CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal: 12975	**Date: November 21, 2024**
	Change Request 13887

SUBJECT: Summary of Policies in the Calendar Year (CY) 2025 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide a summary of the policies in the CY 2025 MPFS Final Rule and to announce the Telehealth Originating Site Facility Fee payment amount. The attached recurring update notification applies to publication 100-04, chapter 12, section 190.5, chapter 13, section 20.2.4, and chapter 18, section 240.

EFFECTIVE DATE: January 1, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 6, 2025

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Recurring Update Notification

Attachment - Recurring Update Notification

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II. GENERAL INFORMATION

A. Background: The CR provides a summary of the policies in the CY 2025 MPFS. Section 1848(b)(1) of the Social Security Act (the Act) requires the Secretary to establish by regulation a fee schedule of payment amounts for physicians' services for the subsequent year. The CMS issued a final rule that updates payment policies and Medicare payment rates for services furnished by physicians and Nonphysician Practitioners (NPPs) that are paid under the MPFS in CY 2025. The final rule also addresses public comments on Medicare payment policies proposed earlier this year.

B. Policy: CMS issued regulation number CMS-1807-F Medicare and Medicaid Programs; CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments. This CR provides a summary of the payment polices under the MPFS and makes other policy changes related to Medicare Part B payment. These changes are applicable to services furnished in CY 2025.

For additional information regarding the following policies, please contact:
MedicarePhysicianFeeSchedule@cms.hhs.gov

Telehealth Services

Absent Congressional action, beginning January 1, 2025, the statutory limitations that were in place for Medicare telehealth services prior to the COVID-19 Public Health Emergency will retake effect for most telehealth services. These include geographic and location restrictions on where the services are provided, and limitations on the scope of practitioners who can provide Medicare telehealth services.

For CY 2025, we are finalizing our proposal to add several services to the Medicare Telehealth Services List, including caregiver training services on a provisional basis and Pre-Exposure Prophylaxis (PrEP) counseling and safety planning interventions on a permanent basis. The list of codes that are added to the telehealth

services list can be found at: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.

We are finalizing to continue the suspension of frequency limitations for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations for CY 2025. We are also finalizing that beginning January 1, 2025, an interactive telecommunications system may include two-way, real-time, audio-only communication technology for any Medicare 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, but the patient is not capable of, or does not consent to, the use of video technology.

Additionally, we are finalizing that, through CY 2025, we will continue to permit distant site practitioners to use their currently enrolled practice locations instead of their home addresses when providing telehealth services from their home. We are also finalizing, for a certain subset of services that are required to be furnished under the direct supervision of a physician or other supervising practitioner, to permanently adopt a definition of direct supervision that allows the supervising physician or practitioner to provide such supervision via a virtual presence through real-time audio and visual interactive telecommunications. We are specifically finalizing to make permanent that the supervising physician or practitioner may provide such virtual direct supervision (1) for services furnished incident to a physician or other practitioner's professional service when provided by auxiliary personnel employed by the billing physician or supervising practitioner and working under his or her direct supervision and for which the underlying Healthcare Common Procedure Coding System (HCPCS) code has been assigned a Professional Component/Technical Component (PC/TC) indicator of "5" and services described by Current Procedural Terminology (CPT) code 99211 and (2) for office or other outpatient visits for the evaluation and management of an established patient who may not require the presence of a physician or other qualified health care professional. For all other services furnished incident that require the direct supervision of the physician or other supervising practitioner, we are finalizing to continue to permit direct supervision be provided through real-time audio and visual interactive telecommunications technology only through December 31, 2025.

We are finalizing a policy to continue to allow teaching physicians to have a virtual presence for purposes of billing for services furnished involving residents in all teaching settings, but only in clinical instances when the service is furnished virtually (for example, a three-way telehealth visit, with the patient, resident, and teaching physician in separate locations) through December 31, 2025. This virtual presence will continue to meet the requirement that the teaching physician be present for the key portion of the service.

Telehealth origination site facility fee payment amount update

Section 1834(m)(2)(B) of the Act establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31, 2002, at $20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased by the percentage increase in the Medicare Economic Index (MEI) as defined in section 1842(i)(3) of the Act. The MEI increase for 2025 is 3.5 percent. Therefore, for CY 2025, the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge, or $31.01 (The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance).

Caregiver Training Services

For CY 2025, we are finalizing our proposal to establish new coding and payment for caregiver training for direct care services and supports (HCPCS codes G0541-G0543). The topics of trainings could include, but would not be limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control. We are also finalizing our proposal to establish new coding and payment for caregiver behavior management and

modification training that could be furnished to the caregiver(s) of an individual patient (HCPCS codes G0539-G0540). We are also finalizing to allow CTS to be furnished via telehealth.

Therapy Services

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

For CY 2025, we are finalizing a regulatory change to allow for general supervision of Physical Therapist Assistants (PTAs) and Occupational Therapy Assistants (OTAs) by PTs in Private Practice (PTPPs) and OTs in Private Practice (OTPPs) for all applicable physical and occupational therapy services. This finalized change will give PTPPs and OTPPs more flexibility in meeting the needs of beneficiaries and safeguard patient access to medically necessary therapy services, including those experiencing challenges accessing these services in rural and underserved areas; and it will align with general supervision of PTAs and OTAs by PTs and OTs who work in institutional providers.

Certification of Therapy Plans of Care with a Physician or Nonphysician Practitioner (NPP) Order/Referral

For CY 2025, We are finalizing amendments to the certification regulations to lessen the administrative burden for therapists (PTs, OTs, and Speech-Language Pathologists (SLPs)) and physician/NPPs. These changes will provide an exception to the physician/NPP signature requirement on the therapist-established treatment plan for purposes of the initial certification in cases where a written order or referral from the patient's physician/NPP is on file and the therapist has documented evidence that the treatment plan was transmitted to the physician/NPP within 30 days of the initial evaluation. We also solicited comment, as suggested by interested parties, as to the need for a regulation to address the amount of time during which the physician/NPP who signed the written order for therapy services could make changes to the therapist-established treatment plan by contacting the therapist directly; but did not adopt such a timeline restriction. Instead, we clarified that for the cases meeting the exception to the signature requirement policy, payment should be made available for the therapy services furnished prior to a physician/NPP-modified treatment plan if all other payment requirements are met, including medical necessity. We did not adopt the comment solicitation as to whether there should be a 90-day (or other) limit to the physician/NPP order extending from the order date to the first date of treatment/evaluation by the therapist.

KX Modifier Thresholds

We are announcing that the KX-modifier threshold amounts for CY 2025 are $2,410 for occupational therapy services and $2,410 for physical therapy and speech-language pathology services combined.

Cardiovascular Risk Assessment and Management

The CMS Innovation Center tested the Million Hearts® Model, which coupled payments for cardiovascular risk assessment with cardiovascular care management, and was found to reduce the rate of death by lowering heart attacks and strokes among Medicare fee-for-service beneficiaries. In order to incorporate these lessons learned and increase access to these lifesaving interventions, beginning with CY 2025, we are finalizing coding and payment for an Atherosclerotic Cardiovascular Disease (ASCVD) risk assessment service and risk management services. The ASCVD risk assessment will be performed in conjunction with an E/M visit when a practitioner identifies a patient at risk for CVD who does not have a diagnosis of CVD. The standardized, evidence-based risk assessment tool used includes demographic data (e.g., age, sex), modifiable risk factors for CVD (e.g., blood pressure & cholesterol control, smoking status/history, alcohol and other drug use, physical activity and nutrition, obesity), possible risk enhancers (e.g., pre-eclampsia), and laboratory data (lipid panel), and the

output must include a 10-year estimate of the patient's ASCVD risk. We are also finalizing coding and payment for ASCVD risk management services that include service elements related to the ABCS of CVD risk reduction (aspirin, blood pressure management, cholesterol management, smoking cessation), for beneficiaries at intermediate, medium, or high risk in the next 10 years) for CVD.

Evaluation and Management (E/M) Visits

Complexity Add-on HCPCS Code G2211

For CY 2025, CMS is finalizing payment of the O/O E/M visit complexity add-on code when the O/O E/M base code is reported by the same practitioner on the same day as an Annual Wellness Visit (AWV), vaccine administration, or any Medicare Part B preventive service, effective January 1, 2025. This would ensure that our policy, which aims to make payment for previously unaccounted resources inherent in the complexity of all longitudinal primary care office visits, is achieved. In part, the visit complexity add-on code recognizes the inherent costs of building trust in the practitioner-patient relationship. We believe that trust-building in the longitudinal relationship is more significant than ever in making decisions about the administration of immunizations and other Medicare Part B preventive services.

Behavioral Health Services

In this rule, CMS is finalizing several additional actions to help support access to behavioral health, in line with the CMS Behavioral Health Strategy.

Several studies have demonstrated that safety planning, when properly performed, can help prevent suicide. For CY 2025, we are finalizing separate coding and payment under the PFS describing safety planning interventions for patients in crisis, including those with suicidal ideation or at risk of suicide or overdose. Specifically, we are finalizing payment for a G-code (HCPCS code G0560) that may be billed in 20-minute increments when safety planning interventions are personally performed by the billing practitioner in a variety of settings. Additionally, we are finalizing payment for a monthly billing code (HCPCS code G0544) that requires specific protocols in furnishing post-discharge follow-up contacts that are performed in conjunction with a discharge from the emergency department for a crisis encounter, as a bundled service describing four calls in a month.

To further support access to psychotherapy, we are finalizing Medicare payment for digital mental health treatment devices cleared under section 510(k) of the FD&C Act or granted de no novo authorization by FDA and classified under 21 CFR 882.580 furnished incident to professional behavioral health services used in conjunction with ongoing behavioral health care treatment under a behavioral health treatment plan of care. CMS is finalizing three new HCPCS codes (HCPCS codes G0552, G0553, and G0554) to describe these services. HCPCS code G0552, which describes "*Supply of digital mental health treatment device and initial education and onboarding, per course of treatment that augments a behavioral therapy plan"* is being assigned contractor-pricing. HCPCS code G0553 and G0554 are being assigned national pricing.

We are also finalizing six G codes describing interprofessional consultation (HCPCS codes G0546-G0551), to be billed by practitioners in specialties whose covered services are limited by statute to services for the diagnosis and treatment of mental illness (including Clinical Psychologists, Clinical Social Workers, Marriage and Family Therapists, and Mental Health Counselors), that mirror current interprofessional consultation CPT codes used by practitioners who are eligible to bill E/M visits.

Advanced Primary Care Management Services

For CY 2025, building on previously finalized policies and lessons learned from CMS Innovation Center primary care models, we are finalizing new coding and payment for advanced primary care management

services (HCPCS codes G0556, G0557, G0558) that incorporate elements of several existing care management and communication technology-based services into a bundle that reflects the essential elements of the delivery of advanced primary care. The codes are stratified based on patient medical and social complexity, and these codes do not have time-based thresholds, which is intended to reduce the administrative burden associated with current coding and billing.

Strategies for Improving Global Surgery Payment Accuracy

For CY 2025, we finalized a policy to broaden the applicability of the transfer of care modifier –54, for all 90-day global surgical packages (global packages) in any case when a practitioner expects to furnish only the surgical procedure portion of the global package (including but not limited to when there is a formal, documented transfer of care as under current policy or an informal, non-documented but expected, transfer of care). This finalized policy will improve payment accuracy for these 90-day global package services, and is expected to inform CMS about how global package services are typically furnished.

For CY 2025, we are also finalizing a new add-on code, HCPCS code G0559, for post-operative care services furnished by a practitioner other than the one who performed the surgical procedure (or another practitioner in the same group practice). This add-on code will more appropriately reflect the time and resources involved in these post-operative follow-up visits by practitioners who were not involved in furnishing the surgical procedure.

Dental and Oral Health Services

For CY 2025, we are finalizing the list of clinical scenarios under which fee-for-service Medicare payment may be made for dental services inextricably linked to covered services to include:

- Dental or oral examination in the inpatient or outpatient setting prior to, or contemporaneously with, Medicare-covered dialysis services for the treatment of end-stage renal disease; and
- Medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to, or contemporaneously with, Medicare-covered dialysis services for the treatment of end-stage renal disease.

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13887.1	Contractors shall be aware of the policies published in the Medicare Physician Fee Schedule Final Rule (Regulation number CMS-1807-F Medicare and Medicaid Programs; CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared	X	X	X						

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments), which are summarized with this change request and apply those policies as appropriate.									
13887.2	Contractors shall continue to pay for the Medicare telehealth originating site facility fee as 80 percent of the lesser of the actual charge or $31.01, as described by HCPCS code Q3014 "Telehealth facility fee," effective for dates of service on and after January 1, 2025.	X	X	X						
13887.3	Contractors shall use the list of telehealth services found on the CMS website at http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.	X	X							
13887.4	Contractors shall use the list of codes that are subject to the CT modifier reduction found on the CMS website at https://www.cms.gov/medicare/payment/fee-schedules/physician-fee-schedule/computed-tomography-modifier-reduction-list.		X							
13887.5	Contractors shall use the prolonged preventive services G0513 and G0514 as an add-on to the covered preventive services located on the CMS website at https://www.cms.gov/medicare/payment/fee-schedules/physician/preventive-services.		X							

IV. PROVIDER EDUCATION

Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the

newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.

Impacted Contractors: A/B MAC Part A, A/B MAC Part B, A/B MAC Part HHH

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information:N/A

VI. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0