HEALTHCARE REGULATORY ROUND-UP - Episode #52

2024 Proposed Rules – Part 2

Hospital OPPS & Medicare Physician Fee Schedule

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WE ARE AN INDEPENDENT MEMBER OF HLB—THE GLOBAL ADVISORY AND ACCOUNTING NETWORK

Introductions

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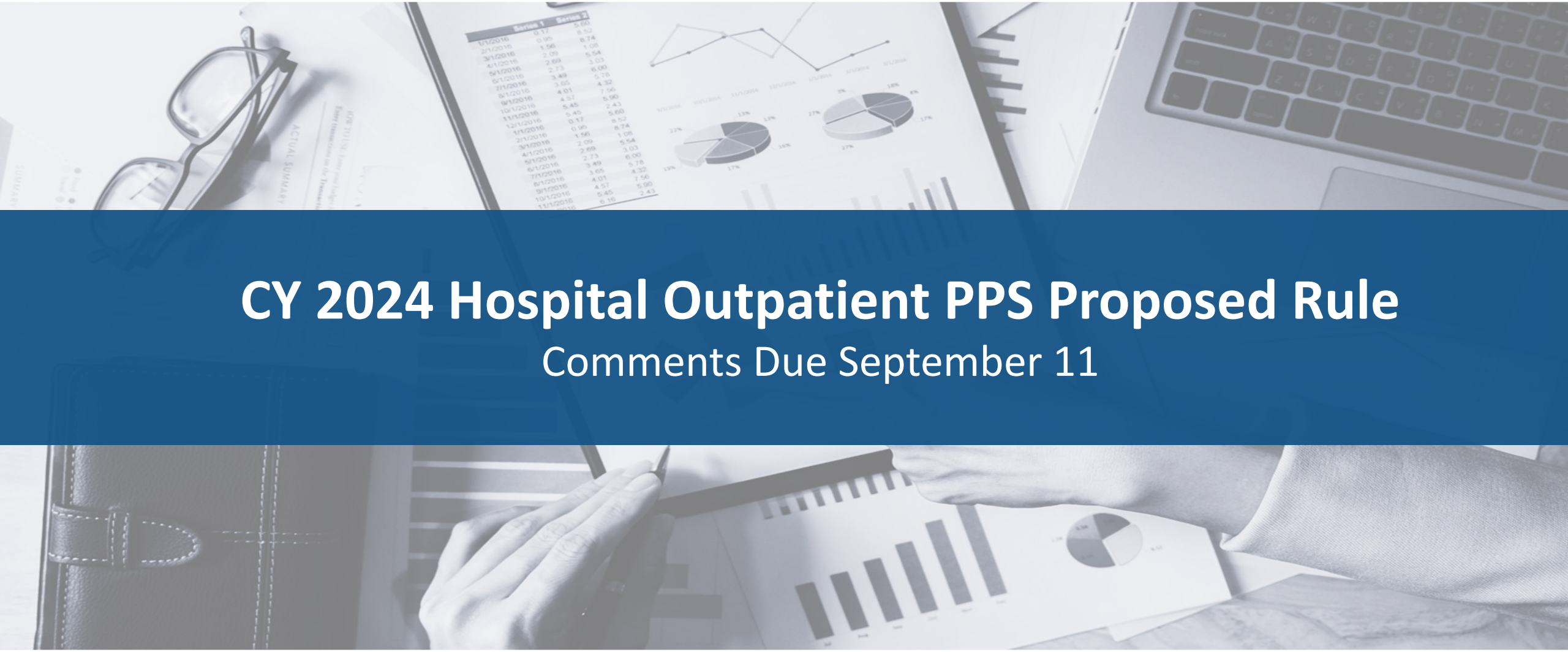


CY 2024 Hospital Outpatient PPS Proposed Rule

Comments Due September 11

Agenda

1. Payment Update
2. Behavioral Health Intensive Outpatient Program
3. Site Neutrality
4. Rural Emergency Hospitals
5. Ambulatory Surgical Center Updates
6. Quality Reporting Programs
7. Price Transparency
8. Other Issues

1. CY 2024 OPPS Proposed Payment

- 2.8% increase in OPPS payment rates for hospitals meeting applicable quality reporting requirements
  - Market basket of 3.0% less 0.2% for productivity
  - Conversion factor would be $87.488 (currently $85.858)
  - Hospitals not meeting quality reporting requirements would receive 0.8% update ($85.782)
- Separately payable drugs, including those purchased through 340B program, paid ASP + 6%
  - Proposes to require single modifier to identify separately payable drugs acquired under 340B
    - Currently use “JG” or “TB” modifiers
    - As of January 1, 2025, hospitals would report only “TB” – can transition early

2. Behavioral Health Intensive Outpatient Program

- Provision of the Consolidated Appropriations Act, 2023
  - Applies to beneficiaries needing a minimum of 9 hours of intensive behavioral health services per week (PHP requires at least 20 hours per week)
    - Requires physician certification of need and re-determination no less frequently than every other month
  - IOP services may be provided in hospital outpatient departments, FQHCs, RHCs, and community mental health centers
  - Service will be paid on per diem basis
    - Proposes two IOP APCs
      - Three services per day
      - Four or more services per day
      - Add-on code/payment for services furnished in opioid treatment program settings
      - RHCs paid OPPS rate; FQHCs paid lesser of charge or OPPS rate

3. Site Neutrality

- Proposes to reimburse intensive cardiac rehab provided in non-grandfathered off-campus hospital outpatient department at full OPPS rate
  - Currently paid at 40% of OPPS rate to “equate to PFS rate”
  - However, ICR services provided in physician office currently paid at 100% of OPPS
    - Requirement of Medicare Improvements for Patients and Providers Act of 2008
- Requesting comment on other services that should be treated similarly

4. Rural Emergency Hospitals

- Proposing that IHS and tribal facilities converting to REH would be paid under current all-inclusive rate
  - Would also receive REH monthly facility payment
- Proposing adoption of four measures for REHQR program
  - Abdomen CT - Use of Contrast Material
  - Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients
  - Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
  - Risk-Standardized Hospital Visits Within seven Days After Hospital Outpatient Surgery

5. Ambulatory Surgical Center Updates

- Proposing 2.8% increase in OPPS payment rates for hospitals meeting applicable quality reporting requirements
  - Market basket of 3.0% less 0.2% for productivity
    - Productivity adjustment will continue for 2 more years (originally intended to run from 2019-2023 only)
    - Extension due to need to gather more non-COVID-19 PHE data
- ASC conversion factor $53.397
- Proposes to add 26 dental procedures to ASC covered procedures list

6. Hospital/ASC Quality Reporting Programs

- Modify three measures –
  - COVID-19 Vaccination Coverage Among Healthcare Personnel (to align with updated CDC measure specs)
  - Improvement in Patient's Visual Function Within 90 Days Following Cataract Surgery (standardize data collection and reduce administrative burden)
  - Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients (align with updated clinical guidelines)
- Remove Left Without Being Seen measure
- Adoption of new measures –
  - Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or total Knee Arthroplasty
  - Hospital Outpatient/ASC Facility Volume Data on Selected Outpatient Surgical Procedures
  - Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography in Adults (hospital OQR program only)

7. Price Transparency

- Proposing to modify standard charge display requirements
  - Add definitions for “CMS template”, “consumer-friendly expected allowed charges”, “encode”, and “machine-readable file” (MRF)
  - Require hospitals to affirm the accuracy and completeness of data in their MRF
  - Revise and expand the data elements hospitals must include in the MRF
    - Requirement to include payer and plan name
    - Contracting method
  - Require hospitals to conform to a CMS template layout and other technical specifications for encoding standard charge information in the MRF
    - Reflect “charge” information in dollar format rather than percentage or algorithm
    - Clear description of services (including inpatient or outpatient)
    - Drug unit and type of measurement
    - Codes used for billing such as modifiers and code type (HCPCS, CPT, etc.)
  - Require hospitals to establish and maintain a txt file and footer as specified by CMS
- Changes would be required by **March 1, 2024**

Price Transparency

- Proposing to update the enforcement provisions
  - Update methods to assess hospital compliance
  - Require hospitals to acknowledge receipt of warning notices
  - Work with health system officials to address noncompliance issues in one or more hospitals that are part of a health system
  - Publicize more information about CMS enforcement activities related to individual hospitals
- Require hospitals to include footer on homepage that links to webpage containing machine-readable tile

1)

8. Other Issues

- No proposed additions to services requiring prior authorization
- No proposed deletions from inpatient only list but proposes to add 9 services described only by placeholder CPT codes
  - Requesting comment on removal of certain gastric restrictive procedures
- Creation of two new comprehensive APCs
  - Splitting Level 2 Intraocular C-APC 5492 to create C-APC 5493
  - New C-APC 5342 for Level 2 Abdominal/Peritoneal/Biliary and Related Procedures

Other Issues

- Requesting comments on current bundling policy for diagnostic radiopharmaceuticals/other alternatives
  - Proposes to increase packaging threshold to $140 per day
- Requesting feedback on what evaluations of health equity should be included for hospital outpatient and ASC services
- Requesting feedback on providing additional payments to hospitals for maintaining access to essential medications

CY 2024 Medicare Physician Fee Schedule Proposed Rule

Comments Due September 11

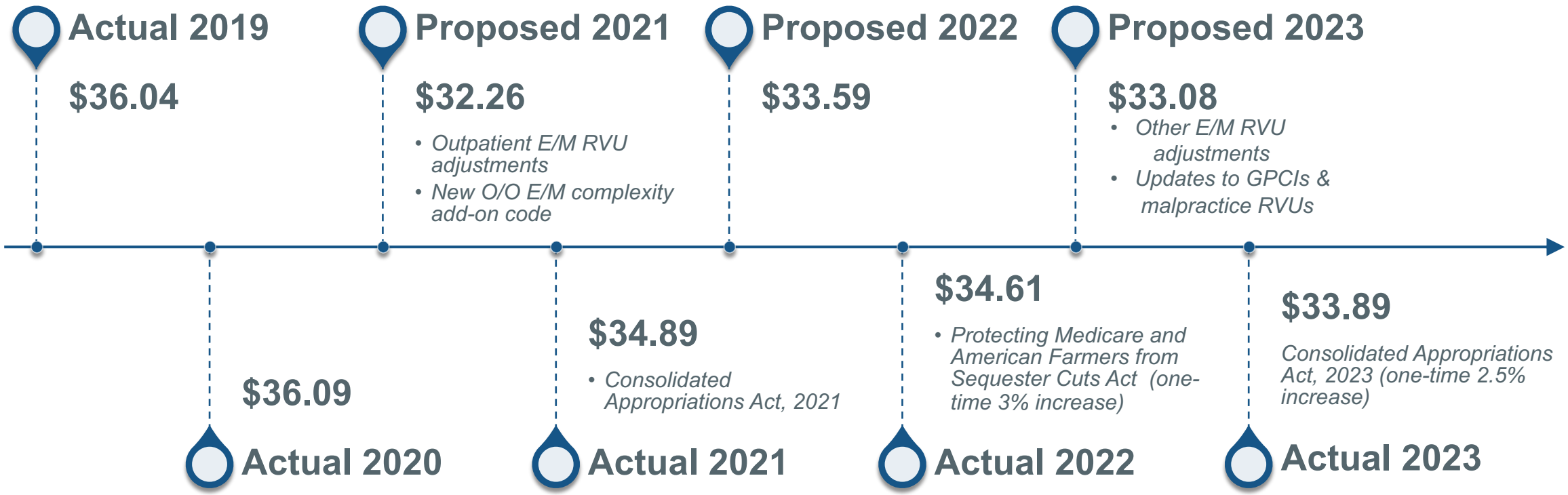
Agenda – Baker's Dozen

1. Conversion Factor
2. Office/Outpatient E/M Visit Complexity Add-On Code
3. Split/Shared Visits
4. Appropriate Use Criteria
5. Services Addressing Health-Related Social Needs
6. Telehealth
7. Remote Monitoring
8. Caregiver Training Services
9. Behavioral Health Services
10. Medicare Diabetes Prevention Program
11. Dental and Oral Health Services
12. Medicare Shared Savings Program
13. Quality Payment Program

Calculating Fee Schedule Payments

- **Relative value for the service**
  - Work
  - Practice expense
  - Malpractice expense
- **Conversion factor** (RVU x CF = national payment rate)
  - Dollar amount based on statutory cap on MPFS spending
  - Sustainable Growth Rate replaced in 2015 by MACRA annual adjustment factor
    - 0 adjustment factor for 2020 to 2025
  - Any increases or decreases in RVUs cannot cause the amount of annual Medicare Part B expenditures to differ by > $20 million from what expenditures would have been in absence of these changes
  - If this threshold is exceeded, CF adjusted to preserve budget neutrality
- **Geographic adjustment factor**
  - Reflects variation in practice costs between metropolitan and non-metropolitan areas between and regions
  - Specific RVU adjustment for each MSA and non-MSA area of state
    - Average = 1 (i.e., if Region A = 1.2, then Region B = 0.8)

Conversion Factor – A Brief History (2019 – 2023)



Proposed 2024 Conversion Factor - $32.75

- Decrease of $1.14 (or 3.34%) compared to current conversion factor
- How did this happen?
  - Consolidated Appropriations Act, 2023 mandates 1.25% reduction for 2024 (42¢)
  - Budget neutrality requirements result in additional 2.17% reduction for 2024 (additional 73¢)
    - 90% attributable to new reimbursement for O/O E/M complexity add-on code
    - 10% attributable to all other new reimbursement and valuation changes

G2211 - O/O E/M Complexity Add-On Code

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 (Add-on code, listed separately in addition to office/outpatient evaluation and management visit, new or established.

G2211 Billing Rules

- Practitioner billing any O/O E/M can include add-on code except –
  - O/O E/M visit reported with payment modifier -25
  - Care delivered by practitioner who does not intend to have ongoing longitudinal relationship with patient (e.g., urgent care, consults, second opinions)
    - No documentation guidelines
- 0.49 wRVUs = $16 (national payment amount)
- CMS assumes G2211 will be billed with 38% all O/O E/M services in 2024 (eventually increasing to 54%)
  - In 2021 MPFS Proposed Rule, CMS assumed 90% utilization resulting in 3% cut to conversion factor ($3.3 billion increase in spending)

Redistributive Effect – Table 104

- Primary care + medicine-based specialties = 0 to 3% increase in allowed charges
  - Family Practice, Endocrinology = +3%
- Proceduralists + emergency medicine = 0 to 4% decrease in allowed charges
  - Nuclear Medicine, Radiology, Vascular Surgery = -3%; interventional radiology = -4%
- Percentages reflect overall impact on specific specialties (not impact on individual practitioners)

3. Split/Shared Visits

- 2023 MPFS Final Rule: Delay for one year policy of using only time to determine whether physician or non-physician practitioner furnished substantive portion of E/M service delivered in facility (excluding critical care)
    - Continue to use history, physical exam, medical decision-making to determine substantive portion
- 2024 MPFS Proposed Rule: delay for another year
    - Afford providers another opportunity to comment on time-only rule

4. Appropriate Use Criteria (AUC) Program

- Mandated by Protecting Access to Medicare Act of 2014
    - Practitioner ordering advanced diagnostic imaging service must consult qualified Clinical Decision Support Mechanism
- Pause efforts to implement AUC program for reevaluation; rescind current AUC program regulations at 42 CFR 414.94

5. Services Addressing Health-Related Social Needs

- New reimbursement for three services
  - SDOH risk assessment – GXXX5
  - Community health integration (CHI) – GXXX1, GXXX2
  - Principal illness navigation (PIN) – GXXX3, GXXX4

SDOH Risk Assessment – GXXX5

- Administration of standardized, evidence-based SDOH risk assessment tool, 5-15 minutes, not more often than once every 6 months
  - Must be furnished by billing practitioner on same day as E/M visit
    - Auxiliary personnel if 'incident to' requirements satisfied
    - Included on Medicare Telehealth Services List
  - Tools include CMS Accountable Health Communities tool, PRAPARE tool, instruments identified for MA Special Needs Population Risk Assessment
    - Identified needs must be documented in medical record; may, but not required to use Z-codes
  - Seeking comment
    - Billing practitioner must have capacity to provide care management services or partnership with CBP to address identified SDOH needs?
    - Where and how these services would be typically provided?
- Proposed payment rates
  - Non-facility: $18.67
  - Facility: $8.84 (+ APC 5821 - $28.29)

Community Health Integration (CHI) – GXXX1, GXXX2

- CHI Initiating Visit - E/M visit 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)
- CHI services performed by certified or trained auxiliary personnel under general supervision of billing practitioner
  - GXXX1 = 60 minutes per calendar month; GXXX2 – each add'l 30 minutes
  - Training must include competencies of patient/family communication, interpersonal and relationship-building , patient/family capacity building, services coordination and system navigation, patient advocacy, facilitation, individual and community assessment, professionalism and ethical conduct, and development of appropriate knowledge base (local community-based resources
  - CHI services include person-centered assessment, performed to better understand individualized context of intersection between SDOH need(s) and problem(s) addressed in initiating E/M visit; 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, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals; facilitating and providing social and emotional support to help patient cope with problem(s) addressed in initiating visit, SDOH need(s), and adjust daily routines to better meet diagnosis and treatment goals; leveraging lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals

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
- Not requiring patient consent based on assumption services would largely be provided in-person
- Only one practitioner can bill for CHI services during given month
- 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
- Payment rates
  - GXXX1 – Non-facility - $78.92; Facility - $48.80 (+ APC 5822 -$86.86)
  - GXXX2 – Non-facility - $49.45; Facility - $34.06 facility
- Add to list of RHC/FQHC care management services for reimbursed under G0511

Principal Illness Navigation (PIN) – GXXX3, GXXX4

- Patients diagnosed with serious high-risk disease
  - 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
  - E.g., cancer, COPD, CHF, dementia, HIV/AIDS, severe mental illness, SUD
- PIN Initiating Visit - E/M visit in which billing practitioner identifies medical necessity for PIN services, establishes appropriate treatment plan, and specifies how PIN services would help accomplish that plan (separately billable)
- PIN services performed by certified or trained auxiliary personnel under general supervision of billing practitioner
  - GXXX3 = 60 minutes per calendar month; GXXX4 – each add'l 30 minutes
  - Same training requirements as CHI
  - Person-centered assessment, performed to better understand individual context of serious, high-risk condition; identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services; practitioner-, home, and community-based care coordination; facilitating access to community-based social services address SDOH need(s); 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; leverage knowledge of condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals

More PIN Details

- 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
- Not requiring patient consent based on assumption services would largely be provided in-person
- Only one practitioner can bill for CHI services during given month
- 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
- Payment rates (same as CHI)
  - GXXX3 – Non-facility - $78.92; Facility - $48.80 (+ APC 5822 -$86.86)
  - GXXX4 – Non-facility - $49.45; Facility - $34.06 facility
- Add to list of RHC/FQHC care management services for reimbursed under G0511

6. 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 non-facility rate; POS 10 to be paid at lower facility rate
- Suspend frequency limitations for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations
- Continue to permit teaching physician to have virtual presence when service furnished via telehealth (three-way telehealth visits)
- 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 HHA)
- 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
- To ensure access to services, CMS now proposes to extend such reimbursement through end of 2024.

Direct Supervision

- Required for incident-to billing, certain diagnostic tests, pulmonary rehab, cardiac rehab, and intensive cardiac rehab
- Current status
  - 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 through **December 31, 2024**; thereafter, revert to physical presence requirement
- Solicit comment on whether to extend definition of direct supervision to include virtual presence on permanent basis (patient safety and quality concerns)

7. Remote Monitoring – What's New

- 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)
- Revises regulations to permit Medicare-enrolled PTs and OTs to bill for RTM services furnished by PTAs/OTAs under general supervision
  - Also seeking comment on whether general supervision should extend to all services, not just RPM
- 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
- Notes RPM 'established patient' requirement again in effect post-PHE; implies there is no RTM established patient requirement
- Extensive RFI on digital therapies/remote monitoring "to improve our understanding of the opportunities and challenges related to our coverage and payment policies, as well as claims processing"

Remote Monitoring – What's Repeated

- RPM and RTM codes require data collection for at least 16 days in a 30-day period
  - Except 98975 (RTM set-up and patient education)?
- "Only one practitioner can bill CPT codes 99453 and 99454, or CPT codes 98976, 98977, 98980, and 98981, during a 30-day period"
  - RPM treatment management services (CPT 99457)?
- Practitioner cannot bill RTM and RPM codes for same time period but can bill other care management services
  - But can one practitioner bill for RPM and another for RTM?
- "[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

8. Caregiver Training Services

- Treating practitioner believes caregiver involvement necessary for successful outcome; training based on established individualized, patient-centered treatment plan or therapy plan of care accounting for the patient's specific medical needs
- CPT 96202/96203 - caregiver behavior management/modification training services furnished by physician or other qualified health professional
  - Train multiple individuals at same time, bill once per beneficiary
  - Initial 60 minutes (CPT 96202) + 15-minute increments (CPT 96203)
  - CPT 96202 - $23.25 (non-facility), $20.63 (facility)
    - Valuation based on training 6 beneficiaries' caregivers simultaneously
- CPT 9X015, 9X016, 9X017 - caregiver training services under therapy plan of care established by PT, OT, SLP and furnished by physician or other qualified health professional
  - CPT 9X015 (30 minutes) and 9X016 (each additional 15 minutes) for individual training; 9X017 for group training.
  - CPT 9X015 - $52.07 (non-facility), $44.54 (facility); RUC intends to review valuation soon

9. Behavioral Health Services

- Implement CAA, 23 provision creating coverage and payment for marriage and family therapists and mental health counselors
  - Payment at 75% of psychologist rate
  - MFTs and MHCs can enroll following publication of final rule
  - Add MFTs and MHCs to list of RHC/FQHC practitioners
- Implement CAA, 23 provision regarding payment for psychotherapy for crisis services
  - Two new G-codes, GPFC1 (1st 60 minutes) and GPFC2 (each add'l 30 minutes), for psychotherapy for crisis services furnished in any non-facility POS other than physician office setting; payment at 150% of rate for physician office setting
- Permit clinical social workers, MFTs, MHCs to bill CPT codes for Health and Behavior Assessment and Intervention
- Increase in wRVUs for timed behavioral health services to be implemented over 4-year period
- Allow general supervision for behavioral health services furnished incident to physician or NPP services in RHC/FQHC

10. 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 (payment after beneficiary attends 1st, 4th, and 9th sessions in months 1-6, and after attends 2nd session in months 7-9 and in months 10-12) 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)

11. Dental and Oral Health Services

- Statute precludes payment for dental and oral health services
- In 2023, Medicare began paying for services inextricably linked to other covered medical services
    - Services prior to organ transplant, cardiac valve replacement, valvuloplasty procedures
- For 2024, extend payment to services prior to or during head and neck cancer treatments (as proposed in 2023) + chemotherapy services, CAR-T cell therapy, and antiresorptive therapy
- Seeking comment on additional circumstances in which services should be covered

12. Medicare Shared Savings Program

- Changes to quality reporting and quality performance requirements
- Expanded window for beneficiary assignment
- Updates to benchmarking methodology
  - Apply same HCC risk adjustment model used in performance year for all benchmark years
- Refinements to Advance Investment Payment program requirements
- Seeks comment on future MSSP policies

13. Quality Payment Program

- Increase MIPS performance threshold from 75 to 82 points
- 5 new MIPS Value Pathways + modifications to existing MVPs
  - Focusing on Women's Health
  - Quality Care for Treatment of ENT Disorders
  - Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV 4
  - Quality Care in Mental Health and Substance Use Disorders
  - Rehabilitative Support for Musculoskeletal Care
- Eliminate health IT vendor category as distinct type of 3rd party intermediary beginning in PY 2025 (will need to meet QCDR requirements)
- Changes to public reporting procedures

Other

- Diabetes self-management training services furnished by registered dietitians and nutrition professionals
- Skin substitutes
- Inflation Reduction Act provisions relating to Part B drugs and biologicals
- Coverage for self-administered drugs and biologicals
- Complex drug administration coding
- Requiring manufacturers of certain single-dose container/single-use package drugs to make refunds for discarded amounts
- Implementing CAA,23 provisions regarding clinical laboratory fee schedule
- Ambulance fee schedule
- Part B payment for preventive vaccine administration services
- Medicare and Medicaid Provider and Supplier Enrollment

Our Next Healthcare Regulatory Round-Ups:

- AUGUST 9:
  Deeper Dive – 2024 Medicare Physician Fee Schedule Proposed Rule

- AUGUST 16:
  FY 2024 Final Rules

- AUGUST 30:
  EMTALA Update