2025 Medicare Physician Fee Schedule Proposed Rule Highlights

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PROFESSIONAL

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On July 10, 2024, the Centers for Medicare & Medicaid Services (CMS) released the CY 2025 Medicare physician fee schedule (PFS) proposed rule. The comment period closes on September 9, 2024, and the final rule is expected by November 1, 2024. If finalized, these policies would generally take effect on January 1, 2025. This article covers certain proposals but does not include an exhaustive list.

Proposed conversion factor

The proposed conversion factor (CF) for 2025 is $32.3562, which represents a 2.8 percent decrease from the 2024 CF. The lower CF reflects the expiration of previous congressional appropriations as well as the 0.00 percent update adjustment factor and a budget neutrality adjustment. The CF is the multiplier by which Medicare payments are calculated – physicians and practitioners should look at specialty-specific impact for a more accurate accounting. The proposed 2025 anesthesia CF is $20.3340, which represents a 2.1 percent reduction from 2024.

Takeaway: As in recent years, physicians face reimbursement cuts in 2025. CMS has little discretion in what it has "proposed," as the conversion factor for 2025 is statutorily set. Congress's appetite to step in and fully mitigate the cut has waned due to the cost associated with a complete payment "fix" and the complexities involved in moving forward with Medicare payment reform. We may see some congressional action to address the CF cuts and the potential PAYGO cut, but that is unlikely before the election.

Telehealth

The Consolidated Appropriations Act of 2023 (CAA, 2023) extended many COVID-19-era telehealth flexibilities through December 31, 2024. Absent congressional action by the end of the year, most critical flexibilities will lapse, i.e., revert to their pre-Public Health Emergency (PHE) status, such as the ability to treat a patient in their home, unless for certain services like behavioral health. While CMS is constrained by statute, there are certain areas within its jurisdiction that the agency can change without congressional action, such as adding services to the telehealth list.

Additions to the Medicare Telehealth Services List

Over the years, CMS has modified its process for adding or deleting services from the Medicare telehealth services list. Originally, CMS assigned requests to add services to the list as "Category 1" (services similar to those currently on the telehealth list) or "Category 2" (services not similar to those on the telehealth list.) In the 2021 PFS final rule, CMS created an additional category — "Category 3" — which included services added to the list during the COVID-19 PHE for which there was a likely clinical benefit to be furnished through telehealth, but still

needed to meet Category 1 or 2 criteria. In the 2024 PFS final rule, CMS once again changed its process by consolidating the 3 categories and instead finalized a 5-step process for making changes to the list. Services will now be considered "provisional" or "permanent" for purposes of staying on the telehealth list. CMS received requests to permanently add certain services to the list for 2025, such as radiation treatment management and caregiver training. CMS proposes to add the following services to the telehealth list for 2025: PrEP for HIV, home international normalized ratio (INR) monitoring and caregiver training.

Frequency Limitations

CMS historically placed frequency restrictions on how often practitioners could furnish subsequent hospital care services, subsequent nursing facility visits, and critical care consultations. During the COVID-19 PHE, CMS removed these frequency limitations and continued to suspend them through 2024. For 2025, CMS proposes to once again remove frequency limitations for those same codes.

Supervision

During the COVID-19 PHE, CMS relaxed direct supervision requirements — changing the definition of "direct supervision" to allow a supervising practitioner to be immediately available through a virtual presence using real-time audio/video technology. This definition was extended through 2024 in last year's final rule. CMS proposes to again extend this definition through 2025 and seeks additional information about safety and quality of care concerns. CMS also proposes to permanently define direct supervision (beyond 2025) that allows "immediate availability" of the supervising practitioner using audio/video real-time communications technology for (1) services described by CPT code 99211, a lower level E&M code, and (2) services furnished incident to a physician or practitioner's service when provided by auxiliary personnel employed by the billing practitioner and working under their direct supervision (the underlying Healthcare Common Procedure Coding System (HCPCS) code must be assigned a PC/TC indicator of '5'). CMS additionally proposes to extend its current policy to allow teaching physicians to have a virtual presence for services furnished involving residents when the service is furnished virtually through 2025.

Audio-only

CMS proposes to revise its regulation to state that an "interactive telecommunications" system may include two-way, real-time audio-only communication technology for any telehealth service furnished to a beneficiary in the home if the distant site practitioner is *capable* of using two-way, real-time audio-only communication technology but the patient does not consent to or is not capable of the use of video. As a reminder, if Congress does not pass legislation to extend the current flexibilities, these audio visits would only be available for behavioral health visits. A modifier must be used for these services.

Providers' home addresses

During the COVID-19 PHE, more telehealth practitioners ("distant site practitioners") rendered telehealth services from their homes, creating concerns about privacy and potential safety if they were required to update their Medicare 855 enrollment information to reflect their home address. In last year's rule, CMS received comments voicing those concerns. For 2025, CMS proposes to continue allowing distant site practitioners to use their currently enrolled practice location rather than their home address when furnishing telehealth services from their homes.

Takeaway: CMS is restricted to what it has the authority to do regarding telehealth expansion. Major changes must come from Congress, such as eliminating the geographic and originating site restrictions for all services. The concerns around permanent expansion and reform remain focused on cost and quality of care. While Congress may not permanently reform telehealth, they are likely to step in and extend for one to two years the current flexibilities as to avoid a "telehealth cliff" and give a future Congress more time to adopt a long-term approach. Any action will likely occur after the election in a lame duck session.

Evaluation and management (E/M) visits

CMS previously finalized add-on HCPCS code 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. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)).* Due to its cost and impact on the CF, Congress delayed its implementation for 3 years, until 2024. CMS continues to provide more clarity around when it is

appropriate to bill this code. In this rule, CMS proposes to allow payment of this add-on code when the E/M base code is reported by the same practitioner on the same day as an annual wellness visit, vaccine administration or Part B preventative service. CMS again emphasizes that the long-term relationship between the patient and the physician/physician practice — not the complexity of the patient's condition — is the determining factor in proper use of G2211.

Outpatient therapy services

CMS proposes to allow for general supervision of occupational therapy assistants (OTAs) and physical therapist assistants (PTAs) by OTs in private practice (OTPPs) and PTs in private practice (PTPPs) when furnishing outpatient occupational and physical therapy services. However, this is subject to what is permitted under State law. Additionally, CMS proposes changes to certification of therapy plans of care to lessen administrative burden. CMS proposes an exception to the signature requirement for purposes of the initial certification in cases where a written order/referral is on file, and it is documented that the treatment plan was transmitted to the physician/NPP within 30 days of the initial evaluation.

Global packages

CMS continues to review payment policies for global surgical packages but makes two proposals in this rule. For 2025, CMS proposes to (1) require that practitioners report transfer of care modifiers for all 90-day global surgery packages whenever a practitioner plans to furnish only a portion of the global package whether there is a formal transfer or not, and (2) develop an add-on code to address resources involved in post-operative care provided by a practitioner who did not perform the surgery (HCPCS code GPOC1). The net effect of the two proposals produces a *positive* budget neutrality adjustment, resulting from a reduction in values in the global package which are not all absorbed in the values attributed to the add-on code.

Dental services

In previous rulemaking, CMS established that fee-for-service (FFS) Medicare payment may be made for dental services "inextricably linked" (IL) to a covered service. In this proposed rule, CMS proposes to add (1) dental or oral examination in the inpatient or outpatient setting prior to Medicare-covered dialysis services for beneficiaries with end-stage renal disease and (2) medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to or with Medicare-covered dialysis services for those with end-stage renal disease to the list. CMS also proposes to require the KX modifier on claims for these inextricably linked dental services, as well as the submission of a diagnosis code on the 837D dental claims beginning in 2025. CMS declined to propose other recommendations from stakeholders for additional IL services, lending further insight into how IL services will be addressed in the future.

Additional Proposals

Radiopharmaceuticals in the physician office

Over the years, there has been confusion about which methodologies are available to Medicare Administrative Contractors (MACs) for pricing of radiopharmaceuticals in physician offices. CMS proposes that MACs can determine payment limits for radiopharmaceuticals based on any methodology in use to determine payment limits prior to enactment of the MMA, i.e. on or prior to November 2003.

Electronic prescribing for controlled substances (EPCS)

For purposes of the CMS electronic prescribing for controlled substances (EPCS) program, CMS proposes to extend the EPCS compliance date for prescriptions written for a beneficiary in a long-term care (LTC) facility from January 1, 2025, to January 1, 2028.

Overpayment

CMS continues to consider earlier overpayment policy proposals, but proposes in this rule, to specify situations under which the deadline for reporting and returning overpayments would be suspended.

Digital mental health treatment devices

CMS proposes new codes for digital mental health treatment (DMHT) devices furnished incident to or integral to professional behavioral health services. In developing these new codes (GMBT1, GMBT2, and GMBT3), CMS proposes the DMHT devices must be cleared by the Food and Drug Administration (FDA).

Advanced primary care management services

In an effort to continue supporting primary care, CMS proposes to build on its experience with discrete primary care models under the Center for Medicare and Medicaid Innovation (CMMI). It proposes the establishment of three new HCPCS G-codes for advanced primary care management (APCM) services. These codes, GPCM1, GPCM2, GPCM3, include shared language from chronic care management and principal care management services. Aside from the focus on primary care, it is noteworthy that CMS is proposing to import services and lessons learned from CMMI Models into FFS — albeit not a full model certified by the Office of the Actuary — under their general authority at Section 1848 of the Act, which might be done with other models in the future.

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