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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%
Rheumatology	$520	0%	-1%	0%	0%
Infectious Diseases	$555	0%	0%	0%	0%
Hematology/Oncology	$1,579	0%	-1%	0%	-1%
Interventional Radiology	$445	0%	-2%	0%	-2%

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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.

Potentially Misvalued Services Under the Physician Fee Schedule – p. 78
Each year the agency reviews potentially misvalued services. The review of values of services priced under the MPFS required by law, and since 2009, CMS has reviewed more than 1,700 codes. Criteria for determining a misvalued service are applied at the code level, with refinements proposed by CMS for any code deemed misvalued.

CPT Codes 10021, 10004, 10005, and 10006 – p. 70
CPT codes used to report services associated with fine aspiration procedures were nominated by an interested party as potentially misvalued. The final rule once again reiterates that the fine needle aspiration services reported by the following codes are not misvalued: CPT codes 10021 (*Fine needle aspiration biopsy, without imaging guidance; first lesion*),10004 (*Fine needle aspiration biopsy, without imaging guidance; each additional lesion*), 10005 (*Fine needle aspiration biopsy, including ultrasound guidance; first lesion*) and 10006 (*Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion*).

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.

Continuous Glucose Monitoring – p. 115
CMS received a request to add CPT code 95251 (*Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report)* to the Medicare Telehealth Services List and assign it permanent status. After reviewing comments, the agency does not consider this to be a Medicare telehealth service and therefore is not adding this service to the Medicare Telehealth Services List. "The agency denied the request because CGM is not an inherently face-to-face service, and the patient does not need to be present for the service to be furnished in it is entirety."

Care Management – p. 122
CMS received a request to permanently add General Behavioral Health Integration (CPT code 99484) and Principal Care Management (CPT codes 99424-99427) to the Medicare Telehealth Services List. The agency does not consider these to be Medicare telehealth services and therefore is not adding these services to the Medicare Telehealth Services List. As noted in the rule the agency states, "We do not consider these services to be Medicare telehealth services because they are not inherently face-to-face services, and the patient need not be present for the services to be furnished in its entirety."

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.

Valuation of Specific Codes

Percutaneous Radiofrequency Ablation of Thyroid (CPT codes 60660 and +60661) – p. 216 Endo
New CPT codes used to report the ablation of the thyroid using radiofrequency were valued by the RUC at the January 2024 RUC meeting. CMS finalized the RUC recommended work values and recommended PE inputs for both services without refinement.

Table 2: Work RVUs for Ablation of Thyroid

CPT Code	Description	Final Work RVUS
60660	*Ablation of 1 or more thyroid nodule(s), one lobe or the isthmus, percutaneous, including imaging guidance, radiofrequency*	5.75
+60661	*Ablation of 1 or more thyroid nodule(s), additional lobe, percutaneous, with imaging guidance, radiofrequency (List separately in addition to code for primary service*)	4.25

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 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.

In the proposed rule, the agency sought comment on fracture care delivery and requested information on programmatic or other policy changes that the agency could implement to improve this care. Other than to thank commenters, the agency provided this clarifying statement on the use of PIN services for facture care. "*We clarify that for billing PIN services, there are circumstances in which osteoporosis may be considered 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*."

Insertion, and Removal and Insertion of New 365-Day Implantable Interstitial Glucose Sensor System (HCPCS Codes G0564 and G0565) – p. 277
Highlight: The agency contractor prices two new HCPCS codes to report implantable glucose sensor system.

CMS stated that during the comment period that a request was made to establish two new HCPCS codes to report glucose monitoring services using an implanted device which was recently FDA approved for 365 days of continuous monitoring.

In response to the comment, CMS agreed and created HCPCS codes G0564 *(Creation of subcutaneous pocket with insertion of 365-day implantable interstitial glucose sensor, including system activation and patient training) and* G0565 *(removal of implantable interstitial glucose sensor with creation of subcutaneous pocket at different anatomic site and insertion of new 365-day implantable sensor, including system activation).* The new codes, effective January 1, 2025, will be Medicare contractor priced. For the use of the 180-day system and to ease transition, CMS supports the use of the Category III CPT codes, 0446T, and 0448T until such time that the 180-day system is phased out of the market.

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

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.

CMS received several comments recommending that G2211 be considering for billing with other services including the Endocrine Society's comment to allow the use of G2211 with ambulatory continuous glucose monitoring (CGM). The Endocrine Society also noted in submitted comments that endocrinologists typically see sicker patients that primary care practitioners, and therefore G2211 should be allowed for use with CGM services. The agency acknowledged that it may consider broadening the situations when G2211 is permissible.

Proposals on Medicare Parts A and B Payment for Dental Services Inextricably Linked to Specific Covered Services – p. 616
Highlight: CMS will not cover dental services for diabetes. Cite lack of evidence.

Submissions through Public Submission Process
Submissions for the CY 2026 PFS rulemaking for additional clinical scenarios for which dental services are inextricably linked to other covered services should be received by February 10, 2025 and may be submitted to MedicarePhysicianFeeSchedule@cms.hhs.gov.

Request for Comment on Dental Services Integral to Specific Covered Services to Treat Diabetes
Stakeholders suggested that dental services are inextricably linked to treatment services for individuals with diabetes. While the evidence demonstrates that an individual with both a diagnosis of diabetes and of periodontitis who receive periodontal treatment services may experience improvements in markers for HbA1c, these outcomes do not align with CMS' framework to pay for dental services inextricably linked to covered services. The agency is not adding these services as they have not identified additional dental services that are inextricably linked to certain services in the treatment of diabetes.

CMS received feedback on the proposed rule and did not find that the information provided identified any specific covered services for the treatment of diabetes to which dental services are inextricably linked. The agency will continue to engage with interested parties and will review information that identifies specific covered medical services that the dental services are inextricably linked to.

Implementation of Payment for Dental Services Inextricably Linked to Other Specific Covered Services
Effective July 1, 2025, the KX modifier is required for claims submissions for dental services inextricably linked to covered medical services on the dental claim format 837D, the professional claim form 837P and the institutional claim form 837I. Practitioners who bill for dental payment must include the KX modifier to indicate that they believe that the dental service meets the established payment criteria; that the practitioner has included appropriate documentation in the medical record to support or justify the medical necessity of the service or item, and that the coordination of care between the medical and dental practitioners has occurred.

Effective July 1, 2025, CMS requires the reporting of a diagnosis code on the dental claim form for physician's services inextricably linked to covered medical services. The agency delayed implementation for these two provisions to allow sufficient time for comprehensive testing, reporting, and educational materials for healthcare providers, vendors, and payors.

CMS finalized that the GY modifier may be used on professional, dental, and institutional claim forms in instances where a Medicare claim denial is sought for purposes of submission to third party payers or where the dental service does not fit within a Medicare benefit category and is statutorily excluded from coverage.

CMS received comments on the need for the agency to educate providers on billing practices and how dental policies apply to different programs. The agency will continue to seek ways to better educate healthcare providers on billing practices and supplemental dental coverage. An FAQ is available here: Medicare Dental Coverage.

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.