



Proposed CY 2024 PHYSICIAN FEE SCHEDULE

FACT SHEET | July 2023

The proposed [CY 2024 Physician Fee Schedule \(PFS\)](#) was released on July 13, 2023. The PFS contains policy changes proposed by the Center for Medicare and Medicaid Services (CMS) for the Medicare program to take place the following year (unless otherwise stated). Many have been anticipating these proposed rules due to certain temporary telehealth policies currently slated to end this year. The proposed 2024 PFS does provide some clarity in how CMS will address several telehealth policy issues in Medicare for next year, but not all. At this time, these are only proposals. The public has until 5 pm September 11, 2023 to provide comments to CMS regarding these proposed policies.

► Adoption of Changes Made by the Consolidated Appropriations Act of 2023

The Consolidated Appropriations Act of 2023 (CAA 2023) contained many of the larger provisions that extended temporary telehealth policies in Medicare. These provisions included:

- Temporarily removing the geographic and site requirements for the patient location at the time the telehealth interaction takes place
- Temporarily allowing a more expansive list of eligible providers in Medicare to provide services via telehealth such as physical and occupational

therapists and federally qualified health centers (FQHCs) and rural health clinics (RHCs)

- Temporarily allowing some services to continue to be provided via audio-only
- Temporarily suspending the in-person service requirement prior to the delivery of mental and behavioral services via telehealth or audio-only in cases where the geographic requirement does not apply, the service takes place in the home and the patient was not being treated for a substance use disorder

The foregoing temporary policies are in effect to December 31, 2024. In the proposed 2024 PFS, CMS makes the necessary changes to incorporate these temporary policies into regulations.

▶ Marriage and Family Therapists & Mental Health Counselors

In 2024, CMS is proposing to amend regulations to add Marriage and Family Therapists and Mental Health Counselors to the permanent list of eligible telehealth providers due to changes made by CAA 2023 which added these professionals to the definition of “practitioner” in 1842(b)(18)(C) of the Social Security Act.

▶ Eligible Services that Can Be Delivered Via Telehealth

For Medicare there is a specific list of services for which a practitioner may be reimbursed if they utilized telehealth to deliver that service (Telehealth Services List). During the COVID-19 pandemic, CMS added additional services to the Telehealth Services List on a temporary basis. This Temporary Telehealth Services List is still in effect through 2023 because it was approved during last year’s PFS process. The question is whether the Temporary Telehealth Services List will also carry over into 2024.

Each year, CMS accepts recommendations from the public to add services to the permanent version of the Telehealth Services List (the services are identified via CPT or HCPCS code). This year, there were requests to add several of the temporarily available services to the permanent list.

CMS, as required by law, created a process to determine which services would be placed on the permanent list. A service code would be placed on the permanent list if it passed one of two tests:

- **Category 1** – The service was similar to a service already approved and on the permanent Telehealth Services List.
- **Category 2** – Sufficient evidence to show patient outcomes similar to what would be seen in-person has been provided.

During the pandemic, CMS added a third category (Category 3) that acted as a temporary holding place for some of the temporary services they had approved during the pandemic, but did not have enough evidence to justify a move onto the permanent list.

In this PFS, CMS considered requests to add the following codes to the permanent telehealth list on a Category 1 or 2 basis. CMS is proposing to continue to allow these codes on a temporary basis through 2024, as further evidence is gathered to support their inclusion in the permanent list. The codes include:

- **Deep Brain Stimulation** – 95970, 95983, 95984
- **Therapy Codes** – 97110, 97112, 97116, 97161-97164, 97530, 97750, 97763, 90901
- **Hospital Care, Emergency Department and Hospital** – 99221-99223, 99234-99236, 99238-99239, 99281-99283
- **Cardiovascular and Pulmonary Rehab** – 93797 and 94626

Additionally, CMS will add through 2024 the following:

- **Health and Well Being Services** – 0591T, 0592T & 0593T

To the permanent list, CMS proposes adding:

- **GXXX5** – Administration of a standardized evidence-based social determinants of health risk assessment tool (5-15 minutes) if the code is finalized.

Changing the Code Approval Process

In this PFS, CMS is proposing a new process for deciding which services will be reimbursed if provided via telehealth. It is their intention to create a more streamlined process. In this proposed process, a suggested code would either be made permanent, provisional or rejected. The new process would have the following steps:

1. Is it a separately payable service? (i.e., Is it a service Medicare covers?)

2. Is the service subject to the provisions of 1834(m)? (i.e., Can some part of the service use telehealth to substitute for in-person or face-to-face?)
3. A review of elements of the service in the HCPCS code definition and determine if each can be done via technology.
4. Map the elements in the proposed service to one that is similar to what’s already on the permanent list. If the service passes this step, it will go onto the permanent list.
5. If the previous bullet is not met, CMS would consider the evidence of clinical benefit that is similar to what benefit would have been obtained if done in-person. If there is not enough evidence to place it on the permanent list, but there is sufficient evidence for further study, it would receive “provisional” status.

CMS believes this process would be easier for the general public to understand and submit suggestions accordingly and help streamline their administrative work in assessing submissions. For CY 2024, they are proposing to redesignate currently Category 1 or 2 telehealth services into the “permanent” category, while services in temporary Category 2 or Category 3 would be assigned to the “provisional” category.

▶ Remote Monitoring Services

In the PFS, CMS provided a clarification on how remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM) are addressed and billed. CMS clarified the following points:

- After the PHE ends, RPM services are only for established patients. CMS notes that “patients that received initial remote monitoring services during the PHE are considered established patients for purposes of the new patient requirements that are effective after the last day of the PHE.” Therefore,

if your patient had received RPM services during the pandemic, they are considered an established patient, so there should be no disruption of services to those patients.

- The 16-day monitoring requirement is reinstated after the PHE. “Monitoring must occur over at least 16 days of a 30-day period.” See the specific details of the requirements for each code’s description.
- Although multiple devices can be provided to a patient, “the services associated with all of the medical devices can be billed only once per patient per 30-day period and only when at least 16 days of data have been collected.”
- Practitioners may bill RPM or RTM, but not both, concurrently with the following services:
 - o Chronic Care Management (CCM)
 - o Transitional Care Management (TCM)
 - o Behavioral Health Integration (BHI)
 - o Principle Care Management (PCM)
 - o Chronic Pain Management (CPM)
- RTM and RPM cannot be billed together
- Regarding global payment and how RTM and RPM maybe used, CMS wrote:

[W]here an individual beneficiary may receive a procedure or surgery, and related services, which are covered under a payment for a global period, RPM services or RTM services (but not both RPM and RTM services concurrently) may be furnished separately to the beneficiary, and the practitioner would receive payment for the RTM or RPM services, separate from the global service payment, so long as other requirements for the global service and any other service during the global period are met. For an individual beneficiary who is currently receiving services during a global period, a practitioner may furnish RPM or RTM services (but not both RPM or RTM services) to the individual beneficiary, and the practitioner

will receive separate payment, so long as the remote monitoring services are unrelated to the diagnosis for which the global procedure is performed, and as long as the purpose of the remote monitoring addresses an episode of care that is separate and distinct from the episode of care for the global procedure - meaning that the remote monitoring services address an underlying condition that is not linked to the global procedure or service.

More details and explanations are relayed in the PFS.

► Supervision

For the public health emergency (PHE), CMS altered the definition of “direct supervision” to permit the presence and “immediate availability” of the supervising practitioner to be through “real-time audio and visual interactive telecommunications.” CMS is proposing this temporary policy to continue through December 31, 2024 (it will also be extended to FQHCs and RHCs).

Additionally, for supervision of teaching residents, the teaching physician may continue to have a virtual presence in all teaching settings but only in clinical instances when the service is furnished virtually. This exception will continue through to December 31, 2024. Both supervision temporary waivers exclude this from happening via audio-only.

CMS also proposes to establish an RTM general supervision policy that would allow for physical and occupational therapy practitioners in private practice who are supervising PT and OT assistants who provide these services to allow the PT and OT to be able to bill for them. Current regulations require there be direct supervision by the OT/PT.

► Facility Rate vs. Non-Facility Rate

During the pandemic, practitioners who often may have been seeing patients when the patient was in their home, were able to bill the place of service (POS code) where the service would have normally occurred. The reasoning behind that was the pandemic created circumstances that prevented the patient from coming into the health facility or office, but the practitioner would still maintain those expenses. Practitioners were also to add the “95” modifier to signify the service took place via telehealth. Practitioners were able then to get the non-facility rate which is higher than the facility fee rate. In last year’s PFS, the final rule noted that practitioners were no longer to bill claims with modifier 95 and providers were to use the POS code that would have been used if the service took place in-person, using either 02 (telehealth provided other than in a patient’s home) or POS 10 (telehealth provided in the patient’s home). This will continue through 2024.

However, in looking at data regarding what and how services were provided during the pandemic, CMS noticed that behavioral health services which would have typically been provided in a health care setting were now often being provided in the patient’s home. CMS writes,

Now that behavioral health telehealth services may be furnished in a patient’s home, which would then serve as an originating site, we believe these behavioral health services are most accurately valued the way they would have been valued without the use of telecommunications technology, namely in an office setting... It appears that practice patterns for many mental health practitioners have evolved, and they are now seeing patients in office settings, as well as via telehealth. As a result, these practitioners continue to maintain their office presence even as a significant proportion of their practice’s utilization may be comprised of telehealth visits. As such, we believe their practice expenses (PEs) are more accurately reflected by the non-facility rate.



Therefore, CMS is proposing for 2024 that claims billed with POS 10 be paid at the non-facility PFS rate (and this appears to not be restricted just to behavioral health). CMS recognized that practitioners will likely still have their practice expenses and noted “that there are few differences in PE when behavioral health services are furnished to the patient at home via telehealth as opposed to services furnished in-person.”

Claims with POS 02 will continue to be paid the PFS facility rate.

Additionally, CMS proposes to extend flexibilities for the Medicare Diabetes Prevention Program (MDPP) for an additional four years. Among the flexibilities is the ability to provide distance learning virtually, including the ability to collect weight measures via technology and no cap on virtual sessions. The proposal will also include clarification of “which virtual modalities can be used in the proposed Extended flexibilities period.” Note that MDPP suppliers who provide services virtually would need to meet certain requirements such as following the Centers for Disease Control and Prevention (CDC)-approved National DPP curriculum requirements and having an in-person Diabetes Prevention Recognition Program organizational code.

▶ Diabetes Self-Management and Medical Nutrition

The 2024 PFS contains several proposals related to diabetes self-management training (DSMT) and medical nutrition training (MNT). During the PHE, CMS allowed institutional staff to provide DSMT and MNT via telehealth to beneficiaries in the home. The PFS proposal would allow institutional providers to continue to do so and be able to bill through the end of 2024. The PFS notes that other types of staff who are not authorized by Medicare to provide these services via telehealth may actually be the professional doing so at institutions. CMS notes that it will exercise, “enforcement discretion in reviewing the telehealth eligibility status of the practitioner personally providing any part of a remotely furnished DSMT service, so long as the persons were otherwise qualified to provide the service.”

In another section of the PFS, CMS is also proposing to change billing rules for DSMT that would allow practitioners who can “appropriately report DSMT services furnished in person by the DSMT entity... to report DSMT services via telehealth by the DSMT entity, including when the services are performed by others as part of the DSMT entity.”

“CMS is proposing for 2024 that claims billed with POS 10 be paid at the non-facility PFS rate (and this appears to not be restricted just to behavioral health).”



► Other Proposals

- **Telephone Evaluation and Management Services** – CPT codes 99441-99443 will remain actively priced through 2024 and are considered telehealth services. CPT codes 98966-98968 are not considered telehealth services but CMS proposes to assign them an active payment status for 2024 “to align with telehealth-related flexibilities that were extended via the CAA, 2023.”
- **Originating Site Facility Fee** – Will be \$29.92 in 2024.
- **Frequency Limitations Removed For 2024:**
 - o Subsequent In-patient Visit – 99231-99233
 - o Subsequent Skilled Nursing Facility Visit – 99307-99310
 - o Critical Care Consultation – G-0508-G0509
- **Telehealth Injection Training for Insulin-Dependent** – Propose to allow one hour of in-person training (for initial or follow-up) that is required for insulin-dependent beneficiaries to take place via telehealth.
- **Periodic Assessments for Opioid Use Disorder (OUD) by Opioid Treatment Program (OTP)** – CMS is proposing to extend allowing audio-only to be used for periodic assessments by OTPs to the end of 2024. The audio-only option will only be available if video is not and to the extent audio-only is permitted by SAMHSA and Drug Enforcement Administration (DEA) and all other relevant requirements.
- **Critical Access Hospital (CAH) Method II** – CMS notes an interest in soliciting comments on how telehealth services under CAH Method II arrangements are furnished and whether they would be most accurately characterized in the context of Medicare telehealth services or of the CAH under Method II.
- **Telehealth Indicator** – CMS is proposing to update how they identify clinicians who provide services via telehealth. Currently, the Indicator uses POS codes 02 or 10 or modifier 95 to identify when a provider used telehealth. The proposal would “use the most recent codes at the time the data are refreshed that identify a clinician as furnishing services via telehealth” as the new way of identifying these providers. CMS made this proposal to keep current with any changes.

► Discussion

CMS provided clarity on what would happen to some waivers set to expire this year. It should be noted that other temporary waivers that at this point are to only last through 2023 were not mentioned in the PFS, such as whether providers may continue to use their office address when enrolling and billing though they may be at home at the time of the telehealth interaction. Unless further notice is provided by CMS, at this point we should expect that those temporary waivers not mentioned in the PFS have the potential to expire at the end of this year.

Continuing on the theme of providing clarity and also streamlining processes, CMS also offered clarifications on how RPM and RTM are billed and proposed a new process for how services are approved for future permanent reimbursement. Both sections likely indicate that CMS has been receiving multiple questions on these issues and the PFS provided the agency an opportunity to provide information in a format that can reach a wider audience, and hopefully alleviate any confusion. The explanations also likely indicate the increased use and interest in technology to provide health services.

Two proposals are particularly interesting: continuing to pay the non-facility rate for services delivered to the patient in the home, and the proposal changing billing rules for DSMT that would allow DSMT certified providers to bill on behalf of a DSMT entity when other health care professionals furnished the service via telehealth. The continued payment of the non-facility rate acknowledges that there are other expenses a provider can incur even if they are using telehealth. In discussions around parity in payment for telehealth delivered services, opponents have often noted that costs such as overhead are reduced

with telehealth, therefore providers should be paid less than what would have been paid in-person. However, here CMS notes that there are still some costs that the telehealth provider will need to carry though they are utilizing telehealth and they should be paid accordingly. It should be noted that in CMS' reasoning they appear to be discussing a practitioner that still has some type of office or location where in-person visits can occur. Whether this will impact future discourse on telehealth payment parity remains to be seen.

The DSMT proposal appears to allow non-eligible health care practitioners providing eligible DSMT services to utilize telehealth to deliver those services and the eligible provider within the DSMT entity to report and bill. CMS notes this mirrors the policy they allow for in-person delivered services, stating that, "Since we allow RDs (registered dietitians) and other DSMT certified providers to bill on behalf of the DSMT entity when other professionals personally furnish the services in face-to-face encounters, we believe that this should also be our policy when DSMT is furnished as a Medicare telehealth service." The DSMT services will still be subject to other telehealth requirements such as geographic location and site and it appears that a telehealth eligible provider will still need to be the one to actually bill, but this may be a way to increase the types of providers who can utilize telehealth and some payment can still be made to the entity.

At this stage these are only proposed rules. The deadline for interested parties to provide CMS with comments is September 11, 2023. Final rules are typically published in November.

Center for Connected Health Policy

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