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Significant 2024 Medicare Physician Fee Schedule Rule Proposals: E/M, Social Determinants of Health, and Behavioral Health

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In this article, we highlight a number of policy proposals in the current year (CY) 2024 Medicare Physician Fee Schedule (MPFS) Proposed Rule that have significant health care delivery and operational implications. These include proposals to:

- Implement a separate payment for an office/outpatient evaluation and management (E/M) visit complexity code;
- Delay implementing a solely time-based definition of the "substantive portion" of a split or shared visit, thereby maintaining the option for the substantive portion to be based on one of three components (history, exam, or medical decision-making (MDM));
- Separately pay for various services to address health-related social needs involving community health workers, care navigators, and peer support specialists;
- Provide payment for a broader range of behavioral health services and professionals including marriage and family therapists (MFTs) and mental health counselors (MHCs);
- Update hospice conditions of participation to allow MFTs and MHCs to be part of the hospice interdisciplinary team; and
- Permit general supervision of physical therapy (PT) and occupational therapy (OT) assistants furnishing remote therapeutic monitoring (RTM) services in outpatient settings.

Evaluation and Management Services

In the 2024 proposed MPFS rule, the Centers for Medicare & Medicaid Services (CMS) focuses on addressing – what it considers to be – two outstanding issues pertaining to evaluation and management (E/M) reimbursement. Those include: (1) implementing separate payment for the office/outpatient (O/O) E/M visit complexity add-on code, and (2) further delaying the proposed policy to define the substantive portion of split/shared visits based on time.

Separate Payment for O/O E/M Visit Complexity Add-On Code

CMS proposes to change the status of the Healthcare Common Procedure Coding System (HCPCS) code G2211 to make it separately payable by assigning an active status indicator, effective January 1, 2024. While HCPCS code G2211 may currently be reported, it is assigned a bundled payment status indicator. By way of background, in the CY 2021 MPFS Final Rule, CMS retained add-on codes to capture visit complexity that is inherent with primary care and non-procedural specialty care. These codes were refined and consolidated into a single code, HCPCS Code G2211 (O/O visit complexity), which CMS refers to as the O/O E/M visit complexity add-on. The O/O E/M visit complexity code is intended to be reported in conjunction with other O/O E/M visits to account for additional resources associated with primary care or ongoing medical care related to a patient's single, serious condition, or complex condition. *See* 84 FR 62854 through 62856, 85 FR 84571.

Specifically, HCPCS code G2211 is defined as: 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.

The stated purpose of the O/O visit complexity add-on is to ensure the appropriate relative valuation of O/O E/M visits to more properly align with CMS's prior policy changes to O/O E/M visits. CMS believes that the O/O visit complexity add-on reflects the time, intensity, and practice expense associated with establishing longitudinal relationships with patients and addressing most of their health care needs with consistency and continuity over longer periods of time.

Although CMS finalized its policy under the MPFS for HCPCS code G2211 – which was implemented by section 113 of Division CC of the Consolidated Appropriations Act (CAA), 2021 (Pub. L. 116-260, December 27, 2020) (CAA, 2021) in 2021 – the O/O E/M visit complexity add-on was suspended until December 31, 2023. CMS's proposal would change the status of HCPCS code G2211 to active status, thus making it separately payable beginning on January 1, 2024. The original opposition to the implementation of the add-on code was the redistributive impact on payments that would disproportionately affect non-primary care physicians. CMS indicates in the proposed rule that, although the redistributive effects will not be eliminated, they will be less severe if implemented for CY 2024 because CMS refined the add-on code and expects it to be used less as explained in further detail below.

CMS reminds providers and practitioners that it would not expect the add-on code to be reported when the O/O E/M service is reported with a payment modifier, such as the modifier -25, which denotes a separately billable E/M service by the same practitioner furnished on the same day of a procedure or other service. See 85 FR 84572. Furthermore, in the 2024 MPFS proposed rule, CMS reminds providers and practitioners that:

- Separately identifiable O/O E/M visits that occur on the same day as minor procedures, such as zeroday global procedures, have resources that are adequately different from the costs associated with furnishing stand-alone O/O E/M visits such that different payment is necessitated. See 85 FR 84572.
- Accordingly, CMS proposes that the O/O E/M visit complexity addon would not be payable when the O/O E/M visit is reported with payment modifier -25 which is used to indicate that a patient's condition required a significant, separately identifiable E/M service above and beyond that associated with another procedure, or service being reported by the same physician or practitioner on the same date.

In prior rulemaking, CMS provided examples where the use of the O/O complexity add-on would be inappropriate.

Through this proposed change, CMS estimates that the O/O E/M visit complexity add-on code will be billed by 38 percent of practitioners and providers initially and once fully adopted, by 54 percent of practitioners and providers. CMS's utilization assumptions are based on the likelihood that the code will be more frequently utilized by primary care specialties and that surgical specialties will have the lowest utilization since they typically do not establish longitudinal care relationships with patients. CMS's assumptions excluded (1) claims from practitioners participating in capitated models, and (2) claims for established patient visits performed by certain specialties that are unlikely to establish a longitudinal care relationship. Visits that consisted of consults or were for the purpose of obtaining a second opinion were excluded. CMS seeks comment on its utilization assumptions and the application of the O/O visit complexity add-on code for CY 2024.

Additional Requests for Comment Pertaining to E/M Services More Broadly

Additionally, CMS is seeking comments on the approaches it could take to improve the accuracy of valuing services under the MPFS. CMS is particularly interested in how it could improve the accuracy of valuation for

certain services and, specifically, how it may better evaluate E/M services, "more regularly and comprehensively." Thus, in the 2024 MPFS proposed rule, CMS seeks comments on specific questions identified in the rule.

Further Delay of Split or Shared Visit Policy

CMS acknowledged ongoing concerns about its intent to implement a policy to use more than half of the total time to define the "substantive portion" of a split or shared visit, as well as requests to continue to recognize MDM as the "substantive portion."

In response, CMS has proposed to once again delay the implementation of its definition of the "substantive portion" as more than half of the total time through at least December 31, 2024, for the same reasons outlined in the CY 2023 final rule (87 FR 69614- 69616).

To implement this delay, CMS proposes to amend 42 CFR 415.140 to specify that for visits other than critical care visits furnished in calendar years 2022 through 2024, "substantive portion" means either one of three key components (history, exam, or MDM) or more than half of the total time spent by the physician and nonphysician practitioner (NPP) performing the split (or shared) visit.

While the policy is delayed further, CMS will consider feedback from commenters and evaluate whether there is a need for additional rulemaking on this aspect of CMS's policy.

In the CY 2022 physician fee schedule (PFS) final rule, CMS created a new payment modifier (modifier FS) to describe split (or shared) visits. CMS anticipates that implementing this modifier will allow them to better quantify split (or shared) visits and better understand billing patterns. Moreover, CMS plans to use data collected using the new modifier to clarify and further revise the split/shared billing policy in the future.

Providers are on notice to be attentive to split/shared billing practices because CMS has also highlighted that the new modifier will be helpful for program integrity purposes.

CMS seeks comments on the following:

- How facilities are currently implementing split (or shared) services policy in their workflows and how they are currently accounting for the services of billing practitioners that are performed split (or shared).
- How to better account for the services of the billing practitioner in team-based care clinical scenarios.

Finally, CMS noted that the Medicare Advantage (MA) Current Procedure Terminology (CPT) Editorial Panel is considering aspects of split or shared visits, which will be considered if they are available before the final rule is released.

Services Addressing Health-Related Social Needs

CMS proposes several payment and coding changes associated with health-related social needs. These changes seek to account for the resources involved when clinicians involve community health workers, care navigators, and peer support specialists in furnishing medically necessary care.

CMS proposes separate payments for:

- Community Health Integration (CHI) Services (HCPCS Codes GXXX1 and GXXX2);
- Principal Illness Navigation (PIN) Services (HCPCS codes GXXX3 and GXXX4); and
- Social Determinants of Health (SDOH) Risk Assessment (HCPCS code GXXX5).

Additionally, under the Proposed Rule, CMS would permanently add SDOH Risk Assessments to the Medicare Telehealth List. The Proposed Rule also proposes making the SDOH assessment optional in a patient's Annual Wellness Visit (AWV), a comprehensive preventive visit for eligible Medicare Part B beneficiaries.

Separate Payment Codes for CHI and PIN Services

CHI and PIN services both seek to address unmet SDOH needs. CHI services address unmet SDOH needs that affect a patient's diagnosis and treatment. CHI services can be performed by certified or trained auxiliary personnel, such as a community health worker, on an incident to basis under the general supervision of a practitioner. Billing practitioners may contract with third parties to provide CHI services, such as a community-based organization as long as incident to billing requirements are satisfied. Such services can be furnished monthly, as medically necessary. The services can only be provided following an initiating E/M visit in which the practitioner identifies the presence of SDOH needs that significantly limits the practitioner's ability to diagnose or treat a patient and establishes an appropriate care plan.

PIN services help connect patients diagnosed with serious high-risk conditions like cancer and HIV/AIDS to appropriate clinical resources. Under the Proposed Rule, PIN services can be provided following an initiating E/M visit addressing a serious high-risk condition. The E/M visit must be performed by the billing practitioner who will be furnishing or generally supervising the PIN services.

CMS describes a serious high-risk condition, as a condition that is expected to last at least three months; places a patient at significant risk of hospitalization, nursing home placement, acute exacerbation/decompensation, functional decline, or death; and requires the development, monitoring, and possible revision of a disease-specific care plan.

CMS also proposes other requirements concerning CHI and PIN services:

- Auxiliary personnel furnishing CHI and PIN services must be certified or trained to perform all included service elements.
- Auxiliary personnel providing CHI and PIN services must be authorized to perform such services under applicable state laws and regulations.
- The diagnosis of the need for CHI and PHI services and the performance of such services must be documented in the medical record.
- Only one practitioner per beneficiary per calendar month can bill for CHI and PIN services.

CMS seeks comments on the following:

- What other services should serve as a prerequisite for initiating visits for CHI and PIN services;
- the typical duration of CHI and PIN services;
- whether CMS should require patient consent for CHI and PIN services;
- the training requirements for auxiliary personnel providing CHI and PIN services; and
- whether there are other service elements that should be included in the proposed CHI and PIN service codes.

Separate Payment Code for SDOH Risk Assessments

Under the proposed HCPCS code, GXXX5, practitioners would be able to bill Medicare for administering a standardized, evidence-based SDOH risk assessment during certain E/M visits. An SDOH Risk Assessment is a review of an individual's SDOH or identified social risk factors that impact medical diagnosis and treatment.

Such risk assessments would be billable when at least five minutes are spent administering the assessment as part of an E/M visit. CMS believes the assessment can help inform diagnoses, care planning, and coordination.

Telehealth

CMS proposes to permanently add a new code to the Medicare Telehealth List for the Administration of a standardized evidence-based SDOH Risk Assessment as long as the broader proposal for Medicare to pay for such risk assessments is finalized. More specifically, CMS is allowing a face-to-face encounter element of the SDOH risk assessment service to be performed via two-way interactive audio-video technology as a substitute for in-person interaction as long as the telehealth modality does not affect the accuracy or validity of the results gathered via a standardized screening tool. Under the Proposed Rule, the telehealth service must also be furnished by the practitioner on the same date they furnish an E/M visit as the SDOH assessment would be reasonable and necessary when used to inform the patient's diagnosis, and treatment plan established during the visit.

SDOH Risk Assessment in the AWV

CMS proposes to add to the AWV an optional SDOH Risk Assessment, which aims to enhance patient-centered care, identify social risks earlier, and respond to resulting health needs proactively through care planning and coordination.

The proposed SDOH Risk Assessment involves administering a standardized, evidence-based, and culturally and linguistically appropriate SDOH risk assessment tool that considers the patient's educational, developmental, and health literacy level. It would be separately payable with no cost sharing for beneficiaries when performed as part of the AWV.

Behavioral Health Services

CMS proposes policies related to behavioral health services, including:

- Providing Medicare Part B coverage and payment for services of marriage and family therapists (MFTs) and mental health counselors (MHCs) and allowing addiction counselors to enroll in Medicare as MHCs.
- Adding payment codes for psychotherapy for crisis services provided in an applicable site of service.
- Allowing MFTs, MHCs, clinical social workers, and clinical psychologists to bill for certain health behavior assessment and intervention services.
- Increasing payment for timed behavioral health services over a four-year transition period.

CMS seeks comments on ways to expand access to behavioral health services.

Proposed Updates to the Hospice Conditions of Participation

In the 2024 proposed MPFS rule, CMS is proposing to update the hospice Conditions of Participation to include MFTs and MHCs as part of the hospice interdisciplinary team (IDT). This is consistent with the CAA which requires the IDT to include at least one social worker, MFT, or MHC. In proposing to modify the hospice conditions of participation (CoP), CMS attempts to broaden access to behavioral health services. Under current regulation, the hospice IDT is currently comprised of physicians, nurses, hospice aides, social workers, counselors, chaplains, therapists, and trained volunteers.

Through this change, CMS would create two new regulatory sections, §410.53 and §410.54 to codify the coverage of MFTs and MHCs. The definition of an MFT would include a person who: (1) possesses a master's or doctorate degree which qualifies for licensure or certification as an MFT under the law of the state where the

individual furnishes services, (2) after obtaining the foregoing degree, the person must have performed at least two years or 3,000 contact hours of post-master's degree clinical supervision experience in marriage and family therapy in an appropriate clinical setting, and (3) is licensed or certified as an MFT by the state where the services are performed. Marriage and family services would be defined as services furnished by an MFT for the diagnosis and treatment of mental illnesses, which the therapist is legally authorized to perform under state law.

CMS also proposes defining an MHC as a professional that (1) holds a master's or doctorate degree which qualifies for licensure or certification as a mental health counselor, clinical professional counselor, or professional counselor under state law; (2) has performed at least two years or 3,000 hours of post master's degree clinical supervised experience in mental health counseling in a setting such as a hospital, skilled nursing facility (SNF), private practice, or clinic; and (3) is a licensed or certified MHC, clinical professional counselor, or professional counselor by the state in which the services are performed. This regulatory change would permit MHCs to provide the same services as a clinical social worker – which is already permitted to be part of the hospice IDT. Covered services would include those for the diagnosis and treatment of mental illness which the MHC is legally authorized to perform under the law of the state where the services are furnished. Additionally, the services furnished by both an MFT and an MHC must be services that Medicare would cover if they were furnished by a physician or incident to and if furnished incident to, must meet those requirements.

Supervision of Outpatient Physical and Occupational Therapy Services

The proposed rule would permit general supervision of PT and OT therapy assistants for remote therapeutic monitoring (RTM) services. Since 2005, CMS has required direct supervision of all physical and occupational therapy services performed in an outpatient setting. Notably, for PT and OT services furnished in an inpatient setting, general supervision is allowed. The current regulations requiring direct supervision make it difficult for PTs and OTs in private practice to bill for RTM services performed by PT and OT assistants because the supervising PTs and OTs in private practice cannot always be immediately available as required for direct supervision. This change would be consistent with CMS's intent, as discussed in the CY 2022 PFS final rule, that PTs and OTs in private practice should be among the primary billers for RTM services. CMS would retain the direct supervision requirements for services furnished by PTs and OTs not yet enrolled in Medicare, but who are supervised by PTs and OTs in private practice.

CMS seeks further comments on whether it should revise its direct supervision policy to allow for general supervision of all services furnished by PTs and OTs in the private practice setting, not just for remote therapeutic monitoring. CMS requests information on the effect of this policy on patient safety, patient care, potential changes in utilization, and any supporting data.

CMS's proposals in the CY 2024 MPFS Proposed Rule implement policies and payments that are intended to compensate for complexity and longitudinal care relationships; and expand coverage and access to services and practitioners addressing health-related social needs and behavioral health. Providers, suppliers, and other stakeholders interested in these policy goals will have to analyze whether these proposed policies can be implemented to achieve their goals.

The Baker Donelson Reimbursement team can assist in considering the implications of these proposals on health care arrangements and operations. If you have any questions, please reach out to Allison M. Cohen, Alissa D. Fleming, Alex S. Lewis, or another member of Baker Donelson's Reimbursement team.