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NEHIA/HFMA
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2024 Coding Updates and Audit Risk Areas

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New England Healthcare Internal Auditors Inc.

Disclaimer

Although every reasonable effort has been made to assure the accuracy of the information within these pages at the time of publication, the Medicare program is constantly changing, and it is the responsibility of each provider to remain abreast of the Medicare program requirements. Any regulations, policies and/or guidelines cited in this publication are subject to change without further notice. Current Medicare regulations can be found on the Center for Medicare and Medicaid Services (CMS) website at www.cms.hhs.gov.

CPT Disclaimer

Learning Objectives

- 2024 Highlights
  - AMA CPT Changes
  - CMS Physician Fee Schedule Final Rule
- Proposed APP Scope of Practice Changes
- 2024 Audit Risks

2024 CPT Updates

2023 AMA CPT Code Changes by Chapter

CY2024 CPT Code Changes by Chapter			
Chapter	Additions	Revisions	Deletions
Evaluation and management (99202-99499)	1	10	0
Anesthesia (00100-01999)	0	0	0
Integumentary system (10030-19499)	0	0	0
Musculoskeletal system (20100-29999)	4	6	0
Respiratory system (30000-32999)	2	0	0
Cardiovascular system (33016-37799)	8	0	0
Digestive system (40490-49999)	0	0	0
Urinary system (50010-53899)	1	0	0
Male genital system (54000-55899)	0	0	0
Female genital system (56405-58999)	1	0	0
Nervous system (61000-64999)	6	4	0
Eye and ocular adnexa (65091-68899)	1	0	0
Auditory system (69000-69979)	0	0	0
Radiology (70010-79999)	5	0	1
Pathology and laboratory (80047-89398), (0001U-0284U)	75	25	15
Medicine (90281-99607), (0001A-0144A)	43	12	0
Category III (0001F-9007F)	82	13	32
Administrative multianalyte assays with algorithmic analyses	1	0	1
TOTAL	230	70	49

2024 CPT Highlights

- The 2024 version aims to **improve transparency for patients who speak Spanish** with the addition of Spanish-language, consumer-friendly descriptors for more than 11,000 medical procedures and services. Adding the descriptors in Spanish will help CPT users assist patients in the Latinx community.
- Changes include the consolidation of more than 50 previous codes that streamline the reporting of immunizations for COVID-19. The CPT editorial panel also approved the provisional codes (91318-91322) to identify monovalent vaccine products from Moderna and Pfizer for immunization against COVID-19.
- A new vaccine administration code (90480) was approved for reporting the administration of any COVID-19 vaccine for any patient, replacing all previously approved product-specific vaccine administration codes.
- 5 new CPT codes have been created to report product-specific respiratory syncytial virus immunizations (90380, 90381, 90683, 90679, and 90678).
- The diagnosis and treatment codes reported on the health insurance claim form or billing statement should be supported by documentation in the medical record.
- The provider must ensure that medical record documentation supports the level of service reported to a payer.

E/M Changes

- Make it clear that the mid-point concept does not apply to E/M services that have a total time threshold.
- Office visit codes **99202-99205** and **99212-99215** have been revised to remove the code range from each code. Instead, clinicians billing based on time will have a single minimum time threshold that must be met or exceeded.
- They do not change the threshold time that the treating practitioner must meet to select a code based on time.

E/M Timing Changes

CODE	2023 "total time … spent on the date of the encounter"	2024 "total time on the date of the encounter" that "must be met or exceeded"
99202	15-29	15
99203	30-44	30
99204	45-59	45
99205	60-74	60
99212	10-19	10
99213	20-29	20
99214	30-39	30
99215	40-54	40

CPT® is not changing the descriptor to 99211 *Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional*. You will continue to bill this code per usual in 2024.

E/M Changes

- Sole new addition to the E/M code set is a new add-on code, **99459** (Pelvic examination [List separately in addition to code for primary procedure.

- Nursing facility setting should note the five-minute time **increase** for 2 visits.
  - **Initial Nursing Facility Care, 99306** will require 50 minutes total time.
  - Subsequent **Nursing Facility Care, 99308** will require 20 minutes of total time.
- Newly added instructions for reporting hospital inpatient/observation care services and admission and discharge services when a patient stay spans over 2 calendar dates.
- The E/M update includes new guidelines for multiple same-day E/M visits in the hospital and nursing facility settings.
  - Per day: The hospital inpatient and observation care services and the nursing facility services are "per day" services. When multiple visits occur over the course of a single calendar date in the same setting, a **single service** is reported. When using MDM for code level selection, use the aggregated MDM over the course of the calendar date. When using time for code level selection, sum the time over the course of the day using the guidelines for reporting time.

E/M Changes

Multiple encounters in different settings or facilities: A patient may be seen and treated in different facilities (e.g., a hospital-to-hospital transfer). When more than one primary E/M service is reported and time is used to select the code level for either service, only the time spent providing that individual service may be allocated to the code level selected for reporting that service. No time may be counted twice when reporting more than one E/M service. Prolonged services are also based on the same allocation and their relationship to the primary service. The designation of the facility may be defined by licensure or regulation. Transfer from a hospital bed to a nursing facility bed in a hospital with nursing facility beds is considered as two services in two facilities because there is a discharge from one type of designation to another. An intra-facility transfer for a different level of care (e.g., from a routine unit to a critical care unit) does not constitute a new stay, nor does it constitute a transfer to a different facility.

Emergency department (ED) and services in other settings (same or different facilities): Time spent in an ED by a physician or other QHP who provides subsequent E/M services may be included in calculating total time on the date of the encounter when ED sets are not reported and another E/M service is reported (e.g., hospital inpatient and observation care services).

Discharge services and services in other facilities: Each service may be reported separately as long as any time spent on the discharge service is not counted towards the total time of a subsequent service in which code level selection for the subsequent service is based on time. Time includes any hospital inpatient or observation care services (including admission and discharge services) time (99234, 99235, 99236) because these services may be selected based on MDM or time. When these services are reported with another E/M service on the same calendar date, time related to the hospital inpatient or observation care service (including admission and discharge services) may not be used for code selection of the subsequent service.

E/M Changes

Discharge services and services in the same facility: If the patient is discharged and readmitted to the same facility on the same calendar date, report a subsequent care service instead of a discharge or initial service. For the purpose of E/M reporting, this is a single stay.

Discharge services and services in a different facility: If the patient is admitted to another facility, for the purpose of E/M reporting this is considered a different stay. Discharge and initial services may be reported as long as time spent on the discharge service is not counted towards the total time of the subsequent service reported when code level selection is based on time.

Critical care services (including neonatal intensive care services and pediatric and neonatal critical care): Reporting guidelines for intensive and critical care services that are performed on the same calendar date as another E/M service are described in the service specific section guidelines.

Transitions between office or other outpatient, home or residence, or emergency department and hospital inpatient or observation or nursing facility: See the guidelines for **Hospital Inpatient and Observation Care Services or Nursing Facility Services.** If the patient is seen in two settings and only one service is reported, the total time on the date of the encounter or the aggregated MDM is used for determining the level of the single reported service. If prolonged services are reported, use the prolonged services code that is appropriate for the primary service reported, regardless of where the patient was located when the prolonged services time threshold was met. The choice of the primary service is at the discretion of the reporting physician or other QHP.

Split/Shared E/M Updates

- The new CPT guidelines adopt the CMS concept of calculating the substantive portion to determine which team member reports the visit for shared/split E/M services.
  - "If code selection is based on total time on the date of the encounter, the service is reported by the professional who spent the majority/more than half of the face-to-face or non-face-to-face time performing the service."
  - "For the purpose of reporting E/M services within the context of team-based care, performance of a substantive part of the MDM requires that the physician(s) or other QHP(s) **made or approved the management plan** for the number and complexity of problems addressed at the encounter and takes responsibility for that plan with its inherent risk of complications and/or morbidity or mortality of patient management. By doing so, a physician or other QHP has performed two of the three elements used in the selection of the code level based on MDM. If a practice codes the visit based on medical decision-making (MDM), the practitioner who performs the problems addressed and risk portions of the visit reports the service."

CMS 2024 Final Rule

2024 Conversion Factor

	2024	2023	YTD % Change
Physician fee schedule conversion factor	$32.7476	$33.8872	-3.4%
Anesthesia conversion factor	$20.4370	$21.1249	-3.3%

**Note: All rates are effective Jan. 1, 2024, according to the final 2024 Medicare physician fee schedule.*

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HCPCS Code G2211

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 {99202-99215}***).

- "Active" status as of January 1, 2024.
- Implementing payment for this add-on code has redistributive impacts for all other CY 2024 payments under the Medicare Physician Fee Schedule, due to statutory budget neutrality requirements.
- Reporting is not restricted based on specialty.
- May be reported with any visit level.
- May not be reported when modifier -25 is used on the E/M service on a day of a minor procedure.

Example:

"A patient has a primary care practitioner that is the continuing focal point for all health care services, and the patient sees this practitioner to be evaluated for sinus congestion," the final rule states. "The inherent complexity that this code (G2211) captures is not in the clinical condition itself—sinus congestion—but rather the cognitive load of the continued responsibility of being the focal point for all needed services for this patient. Building an effective longitudinal relationship, in and of itself, is a key aspect of providing reasonable and necessary medical care and will make the patient more likely to comply with treatment recommendations after the visit and during future visits. It's the work building this important relationship between the practitioner and patient for primary and longitudinal care that has been previously unrecognized and unaccounted for during evaluation and management visits."

Split/Shared E/M Services

- Revision to CMS' definition of "substantive portion" of a shared/split visit.
- "Specifically, for CY 2024, for purposes of Medicare billing for split (or shared) services, the definition of "substantive portion" means 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 [MDM] as defined by CPT," the agency announced in the final rule.
- Split or shared critical care services will continue to follow Medicare's time-based rules.

Other requirements that must be met for a physician to bill a service as split (or shared) under their name/National Provider Identifier (NPI), include the following:

- The physician and PA (or NP) must work for the same group.
- The physician and PA (or NP) must provide their part of the service on the same calendar day.
- The services must be performed in a hospital, facility, or hospital outpatient office.
- The physician must sign and date the medical record, and the claim must be submitted with an FS modifier.

https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule

Telehealth Services Extended Through 12/31/2024

- Expansion which allows telehealth services be provided in any site in the United States where the beneficiaries located, including the patient's home extended.
- Audio only services may continue to be performed during this period.
- All behavioral health services can be performed for Medicare patients via telehealth until the end of 2024.
- Continued coverage and payment of services included on the Medicare telehealth services list as of March 15, 2020, until December 31, 2024.
- Frequency limitations will be extended:
  - During the PHE, frequency limits on telehealth subsequent hospital visits (once every 3 days), nursing facility visits (once every 14 days) and critical care consultations (once per day) were lifted.
- Telephone codes:
  - CMS will continue to pay for 99441-99443, and for 98966-98968.
- DSMT Services:
  - Allow the entirety of DSMT services to be furnished via telehealth.
  - Expand coverage for diabetes screening (include HbA1c).

Telehealth Services Extended through 12/31/2024

Supervision:

- Direct supervision means the supervising clinician is in the suite of offices when the service is performed, immediately available to provide assistance.
- Required for some diagnostic tests and incident to services.
- Direct supervision will continue to be allowed via two-way A/V equipment.
- Teaching physicians may use audio/video real-time communications technology when the resident provides telehealth services in all residency training locations through the end of CY 2024.
- Virtual presence through two-way, A/V technology by teaching physician during key portions of the service would meet teaching physician supervision requirements.

Eligible Providers:

- Qualified occupational therapist, qualified physical therapists, qualified speech language pathologist, and qualified audiologists may continue to be telehealth providers.
- The CAA also mandated coverage for marriage and family therapists (MFTs) and mental Health counselors (MHCs) effective January 1, 2024. These clinicians will be able to perform their services via telehealth.

Telehealth Home Address Enrollment:

- Through CY 2024, CMS will continue to permit a distant site practitioner to use their currently enrolled practice location instead of their home address when providing telehealth services from their home.

Behavioral Health Services – MFTs, MHCs

- Congress mandated Medicare provide payment for Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs) effective 1/1/24.
- The payment rate will be set at 75% of the amount determined for payment of a psychologist. (Psychologists paid at 100% of fee schedule amount).
- MFTs and MHCs may report code G0323 (Care management services for behavioral health conditions) and will add them as billing clinicians.
- Health Behavior Assessment and Intervention (HBAI) services described by CPT codes 96156, 96158, 96159, 96164, 96165, 96167, and 96168, and any successor codes, to be billed by clinical social workers, MFTs, and MHCs, in addition to clinical psychologists.
- Finalizing an increase in the valuation for timed behavioral health services and psychotherapy services billed with an E/M code. Will be implemented over a 4-year transition period.

New Services for Vulnerable Patients – SDOH Risk Assessment

CMS defines SDOH as:

- *"...including but not limited to food insecurity, transportation insecurity, housing insecurity, and unreliable access to public utilities, when they significantly limit the practitioner's ability to diagnose or treat the problem(s)."*
- In cases where the patient suffers from a "serious, high-risk illness" like cancer and is limited by SDOH, a practitioner must dedicate significant time and resources to ensure the patient can access the right care.
- To better characterize the work of combatting health-related social barriers, CMS proposes new reimbursement codes for three types of services:
    1. SDOH risk assessment
    2. Community health integration (CHI) services
    3. Principal illness navigation (PIN)

Auxiliary staff can provide all 3 services "incident to" a billing practitioner's professional services under "general supervision."

Identifying Social Determinants of Health Needs

- New SDOH Risk Assessment code to provide reimbursement for the additional effort and resources needed to address a patient's SDOH needs.
- **HCPCS G0136** – *Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, not more often than every 6 months.*
- Practitioners can use this code to bill for an SDOH risk assessment that includes food insecurity, housing insecurity, transportation needs, and utility difficulties. A practitioner would be able to bill G0136 in conjunction with (and on the same day as) an E/M visit.
- The SDOH assessment optional in a patient's Annual Wellness Visit (AWV).

CMS is finalizing codes and payment for SDOH services.

New Services for Vulnerable Patients - CHI

Similar to other care management programs, Community Health Integration (CHI) services would be furnished monthly and facilitated by certified or trained auxiliary staff, including community health workers (CHWs), under the general supervision of the billing practitioner.

- The initiating visit would be separately billable, but certain E/M visits like inpatient/observation visits, emergency room visits, and skilled nursing facility visits would not qualify as a CHI initiating visit.
- **HCPCS G0019** – *Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities to address social determinants of health (SDOH) need(s) that are significantly limiting ability to diagnose or treat problem(s) addressed in an initiating E/M visit.*
- **HCPCS G0022** – *Community health integration services, each additional 30 minutes per calendar month.*

CMS is finalizing codes and payment for CHI services.

New Services for Vulnerable Patients - PIN

CMS is proposing 2 new codes for Principal Illness Navigation to allow reimbursement for auxiliary support staff like patient navigators or certified peer specialists who provide guidance services to patients. Patient eligibility requirements may be similar to those of the existing Principal Care Management (PIN) services:

- One serious, high-risk disease expected to last at least 3 months that places the patient at significant risk of hospitalization or nursing home placement, acute exacerbation/decompensation, functional decline, or death; and
- The condition requires development, monitoring, or revision of a disease-specific care plan, and may require frequent adjustment in the medication or treatment regimen, or substantial assistance from a caregiver.

HCPCS G0023 – *Principal Illness Navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator or certified peer specialist; 60 minutes per calendar month.*

HCPCS G0024 – *Principal Illness Navigation services, additional 30 minutes per calendar month.*

The following activities classify as Principal Illness Navigation services:

- Person-centered assessment
- Identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services
- Practitioner, Home, and Community-Based Care Coordination
- Facilitating behavioral change
- Health education
- Building patient self-advocacy skills
- Healthcare access/health system navigation
- Facilitating and providing social and emotional support

CMS is finalizing codes and payment for PIN services.

Caregiver Training Services (CTS)

- 3 new CPT® codes.
- These will allow physicians and other qualified health care professionals – NP, PA, CNS, CNM, CP, PT, OT, SLP) to provide training for caregivers of patients.
- Training for caregivers of an individual patient to facilitate the patient's functional performance in their home and community relating to activities of daily living (adls), instrumental adls (iadls), transfers, mobility, communication, swallowing, feeding, problem solving, safety practices (without the patient present).
- Group training for caregivers caring for different patients.

- CPT 97550 – Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community.., face-to-face; initial 30 minutes
- CPT 97551 - Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community.., face-to-face; each additional 15 minutes
- CPT 97552 - Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community.., face-to-face with multiple sets of caregivers

Proposed Scope of Practice Changes

Proposed APP Scope of Practice Changes

- 8 states are considering changes to advanced practitioners' scope of practice and practice requirements to address the ongoing staffing crisis
  - Montana is considering a bill that would allow physician assistants to practice without a supervision agreement
  - In New Jersey, a bill currently in committee seeks to increase an advanced practice nurses' scope to include writing prescriptions and practice as a physician
- Nationally, 2 bills have been proposed that would expand the authority of nurse practitioners and other advanced practice registered nurses
- 60 bills that seek to broaden pharmacists' scope of practice, which "would allow pharmacists to prescribe medications to patients based solely on a test performed at the pharmacy."

https://www.beckershospitalreview.com/hospital-physician-relationships/7-states-considering-scope-of-practice-changes.html

2024 Audit Risk Areas

Risk Areas for Providers

- Shared/Split E/M services
- Incident- to services
- Use of modifier 25
- Wellness and preventive services with a problem-oriented visit
- High levels of E/M services
- Scope of Practice
- Medical necessity
- Overutilization
- Insufficient documentation
- Critical Care Services
- Telehealth compliance
- Opioid prescribing practices
- Home health services

Current OIG and Payer Audits

- Fee for Time Compensation Arrangements
- Hyaluronan or Derivative, Gel-One or Monovisc, for Intra-Articular Injection
- Medicare Annual Wellness Visits
- Psychiatric Diagnostic Evaluation
- Psychotherapy
- DME and Home Infusion Therapy
- Genetic Testing
- Outpatient Physical Therapy, Occupational Therapy, and/or Speech Language Pathology

Audit Strategies

1. Provider receives written notice of the audit outlining the time period and documents requested.
   a) A point person should be put in charge and the relevant documents immediately gathered
   b) Provider needs to be counseled against changing the requested documents in any way.
2. Counsel may recommend conducting a shadow audit to see if coding, documentation or other issues can be identified.
3. Also, advisable to establish a dialog with the auditor to get a sense of the scope of the issues.
4. Consult with an expert, if necessary.
5. Providers need to submit requested documents/meet deadlines:
   a) MACs, CERT, SMRC, UPICs and RACs have the discretion to grant extensions to providers who need more time to comply with the request;
   b) They are instructed to deny claims as not reasonable and necessary when the requested documentation is not received by the expected timeframe (including any applicable extensions).
   c) Reach out as soon as you think you may need an extension.
6. Only send what was requested.

QUESTIONS

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