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Report on Medicare Compliance Volume 33, Number 41. November 18, 2024
Final MPFS Rule Changes Dynamics of 60-Day Rule; Telehealth Coverage Is All Over the Map

By Nina Youngstrom

The new interpretation of Medicare's 60-day overpayment rule in the final 2025 Medicare Physician Fee Schedule (MPFS) regulation, which was released Nov. 1, brings both risk and reward.[1] CMS has replaced the existing method for identifying an overpayment with the False Claims Act (FCA) definition of knowledge of an overpayment. The 2025 version spares providers from applying "reasonable diligence" to hunting down overpayments in favor of requiring them to repay money they know belongs to Medicare—or would know if they didn't stick their head in the sand. Failure to refund an overpayment gives the government grounds for an FCA allegation or civil monetary penalty (CMP).

"The idea that intent should be considered is new to the overpayment rule," said attorney Judy Waltz, with Foley & Lardner LLP.

Providers should think twice before relaxing their auditing and monitoring, said attorney Andrew Ruskin, with K&L Gates. "I wouldn't start deconstructing any of your existing practices," he said. "Whatever you were doing since the 2016 overpayment rule came down, you should continue. But if you get sideways with the Department of Justice, you have all kinds of new arguments you can make" because of the new definition.

The changes to the 60-day rule are one of many new and revised provisions in the MPFS regulation, which was announced the same day as the 2025 final outpatient prospective payment system regulation. For one thing, the MPFS rule extends some telehealth coverage for another year or two and scraps other proposals, while holding off on moving provisional services to the permanent list pending a "comprehensive review."

How consequential this is will depend partly on whether Congress extends telehealth flexibilities past 2024. If it doesn't, telehealth services will again become a narrow Medicare benefit, with payment for services only when they're provided at originating sites (e.g., hospitals) in rural/health professional shortage areas. Without action by Congress, patient homes will no longer be an originating site, with very limited exceptions, said Richelle Marting, an attorney and certified coder who is director of managed care contracting at North Kansas City Hospital in Missouri.

"Providers who were hoping to get the dust settled on telehealth policy and see some of those waivers finalized won't get that sense of closure from the final rule," Marting noted.

There's cautious optimism that Congress will come through in the clutch. Lawmakers returned to work for two weeks in mid-November and after the Thanksgiving break will come back for three more before the end of the congressional session, said Rodney Whitlock, a vice president at McDermott+Consulting, at a Nov. 8 webinar. Although there's a lot on its plate, including government funding, Congress may get to "extenders"—programs that are approved for a short period of time—"and we consider telehealth as an extender," said Debbie Curtis, a vice president at McDermott+Consulting. "We don't see Congress cutting off flexibilities for telehealth."

How Much Changes Under Revised 60-Day Rule?

The 60-day rule—which came to life in the Affordable Care Act—requires providers to report and return Medicare overpayments within 60 days of identifying them, although the statute didn't define an identified overpayment. The 2016 regulation stepped in for Part A and B, obligating providers to use "reasonable diligence" to identify overpayments by doing proactive compliance activities to monitor for overpayments.

That's going away now and so is language about "credible information" of an overpayment. The replacement of "reasonable diligence" with language consistent with the FCA's knowledge standard was set in motion in a 2022 Medicare Advantage (MA) regulation and reprised in the proposed 2025 MPFS rule. CMS has finalized its proposals, explaining that a "person" (including a provider or supplier) has identified an overpayment when the person: "(1) has actual knowledge of an overpayment; (2) acts in deliberate ignorance of the truth or falsity of information regarding the overpayment; or (3) acts in reckless disregard of the truth or falsity of information regarding the overpayment." The 60-day clock starts ticking when the provider or supplier knows about the overpayment.

The new definition was driven by a federal court decision in a lawsuit filed by UnitedHealth and other MA plans. They challenged the 2014 Parts C and D overpayment regulation, and the court sided with them, ruling that requiring MA plans to use reasonable diligence to identify overpayments "impermissibly established False Claims Act liability for mere negligence," as the MPFS rule explained. In response, CMS removed reasonable diligence from the Parts A and B rule even though these provisions weren't the target of the lawsuit, Ruskin said.

Although the revamped definition says goodbye to the reasonable diligence requirement, CMS will continue to permit providers to take up to six months to investigate and calculate overpayments, although it's couched a little differently. The MPFS rule suspends the 60-day deadline for returning a reported overpayment under certain circumstances. They include acceptance into the HHS Office of Inspector General (OIG) Self-Disclosure Protocol or CMS's Self-Referral Disclosure Protocol or when "a person has identified an overpayment but has not yet completed a good-faith investigation to determine the existence of related overpayments that may arise from the same or similar cause or reason as the initially identified overpayment" and "the person conducts a timely, good-faith investigation to determine whether related overpayments exist."

Waltz said the change to the 60-day rule reduces the burden on providers. "Providers won't be under as much pressure to be proactive," she noted. When providers find an overpayment—unless they meet the FCA standard for identification—they may not have to look back six years to determine if the overpayment occurred that entire time, Waltz said. But the risk of a FCA lawsuit looms when a provider knowingly "receives or retains" an overpayment—a phrase from the statute and the new provision--and they could be hit with a CMP from OIG for failure to comply with the 60-day rule. "When you realize you have been overpaid, you generally have to give it back," Waltz emphasized.

FCA Case Law Is a Wild Card

Notwithstanding the changes to the overpayment rule, Ruskin encourages providers to continue their reasonable diligence to identify overpayments. Otherwise, they're vulnerable to the FCA and its various interpretations in different jurisdictions.

As CMS noted that in the regulation, "Using the False Claims Act knowledge standard provides an illustrative body of case law with examples that can be used for case-specific queries and analogous fact-patterns about compliance efforts and the required efforts to identify an overpayment. We note also that providers and suppliers may also have proactive compliance obligations under other laws and regulations."

Because there are several areas of controversy about the FCA's application—including when a provider should know its claim is false—it will be messy to parse the obligation to investigate overpayments in a particular

jurisdiction, Ruskin noted. "There will be myth and innuendo about what this regulation means, and some will interpret it as 'I don't need to follow the breadcrumbs anymore. I will repay this one claim,'" he said. "For some jurisdictions, that will be in disregard of case law saying you have obligations" to look at whether an overpayment continued for months or years, he explained. "That's why I say if you just stick to what you're doing, you don't have to worry about case law in your jurisdiction." In the event of FCA allegations, you can showcase your robust compliance program.

Some Telehealth Coverage Continues

Medicare coverage of telehealth continues its journey, with CMS extending coverage of some services for another year or permanently, although its reach depends on Congress, Marting said. For one thing, the MPFS rule keeps coverage of audio-only services in place for another year, with strings attached. Telehealth services delivered to a patient's home will be reimbursed if the physician uses two-way, real-time audio-only communication technology and the patient isn't capable of, or willing to engage with, audio and video communications.

CMS is taking a beat on whether to shift certain services from provisionally covered to permanently covered. First it will do a comprehensive review of everything on the list. As the rule stated: "For services currently assigned provisional status on the Medicare Telehealth Services List, we believe that, rather than selectively adjudicating only those services for which we received requests for potential permanent status, it would be appropriate to complete a comprehensive analysis of all provisional codes currently on the Medicare Telehealth Services List before determining which codes should be made permanent."

That has implications for providers who have built models around telehealth services on the provisional list, said Marting, who noted there's a Feb. 10 deadline for submitting proposals to CMS for making telehealth services permanent.

On specific services, CMS is all over the map, Marting said. For example, CMS changed its mind about removing radiation treatment management (CPT code 77427) from the covered telehealth list. "It remains on the list as an eligible telehealth service," she said. But CMS didn't finalize a proposal to provisionally cover home international normalized ratio (INR) monitoring (G0248). However, caregiver training (CPT codes 97550 and 97551) was placed on the provisional telehealth list, Marting said.

In terms of permanent Medicare coverage, CMS added codes for HIV counseling, including G0011. Also finalized as a permanent telehealth code is safety planning interventions (G0560), which Marting said is a stand-alone code for helping patients identify when they might be having a behavioral health crisis.

CMS will continue its delay of frequency limits for subsequent inpatient visits, subsequent nursing facility visits and critical care consultation services delivered by telehealth—but only through 2025. Also through next year: distant-site providers who deliver services via telehealth from their homes don't have to report their home addresses on Medicare enrollment forms.

Virtual supervision also will continue, but for how long depends on the circumstances, Marting said. For another year, CMS permits "immediate availability" of the supervising practitioner for certain incident-to services with audiovisual technology. At the same time, CMS permanently extended other "subsets" of virtual supervision, she said. For example, virtual supervision is permanently permitted when it's provided for evaluation and management code 99211.

In terms of virtual presence in the teaching hospital realm, CMS will continue to let teaching physicians satisfy the physical-presence requirement for the critical portion of the service via telehealth. "Unlike virtual supervision for incident-to billing, the teaching physician must actually attend the encounter virtually and not

merely be available to join."

New Codes, Services, Payment Opportunities

Telehealth is far from the only service addressed in the rule. CMS finalized new codes and service categories in a fragmented fashion, Marting said. One of them is advanced primary care management (APCM), "which is like chronic care management, but this is broader primary care management," Marting said. Physician practices will be reimbursed monthly for managing at least one serious condition, with advanced practice providers (APPs) providing care under general supervision.

Marting cautions that physicians and APPs will have to check a lot of boxes to comply with Medicare requirements for APCM, including 24/7 access to care and care plan development. That's a burden, but some practices will already have the infrastructure because they provide CCM, and these requirements are part of many care management service models, she noted. There's also an unanswered question: CMS said not all the services must be performed on every patient every month, so "how much has to be provided to support billing?"

CMS added coverage for other services. For example, physicians or APPs will be able to bill for a post-discharge telephone follow-up (G0544), Marting said. It reimburses them for checking on a patient who has been discharged from the emergency room or has a behavioral health issue or crisis encounter.

Separate payment also was finalized for digital mental health treatment, a service similar to remote patient monitoring and remote therapeutic monitoring. "The theme continues with six other new codes for interprofessional consults," Marting said. CMS will now pay separately for medication or other consultative discussions among professionals (e.g., a social worker consults a psychiatrist about a patient's medication).

There are other new codes and at first blush they offer additional reimbursement opportunities, but they're only optional in theory, Marting said. "If you're not taking advantage of new services, you are getting a decrease in payment," she explained. The reason: CMS reduced the conversion factor, which converts relative value units into payments.

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1 Centers for Medicare & Medicaid Services, Medicare and Medicaid Programs; CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments, released November 1, 2024, https://bit.ly/4fIzO7s.