# Medicare RBRVS Changes in 2025

**CPT® Assistant.**

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### Conversion Factor* for 2025

On November 1, 2024, the Centers for Medicare & Medicaid Services (CMS) released the Final Rule for the calendar year (CY) 2025 Medicare Physician Payment Schedule (MFS**). Absent Congressional intervention, physicians face a 2.83% payment reduction on January 1, 2025. This cut results from the expiration of a 2.93% temporary update to the conversion factor (CF) at the end of 2024 and a 0% baseline update for 2025 under the Medicare Access and CHIP Reauthorization Act (MACRA). Thus, effective January 1, 2025, the Medicare CF will be reduced for the fifth straight year to $32.3465. The anesthesia CF will be reduced to $20.3178, reflecting the same overall MFS adjustments with the addition of anesthesia-specific practice expense (PE) and professional liability insurance (PLI) adjustments.

### Medicare Physician Payment Reform

When adjusted for inflation, Medicare physician payments have declined 29% from 2001 to 2024. Fixing the unsustainable Medicare payment system will remain the top advocacy priority of the American Medical Association (AMA) until meaningful reform is achieved. Essential modifications include an annual, permanent inflationary payment update in Medicare that is tied to the Medicare Economic Index (MEI) and budget neutrality reforms.

Visit FixMedicareNow.org for information on the ongoing work to establish a rational Medicare physician payment system that provides financial stability through positive annual payment updates, improves the financial viability of physician practices, and eases administrative burdens.

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*The conversion factor at the time of the publication of the January 2025 issue of the CPT Assistant. **From the American Medical Association's [AMA's] perspective, the distinction between a "payment schedule" and a "fee schedule" is extremely important: a payment is what physicians establish as the fair price for the services they provide; a fee is what Medicare approves as the payment level for the service. Therefore, the AMA has opted to use the term "payment" where appropriate, instead of "fee" in reference to the Medicare physician fee schedule [PFS] and has abbreviated the acronym to "MFS."

**Coding Changes and Work Relative Values**

For over three decades, the AMA/Specialty Society Relative Value Scale (RVS) Update Committee (RUC) has reviewed the resource costs required to provide physician services. For the 2025 MFS, RUC submitted 127 recommendations for new, revised, and related family Current Procedural Terminology (CPT®) codes and services identified as potentially misvalued. CMS implemented the recommended work values for 91% of these services and nearly all the direct PE recommendations. RUC provided recommendations to CMS for a wide range of services, including fascial plane blocks, excimer laser treatment, behavioral counseling and therapy, as well as annual screenings for alcohol and depression and telemedicine evaluation and management (E/M) services. While the CMS proposal for telemedicine will not use the new CPT telemedicine office visit codes for Medicare payment, the RUC recommendations for these services were published without revision.

The RUC recommendations, minutes, voting records, and other supporting documentation are available at https://www.ama-assn.org/about/rvs-update-committee-ruc/ruc-recommendations-minutes-voting.

**Medicare Telehealth Services**

The Final Rule includes policies that improve telehealth access in multiple ways. Most importantly, CMS has finalized a permanent change to its definition of "interactive telecommunications system" to include audio-only services, not just audio-video. CMS has also extended through December 31, 2025, the ability for teaching physicians to provide virtual direct supervision and virtual supervision of residents when the resident provides telehealth services. Frequency limits on subsequent hospital and nursing facility telehealth visits were lifted for one more year, and physicians providing telehealth from their homes do not have to report their home address to Medicare.

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However, Congress must act before the end of March 2025 to extend the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease 2019 [COVID-19])-era waivers of geographic and originating-site restrictions under the current law. The legislation is needed to ensure that Medicare patients can continue to access telehealth services across the country, not just in rural areas, and to receive telehealth services from their homes without having to go to a separate originating site.

CMS adopted the new CPT code 98016 for brief communication technology-based service, eg, virtual check-in, a service that was previously reported with Healthcare Common Procedure Coding System (HCPCS) code G2012, Brief communication technology-based service, e.g. 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 e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion. However, CMS finalized its decision to publish the other new CPT telemedicine E/M codes and relative values but opted not to adopt them for use in Medicare. Thus, CPT codes 98000-98015 are “I” status (“Not Valid” for Medicare purposes). This could lead to potential confusion if other payers and Medicare Advantage plans utilize the new, more precise CPT telemedicine codes while MFS services continue to be reported with E/M codes for in-person office visits with various modifiers to designate if they are audio-only, audio-video, and/or received at the patient’s home instead of an originating site. CMS states in the Final Rule that it will develop educational materials to assist in the correct coding of telehealth services.

**Caregiver Training Services**

CMS finalized its proposal for three new HCPCS codes (G0541-G0543) describing caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness. These strategies and techniques include but are not limited to preventing decubitus ulcer formation, wound dressing changes, infection control, special diet preparation, and medication administration. CMS also established two new HCPCS codes (G0539, G0540) for caregiver behavior management and modification training. All five HCPCS codes (G0539-G0543) and existing CPT codes (97550-97552, 96202, 96203) for caregiver training services were added to the Medicare Telehealth List on a provisional basis, which can be viewed at https://www.cms.gov/medicare/coverage/telehealth/list-services.

**Advanced Primary Care Management (APCM) Services**

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CMS finalized its proposal to establish and pay for three new HCPCS codes (G0556-G0558) for monthly APCM services. APCM services include elements of existing care management codes, including chronic care management (CCM), transitional care management (TCM), and principal care management (PCM), as well as communication technology-based services (eg, virtual check-in, interprofessional consultation, e-visits). Unlike existing care management codes, the code descriptors for APCM services are not time-based. Based on a patient's status as a Qualified Medicare Beneficiary (QMB), which reflects the patient's medical and social complexity, and the number of chronic conditions, there are three levels of coding:

- Level 1 (G0556) is for all patients with one or fewer chronic conditions,
- Level 2 (G0557) is for two or more chronic conditions, and
- Level 3 (G0558) is for two or more chronic conditions and QMB status.

The approximate national non-facility payment rates for new codes G0556-G0558 are $15, $50, and $110, respectively.

The APCM codes requirements that CMS finalized include elements such as patient consent, an initiating visit, 24/7 access and continuity of care, comprehensive care management, a patient-centered comprehensive care plan, management of care transitions, care coordination, enhanced communication, population-level management, and performance measurement.

CMS modified its concurrent billing restrictions proposal and will allow other specialists in the same group practice, other than the physician who is furnishing APCM services, to separately report services that are now considered bundled into APCM, such as CCM, PCM, and TCM.

**Cardiovascular Risk Assessment and Management**

CMS continued to build upon the success of the CMS Innovation Center's Million Hearts® Model, which coupled payments for cardiovascular risk assessment with cardiovascular care management, by establishing two new HCPCS codes (G0537, G0538) for atherosclerotic cardiovascular disease (ASCVD) risk assessment and management services. The ASCVD risk assessment will generally be performed in conjunction with an E/M visit when a patient who does not have a diagnosis of CVD is identified as being at risk for CVD. CMS agreed, however, that the ASCVD risk assessment should not be required to be performed on the same date as a visit because the physician may need to first obtain the patient's test results.

Output from the risk assessment must include a 10-year estimate of the patient's ASCVD risk. For patients at intermediate or high risk for CVD, ASCVD risk

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management services may include blood pressure management, cholesterol management, smoking cessation, and other elements.

### Behavioral Health Services

CMS finalized a new HCPCS code (G0560) to pay for safety planning interventions (SPI) for patients in crisis in a variety of settings, including those with suicidal ideation or at risk of suicide or overdose, which can be reported in 20-minute increments. SPI can include assisting the patient in following a personalized safety plan, utilizing family members and friends to help resolve the crisis, contacting mental health professionals, and others. The SPI code was also added to the telehealth list. An additional monthly HCPCS code (G0544) is intended to support four follow-up telephone calls after discharge from the emergency department or other specific settings for a crisis encounter.

CMS adopted three HCPCS codes (G0552-G0554) for digital mental health treatment devices furnished under a behavioral health treatment plan of care, and it will monitor how digital mental health treatment devices are used as part of overall behavioral health care. CMS also adopted six HCPCS codes that parallel existing CPT codes for interprofessional consultations to better integrate behavioral health treatment into primary care and other settings. These codes are intended for use by nonphysician mental health professionals, including clinical psychologists, clinical social workers, marriage and family therapists, and mental health counselors, to integrate behavioral health treatment into primary care and other settings.

### Colorectal Cancer Screening

CMS finalized its proposals to expand coverage of colorectal cancer (CRC) screening to promote access and remove barriers for much-needed cancer prevention and early detection, particularly within rural and racial and ethnic minority communities that are significantly affected by CRCs. In response to evidence supporting its efficacy and recommendations by the United States (US) Preventive Services Task Force (USPSTF), CMS established coverage for computed tomography colonography and broadened the definition of “complete CRC screening” in § 410.37(k) to include a follow-up screening colonoscopy with no patient cost-sharing when a Medicare-covered, blood-based biomarker test returns a positive result. Finally, CMS eliminated coverage for the barium enema procedure because it is no longer recommended as an evidence-based screening method and is rarely used in Medicare, according to the USPSTF and the US Multi-Society Task Force on Colorectal Cancer.

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**Preventive Services**

Medicare Part B covers preventive vaccines for influenza, pneumonia, hepatitis B, and COVID-19, and there is no patient cost-sharing. For CY 2025, CMS expanded coverage of hepatitis B vaccinations to all individuals who have not previously received a completed hepatitis B vaccination series or whose vaccination history is unknown. CMS will also allow roster billing for this vaccine by mass immunizers such that a physician's order will no longer be required. Also, for the first time since the law allowing coverage of drugs as "additional preventive services" was enacted in 2008, CMS will pay for a drug in this benefit category which, like other Medicare preventive services, will have no cost-sharing. Specifically, CMS will begin paying for pre-exposure prophylaxis (PrEP) for human immunodeficiency virus (HIV) infection prevention. A new HCPCS code (G0012) will cover PrEP for HIV prevention injections, and two new HCPCS codes (G0011-G0013) will pay for counseling individuals on PrEP to prevent HIV.

**Office/Other Outpatient E/M Visit Complexity HCPCS Add-On Code**

CMS finalized payment for HCPCS add-on code G2211 for office or other outpatient (O/O) E/M visit complexity when the E/M code is reported by the same physician or other qualified health care professional (QHP) on the same day as an annual wellness visit, vaccine administration, or other Medicare preventive service. This is a change from the current policy, which does not allow payment for HCPCS code G2211 when E/M visits are provided by the same physician or other QHP to the same patient on the same day as another service and reported with CPT modifier 25, *Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service. HCPCS code G2211 captures the inherent complexity of the O/O E/M visit that is derived from the longitudinal nature of the physician-patient relationship, and it must be reported with an E/M visit base code (ie, 99202-99205, 99211-99215).*

**Dental and Oral Health Services**

Notwithstanding the important link between dental and physical health, Medicare has generally precluded covering dental services. However, in the CY 2023 PFS Final Rule, CMS codified that Medicare payment could be made when dental services are inextricably linked to and related and integral to the clinical success of other Medicare-covered services. Since then, CMS has gradually added additional dental services to the list of Medicare-covered services. In the 2025 Final Rule, CMS added two new service groupings to this list, including (1) dental or oral examination in the inpatient or outpatient

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setting prior to Medicare-covered dialysis services for beneficiaries with end-stage renal disease (ESRD); and (2) medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to, or contemporaneously with, Medicare-covered dialysis services for beneficiaries with ESRD, with some modifications in the Final Rule to reflect the duration of dialysis services for the treatment of ESRD.

CMS acknowledged logistical processing issues for dental claims and reiterated its ongoing efforts to rectify them. In response to comments, it finalized but delayed until July 1, 2025, two new requirements to report diagnosis codes on dental claim forms and to report modifier KX on professional, dental, and institutional claim forms to identify dental services inextricably linked to covered medical services and to demonstrate coordination between the dental and clinical professional. The delayed implementation date will allow for additional time for provider education, testing, and sorting out any workflow challenges.

**Physician Practice Information (PPI) Survey**

The CY 2025 Final Rule continues to postpone the implementation of updated MEI weights, which were finalized for CY 2023. These updates would change the proportion of Medicare physician payments based on physician work, PEs, and PLI costs with potentially significant payment redistributions across specialties. The re-weighting would have significant effects on MFS payments and could lead to payment reductions for some specialties and geographic localities. CMS delayed the implementation of MEI changes in response to the AMA's national study, the PPI survey, to collect data on physician PEs.

The PPI survey aims to better understand the costs faced by today's physician practices to support physician payment advocacy. Supported by over 170 health care organizations, the study offers an opportunity to communicate accurate financial information to policymakers, including members of Congress and CMS. The MFS relies on the cost information of 2006 to develop PE relative values, the MEI, and resulting physician payments. As the US economy and health care system have undergone substantial changes since 2006, including inflation and the widespread adoption of electronic health records and other information technology systems, PE payments no longer accurately reflect the relative resources that are typically required to provide physician services.

The PPI survey provided the opportunity for physician practices to share their practice cost data and the number of direct patient-care hours provided by both physicians and QHPs. The AMA contracted with Mathematica, an independent research company with extensive experience in survey methods and health care delivery and finance reform, to conduct the study. Beginning in July 2023, 10,000 physician practices were randomly invited via email and mail to participate in the survey. The survey was completed in the summer of 2024, and data will be shared with CMS in early 2025 for the 2026 MFS rulemaking process. A coalition of other nonphysicians or doctors of osteopathic organizations is also working with Mathematica to administer a similar

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study of their professions.

### Clinical Labor Pricing Update

CY 2025 marks the final year of a four-year transition for the clinical staff wage-rate increases, using the Bureau of Labor Statistics (BLS) median wage data. CMS began its clinical labor pricing update in 2022, in conjunction with the final year of its supply and equipment pricing update. That was the first year that the clinical labor prices had been updated since 2002. Over a span of 4 years, CMS finalized the implementation of the clinical labor update, gradually transitioning from existing prices to updated prices, which will be fully effective in 2025. The multiyear transition will help account for the effect of the clinical labor rate update, recognizing that services with substantial direct costs attributable to clinical labor will see increases, while services with proportionally more supplies and equipment direct costs will see declines. Absent congressional action, the increased wage rates must be budget-neutral and, therefore, will create reductions for some physician services, especially those with expensive supplies and equipment. Therefore, the AMA continues to urge Congress to provide a positive update to the Medicare CF in all future years.

### Visits In Global Surgical Package

CMS finalized its proposal to require the use of transfer-of-care modifier 54, Surgical Care Only, for 90-day global surgical packages when a physician plans to furnish only the surgical procedure portion of the global package. This includes when there is a formal, documented transfer of care under current CMS policy or an informal, non-documented but expected transfer of care. Appending this modifier will reduce the payment rate to reflect that the surgeon is not providing the postoperative portion of the service.

Despite concerns that applying a payment reduction to surgical codes reported using modifier

54 and that the multiple procedure payment reduction (MPPR) would duplicate the reduction and be inappropriate because the MPPR already reduces the payment for the second and subsequent services to remove payment for postoperative care, CMS will apply both payment reductions. CMS did not finalize any changes regarding the use of modifiers 55, Postoperative Management Only, and 56, Preoperative Management Only, for CY 2025. Modifiers 55 and 56 will continue to be reported exclusively in cases with a documented formal transfer of care.

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Finally, CMS finalized coding and payment for an E/M add-on code (G0559) to capture the additional time and resources spent providing postoperative care by a physician who did not perform the surgical procedure and who has not been involved in a formal transfer-of-care agreement. This code can be reported only once during the 90-day global period by a physician of a different specialty from the surgeon or of the same specialty as long as they are not in the same group practice. The add-on code is intended to reflect the time and resources involved in postoperative follow-up visits by physicians who were not involved in furnishing the surgical procedure.

**Potentially Misvalued Services**

In 2006, RUC established the Relativity Assessment Workgroup (RAW) to identify potentially misvalued services using objective mechanisms for re-evaluation. Since its inception, RAW and CMS have identified 2,867 services using over 20 screening criteria that resulted in further review by RUC. RUC has reviewed approximately 95% of the MFS-allowed charges. Codes that have not been reviewed are low-volume and represent a minimal amount of allowed-charges. RUC, via its review of potentially misvalued services, has recommended reductions and deletions to 1,614 services, redistributing $5 billion annually. In addition, RUC has charged RAW with maintaining the “new technology” list of services that will be re-reviewed by RUC, as reporting and cost data become available.

**Medicare’s Quality Payment Program**

The quality payment program was created by MACRA 2015, which established two pathways for physicians for Medicare payment: the alternative payment models (APMs) and the merit-based incentive payment system (MIPS). MIPS is the default option for physicians unless they participate in an APM. Participation in APMs and MIPS in 2025 will affect Medicare payment rates in 2027. Under MACRA, qualifying APM participants (QPs) in 2025 will earn a 0.75% update to the CF in 2027, whereas non-QPs, including MIPS-eligible clinicians, will see a 0.25% update to the CF in 2027. In the 2025 MFS Final Rule, CMS estimated that 85% of 2025 MIPS-eligible clinicians will avoid a penalty and/or earn a bonus in 2027, the median MIPS bonus in 2027 will be 1.31%, and the median MIPS penalty in 2027 will be -1.48%.

Together with the Federation of Medicine, the AMA has developed and proposed legislative language to improve the MIPS program. The proposal would address steep penalties that are distributed unevenly and disproportionately impact small, rural, and independent practices; hold CMS accountable for

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providing physicians with timely and actionable data; and reform MIPS so that it is more clinically relevant and less burdensome. For more information, visit FixMedicareNow.org.

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