IDSA
Infectious Diseases Society of America

Summary of CY 2025 Medicare Physician Fee Schedule Final Rule: Relevant Provisions for ID

On Nov. 1, 2024, the Centers for Medicare and Medicaid Services released its calendar year 2025 Medicare Physician Fee Schedule Final Rule.

Thanks to advocacy from IDSA members, CMS included a new add-on code for ID developed and advocated for by IDSA. Details about this new code and other changes in the MPFS can be found below. Please send comments or questions to Yasmin Rafiq, IDSA regulatory and reimbursement policy manager, at yrafiq@idsociety.org.

ID Add-On Code

The final Healthcare Common Procedure Coding System add-on code for ID services describes "the intensity and complexity inherent to hospital inpatient or observation care associated with a confirmed or suspected infectious disease performed by a physician with specialized training in infectious diseases." The new add-on code HCPCS code G0545 includes hospital and inpatient evaluation and management services to "describe service elements, including disease transmission risk assessment and mitigation, public health investigation, analysis, and testing, and complex antimicrobial therapy counseling and treatment."

The final relative value for the new code is 0.89 with a total time of 30 minutes. Under the proposed conversion factor, that translates to a $28.80 boost to hospital and inpatient evaluation and management services where the code is appended.

The new add-on code, as finalized by CMS, would provide an additional payment for the following complex inpatient services when provided by an "an infectious disease specialist." CMS has clarified that the code can be used by any ID specialists, including infectious disease specialty providers, but also mid-level specialists with infectious diseases training (e.g. a nurse practitioner):

- Disease transmission risk assessment and mitigation;
- Public health investigation, analysis and testing;
- Complex antimicrobial therapy counseling and treatment.

CMS has confirmed that code G0545 can be used for one or any combination of the three service elements and recognizes that each service element may not be medically appropriate for all patients with infectious diseases. CMS also has clarified that this add-on code recognizes "the inherent complexity for all infectious diseases and not just emerging infectious diseases with epidemic potential." CMS did not specify any additional medical record documentation requirements for reporting the HCPCS code G0545 add-on code.

G0545 could be billed based on visit level. This means the billing for G0545 depends on the type of visit it is attached to. In hospital settings, there are different visit levels based on the

complexity of the service provided and the time spent with the patient. For example, a simple evaluation might be billed at a lower level, while a more complex case requiring additional time and decision-making is billed at a higher level.

G0545 can be billed along with several hospital visit codes: ***Initial visit codes (e.g., 99221-99223)*****:** Used when a patient is admitted to the hospital and evaluated for the first time during that stay.

- ***Same-day discharge codes (e.g., 99234-99236):*** Used when a patient is admitted and discharged on the same day.
- ***Subsequent visit codes (e.g., 99231-99233):*** Used for follow-up visits with the patient during their hospital stay or observation period.

CMS noted some frequently commented provisions about the code within the final rule but will address these items in future rulemaking:

- A request to modify HCPCS code G0545 to a stand-alone code due to non-face-to-face work, followed by concerns about barriers for infectious diseases specialists using proposed base codes.
- Suggestion to use interprofessional consultation codes for non-face to-face consultations.
- Requested clarification on reporting HCPCS codes G2211 and G0545 together.
- Support for allowing broader practitioner scope to bill for HCPCS code G0545.
- Concerns with development of specialty-specific codes and an emphasis on addressing broader undervaluation of E/M services and payment solutions.

Conversion Factor

The final CY 2025 MPFS CF is set at $32.3465 — a 2.83% reduction from the current CY 2024 CF. The final CY 2025 CF reflects a 0.02% positive budget neutrality adjustment required under section 1848(c)(2)(B)(ii)(II) of the 2024 Consolidated Appropriations Act; the 0.00% update adjustment factor specified under section 1848(d)(19) of the Act; and the removal of the temporary 2.93% payment increase for services furnished from March 9, 2024, through Dec. 31, 2024, as provided in the Consolidated Appropriations Act, 2024 (p. 2323). The combined impact for ID is listed as 0% as shown below.

The specialty impacts in Table 110 reflect changes within the pool of total relative value units. The specialty impact table below does not include any changes in spending that result from finalized policies that are not subject to the statutory budget neutrality adjustment and, therefore, have a neutral impact across all specialties. The 2.50% temporary payment increase for CY 2023 and the 1.25% and 2.93% temporary payment increases that applied for portions of CY 2024 are statutory changes that take place outside of budget neutrality and, therefore, are not captured in the specialty impacts in Table 110.

TABLE 110: CY 2025 PFS Estimated Impact on Total Allowed Charges by Specialty

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
Allergy/Immunology	$218	0%	-1%	0%	-1%
Anesthesiology	$1,591	1%	1%	0%	2%
Audiologist	$74	0%	0%	0%	0%
Cardiac Surgery	$166	0%	0%	0%	-1%
Cardiology	$6,117	0%	0%	0%	0%
Chiropractic	$656	0%	1%	0%	1%
Clinical Psychologist	$737	3%	1%	0%	3%
Clinical Social Worker	$854	3%	1%	0%	4%
Colon And Rectal Surgery	$151	0%	0%	0%	0%
Critical Care	$333	0%	0%	0%	0%
Dermatology	$3,885	0%	0%	0%	0%
Diagnostic Testing Facility	$942	0%	-2%	0%	-2%
Emergency Medicine	$2,440	0%	0%	0%	0%
Endocrinology	$517	0%	0%	0%	0%
Family Practice	$5,515	0%	0%	0%	0%
Gastroenterology	$1,453	0%	0%	0%	0%
General Practice	$379	0%	0%	0%	0%
General Surgery	$1,602	0%	0%	0%	0%
Geriatrics	$222	0%	0%	0%	1%
Hand Surgery	$265	-1%	-1%	0%	-1%
Hematology/Oncology	$1,579	0%	-1%	0%	-1%
Independent Laboratory	$561	0%	0%	0%	0%
Infectious Disease	$555	0%	0%	0%	0%

Physician Fee Schedule Provisions

Practice Expense

- **Medicare Economic Index:** As proposed, CMS will again delay incorporating the 2017-based MEI in PFS ratesetting for CY 2025 as it awaits the American Medical Association's Physician Practice Information Survey and considers other data sources.
- **Updating PE Data Collection and Methods:** CMS appreciated feedback from stakeholders and will consider this in future rulemaking.

Add-On Code G2211:

The add-on code G2211 is defined as payment for office/outpatient E/M visit complexity 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. This is a change from current policy, which does not allow payment for G2211 when E/M visits are provided by the same physician or QHP to the same patient on the same day as another service and billed with CPT Modifier -25.

Purpose of G2211:

- G2211 is aimed at compensating providers for the cognitive work involved in maintaining a long-term continuous relationship with patients. This often includes addressing chronic conditions, coordinating multiple aspects of care or conducting preventive care activities.
- It reflects the provider's efforts to manage and plan for patients' long-term health, requiring careful analysis, planning and coordination of complex medical conditions.

When to Use G2211:

- Establishing or maintaining a long-term relationship: If you're providing ongoing management or engaging in preventive care, G2211 can be added to account for the additional time and resources you invest in the patient.
- Multiple or complex health issues: Use this code if you're handling chronic or multiple health conditions that require a higher level of decision-making and coordination.
- Primary care focus: G2211 is designed for primary care and certain specialties that focus on comprehensive, whole-person care (e.g., family medicine, internal medicine).
- Same-day use with E/M codes: G2211 is an add-on code that should be billed along with an E/M code for outpatient visits, such as 99202-99215.

Documentation Requirements:

- Document the nature of the provider-patient relationship, indicating any long-standing or complex conditions.
- Highlight the scope of issues addressed in the visit and any preventive or health maintenance strategies discussed.
- Show that the care provided goes beyond basic care and involves complexity that merits additional compensation.

Potentially Misvalued Services Under the PFS

COVID Immunization Administration (CPT Code 90480)

CMS agreed with commenters that it would avoid potential confusion if they did not display the RVUs for CPT code 90480 as payment will not be made using this valuation under the PFS. The proposal to assign separate pricing under the PFS for CPT code 90480 was an unintended error; CMS did not intend any confusion that may have been caused by the publication of these RVUs in the proposed rule. After consideration of the comments, CMS is not finalizing the RUC-recommended work RVU and direct PE inputs for CPT code 90480 at this time.

RSV Monoclonal Antibody Administration (CPT Codes 96380 and 96381)

IDSA supported the codes as proposed but recommended that the RUC conduct a more thorough review of the codes. CMS noted that they appreciate the support for the proposed valuations. After consideration of the comments, CMS has decided to finalize the work RVU and

direct PE inputs for the CPT codes in the RSV Monoclonal Antibody Administration family as proposed.

Telemedicine

CMS finalized its proposal not to adopt 16 of 17 new telemedicine codes established by the AMA CPT Editorial Panel. CMS will continue to pay for office and outpatient E/M as telehealth services under its current authority, bearing in mind that geographic and site of service restrictions that were in place prior to the COVID-19 public health emergency will again be in effect starting Jan. 1, 2025, without congressional action. CMS noted that they have developed PFS payment rates for CY 2025, including the statutory budget neutrality adjustment, based on the presumption that changes in telehealth utilization will not affect overall service utilization. CMS also noted that historically they have not considered changes in the Medicare telehealth policies to result in significant impact on utilization such that a budget neutrality adjustment will be warranted. However, CMS is unsure of the continuing validity of that premise under the current circumstances where patients have grown accustomed over several years to broad access to services via telehealth. CMS also finalized its proposal to adopt CPT code 98016 for virtual check-ins in lieu of HCPCS G2012.

Non-Chemotherapy Administration

In response to stakeholder support, CMS finalized updates to its Medicare Claims Processing Manual, Chapter 12, section 30.5, to include language currently consistent with CPT code definitions for the complex non-chemotherapy infusion code series stating that the administration of infusion for particular kinds of drugs and biologics can be considered complex and may be appropriately reported using the chemotherapy administration CPT codes 96401-96549.

CMS also responded to stakeholder requests that the agency establish documentation requirements in the patient medical record to demonstrate that the reported complex drug administration code meets Internet-Only Manual (IOM) guidance; release a Medicare Learning Network article to educate Medicare Administrative Contractors (MACs) and physicians on the finalized guidance; and prohibit audits and recoupments
for these services until the effective date of the finalized IOM revisions. CMS said it believes that the proposed increased detail and considerations of complexity to the IOM will sufficiently assist MACs with their determination of proper payment for these services.

Medicare Telehealth Services

Requests for Changes to the Medicare Telehealth Services List

CMS finalized the addition of individual counseling for HIV pre-exposure prophylaxis to the Medicare Telehealth Services List with a permanent status, as advocated for by IDSA.

Audio-Only Communication

CMS finalized its proposal to allow audio-only communication technology to meet the definition of a "telecommunications system" for the purposes of furnishing telehealth to beneficiaries in their homes, when certain conditions are met. As a reminder, with the expiration of PHE-related telehealth flexibilities on Dec. 31, 2024, under current law, and absent congressional action, a patient's home would not be a permissible originating site except in limited cases starting in 2025. The audio-only flexibility that starts Jan. 1, 2025, would only apply to the services that can be provided in the home, which include only behavioral/mental health services.

Direct Supervision via Virtual Presence

CMS finalized its proposal to allow for direct supervision via virtual presence using audio/video real-time communications technology on a permanent basis, but only for a subset of incident to services when: (1) the service is provided by auxiliary personnel employed by the billing practitioner and working under their direct supervision, and for which the underlying HCPCS code has been assigned a PC/TC indicator of "5"; or (2) the service is an office or other outpatient E/M visit for an established patient that may not require the presence of a physician or other qualified health care practitioner (i.e., CPT 99211).

For all other services, CMS finalized its proposal to continue to allow for direct supervision via virtual presence using real-time audio and visual interactive telecommunications technology through 2025.

Additional Payment Provisions

Hepatitis B Vaccines

CMS reviewed that hepatitis B vaccines are covered at no cost to the beneficiary as a Medicare Part B benefit for "beneficiaries who are at high or intermediate risk of contracting hepatitis B" but stated that "the regulations are outdated as these risk categories have been shown ineffective and are no longer the focus of how the medical community discusses hepatitis B infection and prevention." To address this, CMS finalized a policy that "[i]ndividuals who remain unvaccinated against hepatitis B are at intermediate risk, at minimum, of contracting hepatitis B virus." CMS also finalized a definition of individuals at "intermediate risk" if their hepatitis B vaccine status is unknown.

CMS finalized as proposed to expand coverage to more individuals at intermediate or high risk with a streamlined process that no longer requires a physician's order for vaccine administration, as advocated for by IDSA. Additionally, the rule allows mass immunizers to use roster billing with the aim of improving access.

Medicare Part B Payment for Preventive Services

COVID-19 Monoclonal Antibodies and Their Administration

Monoclonal antibodies used for COVID-19 prevention continue to be covered and reimbursed under the Part B preventive vaccine benefit. Payment policies will be updated based on any new monoclonal antibody authorizations.

Revisions to Payment Policies for Hepatitis B Vaccinations in Rural Health Clinics and Federally Qualified Health Centers

As proposed, RHCs and FQHCs will receive payment for hepatitis B vaccines at 100% of reasonable costs, separate from the bundled payment structure.

Additional Preventive Services Drugs

CMS finalized the proposed payment schedule for DCAPS (with some clarifications), utilizing existing mechanisms like ASP (if available), NADAC, FSS pricing and invoice-based pricing if needed. DCAPS drugs and their administration or supply fees are covered at 100% of the Medicare payment amount, with no beneficiary cost-sharing, aligning with preventive services policy. RHCs and FQHCs will also benefit from separate payments for DCAPS drugs.

Quality and Value-Based Care Provisions

Merit-Based Incentive Payment System

MIPS Value Pathways

While CMS reiterated its intention to move to full MVP adoption and to sunset traditional MIPS in the future, it did not mention 2029 as a potential date, as it did in the proposed rule. Six new MVPs were adopted as proposed for 2025, none relevant to ID.

CMS removed the requirement for MVP participants to select one population health measure at the time of MVP registration and will instead use the highest score of all available population health measures, as proposed.

CMS finalized its proposal to remove high/medium weights from improvement activities in MVPs; MVP participants will only be required to attest to one activity for full credit, rather than two, starting in 2025.

Modification to Infectious Disease MVP

CMS finalized the Q340: HIV Medical Frequency Quality measure to include the Total Per Capita Cost in the MVP, which IDSA was strongly opposed to. This measure currently does not allow for aspects of care that ID physicians have control over and does not provide actionable data to

help clinicians understand what they can do to lower costs and improve short-term investments.

Traditional MIPS

Data Completeness Criteria

CMS finalized its proposal to maintain the data completeness criteria threshold to at least 75% for two additional years — the CY 2027 and CY 2028 performance periods and the 2029 and 2030 MIPS payment years. CMS continues to believe that it is important to incrementally increase the data completeness criteria threshold as MIPS participants gain experience with MIPS. Prior to determining whether or not to increase the data completeness criteria threshold in the future, CMS will analyze data completeness rates from data submission and assess if it is feasible for MIPS participants to achieve a higher data completeness criteria threshold without jeopardizing their ability to successfully participate and perform in MIPS.

Improvement Activities Performance Category

CMS finalized its proposal to add the two new activities and to adopt the revised activity titled "Vaccine Achievement for Practice Staff — COVID-19, Influenza, and Hepatitis B" for the CY 2025 performance period/2027 MIPS payment year. CMS finalized a delayed implementation of the modified activity titled "Engagement of Patients through Implementation of New Patient Portal" so that it will be effective beginning with the CY 2026 performance period/2028 payment year and give practices time to plan for changes.

Qualifying Participant Thresholds and Partial QP Thresholds

As required under statute, starting with payment year 2025 (based on 2023 eligibility), QPs in Advanced Alternative Payment Models (APMs) will receive a lump-sum APM Incentive Payment equal to a 3.5% payment of their estimated aggregate paid amounts for covered professional services furnished during CY 2024 (down from 5%). In payment year 2026 (based on 2024 eligibility), this incentive payment drops to 1.88%. Also beginning in payment year 2026, CMS will apply two separate PFS CF updates—one for QPs (0.75) and one for all non-QP eligible clinicians (0.25)

Also under statute, the thresholds to achieve QP status beginning in the 2025 QP performance period will increase to 75% (from 50%) for the payment amount method, and 50% (from 35%) for the patient count method.

CMS did not finalize its proposal to use claims for <u>all</u> covered professional services to identify attribution-eligible beneficiaries for all Advanced APMs. CMS will continue to rely on the use of E/M claims, which encourages APM Entities to prefer primary care practitioners over specialists on their Participation Lists since they contribute more significantly to achieving QP status. CMS has determined there is more work to be done in this area. While the proposed approach might

make improvements to QP determinations, it could also result in low QP scores in certain Advanced APMs, particularly where an Advanced APM is focused on a limited set of services, diseases, or conditions.

Request for Information: Building Upon the MVP Framework to Improve Ambulatory Specialty Care

CMS provided no discussion about comments received in response to the Innovation Center RFI on a potential future model for specialists in ambulatory settings that would leverage the MVP framework other than noting that it would consider comments during future rulemaking and work related to the design of a future ambulatory specialty model.