Merit-based Incentive Payment System

Traditional MIPS is the original reporting option available to eligible clinicians for collecting and reporting data to the program.

Physical therapists are only required to participate if they meet certain criteria, but voluntary participation options also are available. Physical therapists should verify their eligibility directly with the Centers for Medicare & Medicaid Services by entering their NPI on the QPP Participation Status page.

Performance is measured across four categories — quality, improvement activities, promoting interoperability, and cost, with 2024 being the first year that physical therapy practices participate in the promoting interoperability category.

In this document you'll find information on these topics:

Mandatory Versus Optional Participation

CMS has established a low-volume threshold to determine if an individual PT or a physical therapy private practice can be excluded from mandatory participation in MIPS. Depending on how many of the criteria are met, the PT or practice may be either required to participate or have options to do so voluntarily. The three criteria for meeting the threshold are:

1. Annually receiving more than $90,000 in Medicare Part B payments.
2. Annually providing care for more than 200 Part B-enrolled Medicare beneficiaries.
3. Annually billing more than 200 professional services.

Mandatory Participation

Individual PTs in private practice who exceed all three criteria of the low-volume threshold must participate in MIPS, subject to the payment adjustment of +/-9%. Nonparticipation results in the full 9% penalty.

Opt-In Participation

Individual PTs: PTs in private practice who exceed one or two of the low-volume threshold criteria are eligible to opt in to MIPS. There is no penalty for nonparticipation, but once a PT opts in, they are subject to the payment adjustment of +/-9%.

Groups: If a practice collectively exceeds one, two, or all three criteria of the low-volume threshold it can opt-in to MIPS as a group. Again, there is no penalty for nonparticipation, but once a practice opts in, it is subject to the payment adjustment of +/-9%.

Voluntary Participation

Individual PTs who don't meet the low-volume threshold and don't choose opt-in participation are allowed to report MIPS data voluntarily without being subject to the payment adjustment.

For PTs who are eligible but not required to participate, participation is a business decision in which they must weigh the benefits of earning incentives with the risk for penalties.

APTA has created a decision tree to help PTs navigate this decision.

Participation Options

MIPS eligibility status is specific to each practice (identified by taxpayer identification number) you are associated with and is based on the following four factors:

- Your clinician type.
- The date you enrolled as a Medicare provider.
- Whether you meet or exceed all three criteria of the low-volume threshold.
- Whether you have achieved QP status.

Participate as an Individual

If you are eligible to participate in MIPS as an individual, you are required to do so.

An individual is defined as a single clinician, identified by their individual National Provider Identifier tied to a single TIN. You must participate in MIPS as an individual if you are eligible at the individual level, or you can choose to participate if you are eligible to opt in as an individual.

Participate as a Group

A group is defined as a practice under a single TIN with two or more clinicians, with at least one clinician in the practice being MIPS eligible. Clinicians are identified by their NPI and have reassigned their Medicare billing rights to the TIN. A practice may participate as a group if it exceeds the low-volume threshold and is either MIPS-eligible or opt-in eligible at the practice level. There is no requirement for a practice that is eligible as a group to participate as a group.

When you participate as a group, you collect and report measures and activities based on the aggregated performance of the clinicians billing under the TIN. CMS assesses your practice's performance across all performance categories at the group level, and your payment adjustment is based on your group's final score from the MIPS performance categories.

Submission Methods

You may be eligible to participate in MIPS at various levels: as a group, as an APM entity, or as a virtual group. These participation options are tied to MIPS eligibility and are specific to each practice you are associated with. How you choose to report data and which methods are available to you depend on:

- Whether you are participating as a group.
- The size of your practice.
- The type of information technology you use.
- The performance category you are reporting.

Individuals, groups, APM entities, and virtual groups should consider which submission method(s) best fits their practice.

Most methods are available to groups, virtual groups, APM entities, and individuals. However, two exceptions apply to the quality reporting category:

- CMS Web Interface can only be used by groups and virtual groups of at least 25 clinicians and by ACOs.
- Only those designated as a small practice may use claims to report quality measures.

Performance Reporting Requirements

MIPS performance is measured across four categories — cost, quality, improvement activities, and promoting interoperability. As of 2024, PTs participating in MIPS must submit data under the quality, improvement activities, and promoting interoperability categories. (Before 2024, the physical therapy profession was exempt from the promoting interoperability category.) CMS automatically calculates measures in the cost category if they apply.

The four performance categories are scored and combined to determine a final MIPS score, which determines the payment adjustment applied to Part B claims. Reporting requirements for each category are below:

Cost

The cost performance category is a measure of resource utilization based on Medicare claims for specific services that CMS has identified. The goal of the cost performance category is to track national health care spending and use the resulting data, adjusted for risk and other factors, to create benchmarks (see “What Are Benchmarks?” to learn more) for value-based care.

The cost performance category covers a 12-month calendar year reporting period. Clinicians and groups can be scored on a cost measure if they meet or exceed the measure’s minimum case requirements for number of episodes. For the 2024 reporting period, PTs are eligible to be scored on one measure, low back pain, with a minimum case requirement of 20 episodes.

Clinicians do not report or submit data for this category; the Centers for Medicare & Medicaid Services calculates costs based on claims data.

Calculation of Score

To calculate cost scores for each measure, CMS attributes the costs of a Medicare beneficiary’s treatment for that measure’s condition to a specific clinician or group. Cost is defined as the Medicare-allowed amount on Medicare claims data, which includes Medicare payments plus any applicable patient deductible and coinsurance amounts.

A beneficiary is attributed to a clinician if there is a trigger event — a pair of claims is billed by the same TIN within an attribution window (certain number of days) for patients with a certain condition. Once a beneficiary is attributed, CMS analyzes the claims data to track the services provided to the beneficiary during a specific performance period. The services can include hospital visits, procedures, tests, prescription drugs, and other relevant health care activities. CMS releases patient-level reports of the attributed beneficiaries and their associated cost of care that contribute to the calculation of the Cost scores.

CMS risk-adjusts the cost measures to account for differences in patient health status and complexity. This ensures that clinicians are fairly evaluated based on the severity of their patient population and enables a more accurate assessment of their cost performance within the program.

How Can I Improve My Cost Score?

Although providers do not report cost measures, there are things you can do to monitor your costs and potentially improve your cost measure performance:

- Ensure that you and your support staff review each measure's specifications and code list (for 2024, the LBP cost measure) to determine which ones CMS uses to score it.
- Evaluate your performance over time so you can identify potential areas for improvement such as increased coordination of care or improved patient communication. In particular, review the performance feedback, including the patient-level reports, included in your cost measures scores.
- Ensure accurate diagnosis coding to reflect the complexity of your patients.
- Analyze your claims data to understand cost patterns, identify areas of high expenditure, and pinpoint potential cost-savings opportunities.
- Focus on care coordination. Effective communication and collaboration can prevent duplicate tests, reduce hospital readmissions, and minimize overall costs.
- Educate your patients about their condition and offer options for connecting with you to minimize emergency visits and readmissions.

Cost Measure Terminology

Being familiar with these terms will help you understand how costs are tracked, calculated, and scored.

Trigger event: A pair of services, called the trigger claim and confirming claim, that identifies the start or continuation of an individual clinician's or clinician group's management of a chronic disease identified in an applicable cost measure; for example, for physical therapy in 2024 that condition is low back pain.

Trigger claim: Billing of a measure-applicable CPT code with a relevant chronic condition diagnosis.

Confirming claim: A corresponding billing, within 60 days of the trigger claim, of a measure-applicable CPT code with a relevant chronic condition diagnosis or a condition-related CPT/HCPCS code with a relevant chronic condition diagnosis.

Attribution window: A time period during which the patient's chronic care will be monitored by a clinician or clinician group, measured by number of days.

Reaffirming claim: Evidence of a continuing clinician-patient relationship.

Total attribution window: Total period of time of the clinician-patient relationship.

Episode: A segment of the total attribution window. An episode can be between one year (365 days) and two years minus one day (729 days).

Measurement period: A static year-long period (calendar year) during which a clinician or clinician group will be measured.

Current Cost Measures Impacting Physical Therapists

LBP Cost Measure

The Low Back Pain cost measure was introduced for reporting year 2024 and is the first cost measure that identifies physical therapists as attributed providers in the MIPS program. It is a chronic-condition episode-based cost measure, which means it assesses costs clinically related to the care and management of patients with LBP provided during a total attribution window divided into episodes. Refer to the 2023 Cost Measures for more information on episode-based cost measures.

The case minimum requirement for the LBP cost measure is 20 episodes.

The LBP cost measure can be applied to one or more of 289 IDC-10-identified low back pain diagnoses. The measure identifies the start of a clinician-patient relationship by looking for a TIN that bills a pair of services within 60 days of each other — a trigger claim and corresponding confirming claim. For the LBP cost measure, physical therapy CPT evaluation codes classify as trigger claim codes, and CPT evaluation, reevaluation, or procedure codes classify as confirming claim codes. Once the relationship starts, the TIN is monitored for costs related to the patient's care. The initial period can be extended beyond 120 days if there are more services showing a continuing relationship. This ongoing care is then divided into episodes, or segments of at least 120 days so that the clinician or group can be assessed within a measurement period.

The measure includes only clinically related costs for low back pain, including routine management (such as clinician visits, physical and occupational therapy, and medication) and acute and post-acute care services. However, if you are treating a secondary or tertiary condition in addition to low back pain during the same visit, all costs from that visit will be included in the cost measure as there is no way to separate out the services.

Low Back Pain Cost Measure Subgroups

The LBP cost measure is stratified into four mutually exclusive subgroups that represent distinct patient cohorts:

- Patients with a history of complex low back pain who have undergone surgery.
- Patients with no history of complex low back pain who have undergone surgery.
- Patients with a history of complex low back pain who have not undergone surgery.
- Patients with no history of complex low back pain who have not undergone surgery.

The risk-adjustment model is run separately within each subgroup, which means that episodes within each subgroup are compared only with other episodes within that same subgroup.

Refer to the CMS Chronic Condition Cost Measure Framework for more information on these measures.

Quality

The quality performance category of MIPS evaluates the quality of care you deliver by measuring health care processes, outcomes, and patient experiences of care.

MIPS requires clinicians to collect and submit data on at least six quality measures. These measures must include one outcome measure, or, if there is not an applicable outcome measure available, one high-priority measure.

Beginning with the 2024 performance period, you'll need to report performance data for at least 75% of the denominator-eligible cases for each quality measure (data completeness), which is an increase from the previous data completeness threshold of 70%.

The complete list of quality measures and their exclusions will be available on CMS' website.

Reweighting

If you are facing extreme and uncontrollable circumstances such as a disaster, practice closure, or severe financial distress, you may qualify for reweighting of the quality category, which is when the category is given a weight of 0% among the four MIPS categories, and the PT or practice isn't required to submit data in that category.

CMS has indicated to APTA that the agency will verify the validity of these hardships.

Improvement Activities

The improvement activities performance category of MIPS measures participation in activities that improve clinical practice.

Clinicians must submit data on improvement activities based on the weight of activities selected. You may select one of the following combinations:

- Two high-weighted activities.
- One high-weighted activity and two medium-weighted activities.
- Four medium-weighted activities.

Improvement activities have a minimum of a continuous 90-day performance period unless otherwise stated in the activity description. Each activity must be performed in calendar year 2024, but multiple activities don't have to be performed during the same period.

The complete list of improvement activities and their exclusions will be available on CMS' website.

Reweighting

If you are facing extreme and uncontrollable circumstances such as a disaster, practice closure, or severe financial distress, you may qualify for reweighting of the improvement activities category, which is when the category is given a weight of 0% among the four MIPS categories, and the PT or practice isn't required to submit data in that category.

CMS has indicated to APTA that the agency will verify the validity of these hardships.

Promoting Interoperability

The promoting interoperability performance category of MIPS is intended to promote patient engagement and electronic exchange of information using certified electronic health record technology.

As of performance year 2024, physical therapists must participate in the promoting interoperability category of MIPS, unless they qualify for reweighting, which is when the promoting interoperability category is given a weight of 0% among the four MIPS categories, and the PT or practice isn't required to submit data in that category.

Reweighting

The two circumstances that allow for reweighting are being a small practice and experiencing a hardship:

Small Practice. If your practice has 15 or fewer eligible clinicians, then all clinicians in the practice will automatically receive reweighting for the promoting interoperability performance category.

Check to see if CMS has identified you as a small practice by entering their NPI on the QPP Participation Status page.

Note: Even if you are deemed a small practice, if you submit any data on promoting interoperability you will not be reweighted and will instead receive a promoting interoperability score even if your data is incomplete.

Hardship Exemption. You may apply for any of four hardship exemptions:

- You have insufficient internet connectivity.
- You have decertified electronic health record technology.
- You lack control over the availability of certified EHR technology, or CEHRT. Two items of note that CMS has indicated to APTA:
    - Under this exemption, “lack of control” refers to clinicians who do not have influence over their practice’s decision on the acquisition or selection of CEHRT. In other words, unless you are a decision-maker responsible for acquiring or selecting the practice’s EHR, you qualify for this exemption.
    - CMS does not verify exemption applications that claim lack of control over CEHRT, nor does the agency require supporting documentation. You are expected to attest truthfully, and your application will be honored.
- You face extreme and uncontrollable circumstances such as a disaster, practice closure, severe financial distress, or vendor issues. CMS has indicated to APTA that the agency will verify the validity of these hardships. The severe financial distress has to be unrelated to the investment in CEHRT.

Submit your application in the same way you report MIPS data: If you report MIPS data as an individual, you should submit an individual application. If you report as a group, submit one application for the whole group.

You must apply via QPP.CMS.gov before the submission period ends at the end of the year. CMS indicates that applicants typically receive a decision within one to two days after submission.

Data Submission

If you do not qualify for reweighting, you are required to submit data using an EHR system that meets the ONC Health IT certification criteria. Verify with your EHR vendor whether your EHR meets the criteria.

The performance period is 180 continuous days within the calendar year.

The promoting interoperability category is organized into four objectives:

- ePrescribing.
- Health Information Exchange.
- Provider to Patient Exchange.
- Public Health and Clinical Data Exchange.

Each objective has specific measures and attestations that you must complete unless you meet and claim the exclusion for that measure. Most physical therapists will meet many of the measures’ exclusion criteria. The complete list of promoting interoperability measures and their exclusions are available on the CMS website.

MIPS Value Pathways

MIPS Value Pathways, or MVPs, are a voluntary reporting option that clinicians can participate in as an alternative to traditional MIPS or an APM Performance Pathway. MVPs have reduced complexity in reporting compared with traditional MIPS.

In the 2024 Medicare Physician Fee Schedule, CMS included five new MVPs, including the APTA-recommended Rehabilitative Support for Musculoskeletal Care MVP, or MSK MVP, to be available for Performance Year 2024. This MVP is the first of its kind, allowing a subset of physical therapists to meaningfully participate in CMS' QPP and be benchmarked with their clinical peers.

Impact of Participation

The most immediate impact of participation in an MVP over traditional MIPS is the decreased complexity when selecting and reporting measures and activities — meaning a decrease in administrative burden. Due to the streamlined, reduced set of measures and improvement activities, there is increased potential for a more connected assessment of quality care and enhanced performance feedback from CMS. The feedback should provide more clinically relevant comparisons between similar clinicians who choose to participate in the same MVP.

Additionally, CMS intends to sunset traditional MIPS through rulemaking in future years. Choosing to report an MVP prior to this transition enables clinicians to become comfortable with the process before MVP reporting becomes mandatory.

Finally, participating in MVP reporting provides more data from which CMS can evaluate opportunities to reduce the burden in overall CMS reporting programs. As CMS develops and reviews MVPs, the agency will seek out alignment between MVPs and other CMS programs for future implementation.

How to Participate

If you are a MIPS-eligible individual or group choosing to participate in the MSK MVP as your reporting option instead of traditional MIPS, you will need to register for the MVP sometime in the first half of the performance year, meaning for 2024 you must do so by June 30. CMS provides specific dates and information on how to register for an MVP on its QPP website. When you register, you will need to select if you plan to report as a subgroup. A subgroup is a set of clinicians within a group (identified by a single taxpayer identification number, or TIN) that contains at least two clinicians, at least one of whom is individually MIPS eligible.

As an individual or group, when you register you will select the MSK MVP and two measures, one from each of these categories:

- One population health measure included in the MVP foundational layer.
- Any outcomes-based administrative claims measure (if applicable) for the quality performance category.

If you're registering as a subgroup, you additionally will submit these three items:

- A list of clinicians (NPIs) to be included in the subgroup.
- A plain-language name of the subgroup.
- Description of the composition of the subgroup, such as "This subgroup represents our West Side practice, which uses one EHR platform and collaborates on patient care across orthopedic surgeons, physical therapists, nurse practitioners, and other associated clinicians."

Reporting Requirements and Scoring

MVPs have reduced reporting requirements in comparison to traditional MIPS, which include quality and cost measures and improvement activities that are specific to a given specialty or medical condition. Each MVP also includes promoting interoperability measures and population health measures, which are referred to as the foundational layer. For the MSK MVP, the full list of measures and activities is available on the QPP website.

Scoring and Payment Adjustments

Weighting

Each of the four MIPS categories — quality, improvement activities, promoting interoperability, and cost — is weighted to determine how much influence it has on a clinician's final score. The weights of each category differ depending on how many categories are reported and the size of the practice.

Small-Practice Weighting

Small practices are defined as having 15 or fewer MIPS-eligible clinicians. This count includes clinicians who are eligible even if they do not participate in MIPS. CMS indicates whether a clinician is eligible to participate and whether a facility is considered a small practice on the QPP Participation Status page.

	Quality	Cost	Improvement Activities	Promoting Interoperability
Scores for all four performance categories	30	30	15	25
No Cost	55	0	15	30
No Promoting Interoperability	40	30	30	0
No Cost **and** No Promoting Interoperability	50	0	50	0

Large Practice Weighting

Large practices are defined as having 16 or more MIPS-eligible clinicians. As with small practices, this count includes clinicians who are eligible even if they do not participate in MIPS.

	Quality	Cost	Improvement Activities	Promoting Interoperability
Scores for all four performance categories	30	30	15	25
No Cost	55	0	15	30
No Promoting Interoperability	55	30	15	0
No Cost **and** No Promoting Interoperability	85	0	15	0

Performance Threshold and Payment Adjustments

Once all reporting is completed, participants will receive a final MIPS score for the performance year. The score is a numeric value between 0 and 100 and determines the payment adjustment participants will receive in the corresponding payment year (two years following the performance year). CMS determines an annual performance threshold, which is the MIPS score that receives a neutral payment adjustment. All scores above the performance threshold receive a positive adjustment, and all scores below the threshold receive a negative adjustment.

For performance year 2024 the threshold is 75 points. MIPS participants who score 74.99 or lower will receive up to a negative 9% payment adjustment in 2026, while those who score 75.01 or above will receive up to a positive 3% adjustment in 2026.