CY 2025 Medicare Physician Fee Schedule Final Rule (CMS-1807-F)

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Introductory Summary and Background

On November 1, 2024, the Centers for Medicare & Medicaid Services (CMS) issued the final rule for the Medicare Physician Fee Schedule (MPFS) for Calendar Year (CY) 2025.

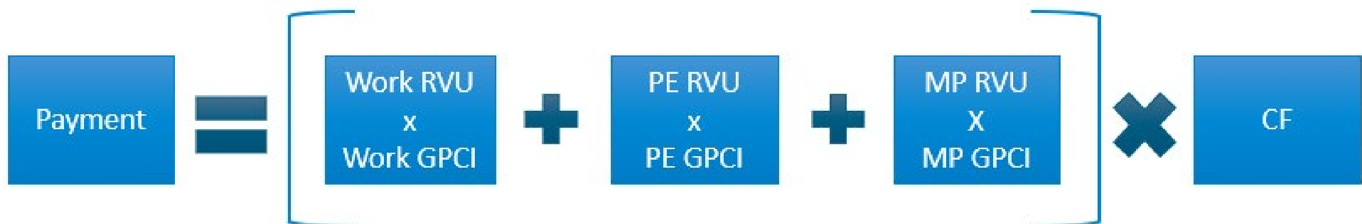
Since 1992, Medicare has paid for physician services under section 1848 of the Social Security Act entitled "Payment for Physicians' Services." This statute requires CMS to establish payments under the physician fee schedule (PFS) based on national uniform relative value units (RVUs) that account for the relative resources used in furnishing a service.

The statute requires that RVUs be established for three categories of resources:

- Work **(Work)** – services the physician provides.
- Practice Expense **(PE)** – resources that are used to provide physician services, such as office overhead and staff salaries.
- Malpractice **(MP)** expense – costs involved in malpractice insurance.

In addition, the statute requires CMS establish by regulation each year's payment amounts for all physicians' services paid under the PFS, incorporating geographic adjustments to reflect the variations in the costs of furnishing services in different geographic areas. This is referred to as the geographic practice cost indices **(GPCIs)**.

RVUs are converted to dollar amounts through the application of the conversion factor **(CF)**. The formula for calculating the MPFS is as follows:



Section 1848 of the Act requires CMS to maintain the budget within $20 million annually. In the event it is projected to exceed this amount, budget neutrality adjustments are made.

MPFS Final Rule

The CY 2025 final rule is 3,088 pages in length and located in its entirety at the following link: https://public-inspection.federalregister.gov/2024-25382.pdf. The format of the following information is intended to serve as a summary of the finalized changes and readers are encouraged to view the document in its entirety for further details.

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Changes to the MPFS Payment Rates

Conversion Factor (CF)

The finalized conversion factor (CF) for CY 2025 was calculated by first removing the 2.93 percent one-year increase set by the Consolidated Appropriations Act, 2024 (CAA 2024) from the CY 2024 CF of 33.2875. This reduced the starting CF for CY 2025 to 32.3400. Additionally, CMS finalized a 0.00 percent statutory update factor and an increase of 0.02 percent budget neutrality adjustment, which results in a final CF of 32.3465 for CY 2025.

It should be noted there is legislation in the works which would propose an increase in the conversion factor for another one-year patch. Because CMS is limited in the adjustments they can make, any changes would have to come from Congress. With the election year, the final rates for CY 2025 may not be set until after the new year begins, if any changes are passed.

TABLE 108: Calculation of the CY 2025 PFS Conversion Factor

CY 2024 Conversion Factor		33.2875
Conversion Factor without the CAA, 2024 (2.93 Percent Increase for CY 2024)		32.3400
CY 2025 Statutory Update Factor	0.00 percent (1.0000)	
CY 2025 RVU Budget Neutrality Adjustment	0.02 percent (1.0002)	
CY 2025 Conversion Factor		**32.3465**

Table 108 outlines the factors set by CMS to calculate the conversion factor:

Several specialties (e.g., vascular surgery, diagnostic testing facilities, interventional radiology, ophthalmology and optometry, hand surgery, and orthopedic surgery) will see higher negative impacts due to the decrease in the conversion factor and changes in relative value units (RVUs) for certain designated services. The decreases outside of the CF are largely due to *"the redistributive effects of increases in work RVUs for other codes, and/or rely primarily on supply/equipment items for their practice expense costs and, therefore, were affected negatively by the updated Year 4 clinical labor pricing under budget neutrality. These decreases are also due to the revaluation of individual procedures based on reviews, including consideration of AMA RUC review and recommendations, as well as decreases resulting from the continued phase-in implementation of the previously finalized supply and equipment pricing updates. The estimated impacts also reflect decreases due to the continued implementation of previously finalized code level reductions that are being phased in over several years."*

Changes in RVUs

The lowering of the CF results in decreases for many specialties and their estimated impacts. In addition, the most widespread specialty-level impacts of the RUV changes result from misvalued codes (including RVUs for new and revised codes), the finalized adjustments for global surgical procedure transfers, year four phase-in of clinical labor updates, and increased payments as a result of supply and equipment pricing updates.

CMS reminded stakeholders the impacts reflected in Table 110, seen below, are at the specialty level, "…*the changes are driven by the valuation of a relatively small number of new and/or potentially misvalued codes. The percentage changes in Table 110 are based upon aggregate estimated PFS allowed charges summed across all services furnished by physicians, practitioners, and suppliers within a specialty to arrive at the total allowed charges for the specialty, and compared to the same summed total from the previous calendar year. Therefore,*

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they are averages and may not necessarily represent what is happening to the particular services furnished by a single practitioner within any given specialty."

The impacts at the specialty level in Table 110 reflect spending changes [payments by CMS] because of the budget neutrality adjustment. This is the adjustment when CMS must maintain a budget that is no more than $20 million above or below the set value. When it is estimated that spending will exceed the threshold, they will decrease spending in one area, or one specialty, and spend it in another area, or for other specialties. That is why some specialties will see increases, while others will see decreases:

TABLE 110: CY 2025 MPFS Estimated Impact on Total Allowed Charges by Specialty

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F)* Combined Impact
Cardiac Surgery	$166	0%	0%	0%	-1%
Cardiology	$6,117	0%	0%	0%	0%
Interventional Radiology	$445	0%	-2%	0%	-2%
Vascular Surgery	$998	0%	0%	0%	0%

* Column F may not equal the sum of columns C, D, and E due to rounding.

TABLE 111: CY 2025 MPFS Estimated Impact on Total Allowed Charges by Setting

(A) Specialty	(B) Total: Non-Facility/Facility	(C) Allowed Charges (mil)	(D) Combined Impact
Cardiac Surgery	*TOTAL*	$166	-1%
	Non-Facility	$30	-2%
	Facility	$136	0%
Cardiology	*TOTAL*	$6,117	0%
	Non-Facility	$3,826	-1%
	Facility	$2,290	0%
Interventional Radiology	*TOTAL*	$445	-2%
	Non-Facility	$273	-3%
	Facility	$179	1%
Vascular Surgery	*TOTAL*	$937	-2%
	Non-Facility	$676	-2%
	Facility	$261	0%

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CMS also provided an additional file, breaking down the impacted specialties by the estimated percent of weighted total RVUs:

Distribution of Practitioners by % Change in Total RVUs and IMPACT Specialty, (weighted by total RVUs) FR2025 (using 2023 CCW claims)

Impact Specialty		Practitioner RVUs (millions)	% Change in Total RVUs *per practitioner*										
			< -%20	-20% to < -10%	-10% to < -5%	-5% to < -2%	-2% to < -1%	-1% to < 1%	1% to < 2%	2% to < 5%	5% to < 10%	10% to < 20%	>=20%
Total		**2,575**	**Share of Total Practitioner RVUs in Specialty**										
3	Cardiac Surgery	5	0%	0%	0%	7%	4%	**89%**	0%	0%	0%	0%	0%
4	Cardiology	182	0%	0%	0%	8%	12%	**77%**	1%	1%	0%	0%	0%
20	Interventional Radiology	13	0%	0%	0%	**49%**	4%	45%	1%	0%	0%	0%	0%
42	Vascular Surgery	29	0%	0%	0%	**54%**	12%	34%	0%	0%	0%	0%	0%

Work RVUs

Work RVUs are established for new, revised and potentially misvalued codes based on a portion of resources used in furnishing the service that reflects physician time and intensity. CMS conducts a review that includes the current work RVU; RUC-recommended work RVU; intensity; time to furnish the pre-service, intraservice, and post-service activities; and other components of the service that contribute to the value. CMS modifies the work RVUs for particular codes in direct proportion to the changes in the best information regarding the time resources involved to furnish particular services, considering the total time of the intraservice time. Common modifications include:

- Changes in work time;
- Equipment time;
- Standard tasks and minutes for clinical labor tasks;
- Recommended items that are not direct PE inputs;
- New supply and equipment items;
- Service period clinical labor time in the facility setting; and
- Procedures subject to the multiple procedure payment reductions (MPPR) and HOPPS cap.

In each final rule, CMS seeks nominations from the public and interested parties of codes which they consider potentially misvalued. For CY 2025, CMS has identified multiple new, revised and potentially misvalued code categories for valuation. See section entitled "Specific Codes and Code Set Valuations" below for details.

Practice Expense (PE) RVUs

PE RVUs are developed by reviewing practice resources involved in providing each service excluding malpractice expenses (MP), which are comprised of direct and indirect PE. Direct PE costs (clinical staff, medical supplies, medical equipment), are calculated based on inputs from the CMS PE database, and are generally centered on recommendations of the Relative Value Scale Update Committee (RUC). Indirect PE costs (administrative labor, office expense and all other expenses) are developed primarily on the Physician Practice Expense Information Survey (PPIS). Implemented in CY 2010, the PPIS is a multispecialty, nationally representative, PE survey of both physicians and NPPs paid under the PFS.

For procedures provided in a physician's office or facility setting in which Medicare makes a separate payment to the facility, CMS establishes 2 PE RVUs: facility and nonfacility. In calculating PE RUVs for physician services provided in a facility, resources not typically utilized by physicians while providing services are excluded. Thus, facility PE RVUs are typically lower than nonfacility PE RVUs.

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Diagnostic services are generally comprised of a professional component (PC) and a technical component (TC). The PC and TC may be furnished independently, by different providers or together as a global service. Each component has a separate reimbursement, and payment for the global service equals the sum of the payment for TC and PC. This is based on a weighted average of the ratio of direct to indirect costs across all specialties that provide the global service.

Payment modifiers are included in the creation of the PE MP RUV utilization files. These modifiers reflect current payment policy as implemented in claims processing. For example, services billed with the assistant at surgery modifiers are paid at 16 percent for a PFS service in which an assistant surgeon is allowed and has the assistant at surgery modifier appended to the code. This means the utilization file is modified to allow for 16 percent of the service that contains the assistant at surgery modifier. Table 3 below details how the modifiers are applied:

TABLE 3: Application of Payment Modifiers to Utilization Files

Modifier	Description	Volume Adjustment	Time Adjustment
80,81,82	Assistant at Surgery	16%	Intraoperative portion
AS	Assistant at Surgery – Physician Assistant	14% (85% * 16%)	Intraoperative portion
50 or LT and RT	Bilateral Surgery	150%	150% of work time
51	Multiple Procedure	50%	Intraoperative portion
52	Reduced Services	50%	50%
53	Discontinued Procedure	50%	50%
54	Intraoperative Care only	Preoperative + Intraoperative Percentages on the payment files used by Medicare contractors to process Medicare claims	Preoperative + Intraoperative portion
55	Postoperative Care only	Postoperative Percentage on the payment files used by Medicare contractors to process Medicare claims	Postoperative portion
62	Co-surgeons	62.5%	50%
66	Team Surgeons	33%	33%
CO, CQ	Physical and Occupational Therapy Assistant Services	88%	88%

Other adjustments are made, including volume and time that correspond to other payment rules such as special multiple procedure endoscopy rules and multiple procedure payment reductions (MPPRs). There are certain reduced payments for multiple imaging procedures and multiple therapy services which are not included in the development of the RVUs.

Malpractice (MP) RVUs

MP RVUs are considered to be resourced based, and required to be reviewed annually to more accurately represent and evaluate the mix of practitioners providing services on Medicare claims. There are three factors which are considered to determine MP RVUs for MPFS services:

1) Specialty-level risk factors derived from data on specialty-specific MP premiums incurred by practitioners;
2) Service-level risk factors derived from Medicare claims data of the weighted average risk factors of the specialties that furnish each service; and

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3) Intensity/complexity of service adjustment to the service level risk factor based on either the higher of the work RVU or clinical labor RVU.

In CY 2023, CMS finalized their proposal to create a specialty-level risk index for the calculation of MP RVUs. The service risk group structure change is reflective of patterns seen in the most current premium data. For some specialties, a single risk index value was applied to all services performed by those specialties. Consequently, CMS performed an analysis of the new risk index data and identified an impact threshold to incorporate the new information into their calculations while minimizing the impact on affected specialties – a reduction of approximately 1/3 to the risk index calculated for specialties based on the new specialty-specific premium data compared to the information previously used.

Based on these findings, CMS finalized a methodology to phase in the reduction in MP RVUs over the 3 years that precede the next update by 1/3 of the change in the MP RVUs for those specialties in each year. This applies to those specialties that have a 30 percent or greater threshold reduction in risk index value as a result of the update. This policy update still stands, and no new proposals were made for MP RVUs for CY 2025.

Geographic Practice Cost Indices (GPCIs)

CMS is required to develop separate GPCIs to measure cost differences among localities compared to the national average. CMS adjusts reimbursement to align with the cost of those services specific to where they were provided. This is done by applying the GPCI values for a specific area to each of the RVUs (work, practice expense, and malpractice). This is one of the reasons when discussing reimbursement, it is not always an apples-to-apples comparison regarding how much is reimbursed from one location to another.

The current fee schedule areas are referred to as payment localities and are defined by state boundaries, metropolitan areas, portions of a metropolitan area or rest-of state areas. There are currently 109 payment localities. This locality configuration is used to calculate GPCIs, which in turn, are used to calculate locality adjusted payment for physicians under MPFS.

The Consolidated Appropriations Act, 2021 (CAA 2021), required CMS to use a work GPCI floor of 1.000 through December 31, 2023. The final GPCIs for CY 2025 do not reflect 1.000 floor "base" values as they have for the last 3 years. The exceptions to this are Alaska, which continues the permanent 1.500 work GPCI; and the Frontier States (Montana, Wyoming, North Dakota, South Dakota and Nevada) which continue the permanent 1.000 floor for work RVUs as well.

The Protecting Access to Medicare Act (PAMA) modified fee schedule areas specific to the State of California. Changes which had been proposed in the CY 2023 proposed rule were not finalized for CY 2023 but were finalized for CY 2024. The next proposed GPCI update is expected for CY 2026.

Medicare Economic Index (MEI)

The Medicare Economic Index (MEI) is the "reasonable charge-based payment methodology" that was in place for physicians' services prior to the MPFS. The MEI reflects the change in the average annual market price of various inputs involved in providing physicians' services. This measure was authorized by statute and CMS began calculating the MEI on July 1, 1975. CMS continues to calculate this index for statutory and other purposes.

The MEI is comprised of two major categories: 1) physicians' own time or compensation; and 2) physicians' practice expense (PE). In addition, it includes an adjustment for the change in the economy-wide, private nonfarm business total factor productivity (also known as the relativity adjustment). Measures of productivity are provided by the U.S. Department of Labor's Bureau of Labor Statistics (BLS).

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The current 2006-based MEI is based on data collected by the AMA for self-employed physicians from the Physician Practice Information Survey (PPIS). The AMA had not conducted another survey since the 2006 data collection effort; however, the latest survey was completed on August 31, 2024, and data analysis is currently underway. Due to this, CMS proposed to delay the 2017-based MEI in ratesetting for CY 2025. They sought comments and any information on the timing of the AMA's practice cost data collection efforts and other sources of data they should consider for updating the MEI. Comments received included support for the continued delay of the 2017-based MEI, while others urged CMS to implement the 2017-based MEI "as soon as possible". There was also a request for a more frequent update of the PPIS every 3 to 5 years and a consideration for an alternative to the PPIS to address the lack of data available. CMS will consider this feedback in future rulemaking and finalized their proposal to delay the 2017-based MEI in ratesetting for CY 2025.

Specific Codes and Code Set Valuations

Within the CY 2025final rule, CMS addressed multiple misvalued and/or value changes to specific series of new and established CPT® codes. CMS explains the rationale for the finalized changes are based on values recommended by the Relative Value Scale Update Committee (RUC) and other organizations which CMS utilizes for assistance in setting appropriate values for codes. As part of the code valuation, CMS sought input from stakeholders on nominations of codes that should be considered as potentially misvalued. In this final rule, CMS summarizes the 5 submissions under the potentially misvalued code initiative and 40 code set valuations for CY 2025, including telemedicine Evaluation and Management (E/M) services (discussed below in the "Evaluation and Management (E/M) Changes" section.

Evaluation and Management (E/M) Changes

E/M visits comprise approximately 40 percent of all allowed charges under MPFS. Of these, the office/outpatient (O/O) E/M visits include approximately half (or 20 percent of all allowed charges). Policies for reevaluation of E/M visits have a significant impact on resource valuation under MPFS, which could potentially impact patient care as a whole.

In this final rule, CMS addressed two outstanding issues in E/M visit payment: implementing separate payment for the O/O E/M visit complexity add-on payment and payment for telehealth services.

Office/Outpatient E/M Visit Complexity Add-On

From CY 2018 on, CMS and the AMA have worked to reform the E/M documentation guidelines; establish HCPCS add-on codes for additional payments based on visit complexity related to primary care; revise the O/O E/M codes to reflect the option of selecting time or Medical Decision Making (MDM) level for visit level selection; and revise the visit descriptor times, which resulted in increased valuation of the codes. CMS did not believe these increased valuations accounted for the resources involved in providing certain kinds of care included in the O/O E/M visit code set, specifically visit complexity associated with primary care and non-procedural specialty care. Therefore, in the CY 2021 final rule, CMS created 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)).* CMS refers to this code as the "O/O E/M visit complexity add-on".

Code G2211 can be reported with all O/O E/M visits, rather than just the higher-level visits. But it is not to be reported with E/M visits billed with a payment modifier, such as modifier 25 (*Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the*

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Same Day of the Procedure or Other Service), when other services are provided during the same encounter. This code is used to represent the longitudinal relationship between the patient and practitioner. The practitioner is the "focal point" of the services needed to manage the patient. Additionally, there is cognitive effort in using the knowledge of this relationship to make a diagnosis, create a care plan, and ascertain any factors that impact the patient/practitioner relationship. For additional information, CMS did release a FAQs document, https://www.cms.gov/files/document/hcpcs-g2211-faq.pdf, which they directed stakeholders to review.

Due to the feedback from stakeholders, CMS finalized their proposal to allow payment of G2011 when the O/O E/M base code is reported by the same practitioner on the same day as an annual wellness visit (AWV), vaccine administration, or any Medicare Part B preventive service furnished in the office or outpatient setting. CMS states that allowing payment for add-on code G2211 will support their policy aims, which is to pay for previously unaccounted resources required for all longitudinal primary care office visits. CMS believes trust building in the longitudinal relationship is more significant than ever in decision making when providing Medicare Part B preventive services.

Telehealth Services

In the CY 2024 PFS final rule, CMS finalized consolidation of Category 1, Category 2 and Category 3 criteria for determining the addition or deletion of services to the Medicare Telehealth Services List into a 5-step process. This process involves categorizing each service as "permanent" or "provisional" status rather than one of the three Categories. A service is assigned "provisional" status if there is not enough evidence to determine the service provides clinical benefit to the patient, but there is enough evidence to suggest further review may show the clinical benefit. This 5-step process includes:

1) Determination if the service is separately payable under PFS.
2) Determination if the service is subject to the Act which allows payment to a physician for a service provided via an interactive telecommunications system.
3) Determination if all service elements can be provided via an interactive telecommunications system.
4) Determination if service elements can be mapped to a permanent code with the same service elements.
5) Determination if the clinical benefit support equal between the service performed in-person versus the service being performed via interactive telecommunication system.

For CY 2025, CMS has evaluated multiple services for addition to or removal from the Medicare Telehealth Services List using this 5-step process.

Telehealth Originating Site Facility Fee Payment Amount Update

For CY 2025, CMS is finalizing their proposal with modifications to continue payment for telehealth services to the originating site. CMS uses the baseline rate set in 2002 of $20.00 and adjusts each year based on the percent increase in the Medicare Economic Index (MEI). The proposed MEI for CY 2025 is 3.6 percent and the final MEI for CY 2025 is 3.5 percent. This results in a final originating site fee of $31.01, slightly less than proposed, for HCPCS code Q3014 (*Telehealth originating site facility fee*).

Telemedicine Evaluation and Management (E/M) Services (CPT® codes 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, and 98016)

In February 2023, the CPT® Editorial Panel added a new Evaluation and Management (E/M) subsection to the draft CPT® codebook for Telemedicine Services. The Panel added 17 codes for reporting telemedicine E/M services. Changes were made to the code descriptors and a new survey in September 2023 included code descriptors and times approved by the CPT® Editorial Panel in May 2023.

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The new codes include four new patient synchronous audio-video (98000-98003) and four audio-only visits (98008-98011) and four established patient synchronous audio-video (98004-98007) and four audio-only (98012-98015) visits, a total of 16 new codes. The last code is CPT® 98016 which is a brief communication technology based, virtual check-in code.

With the addition of these new telehealth codes, the AMA CPT® Editorial Panel has deleted the current audio-only CPT® codes 99441-99443. CMS does have them listed on the telehealth list as "provisional" through December 31, 2024. The information from the RUC to CMS indicates the new codes (98000-98015) describe services that would otherwise be provided in person, which means they are subject to consideration and valuation by CMS. Additionally, the introductory language in the CY 2025 CPT® manual indicates if a telehealth visit and in-person visit are performed on the same date of service, the elements of the two services are summed rather than reported separately. This ensures any overlapping time is only counted once. CMS believes this further supports the work associated with the telehealth codes is the same as in-person visits.

The RUC-recommended values for the audio-video visits are identical to the current in-person visits values. The audio-only visits typically have less work RVUs than in-person visits. The RUC stated this is due to the surveyed specialty societies, which reiterated throughout Panel discussions, "the audio-video and in-person office visits require more physician work than the audio-only office visits." CMS provided Table 14 to reflect the similarities of the 16 new telehealth codes per the current in-person E/M codes.

TABLE 14: Comparison of Elements and Work RVU between Telemedicine E/M Codes (98000 through 98015) and Office/Outpatient E/M Codes (99202 through 99215)

	A	B	C	D	E	F	G	H
	Telemedicine E/M HCPCS	RUC-recommended Work RVU	Modality	Level of Medical Decision-Making	Time Threshold (minutes)	New or Established Patient?	Analogous Current Office/Outpatient E/M Code	Current Work RVU
1	98000	0.93	Audio/Video (A/V)	Straightforward	15	New	99202	0.93
2	98001	1.60	(A/V)	Low	30	New	99203	1.60
3	98002	2.60	(A/V)	Moderate	45	New	99204	2.60
4	98003	3.50	(A/V)	High	60	New	99205	3.50
5	98004	0.70	(A/V)	Straightforward	10	Established	99212	0.70
6	98005	1.30	(A/V)	Low	20	Established	99213	1.30
7	98006	1.92	(A/V)	Moderate	30	Established	99214	1.92
8	98007	2.60	(A/V)	High	40	Established	99215	2.60
9	98008	**0.90**	Audio-only	Straightforward	15	New	99202	0.93
10	98009	1.60	Audio-only	Low	30	New	99203	1.60
11	98010	**2.42**	Audio-only	Moderate	45	New	99204	2.60
12	98011	**3.20**	Audio-only	High	60	New	99205	3.50
13	98012	**0.65**	Audio-only	Straightforward	10	Established	99212	0.70
14	98013	**1.20**	Audio-only	Low	20	Established	99213	1.30
15	98014	**1.75**	Audio-only	Moderate	30	Established	99214	1.92
16	98015	**2.60**	Audio-only	High	40	Established	99215	2.80

CMS reiterated there are already services listed on the Medicare telehealth services list identifying which services can be provided by audio-video and audio-only methodology. If they were to incorporate the AMA

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codes, CMS would have to value RVUs to each telemedicine service. Essentially two values, one for telehealth and one for in-person, would be required.

The Consolidated Appropriations Act of 2023 (CAA 2023) extended the geographic location of Medicare beneficiaries to be located essentially anywhere and receive telehealth services through December 31, 2024. According to Medicare, effective January 1, 2025, the geographic location and site of service restrictions on Medicare telehealth services will once again take effect. Even though there are new telehealth codes from the AMA, this does not require CMS to recognize and reimburse the codes for telehealth services.

There will be a few exceptions. Behavioral health services and ESRD-related clinical assessments are excluded from reverting back to the pre-pandemic telehealth policy. Telehealth services for any Medicare beneficiaries/patients will only be available in rural areas, and only when the patient is located in certain types of medical settings.

After review of the comments received, CMS was not persuaded to recognize and separately pay for the 16 new telemedicine CPT® codes. CMS believes the current outpatient codes already in use and for which CMS does recognize for telemedicine with the use of a modifier and place of service (POS) codes were not distinctly different and therefore unnecessary to recognize.

Separately, the new brief communication, virtual check-in code 98016, was proposed and finalized to be implemented by CMS. Due to this, CMS is deleting HCPCS G2012 and accepted the RUC-recommended values work RVU of 0.30 and direct PE inputs for 98016.

Physician Supervision via Two-way Audio/Video

Direct supervision requires the immediate availability of the physician in the office suite, but they are not required to be present in the same room. In previous rule making, CMS has established "immediate availability" to mean in-person, physical, not virtual, availability. During the PHE for COVID-19, CMS adjusted the definition for direct supervision, as it pertains to supervision of diagnostic tests, physicians' services, and some hospital outpatient services, to allow the supervising professional to be immediately available through virtual presence using two-way, real-time audio/video technology, instead of their physical presence. The option to use real-time audio/video capabilities was expected to expire December 31, 2024.

For CY 2025, CMS proposed and finalized an incremental approach to changes. Specifically, they are temporarily extending the definition of direct supervision and "immediate availability" of the supervising practitioner to include the use of real-time audio and visual interactive telecommunications (excluding audio-only) through December 31, 2025.

CMS is also finalizing their proposal to permanently extend the ability to provide direct supervision using audio/video capabilities for a subset of services they indicate are performed entirely by auxiliary personnel. The subset of indicated services have been assigned the PC/TC indicator of "5" within the CMS RVU file and CPT® 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)* which does not require physician presence or participation for staff to provide the service.

Residents in Teaching Settings

In previous rule making, CMS established a policy that allows teaching physicians to fulfil supervision requirements to be present for the key or critical portions of services through audio/video real-time communications technology, when services are provided by a resident. This policy was only valid for services furnished in residency training sites that are located outside of an Office of Management and Budget (OMB) –

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defined metropolitan statistical area (MSA). This distinction was made to increase beneficiary access to Medicare-covered services in rural areas.

For CY 2025, CMS is finalizing their proposal to continue to allow the teaching physician to have a virtual presence in all teaching settings, but only in clinical instances when the service is furnished virtually (3-way telehealth visit, with all parties in separate locations). The proposal would permit teaching physicians to have a virtual presence during the key portion of the Medicare telehealth service through real-time audio/video communication for all residency training locations extended through December 31, 2025.

CMS sought comments and information regarding the allowance for teaching physicians to bill for certain lower and mid-level complexity physician services when furnished by the resident, even when the teaching physician is not present with the resident. All of the following criteria must be met, including the resident must have more than 6 months of training in the approved residency program; the teaching physician is directing the care of no more than four residents at the same time, must remain immediately available, and must have no other responsibilities while directing the care. Additionally, the teaching physician assumes management responsibility for beneficiaries seen by the residents, ensuring the services furnished are appropriate, and must review certain elements of the services with each resident during or immediately after each visit.

CMS also sought comments on whether certain preventative services or higher-level E/M visits could be added without hindering the teaching physician. Specifically, if the addition of the services would negatively impact the teaching physician's ability to remain immediately available for up to four residents at any given time while managing and directing the care furnished. Based on comments received, CMS did not make any further changes, but will consider for future rulemaking.

CHI, SDOH and PIN Service Request for Information (RFI)

A primary focus for CMS now is related to equity in and access to care and how social determinants of health (SDOH) impact the ability to diagnose or treat the patient. To accomplish this, CMS is trying to determine how to improve payment accuracy for additional time and resources dedicated to helping patients with serious illnesses as they navigate the healthcare system or remove health-related social barriers.

Payment for many of these activities is currently included in payment for other services such as evaluation and management (E/M) visits. Since the work for these important activities is not explicitly identified in current coding, CMS believes it is underutilized and undervalued.

For CY 2024, CMS proposed and finalized the creation of new G-codes to identify and value these services for PFS payment and distinguish them from current care services:

- Community Health Integration (CHI) code G0019 (Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month), and code G0022 (Community health integration services, each additional 30 minutes per calendar month), which may include a community health worker (CHW), incident to the professional services and under the general supervision of the billing practitioner.
- Social Determinants of Health (SDOH) code G0136 (Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, not more often than every 6 months). SDOH risk assessment refers to a review of the individual's SDOH or identified social risk factors that influence the diagnosis and treatment of medical conditions.
- Principal Illness Navigation (PIN) Services code G0023 (Principal Illness Navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient

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navigator or certified peer specialist; 60 minutes per calendar month) and code G0024 (Principal Illness Navigation services, additional 30 minutes per calendar month); G0140 (Principal Illness Navigation—Peer Support by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a certified peer specialist; 60 minutes per calendar month) and G0146 (Principal Illness Navigation—Peer Support, additional 30 minutes per calendar month), to better recognize through coding and payment policies when certified or trained auxiliary personnel under the direction of a billing practitioner, which may include a patient navigator or certified peer support specialist, are involved in the patient's health care navigation as part of the treatment plan for a serious, high risk disease expected to last at least 3 months, that places the patient at significant risk of hospitalization or nursing home placement, acute exacerbation/decompensation, functional decline or death.

In the CY 2025 MPFS proposed rule, CMS made a broad request for information (RFI) on these newly implemented codes for CHI, SDOH and PIN. This feedback is needed for CMS to consider in future rulemaking regarding how to address the social needs of beneficiaries. In this final rule, CMS clarified "certified or trained auxiliary personnel" includes Certified Social Workers (CSWs) in the description of the following codes: G0019, G0022, G0023, G0024, G0140 and G0146. Beyond this clarification, based on the comments and information received, CMS indicated they would consider how the services were being used for future rulemaking.

Strategies for Improving Global Surgery Payment Accuracy

CMS indicated there are currently 4,100 physician services coded and valued under MPFS as global surgical packages. For reference global packages include the following:

- The surgical procedure itself, including day-of pre-service activities and day-of recovery care;
- Post-operative evaluation and management (E/M) visits and discharge services provided during specified post-operative periods (10- or 90-day periods for most minor and major procedures, respectively; 0-day global packages do not include post-operative visits);
- Pre-operative visits on the day of the procedure (for services with 10- and 90-day periods) and pre-operative visits on the day prior to the procedure (for major procedures with 90-day periods only); and
- Services provided during the post-operative period (for services with 10- and 90-day periods) related to the procedure (for example, treatment of complications, pain management).

In the event the patient might need to return to the OR, this is paid separately and a new global period begins. The concerns expressed over the last few years are not related to this, but to the fact there are many scenarios in which the physician who performed the surgical procedure is not the one to manage them in the follow-up global period. There may be multiple reasons for this, but often the patient is referred to their primary care physician for ongoing support and follow-up care.

This creates issues for CMS in the follow-up visits for those surgical procedures assigned a 90-day global period which include the E/M visits for following up with the patient and managing their outcome. The surgeon is being paid for a surgical procedure and E/M visits they never perform. Separately, the physician who is now managing the patient is being paid for these services, but also must spend considerable time getting up to speed on the pre- and post-surgical variances in the patient and how to best manage them.

CMS is proposing to address their ongoing concerns with two different proposals:

1) Revise the transfer of care policy for global packages to address instances where one practitioner furnishes the surgical procedure and another practitioner furnishes related post-operative E/M visits during the global period, and

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2) Develop a new add-on code that would account for resources involved in postoperative care provided by a practitioner who did not furnish the surgical procedure.

Transfer of Care Following Surgical Procedure for 90-day Global

For 2025, CMS is finalizing their proposal to broaden the applicability of transfer of care modifiers -54, -55, and -56. These modifiers are to be used for all 90-day global surgical packages *"in any case when a practitioner plans to furnish only a portion of a global package (including but not limited to when there is a formal, documented transfer of care as under current policy, or an informal, non-documented but expected, transfer of care)."* Although this broadening of transfer of care modifiers was proposed for 90-day global surgical procedures, no changes were finalized for modifiers -55 and -56 in CY 2025. These modifiers will continue to be billed exclusively in cases where there is a documented formal transfer of care.

Add-on Code for Post-Operative Care by Practitioner Other Than Surgeon

For CY 2025, CMS proposed and finalized a new add-on HCPCS code (G0559) to account for the work and time spent by a physician who is providing post-operative follow-up care to a patient for which they did not perform the surgical procedure and were not part of the formal transfer agreement. This will allow the physician to recoup and bill for the time and effort spent getting up to speed on the surgical procedure and status of the patient they are now managing.

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:*

- *Read available surgical note to understand the relative success of the procedure, the anatomy that was affected, and potential 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)).*

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