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2024 Oncology Coding Update

BY TERI BEDARD, BA, RT(R)(T), CPC

This article outlines coding changes specific to the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM), Current Procedural Terminology (CPT®), and the Healthcare Common Procedure Coding System (HCPCS) for services that may be provided by or related to services by oncology specialties. Items in bold highlight changes for 2024 released by both the American Medical Association (AMA) and the Centers for Medicare & Medicaid Services (CMS).

ICD-10-CM Diagnosis Coding Updates

The following ICD-10-CM guidelines went into effect October 1, 2023, as the updates run on the fiscal year calendar. Additional updates are expected for implementation on April 1, 2024, due to the change to a biannual update to diagnosis coding.

Revised Guidelines

Many of the 2024 guideline updates focus on the need to code the diagnosis to the highest level of specificity. Language was added in several sections of the ICD-10-CM Official Guidelines for Coding and Reporting to stress this point. Notably:

Conventions for ICD-10-CM

- Documentation by clinicians other than the patient's provider. Code assignment is based on the documentation by the patient's provider (ie, physician or other qualified health care practitioner legally accountable for establishing the patient's diagnosis). There are a few exceptions when code assignment may be based on medical record documentation from clinicians who

are not the patient's provider. In this context, "clinicians" other than the patient's provider refer to health care professionals permitted, based on regulatory or accreditation requirements or internal hospital policies, to document in a patient's official medical record.

- The term "social determinants of health" (SDOH), classified in Chapter 21, has been added to the list of items that may be documented by another provider and used to support any necessary secondary diagnosis coding.

Chapter 1: Certain Infectious and Parasitic Diseases (A00-B99), U07.1, U09.9

(Editor's Note: In 2024, copy that is struck through was replaced with the new copy in bold.)

- Sepsis due to a postprocedural infection. For infections **sepsis** following a procedure **postprocedural wound (surgical site) infection**, use codes ~~T81.40~~ **T81.41 to T81.43**. For infection following a procedure, use codes **O86.00 to O86.03**. Infection of obstetric surgical wound that identifies the site of the infection should be coded **sequenced** first, if known.

Chapter 2: Neoplasms (C00-D49)

- Admission/encounter for treatment of primary site. If a patient admission/encounter is solely chiefly for the administration of chemotherapy, immunotherapy, or external beam radiation therapy, assign code **Z51.0** (encounter for antineoplastic radiation therapy), code **Z51.11** (encounter for antineoplastic chemotherapy), or code **Z51.12** (encounter for antineoplastic

immunotherapy) as the first-listed or principal diagnosis. If a patient receives more than 1 of these therapies during the same admission, more than 1 of these codes may be assigned, in any sequence.

- Secondary malignant neoplasm of lymphoid tissue. When a malignant neoplasm of lymphoid tissue metastasizes beyond the lymph nodes, a code from categories **C81-C85** with a final character "9" should be assigned identifying "extranodal and solid organ sites" rather than a code for the secondary neoplasm of the affected solid organ. For example, for metastasis of diffuse large B-cell lymphoma to the lung, brain, and left adrenal gland, assign code **C83.39**, which signifies "diffuse large B-cell lymphoma, extranodal, and solid organ sites."

Chapter 19: Injury, Poisoning, and Certain Other Consequences of External Causes (S00-T88)

The occurrence of drug toxicity is classified in ICD-10-CM as follows:

- Underdosing: noncompliance (**Z91.12-**, **Z91.13-**, **Z91.14-**, and **Z91.A4-**) or complication of care (**Y63.6-Y63.9**) codes are to be used with an underdosing code to indicate intent, if known.

Chapter 21: Factors Influencing Health Status and Contact With Health Services (Z00-Z99)

Follow-up

- Follow Up Code **Z08**, encounter for follow-up examination after completed treatment for malignant neoplasm and code **Z09**, encounter for follow up examination after

completed treatment for conditions other than malignant neoplasm, may be assigned following any type of completed treatment modality (including both medical and surgical treatments).

Revised ICD-10-CM Codes

These codes continue to expand to allow for specificity with diagnosis coding. Several codes were expanded from the single ICD-10-CM designation to break out into a specified diagnosis with unspecified or not otherwise specified (NOS) into a separate subcode. The following are highlights of ICD-10-CM coding changes for 2024.

Neoplasms (C00-D49)

- New code **C92**: Myeloid leukemia. Code also, if applicable, pancytopenia (acquired) (**D61.818**)
- New code **C94.8**: Other specified leukemias. Code also, if applicable, eosinophilia (**D72.18**)

D13.9 Benign Neoplasm of Ill-Defined Sites Within the Digestive System

- Previous: Benign neoplasm of digestive system NOS, benign neoplasm of intestine NOS, and benign neoplasm of spleen
- New code **D13.91**: Familial adenomatous polyposis. Code also associated with conditions, such as benign neoplasm of colon (**D12.6**) and malignant neoplasm of colon (**C18.-**)
- **D13.99**: Benign neoplasm of ill-defined sites within the digestive system, benign neoplasm of digestive system NOS, benign neoplasm of intestine NOS, and benign neoplasm of spleen

D48.1 Neoplasm of Uncertain Behavior of Connective and Other Soft Tissue

- New code **D48.11**: Desmoid tumor
 - **D48.110**: Desmoid tumor of head and neck
 - **D48.111**: Desmoid tumor of chest wall
 - **D48.112**: Desmoid tumor, intrathoracic
 - **D48.113**: Desmoid tumor of abdominal wall
 - **D48.114**: Desmoid tumor, intraabdominal; desmoid tumor of pelvic

cavity; desmoid tumor, peritoneal, retroperitoneal

- **D48.115**: Desmoid tumor of upper extremity and shoulder girdle
- **D48.116**: Desmoid tumor of lower extremity and pelvic girdle; desmoid tumor of buttock
- **D48.117**: Desmoid tumor of back
- **D48.118**: Desmoid tumor of other site
- **D48.119**: Desmoid tumor of unspecified site
- **D48.19**: Other specified neoplasm of uncertain behavior of connective and other soft tissue

Other Disorders of Blood and Blood-Forming Organs (D70-D77)

D57: Sickle Cell Disorders

- New code **D57.04**: Hb-SS disease with dactylitis
 - **D57.214**: Sickle-cell/Hb-C disease with dactylitis
 - **D57.414**: Sickle-cell thalassemia, unspecified, with dactylitis
 - **D57.434**: Sickle-cell thalassemia beta-zero with dactylitis
 - **D57.454**: Sickle-cell thalassemia beta-plus with dactylitis

D89: Other Disorders Involving Immune Mechanism

- New code **D89.84**: IgG4-related disease, Immunoglobulin G4-related disease

D61: Other Aplastic Anemias and Other Bone Marrow Failure Syndromes

- **New code D61.02**: Shwachman-Diamond syndrome. Code also, if applicable, associated conditions such as: acute myeloblastic leukemia (**C92.0-**), exocrine pancreatic insufficiency (**K86.81**), and myelodysplastic syndrome (**D46.-**). Use an additional code, if applicable, for genetic susceptibility to other malignant neoplasm (**Z15.09**).

Diseases of the Nervous System (G00-G99)

- **G20**: Parkinson's disease
 - New code **G20.A**: Parkinson disease without dyskinesia

- **G20.A1**: Parkinson disease without dyskinesia, without mention of fluctuation, Parkinson disease NOS, Parkinson disease without dyskinesia, without mention of OFF episodes
- **G20.A2**: Parkinson disease without dyskinesia, with fluctuations, Parkinson disease without dyskinesia, with OFF episodes
- **G20.B**: Parkinson disease with dyskinesia, excludes: drug induced dystonia (**G24.0-**)
 - **G20.B1**: Parkinson disease with dyskinesia, without mention of fluctuations; Parkinson disease with dyskinesia, without mention of OFF episodes
 - **G20.B2**: Parkinson disease with dyskinesia, with fluctuations; Parkinson disease with dyskinesia, with OFF episodes
- **G20.C**: Parkinsonism, unspecified
 - Parkinsonism, NOS
 - Excludes1: Parkinson disease NOS (**G20.A1**)
 - Parkinson disease with dyskinesia (**G20.B-**)
 - Parkinson disease without dyskinesia (**G20.A-**)
 - Secondary Parkinsonism (**G21-**)
- **G40**: Epilepsy and recurrent seizures. New code **G40.C**: Lafora progressive myoclonus epilepsy, Lafora body disease, code also, associated conditions such as dementia (**F02.8-**)
 - **G40.Co**: Lafora progressive myoclonus epilepsy, not intractable
 - **G40.Co1**: Lafora progressive myoclonus epilepsy, not intractable, with status epilepticus
 - **G40.Co9**: Lafora progressive myoclonus epilepsy, not intractable, without status epilepticus; Lafora progressive myoclonus epilepsy NOS
 - **G40.C1**: Lafora progressive myoclonus epilepsy, intractable
 - **G40.C11**: Lafora progressive myoclonus epilepsy, intractable, with status epilepticus

- **G40.C19:** Lafora progressive myoclonus epilepsy, intractable, without status epilepticus

A new section of codes was added to identify noncompliance to a patient's medication, dialysis, or other medical treatment due to caregiver noncompliance. Codes already exist to identify patient noncompliance, but previously there was no way to identify when the noncompliance was due to a caregiver. These codes would be added as informational when documented within the encounter note.

Factors Influencing Health Status and Contact With Health Services

Z91: Personal risk factors, NEC

- New code **Z91.A4:** Caregiver's other noncompliance with patient's medication regimen; caregiver's underdosing with patient's medication NOS
 - **Z91.A41:** Caregiver's other noncompliance with patient's medication regimen due to financial hardship
 - **Z91.A48:** Caregiver's other noncompliance with patient's medication regimen for other reason
- New code **Z91.A51:** Caregiver's noncompliance with patient's renal dialysis due to financial hardship
- New code **Z91.A58:** Caregiver's noncompliance with patient's renal dialysis for other reason
- New code **Z91.A91:** Caregiver's noncompliance with patient's other medical treatment and regimen due to financial hardship
- New code **Z91.A98:** Caregiver's noncompliance with patient's other medical treatment and regimen for other reason
- New code **Z91.85:** Personal history of military service, personal history of serving in the armed forces; personal history of veteran, excludes2; personal history of military deployment (**Z91.82**)
- New code **Z91.89:** Other specified personal risk factors, not elsewhere classified; increased risk for social isolation

CPT CODING UPDATES

Evaluation and Management (E/M): Revised Codes

For 2024, the office/outpatient codes were revised to remove the time range and instead list the time that must be met or exceeded. This change aligns with the other E/M codes that have been updated and only reflect time thresholds, not ranges. Additionally, the full time must be spent with the patient. There is no credit given for any time-based coding of E/M visits when spending the midpoint amount of time.

New Patient Visits

(Editor's Note: Bold copy indicates new language, or revisions, for 2024.)

- **99202:** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision-making. When using **total time on the date of the encounter** for code selection, **15 minutes must be met or exceeded.**
- **99203:** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and a low level of medical decision-making. When using **total time on the date of the encounter** for code selection, **30 minutes must be met or exceeded.**
- **99204:** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and a moderate level of medical decision-making. When using **total time on the date of the encounter** for code selection, **45 minutes must be met or exceeded.**
- **99205:** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and a high level of medical decision-making. When using **total time on the date of the encounter** for code selection, **60 minutes must be met or exceeded.**

Established Patient Visits

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- **99212:** Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision-making. When using **total time on the date of the encounter** for code selection, **10 minutes must be met or exceeded.**
- **99213:** Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and a low level of medical decision-making. When using **total time on the date of the encounter** for code selection, **20 minutes must be met or exceeded.**
- **99214:** Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and a moderate level of medical decision-making. When using **total time on the date of the encounter** for code selection, **30 minutes must be met or exceeded.**
- **99215:** Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and a high level of medical decision-making. When using **total time on the date of the encounter** for code selection, **40 minutes must be met or exceeded.**

New Codes

- **96547:** Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; first 60 minutes (list separately in addition to code for primary procedure)
- **96548:** Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; each additional 30 minutes (list separately in addition to code for primary procedure)

Revised Codes

- **96446:** Chemotherapy administration into the peritoneal cavity via implanted port or catheter

HCPCS CODING UPDATES

Added Codes

Three new codes are available and applicable in radiation oncology with the use of technology that provides radiation simulation and treatment with PET/CT treatment delivery linear accelerators:

- **A9609:** Fludeoxyglucose f18 up to 15 millicuries
- **C9794:** Therapeutic radiology simulation-aided field setting; complex, including acquisition of PET and CT imaging data required for radiopharmaceutical-directed radiation therapy treatment planning (ie, modeling)
- **C9795:** Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance and real-time positron emissions-based delivery adjustments to 1 or more lesions, entire course not to exceed 5 fractions

Community Health Integration Services

CMS created 7 new G codes in total: 2 (**G0019 and G0022**) describing Community Health Integration services performed, 1 (**G0136**) for identification of any social determinants of health (SDOHs) that significantly limit the provider's ability to diagnose or treat the problem(s) addressed in the visit, and 4 for principal illness navigation (PIN) and principal illness navigation–peer support (PIN-PS) services codes, 2 (**G0023 and G0024**) specific to any provider and 2 (**G0140 and G0146**) specific to peer support for behavioral health. More detailed information on these new codes follows.

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 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 health care practitioners, providers, and facilities and from home- and community-based service providers, social service providers, and caregiver (if applicable).
 - Communicating 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
 - Coordinating 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 (eg, 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 health care, 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 Determinants of Health (SDOHs)

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

Principal Illness Navigation (PIN) Services

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 health care practitioners, providers, and facilities; home- and community-based service providers; and caregivers (if applicable)
 - Communicating 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
 - Coordinating 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 (eg, housing, utilities, transportation, food assistance) as needed to address SDOH need(s) strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors
- 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 health care, 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**)

Principal Illness Navigation–Peer Support (PIN-PS) Services

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 the patient (and caregiver or family, if applicable) to appropriate supportive services
- Practitioner-, home-, and community-based care communication

- Assisting 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 (eg, 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 and 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**) 

Teri Bedard, BA, RT(R)(T), CPC, Executive Director, Client & Corporate Resources at Revenue Cycle Coding Strategies in Des Moines, Iowa

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CY 2024 HOPPS Final Rule Highlights

BY TERI BEDARD, BA, RT(R)(T), CPC

On November 2, 2023, the Centers for Medicare & Medicaid Services (CMS) released the calendar year (CY) 2024 final rules for the Hospital Outpatient Prospective Payment System (HOPPS)¹ and separately released the Remedy Payment Policy for the 340B-Acquired Drug Payment Policy for Calendar Years 2018-2022.² The agency finalized an overall increase to the outpatient fee schedule along with some changes in payment policy that decrease the drug administration threshold and cancer hospital payment adjustment.

Payment Rates

For CY 2024, CMS used CY 2022 claims data; this is the normal process when establishing payment rates based on the most recent completed year of filing. The outpatient department increase factor is equal to the hospital inpatient market basket percentage increase applicable to hospital charges. CMS finalized a 3.1% increase to the hospital outpatient department fee schedule. The agency estimates total payments to HOPPS providers will be approximately \$88.9 billion, an increase of approximately \$6.0 billion compared with CY 2023 HOPPS payments.

Cancer Hospital Payment Adjustment

For CY 2024, CMS will continue additional payments to cancer hospitals using a payment-to-cost ratio (PCR) factor. Beginning in CY 2018, the 21st Century Cures Act required that the weighted average PCR be reduced by 1.0 percentage point. CMS finalized the target PCR of 0.88 to determine the CY 2024 cancer hospital payment adjustment to be paid at cost

report settlement, which includes the reduction of 1.0 percentage point, which is a decrease from recent year adjustment factors.

Payments of Drugs, Biologicals (Including Biosimilar Products), and Radiopharmaceuticals

Each year, CMS assesses payments for drugs and biologicals based on current pricing methodologies, which include payments for drugs and biologicals considered separately payable based on the assigned ambulatory payment classification or pass-through status. For CY 2024, CMS will continue this current payment policy, which has been in effect from CY 2013. Below is a summary of the items CMS finalized for CY 2024: Each year, CMS assesses payments for drugs and biologicals based on current pricing methodologies, which include payments for drugs and biologicals considered separately payable based on the assigned ambulatory payment classification or pass-through status. For CY 2024, CMS will continue this current payment policy, which has been in effect from CY 2013. Below is a summary of the items CMS finalized for CY 2024:

- CMS proposed to package drugs and biologicals estimated at a per-day administration cost less than or equal to \$140; however, in the final rule, the agency maintained the CY 2023 value of less than or equal to \$135.
- Qualifying biosimilar products (defined as a biosimilar product with an average sales price [ASP] of less than the ASP of the reference biological) for a calendar quarter during an applicable 5-year period will be paid at ASP plus 8% of the ASP for the reference biological.

- Biosimilars are excepted from the threshold packaging policy when their reference biologicals are separately paid. The agency had proposed that all biosimilars related to the reference product would be similarly packaged regardless of whether their per-day costs are above the threshold. After consideration, CMS did not finalize this proposal. Instead, these biosimilars will also be paid separately, even if their per-day cost is below the packaging threshold. The agency will continue to evaluate this issue, but it believes that this practice will help promote biosimilar use as a lower cost alternative to higher cost reference biologicals.
- To simplify the process of reporting drugs purchased under the 340B Drug Pricing Program, CMS finalized that hospitals will only use the modifier **"TB"** to identify drugs. In 2024, hospitals that previously reported modifier **"JG"** have the option to report either modifier **"JG"** or **"TB"**; effective January 1, 2025, however, the modifier **"TB"** must be used. Effective January 1, 2024, the description for modifier **"TB"** no longer includes for select entities, as all entities would report this modifier after this date. The new descriptor for modifier **"TB"** is now "drug or biological acquired with 340B drug pricing program discount, reported for informational purposes for select entities."

Remedy for the 340B-Acquired Drug Payment Policy for CY 2018–2022

After a June 15, 2022, Supreme Court ruling on the 340B Drug Pricing Program, CMS was tasked with devising a viable solution to pay

back monies to hospitals that purchased drugs under this program. After the ruling, the agency adjusted part of CY 2022 payments (from September 28, 2022, through December 31, 2022) and CY 2023 payments. In a proposal separate from the CY 2023 HOPPS proposed rule, CMS addressed the remaining payments (September 28, 2022, through December 31, 2022) in its proposal “Medicare Program; Hospital Outpatient Prospective Payment System: Remedy for the 340B-Acquired Drug Payment Policy for Calendar Years 2018-2022, CMS-1793-P.”³ In the final HOPPS rule, the agency finalized what it believes is the best way to remedy these payment adjustments. Specifically, CMI will make a 1-time lump sum payment to affected 340B covered entities. To arrive at this lump sum, the agency is calculating the difference between what hospitals were paid for 340B drugs (at ASP minus 22.5%, at an adjusted wholesale acquisition cost [WAC], or at average wholesale price [AWP] amount) between January 1, 2018, and September 27, 2022, and what hospitals would have been paid at ASP plus 6%.


From January 1, 2018, through September 27, 2022, approximately 1686 hospitals were paid at the 340B payment rate of ASP minus 22.5%. CMS estimates that these hospitals are now owed approximately \$10.6 billion. The agency also estimates that these hospitals have already received \$1.6 billion in remedy payments from reprocessed claims from January 1, 2022, through September 27, 2022, reducing the overall estimated payment amount to \$9.004 billion. To determine the amount owed to each of these 1686 hospitals, CMS will calculate how much each hospital would have been paid for drugs acquired through the 340B program from January 1, 2018, through September 27, 2022, if the payment policy had been set at ASP plus 6% and minus any remedy payments already made to each hospital.

CMS will provide instructions to the Medicare administrative contractors (MACs) to remit payments to the hospitals within their jurisdiction. Each MAC will have 60 calendar days to make the lump sum payment; these payments will not include any interest to the hospital. CMS expects to begin making these

payments at the beginning of CY 2024. Any hospital that submits a request for a technical correction of the estimated lump sum payment will be paid after the request is resolved. Hospitals that do not submit a correction request will be paid first. Addendum AAA of the 2024 HOPPS final rule includes the list of hospitals and their final lump sum remedy payment as calculated by CMS.³

To address beneficiary cost-sharing, CMS estimated that \$1.8 billion is the amount paid by beneficiaries as part of their cost sharing (co-payment) to the covered hospitals as estimated from the \$9 billion total owed to 340B-covered hospitals. CMS finalized that 340B-covered entities may not bill beneficiaries for coinsurance on remedy payments regardless of any adjustment.

Non-drug services under HOPPS increased from January 1, 2018, through December 31, 2022. CMS must calculate these increases to offset the remedy payments made and maintain budget neutrality. A reduction of 3.09% was already applied for CY 2023. To determine the amount paid for non-drug services, CMS includes codes reported during the time in question and assigned to status indicator **J1, J2, P, Q1, Q2, Q3, R, S, T, U, or V**. CMS estimates the offset amount is \$7.8 billion, which is less than the estimated remedy amount of \$9 billion.

Beginning January 1, 2026, CMS will reduce payments for non-drug items and services to all HOPPS providers except new providers (defined as hospitals with a CMS certification number effective date of January 2, 2018, or later) by 0.5% (applied to the conversion factor) each year until the total offset amount is reached, estimated to be 16 years. CMS believes that the 0.5% reduction would be less burdensome to hospitals, especially rural entities and in situations for which other factors may impact payments over the next several years. 

Teri Bedard, BA, RT(R)(T), CPC, is executive director of client and corporate resources at Revenue Cycle Coding Strategies in Des Moines, Iowa.

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compliance

CY 2024 MPFS Final Rule Highlights

BY TERI BEDARD, BA, RT(R)(T), CPC

On November 2, 2023, the Centers for Medicare & Medicaid Services (CMS) released the calendar year (CY) 2024 final rules for the Medicare Physician Fee Schedule (MPFS).¹ As proposed, the agency finalized implementation of a new complexity add-on code, a new series of codes to recognize the resources provided for patients to ensure equity of and access to health care, and payment cuts across the board.

Payment Rates

The MPFS provides regulatory information and payment rates for physicians regardless of their work setting (facility and non-facility) or employer as well as office-based (non-facility) settings. Stakeholders had 60 days to submit comments to CMS on the proposed changes for CY 2024; CMS reviewed the comments and provided a rationale for its decisions.

The conversion factor (CF) is a value set that is determined each year to convert the relative value units (RVUs) of physician work, practice expenses, and malpractice expenses of each code and geographic locations of service provision into the assigned CMS payment rate; this rate is determined by building on the CF from the preceding year. As defined in previous legislation, the CF has a statutory increase of 0% through CY 2025; any adjustments are solely due to other regulatory or maintenance of the Medicare budget constraints.

For CY 2024, the CF published in Table 116 of the MPFS was incorrect. On November 2, 2023, the American Medical Association (AMA) sent out confirmation from CMS that the correct values for budget neutrality and the final CF are outlined in the paragraph preceding Table 116, but the values listed in the table itself are incorrect, stating, “CMS has confirmed to the

AMA that the 2024 Medicare conversion factor is \$32.7442, not \$32.7375 as identified in Table 116 and as previously reported. The decrease from the 2023 conversion factor is 3.37%.” This results in an estimated 3.7% reduction from 2023, not 3.4% as published by CMS within their Fact Sheet for the MPFS final rule. **Table 1** shows the breakdown between facility and non-facility settings as estimated per the total allowed charges for CY 2024.

The lower CF does result in decreases for many specialties; however, additional decreases to RVUs due to misvalued codes, the inclusion of the office/outpatient evaluation and management (E/M) complexity add-on code, year 3 phase-in of clinical labor updates, and adjustments to behavioral health services also factored into this 3.7% reduction.

Table 1. CY 2024 MPFS Estimated Impact on Total Allowed Charges by Setting

SPECIALTY	TOTAL NON-FACILITY/FACILITY	ALLOWED CHARGES (MILLIONS)	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%

Specific Codes and Code Set Valuations

Within the CY 2024 MPFS final rule, CMS addressed several potentially misvalued and/or value changes to new and established *Current Procedure Terminology (CPT)* codes. The agency reviewed each code or code family and whether it accepted the valuations by the Specialty Society Relative Value Scale Update Committee (RUC) and other organizations.

- Advanced care planning *CPT* codes **99497** and **99498**. The RUC Relativity Assessment Workgroup reviewed codes **99497** and **99498** in January 2022 and determined that they should be examined due to changes in E/M services. At its April 2022 meeting, the RUC recommended no changes in physician time, work RVUs, or direct practice expense (PE) inputs for these services. For 2024, CMS finalized without refinement the RUC-recommended work RVU of 1.50 for code **99497** and of 1.40 for code **99498**; the codes currently have those values.
- Hyperthermic intraperitoneal chemotherapy *CPT* codes **96547** and **96548**. In September 2022, 2 time-based add-on category 1 *CPT* codes were created: **96547** (“intraoperative hyperthermic intraperitoneal chemotherapy [HIPEC] procedure, including separate incision[s] and closure, when performed; first 60 minutes”) and **96548** (“intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision[s] and closure, when performed; each additional 30 minutes”). During the January 2023 RUC meeting, the specialty societies noted that data reflected time estimates that were higher than those specified in these time-based codes. The RUC concluded that survey results for these codes were incorrect and that they should be resurveyed for 2025. Based on this, the RUC recommended contractor pricing and referral to the *CPT* Editorial Panel for revision. For CY 2024, CMS agreed with the RUC’s recommendations; these codes will be priced individually by the different Medicare administrative contractors (MACs) until new data are available.

E/M Changes for 2024

CMS addressed 2 outstanding issues in E/M visit payment: 1) implementing separate payment for the office/outpatient evaluation E/M visit complexity add-on payment, and 2) defining split (or shared) visits, which was delayed for CY 2023.

Office/Outpatient E/M Visit Complexity Add-On

Prior to the E/M changes which began in 2021, CMS was not in agreement with the AMA. Therefore, CMS created an add-on code to recognize complex care provided to Medicare beneficiaries not represented in the updated values. The add-on 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”) was proposed as part of the CY 2021 proposed rule.

After code **G2211** was established, the Consolidated Appropriations Act of 2021 put a moratorium on Medicare payment for this service by disallowing CMS from its reimbursement under the MPFS before January 1, 2024. For CY 2023, the rest of the E/M visit code families (except critical care services) were revised to match the general framework of the office/outpatient E/M visits, including visit level selection based on time or MDM (medical decision-making) level. Despite revisions to the other E/M visit families in the CY 2023 final rule, CMS believed that certain types of office/outpatient E/M visits still did not account for the complexity and resources needed to perform certain types of care.

CMS finalized a change in the status of code **G2211** to active to make it separately payable effective January 1, 2024. After many comments were received, the agency acknowledged the need to clarify when the **G2211** code can be used. Use of this add-on code is intended for services that are part of ongoing care to better account for the inherent complexity of all needed health care services and/or ongoing care related to a patient’s single, serious, or

complex condition. The agency emphasized that the add-on code is not based on the characteristics of a particular patient but rather on the *relationship* between the patient and practitioner.

Providers who may best qualify to use this code are physicians who are the continuing focal point for all of a patient’s health care services. These providers must not only decide upon the best course of treatment but also for every care decision; this includes best communicating with the patient during the visit to achieve the optimal health outcome and to build an effective, trusting, ongoing relationship for all primary health care needs. CMS believes that the provider has to weigh these factors even for a seemingly simple condition such as sinus congestion; this makes the physician-patient interaction inherently complex.

The ongoing care described within the code descriptor speaks to the longitudinal relationship between the provider and patient for a single, serious, or complex condition. As provided by CMS, the example of an HIV patient could easily be extrapolated to a patient with cancer who is seeing their oncologist for ongoing care. The oncologist and the primary care physician must weigh the same factors during regularly scheduled visits; the E/M becomes more complex due to the compounded building of decisions and considerations for the patient. The oncologist may not be the focal point for all services, yet cancer is a serious and/or complex condition. If the provider and patient relationship is ongoing, **G2211** could be billed along with to the E/M code for the visit.

Split (or Shared) Visits

For CY 2024, CMS again proposed to delay implementation of the updated definition for substantive portion. However, CMS has decided to forego its previous proposed and finalized definitions and align with the AMA’s *CPT* E/M guidelines for CY 2024. This decision was made after a review of revisions made by the AMA *CPT* Editorial Panel and included in the 2024 *CPT* manual publication—specifically, the Evaluation and Management Services

Guidelines language surrounding *substantive portion* for split (or shared) services.

Effective January 1, 2024, the revised definition of substantive portion of a split (or shared) visit for Medicare billing purposes means that more than half of the total time spent by the physician and nonphysician practitioner (NPP) to perform the split (or shared) visit, or a substantive part of the medical decision-making, is used to determine the appropriate code level. (Critical care visits, which only use time, are exempted from this definition.)

Telephone Evaluation and Management Services

As required by Consolidated Appropriations Act, CPT codes **99441–99443** for audio-only telehealth services will continue coverage and payment by CMS through December 31, 2024. CPT codes **98966–98968**, which describe telephone assessment and management by nonphysician health care professionals, are not considered telehealth services by CMS. However, these codes have been extended provisional status on the telehealth list, and they will be allowed through December 31, 2024.

After code **G2211** was established, the Consolidated Appropriations Act of 2021 put a moratorium on Medicare payment for this service by disallowing CMS from its reimbursement under the MPFS

Location of Practitioner Providing Telehealth Services

After feedback from a coalition of interested parties, CMS will continue to allow individual practitioners to provide telehealth services from their home without enrolling their home address through the agency. This provision was set to expire December 31, 2023; however, the coalition pointed out safety issues for providers who must disclose their home address through the enrollment process. This issue was supported by recent incidents of workplace violence identified by the coalition and the risk it may add to many health care practitioners.

CMS indicated that it will continue to allow practitioners to use their practice location address instead of their home address when providing telehealth services from their home

through December 31, 2024. The agency is also seeking information to better understand considerations involved enrolling a practitioner's home address as a practice location for Medicare telehealth services.

Place of Service for Telehealth Services

Due to the end of the public health emergency (PHE), the use of **modifier 95** along with the place of service (POS) code—as if the service had been performed in-person—is no longer accepted. Instead, providers will report **modifier 95** with 1 of 2 new POS codes specific to telehealth that identify where the patient is located, unless the physician is in the hospital setting when the visit is performed:

- **POS “02”** (Telehealth provided other than in patient's home)
- **POS “10”** (Telehealth provided in patient's home).

Beginning January 1, 2024, claims billed with **POS 02** will continue to be paid at the MPFS facility rate; claims for any services—not just mental health services—with the code **POS 10** will be paid at the MPFS nonfacility rate. CMS indicated that **POS 02** also represents services provided in an originating site such as hospitals or rural health clinics. The agency clarified that if the physician is working in the hospital and the patient is in their home for the telehealth visit, the physician will report using **modifier 95** and the POS code for the hospital.

Physician Supervision via 2-Way Audio/Video

For CY 2024, CMS extended the definition that allowed for direct supervision to be met with the use of real-time audio and video interactive telecommunications through December 31, 2024. This provision aligns with the timeframe of many of the PHE-related telehealth policies and avoids an abrupt transition to policies in place before the PHE.

Residents in Teaching Settings

For CY 2024, the teaching physician can continue to have a virtual presence in all teaching settings but only in clinical instances

when the service is furnished virtually. An example of this would be a 3-way telehealth visit with all parties in separate locations. This provision permits teaching physicians to have a virtual presence during the key portion of the Medicare telehealth service via real-time audio/video communication for all residency training locations through December 31, 2024.

New Codes for Community Health Integration, Social Determinants of Health, and Principal Illness Navigation Services

Equity and access—specifically, how social determinants of health (SDOH) impact the ability to diagnose or treat the patient—are now primary areas of focus for CMS. Accordingly, the agency is trying to determine how to improve payment accuracy for additional time and resources dedicated to helping patients with serious illnesses as they navigate the health care system or to removing health-related social barriers.

For 2024, CMS created 7 new G codes:

- 2 codes (**G0019** and **G0022**) describe community health integration (CHI) services performed
- 1 code (**G0136**) identifies any social determinants of health that significantly limit the provider's ability to diagnose or treat the problem(s) addressed in the visit
- 4 codes for principal illness navigation (PIN) and principal illness navigation—peer support (PIN-PS) services include 2 codes (**G0023** and **G0024**) specific to any provider and 2 codes (**G0140** and **G0146**) specific to peer support for behavioral health.

Community health integration, principal illness navigation, and principal illness navigation—peer support can be provided under general supervision after initiating an E/M visit that addresses a serious high-risk condition, illness, and/or disease. Use of the social determinants of health code requires use of a standardized, evidence-based risk assessment tool that can be provided with in-person, audio-only, or real-time audio and video capabilities.


Dental Service Coverage for Oncology Patients

Medicare Parts A and B prohibit payment for services in connection with care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth. CMS received 8 submissions to consider for CY 2024 and finalized the following related to cancer treatment services. For 2024, CMS created 7 new G codes:

The agency added these examples of services that are *not* subject to the exclusion:

- Dental or oral examination performed as part of a comprehensive workup before cancer treatment with chemotherapy, chimeric antigen receptor (CAR) T-cell therapy, and administration of high-dose bone-modifying agents (antiresorptive therapy) to treat cancer
- Medically necessary diagnostic and treatment services to eliminate an oral or dental infection before or contemporaneously with cancer treatment (eg, chemotherapy, CAR T-cell therapy, and administration of high-dose bone-modifying agents [antiresorptive therapy])
- Dental services inextricably linked to, substantially related to, and integral to the clinical success of administration of high-dose bone-modifying agents (antiresorptive therapy) in cancer treatment.

CMS also provided clarification to allow payment under Medicare Part A and Part B, for dental services required during the period after direct treatment for the head and neck cancer.

As always, the possibility of an update or correction notice from CMS regarding the MPFS final rule is a real possibility. If changes or corrections are made, impacts on payment rates—but no updates to finalized policies—are expected. Due to grassroots efforts for continued support from the US Congress to address physician payment cuts, anything is possible. 

Teri Bedard, BA, RT(R)(T), CPC, is executive director of client and corporate resources at Revenue Cycle Coding Strategies in Des Moines, Iowa.

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