## HEALTHCARE REGULATORY ROUND-UP #83

# 2025 Medicare Physician Fee Schedule Final Rule – Part I

## November 20, 2024

# Introductions

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# Today's Agenda

1. CY 2025 Payment Rate Reduction
2. Reporting Overpayments
3. Advanced Primary Care Management
4. Telehealth Coverage
5. Federally Qualified Health Centers and Rural Health Clinics

# Parts 2 and 3

- **Part 2 – December 4**
  - Global surgery payment accuracy
  - Evaluation & management services (including HCPCS G2211)
  - New reimbursement for preventive services
  - Digital therapeutics for behavioral health
  - Supervision of outpatient therapy services
  - Opioid treatment programs
  - Skin substitutes
- **Part 3 –December 11**
  - Quality Payment Program (MIPS)
  - Medicare Shared Savings Program
  - SDOH-related services
  - Clinical Laboratory Fee Schedule payment reductions

# 1. CY 2025 Payment Rate Reduction

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# Medicare Access and CHIP Reauthorization Act of 2015

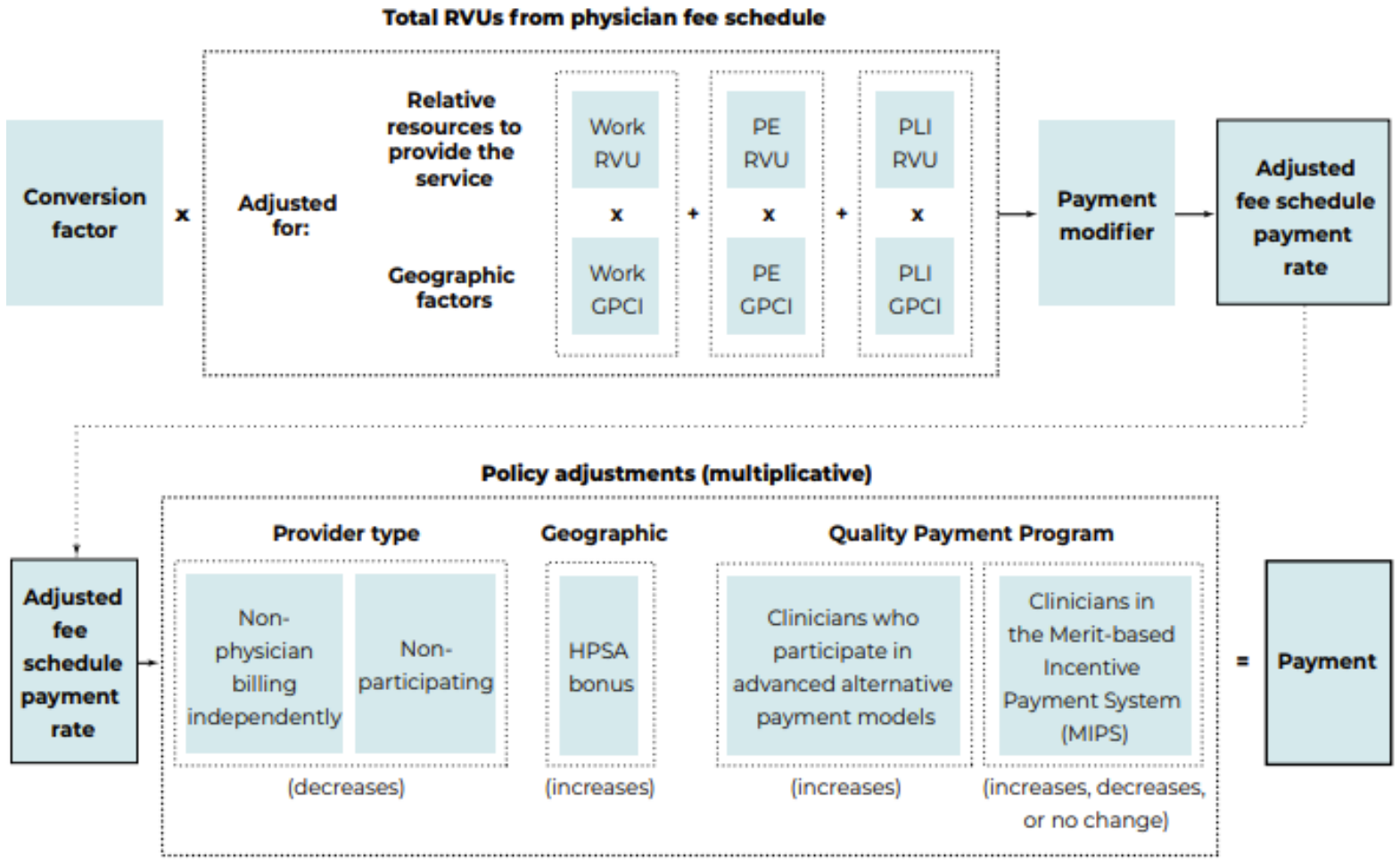
- Passed with overwhelming bipartisan support
  - 392 to 37 in the House; 92 to 8 in the Senate
- Repealed existing Medicare physician payment formula
  - Sustainable Growth Rate (SGR) tied payments to gross domestic product, resulting in significant cuts (up to 25%) beginning in 2001 requiring annual Congressional intervention
- Replaced with specified annual payment increases (vs. adjustments for inflation)
  - 2015 – 2019: 0.5% annual increase
  - 2020 – 2025: 0% annual increase
  - 2026 forward: 0.75% (APM participants) or 0.25% (everyone else) annual increases
- Established Quality Payment Program (performance-based payments/penalties)

# Calculating Fee Schedule Payments

- **Assigned relative value** (Appendix B)
  - Work
  - Practice expense
  - Malpractice expense
- **Conversion factor** (RVU x CF = national payment rate)*
  - Dollar amount based on statutory cap on MPFS spending
  - If any +/- in RVUs causes amount of annual Part B expenditures to differ by > $20 million from what expenditures would have been, CF must be adjusted to preserve ***budget neutrality***
    - Coverage changes (e.g., HCPCS G2211 (complexity add-on code))
    - Misvalued codes (e.g., 2021 E/M adjustments)

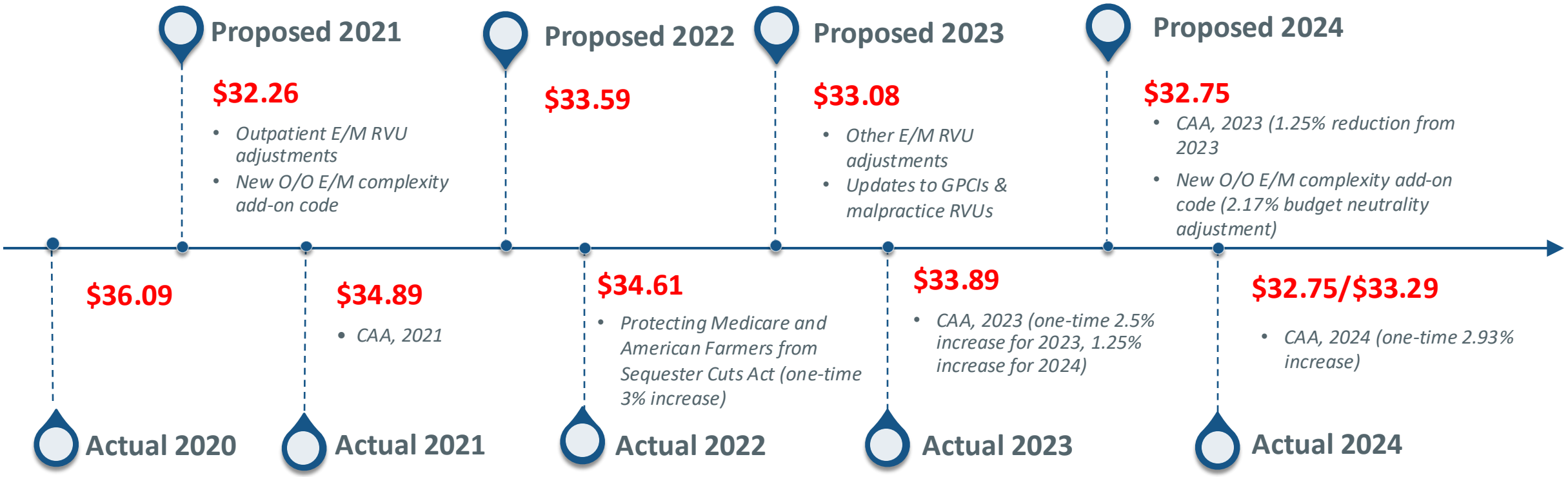
*Different formula used to calculate anesthesia conversion factor

# Payment Adjustments




https://www.medpac.gov/wp-content/uploads/2022/10/MedPAC_Payment_Basics_23_Physician_FINAL_SEC.pdf

# Conversion Factor – A Brief History (2020 – 2024)



| Year | MPFS Final Rule | Congressional Fix | Final Cut |
|---|---|---|---|
| 2021 | -10.2% | +6.9% | -3.3% |
| 2022 | -3.8% | +3% | -0.8% |
| 2023 | -4.5% | +2.5% | -2.0% |
| 2024 | -3.37% | +1.68% | -1.69% (services furnished on or after 3/9/24) |

From 2020 to 2024, conversion factor reduced by $2.80 (7.8% reduction)

Medicare Economic Index: +2.5% in 2021, +4.6% in 2022, +4.1% in 2023, +4.6% in 2024, +3.6% in 2025

# 2025 Conversion Factor - $32.35*

- Decrease of $0.94 compared to current conversion factor ($33.29)
  - 2.83% reduction
- How did we get here?
  - Removal of temporary 2.93% payment increase authorized by CAA, 2024
  - Zero adjustment factor mandated by MACRA
  - 0.02% *positive* budget neutrality adjustment (Proposed Rule = 0.05% adjustment; no explanation for reduction)

**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** |

*2025 anesthesia conversion factor = $20.32 (down from current $20.77)

# What About Telehealth?

- 12/31/2024 end of telehealth flexibilities (reinstatement of geographic and originating site requirements for coverage)
- In July, CBO estimated 2-year extension of flexibilities would cost $4 billion due to increases in utilization (although still gathering data)
- CMS: "[H]istorically we have not considered changes in the Medicare telehealth policies to result in significant impact on utilization such that a budget neutrality adjustment will be warranted."
    - No budget neutrality adjustment based on end of telehealth flexibilities

# 2. Reporting Overpayments

Image Source: Shutterstock

# December 2022 Overpayment Proposed Rule

- Addressed standard for identification of overpayment
  - Modify regulations for reporting and returning Medicare overpayments
  - Remove “reasonable diligence” standard and adopt FCA definition of “knowing” and “knowingly”
    - FCA: includes information about which person “has actual knowledge,” “acts in deliberate ignorance of the truth or falsity of the information,” or “acts in reckless disregard of the truth or falsity of the information”
  - Included Medicare Parts C and D
- December 2022 proposed rule was never finalized
- CMS revisited this matter in Proposed Rule and now is finalizing changes as proposed for Parts A, B, C, and D.
  - Part C changes apply to MA plans and Part D changes to drug plan sponsors

# Finalized Changes – Medicare Parts A and B

- Finalized knowledge standard from False Claims Act
  - Overpayment has been identified when "a provider or supplier has identified an overpayment if it has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment"
- Finalized 42 CFR § 401.305(b)(3)
  - "a suspension of the applicable requirements for 180 days, to conduct a timely, good faith investigation to determine the existence of related overpayments that may arise from the same or similar cause or reason as the initially identified overpayment"
- No longer ties identification to quantification
- No reference to credible evidence

# 60-Day Rule Changes Simplified

## Through December 31, 2024

**Day 1 of 180:** Provider has credible evidence

**Days 1 – 180:** Allowance for investigation and quantification

**Day 1 of 60: O**verpayment identified as of date of quantification of overpayment

**Days 1 – 60:** Timeframe to refund overpayment

## Requirements Effective January 1, 2025

**Day 1 of 60:** Overpayment identified when person has knowledge of overpayment or acts in reckless disregard or deliberate ignorance.

**Days 1 – 180:** Suspension for up to 180 days allows for investigation and quantification - investigation period stops 60-day clock

**Days remaining in 60-day period:** Restart of 60-day clock. Timeframe to refund overpayment.

# Additional 60-Day Rule Changes Finalized

- Revised § 401.305(b)(2) to address specific circumstances for suspension of deadline to return overpayments after 180 days of investigation:
  - OIG acknowledges receipt of submission to OIG Self-Disclosure Protocol
  - CMS acknowledges receipt of submission to CMS Voluntary Self Referral Disclosure Protocol
  - Under specified conditions if person requests extended repayment schedule as defined in § 401.603.

# CMS Responses to Comments – 60-Day Rule

- Overpayment definition per SSA §1128J(d)(4)(B) is “funds that a person receives or retains” using plain language meaning of those terms
  - Stated use of plain meaning of “timely” and “good faith” as well
- Because FCA uses knowledge standard it is supported by caselaw and examples to analyze each scenario to determine if “a person has the requisite knowledge to have identified an overpayment….”
- CMS refers to ability to suspend repayment schedule of 60 days by 180 days (see § 401.305(b)(3)) as sufficient to avoid FCA liability during process of identifying overpayment
- Calculate overpayment in 60 days to include related overpayments or suspend under § 401.305(b)(3) allowing 180 days for investigation
- CMS agreed with commenter that single overpayment which is suspect for related overpayments should be investigated and overpayments identified should be refunded

# 3. Advanced Primary Care Management

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# Overview

- New reimbursement for employing advanced primary care delivery model
  - “We anticipate that a practitioner using the advanced primary care model will bill for APCM services for all or nearly all the patients for whom they intend to assume responsibility for primary care.”
- 3 new codes based on patient complexity (vs. level of service provided)
  - G0556 – beneficiaries with one or no chronic conditions
  - G0557 – beneficiaries with multiple chronic conditions
  - G0558 –beneficiaries with multiple chronic conditions who are Qualified Medicare Beneficiaries
- No monthly minimum time requirements
- Services “provided by clinical staff and directed by a physician or other qualified health care professional who is responsible for all primary care and serves as the continuing focal point for all needed health care services”

# Service Elements and Practice-Level Capabilities

- Prerequisites to billing services for individual beneficiary
  - Consent (prior CCM consent sufficient?)
  - Initiating visit for patients not seen within last 3 years (separately paid)
  - Electronic patient-centered comprehensive care plan
- Practice capabilities (services provided to individual beneficiary as appropriate)
  - 24/7 access to care to address urgent needs
  - Continuity of care (ability to schedule successive routine appointments)
  - Alternatives to traditional office visit to meet patient's needs
  - Comprehensive care management services
  - Coordination of care transitions
  - Enhanced communication opportunities (e.g., secure messaging, patient portal, virtual services) *
  - Communication and coordination with community-based organizations
- Ongoing practice activities
  - Analysis of patient population data to identify gaps in care and needed services*
  - Assessment through performance measures (primary care quality, total cost of care, meaningful use)*

**APCM elements beyond CCM/ PCM requirements*

**TABLE 25: APCM Service Elements* and Practice-Level Capabilities**

| |
|---|
| **Consent**<br>• Inform the patient of the availability of APCM services; that only one practitioner can furnish and be paid for these services during a calendar month; of the right to stop services at any time (effective at the end of the calendar month); and that cost sharing may apply* (may be covered by supplemental health coverage)<br>• Document in patient's medical record that consent was obtained |
| **Initiating Visit for New Patients (separately paid)**<br>• Initiation during a qualifying visit for new patients<br>• An initiating visit is not needed: (1) if the beneficiary is not a new patient (has been seen by the practitioner or another practitioner in the same practice within the past three years) or (2) if the beneficiary received another care management service (APCM, CCM, or PCM) within the previous year with the practitioner or another practitioner in the same practice. |
| **24/7 Access to Care and Care Continuity**<br>• Provide 24/7 access for urgent needs to care team/practitioner, including providing patients/caregivers with a way to contact health care professionals in the practice to discuss urgent needs regardless of the time of day or day of week. In the event of afterhours communication with a beneficiary, whoever is responsive to the patient's concerns must document and communicate their interaction with the beneficiary to the primary care team/practitioner.<br>• Continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments<br>• Deliver care in alternative ways to traditional office visits to best meet the patient's needs, such as home visits and/or expanded hours, as appropriate |
| **Comprehensive Care Management**<br>• Overall comprehensive care management may include, as applicable<br>• Systematic needs assessment (medical and psychosocial)<br>• System-based approaches to ensure receipt of preventive services<br>• Medication reconciliation, management and oversight of self-management |
| **Patient-Centered Comprehensive Care Plan**<br>• Development, implementation, revision, and maintenance of an electronic patient-centered comprehensive care plan which is available timely within and outside the billing practice as appropriate to individuals involved in the beneficiary's care, can be routinely accessed and updated by care team/practitioner, and copy of care plan to patient/caregiver |
| **Management of Care Transitions** (for example, discharges, ED visit follow-up, referrals, as applicable)<br>• Coordination of care transitions between and among health care providers and settings, including transitions involving referrals to other clinicians, follow-up after an emergency department visit, or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities, as applicable<br>• Ensure timely exchange of electronic health information with other practitioners and providers to support continuity of care.<br>• Ensure timely follow-up communication (direct contact, telephone, electronic) with the patient and/or caregiver after ED visits and discharges from hospitals, skilled nursing facilities, or other health care facilities, within 7 calendar days of discharge, as clinically indicated |
| **Practitioner, Home-, and Community-Based Care Coordination**<br>• Ongoing communication and coordinating receipt of needed services from practitioners, home- and community-based service providers, community-based social service providers, hospitals, and skilled nursing facilities (or other health care facilities), as applicable, and document communication regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors in the patient's medical record |
| **Enhanced Communication Opportunities**<br>• Enhanced opportunities for the beneficiary and any caregiver to communicate with the care team/practitioner regarding the beneficiary's care through the use of asynchronous non-face-to-face consultation methods other than telephone, such as secure messaging, email, internet, or patient portal, and other communication technology-based services, including remote evaluation of pre-recorded patient information and interprofessional telephone/internet/EHR referral service(s), to maintain ongoing communication with patients, as appropriate<br>• Ensure access to patient-initiated digital communications that require a clinical decision, such as virtual check-ins and digital online assessment and management and E/M visits (or e-visits) |
| **Patient Population-Level Management**<br>• Analyze patient population data to identify gaps in care and offer additional interventions, as appropriate<br>• Risk stratify the practice population based on defined diagnoses, claims, or other electronic data to identify and target services to patients<br>• A practitioners who is participating in a Shared Savings Program ACO, REACH ACO, Making Care Primary, or Primary Care First satisfies this requirement |
| **Performance Measurement**<br>Be assessed on primary care quality, total cost of care, and meaningful use of CEHRT, which can be met in several ways:<br>• For practitioners who are MIPS eligible clinicians, by registering for and reporting the Value in Primary Care MVP**<br>• A practitioner who is part of a TIN participating in a Shared Savings Program ACO satisfies this requirement through the ACO's reporting of the APM Performance Pathway***<br>• A practitioner who is participating in a REACH ACO, a Making Care Primary, or a Primary Care First practice satisfies this requirement by virtual of meeting requirements under the CMS Innovation Center ACO REACH, Making Primary Care Primary, or Primary Care First models. |

# Performance Measurement – Four Options

- If part of TIN that participates in Medicare Shared Savings Program
  - Also satisfy patient population-level management requirement
- If participate in ACO REACH, Making Care Primary, or Primary Care First
  - "[Practitioners participating [in these models] would satisfy the … patient population-level management … and practice-level capabilities by virtue of meeting requirements of their model participation"
- If achieve status as Qualifying APM Participant under Quality Payment Program
- If MIPS eligible clinician who registers and reports Value in Primary Care MVP
  - If do not qualify as MIPS eligible clinician (newly enrolled, low volume), requirement is waived

# Medical Record Documentation

- Electronic patient-centered comprehensive care plan
- “[W]e will expect that any actions or communications that fall within the APMC elements of service will be described in the medical record and, as appropriate, their relationship to the clinical problem(s) they are intended to resolve and the treatment plan, just as all clinical care is documented in the medical record.”
- Bill APCM for month during which no specific action take and no direct communication with or on behalf of beneficiary?
  - “We also reiterate our assumption that beneficiaries receiving APCM services may not required any services on month and may have increased utilization the next month.”
  - CMS acknowledges resources required to maintain practice capabilities and continuous readiness and monitoring activities
  - Primary care models with population-based payments have not required monthly activities on per-beneficiary basis

# Billing for APCM

- Submission of claim = attesting to compliance with required practice capabilities
- Billed once per calendar month (no add-on code) by practitioner who has assumed responsibility for beneficiary's primary care
- Billing practitioner/another practitioner in same practice and same specialty cannot bill following services in same month as APCM: CCM, PCM, TCM, interprofessional consultation, remote evaluation of patient video/images, virtual check-in, e-visit
  - Can bill separately for remote patient monitoring (RPM, RTM), behavioral health integration (CPT 99492-94, 99484, G0323), interprofessional consultation (CPT 99446-49 and 99451)
- Medicare cost-sharing applies

# Final RVUs and Payment Rates

| Code | wRVUs | PE RVU | Full RVU | Non-Facility | Facility | OPPS |
|---|---|---|---|---|---|---|
| G0556 | 0.25 | 0.2 | 0.47 | $15.20 | $11.97 | $29.79 |
| G0557 | 0.77 | 0.7 | 1.51 | $48.85 | $36.23 | $29.79 |
| **CPT 99490** | **1.00** | **0.81** | **1.87** | **$60.49** | **$47.88** | **$92.50** |
| G0558 | 1.67 | 1.52 | 3.31 | $107.07 | $79.90 | $92.50 |

# 4. Telehealth

Image Source: Shutterstock

# Medicare Telehealth Coverage

- Absent Congressional action, existing waivers of Section 1834(m) limitations on Medicare telehealth coverage will expire 12/31/2024 (in 41 days)
  - Coverage for medical telehealth services limited to beneficiaries residing in rural areas physically present at specified facilities at time service provided
    - Coverage for telephonic E/M services (CPT codes 99441-99443) will expire 12/31/2024
  - Coverage for tele-behavioral health services not subject to geographic and originating site restrictions per Consolidated Appropriations Act, 2021
    - For services initiated on or after 01/01/2025, must have in-person visit within 6 months of initiating tele-behavioral health services

# Medicare Telehealth Services List

- Maintain provisional services on list through 2025 while completing comprehensive analysis to determine if permanent status is appropriate
  - Examples of provisional services
    - Cardiovascular and Pulmonary Rehabilitation (CPT codes 93797, 93798, 94625, 94626)
    - Health and Well Being-Coaching (CPT codes 0591T-0593T)
    - Psychological Testing and Developmental Testing (CPT codes 96112, 96113, 96130, 96136, 96137)
- Delete CPT 99441-99443 (telephonic E/M services)
- Add three new services
  - Caregiver Training (CPT 97550, 97551, 97552, 96202, 96203) with provisional status
  - PrEP Counseling for HIV (HCPCS G0011 and G0013) with permanent status
  - Safety Planning Interventions (HCPCS G0560) with permanent status

# Interactive Telecommunications System

- Section 1834(m) requires use of two-way real-time audio-visual connectivity
- CMS revised implementing regulation to permit use of two-way, real-time *audio-only* communication technology for any covered telehealth service furnished in patient's home, but only if -
  - Provider possesses capability to provide audio + visual; and
  - Patient is unable/unwilling to connect via video
- Audio-only services billed with modifier 93 (modifier FQ for FQHCs/RHCs)

# Telehealth E/M Services

- CMS proposed  but did not finalize  17 new codes for telehealth and virtual  E/M services
  - Did replace HCPCS G2012 with CPT 98016 (virtual check-in)
    - Unlike telehealth services, virtual services not subject to geographic and originating site restrictions
- Continue to use E/M codes for telehealth services with appropriate POS code

# Telehealth – Extensions

- Extend through CY 2025 suspension of telehealth frequency limitations for –
  - Inpatient subsequent care services (CPT Codes 99231–99233)
  - Nursing facility subsequent care services (99307–99310)
  - Critical care consultations (G0508 and G0509)
- Continue through CY 2025 to permit distant site practitioner to use currently enrolled practice location instead of home address for telehealth services furnished from practitioner's home

# Virtual Presence

- Current direct supervision flexibilities extended through December 31, 2025
- Direct supervision may be accomplished by real-time audio/visual connection on permanent basis for specified services –
  - Services furnished incident to physician's service when provided by auxiliary personnel employed by physician and for which the underlying HCPCS code has been assigned PC/TC indicator of "5."
  - Services described by CPT 99211: office and other outpatient visits for evaluation and management of established patient that may not require the presence of physician/other qualified healthcare professional
- Virtual presence for purposes of billing for resident services in all teaching settings – meets requirement for physician presence for key portion of services
  - Example: 3-way telehealth visit with patient, resident, and teaching physician, all parties in separate locations

# 5. RHCs and FQHCs

Image Source: Shutterstock

# Telehealth – Behavioral Health Services

- New coverage created under Consolidated Appropriations Act, 2021
- Qualifies as FQHC/RHC visit (and thus pays PPS rate/AIR) if –
  - Service included on CMS approved list of telehealth services
    - Available at https://www.cms.gov/medicare/medicare-general-information/telehealth/telehealth-code
  - Use audio/visual connection (audio only if patient cannot/does not want to connect visually)
  - Effective **01/01/2026** -
    - In-person mental health service furnished within 6 months prior to furnishing telehealth services (unless services initiated prior to 01/01/2026)
    - In-person, non-telehealth visit furnished at least every 12 months (may be waived; reason documented in medical record)

# Telehealth – Medical Services

- Continue current reimbursement methodology through 12/31/25 while evaluating alternatives
  - Service must be included on CMS approved list of telehealth services
  - Not reimbursed PPS/AIR; instead, billed under G2025 – reimbursed at $94.96 (regardless of service provided via telehealth)
- May also bill telehealth originating site fee under Q3014 – reimbursed at $29.96 (2024 rate)
  - Patient physically present at RHC facility receiving telehealth from distant site provider

# Virtual Communication Services

- Billed under G0071 - $13.91
  - At least 5 minutes of virtual (non-face-to-face) communication between RHC practitioner and patient, or at least 5 minutes of remote evaluation of recorded video and/or images by RHC practitioner
- Billing rules
  - Patient must have been seen at RHC within last year
  - Patient must consent to services
  - Must be in lieu of in-person visit, i.e., not originating from a related E/M service provided within the previous 7 days nor leading to E/M service or procedure within the next 24 hours or soonest available appointment

# FQHC/RHC Care Management Services – 2024

- Non-face-to-face services billed under G0511 - General Care Management
  - Transitional care management
  - Chronic care management
  - Principal care management
  - General behavioral health integration
  - Chronic pain management
  - Community Health Integration
  - Principal Illness Navigation
  - Principal Illness Navigation – Peer Support
  - Remote Physiological Monitoring
  - Remote Therapeutic Monitoring
- G0511 rate = average of national non-facility payment rate for these services
  - For 2024, $72.90
- Psychiatric Collaborative Care Model (CoCM) billed under G0512 - $146.73 (no more than once/month) (revenue code 0521)

# FQHC/RHC Care Management Services - 2025

- Discontinue use of G0511
- FQHC/RHC may bill for following non-face-to-face services under assigned CPT code:
  - Transitional Care Management
  - Chronic Care Management
  - Complex Chronic Care Management
  - Principal Care Management
  - Advanced Primary Care Management
  - Psychiatric Collaborative Care Model
  - General Behavioral Health Integration
  - Chronic Pain Management
  - Community Health Integration
  - Principal Illness Navigation
  - Principal Illness Navigation – Peer Support
  - Remote Physiological Monitoring
  - Remote Therapeutic Monitoring

# FQHC/RHC Care Management Services - 2025

- Non-face-to-face services reimbursed at national non-facility payment rate
  - Co-payment based on charges or Medicare allowable?
- 6-month transition period; may continue to bill G0511 through 6/30/2025
  - 2025 reimbursement for G0511 reduced from $72.90 to $54.67
  - All-or-nothing; can't pick and choose when to bill G0511
- Continue to bill CoCM under G0512 ($139.43)

| Code | 2025 Payment Rate |
|---|---|
| HCPCS G0511 | $54.67 |
| CPT 99490 (CCM, 1st 20 min) | $60.55 |
| CPT 99439 (CCM, each add'l 20 min) | $45.93 |
| CPT 99454 (RPM monthly monitoring) | $47.27 |

# Vaccinations - 2024

- Influenza, Pneumococcal, and COVID-19 Vaccines
  - Vaccines and their administration paid at 100% of reasonable cost through cost report
  - Report charges on cost report Worksheet M-4 (provider-based) or B-1 (independent)
  - Do not report on UB-04
  - Coinsurance waived
- Hepatitis B Vaccine
  - Requires physician order; reimbursement included in PPS/AIR

# Vaccinations – After June 30, 2025

- Bill for Part B vaccines (including hepatitis b) and vaccine administration at time of service
  - Includes expanded coverage for hepatitis b – doctor's order no longer required
  - Also bill M0201 for in-home administration
- Due to statutory requirement that RHCs be reimbursed 100% of costs for vaccines and vaccine administration, will reconcile annually as part of cost report
- Additional guidance (including updated cost report instructions) to be released in early 2025

# RHC Conditions of Certification/Coverage

- No longer require >50% of RHC's total hours of operation must involve primary care services
  - Still must provide primary care services, but not at specified level
  - Still cannot be rehabilitation agency or facility primarily for treatment of 'mental diseases'
  - May provide outpatient specialty services within practitioner's scope of practice to meet community needs
- RHC clinical lab services
  - Remove hemoglobin and hematocrit from list of services RHC must provide directly
  - Change "primary culturing for transmittal to certified laboratory" to "collection of patient specimens for transmittal to a certified lab for culturing"

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# In Other News

- Updated payment rate for Intensive Outpatient Program services furnished in RHC/FQHC
- Elimination of RHC productivity standards (specified # of visits per FTE)
- Re-basing of FQHC market basket (change base year from 2017 to 2022)
- Clarification regarding payment for dental services furnished in FQHCs

# Our Next Healthcare Regulatory Round-Ups

## December 4:  2025 Medicare Physician Fee Schedule Final Rule Part 2

## December 11:  2025 Medicare Physician Fee Schedule Final Rule Part 3

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