# Proposed CY 2025 MEDICARE PHYSICIAN FEE SCHEDULE

FACT SHEET I July 2024

**On July 10, 2024, the Centers for Medicare and Medicaid Services (CMS) released their proposed Physician Fee Schedule (PFS) for CY 2025.** The PFS provides new policy updates for the Medicare program for the following year. Each year, there has typically been some policy proposed that impacts telehealth. With December 31, 2024 as the current end date to the COVID-19 telehealth policy waivers (See CCHP's Medicare 101 page), many have been waiting to see what CMS would be proposing for 2025. At this time, these are only proposals. The public has until 5 pm September 9, 2024 to provide comments to CMS regarding these proposed policies.

The majority of the proposals appear to be attempts to extend or create a flexible environment to act further should other policy changes impact the current telehealth landscape, such as passage of legislation by Congress, that might again extend the current telehealth waivers, this time beyond the existing end date of December 31, 2024. The language in the proposed PFS illustrates CMS' concern with a potentially abrupt end to the temporary telehealth policies and the impact on Medicare enrollees. Therefore, CMS has attempted to mitigate these impacts (should no further action be taken to change the current December 31, 2024 waiver end date), but acknowledge there are some items that are beyond the scope of their powers.

Note, for ease in locating specific proposals, CCHP has provided the page numbers in the unpublished version of the PFS.

## Audio-Only (page 101)

While current temporary telehealth policy in Medicare allows audio-only to be used to provide certain services, permanent telehealth Medicare policy only allows audio-only to be used to provide mental health services. This change was made in 2022 when CMS included audio-only in the definition of an "interactive telecommunication system" when providing mental and behavioral health services. In the CY 2025 PFS, CMS is proposing once again to change the definition of "interactive telecommunication system" to now allow audio-only for any telehealth service. The proposed definition would read

> *An interactive telecommunications system may also include two-way, real-time audio-only communication technology for any telehealth service furnished to a beneficiary in their home if the distant site physician or practitioner is technically capable of using an interactive telecommunications system as defined as multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication, but the patient is not capable of, or does not consent to, the use of video technology."*

It is also noted that CPT modifiers 93 and FQ should be added to claims for these services, which are identical in meaning use of audio-only, however FQ is specific to use by RHCs and FQHCs.

## Eligible Telehealth Services (page 83)

Each year the public is allowed to submit to CMS proposed service codes to be added to the telehealth eligible services list for Medicare. Last year, CMS changed their process to a five-step assessment in deciding if a code should be added to the list either in a permanent or provisional status. (See CCHP's Final Rule for CY 2024 PFS for more details on the five-step process). Utilizing that process for the first time, CMS is proposing a mix of new services to be added to the telehealth eligible service list for Medicare either in a permanent or provisional status.

### TABLE 1: CMS PROPOSED CODES, DESCRIPTION & PROPOSED STATUS

| CODE | DESCRIPTION | PROVISIONAL/ PERMANENT |
|---|---|---|
| **G0248** | Demonstration, prior to initiation of home inr monitoring, for patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria, under the direction of a physician; includes: face-to-face demonstration of use and care of the inr monitor, obtaining at least one blood sample, provision of instructions for reporting home inr test results, and documentation of patient's ability to perform testing and report results | Provisional |
| **97550** | Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [adls], instrumental adls [iadls], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; initial 30 minutes | Provisional |

## TABLE 1: CMS PROPOSED CODES, DESCRIPTION & PROPOSED STATUS (CONT)

| CODE | DESCRIPTION | PROVISIONAL/ PERMANENT |
|---|---|---|
| **97551** | Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [adls], instrumental adls [iadls], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; each additional 15 minutes (list separately in addition to code for primary service) | Provisional |
| **97552** | Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [adls], instrumental adls [iadls], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face with multiple sets of caregivers | Provisional |
| **96202** | Multiple-family group behavior management/modification training for parent(s)/ guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); initial 60 minutes | Provisional |
| **96203** | Multiple-family group behavior management/modification training for parent(s)/ guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); each additional 15 minutes (List separately in addition to code for primary service) | Provisional |
| **G0011** | Individual counseling for preexposure prophylaxis (PrEP) by physician or QHP to prevent human immunodeficiency virus (HIV), includes: HIV risk assessment (initial or continued assessment of risk), HIV risk reduction and medication adherence, 15-30 minutes | Permanent |
| **G0013** | Individual counseling for preexposure prophylaxis (PrEP) by clinical staff to prevent human immunodeficiency virus (HIV), includes: HIV risk assessment (initial or continued assessment of risk), HIV risk reduction and medication adherence | Permanent |

## TABLE 1: CMS PROPOSED CODES, DESCRIPTION & PROPOSED STATUS (CONT)

| CODE | DESCRIPTION | PROVISIONAL/ PERMANENT |
|---|---|---|
| **GCTD1** | Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (without the patient present), face-to-face; initial 30 minutes | Provisional |
| **GCTD2** | Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service) (Use GCTD2 in conjunction with GCTD1) | Provisional |
| **GCTD3** | Group caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (without the patient present), face-to-face with multiple sets of caregivers | Provisional |
| **GCTB1** | Caregiver training in behavior management/modification for caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face; initial 30 minutes | Provisional |
| **GCTB2** | Caregiver training in behavior management/modification for parent(s)/guardian(s)/ caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service) (Use GCTB2 in conjunction with GCTB1) | Provisional |

## AMA Proposed Telehealth E/M CPT Codes (page 157)

The American Medical Association (AMA) CPT Editorial Board added to the Evaluation and Management (E/M) section a Telemedicine Services part. These codes are to be strictly used when telehealth is the means in which services were provided. Citing several reasons including the similarity to already existing codes and the current requirement for payment parity with a telehealth delivered service that's equivalent to an in-person delivered service, CMS is not adopting the AMA Telemedicine codes at this time with one exception. Noting the similarities between Code 9X091 and G2012, CMS is proposing the deletion of G2012 and replacing it with 9X091. G2012 however is not a telehealth code in Medicare, but a communication technology-based service (CTBS) code and thus is not subject to the telehealth statutory requirements.

CPT codes 99441, 99442, and 99443 were deleted by the AMA CPT Panel. CMS writes that these codes will return to a bundled status when the telehealth flexibilities expire on December 31, 2024. (page 162).

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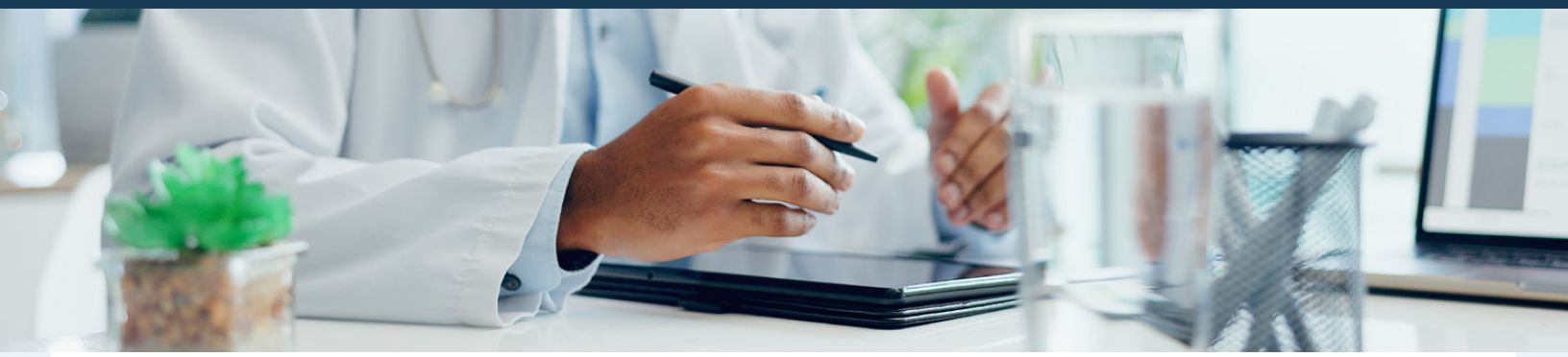

## Frequency Limitations on Inpatient Visits, Nursing Facilities, and Critical Care Consults (page 96)

Frequency limitations for inpatient visits, nursing facilities and critical care consults were among the COVID-19 waivers that were extended to the end of 2024. CMS is proposing removing the frequency limitations to the end of 2025. This will apply to the following codes:

- Inpatient Visits – 99231-99233
- Nursing Facility – 99307-99310
- Critical Care Consult – G0508-G0599

In discussing their reasoning for continuing to remove frequency limitations, CMS states that claims data thus far do not show an increase in utilization nor that these services are being used so often that they meet or exceed the limitations. Nevertheless, CMS states they remain interested in more information from stakeholders on concerns regarding potential acuity and complexity of these patients, which may justify a need for care that cannot be provided only via telehealth and a return to additional limitations.

## Direct Supervision Using Live Video (page 106)

Certain allowances have been made to allow the use of live video to meet direct supervision requirements. These allowances have been temporary and are currently set to end in 2024. CMS proposes the following regarding direct supervision:

- Through December 31, 2025, continue to allow live video to be used by the supervising practitioner to meet "immediate availability" definition.
- Change the definition of direct supervision that would allow "immediate availability" of the supervising practitioner to include live video (audio-only would be excluded) permanently in certain incident-to services.
- Through December 31, 2025, continue to allow teaching physicians to have a virtual presence for billing purposes when services are furnished by residents in any residency training location but only when the service is furnished via telehealth.
- Continue to allow the current flexibility for federally qualified health centers (FQHCs) and Rural Health Clinics (RHCs) to use live video to meet the "immediately available" requirement for direct supervision.

## Federally Qualified Health Centers (FQHCs) & Rural Health Clinics (RHCs) (page 519)

CMS proposes to continue to allow on a temporary basis payment to FQHCs and RHCs for non-behavioral health visits that use telecommunications technology. FQHCs and RHCs are already allowed under permanent policy to provide mental and behavioral health services via telecommunications technology due to a prior change CMS made to the definition of a "mental health visit" for these entities. This proposed temporary policy would allow other non-mental health services to be provided via telehealth by FQHCs and RHCs through 2025. Note, this change would likely not be necessary should the current telehealth waivers be extended beyond December 31, 2024. The reason behind this proposal may be to ensure that should the waivers not be extended, CMS has policy in place to mitigate the effects ceasing telehealth-delivered services will have on Medicare enrollees who receive such services from FQHCs and RHCs.

The proposal also notes:

> *Since the costs associated with non-behavioral health visits furnished via telecommunication technology are not included in the calculations for the RHC AIR methodology and FQHC PPS, we believe that we need to propose a proxy that would represent such resources used when furnishing these services. Therefore, we propose to continue to 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."*

Additionally, CMS is asking for comments on other payment methodologies, as well as potentially redefining "visit" for FQHCs and RHCs to include live video.

CMS is also proposing to 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. (page 529). Note, a similar proposal was not made for other telehealth practitioners. The in-person visit requirement for mental health for other practitioners is in federal statute. The requirement for FQHCs and RHCs was placed upon them as part of CMS' change to the definition of visit mentioned previously which allows CMS to make this change without further action from Congress. For non-FQHC or RHC providers, delaying or waiving this in-person visit would require Congressional action before CMS can act.

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## Opioid Treatment Programs (page 610)

Aligning with regulations adopted by SAMSHA, CMS proposes the following:

- Allow opioid treatment programs (OTPs) to furnish periodic assessments via audio-only on a permanent basis if live video is not available.
- Allow OTP intake add-on code (G2076) to be furnished by live video when it is being billed for the initiation of treatment with methadone.

## Other Proposals

- Originating site fee - $31.04
- CMS is proposing to extend to the end of 2025 the ability of distant site providers to continue to use their currently enrolled practice location address instead of their home address as the location of where they are providing services via telehealth.
- Creation of a newly defined set of Advance Primary Care Management (APCM) for FQHCs and RHCs. The coding for these services incorporates elements of existing CTBS services. (page 513)
- New codes that would allow clinical psychologists, clinical social workers, marriage and family therapists, and mental health counselors to bill for interprofessional consultations with other practitioners whose practice is similarly limited, as well as with physicians and practitioners who can bill Medicare for E/M services and would use the current CPT codes to bill for interpersonal consultations. (page 385)
    - o Additionally new G-codes for behavioral health services (page 387).

## Discussion

> "Much about the CY 2025 PFS is about ensuring there is some transition period for enrollees if there is no additional temporary extension."

As noted earlier, many of the proposals made by CMS are attempts to mitigate a "telehealth cliff" scenario should the December 31, 2024 deadline to the end of waivers hold. Much about the CY 2025 PFS is about ensuring there is some transition period for enrollees if there is no additional temporary extension.

However, there are some intriguing and potentially significant items that speak to potential future policies that could have great impact on the use of telehealth in Medicare. The most obvious is the proposal to add audio-only in the definition of "interactive telecommunications system" for any telehealth service. This would in effect permanently allow audio-only be to be used as a modality to deliver services via telehealth. However, the scope of such a policy change is blunted somewhat by the fact that other permanent limitations, such as geographic and site locations and types of providers eligible to provide services via telehealth under Medicare, will still be in effect (all of which would require a statutory change by Congress).

Another piece of intriguing information is in the discussion regarding the AMA Telemedicine Codes. While CMS is not proposing adopting the majority of these codes at this time, they instead write:

> *"We are seeking comment from interested parties on our understanding of the applicability of section 1834(m) of the Act to the new telemedicine E/M codes, and how we might potentially mitigate negative impact from the expiring telehealth flexibilities, preserve some access, and assess the magnitude of potential reductions in access and utilization. On the latter point, we note that we have developed proposed PFS payment rates for CY 2025, including the statutory budget neutrality adjustment, based on the presumption that changes in telehealth utilization will not affect overall service utilization. We also note that historically we have not considered changes in the Medicare telehealth policies to result in significant impact on utilization such that a budget neutrality adjustment would be warranted. However, we are unsure of the continuing validity of that premise under the current circumstances where patients have grown accustomed over several years to broad access to services via telehealth. We are seeking comment on what impact, if any, the expiration of the current flexibilities would be expected to have on overall service utilization for CY 2025."*

There are two issues in the passage cited above. The first is the applicability of statutory telehealth requirements on new telehealth specific codes (the ones AMA created). A telehealth service is specifically defined in federal law as, "professional consultations, office visits, and office psychiatry services…and any additional service specified by the Secretary." Would the new telehealth codes fit into that definition? If they do not, then the codes may not be held to the same requirements as the current services on Medicare's eligible telehealth services list, similar to the way CTBS services are not.

On the second point, CMS is seeking comments on the utilization of telehealth, particularly since we have now had several years where enrollees have become accustomed to receiving services via telehealth. Utilization and volume were also mentioned in the FQHC/RHC section noting it'll be used to weight the reimbursement amount. This underscores CMS', as well as Congressional members', continued interest on the amount of utilization of telehealth delivered services.

As noted earlier, CMS is asking for comments on redefining "visit" for FQHCs and RHCs to include live video for all services. This, like audio-only, can have a significant impact on the telehealth landscape. Temporary waiver policies aside, under permanent Medicare telehealth policy, FQHCs and RHCs are not eligible telehealth providers. Therefore, if the temporary waivers end with no statutory changes, FQHCs and RHCs will only be eligible originating sites. However, by redefining what a visit means for FQHCs and RHCs to include live video, that would mean these entities can provide services with telehealth technologies (this is similar to adding audio-only in the definition for mental and behavioral health visits for FQHCs and RHCs in 2022). Additionally, this is a change to the definition of a visit and the technology-delivered services would not be regarded as telehealth services. Therefore, the statutory telehealth requirements (such as geographic location of the patient) would not apply. Please note this was not a proposal for 2025, but a call for comments on the idea.

While a significant portion of what is in the proposed 2025 PFS is an attempt to mitigate any effects should the temporary telehealth waivers end on December 31, 2024, some items and calls for comments on potential proposals may lay the groundwork for future significant changes in telehealth Medicare policy. If these are issues that you wish to weigh in on, the comment period for the 2025 PFS will close on September 9, 2024.

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