

CPT® Code Changes and the 2025 CMS Final Rules

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CMS has issued the Final Rules and CPT® codes for use in 2025 have been released. The following is a summary of the changes that Optometrists need to know for the coming year.

At this time, unless the US Congress enacts changes, the 2025 Physician Fee Schedule (PFS) will be reduced by 2.93%. While there is no change in the PFS conversion factor, the temporary PFS increase implemented by the US Congress for 2024 will expire accounting for the decrease in the 2025 PFS. In addition, there will be an approximately 0.02% adjustment in Relative Values Units (RVUs) due to changes in the work RVUs. Ultimately the RVU conversion factor for 2025 will show a decrease of \$0.84 to \$32.35. (The 2024 conversion factor was \$33.29.) You can find the 2025 PFS for specific codes [here](#) (Novitas) or [here](#) (CMS).

The Medicare Part B deductible for 2025 will be \$257 (a \$17 increase). This is the amount that all traditional Medicare patients will need to pay before Medicare begins paying any claims. Keep in mind that the deductible requirement is based on the date of service rather than the date of the Medicare explanation of benefits (EOB). Providers can learn how to check the Medicare eligibility, including whether the deductible has been met and the secondary Medicare payor, [here](#).

The complete PFS Final Rules can be found [here](#) and a summary press release found [here](#). The PFS Final Rule document is quite long and complex. The following is a summary of the most important points for Optometry.

Amniotic Membrane CMS approved a 23% pricing increase for amniotic membranes, from a national average of \$931.33 to \$1149.00 for 2025. This is based on a re-evaluation of the actual costs of the amniotic membranes.

Telehealth: For 2025, CPT® deleted the Telephone E&M services 99441-99443. The 2025 CPT® manual has a new set of telehealth evaluation and management (E&M) services for audio-visual telehealth services (98000-98007) and audio only telehealth services (98008 – 98015). **BUT CMS did not approve the use of these new audio-visual and audio-only telehealth services** because they exactly mirror the E&M service levels for office-based visits and were considered duplicative. Audio-visual and audio-only telehealth services can be billed using the office-based E&M codes with the appropriate modifiers (Modifier 93, 95 or FQ) and place of service codes (02 or 10). However, these new codes may be used by private payors. (See the separate listing of applicable CPT® code changes for 2025 for code details.)

Beginning in January 2025, the majority of telehealth services under Medicare will require the patient to be located in a rural medical facility, with the exception of specific services, like mental health treatment, which can still be provided with the patient remaining at home. Any provider who is eligible to bill Medicare for professional services can generally provide telehealth services. Congress could change this decision. Other points to keep in mind:

1. CMS has streamlined the classification of telehealth service to “Permanent” and “Provisional” and laid out a five-step evaluation process when considering any changes to a procedure’s telehealth status.
2. A request to add Psychological Testing and Developmental Testing (CPT codes 96112, 96113, 96130, 96136, and 96137) to the Medicare Telehealth Services List on a permanent basis was denied. These services will remain under the “Provisional” category.
3. CMS is changing the regulatory definition of an “interactive telecommunications system to include two-way, real-time audio-only communication technology for any telehealth services furnished to beneficiaries in their homes if the distant site physician or practitioner is technically capable of using an interactive telecommunications system that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner, but the patient is not capable of, or does not consent to, the use of video technology. We clarify that no additional documentation, except for the appropriate modifier as mentioned above, are needed.” The appropriate modifier can be either or both of the following as applicable:
 - a. Modifier 93: Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System
 - b. Modifier FQ: Medicare telehealth service was furnished using audio-only communication technology (for RHCs and FQHCs)
4. CMS has made permanent that telehealth services claims using the Place of Service (POS) 10 - telehealth in a patient’s home - will be paid at the non-facility rate.

5. CMS will not pay separately for the new CPT codes for telehealth visits (98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, and 98015) since they duplicate the current E&M codes for office visits (99202-99215) and are duplicative when billed with the appropriate POS. (see new CPT® code list for details)

Brief communication technology-based service: For 2025, CMS will discontinue the use of G2012 (virtual check in) and replace it with the new CPT® 98016.

NEW 98016: Brief communication technology-based service (e.g., 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

(Do not report 98016 in conjunction with 98000-98015)

(Do not report services of less than 5 minutes of medical discussion)

OCT Codes: CPT edited the description of 92132, 92133 and 92134 to delete the word “scanning” and to include the words Ocular Coherence Tomography (OCT). A new code for OCT-angiography or OCT-A was added (92317). CMS has elected to use the proposed RVUs for these codes. Ultimately the RVUs for 92132, 92133, and 92134 decreased slightly while the valuation for 92137 was set at twice the RVU of 92134.

NEW 92137 Computerized ophthalmic diagnostic imaging (e.g., optical coherence tomography [OCT]), posterior segment, with interpretation and report, unilateral or bilateral; retina, including OCT angiography

(Do not report 92133, 92134, 92137 at the same patient encounter)

(Report 92137 separately when performed at same encounter as 92235, 92240, 92242)

HCPCS	Descriptor	CY 2024 Work RVU	Proposed CY 2025 Work RVU	Final CY 2025 Work RVU	CMS Work Time Refinement
92132	Computerized ophthalmic diagnostic imaging (eg, optical coherence tomography [OCT]), anterior segment, with interpretation and report, unilateral or bilateral	0.30	0.29	0.29	No
92133	Computerized ophthalmic diagnostic imaging (eg, optical coherence tomography [OCT]), posterior segment, with interpretation and report, unilateral or bilateral; optic nerve	0.40	0.31	0.31	No
92134	Computerized ophthalmic diagnostic imaging (eg, optical coherence tomography [OCT]), posterior segment, with interpretation and report, unilateral or bilateral; retina	0.45	0.32	0.32	No
92137	Computerized ophthalmic diagnostic imaging (eg, optical coherence tomography [OCT]), posterior segment, with interpretation and report, unilateral or bilateral; retina, including OCT angiography	NEW	0.64	0.64	No

Iris Prosthesis Implantation: A new CPT® I code for iris prosthesis implantation was added and the following CPT® III codes were deleted – 0616T, 0617T and 0618T.

NEW 66683 Implantation of iris prosthesis, including suture fixation and repair or removal of iris, when performed

G2211: CMS opted to retain the G2211. Optometrists may use this code as appropriate. Please review the AOA document this code use [here](#). In response to some issues that were raised, CMS did decide to include the use of G2211, as appropriate, when reported by the same practitioner on the same day as an AWV, vaccine administration, or any Medicare Part B preventive service furnished in the office or outpatient setting. Otherwise, the usage guidance does not change for 2025.

G2211: Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition

G0559 and Modifier 54: CMS is finalizing a policy to expand the applicability of the transfer of care modifier 54 to all 90-day global surgical procedures when the provider expects to only provide the surgical procedure itself. The -54 modifier use requirement will include but not be limited to situations where there is a formal and documented transfer of care as

under current policy or whether the transfer of care is informal and not documented but is expected. The goal of this policy is to provide CMS with accurate information regarding the manner in which global services are typically provided. G0559 is a new add-on code used for post-operative care services furnished by a practitioner other than the one who performed the surgical procedure (or another practitioner in the same group practice) when a formal transfer of care does not occur and is intended to more appropriately account for the time and resources involved in these post-operative follow-up visits provided (without a formal transfer of care). This code should be billed with an office or other outpatient evaluation and management (E/M) visit and only where there has not been a formal transfer of care, for new or established patients, and is only be billed once during the 90-day global period. This code encompasses tasks such as:

- Reviewing surgical notes full understanding of any unique aspects of procedure and potential complications possible
- Any research that might be required to understand the expected postoperative recovery (if outside your specialty)
- Examine the patient to determine if the postoperatively recovery is progressing normally
- Communicate with the surgeon in the event of any concerns or questions arising from the surgery occur

Please note that CMS has not made any changes for the use of Modifier -55 and should be billed exclusively in cases where there is a documented formal transfer of care between the surgeon and the Optometrist.

NEW G0559 Post-operative care services furnished by a practitioner other than the one who performed the surgical procedure (or another practitioner in the same group practice).

Transcranial Doppler: This code set has some changes for 2025. Codes 93886, 93888, 93892, or 93893 would be used when a single study is performed. CPT® codes 93896, 93897, and 93898 were added. 93890 (Transcranial Doppler study of the intracranial arteries; vasoreactivity study) was deleted and 93893 (Transcranial Doppler study of the intracranial arteries; venous-arterial shunt detection with intravenous microbubble injection) was edited. The three new codes added are meant to be used when they are performed in conjunction with a complete TCD on the same day.

NEW 93896 Vasoreactivity study performed with transcranial Doppler study of intracranial arteries, complete

NEW 93897 Emboli detection without intravenous microbubble injection performed with transcranial Doppler study of intracranial arteries, complete

NEW 93898 Venous-arterial shunt detection with intravenous microbubble injection performed with transcranial Doppler study of intracranial arteries, complete

Photobiomodulation: New CPT® III Code for photobiomodulation of the retina was added. This new experimental therapy uses specific wavelengths of light that are delivered via low-power lasers or LEDs and is thought to stimulate and improve retinal cell function, to promote cellular health & reducing oxidative stress in eye tissue. At this time, it is used for age-related macular degeneration (AMD).

NEW 0936T Photobiomodulation therapy of retina, single session

Sunset January 2030

(For bilateral procedure, report 0936T with modifier 50)

OTHER INFORMATION

Modifier Use and Impact on Reimbursement

If you use any of these modifiers, the amount CMS allows will be adjusted by the amount shown in the table (p.28 of PFS.) For surgery codes, the amount attributed to the post-operative care is in the full Physician Fee Schedule (PFS) listed for each code. You can search for any CPT code in the PFS [here](#) or [here](#). The global period and division of labor are found by scrolling to the right in the PFS displayed. For example, a search for CPT® 66984 the following is displayed meaning the global period is 90 days, the preop accounts for 10%, the surgery accounts for 70% and the postop accounts for 20% of the total fee.

Global	Pre Op	Intra Op	Post Op
090	0.10	0.70	0.20

TABLE 3: Application of Payment Modifiers to Utilization Files

Modifier	Description	Volume Adjustment	Time Adjustment
80,81,82	Assistant at Surgery	16%	Intraoperative portion
AS	Assistant at Surgery – Physician Assistant	14% (85% * 16%)	Intraoperative portion
50 or LT and RT	Bilateral Surgery	150%	150% of work time
51	Multiple Procedure	50%	Intraoperative portion
52	Reduced Services	50%	50%
53	Discontinued Procedure	50%	50%
54	Intraoperative Care only	Preoperative + Intraoperative Percentages on the payment files used by Medicare contractors to process Medicare claims	Preoperative + Intraoperative portion
55	Postoperative Care only	Postoperative Percentage on the payment files used by Medicare contractors to process Medicare claims	Postoperative portion
62	Co-surgeons	62.5%	50%
66	Team Surgeons	33%	33%
CO, CQ	Physical and Occupational Therapy Assistant Services	88%	88%

Be sure to listen to the AOA webinar on these changes to be posted soon on the AOA [EyeLearn #AskAOA](#).

Happy Coding....