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2025 Medicare Physician Fee Schedule Proposed Rule Summary

On Wednesday, July 10, 2024, the Centers for Medicare & Medicaid Services (CMS) issued the 2025 Medicare Physician Fee Schedule (MPFS) proposed rule with no additional direct payment cuts to radiation therapy physician services, but existing policies will continue to depress payments. The proposed rule updates the payment policies, payment rates, and quality provisions for services furnished under the MPFS effective January 1, 2025.[1]

Takeaways for Radiation Oncology

- **MPFS Proposed Rule Estimated Impact on Radiation Oncology: 0%**
- **2025 Proposed Conversion Factor: $32.3562 (a reduction of almost 3% from 2024)**

Why it matters: In aggregate, CMS estimates flat payments for radiation oncology in 2025, but the clinical labor cuts and 2.8% proposed conversion factor reduction will cause many key codes to drop. ASTRO remains very concerned by the 23% decline in radiation oncology payments since 2011 and significant payment threats in future years, and we urge Congress to pass the bipartisan Radiation Oncology Case Rate (ROCR) Act to secure long-term stable payments and enhanced quality.

Comments in response to the proposed rule are due to CMS by September 9, 2024.

Go deeper on these issues in the summary below:

- *MPFS Conversion Factor*
- *CY 2025 Clinical Labor Pricing Update Proposals*
- *Development of Strategies for Updates to Practice Expense (PE) Data Collection and Methodology*
- *Payment for Medicare Telehealth Services under § 1834(m) of the Act*
- *Direct Supervision via Use of Two-way Audio/Video Communications Technology*
- *Office/Outpatient (O/O) Evaluation and Management (E/M) Visit Complexity Add-on*
- *Proposals on Medicare Parts A and B Payment for Dental Services Inextricably Linked to Specific Covered Services*
- *Payment of Radiopharmaceuticals in the Physician Office*
- *Request for Information for Services Addressing Health-Related Social Needs*
- *Health Integration (G0019, G0022), Principal Illness Navigation (G0023, G0024), Principal Illness Navigation-Peer Support (G0140, G0146), and Social Determinants of Health Risk Assessment (G0136))*
- *Quality Payment Program*

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[1] The MPFS pays for services furnished by physicians and other practitioners in all sites of service. These services include visits, surgical procedures, diagnostic tests, therapy services, specified preventative services and more. Payments are based on the relative resources typically used to furnish the service. Relative value units (RVUs) are applied to each service for physician work, practice expense and malpractice. These RVUs become payment rates through the application of a Conversion Factor, which is updated annually.

MPFS Conversion Factor

According to the MPFS Total Allowed Charges Impact Table, the estimated impact on total allowed charges for radiation oncology services for 2025 is 0%. Despite a neutral direct impact on radiation oncology services, many services will see reduced rates due to a decline in the Conversion Factor and implementation of the final year of clinical labor pricing updates.

Table 128: CY 2025 PFS Estimated Impact on Total Allowed Charges by Specialty

Specialty	Allowed Charges (mil)	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of MP RVU Changes	Combined Impact
Radiation Oncology and Radiation Therapy Centers	$1,458	0%	0%	0%	0%

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

Specialty	Total/Nonfacility/Facility	Allowed Charges (mil)	Combined Impact
Radiation Oncology and Radiation Therapy Centers	Total	$1,458	0%
	Nonfacility	$1,002	-1%
	Facility	$457	2%

The 2025 MPFS Conversion Factor (CF), based on the proposed 2025 rates, is set at $32.3562. This represents a decrease of $0.93, or 2.80%, from the 2023 MPFS CF rate update of $33.2875. This 2.80% decline stems from a statutorily mandated budget neutrality adjustment (0.05%), the 0% update adjustment factor specified under § 1848(d)(19) of the Act, and the removal of the temporary 2.93% payment increase for services furnished from March 9, 2024-December 31, 2024.

Table 126: Calculation of the CY 2025 PFS Conversion Factor

CY 2024 Conversion Factor		$33.2875
Conversion Factor without CAA, 2023 (2.93% increase for CY 2024)		$32.3400
CY 2025 RVU Budget Neutrality Adjustment	0.00% (1.0000)	
CY 2025 1.25% increase provided by the CAA, 2023	0.05% (1.0005)	
CY 2025 Conversion Factor		**$32.3562**

The table below reflects the impact of the proposed Conversion Factor on key radiation oncology services.

CPT Code	MOD/SOS	CPT Descriptor	2024 National Rate	2025 National Rate	2025 Impact
G6015		Radiation tx Delivery IMRT	$355.54	$338.49	**-5%**

77427		Radiation tx Management x5	$189.75	$188.34	**-1%**
77014		CT Scan for Therapy Guide	$119.51	$116.17	**-3%**
77301		Radiotherapy Dose Plan IMRT	$1,842.93	$1,801.48	**-2%**
G6012		Radiation Treatment Delivery	$229.37	$216.81	**-5%**
77523		Proton Treatment Delivery	Carrier Priced	Carrier Priced	**N/A**
77014	26	CT Scan for Therapy Guide	$44.28	$44.01	**-1%**
77263		Radiation Therapy Planning	$166.78	$165.04	**-1%**
77301	26	Radiotherapy Dose Plan IMRT	$415.79	$411.62	**-1%**
77373		SBRT Delivery	$993.71	$951.38	**-4%**
G6013		Radiation Treatment Delivery	$230.37	$217.78	**-5%**
77334	26	Radiation Treatment Aid(s)	$59.92	$58.90	**-2%**
99205		Office o/p new hi 60-74 minutes	$220.38	$216.16	**-2%**
77336		Radiation Physics Consult	$88.88	$88.99	0%
77338		Design Mlc Device for IMRT	$468.06	$462.75	**-1%**
77338	26	Design Mlc Device for IMRT	$223.38	$220.70	**-1%**
77435		SBRT Management	$637.84	$629.40	**-1%**
77300	26	Radiation Therapy Dose Plan	$32.29	$32.04	**-1%**
77300		Radiation Therapy Dose Plan	$65.91	$65.04	**-1%**

CY 2025 Clinical Labor Pricing Update Proposals

CMS did not receive new wage data or other additional information for use in clinical labor pricing from interested parties prior to the publication of the CY 2025 PFS proposed rule. Therefore, the proposed clinical labor pricing for CY 2025 in Table 5 (below) is based on the clinical labor pricing CMS finalized in the CY 2024 PFS final rule.

Table 5: Proposed CY 2025 Clinical Labor Pricing Relevant to Radiation Oncology

Labor Code	Labor Description	Source	CY 2021 Rate Per Minute	Final Y4 Rate Per Minute	Total % Change
L050C	Radiation Therapist	BLS 29-1124	0.50	0.89	78%
L050D	Second Radiation Therapist for IMRT	BLS 29-1124	0.50	0.89	78%
L063A	Medical Dosimetrist	BLS 19-1040	0.63	0.91	44%
L107A	Medical Dosimetrist/Medical Physicist	L063A, L152A	1.08	1.52	41%
L152A	Medical Physicist	AAPM Wage Data	1.52	2.14	41%

The clinical labor rates will remain open for public comment during the 60-day comment period for this proposed rule. CMS expects to set the updated clinical labor rates for CY 2025 in the final rule.

Development of Strategies for Updates to Practice Expense (PE) Data Collection and Methodology

Currently, CMS relies on the AMA's Physician Practice Information Survey (PPIS) data for its PE methodology (in addition to legislatively mandated supplemental data sources, and crosswalks in some cases to allocate indirect PE as necessary for certain specialties and provider types), but it acknowledges the limitations and challenges interested parties have raised about using the current data for indirect PE allocations. In the CY 2023 and 2024 MPFS rules, the Agency issued an RFI to solicit public comment on strategies to update PE data collection and methodology, and it has continued interest in "developing a roadmap for updates to [its] PE methodology that account for changes in the health care landscape… [A]llocations of indirect PE continue to present a wide range of challenges and opportunities."

In response to last year's RFI, most commenters stated that CMS should defer significant changes until the AMA PPIS results become available. CMS thinks the AMA's approach may possibly mitigate nonresponse bias, which created challenges using previous PPIS data. However, it remains uncertain about whether endorsements prior to fielding the survey injected other types of bias in the validity and reliability of the information collected. CMS states in the proposed rule that it will continue to consider alternatives to improve the stability and accuracy of its overall PE methodology.

CMS has started new work under contract with the RAND Corporation to analyze and develop alternative methods for measuring PE and related inputs for implementation of updates to payment under the PFS. It continues to study possible alternatives, including analysis of updated PPIS data, as part of its ongoing work. In the meantime, the Agency requests general information from the public on ways that CMS may continue work to improve the stability and predictability of any future updates.

Specifically, CMS requests feedback from interested parties regarding scheduled, recurring updates to PE inputs for supply and equipment costs. It is proposing establishing a cycle of timing to update supply and equipment cost inputs every 4 years, which may be one means of advancing shared goals of stability and predictability. CMS would collect available data, including, but not limited to, submissions and independent third-party data sources, and propose a phase-in period over the following 4 years. The phase-in approach maps to its experience with previous updates. Additionally, CMS believes that more frequent updates may have the unintended consequence of disproportionate effects of various supplies and equipment that have newly updated costs.

The Agency also seeks feedback on possible mechanisms to establish a balance whereby its methodology would account for inflation and deflation in supply and equipment costs. It wants information about specific mechanisms that may be appropriate, and in particular, approaches that would leverage verifiable and independent, third-party data that is not managed or controlled by active market participants.

Payment for Medicare Telehealth Services under § 1834(m) of the Act

CPT code 77427, *Radiation tx management x5*, was added to the Telehealth List on a temporary basis during the COVID-19 Public Health Emergency (PHE) and through various regulatory actions, was continued through the end of 2024.

ASTRO initially supported the addition of 77427 to the telehealth list during the onset of the PHE, but as radiation oncology clinics quickly adjusted to providing care, ASTRO asked CMS to remove the code from the list given the critical nature of the in-person comprehensive physical examination. In the CY 2021 final rule, CMS agreed with ASTRO, but for unknown reasons never removed 77427 from the List.

In February 2024, ASTRO requested again that the code be removed from the Telehealth List, and more recently, the ASTRO Board approved recommendations from ASTRO's Supervision Workgroup that the OTV component of radiation treatment management should always be conducted in-person by the radiation oncologist.

CMS also received a separate request from a stakeholder to permanently add 77427 to the Medicare Telehealth List, stating that the telehealth option is as safe as the in-person equivalent. However, given the safety concerns raised in ASTRO's advocacy, CMS said it believes this service may not be safely and effectively furnished via telehealth. Therefore, the Agency proposes to remove 77427 from the Medicare Telehealth Services List and is seeking comment on quality of care concerns.

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

Proposal to Extend Definition of "Direct Supervision" to Include Audio-Video Communications Technology through 2025

In the absence of evidence that patient safety is compromised by virtual direct supervision, CMS remains concerned that an abrupt transition to the pre-PHE policy that defines direct supervision to require the physical presence of the supervising practitioner would present a barrier to access to many services, such as incident-to services. According to the rule, the Agency believes that physicians and/or other supervising practitioners, in certain instances, need time to reorganize practice patterns established during the PHE to reimplement the pre-PHE approach to direct supervision without the use of audio/video technology.

CMS acknowledges the utilization of this flexibility and recognizes that many practitioners want to maintain it; however, the Agency seeks additional information regarding potential patient safety and quality of care concerns. It believes an incremental approach is warranted, particularly in instances where unexpected or adverse events may arise for procedures which may be riskier or more intense.

In light of these potential safety and quality of care implications, and exercising an abundance of caution, CMS is extending this flexibility for all services on a temporary basis only. It is therefore proposing 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 through December 31, 2025.

Go Deeper
Direct supervision requires the immediate availability of the supervising physician or other practitioner, but the professional need not be present in the same room during the service. The Agency has established this "immediate availability" requirement to mean in-person, physical, not virtual, availability. It does not mean that the physician (or other supervising practitioner) must be present in the room when the service is performed. However, during the COVID-19 public health emergency (PHE), CMS changed the definition of "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 requiring their physical presence. Via various rules, this policy was extended through the end of 2024, after which the pre-PHE supervision rules would apply.

ASTRO's Supervision Work Group, which included volunteers from academic and private practices, rural and urban settings, and with diverse practice patterns and perspectives, was created to inform ASTRO's position in response to changes to CMS's supervision policies. On June 28, the Board approved the following supervision recommendations from the workgroup, which acknowledge the need for:

a. **Direct supervision or more personal involvement** by a radiation oncologist for selected therapeutic services, including simulations, stereotactic radiosurgery (SRS), and stereotactic body radiation therapy (SBRT).
b. **Physical presence** of the radiation oncologist at procedures using radioactive materials, including brachytherapy and Gamma Knife stereotactic therapy, as required by the Nuclear Regulatory Commission.
c. **Personal performance** of radiation treatment management professional services by a radiation oncologist.

However, the work group unanimously recommended that **general supervision** be the standard for other radiation therapy procedures, including routine linear accelerator treatments and all forms of image guided radiation therapy (IGRT). In the instance where the level of supervision and/or physical presence required for the procedure cannot be met, the respective code should not be billed.

Proposal to Permanently Define "Direct Supervision" to Include Audio-Video Communications Technology for a Subset of Services
CMS is proposing to adopt a definition of direct supervision that allows "immediate availability" of the supervising practitioner using audio/video real-time communications technology (excluding audio-only), but only for the following subset of incident-to services described under § 410.26:

(1) Services furnished incident to a physician or other practitioner's service when provided by auxiliary personnel employed by the billing practitioner and working under their direct supervision, and for which the underlying HCPCS code has been assigned a PC/TC indicator of '5'; and
(2) Services described by CPT code 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*).

For all other services required to be furnished under the direct supervision of the supervising physician or other practitioner, CMS is proposing, as described above, to continue to define "immediate availability" to include real-time audio and visual interactive telecommunications technology only through December 31, 2025.

Office/Outpatient (O/O) Evaluation and Management (E/M) Visit Complexity Add-on

In the CY 2024 PFS final rule, CMS finalized separate payment for the O/O E/M visit complexity add-on code, HCPCS 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))*. It is the relationship between the patient and the practitioner that is the determining factor for when the add-on code should be billed; it is not payable when the E/M visit is reported with CPT Modifier -25, which denotes a significant, separately identifiable O/O E/M visit by the same physician or other qualified health care professional on the same day as a procedure or other service.

CMS has heard from some practitioners that nonpayment of G2211 when the base code is reported on the same day as a preventive service is disruptive to the way in which care is usually furnished and to CMS's policy objectives for the add-on payment. CMS agrees that this is not well-aligned with policy objectives and is proposing to allow payment for G2211 when the base codes is reported the same day as an annual wellness visit, vaccine administration, or any Medicare Part B preventive service furnished in the office or outpatient setting.

Proposals on Medicare Parts A and B Payment for Dental Services Inextricably Linked to Specific Covered Services

In the CY 2023 PFS final rule, CMS clarified and codified at § 411.15(i)(3) that Medicare payment under Parts A and B could be made when dental services are furnished in either the inpatient or outpatient setting *when the dental services are inextricably linked to, and substantially related and integral to the clinical success of, other covered services*. A process to accept and consider submissions from the public to assist in identifying these dental services was created in the CY 2024 MPFS final rule; however, Medicare administrative contractors (MACs) retain discretion to determine on a claim-by-claim basis whether a patient's circumstances do or do not fit within the terms of the preclusion or exceptions.

For the latest public comment cycle, CMS received one submission that asserted that patients frequently present with complications extending three years or more following the direct treatment of not only head and neck cancers, but also other cancer types, as well as for patients experiencing complications following anti-resorptive drug therapy for non-cancer-related conditions. It was recommended that payment be available for specific dental services during a minimum of two years post-treatment for head and neck cancer and up to 5 years for those who have received radiotherapy.

Although the submitter presented evidence in support of the request, CMS declined to include specific time limits within the dental services exception. It emphasized that MACs have the flexibility to determine on a claim-by-claim basis whether payment can be made for certain dental services for beneficiaries. The regulation states the general rule that Medicare Parts A and B payment can be made for certain dental services that are inextricably linked to, and substantially related and integral to the clinical success of, covered services. It then provides a non-exclusive list of examples of clinical scenarios under which payment can be made. Thus, a MAC has discretion to decide on a case-by-case basis that payment can be made for certain dental services in other circumstances not specifically addressed under the regulation.

Implementation of Payment for Dental Services Inextricably Linked to Other Specific Covered Services

CMS is proposing that the KX modifier would be required for claims submission for dental services inextricably linked to covered medical services on both the dental claim format 837D and the professional claim format 837P. It is proposing that practitioners who bill for dental services for which they seek payment in accordance with § 411.15(i)(3) must include the KX modifier on the 837D or 837P claim 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 demonstrates the inextricable linkage to covered medical services; and that coordination of care between the medical and dental practitioners has occurred.

Go Deeper
In the CY 2024 PFS final rule, CMS solicited comments on whether it should provide additional guidance that would aid in processing claims for dental services that are inextricably linked to a Medicare-covered medical service. Some commenters suggested the usage of a modifier on the dental claim format that would better identify when dental services are inextricably linked to specific covered medical services. Currently, the KX modifier is submitted on a Medicare Part B claim to indicate that the service or item is medically necessary, and that the healthcare provider has included appropriate documentation in the medical record to support or justify the medical necessity of the service or item.

CMS believes that usage of the KX modifier in the context of claims for dental services inextricably linked to covered services would be appropriate and support claims processing and program integrity efforts. The Agency believes that the use of the KX modifier would allow practitioners to signal that the dental services meet the criteria to support payment. Also, use of the KX modifier may improve the MACs' ability to ascertain the volume of claims that are being submitted for dental services inextricably linked to covered services.

Payment of Radiopharmaceuticals in the Physician Office
CMS is proposing to clarify that *any* methodology that was in place to set pricing of radiopharmaceuticals in the physician office setting prior to November 2003 can be used by *any* MAC, whether or not that specific MAC used the methodology prior to November 2003.

Go Deeper
In accordance with the law, radiopharmaceuticals are not required to be paid using payment methodology under section 1847A of the Act, as currently described in the Medicare Claims Processing Manual (MCPM) Chapter 17, § 20.1.3. The manual instructs MACs to determine payment limits for radiopharmaceuticals based on the methodology in place as of November 2003, before the passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, in the case of radiopharmaceuticals furnished in settings other than the hospital outpatient department.

Currently, payment can vary by MAC. For example, payment can be based on 95 percent of Average Wholesale Price (AWP), invoices, or other reasonable payment methods/data made available when the product is contractor priced. CMS has heard from MACs and other interested parties that there is confusion about which exact methodologies are available to MACs for pricing of radiopharmaceuticals in the physician office setting, as different MACs had different methodologies in place as of November 2003. MACs are uncertain whether they can use *any* of these payment policies that were in place, or only the policy that was in place for their jurisdiction as of November 2003.

Accordingly, while CMS evaluates its broader policies in this space for future rulemaking, it is proposing to clarify that *any* payment methodology that was being used by *any* MAC prior to the enactment of the

MMA can continue to be used by any MAC, including the use of invoice pricing. The proposal applies to radiopharmaceuticals furnished in a setting other than the hospital outpatient department.

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))

For CY 2025 CMS is issuing a broad request for information (RFI) on the newly implemented Community Health Integration (CHI) (HCPCS codes G0019, G0022), Principal Illness Navigation (PIN) (HCPCS codes G0023, G0024), Principal Illness Navigation- Peer Support (PIN-PS) (HCPCS codes G0140, G0146), and Social Determinants of Health Risk Assessment (SDOH RA) (HCPCS code G0136) services to engage interested parties on additional policy refinements for CMS to consider in future rulemaking.

The Agency is interested in better addressing the social needs of beneficiaries and is requesting information on the aforementioned codes to fully understand what interested parties and commenters believe should be included in the coding and payment. The Agency is seeking comment on any related services that may not be described by the current coding that was finalized in the CY 2024 PFS final rule and that are medically reasonable and necessary "for the diagnosis or treatment of illness or injury" under section 1862(a)(1)(A) of the Act. CMS interested in feedback regarding any barriers to furnishing the services addressing health-related social needs, and if the service described by the codes allow practitioners to better address unmet social needs that interfere with the practitioners' ability to diagnose and treat the patient. This could include barriers specific to certain populations, including rural and tribal communities, residents of the U.S. Territories, individuals with disabilities, individuals with limited English proficiency, or other populations who experience specific unmet social needs. The Agency is also requesting information if there are other types of auxiliary personnel, other certifications, and/or training requirements that are not adequately captured in current coding and payment for these services. Finally, the Agency is also seeking comment about how these codes are being furnished in conjunction with community-based organizations.

Quality Payment Program

Additional information regarding proposed changes to the Quality Payment Program will be included in a subsequent summary document.

For a copy of the proposed rule: https://public-inspection.federalregister.gov/2024-14828.pdf

For a fact sheet on the proposed rule: https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2025-medicare-physician-fee-schedule-proposed-rule