2025 Medicare Physician Fee Schedule Final Rule

Background:
The Centers for Medicare & Medicaid Services (CMS) released the Calendar Year (CY) 2025 Medicare Physician Fee Schedule final rule on November 1, 2024. The rule takes effect on January 1, 2025.

What this rule will do:
The final rule updates the physician fee schedule (PFS) and other Medicare Part B payment policies to ensure that payment systems are updated to reflect changes in medical practice, relative value of services, and changes in the statute. Key changes include the following:

- **CY 2025 PFS Rate Setting and Conversion Factor**: The final CY 2025 MPFS conversion factor (CF) is set at $32.3465 – a 2.83% reduction from the current CY 2024 CF. The final CY 2025 CF reflects a 0.02 percent positive budget neutrality adjustment as required by law; the 0.00 percent update adjustment factor specified under the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA); and the removal of the temporary 2.93 percent payment increase for services furnished from March 9, 2024, through December 31, 2024, as provided in the *Consolidated Appropriations Act, 2024*. ***AAOS continues to oppose regulatory changes that further reduce reimbursement under the Fee Schedule and urges CMS to reconsider the proposed conversion factor reduction, exploring alternative methods for budget neutrality that do not disproportionately impact physician reimbursement. We remain committed to advocating for an inflationary update to the Medicare Physician Fee Schedule, supporting CMS initiatives to stabilize the MPFS and promote a more equitable, sustainable payment system that reflects rising healthcare delivery costs.***
- **Potentially Misvalued Services Under the PFS:** AAOS strongly urged CMS not to finalize the designation of these codes as potentially misvalued, as the information provided demonstrates that the nominator's claims are invalid. Although CMS acknowledged these concerns, it agreed with the AMA RUC that these codes may benefit from further review. Therefore, CMS is finalizing the proposal to designate CPT codes 22210, 22212, 22214, and 22216 as potentially misvalued. AAOS also expressed concerns regarding the safety of performing sacroiliac joint fusion in an office setting and urged CMS not to price CPT code 27279 for non-facility/office use. CMS finalized its proposal not to designate CPT code 27279 as potentially misvalued.
- **Valuation of Specific Codes:** AAOS urged CMS to accept the RUC recommended work value for the four Hand, Wrist & Forearm Repair & Recon CPT codes. CMS is finalizing the work RVUs for all four codes (25310, 25447, 2X005, and 26480) in the Hand, Wrist, & Forearm Repair & Recon family as proposed, without adopting the higher RUC-recommended values.
- **Advanced Primary Care Management (APCM) Services**: AAOS opposes the proposed G codes, as they lack specificity in addressing fracture management and fracture prevention needs. CMS finalized the creation of three new G-codes (GPCM1, GPCM2, and GPCM3) to describe Advanced Primary Care Management (APCM) services, effective January 1, 2025. These codes can be billed monthly by the physician or qualified practitioner responsible for the patient's primary care, without limitations on specialty, following an initial qualifying visit.
- **Global Surgical Packages & Transfer of Care Modifiers:** AAOS opposed CMS's refusal to apply RUC-recommended work and time increases to global surgical codes. We recommended that CMS adopt these changes to ensure Fee Schedule relativity. CMS finalized the proposal to apply Modifier -54

(Surgical Care Only) for instances when a practitioner performs only the procedure without intending to provide post-operative care. Under this change, for 90-day globals Modifier 54 would be applied in instances beyond which there is formal, documented transfer of care (as is the case under current policy) to also include when there is an informal, expected transfer of care. CMS will not, however, change the current policy for Modifiers ~55 and ~56; and CMS finalized the new E/M add-on code for practitioners (who are neither the surgeon who conducted the surgery or anyone in their practice) delivering an E/M service outside a formal transfer of care when that service is related to the procedure with the modification that physicians in the same specialty as the surgeon can bill the add-on code (as long as they are outside the surgeon's group practice). Both policies apply only to 90-day globals.

- **Rebasing and Revising the Medicare Economic Index:** AAOS supports the delay and the decision to wait for updated AMA practice cost data before proceeding and CMS will again delay incorporating the 2017-based Medicare Economic Index (MEI) in PFS ratesetting for CY 2025 as it awaits the AMA PPIS and considers other data sources.
- **Supervision Policy for Physical Therapists (PTs) and Occupational Therapists (OTs) in Private Practice:** For CY 2025, CMS is finalizing a regulatory change to allow for general supervision of physical therapist assistants (PTAs) and occupational therapy assistants (OTAs) by PTs in private practice (PTPPs) and OTs in private practice (OTPPs) for all applicable physical and occupational therapy services. This finalized change will give PTPPs and OTPPs more flexibility in meeting the needs of beneficiaries and safeguard patient access to medically necessary therapy services, including those experiencing challenges accessing these services in rural and underserved areas, and it will align with general supervision of PTAs and OTAs by PTs and OTs who work in institutional providers.

What Happens Next:

AAOS will continue to advocate for the policies we recommended as well as monitor CMS policy for changes.

For more information, contact Lori Shoaf in the AAOS Office of Government Relations at shoaf@aaos.org.
www.aaos.org/dc