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

imaging providers wait to receive AUC consultation information from reporting providers. In addition, CMS raises the concern of patients being financially liable for advanced diagnostic imaging claims denied by Medicare for failure to include consultation information.

CMS indicated that they will continue efforts to identify workable implementation approaches and will propose to adopt m tʃ innsui d"a א ! p ł]

Updates to Prices for Existing Direct Practice Expense Inputs (Page 35)

CMS continues to review and consider invoices they receive for existing direct practice expense (PE) inputs. For CY 2024, many stakeholders submitted invoices for consideration. CMS accepted and updated pricing for 18 supply and equipment items (none affecting Radiology). However, they are not proposing to update the pricing for 11 supply items, mostly due to the availability of the items for cheaper or the submission of only one invoice for common items that may have far-reaching effects across the fee schedule.

CMS continues to welcome the submission of invoices to assist with the pricing of supplies and equipment.

Clinical Labor (CL) Pricing Update (Page 37)

CY 2024 will mark the third year of the clinical labor pricing update phase-in, which will end in 2025. CMS is in the process of updating the pricing for clinical labor staff, in line with recent updates to the supplies and equipment pricing.

CMS relied on data from the Bureau of Labor Statistics (BLS) for most of their clinical staff pricing, but also considered other data from Salary Expert or data provided by stakeholders. CMS continues to welcome input from commenters on appropriate pricing for all clinical staff.

For CY 2024, no new information or wage data was submitted. CMS is moving forward with the pricing finalized in the CY 2023 MPFS.

Soliciting Public Comment on Strategies for Updates to Practice Expense Data Collection and Methodology (Page 44)

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

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

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

CMS is soliciting comments from stakeholders on the following:

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

After consideration, CMS is proposing to maintain the CY 2023 values for these codes, but they are open to further comments.

Valuation of Specific Codes for CY 2024 (Page 145)

Dorsal Sacroiliac Joint Arthrodesis (CPT code 2X000) (Page 145)
CPT code 2X000 *(Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including placement of intraarticular implant(s) (eg, bone allograft[s], synthetic device[s]), without placement of transfixation device*)), was created by CPT to replace CPT code 0775T *(Arthrodesis, sacroiliac joint, percutaneous, with image guidance, includes placement of intra-articular implant(s) (eg,bone allograft[s], synthetic device[s]).* CPT codes 27279 *(Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device)* and 27280 *(Arthrodesis, sacroiliac joint, open, includes obtaining bone graft, including instrumentation, when performed)* were also flagged for review as part of the code family. However, the RUC agreed with the specialty societies that these codes were clinically different and did not need to be reviewed together. CPT code 27279 was also recently reviewed by the RUC in 2018.

CMS is proposing to accept the RUC's recommended 7.86 work RVUs for CPT code 2X000, as well as the RUC-recommended PE inputs with no refinements.

Fractional Flow Reserve with CT (CPT code 7X005) (Page 158)
In 2018, four new category III codes, 0501T-0504T, were created to describe Fractional Flow Reserve with CT (FFRCT). Medicare began paying for 0503T *(Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; analysis of fluid dynamics and simulated maximal coronary hyperemia, and generation of estimated FFR model)* under the Hospital Outpatient Prospective Payment System (HOPPS). Category III codes are typically contractor priced in the

The RUC reviewed the specialties' updated PE inputs at the recent January 2023 meeting, with only changes recommended for CPT code 76882. CMS is proposing to accept the RUC-recommended PE inputs for 76881 and 76883. CMS is proposing some refinements to the RUC-recommended PE inputs for CPT code 76882, including correcting the Professional PACS Workstation (ED053) time from 13.5 minutes to 17.5 minutes, and maintaining the ultrasound unit, portable (EQ250) time of 15 minutes to be consistent with how this time was allotted for CPT codes 76881 and 76883.

CMS is not proposing any changes to the work RVUs for these codes.

Evaluation and Management (E/M) Visits

specifically for reporting prolonged O/O E/M services and complexity of O/O E/M visits, respectively. It is important to note that Medicare payment for HCPCS code G2211 is prohibited until January 1, 2024, as mandated by the Consolidated Appropriations Act (CCA), 2021. CMS is proposing to change the status of HCPCS code G2211 to make it separately payable by assigning the “active” status indicator, effective January 1, 2024. CMS estimated that the add-on code (G2211) will be billed with 54% of all O/O E/M visits when fully adopted.

CMS is also proposing that the O/O E/M visit complexity add-on code, HCPCS code G2211, would not be payable when the O/O E/M visit is reported with payment modifier-25, *Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service*

evidence that patient safety is compromised by virtual direct supervision, CMS believes that an immediate reversion to the pre-PHE definition of direct supervision would prohibit virtual direct supervision, which may present a barrier to access to many services. CMS is proposing to revise the regulatory text to state that, through December 31, 2024, the presence of the physician (or other practitioner) includes virtual presence through audio/video real-time communications technology (excluding audio-only).

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

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As of January 1, 2023, 10.9 million people with Medicare receive care from one of the 573,126 health care providers in the 456 ACOs participating in the Medicare Shared Savings Program (MSSP). CMS expects there will continue to be an increased number of beneficiaries engaged in ACO’s participating in MSSP. In the CY 2021 PFS final rule, CMS finalized modifications to the MSSP quality reporting requirements and quality performance standard for performance year 2021 and subsequent performance years. CMS is proposing changes to the MSSP that CMS hope will advance their overall value-base care s

Facility-based measurement and scoring policies exclude MVP Participants that are subgroups from facility-based scoring. However, CMS does not intend to calculate facility-based scores at the subgroup level. Therefore, final MIPS scores would not be calculated using the facility-based scores since there isn't an MVP specifically addressing facility-based measurement.

CMS explains that they have identified problems with using claims data associated with subgroup clinicians preventing them from calculating the complex patient bonus at the subgroup level because they cannot determine the beneficiaries seen by subgroup clinicians. Comments are being sought on ways to fix this problem.

MIPS Category Weighting (p. 870)

The proposed category weights for the 2024 performance year are **Quality 30%, Cost 30%, Promoting Interoperability (PI) 25%, and Improvement Activities (IA) 15%.** These are the same values finalized for the 2022 performance year and are unlikely to change in future years.

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

MIPS Performance Threshold and Incentive Payments (p. 877)

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

During the 2022 and 2023 performance years, CMS set the MIPS performance threshold based on a mean or median value derived from a previous year's scoring data. **Beginning with the 2024 performance year, CMS proposes using performance scores starting with 2017-2019 scoring data, which would result in a 2024 performance threshold of 82 points.** This means that clinicians scoring 82 points or higher will receive a neutral or positive payment adjustment, while clinicians falling below 82 points will receive a negative adjustment, **a sizable increase from the 2022-2023 performance threshold of 75 points.**

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

Low-Volume Threshold and Small Practice (15 or fewer eligible clinicians) Considerations (p. 1148)

CMS has not proposed changes to the low-volume threshold criteria. To be excluded from MIPS in 2023, clinicians or groups must meet one of the following three criteria: have ≤ $90K in

or provide ≤ 200 covered professional services under the Physician Fee Schedule. CMS proposes retaining the established opt-in policy, allowing physicians who meet some but not all of the low-

factor for cancer, while preserving image quality. It is expressed as a percentage of CT exams that are out-of-range based on having either excessive radiation dose or inadequate image quality relative to evidence-based thresholds based on the clinical indication for the exam. All diagnostic CT exams of specified anatomic sites performed in inpatient, outpatient and ambulatory care settings are eligible. This eCQM requires the use of additional software to access primary data elements stored within radiology electronic health records and translate them into data elements that can be ingested by this eCQM.
Denominator: All CT scans in adults aged 18 years and older at the start of the measurement period that have a CT Dose and Image Quality Category and were performed during the measurement period.
Numerator: Calculated CT size-adjusted dose greater than or equal to a threshold specific to the CT dose and Image Quality Category, or Calculated CT Global Noise value greater than or equal to a threshold specific to the CT Dose and Image Quality Category. (p. 1437)

Quality Data Completeness Requirements (p. 875)

CMS signaled in the 2023 MPFS final rule that they intend to raise the quality measure data completeness requirement to 75% for the 2024 and 2025 performance periods. This number defines the minimum subset of patients within a measure denominator that must be reported. **CMS also proposes increasing this threshold to 80% beginning with the 2026 performance year.**

Cost Performance Category (p. 875)

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

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

Improvement Activities Performance Category (p. 1106)

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

Table 1. Improvement Activities Proposed for Adoption.

Improvement Activity Title	Description	Category Weight
Improving practice capacity for Human	Establish policies and procedures to improve practice capacity to increase HIV prevention	Medium

Immunodeficiency Virus (HIV) prevention services	screening, improve HIV prevention education and awareness, and reduce disparities in pre-exposure prophylaxis (PrEP) uptake. Use one or more of the following activities: • Implement electronic health record (EHR) prompts or clinical decision support tools to increase appropriate HIV prevention screening; • Require that providers and designated clinical staff take part in at least one educational opportunity that includes components on the importance and application of HIV prevention screening and PrEP initiation in clinical practice; and/or • Assess and refine current policies for HIV prevention screening, including integrated sexually transmitted infection (STI)/HIV testing processes, universal HIV screening, and PrEP initiation.	
Practice-Wide Quality Improvement in MIPS Value Pathways	Create a quality improvement initiative within your practice and create a culture in which all staff actively participates. Clinicians must be participating in MIPS Value Pathways (MVPs) to attest to this activity. Create a quality improvement plan that involves a minimum of three of the measures within a specific MVP and that is characterized by the following: • Train all staff in quality improvement methods, particularly as related to other quality initiatives currently underway in the practice; • Promote transparency and accelerate improvement by sharing practice-level and panel-level quality of care and patient experience and utilization data with staff; • Integrate practice change/quality improvement into all staff duties, including communication and education regarding all current quality initiatives; • Designate regular team meetings to review data	

	In addition, clinicians may consider: • Creation of specific plans for recognition of individual or groups of clinicians and staff when they meet certain practice-defined quality goals. Examples include recognition for achieving success in measure reporting and/or a high level of effort directed to quality improvement and practice standardization; and • Participation in the American Board of Medical Specialties (ABMS) Multi-Specialty Portfolio Program.	

Use of Computable Guidelines and Clinical Decision Support to Improve Adherence for Cervical Cancer Screening and

Behavioral/Mental Health and Substance Use Screening & Referral for Pregnant and Postpartum Women	Screen for perinatal mood and anxiety disorders (PMADs) and substance use disorder (SUD) in pregnant and postpartum women, and screen and refer to treatment and/or refer to appropriate social services, and document this in-patient care plans.	High
Behavioral/Mental Health and Substance Use Screening & Referral for Older Adults	Complete age-appropriate screening for mental health and substance use in older adults, as well as screening and referral to treatment and/or referral to appropriate social services, and document this in-patient care plans.	High

Table 2. Improvement Activities Proposed for Removal.

Improvement Activity Title	
IA_BMH_6: Implementation of co-location PCP and MH services	We propose to remove this activity under removal factor two, there is an alternative activity with a stronger relationship to quality care or improvements in clinical practice, and factor three, activity does not align with current clinical guidelines or practice. We have received interested-party feedback expressing concern that this activity is out-of-date, and that IA_BMH_6 substantially overlaps with IA_BMH_7 (Implementation of Integrated Patient Centered Behavioral Health Model). IA_BMH_7 better aligns with evidence supporting improved patient outcomes. Furthermore, IA_BMH_6 focuses on co-location of mental health and substance use disorder services in primary and/or nonprimary clinical care settings, which has not been found to consistently improve patient outcomes. In the current rulemaking cycle, we are proposing two new activities in the Behavioral and Mental Health subcategory. We note that the removal of IA_BMH_6 is being proposed in order to ensure that the improvement activities Inventory best reflects current clinical practice, and in no way reflects a de-emphasis of the ongoing priority CMS is placing on behavioral and mental health

Administration (DEA) to be able to prescribe buprenorphine (medication-assisted treatment; MAT). Section 1262 of the Consolidated Appropriations Act of 2023 (also referred to as the “Omnibus Bill”) was passed in December 2022.

We note that the removal of IA_BMH_13 is being proposed in order to ensure that the improvement

either “yes” or “no.” Additionally, CMS proposes to modify the measure exclusion for “Query of Prescription Drug Monitoring Program” to accommodate clinicians who do not prescribe Schedule II opioids and Schedule III and IV drugs during the performance period.

APM Performance Pathway

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

Advanced Alternative Payment Models

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

Use of Certified Electronic Health Record Technology (CEHRT)

clinicians who are QPs. Eligible clinicians who are QPs for a year will continue to be excluded from MIPS reporting and payment adjustments for the year.

ACR staff continue to further analyze the proposed rule and will be submitting comments to CMS by the September 11th deadline.