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CMS publishes 2024 proposed Medicare Physician Fee Schedule rule

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On July 13, 2023, the Centers for Medicare & Medicaid Services' (CMS) proposed rule for the 2024 Medicare Physician Fee Schedule (MPFS) suggests significant programmatic and reimbursement changes in their annual MPFS.[1] In the proposed rule, CMS considers whether to extend certain temporary flexibilities that were in place during the COVID-19 public health emergency (PHE) to permanent solutions.[2] To facilitate the progression of CMS' telehealth policies going forward, CMS is proposing a streamlined approach for adding new services to the Medicare Telehealth Services List. The proposed rule provides important clarification on various payment policies, including remote patient monitoring, behavioral health services, and shared evaluation and management (E/M) visits. The proposed rule also expands CMS' authority to revoke Medicare enrollment and clarify when notice is required upon a provider's or supplier's enrollment change. As such, providers and suppliers should be aware of all requirements for coverage and anticipate how they will respond if and when CMS publishes the final rule.

CMS emphasizes the need for clinical evidence of benefits of services delivered via telehealth

The Medicare Telehealth Services List (List) is updated annually and represents all services that are covered by Medicare when delivered via telehealth.[3] As it stands, CMS considers whether a particular service falls into one of the following three categories to determine whether the service should be added to the List:

1. Services that are similar to those already included on the List;
2. Services that are not similar to those already on the List but are accurately described by the corresponding code when delivered via telehealth and have a demonstrated benefit to the patient when delivered via telehealth; or
3. Temporary coverage for services that likely have a clinical benefit but for which there is insufficient evidence to consider permanent addition to the List.

Recognizing the potential for confusion when using these categories, CMS is proposing to consolidate services into two categories only: one permanent and one provisional.[4] The provisional category will still encompass services for which a benefit is likely, but further evidence is needed before it reaches permanent status on the list. Implementation of the new categories would begin calendar year (CY) 2025.

In addition, CMS proposed the following five-step process to consider whether a service should be added to the List, which emphasizes the need for clinical evidence that a service is beneficial when delivered via telehealth.[5]

1. "Determine whether the service is separately payable under the [M]PFS."
2. "Determine whether the service is subject to the provisions of § 1834(m) of the Social Security Act," which provides payment amounts for telehealth services furnished via a "telecommunications system." This includes store-and-forward technologies that transmit asynchronous healthcare information in single or multimedia formats.
3. "Review the elements of the service as described by the HCPCS [Healthcare Common Procedure Coding System] and determine whether each of them is capable of being furnished using an interactive telecommunications system as defined in 42 C.F.R. § 410.78(a)(3) " (conditions for payment of telehealth services under Medicare).
4. "Consider whether the service elements of the requested service map to the service elements of a service on the list with a permanent status described in previous final rulemaking."
5. "Consider whether evidence of clinical benefit is 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."

CMS would assign either a "provisional" or "permanent" status to a service that it determines either has elements that map to a service already on the List or for which there is evidence of a clinical benefit—similar to the benefit from receiving the service in person when the service is furnished via telehealth. CMS could assign permanent status to a previously designated provisional service as evidence accumulates and would propose any updates during the annual rulemaking process.[6]

In addition, CMS is proposing to add an individual and group face-to-face health and well-being coaching service to the List on a temporary basis. CMS rejected all requests for permanent additions to the List, including cardiovascular procedures, deep brain stimulation, physical therapy, and emergency department (ED) hospital care. Deep brain stimulation, physical therapy, and ED hospital care services will remain as temporarily covered services when furnished via telehealth. However, CMS completely rejected cardiovascular procedures from being included on the List.

CMS grapples with finalizing telehealth policies beyond the COVID-19 PHE

Providers should be aware of certain policies from the Consolidated Appropriations Act (CAA), 2023 amendments that CMS is *extending through the end of 2024*. Notably, the proposed rule would extend certain telehealth flexibilities, including, but not limited to, the following:[7]

- Delaying the in-person visit requirement for tele-mental health services furnished by rural health clinics (RHCs) and federally qualified health centers (FQHCs).
- Expanding the scope of telehealth originating sites for services furnished via telehealth to include any site

in the U.S. where the beneficiary is located at the time of the telehealth service, including an individual's home.

- Expanding the definition of telehealth practitioners to include qualified occupational therapists, physical therapists, speech-language pathologists, and audiologists (adding marriage and family therapists (MFTs) and mental health counselors (MHCs) to the list of eligible providers).
- Continuing coverage of certain audio-only telehealth services on the List.
- Removing frequency limitations for certain subsequent inpatient visits, nursing facility visits, and critical care consultation services.
- Continuing to allow for "direct supervision" to permit the presence and "immediate availability" of the supervising practitioner through real-time audio and visual interactive telecommunications (pre-PHE direct supervision could only be met via in-person immediate availability). CMS is seeking comment on whether to extend the flexibilities related to direct supervision and the virtual presence of teaching physicians beyond CY 2024.
- Continuing to allow teaching physicians to have a virtual presence in all teaching settings, but only in clinical instances when the service is furnished virtually (for instance, a three-way telehealth visit with all parties in separate locations).
- Continuing to allow outpatient therapy (physical therapy, occupational therapy, speech–language pathology), diabetes self-management training, and medical nutrition therapy to be provided via telehealth when delivered by institutional staff.
- Allowing for periodic assessments to be furnished via audio-only communications technology when video is not available to the extent that use of audio-only communications technology is permitted under the applicable Substance Abuse and Mental Health Services Administration and U.S. Drug Enforcement Administration requirements at the time the service is furnished and provided that all other applicable requirements are met.

CMS is also seeking comment on whether to extend the flexibilities related to direct supervision and virtual presence of teaching physicians beyond CY 2024. Also related to PHE considerations, CMS confirmed that remote physiological and therapeutic monitoring services can only be furnished to an established patient. In the 2021 MPFS final rule, CMS stated it would require that remote physiological monitoring (RPM) services only be furnished to "established patients" when the PHE ended. However, patients who received an initial remote monitoring service during the PHE will be considered established for purposes of this requirement.[8]

CMS recognized in the proposed rule that certain other PHE flexibilities should not continue, given the evolution of care delivery for these services. Specifically, CMS discussed the shift in industry practice since the COVID-19 pandemic from providing behavioral health services in person, in an office setting, to telehealth. As a result, CMS proposed that a nonfacility rate more accurately reflects the practice expenses for behavioral health providers and should be reported using point of service (POS) 10 for telehealth services provided in a patient's home, which results in a lower payment rate. In contrast, telehealth provided in locations other than the patient's home should be billed with POS 02 and reimbursed at the facility rate, which is reimbursed at a higher rate.

Remote physiological and therapeutic monitoring services

CMS is proposing that starting in CY 2024, RPM and remote therapeutic monitoring (RTM) services be separately payable to RHCs and FQHCs using the general care management code: HCPCS G0511. Currently, when RPM and

RTM services are furnished incident-to an RHC or FQHC visit, payment is included in the RHC's rate.

In addition, CMS proposes allowing RTM services to be furnished under general rather than direct supervision when provided by occupational therapists or physical therapists in private practice. This change would mean the supervisor would not need to meet the previous standard of being "immediately available."

Coverage for behavioral health services expands and evolves

In response to the 2023 CAA amendments, CMS is proposing to permit MFTs and MHCs to enroll in Medicare as Part B providers. In addition, CMS proposed to add these provider types to the list of providers who can perform telehealth effective January 1, 2024.[9] Covered services for MFTs and MHCs would include services furnished for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital), which the provider is legally authorized to perform under state law, which would otherwise be covered if furnished by a physician, or as incident to a physician's professional service. In addition, MFTs and MHCs may provide and bill for health behavior assessment and intervention services described by Current Procedural Terminology codes 96156, 96158, 96159, 96164, 96165, 96167, and 96168.[10]

In the proposed rule, CMS recognized the ongoing need for behavioral health services after the COVID-19 pandemic and thus made attempts to capture and pay for psychotherapy services more accurately. CMS proposed to shift to a timed valuation of psychotherapy services by adding an add-on code for office/outpatient E/M services that involve inherent complexity. CMS proposes adjusting the work relative value units (RVUs) for psychotherapy codes payable under the MPFS. The adjustment would be based on the difference in total work RVUs for office/outpatient E/M services that are billed with the proposed inherent complexity add-on code compared to the total work RVUs for visits that are not billed with the inherent complexity add-on code.[11] CMS estimates that this will result in an estimated 19.1% upward adjustment for work RVUs for these services.[12]

Policies regarding shared E/M visits not finalized

CMS is delaying implementation of its new definition for "substantive portion" with respect to shared E/M visits in a facility. A shared visit is generally a service provided in part by a physician and a nonphysician practitioner (NPP) (e.g., nurse practitioner, physician assistant) in a hospital or facility.

CMS previously proposed that a physician could bill for a shared visit, provided the physician performs a substantive portion of the visit. Otherwise, an NPP would bill for the service. Under the new definition, substantive portion would mean more than half of the total practitioner time. Through CY 2024, providers can continue to rely on the prior definition for substantive portion, which allows for consideration of either (1) one of the three key E/M elements (history, exam, medical decision-making) or (2) more than half of total time. During this interim period, CMS will continue to consider whether they will permanently change the definition.[13]

Expansion of provider enrollment revocation authorities[14]

CMS is proposing changes to its Medicare enrollment revocation authority to strengthen its ability to act against fraudulent and abusive practices. Specifically, CMS is proposing to clarify and expand its revocation authority to include:

- Instances when the provider or supplier does not comply with requirements in the enrollment application or that are described in Title 42 of the Code of Federal Regulations (CMS and U.S. Department of Health and Human Services Office of Inspector General requirements). Previously, CMS only had express authority to revoke an enrollment based on violating requirements on the enrollment application.

- When a provider or supplier is convicted of a misdemeanor under federal or state law within the previous 10 years, CMS deems the conviction detrimental to the best interests of the Medicare program and its beneficiaries. Notably, this would apply not only to providers and suppliers but also any owner, managing employee or organization, officer, or director of a provider or supplier.
- A civil judgment under the federal False Claims Act within the preceding 10 years by the provider, supplier, or an owner, managing employee or organization, officer, or director of a provider or supplier.
- A violation by an independent diagnostic testing facility (IDTF), durable medical equipment provider or supplier, opioid treatment program, home infusion therapy supplier, or Medicare diabetes prevention program of regulations specific to their provider type.
- Failure to repay any debt to Medicare, including any debt that is no longer being collected or "written off."

CMS proposes "pattern or practice" to generally mean three or more instances of noncompliance, including any pattern or practice of submitting claims that fail to meet Medicare requirements; however, CMS clarified that a pattern or practice alone may not always warrant a revocation, and it will continue to consider all relevant factors when making a revocation determination.

CMS further proposed a "stay of enrollment" period for providers or suppliers who are noncompliant but whom CMS determines can remedy noncompliance by submitting new information on its enrollment form, such as a provider's failure to report a change of information within the required 90-day period. During the stay of enrollment, the provider or supplier cannot receive payment for services. A stay of enrollment period would be for no longer than 60 days.

Changes to provider enrollment notice requirements

CMS proposes changing the time frame within which IDTFs, physicians, NPPs, and physician and NPP organizations must report adding or removing a location to 30 days of the change (reduced from the current 90 days).

CMS is also proposing to define an "indirect" ownership interest as one that includes entities with an ownership interest at the grandparent or great-grandparent levels of the organization, as opposed to the existing definition, which left some uncertainty as to whether certain changes of ownership required reporting to CMS.

CMS clarifies when Medicare covers dental services

CMS proposed to clarify when certain dental services are "inextricably linked" to other covered services and, thus, payable by Medicare. Specifically, CMS is proposing coverage under Parts A and B for dental or oral examinations that are:

1. Performed as part of a comprehensive workup in either inpatient or outpatient settings prior to services for cancer, and
2. Medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to or contemporaneously with cancer services.

Such services for cancer would include chemotherapy, chimeric antigen receptor therapy, T-cell therapy, and administration of high-dose, bone-modifying agents. Payment could also include coverage of ancillary services, including X-rays, anesthesia, and use of the operating room.[15]

New payment to address the social needs of Medicare beneficiaries

CMS is proposing a new, separate payment for the following services to enhance social needs of Medicare beneficiaries: (1) community health integration (CHI); (2) principal illness navigation (PIN); and (3) social determinants of health (SDOH) risk assessments. In general, these services would assist patients in accessing both clinical and social services they require to improve their health. SDOH screenings would involve a standardized, evidence-based risk assessment including, at a minimum, food insecurity, housing insecurity, transportation needs, and utility difficulties. The screening must be performed on the same date as an E/M visit.[16]

Practitioners, auxiliary personnel, and community health workers are permitted to provide these services; however, a CHI or a PIN must be provided incident-to and under the general supervision of the billing practitioner after the practitioner has an initiating visit. In general, "incident-to" billing permits physicians to bill Medicare under their own National Provider Identifier for services jointly performed by them and an NPP. The physician is permitted to collect 100% of the MPFS rate for such services.[17] Services that may be performed by NPPs on this incident-to basis include (i) services ordinarily rendered by a physician's office staff person and (ii) services that would typically be personally performed by the physician.[18] Under this model, the physician is considered the "billing practitioner," and general supervision generally requires that the NPP render services under the physician's overall direction and control, but does not require the physician's presence during furnishing of the service.[19]

A third-party contractor—including a community-based organization—could also render services. Note that CHI and PIN services would be limited to one practitioner per beneficiary per calendar month under the proposal. CMS also proposes permanently adding an HCPCS code GXXX5 for an SDOH screening to the List. The code could be used for a five-to-15-minute service.

Takeaways

- The Centers for Medicare & Medicaid Services (CMS) is extending some, but not all, public health emergency flexibilities for telehealth through calendar year 2024.
- Providers may have to change how they provide and bill for certain telehealth services.
- Providers and suppliers may need to update their policies and procedures regarding Medicare enrollment and reporting changes if the proposed rule is adopted to avoid CMS revoking their enrollment.
- CMS proposes to expand coverage of remote patient monitoring.
- CMS recognizes a need for social services' and community service organizations' roles in providing comprehensive care to Medicare beneficiaries and has proposed three new covered services.

1 Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program, 88 Fed. Reg. 52,262 (Aug. 7, 2023), https://www.govinfo.gov/content/pkg/FR-2023-08-07/pdf/2023-14624.pdf.
2 U.S. Department of Health & Human Services, "HHS Secretary Xavier Becerra Statement on End of the COVID-19 Public Health Emergency," news release, May 11, 2023, https://www.hhs.gov/about/news/2023/05/11/hhs-secretary-xavier-becerra-statement-on-end-of-the-covid-19-public-health-emergency.html.

3 Centers for Medicare & Medicaid Services, "List of Telehealth Services," updated May 9, 2023, https://www.cms.gov/Medicare/Medicare-general-information/telehealth/telehealth-codes.
488 Fed. Reg at 52,294–97.
5 88 Fed. Reg. at 52,294–97.
6 88 Fed. Reg. at 52,297.
7 88 Fed. Reg. at 52,298–301.
8 88 Fed. Reg. at 52,304.
9 Qualified marriage and family therapists and mental health counselors will generally be required to maintain licensure in the state in which they provide services, and meet certain education requirements, including obtaining an advance degree and performing at least two years (or 3,000 hours) of supervised clinical experience.
10 88 Fed. Reg. at 52,361–64
11 88 Fed. Reg. at 52,366–69.
12 88 Fed. Reg. at 52,368.
13 88 Fed. Reg. at 52,354-55.
14 88 Fed. Reg. at 52,516-24.
15 88 Fed. Reg. at 52,379–80.
16 88 Fed. Reg. at 52,325–50.
1742 C.F.R. § 410.26(b) .
18 Centers for Medicare & Medicaid Services, *Medicare Benefit Policy Manual*, "Chapter 15 – Covered Medical and Other Health Services," § 60.2, August 3, 2023, https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c15.pdf.
1942 C.F.R. § 410.26(a)(3) .