

2025 Medicare Physician Fee Schedule Proposed Rule: Provisions of Interest to AHCA/NCAL Members

On July 10, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule for Medicare payments under the Physician Fee Schedule (PFS) and other Medicare Part B issues. The Medicare Part B payment policies directly and indirectly impact multiple types of services furnished to residents of short- and long-stay nursing homes, assisted living communities, and residences for individuals with intellectual and developmental disabilities (ID/DD).

These services include those from physicians, nurse practitioners, physical and occupational therapists, speech-language pathologists, and portable x-ray and laboratory service providers. When finalized, these policies would become effective January 1, 2025.

Links for more information:

- [Proposed Rule Advance Notice](#)
- [Proposed Rule Fact Sheet](#)
- [Proposed Rule Medicare Shared Savings Program \(MSSP\) Fact Sheet](#)

AHCA/NCAL is currently reviewing the proposed rule and has identified several policy changes that could impact the long term and post-acute sector. **Highlights of many of these potential policy changes are available to members below.**

The Association will be submitting comments by the end of the comment period that concludes **September 9, 2024**.

For more information and comment suggestions, please contact Dan Ciolek at dciolek@ahca.org about the PFS and Medicare Part B issues, and Nisha Hammel at nhammel@ahca.org about the MSSP provisions.

Key Proposed Medicare Part B Policy Changes Impacting AHCA/NCAL Members and Residents

Payment Rate Update: CMS proposes an estimated CY 2025 PFS rate conversion factor of \$32.36, which represents a decrease of \$0.93 (or 2.80%) from the current CY 2024 conversion factor of \$33.29. By factors specified in law, average payment rates under the PFS are proposed to be reduced by a net 2.93% in CY 2025 compared to the average amount these services are being paid for most of CY 2024. The change to the PFS conversion factor incorporates the 0.00 percent overall update required by statute, the expiration of the 2.93% increase in payment for CY 2024 required by statute, and a relatively small estimated 0.05% adjustment necessary to account for changes in work relative value units (RVUs) for some services.

Telehealth: Due to expiration of several statutory waivers, the following telehealth flexibilities would be eliminated after December 31, 2024, unless there is Congressional action.

- Geographic waivers for non-behavioral health services would sunset and the policy would return to the pre-pandemic policy of only being available for rural and medically underserved locations.
- Site-of-service waivers permitting non-behavioral telehealth from a beneficiary's home would sunset and the policy would return to the pre-pandemic policy and would only be able to be provided from a recognized telehealth location (nursing home is recognized).
- PT/OT/SLP waivers permitting outpatient rehabilitation services to be furnished would sunset, and physical and occupational therapy and speech-language pathology services would no longer be able to be furnished by therapy professionals via telehealth.

Telehealth: CMS does propose other potentially positive changes to telehealth policy impacting AHCA/NCAL members and residents, including the following.

- **Telehealth Originating Site Facility Fee Payment Amount Update** – For CY 2025, the proposed payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) that the nursing facility could bill for under Part B is \$31.04, an increase of 3.6 percent from the \$29.96 rate in 2024.
- **Physician telehealth nursing home visit limits** – CMS is proposing to continue the suspension of frequency limitations for subsequent nursing facility visits for CY 2025. If not finalized, only one follow-up telehealth visit would be permitted every 14 days for nursing home residents. The proposal applies to the following codes:
 - 99307 - Subsequent nursing facility care, per day...; 10+ minutes
 - 99308 - Subsequent nursing facility care, per day...; 15+ minutes
 - 99309 - Subsequent nursing facility care, per day...; 30+ minutes
 - 99310 - Subsequent nursing facility care, per day...; 45+ minutes

- **Audio-only telehealth** – CMS is proposing that beginning January 1, 2025, an interactive telecommunications system may 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 or practitioner is technically capable of using an interactive telecommunications system, but the patient is not capable of or does not consent to the use of video technology.
- **Caregiver Training** – CMS is proposing to add several current and proposed new caregiver training codes to the provisional telehealth list that may benefit AHCA/NCAL members and residents. The topics of training could include, but would not be limited to, techniques to prevent decubitus ulcer formation, wound dressing changes, infection control, special diet preparation, and medication administration, as well as for caregiver behavior management and modification training that could be furnished to the caregiver(s) of an individual patient.
- Several of these codes to train unpaid caregivers (examples below) are typically performed by PT/OT/SLP professionals, so unless there is Congressional action to permit therapists to perform telehealth services in 2025, beneficiary access to these services via telehealth may be severely restricted.
 - **97550** - Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community; initial 30 minutes.
 - **97551** - Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community; each additional 15 minutes.
 - **GCTD1-3** – New Codes - Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound dressing changes, and infection control) (without the patient present); initial 30 minutes, each additional 15 minutes, or (group) with multiple sets of caregivers.
 - **GCTB1-2** – New Codes - Caregiver training in behavior management/modification for caregiver(s) of a patient with a mental or physical health diagnosis, administered by a physician or other qualified healthcare professional (without the patient present); initial 30 minutes, or each additional 15 minutes.

Modifications Related to Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs): CMS is proposing several telecommunication technology flexibilities for opioid use disorder (OUD) treatment services furnished by OTPs, as long as the use of these technologies is permitted under the applicable SAMHSA (Substance Abuse and Mental Health Services Administration) and DEA requirements at the time the services are furnished, and all other applicable requirements are met.

- CMS is proposing to make 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.
- CMS is proposing to allow the 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.

Outpatient Therapy Provisions: CMS proposes certification burden reduction and other statutory required updates.

- **Outpatient Therapy Certification** – CMS proposes to revise the outpatient therapy physician certification requirements for the first 30 days so that a signed and dated order/referral from a physician/NPP combined with documentation of such order/referral in the patient’s medical record, along with further evidence in the medical record that the therapy plan of treatment was transmitted/submitted to the ordering/referring physician or NPP, is sufficient to demonstrate the physician or NPP’s certification of these required conditions. Rather than characterizing this proposal as a “presumption,” CMS is taking the view that when the patient’s medical record includes a signed and dated written order or referral indicating the type of therapy needed, CMS (and the CMS contractors) would treat the signature on the order or referral as equivalent to a signature on the plan of treatment. No separate physician signature on a certification statement would be necessary if the above documentation is present. CMS is not proposing to change the requirement for a physician signature on subsequent recertifications at this time but is requesting feedback on this topic for future rulemaking consideration.
- **KX Modifier Thresholds** - The KX modifier thresholds were established through section 50202 of the Bipartisan Budget Act of 2018 (Pub. L. 115-123, February 9, 2018) (BBA). For CY 2025, CMS proposes to increase the CY 2024 KX modifier threshold amount by 3.6 percent by law to \$2,410 for physical therapy and speech-language pathology services combined and \$2,410 for occupational therapy services. Once a beneficiary surpasses this annual threshold, the provider must add the KX modifier to outpatient therapy services as an attestation of medical necessity. Claims above this threshold without the KX modifier will be denied.
- **Medical Review Thresholds** - Section 1833(g)(7)(B) of the Act describes the targeted medical review (MR) process for services of physical therapy, speech-language pathology, and occupational therapy services. The threshold for targeted MR remains at \$3,000 through CY 2027.

Outpatient Therapy Codes on Telehealth List: CMS proposes to keep the current outpatient therapy codes on the provisional telehealth procedure list for further analysis and to be prepared in case Congress acts to permit PT, OT, and SLP clinicians to provide telehealth services beyond December 31, 2024.

Value of Outpatient Therapy Codes: CMS reviewed data from the AMA CPT RUC panel and from the APTA and AOTA therapy associations regarding the practice expense portion of the therapy codes and proposes not to change the values at this time but welcomes comments on potential revisions in future rulemaking.

E-Prescribing: Requirements for Electronic Prescribing for Controlled Substances for a Covered Part D Drug under a Prescription Drug Plan or an MA-PD Plan - Extended Compliance Date.

- Section 2003 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act (Pub. L. 115-271, October 24, 2018) generally mandates that the prescribing of a Schedule II, III, IV, or V controlled substance under Medicare Part D be done electronically in accordance with an electronic prescription drug program beginning January 1, 2021. In prior rulemaking, CMS finalized policies for the Electronic Prescribing for Controlled Substances (EPCS) Program requirements specified in section 2003 of the SUPPORT Act. CMS finalized a policy to require prescribers to electronically prescribe at least 70 percent of their Schedule II, III, IV, and V controlled substances that are Part D drugs, except in cases where an exception or waiver applies. The implementation date applying to long-term care (LTC) settings was delayed until January 1, 2025.
- Due to numerous technical and administrative challenges described in the proposed rule, CMS proposes to extend the date after which prescriptions for covered Part D drugs for Part D eligible individuals in LTC facilities would be included in the CMS EPCS Program compliance threshold calculation from January 1, 2025, to January 1, 2028, and that related non-compliance actions would commence on or after January 1, 2028.

Medicare Shared Savings Program: CMS is proposing several changes to strengthen the Medicare Shared Savings Program (MSSP) including “prepaid shared savings,” health equity benchmark adjustment, and alternative payment model pathway to align the Shared Savings program with the Universal Foundation Measure Set, as well as proposals to minimize the impact of “Significant, Anomalous, and Highly Suspect (SAHS) billing activity.”

- **Prepaid shared savings:** For certain ACO providers in Basic (levels C-E) and Enhanced tracks, with a history of success in earning shared savings, the opportunity for advance shared savings to invest in direct beneficiary services and care coordination services through staffing and healthcare infrastructure.

- **Health Equity Benchmark Adjustments:** Similar to CMMI's ACO REACH program, CMS is proposing a health equity benchmark adjustment to increase participation by safety net providers who care for underserved and rural populations.
- **Alternative Payment Model (APM) Performance Pathway (APP) Plus Quality Measure Set, Scoring Methodology, and Incentives to Report via electronic Clinical Quality Measures (eCQMs):** In an effort to move the Shared Savings Program towards the Universal Foundation of quality measures, CMS is creating an alternative payment model performance pathway to create better quality measure alignment for providers and propelling care transformation.
- **Significant, Anomalous, and Highly Suspect (SAHS) Billing Activity:** CMS is putting forth proposals to update the financial methodology to curb improper payments that are complementary to proposals in the recent June 28, 2024 proposed rule, "Medicare Program: Mitigating the Impact of Significant, Anomalous, and Highly Suspect Billing Activity on Medicare Shared Savings Program Financial Calculations in Calendar Year 2023" (CMS-1799-P).
 - NOTE: The 30-day SAHS Billing Activity comment deadline is July 29.
 - MSSP comments are due on September 9 with the PFS comment deadline.

Other Proposed Policies Impacting AHCA/NCAL Members and Residents:

- **Portable X-Ray (HCPCS codes R0070-R0075):** Several Portable X-Ray (PXR) suppliers and trade organizations continue to express longstanding concerns with how payment is established for transportation related to these services and are wanting more consistency in the pricing of these services, including the application of an inflation factor. This issue is creating portable x-ray access issues for nursing facilities in certain geographic areas. To remain consistent and transparent in the pricing of PXR services, CMS is proposing to revise language in our Medicare Claims Processing manual (Chapter 13, 90.3 and Chapter 23, 30.5) to reflect any updates to the Agency's guidance to the Medicare Administrative Contractors (MACs) for these services.
- **Clinical Laboratory Fee Schedule (CLFS):** Clinical laboratory rates are due for significant reductions that could impact access to these services for certain nursing facilities. On November 17, 2023, section 502 of the Further Continuing Appropriations and Other Extensions Act, 2024 (Pub. L. 118-22) (FCAOEA, 2024) was passed and delayed data reporting requirements for CDLTs that are not ADLTs, and it also delayed the phase-in of payment reductions under the CLFS from private payor rate implementation under section 1834A of the Act.
 - CMS proposes to change data collection periods to base the cuts from and then to make conforming changes to the phase-in of payment reductions requirements to indicate that for CY 2024, payment may not be reduced by more than 0.0% as compared to the amount established for CY 2023, and for

CYs 2025 through 2027, payment may not be reduced by more than 15% as compared to the amount established for the preceding year. This proposal reflects amendments to section 502(a) of the Further Continuing Appropriations and Other Extensions Act, 2024 (FCAOEA, 2024).

- **Dental Services - Proposed Additions to Current Policies Permitting Payment for Dental Services Inextricably Linked to Other Covered Services:** CMS is proposing to amend regulations at § 411.15(i)(3) to add to the list of clinical scenarios under which FFS Medicare payment may be made for dental services inextricably linked to covered services to include: (1) dental or oral examination in the inpatient or outpatient setting prior to Medicare-covered dialysis services for beneficiaries with end-stage renal disease; and (2) medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to, or contemporaneously with, Medicare-covered dialysis services for beneficiaries with end-stage renal disease.
- **Expand Hepatitis B Vaccine Coverage:** CMS proposes to expand coverage of hepatitis B vaccinations by covering individuals who have not previously received a completed hepatitis B vaccination series or whose vaccination history is unknown. This proposal will help protect Medicare beneficiaries from acquiring hepatitis B infection and contribute to eliminating viral hepatitis as a viral health threat in the United States. If the proposed coverage expansion of hepatitis B vaccines under Part B is finalized, CMS clarifies that a physician's order would no longer be required for the administration of a hepatitis B vaccine in Part B, which would facilitate roster billing by mass immunizers for hepatitis B vaccine administration.
- **Medicare Parts A and B Overpayment Provisions of the Affordable Care Act:** CMS proposes several changes to reporting and repayment timelines and exception circumstances associated with overpayments.