FINAL RULE FOR CY 2024 PHYSICIAN FEE SCHEDULE

FACT SHEET I November 2023

At the beginning of November 2023, the Centers for Medicare and Medicaid Services (CMS) released its unpublished Final Rule for the 2024 Physician Fee Schedule (PFS). The official version was published in the Federal Register on November 16, 2023. The PFS contains policy changes for the Medicare program to go into effect January 1, 2024 (unless otherwise stated). Many of the proposals in the final rule mirror what was proposed by CMS in July 2023, however, there were some differences. For easy reference, throughout this factsheet we have provided the page numbers where each referenced policy appears in the final rule. Please note these page numbers correlate to the unpublished version of the final rule.

Home Address

During the pandemic, CMS allowed providers to use their currently enrolled locations (typically a practice address) instead of a home address when providing services via telehealth. Previously CMS extended this policy to the end of 2023. In the proposals for the 2024 PFS, CMS did not address this issue, but after receiving comments from the public and holding meetings with interested parties, the agency has decided to extend this policy to the end of 2024. Many telehealth providers and advocates have raised the issue that addresses may be publicly accessible and for providers to have their home addresses listed could create a safety issue. While the temporary waiver at this time will only be extended to the end of 2024, CMS did note in the final rule that it "will also consider this issue further for future rulemaking and request that interested parties provide clear examples of how the enrollment process shows material privacy risks to inform future enrollment and payment policy development." (Page Reference, p. 151)

Adoption of Changes Made by the Consolidated Appropriations Act of 2023

The Consolidated Appropriations Act of 2023 (CAA 2023) contained many of the larger provisions that extended temporary telehealth policies in Medicare. These provisions included:

- Temporarily removing the geographic and site requirements for the patient location at the time the telehealth interaction takes place
- Temporarily allowing a more expansive list of eligible providers in Medicare to provide services via telehealth such as physical and occupational therapists and federally qualified health centers (FQHCs) and rural health clinics (RHCs)
- Temporarily allowing some services to continue to be provided via audio-only
- Temporarily suspending the in-person service requirement prior to the delivery of mental and behavioral services via telehealth or audio-only in cases where the geographic requirement does not apply, the service takes place in the home and the patient was not being treated for a substance use disorder

The foregoing temporary policies are in effect through December 31, 2024 and CMS will make the necessary changes to incorporate these temporary policies into regulations. (Reference Page, 144).

Marriage and Family Therapists & Mental Health Counselors

Starting in 2024, Marriage and Family Therapists and Mental Health Counselors will be added to the permanent list of eligible telehealth providers due to changes made by the CAA 2023 which added these professions to the definition of “practitioner” in 1842(b)(18)(C) of the Social Security Act. (Reference Page, p. 152).

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Eligible Services that Can Be Delivered Via Telehealth

CMS will be finalizing its proposal for changing the process in which services will be added to the permanently eligible telehealth services list. In the new process, a suggested code would either be made permanent, provisional or rejected. The new process will include the following steps:

1. Is it a separately payable service? (i.e., Is it a service Medicare covers?)
2. Is the service subject to the provisions of 1834(m)? (i.e., Can some part of the service use telehealth to substitute for in-person or face-to-face?)
3. A review of elements of the service in the HCPCS code definition and determine if each can be done via technology.
4. Map the elements in the proposed service to one that is similar to what's already on the permanent list. If the service passes this step, it will go onto the permanent list.
5. If the previous bullet is not met, CMS would consider the evidence of clinical benefit that is similar to what benefit would have been obtained if done in-person. If there is not enough evidence to place it on the permanent list, but there is sufficient evidence for further study, it would receive "provisional" status.

CMS believes this process will be easier for the general public to understand and submit suggestions accordingly and will help streamline their administrative work in assessing submissions. (Page Reference, p. 124).

During the COVID-19 pandemic, CMS added additional services to the Telehealth Services List on a temporary basis. Some services were allowed to continue to be provided via telehealth and reimbursed by Medicare throughout 2023. For 2024, CMS is continuing certain services and have noted which ones are labeled "permanent," "provisional" (temporary through to 2024) and which services can be provided via audio-only. Additionally, CMS added Health and Well-being coaching codes 0591T, 0592T and 0593T on a temporary basis to the eligible list, and on a permanent basis added G0136 (administration of standardized, evidence-based Social Determinants of Health Risk Assessment tool, 5-15 minutes). The final rule provides a list of the services and their status. (Reference Page, p. 140).

CMS also notes that February 10, 2024 is the deadline to submit codes for consideration to be placed on the telehealth eligible list for CY 2025.

Remote Monitoring Services

In the Final Rule, CMS provided a clarification on how remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM) are addressed and billed. CMS clarified the following points:

- After the PHE ends, RPM services are only for established patients. Patients who had received services during the PHE are considered established patients. (Page Reference, p. 180).
- The 16-day monitoring requirement is reinstated after the PHE. See the specific details of the requirements for each code's description. (Page Reference, p. 180).
- Although multiple devices can be provided to a patient, the services associated with all of the medical devices "can be billed only once per patient per 30-day period and only when at least 16 days of data have been collected." This applies even when multiple devices are used. (Page Reference, p. 182).
- Practitioners may bill RPM or RTM, but not both, concurrently with the following services:
  - o Chronic Care Management (CCM)
  - o Transitional Care Management (TCM)
  - o Behavioral Health Integration (BHI)
  - o Principle Care Management (PCM)
  - o Chronic Pain Management (CPM) (Page Reference, p. 182).
- RTM and RPM cannot be billed together (Page Reference, p. 183).
- Regarding global payment and how RTM and RPM maybe used, CMS notes that when a beneficiary's procedure/surgery and related services are covered by a global payment, RPM or RTM services may be furnished separately and the provider will be paid for them separately from the global payment. If the beneficiary is currently receiving services during a global period, the provider may also furnish RPM or RTM services and the provider will receive a separate payment if the RPM/RTM services are unrelated to the diagnosis for the global procedure and are separate and distinct from the global procedure. See the 2024 Final Rule for more details. (Page Reference, 183).

More details and explanations are relayed in the Final Rule. (Page Reference, p. 178).

FQHC/RHC & RTM/RPM

CMS will include the CPT codes related to RPM and RTM in the general care management code HCPCS G0511 which will provide FQHCs/RHCs payment for RTM and RPM services. CMS noted that these services are similar to the non-face-to-face requirements for general care management services and reflect the additional resources needed to provide such services by an FQHC/RHC. (Page Reference, p. 760).

Supervision

For the public health emergency (PHE), CMS altered the definition of "direct supervision" to permit the presence and "immediate availability" of the supervising practitioner to be through "real-time audio and visual interactive telecommunications." CMS will continue this policy through December 31, 2024 (it will also be extended to FQHCs and RHCs). (Reference Page, p. 167).

Additionally, for supervision of teaching residents, the teaching physician may continue to have a virtual presence in all teaching settings but only in clinical instances when the service is furnished virtually. Otherwise, the teaching physician would need a physical presence, unless the service is performed at a residency training site outside of a Metropolitan Statistical Area (MSA). This exception for virtual presence in teaching settings during services furnished virtually will continue through December 31, 2024. Both supervision temporary waivers exclude this from happening via audio-only. (Reference Page, p. 171).

CMS will establish an RTM general supervision policy for physical and occupational therapy practitioners in private practice who are supervising physical therapist (PT) and occupational therapist (OT) assistants. The direct supervision requirement for unenrolled PTs and OTs will continue. (Page Reference, p. 495).

Facility Rate vs. Non-Facility Rate

During the pandemic, practitioners who often may have been seeing patients when the patient was in their home, were able to bill the place of service (POS) code where the service would have normally occurred. The reasoning behind that was the pandemic created circumstances that prevented the patient from coming into the health facility or office, but the practitioner would still maintain those expenses. Practitioners were to add the "95" modifier to signify the service took place via telehealth. Practitioners were then able to get the non-facility rate which is higher than the facility fee rate. In last year's PFS, the final rule noted that practitioners were no longer to bill claims with modifier 95 and providers were to use the POS code that would have been used if the service took place in-person, using either 02 (telehealth provided other than in a patient's home) or POS 10 (telehealth provided in the patient's home).

However, in looking at what and how services were provided during the pandemic, CMS noticed that behavioral health services that would have been provided in a health care setting were provided in the patient's home. With the public health emergency declared over, CMS notes that providers will likely be providing services both in-person and via telehealth, and providers will still have practice expenses.

CMS concluded then that claims billed with POS 10 will be paid at the non-facility PFS rate for CY 2024. CMS also clarified that the non-facility rate will apply to all eligible services delivered via telehealth and not be limited to mental and behavioral health services. Claims with POS 02 will continue to be paid the PFS facility rate. (Reference Page, p. 156).

Diabetes Self-Management and Medical Nutrition

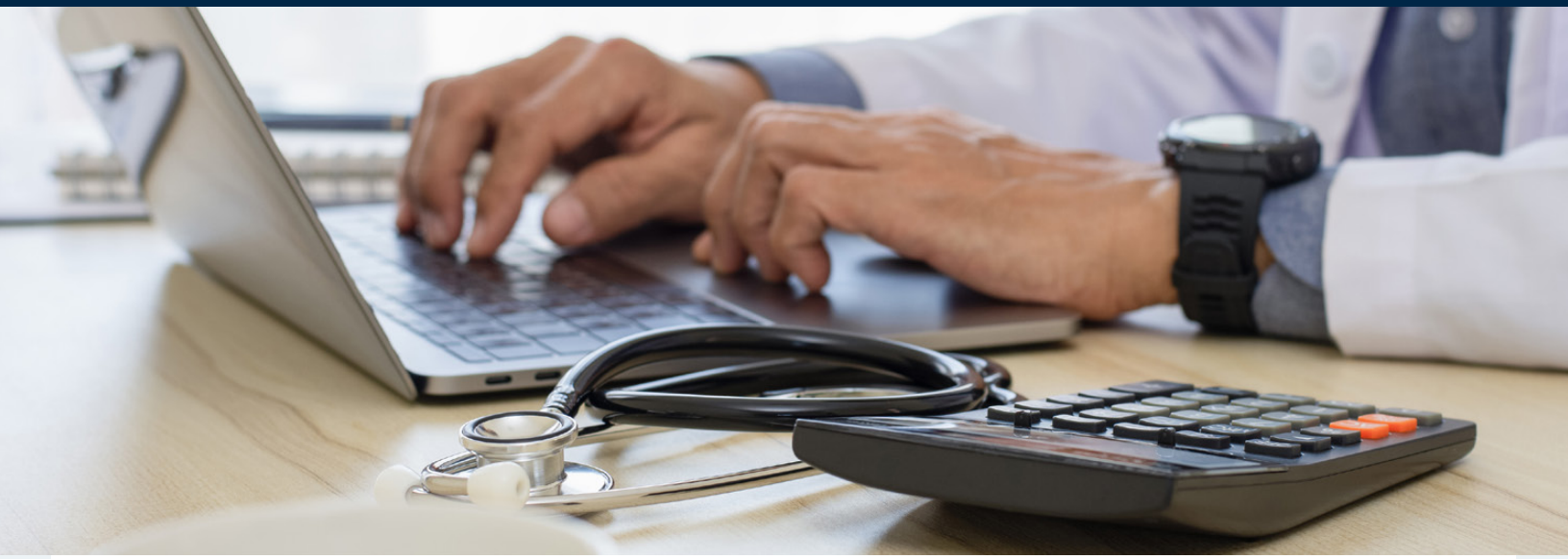
The 2024 PFS contains several policies related to diabetes self-management training (DSMT) and medical nutrition training (MNT). CMS is finalizing its proposal that would allow practitioners who can "appropriately report DSMT services furnished in person by the DSMT entity…to report DSMT services via telehealth by the DSMT entity, including when the services are performed by others as part of the DSMT entity." (Page Reference, p. 510)

Additionally, flexibilities for the Medicare Diabetes Prevention Program (MDPP) will be extended for an additional four years. Among the flexibilities is the ability to provide distance learning virtually. (Page Reference, p. 2008).

Outpatient Therapy, Diabetes Self-Management Training (DSMT) and Medical Nutrition Training (MNT) Billing

During the PHE, outpatient therapy services, DSMT and MNT could be provided to the patient while in their home via telehealth. Payments were made when provided by a billing practitioner or if the service was provided by an institution's staff (hospital outpatient department (HOPD), skilled nursing facility (SNF) or home health agency (HHA)) and billed by that institution. When physical and occupational therapists were allowed to provide services via telehealth, CMS used waiver authority to implement the Hospital Without Walls (HWW) policy that allowed the patients' home to be classified as part of the hospital. This allowed the hospital "to bill both the hospital facility payment in association with professional services billed under the PFS and single payment for a limited number of practitioners services, when statute or other applicable rules only allow the hospital to bill for services personally provided by their staff. These services are either billed by hospitals or by professionals, there would not be separate facility and professional billing." When the PHE ended, CMS originally thought to end this policy but is now considering whether some institutions may be able to bill for certain services provided remotely by employed practitioners. Therefore, institutional staff providing outpatient therapy, DSMT and MNT services via telehealth may bill the same way they did during the PHE until the end of 2024. For hospitals, beneficiaries' homes will no longer need to be registered as provider-based departments of the hospital to allow for hospitals to bill for these services. With the exception of Method II critical access hospitals (CAHs), the 95 modifier will be used on each applicable line if telehealth is used. CAHs using Method II payment will continue using GT/GQ. (Reference Page, p. 188).

> **"Institutional staff providing outpatient therapy, DSMT and MNT services via telehealth may bill the same way they did during the PHE until the end of 2024."**



Other Proposals

- **Telephone Evaluation and Management Services** – CPT codes 99441-99443 will remain actively priced through 2024 and are considered telehealth services. CPT codes 98966-98968 were temporarily added to the telehealth services list during the PHE. CMS will assign them an active payment status for 2024 "to align with telehealth-related flexibilities that were extended via the CAA, 2023." (Page Reference, p. 185).
- **Originating Site Facility Fee** – Will be $29.96 in 2024. (Page Reference, p. 186).
- **Frequency Limitations Removed For 2024:**
  - o Subsequent In-patient Visit – 99231-99233
  - o Subsequent Skilled Nursing Facility Visit – 99307-99310
  - o Critical Care Consultation – G0508-G0509

  (Page Reference, p. 160.)
- **Telehealth Injection Training for Insulin-Dependent** – The final rule would allow the use of telehealth to provide the full initial 10 hours or annual 2 hours of insulin injection-training that is required for insulin-dependent beneficiaries to take place via telehealth. CMS clarified that only physicians and those nonphysician practitioners listed in section 1842(b)(18)(C) may bill and hospitals and pharmacies are not included. (Page Reference, p. 512).
- **Periodic Assessments for Opioid Use Disorder (OUD) by Opioid Treatment Provider (OTP)** – CMS will extend periodic assessments by OTPs to the end of 2024. The audio-only option will only be available if video is not and to the extent audio-only is permitted by SAMHSA and Drug Enforcement Administration (DEA) and all other relevant requirements. (Page Reference, p. 821).
- **Telehealth Indicator** – CMS finalized its proposal to update how they identify clinicians who provide services via telehealth. The new methodology would use the most recent CMS coding policies at the time the data is updated. (Page Reference, p. 1767).

Discussion

Overall, the majority of the proposals made by CMS in July remained intact. The most significant difference was the extension of allowing the business practice address to be used even if the telehealth service was provided from the practitioner's home. This issue was not addressed in the July proposals. Telehealth advocates have raised concerns around privacy and safety issues if providers were required to provide their home address because the information could be publicly accessible. Taking into consideration these concerns, CMS extended the waiver for another year, through the end of 2024.

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CMS also explicitly clarified that the non-facility rate will be paid for services other than telemental/telebehavioral health when provided to the patient in the home. Some may have been confused after reading the proposed PFS in July because though CMS based their reasoning for this policy on a telemental health example, their proposal was crafted to not limit it only to mental and behavioral health services.

It should be noted that a majority of these policies are temporary and will expire after December 31, 2024. While another year of consistent policy has been provided, it also means that a more permanent solution will still need to be implemented.

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