Addressing the 2024 Physician Fee Schedule – Key Updates and Adjustments

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The 2024 Medicare Physician Fee Schedule is full of updates and adjustments that are impactful to providers. Medicare policies continue to acknowledge the importance of primary care and attempt to provide additional reimbursement for a variety of services aimed at improving the management of acute and chronic conditions.

Physicians with large volumes of evaluation and management (E/M) visits may reap the benefit of the new complexity add-on HCPCS code, G2211, as a revenue boost to contrast the 3.4% decrease in Medicare conversion factor, which now sits at $32.7442. Meanwhile, unless the complexity add-on code is prevalent within their patient populations, many surgical and procedural specialties may experience a negative reimbursement impact as a result of various 2024 Medicare payment changes.

Other impactful shifts including revisions to split/shared guidelines, changes associated with telehealth, virtual supervision, remote patient monitoring, and health-related social need services are important to note. Similar to the specialty specific impacts experienced in prior years, any increase exceeding $20 million in spending must have a corresponding decrease to maintain budget neutrality. As the dollars shift toward primary care related services, the effects of 2024 fee schedule changes are less than positive for a number of specialties, including anesthesiology, radiology and interventional radiology, and vascular and thoracic surgery.[1]

1. **Add-On Code G2211 for Complexity –** The code description for G2211 is "Visit complexity inherent to evaluation and management associated [1][2] with medical care services that serve as the continuing focal point for all needed healthcare services and/or [2] with medical care services that are part of ongoing care related to a patient's single, serious condition, or a complex condition." This code was finalized previously but delayed until January 1, 2024 by the Consolidated Appropriations Act of 2021. This code has 0.33 work relative value units (work RVUs) and a national Medicare allowed amount of $16.05. There are no frequency limitations for billing or minimum face-to-face visit requirements for patient and provider visits to bill for the service, either. This code can be reported by any physician specialty and by non-physician practitioners. It is billed as an "add-on" along with only office and other outpatient E/M codes (99202-99205 and 99211-99215) and can be reported when the E/M service is furnished via telehealth. However, if the E/M code is reported with a -25 modifier, G2211 cannot also be reported. The Center for Medicare & Medicaid Services (CMS) anticipates that the add-on code will be billed with 38% of outpatient E/M services this calendar year, eventually increasing in utilization to over 50%. So, **depending upon the volume of its use across a provider's Medicare patient population, this complexity add-on could be impactful to some providers' productivity and/or professional**

collections, without requiring an increase in the providers' overall patient visit volume. Health systems employing physicians under a productivity-based compensation model and/or who are using prior calendar year fee schedules to calculate work RVUs will need to consider how to properly account for this new code.

2. **Split/Shared Visits –** CMS requirements associated with billing for split/shared visit services have continued to be a topic in proposed and final rulemaking, and the 2024 Final Rule is no exception. This year, CMS aligned with the CPT[3] definition of split/shared which requires either the provider performing the "substantive portion" of the Medical Decision Making (MDM) component of the visit or the provider who renders more than half of the total time for the visit to report the service as the billing provider. Watch for additional clarification from CMS and MACs regarding the documentation requirements for the substantive portion of the visit from a Medicare payment perspective, as there is some conflicting language in the final rule when compared to CPT's definition of substantive per the elements of MDM performed. These guidelines are impactful as facility-based specialties[4] such as hospitalists often leverage non-physician providers (NPP) in their workflow. From a provider compensation perspective, services reported by an NPP will be paid at a reduced rate (85% of the physician fee schedule rate) by Medicare and some commercial payers who have similar payment policies. One component that remains generally unchanged is the expectation that both the physician and the NPP bill for their combined service effort under one provider's name, assuming both providers are in the same group practice. However, refer to the new CPT definition for scenarios when the billing provider did not perform, for example, the independent interpretation of a test, as this data element would not be counted toward the level of service even if the other provider did perform it. **From a work RVU productivity standpoint, split/shared services continue to pose challenges when calculating personally-performed productivity; contractual decisions must be made when determining how to credit providers who are rendering care under this model.**

3. **Telehealth –** CMS continues to collect data on the use of telehealth post the COVID-19 public health emergency (PHE). The list of eligible telehealth practitioners has expanded to include marriage and family therapists and mental health counselors for 2024. Additionally, CMS has removed the prior categorization method for feedback and replaced it with permanent and provisional categories. Requirements for an in-person visit for tele-behavioral health has been delayed until December 2024. Claims should include the billing provider's "regular" office location where services are typically provided (instead of the proposed use of the provider's home address, when the provider is rendering telehealth from that location). This is welcome news for clinic-based providers across the country. Additional impactful updates from a claim submission standpoint include the use of Place of Service (POS) 02 for telehealth provided other than in patient's home and POS 10 for telehealth provided in the patient's home, both referring to where the patient is located. These POS indicators will drive site of service reimbursement, with POS 02 paid at a facility rate and POS 10 at a non-facility rate. However, when the provider is rendering telehealth services from a hospital facility location, the hospital POS should be reported on the claim. **Given the shifts in telehealth services during and since the COVID-19 PHE, a review of documentation, coding, and billing practices is recommended to assess compliance with current guidelines as failure to submit properly can have immediate impacts to reimbursement (and work RVU calculations).**

4. **Virtual Supervision –** Supervision requirements for diagnostic tests, pulmonary rehab, cardiac rehab, and incident-to billing were relaxed during the PHE to allow virtual presence via real-time audio/video technology. This has been extended through 2024; however, the potential for a reversion to the more stringent physical pre-PHE requirements may occur in the future. This is impactful for providers this year as it affects the logistics associated with the supervisory oversight services they provide. **If these services are being rendered virtually within an organization today, it is important for billing and compliance teams to be mindful of potential future shifts to align organizational policies and processes with the most current CMS guidelines. It is possible that some services will be deemed safe to remain under virtual supervision after the 2024 extension has ended. Therefore, monitoring proposed rule releases mid-year will be prudent to avoid unnecessary time spent toward significant operational and staffing changes.**

5. **Remote Monitoring –** In the 2024 Final Rule, CMS clarified a number of items related to Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM). First, patients may be considered established patients if they received initial remote monitoring services during the PHE. For both RPM and RTM data collection services, data collection must occur for a minimum of 16 days within a 30-day time period to report the service; the care management services do not have this same requirement. Providers can bill for either RPM or RTM within the 30-day period, but not both. However, other care management services, such as chronic care management and transitional care management services can be reported for the same time period as long as time is not double counted. When RTM or RPM services are rendered during a global surgical period, they are separately billable if the monitoring is unrelated to the global surgical service performed. When properly performed, documented, and billed, remote monitoring services can be a crucial care component for patients requiring services in remote areas. **Capturing the work effort associated with these important monitoring services can impact provider productivity and/or collections.**

6. **Health-Related Social Needs**[5] **–** The 2024 Final Rule also added new reimbursement for specific services addressing various health-related social needs for Medicare beneficiaries. This is important as it allows providers to report and bill for these impactful and often time-consuming activities in addition to their existing visit codes. HCPCS codes to report services related to social determinants of health (SDOH), Community Health Integration (CHI), Principal Illness Navigation (PIN), and PIN Peer Support have been created.

- Performing an SDOH risk assessment is a billable service under G0136. The 5 to 15 minute assessment may be billed once every 6 months and can be billed in addition to an E/M, behavioral health visit, or annual wellness visit (AWV). It is not required to be performed with an E/M visit and can be conducted via telehealth. The Medicare allowable amount for 2024 is $18.66.[6]

- CHI services are billed when, during an E/M visit, TCM[7], or AWV (collectively considered a CHI-initiating visit), the provider identifies the presence of an SDOH need(s) that would limit the provider's ability to diagnose or treat the patient's problems. It is important to note that E/M visits associated with patients in the Emergency Department, Inpatient or Observation status within the hospital, or in a skilled nursing facility do not qualify as CHI initiating visits. CHI services are separately billable services under G0019[8] (60 minutes per calendar month) and G0022 [9](add-on code for each additional 30 minutes per calendar month). These codes are paid at $79.24 and $49.44, respectively.

[10] Similar to other care management services, only one provider may bill for CHI services in a given month. Trained or certified auxiliary personnel must document activities (including time spent) in the patient's medical record, the associated SDOH needs addressed and the clinical problem(s) that they intend to help resolve.

- PIN services are billed with G0023 and G0024 (add-on code). PIN services are performed by certified or trained auxiliary personnel, including a patient navigator or certified peer specialist, under the direction of a physician or other practitioner and are reported based on time spent per calendar month (60 minutes for G0023 and 30 additional minutes for G0024). These services have the same reimbursement as CHI services at $79.24 for G0023 and $49.44 for G0024. PIN services are applicable for patients who have been diagnosed with severe high-risk diseases such as cancer, chronic obstructive pulmonary disease (COPD), dementia, severe mental illness and/or substance use disorder. The patient's condition must be expected to last at least 3 months and place the patient at a significant risk of hospitalization or nursing home placement, acute exacerbation/decomposition, functional decline, or death. Billing for PIN services requires the development, monitoring, or revision of a disease-specific care plan and may require frequent adjustments in treatments and/or medication regimen or substantial assistance from the patient's caregiver. Like CHI services, PIN services require an initiating visit which can occur during an E/M, TCM, or AWV during which time the provider determines medical necessity for PIN services and establishes a treatment plan, including specifying how PIN services will help accomplish that plan. While more than one provider can bill for PIN services during a given month, CMS expects those instances to be limited in nature. Providers should ensure PIN time and effort is not being duplicated for patients with multiple principal illnesses occurring at the same time.

The addition of SDOH services is another example of Medicare's recognition of the importance of patient care management toward avoiding more costly hospitalizations and higher levels of care.

Conclusion

Providers should ensure their billing teams are aware of these important updates for 2024. Care should be taken to regularly review coding and documentation to proactively assess compliance with current Medicare guidelines, particularly when reporting these new services. Provider compensation professionals should stay updated on these Physician Fee Schedule changes, as related impacts to provider compensation plans are inevitable.

[1] Table 118 in the Final Rule. https://public-inspection.federalregister.gov/2023-24184.pdf
[2] Numbers added by author for reader context. Note the two scenarios in which the code is permitted to be billed.
[3] Current Procedural Terminology® (CPT) is a registered trademark of the American Medical Association (AMA).
[4] Including critical care and skilled nursing facility services since revision to guidelines in 2022.
[5] https://www.cms.gov/files/document/mln9201074-health-equity-services-2024-physician-fee-schedule-final-rule.pdf-0
[6] National Medicare allowable amount
[7] Transitional Care Management
[8] Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner, 60 minutes per calendar month.
[9] Community health integration services, each additional 30 minutes per calendar month (list separately in addition to G0019).
[10] Figures represent Calendar Year 2024 National Medicare amounts.