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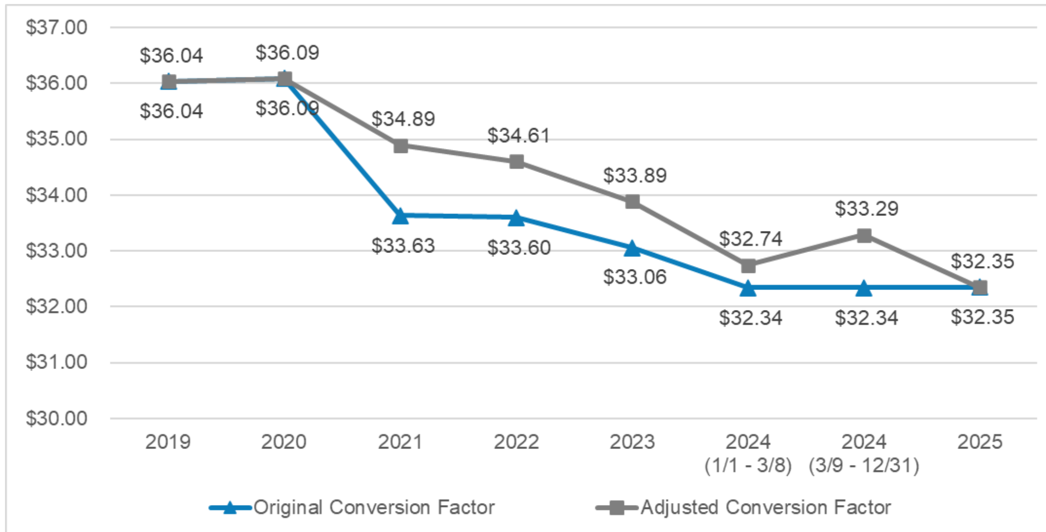
CY 2025 Medicare Physician Fee Schedule Final Rule

*The Centers for Medicare and Medicaid Services (CMS) recently released the Calendar Year (CY) 2025 Medicare Physician Fee Schedule (MPFS) Final Rule, which includes a **conversion factor of $32.35 resulting in a 2.8% decrease from the current rate.** Industry groups claim that continuing reductions in reimbursement in an era of rising costs are unsustainable and will have a negative impact on Medicare patients' access to care. This article recaps key provisions contained in the rule and current activity in the push for legislative changes.*

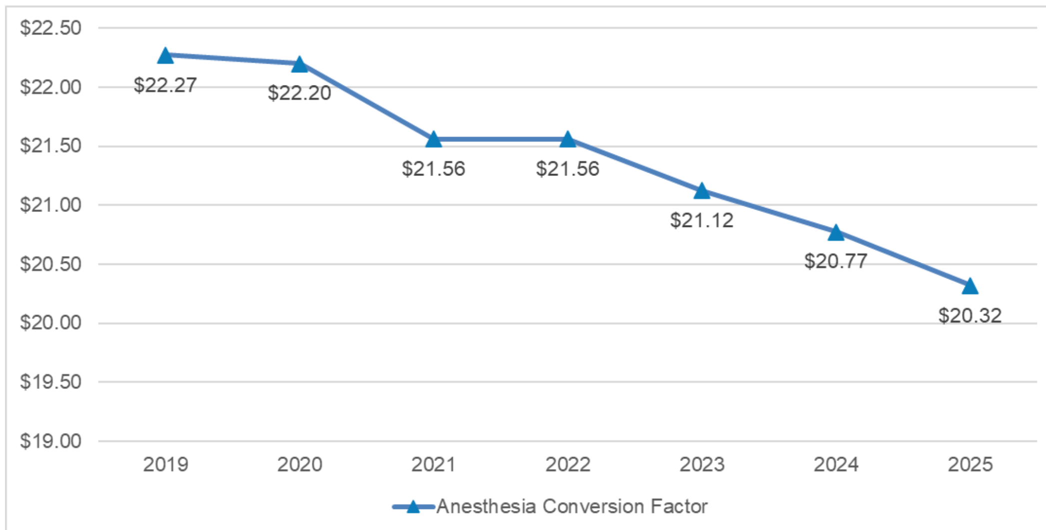
Conversion Factor

The rule reflects a conversion factor of **$32.35** for 2025, which is a **decrease of $0.94 (2.8%) from the current rate**. This marks the fifth consecutive year of decreases, while inflation continues to increase costs. The rate reflects a **10.4% decrease from the 2020 conversion factor**. According to the American Medical Association (AMA), **Medicare physician payments have declined 29% from 2001 to 2024 when adjusted for inflation in practice costs**.

Medicare reimbursement for professional services is generally determined by multiplying the applicable relative value unit (RVU) amounts for billed services by the conversion factor in place on the date the service was rendered, adjusted for the specific locality. Significant volatility in the conversion factor began in 2021 in response to substantial increases in Work RVUs (wRVUs) for many office visits and similar services that were determined to be undervalued historically. That increase in wRVUs resulted in a significant reduction in the conversion factor to achieve budget neutrality, as required by law. Congress intervened and staved off the expected 10.2% reduction. However, the impact of the wRVU increases remained, so the conversion factor for 2022 was once again set to be significantly reduced in light of budget neutrality requirements. Again, the rate was increased as a result of last-minute legislation. Continuing the pattern, legislation passed at the end of 2022 averted what would have been a 4.5% decrease in the conversion factor. This legislation also stipulated that a 1.25% adjustment would be applied to the rates that would otherwise be calculated by CMS for 2024, which ultimately yielded a 3.4% decrease in the conversion factor based on the CY 2024 MPFS Final Rule compared to the rate in effect for 2023. The legislative fix for 2024 did not come until March, when the Consolidated Appropriations Act, 2024 (2024 CAA) applied an adjustment that effectively increased the rate by 1.7% for services rendered through the remainder of 2024. The final rule does not contain any stipulated adjustment. Accordingly, the conversion factor is subject to the statutory budget neutrality requirements unless Congress intervenes.



The anesthesia conversion factor has followed a similar storyline, with an 8.5% decrease since 2020:



Sequestration Impact

It should be noted that the rates reflected above do not incorporate the impact of sequestration. Sequestration is a required across-the-board spending cut resulting from three budget enforcement rules:

- The Statutory Pay-As-You-Go Act of 2010 (PAYGO);
- The Budget Control Act of 2011 (BCA); and
- The Fiscal Responsibility Act of 2023 (FRA).

Only the sequestration stemming from the BCA is currently in effect, and it will impact Medicare payments through fiscal year 2032. Under this law, cuts to Medicare benefit payments cannot exceed 2%. The sequestration adjustment only applies to the portion of the payment made by Medicare and excludes the patient share.

PAYGO requires spending cuts across the federal government if legislation enacted in a given year results in an increase in projected budget deficits. Subsequent legislation has postponed these spending cuts

through the end of 2024. Without additional Congressional action, PAYGO may be triggered in 2025. PAYGO cuts to Medicare benefit payments would be capped at 4%. According to the Committee for a Responsible Federal Budget, this would result in a $45 billion reduction in Medicare payments in 2025. However, neither PAYGO nor the BCA include details on how the two sequesters would be implemented together.

The FRA sequester applies to discretionary funding and can be triggered if applicable budget enforcement rules are broken. Since the Medicare program is funded by both mandatory and discretionary spending, any FRA sequester could impact Medicare. However, this sequester would impact only discretionary components of the Medicare program, such as administration and fraud investigation activities. Payments to providers for services rendered to Medicare beneficiaries would not be impacted.

Other Key Provisions

The 2025 MPFS Final Rule contains additional provisions that impact billing and reimbursement for a variety of services. While this is not a comprehensive summary, key components are recapped below.

Advanced Primary Care Management Services

As proposed, CMS established three new HCPCS G-codes for a set of advanced primary care management (APCM) services in an effort to provide a mechanism for continued and intentional improvements to primary care. The practitioner 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. It is anticipated that these codes will most often be used by primary care specialties (family medicine, internal medicine, geriatric medicine, and pediatrics) but could also be used by certain specialists in some instances (such as OB/GYN or cardiology). 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 new APCM codes are not time-based, but rather are based on certain patient characteristics that are deemed to be indicative of patient complexity and therefore resource intensity:

Level 1 (G0556)	Level 2 (G0557)	Level 3 (G0558)
Patients with 1 or fewer chronic conditions	Patients with 2 or more chronic conditions	Patients with 2 or more chronic conditions and who are Qualified Medicare Beneficiaries

Derived from Table 24: Patient-Centered Risk Stratification for Billing APCM Codes.

The Qualified Medicare Beneficiary (QMB) status was included as a method of identifying beneficiaries with social risk factors that often require greater resources to effectively furnish advanced primary care. The rule notes that there are approximately 8.5 million QMBs, comprising 66% of the Medicare-Medicaid dual eligible population. These beneficiaries are believed to be the most at-risk for poor clinical outcomes.

The final rule includes a lengthy list of practice capabilities and requirements that are considered inherent to the provision of APCM services. Not all elements must be furnished during a given calendar month when the code is billed, but the billing practitioner must have the ability to furnish every element as appropriate for any individual patient during any calendar month. Practitioners who participate in the ACO REACH model, the Making Care Primary model, and the Primary Care First model are deemed to satisfy certain of the required elements simply by virtue of their participation in these CMS Innovation Center models.

Global Surgery Payment Accuracy

CMS currently requires transfer of care modifiers to be used when there is a formal documented transfer of care agreement. However, the modifiers have been rarely used other than for ophthalmology services. Further, there are mismatches between the number of claims billed with modifier -54 (for procedures) and -55 (for post-operative care), which may result in duplicative payment (i.e., payment of the global rate to one provider and payment for post-op care to another provider for the same case).

Beginning for services furnished in 2025, CMS will require the use the transfer of care modifier -54 for all 90-day global surgical packages whenever a practitioner plans to furnish only the surgical portion of a global package. This would include formal, documented transfers of care, as well as informal, nondocumented – but expected – transfer of care. While CMS had initially proposed similar treatment for modifiers -55 (for post-operative care) and -56 (for pre-operative care), the final rule does not reflect any changes to current policy with regard for these two modifiers. Accordingly, -55 and -56 will continue to be billed exclusively in cases where there is a documented formal transfer of care.

Additionally, CMS implemented a new add-on code, HCPCS G0559, that could be utilized by a practitioner that provides post-operative care for a patient but did not have the benefit of a formal transfer of care. This is intended to account for additional complexity involved since the practitioner may not have been involved in creating the surgical plan and may not have access to the operative notes. CMS expects this code to be billed with an office or other outpatient evaluation and management (E/M) visit for a new or established patient. G0559 should not be billed by another practitioner in the same group practice as the practitioner who performed the surgical procedure, or in the same specialty. Documentation in the medical record must justify use of the add-on code, and the code could be billed only once during the 90-day global period.

Cardiovascular Risk Assessment and Risk Management

The CMS Innovation Center’s Million Hearts® Cardiovascular Disease Risk Reduction model was found to reduce the risk of death from a cardiovascular event by 11%. To encourage greater cardiovascular-focused risk management services, CMS is proposing two new codes:

- **ASCVD Risk Assessment** – HCPCS code G0537 would be used for administration of a standardized, evidence-based Atherosclerotic Cardiovascular Disease (ASCVD) Risk Assessment, which includes a review of the patient’s demographic characteristics, modifiable risk factors, and risk enhancers for cardiovascular disease. The final rule does not require the ASCVD Risk Assessment to be performed on the same date as the associated E/M visit (as it had originally proposed). This code could be billed once a year per practitioner, per beneficiary, but would not be billable for patients with a cardiovascular disease diagnosis or a history of heart attack or stroke.
- **ASCVD Risk Management Services** – HCPCS code G0538 would be used for risk management services for patients without a current ASCVD diagnosis, but determined to be at medium or high risk for ASCVD as determined by the ASCVD Risk Assessment. Risk management services include the development, implementation, and monitoring of an individualized care plan for reducing cardiovascular risk. This code could be billed once a month. While there are no minimum service time requirements, there are certain elements that must be addressed to bill this code. Consent must be obtained from the patient before starting ASCVD risk management services.

Evaluation/Management Add-On Codes

A separate add-on code – HCPCS code G2211 – was added in 2024 to provide additional reimbursement to compensate for the increased time and resources related to the intensity and complexity inherent in office or outpatient E/M visits that are part of ongoing care related to a patient’s single, serious, or complex condition. However, under the current rules the add-on code may not be utilized when an E/M code is billed with payment modifier 25, which is used to indicate that a minor procedure was performed on the same day. Beginning in 2025, CMS will allow payment for G2211 when the office or outpatient E/M code is

reported by the same practitioner on the same day as an annual well visit, vaccine administration, or any Medicare Part B preventive service provided in the office or outpatient setting.

Additionally, for 2025 CMS is proposing a new add-on code – HCPCS code G0545 – to provide additional reimbursement to infectious disease specialists for disease transmission risk assessment and mitigation and public health investigation, analysis, and testing. In response to comments received on the proposed rule, CMS broadened the scope of qualifying practitioners to include all practitioners with specialized training in infectious diseases who can independently bill Medicare for E/M visits. This would include not only physicians but also nurse practitioners, physician assistants, and certified nurse specialists. This code may be used as an add-on to hospital inpatient or observation care codes associated with a confirmed or suspected infectious disease.

Expansion of Colorectal Cancer Screening

To update coverage for colorectal cancer (CRC) screening to align with current standards of care, CMS is making the following changes beginning in 2025:

- Eliminate coverage for barium enema procedures, which are rarely utilized and no longer recommended in clinical guidelines;
- Add coverage for the computed tomography colonography (CTC) procedure, which uses x-rays and computers to produce images of the entire colon; and
- Expand coverage to include a follow-up screening colonoscopy after a Medicare-covered blood-based biomarker CRC screening test.

CMS believes these changes will allow patients and their doctors to make the decision regarding the most appropriate choice in CRC screening, considering the risks, burdens, and benefits of each approach.

Behavioral Health Services

In response to increased death by suicide in older adults, the final rule establishes coding and payment for Safety Planning Interventions (SPI). SPIs involve a patient working with a clinician to develop a personalized list of coping strategies and sources of support that the individual can use when experiencing thoughts of harm to themselves or others. This is not a suicide risk assessment, but rather an intervention provided to people determined to have elevated risk. CMS had originally proposed an add-on code that would be billed along with an E/M visit or psychotherapy when SPIs are personally performed by the billing practitioner. However, the final rule instead adopted HCPCS code G0560 as a standalone code that may be billed in 20-minute increments. This change was in response to comments that in certain settings SPIs may be conducted either on their own or in addition to other services, and that 20 minutes reflects the minimum rather than the typical amount of time spent with patients to provide this service. Additionally, the code descriptor was expanded from the original proposal to also include planning interventions for a substance-use related crisis. SPIs must be personally performed by the billing provider in 2025, though CMS will consider expanding this to other clinical staff in future rulemaking. HCPCS code G0560 is also being added to the Medicare Telehealth list for 2025.

Research has shown that patients seen in the emergency department (ED) with deliberate self-harm, intentional overdose, and/or suicidal ideation have a substantially increased risk of suicide or other mortality during the year following their ED visit. In response, CMS has established coding and payment for post-discharge telephone Follow-up Contacts Intervention (FCI). FCI is described as a specific protocol of services for individuals with suicide risk involving a series of telephone contacts between a provider and a patient in the weeks or months following discharge from the ED or other relevant care settings. It is designed to reduce the risk for subsequent adverse outcomes. FCI calls are intended to encourage use of the Safety Plan and update it to optimize effectiveness, express psychosocial support, and facilitate engagement in any indicated follow-up care. These are specifically structured to be audio-only calls and are not within the scope of Medicare telehealth services.

CMS is implementing a monthly billing code – HCPCS code G0544 – as a bundled service describing four FCI calls in a month, each between 10 to 20 minutes in duration. This code could be billed regardless of whether G0560 was also provided and billed for the same patient. At least one real-time telephone interaction with the patient would be required, not including unsuccessful attempts to reach the patient. The treating practitioner will be required to obtain the patient's consent either prior to or during the initial FCI phone call and document it in the patient's medical record. Consent would include: (1) ensuring that the patient is aware that Medicare cost-sharing applies to FCI services; (2) furnishing and receiving necessary information to enable the patient to receive services (e.g., obtaining the patient's telephone number); and (3) confirming that the patient consents to the contacts.

CMS is also creating three new HCPCS codes for digital mental health treatment (DMHT) devices. Beginning in 2025, qualified practitioners would utilize HCPCS code G0552 to bill for furnishing a DMHT device that has been cleared by the Food and Drug Administration (FDA) if the billing practitioner is incurring the cost of furnishing the device to the patient. The device must be part of an ongoing treatment plan, and the billing practitioner must diagnose the patient and prescribe or order the DMHT device. Two additional codes would then be utilized for monthly treatment management services directly related to the patient's therapeutic use of the DMHT device – G0553 for the first 20 minutes, and G0554 for each additional 20 minutes. These codes should not be utilized when the patient discontinues use of the device.

The rule adds six new G codes to further expand access to behavioral health services. These codes would all be used to bill for interprofessional consultations provided by practitioners whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including substance use disorders. This includes clinical psychologists, clinical social workers, marriage and family therapists, and mental health counselors. The treating practitioner would be required to obtain the patient's consent in advance of these services and document it in the patient's medical record. In obtaining consent, the practitioner must ensure that the patient is aware that Medicare cost-sharing applies to these services, and there may be a charge for two services – one for the treating/requesting practitioner's service and another for the consultant practitioner's service.

Telehealth Services

Medicare telehealth frequency limitations were suspended during the COVID-19 public health emergency (PHE) for a variety of services. Although the limitations resumed upon expiration of the PHE in 2023, they were again suspended through the end of 2024 for the following services:

- Subsequent Inpatient Visit CPT Codes (99231, 99232, and 99233);
- Subsequent Nursing Facility Visit CPT Codes (99307, 99308, 99309, and 99310); and
- Critical Care Consultation Services (HCPCS Codes G0508 and G0509).

The final rule extends the suspension of frequency limitations for these services through 2025.

CMS will also allow audio-only communication technology for telehealth services provided to a beneficiary in their home, so long as the practitioner has the technical capability to provide two-way, real-time interactive audio and video communication but the patient is either not capable of or does not consent to the use of video technology. Applicable services must be billed with a modifier to verify that these conditions have been met, but no additional documentation is needed. The rule will continue to allow practitioners to utilize their currently enrolled practice location rather than their home address when providing telehealth services from their home, through the end of 2025.

Physicians may continue utilizing real-time audio and video interactive telecommunication to meet the presence and "immediately available" requirement for direct supervision through the end of 2025. For services provided after December 31, 2025, audio/video real-time communication technology (excluding audio-only) shall meet the requirement for "direct supervision" for certain services determined to inherently carry lower risk. These services do not ordinarily require the presence of the billing practitioner or direction

by the supervising practitioner, and are not services typically performed directly by the supervising practitioner. Specifically, the final rule defines these as services with CPT Code 99211 and services with a HCPCS status indicator of ‘5’. For all other services, audio/video supervision will be extended only through the end of 2025.

Teaching physicians will be allowed to have a virtual presence during the provision of telehealth services in 2025, but must provide real-time observation utilizing audio/video technology (not audio-only). Additionally, current flexibilities that allow audio-only telecommunications for periodic assessments in connection with opioid treatment programs when video is not available would be made *permanent* beginning on January 1, 2025, under the provisions of the final rule.

Medicare Shared Savings Program

The rule finalized numerous proposed revisions to the Medicare Shared Savings Program (MSSP). One component is the introduction of a new prepaid shared savings option for certain established accountable care organizations (ACOs) that have a history of achieving shared savings. These ACOs could receive quarterly advances that would be used to make investments that would aid beneficiaries. At least 50% of the prepaid amounts must be spent on direct beneficiary services that are not generally available through traditional Medicare. This could include items such as transportation or dental/vision/hearing services. Up to 50% of the advance payments may be spent on staffing and healthcare infrastructure. If the prepaid amounts exceed the actual shared savings, the ACO will be required to pay back the difference. Interested ACOs may apply to participate in the prepared shared savings program in 2025 for a January 1, 2026, start date.

Other revisions to the MSSP include the following:

- A Health Equity Benchmark Adjustment for periods beginning January 1, 2025, based on the proportion of the ACO’s assigned beneficiaries who are enrolled in the Medicare Part D low-income subsidy or dually eligible for Medicare and Medicaid;
- Expansion of quality measure sets that will be incrementally incorporated from 2025 through 2028;
- Modification to eligibility requirements that will allow ACOs to fall below 5,000 assigned beneficiaries during an agreement period, beginning on January 1, 2025;
- Modification to the beneficiary assignment methodology, beginning on January 1, 2025; and
- Modification to beneficiary notification requirements, beginning on January 1, 2025.

Specialty Impact

CMS performed an analysis to estimate the ranges of impact for practitioners within each specialty, based on 2023 utilization data. According to this analysis, most specialties will see a minimal change (plus or minus 1%) in Total RVUs as a result of the provisions reflected in the final rule. In fact, CMS notes that based on 2023 utilization, more than 80% of practitioners would experience a change of +/- 1% in total RVUs. For these specialties, the most significant impact comes in the form of the lower Conversion Factor, which when applied to a similar level of Total RVUs will yield lower revenue.

However, there are some “winners” and “losers” that are anticipated to see more significant swings in Total RVUs. Those expected to see an increase are shown below:

Specialty	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of MP RVU Changes	Combined Impact
Clinical Social Worker	3%	1%	0%	4%
Clinical Psychologist	3%	1%	0%	3%
Anesthesiology	1%	1%	0%	2%

According to CMS, the increases for these specialties are largely attributed to the Year 4 update to clinical labor pricing and/or the adjustments to transfer of postoperative care for global surgical procedures. Some of the increases are also related to increases in Work RVU values for specific services based on recommendations from the AMA Relative Value Scale Update Committee and CMS review, and increased practice expense (PE) RVU values resulting from supply and equipment pricing updates. For these specialties, the increase in Total RVUs may mitigate the impact of the decreased Conversion Factor.

On the other hand, a few specialties are likely to see a decrease in Total RVUs:

Specialty	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of MP RVU Changes	Combined Impact
Diagnostic Testing Facility	0%	-2%	0%	-2%
Interventional Radiology	0%	-2%	0%	-2%
Ophthalmology	-1%	-1%	0%	-2%
Vascular Surgery	0%	-2%	0%	-2%

CMS explains that these decreases are due to the redistributive effects of the Year 4 update to clinical labor pricing and/or the adjustments to transfer of postoperative care for global surgical procedures, and by the redistributive effect of Work RVU increases for other codes. Additionally, they rely on supply and equipment for their practice expense costs and were therefore negatively affected by the updated Year 4 clinical labor update due to budget neutrality requirements. The estimated impact also encompasses decreases resulting from the continued phase-in implementation of previously finalized supply and equipment pricing updates. Unfortunately, these practitioners will have the compounded impact of reduced RVUs *and* a reduced conversion factor, which will result in even lower reimbursement.

CMS also provides the impact on selected procedures. This indicates that several office E/M visits, hospital inpatient/observation, emergency department visits, and critical care codes would all see payment cuts around 1%.

Industry and Legislative Response

Industry advocates were pushing for change long before the final rule was released. The AMA has been lobbying for months that a comprehensive legislative solution is needed. According to a statement issued by AMA president Bruce A. Scott, M.D., “To put it bluntly, Medicare plans to pay us less while costs go up. You don’t have to be an economist to know that is an unsustainable trend, though one that has been going on for decades.” MGMA released a statement that the final rule “throws the financial viability of physician practices into question and threatens beneficiary access to care.” According to the American Medical Group Association (AMGA), “the cut may force AMGA members to lay off staff and clinicians, further exacerbating access to care; not accept new Medicare beneficiaries as patients; and delay investments in social drivers for health. … This cut demonstrates the flaws in how Medicare reimburses Part B care and services. Specifically, the lack of an inflationary update in Part B reimbursement creates an unsustainable situation for AMGA members, who are facing a fifth consecutive year of lower Medicare reimbursement for physician and other clinician services.”

The push for a change is coming from other avenues as well. In its March 2024 report to Congress, the Medicare Payment Advisory Commission (MedPAC) noted that “expected increases in clinicians’ input costs are larger than the increases in FFS Medicare payment rates scheduled under current law.” In response, MedPAC recommended that the payment rate for physicians and other healthcare practitioners should be increased for 2025 by 50% of the projected increase in the MEI. This mirrored the recommendation made by MedPAC in its March 2023 report to Congress. However, it still has not been adopted by CMS because Congressional intervention is required to remove the budget neutrality requirement.

The 2024 Medicare Trustees Report similarly noted concern with the current payment levels for physicians, stating that physician payment amounts “do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases. These rate updates could be an issue in years when levels of inflation are high and would be problematic when the cumulative gap between the price updates and physician costs becomes large. … If the health sector cannot transition to more efficient models of care delivery and if the provider reimbursement rates paid by commercial insurers continue to be based on the same negotiated process used to date, then the availability, particularly with respect to physician services, and quality of health are received by Medicare beneficiaries would, under current law, fall over time compared to that received by those with private health insurance.” Again, this mirrored exactly the observations from the 2023 Medicare Trustees Report, but nothing has been done to address the concerns.

The *Strengthening Medicare for Patients and Providers Act* (H.R. 2474), introduced in April 2023, would adjust the conversion factor each year by a percentage equal to the MEI. However, although the bill has bipartisan support with 170 cosponsors currently, and broad support from industry groups such as the AMA and the Medical Group Management Association, there has been no action in over a year. Most recently, a bipartisan bill – the *Medicare Patient Access and Practice Stabilization Act of 2024* (H.R. 10073) – was introduced on October 29, 2024, that would provide a statutory adjustment of 4.73% to the 2025 conversion factor. If passed, that would effectively negate the decrease reflected in the final rule for 2025 and instead apply an increase to the current 2024 conversion rate equivalent to half of the MEI. While it would provide some level of short-term relief – if it can get through Congress – this would be another one-year band-aid on the bigger problem.

The Senate Committee on Finance held a hearing in April focused on the importance of high-quality, accessible clinician care. The hearing highlighted the challenges of the current MPFS structure, especially as practice costs rise, the administrative burdens of operating a medical practice increase, and the population ages. In response, the Committee issued a white paper in May to describe key issues and explore potential policy solutions. It is crucial for the Medicare payment system to reflect the economic reality of practice operating expenses, which the current budget neutrality requirements do not allow. Only a permanent fix to the methodology used to derive the conversion factor will prevent us from being in a similar position again this time next year.

JTaylor’s healthcare consulting team includes a group of professionals who specialize in physician practice dynamics, as well as individuals who focus on strategy and operations. If you are interested in finding out how the 2025 MPFS Final Rule would impact reimbursement for your practice, with its unique services and payer mix, we can help. Our team can also support you from a strategic perspective as you plan for impact of these final rules, including the impact of reduced reimbursement. To find out more or to contact a member of our team, please visit our website. We will continue to monitor developments related to legislative activity impacting the healthcare industry.

Sources:

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- *Congress must act as Medicare pay cut is set.* AMA. (10 July 2024.) [Press Release.]
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- *AMGA Calls on Congress to Stop Medicare Cuts.* American Medical Group Association. (1 November 2024.) [Press Release.]
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- H.R.10073 - 118th Congress (2023-2024): *Medicare Patient Access and Practice Stabilization Act of 2024*. (2024, October 29). https://www.congress.gov/bill/118th-congress/house-bill/10073
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