September 14, 2026

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

RE: Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies **(CMS-1848-P**)

Dr. 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 joint comments on the Calendar Year (CY) 2027 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 2027 MPFS Proposed Rule:

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 2027 rule. As noted in our previous communication with the Agency and meetings with Agency staff, we remain concerned that CMS's "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 2027

remains silent on this issue, perpetuating burden on providers delivering critical care services and resulting in confusion as to appropriate billing.

We strongly urge CMS to return to the long-standing pre-2022 policy regarding interpretation of time for billing CPT 99292. For over 0 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. In addition, 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 Critical Care
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%

The ATS and CHEST remained concerned with CMS inaction on this important issue.

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 Congressional efforts to provide temporary relief, the constant need to seek 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 physicians.**

Practice Expense Methodology

The ATS and CHEST are intrigued by CMS's proposal to eliminate steps 12-17 of practice expense calculations formula. We appreciate CMS's detailed description of the challenges with the current formula and how improvements in CMS practice expense data collection may make steps 12-17 of the practice expense calculation unnecessary. We encourage CMS to produce and share with the community a specialty specific estimate of the financial impacts the PE proposal would entail.

Practice Expense Input – Paid Equipment Invoices

In this proposed CY 2027, CMS reminds readers that they routinely accept public submissions of invoices as part of the process for developing payment rates for new, revised, and potentially misvalued codes. Often, these invoices are submitted in conjunction with the RUC-recommended values for the codes. Our societies have tried, with great difficulty, to obtain paid invoices to update supply and equipment prices over the years.

CMS also encourages interested parties to submit invoices with their public comments or, if outside the notice and comment rulemaking process, via email at E_Price_Input_Update@cms.hhs.gov. While both these methods have resulted in limited success, we believe a better method for accurately pricing supplies and invoices would be to implement a model similar to the Drugs and Biologicals ASP for both supplies and invoices. We are not suggesting that CMS pay ASP plus 6 percent, rather we are suggesting that CMS collect quarterly ASP data from manufacturers through the ASP data collection system to calculate pricing for supplies and equipment. CMS could work with medical specialties and manufacturers to develop a standardized method for reporting, using the drug ASP as a model such as found at the following CMS web site https://www.cms.gov/medicare/payment/fee-for-service-providers/part-b-drugs/average-drug-sales-price. Quarterly files could be made public, and CMS can continue to accept comments to ensure more accurate pricing of supplies and equipment.

Telehealth Critical Care Consultations

ATS and CHEST notes the proposal to adjust the time increments for telehealth critical care codes:

> G0508 (*Telehealth consultation, critical care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth*) and
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> G0509 (*Telehealth consultation, critical care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth*)

Note that the time increasements for in-person critical care are:

CPT 99291 – initial critical care (30-74 minutes)

CPT 99292 – subsequent critical care (30 minutes)

ATS and CHEST are submitting CPT proposals to revise many aspects of the CPT codes for critical care. Our proposal, if adopted, will change time increments for both initial and subsequent critical care codes, as well as other aspects of the code. We urge CMS to

forestall any time increment changes for critical care, including telehealth critical care, until the CPT code proposal has been reviewed.

Changes To Teaching Physicians' Billing for Services Involving Residents or Teaching Physicians with Virtual Presence

The ATS and CHEST appreciate CMS's proposal to allow teaching physicians to bill for services involving residents when either the teaching physician or resident is in the same physical location as the beneficiary. We urge CMS to finalize this proposal.

Efficiency adjustment for physician work relative value units (RVUs)

The ATS and CHEST continue to oppose 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.

Unattended Sleep Testing (CPT Codes 95X18, 95X19, 95X20, 95X21, 95X22, and 95X23)

As CMS is aware, the family of unattended sleep codes was identified by the high-volume growth screen, triggering a plan of action request of specialty societies that use the codes. The society plan involved revision of the entire code family and a survey of the new code family and deletion of the previous unattended sleep study code structure.

ATS and CHEST appreciate CMS's proposal to accept the RUC recommended direct PE inputs for 95X18, 95X19 and 95X20. The ATS also supports the comments in the AMA RUC letter that fully document the 960 minutes of equipment time for 95X18-95X20. ATS and CHEST note that 960 minutes of equipment time is supported by clinical practice recommendations and best practices for home sleep test.

ATS and CHEST further appreciate CMS's proposal to accept the RUC recommended work values for RVUs for CPT codes 95X21 and 95X22 and the accompanying deletion of HCPCS codes G0398, G0399, and G0400.

95X23

ATS and CHEST are concerned with CMS's rejection of the RUC recommend work RVU of 1.60 for CPT code 95X23. CMS's alternative of 1.42 and crosswalk to *92014 Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits* (work RVU = 1.42, 24 minutes intra-service, and 37 minutes total time), which is below the survey 25th percentile, is inappropriate and unsupported by available data.

As outlined in the AMA RUC comment letter there are several reasons why CMS's proposed crosswalk is inappropriate including,

> The RUC crosswalk describes a low level of decision making and has slightly lower total time than the surveyed code. The surveyed code describes interpretation of at least 11 channels that generate at least 9 parameter categories. The CMS crosswalk to 92014 seems to solely be selected because the intensity of the code is lower, even though the times are very similar to the RUC recommended crosswalk. CMS also asserts that the intensity of the surveyed code with the RUC recommended work RVU of 1.60 is nearly double that of codes 95X21 and 95X22. The RUC value is appropriate given that the surveyed code requires review of twice as many channels and parameters as the first code in the family, offering justification for the work RVU and associated intensity.
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> The RUC maintains that the RUC referenced CPT code 74176 *Computed tomography, abdomen and pelvis; without contrast material* (work RVU = 1.70, 21.45 minutes intra-service time, and 31.45 minutes total time) and MPC code 93351 *Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with supervision by a physician or other qualified health care professional* (work RVU = 1.71, 19.5 minutes intra-service time, and 39.5 minutes total time) are excellent comparison codes given the similar intra-service and total times, yet higher recommended work RVUs.
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> For additional support, the RUC references CPT code 78452 *Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection* (work RVU =

1.58, 19.5 minutes intra-service, and 39.5 minutes total time). The codes have similar intra-service and total time and therefore should be valued similarly. The RUC urges CMS to finalize a work RVU of 1.60 for CPT code 95X23."

ATS and CHEST refer CMS to page 66 of the AMA RUC comments for a complete listing or appropriate crosswalks for the new family of unattended sleep codes.

The ATS and CHEST request CMS to adopt the RUC recommended time, physician work and practice expense values for CPT codes 95X18-95X23.

Smoking and Tobacco Use Cessation (CPT Codes 99406, 99407) and Screening, Brief Intervention, and Referral to Treatment (SBIRT) (HCPCS Codes G2011, G0396, G0397)

The ATS and CHEST appreciate CMS's efforts to expand Medicare beneficiary access to effective smoking and tobacco cessation efforts by increasing reimbursement for cessation codes. The 19.1 percent increase in smoking and tobacco cessation related codes (CPT 99406, CPT 99407, HCPCS G2011, G0396, G0397) proposed for 2027 will help expand access to these important services.

We request CMS finalize this proposal.

Evaluation and Management (E/M) Visit Complexity Add-On (HCPCS Code G2211)

ATS and CHEST appreciate CMS's proposal to transition the E/M Visit Complexity payment from an add on code to a code modifier. We appreciate CMS's ongoing recognition of the extra effort and value provided by physicians who provide longitudinal care to Medicare beneficiaries with complex medical conditions.

We urge CMS to finalize this proposal.

Vaccine Adverse Effects Management (HCPCS Code GADV1)

The ATS and CHEST are extremely alarmed and concerned with the Administration's persistent and coordinated efforts to undermine the public confidence in the safety and efficacy of vaccines. The Administration's actions on vaccine policy are not supported by science or thoughtful public health policy.

The creation of an add on code to capture the additional physician work in documenting potential adverse reactions to a vaccine is part of an overall effort to question the overall safety and efficacy of childhood and adult vaccines. Further, use Medicare claims to document potential adverse reactions seems more likely to build data to support legal claims against vaccines manufacturers rather than improve patient access to live saving vaccines.

The ATS and CHEST would welcome CMS policy that expands Medicare beneficiary access to safe and effective vaccines and further support policy and communication from CMS and HHS that accurately informs the public of the enormous benefits from vaccines.

We urge CMS to reconsider this proposal.

Proposed Changes to Payments Using Modifier-25

The proposed modifier-25 payment reduction creates a direct financial disincentive for physicians to provide clinically appropriate evaluation and procedural care during a single encounter. Practices may respond by scheduling the E/M service and procedure on separate dates, allowing both services to receive full reimbursement but requiring Medicare beneficiaries to make two visits for care that could safely and efficiently have been delivered in one. This fragmentation will consume additional appointment capacity, increase patient travel and caregiver burden, and delay diagnosis and treatment. The policy therefore risks reducing access while paradoxically rewarding less efficient care delivery. Rather than applying an arbitrary 50% reduction, CMS should preserve full payment when documentation demonstrates that the E/M service meets the existing standard for a significant, separately identifiable service.

Comment Solicitation on Payment for Physician-Patient Clinical Trial Discussions

ATS and CHEST welcome CMS's interest in expanding patient access to clinical trials and generally support CMS's exploring the idea of a new G-code to capture physician or staff time engaged in clinical trial discussions. As CMS further considers this idea, we encourage the agency to allow these clinical trial discussions to be initiated by either the physician or the patient, including the time spent outside of the face-to-face encounter doing background research on clinical trial options, in the allowable time for this proposed code.

We envision this yet-to-be proposed code as being used most frequently in academic medical centers where, in most cases, the physician is aware of a clinical trial that might be of interest to a patient. In most cases, the physician is effectively recruiting a patient for a trial that they, their practice, their colleagues or their academic institution is actively involved in. However, we also could envision instances where the patient asks a physician about experimental treatment options for their condition or willingness to consider a clinical trial. In this case the physician would either provide guidance to the patient on where the patient can learn more about clinical trial opportunities, or the physician, or their staff, will research options of clinical trials that might be appropriate for their patient. For the latter, this research will likely be done outside of the face-to-face encounter. We

encourage CMS to allow for background research time to be allowable for the time threshold for this code.

As CMS considers a new G-code to capture the time and intensity of clinical trial discussion, CMS must think about disclosure issues. For many industry-sponsored clinical trials, industry will pay physicians for successfully recruiting patients into a trial. Further, in many cases, the physician may have a person interest, as a principal investigator or collaborator on the clinical trials. In both cases, the physician has a potential conflict of interest that should be disclosed to the patient. As CMS further considers how to construct a clinical trials discussion G-code, we urge the agency to consider COI disclosure and whether documentation of such potential COI should be part of the code documentation.

We encourage CMS to move forward with a G-code proposal for clinical trials discussion with patients.

Advance Care Planning (ACP) Services (HCPCS Codes GACP1 and GACP2)

The ATS and CHEST support the proposal to create HCPCS G-code GACP1 that would account for the time of clinical staff members providing Advanced Care Planning (ACP) services patients. The initial ACP services are most frequently provided by a physician or QHP as an adjunct to a patient evaluation and management service, not separately. The non-QHP clinical staff often assist in the explanation and completion of required documentation for the patient's record among other services. We would support the use of CPT codes 99497-98 with the new codes accounting separately for the physician and clinical staff work.

Telehealth Originating Site Facility Fee Payment Amount Proposed Update

The ATS and CHEST support the update telehealth origination fee for 2027 of $32.65. We urge CMS to finalize the updated telehealth origination fee.

We hope our comments are useful as CMS prepares to issue a final Medicare Physician Fee Schedule for 2027.

Sincerely,



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