to incorporate the 2017-based MEI in PFS [rate setting] for CY 2024.”

The AMA and Mathematica formally launched the PPI Survey on July 31, 2023. [The PPI Survey](#), supported by [173 healthcare organizations](#), including the AAO-HNS, will provide more than 10,000 physician practices with the opportunity to share their practice cost data and number of direct patient care hours provided by both physicians and qualified healthcare professionals.

A coalition of other non-MD/DO organizations is also working with Mathematica to administer a similar study of their respective professions. These physicians and QHP surveys will be open through April 2024. Data would be shared with CMS in early 2025 for the 2026 Medicare Physician Payment Schedule rulemaking process.

Major Flaw with Updated MEI Weight Methodology

CMS used data from the U.S. Census Bureau's SAS as the primary source for the proposed MEI cost-component weights. The changes lead to substantial increases in the weights for many of the key components of physician practice expense and would greatly reduce the MEI weights for physician payment and professional liability insurance.

If the implementation of the MEI weights is budget neutral, overall physician work payment would be cut by 7% and PLI payment would be reduced severalfold. The weight of non-physician compensation would increase from 16.6% to 24.7% under the new MEI. These large shifts are principally due to a substantial error in CMS analysis, which omitted nearly 200,000 facility-based physicians. After correcting for this major omission, the physician work MEI weight would instead increase and PLI would likely experience a much smaller reduction.

CMS relied on U.S. Bureau of Labor Statistics (BLS) Occupational Employment and Wage Statistics (OEWS) data to split out the U.S. Census SAS data using only the "Offices of Physicians" North American Industry Classification System (NAICS) category 6211. However, only 64% of employed physicians are in this category. CMS' updated MEI erroneously excluded 36% of physicians who are employed in other health care settings, such as hospitals. For example, the "General Medical and Surgical Hospitals" category (NAICS 6221) was not included in CMS analysis and this category includes 158,880 employed physicians according to the 2017 BLS OEWS data.

In the CY2023 MPFS final rule, in responses to the RUC pointing out this omission of data in CMS analysis, CMS responded that "for physicians who are employed in other healthcare settings directly, such as hospitals, we do not believe that including costs for physicians that do not incur any operating expenses associated with running a practice would be technically appropriate." However, this fails to consider that the MEI weights also cover physician compensation and professional liability insurance. By excluding NAICS 6221 *General Medical and Surgical Hospitals* in

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CMS MEI weights analysis, CMS inadvertently omitted over \$30 billion in physician compensation and over \$7 billion in professional liability insurance compensation. Also, physician practices do still have some indirect practice expense costs even for providers that are solely facility-based (coding, billing, scheduling, etc.). CMS analysis of the U.S. Census SAS data captured a large majority of practice expense covered by the MPFS, but only a subset of the physician compensation and professional liability insurance premiums.

For facility-based services, the MPFS includes the payment for physician work, professional liability insurance, and the practice expense associated with the physician (e.g., billing costs) only. A separate facility payment (e.g., Hospital Outpatient Prospective Payment System (OPPS), Ambulatory Surgical Center (ASC) covers the cost of the service when performed in that setting. With the omission of over \$30 billion in physician compensation and over \$7 billion in professional liability insurance premiums for most facility-based physicians, CMS updated MEI greatly underrepresented the actual proportion of work and PLI costs that practices incur when performing services paid for by the Medicare physician payment schedule. **The Academy strongly urges CMS to correct the substantial error in their updated MEI weights and to postpone implementation of the updated MEI weights until after the AMA completes its national study to collect representative data on physician practice expenses.**

ii. Soliciting Public Comment on Strategies for Updates to Practice Expense Data Collection Methodology

In the proposed rule, CMS included 5 questions related to the AMA Physician Practice Information (PPI) Survey:

1) If CMS should consider aggregating data for certain physician specialties to generate indirect allocators so that PE/HR calculations based on PPI survey data would be less likely to over-allocate (or under-allocate) indirect PE to a given set of services, specialties, or practice types. Further, what thresholds or methodological approaches could be employed to establish such aggregations?

The AMA PPI survey uses stratification to control the distribution of sampled cases, either to match the distribution of the population or to differ from it in a controlled way. The use of stratification will improve the precision of estimates, both overall and within subgroups defined by the stratification. The AAO-HNS recommends that CMS postpone any consideration of the level of granularity of specialty-level data until after the PPI demonstrates the differences and similarities of practice costs by specialty. The AMA and Mathematica could consider recommendations related to this question once the study is completed.

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2) Whether aggregations of services, for purposes of assigning PE inputs, represent a fair, stable and accurate means to account for indirect PE across various specialties or practice types?

The Academy believes it is important for CMS practice expense methodology to have sufficient granularity to reflect actual practice costs incurred by physician practices. Ambulatory payment classification (APC) codes from the Hospital Outpatient Prospective Payment System (OPPS), for example, would not represent a fair, stable and accurate means to account for indirect practice expense for the MPFS due to lack of granularity.

Resource costs in the MPFS are developed through an extremely granular “bottom-up” methodology in which the necessary resource costs are added line by line to achieve the actual costs for the physician to provide the care. In contrast, payment to facilities under the OPPS is calculated on the geometric mean of the costs of services in the same APC codes. To equate the rigorously developed line-item costs associated with services performed in the non-facility setting, with charges that are intended to be an average of “similar” services when performed in the facility is severely flawed because the two systems are making payments under vastly different assumptions.

While hospital charge information is updated on a rolling basis, it does not mean that these cost data are more accurate. Under the OPPS, each APC is assigned a cost weight based on the geometric mean costs of all the procedures assigned to that APC. These estimated costs are derived from hospital charges adjusted to costs using each hospital’s cost to charge ratio (CCR). Rather than estimating the costs of each resource on a per line-item basis, this ratio is an average at the hospital department level. Since the creation of the OPPS, this averaging mechanism has consistently resulted in charge compression. CMS defines charge compression as the “practice of applying a lower charge markup to higher cost services and a higher charge markup to lower cost services.” As a result, the cost-based weights may reflect some aggregation bias, undervaluing high-cost items and overvaluing low-cost items when an estimate of average markup, embodied in a single CCR, is applied to items of widely varying costs in the same cost center.

For the over 8,000 CPT/Healthcare Common Procedure Coding System (HCPCS) codes that have “Active” or “Restricted Coverage” status the CY2024 MPFS NPRM Addendum B, there are only 162 unique APC codes in the CY2024 OPPS NPRM addendum B. Over 3,000 of the CPT/HCPCS codes that are “Active” or have “Restricted Coverage” status do not even have an assigned APC code.

3) If and how CMS should balance factors that influence indirect PE inputs when these factors are likely driven by a difference in geographic location or setting of care, specific to individual practitioners (or practitioner types) versus other

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specialty/practice specific characteristics (for example, practice size, patient population served)?

In the PPI study, the AMA and Mathematica are controlling for the number of sampled practices within strata defined by: (1) specialty, (2) proportion of time in the facility setting, (3) practice size, (4) ownership type (individual ownership vs. more complex ownership types), (5) geographic region, and among practices with complex ownership, whether (6) the practice is part of a vertically integrated health system, and (7) private equity ownership.

The AMA and Mathematica are using these criteria for their initial sampling, and if there is variance in the response rates between different practice types, they will also use these criteria to adjust the sampling midway through the data collection period. Finally, the AMA and Mathematica will develop final analysis weights to adjust for the probability of selection, practice eligibility, and cooperation, ensuring selected weighted totals match marginal population totals from the sample frame. In the survey itself, participating practices are asked to split out their provider compensation and time, staffing and other direct and indirect practice expenses at the Medicare specialty level, if possible.

The AMA and Mathematica could provide recommendations related to this question once the PPI survey is completed. The PPI sampling and weighting methodology should account for most of these factors.

4) What possible unintended consequences may result if CMS were to act upon the respondents' recommendations for any of highlighted considerations above?

Medicare payment differentials between the MPFS and the OPFS are significant and have been growing and this may be a factor in the decline in private practice. In fact, physician survey data indicates that payment and practice costs are two of the three leading reasons for private practices selling to hospitals or health systems.² **It is important to ensure that any potential changes to CMS practice expense methodology do not further exacerbate this relationship and instead work towards correcting site of service inconsistencies.**

In last year's NPRM, CMS provided an impact table related to the initiative of rebasing and revising the MEI weights. The Agency noted that implementation of that change in the PE methodology would have shifted payment weights from physician work to practice expense principally favoring Diagnostic Testing Facility

² Kane CK. Recent Changes in Physician Practice Arrangements: Shifts Away from Private Practice and Towards Larger Practice Size Continue Through 2022. Chicago (IL): American Medical Association; 2023. Policy Research Perspective 2023. <https://www.ama-assn.org/system/files/2022-prp-practice-arrangement.pdf>

(+13%), Portable X-Ray Supplier (+13%), Independent Laboratory (+10%) and Radiation Therapy Centers (+6%) to the detriment of Cardiothoracic Surgery (-8%), Neurosurgery (-8%), Emergency Medicine (-8%) and Anesthesiology (-5%). Modest increases occur to specialties who provide services in the office with extremely expensive disposable supplies embedded into physician payment. Primary Care would face decreases (Family Medicine (-1%), Geriatrics (-2%), Internal Medicine (-2%) and Pediatrics (-2%). Similar to that separate policy change, other changes to the PE methodology would cause massive shifts between specialties, as well as within specialties, and put the solvency of many physician practices and other healthcare organizations in jeopardy. Any changes considered should be made carefully to reflect actual practice costs incurred by physician practices. All changes that impact physician practices should be phased in.

Practices develop business plans based on multi-year projections and are unable to do so without some consistency and predictability. That leads to postponement in upgrading aging technology as well as acquiring new equipment essential for state-of-the-art care.

5) Whether specific types of outliers or non-response bias may require different analytical approaches and methodological adjustments to integrate refreshed data?

The AMA and Mathematica will develop final analysis weights to adjust for probability of selection, practice eligibility, and cooperation, ensuring selected weighted totals match marginal population totals from the sample frame. The AMA and Mathematica will evaluate the potential for nonresponse bias by conducting a nonresponse bias analysis. The AMA and Mathematica are using strata for our initial sampling, as described above. Also, if there is variance in the response rates between different practice types, these criteria will be utilized to adjust the sampling midway through the data collection period.

iii. Supply Packs Pricing

The RUC recently determined that there are numerous discrepancies between the aggregated cost of a supply pack and the individual item components. **The Academy strongly recommends that CMS resolve these pricing discrepancies in the supply packs during CY 2024 rulemaking.** As the supply packs simplify the process of identifying and recommending PE supply direct inputs, one would expect the supply pack price to be identical to the total cost of its individual supply code contents. The mathematical errors should be rectified as soon as possible by CMS to ensure that the sum totals from the individual items.

At the April 2023 meeting, the PE Subcommittee formed a workgroup to review the content of the supply packs to assess if each of them are still typical and revise as necessary. The Workgroup affirmed the contents of the complete packs for

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submission to CMS with the RUC request to ensure accurate packs pricing. The RUC concurs that mathematical correction is needed immediately. **The AAO-HNS supports the RUC recommendations that:**

- **CMS revise packs SA042, SA045, SA046, SA049 and SA082.**
- **CMS immediately initiate correction of the packs pricing such that the sum of the individual components match the price of the corresponding pack.**

iv. Updates to Prices for Existing Direct PE Inputs

CMS proposes to update pricing for the following direct PE inputs for ENT services (Table 1). The Academy agrees with several of these proposed changes and disagrees with a few of them. Please see our rationale for disagreement in the table below.

Table 1: CY 2024 Direct PE Refinements

Specialty Society Surveyed/Presented	Input Code	Input code desc.	Non facility (NF) / Facility (F)	Labor activity (where applicable)	RUC recommendation or current value (min or qty)	CMS refinement (min or qty)	Comment	Direct costs change (in dollars)	Specialty Agree/ Disagree	(If Disagree) Specialty Comment
AAO-HNS	L037D	RN/LPN/MTA	NF	Conduct patient communications	3	0	G1: See preamble text	-1.49	Disagree	This staff contact with the patient is different than, and separate from, anything that occurs the day of the procedure. This is a follow-up phone call by staff to see how the patient is doing after the procedure and see if they have any specific questions. This is completely different than the discharge management on the day of the procedure.
AAO-HNS	L037D	RN/LPN/MTA	F	Conduct patient communications	3	0	G1: See preamble text	-1.49	Disagree	This staff contact with the patient is different than, and separate from, anything that occurs the day of the procedure. This is a follow-up phone call by staff to see how the patient is doing after the procedure and see if they have any specific questions. This is completely different than the discharge management on the day of the procedure.

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AAO-HNS	SB027	gown, staff, impervious	NF		2	0	S1: Duplicative; supply is included in SA042	-2.37	Agree	
AAO-HNS	ES031	scope video system (monitor, processor, digital capture, cart, printer, LED light)	NF		39	32	E19: Refined equipment time to conform to established policies for scope accessories	-1.87	Agree	
AAO-HNS	SB027	gown, staff, impervious	NF		2	0	S1: Duplicative; supply is included in SA042	-2.37	Agree	
AAO-HNS	ES031	scope video system (monitor, processor	NF		39	34	E19: Refined equipment time to conform	-1.34	Agree	

Specialty Society Surveyed/Presented	Input Code	Input code desc.	Non facility (NF) / Facility (F)	Labor activity (where applicable)	RUC recommendation or current value (min or qty)	CMS refinement (min or qty)	Comment	Direct costs change (in dollars)	Specialty Agree/Disagree	(If Disagree) Specialty Comment
		, digital capture, cart, printer, LED light)					to established policies for scope accessories			
AAO-HNS	ES040	PROXY endoscope, rigid, sinoscopy (0 degrees)	NF		39	41	E4: Refined equipment time to conform to established policies for scopes	0.02	Agree	
AAO-HNS	SB027	gown, staff, impervious	NF		2	0	S1: Duplicative; supply is included in SA042	-2.37	Agree	

C. Evaluation and Management Services

i. G2211 Add-On Code

The proposed rule implements G2211, previously finalized but delayed by Congress until 2024, for separate payment for the office/outpatient E/M visit complexity add-on code.

G2211 has the potential to recognize the resources required to provide comprehensive, team-based care. **The existing CPT and RUC methodologies for creating, describing, and valuing E/M services do not account for this additional complexity and comprehensiveness, leaving a gap in office-based coding in the MPFS that will be filled by G2211.**

For instance, CPT describes levels of office/outpatient E/M codes based only on time and medical decision making, which CPT divides into:

- Number and Complexity of Problems Addressed at the Encounter
- Amount and/or Complexity of Data to Be Reviewed and Analyzed
- Risk of Complications and/or Morbidity or Mortality of Patient Management

However, under the resource-based relative value scale, “work” is understood to be a product of time and “intensity.” “Intensity,” in turn, is understood as a function of:

- Mental effort and judgment (possible diagnoses and management options, amount/complexity of data to be considered, and urgency of medical decision making)
- Technical skill
- Physical effort
- Psychological stress (risk of complications/morbidity/mortality, outcome dependent on skill/judgment of physician, and estimated risk of malpractice suit with poor outcome)

“Intensity” is broader than medical decision making and encompasses elements of work not considered in the CPT E/M descriptors. For example, some office/outpatient E/M services are more urgent than others, and some require more technical skill with respect to the physical exam, but CPT makes no distinctions in that regard.

The RUC is also challenged to comprehensively capture coordinated, team-based care in its current process of valuing E/M services. There are two ways in which this happens. First, the RUC survey process focuses on the “typical” patient and

distributes surveys based on vignettes for E/M services that are much less specific, making it more difficult to quantify the physician work involved than for more specific procedural service vignettes. Second, this problem is compounded when these broad E/M vignettes are surveyed across more than 50 specialty societies many of which do relatively few and much more straight-forward E/M visits. This approach undervalues the input of the specialties that provide the most complex E/M services and do so most commonly.

Implementation of this code will allow physicians to account for services like chronic disease management tracking, review of consult or lab reports, medication-related monitoring and safety outside of patient visits, and physician input at assisted living or nursing homes. As CMS has [recognized](#), these coordinated, team-based actions take considerable physician time, yet up until this point, there has been no way to fully capture nor compensate for the resources and unique costs required to establish and maintain these longitudinal relationships. Existing coding processes are better at describing procedures than cognitive services such as continuous, team-based care.

The AAO-HNS wholeheartedly agrees with CMS that, for selected disease processes and patients, there are additional resources not accounted for in the standard E/M valuations as they currently exist. **We fully support the HCPCS add-on code G2211.**

We also agree with CMS' revised utilization estimates. As was stated in our 2021 comments, we estimate that the utilization of this code for otolaryngology would be closer to 50%. The initial utilization assumption of the add-on code was 90% in the 2021 rule, and now the revised utilization assumption is 38% when initially implemented in 2024 and 54% once the code has been fully adopted.

Lastly, once the code is finalized, **we suggest that CMS produce educational materials for participating providers designed to clarify appropriate usage of the code.** The AAO-HNS would be willing to assist CMS in that endeavor in any way we can.

ii. E/M Split or Shared Visits

The AAO-HNS thanks CMS for the decision to delay the implementation of changes once again to how split/shared E/M visits are billed while working to determine how best to define time as the "substantive portion" of split/shared E/M services.

The AAO-HNS reaffirms our previous comments submitted in 2022 in response to the CY 2023 MPFS proposed rule, in which we stated this policy change would have drastically disruptive consequences to team-based care and would interfere with the way in which care is delivered in the facility setting.

Time alone does not always determine who performs the critical elements of a visit. Medical decision making determines the course of treatment for the patient, but it typically does not require the most time. In addition, there is significant variability in how much time it takes to perform elements of a visit based on factors such as the level of training and expertise of the physician and other providers.

While a year long delay is very much needed, **the ideal outcome beyond 2024 would be for CMS to propose an alternative policy that allows physicians and other providers to bill split or shared visits based on time or medical decision making.**

iii. Regular and Comprehensive Reviews of E/M Services

In the proposed rule, CMS is seeking feedback on how to improve the accuracy of valuation for services, and how to evaluate E/M services with greater specificity, more regularly and comprehensively. **The AAO-HNS believes the existing E/M HCPCS codes, with the inclusion of the G2211 add-on code, accurately define the full range of E/M services with the appropriate gradations for intensity of services.** As stated above, the AAO-HNS believes that the implementation of the G2211 add-on code will comprehensively recognize the resources required to provide comprehensive, team-based care – which is optimal for patient outcomes.

HCPCS codes are an integral part of the provision of many physician services. To be used appropriately and to capture their intended utilization, a HCPCS code needs to be precisely and accurately defined and described. A concise and precise descriptive definition allows for a procedure, supply, or product to be appropriately valued. A HCPCS code that is accurately valued benefits the entire house of medicine as it contributes to maintaining a fair distribution of reimbursements in the MPFS.

Appropriate evaluations of E/M services as well as procedural services will only be successful if physicians across all specialties utilize survey instruments that can be validated objectively. The current survey process lacks a mechanism to validate the actual time spent performing a service. Time inaccuracies flow throughout the current fee schedule using the current system. Technology is available in most Electronic Health Records, as well as in operating rooms and ASCs, to record time spent for a particular service.

The AAO-HNS recommends that consideration be given to investigation of a replacement methodology. Until a replacement methodology can be identified and approved, it is essential that the RUC ensures that surveys be as robust as possible to meticulously provide data that assists in valuation and the assignment of appropriate RVUs. We encourage CMS to proactively engage and educate the physician community on the importance of robust participation in the RUC survey process. This will confirm that the agency has the information its needs to determine fair and

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accurate reimbursement across physician services, until such time that the replacement strategy can be implemented.

D. Valuation of Otolaryngology Services

i. Posterior Nasal Nerve Ablation (CPT codes 30117, 30118, 3X016, and 3X017)

In September 2022, the CPT Editorial Panel created two new endoscopy codes for ablation of the posterior nasal nerve: CPT code 3X016 (*Nasal/sinus endoscopy, surgical; with destruction by radiofrequency ablation, posterior nasal nerve*), and CPT code 3X017 (*Nasal/sinus endoscopy, surgical; with destruction by cryoablation, posterior nasal nerve*). In preparation for the January 2023 RUC meeting, both new posterior nasal nerve codes, 3X016 and 3X017, as well as family CPT codes 30117 and 30118, were surveyed. For CY 2024, the RUC recommended a work RVU of 3.91 for CPT code 30117, a work RVU of 9.55 for CPT code 30118, and a work RVU of 2.70 for both CPT codes 3X016 and 3X017.

CMS is proposing the RUC-recommended work RVU of 3.91 for CPT code 30117. They are proposing to remove the clinical labor for the CA037 (*Conduct patient communications*) activity code for CPT code 30117. This clinical labor is associated with patient communications which already take place during the CA036 (*Discharge day management*) activity code for 10-day and 90-day global procedures. They are proposing to remove this clinical labor as it would be duplicative with the communications already taking place under the CA036 activity code. They are proposing to delete supply item SB027 (*gown, staff, impervious*) because supply items SA042 (*pack, cleaning and disinfecting, endoscope*) and SA043 (*pack, cleaning, surgical instruments*) each include this same item. Supply items SA042 and SA043 are both included in the direct PE inputs for CPT code 30117.

CMS disagrees with the RUC-recommended work RVU of 9.55 for CPT code 30118 and are proposing a work RVU of 7.75, based on a direct crosswalk from CPT code 28298 (*Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with proximal phalanx osteotomy, any method*) which has the same 60 minutes of intra-service time and similar total time as CPT code 30118. They believe the work RVU should be lower than the RUC recommendation of 9.55 to reflect the decrease in intra-service time from 105 minutes to 60 minutes, and the decrease in total time from 288 minutes to 211 minutes. In the case of CPT code 30118, the intra-service work time is decreasing by 43% and the total work time is decreasing by 27%, but the RUC-recommended work RVU is only decreasing by 4%. Although CMS does not imply that the decrease in time as reflected in survey values must equate to a one-to-one or linear decrease in the valuation of work RVUs, they believe that since the two components of work are time and intensity,

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significant decreases in the surveyed work time should be reflected in commensurate decreases to work RVUs.

CMS also notes that at the RUC-recommended work RVU of 9.55, the intensity of CPT code 30118 would be increasing by more than 50%. They disagree that there would be such a significant increase in the intensity for the procedure, as it is transitioning from inpatient to outpatient status which suggests that the intensity has remained the same or decreased over time.

They also disagree that this would be the case since the intensity for CPT code 30117 is decreasing at the RUC-recommended work RVU of 3.91. Therefore, we are also proposing a work RVU of 7.75 because it maintains the current intensity of CPT code 30118 instead of resulting in an increase in intensity. The proposed work RVU of 7.75 is supported by the reference CPT codes they compared to CPT code 30118 with the same 60 minutes of intra-service time and similar total time as CPT code 30118; reference CPT code 11970 (*Replacement of tissue expander with permanent implant*) has a work RVU of 7.49, and reference CPT code 19325 (*Breast augmentation with implant*) has a work RVU of 8.12. We believe the proposed RVU of 7.75 is a more appropriate value overall than 9.55 when compared to the range of codes with the same intra-service time and similar total time.

CMS is proposing to remove the clinical labor for the CA037 (*Conduct patient communications*) activity code for CPT code 30118. This clinical labor is associated with patient communications which already take place during the CA036 (*discharge day management*) activity code for 10-day and 90-day global procedures. They are proposing to remove this clinical labor from CPT code 30118 as it would be duplicative with the communications already taking place under the CA036 activity code.

CMS is proposing the RUC-recommended work RVU of 2.70 for CPT codes 3X016 and 3X017. Both CPT codes 3X016 and 3X017 are endoscopic procedures; therefore, CMS is proposing CPT code 31231 (*Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)*) as the endoscopic base code for both codes because the description of these procedures includes what is described for CPT code 31231, with the additional component of the posterior nasal nerve ablation. Both procedures are performed with an endoscope. CPT codes 3X016 and 3X017 are not add-on codes, and both have a 0-day global period. The endoscopic base code assigned to CPT codes 3X016 and 3X017 is used in a specific type of multiple procedure payment reduction that applies to some endoscopy codes.

CMS is proposing to refine the RUC-recommended direct PE inputs for both CPT codes 3X016 and 3X017. For CPT code 3X016, they are refining the equipment time for the ES031 equipment (*scope video system (monitor, processor, digital capture, cart, printer, LED light)*) from 39 minutes to 32 minutes. The RUC used the

CA025 (*clean scope*) time of 10 minutes instead of the CA024 (*clean room/equipment by clinical staff*) time of 3 minutes in the Scope Systems formula, when the time for CA024 is the standard; they believe that this was an unintended technical error in the RUC recommendation. They are similarly refining the equipment time for ES031 from 39 minutes to 34 minutes for CPT code 3X017.

For CPT code 3X017, CMS is refining the equipment time for the ES040 equipment (*PROXY endoscope, rigid, sinoscopy (0 degrees)*) from 39 minutes to 41 minutes because the RUC used 18 minutes of intra-service time for CA018 (*Assist physician or other qualified healthcare professional---directly related to physician work time (100%)*) instead of 20 minutes in the standard Scope formula. Also, for both CPT codes 3X016 and 3X017, CMS proposes to delete supply item SB027 (*gown, staff, impervious*) because SA042 (*pack, cleaning and disinfecting, endoscope*) and SA043 (*pack, cleaning, surgical instruments*) each include this same item. Supply items SA042 and SA043 are both included in the PE inputs for CPT codes 3X016 and 3X017.

The AAOHNS strongly disagrees with the decrease in value for 30118. The crosswalk to code 28298, correction of a bunion, is completely inappropriate in terms of intensity. 30118 represents excision or destruction of an intranasal lesion, external approach. This includes an incision along the lateral wall of the nose, reflection of the external nose off the rest of the face, management of the lacrimal drainage system and medial canthal tendon, preservation of the ethmoid artery, careful removal of the tumor, confirming adequate resection with clean margins to ensure it does not return. This is necessary in all malignant and most benign nasal lesions. Furthermore, this code then requires meticulous closure of this incision to optimally restore mid-face normality. **We strongly believe that the skill required to perform 30118 and restore the normal cosmetic appearance of the mid-face and orbital areas is significantly greater than correction of a bunion. While CMS feels the increase in the IWP/UT at the RUC approved value is inappropriate, we argue that this procedure was previously undervalued in terms of intensity.**

All these arguments were discussed by the RUC, which agreed with the above sentiments. Simply cross walking to a code with similar times removes all the nuance from this process and ignores the intensity of the procedure that the RUC carefully considered when making their recommendation. **Therefore, we respectfully request that CMS finalize the RUC recommended work RVU of 9.55 for code 30118 in the 2024 final MPFS.**

ii. **Auditory Osseous Integrated Device Services (CPT codes 926X1 and 926X2)**

CMS proposes the RUC recommended work RVU for codes 976X1 and X2. **The Academy agrees with, and appreciates, this recommendation.** We also support CMS' proposal to add modifier AB to these codes to allow audiologists to independently report these services, as they are likely to be the primary provider of the programming service.

E. Telehealth

AAO-HNS members have exercised many of the telehealth flexibilities offered by CMS to the benefit of the practitioners and their patients. For CY 2024, CMS is proposing the continuation of several telehealth policies under the MPFS to align with the timeframe of flexibilities according to the CAA, 2023. **The AAO-HNS strongly supports the continuation of reasonable telehealth policy through December 31, 2024, which will allow time to wind down these flexibilities and minimize the impact to patient care.**

i. Continuation of Expansion of Telehealth Practitioners to Include Speech-Language Pathologists and Qualified Audiologists

CMS proposes to continue to expand the definition of telehealth practitioners to include qualified speech-language pathologists and qualified audiologists. The physician-led healthcare team that diagnoses and treats both acute and chronic speech, voice, swallowing, and hearing problems can only achieve the best patient outcomes when all the tools are available to care for individual patients. Whether the etiology of these problems is related to trauma, neurologic disease, aging or misuse, the involvement of speech language pathologists and qualified audiologists is essential to carry out the entirety of the team-based plan that is based on individual needs and circumstances. **The use of telehealth services has proven to be an effective way to expand access to these services, particularly for those patients living in areas of under supply of providers. The AAO-HNS strongly supports the continued expansion of telehealth practitioners to include Speech Language Pathologists and Qualified Audiologists.**

ii. Audio-Only Services

Due to provisions in the CAA, 2023, CMS proposes to continue to provide for coverage and payment of telehealth services via an audio-only communications system through December 31, 2024. **The AAO-HNS generally opposes coverage of audio-only services valued at the same level as in-person visits. Audio-only services are not analogous to in-person care, nor are they a substitute for a face-to-face encounter. The AAO-HNS supports the removal of audio-only services from the Medicare Telehealth list after December 31, 2024 or revaluing the audio-only service more appropriately.**

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iii. **Direct Supervision via Use of Two-Way Audio/Video Communications Technology**

CMS proposes to continue to define direct supervision to permit the presence and immediate availability of the supervising practitioner through real-time audio and video interactive telecommunications through December 31, 2024. Additionally, CMS is soliciting comment on whether it should consider extending the definition of direct supervision to permit virtual presence beyond December 31, 2024. **The AAO-HNS supports permanently modifying direct supervision requirements so that direct supervision can be performed via real time interactive audio/video technology for a subset of services. Virtual supervision should be robustly documented to ensure that patients are safely receiving clinically appropriate care from all members of the care team.**

iv. **Category 3 Codes**

CMS proposes to continue the use of a third category of criteria for adding services to the Medicare Telehealth Services List on a temporary basis following the end of the public health emergency (PHE) for the COVID-19 pandemic. This new category describes services that were added to the Medicare Telehealth Services List during the PHE, for which there is likely to be clinical benefit when furnished via telehealth, but there is not yet sufficient evidence available to consider the services for permanent addition under the Category 1 or Category 2 criteria. Otolaryngologists have benefited from the creation of category 3 as it has allowed physicians to safely provide quality care to their patients. While there are concerns about whether these codes can be done virtually or should be added to the permanent telehealth lists, **the AAO-HNS supports keeping the codes on the temporary category 3 list through December 31, 2024, to ensure there is sufficient time to determine whether it is feasible for these codes to remain telehealth eligible.**

Quality Payment Program Updates for Calendar Year (CY) 2024

A. Scoring and Data Completeness

i. Performance Threshold

The AAO-HNS does not support the increase of the performance threshold from 75 to 82 points. While we appreciate the intent of the increase of the performance threshold to pave the way for a more substantial positive payment adjustment, the methodology to assess the CY2017 – 2019 mean scores is inappropriate. The MIPS program in 2017 (Pick your Pace) was vastly different than today's program.

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Clinicians had a greater chance to achieve higher scores in the program's earlier years. A review of the historical benchmarks from 2017 to 2023 as outlined in Table 2 below demonstrates that the limited scoring potential of the MIPS CQM collection type can be attributed to the availability of measures rather than quality healthcare. From 2017-2019, the impact of the 7-point cap was negligible. From 2020 onward, the cap restricted the scoring significantly and in 2023 it impacts nearly one-third of the program's MIPS CQMs. If one considers both the benchmark and the 7-point cap, there are approximately 55 MIPS CQMs with full scoring potential, many of which are specialty specific (emergency medicine, physical therapy, cardiology, surgical, etc.). Further increasing the performance threshold exacerbates the scoring inequity among specialties.

Table 2: Longitudinal Review of MIPS CQM collection type Historical Benchmarks:

PY	7-point cap	Topped Out	Benchmarked
2017	00.0%	32.1%	72.0%
2018	2.4%	26.6%	51.6%
2019	18.0%	39.9%	65.7%
2020	32.1%	37.8%	74.1%
2021	24.3%	30.8%	65.9%
2022	23.6%	31.7%	67.2%
2023	29.1%	34.9%	66.3%

Furthermore, there were more opportunities for acquiring bonus points at the start of the program. Bonus points were awarded for end-to-end reporting, submission of additional outcome (2 points) or for including high priority measures (1 point), meeting Promoting Interoperability (ACI) requirements and finally bonus points were available to designated small practices. In the current MIPS program, bonus point opportunities are restricted to the small practice bonus. In addition to the bonus points, measures without benchmarks were originally awarded three points. These measures currently receive zero points and account for one third of the 2023 MIPS CQMs.

In 2024, for measures which do have benchmarks, they will be derived from data submitted during the public health emergency (2022). **The AAO-HNS encourages CMS to consider the impact of the Extreme and Uncontrollable Circumstance (EUC) exemption during the public health emergency which has led to skewed benchmark data.** During the PHE, physician practices experienced staff shortages, staff and clinician illness, and other challenges which caused many to take the adjustment, particularly if those adjustments were expected to lead to a higher risk for a negative payment adjustment. Other practices that were still affected by the

PHE, yet were scoring above the performance threshold, continued to submit thereby increasing the performance averages for many quality measures. Due to these impacts, it has become increasingly difficult to score points in the quality performance category and the correlation between the quality score and the care clinicians provide may therefore be more indicative of policy constraints and the measures available to the clinician, rather than the care they provide. Coupled with the unknowns of the cost performance category, the **AAO-HNS encourages CMS to delay the proposal and allow the threshold to be determined by a final score derived from a performance year with similar requirements and scoring.**

ii. Data Completeness

The AAO-HNS appreciates the phased in approach to increase data completeness but **encourages CMS to consider the data completeness challenges for practices that change electronic health records (EHR) or add new eligible clinicians mid- or late-performance year.** Consistent with moving towards digital measures, many registries are fully integrated with EHRs which can take months to integrate, perform gap analyses, and validate measure data. Our registry supports over 25 EHRs, each with additional hosting considerations (i.e., local, cloud) and requires various levels of integration, gap analysis, and validation. In our experience, a small private practice requires at least 3 months to fully integrate with a new EHR. For academic medical centers, once legal agreements are in place, integration and validation can take at least 6-8 months. In conjunction with integration, CMS should also consider the additional burden to clinicians and staff as they transition to a new EHR. These transitions require extensive training, clinical workflow evaluation, and can lead to staff turnover. **The AAO-HNS recommends expanding the EUC qualifications to include EHR migrations. This would allow practices to apply and cite the challenges and experiences for consideration.** Alternatively, we suggest adopting a similar policy as the ICD-10 and/or guideline updates which result in truncation. In the instance a practice changes EHRs or adds new eligible clinicians after September 30, the performance year would be truncated to the first nine months of data. Simply adjusting the data completeness is not an appropriate alternative as this would require integration and validation within the new EHR to confirm patient population (denominator). CMS has applied leeway internally to ensure systems can support policy and requests the same latitude be provided to the clinicians.

iii. Third-Party Intermediaries

The AAO-HNS supports CMS' proposal to remove Health IT Vendors from the definition of a third-party intermediary. Qualified Clinical Data Registries are held to a much higher standard than IT vendors require. The absence of auditing requirements may have contributed to elevated benchmarks. This lack of oversight may be contributing to inaccurate and unusable data that could result in improper

payments or otherwise undercut the integrity of the MIPS program. Any third-party intermediaries submitting data for benchmarking purposes should be required to perform the minimum audit requirements.

B. MIPS Value Pathways (MVPs)

i. Quality Care for the Treatment of Ear, Nose, and Throat

The AAO-HNS appreciates the inclusion of Quality Care for the Treatment of Ear, Nose, and Throat Disorders in the proposed rule. This MVP will provide an opportunity for many otolaryngologists to participate in the MVP pathway reporting option. The AAO-HNS looks forward to further collaboration in the MVP maintenance and expansion process. The Academy will also continue to develop and submit additional otolaryngology-specific measures to cover the many sub-specialties within otolaryngology to ensure the MVP is applicable to most of the specialty.

ii. MVP Support Requirement

The AAO-HNS supports the proposed exceptions for QCDRs to support all quality measures within an MVP. CMS' stance that QCDR measures should remain available to the approved QCDRs only and through an agreement with the measure owner is reasonable.

iii. MVP Eligibility

To promote MVP adoption, **the AAO-HNS encourages CMS to allow opt-in and voluntary reporters to register for MVP participation regardless of eligibility status.** Restricting eligible clinicians determined by the first determination period is counterintuitive to the goal to promote broad-based MVP participation.

C. Cost and Quality Measures

i. Proposed to be added to MIPS and the Otolaryngology Specialty Set: Connection to Community Service Provider

CMS is proposing to include the "Connection to Community Service Provider" measure in the Otolaryngology specialty set as screening for and working to address patient's health-related social needs can be a key component to a patient achieving health equity with all clinical settings and clinician types.

The AAO-HNS agrees with the intent of the measure, **however, as constructed it may have limited impact on promoting health equity since the denominator**

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only includes a subset of patients that may benefit from connecting with a community service provider. Patients not screened for health-related social needs will be excluded from the patient population. As constructed, it allows ‘self-selection’ or ‘cherry picking’ of patients.

ii. Proposed Quality Measure Removal

Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use:

While the AAO-HNS understands the scoring limitations of this measure, **we encourage CMS to consider the repercussions of antimicrobial overuse.** Overtreatment with antibiotics may increase patient harm and can lead to antibiotic resistance. In addition, there are new eligible clinicians beginning practice and coming into the program each year who are never measured against some of the very important process measures within a specialty due to these measures being removed after being topped out. We encourage CMS to consider this as they review measures annually for removal from the program.

iii. Digital Measures

The AAO-HNS supports the idea of reducing burden and moving towards digital measures, however, CMS should consider the lack of cooperation from electronic health records companies. Our members use multiple EHRs, each allowing varying degrees and methods of data transfer. The responsibility to standardize data models and elements should not be placed on the clinician. In addition, robust quality measures typically require both structured and unstructured data which can also pose challenges for eCQM implementation and data abstraction. As CMS continues to develop a roadmap to digital measures, we urge the agency to consider the existing roadblocks and burdens to obtain all required data. Transitioning to complete digital measures cannot truly occur until there is policy that requires electronic health record companies to standardize data and interoperability.

D. Request for Information (RFI)

CMS is seeking feedback on how they might modify policies, requirements, and performance standards to encourage clinicians to continuously improve the quality of care, particularly for clinicians with little room for improvement in MIPS.

The AAO-HNS appreciates the RFI on the strategic vision of the program. **We encourage CMS to view specialty societies as partners, especially as the agency transitions to MVPs.** The current measure development timeline and requirements do not allow for timely implementation of quality measures. **The AAO-HNS encourages CMS to consider policies that would promote early adoption of**

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clinical practice guidelines and outcome measures when available. Under the current policy, quality measures promoting adherence take at least two years to implement. Many QCDRs can drive outcomes but are stifled by the complex requirements of the program.

Prior to the PHE, CMS engaged with specialty societies, qualified registries, and QCDRs by holding a whiteboarding session. This in-person meeting was very well-received and generated many great ideas. **The AAO-HNS suggests reviving this meeting to hear from stakeholders post-PHE.**

Lastly, CMS should consider the duration which a clinician is in practice. A clinician in their first years of practice may require more rudimentary quality measures to ensure basic adherence to guidelines (i.e., antimicrobial stewardship). While a physician practicing for many years may benefit from a different set of metrics.

E. Public Reporting of Cost Measures

The AAO-HNS does not support public reporting of cost measure information until there are more meaningful cost measures developed by each specialty with CMS's help. CMS should work to partner with specialty societies, including the AAO-HNS, as they look to develop, validate, and implement meaningful cost measures across the spectrum of care. Specialty practices are very concerned about appropriate attribution of cost within episodes of care and believe utilizing only the Medicare Spending Per Beneficiary or Total Per Capita Cost measures is less than ideal.

In addition, CMS is not currently able to provide meaningful feedback reports to the clinicians. QCDRs are required to provide feedback reports to their clinicians four times a year so that clinicians can adjust clinical workflow for quality improvement. Once there are more meaningful cost measures per specialty, the same should be expected of cost measures so that clinicians are aware of their cost score prior to the final scores, that are provided 9 months after the end of the performance period.

F. Sunset of AUC program

The AAO-HNS appreciates CMS acknowledging the limitations of the current Appropriate Use Criteria (AUC) program and fully supports sunseting the current program. We are hopeful that CMS will consult with stakeholders, including professional societies and medical guideline developers, to evaluate the current program, available data, and a path forward.

The AAO-HNS strongly supports using appropriate use criteria and clinical guidelines to drive decision making for diagnostic imaging services, however, we

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need to ensure providers still can rely on specialty-specific AUC and clinical guidelines as developed by the professional societies for their respective specialty. We look forward to working with CMS and other specialties to consider available options and, if deemed the best solution, to develop an appropriate use program that is viable and beneficial for medical specialties without an increase to the already significant administrative burden.

Conclusion

The American Academy of Otolaryngology-Head and Neck Surgery appreciates the opportunity to provide comments and recommendations regarding these important policies on behalf of our members. We look forward to working with CMS as it continues its efforts to improve patient access to quality care and reduce regulatory burdens for clinicians. If you have any questions or require further information, please contact healthpolicy@entnet.org.

Sincerely,



James C. Denny, III, MD
Executive Vice President and CEO