Medicare and Medicaid Programs: Calendar Year 2024 Payment Policies Under the Physician Fee Schedule Final Rule (CMS-1784-F)

The 2024 PFS final rule includes finalized updates to payment rates, telehealth extensions, changes to split (or shared) visits, Behavioral Health, and Social Determinants of Health, among other policies.

Conversion Factor decrease of approximately 3.4%

On November 2, 2023, the Centers for Medicare and Medicaid Services (CMS) released the final rule to update the Physician Fee Schedule (PFS) effective for Medicare beneficiaries beginning January 1, 2024.[1]

The following summary highlights key changes within the 2024 PFS final rule identified by the Regulatory Compliance Office. Please note that the final rule, in its entirety, may have information that impacts other areas not specified within this document.

Conversion Factor

CMS finalized to change the conversion factor by 3.4% to $32.74 in calendar year (CY) 2024, compared to $33.89 in CY 2023. This decrease reflects the expiration of the 2.5% statutory payment increase for CY 2023 and a 1.25% statutory payment increase for 2024.

Evaluation and Management Visits

CMS finalized the addition of a separate add-on payment for healthcare common procedure coding system (HCPCS) code G2211. The add-on code was created to recognize the resource costs associated with evaluation and management (E/M) visits for primary care and longitudinal care that are particularly complex during outpatient office visits. The add-on code cannot be billed with an office or outpatient E/M visit that is only focused on a procedure or other service and does not focus on the longitudinal care for all needed healthcare services or a single, serious, or complex condition.

Split / Shared Services

CMS revised the definition of “substantive portion” or split (or shared) visits guidelines. Under the new definition, “substantive portion” means more than half of the total time spent by the physician or non-physician practitioner performing the split (or shared) visit or a substantive part of the medical decision-making as defined by Current Procedural Terminology (CPT). This finalization nullifies the prior, postponed policy that would eliminate medical decision making (MDM) as the deciding factor.

Telehealth and Telecommunication Services

CMS has finalized the proposals for the following services effective until December 31, 2024, unless extended through future rulemaking.

- The temporary addition of health and well-being coaching services to the Medicare Telehealth Services List and the permanent addition of Social Determinants of Health Risk Assessments (SDOH).
- The temporary expansion of telehealth originating sites includes any site in the United States where the beneficiary is located at the time of the telehealth service, including an individual's home. The expansion further delays the in-person visit requirement with the physician or practitioner within six months prior to initiating mental health telehealth visits.
    - Eligible telehealth practitioners include qualified occupational therapists, physical therapists, speech-language pathologists, and audiologists.
- The allowance of teaching physicians to use audio/video real-time communications technology to be present when the resident furnishes Medicare telehealth services in all residency training locations.
- The extension to allow audio-only telecommunications for opioid treatment programs.
- The allowance of entire diabetes self-management training services (DSMT) to be performed via telehealth.

Behavioral Health Services

CMS implemented Section 4121 of the Consolidated Appropriations Act, 2023 to allow marriage and family therapists (MFT) and mental health counselors (MHC) the ability to provide telehealth services and behavioral health integration services. CMS has also finalized the proposal to allow addiction counselors or drug and alcohol counselors to enroll in Medicare as an MHC.

CMS established a new HCPCS code for psychotherapy for crisis services when furnished in an applicable site of service, such as the patient's home or mobile unit. The HCPCS are 90839 (*Psychotherapy for crisis; first 60 minutes*) and 90840 (*Psychotherapy for crisis; each additional 30 minutes - List separately in addition to code for primary service*).

CMS also finalized the proposal to allow clinical social workers, MFTs, MHCs, and psychologists to bill for health behavior assessment and intervention services described by CPT codes 96156, 96158, 96159, 96164, 96165, 96167, and 96168.

Diabetes Self-Management Training

CMS finalized regulatory provisions under § 410.72(d), which clarifies that a registered dietitian or nutrition professional, when acting as the diabetes self-management training (DSMT) certified provider, may bill for, or on behalf of, the entire DSMT entity, regardless of which professional personally delivers each aspect of the services.

Dental and Oral Health Services

To continue efforts to expand dental coverage, CMS finalized payment allowance for a dental or oral examination performed as part of a comprehensive workup prior to medically necessary diagnostic and treatment services to eliminate an oral or dental infection and to address dental or oral complications after radiation, chemotherapy, and/or surgery when used in the treatment of head and neck cancer.

CMS will also allow payment for certain dental services that are inextricably linked to other covered services used to treat cancer prior to or during chemotherapy services, Chimeric Antigen Receptor T- (CAR-T) Cell therapy, or the use of high-dose bone modifying agents (antiresorptive therapy).

Preventative Vaccine Administration

CMS has finalized the proposal to continue allowing additional payment for COVID-19 vaccine administration in the patient's home. CMS will also be extending the payment allowance to include the administration of preventative vaccines, pneumococcal, influenza, and hepatitis B, when provided in the patient's home.

Single-Dose Container or Single-Use Package Drugs

CMS is finalizing additional policies requiring manufacturers of certain single-dose containers or single-use package drugs to provide refunds for discarded amounts. Additional policies include:

- Timelines for the initial and subsequent discarded drug refund reports to manufacturers.
- The refund calculation method for discarded amounts.
- The refund calculation method when there are multiple manufacturers for a refundable drug.
- Increased applicable percentages for certain drugs with unique circumstances (e.g., drugs with small volume doses and rarely utilized orphan drugs).
- An application process for manufacturers to request an increased applicable percentage for a drug with unique circumstances.

Social Determinants of Health and Principal Illness Navigation

To better account for resources involved in providing patient-centered care that involves a multidisciplinary team, CMS finalized its proposal to allow payment for Community Health Integration and SDOH Risk Assessment services when performed in conjunction with E/M, behavioral health visits, or annual wellness visits. CMS is also finalizing a subset of SDOH risk assessment codes when practitioners spend time and resources assessing SDOH that may impact their ability to treat the patient.

CMS is finalizing its proposal to allow additional payment for Principal Illness Navigation (PIN), which involves community health workers, care navigators, and peer support specialists when a patient has high-risk conditions such as cancer. CMS is also finalizing a subset of PIN codes to support individuals with behavioral health conditions.

Caregiver Training Services

CMS finalized its proposal to allow payment when caregivers who support patients with certain diseases or illnesses, such as dementia, are trained by a physician or a non-physician practitioner. The training will be part of the patient's individual treatment plan or therapy plan of care.

Questions or Comments

Please contact Regulatory Compliance with any questions and comments at 801-213-3948 or regulatorycompliance@hsc.utah.edu.

References

1. Centers for Medicare & Medicaid Services. Medicare and Medicaid Programs: Calendar Year 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies. *Federal Register*. November 2, 2023. Available at: https://www.federalregister.gov/public-inspection/2023-24184/medicare-and-medicaid-programs-calendar-year-2024-payment-policies-under-the-physician-fee-schedule. Accessed November 15, 2023.

2. Centers for Medicare & Medicaid Services, Health and Human Services. Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Suppl. *Federal Register*. November 2, 2023. Available at: https://public-inspection.federalregister.gov/2023-24184.pdf. Accessed November 15, 2023.

3. Centers for Medicare & Medicaid Services. Calendar Year (CY) 2024 Medicare Physician Fee Schedule Final Rule. *Centers for Medicare & Medicaid Services*. November 2, 2023. Available at: https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule. Accessed November 15, 2023.