CY 2025 Medicare Physician Fee Schedule (MPFS) CMS-1807- F, Final Rule Summary

Introductory Summary and Background

On November 1, 2024, the Centers for Medicare & Medicaid Services (CMS) issued the final rule for the Medicare Physician Fee Schedule (MPFS) for Calendar Year (CY) 2025.

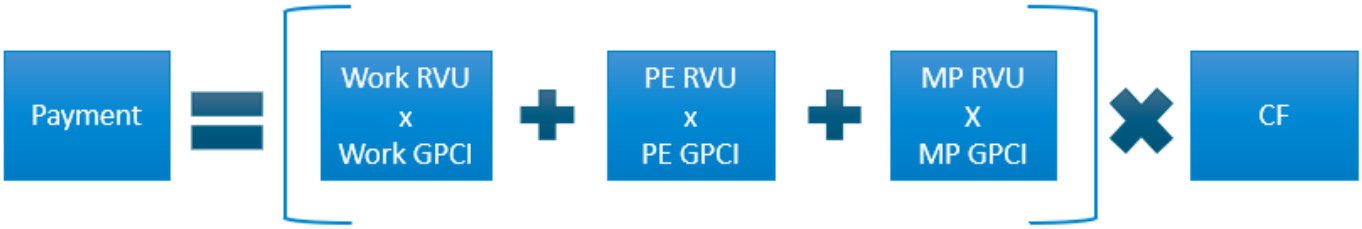
Since 1992, Medicare has paid for physician services under section 1848 of the Social Security Act entitled "Payment for Physicians' Services." This statute requires CMS to establish payments under the physician fee schedule (PFS) based on national uniform relative value units (RVUs) that account for the relative resources used in furnishing a service.

The statute requires that RVUs be established for three categories of resources:

- Work **(Work)** – services the physician provides.
- Practice Expense **(PE)** – resources that are used to provide physician services, such as office overhead and staff salaries.
- Malpractice **(MP)** expense – costs involved in malpractice insurance.

In addition, the statute requires CMS establish by regulation each year's payment amounts for all physicians' services paid under the PFS, incorporating geographic adjustments to reflect the variations in the costs of furnishing services in different geographic areas. This is referred to as the geographic practice cost indices **(GPCIs)**.

RVUs are converted to dollar amounts through the application of the conversion factor **(CF)**. The formula for calculating the MPFS is as follows:



Section 1848 of the Act requires CMS to maintain the budget within $20 million of the prior year's expenditures. In the event it is projected to exceed this amount, budget neutrality adjustments are made.

The final rule is 3,088 pages in length and located in its entirety at the following link: https://www.federalregister.gov/public-inspection/2024-25382/medicare-and-medicaid-programs-calendar-year-2025-payment-policies-under-the-physician-fee-schedule.

The following is intended to serve as a preliminary summary of the finalized changes. SIR is preparing a full summary and impact analysis that will be provided separately.

Changes to the MPFS Payment Rates

Conversion Factor (CF)

The CY 2025 conversion factor (CF) finalized at $32.3465, a decrease from CY 2024 CF of $33.2875. The decrease is due to expiration of the 2.93% ($0.94) which Congress only allowed for the single year of CY 2024, to calculate the factor which will convert RVUs into a dollar amount, CMS had to start with a 2.93% automatic

decrease. CMS was able to increase the CF by 0.02% due to budget neutrality.

The table below details the final conversion factor for CY 2025. It should be noted there is legislation in the works which would propose an increase in the conversion factor for another one-year patch. Because CMS is limited in the adjustments they can make, any changes would have to come from Congress. With the election year, the final rates for CY 2025 may not be set until after the new year begins, if any changes are passed.

TABLE 108: Calculation of the CY 2025 PFS Conversion Factor

CY 2024 Conversion Factor		33.2875
Conversion Factor without the CAA, 2024 (2.93 Percent Increase for CY 2024)		32.3400
CY 2025 Statutory Update Factor	0.00 percent (1.0000)	
CY 2025 RVU Budget Neutrality Adjustment	0.02 percent (1.0002)	
CY 2025 Conversion Factor		**32.3465**

Relative Value Units (RVUs)

Relative Value Units (RVUs) are assigned to all Current Procedural Terminology (CPT®) codes; RVUs are based on resource costs associated with physician work, practice expense (PE) and professional liability insurance (i.e., malpractice (MP)). The assigned RVUs are adjusted by geographic cost index (GPCIs) values, which reflect the variances in practice costs for locations throughout the country; essentially, how the cost-of-living impacts business costs. The Conversion Factor (CF) is a scaling factor used to convert geographically adjusted RVUs into dollar amounts.

Separate from a decrease in the conversion factor, CMS also finalized decreases in practice expense RVUs (i.e., clinical staff, equipment and supplies) in the non-facility setting. Many of these decreases will have an impact on interventional radiology services in the non-facility setting (e.g., office-based labs (OBLs)).

Per CMS the decreases in PE RVUs are largely due to the need to remain budget neutral (not exceed the set budget for CY 2025) and still provide the finalized payment increases for other specialties. For CMS to be within their projected budget, and remain budget neutral, they must pull monies where there may be a "surplus" to pay for the increases finalized. Because interventional radiology primarily relies on supplies and equipment for practice expense costs, and these can be high value, the final year of implementation for the update to clinical labor pricing and/or the adjustments to transfer of post-operative care for global surgical procedures would result in higher payments for IRs. However, CMS redistributes some of these increases to pay for work RVU increases for other specialties who do not have the practice expense items, like high value supplies and equipment to offset payment decreases for their services from CMS

CMS provided different tables outlining the estimated impact breakdown based on setting, non-facility vs. facility, for each specialty. The overall percentages are based on aggregate estimated allowed charges totaled across services by all providers for a specialty and compared to the previous year.

TABLE 110: CY 2025 PFS Estimated Impact on Total Allowed Charges by Specialty

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact ofÆ RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
Interventional Pain Management	$839	0%	0%	0%	0%
Interventional Radiology	$445	0%	-2%	0%	-2%
Radiology	$4,557	0%	0%	0%	0%
Vascular Surgery	$998	0%	-2%	0%	-2%

TABLE 111: CY 2025 PFS Estimated Impact on Total Allowed Charges by Setting

(A) Specialty	(B) Total Non-Facility/Facility	(C) Allowed Charges (mil)	(D) CombinedImpact
Interventional Pain Management	*TOTAL*	$839	0%
	Non-facility	$660	0%
	Facility	$179	0%
Interventional Radiology	*TOTAL*	$445	-2%
	Non-facility	$273	-3%
	Facility	$172	1%
Radiology	TOTAL	$4,557	0%
	Non-facility	$2,004	-1%
	Facility	$2,553	1%
Vascular Surgery	*TOTAL*	$998	-2%
	Non-facility	$715	-3%
	Facility	$283	0%

Practice Expense RVUs

CMS updated for the final year of the 4-year increase in the clinical labor rates, which was based off data provided by SIR in collaboration with the American Society of Radiologic Technologists (ASRT), in which radiologic technologist wage and salary survey data was submitted to CMS in 2022. These were last updated in CY 2002. Selected labor value changes from Table 8 of the final rules are included below. It should be noted that an increase in labor values is indicated for all the labor types reviewed by CMS.

TABLE 5: CY 2025 Clinical Labor Pricing

Labor Code	Labor Description	Source	CY 2021 Rate Per Minute	Final Y4 Rate Per Minute	Total % Change
L041A	Vascular Interventional Technologist	ASRT Wage Data	0.41	0.84	104%
L041B	Radiologic Technologist	BLS 29-2034	0.41	0.63	54%
L041C	Second Radiologic Technologist for Vertebroplasty	BLS 29-2034	0.41	0.63	54%
L043A	Mammography Technologist	ASRT Wage Data	0.43	0.79	84%
L046A	CT Technologist	ASRT Wage Data	0.46	0.78	70%
L047A	MRI Technologist	BLS 29-2035	0.47	0.76	62%

Specific Codes and Code Set Valuations

Within the CY 2025 final rule, CMS addressed multiple misvalued and/or proposed value changes to specific series of new and established CPT® codes. CMS sought input from stakeholders on 5 potentially misvalued codes. CMS explained their rationale for the changes is based on values recommended by the AMA Relative Value Scale Update Committee (RUC) and other organizations which CMS utilizes for assistance in setting appropriate values for codes.

Sacroiliac Joint Arthrodesis (CPT® code 27279)

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) (090 day global code) has been re-nominated as potentially misvalued, based on missing separate direct PE inputs for this code in the nonfacility/office setting. Currently, the CPT® code is priced under PFS in the facility setting only. The nominator had asked CMS to establish separate direct PE inputs for this code when the service is performed in the nonfacility/office setting, so that Medicare beneficiaries would have more access to this service.

In the CY 2024 final rule, CPT® code 27279 was not nominated as a potentially misvalued service due to the lack of agreement this service could be safely and effectively provided in the nonfacility/office setting. The nominator provided clinical studies to help support their claims that this service could be provided safely and effectively in the nonfacility/office setting, mainly the low complication rate as compared to other spinal procedures performed in the nonfacility/office setting. CMS recognized these studies reported "heterogeneous safety outcomes", meaning there was a lack of consistency in the safety outcomes. There were also unreported safety outcomes in these studies. CMS recognized the need for more information; and therefore, did not consider this code as potentially misvalued. However, CMS sought comments and additional studies to determine if this service should be priced under the PFS for the nonfacility/office setting.

CMS did not finalize to nominate CPT® 27279 as potentially misvalued. They indicated they continue to have concerns for the safety of this procedure to be performed in the office-based lab (OBL) and indicated the studies submitted for consideration in support were not supportive. CMS did indicate they would welcome new information, specifically published studies with sound methodology (for example, a systematic review or meta-analysis covering at least three databases) or new data.

Fine Needle Aspiration (CPT® codes 10021, 10004, 10005, and 10006)

CPT® code 10021 *(Fine needle aspiration biopsy, without imaging guidance; first lesion)*, CPT® code 10004 *(Fine needle aspiration biopsy, without imaging guidance; each additional lesion)*, CPT® code 10005 *(Fine needle aspiration biopsy, including ultrasound guidance; first lesion)* and CPT® code 10006 *(Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion)* were nominated as potentially misvalued. The request specifically asked CMS to review the work RVUs and accept the most recent RUC work RVU recommendations.

For 2025, CMS indicated they were appreciative of the comprehensive information submitted by the nominator; however, CMS did not support the nomination and determined that the codes were, in fact, not misvalued.

****New for 2025****

MRI-Monitored Transurethral Ultrasound Ablation (TULSA) of Prostate (CPT® codes 51721, 55881, and 55882)

At the April 2023 CPT Editorial Panel meeting, three new CPT® codes were approved for MRI-monitored transurethral ultrasound ablation (TULSA). These codes were surveyed for the September 2023 RUC meeting and recommendations submitted to CMS for inclusion in the CY 2025 PFS proposed rule.

In response to the proposed rule, CMS indicated they received comments from at least one party suggesting the intraservice times from the AMA RUC survey were too low and did not reflect "*the actual time needed to perform these very complex and critical procedures."* In addition, the commenter indicated they had internal tracking data which disputed the survey times.

CMS indicated the suggested times and RVUs were as follows.

> "For CPT® code 51721, the suggested intraservice times varied from 40 to 101 minutes, as opposed to the RUC-recommended 29 minutes. For CPT® code 55881, the suggested intraservice times varied from 140 to 279 minutes, as opposed to the RUC recommended 120 minutes. For CPT® code 55882, the suggested intraservice times varied from 170 to 317 minutes, as opposed to the RUC-recommended 125 minutes. Due to these increased intra-service times, the commenters also recommended a revised work RVU of 6.75 for CPT® code 51721, 13.13 for CPT® code 55881, and 16.20 for CPT® code 55882."

For CY 2025, CMS finalized the work RVUs and direct PE inputs for all 3 codes as proposed, which were the RUC-recommended values.

****New for 2025****

Percutaneous Radiofrequency Ablation (RFA) of Thyroid (CPT® codes 60660 and 60661)

In January 2024, the RUC surveyed CPT® codes 60660 *(Ablation of 1 or more thyroid nodule(s), one lobe or the isthmus, percutaneous, including imaging guidance, radiofrequency)* and its respective add-on CPT® code 60661 *(Ablation of 1 or more thyroid nodule(s), additional lobe, percutaneous, with imaging guidance, radiofrequency (List separately in addition to code for primary service)*. These codes were surveyed recommendations submitted to CMS for inclusion in the CY 2025 PFS proposed rule.

CMS did receive comments regarding the challenges of endocrinologists and reimbursement in the office setting for RFA of thyroid nodules. Specifically, the high cost of the RF electrode which the commenters believed was not valued appropriately. In response, CMS urged the commenters to submit invoices via email for consideration.

For CY 2025, CMS proposed and finalized the RUC-recommended work RVUs for both (5.75 for CPT® code 60660, and 4.25 for CPT® code 60661). In addition, CMS proposed and finalized the RUC-recommended direct PE inputs.

Ultrasound Elastography (CPT® codes 76981, 76982, and 76983)

This code family was flagged for re-review at the April 2023 RUC meeting by the new technology/new services screen. Due to increased utilization of CPT® code 76981 (Ultrasound, elastography; parenchyma (eg, organ)), the entire code family was resurveyed for the September 2023 RUC meeting.

For CY 2025, CMS proposed and finalized the RUC-recommended direct PE inputs without refinement for CPT® codes 76981, 76982, and 76983.

CT Guidance Needle Placement (CPT® code 77012)

CPT® code 77012 (Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation) was reviewed at the September 2023 RUC meeting to account for deferred updates to the vignette to reflect the typical patient until updated utilization data was available to reflect coding changes that occurred in 2019.

For CY 2025, CMS proposed and finalized the RUC-recommended work RVUs of 1.50 for CPT® code 77012. CMS also finalized the changes proposed to the RUC-recommended direct PE inputs.

CMS proposed and finalized changing the equipment room time for the CT room (EL007) to maintain the current 9 minutes of other (38 others) similar radiological supervision and interpretation (RS&I) codes. This refinement was made in the CY 2019 final rule. CMS believes it would not be appropriate to increase the room time for CPT® 77012 and not address the other codes' equipment room time. This was the only refinement to the direct PE CMS made, as they proposed and finalized the remaining PE inputs without refinement for CPT® 77012.

****New for 2025****

Telemedicine Evaluation and Management (E/M) Services (CPT® codes 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, and 98016)

In February 2023, the CPT Editorial Panel added a new Evaluation and Management (E/M) subsection to the draft CPT® codebook for Telemedicine Services. The Panel added 17 codes for reporting telemedicine E/M services. Changes were made to the code descriptors, and a new survey in September 2023 included code descriptors and times approved by the CPT® Editorial Panel in May 2023. SIR was one of the new specialties which participated in the second survey of members.

The new codes include four new patient synchronous audio-video (CPT® 98000-98003) and four audio-only visits (CPT® 98008-98011) and four established patient synchronous audio-video (CPT® 98004-98007) and four audio-only (CPT® 98012-98015) visits, a total of 16 new codes. The last code is CPT® 98016 which is a brief communication technology based, virtual check-in code.

With the addition of these new telehealth codes, the AMA CPT® Editorial Panel has deleted the current audio-only CPT® codes 99441-99443 effective January 1, 2025. CMS does have them listed on the telehealth list as "provisional" through December 31, 2024. The information from the RUC to CMS indicates the new codes, 98000-98015 describe services that would otherwise be provided in person, which means they are subject to consideration and valuation by CMS.

The RUC-recommended values for the audio-video visits are identical to the current in-person visits values. The audio-only have less work RVUs than in-person visits for some, but not all of the new 8 codes. The RUC stated this is due to the surveyed specialty societies, which reiterated throughout AMA Panel discussions, "the audio-video and in-person office visits require more physician work than the audio-only office visits."

CMS provided Table 14, see below, to show the comparison of the new telemedicine codes and their values to the final values of the current in-person outpatient E/M visits. It is the similarity in the values which CMS indicated they have issues with in recognizing the new code set.

TABLE 14: Comparison of Elements and Work RVU between Telemedicine E/M Codes (98000 through 98015) and Office/Outpatient E/M Codes (99202 through 99215)

	A	B	C	D	E	F	G	H
	Telemedicine E/M HCPCS	RUC-recommended Work RVU	Modality	Level of Medical Decision-Making	Time Threshold (minutes)	New or Established Patient?	Analogous Current Office/Outpatient E/M Code	Current Work RVU
1	98000	0.93	Audio/Video (A/V)	Straightforward	15	New	99202	0.93
2	98001	1.60	(A/V)	Low	30	New	99203	1.60
3	98002	2.60	(A/V)	Moderate	45	New	99204	2.60
4	98003	3.50	(A/V)	High	60	New	99205	3.50
5	98004	0.70	(A/V)	Straightforward	10	Established	99212	0.70
6	98005	1.30	(A/V)	Low	20	Established	99213	1.30
7	98006	1.92	(A/V)	Moderate	30	Established	99214	1.92
8	98007	2.60	(A/V)	High	40	Established	99215	2.60
9	98008	**0.90**	Audio-only	Straightforward	15	New	99202	0.93
10	98009	1.60	Audio-only	Low	30	New	99203	1.60
11	98010	**2.42**	Audio-only	Moderate	45	New	99204	2.60
12	98011	**3.20**	Audio-only	High	60	New	99205	3.50
13	98012	**0.65**	Audio-only	Straightforward	10	Established	99212	0.70
14	98013	**1.20**	Audio-only	Low	20	Established	99213	1.30
15	98014	**1.75**	Audio-only	Moderate	30	Established	99214	1.92
16	98015	**2.60**	Audio-only	High	40	Established	99215	2.80

For CY 2025, CMS has finalized to not recognize the 16 audio-video and audio-only codes. Instead, CMS has assigned CPT® codes 98000-98015 a procedure status indicator of "I", which means there is a more specific code (i.e., existing office/outpatient E/M codes 99202-99215) to be used for Medicare. Providers who provide E/M services to Medicare beneficiaries will need to utilize the office/outpatient E/M codes 99202-99215 and apply modifier 95 when providing the visit using audio-video capabilities. Additionally, providers in the office setting will be required to apply a place of service (POS) code (e.g., 02 and 10) which identifies where the patient is located.

Effective January 1, 2025, the pre-pandemic geographic location and site of service restrictions will once again be in place. This means patients will have to be at an originating site like a rural hospital while the physician performing the audio-video telemedicine visit is at a distant site. There will be a few exceptions. Behavioral health services and ESRD-related clinical assessments are excluded from reverting back to the pre-pandemic telehealth policy. All other services using telemedicine/telehealth services for any Medicare beneficiaries will only be available in rural areas, and only when the patient is in certain types of medical settings.

Note, in addition to the new 16 codes not recognized, Medicare will also not reimburse for any audio-only visits in CY 2025, any audio-only services will be counted as pre or post time for the next or previous encounter with the patient.

Separately, the new brief communication, virtual check-in code 98016 was finalized to be implemented by CMS. Due to this, CMS is deleting HCPCS G2012 and accepted the RUC-recommended values work RVU of 0.30 and direct PE inputs for 98016.

The following table outlines the finalized values for codes which are specific to interventional radiology and/or SIR was active in with the AMA process.

CY 2025 Medicare RVUs for Recent RUC Surveyed Codes							
HCPCS	MODIFIER	DESCRIPTION	WORK RVU	NON-FAC PE RVU	FACILITY PE RVU	MP RVU	CY 2025 RATE
51721*		Ins trurl ablt trnsdc thr us	4.05	11.70	1.92	0.50	$525.63
55881*		Ablt trurl prst8 tis thrm us	9.80	252.08	3.59	1.17	$8,508.75
55882*		Ablt trurl prst8 tis trnsdcr	11.50	259.18	4.88	1.53	$8,805.04
60660*		Abltj 1/+thyr ndul 1lobe prq	5.75	67.15	2.72	1.02	$2,391.05
60661*		Abltj 1/+thyr ndul addl prq	4.25	7.01	1.59	0.73	$387.83
76981		Use parenchyma	0.59	2.53	NA	0.05	$102.54
76981	TC	Use parenchyma	0.00	2.30	NA	0.02	$75.04
76981	26	Use parenchyma	0.59	0.23	0.23	0.03	$27.49
76982		Use 1st target lesion	0.59	2.14	NA	0.04	$89.60
76982	TC	Use 1st target lesion	0.00	1.92	NA	0.01	$62.43
76982	26	Use 1st target lesion	0.59	0.22	0.22	0.03	$27.17
76983		Use ea addl target lesion	0.47	1.28	NA	0.03	$57.58
76983	TC	Use ea addl target lesion	0.00	1.08	NA	0.01	$35.26
76983	26	Use ea addl target lesion	0.47	0.20	0.20	0.02	$22.32
77012		Ct scan for needle biopsy	1.50	2.19	NA	0.09	$122.27
77012	TC	Ct scan for needle biopsy	0.00	1.71	NA	0.01	$55.64
77012	26	Ct scan for needle biopsy	1.50	0.48	0.48	0.08	$66.63
98016		Brief comunicaj tech-bsd svc	0.30	0.17	0.13	0.02	$15.85

*New CPT® code for CY 2025.

Physician Supervision via Two-way Audio/Video

Residents in Teaching Settings

In previous rule making, CMS established a policy that allows teaching physicians to fulfil supervision requirements by being present for the key or critical portions of services through audio/video real-time communications technology, when services are provided by a resident. This policy was only valid for services furnished in residency training sites that are located outside of an Office of Management and Budget (OMB) – defined metropolitan statistical area (MSA). This distinction was made to increase beneficiary access to Medicare-covered services in rural areas.

For CY 2025, CMS will continue to allow the teaching physician to have a virtual presence in all teaching settings, but only in clinical instances when the service is furnished virtually (3-way telehealth visit, with all parties in separate locations). This allows teaching physicians to have a virtual presence during the key portion of the Medicare telehealth service through real-time audio/video communication for all residency training locations extended through December 31, 2025.

Strategies for Improving Global Surgery Payment Accuracy

CMS has long held concerns that services assigned 90-day surgical global period, were reimbursing physicians for post operative care visits which were ultimately not performed. Because procedures which are assigned a 90-day global, the follow-up visits are included in the valuation of the procedure code. To better recognize the transfer of care by the surgeon/proceduralist to a physician who will be providing the follow-up care, CMS has revised their policy for use of modifier -54. Additionally, CMS has created an HCPCS code, G0559, for the physician who did not perform the procedure, but is now managing the follow-up of the patient as a way to recoup the work provided. These changes only pertain to 90-day global procedures. The current list of 90 and 10-day global surgical codes can be accessed on the SIR website.

Regarding Transfer of Care Following Surgical Procedure for 90-Day Global

For CY 2025, CMS finalized with revision to broaden the applicability of transfer of care modifier -54. Beginning January 1, 2025, modifier -54 will be required for all 90-day global surgical packages *"in any case when a practitioner plans to furnish only the surgical procedure portion of the global package (including both formal and other transfers of care)."*

Add-on Code for Post-operative Care by Practitioner Other Than Surgeon

For CY 2025, CMS finalized a new add-on HCPCS code to account for the work and time spent by a physician who is providing post-operative follow-up care to a patient for which they did not perform the surgical procedure and were not part of the formal transfer agreement. This will allow the physician to recoup and bill for the time and effort spent getting up to speed on the surgical procedure and status of the patient they are now managing.

HCPCS G0559 can only be reported with an office or other outpatient E/M visit for the evaluation and management of a new or established patient. G0559 is only billable once by the provider, as it would only be the initial visit they would need to spend the extra time and resources getting up to speed on things; therefore, it would be assigned a ZZZ global surgical period payment indicator. CMS did clarify it may be billed by another practitioner of the same specialty as the proceduralist but cannot be of the same practice or group as the proceduralist. Practitioners can bill for G0559 regardless of whether the proceduralist billed the procedure with or without modifier -54 to indicate a transfer of care.

HCPCS G0559 - (*Post-operative follow-up visit complexity inherent to evaluation and management services addressing surgical procedure(s), provided by a physician or qualified health care professional who is not the practitioner who performed the procedure (or in the same group practice) and is of the same or of a different specialty than the practitioner who performed the procedure, within the 90-day global period of the procedure(s), once per 90-day global period, when there has not been a formal transfer of care and requires the following required elements, when possible and applicable:*

- *Reading available surgical note to understand the relative success of the procedure, the anatomy that was affected, and potential complications that could have arisen due to the unique circumstances of the patient's operation.*
- *Research the procedure to determine expected post-operative course and potential complications (in the case of doing a post-op for a procedure outside the specialty).*
- *Evaluate and physically examine the patient to determine whether the post-operative course is progressing appropriately.*
- *Communicate with the practitioner who performed the procedure if any questions or concerns arise. (List separately in addition to office/outpatient evaluation and management visit, new or established)).*

Medicare Economic Index (MEI)

The Medicare Economic Index (MEI) relates to the reasonable charge-based payment methodology in place for physicians' services prior to MPFS. For services after June 30, 1973, the charge levels could not exceed the level from the previous year except when the Secretary determines, based on appropriate economic index data, a higher level is justified by year-to-year economic changes. CMS began calculating the MEI on July 1, 1975, and continues to do so today for several statutory and other purposes. The MEI reflects the weighted-average annual price change for various inputs involved in furnishing physicians' services.

The MEI is a fixed-weight input price index comprised of two broad categories: (1) physicians' own time (compensation); and (2) physicians' practice expense (PE). The current 2006-based MEI is based on data collected by the AMA for self-employed physicians from the Physician Practice Information Survey (PPIS). The AMA had not conducted another survey since the 2006 data collection effort; however, the survey is underway and expected to be completed by end of CY 2024.

CMS finalized the update to the 2025 MEI is 3.5 percent, slightly less than proposed. This is based on historical data and pending the results of the AMA PPIS survey, results expected at the end of 2024, they will consider other comments in future rulemaking.