Illinois Health and Hospital Association

November 29, 2023

ILLINOIS HEALTH AND HOSPITAL ASSOCIATION
M E M O R A N D U M

SUBJECT: CY 2024 Medicare PFS Final Rule – CMS-1784-F

On Nov. 2, the Centers for Medicare & Medicaid Services (CMS) released its calendar year (CY) 2024 physician fee schedule (PFS) final rule. CMS' fact sheet can be found *here*. Overall, CMS finalized a rate update of –1.25% compared to CY 2023, while finalizing payment increases for primary care and other direct patient care. The finalized CY 2024 PFS conversion factor is –3.4% relative to CY 2023.

Within this rule, CMS finalized new practitioner payments to train caregivers and separate payment for services addressing health-related social needs. CMS adopted changes to evaluation and management visits, made permanent payment for preventative vaccine administration services, relaxed supervision requirements for physical and occupational therapists in private practice and improved access to diabetes self-management training services. The final rule also expanded access to telehealth services, behavioral health services, diabetes screening, and dental services. The rule also implements provisions from the Inflation Reduction Act (Pub. L. 117-169, August 16, 2022) that affect payment limits for beneficiary out-of-pocket costs for certain drugs payable under Medicare Part B.

Services Addressing Health-Related Social Needs

CMS finalized separate payment for Community Health Integration (CHI), Social Determinants of Health (SDOH) Risk Assessment, and Principal Illness Navigation (PIN) services to address resource needs of health care support staff, such as community health workers, care navigators, peer support specialists, and other such auxiliary personnel. These support staff may be employed by community-based organizations, as long as the billing practitioner for the services provides requisite supervision.

CHI Services: These services address unmet SDOH needs that impact the diagnosis and treatment of a beneficiary's medical problem, and may be provided by support staff like community health workers.

PIN Services: These services may be provided by peer support specialists and other support staff to help patients diagnosed with high-risk conditions (for example, dementia, HIV/AIDS, cancer, severe mental illness, and substance use disorder) identify and connect with appropriate clinical and support resources.

SDOH Risk Assessments: These are an optional addition to the annual wellness visit, an evaluation and management visit, or behavioral health visit, with additional payment. The risk assessment payment recognizes practitioner time and resources spent assessing SDOH needs that may impact their ability to treat the patient.

Telehealth Services

New & Continued Services: CMS finalized the proposal to temporarily add health and well-being coaching services to the Medicare Telehealth Services List through CY 2024, while SDOH Risk Assessments are added to the list on a permanent basis.

CMS also finalized the allowance for institutional providers to bill for outpatient therapy, diabetes self-management training, and medical nutrition therapy services furnished to beneficiaries at an originating site (i.e., location of the patient) outside of the healthcare facility, like the home, using telecommunications technology through the end of CY 2024. For this allowance, CMS clarified the addition of a requirement to use the 95 modifier on all claims, except Method II Critical Access Hospitals (CAHs). For outpatient hospital settings, CMS also clarified that beneficiaries' homes no longer need to be designated as provider-based entities.

Provider Location: In addition, CMS will continue to permit providers to use their practice address on the CMS 1500 form instead of their home address through CY 2024, when providing telehealth services from their home. The agency will consider the issue further for future rulemaking, and continues to seek additional feedback on how the enrollment process shows material privacy risks to inform future policies.

Changes under the Consolidated Appropriations Act, 2023 (CAA, 2023): The rule finalized telehealth policy changes mandated by the CAA, 2023, to continue many flexibilities implemented during the COVID-19 Public Health Emergency through the end of CY 2024. Specifically, the continued temporary expansion of:

- Telehealth originating sites, permitting any site in the United States where the beneficiary is located at the time of the service;
- Telehealth practitioners, to include qualified occupational therapists, qualified physical therapists, qualified speech-language pathologists, and qualified audiologists;
- Payment for telehealth services furnished by Rural Health Centers (RHCs) and Federally Qualified Health Centers (FQHCs); and
- Coverage and payment of telehealth services included on the Medicare Telehealth Services List.

As part of the CAA, 2023 implementation, CMS delayed the beneficiary requirement to complete an in-person visit with the provider within six months prior to initiating mental health telehealth services, then at subsequent intervals as the Secretary determines appropriate. This delay applies to RHCs and FQHCs that furnish mental health services as well. To align with

telehealth flexibilities extended by the CAA, 2023, CMS is also finalizing a new requirement that beginning in CY 2024, telehealth services to beneficiaries in their homes will be paid at the non-facility PFS rate.

Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM): CMS finalized that RPM services, but *not* RTM services, require an established patient relationship. As proposed, both RPM and RTM services required an established patient relationship. For RTM services, the agency clarified that billing practitioners are expected to establish a treatment plan prior to providing services.

CMS also finalized allowances for RPM *or* RTM to be billed concurrently with codes for Transitional Care Management, Chronic Care Management, Behavioral Health Integration, Principal Care Management, and Chronic Pain Management. However, both RPM and RTM may not be billed simultaneously with these code sets.

During a global service period, practitioners are also permitted to bill and receive separate payment for RPM or RTM, as long as these services are unrelated to the diagnosis for which the global service was performed.

In addition, CMS finalized the proposal to include RPM and RTM in the general care management HCPCS code G0511 when provided by RHCs and FQHCs.

CMS did not proceed with the proposal to require transmission of 16 days of data in a 30-day period for specified RPM and RTM treatment management codes (CPT codes 99457, 99458, 98980, and 98981). CMS also did not move forward with classifying RPM as primary care for purposes of Medicare Shared Savings Plan beneficiary assignment.

Opioid Treatment Programs (OTP): For OTPs, CMS will extend the permission for periodic assessments via audio-only telecommunications, when video is *not available* to the beneficiary, through the end of CY 2024. This flexibility continues to be permitted only to the extent that use of this technology is allowed under applicable requirements of the Substance Abuse and Mental Health Services Administration and Drug Enforcement Administration at the time a service is delivered.

Supervision and Teaching: For direct supervision, CMS will continue to allow presence and immediate availability of the supervising practitioner through real-time audio and video interactive telecommunications through CY 2024. For RTM services, CMS is finalizing a change to permit *general* supervision of therapy assistants by physical and occupational therapists in private practices, rather than previously required *direct* supervision.

Similarly, virtual presence for teaching physicians via audio/video real-time communications technology will continue to be allowed when the resident furnishes Medicare telehealth

services in all residency training locations through the end of CY 2024. Virtual presence will continue to meet the requirement that the teaching physician be present for the key portion of the service.

Behavioral Health Services

Changes under the CAA, 2023: The rule finalized behavioral health policy changes mandated by the CAA, 2023, for CY 2024, including:

- Coverage and payment for Medicare Part B coverage and payment under the PFS for services of marriage and family therapists (MFT) and mental health counselors (MHC), when billed by the professionals beginning CY 2024. Coverage includes Behavioral Health Integration codes. MFTs and MHCs may submit Medicare enrollment applications immediately following this rule's issuance (see enrollment information here);
- Allowing Medicare enrollment of addiction counselors or drug and alcohol counselors who meet requirements to be an MHC under this professional designation;
- New HCPCS codes for psychotherapy for crisis services provided in a service site at which the non-facility rate for psychotherapy for crisis services applies, including the home or a mobile unit, while excluding the office setting. Payment will be 150% of the fee schedule rate for non-facility sites of service for services identified by HCPCS codes 90839, 90840, and any succeeding codes;
- Modifying the requirements for the hospice Conditions of Participation to allow social workers, MHCs or MFTs to serve as members of the hospice interdisciplinary group; and
- Permitting MFTs and MHCs to provide services in RHCs and FQHC.

Other Professional Coverage and Payment Expansion: CMS finalized revisions to the definitions of several healthcare professionals who may currently provide services in RHCs and FQHCs. For nurse practitioners specifically, CMS removed the requirement to be certified in primary care to provide care in these settings.

Beginning in CY 2024, clinical social workers, MFTs and MHCs will be permitted to bill Health Behavior Assessment and Intervention (HBAI) services. These services are described by CPT codes 96156, 96158, 96159, 96164, 96165, 96167, and 96168, and any successor codes.

Increasing the valuation for timed behavioral health services, CMS is also finalizing the proposed application of an adjustment to the work relative value units (RVU) for psychotherapy codes, which will be implemented over a four-year transition. This adjustment will also apply to psychotherapy codes that are billed with an evaluation and management visit and to the HBAI codes.

Please send questions or comments here.