CY 2025 Medicare Physician Fee Schedule (MPFS) CMS-1807- P, Proposed Rule Summary

On July 10, 2024, the Centers for Medicare and Medicaid Services (CMS) issued the proposed rule for the Medicare Physician Fee Schedule (MPFS) for CY 2025.

The proposed rule is 2,248 pages in length and located in its entirety at the following link: https://www.federalregister.gov/public-inspection/2024-14828/medicare-and-medicaid-programs-calendar-year-2025-payment-policies-under-the-physician-fee-schedule.

The following is intended to serve as a summary of the proposed changes. SIR is preparing comments on the proposed ruling which will be submitted to CMS.

Highlights

- CY 2025 conversion factor (CF) proposed to be $32.3562, a decrease from CY 2024 CF of $33.2875.
    - The decrease of 2.93% is due to the expiration of legislative increase valid for 2024 only and budget neutrality increase of 0.05%.
- Separate from a decrease in the conversion factor, CMS has proposed a decrease in practice expense RVUs (i.e., clinical staff, equipment and supplies) in the non-facility setting. CMS provided an estimated impact breakdown based on setting, non-facility vs. facility for each specialty. The overall percentages are based on aggregate estimated allowed charges summed across services by all providers for a specialty and compared to the previous year. The decrease in PE RVUs is specific to physicians working in nonfacility settings (e.g. OBLs). The actual decrease will vary for each physician in the non-facility setting and depend on factors such as practice patterns.
    - Estimated impacts for select specialties are as follows:
        - Interventional Radiology -2%, Non-facility -3% and Facility 1%
        - Radiology 0%, Non-facility -1% and Facility 1%
        - Interventional Pain Management 0%, Non-facility 0% and Facility 1%
- Changes to relative value units (RVUs) for physician work and practice expense are also proposed to impact reimbursement, again negatively for many which are highly specialized.
    - Year 4 of the clinical labor pricing update, and
    - Proposed adjustments to transfer of postoperative care for global surgical procedures.
- CMS proposed the year 4 (final year) phase-in changes to the clinical labor values, which increase the PE RVUs based on data that SIR provided on the higher salaries for vascular interventional technologists.
- CMS codes and code sets for CY 2025 valuation, many of the RUC recommendations were accepted.
    - MRI-Monitored Transurethral Ultrasound Ablation of Prostate (CPT® codes 5X006, 5X007, and 5X008) – **New for 2025**
    - Percutaneous Radiofrequency Ablation of Thyroid (CPT® codes 6XX01 and 6XX02) – **New for 2025**
    - Ultrasound Elastography (CPT® codes 76981, 76982, and 76983)
    - CT Guidance Needle Placement (CPT® code 77012)
    - Telemedicine Evaluation and Management (E/M) Services (CPT codes 9X075, 9X076, 9X077, 9X078, 9X079, 9X080, 9X081, 9X082, 9X083, 9X084, 9X085, 9X086, 9X087, 9X088, 9X089, 9X090, and 9X091) – **New for 2025**

CY 2024 Medicare Proposed RVUs						
HCPCS	Modifier	DESCRIPTION	WORK RVU	NON-FAC PE RVU	FACILITY PE RVU	MP RVU
5X006		Ins trurl ablt trnsdc thr us	4.05	11.95	1.98	0.50
5X007		Ablt trurl prst8 tis thrm us	9.80	256.50	3.71	1.17
5X008		Ablt trurl prst8 tis trnsdcr	11.50	263.64	5.00	1.51
6XX01		Abltj 1/+thyr ndul 1lobe prq	5.75	67.32	2.73	0.91
6XX02		Abltj 1/+thyr ndul addl prq	4.25	7.02	1.59	0.66
76981		Use parenchyma	0.59	2.54	NA	0.05
76981	TC	Use parenchyma	0.00	2.31	NA	0.02
76981	26	Use parenchyma	0.59	0.23	0.23	0.03
76982		Use 1st target lesion	0.59	2.15	NA	0.04
76982	TC	Use 1st target lesion	0.00	1.93	NA	0.01
76982	26	Use 1st target lesion	0.59	0.22	0.22	0.03
76983		Use ea addl target lesion	0.47	1.28	NA	0.03
76983	TC	Use ea addl target lesion	0.00	1.08	NA	0.01
76983	26	Use ea addl target lesion	0.47	0.20	0.20	0.02
77012		Ct scan for needle biopsy	1.50	2.19	NA	0.09
77012	TC	Ct scan for needle biopsy	0.00	1.71	NA	0.01
77012	26	Ct scan for needle biopsy	1.50	0.48	0.48	0.08

- CMS proposed some strategies for improving global surgery payment accuracy, specifically related to the 90-day global surgical period, but also seeking comments whether the proposed changes should be extended to 10-day global surgical periods as well. The current list of 90 and 10-day global surgical codes can be accessed on the CMS website.
- CMS proposed to extend direct supervision of diagnostic tests, physicians' services, and some hospital outpatient services, to allow the supervising professional to be immediately available through virtual presence using two-way, real-time audio/video technology, instead of their physical presence, through December 31, 2025. The list of codes impacted this will have a PC/TC indicator "2" to the technical component or physician service code. The RVU file is updated quarterly and can be accessed on the CMS website.
- CMS proposed to allow the teaching physician to have a virtual presence in all teaching settings, but only in clinical instances when the service is furnished virtually (3-way telehealth visit, with all parties in separate locations) through December 31, 2025.
    - CMS is also seeking comments regarding adjusting policy for teaching physician billing of low-level services performed by resident without direct input and participation by teaching physician.
- CMS proposed delay of the finalized 2017-based MEI costs weights for CY 2025, pending the outcomes of the AMA new survey expected to be complete at end of CY 2024.

Within the following pages are expanded details and explanations of the key highlights pertinent to interventional radiology as outlined above.

Payment Rates

The proposed conversion factor (CF) for CY 2025 was calculated by first removing the 2.93 percent one-year increase set by the Consolidated Appropriations Act, 2024 (CAA 2024) from the CY 2024 CF of 33.2875. This reduced the starting CF for CY 2025 to 32.3400. Additionally, CMS proposed a 0 percent statutory update fraction and an increase of 0.05 percent budget neutrality adjustment, which results in a proposed CF of 32.3562 for CY 2025.

Table 126 from the proposed rule outlines the factors set by CMS to calculate the conversion factor:

TABLE 126: Calculation of the CY 2025 PFS Conversion Factor

CY 2024 Conversion Factor		33.2875
Conversion Factor without the CAA, 2024 (2.93 Percent Increase for CY 2024)		32.3400
CY 2025 Statutory Update Factor	0.00 percent (1.0000)	
CY 2025 RVU Budget Neutrality Adjustment	0.05 percent (1.0005)	
CY 2025 Conversion Factor		**32.3562**

The lowering of the CF does result in decreases for many specialties and their estimated impacts; however, additional changes due to misvalued codes, year 4 of the clinical labor pricing update, and proposed adjustments to transfer of postoperative care for global surgical procedures are also contributing factors.

In addition to the estimated impact on total allowed charges by specialty provided in Table 128, CMS also provided additional estimated impact on total charges by setting (Table 129) after requests by stakeholders to provide more transparency.

Once again specialties (i.e., clinical social workers and clinical psychologists, geriatrics, anesthesiology, and nurse anesthetists, psychiatry, and family practice) which rely on E/M services or clinical labor to make up the bulk of their practice expense are proposed to see positive impacts, or not as significant of decreases, related to RVU changes. Other specialties, such as diagnostic testing facilities, vascular surgery, interventional radiology, ophthalmology, and orthopedic surgery are proposed to see negative impacts related to RVU changes. This is primarily due to how practice expense contributes to valuation of services. The cost of equipment and supplies to perform procedures make up the bulk of valuation, with clinical labor and E/M being much smaller factors for specialties like interventional radiology.

CMS must maintain budget neutrality when increasing or decreasing payment rates. CMS cannot exceed their projected budget each year by $20 million above or below the set amount. If they calculate based on the changes in code values or other updates, they will exceed the amount in payments for services because certain specialties are calculated to see an increase, they do not get extra money from somewhere else in the government, they must work within their given budget. CMS will "pay" for the increase in values to codes and overall reimbursement for specialties by lowering the rates or values of codes primary to other specialties which provides them with the added monies needed to make up the difference.

In addition to the estimated impact on total allowed charges by specialty provided in Table 128, CMS also provided additional estimated impact on total charges by setting (Table 129), and additionally a separate addendum file outlining the distribution of practitioners by percent change in total RVUs and IMPACT Specialty, (weighted by total RVUs). Sections of these tables are provided here.

TABLE 128: 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
Interventional Pain Management	$792	0%	0%	0%	0%
Interventional Radiology	$418	0%	-2%	0%	-2%
Radiology	$4,273	0%	0%	0%	0%
Vascular Surgery	$937	0%	-2%	0%	-2%

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

TABLE 129: CY 2025 PFS Estimated Impact on Total Allowed Charges by Setting

(A) Specialty	(B) Total Non-Facility/Facility	(C) Allowed Charges (mil)	(D) CombinedImpact
Interventional Pain Management	*TOTAL*	$792	0%
	Non-facility	$624	0%
	Facility	$168	1%
Interventional Radiology	*TOTAL*	$418	-2%
	Non-facility	$259	-3%
	Facility	$159	1%
Radiology	*TOTAL*	$4,273	0%
	Non-facility	$1,894	-1%
	Facility	$2,379	2%
Vascular Surgery	*TOTAL*	$937	-2%
	Non-facility	$676	-2%
	Facility	$261	0%

CMS also provided an additional file, breaking down the impacted specialties by the estimated percent of in weighted total RVUs.

Distribution of Practitioners by % Change in Total RVUs and IMPACT Specialty, (weighted by total RVUs)

NPRM2025 (using 2023 CCW claims)

Impact Specialty		Practitioner RVUs (millions)	% Change in Total RVUs *per practitioner*										
			< -%20	-20% to < -10%	-10% to < -5%	-5% to < -2%	-2% to < -1%	-1% to < 1%	1% to < 2%	2% to < 5%	5% to < 10%	10% to < 20%	>=20%
Total		**2,633**	**Share of Total Practitioner RVUs in Specialty**										
19	Interventional Pain Management	25	0%	0%	0%	2%	15%	**81%**	2%	1%	0%	0%	0%
20	Interventional Radiology	13	0%	0%	0%	49%	4%	**46%**	1%	0%	0%	0%	0%
37	Radiology	135	0%	0%	0%	4%	7%	**85%**	3%	1%	0%	0%	0%
42	Vascular Surgery	29	0%	0%	0%	52%	12%	**35%**	0%	0%	0%	0%	0%

Practice Expense RVUs

CMS updated clinical labor rates for the first time in 20 years in CY 2002 using CY 2019 survey data from the Bureau of Labor and Statistics (BLS) and other supplementary data when BLS data is not available. Selected labor value changes from Table 5 of the proposed rules are included below. It should be noted, an increase in labor values is indicated for all of the labor types reviewed by CMS. Because the values are maintained in

budget neutral manner, increases for one specialty or one code (or code set) are possible because it was taken or adjusted from another specialty or code (or code set).

TABLE 5: Proposed CY 2025 Clinical Labor Pricing

Labor Code	Labor Description	Source	CY 2021 Rate Per Minute	Final Y4 Rate Per Minute	Total % Change
L041A	Vascular Interventional Technologist	ASRT Wage Data	0.41	0.84	104%
L041B	Radiologic Technologist	BLS 29-2034	0.41	0.63	54%
L041C	Second Radiologic Technologist for Vertebroplasty	BLS 29-2034	0.41	0.63	54%
L043A	Mammography Technologist	BLS 29-2034	0.43	0.79	47%
L046A	CT Technologist	ASRT Wage Data	0.46	0.78	70%
L047A	MRI Technologist	BLS 29-2035	0.47	0.76	62%

Specific Codes and Code Set Valuations

Within the CY 2025 proposed rule, CMS addressed multiple misvalued and/or proposed value changes to specific series of new and established CPT® codes. CMS is seeking input from stakeholders on 5 potentially misvalued codes, for which they received nominations, 2 of them specific to IR. CMS explains their rationale for the proposed changes are based on values recommended by the Relative Value Scale Update Committee (RUC) and other organizations which CMS utilizes for assistance in setting appropriate values for codes.

The following codes are a pertinent sample among the codes selected for valuation by CMS in the proposed rule:

Sacroiliac Joint Arthrodesis (CPT® code 27279)

CPT® code 27279 *(Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device)* was not nominated by CMS, in fact this was a renomination of the code based on the absence of separate direct practice expense (PE) inputs in the nonfacility setting.

CPT® code 27279 is a 90-day surgical global procedure only currently valued in the facility setting. The nominator is requesting CMS to establish PE inputs when performed in the office-based lab (OBL). As part of the nomination three post-market surveillance publications and two independent reviews of minimally invasive sacroiliac (SI) joint fusion procedures were provided in support of this procedure course being safely and effectively furnished in the OBL (nonfacility setting).

CMS did indicate they recognize the possibility for this procedure to be potentially misvalued, given the assertion the complication rate is low. CMS did note however, the studies collectively report heterogeneous safety outcomes, ultimately requiring further investigation. Due to this CMS is not proposing CPT® 27279 is misvalued, instead, they are seeking comments and additional studies on whether this code should be valued in the OBL/nonfacility setting.

Fine Needle Aspiration (CPT® codes 10021, 10004, 10005, and 10006)

CPT® code 10021 (*Fine needle aspiration biopsy, without imaging guidance; first lesion*), CPT® code 10004 (*Fine needle aspiration biopsy, without imaging guidance; each additional lesion*), CPT® code 10005 (*Fine needle*

aspiration biopsy, including ultrasound guidance; first lesion) and CPT® code 10006 (*Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion*) were nominated as potentially misvalued. The request specifically asked CMS to review the work RVUs and accept the most recent RUC work RVU recommendations.

The request stated thyroid fine needle aspiration should exclusively be performed as an outpatient procedure and does not require hospitalization. Due to the current valuation for these specific FNA codes, the nominator indicated services are now being referred to hospital-based radiology practices and away from endocrinology office-based practices. This shift to physicians who are not specifically trained for these procedures may lead to an increase in medically unnecessary procedures and/or limited access to care.

CMS indicated they disagree with the nominator these codes may be potentially misvalued. The FNA code family has been reviewed multiple times recently, but CMS does agree it is possible the practice patterns for these codes could have changed and are not reflected in the current work RVUs. If this is the case, they should be referred to the AMA RUC for a new survey. Regardless, CMS is seeking comments on whether or not the codes should be re-reviewed, based on the nominator's comments.

MRI-Monitored Transurethral Ultrasound Ablation of Prostate (CPT® codes 5X006, 5X007, and 5X008)

At the April 2023 CPT Editorial Panel meeting, three new CPT® codes were approved for MRI-monitored transurethral ultrasound ablation (TULSA). These codes were surveyed for the September 2023 RUC meeting and recommendations submitted to CMS for inclusion in the CY 2025 PFS proposed rule.

For CY 2025, CMS is proposing the RUC-recommended work RVUs for all three codes (4.05 for CPT® code 5X006, 9.80 for CPT® code 5X007, and 11.50 for CPT® code 5X008). CMS did indicate there may be concerns regarding the experience of the survey respondents and the intra-services time. CMS welcomes commenters to provide additional data to be considered in the valuation of the work and direct PE for these codes. In addition, CMS is proposing the RUC-recommended direct PE inputs.

Percutaneous Radiofrequency Ablation of Thyroid (CPT® codes 6XX01 and 6XX02)

In January 2024, the RUC surveyed CPT® codes 6XX01 (*Ablation of 1 or more thyroid nodule(s), one lobe or the isthmus, percutaneous, including imaging guidance, radiofrequency*) and its respective add-on CPT® code 6XX02 (*Ablation of 1 or more thyroid nodule(s), additional lobe, percutaneous, with imaging guidance, radiofrequency (List separately in addition to code for primary service)*. These codes were surveyed recommendations submitted to CMS for inclusion in the CY 2025 PFS proposed rule.

For CY 2025, CMS is proposing the RUC-recommended work RVUs for both (5.75 for CPT® code 6XX01, and 4.25 for CPT® code 6XX02). In addition, CMS is proposing the RUC-recommended direct PE inputs.

Ultrasound Elastography (CPT® codes 76981, 76982, and 76983)

This code family was flagged for re-review at the April 2023 RUC meeting by the new technology/new services screen. Due to increased utilization of CPT® code 76981 *(Ultrasound, elastography; parenchyma (eg, organ))*, the entire code family was resurveyed for the September 2023 RUC meeting.

For CY 2025, CMS is proposing the RUC-recommended direct PE inputs without refinement for CPT® codes 76981, 76982, and 76983.

CT Guidance Needle Placement (CPT® code 77012)

CPT® code 77012 (*Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation*) was reviewed at the September 2023 RUC meeting to account for deferred updates to the vignette to reflect the typical patient until updated utilization data was available to reflect coding changes that occurred in 2019.

For CY 2025, CMS is proposing the RUC-recommended work RVUs of 1.50 for CPT® code 77012. CMS is proposing changes to the RUC-recommended direct PE inputs.

CMS is proposing to change the equipment room time for the CT room (EL007) to maintain the current 9 minutes of other (38 others) similar radiological supervision and interpretation (RS&I) codes. This refinement was made in the CY 2019 final rule. CMS believes it would not be appropriate to increase the room time for CPT® 77012 and not address the other codes' equipment room time. This is the only refinement to the direct PE CMS is making, as they are proposing the remaining PE inputs without refinement for CPT® 77012.

Telemedicine Evaluation and Management (E/M) Services (CPT codes 9X075, 9X076, 9X077, 9X078, 9X079, 9X080, 9X081, 9X082, 9X083, 9X084, 9X085, 9X086, 9X087, 9X088, 9X089, 9X090, and 9X091)

In February 2023, the CPT Editorial Panel added a new Evaluation and Management (E/M) subsection to the draft CPT codebook for Telemedicine Services. The Panel added 17 codes for reporting telemedicine E/M services. Changes were made to the code descriptors and a new survey in September 2023 included code descriptors and times approved by the CPT® Editorial Panel in May 2023. SIR was one of the new specialties which participated in the second survey of members.

The new codes include four new patient synchronous audio-video (9X075-9X078) and four audio-only visits (9X083-9X086) and four established patient synchronous audio-video (9X079-9X082) and four audio-only (9X087-9X090) visits, a total of 16 new codes. The last code is CPT® 9X091 which is a brief communication technology based, virtual check-in, code.

With the addition of these new telehealth codes, the AMA CPT® Editorial Panel has deleted the current audio-only CPT® codes 99441-99443. CMS does have them listed on the telehealth list as "provisional" through December 31, 2024. The information from the RUC to CMS indicates the new codes, 9X075-9X090 describe services that would otherwise be provided in person, which means they are subject to consideration and valuation by CMS. Additionally, the prefatory language in the CY 2025 CPT® manual indicates if a telehealth visit and in-person visit are performed on the same date of service, the elements of the two services are summed rather than reported separately. This ensures any overlapping time is only counted once. CMS believes this further supports the work associated with the telehealth codes is the same as in-person visits.

The RUC-recommended values for the audio-video visits are identical to the current in-person visits values. The audio-only visits typically have less work RVUs than in-person visits. The RUC stated this is due to the surveyed specialty societies, which reiterated throughout Panel discussions, "the audio-video and in-person office visits require more physician work than the audio-only office visits." CMS provided Table 10 to reflect the similarities of the 16 new telehealth codes per the current in-person E/M codes provided below.

TABLE 10: Comparison of Elements and Work RVU between Telemedicine E/M Codes (9X075 through 9X090) and Office/Outpatient E/M Codes (99202 through 99215)

	A	B	C	D	E	F	G	H
	Telemedicine E/M HCPCS	RUC-recommended Work RVU	Modality	Level of Medical Decision-Making	Time Threshold (minutes)	New or Established Patient?	Analogous Current Office/Outpatient E/M Code	Current Work RVU
1	9X075	0.93	Audio/Video (A/V)	Straightforward	15	New	99202	0.93
2	9X076	1.60	(A/V)	Low	30	New	99203	1.60
3	9X077	2.60	(A/V)	Moderate	45	New	99204	2.60
4	9X078	3.50	(A/V)	High	60	New	99205	3.50
5	9X079	0.70	(A/V)	Straightforward	10	Established	99212	0.70
6	9X080	1.30	(A/V)	Low	20	Established	99213	1.30

	Telemedicine E/M HCPCS	RUC-recommended Work RVU	Modality	Level of Medical Decision-Making	Time Threshold (minutes)	New or Established Patient?	Analogous Current Office/Outpatient E/M Code	Current Work RVU
7	9X081	1.92	(A/V)	Moderate	30	Established	99214	1.92
8	9X082	2.60	(A/V)	High	40	Established	99215	2.60
9	9X083	**0.90**	Audio-only	Straightforward	15	New	99202	0.93
10	9X084	1.60	Audio-only	Low	30	New	99203	1.60
11	9X085	**2.42**	Audio-only	Moderate	45	New	99204	2.60
12	9X086	**3.20**	Audio-only	High	60	New	99205	3.50
13	9X087	**0.65**	Audio-only	Straightforward	10	Established	99212	0.70
14	9X088	**1.20**	Audio-only	Low	20	Established	99213	1.30
15	9X089	**1.75**	Audio-only	Moderate	30	Established	99214	1.92
16	9X090	**2.60**	Audio-only	High	40	Established	99215	2.80

CMS reiterated there are already services listed on the Medicare telehealth services list identifying which can be provided by audio-video and audio-only methodology. If they were to incorporate the AMA codes, CMS would have to value RVUs to each telemedicine service. Essentially two values, one for telehealth and one for in-person, would be required.

For CY 2025, CMS is proposing to assign CPT® codes 9X075-9X090 a Procedure Status indicator of "I", which means there is a more specific code (i.e., existing office/outpatient E/M codes) to be used for Medicare. Providers would utilize modifiers and place of service (POS) codes, as defined by Medicare, to identify the correct location of the patient, if applicable, for payments.

The CCA 2023 extended the geographic location of Medicare beneficiaries to be located essentially anywhere and receive telehealth services through December 31, 2024. According to Medicare, effective January 1, 2025, the geographic location and site of service restrictions on Medicare telehealth services will once again take effect. Even though there are new telehealth codes from the AMA, this does not require CMS to recognize and reimburse the codes for telehealth services.

There will be a few exceptions. Behavioral health services and ESRD-related clinical assessments are excluded from reverting back to the pre-pandemic telehealth policy. Telehealth services for any Medicare beneficiaries/patients will only be available in rural areas, and only when the patient is located in certain types of medical settings

CMS is seeking comments from stakeholders on the impact of not recognizing the new telehealth codes and how the expiring telehealth flexibilities may impact access to services.

Separately, the new brief communication, virtual check-in code 9X091, which was not surveyed by SIR members, is proposed to be implemented by CMS. Due to this, CMS is proposing to delete G2012 and accept the RUC-recommended values work RVU of 0.30 and direct PE inputs for 9X091.

A table of the proposed RVUs for each new telehealth CPT® code effective January 1, 2025, from the AMA is included below.

CY 2024 Proposed New Telehealth Visit Codes					
HCPCS	DESCRIPTION	WORK RVU	NON-FAC PE RVU	FACILITY PE RVU	MP
9X075	Synch audio-video new sf 15	0.93	0.56	0.37	0.05
9X076	Synch audio-video new low 30	1.60	0.84	0.63	0.10
9X077	Synch audio-video new mod 45	2.60	1.29	1.02	0.16
9X078	Synch audio-video new hi 60	3.50	1.68	1.38	0.21
9X079	Synch audio-video est sf 10	0.70	0.46	0.28	0.04
9X080	Synch audio-video est low 20	1.30	0.71	0.51	0.07
9X081	Synch audio-video est mod 30	1.92	1.03	0.76	0.13
9X082	Synch audio-video est hi 40	2.60	1.31	1.02	0.16
9X083	Synch audio-only new sf 15	0.90	0.52	0.35	0.04
9X084	Synch audio-only new low 30	1.55	0.79	0.61	0.08
9X085	Synch audio-only new mod 45	2.42	1.19	0.95	0.16
9X086	Synch audio-only new high 60	3.20	1.53	1.26	0.18
9X087	Synch audio-only est sf 10	0.65	0.41	0.26	0.04
9X088	Synch audio-only est low 20	1.20	0.64	0.47	0.06
9X089	Synch audio-only est mod 30	1.75	0.91	0.69	0.12
9X090	Synch audio-only est high 40	2.60	1.28	1.02	0.16
9X091	Brief comunicaj tech-bsd svc	0.30	0.17	0.13	0.02

Due to the work of SIR staff and volunteers in the SIR CPT® Editorial and RUC workgroup who undertake in both suggesting new CPT® codes and helping to value approved codes in the AMA CPT® and RUC processes for CY 2025, CMS accepted the RUC-recommended values for 5 new and 4 existing codes of procedures applicable to the interventional radiology specialty.

Changes to Evaluation and Management (E/M) Services

E/M visits comprise approximately 40 percent of all allowed charges under MPFS. Of these, the office/outpatient (O/O) E/M visits comprise approximately half (or 20 percent of all allowed charges). Policies for reevaluation of E/M visits have a significant impact on resource valuation under MPFS, which could potentially impact patient care as a whole.

In the MPFS proposed rule for CY 2025, CMS is addressing two outstanding issues in E/M visit payment: implementing separate payment for the O/O E/M visit complexity add-on payment.

Office/Outpatient E/M Visit Complexity Add-On G2011

From CY 2018 on, CMS and the AMA have worked to reform the E/M documentation guidelines; establish HCPCS add-on codes for additional payments based on visit complexity related to primary care; revise the O/O E/M codes to reflect the option of selecting time or Medical Decision Making (MDM) level for visit level selection; and revise the visit descriptor times, which resulted in increased valuation of the codes. CMS did not believe these increased valuations accounted for the resources involved in providing certain kinds of care included in the O/O E/M visit code set, specifically visit complexity associated with primary care and non-procedural specialty care. Therefore, in the CY 2021 final rule and instituted in CY 2024, CMS created code G2211 *(Visit complexity inherent to evaluation and management associated with medical care services that*

serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)). CMS refers to this code as the "O/O E/M visit complexity add-on". Code G2211 could be reported with all O/O E/M visits, rather than just the higher-level visits, but it is not to be reported with E/M visits billed with a payment modifier, such as modifier 25.

CMS indicated they have begun to monitor utilization of this code but continue to receive requests for clarification and adjustment to the limitations of this service when performed on same date as preventive immunizations. Due to the feedback from stakeholders, CMS is refining the current policy and proposing to allow payment of G2011 when the O/O E/M base code is reported by the same practitioner on the same day as an AWV, vaccine administration, or any Medicare Part B preventive service furnished in the office or outpatient setting.

After code G2211 was established, the Consolidated Appropriations Act, 2021 (CAA 2021) put a moratorium on Medicare payment for this service by disallowing CMS from reimbursing code G2211 under the MPFS before January 1, 2024. Currently, this add-on code can be reported, but is assigned a bundled status indicator "B" *(Payment for covered services are always bundled into payment for other services not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident)*.

Strategies for Improving Global Surgery Payment Accuracy

CMS indicated there are currently 4,100 physician services coded and valued under MPFS as global surgical packages. For reference global packages include the following:

- The surgical procedure itself, including day-of pre-service activities and day-of recovery care;
- Post-operative evaluation and management (E/M) visits and discharge services provided during specified post-operative periods (10- or 90-day periods for most minor and major procedures, respectively; 0-day global packages do not include post-operative visits);
- Pre-operative visits on the day of the procedure (for services with 10- and 90-day periods) and pre-operative visits on the day prior to the procedure (for major procedures with 90-day periods only);
- Services provided during the post-operative period (for services with 10- and 90-day periods) related to the procedure (for example, treatment of complications, pain management).

In the event the patient might need to return to the OR, this is paid separately, and a new global period begins. The concerns expressed over the last few years are not related to this, but to the fact there are many scenarios in which the physician who performed the surgical procedure is not the one to manage them in the follow-up global period. There may be multiple reasons for this, but often the patient is referred to their primary care physician for ongoing support and follow-up care.

This creates issues for CMS in the follow-up visits for those surgical procedures assigned a 90-day global period which include the E/M visits for following up with the patient and managing their outcome. The surgeon is being paid for a surgical procedure and E/M visits they never perform. Separately, the physician who is now managing the patient is being paid for these services, but also must spend considerable time getting up to speed on the pre and post-surgical variances in the patient and how to best manage them.

CMS is proposing to address their ongoing concerns with two different proposals.

1. Revise our transfer of care policy for global packages to address instances where one practitioner furnishes the surgical procedure and another practitioner furnishes related post-operative E/M visits during the

global period, and

2. Develop a new add-on code that would account for resources involved in postoperative care provided by a practitioner who did not furnish the surgical procedure.

Proposal Regarding Transfer of Care

For 2025, CMS is proposing to broaden the applicability of transfer of care modifiers -54, -55, and -56. These modifiers are proposed to be used for all 90-day global surgical packages "in any case when a practitioner plans to furnish only a portion of a global package (including but not limited to when there is a formal, documented transfer of care as under current policy, or an informal, non-documented but expected, transfer of care)." Although this broadening of transfer of care modifiers is only proposed for 90-day global surgical procedures, CMS is seeking comments whether transfer of care modifiers should also be broadened for 10-day global surgical procedures.

Proposal Regarding Add-on Code

For 2025, CMS is proposing to a new add-on HCPCS code GPOC1 (*Post-operative follow-up visit complexity inherent to evaluation and management services addressing surgical procedure(s), provided by a physician or qualified health care professional who is not the practitioner who performed the procedure (or in the same group practice), and is of a different specialty than the practitioner who performed the procedure, within the 090-day* global period *of the procedure(s), once per 090-day global period, when there has not been a formal transfer of care and requires the following required elements, when possible and applicable:*

- *Reading available surgical note to understand the relative success of the procedure, the anatomy that was affected, and potential complications that could have arisen due to the unique circumstances of the patient's operation.*
- *Research the procedure to determine expected post-operative course and potential complications (in the case of doing a post-op for a procedure outside the specialty).*
- *Evaluate and physically examine the patient to determine whether the post-operative course is progressing appropriately.*
- *Communicate with the practitioner who performed the procedure if any questions or concerns arise. (List separately in addition to office/outpatient evaluation and management visit, new or established)*).

HCPCS GPOC1 would be used by the physician who did not perform the surgical procedure but must now spend extra time and resources to provide the necessary follow-up post-operative care and was not part of the formal transfer agreement. It would also only be reported with an office or other outpatient E/M visit for the evaluation and management of a new or established patient. GPOC1 would only be billable once by the provider, as it would only be the initial visit they would need to spend the extra time and resources getting up to speed on things; therefore, it would be assigned a ZZZ global surgical period payment indicator.

CMS proposed documentation would need to include the following within the medical record, "the relevant surgical procedure, to the extent the billing practitioner can readily identify it, in order to aid in our understanding of the post-operative care being furnished and when there is no transfer of care modifier appended on the claim."

Lastly, CMS did indicate if the CPT® Editorial Panel were to create a new CPT® code to describe this additional work and resources, they would consider using it in place of the newly proposed HCPCS code in future ratesetting.

Physician Supervision via Two-way Audio/Video

Direct supervision requires the immediate availability of the physician in the office suite, but they are not required to be present in the same room. In previous rule making, CMS has established "immediate availability" to mean in-person, physical, not virtual, availability. During the PHE for COVID-19, CMS adjusted the definition for direct supervision, as it pertains to supervision of diagnostic tests, physicians' services, and some hospital outpatient services, to allow the supervising professional to be immediately available through virtual presence using two-way, real-time audio/video technology, instead of their physical presence. The option to use real-time audio/video capabilities was expected to expire December 31, 2024.

For CY 2025, CMS is proposing an incremental approach to changes. They are proposing to temporarily extend and define direct supervision and "immediate availability" of the supervising practitioner through real-time audio and visual interactive telecommunications (excluding audio-only) through December 31, 2025.

CMS is proposing to permanently extend the ability to provide direct supervision using audio/video capabilities for a subset of services they indicate are performed entirely by auxiliary personnel. The subset of indicated services have been assigned the PC/TC indicator of "5" within the CMS RVU file and CPT® 99211 *(Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional)* which does not require physician presence or participation for staff to provide the service.

In CY 2024, the list of services currently assigned PC/TC "5" are predominantly therapeutic and chemotherapy injections and infusions.

Residents in Teaching Settings

In previous rule making, CMS established a policy that allows teaching physicians to fulfil supervision requirements to be present for the key or critical portions of services through audio/video real-time communications technology, when services are provided by a resident. This policy was only valid for services furnished in residency training sites that are located outside of an Office of Management and Budget (OMB) – defined metropolitan statistical area (MSA). This distinction was made to increase beneficiary access to Medicare-covered services in rural areas.

For CY 2025, CMS is proposing to continue to allow the teaching physician to have a virtual presence in all teaching settings, but only in clinical instances when the service is furnished virtually (3-way telehealth visit, with all parties in separate locations). The proposal would permit teaching physicians to have a virtual presence during the key portion of the Medicare telehealth service through real-time audio/video communication for all residency training locations extended through December 31, 2025.

CMS is also seeking comment and information regarding the allowance for teaching physicians to bill for certain lower and mid-level complexity physician services when furnished by the resident, even when the teaching physician is not present with the resident. All of the criteria must be met, including the resident must have more than 6 months of training in the approved residency program, the teaching physician is directing the care of no more than four residents at the same time, remain immediately available, and have no other responsibilities while directing the care. Additionally, the teaching physician assumes management responsibility for beneficiaries seen by the residents, ensuring the services furnished are appropriate, and reviews certain elements of the services with each resident during or immediately after each visit.

CMS is seeking comments on whether certain preventative services or higher-level E/M visits could be added without hindering the teaching physician. Specifically, if the addition of the services would impact the teaching physician's ability to remain immediately available for up to four residents at any given time while managing and directing the care furnished would create difficulty.

Medicare Economic Index (MEI)

CMS is continuing the conversation regarding the need for ongoing updates and utilization of data used to set values and payment rates for CPT®/HCPCS codes. Stakeholders have pushed back and claimed CMS has been using data which is not current or due to other factors has not been updated when setting rates. This leads to comments arguing proposed values are inaccurate or invalid because the data used is so old. While at the same time other arguments claim the proposed changes will dramatically impact societies because the change needed based on new data is so drastic. This is creating significant issues for CMS and stakeholders.

The Medicare Economic Index (MEI) relates to the reasonable charge-based payment methodology in place for physicians' services prior to MPFS. For services after June 30, 1973, the charge levels could not exceed the level from the previous year except when the Secretary determines, based on appropriate economic index data, a higher level is justified by year-to-year economic changes. CMS began calculating the MEI on July 1, 1975, and continues to do so today for several statutory and other purposes. The MEI reflects the weighted-average annual price change for various inputs involved in furnishing physicians' services.

The MEI is a fixed-weight input price index comprised of two broad categories: (1) physicians' own time (compensation); and (2) physicians' practice expense (PE). The current 2006-based MEI is based on data collected by the AMA for self-employed physicians from the Physician Practice Information Survey (PPIS). The AMA had not conducted another survey since the 2006 data collection effort; however, the survey is underway and expected to be completed by end of CY 2024. Due to this, CMS is not proposing to incorporate the 2017-based MEI in ratesetting for CY 2025. They are seeking comments and any information on the timing of the AMA's practice cost data collection efforts and other sources of data they should consider for updating the MEI.

Submitting Comments

Comments to CMS regarding the MPFS proposed rule **CMS-1807-P** will be submitted by SIR to CMS and are due no later than **5 pm EST September 9, 2024**.