2025 Medicare Physician Fee Schedule Final Rule Summary

Overview

On Nov. 1, 2024, the U.S. Centers for Medicare & Medicaid Services (CMS) released the 2025 Medicare Physician Fee Schedule (MPFS) final rule. CMS finalized a CY 2025 PFS conversion factor of $32.35, representing a 2.83% decrease (or $0.94) from the current conversion factor. This cut is a result of the expiration of a 2.93 percent temporary update to the conversion factor at the end of 2024 and a 0 percent baseline update for 2025 under the Medicare Access and CHIP Reauthorization Act. Eligible physicians who fail to comply with the requirements of the Merit-based Incentive Payment System (MIPS) in 2025 will also be subject to a penalty of up to 9% of their Part B Medicare payments. The AANS and the CNS provided detailed comments on the CMS 2025 MPFS proposed rule on September 9, 2024.

Additional resources on the final rule from CMS are provided below:

- **CY 2025 MPFS Final Rule:** Link
- **MPFS Press Release:** Link
- **MPFS Fact Sheet:** Link
- **Quality Payment Program (QPP) Fact Sheet:** Link (to download)
- **2025 Finalized Merit-Based Incentive Payment System (MIPS) Value Pathways (MVPs):** Link (to download)
- **Medicare Shared Savings Program (MSSP) Fact Sheet:** Link
- **Medicare Prescription Drug Inflation Rebate Program:** Link

The following includes highlights of issues of interest to neurosurgery.

Reimbursement Issues

Global Surgical Codes

For over a decade since the largely discredited 2012 HHS OIG Report on the number and level of E/M visits in global surgical procedures, CMS has spent time and resources on attempts to dismantle the long-standing global surgical payment convention for surgery. CMS has made a number of efforts to seek data on E/M visits provided to patients after having a procedure reported within a global period. In 2025, for 90-day global surgical services, CMS has finalized the following requirements.

- **Transfer of Care Modifiers.** For 90-day global surgical packages, CMS finalized its proposal to require the use of modifier -54 when a physician plans to furnish only the surgical procedure portion of the global package, including when there is a formal, documented transfer of care as under current CMS policy or an informal, non-documented but expected transfer of care. Appending this modifier will reduce the payment rate to reflect that the surgeon is not providing the post-operative portion of the

service. Commenters noted that applying a payment reduction to surgical codes billed using modifier -54 and the multiple procedure payment reduction (MPPR) would duplicate the reduction and be inappropriate because the MPPR already reduces the payment for the second and subsequent services to remove payment for post-operative care. Despite these objections, CMS will apply both payment reductions. CMS did not finalize any changes regarding the use of modifiers -55 and -56 for CY 2025. Modifiers -55 and -56 will continue to be reported exclusively in cases where there is a documented formal transfer of care.

CMS estimated that the finalized transfer of care policy change would result in a $150 million reduction in total Medicare-allowed charges for CY2025. CMS acknowledged that their analysis only included a relatively small set of codes (approximately 180 codes) even though this policy would apply to all 90-day global services. CMS noted that the subset of codes they used for their analysis accounted for about 73 percent of the total Medicare 90-day global procedure volume.

The AANS and the CNS opposed the expansion of the use of these modifiers.

- **New E/M "G" Code to Report Post-operative Care**. CMS finalized coding and payment for an E/M add-on code (G0559) to capture the additional time and resources spent providing post-operative care by a physician who did not perform the surgical procedure and who has not been involved in a formal transfer of care agreement. This code can be billed only once during the 90-day global period. CMS estimates $370k in total Medicare-allowed charges for G0559 in CY2025.

  The AANS and the CNS opposed the creation of the new "G" code for physicians other than the operating surgeon to report services provided in the post-operative portion of a global period.

- **Increasing the E/M Values in the Global Periods**. As we have for many years, the AANS and the CNS urged CMS to immediately increase the 10- and 90-day global codes to reflect the proportionate increase in value for evaluation and management (E/M) codes to maintain the relativity of the fee schedule and comply with the Medicare statute prohibiting specialty payment differentials. CMS acknowledged receiving comments on this subject but declined to address them.

Practice Expense (PE) Relative Value Units (RVUs)

- **Low Volume Overrides.** CMS accepted the AMA/Specialty Society Relative Value Scale Update Committee (RUC) recommendations for low-volume services, including a specialty override for anterior arthrodesis CPT Code 22808 from neurosurgery to orthopaedic surgery. The AANS and the CNS support this change.

- **Medicare Economic Index and AMA PPI Survey.** CMS agreed to delay changes in the Medicare Economic Index (MEI) until the AMA Physician Practice Information (PPI) Survey data can be analyzed and reviewed by stakeholders. CMS has contracted with the RAND Corporation to analyze and develop alternative methods for measuring practice expenses for updates to payment under the MPFS, and they state they will include the PPI Survey data in their analysis. AMA expects to share its survey data with CMS in early 2025.

CMS Valuation of Specific Codes

CMS accepted 91 percent of the values proposed by the RUC for the new, revised, and revalued codes in the 2025 MPFS proposed rule. However, CMS reduced the RUC-passed work relative values (wRVU) for the new MRI-guided focused ultrasound (MRgFUS) Category I code. The AANS and the CNS objected to this reduction and met virtually with CMS staff on Aug. 21 to advocate for the RUC-passed value. **Following advocacy from the AANS and CNS in writing and a virtual meeting with CMS staff, CMS reversed its proposal to lower the value for MRgFUS and restored the RUC-passed value.**

CPT Code	Descriptor	RUC Proposed-wRVU	CMS Proposed wRVU	CMS Final wRVU
61715	MRgFUS, stereotactic ablation of target, intracranial, including stereotactic navigation and frame placement, when performed	18.95	16.60	18.95

- **Potentially Misvalued Procedure**.

    - **Osteotomy Codes**. CMS received a public nomination from an interested party for CPT codes 22210 (Osteotomy of the spine, posterior or posterolateral approach, 1 vertebral segment; cervical) (090 day global code), 22212 (Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; thoracic) (090 day global code), 22214 (Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar) (090 day global code), and 22216 (Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; each additional vertebral segment [List separately in addition to primary procedure]) (add-on ZZZ), as potentially misvalued for six reasons: (1) incorrect global period; (2) incorrect inpatient days; (3) incorrect intraservice work description; (4) overvalued intraservice times; (5) changed surgical practice; and (6) incorrect use of posterior osteotomy codes. In the final rule, CMS agreed with the commenter and referred the codes to the RUC for re-survey.

      The AANS and the CNS disagreed with the request to designate osteotomy CPT codes 22210, 22212, 22214, and 22216 as potentially misvalued at this time.

    - **S.I. Joint Fusion.** CMS received a comment nominating 27279 (Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device), as misvalued. Specifically, the commenter asked CMS to price the service in the non-facility setting in addition to the facility setting. CMS has expressed concerns about whether this 90-day surgical service can be safely and effectively furnished in the non-facility/office setting (for example, in an office-based surgical suite). In the final rule, CMS found that 1) the majority of commenters recommended that CMS not extend its use to nonfacility settings; and 2) since this service is not routinely furnished in a nonfacility setting, they have decided not to nominate CPT code 27279 as potentially misvalued.

The AANS and the CNS agree with CMS and oppose the pricing of sacroiliac joint arthrodesis procedure CPT code 27279 in the non-facility/office setting.

Quality Provisions

CMS finalized the following policies related to the Quality Payment Program (QPP) starting with the 2025 performance year, which affects 2027 payments unless otherwise noted:

MIPS

- **MVPs.**
    - MVPs will remain voluntary for the 2025 performance year. However, starting in 2026, multi-specialty group practices that opt to participate via MVPs must break into subgroups for purposes of reporting. CMS reiterated its intention to move to full MVP adoption and to sunset traditional MIPS in the future despite concerns about the MVP framework and clinician readiness to transition to MVPs.
    - CMS finalized six new MVPs for 2025, as proposed, including the Surgical Care MVP, despite opposition from organized neurosurgery and other surgical specialties impacted by the MVP.
    - CMS finalized its proposal to remove high/medium weights from Improvement Activities in MVPs; MVP participants will only be required to attest to 1 activity for full credit, rather than 2, starting in 2025.
- **Traditional MIPS.**
    - CMS will maintain a 75-point performance threshold for 2025, which is the minimum performance score needed to avoid a penalty.
    - For the Quality category, CMS finalized the removal of two measures in the Neurosurgical Specialty Set:
        - *#260: Rate of Carotid Endarterectomy (CEA) for Asymptomatic Patients, Without Major Complications* since CMS believes it is duplicative of measure *#344: Rate of CEA or Carotid Artery Stenting (CAS) for Asymptomatic Patients, Without Major Complications (Discharged to Home by Post-Operative Day #2).*
        - *#409: Clinical Outcome Post Endovascular Stroke Treatment* at the request of the measure steward, the Society of Interventional Radiology, which opted to maintain the measure no longer.
    - CMS finalized the removal of existing scoring caps on certain high-performing (i.e., "topped out") quality measures. CMS will remove the cap for select measures commonly used by specialties with limited measures. While none of the measures that would benefit from this policy in 2025 are relevant to neurosurgery, CMS' willingness to address this scoring limitation, even in a limited manner, is a step in the right direction.

- Similar to MVP, CMS finalized to remove Improvement Activity weights under traditional MIPS and to reduce the required number of activities to two (versus 2-4) for non-small practices and one for small practices starting in 2025.

- For the Cost category, CMS finalized an important revision to the scoring methodology that will more appropriately score clinicians in relation to national averages (i.e., based on standard deviations from the median), starting with the *2024* performance period. This policy is expected to raise Cost category scores for most clinicians whose average costs are around the median.

Qualifying Participants (QPs) in Advanced APMs.

- As required under statute, starting with payment year 2025 (based on 2023 eligibility), QPs in Advanced APMs will receive a lump-sum APM Incentive Payment equal to 3.5% payment of their estimated aggregate paid amounts for covered professional services furnished during CY 2024 (down from 5%). In the payment year 2026 (based on 2024 eligibility), this incentive payment drops to 1.88%. Also beginning in payment year 2026, CMS will apply two separate PFS conversion factor updates—one for QPs (0.75) and one for all non-QP eligible clinicians (0.25). Barring Congressional action, the APM incentive payment ends after the 2026 payment year.

- Also under statute and barring Congressional action, the thresholds to achieve QP status will increase beginning with the 2025 QP performance period, making it more difficult for clinicians to qualify for this track of the QPP just as the incentives to move into this track are dwindling.