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SPECIAL ISSUE
Coverage of the final 2025 Medicare physician fee schedule

In this issue

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Coding

Complexity of care add-on cleared for same-day preventive services

CMS finalized its proposal to relax restrictions on complexity of care add-on code **G2211**. The changes come in response to stakeholder concerns that the current CMS policy is disruptive to the way providers normally treat patients.

Under current regulations a practice can report the code with an office/other outpatient E/M visit (**99202-99215**) when appropriate. However, CMS doesn't cover the add-on code if the practice uses modifier **25** (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to unbundle the E/M visit from another service.

In the final 2025 Medicare physician fee schedule, CMS observed that it could not find evidence that this policy disrupted care when it reviewed claims data. "However, we do agree with practitioners expressing concerns that the current policy is not well-aligned with our policy objective for establishing the add-on payment," the agency stated in the final rule.

Effective Jan. 1, 2025, you will be able to report the add-on code when the E/M service is unbundled from a vaccination covered by Medicare Part B or any of the 24 preventive services. Under those circumstances, appending modifier 25 to the E/M visit should not trigger a denial. However, you should check up on claims at the start of the year to make sure your Medicare administrative contractor has updated its system and is not improperly denying claims.

In the meantime, make sure your staff understand the update is limited to vaccinations and preventive services *(see chart, p. 3)*. Reporting the primary E/M visit with a minor procedure such as a joint injection on the same day will continue to trigger a denial.

CMS turned down requests to expand the list of services that could be reported in conjunction with the E/M visit to include services such as an echocardiogram and nerve blocks. "As we discussed in the proposed rule, building trust as part of a longitudinal practitioner-patient relationship may be particularly significant in the context of preventive services, and for this reason, we believe it is appropriate to limit billing of HCPCS code G2211 to preventive services at this time," CMS wrote in the final rule.

The update is also an opportunity to remind staff that they can only report G2211 with office/other outpatient E/M visits. In the final rule CMS declined requests to allow providers to append the code to home or nursing facility E/M visits. — *Julia Kyles, CPC* (julia.kyles@decisionhealth.com) ■

Coding

Batch of behavioral health services bolsters options, goes digital

The changes proposed in the final rule for Medicare's burgeoning behavioral health category have been finalized, expanding its purview beyond previous therapeutic models and even into digital care engaged by the patients themselves.

The safety planning interventions code **G0560** for patients in crisis is not only finalized but also made a stand-alone rather than an add-on code. Its code descriptor is expanded from that of the proposed placeholder **GSPI1** with the new substance-use-related language in bold below:

- "Safety planning interventions, each 20 minutes personally performed by the billing practitioner, including assisting the patient in the identification of the following personalized elements of a safety plan: recognizing warning signs of an impending suicidal **or substance use-related crisis;** employing internal coping strategies; utilizing social contacts and social settings as a means of distraction from suicidal thoughts **or risky substance use;** utilizing family members, significant others, caregivers, and/or friends to help resolve the crisis; contacting mental health or substance use disorder professionals or agencies; and making the environment safe."

Also, the service may be performed by telehealth.

Sonda Kunzi, president of Coding Advantage, thinks this is a "win" for behavioral health providers, for whom such planning is a staple and for which they may not currently be reimbursed under other codes. She also thinks "having a means to capture time spent with a patient creating a plan of safety will come in handy for those non-psych providers seeing more behavioral health issues with their patients."

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But since it's "not typical" for non-psych providers to create such plans, and they "may not have that additional time to spend during an encounter," Kunzi thinks that only time will tell how many such providers pick it up and use it.

CMS also cleared the post-discharge telephonic follow-up contacts intervention (FCI) code **G0544**, to be performed in conjunction after a discharge from the emergency department for behavioral health or other crisis encounters. This too is a stand-alone code for a bundle of calls per month, "paid for as long as the service is medically reasonable and necessary" so long as at least one real-time telephone interaction with the patient takes place, CMS says. It can be provided by auxiliary personnel incident to the services, but the billing provider must obtain verbal or written beneficiary consent either prior to or during the initial phone call.

Digital mental health treatment (DMHT), aka "digital CBT" (cognitive behavioral therapy) dispensed mostly through self-directed patient interaction with devices including smartphones, will now be officially payable by Medicare in 2025 (*PBN 8/19/24*). DMHT services may be billed with codes **G0552** (Supply of digital mental health treatment device and initial education and onboarding, per course of treatment that augments a behavioral therapy plan), **G0553** (First 20 minutes of monthly treatment management services ...) and **G0554** (… ; each additional 20 minutes).

The service requires at least one interactive communication with the patient or caregiver during the calendar month, and the provider or their staff "must monitor the patient's therapeutic response to the DMHT device and adjust the behavioral health therapy plan as needed." The billing provider "diagnoses the patient with a mental health condition and prescribes or orders the DMHT device," and incurs the cost of furnishing the DMHT device. In most cases, that may look like an app to put on their phone or a module.

CMS stresses DMHT is distinct from services involving a therapeutic monitoring device "that transmits patient data as described by CPT code **98978**," and that it can only be provided via "devices cleared under section 510(k) of the Food, Drug, and Cosmetics Act (FD&C Act) or granted De Novo authorization by FDA." CMS says it can accept gaps in treatment, acknowledging that "individuals with certain behavioral health conditions are at a higher risk of not adhering to treatment or experiencing events that may necessitate temporary pauses in treatment."

CMS says that "presently use cases for insomnia, substance use disorder, depression and anxiety have been classified by the FDA" but "future use cases are not necessarily limited to these."

"We have definitely seen a lot of interest in this space," Kunzi says. "We hope to see a cautious but thoughtful approach as there tends to be confusion [between] wellness or well-being — [i.e.] improvement

Coding

Find full list of preventive services eligible for G2211 co-billing

Effective Jan. 1, 2025, you will be able to report an office or other outpatient E/M visit with complexity of care add-on code **G2211** with the following preventive services (*see story, p. 1*).

Alcohol misuse screenings & counseling	Annual wellness visit, including the Welcome to Medicare visit
Bone mass measurements	Cardiovascular disease screening tests
Cervical cancer screenings with Human Papillomavirus (HPV) tests	Colorectal cancer screening tests
Counseling to prevent tobacco use	Depression screening
Glaucoma screening	Hepatitis screening (B and C)
High intensity behavioral counseling to prevent STIs	Human immunodeficiency virus screening
Intensive behavioral therapy for cardiovascular disease	Intensive behavioral therapy for obesity
Lung cancer screening	Mammography screening
Medical nutrition therapy	Pap tests screening
Prostate cancer screening	Screening pelvic exams, including clinical breast exam
Sexually transmitted infection (STI) screening	Ultrasound Abdominal Aortic Aneurysm (AAA) screening

Source: CMS preventive services: www.cms.gov/medicare/coverage/preventive-services-coverage

of mental health through wellness technique apps — and mental health treatment."

The agency also authorizes providers to report a range of interprofessional consultation and referral services for the diagnosis and treatment of mental health illness. CMS finalized four interprofessional consult HCPCS codes (**G0546-G0549**), which are time-based and range from five minutes to as much as 31 minutes or more. The agency also approved an interprofessional record assessment and management code (**G0550**), and a health record referral service code (**G0551**), which are also time-based. All codes will be payable under the 2025 Part B fee schedule. — *Roy Edroso* (*roy.edroso@decisionhealth.com*) ■

Quality Payment Program

CMS slow-rolls QPP/MIPS progress, with eye toward electronic reporting

The changes to the Quality Payment Program (QPP) and Merit-Based Incentive Payment System (MIPS) in the physician fee schedule final rule show CMS cautiously pushing forward into new forms of reporting and quantifying provider performance, with a focus on programs such as the Alternative Payment Model (APM) Performance Pathway (APP) Plus quality measure set and MIPS Value Pathways (MVP) (*PBN 11/11/24*). The long-term hope is to achieve universal quality reporting for all patients regardless of payer.

The original APP method of reporting rolled out in 2021 was meant for Medicare Shared Savings Program (MSSP) accountable care organizations (ACO), though other ACO-based MIPS reporters were invited to use it (*PBN 12/14/20*). Some ACOs were upset at the change because it killed the popular Web Interface reporting method, the transition for which was partially delayed through this year.

More importantly, APP was meant to push ACOs into full electronic clinical quality reporting (eCQM), with which CMS hoped to make universal reporting for performance regardless of payer (the "all-payer/all-patient" idea) possible (*PBN 7/25/22*).

But on that score many ACOs have stalled. CMS has tried to help them along with MIPS CQMs, a sort of easy-mode eCQM specific to MIPS reporting categories but, like eCQMs, reportable for all patients regardless of payer.

However, both all-payer modes have lagged. CMS reports in the final rule that "in 2021, 12 out of 475 ACOs reported eCQMs/MIPS CQMs under the APP, while 37 out of 482 ACOs reported eCQMs/MIPS CQMs in performance year 2022."

In 2024, CMS added Medicare CQMs, which are MIPS CQMs that are reported on an ACO's Medicare fee-for-service population (*PBN 7/24/23*). In this year's proposed rule, the agency considered dropping MIPS CQMs as a separate category.

5-year plan for full eCQM

But MIPS CQMs are still in the picture, at least for a few years. Also note that APP becomes APP Plus in 2025. Mandatory in MSSP, APP Plus will eventually comprise 11 measures, but in 2025 will require reporting of four clinical quality measures, the CAHPS for MIPS survey, and one administrative claims-based measure. For now users can still report via a mix of CQM types, but CMS warns that after five years providers will be required to go full eCQM.

The idea is to "cover as many Medicare beneficiaries as possible," says Dave Halpert, chief of client team, Roji Health Intelligence in Chicago. "Since CMS intends to have all traditional Medicare beneficiaries in an accountable care relationship with a provider by 2030, a relevant quality reporting component needs to be in place. To facilitate this for both attributed ACO patients and the population at large, CMS is incentivizing all-patient reporting."

To push this all-patient model, CMS is extending its all-patient reporting incentive: An ACO earning a performance score greater than or equal to the 10th percentile of the benchmark on at least one of four outcome measures, and a score at or above the 40th percentile on at least one of the remaining measures, can meet the Quality Standard for maximum shared savings if they report MIPS CQMs or eCQMs.

And for eCQM reporters there's also a one-point-per-eCQM "Complex Organization Adjustment" for Virtual Groups and APM Entities including Shared Saving Program ACOs. This adjustment may not exceed 10% of the total available measure achievement points, and will

(continued on p. 6)

Benchmark of the week

Conversion factor impact will vary for high utilization codes

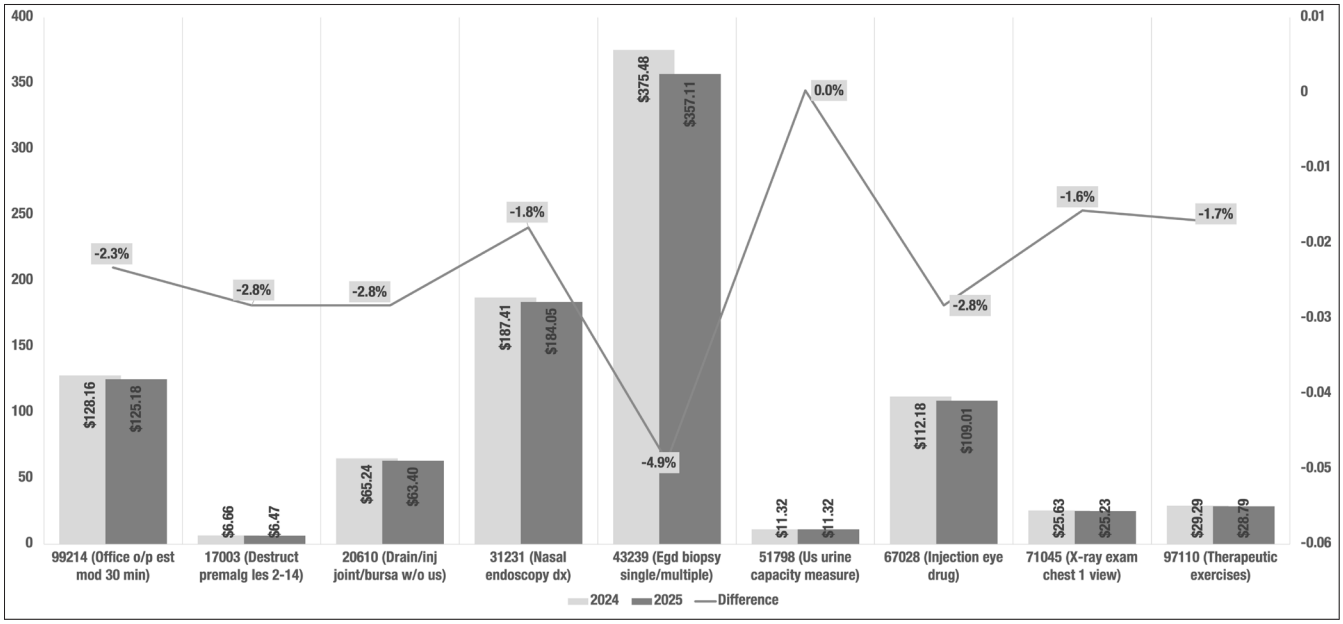
You've read about the coming 2.8% pay cut that is on deck for 2025 (*PBN 11/11/24*). However, a closer look at specific codes reveals that the impact of the cut will vary across services that are covered under the final 2025 Medicare physician fee schedule.

To create this benchmark *Part B News* reviewed the latest Medicare Part B claims data to find the CPT codes for procedures with the highest utilization for each chapter of the CPT manual and are paid under the Medicare physician fee schedule.

The following chart shows the national, non-facility payments for each selected code in 2024 and 2025, along with the change in payment as a percentage. Codes such as **17003** (Destruct premalg les 2-14) and **20610** (Drain/inj joint/bursa w/o us) will experience the 2.8% cut. But the cuts to codes such as **31231** (Nasal endoscopy dx) and **97110** (Therapeutic exercises) will come in under 2%.

Note also the two ends of the conversion factor cut with reimbursement for **51798** (Us urine capacity measure) staying the same, while **43239** (Egd biopsy single/multiple) will experience a 4.9% cut. — *Julia Kyles, CPC (julia.kyles@decisionhealth.com) with additional reporting by Laura Evans, CPC (laura.evans@decisionhealth.com)*

National, non-facility fee update for top E/M, procedure services



Source: Part B News *analysis of 2023 Medicare claims data and the final 2025 Medicare physician fee schedule addenda files, www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1807-f*

(continued from p. 4)

be given only when the reporter meets case minimum and data completeness standards for the eCQM.

"We're delighted that CMS seems to be recognizing that ACOs need flexibility in how they report quality measures, particularly in complex organizations," says Ashley Ridlon, vice president of health policy with Evolent Health. "There's a new complex organization adjustment that starts in 2025 as an incentive to report eCQMs, which fortunately recognizes that there is added burden for APM entities with multiple provider groups and electronic health record systems."

eCQM or dCQM?

Ridlon points out, though, that there's another complicating factor for eCQMs: CMS' initiative to introduce digital CQMs (dCQM). In 2021, the U.S. Office of the National Coordinator for Health IT (ONC) put out, via its Electronic Clinical Quality Improvement (eCQI) Resource Center, a dCQM Strategic Roadmap, "with the goal of advancing quality measurement by transitioning all quality measures used in its reporting programs to digital quality measures." As of this writing, no due date has been announced.

Ridlon's company and other stakeholders "have recommended that CMS not require eCQMs until dCQMs are possible," she tells us. "The challenge is that you may invest in and build capacity around one reporting mechanism and then that mechanism changes and you have to start from scratch again — so why not skip eCQMs and go right to DQMs if that's the ultimate goal?"

MVP PDQ or DOA?

The MIPS-MVP transition is not going so quickly. Though the new reporting and scoring paradigm was announced in 2019 and partially introduced on a voluntary basis in 2021, and it continues to accrete "pathways" and measures, CMS has still not announced a full implementation date (*PBN 8/8/2019*).

Halpert is not concerned, though. "CMS sees MVPs as the future of MIPS," he says. "While they have not proposed a date to sunset traditional MIPS, its days are numbered. By freezing the minimum performance threshold, data completion threshold, and easing Improvement Activity requirements, CMS is providing a window of stability so that clinicians can make the jump to MVPs now, so that they have the experience they need to succeed once traditional MIPS is phased out."

Ridlon points out, though, that there's a complicating factor for MVP or indeed any major CMS initiative: the election of Donald Trump, and an expected new hostility toward federal programs (*PBN 9/26/24*).

"I think we can expect CMS will continue to look at MVPs, perhaps in a broader context," Ridlon says. "Will they be kicking the can down the road on physician payment cuts, or is there an appetite for broader reform on things like MACRA [the law that authorized QPP/MIPS]? And what's the appetite for that next year, versus what gets done in the lame duck session?"

Basics: Mostly status quo

In the here-and-now, the traditional MIPS reporting done by most QPP reporters retains the 75-point performance threshold and 75% data completeness criteria threshold, with scoring weights at 30% for the quality performance category, 30% for cost, 15% for improvement activities and 25% for promoting interoperability.

The rule finalizes 195 quality measures with 10 measures removed from the current 198, and seven added, including Adult COVID-19 Vaccination Status (**Q508**) and Melanoma: Tracking and Evaluation of Recurrence (**Q509**). Six new cost measures are added: the acute inpatient medical condition measure Respiratory Infection Hospitalization, and the five chronic condition measures Chronic Kidney Disease, End-Stage Renal Disease, Kidney Transplant Management, Prostate Cancer, and Rheumatoid Arthritis. Also, there's a new cost scoring methodology in which the median cost for a measure will be set at "achievement points" equal to 10% of the performance threshold; thus, for 2024, it's 7.5.

There are two new improvement activities in the population management category: Implementation of Protocols and Provision of Resources to Increase Lung Cancer Screening Uptake; and Save a Million Hearts: Standardization of Approach to Screening and Treatment for Cardiovascular Disease Risk. Promoting interoperability standards are unchanged from 2024. The methodology for determining the MIPS complex patient bonus for "safety net practitioners" based on practice size and performance threshold remains stable.

For the Advanced APM track of the QPP, Qualifying APM Participants (QP) continue to receive an APM Incentive Payment amount of 1.88% of the

eligible clinician's estimated aggregate payments for covered professional services, plus a higher PFS payment rate than non-participants calculated using the qualifying APM conversion factor. — *Roy Edroso* (*roy.edroso@decisionhealth.com*) ■

RESOURCE

- ONC, "dCQM Strategic Roadmap": *https://ecqi.healthit.gov/dqm?qt-tabs_dqm=dqm-strategic-roadmap*

Medicare Shared Savings Program

After 'banner year,' Shared Savings pushes ahead with bold changes, good numbers

The change of quality reporting method for accountable care organizations (ACO) in the Medicare Shared Savings Program (MSSP) from APP to APP Plus is significant, and will grow even more important with the proposed full switch-over to electronic clinical quality measures (eCQM) in five years (*see the Quality Payment Program article, p. 4).* But other bold strokes, like the new prepaid model and the Health Equity Benchmark Adjustment (HEBA), are expected to have a more immediate effect.

"The [MSSP] policies in the CY 2025 PFS final rule are expected to further drive growth in participation, particularly in rural and underserved areas, promote equity, and advance alignment across accountable care initiatives, and are central to achieving CMS' goal of having 100% of people with traditional Medicare in a care relationship with accountability for quality and total cost of care by 2030," CMS says.

As the rule points out, 19 MSSP ACOs are already getting advance investment payments (AIP) for "caring for underserved communities" in the health-equity-conscious Primary Flex model under CMS' Center for Medicare and Medicaid Innovation (CMMI) (*PBN 4/1/24*). The new prepaid option, which authorizes upfront payment to certain MSSP participants on the condition that they devote 50% of the payment to the provision of "direct beneficiary services … not otherwise payable in traditional Medicare," has been finalized without significant changes from the proposed rule.

Notably, the mention of specific direct beneficiary services that was made in the proposed rule, e.g. meals, dental, vision or hearing coverage, was not repeated in the final.

"CMS certainly received a lot of feedback that the 50% requirement to use pre-paid shared savings for certain things ['non-Medicare covered services'] is a major departure from how the program operates today," says Ashley Ridlon, vice president of health policy with Evolent Health. "Having more flexibility is generally preferred. I think it's reasonable to assume there will have to be more guidance there."

The Health Equity adjustment, in which an MSSP ACO's benchmark is upwardly adjusted if at least 15% of assigned beneficiaries are enrolled in Medicare Part D low-income subsidy (LIS) or are dually eligible for Medicare and Medicaid, is "critical," says Dave Halpert, chief of client team, Roji Health Intelligence in Chicago.

"In order to ensure that all traditional Medicare beneficiaries are in an accountable care relationship, support for ACOs in rural and underserved areas is critical," Halpert says. With this adjustment, "to entice providers in these areas, an ACO will be able to spend more on patient care before crossing from shared savings into shared losses. The HEBA will also offset the CBO's finding that ACOs launching in rural and underserved communities have higher start-up costs than their peers. Furthermore, this will help to mitigate the historically — and unfortunately — low health care spending trends in rural and underserved communities."

Ridlon and Halpert believe these investments are promising for the program, which CMS reports now stands at "480 ACOs with over 634,000 health care providers and organizations providing care to over 10.8 million assigned beneficiaries," and which the Biden administration recently reported had yielded $2.1 billion in savings for the Medicare fund in 2023 alone.

"It's been a banner year for the Medicare Shared Savings Program," Ridlon says. "All of the changes in this rule are mainly at the margins, tweaks to improve the program. Regardless of politics and changes in administration, the work will continue to make this program better."

Note other changes

Along with technical changes in benchmarking and other metrics, CMS made a number of other program changes including:

A break for sub-5,000 ACOs. When an MSSP ACO's assigned population fall below 5,000 beneficiaries during their agreement period, they're supposed to submit a corrective action plan (CAP), whereupon CMS adjusts their Minimum Savings Rate (MSR)/ Minimum Loss Rate (MLR) so "both CMS and the ACO from inappropriate over or underpayments" until such time as the ACO either gets back to 5,000 beneficiaries or is cut from the program. CMS proposes no longer cutting such ACOs, although they must have 5,000 at the outset of any reporting period or they cannot join or re-up.

Sharing with the feds. New entrants must agree that CMS may share their application information with "the Antitrust Agencies" — that is, the U.S. Federal Trade Commission (FTC) and the U.S. Department of Justice (DOJ).

New non-primary beneficiary assignment codes, standard. Attribution of beneficiaries to an ACO has traditionally been based on their utilization of primary care services as indicated by selected CPT and HCPCS codes billed by an ACO-affiliated primary care physician. CMS will now add 14 new primary care codes as well, including the post-discharge telephonic follow-up contacts intervention code **G0544**; advanced primary care management services codes **G0556, G0557** and **G0558**; and the direct care caregiver training services codes **G0541, G0542** and **G0543**. (The interprofessional consultation codes that had been proposed were not finalized for attribution.)

Also, CMS will allow ACOs in certain circumstances to assign MSSP beneficiaries to entities participating in certain disease- or condition-specific CMS Innovation Center ACO models, such as the Comprehensive ESRD Care (CEC) model.

Significant, anomalous, and highly suspect (SAHS) billing activity. As proposed, CMS "will exclude payment amounts from expenditure and revenue calculations for the relevant calendar year for which the SAHS billing activity is identified, as well as from historical benchmarks used to reconcile the ACO for a [relevant] performance year."

Beneficiary notification requirement modifications. ACOs already have to provide notification to beneficiaries when they have been assigned; now they must also send a follow-up notice no later than 180 days after the first one. — *Roy Edroso* (*roy.edroso@decisionhealth.com*) ■

Coding

New 'enhanced care' codes include tough reporting requirements

The enhanced care management codes floated in the physician fee schedule proposed rule have been cleared, including "advanced primary care management services" (APCM) that promise to level up primary care treatment of patients with chronic conditions — if their providers can meet the terms (*PBN 7/22/24*).

APCM services are to be directed by a physician or other qualified health care professional "who is responsible for all primary care and serves as the continuing focal point for all needed health care services," CMS says, and provided by their clinical staff. While the services resemble other Medicare care management services, such as chronic care management (CCM), the APCM codes are not based on time but on patient condition and eligibility status.

For example, the Level 1 code **G0556** is for care of a patient with "one or fewer chronic conditions … expected to last at least 12 months or until the patient's death and or that place them at significant risk of death, acute exacerbation and or decompensation, or functional decline." Level 2 (**G0557**) is for patients who have two or more chronic conditions, and Level 3 (**G0558**) should be reported when the patient has two or more chronic conditions and is a Qualified Medicare Beneficiary.

Providers must obtain at least verbal consent for the service from patients. Also, APCM payment can be made to only one provider for services in any single month, and cannot be billed concurrently with codes for principal care management (PCM), transitional care management (TCM), interprofessional internet consultation (IPC), remote evaluation of patient videos/ images (**G2250**), virtual check-in (**G2251, G2252**), or e-visits (**98970, 98971, 98972, 99421, 99422** and **99423**). However, services may be rendered by auxiliary personnel under general supervision.

Check out extensive billing elements

Billing providers and their teams have a lot to do: They must coordinate "continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments" and "deliver care in alternative ways to traditional office visits to best meet the patient's needs, such as home visits and/or expanded hours."

Also, patients must receive "overall comprehensive care management" run by "a clinically trained individual in the practice who is accountable for active, ongoing care management that goes beyond office based clinical diagnosis and treatment"; a "comprehensive electronic care plan"; "management of care transitions," which includes a "requirement for timely follow-up communication within 7 days of an ED visit or hospital discharge"; "practitioner, home-, and community-based care coordination"; "enhanced communications opportunities" including "remote evaluation of pre-recorded patient information and interprofessional telephone/internet/EHR"; and "'performance measurement' of primary care quality, total cost of care, and meaningful use of CEHRT."

But CMS did strike a proposed requirement that providers have the ability to "analyze patient population data to identify gaps in care and offer additional interventions, as appropriate." (While CMS considers that "beneficial," they "agree with commenters that it is not necessary to require the practitioner to conduct this work.")

For some providers this will also involve a push into CMS's so-far-voluntary MIPS Value Pathway (MVP) model. Providers who are MIPS participants and not already qualified to provide this level of treatment by their participation in the ACO REACH Model, the Making Care Primary model, or the Primary Care First model "must register for and report the Value in Primary Care MVP for the performance year in which they bill for APCM services."

Also under the "enhanced" umbrella are codes for assessment and care of atherosclerotic cardiovascular disease (ASCVD): **G0537** (Administration of a standardized, evidence-based ASCVD risk assessment for patients with ASCVD risk factors on the same date as an E/M visit, 5-15 minutes, not more often than every 12 months) and, for patients found at assessment to be at medium or high risk of cardiovascular disease, **G0538** (ASCVD risk management services, per month). — *Roy Edroso* (*roy.edroso@decisionhealth.com*) ■

Code	Short descriptor	wRVU	Total NFRVU	NF National $
G0537	Risk ascvd tst once pr 12 mo	0.18	0.57	$18.44
G0538	Ascvd rsk mng clin stf pr mo	0.18	0.47	$15.20
G0539	Initial care training 30 m	1.00	1.61	$52.08
+G0540	Train for caregiver add 15	0.54	0.79	$25.55
G0541	No pt prsnt train initial 30	1.00	1.61	$52.08
+G0542	No pt prsnt train add 15	0.54	0.79	$25.55
G0543	Group train w/o patient	0.23	0.68	$22.00
G0544	Post d/c phone follow up	1.00	1.91	$61.78
+G0545	Inherent visit to inpt	0.89	1.33	$43.02
G0546	Phone/internet ehr assess	0.35	0.53	$17.14
G0547	Phone/internet svs 11-20 m	0.70	1.07	$34.61
G0548	Phone/inter svs 21-30 m	1.05	1.62	$52.40
G0549	Phone/inter for treat>31m	1.40	2.17	$70.19
G0550	Phone/inter for dx/treat >5m	0.70	1.00	$32.35
G0551	Phn/intr svs fr dx treat 30m	0.70	1.05	$33.96
G0553	Monthly tx for dmht 20mins	0.62	1.60	$51.75
+G0554	Add 20 m of monthly tx	0.61	1.23	$39.79
G0556	Adv prim care mgmt lvl 1	0.25	0.47	$15.20
G0557	Adv prim care mgmt lvl 2	0.77	1.51	$48.84
G0558	Adv prim care mgmt lvl 3	1.67	3.31	$107.07
+G0559	Unrelat prac follow up visit	0.16	0.27	$8.73
+G0560	Safety plan interven	1.09	1.28	$41.40

Physician payments

Review the pay rates for 22 new HCPCS codes

Take note of the final payments for new HCPCS codes that CMS will cover effective Jan. 1, 2025.

The majority of new codes expand behavioral health services but services such as atherosclerotic cardiovascular disease (ASCVD) risk assessment and management (**G0537-G0538**), infectious disease consults **G0545** and advanced primary care management (**G0556-G0558**) are included in the list of new codes.

CMS stuck with the work relative value units (wRVU) it released in the proposed rule, with the exception of a level 1 primary care management code, where CMS boosted the wRVU from 0.17 to 0.25. The following chart contains the wRVUs, total non-facility RVUs (NFRVU) and the national payment for the service in the non-facility setting.

See the chart, p. 9, for the 2025-effective fees. — *Julia Kyles, CPC* (*julia.kyles@decisionhealth.com*) ■

Physician fee schedule

Fee schedule round-up: Dental services, MDPP, vaccine fee rates and more

Discover additional coverage and policy changes contained in the final fee schedule, from an expansion of dental services and vaccine payment rates to diabetes program changes and overpayment rules. The round-up below digs into the deeper, but no less important, portions of the final rule.

ESRD approved for dental services. Last year CMS allowed payment for dental services "inextricably linked" to certain covered head and neck cancer diagnostic and treatment services, including some post-cancer-treatment dentistry for "oral complications," notwithstanding dental services in general cannot by law be provided by Medicare (*PBN 11/20/23*). At that time the agency also established a process by which the public could submit other suggested dental-coverage opportunities.

This year CMS considered and rejected coverage of dental care related to side effects of treatment of sickle cell disease (SCD) including hydroxyurea; related to hemophilia, which can lead to "serious gum bleeding" issues; related to diabetes; and related to systemic autoimmune diseases such as lupus and Crohn's disease that require immunosuppressive therapies with dental implications.

But CMS agreed dental services "are inextricably linked to the clinical success of the medical service" in treatment of end stage renal disease (ESRD) and approved them for "workup prior to dialysis services" and to "eliminate an oral or dental infection prior to, or contemporaneously with, dialysis services." (CMS added that dental implants or crowns might not be covered because they "have other uses in the dental space.")

CMS also approved a requirement that claims for dental services they had cleared in dental claim format 837D and professional claim format 837P must be submitted with appropriate diagnosis codes, modifier **KX** (Requirements specified in the medical policy have been met) and, if denial is sought, modifier **GY** (Item or service statutorily excluded), starting July 1, 2025.

Vaccine administration payment rates on the rise in 2025. Applying to vaccine administration codes **G0008** (influenza), **G0009** (pneumococcal) and **G0010** (hepatitis B), payments will jump by 3.5%, the same rate as the Medicare Economic Index (MEI) increase factor. The same rate increase also applies to in-home additional payments for Part B vaccine administrations, reported via code **M0201**. Before geographic adjustments, the 2025 payments rates will be $33.71 for G0008, G0009, G00010 and $33.90 for M0201. The year-to-year payment rate for COVID-19 vaccine administration (**90480**) depends on whether the emergency use authorization (EUA) for COVID-related products remains in effect through the end of CY 2024. If the EUA is terminated prior to Jan. 1, the payment rate for 90480 will be the same as other Part B-covered vaccine administrations, or $33.71. Should the EUA continue into CY 2025, the pay rate for 90480 will be $44.95 in 2025.

Hepatitis B vaccine eligibility is expanded. You may find that more patients are eligible for the hepatitis B vaccine than in years past now that CMS has expanded coverage parameters to include "individuals who have not previously received a completed hepatitis B vaccination series and individuals whose previous history is unknown." CMS is also removing from the Benefit Policy Manual and Claims Processing Manual its mandate that requires

a doctor's order for the vaccine. Additionally, CMS "will also change our procedures to allow mass immunizers to use the roster billing process to submit Medicare Part B claims for hepatitis B vaccines and their administration," the agency states in the final rule. The expansion of coverage guidelines was a popular shift, according to CMS. "All the commenters supported the proposals to expand access to the hepatitis B vaccine in order to increase utilization," the agency says.

Coverage for colorectal cancer screening updated. CMS is making several changes to its policies for colorectal cancer screening tests under Part B coverage. Effective Jan. 1., the barium enema procedure will no longer be covered. However, CMS is adding coverage for the computed tomography colonography (CTC) procedure and also expanding the definition of "complete colorectal cancer screening" so that it will include "a follow-on screening colonoscopy after a Medicare covered blood-based biomarker" screening test. The screening CTC must be ordered in writing by the patient's physician, physician assistant, nurse practitioners or clinical nurse specialist, CMS says.

Work RVUs for acupuncture drop, supply prices jump. CMS is reducing the work relative value units (RVU) for two acupuncture codes, **97811** and **97814**, by 13% and 7%, respectively. Some commenters weren't pleased, telling CMS that "the reduction of the work RVUs could potentially discourage the delivery of acupuncture and limit the availability of this beneficial service to the elderly population." However, without further data, CMS is sticking with the RBRVS Update Committee's recommended valuations for 2025. In a related change, supply prices for acupuncture needles (SC075) will leap from $0.10 to $0.199 per unit in 2025, a 99% increase.

Medicare Diabetes Prevention Program (MDPP) changes. The Centers for Disease Control and Prevention (CDC) made changes to its Diabetes Prevention Recognition Program in June, and CMS is making updates to the MDPP to reflect these.

CMS adds a new term, "in-person with a distance learning component," defined as "MDPP sessions that are delivered in person by trained coaches where participants have the option of attending sessions via MDPP distance learning." They give as an example "participants choosing from session to session which mode (in-person or distance learning) they wish to use." CMS also adds "combination with an online component" for mixed live/non-live online sessions, and removes its prior "online delivery" term, switching in "online" to describe completely asynchronous (non-live) sessions.

CMS will continue to allow beneficiaries to restart their MDPP program beyond the original once-per-lifetime if their services were interrupted by the COVID-19 public health emergency.

The self-reported weight totals MDPP currently allows either require a live weigh-in via "live, synchronous online video technology" in which the MDPP coach observes the weigh-in, or the delivery of a time-stamped image or video recording of same. Now, if the beneficiary is able to capture both their body and their weight on a digital scale in one time-stamped photo, that suffices; if not, they must send two, one showing weight on the digital scale, and another showing "the beneficiary visible in their home," both date-stamped.

MDPP bridge payment is suspended. While it was meant to "account for the financial risk a subsequent MDPP supplier took on by furnishing services to a beneficiary changing MDPP suppliers," it is now thought to be unnecessary as well as a fraud risk. Also, if a MDPP make-up session is held on the same day as a regularly scheduled MDPP session, suppliers are instructed to report modifier **76** (Repeat procedure or service by same physician or other qualified health care professional) instead of **79** (Unrelated procedure or service by the same physician during the postoperative period).

New overpayments rules: FCA standard, 180-day window. The rule finalizes two major changes for Part A and B overpayments: The current "reasonable diligence" standard for discovery of overpayments will be replaced by the "knowing" or "knowingly" standard used in the False Claims Act (FCA); and the current 60-day report-and-repay timeline is changed to a 180-day period within which a "timely, good faith investigation to determine the existence of related overpayments that may arise from the same or similar cause or reason as the initially identified overpayment" may be conducted and the debt repaid. (Many commenters to the proposed rule sought a longer period than 180 days, but were rebuffed.)

CMS also reaches back to a never-finalized overpayment rule for Parts C and D to establish that "knowing" or "knowingly" standard for overpayments

made to Medicare Advantage organizations (MAO) and Part D sponsors. But it does not expand the report-and-repay timeline, which remains at 60 days, in part because, CMS says, MAOs "have from the beginning of the data collection period through the final risk adjustment data submission deadline, which is a minimum of 13 months, to investigate any issues with their data submissions and submit corrections."

RHC and FQHC policy updates. CMS has been allowing rural health clinics (RHC) and federally qualified health centers (FQHC) to bill general care management code **G0511** using an approach based on an average of related services including chronic care management (CCM), remote physiologic monitoring (RPM) and chronic pain management. But stakeholders have asked for the right to bill those codes separately, and to "bill the add-on codes for additional time spent once the minimum threshold of time was met to account for a complete encounter."

So CMS will unbundle those codes, listed in Table 28 of the final rule, and give RHCs and FQHCs until July 1, 2025, "to implement systems changes needed to incorporate the change for billing purposes." But starting Jan. 1, RHCs and FQHCs "that have the infrastructure in place to report the individual HCPCS codes that describe the individual services may do."

CMS lists the codes affected and notes that not all similar codes will be unbundled — for example, "since cognitive assessment and care planning and the ASCVD risk assessment services happen in face-to-face visits with a provider, they would be included in the RHC AIR and the FQHC PPS and not be paid separately."

CMS will also let RHCs and FQHCs bill for the new advanced primary care management (APCM) services with **G0556**, **G0557** and **G0558**.

In a holdover from the COVID-19 public health emergency, CMS will continue to allow RHCs and FQHCs payment for nonbehavioral medical health visits furnished via telehealth in an "amount based on the average amount for all Medicare telehealth services paid under the PFS, weighted by volume"; to allow direct supervision of care by a physician or other practitioner for services to be provided virtually by audio/video real-time communications technology excluding audio-only through Dec. 31, 2025; and to delay a proposed requirement that mental health services furnished via telehealth be preceded by an in-person visit until Jan. 1, 2026.

Intensive outpatient program (IOP) services are currently paid to RHCs and FQHCs at a three-service-per-day payment rate. CMS adjusts that to a four-or-more-services-per-day rate in 2025. Also, FQHC beneficiaries do not have to meet a deductible before Medicare begins to cover their services.

CMS also proposes to harmonize the billing of Part B preventive vaccines under the program and allow RHCs and FQHCs to bill administration of pneumococcal, influenza, hepatitis B and COVID-19 vaccines at the time of service, with vaccine products paid at 95% of the Part B Average Wholesale Price (AWP) and vaccine administration paid according to the Part B fee schedule, and to make them eligible for additional payment for in-home Part B preventive vaccine administration. This policy will be delayed, however, until July 1, 2025.

In payment, CMS proposes to abandon its long-standing "productivity" adjustment to payment at RHCs. FQHCs will retain the adjustment and their market basket update in 2025 of 4.0% will be productivity-adjusted to 3.4%. The recent allowance of Part B providers to bill some dental services related to covered Medicare procedures is also extended to RHCs and FQHCs, and would be paid under the AIR/PPS.

While both RHCs and FQHCs are required by statute to provide primary care services to their patient populations, in order to offer greater flexibility in care offerings CMS will no longer enforce the standard of RHCs "being primarily engaged in furnishing primary care services." CMS declined to do the same for FQHCs, in part because these clinics are overseen by the U.S. Health Resources and Services Administration (HRSA) rather than CMS.

CMS withdraws a proposal that "RHCs cannot be a rehabilitation agency or a facility primarily for the care and treatment of mental diseases," in accordance with "the HHS strategic goal to protect and strengthen equitable access to health care." It also finalizes a proposal that relieves RHCs from a requirement to directly perform hemoglobin and hematocrit tests and examination of stool specimens for occult blood. — *Roy Edroso* (*roy.edroso@decisionhealth.com*) *and Richard Scott* (*richard.scott@decisionhealth.com*) ■