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2025 Medicare Physician Fee Schedule
Final Rule Summary

On Friday, November 1, 2024, the Centers for Medicare & Medicaid Services (CMS) issued the 2025 Medicare Physician Fee Schedule (MPFS) final rule with no additional direct payment cuts to radiation therapy physician services, but existing policies will continue to depress payments, underscoring the importance of the Radiation Oncology Case Rate (ROCR) Value Based Payment Program Act. The final 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 Final Rule Estimated Impact on Radiation Oncology: 0%**
- **2025 Final Conversion Factor: $32.3465 (a 2.8% reduction from the 2024 MPFS CF rate update of $33.2875)**
- **CPT Code 77427, *Radiation treatment management 5x,* will remain on the Medicare Telehealth List on a provisional basis.**

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.

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*
- *Implementation of Payment for Dental Services Inextricably Linked to Other Specific Covered Services*
- *New Codes for Biology-Guided Radiation Therapy (BgRT)*
- *Payment of Radiopharmaceuticals in the Physician Office*
- *Prostate Cancer Cost Measure*
- *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))*

[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 (CF), implementation of the final year of clinical labor pricing updates, and the expiration of the 2.93% increase to the CF for 2024 under the Consolidated Appropriations Act (CAA).

Table 110: 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	$1,538	0%	0%	0%	0%

Table 111: 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	$1,538	0%
	Nonfacility	$1,048	-1%
	Facility	$490	2%

The 2025 MPFS CF, based on the final rates, is set at $32.3465. This represents a decrease of $0.94, or 2.8%, from the 2024 MPFS CF rate update of $33.2875. This 2.8% decline stems from a statutorily mandated budget neutrality adjustment (0.02%), the 0% update adjustment factor specified under § 1848(d)(19) of the Social Security Act, and the removal of the temporary 2.93% payment increase for services furnished from March 9, 2024-December 31, 2024.

Table 108: Calculation of the CY 2025 PFS Conversion Factor

CY 2024 Conversion Factor (March 9-December 31, 2024)		$33.2875
Conversion Factor (original)		$32.3400
CY 2025 Statutory Update Factor	0.00% (1.0000)	
CY 2025 RVU Budget Neutrality Adjustment	0.02% (1.0002)	
CY 2025 Conversion Factor		**$32.3465**

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**	**2024 National Rate (with CAA 2.93% increase to CF)**	**2025 National Rate**	**2025 Impact**	**2025 Impact w/expiration of CAA**
G6015		Radiation tx Delivery IMRT	$345.39	$355.54	$337.37	-2%	-5%
77427		Radiation tx Management x5	$184.34	$189.75	$187.93	2%	-1%
77014		CT Scan for Therapy Guide	$116.10	$119.51	$115.80	0%	-3%
77301		Radiotherapy Dose Plan IMRT	$1,790.34	$1,842.93	$1,797.82	0%	-2%
G6012		Radiation Treatment Delivery	$222.82	$229.37	$216.40	-3%	-6%
77523		Proton Treatment Delivery	Carrier Priced	Carrier Priced	Carrier Priced	N/A	N/A
77014	26	CT Scan for Therapy Guide	$43.01	$44.28	$43.99	2%	-1%
77263		Radiation Therapy Planning	$162.02	$166.78	$164.97	2%	-1%
77301	26	Radiotherapy Dose Plan IMRT	$403.93	$415.79	$411.12	2%	-1%
77373		SBRT Delivery	$965.35	$993.71	$949.37	-2%	-4%
G6013		Radiation Treatment Delivery	$223.79	$230.37	$217.37	-3%	-6%
77334	26	Radiation Treatment Aid(s)	$58.21	$59.92	$58.87	1%	-2%
99205		Office o/p new hi 60-74 minutes	$214.09	$220.38	$215.75	1%	-2%
77336		Radiation Physics Consult	$86.35	$88.88	$88.63	3%	0%

77338		Design Mlc Device for IMRT	$454.70	$468.06	$461.58	2%	-1%
77338	26	Design Mlc Device for IMRT	$217.00	$223.38	$220.28	2%	-1%
77435		SBRT Management	$619.63	$637.84	$629.46	2%	-1%
77300	26	Radiation Therapy Dose Plan	$31.37	$32.29	$32.02	2%	-1%
77300		Radiation Therapy Dose Plan	$64.03	$65.91	$65.34	2%	-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 clinical labor pricing for CY 2025 in Table 8 (below) is based on the clinical labor price inputs that CMS finalized in the CY 2024 PFS final rule, which account for the final year of the update.

Table 8: 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%

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

In the CY 2025 MPFS proposed rule, CMS sought information about specific mechanisms that may be appropriate, and would leverage verifiable and independent third-party data that is not managed or controlled by active market participants (as it relates to PE data collection). Several commenters criticized the current methodology's inability to account for modern medical technologies like software as a medical device (SaMD) and AI. Many also supported the AMA's ongoing Physician Practice Information Survey (PPIS) to ensure updated and accurate data informs PE calculations. Commenters urged CMS to collaborate closely with medical associations and incorporate broad stakeholder feedback without increasing reporting burdens, particularly for smaller practices.

CMS stated it would consider this information in future rulemaking.

Go Deeper

Currently, CMS relies on the AMA's 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 requests for information (RFIs) 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 stated 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 requested general information from the public on ways that CMS may continue work to improve the stability and predictability of any future updates.

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

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

The Agency received several comments both for and against leaving 77427 on the Telehealth List. In ASTRO's comments and in prior advocacy efforts, we asked that the code be removed from the Telehealth List out of concern for patient safety, as well as the importance of in-person examinations for the monitoring and treatment of radiation therapy side effects. CMS said it was "compelled by the points raised by commenters regarding the lack of evidence of adverse patient safety outcomes and the importance of allowing clinical judgement in determining whether a patient can be seen via Medicare telehealth or whether the patient needs to be seen in-person." However, recognizing ongoing concerns, it is leaving the code on the Telehealth List on a provisional (i.e., not permanent) basis.

It remains ASTRO's position that the OTV component of radiation treatment management should always be conducted in-person by the radiation oncologist.

Go Deeper

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 in-person care, ASTRO asked CMS to remove the code from the list given the critical nature of the 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 believed this service may not be safely and effectively furnished via telehealth. Therefore, the Agency proposed to remove 77427 from the Medicare Telehealth Services List and sought comment on quality-of-care concerns.

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

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

After consideration of public comments, CMS is finalizing its 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 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.

In the absence of evidence that patient safety is compromised by virtual direct supervision, CMS was 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 proposed 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.

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.

Permanently Defining "Direct Supervision" to Include Audio-Video Communications Technology for a Subset of Services
CMS is finalizing its proposal that for the following services furnished after December 31, 2025, the presence of the physician (or other practitioner) required for direct supervision shall continue to include virtual presence through audio/video real-time communications technology (excluding audio-only):

- Services furnished incident to a physician's service when they are provided by auxiliary personnel employed by the physician and working under his or her direct supervision and for which the underlying HCPCS code has been assigned a PC/TC indicator of '5'; and
- Office and other outpatient visits for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional (CPT Code 99211)

In instances where a service on the Medicare Telehealth List is available to beneficiaries in their homes, and also has the requirement of direct supervision, under the applicable definition of direct supervision, the physician/practitioner is required to be available using both and audio and video.

Commenters provided additional services for consideration of permanent direct supervision via audio/video flexibility, and the Agency said it will consider adding services for which direct supervision can include virtual presence in future rulemaking.

Office/Outpatient (O/O) Evaluation and Management (E/M) Visit Complexity Add-on
CMS is finalizing its proposal to allow payment of the O/O E/M visit complexity add-on code (HCPCS code G2211) when the O/O E/M base code (CPT 99202-99205, 99211-99215) is reported by the same practitioner on the same day as an annual wellness visit, vaccine administration, or any Medicare Part B preventive service.

Go Deeper
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 heard from some practitioners of 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 agreed that this was not well-aligned with policy objectives and proposed to allow payment for G2211 when the base code 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.

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

CMS is finalizing two policies related to billing of dental services inextricably linked to covered services. Effective July 1, 2025, CMS will require the submission of the KX modifier on claims for dental services that clinicians believe to be inextricably linked to covered medical services. It believes that the required usage of the KX modifier will support claims processing and program integrity efforts and that the delay provides time for any testing and education needed for implementation.

CMS is also finalizing its proposal to require the submission of a diagnosis code on the 837D dental claims format beginning July 1, 2025. Both the statute and regulations require the submission of a diagnosis code on claims for physician services. However, this requirement has not been specifically addressed in the context of the 837D dental claims format. Therefore, it is finalizing that a diagnosis code will be required on claims for dental services inextricably linked to covered medical services submitted via the 837D dental claims format.

Go Deeper

CMS proposed that the KX modifier 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 proposed 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.

New Codes for Biology-Guided Radiation Therapy (BgRT)

Effective January 1, 2024, CMS created HCPCS codes C9794 (Therapeutic radiology simulation-aided field setting; complex, including acquisition of PET and CT imaging data required for radiopharmaceutical-directed radiation therapy treatment planning (i.e., modeling) and C9795 (Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance and real-time positron emissions-based delivery adjustments to 1 or more lesions, entire course not to exceed 5 fractions) to describe the modeling and treatment delivery portions of the BgRT service. These C-codes were only billable in the hospital setting.

Effective January 1, 2025, two new G-codes are replacing these C codes for BgRT. Specifically, HCPCS codes C9794 and C9795 are being deleted and replaced by G0562 and G0563, respectively, to allow for payment in settings other than hospital outpatient departments for CY 2025. The descriptors for the new G-codes are the same as existing HCPCS codes C9794 and C9795. Because these codes have not been valued under the MPFS, they will be carrier priced at this time.

Table 17 below lists the new G codes for BgRT, which will be effective January 1, 2025.

Table 17: CY 2025 Work RVUs for New, Revised, and Potentially Misvalued Codes

HCPCS	Descriptor	CY 2024 Work RVU	Proposed CY 2025 Work RVU	Final CY 2025 Work RVU	CMS Work Time Refinement
G0562	Therapeutic radiology simulation-aided field setting; complex, including acquisition of PET and CT imaging data required for radiopharmaceutical-directed radiation therapy treatment planning (i.e., modeling)	NEW	-	C	No
G0563	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance and real-time positron emissions-based delivery adjustments to 1 or more lesions, entire course not to exceed 5 fractions	New	-	C	No

Payment of Radiopharmaceuticals in the Physician Office

CMS is finalizing its proposed revision to §414.904(e)(6): for radiopharmaceuticals furnished in a setting other than the hospital outpatient department, Medicare Administrative Contractors (MACs) shall determine payment limits for radiopharmaceuticals based on any methodology used to determine payment limits for radiopharmaceuticals in place on or prior to November 2003. Such methodology may include, but is not limited to, the use of invoice-based pricing.

Go Deeper

CMS proposed 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.

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.

Prostate Cancer Cost Measure

CMS finalized its decision to establish a Prostate Cancer Cost measure beginning with the CY 2025 performance period/2027 MIPS payment year. The cost measure will assess MIPS eligible clinicians on the risk-adjusted and specialty-adjusted cost to Medicare for the management and treatment of prostate cancer.

ASTRO, along with several other stakeholder groups, expressed concern about the measure proposal and pointed to the heterogenous nature of prostate cancer, which results in significant variation in treatment costs, which cannot be addressed via claims data. There was also common concern regarding the lack of consensus among the clinician experts involved in measure development and no additional testing after the measure was modified after an initial test. The Agency disagreed with these assertions.

CMS claims that the Prostate Cancer Cost measure accounts for severity using claims-based risk adjustment variables including ADT drugs, chemotherapy, immunotherapy, prostatectomy, PSA tests, and radiation. Furthermore, the Agency asserted that the measure stratifies patients based on whether they have a metastatic cancer diagnosis or metastatic cancer drug usage in the year prior to the episode.

ASTRO is supportive of high-value approaches to cancer treatment; however, we remain concerned that this measure adds to the complexity and burden of the MIPS payment system. Additionally, it may unfairly penalize radiation oncologists. ASTRO will monitor its implementation and continue to advocate for modifications.

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 issued 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.

It received several comments in response to this RFI, which it will consider in future rulemaking.

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/2024-25382.pdf

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