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CY 2024 Medicare Physician Fee Schedule Final Rule (CMS-1784-F)

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INTRODUCTORY SUMMARY AND BACKGROUND

On November 2, 2023, the Centers for Medicare & Medicaid Services (CMS) issued the final rule for the Medicare Physician Fee Schedule (MPFS) for Calendar Year (CY) 2024.

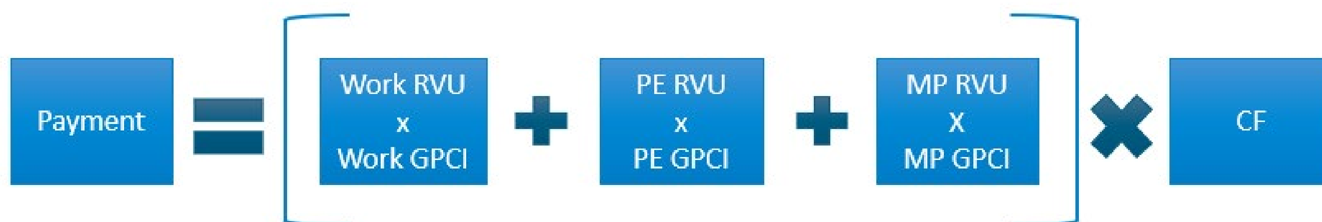
Since 1992, Medicare has paid for physician services under section 1848 of the Social Security Act entitled "Payment for Physicians' Services." This statute requires CMS to establish payments under the physician fee schedule (PFS) based on national uniform relative value units (RVUs) that account for the relative resources used in furnishing a service.

The statute requires that RVUs be established for three categories of resources:

- Work **(Work)** – services the physician provides.
- Practice Expense **(PE)** – resources that are used to provide physician services, such as office overhead and staff salaries.
- Malpractice **(MP)** expense – costs involved in malpractice insurance.

In addition, the statute requires CMS establish by regulation each year's payment amounts for all physicians' services paid under the PFS, incorporating geographic adjustments to reflect the variations in the costs of furnishing services in different geographic areas. This is referred to as the geographic practice cost indices **(GPCIs)**.

RVUs are converted to dollar amounts through the application of the conversion factor **(CF)**. The formula for calculating the MPFS is as follows:



MPFS Final Rule

The CY 2024 final rule is 2,709 pages in length and located in its entirety at the following link:

https://public-inspection.federalregister.gov/2023-24184.pdf.

The format of the following information is intended to serve as a summary of the proposed changes and readers are encouraged to view the document in its entirety for further details.

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CHANGES TO MPFS PAYMENT RATES

Conversion Factor (CF)

****NOTE**** The conversion factor (CF) published in Table 116 by CMS did not match the context of information preceding the table. On Friday November 3, 2023, the American Medical Association (AMA) sent out confirmation from CMS the information preceding Table 116 reflected the correct values, not in the information listed in the table. According to the AMA, "*CMS has confirmed to the AMA that the 2024 Medicare conversion factor is $32.7442, not $32.7375 as identified in Table 116 and as previously reported. The decrease from the 2023 conversion factor is 3.37%.*"

It is unclear if CMS will publish a different Table 116 or correction notice before the end of year, but the context preceding the table explains the estimated value for 2024, "*We estimate the CY 2024 PFS CF to be 32.7442 which reflects the -2.18 percent budget neutrality adjustment under section 1848(c)(2)(B)(ii)(II) of the Act, the 0.00 percent update adjustment factor specified under section 1848(d)(19) of the Act, and the 1.25 percent payment increase for services furnished in CY 2024, as provided in the CAA, 2023.*" This reflects the fact that the budget neutrality factor was listed in the table incorrectly, which then resulted in the wrong CF. Budget neutrality was listed correctly in Table 117 for the Anesthesia CF. This results in an estimated 3.7% reduction from 2023, not 3.4% as published by CMS within their Fact Sheet for the MPFS final rule. The following is information contained within Table 116, both the incorrect and correct values.

Calculation of the CY 2024 PFS Conversion Factor - Incorrect Values and Correct Values per CMS

Factors	**INCORRECT** Original Table 116 Values	**INCORRECT** Original Table 116 CF Results	CORRECT Values per CMS	CORRECT CF Results per CMS
CY 2023 Conversion Factor		33.8872		**33.8872**
Conversion Factor without the CAA, 2023 (2.5 Percent Increase for CY 2023)		33.0607		**33.0607**
CY 2024 RVU Budget Neutrality Adjustment	-2.20 percent (0.9780)		**-2.18 percent (0.9782)**	
CY 2024 1.25 Percent Increase Provided by the CAA, 2023	+1.25 percent (1.1025)		**+1.25 percent (1.1025)**	
CY 2024 Conversion Factor		32.7375		**32.7442**

Changes in RVUs

The lowering of the CF results in decreases for all services, but there are additional adjustments at the code level due to changes in the RUVs for the PE and MP. These RVU changes are not finalized to impact all specialties equally. Impacts to the RVUs are related to changes associated to RVUs for specific services resulting from the misvalued code initiative, including RVUs for new and revised codes. CMS does acknowledge the specialties of anesthesiology, interventional radiology, vascular surgery, thoracic surgery, physical/occupational therapy, and audiology, have decreases in payments, as opposed to other specialties. This is largely due to the revaluation of evaluation and management (E/M) services, and/or the third-year transition to updated clinical labor pricing, since their services generally rely on clinical labor for their Practice Expense (PE) costs. These increases are also due to proposed increases in value for specific services based on recommendations from the American Medical Association's (AMA's) Relative Value Scale Update Committee (RUC); CMS review; and increased payments resulting from updates to supply and equipment pricing.

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Table 118 outlines the combined payment impact per specialties including cardiac surgery, cardiology, interventional radiology and vascular surgery pertaining to the finalized RUV changes for CY 2024. These impacts reflect spending changes as a result of the budget neutrality adjustment. This is the adjustment when CMS must maintain a budget that is no more than $20 million above or below the set value. When it is estimated that spending will exceed the threshold, they will decrease spending in one area, or on specialties, and spend it in another area or for other specialties. The finalized changes for 2024 include the complexity add-on code G2211 and clinical labor update pricing. Any policies not subjected to budget neutrality are not reflected in the table of estimated impacts at specialty level:

TABLE 118: CY 2024 MPFS Estimated Impact on Total Allowed Charges by Specialty

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F)* Combined Impact
Cardiac Surgery	$175	-1%	-1%	0%	-2%
Cardiology	$6,015	0%	0%	0%	0%
Interventional Radiology	$458	-1%	-3%	0%	-4%
Vascular Surgery	$1,011	-1%	-3%	0%	-3%

* Column F may not equal the sum of columns C, D, and E due to rounding.

CMS has received requests to provide more detailed information which separates specialty-specific impacts by site of service. These requests reflect a need to update the information under the MPFS to account for current trends in healthcare delivery, particularly independent versus facility-based practices. To that end, CMS has provided this impact information in Table 119:

TABLE 119: CY 2024 MPFS Estimated Impact on Total Allowed Charges by Setting

(A) Specialty	(B) Total: Non-Facility/Facility	(C) Allowed Charges (mil)	(D) Combined Impact
Cardiac Surgery	*TOTAL*	$175	-2%
	Non-Facility	$34	-2%
	Facility	$141	-2%
Cardiology	*TOTAL*	$6,015	0%
	Non-Facility	$3,724	1%
	Facility	$2,292	-1%
Interventional Radiology	*TOTAL*	$458	-4%
	Non-Facility	$292	-5%
	Facility	$167	-3%
Vascular Surgery	*TOTAL*	$1,011	-3%
	Non-Facility	$725	-4%
	Facility	$286	-2%

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Allowed charges are the amounts for covered services provided by physicians, practitioners and suppliers within each specialty to generate the total allowed charges. These totals include coinsurance and deductibles, which are the beneficiary's financial responsibility.

CMS also provided an additional file, breaking down the impacted specialties by the estimated percent in weighted total RVUs:

Distribution of Practitioners by % Change in Total RVUs and IMPACT Specialty, (weighted by total RVUs) NPRM2024 (using 2022 CCW claims)

Impact Specialty		Practitioner RVUs (millions)	% Change in Total RVUs *per practitioner*										
			< -%20	-20% to < -10%	-10% to < -5%	-5% to < -2%	-2% to < -1%	-1% to < 1%	1% to < 2%	2% to < 5%	5% to < 10%	10% to < 20%	>=20%
Total		**2,589**	**Share of Total Practitioner RVUs in Specialty**										
3	Cardiac Surgery	5	0%	0%	0%	18%	**79%**	3%	0%	0%	0%	0%	0%
4	Cardiology	180	0%	0%	0%	10%	18%	**46%**	15%	10%	2%	0%	0%
20	Interventional Radiology	13	0%	0%	3%	**91%**	4%	2%	0%	0%	0%	0%	0%
42	Vascular Surgery	29	0%	0%	0%	**67%**	30%	3%	0%	0%	0%	0%	0%

Work RVUs

Work RVUs are established for new, revised and potentially misvalued codes based on a portion of resources used in furnishing the service that reflects physician time and intensity. CMS conducts a review that includes the current work RVU; RUC-recommended work RVU; intensity; time to furnish the preservice, intraservice, and postservice activities; and other components of the service that contribute to the value. For particular codes, CMS refines the work RVUs in direct proportion to the changes in the best information regarding the time resources involved to furnish particular services, considering the total time of the intraservice time. Common refinements include:

- Changes in work time
- Equipment time
- Standard tasks and minutes for clinical labor tasks
- Recommended items that are not direct PE inputs
- New supply and equipment items
- Service period clinical labor time in the facility setting
- Procedures subject to the multiple procedure payment reductions (MPPR) and OPPS cap

In each proposed rule, CMS seeks nominations from the public and interested parties of codes which they consider potentially misvalued. For CY 2024, CMS has identified multiple new, revised and potentially misvalued code categories for proposed and finalized valuation. See section entitled "**Valuation of Specific Codes for CY 2024**" below for detail

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Practice Expense (PE) RVUs

PE RVUs are developed by reviewing practice resources involved in providing each service and are comprised of direct and indirect PE. For direct PE (clinical staff, medical supplies, medical equipment), these costs are calculated based on inputs from the CMS PE database, generally centered on recommendations of the Relative Value Scale Update Committee (RUC). Indirect PE costs are developed primarily on the Physician Practice Expense Information Survey (PPIS). Implemented in CY 2010, the PPIS is a multispecialty, nationally representative, PE survey of both physicians and NPPs paid under the PFS.

For procedures provided in a physician's office or facility setting in which Medicare makes a separate payment to the facility, CMS establishes 2 PE RVUs: facility and nonfacility. In calculating PE RUVs for physician services provided in a facility, resources not typically utilized by physicians while providing services are excluded. Thus, facility PE RVUs are typically lower than nonfacility PE RUVs.

Diagnostic services are generally comprised of a professional component (PC); and a technical component (TC). The PC and TC may be furnished independently, by different providers, or together as a global service. Each component has a separate reimbursement; however, payment for the global service equals the sum of the payment for TC and PC. This is based on a weighted average of the ratio of direct to indirect costs across all specialties that provide the global service.

Payment modifiers are included in the creation of the PE MP RUV utilization files. These modifiers reflect current payment policy as implemented in claims processing. For example, services billed with the assistant at surgery modifiers are paid at 16 percent for a PFS service in which an assistant surgeon is allowed and has the assistant at surgery modifier appended to the code. This means the utilization file is modified to allow for 16 percent of the service that contains the assistant at surgery modifier. Table 3 below details how the modifiers are applied:

TABLE 3: Application of Payment Modifiers to Utilization Files

Modifier	Description	Volume Adjustment	Time Adjustment
80,81,82	Assistant at Surgery	16%	Intraoperative portion
AS	Assistant at Surgery – Physician Assistant	14% (85% * 16%)	Intraoperative portion
50 or LT and RT	Bilateral Surgery	150%	150% of work time
51	Multiple Procedure	50%	Intraoperative portion
52	Reduced Services	50%	50%
53	Discontinued Procedure	50%	50%
54	Intraoperative Care only	Preoperative + Intraoperative Percentages on the payment files used by Medicare contractors to process Medicare claims	Preoperative + Intraoperative portion
55	Postoperative Care only	Postoperative Percentage on the payment files used by Medicare contractors to process Medicare claims	Postoperative portion
62	Co-surgeons	62.5%	50%
66	Team Surgeons	33%	33%
CO, CQ	Physical and Occupational Therapy Assistant Services	88%	88%

Other adjustments are made, including volume and time that correspond to other payment rules such as special multiple procedure endoscopy rules and multiple procedure payment reductions (MPPRs). There are certain

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reduced payments for multiple imaging procedures and multiple therapy services which are not included in the development of the RVUs.

Malpractice (MP) RVUs

MP RVUs are considered to be resourced based, and required to be reviewed annually to more accurately represent and evaluate the mix of practitioners providing services on Medicare claims. There are three factors which are considered to determine MP RVUs for MPFS services:

1) Specialty-level risk factors derived from data on specialty-specific MP premiums incurred by practitioners;
2) Service-level risk factors derived from Medicare claims data of the weighted average risk factors of the specialties that furnish each service; and
3) Intensity/complexity of service adjustment to the service level risk factor based on either the higher of the work RVU or clinical labor RVU.

Effective beginning in CY 2020, CMS finalized their proposal that the values of the MP RVUs and MP GPCI be coordinated because the MP premium data used to update the MP GPCI is the same to determine the risk levels of the specialties. By aligning the updates, CMS believes this will increase efficiency in the reviews.

In CY 2023, CMS finalized the calculated MP RVUs based on MP data received from State insurance rate filings. The calculation methodology used for the review and update is similar to that of the CY 2020 update. CMS also finalized to improve and develop a more comprehensive data set when CMS specialty names are not clearly identified in the insurer filings by using rates mapped from the more commonly reported specialties within risk class. CMS has also finalized their proposal to create a specialty-level risk index for the calculation of MP RVUs. The determination of the service risk group structure change is reflective of patterns seen in the most current premium data. For some specialties, a single risk index value was applied to all services performed by those specialties.

CMS performed an analysis of the new risk index data and identified an impact threshold to incorporate the new information into their calculations while minimizing the impact on affected specialties – a reduction of approximately 1/3 to the risk index calculated for specialties based on the new specialty-specific premium data compared to the information previously used. Based on this, CMS finalized to phase in the reduction in MP RVUs over 3 years that precedes the next update by 1/3 of the change in the MP RVUs for those specialties in each year that have a 30 percent or greater threshold reduction in risk index value as a result of the update. This policy update still stands for CY 2024 and no new proposals were made for MP RVUs.

Geographic Practice Cost Indices (GPCIs)

CMS is required to develop separate GPCIs to measure cost differences among localities compared to the national average. CMS adjusts reimbursement to align with the cost of those services specific to where they were provided. This is done by applying the GPCI values for a specific area to each of the RVUs (work, practice expense, and malpractice). This is one of the reasons when discussing reimbursement, it is not always an apples-to-apples comparison with regard to how much is reimbursed from one location to another.

The current fee schedule areas are referred to as payment localities and are defined by state boundaries; metropolitan areas; portions of a metropolitan area; or rest-of state areas. There are currently 108 payment

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localities. This locality configuration is used to calculate GPCIs, that are in turn are used to calculate locality adjusted payment for physicians under MPFS.

The Consolidated Appropriations Act, 2021 (CAA 2021), required CMS to use a work GPCI floor of 1.000 through December 31, 2023. The finalized GPCIs for CY 2024 do not reflect 1.000 floor "base" values as they have for the last 3 years. The exceptions to this are Alaska, which continues the permanent 1.500 work GPCI; and the Frontier States (Montana, Wyoming, North Dakota, South Dakota and Nevada) which continue the permanent 1.000 floor for work RVUs as well.

The Protecting Access to Medicare Act (PAMA) modified fee schedule areas specific to the State of California. Changes which had been proposed in the CY 2023 proposed rule, were not finalized, but it was indicated they would be finalized for CY 2024. Additionally, CMS finalized new GPCIs beginning for CY 2023 and sought comments on refining several of the California locales as they are not transition areas. This would decrease the 32 California payment locales to 29, but there would be no payment implications under MPFS if the change was enacted.

Based on support from commenters, CMS finalized its proposal in the CY 2023 final rule to change several of the California locality identities, decreasing the 32 California payment locales to 29. The changes include:

- Recognize Los Angeles-Long Beach-Anaheim MSA (Metropolitan Statistical Area), which contains Orange and Los Angeles counties and locality numbers 18 and 26, as locality 18 by retiring locality number 26, as it is no longer needed.
- Recognize San Francisco-Oakland-Berkeley MSA, which contains San Francisco, San Mateo, Alameda and Contra Costa counties and locality numbers 05-07, as locality 05, by retiring locality numbers 06 and 07, as they are no longer needed.
- Modify the MSA names as follows:
  - San Francisco Oakland-Berkeley (San Francisco County) locality (locality 05) would become San Francisco-Oakland-Berkeley (San Francisco/San Mateo/Alameda/Contra Costa County).
  - Los Angeles-Long Beach-Anaheim (Los Angeles County) locality (locality 18) would become Los Angeles-Long Beach-Anaheim (Los Angeles/Orange County).
  - Because Marin County is in a transition area and subject to the hold harmless provision, CMS must retain a unique locality number for San Francisco-Oakland-Berkeley (Marin County), locality 52.

Although finalized for CY 2023, due to timing constraints relating to the operationalization of the finalized locality changes, implementation will begin in CY 2024. CMS clarified the MACs were instructed to not use locality numbers 06, 07 and 26 for the PFS effective January 1, 2024. Because these counties are not transitional areas, they will receive the same GPCI values for payment purposes, moving forward.

These finalized changes are reflected in Addenda D and E for CY 2024:

https://www.cms.gov/medicare/medicare-fee-service-payment/physicianfeesched/pfs-federal-regulation-notices/cms-1784-f.

Medicare Economic Index (MEI)

CMS is continuing the conversation regarding the need for ongoing updates and utilization of data used to set values and payment rates for CPT®/HCPCS codes. Stakeholders have pushed back and claimed CMS has been

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using data which is not current or due to other factors has not been updated when setting rates. This leads to comments arguing proposed values are inaccurate or invalid because the data used is so old. While at the same time, other arguments claim the proposed changes will dramatically impact societies because the change needed based on new data is so drastic. This is creating significant issues for CMS and stakeholders.

The Medicare Economic Index (MEI) is the "reasonable charge-based payment methodology" that was in place for physicians' services prior to the MPFS. The MEI reflects the change in the average annual market price of various inputs involved in providing physicians' services. This measure was authorized by statute and CMS began calculating the MEI on July 1, 1975. CMS continues to calculate this index for statutory and other purposes.

The MEI is comprised of two major categories: 1) physicians' own time or compensation; and 2) physicians' practice expense (PE). In addition, it includes an adjustment for the change in the economy-wide, private nonfarm business total factor productivity (also known as the relativity adjustment). Measures of productivity are provided by the U.S. Department of Labor's Bureau of Labor Statistics (BLS).

The current 2006-based MEI is based on data collected by the AMA for self-employed physicians from the Physician Practice Information Survey (PPIS). As of this final rule, the AMA has not conducted another survey since the 2006 data collection effort; however, CMS understands the AMA is currently collecting physician expense data; and CMS will analyze the data once it is made available to them. Due to the impact this data will have on payments under MPFS, CMS is delaying implementation of the finalized 2017-based MEI costs weights for CY 2024.

VALUATION OF SPECIFIC CODES FOR CY 2024

Within the CY 2024 proposed rule, CMS addressed multiple misvalued and/or proposed value changes to specific series of new and established CPT® codes. CMS explains the rationale for the proposed changes are based on values recommended by the Relative Value Scale Update Committee (RUC) and other organizations which CMS utilizes for assistance in setting appropriate values for codes. The following code is pertinent among the codes selected for valuation by CMS in the proposed rule:

Ultrasound Guidance for Vascular Access (CPT® code 76937)

In September of 2017, codes 36572 and 36573 were created and codes 36568, 36569 and 36584 were revised, respectively. These codes provided bundled services for the insertion of a peripherally inserted venous catheter (PICC) that could be performed either by a physician without imaging guidance, or a radiologist with imaging guidance. Since code 76937 *(Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure))* was bundled with PICC services, the specialty societies proposed to review this code after 2 years when more data was available. CPT® code 76937 was reviewed at the October 2022 RUC meeting for CY 2024.

For CY 2024, CMS is finalizing the RUC-recommended work RVU of 0.30 for CPT® code 76937. In addition, CMS is finalizing the RUC-recommended direct PE inputs. Table 14 reflects the results of these select new codes specific to work RVUs for 2024:

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TABLE 14: CY 2024 Work RVUs for New, Revised, and Potentially Misvalued Codes

HCPCS	Descriptor	Current work RVU	RUC work RVU	CMS work RVU	CMS time refinement
76937	Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting	0.30	0.30	0.30	No

EVALUATION AND MANAGEMENT (E/M) SERVICES

E/M visits comprise approximately 40 percent of all allowed charges under MPFS. Of these, the office/outpatient (O/O) E/M visits comprise approximately half (or 20 percent of all allowed charges). Policies for reevaluation of E/M visits have a significant impact on resource valuation under MPFS, which could potentially impact patient care as a whole.

In the MPFS proposed rule for CY 2024, CMS is addressing two outstanding issues in E/M visit payment: (1) implementing separate payment for the O/O E/M visit complexity add-on payment; and (2) the definition of split (or shared visits) which was delayed for CY 2023.

Office/Outpatient E/M Visit Complexity Add-On

From CY 2018 on, CMS and the AMA have worked to reform the E/M documentation guidelines; establish HCPCS add-on codes for additional payments based on visit complexity related to primary care; revise the O/O E/M codes to reflect the option of selecting time or Medical Decision Making (MDM) for visit level selection; and revise the visit descriptor times, which resulted in increased valuation of the codes. CMS did not believe these increased valuations accounted for the resources involved in providing certain kinds of care included in the O/O E/M visit code set, specifically visit complexity associated with primary care and non-procedural specialty care. Therefore, in the CY 2021 final rule, CMS created code 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)).* CMS refers to this code as the “O/O E/M visit complexity add-on". Under the final policy, code G2211 could be reported with all O/O E/M visits rather than just the higher-level visits as suggested. CMS also stated they did not expect this code to be reported with visits billed with a payment modifier, such as modifier 25 *(Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service)*.

After code G2211 was established, the Consolidated Appropriations Act, 2021 (CAA 2021) put a moratorium on Medicare payment for this service by disallowing CMS from reimbursing code G2211 under the MPFS before January 1, 2024. Currently, this add-on code can be reported, but is assigned a bundled status indicator “B” *(Payment for covered services are always bundled into payment for other services not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident)*.

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For CY 2023, the rest of the E/M visit code families (except critical care services) were revised to match the general framework of the O/O E/M visits, including visit level selection based on time or MDM level. These E/M codes included inpatient and observation visits; emergency department (ED) visits; nursing facility visits; domiciliary or rest home visits; home visits; and cognitive impairment assessment. CMS refers to these other E/M visit code families as "Other E/M" visits. Despite revisions to the Other E/M visit families in the CY 2023 final rule, CMS believed certain types of O/O E/M visits still did not account for the complexity and resources needed to perform certain types of care.

In anticipation of the end of the CAA 2021 moratorium on December 31, 2023, several interested parties, including the AMA and specialty societies, have contacted CMS with comments regarding code G2211. Some commenters have expressed concerns regarding the budget neutrality adjustment and redistributive impact as a result of the implementation of code G2211, instead recommending a delay. Other commenters who rely heavily on O/O E/M visits to report their services recommended implementation.

CMS is finalizing their proposing to change the code status indicator of G2211 from "B" (bundled) to "A" (active), effective January 1, 2024. Based on feedback received, CMS is also proposing policy revisions relating to HCPCS code G2211, including it would not be payable when the O/O E/M visit code is reported with payment modifier 25 due to performance with a minor procedure. The components of the minor procedure, along with the O/O E/M, would negate the opportunity to bill for the added complexity.

CMS was requested to reconsider their previous utilization assumptions from the CY 2021 final rule, in which CMS presumed specialties that rely on O/O E/M visit codes to report the majority of their services would most likely report the complexity add-on code with every O/O E/M visit code they report. Commenters reasoned many practitioners would provide acute health care without coordination, follow up or continuity of care. After consideration of comments, CMS estimates when code G2211 is fully adopted, this complexity add-on code will be billed with 54 percent of all O/O E/M visits. CMS sought comments on the utilization assumptions and implementation of this new policy for CY 2024; and generally regarding improved processes and methodologies to evaluate E/M services on a more regular and comprehensive basis.

After many comments received, CMS acknowledged the need to clarify when G2211 can be used. The add-on code is intended to be used for services that are part of ongoing care to better account for the inherent complexity for all needed health care services and/or ongoing care related to a patient's single, serious, or complex condition.

Clarifying Utilization

CMS emphasized the add-on code is not based on the characteristics of a particular patient but rather the *relationship* between the patient and practitioner. The first part of the add-on code, *"continuing focal point for all needed health care services"* describes a relationship between the patient and the practitioner, when the practitioner is the continuing focal point for all health care services the patient needs. CMS provides the following 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 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."*

The primary care practitioner is tasked with not only deciding the best course of treatment for the sinus congestion but also every decision in the patient's care down to how to best communicate with the patient during the visit to lead to the best health outcome in this visit to build an effective, trusting ongoing relationship with the patient for all primary health care needs. CMS believes the practitioner having to weigh these various factors,

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even for a seemingly simple condition such as sinus congestion, makes the interaction inherently complex between the patient and physician.

The second part of the add-on code, *"medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition"* describes the relationship between the practitioner and patient for a specific type of condition(s). Unlike the first part of the code, described above, this part of the code is specific to a serious condition or a complex condition. The "ongoing care" describes the longitudinal relationship between the practitioner and patient but in reference to a single, serious or complex condition. CMS provides the example of a patient with HIV who has an office visit with their infectious disease physician, as part of their ongoing care. Since the infectious disease physician is part of ongoing care and will have to weigh the same factors as the primary care physician in the above example during regularly scheduled visits, the E/M becomes more complex in nature due to the compound building of decisions and considerations for the patient. Even though the infectious disease doctor may not be the focal point for all services, HIV is a single, serious and/or complex condition, if the relationship between the infectious disease physician and patient is ongoing, G2211 could be billed.

Utilization Assumptions

In the CY 2021 MPFS final rule, CMS assumed specialties that rely on O/O E/M visit codes to report most of their services would most likely be the practitioners to report the O/O E/M visit complexity add-on code G2211 and would report it with every O/O E/M visit. CMS estimated, when fully adopted, G2211 would be billed with 54 percent of all O/O E/M visits. Interested parties requested reconsideration of these utilization assumptions.

CMS received persuasive reasons that certain practitioners who rely on O/O E/M visits to report most of their services would not be likely to report HCPCS code G2211 on every O/O E/M visit they report. Commenters reasoned that many practitioners delivering care in settings designed to address acute healthcare needs, without coordination or follow-up, will regularly have encounters with patients that are not part of continuous care. CMS believes there are many visits with new or established patients where the O/O E/M visit complexity add-on code would not be appropriately reported. These visits would be when care if furnished by a professional whose relationship with the patient is discrete, routine, or time-limited in nature. The examples given include mole removal or referral to a physician for a removal of a mole; treatment of a simple virus; counseling related to seasonal allergies, initial onset of gastroesophageal reflux; and where comorbidities are either not present or not addressed, and/or when the billing practitioner has not taken responsibility for ongoing medical care for that patient with consistency and continuity over time.

Factoring in the above considerations along with the proposal that HCPCS code G2211, would not be payable when the O/O E/M visit is reported with payment modifier -25, CMS revised their utilization assumptions and now estimate HCPCS code G2211 will be billed with 38 percent of all O/O E/M visits for CY 2024.

Ultimately, CMS believes the outcomes will outweigh the impact on payment policy. Specifically, CMS believes utilization of the O/O/ E/M complexity add-on code will improve accuracy in the resources inherent to primary care. By recognizing upfront the impact of managing on-going care on the practitioner and the patient, it will in many ways incentivize practitioners to utilize services which may decrease more complex, costly care in the future. With better management of conditions and diseases, CMS sees the increased payments upfront as a way to create a better future.   CMS also believes if they do not provide separate payment for what they have for a long time pointed out as gaps in payments for the resources and care provided in various rulemaking policy, there would be strong reactions from primary care practitioners.

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Split (or Shared) Visits

In CY 2022, CMS updated the language regarding split (or shared) visits due to the extensive E/M changes which began in CY 2021. Allowing for either one of the pre-2021 three key E/M elements (history, exam, or medical decision making (MDM)) or more than half the total time spent. CMS also finalized their proposal for a new payment modifier "FS" (Split (or shared) evaluation and management visit) to be reported with the E/M code when the visit met the split (or shared) criteria. Since that time, comments received expressed dislike of the term "substantiative portion" of the visit and requested "MDM" be recognized as the substantiative portion instead. In response, CMS finalized to delay implementation of their definition of substantiative portion to mean more than half of the total provider time until January 1, 2024.

For CY 2024, CMS proposed to again delay the implementation of their definition of "substantiative portion" as more than half of the total provider time through at least December 31, 2024. In addition, CMS is proposing to maintain the current definition of substantiative portion that allows for use of either one of the three key components (history, exam, or MDM); or more than half the total time spent to determine the billing practitioner. The delay will also allow stakeholders more time to consider the proposals and provide feedback for future rulemaking.

However, after review of the revisions made by the AMA CPT® Editorial Panel included in the 2024 CPT® manual publication, specifically the Evaluation and Management (E/M) Services Guidelines language surrounding "substantive portion" for split (or shared) services, CMS has decided to forego their previous proposed and finalized definitions and align with the AMA's CPT® E/M guidelines for CY 2024.

For CY 2024, the CPT® E/M Guidelines for billing split or shared services now state, "*physician(s) and other QHP(s) may act as a team in providing care for the patient, working together during a single E/M service. The split or shared visits guidelines are applied to determine which professional may report the service. If the physician or other QHP performs a substantive portion of the encounter, the physician or other QHP may report the service. 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 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 the amount and/or complexity of data to be reviewed and analyzed is used by the physician or other QHP to determine the reported code level, assessing an independent historian's narrative and the ordering or review of tests or documents do not have to be personally performed by the physician or other QHP, because the relevant items would be considered in formulating the management plan. Independent interpretation of tests and discussion of management plan or test interpretation must be personally performed by the physician or other QHP if these are used to determine the reported code level by the physician or other QHP*" (2024 CPT® Codebook, pg. 6).

CMS does acknowledge there can be instances where medical decision making (MDM) is not easily attributed to a single physician or nonphysician practitioner (NPP) when the work is shared, they do expect that whoever performs the MDM and subsequently bills the visit would appropriately document the MDM in the medical record to support billing the visit.

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After delaying the implementation of their definition of "substantiative portion" several times, to avoid the administrative burden for time and resources spent preparing for potential policy changes that are delayed year after year, CMS is finalizing a revised definition of "substantive portion" of a split (or shared) visit to reflect the revisions to the CPT® E/M guidelines. For Medicare billing purposes, the "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, except critical care visits which only use time.

Telehealth Services

In response to the COVID-19 public health emergency (PHE), within the CY 2021 MPFS final rule, CMS created a third category of criteria for adding services to the Medicare telehealth list on a temporary basis. The services added to this category are considered to be a clinical benefit when furnished via telehealth; however, there is not sufficient evidence available to consider the services as permanent additions under Category 1 or Category 2 criteria. CMS acknowledges the services under Category 3 would ultimately need to meet criteria under Categories 1 and 2 in order to be permanently added to the Medicare telehealth services list. A complete list of telehealth services effective January 1, 2024, can be found on the CMS website:

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.

CMS received multiple requests from stakeholders to permanently add services to the Medicare telehealth services list effective for CY 2024. None of the requests received by the February 10th deadline met the criteria for Category 1 or Category 2 to be added permanently.

Confusion has ensued over requests and submissions between CMS' use of wavier authority and regulatory flexibilities related to the PHE versus those outside the PHE. Now that the PHE has ended, CMS is finalizing their proposal to classify additions to the Medicare Telehealth Services List as either permanent (Category 1 or 2) or provisional (temporary Category 2 or Category 3) Category; and revising the process for addition, removal or change in status to this list:

1) Determine whether the service is separately payable under the PFS;
2) Determine whether the service is subject to the provisions of the Act (at least some elements of the telehealth service are a substitute for an in-person, face to face encounter, provided via interactive telecommunications system as defined in the Act);
3) Review the elements of the service as described by the HCPCS code and determine whether each of them is capable of being furnished using an interactive telecommunications system as defined in the Act;
4) Consider whether the service elements of the requested service map to the service elements of a service on the list that has a permanent statue described in previous final rulemaking; and
5) Consider whether there is evidence of clinical benefit analogous to the clinical benefit of the in-person service when the patient, who is located at a telehealth originating site, receives a service furnished by a physician or practitioner located at a distant site using an interactive telecommunications system.

Assignment of telehealth services as permanent or provisional is intended to replace the Category 1-3 classification that currently exists. This finalized change is intended to alleviate confusion regarding the status of codes on the Medicare Telehealth List, as well as simplify CMS' analysis outcomes. After a code receives a provisional status, CMS may re-assign the code to a permanent status in the future or remove it, using the 5-step process listed above, without establishment of any specific timeframe for re-assignment.

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Telehealth Originating Site Facility Fee Payment Amount Update

For CY 2024, CMS is finalizing their proposal to continue payment for telehealth services to the originating site. CMS uses the baseline rate set in 2002 of $20.00 and adjusts each year based on the percent increase in the Medicare Economic Index (MEI). The finalized MEI for CY 2024 is 4.6 percent, resulting in a finalized originating site fee of $29.96 for HCPCS code Q3014 (*Telehealth originating site facility fee*).

Telephone Evaluation and Management Services

In previous rulemaking and response to the PHE, CMS recognized and finalized separate payment for E/M services furnished via telephone, CPT® codes 99441-99443 and 98966-98968. Codes 99441-99443 are telehealth services and will continue coverage and payment by CMS through December 31, 2024. Codes 98966-98968, which describe telephone evaluation and management by non-physician healthcare professionals, are not considered telehealth services by CMS.

For CY 2024, CMS is finalizing their proposal to continue payment for CPT® codes 98966-98968, extending the telehealth-related flexibilities provided to other audio-only services covered in the CAA 2023.

PHYSICIAN SUPERVISION OF THERAPEUTIC SERVICES

Direct supervision requires the immediate availability of the physician in the office suite, but they are not required to be present in the same room. In previous rule making, CMS has established “immediate availability” to mean in-person, physical, not virtual, availability. During the PHE for COVID-19, CMS adjusted the definition for direct supervision as it pertains to supervision of diagnostic tests, physicians’ services, and some hospital outpatient services, to allow the supervising professional to be immediately available through virtual presence using two-way, real-time audio/video technology, instead of their physical presence.

Within the CY 2021 final rule, CMS finalized the definition and guidelines related to direct supervision would return to the pre-PHE definition and rules effective January 1, 2024.

For CY 2024, CMS is finalizing their proposal to extend the definition that allowance for direct supervision to be met with the use of real-time audio and video interactive telecommunications through December 31, 2024. This would align with the timeframe of many of the PHE-related telehealth policies and avoid an abrupt transition to pre-PHE policies. CMS is also seeking comments on whether the definition of direct supervision to permit virtual presence should be extended beyond December 31, 2024.

Residents in Teaching Settings

In previous rule making, CMS established a policy that allows teaching physicians to meet the requirements to be present for the key or critical portions of services when furnished involving residents through audio/video real-time communications technology. This policy was only valid for services furnished in residency training sites that are located outside of an Office of Management and Budget (OMB) – defined metropolitan statistical area (MSA). This distinction was made to increase beneficiary access to Medicare-covered services in rural areas.

At the end of the PHE, CMS policy indicated the teaching physician would be required to have a physical presence during the key portion of the service personally provided by the residents, in locations that were within an MSA. This policy applies to all services, whether the patient is co-located with the resident or only present

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virtually (for example, the service was furnished as a 3-way telehealth visit, with the teaching physician, resident, and patient in different locations).

After CMS received comments stating during the PHE residents provided telehealth services and the teaching physician were virtually present, the same oversight was provided as when the teaching physician and resident were physically located in the same place. Additionally, CMS received comments indicating during the telehealth visit, the teaching physician was virtually present during the key and critical portions of the telehealth services, available immediately in real-time, and had access to the electronic health record.

For CY 2024, CMS is finalizing their proposal to allow the teaching physician to have a virtual presence in all teaching settings, but only in clinical instances when the service is furnished virtually (3-way telehealth visit, with all parties in separate locations). The proposal would permit teaching physicians to have a virtual presence during the key portion of the Medicare telehealth service through real-time audio/video communication for all residency training locations through December 31, 2024.

NEW CODES FOR COMMUNITY HEALTH INTEGRATION, SOCIAL DETERMINANTS OF HEALTH AND PRINCIPAL ILLNESS NAVIGATION SERVICES

A primary focus for CMS now is related to equity in and access to care and how social determinants of health (SDOH) impact the ability to diagnose or treat the patient. To accomplish this, CMS is trying to determine how to improve payment accuracy for additional time and resources dedicated to helping patients with serious illnesses as they navigate the healthcare system or remove health-related social barriers.

Payment for many of these activities is currently included in payment for other services such as evaluation and management (E/M) visits. Since the work for these important activities is not explicitly identified in current coding, CMS believes it is underutilized and undervalued.

For CY 2024, CMS is finalizing their proposal to establish new codes to identify and value these services for PFS payment and distinguish them from current care services with modifications as specified below. CMS has defined SDOH as economic and social condition(s) that influence the health of people and communities, as indicated in these same CPT® E/M Guidelines, and finalized to adopt CPT®'s examples of SDOH). CMS encouraged the use of the ICD-10-CM Z codes (Z55-Z65) for the reporting of SDOH to improve data collection, and thus, assist in future rulemaking.

Community Health Integration (CHI) Services

In the CY 2024 proposed rule, CMS is proposed to establish two new G codes describing Community Health Integration (CHI) services performed by certified or trained auxiliary personnel, such as a community health worker (CHW), incident to the physician services, but under general supervision of the billing practitioner (the service is furnished under the practitioner's overall direction and control, but the practitioner's presence is not required during the performance of the service). The proposal would include CHI services furnished monthly, as medically necessary, once a CHI initiating E/M visit is provided. The practitioner would need to identify any SDOHs which significantly limit their ability to diagnose or treat the problem(s) addressed in the visit, and establish an appropriate treatment plan. The subsequent CHI services would be performed by a CHW or other auxiliary personnel incident to the professional services of the practitioner who bills the CHI initial visit. Meaning, the same practitioner would provide and bill for both the CHI initial visit and CHI services in accordance with the "incident to" policy.

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A CHI initiating E/M visit would not qualify when the service is an inpatient/observation visit, emergency department (ED) visit, or skilled nursing facility (SNF) visit. The practitioners in these scenarios would not provide ongoing care to the patient as would be needed to support their use. CMS sought comment on the typical amount of time practitioners spend per month furnishing CHS services to address SDOH needs that may pose barriers to the diagnosis and treatment of problem(s) addressed in an E/M visit; as well as the typical duration in terms of months for which practitioners furnish the services. The following codes (with lengthy descriptors) were proposed to be established for CY 2024:

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 assessment, performed to better understand the individualized context of the intersection between the SDOH need(s) and the problem(s) addressed in the initiating E/M visit.*
    - *Conducting a person-centered assessment to understand patient's life story, strengths, needs, goals, preferences and desired outcomes, including understanding cultural and linguistic factors.*
    - *Facilitating patient-driven goal-setting and establishing an action plan.*
    - *Providing tailored support to the patient as needed to accomplish the practitioner's treatment plan.*
- *Practitioner, Home-, and Community-Based Care Coordination*
    - *Coordinating receipt of needed services from healthcare practitioners, providers, and facilities; and from home- and community-based service providers, social service providers, and caregiver (if applicable).*
    - *Communication with practitioners, home- and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors.*
    - *Coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians; follow-up after an emergency department visit; or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities.*
    - *Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) to address the SDOH need(s).*
- *Health education- Helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, and preferences, in the context of the SDOH need(s) and educating the patient on how to best participate in medical decision-making.*
- *Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services addressing the SDOH need(s), in ways that are more likely to promote personalized and effective diagnosis or treatment.*
- *Health care access / health system navigation*
    - *Helping the patient access healthcare, including identifying appropriate practitioners or providers for clinical care and helping secure appointments with them.*
- *Facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals.*

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- *Facilitating and providing social and emotional support to help the patient cope with the problem(s) addressed in the initiating visit, the SDOH need(s), and adjust daily routines to better meet diagnosis and treatment goals.*
- *Leveraging lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals.*

G0022 – *Community health integration services, each additional 30 minutes per calendar month (List separately in addition to G0019)*

Based on CMS' consideration of the comments received, CMS is finalizing their proposal to establish codes G0019 and G0022 following codes with a modification to the final code descriptor of G0019 – the term "E/M" was removed since CMS is allowing an E/M service (except CPT® code 99211), including and E/M service as part of a transitional care management (TCM) service and/or an annual well visit (AWV) to act as the initial CHI service. In addition, CMS is adding a service element for the SDOH risk assessment to describe situations in which auxiliary personnel performing CHI services identifies an SDOH need that a furnishing practitioner did not identify, and provides that information to the billing practitioner to assess whether that need impacts the diagnosis and treatment. Code G0019 is modified as follows:

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 assessment, performed to better understand the individualized context of the intersection between the SDOH need(s) and the problem(s) addressed in the initiating ~~E/M~~ visit.*
    - *Conducting a person-centered assessment to understand patient's life story, strengths, needs, goals, preferences and desired outcomes, including understanding cultural and linguistic factors and including unmet SDOH needs (that are not separately billed)*

The rest of the code description for G0019 remains the same. Code G0022 is finalized without modification, including no defined time frequency limitation, which will be monitored and re-evaluated in future rulemaking as appropriate. All auxiliary personnel performing CHI services must be certified and trained to perform all included service elements and authorized to perform them under applicable State laws and regulations. Consent by the patient is required, can be obtained by auxiliary personnel, as services could occur over many months and consent may be verbal or written but must be documented in the medical record. If there is any change in the billing practitioner, consent must be re-obtained by the patient.

CMS is finalizing their proposed work RVU of 1.00 based on CPT® code 99490 (*Chronic care management… first 20 minutes*) for code G0019; and a work RUV of 0.70 and work time of 20 minutes for code G0022 based on code 99439 (*Chronic care management…each add'l 20 minutes)*.

Social Determinants of Health (SDOH)

Social determinants of health (SDOH) include a large set of factors: economic stability, education access and quality, healthcare access and quality, neighborhood and build environment, and social and community context (factors such as housing, food, nutrition access, and transportation needs).

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For CY 2024, CMS proposed to establish a single G code to identify and value the work involved in administering a SDOH risk assessment as part of a comprehensive social history in relation to an E/M visit. CMS is proposing the risk assessment must be furnished on the same date as an E/M, as a reasonable and necessary part of the patient's diagnosis and treatment plan established during the visit:

G0136 - *Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, not more often than every 6 months*

CMS outlines the required elements of the risk assessment to include:

- Administration of a standardized, evidence-based SDOH risk assessment tool that has been tested and validated through research, and includes the domains of food insecurity, housing insecurity, transportation needs, and utility difficulties.
    - Billing practitioners may choose to assess for additional domains beyond those listed above if there are other prevalent or culturally salient social determinants in the community being treated by the practitioner.

After consideration of comments received, CMS has finalized their proposal to establish code G0136 with modification – they are not finalizing the requirement that he SDOH risk assessment must be performed on the same date as the associated E/M visit. In addition, CMS is finalizing that SDOH risk assessment can also be performed with CPT® code 90791 (*Psychiatric diagnostic evaluation*) and health behavior assessment and intervention services (codes 96156-96168), as well as an Annual Wellness Visit (AWV), hospital discharge visits and outpatient settings. SDOH needs identified must be documented in the medical record.

CMS is finalizing their proposed work RVU of 0.18 and a work time of 15 minutes based on CPT® code G0444 (*Screening for depression in adults, 5-15 minutes*) for code G0136.

Principal Illness Navigation (PIN) Services

Navigation, in the context of healthcare, refers to providing individualized help to the patient to identify appropriate practitioners and providers for care needs and support; and access necessary care timely, especially when the landscape is complex and delaying care can be deadly. Navigation is often referred to in the context of patients diagnosed with cancer or other severe, debilitating illnesses and includes identifying and referring to appropriate supportive care. CMS noted SDOH needs are not required for PIN services, but may be applicable.

For CY 2024, CMS is proposing two principal illness navigation (PIN) services codes. These would be provided under general supervision, following an initiating E/M visit addressing a serious high-risk condition/illness/disease, with the following criteria:

- One serious, high-risk condition expected to last at least 3 months and that places the patient at significant risk of hospitalization, nursing home placement, acute exacerbation/decompensation, functional decline, or death;
    - Examples of serious high-risk conditions/illness/disease include, but are not limited to, cancer, chronic obstructive pulmonary disease, congestive heart failure, dementia, HIV/AIDS, severe mental illness, and substance use disorder.
- 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.

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The PIN initiating E/M visit would not qualify when the service is an inpatient/observation visit, emergency department (ED) visit, or SNF visit. The practitioners in these scenarios would not provide ongoing care to the patient as would be needed to support their use.

CMS proposed the following 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 assessment, performed to better understand the individual context of the serious, high-risk condition.*
  - *Conducting a person-centered assessment to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors.*
  - *Facilitating patient-driven goal setting and establishing an action plan.*
  - *Providing tailored support as needed to accomplish the practitioner's treatment plan.*
- *Identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services.*
- *Practitioner, Home, and Community-Based Care Coordination*
  - *Coordinating receipt of needed services from healthcare practitioners, providers, and facilities; home- and community-based service providers; and caregiver (if applicable).*
  - *Communication with practitioners, home-, and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors.*
  - *Coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians; follow-up after an emergency department visit; or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities.*
  - *Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) as needed to address SDOH need(s).*
- *Health education- Helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, preferences, and SDOH need(s), and educating the patient (and caregiver if applicable) on how to best participate in medical decision-making.*
- *Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services (as needed), in ways that are more likely to promote personalized and effective treatment of their condition.*
- *Health care access / health system navigation*
  - *Helping the patient access healthcare, including identifying appropriate practitioners or providers for clinical care, and helping secure appointments with them.*
  - *Providing the patient with information/resources to consider participation in clinical trials or clinical research as applicable.*
- *Facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals.*
- *Facilitating and providing social and emotional support to help the patient cope with the condition, SDOH need(s), and adjust daily routines to better meet diagnosis and treatment goals.*

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- *Leverage knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals.*

G0024 – *Principal Illness Navigation services, additional 30 minutes per calendar month (List separately in addition to G0023).*

To help inform whether the proposed descriptor times are appropriate and reflect typical service times, and whether a frequency limit is relevant for the add-on code, CMS sought comment on the typical amount of time practitioners spend per month furnishing PIN services. They also sought comments to better understand the typical duration of PIN services, in terms of the number of months for which practitioners furnish PIN services following an initiating visit.

After consideration of all comments received, CMS is finalizing their proposal to establish codes G0023 and G0024 with modification – with the addition of "and including unmet SDOH needs (that are not separately billed)" as part of the person-centered assessment. This service element describes the need to reassess SDOH needs within both CHI and PIN, and clarifies this time cannot be duplicated by code G0136 or any other service.

Code G0023 is modified as follows:

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 assessment, performed to better understand the individual context of the serious, high-risk condition.*
  - *Conducting a person-centered assessment to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors and including unmet SDOH needs (that are not separately billed)*

The rest of the code description for G0023 remains the same. Code G0024 is finalized without modification, including no defined time frequency limitation, which will be monitored and re-evaluated in future rulemaking as appropriate. All auxiliary personnel performing CHI services must be certified and trained to perform all included service elements and authorized to perform them under applicable State laws and regulations. Consent by the patient is required, can be obtained by auxiliary personnel, as services could occur over many months and consent may be verbal or written but must be documented in the medical record. If there is any change in the billing practitioner, consent must be re-obtained by the patient.

In addition, CMS is finalizing that CPT® code 90791 (*Psychiatric diagnostic evaluation*) and health behavior assessment and intervention services (codes 96156-96168), and Annual Wellness Visits (AWVs) can act as an initiating PIN service, hospital discharge visits and outpatient settings.

CMS is finalizing their proposed work RVU of 1.00 and a work time of 25 minutes for code G0023 based on CPT® code 99490 (*Chronic care management services…first 20 minutes);* and a work RUV of 0.70 and a work time of 20 minutes for code G0024 based on CPT® code 99439 *(Chronic care management services…each add'l 20 minutes)* and matching PE inputs for both HCPCS codes.

CMS finalized two additional new HCPCS codes (G0140 and G0146), not previously proposed separately, under PIN based on feedback from stakeholders for certified peer support specialists to be recognized by Principal

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Illness Navigation – Peer Support (PIN-PS). These two codes are limited to treatment of behavioral health conditions that satisfy the definitions of high-risk condition(s). These patients can receive the PIN codes, G0223 and G0224, in addition to G0140 and G0146.

G0140 – *Principal Illness Navigation – Peer Support by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a certified peer specialist; 60 minutes per calendar month, in the following activities:*

- *Person-centered interview, performed to better understand the individual context of the serious, high-risk condition.*
    - *Conducting a person-centered interview to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors, and including unmet SDOH needs (that are not billed separately).*
    - *Facilitating patient-driven goal setting and establishing an action plan.*
    - *Providing tailored support as needed to accomplish the person-centered goals in the practitioner's treatment plan.*
  - *Identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services.*
  - *Practitioner, Home, and Community-Based Care Communication*
      - *Assist the patient in communicating with their practitioners, home-, and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, goals, preferences, and desired outcomes, including cultural and linguistic factors.*
      - *Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) as needed to address SDOH need(s).*
  - *Health education—Helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, preferences, and SDOH need(s), and educating the patient (and caregiver if applicable) on how to best participate in medical decision-making.*
  - *Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services (as needed), in ways that are more likely to promote personalized and effective treatment of their condition.*
  - *Developing and proposing strategies to help meet person-centered treatment goals and supporting the patient in using chosen strategies to reach person-centered treatment goals.*
  - *Facilitating and providing social and emotional support to help the patient cope with the condition, SDOH need(s), and adjust daily routines to better meet person-centered diagnosis and treatment goals.*
  - *Leverage knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals.*

G0146 – *Principal Illness Navigation – Peer Support, additional 30 minutes per calendar month (List separately in addition to G0140).*

CMS is not defining a time frequency limitation, which will be monitored and re-evaluated in future rulemaking as appropriate. In addition, they are not limiting the duration of PIN services, but finalizing a requirement that a new initiating visit be performed once annually. If no applicable State requirements exist, CMS is finalizing that training must be consistent with the National Model Standards for Peer Support Certification published by SAMHSA, which the most widely recognized standard for peer support specialists in the country. Consent by the

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patient is required, can be obtained by auxiliary personnel, as services could occur over many months and consent may be verbal or written but must be documented in the medical record. If there is any change in the billing practitioner, consent must be re-obtained by the patient.

CMS is finalizing their proposed work RVU of 1.00 and a work time of 25 minutes for code G0140 based on CPT® code 99490 (*Chronic care management services…first 20 minutes);* and a work RUV of 0.70 and a work time of 20 minutes for code G00146 based on CPT® code 99439 *(Chronic care management services…each add'l 20 minutes)* and matching PE inputs for both HCPCS codes.

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