

2024 Medicare Physician Fee Schedule Final Rule Summary

On Thursday, November 2, 2023, the Centers for Medicare & Medicaid Services (CMS) issued the 2024 Medicare Physician Fee Schedule (MPFS) [final rule](#). The final rule updates the payment policies, payment rates, and quality provisions for services furnished under the MPFS effective January 1, 2024.¹

Takeaways for Radiation Oncology

- **MPFS Final Rule Cuts Radiation Oncology by -2%**
- **2024 Conversion Factor: \$32.74 (a reduction of more than 3% from 2023)**
- **Medicare Parts A and B will pay for certain dental services in connection with the treatment of head and neck cancer**
- **New E/M code for visit complexity, G2211, will be implemented beginning January 1, 2024; radiation oncologists may report it**
- **New G-codes for reporting Community Health Integration, Social Determinants of Health (SDOH) Risk Assessment, and Principal Illness Navigation services were finalized**

Why it matters: The cut, in combination with year over year reductions, jeopardizes access to care for cancer patients. This underscores the need for ASTRO's proposed Radiation Oncology Case Rate (ROCR) Program, which would secure stable payment rates and protect access to care. ASTRO will continue its advocacy efforts to achieve more appropriate rate updates that recognize the important role that radiation oncology plays in cancer treatment. Radiation oncologists are encouraged to [contact Congress](#) to advance legislation to help mitigate these proposed cuts.

Go deeper on these issues in the summary below:

- **MPFS Impact**
- **Conversion Factor/Target**
- **Direct Supervision via Use of Two-way Audio/Video Communications Technology**
- **Payment for Dental Services Linked to Specific Covered Medical Services**
- **Request for Information (RFI): Drugs and Biologicals which are Not Usually Self Administered by the Patient, and Complex Drug Administration Coding**
- **Soliciting Public Comment on Strategies for Updates to Practice Expense Data Collection and Methodology**

¹ The MPFS pays for services furnished by physicians and other practitioners in all sites of service. These services include visits, surgical procedures, diagnostic tests, therapy services, specified preventative services and more. Payments are based on the relative resources typically used to furnish the service. Relative value units (RVUs) are applied to each service for physician work, practice expense and malpractice. These RVUs become payment rates through the application of a Conversion Factor, which is updated annually.

- **Evaluation and Management (E/M) Visit Complexity**
- **Services Addressing Health-Related Social Needs**
- **Payment for Medicare Telehealth Services**
- **Quality Payment Program**

MPFS Impact

The MPFS Impact Table shows the estimated impact on total allowed charges by specialty of all the RVU changes. CMS will reduce payments for radiation oncology services for 2024 by approximately 2%.

Table 118: CY 2024 PFS Estimated Impact on Total Allowed Charges by Specialty

| Specialty | Allowed Charges (mil) | Impact of Work RVU Changes | Impact of PE RVU Changes | Impact of MP RVU Changes | Combined Impact |
|---|-----------------------|----------------------------|--------------------------|--------------------------|-----------------|
| Radiation Oncology and Radiation Therapy Centers | \$1,556 | 0% | -2% | 0% | -2% |

Additionally, 2024 marks the third year of the four-year phase-in of the Clinical Labor Price update, which has the effect of lowering payments to specialties that use expensive equipment, such as radiation oncology, in the budget neutral environment for practice expense (PE).

Conversion Factor/Target

The 2024 MPFS Conversion Factor (CF), based on the proposed 2024 rates, is set at \$32.7442. This represents a decrease of \$1.14, or more than 3%, from the 2023 MPFS CF rate update of \$33.8872. This decline stems from a statutorily mandated budget neutrality adjustment (-2.18%) to account for changes in work RVUs and the increase provided by the Consolidated Appropriations Act of 2023 (1.25%).

The table below reflects the impact of the Conversion Factor reduction and Clinical Labor Price changes on key radiation oncology services.

| CPT Code | MOD/SOS | CPT Descriptor | 2023 National Rate | 2024 National Rate | 2024 Impact |
|--------------|---------|----------------------------|--------------------|--------------------|-------------|
| G6015 | | Radiation tx Delivery IMRT | \$364.97 | \$349.64 | -4% |
| 77427 | | Radiation tx Management x5 | \$192.82 | \$186.60 | -3% |

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|--------------|----|---------------------------------|----------------|----------------|------------|
| 77014 | | CT Scan for Therapy Guide | \$122.33 | \$117.53 | -4% |
| 77301 | | Radiotherapy Dose Plan IMRT | \$1,861.76 | \$1,812.35 | -3% |
| G6012 | | Radiation Treatment Delivery | \$238.23 | \$225.56 | -5% |
| 77523 | | Proton Treatment Delivery | Carrier Priced | Carrier Priced | N/A |
| 77014 | 26 | CT Scan for Therapy Guide | \$45.07 | \$43.54 | -3% |
| 77263 | | Radiation Therapy Planning | \$170.11 | \$164.01 | -4% |
| 77301 | 26 | Radiotherapy Dose Plan IMRT | \$423.25 | \$409.02 | -3% |
| 77373 | | SBRT Delivery | \$1,018.99 | \$977.21 | -4% |
| G6013 | | Radiation Treatment Delivery | \$238.90 | \$226.54 | -5% |
| 77334 | 26 | Radiation Treatment Aid(s) | \$60.66 | \$58.93 | -3% |
| 99205 | | Office o/p new hi 60-74 minutes | \$220.94 | \$216.72 | -2% |
| 77336 | | Radiation Physics Consult | \$87.43 | \$87.41 | 0% |
| 77338 | | Design Mlc Device for IMRT | \$469.68 | \$460.29 | -2% |
| 77338 | 26 | Design Mlc Device for IMRT | \$227.04 | \$219.67 | -3% |
| 77435 | | SBRT Management | \$646.91 | \$627.25 | -3% |
| 77300 | 26 | Radiation Therapy Dose Plan | \$33.21 | \$31.76 | -4% |
| 77300 | | Radiation Therapy Dose Plan | \$66.76 | \$64.82 | -3% |

Direct Supervision via Use of Two-way Audio/Video Communications Technology

CMS is finalizing its proposal to allow for the continued use of real-time audio and video interactive telecommunications to satisfy direct supervision requirements through December 31, 2024. The Agency believes this is appropriate given that many other telehealth flexibilities for the COVID-19 PHE are set to expire at the same time.

In the proposed rule, CMS also proposed extending this flexibility beyond 2024, but it did not finalize this. The Agency will consider the comments it received, including those about patient

safety concerns, and expects to address this in future rulemaking.

Go Deeper

Direct supervision requires the immediate availability of the supervising physician or other practitioner, but the professional need not be present in the same room during the service. The Agency has established this “immediate availability” requirement to mean in-person, physical, not virtual, availability. During the COVID-19 public health emergency (PHE), CMS changed the definition of “direct supervision” as it pertains to supervision of diagnostic tests, physicians’ services, and some hospital outpatient services, to allow the supervising professional to be immediately available through virtual presence using two-way, real-time audio/video technology, instead of requiring their physical presence. Via various rules, this policy was extended through the end of 2023, after which the pre-PHE supervision rules would apply.

Payment for Dental Services Linked to Specific Covered Medical Services

CMS finalized its proposal that Medicare Part A and Part B payment can be made for certain dental services when furnished prior to or contemporaneously with the treatment of head and neck cancer, including when the treatment modality is radiation therapy. For other types of cancer, CMS did not think there was enough evidence to prove that dental procedures are closely connected to the success of radiation therapy. However, CMS noted that in instances where patients are scheduled for a stem cell or bone marrow transplant and are receiving total body irradiation (TBI) prior to the transplant, Medicare Parts A and B payment may be made for dental services.

The Agency continues to seek medical evidence that certain dental services are “so integral to medically necessary services that they are not in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth...and that such dental services are inextricably linked to other covered services.”

Go Deeper

In the 2023 MPFS final rule, CMS identified certain clinical scenarios where payment is permitted under both Medicare Parts A and B for certain dental services in circumstances where the services are not considered to be in connection with dental services within the meaning of section 1862(a)(12) of the Act. Dental services for which payment can be made under Parts A and B must be “inextricably linked to” and substantially related to the clinical success of a covered service.

For 2024, CMS proposed to codify the previously finalized payment policy for dental services prior to, or during, head and neck cancer treatments. Additionally, CMS identified several clinical scenarios where dental services are inextricably linked to a primary medical service that is covered by Medicare. After further review of current medical practice, and through internal and external consultations and consideration of the submissions received through the public process, it believes that there are additional circumstances under which Medicare payment may be made for dental services because they are inextricably linked to other covered medical services.

Additionally, the Agency also sought comment on whether it should consider radiation therapy in the treatment of cancer more broadly (not in conjunction with chemotherapy, and not in relation to head and neck cancer treatment) as medical services that may be inextricably linked to dental services.

Request for Information (RFI): Drugs and Biologicals which are Not Usually Self-Administered by the Patient, and Complex Drug Administration Coding

CMS sought feedback related to Part B drug payments for drugs or biologicals that are not usually self-administered by the patient because there have been recent changes in the field. The Agency requested information regarding the resources involved, as well as inputs, and payment considerations that should be used for determining appropriate payment, while also ensuring patients' access to infusion services. CMS also asked for opinions on whether it should update its policy guidelines to better match how these infusion services are provided and billed.

The Agency received many comments in response to the RFI and acknowledged that the clinical work and expense for some complex drug infusion services are not adequate. CMS stated that it is interested in working with interested parties towards developing policies that accurately account for costs involved and that it will consider those requirements in future rulemaking.

Go Deeper

Under the Hospital Outpatient Prospective Payment System (HOPPS), radiopharmaceuticals are considered a “drug” and are paid at Average Sales Price (ASP) + 6%. The additional 6% is meant to reimburse for the complexity of the drugs, many of which are used to treat various types of cancer. However, under the MPFS, radiopharmaceuticals are not considered a “drug,” and are therefore considered a carrier-priced procedure by the Medicare Administrative Contractors (MACs). As a result, freestanding centers are paid significantly less than a HOPD facility and often cannot justify offering radiopharmaceutical therapies because of the low reimbursement, which frequently does not cover the cost of acquisition. ASTRO believes this discrepancy is limiting access to care for patients with cancer in many communities. Radiopharmaceuticals are no less complex to administer in the freestanding setting than the HOPD setting, and they should be reimbursed in comparable ways.

Soliciting Public Comment on Strategies for Updates to Practice Expense Data Collection and Methodology

The Agency received several responses to its request for information (RFI) on strategies for updates to practice expense (PE) data collection and methodology. Many commenters suggested that CMS should wait for the results from the AMA Physician Practice Information Survey (PPIS) before making any big changes. However, CMS believes it is important to consider the challenges with the current methodology and to continue to look at alternatives that improve the stability and accuracy of the overall PE methodology. Nothing was finalized in the rule and the Agency stated that it, “remain[s] committed to fostering dialogue with interested parties on a variety of PE issues, including how to most appropriately incorporate new and evolving technologies in both collection of PE data and the PE methodology itself.”

Go Deeper

In the CY 2023 MPFS final rule, CMS issued an RFI on strategies to update practice expense (PE) data collection and methodology. The Agency currently relies on the AMA's PPIS, which it notes "may represent the best aggregated available source of information at this time." CMS asked again in the CY 2024 proposed rule for interested parties to provide feedback on how to achieve optimal PE data collection and methodological adjustments over time.

The new AMA PPIS is [currently underway](#), and the input from physician practices and individual physicians that are randomly selected to participate is critical for its success. Participation will ensure that practice expenses and patient care hours are accurately reflected.

Evaluation and Management (E/M) Visit Complexity

CMS is finalizing implementation of a separate add-on payment for HCPCS code G2211 beginning January 1, 2024. The full descriptor for this code is:

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)

The Agency states that, in consideration of the many comments received (including ASTRO's), it needed to clarify when this code can be used. It provided that G2211 is used to describe and account for the complexity of certain medical visits, such as those related to ongoing care for serious or complex conditions. It is not about the patient's characteristics but rather the relationship between the patient and the doctor.

For instance, G2211 applies when a patient has a primary care doctor who is responsible for all of the patient's health care needs. Even for seemingly simple issues like sinus congestion, the doctor has to consider how his or her decisions during the visit can impact the patient's trust and the long-term doctor-patient relationship. This adds complexity to the visit, and the code captures this relationship complexity.

G2211 also applies when patients have a single, serious, or complex medical condition, like HIV, and they see a specialist regularly. In this case, the code is used when the doctor has to balance providing medical advice with maintaining the patient's trust over time. This complexity arises from the ongoing relationship between the patient and the doctor. Under this component of the code, it appears that radiation oncologists can bill G2211, as there is tremendous complexity and management associated with the ongoing relationship with a patient with cancer. Additionally, CMS states in the final rule:

We also note unequivocally that [G2211] is not restricted to medical professionals based on particular specialties. Instead, it should be used by medical professionals, regardless of specialty, with O/O E/M visits (other than those

reported with the -25 modifier) for care that serves 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.

CMS clarified that modifier -25 should only be used when the same doctor or practitioner who bills the office/outpatient (O/O) E/M visit also bills a separate, significant procedure or service on the same day (some commenters suggested it could be used when a patient saw a different doctor or practitioner on the same day).

Go Deeper

The Agency believes this add-on code will better recognize the resource costs associated with E/M visits for primary care and longitudinal care of complex patients. This policy was originally finalized in the 2021 MPFS final rule, but Congress suspended the use of the code by prohibiting CMS from making additional payment under the MPFS for complex E/M visits before January 1, 2024.

Services Addressing Health-Related Social Needs

CMS is finalizing its proposal to pay separately for Community Health Integration, Social Determinants of Health (SDOH) Risk Assessment, and Principal Illness Navigation services to account for resources associated with health care support staff such as community health workers, care navigators, and peer support specialists in furnishing medically necessary care. It is finalizing the following new codes to recognize these services.

Table 14: CY 2024 Work RVUs for New, Revised, and Potentially Misvalued Codes

| HCPCS Code | Descriptor | Current Work RVU | RUC Work RVU | CMS Work RVU | CMS Time Refinement |
|-------------------|--|-------------------------|---------------------|---------------------|----------------------------|
| G0019 | Community health integration (CHI) services by certified or trained auxiliary personnel under the direction of the physician/other Qualified Healthcare Professional (QHP), including a community health worker located in the patient's community; 60 minutes per calendar month, in the following activities: <ul style="list-style-type: none"> Holistic personal assessment, performed in order to better understand the individualized context of the intersection between the identified social determinants of health (SDOH(s)) and problem(s) addressed in the CHI initiating visit (required only during the first month | NEW | 1.00 | 1.00 | No |

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| | <p>CHI services are provided). o</p> <ul style="list-style-type: none"> o Conducting a holistic personal assessment to understand patient’s life story, needs, goals and preferences, including understanding cultural and linguistic factors. o Setting personalized goals and creating action plans o Providing tailored support as needed to accomplish the billing practitioner’s treatment plan. o Periodic administration of SDOH survey tools and monitoring of related SDOH, that is not separately billed. As new SDOH that may affect the diagnosis and treatment of problem(s) in the initiating visit are identified, these SDOH may be focused on for CHI services. <ul style="list-style-type: none"> • Practitioner, Home, and Community-Based Care Coordination • Coordination with practitioner, home, and community based services. <ul style="list-style-type: none"> o Communication to and from practitioners, home and community-based services, and hospital, and skilled nursing facilities (or other health care facilities) regarding the patient’s psychosocial needs, functional deficits, goals, and preferences, including cultural and linguistic factors. o Coordination of care transitions between and among health care practitioners and settings, including referrals to other | | | | |
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| | <p>clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities.</p> <ul style="list-style-type: none"> ○ Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) to address SDOH that the billing practitioner identifies as significantly limiting their ability to diagnose or treat the problem(s) identified in the CHI initiating visit ● Health education- Helping patients contextualize health education provided by the patient’s treatment team with their individual needs, goals, and preferences, and SDOH that affect problem(s) identified during the initiating visit, 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 SDOH, in ways that are more likely to promote personalized and effective treatment of their problem(s) identified during the initiating visit. ● Health care access / health system navigation Helping the patient arrange access to medical care, including securing medical or community-based appointments, identifying appropriate providers for care needs, identifying appropriate community-based resources for SDOH related to problem(s) | | | | |
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| | <p>identified during the initiating visit, and for accessing all clinical care services necessary</p> <ul style="list-style-type: none"> • Facilitating behavioral change necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach treatment goals for the problem(s) addressed in the CHI initiating visit. • Facilitating and providing social and emotional support for the patient related to coping with the problem(s) addressing during the CHI initiating visit, related SDOH, and adjusting daily routines to better meet diagnosis and treatment goals for those problem(s). | | | | |
| G0022 | Community health integration services, each additional 30 minutes per calendar month | NEW | 0.70 | 0.70 | No |
| G0023 | <p>Principal Illness Navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator; 60 minutes per calendar month, in the following activities:</p> <ul style="list-style-type: none"> • Person-centered assessment, performed to better understand the individual context of the serious, high-risk condition. <ul style="list-style-type: none"> ○ 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. ○ 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 | NEW | 1.00 | 1.00 | No |

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| | <p>appropriate supportive services.</p> <ul style="list-style-type: none"> • Practitioner, Home, and Community-Based Care Coordination <ul style="list-style-type: none"> ○ Coordinating receipt of needed services from healthcare practitioners, providers, and facilities; home and community-based 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) 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, | | | | |
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| | <p>and SDOH need(s), and educating the patient (and caregiver if applicable) on how to best participate in medical decision-making.</p> <ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> ○ 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. <ul style="list-style-type: none"> ○ Periodic administration of SDOH survey tools and monitoring of related SDOH, that is not separately billed. PIN services may address newly discovered SDOH if the practitioner determines they are significantly impacting the practitioner’s ability to diagnose or treat the high-risk condition(s). • Facilitating and providing social and emotional support to help the patient cope with the condition, SDOH | | | | |
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| | <p>need(s), and adjust daily routines to better meet diagnosis and treatment goals.</p> <ul style="list-style-type: none"> • 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 | NEW | 0.70 | 0.70 | No |
| G0140 | <p>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:</p> <ul style="list-style-type: none"> • Person-centered assessment, performed to better understand the individual context of the serious, high-risk condition. <ul style="list-style-type: none"> ○ 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. ○ 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 <ul style="list-style-type: none"> ○ Assist the patient in communicating with their practitioners, home-, and community-based service providers, hospitals, and skilled nursing facilities (or | | | | |

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| | <p>other health care facilities) regarding the patient's psychosocial strengths and needs, goals, preferences, and desired outcomes, including cultural and linguistic factors.</p> <ul style="list-style-type: none"> ○ 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. <ul style="list-style-type: none"> ○ Periodic administration of SDOH survey tools and monitoring of related SDOH, that is not separately billed. PIN services may address newly discovered SDOH if the practitioner determines they are significantly impacting the practitioner's ability to diagnose or treat the high-risk condition(s). | | | | |
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| | <ul style="list-style-type: none"> 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 | NEW | 0.70 | 0.70 | No |

Payment for Medicare Telehealth Services

CMS is finalizing implementation of several telehealth-related provisions of the CAA of 2023, including the temporary expansion of the scope of originating sites for services furnished via telehealth to include any site in the United States where the beneficiary is located at the time of the service, including the beneficiary’s home. The Agency is also finalizing its proposal to continue active payment status for CPT codes 98966-98968, which describe E/M and assessment and management services furnished via telephone. These services will be available through the end of CY 2024.

Go Deeper

The CAA of 2022 included several provisions that extended certain Medicare telehealth flexibilities adopted during the COVID-19 PHE for 151 days after the end of the PHE. In part, it temporarily removed restrictions on telehealth originating sites for those services to allow telehealth services to patients located in any site in the United States at the time of the telehealth service, including an individual's home.

In the March 31, 2020, COVID-19 interim final rule, CMS finalized separate payment for CPT codes 99441-99443, which are telehealth services that will remain actively priced through 2024; however, CPT codes 98966-98968 describe telephone assessment and management services provided by a qualified non-physician healthcare professional, which are not considered telehealth services. Active payment status is assigned to CPT codes 98966-98968 for CY 2024 to align with telehealth-related flexibilities that were extended via the CCA, specifically section 4113(e), which permits the provision of telehealth services through audio-only telecommunications through the end of 2024.

Quality Payment Program

Additional information regarding changes to the Quality Payment Program will be included in a subsequent summary document.

Additional information about the 2024 MPFS final rule can be found at the following links:

A display copy of the final rule can be found at: <https://public-inspection.federalregister.gov/2023-24184.pdf>

The addenda relating to the MPFS final rule are available at:
<https://www.cms.gov/medicare/medicare-fee-service-payment/physicianfeesched/pfs-federal-regulation-notices/cms-1784-f>

A fact sheet on this final rule is available at: <https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule>