2024 Medicare Physician Fee Schedule- Overview

On November 2, 2023, the Centers for Medicare & Medicaid Services (CMS) released the Calendar Year (CY) 2024 Revisions to Payment Policies under the Medicare Physician Payment Schedule (MFS) and Other Changes to Part B Payment and Coverage Policies final rule. The rule includes finalized proposals related to Medicare physician payment; these policies will take effect on January 1, 2024. The following are some key elements of the Final Rule:

Conversion Factor (CF)

The 2024 physician CF is $32.7442. This represents a decrease of approximately 3.37 percent from the 2023 CF of $33.8872.

G2211 Add-On Complexity Code

CMS will implement a new add-on code for complex patients, G2211. The add-on code is designed to capture resource costs associated with E/M visits for primary care and longitudinal care of complex patients. The add-on code will generally be available for outpatient office visits. CMS finalized this policy in 2021, but Congress suspended its use and prohibited CMS from implementing it before 2024.

Split/Shared Services E/M Visits

For care rendered to a patient by a physician and an Advance Practice Practitioner (APP) by members of the same group and specialty, E/M services can only be billed by one clinician. If the APP bills, they receive 85% of the fee schedule while the physician receives 100%. The primary issue around Split/Shared Services is determining who provides the "substantive portion" and therefore who can bill for it. In the Final Rule, CMS established the definition of "substantive portion" of a split or shared service in 2024 to mean more than half of the total time spent by the physician and the APP performing the split (or shared) visit, or medical decision making (MDM) – aligning with CPT® (Current Procedural Terminology) guidelines.

Services Addressing Health-Related Social Needs

CMS finalized several new codes and payment methods for social determinants of health (SDOH) risk assessments, community health integration (CHI) services, principal illness navigation (PIN) services and caregiver training services. The rule clarifies eligibility criteria for initiating visits and addresses comments on roles and billing requirements.

Social Determinants of Health (SDOH) Risk Assessment HCPCS Code *G0136*. CMS finalized the adoption of a new code for administering a SDOH risk assessment as part of a comprehensive social history when medically reasonable and necessary in relation to an E/M visit. (Beneficiary cost sharing may apply when the assessment is not conducted as part of the annual wellness visit.)

Community Health Integration (CHI) Services HCPCS Codes *G0019* and *G0022*. CMS also finalized the creation of two new codes to pay for CHI services. CHI services focus on addressing the particular SDOH needs that interfere with, or present a barrier to, diagnosis or treatment of the patient's problem(s) addressed in the CHI initiating visit. CHI services can be performed by certified or trained auxiliary personnel, which may include community health workers or others who are external to, and under contract with, the practitioner or the practitioner's practice, such as through a community-based organization. *This is considered incident-to.*

Principal Illness Navigation (PIN) Services HCPCS codes *G0023* and *G0024* & Principal Illness Navigation – Peer Services (PIN-PS) HCPCS codes *G0140* and *G0146.* Other new codes include those for PIN services, which can be furnished following an initiating E/M visit addressing a serious high-risk condition/illness/disease expected to last longer than three months, such as cancer, chronic obstructive pulmonary disease, congestive heart failure, dementia, HIV/AIDS, severe mental illness and substance use disorder. PIN services can be provided by trained patient navigators or certified peer specialists. Services can be provided more than once per practitioner per month can. A new initiating visit must be conducted once per year. Written or verbal patient consent will be required in advance of providing these services. *This is considered incident-to.*

Caregiver Training Services (CTS) CPT Codes *97550, 97551, 97552*. Payment when practitioners train caregivers to support patients with certain diseases or illnesses (e.g., dementia) in carrying out a treatment plan. Medicare will pay for these services when furnished by a physician or a non-physician practitioner (nurse practitioners, clinical nurse specialists, certified nurse-midwives, physician assistants, and clinical psychologists) or therapist (physical therapist, occupational therapist, or speech language pathologist) as part of the patient's individualized treatment plan or therapy plan of care.

Telehealth Services

Physician Home Address. Physicians who provide telemedicine services from their home office will not have to enroll that address in the PECOS system; physicians will only need to list their practice address.

Place of Service Codes for Medicare Telehealth Services. Beginning CY 2024, claims billed with place of service (POS) 10 (Telehealth Provided in Patient's Home) will be paid at the non-facility physician fee schedule rate. Claims billed with POS 2 (Telehealth Provided Other than in Patient's Home) will be paid at the PFS facility rate for non-home originating sites, such as physician's offices and hospitals.

Simplification of Determining Telehealth Codes. During the COVID-19 public health emergency (PHE), CMS introduced more flexibility for telehealth services to enhance Medicare beneficiary access to healthcare. Codes were categorized as either temporary or permanent basis under the Category 1, 2, or 3 criteria. In the Final Rule, CMS finalized its proposal to simplify its multi category approach and consider additions to the list as either permanent or provisional.

PHE Telehealth Policies to Extend Through End of 2024. The Final Rule implements several telehealth provisions extended through the end of 2024 by CAA 2023. This includes:

- The removal of telehealth frequency limitations for subsequent inpatient visits, observation stays, and nursing facility visits
- Extended payment for Telephone Evaluation and Management Services (CPT codes 98966 through 98968), supporting audio-only visits until Dec. 31, 2024

- An extension of the definition of direct supervision through Dec. 31, 2024, to include the presence of the physician (or other practitioner) via audio/visual real-time communication technology.

Behavioral Health Services

New Eligible Billing Provider Types. The final rule will now provide Medicare Part B coverage and payment under the Medicare Physician Fee Schedule for the services of marriage and family therapists (MFTs) and mental health counselors (MHCs) when billed by these professionals. MFTs and MHCs will be able to begin submitting Medicare enrollment applications after the CY 2024 Physician Fee Schedule final rule is issued, and they will be able to bill Medicare for services starting January 1, 2024, consistent with statute.