CY 2025 Medicare Physician Fee Schedule Proposed Rule Summary

On July 10, the Centers for Medicare & Medicaid Services (CMS) released the Medicare Physician Fee Schedule (MPFS) proposed rule for CY 2025 (CMS-1807-P). This rule updates payment policies and payment rates for Part B services furnished under the MPFS, as well as makes changes to the Quality Payment Program (QPP). The rule in its entirety and the addenda, including Addendum B, which lists the proposed RVUs for each CPT® code can be found here. Comments are due September 9.

In this proposed rule, CMS discusses several significant policy changes, including creating a new code to address the global surgical package policy, requiring use of modifiers for 90-day global surgeries, redefining telehealth services to include audio-only services, and declining to accept and pay for the new 16 of the 17 telemedicine E/M codes. The following summarizes the major policies in the proposal. Note that the page numbers listed in this document refer to the display copy of the proposed rule. Additionally, revised and new CPT codes do not have final code numbers assigned. The complete code numbers will be provided when the final rule is released in early November.

Regulatory Impact Analysis
Highlight: Conversion factor set for a decrease yet again for CY 2025

Conversion Factor for 2025
The conversion factor for 2025 is set to decrease by approximately **2.80% from $33.2875 to $32.3562.** The cut is primarily driven by the expiration of the conversion factor increase that Congress passed in March.

Specialty Level Impact of the Proposed Changes – p. 1,561
The impact of the proposed rule's policies on group practices and individual physicians varies based on practice type and the mix of patients and services provided to those patients. Table 128 of the rule, (Appendix A of this summary) estimates the specialty level impacts of the policies included in the proposed rule and includes impacts of rate-setting changes and changes to RVUs within the budget neutral system. Table 1 below highlights estimated specialty level impacts and includes some of the specialties with the greatest impact, both positive and negative for comparison. Note that the impact table values do not reflect the decrease in the conversion factor for 2025.

Table 1: CY 2025 Estimated Impact Total Allowed Charges by Specialty

Specialty	Medicare Allowed Charges (millions)	Work RVU Impact	PE RVU Impact	MP RVU Impact	Overall Impact
Clinical Social Worker	$794	3%	1%	0%	4%
Clinical Psychologist	$680	3%	1%	0%	3%
Endocrinology	**$491**	**0%**	**1%**	**0%**	**1%**
Internal Medicine	$8,771	0%	0%	0%	1%
Hematology/Oncology	$1,501	0%	0%	0%	0%
Neurology	$1,252	0%	0%	0%	0%
Allergy/Immunology	$207	0%	0%	0%	0%
Infectious Diseases	$513	0%	0%	0%	0%
Urology	$1,532	0%	0%	0%	-1%
Vascular Surgery	$937	0%	-2%	0%	-2%

Determination of Practice Expense RVUs – p. 31
Highlight: No change in the MEI methodology while CMS waits for updated practice expense data from the AMA.
Citing the continued collection of data from the American Medical Association's Physician Practice Information Survey (PPIS), CMS has again delayed implementation of the rebased MEI data. The agency does not wish to duplicate efforts, and "will continue to monitor data available related to physician services' inputs" while the AMA PPIS survey is completed.

CY 2025 Clinical Labor Pricing Update Proposals – p. 49
Highlight: CMS is accepting comments on updated clinical labor types.
The agency did not receive new wage data or any other information for use in its calculation of clinical labor pricing. Therefore, the data finalized in 2024 will be used for the proposed clinical labor pricing in 2025. Table 5 of the proposed rule lists the clinical labor types and price per minute for 2025. The agency is accepting comments if stakeholders wish to recommend changes to any of the labor types and rates.

Development of Strategies for Updates to Practice Expense Data Collection and Methodology – p. 51
Highlight: CMS seeks comment on ways to improve practice expense inputs.

CMS continues to grapple with updating direct and indirect practice expense data inputs. In recent years, the agency has requested information from stakeholders that would provide the

agency with alternatives and solutions to update these inputs. Through this work, the agency has determined that using the PPIS data, despite its limitations, is the best source for data at this point. However, CMS notes in this year's proposed rule that they still have concerns about the use and validity of the new PPIS data. The agency believes that advertising and endorsements for the PPIS survey may have "injected bias in the validity and reliability of the information collected."

To assist the agency with updating, revising, and implementing new PE data, CMS has contracted with the RAND Corporation to create and develop other methods for measuring PE and the related inputs for future implementation. As such, the agency seeks comment on how to "improve the stability and predictability of future updates." Specific topics the agency has requested comments for include:

- Alternatives to using the PPIS data.
- Timing of recurring updates.
- Updates to supply and equipment costs including submission of third-party data sources.
- The use of a four-year phase-ins of new data.
- How do or should economies of scale (meaning a general principle that cost per unit of production decreases as the scale of production increases) factor into the PE methodology.
- Use of data, mechanisms, or approaches that "leverage meaning a general principle that cost per unit of production decreases as the scale of production increases."

Potentially Misvalued Services Under the Physician Fee Schedule – p. 56
Each year the agency reviews potentially misvalued services. The criteria are applied at the code level, and refinements are proposed by CMS for each code that may be misvalued. The review of values for the CPT code set is required by law, and since 2009, CMS has reviewed more than 1,700 codes.

CPT Codes 10021, 10004, 1005, and 10006 – p. 70
CPT codes used to report services associated with fine aspiration procedures have again been nominated by an interested party as potentially misvalued. The rule notes that the code family has been nominated as misvalued several times in recent rulemaking cycles. CMS does not believe that codes are misvalued, and notes that the code family has undergone extensive review and RUC surveys. Therefore, CMS has affirmed the values for CPT codes 10021 (*Fine needle aspiration biopsy, without imaging guidance; first lesion*),10004 (*Fine needle aspiration biopsy, without imaging guidance; each additional lesion*), 10005 (*Fine needle aspiration biopsy, including ultrasound guidance; first lesion*) and 10006 (*Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion*).

Additionally, the agency suggests the entity(s) that nominated the codes as misvalued may wish to refer the codes to the AMA RUC for revaluation if they believe that there have been

"significant changes in the practice of delivering services described these codes that were not fully reflected in the current work RVUs."

Payment for Medicare Telehealth Services under Section 1834(m) of the Act – p. 75
Highlight: CMS adds audio-only communication technology to the definition of a telehealth service.

Requests to Add Services to the Medicare Telehealth Services List for CY 2025
CMS plans to complete a comprehensive analysis in future rulemaking of all the services on the Medicare Telehealth Services List provisionally before determining which codes should be made permanent. The process and decision-making parameters that the agency uses to make determinations as to whether a code(s) may be placed on the telehealth service list is found on page 78 of the proposed rule.

Continuous Glucose Monitoring – p. 84
CMS received a request to add CPT code 95251 (*Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report)* to the Medicare Telehealth Services List and assign it permanent status. The agency does not consider this to be a Medicare telehealth service and therefore is not proposing to add this service to the Medicare Telehealth Services List. "The agency denied the request because CGM is not an inherently face-to-face service, and the patient does not need to be present for the service to furnished in it is entirety."

Care Management – p. 87
CMS received a request to permanently add General Behavioral Health Integration (CPT code 99484) and Principal Care Management (CPT codes 99424-99427) to the Medicare Telehealth Services List. The agency does not consider these to be Medicare telehealth services and therefore is not proposing to add these services to the Medicare Telehealth Services List. As noted in the rule the agency states "We do not consider these services to be Medicare telehealth services because they are not inherently face-to-face services, and the patient need not be present for the services to be furnished in its entirety."

Frequency Limitations of Medicare Telehealth Subsequent Care Services in Inpatient and Nursing Facility Settings, and Critical Care Consultations – p. 96
Prior to the COVID pandemic, there were frequency limitations (i.e., the number of times a provider may bill for a service during a given time frame) for services associated with subsequent inpatient visits (CPT codes 99231, 99232, and 99233), subsequent nursing facility visits (CPT codes 99307, 99308, 99309, and 99310), and critical care consultation

services (HCPCS G codes, G0508 and G0509). However, during the pandemic, CMS lifted the frequency restrictions to allow greater access to care.

Now, the agency proposes to permanently remove frequency limitations for these services when provided via telehealth. The agency received many comments in last year's rule supporting removal. CMS has stated that frequency limitation for these services is rarely met, and that removing the frequency limitations will have little impact on overall telehealth volume. The agency will accept comments on this proposal, and requests information on the importance of in-person care for patients with higher acuity, and if there are other considerations or changes the agency should consider given the way that practice patterns have changed since the pandemic.

Audio-only Communication Technology to Meet the Definition of "Telecommunications Systems" – p. 99
CMS proposes to revise the definition of an interactive telecommunications system to also include two-way, real-time audio-only communication technology for any telehealth service furnished to a beneficiary in their home if the distant site physician is technically capable of using an audio/video system, but the patient is not capable of, or does not consent to, the use of video technology. The agency notes that providers should continue to use their clinical judgment to decide if audio-only technology is sufficient to provide a telehealth service. However, the agency recognizes that lack of access to broadband may make video calls impractical, or that patients may prefer to engage with their provider in their homes using audio-only technology. For claims for audio-only services, providers must use CPT modifier 93 to verify that all conditions have been met.
Distant Site Requirements – p. 101
CMS proposes to continue through CY 2025 to allow a distant site practitioner to use their currently enrolled practice location instead of their home address when providing telehealth services from their home. The agency will consider proposals to better protect the safety and privacy of providers.

Direct Supervision via Use of Two-way Audio/Video Communications Technology – p.103
CMS proposes to continue to define direct supervision to permit the presence and immediate availability of the supervising practitioner through real-time audio and visual interactive telecommunications through December 31, 2025. The agency proposes to permanently adopt the definition of direct supervision permitting virtual presence for services that are considered lower risk, such as services that do not ordinarily require the presence of the billing practitioner, do not require as much direction by the billing practitioner as other services, and are not typically performed by the supervising practitioner.

Teaching Physician Billing for Services Involving Residents with Virtual Presence – p.109
CMS proposes to continue the current policy through December 31, 2025, that allows teaching physicians to have a virtual presence when billing for services involving residents in teaching settings only when the service is furnished virtually (i.e., the patient, resident and teaching physician are all in separate locations). The teaching physician's virtual presence requires real-time observation and excludes audio-only technology.

Telehealth Originating Site Facility Fee Payment Amount Update – p. 113
CMS proposes that for CY 2025, the payment amount for HCPCS code Q3014 (*Telehealth originating site facility fee*) will be $31.04. This will be updated in the final rule based on historical data through the second quarter of 2024.

Valuation of Specific Codes

Percutaneous Radiofrequency Ablation of Thyroid (CPT codes 6XX01 and 6XX02) – p. 146
New CPT codes used to report the ablation of the thyroid using radiofrequency were valued by the RUC at the January 2024 RUC meeting. In this rule, CMS proposes to accept the RUC recommended work values and recommended PE inputs for both services with refinement.

Table 2: Work RVUs for Ablation of Thyroid

CPT Code	Description	CMS Recommended Work RVUS
6XX01	*Ablation of 1 or more thyroid nodule(s), one lobe or the isthmus, percutaneous, including imaging guidance, radiofrequency*	5.75
+6XX02	*Ablation of 1 or more thyroid nodule(s), additional lobe, percutaneous, with imaging guidance, radiofrequency (List separately in addition to code for primary service*)	4.25

Telemedicine Evaluation and Management (E/M) Services (CPT codes 9X075, 9X076, 9X077, 9X078, 9X079, 9X080, 9X081, 9X082, 9X083, 9X084, 9X085, 9X086, 9X087, 9X088,
9X089, 9X090, and 9X091) – p. 157

As a part of its work in a nearly complete overhaul of the E/M section of the CPT code book, the CPT Editorial Panel created, and the RUC subsequently valued 17 new codes to describe services for the provision of telemedicine E/M. The new codes for telemedicine E/M, notes the agency, mirror nearly exactly the codes for new and established office E/M services, and the RUC recommended RVUs also are nearly identical to the office visit E/M services.[1] The agency also created a table for stakeholders to reinforce this point. Table 10, *Comparison of Elements and Work RVU between Telemedicine E/M Codes (9X075 through 9X090) and Office/Outpatient E/M Codes (99202 through 99215),* can be found on page 165.

Noting that there are already services on the Medicare telehealth services list (office/outpatient E/M code set) that describe E/M services when furnished via telemedicine and that the agency is required by section 1834(m)(2)(A) to "pay an equal amount for a service furnished using a "telecommunications system" as for a service furnished in person, the agency believes that there is not a programmatic need to recognize and provide payment for the newly established telemedicine E/M codes. The codes 9X075-9X090 will be assigned a procedure status indicator of "I" indicating that there is a more specific code that should be used in the Medicare program, in this instance the existing office E/M codes. Providers should continue to use the appropriate modifier and place service codes.

However, CMS did propose to value one of the 17 new codes. CMS proposes to accept the RUC recommended value, and make payment for CPT 9X091 (*Brief communication technology-based service (eg, virtual check-in) by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion).* This code is almost identical to the code that CMS created to report these services. Therefore, CMS will delete HCPCS code G2012, and instead providers should use the new CPT code to report a virtual check-in. CMS proposes to accept the RUC recommended work value of 0.30, and the RUC recommended direct PE inputs

The agency does realize that the statutory extension of certain Medicare telehealth flexibilities—the waiver of the originating site requirement and geographic restrictions and coverage of audio-only services—will expire at the end of 2024 unless Congress takes additional action to maintain the flexibilities. Therefore, considering this, the agency seeks

[1] Medicare Physician Fee Schedule, 2025 proposed rule, pg. 163/164 display copy.

comment on mitigating the negative impact of the expiration of the flexibilities, and how the agency may be able, under its authority, to maintain access to care.

Request for Information for Services Addressing Health-Related Social Needs (Community Health Integration (G0019, G0022), Principal Illness Navigation (G0023, G0024), Principal Illness Navigation-Peer Support (G0140, G0146), and Social Determinants of Health Risk Assessment (G0136) – p. 213

Highlight: CMS seeks comment on ways to improve new codes used for reporting services like illness navigation and community health integration.

During last year's rule making cycle, the agency proposed and finalized payment under the MPFS for services that address the health-related social needs of Medicare beneficiaries. These services included community health integration, principal illness navigation, principal illness navigation-peer support, and the provision of a social determinants of health risk assessment. The new services were created as part of the Biden administration's plan to increase access to care in a fair and equitable manner. Now, the agency is requesting additional information on ways to improve these services, address any care gaps that may not be covered by the new codes, and possibly create additional codes within the scope of this policy. Other comments and information requested include:

- Are there any real or perceived barriers to furnishing the services?
- Are there other types of auxiliary personnel, other certifications or training requirements that should be allowed to provide these services?
- What types of auxiliary personnel are providing these services?
- How does the provision of community health integration services, and principal illness navigation services interact with community-based organizations (CBOs)? Have collaborative roles been developed between the billing practitioners and the CBOs?
- Seeking comment on the extent of practitioners contracting with CBOs to provide these services.

The agency is requesting information on fracture care delivery, and if there are programmatic or other policy changes that the agency could implement to improve this care.

- Seeking comment on how often evidence-based care for persons with factures is NOT adhered to? What are the barriers to providing evidenced-based care for fractures?
- Are the codes for principal illness navigation, transitional care management, and other E/M services appropriately used and reimbursed for fracture care?
- Could the new GPOC1 code (see the code descriptor in the discussion of global surgery coding), used to report care by a practitioner that is different form the one that provided the surgical treatment, be used to report care associated with fractures?

Office/Outpatient (O/O) E/M Visit Complexity Add-on – p. 243
Highlight: CMS continues to update, revise and implement policies that support primary and non-procedural care provided to Medicare beneficiaries including expanding the use of G2211.

In the CY 2024 MPFS final rule, CMS finalized separate payment for the O/O visit complexity add-on code G2211 to reflect "the time, intensity, and PE resources involved when practitioners furnish the kinds of O/O E/M visits that enable them to build longitudinal relationships with all patients…and to address the majority of a patient's health care needs with consistency and continuity over longer periods of time." The final policy prohibited payment for the add-on code when the O/O E/M code is reported with modifier -25. In response to stakeholder concerns, CMS proposes to allow the add-on code to be billed when an O/O E/M code is reported on the same day as an annual wellness visit (AWV), vaccine administration service, or any Medicare Part B preventive service delivered in the office or outpatient setting.

Proposals on Medicare Parts A and B Payment for Dental Services Inextricably Linked to Specific Covered Services – p. 392
Highlight: CMS continues to study the payment for dental services for Medicare beneficiaries.

Submissions Received through Public Submission Process
CMS received thirteen submissions for additional clinical scenarios for which dental services are inextricably linked to other covered services. Submissions for the CY 2026 PFS rulemaking should be received by February 10, 2025, and may be submitted to MedicarePhysicianFeeSchedule@cms.hhs.gov.

Request for Comment on Dental Services Integral to Specific Covered Services to Treat Diabetes -p. 422
Stakeholders suggested that dental services are inextricably linked to treatment services for individuals with diabetes. While the evidence demonstrates that an individual with both a diagnosis of diabetes and of periodontitis who receive periodontal treatment services may experience improvements in markers for HbA1c, these outcomes do not align with CMS' framework to pay for dental services inextricably linked to covered services. The agency is not proposing to add these services as they have not identified additional dental services that are inextricably linked to certain services in the treatment of diabetes.

CMS seeks feedback about what the coordination between a medical and dental professional would entail when an individual with a diabetes diagnosis presents with suspected periodontitis. Specifically, how are recommendations conveyed between the medical and dental professionals? What coordination, if any, occurs between the medical and dental professionals? The agency also seeks feedback on how oral treatment services may be a clinical prerequisite in the treatment protocol for the care of individuals with diabetes.

Implementation of Payment for Dental Services Inextricably Linked to Other Specific Covered Services – p. 441
CMS proposes that the KX modifier will be required for claims submissions for dental services inextricably linked to covered medical services on both the dental claim format 837D and the professional claim format 837P. Use of the KX modifier will indicate that the dental services meet the established payment criteria; that the provider has included appropriate documentation in the medical record to support the medical necessity; and that there is coordination of care between the medical and dental providers. The modifier will be required effective January 1, 2025; providers can choose to begin using the modifier for CY 2024 services to support the transition. The agency intends to provide additional instruction and education through guidance.

Medicare Diabetes Prevention Program (MDPP) – p. 591
Highlight: The agency proposes to refine certain terms used to outline the parameters of the MDPP such the term online.

CMS proposes changes to align the MDPP with the Centers for Disease Control and Prevention's (CDC) Diabetes Prevention Recognition Program (DPRP) Standards. To facilitate this alignment, the agency proposes new and revised terms for the MDPP program.

Consistent with CDC DPRP Standards for in-person and distance learning sessions, CMS proposes a new MDPP term, "in-person with a distance learning component," which is defined as "MDPP sessions that are delivered in person by trained Coaches where participants have the option of attending sessions via MDPP distance learning. These sessions must be furnished in a manner consistent with DPRP Standards for in-person and distance learning sessions." Additionally, CMS proposes to add a new term "combination with an online component" defined as "sessions that are delivered as a combination of online (non-live) with in-person or distance learning. These sessions must be furnished in a manner consistent with the DPRP Standards for the modality being used."

The agency proposes to remove the term "combination delivery," which is defined as "MDPP sessions that are delivered by trained coaches and are furnished in a manner

consistent with the DPRP Standards for distance learning and in-person sessions for each individual participant." Additionally, the agency proposes to revise the definition for "online delivery." First, the term will be changed to "online" from "online delivery" and the definition of "online" delivery mode to provide that sessions that are delivered one hundred percent through the internet via phone, tablet, or laptop are an asynchronous classroom where participants are experiencing the content on their own time without a live (including non-artificial intelligence) Coach teaching the content. These sessions must be offered in a manner consistent with the DPRP Standards for online sessions.

Additionally, CMS proposes to modify its regulation to clarify that MDPP make-up sessions can only be furnished in-person or through distance learning. Specifically, the agency proposes adding the following language to its regulation: MDPP make-up sessions may only use in-person or distance learning delivery. This change necessitates further change requiring that self-reported weights must be obtained during live, synchronous online video technology, such as video-chatting or video conferencing during which the MDPP Coach observes the beneficiary weighing themselves and view the weight indicated at the at-home digital scale, or the MDPP supplier receives two date-stamped photos or a video recording of the beneficiary's weight, with the beneficiary visible on the scale

Since make-up sessions are essential to assisting a MDPP beneficiary remain on track, CMS proposes to require MDPP suppliers to append a modifier to the applicable G-code for the second session held on the same day as a regularly scheduled session. Specifically, modifier 79 (repeat services by the same physician) must be added to any claim for G9886 or G9887 to identify that a makeup session was held on the same day as a regularly scheduled session.

CMS proposes a revision to specify in-person and distance learning delivery for MDPP core and maintenance sessions to require MDPP suppliers to offer MDPP beneficiaries no fewer than all the following:

- 16 in-person distance learning core sessions no more frequency than weekly for the first six months of the MDPP services period, which begins on the date of attendance at the first such core session.
- One in-person or distance learning core maintenance session each month during months seven through 12 (six months total) of the MDPP services period.

CMS has clarified that the performance payment for the required minimum weight loss is made for five percent weight loss and can be made for distance learning and in-person MDPP sessions. For Performance Goal 2, performance payments can be made when nine percent weight loss is achieved either at an in-person or distance learning sessions.

Appendix A: Specialty Level Impact Table

TABLE 128: 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 of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
Allergy/Immunology	$207	0%	0%	0%	0%
Anesthesiology	$1,488	1%	1%	0%	2%
Audiologist	$70	0%	0%	0%	0%
Cardiac Surgery	$155	0%	0%	0%	0%
Cardiology	$5,748	0%	0%	0%	0%
Chiropractic	$616	0%	1%	0%	1%
Clinical Psychologist	$680	3%	1%	0%	3%
Clinical Social Worker	$794	3%	1%	0%	4%
Colon And Rectal Surgery	$143	0%	1%	0%	0%
Critical Care	$309	0%	0%	0%	1%
Dermatology	$3,717	0%	0%	0%	0%
Diagnostic Testing Facility	$875	0%	-2%	0%	-2%
Emergency Medicine	$2,240	0%	0%	0%	0%
Endocrinology	$491	0%	1%	0%	1%
Family Practice	$5,133	0%	0%	0%	1%
Gastroenterology	$1,372	0%	0%	0%	0%
General Practice	$341	0%	0%	0%	0%
General Surgery	$1,484	0%	0%	0%	0%
Geriatrics	$193	0%	1%	0%	1%
Hand Surgery	$251	-1%	0%	0%	-1%
Hematology/Oncology	$1,501	0%	0%	0%	0%
Independent Laboratory	$512	0%	0%	0%	0%
Infectious Disease	$513	0%	0%	0%	0%
Internal Medicine	$8,771	0%	0%	0%	1%
Interventional Pain Mgmt	$792	0%	0%	0%	0%
Interventional Radiology	$418	0%	-2%	0%	-2%
Multispecialty Clinic/Other Phys	$142	0%	0%	0%	0%
Nephrology	$1,571	0%	1%	0%	1%
Neurology	$1,252	0%	0%	0%	0%
Neurosurgery	$658	0%	0%	0%	0%
Nuclear Medicine	$47	0%	0%	0%	0%
Nurse Anes / Anes Asst	$987	0%	1%	0%	1%
Nurse Practitioner	$6,531	0%	0%	0%	0%
Obstetrics/Gynecology	$531	0%	0%	0%	-1%
Ophthalmology	$4,469	-1%	-1%	0%	-1%
Optometry	$1,280	0%	0%	0%	-1%

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
Oral/Maxillofacial Surgery	$57	0%	0%	0%	0%
Orthopedic Surgery	$3,239	-1%	0%	0%	-1%
Other	$54	0%	0%	0%	0%
Otolaryngology	$1,095	0%	0%	0%	0%
Pathology	$1,090	0%	0%	0%	0%
Pediatrics	$51	0%	0%	0%	1%
Physical Medicine	$1,054	0%	0%	0%	0%
Physical/Occupational Therapy	$5,607	0%	0%	0%	0%
Physician Assistant	$3,472	0%	0%	0%	0%
Plastic Surgery	$280	0%	0%	0%	-1%
Podiatry	$1,780	0%	0%	0%	0%
Portable X-Ray Supplier	$69	0%	1%	0%	1%
Psychiatry	$795	1%	0%	0%	1%
Pulmonary Disease	$1,188	0%	0%	0%	1%
Radiation Oncology and Radiation Therapy Centers	$1,458	0%	0%	0%	0%
Radiology	$4,273	0%	0%	0%	0%
Rheumatology	$496	0%	0%	0%	0%
Thoracic Surgery	$277	0%	0%	0%	0%
Urology	$1,532	0%	-1%	0%	-1%
Vascular Surgery	$937	0%	-2%	0%	-2%
Total	$106,413	0%	0%	0%	0%

* Column F may not equal the sum of columns C, D, and E due to rounding.