HEALTHCARE REGULATORY ROUND-UP - Episode #53

Deeper Dive

2024 Medicare Physician Fee Schedule (MPFS)

August 9, 2023

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

Introductions

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Agenda

1. Conversion Factor
2. Office/Outpatient E/M Visit Complexity Add-On Code
3. Split/Shared Visits
4. Telehealth Update
5. Remote Patient Monitoring
6. Medicare Diabetes Prevention Program
7. Medicare Shared Savings Program Modifications
8. Quality Payment Program/Merit-Based Incentive Program System
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Conversion Factor

2024 Conversion Factor

- Proposed:
  - **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
  - The cost may limit its ability to pass

2024 Conversion Factor – *Physician Compensation Impact*

- Proposed:
  - **Physician: $32.7476 (-3.36%)**
  - **Anesthesia: $20.4370 (-3.26%)**
- Continued reimbursement decreases for certain services without wRVU increases will create collections pressures for certain practices with high Medicare volume.
  - wRVU changes are universal; collections changes are Medicare specific
- Anesthesia practices, already feeling the impact from the No Surprises Act, may continue to struggle operationally and may require additional financial assistance or begin to seek employment (where possible)

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

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

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- **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.

*Note:

Office and Other Outpatient Evaluation and Management Visit

O/O E/M Visit Complexity Add-On Code: G2211 (*cont.*)

- The Consolidated Appropriations Act, 2021 imposed moratorium until 2024.
- About 90% of the -2.17% adjustment is addressing this new code
  - Anticipated on 90% of office and other outpatient E/M visits ($3.3B) now revised to 38% initially and 54% when fully adopted
  - Budget Neutrality (BN) adjustment reduces payments for specialists who do not have a high volume of office or other outpatient visits which is why it was delayed originally
  - The value of this code is being included in an upward adjustment of the wRVUs for psychotherapy codes w/o E/M (19.1%) – 4-year implementation

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

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- For primary care physicians or specialists serving patients predominantly in the O/O setting

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 25 (same day procedure) • 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)

O/O E/M Visit Complexity Add-On Code: G2211 – *Physician Compensation Impact*

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- CMS assigned .33 wRVUs to G2211
- Use of G2211 will impact wRVUs earned and related reimbursement
- Individual impact of the code will vary based on facts and circumstances
- Will increase wRVUs for providers and as a result could increase wRVU-based compensation
- 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.

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 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

- **May of 2021**, CMS removed the split/shared guidelines from the Medicare Claims Processing Manual, Chapter 12 – 30.6
  - No guidance from removal until 2022 Final Rule, effective January 1, 2022
  - MLN Matters: MM12543 (Related CR 12543)
- **Prior to May 2021** shared visits required:
  - Face-to-face visit by the physician
  - Documentation of some portion of the history, exam, or MDM
- **2022 Final Rule implemented in the manual effective January 1, 2023**
  - MCPM, Ch. 12: 30.6.18 - Split (or Shared) Visits (Rev. 11842; Issued; 02-09-23 Effective:01-01-23; Implementation: 05-09-23)
  - Finalized that substantive portion as of January 1, 2024 would mean that half of the time spent by the billing provider would determine the billing provider.

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

2024 MPFS Proposed Rule Update

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- The implementation of time only will be **postponed to January 1, 2025** for visits other than Critical Care. (Eff. CY2022 – CY2024)
- **CMS heard concerns:**
  - Disruptions to current team-based practice patterns
  - Potential for significant adjustments to the practice's internal processes or information systems to allow for tracking visits based on time, rather than MDM
- **Maintaining current definition of substantive portion to determine the billing provider**
  - One of three key components (history, exam, or MDM) **– *or* –**
  - More than half of the time spent by the physician and NPP
- AMA CPT Editorial Panel is considering revising aspects associated with split/shared visits that would impact the final rule or future rulemaking.

Split/Shared…Delay of Time Requirement

- CMS finalized a one-year delay of the split/shared visits policy finalized in CY 2022 (with a few exceptions) – **EXTENDED to January 1, 2025 in 2023 Proposed Rule**.
- For CY 2022 – 2024, clinicians will continue to have a choice of history, physical exam, MDM, or more than half of the total practitioner time spent to define the substantive portion, instead of using total time to determine the substantive portion.
  - "Therefore, the proposed paragraph would specify, for visits other than critical care visits furnished in calendar **years 2022 through 2024**, substantive portion means **one of the three key components (history, exam or MDM)** or more than half of the total time spent by the physician and NPP performing the split (or shared) visit."
- 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).

Split/Shared Documentation

- 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

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Split/Shared Analysis

"When one of the three **key components** is used as the substantive portion in 2022, the practitioner who bills the visit must perform that component in its entirety in order to bill. For example, if **history** is used as the substantive portion and both practitioners take part of the history, the billing practitioner must perform the level of history required to select the visit level billed. If **physical exam** is used as the substantive portion and both practitioners examine the patient, the billing practitioner must perform the level of exam required to select the visit level billed. If **MDM** is used as the substantive portion, each practitioner could perform certain aspects of MDM, but the billing practitioner must perform all portions or aspects of MDM that are required to select the visit level billed." - *MCPM Ch. 12, S. 30.6.18*

E/M Guidelines effective 2023 for Facility E/M Codes:
History and/or Examination ►E/M codes that have levels of services include a **medically appropriate** history and/or physical examination, when performed. The nature and extent of the history and/or physical examination are determined by the treating physician or other qualified health care professional reporting the service. The care team may collect information, and the patient or caregiver may supply information directly (eg, by electronic health record [EHR] portal or questionnaire) that is reviewed by the reporting physician or other qualified health care professional. The extent of history and physical examination is not an element in selection of the level of these E/M service codes.◄

Sources:
MCPM Ch 12 Section 30.6.18
https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf

Substantive History or Exam

"Given the proposed delayed implementation of our substantive portion policy until CY 2024, our current policy remains in place. As such, when an E/M visit requires a medically appropriate history and/or physical exam, in accordance with its code descriptor, these service element(s) can qualify as the substantive portion, when performed."

MPFS 2023 Final Rule

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Split/Shared Analysis

Key Components	2022 Final Rule	2023/2024 Final Rule	New E/M Guidelines	Objective/ Subjective in 2023/2024
History	Complete per 95/97 GL	Complete per 2023 GL	Medically Appropriate	Subjective
Exam	Complete per 95/97 GL	Complete per 2023 GL	Medically Appropriate	Subjective
MDM	Complete per 95/97 GL	Complete per 2023 GL	Per 2023 GL Quantification	Objective
Time	>50% per New E/M GL	>50% per 2023 GL	>50% per 2023 GL	Objective

Continued Valuation Changes

- CMS is requesting comment for approaches to evaluating E/M Services more regularly and comprehensively:
  - Suggestions for research and data analysis other than the AMA RUC specialty-specific studies
  - Considering the evolution of the medical practice is different from the time when RBRVS was established 30 years ago

Continued Valuation Changes (*cont.*)

- **CMS is requesting answers to the following questions:**
  1. Do the existing E/M HCPCS codes accurately define the full range of E/M services with appropriate gradations for intensity of services?
  2. Are the methods used by the RUC and CMS appropriate to accurately value E/M and other HCPCS codes?
  3. Are the current Non-E/M HCPCS codes accurately defined?
  4. Are the methods used by the RUC and CMS appropriate to accurately value the non-E/M codes?
  5. What are the consequences if services described by HCPCS codes are not accurately defined?
  6. What are the consequences if services described by HCPCS codes are not accurately valued?
  7. Should CMS consider valuation changes to other codes similar to the approach in section II.J.5. of this rule?

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

- Changes in attribution of wRVUs between providers should be anticipated and may impact provider compensation as compared to historical compensation levels
- The continued modification in the wRVU values may compound the impact of split/shared visit changes
- Application of current benchmark data could have fundamental differences while the split/shared visit transition occurs

Telehealth Update

Telehealth

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- 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
- 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

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- 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)

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.

Remote Patient Monitoring

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"

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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

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 (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)

Medicare Shared Savings Program (MSSP) Modifications

MSSP Modifications

- 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

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MSSP Modifications (*cont.*)

- Proposal to add a 3rd step to the “step-wise beneficiary assignment methodology to provide greater recognition of the role of nurse practitioners, physician assistants and clinical nurse specialists in delivering primary care services.
  - Creates Medicare CQMs – a transition collection type to help ACOs build infrastructure, skills, knowledge, etc. to report the all payer/all patient MIPS CQMs
  - Same data completeness requirement at MIPS
  - CMS proposes to provide ACOs with a list of beneficiaries who are eligible for Medicare CQMs within the ACO, upon the ACO’s request for the data for purposes of population-based activities relating to improving health or reducing growth in health care cost

Quality Payment Program (QPP)/
Merit-Based Incentive Payment System (MIPS)

MPFS 2024 Proposed QPP Changes – Quality

- **Data completeness**
  - 2024 and 2025 – 75% as finalized in the 2023 MPFS
  - 2026 - proposed to hold at 75%
  - 2027 – proposed to increase to 80%
- **200 quality measures**
  - Adding 14 including:
    - 1 composite measure
    - 7 high priority measures of which 4 are patient-reported outcome measures
  - Substantive changes to 59 existing measures
  - Removal of 12 quality measures from inventory and partial removal of 3 measures (112, 113, 128)
- **CAHPS for MIPS Survey**
  - Proposing to require use of Spanish-translation

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MPFS 2024 Proposed QPP Changes – Cost

- **Existing Policy** – Maximum cost improvement score of 1 percentage point out of 100 percentage points available starting with the 2022 performance period.
- **Proposed** – Maximum cost improvement score of 1 percentage point out of 100 percentage points available starting with the 2023 performance period; and maximum available for 2022 performance period will be 0 percentage points
- **Proposed** – Improvement scoring will be calculated at the category level without using statistical significance beginning in 2023 performance period

MPFS 2024 Proposed QPP Changes – Cost (*cont.*)

- Currently 25 cost measures including Total per Cost Capita (TPCC) measure, Medicare Spend per Beneficiary (MSBP) Clinician Measure and 23 episode-based cost measures
- Proposing 5 new episode-based cost measures with a 20-case minimum
  - Acute inpatient medical condition (Psychoses & Related Conditions)
  - Three chronic condition measures (Depression, Heart Failure, and Low Back Pain)
  - Measure focusing on care in the Emergency Department setting
- Proposing to remove Simple Pneumonia with Hospitalization
- Field testing of cost measures

Table 1. Information on the Clinician Expert Workgroups with Measures in 2023 Field Testing

Measure-Specific Clinician Expert Workgroup	# Workgroup Members	# Affiliated Specialty Societies
Chronic Kidney Disease/End-Stage Renal Disease	16	10
Kidney Transplant Management	14	11
Prostate Cancer	17	15
Rheumatoid Arthritis	14	11

MPFS 2024 Proposed QPP Changes – Improvement Activities

- **2023**
  - 104 Improvement Activities in 8 categories

Expanded Practice Access	Population Management	Care Coordination	Beneficiary Engagement
Patient Safety Practice Assessment	Achieving Health Equity	Emergency Response and Preparedness	Integrated Behavioral and Mental Health

- **2024 Proposed**
  - Adding 5
  - Modify 1
  - Remove 3
  - Net would be 106 Improvement Activities in the inventory

MPFS 2024 Proposed QPP Changes – Promoting Interoperability

- **Proposing to discontinue automatic reweighting for:**
  - Physical/occupational therapists
  - Qualified speech-language pathologists
  - Qualified audiologists
  - Clinical psychologists
  - Registered dieticians or nutrition professionals

- **Proposing to continue for:**
  - Clinical social workers
  - Ambulatory Surgical Center-based
  - Hospital-based
  - Non-patient facing
  - Small practice

MPFS 2024 Proposed QPP Changes – Quality

- **Performance period**
  - Proposing to increase to 180 days from 90 days to align with hospital/CAH requirements
- **Query of Prescription Drug Monitoring Program**
  - Modifying exclusion to “Does not electronically prescribe any Schedule II opioids or Schedule III or IV drugs during the performance period”
- **Safety Assurance Factors for EHR Resilience (SAFER) Guides Measure**
  - Proposing to require a “yes” answer

MPFS 2024 Proposed QPP Changes – Other

- Increase MIPS performance threshold from 75 to 82 points
- 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
- **Targeted reviews**
  - Proposing to open the targeted review submission period upon release of MIPS final scores and keep it open 30 days after MIPS payment adjustments are released
  - Change shifts 60-day window to allow finalized provider list by October 1

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MPFS 2024 Proposed QPP Changes – MVPs

- **5 new MIPS Value Pathways + modifications to existing MVPs**
    1. Focusing on Women's Health
    2. Quality Care for Treatment of ENT Disorders
    3. Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV 4
    4. Quality Care in Mental Health and Substance Use Disorders
    5. Rehabilitative Support for Musculoskeletal Care
- "Partially-removed" measures (proposed) are still available within MVP reporting only; similar for prior year

MIPS/QPP Comments –
Physician Compensation Impact

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- Understanding the overall estimated amount of reimbursement at-risk for quality (and cost) within your organization is required. Otherwise, you could create a trend between reimbursement and provider compensation that is unsustainable.
  - Consider FMV and CR where appropriate – should individual provider compensation be adjusted when a significant penalty has been assessed?
  - Consider 2 -year time lag
- Now is a good time to consider analysis of at-risk reimbursement and at-risk provider compensation, to ensure alignment of metrics and goals, where possible

Resources

Resources

- **CY 2024 PFS Proposed Rule:**
  - https://public-inspection.federalregister.gov/2023-14624.pdf
  - Scheduled to be published in the Federal Register on August 7, 2023
- **CMS Fact Sheet**
  - https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-proposed-rule
- **www.qpp.cms.gov/resources**

2024 MPFS Comments Due
September 11, 2023 by 5pm

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