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NEW ENGLAND HEALTHCARE INTERNAL AUDITORS INC.

HFMA/NEHIA

2025 Compliance & Internal Audit Conference

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2025 Coding Updates and Audit Risks: Navigating Compliance Pitfalls

Pam D’Apuzzo, CPC, ACS-EM, ACS-MS, CPMA

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Learning Objectives

- Understand the key coding changes for 2025
- Assess potential audit risks
- Evaluate common audit triggers associated with the new coding updates
- Understand how to identify and mitigate audit risks in your organization
- Implement effective compliance strategies
- Learn best practices for incorporating the 2025 coding updates into your compliance framework

CPT® 2025 Updates

CPT® 2025 Code Changes

Overall Updates	New Codes	Deletions	Revisions
420	270	112	38

Highlights

- Telemedicine
- Remote Therapeutic Monitoring (RTM)
- Vaccine Reporting
- Ophthalmology
- Augmented and artificial intelligence (AI)

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CPT® 2025 Code Set Changes

	Added	Deleted	Revised	Code Count
Evaluation and Management Services	17	3	0	171
Anesthesia	0	0	0	276
Surgery	33	13	5	5,880
Radiology Procedures	6	0	0	663
Pathology and Laboratory Procedures	14	6	5	1,674
Medicine Services and Procedures	18	69	22	1,071
Category II Codes	0	0	0	565
Category III Codes	81	13	2	550
PLA Codes	101	8	4	471
Total	**270**	**112**	**38**	**11,231**

420
Total changes

11,321
Total codes in 2025 code set

CPT® 2025 Highlights - Telemedicine

Telephone E/M Codes **99441-99443 DELETED.**

CPT is debuting an entirely new section of E/M to the CPT code book.

- **Audio-video telemedicine visits** for new patients and established patients:
  - **98000-98003**
  - **98004-98007**
- For the highest level synchronous audio-video and audio only E/M services (**98003, 98007, 98011, and 98015**), you'll be able to use existing prolonged service **add-on code +99417** (*Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the outpatient Evaluation and Management service)*) for services that go beyond the codes' time parameters.
- **Audio-only telemedicine visits** for new patients and established patients:
  - **98008-98011**
  - **98012-98015**

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CPT® 2025 Audio-Only

Deleted CPT telephone and HCPCS “Virtual Check-In” G-codes share many attributes that are different than office visits

Issue	Office	Telephone
New and/or Established	Both	Established only
Patient initiated only	No	Yes
Report if seen next day	Allowed	No
Allowed if “related” E/M prior 7 days	Yes	No
Licensure class limited	Phys/NPP only	Unique codes
Time or MDM	Either	Time
Time Max or Cap	No	Yes

CPT® 2025 Telemedicine and Non-Face-to-Face Services

Service	New/Established	Synchronous	Level/Unit Reported	Service Reported	Other E/M Notations
Synchronous audio-video (98000-98007)	Both	Yes	MDM or total time on the date of the service. No minimum required time, unless level selected by time.	Per single calendar date	Do not report with same-day in-person E/M
Synchronous audio-only (98008-98015)	Both	Yes	MDM or total time on the date of the service. Must be more than 10 minutes of medical discussion.	Per single calendar date	Do not report with same-day in-person E/M
Brief synchronous communication technology service (98016)	Established	Yes	A single 5- to 10-minute medical discussion	Per single calendar date	Not related to E/M in prior 7 days or leading to E/M in next 24 hours
Online digital E/M (99421-99423)	Established	No	Minutes during 7-day period	Per 7 days	Not related to E/M in prior 7 days or leading to E/M in next 24 hours

CPT® 2025 Telemedicine and Non-Face-to-Face Services

Service	New/Established	Synchronous	Level/Unit Reported	Service Reported	Other E/M Notations
Interprofessional telephone/Internet/EHR consultations (99446-99451)	Both	Not required	Minutes during 7-day period	Per 7 days	No in-person encounter within 14 days
Interprofessional telephone/Internet/EHR consultations (99452)	Both	Not required	Minutes during a single day	Per 14 days	~~No in-person encounter within 14 days~~
Care management and remote treatment management (99424, 99425, 99437, 99484, 99491)	Established	Not required	Minutes	Per calendar month	Physician or QHP time excluded on date of other E/M
All services (98000-98016, 99421-99425, 99437, 99446-99452, 99484, 99491)	Same time is not counted twice				

CPT® 2025 Highlights – Audio-Video Telemedicine

Audio-Video telemedicine visits for **new patients**:

- **98000** – *Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.*
- **98001** – *…which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.*
- **98002** – *…which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.*
- **98003** – *…which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.*

Audio-Video services for **established patients**:

- **98004** – *Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.*
- **98005** – *… which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.*
- **98006** – *…which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.*
- **98007** – *…which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.*

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CPT® 2025 Telemedicine E/M Services

CTP Code	RUC Recommended Work RVU	CPT Code	Current Work RVU
98000	0.93	99202	0.93
98001	1.60	99203	1.60
98002	2.60	99204	2.60
98003	3.50	99205	3.50

CPT® 2025 Telemedicine E/M Services

CPT Code	RUC Recommended Work RVU	CPT Code	Current Work RVU
98004	0.70	99212	0.70
98005	1.30	99213	1.30
98006	1.92	99214	1.92
98007	2.60	99215	2.80

CPT® 2025 Highlights – Audio-Only Telemedicine

Audio-Only telemedicine visits for **new patients**:

- **98008** – *Synchronous audio-only visit for the evaluation and management of a new 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, 15 minutes must be met or exceeded.*
- **98009** – *…which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.*
- **98010** – *…which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.*
- **98011** – *…which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.*

Audio-Only services for **established patients**:

- **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.*
- **98013** – *…which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.*
- **98014** – *…which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.*
- **98015** – *…which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.*

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CPT® 2025 Telemedicine E/M Services

CPT Code	RUC Recommended Work RVU	CPT Code	Current Work RVU
98008	0.90	99202	0.93
98009	1.55	99203	1.60
98010	2.42	99204	2.60
98011	3.20	99205	3.50

CPT® 2025 Telemedicine E/M Services

CPT Code	RUC Recommended Work RVU	CPT Code	Current Work RVU
98012	0.65	99212	0.70
98013	1.20	99213	1.30
98014	1.75	99214	1.92
98015	2.60	99215	2.80

CPT® 2025 Audio-Only E/M Services *ERRATA*

►Established Patient◄	
#●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. ►(Do not report 98012 for home and outpatient INR monitoring when reporting 93792, 93793)◄ correct ►(Do not report 98012 when using 99374, 99375, 99377, 99378, 99379, 99380 for the same call[s])◄ correct ►(Do not report 98012 during the same month with 99487, 99489)◄ incorrect ►(Do not report 98012 when performed during the service time of 99495, 99496)◄ incorrect

CPT® 2025 Audio-Only E/M Services Reporting Highlights

- Do not replace the **99441-9944**3 codes with audio-only codes.
- Do treat them the same as office visit codes regarding exclusionary language.
- Never count the same time twice for all time-based codes or potentially time-based (i.e. either MDM or total on the date of the encounter)
- For example:
  - One **can report** audio only visits after the first E/M that qualified the service to be Transitional Care Management
  - One **can report** audio-only visits in the same month as reporting Complex Chronic Care Management
  - One **cannot use any time** of the physician/QHP on the date of an audio-only E/M towards the time of any Care Management code.

CPT® 2025 Highlights - Telemedicine

Virtual Check-in: **98016** - Brief communication technology-based service 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.

CPT Code	Current Work RVU	RUC Recommended Work RVU	2025 CMS Work RVU
98016	N/A	0.30	0.30
G2012	0.25	N/A	Delete

CPT® 2025 Highlights – RTM

- **98975**: Remote therapeutic monitoring (e.g., therapy adherence, therapy response); initial set-up and patient education on use of equipment ***In 2025, this descriptor will add a mention of digital therapeutic intervention.***
- **98976**: Remote therapeutic monitoring (e.g., therapy adherence, therapy response); device(s) supply with scheduled (e.g., daily) recording(s) and/or programmed alert(s)transmission to monitor respiratory system, each 30 days ***In 2025, this descriptor will add a mention of device supply for data access or data transmissions to support RTM.***
- **98977**: Remote therapeutic monitoring (e.g., therapy adherence, therapy response); device(s) supply with scheduled (e.g., daily) recording(s) and/or programmed alert(s)transmission to monitor musculoskeletal system, each 30 days ***In 2025, this descriptor will add a mention of device supply for data access or data transmissions to support RTM.***
- **98978**: Remote therapeutic monitoring (e.g., therapy adherence, therapy response); device(s) supply with scheduled (e.g., daily) recording(s) and/or programmed alert(s)transmission to monitor cognitive behavioral therapy, each 30 days ***In 2025, this descriptor will add a mention of device supply for data access or data transmissions to support RTM.***

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CPT® 2025 Highlights – Vaccines

- CPT® 2025 will be rolling out new code **90684** (Pneumococcal conjugate vaccine, 21 valent(PCV21), for intramuscular use) to describe inoculations that protect patients against pneumococcal pneumonia and other pneumococcal diseases.
- **90684** joins new flu vaccine code **90695** (Influenza virus vaccine, H5N8, derived from cell cultures, adjuvanted, for intramuscular use), which protects patients against the H5N8strain of bird flu (avian influenza). Use 90695 with the corresponding administration code (**90460 or 90471**).
- There are also changes to some of the other vaccination codes effective January 1. For instance, the descriptor for **90661** will change to “Influenza virus vaccine, trivalent(ccIIV3), derived from cell cultures, subunit, antibiotic free, 0.5 mL dosage, for intramuscular use.”

CPT® 2025 Highlights – Ophthalmology

Eye and ocular adnexa surgery: New CPT code **66683** for implantation of an iris prosthesis.

CPT® 2025 has revised the descriptors to the computerized ophthalmic diagnostic imaging codes, deleting the word “scanning” from the parent code. The 2025 code set will also include a new code for retina imaging including optical coherence tomography (OCT); in all, the **four codes** changes are:

- **92132** (*Computerized ophthalmic diagnostic imaging (e.g., optical coherence tomography [OCT]), anterior segment, with interpretation and report, unilateral or bilateral*)
- **92133** (*Computerized ophthalmic diagnostic imaging (e.g., optical coherence tomography [OCT]), posterior segment, with interpretation and report, unilateral or bilateral; optic nerve*)
- **92134** (… *retina*)
- **92137** (… *retina, including OCT angiography*)

CPT® 2025 Highlights – AI

- CPT 2025 will also include seven additional **Category III codes** that describe augmentative data analysis using artificial intelligence. These apply to medical chest imaging (**0877T-0880T**), electrocardiogram measurements (**0902T-0932T**) and image-guided prostate biopsies (**0898T**).
- The AI Taxonomy introduced in 2023 has been implemented in category III CPT codes to classify AI medical services and procedures as assistive, augmentative, or autonomous based on the work performed by the AI application on behalf of the physician or other qualified health care professional (QHP). Seven category III code have been established for AI augmentative data analysis involved in electrocardiogram measurements (**0902T and 0932T**), medical chest imagining (**0877T-0880T**), and image-guided prostate biopsy (**0898T**).

CMS 2025 Final Rule

2025 Conversion Factor

	2025	2024	YTD % Change
Physician fee schedule conversion factor	$32.35	$33.29	2.8-%
Anesthesia conversion factor	$20.32	$20.77	2.2-%

**Note: All rates are effective Jan. 1, 2025, according to the final 2025 Medicare physician fee schedule.*

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CMS Final Rule – Permanent Allowance of Audio-Only

- When practitioner is AV capable but patient declines or is unable
- Only Home because in a facility the technology would exist, and the privacy would not be expected

“However, with the successive statutory extensions of the telehealth flexibilities implemented in response to the PHE for COVID-19, most recently by the CAA, 2023, and our adoption of other extensions where we have had authority to do so, we have come to believe that it would be appropriate to allow interactive audio-only telecommunications technology when any telehealth service is furnished to a beneficiary in their home (when the patient’s home is a permissible originating site) and when 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.”

CMS Final Rule – Telemedicine

- Originating site location telehealth flexibilities that began during the COVID-19 public health emergency and were extended through 2024 by Congress will end, as required by current law. Starting Jan. 1, 2025, telehealth originating site rules will **limit patient location to certain rural and underserved areas**.
- Starting Jan. 1, 2025, **two-way, real-time audio-only communication** will satisfy the requirement for an interactive telecommunications system under specific circumstances when a patient cannot use or does not consent to using video technology. However, the **distant site practitioner must still have audio-video capabilities**.
- PHE waivers currently allow any site in the United States, including the patient's home, to serve as an originating site. After the waivers expire on December 31, 2024, **the patient's home may be an originating site only for:**
    1) the diagnosis, evaluation, or treatment of a mental health or substance use disorder; or
    2) monthly End-Stage Renal Disease clinical assessments.
- CMS will add services to the Medicare Telehealth Services List, including caregiver training, PrEP for HIV counseling, and home INR monitoring.
    - **G0248** *(Home International Normalized Ratio Monitoring)*
    - **G0011** *(PrEP for HIV)*
    - **G0013** *(PrEP for HIV)*
    - **GCTD1 – 3** *(Caregiver Training In Direct Care Strategies and Techniques)*
    - **GCTB1 – 2** *(Individual Behavior Management/Modification Caregiver Training)*
    - **97550-97552** *(Caregiver Training in Strategies To Facilitate Patient Functional Performance in the Home or Community)*
    - **96202 – 96203** *(Group Behavior Management/Modification Caregiver Training)*

CMS Final Rule – Telemedicine

- CMS will permanently allow audio-only telehealth visits
  - New codes for audio-only telemedicine visits for new patients (**98008-98011**) and established patients (**98012-98015**)
  - Claims which meet these requirements and are furnished via audio-only telehealth should be submitted with CPT modifier “93”.
- CMS will **implement 98016** to replace **G2012 brief** virtual check-in.
- Continuing the suspension of frequency limitations for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations
- Continue to permit the distant site practitioner to use their currently **enrolled practice location** instead of their home address when providing telehealth services from their home

CMS Final Rule – Telemedicine

- For a certain subset of services that are required to be furnished under the **direct supervision of a supervising practitioner,** to permanently adopt a definition of direct supervision that allows the supervising practitioner to provide such **supervision through real-time audio and visual interactive telecommunications** (excluding audio-only)
    - Services furnished incident to a 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"; and**
    - 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).
- CMS to continue the current policy to allow teaching physicians to have a **virtual presence** for purposes of billing for services furnished involving residents in all teaching settings (only in clinical instances when the service is furnished virtually)
    - Example, **a three-way telehealth visit**, with the patient, resident, and teaching physician all parties in separate locations
    - This virtual presence will continue to meet the requirement that the teaching physician be **present for the key portion of the service**
    - CMS is requesting information to help us consider whether and how best to expand the array of services included under the primary care exception in future rulemaking

CMS Final Rule – Digital Mental Health Treatment

CMS finalized the following **three new codes** for digital mental health treatment (DMHT):

- **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)
- **G0552** (Supply of digital mental health treatment device and initial education and onboarding, per course of treatment that augments a behavioral therapy plan)
- The therapeutic codes **G0553 and G0554** may be billed only when there is ongoing use of the DMHT device, and **G0554** should be listed separately from **G0553**.

The following conditions must be met to report **G0552**:

- The DMHT device must have been previously approved by the FDA
- Supplying the device must be incident-to the billing practitioner's professional services in association with ongoing treatment under a plan of care by the billing practitioner
- For **G0552** to be payable, the billing practitioner must incur a cost to acquire and furnish the DMHT device.
- In addition to DMHT, CMS made several other changes to coverage, coding, and reimbursement for behavioral health services, including coverage of HCPCS codes **G0546-G0551** for certain interprofessional consultation services. The agency also finalized new HCPCS codes for safety planning interventions (**G0560**) and follow-up after a behavioral health crisis (**G0544)**.

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CMS Final Rule – Behavioral Health Services

In addition to DMHT, CMS made several other changes to coverage, coding, and reimbursement for behavioral health services, including:

- HCPCS codes **G0546-G0551** for certain interprofessional consultation services.
- HCPCS codes for safety planning interventions (**G0560**)
- Follow-up after a behavioral health crisis (**G0544**).

CMS Final Rule – Interprofessional Consults

- **Interprofessional consults** “by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis of mental illness,” according to the codes’ descriptors.
- The new codes “mirror current interprofessional consultation CPT codes used by practitioners who are eligible to bill E/M visits.”

CMS Final Rule – G2211

Providers will be able to report complexity of care add-on code **G2211** with an Office/Other outpatient E/M visit (**99202-99215**) when the patient receives:

- An Annual Wellness Visit (AWV);
- Initial Preventive Physical Examination (IPPE);
- Vaccine administration; or
- Any covered preventive service on the same day.

Under current policy, appending modifier **25** (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to the E/M code will prompt a denial of the add-on code. CMS will loosen its policy and allow payment when the E/M code is reported with the listed services, effective Jan. 1.

CMS Final Rule – Add-On for Infectious Diseases

New HCPCS **G0545.**

- Add-on code to describe the **intensity and complexity** inherent to **hospital inpatient or observation care**, associated with a **confirmed or suspected infectious disease**, performed by a practitioner with specialized training in infectious diseases.
- The final relative value for the new code is **0.89** with a total time of **30 minutes**. Under the proposed conversion factor, which translates to a **$28.80** addition to hospital and inpatient E/M services when appended.
- The new HCPCS add-on code describes service elements, including:
  - Disease transmission risk assessment and mitigation;
  - Public health investigation, analysis, and testing; and
  - Complex antimicrobial therapy counseling and treatment.

CMS Final Rule – CTS

New coding and payment for **Caregiver Training (CTS)** for direct care services and supports.

- The topics of trainings can include, but would not be limited to:
  - Techniques to prevent decubitus ulcer formation;
  - Wound care; and
  - Infection control.
- Finalizing proposal to establish new coding and payment for caregiver behavior management and modification training that can be furnished to the caregiver(s) of an individual patient.
- Finalizing a policy to allow these CTS to be furnished via telehealth.

CMS Final Rule - APCM

3 new **Advanced Primary Care Management (APMC)** codes.

- The codes do not have specific time requirements so practices will not have to keep track of the minutes treating providers and ancillary staff spend on the services within a calendar month. CMS skipped time requirements "to reduce the administrative burden associated with current coding and billing."
    1. **G0556** (Level 1) is for patients with one (1) chronic condition.
    2. **G0557** (Level 2) is for patients who have two (2) or more chronic conditions
    3. **G0558** (Level 3) should be reported when the patient has two (2) or more chronic conditions and is a Qualified Medicare Beneficiary.
- CMS also boosted the final work relative value units (RVU) for a Level 1 APCM to 0.25.
- CMS did not place limits on the specialties that can perform the service, but the agency will only pay one provider per patient per month for an APCM service and stressed the importance of explaining the service to the patient and getting patient consent in order to avoid unexpected denials.

CMS Final Rule - APCM

- The provider who bills for APCM service would be responsible for the patient's primary care and serve as the continuing focal point for all needed health care services.
- CMS expects that APCM services would ordinarily be provided by clinical staff incident to the professional services of the billing practitioner.
- The G-codes may only be billed once per calendar month and only by the single practitioner who assumes the care management role.

- The code requirements that are finalized include:
  - consent,
  - initiating visit,
  - 24/7 access,
  - continuity of care,
  - comprehensive care management,
  - patient-centered comprehensive care plan,
  - management of care transitions,
  - care coordination,
  - enhanced communication,
  - population-level management,
  - and performance measurement

CMS Final Rule – Safety Planning

- HCPCS code **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).
- The code should be **billed along with an E/M visit or psychotherapy service**, as it establishes separate payment or safety planning interventions addressing a patient's risk of harm to themselves or others.
- Monthly code for follow-up care after a patient's time of mental health crisis. **G0544** (Post discharge telephonic follow-up contacts performed in conjunction with a discharge from the emergency department for behavioral health or other crisis encounter, 4 calls per calendar month).

CPT® 2025

CMS Final Rule – Transfers of Care Modifiers

- CMS will require use of modifiers **54** (Surgical care only), **55** (Post-operative management only and **56** (Pre-operative management only) for all 90-day global surgical packages when the practitioner provides **only a portion of the global package**. Practices that provide the full global surgical package would be **exempt** from the requirement.
- CMS also finalized establishment of a new HCPCS add-on code, **G0559**, for post-operative follow-up visit complexity.
- After consideration of public comments, CMS will allow **HCPCS code G0559** to be billed by a practitioner of the **same specialty as the proceduralist** so long as they are **not in the same group practice** as the proceduralist. CMS originally proposed that the code may only be billed by a practitioner of a different specialty however, after consideration of public comments they recognized that in some clinical scenarios, it is possible that post-operative care would be furnished only by a particular specialty.

CPT® 2025

CMS Final Rule – Therapy Plans of Treatment

- CMS is finalizing amendments to the certification regulations to lessen the administrative burden for therapists (PTs, OTs, and speech-language pathologists [SLPs]) and physician/QHPs.
- These changes will provide an exception to the physician/QHP signature requirement on the therapist-established treatment plan for purposes of the **initial certification**, in cases where a written order or referral from the patient's physician/QHP is **on file** and the therapist has **documented evidence** that the treatment plan was transmitted to the physician/QHP **within 30 days of the initial evaluation**.
- CMS clarified that, for the cases meeting the exception to the signature requirement policy, payment should be made available for any therapy services furnished prior to a physician/QHP-modified treatment plan if all payment requirements are met.

CPT® 2025

CMS Final Rule – Overpayment Rules

- The rule finalizes **two (2) major changes** for Part A and B overpayments:
  - The current “reasonable diligence” standard for discovery of overpayments will be replaced by the “knowing” or “knowingly” standard used in the False Claims Act (FCA); and
  - The current 60-day report-and-repay timeline is changed to a 180-day period within which a “timely, good faith investigation to determine the existence of related overpayments that may arise from the same or similar cause or reason as the initially identified overpayment” may be conducted and the debt repaid.

CPT® 2025

2025 Audit Risk Areas

Risk Areas for Providers

- Telehealth compliance
- Split/Shared E/M services
- Use of modifier 25
- Wellness and preventive services with a problem-oriented visit
- TCM
- CCM
- RPM
- Reporting of provider refunds, overpayments, and recoveries
- Opioid prescribing practices
- Behavioral Health
- Durable Medical Equipment
- Hospice Services
- High levels of E/M services

Current OIG and Payer Audits

- Hyaluronic Acid Knee Injections
- Lower Extremity Peripheral Vascular Procedure Payments
- Oxygen and Oxygen Equipment
- Medicare Claims for Which Payments Exceeded Charges
- DME
- Spinal Pain Management Services
- Dermatologist Claims for E/M Services on the Same Day as Minor Surgical Procedures
- Psychotherapy Services
- Incident-To – *added to OIG Work Plan November 2024*

Audit Strategies

Telehealth Services

- Verify that telehealth encounters meet CMS standards for virtual care, including clear documentation of provider-patient interactions, service type, and patient location.

Opioid and Substance Use Disorder (SUD) Compliance

- Validate that opioid prescriptions and MAT services follow CMS's specific protocols and guidelines.
- Documentation should reflect clear justifications for opioid use, dose, and frequency.

Risk Adjustment Documentation for Medicare Advantage Plans

- Increase the importance of validating HCC codes
- Assess whether diagnoses are substantiated by clinical documentation and accurately captured to justify risk scores

AI Software

- Performance monitoring
- Frequent re-evaluation, especially after updates or changes

Data Analytics

- Use Predictive Analytics to Identify Risks
- Conduct Targeted Audits Using Data-Driven Insights
- Enhance Compliance Reporting and Visualization
- Measure the Effectiveness of Compliance Training Programs
- Implement a Feedback Loop to Continuously Improve Compliance Efforts

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QUESTIONS

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VMG HEALTH

WE VALUE HEALTHCARE

Contact Us:

(631) 231-0505
pam.dapuzzo@vmghealth.com
www.vmghealth.com

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