Healthcare Regulatory Round-Up Episode #60

CY 2024 Final Rules

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Introductions

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Agenda

1. CY 2024 ESRD PPS Final Rule
2. CY 2024 Home Health PPS Final Rule
3. OPPS Remedy for 340B-Acquired Drug Payment Policy for CYs 2018-2022 Final Rule
4. CY 2024 OPPS Final Rule
5. CY 2024 Medicare Physician Fee Schedule Final Rule

1. CY 2024 ESRD PPS Final Rule

Payment Changes

- Increased base rate to $271.01 (currently $265.57)
- Fixed dollar loss thresholds
  - Pediatric beneficiaries
    - FDL decreased from $23.20 to $11.32
  - Adult beneficiaries
    - FDL decreased from $73.19 to $71.76
- Low volume payment adjustment (LVPA)
    - Allow facilities to close temporarily and reopen in response to disaster/ emergency and still receive LPVA
    - Allow facilities to maintain LVPA if treatment counts increase due to treating additional patients displaced by disaster/emergency
- Effective 1/1/2025, facilities must report “time on machine” to better measure resource use

Payment Changes

- Transitional pediatric ESRD add-on payment adjustment (TPEAPA) of 30% of per treatment payment amount (2024-2026)
- Additional 3-year payment adjustment for certain new renal dialysis drugs and biological products (in addition to current 2-year Post-Transitional Drug Add-on Payment Adjustment)
- Effective 1/1/2025, must report
  - Total number of billing units of any discarded amount of renal dialysis drug or biological from single-dose container/single-use package (JW modifier)
  - For any drug or biological from single-dose container/ single-use package for which there is NO discarded amount (JZ modifier)

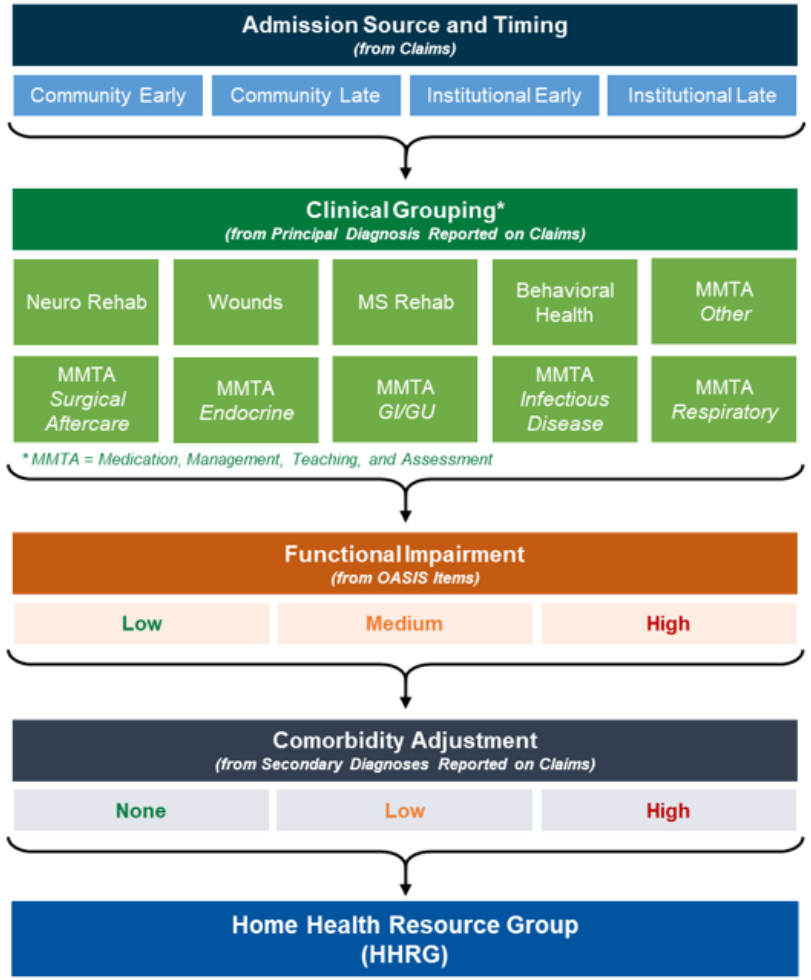
ESRD Quality Incentive Program

- Changes for PY 2026 (finalized as proposed)
  - Add Facility Commitment to Health Equity reporting measure
  - Update COVID-19 Vaccination Coverage Rate Among Healthcare Personnel reporting measure to align with updated CDC measure specifications
  - Convert Clinical Depression Screening and Follow-Up reporting measure to clinical measure
  - Remove Ultrafiltration Rate reporting measure
  - Remove Standardized Fistula Rate clinical measure
- Changes for PY 2027 (finalized as proposed)
  - Add Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health reporting measures

2. CY 2024 Home Health PPS Final Rule

Patient-Driven Groupings Model (PDGM)

- National, standardized 30-day period payment rate
- Agency-specific adjustments
  - Wage Index
  - Quality Reporting Program
  - Value-Based Purchasing Model
- Case-specific adjustments
  - Each 30-day period assigned to one of 432 Home Health Resource Groups based on beneficiary's health conditions and care needs
  - Additional adjustments for low-utilization and partial periods, outliers, rural add-on payment



2024 Base Rate

- Overall rates to increase by net 0.8% (vs. proposed 2.2% reduction to base rate)
  - 3.3% market-basket increase
  - 0.3 percentage point productivity cut (required by statute)
  - 2.6 percentage point reduction due to behavioral adjustment required to achieve PDGM budget neutrality*
  - 0.4 percentage point increase associated with increases in outlier payments

*Note: did not implement full 5.635% cut to 30-day episode payment as proposed; remainder of permanent offset will be applied in future years

Other Payment-Related Changes

- Reduce labor-related share to 74.9% (currently 76.1%)
- Recalibrate the PDGM case-mix weights
- Update low utilization payment adjustment thresholds, functional impairment levels, and comorbidity adjustment subgroups
- Establish separate payment for disposable device used in negative pressure wound therapy (per Consolidated Appropriations Act, 2023)
- Establish regulations to implement payment for items and services under 2 new benefits (lymphedema compression treatment items and home intravenous immune globulin)

Home Health Quality Reporting Program

- Adopted 2 new measures
  - Discharge Function Score Measure
    - Estimates percentage of home health patients meeting/exceeding expected discharge score during reporting period
    - Publicly reported beginning in CY 2025
  - Percent of Patients/Residents Who Are Up to Date with COVID-19 Measure
- Removed 3 measures effective in CY 2025
  - Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
    - Replaced by new Functional Discharge Score
  - Two OASIS items no longer necessary for collection
    - M0110 - Episode Timing
    - M2220 - Therapy Needs items

Final 30-Day Period Payment Rates

TABLE B24: CY 2024 NATIONAL, STANDARDIZED 30-DAY PERIOD PAYMENT AMOUNT

CY 2023 National Standardized 30-Day Period Payment	CY 2024 Permanent BA Adjustment Factor	CY 2024 Case-Mix Weights Recalibration Neutrality Factor	CY 2024 Wage Index Budget Neutrality Factor	CY 2024 Labor-Related Share Neutrality Factor	CY 2024 HH Payment Update	CY 2024 National, Standardized 30-Day Period Payment
$2,010.69	0.97110	1.0124	1.0012	0.9998	1.030	$2,038.13

TABLE B25: CY 2024 NATIONAL, STANDARDIZED 30-DAY PERIOD PAYMENT AMOUNT FOR HHAs THAT DO NOT SUBMIT THE QUALITY DATA

CY 2023 National Standardized 30-Day Period Payment	CY 2024 Permanent BA Adjustment Factor	CY 2024 Case-Mix Weights Recalibration Neutrality Factor	CY 2024 Wage Index Budget Neutrality Factor	CY 2024 Labor-Related Share Neutrality Factor	CY 2024 HH Payment Update Minus 2 Percentage Points	CY 2024 National, Standardized 30-Day Period Payment
$2,010.69	0.97110	1.0124	1.0012	0.9998	1.010	$1,998.56

Home Health Value-Based Purchasing Model

- Changes effective 01/01/2025
  - Measures removed:
    - OASIS-based Discharge to Community
    - Total Normalized Composite to Self-Care Score
    - Total Normalized Composite Mobility Score
    - Acute Care Hospitalization During the First 60 Days of Home Health Use
    - Emergency Department Use without Hospitalization During the First 60 Days of Home Health
  - New measures:
    - Claims-based Discharge to Community
    - Potentially Preventable Hospitalization
    - Discharge Function Score

DMEPOS Refill Policy

- Require documentation that beneficiary confirmed need for refill within 30-day period prior to end of current supply
- DMEPOS items cannot be delivered more than 10 calendar days before expected end of current supply

3. OPPS Remedy for 340B-Acquired Drug Payment Policy for CYs 2018-2022 Final Rule

American Hospital Association vs. Becerra

- In 2018, CMS adjusted OPPS payment rate for 340B acquired drugs from average sales price (ASP) + 6% to ASP minus 22.5% based on estimated acquisition costs
  - Exempted rural sole community hospitals, children's hospitals, and PPS-exempt cancer hospitals
  - CMS re-distributed $1.6B drug savings with 3.19% increase to OPPS conversion factor for non-drug items and services for all OPPS hospitals
- In 2018, AHA filed lawsuit arguing CMS failed to follow statutory rate setting requirements
- In 2022, Supreme Court ruled in AHA's favor; remanded case to District Court to determine remedy
- From 09/27/22 to 12/31/22 and CY 2023, CMS changed payment rate back to ASP +6%
  - CMS also reprocessed claims for 340B drugs back to 01/01/2022
  - Correspondingly, CMS reduced OPPS conversion factor by 3.09% for CY 2023
- In January 2023, District Court gave CMS opportunity to determine proper remedy for reduced payments to 340B hospitals for CY 2018 through CY 2022

CMS Final Remedy

- One-time lump sum payments to ~1,600 340B hospitals based on difference between actual payments received and what hospital would have received without payment adjustment including beneficiary co-payments (~$9 billion total)
  - Eligible hospitals should receive lump sum payment from MAC in Q1 2024
- To offset additional payments for non-drug items and services (3.19% increase in OPPS conversion factor from 2018 to 2022), adjust OPPS conversion factor by minus 0.5% starting in 2026 (had proposed 2025) and continuing for ~next 16 years
  - Not applicable to new hospitals
- Declined to address issues related to Medicare Advantage plans
  - “out of the scope of this final rule”
  - “cannot interfere…”

4. CY 2024 OPPS Final Rule

CY 2024 OPPS Payment

- 3.1% increase in OPPS payment rates for hospitals meeting quality reporting requirements
  - Market basket of 3.3% less 0.2% for productivity
  - Conversion factor would be $87.382 (currently $85.585)
  - Hospitals not meeting quality reporting requirements will receive 0.8% update ($85.687)
- Separately payable drugs, including those purchased through 340B program, paid ASP + 6%
  - Requires single modifier to identify separately payable drugs acquired under 340B
    - Currently use “JG” or “TB” modifiers
    - By 1/1/2025, hospitals will report “TB” only – can transition early

Behavioral Health Intensive Outpatient Program

- Provision of the Consolidated Appropriations Act, 2023
  - Applies to beneficiaries needing 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 at least 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
    - Minimum number of services per week – 9
    - Frequency – at least every other month
    - Two APCs for each provider type and number of services provided per day
  - Substance use disorder services included in scope of benefits

Site Neutrality

- Finalized policy 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

Rural Emergency Hospitals

- Finalized policy that IHS and tribal facilities converting to REH will be paid under current all-inclusive rate
  - Would also receive REH monthly facility payment
- Adopted 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

Hospital/ASC Quality Reporting Programs

- Modified 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)
- Did not remove Left Without Being Seen measure
- Adopted two new measures –
  - Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty
  - Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography in Adults (hospital OQR program only)
  - Did not adopt Hospital Outpatient/ASC Facility Volume Data on Selected Outpatient Surgical Procedures

Price Transparency

- Modified standard charge display requirements
  - Hospitals must conform to CMS template layout and other technical specifications for encoding standard charge information in MRF
    - Information on payer negotiated rate type (dollars, percentage, algorithm)
    - Expected allowed amount
    - Location (inpatient/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 txt file and footer as specified by CMS
- Compliance required by **July 1, 2024** (had proposed March 1)

Price Transparency

- Requirement to certify completeness and accuracy of MRF
- Updates to enforcement provisions
  - Require hospitals to acknowledge receipt of warning notices
  - Require hospitals to submit additional information including contracts to assist in assessing compliance
  - Work with health system officials to address noncompliance issues in one or more hospitals that are part of health system
  - Publicize more information about CMS enforcement activities related to individual hospitals
- Detailed requirements on linking transparency information to facility's public facing website
- Requires public attestation of completeness and accuracy

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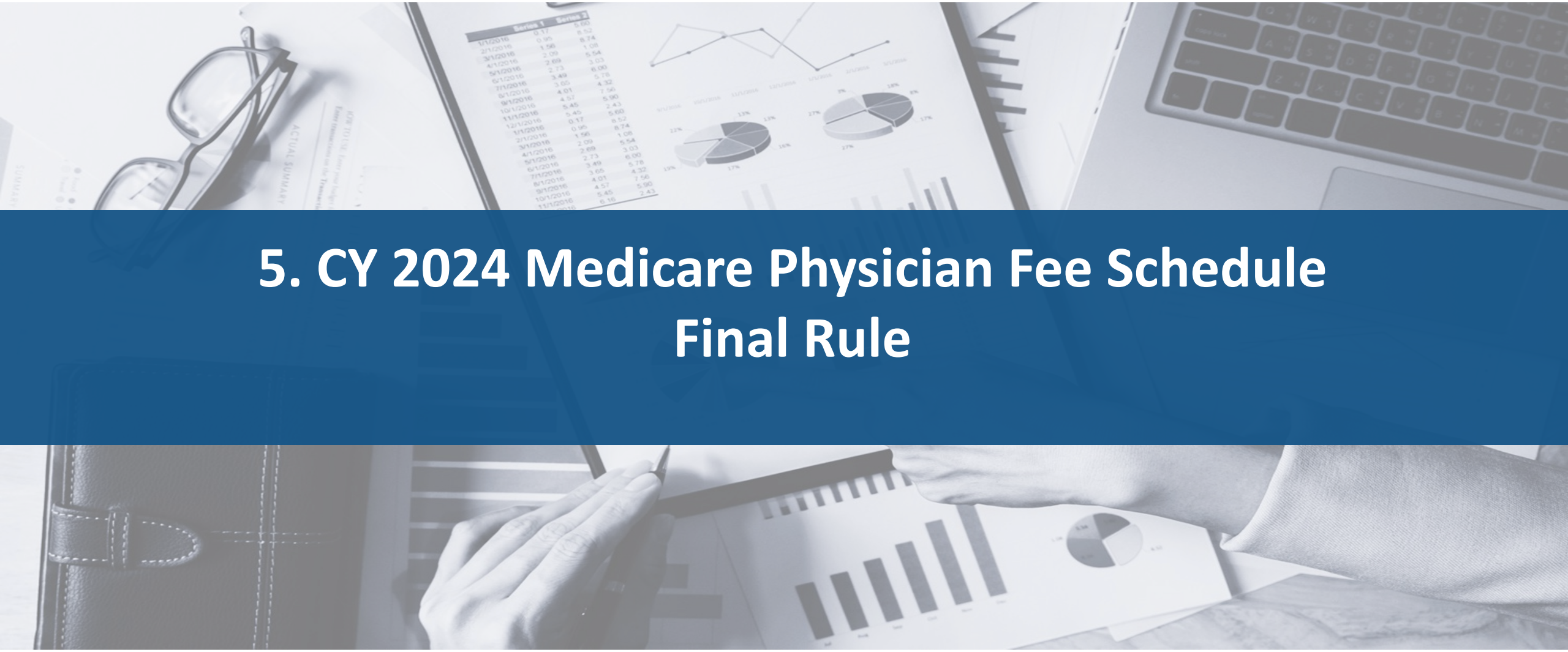

5. CY 2024 Medicare Physician Fee Schedule Final Rule

Top Ten

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 Patient Monitoring
8. Caregiver Training Services
9. Behavioral Health Services
10. Medicare Diabetes Prevention Program

1. 2024 Conversion Factor - $32.74

- Decrease of $1.15 (or 3.34%) compared to CY2023 conversion factor ($33.89)
- 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 (73¢)
    - 90% attributable to new reimbursement for O/O E/M complexity add-on code (G2211)
    - 10% attributable to all other new reimbursement and valuation changes

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

- CPT Definition: 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)
- "[W]hile many medical professionals rely on procedural codes with work RVUs that account – appropriately – for their particular expertise and the intensity associated with their overall costs in furnishing care, the expertise of those who rely predominantly on E/M services to report their services is left relatively underrecognized with the previously and current E/M coding and valuation structure."

G2211 Billing Rules

- "[A]ccounts for the additional time, intensity, and practice expense inherent to longitudinal care"
- 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)
- May be used with telehealth services
- No documentation guidelines
- CMS assumes G2211 will be billed with 38% all O/O E/M services in 2024 (eventually increasing to 54%)
- National payment rate = $16.04 (offset losses due to lower conversion factor)

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
- 2024 MPFS Proposed Rule
  - Delay for another year
- 2024 MPFS Final Rule
  - Based on revision to CPT E/M guidelines, CMS finalizing that 'substantive portion' means either (1) more than half of total time spent by physician and NPP, or (2) substantive part of medical decision making (except for critical care visits which do not use MDM)
  - "[P]erformance 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."

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
  - No timeframe within which implementation efforts will recommence
  - Lengthy description of technical challenges associated with implementing AUC program

5. Services Addressing Health-Related Social Needs

- New reimbursement for three services
  - SDOH risk assessment – G0136
  - Community health integration (CHI) – G0019, G0022
  - Principal illness navigation (PIN) – G0023, G0024
  - PIN Peer Support – G0140, G0146

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** have to be furnished on same day as E/M visit (but generally not performed prior to visit)
    - Not intended as screening tool; used when practitioner has reason to believe there are unmet SDOH needs interfering with ability to diagnose and/or treat patient
    - May be furnished by 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
- Payment rates
  - Non-facility: $18.67
  - Facility: $8.84 (+ APC 5821 - $28.29)

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
- Performed by certified or trained auxiliary personnel under general supervision of billing practitioner
  - G0019 = 60 minutes per calendar month; G0022 – each add'l 30 minutes (no frequency limitation)
  - 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
- Payment rates
  - G0019 – Non-facility - $79.23; Facility - $48.78 (+ APC 5822 -$86.86)
  - G0022 – Non-facility - $49.44; Facility - $34.05 facility (no APC)
- Add to list of RHC/FQHC care management services for reimbursed under G0511

Principal Illness Navigation (PIN) - G0023, G0024

- 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 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
  - G0023 = 60 minutes per calendar month; G0024 – each add'l 30 minutes (no frequency limitations)
  - 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
    - Health care access/health system navigation
    - Facilitating and providing social and emotional support
    - Identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services
    - Building patient self-advocacy skills
    - Facilitating behavioral change as necessary for meeting diagnosis and treatment goals
    - Leverage knowledge of condition and/or lived experience to provide support 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
- 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
- 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)
  - G0023 – Non-facility - $79.23; Facility - $48.78 (+ APC 5822 -$86.86)
  - G0024 – Non-facility - $49.44; Facility - $34.05 facility (no APC)
- Add to list of RHC/FQHC care management services for reimbursed under G0511

PIN Peer Support - G0140, G0146

- 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
  - G0140 = 60 minutes per calendar month; G0146 – each add'l 30 minutes (no frequency limitations)
  - Same reimbursement as corresponding PIN codes

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)
  - Coverage of audio-only services
- Telehealth Services List
  - Replace Categories 1, 2, and 3 with permanent and provisional categories; refine process to evaluate eligibility
  - All services (not just Category 3 services) added to list during PHE moved to provisional category
  - Provisional codes will not be removed from list “where evidence generation remains in process” unless patient safety issue identified

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 10 to be paid at non-facility rate; POS 02 to be paid at lower facility rate
- Suspend frequency limitations for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations thru 2024
- Continue to permit teaching physician to have virtual presence when service furnished via telehealth (three-way telehealth visits) thru 2024
- 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 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 is extending such reimbursement through 2024
    - Apply 95 modifier on each applicable line (except CAH Method II applies GT/GQ modifier)

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
- Continue virtual presence thru 2024; thereafter, revert to physical presence requirement

7. Remote Patient Monitoring

- Revises regulations to permit Medicare-enrolled PTs and OTs to bill for RTM services furnished by PTAs/OTAs under general supervision
- 16-day data collection requirement does not apply to RPM/RTM treatment management services
- RPM/RTM may be furnished to patients within global surgery period by practitioner who receives global surgery payment if monitoring 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
- Practitioner cannot bill RTM and RPM codes for same time period but can bill other care management services
- "[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
- Adds RPM and RTM monthly monitoring (CPT 99454, 98976, 98977, 98978) and treatment management services (CPT 99457 and 98980) to list of RHC/FQHC care management services reimbursed under G0511

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
- Must obtain patient consent prior to initiating training
- CPT 96202/96203 - Caregiver behavior management/modification training services furnished by physician/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 97550, 97551, 97552 - Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community
  - CPT 97550 (30 minutes) and 97551 (each additional 15 minutes) for individual training; 97552 for group training
  - CPT 97550 - $52.06 (non-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 (including qualifying addiction, alcohol, or drug counselors)
  - 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
- Implement CAA, 23 provision regarding payment for psychotherapy for crisis services
  - Two new G-codes, G0017 (1st 60 minutes) and G0018 (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 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)

Still More…

- Quality Payment Program
- Medicare Shared Savings Program
- Payment for Dental Services Related to Certain Cancer Treatments
- Provider and Supplier Enrollment (report changes to practice locations within 30 days)
- Clinical Laboratory Fee Schedule
- Ambulance Fee Schedule
- Drugs and Biologics Payable Under Part B
- Diabetes Screening (expand frequency limitations and include HbA1c testing)

Our Next Healthcare Regulatory Round-Up

Deeper Dive – 2024 Medicare Physician Fee Schedule Final Rule