NATIONAL QUALITY FORUM

Memo

October 23, 2018

To: Consensus Standards Approval Committee (CSAC)

From: Surgery Project Team

Re: Surgery Spring 2018 Review Cycle

CSAC Action Required

The CSAC will review recommendations from the Surgery project at its October 23-24, 2018 meeting and vote on whether to uphold the recommendations from the Committee.

This memo includes a summary of the project, measure recommendations, themes identified and responses to the public and member comments and the results from the NQF member expression of support. The following documents accompany this memo:

1. **Surgery Spring 2018 Draft Report**. The draft report has been updated to reflect the changes made following the Standing Committee's discussion of public and member comments. The complete draft report and supplemental materials are available on the project webpage.
2. **Comment Table**. Staff has identified themes within the comments received. This table lists nine comments received during the post-meeting comment period and the NQF/Standing Committee responses.

Background

The measures in NQF's surgery endorsement project focus on key surgical care processes across an array of procedure types that include outcomes for general and subspecialty surgical procedures, including cardiac, orthopedic, ophthalmological, and vascular surgeries and procedures, and all phases of perioperative care. In this project, measures focused on urogynecologic and cardiac procedures. The Surgery Standing Committee reviewed two maintenance measures and both were recommended for continued endorsement.

Draft Report

The Surgery Spring 2018 draft report presents the results of the evaluation of two measures considered under the Consensus Development Process (CDP). Both measures are recommended for endorsement.

The measures were evaluated against the 2017 version of the measure evaluation criteria.

	Maintenance	New	Total
Measures under consideration	2	0	2
Measures recommended for endorsement	2	0	2

	Maintenance	New	Total
Measures recommended for inactive endorsement with reserve status	0	0	0
Measures approved for trial use	0	0	0
Measures not recommended for endorsement or trial use	0	0	0
Measures withdrawn from consideration	0	0	0
Reasons for not recommending	Importance - 0 Scientific Acceptability - 0 Use - 0 Overall - 0 Competing Measure - 0	Importance - 0 Scientific Acceptability - 0 Overall - 0 Competing Measure – 0	

Measures Recommended for Endorsement

- 2063: Performing cystoscopy at the time of hysterectomy for pelvic organ prolapse to detect lower urinary tract injury (American Urogynecologic Society)

Overall Suitability for Endorsement: Yes-15; No-0

- 2558: Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery (Centers for Medicare & Medicaid Services/Yale CORE)

Overall Suitability for Endorsement: Yes-15; No-0

Comments and Their Disposition

NQF received nine comments from five organizations (including three NQF member organizations) and individuals pertaining to the draft report and to the measures under consideration.

A table of comments submitted during the comment period, with the responses to each comment and the actions taken by the Standing Committee and measure developers, is posted to the Surgery project webpage.

Comment Themes and Committee Responses

Comments about specific measure specifications and rationale were forwarded to the developers, who were invited to respond.

The Standing Committee reviewed all of the submitted comments (general and measure specific) and developer responses. Committee members focused their discussion on measures or topic areas with the most significant and recurring issues.

Measure-Specific Comments

2063: Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery

Five comments were submitted and all were supportive of the Committee's decision to recommend this measure for continued endorsement.

Committee Response:

The Committee appreciates comments from members and the public and upholds their decision to recommend this measure for continued endorsement.

2558: Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery

Three comments were submitted for this measure and all were supportive of the Committee's decision to recommend this measure for continued endorsement. One comment submitted suggested that the measure should have empirical validity testing and that the developer explore the underlying relationship between factors like poverty or neighborhood deprivation on mortality.

Measure Steward/Developer Response:

We mainly assessed the validity of the CABG mortality measure (NQF # 2558) using a systematic assessment of face validity. As we noted in the submission materials, we convened a Technical Expert Panel with (TEP), which included individuals with a range of perspectives including clinicians, consumers, and purchasers, as well as individuals with experience in quality improvement, performance measurement, and health care disparities.

Separate from this assessment of face validity, we also validated the CABG mortality measure against New York registry data (New York State Cardiac Surgery Reporting System (CSRS) from the New York Department of Health), which served as empiric validity testing of both the risk model and the hospital level score. Specifically, we compared the performance of the risk model and hospitals risk-standardized outcome rates calculated from the measure which is risk adjusted using claims, with the performance and hospital RSRRs calculated from the registry-based CABG mortality measure, which uses data abstracted from patients' medical records for risk adjustment. The results of these amylases show that the claims-adjusted model performs similarly and characterizes hospital performance similarly to the measure adjusted using data from patients' medical records. This analysis is not submitted as an assessment of the measure's validity. Rather, it is supplemental information presented to the committee for consideration.

For more information, see validation report attached to the response memo.

In addition, we note that mortality as an outcome allows for a broad view of quality of care that encompasses more than what can be captured by individual process-of-care measures. Specifically, mortality is the primary negative outcome associated with a surgical procedure. Many aspects of peri-operative care, intra- and peri-operative practices and several aspects of post-operative care, including prevention of and

response to complications and coordinated transitions to the outpatient environment, have been shown to impact CABG mortality. A number of recent studies have demonstrated that improvements in care can reduce 30-day mortality rates (see NQF Evidence Form for more detail.

We thank the Henry Ford Health System for this thoughtful comment. We did not examine the underlying relationship between factors like poverty or neighborhood deprivation and mortality as an outcome. There are currently no national data sources that make this information available at the level of the individual beneficiary. Therefore, we are limited to the use of data mapped to census block group as a proxy for patient-level information or the use of binary variables such as the dual eligibility for Medicare and Medicaid benefits which does not lend itself to analysis of the extremes. However, CMS remains committed to examining alternative solutions that better reflect the balance of hospital- and patient-level influences on hospital outcome measures for socioeconomically disadvantaged groups and we will examine this suggestion in the future.

Committee Response:

The Committee appreciates the developer's response and upholds their decision to recommend this measure for continued endorsement.

NQF Response:

Thank you for your comments. NQF accepts a variety of empirical validity testing methods including demonstrating the correlation of the performance measure score on this measure and other performance measures, differences in performance scores between groups known to differ on quality, or assessing the accuracy of all critical data elements.

NQF encourages measure developers to continue exploring additional social and economic risk factors and their impact on patient health outcomes.

Member Expression of Support

Throughout the 16-week continuous public commenting period, NQF members had the opportunity to express their support ('support' or 'do not support') for each measure submitted for endorsement consideration to inform the Committee's recommendations. Three NQF members provided their expression of support. Appendix B details the expression of support.

Removal of NQF Endorsement

Three measures previously endorsed by NQF have not been re-submitted, and endorsement has been removed.

Measure	Measure Description	Reason for Removal of Endorsement
0178 Improvement in Status of Surgical Wounds	The percentage of home health episodes of care during which the patient demonstrates an improvement in the condition of surgical wounds.	The developer states that the measure "is becoming limited in its ability to discriminate among providers' performance and exhibits poor usability with fewer than 50% of agencies with at least 20 episodes."
2052 Reduction of Complications Through the Use of Cystoscopy During Surgery for Stress Urinary Incontinence	Percentage of SUI surgeries for which cystoscopy was used during the surgical procedure to reduce complications	Lack of resources to maintain
1536 Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery	Percentage of patients aged 18 years and older who had cataract surgery and had improvement in visual function achieved within 90 days following the cataract surgery.	Developer is working on a new instrument to measure visual function

Appendix A: CSAC Checklist

The table below lists the key considerations to inform the CSAC's review of the measures submitted for endorsement consideration.

Key Consideration	Yes/No	Notes
Were there any process concerns raised during the CDP project? If so, briefly explain.	No	
Did the Standing Committee receive requests for reconsideration? If so, briefly explain.	No	
Did the Standing Committee overturn any of the Scientific Methods Panel's ratings of Scientific Acceptability? If so, state the measure and why the measure was overturned.	No	
If a recommended measure is a related and/or competing measure, was a rationale provided for the Standing Committee's recommendation? If not, briefly explain.	Yes	The Committee noted that NQF 2558 is related to NQF 0119 Risk Adjusted Operative Mortality for CABG, however they believed both measures should be endorsed since NQF 0119 also assesses deaths during CABG hospitalization and deaths occurring within 30 days of the procedure.
Were any measurement gap areas addressed? If so, identify the areas.	No	
Are there additional concerns that require CSAC discussion? If so, briefly explain.	No	

Appendix B: NQF Member Expression of Support Results

Three NQF members provided their expression of support. NQF members provided their expression of support for both measures under consideration. Results for each measure are provided below.

2063: Performing cystoscopy at the time of hysterectomy for pelvic organ prolapse to detect lower urinary tract injury (American Urogynecologic Society)

Member Council	Support	Do Not Support	Total
Consumer	1	0	1
Supplier/Industry	1	0	1

2558: Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery (Centers for Medicare & Medicaid Services/Yale CORE)

Member Council	Support	Do Not Support	Total
Consumer	1	0	1

Appendix C: Details of Measure Evaluation

2063 Performing Cystoscopy at the Time of Hysterectomy to Detect Pelvic Organ Prolapse

Submission | Specifications

Description: Percentage of patients who undergo cystoscopy to evaluate for lower urinary tract injury at the time of hysterectomy for pelvic organ prolapse.

Numerator Statement: Numerator is the number of patients in whom an intraoperative cystoscopy was performed to evaluate for lower urinary tract injury at the time of hysterectomy for pelvic organ prolapse.

Denominator Statement: The number of patients undergoing hysterectomy for pelvic organ prolapse (identified by CPT codes for hysterectomy and ICD9/10 diagnoses of prolapse as listed in S.9).

Exclusions: None

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Clinician : Group/Practice, Clinician : Individual

Setting of Care: Inpatient/Hospital

Type of Measure: Process

Data Source: Paper Medical Records, Registry Data

Measure Steward: American Urogynecologic Society

STANDING COMMITTEE MEETING [June 28, 2018]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-1; M-14; L-0; I-0**; 1b. Performance Gap: **H-0; M-14; L-2; I-0**;

Rationale:

- This measure is based on evidence that routine cystoscopy increases identification of urinary tract injuries intraoperatively. The Committee also discussed new evidence by Teeluckdharry et al. 2015 that showed 0.2 per thousand (0.02%) of ureteral injuries were recognized at time of hysterectomy performed for prolapse without cystoscopy compared to 10.8 per thousand (0.18%) ureteral injuries recognized with cystoscopy. The Committee also discussed the 2017 American College of Obstetricians and Gynecologist (ACOG) Practice Bulletin on Pelvic Organ Prolapse (Level C evidence) that stated routine cystoscopy during pelvic organ prolapse surgery is recommended when the surgical procedure performed is associated with a significant risk of injury to the bladder or ureter. Finally, the Committee reviewed evidence from an academic study by Chi et al. 2016 that showed that with universal cystoscopy, the unrecognized ureteral injury rate decreased from 0.7% to 0.1%. The Committee stated that performing routine cystoscopy could prevent any delayed complications.

- Committee members noted that this was a process measure and questioned why the developer did not develop an outcome measure to address pelvic organ prolapse. The developer responded that an outcome measure would be desirable, but the outcome is so rare that an outcome measure is not needed. Committee members then questioned the importance of the process measure. The developer clarified that five percent of injuries can go undetected and that the completion of this process is the appropriate action to take for high risk surgeries.
- Committee members also questioned what injury the measure addressed (i.e., ureteral kinking/injury or bladder injury). The developer clarified that the cystoscopy provides information on bladder injuries and whether there is diminished or altered flow through the ureter.
- The Committee agreed that the evidence supported this measure.
- The developer provided performance data from the AUGS Urogynecology Quality Registry (AQUIRE) for 16 providers (503 patients) who submitted 2017 data to Merit-Based Incentive Payment System (MIPS). Cystoscopy procedures ranged from 88.24% to 100%. The overall registry average, which includes providers who did not submit data to MIPS, is 94.7%.
- Ultimately, Committee members agreed that the measure met the performance gap subcriteria.

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2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-0; M-15; L-0; I-0**; 2b. Validity: **H-0; M-16; L-0; I-0**

Rationale:

- The measure calculates the percentage of patients who undergo cystoscopy to evaluate lower urinary tract injury during hysterectomy for pelvic organ prolapse. A Committee member questioned whether prolapses were graded. The developer clarified that prolapses are graded but the grade of prolapse is not relevant for this measure.
- Reliability testing was conducted by comparing chart-abstracted data and billing documents to self-reported performance rates in the AQUIRE registry. The developer calculated the physician-to-physician variance for data in the registry and the variance from the abstracted charts. Physician to physician variance was similar within the registry data set (variance=0.0012222) and the chart review data set (variance=0).
- Validity testing was conducted on 638 patient records. Chi square tests evaluated the differences between the percentage of patients who have an injury detected compared to those who did not have concurrent cystoscopy; readmissions rates due to all cause among those who did and did not have cystoscopy; and rate of readmission among those who do and do not have a lower urinary tract injury detected with intraoperative cystoscopy.
- Cystoscopy was performed in 84.5% of procedures. Women who had cystoscopy were more likely than those who did not have cystoscopy to have an injury detected (6.9% of women who had cystoscopy and 0% of those who did not). Readmission rates due to all causes did not differ among women who did and did not have cystoscopy (4.8% vs 5.1%)

and the readmission rate among women who had a lower urinary tract injury was lower than that observed among those who did not have an injury (2.7% vs 5%).
- Overall, the Committee did not have any major concerns regarding the reliability or validity of the measure and agreed that the measure met these criteria.

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3. Feasibility: H-0; M-13; L-3; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified; 3d. Data collection strategy can be implemented)

Rationale:

- The Committee agreed that the data elements are routinely generated, used during care delivery and the measure is feasible to implement.

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4. Usability and Use: The maintenance measure meets the Use subcriterion

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Pass-16; No Pass-0**; 4b. Usability: **H-0; M-13; L-3; I-0**

Rationale:

- This measure is currently used in the Centers for Medicare & Medicaid Services the Merit-based Incentive Payment System (MIPS). The developer indicated that the measure will be publically reported in the Qualified Clinical Data Registry (QCDR) in 2018.

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5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: **Yes-15**; **No-0**

6. Public and Member Comment

Five comments were submitted supporting the Committee's decision to recommend the measure for endorsement.

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7. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Yes-X; No-X

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8. Appeals

2558 Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery

Submission | Specifications

Description: The measure estimates a hospital-level, risk-standardized mortality rate (RSMR) for patients discharged from the hospital following a qualifying isolated CABG procedure. Mortality is defined as death from any cause within 30 days of the procedure date of an index CABG admission. An index CABG admission is the hospitalization for a qualifying isolated CABG procedure considered for the mortality outcome. The measure was developed using Medicare Fee-for-Service (FFS) patients 65 years and older and was tested in all-payer patients 18 years and older.

Numerator Statement: The outcome for this measure is 30-day all-cause mortality. Mortality is defined as death for any reason within 30 days of the procedure date from the index admission for patients 18 and older discharged from the hospital after undergoing isolated CABG surgery.

Denominator Statement: This claims-based measure can be used in either of two patient cohorts: (1) patients aged 65 years or older or (2) patients aged 18 years or older. We have tested the measure in both age groups.

The cohort includes admissions for patients who receive a qualifying isolated CABG procedure (see the attached Data Dictionary) and with a complete claims history for the 12 months prior to admission. CMS publicly reports this measure for those patients 65 years or older who are Medicare FFS beneficiaries admitted to non-federal hospitals.

If a patient has more than one qualifying isolated CABG admission in a year, the first CABG admission is selected for inclusion in the measure and the subsequent CABG admission(s) are excluded from the cohort.

Exclusions: The CABG surgery mortality measure excludes index admissions for patients:

1. With inconsistent or unknown vital status or other unreliable demographic (age and gender) data; or,

2. Discharged against medical advice (AMA).

For patients with more than one qualifying CABG surgery admission in the measurement period, the first CABG admission is selected for inclusion in the measure and the subsequent CABG admission(s) are excluded from the cohort.

Adjustment/Stratification: Statistical risk model

Level of Analysis: Facility

Setting of Care: Inpatient/Hospital

Type of Measure: Outcome

Data Source: Claims

Measure Steward: Centers for Medicare & Medicaid Services

STANDING COMMITTEE MEETING [June 28, 2018]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Accepted previous evaluation**; 1b. Performance Gap: **H-7; M-8; L-0; I-0**;

Rationale:

- The Committee agreed that the measure is supported by evidence that aspects of perioperative, intra and perioperative, and post-operative care practices can reduce 30-day mortality rates following coronary artery bypass graft (CABG) surgery.
- The developer provided performance data from 1,185 hospitals and 138,661 admissions from July 1, 2013 to June 30, 2016. Reported hospital-level risk-standardized mortality rate was 3.3%, ranging from 1.3% - 7.4%. The Committee agreed there is a gap based on the performance data presented by the developer.
- The developer provided performance data for July 2013 – June 2016 by proportion of dual eligible patients, African-American patients, and by the proportion of patients with the Agency for Healthcare Research and Quality (AHRQ) socioeconomic status (SES) Index Scores equal to or below 42.6. Median scores were higher in hospitals with higher proportions of dual eligible patients and in hospitals with higher proportions of patients with SES index scores.
- Ultimately, Committee members agreed that the measure met both the evidence and performance gap subcriteria.

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2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **Accepted the Scientific Methods Panel evaluation**; 2b. Validity: **Accepted the Scientific Methods Panel evaluation**

Rationale:

- The measure estimates a hospital-level, risk-standardized mortality rate (RSMR) for patients discharged from the hospital following a qualifying isolated CABG procedure. The Committee did not have any concerns that the measure as specified could be consistently implemented.
- Reliability testing was conducted at the performance measure score level. A test-retest approach was performed with the correlation coefficient being 0.35, which the Committee stated was sufficient for reliability. Overall, the Committee did not have any major concerns regarding the reliability of the measure and noted that the NQF Scientific Methods Panel was satisfied with the reliability analyses for the measure. The Committee accepted the Methods Panel's evaluation and did not have a separate vote for reliability of the measure.
- Validity was conducted at the measure score level. Face validity was also assessed by a Technical Expert Panel using a six-point scale obtained from the mortality measure as specified, to provide an accurate distinction between good and bad quality of care. Overall, the Committee did not have any major concerns regarding the validity of the measure and noted that the NQF Scientific Methods Panel was satisfied with the validity analyses for the measure. The Committee accepted the Methods Panel's evaluation and did not have a separate vote for validity of the measure.

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3. Feasibility: H-11; M-4; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified; 3d. Data collection strategy can be implemented)

Rationale:

- The Committee agreed that the data elements are routinely generated, used during care delivery and the measure is feasible to implement.

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4. Usability and Use: The maintenance measure meets the Use subcriterion

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Pass-15; No Pass-0**; 4b. Usability: **H-14; M-1; L-0; I-0**

Rationale:

- This measure is currently publicly reported and used in CMS Hospital Inpatient Quality Reporting (IQR) program, and has been finalized for the Hospital Value-Based Purchasing (VBP) program.
- The developer indicated that the median risk-standardized mortality rate decreased by 0.1 absolute percentage points from July 2013-June 2014 (median – 3.1%) to July 2015-June 2016 (median – 3.0%).
- Committee members noted that performance results for this measure are considered useful for both accountability and performance improvement activities.

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5. Related and Competing Measures

- This measure is related to:
    - 0119: Risk-Adjusted Operative Mortality for CABG
- The measure under review has the same target population and measure focus as 0119: Risk Adjusted Operative Mortality for CABG (STS). The developer reported that they have sought to harmonize components of the measure with 0119. Potential areas of harmonization include, target patient population, age, isolated CABG, period of observation, and included hospitals. Measure #2558 assesses death within 30 days of the procedure date. In contrast, measure 0119 assesses both deaths occurring during CABG hospitalization (in-hospital death, even if after 30 days) and deaths occurring within 30 days of procedure date. Additionally, measure #2558 captures all qualifying Medicare FFS patients undergoing CABG regardless of whether their hospital or surgeon participates in the STS registry as required for #0119.

Standing Committee Recommendation for Endorsement: **Yes-15**; **No-0**

6. Public and Member Comment

Three comments were submitted for this measure and all were supportive of the Committee's continued endorsement recommendation. One comment submitted suggested that the measure should have empirical validity testing and that the developer explore the underlying relationship between factors like poverty or neighborhood deprivation on mortality.

The developer provided the following response:

> We mainly assessed the validity of the CABG mortality measure (NQF # 2558) using a systematic assessment of face validity. As we noted in the submission materials, we convened a Technical Expert Panel with (TEP), which included individuals with a range of perspectives including clinicians, consumers, and purchasers, as well as individuals with experience in quality improvement, performance measurement, and health care disparities.
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> Separate from this assessment of face validity, we also validated the CABG mortality measure against New York registry data (New York State Cardiac Surgery Reporting System (CSRS) from the New York Department of Health), which served as empiric validity testing of both the risk model and the hospital level score. Specifically, we compared the performance of the risk model and hospitals risk-standardized outcome rates calculated from the measure which is risk adjusted using claims, with the performance and hospital RSRRs calculated from the registry-based CABG mortality measure, which uses data abstracted from patients' medical records for risk adjustment. The results of these amylases show that the claims-adjusted model performs similarly and characterizes hospital performance similarly to the measure adjusted using data from patients' medical records. This analysis is not submitted as an assessment of the measure's validity. Rather, it is supplemental information presented to the committee for consideration.
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> In addition, we note that mortality as an outcome allows for a broad view of quality of care that encompasses more than what can be captured by individual process-of-care measures. Specifically, mortality is the primary negative outcome associated with a surgical procedure. Many aspects of peri-operative care, intra- and peri-operative practices and several aspects of post-operative care, including prevention of and response to complications and coordinated transitions to the outpatient environment, have been shown to impact CABG mortality. A number of recent studies have demonstrated that improvements in care can reduce 30-day mortality rates (see NQF Evidence Form for more detail.
>
> We thank the Henry Ford Health System for this thoughtful comment. We did not examine the underlying relationship between factors like poverty or neighborhood deprivation and mortality as an outcome. There are currently no national data sources that make this information available at the level of the individual beneficiary. Therefore, we are limited to the use of data mapped to census block group as a proxy for patient-level information or the use of binary variables such as the dual eligibility for Medicare and Medicaid benefits which does not lend itself to analysis of the extremes. However, CMS remains committed to examining alternative solutions that better reflect the balance of hospital- and patient-level influences on hospital outcome measures for socioeconomically disadvantaged groups and we will examine this suggestion in the future.

Committee members were satisfied with the developer's response to the public comments and upheld its decision to recommend the measure for endorsement.

7. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Yes-X; No-X

8. Appeals