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CY 2025 CMS Final Rule Unpacked: What Home-Based Medical Care Professionals Need to Know

HCCIntelligence™ Community– January 22, 2025

Presenters

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Objectives

- Review the coding, reimbursement, and policy impacts specific to home-based medical care as a result of the CY 2025 Medicare Physician Fee Schedule Final Rule (MPFS) and how to best respond to these changes.
- Discuss changes to & newly implemented CPT codes to maximize revenue in home-based medical care.
- Discuss documentation requirements to ensure coding compliance.

Agenda

- **Welcome**
- **Review Disappointing News**
  - Conversion Factor Change
- **Uncertain News**
  - Telehealth Extension
- **Old News**
  - Transitional Care Management
  - Chronic Care Management
  - Cognitive Assessment and Care Planning Visit
  - Advanced Care Planning
  - Remote Evaluation of Recorded Video/Images
  - Online Digital E/M Service
  - Annual Wellness Visit
  - Vaccinations
- **Good News**
  - Advanced Primary Care Management
  - Caregiver Training
  - Cardiovascular Risk Assessment
  - Additional Opportunities
- **HCCIntelligence™ Community**
  - Resources
  - Join
- **Ask the Experts**

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Disappointing News

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Conversion Factor Update

- The final CY 2025 PFS conversion factor is $32.35, down 2.83% from 2024.
- G2211 only allowed for office based
- Discontinuation of Telephone E/M 99441-99443

Uncertain News

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Telehealth Extension

- Extend telehealth flexibility until 3/31/2025 (no originating site restriction)

Old News

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Reminder of Ongoing Billing Opportunities

- Transitional Care Management
- Chronic Care Management
- Cognitive Assessment and Care Planning Visit
- Advanced Care Planning
- Annual Wellness Visit
- Vaccinations
- Remote Evaluation of Recorded Video/Images
- Online Digital E/M Service
- Community Health Integration
- SDoH

Good News

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Advanced Primary Care Management

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Advance Primary Care Management: Goals

Simply Billing and Documentation

Support Complex Patient Care

Reduce ER/Hospitalization

Encourage Transition to VBC

Improve Patient Outcomes

Quality Reporting

Financial Benefits for Providers

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Advance Primary Care Management: Patient Example

77 Years-old patient

PMH: Group E COPD, HFrEF, CKD Stage 3b, DM, HTN, Hypothyroidism, High Cholesterol

Medications: 8 prescriptions

Multiple Hospitalizations due to CHF/COPD Exacerbations

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Advance Primary Care Management

Code	Description	2025 wRVU	2025 National Payment
G0556	For patient with no more than one chronic condition	0.18	$15.20
G0557	For patient with 2 or more chronic conditions, expected to last 12 months or until death of patient, place the patient at significant risk of death/acute exacerbation/decompensation, or functional decline	0.77	$48.84
G0558	For patient who is a qualified Medicare Beneficiary with 2 or more chronic conditions, expected to last 12 months or until death of patient, place the patient at significant risk of death/acute exacerbation/decompensation, or functional decline	1.67	$107.07

- Must report Quality Measures, unless exempt

Advance Primary Care Management: Case Example

Quality Measures

- Chronic condition management (such as DM, HTN)
- Patient safety (such as med reconciliation)
- Care Coordination (such as FU as discharge)
- Patient/CG experience (patient satisfaction survey)
- Population health (such as vaccination rates)
- Cost (such as reducing hospital readmissions)

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Advance Primary Care Management

Key Requirements

- Consent
- Conduct an initiating visit
- Provide 24/7 access and continuity of care
- Provide comprehensive care management
- Develop, implement, revise, and maintain an electronic patient-centered comprehensive care plan
- Coordinate care transitions
- Coordinate practitioner, home-, and community-based care
- Provide enhanced communication opportunities
- Conduct patient population-level management
- Measure and report performance

Note: If a patient has already given consent for CCM we do not get a new one for APCM

Caregiver Training

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Caregiver Training

Code	Description	2025 wRVU	2025 National Payment
G0539	Caregiver training in behavior management/modification for caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional, without the patient present, face-to-face; initial 30 minutes)	1.00	$52.08
G0540	Caregiver training in behavior management/modification for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional without the patient present, face-to-face; each additional 15 minutes)	0.54	$25.55
G0541	Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control, without the patient present), face-to-face; initial 30 minutes	1.00	$52.08
G0542	Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control, without the patient present), face-to-face; each additional 15 minutes of caregiver training	0.54	$25.55
G0543	Group caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control without the patient present), face-to-face with multiple sets of caregivers	0.23	$22.00

Caregiver Training: Case Example

G0541
Bob receives wound care from the provider. Provides training to a spouse who is the caregiver. Spent 30 extra minutes providing training.

Train wife to clean, dress, and monitor the wound effectively.
Review the patient's wound care plan with wife.
Demonstrate to wife wound cleaning using proper technique and step-by-step guidance on dressing application. Explain to wife signs of infection to monitor
Evaluate the wife's understanding through questions and teach back method.

G0539
John has dementia and caregiver. Educated

Teach wife strategies to manage behavioral disturbances to maximize patient's safety and well-being.
Provider overview of dementia and common behavioral issues.
Discuss techniques to reduce behavioral issues such as addressing possible unmet physical needs, use short, clear sentences, speak slowly and calmly, use gentle touch when appropriate, redirect attention, reassurance, and avoid confrontation.
Provide wife with ongoing support in caring for husband reduce risk of caregiver burn out

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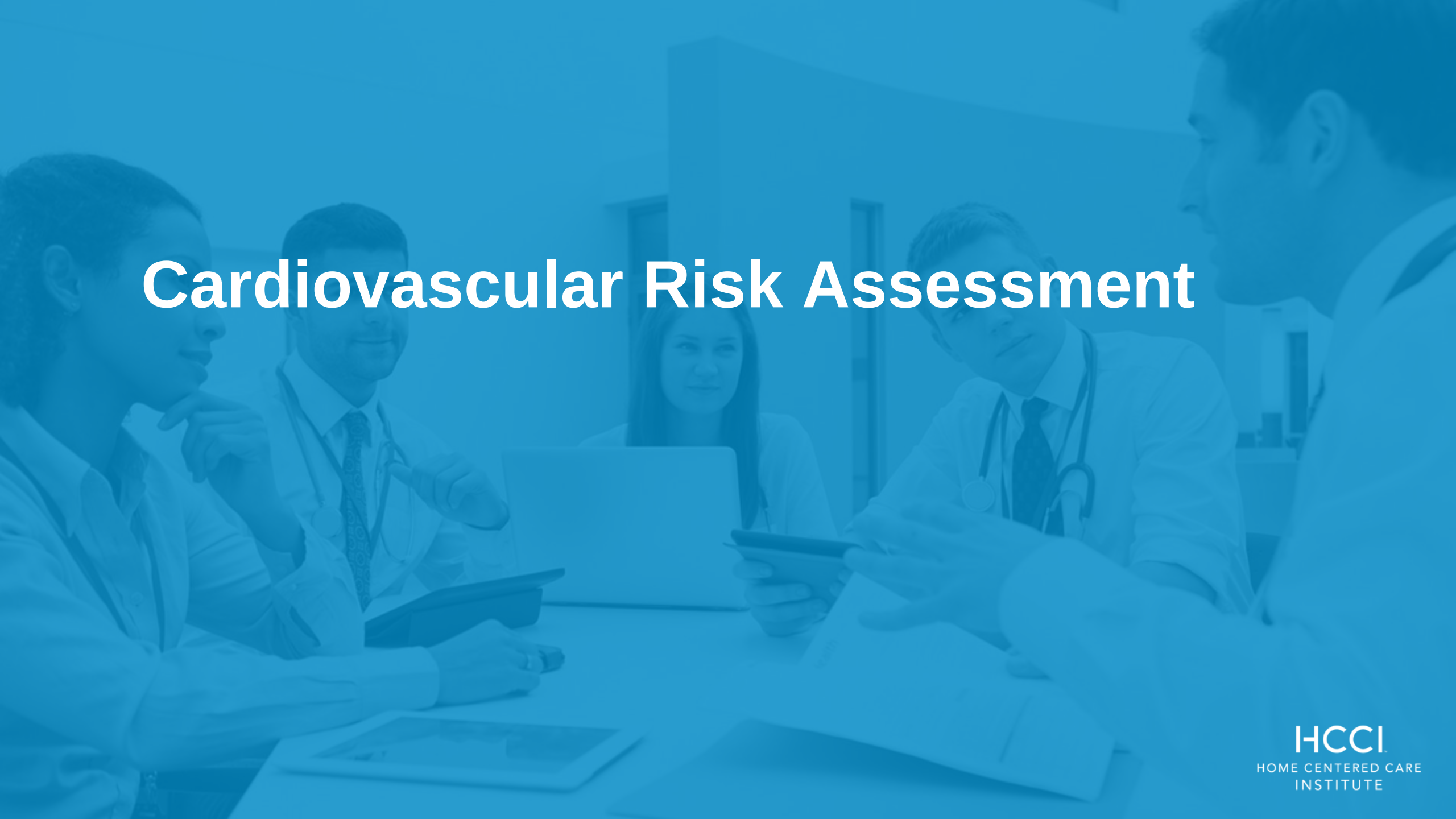
Cardiovascular Risk Assessment



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Cardiovascular Risk Assessment

Code	Description	2025 wRVU	2025 National Payment
G0537	Administration of an ASCVD risk assessment tool such as ACC's ASCVD Risk Estimator or the American Heart Association's PREVENT Tool. The assessment should be done on a patient that does not currently have a cardiovascular disease diagnosis or history of heart attack or stroke and has at least one predisposing condition that would put them at risk for future ASCVD diagnosis.	0.18	$18.44
G0538	Management of patients found to have intermediate, medium or high risk for cardiovascular disease as determined by the ASCVD risk assessment	0.18	$15.20

Note: Modifier 25 is necessary for G0537 and G0538 when billed with E/M code.

G0537 can be billed once per year
G0538 can be billed every month

Cardiovascular Risk Assessment: Case Example

- Mr X is a 58 year old patient with HTN, high cholesterol, diabetes, and morbid obesity.
- The patient does not have documented history of ASCVD.
- Use of a standardized evidence-based ASCVD risk assessment tool (AHA PREVENT Tool, ACC ASCVD Risk Estimator, 5-15 minutes) during to visit to assess the patient's CV risk profile and provide guidance on management
- Documentation of the risk assessment results and medical recommendations in the EHR.

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Additional Updates

- Telephone E/M 5 – 30 minutes 99441-99443 discontinued

- CMS will only pay separately for code 98016, which pertains to brief virtual check-ins (5 – 10 minutes).

Where to Learn More

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HCCIntelligence™ Community

- Members can access a recording of todays webinar and presentation deck via **MY HCCI Learning Hub**

HCCIntelligence™ Community Webinar Series

Safety First: Essential Strategies for House Call Providers

March 11th @ 1 pm CST

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HCCIntelligence™ : Ask the Experts

An open forum for questions and answers

HCCI Upcoming Events

Chronic Care Management in Home-Based Medical Care: Transform Patient Outcomes & Drive Revenue

February 18, 2025

1pm CT

Open Access Webinar

Topic: Chronic Care Management (CCM).

Focus: Enhance patient outcomes while driving sustainable revenue growth.

Key Insights:

- Understand CCM's definition, purpose, benefits, and requirements.
- Learn how to establish, implement, and monitor comprehensive care plans.
- Navigate CMS billing, coding, and documentation for optimized revenue.

Goal: Equip healthcare professionals with actionable strategies to implement CCM successfully.

Act Now: Space is limited!

REGISTER NOW

Measuring the Performance of House Call Programs in Medicare Advantage

March 25, 2025

1pm CT

Open Access Webinar

Topic: The growing role of Medicare Advantage (MA) in home-based primary care.

Focus: Learn how medium and large house call programs operate in MA.

Key Insights:

- Analyze key metrics, such as costs of care, hospitalization rates, ER visits, readmission rates, patient attribution, and risk scores.
- Find out how data-driven insights can optimize program outcomes.
- Leverage the data to better serve patients.

Goal: Showcase how data-driven strategies improve outcomes and patient care.

Act Now: Space is limited!

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