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ATA CY2024 Medicare Physician Fee Schedule Comparison Chart

This chart compares the Medicare CY2024 Physician Fee Schedule proposed rule to the final rule. This Physician Fee Schedule was a huge win for the telehealth community.

Issue	Proposed Rule	ATA's Comment	Final Rule
Medicare Telehealth Flexibilities	CMS extends the flexibilities below through CY2024 in alignment with the CAA (Consolidated Appropriations Act of 2022) • Waiving the geographic and originating site restrictions • Audio-only coverage • Allowing RHCs and FQHCs to be considered distant sites • Waiving the 6 month in-person telemental health requirement • Expanding the list of eligible providers who can provide telehealth services	The ATA applauded CMS for extending these critical flexibilities.	Same as proposed
Telehealth Services Codes	CMS didn't propose adding any new codes to category 1 or 2 to the Medicare Services List	The ATA recommended the following codes be added permanently: inpatient hospital care services (99221–99223); observation admission services (99218–99220); same-day inpatient/observation admission and discharge services (99234–99236); new patient domiciliary, rest home services (99324–99328); and home-visit new-patient services (99341– 99345). Another set of codes we would like flagged for permanent consideration were ophthalmologic services (92002, 92004, 92012 and 92014).	Same as proposed
	CMS proposed temporarily adding three health and well-being coaching codes (0591T, 0592T, and 0593T) through CY2024	The ATA supported this proposal.	Same as proposed

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	HCPCS code GXXX5 (Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment tool, 5-15 minutes) to be permanently added to the Medicare Telehealth Services List, but contingent upon finalizing the service code description in the proposed rule.	The ATA supported this proposal.	Same as proposed CMS finalized as proposed and assigned HCPCS code G0136 (Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment tool, 5-15 minutes) permanent status on the Medicare Telehealth List, beginning in CY 2024.
Refinements to Medicare Telehealth Service List Process	CMS proposed a 5-step process to reviewing codes for the Medicare Telehealth Services list CMS proposed new code assignments such as "permanent" or "provisional status", foregoing the old taxonomy of Categories 1 – 3	The ATA is supportive of this simplified process and categorization of the codes.	Same as proposed
Telehealth Practitioners	CMS proposed to add marriage and family therapists (MFT) and mental health counselors (MHC) as telehealth practitioners allowed to practice Medicare telehealth services as of January 1, 2024.	The ATA is supportive.	Same as proposed
Audio only	CMS proposed to continue to provide for coverage and payment of telehealth services via an audio-only communications system until December 31, 2024 (only to telehealth services specified on the Medicare Telehealth Services List)	The ATA is supportive of this extension and urges CMS to make audio-only services permanent.	Same as proposed
Telehealth Place of Service Codes	CMS proposed that claims billed with POS 10 (Telehealth Provided in Patient's Home) be paid at the non-facility PFS rate and claims billed with POS 02 (Telehealth Provided Other than in Patient's Home) be paid at the PFS facility rate beginning on January 1, 2024	The ATA supported CMS' approach and outlined our fair payment policy position.	Same as proposed
Telehealth Originating Site Payment	CMS proposed payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is $29.92	The ATA did not provide specific comments on this payment rate.	Same as proposed

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Outpatient Therapists	CMS extended the flexibility that would allow hospital-employed PT, OT, and SLP providers to continue billing for telehealth services through the end of 2024	The ATA applauded CMS for making this needed clarification.	Same as proposed

Nursing Frequency Limitations	CMS proposed to temporarily remove the telehealth frequency limitations for the following codes through CY2024:
	• Inpatient visits
	  ○ 99231
	  ○ 99232
	  ○ 99233
	• Nursing Facility visits
	  ○ 99307
	  ○ 99308
	  ○ 99309
	  ○ 99310
	• Critical Care
	  ○ G0508
	  ○ G0509
		The ATA applauded CMS for the extension but urged to eliminate these barriers permanently.	Same as proposed

Virtual Direct Supervision	CMS proposed to continue to define direct supervision to permit the presence and "immediate availability" of the supervising practitioner through real-time audio and visual interactive telecommunications through December 31, 2024.	The ATA urged CMS to make direct supervision via telehealth a permanent option.	Same as proposed
Remote Monitoring Services (RM)	CMS proposed that RPM services be furnished only to an established patient.	The ATA urged CMS to allow providers to render RTM and RPM services to both new and established patients.	CMS offered additional clarification regarding the new patient requirement and that RPM, not RTM, services require an established patient relationship after the end of the PHE. While CMS has not specified in rulemaking whether the RTM services require an established patient relationship, CMS believe that similar to RPM, such services would be furnished to a patient after a treatment plan had been established.
	CMS reiterated the 16-day monitoring requirement was reinstated after the end of the PHE. Therefore,	The ATA outlined concerns with this policy and urged CMS to	16-day data collection requirement still applicable but CMS offered clarification

	monitoring must occur over at least 16 days of a 30-day period.	forgo the 16-day data collection requirement. ATA also expressed the need for clarify as the proposed rule is written makes it seem as though the requirement is applicable to both the supply of devices as well as 98980 and 98981 or the RTM treatment management codes.	that the 16 day data collection requirement does not apply to CPT codes 99457, 99458, 98980, and 98981. These CPT codes are treatment management codes that account for time spent in a calendar month and do not require 16 days of data collection in a 30-day period.
	CMS proposed allowing RHCs and FQHCs to be reimbursed for providing remote physiological monitoring (RPM) and remote therapeutic monitoring (RTM) services.	The ATA applauded CMS for this long-awaited policy change.	Same as proposed
	Practitioners may bill RPM or RTM, but not both RPM and RTM, concurrently with the following care management services: CCM/TCM/BHI, PCM, and CPM.	The ATA is fully supportive of this policy and applauded CMS for this proposal. However, CMS states that RPM and RTM may not be billed concurrently. ATA believes RPM and RTM should be allowed to be billed together and urged CMS to reconsider its policy.	Same as proposed
	CMS proposed to classify CPT codes 99457 and 99548 as primary care services under the Medicare Shared Savings Program ("MSSP")	The ATA seeks clarity around this proposal and encourages all RPM and RTM codes to be reimbursable in the MSSP context without the cost of these care management codes being factored into the determination of eligibility for savings, thereby appropriately incentivizing use of these codes for patients as appropriate.	CMS chose not to add codes 99457 and 99548.
	CMS proposed extending the flexibility that allows physical therapists and occupational therapists in private practice that qualify as a supplier to generally supervise, for RTM services,	The ATA was supportive of this. However, the Medicare Benefit Policy Manual (chapter 15) defines the term therapist in a private practice and outlines the	CMS finalized the proposal for RTM services to allow general supervision of OTAs and PTAs by OTs and PTs in private practice; and finalized the proposal to

	physician therapist assistants and occupational therapist assistants.	qualifications for a supplier, but it's convoluted and arduous. The ATA urged CMS to simplify and clarify this language to ensure that stakeholders understand easily who qualifies.	continue the requirement for direct supervision of unenrolled PTs and OTs, including for RTM services.
Box 32: Medicare Provider Address	This issue wasn't addressed in the proposed rule.	The ATA outlined the issue and urged CMS to address.	CMS thanked commenters for bringing this issue to their attention. Through CY 2024, CMS will continue to permit the distant site practitioner to use their currently enrolled practice location instead of their home address when providing telehealth services from their home. CMS will also consider this issue further for future rulemaking and request that interested parties provide clear examples of how the enrollment process shows material privacy risks to inform future enrollment and payment policy development.
Opioid Treatment Programs	CMS proposed to extend the flexibility that allows periodic assessments to continue to be furnished using audio-only communication technology following the end of CY2024 for patients who are receiving treatment via buprenorphine, methadone, and/or naltrexone at OTPs.	The ATA is supportive of this policy	Same as proposed
Payment for Software Algorithms	CMS approved new CPT code 7X005 to report non-invasive estimate of coronary fractional flow reserve derived from augmentative software analysis of the dataset from a coronary computed tomography angiography.	The ATA is supportive of this code but remain concerned with the way CMS generally accounts for software algorithms in its Practice Expense (PE) methodology.	CMS continues to believe that the software analysis fee would not be considered as a form of direct PE under our current methodology, and therefore, CMS will maintain the previous valuation crosswalk to the technical component of CPT code 93457 to incorporate these costs.
Medicare Diabetes	CMS proposed allowing the MDPP to be offered virtually through the end of 2027. However, this only	The ATA is supportive of allowing virtual providers offering CDC-recognized Diabetes	Same as proposed

Prevention Program	applies to MDPP suppliers that have and maintain CDC DPRP in-person recognition.	Prevention Programs (DPPs) to enroll in the Medicare DPP. We encourage CMS to work with Congress to improve the accessibility of the MDPP by allowing it to be offered virtually.	CMS will assess the health equity impact of excluding fully virtual suppliers once they have updated data from the PHE for COVID-19 time period.