2024 Medicare Physician Fee Schedule (MPFS) Updates

November 30, 2023

Webinar FAQ Document

1. **Question:** Can Current Procedural Terminology (CPT®) code 99459 be reported if the patient is offered a chaperone and declines (and this is documented by the provider), given that they are still using a speculum for the exam and that still needs reimbursement?

   Answer: The Calendar Year (CY) 2024 Medicare Physician Fee Schedule (MPFS) Final Rule discussed CPT® code 99459 "Pelvic examination (List separately in addition to code for primary procedure)" briefly. The code is to capture the direct practice expenses associated with performing a pelvic exam in the non-facility setting. The valuation of the Relative Value Units (RVUs) assigned four clinical staff minutes associated with chaperoning the procedure but did not address scenarios where the clinical staff time was not provided but other supplies were used.[1]

   You may wish to discuss the scenario with your Compliance Department or Decision Support team.

2. **Question:** For split/shared visits, does an attestation suffice for the "made or approved" and "take on risk of MDM"?

   Answer: CPT® Guidelines do not address documentation issues. It is possible that the documentation in the note makes it easy to infer who has either made or approved the plan for the number and complexity of problems addressed at the encounter and who has assumed the risk of complications and/or morbidity or mortality of the patient's management. If this is not occurring, then you may wish to follow your practice's policies for this scenario.[2]

3. **Question:** Office visits reported with Place of Service (POS) 11 are not split/shared, they are "incident to", correct?

   Answer: Yes, E/M visits reported with POS 11, *Office* should follow the "incident to" requirements. Split/shared visits may be reported where "incident to" services are not allowed, such as in an outpatient hospital setting. "Incident to" applies to noninstitutional patients in a noninstitutional setting.[3]

4. **Question:** What will the changes to the times listed in the office evaluation and management (E/M) visits do in regard to the Prolonged Service codes if you bill based on time? For example, CPT® code 99205 used to be 60-74 minutes and if you spent 120

minutes with a patient, you could figure out the time to bill for the prolonged service. Now the code says 60 minutes must be met or exceeded. How would you determine using Prolonged Service codes for time?

Answer: CPT® Guidelines for prolonged services state that prolonged total time is time that is 15 minutes beyond the time threshold required to report the highest-level primary service. With the revised description for 99205, *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded* removing the time range, the prolonged services CPT® code 99417, *Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the outpatient Evaluation and Management service),* may be reported when 75 minutes of time has been reached.

When 120 minutes is the reported time, then you may report:

99205 x1

99417 x4[4]

You may wish to review the MLN Booklet, 'Evaluation and Management Services Guide,' which has a section on Prolonged Services. CMS expects Healthcare Common Procedure Coding System (HCPCS) code G2212, *Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (List separately in addition to CPT codes 99205, 99215, 99483 for office or other outpatient evaluation and management services) (do not report G2212 on the same date of service as 99358, 99359, 99415, 99416). (do not report G2212 for any time unit less than 15 minutes),* to be used for outpatient office E/M codes.[5]

5. **Question:** If the patient was transferred from hospital A to hospital B but in the same health network, would that be two visits or one?

Answer: The answer may take a little research. As long as the hospitals are separate facilities, then this may be considered two visits. The guideline states:

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[1] Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies, CMS-1784-F, "(23) Pelvic Exam (CPT code 99459)," page 78912, available at: https://www.federalregister.gov/documents/2023/11/16/2023-24184/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other

[2] CPT® 2024 Manual, Professional Edition, "Evaluation and Management (E/M) Guidelines," page 6

[3] 42 CFR Subsection 410.26(b)(1), "Services and supplies incident to a physician's professional services: Conditions," pages 371-372, available at: https://www.govinfo.gov/content/pkg/CFR-2014-title42-vol2/pdf/CFR-2014-title42-vol2-sec410-26.pdf

[4] CPT® 2024 Manual, Professional Edition, "Evaluation and Management / Prolonged Services," pages 32-33

[5] MLN Booklet, Evaluation and Management Services Guide, "Prolonged Services," pages 9-10, available at: https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/eval-mgmt-serv-guide-icn006764.pdf

"***Multiple encounters in different settings or facilities:*** A patient may be seen and treated in different facilities (eg, a hospital-to-hospital transfer). When more than one primary E/M service is reported and time is used to select the code level for either service, only the time spent providing that individual service may be allocated to the code level selected for reporting that service. No time may be counted twice when reporting more than one E/M service…."[6]

6. **Question:** Is CPT® code 96446 used for the catheter placement into the abdomen and you would report with 96547 and/or 96548? For example, would you report 96446 and 96547 for 50 minutes of the chemo in addition to CPT® code 49203 as an example of tumor removal?

   Answer: The Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedures 96547, *Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; first 60 minutes (List separately in addition to code for primary procedure)* and 96548, *Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; each additional 30 minutes (List separately in addition to code for primary procedure),* are reported when the HIPEC infusion is performed during the same operative session as a tumor removal.

   For example, CPT® code 49203, *Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, 1 or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor 5 cm diameter or less,* may be the primary surgical procedure, and then 96547 may be reported for the first hour of HIPEC. The HIPEC procedure includes intraoperative perfusion of a heated chemotherapy agent into the abdominal cavity through catheters.[7]

   CPT® code 96446, *Chemotherapy administration into the peritoneal cavity via implanted port or catheter* is a separate service and not considered to be a HIPEC procedure.

[6] CPT® 2024 Manual, Professional Edition, "Evaluation and Management (E/M) Guidelines," pages 6-7
[7] CPT® 2024 Manual, Professional Edition, "Medicine / Other Injection and Infusion Services," page 861