HEALTHCARE REGULATORY ROUND-UP #76

2025 Proposed Rules Part 3: Medicare Physician Fee Schedule

August 14, 2024

Introductions

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Today's Agenda

1. Improving Global Surgery Payment Accuracy
2. Evaluation & Management Services (Including HCPCS G2211)
3. New Reimbursement for Preventive Services
4. Digital Therapeutics for Behavioral Health
5. Supervision of Outpatient Therapy Services
6. Opioid Treatment Programs
7. Skin Substitutes

Comments on MPFS Proposed Rule due September 9, 2024

https://www.regulations.gov

Follow "Submit a comment" instructions (File Code CMS-1807-P)

MPFS Part 4, and IPPS Final Rule

- **Part 4 – August 21**
  - Quality Payment Program (MIPS)
  - Medicare Shared Savings Program
  - SDOH-related services
  - Clinical Laboratory Fee Schedule payment reductions
- **Healthcare Regulatory Round-up #78 – September 4**
  - TEAM and Other Key Provisions in 2025 IPPS Final Rule

1. Improving Global Surgery Payment Accuracy

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The Basics – Global Surgery Packages

- Approximately 4,100 CPT[1] codes valued as global surgery packages (GSPs)
- Single CPT codes valued to include all services provided during a specific number of days by a physician or other practitioner in the same group practice
  - 0 days
  - 10 days
  - 90 days
- GSP includes:
  - Pre-operative visits
  - Surgical procedure
  - Post-operative visits and discharge services (when applicable)
  - Services provided during post-operative period related to the procedure itself

[1] Current Procedural Terminology (CPT® or CPT) and Healthcare Common Procedure Coding System (HCPCS) are registered trademarks of the American Medical Association (AMA).

GSP Payments – A Brief History

- **2015: Proposed converting all 10-, and 90-day GSPs to 0-day**
  - Goal of allowing GSP services to be billed separately
  - Ultimately prohibited
- **2017-Present: Collecting data regarding count and level of post-op evaluation and management (E&M) visits**
- **Concerns regarding accuracy of GSP payments**
  - Real world counts of post-op follow up visits
  - Assumes one model of care
  - Does not consider scenarios where the procedure and post-op follow up care are furnished by different practitioners of different specialties and/or from different group practices.

Goals for 2025 – No Formal Transfer of Care

- Revise transfer of care policy to address instances where surgical procedure and post-op follow up care are furnished by different providers when there is no formal but expected transfer of care.
- Develop an add-on CPT code that would account for the resources involved with providing post-op follow-up care provided by a practitioner who did not furnish the surgical procedure when there is no formal and unexpected transfer of care.

Clarifying the Scope of GSPs

- Under current Medicare policy, GSP scope extends to services furnished by the group practice of the proceduralist.
- Must use modifier(s) to separately bill for services unrelated to the GSP (e.g., modifier 24, modifier 57)
- Transfer of care modifiers allow GSPs to be “split” into separate components
  - Modifier 54 – Surgical care only
  - Modifier 55 – Post-operative management only
  - Modifier 56 – Pre-operative management only
- When transfer of care modifiers are reported, GSP is adjusted based upon the percentage noted in the PFS Relative Value File.

Code	Description	Global Days	Pre-Op %	Intra-Op %	Post-Op %
CPT 27130	Total Hip Arthroplasty	90	.10	.69	.21

Transfers of Care

- Under current policy, transfer of care (TOC) modifiers are required to be appended to the CPT code for the GSP only when the transfer is formally documented by the practitioners involved.
- Analysis of 2022 Medicare claims data revealed that TOC modifiers were rarely used.
  - Disproportionate number of claim lines with -54 (surgical care only) and -55 (post-op only) modifiers.
  - 99% of claim lines reported with modifier-54 were ophthalmology services*
- What does it all mean?

*Primarily cataract-related procedure

Transfers of Care (cont.)

- Proposing to require TOC modifiers to be used for all 90-day GSPs in any case when a practitioner plans to furnish only a portion of the global package.
- Including, but not limited to:
  - When there is a formal, documented TOC; or
  - When there is an informal, non-documented but expected TOC.
- No change to billing guidelines for separately identifiable E&M services
- CMS seeking comment on proposing similar changes for 10-day GSPs in future rulemaking.

Transfers of Care (cont.)

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GSP Valuation Strategies

- CMS is seeking feedback on potential approaches for revising the payment allocations percentages.
- Radiation Oncology Services (90-day GSP with no assigned pre-, intra-, or post-op payment allocation percentages)
  - *77750 - Infusion or instillation of radioelement solution (includes 3-month follow-up care)*
  - *77761 - Intracavitary radiation source application simple*
  - *77762 - Intracavitary radiation source application, intermediate*
  - *77763 - Intracavitary radiation source application, complex*
- Seeking comment on whether these services are appropriately considered 90-day GSPs, and if so, what the assigned percentages should be.

Add-On Code GPOC1

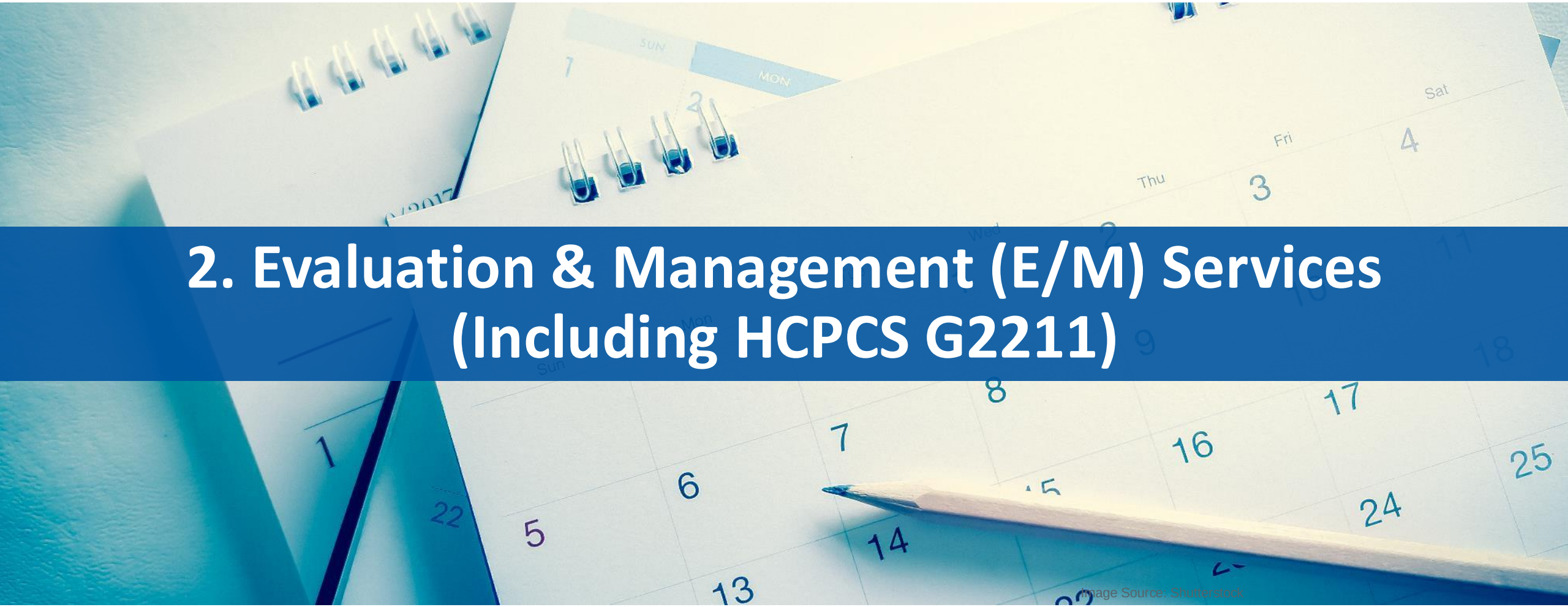
- HCPCS code GPOC1 is intended to reflect the additional time, complexity, and resource costs involved when a practitioner sees a patient post-operatively after a surgical procedure performed by another practitioner.
  - ***GPOC1*** *- (Post-operative follow-up visit complexity inherent to evaluation and management services addressing surgical procedure(s), provided by a physician or qualified health care professional who is not the practitioner who performed the procedure (or in the same group practice), and is of a different specialty than the practitioner who performed the procedure, within the 090-day global period of the procedure(s), once per 090-day global period, when there has not been a formal transfer of care.*
- Reported separately in addition to office/outpatient E&M (new or established)

Add-On Code GPOC1 (cont.)

- Elements required to support GPOC1 include, but are not limited to:
  - Reading available surgical note to understand certain elements of the procedure (e.g., success of the procedure, anatomy affected, and potential complications)
  - Researching the procedure to determine expected post-operative course
  - Evaluation and physical exam to determine if post-op course is progressing correctly
  - Communicate with the practitioner who performed the procedure if any questions or concerns arise
- Valuation for GPOC1 based upon CPT 90785 (Interactive complexity)

Code	Work RVU	Physician Time
CPT 90785	0.33	11 minutes
HCPCS GPOC1	0.16	5.5 minutes

2. Evaluation & Management (E/M) Services (Including HCPCS G2211)



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Changes to G2211 Allowance

G2211
Visit complexity inherent to evaluation and management associated **[1]** with medical care services that serve as the continuing focal point for all needed health care services **and/or [2]** with medical care services that are part of ongoing care related to a patient's single, serious condition, or a complex condition

- **CY 2024 Final Rule**
  - G2211 is not payable on the same day as an office/outpatient E/M billed with Modifier 25.
    - MLN: https://www.cms.gov/files/document/mm13473-how-use-office-and-outpatient-evaluation-and-management-visit-complexity-add-code-g2211.pdf
    - Concerns regarding same day annual wellness visits (AWVs) and/or vaccine administrations on the same day as an E/M visit
- **CY 2025 Proposed Rule**
  - Will allow G2211 to be billed with an E/M if the additional service billed is an annual wellness visit, vaccine administration, or other preventive service.

Addition of HCPCS Code: GIDXX

GIDXX
Visit complexity inherent to hospital inpatient or observation care associated with a confirmed or suspected infectious disease by an **infectious diseases consultant**, including disease transmission risk assessment and mitigation, public health investigation, analysis, and testing, and complex antimicrobial therapy counseling and treatment. **(add-on code, list separately in addition to hospital inpatient or observation evaluation and management visit, initial, same day discharge, or subsequent)**

- **CY 2025 Proposed Rule**
  - Allow GIDXX in additional to a hospital E/M visit specifically for infectious disease providers
  - Increased work associated with diagnosis, management, and treatment of infectious diseases that may not be adequately accounted for in current hospital inpatient or observation E/M codes
  - Managing of infectious diseases present unique challenges to health care staff and patients and requires additional unique management decisions based on specific expertise
  - Projected work RVU: 0.89

3. New Reimbursement for Preventive Services

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2025 Coverage and Payment Updates

- **Hepatitis B Vaccine + Administration**
  - Proposing to expand coverage to include individuals who have not previously received a completed hepatitis B vaccination series, and individuals with unknown vaccination history.
  - Physician order no longer required
  - Updated payment rate for G0010 *(Administration of hepatitis B vaccine)* to be determined
- **RHCs and FQHCs**
  - Beginning July 1, 2025, Part B vaccination claims (including influenza, pneumococcal, and COVID-19) would be billed at time of service
  - Paid at 100% of reasonable cost, separate FQHC PPS or the RHC All-Inclusive Rate

Drugs Covered as Additional Preventive Services

- Historically, Medicare has not paid for drugs under the benefit category of additional preventive services.
- **Proposed DCAPS Fee Schedule**
  - Will use existing Part B drug pricing mechanisms (i.e., Average Sale Price).
  - Alternative pricing methods to be used as needed based upon available data for specific drugs.
  - If ASP data unavailable; payment limit based on National Average Drug Acquisition Cost (NADAC).
  - If NADAC data unavailable; payment limit based on Federal Supply Schedule (FSS).
  - If FSS unavailable; payment would be the invoice price determined by the MAC.
- Same fee schedule for DCAPS drugs to be used in RHCs/FQHCs.

4. Digital Therapeutics for Behavioral Health

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Digital Mental Health Treatment (DMHT)

- Software devices cleared by the Food and Drug Administration (FDA) that are intended to treat or alleviate a mental health condition.
- CMS proposes three new HCPCS codes for DMHT devices modeled on coding for Remote Therapeutic Monitoring services:
  - **GMBT1** – Supply of digital mental health treatment device and initial education and onboarding, per course of treatment that augments a behavioral therapy plan
  - **GMBT2** – First 20 minutes of monthly treatment management services directly related to the patient's therapeutic use of the DMHT device that augments a behavioral therapy plan, physician/other qualified health care professional time reviewing data generated from the DMHT device from patient observations and patient specific inputs in a calendar month and requiring at least one interactive communication with the patient/caregiver during the calendar month
  - **GMBT3** – Each additional 20 minutes of monthly treatment management services directly related to the patient's therapeutic use of the digital mental health treatment (DMHT) device that augments a behavioral therapy plan, physician/other qualified health care professional time reviewing data generated from the DMHT device from patient observations and patient specific inputs in a calendar month and requiring at least one interactive communication with the patient/caregiver during the calendar month

Interprofessional Consultation

- CMS proposing the creation of 6 time-based G-codes for interprofessional consultation for behavioral health providers.
  - These would facilitate interprofessional consultations between treating/requesting practitioners and consultant practitioners, whether one or both of the practitioners is in a specialty whose practice is limited to the diagnosis and treatment of mental illness.
- Can be performed via communications technology such as telephone or internet (including videoconference).
- The treating practitioner must obtain the patient's consent in advance of these service.
- The proposed G-codes will be valued similarly to the 6 CPT codes for interprofessional consultations for practitioners who can independently bill Medicare for E/M visits.

5. Supervision of Outpatient Therapy Services

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Supervision Policy for PTAs and OTAs

- **Current Rule**
  - Direct supervision of physical therapy assistants (PTAs) and occupational therapy assistants (OTA)
    - Direct supervision: physician is present in the office suite and immediately available
    - Concerns regarding current workforce shortages which prevents sufficient availability for beneficiaries
- **CY 2025 Proposed Rule**
  - PTAs and OTAs may practice under general supervision.
    - General supervision: provided under the physical therapist (PT) or occupational therapist (OT) overall direction and control, but the PT or OTs presence is not required in the office suite

6. Opioid Treatment Programs

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Opioid Treatment Programs (OTPs)

- Makes permanent the current flexibility for furnishing periodic assessments via audio-only telecommunications so long as all other applicable requirements are met.
- Allows the OTP intake add-on code to be furnished via two-way audio-video communications technology when billed for the initiation of treatment with methadone (using HCPCS code G2076) if the OTP determines that an adequate evaluation of the patient can be accomplished via an audio-visual telehealth platform.

OTPs

- Updates payment for intake activities furnished by OTPs to include payment for social determinants of health risk assessments.
- Pays for new opioid agonist and antagonist medications approved by the FDA:
  - Nalmefene hydrochloride nasal spray product (Opvee®)
  - Injectable buprenorphine product (Brixadi®)
- Clarifies a billing requirement that OTPs must append an Opioid Use Disorder (OUD) diagnosis code on claims for OUD treatment services.

7. Skin Substitutes

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Payment for Skin Substitutes

- **CY 2023 Proposed Rule**
  - Consistent payment approach for skin substitute products across the physician office and hospital outpatient department settings;
  - Appropriate HCPCS codes that describe skin substitute products;
  - Uniform benefit category across products in the physician office setting (i.e., synthetic or comprised of human or animal-based material) for more consistent payment methodologies; and
  - Maintaining clarity for interested parties on CMS skin substitutes policies and procedures
- **CY 2024 Final Rule**
  - Approaches for identifying appropriate practice expense

Payment for Skin Substitutes

- **Market Happenings**
  - Increase in the number of HCPCS Levell II coding requests for new skin substitute products
  - CY 2024 final rule – billing and payments codes for skin substitute products are not counted for identifying refundable drugs in 2023 and 2024
- **2025 Proposed Rule**
  - Exclude billing and payment codes for skin substitutes from discarded drug refund policy

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August 21: 2025 Proposed Rules, Part 4: Medicare Physician Fee Schedule

September 4: TEAM and Other Key Provisions in 2025 IPPS Final Rule

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