Release of 2025 Final Medicare Payment Rule

On November 1, the Centers for Medicare & Medicaid Services (CMS) released the 2025 Physician Fee Schedule (PFS) final rule. Medicare payments to physicians will be reduced by 2.93% in 2025 compared to the current payment rate, in place since the spring of 2024 when Congress stepped in to stabilize rates. The Calendar Year 2025 PFS conversion factor is $32.35, a decline of $0.94 from the current conversion factor of $33.29. The negative impact of code-specific refinements on any one specialty is minimal, although ophthalmology, vascular surgery, and interventional radiology have the biggest decline at a negative 2%. (See page 2,326 for the impact-by-specialty table.)

On the flip side, Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) receive a boost in payment of 3.4%, with RHCs no longer being subject to providing certain lab services or complying with productivity standards.

In addition to the payment decline, CMS acknowledges the conclusion of the flexibilities allowed for telehealth coverage, with the ruling preserving those within the agency's authority. That includes the permission for teaching physicians supervising residents and

direct supervision of auxiliary personnel (when required), via real-time, audio-visual technology through the end of 2025. For those services that remain covered, CMS will also recognize payment for audio-only services if the patient does not have the capability or does not consent to video. Distant site practitioners can use their currently enrolled practice locations instead of their home addresses when providing telehealth services from home. Payment for telehealth will remain in place for RHCs and FQHCs, according to CMS. "RHCs and FQHCs can continue to bill for…services furnished using telecommunication technology by reporting… G2025 on the claim, including services furnished using audio-only communications." **Absent Congressional action, telehealth services provided to patients in their homes will no longer be covered, with exceptions.**

The big winners in the coming year are primary care physicians, with new coding and payment policies for advanced primary care management (APCM) services that are stratified based on patients' medical and social complexity. The payment will be made through three new G-codes - G0556, G0557, G0558 – for patients with one chronic condition, two or more chronic conditions, and two or more plus status as a Qualified Medicare Beneficiary, respectively. The new APCM codes "include consent, initiating visit, 24/7 access and continuity of care, comprehensive care management, patient-centered comprehensive care plan, management of care transitions, care coordination, enhanced communication, population-level management, and performance measurement." Clinicians can use these codes based on their role as the "continuing focal point for all needed health care services and responsible for all the patient's primary care services." RHCs and FQHCs can also report the new codes, in addition to the RHC All-Inclusive Rate (AIR) or FQHC prospective payment system (PPS).

Mental health is a key focus of the new ruling. There is a new G-code, which may be billed in 20-minute increments, when safety planning interventions are personally performed by the billing practitioner. In addition, CMS approved a new monthly billing code for four post-discharge follow-up contacts performed in conjunction with a crisis encounter in the emergency department (ED). New coding and payment has been approved for Food & Drug Administration (FDA)-cleared digital mental health treatment devices used in conjunction with ongoing treatment. Arguably the most impactful change for behavioral health care is a set of six new codes for health care professionals including clinical psychologists, clinical social workers, marriage and family therapists, and mental health counselors, that mirror those CPT codes that can be reported by clinicians eligible to use evaluation and management visit codes.

The visit complexity add-on code, CPT® code G2211, can now be reported on the same day as an annual wellness visit or any Medicare Part B preventive service including a vaccine. The G2211 should be added to the evaluation and management code.

Cardiovascular risk assessment and cardiovascular care management are cited as evidence-based services to improve care. Therefore, CMS greenlighted coding and payment for an Atherosclerotic Cardiovascular Disease (ASCVD) risk assessment service and accompanying risk management services.

The federal agency updated the coverage of colorectal cancer screening, with the removal barium enema coverage and the inclusion of computed tomography colonography (CTC) and blood-based biomarker screening tests. Hepatitis B vaccinations will no longer need a physician's order and be covered without cost-sharing for Medicare beneficiaries.

Caregiver training, including those provided virtually, will be reimbursed. In addition to caregiver training for direct care services, coding and payment for caregiver behavior management and modification training has been extended. These services may also be provided via telehealth.

CMS added a new health equity benchmark adjustment for Accountable Care Organizations (ACOs) participating in Medicare's Shared Savings Program; physicians participating in Medicare through this manner should benefit.

Another add-on code was greenlighted for the inpatient setting – physicians can get a boost in payment for managing patients with a confirmed or suspected infectious disease.

When they are performing only the surgical portion of a patient's care, surgeons can use modifier 54 to signal a transfer of care for patients within the 90-day global surgical package. The managing provider, in turn, will use the new add-on code, CPT® G0559, for their post-operative care.

RHCs and FQHCs are instructed to report the individual codes that describe care coordination services instead of the single code G0511, although the community health centers will have until July 1 to comply.

Medicare's Quality Payment Program rolls on, with substantive changes that can be viewed in the 2025 QPP Policies Final Rule Fact Sheet. The performance threshold for the Merit-based Incentive Payment System (MIPS) remains at 75 points, as well as the 75% data completeness criteria threshold. Age-Appropriate Screening Colonoscopy and nine other quality measures have been deleted; seven new metrics, including Adult COVID19 Vaccination Status, have been added; and substantive changes were made to 66 quality measures in the program. Specialty-specific MIPS Value Pathways (MVPs) for ophthalmology, dermatology, gastroenterology, pulmonology, urology, and surgical care have been added, and the existing neurology guidance have been merged into a single neurological MVP.

Within minutes of the release of the November 1 rule, actions were taken to lobby Congress to reverse the payment cuts – we'll know soon whether those efforts are successful. For more information about the 2025 reimbursement landscape for Medicare, read CMS' press release here – and download the full 3,088-page report here.

Ransomware Cost This Practice $240,000 in Government Penalties: How Phishing Set Off a Chain Reaction

On October 3, 2024, the Office for Civil Rights (OCR) announced Providence Medical Institute (PMI) in Southern California was ordered to pay $240,000 because of a ransomware breach investigation. What makes this announcement unique compared to other OCR investigations is that, in a rare move, the payment was the result of a Civil Monetary Penalty rather than a settlement.

Why was a penalty imposed?

After receiving the results of the OCR's investigation in September 2023, PMI was offered the opportunity to settle the investigation but failed to do so. In January 2024, the OCR then sent PMI a Letter of Opportunity informing them that they had failed to comply with

certain provisions of the HIPAA Privacy and Security Rules and failed to resolve these matters through informal means. As a result, PMI was provided with an opportunity to submit evidence of any mitigating factors or defenses against the allegations to support a waiver of Civil Monetary Penalties. While they provided arguments in February 2024, the OCR determined this information did not support an affirmative defense or waiver of Civil Monetary Penalties, and thus, after obtaining authorization from the Attorney General of the US, a Notice of Proposed Determination to impose a Civil Monetary Penalty (CMP) was issued. PMI chose to waive their right to a hearing and not contest the OCR's proposed determination. On July 1, 2024, the OCR published a Notice of Final Determination. As a result, PMI was required to pay $240,000, in full, upon receipt of the notice.

How did we get here?

Before discussing what violations led to the CMP, let's first discuss what happened to trigger an investigation. In July 2016, Providence Medical Institute acquired Center for Orthopaedic Specialists with an end goal to transition them into PMI's IT environment over the next two years. During the transition period, Center for Orthopaedic Specialists (COS) was allowed to maintain their relationship with their current IT vendor. Before the transition into the PMI IT environment was completed, an employee of COS clicked on a phishing email that resulted in a ransomware attack on February 18, 2018. Systems were quickly restored using system backups; however, the same ransomware attacker was able to ransom the systems two additional times on February 25, 2018 and March 4, 2018. A breach report was submitted to the OCR on April 18, 2018 reporting that 85,000 individuals' data, including names, had been compromised in the ransomware attacks. As a result of the report, the OCR opened an investigation into the incident in May 2018.

What did the investigation find?

During the OCR's investigation, PMI also conducted a post-incident investigation in June 2018. That investigation found that COS:

- utilized outdated and unsupported operating systems on computers that housed ePHI,
- failed to separate their private network from the public internet,
- had a misconfigured firewall that did not properly track network access,
- allowed insecure remote access to workstations, and
- workforce members shared administrative login credentials, allowing unrestricted administrator access.

The OCR found additional evidence during their investigation that COS had not deployed encryption on their workstations or servers, allowing ePHI to be visible and accessible during the ransomware attacks. They also found that PMI, being the owner of COS, did not have a signed Business Associate Agreement with the IT vendor providing services to COS during the transition to PMI's systems until June 2018.

The final ruling from the OCR found PMI failed to uphold the HIPAA Security Rule by:

- failing to implement various required technological policies and procedures to prevent unauthorized access to ePHI, and
- failing to have a signed Business Associate Agreement with the IT vendor providing services to COS during the transition period.

Takeaways

Regardless of the size of the practice, many things can be learned from this case. Here are a few helpful points:

- All workforce members, including all staff, physicians, advanced practice practitioners, volunteers, and students, must have proper cybersecurity education to include how to spot phishing emails and what to do if one is received.
- Ensure Business Associate Agreements (BAA) are signed and maintained with any business associate who has access to systems containing ePHI. Anytime there is a change in ownership of either the covered entity or business associate, a new BAA must be signed.
- Utilize systems with current and up-to-date operating systems. Install all system security updates to keep devices containing and accessing ePHI secure, including all workstations and servers.
- All employees must have their own login credentials that should not be shared with anyone. Only select users should have administrative access.
- Conduct routine Security Risk Analyses, especially when there are significant changes within the practice, including changes in ownership/administration, changes in hardware/software, changes in location, or any other event that could change the security risk of ePHI.
- Change any compromised user credentials or passwords whenever a security incident occurs involving the improper acquisition of a user's login credentials. However, select circumstances may require all user credentials to be reset. Conduct an incident assessment to determine the level of credential reset necessary to ensure all unauthorized access to systems has been eliminated.

In conclusion, the case of Providence Medical Institute underscores the critical importance of robust cybersecurity measures and compliance with HIPAA regulations. The significant financial penalty imposed by the OCR serves as a stark reminder that healthcare organizations must prioritize the security of ePHI. By implementing comprehensive security protocols, ensuring all workforce members are educated on cybersecurity best practices and maintaining up-to-date systems and agreements, healthcare practices can better protect themselves against cyber threats and avoid costly penalties. This case highlights that proactive measures and timely responses to security incidents are essential in safeguarding patient data and maintaining regulatory compliance.

If you have questions about HIPAA, cybersecurity, or access to SVMIC resources, call 800-342-2239 or email Contact@svmic.com.

If you experience a cybersecurity or other HIPAA related incident, contact SVMIC as soon as possible by calling the Claims department at 800-342-2239.

Other individuals in your organization who may benefit from these articles and resources include your administrator, privacy or security officer, or information technology professional. They can sign up for a Vantage account here.

References:

1. (2024, October 3). *HHS Office for Civil Rights Imposes a $240,000 Civil Monetary Penalty Against Providence Medical Institute in HIPAA Ransomware Cybersecurity Investigation*. U.S. Department of Health and Human Services. https://www.hhs.gov/about/news/2024/10/03/hhs-ocr-imposes-civil-monetary-penalty-against-providence-medical-institute-hipaa-ransomware-cybersecurity-investigation.html
2. (2024, March 29). *Providence Medical Institute Notice of Proposed Determination*. U.S. Department of Health and Human Services. https://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/agreements/pmi-npd/index.html
3. (2024, July 1). *Providence Medical Institute Notice of Final Determination*. U.S. Department of Health and Human Services. https://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/agreements/pmi-nfd/index.html

A Year-End Recap

Through the monthly Risk Matters, online programs including specialty-specific programs, seminars, and individual communications with physicians, advanced practitioners, and practice executives, our Risk Education Department provides you with the most up-to-date, practical information to improve patient safety, avoid a malpractice claim or lawsuit, and inform you on the latest trends and laws that might adversely affect your practice. For example, the topics we addressed in this year's *Sentinel* were:

Curbside Opinions

Obstetrics Risks

Wearable Medical Devices

Remote Healthcare

Medical Malpractice Stress Syndrome

AI in Healthcare

Physicians Treating Self and Family

Informed Consent for Minors

Shadows

They Are Not Just "Little Adults"

In 2025, we will continue to provide live and online educational opportunities in both one hour and two-hour CME and premium credit courses, as well as courses designed specifically for staff members. We are especially proud of our upcoming 2025 Live seminar which will take attendees “into the courtroom” to observe a medical malpractice trial. This is our largest educational endeavor to date, and we strongly encourage everyone to attend.

We hope everyone has a great rest of the year and we look forward to serving you in 2025.

Credibility is Crucial

Pearl McGuire[1], a 70-year-old retired nursing assistant with chronic back pain, scheduled an appointment to see orthopedic surgeon, Dr. Howard Glover, for evaluation of ongoing back issues. During her initial visit, Mrs. McGuire reported significant back pain, bilateral leg numbness, and difficulty walking. She also reported a history of three prior lumbar disc surgeries. In order to evaluate Mrs. McGuire's back, Dr. Howard ordered an MRI.

The MRI showed degenerative changes in the lumbar spine and evidence of postoperative changes, particularly at L4-5. Based on the MRI, Dr. Glover diagnosed Mrs. McGuire with post-laminectomy syndrome. Dr. Glover recommended conservative treatment and ordered physical therapy. He discussed with Mrs. McGuire that if her symptoms persisted despite physical therapy, then she might be a candidate for surgery.

Mrs. McGuire began a course of physical therapy that lasted approximately two months. After her completion of physical therapy, Mrs. McGuire returned to see Dr. Glover. She told Dr. Glover that she felt the physical therapy improved her overall pain level. Dr. Glover instructed her to continue exercises at home and to return for another office visit in three months.

At her return visit, Mrs. McGuire complained of increased back pain due to a recent motor vehicle accident. Dr. Glover prescribed pain medication, steroid pack, and physical therapy. He instructed Mrs. McGuire to follow up in one month.

When Mrs. McGuire came back to see Dr. Glover one month later, she complained that her pain had continued to get worse. Given the circumstances, Dr. Glover ordered another MRI, which showed severe stenosis at L3 due to disc bulge and severe stenosis at L4. Mrs. McGuire underwent epidural steroid injections at L3 and L4. The injections provided relief at first, but the pain and leg numbness returned within days.

Dr. Glover ordered an EMG of the lower extremities to further evaluate Mrs. McGuire's condition. The EMG results indicated that there was denervation in multiple L4 and L5 myotomes in both lower extremities. Dr. Glover recommended decompression at L3-4 and L4-5, which he performed soon after.

Postoperatively Mrs. McGuire had initial improvement, but it did not last. Over the course of several months, Mrs. McGuire's pain increased, and her mobility and gait worsened despite medication and physical therapy. Additional imaging studies revealed a spondylolisthesis at L3-4 that was not present on earlier films. Since Mrs. McGuire's symptoms were more pronounced on the right side, Dr. Glover recommended right L3-4 fusion with transforaminal lumbar interbody infusion. After receiving medical and cardiac clearance, Mrs. McGuire scheduled the surgery with Dr. Glover at a local hospital.

The day of surgery arrived. After the informed consent process and signing of the operative permit, Mrs. McGuire was prepped for surgery. Dr. Glover began the procedure with a midline incision to expose L2-4. He detached scar tissue which was particularly extensive at L3-4. Dr. Glover used pituitary rongeurs to prepare the disc space and remove disc material.

Near the end of the disc preparation, Dr. Glover introduced a pituitary rongeur into the disc space to check the lateral view. After a few additional passes, Dr. Glover noted significant, brisk bleeding. He immediately notified anesthesia and blood was administered. The OR staff urgently called general and vascular surgeons for assistance. Dr. Glover, anesthesia, and the OR staff worked to stabilize Mrs. McGuire until the other surgeons arrived.

A cardiovascular surgeon identified a tear in the aorta and made a surgical repair. Mrs. McGuire developed severe coagulopathy and was admitted to ICU. Her condition remained unstable, and she passed away later that day.

Less than one year after her death, Mrs. McGuire's husband filed suit against Dr. Glover. Lengthy, extensive litigation followed. The case went through the discovery process which included the deposition of Dr. Glover.

During his deposition, Dr. Glover made a strong witness on his own behalf. He testified consistent with the medical records and was able to explain the complex medical issues and procedures at issue very well. He provided testimony on the standard of care and

causation. With respect to causation, he stated that it was likely he went outside the disc space with the rongeur resulting in the injury. Once the parties completed discovery, they proceeded with a jury trial.

At trial, plaintiff's counsel called Dr. Glover to testify. Once again, he did a good job of explaining the facts and the medicine in this case. Unfortunately, at the end of the direct examination, Dr. Glover surprised everyone, including defense counsel, when he opined that he likely stayed within the disc space and pulled disc material attached to the vessel causing the injury. This was a material change from his deposition testimony, and the plaintiff's attorney seized the opportunity to impeach him. And just like that, Dr. Glover's credibility went down the drain.

The trial proceeded with the testimony of other providers, Mrs. McGuire's family members, and experts for both sides. During his closing statement, the plaintiff's counsel highlighted Dr. Glover's change in testimony. At the conclusion of the proof the case went to the jury. It took the jury one hour to return a verdict in favor of the plaintiff. Post-trial interviews with some of the jurors revealed that their decision was heavily influenced by Dr. Glover's change in testimony. They simply did not believe or trust him.

Although this was a sympathetic case, throughout the course of litigation, it appeared defensible on the medicine. The defense team for Dr. Glover had obtained strong expert support. The well-qualified defense experts testified that the injury was a known risk of the procedure and not the result of negligence. Nonetheless, the expert proof for Dr. Glover at trial could not overcome the impact made by his change in testimony.

This case demonstrates the importance of a defendant physician's credibility at trial. It cannot be overstated how crucial credibility is to a jury. Any changes in testimony between deposition and trial can have a devasting effect on the outcome of the trial unless there is a reasonable and honest explanation.

It should go without saying, whether at deposition or at trial, the physician testifying should be truthful in their testimony. However, there may be times when a physician who has been deposed realizes later that they have explained something poorly or that there was something wrong or incomplete with their testimony. In those instances, the physician should consult with their defense attorney. The defense attorney will have to evaluate what, if anything, may be done procedurally to rehabilitate or explain that testimony.

By the time a case makes it to trial, all the facts and anticipated proof should be known to all parties. If there is an extenuating circumstance that may compel a change in the proof, then the defense attorney should be notified immediately and in advance of trial. This information could impact trial strategy or even prompt settlement negotiations. Contradictory testimony at trial, without an explanation, may lead to a loss of and potentially an adverse verdict. The defendant physician does not have to carry the burden of a lawsuit alone. He or she should contact their defense counsel any time a concern arises, no matter how small it may seem.

[1] Names of all parties involved have been changed.

The contents of The Sentinel are intended for educational/informational purposes only and do not constitute legal advice. Policyholders are urged to consult with their personal attorney for legal advice, as specific legal requirements may vary from state to state and/or change over time.