Release of 2025 Final Medicare Payment Rule

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On November 1, the Centers for Medicare & Medicaid Services (CMS) released the 2025 Physician Fee Schedule (PFS) final rule. Medicare payments to physicians will be reduced by 2.93% in 2025 compared to the current payment rate, in place since the spring of 2024 when Congress stepped in to stabilize rates. The Calendar Year 2025 PFS conversion factor is $32.35, a decline of $0.94 from the current conversion factor of $33.29. The negative impact of code-specific refinements on any one specialty is minimal, although ophthalmology, vascular surgery, and interventional radiology have the biggest decline at a negative 2%. (See page 2,326 for the impact-by-specialty table.)

On the flip side, Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) receive a boost in payment of 3.4%, with RHCs no longer being subject to providing certain lab services or complying with productivity standards.

In addition to the payment decline, CMS acknowledges the conclusion of the flexibilities allowed for telehealth coverage, with the ruling preserving those within the agency's authority. That includes the permission for teaching physicians supervising residents and direct supervision of auxiliary personnel (when required), via real-time, audio-visual technology through the end of 2025. For those services that remain covered, CMS will also recognize payment for audio-only services if the patient does not have the capability or does not consent to video. Distant site practitioners can use their currently enrolled practice locations instead of their home addresses when providing telehealth services from home. Payment for telehealth will remain in place for RHCs and FQHCs, according to CMS. "RHCs and FQHCs can continue to bill for…services furnished using telecommunication technology by reporting… G2025 on the claim, including services furnished using audio-only communications." **Absent Congressional action, telehealth services provided to patients in their homes will no longer be covered, with exceptions.**

The big winners in the coming year are primary care physicians, with new coding and payment policies for advanced primary care management (APCM) services that are stratified based on patients' medical and social complexity. The payment will be made through three new G-codes - G0556, G0557, G0558 – for patients with one chronic condition, two or more chronic conditions, and two or more plus status as a Qualified Medicare Beneficiary, respectively. The new APCM codes "include consent, initiating visit, 24/7 access and continuity of care, comprehensive care management, patient-centered comprehensive care plan, management of care transitions, care coordination, enhanced communication, population-level management, and performance measurement." Clinicians can use these codes based on their role as the "continuing focal point for all needed health care services and responsible for all the patient's primary care services." RHCs and FQHCs can also report the new codes, in addition to the RHC All-Inclusive Rate (AIR) or FQHC prospective payment system (PPS).

Mental health is a key focus of the new ruling. There is a new G-code, which may be billed in 20-minute increments, when safety planning interventions are personally performed by the billing practitioner. In addition, CMS approved a new monthly billing code for four post-discharge follow-up contacts performed in conjunction with a crisis encounter in the emergency department (ED). New coding and payment has been approved for Food & Drug Administration (FDA)-cleared digital mental health treatment devices used in conjunction with ongoing treatment. Arguably the most impactful change for behavioral health care is a set of six new codes for health care professionals including clinical psychologists, clinical social workers, marriage and family therapists, and mental health counselors, that mirror those CPT codes that can be reported by clinicians eligible to use evaluation and management visit codes.

The visit complexity add-on code, CPT® code G2211, can now be reported on the same day as an annual wellness visit or any Medicare Part B preventive service including a vaccine. The G2211 should be added to the evaluation and management code.

Cardiovascular risk assessment and cardiovascular care management are cited as evidence-based services to improve care. Therefore, CMS greenlighted coding and payment for an Atherosclerotic Cardiovascular Disease (ASCVD) risk assessment service and accompanying risk management services.

The federal agency updated the coverage of colorectal cancer screening, with the removal barium enema coverage and the inclusion of computed tomography colonography (CTC) and blood-based biomarker screening tests. Hepatitis B vaccinations will no longer need a physician's order and be covered without cost-sharing for Medicare beneficiaries.

Caregiver training, including those provided virtually, will be reimbursed. In addition to caregiver training for direct care services, coding and payment for caregiver behavior management and modification training has been extended. These services may also be provided via telehealth.

CMS added a new health equity benchmark adjustment for Accountable Care Organizations (ACOs) participating in Medicare's Shared Savings Program; physicians participating in Medicare through this manner should benefit.

Another add-on code was greenlighted for the inpatient setting – physicians can get a boost in payment for managing patients with a confirmed or suspected infectious disease.

When they are performing only the surgical portion of a patient's care, surgeons can use modifier 54 to signal a transfer of care for patients within the 90-day global surgical package. The managing provider, in turn, will use the new add-on code, CPT® G0559, for their post-operative care.

RHCs and FQHCs are instructed to report the individual codes that describe care coordination services instead of the single code G0511, although the community health centers will have until July 1 to comply.

Medicare's Quality Payment Program rolls on, with substantive changes that can be viewed in the 2025 QPP Policies Final Rule Fact Sheet. The performance threshold for the Merit-based Incentive Payment System (MIPS) remains at 75 points, as well as the 75% data completeness criteria threshold. Age-Appropriate Screening Colonoscopy and nine other quality measures have been deleted; seven new metrics, including Adult COVID19 Vaccination Status, have been added; and substantive changes were made to 66 quality measures in the program. Specialty-specific MIPS Value Pathways (MVPs) for ophthalmology, dermatology, gastroenterology, pulmonology, urology, and surgical care have been added, and the existing neurology guidance have been merged into a single neurological MVP.

Within minutes of the release of the November 1 rule, actions were taken to lobby Congress to reverse the payment cuts – we'll know soon whether those efforts are successful. For more information about the 2025 reimbursement landscape for Medicare, read CMS' press release here – and download the full 3,088-page report here.

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