Legislative, Practice Management, and Coding Updates for 2025

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PRACTICE **POINTS**

- The Centers for Medicare & Medicaid Services released the 2025 Medicare Physician Fee Schedule final rule on November 1, 2024, setting the 2025 conversion factor at $32.35—a 2.83% reduction from 2024.
- With this change, dermatology practices may see an overall 2.83% reduction in payments in 2025 compared to 2024, although individual outcomes will vary based on practice mix.
- The American Academy of Dermatology Association continues to advocate for change, and members need to urge their federal legislators to support critical bills aimed at reforming Medicare physician payment.

This column highlights the ongoing instability of the Medicare Physician Fee Schedule (MPFS) and its impact on physicians and their ability to provide care for patients in 2025. An overview of key coding updates and changes, telehealth flexibilities, and a new dermatology-focused Merit-based Incentive Payment System (MIPS) Value Pathways is provided.

Health care costs continue to increase in 2025 while physician reimbursement continues to decrease. Of the $4.5 trillion spent on health care in 2022, only 20% was spent on physician and clinical services.[1] Since 2001, practice expense has risen 47%, while the Consumer Price Index has risen 73%; adjusted for inflation, physician reimbursement has declined 30% since 2001.[2]

The formula for Medicare payments for physician services, calculated by multiplying the conversion factor (CF) by the relative value unit (RVU), was developed by the Centers for Medicare & Medicaid Services (CMS) in 1992. The combination of the physician's work, the practice's expense, and the cost of professional liability insurance make up RVUs, which are aligned by geographic index adjustments.[3] The 2024 CF was $32.75, compared to $32.00 in 1992. The proposed 2025 CF is $32.35, which is a 10% decrease since 2019 and a 2.8% decrease relative to the 2024 Medicare Physician Fee Schedule (MPFS). The 2.8% cut is due to expiration of the 2.93% temporary payment increase for services provided by the Consolidated Appropriations Act 2024 and the supplemental relief provided from March 9, 2024, to December 31, 2024.[4] If the CF had increased with inflation, it would have been $71.15 in 2024.[4]

Declining reimbursement rates for physician services undermine the ability of physician practices to keep their doors open in the face of increased operating costs. Faced with the widening gap between what Medicare pays for physician services and the cost of delivering value-based, quality care, physicians are urging Congress to pass a reform package to permanently strengthen Medicare.

Herein, an overview of key coding updates and changes, telehealth flexibilities, and a new dermatology-focused Merit-based Incentive Payment System (MIPS) Value Pathways is provided.

Update on the Medicare Economic Index Postponement

Developed in 1975, the Medicare Economic Index (MEI) is a measure of practice cost inflation. It is a yearly calculation that estimates the annual changes in physicians' operating costs to determine appropriate Medicare physician payment updates.[5] The MEI is composed of physician practice costs (eg, staff salaries, office space, malpractice insurance) and physician compensation (direct earnings by the physician). Both are used to calculate adjustments to Medicare physician payments to account for inflationary increases in health care costs. The MEI for 2025 is projected to increase by 3.5%, while physician payment continues to dwindle.[5] This disparity between rising costs

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and declining physician payments will impact patient access to medical care. Physicians may choose to stop accepting Medicare and other health insurance, face the possibility of closing or selling their practices, or even decide to leave the profession.

The CMS has continued to delay implementation of the 2017 MEI cost weights (which currently are based on 2006 data[5]) for RVUs in the MPFS rate setting for 2025 pending completion of the American Medical Association (AMA) Physician Practice Information Survey.[6] The AMA contracted with an independent research company to conduct the survey, which will be used to update the MEI. Survey data will be shared with the CMS in early 2025.[6]

Future of Telehealth is Uncertain

On January 1, 2025, many telehealth flexibilities were set to expire; however, Congress passed an extension of the current telehealth policy flexibilities that have been in place since the COVID-19 pandemic through March 31, 2025.[7] The CMS recognizes concerns about maintaining access to Medicare telehealth services once the statutory flexibilities expire; however, it maintains that it has limited statutory authority to extend these Medicare telehealth flexibilities.[8] There will be originating site requirements and geographic location restrictions. Clinicians working in a federally qualified health center or a rural health clinic would not be affected.[8]

The CMS rejected adoption of 16 of 17 new *Current Procedural Terminology* (*CPT*) codes (98000–98016) for telemedicine evaluation and management (E/M) services, rendering them nonreimbursable.[8] Physicians should continue to use the standard E/M codes 99202 through 99215 for telehealth visits. The CMS only approved code 99016, which will replace Healthcare Common Procedure Coding System code G2012, for brief virtual check-in encounters. The CMS specified that *CPT* codes 99441 through 99443, which describe telephone E/M services, have been removed and are no longer valid for billing. Asynchronous communication (eg, store-and-forward technology via an electronic health record portal) will continue to be reported using the online digital E/M service codes 99421, 99422, and 99423.[8]

Practitioners can use their enrolled practice location instead of their home address when providing telehealth services from home.[8] Teaching physicians will continue to be allowed to have a virtual presence for purposes of billing for services involving residents in all teaching settings, but only when the service is furnished remotely (ie, the patient, resident, and teaching physician all are in separate locations). The use of real-time audio and video technology for direct supervision has been extended through December 31, 2025, allowing practitioners to be immediately available virtually. The CMS also plans to permanently allow virtual supervision for lower-risk services that typically do not require the billing practitioner's physical presence or extensive direction (eg, diagnostic tests, behavioral health, dermatology, therapy).[8]

It is essential to verify the reimbursement policies and billing guidelines of individual payers, as some may adopt policies that differ from the AMA and CMS guidelines.

When to Use Modifiers -59 and -76

Modifiers -59 and -76 are used when billing for multiple procedures on the same day and can be confused. These modifiers help clarify situations in which procedures might appear redundant or improperly coded, reducing the risk for claim denials and ensuring compliance with coding guidelines. Use modifier -59 when a procedure or service is distinct or separate from other services performed on the same day (eg, cryosurgery of 4 actinic keratoses and a tangential biopsy of a nevus). Use modifier -76 when a physician performs the exact same procedure multiple times on the same patient on the same day (eg, removing 2 nevi on the face with the same excision code or performing multiple biopsies on different areas on the skin).[9]

What Are the Medical Team Conference *CPT* Codes?

Dermatologists frequently manage complex medical and surgical cases and actively participate in tumor boards and multidisciplinary teams conferences. It is essential to be familiar with the relevant *CPT* codes that can be used in these scenarios: *CPT* code 99366 can be used when the medical team conference occurs face-to-face with the patient present, and *CPT* code 99367 can be used for a medical team conference with an interdisciplinary group of health care professionals from different specialties, each of whom provides direct care to the patient.[10] For *CPT* code 99367, the patient and/or family are not present during the meeting, which lasts a minimum of 30 minutes or more and requires participation by a physician. *Current Procedural Terminology* code 99368 can be used for participation in the medical team conference by a nonphysician qualified health care professional. The reporting participants need to document their participation in the medical team conference as well as their contributed information that explains the case and subsequent treatment recommendations.[10]

No more than 1 individual from the same specialty may report *CPT* codes 99366 through 99368 at the same encounter.[10] Codes 99366 through 99368 should not be reported when participation in the medical team conference is part of a facility or contractually provided by the facility such as group therapy.[10] The medical team conference starts at the beginning of the review of an individual patient and ends at the conclusion of the review for coding purposes. Time related to record-keeping or report generation does not need to be reported. The reporting participant needs to be present for the entire conference. The time reported is not limited to the time that the participant is communicating with other team members or the patient and/or their family/caregiver(s). Time reported for medical team conferences may not be used in the determination for other services, such as care plan oversight (99374-99380), prolonged services (99358, 99359), psychotherapy, or any E/M service. When the patient is present for any part of the duration

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of the team conference, nonphysician qualified health care professionals (eg, speech-language pathologists, physical therapists, occupational therapists, social workers, dietitians) report the medical team conference face-to-face with code 99366.[10]

Update on Excimer Laser *CPT* Codes

The CMS rejected values recommended for *CPT* codes (96920-96922) by the Relative Value Scale Update Committee, proposing lower work RVUs of 0.83, 0.90, and 1.15, respectively (Table).[2,11] The *CPT* panel did not recognize the strength of the literature supporting the expanded use of the codes for conditions other than psoriasis. Report the use of excimer laser for treatment of vitiligo, atopic dermatitis, and alopecia areata using *CPT* code 96999 (unlisted special dermatological service or procedure).[11]

Update on the New G2211 Code

Healthcare Common Procedure Coding System code G2211 is an add-on complexity code that can be reported with all outpatient E/M visits to better account for additional resources associated with primary care or similarly ongoing medical care related to a patient's single serious condition or complex condition.[12] It can be billed if the physician is serving as the continuing focal point for all the patient's health care service needs, acting as the central point of contact for the patient's ongoing medical care, and managing all aspects of their health needs over time. It is not restricted based on specialty, but it is determined based on the nature of the physician-patient relationship.[12]

Code G2211 should not be used for the following scenarios: (1) care provided by a clinician with a discrete, routine, or time-limited relationship with the patient, such as a routine skin examination or an acute allergic contact dermatitis; (2) conditions in which comorbidities are not present or addressed; (3) when the billing clinician has not assumed responsibility for ongoing medical care with consistency and continuity over time; and (4) visits billed with modifier -25.[12] In the 2025 MPFS, the CMS is proposing to allow payment of G2211 when the code is reported by the same practitioner on the same day as an annual wellness visit, vaccine administration, or any Medicare Part B preventive service furnished in the office or outpatient setting (ie, creating a limited exception to the prohibition of using this code with modifier -25).[2]

Documentation in the medical record must support reporting code G2211 and indicate a medically reasonable and necessary reason for the additional RVUs (0.33 and additional payment of $16.05).[12]

TABLE. ***Current Procedural Terminology*** **Codes for Excimer Laser**

CPT code	Description	2024 Payment value, $	2025 Proposed payment value, $
96920	Laser treatment of skin areas <250 cm^2	155.45	134.93
96921	Laser treatment of skin areas 250-500 cm^2	170.45	144.63
96922	Laser treatment of skin areas >500 cm^2	232.01	182.81

Abbreviation: *CPT*, *Current Procedural Terminology.*

Underutilization of Z Codes for Social Determinants of Health

Barriers to documentation of social determinants of health (SDOH)–related International Classification of Diseases, Tenth Revision, Z codes (Z55-Z66)(eTable 1), include lack of clarity on who can document patients' social needs, lack of systems and processes for documenting and coding SDOH, unfamiliarity with these Z codes, and a low prioritization of collecting these data.[13] Documentation of a SDOH-related Z code relevant to a patient encounter is considered moderate risk and can have a major impact on a patient's overall health, unmet social needs, and outcomes.[13] If the other 2 medical decision-making elements (ie, number and complexity of problems addressed along with amount and/or complexity of data to be reviewed and analyzed) for the E/M visit also are moderate, then the encounter can be coded as level 4.[13]

New Codes for Alopecia and Acne Surgery

New International Classification of Diseases, Tenth Revision, Clinical Modification, codes for alopecia have been developed through collaboration of the American Academy of Dermatology Association and the Scarring Alopecia Foundation (eTable 2). Cutaneous extraction—previously coded as acne surgery (*CPT* code 10040)—will now be listed in the 2026 *CPT* coding manual as "extraction" (eg, marsupialization, opening of multiple milia, acne comedones, cysts, pustules).[14]

Quality Payment Program Update

The MIPS performance threshold will remain at 75 for the 2025 performance period, impacting the 2027 payment year.[15] The MIPS Value Pathways will be available but optional in 2025, and the CMS plans to fully replace MIPS by 2029. The goal for the MVPs is to reduce the administrative burden of MIPS for physicians and their staff while simplifying reporting; however, there are several concerns. The MIPS Value Pathways build on the MIPS's flawed processes; compare the cost for one condition to the quality of another; continue to be burdensome to physicians; have not demonstrated improved patient care; are a broad, one-size-fits-all model that could lead

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to inequity based on practice mix; and are not clinically relevant to physicians and patients.[15]

Beginning in 2025, dermatologists also will have access to a new high-priority quality measure—Melanoma: Tracking and Evaluation of Recurrence—and the Melanoma: Continuity of Care–Recall System measure (MIPS measure 137) will be removed starting in 2025.[15]

What Can Dermatologists Do?

With the fifth consecutive year of payment cuts, the cumulative reduction to physician payments has reached an untenable level, and physicians cannot continue to absorb the reductions, which impact access and ability to provide patient care. Members of the American Academy of Dermatology Association must urge members of Congress to stop the cuts and find a permanent solution to fix Medicare physician payment by asking their representatives to cosponsor the following bills in the US House of Representatives and Senate[16]:

- *HR 10073*—The Medicare Patient Access and Practice Stabilization Act of 2024 would stop the 2.8% cut to the 2025 MPFS and provide a positive inflationary adjustment for physician practices equal to 50% of the 2025 MEI, which comes down to an increase of approximately 1.8%.[17]
- *HR 2424*—The Strengthening Medicare for Patients and Providers Act would provide an annual inflation update equal to the MEI for Medicare physician payments.[18]
- *HR 6371*—The Provider Reimbursement Stability Act would revise budget neutrality policies that contribute to eroding Medicare physician reimbursement.[19]
- *S 4935*—The Physician Fee Stabilization Act would increase the budget neutrality trigger from $20 million to $53 million.[20]

Advocacy is critically important: be engaged and get involved in grassroots efforts to protect access to health care, as these cuts do nothing to curb health care costs.

Final Thoughts

Congress has failed to address declining Medicare reimbursement rates, allowing cuts that jeopardize patient access to care as physicians close or sell their practices. It is important for dermatologists to attend the American Medical Association's National Advocacy Conference in February 2025, which will feature an event on fixing Medicare. Dermatologists also can join prominent House members in urging Congress to reverse Medicare cuts and reform the physician payment system as well as write to their representatives and share how these cuts impact their practices and patients.

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APPENDIX

eTABLE 1. ICD-10 Codes for Social Determinants of Health

ICD-10 code	Social Determinant of Health
Z55	Problems related to education and literacy
Z56	Problems related to employment and unemployment
Z57	Occupational exposure to risk factors
Z58	Problems related to physical environment
Z59	Problems related to housing and economic circumstances
Z60	Problems related to social environment
Z61	Problems related to negative events in childhood
Z62	Problems related to upbringing
Z63	Other problems related to primary support group, including family circumstances
Z64	Problems related to certain psychosocial circumstances
Z65	Problems related to other psychosocial circumstances

Abbreviation: ICD-10, International Classification of Diseases, Tenth Revision.

eTABLE 2. ICD-10-CM Codes for Scarring Alopecia

ICD-10-CM Code	Revisions/Update
Lichen planopilaris (L66.1)	
L66.10	Lichen planopilaris, unspecified
L66.11	Classic lichen planopilaris; follicular lichen planus
L66.12	Frontal fibrosing alopecia
L66.19	Other lichen planopilaris; Graham-Little-Piccardi-Lassueur syndrome
Other cicatricial alopecia (L66.8)	
L66.81	Central centrifugal cicatricial alopecia
L66.89	Other cicatricial alopecia

Abbreviation: ICD-10-CM, International Classification of Diseases, Tenth Revision, Clinical Modification.

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