

<b>CMS Manual System</b>	<b>Department of Health &amp; Human Services (DHHS)</b>
<b>Pub 100-04 Medicare Claims Processing</b>	<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>
<b>Transmittal 12372</b>	<b>Date: November 22, 2023</b>
	<b>Change Request 13452</b>

**SUBJECT: Summary of Policies in the Calendar Year (CY) 2024 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List**

**I. SUMMARY OF CHANGES:** The purpose of this Change Request (CR) is to provide a summary of the policies in the CY 2024 MPFS Final Rule and to announce the Telehealth Originating Site Facility Fee payment amount. The attached recurring update notification applies to publication 100-04, chapter 12, section 190.5, chapter 13, section 20.2.4, and chapter 18, section 240.

**EFFECTIVE DATE: January 1, 2024**

*\*Unless otherwise specified, the effective date is the date of service.*

**IMPLEMENTATION DATE: January 2, 2024**

*Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revise information only, and not the entire table of contents.*

**II. CHANGES IN MANUAL INSTRUCTIONS:** (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

<b>R/N/D</b>	<b>CHAPTER / SECTION / SUBSECTION / TITLE</b>
N/A	N/A

**III. FUNDING:**

**For Medicare Administrative Contractors (MACs):**

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**IV. ATTACHMENTS:**

**Recurring Update Notification**

# Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 12372	Date: November 22, 2023	Change Request: 13452
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## I. GENERAL INFORMATION

**A. Background:** The CR provides a summary of the policies in the CY 2024 MPFS. Section 1848(b)(1) of the Social Security Act (the Act) requires the Secretary to establish by regulation a fee schedule of payment amounts for physicians' services for the subsequent year. The CMS issued a final rule that updates payment policies and Medicare payment rates for services furnished by physicians and Nonphysician Practitioners (NPPs) that are paid under the MPFS in CY 2024. The final rule also addresses public comments on Medicare payment policies proposed earlier this year.

**B. Policy:** CMS issued regulation number CMS-1784-F Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program. This CR provides a summary of the payment policies under the MPFS and makes other policy changes related to Medicare Part B payment. These changes are applicable to services furnished in CY 2024.

### Medicare Telehealth Services

For CY 2024, CMS is adding new codes to the list of Medicare telehealth services, including Current Procedural Terminology (CPT) codes 0591T - 0593T for health and well-being coaching services, which we are adding on a temporary basis, as well as new Healthcare Common Procedure Coding System (HCPCS) code G0136 for Social Determinants of Health Risk Assessment, which we are adding on a permanent basis. We are implementing several telehealth-related provisions of the Consolidated Appropriations Act (CAA), 2023, including the temporary expansion of the scope of telehealth 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 telehealth service, including an individual's home; the expansion of the definition of telehealth practitioners to include qualified occupational therapists, qualified physical therapists, qualified speech-language pathologists, and qualified audiologists; the continued payment for telehealth services furnished by Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) using the methodology established for those telehealth services during the PHE; delaying the requirement for an in-person visit with the physician or practitioner within six (6) months prior to initiating mental health telehealth services, and again at subsequent intervals as the Secretary determines appropriate, as well as similar requirements for RHCs and FQHCs; and the continued coverage and payment of telehealth services included on the Medicare Telehealth Services List (as of March 15, 2020) until December 31, 2024.

We added Mental Health Counselors (MHCs) and Marriage and Family Therapists (MFTs) as distant site practitioners for purposes of furnishing telehealth services.

We are implementing that, beginning in CY 2024, telehealth services furnished to people in their homes will be paid at the non-facility PFS rate. We clarified that modifier '95' should be used when the clinician is in the hospital and the patient is in the home, as well as for outpatient therapy services furnished via telehealth

by PT, OT, or SLPs.

We removed frequency limitations for Subsequent Inpatient Visits, Subsequent Nursing Facility Visits, and Critical Care Consultation for 2024.

We finalized to allow teaching physicians to use audio/video real-time communications technology when the resident furnishes Medicare telehealth services in all residency training locations through the end of CY 2024.

The list of codes that are added to the telehealth services list can be found at:

<https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>

### **Telehealth origination site facility fee payment amount update**

Section 1834(m)(2)(B) of the Act establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31, 2002, at \$20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased by the percentage increase in the Medicare Economic Index (MEI) as defined in section 1842(i)(3) of the Act. The MEI increase for 2024 is 4.6 percent. Therefore, for CY 2024, the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge, or \$29.96 (The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance).

For more information regarding telehealth services, please contact Patrick Sartini at- (410)786-9252 or email us at [medicarephysicianfeeschedule@cms.hhs.gov](mailto:medicarephysicianfeeschedule@cms.hhs.gov) and include telehealth services in the email subject line.

### **Payment for Outpatient Therapy (including PT, OT, SLP), Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT) Services when Furnished by Institutional Staff to Beneficiaries in Their Homes Through Communication Technology**

As discussed in Frequently Asked Questions on CMS waivers, flexibilities, and the end of the COVID-19 Public Health Emergency (PHE), institutional providers are able to continue to bill for Physical Therapy (PT), Occupational Therapy (OT), Speech-Language Pathology (SLP), DSMT and MNT services furnished remotely the same way that they could during the PHE and through the end of CY 2023. We are finalizing the proposed policy for CY 2024, with modifications, as follows:

- Hospitals and other providers of physical therapy, occupational therapy, speech-language pathology, diabetes self-management training and medical nutrition therapy services that remain on the Medicare Telehealth Services List, can continue to bill for these services when furnished remotely in the same way they have been during the PHE and the remainder of CY 2023, except that: (a) for outpatient hospitals, beneficiaries' homes no longer need to be registered as provider-based entities to allow for hospitals to bill for these services; and, (b) the 95 modifier is required on claims from all providers, except for Critical Access Hospitals (CAHs) electing Method II, as soon as hospitals needing to do so can update their systems.

In the proposed rule, we sought comment on the effectiveness of these services when furnished remotely, compared to in person, and may consider this feedback for future rulemaking.

For more information on Payment for PT, OT, SLP, DSMT and MNT Services when Furnished by Institutional Staff to Beneficiaries Through Communication Technology, please contact Pamela West at- (410)-786-2302.

## **Telehealth Finalized Policies for DSMT Services**

A: Distant Site Practitioners — To increase access to DSMT telehealth services, we are finalizing the codification of billing rules for telehealth DSMT services at § 410.78(b)(2)(x) to allow distant site practitioners who can appropriately bill for DSMT services, such as RDs and nutrition professionals, physicians, Nurse Practitioners (NPs), Physician Assistants (PAs), and Clinical Nurse Specialists (CNSs), to do so on behalf of others who personally provide the services as part of the DSMT entity.

B: Injection Training for Insulin-Dependent Beneficiaries — During the PHE for COVID-19, we permitted insulin injection training to be furnished via telehealth for patients receiving DSMT services. We are finalizing a policy to allow DSMT insulin injection training (for initial and/or follow-up training) to be provided via telehealth when it aligns with clinical standards, guidelines, or best practices, instead of the previous subregulatory policy that required certain hours of training to be provided in-person (Pub. 100-04, Medicare Claims Processing Manual, Chapter 12, section 190.3.6).

The above policies are expected to promote access to historically underutilized DSMT services that have been shown to improve care for individuals with diabetes.

For more information on DSMT Services Furnished by RD and Nutrition Professionals and Telehealth Finalized Policies for DSMT Services, please contact Pamela West at- (410)-786-2302.

## **Evaluation and Management (E/M) Visits**

### **Complexity Add-on HCPCS Code G2211**

For CY 2024, with the end of the Congressionally mandated suspension of payment for O/O E/M visit complexity add-on code G2211, CMS is finalizing changing the status of code G2211 to make it separately payable by assigning it an "active" status indicator, effective January 1, 2024. HCPCS code G2211 includes services that enable practitioners to build longitudinal relationships with all patients (that is, not only those patients who have a chronic condition or single, high-risk disease) and to address the majority of patients' health care needs with consistency and continuity over longer periods of time. This includes furnishing services to patients on an ongoing basis that result in care that is personalized to the patient. The services result in a comprehensive, longitudinal, and continuous relationship with the patient and involve delivery of team-based care that is accessible, coordinated with other practitioners and providers, and integrated with the broader health care landscape. The "continuing focal point for all needed health care services" describes a relationship between the patient and the practitioner when the practitioner is the continuing focal point for all health care services that the patient needs.

This code is not restricted to medical professionals based on specialties. Instead, it should be used by medical professionals, regardless of specialty, with O/O E/M visits of any level (other than those reported with the -25 modifier, see below) 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.

Example 1: A patient has a primary care practitioner that is the continuing focal point for all health care services, and the patient sees this practitioner to be evaluated for sinus congestion. The inherent complexity that this code (G2211) captures is not in the clinical condition itself— sinus congestion —but rather the cognitive load of the continued responsibility of being the focal point for all needed services for this patient. There is previously unrecognized but important cognitive effort of utilizing the longitudinal relationship itself in the diagnosis and treatment plan and weighing the factors that affect a longitudinal doctor patient relationship. In this example, the primary care practitioner could recommend conservative treatment or prescription of antibiotics. If the practitioner recommends conservative treatment and no new prescriptions, some patients may think that the doctor is not taking the patient's concerns seriously and it could erode the trust placed in that practitioner. In turn, an eroded primary care practitioner/ patient relationship may make it less likely that the patient would follow that practitioner's advice on a needed vaccination at the next visit.

The primary care practitioner must decide—what course of action and choice of words in the visit itself, would lead to the best health outcome in this single visit, while simultaneously building up an effective, trusting longitudinal relationship with this patient for all their primary health care needs. Weighing these various factors, even for a seemingly simple condition like sinus congestion, makes the entire interaction inherently complex, and it is this complexity in the relationship between the doctor and patient that this code captures.

Example 2: a patient with HIV has an office visit with their infectious disease physician, who is part of ongoing care. The patient with HIV admits to the infectious disease physician that there have been several missed doses of HIV medication in the last month. The infectious disease physician has to weigh their response during the visit—the intonation in their voice, the choice of words—to not only communicate clearly that it is important to not miss doses of HIV medication, but also to create a sense of safety for the patient in sharing information like this in the future. If the interaction goes poorly, it could erode the sense of trust built up over time, and the patient may be less likely to share their medication adherence shortcomings in the future. If the patient isn't forthright about their medication adherence, it may lead to the infectious disease physician switching HIV medicines to another with greater side effects, even when there was no issue with the original medication. It is because the infectious disease physician is part of ongoing care, and has to weigh these types of factors, that the E/M visit becomes inherently more complex, and the practitioner bills this code (G2211). Even though the infectious disease doctor may not be the focal point for all services, such as in the previous example, HIV is a single, serious condition, and/or a complex condition, and so as long as the relationship between the infectious disease physician and patient is ongoing, this E/M visit could be billed with the add-on.

To reiterate, the most important information used to determine whether the add-on code could be billed is the relationship between the practitioner and the patient. If the practitioner is the focal point for all needed services, such as a primary care practitioner, the HCPCS G2211 add-on code could be billed. Or, if the practitioner is part of ongoing care for a single, serious and complex condition, e.g., sickle cell disease, then the add-on code could be billed. The add-on code captures the inherent complexity of the visit that is derived from the longitudinal nature of the practitioner and patient relationship.

CMS is also finalizing that the O/O E/M visit complexity add-on code G2211 would not be payable when the O/O E/M visit is reported with payment Modifier 25, given that separately identifiable visits occurring on the same day as minor procedures (such as zero-day global procedures) have resources that are sufficiently distinct from the costs associated with furnishing stand-alone office/outpatient E/M visits to warrant different payment.

For more information regarding G2211, please contact Erick Carrera at- (410)786-8949 or email us at [medicarephysicianfeeschedule@cms.hhs.gov](mailto:medicarephysicianfeeschedule@cms.hhs.gov) and include complexity Add-on services in the email subject line.

### **Split (or Shared) Visits**

Split (or shared) E/M visits refer to visits provided in part by physicians and in part by other nonphysician practitioners in hospitals and other institutional settings. For CY 2024, we are finalizing a revision to our definition of “substantive portion” of a split (or shared) visit to include the revisions to the CPT guidelines, such that for Medicare billing purposes, the “substantive portion” means more than half of the total time spent by the physician and or nonphysician practitioner performing the split (or shared) visit, or a substantive part of the medical decision making.

For more information regarding split (or shared) visits, please contact Sarah Leipnik at- (410)786-3933 or email us at [medicarephysicianfeeschedule@cms.hhs.gov](mailto:medicarephysicianfeeschedule@cms.hhs.gov) and include split/shared services in the email subject line.

### **Behavioral health Services**

For CY 2024, we are implementing Section 4121 of the CAA, 2023, which provides for Medicare Part B coverage and payment under the Medicare Physician Fee Schedule for the services of Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs) when billed by these professionals. Additionally, we are finalizing to allow addiction counselors that meet all of the applicable requirements to be a MHC to enroll in Medicare as MHCs. We are finalizing to allow MFTs and MHCs to enroll in Medicare after the CY 2024 Physician Fee Schedule final rule is published, and they would be able to bill Medicare for services starting January 1, 2024, consistent with statute. We are also making corresponding changes to Behavioral Health Integration codes to allow MFTs and MHCs to provide integrated behavioral health care as part of primary care settings.

CMS is also implementing Section 4123 of the CAA, 2023 which requires the Secretary to establish new HCPCS codes under the PFS for psychotherapy for crisis services that are furnished in an applicable site of service (any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting, including the home or a mobile unit) furnished on or after January 1, 2024. Section 4123 of the CAA, 2023 specifies that the payment amount for these psychotherapy for crisis services shall be equal to 150 percent of the fee schedule amount for non-facility sites of service for each year for the services identified (as of January 1, 2022) by HCPCS codes 90839 (Psychotherapy for crisis; first 60 minutes) and 90840 (Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)), and any succeeding codes.

Additionally, CMS is finalizing to allow the Health Behavior Assessment and Intervention (HBAI) services described by CPT codes 96156, 96158, 96159, 96164, 96165, 96167, and 96168, and any successor codes, to be billed by clinical social workers, MFTs, and MHCs, in addition to clinical psychologists. Health Behavior Assessment and Intervention codes are used to identify the psychological, behavioral, emotional, cognitive, and social factors included in the treatment of physical health problems. Finalizing our proposal to allow a wider range of practitioner types to furnish these services would allow for better integration of physical and behavioral health care, particularly given that there are so many behavioral health ramifications of physical health illness.

We are also finalizing an increase in the valuation for timed behavioral health services under the PFS. Specifically, we are finalizing to apply an adjustment to the work Relative Value Units (RVUs) for psychotherapy codes payable under the PFS, which we are finalizing to implement over a four (4)-year transition. This adjustment will begin to address potential distortions that may have occurred in valuing time-based behavioral health services in the past.

Additionally, we are finalizing an increase to the payment rate for office-based treatment for substance use disorders (HCPCS codes G2086 and G2087) to reflect two individual psychotherapy sessions per month, based on a crosswalk to the work RVUs assigned to CPT code 90834 (*Psychotherapy, 45 minutes with patient*), rather than CPT code 90832 (*Psychotherapy, 30 minutes with patient*).

For more information regarding Behavioral Health Services, please contact Lindsey Baldwin at- (410)-786-1694 or email us at [medicarephysicianfeeschedule@cms.hhs.gov](mailto:medicarephysicianfeeschedule@cms.hhs.gov) and include behavioral health services in the email subject line.

### **Dental and Oral Health Services**

In general, the statute precludes payment under Medicare Parts A or B for any expenses incurred for coverage, items, and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth. However, Medicare Parts A and B makes payment 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 or our regulation at § 411.15(i). Dental services that are so integral to other medically necessary services that they are inextricably linked to the clinical success of that medical service(s) are not in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth within the meaning of section 1862(a)(12) of the Act. Rather, these dental services are inextricably linked to the clinical success of an otherwise covered medical service,

and are payable under Medicare Parts A and B.

For CY 2024, we are finalizing:

- To permit payment for certain dental services inextricably linked to other covered services used to treat cancer, prior to, or contemporaneously with —
  - Chemotherapy services;
  - Chimeric Antigen Receptor T- (CAR-T) Cell therapy; and,
  - The use of high-dose bone modifying agents (antiresorptive therapy).
- Codification of and amendments to the previously finalized payment policy for dental services prior to, contemporaneously with, and/or after treatment of head and neck cancer using radiation, chemotherapy, surgery, or any combination of these, whether primary or metastatic.

For more information regarding Dental and Oral Health Services, please contact Laura Ashbaugh at- (410)-786-1113 or email us at [medicarephysicianfeeschedule@cms.hhs.gov](mailto:medicarephysicianfeeschedule@cms.hhs.gov) and include dental and oral health services in the email subject line.

## **Therapy Services**

### **Supervision Policy for Physical and Occupational Therapists in Private Practice**

Since 2005, we have required PTs Private Practices and OTs Private Practices (PTPPs and OTPPs, respectively) to provide direct supervision of their therapy assistants. We are finalizing a regulatory change to allow for general supervision of therapy assistants by PTPPs and OTPPs for Remote Therapeutic Monitoring (RTM) services, effective beginning on or after January 1, 2024. This will align with the RTM general supervision policy that we finalized in our CY 2023 rulemaking.

In the proposed rule, we solicited comments on whether to revise the current direct supervision policy for therapy assistants working with PTPPs and OTPPs to require general supervision for all therapy services, not just for RTM services. In particular, we sought feedback and any available supporting data on the potential effects of implementing such a policy, including but not limited to patient quality of care, patient safety, and changes in utilization. We received feedback in response to our questions and will take the feedback into consideration for future rulemaking.

Additionally, we are announcing that the KX-modifier threshold amounts for CY 2024 are \$2,330 for occupational therapy services and \$2,330 for physical therapy and speech-language pathology services combined.

For more information regarding Supervision Policy for PTs and OTs in Private Practice or the KX-modifier Threshold Amounts, please contact Pamela West at- (410)-786-2302 or email us at [medicarephysicianfeeschedule@cms.hhs.gov](mailto:medicarephysicianfeeschedule@cms.hhs.gov) and include therapy services in the email subject line.

### **Diabetes Self-Management Training (DSMT) Services Furnished by Registered Dietitians (RDs) and Nutrition Professionals**

We are finalizing an amendment to the regulatory provision at § 410.72(d) established during CY 2022 PFS rulemaking that clarifies that an RD or nutrition professional must personally perform MNT services, but that the enrolled RD or nutrition professional may bill for, or on behalf of, the entire DSMT entity as the DSMT certified provider, regardless of which professional personally delivers the service. This finalized policy builds on recent policy changes designed to improve access to DSMT services.

For more information regarding DSMT services, please contact Pamela West at- (410)-786-2302 or email us at [medicarephysicianfeeschedule@cms.hhs.gov](mailto:medicarephysicianfeeschedule@cms.hhs.gov) and include DSMT services in the email subject line.

## Community Health Integration (CHI) services

We are finalizing separate coding and payment for CHI services, which include person-centered planning, health system coordination, promoting patient self-advocacy, and facilitating access to community-based resources to address unmet social needs that interfere with the practitioner's diagnosis and treatment of the patient. These are the first Physician Fee Schedule services designed to specifically include care involving community health workers, who link underserved communities with critical health care and social services in the community and expand equitable access to care, improving outcomes for the Medicare population.

For more information regarding CHI services, please contact Sarah Leipnik at- (410)-786-3933 or email us at [medicarephysicianfeeschedule@cms.hhs.gov](mailto:medicarephysicianfeeschedule@cms.hhs.gov) and include CHI services in the email subject line.

## Principal Illness Navigation (PIN) services and Social Determinants of Health (SDOH)

For CY 2024, we are finalizing new coding and payment for PIN services (HCPCS codes G0023, G0024, G0140, and G0146), which use auxiliary personnel such as patient navigators and peer support specialists to provide navigation in the treatment of a serious, high-risk condition or illness. These services include items such as person-centered planning, promoting patient self-advocacy, and facilitating access to community-based resources to address unmet social needs and other factors that are relevant to the practitioner's diagnosis and treatment of the patient. We are also finalizing new coding and payment for the administration of SDOH risk assessments (G0136), which must be furnished in conjunction with a qualifying visit, including an E/M visit, some behavioral health visits, or the Annual Wellness Visit. The evidence-based, standardized SDOH risk assessment tool used must cover domains such as housing insecurity, food insecurity, transportation needs, and utility difficulty, but practitioners may choose to add other domains if prevalent or culturally salient to their patient population.

For more information regarding PIN and SDOH, please email us at [medicarephysicianfeeschedule@cms.hhs.gov](mailto:medicarephysicianfeeschedule@cms.hhs.gov) and include PIN and SDOH services in the email subject line.

## Caregiver Training

For CY 2024, we are finalizing new coding (CPT codes 96202, 96203, 97550, 97551, and 97552) to make payment when practitioners train and involve one or more caregivers to assist patients with certain diseases or illnesses (e.g., dementia) in carrying out a treatment plan. We are finalizing our proposal to pay for these services when furnished by a physician or a non-physician practitioner (nurse practitioners, clinical nurse specialists, certified nurse-midwives, physician assistants, and clinical psychologists), or therapist (physical therapist, occupational therapist, or speech language pathologist) under an individualized treatment plan or therapy plan of care, without the patient present. This action is consistent with the recent Biden-Harris Administration Executive Order on Increasing Access to High Quality Care and Supporting Caregivers would help support care for persons with Medicare, by better training caregivers.

For more information regarding caregiver training, please contact Mikayla Murphey at- (667)-414-0093 or email us at [medicarephysicianfeeschedule@cms.hhs.gov](mailto:medicarephysicianfeeschedule@cms.hhs.gov) and include caregiver training services in the email subject line.

## II. BUSINESS REQUIREMENTS TABLE

*"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.*

Number	Requirement	Responsibility			
		A/B MAC	DM E	Shared-System Maintainers	Other



		A	B	HH H	MA C	FIS S	MC S	VM S	CW F	
13452.1	Contractors shall be aware of the policies published in the Medicare Physician Fee Schedule Final Rule (Regulation number CMS-1784-F Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program, which are summarized with this change request and apply those policies as appropriate.	X	X	X						
13452.2	Contractors shall continue to pay for the Medicare telehealth originating site facility fee as 80 percent of, the lesser of the actual charge or \$29.96, as described by HCPCS code Q3014 "Telehealth facility fee," effective for dates of service on and after January 1, 2024.	X	X	X						
13452.3	Contractors shall use the list of telehealth services found on the CMS website at <a href="http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes">http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes</a> .	X	X							
13452.4	Contractors shall use the list of codes that are subject to the CT modifier reduction found on the CMS website at <a href="https://www.cms.gov/medicare/payment/fee-schedules/physician/ct-modifier-reduction-list">https://www.cms.gov/medicare/payment/fee-schedules/physician/ct-modifier-reduction-list</a> .		X							
13452.5	Contractors shall use the prolonged preventive services G0513 and G0514 as an add-on to the covered preventive services located on the CMS website at <a href="https://www.cms.gov/medicare/payment/fee-schedules/physician/preventive-services">https://www.cms.gov/medicare/payment/fee-schedules/physician/preventive-services</a> .		X							

### III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
13452.6	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the “MLN Connects” listserv to get MLN content notifications. You don’t need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.	X	X	X		

### IV. SUPPORTING INFORMATION

**Section A: Recommendations and supporting information associated with listed requirements: N/A**

*"Should" denotes a recommendation.*

X-Ref Requirement Number	Recommendations or other supporting information:

**Section B: All other recommendations and supporting information: N/A**

### V. CONTACTS

**Post-Implementation Contact(s):** Contact your Contracting Officer's Representative (COR).

### VI. FUNDING

**Section A: For Medicare Administrative Contractors (MACs):**

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**ATTACHMENTS: 0**