2025 Medicare Physician Fee Schedule Proposed Rule: Regulatory Changes and Updates to Physician Payment System

Each year, the Centers for Medicare & Medicaid Services (CMS) proposes regulations that impact the reimbursement of physicians. On July 10, 2024, CMS issued a proposed rule updating payment policies and rates for physicians paid under the Medicare Physician Fee Schedule (PFS) in 2025. The proposed rule illustrates the importance of the AAN's regulatory advocacy efforts on behalf of neurologists and their patients.

CMS is projecting that the overall impact of changes contained in the proposed rule will have minimal impact on overall payment to neurology, resulting in a projected net 0% change in payments to neurology as a specialty broadly. Due to the phase-out of temporary relief measures contained in the Consolidated Appropriations Act of 2024 and statutory budget neutrality requirements, CMS is also currently proposing a reduction in the Fee Schedule conversion factor of approximately 2.8%. The AAN recognizes the detrimental impact that annual projected cuts to the conversion factor have on the sustainability of neurological practice. The AAN will continue to work with legislators to offset the impacts of statutorily required cuts. The AAN is committed to payment reform efforts to promote a sustainable payment system, such as ensuring physicians receive an inflationary adjustment tied to the Medicare Economic Index, and to working with regulators and legislators to address structural constraints within the Fee Schedule to ensure that CMS appropriately values the work done by neurologists.

Telehealth

Representing a win for AAN advocacy, CMS is proposing to redefine "interactive telecommunications system" to permanently include two-way, real-time, audio-only communication technology for any telehealth service furnished to a Medicare beneficiary in their home if the distant site physician or practitioner is technically capable of using an interactive audio-video telecommunications system but the patient is not capable of, or does not consent to, the use of video technology. CMS has historically excluded audio-only services from its definition of telehealth.

The Consolidated Appropriations Act of 2023 removed statutory restrictions on the provision of telehealth services, such as restrictions on geographic and originating sites, including the patient's home, and the provision of audio-only services, through December 31, 2024. Absent further congressional action, pre-existing restrictions on site of service and audio-only services will again go into effect beginning January 1, 2025, functionally limiting the authority of CMS to pay for telehealth visits in many settings. The AAN is committed to working with legislators to ensure that these critical flexibilities are extended beyond 2024. CMS recognizes stakeholder concerns about a potential abrupt end to telehealth services outside of rural areas and in certain types of medical

settings. As such, CMS seeks comments on its interpretation of statutory restrictions and how it might mitigate negative impacts of expiring telehealth flexibilities.

During the COVID-19 Public Health Emergency (PHE), CMS granted flexibility in certain reporting requirements whereby practitioners could perform telehealth visits from their homes without having to report their home address on publicly available Medicare enrollment files. This flexibility was due to expire at the end of 2024. Citing safety and privacy concerns, CMS is proposing to continue to permit distant site practitioners to use their currently enrolled practice location instead of their home address when providing telehealth services from their home.

In previous rulemaking, CMS established a policy through which the agency can assign codes "provisional status," which allows services to be included on the Medicare telehealth list on a temporary basis. CMS believes that it would be appropriate to complete a comprehensive analysis of all "provisional" codes currently on the Medicare Telehealth Services List before determining which codes should be made permanent. The agency is therefore not proposing to make determinations to recategorize "provisional" codes as "permanent" until such time as CMS can complete a comprehensive analysis of all such provisional codes.

In February 2023, the CPT Editorial Panel finalized new codes that describe outpatient telemedicine services delivered by synchronous audiovisual and audio-only communication technologies for new and established patients. With the addition of these codes, the CPT Editorial Panel deleted CPT codes 99441-99443, which describe telephone E/M services. After reviewing the new codes, CMS stated that the agency does not believe there is a programmatic need to recognize the new telehealth CPT code set for audio-only and audiovisual E/M codes for payment under Medicare. As such, CMS will continue to pay for telehealth E/M services using the existing office/outpatient E/M codes that are currently on the Medicare telehealth services list when they are billed with the appropriate place of service code to identify the location of the beneficiary and, when applicable, the appropriate modifier to identify the service as being furnished via audio-only communication technology. The AAN lauds CMS for acting consistent with our long-standing advocacy to ensure payment parity between in-person and telehealth service.

The agency has also proposed to cover new CPT code 9X091, which describes a brief virtual check-in encounter that is currently reported with G2012.

CMS has also historically included restrictions on how frequently a service may be furnished via telehealth. CMS is proposing to suspend the telehealth frequency limitations for the following codes through 2025:

- Subsequent Inpatient Visits: CPT Codes 99231–99233
- Subsequent Nursing Facility Visits: CPT Codes 99307–99310
- Critical Care Consultation Services: HCPCS Codes G0508 and G0509

CMS believes an abundance of caution is warranted in permanently extending virtual direct supervision policies that were established during the PHE. Therefore, the agency is proposing to adopt a policy for virtual direct supervision, but only for the following subset of incident-to services that are considered inherently lower-risk:

- Services furnished incident to a physician or other practitioner's service when 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,' which indicates services that are nearly always performed entirely by auxiliary personnel.
- Services described by CPT code 99211 (Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional).

Nevertheless, citing concerns that abruptly reverting to pre-PHE policies may impact access to care and practice patterns that were implemented during the PHE, CMS will continue to permit direct supervision that is defined by the presence and "immediate availability" of the supervising practitioner through real-time audio and visual interactive telecommunications through December 31, 2025.

In alignment with the telehealth policies that were extended in 2024, CMS is also proposing to extend its policies to permit teaching physicians to have a virtual presence in all teaching settings regardless of geographic location, but only in instances when a service is furnished virtually. This allows teaching physicians to have a virtual presence during the key portion of the Medicare telehealth service for which payment is sought, when the patient, resident, and teaching physician are all in separate locations using real-time audiovisual communications technology through December 31, 2025. This virtual presence policy excludes audio-only technology.

Evaluation and Management (E/M) Visits

CMS is proposing to make minor modifications to the G2211 complexity add-on code. Specifically, CMS is proposing to remove restrictions that previously prohibited using G2211 by the same practitioner on the same day as an annual wellness visit, vaccine administration, or any Medicare Part B preventive service furnished in the office or outpatient setting.

Caregiver Training- and Health-Related Social Needs

CMS is proposing to establish new coding and payment for caregiver training for direct care services and supports. CMS is also proposing to establish new coding and payment for caregiver behavior management and modification training that could be furnished to the caregivers of an individual patient.

CMS is also seeking additional information from stakeholders regarding initial experiences related to coding and payment changes implemented in 2024 for Community Health Integration Services, Principal Illness Navigation Services, and Social Determinants of Health Risk Assessment.

Part B and Part D Drugs

CMS is proposing to implement requirements under the Inflation Reduction Act under which drug manufacturers must pay inflation rebates if they raise the price of certain Part B and Part D drugs higher than the rate of inflation. CMS has proposed a number of methodological changes related to the calculation of rebates for impacted drugs.

CMS is proposing that for radiopharmaceuticals furnished in a setting other than a hospital outpatient department, the Medicare Administrative Contractors (MACs) shall determine payment limits based on any methodology used to determine payment limits for radiopharmaceuticals in place on or prior to November 2003, including through the use of invoice-based pricing.

Complex Infusions

In response to concerns from stakeholders including the AAN, CMS is providing clarification to the MACs regarding the administration of infusion for particular kinds of drug and biologics that can be considered complex and may be appropriately reported using chemotherapy administration CPT codes 96401-96549. This clarification will also provide complex clinical characteristics for the MACs to consider as criteria when determining payment of claims for these services.

Medicare Economic Index

CMS had previously finalized a policy to update the Medicare Economic Index (MEI) to reflect more current market conditions faced by physicians in furnishing services. Doing so would have significant impacts on the relative weights of physician work, practice expense, and malpractice RVUs. Although the agency finalized this policy, CMS chose to delay implementation, citing a need for further comment. Based on stakeholder feedback, CMS is proposing to not incorporate the updated MEI methodology for PFS rate-setting in 2025. CMS will continue to solicit feedback on how to update this index, including using data collected through an ongoing American Medical Association-led effort.

Quality Payment Program

MIPS

CMS proposes that for the 2025 performance period, the weights for Merit-based Incentive Payment System (MIPS) performance categories will be maintained at their current weightings. These are: 30% for Quality, 30% for Cost, 15% for Improvement Activities, and 25% for Promoting Interoperability. CMS proposes to continue setting the performance threshold at 75 points for the Calendar Year 2025 performance period.

CMS has proposed policy modifications to measure/activity inventories and scoring methodologies across performance categories:

- Cost:
    - 6 new episode-based cost measures (1 acute patient medical condition measure (Respiratory Infection Hospitalization); 5 chronic condition measures (Chronic Kidney Disease, End-Stage Renal Disease, Kidney Transplant Management, Prostate Cancer, and Rheumatoid Arthritis)
    - Revisions to 2 existing episode-based cost measures
    - Revisions to the cost measure scoring methodology to assess clinician cost of care more appropriately in relation to national averages

- Quality:
    - Methodology revisions for scoring topped-out quality measures in specialty sets with limited measures
- Promoting Interoperability
    - Changes to the policy governing the treatment of multiple data submissions received for the Promoting Interoperability performance category
- Improvement Activity
    - Removal of improvement activity weighting and streamlining of the reporting requirements for the performance category
    - Establishing minimum criteria for a qualifying data submission (i.e., eligible for scoring) in the Quality, Improvement Activities, and Promoting Interoperability performance categories.

APM Performance Pathway (APP)

CMS proposes to establish the Alternative Payment Model (APM) Performance Pathway (APP) Plus quality measure set. The goal of the proposed change is for MIPS APM participants to focus on the quality measures being reported through their APMs, while relying on a consistent measure set within the APP from year to year.

MIPS Value Pathways (MVPs)

CMS has proposed to combine the Optimal Care for Patients with Episodic Neurological Conditions and the Supportive Care for Neurodegenerative Conditions MVP into one MVP titled Quality Care for Patients with Neurological Conditions.

CMS has proposed that the Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes MVP remain available with minor modifications.

CMS has also proposed six new MVPs be available in the 2025 performance period related to ophthalmology, dermatology, gastroenterology, pulmonology, urology, and surgical care.

The AAN will continue to engage with CMS during the comment period to provide feedback on how the relevant policies and performance standards best reflect the quality of care provided by our members.

Access AAN resources to help you understand MVPs and the Quality Payment Program.