2025 Physician Reimbursement Update and What It Means for Your Practice

The 2025 Medicare Physician Fee Schedule (PFS) update by the Centers for Medicare & Medicaid Services (CMS) introduces significant changes to physician reimbursement, with far-reaching effects on medical practices, especially in the areas of **Medical billing and coding**. This update, finalized on November 4, 2024, impacts conversion factors, introduces new codes, and makes several policy adjustments. While some changes aim to support primary care, behavioral health, and preventive services, others raise concerns about the financial stability of practices due to payment cuts and adjustments for inflation.

Let's have a look at the analysis of key aspects of the 2025 PFS and their implications for medical billing and coding practices:

Key Insights on 2025 PFS: Implications for Medical Billing and Coding

Conversion Factor Reduction

The conversion factor, which is used to calculate payments for Medicare Part B services, is a fundamental element of the Medicare payment system. CMS set the conversion factor at

$32.35 for 2025, a 2.83% decrease from 2024's $33.29. This reduction reflects the expiration of the temporary 2.93% increase applied in 2024 to aid practices through post-pandemic financial strain. However, the cut is expected to create financial challenges for many medical practices with inflationary pressures on practice expenses. The American Medical Association (AMA) and other advocacy groups argue that ongoing cuts to the conversion factor exacerbate financial instability, potentially compromising patient access to Medicare-participating physicians and services.

For practices, this decrease means a smaller payment per service, affecting revenue streams, especially for specialties with heavy reliance on Medicare reimbursements. Practices may need to adjust their financial strategies, possibly revisiting service offerings, adjusting patient volumes, or exploring alternative revenue sources.

New Advanced Primary Care Management (APCM) Codes

CMS introduced new codes, GPCM1 through GPCM3, dedicated to advanced primary care management services. These codes support comprehensive care coordination, which is central to primary care and complex patient management. The APCM codes cover services that go beyond traditional primary care visits, including follow-ups, preventive care, and coordination with specialists. Billing for these codes allows practices to receive compensation for a more holistic approach to patient care, encouraging a focus on long-term health outcomes.

From a **Medical coding and billing** perspective, the new APCM codes create an opportunity for primary care practices to enhance revenue by billing for previously unreimbursed services. Coders need to be trained in the application and documentation requirements of these codes, ensuring that each service billed under APCM aligns with CMS guidelines. Accurately capturing APCM services may also involve adjustments to electronic health record (EHR) systems, as well as additional administrative work to ensure comprehensive care is documented.

Cardiovascular Service Codes and ASCVD Risk Management

The rule introduces new codes for atherosclerotic cardiovascular disease (ASCVD) risk assessment (G0537) and risk management (G0538). G0537 covers the ASCVD risk assessment process for patients without a cardiovascular disease diagnosis but with risk factors like high blood pressure, high cholesterol, obesity, and family history of cardiovascular disease. G0538 reimburses practices for risk management services for patients at intermediate, medium, or high risk of developing cardiovascular disease. These services may include medication management, blood pressure and cholesterol control, and lifestyle counseling for smoking cessation.

For cardiovascular practices, the addition of ASCVD risk assessment and management codes represents an opportunity to expand services and revenue. Practices will need to develop workflows to identify eligible patients, complete risk assessments, and document management plans accordingly. Billing departments should ensure accurate coding for ASCVD-related visits to capture these new reimbursements.

Global Payment Policy Revisions

CMS has introduced new requirements for 90-day global surgical packages, with the addition of the -54 modifier for surgical-only cases. Previously, surgical packages bundled postoperative care with the surgical procedure under a single reimbursement. Starting in 2025, the -54 modifier allows practitioners to bill only for the surgical portion when they are not providing postoperative care. In such cases, CMS will adjust the surgical reimbursement to reflect the removal of the non-surgical portion of the package.

Additionally, CMS created a postoperative add-on code, G0559, to address resources used when postoperative care is provided by a different practitioner within the 90-day global period. This change facilitates more flexible billing but requires that practices accurately document and apply the -54 modifier and G0559 add-on code as appropriate.

These global payment revisions necessitate precise documentation and coding workflows to ensure compliance with new billing protocols. Practices should review their processes for global surgical packages and educate providers on the new rules, ensuring modifiers are used correctly to **prevent denied claims** and maximize revenue for services provided.

Telehealth and Audio-Only Flexibilities

With the expiration of pandemic-related telehealth flexibilities, CMS has outlined stricter requirements for telehealth services. Starting in 2025, telehealth originating site rules limit patient location eligibility to certain rural and underserved areas. For telehealth visits, two-way audio-only communication will satisfy telecommunication requirements under specific circumstances, particularly when patients cannot use video technology.

For practices, these telehealth changes will affect the types of services billable under Medicare. Patients outside designated rural or underserved areas may no longer be eligible for Medicare-covered telehealth visits, which may reduce telehealth utilization. Additionally, practices must ensure they have audio-visual telecommunication capabilities in cases where video-based telehealth is preferred.

Billing teams will need to update telehealth coding practices and confirm patient eligibility to avoid issues with Medicare claims. Clear communication with patients regarding eligibility criteria and available telehealth options will be essential to maintaining patient satisfaction and compliance with CMS policies.

Merit-based Incentive Payment System (MIPS) Updates and MIPS Value Pathways (MVPs)

For the 2025 performance year, CMS introduced minimal changes to MIPS but added several quality measures specific to cardiovascular care. CMS also included a new quality measure and improvement activity in the Advancing Care for Heart Disease MVP. CMS's intention with these adjustments is to encourage performance improvements in quality, cost, and care coordination.

Billing and coding departments in practices participating in MIPS need to incorporate these new quality measures into their reporting systems. Successful participation in MIPS requires an understanding of specific metrics tied to Medicare reimbursement. In cardiovascular care, adherence to these measures can benefit practices financially through MIPS performance incentives, which reward practices meeting or exceeding performance benchmarks.

Impact of Legislative Advocacy on 2025 Reimbursement

In response to these changes, the medical community is advocating for reforms to Medicare's payment system. The Medicare Patient Access and Practice Stabilization Act of 2024, introduced by Congress, aims to prevent the 2.83% cut in the conversion factor and add an inflationary update for 2025 equal to 50% of the Medicare Economic Index. Longer-term reforms, such as the Strengthening Medicare for Patients and Providers Act (H.R. 2474), propose annual updates based on the Medicare Economic Index to provide a sustainable payment model.

For practices, these legislative developments represent hope for future payment stability. By advocating for sustainable Medicare reimbursement models, practices can ensure they can continue providing quality care to Medicare patients without financial strain. Practices should consider actively engaging in these advocacy efforts and staying informed on legislative progress, which could significantly influence Medicare billing and coding practices.

Conclusion

The 2025 Medicare Physician Fee Schedule presents both opportunities and challenges for medical practices. The conversion factor cut, introduction of new APCM and ASCVD risk codes, revisions in global payment policies, telehealth restrictions, and minor MIPS updates will necessitate adjustments in billing, coding, and practice workflows. By adapting to these changes and actively engaging in advocacy for sustainable reimbursement models, practices can navigate the complex scenario of Medicare reimbursement, balancing patient care with financial viability.