



Medicare Physician Fee Schedule Final Rule Summary: CY 2024

Related CR Release Date: November 22, 2023 MLN Matters Number: MM13452

Effective Date: January 1, 2024

Related Change Request (CR) Number: [CR 13452](#)

Implementation Date: January 2, 2024

Related CR Transmittal Number: R12372CP

Related CR Title: Summary of Policies in the Calendar Year (CY) 2024 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List

Affected Providers

- Physicians
- Hospitals
- Suppliers
- Other providers billing Medicare Administrative Contractors (MACs) for Medicare services paid under the PFS

Action Needed

Make sure that your billing staff knows about changes to:

- Telehealth services
- Evaluation and management (E/M) visits
- Behavioral health services
- Dental and oral health services
- Therapy services
- Diabetes self-management training (DSMT) services
- Community Health Integration (CHI) services
- Principal Illness Navigation (PIN) services
- Social Determinants of Health (SDOH)
- Caregiver training

Background

CMS issued a [final rule](#) that updates payment policies and Medicare payment rates for services provided by physicians and NPPs that are paid under the MPFS in CY 2024. These changes apply to services you provide in CY 2024.

Medicare Telehealth Services

For CY 2024, we're adding new codes to the list of Medicare telehealth services, including:

- CPT codes 0591T - 0593T for health and well-being coaching services, which we're adding on a temporary basis
- HCPCS code G0136 for Social Determinants of Health Risk Assessment, which we're adding on a permanent basis.

We're implementing several telehealth-related provisions of the [Consolidated Appropriations Act \(CAA\)](#), 2023, including:

- The temporary expansion of the scope of telehealth originating sites for services provided via telehealth to include any site in the U.S. where the patient is at the time of the telehealth service, including a person's home
- The expansion of the definition of telehealth practitioners to include qualified occupational therapists (OTs), physical therapists (PTs), speech-language pathologists (SLPs), and audiologists
- The continued payment for telehealth services rural health clinics (RHCs) and federally qualified health centers (FQHCs) provide using the methodology established for those telehealth services during the public health emergency (PHE)
- Delaying the requirement for an in-person visit with the physician or practitioner within 6 months prior to initiating mental health telehealth services, and, again, at subsequent intervals as the Secretary determines appropriate, as well as similar requirements for RHCs and FQHCs
- The continued coverage and payment of telehealth services included on the Medicare [Telehealth Services List](#) (as of March 15, 2020) until December 31, 2024
- Adding mental health counselors (MHCs) and marriage and family therapists (MFTs) as distant site practitioners for purposes of providing telehealth services

We're implementing that, starting in CY 2024, telehealth services provided to people in their homes will be paid at the non-facility PFS rate. We clarified that modifier '95' should be used when the clinician is in the hospital and the patient is in the home, as well as for outpatient therapy services provided via telehealth by PT, OT, or SLPs.

We removed frequency limitations in 2024 for:

- Subsequent inpatient visits
- Subsequent nursing facility visits
- Critical care consultation

We're allowing teaching physicians to use audio or video real-time communications technology when the resident provides Medicare telehealth services in all residency training locations through the end of CY 2024.

Telehealth Origination Site Facility Fee Payment Update

The MEI increase for 2024 is 4.6%. Therefore, for CY 2024, the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80% of the lesser of the actual charge, or \$29.96. The patient is responsible for any unmet deductible amount and Medicare coinsurance.

Payment for Outpatient Therapy (including PT, OT, SLP), DSMT, and Medical Nutrition Therapy (MNT) Services when Institutional Staff Provide the Services to Patients in Their Homes through Communication Technology

Institutional providers are able to continue to bill for PT, OT, SLP, DSMT and MNT services provided remotely in the same way they could during the PHE and through the end of CY 2023.

We're finalizing the proposed policy for CY 2024, with modifications, as follows:

- Hospitals and other providers of PT, OT, SLP, DSMT and MNT services that remain on the Medicare Telehealth Services List can continue to bill for these services when provided remotely in the same way they've been during the PHE and the remainder of CY 2023, except that:
 - For outpatient hospitals, patients' homes no longer need to be registered as provider-based entities to allow for hospitals to bill for these services
 - Except for Critical Access Hospitals (CAHs) electing Method II, the 95 modifier is required on claims from all providers, as soon as hospitals needing to do so can update their systems.

Telehealth Finalized Policies for DSMT Services

Distant Site Practitioners: To increase access to DSMT telehealth services, we're finalizing billing rules for telehealth DSMT services at [42 CFR 410.78\(b\)\(2\)\(x\)](#) to allow distant site practitioners who can appropriately bill for DSMT services, such as registered dietitians (RDs) and nutrition professionals, physicians, NPPs, physician assistants (PAs), and clinical nurse specialists (CNSs), to do so on behalf of others who personally provide the services as part of the DSMT entity.

Injection Training for Insulin-Dependent Patients: During the PHE for COVID-19, we permitted insulin injection training to be done via telehealth for patients getting DSMT services. We're finalizing a policy to allow DSMT insulin injection training (for initial or follow-up training) to be provided via telehealth when it aligns with clinical standards, guidelines, or best practices, instead of the previous sub-regulatory policy that required certain hours of training be provided in-person. See Chapter 12, Section 190.3.6 of the [Medicare Claims Processing Manual](#).

Evaluation and Management (E/M) Visits

Complexity Add-on HCPCS Code G2211

With the end of the Congressionally mandated suspension of payment for Office Outpatient

Evaluation Management (O/O E/M) visit complexity add-on HCPCS code G2211, for CY 2024, we're finalizing changing the status of code G2211 to make it separately payable by assigning it an "active" status indicator, effective January 1, 2024. We recognize that separately identifiable visits occurring on the same day as minor procedures (such as zero-day global procedures) have resources that are sufficiently distinct from the costs associated with providing stand-alone office or outpatient E/M visits to warrant different payment. We're also finalizing that the O/O E/M visit complexity add-on code G2211 wouldn't be payable when you report the O/O E/M visit with payment modifier 25.

[CR 13452](#) has more details along with several examples on the use of G2211.

Split (or Shared) Visits

Split (or shared) E/M visits refer to visits provided in part by physicians and in part by other NPPs in hospitals and other institutional settings. For CY 2024, we're finalizing a revision to our definition of "substantive portion" of a split (or shared) visit to include the revisions to the CPT guidelines. For Medicare billing purposes, the "substantive portion" means more than half of the total time spent by the physician and or non-physician practitioner performing the split (or shared) visit, or a substantive part of the medical decision making.

Behavioral Health Services

For CY 2024, we're implementing Section 4121 of the [CAA, 2023](#), which provides for Medicare Part B coverage and payment under the PFS for the services of MFTs and MHCs when billed by these professionals. We're also finalizing allowing addiction counselors that meet all of the applicable requirements to be an MHC and to enroll in Medicare as MHCs. MFTs and MHCs to enroll in Medicare and these providers would be able to bill Medicare for services, starting January 1, 2024, consistent with statute. We're also making corresponding changes to Behavioral Health Integration codes to allow MFTs and MHCs to provide integrated behavioral health care as part of primary care settings.

CMS is also implementing Section 4123 of the CAA, 2023, which requires the Secretary to establish new HCPCS codes under the PFS for psychotherapy for crisis services provided in an applicable site of service (any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting, including the home or a mobile unit) provided on or after January 1, 2024. Section 4123 of the CAA, 2023, specifies that the payment amount for these psychotherapy for crisis services must be equal to 150% of the fee schedule amount for non-facility sites of service for each year for the services identified (as of January 1, 2022) by HCPCS codes:

- 90839 (Psychotherapy for crisis; first 60 minutes)
- 90840 (Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)), and any succeeding codes.

We're also finalizing allowing the Health Behavior Assessment and Intervention (HBAI) services described by CPT codes 96156, 96158, 96159, 96164, 96165, 96167, and 96168, and any successor codes, to be billed by clinical social workers, MFTs, and MHCs, in addition to clinical

psychologists. HBAI codes are used to identify the psychological, behavioral, emotional, cognitive, and social factors included in the treatment of physical health problems.

We're also finalizing an increase in the valuation for timed behavioral health services under the PFS. We're going to apply an adjustment to the work Relative Value Units (RVUs) for psychotherapy codes payable under the PFS, which we're implementing over a 4-year transition.

We're finalizing an increase to the payment rate for office-based treatment for substance use disorders (HCPCS codes G2086 and G2087) to show 2 individual psychotherapy sessions per month, based on a crosswalk to the work RVUs assigned to CPT code 90834 (Psychotherapy, 45 minutes with patient), rather than CPT code 90832 (Psychotherapy, 30 minutes with patient).

Dental and Oral Health Services

Medicare Parts A and B makes payment for certain dental services in circumstances where the services aren't considered to be in connection with dental services within the meaning of Section 1862(a)(12) of the [Social Security Act](#) or our regulation at [42 CFR 411.15\(i\)](#). Dental services that are so integral to other medically necessary services that they're inextricably linked to the clinical success of that medical services aren't in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth within the meaning of Section 1862(a)(12) of the Act. Rather, these dental services are inextricably linked to the clinical success of an otherwise covered medical service, and are payable under Medicare Parts A and B.

For CY 2024, we're finalizing:

- Permitting payment for certain dental services inextricably linked to other covered services used to treat cancer, prior to, or contemporaneously with
 - Chemotherapy services,
 - Chimeric Antigen Receptor - T (CAR-T) Cell therapy, and,
 - The use of high-dose bone modifying agents (antiresorptive therapy)
- Codification of and amendments to the previously finalized payment policy for dental services prior to, contemporaneously with, or after treatment of head and neck cancer using radiation, chemotherapy, surgery, or any combination of these, whether primary or metastatic.

Therapy Services

Supervision Policy for Physical and Occupational Therapists in Private Practice

Since 2005, we've required PTs Private Practices and OTs Private Practices (PTPPs and OTPPs, respectively) to provide direct supervision of their therapy assistants. We're finalizing a regulatory change to allow for general supervision of therapy assistants by PTPPs and OTPPs for remote therapeutic monitoring (RTM) services, starting January 1, 2024.

The KX-modifier threshold amounts for CY 2024 are \$2,330 for OT services and \$2,330 for PT and SLP services combined.

DSMT Services Provided by Registered Dietitians (RDs) and Nutrition Professionals

We're finalizing an amendment to the regulatory provision at [42 CFR 410.72\(d\)](#) established during CY 2022 PFS rulemaking that clarifies that an RD or nutrition professional must personally perform MNT services. The enrolled RD or nutrition professional may bill for, or on behalf of, the entire DSMT entity as the DSMT certified provider, regardless of which professional personally delivers the service.

CHI Services

We're finalizing separate coding and payment for CHI services, which include person-centered planning, health system coordination, promoting patient self-advocacy, and facilitating access to community-based resources to address unmet social needs that interfere with the practitioner's diagnosis and treatment of the patient. These are the first PFS services designed to specifically include care involving community health workers, who link underserved communities with critical health care and social services in the community and expand equitable access to care, improving outcomes for the Medicare population.

PIN Services and SDOH

For CY 2024, we're finalizing new coding and payment for PIN services, HCPCS codes G0023, G0024, G0140, and G0146, which use auxiliary personnel such as patient navigators and peer support specialists to provide navigation in the treatment of a serious, high-risk condition or illness. These services include items such as person-centered planning, promoting patient self-advocacy, and facilitating access to community-based resources to address unmet social needs and other factors that are relevant to the practitioner's diagnosis and treatment of the patient.

We're also finalizing new coding and payment for the administration of SDOH risk assessments (G0136), which must be provided in conjunction with a qualifying visit, including an E/M visit, some behavioral health visits, or the Annual Wellness Visit. The evidence-based, standardized SDOH risk assessment tool used must cover domains such as housing insecurity, food insecurity, transportation needs, and utility difficulty, but practitioners may choose to add other domains if prevalent or culturally salient to their patient population.

Caregiver Training

For CY 2024, we're finalizing new coding (CPT codes 96202, 96202, 97550, 97551, and 97552) to make payment when practitioners train and involve one or more caregivers to assist patients with certain diseases or illnesses (such as dementia) in carrying out a treatment plan.

We're finalizing our proposal to pay for these services when provided by a physician or a NPP (nurse practitioners, CNSs, certified nurse-midwives, PAs, and clinical psychologists), or therapist (PT, OT, or SLP) under an individualized treatment plan or therapy plan of care, without the patient present.

More Information

We issued CR 13452 to your MAC as the official instruction for this change.

Your MAC will use the prolonged preventive services G0513 and G0514 as an add-on to the [covered preventive services list](#).

The list of codes subject to the [CT modifier reduction](#) is available.

For more information, [find your MAC's website](#).

Document History

Date of Change	Description
November 22, 2023	Initial article released.

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