

CY 2025 Medicare Physician Fee Schedule Final Rule Summary

On November 1, the Centers for Medicare & Medicaid Services (CMS) released the Medicare Physician Fee Schedule (MPFS) final rule for Calendar Year (CY) 2025 (CMS-1807-F). The rule updates payment policies and rates for Part B services furnished under the MPFS, as well as makes changes to the Quality Payment Program (QPP). The rule in its entirety and the addenda, including Addendum B, which lists the proposed RVUs for each CPT® code can be found [here](#).

CMS finalized several significant policy changes, including creating a new code to address the global surgical package policy, requiring use of a modifier for 90-day global surgeries, redefining telehealth services to include audio-only services, and declining to accept and pay for the new 16 of the 17 telemedicine E/M codes. The following summarizes the major policies of the final rule. Note that the page numbers listed in this document refer to the [display copy](#) of the final rule.

Regulatory Impact Analysis

Highlight: Conversion factor set for a decrease yet again for CY 2025

Conversion Factor for 2025

The conversion factor for 2025 is set to decrease by approximately **2.83% from \$33.2875 to \$32.3464**. The cut is primarily driven by the expiration of the conversion factor increase that Congress passed in March, coupled with a 0% baseline update.

Changes in Relative Value Unit Specialty Level Impact – p. 2,326

The impact of the final rule’s policies on group practices and individual physicians varies based on practice type, the mix of services provided to patients, and the patient mix. Table 110 of the rule, (Appendix A of this summary) estimates the specialty level impacts of the policies finalized for 2025 and includes impacts of rate-setting changes and changes to RVUs within the budget neutral system. Table 1 below highlights estimated specialty level impacts and includes some of the specialties with the greatest impact, both positive and negative for comparison. Note that the impact table values do not reflect the decrease in the conversion factor for 2025.

Table 1: CY 2025 Estimated Impact Total Allowed Charges by Specialty

Specialty	Medicare Allowed Charges (millions)	Work RVU Impact	PE RVU Impact	MP RVU Impact	Overall Impact
Clinical Social Worker	\$894	3%	1%	0%	4%
Endocrinology	\$517	0%	0%	0%	1%
Internal Medicine	\$9,491	0%	0%	0%	0%
Dermatology	\$3,885	0%	0%	0%	0%
Hematology/Oncology	\$1,579	0%	-1%	0%	-1%
Allergy/Immunology	\$218	0%	-1%	0%	-1%
Vascular Surgery	\$998	0%	-2%	0%	-2%

Determination of Practice Expense RVUs – p. 31

Highlight: No change in the MEI methodology while CMS waits for updated practice expense data from the AMA.

The agency finalized its policy not to adjust RVUs using MEI methodology. The agency reiterated that it would continue to wait for the results of the American Medical Association’s Physician Practice Information Survey before making any significant changes to the data inputs and calculation of the practice expense RVUs.

CY 2025 Clinical Labor Pricing Update – p. 61

Highlight: CMS finalized pricing for clinical labor types.

The agency did not receive new wage data during the comment period or any other information for use in its calculation of clinical labor pricing. Therefore, the data finalized in 2024 will be used for clinical labor pricing again in 2025. Table 8 of the final rule lists the clinical labor types and their price per minute for 2025.

Development of Strategies for Updates to Practice Expense Data Collection and Methodology – p. 71

Highlight: CMS provides no additional information on how it will update practice expense inputs.

The agency said very little in the final rule regarding how they intend to update the practice expense portion of the MPFS, and thanked commenters for their input, while noting that CMS will consider comments in future rulemaking. The agency requested information on many topics including alternative data sources to AMA Physician Information Survey, timing of recurring updates to the practice expense inputs, and the use of four-year phase-in policy when new data is implemented.

Payment for Medicare Telehealth Services under Section 1834(m) of the Act – p. 106

Highlight: CMS adds audio-only communication technology to the definition of a telehealth service.

Requests to Add Services to the Medicare Telehealth Services List for CY 2025

CMS plans to complete a comprehensive analysis in future rulemaking of all the services on the Medicare Telehealth Services List provisionally before determining which codes should be made permanent. The process and decision-making parameters that the agency uses to make determinations as to whether a code(s) may be placed on the telehealth service list is found on page 108 of the final rule.

Frequency Limitations of Medicare Telehealth Subsequent Care Services in Inpatient and Nursing Facility Settings, and Critical Care Consultations

Prior to the COVID pandemic, there were frequency limitations (i.e., the number of times a provider may bill for a service during a given time frame) for services associated with subsequent inpatient visits (CPT codes 99231, 99232, and 99233), subsequent nursing facility visits (CPT codes 99307, 99308, 99309, and 99310), and critical care consultation services (HCPCS G codes, G0508 and G0509). However, during the pandemic, CMS lifted the frequency restrictions to allow greater access to care.

The agency finalized the proposal to continue suspension of the telehealth frequency limits on subsequent inpatient and nursing facility visits and critical care consultations for CY 2025. This will give the agency to gather an additional year of data to determine how practice patterns are evolving and what changes, if any, should be made to this policy permanently.

Audio-only Communication Technology to Meet the Definition of “Telecommunications Systems”

CMS permanently revised the definition of an interactive telecommunications system to include two-way, real-time audio-only communication technology for any telehealth service furnished to a beneficiary in their home if the distant site physician is technically capable of using an audio/video system, but the patient is not capable of, or does not consent to, the use of video technology. The agency notes that providers should continue to use their clinical judgment to decide if audio-only technology is sufficient to provide a telehealth service.

However, the agency recognizes that lack of access to broadband may make video calls impractical, or that patients may prefer to engage with their provider in their homes using audio-only technology. For claims for audio-only services, providers must use CPT modifier 93 to verify that all conditions have been met. No additional documentation except for the appropriate modifier is needed.

Distant Site Requirements

For CY 2025, CMS finalized the proposal to continue to allow a distant site practitioner to use their currently enrolled practice location instead of their home address when providing telehealth services from their home. The agency will consider proposals to better protect the safety and privacy of providers.

Direct Supervision via Use of Two-way Audio/Video Communications Technology

CMS finalized the proposal to continue to define direct supervision to permit the presence and immediate availability of the supervising practitioner through real-time audio and visual interactive telecommunications systems through December 31, 2025. The agency permanently adopted the definition of direct supervision permitting virtual presence for services that are considered lower risk, such as services that do not ordinarily require the presence of the billing practitioner, do not require as much direction by the billing practitioner as other services, and are not typically performed by the supervising practitioner.

Teaching Physician Billing for Services Involving Residents with Virtual Presence

CMS will continue the current policy, which allows teaching physicians to have a virtual presence when billing for services involving residents in teaching settings only when the service is furnished virtually (i.e., the patient, resident and teaching physician are all in separate locations), through December 31, 2025. The teaching physician's virtual presence requires real-time observation and excludes audio-only technology.

Telehealth Originating Site Facility Fee Payment Amount Update

For CY 2025, the payment amount for HCPCS code Q3014 (*Telehealth originating site facility fee*) will be \$31.01.

Telehealth Place of Service Code

The agency noted that claims for telehealth services billed with POS 10 (telehealth provided in patient's home) will continue to be paid at the non-facility PFS rate for CY 2025 and beyond.

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) – p. 234

As a part of its work in a nearly complete overhaul of the E/M section of the CPT code book, the CPT Editorial Panel created, and the RUC subsequently valued 17 new codes to describe services for the provision of telemedicine E/M services. CMS finalized policy stating that there is no programmatic need to recognize and provide payment for 16 of the 17 newly established telemedicine E/M codes, and therefore assigned 16 of the codes a status indicator of "I" which indicates there is a more specific code that should be used in the Medicare program, in this instance the existing office E/M codes. Instead, the agency states that providers should continue to use the existing office/outpatient E/M CPT codes, which are on the telehealth services list. Providers should use appropriate place of service codes to identify the location of the Medicare beneficiary, and use appropriate modifiers as required.

However, CMS finalized payment for CPT code 98016 (*Brief communication technology-based service (eg, virtual check-in) by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion*). CMS will delete HCPCS code G2012, used to report similar services, and instead beginning January 1, 2025, providers should use the new CPT code to report a virtual check-in. Code 98016 will have a work RVU of 0.30, and the RUC recommended direct PE inputs have been finalized by CMS.

Request for Information for Services Addressing Health-Related Social Needs (Community Health Integration (G0019, G0022), Principal Illness Navigation (G0023, G0024), Principal Illness Navigation-Peer Support (G0140, G0146), and Social Determinants of Health Risk Assessment (G0136) – p. 213

Highlight: CMS thanks commenters for additional information but did not finalize new policy.

During last year's rule making cycle, the agency proposed and finalized payment under the MPFS for services that address the health-related social needs of Medicare beneficiaries. These services included community health integration, principal illness navigation, principal illness navigation-peer support, and the provision of a social determinants of health risk assessment. The new services were created as part of the Biden administration's plan to increase access to care in a fair and equitable manner. The agency requested

additional information on ways to improve these services, address any care gaps that may not be covered by the new codes, and possibly create additional codes within the scope of this policy. The agency simply thanked commenters and stated that comments will be taken into consideration if future rulemaking.

Evaluation and Management (E/M) Visits – p. 375

Highlight: CMS updated and revised policy to support primary and non-procedural care provided to Medicare beneficiaries including finalizing the creation of new HCPCS codes for advanced primary care.

Office/Outpatient (O/O) E/M Visit Complexity Add-on – p. 375

In this final rule, CMS finalized policy that allows billing of HCPCS code G2211, the add-on code to report patient complexity, with an annual wellness visit (AWV), vaccine administration service, or any Medicare Part B preventive service delivered in the office or outpatient setting. These services are generally reported with a modifier -25, and therefore reporting G2211 would not have been allowed. Previous policy prohibited payment for G2211 when the O/O E/M code is reported with modifier -25.

In the CY 2024 MPFS final rule, CMS finalized separate payment for the O/O visit complexity add-on code G2211 to reflect “the time, intensity, and PE resources involved when practitioners furnish the kinds of O/O E/M visits that enable them to build longitudinal relationships with all patients...and to address the majority of a patient’s health care needs with consistency and continuity over longer periods of time.” This policy remains in place.

Drugs and Biological Products Paid under Medicare Part B – p. 454

Requiring Manufacturers of Certain Single-Dose Container or Single-Use Package Drugs to Provide Refunds with Respect to Discarded Amounts

Recently, CMS finalized several policies to implement section 90004 of the Infrastructure Investment and Jobs Act, which requires manufacturers to provide a refund to CMS for certain discarded amounts from a refundable single-dose container or a single-use package drug for calendar quarters starting on January 1, 2023.

The agency finalized a modification to the regulatory text to revise how they determine the beginning of the 18-month exclusion period for certain drugs where the date the drug was first marketed (as reported to CMS) does not adequately approximate the first date of payment under Part B. In these cases, the first date where the drug is actually paid under Part B would be used to determine the start of the 18-month exclusion period.

CMS finalized the proposal to revise the definition of refundable single-dose container or single-use package drug to include injectable drugs with a labeled volume of 2 mL or less and that lack the package type terms and explicit discard statements in their product labeling, as well as to include drugs supplied in ampules.

Payment Limit Calculation when Manufacturers Report Negative or Zero Average Sales Price (ASP) Data

CMS finalized a methodology for calculating payment limits when manufacturers report negative or zero ASP data. The agency will consider that positive manufacturer’s ASP data is “available” while negative or zero ASP data is “not available” for CMS to calculate a payment limit. The agency sets out several calculations that depend on the following factors:

- Whether the drug is single source or multiple sources.
- Whether some, but not all National Drug Codes (NDCs) for a billing and payment code have a negative or zero ASP; or all NDCs for a billing and payment code have a negative or zero ASP; and
- Whether relevant applications to all NDCs for a billing and payment code have a marketing status of discontinued.

Pneumococcal, Influenza and Hepatitis B Vaccine Administration – p. 1476

Based on the revised definition of intermediate risk of hepatitis B, an assessment of an individual’s vaccination status can now be made without a physician’s clinical expertise, eliminating the requirement for

a doctor's order to administer a hepatitis B vaccine under Part B. This will allow mass immunizers to deliver and bill for hepatitis B vaccines should the physician's order requirement be eliminated. The agency will make corresponding changes to the Medicare Benefit Policy and Medicare Claims Processing Manuals.

Revised Payment Policies for Hepatitis B Vaccine Administration – p. 885

Even though hepatitis B vaccines and their administration are preventive services for which coinsurance is waived, they are still paid as part of the facilities' capitated rate—rural health clinics (RHCs) all-inclusive rate (AIR methodology) and federally qualified health center (FQHC) prospective payment system. This differs from how other Part B vaccines are paid in these settings. CMS will align payment for hepatitis B vaccines in RHCs and FQHCs with the payment for pneumococcal, influenza, and COVID-19 vaccines in those settings by paying for the vaccine and its administration at 100 percent of reasonable cost, separate from the capitated rates in those settings. This change will take effect on January 1, 2025.

Appendix A: Specialty Level Impact Table

TABLE 110: CY 2025 PFS 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
Allergy/Immunology	\$218	0%	-1%	0%	-1%
Anesthesiology	\$1,591	1%	1%	0%	2%
Audiologist	\$74	0%	0%	0%	0%
Cardiac Surgery	\$166	0%	0%	0%	-1%
Cardiology	\$6,117	0%	0%	0%	0%
Chiropractic	\$656	0%	1%	0%	1%
Clinical Psychologist	\$737	3%	1%	0%	3%
Clinical Social Worker	\$854	3%	1%	0%	4%
Colon And Rectal Surgery	\$151	0%	0%	0%	0%
Critical Care	\$333	0%	0%	0%	0%
Dermatology	\$3,885	0%	0%	0%	0%
Diagnostic Testing Facility	\$942	0%	-2%	0%	-2%
Emergency Medicine	\$2,440	0%	0%	0%	0%
Endocrinology	\$517	0%	0%	0%	0%
Family Practice	\$5,515	0%	0%	0%	0%
Gastroenterology	\$1,453	0%	0%	0%	0%
General Practice	\$379	0%	0%	0%	0%
General Surgery	\$1,602	0%	0%	0%	0%
Geriatrics	\$222	0%	0%	0%	1%
Hand Surgery	\$265	-1%	-1%	0%	-1%
Hematology/Oncology	\$1,579	0%	-1%	0%	-1%
Independent Laboratory	\$561	0%	0%	0%	0%
Infectious Disease	\$555	0%	0%	0%	0%
Internal Medicine	\$9,491	0%	0%	0%	0%
Interventional Pain Mgmt	\$839	0%	0%	0%	0%
Interventional Radiology	\$445	0%	-2%	0%	-2%
Multispecialty Clinic/Other Phys	\$152	0%	0%	0%	0%
Nephrology	\$1,706	0%	0%	0%	0%
Neurology	\$1,333	0%	0%	0%	0%
Neurosurgery	\$706	0%	0%	0%	0%
Nuclear Medicine	\$50	0%	0%	0%	0%
Nurse Anes / Anes Asst	\$1,056	0%	1%	0%	1%
Nurse Practitioner	\$7,029	0%	0%	0%	0%
Obstetrics/Gynecology	\$565	0%	0%	0%	-1%
Ophthalmology	\$4,667	-1%	-1%	0%	-2%
Optometry	\$1,361	0%	0%	0%	-1%
Oral/Maxillofacial Surgery	\$64	0%	0%	0%	0%
Orthopedic Surgery	\$3,426	-1%	0%	0%	-1%
Other	\$58	0%	-1%	0%	-1%
Otolaryngology	\$1,155	0%	0%	0%	0%
Pathology	\$1,187	0%	0%	0%	0%
Pediatrics	\$55	0%	0%	0%	0%
Physical Medicine	\$1,127	0%	0%	0%	0%
Physical/Occupational Therapy	\$5,905	0%	0%	0%	0%
Physician Assistant	\$3,699	0%	0%	0%	0%
Plastic Surgery	\$303	0%	0%	0%	-1%
Podiatry	\$1,928	0%	0%	0%	0%
Portable X-Ray Supplier	\$79	0%	1%	0%	1%
Psychiatry	\$867	1%	0%	0%	1%

(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
Pulmonary Disease	\$1,269	0%	0%	0%	0%
Radiation Oncology and Radiation Therapy Centers	\$1,538	0%	0%	0%	0%
Radiology	\$4,557	0%	0%	0%	0%
Rheumatology	\$520	0%	-1%	0%	0%
Thoracic Surgery	\$297	0%	0%	0%	-1%
Urology	\$1,617	0%	0%	0%	0%
Vascular Surgery	\$998	0%	-2%	0%	-2%
Total	\$90,861	0%	0%	0%	0%

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