Calendar Year (CY) 2025 Medicare Physician Fee Schedule (PFS) Proposed Rule | APTA Initial Summary

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This is the initial summary of the 2025 Medicare Physician Fee Schedule Final rule; citations provided below correspond to the display copy of the proposed rule. Sections indicated by teal divider.

2025 Conversion Factor (p. 12, 1559-64)

In Short: As expected, CMS moved forward with another payment cut this year—approximately -2.8%. The estimated PT/OT impact on total allowed charges is neutral (0%) compared to other clinical specialties, which ranged from -2% to +2% (with the sole exception of clinical social work, which saw a +4% estimate).

- **Proposed CY 2025 Conversion Factor [Table 126, p. 1560]:** $32.3562 (approximately -2.8% change from 2024)
    - **Calculated Based on:**
        (1) *2024 Conversion Factor*: $33.2875
        (2) *Removal of 2024 CAA Statutory Increase* (-2.93%): $32.3400
        (3) *Statutory Update Factor*: 0.00% (No Change)
        (4) *Relative Value Unit (RVU) Budget Neutrality Adjustment*: 0.05%
- **Estimated Impact on Total Allowed Charges, PT/OT [Tables 128 and 129, p. 1561-64]:** 0% (combined)
    - **Est. Allowed Charges in 2025 PT/OT:** $5,607,000, a 0% change. Table 128 does not indicate an increase in RVUs, but in the discussion, CMS notes that PT/OT received a 1% increase in Total RVUs.[1] APTA is aware of this discrepancy and is working to identify the source.
    - **Splits by Facility/Non-Facility, PT/OT:** PT/OT services are only billed in the PFS at the non-facility rate, thus there is no split listed for "facility" charges as there are for other specialties, and all impacts are based on non-facility charges.[2] The table shows the 0% increase in non-facility charges consistent with the above impact.

[1] CMS notes in reference to Table 128 (pg. 1570) that PT/OT sees "a 1 percent increase in RVUs for the physical/occupational therapy specialty as a whole; however, 24 percent of physical/occupational therapy specialty practitioners—representing over 21 percent of Total RVUs for the specialty—will experience a 1 percent or more increase in Total RVUs. Meanwhile, 13 percent of physical/occupational therapy specialty practitioners will experience 1 percent or more decreases in Total RVUs, and these practitioners account for 14 percent of Total RVUs for this specialty."

[2] The "facility" charges are blank in the PT/OT category, however, the impact listed is "+4%" – it is unclear why it's listed as an increase despite no charges being attributed (last year it was listed as 0%).

Medicare Economic Index (MEI) Updates (p. 32)

In Short: CMS is continuing to delay implementation of the recalibration of the relativity weighting of work, practice expense, and malpractice based on the MEI cost share weights. The MEI impact remains dependent on the ongoing Mathematica survey of practice cost. Preliminary estimates of this policy from approximately two years ago anticipated a pay bump for PT, but it's not clear if those estimates have any merit still. APTA continues to strongly encourage those practices who have been selected by Mathematica to participate in this survey to submit their data. Currently the deadline for data submission is July 31st but this is subject to change.

- CMS is **not proposing** to update the data underlying the MEI cost weights in CY 2025.
- CMS is **not proposing** to incorporate the 2017-based MEI in PFS ratesetting for CY 2025
    - **Comment Solicitation [p. 56]:** CMS is inviting comments on this approach and requesting comments on scheduled, recurring updates to PE inputs for supply and equipment costs to account for inflation and deflation.

KX Modifier (p. 368)

In Short: CMS proposes to increase the KX modifier threshold to $2,410, 3.6% increase from last year.

- 2025: $2,410 for PT and SLP services combined (2024: $2,330—3.6% increase).[3]

PTA Supervision (p. 356-361)

In Short: CMS is proposing PTA general supervision for Medicare Part B outpatient therapy services, a significant advocacy win. Our work with CMS over the last several years, our comment campaign around the RFI last year, and the pressure of the EMPOWER Act were directly responsible for the change. We will mobilize the comment tool to get this finalized.

- **Current Policy:** Medicare permits general supervision of physical therapist assistants by physical therapists in all settings—except for outpatient private practice under Part B, which requires direct supervision. The requirement of direct supervision means the physical therapist must physically be onsite with the assistant at all times when care is being delivered.
- **APTA Advocacy in Action:** CMS is proposing to change the regulatory requirements for OTs and PTs who are enrolled as suppliers in Medicare as PTs in private practice to allow for general supervision of their physical therapist assistants to the extent permitted under State law. If finalized as proposed, PTs would be allowed to bill for and receive Medicare Part B payment for therapy services furnished by PTAs if they meet the general supervision standard; for instance, when the PT is not in the office or patient's home at the same time as the PTA.
    - **Note:** CMS reminds readers that *unenrolled* PTs would still be subject to direct supervision.
- **CMS' Rationale:** CMS specifically notes that after reviewing responses to last year's request for information on PTA supervision that the existing direct supervision requirement for Part B

[3] Identical change to OT as well.

outpatient physical therapy may have had an unintended consequence of limiting access to therapy services.[4] CMS sought to make supervision requirements uniform across all Medicare settings and bring Medicare policy in line with most state-established supervision levels (44 states) for PTAs, and indicates that the change also allows PTAs the flexibility to better accommodate patients' availability and act to ensure access to necessary therapy services.

Certification of Therapy Plans of Care with a Physician or NPP Order (p. 361-68)

In Short: This is another huge advocacy win, which draws directly from feedback communicated to the Agency, and the policy proposal itself aligns with the REDUCE Act. The primary change being proposed is an exception to the PoC signature requirement, which allows a signed order/referral, with additional evidence below, to meet the certification signature requirement. We will mobilize the comment tool to get this finalized.

- **Background:** Payment for Medicare outpatient physical therapy services is currently only made when a claim has appropriate initial physician certification of the plan of care that indicates: (1) services are medically necessary; (2) a plan of services was established by a physician or qualified therapist; and (3) the services were furnished while under the care of a physician.
- **APTA Advocacy in Action:** CMS is proposing to amend the regulation at §424.24(c) so that a signed and dated order/referral is sufficient to demonstrate the physician/NPP's ***initial*** certification of the plan of care. However, the signed and dated referral must also be *supported* with documentation of both: (1) the order/referral in the patient's medical record; and (2) further evidence in the medical record that the therapy plan of treatment was transmitted/submitted to the ordering/referring physician or NPP within 30 days of the completed initial evaluation. This policy would be added as an exception to the physician signature requirement at §424.24(c), indicating that a signed order/referral can serve to meet the initial certification requirements in cases where a signed and dated order/referral from a physician, NP, PA, or CNS is on file, and the therapist has documented evidence that the plan of treatment has been delivered to the physician, NP, PA, or CNS within 30 days of completion of the initial evaluation. Please note that the agency is NOT proposing an exception to the ***recertification*** process.
    - **Note:** CMS notes that this is not characterized as a "presumption" (as we requested) but it would be functionally similar; CMS explicitly notes that if a patient's medical record includes a signed and dated written order or referral indicating the type of therapy needed, that Medicare and its contractors would treat the signature on the order or referral as equivalent to a signature on the plan of treatment.
- **Comment Solicitation #1 [p. 367].** Additionally, CMS is soliciting comments on whether there is need for a regulation addressing the amount of time for changes to a plan of treatment. Currently, there are no time restrictions in regulation, or specific proposals to modify the regulation. However, APTA recommended that physicians/NPPs have 10 business days from the date of

[4] CMS also acknowledges the shortages of OTs and OTAs, PTs, and PTAs in the United States Bureau of Labor Statistics, which shows thousands of open positions in all of these fields, and that 22,000 PTs left the workforce in 2021.

receipt of the plan of care to modify that plan of care through the REDUCE Act. CMS is unsure if that is sufficient time to review the plan of care.

- **Comment Solicitation #2 [p. 367].** CMS is also soliciting comments on whether there should be a time limit on the order/referral when it's intended to serve as the initial certification. CMS seeks comments on whether a 90-day timeframe is appropriate from the order/referral date until the initial treatment (including evaluation) for therapy, or if another duration is more appropriate.
    - **Note:** Separately, CMS reminds readers that this change does not apply to CORF PT.

Response to RUC Recommendations for 19 CPT Codes (p.180)

In Short: Following much APTA advocacy on the issue, CMS seeks to increase the practice expense (PE) for sixteen Physical Medicine and Rehabilitation CPT codes while also seeking to decrease the PE in three codes of the same family beginning in CY 2025. While not at the level APTA and AOTA recommended, this is a win for therapy providers and APTA will continue to engage with CMS as they conduct an additional review of the code family.

- **Background:** In the CY 2024 final PFS, CMS instructed the RUC Health Care Professionals Advisory Committee (HCPAC) to review all 19 codes in the Physical Medicine and Rehabilitation code family to address the position of APTA that MPPR was erroneously applies twice to these codes, once during the RUC valuation and again at the time of claim submission. Both APTA and AOTA provided detailed evidence on the subject so that the committee could properly evaluate clinical labor time and equipment minutes for all 19 codes. After reviewing our recommendations, the RUC HCPAC provided their recommendations to CMS ahead of the proposed rule.
- **APTA Advocacy in Action:** Ultimately, the RUC HCPAC did recommend an increase in clinical labor time for all 19 codes, but the increase fell short of what APTA and AOTA were recommending. After consideration of the RUC HCPAC recommendations, CMS is proposing the direct PE inputs as recommended by the HCPAC for all 19 codes. The net result is that 16 of the 19 codes had a slight increase in the PE and 3 of the 19 codes had a slight decrease in PE.
- **Rationale:** The agency believes that the HCPAC's equipment time recommendations better maintain relativity with the rest of the fee schedule because they use standard equipment time formulas, along with limited exceptions for additional equipment time in cases where more time for equipment cleaning or patient positioning would be typical. Although CMS agrees that some additional equipment time beyond the timed 15 minutes would be typical for setup and cleaning, the agency believes that the alternate equipment time formula recommended by APTA and AOTA leads to inconsistent equipment times for many of these procedures.
- **Next Steps:** Given the complexity of determining appropriate direct PE inputs across multiple billings of these therapy codes, and the need to factor in the MPPR, CMS seeks to conduct an additional review of the Physical Medicine and Rehabilitation code family to specifically concerning how to determine appropriate equipment minutes.

Telehealth (p. 75-114)

In Short: CMS elected to whole cloth delay its decisions on adding codes, including our PT codes, to the permanent list. We also note that CMS has an alignment policy in place for OPPS that would ensure any legislative changes to extend or make permanent the list of approved telehealth providers under the PFS would be uniformly applied to OPPS as well. Audio-only telehealth could be available under a new proposal; although it would require a legislative extension to allow PTs to continue billing telehealth, this would theoretically be available to PTs based on their clinician judgment. Practically speaking, it might be of limited utility given the common need for visual demonstration.

- **Background on Medicare Telehealth Services List:** In the CY 2024 PFS final rule, CMS consolidated the existing three categories for telehealth services into a revised 5-step process for making changes to the Medicare Telehealth Services List. Codes are now labeled as either "provisional" or "permanent" status. PT codes are currently set at provisional status and have been since March 31, 2020. This year, APTA submitted the following codes for permanent status: 97161-4, 97110, 97112, 97116, 97530, 97535.
- **No Provisional Codes (Including All PT Codes) Will Move to Permanent Status in the Proposed Rule:** Rather than selectively adjudicate the services requested for permanent status via the proposed rule, CMS instead chose to conduct a comprehensive analysis of all provisional codes currently on the Medicare Telehealth Services List and will address the issue in future rulemaking. Therefore, CMS is not proposing to revise the status of any PT codes from provisional to permanent status on the Medicare Telehealth Services List.
- **CMS is adding caregiver training codes (97550, 97551, 97552) to the Medicare Telehealth Services List on a provisional basis.**
    - **Rationale:** CMS believes these codes are similar to other services already available on the List.

Audio-Only Telecommunications [p. 100]

- CMS is proposing to revise the regulation at §410.78(a)(3) to state that an interactive telecommunications system may also include two-way, real-time audio-only communication technology for **ANY** telehealth service furnished to a beneficiary in their home if the distant site physician or practitioner is technically capable of using an interactive telecommunications system, but the **patient is not capable of, or does not consent to, the use of video technology.** Providers must use their clinical judgment to determine whether the use of interactive audio-only technology is sufficient to furnish a Medicare telehealth service.
    - **Note:** To submit claims for audio-only services, providers must use the "93" modifier to verify that the patient is not capable of, or does not consent to the use of video technology.
- **CMS Rationale:** There is variable broadband access in patients' homes, and even when technologically feasible, some patients do not always wish to engage with their provider in their home using interactive audio and video.

Distant Site [p. 101]

- CMS is proposing to continue to permit the distant site practitioner to use their currently enrolled practice location instead of their home address when providing telehealth services from their home through CY 2025.
    - **Rationale:** Previous commenters believe that using a home address poses a potential threat to the safety and privacy of health professionals who work from home and furnish telehealth services. Additionally, a significant number of practitioners would need to change their billing practices or add their home address to the Medicare enrollment file which would present administrative burden.

Direct Virtual Supervision* (DOES NOT INCLUDE PT SERVICES) *[p. 106]

- CMS is 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. Such services are limited to incident-to services or other outpatient E/M visits for established patients.

Crossover with OPPS [p. 114]

- **Background:** In the CY 2025 PFS proposed rule, CMS refers stakeholders seeking information related to outpatient physical therapy services furnished by institutional staff in hospitals and other institutional settings to beneficiaries in their homes through communication technology to the CY 2025 Hospital Outpatient Prospective Payment System (OPPS) proposed rule.
- According to the OPPS proposed rule, Section 1834(k)(3) of the Act requires payment for outpatient therapy services to be made based on the PFS (via section 1848 of the Act), for all institutional providers listed at sections 1833(a)(8) and (9) of the Act. Therefore, CMS has decided that future telehealth policies regulating these services will be aligned with policies under the PFS. As it stands, telehealth flexibilities for physical therapists will end on Dec 31, 2024 for both institutional outpatient therapy providers and therapists under the PFS and following the language in both proposed rules, any future legislative extensions of telehealth flexibilities will apply to therapists within both settings.

Quality Payment Program (QPP Resource Library)

In Short: There are few substantial changes to the MIPS elements that typically concern our members. The MVP received a few more measures, although none we directly asked for. Promoting Interoperability in MIPS will move ahead, and we will focus on education with our members related to reweighting based on the lack of control over CEHRT. CMS is creating a reweighting option where a third-party is responsible for failed measure submission in Quality, IA, or PI.

QPP, MIPS, and AAPMs

- **Measures:** Added 9 measures, removed 11; none related to PT.
- **Promoting Interoperability:** No changes to these policies. Policy proposal to mitigate impact of accidental submissions.

- **New MVPs Beginning in 2025 Performance Period:** Ophthalmology, Dermatology, Gastroenterology, Pulmonology, Urology, and Surgical Care. CMS is also proposing to consolidate two neurological MVPs into a single MVP.
- **Threshold Policies:** CMS is proposing to maintain its performance threshold for the CY 2025 performance period (75 points) and data completeness threshold (75%) through CY 2028 performance period.
- **Advanced APMs and MSSP:** Proposing new measure set under AAPMs for the CY 2028 performance period. Will also be required under the MSSP.
- **Cost Measure Scoring:** Proposing to revise the methodology to assess clinician cost of care more appropriately in relation to national averages.
- **Multiple Quality Submissions:** For multiple data submissions received for an individual clinician, group, subgroup, or virtual group from the same organization (for example, by 2 practice administrators), CMS is proposing to codify the existing process, so that it would: (1) Score the most recent submission; and (2) The new submission would override a previous submission (of the same submission type) from the same organization.
- **Improvement Activity Weighting:** CMS is proposing to remove improvement activity weightings to simplify scoring.
- **Population Health Measures:** CMS is proposing to calculate all available population health measures for an MVP participant and apply the highest scoring population health measure to their quality performance category score.
- **Reweighting Policy:** CMS is proposing to allow clinicians to request reweighting for quality, improvement activities, and/or Promoting Interoperability performance category(ies) where data are inaccessible and unable to be submitted due to reasons outside of the control of the clinician because the clinician delegated submission of the data to their third party intermediary (evidenced by a written agreement) and the third party intermediary didn't submit the data on the clinician's behalf in accordance with applicable deadlines.

Rehabilitative Support for Musculoskeletal Care MVP [p.2242]

- **Quality Measures:** Proposed to include one additional MIPS quality measure and four QCDR measures.
    - **Q050:** Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older
    - **MSK6/MSK7/MSK8/MSK9:** Patients Suffering From a Neck/Upper Extremity/Back/Lower Extremity Injury who Improve Pain
- **Improvement Activities:** Add the proposed modified IA_ERP_6 on vaccination status to all MVPs (not just this one). Removing IA_CC_1 and IA_EPA_1.
    - IA_ERP_6: COVID-19 Vaccine Achievement for Practice Staff
- **Cost Measure:** No change.