HEALTHCARE REGULATORY ROUND-UP – Episode #61

Deeper Dive

2024 Medicare Physician Fee Schedule (MPFS)

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Introductions

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Agenda

1. Conversion Factor
2. Office/Outpatient Evaluation & Management (E/M) Visit Complexity Add-On Code G2211
3. Split/Shared Visits
4. Telehealth
5. Virtual Supervision
6. Remote Patient Monitoring
7. Diabetes Programs
8. Health-Related Social Needs
9. Behavioral Health
10. Resources

Conversion Factor

2024 Conversion Factor

- **Finalized:**
  - **Physician: $32.7476 (-3.36%)**
  - **Anesthesia: $20.4370 (-3.26%)**
- Continued negative adjustments since 2021 in the midst of inflation and workforce shortages will likely push Congress to act.
- H.R. 2474, the Strengthening Medicare for Patients and Providers Act
  - Creates a permanent annual update to the CF equal to the Medicare Economic Index
- Negative reimbursement impact to proceduralist and surgical practices

Office/Outpatient E/M Visit Complexity Add-On Code G2211

Office and Other Outpatient (O/O) E/M Visit Complexity Add-on Code: G2211

- The Consolidated Appropriations Act, 2021 imposed moratorium until 2024.
- Code Status will be **Active** effective **January 1, 2024**
- **Description:**
  - Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition
- Beyond the 2021 O/O E/M visit wRVU value increases, this code is intended to account for additional resources associated with:
  - primary care, or
  - ongoing medical care related to a patient's single, serious condition, or complex condition.

O/O E/M Visit Complexity Add-On Code: G2211 – *Policy*

- For primary care physicians or specialists serving patients predominantly in the O/O setting
- No documentation requirements

Will be billable	Will not be billable
• To Medicare • With new or established O/O E/M visits • When E/M and psychotherapy billed together • When provider is taking responsibility for ongoing, subsequent medical care for the patient (longitudinal care relationship)	• To non-Medicare payers or those in capitated models (Watch for other payer adoption – though unlikely) • With E/M when billed with Modifier 24, 25, or 53 • Certain specialties and generally when the provider does not have an ongoing relationship with the patient with consistency and continuity over time (acute, time-limited services)

Source: https://www.cms.gov/files/document/physician-fee-schedule-pfs-payment-officeoutpatient-evaluation-and-management-em-visits-fact-sheet.pdf

O/O E/M Visit Complexity Add-On Code: G2211 – *Financial Impact and Risk*

- About 90% of the -2.17% budget neutrality adjustment is addressing this new code
- CMS assigned 0.33 wRVUs to G2211 / $16.04 National payment rate
- Use of G2211 will increase wRVUs earned by physicians and related reimbursement for the practice.
- An increase in wRVUs for providers could increase wRVU-based compensation.
- Individual impact of the code will vary based on utilization and volume.
- For those employers using prior year fee schedules to determine wRVU values, the value and potential frequency of this new code will need to be considered when updating to the 2024 MPFS values.
- Risk will include utilization outside of the MAC's or RAC's interpretation of the policy, implicating an overpayment or false claim.

O/O E/M Visit Complexity Add-On Code: *G2211 Utilization*

- Expected Utilization:
  - Originally anticipated on 90% of O/O E/M visits ($3.3B) now revised to 38% initially and 54% when fully adopted
  - These percentages should not be used as a benchmark
- Possible strategy:
  - Identify patients with diagnoses which require monitoring and management with visits at least annually
  - Consider excluding patients which commonly have procedures (injections, infusions, other surgical procedures) at each visit (modifier 25)
  - Flag identified patients or create an automated billing procedure to add the G2211 to each O/O E/M for those patients

Split/Shared Visits

Split/Shared Visit

An E/M visit performed by a physician and a non-physician practitioner (NPP) in the facility setting on the same calendar date

Does not apply to non-facility settings

Since 2022, critical care and SNF services are permitted to be billed as split/shared services

Combined service must be billed under one provider if in the same group practice

When the NPP bills, 85% of the MPFS is reimbursed

History of Split/Shared Rule (2022 – 2023)

- **2022:**
  - NPP or Physician performs face-to-face visit
  - Substantive portion based on time, or
  - History, Exam, or MDM – per 1995 or 1997 E/M Documentation Guidelines
- **2023:** Face-to-face visit by the physician
  - NPP or Physician performs face-to-face visit
  - Substantive portion based on time, or
  - History, Exam, or MDM – per 2023 E/M Documentation Guidelines
  - Issue: History and Exam no longer a part of level determination (Subjective)
  - 2023 Note: Critical care changes were not delayed, and CMS corrected its error in the guidelines and reiterates that the full 30 minutes must be met to bill for the 99292 (104 minutes).

Source: https://www.cms.gov/files/document/mm12543-internet-only-manual-updates-iom-critical-care-split-shared-evaluation-and-management-visits.pdf

2024 MPFS Final Rule Update

- The implementation of time only will not be finalized.
- **CMS will align with CPT 2024 just released definition of Split/Shared:**
  - Maintains requirement of substantive portion to determine the billing provider
  - NPP or Physician performs face-to-face visit
  - More than half of the time spent by the physician or NPP **– *or* –**
  - Substantive part of the MDM

CPT 2024: Split/Shared Guidelines

"The split or shared visits guidelines are applied to determine which professional may report the service. If the physician or other QHP performs a substantive portion of the encounter, the physician or other QHP may report the service.

If code selection is based on total time on the date of the encounter, the service is reported by the professional who spent the majority of the face-to-face or non-face-to-face time performing the service.

For the purpose of reporting E/M services within the context of team-based care, performance of a substantive part of the MDM requires that the physician(s) or other QHP(s) **made or approved the management plan for the number and complexity of problems addressed at the encounter** and **takes responsibility for that plan** with its **inherent risk** of complications and/or morbidity or mortality of patient management. By doing so, a physician or other QHP has performed two of the three elements used in the selection of the code level based on MDM. If the **amount and/or complexity of data** to be reviewed and analyzed is used by the physician or other QHP to determine the reported code level, assessing an independent historian's narrative and the ordering or review of tests or documents do not have to be personally performed by the physician or other QHP, because the relevant items would be considered in formulating the management plan. Independent interpretation of tests and discussion of management plan or test interpretation must be personally performed by the physician or other QHP if these are used to determine the reported code level by the physician or other QHP" (2024 CPT Codebook, pg. 6).

CMS Documentation Expectations: Final Rule

- "Although we continue to believe there can be instances where MDM is not easily attributed to a single physician or NPP when the work is shared, we expect that whoever performs the MDM and subsequently bills the visit would **appropriately document the MDM in the medical record to support billing of the visit." – 2024 MPFS Final Rule**
- CMS says that they are aligning with CPT, but this statement could be interpreted as requiring the physician to document the MDM independently in support of the code.
- Conservative application for Medicare: Even if the NPP documents the MDM, the physician will need to redocument the MDM in support of the code billed in order to be the billing provider (summary of diagnoses, status, and plan).
- CPT application (other payers) of minimum documentation requirements: "Reviewed and agree with plan at my direction." and physician signature

Split/Shared Documentation: CMS Manual

- Documentation in the medical record must identify the physician and NPP who performed the visit.
- The individual who performed the substantive portion of the visit (and therefore bills for the visit) must sign and date the medical record.
- For all split (or shared) visits, one of the practitioners **must have face-to-face (in-person) contact with the patient**, but it does not necessarily have to be the physician, nor the practitioner who performs the substantive portion and bills for the visit.
  - The **substantive portion** can be entirely with or without direct patient contact, and is determined by the proportion of total time, not whether the time involves patient contact.
- Modifier -FS (Split or Shared E/M Visit) must be reported on claims for split (or shared) visits, to identify that the service was a split (or shared) visit.

Source: https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c12.pdf

Split/Shared Impact Analysis and Comments – *Physician Compensation Impact*

- Changes in attribution of wRVUs between providers are not likely
- Fears over impact to provider compensation should be alleviated with this update

Telehealth

Telehealth

Align policies with telehealth extensions in Consolidated Appropriations Act, 2023.

- Waiver of geographic and location requirements
- Delay in-person requirement for tele-behavioral health services
- FQHC and RHC reimbursement for telehealth services
- Expanded list of telehealth practitioners (add marriage and family therapists and mental health counselors for 2024)
- Coverage of audio-only services

Telehealth services list:

- Replace Categories 1, 2, and 3 with permanent and provisional categories; refine process to evaluate eligibility
- Appears all services (vs. Category 3 services only) added to list during PHE moved to provisional category; current and proposed 2024 Telehealth Services List substantially the same)
- No stated timeframe for removing provisional codes from list

More Telehealth

- Billing and payment:
  - Beginning 1/1/2024, use POS 02 (telehealth provided other than in patient's home) or POS 10 (telehealth provided in patient's home).
    - Discontinue use of 95 modifier + POS if service had been furnished in person.
  - POS 02 to be paid at facility rate; POS 10 to be paid at non-facility rate.
- Suspend frequency limitations for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations.
- Permanently eliminate in-person requirement for injection training for Diabetes Self-Management Training; expands list of eligible DSMT distant site providers.
- Continue to permit Opioid Treatment Programs to furnish periodic assessments via audio-only telecommunications thru end of 2024.
- For 2024, originating site facility fee (Q3014) will be $29.92 (up from current $28.64) (based on increase in Medicare Economic Index).

Telehealth Services Furnished by Institutional Staff

- Payment for outpatient therapy services (PT, OT, SLP), diabetes self-management training, and medical nutrition therapy services furnished by institutional staff based on MPFS (e.g., HOPDs, SNFs, and HHAs).
- **During PHE**, institution received reimbursement for these services furnished by staff to patients in their homes via telehealth (Hospital Without Walls)
- CMS' **post-PHE** guidance = such reimbursement no longer available

Best Practice Telehealth Service Documentation

- Document E/M services as typically done for an in-person visit.
  - History, exam, and MDM
- Include a statement that the service was provided via telehealth, the platform used, where the provider and the patient are located, and names and roles of any others participating.

Virtual Supervision

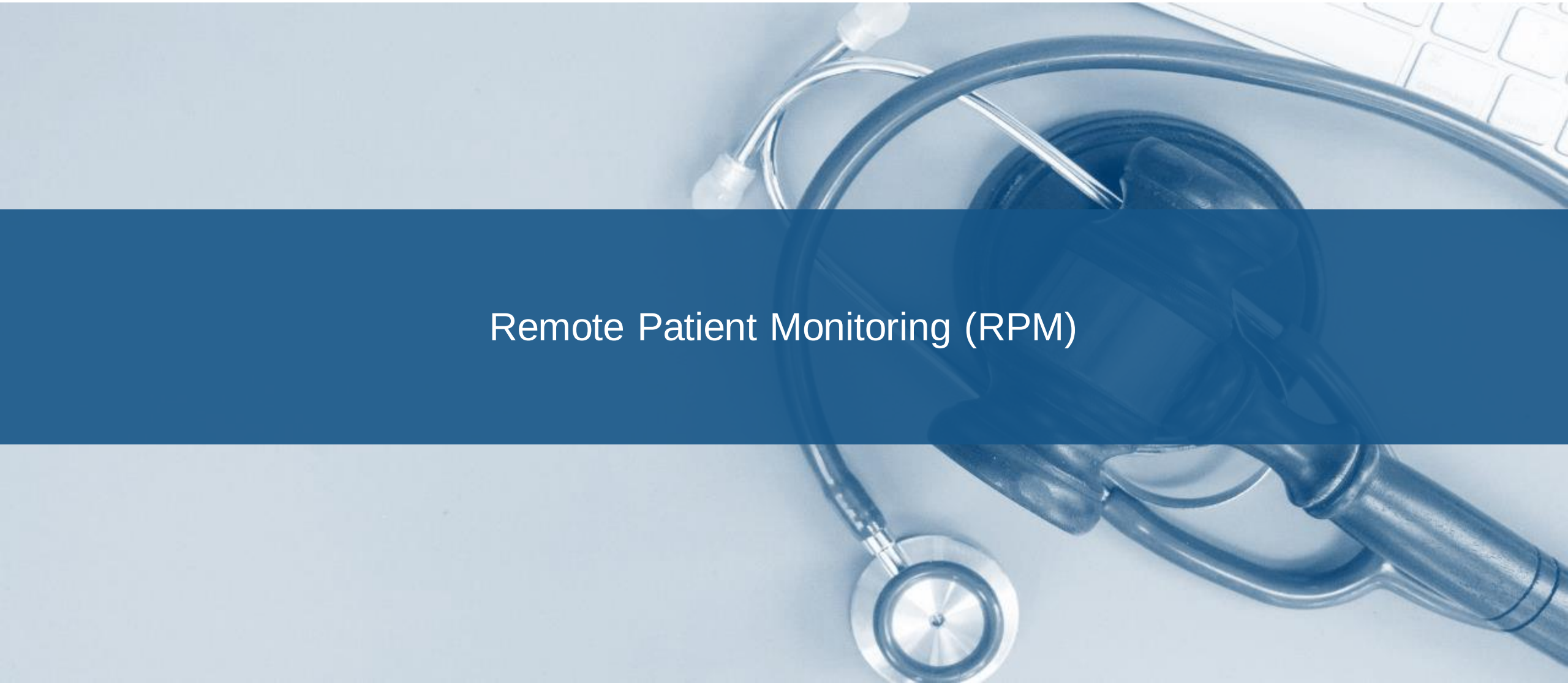
Direct Supervision vs. Virtual Supervision

- Direct Supervision required for:
  - Incident-to billing
  - Certain diagnostic tests
  - Pulmonary rehab
  - Cardiac rehab and intensive cardiac rehab
- **Pre-PHE:** Supervising practitioner physically present and immediately available to provide assistance.
- **During PHE:** Virtual presence using real-time audio/video technology.
- **Post-PHE:** Continue virtual presence thru 2024; potentially, revert to physical presence requirement.

Virtual Supervision for Teaching Physician Services

- Continue to permit teaching physician to have virtual presence when service furnished via telehealth (three-way telehealth visits).
- Teaching physician must present for the critical portions of the procedure and immediately available:
  - Surgical, high risk, interventional, endoscopic, or other complex procedures

Remote Patient Monitoring (RPM)



Remote Monitoring – What's New

- Revises regulations to permit Medicare-enrolled PTs and OTs to bill for RTM services furnished by PTAs/OTAs under general supervision.
- Clarifies that RPM or RTM may be furnished to patients within a global surgery period for surgery if services unrelated to diagnosis for which surgery performed, and addresses episode of care distinct from surgical episode.
- While RTM does not have established patient requirement, such services would be furnished after treatment plan established.
- Adds certain RPM and RTM codes to to list of RHC/FQHC care management services reimbursed under G0511.
  - Includes monthly monitoring (CPT 99454, 98976, 98977, 98978) and treatment management services (CPT 99457 and 98980).

Remote Monitoring – What's Repeated

- RPM and RTM codes require data collection for at least 16 days in a 30-day period.
  - 16-day data collection does not apply to RPM/RTM treatment management services (CPT codes 99457, 99458, 98980, 98981)
- Only one practitioner can bill CPT codes 99453 and 99454, or CPT codes 98976, 98977, 98980, and 98981, during a 30-day period
- Practitioner cannot bill RTM and RPM codes for same time period but can bill other care management services (CCM, TCM, PCM, CPM, and BHI)
- "[S]ervices associated with all medical devices can be billed only once per patient per 30-day period", even if multiple devices are reporting data.

Medicare Diabetes Prevention Program

Medicare Diabetes Prevention Program (MDPP)

- MDPP began in 2018 with initial enrollment of MDPP suppliers who have achieved CDC Diabetes Prevention Recognition Program (DPRP) recognition.
  - Program includes no fewer than 22 intensive sessions furnished over 12 months by trained coach using approved curriculum to help beneficiaries reduce risk for developing type 2 diabetes.
- Replace current attendance-based performance payments with fee-for-service payments for up to 22 sessions.
- Extend PHE flexibilities thru end of 2027, but only for MDPP suppliers that have and maintain CDC DPRP in-person recognition.
  - Alternatives to the requirement for in-person weight measurement.
  - Permit all-virtual programs (synchronous only).
- Purpose is to continue the MDPP program to encourage diabetes control and weight-loss for positive health outcomes for beneficiaries.

Other Diabetes Services

- Diabetes Screening Tests
  - Expanded diabetes screening – CMS is including Hemoglobin A1C (HbA1c) test in the coverage of diabetes screening.
  - Intent is to reduce provider and patient burden and improve patient-centered care.
- DSMT and MNT
  - Allow either Registered Dietician (RD) or nutrition professional to personally perform MNT services.
  - RD or nutrition professional may bill for the DSMT services.
  - Purpose is to promote access to DSMT to beneficiaries and improve care for individuals with diabetes.

Health-Related Social Needs

New Reimbursement for Services Addressing Health-Related Social Needs

Social Determinates of Health (SDOH):
G0136

Community Health Integration (CHI):
G0019 and **G0022**

Principal Illness Navigation (PIN):
G0023 and **G0024**

PIN Peer Support:
G0140 and **G0146**

Social Determinates of Health (SDOH) Risk Assessment – G0136

- Administration of standardized, evidence-based SDOH risk assessment tool, 5-15 minutes, not more often than once every 6 months
  - Does not serve as a screening tool but rather is tied to one or more known or suspected SDOH needs that may interfere with the practitioner's diagnosis or treatment of the patient.
- Does not have to be furnished on same day as E/M visit (but generally not performed prior to visit)
- An optional, additional element of the Annual Wellness Visit (AWV)
  - No beneficiary cost sharing when conducted as part of the AWV.
- Tools could include CMS Accountable Health Communities tool, PRAPARE tool, instruments identified for MA Special Needs Population Risk Assessment
  - May be furnished by auxiliary personnel if 'incident to' requirements satisfied
  - Included on Medicare Telehealth Services List

Community Health Integration (CHI) – G0019, G0022

- **CHI Initiating Visit:** E/M visit, TCM, or AWV in which billing practitioner identifies presence of SDOH need(s) that limit practitioner's ability to diagnose or treat problem(s) addressed in visit (separately billable).
  - ED, inpatient/observation, and SNF E/M visits cannot serve as CHI initiating visits.
- **G0019:** Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month.
- **G0022:** Community health integration services, each additional 30 minutes per calendar month (List separately in addition to G0019).

CHI – G0019, G0022 (cont.)

- Performed by certified or trained auxiliary personnel under general supervision of billing practitioner
  - Auxiliary personnel must be certified or trained to perform all included service elements, and authorized to perform then under applicable state laws and regulations.
  - **Service elements:**
    - ✓ Person-centered assessment
    - ✓ Practitioner-, home-, and community-based care coordination
    - ✓ Health education
    - ✓ Building patient self-advocacy skills
    - ✓ Health care access/health system navigation
    - ✓ Facilitating behavioral change as necessary for meeting diagnosis and treatment goals
    - ✓ Facilitating and providing social and emotional support

More CHI Details

- Auxiliary personnel must document activities (including amount of time spent) in billing practitioner's EHR; include relationship to SDOH need(s) intended to address and clinical problem(s) intended to help resolve.
- Only one practitioner can bill for CHI services during given month.
- Must obtain oral or written patient consent following notice of cost-sharing and that only one practitioner can bill for CHI services during given month; only required to obtain once (not annually).
- Cannot be billed when patient under home health plan of care.
- Can bill in same month as care management services (no double-counting).
- Billing practitioner can arrange to have CHI services furnished through third party (e.g., CBO), provided there is sufficient clinical integration between third party and billing practitioner.

Principal Illness Navigation (PIN) - G0023, G0024

- **G0023** – PIN services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator or certified peer specialist; 60 minutes per calendar month
- **G0024** – each additional 30 minutes (no frequency limitations)
- Patients diagnosed with serious high-risk disease (e.g., cancer, COPD, dementia, severe mental illness, SUD)
  - Expected to last at least 3 months that places patient at significant risk of hospitalization or nursing home placement, acute exacerbation/decomposition, functional decline, or death
  - Requires development, monitoring, or revision of disease-specific care plan, and may require frequent adjustment in medication/treatment regimen, or substantial assistance from caregiver

PIN – G0023, G0024 (cont.)

- **PIN Initiating Visit**
  - E/M visit, TCM, or AWV in which billing practitioner identifies medical necessity for PIN services, establishes treatment plan, and specifies how PIN services would help accomplish that plan
  - Performed by certified or trained auxiliary personnel under general supervision of billing practitioner
    - Auxiliary personnel must be certified or trained to perform all included service elements, and authorized to perform then under applicable state laws and regulations

PIN – G0023, G0024

- Auxiliary personnel must document activities (including amount of time spent) in billing practitioner's EHR:
  - Include relationship to treatment plan.
  - Document any identified SDOH need(s); preference for use of Z codes in EHR and claim.
- Ensure PIN time and effort is not being duplicated for patients with multiple principal illnesses at one time.
- More than one practitioner can bill for PIN services during given month in limited circumstances.
  - *"[W]e do not expect a patient to require multiple PIN services for a prolonged period of time, except in circumstances in which a patient is receiving PIN services for highly specialized navigation, such as behavioral health or oncology"*
- Must obtain oral or written patient consent following notice of cost-sharing before or at initiation of PIN services and annually thereafter.
- Billing practitioner can arrange to have CHI services furnished through third party (e.g., CBO), provided there is sufficient clinical integration between third party and billing practitioner.

PIN Peer Support - G0140, G0146

- **G0140** – Peer support by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a certified peer specialist; 60 minutes per calendar month
- **G0146** – Each additional 30 minutes (no frequency limitations)
- PIN services furnished by peer support specialists
  - Limited to beneficiaries with severe mental illness or SUD
  - Like PIN, except tailored scope of services consistent with peer support specialists' scope of practice
  - PIN and PIN-PS cannot be furnished concurrently for same condition
  - Facilitating patient-driven goal setting and establishing an action plan.
- Patient consent is required. Consent can be written or verbal, so long as it is documented in the patient's medical record.

PIN vs. PCM

- It is important to note the differences in the required time for reporting PIN G-codes compared to Principal Care Management (PCM) codes (99425-99427).

Service	Principal Care Management (PCM)		Principal Illness Navigation (PIN)	
CPT/ HCPCS Code	**99424**	**99426**	**G0023**	**G0140**
Staff Type	Physician or other QHP	Clinical Staff	Patient Navigator/ Certified Peer Specialist	Peer Specialist
Patient Conditions	1 complex	1 complex	1 serious	Behavioral Health
Reporting Time Interval	30 min	30 min	60 min	60 min

Source: https://www.ama-assn.org/system/files/cpt-assistant-oncology-navigation-codes.pdf

Behavioral Health

Behavioral Health Services

Coverage and payment for Marriage and Family Therapists (MFT) and Mental Health Counselors (MHC)

- Payment at 75% of psychologist rate (same as clinical social workers)
- MFTs and MHCs can enroll following publication of final rule
- Add MFTs and MHCs to list of RHC/FQHC practitioners

Psychotherapy for Crisis Services

- **G0017-** Psychotherapy for crisis furnished in an applicable site of service; first 60 minutes
- **G0018-** each additional 30 minutes (List separately in addition to code for primary service)
- Furnished in any non-facility POS other than physician office setting
- Payment at 150% of rate for physician office setting

Behavioral Health Services (cont.)

- Permit clinical social workers, MFTs, and MHCs to bill Health and Behavior Assessment and Intervention (HBAI) services.
  - CPT codes: 96156, 96158, 96159, 96164, 96165, 96167, and 96168
- Increase in wRVUs for patient one- on- one timed behavioral health services, to be implemented over a 4-year period.
  - CPT codes: 90832, 90834, 90837, 90839, 90840, 90845, 90846, 90847, 90849, 90853, G0017, G0018
- Allow general supervision for behavioral health services furnished incident to physician or NPP services in RHC/FQHC.
- Coverage and payment for intensive outpatient services in hospital outpatient departments, community mental health centers, RHC/ FQHC, and Opioid Treatment Programs.
  - Physician determination that patient needs a minimum of nine hours of IOP services per week. Must occur every other month at minimum.

Resources

Resources

- **CY 2024 PFS Final Rule:**
  - https://public-inspection.federalregister.gov/2023-24184.pdf
  - https://www.federalregister.gov/documents/2023/11/16/2023-24184/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other
- **CMS Fact Sheet**
  - https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule

2024 MPFS Effective
January 1, 2024

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