



Welcome!

WE WILL BEGIN MOMENTARILY



Association of Community Cancer Centers

ACCC **2023**

Oncology
Reimbursement
MEETINGS

Final Medicare Physician Fee Schedule and Hospital Outpatient Prospective Payment System Rules and Policy Update

December 12, 2023



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Revenue Cycle Coding Strategies



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Policy
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40,000+
multidisciplinary practitioners
from every discipline in oncology

CANCER PROGRAM LEADERSHIP

Hospital Presidents
CEOs, COOs, CMOs
Vice Presidents
Department Directors

ADMINISTRATION

Oncology Program and Practice
Administrators, Managers, and
Service Line Executives
Program Administrative Staff



CLINICIANS

Medical
Radiation
Surgical
Pharmacy

PATIENT CARE

Allied Physicians
Oncology Nurses
Nurse Practitioners
Physician's Assistants

SUPPORTIVE CARE STAFF

Social Workers
Patient Navigators
Financial Advocates
Palliative Specialists

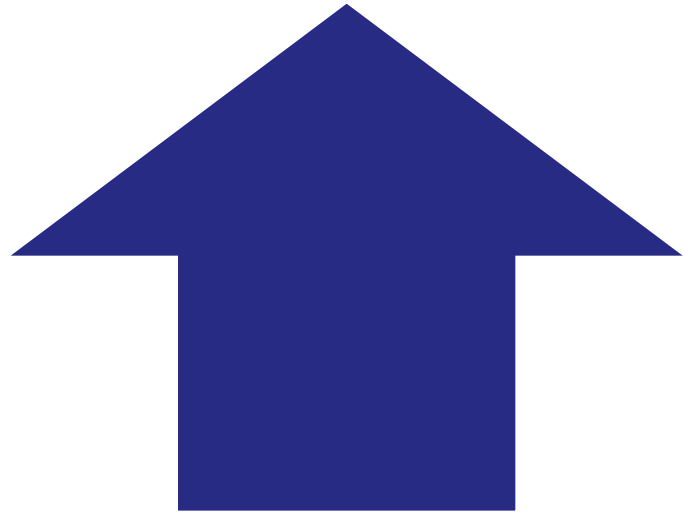
THE ENTIRE TEAM

Genetic Counselors
Quality Officers
Data Manager/Registrars
Billers & Coders

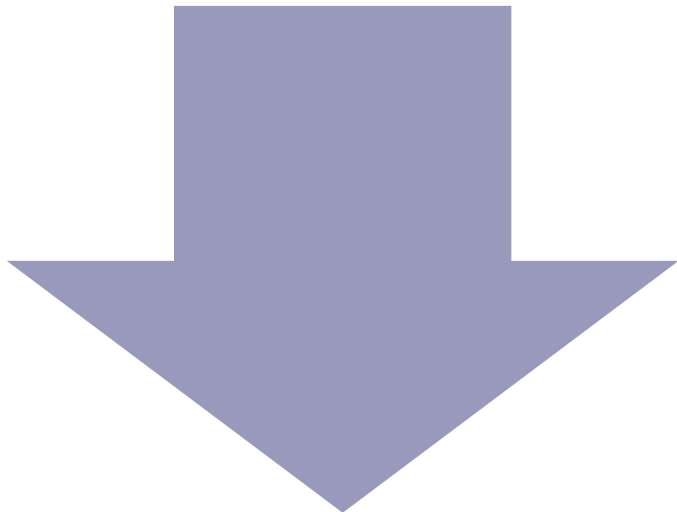
1,700

**Private Practices, Hospital Cancer
Programs, Healthcare Systems, &
Major Academic Centers Nationwide**

FEDERAL REGISTER



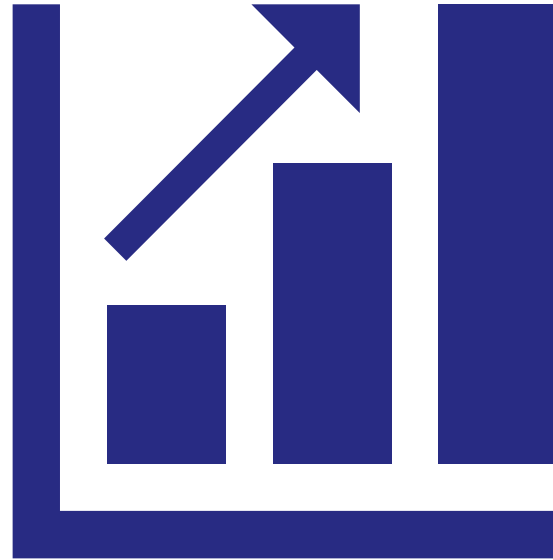
HOPPS (Facilities = Hospitals and Ambulatory Surgical Centers)



MPFS (Physicians and Offices)

2024 HOPPS FINAL RULE

HOPPS FINAL PAYMENT RATES



3.1% increase to
Outpatient Department
(OPD) fee schedule



Total payments of
\$88.9 billion for CY
2024

CANCER HOSPITAL PAYMENT ADJUSTMENT

ACCC
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MEETINGS

Finalized target PCR of 0.88 to determine the CY 2024 cancer hospital payment adjustment

| TABLE 6.—ESTIMATED CY 2024 HOSPITAL-SPECIFIC PAYMENT ADJUSTMENT FOR CANCER HOSPITALS TO BE PROVIDED AT COST REPORT SETTLEMENT | | |
|---|---|--|
| Provider Number | Hospital Name | Estimated Percentage Increase in OPPS Payments for CY 2024 due to Payment Adjustment |
| 050146 | City of Hope Comprehensive Cancer Center | 58.0% |
| 050660 | USC Norris Cancer Hospital | 34.2% |
| 100079 | Sylvester Comprehensive Cancer Center | 41.9% |
| 100271 | H. Lee Moffitt Cancer Center & Research Institute | 25.0% |
| 220162 | Dana-Farber Cancer Institute | 43.1% |
| 330154 | Memorial Sloan-Kettering Cancer Center | 58.1% |
| 330354 | Roswell Park Cancer Institute | 19.1% |
| 360242 | James Cancer Hospital & Solove Research Institute | 14.5% |
| 390196 | Fox Chase Cancer Center | 20.8% |
| 450076 | M.D. Anderson Cancer Center | 44.8% |
| 500138 | Seattle Cancer Care Alliance | 39.4% |

PAYMENTS DRUGS, BIOLOGICALS & RADIOPHARMACEUTICALS



CY 2024 & subsequent years – only re-propose policies when there are changes



340B Program Drugs paid ASP +6%



Policies – Pass-through status payments (new, expiring etc.) addressed only when changes are proposed. Continue APS+6%, WAC+3%, or AWP%

DRUGS, BIOLOGICALS & RADIOPHARMACEUTICALS



- Drugs & biologicals **finalized** to be packaged @ per day admin cost of \leq \$135
 - Drugs & biologicals proposed to be packaged @ per day admin cost of \leq \$140
- Drugs & biologicals $>$ \$135 paid separately **except**
 - Diagnostic radiopharmaceuticals*
 - Contrast agents
 - Anesthesia drugs
 - Drugs, biologicals and radiopharmaceuticals that function as supplies when used in a diagnostic test or procedure
 - Drugs and biologicals that function as supplies or devices when used in a surgical procedure
- Drugs with no sufficient pricing data during initial sales period
 - **WAC+3% finalized for CY 2024**

BIOSIMILAR BIOLOGICAL PRODUCTS



Inflation Reduction Act (IRA)

- New biosimilars furnished before average sales price (ASP) data is available must have a payment limit set
- Limit not to exceed 103% WAC or 106% lesser of WAC or ASP
- Qualifying Biosimilar Product = a biosimilar product with an ASP less than the ASP of the reference biological for a calendar quarter during an applicable five-year period
- ASP+8% of the reference biological's ASP

CY 2024 Finalized

- ASP of biosimilar product <ASP of the reference biological, for a calendar quarter during an applicable five-year period will be paid at ASP plus 8 percent of the reference biological's ASP.
- To promote biosimilar use as a lower cost alternative – Biosimilars are excepted from the threshold packaging policy when their reference biologicals are separately paid. Biosimilars will also be paid separately, even if their per-day cost is below the packaging threshold.

BRACHYTHERAPY SOURCES



- Rates based on cost reports & claims utilization
- **Very important to report correctly!**
- Continuation of Low Volume APCs

| APC | APC Description | CY 2022 Claims Available for Ratesetting | Geometric Mean Cost without Low Volume APC Designation | CY 2024 APC Cost |
|------|--|--|--|------------------|
| 2632 | Iodine I- 125 sodium iodide | 0 | --- | \$61.83 |
| 2635 | Brachytx, non-str, HA, P-103 | 21 | \$98.73 | \$60.86 |
| 2636 | Brachy linear, non- str, P-103 | 1 | \$89.34 | \$57.15 |
| 2642 | Brachytx, stranded, C- 131 | 76 | \$99.92 | \$100.65 |
| 2647 | Brachytx, NS, Non- HDRIr-192 | 2 | \$452.28 | \$403.29 |
| 5244 | Level 4 Blood Product Exchanges and Related Services | 55 | \$52,105.34 | \$53,360.21 |
| 5494 | Level 4 Intraocular Procedures | 50 | \$13,410.30 | \$14,227.94 |
| 5495 | Level 5 Intraocular Procedures | 88 | \$7,399.50 | \$16,660.19 |
| 5496 | Level 6 Intraocular Procedures | 26 | \$11,183.21 | \$17,309.37 |

SCALP COOLING – RATE CHANGE



- Effective July 1, 2021
- Initial measurement and calibration of a scalp cooling device for use during chemotherapy administration to prevent hair loss
- Medicare’s National Coverage Determination (NCD) policy, NCD 110.6 (*Scalp Hypothermia During Chemotherapy to Prevent Hair Loss*)
 - Scalp cooling cap is classified as a supply and not paid separately under HOPPS
- Requests to establish payment – assigned to New Technology APC for CY 2024, decrease from 2023

| CPT® Code | Long Descriptor | CY 2024 OPPS APC | CY 2024 National Rate |
|-----------|---|------------------|-----------------------|
| 0662T | Scalp cooling, mechanical; initial measurement and calibration of cap | 1514 | \$1,250.50 |

EXCESSIVE RADIATION QUALITY MEASURE



- Most of the over 80 million CT scans performed each year in the U.S. are done as outpatient procedures
- Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults electronic clinical quality measure (the Excessive Radiation eCQM)
- Measure Specifications include:
 - The measure numerator is diagnostic CT scans that have a size-adjusted radiation dose greater than the threshold defined for the specific CT category, as defined by body region and reason for the exam. Also included are CT scans with a noise value greater than a threshold specific to the CT category.
 - The measure denominator is all diagnostic CT scans performed on patients ages 18 and older during the one-year measurement period which have an assigned CT category, a size-adjusted radiation dose value, and global noise value.

TABLE 133: FINALIZED PROGRESSIVE INCREASE IN ECQM REPORTING BEGINNING WITH THE CY 2025 REPORTING PERIOD AND FOR SUBSEQUENT YEARS

| Calendar Year Period | Calendar Quarters of Reporting | Reporting Requirement |
|--|-----------------------------------|-----------------------|
| CY 2025 Reporting Period | Any quarter(s) | Voluntary |
| CY 2026 Reporting Period | Any quarter(s) | Voluntary |
| CY 2027 Reporting Period/CY 2029 Payment Determination | Two self-selected quarters | Mandatory |
| CY 2028 Reporting Period/CY 2030 Payment Determination | Four quarters (one calendar year) | Mandatory |

340B DRUG PROGRAM SEPARATE



- Addresses payback from January 1, 2018 through September 27, 2022
- CMS considered the following ways to remedy the needed payment adjustments.
 - Make additional payments to affected 340B covered entity hospitals for 340B-acquired drugs from CY 2018 through September 27th of CY 2022 without proposing an adjustment to maintain budget neutrality
 - Full claims reprocessing from January 1, 2018 through September 27, 2022
 - Aggregate hospital payments from January 1, 2018 through September 27, 2022

FINALIZED REMEDY TO 340B HOSPITALS

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One-time Lump Sum

- Easier than reprocessing claims
- Based on difference what was paid, ASP-22.5% & ASP+6%
- List of affected hospitals included in Addendum AAA

Affected Claims

- 1,686 340B hospitals paid ~\$10.5 billion
- \$1.6 billion remedied 1/1/22-9/27/22
- \$9.004 billion remains

CMS to Direct MACs

- Hospital est. remedied payment \$10 million, already paid \$7.31 million, \$2.69 million lump sum
- Each MAC 60 calendar days to pay back after CMS direction
- Beneficiaries cannot be billed for additional cost sharing

ADDRESSING NON-DRUG SERVICES



Calculated Amount

Services SI J1, J2, P, Q1, Q2, Q3, R, S, T, U, V

Est. offset amount
\$7.8 billion

Adjustments

All providers (except new hospitals) decreased CF

3.09% reduction applied CY 2023

Timeline

Beginning January 1, 2026
(i.e., est. 16 years)

0.5% reduction to CF

REQUEST COMMENTS – ESSENTIAL MEDICATIONS



- January 26, 2021, Executive Order 14001, “A Sustainable Public Health Supply Chain” kicked off focus on supply chains
 - Specifically, pharmaceuticals and simple medical devices
- Recent data supports hospitals are estimated to spend more than 8.6 million personnel hours and \$360 million per year to address drug shortages
- Sought comments on separate payment under IPPS – establish and maintain access to buffer stock of essential medicines to “foster a more reliable, resilient supply of these medicines”.
- Many concerns raised in comments received, not moving forward with changes. Will continue to evaluate and discuss with stakeholders.

2024 MPFS FINAL RULE

CALCULATING CONVERSION FACTOR



| Factors | CORRECT Values per CMS | CORRECT CF Results per CMS |
|--|---------------------------|-------------------------------|
| CY 2023 Conversion Factor | | 33.8872 |
| Conversion Factor without the CAA, 2023 (2.5 Percent Increase for CY 2023) | | 33.0607 |
| CY 2024 RVU Budget Neutrality Adjustment | -2.18 percent (0.9782) | |
| CY 2024 1.25 Percent Increase Provided by the CAA, 2023 | +1.25 percent (1.1025) | |
| CY 2024 Conversion Factor | | 32.7442 |

ESTIMATED SPECIALTY IMPACTS



| CY 2024 PFS Estimated Impact on Total Allowed Charges by Specialty | | | | | |
|--|---------------------------------|---|---------------------------------------|---------------------------------------|---------------------------|
| (A) Specialty | (B) Allowed Charges (mil) | (C) Impact of Work RVU Changes | (D) Impact of PE RVU Changes | (E) Impact of MP RVU Changes | (F) Combined Impact |
| Hematology/Oncology | \$1,595 | 1% | 0% | 0% | 2% |
| Radiation Oncology and Radiation Therapy Centers | \$1,556 | 0% | -2% | 0% | -2% |

*Column F may not equal the sum of columns C, D, and E due to rounding.

ESTIMATED IMPACT BY SETTING



| (A) Specialty | (B) Total Non-Facility/Facility | (C) Allowed Charges (mil) | (D) Combined Impact |
|---|------------------------------------|------------------------------|------------------------|
| Hematology/Oncology | TOTAL | \$1,595 | 2% |
| | Non-facility | \$1,039 | 1% |
| | Facility | \$556 | 2% |
| Radiation Oncology and Radiation Therapy Centers | TOTAL | \$1,556 | -2% |
| | Non-facility | \$1,078 | -2% |
| | Facility | \$478 | -2% |

EXTENSION GPCI PHYSICIAN WORK FLOOR



- Geographic practice cost indices (GPCI) reflect the cost-of-living differences between geographical locations. GPCI values must be reviewed and, if necessary, adjusted every 3 years.
- The Consolidated Appropriations Act, 2021 (CAA 2021), required CMS to use a work GPCI floor of 1.000 through December 31, 2023.
- Further Continuing Appropriations and Other Extensions Act, 2024
 - Government funded through January 19, 2024
 - Includes extension of the physician work geographic cost index (GPCI) under MPFS of 47 payment locales to the floor value of 1.000 through January 19, 2024

NEW CODES 2024



Hyperthermic Intraperitoneal Chemotherapy (HIPEC) (CPT® codes 96547 and 96548)

| Code | Description |
|-------|--|
| 96547 | Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; first 60 minutes |
| 96548 | Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; each additional 30 minutes |

- January 2023 RUC meeting, specialty societies noted the data reflected time estimates higher than the time specified in these time-based codes.
 - RUC concluded the survey results for these codes were incorrect and should be resurveyed for 2025.
- For CY 2024, contractor pricing for codes 96547 and 96548.

OFFICE/OUTPATIENT E/M VISIT COMPLEXITY ADD-ON



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)

- Office/Outpatient visits only
- Documentation should identify the complex additional management
- Not billable with E/M using modifier 25
- MLN Matters, MM13272 released December 7, 2023
- Key is the relationship between patient and practitioner

TELEMEDICINE VISITS



CPT® 77427 will remain available for real-time audio/video through 12/31/24

- Corrected from end date of 12/31/23

Location of provider continue to allow services from home without enrolling home address through 12/31/24

- Adjusted from originally finalized date of 12/31/23

OTHER E/M FACTORS



- Split (or Shared) visits using time or MDM to align with AMA definition of substantive portion

- CMS to continue payment for CPT® codes 98966-98968 (telephone NPPs) extending the telehealth-related flexibilities provided to other audio-only services covered in the CAA 2023

- CMS to continue payment for telehealth services to the originating site

CMS FOCUS OF EFFORTS FOR BENEFICIARIES



GAPS IN CARE MANAGEMENT AND PRIMARY CARE



Improve payment
accuracy to account
for...

Additional resources
and time for patients
with serious illnesses

Remove health-related
social barriers
interfering with
practitioner's medically
necessary care plan

CMS PILLARS



COMMUNITY HEALTH INTEGRATION (CHI)

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- 2 new G codes, G0019 and G0022
- Only one practitioner will bill CHI; there is only one initiating visit
- Initiating visit can be an E/M, except CPT® 99211, performed by the billing practitioner who also furnishes the CHI services during the subsequent calendar month(s).
- E/M visits furnished as part of transitional care management (TCM), or an annual wellness visit (AWV) can qualify
- CHI services performed by certified or trained auxiliary personnel, (i.e., community health worker (CHW)), who can perform all included service elements, incident to and under general supervision
- Patient consent (written or verbal) is required – can be obtained by auxiliary personnel, maintained in medical record
 - Any changes in billing practitioner new consent must be obtained
- Practitioner must identify any SDOHs which significantly limit their ability to diagnose or treat the problem(s) addressed in the visit
- Excluded for inpatient, observation, emergency dept., or SNF visit – ongoing care is not provided

G0019 - 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.

G0022 – Community health integration services, each additional 30 minutes per calendar month (List separately in addition to G0019)

SOCIAL DETERMINANTY OF HEALTH (SDOH)



- 1 new code, G0136
- Risk assessment does not need to be completed on the same date as the associated E/M or behavioral health visit.
 - CMS does not believe this assessment will be provided in advance of the associated E/M visit
- Provided no more than once every 6 months
 - Not intended for routine screening for SDOH at standard intervals or every visit
- Time spent conducting SDOH risk assessment can count towards monthly 60 minutes for CHI and PIN services
- Include a large set of factors:
 - Economic stability,
 - Education access and quality,
 - Healthcare access and quality,
 - Neighborhood and build environment,
 - Social and community context (factors such as housing, food, nutrition access, and transportation needs)

SDOH REQUIREMENTS



G0136 - Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, not more often than every 6 months

CMS required elements of the risk assessment to include:

- Administration of any standardized, evidence based SDOH risk assessment tool
 - Must be tested and validated through research, include the domains of food insecurity, housing insecurity, transportation needs, and utility difficulties.
 - Billing practitioners may choose to assess for additional domains beyond those listed if there are other prevalent or culturally salient social determinants in the community being treated by the practitioner
- The assessment can be furnished with hospital discharge visits and billed in outpatient settings.
- CMS encourages use of ICD-10-CM Z codes specific to SDOH, not required, to better understand patient populations enrolled in CMS programs
- Can be provided in-person, audio/video capabilities, or audio-only – permanently added to telehealth list

PRINCIPAL ILLNESS NAVIGATION (PIN) & (PIN-PS)



Principal Illness Navigation (PIN)

- G0023 & G0024
- Auxiliary staff trained and certified to follow State requirements to provide PIN services. States without requirements, CMS established competencies
 - Including specific certification or training on the serious, high-risk condition/illness/disease addressed in the initiating visit

Principal Illness Navigation Peer Support (PIN-PS)

- G0140 & G0146
 - Created after proposed rule comments – pulled from PIN codes
- Provided by peer support specialists
- Codes are limited to treatment of behavioral health conditions that satisfy the definitions of high-risk condition(s)
- Auxiliary staff providing services must be trained and certified in all parts of code descriptors
 - If no State requirements, training must be consistent with National Model Standards for Peer Support Certification published by SAMHSA

PIN & PIN-PS GUIDELINES



- Established to individualize help the patient identifying appropriate practitioners and providers for care needs and support, and access necessary care timely, especially when the landscape is complex and delaying care can be deadly
- PIN and PIN-PS **should not** be billed concurrently for the same serious, high-risk condition
- Practitioners furnishing PIN services may bill care management services as appropriate for managing and treating a patient's illness
- Services provided under general supervision following initiating E/M visit addressing a serious high-risk condition/illness/disease
- Excluded for inpatient, observation, emergency dept., or SNF visit – ongoing care is not provided
- Patient consent (written or verbal) is required – can be obtained by auxiliary personnel, maintained in medical record
 - Any changes in billing practitioner new consent must be obtained
- No duration limit, but new initiating visit must be conducted once per year
- No frequency limit established for add-on codes G0024 & G0146, CMS to monitor utilization

CRITERIA FOR PIN VISITS



1. One serious, high-risk condition expected to last at least 3 months and that places the patient at significant risk of hospitalization, nursing home placement, acute exacerbation/decompensation, functional decline, or death;
 - a) Examples of serious high-risk conditions/illness/disease include, but are not limited to, cancer, chronic obstructive pulmonary disease, congestive heart failure, dementia, HIV/AIDS, severe mental illness, and substance use disorder.
2. The condition requires development, monitoring, or revision of a disease specific care plan, and may require frequent adjustment in the medication or treatment regimen, or substantial assistance from a caregiver.

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 caregivers (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)

G0140 - Principal Illness Navigation – Peer Support by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a certified peer specialist; 60 minutes per calendar month, in the following activities:

- Person-centered interview, performed to better understand the individual context of the serious, high-risk condition.
 - Conducting a person-centered interview 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 billed separately).
 - Facilitating patient-driven goal setting and establishing an action plan.
 - Providing tailored support as needed to accomplish the person-centered goals in 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 Communication
 - Assist the patient in communicating with their 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, goals, preferences, and desired outcomes, including cultural and linguistic factors.
 - 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.
- Developing and proposing strategies to help meet person-centered treatment goals and supporting the patient in using chosen strategies to reach person-centered 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 person-centered 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.

G0146 – Principal Illness Navigation – Peer Support, additional 30 minutes per calendar month (List separately in addition to G0140)

CHI, SDOH, AND PIN/PIN-PS HIGHLIGHTS



| Type of Visit | Excluded When Patient Visit is... | Initiating E/M Visit Required | Provided by Certified/Trained Auxiliary Staff (Incident to and under General Supervision) | CMS Approved Telehealth Service | 2024 Nonfacility Rate | 2024 Facility Rate |
|--|--|-------------------------------|---|---------------------------------|------------------------------------|------------------------------------|
| Community Health Integration (CHI) | Inpatient/observation, emergency department (ED), or SNF | Yes | Yes | No | G0019 = \$79.24 G0022 = \$49.44 | G0019 = \$48.79 G0022 = \$34.05 |
| Social Determinants of Health (SDOH) | - | No | Yes | Yes | G0136 = \$18.66 | G0136 = \$8.84 |
| Principal Illness Navigation (PIN) | Inpatient/observation, emergency department (ED), or SNF | Yes | Yes | No | G0023 = \$79.24 G0024 = \$49.44 | G0023 = \$48.79 G0024 = \$34.05 |
| Principal Illness Navigation – Peer Support (PIN-PS) | Inpatient/observation, emergency department (ED), or SNF | Yes | Yes | No | G0140 = \$79.24 G0146 = \$49.45 | G0140 = \$48.79 G0146 = \$34.05 |

DENTAL COVERAGE



Chemotherapy

- Addition of dental or oral examination performed as part of a comprehensive workup prior to, and medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to, or contemporaneously with, **chemotherapy** in the treatment of cancer to the list of examples of services that are not subject to the exclusion

CAR T-cell Therapy

- Addition of dental or oral examination performed as part of a comprehensive workup prior to, and medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to, or contemporaneously with **CAR T-cell therapy** in the treatment of cancer to the list of examples of services that are not subject to the exclusion.

High-dose Bone-modifying Agents (Antiresorptive Therapy)

- Addition of dental services that are inextricably linked to, substantially related, and integral to the clinical success of administration of **high-dose bone-modifying agents (antiresorptive therapy)** in the treatment of cancer. Payments can be made under Medicare Parts A and B, under the applicable payment system, for these dental services that occur within the inpatient hospital and outpatient setting, as clinically appropriate.

ADDITIONAL PROVISIONS



- Finalization of an amendment – addition of dental or oral examination performed as part of a comprehensive workup prior to, and medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to, or contemporaneously with the administration of high-dose bone-modifying agents (antiresorptive therapy) in the treatment of cancer to the list of examples of services that are not subject to the exclusion.
- CMS did not receive comments they believe provide the necessary or sufficient evidence to support an inextricable linkage between dental services and the success of single modality radiation therapy during the treatment of certain cancers (aside from head and neck cancers).
- CMS did note MACs do retain the flexibility to determine on a claim-by-claim basis whether a patient's circumstances do or do not fit within the terms of the preclusion or exception and may decide for payment of dental services.
- Finalized – clarifying for the purposes of treatment for head and neck cancer, treatment may include dental services required in the period following direct treatment for the head and neck cancer.

OUTPATIENT TOTAL TIME - UPDATED



| New Patient E/M Code | 2023 Total Time | **NEW** 2024 Total Time (must be met or exceeded) | Established Patient E/M Code | 2023 Total Time | **NEW** 2024 Total Time (must be met or exceeded) |
|----------------------|-----------------|--|------------------------------|-----------------|--|
| 99202 | 15 minutes | 15 minutes | 99212 | 10 minutes | 10 minutes |
| 99203 | 30 minutes | 30 minutes | 99213 | 20 minutes | 20 minutes |
| 99204 | 45 minutes | 45 minutes | 99214 | 30 minutes | 30 minutes |
| 99205 | 60 minutes | 60 minutes | 99215 | 40 minutes | 40 minutes |

When using total time on the date of the encounter for code selection, time threshold *must be* met or exceeded for evaluation and management (E/M) visits.

INPATIENT PROLONGED SERVICES – CMS

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| Primary E/M Service Prolonged | Prolonged Code | Time Threshold to Report Prolonged | Count physician/NPP time spent within this time period (surveyed timeframe) |
|--|----------------|------------------------------------|---|
| Initial IP/Obs. Visit (99223) | G0316 | 90 minutes | Date of visit |
| Subsequent IP/Obs. Visit (99233) | G0316 | 65 minutes | Date of visit |
| IP/Obs. Same-Day Admission/Discharge (99236) | G0316 | 110 minutes | Date of visit to 3 days after |

AMA CPT® and CMS thresholds now match for inpatient or observation services with prolonged services! Still have different codes, but times match.

PROLONGED SERVICES CMS – MUE



| CPT®/ HCPCS | DESCRIPTION | PREVIOUS MUE | MUE EFFECTIVE Jan 1, 2024 |
|------------------|--|-----------------|------------------------------|
| <i>Additions</i> | | | |
| G0316 | Prolonged hospital inpatient or observation care evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99223, 99233, and 99236 for hospital inpatient or observation care evaluation and management services). (Do not report G0316 on the same date of service as other prolonged services for evaluation and management codes 99358, 99359, 99418, 99415, 99416). (Do not report G0316 for any time unit less than 15 minutes) | N/A | 4 |

Medically Unlikely Edits (MUEs) released quarterly, the maximum quantity Medicare determines is appropriate to bill per date of service.

REFERENCES



1. Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program, <https://www.federalregister.gov/public-inspection/2023-24184/medicare-and-medicaid-programs-calendar-year-2024-payment-policies-under-the-physician-fee-schedule>
2. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Acquisition; etc., <https://www.federalregister.gov/public-inspection/2023-24293/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment>
3. Medicare Program; Hospital Outpatient Prospective Payment System: Remedy for the 340B-Acquired Drug Payment Policy for Calendar Years 2018-2022
<https://www.federalregister.gov/documents/2023/11/08/2023-24407/medicare-program-hospital-outpatient-prospective-payment-system-remedy-for-the-340b-acquired-drug>
4. American Medical Association (AMA) *CPT® 2024 Professional Edition* codebook, <https://www.ama-assn.org/press-center/press-releases/ama-releases-cpt-2024-code-set>

Thank you

Federal Policy Update



- Inflation Reduction Act
- Drug Shortages
- Prior Authorization
- Medicare Multi-Cancer Early Detection (MCED) Screening Coverage Act (HR 2407/S 2085)
- Cancer Care Planning and Communications Act (HR 5183)

Inflation Reduction Act: Some Key Medicare Drug Coverage and Pricing Developments



- CMS announced the first 10 drugs selected for price negotiation under Medicare Part D at the end of August 2023.
- The list includes 1 oncology medicine, ibrutinib (Imbruvica®). Additionally, it includes 2 medicines used for the treatment of cancer-associated blood clots, rivaroxaban (Xarelto®), and apixaban (Eliquis®).
- CMS selected these drugs for the initial rounds of negotiation (for price applicability year 2026) based on total gross covered prescription drug costs under Medicare Part D and other criteria required by the law.¹
- All of these manufacturers have agreed to participate in the negotiations.
- Discounted prices will go into effect in 2026.

1. Centers for Medicare and Medicaid Services (CMS). Fact Sheet. Medicare Drug Price Negotiation Program: Selected Drugs for Initial Price Applicability Year 2026. August 2023. <https://www.cms.gov/files/document/fact-sheet-medicare-selected-drug-negotiation-list-ipay-2026.pdf> (Accessed December 11, 2023.)

Inflation Reduction Act: Some Key Medicare Drug Coverage and Pricing Developments

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- The IRA included several provisions that reduce beneficiary/patient out-of-pocket expenses under Part D:
 - As of 2025, beneficiary out-of-pocket spending is capped at \$2000, with the option to spread these costs out over the year (smoothing).
 - It eliminates cost sharing above the catastrophic threshold in 2024.
 - It limits increases in Part D premiums from 2024 to 2030.
 - It expands eligibility for full Part D low-income subsidies (LIS) to low-income beneficiaries with incomes up to 150% of the federal poverty level and modest assets.
 - Cost sharing for vaccines under Part D has been eliminated as of 2023.
- Cost sharing for insulin has been limited to \$35/per month as of 2023 for all Medicare beneficiaries.

Inflation Reduction Act Negotiation for Drug Prices Under Medicare Part B Could Begin in 2028

- Medicare will include Medicare Part B drugs in its pool of drugs eligible for negotiation in 2026, with any possible negotiated prices for Part B drugs going into effect in 2028.
- This could result in a reduction in reimbursement for providers administering Medicare Part B drugs.
- ACCC supports the Protecting Patient Access to Cancer and Complex Therapies Act of 2023 (S 2764/HR 5391), which would mitigate some of the effects of the IRA on provider payments under Medicare Part B.

Drug Shortages



- While the shortages of platinum-based products have improved since earlier this year, the situation continues for some centers and additional products have been affected.
- There is a recognition that the shortages stem from systemic and complex issues and a multipronged approach will be required to address the challenges.
- ACCC is working with a coalition, drawing upon outside experts, to help devise proposed policy changes that could help address the ongoing shortages and help prevent them in the future.
- The US Senate Finance Committee held a hearing on drug shortages on December 5.

Prior Authorization



- ACCC member providers are concerned about the impact of payers' prior authorization (PA) requirements on timely access to care, as well as the administrative burden of processing PA requests and appeals.
- The US House Ways and Means Committee passed provisions like those in the Improving Seniors' Timely Access to Care Act this summer. This legislation would help add transparency to the PA processes for Medicare Advantage plans as well as add timelines for some decisions and enhance the use of electronic PA in these plans.
- The Centers for Medicare and Medicaid Services (CMS) proposed a regulation that would address many of the same issues as this legislation. The deadline for comments was earlier this year.
- Providers are facing challenges relating to PA across commercial and public payer markets.

Medicare Multi-Cancer Early Detection (MCED) Screening Coverage Act (HR 2407/S 2085)



- For years, health care professionals have relied on early detection screenings for just 5 types of cancer. MCED tests give clinicians the ability to screen for dozens of types of cancers at once – many of which currently have no early detection methods.
- MCED screening harnesses the latest technology to catch cancer earlier, giving patients a greater chance at survival.
- Seventy percent of all cancer diagnoses occur among Medicare beneficiaries. Medicare coverage of these screening tools could help ensure that older Americans who are particularly vulnerable to a cancer diagnosis have access to these game-changing tools.
- Because they require only a single draw of blood, the tests can be administered in a wide variety of health care settings.
- This legislation would permit CMS to cover MCED tests under Medicare once they receive FDA approval.

Cancer Care Planning and Communications Act (HR 5183)



- ACCC supports this legislation, which would allow physicians to bill Medicare for the time they spend developing comprehensive cancer care plans for individuals diagnosed with or treated for cancer.
- These plans help make patients more aware of what is to come after a cancer diagnosis and be more active participants in their own care.
- Such planning is consistent with the recommendations of the Institute of Medicine (IOM) in its report *From Cancer Patient to Cancer Survivor: Lost in Transition*.
- In this report, the IOM recommended that individuals diagnosed with cancer completing primary treatment be provided with a comprehensive summary of their care, together with a follow-up survivorship plan of treatment.

Thank you