APRIL 29, 2024

Key Updates in the CY 2024 Outpatient Prospective Payment System (OPPS) and Medicare Physician Fee Schedule (MPFS) Final Rules

Presented by: ***Amy Rinkle, Nimitt Consulting***

nimitt CONSULTING

Health Policy Partners

Agenda:
OPPS Final Rule

- OPPS overall payment update
- APC and C-APC updates
- Devices, drugs, and biologicals
- Passthrough payment
- 340B purchasing program
- Discarded drug policy updates: modifiers JZ and JW
- Inpatient-only list (IPO)
- Supervision of cardiac rehab, intensive cardiac rehab, and pulmonary rehab
- Dental coverage and payment issues
- Price transparency
- OPPS topics with no policy changes

CY 2024 conversion factor and outlier payment updates

- Final **3.1%** percent increase
  - Market basket percentage increase of **3.0%**
  - **-0.2%** - reduction due to the multifactor productivity adjustment
- CMS finalized the fixed-dollar threshold for outliers at **$7,750** (compared to *$8,625* in CY 2023)
  - CMS incorrectly published $8,350 as the proposed threshold, when it should have been proposed as $6,875

TABLE 168: ESTIMATED IMPACT OF THE FINAL CY 2024 CHANGES FOR THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

	(1)	(2)	(3)	(4)	(5)
	Number of Hospitals	APC Recalibration (all changes)	New Wage Index and Provider Adjustments	All Budget Neutral Changes (combined cols 2 & 3) with Market Basket Update	All Changes
ALL PROVIDERS *	3,611	0.0	0.1	3.2	3.2
ALL HOSPITALS	3,511	0.1	0.2	3.4	3.3
(excludes hospitals held harmless and CMHCs)					
URBAN HOSPITALS	2,801	0.1	0.1	3.2	3.2
LARGE URBAN	1,452	0.0	-0.1	3.0	3.1
(GT 1 MILL.)					
OTHER URBAN	1,349	0.1	0.3	3.4	3.2
(LE 1 MILL.)					
RURAL HOSPITALS	710	0.3	1.2	4.6	4.2
SOLE COMMUNITY	373	0.1	1.5	4.8	4.3
OTHER RURAL	337	0.5	0.6	4.3	4.2
BEDS (URBAN)					

APC and C-APC updates

- Annually, CMS reconfigures and recalibrates the APC groupings, relative weights and conversion factor based on claims data
  - CMS used CY 2022 claims data with cost report data from CY 2021 to set CY 2024 OPPS rates
    - This is a return to CMS' typical rate-setting process: data from 2 years prior is used to set rates, just as it was prior to the Public Health Emergency (PHE)
  - CMS is changing the mapping of specified CAR-T-related revenue codes to clinic, hematology, IV therapy, and drug cost centers as proposed
- The conversion factor (after all budget neutrality adjustments) is **$87.382**

APC co-insurance deviations

- In the final rule addenda, three APCs continue to have a co-insurance higher than 20%
  - APC 5166 - Cochlear Implant Procedure: 21.83%
  - APC 5191 - Level 1 Endovascular Procedure: 27.64%
  - APC 5611 - Level 1 Therapeutic Radiation Treatment Preparation: 23.91%
- Addendums A and B also have a new “Note” column with coinsurances less than 20%
  - Copayments are capped at the inpatient deductible of $1,600
  - Copayments are capped at the inflation-adjusted coinsurance amount (drugs only)
  - Also, in the “Note” column biosimilars paid ASP plus 8% of reference product’s ASP
- Colorectal cancer screening tests that result in biopsy have a coinsurance set at 15% for CY 2023 – CY 2026

Comprehensive APC (C-APC) updates

- CMS did not propose to convert any APCs into C-APCs, but did finalize splitting two current C-APC into additional C-APCs, bringing the total number of C-APCs to **72**
  - CMS split C-APC 5492 (Level 2 intraocular Procedures), effectively adding new C-APC 5493 (Level 3 Intraocular Procedures) and shifting C-APCs 5493, 5494, and 5495 to Levels 4, 5, and 6 respectively (see Appendix A for slide on procedure-to-procedure edits for interocular procedures for APC 5496)
  - CMS split C-APC 5341 (Abdominal/Peritoneal/Biliary and Related Procedures) to C-APC 5341 and 5342 (Level 1 and Level 2 Abdominal/Peritoneal/Biliary and Related Procedures) respectively
  - Table 2, published with the rule, has the full list of final C-APCs for CY 2024
- CMS is continuing to exclude New Technology APCs (APCs 1491 through 1599 and APCs 1901 through 1908), and drugs coded with C9399, from packaging into C-APCs
- There are 38 codes assigned to new technology APCs, including 2 new codes and 9 with a change in APC

Transitional passthrough payment for devices

- CMS received six applications for device pass-through payments, and finalized four:
  - CavaClear Inferior Vena Cava (IVC) Filter Removal Laser Sheath
  - Cerament® G – approved for IPPS New Technology Add-on Payment for FY2024
  - Ambu® aScopeTM 5 Broncho HD
  - FLEX Vessel PrepTM System
  - *Praxis Medical CytoCore (not finalized)*
  - *EchoTip® (not finalized)*
- Table 84, published with the rule, has a list of the 15 current pass-through devices, with expiration dates

Passthrough and non-passthrough drugs and biologicals

- Passthrough status for 43 drugs and biologicals expired during CY 2023
- Passthrough status for 25 drugs and biologicals expires in CY 2024:
  - 3 on 3/31/24 (1Q)
  - 11 on 6/30/24 (2Q)
  - 6 on 9/30/24 (3Q)
  - 5 on 12/31/24 (4Q)
- Pass-through status for 42 drugs and biologicals will continue through CY 2024
- Non-passthrough drugs and biologicals receive separate payment when the per day cost is above final packaging threshold
  - The threshold remains at $135 for CY 2024

Reminder: policies related to biosimilars and OPPS

- **Inflation Reduction Act:** Payment limit for new biosimilars furnished on or after July 1, 2024, when ASP data are not available is the lesser of:
  - Not to exceed 103% of the Wholesale Acquisition Cost (WAC) or the Part B drug payment methodology in effect on November 1, 2003
  - 106% of the lesser of the WAC or ASP of the reference biological, or in the case of a selected drug during a price applicability period, 106% of the maximum fair price of the reference biological
- **Inflation Reduction Act:** Temporary payment increase for biosimilar biological products with an ASP less than the ASP of the reference biological during an applicable period
  - Payment increase: ASP plus 8% of the reference biological's ASP
  - Applicable period for biosimilar paid ASP prior to 9/30/22: 5-years beginning 10/1/22
  - Applicable period for biosimilars first paid ASP 10/1/22-12/31/27: 5-year period beginning on the first day of the first quarter of ASP payment
- OPPS packaging threshold applied to a reference product is applied in the same manner to biosimilars

340B drug payment policy

- CMS published a separate final rule on November 2, 2023 (CMS-1793-F) with a repayment remedy for drugs paid at the overturned rate of ASP minus 22.5% for CY 2018-2022
  - **$9 billion** owed to 1,600 affected hospitals
    - One lump sum payment: amount is published in Addendum AAA
    - No beneficiary copayments will apply
  - **$7.8 billion** in additional non-drug payments to provider that need to be recouped
    - Finalized a 0.5% adjustment to the OPPS conversion factor starting in CY 2026
    - CMS estimates this adjustment will take approximately 16 years
    - Exception from reduction for ~300 new providers enrolled after January 1, 2018 – list published in Addendum BBB
      - This would result in 2 conversion factors, it's unclear how this will be implemented
- *April 18, 2024* – HHS published a final rule on 340B administrative dispute resolution process for manufacturers and providers

Single use package reporting modifiers (JW, JZ)

- HCPCS modifier implementation for wastage is continuing, no major policy changes:
  - -JW required January 1, 2023 (previously implemented through sub-regulatory guidance in 2017)
  - -JZ effective January 1, 2023, required July 1, 2023
  - -JW/-JZ not used between July 1, 2023, and September 30, 2023, subject to provider audits
  - -JW/-JZ editing October 1, 2023 (returned as un-processable, rejection)

Refresher: single use packaging reporting

Applies to “single-dose container or single-use package drugs” (based on FDA-approved labeling)

- FDA labeling “typically” includes an instruction to discard unused portions
- This definition includes drugs labeled as part of a kit that is intended for single dose or single use

This applies to **all** single dose containers separately payable under Part B, **it is not** limited to those subject to the refund requirement

- HOPD: applies to drugs with status indicator G or K; does not apply to drugs that are not separately payable under Part B (i.e., status indictor N for HOPD and N1 for ASCs)
- CY 2024 MPFS Final Rule: for drugs furnished under Part B but not administered by the provider, the provider should append modifier -JZ to ensure edits aren’t applied inappropriately

Note: a refresher slide on calculating and documenting wastage is in Appendix A

Devices, drugs, and biologicals: additional OPPS policies

- **Non-Opioid Treatments for Pain Relief**
  - CAA of 2023 mandates separate/additional payment for OPPS during CY 2025 – CY 2028
- **Diagnostic Radiopharmaceuticals**
  - Expensive new radiopharmaceuticals are policy packaged after pass-through status expires
  - May be barrier beneficiary access to advanced tests using new radiopharmaceuticals
  - CMS sought comments on barriers for patients, and new payment approaches, but did not make any specific proposals and did not finalize any changes
- **Self-administered drugs**
  - RFI on definitions and policies – received lots of responses and will consider for future
- **Non-chemotherapy complex drug infusions**
  - RFI related to coding with therapeutic vs. chemo drug infusion codes – received lots of comments and will consider for future

Inpatient-only list (IPO)

- 9 new CPT codes are to be added to the inpatient-only procedure list
- 1 code is being reassigned from E1 to the IOP list

TABLE 103: CHANGES TO THE INPATIENT ONLY (IPO) LIST FOR CY 2024

CY 2024 CPT Code	CY 2024 Long Descriptor	Action	CY 2024 Final Status Indicator
0790T	Revision (e.g., augmentation, division of tether), replacement, or removal of thoracolumbar or lumbar vertebral body tethering, including thoracoscopy, when performed	Add to the IPO list	C
22836	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; up to 7 vertebral segments	Add to the IPO list	C
22837	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; 8 or more vertebral segments	Add to the IPO list	C
22838	Revision (e.g., augmentation, division of tether), replacement, or removal of thoracic vertebral body tethering, including thoracoscopy, when performed	Add to the IPO list	C
61889	Insertion of skull-mounted cranial neurostimulator pulse generator or receiver, including craniectomy or craniotomy, when performed, with direct or inductive coupling, with connection to depth and/or cortical strip electrode array(s)	Add to the IPO list	C
76984	Ultrasound, intraoperative thoracic aorta (e.g., epiaortic), diagnostic	Add to the IPO list	C
76987	Intraoperative epicardial cardiac (e.g., echocardiography) ultrasound for congenital heart disease, diagnostic; including placement and manipulation of transducer, image acquisition, interpretation and report	Add to the IPO list	C
76988	Intraoperative epicardial cardiac ultrasound (ie, echocardiography) for congenital heart disease, diagnostic; placement, manipulation of transducer, and image acquisition only	Add to the IPO list	C
76989	Intraoperative epicardial cardiac ultrasound (ie, echocardiography) for congenital heart disease, diagnostic; interpretation and report only	Add to the IPO list	C
0646T	Transcatheter tricuspid valve implantation (ttvi)/replacement with prosthetic valve, percutaneous approach, including right heart catheterization, temporary pacemaker insertion, and selective right ventricular or right atrial angiography, when performed	Add to the IPO list	C

Supervision of CR, ICR, and PR

- CMS finalized amending supervision requirements for Cardiac Rehab (CR), Intensive Cardiac Rehab (ICR) and Pulmonary Rehab (PR)
  - Required under BBA of 2018, effective January 1, 2024
  - Adding physician assistants (PAs), nurse practitioners (NPs), and clinical nurse specialists (CNS) to supervision provision of CR, ICR, and PR
  - MPFS: amending §§ 410.47 and 410.49
  - OPPS: conforming changes to 410.27 section on direct supervision of CR, ICR, PR
    - To remove MD/DO requirement for supervision of CR, ICR, and PR
    - Add non-physician practitioner to the section on virtual presence through audio/video real-time communication
    - Extend the virtual presence exception through 12/31/24 to match extension under the CAA of 223

Payment of ICR in off-campus departments

Payment disparity for ICR between in the physician office setting and off-campus PBDs	ICR in physician office is paid 100% of the OPPS rate for CR ($120.47 CY23) …BUT ICR in an off-campus non-excepted PBD (i.e., billed with modifier PN) is paid 40% of the OPPS rate ($48.03 CY 2023)
CMS finalized exclude G0422 and G0423 for ICR from the off-campus adjustment regardless of the presence of the PN modifier	Result is payment at 100% of the OPPS amount

CMS received numerous comments on other services paid at the OPPS rate under MPFS (including imaging) creating a similar disparity, but did not accept comments and made no other proposals

16

Dental coverage and payment

- Though these were topics in MPFS, we are discussing in the context of OPPS as it impacts facility payment for these services
- In the CY 2023 MPFS Final Rule CMS distinguished
  - The "*care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth*" which are excluded services; and
  - Dental services that are so integral to medically necessary services that they are NOT considered provided in connection with exclude dental services
    - "*Inextricably linked*" to the clinical success of otherwise covered medical services and "substantially related and integral" to that primary medical service
- In the CY 2024 MPFS Final Rule, CMS said:
  - That dental services should be covered when "*the standard of care for that medical service would be compromised or require dental services to be performed in conjunction with the covered services*" or if the dental services are considered to be "*a critical clinical precondition to proceeding with the primary medical procedure or treatment*" if the patient does not receive dental care services

Dental coverage and payment (cont.)

- In the CY2023 MPFS Final Rule CMS applied inextricably linked coverage to
  - Organ transplants, cardiac valve replacement, and valvuloplasty for CY 2023
  - Stem cell transplants for CY 2023
  - Services related to treatment of head and neck cancer (for CY 2024)
- CMS also finalized a process to submit additional services for consideration
- In the CY 2024 MPFS Final Rule, CMS is proposing to expand covered dental services to include dental/oral examination as part of comprehensive work-up prior to and medically necessary diagnostic and treatment services to eliminate oral/dental infection prior to or during:
  - Chemotherapy when used in the treatment of cancer
  - CAR-T cell therapy, when used in the treatment of cancer
  - Administration of high-dose bone-modifying agents (antiresorptive therapy) when used in the treatment of cancer
- For head and neck cancers, CMS also finalized **post-treatment dental services for a period determined by the clinician**

Dental coverage and payment (cont.)

- CMS finalized new language in §411.15

(A) Dental or oral examination performed as part of a comprehensive workup prior to, and medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to, or contemporaneously with, the following Medicare-covered services: organ transplant, hematopoietic stem cell transplant, bone marrow transplant, cardiac valve replacement, valvuloplasty procedures, chemotherapy when used in the treatment of cancer, chimeric antigen receptor (CAR) T-cell therapy when used in the treatment of cancer, and administration of high-dose bone-modifying agents (antiresorptive therapy) when used in the treatment of cancer.

(E) Dental or oral examination performed as part of a comprehensive workup prior to, medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to or contemporaneously with, and medically necessary diagnostic and treatment services to address dental or oral complications after, treatment of head and neck cancer using radiation, chemotherapy, surgery, or any combination of these.

- Dentists & oral surgeons can enroll directly in Medicare or work "incident to" other clinicians enrolled in Medicare
- CMS has a webpage for dental services at https://www.cms.gov/medicare/coverage/dental
- In the CY 2023 OPPS Final Rule, CMS finalized 57 CDT codes, 41899 and G0330, facility services for dental rehabilitation procedures performed on a patient who requires monitored anesthesia and use of an operating room with SI of S, and a payment rate of $1,722.43

Dental coverage and payment (cont.)

- In the CY 2024 OPPS Final Rule, CMS finalized:
  - Assigning 240 dental codes to clinical APCs, which CMS identified may describe service covered under adopted coverage policies
  - If a CDT code describes a service that has an existing CPT code, CMS clarified hospitals use the CPT code even if in OR or under anesthesia
    - If no CDT/CPT code for the service, then use G0330 for OR/anesthesia
  - "*We are clarifying that providers should bill any other more specific CPT and/or CDT codes assigned to APCs that describe the service performed, instead of HCPCS code G0330, whenever possible. HCPCS code G0330 should only be billed when no other, more specific code is available to describe the service performed*."
- Reemphasized that services must meet coverage requirements discussed in the MPFS CY 2023 and CY 2024 final rules

Price transparency

- CMS proposed and finalized numerous price transparency changes in the CY 2024 OPPS final rule
- One of the most important was additional requirements geared towards standardizing the Machine Readable File (MRF) of charges that hospitals must post
- CMS finalized that hospitals must display standard charges using a CMS template, similar to the sample templates currently provided:
  - CSV “wide” format
  - CSV “tall” format
  - JSON schema
- “Encode” standard charge information in four required data element categories
  - General information regarding the file
  - Hospital-specific information
  - Types of charges (gross charge, discounted cash price, payer-specific negotiated charge and min and max negotiated rates) and estimated allowed amounts (only discussed in final rule)
  - Data elements that “enhance understanding of the items and services”

Price transparency (cont.)

- In the MRF, CMS is finalizing further standards around the display of types of charges
  - Payer negotiated charges would require:
    - Payer/plan name
    - Type of contracting method
    - Whether displayed amount is a defined dollar amount or based on percentage or algorithm
      - If percentage or algorithm, a consumer-friendly expected allowed amount in dollars
  - Elements to enhance understanding
    - Facility vs. professional charges, and inpatient vs. outpatient
    - “Billing” codes, revenue codes, and modifiers, including drug specific units of measure

Price transparency (cont.)

- CMS also finalized requirements around the “accessibility” of the MRF, such as:
  - Including a .txt (text) file in the root folder of the publicly available website that points to where the MRF is posted, which would include the URL for the MPF and which page links to the file
  - Having a footer on the hospital’s homepage to link to the webpage with the MPRF
- CMS finalized definitions for “CMS Template”. “consumer-friendly expected allowed amount”, “encode”, “MRF”, and confirming that “file” means “digital file”
- There would also be an attestation required of hospitals as to the accuracy and completeness of the MRF, as of the date of posting
- All requirements are effective starting CY 2024, but in response to comments, CMS changed its “grace period” for compliance to allow for 2 months, meaning only past March 1, 2024, would enforcement become effective, and would be phased in

Enforcement timelines for price transparency

TABLE 151A: Implementation Timeline for CMS Template Adoption and Encoding Data Elements

Requirement	Regulation cite	Implementation (Compliance) Date
MRF INFORMATION		
MRF Date	45 CFR 180.50(b)(2)(i)(B)	July 1, 2024
CMS Template Version	45 CFR 180.50(b)(2)(i)(B)	July 1, 2024
HOSPITAL INFORMATION		
Hospital Name	45 CFR 180.50(b)(2)(i)(A)	July 1, 2024
Hospital Location(s)	45 CFR 180.50(b)(2)(i)(A)	July 1, 2024
Hospital Address(es)	45 CFR 180.50(b)(2)(i)(A)	July 1, 2024
Hospital Licensure Information	45 CFR 180.50(b)(2)(i)(A)	July 1, 2024
STANDARD CHARGES		
Gross Charge	45 CFR 180.50(b)(2)(ii)	July 1, 2024
Discounted Cash	45 CFR 180.50(b)(2)(ii)	July 1, 2024
Payer Name	45 CFR 180.50(b)(2)(ii)(A)	July 1, 2024
Plan Name	45 CFR 180.50(b)(2)(ii)(A)	July 1, 2024
Standard Charge Method	45 CFR 180.50(b)(2)(ii)(B)	July 1, 2024
Payer-Specific Negotiated Charge –Dollar Amount	45 CFR 180.50(b)(2)(ii)(C)	July 1, 2024
Payer-Specific Negotiated Charge – Percentage	45 CFR 180.50(b)(2)(ii)(C)	July 1, 2024
Payer-Specific Negotiated Charge – Algorithm	45 CFR 180.50(b)(2)(ii)(C)	July 1, 2024
Estimated Allowed Amount	45 CFR 180.50(b)(2)(ii)(C)	January 1, 2025
De-identified Minimum Negotiated Charge	45 CFR 180.50(b)(2)(ii)	July 1, 2024
De-identified Maximum Negotiated Charge	45 CFR 180.50(b)(2)(ii)	July 1, 2024
ITEM & SERVICE INFORMATION		
General Description	45 CFR 180.50(b)(2)(iii)(A)	July 1, 2024
Setting	45 CFR 180.50(b)(2)(iii)(B)	July 1, 2024
Drug Unit of Measurement	45 CFR 180.50(b)(2)(iii)(C)	January 1, 2025
Drug Type of Measurement	45 CFR 180.50 (b)(2)(iii)(C)	January 1, 2025
CODING INFORMATION		
Billing/Accounting Code	45 CFR 180.50(b)(2)(iv)(A)	July 1, 2024
Code Type	45 CFR 180.50(b)(2)(iv)(B)	July 1, 2024
Modifiers	45 CFR 180.50(b)(2)(iv)(C)	January 1, 2025

TABLE 151B: Implementation Timeline for Other New Hospital Price Transparency Requirements

Requirement	Regulation Cite	Implementation (Compliance) Date
Good faith effort	45 CFR 180.50(a)(3)(i)	January 1, 2024
Affirmation in the MRF	45 CFR 180.50(a)(3)(ii)	July 1, 2024
Txt file	45 CFR 180.50(d)(6)(i)	January 1, 2024
Footer link	45 CFR 180.50(d)(6)(ii)	January 1, 2024

Price transparency enforcement (cont.)

- CMS finalized requiring an authorized hospital official submit to CMS a certification to the accuracy and completeness of the standard charge information – at any stage of the monitoring, assessment or compliance phase
  - This is in addition to the "attestation" required within the MRF
  - CMS indicates this may be necessary in the case of a complainant alleges information is missing, to assure CMS the official has verified the information is complete
  - In a separate final regulation, CMS stated that hospitals would have to provide to the documentation necessary to assess the hospital's compliance
    - CMS indicates this may include contracting documentation
- Hospitals will also be required to acknowledge warning notices "in the form and manner, and by the deadline" specified in the notice of violation

Price transparency enforcement (cont.)

- CMS states that if it takes action against a hospital AND determine the hospital is part of a health system, CMS may:
  - Contact the leadership of the system
  - Work with the system to address similar deficiencies for hospitals across the system
- CMS plans to use data from the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) or the Chronic Conditions Data Warehouse (CCW) to determine if a hospital is part of a system and health system contact information
- CMS will publish on its website information on assessment of hospital's compliance, compliance actions taken again a hospital, status of those actions, the outcome, and any notices to health system leadership

OPPS topics with no policy changes

- Composite APCs
- Reporting no cost/full credit and partial credit devices
- Overall payment methodology for drugs and drug administration (except as discussed earlier in this deck)
- Clinical and emergency department visits and critical care services
- Prior authorization for outpatient surgical services

Agenda:
MPFS Final Rule

- Payment update
- E/M shared/split visits and E/M add-on
- The end of Appropriate Use Criteria (AUC)
- Telehealth extensions
- Care management and Principal Illness Navigation (PIN)
- Caregiver Training Services (CTS)

CY 2024 MPFS final rule payment update

- Final 2024 conversion factor = **$32.7442**
  - This is not $32.7375 as published – AMA caught the error and CMS confirmed (CY 2023 CF is $33.89, for comparison)
  - This is a decrease of $1.15 (3.37%)
    - 1.25% payment reduction mandated by CAA 2023 for 2024
    - 2.12% reduction through budget neutrality adjustment for 2024

E/M shared/split visits and add-on

- Split (or shared) E/M visits refer to visits provided in part by physicians and in part by other nonphysician practitioners in hospitals and other institutional settings
- CMS is finalizing a revision to the definition of "substantive portion" of a split (or shared) visit to include the revisions to the CPT guidelines,
  - This means that for Medicare billing purposes, the "substantive portion" means more than half of the total time spent by the physician or nonphysician practitioner performing the split (or shared) visit, or a substantive part of the medical decision making
  - This responds to public comments asking that CMS allow either time or medical decision making to serve as the substantive portion of a split (or shared) visit
- CMS finalized a new code, G2211, for visit complexity inherent to E/M, associated with medical care services that serve as the continuing focal point for all needed services, or those that are part of ongoing care related to patient's single, serious condition or complex condition
  - This is an add-on cost, listed separately in addition to the office/outpatient E/M visit, but can't be billed with an E/M or other visit where the focus of the visit is a procedure or other service (instead of for longitudinal care, or a single, serious health condition)
- Based on feedback from commenters, CMS refined its utilization estimates for the code, which reduces the impact to the CY 2024 conversion factor by nearly a third from the impact described in the CY 2021 MPFS final rule

Appropriate User Criteria (AUC)

CMS is finalizing its proposal to essentially pause indefinitely (cancel) the AUC program

CMS is formally rescinding the current regulations for the AUC program at 42 CFR 414.94

In the final rule, CMS stated that they will continue efforts to identify a workable implementation approach, and any such approach would be proposed through subsequent rulemaking

Telehealth extensions

- In the final rule, the telehealth flexibilities in place for the PHE were extended until the end of CY 2024 (December 31, 2024)
- This includes:
  - Originating Sites Expansion
  - Eligible Telehealth Providers
  - Payment for Telehealth by FQHC and RHCs
  - Delay of In-person Visit Requirements for Mental Health Telehealth
  - Including in RHCs and FQHCs
  - Audio-only Telehealth (only for services on list permitted via audio-only)
- Updates for telehealth services include:
  - Services process of telehealth approval
    - Change from category 1, 2, or 3 to Permanent or Provisional
    - Currently on category 1 or 2 Final to be Permanent category
    - Temporary or category 3 codes Final to be Provisional category

Telehealth extensions (cont.)

- For CY 2024, CMS finalized:
  - Removing frequency limitations on subsequent inpatient and subsequent nursing facility visits and critical care consultation services
  - Continuing direct supervision via real-time audio and visual interactive telecommunications
  - Allowing Diabetes Self-Management Training (DSMT)
  - Eliminating in-person requirement for injection training
  - Allowing institutional providers to continue to bill claims for services rendered remotely by qualified staff (includes PT, OT, SLP, and Medical Nutrition Therapy in addition to DSMT)
- Starting CY 2024 (January 1, 2024):
  - Place of service (POS) 02 Telehealth other than patient's home continue at facility rate
  - Hospital POS and Modifier -95 for clinicians in hospital & patients at home
  - POS 10 Telehealth in patient's home (clinician at home or non-hospital location) paid at non-facility rate

Care management services

- CMS finalized three new sets of codes to expand care management services:
  - Community Health Integration (CHI)
  - Principal Illness Navigation (PIN)
  - Social Determinants of Health (SDOH) Risk Assessment
- CMS finalized payment for a set of AMA CPT codes for caregiver training services
  - CMS stated these codes are "incident to" a professional service
- Final rule page 311 states: "*As proposed, these services can only be furnished and billed by physicians and practitioners who can bill for services performed by auxiliary personnel incident to their professional services*."
  - Appears no professional billing; the OPPS rule discusses these services solely in the context of PHP/IOP

Community Health Integration (CHI)

- CMS finalized new CHI policies
- CMS defined CHI as:
  - Following initiating E/M
    - Not inpatient, SNF, or ED
    - Establishes plan of care
  - "Incident to" – seeking clarification from CMS given OPPS payment rates
  - Addressing SDOH factors that impact practitioner's ability to diagnose and treat health problem(s)
    - Document time spent and activities in relation to SDOH needs to address the problem
  - General supervision (Care management service)
  - Certified, trained auxiliary personnel
  - Patient consent required – verbal or written and documented in medical record

Community Health Integration (CHI) HCPCS codes

- As part of the CHI finalized policies, CMS finalized HCPCS codes
- **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*
  - *Person-centered assessments; Health education; Self-advocacy skills; Health navigation; Care coordination; Facilitating behavioral change; Social/emotional support; Leveraging lived experience
  - See the MPFS final rule for the full list of activities
- **G0022:** *Community health integration services, each additional 30 minutes per calendar month* (List separately in addition to G0019)

Principal Illness Navigation (PIN)

- CMS finalized new PIN policies, and defined PIN as:
  - Following initiating E/M & consent required
  - Addressing high-risk condition/illness/disease
    - One serious, high-risk condition expected to last 3 months
      - Significant risk of hospitalization, nursing home placement, acute exacerbation/decompensation, functional decline, or death
    - Condition requires development, monitoring, or revision of a disease-specific care plan, and may require frequent adjustment in medication or treatment regimen, or substantial assistance from a caregiver
  - Examples: cancer; COPD; CHF; dementia; HIV/AIDS, severe mental illness, or SUD

Principal Illness Navigation (PIN) HCPCS codes

- **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, in the following activities:*
  - *Person-centered assessments; Health education; Self-advocacy skills; Health navigation; Care coordination; Facilitating behavioral change; Social/emotional support; Leveraging lived experience*
  - *See page 382 for full description of activities
- **G0024:** *Principal Illness Navigation services, additional 30 minutes per calendar month* (List separately in addition to G0023)
- CMS is also finalizing two new codes, HCPCS code G0140 and HCPCS code G0146 for Principal Illness Navigation – Peer Support (PIN-PS)
- Given the nature of work typically performed by peer support specialists, CMS is limiting these codes to the treatment of behavioral health conditions that otherwise satisfy its definition of a high-risk condition(s)

Social Determinates of Health (SDOH) Assessment

- CMS finalized SDOH assessment (G0136) policies, and defined as:
  - Following initiating E/M, including AWV
  - Not a screening, must be performed based on evidence of at least one SDOH need
  - Using standardized assessment tool that assesses a minimum of housing, food, transportation and utility difficulties and documented in the medical record including using “Z codes” (Z55-Z65)

Social Determinants of Health (SDOH) risk assessment

- **G0136:** Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, not more often than every 6 months.
- The assessment described by this code must:
  - Be standardized, and evidence-based
    - CMS Accountable Health Communities, PRAPARE, instruments for Medicare Advantage Special Needs Population Health Risk Assessment
    - Include domains: Food insecurity, housing insecurity, transportation needs, and utility difficulties
  - Be billed by billing practitioner same day as an E/M
  - Document identified needs; May use Z-codes
  - Added to telehealth list

Caregiver Training Services (CTS)

- CMS finalized active payment for 3 AMA CPT codes for CTS:
  - **97550** (Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [IADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face-to-face; initial 30 minutes)
  - Add-on code, CPT code **97551** (each additional 15 minutes (List separately in addition to code for primary service) (Use 97551 in conjunction with 97550)), and
  - **97552** (Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [IADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face-to-face with multiple sets of caregivers).

Caregiver Training Services (CTS) (cont.)

- Definition of a caregiver: as "*an adult family member or other individual who has a significant relationship with, and who provides a broad range of assistance to, an individual with a chronic or other health condition, disability, or functional limitation" and "a family member, friend, or neighbor who provides unpaid assistance to a person with a chronic illness or disabling condition.*"
- CMS examples of conditions that may require a caregiver, including stroke, traumatic brain injury (TBI), various forms of dementia, autism spectrum disorders, individuals with other intellectual or cognitive disabilities, physical mobility limitations, or necessary use of assisted devices or mobility aids, **cell therapy, stem cell transplants, cancer**, ESRD, lymphedema
- The treatment plan should detail clinical circumstances where the treating practitioner believes a caregiver's involvement is necessary to ensure a successful outcome for the patient and where, as appropriate, the patient agrees to caregiver involvement
- CMS requires the treating practitioner (can be PT, OT, SLP) to document the need for each occurrence of CTS in the medical record
  - Treating practitioner must perform the CTS

Appendices

Appendix A – Additional OPPS updates

Appendix B – Behavioral health policies

Appendix C - Quality Payment Program (QPP) updates

APPENDIX A

Refresher: documenting and calculating wastage

Wastage should be documented in the patient's medical record

- No documentation is needed if no wastage for the use of the -JZ modifier
- CMS states general documentation instructions are in SE1316, but no longer posted

Calculate discarded amount by subtracting the dose administered from the labeled amount on the vial

- Dose is the administered amount
- Don't count overfill

Calculated on the actual purchased vial size and not the smallest vial for purchase

- Prior guidance in SE1316 had stated to bill only smallest available vial, CMS states this was superseded by MM9603 (but they also state to use SE1316 for general documentation guidance?)

APPENDIX A

OPPS procedure-to-device edits for intraocular procedures

- CMS finalized its proposal for a procedure-to-device edit for four procedures assigned to APC 5496 (Level 6 Intraocular Procedures)
  - Low-volume APC (fewer than 100 claims)
  - Variance in devices reported: $430.72 - $15,030.04
- CPT codes impacted by this change:
  - 0308T (Insertion of ocular telescope prosthesis) w/ C1840 (lens, intraocular [telescopic])
  - 0616T (Insertion of iris prosthesis w/o removal of lens) w/ C1839 (Iris prosthesis)
  - 0617T (Insertion of iris prosthesis w/ removal of lens) w/ C1839 (Iris prosthesis)
  - 0618T (Insertion of iris prosthesis w/ secondary lens) w/ C1839 (Iris prosthesis)

APPENDIX B

Partial Hospitalization Program

- **Finalized:**
  - Section 4124(a) of Division FF of the CAA, 2023 amends section 1861(ff)(1) of the Act
    - Define the PHP services beginning on of after January 1, 2024
      - Minimum of less than 20 hours per week included in the § 424.24(e)(1)(i).
      - Initial physician certification within 18 days and recertification no less than every 30 days (consistent with the CAA)
- Continue to apply current policies to calculate the four PHP APC per diem rates based on geometric mean per diem for CY 2014 and 2015
- CY 2016 - there was an extensive analysis of claims and cost data and ratesetting methodology to correct a cost inversion
- CY 2017 - continued with set policies to calculate rate and finalized a Level 1 and 3 PHP APCs for CMHCs and hospital-based PHP
- Implemented an 8% outlier cap for CHMCs to mitigate outlier billing vulnerabilities

APPENDIX B

Intensive outpatient program

- Established based on Section 4124 of the Consolidated Appropriations Act, 2023
- Services effective January 1, 2024
- Intensive outpatient services provided by CMHCs specifically as an “incident to a physicians’ service”
- Minimum of 9 hours per week and under the supervision of a physician
- Treatment plans and periodic review
- No requirement for inpatient psychiatric care services
- Distinct and organized ambulatory service offered by:
  - Hospitals, Community Mental Health Center, Rural Health Clinics, or Federally Qualified Health Centers

Intensive outpatient program (cont.)

- **Finalized:**
  - IOP Benefits that are reasonable and necessary for the diagnosis of the patient
    - Individual and group therapy with physicians and psychologists
    - Occupational therapy
    - Services by social workers, psychiatric nurses, drugs and biologicals for therapeutic purposes
    - Activity therapy
    - Family counseling
    - Patient training and education
    - Diagnostic services
  - Create regulations to establish requirements of coverage for IOP services furnished in CMHCs

Intensive outpatient program (cont.)

- **Finalized:**
  - Coverage under Medicare Part B services (incident to physician services at a hospital or CAH)
  - Certification requirement no less than every other month
  - Mirror the PHP certification and treatment plan content
  - Payment Rate for PHP/IOP:
    - Four separate PHP APC payment rates
      - CMHCs for 3 service days and CMHCs for 4 service days (APC 5853 $97.59 and APC 5854 $153.09)
      - Hospital PHPs for 3 service days and hospital-based PHPs for 4 service days (APC 5863 $284.00and APC 5864 $368.18)
      - HB PHPs calculate payment rate using the broader OPPS data set, which will allow CMS to capture data from claims not identified as PHP
  - Four separate IOP APC payment rates
    - CMHCs for 3 service days and one for CMHCs for 4 service days (APC 5851 and APC 5852)
    - Hospital based IOPs for 3 service days and Hospital based IOPs for 4 service days (APC 5861 and CPS 5862)

APPENDIX B

Intensive outpatient program (cont.)

- Coding for services:
  - NUBC new condition code of 92 for IOP claims
    - Used by hospitals and CMHCs
    - Code 41 will be used by hospitals for PHP claims
  - Removal of 90865 – Narcosyntheses from approved list for PHP
  - Add 18 new codes for PHP/IOP covered diagnosis
    - https://public-inspection.federalregister.gov/2023-14768.pdf (page 365)
- The following HCPCS codes describing services related to caregivers:
  - **96202** multiple -family group behavior management/modification training for parents(s) guardians(s) caregivers(s) with a mental or physical health diagnosis, administered by a physician or other QHP without the patient present, face to face up to 60 minutes.
  - **96203** each additional 15 minutes.
  - **96161** administration of caregiver -focused health risk assessment instrument (that is, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument.
  - **9X015** CAREGIVER TRAING 1ST 30 MIN
  - **9X016** CAREGIVER TRAING EA ADDL 15
  - **9X017** GROUP CAREGIVER TRAINING

APPENDIX B

Remote mental health – untimed group therapy

Feedback from parties to CMS:

- Administrative burden to report and document times codes for multiple group therapy sessions
- Request for one single code to be used when multiple group therapy sessions occur on the same day
- C79XX - Group psychotherapy service for diagnosis, evaluation, or treatment of a mental health or substance use disorder provided remotely by hospital staff who are licensed to provide mental health services under applicable State law(s), when the patient is in their home, and there is no associated professional service

HCPCS	Short Descriptor	Proposed SIP	Proposed Proxy Service	PFS Facility Rate	Proposed APC	APC GMC
C79XX	HOPD mntl hlt, grp	S	90853	$23.38	5821	$28.62

APPENDIX B

Remote mental health

- Final Descriptors for HCPCS codes C9700 and C9701

HCPCS	Proposed Long Descriptor
C7900	Service for diagnosis, evaluation, or treatment of a mental health or substance use disorder, 15 - 29 minutes, provided remotely by hospital staff who are licensed to provide mental health services under applicable State law (s), when the patient is in their home, and there is no associated professional service
C7901	Service for diagnosis, evaluation, or treatment of a mental health or substance use disorder, 30 - 60 minutes, provided remotely by hospital staff who are licensed to provide mental health services under applicable State law (s), when the patient is in their home, and there is no associated professional service
C7902	Service for diagnosis, evaluation, or treatment of a mental health or substance use disorder, each additional 15 minutes, provided remotely by hospital staff who are licensed to provide mental health services under applicable State law (s), when the patient is in their home, and there is no associated professional service (List seperately in addition to HCPCS code C9701)

APPENDIX B

Marriage and Family Therapist (MFT) Mental Health Counselors (MHC)

- **Marriage and Family Therapist (MFT)**
  - Master's/Doctorate degree qualifying for licensure or certification as MFT
  - Licensed or certified as MFT in state in which they are furnishing services
  - Performed at least 2 years post degree, supervised, clinical experience
  - Final as 2 years or 3000 hours (88 FR 52362)
  - Meets other requirements specified by the Secretary
- **Mental Health Counselor (MHC)**
  - Master's/Doctorate degree qualifying for licensure or certification as MHC
  - Licensed or certified as MHC in state in which they are furnishing services
  - Performed at least 2 years post degree, supervised, clinical experience
  - Final as 2 years or 3000 hours (88 FR 52363)
    - Meets other requirements specified by the Secretary
  - https://www.federalregister.gov/d/2023-14624/p-832
- Eligible to enroll after final rule with effective date on or after January 1, 2024

APPENDIX B

MFT / MHC Services

- CMS says that MFT/MHC services are furnished by MFT or MHC to diagnose and treat mental illness
  - Legally authorized under State law
  - Other than inpatient
  - Otherwise covered if furnished by physician or incident to a physician's professional services
    - https://www.federalregister.gov/d/2023-14624/p-832

In the final rule, CMS finalized that MFT/MHC services are:

- Paid 75% of the psychologist payment amount
- Add to telehealth eligible practitioners
- Add to list of NPPs to order diagnostic tests (within state law authorization)
- Added MFT and MHC services to RHC and FQHC definitions
  - Same policies and supervision as other RHC / FQHC NPPs
- Added MFT and MHC to Hospice interdisciplinary team (CSW, MFT or MHC)
- Allow addiction counselors meeting MHC requirements to enroll as MHCs
- Revision to Code G0323 to add MFT and MHC

APPENDIX B

Psychotherapy for crisis

- CAA 2023 required HCPCS codes for payment of psychotherapy in crisis
  - GPFC1: Psychotherapy for crisis furnished in an applicable site of service (any place of service at which non-facility rate for psychotherapy for crisis services applies, other than the office setting); first 60 minutes
  - GPFC2: Psychotherapy for crisis furnished in an applicable site of service (any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting); each additional 30 minutes
    - https://www.federalregister.gov/d/2023-14624/p-872
- Proposing fee schedule amount 150% current PFS of non-facility RVUs for 90839 and 90840
- Proposing to exclude from budget neutrality

APPENDIX C

Quality payment program (QPP) updates

- CMS is continuing to move forward with QPP modifications focused around MIPS Value Pathways (MVPs) in the CY 2024 Final Rule
- CMS finalized 5 new MVPs, with modifications to previously finalized MVPs for a total of 16 available for reporting in the 2024 performance period
- CMS finalized a 180 day minimum performance period for Promoting Interoperability under MIPS
- CMS finalized the Medicare Clinical Quality Measures (CQMs) for Accountable Care Organizations participating in the Medicare shared savings program collection type under the APM performance pathway
- CMS **did not** finalize its proposed change to the performance threshold, it will remain at 75 points for the CY 2024 performance year
- CMS also did not finalize changes to the data completeness threshold for the 2027 performance period, or making APM participation determinations at the individual clinical level