



September 10, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: File Code CMS-1751-P. Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-Payment Medical Review Requirements.

Dear Administrator Brooks-LaSure:

On Behalf of the Society of Critical Care Medicine (SCCM), we appreciate the opportunity to offer our comments to Centers for Medicare & Medicaid Services (CMS) on the 2022 Physician Fee Schedule (PFS) and Quality Payment Program (QPP) proposed rule, published in the *Federal Register* on July 23, 2021 (86 Fed. Reg. 39104).

The SCCM comments are guided by our members' dedication to providing care for critically ill patients. Our members represent adult, pediatric and neonatal critical care. Over the past 20 years, critical care has evolved from intermittent physician coverage to teams of intensivists and NPPs caring for critically ill patients on a continuous basis. While the withdrawn CMS critical care guidance acknowledged follow-on critical care by physicians and NPPs, given the disparity in reimbursement between physicians and NPPs, Medicare Administrative Contractors (MACs) had no guidance on how to account for follow-on critical care time. The proposed rule clarifies the follow-on care within a framework previously used for inpatient work.

We generally support this proposed rule with the following important exceptions:

1. We strongly support defining group by specialty and subspecialty. While critical care has multiple entry points, critical care requires a multidisciplinary approach. Intensivists (critical care specialists) rely on support from other specialties who may also supply medically necessary critical care. Defining group by Tax ID or "physician organization" places these specialties within the same group and makes a multidisciplinary approach financially untenable. In addition, the use of "physician organization" does not support the physician model used by academic medical centers.

2. We strongly request that CMS clarify the proposal on reimbursement for critical care services during the global surgical period. Most postoperative care is undertaken by intensivists whose parent training flows from surgery, internal medicine, anesthesiology, neurology, pediatrics, and emergency medicine. The American Board of Medical Specialties has defined training pathways recognizing the acquired skills and knowledge base required to care for the critically ill or injured as unique and separately definable from those found in any parent discipline. Prohibiting intensivist reimbursement for critical care during the postoperative period by bundling critical care services into the global surgical period would have a devastating impact on the provision and quality of postoperative critical care. Overall, the lack of intensivist coverage during the global surgical period would lead to longer ICU stays and poorer patient outcomes.

In the best interest of our patients, who are the CMS beneficiaries, we strongly recommend reconsideration of this proposal and suggest working with various organizations to understand and develop models of care delivery during the global surgery period. In addition, there are existing procedures outlined by CMS to protect CMS beneficiaries from inappropriate billing. Hence, if there are concerns around inappropriate billing, those can be addressed through a review of current policies and procedures for audit of inappropriate billing and follow-up actions. Our goal is to ensure all CMS beneficiaries get the best possible care and the services provided are appropriately reimbursed to have a sustainable healthcare delivery model.

3. We propose that CMS adopt a standard for distinct time for split (or shared) visits to represent the nature of team-based care. The CMS definition should acknowledge that more than two providers may care for a patient within a calendar day. We support a definition that aggregates the time for split (or shared) visits for inpatient E/M (including critical care) and allocates the CPT code to the provider with the greatest percentage of total time.

4. We request that CMS define both concurrent and follow-on time. In the proposal, CMS uses the terms interchangeably, which may cause confusion and is potentially inaccurate. We propose that concurrent time be defined as two providers providing medically necessary services to the same patient at the same time. We propose that follow-on time be defined as two providers providing medically necessary services to the same patient at different times. For purposes of reimbursement, two providers of different specialties would be able to provide concurrent medically necessary services. For purposes of reimbursement, when two providers of the same specialty provide concurrent services, only one of them could bill for the appropriate CPT code. Two providers of the same specialty would be able to bill E/M services and separately billable procedural codes that occur concurrently.

5. We strongly recommend that CMS adopt the CPT definition for allocating critical care time. In the proposal, CMS proposed two other time allocation systems in 2.d. (Critical Care Furnished Concurrently by Practitioners in the Same Specialty and Same Group [Follow-Up Care]) and 2.e. Split (or Shared) Critical Care Services. This introduces additional complexity into time allocation for critical care. Instead, we propose that critical care time for providers be aggregated and then allocated based on the method outlined in the CPT manual. If CMS wishes to change time accounting for Critical Care, it should do so through the CPT/RUC committee structure.

6. We strongly recommend inclusion of Adult Critical Care billing codes 99291, 99292 in the Category 3 Telehealth services until the end of CY 2023. This will allow delivery of telehealth critical care services to CMS beneficiaries during the COVID-19 pandemic in a manner similar to other allowable inpatient services. The ability to provide Adult Critical Care Services through telehealth enhances the provision of safe, timely, and optimal care of CMS beneficiaries and care providers. The proposal is to extend Category 3 Telehealth services until the end of CY 2023. Specifically, in Table 11, Hospital inpatient services and Pediatric Critical Care Services are included but Adult Critical Care Services are omitted.

Specific Questions from CMS 1751-P

Additionally, we are seeking public comment on whether there should be a different listing of qualifying activities for purposes of determining the total time and substantive portion of split (or shared) emergency department visits, since those visits also have a unique construct.

SCCM has no comment on split (or shared) emergency department visits.

We are seeking public comment on whether we should further define “group” for purposes of split (or shared) visit billing.

The concept of medical specialty, especially in the field of critically care, is increasingly complex while also being vitally important. Critical care physicians have multiple entry points including internal medicine, surgery, anesthesiology, pediatrics and emergency medicine. In addition, other specialties have evolved into critical care-specific subspecialties such as neurocritical care. Depending on the organizational structure, these intensivists may be called to provide care for any critically ill patient (for example, when a stroke patient is admitted into a medical ICU, or a sepsis patient is admitted into a neurological critical care unit). **Broadly the group should be defined by the service they provide regardless of the primary or parent specialty.** However, if medically necessary expertise by a subspecialty is required to provide optimal patient care, then concurrent care by subspecialists should be allowed.

CMS should also recognize that, as subspecialists, intensivists may have more than one primary duty. An anesthesiologist may work in the operating room one week and the ICU the next week. The lack of recognition of secondary specialty codes leads to a high rate of claims denials even when the service is separately identifiable and medically necessary. CMS should ensure that claims for intensivists in the ICU are reimbursed appropriately regardless of primary specialty identified.

Since NPPs are not assigned specialty ratings, it is appropriate to use the specialty or subspecialty of the physician they work with. In addition, CMS should recognize that NPPs may work with more than one specialty and ensure that claims are reimbursed appropriately.

The proposal also discusses using Tax ID or “physician organization” as the group identifier. As noted in the proposal, these designators are inappropriately broad. By using an inappropriately broad designator, they run afoul of the ability to provide concurrent E/M services. This is the antithesis of the desired multidisciplinary approach taken in critical care and indeed with all inpatient medicine.

In summary, we propose identifying a group for critical care by the services delivered. This is best encapsulated by the intensivist physician designator. CMS should recognize that, as subspecialists, intensivists will have other designators and may have other work areas outside of

the ICU. CMS should ensure that the use of other physician specialty codes do not interfere with the ability of intensivists to receive timely reimbursement.

We are seeking comment about how practitioners should report CPT codes 99291 and 99292 when a service extends beyond midnight to the following calendar day.

With the advent of shift work in the ICU, billing within a calendar day exposes difficulties. Care generally occurs 24/7 but the shifts are often not aligned to the calendar day, with day or night shifts being the most common. The current midnight-to-midnight system poses difficulties in billing after midnight as the providers may not generate sufficient time (>30 minutes) to bill the first hour of critical care (99291).

One possible solution is to allow institutions to define the “day” based on their shifts. For example, an institution with staffed with providers either on a day (7 a.m. to 7p.m.) or night (7 p.m. to 7 a.m.) could define their day as starting at 7 a.m. and continuing to 7 a.m. on the following day. This allows the institution to capture the full measure of CPT codes 99291 and 99292 as the time crosses midnight.

An alternative method was encapsulated in previous (now withdrawn) guidance for critical care time accounting. If the critical care time is continuous and crosses midnight, then the time is billed on the day starting before midnight. This becomes especially important when a patient is seen shortly before midnight. The provider must either document a separate E/M encounter for the time before midnight (less than 30 minutes), then document additional critical care time after midnight. This duplication of effort leads to unnecessary documentation and wasted time. Noncontinuous critical care time would be documented on the day of service.

It should also be noted that, with allowance of aggregated time for critical care, time after midnight may not remain an issue as the time would be captured and billed in aggregate.

We are seeking comment on this proposal to better understand current clinical practice for critical care, and when it would be appropriate for more than one physician or NPP of the same or different specialties, and within the same or a different group, to provide critical care services.

Critical care has evolved over the past 20 years. While episodic care by a single physician may have previously been the norm, today’s critical care is characterized by high-intensity care provided by a team of physician intensivists and NPPs. With the advent of Leapfrog, many institutions have moved to 24/7 coverage with dedicated NPPs and intensivists.

Another issue is the difficulty of defining specialty critical care. Board certification has several entry pathways including surgery, internal medicine, emergency medicine, pediatrics, and anesthesia. In addition, specialty critical care such as neurocritical care is available within neurology. All these specialties provide critical care services, and depending on institutional organization, may cover critical care services among a broad patient population. In terms of NPPs, PAs and NPs do not have specialty certification. Instead, they traditionally take the specialty or subspecialty of the physician they work with. This is vitally important in critical care, where NPPs may work with a variety of physician specialties working in the intensivist role. Outside of large academic medical centers, critical care may be provided by hospitalists or intermittent intensivist services. Many of these hospital medicine services use NPPs to deliver critical care services.

There are several models to achieve this coverage, which generally revolve around continuous NPP coverage with continuous or intermittent intensivist coverage. A typical ICU coverage might include an overnight NPP with an intensivist and one or more APPs during the day. In this example, a patient might be seen by the night NPP after midnight, by the intensivist and NPP during the day, and by a different NPP after 7 p.m. It is relatively common for multiple NPPs and physicians of the same specialty (intensivist) and same group to provide critical care services to a given patient in a calendar day.

In the previous guidance, CMS recognized that follow-on care would be provided by different physicians or NPPs in the same group. However, since CPT codes 99291 and 99292 are time-based codes, CMS did not state how time would be aggregated for follow-on care. This has led to a variety of MAC determinations and frequent denials of CPT code 99292 when provided by a different provider from the one who delivered the services for CPT code 99291.

The use of split (or shared) visits for CPT codes 99291 and 99292 allows for consistent aggregation of time within a construct that is generally understood by business departments.

While crediting the aggregated time to the provider with the greatest percentage of the aggregated time may represent a discount on physician time (in terms of NPP vs. physician reimbursement), the efficiencies in using the shared billing model make up for this.

The multidisciplinary nature of critical care also necessitates the inclusion of other specialties or groups delivering critical care. Specialty or subspecialty expertise may be necessary to address specific aspects of critical care. These separate and medically necessary critical care services help optimize patient outcome.

In summary, in current clinical practice, it is the norm for more than one physician or NPP within the same group to provide critical care services. It would be appropriate to reimburse the providers for critical care services rendered in either primary or follow-on care. In addition, it is appropriate for additional physicians or NPPs of a different group or specialty to provide critical care services when their expertise is medically necessary to ensure optimal patient care.

We are seeking comment on these proposals to ensure they reflect a clinically appropriate approach, and intend to assess whether we should instead require that an individual physician or NPP directly perform the entirety of each critical care visit. We are seeking comment on this proposal to better understand current clinical practice for critical care, and when it would be appropriate for more than one physician or NPP of the same or different specialties, and within the same or a different group, to provide critical care to a patient.

See above response.

Thus, we are seeking comment on this proposal to better understand clinical practice for critical care, whether and how CMS could pay for E/M services furnished on the same date as critical care services when provided by the same practitioner, or practitioners in the same specialty within a group, while also reducing the potential for duplicative payment.

The nature of critically ill patients dictates frequent changes in condition. In previous guidance, CMS acknowledged this change in condition when they elected to allow other E/M CPT codes for patients who were not critically ill and then sustained decompensation. The CPT code for critical care (99291 and 99292) specifically states that “Critical care and other E/M services may be provided to the same patient on the same date by the individual.” This reflects the reality of

the critically ill. A patient may be critically ill, then improve, and still require other medically necessary E/M services. Conversely a patient may not be critically ill but may have a sudden catastrophic event and become critically ill.

Example: A patient with pneumonia is intubated. After extubation the patient is doing well but then aspirates and requires invasive ventilation. Prior to aspiration the patient was not critically ill and would be appropriate for other E/M services. After aspiration the patient is now critically ill and CPT codes 99291 and 99292 are appropriate. Reimbursement for both other E/M and critical care (99291 and 99292) services is appropriate.

Example: A patient with severe shock is treated and resuscitated. During the day the patient is weaned off vasopressors. Later in the day the patient develops hypertension necessitating treatment with antihypertensives and abdominal pain necessitating parenteral opioids as well as evaluation involving a CT scan. The patient is critically ill earlier in the day and CPT codes 99291 and 99292 are appropriate. Later in the day the patient is not critically ill but now requires high-level E/M services. It would be appropriate to reimburse for both critical care (99291 and 99292) as well as other E/M services.

CMS is rightly concerned about duplicative payment. However, each CPT code (both 99291/99292 and other E/M services) would require separate documentation, which would include time spent and medical necessity. The medical necessity would need to reflect the specific reasons the patient was either critically ill or needed other E/M services.

Specific Responses

1. Split (or Shared) Visits

a. Background

We support the CMS definition of shared visit and agree that the time for the visit should be the summed distinct time for the visit.

We agree that only distinct time should be counted and that, when two or more providers discuss the patient, only the time for one individual should be counted.

b. Definition of Split (or Shared) Visits

We agree that modifying the CMS policy to allow physicians and NPPs to bill for split (or shared) visits for both new and established patients, and for critical care and certain Skilled Nursing Facility/Nursing Facility (SNF/NF) E/M visits accurately captures the role of NPPs on the medical team.

c. Definition of Substantive Portion

(1) More Than Half of the Total Time

We agree that the provider providing the substantial portion of the services should be credited with the work. However, the proposal to use a measure of “more than half of the total time” fails to describe the nature of inpatient medical work. Inpatient work, especially in the critical care

environment routinely, involves shift work with multiple medical providers. This leads to situations where no one provider accounts for more than half of the total time (in the event of three or more providers). SCCM instead proposes that “substantive portion” be defined as the ***provider with the greatest percentage of time***. For example, if three providers saw a patient for 30%, 40%, and 30% of the total time, the CPT would be submitted under the provider with 40% of the time. This change accounts for shift-based and team-based approaches common in current medical care.

We appreciate the concerns from CMS over tracking time and note that current electronic medical records (EMRs) are capable of capturing time and reporting time for billing purposes.

(2) Distinct Time

We support reporting distinct time with the caveat that distinct time can happen with more than three providers as noted in our response to 1.c.(1).

(3) Qualifying Time

We support the definition of qualifying time and activities used by CMS. However, for non-critical care CPT codes, we request that CMS clarify whether the qualifying time can be done remotely. With the advent of EMRs, it is not necessary for the provider to be physically present on the unit or floor to accomplish some of the listed tasks. Clarity over physical presence would help establish what time counts as qualifying time.

We have no current opinion as to whether there should be a different listing of qualifying activities for purposes of determining the total time and substantive portion of split (or shared) emergency department visits, since those visits also have a unique construct.

(4) Application to Prolonged Services

We support the application of prolonged E/M visit for a split (or shared) visit. We support prolonged services codes with the same caveat as noted in our response to 1.c.(1). When more than two providers engage in prolonged services, the provider with the greatest percentage of the total time would submit the CPT code for prolonged services.

d. New and Established Patients, and Initial and Subsequent Visits

We support allowing split (or shared visits) for both new and established patients as well as for initial and subsequent visits. This model supports the current team-based approach to medical care.

e. Settings of Care

We have no current opinion on split (or shared) visits in SNF/NF facilities.

f. Same Group

We support defining “same group” for the purposes of split (or shared) billing by physician specialty and subspecialty. In addition, we support defining the NPP specialty or subspecialty as the physician with whom they are working. This approach ensures that different specialties are reimbursed for necessary services provided to the patient. This approach also ensures that

different specialties can jointly manage a patient for optimal outcomes.

The Tax ID approach or “physician organization” approach does not sufficiently differentiate between specialties or subspecialties, limiting their ability for reimbursement for medically necessary services. In addition, the “physician organization” model is ill suited to many academic medical centers and does not address the specialty designation for NPPs (or their membership in the “physician organization”).

g. Medical Record Documentation

We support documentation of the individual practitioners who provide care but again note the issue raised in 1.c.(1) that there may be more than two individual providers involved. We instead support language that **all practitioners involved in the care of the patient must individually document their involvement and time.**

h. Claim Identification

We support a modifier to identify split (or shared) services. This will enable CMS to properly identify and manage split (or shared) services. In addition, we support the elimination of reimbursement for partial E/M services.

2. Critical Care Services (CPT codes 99291-99292)

a. Definition of Critical Care

We support allowing a physician or qualified healthcare provider (QHP) to provide critical care services as noted in the proposal. We support inclusion of bundled procedures as outlined in CPT with critical care services. We support separate reporting of non-bundled procedures. We request that CMS clarify the bundling of vascular procedures in 2.a. The proposal excludes the CPT codes from vascular procedures that are present in the CPT manual (CPT 36000, 36410, 36415, 36591, 36600).

b. Critical Care by a Single Physician or NPP

We support using the CPT to describe critical care by a single physician or NPP. We propose that continuous critical care extending across midnight of the following calendar day be included in the previous calendar day. We propose that critical care services after midnight on the following calendar day be reported for the following calendar day. We also recommend that CMS consider alternative time periods for reporting E/M CPT codes in the inpatient setting. Other time periods may better align with shift work that occurs in the inpatient setting.

c. Critical Care Services Furnished Concurrently by Different Specialties

We support separately reporting CPT codes for critical care furnished concurrently on the same patient by different specialties when the care is medically necessary. However, we oppose the definition of concurrent care proposed in the proposed rule.

Instead, we propose that CMS adopt a definition that clearly differentiates between concurrent care by different specialties and follow-on care by the same specialties. We propose that concurrent care be defined as critical care at the same time on the same patient by different specialties. We propose to define follow-on care as care provided by different physicians or NPPs of the same specialty to the same patient on the same day.

d. Critical Care Furnished Concurrently by Practitioners in the Same Specialty and Same Group (Follow-Up Care)

We support the proposal that, when one practitioner does not meet the minimum time requirement and another provider continues to provide care to the same patient on the same day, the time be aggregated.

We oppose the time accounting listed in 2.d. paragraph 2. This time accounting (billing CPT 99292 is not reported until an additional 30 minutes of critical care are furnished to the same patient on the same day) contradicts the guidance given in the CPT manual and is at odds with guidance given in the proposal in 2.b. (Critical Care Services by a Single Physician or NPP). In addition, there appears to be a math error in the proposed rule (114 minutes). Finally, this contradicts the proposed rule in 2.e. (Split (or shared) Critical Care Services).

e. Split (or Shared) Critical Care Services

We support the CMS proposal to adopt split (or shared) billing for critical care services. However, we oppose the adoption of prolonged time accounting for critical care. Instead, we propose to use the method proposed in 1.c.(1) where providers aggregate their time and then use appropriate CPT codes 99291 and 99292 as related in the CPT manual. We also propose that the aggregated time and CPT codes be billed under the provider with the greatest percentage of the total time.

f. Critical Care Visits and Same-Day Emergency Department, Inpatient or Office/Outpatient Visits

We oppose the prohibition for billing other E/M services on the same patient on the same date as critical care services by practitioners in the same specialty in the same group. This directly contradicts the CPT guidance for critical care, which states that critical care and other E/M services may be provided to the same patient on the same day. While critical care may be intermittent, the patient may not be continuously critically ill in the same calendar day. The patient may not be critically ill early in the calendar day but then may deteriorate and become critically ill. If a provider provides other medically necessary E/M services, these should be reimbursed. This scenario was specifically allowed by CMS in the now-withdrawn CMS guidance on critical care. The patient may also improve during the calendar day and not be critically ill. The patient may still need medically necessary E/M services and providers rendering these services should be reimbursed.

g. Critical Care Visits and Global Surgery

We request that CMS clarify the proposal regarding bundling critical care visits during the global period. The proposal to disallow critical care codes during the global surgical period will have profound effects on the delivery of critical care to postoperative patients. In particular, the effect of bundling critical care on academic surgical programs, rural hospitals, and pediatric hospitals will lead to worse outcomes and barriers to patient care. Bundling critical care into the global surgical period will strongly disincentive systems to provider postoperative intensivist coverage.

While adult postoperative critical care in community facilities is commonly provided by intensivists trained in internal medicine, anesthesia, or emergency medicine, there are important

differences in academic centers. In teaching facilities, a significant portion of postoperative care is undertaken by intensivists whose parent training flows from surgery. The American Board of Medical Specialties and the American Board of Surgery have defined a pathway for Surgical Critical Care, recognizing the acquired skills and knowledge base as unique and separately definable from those found in any parent surgical discipline. Additionally, the American College of Surgeons Committee on Trauma verified trauma center has specific requirements for surgical involvement in trauma patients. As a requirement of verification, the surgeon must remain involved in patient care whether they are on the acute care floor or in the ICU. In academic centers, that ICU care is commonly rendered by a surgical intensivist who is different from the trauma surgeon. At present, there is no board certification pathway for trauma surgery. As a result, surgical critical care board certification is most densely represented in surgeons who practice general surgery, trauma, and surgical critical care during different weeks of service. The CMSS proposal would effectively devalue time spent in training as a surgical intensivist, as well as the time and effort dedicated to maintenance of continuous certification.

In addition to the significant impact on trauma services when bundling critical care into the global surgical period, rural hospitals will suffer disproportionate impact. Rural hospitals have significantly less resources and rely on other specialties including internal medicine, emergency medicine, and family medicine to provide care to the critically ill patient. Bundling critical care into the global surgical period provides a strong disincentive for other specialties to care for these critically ill patients and may render surgery untenable at some rural hospitals.

Finally, the impact of the proposal bundling critical care into the global surgical period will have a significant impact on the delivery of pediatric and neonatal critical care. The population of pediatric and neonatal ICUs includes a significant proportion of postoperative patients. Given the fragility and size of these patients, the additional expertise provided by pediatric critical care and neonatologists is necessary for the recovery of these patients. In addition, the specialty of pediatric neurocritical care is rapidly evolving following the footsteps of adult neurocritical care. The loss of the ability to bill for critical care in the postoperative period will have a devastating impact on pediatric hospitals' ability to provide pediatric or neonatal critical care.

Given the disparate impact on rural, academic, and pediatric medical centers, we urgently request that CMS withdraw its proposed rule to bundle critical care during the global postoperative period. We strongly recommend that CMS continue to reimburse medically necessary intensivist care provided to postoperative patients.

h. Documentation Requirements

We support the proposal for documentation requirements including individual services provided and total time of critical care services provided by each reporting practitioner. We agree that start and stop times are impractical given the intermittent nature of critical care.

Telehealth services

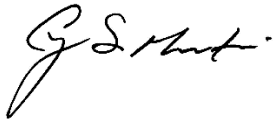
The proposal is to extend Category 3 Telehealth services until the end of CY 2023 (Table 11: Services Added to the Medicare Telehealth Services List for the Duration of the PHE for COVID-19 but Were not Added to the Medicare Telehealth Services List on a

Category 3 Basis Services).

There are three categories of telehealth services. Category 3 was a new category created to address the COVID-19 pandemic and allow billing for telehealth services where corresponding codes exist (Page 39131). A Category 2 service requiring the use of a telecommunications system to furnish the service produces demonstrated clinical benefit to the patient.

The proposal specifically does not address critical care billing codes such as 99291 and 99292. We advocate adding these codes to reimburse tele-critical care delivery during the unpredictable COVID-19 pandemic, as for other allowable inpatient services. The COVID-19 pandemic dramatically impacted the normal transfer process for critically ill patients. The use of telehealth allows intensivists to help deliver critical care to rural ICUs when transfer is impossible due to overcrowding.

Sincerely,

A handwritten signature in black ink, appearing to read "G. S. Martin". The signature is fluid and cursive, with a horizontal line extending from the end.

Greg S. Martin, MD, MSc, FCCM
SCCM President