September 12, 2025

Mehmet Oz, MD, MBA
Administrator, Centers for Medicare & Medicaid Services
7500 Social Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies **(**CMS-1832-CN)

Administrator Oz:

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) 2026 Medicare Physician Fee Schedule Proposed Rule (MPFS or "the Proposed Rule"). Our societies represent over 30,000 pulmonary, critical care and sleep specialists dedicated to the prevention, treatment, research and cure of respiratory disease, critical care illness and sleep disorders. Our members provide care to Medicare beneficiaries for a wide range of conditions including asthma, COPD, lung cancer, alpha-1 antitrypsin deficiency, pulmonary fibrosis, pulmonary hypertension, and other disorders of the lung; critical illnesses such as respiratory failure, shock, sepsis, strokes and myocardial infarctions; 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' ability to provide adequate support to their Medicare-dependent patients. ATS and CHEST are submitting comments on the following issues in the CY 2026 MPFS Proposed Rule:

- CMS time policy on critical care services (CPT code 99292)
- Conversion factor
- Efficiency adjustment for physician relative value units (RVUs)
- Telehealth services
- Practice expense data collection and methodology – PPI Survey
- G2211 add-on code utilization correction
- RUC surveys and the use of extant data
- CPT 95800 (Sleep study, unattended)
- Medicare shared savings program (MSSP) and Health equity adjustment (HEA)

CMS time policy on critical care services (CPT code 99292)
ATS and CHEST remain disappointed that CMS has not resolved the coding issues for critical care services in the proposed CY 2026 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 note that ATS and CHEST have had several meetings with key senior staff to discuss our concerns. Despite our repeated efforts to have this issue addressed in rulemaking, the proposed rule for 2026 remains silent on this issue, perpetuating the burden on providers delivering critical care services.

We strongly urge CMS to return to the long-standing pre-2022 policy regarding interpretation of time for billing CPT 99292. 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. Importantly, this is based on providing the "first hour" of critical care, and thus the extension to 74 minutes already takes into account providing an additional 50% of the time of any additional 30 minutes (as coded by 99292), consistent with standards for other time-based codes. Thus, 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 continue to report additional units of CPT 99292 for each additional 30 minutes of critical care provided on the same calendar day. This technical correction is contradictory to other time-based codes, such as physical and occupational therapy codes, advanced care planning, and most importantly the parallel pediatric critical care codes.

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%

Conversion factor

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, the medical community in general, and physicians specifically, are subject to the same inflationary trends impacting the general economy. Rent, equipment, supplies, labor and malpractice costs are all impacted by inflation. The recent trends in conversion factor equate to a deficit and loss for physicians and physician practices. While we recognize and appreciate the one-year legislative relief provided in H.R. 1 to address the Medicare conversion factor in 2026, the constant need to appeal to Congress to provide legislative relief diverts attention from other pressing issues of concern for patients, physicians and CMS. **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.**

Efficiency adjustment for physician work relative value units (RVUs)

The ATS and CHEST strongly oppose the unprecedented and arbitrary efficiency adjustment to CPT and request that this be removed from the PFS. ATS and CHEST believe such action directly undermines the validity of the relative values established for these codes and significantly erodes provider trust in the fairness and appropriateness of the entire resource-based relative value system (RBRVS). While the RBRVS system is not without flaws, the RBRVS system is the physician reimbursement system that Congress mandated CMS use to establish physician reimbursement rates for physician services. The RBRVS system relies on the physicians who provide a given CPT coded service to provide their expert opinions on the time and intensity required for that service. By unilaterally applying an efficiency adjustment to selected CPT codes, CMS is destabilizing the current system and eroding the collaborative effort

between CMS and the physician community to build and maintain a fair and responsive system for establishing and monitoring reimbursement rates for physician services.

If the CMS chooses to proceed with this unprecedented action, the ATS and CHEST strongly recommend a one-time only application of the efficiency adjustment and that CMS exempt E/M codes and time-based CPT codes from the efficiency adjustment. We further recommend this efficiency adjustment not be applied to new CPT codes.

Telehealth services

The ATS and CHEST support CMS's proposal to permanently remove frequency limitations for telehealth subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations. We encourage CMS to finalize this proposal.

The ATS and CHEST support CMS's proposal to permanently adopt a definition of direct supervision that allows the physician or supervising practitioner to provide such supervision through real-time audio and visual interactive telecommunications (excluding audio-only). We urge CMS to finalize this proposal.

Practice expense data collection and methodology – PPI survey data

ATS and CHEST note with interest the discussion in the proposed rule about practice expense data and methodology. The ATS and CHEST believe the PPI survey information, despite its flaws, remains the most current and accurate national data set of practice expense information. **We urge CMS to delay changes to indirect practice expense methodology until the 2024 PPI data are implemented.**

G2211 add-on code utilization correction

The ATS and CHEST note the significant over-estimate of G2211 utilization by the Biden Administration contributed to the significant reduction in the 2024 conversion factor because of budget neutrality constraints. The cut to the conversion factor paradoxically hurt the specialties that the G2211 add-on code was intended to help. **We urge the Administration to correct inflated utilization assumptions for G2211 which will result in a $1 billion positive adjustment to the 2026 Medicare conversion factor.**

RUC surveys and the use of extant data

The ATS and CHEST appreciate the proposed rule's discussion about the appropriate role of extant data as a supplemental data source for the establishing of physician work values. We believe that physician surveys using the established RUC survey process continue to be the preferred method of collecting information on physician work and physician time. We agree that extant data bases can provide valuable supplemental information, including guardrails on maximal times, but extant data bases cannot yet provide precise time estimates. There is also currently a lack of resources with which to build extant databases. **The ATS and CHEST urge**

CMS to continue to rely on RUC survey data to ensure physician participation the development of work values.

CPT 95800 (Sleep study, unattended)
The ATS and CHEST note with interest that 95800 has again been nominated for consideration as a misvalued code. **We agree with CMS's proposal not to add 98500 to the 2026 list of misvalued codes.**

Medicare shared savings program (MSSP) and Health equity adjustment (HEA)
ATS and CHEST oppose the proposal to remove the health equity adjustment from the ACOs quality score. The HEA is an important recognition of the health disparities that exist within the US healthcare system and allows health systems with accountable care organizations that include significant numbers of low-income patients to participate in the MSSP program. We strongly recommend CMS maintain the HEA in the MSSP program.

The ATS and CHEST appreciate the opportunity to comment on the proposed Medicare Physician Fee Schedule for CY 2026. We hope our comments will help CMS develop a final rule that continues to support quality care for Medicare beneficiaries.

Sincerely,

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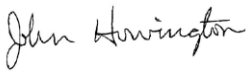

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