National Rural Health Association

Calendar Year (CY) 2025 Medicare Physician Fee Schedule Final Rule

On November 1, the Centers for Medicare and Medicaid Services (CMS) released its final CY 2025 Medicare Physician Fee Schedule (PFS) rule. This rule includes a significant decrease in physician payments, improvements for rural health clinics, and other policy changes.

For more information, see the summary below or find CMS' fact sheet here. If you have any questions, contact NRHA's Government Affairs and Policy Director Alexa McKinley Abel (amckinley@ruralhealth.us).

Key provisions include:

Payment update. CMS is finalizing a -2.93% decrease in physician payment for CY 2025. This reflects a 0% overall update required by statute and the expiration of a 2.93% increase for CY 2024 passed by Congress in March. NRHA is working with members of Congress to pass another legislative fix and increase physician payment. For more information, see the *Medicare Patient Access and Practice Stabilization Act*.

Telehealth. Without congressional action, current Medicare telehealth flexibilities will expire on January 1, 2025. However, CMS is finalizing the following policies:

- Audio-only permanence: Beginning January 1, 2025, absent congressional action, CMS is preserving the ability to use audio-only telehealth with beneficiaries that cannot use audio-video or do not consent to audio-video technology. The modified definition of an interactive telecommunications system now includes audio-only communications for any service furnished to a beneficiary *in their home*. **This means that if Congress does not extend current flexibilities, audio-only telehealth will remain an option for providers and beneficiaries when their home is the originating site.**
- Direct supervision: CMS is again extending its policy to allow direct supervision via audio-video telecommunications through December 31, 2025. This policy also applies to rural health clinics (RHCs) and federally-qualified health centers (FQHCs).
    - CMS is also finalizing a similar policy to permanently change the definition of direct supervision to allow immediate availability through audio-video technology for certain incident-to services. This includes services described in 42 C.F.R. § 410.26 where services are provided by auxiliary personnel working under direct supervision and services described by CPT code 99211, an office or outpatient evaluation and management visit for an established patient.
- Opioid Treatment Programs (OTPs): CMS is finalizing its proposal to permanently allow periodic assessment to be furnished via audio-only technology. Additionally, CMS will allow the OTP intake add-on code to be furnished via audio-video technology when it is used to initiate methadone treatment for Medicare beneficiaries.

RHCs and FQHCs. CMS is finalizing several new or modified policies for RHCs, including:

- Telehealth: **Through December 31, 2025, RHCs and FQHCs will be able to provide telehealth visits as a distant site provider, even without a congressional extension of**

telehealth flexibilities. Clinics will continue to bill telehealth services with code G2025. Payment will be based on the average amount for all PFS telehealth services.

- Conditions for Certification: CMS is amending RHC conditions for certification (CfCs) to add language clarifying that RHCs must provide primary care services. CMS is not finalizing the corresponding change for FQHCs. Further, RHCs will no longer be surveyed based on whether a majority of their total hours of operation are spent on primary care. **This will allow RHCs to provide more specialty and behavioral health care as long as they also provide some level of primary care services. RHCs will be able to provide more than 50% specialty or behavioral health care.**
    - However, **CMS did not finalize its proposal to define "mental diseases".** NRHA and other commenters asked CMS not to define mental diseases but instead to define facilities that are considered to be "primarily for the care and treatment of mental diseases."
- Care coordination services (G0511): Beginning in 2025, RHCs and FQHCs will report individual CPT and HCPCS codes for care coordination services instead of billing under the single G0511 code. CMS will allow a 6-month transition period (until July 1, 2025) to enable clinics to update their billing systems.
    - This change will improve payment accuracy, allow beneficiaries to understand which services they are receiving, and allow clinics to track which care coordination services they are providing.
- Lab services: CMS is finalizing both proposals to remove hemoglobin and hematocrit from the list of required lab services and to modernize language around primary culturing. Additionally, in response to comments, CMS is also finalizing the removal of "examination of stool specimens for occult blood" from required lab services.
- Preventive vaccine costs: Effective for dates of services on or after July 1, 2025, RHCs and FQHCs will be able to bill and be paid for Part B preventive vaccines and their administration at the time of service. This change will improve the timeliness of payment and cash flow concerns.
- Productivity standards: CMS is removing RHC productivity standards for cost reporting periods beginning on or after January 1, 2025.
- Dental services: CMS is clarifying that Medicare-covered dental services furnished at RHCs and FQHCs are paid under the RHC all-inclusive rate and FQHC PPS. CMS also clarifies that dental services can be billed separately from a medical visit provided on the same day.
- Intensive Outpatient Program (IOP): RHCs and FQHCs can furnish new IOP services, created in the CY 2024 Outpatient Prospective Payment System rule. However, clinics were limited to the lower payment rate. CMS is finalizing its proposal to allow RHCs and FQHCs to bill for both the 3-service day rate and the higher 4-services per day rate.

Evaluation and Management (E/M) visits. CMS is finalizing its proposal to allow the office/outpatient (O/O) E/M visit complexity add-on code, G2211, to be billed when the O/O E/M base code is reported by the same practitioner on the same day as an annual wellness visit, vaccine administration, Initial Preventive Physical Examination, or any Part B preventive service.

Dental services. CMS is adding to the list of clinical scenarios under which Medicare payment made be made. These include a dental or oral exam and medically necessary diagnostic and treatment

services to eliminate an oral or dental infection prior to or contemporaneously with dialysis services for the treatment of end-stage renal disease (ESRD).

CMS is requiring the KX modifier on claims for dental services that practitioners believe are inextricably linked to Medicare covered services, beginning July 1, 2025. CMS is also finalizing its proposal to require the submission of a diagnosis code on the 837D dental claims format beginning July 1, 2025.

Advanced Primary Care Management Services (APCM). CMS is finalizing three new codes that describe a set of APCM services. APCM services incorporate elements of existing care management and communication technology-based services into a bundle with no time-based thresholds. Each new code reflects different payment based on the number of chronic conditions that the beneficiary has or Qualified Medicare Beneficiary status. RHCs and FQHCs can provide APCM services and will be paid at the non-facility PFS amount outside of their all-inclusive rate or FQHC PPS.

Requirements to bill for APCM services:

- Beneficiary consent, including around cost sharing.
- Initiation during a qualifying visit for new patients or patients not seen within 3 years.
- 24/7 access to a care team or practitioner for urgent needs.
- Continuity of care with a designated member of the care team.
- Deliver care in alternative ways to traditional office visits to best meet beneficiary's needs.
- Overall comprehensive care management.
- Development, implementation, revision, and maintenance of an electronic patient centered comprehensive care plan.
- Coordination of care transitions between and among health care providers and settings.
- Enhanced opportunities for beneficiaries to communicate with the care team or practitioner through asynchronous, non-face-to-face means.
- Analyze patient population data to identify gaps in care and offer additional interventions.
- Risk stratify the practice population based on defined diagnoses, claims, or other electronic data to identify and target services to patients.
- Be assessed through performance measurement of primary care quality, total cost of care, and meaningful use of Certified EHR Technology.