2025 Medicare Physician Fee Schedule (MPFS) Updates

December 5, 2024

Webinar FAQ Document

1. **Question:** For G2211, does the doctor need to indicate they will follow up with the patient?

   Answer: Healthcare Common Procedure Coding System (HCPCS) code G2211 *Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)* does not have any additional documentation requirements. The main requirements for reporting code G2211 are that the provider is the continuing focal point for all of the patient's health care service needs and has responsibility for ongoing medical care related to a patient's single, serious condition, or complex condition. You may wish to reach out to your local Medicare Administrative Contractor (MAC) for questions regarding documentation requirements.[1]

2. **Question:** Could you use the G0556-G0558 for patients taking Wegovy® or Ozempic® (semaglutide)?

   Answer: The Centers for Medicare & Medicaid Services (CMS) did not specifically address the patient's use of semaglutide drugs. The Advanced Primary Care Management (APCM) codes G0556-G0558 do not appear to be diagnosis-specific; however, the improvement activities and cost measures information lists common chronic conditions such as asthma, chronic obstructive pulmonary disease (COPD), diabetes, depression and heart failure. It may be assumed that those diseases would be appropriate conditions for use of the codes. You may wish to reach out to your local Medicare Administrative Contractor (MAC) for clarification on the diagnosis codes they would consider to be medically necessary for the service.[2]

3. **Question:** May we report the G055X codes in the same month we bill an office visit, such as 99214, with G2211?

   Answer: There does not appear to be a restriction for the APCM codes G0556-G0558 and an office visit such as Current Procedural Terminology (CPT®) code 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded* with HCPCS code G2211.

Codes G0556-G0558 should not be reported concurrently with chronic care management (CCM), principal care management (PCM), transitional care management (TCM), interprofessional consultations, remote evaluation of patient videos/images, virtual check-in and e-visits. Table 26 provides a list of the codes that CMS found that are substantially duplicative of APMC services and shouldn't be reported at the same time.[3]

4. **Question:** The "G" codes mentioned at the beginning of the webinar, can they be billed with CPT® codes 99304-99350? Services are performed in the nursing home or assisted living facility.

   Answer: HCPCS code G2211 is only available to be reported in the office setting and reported with codes 99202-99215. For 2025, CMS has indicated that the service may be reported with other Medicare Part B Preventive services, such as the annual wellness visit (AWV). Commenters asked about adding nursing home or assisted living facility visits, and CMS said they would consider it for future rule making.[4]

5. **Question:** Do you think it would be appropriate to bill G0559 Post Operative Care for when a hospitalist is picking up the postoperative care in the hospital?

   Answer: CMS didn't restrict usage of HCPCS code G0559 *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 the same or of a different specialty than the practitioner who performed the procedure, within the 90-day global period of the procedure(s), once per 90-day global period, when there has not been a formal transfer of care and requires the following required elements, when possible and applicable: reading available surgical note to understand the relative success of the procedure, the anatomy that was affected, and potential*

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[1] MLN Matters®, How to Use the Office & Outpatient Evaluation and Management Visit Complexity Add-on Code G2211, pages 1-3, available at: https://www.cms.gov/files/document/mm13473-how-use-office-and-outpatient-evaluation-and-management-visit-complexity-add-code-g2211.pdf

[2] Medicare and Medicaid Programs: Calendar Year 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; Medicare Overpayments, CMS-1807-F, "2. Advanced Primary Care Management (APCM) Services (HCPCS codes G0556, G0557, and G0558)", pages 386-513 (Display copy), available at: https://www.federalregister.gov/public-inspection/2024-25382/medicare-and-medicaid-programs-calendar-year-2025-payment-policies-under-the-physician-fee-schedule

[3] Medicare and Medicaid Programs: Calendar Year 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; Medicare Overpayments, CMS-1807-F, "2. Advanced Primary Care Management (APCM) Services (HCPCS codes G0556, G0557, and G0558)", pages 491-492 (Display copy), available at: https://www.federalregister.gov/public-inspection/2024-25382/medicare-and-medicaid-programs-calendar-year-2025-payment-policies-under-the-physician-fee-schedule

[4] Medicare and Medicaid Programs: Calendar Year 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; Medicare Overpayments, CMS-1807-F, "F. Evaluation and Management (E/M) Visits, 1. Office/Outpatient (O/O) Evaluation and Management (E/M) Visit Complexity Add-on", pages 375-379 (Display copy), available at: https://www.federalregister.gov/public-inspection/2024-25382/medicare-and-medicaid-programs-calendar-year-2025-payment-policies-under-the-physician-fee-schedule

complications that could have arisen due to the unique circumstances of the patient's operation. Research the procedure to determine expected post-operative course and potential complications (in the case of doing a post-op for a procedure outside the specialty). Evaluate and physically examine the patient to determine whether the post-operative course is progressing appropriately. Communicate with the practitioner who performed the procedure if any questions or concerns arise. (List separately in addition to office/outpatient evaluation and management visit, new or established) to a specific specialty. The provider may not be the provider who performed the service with a 90-day global period and may not be in the same group practice.[5]

6. **Question:** Is there a list of Mental Health devices that are covered with Digital Mental Health Treatment (DMHT)?

   Answer: CMS did not provide a list of devices that are covered under the new DMHT codes, G0552-G0554. The devices must be cleared, approved or granted De Novo authorization by the U.S. Food & Drug Administration (FDA) and are intended to treat or alleviate a mental health condition.[6]

7. **Question:** The way I'm reading it, we will have two different sets for audio-only services. The new 98008-98015, or for nonphysician practitioners (NPPs) 98966-98968. Are these distinct other than the billing provider?

   Answer: There is a separate webinar to address changes in the CPT® code set. The new audio-only codes, CPT® codes 98008-98015, are intended to be reported by providers who may report evaluation and management (E/M) services. This would include physicians and nonphysician practitioners (NPPs) or other qualified healthcare professionals (QHPs). The intent of the codes is to be an E/M code, only provided in an audio-only format.

   CPT® codes 98966-98968 are undergoing a slight revision to the description, along with changes to the CPT® Guidelines. The new description will read *Telephone assessment and management service provided by a nonphysician qualified health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment;*. The verbiage is placing the term "nonphysician" before the term

[5] Medicare and Medicaid Programs: Calendar Year 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; Medicare Overpayments, CMS-1807-F, "L. Strategies for Improving Global Surgery Payment Accuracy, 6. Post-operative Care Services Add-on Code", pages 733-741 (Display copy), available at: https://www.federalregister.gov/public-inspection/2024-25382/medicare-and-medicaid-programs-calendar-year-2025-payment-policies-under-the-physician-fee-schedule

[6] Medicare and Medicaid Programs: Calendar Year 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; Medicare Overpayments, CMS-1807-F, "I. Advancing Access to Behavioral Health Services, 2. Digital Mental Health Treatment (DMHT)", page 583 (Display copy), available at: https://www.federalregister.gov/public-inspection/2024-25382/medicare-and-medicaid-programs-calendar-year-2025-payment-policies-under-the-physician-fee-schedule

"qualified". Under the Telephone Services guidelines, CPT® states that the codes are for nonphysician providers. The intent is that codes 98966-98968 would be used by nonphysician clinical staff.[7]

[7] CPT® 2025 Professional Manual, Non-Face-to-Face Nonphysician Qualified Health Care Professional Services, "Telephone Services", page 884