

Summary for the CMS 2024 Physician Fee Schedule

Rebecca Wartman OD November 2023

CMS issued the final 2024 Physician Fee Schedule rules on November 2, 2023. While some of the provision in this release will most likely be challenged in Congress, the following will be the rules for now.

Reimbursement Rates for 2024

First, the bad news: CMS has announced an overall decrease in reimbursement of 4.65% for 2024.

Due to factors specified in law, the overall payment rates under the PFS will be reduced by 1.25% in CY 2024 compared to CY 2023. **AND**

The final CY 2024 PFS conversion factor is \$32.74, a decrease of \$1.15 (or 3.4%) from the current CY 2023 conversion factor of \$33.89.

Evaluation and Management Services (p 422-442 of PFS)

CMS decided to finalize the use of the separate add-on code and payment for G2211 beginning January 1, 2024. G2211 is designed to recognize the cost of resources necessary to provide E&M services in the primary care and long-term care of patients. G2211 will be used for outpatient office visit services needed for primary care providers and those providers involved in the on-going care of a patient's single, serious and/or complex condition. It is important to note that G2211 cannot be used with an office E&M that is focused on procedure or other service but is focused on the single serious or complex condition or on the longitudinal care necessary for all needed health care services.

G2211: 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, list separately in addition to office/outpatient evaluation and management visit, new or established)

Telehealth Policies (p 97-196 of PFS)

CMS is continuing to review some Telehealth policies to determine which pandemic-era changes will become permanent and which will not. At this time, the following policies will be in place at least until December 31, 2024.

At this time, the Place of Service code for telehealth provided in the patient's home will be "10", a new POS.

POS "02" - Redefined as Telehealth Provided Other than in Patient's Home

POS "10" - Telehealth Provided in Patient's Home

Modifier 95 will now only be used in specific situation related to hospital care and some therapies provided by Physical Therapy, Occupational Therapy and Speech-Language Pathologists.

Through December 31, 2024, CMS has decided that the current definition of direct supervision will continue to include the presence and immediate availability of the supervision physician via real-time audio-video interactive telecommunications.

92002-92014 eye care services will still be allowed but are only provisionally approved through the end of 2024. This means that CMS has yet to decide if these services will be permanently allowable via Telehealth. As well, CMS finalized separate payment for CPT codes 99441 through 99443 (E/M assessment and management services furnished via telephone) through the end of 2024. Of the provisions CMS reviewed, the Social Determinants of Health Risk Assessment (G0136) available via telehealth will become permanent.

Social Determinates of Health (SDOH) Assessment (p344 – 360 PFS)

CMS will use G0136 and reimburse for the administration of a standardized and evidence-based SDOH Risk assessment tool (tested and validated through research, and includes the domains of food insecurity, housing insecurity, transportation needs, and utility difficulties. And other domains can be included if the provider feels they occur and are culturally important in the community of patients being served. The tool developed by AOA has NOT been standardized

and cannot be used for the CMS paid code being discussed. This assessment should identify and relate to the patient's individual SDOH that may influence the diagnosis and treatment of their specific medical conditions.

G0136, Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, not more often than every 6 months.

Per the PFS: "Possible evidence-based tools include the CMS Accountable Health Communities (AHC)²⁴ tool, the Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE)²⁵ tool, and instruments identified for Medicare Advantage Special Needs Population Health Risk Assessment²⁶".

²³ <https://health.gov/healthypeople/tools-action/browse-evidence-based-resources/types-evidence-based-resources>

²⁴ <https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf>.

²⁵ <https://www.nachc.org/research-and-data/prapare/>

Caregiver Training Services (CTS) (p285- 303 PFS)

CMS states that, in certain circumstances, caregivers can play a key role in developing and carrying out the treatment plan or, as applicable to physical, occupational, or speech-language therapy, the therapy plan of care (collectively referred to in this discussion as the "treatment plan") established for the patient by the treating practitioner. A caregiver is defined as "an adult family member or other individual who has a significant relationship with, and who provides a broad range of assistance to, an individual with a chronic or other health condition, disability, or functional limitation" as well, the caregiver can be "a family member, friend, or neighbor who provides unpaid assistance to a person with a chronic illness or disabling condition". Any particular patient may have more than one caregiver who needs to be training. This training may be particularly necessary ensure successful treatment outcomes for the certain patients (e.g.: when the patient cannot follow through with the treatment plan for themselves). When this training is performed outside the patient's presence, the physician must obtain the patient's (or representative's) consent for the caregiver to receive the CTS.

CTS would be billed using the appropriate group code (CPT code 96202, 96203, or 97552) if more than one caregiver is trained at the same time, or individual code (CPT code 97550, 97551) if one individual caregiver is trained.

96202 Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); initial 60 minutes

96203 ; each additional 15 minutes (List separately in addition to code for primary service

97550 Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [IADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face-to-face; initial 30 minutes)

97551 ; each additional 15 minutes (List separately in addition to code for primary service)

97552 Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [IADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face-to-face with multiple sets of caregivers

Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM) Services (PFS p178-186)

CMS finalized the Medicare payment policies for the CPT codes for RPM (99453-99458, 99091) and RTM (98975-98981) in the post-PHE era. The final PFS clarifies that: RPM services can only be provided to established patients; codes for monthly monitoring can be reported only if a minimum of 16 days of data have been collected. The RTM codes are not included in this limitation and the services may be reported for months when care management or surgical global services are also being reported. CMS clarified that these codes should be reported only once during a 30-day period and can only be billed by one provider in a month, regardless of number of medical devices are provided to a patient.

Potentially Misvalued Codes (p406 of PFS)

CMS has determined that the following codes are potentially misvalued and have assigned a different Relative Value to each of the following:

HCPCS	Descriptor	Current work RVU	RUC work RVU	CMS work RVU	CMS time refinement
65778	Placement of amniotic membrane on the ocular surface; without sutures	1.00	0.84	0.84	No
65779	Placement of amniotic membrane on the ocular surface; single layer, sutured	2.50	1.75	1.75	No
65780	Ocular surface reconstruction; amniotic membrane transplantation, multiple layers	7.81	7.03	7.03	No
67516	Suprachoroidal space injection of pharmacologic agent (separate procedure)	NEW	1.53	1.53	No
G2211	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.	B	0.33	0.33	No

Stay tuned for the AOA Recorded Webinar which will review the CPT® Code changes, the ICD-10-CM changes, and the PFS changes for 2024.

<https://www.cms.gov/medicare/medicare-fee-service-payment/physicianfeesched/pfs-federal-regulation-notice/cms-1784-f>

<https://public-inspection.federalregister.gov/2023-24184.pdf>