American Academy of Dermatology Association Policy Analysis:
2025 Medicare Physician Fee Schedule and Quality Payment Program Proposed Rule

On July 10, the Centers for Medicare & Medicaid Services (CMS) released the calendar year (CY) 2025 Medicare Physician Fee Schedule (PFS) proposed rule, which includes important policy changes to fee-for-service payments and the Quality Payment Program (QPP).

For CY 2025, CMS is proposing a conversion factor of $32.3562, representing a 2.8% reduction from the final 2024 conversion factor of $33.2875. This reduction is primarily due to the removal of the 2.93% temporary payment increase for services provided from March 9, 2024, through December 31, 2024, as authorized by the Consolidated Appropriations Act (CAA) of 2024. Additionally, the statutory annual update factor remains frozen at 0%, though there is a slight positive budget neutrality adjustment of 0.05%. The table below provides a detailed breakdown.

Conversion Factor Breakdown		
Final 2024 Conversion Factor		$33.2875
Removal of temporary payment increase for services furnished from 3/9/24 to 12/31/24 authorized by CAA, 2024	-2.93%	
CY 2025 Statutory Update Factor	0%	
CY 2025 RVU Budget Neutrality Adjustment	+0.05%	
2025 Proposed Conversion Factor		**$32.3562**

The CMS specialty impact tables do not account for the removal of the temporary 2.93% payment increase for CY 2024. As a result, dermatologists are experiencing a greater impact than the 0% initially estimated by CMS. The AADA anticipates an impact closer to a 2.8% payment cut for dermatology; however, individual practitioner outcomes may vary based on specific practice mix. Access the AADA's analysis of the top dermatology codes and RVUs for nearly 400 dermatology codes.

The AADA continues to advocate for a permanent fix to the broken Medicare payment system. The decline in Medicare physician payment by 29% from 2001 to 2024 has disproportionately impacted small, independent, and rural practices, and those caring for low-income or historically marginalized patients. Additionally, these cuts come at a time when the cost of practicing medicine is increasing, with CMS projecting a 3.6% rise in the Medicare Economic Index (MEI) for 2025. **The AADA maintains that annual payment cuts have escalated to a critical level, and physicians cannot continue to absorb the**

costs, ultimately impacting their ability to provide patient care.

OTHER PROPOSED MEDICARE PFS POLICIES:

Medicare Telehealth Services

While several telehealth proposals are included in the CY 2025 Medicare PFS proposed rule, it's important to note that CMS has acknowledged significant concerns about maintaining access to Medicare telehealth services once the COVID-19 Public Health Emergency (PHE) flexibilities expire. CMS has limited statutory authority to extend most Medicare telehealth policies, but it is seeking input on strategies to mitigate the negative impacts and is evaluating how the expiration might affect overall service utilization.

Telehealth

Proposed Telehealth CPT Codes

CMS rejected 16 of 17 new telemedicine codes established by the AMA CPT Editorial Panel. CMS says it does not see a need to recognize new audio/video and audio-only telemedicine evaluation and management (E/M) codes for payment, as existing office/outpatient E/M codes with appropriate modifiers can be used to identify these services.

CMS is proposing to pay for a new telehealth service, CPT code 9X091 (virtual check-in), which would delete code G2012 (brief communication technology-based service, e.g., virtual check-in), given the similarity between these codes.

Additionally, CMS proposes to delete CPT codes 99441–99443, which describe telephone E/M services.

Distant Site Requirements & Reporting Home Address

CMS proposes that through CY 2025, it will continue to allow physicians to use their currently enrolled practice location instead of their home address when providing telehealth services from their home. The AADA has actively advocated for this policy, emphasizing that physicians should not be required to report their home addresses due to privacy and safety concerns.

Supervision Proposals

CMS has proposed changes to supervision requirements for teaching physicians and direct supervision in medical settings. CMS proposes allowing teaching physicians to continue having a virtual presence when billing for services involving residents across all teaching settings. This policy, however, only applies when the service is provided virtually. For instance, in a three-way telehealth visit, the patient, resident, and teaching physician can all

be in separate locations.

Additionally, CMS proposes 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. The agency proposes to permanently adopt the definition of direct supervision permitting virtual presence for services that are considered lower risk, like services that do not ordinarily require the presence of the billing practitioner, do not require as much direction by the billing practitioner as other services, and are not typically performed by the supervising practitioner.

Excimer Laser Codes

CMS has rejected the RUC-recommended values for CPT codes 96920 – 96922 (Excimer laser treatment for psoriasis) and is proposing lower work Relative Value Units (RVUs) of 0.83, 0.90, and 1.15, respectively. Although these devices are now predominantly used under a subscription model, as attested by the company that owns the only two FDA-approved excimer laser devices available in the United States, CMS has declined to include those costs in the practice expense calculations. The Academy strongly opposes the proposed CMS values, as they hinder practices' ability to use the device and, more importantly, limit patients' access to psoriasis treatment. The Academy will urge CMS to implement the RUC-recommended values and to recognize the subscription model in the practice expense calculations.

Global Surgical Codes

In the proposed rule, CMS expresses ongoing concerns regarding the accuracy of the valuation and payment of global surgical packages. However, it noted that it is prohibited from converting all 10- and 90-day global packages to 0-day globals. To improve accuracy, CMS proposes requiring the use of existing modifiers (-54, -55, -56) for 90-day global codes when practitioners provide only part of the care, such as pre-operative, procedure, or post-operative, but not all. This proposed policy applies to both formal and informal care transfers. The modifiers are defined as follows: modifier 54 for surgical care only, modifier 55 for post-operative management only, and modifier 56 for pre-operative management only. Additionally, CMS is seeking feedback on whether these changes should apply to 10-day global packages in the future.

CMS is also introducing a new E/M add-on code, GP0C1, for situations where a physician, who did not perform the procedure and is not in the same group or specialty as the performing physician, sees a patient during the 90-day global period for a post-operative follow-up visit addressing the surgical procedure, without a formal transfer of care.

Complexity Add-On (G2211)
CMS is proposing to expand the use of the Complexity Add-On code (G2211). This change would allow payment when the visit is reported by the same practitioner on the same day as:

- An annual wellness visit,
- Vaccine administration, and
- Any Medicare Part B preventive service provided in the office or outpatient setting

Adjusting RVUs To Match Practice Expense Share of the Medicare Economic Index
For another year, CMS is proposing to delay incorporating the finalized 2017-based Medicare Economic Index (MEI) cost weights for the Relative Value Units (RVUs) in the Medicare PFS ratesetting for CY 2025, due to the pending completion of the AMA's Physician Practice Information (PPI) Survey. According to CMS estimates, dermatology would fare well under the CMS policy, seeing an estimated 5% increase for procedures done in the non-facility setting.

As a reminder, the AMA is conducting the PPI Survey to collect data on physician practice expenses. The goal of the survey is to better understand the costs faced by today's physician practices to support physician payment. The survey was last conducted in 2007 and 2008 and is reflective of 2006 data. The Academy has requested to review the data once the survey is closed.

QUALITY PAYMENT PROGRAM POLCIY UPDATE:

MIPS Value Pathways (MVPs)
The most significant change in the proposed rule related to the QPP, which will impact dermatology, is the introduction of a Merit-based Incentive Payment System (MIPS) Value Pathway (MVP) for dermatology. CMS is proposing six new MVPs for 2025, including a comprehensive model called Dermatological Care.

The AADA has been advocating against the MVP for over two years. Despite our strong efforts to urge CMS to delay the implementation of the MVP for dermatology, CMS has made it clear that they intend to proceed. Throughout this period, we have proposed an MVP that aligns cost and quality metrics to enhance patient care, but these suggestions have been ignored. Instead, CMS is moving forward with a comprehensive, one-size-fits-all MVP for dermatology, which fails to address the critical issue of effectively comparing costs and quality of care.

The proposed MVP differs from the candidate MVP released in December 2024. It includes 11 MIPS quality measures and 6 Qualified Clinical Data Registry (QCDR) measures within the quality performance category specific to dermatology, including dermatopathology measures.

Performance Threshold
CMS proposes maintaining the performance threshold at 75 points for the 2025 MIPS performance period, affecting the 2027 payment year. This decision is a significant win for dermatologists because if the performance threshold increases, there could be more MIPS eligible clinicians receiving penalties, which could be up to -9%.

Performance Category Weights
The performance category weights for the 2025 performance year, affecting the 2027 payment year, will remain unchanged from the 2024 performance year. Therefore, the proposed 2025 weights are as follows:

- 30% for the Quality performance category.
- 30% for the Cost performance category.
- 15% for the Improvement Activities performance category.
- 25% for the Promoting Interoperability performance category.

Quality Measures
CMS proposes to introduce a new high-priority dermatology quality measure, "Melanoma: Tracking and Evaluation of Recurrence," for the 2025 performance period and future years. This measure focuses on steps taken to assess melanoma recurrence. CMS proposes to add this measure to the dermatology specialty measure set, which the AADA supports.

Additionally, CMS proposes to remove MIPS Measure 137, "Melanoma: Continuity of Care – Recall System," for the 2025 performance year and beyond because it thinks this measure is duplicative of the Melanoma: Tracking and Evaluation of Recurrence.

Cost Measures
CMS proposes revising the cost scoring benchmarking methodology starting in the 2024 performance period/2026 MIPS payment year. If finalized, these changes would take effect when the 2024 final scores are released in the summer of CY 2025. The proposed cost scoring methodology would use a new distribution for cost scoring, in which the median cost for a measure would be set at a score derived from the performance threshold

established for that MIPS payment year.

Topped-Out Measures
CMS proposes to remove the 7-point topped-out scoring cap for 16 measures related to specialties that CMS has determined are impacted by limited measure choice. For these measures, CMS will instead use a "defined topped out measure benchmark" that allows clinicians to score up to the maximum of 10 points. Dermatology measure Q440: Skin Cancer: Biopsy Reporting Time – Pathologist to Clinician (MIPS CQMs) and Q397: Melanoma Reporting (Medicare Part B Claims, MIPS CQMs) are among the measures that would fall under this policy. However, these measures are pathology measures and are not reportable by most non-dermatopathologists.

Transition: Traditional MIPS to MVPs
CMS is considering sunsetting traditional MIPS in CY 2028 and making MVP participation mandatory beginning in CY 2029. It is important to note that this is not a formal proposal but rather a potential timeline shared by CMS. The Academy strongly opposes the discontinuation of traditional MIPS and the mandatory adoption of MVPs.

Additional Resources

- CY 2025 Medicare PFS Proposed Rule
- CMS CY 2025 Medicare PFS Press Release
- CMS CY 2025 Medicare PFS Fact Sheet
- CMS CY 2025 QPP Fact Sheet
- CMS CY 2025 Proposed and Modified MVP Guide
- CMS CY 2025 MSSP ACO Fact Sheet
- CMS Rx Drug Inflation Rebate Program Fact Sheet