

Issues affecting the payment accuracy of the physician fee schedule and the clinical laboratory fee schedule

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Background

Payment accuracy

- Commission believes that payment rates should:
 - Be set high enough to ensure beneficiary access to high-quality care
 - Minimize financial burdens on beneficiaries and taxpayers
- Payment accuracy is also important to reduce inappropriate incentives
- CMS has recently taken multiple steps to improve payment accuracy, but opportunities for improvement remain
- Materials presented today not intended for published chapter

CMS has taken several steps in the last few years to improve the accuracy of PFS valuations

- Finalized policies
 - Revalued E&M office visits (2021)
 - Updated clinical labor rates (2022)
 - Efficiency adjustment (2026)
 - Redistributed PE RVUs from facility to non-facility settings (2026)
- CMS proposed policies for 2027
 - Eliminating indirect practice expense cost index
 - MPPR for E&M visits billed with global surgical services
- All of these policies have been budget neutral; spending effects of future changes is at the discretion of the Congress

Note: PFS (physician fee schedule), E&M (evaluation and management), PE (practice expense), RVU (relative value unit), IPCI (indirect practice expense cost index), MPPR (multiple procedure payment reduction)

Source: CMS physician fee schedule proposed rule for calendar year 2027.



Global surgical services

The payment unit for global surgical services is broader than most services under the PFS

- Payment unit includes the procedure itself and associated visits within certain timeframes
 - 10-day global surgical services: visits on day of procedure + postoperative visits within 10 days
 - 90-day global surgical services: preoperative visit 1 day before procedure + visits on day of procedure + postoperative visits within 90 days
- In 2024, FFS Medicare spent \$8.2 billion on global surgical services
 - 10-day global surgical services: \$2.3 billion
 - 90-day global surgical services: \$5.9 billion

Note: PFS (physician fee schedule), FFS (fee-for-service).
Source: MedPAC analysis of PFS claims data.

Valuation of global surgical services includes postoperative visits

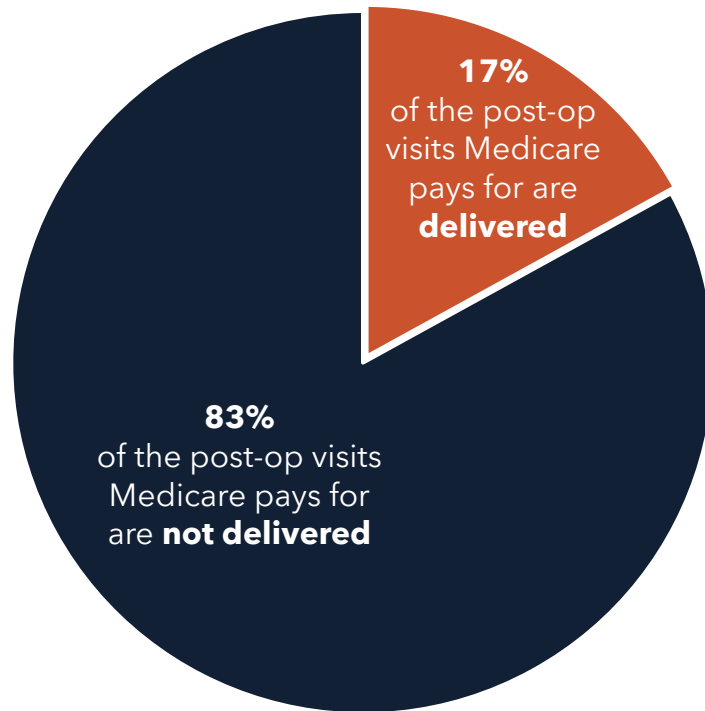
- To set the RVUs for global surgical services, CMS assumes a certain number and type of postoperative visits take place, on average
- E.g., the valuation for a total knee replacement assumes 6 postoperative E&M visits:
 - 3 office visits
 - 2 hospital inpatient/observation visits
 - 1 hospital inpatient/discharge visit
- But research using medical records and claims data finds that clinicians furnish far fewer postoperative visits, on average, than are included in the valuation of services

Note: RVU (relative value unit), PFS (physician fee schedule), FFS (fee-for-service), HCPCS (healthcare common procedure coding system). Example procedure is for HCPCS code 27447. Postoperative visits for this service include three office visits (HCPCS code 99213), two hospital inpatient/observation visits (HCPCS code 99232), and one hospital inpatient/discharge visit (HCPCS code 99238).

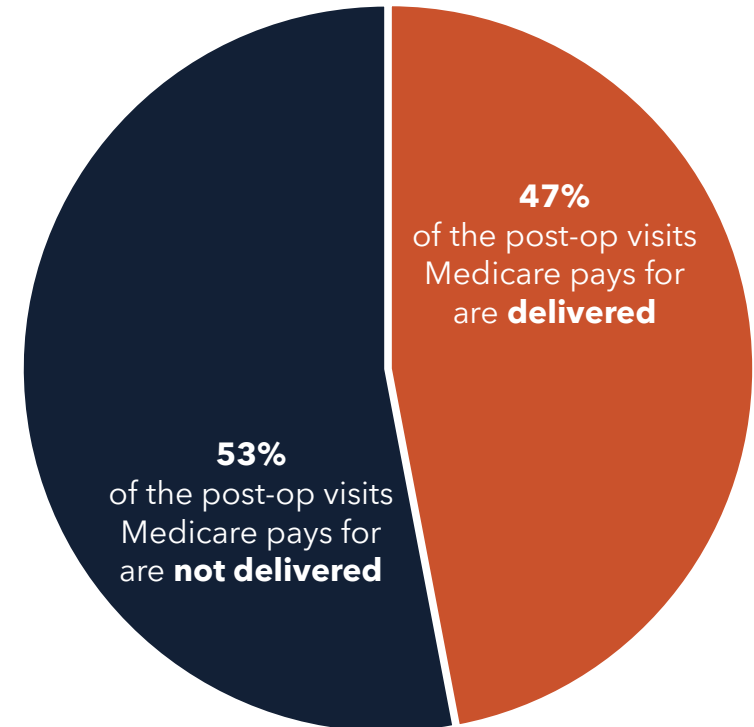
Source: CMS time file, Crespín, D. J., A. M. Kranz, T. Ruder, et al. 2021. *Claims-based reporting of post-operative visits for procedures with 10- or 90-day global periods: Updated results using calendar year 2019 data*. Santa Monica, CA: RAND. <https://www.cms.gov/files/document/rand-cy-2019-claims-report-2021.pdf>. Office of Inspector General, Department of Health and Human Services. 2025a. *CMS should confirm it is receiving Medicare postoperative visit data on global surgeries when reporting is required*. A-05-20-00027. Washington, DC: OIG. Office of Inspector General, Department of Health and Human Services. 2025b. *CMS should improve its methodology for collecting Medicare postoperative visit data on global surgeries*. A-05-20-00021. Washington, DC: OIG.

Most of the postoperative visits included in the valuation of global surgical services are not actually furnished

10-day global surgical services



90-day global surgical services



Note: These are results of a sensitivity analysis restricted to the subset of clinicians who billed for any postoperative visits during 90-day global periods. RAND's main results (using a larger pool of clinicians) suggested an even higher share of post-operative visits were not provided. RAND studied commonly used 10- and 90-day global codes.

Source: Crespín, D. J., A. M. Kranz, T. Ruder, et al. 2021. *Claims-based reporting of post-operative visits for procedures with 10- or 90 day global periods: Updated results using calendar year 2019 data*. Santa Monica, CA: RAND. <https://www.cms.gov/files/document/rand-cy-2019-claims-report-2021.pdf>.

Improving the accuracy of global surgical services

- MedPAC recommended that CMS improve the accuracy of relative payment rates for clinician services, including addressing overvaluations for global surgical services (June 2025)
- Two broad policy approaches:
 - Convert 10- and 90-day global surgical services to 0-day services and let clinicians separately bill for postoperative visits
 - Keep the current payment structure but adjust valuations for 10- and 90-day global surgical services to reflect postoperative visits actually performed
- Phase-in of reforms could be considered

Source: MedPAC June 2025 Report to the Congress.



“Incident to” billing

Certain individuals can bill under the NPI of a supervising physician

- This practice is known as “incident to” billing
- Medicare’s “incident to” rules are complex and include:
 - Services must be furnished in a noninstitutional setting
 - Services must generally be rendered under a physician’s direct supervision
 - Not allowed for new patients or established patients with new problems
- We focus on NPs (the largest subset of APRNs) and PAs who bill “incident to” because:
 - Beneficiaries increasingly rely on them to access care
 - They can directly bill Medicare yet commonly bill “incident to”
- Medicare payment varies based on how an NP’s or PA’s service is billed:
 - “Incident to”: 100% PFS rate
 - Direct billing: 85% PFS rate

Note: NPI (national provider identifier), NP (nurse practitioner), APRN (advanced practice registered nurse), PA (physician assistant), PFS (physician fee schedule)

MedPAC has noted that “incident to” billing creates multiple issues for Medicare

- Reduces transparency and impedes program integrity functions
- Increases beneficiary and program spending
- Inhibits accurate PFS valuations
- Limits ability to evaluate cost and quality of care furnished by NPs and PAs

Note: PFS (physician fee schedule), NP (nurse practitioner), PA (physician assistant).
Source: MedPAC June 2019 Report to the Congress.

MedPAC recommended requiring direct billing for APRNs and PAs, eliminating “incident to billing” for their services (June 2019)

- Would enhance transparency and program integrity
- Would reform Medicare billing rules but would not affect what care could be delivered by APRNs or PAs
- Groups representing NPs and PAs generally support a direct billing requirement

Note: APRN (advanced practice registered nurse), PA (physician assistant), NP (nurse practitioner). NPs are one type of APRN. Other types of APRNs include clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists.

Source: American Association of Nurse Practitioners. 2024. Federal legislative policy priorities. American Academy of Physician Assistants. 2019. American Academy of PAs responds to MedPAC’s report on Medicare and the health care delivery system.

Recent “incident to” developments

- Recent research finds that “incident to” billing is common and that most NPs and PAs practice in specialty care
 - In 2022, an estimated 38 million encounters for NPs, PAs, and CNSs were billed “incident to” in MA and FFS (39% these clinicians’ office encounters)
 - Physicians with a surgical specialty had a higher share of their visits billed “incident to” compared with PCPs
 - An estimated 40%–45% of NPs and 27%–30% of PAs who billed FFS Medicare in 2019 practiced in primary care
- Beginning in 2026, CMS allows for supervision of “incident to” services via audiovisual interactive telecommunications
- Beginning in 2027, Congress required a modifier for telehealth visits furnished “incident to”

Note: NP (nurse practitioner), PA (physician assistant), CNS (clinical nurse specialist), PCP (primary care physician). NPs are one type of APRN. Other types of APRNs include clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists.

Source: Mulcahy, J. F., S. Y. Patel, A. Mehrotra, et al. 2025. Quantifying indirect billing within the Medicare physician fee schedule. *JAMA Health Forum* 6, no. 4 (April 4): e250433. O'Reilly-Jacob, M, J. Chapman, S. Subbiah, and J. Perloff. 2023. Estimating the Primary Care Workforce for Medicare Beneficiaries Using an Activity-Based Approach. *J Gen Intern Med*. Oct;38(13):2898-2905.



Telehealth

Telehealth under the PFS

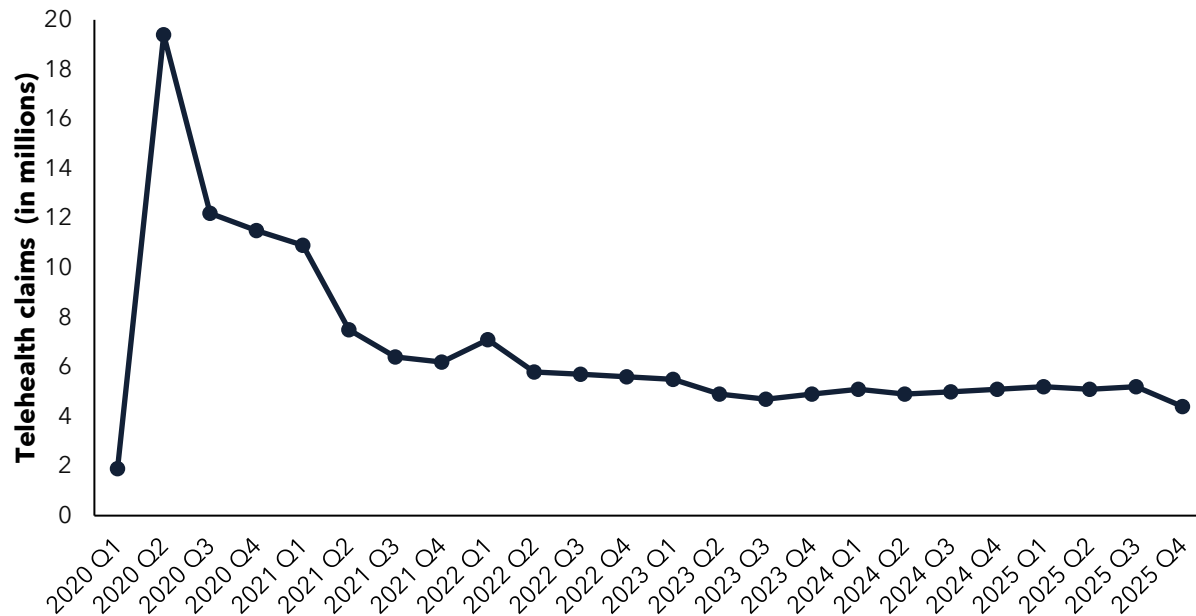
- Before the PHE, coverage of telehealth was limited under the PFS, and use was very low
- During the PHE, CMS temporarily expanded coverage of telehealth (e.g., geographic location, home as an originating site, more services)
- Congress permanently expanded telehealth flexibilities for mental health services
- For non-mental health services, Congress temporarily extended flexibilities multiple times, currently through the end of 2027
- MedPAC has discussed weighing principles of access, quality, and cost when considering telehealth coverage
 - Telehealth can be an important source of access
 - Should consider adding guardrails

Note: PFS (physician fee schedule), PHE (public health emergency), MA (Medicare Advantage), FFS (fee-for-service).

Source: MedPAC March 2018, March 2021, and June 2023 reports to the Congress.

Telehealth use in FFS Medicare has stabilized

Telehealth use under the PFS declined after 2020 but has stabilized over the last few years



Note:

FFS (fee-for-service), PFS (physician fee schedule)

Source:

MedPAC analysis of FFS PFS claims. Nakamoto et al. 2024, Lake et al. 2026. MedPAC March 2021 report to the Congress.

- 2025 FFS PFS telehealth:
 - \$2.4 billion in spending
 - 6.1 million FFS beneficiaries with a visit
- Academic research on the effects of telehealth cost, utilization, and quality is mixed, but small increases in utilization and spending are often found
- Consistent with past MedPAC work, permanent access to telehealth should be balanced with appropriate guardrails

Congress could consider potential guardrails when extending telehealth flexibilities

- Guardrails already implemented for telehealth services:
 - In-person visit requirement (delayed through 2027)
 - Audio-only modifier (2023)
 - Virtual platform modifier (2027)
 - “Incident to” modifier (2027)
- MedPAC has considered additional guardrails:
 - Eliminating “incident to” billing for certain clinicians providing telehealth
 - Reducing payment rates for telehealth services
 - Protections for beneficiaries treated at rural health clinics
 - In-person visit before ordering certain services

Medicare currently pays the same rate for in-person and most telehealth visits

- MedPAC has said that CMS should:
 - Pay telehealth services lower rates
 - Collect data on the cost of furnishing telehealth services and adjust telehealth payment rates based on those costs
- AMA collected data on the costs to furnish E&M office visits via telehealth
- CMS did not use these data to adjust telehealth payment rates because the agency said the law requires it to pay an equal amount for a telehealth service as a service furnished in person

Note: AMA (American Medical Association), E&M (evaluation and management).
Source: MedPAC March 2021 report to the Congress. Calendar year 2025 physician fee schedule final rule.

Recent data suggest lower payment rates for some telehealth services are likely appropriate

Providing a common E&M service via telehealth modality requires fewer resources than in person

Modality	Direct practice expenses	
	Total (dollars)	Nurse / medical assistant (minutes)
In-person	\$33.57	51
Audiovisual telehealth	9.72	18
Audio-only telehealth	8.10	15

Note: E&M (evaluation and management), PE (practice expense), PFS (physician fee schedule). Data in table are from billing code 99214 (in person) and equivalent audiovisual and audio-only telehealth visits in the nonfacility setting.

Source: MedPAC analysis of PFS claims data and information in CMS’s PFS final rule for calendar year 2025.

- Recent evidence for E&M office visits suggests it costs less to furnish similar services via telehealth modality
 - For most common telehealth service, an audiovisual telehealth service requires 71% less direct PE than an in-person visit (\$33.57 vs. \$9.72)
- Adopting lower rates for telehealth E&M office visits consistent with their lower costs would have reduced 2025 FFS spending on these services by an estimated 20% or \$278 million



Clinical laboratory fee schedule

Medicare covers separately payable lab tests under the CLFS

- In 2025, Medicare spent about \$9 billion on CLFS tests
- CLFS tests are typically furnished by three types of labs
 - Independent
 - Hospital
 - Physician office
- No beneficiary cost sharing for CLFS tests
 - No beneficiary coinsurance
 - Part B deductible does not apply
- CLFS spending contributes to Part B premiums

Note:

Source:

CLFS (clinical laboratory fee schedule). CLFS spending total excludes specimen collection, travel expenses, unlisted codes, and professional services only codes.
MedPAC analysis of CLFS claims.

Congress reformed the CLFS because Medicare's rates were significantly higher than private-payer rates

- Prior to 2018, CLFS payment rates were largely based on historical lab charge data that were capped and inflated over time
- OIG found that CLFS rates were far above private-payer rates
- In 2014, PAMA required the CLFS to be based on private-payer rates
 - CLFS rates set at volume-weighted median of private-payer rates
 - Labs required to report data every three years, so CMS can update rates
 - First round of data collection suggested CLFS rates were far above private-payer rates
- 2018: Implementation of first round of private-payer-based rates
 - By law, maximum per year payment-rate reduction for individual tests: 10% (2018-2020), 0% (2021-2026), 15% (2027-2029)
 - As of 2026, reductions not fully phased in

Note:

CLFS (clinical laboratory fee schedule), PAMA (Protecting Access to Medicare Act of 2014)

Source:

MedPAC June 2021 Report to the Congress. Office of Inspector General, Department of Health and Human Services. 2013. *Comparing lab test payment rates: Medicare could achieve substantial savings*. Washington, DC.

Findings from MedPAC's mandated report on the first round of data reporting (June 2021)

- Estimated CLFS rates would decrease 24% once fully implemented
 - Larger reductions for routine tests than for newer, more expensive tests (e.g., genetic tests)
- Estimated that private-payer data was collected from 51% of labs, weighted by CLFS spending
 - Independent labs were overrepresented
 - Hospital outpatient and physician-office labs were underrepresented
- Hospital and physician-office labs had higher private-payer rates than independent labs

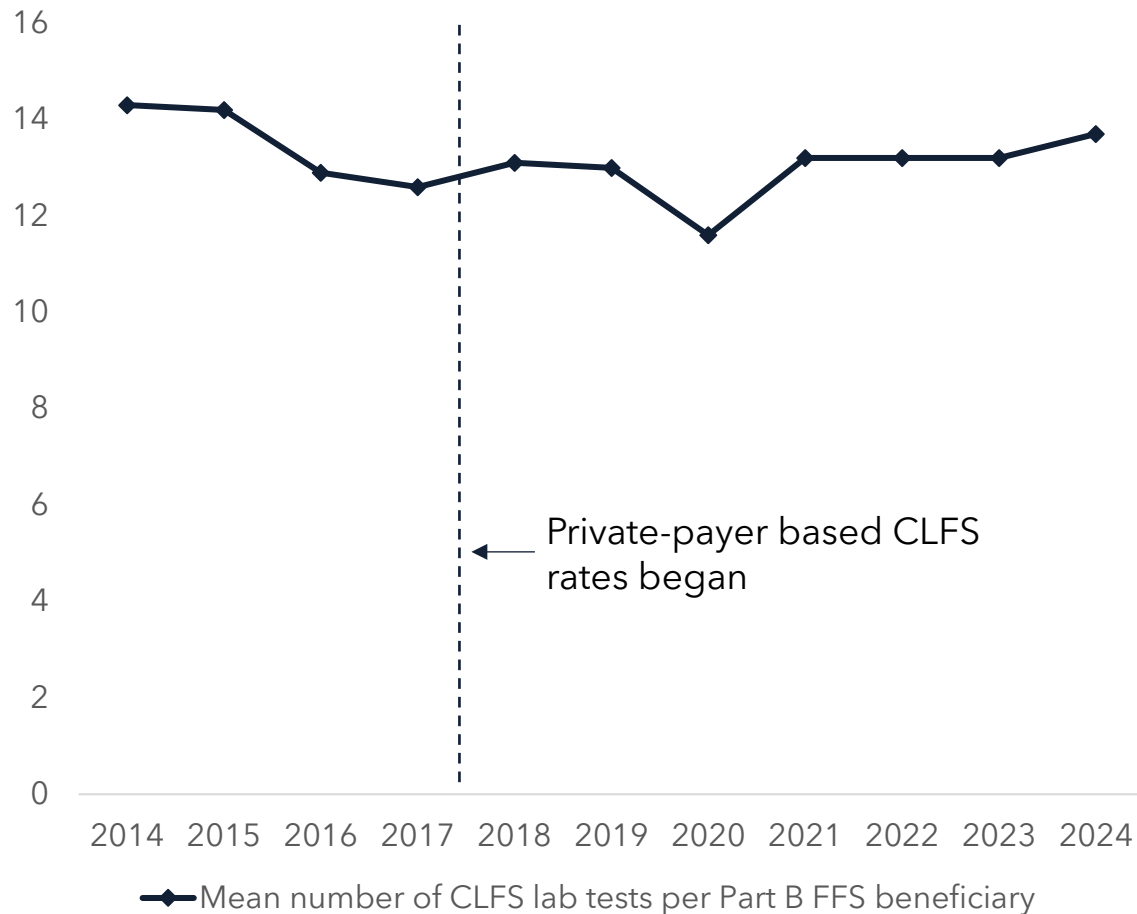
Note: CLFS (clinical laboratory fee schedule), PAMA (Protecting Access to Medicare Act of 2014)
Source: MedPAC June 2021 Report to the Congress.

Findings from MedPAC's mandated report on the first round of data reporting (June 2021), cont.

- Routine, low-cost tests
 - Higher private-payer rates for some lab types (e.g., hospitals) likely reflect greater negotiating leverage
 - Incorporating data from all labs could thus result in higher-than-necessary rates
 - MedPAC: "Policymakers should consider setting lab payment rates based on private-payer data from certain types of labs (e.g., independent labs) while excluding the data from others (e.g., hospital outpatient labs)"
- Newer, higher cost tests (e.g., genetic tests)
 - Rapid spending growth and modest effect of incorporating private-payer rates suggest relying on private-payer rates alone will not control future spending growth

Note: CLFS (clinical laboratory fee schedule), PAMA (Protecting Access to Medicare Act of 2014).
Source: MedPAC June 2021 Report to the Congress.

Use of CLFS tests has been stable since payment rate reductions began in 2018



- MedPAC monitors use of CLFS tests as one measure of access to care
- Since 2017 (the year before private-payer-based rates began), the number of CLFS tests per Part B FFS beneficiary has been relatively stable
- Suggests that Medicare beneficiaries continue to have access to lab tests

Note:
Source:

CLFS (clinical laboratory fee schedule), FFS (fee-for-service).
MedPAC analysis of FFS Medicare CLFS claims data.

Update on second round of private-payer data reporting

- CMS collected a second round of private-payer data in 2026
 - Data are from January–June 2025
 - CMS changed reporting rules to require more hospitals to report data
- CMS: More labs reported in second round of data collection
 - 875 hospital labs (up 4,067%)
 - 3,262 physician-office labs (up 195%)
 - 775 independent labs (up 18%)
- CMS: Preliminary rates based on new data would reduce 2026 CLFS rates by 16%, on average

Note: CLFS (clinical laboratory fee schedule).
Source: CMS fact sheet.

MedPAC preliminary analysis of new private-payer data

- Some of the reductions stem from the fact that reductions from the first round of private-payer data collection have not been fully phased-in yet
- Required caps in 2027 on rate reductions prevents full payment reductions for nearly 800 tests
- Payment increases implemented immediately, with no phase-in
- Payment rate declines would have been slightly larger if CLFS rates were based on independent lab rates (as MedPAC had suggested)
- CMS collected data from labs that accounted for a higher share of CLFS spending than the first round of data collection

Note: CLFS (clinical laboratory fee schedule).

Source: MedPAC analysis of 2025 private-payer laboratory payment rates. MedPAC June 2021 Report to the Congress.

MedPAC preliminary analysis of new private-payer data

- Some payment rates reductions from the first round of private-payer data collection have not been fully phased in
- The results of a long and incomplete phase-in:
 - Medicare’s rates remain above private-payer rates
 - Increases in Medicare spending
 - Payment rates are less accurate

Lab test	2016 private-payer weighted median	2026 CLFS payment rate	2025 private-payer data		
			Weighted median rate	Percent change (compared with 2026 CLFS rate)	Percent change (compared 2016 private-payer rate)
Comprehensive metabolic panel	\$9.08	\$10.56	\$9.10	-14%	0%
Lipid panel	11.23	13.39	10.85	-19	-3
Assay thyroid stimulating hormone	14.87	16.80	14.90	-11	0

Note: CLFS (clinical laboratory fee schedule). Example lab tests in table were chosen because they were three of the top five CLFS tests in terms of 2025 FFS spending. Other labs tests may have different patterns.

Source: MedPAC analysis of CLFS claims data and private-payer data

Summary

- Accurate payments are important for:
 - Ensuring access to care
 - Avoiding inappropriate incentives
 - Limiting the financial burden on beneficiaries and taxpayers
- CMS has recently taken multiple steps to improve payment accuracy, but opportunities for improvement remain

Discussion

- Questions about material?
- Suggestions for future analyses?



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