RESEARCH BRIEF

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Medicare Fee Schedules and Workers Compensation in 2025

The Centers for Medicare and Medicaid Services (CMS) updates its reimbursement rules and rates for medical services each year. This report highlights key changes in the 2025 update and the potential impact on workers compensation (WC) medical costs.

INTRODUCTION

The National Council on Compensation Insurance (NCCI) monitors changes in CMS reimbursement rules and rates that impact WC medical costs. The impacts of these changes on WC medical costs vary by state. The medical service categories covered by medical fee schedules, the extent to which each fee schedule incorporates the CMS rules and rates, and the distribution of medical costs all influence how each state is impacted. NCCI's report, Medicare Fee Schedules and Workers Compensation in 2024, highlighted noteworthy aspects of the 2024 update.

This report highlights the 2025 changes to CMS fee schedules for the following service categories:

- Physician
- Facility
- Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

KEY FINDINGS

- The physician conversion factor was updated to 32.3465, a 2.8% decrease from the 2024 conversion factor of 33.2875
- Facility base rates saw moderate increases that were in line with the increases seen in prior years
- Changes to the rural floor and low wage hospital policy in the wage index calculation have impacted wage indices in recent years
- The 2.4% increase to the CMS DMEPOS update factor in 2025 is in line with the increase from last year

Physician Fee Schedule Changes

Physician costs account for about 40% of countrywide[1] WC medical expenditures. Physician fee schedules in WC are often based on factors published in the annual CMS Physician Fee Schedule (PFS).

There are two general components involved in the calculation of the maximum allowable reimbursement (MAR) for a given physician service: a Relative Value Unit (RVU) and a conversion factor. RVUs are procedure-specific weights

[1] Based on NCCI's Medical Data Call. Includes data from the following jurisdictions: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, TX, UT, VA, VT, and WV. Unless stated otherwise, statistics are for Service Year 2023 WC data.

that represent the relative expense to perform the procedure. The physician conversion factor is a constant factor applied to all non-anesthesia physician procedures that converts RVUs into dollars.

CMS publishes the physician conversion factor annually. CMS determines the conversion factor by beginning with the prior year's conversion factor and adjusting it with respect to multiple factors, including statutory requirements and compliance with budget neutrality.

Of note, there is currently no inflationary adjustment to account for changes to the prices of goods and services reflected in the annual update to the physician conversion factor. For reference, the CMS calculates a measure of cost inflation for operating a physician practice, the Medicare Economic Index (MEI), each year even though it is not used to update payments. In 2025, the MEI increased by 3.5% according to CMS.

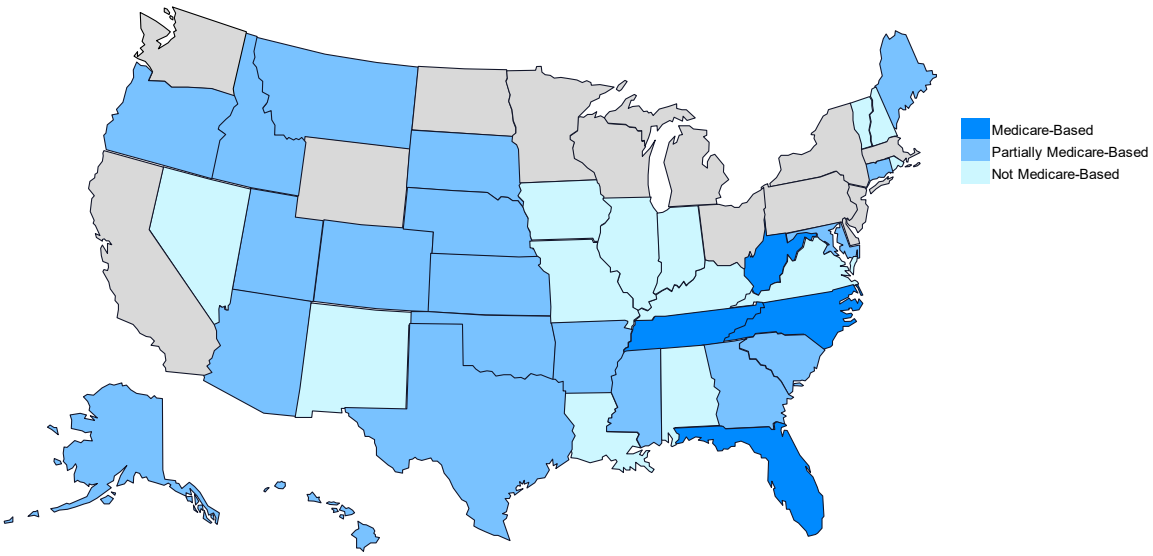
The table below shows the conversion factors for physician services for the latest four calendar years:

	Effective Date				
	1/1/2022	1/1/2023	1/1/2024	3/9/2024	1/1/2025
Conversion Factor	34.6062	33.8872	32.7442	33.2875	32.3465
Percentage Change From Prior Year	−0.8%	−2.1%	−3.4%	−1.8%	−2.8%

The physician conversion factor updates are influenced by legislative changes. In each update from 2022 through 2024, CMS initially published a conversion factor lower than the final effective factor as shown in the table above. Various acts of Congress have resulted in temporary payment increases to the conversion factor proposed by CMS. For the 2022 and 2023 updates, these increases were established prior to the January publication of the final conversion factor. In 2024, the original proposed conversion factor was effective through March 8 when the Consolidated Appropriations Act of 2024 was signed into law, offsetting the initial decrease to the factor. In 2025, the original conversion factor of 32.3465, which became effective on January 1, 2025, has remained unchanged.

For states that incorporate the physician conversion factor from CMS, the conversion factor applies to all non-anesthesia physician services on the fee schedule. Therefore, a decrease to the physician conversion factor will impact the majority of physician services in those Medicare-based states.

The map below displays each state's level of reliance on the physician payment rates that are published annually by the CMS.



Note: NCCI does not provide ratemaking services to the states in gray.
As of 1/1/2025.

- **Medicare-Based:** These states incorporate both the CMS-published conversion factor and RVUs into their fee schedules
- **Partially Medicare-Based:** These states use state-specific conversion factors in combination with CMS-published RVUs
- **Not Medicare-Based:** These states do not incorporate the CMS-published conversion factor or RVUs

The second key piece of the physician MAR formula is the RVUs. CMS has not made significant changes to physician service RVUs since the 2021 update, which implemented large increases to evaluation and management codes. In recent updates, RVUs have remained relatively unchanged.

The RVUs determined by CMS are budget-neutral, meaning that the changes in RVUs must not result in an increase or decrease in total Medicare spending. However, the basket of services used in general medicine differs from the services typically utilized in WC. The RVUs for the mix of services utilized in the WC system see slight increases from the 2025 updates.

The impact of these changes on WC medical costs will vary by state depending on the state's reliance on CMS values when setting MARs. The interaction between the decrease in the conversion factor and increase in RVUs may result in a small decrease in physician costs for states that incorporate the CMS conversion factor.

Facility Fee Schedule Changes

In WC, facility costs also account for about 40% of countrywide WC medical expenditures.

CMS publishes annual updates to the payment systems that govern payment rates for services performed at the following facility types: hospital outpatient, ambulatory surgical centers (ASC), and hospital inpatient.

The table below displays the CMS payment system associated with each facility type:

Facility Type	CMS Payment System
Hospital Outpatient	Outpatient Prospective Payment System (OPPS)
ASC	ASC Payment System
Hospital Inpatient	Inpatient Prospective Payment System (IPPS)

As is the case with physician services, for each facility type, CMS determines the payment rate for any given service by considering two main factors: the base rate and the relative weight.

The base rate change is analogous to the change in the physician conversion factor; it applies to all facility procedures and converts relative weights for each procedure into a dollar amount.

Unlike physician services, the CMS annual updates to the base rates for facility services account for changes in the prices of goods and services used by hospitals in treating Medicare patients. This is referred to as the market basket update.

In 2025, the market basket update is a 3.4% increase.

The national base rates are additionally adjusted for productivity and budget neutrality, among other changes. The changes in the national base rates for the most recent five calendar years are shown below:

		Base Rate				
Facility Type	Payment System	2021	2022	2023	2024	2025
Hospital Outpatient	OPPS	$82.80	$84.18	$85.59	$87.38	$89.17
ASC	ASC Payment System	$48.95	$49.92	$51.85	$53.51	$54.90
Hospital Inpatient	IPPS	$6,427.52	$6,594.24	$6,859.53	$7,001.60	$7,136.53

		Change From Prior Year				
Facility Type	Payment System	2021	2022	2023	2024	2025
Hospital Outpatient	OPPS	—	+1.7%	+1.7%	+2.1%	+2.0%
ASC	ASC Payment System	—	+2.0%	+3.9%	+3.2%	+2.6%
Hospital Inpatient	IPPS	—	+2.6%	+4.0%	+2.1%	+1.9%

Additional factors are applied to the national base rate to calculate the base rate used for payments to individual hospitals.

One such additional factor is the wage index, which adjusts the base rate to reflect geographic differences in hospital wage levels. Changes to two components of the wage index calculation have impacted wage indices in recent years.

The rural floor calculation uses the wage index for rural hospitals to set a minimum wage index for all hospitals within a state. The Fiscal Year (FY) 2024 IPPS update changed the definition of rural hospitals in the rural floor calculation to include hospitals which are reclassified from urban to rural. CMS rules allow hospitals to reclassify for various reasons. This definition change, as well as subsequent hospital reclassifications, have led to a significant increase in the number of hospitals to which the rural floor applies. This has contributed to increases in average wage index values in states where the rural floor has increased. These increases are offset by the rural floor budget neutrality factor which impacts all hospitals. To offset states where the rural floor has increased, CMS reduced the overall wage index in all states by a small offsetting factor of 2.3%.

The low wage index policy, introduced in FY 2020, increased the wage index values for hospitals below the 25th percentile wage index. The low wage index hospital policy was discontinued in the FY 2025 IPPS based on a decision by the United States Court of Appeals for the District of Columbia Circuit. This is most impactful to rural states, where a larger share of hospitals previously qualified for the low wage index adjustment. For hospitals significantly impacted by the removal of the low wage policy, CMS implemented a one-time transitional payment exception to smooth the transition.

The overall impact in WC of changes to the CMS relative weights for Hospital Outpatient and ASC services in 2025 are minor.

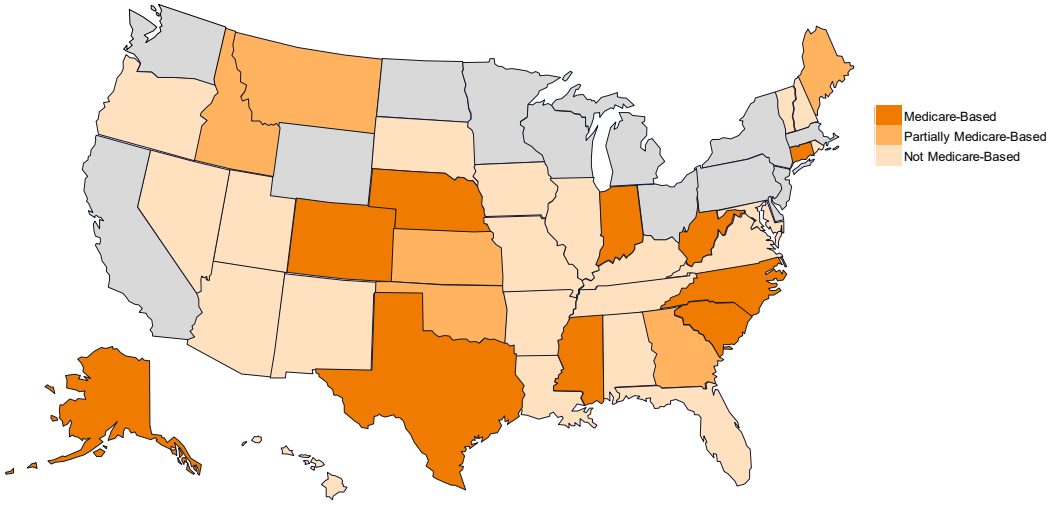
One notable change to the relative weights in the 2025 IPPS update is the reclassification of Medicare Severity Diagnosis-Related Groups (MS-DRGs) for spinal fusion procedures. For states that base their hospital inpatient fee schedules on IPPS, this update replaces 5 current MS-DRGs for spinal fusions with 10 new, more granular, MS-DRGs. The new MS-DRGs differentiate the complexity and cost differences between single-level and multiple-level spinal fusions. Payment rates for single-level spinal fusions will be lower than they were under the prior system, while payment rates for multiple-level spinal fusions will be higher.

Spinal fusions are relatively common in WC, accounting for around 10% of total inpatient costs. In WC, single-level spinal fusions are more common, representing about 60% of all spinal fusion procedures in 2023. Based on the mix of spinal fusion procedures in WC, the new MS-DRG codes are likely to decrease the average amount paid per spinal fusion procedure.

The impact of the 2025 CMS facility payment rate changes on WC medical costs will vary by state depending on the state's reliance on CMS values when setting rates. The interaction between the increase in the base rates and minor changes in relative weights may result in a moderate increase in facility costs for states that incorporate the CMS base rates.

The maps below display each state's level of reliance on the facility payment rates that are published annually by the CMS.

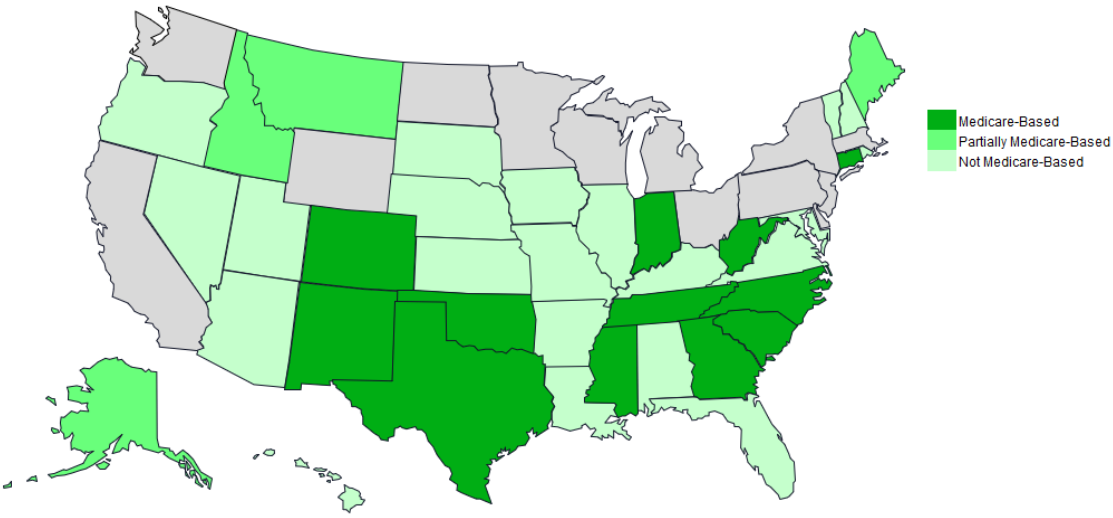
Inpatient:



Note: NCCI does not provide ratemaking services to the states in gray.
As of 1/1/2025.

- **Medicare-Based:** These states incorporate both the CMS-published IPPS base rates and relative weights into their fee schedules
- **Partially Medicare-Based:** These states use state-specific base rates in combination with CMS-published IPPS relative weights
- **Not Medicare-Based:** These states do not incorporate the CMS-published base rates or relative weights

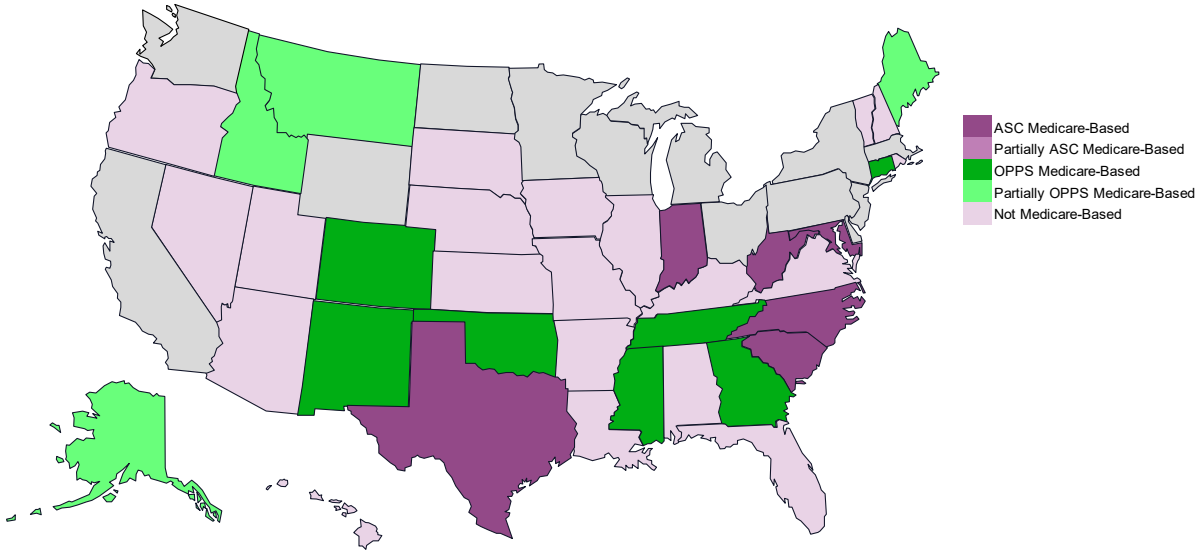
Outpatient:



Note: NCCI does not provide ratemaking services to the states in gray.
As of 1/1/2025.

- **Medicare-Based:** These states incorporate both the CMS-published OPPS base rates and relative weights into their fee schedules
- **Partially Medicare-Based:** These states use state-specific base rates in combination with CMS-published OPPS relative weights
- **Not Medicare-Based:** These states do not incorporate the CMS-published base rates or relative weights

ASC:



Note: NCCI does not provide ratemaking services to the states in gray.
As of 1/1/2025.

- **ASC Medicare-Based:** These states incorporate both the CMS-published ASC Payment System base rates and relative weights into their fee schedules
- **Partially ASC Medicare-Based:** These states use state-specific base rates in combination with the CMS-published ASC Payment System relative weights
- **OPPS Medicare-Based:** These states incorporate both the CMS-published OPPS base rates and relative weights into their fee schedules
- **Partially OPPS Medicare-Based:** These states use state-specific base rates in combination with the CMS-published OPPS relative weights
- **Not Medicare-Based:** These states do not incorporate the CMS-published base rates or relative weights

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

The share of costs that DMEPOS represents varies by state, ranging between 4% and 14% of WC medical costs.

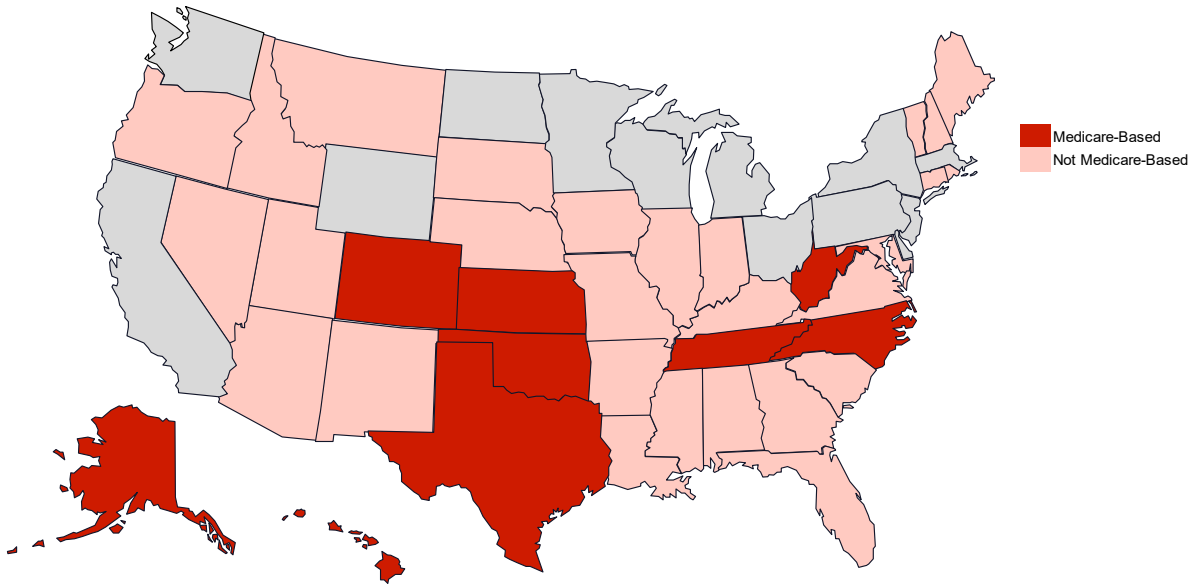
CMS groups codes into two categories for the purpose of adjusting the DMEPOS fee schedule each year. The first group includes codes subject to the DMEPOS Competitive Bidding Program. The second group—comprising the majority of DMEPOS payments in WC—is for codes not subject to the Competitive Bidding Program. A CMS-calculated factor, composed of the Consumer Price Index for All Urban Consumers (CPI-U) and a productivity adjustment, updates the reimbursable amount for the latter group.

The table below shows the CMS-published fee schedule update factors for DMEPOS services for the four most recent calendar years:

2022 Fee Schedule Update Factor	2023 Fee Schedule Update Factor	2024 Fee Schedule Update Factor	2025 Fee Schedule Update Factor
+5.1%	+8.7%	+2.6%	+2.4%

The impact of the 2025 CMS DMEPOS payment rate changes on WC medical costs will vary by state depending on the state's reliance on CMS values in its rate setting.

The map below displays each state's level of reliance on the DMEPOS payment rates that are published annually by the CMS.



Note: NCCI does not provide ratemaking services to the states in gray.
As of 1/1/2025.

- **Medicare-Based:** These states incorporate CMS-published DMEPOS payment rates into their fee schedules
- **Not Medicare-Based:** These states do not incorporate the DMEPOS payment rates published by CMS

CONCLUDING REMARKS

The 2025 physician conversion factor has decreased by 2.8% from the 2024 factor. Facility base rates saw moderate increases in line with prior years. As in 2024, the factors published by CMS are **not** a significant source of upward pressure on workers compensation medical costs. The impacts of these changes on WC medical costs vary by state. The medical service categories covered by medical fee schedules, the extent to which each fee schedule incorporates the CMS rules and rates, and the distribution of medical costs all influence how each state is impacted.