September 9, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Social Security Boulevard
Baltimore, MD 21244-1850

RE: **Medicare and Medicaid Programs; CY 2025 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies (**CMS-1807-P)

Administrator Brooks-LaSure:

On behalf of our membership, the American Thoracic Society (ATS) and the American College of Chest Physicians (CHEST) appreciate the opportunity to submit our shared comments on the Calendar Year (CY) 2025 Medicare Physician Fee Schedule Proposed Rule (MPFS or "the Proposed Rule"). Our societies represent over 25,000 pulmonary, critical care and sleep specialists dedicated to prevention, treatment, research and cure of respiratory disease, critical care illness and sleep disordered breathing. Our members provide care to Medicare beneficiaries for a wide range of conditions including critical care illness, asthma, COPD, lung cancer, alpha-1 antitrypsin deficiency, pulmonary fibrosis, pulmonary hypertension, and other disorders of the lung, and sleep disorders including sleep apnea, narcolepsy and restless leg syndrome.

The Proposed Rule includes several policy changes and payment revisions that are of direct interest and impact to our members.

ATS and CHEST are submitting comments on the following provisions of the CY 2025 MPFS Proposed Rule

- 2025 Conversion Factor
- CMS time policy on critical care services (CPT code 99292)
- Disposable Supplies (bronchscopes and home sleep testing devices)
- Depression Screening
- Surgical Global Period
- Telehealth Services
- Lung Cancer Screening Improvement Activities
- Primary Care

2025 Conversion Factor

ATS and CHEST share concern on the impact of the proposed conversion factor applicable to CY 2025. For 2025, CMS is proposing a conversion factor of $32.36, which represents a decrease of $0.93 or 2.80%. We recognize that the Agency must adhere to the budget neutrality requirement within the confines of legislation and statute, and CMS does not have the authority to provide additional funds. However, we note that for the past few years the medical community in general and physicians in specific have been subject to the same inflationary trends impacting the general economy. Even with Congressional intervention, the proposed conversion factor represents another year of declining payments

for physicians under the Medicare program. The proposed conversion factor cut of 2.80%, is disappointing, will create economic challenges for Medicare providers, and adds to the strain of 3 straight years of decline in the conversion factor. It will also result in a decrease in patient access, as these policies create an environment in which providers trying to retain viable practices may reconsider accepting new Medicare beneficiaries in their practice. ATS and CHEST call on CMS to work with Congress to initiate legislative changes that will put the Medicare program on a more sustainable path by ensuring appropriate, inflation-adjusted payment to providers.

CMS time policy on critical care services (CPT 99292)

ATS and CHEST are extremely disappointed CMS did not address coding issues for critical care services in the proposed CY 2025 rule. As noted in our previous communication with the Agency and meetings with agency staff, we remain concerned that CMS's recent "technical correction" requires providers to deliver 105 minutes of critical care services before being allowed to report CPT code 99292. We urge CMS to return to the long-standing pre-2022 policy.

20+ Years of Stable Coding and Billing Policy - For over 20 years, the definition and time application of critical care coding and billing guidance has been unchanged. The primary critical care codes are:

• 99291 – critical care, first hour (30-74 minutes)

• 99292 – critical care, subsequent 30 minutes

The correct coding rules for critical care, including a timetable, were published in an AMA CPT Assistant article in December 1998 and have been stable since that time. For cumulative critical care services of less than 30 minutes provided during a calendar day, physicians should report an appropriate E/M code. For a cumulative critical care time of 30 and 74 minutes provided during a calendar day, physicians should report CPT 99291. For a cumulative critical care time of 75 to 104 minutes during a calendar day, physicians should report one unit CPT 99291 for the first hour of care and one unit of CPT 99292 for the subsequent 30 minutes. For a cumulative critical care time from 105 to 134 minutes, physicians should report one unit of CPT 99291 and two units of CPT 99292. Providers would report additional units of CPT 99292 for each additional 30 minutes of critical care provided on the same calendar day.

As noted, the above definitions on the appropriate use of the time increments for each code have been unchanged for over 20 years.

Billing Patterns Have Been Stable for 20 Years - A review of Medicare data shows that billing patterns for critical care codes have been remarkably stable over time. Approximately 10 percent of all critical care services reporting 99291, report one or more units of 99292.

Medicare Critical Care Billing (99291 and 99292) -Years 2011 to 2021 Year	Medicare 99291 only	Medicare 99291 + 99292	% 99292 reported for CC
2011	5,045,723	434,114	8.60%
2012	5,177,201	450,314	8.70%
2013	5,227,641	455,682	8.72%
2014	5,289,061	467,217	8.83%

2015	5,330,001	474,712	8.91%
2016	5,466,429	508,905	9.31%
2017	5,659,392	536,320	9.48%
2018	5,743,887	539,583	9.39%
2019	5,885,506	571,615	9.71%
2020	6,267,478	596,785	9.52%
2021	6,123,712	544,725	8.90%

We share this data to illustrate that billing patterns have been remarkably stable over time, and that there is no significant relative change that might trigger further scrutiny or concern on the part of CMS.

The New Policy Effectively Devalues the CPT 99291 Physician Work by 30% - Under previous policy, physicians were required to provide at least 74 minutes of critical care time before they could bill the first unit of CPT 99292. Under the newly "corrected" CMS policy, physicians must now provide 104 minutes of critical care service before they can bill the first unit of 99292. The net result is that CMS has administratively made the duration of the 99291 code 30 minutes longer, while maintaining the same physician work value. Put in different terms, this policy change has effectively devalued the CPT code 99291 (critical care, first hour 30-74 minutes) by 30%. We assume the devaluation effect was unintended, but regardless of intent the end result is the unprecedented devaluation of critical care providers' services.

Time and Other Families of CPT Codes - We understand that CMS is wrestling with how to apply the use of "time" across a several different families of CPT codes. We appreciate CMS's desire to develop a consistent use of time across a wide range of CPT codes. However, CMS's goal of a consistent application of time is not sufficient justification to fundamentally revalue critical care services. As we noted during our recent call with senior CMS staff, "time" when applied to critical care services is extremely limited by the CPT guidance. We do not believe that a general "time" rule should be applied for situations when time allowed is clearly defined with specific criteria. Below are a few examples from the AMA CPT© introductory guidance.

"Codes 99291, 99292 are used to report the ***total duration of time spent*** *in provision of critical care services to a critically ill or critically injured patient,* ***even if the time spent providing care on that date is not continuous.*** *For any given period of time spent providing critical care services****, the individual must devote his or her full attention to the patient and, therefore, cannot provide services to any other patient during the same period of time****. Time spent with the individual patient should be recorded in the patient's record. The time that can be reported as critical care is* ***the time spent engaged in work directly related to the individual patient's care whether that time was spent at the immediate bedside or elsewhere on the floor or unit.***

For example, time spent on the unit or at the nursing station on the floor reviewing test results or imaging studies, discussing the critically ill patient's care with other medical staff or documenting critical care services in the medical record would be reported as critical care, even though it does not occur at the bedside. Also, when the patient is unable or lacks capacity to participate in discussions, time spent on the floor or unit with family members or surrogate decision makers obtaining a medical history, reviewing the patient's condition or prognosis, or discussing treatment or limitation(s) of treatment may be reported

as critical care, provided that the conversation bears directly on the management of the patient. Time spent in activities that occur outside of the unit or off the floor (e.g., telephone calls whether taken at home, in the office, or elsewhere in the hospital) may not be reported as critical care ***since the individual is not immediately available to the patient.*** *[…] Code 99291 is used to report the* ***first 30-74 minutes*** *of critical care on a given date. It should be used only once per date even if the time spent by the individual is not continuous on that date. Critical care of less than 30 minutes total duration on a given date should be reported with the appropriate E/M code. Code 99292 is used to report additional block(s) of time, of up to 30 minutes each* ***beyond the first 74 minutes****."*

We further note there are many other examples in the Medicare program where policy allows billing an additional unit of a time-based code once a threshold of 50% of the time of the next unit of time-based care is provided. Such examples cross many specialties and disciplines, including physical therapy (CPT 97110 – a 15-minute time-based code billable after the 8th minute of care is provided), speech language pathology and occupational therapy (CPT 97129 – a 15-minute time-based code billable after the 8th minute of care is provided), and both primary care and many medical specialties (CPT 99497 and 99498 for advance care planning). We believe these examples provide ample precedent for CMS to return to its previous policy regarding appropriate billing for 99292.

CMS's Policy Change Meets the Definition of Compelling Evidence – We will continue to advocate for this change to be made by CMS. ATS and CHEST recognize and appreciate the work that has been done to address E/M code definition changes and subsequent values. We are concerned that a revision of the critical care codes could add avoidable instability to the family of E/M codes as well.

The ATS and CHEST strongly urge CMS to address the time issue in critical care by publishing in the 2025 Medicare Physician Fee Schedule final rule that the agency is rescinding the technical correction for CPT code 99292. We believe that the critical care guidelines are specific enough and different enough from other services to allow CMS to affirm the AMA CPT guidelines. Specifically, CMS could rescind the technical correction; CMS did not intend to alter the time policy for the important services of critical care and is clarifying that CMS will follow the AMA CPT guidelines regarding when to report 99292.

<u>Disposable Supplies (Bronchoscopes and Home Sleep Testing Devices)</u>

The ATS and CHEST use and reimbursement of high-cost disposable supplies continues to be an important issue in pulmonary and critical care medicine. The advent and use of disposable bronchoscopy devices continues to grow in the field of pulmonary and critical care medicine. The unit cost for disposable bronchoscopies meets the threshold (i.e., priced more than $500) high-cost disposable device and recently was assigned code (C1601). Similarly, in sleep medicine practice there is a growing trend toward using disposable equipment for testing patients in their homes. This is seen not only as a convenience for patients but also decreases the infection risk from previously used equipment. As infection control requirements continue to advance ATS and CHEST expect to see a continued growth in the use of disposable bronchoscopes and home sleep testing devices.

ATS and CHEST support the RUC recommendation for CMS to separately identify and pay for high-cost disposable supplies priced more than $500 using appropriate Healthcare Common Procedure Coding System (HCPCS) codes. The pricing of these supplies should be based on a transparent process, where items are annually reviewed and updated.

Surgical Global Period

ATS and CHEST note with interest CMS's proposed HCPCS G (GP0C1) to track additional time and resources provided in the surgical period by a physician not involved in the surgical procedure and not covered by a transfer of care agreement.

The ATS and CHEST support the proposal and urge CMS to finalize for CY 2025 HCPCS GP0C1 to collect more accurate data on the provision of care to Medicare beneficiaries in the post-operative global period and urge CMS to finalize this proposal.

Telehealth Services

The COVID pandemic was devasting health crisis but did force innovation and adaptation across the field of medicine. No area of medicine saw more dramatic change, innovation and adoption that telemedicine. COVID forced the expansion of telemedicine as a way to provide much needed care while minimizing face-to-face interactions however, the utility of telemedicine has expanded well beyond its effectiveness as a strategy to reduce communicable disease transmission and now serves as essential tool to reduce barriers to care and expand access to care for Medicare beneficiaries. The ATS and CHEST strongly support the evolution of payment and regulatory systems to support the thoughtful expansion of telehealth services.

The ATS and CHEST strongly urge Congressional action to permanently extend the current Medicare payment policy on telehealth. Further, we urge CMS to adopt policies that ensure coverage for telehealth services including audio-only services at payment rates comparable to in-person services. We support CMS's rational and decision not to recognize the recently developed AMA CPT codes for telehealth services. We believe CMS and other payers have developed mechanisms to identify and pay for these services and believe that the new code set only adds administrative burden to the system. CMS should finalize Medicare policy to not adopt the CY 2025 telehealth services AMA CPT codes.

Lung Cancer Screening Improvement Activities

ATS and CHEST urge CMS to finalize its proposal to add the new Population Health MIPS activity, Implementation of Protocols and Provision of Resources to Increase Lung Cancer Screening Uptake.

ATS and CHEST believe this improvement activity is an important component of fulfilling the Biden-Harris Administration's Cancer Moonshot goals. Lung cancer is a leading cause of cancer deaths and yet screening rates lag drastically behind those of other cancers, like breast and colon cancer. Additional resources are required to combat the stigma associated with lung cancer in particular, while improving the identification and longitudinal engagement of those persons who are screening eligible, aligned with clinical practice guidelines recommended by CHEST as well as the USPSTF.

Advance Primary Care

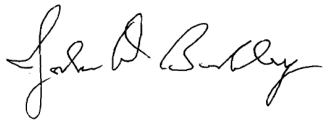
ATS and CHEST applaud the CMS proposal on Advance Primary Care. We believe the proposal will enhance current primary care practices and improve overall Medicare beneficiary health.

The ATS and CHEST urge CMS to finalize the Advance Primary Care proposal.

We hope these comments are useful to you and your staff as you all work to finalize the 2025 Medicare Physician Fee Schedule. We are particularly hopeful that you and your staff will take immediate action to address the time issue policy for subsequent critical care (CPT code 99292). Please feel free to contact staff at the American Thoracic Society (Gary Ewart gewart@thoracic.org) or CHEST (Nicki Augustyn naugustyn@chestnet.org) if you need additional information.

Sincerely,

Irina Petrache, MD, ATSF
President
American Thoracic Society



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