

ACR Preliminary Summary of Radiology Provisions in the 2024 MPFS Final Rule

The Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2024 Medicare Physician Fee Schedule (MPFS) final rule on Thursday, November 2, 2023. In this rule, CMS describes changes to payment provisions and to policies for the Quality Payment Program (QPP) and its component participation methods – the Merit-Based Incentives Payment System (MIPS) and Advanced Alternative Payment Models (APMs).

Conversion Factor and CMS Overall Impact Estimates

CMS announced a CY 2024 conversion factor of \$32.74 compared to the 2023 conversion factor of \$33.89. 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 actual impact will be little higher as the overall impact numbers 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.

Protecting Access to Medicare Act (PAMA) Appropriate Use Criteria (AUC) Program

In light of continual implementation issues, CMS finalized its proposal to pause the PAMA AUC program for advanced diagnostic imaging services for reevaluation, including ending the current educational and operations testing period. CMS did not indicate a time frame that implementation efforts may resume. The Agency stated that the real time claims processing aspect of the statute “presents an insurmountable barrier for CMS to fully operationalize the AUC program”. CMS acknowledges the value of clinical decision support to “improve the quality, safety and efficiency and effectiveness of health care” and encourages the continued voluntary use of clinical decision support tools.

The ACR recognizes the significant issues CMS faces with the real time claims processing aspect of the AUC program and the potential impact on our members should claims be denied inappropriately. The College is working with Congress to streamline and modernize the PAMA AUC program, including the removal of this requirement, to allow the program to move forward and ensure Medicare patients receive the right imaging tests at the right time.

Clinical Labor Pricing

CMS did not receive any new data on clinical labor pricing for CY 2024 and are proceeding with implementation of the pricing finalized for CY 2023.

Office/Outpatient E/M Visit Complexity Add-On

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. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)*) will have an “active” status indicator beginning January 1, 2024. In the final rule, CMS clarified when this code should be used. It is intended to account for inherent complexities of the base E/M visits that would

otherwise be unaccounted for and that the determining factor of when the add-on code should be billed is based on the *relationship* between the patient and the practitioner, as a sense of trust needs to be fostered between both parties and a longitudinal relationship is required. CMS also states that this code is not restricted to use by any particular specialty.

Potentially Misvalued Codes

Stakeholders had identified 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) as potentially misvalued in the proposed rule, leading CMS to solicit input. Nominators were requesting direct PE inputs for this code in the non-facility office setting. However, based on comments submitted to CMS, there was not a consensus on whether these services can be safely performed in the office setting. Therefore, CMS is not finalizing CPT code 27279 as potentially misvalued.

New/Revised Codes

In the MPFS 2024 Final Rule, CMS accepted the RUC-recommended values for the radiology codes pertaining to ultrasound guidance for vascular access, dorsal sacroiliac joint, and fractional flow reserve. CMS is also finalizing the practice expense inputs for the neuromuscular ultrasound codes as proposed.

Practice Expense (PE) Data Collection

In the proposed rule, CMS presented several questions, below, to stakeholders requesting feedback on potential alternatives they may need to consider following the updated AMA PPI survey:

- Whether they should consider aggregating data for certain specialties, and if so what thresholds or methodologies should be employed to establish such aggregations?
- Whether aggregations of services, for the purposes of assigning PE inputs, represent a fair, stable and accurate means to account for indirect PEs across various specialties or practice types?
- 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)?
- What possible unintended consequences may result if CMS were to act upon the respondents' recommendations for any highlighted considerations above?
- Whether specific types of outliers or non-respond bias may require different analytical approaches and methodological adjustments to integrate refreshed data?

CMS stated that many of the stakeholders supported AMA RUC comments to wait for the updated PPI survey to be completed and to not make any significant changes right now. There were also stakeholders who expressed continued concern with the transparency of the process, sampling methodology, how to incorporate new technologies into the methodology, and also frequency of these updates.

Medicare Economic Index (MEI)

CMS continues to wait for updated 2022 data from the U.S. Census Bureau's Services Annual Survey (SAS), expected later this year. They are not moving forward with rebasing or revising the Medicare Economic Index (MEI) at this time. CMS did receive mixed responses from stakeholders, with some encouraging CMS to implement the MEI updates as soon as possible, while most commenters supported the delay in implementation. CMS continues to welcome feedback about possible other data sources they should consider in concert with SAS data. CMS did not receive any new data on clinical labor pricing for CY 2024 and are proceeding with implementation of the pricing finalized for CY 2023.

Medicare Shared Savings Program

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 had several policy proposals included in the CY 2024 PFS proposed rule. CMS finalized proposed policies, with a one-year delay. CMS is delaying implementation of these policies for one year to give ACOs time to work with their participants to meet this new requirement. 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.

Telehealth

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 policy to 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. CMS is restoring the binary that existed with Category 1 and 2, without displacing or disregarding the flexibility of Category 3.

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 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. CMS stated they will consider addressing this topic in possible future rulemaking.

Quality Payment Program (QPP)

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, they will consider the information and comments collected for future rulemaking. CMS is also finalizing the inclusion of five new MVPs beginning in the 2024 MIPS performance year. Topics include women's health; infectious disease; quality care for ear, nose, and throat; rehabilitative services for musculoskeletal care; and mental health and substance use disorders. Subgroup reporting updates are also finalized in this rule.

MIPS Scoring Overview

The category weights for the 2023 performance year are proposed to remain the same as the 2023 weights: **Quality – 30%, Cost – 30%, PI – 25%, and IAs – 15%**. These percentages are likely to remain fixed for the future of the MIPS program.

The proposed 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.

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

Low-Volume Threshold and Small Practice (15 or fewer eligible clinicians) Considerations

For 2024 CMS maintains its low-volume threshold criteria as previously established. 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 did not change the opt-in policy established which allows physicians who meet some, but not all, of the low-volume threshold criteria to opt-in to participate in MIPS.

CMS has finalized the 2024 performance period threshold to remain at 75 points, which is based on the mean of the final scores for all MIPS-eligible clinicians using CY 2017 performance period/2019 MIPS payment year data.

Quality Category

As established in previous rules, this category will remain weighted at 30% of the overall MIPS score.

There are no quality scoring changes for 2024. As in 2023, benchmarked measures will continue to be scored from 1 to 10 points, doing away with the 3-point floor. CMS will continue to score non-benchmarked measures at 0 points even if data completeness is met. New measures will continue to be scored at a minimum of 7 points for their first year and a minimum of 5 points in their second year.

CMS has finalized the decision to remove the following measures (p. 2285):

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

CMS has also decided to add the following new measure to the Diagnostic Radiology measure set beginning with the performance year 2025 (p. 2285):

- MIPS 494: Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults

This measure is finalized for use in the Inpatient Quality Reporting program under the FY 2024 IPPS/LTCH PPS and will become available for the Hospital Outpatient Quality Reporting program.

Data Completeness Requirement

As stated in the 2023 MPFS Final Rule, CMS will raise the quality measure data completeness requirement from 70% to 75% of the total exam volume. This number defines the minimum subset of patients within a measure denominator that must be reported. They propose to maintain data completeness at 75% through 2026 and raise it to 80% in the 2027 program year (p. 875).

Cost Category

CMS will continue to weigh the Cost performance category at 30% for MIPS performance year 2024 and likely for all subsequent years.

CMS will add the episode-based Low Back Pain cost measure that was 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 input on specifications for the measure. The ACR participated in the review. This will be a new measure beginning in the 2024 performance period.

Improvement Activities

CMS will maintain the 15% weight for the Improvement Activities category. The 2024 Proposed Rule also adds 5 new activities and removes 3 previously adopted activities.

The IAs finalized for addition are:

- IA_PM_22: Improving practice capacity for Human Immunodeficiency Virus (HIV) prevention services
- IA_MVP: Practice-wide quality improvement in MIPS Value Pathways
- IA_PM_23: Use of computable guidelines and clinical decision support to improve adherence for cervical cancer screening and management guidelines
- IA_BMH_14: Behavioral/mental health and substance use screening and referral for pregnant and postpartum women
- IA_BMH_15: Behavioral/mental health and substance use screening and referral for older adults

The IAs proposed for removal are:

- 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 Category

CMS proposes to modify Certified EHR Technology (CEHRT)-related requirements to remove “Edition” titles to reflect proposed regulatory changes within the HHS Office of the National Coordinator for Health IT (ONC) to that agency’s health IT certification criteria naming conventions. ONC updates to any criteria incorporated by reference into CMS’ CEHRT definition would be automatically accounted for without needing additional rulemaking. CMS proposes to align Shared Savings Program CEHRT requirements with MIPS CEHRT requirements. CMS also proposes to lengthen the Promoting Interoperability performance period from 90 days to 180 days and make various minor modifications to existing Promoting Interoperability measures and exclusions.

Advanced Alternative Payment Models

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.

APM Entity Reporting

CMS is not finalizing policy at this time 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. Current policy of making QP determinations at the APM-Entity will remain in place for 2024.

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.

If an eligible clinician participates in an Advanced APM and achieves Qualifying APM Participant (QP) or Partial QP status, they are excluded from the MIPS reporting requirements and payment adjustment (though eligible clinicians who are Partial QPs may elect to be subject to the MIPS reporting requirements and payment adjustment). Eligible clinicians who are QPs for the 2023 performance year receive a 3.5 percent APM Incentive Payment in the 2025 payment year, and, beginning with the 2024 performance year (payment year 2026), a higher PFS payment rate (calculated using the differentially higher “qualifying APM conversion factor”) than non-QPs. QPs will continue to be excluded from MIPS reporting and payment adjustments for the applicable year.

CMS finalized policy to modify the CEHRT use criterion for Advanced APMs to provide greater flexibility for APMs to tailor CEHRT use requirements to the APM and its participants.

ACR staff will review the entire MPFS final rule in the coming weeks and will provide a comprehensive summary of the rule. Please also refer to the general MPFS fact sheet and fact sheet on the major changes in this rule for the seventh year of Medicare’s Quality Payment Program for physicians who are required to participate in either APMs or MIPS.