



## **Medicare Physician Fee Schedule Final Rule for Calendar Year 2024 Detailed Summary of the Payment and Quality Payment Program Provisions**

On November 2, 2023, the Centers for Medicare & Medicaid Services (CMS) released the 2024 Medicare Physician Fee Schedule (MPFS) Final Rule. The American College of Radiology (ACR) has prepared this detailed analysis of final changes to the MPFS for calendar year (CY) 2024. These rule changes are effective January 1, 2024.

### **Conversion Factor and CMS Overall Impact Estimates** (Page 1948)

CMS announced a CY 2024 conversion factor of \$32.7442 compared to the 2023 conversion factor of \$33.8872. CMS estimates an overall impact of the MPFS proposed changes to radiology to be a 3 percent decrease, while interventional radiology would see an aggregate decrease of 4 percent, nuclear medicine a 3 percent decrease and radiation oncology and radiation therapy centers a 2 percent decrease. The payment impacts will be higher as the overall payment impact estimates mentioned above do not take into account the impact of the Consolidated Appropriations Act (CAA) payment supplements of 2.50 percent for 2023 and 1.25 percent for 2024.

### **Appropriate Use Criteria for Advanced Diagnostic Imaging** (Page 1319)

**CMS finalized its proposal to pause the Protecting Access to Medicare Act (PAMA) imaging appropriate use criteria (AUC) program due to continued concerns with the real-time claims processing aspect of the statute**, stating “...we have exhausted all reasonable options for fully operationalizing the AUC program consistent with the statutory provisions...”. The rule indicated that more time is needed to reevaluate the program to ensure that imaging claims are not inappropriately denied.

### **Background and Rulemaking History**

The rule includes a detailed background of the PAMA imaging AUC program, including an outline of the law and the associated regulations that were developed over the past 8 years. The law requires ordering providers to consult AUC developed by provider-led entities (PLEs) through a clinical decision support mechanism (CDSM) when ordering advanced diagnostic imaging, including CT, MR, PET and nuclear medicine, for Medicare Part B patients. CMS defined PLEs and the process to become a certified PLE in the 2016 rulemaking cycle. The first qualified PLEs were posted on the CMS website in June 2016. The 2017 rulemaking cycle outlined the requirements and process for CDSMs to become qualified. The first qualified CDSMs were posted on the CMS website in July 2017.

In 2018, CMS began a voluntary reporting program for providers who were ready to participate in the ACR program. To incentivize the early use of CDSMs, the agency provided high-weight quality improvement activity credit for ordering professionals who consult AUC using a qualified CDSM for the Merit-based Incentive Payment System (MIPS).



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Since 2018, CMS has struggled with operationalizing the portion of the law that requires imaging providers to report AUC consultation information on applicable imaging claims in order to receive reimbursement. If the program were to be fully implemented, payment for imaging services that do not contain the appropriate AUC consultation information on applicable claims would be denied.

### **Finalization of Proposal to Pause Program for Reevaluation**

The AUC program has been operating in an “educational and operations testing period” without payment penalties in place since January 1, 2020. **CMS finalized its proposal to pause the program for reevaluation, including pausing the ongoing educational and operations testing period. In conjunction with this, CMS also finalized its proposal to rescind the current AUC program regulations and reserve them for future use. The agency did not suggest a time frame for resumption of implementation.** The rule states, “...the real-time claims-based reporting requirement prescribed by section 1834(q)(4)(B) of the Act presents an insurmountable barrier for CMS to fully operationalize the AUC program”.

#### *Real-Time Claims-Based Reporting*

CMS indicated that the greatest challenge in implementing the imaging AUC program has been operationalizing the real-time claims-based reporting requirement. Despite the development of what the agency believed to be meaningful and workable solutions, there are significant concerns that payment delays and inappropriate claims denials would occur. The existing Medicare claims processing system does not have the capacity to fully automate the process for distinguishing between advanced diagnostic imaging claims that are or are not subject to the AUC program reporting requirements. In addition, CMS stated in the rule, “...reliance on manual reporting by one party of information supplied by another party presents a serious risk to data accuracy and integrity”.

#### *Effect on Medicare Beneficiaries*

Despite the implementation barriers necessitating the program reevaluation of the program, CMS recognizes the value of the AUC program to improve utilization patterns for Medicare beneficiaries. The Agency indicated that utilizing AUC to ensure that patients receive the right imaging at the right time would “inform more efficient treatment plans and address medical conditions more quickly and without unnecessary tests”. The rule states that this could result in potential savings to the Medicare program of \$700,000,000 annually. CMS arrived at this estimate by extrapolating savings from a clinical decision support pilot project performed by the Institute for Clinical Systems Improvement in Bloomington, Minnesota.

Nevertheless, CMS is concerned that the real-time claims-based reporting requirement may impact beneficiaries’ ability to receive timely imaging services if scheduling is delayed while imaging providers wait to receive AUC consultation information from reporting providers. In addition, CMS raises the concern of patients being financially liable for advanced diagnostic imaging claims denied by Medicare for failure to include consultation information.



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CMS indicated that they will continue efforts to identify workable implementation approaches and will propose to adopt such solutions in future rulemaking. In the meantime, CMS **encourages clinicians to continue to use CDS**.

*Summary of Other Quality Initiatives*

CMS states, “Promoting the use of AUC in clinical practice is an activity that encourages the use of evidence-based information/guidelines/recommendations to guide patient care thus resulting in improved value and quality.”. Subsequent to PAMA, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114-10, April 16, 2015) established the Quality Payment Program (QPP), which is an incentive program to tie Medicare PFS payment to performance by rewarding high-value, high-quality care. Recognizing the QPP do not specifically target advanced diagnostic imaging services, the agency indicated they believe many of the goals of the AUC program have been met by the QPP and other accountable care initiatives.

MIPS includes 10 specific quality measures pertaining to imaging or under the “Diagnostic Radiology” Specialty Measure Set. Additionally, the Meaningful Measures 2.0 Framework includes a priority area for safety with the goal of “Reduced Preventable Harm” (<https://edit.cms.gov/files/document/cascademeaningful-measures-framework.xlsx>). An objective under this goal is “Diagnostic Accuracy/Error” which includes a cascade measure concept/family of “Appropriate use of radiology and lab testing.” An example of an existing measure within this concept is “Appropriate Follow-up Imaging for Incidental Abdominal Lesions” (<https://www.cms.gov/files/document/cascade-measures.xlsx>).

CMS concluded this section of the proposed rule by stating:

**“We want to acknowledge and emphasize the value of clinical decision support to bolster efforts to improve the quality, safety, efficiency and effectiveness of health care. We welcome and encourage the continued voluntary use of AUC and/or clinical decision support tools in a style and manner that most effectively and efficiently fits the needs and workflow of the clinician user. Across many specialties and services, not just advanced diagnostic imaging, clinical decision support predates the enactment of the PAMA and, given its utility when accessed and used appropriately, we expect it to continue being used to streamline and enhance decision making in clinical practice and improve quality of care.”**

*CMS Response to Comments Received*

CMS noted that many commenters supported the proposal to pause implementation of the AUC program for reevaluation, recognizing the “insurmountable barriers” with the real-time claims-based reporting requirement and claims processing issues. Commenters who represent ordering providers believe the AUC program imposes “undue burdens and administrative costs on providers”. Commenters who represent providers who furnish imaging services expressed concerns that the penalty portion of the statute penalizes furnishing professionals for the failure of ordering professionals to consult AUC. Commenters, including the ACR, agreed with CMS’s concerns that the claims processing systems challenges present substantial risks for data integrity



and accuracy that may lead to inappropriate claim denials. CMS thanked the commenters for their support of the proposal.

Some commenters encouraged CMS to abandon the program altogether. CMS responded that there is utility in the PAMA AUC program. The rule states, “Across many specialties and services, not just advanced diagnostic imaging, clinical decision support predates the enactment of the PAMA and, given its utility when accessed and used appropriately, we expect it to continue being used to streamline and enhance decision-making in clinical practice and improve quality of care.”

In response to comments that CMS should continue to qualify PLEs and CDSMs, the rule states, “We appreciate comments recommending that we keep certain parts of § 414.94; however, we believe it would be confusing for all interested parties if CMS were to continue annually reviewing and qualifying PLE and CDSM applications while the rest of the program is paused.”

One commenter recommended that CMS audit the current eight priority clinical areas to assess the impact of clinical decision support on quality of care. CMS thanked the commenter for their recommendation and will consider this suggestion as part of its reevaluation.

Some commenters opposed CMS’s proposal to pause the AUC program, citing the benefits of using AUC as well as the time, effort, money and staff training resources spent to prepare health systems for implementation. Another commenter suggested that CMS focus on the quality improvement aspect of the statute rather than the payment penalty. CMS responded by again encouraging providers to continue to use CDS for quality purposes. The Agency also disagreed with the commenters who suggested that the PAMA statute be “reinterpreted” to disregard the real-time claims-based reporting requirements. CMS stated, **“We will continue efforts to identify a workable implementation approach and will propose to adopt any such approach through subsequent rulemaking, including implementing any amendments Congress might make to the AUC program statutory provisions.”**

#### **Adjusting RVUs to Match the PE Share of the Medicare Economic Index (MEI)** (Page 32)

The Medicare Economic Index (MEI) is a measure of the relative weights of the work RVU, PE RVU, and malpractice (MP) RVU. The MEI is currently based on 2006 American Medical Association (AMA) data collected from the Physician Practice Information Survey (PPIS), which has not been updated.

In the 2023 MPFS, CMS finalized their plan to revise and rebase the MEI to better reflect current market conditions faced by physicians furnishing physician’s services. The 2017-based MEI that CMS finalized relies on annual expense data from the U.S. Census Bureau’s services Annual Survey (SAS). However, CMS delayed implementation of the revised and rebased MEI, seeking feedback from stakeholders on how best to incorporate it (full implementation vs. 4-year transition) and maintain payment stability.



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CMS is aware that the AMA is working to collect data that could be used to derive cost share weights for the MEI and RVU shares. In the proposed rule for CY 2024, CMS is not planning to move forward with incorporating the 2017-based MEI at this time. The Agency notes that 2022 SAS data will be available later this year and will continue to monitor that data and any other data that becomes available and will revisit this in future rulemaking.

In the final rule, commenters largely supported the delay in implementing the revised and rebased MEI, citing the AMA's effort to collect updated practice cost information. However, there were a few stakeholders who pushed CMS to implement the updated MEI as soon as possible. One commenter also questioned the appropriateness of SAS data as the primary data source, but CMS reiterated that they believe it to be the best and most up-to-date, comprehensive, and regularly published data on physician expenses for the majority of physicians. However, CMS is open to accepting recommendations for other potential data sources, including the AMA's current practice cost survey data if it becomes available.

#### **Updates to Prices for Existing Direct Practice Expense Inputs** (Page 41)

In the proposed rule, CMS states that they plan to update the pricing for 16 supply items and 2 equipment items in their list of direct practice expense (PE) inputs based on invoices that they received from stakeholders. None of these items apply to Radiology. CMS also shared that they received invoices for 11 additional common supply items whose pricing they are not planning to update since these items are available at a cheaper price than listed on the submitted invoice. Additionally, CMS is not comfortable updating pricing for common items based on a single submitted invoice since it may not represent the current market price and changes to these items could have far-reaching effects on reimbursement due to their inclusion in many codes.

In the final rule, CMS received a lot of comments, most of which were supportive of CMS's proposal to update and implement the pricing for the 18 supply and equipment items.

CMS continues to welcome the submission of invoices to assist with the pricing of supplies and equipment. CMS also received additional comments associated with supply and equipment pricing. The ones impacting Radiology are listed below:

- A commenter disagreed with the non-facility reimbursement for CPT code 36836 (*Percutaneous arteriovenous fistula creation, upper extremity, single access of both the peripheral artery and peripheral vein, including fistula maturation procedures (eg, transluminal balloon angioplasty, coil embolization) when performed, including all vascular access, imaging guidance and radiologic supervision and interpretation*), arguing that it was too low. The commenter stated that CPT Code 36836 should include the angiography room (EL011) instead of the vascular ultrasound room (EL016). Additionally, they submitted about 70 invoices in an effort to update the pricing for the Ellipsys Vascular Access Catheter (SD351) from the current \$6,000 to \$7,378.75. While CMS disagreed with the inclusion of the angiography room in CPT code 36836, based on the extensive invoices submitted, CMS will be updating the pricing for SD351 to \$7,378.75 to reflect the typical market price.



- A commenter noted discrepancies in the aggregated cost of some supply packs and the individual component within those packs and recommended that CMS correct these errors as soon as possible. RUC Workgroup recommendations on pricing for the supply packs were submitted for consideration. Upon review, CMS feels it is more appropriate to address this in future rulemaking, as they did not propose to address supply pack pricing for CY 2024 and they are also concerned about significant cost revisions with the updated pricing. CMS plans to address this more comprehensively in future rulemaking to allow for comments from stakeholders.
- Several comments recommended that CMS pay for high-cost (more than \$500) disposable supplies separately using HCPCS codes. CMS reiterated their position that this could lead to challenges regarding their ability to price high cost disposable supply items.

### **Clinical Labor Pricing Update** (Page 48)

In the proposed rule, CMS recapped that their clinical labor prices had not been updated since CY 2002, leading to concern from stakeholders that there was a discrepancy between CMS's clinical wage data and the average market pricing. CMS primarily utilized data from the Bureau of Labor Statistics to update the pricing for clinical staff, but also considered other sources such as Salary Expert and data provided by stakeholders. The four-year phase-in of the pricing began in CY 2022 and will end in CY 2025.

For CY 2024, the third year of the phase-in, no new wage data was submitted. Therefore, CMS is moving forward with the pricing finalized in the CY 2023 MPFS.

### **Soliciting Public Comment on Strategies for Updates to Practice Expense Data Collection and Methodology** (Page 62)

CMS has been using the AMA's PPIS data in its MPFS calculations, including the PE methodology, since 2010. The current PPIS is based on data collected from 2007 and 2008, making it over 15 years old. Even at the time, there were some concerns about gaps in the data and its impact on the allocation of indirect PE for certain specialties.

In CY 2023, CMS sought stakeholder feedback on how to improve and update the PE data collection and methodology. They received several comments asking CMS to wait for the AMA to complete a new PPI survey, which they had started working on.

CMS continues to be open to comments and feedback related to their ongoing PE data collection efforts. They are looking for ways to streamline the process to make it more feasible, easy to update regularly, and to be more transparent and accurate about how the information affects valuations for services paid under the MPFS.

In the proposed rule, CMS requested comments from stakeholders on the following topics:

- (1) If CMS should consider aggregating data for certain physician specialties to generate indirect allocators so that PE/HR calculations based on PPIS data would be less likely to over-



allocate (or under-allocate) indirect PE to a given set of services, specialties, or practice types. Further, what thresholds or methodological approaches could be employed to establish such aggregations?

- (2) Whether aggregations of services, for purposes of assigning PE inputs, represent a fair, stable and accurate means to account for indirect PEs across various specialties or practice types?
- (3) If and how CMS should balance factors that influence indirect PE inputs when these factors are likely driven by a difference in geographic location or setting of care, specific to individual practitioners (or practitioner types) versus other specialty/practice-specific characteristics (for example, practice size, patient population served)?
- (4) What possible unintended consequences may result if CMS were to act upon the respondents' recommendations for any of highlighted considerations above?
- (5) Whether specific types of outliers or non-response bias may require different analytical approaches and methodological adjustments to integrate refreshed data?

In the final rule, most of the comments received by CMS referred to the AMA's PPIS effort which is currently in progress. Many of the comments submitted by stakeholders aligned with comments submitted by the AMA RUC in requesting that CMS not make any changes until the AMA data is available for consideration. CMS did indicate a concern about nonresponse bias since many specialties endorsed the AMA survey prior to its launch. There were some commenters who stated that any new PPIS data may not improve the accuracy and stability of the PE methodology, citing such issues as lack of transparency in the process. CMS agrees that the current methodology does need to be evaluated and that they plan to move to a standardized and routine process that allows for regular and efficient updates in later years. CMS will continue to consider alternative options for verifiable and objective data.

Stakeholders also provided comments to CMS requesting a separate request for information on AI or machine learning and how to incorporate new technology software into the PE methodology. CMS stated that they remain committed to continuing the dialogue with stakeholders on issues relating to new technologies and how to account for those costs in the PE methodology.

### **Potentially Misvalued Services Under the PFS (Page 71)**

In the proposed rule for CY 2024, there were 10 public nominations concerning various codes.

CPT code 27279 (*Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device*) was flagged as potentially misvalued because nominators believe that it should also have non-facility direct PE inputs. This code currently contains practice expense inputs and pricing in the facility setting only. However, the nominator believes that this procedure can be safely performed in the office/non-facility setting and that allowing payment in the office will increase access for Medicare patients. CMS expressed concern about the safety and effectiveness of this procedure being performed in the office setting and sought comments on whether CPT code 27279 should be considered potentially misvalued.



In the final rule, CMS received mixed support for the performance of this code in the non-facility setting, which was a concern as it raised questions about the effectiveness and safety of the procedure in the non-facility setting. For that reason, CMS is not finalizing CPT code 27279 as potentially misvalued for CY 2024. However, CMS does note that there are a growing number of codes being nominated as potentially misvalued with a request for non-facility payment where there currently isn't one. The Agency states that they look forward to considering valuation recommendations for such services in future rulemaking.

Another nomination pertains to the Hospital Inpatient and Observation Care Visit codes 99221 (*Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.*), 99222 (*Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.*), and 99223 (*Initial hospital inpatient or observation care, per day, for the evaluation and management of a 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, 75 minutes must be met or exceeded.*), which CMS reviewed in CY 2023. The work RVUs established by CMS for these codes in CY 2023 were a decrease from the work RVUs in CY 2022. The nominator disagreed with the new values, asserting that these codes, which are performed in the non-facility setting, are more intense than other E/M services performed in other settings. The nominator requested that the CY 2022 work RVU for 99221 be reinstated, but requested an increase in value for CPT Codes 99222 and 99223. See Table 8 below.

**TABLE 8: A Comparison of Work RVU values for CY 2022, CY 2023, and Those Requested by the Nominator**

CPT Code	CY 2022 Work RVU	CY 2023 Work RVU	Requested Work RVU
99221 - 1st hosp ip/obs sf/low 40	1.92	1.63	1.92
99222 - 1st hosp ip/obs moderate 55	2.61	2.60	2.79
99223 - 1st hosp ip/obs high 75v	3.86	3.50	4.25

In the proposed rule, CMS proposed to maintain the CY 2023 values for these codes, but they were open to stakeholder comments.

In the final rule, CMS many commenters were in favor of CMS either reverting back to the CY 2022 work RVUs or increasing the RVUs to mimic the increases in the E/M code families have experienced recently. They cited flaws with the RUC process, which CMS does not agree with. CMS is not identifying this family of codes as potentially misvalued.



## **Valuation of Specific Codes for CY 2024** (Page 217)

### **Dorsal Sacroiliac Joint Arthrodesis (CPT code 27278)** (Page 217)

CPT code 27278 (*Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including placement of intraarticular implant(s) (eg, bone allograft[s], synthetic device[s]), without placement of transfixation device*)), was created by CPT to replace CPT code 0775T

(*Arthrodesis, sacroiliac joint, percutaneous, with image guidance, includes placement of intraarticular implant(s) (eg, bone allograft[s], synthetic device[s])*). CPT codes 27279 (*Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device*) and 27280 (*Arthrodesis, sacroiliac joint, open, includes obtaining bone graft, including instrumentation, when performed*) were also flagged for review as part of the code family.

However, the RUC agreed with the specialty societies that these codes were clinically different and did not need to be reviewed together. CPT code 27279 was also recently reviewed by the RUC in 2018.

In the proposed rule, CMS proposed to accept the RUC's recommended 7.86 work RVUs for CPT code 27278, as well as the RUC-recommended PE inputs with no refinements.

In the final rule, CMS received many supportive comments for the RUC-recommended value and PE inputs for CPT code 27278. However, some stakeholders did express some concern about the CPT code 27278 being performed in the non-facility setting. CMS stated that while they understand the concern, they are accepting the RUC recommendations but agree that this code could benefit from future review by the RUC. Commenters also shared their concern about the new supply item, dorsal SI joint arthrodesis implant, priced at \$11,500 and its impact on the PE RVUs and budget neutrality, as well as overutilization of the service. CMS stated that the supply item was priced according to the standard code review process and submitted invoices, and that it would not be appropriate to undervalue a service to minimize impacts on budget neutrality.

CMS will be implementing the 7.86 RVU and RUC-recommended direct PE inputs.

### **Fractional Flow Reserve with CT (CPT code 75580)** (Page 241)

In 2018, four new category III codes, 0501T-0504T, were created to describe Fractional Flow Reserve with CT (FFRCT). Medicare began paying for 0503T (*Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; analysis of fluid dynamics and simulated maximal coronary hyperemia, and generation of estimated FFR model*) under the Hospital Outpatient Prospective Payment System (HOPPS). Category III codes are typically contractor priced in the MPFS, but an exception was made for FFRCT and CMS has since been trying to understand the resource costs associated with CPT code 0503T in the office setting. CMS, for CY 2022, valued 0503T based on a crosswalk to the technical component of CPT code 93457 (*Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in*



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bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization).

CPT code 75580 (*Noninvasive estimate of coronary fractional flow reserve derived from augmentative software analysis of the data set from a coronary computed tomography angiography, with interpretation and report by a physician or other qualified health care professional*) will replace 0501T-0504T in CY 2024. 75580 was reviewed by the RUC in January 2023, and a software analysis fee listed as a supply item in the practice expense makes up the majority of its valuation. While CMS acknowledges that there is a cost incurred as part of this procedure, these types of software and analysis fees are not well represented in CMS's current PE methodology and not typically accounted for in the direct PE. Therefore, CMS is proposing to crosswalk the technical component of CPT code 93457 to the technical component for CPT code 75580.

In the proposed rule, CMS proposed the RUC-recommended 0.75 RVU for the professional component of CPT code 75580 and to crosswalk the technical component to CPT code 93457. The Agency also proposed to correct the Professional PACS Workstation (ED053) time in the practice expense from 14.5 minutes to 13.5 minutes.

In the final rule, many commenters agreed with the professional valuation of the service at 0.75 RVU, as well as the proposal to maintain the technical component crosswalk of 75580 (formerly 0503T) to CPT code 93457. In response to some stakeholders who disagreed with the crosswalk, CMS stated that they believe this is the more accurate way to value the service, given that the current PE methodology does not accommodate inputs such as the service analysis fee associated with this procedure.

CMS will be finalizing 0.75 RVU for CPT code 75580 and a crosswalk of the technical component to CPT code 93457. The equipment time for the Professional PACS Workstation will also be implemented as proposed.

#### **Ultrasound Guidance for Vascular Access (CPT code 76937) (Page 245)**

CPT code 76937 (*Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)*) was flagged for review with the peripherally inserted central venous catheter (PICC) codes in January 2018. Since the new PICC codes now include imaging, utilization for 76937 was expected to decrease, prompting review in October 2022.

In the proposed rule, CMS proposed to accept the RUC-recommended 0.30 work RVU and practice expense inputs for CPT code 76937.

Stakeholders supported CMS's decision to finalize the RUC-recommended value and PE inputs in the final rule for CY 2024.



### **Neuromuscular Ultrasound (CPT codes 76881, 76882, and 76883) (Page 246)**

In the 2023 MPFS, CMS recommended that the RUC carefully re-review and confirm the PE inputs for this neuromuscular code family, CPT codes 76881 (*Ultrasound, complete joint (ie, joint space and periarticular soft-tissue structures), real-time with image documentation*), 76882 (*Ultrasound, limited, joint or focal evaluation of other nonvascular extremity structure(s) (eg, joint space, peri-articular tendon[s], muscle[s], nerve[s], other soft-tissue structure[s], or soft tissue mass[es]), real-time with image documentation*), and 76883 (*Ultrasound, nerve(s) and accompanying structures throughout their entire anatomic course in one extremity, comprehensive, including real-time cine imaging with image documentation, per extremity*), based on the latest Medicare claims data. The practice expense inputs for CPT code 76882, specifically, have been under scrutiny, due to frequent shifts in the dominant specialty over the years.

At the January 2023 meeting, changes were recommended for the PE for CPT code 76882. In the proposed rule, CMS proposed to accept the RUC-recommended PE inputs for 76881 and 76883. CMS also proposed some refinements to the RUC-recommended PE inputs for CPT code 76882, including correcting the Professional PACS Workstation (ED053) time from 13.5 minutes to 17.5 minutes, and maintaining the ultrasound unit, portable (EQ250) time of 15 minutes to be consistent with how this time was allotted for CPT codes 76881 and 76883. CMS did not propose any changes to the work RVUs for these codes.

In the final rule, CMS did receive support from some commenters regarding the updated PE inputs for CPT code 76882. However, there were some stakeholders who believe that the clinical staff and ultrasound room are not appropriately captured in the inputs for CPT code 76881 for rheumatologists. There was a request for re-review of the PE inputs of CPT code 76881, similar to what was done for CPT code 76882. In response, CMS encouraged the commenters to coordinate with the RUC for reconsideration of the PE inputs and reminded the stakeholders that there is an annual process for nomination codes as potentially misvalued.

CMS will be finalizing the PE inputs for CPT codes 76881, 76882, and 76883 as proposed.

### **Evaluation and Management (E/M) Visits (Page 422)**

#### **Background**

E/M visits account for around 40% of all allowed charges under the PFS. Office/outpatient (O/O) E/M visits make up approximately half of these charges (around 20% of total PFS allowed charges), while other types of E/M visits (eg, inpatient/observation visits, nursing facility visits, home/residence visits) make up the other half (also around 20% of the total PFS allowed charges). Medicare claims data shows that E/M visits are provided by nearly all specialties, but they represent a larger portion of the total allowed services for physicians and practitioners who do not typically perform procedural interventions or diagnostic tests.

Two outstanding issues in E/M visit payment: implementing separate payment for the O/O E/M visit complexity add-on code (G2211) and defining split (or shared) visits.



## O/O E/M Visit Complexity Add-on HCPCS code G2211

Effective January 1, 2024, CMS is changing the status indicator to “active” for HCPCS code G2211, *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*, to make it separately payable. This add-on code should be used by medical professionals, regardless of specialty, with office and outpatient E/M visits (other than those reported with the -25 modifier, *Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service*), for care that serves 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.

When fully adopted, CMS estimated that G2211 will be billed with 54 % of all O/O E/M visits.

## Split (or Shared) Visits

A split (or shared) visit refers to an E/M visit performed by both a physician and a non-physician practitioner (NPP) in the same group practice. In the non-facility (for example, office) setting, the rules for "incident to" billing apply under this circumstance. CMS' longstanding policy is that, for split (or shared) visits in the facility (for example, hospital) setting, the physician can bill for the services if they perform a “substantive portion” of the encounter. Otherwise, the NPP would bill for the service.

For CY 2024, for Medicare billing purposes, “substantive portion” means more than half of the total time spent by the physician and NPP performing the split (or shared) visit, or a substantive part of the medical decision making (MDM) as defined by CPT E/M guidelines in the 2024 CPT codebook publication. For critical care visits, which do not use MDM and only use time, “substantive portion” continues to mean more than half of the total time spent by the physician and NPP performing the split (or shared) visit.

## Payment for Medicare Telehealth Services Under Section 1834(m) of the Act (Page 97)

As discussed in prior rulemaking, several conditions must be met for Medicare to make payment for telehealth services under the PFS.

### Clarifications and Revisions to the Process for Considering Changes to the Medicare Telehealth Services List

In CY 2020, CMS issued an array of waivers and new flexibilities for Medicare telehealth services to respond to the serious public health threats posed by the spread of COVID-19. Prior to CY 2020, CMS had not added any service to the Medicare Telehealth Services List on a temporary basis. In response to the PHE for COVID-19, CMS revised the criteria for adding or removing services on the Medicare Telehealth Services List using a combination of emergency waiver authority and interim final rule making, so that some services would be available for the duration of the PHE on a "temporary Category 2 basis." In the CY 2021 PFS final rule CMS created a third, temporary category for services included on the Medicare Telehealth Services



List on a temporary basis. Services added to the Medicare Telehealth Services List on a temporary, Category 3 basis will ultimately need to meet the Category 1 or 2 criteria to be added to the Medicare Telehealth Services List on a permanent basis.

CMS believes that simplification toward a binary classification approach could address the confusion that CMS has noticed from interested parties submitting requests during the PHE. CMS finalized to restore the binary that existed with Category 1 and 2, without displacing or disregarding the flexibility of Category 3. CMS finalized policy to simply classify and consider additions to the Medicare Telehealth Services List as either permanent, or provisional. Under this new system, CY 2025 submissions would be due by February 10, 2024.

**Direct Supervision via Use of Two-way Audio/Video Communications Technology**

In the March 31, 2020 COVID-19 IFC, CMS changed the definition of “direct supervision” during the PHE for COVID-19 as it pertains to supervision of diagnostic tests, physicians’ services, and some hospital outpatient services, to allow the supervising professional to be immediately available through virtual presence using two-way, real-time audio/video technology, instead of requiring their physical presence. CMS states that in the absence of evidence that patient safety is compromised by virtual direct supervision, CMS believes that an immediate reversion to the pre-PHE definition of direct supervision would prohibit virtual direct supervision, which may present a barrier to access to many services. CMS has finalized policy to revise the regulatory text to state that, through December 31, 2024, the presence of the physician (or other practitioner) includes virtual presence through audio/video real-time communications technology (excluding audio-only).

CMS sought comments on whether CMS should consider extending the definition of direct supervision to permit virtual presence beyond December 31, 2024. Specifically, CMS was interested in input on potential patient safety or quality concerns when direct supervision occurs virtually; for instance, if virtual direct supervision of certain types of services is more or less likely to present patient safety concerns, or if this flexibility would be more appropriate for certain types of services, or when certain types of auxiliary personnel are performing the supervised service. CMS stated they will consider addressing this topic in possible future rulemaking.

**Medicare Shared Savings Program (Page 828)**

As of January 1, 2023, 10.9 million people with Medicare receive care from one of the 573,126 health care providers in the 456 ACOs participating in the Medicare Shared Savings Program (MSSP). CMS expects there will continue to be an increased number of beneficiaries engaged in ACO’s participating in MSSP. In total, these changes are expected to increase participation in the MSSP by roughly 10% to 20%.

**Medicare CQMs for Shared Savings Program ACOs**

For performance year 2024 and subsequent performance years, CMS will establish the Medicare CQMs for Accountable Care Organizations Participating in the Medicare Shared Savings



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Program (Medicare CQMs) as a new collection type for Shared Savings Program ACOs under the Alternative Payment Model (APM) Performance Pathway (APP).

CMS finalized changes to continue to move ACOs toward a digital measurement of quality by establishing a new Medicare Clinical Quality Measure (CQM) collection type for ACOs under the Alternative Payment Model (APM) Performance Pathway (APP). The changes CMS finalized continue to move ACOs toward digital measurement of quality by establishing a new Medicare Clinical Quality Measure (CQM) collection type for ACOs and aligning Shared Savings Program and Merit-based Incentive Payment System (MIPS) Promoting Interoperability requirements starting January 1, 2025.

*Aligning CEHRT Requirements for Shared Savings Program ACOs with MIPS*

CMS finalized finalizing policies, with a one-year delay. As such, for performance years beginning on or after January 1, 2025, unless otherwise excluded, an ACO participant, ACO provider/supplier, and ACO professional that is a MIPS eligible clinician, Qualifying APM Participant (QP), or Partial QP, regardless of track, would be required to report the MIPS Promoting Interoperability performance category measures and requirements to MIPS and earn a performance category score for the MIPS Promoting Interoperability performance category at the individual, group, virtual group, or APM Entity level. CMS is delaying implementation of these policies for one year to give ACOs time to work with their participants to meet this new requirement.

Further, CMS finalized an update that would add a third step to the stepwise beneficiary assignment methodology CMS would use an expanded period of time to identify whether a beneficiary has met the requirement for having received a primary care service from a physician who is an ACO professional in the ACO to allow additional beneficiaries to be eligible for assignment. The policies CMS finalized included adding a third step to the beneficiary assignment methodology to provide greater recognition of the role of nurse practitioners, physician assistants and clinical nurse specialists in delivering primary care services, updating the definition of “primary care services,” used for purposes of beneficiary assignment to remain consistent with billing and coding guidelines, and refining policies for the newly established advance investment payments (AIP).

Lastly, CMS sought comment on potential future developments to MSSP policies, including with respect to incorporating a new track that would offer a higher level of risk and potential reward than currently available under the ENHANCED track, refining the three-way blended benchmark update factor and the prior savings adjustment, and promoting ACO and community-based organization (CBO) collaboration.

*Requiring Manufacturers of Certain Single-Dose Container or Single-Use Package Drugs to Provide Refunds With Respect to Discarded Amounts*

In the CY 2023 PFS final rule CMS adopted policies to implement section 90004 of the Infrastructure Act.



CMS finalized the requirement that billing providers and suppliers report the JW modifier for all separately payable drugs with discarded drug amounts from single use vials or single use packages payable under Part B, beginning January 1, 2023. CMS also finalized the requirement that billing providers and suppliers report the JZ modifier for all such drugs with no discarded amounts beginning no later than July 1, 2023; and CMS stated that they would begin claims edits for both the JW and JZ modifiers beginning October 1, 2023. CMS received comments that were out of scope of the rule including, support for CMS's reaffirmation of the exclusion of radiopharmaceuticals and imaging agents from the definition of refundable drugs; and requests that all non-refundable drugs or just radiopharmaceuticals and imaging agents be excluded from the JW and JZ modifier reporting policy. CMS did not address those comments directly but stated they appreciate the feedback and may consider these recommendations for future rulemaking.

**Services Addressing Health-Related Social Needs (Community Health Integration services, Social Determinants of Health Risk Assessment, and Principal Illness Navigation Services)**  
(Page 303)

For CY 2024, CMS is finalizing coding and payment changes to better account for resources involved in furnishing patient-centered care involving a multidisciplinary team of clinical staff and other auxiliary personnel. These finalized services are aligned with the HHS Social Determinants of Health Action Plan and help implement the Biden-Harris Cancer Moonshot goal of every American with cancer having access to covered patient navigation services. CMS is finalizing to pay separately for Community Health Integration, Social Determinants of Health (SDOH) Risk Assessment, and Principal Illness Navigation services to account for resources when clinicians involve certain types of healthcare support staff such as community health workers, care navigators, and peer support specialists in furnishing medically necessary care. The services described by the finalized codes are the first that are specifically designed to describe services involving community health workers, care navigators, and peer support specialists.

**HCPCS codes**

- G0019 and G0022 (codes for community health integration services)
- G0136 (code for social determinants of health risk assessment services)
- G0023, G0024, G0140, and G0146 (codes for principal illness navigation services)

*Community Health Integration (CHI) Services (page 307)*

Commenters were generally supportive of CMS proposal to establish CHI services, including allowing monthly furnishing of CHI services, as medically necessary, following an initiating E/M visit (CHI initiating visit). CMS believes the new G codes will describe and account for integrated services supported by certified or trained auxiliary personnel, including CHWs, who will assist the practitioner in connecting the patient with helpful resources. This is separate from the work being furnished as part of the medical decision-making in an E/M visit and reiterated that CHI services are separate and different from an E/M service. Services described by the CHI codes will help to resolve the patient's health-related social needs that are impacting their care



and the practitioner's ability to properly diagnose and treat the patient. As proposed, CHI services can only be furnished and billed by physicians and practitioners who can bill for services performed by auxiliary personnel incident to their professional services. Only physicians and other types of practitioners who are authorized by statute to enroll and bill the PFS directly will be included among those who can bill for CHI services. Throughout its final proposal, CMS clarifies that CHI services are consistent with the "incident to physicians' services" benefit category under section 1861(s)(2)(A) of the Act.

After consideration of the public comments, CMS is finalizing its proposal to designate CHI services as care management services that may be furnished under the general supervision of the billing practitioner.

On page 327, CMS is finalizing the code descriptor for HCPCS code G0019 to read as follows:

Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities to address social determinants of health (SDOH) need(s) that are significantly limiting the ability to diagnose or treat problem(s) addressed in an initiating visit:

- Person-centered assessment, performed to better understand the individualized context of the intersection between the SDOH need(s) and the problem(s) addressed in the initiating visit.

++ Conducting a person-centered assessment to understand patient's life story, strengths, needs, goals, preferences and desired outcomes, including understanding cultural and linguistic factors and including unmet SDOH needs (that are not separately billed).

++ Facilitating patient-driven goal-setting and establishing an action plan.

++ Providing tailored support to the patient as needed to accomplish the practitioner's treatment plan.

- Practitioner, Home-, and Community-Based Care Coordination

++ Coordinating receipt of needed services from healthcare practitioners, providers, and facilities; and from home- and community-based service providers, social service providers, and caregiver (if applicable).

++ Communication with practitioners, home- and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors.

++ Coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians; follow-up after an emergency department visit; or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities.



++ Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) to address the SDOH need(s).

- Health education- Helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, and preferences, in the context of the SDOH need(s) and educating the patient on how to best participate in medical decision-making.

- Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services addressing the SDOH need(s), in ways that are more likely to promote personalized and effective diagnosis or treatment.

- Health care access/health system navigation

++ Helping the patient access healthcare, including identifying appropriate practitioners or providers for clinical care and helping secure appointments with them.

- Facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals.

- Facilitating and providing social and emotional support to help the patient cope with the problem(s) addressed in the initiating visit, the SDOH need(s), and adjust daily routines to better meet diagnosis and treatment goals.

- Leveraging lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals.

Commenters did not suggest any changes to the add-on code descriptor HCPCS code G0022 so the descriptor will read as follows: HCPCS code G0022 – Community health integration services, each additional 30 minutes per calendar month (List separately in addition to G0019). CMS has not established a frequency limitation for HCPCS code G0022. They will monitor the utilization of the add-on HCPCS code G0022 and may re-evaluate these policies in future rulemaking.

CMS believes its rules for all incident to services should apply such that applicable State rules and requirements must be met and that training/certification must meet any applicable requirements to provide the services performed incident to the billing practitioner's professional services, including licensure, that are imposed by the State. After consideration of the public comments, CMS is finalizing its proposal that all auxiliary personnel who provide CHI services must be certified or trained to perform all included service elements, and authorized to perform them under applicable State laws and regulations. For CHI services, as with all incident to services, it is the billing practitioner's responsibility to ensure that all payment rules and applicable State requirements are met including licensure, certification, and/or training.

CMS believes that the training required to provide CHI services must include the competencies of patient and family communication, interpersonal and relationship-building, patient and family capacity-building, service coordination and system navigation, patient advocacy, facilitation,



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individual and community assessment, professionalism and ethical conduct, and the development of an appropriate knowledge base, including of local community-based resources.

CMS acknowledges the commenters' suggestion that CHI services would be available either in person, virtually, or a mix of both. However, CMS continues to believe that most of the elements of CHI services would involve direct contact between the auxiliary personnel and the patient. Thus, they do not plan to provide a higher payment for services when they are delivered in person.

After considering public comments, CMS is finalizing that patient consent is required in advance of providing CHI services but may be obtained either in writing or verbally, so long as the consent is documented in the patient's medical record. CMS is also finalizing that consent for CHI services may be obtained by auxiliary personnel and must be obtained if there is a change in the billing practitioner. The consent process must include explaining to the patient that cost sharing applies and that only one practitioner may furnish and bill the services in a given month.

CMS is finalizing as proposed that a billing practitioner may arrange to have CHI services provided by auxiliary personnel who are external to, and under contract with, the practitioner or their practice, such as through a community-based organization (CBO) that employs CHWs, if all of the "incident to" and other requirements and conditions for payment of CHI services are met, and that there must be sufficient clinical integration between the third party and the billing practitioner in order for the services to be fully provided. CMS is also finalizing as proposed that CHI services could not be billed while the patient is under a home health plan of care under Medicare Part B.

CMS emphasizes the idea that CHI is covered and paid under the Medicare program when there are SDOH needs that interfere with the billing clinician's diagnosis and treatment of the patient. These services are meant to resolve those specific concerns to facilitate the patient's medical care, which would distinguish CHI from other social services and programs that may be available through Medicaid State plans or other State or community programs.

CMS thanked commenters for their feedback and recommendation to have these new G codes for CHI services be reviewed by the RUC. While the RUC does not typically review G codes created by CMS, these codes could be potentially reviewed in a future rule cycle if the RUC chooses to do so. CMS reminds readers that the RUC is an independent organization not administered by CMS that typically decides which codes will be reviewed based on its own internal criteria. CMS finalized the valuation of these codes as proposed and will monitor the utilization of these new codes and consider any changes in possible future rulemaking.



### *Social Determinants of Health (SDOH) Risk Assessment (page 343)*

There is increasing recognition within the health care system of the need to take SDOH into account when providing health care services, given that it is estimated that around 50 percent of an individual's health is directly related to SDOH. CMS proposed a new stand-alone G code, now assigned as HCPCS code G0136, Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, not more often than every 6 months. SDOH risk assessment refers to a review of the individual's SDOH or identified social risk factors that influence the diagnosis and treatment of medical conditions. HCPCS code G0136 will be used to identify and value the work involved in administering a SDOH risk assessment as part of a comprehensive social history when medically reasonable and necessary in relation to an E/M visit. CMS proposed that the SDOH risk assessment must 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. Required elements would include:

- Administration of a standardized, evidence-based SDOH risk assessment tool that has been tested and validated through research, and includes the domains of food insecurity, housing insecurity, transportation needs, and utility difficulties.

++ Billing practitioners may choose to assess for additional domains beyond those listed above if there are other prevalent or culturally salient social determinants in the community being treated by the practitioner.

Given the multifaceted nature of unmet SDOH needs appropriate follow-up is critical for mitigating the effects of the identified, unmet SDOH needs on a person's health. CMS solicited comment on whether they should require as a condition of payment for SDOH risk assessment that the billing practitioner also have the capacity to furnish CHI, PIN, or other care management services, or have partnerships with community-based organizations (CBO) to address identified SDOH needs.

CMS clarifies, the SDOH needs identified through the risk assessment must be documented in the medical record and may be documented using a set of ICD-10-CM codes known as "Z codes"<sup>27</sup> (Z55-Z65) which are used to document SDOH data to facilitate high-quality communication between providers. CMS proposed a duration of 5-15 minutes for HCPCS code G0136 for the administration of an SDOH risk assessment tool, billed no more often than once every 6 months.

CMS clarifies cost sharing remains applicable for the proposed SDOH risk assessment and other care management services we do not have statutory authority to waive cost-sharing for care management or other services except as specified in statute, such as for certain preventive services. They note that the beneficiaries likely to benefit the most from this risk assessment may qualify or already be enrolled in programs to reduce or eliminate cost-sharing, such as Medicaid or other supplemental insurance.



CMS decided to not finalize the requirement that the SDOH risk assessment must be performed on the same date as the associated E/M or behavioral health visit. Regarding the types of associated visits that can be performed with HCPCS code G0136, CMS aim is to allow behavioral health practitioners to furnish the SDOH risk assessment in conjunction with the behavioral health office visits they use to diagnose and treat mental illness and substance use disorders.

CMS finalized that HCPCS code G0136 may also be performed in conjunction with an Annual Wellness Visit (AWV). Additionally, CMS will permit the use of HCPCS code G0136 in conjunction with hospital discharge, to remain consistent with other CMS policies promoting assessment of SDOH as an indicator of quality care and to promote safe discharge planning. CMS finalized that HCPCS code G0136 can be billed in outpatient settings. CMS is interested in learning more about the ideal settings for HCPCS code G0136 and they will work with interested parties about how HCPCS code G0136 is used, and CMS will continue to examine this issue in future rulemaking.

At this time, there is not a national consensus around one specific tool for the assessment of SDOH needs. Currently, practitioners and researchers choose the tool (or tools) that fit their needs, and CMS has no desire to limit or restrict this current work, so long as it meets the parameters specified in this rule. CMS is committed to finding a balance between the benefits of allowing maximum operational flexibility and encouraging evidence-based standardization and interoperability.

After consideration of public comments, CMS is finalizing as proposed, that any standardized, evidence-based SDOH risk assessment tool that has been tested and validated through research, may be used to conduct the SDOH risk assessment. The tool must include the domains of food insecurity, housing insecurity, transportation needs, and utility difficulties.

CMS did not finalize the requirement that the practitioner who furnishes the SDOH risk assessment must also have the capacity to furnish CHI, PIN, and other care management services, or have partnerships with CBOs. CMS does expect that the practitioner furnishing an SDOH risk assessment would, at a minimum, refer the patient to relevant resources and take into account the results of the assessment in their medical decision-making, or diagnosis and treatment plan for the visit.

CMS is finalizing as proposed that any SDOH need identified during HCPCS code G0136 must be documented in the medical record. CMS clarified they are not requiring the use of the Z code for documentation, though CMS confirmed that the use of Z codes would be appropriate to document SDOH needs in the medical record. CMS encourages the use of Z codes across CMS programs to better understand the needs of its beneficiaries. Lastly, CMS is finalizing a limitation on payment for the SDOH risk assessment service of once every 6 months per practitioner per beneficiary.

CMS proposed to add HCPCS code G0136 to the Medicare Telehealth Services List to accommodate a scenario in which the practitioner (or their auxiliary personnel incident to the



practitioner's services) completes the risk assessment in an interview format, if appropriate. CMS believes it is important that when furnishing this service, all communication with the patient be appropriate for the patient's educational, developmental, and health literacy level, and be culturally and linguistically appropriate. CMS finalized the addition of the SDOH risk assessment service to the Medicare Telehealth List. CMS reiterated that HCPCS code G0136 is not intended to be a routine screening for SDOH at standard intervals or every visit. CMS agrees with commenters that SDOH risk assessment is related to CHI and PIN services, and believes that time spent performing HCPCS code G0136 should count towards the 60 minutes per month spent in the performance of PIN services.

*Principal Illness Navigation Services (page 361)*

CMS wants to better understand whether there are gaps in coding for patient navigation services for treatment of serious illness, that are not already included in current care management services. Experts on navigation of treatment for cancer and other high-risk, serious illnesses have demonstrated the benefits of navigation services for patients experiencing these conditions. For CY 2024, CMS proposed to better recognize through coding and payment policies when certified or trained auxiliary personnel under the direction of a billing practitioner, which may include a patient navigator or certified peer specialist, are involved in the patient's health care navigation as part of the treatment plan for a serious, high-risk disease expected to last at least 3 months, that places the patient at significant risk of hospitalization or nursing home placement, acute exacerbation/decompensation, functional decline, or death. CMS is finalizing new coding for Principal Illness Navigation (PIN) services to include the following HCPCS codes: G0023, G0024, G0140, and G0146. Additionally, CMS defines PIN services.

CMS received comments on its definition of a serious high-risk condition and believes this is dependent on clinical judgment. CMS agrees with the commenters that additional conditions such as chronic liver disease, chronic kidney disease, stroke, and conditions that require stem cell transplantation could all meet the outlined definition depending on the specific severity of the illness in individuals with these conditions. However, CMS disagrees with commenters who requested the inclusion of conditions that can be treated fully within the 3-month time frame, as they do not believe a condition of this limited duration would require the extent of navigation services provided by PIN. CMS reiterates an expected 3-month period is a reasonable benchmark for the use of PIN services, as they envision PIN services as necessary to treat serious, high-risk conditions that require navigation over several months. CMS also clarifies that a definitive diagnosis is not required before the practitioner makes a clinical determination that the patient has a serious high-risk condition.

Many commenters recommended that CMS should not restrict PIN initiating visits to only E/M visits and recommend CMS allow the Annual Wellness Visit (AWV) to count as an initiating visit for PIN. Examples were provided for mental health, substance abuse, and dementia care. CMS has determined clinical psychologist and behavioral health integration services do not serve the purpose of an initiating visit, which is meant to establish the beneficiary's relationship with the furnishing practitioner, ensure the practitioner assesses the beneficiary, and identifies a clinical



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need for services before initiating care management, and provide an opportunity to inform the beneficiary about the services and obtain beneficiary consent (if applicable). CMS agrees with commenters that the E/M visit done as part of Transitional Care Management (TCM) services could serve as an initiating visit for PIN services because it includes a high-level office/outpatient E/M visit furnished by a physician or nonphysician practitioner managing the patient in the community after discharge. CMS finalizing that the AWV may serve as an initiating visit for PIN services when the AWV is furnished by a practitioner who has identified in the AWV a high-risk condition(s) that would qualify for PIN services under this rule. For purposes of assigning a supervision level for payment, CMS proposed to designate PIN services as care management services that may be furnished under general supervision; general supervision means the service is furnished under the physician's (or other practitioner's) overall direction and control, but the physician's (or other practitioner's) presence is not required during the performance of the service.

CMS received several comments about its proposals for PIN and the SDOH risk assessment requesting that CMS clarify the requirements surrounding the reassessment of unmet social needs and proposed frequency limitations. CMS agrees with commenters that the reassessment of known SDOH needs is interrelated to PIN services, especially within the presence of a serious, high-risk condition, and agrees that a reassessment should not be confined to the frequency limitations described for HCPCS code G0136.

Below are the final code descriptors for HCPCS codes G0023 and G0024. (Pages 382 – 384)

G0023 Principal Illness Navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator or certified peer specialist; 60 minutes per calendar month, in the following activities:

- Person-centered assessment, performed to better understand the individual context of the serious, high-risk condition.
  - ++ Conducting a person-centered assessment to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors and including unmet SDOH needs (that are not separately billed).
  - ++ Facilitating patient-driven goal setting and establishing an action plan. ++ Providing tailored support as needed to accomplish the practitioner's treatment plan.
- Identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services.
- Practitioner, Home, and Community-Based Care Coordination
  - ++ Coordinating receipt of needed services from healthcare practitioners, providers, and facilities; home- and community-based service providers; and caregiver (if applicable).
  - ++ Communication with practitioners, home-, and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial



strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors.

++ Coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians; follow-up after an emergency department visit; or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities.

++ Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) as needed to address SDOH need(s).

- Health education- Helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, preferences, and SDOH need(s), and educating the patient (and caregiver if applicable) on how to best participate in medical decision-making.

- Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services (as needed), in ways that are more likely to promote personalized and effective treatment of their condition.

- Health care access/health system navigation.

++ Helping the patient access healthcare, including identifying appropriate practitioners or providers for clinical care, and helping secure appointments with them.

++ Providing the patient with information/resources to consider participation in clinical trials or clinical research as applicable.

- Facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals.

- Facilitating and providing social and emotional support to help the patient cope with the condition, SDOH need(s), and adjust daily routines to better meet diagnosis and treatment goals.

- Leverage knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals.

G0024 – Principal Illness Navigation services, additional 30 minutes per calendar month (List separately in addition to G0023).

CMS believes the work provided by peer support specialists is crucial to the treatment of some patients with behavioral health conditions. Given the public comments CMS received, they are also finalizing two new codes, HCPCS code G0140 and HCPCS code G0146 for Principal Illness Navigation – Peer Support (PIN-PS). Given the nature of work typically performed by peer support specialists, CMS is limiting these codes to the treatment of behavioral health conditions that otherwise satisfy its definition of high-risk conditions. Patients with behavioral health conditions can still receive HCPCS code G0023 and HCPCS code G0024 services, so



long as the auxiliary staff providing them is trained and certified in all parts of those code descriptors. See pages 385-386 for more details and the code descriptors for peer support specialists.

CMS is not finalizing a frequency limitation for the services described by HCPCS codes G0024 or G0146 and will monitor the utilization of these codes going forward to ascertain the time spent per month per PIN service. CMS is not limiting the duration of PIN services, but CMS is finalizing a requirement that a new initiating visit be conducted once per year. CMS proposed that all auxiliary personnel who provide PIN services must be certified or trained to provide all elements in the corresponding service and be authorized to perform them under applicable State law and regulations.

After consideration of comments received, CMS is not finalizing a required number of hours of training for auxiliary personnel to provide PIN services. They will defer to State requirements where applicable for all types of auxiliary personnel. For States with no applicable State requirements, CMS is finalizing as proposed that the training and certification for auxiliary personnel providing HCPCS codes G0023 and G0024 include the competencies of patient and family communication, interpersonal and relationship-building, patient and family capacity building, service coordination and systems navigation, patient advocacy, facilitation, individual and community assessment, professionalism and ethical conduct, and the development of an appropriate knowledge base, including specific certification or training on the serious, high-risk condition/illness/disease addressed in the initiating visit.

CMS did not finalize the inclusion of PIN services (HCPCS codes G0023, G0024, G0140, G0146) on the Medicare Telehealth Services List at this time. They will continue to consider this issue for potential rulemaking in the future. CMS could not make a determination at this time regarding whether or not PIN services meet the standards of services that are inherently in-person services that are instead furnished using an interactive telecommunications system.

CMS finalized that patient consent is required for PIN services, and that consent can be written or verbal, so long as it is documented in the patient's medical record. CMS believes that the commenters' feedback regarding the potential duration of PIN services over multiple months, in addition to the fact that PIN services may not be furnished with the patient present is convincing evidence that patients should be aware of their cost-sharing obligations over time for PIN services. In response to comments, CMS notes it does not have statutory authority to waive cost-sharing for care management or other services. CMS is finalizing that consent must be obtained annually and may be obtained by the auxiliary personnel either before or at the same time that they begin performing PIN services for the patient.

CMS proposed that a practitioner may arrange to have PIN services provided by auxiliary personnel who are external to, and under contract with, the practitioner or their practice, such as through a community-based organization (CBO) that employs CHWs or other auxiliary personnel, if all of the "incident to" and other requirements and conditions for payment of PIN services are met. CMS clarifies for instances where PIN services are performed by auxiliary



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personnel under a contract with a third party that there must be sufficient clinical integration between the third party and the billing practitioner in order for the services to be fully provided, and the connection between the patient, auxiliary personnel, and the billing practitioner must be maintained. CMS expects the auxiliary personnel performing the PIN services to communicate regularly with the billing practitioner to ensure that PIN services are appropriately documented in the medical record, and to continue to involve the billing practitioner in evaluating the continuing need for PIN services to address the serious, high-risk condition.

To reduce administrative burden, CMS is not requiring that all auxiliary personnel performing PIN services must document the services in the medical record themselves. Rather, the billing practitioner is responsible for ensuring appropriate documentation of the PIN services provided to the patient is included in the medical record.

After consideration of public comments, CMS is finalizing that PIN services can be provided more than once per practitioner per month for any single serious high-risk condition, to avoid duplication of PIN service elements when utilizing the same navigator or billing practitioner. CMS also clarifies that PIN and PIN-Peer Support should not be billed concurrently for the same serious, high-risk condition. However, practitioners furnishing PIN services may bill care management services as appropriate for managing and treating a patient's illness. CMS finalizes, that PIN services can be furnished in addition to other care management services as long as time and effort are not counted more than once, requirements to bill the other care management services are met, and the services are medically reasonable and necessary.

CMS remains concerned about care fragmentation should patients receive multiple PIN services for different high-risk conditions. They believe that PIN is best suited for situations in which the navigator can serve as a point of contact for the patient. Given this, CMS does not expect a patient to require multiple PIN services for a prolonged period of time, except in circumstances in which a patient is receiving PIN services for highly specialized navigation, such as behavioral health or oncology.

For more information on final Work RVUs refer to *TABLE 14: CY 2024 Work RVUs for New, Revised, and Potentially Misvalued Codes (page 404)*

### **Quality Payment Program (Page 1527)**

#### *MIPS Value Pathways (MVPs)*

While CMS proposed implementing scoring incentives to those ACOs participating in MIPS through MVPs, within the proposed rule and collected responses to a request for information (RFI) regarding multiple aspects of MPV reporting for specialists in Shared Savings Program ACOs will consider the information and comments collected for future rulemaking.

Of the 16 MVPs available in 2024, five are new, with topics addressing women's health; infectious disease; quality care for ear, nose, and throat; rehabilitative services for musculoskeletal care; and mental health and substance use disorders. The subgroup reporting update finalized in this rule includes limitations to reweighting applied to a subgroup when also applied to its affiliated group beginning with the CY 2024 performance period/2026 MIPS



payment year (p. 1555). This change eliminates the policy allowing a subgroup to submit a separate reweighting application request independent of its affiliated group.

CMS clarified that facility-based clinicians may participate as a subgroup when reporting an MVP. However, the facility-based score calculated for these clinicians is based on their participation in traditional MIPS rather than as a subgroup in MVP reporting.

Not calculating a facility-based score at the subgroup level will not affect individual facility-based clinicians in a subgroup for which the clinician would also receive all available scores from the affiliated group, including the traditional MIPS score derived from facility-based scoring. As previously finalized for the performance year 2022, CMS will assign the highest available final score associated with the clinician TIN/NPI. In this rule, CMS finalized for subgroups that beginning with the CY 2023 performance period/2025 MIPS payment year, the affiliated group's complex patient bonus will be included in the final score.

#### *MIPS Category Weighting*

The category weights for the 2024 performance year are **Quality – 30%, Cost – 30%, Promoting Interoperability (PI) – 25%, and Improvement Activities (IA) – 15%**. These are the same values finalized for the 2023 performance year and are unlikely to change in future years.

The final rule continues to offer category reweighting for physicians who are unable to submit data for one or more performance categories. In most cases, the weight of these categories will continue to be redistributed to the Quality category.

#### *MIPS Performance Threshold and Incentive Payments (p. 1705)*

The MIPS performance threshold is the value that determines whether a MIPS participant will receive a positive, negative, or neutral payment adjustment during the associated MIPS payment year. During the first five years of MIPS, this threshold was set at a low value and incrementally increased each subsequent year to reduce the burden on clinicians and ease them into the program.

During the 2022 and 2023 performance years, CMS set the MIPS performance threshold based on a mean or median value derived from a previous year's scoring data. Using the mean performance score from 2017 MIPS, CMS set the threshold at 75 points beginning in 2022. **Although CMS had proposed to raise the performance threshold for the 2024 performance year, the agency has opted to maintain the 75-point threshold.**

CMS finalized the minimum and maximum payment adjustment of +/- 9% for performance years 2020 and beyond. No changes are proposed to the MIPS adjustment.



*Low-Volume Threshold and Small Practice (15 or fewer eligible clinicians) Considerations (p. 1882)*

CMS has not changed the low-volume threshold criteria. To be excluded from MIPS in 2024, clinicians or groups must meet one of the following three criteria: have  $\leq \$90K$  in allowed charges for covered professional services, provide covered care to  $\leq 200$  beneficiaries, or provide  $\leq 200$  covered professional services under the Physician Fee Schedule. CMS proposes retaining the established opt-in policy, allowing physicians who meet some but not all of the low-volume threshold criteria to participate in MIPS.

CMS maintains the six-point small practice bonus included in the Quality performance category score and continues to award small practices three points for submitted quality measures that do not meet case minimum requirements or lack a benchmark.

*Quality Performance Category (p. 1571)*

**CMS has not finalized any major changes to the Quality category.** Continuing scoring policies that became effective in 2023, the scoring range for benchmarked measures is one to ten points, and CMS will continue to assign zero points to non-benchmarked measures that have been in the program for three or more years (excluding small practices, who will continue to receive three points). New measures will again receive a minimum of seven points in their first year and five points in their second year. **CMS finalized the removal and addition of quality measures as well as a moderate increase in the quality measure data completeness requirement.**

*Quality Measures Proposed for Addition and Removal (p. 2234)*

**CMS will remove two measures historically available for reporting through ACR's NRDR QCDR:**

- #147: Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy
- #324: Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Testing in Asymptomatic, Low-Risk Patients

Measures 147 and 324 have been removed due to their status as topped out and extremely topped out, respectively.

**CMS has also finalized its proposal to add a new eCQM to the Diagnostic Radiology measure set. However, this measure will not become available for reporting to the program until 2025:**

- **Title:** Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults



- **Description:** This measure provides a standardized method for monitoring the performance of diagnostic CT to discourage unnecessarily high radiation doses, a risk factor for cancer while preserving image quality. It is expressed as a percentage of CT exams that are out-of-range due to either excessive radiation dose or inadequate image quality relative to evidence-based thresholds established by the clinical indication(s) for the exam. All diagnostic CT exams of specified anatomic sites performed in inpatient, outpatient, and ambulatory care settings are eligible. This eCQM requires the use of additional software to access primary data elements stored within radiology electronic health records and translate them into data elements that can be ingested by this eCQM.
- **Denominator:** All CT scans in adults aged 18 years and older at the start of the measurement period that have a CT Dose and Image Quality Category and were performed during the measurement period.
- **Numerator:** Calculated CT size-adjusted dose greater than or equal to a threshold specific to the CT dose and Image Quality Category, or Calculated CT Global Noise value greater than or equal to a threshold specific to the CT Dose and Image Quality Category. (p. 2203)

**CMS will remove MIPS measure #436, *Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques*, due to being considered duplicative of the new radiation dose measure. However, since CMS is delaying this measure's adoption until 2025, MIPS measure #436 will remain available during the 2024 performance year, and eventually removed for the 2025 performance year (p. 2282).**

*Quality Data Completeness Requirements (p. 1594)*

**CMS finalized its proposal to raise the data completeness threshold for quality measures to 75% for the 2024 performance year.** This number defines the minimum subset of patients within a measure denominator that must be reported. **CMS has not finalized its proposal to increase this threshold to 80% beginning with the 2026 performance year. Instead, data completeness will remain at 75% at least through 2026, with the possibility of a higher threshold beginning with the 2027 performance period.**

*Cost Performance Category (p. 1603)*

**CMS has finalized its proposal to reintroduce the episode-based Low Back Pain cost measure previously used in the MIPS Cost category.** The measure underwent comprehensive reevaluation and field testing from 2020-2022. Stakeholder input and workgroup review were used to obtain detailed information on specifications for the measure, and the ACR participated in the review. CMS also finalized the proposal to add Depression, Emergency Medicine, Heart Failure, and Psychoses and Related Conditions as new episode-based Cost measures for 2024.

The Cost category will remain weighted at 30% for 2024.



*Improvement Activities Performance Category (p. 1636)*

**CMS has not finalized any major changes to the Improvement Activities performance category.** This category will remain weighted at 15% as in previous years. CMS has finalized the proposal to add five new activities and remove three previously adopted activities.

Improvement Activities Finalized for Adoption (p. 2629):

Improvement Activity Title	Description	Category Weight
Improving practice capacity for Human Immunodeficiency Virus (HIV) prevention services	<p>Establish policies and procedures to improve practice capacity to increase HIV prevention screening, improve HIV prevention education and awareness, and reduce disparities in pre-exposure prophylaxis (PrEP) uptake. Use one or more of the following activities:</p> <ul style="list-style-type: none"><li>• Implement electronic health record (EHR) prompts or clinical decision support tools to increase appropriate HIV prevention screening;</li><li>• Require that providers and designated clinical staff take part in at least one educational opportunity that includes components on the importance and application of HIV prevention screening and PrEP initiation in clinical practice; and/or</li><li>• Assess and refine current policies for HIV prevention screening, including integrated sexually transmitted infection (STI)/HIV testing processes, universal HIV screening, and PrEP initiation.</li></ul>	Medium
Practice-Wide Quality Improvement in MIPS Value Pathways	<p>Create a quality improvement initiative within your practice and create a culture in which all staff actively participates. Clinicians must be participating in MIPS Value Pathways (MVPs) to attest to this activity.</p> <p>Create a quality improvement plan that involves a minimum of three of the measures within a specific MVP and that is characterized by the following:</p> <ul style="list-style-type: none"><li>• Train all staff in quality improvement methods, particularly as related to other quality initiatives currently underway in the practice;</li><li>• Promote transparency and accelerate improvement by sharing practice-level and panel-level quality of care and patient experience and utilization data with staff;</li></ul>	High



	<ul style="list-style-type: none"><li>• Integrate practice change/quality improvement into all staff duties, including communication and education regarding all current quality initiatives;</li><li>• Designate regular team meetings to review data and plan improvement cycles with defined, iterative goals as appropriate; or</li><li>• Promote transparency and engage patients and families by sharing practice-level quality of care and patient experience and utilization data with patients and families, including activities in which clinicians act upon patient experience data.</li></ul> <p>In addition, clinicians may consider:</p> <ul style="list-style-type: none"><li>• Creation of specific plans for recognition of individual or groups of clinicians and staff when they meet certain practice-defined quality goals. Examples include recognition for achieving success in measure reporting and/or a high level of effort directed to quality improvement and practice standardization; and</li><li>• Participation in the American Board of Medical Specialties (ABMS) Multi-Specialty Portfolio Program.</li></ul>	
Use of Computable Guidelines and Clinical Decision Support to Improve Adherence for Cervical Cancer Screening and Management Guidelines	<p>Incorporate the Cervical Cancer Screening and Management (CCSM) Clinical Decision Support (CDS) tool within the electronic health record (EHR) system to provide clinicians with ready access to and assisted interpretation of the most up-to-date clinical practice guidelines in CCSM to ensure adequate screening, timely follow-up, and optimal patient care.</p> <p>The CCSM CDS helps ensure that patient populations receive adequate screening and management, according to evidence-based recommendations in the United States Preventive Services Task Force (USPSTF) screening and American Society for Colposcopy and Cervical Pathology (ASCCP) management guidelines for cervical cancer. The CDS integrates into the clinical workflow a clinician-facing dashboard to support the clinician's awareness and adoption of and preventive care for cervical cancer, including screening and any necessary follow-up treatment.</p>	High



	The CCSM CDS is fully conformant with the HL7 Fast Healthcare Interoperability Resources (FHIR) standard, so it can be used with any certified EHR platform. The CDS Hooks and SMART-on-FHIR interoperability interface standards provide two ways to integrate with the clinical workflow in a way that complements existing displays and information pre-visit, during visit, and for post-visit follow-up. CCSM CDS helps the clinician evaluate the patient's clinical data against existing guidance and displays patient-specific recommendations.	
Behavioral/Mental Health and Substance Use Screening & Referral for Pregnant and Postpartum Women	Screen for perinatal mood and anxiety disorders (PMADs) and substance use disorder (SUD) in pregnant and postpartum women, and screen and refer to treatment and/or refer to appropriate social services, and document this in-patient care plans.	High
Behavioral/Mental Health and Substance Use Screening & Referral for Older Adults	Complete age-appropriate screening for mental health and substance use in older adults, as well as screening and referral to treatment and/or referral to appropriate social services, and document this in-patient care plans.	High

Improvement Activities Finalized for Removal (p. 2639):

- IA\_BMH\_6: Implementation of co-location PCP and MH services
- IA\_BMH\_13: Obtain or Renew an Approved Waiver for Provision of Buprenorphine as Medication-Assisted Treatment for Opioid Use Disorder
- IA\_PSPA\_29: Consulting Appropriate Use Criteria (AUC) Using Clinical Decision Support when Ordering Advanced Diagnostic Imaging

*Promoting Interoperability Performance Category (p. 1199)*

CMS finalized its proposal to modify Certified EHR Technology (CEHRT)-related requirements to remove “Edition” title references and transition to an “edition-less state” for the technology requirements of the Promoting Interoperability performance category. As a result, future updates to specific Office of the National Coordinator for Health IT (ONC) certification criteria under 45 CFR 170.315 incorporated by reference into CMS’ regulatory definition of “CEHRT” will be automatically accounted for without needing regulatory language revisions by CMS. The agency also finalized its proposal to align CEHRT definition requirements in the Shared Savings Program with MIPS.



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Most radiologists will continue to be exempted from the MIPS Promoting Interoperability performance category and thereby reweighted. However, for any MIPS eligible clinicians participating in this category, CMS finalized its proposal to lengthen the performance period from 90 days to 180 days beginning with the CY 2024 performance period. CMS finalized its proposal to change the “Safety Assurance Factors for EHR Resilience (SAFER) Guides” measure to require a “yes” attestation for completion, rather than allowing either “yes” or “no.” Additionally, CMS finalized its proposal to modify the measure exclusion for “Query of Prescription Drug Monitoring Program” to accommodate clinicians who do not prescribe Schedule II opioids and Schedule III and IV drugs during the performance period.

#### *APM Performance Pathway*

CMS finalized to include the Medicare Clinical Quality Measure (Medicare CQM) for Accountable Care Organizations Participating in MSSP collection type in the APM Performance Pathway (APP) measure set.

#### *Advanced Alternative Payment Models*

An Advanced APM is an APM that: 1) requires participants to use certified EHR technology (CEHRT), 2) provides payment for covered services based on quality measures comparable to MIPS, and 3) requires participating entities to bear more than nominal financial risk or participate as a Medical Home Model.

#### *Use of Certified Electronic Health Record Technology (CEHRT)*

CMS stated that CEHRT use for Advanced APMs may have been unnecessarily burdensome, imposing unwarranted barriers to organization of and participation in Advanced APMs, and not clinically relevant for many prospective and current participants in Advanced APMs. CMS finalized to remove the numerical 75% threshold and specify that, to be an Advanced APM, the APM must require the use of certified EHR technology but modified the implementation date to CY 2025.

CMS finalized to amend the definition of CEHRT at § 414.1305 by adding a new paragraph (3) to specify that, for purposes of the Advanced APM criterion under § 414.1415, beginning with CY 2024, CEHRT means EHR technology certified under the ONC Health IT Certification Program that meets: (1) the 2015 Edition Base EHR definition, or any subsequent Base EHR definition (as defined in at 45 CFR 170.102); and (2) any such ONC health IT certification criteria adopted or updated in 45 CFR 170.315 that are determined applicable for the APM, for the year, considering factors such as clinical practice areas, promotion of interoperability, relevance to reporting on applicable quality measures, clinical care delivery objectives of the APM, or any other factor relevant to documenting and communicating clinical care to patients or their health care providers in the APM.

CMS finalized with modification to add a new paragraph at § 414.1415(a)(1)(iii) to specify that beginning with the CY 2025 QP performance period, to be an Advanced APM, the APM must



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require all eligible clinicians in each participating APM Entity, or for APMs in which hospitals are the participants, each hospital, to use CEHRT that meets the new paragraph (3) of the CEHRT definition at § 414.1305.

*APM Incentive*

CMS finalized to amend § 414.1430 to reflect the statutory QP and Partial QP threshold percentages for both the payment amount and patient count methods under the Medicare Option and the All-Payer Option with respect to payment year 2025 (performance year 2023) in accordance with amendments made by the CAA, 2023. Based on the CAA, 2023 the APM Incentive Payment with respect to payment year 2025 is 3.5% of the clinician's estimated aggregate payments for covered professional services during the incentive payment base period.

After the 2023 performance year/2025 payment year, the APM Incentive Payment will end. Beginning for the 2024 performance year/2026 payment year, QPs will receive a higher PFS update “qualifying APM conversion factor” of 0.75% compared to non-QPs, who will receive a 0.25% PFS update, which will result in a differentially higher PFS payment rate for eligible clinicians who are QPs. Eligible clinicians who are QPs for a year will continue to be excluded from MIPS reporting and payment adjustments for the year.

*APM Entity Reporting*

CMS did not finalize the policy to end the use of APM Entity-level QP determinations and instead make all QP determinations at the individual eligible clinician level. CMS recognized the concerns raised by commenters with respect to specialist participation in advanced APMs, and that the changes in incentives and the interactions between them, combined with the anticipated statutory increases in QP thresholds, would create significant uncertainty among specialist communities. CMS did not finalize their proposal to include as attribution-eligible any beneficiary who has received a covered professional service furnished by the NPI for the purpose of making QP determinations. The current policy of making QP determinations at the APM-Entity will remain in place for 2024.