Question 1: Is there any data that radiopharmaceuticals that are now going to be SI K will need 340B modifiers? I think they were previously excluded.

Answer: There is no indication that the separately payable radiopharmaceuticals are exempt from reporting the 340B modifier. Prior to January 1, 2025, radiopharmaceuticals were "policy packaged" and assigned to status indicator "N". Beginning January 1, 2025, radiopharmaceuticals with a per-day cost of $630 or higher will be separately payable. Because certain radiopharmaceuticals will be assigned to a payable SI, it appears that the 340B modifier TB, *Drug or biological acquired with 340b drug pricing program discount, reported for informational purposes,* would be appropriate.[1]

Question 2: Can we use regular office visit codes with modifier GT for phone calls for Medicare? It seems that Medicare will not cover the new codes as there are other more specific codes.

Answer: For 2025, the telehealth regulations revert to the pre-COVID-19 regulations. This means that the geographical restrictions (patient must be located in a rural area) and originating site requirements are back in place. When appropriate, facilities may report HCPCS code Q3014, *Telehealth originating site facility fee*. There are certain audio-video or audio-only codes that may be provided to patients at home when the call is for the diagnosis and treatment of a behavioral health or substance abuse condition. In this limited circumstance, modifier GT, *Via interactive audio and video telecommunication systems,* may be used.[2]

Question 3: Will Medicare still accept the office visit codes with modifier 95 or just not cover telehealth at all?

Answer: Barring any legislative change, Medicare will not cover telehealth for facilities reimbursed under the Outpatient Prospective Payment System (OPPS).[3]

Question 4: I had a clarifying question about policy changes to remote services, specifically therapies and medical nutrition therapy (MNT). Will this be an across the board change that hospital staff may no longer provide remote services beginning January 1, 2025?

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[1] Calendar Year (CY) 2025 Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems, II. Updates Affecting OPPS Payments, "(2) Packaging Threshold for Diagnostic Radiopharmaceuticals," page 93950, located at: https://www.govinfo.gov/content/pkg/FR-2024-11-27/pdf/2024-25521.pdf

[2] Calendar Year (CY) 2025 Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems, X. Nonrecurring Policy Changes, "A. Remote Services," pages 94275-94278, located at: https://www.govinfo.gov/content/pkg/FR-2024-11-27/pdf/2024-25521.pdf

[3] Calendar Year (CY) 2025 Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems, X. Nonrecurring Policy Changes, "A. Remote Services," pages 94277-94278, located at: https://www.govinfo.gov/content/pkg/FR-2024-11-27/pdf/2024-25521.pdf

Answer: That is correct. Barring any legislative changes, outpatient therapy services, diabetes self-management training, and medical nutrition therapy services provided by facility staff will no longer be available via telehealth. The practitioners were added as "approved providers" for the COVID-19 pandemic and will be removed as providers effective January 1, 2025.[4]

Question 5: Is the digital mental health technology (DMHT) limited to a certain product name or brand?

Answer: No. DMHT devices are not limited to a certain product or brand. However, the devices must meet the following criteria, which was outlined in the Physician Final Rule:

- The device must be cleared under section 510(k) of the Federal Food, Drug, and Cosmetic Act or granted De Novo authorization by the FDA
- The billing practitioner must be incurring the cost of furnishing the device
- The device must be furnished in association with ongoing mental health treatment under a plan of care
- The patient must be diagnosed with a mental health condition and have been prescribed the device[5]

Question 6: What is the service category and subcategory for HCPCS codes G0552 and G0560?

Answer: The Centers for Medicare & Medicaid Services (CMS) does not provide categories and subcategories for their codes. Several of the book manufacturers have created helpful categories when publishing the HCPCS codes. In one edition of the HCPCS book, these codes are listed under category "Procedures" and subcategory "Professional Services".

Question 7: Do the pass-through devices apply to specific products/brands?

Answer: Yes. The newly created pass-through codes apply to only devices that have met CMS criteria for pass-through payment. At the current time, there is a specific device described by each of the new codes.

- HCPCS code C1735 describes the Symplicity Spyral™ Catheter
- HCPCS code C1736 describes the Paradise® Ultrasound Renal Denervation System
- HCPCS code C1737 describes the iFuse Bedrock Granite™ Implant System
- HCPCS code C1738 describes the Precision GI

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[4] Calendar Year (CY) 2025 Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems, X. Nonrecurring Policy Changes, "A. Remote Services," pages 94275-94277, located at: https://www.govinfo.gov/content/pkg/FR-2024-11-27/pdf/2024-25521.pdf

[5] "CY 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; and Medicare Overpayments", I. Advancing Access to Behavioral Health Services, 2. Digital Mental Health Technology, pages 97923-97928, located at https://www.govinfo.gov/content/pkg/FR-2024-12-09/pdf/2024-25382.pdf

- HCPCS codes C1739 and C9610 have also been added to the code set for 2025, but these code were not addressed in the Final Rule, and there is no additional information available at the current time

Question 8: For procedures that have been miscalculated by CMS, is it possible to request retrospective reimbursement?

Answer: Unfortunately, no. The OPPS is a budget-neutral payment system, meaning that any increases in reimbursement must be offset somewhere else. CMS will occasionally make adjustments elsewhere in order to offset potential harm to hospitals. However, with the recent miscalculations, CMS is correcting their error before the codes go into effect in 2025 because an alert reader noticed the error in the Proposed Rule.

Question 9: Is modifier JG expiring only for Medicare? Will it still be valid for Medicaid?

Answer: Modifier JG, *Drug or biological acquired with 340B drug pricing program discount, reported for informational purposes,* is a HCPCS Level II modifier that will not be validated as of January 1, 2025. Although each payer, including the state Medicaid programs, can create their own billing and payment rules, it would be unusual to allow use of an expired code.

Question 10: CPT® code 99441 has been deleted and replaced with 98012, which Medicare will not cover. Is there an equivalent code that Medicare will cover?

Answer: Medicare does not provide reimbursement for CPT® code 99441, *Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian 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,* which is assigned a status indicator of "B" under the OPPS and will also not provide reimbursement for CPT® code 98012, *Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 10 minutes must be exceeded,* which will also be assigned a status indicator of "B" in 2025 under the OPPS.

Question 11: Are the TB, JZ, and JW modifiers still required based on the status indicator: Is the K1 status indicator the same as the K for reimbursement purposes?

Answer: CMS has not published any new information regarding reporting drug waste nor 340B modifiers. Status indicator "K1", *Non-Opiod Drugs and Biologicals for Post-Surgical Pain Relief,* functions the same as status indicator "K" for reimbursement purposes. Therefore, we assume that modifier requirements will apply to status indicator "K1". However, you may wish to reach out to your local

Medicare Administrative Contractor (MAC) for additional guidance. Additional information will be provided through Vitalware as it becomes available. You will receive separate reimbursement for any item with a status indicator of "K1", although the reimbursement calculations are different for these products, which are not subject to the drug-threshold packaging policies. Current reimbursement amounts may be viewed in VitalKnowledge for all codes, including those items assigned status indicator "K1".

Question 12: Do we assign HCPCS codes C9804 to the ON-Q pump as well as to the drug? There are two parts to the pump. Should we use two lines with C9804?

Answer: HCPCS code C9804, *Elastomeric infusion pump (e.g., On-Q* pump with bolus), including catheter and all disposable system components, non-opioid medical device (must be a qualifying Medicare non-opioid Medical device for post-surgical pain relief in accordance with section 4135 of the CAA, 2023),* includes the catheter and all disposable system components per the code description and should therefore only be assigned once. It is important that the cost of the full device be reported to CMS, so it is recommended to report the cost of all the components on a single line with HCPCS code C9804. Note that the drug used in the device is separately reportable from the device and should be billed separately using revenue codes and HCPCS codes, as appropriate.

Question 13: Will CMS reimburse CPT® code 98016?

Answer: CMS has assigned a status indicator of "B" to 98016, *Brief communication technology-based service (eg, 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 evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion,* for 2025, meaning that the code will not be reimbursed under the Hospital OPPS. This code is for use by physicians or other qualified healthcare professionals who are able to report E/M services.

Question 14: How do we identify items with a status indicator of "H1"? Are these items specific to certain products/brands?

Answer: The list of items that have been assigned status indicator "H1", *Non-opioid Medical Devices For Post-Surgical Pain Relief,* as of January 1, 2025 was provided in the PowerPoint presentation and is listed again below for your convenience. The new codes are device specific and can only be used when the product meets the definition in the code descriptor. To qualify for separate reimbursement, the device must be used to deliver a therapy to reduce postoperative pain or produce postsurgical or regional analgesia; must be FDA approved; and must demonstrate the ability to replace, reduce, or avoid opioid use.

Code	Descriptor
C9804	Elastomeric infusion pump (e.g., On-Q* pump with bolus), including catheter and all disposable system components, non-opioid medical device
C9806	Rotary peristaltic infusion pump (e.g., ambIT pump), including catheter and all disposable system components, non-opioid medical device
C9807	Nerve stimulator, percutaneous, peripheral (e.g., SPRINT peripheral nerve stimulation system), including electrode and all disposable system components, non-opioid medical device
C9808	Nerve cryoablation probe (e.g., cryoICE, cryoSPHERE, cryoSPHERE MAX, cryoICE cryoSPHERE, cryoICE cryO2), including probe and all disposable system components, non-opioid medical device
C9809	Cryoablation needle (e.g., Iovera system), including needle/tip and all disposable system components, non-opioid medical device

Question 15: Is there anything that our hospital needs to report on the facility claims we bill to satisfy the HCHE Measure?

Answer: There is nothing to report on individual facility claims to satisfy this measure. The Hospital Commitment to Health Equity (HCHE) measure in the Hospital Outpatient Quality Reporting (OQR) Program is an attestation-based measure designed to assess a hospital's commitment to health equity across five domains. Affirmative attestation is required for all elements within each domain in order to qualify for a point in the domain. Table 159 shows the attestation domains for this measure.

TABLE 159: HOSPITAL COMMITMENT TO HEALTH EQUITY MEASURE ATTESTATION DOMAINS

Attestation	**Elements: Select all that apply** (Note: Affirmative attestation of all elements within a domain would be required for the hospital to receive a point for the domain in the numerator)
Domain 1: Equity is a Strategic Priority	
Hospital commitment to reducing healthcare disparities is strengthened when equity is a key organizational priority. Please attest that your hospital has a strategic plan for advancing health equity and that it includes all the following elements.	(A) Our hospital strategic plan identifies priority populations who currently experience health disparities. (B) Our hospital strategic plan identifies health equity goals and discrete action steps to achieving these goals. (C) Our hospital strategic plan outlines specific resources which have been dedicated to achieving our equity goals. (D) Our hospital strategic plan describes our approach for engaging key stakeholders, such as community-based organizations.
Domain 2: Data Collection	
Collecting valid and reliable demographic and social determinant of health data on patients served in a hospital is an important step in identifying and eliminating health disparities. Please attest that your hospital engages in the following activities.	(A) Our hospital collects demographic information (such as self-reported race, national origin primary language and ethnicity data), and/or social determinant of health information on the majority of our patients. (B) Our hospital has training for staff in culturally sensitive collection of demographic and/or social determinant of health information. (C) Our hospital inputs demographic and/or social determinant of health information collected from patients into structured, interoperable data elements using a certified EHR technology.
Domain 3: Data Analysis	
Effective data analysis can provide insights into which factors contribute to health disparities and how to respond. Please attest that your hospital engages in the following activities.	(A) Our hospital stratifies key performance indicators by demographic and/or social determinants of health variables to identify equity gaps and includes this information on hospital performance dashboards.
Domain 4: Quality Improvement	
Health disparities are evidence that high-quality care has not been delivered equitably to all patients. Engagement in quality improvement activities can improve quality of care for all patients.	(A) Our hospital participates in local, regional, or national quality improvement activities focused on reducing health disparities.
Domain 5: Leadership Engagement	
Leaders and staff can improve their capacity to address disparities by demonstrating routine and thorough attention to equity and setting an organizational culture of equity. Please attest that your hospital engages in the following activities.	(A) Our senior leadership, including chief executives and the entire board of trustees, annually reviews our strategic plan for achieving health equity. (B) Our senior leadership, including chief executives and the entire board of trustees, annually reviews key performance indicators stratified by demographic and/or social factors.