American College of Radiology

American College of Radiology Preliminary Summary of Radiology Provisions in the 2025 MPFS Final Rule

The Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2025 Medicare Physician Fee Schedule (MPFS) final rule on Friday, November 1, 2024. In this rule, CMS describes changes to payment provisions and to policies for the Medicare Shared Saving Program, Medicare Prescription Drug Inflation Rebate Program and Medicare Overpayments.

Conversion Factor and CMS Overall Impact Estimates
CMS finalized the CY 2025 conversion factor at $32.3465 compared to the 2024 conversion factor of $33.2875. This was calculated by removing the 1.25 percent provided by the Consolidated Appropriations Act of 2023 that applied to services furnished from January 1, 2024, through March 8, 2024, and the 2.93 percent payment increase provided by the Consolidated Appropriations Act of 2024 that replaced the previous 1.25 percent increase and applied to services furnished from March 9, 2024, through December 31, 2024. CMS then applied a positive 0.02 percent budget neutrality adjustment.

CMS estimates an overall impact of the MPFS changes to radiology, nuclear medicine and radiation oncology to be 0 percent, while interventional radiology will see an aggregate decrease of 2 percent under the finalized fee schedule.

Coverage of Computed Tomography Colonography (CTC) for Colorectal Cancer Screening
CMS used its statutory authority under the Balanced Budget Act of 1997 for the Secretary to add additional colorectal cancer screening tests and procedures to its definition of screening tests to finalize its proposal of coverage of CTC for Medicare beneficiaries. The rule points out that the U.S. Preventative Services Task Force (USPSTF) included CTC as a CRC screening method in its June 2016 revised Final Recommendation Statement and again in its May 2021 guideline update. CMS issued a non-coverage determination for CTC in 2009. CMS states that they will address and revise the current non-coverage policy for CTC.

In addition to the addition of coverage of CTC, CMS finalized its proposal to remove coverage of double contrast barium enema, stating that in the U.S., CTC has largely replaced double contrast barium enema as a radiographic option for colorectal cancer screening.

Valuation of Imaging Services
CMS accepted all of the radiology code values as proposed in July, including those for six new MR Safety procedures. CMS had proposed several reductions to the practice expense (PE) minutes for some of the MR Safety codes, but following stakeholder feedback, CMS made adjustments to some of its refinements. Staff will review and provide a detailed report in the coming weeks.

Potentially Misvalued Services
Two radiology codes were nominated as potentially misvalued in the proposed rule. Following stakeholder feedback, CMS maintains that CPT code 27279 (*Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes*

obtaining bone graft when performed and placement of transfixing device) should not be performed in the non-facility setting and should only be paid in the facility at this time. After careful consideration of the feedback received, CMS ruled this code to not be misvalued.
For CPT code(s) 10021, 10004,10005 and 10006 (Final needle aspiration), stakeholders petitioned CMS to reconsider accepting the RUC recommended values. However, CMS continues to affirm the belief that the valuation is accurate and reflects typical work and direct PE inputs. CMS has not nominated this code family as potentially misvalued.

Clinical Labor Update
In 2022, CMS began its four-year phase in to update the pricing for the clinical labor staff. This is the final year of the phase-in of the updates, and with no new wage data submitted by stakeholders, CMS finalized the values previously established by adding the last incremental price increase for CY 2025.

Practice Expense (PE) Data Collection/Methodology
In response to its solicitation for feedback on potential adjustments to the PE methodology, CMS shared that they received a "diversity of perspectives". One of the stakeholder concerns CMS highlighted relates to Software as a Medical Device and artificial intelligence (AI) and how these might be captured as direct costs. There was also support for CMS to wait for the American Medical Association's (AMA) new Physician Practice Information Survey (PPIS) data, anticipated to be shared with CMS after the reports are completed at the end of CY 2024. Commenters also urged CMS to collaborate with medical associations in this effort. As disclosed in the proposed rule, CMS has started a new contract with RAND to analyze and develop possible alternatives to the PE methodology.

Medicare Economic Index (MEI)
CMS received support from many stakeholders for its decision to delay the incorporation of the 2017-based MEI for CY 2025. These stakeholders are requesting that CMS wait for the AMA's new PPIS data collection effort to conclude. While some are supportive of having regular updates to the PPIS to minimize any large redistributive impacts, others feel this may become too burdensome of an effort, especially on smaller independent practices. A few individuals contend that SAS Census Bureau data is more reliable and objective and are in support of implementing the 2017-based MEI as soon as possible. CMS continues to consider and accept feedback from stakeholders.

Drugs and Biological Products Paid Under Medicare Part B
Requiring Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts
In rulemaking over the last few years, CMS finalized many policies to implement section 90004 of the Infrastructure Investment and Jobs Act, which established a refund for discarded amounts of certain single-dose container or single-use package drugs under Part B. CMS finalized clarifications to several policies implemented in the CY 2023 and CY 2024 PFS final rules, including: exclusions of drugs, for which payment has been made under Part B for fewer than 18 months, from the definition of refundable single-dose container or single-use package drug, and identifying single-dose containers. CMS also finalized a requirement that the JW modifier must

be used if a billing supplier is not administering a drug, but there are amounts discarded during the preparation process before supplying the drug to the patient. Finally, CMS finalized its proposal that skin substitutes will not be included in the identification of refundable drugs for the calendar quarters in 2025.

Payment for Radiopharmaceuticals in the Physician Office
In an effort to provide clarity on which methodologies are available to Medicare Administrative Contractors (MACs) for pricing of radiopharmaceuticals in the physician office setting, CMS finalized a clarification that, for radiopharmaceuticals furnished in a setting other than a hospital outpatient department, MACs shall determine payment limits for radiopharmaceuticals based on any methodology used to determine payment limits for radiopharmaceuticals in place on or prior to November 2003. Such a methodology may include, but is not limited to, the use of invoice-based pricing.

Direct Supervision via Use of Two-way Audio/Video Communications Technology
In the March 31, 2020, COVID-19 IFC, CMS changed the definition of "direct supervision" during the PHE for COVID-19 as it pertains to supervision of diagnostic tests, physicians' services, and some hospital outpatient services, to allow the supervising professional to be immediately available through virtual presence using two-way, real-time audio/video technology, instead of requiring their physical presence. CMS has previously extended this flexibility through rulemaking. The ACR provided comments supporting CMS's extension of this policy. CMS will consider the most appropriate way to balance patient safety concerns with the interest of supporting access that CMS may address in future rulemaking. CMS finalized its proposal to extend this flexibility for all services on a temporary basis only. CMS will 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. CMS noted in the final rule that most commentors requested that CMS make this flexibility permanent.

Medicare Shared Savings Program
As of January 1, 2024, the Shared Savings Program has 480 ACOs with over 634,000 healthcare providers and organizations providing care to over 10.8 million assigned beneficiaries in the Medicare Shared Savings Program (MSSP). CMS finalized a new "prepaid shared savings" option for eligible ACOs with a history of earning shared savings. ACOs that apply and are determined eligible to receive prepaid shared savings will receive advances of earned shared savings that they can use to make investments that will aid beneficiaries, such as investments in direct beneficiary services and investments to improve care coordination and quality through staffing or healthcare infrastructure. Eligible ACOs include those participating in Levels C-E of the BASIC track or the ENHANCED track with consistent prior success in earning shared savings in the Shared Savings Program. Eligible ACOs will be eligible for quarterly payments to invest in staffing, health care infrastructure, and additional services for beneficiaries. Under this approach at least 50% of prepaid shared savings will be required to be spent on direct beneficiary services, not otherwise payable in Traditional Medicare, that are evidence-based and medically appropriate for the beneficiary based on clinical and social risk

factors. Additionally, up to 50% of the prepaid shared savings can be spent on staffing and health care infrastructure.

Quality Payment Program (QPP)

Notably, the final rule includes significant changes to the MIPS Quality performance category scoring, likely to benefit radiologists.

Alternative Payment Model (APM) Performance Pathway
CMS will establish the APM Payment Pathway (APP) Plus quality measure set beginning in the CY 2025 performance period/2027 MIPS payment year. The APP Plus quality measure set will incrementally grow to be comprised of 11 measures, consisting of the six measures in the existing APP quality measure set and five new measures from the Adult Universal Foundation measure set. These 11 measures will be incrementally incorporated into the APP Plus quality measure set over performance year 2025 through performance year 2028, or the performance year that is one year after eCQM specifications become available for Quality IDs: 487 (Screening for Social Drivers of Health) and 493 (Adult Immunization Status), whichever is later.

Advanced APMs
CMS had proposed to amend the 6th criterion to use claims for all covered professional services to identify attribution-eligible beneficiaries for all Advanced APMs, beginning with performance year 2025. The sixth criterion identifies beneficiaries who have received certain services from an eligible clinician who is associated with an APM Entity for any period during the QP Performance Period. By no longer specifying a claim for E/M services as the default attribution basis in the sixth criterion, instead making the default attribution based on covered professional services, CMS aimed to eliminate the need to create unique attribution bases that are tied to a specific Advanced APM's attribution methodology. CMS had solicited comment on this proposal to revise the sixth criterion of the definition of "attribution-eligible beneficiary" at § 414.1305 to include a beneficiary who has at least one claim for a covered professional service furnished by an eligible clinician who is on the Participation List for the APM Entity (or by the individual eligible clinician, as applicable) at any determination date during the QP Performance Period. CMS did not finalize the proposed change to the definition of "attribution-eligible beneficiary."

MIPS Value Pathways (MVPs)
CMS introduced a new request for information (RFI) in the proposed rule, *Building upon the MIPS Value Pathways (MVPs) Framework to Improve Ambulatory Specialty Care*. This RFI invited public comments on how CMS should develop the MVP and the considerations it should take regarding the varying medical specialties eligible for this type of MVP. CMS thanked all commenters, including ACR, for this input on this potential MVP on the design of a future ambulatory specialty model.

In the proposed rule, CMS continued to collect comments through the *Transforming the Quality Payment Program RFI*, with questions regarding MVPs for non-patient-facing

specialties and developing MVPs based on existing Specialty Measure Sets for specialties that do not have MVP coverage. In the final rule, CMS thanked commenters for responding to the RFI and noted its plan to use the feedback submitted for consideration in future rulemaking.

MIPS Scoring Overview
The category weights for the 2025 performance year will remain the same as the 2022 weights: Quality – 30%, Cost – 30%, PI – 25%, and IAs – 15%. These percentages will likely remain fixed for the future of the MIPS program. Previously established reweighting formulas for non-patient-facing clinicians and small practices are set to continue with no changes. CMS will maintain the performance threshold at 75 points for 2025. This figure is based on the rounded mean final score from the 2017 performance year. The same threshold was used in performance years 2023 and 2024.

CMS finalized the payment adjustment of +/- nine percent for performance years 2020 and beyond. No changes were proposed to the MIPS adjustment. Additionally, CMS finalized its proposal of a reweighting policy, which will go into effect with the 2024 performance year. With this new policy, groups or individuals can request re-weighting of a performance category if a third-party intermediary to whom they delegated the responsibility of submitting their MIPS data failed to submit their data within the required timeframe.

CMS will maintain the small practice bonus of 6 points for the Quality performance category score and all previously finalized considerations for small practices.

Quality Category
CMS finalized its proposed change to the scoring of the Quality category to mitigate the difficulty that certain specialties—such as radiology—face due to the increasing number of measures being removed from the program or capped at seven points. Specifically, CMS will eliminate the seven-point cap on measures deemed to come from specialty sets with a limited number of measures available. For CY 2025, this will include all the topped-out Diagnostic Radiology measures (360, 364, 405, and 406).

The following measure was previously finalized for removal:

- #436: Radiation Consideration for Adult CT – Utilization of Dose Lowering Techniques

Measure #436 will be replaced with the following measure (#494), which was previously finalized for addition to the program in 2025:

- #494: Excessive Radiation Dose or Inadequate Image Quality for Diagnostic CT in Adults

As previously finalized, the quality measure data completeness threshold will remain at 75% for 2025.

Improvement Activities
CMS finalized its proposal to simplify the scoring of the Improvement Activities category by eliminating the weights associated with activities. Previously, activities were identified as either high-weight or medium-weight. With this new change, all activities will be weighted equally. Standard MIPS participants will be required to report two activities, while small, rural, and non-patient-facing clinicians and MVP participants will be required to report one activity.

CMS also finalized its proposal to add a new Population Management Improvement Activity titled "Implementation of Protocols and Provision of Resources to Increase Lung Cancer Screening Uptake".

Cost Performance Category
CMS finalized several new episode-based Cost measures unlikely to be attributed to radiology groups but may contain imaging in the cost calculations: Chronic Kidney Disease, End-Stage Renal Disease, Kidney Transplant Management, Prostate Cancer, and Rheumatoid Arthritis.

CMS published Fact Sheets on the overall MPFS final rule, the Quality Payment Program, the Shared Savings Program and a Press Release.

ACR staff and volunteer physician experts will review the entire MPFS final rule in the coming weeks and will provide a comprehensive summary of the rule.