Summary of the Calendar Year 2025 Medicare Physician Fee Schedule Final Rule

The Centers for Medicare and Medicaid Services released the CY 2025 Medicare Physician Fee Schedule (MPFS) Final Rule on November 1, 2024. KHA has prepared the summary of major provisions below. Our comments to CMS on the proposed rule can be found here.

Summary of Major Provisions:

- Average payment rates will be reduced by 2.93% in CY 2025
  - This amounts to an estimated conversion factor of $32.35, a decrease of $0.94 from the CY 2024 conversion factor.

- Caregiver Training Services (CTS)
  - Establishes new coding and payment for caregiver training for direct care services and supports.
    - Topics of training can include, but are not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control.
  - New codes and payment are also established for caregiver behavior management and modification training that can be furnished to the caregiver(s) of an individual patient.
  - These CTS can be furnished via telehealth.

- Services Addressing Health-Related Social Needs (Community Health Integration Services, Social Determinants of Health Risk Assessment, and Principal Illness Navigation Services)
  - CMS will consider comments received in this RFI for future rulemaking.

- Office/Outpatient (O/O) Evaluation and Management (E/M) Visits
  - Allows payment of the O/O E/M visit complexity add-on code, HCPCS code G2211 when the O/O E/M base code CPT 99202-99205, 99211-99215, is reported by the same practitioner on the same day as an annual wellness visit, vaccine administration, or any Medicare Part B preventive service furnished in the office or outpatient setting.

- Telehealth Services under the PFS
  - Medicare Telehealth Services List:
    - Various services were retained on provisional status to the Medicare Telehealth Services List
    - New services added:
      - Caregiver training services and PrEP counseling and safety planning interventions
    - The suspension of frequency limitations for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations for CY 2025 is continued.
  - Audio-Only Communication Technology to Meet the Definition of "Telecommunications System"
    - The definition of "interactive telecommunications system" is updated to include two-way, real-time, audio-only communication technology for any telehealth services furnished to

beneficiaries in their homes if the distant site physician or practitioner is technically capable of using an interactive telecommunications system that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner, but the patient is not capable of, or does not consent to, the use of video technology.

- Distant Site Requirements
  - CMS will continue to permit distant site practitioners to use their currently enrolled practice location instead of their home address when providing Medicare telehealth services from their home.
- Direct Supervision via Use of Two-way Audio/Video Communications Technology
  - CMS will 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, 2025.
- Proposal to Permanently Define "Direct Supervision" to Include Audio-Video Communications Technology for a Subset of Services
  - For services furnished after December 31, 2025, the presence of the physician (or other practitioner) required for direct supervision shall continue to include virtual presence through audio/video real-time communications technology (excluding audio-only): services furnished incident to a physician's service when they are provided by auxiliary personnel employed by the physician and working under his or her direct supervision and for which the underlying HCPCS code has been assigned a PC/TC indicator of '5'; and office and other outpatient visits for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional.
- Teaching Physician Billing for Services Involving Residents with Virtual Presence
  - CMS will continue to allow teaching physicians to have a virtual presence in all teaching settings, but only for services furnished as a Medicare telehealth service through December 31, 2025.

- Advanced Primary Care Management Services (APCM)
  - Establishes coding and payment for advanced primary care management services.
    - APCM services will be described by three new HCPCS G-codes (G0556, G0557, G0558).
    - APCM services must be delivered with essential elements including Principal Care Management, Transitional Care Management, and Chronic Care Management. However, unlike existing care management codes, there are no time-based thresholds included in the service elements, which is intended to reduce the administrative burden associated with current coding and billing. Instead, the new APCM codes are stratified into three levels based on an individual's number of chronic conditions and status as a Qualified Medicare Beneficiary, reflecting the patient's medical and social complexity.
  - Service elements and practice-level capabilities of APCM services required include consent, initiating visit, 24/7 access and continuity of care, comprehensive care management, patient-

centered comprehensive care plan, management of care transitions, care coordination, enhanced communication, population-level management, and performance measurement.
    - For MIPS eligible clinicians, the performance management service element can be satisfied by reporting the Value in Primary Care MIPS Value Pathway (MVP).

- Cardiovascular Risk Assessment and Management
  - Establishes coding and payment for an Atherosclerotic Cardiovascular Disease (ASCVD) risk assessment service and risk management services.
    - The ASCVD risk assessment will be performed in conjunction with an E/M visit when a practitioner identifies a patient at risk for CVD who does not have a diagnosis of CVD.

- Behavioral Health Services
  - Establishes coding and payment describing safety planning interventions for patients in crisis, including those with suicidal ideation or at risk of suicide or overdose.
    - Payment for a G-code that may be billed in 20-minute increments when safety planning interventions are personally performed by the billing practitioner in a variety of settings.
    - Payment for a monthly billing code that requires specific protocols in furnishing post-discharge follow-up contacts that are performed in conjunction with a discharge from the emergency department for a crisis encounter, as a bundled service describing four calls in a month.
  - Establishes payment for digital mental health treatment devices furnished incident to professional behavioral health services, used in conjunction with ongoing behavioral health care treatment under a behavioral health treatment plan of care.
    - Three new HCPCS codes to describe these services.
    - Six G codes, to be billed by practitioners in specialties whose covered services are limited by statute to services for the diagnosis and treatment of mental illness (including clinical psychologists, clinical social workers, marriage and family therapists, and mental health counselors), that mirror current interprofessional consultation CPT codes used by practitioners who are eligible to bill E/M visits.

- Opioid Treatment Programs (OTPs)
  - CMS is making permanent the current flexibility for furnishing periodic assessments via audio-only telecommunications beginning January 1, 2025, so long as all other applicable requirements are met.
  - CMS is allowing the OTP intake add-on code to be furnished via two-way audio-video communications technology when billed for the initiation of treatment with methadone (using HCPCS code G2076) if the OTP determines that an adequate evaluation of the patient can be accomplished via an audio-visual telehealth platform.
  - CMS is increasing payment for SDOH risk assessments as part of intake activities within OUD treatment services furnished by OTPs, if medically reasonable and necessary to adequately reflect additional effort for OTPs, to identify a patient's unmet health-related social needs

  (HRSNs) or the need and interest for harm reduction interventions and recovery support services that are critical to the treatment of an OUD.
  - CMS is updating payment for periodic assessments to include payment for SDOH risk assessments to reflect additional reassessments that OTPs may conduct throughout treatment, to monitor potential changes in a patient's HRSNs or support services.
  - CMS is finalizing new add-on codes to account for coordinated care and referral services, patient navigational services, and peer recovery support services.
  - CMS is finalizing payment for new opioid agonist and antagonist medications approved by the FDA.
    - New add-on code for nalmefene hydrochloride nasal spray, indicated for the emergency treatment of known or suspected opioid overdose.
    - Payment for a new injectable buprenorphine product via (1) a new weekly bundled payment code for the weekly formulation of the new injectable buprenorphine product, and (2) including payment for the monthly formulation of the new injectable buprenorphine product into the existing code for monthly injectable buprenorphine.

- Hospital Inpatient or Observation (I/O) Evaluation and Management (E/M) Add-On for Infectious Diseases
  - New HCPCS add-on code to describe the intensity and complexity inherent to hospital inpatient or observation care, associated with a confirmed or suspected infectious disease, performed by a practitioner with specialized training in infectious diseases.

- Strategies for Improving Global Surgery Payment Accuracy
  - CMS finalized a policy to broaden the applicability of the transfer of care modifier 54, for all 90-day global surgical packages (global packages), in any case when a practitioner expects to furnish only the surgical procedure portion of the global package, including but not limited to when there is a formal, documented transfer of care as under current policy or an informal, non-documented but expected, transfer of care.
  - New add-on code, HCPCS code G0559, for post-operative care services furnished by a practitioner other than the one who performed the surgical procedure (or another practitioner in the same group practice).
    - This add-on code will more appropriately reflect the time and resources involved in these post-operative follow-up visits by practitioners who were not involved in furnishing the surgical procedure.

- Supervision Policy for Physical Therapists (PTs) and Occupational Therapists (OTs) in Private Practice
  - Allow for general supervision of physical therapist assistants (PTAs) and occupational therapy assistants (OTAs) by PTs in private practice (PTPPs) and OTs in private practice (OTPPs) for all applicable physical and occupational therapy services.

- Certification of Therapy Plans of Treatment with a Physician or NPP Order

- Amended the certification regulations to lessen the administrative burden for therapists (PTs, OTs, and speech-language pathologists (SLPs)) and physician/NPPs.
  - This will provide an exception to the physician/NPP signature requirement on the therapist-established treatment plan for purposes of the initial certification, in cases where a written order or referral from the patient's physician/NPP is on file and the therapist has documented evidence that the treatment plan was transmitted to the physician/NPP within 30 days of the initial evaluation.

- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)
  - Care Coordination Services in RHCs and FQHCs
    - Starting in 2025, RHCs and FQHCs will report the individual CPT and HCPCS codes that describe care coordination services instead of the single HCPCS code G0511.
      - A transition period of six-months, to at least until July 1, 2025, is provided to enable those RHCs/FQHCs to be able to update their billing systems.
      - Billing of the add-on codes associated with these services is permitted.
    - Adopted coding and policies regarding APCM services for RHC and FQHC payments.
      - Under these finalized rules, payments to RHCs and FQHCs would be made at the national, non-facility, PFS amounts when the individual code is on an RHC or FQHC claim, either alone or with other payable services and payment rates. CMS will pay for these services in addition to the RHC All-Inclusive Rate (AIR) or FQHC prospective payment system (PPS). Payment rates would be updated annually based on the PFS amounts for these codes. RHCs and FQHCs, not eligible for MIPS, are not required to report the Value in Primary Care MVP to meet the performance measurement requirement.
  - Telecommunications Services in RHCs and FQHCs
    - CMS will continue to allow direct supervision via interactive audio and video telecommunications and extends the definition of "immediate availability" as including real-time audio and visual interactive telecommunications (excluding audio-only) through December 31, 2025.
    - Finalized a policy to allow payment, on a temporary basis, for non-behavioral health visits furnished via telecommunication technology under the methodology that has been in place for these services during and after the COVID-19 PHE through December 31, 2024.
      - Specifically, RHCs and FQHCs can continue to bill for RHC and FQHC services furnished using telecommunication technology by reporting HCPCS code G2025 on the claim, including services furnished using audio-only communications technology through December 31, 2025.
      - For payment for non-behavioral health visits furnished via telecommunication technology in CY 2025, CMS will calculate the payment amount based on the average amount for all PFS telehealth services on the telehealth list, weighted by volume for those services reported under the PFS.

    - CMS will continue to delay the in-person visit requirement for mental health services furnished via communication technology by RHCs and FQHCs to beneficiaries in their homes until January 1, 2026.
  - Intensive Outpatient Program Services (IOP) in RHCs and FQHCs
    - CMS is adding a new payment rate when four or more services per day in the RHC and FQHC setting, in addition to the current payment amount based on only three services.
    - CMS is aligning the four or more IOP services per day payment rate with the same payment rate for four or more IOP services in hospital outpatient departments, which will be updated annually.
  - Payment for Preventive Vaccine Costs in RHCs and FQHCs
    - CMS is allowing RHCs and FQHCs to bill and be paid for Part B preventive vaccines and their administration at the time of service.
      - To account for operational systems changes needed to facilitate payment through claims, RHCs and FQHCs can begin billing for preventive vaccines and their administration at the time of service, effective for dates of service beginning on or after July 1, 2025.
  - RHC Productivity Standards
    - CMS is removing the productivity standards that RHCs are subject to, effective for cost reporting periods beginning on or after January 1, 2025. CMS believes productivity standards are outdated and redundant with the CAA, 2021 provisions.
  - RHC Conditions for Certification
    - CMS will no longer determine or enforce the standard of RHCs "being primarily engaged in furnishing primary care services" and would no longer consider the total hours of an RHC's operation and whether a majority, that is, more than 50 percent, of those hours involve the provision of primary care services through the survey process.