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2025 Medicare Physician Fee Schedule: Payment and Overpayment Policies

Authors: Allison M. Cohen, Alissa D. Fleming, Gregory M. Fliszar, Kathleen Rose Salsbury, Anna Grace Cole, Samuel E. Cottle, Katherine A. Denney, Alexander S. Lewis
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On December 9, 2024, the Centers for Medicare & Medicaid Services' (CMS's) Calendar Year 2025 Physician Fee Schedule Final Rule (the Final Rule) was published in the Federal Register. The Final Rule includes noteworthy payment policies related to the Medicare Overpayment Rule, telehealth, supervision requirements, advanced primary care management services, evaluation and management services, clinical laboratory tests, the Medicare Shared Savings Program, and behavioral health services. We have previously discussed several of these policies when they were proposed in our articles detailing the CY 2025 Medicare Physician Fee Schedule Proposed Rule (the Proposed Rule).

Key policy changes, which go into effect on January 1, 2025, are summarized below along with our takeaways.

1. Updates to the 60-Day Overpayment Regulations for Medicare Parts A, B, C, and D That Affect How Overpayments are "Identified" and the Time Frame for Investigation and Quantification.

CMS finalized changes to the overpayment regulations to state that a person has "identified" an overpayment when the person "knowingly receives or retains an overpayment." The term "knowingly" is assigned the meaning set forth in the False Claims Act at 31 U.S.C. § 3729(b)(1)(A). Under this new definition, the provider or supplier has to have actual knowledge of the existence of the overpayment, or to act in reckless disregard or deliberate ignorance of the overpayment in order to trigger the 60-day timeframe to report and return the overpayment to avoid False Claims Act liability.

By tying the identification of an overpayment to the False Claims Act's subjective "knowledge" standard, CMS sought to address legal challenges to the overpayment regulations based on the premise that the "reasonable diligence" standard could result in the imposition of False Claims Act liability for "mere negligence."

The Final Rule appropriately aligns the obligations of overpayment regulation with the False Claims Act scienter standard. In making this necessary modification, CMS also removed the so-called "reasonable diligence standard," which stated that a person was deemed to have "identified" an overpayment when the person either determined or should have determined "through the exercise of reasonable diligence" that it received an overpayment and "quantified the amount of the overpayment."

Despite its ambiguity and misalignment with the False Claims Act, the "reasonable diligence standard" included language that allowed providers time to quantify an overpayment before it was deemed to be "identified" for purposes of triggering the 60-day clock. In an attempt to address the gap left by the removal of the quantification language, CMS also finalized its proposal to allow suspension of the 60-day deadline under certain conditions. Specifically, if a provider or supplier believes that there may be other related overpayments, the 60-day deadline for reporting and returning an overpayment can be stayed for up to 180 days. This allows for a timely, good-faith investigation to determine the existence of related overpayments that may arise from the same or similar causes or reasons as the initially identified overpayment. The suspension of the deadline remains in place until the investigation is completed or 180 days, whichever occurs earlier. CMS confirmed this up-to-180-day investigation period stays the 60-day return window rather than encompassing it. Thus, if a

provider or supplier begins an investigation on the day the overpayment is identified, they would still have 60 days to return the overpayment once the investigation period ends.

Stakeholders have raised concerns about the sufficiency of 180 days for investigation and have requested that CMS extend the timeframe or allow exceptions/extensions in complex cases. CMS did not reconsider its policy despite this request, instead making it clear that CMS believes that the total potential time period available of 240 days (essentially eight months) provides sufficient time to investigate, report, and return identified overpayments (including the initial overpayment and any related overpayments). Providers and suppliers will have to be acutely aware of the newly imposed rigid timeframe for completing even the most complex investigations.

Takeaways: Based on CMS's commentary in the Final Rule, suppliers and providers should no longer expect flexibility to extend their investigation of an identified overpayment beyond the stated regulatory timeframe, even when there are extraordinary circumstances. The provisions as finalized codify a brightline outer boundary of no more than 240 days to investigate and return overpayments (including additional related overpayments) once they are identified. This inflexible approach creates new challenges, particularly in the context of complex quantifications and investigations of related overpayments. Providers and suppliers should work with legal counsel to ensure that necessary changes are made to internal processes to take into account the Final Rule's implications for overpayment identification and investigations.

2. Telehealth.

CMS finalized a number of proposals to extend COVID-era regulatory flexibilities related to telehealth, remote services, and supervision. These extensions are limited to policies within CMS's rulemaking authority. Providers and practitioners will have to wait for legislative action by Congress to determine if other regulatory flexibilities can be extended beyond the end of 2024. Flexibilities that can only be extended by Congressional action include the temporary removal of originating site restrictions, which currently allow telehealth services to be covered by Medicare when furnished to patients in their homes and urban clinical sites. Policies within CMS's rulemaking authority that CMS chose to extend in the Final Rule are explained in further detail below:

Audio-Only Telehealth Services.

CMS is finalizing its proposed revised definition of an interactive telecommunications system. Under this revised definition, interactive audio-only telecommunications would be permitted when any telehealth service is furnished to the patient in their home as long as certain criteria are satisfied: (1) the home must be a permissible originating site; (2) the distant-site practitioner has to be capable of using an interactive audio-visual system; and (3) the patient must not be capable of or not consent to the use of video technology. Modifier 93 has to be appended to the claim for services to verify these conditions have been met.

Take-away: CMS is permanently allowing coverage for audio-only telehealth services as long as certain conditions are satisfied including that the patient is unable to use or does not consent to using audio-visual technology.

Distant/Originating Site.

CMS finalized its proposal to allow distant-site practitioners to use their currently enrolled practice location for billing and claims submission when providing services from their homes through December 31, 2025.

Takeaway: Telehealth providers and practitioners will not have to update enrollment applications to report the home addresses of telehealth practitioners who are already enrolled at their practice locations.

Frequency Limitations.
CMS is finalizing the pause of frequency limitations for certain services performed via telehealth in certain settings through December 31, 2025. The suspension of frequency limitations applies to the following codes:

- Subsequent Inpatient Visit CPT Codes: 99231, 99232, 99233 (previously limited to one telehealth visit every three days);
- Subsequent Nursing Facility Visit CPT Codes: 99307, 99308, 99309, 99310 (previously limited to one telehealth visit every 14 days); and
- Critical Care Consultation Services HCPCS Codes: G0508, G0509 (previously limited to one telehealth visit per day.

Takeaway: CMS will not reinstate the previous limitations on the number of times the aforementioned services in high acuity settings may be performed via telehealth until January 1, 2026. In the meantime, CMS will continue to evaluate whether these frequency limits are necessary to ensure patients in inpatient settings, nursing facilities, and receiving critical care services are regularly seen in person by physicians responsible for their care.

Medicare Telehealth Services List.
CMS exercised its authority to expand the list of services that are covered by Medicare when provided via telehealth (the Medicare Telehealth List). Services that were added on a provisional or permanent basis are included below:

- Caregiver training services (on a provisional basis); and
- PreP for HIV counseling services (on a permanent basis).

Modifying Policies Related to Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs).
In the Final Rule, CMS finalized its proposal to allow several telecommunication technology flexibilities for OUD treatment services furnished by OTPs, so long as the use of these technologies is permitted under the applicable SAMHSA and DEA requirements at the time the services are furnished, and all other applicable requirements are met. More specifically, CMS finalized the following related to these flexibilities:

- CMS made permanent the current flexibility for furnishing periodic assessments via audio-only telecommunications beginning January 1, 2025, so long as all other applicable requirements are met; and
- CMS finalized an OTP intake add-on code to be furnished via two-way audio-video communications technology when billed for the initiation of treatment with methadone (using HCPCS code G2076) if the OTP determines that an adequate evaluation of the patient can be accomplished via an audio-visual telehealth platform.

3. Continuing Virtual Immediate Availability for Direct Supervision.
CMS finalized its definition of 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. For certain services, CMS finalized a permanent policy of allowing the supervising practitioner to satisfy direct supervision requirements by being "immediately available" through audio/video real-time communications technology. This permanent policy would apply to the following subset of incident-to-services described under § 410.26:

- Services furnished incident to a physician or other practitioner's service when provided by auxiliary personnel employed by the billing practitioner and working under their direct supervision, and for

which the underlying HCPCS code has been assigned a PC/TC indicator of "5"; and

- Services described by CPT code 99211 (Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional).

Takeaway: CMS is permanently allowing immediate availability via telehealth to satisfy requirements for direct supervision for a limited subset of services that do not often demand in-person supervision and are typically furnished entirely by the supervised personnel.

4. Teaching Physician Billing for Services Involving Residents with Virtual Presence.

CMS finalized its proposal to continue to allow teaching physicians to meet teaching physician billing requirements to be present for key and critical portions of a service performed with a resident in circumstances in which the medical resident is providing the medical services in a virtual setting. The teaching physician's virtual presence must involve real-time observation and may not be through audio-only technology.

Takeaway: The virtual presence of a teaching physician will only result in a billable service in clinical instances when the resident's service is furnished virtually such as a three-way telehealth visit with the physician, resident, and patient in different locations.

5. Establishment of Coding and Payment for a New Set of Advanced Primary Care Management (APCM) Services.

CMS added to a growing list of care management services by finalizing three new APCM codes that differ based on patient complexity:

- Level 1 [HCPCS G0556] Patients with one or fewer chronic conditions;
- Level 2 [HCPCS G0557] Patients with two or more chronic conditions; and
- Level 3 [HCPCS G0558] Patients with two or more chronic conditions and who are Qualified Medicare Beneficiaries.

The patient's physician or advanced practice provider (nurse practitioner, physician assistant, certified nurse midwife, or clinical nurse specialist) (APP) who is responsible for the patient's primary care and serves as the continuing focal point for all health care services can bill monthly for the APCM code following an initiating qualifying visit. APCM services are designed to encourage patient communication outside of face-to-face visits. While a physician or other qualified practitioner is ultimately responsible for the patient's care, the codes allow primary care physicians and APPs to be reimbursed for services provided by care teams working under the billing practitioner's supervision to allow for more accessibility. Similar to other care management services, APCM services generally may be performed on an "incident to" basis by auxiliary personnel under the general supervision of a physician or another APP who is permitted to bill for an E/M service. An initiating visit must be performed by the physician or APP for any new patients who have not received professional services from the physician or another physician/APP in the same practice within the previous three years.

Each of the APCM codes incorporates elements of several existing care management services into a bundle that reflects the essential elements of the delivery of advanced primary care. Unlike the codes for chronic care management (CCM) and principal care management (PCM), APCM codes are not billed based on actual time spent by the practitioner.

6. Evaluation and Management (E/M) Add-On Codes.

- ***Office/Outpatient (O/O) E/M Add-on Code.***
  CMS finalized its proposal to allow the Office/Outpatient (O/O) E/M visit complexity add-on code

(HCPCS code G2211) to be billed by the same practitioner when the O/O E/M base code (CPT 99202-99205, 99211-99215) is reported on the same day as an annual wellness visit, vaccine administration, or any Medicare Part B preventive service in the office or outpatient setting.

- ***Hospital Inpatient or Observation (I/O) E/M Add-on for Infectious Diseases.*** CMS finalized its proposal to create a new add-on code (HCPCS G0545) to describe the intensity and complexity inherent to hospital inpatient or observation care associated with a confirmed or suspected infectious disease performed by a physician with specialized training in infectious diseases. HCPCS G0545 includes three service elements: (1) disease transmission risk assessment and mitigation; (2) public health investigation, analysis, and testing; and (3) complex antimicrobial therapy counseling and treatment. Each service element may not be medically appropriate for every patient with an infectious disease. As such, HCPCS code G0545 is intended to be used for one or any combination of the three service elements.

7. General Supervision of Therapists.

- CMS is allowing general supervision of physical therapy and occupational therapy assistants by occupational and physical therapists in *private practice*, to align with the general supervision policies for PTs and OTs in institutional settings (rehabilitation facilities, SNFs, etc.).

- In states that require more strict supervision levels (such as direct supervision), Medicare-covered therapies in those states must comply with state law.

8. Revised Data Reporting and Phase-In of Payment Reductions for Clinical Diagnostic Laboratory Tests.

The Continuing Appropriations and Extensions Act of 2025 (CAEA 2025) was passed on September 26, 2024, which delayed data reporting requirements for clinical diagnostic laboratory tests (CDLTs) that are not advanced diagnostic laboratory tests (ADLTs) and delayed the phase-in of payment reductions under the Clinical Laboratory Fee Schedule from private payor rate implementation. Due to CAEA 2025, the Final Rule contains several updates to the Clinical Fee Schedule. First, the next data reporting period for CDLTs that are not ADLTs will now be January 1 through March 31, 2026, and based on the original data collection period of January 1 – June 30, 2019. Second, following this data period, the data reporting cycle for CDLTs that are not ADLTs will be every three years (2029, 2032, 2035, etc.). Third, a zero percent payment reduction will be applied for calendar year 2025, so that a CDLT that is not an ADLT may not be reduced compared to the payment amount for that test in CY 2024. Fourth, for calendar years 2026-2028, payment may not be reduced by more than 15 percent per year compared to the payment amount established for a test the preceding year.

9. Reduction in Average Payment Rates under the Physician Fee Schedule (PFS).

CMS finalized that the 2025 PFS conversion factor will be reduced by 2.83 percent, from $33.2875 in 2024 to $32.3465 in 2025. This change reflects a 0.02 percent positive budget neutrality adjustment, a 0 percent update adjustment factor, and the removal of the 2.93 percent payment increase for services that was granted from March 9, 2024, through December 31, 2024. This decrease will result in lower payments for many practitioners and providers, including those involved in long term care who are particularly impacted by the squeeze of these cuts as generally long-term practice expenses are rising and payments decreasing.

10. Updates to Medicare Shared Savings Program.

CMS finalized several of its proposed changes to the Medicare Shared Savings Program (MSSP). Specifically, it finalized its proposals to:

- Require Accountable Care Organizations (ACOs) to report the APM Performance Pathway (APP) Plus quality measure set through a phase-in that has been slightly amended from the Proposed Rule. CMS finalized a modified proposal that incrementally phases in additional quality measures between

2025 and 2028. For the performance year 2025 and subsequent performance years, MSSP ACOs will be required to report using the APP Plus quality measure set and remove the current APP quality measures as a reporting choice;

- Establish a new "prepaid shared savings" (PSS) option to assist eligible ACOs with a history of earning shared savings; PSS will be an advance on shared savings earned during a performance year and be paid in quarterly installments, thus allowing ACOs to make contributions to staffing, infrastructure, and direct beneficiary services. PSS will be available to ACOs taking on downside risk and are different from the advance investment payments available to new MSSP participants. To ensure that PSS are used properly, CMS will require ACOs to publicly report the total amount of PSS received and an itemization of how PSS were spent during a performance year;

- Implement a health equity benchmark adjustment applicable to ACOs in the agreement period beginning on January 1, 2025, and in subsequent years (informed by the ACO REACH Model); The purpose of a health equity benchmark adjustment is to make certain benchmarks continue to serve as a threshold for ACOs serving a high proportion of beneficiaries from underserved populations, thus furthering the ACOs ability to earn shared savings. This adjustment will be available to ACOs with at least 15 percent of their assigned beneficiaries who are enrolled in Medicare Part D, low-income subsidy, or dually eligible for Medicare and Medicaid;

- Implement additional protections against Significant, Anomalous, and Highly Suspect (SAHS) billing activity; In adopting the final rule, CMS acknowledged that suspect billing activity can negatively affect the calculation of an ACO's shared savings and losses. CMS will now have the ability to remove any billing codes and implement adjustments to MSSP calculations based on SAHS; and

- Establish a calculation methodology to account for, and other processes to address improper payments. CMS will have the discretion to reopen payment determinations on a potential improper payment when good cause exists, including to address potential fraud and abuse.

11. New Behavioral Health Codes.

The Final Rule also details the creation of a new, stand-alone HCPCS code for safety planning interventions for patients in crisis. This code, G0560, allows the billing practitioner to bill for safety planning personally performed in 20-minute increments. Safety planning activities include:

- Assisting the patient in identifying warning signs of an impending suicidal or substance use-related crisis;
- Employing internal coping strategies;
- Distracting from suicidal thoughts;
- Utilizing family members, caregivers, and others in solving patient crises; and
- Making a safe patient environment.

CMS was persuaded by comments that these services should be given a stand-alone code, rather than an add-on code as originally proposed.

Takeaways:

- The safety planning must be a patient intervention, not just a suicide or drug overdose risk assessment;
- Can be furnished via Telehealth; and
- Must be performed by the billing practitioner for CY 2025, but CMS will continue to consider this issue.

Additionally, CMS is adding a stand-alone HCPCS code G0544 as a monthly billing code for furnishing post-discharge follow-up contacts that are performed in conjunction with discharge from an ED for a crisis encounter as a bundled service describing four calls in a month, each lasting between 10-20 minutes.

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If you have any questions about this alert, please reach out to Allison M. Cohen, Alissa D. Fleming, Gregory M. Fliszar, Kathleen R. Salsbury, or a member of the Health Law group with whom you regularly work.