2024 MEDICARE PHYSICIAN FEE SCHEDULE FINAL RULE

AMERICAN ACADEMY OF NEUROLOGY®

2024 Medicare Physician Fee Schedule Final Rule: Regulatory Changes and Updates to Physician Payment System

Each year, the Centers for Medicare & Medicaid Services (CMS) issues regulations that impact the reimbursement of physicians. On November 2, 2023, CMS issued a final rule updating payment policies and rates for physicians paid under the Medicare Physician Fee Schedule in 2024. The final rule illustrates the importance of the AAN's regulatory advocacy efforts on behalf of neurologists and their patients. The AAN previously submitted 48 pages of detailed comments in response to the various proposals made by CMS.

CMS is projecting that the overall impact of changes contained in the rule will result in a one percent increase in payments to neurology as a specialty broadly. Due to the phase-out of temporary relief measures contained in the Consolidated Appropriations Act of 2023 and statutory budget neutrality requirements, CMS finalized a reduction in the Fee Schedule conversion factor of approximately 3.4 percent to 32.74. The AAN will continue to work with legislators to offset the impacts of statutorily required cuts. The AAN is committed to payment reform efforts to promote a sustainable payment system, such as ensuring physicians receive an inflationary adjustment tied to the Medical Economic Index, and to working with regulators and legislators to ensure that CMS appropriately values the work done by neurologists.

Evaluation and Management (E/M) Visits

In a major win for AAN advocacy, CMS is modifying previously finalized policies impacting split (or shared) E/M visits. The agency is finalizing a revised definition of "substantive portion" for Medicare billing purposes. Under the new definition, the substantive portion is more than half of the total time spent by the physician and NPP performing the split (or shared) visit, or a substantive part of the medical decision making as defined by CPT. The final rule specifically calls out concerns raised by the AAN and other aligned stakeholders and aligns with recommendations that the AAN previously made to ensure that split (or shared visits) can be billed on the basis of both time and medical decision making.

In another significant positive development on a long-standing AAN priority, CMS is heeding the AAN's recommendations to implement a new add-on code, G2211, effective January 1, 2024, to account for visit complexity for patients whose overall, ongoing care is being managed and monitored by a specialist for a complex condition. The AAN strongly supports implementation of this new code and believes implementation is critical to account for the work associated with serving as the focal point of care for a patient with a complex condition. The AAN has been very active with policymakers with the goal of ensuring that Congress does not take action to delay or eliminate this much needed increase for complex E/M services.

Telehealth Regulations

CMS is implementing key provisions of the Consolidated Appropriations Act (CAA) of 2023 that extend certain flexibilities in place during the COVID-19 Public Health Emergency (PHE) through December 31, 2024. These key flexibilities include allowing telehealth services to be furnished in any geographic area and in any originating site setting, including the beneficiary's home, allowing certain services to be furnished via audio-only communication technology, and continued coverage of services temporarily added to the Medicare Telehealth list through December 31, 2024. Recognizing that many practitioners providing telehealth must

functionally maintain their practice expenses, CMS will pay for telehealth services furnished to beneficiaries in their homes at the higher non-facility rate. Telehealth provided to patients in locations other than a patient's home, such as physicians' offices and hospitals, will be reimbursed at the facility rate.

Prior to the PHE, CMS included restrictions on how frequently certain services may be furnished via telehealth. Beyond 2024, CMS is broadly assessing its telehealth regulations considering the ways in which practice patterns may have changed during the PHE. For 2024, CMS is removing the telehealth frequency limitations for the following codes:

- Subsequent Inpatient Visits: CPT Codes 99231–99233
- Subsequent Nursing Facility Visits: CPT Codes 99307–99310
- Critical Care Consultation Services: HCPCS Codes G0508 and G0509

Citing concerns that modifying the temporary PHE policy related to direct supervision may disrupt practice patterns and present a barrier to access, consistent with the AAN's advocacy, CMS will continue to allow for the presence and "immediate availability" of the supervising practitioner through real-time audiovisual telecommunication technology through December 31, 2024. CMS also finalized a policy that allows for virtual direct supervision of services furnished incident to a physician's professional service, such as Level I office visits. The AAN will continue to work with CMS on permanent policy to further extend these flexibilities as appropriate.

In alignment with the telehealth policies that were extended under the provisions of the CAA through December 31, 2024, CMS is also allowing teaching physicians to have a virtual presence in all teaching settings regardless of geographic location, but only in instances when a service is furnished virtually. This permits teaching physicians to have a virtual presence during the key portion of the Medicare telehealth service for which payment is sought, when the patient, resident, and teaching physician are all in separate locations using audiovisual real-time communications technology. This virtual presence policy will continue to require real-time observation by the teaching physician and excludes audio-only technology. As with direct supervision of auxiliary personnel, CMS will consider other clinical instances in which a teaching physician has a virtual presence in future rulemaking.

CMS declined to add several codes to the permanent Medicare Telehealth Services List, citing a need for further evidence generation. The following codes will remain on the Telehealth Services List on a temporary basis through 2024:

- Deep Brain Stimulation: CPT Codes 95970, 95983, and 95984
- Inpatient Hospital or Observation Care: CPT Codes 99221–99223, 99234–99236
- Inpatient Hospital or Observation Discharge Day Management: CPT Codes 99238 and 99239
- Emergency Department Evaluation and Management: CPT Codes 99281–99283

During the PHE, CMS granted flexibility in certain reporting requirements whereby practitioners could perform telehealth visits from their homes without having to report their home address on publicly available Medicare enrollment files. This flexibility was due to expire at the end of 2023. Although CMS did not address this topic in the proposed rule, the agency received significant feedback from stakeholders, including the AAN, citing privacy and safety concerns. In response, CMS will continue to permit distant site practitioners to use their currently enrolled practice locations instead of their home addresses when providing telehealth services from home in 2024 and will consider this issue in future rulemaking.

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Health-related Social Needs

In alignment with the AAN's advocacy, CMS finalized new coding and payment (CPT codes 96202-96203 and 97550-97552) for caregiver training services to support patients in carrying out a treatment plan. Medicare will pay for these services when furnished by a physician, a non-physician practitioner or therapist to one or more caregivers as part of the patient's individualized treatment plan or therapy plan of care.

The AAN is pleased that CMS is finalizing the proposal to establish separate coding and payment for community health integration services, which would be performed by certified or trained auxiliary personnel, reported as incident to or under the general supervision of the billing practitioner. The services can be provided monthly following an initiating E/M visit in which the practitioner identifies the presence of social determinants of health (SDOH) needs that significantly limit the practitioner's ability to diagnose or treat the problem(s) addressed in the visit. G0019 will be reported for services of 60 minutes per calendar month and G0022 will be reported for each additional 30 minutes per calendar month.

CMS will also finalize code G0136 for the administration of a standardized, evidence-based SDOH risk assessment tool to review an individual's social risk factors that may influence the diagnosis and treatment of medical conditions.

A final set of health-related social need services that CMS will cover for 2024 are for principal illness navigation (PIN) services. G0023 and G0024 will be reported for the time spent with patients requiring assistance navigating the healthcare system and coordinating care for their complex or high-risk conditions.

Appropriate Use Criteria

CMS has been working since 2014 to implement the Appropriate Use Criteria (AUC) Program, which requires practitioners to consult a qualified clinical decision support mechanism at the time the practitioner orders an advanced diagnostic imaging service for a Medicare beneficiary. The AAN has repeatedly expressed concerns about the feasibility of this program, the subsequent increase in administrative burden, and the unintended consequences it would have on practice patterns. CMS has continually delayed implementation of the penalty phase of this program in recent years. Now, in a significant win for AAN advocacy, CMS is rescinding the AUC program and all implementing regulations to allow for reevaluation. CMS states that in doing this, in alignment with the AAN's long-standing advocacy on this topic, the goals of appropriate, evidence-based, coordinated care can be achieved more effectively, efficiently, and comprehensively through other CMS quality initiatives.

Medicare Economic Index

CMS had previously finalized a policy to update the Medicare Economic Index (MEI) to reflect current market conditions faced by physicians in furnishing services. Although the agency finalized this policy, CMS chose to delay implementation, citing a need for further comment. Based on stakeholder feedback, CMS is not incorporating the updated MEI methodology for PFS rate-setting in 2024. CMS will continue to solicit feedback on how to update this index, including data collected through a forthcoming American Medical Association-led effort.

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Quality Payment Program

MIPS

The weights for MIPS performance categories remain the same as in 2023: 30 percent for Quality, 30 percent for Cost, 15 percent for Improvement Activities, and 25 percent for Promoting Interoperability. In alignment with the AAN's comments, the performance threshold will remain at 75 points for the Calendar Year (CY) 2024 performance period.

Neurology will not see major modifications to the Quality, Cost, and Improvement Activity categories. CMS has finalized policy modifications to the Promoting Interoperability category aimed at alleviating administrative burden. The revisions would:

1. Lengthen the performance period for this category from 90 days to 180 days.
2. Modify one of the exclusions for the Query of Prescription Drug Monitoring Program (PDMP) measure.
3. Provide a technical update to the e-Prescribing measure's description to ensure it clearly reflects the previously finalized policy.
4. Modify the Safety Assurance Factors for Electronic Health Record Resilience (SAFER) Guide measure to require MIPS eligible clinicians to affirmatively attest to completion of the self-assessment of their implementation of safety practices.
5. Continue to reweigh this performance category at zero percent for clinical social workers for the CY 2024 performance period/2026 MIPS payment year.

MIPS Value Pathways

Five new MIPS Value Pathways (MVPs) are being implemented in the rule, including:

- Focusing on Women's Health MVP
- Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV MVP
- Quality Care in Mental Health and Substance Use Disorder MVP
- Quality Care for the Treatment of Ear, Nose, and Throat Disorders MVP
- Rehabilitative Support for Musculoskeletal Care MVP

CMS is modifying the previously finalized Promoting Wellness and Optimize Chronic Disease Management MVPs into a single consolidated MVP titled Value in Primary Care MVP.

CMS has already implemented three models which focus on neurologic conditions:

- Optimal Care for Patients with Episodic Neurological Conditions MVP
- Supportive Care for Neurodegenerative Conditions MVP
- Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes MVP

Access AAN resources to help you understand MVPs and the Quality Payment Program.