HEALTHCARE REGULATORY ROUND-UP #84

2025 Medicare Physician Fee Schedule (MPFS) Final Rule – Part 2

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Introductions

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Today's Agenda

1. Improving Global Surgery Payment Accuracy
2. Evaluation & Management Services (Including HCPCS G2211)
3. New Reimbursement for Preventive Services
4. Digital Therapeutics for Behavioral Health
5. Supervision of Outpatient Therapy Services
6. Opioid Treatment Programs
7. Skin Substitutes

1. Improving Global Surgery Payment Accuracy

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2024 Recap – Global Surgery Packages

- Approximately 4,100 CPT* codes valued as Global Surgery Packages (GSPs)
- Single CPT codes valued to include all services provided during a specific number of days by a physician or other practitioner in the same group practice
  - 0 days
  - 10 days
  - 90 days
- GSP includes:
  - Pre-operative visits
  - Surgical procedure
  - Post-operative visits and discharge services (when applicable)
  - Services provided during post-operative period related to the procedure itself

*Current Procedural Terminology (CPT® or CPT) and Healthcare Common Procedure Coding System (HCPCS) are registered trademarks of the American Medical Association (AMA).

GSP Payments – A Brief History

- **2017 to Present: Collecting data regarding count and level of post-op evaluation and management (E/M) visits**
- **Concerns regarding accuracy of GSP payments**
  - Real world counts of post-op follow up visits
  - Assumes one model of care
  - Does not consider scenarios where the procedure and post-op follow up care are furnished by different practitioners of different specialties and/or from different group practices.

Clarifying the Scope of GSPs

- Under current Medicare policy, GSP scope extends to services furnished by the group practice of the proceduralist.
- Must use modifier(s) to separately bill for services unrelated to the GSP (e.g., modifier 24, modifier 57)
- Transfer of care modifiers allow GSPs to be “split” into separate components
  - Modifier 54 – Surgical care only
  - Modifier 55 – Post-operative management only
  - Modifier 56 – Pre-operative management only
- When transfer of care modifiers are reported, GSP is adjusted based upon the percentage noted in the PFS Relative Value File.

Code	Description	Global Days	Pre-Op %	Intra-Op %	Post-Op %
CPT 27130	Total Hip Arthroplasty	90	.10	.69	.21

Key Changes for 2025

- Revised transfer of care policy to address instances where surgical procedure and post-op follow up care are furnished by different providers **when there is an informal, but expected, transfer of care**.
- New add-on CPT code G0559 to account for the resources involved with providing post-op follow-up care provided by a practitioner who did not furnish the surgical procedure **when there is no formal transfer of care has occurred**.

Transfers of Care – 2025

- For CY 2025, providers may append modifier 54 (surgical care only) for all 90-day GSPs, when there is an informal, non-documented, but expected transfer of care.
- The Final Rule is unclear as to whether a proceduralist reporting modifier 54 also receives credit for pre-op care.
  - A/B MACs (B) multiply the fee schedule amount (Field 34 or Field 35 of the MFSDB) by this percentage and round to the nearest cent. Assume that a physician who bills with a "-54" modifier has provided both preoperative, intra-operative and postoperative hospital services. Pay this physician the combined preoperative and intra-operative portions of the fee schedule payment amount.
- No change to billing guidelines for separately identifiable E/M services.

Source: Medicare Claims Processing Manual, Chapter 12, 40.4 B

Add-On Code G0559

- HCPCS* code G0559 (proposed as GPOC1) is intended to reflect the additional time, complexity, and resource costs involved when a practitioner sees a patient post-operatively after a surgical procedure performed by another practitioner.
  - ***G0559*** *– (Post-operative follow-up visit complexity inherent to evaluation and management services addressing surgical procedure(s), provided by a physician or qualified health care professional who is not the practitioner who performed the procedure (or in the same group practice), and is of a different specialty than the practitioner who performed the procedure, within the 090-day global period of the procedure(s), once per 90-day global period, when there has not been a formal transfer of care.*
- Reported separately in addition to office/outpatient E/M (new or established)
- May only be reported once during the 90-day global period
- Unclear relationship with G2211

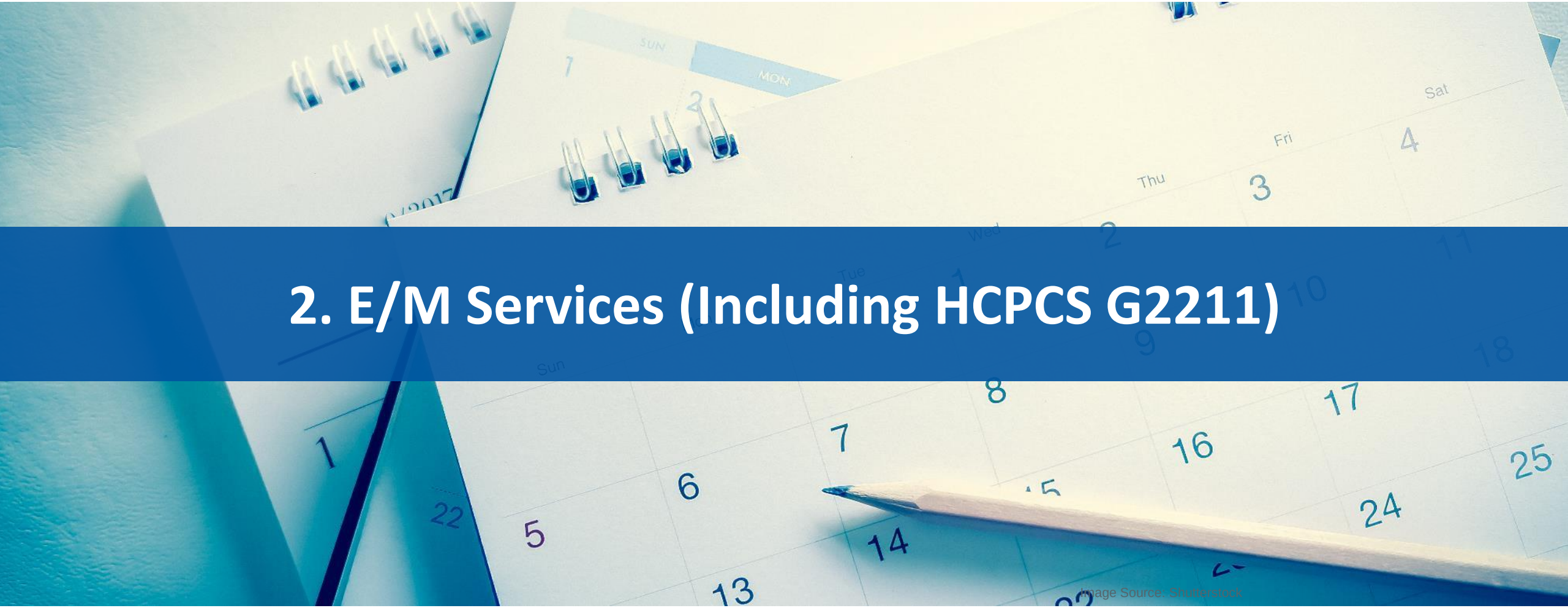
*Healthcare Common Procedure Coding System® (HCPCS) is a registered trademark of the AMA.

Add-On Code G0559 (cont.)

- Elements required to support G0559 include, but are not limited to:
  - Reading available surgical note to understand certain elements of the procedure (e.g., success of the procedure, anatomy affected, and potential complications)
  - Researching the procedure to determine expected post-operative course
  - Evaluation and physical exam to determine if post-op course is progressing correctly
  - Communicate with the practitioner who performed the procedure if any questions or concerns arise
- Valuation for G0559 based upon CPT 90785 (Interactive complexity)

Code	Work RVU	Physician Time
CPT 90785	0.33	11 minutes
HCPCS G0559	0.16	5.5 minutes

2. E/M Services (Including HCPCS G2211)



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Changes to G2211 Allowance

G2211
Visit complexity inherent to evaluation and management associated **[1]** with medical care services that serve as the continuing focal point for all needed health care services **and/or [2]** with medical care services that are part of ongoing care related to a patient's single, serious condition, or a complex condition

- **CY 2024 Final Rule**
  - G2211 is not payable on the same day as an office/outpatient E/M billed with Modifier 25.
- **CY 2025 Final Rule**
  - Will allow G2211 to be billed with an E/M if the additional service billed is an annual wellness visit, vaccine administration, or other preventive service. This includes the Welcome to Medicare preventive visit.
  - FAQ published in response to comments regarding medical necessity and documentation requirements.
    - https//www.cms.gov/files/document/hcpcs-g2211-faq.pdf

Addition of HCPCS Code: G0545

G0545
Visit complexity inherent to hospital inpatient or observation care associated with a confirmed or suspected infectious disease by an **infectious diseases consultant**, including disease transmission risk assessment and mitigation, public health investigation, analysis, and testing, and complex antimicrobial therapy counseling and treatment. **(add-on code, list separately in addition to hospital inpatient or observation evaluation and management visit, initial, same day discharge, or subsequent)**

- **CY 2025 Final Rule**
  - Allow G0545 in additional to a hospital E/M visit specifically for infectious disease providers
  - Increased work associated with diagnosis, management, and treatment of infectious diseases that may not be adequately accounted for in current hospital inpatient or observation E/M codes
  - Final Rule provides list of activities considered as part of the visit complexity (pgs. 304-305); however, there are no specific documentation requirements.
  - Work RVU: 0.89

3. New Reimbursement for Preventive Services

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2025 Coverage and Payment Updates

- **Hepatitis B Vaccine Administration**
  - Expanding coverage to include individuals who have not previously received a completed hepatitis B vaccination series, and individuals with unknown vaccination history.
  - Physician order no longer required
  - Updated payment rate for G0010 *(Administration of hepatitis B vaccine)*: $33.71
- **Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)**
  - Beginning July 1, 2025, Part B vaccination claims (including influenza, pneumococcal, and COVID-19) may be billed at time of service
  - Paid at 100% of reasonable cost, separate FQHC prospective payment system (PPS) or the RHC All-Inclusive Rate

Drugs Covered as Additional Preventive Services (DCAPS)

- Historically, Medicare has not paid for drugs under the benefit category of additional preventive services.
- **2025 DCAPS Fee Schedule**
  - Will use existing Part B drug pricing mechanisms (e.g., Average Sale Price).
  - Alternative pricing methods to be used as needed based upon available data for specific drugs.
  - If ASP data unavailable, payment limit based on National Average Drug Acquisition Cost (NADAC).
  - If NADAC data unavailable, payment limit based on Federal Supply Schedule (FSS).
  - If FSS unavailable, payment would be the invoice price determined by the MAC.
- Same fee schedule for DCAPS drugs to be used in RHCs/FQHCs.

4. Digital Therapeutics for Behavioral Health

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Digital Mental Health Treatment (DMHT)

- Software devices cleared or granted De Novo authorization by the FDA that are intended to treat or alleviate a mental health condition. Inclusive of *digital cognitive behavioral therapy* (digital CBT).
- Three new HCPCS codes developed modeled on coding for RTM services:
  - ***G0552*** *– supply of DMHT device and initial education and onboarding, per course of treatment that augments a behavioral therapy plan*
    - *The billing practitioner must incur the cost of furnishing the DMHT device*
    - *Furnishing of the DMHT device must be incident to the billing practitioner's professional services in association with ongoing treatment under a plan of care by the billing practitioner.*
    - *The billing practitioner must diagnose the patient and prescribe or order the DMHT device.*
  - ***G0553*** *– First 20 minutes of monthly treatment management services directly related to the patient's therapeutic use of the DMHT device that augments a behavioral therapy plan, physician/other qualified health care professional time reviewing data generated from the DMHT device from patient observations and patient specific inputs in a calendar month and requiring at least one interactive communication with the patient/caregiver during the calendar month.*
  - ***G0554*** *– Each additional 20 minutes of monthly treatment management services directly related to the patient's therapeutic use of the DMHT device*

Interprofessional Consultation for Behavioral Health Providers

- **G0546 – G0551:**
  - Codes established to include clinical psychologists, clinical social workers, marriage and family therapists, and mental health counselors.
    - These codes will mirror the current interprofessional consultation CPT codes used by practitioners eligible to bill E/M visits.
  - The treating/requesting practitioner and the consulting provider do not have to be in the same organization to furnish interprofessional consultation services.
  - Patient consent is required.

5. Supervision of Outpatient Therapy Services

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Supervision Policy for PTAs and OTAs

- **Current Rule**
  - Direct supervision of physical therapy assistants (PTAs) and occupational therapy assistants (OTA)
    - Direct supervision: physician is present in the office suite and immediately available
    - Concerns regarding current workforce shortages which prevents sufficient availability for beneficiaries
- **CY 2025 Final Rule**
  - PTAs and OTAs may practice under general supervision.
    - General supervision: provided under the physical therapist (PT) or occupational therapist (OT) overall direction and control, but the PT or OTs presence is not required in the office suite
  - State laws should still be followed if direct supervision is required.

6. Opioid Treatment Programs

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Opioid Use Disorder Treatment Services Furnished by Opioid Treatment Programs (OTPs)

- CMS made permanent the flexibility allowing periodic assessments be performed via **audio-only telecommunications** for patients who are receiving buprenorphine, methadone, and/or naltrexone at OTPs.
- Also, made permanent that the initiation of treatment with methadone (G2076) can be furnished via two-way audio-video communications technology.

Other OTP Updates

- **G2076 – OTP Intake Activities:**
  - Revised the payment amount to account for social determinants of health (SDOH) risk assessments
  - Revised the descriptor to be more inclusive of other types of professionals who may conduct SDOH assessments in an OTP setting
  - The tool used should allow the OTP to identify more specific individual-level HRSNs
- **Payment for new opioid agonist and antagonist medications approved by the FDA:**
  - G0532- new add-on code for nalmefene hydrochloride nasal spray, indicated for the emergency treatment of known or suspected opioid overdose.
    - Limited to billing once every 30 days
  - Finalized coding and payment for the weekly and monthly injectable buprenorphine
- *OTPs must append an Opioid Use Disorder (OUD) diagnosis code on claims for OUD treatment services.*

7. Skin Substitutes

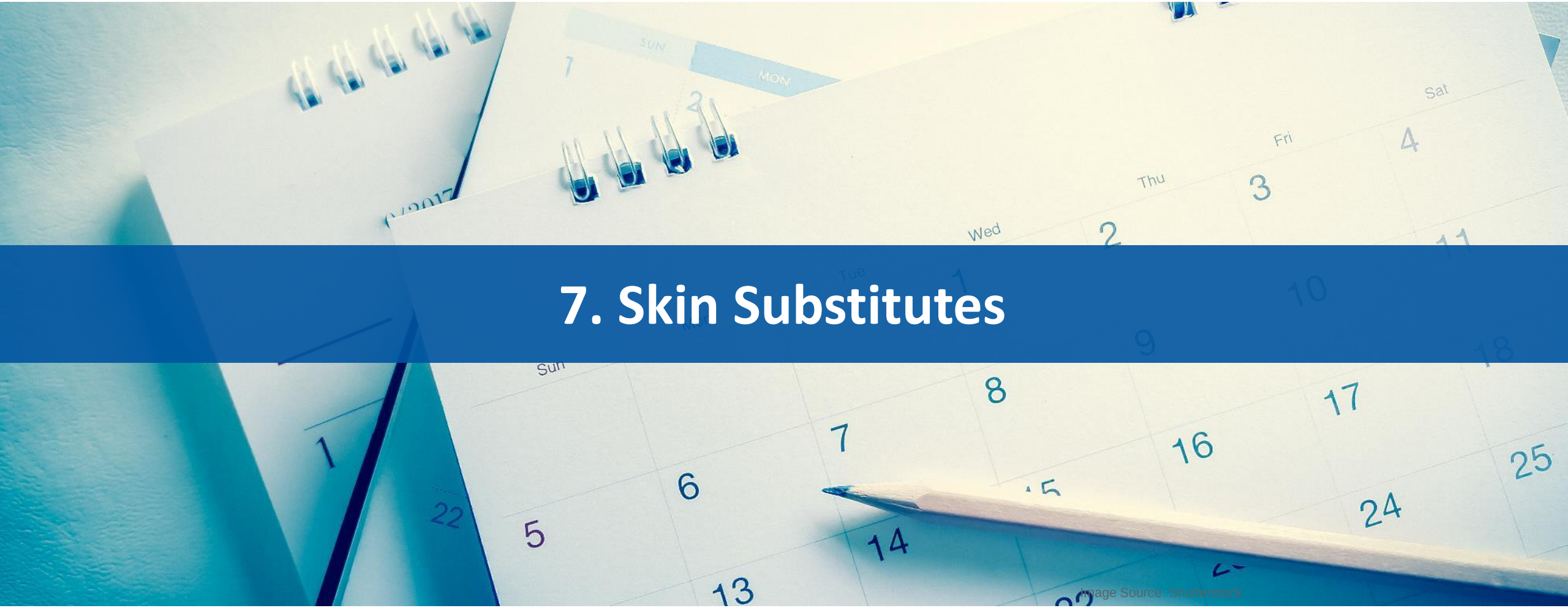

Image Source: Shutterstock

Payment for Skin Substitutes

- **CY 2023 Proposed Rule**
  - Consistent payment approach for skin substitute products across the physician office and hospital outpatient department settings
  - Appropriate HCPCS codes that describe skin substitute products
  - Uniform benefit category across products in the physician office setting (i.e., synthetic or comprised of human or animal-based material) for more consistent payment methodologies
  - Maintaining clarity for interested parties on CMS skin substitutes policies and procedures
- **CY 2024 Final Rule**
  - Approaches for identifying appropriate practice expense

Payment for Skin Substitutes

- **Market Happenings**
  - Increase in the number of HCPCS Levell II coding requests for new skin substitute products
  - CY 2024 final rule – billing and payments codes for skin substitute products are not counted for identifying refundable drugs in 2023 and 2024
- **2025 Final Rule**
  - Exclude billing and payment codes for skin substitutes from discarded drug refund policy

Our Upcoming Webinars:

December 5, 2024; 2 – 3:30 pm ET

Let's Get Rural: Regulatory Update and 2025 Final Rule

(1.5 CPE credits available)

December 11, 2024; 11 am – 12 pm ET

Healthcare Regulatory Round-Up #85: 2025 MPFS Final Rule – Part 3

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