CY 2024 Medicare Physician Fee Schedule Proposed Rule
Summary of Provisions Impacting Epilepsy Centers

On July 13, the Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2024 Medicare Physician Fee Schedule (MPFS) proposed rule, which was published in the Federal Register on August 7, 2023. Comments must be submitted by September 11. The final rule is typically released in early November and the provisions of the rule are effective on January 1, 2024.

Conversion Factor

CMS is proposing a reduction in the 2024 Medicare conversion factor (CF) of about 3.36%; from $33.89 to $32.75. The proposed reduction is due to budget neutrality requirements stemming from the increase in evaluation and management (E/M) codes and a projected increase in the Medical Economic Index in 2024.

Impact of Proposed Rule on Epilepsy Center Services

Attached to this summary are the CMS impact table (attachment 1), which shows the overall impact of changes made by the rule on each specialty and charts (attachment 2) created by NAEC showing the relative values and payment rates for neurology, epilepsy surgery and E/M services for CY 2024, along with a comparison to the payment rates published in the final MPFS for CY 2023. Payment for the professional component of neurology services and most E/M services are proposed to decrease at a rate comparable to the reduction in the conversion factor. Practice expense values and malpractice values are fluctuating based on updates on labor and malpractice insurance costs being recognized by CMS. While the impact of the changes made by the rule will vary depending on an individual physician's practice, CMS anticipates that payment for neurology services will remain close to 2023 levels.

The CPT Editorial Panel approved three new codes for a skull-mounted cranial neurostimulator (e.g., NeuroPace's RNS neurostimulator), which go into effect on January 1, 2024. There is one code for the initial implantation of the neurostimulator (619X1), one for the replacement/revision (619X2) and one for the removal (619X3). While the final CPT Code numbers are not available, CMS has proposed relative values for the new codes, which are included in attachment 2.

Evaluation and Management (E/M) Services

In 2021, CMS adopted major changes to the office and outpatient E/M visits, which allowed physicians to select the E/M visit level to bill based on either total time spent on the date of a patient encounter or the medical decision making utilized in the provision of the visit. In 2023, increases in the remaining families of E/M services, including hospital visits, were increased. In this rule, CMS proposes to implement a new code, G2211 a code for the care of a single serious or chronic complex condition (G2211 - *Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition).* G2211 is considered an add-on code reported with office or outpatient visits for new or established patients. CMS clarifies that it will not allow payment for G2211 when reported on the same date as an E/M visit reported with modifier -25. The proposed national average payment for G2211 in 2024 is $16.

Split/Shared Services

A split (or shared) visit refers to an E/M service performed by both a physician and a non-physician practitioner (NPP) in the same group practice. The longstanding CMS policy has been that the physician can bill for the split/shared service if he/she performs a “substantive portion” of the encounter. Medicare reimbursement for split/shared services is at 100 percent of the PFS rate, when the physician bills for the service, while reimbursement is at 85 percent of the PFS rate when NPPs bill for the service.

In this proposed rule, CMS proposes to continue to extend the delay until December 31, 2024, in implementing its policy (included in the 2022 MPFS proposed rule) that would require a physician to see the patient for more than half of the total time of a split or shared E/M visit to bill for the service. Through calendar year 2024, physicians can continue to bill split or shared visits based on the current definition of substantive portion as one of the following: history, exam, medical decision-making, or more than half of total time.

Telehealth

CMS is proposing to continue the implementation of the telehealth related proposals mandated by Congress in legislation in 2022, including coverage for audio-only telephone visits and the flexibility of allowing patients to be at any site in the US to receive a telehealth service, including the patient’s home. CMS is also proposing to continue to pay for telehealth services at the non-facility/office visit rate and allow for direct supervision to be provided virtually. These proposals and coverage and payment for telehealth services on the Medicare Telehealth Services list are extended through December 31, 2024.

CMS is also proposing to simplify its classification system under the Medicare telehealth list by deeming services as either permanent or provisional. Currently, telehealth services under Medicare are assigned to one of three categories. Category 1 includes services that are similar to professional consultations and office visits and Category 2 are non-E/M services; services in these categories are considered a covered service via telehealth. Category 3, which was newly created in 2021 due to the COVID-19 pandemic, includes services added to the Medicare Telehealth Services List on a temporary basis.

CMS is proposing to redesignate any services that are currently on the Medicare Telehealth Services List under Category 1 or 2 to be on the proposed new “permanent” category list in 2024. Those services designated “temporary Category 2” – a subcategory created in response to the COVID-19 pandemic – or Category 3 basis would be assigned to the “provisional” category.

Services Addressing Health-Related Social Needs: Community Health Integration Services, Social Determinants of Health Risk Assessment, and Principal Illness Navigation Services

CMS is proposing new coding to describe and separately value three types of services: community health integration services, social determinants of health (SDOH) risk assessment, and principal illness navigation. This is an effort to continue to recognize significant changes in health care practice and identify gaps in appropriate coding and payment for care management/coordination and primary care services under the MPFS. CMS is currently exploring ways to better identify and value practitioners’ work when they incur additional time and resources helping patients with serious illnesses navigate the healthcare system or removing health-related social barriers that are interfering with the practitioner’s ability to execute a medically necessary plan of care. More details on these proposed services and CMS’ request for information can be found on pages 64-75 of the proposed rule.

Community Health Integration (CHI) Services

In the CY 2023 proposed rule, CMS issued a request for information related to Medicare Part B Payment for services involving Community Health Workers (CHWs). For CY 2024, CMS is considering how the agency can better recognize, through coding and payment policies, when members of an interdisciplinary team, including CHWs, are involved in treatment of Medicare beneficiaries.

CMS is proposing to create two new G codes describing community health integration (CHI) services performed by certified or trained auxiliary personnel, which may include a CHW, incident to the professional services and under the general supervision of the billing practitioner. Specifically, CMS is proposing that CHI services could be furnished monthly, as medically necessary, following an initiating evaluation and management (E/M) visit (CHI initiating visit) in which the practitioner identifies the presence of SDOH need(s) that significantly limit the practitioner's ability to diagnose or treat the problem(s) addressed in the visit.

For the purposes of CHI services (and PIN services discussed later), CMS is proposing that SDOH means economic and social condition(s) that influence the health of people and communities (e.g., food insecurity, transportation insecurity, housing insecurity, and unreliable access to public utilities when they significantly limit the practitioner's ability to diagnose or treat the problem(s) addressed in the CHI initiating visit).

CMS proposes the following specific codes and descriptors for **Community Health Integration (CHI)** Services (more information on the codes can be found on pages 66-69 of the proposed rule):

GXXX1 *Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities to address social determinants of health (SDOH) need(s) that are significantly limiting ability to diagnose or treat problem(s) addressed in an initiating E/M visit:*

GXXX2 *Community health integration services, each additional 30 minutes per calendar month (List separately in addition to GXXX1).*

CMS is also proposing that a billing practitioner may arrange to have CHI services provided by auxiliary personnel who are external to, and under contract with, the practitioner or their practice, such as through a community-based organization (CBO) that employes CHWs, if all of the "incident to" and other requirements and conditions for payment of CHI services are met.

Social Determinants of Health (SDOH) – Proposal to establish a stand-alone G code

CMS is proposing to establish a code to separately identify and value a SDOH risk assessment that is furnished in conjunction with an E/M visit.

GXXX5, *Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, not more often than every 6 months*.

SDOH risk assessment refers to a review of the individual's SDOH or identified social risk factors that influence the diagnosis and treatment of medical conditions.

Required elements would include:

- Administration of a standardized, evidence based SDOH risk assessment tool that has been tested and validated through research, and includes the domains of food insecurity, housing insecurity, transportation needs, and utility difficulties.
    - Billing practitioners may choose to assess for additional domains beyond those listed above if there are other prevalent or culturally salient social determinants in the community being treated by the practitioner.

CMS is proposing to add this code to the Medicare Telehealth Services List to accommodate a scenario in which the practitioner (or their auxiliary personnel incident to the practitioner's services) completes the risk assessment in an interview format, if appropriate. CMS believes it is important that when furnishing this service, all communication with the patient be appropriate for the patient's educational, developmental, and health literacy level, and be culturally and linguistically appropriate. CMS is seeking comment on where and how these services would be typically provided, along with other aspects of the proposed SDOH assessment service.

Principal Illness Navigation (PIN) Services

CMS is proposing to better recognize through coding and payment policies when certified or trained auxiliary personnel under the direction of a billing practitioner, which may include a patient navigator or certified peer specialist, are involved in the patient's health care navigation as part of the treatment plan for a serious, high-risk disease expected to last at least 3 months, that places the patient at significant risk of hospitalization or nursing home placement, acute exacerbation/decompensation, functional decline, or death.

CMS is proposing for PIN services a parallel set of services to the proposed CHI services, but focused on patients with a serious, high-risk illness who may not necessarily have SDOH needs; and adding service elements to describe identifying or referring the patient to appropriate supportive services, providing information/resources to consider participation in clinical research/clinical trials, and inclusion of lived experience or training in the specific condition being addressed.

PIN services could be furnished following an initiating E/M visit addressing a serious high-risk condition/illness/disease, with the following characteristics:

- One serious, high-risk condition expected to last at least 3 months and that places the patient at significant risk of hospitalization, nursing home placement, acute exacerbation/decompensation, functional decline, or death;
- The condition requires development, monitoring, or revision of a disease-specific care plan, and may require frequent adjustment in the medication or treatment regimen, or substantial assistance from a caregiver.

CMS proposes the following specific codes and descriptors for **Principal Illness Navigation (PIN)** Services (more detailed can be found on pages 70-75 of the proposed rule):

GXXX3 *Principal Illness Navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator or certified peer specialist; 60 minutes per calendar month, in the following activities:*

GXXX4 – *Principal Illness Navigation services, additional 30 minutes per calendar month (List separately in addition to GXXX3).*

As with CHI services, CMS is proposing that a billing practitioner may arrange to have PIN services provided by auxiliary personnel who are external to, and under contract with, the practitioner or their practice, such as through a community-based organization (CBO) that employs CHWs, if all of the "incident to" and other requirements and conditions for payment of PIN services are met. CMS notes that many CBOs provide social services and do other work that is beyond the scope of PIN services, but believes they are well-positioned to develop relationships with practitioners for providing reasonable and necessary PIN services.

CMS is proposing that only one practitioner per beneficiary per calendar month could bill for PIN services for a given serious, high-risk condition, because they are concerned about potential care fragmentation if the patient has more than one navigator for their condition during a given month. The proposal would allow the patient to have a single point of contact for navigation of their condition.

TABLE 104: CY 2024 PFS Estimated Impact on Total Allowed Charges by Specialty

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
ALLERGY/IMMUNOLOGY	$216	0%	-1%	0%	-1%
ANESTHESIOLOGY	$1,647	-2%	-1%	0%	-2%
AUDIOLOGIST	$69	-1%	-1%	0%	-2%
CARDIAC SURGERY	$174	-1%	-1%	0%	-2%
CARDIOLOGY	$5,989	0%	0%	0%	0%
CHIROPRACTIC	$644	-1%	-1%	0%	-2%
CLINICAL PSYCHOLOGIST	$711	1%	0%	0%	2%
CLINICAL SOCIAL WORKER	$795	2%	0%	0%	2%
COLON AND RECTAL SURGERY	$147	-1%	-1%	0%	-2%
CRITICAL CARE	$331	-1%	0%	0%	-1%
DERMATOLOGY	$3,713	0%	0%	0%	-1%
DIAGNOSTIC TESTING FACILITY	$828	0%	-2%	0%	-2%
EMERGENCY MEDICINE	$2,460	-2%	-1%	0%	-2%
ENDOCRINOLOGY	$507	1%	1%	0%	3%
FAMILY PRACTICE	$5,504	2%	2%	0%	3%
GASTROENTEROLOGY	$1,474	0%	0%	0%	0%
GENERAL PRACTICE	$361	1%	1%	0%	2%
GENERAL SURGERY	$1,614	-1%	-1%	0%	-1%
GERIATRICS	$180	0%	1%	0%	1%
HAND SURGERY	$251	-1%	0%	0%	-1%
HEMATOLOGY/ONCOLOGY	$1,591	1%	0%	0%	2%
INDEPENDENT LABORATORY	$546	-1%	-1%	0%	-1%
INFECTIOUS DISEASE	$573	-1%	0%	0%	-1%
INTERNAL MEDICINE	$9,618	0%	1%	0%	1%
INTERVENTIONAL PAIN MGMT	$849	0%	0%	0%	0%
INTERVENTIONAL RADIOLOGY	$457	-1%	-3%	0%	-4%
MULTISPECIALTY CLINIC/OTHER PHYS	$146	0%	0%	0%	0%
NEPHROLOGY	$1,803	-1%	0%	0%	-1%
NEUROLOGY	$1,323	0%	0%	0%	1%
NEUROSURGERY	$694	-1%	0%	0%	-1%
NUCLEAR MEDICINE	$51	-1%	-2%	0%	-3%
NURSE ANES / ANES ASST	$1,081	-2%	0%	0%	-2%
NURSE PRACTITIONER	$6,260	1%	1%	0%	2%
OBSTETRICS/GYNECOLOGY	$558	0%	1%	0%	1%
OPHTHALMOLOGY	$4,647	0%	0%	0%	-1%
OPTOMETRY	$1,292	-1%	-1%	0%	-2%
ORAL/MAXILLOFACIAL SURGERY	$62	-1%	-1%	0%	-2%
ORTHOPEDIC SURGERY	$3,358	-1%	0%	0%	-1%
OTHER	$55	0%	-1%	0%	0%
OTOLARYNGOLOGY	$1,112	0%	0%	0%	0%
PATHOLOGY	$1,136	-1%	-1%	0%	-2%
PEDIATRICS	$55	0%	1%	0%	1%
PHYSICAL MEDICINE	$1,087	0%	0%	0%	-1%
PHYSICAL/OCCUPATIONAL THERAPY	$5,257	-1%	-2%	0%	-2%
PHYSICIAN ASSISTANT	$3,366	1%	1%	0%	2%
PLASTIC SURGERY	$300	-1%	-1%	0%	-1%
PODIATRY	$1,890	0%	0%	0%	0%
PORTABLE X-RAY SUPPLIER	$75	0%	0%	0%	-1%

Attachment 2

CPT Code	Mod	Descriptor	2024 Work RVUs	2024 Total RVUs	2024 Payment CF=$32.7476	2023 Payment CF=$33.8872	% payment change 2023 to 2024
2024 Final Physician Fee Schedule							
Payment Rates for Medicare Physician Services - Neurology							
95700		Eeg cont rec w/vid eeg tech	0.00	0.00	$0.00	$0.00	NA
95705		Eeg w/o vid 2-12 hr unmntr	0.00	0.00	$0.00	$0.00	NA
95706		Eeg wo vid 2-12hr intmt mntr	0.00	0.00	$0.00	$0.00	NA
95707		Eeg w/o vid 2-12hr cont mntr	0.00	0.00	$0.00	$0.00	NA
95708		Eeg wo vid ea 12-26hr unmntr	0.00	0.00	$0.00	$0.00	NA
95709		Eeg w/o vid ea 12-26hr intmt	0.00	0.00	$0.00	$0.00	NA
95710		Eeg w/o vid ea 12-26hr cont	0.00	0.00	$0.00	$0.00	NA
95711		Veeg 2-12 hr unmonitored	0.00	0.00	$0.00	$0.00	NA
95712		Veeg 2-12 hr intmt mntr	0.00	0.00	$0.00	$0.00	NA
95713		Veeg 2-12 hr cont mntr	0.00	0.00	$0.00	$0.00	NA
95714		Veeg ea 12-26 hr unmntr	0.00	0.00	$0.00	$0.00	NA
95715		Veeg ea 12-26hr intmt mntr	0.00	0.00	$0.00	$0.00	NA
95716		Veeg ea 12-26hr cont mntr	0.00	0.00	$0.00	$0.00	NA
95717	Hospital	Eeg phys/qhp 2-12 hr w/o vid	2.00	3.13	$102.50	$100.98	1.5%
95717	Office	Eeg phys/qhp 2-12 hr w/o vid	2.00	3.18	$104.14	$102.00	2.1%
95718	Hospital	Eeg phys/qhp 2-12 hr w/veeg	2.50	3.97	$130.01	$133.18	-2.4%
95718	Office	Eeg phys/qhp 2-12 hr w/veeg	2.50	4.04	$132.30	$135.55	-2.4%
95719	Hospital	Eeg phys/qhp ea incr w/o vid	3.00	4.74	$155.22	$156.22	-0.6%
95719	Office	Eeg phys/qhp ea incr w/o vid	3.00	4.82	$157.84	$158.25	-0.3%
95720	Hospital	Eeg phy/qhp ea incr w/veeg	3.86	6.11	$200.09	$205.02	-2.4%
95720	Office	Eeg phy/qhp ea incr w/veeg	3.86	6.22	$203.69	$208.41	-2.3%
95721	Hospital	Eeg phy/qhp>36<60 hr w/o vid	3.86	6.10	$199.76	$204.34	-2.2%
95721	Office	Eeg phy/qhp>36<60 hr w/o vid	3.86	6.22	$203.69	$208.07	-2.1%
95722	Hospital	Eeg phy/qhp>36<60 hr w/veeg	4.70	7.40	$242.33	$248.73	-2.6%
95722	Office	Eeg phy/qhp>36<60 hr w/veeg	4.70	7.54	$246.92	$253.48	-2.6%
95723	Hospital	Eeg phy/qhp>60<84 hr w/o vid	4.75	7.40	$242.33	$249.41	-2.8%
95723	Office	Eeg phy/qhp>60<84 hr w/o vid	4.75	7.55	$247.24	$254.49	-2.8%
95724	Hospital	Eeg phy/qhp>60<84 hr w/veeg	6.00	9.31	$304.88	$314.81	-3.2%
95724	Office	Eeg phy/qhp>60<84 hr w/veeg	6.00	9.48	$310.45	$320.57	-3.2%
95725	Hospital	Eeg phy/qhp>84 hr w/o vid	5.40	8.54	$279.66	$285.33	-2.0%
95725	Office	Eeg phy/qhp>84 hr w/o vid	5.40	8.75	$286.54	$291.43	-1.7%
95726	Hospital	Eeg phy/qhp>84 hr w/veeg	7.58	11.93	$390.68	$399.53	-2.2%
95726	Office	Eeg phy/qhp>84 hr w/veeg	7.58	12.17	$398.54	$406.99	-2.1%
95812		Eeg 41-60 minutes	1.08	10.53	$344.83	$351.41	-1.9%
95812	TC	Eeg 41-60 minutes	0.00	8.86	$290.14	$296.51	-2.1%
95812	26	Eeg 41-60 minutes	1.08	1.67	$54.69	$54.90	-0.4%
95813		Eeg over 1 hour	1.63	13.31	$435.87	$435.45	0.1%
95813	TC	Eeg over 1 hour	0.00	10.79	$353.35	$352.43	0.3%
95813	26	Eeg over 1 hour	1.63	2.52	$82.52	$83.02	-0.6%
95816		Eeg awake and drowsy	1.08	11.86	$388.39	$389.36	-0.3%
95816	TC	Eeg awake and drowsy	0.00	10.19	$333.70	$334.47	-0.2%
95816	26	Eeg awake and drowsy	1.08	1.67	$54.69	$54.90	-0.4%
95819		Eeg awake and asleep	1.08	13.66	$447.33	$453.07	-1.3%
95819	TC	Eeg awake and asleep	0.00	11.99	$392.64	$397.84	-1.3%
95819	26	Eeg awake and asleep	1.08	1.67	$54.69	$55.24	-1.0%
95822		Eeg coma or sleep only	1.08	12.86	$421.13	$423.25	-0.5%
95822	TC	Eeg coma or sleep only	0.00	11.19	$366.45	$368.01	-0.4%
95822	26	Eeg coma or sleep only	1.08	1.67	$54.69	$55.24	-1.0%
95824	26	Eeg cerebral death only	0.74	1.14	$37.33	$37.61	-0.8%
95829		Surgery electrocorticogram	6.20	53.10	$1,738.90	$1,791.28	-2.9%
95829	TC	Surgery electrocorticogram	0.00	43.43	$1,422.23	$1,473.75	-3.5%
95829	26	Surgery electrocorticogram	6.20	9.67	$316.67	$317.52	-0.3%
95830	Hospital	Insert electrodes for EEG	1.70	2.71	$88.75	$90.82	-2.3%
95830	Office	Insert electrodes for EEG	1.70	20.63	$675.58	$704.18	-4.1%
95836		Ecog impltd brn npgt <30 d	1.98	3.13	$102.50	$105.39	-2.7%
95954		Eeg monitoring/giving drugs	2.45	11.81	$386.75	$410.04	-5.7%
95954	TC	Eeg monitoring/giving drugs	0.00	8.51	$278.68	$305.66	-8.8%
95954	26	Eeg monitoring/giving drugs	2.45	3.30	$108.07	$104.37	3.5%
95955		Eeg during surgery	1.01	5.72	$187.32	$193.83	-3.4%
95955	TC	Eeg during surgery	0.00	4.16	$136.23	$142.33	-4.3%
95955	26	Eeg during surgery	1.01	1.56	$51.09	$51.51	-0.8%
95957		Eeg digital analysis	1.98	8.80	$288.18	$277.88	3.7%
95957	TC	Eeg digital analysis	0.00	5.81	$190.26	$179.94	5.7%
95957	26	Eeg digital analysis	1.98	2.99	$97.92	$97.93	0.0%
95958		Eeg monitoring/function test	4.24	21.02	$688.35	$629.62	9.3%
95958	TC	Eeg monitoring/function test	0.00	14.44	$472.88	$411.73	14.9%
95958	26	Eeg monitoring/function test	4.24	6.58	$215.48	$217.89	-1.1%
95961		Electrode stimulation brain	2.97	9.88	$323.55	$311.42	3.9%
95961	TC	Electrode stimulation brain	0.00	5.12	$167.67	$156.90	6.9%
95961	26	Electrode stimulation brain	2.97	4.76	$155.88	$154.53	0.9%
95962		Electrode stim brain add-on	3.21	8.35	$273.44	$269.06	1.6%
95962	TC	Electrode stim brain add-on	0.00	3.28	$107.41	$103.69	3.6%
95962	26	Electrode stim brain add-on	3.21	5.07	$166.03	$165.37	0.4%
95965	26	Meg spontaneous	7.99	12.06	$394.94	$397.84	-0.7%
95966	26	Meg evoked single	3.99	5.82	$190.59	$202.98	-6.1%
95967	26	Meg evoked each addl	3.49	5.05	$165.38	$177.23	-6.7%
95970	Hospital	Alys npgt w/o prgrmg	0.35	0.54	$17.68	$17.96	-1.6%
95970	Office	Alys npgt w/o prgrmg	0.35	0.56	$18.34	$18.30	0.2%
95971	Hospital	Alys smpl sp/pn npgt w/prgrm	0.78	1.15	$37.66	$39.65	-5.0%
95971	Office	Alys smpl sp/pn npgt w/prgrm	0.78	1.44	$47.16	$48.80	-3.4%
95972	Hospital	Alys cplx sp/pn npgt w/prgrm	0.80	1.19	$38.97	$40.33	-3.4%
95972	Office	Alys cplx sp/pn npgt w/prgrm	0.80	1.70	$55.67	$56.93	-2.2%
95976	Hospital	Alys smpl cn npgt prgrmg	0.73	1.15	$37.66	$39.31	-4.2%
95976	Office	Alys smpl cn npgt prgrmg	0.73	1.17	$38.31	$39.99	-4.2%
95977	Hospital	Alys cplx cn npgt prgrmg	0.97	1.53	$50.10	$52.19	-4.0%
95977	Office	Alys cplx cn npgt prgrmg	0.97	1.56	$51.09	$53.20	-4.0%
95983	Hospital	Alys brn npgt prgrmg 15 min	0.91	1.46	$47.81	$49.48	-3.4%
95983	Office	Alys brn npgt prgrmg 15 min	0.91	1.49	$48.79	$50.49	-3.4%
95984	Hospital	Alys brn npgt prgrmg addl 15	0.80	1.28	$41.92	$43.38	-3.4%
95984	Office	Alys brn npgt prgrmg addl 15	0.80	1.30	$42.57	$44.05	-3.4%

2024 Final Physician Fee Schedule							
Payment Rates for Medicare Physician Services - Epilepsy Surgery							
CPT Code	Mod	Descriptor	2024			2023	% payment change 2023 to 2024
			Work RVUs	Total RVUs	Payment CF=$32.7476	Payment CF=$33.8872	
61531		Implant brain electrodes	16.41	37.55	$1,229.67	$1,277.55	-3.7%
61534		Removal of brain lesion	23.01	50.41	$1,650.81	$1,718.42	-3.9%
61536		Removal of brain lesion	37.72	78.33	$2,565.12	$2,674.38	-4.1%
61537		Removal of brain tissue	36.45	74.61	$2,443.30	$2,548.32	-4.1%
61538		Removal of brain tissue	39.45	80.76	$2,644.70	$2,758.42	-4.1%
61539		Removal of brain tissue	34.28	71.81	$2,351.61	$2,451.06	-4.1%
61540		Removal of brain tissue	31.43	66.25	$2,169.53	$2,260.62	-4.0%
61541		Incision of brain tissue	30.94	65.48	$2,144.31	$2,234.18	-4.0%
61543		Removal of brain tissue	31.31	66.20	$2,167.89	$2,257.57	-4.0%
61566		Removal of brain tissue	32.45	68.17	$2,232.40	$2,326.02	-4.0%
61567		Incision of brain tissue	37.00	77.66	$2,543.18	$2,649.64	-4.0%
61720		Incise skull/brain surgery	17.62	38.87	$1,272.90	$1,324.99	-3.9%
61735		Incise skull/brain surgery	22.35	48.71	$1,595.14	$1,661.15	-4.0%
61750		Incise skull/brain biopsy	19.83	42.95	$1,406.51	$1,464.27	-3.9%
61751		Brain biopsy w/ct/mr guide	18.79	42.44	$1,389.81	$1,444.61	-3.8%
61760		Implant brain electrodes	22.39	48.10	$1,575.16	$1,650.98	-4.6%
61770		Incise skull for treatment	23.19	49.44	$1,619.04	$1,686.90	-4.0%
61790		Treat trigeminal nerve	11.60	27.03	$885.17	$921.73	-4.0%
61791		Treat trigeminal tract	15.41	34.50	$1,129.79	$1,175.55	-3.9%
61796		Srs, cranial lesion simple	13.93	31.14	$1,019.76	$1,060.33	-3.8%
61797		Srs, cran les simple, addl	3.48	6.59	$215.81	$226.03	-4.5%
61798		Srs, cranial lesion complex	19.85	42.11	$1,379.00	$1,434.11	-3.8%
61799		Srs, cran les complex, addl	4.81	9.12	$298.66	$311.42	-4.1%
61736		Litt icr 1 traj 1 smpl les	19.06	36.46	$1,193.65	$901.40	32.4%
61737		Litt icr mlt trj mlt/cplx ls	22.67	43.93	$1,438.60	$1,077.27	33.5%
61800		Apply srs headframe add-on	2.25	4.54	$148.67	$155.54	-4.4%
61867		Implant neuroelectrode	33.03	69.42	$2,273.34	$2,368.04	-4.0%
61868		Implant neuroelectrde, add'l	7.91	15.00	$491.21	$514.07	-4.4%
61880		Revise/remove neuroelectrode	6.95	18.03	$590.44	$612.00	-3.5%
61885		Insrt/redo neurostim 1 array	6.05	16.21	$530.84	$547.96	-3.1%
61886		Implant neurostim arrays	9.93	27.03	$885.17	$913.94	-3.1%
61888		Revise/remove neuroreceiver	5.23	12.15	$397.88	$415.12	-4.2%
63620		Srs, spinal lesion	15.60	34.43	$1,127.50	$1,171.82	-3.8%
63621		Srs, spinal lesion, addl	4.00	7.58	$248.23	$260.25	-4.6%
619X1		Ins sk-mnt crnl nstm pg/rcvr (RNS)	25.75	38	$1,244.41	NA	NA
619X2		Rev/rplcmt sk-mnt crnl nstm (RNS)	11.25	18.03	$590.44	NA	NA
619X3		Rmv sk-mnt crnl nstm pg/rcvr (RNS)	15	24.82	$812.80	NA	NA

2024 Final Physician Fee Schedule										
Payment Rates for Medicare Physician Services - Evaluation and Management										
CPT Code	Descriptor	2024	NON-FACILITY (OFFICE)				FACILITY (HOSPITAL)			
			2024		2023	% payment change 2023 to 2024	2024		2023	% payment change 2023 to 2024
		Work RVUs	Total RVUs	Payment CF=$32.7476	Payment CF=$33.8872		Total RVUs	Payment CF=$32.7476	Payment CF=$33.8872	
99202	Office o/p new sf 15-29 min	0.93	2.17	$71.06	$73.20	-2.9%	1.41	$46.17	$48.46	-4.7%
99203	Office o/p new low 30-44 min	1.60	3.35	$109.70	$112.51	-2.5%	2.44	$79.90	$82.68	-3.4%
99204	Office o/p new mod 45-59 min	2.60	5.02	$164.39	$168.42	-2.4%	3.97	$130.01	$134.19	-3.1%
99205	Office o/p new hi 60-74 min	3.50	6.62	$216.79	$221.62	-2.2%	5.40	$176.84	$182.65	-3.2%
99211	Office o/p est minimal prob	0.18	0.70	$22.92	$23.38	-2.0%	0.26	$8.51	$8.81	-3.4%
99212	Office o/p est sf 10-19 min	0.70	1.70	$55.67	$56.25	-1.0%	1.05	$34.38	$35.24	-2.4%
99213	Office o/p est low 20-29 min	1.30	2.73	$89.40	$90.82	-1.6%	1.96	$64.19	$66.08	-2.9%
99214	Office o/p est mod 30-39 min	1.92	3.85	$126.08	$128.77	-2.1%	2.89	$94.64	$97.60	-3.0%
99215	Office o/p est hi 40-54 min	2.80	5.42	$177.49	$180.96	-1.9%	4.29	$140.49	$144.02	-2.5%
99221	1st hosp ip/obs sf/low 40	1.63	NA	NA	NA	NA	2.46	$80.56	$83.02	-3.0%
99222	1st hosp ip/obs moderate 55	2.60	NA	NA	NA	NA	3.88	$127.06	$130.80	-2.9%
99223	1st hosp ip/obs high 75	3.50	NA	NA	NA	NA	5.14	$168.32	$175.20	-3.9%
99231	Sbsq hosp ip/obs sf/low 25	1.00	NA	NA	NA	NA	1.47	$48.14	$49.48	-2.7%
99232	Sbsq hosp ip/obs moderate 35	1.59	NA	NA	NA	NA	2.34	$76.63	$79.63	-3.8%
99233	Sbsq hosp ip/obs high 50	2.40	NA	NA	NA	NA	3.52	$115.27	$118.61	-2.8%
99291	Critical care first hour	4.50	8.18	$267.88	$277.54	-3.5%	6.32	$206.96	$215.86	-4.1%
99292	Critical care addl 30 min	2.25	3.57	$116.91	$120.98	-3.4%	3.17	$103.81	$108.10	-4.0%
99421	Ol dig e/m svc 5-10 min	0.25	0.45	$14.74	$14.91	-1.1%	0.38	$12.44	$12.88	-3.4%
99422	Ol dig e/m svc 11-20 min	0.50	0.88	$28.82	$28.80	0.1%	0.75	$24.56	$24.74	-0.7%
99423	Ol dig e/m svc 21+ min	0.80	1.40	$45.85	$46.76	-2.0%	1.20	$39.30	$39.99	-1.7%
99446	Ntrprof ph1/ntrnet/ehr 5-10	0.35	0.53	$17.36	$17.28	0.4%	0.53	$17.36	$17.28	0.4%
99447	Ntrprof ph1/ntrnet/ehr 11-20	0.70	1.08	$35.37	$35.92	-1.5%	1.08	$35.37	$35.92	-1.5%
99448	Ntrprof ph1/ntrnet/ehr 21-30	1.05	1.60	$52.40	$53.54	-2.1%	1.60	$52.40	$53.54	-2.1%
99449	Ntrprof ph1/ntrnet/ehr 31/>	1.40	2.13	$69.75	$72.52	-3.8%	2.13	$69.75	$72.52	-3.8%
99451	Ntrprof ph1/ntrnet/ehr 5/>	0.70	1.04	$34.06	$35.92	-5.2%	1.04	$34.06	$35.92	-5.2%
99452	Ntrprof ph1/ntrnet/ehr rfrl	0.70	1.01	$33.08	$32.87	0.6%	1.01	$33.08	$32.87	0.6%
99453	Rem mntr physiol param setup	0.00	0.60	$19.65	$19.32	1.7%	NA	NA	NA	NA
99454	Rem mntr physiol param dev	0.00	1.43	$46.83	$50.15	-6.6%	NA	NA	NA	NA
99457	Rem physiol mntr 20 min mo	0.61	1.47	$48.14	$48.46	-0.7%	0.89	$29.15	$29.82	-2.2%
99458	Rem physiol mntr ea addl 20	0.61	1.18	$38.64	$39.31	-1.7%	0.89	$29.15	$29.82	-2.2%
99471	Ped critical care initial	15.98	NA	NA	NA	NA	22.94	$751.23	$777.71	-3.4%
99472	Ped critical care subsq	7.99	NA	NA	NA	NA	11.76	$385.11	$395.12	-2.5%
99487	Cmplx chron care w/o pt vsit	1.81	4.03	$131.97	$133.52	-1.2%	2.68	$87.76	$91.16	-3.7%
99489	Cmplx chron care addl 30 min	1.00	2.17	$71.06	$70.49	0.8%	1.49	$48.79	$50.15	-2.7%
99490	Chron care mgmt srvc 20 min	1.00	1.88	$61.57	$62.69	-1.8%	1.49	$48.79	$50.49	-3.4%
99491	Chrnc care mgmt svc 30 min	1.50	2.54	$83.18	$84.38	-1.4%	2.24	$73.35	$75.57	-2.9%
99495	Trans care mgmt 14 day disch	2.78	6.21	$203.36	$205.02	-0.8%	4.16	$136.23	$139.62	-2.4%
99496	Trans care mgmt 7 day disch	3.79	8.40	$275.08	$277.88	-1.0%	5.65	$185.02	$190.78	-3.0%
G0396	Alcohol/subs interv 15-30mn	0.65	1.03	$33.73	$35.24	-4.3%	0.94	$30.78	$31.85	-3.4%
G0397	Alcohol/subs interv >30 min	1.30	2.00	$65.50	$68.45	-4.3%	1.91	$62.55	$65.40	-4.4%
G0506	Comp asses care plan ccm svc	0.87	1.88	$61.57	$61.34	0.4%	1.31	$42.90	$43.71	-1.9%
G0316	Prolong hosp inpt each ad 15m	0.61	0.95	$31.11	$31.52	-1.29%	0.9	$29.47	$30.16	-2.29%
G2211	Complex e/m visit add on	0.33	0.49	$16.05	NA	NA	0.49	$16.05	NA	NA