2024 Medicare Physician Fee Schedule (MPFS) Updates

November 30, 2023

Webinar FAQ Document

1. **Question:** How is Current Procedural Terminology (CPT®) code 99459 used? For example, if we're providing a well woman exam with a Pap and pelvic exam service such as (CPT®) code 99386, can we add 99459?

   Answer: CPT® code 99459 "Pelvic examination (List separately in addition to code for primary procedure)" is a practice expense (PE) only code, as the physician or other qualified healthcare provider (QHP) work is captured in the evaluation and management service. Reimbursement for CPT® 99459 is to capture the clinical staff time for chaperoning the procedure, as well as additional supplies, such as the speculum.[1]

   The 2024 CPT® Manual parenthetical notes state, " (Use 99459 in conjunction with 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99383, 99384, 99385, 99386, 99387, 99393, 99394, 99395, 99396, 99397)."

2. **Question:** Regarding the telephone codes 99441-99443 in 2024, are these for established patients or may they be used on new patients, too?

   Answer: The CY 2024 MPFS Final Rule did not specifically address the new versus established patient issue on the telephone visit codes. In another area, CMS did state that they believe new patients should be seen in person when the temporary telehealth flexibilities end when discussing hospital and emergency department visits. You may wish to reach out to your local Medicare Administrative Contractor (MAC) for clarification.[2]

3. **Question:** How would a split/shared visit apply if the physician and other qualified healthcare professional (QHP) are employed in different group practices but share in the care of the patient?

   Answer: The MPFS states that a split (or shared) visit is where a physician and nonphysician practitioner (NPP) in the same group practice provide the service together. The services do not need to be concurrent.[3]

4. **Question:** For a split/shared visit, who would you interpret to be the billing provider if a QHP does the assessment and plan (the first portion) but the physician assumes responsibility for the outcome? I can see those as being two separate providers in many scenarios.

Answer: CPT® Guidelines state that when Medical Decision Making (MDM) is used for code selection, the one who made or approved the management plan for the number and complexity of problems addressed at the encounter **and** takes responsibility for that plan and inherent risk of complications and/or morbidity or mortality of patient management is used to select the provider of the "substantive" portion. Neither CMS nor the AMA address documentation issues, but documentation in the chart should support the services billed. If the physician is assuming the responsibility of the outcome, then there may be tacit approval of the treatment plan. You may wish to educate providers on documentation tips to allow coders to understand when the physician is approving the treatment plan and assuming the risk of the outcome. Another possibility is to update your policies and procedures (P&P) to cover the scenario.

You may wish to reach out to your local Medicare Administrative Contractor (MAC) for further information.[4]

5. **Question:** For the new caregiver services, would they be billed to the patient's insurance or the caregiver's insurance?

   Answer: Because the services are on behalf of the patient, the patient's insurance would be billed.[5]

6. **Question:** Can the new caregiver services be used above and beyond rehabilitation? Are the codes appropriate for reporting to patients receiving Intensive Outpatient (IOP) therapy or Partial Hospitalization Program (PHP) services?

   Answer: The new caregiver training services, such as CPT® code 97550 *Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety*

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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] 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, "c. Telephone Evaluation and Management Services," page 78884 and "(5) Hospital Care, Emergency Department and Hospital," page 78858-78859, 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

[3] 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, "3. Split (or Shared) Visits," page 78982, 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

[4] 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, "3. Split (or Shared) Visits," pages 78982-78985, 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

[5] 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, "(27) Payment for Caregiver Training Services," pages 78914-78920, 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

practices) (without the patient present), face to face; initial 30 minutes, were created to provide caregiver training with interventions aimed at improving the patient's ability to successfully perform activities of daily living (ADLs). This generally includes ambulating, feeding, dressing, personal hygiene, continence and toileting.

Conditions include traumatic brain injury (TBI), various forms of dementia, autism spectrum disorders, individuals with other intellectual or cognitive disabilities, physical mobility limitations, or necessary use of assisted devices or mobility aids. While conditions are not limited to these specific clinical conditions, patients receiving PHP and/or IOP services are not listed. You may wish to contact your local MAC for clarification.[6]

7. **Question:** Would the caregiver codes apply for respiratory therapists instructing kids' parents on ventilators when the patient is discharged?

   Answer: Caregiver training services are provided without the patient present and focus on assisting the patients with their ADLs for patients with certain clinical conditions. Clinical conditions listed within the MPFS Final Rule include TBI, dementia, autism spectrum disorders, individuals with other intellectual or cognitive disabilities, physical mobility limitations, or the necessary use of assisted devices or mobility aids.

   It is possible that the respiratory therapist instructions to the parent for children on ventilators may be included in the room and board (daily rate) and/or discharge services provided.

   Patients on ventilators may be inpatient status, and in that instance, it may not be appropriate to report the new caregiver training services. You may wish to seek clarification from your local MAC.[7]

8. **Question:** For split/shared services, how would this affect patients seen by two different providers on the same day with the same chief complaint(s), but the providers are not aware of the other visit?

   Answer: The MPFS states that a split (or shared) visit is where a physician and nonphysician practitioner (NPP) in the same group practice provide the service together.

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[6] 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, "(27) Payment for Caregiver Training Services," pages 78914-78920, 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

[7] 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, "(27) Payment for Caregiver Training Services," pages 78914-78920, 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

The services do not need to be concurrent. This may qualify as a split or shared visit; however, you may wish to reach out to your local MAC for clarification.[8]

9. **Question:** Who qualifies as a community health worker (CHW)?

   Answer: The definition of a CHW as defined by the U.S. Health and Human Services Administration (HHS) Bureau of Health Professions is:

   "CHW Definition
   Community health workers are lay members of communities who work either for pay or as volunteers in association with the local health care system in both urban and rural environments and usually share ethnicity, language, socioeconomic status and life experiences with the community members they serve. They have been identified by many titles such as community health advisors, lay health advocates, "promotores(as),"1 outreach educators, community health representatives, peer health promoters, and peer health educators. CHWs offer interpretation and translation services, provide culturally appropriate health education and information, assist people in receiving the care they need, give informal counseling and guidance on health behaviors, advocate for individual and community health needs, and provide some direct services such as first aid and blood pressure screening."[9]

   Each state may have their own scope of practice and training requirements. The MPFS Final Rule contains a footnote with an organization that has training programs and a list of learning requirement in each state. You may access the CHWTraining site, available here:

   https://chwtraining.org/c3-project-chw-skills/

10. **Question:** When considering if a visit is split/shared, can the initial visit be performed by BOTH the QHP and the physician jointly? Then the service would be billed with the physician as the billing provider as long as they add an addendum stating they performed the substantive portion of the visit (and all documentation necessary)?

    Answer: When there is a split (shared) visit, the provider who provided the substantive portion of the visit should be the reporting provider. The substantive portion may be based on time or on medical decision making (MDM).[10]

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[8] 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, "3. Split (or Shared) Visits," page 468, 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

[9] U.S. Department of Health and Human Services Administration Bureau of Health Professions, Community Health Worker National Workforce Study "Executive Summary," pages iii-iv, available at: https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/community-health-workforce.pdf

[10] 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, "3. Split (or Shared) Visits," pages 78982-78985, 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

When using time for code selection, concurrent time spent by the providers should only be counted once. Only the distinct time for the providers may be summed.[11]

11. **Question:** What is the difference between principal illness navigation and principal care management?

    Answer: Principal care management services focus on the medical and/or psychosocial needs of the patient based on a single, complex chronic condition.[12]

    Principal Illness Navigation (PIN) services have two types of services and may be provided by a patient navigator with another set of codes to report services provided by a trained or certified peer support (PS) navigator. Services provided by the PIN clinical staff or the PIN-PS staff may focus on clinical navigation services or patient navigation services.

    Clinical navigation services may focus on clinical care, clinical coordination and clinical education. Patient navigation services may focus on improving access to care related to social determinants of health (SDOH).[13]

    Services may appear to overlap, so it is important that documentation supports the service(s) provided.

[11] CPT® Assistant, March 2020, "E/M Office or Other Outpatient Visit Revisions for 2021: Time," page 3
[12] CPT® Assistant November 2023 Special Edition, "Reporting CPT Codes for Oncology Navigation Services: The Cancer Moonshot," page 4, available at: https://www.ama-assn.org/system/files/cpt-assistant-oncology-navigation-codes.pdf
[13] CPT® Assistant November 2023 Special Edition, "Reporting CPT Codes for Oncology Navigation Services: The Cancer Moonshot," page 3, available at: https://www.ama-assn.org/system/files/cpt-assistant-oncology-navigation-codes.pdf