

AAOS Executive Summary of CY 2024 Medicare Physician Fee Schedule Proposed Rule: What Physicians Need to Know

The Calendar Year (CY) 2024 Medicare Physician Fee Schedule (MPFS) was released on July 13, 2023, by the Centers for Medicare & Medicaid Services (CMS). The annual payment rule sets policy for physicians participating in the Medicare program and makes updates to the Quality Payment Program.

CY 2024 PFS Ratesetting and Conversion Factor:

- The conversion factor, which is the primary factor determining increases or decreases to overall payment rates in the Medicare Physician Fee Schedule, will be reduced from \$33.89 to \$32.75 and represents a decrease of 3.36%.

Potentially Misvalued Services Under the PFS

- 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*) has been nominated as misvalued.
- Currently, the PFS prices code 27279 in the facility setting at \$826.85 for the physician's professional services. The PE amounts are expected to be \$21,897.63 total (the Medicare outpatient for CY2023).
- CMS expressed concerns regarding the safety of this procedure being performed in the non-facility/office setting and is asking for comment.

Payment for Medicare Telehealth Services Under Section 1834(m) of the Social Security Act

- CMS is proposing a streamlined process to review requests to add services to the Medicare Telehealth Services List, both permanently and temporarily, as well as consolidate Categories 1, 2, and 3, and redesignate current Category 1 and 2 services to a new "permanent" or "provisional" category.
- CMS continues to define direct supervision to permit the presence and immediate availability of the supervising practitioner through real-time audio and video interactive telecommunications through December 31, 2024 and is seeking input on potential patient safety or quality concerns when direct supervision occurs virtually.

Telephone Evaluation and Management Services

- In the March 31st COVID-19 IFC CMS finalized separate payment for E/M telephone (audio only) physician visits (CPT codes 99441 – 99443) and will remain actively priced through the end of 2024.

Remote Physiologic Monitoring (RPM)

- With the expiration of the PHE, the 16-day monitoring requirement was reinstated. RPM monitoring must occur over at least 16 days of a 30-day period. CMS is proposing to clarify that the data collection minimums apply to existing RPM and RTM code families for CY 2024.

- The CY 2023 PFS final rule stated if all requirements to report each service were met, without time or effort being counted more than once, RPM or RTM (but not both) may be billed in conjunction with any one of CCM, TCM, BHI, PCM, or CPM codes. CMS proposes to clarify that RPM and RTM may not be billed together, as is listed in CPT guidelines, so that no time is counted twice by billing for concurrent RPM and RTM services.

Valuation of Specific Codes

- CPT code 2X000 (*Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including placement of intra-articular implant(s) (eg, bone allograft[s], synthetic device[s]), without placement of transfixation device*), was surveyed for the January 2023 RUC meeting. CMS is proposing the RUC recommended work RVU of 7.86 as well as the RUC-recommended direct PE inputs without refinement.
- Vertebral body tethering codes, 2X002 (*Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; up to 7 vertebral segments*), 2X003 (*Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; 8 or more vertebral segments*), and 2X004 (*Revision (eg, augmentation, division of tether), replacement, or removal of thoracic vertebral body tethering, including thoracoscopy, when performed*) were also surveyed for the January 2023 RUC meeting. CMS is proposing the RUC-recommended wRVUs of 32.99 for 2X002, 35.50 wRVUs for 2X003, and 36.00 wRVUs for code 2X004 as well as the RUC-recommended direct PE inputs without refinement.
- CMS is proposing to maintain the current wRVU of 27.13 for CPT code 22857 (*Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); single interspace, lumbar*). However, CMS disagrees with the RUC's April 2022 recommended survey median wRVU of 7.50 for code 22860 (*Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); second interspace, lumbar (List separately in addition to code for primary procedure)*) and is proposing the survey 25th percentile wRVU of 6.88.

Evaluation and Management (E/M) Visits

- On January 1, 2024, CMS is proposing to implement a separate add-on payment with HCPCS code G2211 to be used with existing E/M visits for complex patients.
- Code G2211 will not be reimbursable when the office/outpatient E/M is billed with a modifier –25.

Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging

- CMS proposes to permanently sunset the AUC requirements for advanced diagnostic imaging services.
- In this year's rule, CMS proposes to take more permanent action on the AUC program by indefinitely pausing the program to allow the agency to re-evaluate the program and consider alternatives.
- CMS acknowledges that there have been "insurmountable" challenges to implementation and hence, the decision to sunset the current requirement.

Quality Payment Program

Merit-Based Incentive Payment System (MIPS)

- “For CY 2024 performance period/2026 MIPS payment year, the scoring weights are 30 percent for quality performance, 30 percent for cost performance, 15 percent for improvement activities, and 25 percent for the Promoting Interoperability performance category.”
- “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/2026 payment year, a high PFS 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.”
- “**To align implementation of the measures in the Universal Foundation across MIPS and APMs, CMS is proposing updates to consolidate the Promoting Wellness and Managing Chronic Conditions MVPs to align with the adult Universal Foundation measure set.**”
- CMS is proposing to update the subgroup policy for reweighting of MVP performance categories, update the facility-based scoring as well as the complex patient bonus for subgroups under the final score calculation, and add subgroups to the targeted review.
- CMS is proposing changes to the MIPS quality measure set. For the CY 2024 performance period, CMS is proposing a measure set of 200 MIPS quality measures in the inventory.
- “For the CY 2024 performance period, CMS proposed 14 new MIPS quality measures, which includes one composite measure; and 7 high priority measures, of which **4 are also patient-reported outcome measures.**”

The PROMs are:

- Gains in Patient Activation Measure Scores at 12 Months
- Reduction in Suicidal Ideation or Behavior Symptoms
- Improvement or Maintenance of Functioning for Individuals with a Mental and/or Substance Use Disorder
- Ambulatory Palliative Care Patients’ Experience of Feeling Heard and Understood

- One measure is proposed for addition to orthopedic surgery specialty set: Connection to Community Service Provider (MIPS CQM)
- Two measures are proposed for removal from orthopedic surgery specialty set: Preventive Care and Screening: BMI Screening and Follow-Up Plan (Part B claims measure, eCQM, MIPS CQM) and Tobacco Use and Help With Quitting Among Adolescents (MIPS CQMs)

MIPS Quality Performance Category Updates:

- “Maintain the data completeness criteria threshold to at least 75 percent for the CY26 performance period/CY28 payment year and increase the data completeness threshold to 80 percent for CY27 PP/CY29 PY.”

MIPS Cost Performance Category Updates:

- CMS is proposing to add five new episode-based measures to the cost performance category beginning with the CY24/26 MIPS payment year including **'Low Back Pain'**

Low Back Pain cost measure: 20-episode case minimum for each measure.

- CMS is requesting comment on their clarification of the indented interpretation of the language on case minimums.
- CMS is proposing to update the operational list of care episode and patient condition groups and codes to add all five new measures from the operational list of care episode and patient condition groups and codes.

MIPS Improvement Activities Performance Category:

- CMS is proposing to add five new, modify one existing, and remove three existing Improvement Activities from the inventory.

MIPS Promoting Interoperability Performance Category:

- CMS is proposing five policy modifications: Lengthen the performance period from 90 to 180 days
- Modify one of the exclusions for the Query of PDMP measure
- Provide a technical update to the e-prescribing measure's description to ensure it clearly reflects previously finalized policy
- Modify the safety assurance factors for EHR guide measure to require MIPS eligible clinicians to affirmatively attest to completion of the self-assessment of their implementation of safety practices
- Continue to reweight this performance category at zero percent for clinical social workers

CMS is also proposing to revise the regulatory definition of CEHRT for the Promoting Interoperability performance category.

MIPS Final Scoring Methodology

Performance Category Scores:

- CMS is proposing updates to the scoring flexibilities policy including updating the criteria by which they assess the scoring impacts of coding changes and apply the scoring flexibilities.
- CMS is proposing that the eCQM measure specifications would be required to include the ability to be truncated to a 9-month performance period.

Cost Improvement Scores:

CMS is proposing two modifications to the cost improvement scoring method:

- Change improvement scoring from a measure-level to a category-level method and remove the statistical significance requirement.
- The maximum cost improvement score is zero percentage points through the 2024 MIPS payment year, then one percentage point beginning with the CY23 performance period/2025 MIPS payment year.

MIPS Payment Adjustments

- CMS is proposing to “revise the policy for identifying the ‘prior period’ by which they will establish the performance threshold beginning with the CY24 performance period/CY26 MIPS payment year.
- It will be defined as three performance periods, instead of a single prior performance period. For example, for the CY24/CY26 MIPS payment year, CMS is proposing to use the CY2017/2019 MIPS payment year through the CY2019/CY2021 MIPS payment year as the prior period.
- “Based on the mean final score from that prior period, CMS is proposing to establish the performance threshold at 82 points for the CY24 performance period/26 MIPS payment year.”

MIPS Value Pathways (MVPs)

CMS is proposing five new MIPS Value Pathways (MVPs), one of which is “Rehabilitative Support for Musculoskeletal Care.”

- The Rehabilitative Support for Musculoskeletal Care MVP is designed for the following clinicians: chiropractors, physiatrists, physical therapists, occupational therapists, nurse practitioners, and physician assistants.

CMS is also proposing to add one quality measure and one improvement activity to the Improving Care for Lower Extremity Joint Repair MVP:

- Quality measure: Q487: Screening for Social Drivers of Health (Collection Type: MIPS CQMs Specifications)
- Improvement activity measure: IA_MVP: Practice-Wide Quality Improvement in MIPS Value Pathways (High)

Third Party Intermediaries

- CMS proposes numerous policies relating to the use of QCDRs for MIPS submissions.
- **Given that many third party intermediaries may not support measures for clinicians in all specialty areas that might report a MVP, CMS is proposing to update the law to state that “a QCDR or a qualified registry is required to support MVPs pertinent to the specialties they support.”**
- “The proposed addition states that a QCDR or a qualified registry must support all measures and improvement activities available in the MVP with two exceptions:
- The first proposed exception to this requirement is that if an MVP includes several specialties, then a QCDR or a qualified registry is only expected to support the measures that are pertinent to the specialty of their clinicians. For example, if an orthopedic care MVP includes both surgery and physical therapy measures, and the third party intermediary caters specifically to physical therapists, they are not required to support the surgical measures.



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- The second proposed exception is that QCDR measures are only required to be reported by the QCDR measure owner. In instances where a QCDR does not own the QCDR measures in the MVP, the QCDR may only support the QCDR measures if they have the appropriate permissions.”

Sources:

[CY 2024 MPFS Proposed Summary](#)

[CY 2024 MPFS Fact Sheet](#)