Medicare Physician Fee Schedule CY2025 Final Rule
Key Payment and Policy Provisions for ACOI Members

TOPIC	CMS PROPOSAL	ACOI COMMENTS TO CMS	CMS FINAL RULE
Enhanced Care Management	CMS proposed to incorporate some payment and service delivery elements from CMS Innovation Center models, including Comprehensive Primary Care Plus and Primary Care First (PCF), into three new APCM services, which could be furnished per calendar month, following the initial qualifying visit for new patients and obtaining patient consent. APCM services would include elements of existing care management codes, including chronic care management (CCM), transitional care management (TCM), and principal care management (PCM), as well as communication technology-based services (CTSB), including virtual check-in services. Unlike existing care management codes, CMS proposed the code descriptors for APCM services would not be time-based. CMS proposed that APCM services could not be billed by the same practitioner or another practitioner within the same practice for the same patient concurrent with these other services: CCM, PCM, TCM, inter-professional consultation, remote evaluation of patient videos/images, virtual check-ins, and e-visits. To bill for APCM services, CMS proposed requiring the following service elements and practice-level capabilities: 24/7 access to care and care continuity; comprehensive care management; patient-centered comprehensive care plan; management of care transitions; practitioner-, home- and community-based-organization coordination; enhanced communication opportunities; patient population-level management; and performance measurement.	Given substantial infrastructure requirements to bill the proposed APCM codes, coding complexity, and low-to-modest payment rates, ACOI commented that it anticipated uptake of new APCM activities would be limited to practices already participating in alternative payment models. ACOI concurred with the American Medical Association that CMS should review the RUC's recommendations for a patient-centered medical home and consider its framework for tiering payment based on capabilities of the practice, ranging from entry-level to comprehensive, which may enable more primary care physician practices, including independent physician practices, to qualify to report APCM services. ACOI commented the proposed payment for a Level 1 APCM code was too low at $10 — $40 less than the approximate payment rate for Level 2, which was proposed at $50. ACOI commented that a patient with one chronic condition, depending on the chronic condition, could require as many, if not more, APCM services that a beneficiary with two chronic conditions.	CMS finalized its proposal to establish and pay for three new codes (HCPCS codes G0556, G0557, G0558) for monthly APCM services. APCM services include elements of existing care management codes (CCM, TCM and PCM, as well as communication technology-based services, including virtual check-in services). Code descriptors for APCM services are not time-based. CMS modified its concurrent billing restrictions proposal and will allow other specialists in the same group practice, other than the physician who is furnishing APCM services, to bill for services that are now considered bundled into APCM, such as CCM, PCM, and TCM. CMS finalized the practice-level infrastructure requirements as proposed. CMS noted the RUC recommendations for tiering APCM payment based on practice capabilities are inconsistent with CMS' goals to pay physicians who have already transitioned to an advanced primary care delivery model.
Request for Information: Advanced Primary Care Hybrid Payment	CMS sought feedback regarding potential changes to coding and payment policies for advanced primary care services to be incorporated in traditional Medicare, including mechanisms that create pathways to recognize movement away from encounter-based to population-based care.	ACOI recommended that CMS work through the CPT Editorial Panel and RUC process to create an appropriate bundled payment for primary care services that reduces physician administrative burden. ACOI added that any new approach to increase payment for primary care services, including through a primary care hybrid payment model, should be done outside Medicare's budget neutrality parameters.	CMS responded it will continue to review feedback as it pertains to future rulemaking.

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Payment for Medicare Telehealth Services		ACOI encouraged CMS to explore policies to better integrate telehealth with in-person care, and to support the use of patient navigators to help connect patients to telehealth appointments and follow-up support. ACOI supported proposed additions to the Medicare Telehealth Services List to include pre-exposure prophylaxis (PrEP) for HIV, home International Normalized Ratio monitoring, and caregiver training services.	CMS finalized adding caregiver training services (CPT codes 97550, 97551, 97552, 96202, 96203 and HCPCS codes G0541-G0543 (GCTD1-3) and G0539-G0540 (GCTB1-2)) to the Medicare Telehealth Services list for CY 2025 on a provisional basis. CMS also finalized to add HCPCS codes G0011 *[Individual counseling for pre-exposure 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]* and G0013 *[Individual counseling for pre-exposure 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]* to the Medicare Telehealth Services List with a permanent status on the Medicare Telehealth Services List, beginning in CY 2025.
	Audio Only CMS proposed a new permanent policy allowing audio-only telehealth services for services delivered to patients in their home if the physician is capable of using audio-video but the patient does not have or does not consent to video use. This is an expansion of the policy previously adopted that allowed audio-only services for patients receiving telehealth for mental health conditions. Through 2025, CMS also proposed to continue lifting frequency limits on telehealth for subsequent inpatient and nursing facility visits and critical care consultations, as well as to not require physicians providing telehealth to report their home address.	ACOI supported CMS' proposal for a new permanent policy allowing audio-only telehealth for services delivered to patients in their home (when the patient's home is a permissible originating site) if the physician is capable of using audio-video, but the patient does not have or does not consent to video use.	CMS finalized a permanent change to its definition of interactive telecommunications system to include audio-only services, not just audio-video. Congress acted before the end of 2024 to extend the COVID-era waivers of geographic and originating site restrictions under current law through March 31, 2025.
	Distant Site Practitioner CMS previously finalized through CY 2024 that it would continue to permit a distant site practitioner to use their currently enrolled practice location instead of their home address when providing telehealth services from their home. CMS proposed to extend this flexibility.	ACOI supported CMS' proposal and commented that this policy should be made permanent.	CMS finalized as proposed that, through CY 2025, CMS will continue to permit the distant site practitioner to use their currently enrolled practice location instead of their home address when providing Medicare telehealth services from their home.

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Direct Supervision Through Communications Technology	Since COVID-19, CMS has defined the physician's "immediate availability" for services that require direct supervision to include real-time audio and visual interactive telecommunications technology. CMS proposed permitting virtual direct supervision as permanent policy for a subset of services requiring direct supervision, while for others virtual direct supervision would continue to be allowed through December 31, 2025. CMS proposed to adopt a definition of direct supervision that allows "immediate availability" of the supervising practitioner using audio/video real-time communications technology (excluding audio-only), but only for a subset of incident-to services.	ACOI thanked CMS for defining, since the COVID PHE, the physician's "immediate availability" for services that require direct supervision to include real-time audio and visual interactive telecommunications technology. ACOI supported CMS' proposal to permit virtual direct supervision as permanent policy for a subset of services requiring direct supervision which CMS views as being typically performed in their entirety by auxiliary personnel, including services described by CPT code 99211 which, by definition, "may not require the presence of a physician or other qualified health professional."	CMS finalized, as proposed, to continue to define direct supervision to permit the presence and "immediate availability" of the supervising practitioner through real-time audio and visual interactive telecommunications through December 31, 2025. CMS finalized, as proposed, and revised its regulations to state that, for the following services furnished after December 31, 2025, the presence of the physician (or other practitioner) required for direct supervision shall continue to include virtual presence through audio/video real-time communications technology (excluding audio-only): • services furnished incident to a physician's service when they are provided by auxiliary personnel employed by the physician and working under his or her direct supervision and for which the underlying HCPCS code has been assigned a PC/TC indicator of '5'; and • office and other outpatient visits for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional. In instances where a service on the Medicare telehealth list is available to beneficiaries in their homes, and also has the requirement of direct supervision, the physician/practitioner is required to be available using both and audio and video. CMS notes this does not necessarily mean that any interaction between the patient and the physician/practitioner supervising the service would require a video component.
Supervision of Residents in Teaching Settings	CMS proposed continuing its current policy through 2025 allowing teaching physicians to virtually supervise residents, but only when the service is furnished virtually (e.g., when the patient, resident, and teaching physician are all in separate locations).	ACOI supported CMS' proposal and encouraged CMS to create a permanent policy allowing virtual supervision of residents for both non-MSA and MSA areas. ACOI commented that this policy should include virtual supervision of residents who are providing in-person services.	CMS will continue to allow teaching physicians to have a virtual presence through Dec. 31, 2025. Teaching physicians can virtually supervise residents, but only when the service is furnished virtually (e.g., when the patient, resident, and teaching physician are all in separate locations).

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Office/Outpatient (O/O) Evaluation and Management (E/M) Visit Complexity Add-on (G2211) Implementation	CMS previously finalized a policy that the evaluation and management (E/M) visit complexity add-on code (G2211) is not payable when the E/M visit is reported with CPT Modifier -25, which denotes a significant, separately identifiable E/M visit by the same physician or other qualified health care professional on the same day as a procedure or other service. CMS proposed to amend its policy to allow payment of the add-on code when reported with Modifier -25 and to pay for the add-on code when the E/M visit is reported by the same practitioner on the same day as an annual wellness visit, vaccine administration, or any Medicare Part B preventive service furnished in the office or outpatient setting.	ACOI shared with CMS that it had heard from its members that claims for G2211 were getting kicked back when billed with an annual wellness visit. ACOI agreed with the proposed change in policy.	CMS finalized payment for the office/outpatient E/M visit complexity add-on code (HCPCS code G2211) when the E/M code is reported by the same physician or qualified health care professional on the same day as an annual wellness visit, vaccine administration, or other Medicare preventive service.
Payment for Caregiver Training Services (CTS)	CMS proposed to implement three new codes (GCTM1-3) for these services, which would be in addition to existing CPT codes for caregiver training services (97550-52, 96202-03).	ACOI supported payment for caregiver training for direct care services. ACOI asked CMS to consider whether duplicate G-codes are necessary, or whether revisions to the existing CPT codes or new codes would be a better approach, especially to avoid confusion, and potentially under-utilization of the G codes, by providers.	CMS finalized its proposal for three new codes (G0541-G0543) for caregiver training for direct care services and supports, such as preventing decubitus ulcer formation, wound dressing changes, infection control, special diet preparation, and medication administration. CMS corrected that the code descriptors for HCPCS codes G0541-G0543 are GCTD1-3. CTS would not be billable for caregiver training that is already being separately billed for patients under a home health plan of care, receiving at-home therapy, or receiving DME services for involved medical equipment and supplies.

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Atherosclerotic Cardiovascular Disease (ASCVD) Risk Assessment and Management Services	CMS proposed new codes for ASCVD risk assessment and risk management services starting in 2025 (new codes GCDRA and GCDRM). An ASCVD risk assessment would be performed with a visit and the output must include a 10-year estimate of the patient's ASCVD risk. For patients at medium or high risk for CVS, ASCVD risk management services are proposed to include blood pressure management, cholesterol management, smoking cessation, and other elements.	ACOI supported the proposal, although recommended payment for risk management services should capture all individuals in the intermediate- (7.5-19.9 percent) and high- (20+ percent) risk groups. ACOI supported that CMS did not propose any specific tool that would have to be used for the ASCVD risk assessment, although the assessment tool must be standardized and evidence-based. ACOI asked CMS to clarify in a final rule whether a patient with a finding of coronary artery calcium would be considered as having a cardiovascular disease diagnosis for purposes of a clinician being able to separately bill for code GCDRM. ACOI supported that CMS would not require a minimum service time for ASCVD risk management services in a month. ACOI asked CMS to clarify in the final rule whether the same practitioner could bill for GCDRM and separately for other risk management services (e.g., tobacco cessation counseling services) in any one month.	CMS finalized two new codes (G0537-G0538) ASCVD risk assessment and risk management services. G0537 —Administration of a standardized, evidence-based ASCVD Risk Assessment for patients with ASCVD risk factors, 5-15 minutes, not more often than every 12 months per practitioner G0538 — ASCVD risk management services with the following required elements: patient is without a current diagnosis of ASCVD, but is determined to be at intermediate, medium, or high risk for CVD as previously determined by the ASCVD risk assessment; ASCVD-Specific care plan established, implemented, revised, or monitored that addresses risk factors and risk enhancers and must incorporate shared decision-making between the practitioner and the patient; clinical staff time directed by physician or other qualified health care professional; per calendar month. ASCVD risk assessment is reasonable and necessary for a patient who has at least one predisposing condition to cardiovascular disease that may put them at increased risk for future ASCVD diagnosis and is not separately billable for patients with a cardiovascular disease diagnosis or those who have history of a heart attack or stroke. CMS did not clarify whether a finding of coronary artery calcium would be considered as having a cardiovascular disease diagnosis. ASCVD finalized that risk assessment is not required to be performed on the same date as a visit since the physician may need to first obtain the patient's test results. CMS removed the risk management threshold percentile from the code description for G0538 services.

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Revised Payment Policies for Hepatitis B Vaccine Administration	CMS proposed to expand coverage, effective CY2025, of Hepatitis B vaccinations to all individuals who have not previously received a completed Hepatitis B vacation or whose vaccination history is unknown. The change in policy would allow these individuals to receive a covered vaccination series when medical history may not be available. CMS also proposed to remove its policy that the administration of a Part B-covered hepatitis B vaccine be preceded by a doctor's order and to allow mass immunizers to use the roster billing process to submit Medicare Part B claims for Hepatitis B vaccines and their administration.	ACOI urged caution in allowing administration of a Hepatitis B vaccine without a doctor's order, noting a patient's primary or regular physician may not be aware of the administration of the vaccine. ACOI also supported CMS' proposal to pay for a drug in the "additional preventive services" benefit category without patient cost-sharing like other Medicare preventive services.	For CY 2025, CMS is expanding coverage of hepatitis B vaccinations to all individuals who have not previously received a completed hepatitis B vaccination series or whose vaccination history is unknown. CMS will also allow roster billing for this vaccine by mass immunizers such that a physician's order would no longer be required. Also, for the first time since the law allowing coverage of drugs as "additional preventive services" was enacted in 2008, CMS will pay for a drug in this benefit category which, like other Medicare preventive services, will have no cost-sharing. Specifically, CMS will begin paying for pre-exposure prophylaxis (PrEP) for human immunodeficiency virus (HIV) infection prevention. A new code, G0012, will cover PrEP for HIV prevention injections and two new codes, G0011-G0013, will pay for counseling individuals on PrEP to prevent HIV.