CY 2025 Final Rule Review Findings Summarized

The CY 2025 Medicare Physician Fee Schedule final rule, as summarized by CMS, includes several notable updates to physician payment policies, the Quality Payment Program (QPP), and the Medicare Shared Savings Program (MSSP). A significant change is the 2.83% reduction in the conversion factor, which decreases from $33.288 to $32.347, with the anesthesia conversion factor also reduced from $20.774 to $20.318. These reductions, mandated by statute, continue to challenge providers, though organizations like the AOA are advocating for legislative changes to address them.

CMS emphasizes support for longitudinal, coordinated care with the inclusion of the G2211 evaluation/management care complexity add-on code for Medicare preventive services and the introduction of Advanced Primary Care Management (APCM) codes. Telehealth remains a priority, with policies finalizing payment parity with in-person services, coverage for audio-only telehealth, and expanded access, although some flexibility depends on Congressional action. Behavioral health services also receive expanded payment, including opioid treatment programs and crisis intervention follow-up services.

Additional changes impact surgical care, with new requirements for reporting transfer of care modifiers and the introduction of a code for post-operative care within a 90-day global period by non-surgical physicians. Updates to the QPP include changes to MIPS measure lists and MIPS Value Pathways, with CMS maintaining the performance threshold at 75 points following advocacy. However, the shift towards MIPS Value Pathways and the planned sunset of traditional MIPS by 2029 remain points of concern for smaller practices. These updates reflect CMS's continued evolution of policies to address the needs of both patients and providers.

CY 2025 Conversion Factor

The CY 2025 Medicare Physician Fee Schedule (PFS) includes a 2.83% reduction in the conversion factor, lowering it from $33.288 in CY 2024 to $32.347. The anesthesia conversion factor has similarly decreased from $20.774 to $20.318. These reductions, which apply to services across the fee schedule, are a result of statutory budget neutrality requirements. Payments for physician services, excluding anesthesia, are calculated by multiplying the total relative value units (RVUs)—comprising physician work, practice expense, and liability insurance—by the conversion factor. These adjustments reflect ongoing financial constraints in Medicare reimbursement policies under CMS.

Potential Impact on DOs:

The CY 2025 PFS changes pose significant challenges for DOs, including financial pressures, operational adjustments, and potential impacts on patient care quality. The immediate reduction in reimbursement could hinder DOs' ability to sustain their practices, particularly in underserved areas. Advocacy efforts to address these reductions and support sustainable payment reforms will be critical for the osteopathic community.

Caregiver Training (CTS)

For CY 2025, CMS is introducing new coding and payment policies to support caregiver training services (CTS). These services include training on direct care topics such as preventing decubitus ulcers, wound care, infection control, and behavior management and modification techniques for caregivers of individual patients. Importantly, these services can also be delivered via telehealth, expanding access for caregivers.

CMS has provisionally added several caregiver training service codes (CPT codes 97550-97552, 96202, 96203; HCPCS codes GCTD1-GCTD3, GCTB1, GCTB2) and granted permanent status to new codes for individual counseling related to preexposure prophylaxis (PrEP) (HCPCS codes G0011 and G0013), signaling a continued focus on enhancing preventive and support services.

Potential Impact on DOs:

Expanded Scope for Patient-Centered Care

- The ability to provide behavior management training, wound care education, and infection control guidance to caregivers enhances the comprehensive care DOs can offer to their patients.
- Opportunity to integrate these services into their practice models, particularly in primary care and chronic disease management.

Increased Billing and Documentation Complexity

- The addition of provisional caregiver training codes (CPT 97550-97552, 96202, 96203; HCPCS GCTD1-GCTD3, GCTB1, GCTB2) and permanent codes for PrEP counseling requires DOs to adapt their billing and documentation processes.
- Billing staff may need additional training to correctly document and submit claims under these codes, increasing administrative workload.

Broader Use of Telehealth

- CMS allowing CTS to be delivered via telehealth could help expand reach to patients in rural or underserved areas, supporting caregivers who cannot attend in-person sessions.
- Invested in telehealth infrastructure will benefit from the ability to extend services. However, without telehealth capabilities may face challenges in fully utilizing these opportunities.

Revenue Opportunities

- Proper utilization of these codes provides new billing opportunities for services that may already be offering informally, such as educating caregivers on managing chronic conditions.
- Potentially increasing revenue streams if the services are correctly documented and billed.

Office/Outpatient (O/O) Evaluation and Management (E/M) Visits

For CY 2025, CMS finalized a policy allowing the G2211 O/O E/M visit complexity add-on code to be billed alongside preventive services, such as annual wellness visits (AWVs), vaccine administration, and Medicare Part B preventive services, including the Initial Preventive Physical Examination

(IPPE). The add-on code reflects the additional time, intensity, and practice expense (PE) resources required for practitioners to provide longitudinal, comprehensive care for their patients, not limited to those with chronic or high-risk conditions.

Originally implemented in the CY 2024 Medicare Physician Fee Schedule, G2211 was designed to recognize the effort required for primary care practitioners to build consistent, long-term care relationships. Typically, the code cannot be billed when an E/M service is appended with a modifier-25 for a minor procedure on the same date. However, CMS now allows G2211 to be billed with O/O E/M base codes (CPT 99202-99205, 99211-99215) furnished on the same day as preventive services, aligning payment with the realities of primary care delivery. This change aims to better support the time and effort physicians dedicate to prevention and wellness-focused care, enhancing continuity and comprehensive patient relationships.

Potential Impact on DOs

Enhanced Reimbursement Opportunities

- The ability to bill G2211 alongside preventive services such as annual wellness visits (AWVs), vaccine administration, and other Medicare Part B preventive services provides an opportunity to receive additional payment for their efforts in building longitudinal patient relationships.
- Will need to ensure proper documentation and coding compliance when billing G2211 alongside E/M services and preventive care. The restriction on using G2211 with modifier-25 for minor procedures may add complexity to claim submissions.

Telehealth Services under the PFS

CMS's CY 2025 Physician Fee Schedule final rule outlines important updates to telehealth services. Effective January 1, 2025, statutory limitations in place before the COVID-19 Public Health Emergency (PHE) will resume unless Congress takes action. These restrictions include geographic and site limitations for non-behavioral health services and limitations on practitioner types allowed to deliver telehealth. CMS aims to preserve flexibility by expanding telehealth access where possible, including continuing payment parity with in-person services, supporting audio-only communication for patients unable to use video technology, and finalizing new telehealth service codes for caregiver training and safety planning interventions.

Key Changes:

1. Additions to the Medicare Telehealth Services List: New codes for caregiver training and PrEP counseling.
2. Flexibility for Practitioners: CMS will allow distant site practitioners to use their enrolled practice locations rather than home addresses when conducting telehealth visits.
3. Virtual Direct Supervision: CMS permits virtual direct supervision for certain services via real-time audio and video through December 31, 2025.
4. Teaching Physicians: Virtual presence for teaching physicians during key portions of services is allowed through CY 2025.

5. Coding Updates: Newly created CPT codes for telehealth evaluation and management (E/M) services are integrated, with CMS recommending the use of existing codes with appropriate modifiers.

Potential Impact on DOs

- Geographic and Location Restrictions: Unless Congress intervenes, patients outside rural areas or medical facilities may face challenges accessing telehealth services, limiting DOs' ability to provide holistic care remotely.
- Must stay current with telehealth coding requirements, including selecting appropriate modifiers and understanding payer-specific policies, which may increase administrative burden.
- CMS's CY 2025 updates to telehealth policies reflect a balanced effort to maintain access while adhering to statutory constraints. For DOs, the changes present opportunities to expand telehealth services, but challenges remain due to potential geographic restrictions, administrative demands, and payer variability.

Advanced Primary Care Management Services (APCM)

CMS finalized new Advanced Primary Care Management (APCM) codes for CY 2025 under the Medicare Physician Fee Schedule to strengthen primary care and promote comprehensive, coordinated care. These three codes—G0556, G0557, and G0558—represent different levels of patient complexity, ranging from single chronic conditions to more complex care for Qualified Medicare Beneficiaries. APCM services integrate care management elements such as Principal Care Management (PCM), Chronic Care Management (CCM), and Transitional Care Management (TCM) into a simplified bundle, eliminating time-based thresholds to reduce administrative burdens.

Key Features of APCM Services:

- **Stratified Codes:**
    - G0556: One chronic condition, payment $15.
    - G0557: Two or more chronic conditions, payment $50.
    - G0558: Two or more chronic conditions with Qualified Medicare Beneficiary status, payment $110.
- **Practice Requirements:**
    - Comprehensive care management.
    - 24/7 access to the care team.
    - Development and implementation of patient-centered care plans.
    - Coordination of care transitions and enhanced communication.
- **Prohibited Concurrent Billing:**

- APCM cannot be billed alongside care management services like CCM, PCM, TCM, or certain virtual and online evaluation services to prevent duplicative billing.

Potential Impact on DOs

- APCM offers an opportunity to strengthen patient care through enhanced primary care models without the administrative burden of time-based coding. However, the prohibition of concurrent billing for similar services could reduce flexibility in coding and revenue generation. The new codes emphasize patient-centered care, aligning with osteopathic philosophy. These changes incentivize adoption of advanced primary care practices, potentially increasing workload and requiring adjustments in practice workflows and capabilities to meet the requirements for APCM billing.

Cardiovascular Risk Assessment and Management

CMS has finalized new policies for CY 2025 to address cardiovascular disease (CVD) prevention, based on the Million Hearts® Model's success in reducing first-time heart attacks and strokes among Medicare beneficiaries. These policies introduce two new G-codes to support comprehensive cardiovascular care: one for Atherosclerotic Cardiovascular Disease (ASCVD) risk assessment and the other for ASCVD risk management.

- **G0537:** ASCVD Risk Assessment
    - Conducted during an E/M visit for patients identified as at-risk but without a CVD diagnosis.
    - Includes demographic data, modifiable risk factors (e.g., blood pressure, cholesterol, smoking status), and laboratory data (e.g., lipid panel).
    - Provides a 10-year ASCVD risk estimate based on evidence-based tools.
    - Limited to once per 12 months per practitioner.
- **G0538:** ASCVD Risk Management
    - Designed for patients at intermediate, medium, or high risk for CVD.
    - Requires the development, implementation, and monitoring of an ASCVD-specific care plan with shared decision-making.
    - Care management includes elements such as blood pressure and cholesterol management, smoking cessation, and patient education.
    - Billed per calendar month, with patient consent required.

These codes aim to incentivize early identification and proactive management of CVD risk, encouraging clinicians to adopt a more preventive approach.

Potential Impact on DOs:

- The finalized codes align with osteopathic principles of holistic care and preventive health. DOs can leverage these codes to enhance their focus on patient-centered cardiovascular care, promoting long-term health outcomes. However, the introduction of these codes may increase documentation requirements and necessitate workflow adjustments to incorporate evidence-based risk assessments and management strategies effectively. With their emphasis on whole-person care, DOs are well-positioned to implement these services, but they should remain mindful of the administrative burden and ensure their practices are equipped to meet the coding and compliance requirements.

Behavioral Health Services

CMS has finalized several initiatives to improve access to behavioral health services under the CY 2025 Medicare Physician Fee Schedule (PFS), aligning with the CMS Behavioral Health Strategy. Key changes include:

- Safety Planning Interventions: CMS introduced two new HCPCS codes:
    - G0560 for safety planning interventions performed by billing practitioners. These services help patients in crisis develop personalized strategies and support systems to address suicidal thoughts or risk of harm. It can be billed as a standalone service or alongside E/M or psychotherapy services, with a work RVU of 1.09.
    - G0544, a monthly bundled code, covers post-discharge follow-up for patients discharged from the emergency department after a behavioral health crisis. It includes four 10–20-minute calls within a month, with a work RVU of 1.00.
- Digital Mental Health Treatment Devices (DMHT): CMS finalized payment for digital mental health treatment devices, which are FDA-cleared and integral to professional behavioral health services. These devices support ongoing treatment plans and include three HCPCS codes:
    - G0552: Device supply.
    - G0553: First 20 minutes of monthly treatment management.
    - G0554: Additional 20 minutes of treatment management.
- Interprofessional Consultation G-Codes: CMS introduced six G-codes for behavioral health practitioners (e.g., clinical psychologists, social workers) that align with interprofessional consultation CPT codes used by E/M-eligible practitioners.
- Future Rulemaking for Intensive Outpatient Programs (IOP): CMS summarized comments on IOP services, Certified Community Behavioral Health Clinics (CCBHCs), and crisis stabilization facilities and will consider these for future regulations.

Potential Impact on DOs:

- These changes provide new opportunities for DOs to enhance patient care in behavioral health. The new safety planning and follow-up services, along with digital mental health treatment codes, align with osteopathic principles emphasizing patient-centered, holistic care. However, the additional services may increase administrative responsibilities, requiring DOs to integrate these new codes and protocols into their workflows effectively. The expansion of billing options also offers potential revenue growth for practices with behavioral health services.

Opioid Treatment Programs (OTPs)

CMS has introduced several updates and flexibilities for opioid use disorder (OUD) treatment services provided by OTPs in the CY 2025 Final Rule. These changes aim to improve access to care and address patient needs comprehensively. Key updates include:

1. **Telecommunication Flexibilities:**
    - Permanent authorization for periodic assessments via audio-only telecommunications starting January 1, 2025, provided all other requirements are met.
    - OTP intake add-on code can be billed using two-way audio-video technology for methadone treatment initiation (HCPCS code G2076) if an adequate evaluation can be conducted through this platform.
2. **Payment Updates for Social Determinants of Health (SDOH) Assessments:**
    - Enhanced payment for intake and periodic assessments, reflecting additional effort to identify patients' unmet health-related social needs (HRSNs), harm reduction interventions, and recovery support services.
    - These updates address barriers to treatment engagement and risks that may lead to patients prematurely leaving OUD treatment.
3. **New Add-On Codes for Coordinated Care:**
    - Payment for care coordination, patient navigation, and peer recovery support services, enabling OTPs to collaborate with community-based organizations and better assist patients in achieving their treatment and recovery goals.
4. **FDA-Approved Medications:**
    - New codes and payments for nalmefene hydrochloride nasal spray for opioid overdose treatment and injectable buprenorphine formulations, including weekly and monthly options.
5. **Billing Clarification:**
    - OTPs must append an OUD diagnosis code to claims for OUD treatment services, aligning with Medicare coverage provisions.

Potential Impact on DOs:

- These updates offer expanded opportunities for DOs to deliver comprehensive care to patients with OUD. The inclusion of telehealth flexibilities, payment for SDOH assessments, and new medication options aligns with osteopathic principles of holistic and patient-centered care. However, these changes may also introduce additional administrative responsibilities, including adapting workflows to incorporate new billing requirements, codes, and expanded service options. DOs engaged in behavioral health and addiction medicine can leverage these updates to enhance care delivery and improve outcomes for patients with OUD.

Hospital Inpatient or Observation (I/O) Evaluation and Management (E/M) Add-On for Infectious Diseases

For CY 2025, CMS has finalized a new HCPCS add-on code (G0545) to address the unique intensity and complexity of inpatient or observation care related to confirmed or suspected infectious diseases. This add-on code is specifically designed for services performed by infectious disease specialists and highlights the advanced expertise required for managing such conditions.

The service elements included in G0545 are:

- **Disease Transmission Risk Assessment and Mitigation:** Evaluating and managing risks associated with the transmission of infectious diseases.
- **Public Health Investigation, Analysis, and Testing:** Activities supporting broader public health measures and diagnosis.
- **Complex Antimicrobial Therapy Counseling and Treatment:** Managing intricate antimicrobial regimens to treat infections effectively.

This code is to be billed alongside hospital inpatient or observation E/M visits, including initial, same-day discharge, subsequent, or discharge services, and has a **work RVU of 0.89**.

Potential Impact on DOs:

- The addition of G0545 provides an opportunity for DOs with specialized training in infectious diseases to better capture the complexity of their work and be compensated for services that go beyond standard E/M visits. This supports osteopathic physicians who emphasize a holistic approach, particularly in addressing the public health implications of infectious diseases. However, DOs outside of infectious disease specialization may not directly benefit from this new code but should be aware of its implications for care coordination and referrals involving infectious disease specialists. The administrative aspects of incorporating this code into billing processes may require additional training and adjustment for practices.

Strategies for Improving Global Surgery Payment Accuracy

For CY 2025, CMS has finalized policies aimed at improving the accuracy of payments for 90-day global surgical packages. These updates address how care is typically provided during the global period and ensure equitable compensation for practitioners involved in different stages of patient care.

1. **Expansion of Modifier -54 Use:**
   CMS is broadening the use of the transfer of care modifier -54. This modifier must now be applied in all cases where a practitioner intends to perform only the surgical portion of a global package and not the post-operative care. This includes both formally documented transfers of care (current policy) and informal, non-documented but expected transfers of care. Using modifier -54 adjusts the payment to reflect that the proceduralist is not responsible for post-operative services. Meanwhile, practitioners receiving the patient for post-operative care can bill separately for those services without needing to append a modifier.

2. **New Add-On Code for Post-Operative Care (G0559):**
   CMS has introduced HCPCS code G0559 for post-operative care provided by a physician who did not perform the surgery and does not benefit from the global surgical payment. This add-on code accounts for the time and resources involved in post-operative follow-up visits. Proper documentation is required to justify the use of this code, confirming that the visit was related to post-operative care during the 90-day global period.

Potential Impact on DOs:

- Improved Payment Accuracy: DOs specializing in surgical procedures will benefit from clearer guidelines for using modifier -54, ensuring they are compensated accurately when they only perform the surgical portion of the global package.
- Equitable Reimbursement for Non-Surgeons: DOs involved in primary care or other specialties who provide post-operative care can now bill for their services separately using the G0559 add-on code. This creates new billing opportunities for primary care DOs and others supporting post-surgical care.
- Administrative Adjustments: The implementation of these policies will require DOs to adapt their billing practices, particularly for documenting and reporting care transitions during the global period. Practices may need additional training to ensure compliance and avoid claim denials.
- Overall, these changes are designed to ensure fair payment distribution and may encourage improved collaboration among healthcare providers. For DOs, the policies represent an opportunity to receive appropriate compensation for their roles in comprehensive, patient-centered care.

Supervision of Residents in Teaching Settings

CMS has finalized a policy allowing teaching physicians to maintain a virtual presence during clinical services provided in teaching settings. This policy permits teaching physicians to participate in telehealth services through a three-way connection, with the teaching physician, resident, and patient located in separate locations. The policy, initially implemented during the COVID-19 public health emergency, has been extended through the end of CY 2025.

This extension aims to support ongoing telehealth use in medical education and clinical care, ensuring flexibility for teaching physicians to supervise residents virtually when services are provided via telehealth.

Potential Impact on DOs:

- Enhanced Educational Flexibility: DOs in academic roles can effectively supervise residents in telehealth settings without being physically present, fostering education while accommodating telehealth's growing role.
- Improved Access for Patients: The ability to supervise virtually allows for uninterrupted patient care, particularly for underserved or rural populations where telehealth services may be critical.
- Operational Efficiency: This policy reduces the logistical challenges of in-person supervision, enabling teaching physicians to oversee more cases or balance other responsibilities more effectively.
- Overall, the policy supports the integration of telehealth into medical education and patient care, aligning with the evolving role of technology in healthcare delivery.

Supervision Policy for Physical Therapists (PTs) and Occupational Therapists (OTs) in Private Practice

For CY 2025, CMS has finalized a policy change allowing general supervision of physical therapist assistants (PTAs) and occupational therapy assistants (OTAs) by physical therapists (PTs) and occupational therapists (OTs) in private practice. This replaces the previous requirement for direct supervision. Under general supervision, the supervising therapist is not required to be physically present but must be available for consultation.

The change aligns the supervision requirements for PTAs and OTAs in private practices with those already in place for institutional providers. This policy aims to improve flexibility for private practice providers and safeguard patient access to therapy services, particularly in rural and underserved areas where access challenges are more pronounced.

- While the change primarily affects PTs and OTs, it indirectly supports DOs by ensuring their patients can more easily access critical therapeutic services, enhancing overall patient care continuity.