CMS Finalizes a 2.83 Percent Cut to Physician Payments in 2025
Telehealth Flexibilities will Largely End in 2024 without Congressional Action!

On November 1, 2024, the Centers for Medicare and Medicaid Services (CMS) released the CY 2025 Medicare Physician Fee Schedule (MPFS) and the Hospital Outpatient Prospective Payment System (OPPS)/Ambulatory Surgical Center (ASC) proposed regulations. Unless otherwise noted, the regulations are effective on January 1, 2025.

While the Medicare agency is proposing a 2.9 percent positive increase for the facility payment for hospital outpatient services, a 2.83 percent cut is proposed for physician service in CY 2025. Medicare payments currently do not keep up with the rising costs of inflation and running a practice. An additional cut for 2025 will further harm already overburdened physician practices.

CY 2025 MPFS Key takeaways for GI:

Physician payments decline: Our societies will urge Congress to reverse the 2.83 percent cut to Medicare physician reimbursement announced in the 2025 fee schedule. This cut is based on a proposed 2025 physician conversion factor of $32.3465 from the current CY 2024 conversion factor of $33.2875. This is the fifth year in a row that the conversion factor is facing a cut.

We support the bipartisan Medicare Patient Access and Practice Stabilization Act of 2024, which would address CY 2025 Medicare PFS payment cuts. This bill seeks to eliminate the 2.8% conversion factor cut and provide an approximately +1.80 update. We will continue to urge Congress to include this bill in an end-of-the-year package during the lame-duck session after the election.

COVID-19 era telehealth flexibilities to end without congressional action: COVID-19 telehealth flexibilities will remain in place until the end of CY 2024. However, absent congressional action, beginning January 1, 2025, CMS is proposing that the statutory restrictions on geography, site of service, and practitioner type that existed prior to the COVID-19 PHE will go back into effect. CMS is proposing to maintain virtual direct supervision to auxiliary personnel when required. CMS is also proposing temporary extensions of virtual supervision for certain services when teaching physicians virtually supervise telehealth services provided by residents in teaching settings. Congress has been debating a temporary two-year extension of current COVID-19 telehealth flexibilities, and it is hoped this will be included in a year-end legislative package. Our societies are actively advocating for long-term access to telehealth services for your patients.

CMS does not accept new telemedicine office visit codes: For CY 2025, the American Medical Association (AMA) CPT Editorial Panel created 16 new codes (98000-98015) to describe telemedicine office visit services, which are patterned after the in-office visit codes, in addition to code 98016 (*Virtual check-in*). CMS finalized its proposal not to pay separately for 98000-98015 since they do not believe there is a programmatic need for these codes. CMS states that the currently available office visit codes with appropriate modifiers could distinguish office visit codes provided virtually from those provided face-to-face. Retaining the existing coding methodology using current E/M office visit codes with the appropriate modifier will maintain payment parity in physician work between in-person and telehealth services and eliminate the need for physicians to learn how to use and report a new family of CPT code for telemedicine services. CMS is publishing

the RVU values for codes 98000-98015, so potentially private payors could permit the reporting of these codes.

CMS does propose to accept 98016 - Brief communication technology-based service (e.g., virtual check-in) with the RUC recommended value of 0.30 work RVUs and it proposes to delete HCPCS code G2012, which describes a very similar service to 98016.

CMS allows for expanded reporting of office/outpatient (O/O) Evaluation and Management (E/M) visit complexity add-on code G2211. CMS established payment for G2211 in 2024 but excluded payment when Modifier-25 (a *separately identifiable service reported on the same day as an E/M service*) was reported. For CY 2025, CMS is finalizing its proposal to allow payment for G2211 when the O/O E/M base code is reported by the same practitioner on the same day as an annual wellness visit (AWV), vaccine administration, or any Medicare Part B preventive service furnished in the office or outpatient setting.

Expanded Colorectal Cancer Screening: CMS finalized several policies to update and expand coverage of colorectal cancer (CRC) screening.

- CMS is removing coverage of barium enema as a method of screening. This service is rarely used in Medicare and is no longer recommended as an evidence-based screening method.

- CMS is adding coverage for Computed Tomography (CT) Colonography.

- CMS is expanding the "Complete CRC Screening" policy finalized in the CY 2023 PFS by adding that either a positive Medicare-covered blood-based biomarker test or non-invasive stool-based test is part of the CRC screening continuum, and the follow-on colonoscopy would not incur beneficiary cost-sharing. The proposed addition of coverage for blood-based tests expands the CRC screening continuum and will remove the financial burden from patients and encourage them to be screened without fear of a surprise bill.

Increasing CRC screening rates at the recommended age is crucial, as CRC prevention and early detection brings us closer to saving lives. For those who may avoid traditional screening methods, access to other effective options is vital.

Quality Payment Program: CMS finalized its proposal for a Gastroenterology (GI) Care MIPS Value Pathway (MVP) as a reporting option to fulfill requirements for reporting to the Merit-based Incentive Payment System beginning with the 2025 performance year. Our societies consistently have stated opposition this GI MVP as finalized. We strongly believe the GI MVO falls short of comprehensive measurement and evaluation of "Gastroenterology Care" thus misleading patients and further confusing practicing gastroenterologists seeking meaningful measurement and reduced reporting burden.

Additionally, CMS has finalized its proposal to remove a meaningful quality measure from public reporting, specifically Quality Measure 439, Age-Appropriate Screening Colonoscopy, beginning with the 2025 performance year. Our societies opposed removal of this measure for many reasons, among them the limited number of GI-specific quality measures available for public reporting.

CY 2025 HOPD / ASC Key takeaways for GI:

Hospital and ASC payments increase: For CY 2025, CMS is increasing payment rates under the Hospital Outpatient Prospective Payment System (OPPS) and the Ambulatory Surgical Center (ASC) Payment Systems by 2.9%. This increase is based on a hospital market basket percentage increase of 3.4% reduced by a productivity adjustment of 0.5 percentage point. In continuation of an existing policy, hospitals and ASCs that fail to meet their respective quality reporting program requirements are subject to a 2.0% reduction in the conversion factor for CY 2025.

Changes to Colonoscopy Cost Sharing: CMS finalized previous proposals to modify the definition of "CRC screening tests" to include a follow-on screening colonoscopy after a positive stool-based colorectal cancer (CRC) screening test. This change aims to eliminate cost-sharing for beneficiaries, making the necessary follow-up colonoscopy free of charge if the initial non-invasive CRC screening test yields a positive result. The goal of this change is to ensure beneficiaries have access to essential follow-up care without financial barriers, enhancing early detection and treatment of colorectal cancer.

Quality: Quality: CMS has finalized three health equity measures for the ASC Quality Reporting Program. Reporting on the measures will be mandatory starting with the CY2026 reporting period. Our societies opposed the measures as proposed and emphasized in comments to CMS that ASCs are not the appropriate site of care for social determinants of health screening, analysis and for implementing patient referrals to address social needs when necessary.

Resources

Physician Fee Schedule

2025 Physician Fee Schedule Final Rule

2025 Physician Fee Schedule Final Rule Press Release

2025 Physician Fee Schedule Final Rule Fact Sheet

2025 MPFS Final Rule GI Payment Changes

2025 MPFS Final Physician Work, PE and RVU Changes

Outpatient Prospective Payment System/ASC

2025 OPPS/ASC Payment System Final Rule

2025 OPPS/ASC Payment System Final Rule Press Release

2025 OPPS/ASC Payment System Final Rule Fact Sheet

2025 Final ASC Payment Rates

2025 Final ASC Top 10 Base and Biopsy Codes

2025 Final Hospital Outpatient Payment Rates

2025 Final Hospital Outpatient Top 10 Base and Biopsy Codes