February 5, 2024

Gift Tee
Director, Division of Practitioner Services
Center for Medicare
Centers for Medicare & Medicaid Services (CMS)
7500 Security Blvd.
Baltimore, MD 21244

Director Tee:

On behalf of the undersigned medical organizations, we strongly urge to you address critical care, subsequent 30 minutes (CPT 99292) in the 2025 Medicare Physician Fee Schedule proposed rule. We hope CMS will take the opportunity in the 2025 proposed rule to revise its policy regarding billing for critical care subsequent 30 minutes (CPT© code 99292) to the billing policy established prior to 2022 and consistent with CPT© guidance. Returning to the pre-2022 policy is not only consistent with over 20 years of coding guidance and clinical practice, but it more importantly restores the appropriate use and valuation of these services.

20+ Years of Stable Billing Policy
For over 20 years, the definition and time application of critical care coding and billing guidance has been stable and unchanged. The correct coding rules for critical care, including a timetable, were published in CPT© Assistant in December 1998 and have been stable since that time. These primary critical care codes and rules are as follows:

- 99291 – critical care, first hour (30-74 minutes)
- 99292 – critical care, subsequent 30 minutes

For cumulative critical care services of less than 30 minutes provided during a calendar day, physicians should report an appropriate E/M code. For cumulative critical care time between 30 and 74 minutes provided during a calendar day, physicians should report code 99291. For cumulative critical care time of 75 to 104 minutes during a calendar day, physicians should report one unit of code 99291 for the first hour of care and one unit of code 99292 for subsequent 30 minutes. For critical care cumulative time of 105 to 134 minutes, physicians should report one unit

of code 99291 and two units of code 99292. Providers then report additional units of code 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.

20+ Years of Stable Billing Patterns

A review of Medicare data shows that billing patterns for critical care codes have been remarkably stable over time as well, with approximately 10% of all critical care services reporting code 99291 also reporting one or more units of code 99292. The billing instances and rates can be seen below in Table 1.

***Table 1**. Medicare Critical Care Billing of CPT© Codes 99291 and 99292, 2011-2021*

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 these data with you to illustrate that billing patterns have been remarkably stable over time, and upon review of these data, there is no signal of dramatic volume change that might trigger further scrutiny or concern on the part of CMS.

New Policy Results in Significant % Devaluation of the 99291 Physician Work
Under previous policy, physicians were required to provide at least 74 minutes of critical care time before they could bill the first unit of code 99292. Under the current 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 code 99291 30 minutes longer, while maintaining the same physician work value. Put in different terms, this policy change has effectively devalued the 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 highly concerning and unfair to critical care providers.

Time Considerations and Other Families of CPT Codes

We understand the challenge CMS faces as the Agency considers how to apply the use of "time" across several different families of CPT codes. We appreciate CMS' efforts to develop a consistent use of time across a wide range of CPT codes. However, CMS' goal of a consistent application of time is not sufficient justification to fundamentally revalue critical care services. As we noted during our recent call on August 8, 2023, which was attended by you and your senior 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 that the definition of time that we are requesting be applied to critical care codes is common throughout the RBRVS payment structure. Evaluation and management codes 99490, 99497, 99498, 99457 and 99458 currently operate on the same definition that previously was applied to critical care codes and that we are requesting be restored to critical care codes.

Further, this understanding of time is common throughout the fee structure and is applied to:

- PT and OT codes 97110, 97124, 97129, 97130, 97140, 97151 – 97158, 917161-97172
- Behavioral health codes 90832-90840, 90846-90847, 90912-90913
- Audiology codes 92620-92621
- Intraoperative hyperthermic intraperitoneal chemotherapy codes 96547-96548
- Photodynamic therapy codes 96570-96751

This understanding of time and its use in time-based codes is consistently applied through the fee structure and is essential to maintain appropriate relativity throughout the fee structure.

For the outlined reasons, the undersigned medical organizations urge CMS to address this issue in the 2025 proposed Medicare Physician Fee Schedule rule.

Sincerely,

American Thoracic Society
American College of Chest Physicians
Society for Critical Care Medicine
American College of Emergency Physicians
American Society of Anesthesiologists