CMS Final Rule:
2025 Medicare Physician Fee Schedule + Hospital Outpatient Rule
ASAM Summary of Major Provisions

On November 1, 2024 the Centers for Medicare and Medicaid Services (CMS) released the unpublished version of the final rule which revises calendar year (CY) 2025 payment policies under the Medicare Physician Fee Schedule (PFS) and makes other policy changes. The rule is set to be published in the Federal Register on December 9, 2024.

CMS has also published a fact sheet on the 2024 Medicare PFS proposed rule, available here.

CMS separately released the CY 2025 Medicare Hospital Outpatient Prospective Payment System final rule and a separate fact sheet here.

A summary of the major finalized changes that impact addiction medicine are listed below.

Conversion Factor

CMS finalized a CY 2025 Medicare conversion factor (CF) of $32.35, a decrease of $0.94 or 2.83 percent from the current 2024 CF rate of $33.29. This conversion factor multiplied by the total relative value units applied to a service totals the payment amount for a given service.

Telehealth Services

Changes to the list of telehealth services

CMS received a request to add General Behavioral Health Integration (CPT code 99484) and Principal Care Management (CPT codes 99424 – 99427) services to the list of telehealth services but are declining as they note that the codes do not meet federal regulatory definitions of telehealth services.

Inclusion of Audio-only Under the Definition of Telehealth

During the COVID-19 public health emergency (PHE), CMS used its statutory waiver authority to allow the use of audio-only technology to furnish evaluation and management (E/M) services, as well as behavioral health counseling and education services. Further, the Consolidated Appropriations Act (CAA) of 2021 removed the geographic restrictions for Medicare telehealth services for the diagnosis, evaluation, or treatment of a mental health disorder and the addition of the patient's home as a permissible originating site for these services. Following this change, CMS changed the regulatory definition of "interactive telecommunications system" to allow for audio-only to be used to furnish services to established patients in their homes for purposes of diagnosis, evaluation, or treatment of a mental health disorder (including substance use disorder) if the distant site physician or practitioner is technically capable of using an interactive telecommunications system as defined previously, but the patient is not capable of, or does not consent to, the use of video technology.

Section 4113 of the CAA, 2023 further extended the availability of telehealth services that can be furnished using audio-only technology and provided for the extension of other PHE-related

flexibilities including removal of the geographic and location limitations under section 1834(m) of the Social Security Act through December 31, 2024.

In response to these evolving regulatory flexibilities, CMS has finalized that for CY 2025, audio-only technology can be used to furnish ***any*** service on the Medicare telehealth list. Note that the list ***does not*** include services furnished in opioid treatment programs (OTPs) as these services described by those codes do not meet Medicare's definition of a telehealth service.

The full list of finalized services on the telehealth list can be found here. CMS has finalized policies to maintain most of the services already on the list of telehealth services, including codes for psychotherapy, outpatient evaluation and management (E/M) services, smoking cessation, social determinants of health risk assessments, SBIRT, unhealthy alcohol use screenings, office-based treatment of OUD, complex E/M visits, and chronic pain treatment. However, CMS has finalized policy to remove telephone E/M services from the list of Medicare telehealth services. Notably, since CPT codes 99202-05 and 99211-15 are now permanently on the list of Medicare telehealth services, CMS' change in the definition of "interactive telecommunications system" to encompass audio-only for any service on the telehealth list, these services may be provided via audio-only.

Telehealth Codes Proposed by AMA CPT Editorial Panel

CMS is finalizing its proposal not to recognize a broad swatch of new telehealth evaluation and management codes authored by the AMA's CPT Editorial Panel. CMS notes that the agency already pays for analogous evaluation and management (E/M) services for telehealth and thus, these new codes are unnecessary. Further, the statute would require CMS to pay for these services at equivalent rates to the services that CMS already covers, duplicating payments. Hence, CMS has finalized proposals for clinicians to continue to bill existing E/M codes with a telehealth indicator in 2025.

However, CMS is finalizing its proposal to adopt CPT code 98016 *(Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion)* and delete code G2012. The national payment rate for this code will be approximately $15.85.

Distant Site Requirements

CMS will continue to allow practitioners to use their practice address on enrollment forms, rather than their home address in response to safety and privacy concerns from practitioners.

Direct Supervision

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Currently, CMS allows certain services, including most incident-to services to be performed under direct supervision, meaning that the supervising physician or other supervising practitioner must be present in the office suite and "immediately available" to furnish assistance and direction throughout the performance of the procedure. Through December 31, 2024, the presence of the physician (or other practitioner) includes virtual presence through audio/video real-time communications technology (excluding audio-only). CMS will continue this status quo through 2025.

After 2025, CMS will permanently redefine direct supervision for certain services to note that the presence of the physician (or other practitioner) includes virtual presence through audio/video real-time communications technology (excluding audio-only). The services that would be included under this definition include services furnished incident to a physician's service when they are provided by auxiliary personnel employed by the physician and working under his or her direct supervision and for which the underlying HCPCS code has been assigned a PC/TC indicator of '5' (meaning that it's an incident-to service); and office and other outpatient visits for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional, such as CPT code 99211.

Services that do not fall in this category after 2025 would require direct supervision without the ability to provide this supervision via audio/video real-time communications technology.

Teaching Physician Services

CMS will continue to require through 2025 the requirement that teaching physicians have a virtual presence for purposes of billing for services furnished involving residents in all teaching settings, but only when the service is furnished virtually. This cannot be provided via audio-only.

Visit Complexity (G2211)

CMS will allow payment of the office/outpatient 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 furnished in the office or outpatient setting.

Advancing Access to Behavioral Health Services

Safety Planning Interventions

CMS has finalized a new G code to describe safety planning interventions: *G0560 (Safety planning interventions, each 20 minutes personally performed by the billing practitioner, including assisting the patient in the identification of the following personalized elements of a safety plan: recognizing warning signs of an impending suicidal or substance use-related crisis; employing internal coping strategies; utilizing social contacts and social settings as a means of distraction from suicidal thoughts or risky substance use; utilizing family members, significant others, caregivers, and/or*

friends to help resolve the crisis; contacting mental health or substance use disorder professionals or agencies; and making the environment safe.)

In response to concerns from ASAM and others, CMS has modified the code descriptor to include references to substance use and SUD clinicians.

The code will be valued based on the valuation of CPT code 90839 (Psychotherapy for crisis), which describes 60 minutes of service. CMS is assuming a typical time of 20 minutes for G0560 and is valuing the code at a work RVU of 1.09, based on one-third of the value assigned to 90839. The finalized national payment rate for this code will be approximately $41.41. Additionally, CMS will allow this code to be billed as a stand-alone service that can be billed in 20-minute increments.

CMS has also placed this code on the list of eligible telehealth services.

Post-Discharge Telephonic Follow-up Contacts Intervention

CMS finalized a new G code to describe post-discharge telephonic follow-up contacts interventions. These services would be used to describe the specific protocols involved in furnishing post-discharge follow-up contacts that are performed in conjunction with a discharge from the emergency department for a crisis encounter. The code can be billed monthly, describing four calls in a month, 10-20 minutes each. The new code is HCPCS code *G0544: Post discharge telephonic follow-up contacts performed in conjunction with a discharge from the emergency department for behavioral health or other crisis encounter, per calendar month*. As finalized, the national payment rate for this code will be approximately $61.79.

Clinicians need to have at least one phone call per month to bill for G0544 and unsuccessful attempts to reach the patient cannot be billed. Since patient cost sharing would apply, CMS will require that patient consent be obtained either before or during the furnishing of the service.

This is not an eligible Medicare telehealth service.

Digital Mental Health Treatment (DMHT)

CMS finalized three new G codes to describe digital mental health treatment. Specifically, CMS has established the following codes to allow clinicians authorized to furnish services for the diagnosis and treatment of mental illness:

- *G0552 (Supply of digital mental health treatment device and initial education and onboarding, per course of treatment that augments a behavioral therapy plan)* – billable ***only if*** the device is FDA-cleared and the billing practitioner is incurring the cost of furnishing the DMHT device to the beneficiary.
- *G0553 (First 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 information related to the use of the DMHT device, including 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).)

- *G0554 (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 information related to the use of the DMHT device, including 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. (List separately in addition to HCPCS code G0553)).*

G0522 will be based on carrier pricing. As finalized under the 2025 conversion factor, the national payment rate for G0553 will be approximately $51.76, and the national payment rate for G0554 will be approximately $39.79.

In response to concerns by ASAM and others that it is unclear whether these codes could be used to furnish services for the diagnosis and treatment of a SUD, consistent with other related changes that CMS has made in regulations to permit SUD to be included in the definition of mental health, CMS responded that the agency understands a behavioral health service to be any service furnished for the diagnosis, evaluation, or treatment of a mental health disorder, including substance use disorders (SUD). In all cases, DMHT devices under this payment policy must be cleared under section 510(k) of the FD&C Act or granted De Novo authorization by FDA and in each case must be classified under 21 CFR 882.5801 for mental or behavioral health treatment to be eligible for billing.

Interprofessional Consultation Billed by Practitioners Authorized by Statute to Treat Behavioral Health Conditions

Currently, there are six CPT codes that can be used to bill for interprofessional consultations (99451, 99452, 99446, 99447, 99448, 99449). However, these codes are limited to clinicians that can independently bill E/M services. This means that these codes cannot be billed by clinical psychologists, clinical social workers, marriage and family therapists, or mental health counselors because these practitioners cannot independently bill Medicare for E/M visits.

In response, CMS is proposing to create six new HCPCS codes to allow these mental health professionals to independently bill for consultative services with other clinicians. These services would be described by the following codes:

- G0546 (Interprofessional telephone/Internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a

verbal and written report to the patient's treating/requesting practitioner; 5-10 minutes of medical consultative discussion and review),

- G0547 (Interprofessional telephone/Internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a verbal and written report to the patient's treating/requesting practitioner; 11-20 minutes of medical consultative discussion and review),
- G0548 (Interprofessional telephone/Internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a verbal and written report to the patient's treating/requesting practitioner; 21-30 minutes of medical consultative discussion and review),
- G0549 (Interprofessional telephone/Internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a verbal and written report to the patient's treating/requesting practitioner; 31 or more minutes of medical consultative discussion and review),
- G0550 (Interprofessional telephone/Internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a written report to the patient's treating/requesting practitioner, 5 minutes or more of medical consultative time), and
- G0551 (Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, 30 minutes)

CMS will require the treating practitioner to obtain patient consent before the provision of these services, noting that cost-sharing applies, potentially for two services (the treating and the consultative practitioner). CMS is valuing these services based on a direct crosswalk to the existing CPT codes that describe these services for clinicians that can directly bill E/M services.

Here are the finalized national Medicare payment rates:

G0546: $17.15
G0547: $34.62
G0548: $52.41
G0549: $70.20
G0550: $32.35
G0551: $33.97

Opioid Treatment Program Services

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Audio-only for Periodic Assessments and Initiation of Treatment with Methadone

CMS is permitting OTPs to furnish periodic assessments using audio-only communications technology when video is not available on a permanent basis beginning January 1, 2025, so long as these services meet SAMHSA and DEA requirements.

Telehealth for Initiation of Methadone Treatment

Consistent with regulatory changes finalized by SAMHSA under 42 CFR Part 8 for methadone, and to be consistent with regulatory changes made to allow initiation of buprenorphine via telehealth in OTPs, CMS will for the first time in 2025 allow OTPs to bill G2076 (intake activities) via telehealth (excluding audio-only). This flexibility would remain in place so long as DEA and SAMHSA permit it.

Payment for Social Determinants of Health (SDOH) Risk Assessments

Consistent with regulatory changes made by SAMHSA under the 42 CFR Part 8 revisions and to sync payment with revised standards for assessing various SDOHs in OTPs, CMS is updating the payment rate for G2076 (intake activities) by adding HCPCS code G0136: *Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5–15 minutes, not more often than every 6 months* to the value of G0136. The new payment rate for G2076 will be $228.42.

Payment for Brixadi and Opvee

In line with FDA approvals of Brixadi and Opvee, CMS has finalized payment for these medications under the OTP Medicare benefit. Specifically, CMS has finalized G0532 *[Take-home supply of nasal nalmefene hydrochloride; one carton of two, 2.7 mg per 0.1 mL nasal sprays (provision of the services by a Medicare-enrolled Opioid Treatment Program); (List separately in addition to each primary code)].* The payment for this code would consist of the drug component and non-drug component of the code, consistent with the payment methodology adopted by CMS under previous rulemaking. The drug component would be priced at $75.44 while payment for the non-drug component of the code would cross-walked to CPT code 96161 *(Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument),* which is currently valued at ~$3.00. Hence, the payment total for Opvee would be about $78. CMS is further proposing to limit payment for the drug to once every 30 days with an exception for a beneficiary who has an overdose and uses the initial supply of Opvee.

Furthermore, CMS finalized a revision to G2069 (Medication-assisted treatment, buprenorphine (injectable)) to include payment for the monthly formulation of Brixadi. Specifically, the volume-weighted average sales price of Sublocade and Brixadi has been averaged to calculate the payment amount for the drug component of the revised code. Additionally, the code descriptor has been updated to reflect that G2069 is to be billed monthly.

CMS also finalzied a new code G0533 *(Medication assisted treatment, buprenorphine (injectable) administered on a weekly basis; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed)* to bill for the weekly formulation of Brixadi. The payment would be cross-walked to the payment amount described by HCPCS code J0577 *(Injection, buprenorphine extended release (brixadi), less than or equal to 7 days of therapy)*.

Require OUD Diagnosis on Claims for OUD Treatment Services

CMS has finalized a requirement that OTP claims contain an OUD diagnosis to permit payment.

Finally, CMS is finalizing three new codes for use in OTPs:

- *G0534 (Coordinated care and/or referral services, such as to adequate and accessible community resources to address unmet health-related social needs, including harm reduction interventions and recovery support services a patient needs and wishes to pursue, which significantly limit the ability to diagnose or treat an opioid use disorder; each additional 30 minutes of services (provision of the services by a Medicare-enrolled Opioid Treatment Program); List separately in addition to each primary code).*
- *G0535 (Patient navigational services, provided directly or by referral; including helping the patient to navigate health systems and identify care providers and supportive services, to build patient self-advocacy and communication skills with care providers, and to promote patient-driven action plans and goals; each additional 30 minutes of services (provision of the services by a Medicare-enrolled Opioid Treatment Program); List separately in addition to each primary code).*
- *G0536 (Peer recovery support services, provided directly or by referral; including leveraging knowledge of the condition or lived experience to provide support, mentorship, or inspiration to meet OUD treatment and recovery goals; conducting a person-centered interview to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes; developing and proposing strategies to help meet person-centered treatment goals; assisting the patient in locating or navigating recovery support services; each additional 30 minutes of services (provision of the services by a Medicare-enrolled Opioid Treatment Program); List separately in addition to each primary code).*

The value for all these new add-on codes will be $41.69.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

General Care Management

CMS finalized that beginning in CY 2025, rather than pay a weighted average of the compilation of individual CPT and HCPCS codes that bundled by HCPCS code G0511 (care management), Medicare will pay RHCs and FQHCs for billing the individual codes that make up G0511. Under this

proposal, HCPCS code G0511 would no longer be payable when billed by RHCs and FQHCs. CMS will give RHCs/FQHCs 6 months to transition to this new policy.

Direct Supervision

Like the temporary policy that CMS is proposing for services that require direct supervision under the MPFS, CMS is finalizing that until December 2025, FQHCs and RHCs may continue to provide direct supervision via virtual presence (audio/video real-time communications technology, excluding audio-only).

Telehealth for Mental Health Services

Currently, regulatory flexibilities are set to expire in December 2024 for mental health services provided by FQHCs and RHCs. Afterwards, individuals visiting FQHCs/RHCs for mental health reasons would need to have an in-person visit at least 6 months prior to a telehealth visit. Furthermore, a subsequent visit within a year following the telehealth visit must occur. CMS will delay this requirement until January 2026. While CMS is allowed to make this change for FQHCs and RHCs, allowing the same flexibility for mental health visits outside of these facilities would require action from Congress.

Intensive Outpatient Program (IOP) Services

In 2024 MPFS, CMS established payment for IOP services provided in FQHCs/RHCs, hospital outpatient departments, and community mental health centers. CMS established payment based on 3 and 4 or more services provided per day for hospital outpatient departments and community mental health centers. However, CMS only established a three service per day payment for FQHCs/RHCs. CMS has now established four or more services per day payment for FQHCs/RHCs in addition to the current three services per day payment.

Other Proposals of Interest in the Medicare Hospital Outpatient Prospective Payment System Proposed Rule

Medicaid Clinic Services Four Walls Exceptions

CMS will amend the Medicaid clinic services regulation to authorize federal reimbursement (at the state's request) for services provided by behavioral health clinics and services provided by clinics located in rural areas. CMS is finalizing an approach to defining "rural area" where states will select either a definition used by a federal agency for programmatic purposes, or a definition adopted by a state agency with a role in setting state rural health policy.

Individuals Formerly in the Custody of Penal Authorities

CMS is finalizing its proposal to narrow the definition of "custody" to no longer include individuals who are on parole, probation, and home detention. This change will remove the presumption that Medicare is prohibited from paying for health care items or services furnished to individuals on

parole, probation, or home detention, thus facilitating access to Medicare payment. To facilitate access to Medicare coverage, CMS has also revised the eligibility criteria for the special enrollment period for formerly incarcerated individuals to include individuals who have been released from incarceration or on parole, probation, or home detention.