How Updates to the PE Methodology Harm Office-Based Procedures

Clinical Labor Updates Caused Significant Harm to Office-Based Procedures

Updates to clinical labor valuations (implemented from 2022-2025) in the 2022 PFS were intended to update clinical labor data but have led to significant reimbursement cuts to office-based procedural care due to flaws in the Physician Fee Schedule (PFS).[1]

These cuts disproportionately affect office-based procedures requiring advanced technology, high-cost supplies, and equipment, widening the payment gap between hospitals and office-based care. Payment disparities are so severe and nonsensical that they distort rational market economics and choke access to critical care.

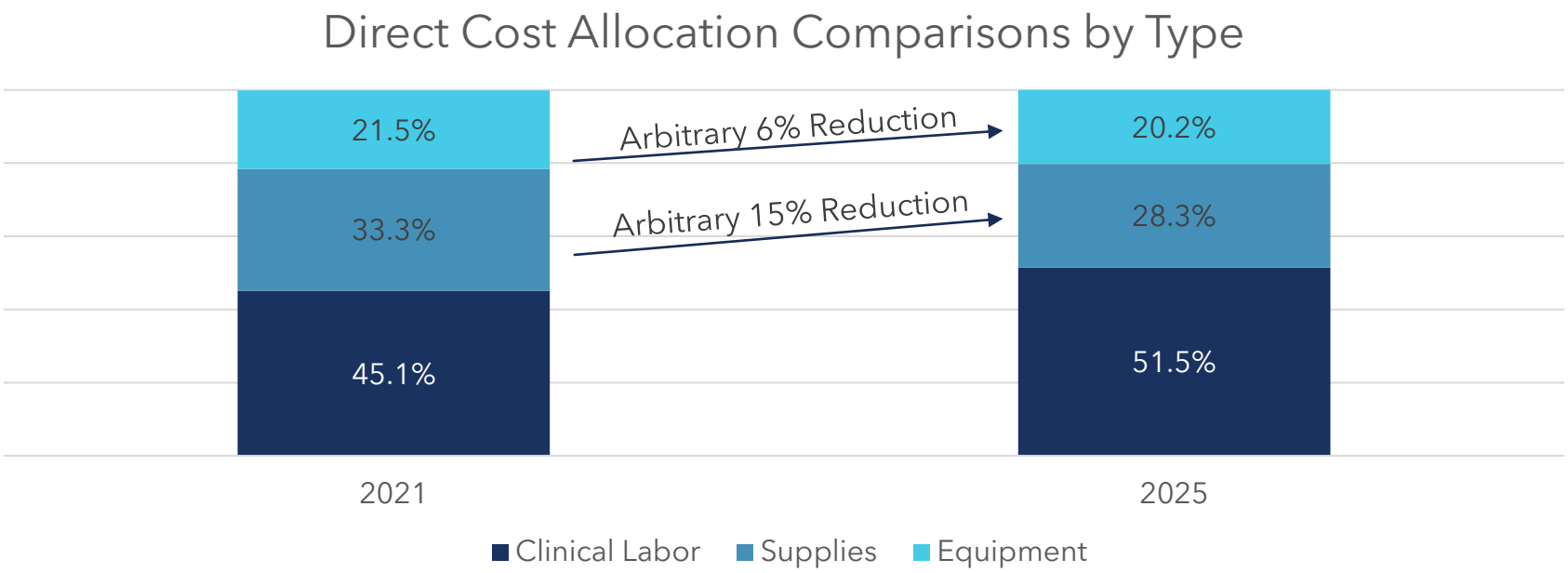
At least 300 CPT codes in the PFS are now reimbursed below cost, jeopardizing the financial viability of office-based specialists. While CMS has acknowledged the issue, no action has been taken, threatening patient access to high-quality, cost-effective care.

[1] Many terms are synonymous with the office-setting, including “freestanding,” “non-facility,” or “place of service 11” and many office-based providers are private practice, independent physicians, or small business.

Causes

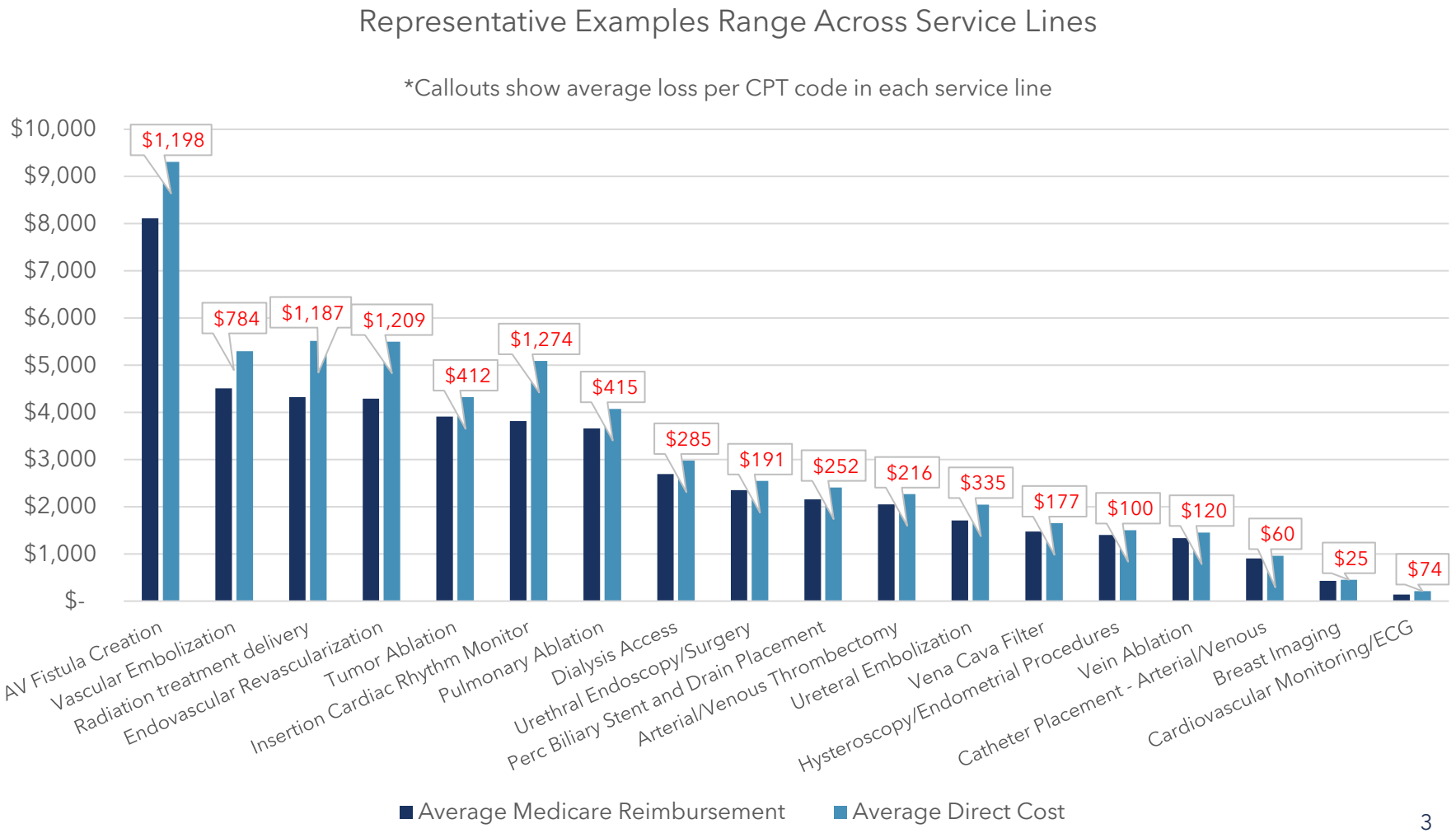
Flawed Reimbursement Structure – The Physician Fee Schedule (PFS) was designed to reimburse for physician work, not high-cost supplies and equipment. In contrast, the Hospital Outpatient Prospective Payment System (HOPPS) *was* designed for high-cost supplies and equipment.

Direct Cost Adjustment – To offset the 2022 PFS increase to clinical labor costs, the PFS "direct scaling adjustment" inadvertently devalued supply and equipment costs, despite their actual costs increasing.



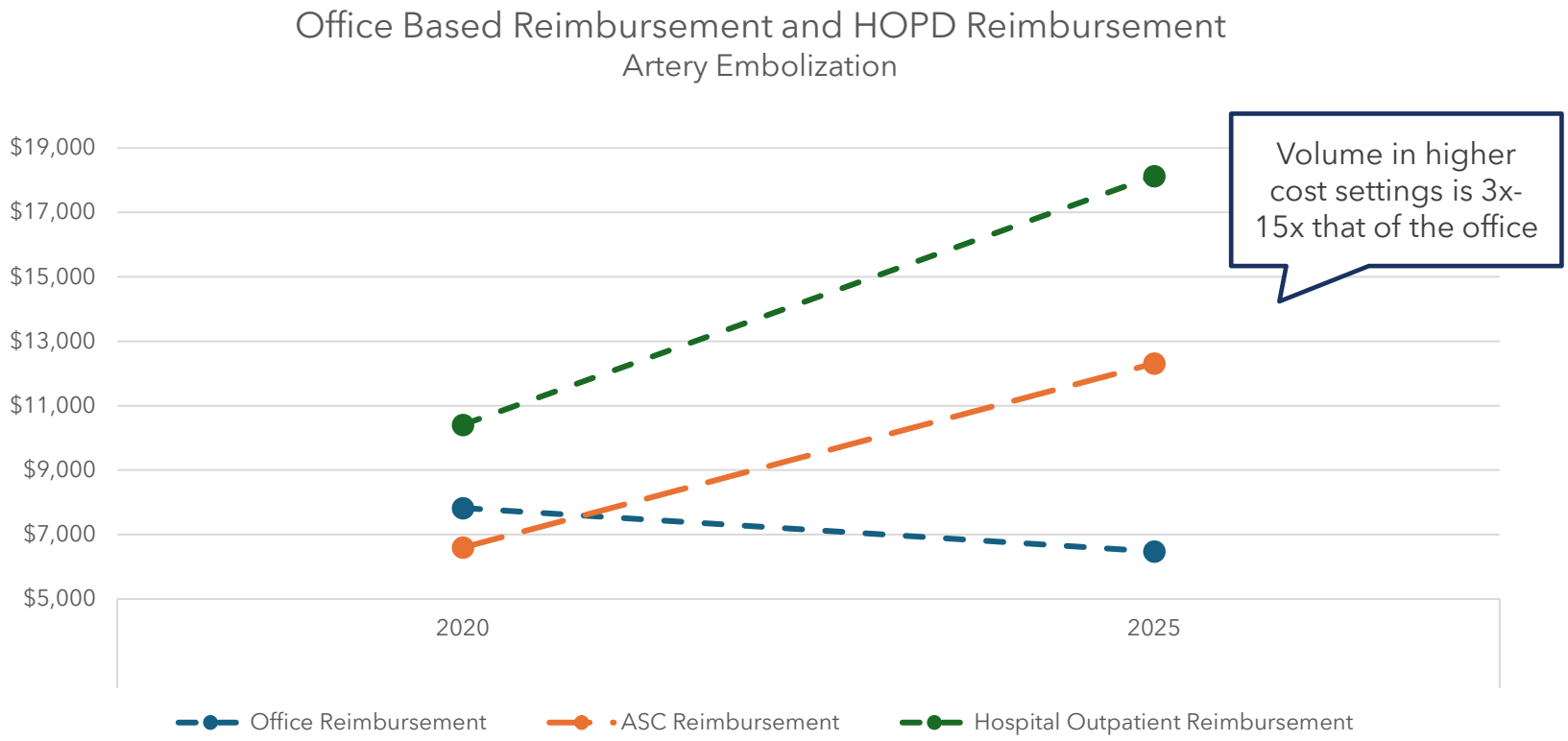
Medicare Physician Fee Schedule Reimbursement is Less Than Costs for At Least 300 Office-Based Interventional and Related Services in the PFS

In 2025, according to CMS data, there are 300 CPT codes – all office-based codes in the community setting – for which total reimbursement is less than their direct costs. In other words, payment is insufficient for these codes before even considering the added costs associated with indirect costs, provider work, and malpractice insurance. ***This number grew from 195 in 2024 (an increase of 50%) showing the urgency of the problem.***



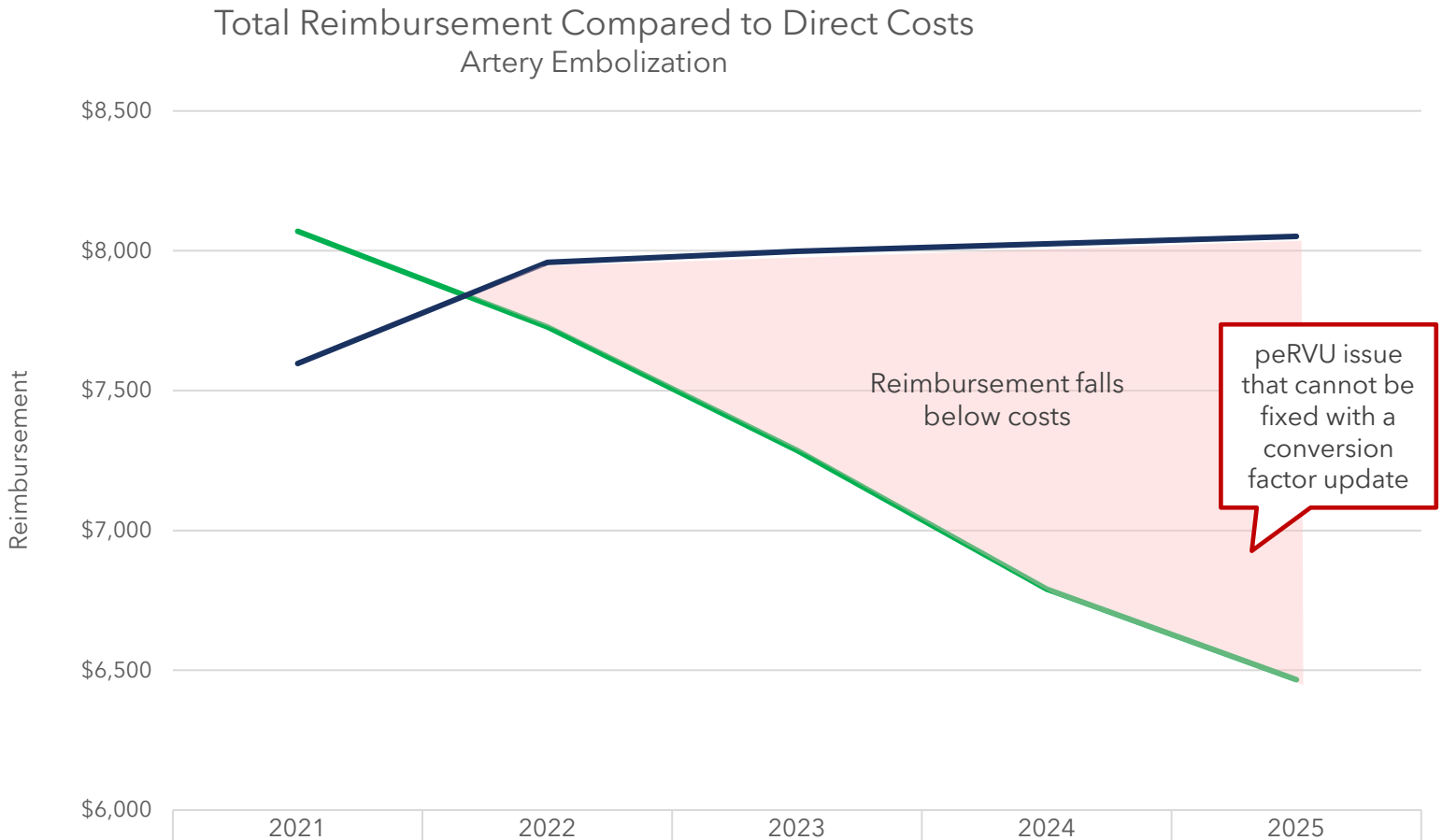
1. Data is based on 2025 Physician Fee Schedule Final Rule Total Non-Facility Reimbursement and Total Direct Costs.
2. Radiation Treatment Delivery data assumes 25 fractions for typical prostate cancer patient. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9441303/ .

Growing Payment Disparities - Example



	2020 Payment	2025 Payment	$ Change	% Change
Office	$7,824	$6,474	**($1,349)**	**(17.2%)**
ASC	$6,597	$12,311	**$5,714**	**86.6%**
Outpatient Hospital	$10,408	$18,130	**$7,722**	**74.2%**

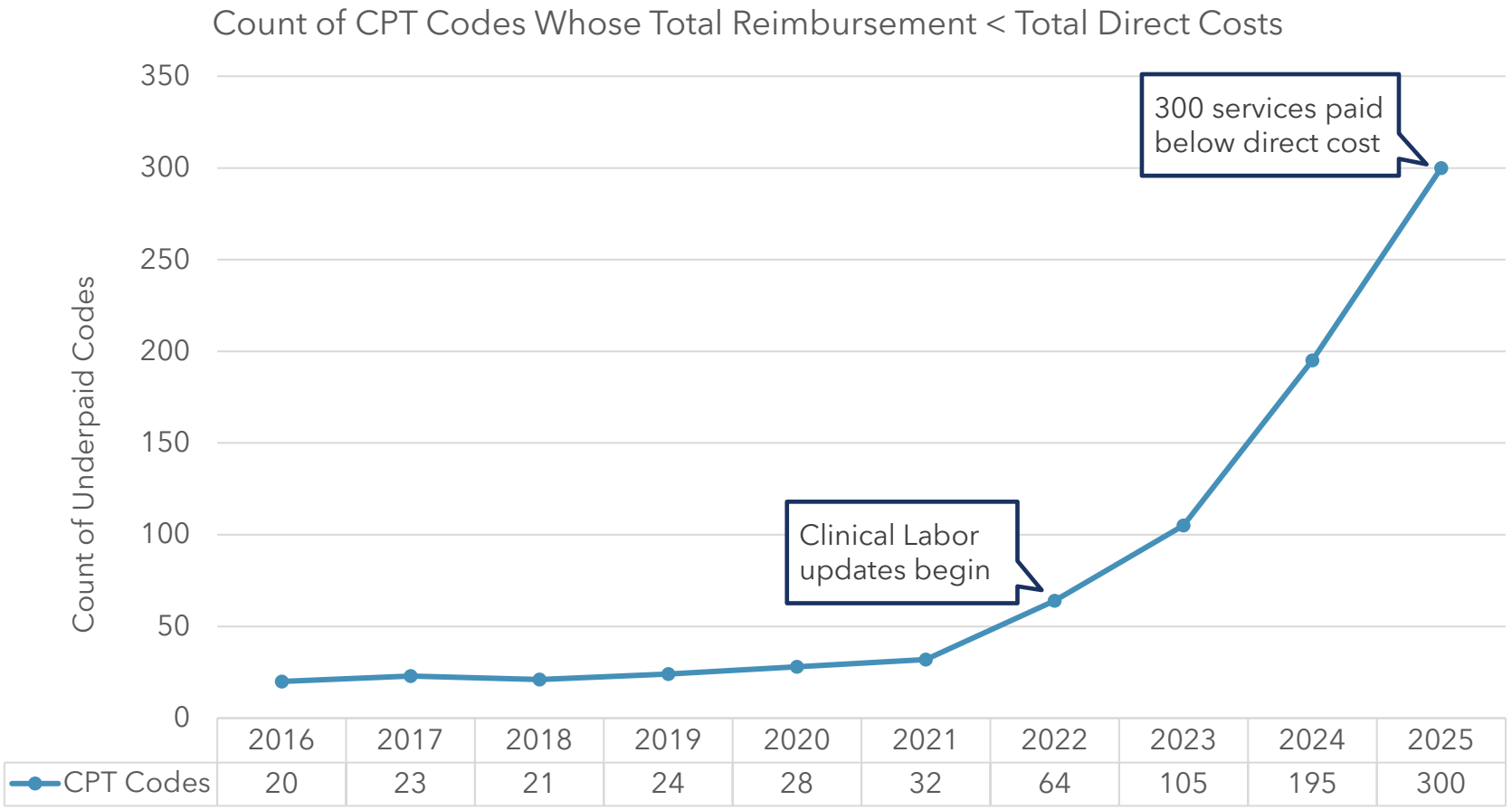
Flawed Logic for Office-Based Interventionalists - Example



	2021	2022	2023	2024	2025
CMS Office Total Reimbursement	$8,070	$7,727	$7,286	$6,790	$6,466
CMS Office Direct Costs	$7,597	$7,958	$7,998	$8,025	$8,051
Variance*	$473	($231)	($712)	($1,235)	($1,585)

An Issue with a Clear Sense of Urgency

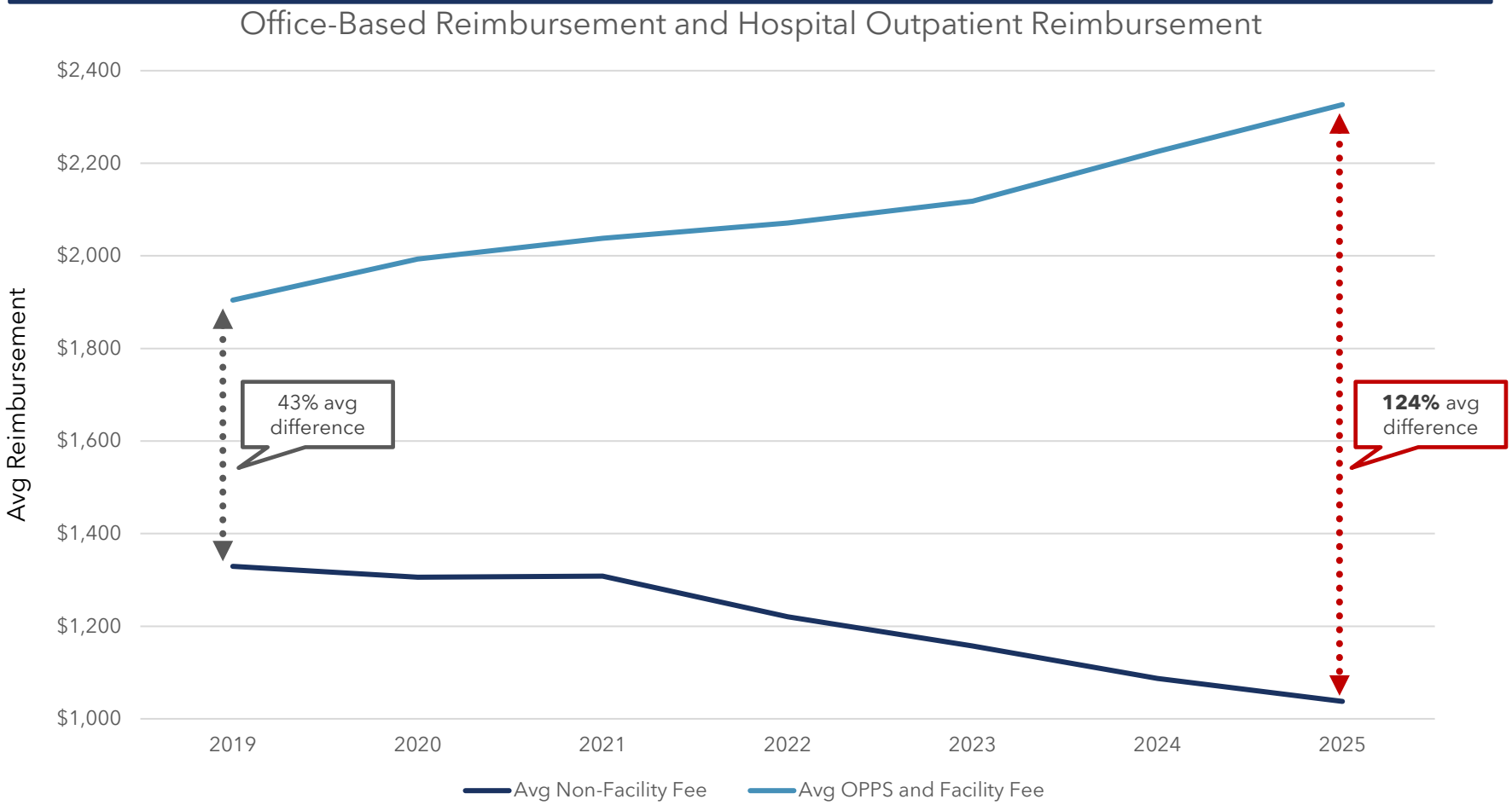
Since 2021, the number of CPT codes whose total reimbursement is less than their CMS calculated direct costs have dramatically increased each year. It is undeniable that the PFS reimbursement logic is flawed and not built to accommodate high-cost services.



	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
CPT Codes	20	23	21	24	28	32	64	105	195	300

Average Office and Hospital Outpatient Reimbursement of 300 Underpaid Codes

As reimbursements for high-tech procedures decrease in the office setting, the same services provided in the hospital show significant increases. This further distorts markets, driving hospital consolidation and reducing the number of specialists in lower cost settings.

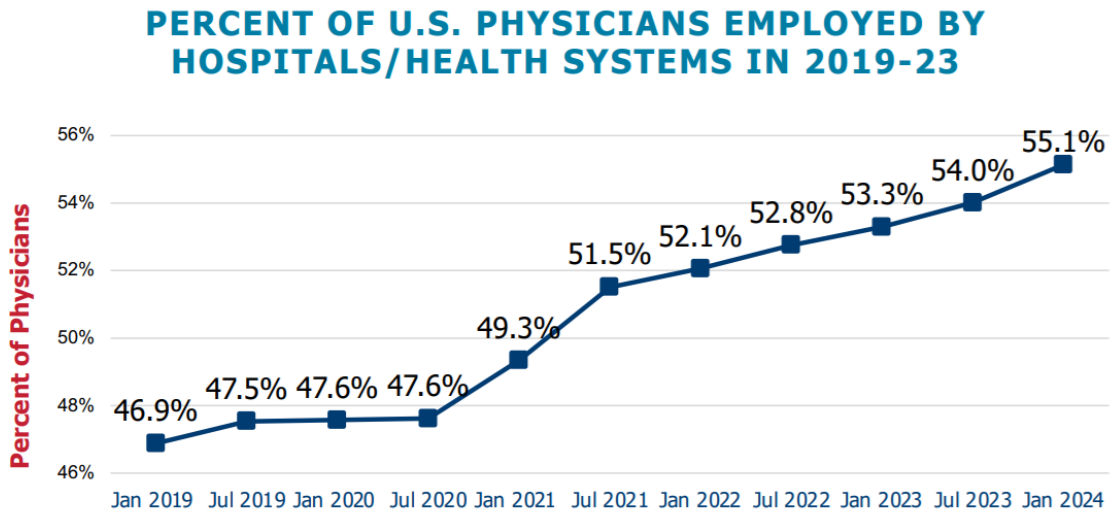


Reimbursement is calculated as the average PFS non facility fee compared to the average PFS facility fee plus the average hospital outpatient department OPPS fee. Graph shows 273 of the 300 codes where total reimbursement is less than direct costs. 27 CPT codes were excluded as they were added to the fee schedule after 2019.

Pricing Disparities Drive Hospital Consolidation

In 2012, only 25.8% of physicians were employed by hospitals or health systems. This grew to 44% by the start of 2018. Furthermore, from January 2019 to January 2024, there has been over a 17.5% increase in the total number of US physicians employed by health systems/hospitals with 55.1% of all physicians employed by January 2024.

National Five-Year Trends: More Than Half of Physicians Employed by Hospitals/Health Systems

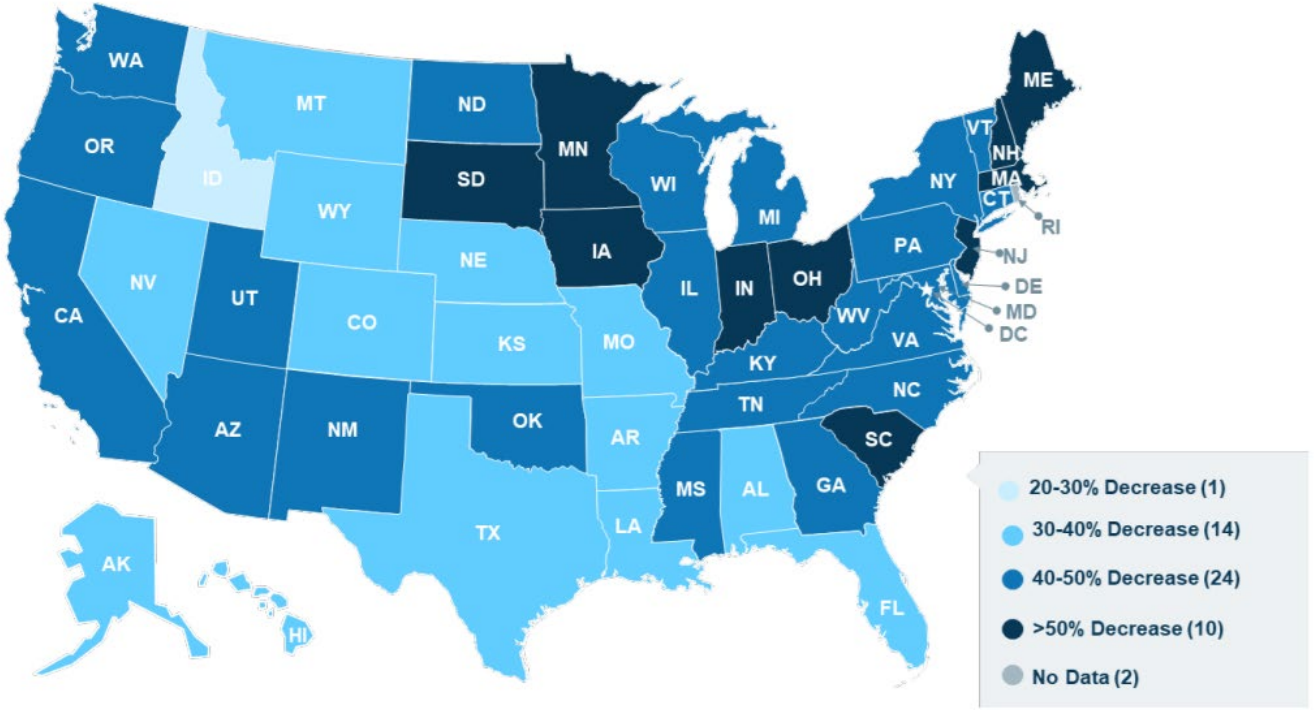


- **55.1%** of physicians were hospital-employed by January 2024
- Over the last two years, the percentage of hospital-employed physicians grew by **5.9%**

Pricing Disparities Impact Rural Communities

While pricing disparities drive patient care away from independent physician offices, rural areas lose access to essential healthcare services. As evidenced below, the number of practicing independent physicians has decreased in almost all states over the past 5 years.

Figure 3: Percentage Change in the Number of Independent Physicians in Rural Areas, January 1, 2019-January 1, 2024



Physicians Advocacy Institute, Rural Areas Face Steep Decline in Independent Physicians and Practices, 2025

Consequences

300 Procedures Now Paid Below Cost – According to CMS, direct costs exceed reimbursement for 300 procedures.

Impact on Office-Based Care – Office-based vascular surgery, interventional radiology, radiation oncology, have experienced major cuts. This accelerates the decline of office-based procedural care and further limits access for patients in rural areas, community systems and overrun urban settings.

Site of Service Disparities – The disparity between hospital outpatient payment and office-based payment for the same interventional procedures has more than doubled in four years. Some procedures are reimbursed 5x more in a hospital outpatient setting (See CPT 37242).

Forced Consolidation – Unreliability of CMS payments has pushed physicians into hospital employment. This leads to higher healthcare costs and reduced access.

Patient Access at Risk – Fewer office-based options result in longer wait times, higher out-of-pocket costs, and higher costs to Medicare as a whole. Limited access increases risks of emergent procedures, limb loss, organ failure, severe complications, and death.

Acknowledgments

CMS – "We are aware of the issues with the current PE methodology caused by very expensive supply and equipment items, and this is a subject that we may consider for future rulemaking alongside other updates to the PE methodology. We appreciate the continued feedback from commenters as we consider potential approaches to this complicated topic." CY 2025 Physician Fee Schedule (PFS) final rule

MedPAC – "The Commission is concerned that ongoing site-of service payment differentials distort competition and encourage vertical consolidation. The result is that markets may gravitate toward a particular care delivery model (in this case, a vertically consolidated one) […] not because such a model is the most efficient way to deliver high-quality care but because it generates higher revenues-at the expense of Medicare beneficiaries and taxpayers." June 2024 Report to the Congress: Medicare and the Health Care Delivery System

AMA – "The RUC recommends that CMS separately identify and pay for high-cost disposable supplies priced in excess of $500 using appropriate HCPCS codes." AMA/Specialty Society RVS Update Process RUC Recommendations for CPT 2022

PFS Practice Expense Methodology

	Step	Source	Formula	99213 Office visit, est Nonfacility	33533 CABG, arterial single Facility
(1) Labor cost (Lab)	Step 1	AMA		19.44	115.50
(2) Supply cost (Sup)	Step 1	AMA		5.54	14.84
(3) Equipment cost (Eqp)	Step 1	AMA		0.34	1.10
(4) Direct cost (Dir)	Step 1		=(1)+(2)+(3)	25.31	131.50
(5) Direct Scaling Adjustment (Dir. Adj.)	Steps 2-4	See footnote*		0.4385	0.4385
(6) Adjusted Labor	Steps 2-4	=Labor * Dir Adj	=(1)*(5)	8.52	50.65
(7) Adjusted Supplies	Steps 2-4	=Eqp * Dir Adj	=(2)*(5)	2.43	6.51
(8) Adjusted Equipment	Steps 2-4	=Sup * Dir Adj	=(3)*(5)	0.15	0.48
(9) Adjusted Direct	Steps 2-4		=(6)+(7)+(8)	11.10	57.65
(10) Conversion Factor (CF)	Step 5	PFS		33.2875	33.2875
(11) Adj. labor cost converted	Step 5	=(Lab * Dir Adj)/CF	=(6)/(10)	0.26	1.52
(12) Adj. supply cost converted	Step 5	=(Sup * Dir Adj)/CF	=(7)/(10)	0.07	0.20
(13) Adj. equipment cost converted	Step 5	=(Eqp * Dir Adj)/CF	=(8)/(10)	0.00	0.01
(14) Adj. direct cost converted	Step 5		=(11)+(12)+(13)	0.33	1.73
(15) Work RVU	Setup File	PFS		1.30	33.75
(16) Dir_pct	Steps 6,7	Surveys		0.25	0.17
(17) Ind_pct	Steps 6,7	Surveys		0.75	0.83
(18) Ind. Alloc. Formula (1st part)	Step 8	See Step 8		(14)/(16)*(17)	(14)/(16)*(17)
(19) Ind. Alloc.(1st part)	Step 8		See 18	1.01	8.36
(20) Ind. Alloc. Formula (2nd part)	Step 8	See Step 8		(15)	(15)
(21) Ind. Alloc.(2nd part)	Step 8		See 20	1.30	33.75
(22) Indirect Allocator (1st + 2nd)	Step 8		=(19)+(21)	2.31	42.11
(23) Indirect Scaling Adjustment (Ind. Adj.)	Steps 9-11	See Footnote**		0.3965	0.3965
(24) Adjusted Indirect Allocator	Steps 9-11	=Ind Alloc * Ind Adj		0.92	16.70
(25) Ind. Practice Cost Index (IPCI)	Steps 12-16			1.12	0.72
(26) Adjusted Indirect	Step 17	= Adj.Ind Alloc * PCI	=(24)*(25)	1.02	11.99
(27) Adjusted Indirect for high work/low direct PE office-based services	Step 17 Cog	See Footnote***		1.01	11.88
(28) Sum of Direct and Indirect PE	Step 18	=Adj Dir + Adj Ind	=(14)+(27)	1.35	13.61
(29) Budget Neutrality Adjustment (BN Adj.)	Step 18			0.9985	0.9985
(30) Adjusted Sum of Direct and Indirect PE	Step 18		=(28)*(29)	1.35	13.59
(31) Final PE RVU (with Phase-In)	Step 19	Apply Phase-In Transition		1.35	13.54

				CY 2021	CY 2025
	Step	Source	Formula	36902 Nonfacility	36902 Nonfacility
(1) Labor cost (Lab)	Step 1	AMA		54.96	99.14
(2) Supply cost (Sup)	Step 1	AMA		707.73	748.62
(3) Equipment cost (Eqp)	Step 1	AMA		238.79	229.71
(4) Direct cost (Dir)	Step 1		=(1)+(2)+(3)	1,001.48	1077.47
(5) Direct Scaling Adjustment (Dir. Adj.)	Steps 2-4	See footnote*		0.5916	0.4385
(6) Adjusted Labor	Steps 2-4	=Labor * Dir Adj	=(1)*(5)	32.51	43.47
(7) Adjusted Supplies	Steps 2-4	=Eqp * Dir Adj	=(2)*(5)	418.69	328.27
(8) Adjusted Equipment	Steps 2-4	=Sup * Dir Adj	=(3)*(5)	141.27	100.73
(9) Adjusted Direct	Steps 2-4		=(6)+(7)+(8)	592.47	472.47

*The direct adj = [current pe rvus * CF * avg dir pct]/[sum direct inputs] = [step2]/[step3]

- 2021: Direct scaling adjustment automatically reduced the total value of direct costs by 41% to ensure that the peRVU budget remains neutral year over year.
- 2022 – 2025: Clinical Labor updates resulted in an *additional* reduction to the direct scaling adjustment of 15 percentage points and now reduces direct costs by 56%.