

September 25, 2019

Seema Verma, MPH  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
CMS-1715-P  
Room 445-G  
Hubert Humphrey Building  
200 Independence Ave, SW  
Washington, DC 20201

*Submitted electronically*

**RE: Medicare Program; CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations [CMS-1715-P]**

Dear Administrator Verma:

On behalf of our more than 100,000 member physical therapists, physical therapist assistants (PTAs), and students of physical therapy, the American Physical Therapy Association (APTA) is pleased to submit comments on the Centers for Medicare and Medicaid Services' (CMS) Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule (PFS) and Other Revisions to Part B for Calendar Year (CY) 2020; Medicare Shared Savings Program Requirements; and Updates to the Quality Payment Program (QPP) proposed rule. The mission of APTA is to build a community to advance the physical therapy profession to improve the health of society. Physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability by serving as a dynamic bridge between health and health services delivery for individuals across the age span. While physical therapists are experts in rehabilitation and habilitation, they also have the expertise and the opportunity to help individuals improve overall health and prevent the need for otherwise

avoidable health care services. Physical therapists' roles may include education, direct intervention, research, advocacy, and collaborative consultation. These roles are essential to the profession's vision of transforming society by optimizing movement to improve the human experience.

The physical therapy profession is committed to the restoration, maintenance, and promotion of optimal physical function. Physical therapists are licensed health care professionals who diagnose and manage movement dysfunction and enhance physical and functional status across all age populations. Physical therapists also help patients maintain health by preventing further deterioration or future illness. Ensuring continued access to physical therapist services is integral to ensure patients' recovery and to prevent further deterioration of patients' conditions.

Please find below our detailed comments on the proposed rule.

## **PHYSICIAN FEE SCHEDULE**

### **Estimated Specialty Level Impacts of Proposed E/M Payment and Coding Policies if Implemented for CY 2021**

In the 2020 PFS proposed rule, CMS proposes to increase the payment for the office/outpatient evaluation and management (E/M) codes for 2021. To account for these increases, providers with low utilization of E/M services and providers who do not bill office/outpatient E/M codes would see significant decreases in Medicare reimbursement in 2021. As demonstrated in Table 111 in the PFS proposed rule, physical/occupational therapy providers would see a combined impact of -8% in 2021. **These reductions, while necessary to maintain the budget neutrality of the fee schedule, are arbitrary cuts to codes that physical therapy providers bill when providing services to Medicare beneficiaries, and if adopted as proposed, will impede access to essential services for seniors and individuals with disabilities.**

It is imperative that CMS reimburse physical therapists at a level that will continue to allow them to deliver high-quality care to their patients. We understand that CMS must maintain budget neutrality with the fee schedule. In modifying the values to accommodate increases for the E/M codes, however, it appears that CMS may not have considered the overall impact that the E/M value increases would have on budget neutrality, resulting in consequential payment decreases for health care professionals, including physical therapists, who do not bill E/M codes.

The significant reduction in reimbursement for physical therapy services will result in a decreased workforce and an inability to meet the needs of the Medicare population. Over the last several years, the number of Medicare beneficiaries accessing physical therapy has increased. While outpatient physical therapy services are delivered across numerous settings (hospital outpatient, skilled nursing facility (SNF), home health agency (HHA), CORF, and rehabilitation agency), the only detailed data that is available is for physical therapists in private practice, which illustrates the increasing number of Medicare beneficiaries accessing physical therapy (from private practitioners) as follows:<sup>1</sup>

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<sup>1</sup> [https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/2017/2017\\_Utilization.html#Medicare%20Physician/Supplier](https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/2017/2017_Utilization.html#Medicare%20Physician/Supplier)

- 2013: 2,091,751
- 2014: 2,198,616
- 2015: 2,354,958
- 2016: 2,546,041
- 2017: 2,673,120

During a similar timeframe, between CY 2011 to 2020, CMS has put forward reimbursement changes for physical/occupational therapy services that ranged between -5% to 4%, whereas, during that same time period, CMS put forward reimbursement changes for services billed by specific physician specialties, such as family practice and general practice, that ranged between 0% to 7%. Now, CMS proposes to adopt an 8% reimbursement reduction for physical/occupational therapy in 2021, whereas, for example, codes billed by general practice and family practice physician specialties will experience an 8% and 12% increase in reimbursement, respectively.

Medicare margins for physical therapy providers are already low and have challenged the sustainability of practices; severe and arbitrary reimbursement reductions will create challenging and likely untenable financial circumstances that may adversely impact patients' access to care and the ability of physical therapy providers to continue to furnish care to beneficiaries. Rising debt and shrinking reimbursement provide the perfect storm for discouraging individuals from choosing to enter the profession in the future. Such shortages would be problematic as the baby boomers reach Medicare age and more individuals seek access to services as health care reform provisions become effective. **Modifications in payment and policy should be fair and balanced, ensuring no specialty favoritism over others. Medicare reimbursement rates should be adopted that are designed to maintain and enhance a robust network of participating providers.** Unfortunately, we foresee that physical therapy providers, particularly those in rural and underserved areas, will be unable to sustain these lower Medicare payments and be forced to reduce essential staff or even close their doors as a result of this change, thus restricting beneficiary access to medically necessary physical therapy services.

For the reasons discussed in more detail below, APTA has serious concerns with CMS' proposal to impose steep reimbursement reductions for physical therapy services in 2021. Accordingly, rather than adopt what amounts to a detrimental reimbursement reduction to physical therapy services in 2021, which will result in a severe disruption of patient care and access issues, APTA urges CMS to minimize the impact of the E/M code revaluations on the health care community as follows:

- 1. Do not implement budget neutrality adjustments; rather, additional funding is appropriate and necessary.**
  - a. If CMS disagrees, then the agency should minimize any unintended impacts by applying budget neutrality adjustments uniformly across all services, not excluding any specialties, procedures, or service codes.
  - b. Alternatively, or in conjunction with this proposal, CMS should increase the Medicare conversion factor.

2. **Redistribute reductions to practice expense (PE) across health care providers who do not have as demonstrable costs for equipment and supplies as physical therapy providers.**
3. **Slowly phase in changes to the relative value units (RVUs).** As referenced by the Medicare Payment Advisory Commission (MedPAC) in Chapter 3 of the Commission's June 2018 Report to Congress, adjustments to the fee schedule to address devaluation of E/M services could be phased in over multiple years to reduce the impact on other services.<sup>2</sup>
4. **Work with Congress to add physical therapists to the list of providers that may opt out of Medicare.** Otherwise, beneficiary access to physical therapy will be severely limited due to physical therapists being financially incapable of treating Medicare beneficiaries.

We urge CMS to take into consideration the following comments and concerns:

First, the proposed drastic reduction in payment is an arbitrary, across-the-board cut, which, if implemented, would be in addition to the 2% sequestration reduction, thereby amounting to up to **a 10% cut in reimbursement. This 10% reduction is in addition to the 50% multiple procedure payment reduction (MPPR) policy for the PE RVUs and the Correct Coding Initiative (CCI) edits** that impose a significant penalty on code combinations that represent standard and necessary care, which have decimated reimbursement for skilled physical therapy services. **Further, due to the recent revaluation of codes used by physical therapists, several of the codes frequently utilized by physical therapists were significantly cut, especially to the PE.** We also urge CMS to recognize that **outpatient physical and occupational therapy providers will be faced with a 15% reimbursement reduction for services furnished in whole or in part by the PTA or occupational therapy assistant (OTA) beginning in 2022.**

Due to inadequate access, beneficiaries will be forced to delay or forgo necessary care, leading to negative health outcomes and greater overall cost to the system. The federal government, as well as patients and tax payers, are better served in the long run by ensuring the Medicare program promotes efficient treatment of beneficiaries, which cannot happen unless there enough providers to do so. It is unrealistic for CMS to expect physical therapy providers to continue operate their practices without affording them sufficient payment. Because physical therapists are not currently a provider type that may opt out of Medicare, physical therapists will simply choose to stop treating Medicare beneficiaries. **Thus, how will CMS reconcile what likely will result in a significant decline in beneficiary access if the agency adopts the proposed 8% reimbursement reduction?**

**Second, the proposed reimbursement cuts for physical therapists fail to align with CMS' efforts to drive better patient access to care and management.** At a time when both Congress and US Department of Health and Human Services (HHS) are focused on engaging patients,

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<sup>2</sup> MedPAC June 2018 Report to Congress. [http://medpac.gov/docs/default-source/reports/jun18\\_ch3\\_medpacreport\\_sec.pdf?sfvrsn=0](http://medpac.gov/docs/default-source/reports/jun18_ch3_medpacreport_sec.pdf?sfvrsn=0) Accessed September 17, 2019.

increasing the delivery of integrated, team-based care, expanding chronic disease management, and reducing hospital admission/readmission rates for beneficiaries residing in the community as well as those residing in long-term nursing facilities, **it is nonsensical to propose to reduce the reimbursement for those health care professionals who are movement experts, particularly physical therapists, who have knowledge and skills in identifying, measuring and improving balance system deficits, functional limitations, and strength and flexibility deficits that have been shown to contribute to falls.**

The role of physical therapists in falls prevention includes assessing risk for falling; designing an individualized plan for a patient's fall-prevention needs; providing appropriate exercises and balance training; working with other health care professionals to address any underlying medical conditions that could increase fall risk; and providing recommendations on evidence-based community programs. Physical therapists also address the identified deficits following physical examination and objective tests of movement patterns.

Physical therapists are a vital component of multifactorial interventions that address modifiable risk factors for falls. Interventions provided by physical therapists are targeted and dosed to provide neural plasticity adaptation that move toward increased anticipated and reactive balance strategies under varying conditions. Progression in the multifactorial components of the balance systems and body structure/function domains leads to enhanced effectiveness of the activities and participation domains that support life and social role success.<sup>3456</sup> Physical therapy also is an alternative to a mechanism that may reduce long-term opioid medication as an effective means to decrease preventable falls in community dwelling older adults.<sup>78</sup> As documented by HHS in the Physical Activity Guidelines for Americans: Second Edition, physical activity reduces the risk of falling and injuries from falls.<sup>9</sup> Further, individually prescribed muscle strengthening and balance retraining exercises can reduce the number of falls and fall-related injuries by 35%.<sup>10</sup>

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<sup>3</sup> El-Khoury F, Cassou B, Charles MA, Dargent-Molina P. The effect of fall prevention exercise programmes on fall induced injuries in community dwelling older adults: systematic review and meta-analysis of randomised controlled trials. *BMJ*. 2013;347:f6234.

<sup>4</sup> Goodwin, V AR, Whear R, Bethel A, Ukouminne O, Thompson-Coon J, and Stein K. Multiple component interventions for preventions falls and fall-related injuries among older people. *BMC Geriatrics*. 2014;14(15):1-8.

<sup>5</sup> Nematollahi A, Kamali F, Ghanbari A, Etminan Z, Sobhani S. Improving Balance in Older People: A Double-Blind Randomized Clinical Trial of Three Modes of Balance Training. *J Aging Phys Act*. 2016;24(2):189-195.

<sup>6</sup> Cadore EL, Rodríguez-Mañas L, Sinclair A, Izquierdo M. Effects of different exercise interventions on risk of falls, gait ability, and balance in physically frail older adults: a systematic review. *Rejuvenation Res*. 2013;16(2):105-114.

<sup>7</sup> Krebs, E., Paudel, M., Taylor, B., Bauer, D., Fink, H., Lane, N., & ... Ensrud, K. E. (2016). Association of Opioids with Falls, Fractures, and Physical Performance among Older Men with Persistent Musculoskeletal Pain. *JGIM: Journal Of General Internal Medicine*, 31(5), 463-469. doi:10.1007/s11606-015-3579-9

<sup>8</sup> Patricia, Z., Ming-Chih, K., Karayannis, N. V., Smuck, M., Zheng, P., & Kao, M. (2017). Stagnant Physical Therapy Referral Rates Alongside Rising Opioid Prescription Rates in Patients With Low Back Pain in the United States 1997-2010. *Spine (03622436)*, 42(9), 670-674. doi:10.1097/BRS.0000000000001875

<sup>9</sup> Physical Activity Guidelines for Americans Second Edition. US Department of Health and Human Services. 2018. [health.gov/paguidelines/](http://health.gov/paguidelines/)

<sup>10</sup> Non-Pharmacological Management of Osteoporosis: a Consensus of the Belgian Bone Club. *Osteoporosis Intl*. 2011;22(11):2679-88

**Third, CMS should promote access to physical therapist services in order to reduce downstream costs.** Physical therapists can help to reduce downstream costs, including avoidable hospital readmissions, by contributing to existing care transition models and collaborating with other health care disciplines. Research shows that individuals who received outpatient therapy in the first 30 days after discharge home from the hospital following stroke were less likely to be readmitted in the subsequent 30 days than were individuals who received no therapy.<sup>11</sup> Hospital-based physical therapist services also are associated with lower risk of 30-day hospital readmission in patients with ischemic stroke.<sup>12</sup>

**Early access to a physical therapist for musculoskeletal assessment or pain management also results in lower downstream costs to the payer and patient.** The presence of pain is one of the most common reasons people seek health care. The source of pain for any individual can vary, whether it is an injury or an underlying condition such as arthritis, heart disease, or cancer. Because pain can be so difficult to treat and presents differently in every individual, its prevention and management require an integrated, multidisciplinary effort that takes into consideration the many variables that contribute to it, including the underlying cause(s) of the pain and the anticipated course of that condition; the options that are available for pain prevention and treatment, and patient access to these options; and the patient’s personal goals, and their values and expectations around health care. That evidence, in fact, was the driving force behind recent recommendations by the CDC in its Guideline for Prescribing Opioids for Chronic Pain. “Non-pharmacologic therapy and non-opioid pharmacologic therapy are preferred for chronic pain,” the CDC states. The report goes on to explain that “many non-pharmacologic therapies, including physical therapy...can ameliorate chronic pain.” The CDC concluded that there is insufficient evidence that opioid usage alone improves functional outcomes for those in pain.

Studies have shown that patients who seek primary care for musculoskeletal disorders and are triaged to a physical therapist report slightly better patient-reported outcomes related to pain, disability, and health-related quality of care.<sup>13</sup> Moreover, patients with low back pain (LBP) who received care from a physical therapist **first** experienced lower out-of-pocket, pharmacy, and outpatient costs after 1 year and reduced their likelihood of receiving an opioid prescription by 87% compared with patients who never visited a physical therapist. The physical therapist-first group also was associated with a 28% lower probability of having imaging services and 15% lower odds of making a visit to an emergency department.<sup>14</sup> Additionally, research has shown that early mobilization after cervical spine surgery has the potential to significantly decrease

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<sup>11</sup> Community Use of Physical and Occupational Therapy After Stroke and Risk of Hospital Readmission <https://www.ncbi.nlm.nih.gov/pubmed/28807692>

<sup>12</sup> Use of Hospital-Based Rehabilitation Services and Hospital Readmission Following Ischemic Stroke in the United States <https://www.ncbi.nlm.nih.gov/pubmed/30684485>

<sup>13</sup> Health Effects of Direct Triaging to Physiotherapists in Primary Care for Patients with Musculoskeletal Disorders: A Pragmatic Randomized Controlled Trial <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6378424/>

<sup>14</sup> Physical Therapy as the First Point of Care to Treat Low Back Pain: An Instrumental Variables Approach to Estimate Impact on Opioid Prescription, Health Care Utilization, and Costs <https://www.ncbi.nlm.nih.gov/pubmed/29790166>

adverse events<sup>15</sup> and early physical rehabilitation programs for acutely hospitalized older adults have the potential to improve physical functioning.<sup>16</sup> Accordingly, CMS should adopt reimbursement methodologies that promote early access for patients with musculoskeletal disorders to physical therapists for primary assessment in primary care.

Here, CMS is proposing an 8% cut to physical/occupational therapy services for 2021, while other pain management specialties, e.g. Interventional Pain Management, will experience a reimbursement increase of 8%. **With the strong support of literature proving the efficacy of nonpharmacological therapies, we request that CMS clarify in final rulemaking how an 8% payment reduction for physical therapy services supports the use of nonpharmacological physical therapist services for preventing, treating, and managing Medicare beneficiaries' acute and chronic pain.**

Early access to physical therapy also holds the promise of reducing opioid use among patients with musculoskeletal pain. Researchers recently examined claims data to assess whether early physical therapy was associated with decreases in long-term opioid use. The results suggest that early physical therapy is associated with an approximate 10% reduction in the probability of any long-term opioid use for patients with shoulder, neck, knee, and/or LBP.<sup>17</sup> Evidence also shows that when patients with low back pain see a physical therapist first, there is lower utilization of high-cost medical services as well as lower opioid use, and cost shifts reflecting the change in utilization. An analysis of more than 200,000 commercial and Medicare Advantage insurance beneficiaries revealed what researchers describe as a "significant" pattern: among patients seeking treatment for LBP, those whose initial visit was with a physical therapist, chiropractor, or acupuncturist decreased their odds of early opioid use by between 85% and 91%, and lowered their odds of long-term opioid use by 73% to 78% compared with those whose initial visit was with a primary care physician.<sup>18</sup>

**It is critical that CMS provide appropriate payment for a broad range of pain management and treatment services, including physical therapy.** This sentiment was expressed by the President's Commission on Combating Drug Addiction and the Opioid Crisis in its final report, recommending that "CMS review and modify rate-setting policies that discourage the use of non-opioid treatments for pain, such as certain bundled payments that make alternative treatment options cost prohibitive for hospitals and doctors, particularly those options for treating immediate post-surgical pain."<sup>19</sup>

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<sup>15</sup> Adverse Events and Their Risk Factors 90 Days After Cervical Spine Surgery: Analysis From the Michigan Spine Surgery Improvement Collaborative. *J Neurosurg Spine*. 2019;Feb 15:1-13

<sup>16</sup> Effectiveness and Feasibility of Early Physical Rehabilitation Programs for Geriatric Hospitalized Patients: A Systematic Review. *BMC Geriatr*. 2013;13:107

<sup>17</sup> Association of Early Physical Therapy With Long-Term Opioid Use Among Opioid-Naïve Patients with Musculoskeletal Pain *JAMA Netw Open*. 2018;1(8):e185909

<https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2718095>

<sup>18</sup> Observational retrospective study of the association of initial healthcare provider for new-onset low back pain with early and long-term opioid use. *BMJ Open*. 2019;9:e029633 <https://bmjopen.bmj.com/content/9/9/e028633>

<sup>19</sup> The President's Commission on Combating Drug Addiction and the Opioid Crisis. Final Report [https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final\\_Report\\_Draft\\_11-1-2017.pdf](https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf)

A recent study published in the *American Journal of Managed Care* that examined the association between health insurance design features and choice of physical therapy or chiropractic care by patients with new-onset LBP affirmed that higher copays and payer restrictions on provider access may steer patients away from more conservative treatments for LBP, including physical therapy and chiropractic services. Authors wrote that “innovative modifications to insurance benefits...offer an opportunity for increased alignment with clinical practice guidelines and greater value.” The study concluded that modification of health insurance benefit designs offers an opportunity for creating greater value in treatment of new-onset LBP by encouraging patients to choose noninvasive conservative management that will result in long-term economic and social benefits.<sup>20</sup>

Physical therapists should be included within the primary care team to increase access to best practice pain management care. Moving forward, it is imperative that CMS acknowledge the important role physical therapists play in the prevention and treatment of acute and chronic pain. To that end, APTA encourages CMS to promote coverage and payment models that eliminate the access barriers to physical therapy and other nonpharmacological therapies that have been proven to be effective for the prevention or treatment of pain. Until such barriers are addressed, access to nonpharmacological therapies will continue to be limited, and opioids will remain a go-to quick fix for pain despite their dangerous side effects and, in some instances, long-term ineffectiveness.

**To truly be effective in improving care for Medicare beneficiaries suffering from pain, there must be adequate payment and coverage of nonpharmacological pain management treatments, which pose one of the biggest challenges in ensuring patient access to such treatments.** Thus, in conjunction with CMS’ current efforts to promote access to physicians who help to address pain and arthritis, CMS must also develop and promote accompanying policies that **increase** access to nonpharmacological alternatives, including physical therapy.

**Fourth, CMS is not being transparent in its rulemaking.** The information provided in the rule is very limited and does not provide enough information regarding the data and analysis used to determine the cuts to specialty providers. CMS is proposing these cuts to physical therapy services, among others, without seeking the input of any health care professionals and providers who furnish physical therapy services. Further, CMS has offered no explanation regarding *how* the agency may redistribute the cuts across the code set. As required by the Regulatory Flexibility Act, **CMS must conduct a regulatory analysis of the options for small businesses, including a justification concerning the reason action is being taken, the kinds and numbers of small entities the rule affects, and an explanation of any meaningful options that achieve the objectives with less significant adverse economic impact on the small entities.**

Because APTA is extensively involved in the establishment and valuation of most of the Current Procedural Terminology (CPT) codes billed by physical therapists through the CPT, RUC, and PE Subcommittee process, CMS could have benefited from engaging directly with APTA to

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<sup>20</sup> Health Insurance Design and Conservative Therapy for Low Back Pain  
<https://www.ajmc.com/journals/issue/2019/2019-vol25-n6/health-insurance-design-and-conservative-therapy-for-low-back-pain>

obtain further clarification regarding the provision of physical therapy services and the current state of physical therapist practice. APTA is in regular contact with CMS staff on policy issues that span the spectrum of care. **With the absence of any input from health care professionals who furnish these services, it is apparent that CMS may have made many flawed assumptions regarding practice.** Considering the magnitude of the cuts proposed in this rule for 2021, it is critical that CMS ensure that the process it uses to develop policies is transparent and decisions are based on accurate information.

**Fifth, PE values should align with current physical therapist practice.** The RVUs for PE are based on the expenses that providers incur when they rent office space, buy supplies and equipment, and hire nonphysician clinical and administrative staff. Starting a private physical therapy practice is a major decision that requires considerable thought, special skills, and a significant financial and administrative commitment. Physical therapy providers must purchase numerous types of equipment, including treatment tables, body weight support systems, transfer slings, exercise bikes, and/or parallel bars, and treatment modalities including electrical muscle stimulation and ultrasound.

Since 2011, CMS has applied a MPPR to the PE part of payment to outpatient physical therapy services. MPPR is designed to avoid duplicate payment for practice expenses when multiple procedures are delivered to the same patient on the same date of service. The rationale for this policy is that efficiencies in PE occur when multiple therapy services are furnished in a single session because certain clinical staff activities are only performed once per session. CMS started applying this policy to "always therapy" services on January 1, 2011. From January 1, 2011, to March 31, 2013, MPPR as applied by CMS included a 20% reduction on the PE for nonfacility providers and a 25% reduction for facility providers. The MPPR increased to 50% for all Medicare therapy providers in all settings on April 1, 2013.

The application of MPPR to physical therapist services is inappropriate, given the fact that the PE values for these CPT codes were already reduced to avoid duplication. The time spent on the pre-service and post-service activities was spread across 3 units of services based on the assessment that the typical therapy visit is approximately 45 minutes. The fact that certain efficiencies exist when multiple therapy services are provided in a single session was explicitly considered when relative values were established for these codes.

Unfortunately, in many instances, reducing the PE on the second and subsequent codes results in underpayments. If CMS adopts an 8% cut to codes billed by physical therapists, which includes at least a 3% reduction in the PE value, there will be an even greater underpayment for physical therapy services, because the PE amount which has already been reduced would be reduced even further. **Rather than taking the time to ensure that individual services are based on the resources required to deliver them, CMS is calling for arbitrary across-the-board cuts that put expediency ahead of equity.** The proposal makes further reductions where duplication of PE has already been addressed, through both recent revaluation of the codes and application of MPPR. **Therefore, we oppose the proposed reduction to the PE value and recommend that CMS redistribute the cuts to PE across health care providers who do not have as demonstrable costs for equipment and supplies as physical therapy providers.**

**In conclusion, the extent and nature of the changes CMS is proposing associated with E/M coding and valuation are monumental and represent changes that warrant further consideration, including the need for additional Medicare funding to maintain adequate beneficiary access to care.** Without additional funding, physical therapists will be forced out of business, leaving Medicare beneficiaries without access to physical therapy. **APTA urges CMS to be mindful of well-intentioned policy changes, as such proposals often result in inappropriate redistributions of Medicare outlays that significantly impact the broader providers community and the patients they treat.** Mass adjustments to the PFS will cause disruptive reductions to revenue that, in turn, will severely jeopardize patient access care.

### **Chronic Care Remote Physiologic Monitoring Codes**

**APTA respectfully requests that CMS issue clarification regarding the use and billing of CPT codes 99453, 99454, 99091, and 99457 by Medicare-enrolled physical therapists.** As discussed in more detail below, physical therapists are recognized by the American Medical Association (AMA) as qualified health care professionals (QHP) and the CPT codes at issue are not restricted to use solely by physicians and others who may bill E/M services. It has recently come to our attention, however, that there are differing interpretations of the use of these codes, prompting the need for additional clarity from the agency.

Physical therapists use remote monitoring technology in treatment to shorten healing times, reduce risk for adverse events, promote patient self-efficacy, improve comfort and quality of life, and increase the overall quality and options of care available. Physical therapists use accelerometers and devices that collect physiologic functions both in real time (in person and remotely) and recorded. They commonly collect data that includes change in upper or lower extremity position, or displacement, that occurs over a given time period, heart rate, blood pressure, pulse, and respiration. This provides a greater understanding of performance of and response to physical activity as well as information to better gauge their home exercise program and determine the need for advancing or revising programs. Physical therapists also use accelerometry to collect data that indicates when a patient may be experiencing balance and or postural changes that may be indications of increased falls risk.

In the CY 2019 PFS final rule, CMS separated payment for CPT codes 99453, 99454, and 99457. Regarding these codes, CMS noted that some commenters “suggested that additional medical professionals, including pharmacists, paramedics, chiropractors, physical therapists, occupational therapists and dentists should be allowed to bill Medicare for these services. Other commenters requested that CMS clarify the practitioners referred to as ‘other qualified healthcare professionals’ in the code descriptor.” CMS responded, stating: **“We note that all practitioners must practice in accordance with applicable state law and scope of practice laws, and that some of the practitioners identified by the commenters are not authorized to bill Medicare independently for their services. We note that the term, ‘other qualified healthcare professionals,’ used in the code descriptor is a [sic] defined by CPT, and that definition can be found in the CPT Codebook”** (emphasis added).<sup>21</sup>

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<sup>21</sup> CY 2019 Physician Fee Schedule final rule page 59575 <https://www.govinfo.gov/content/pkg/FR-2018-11-23/pdf/2018-24170.pdf> Accessed August 13 2019.

The *AMA 2019 CPT Professional* states that “throughout the CPT code set, the use of terms such as “physician,” “qualified health care professional,” or “individual” is not intended to indicate that other entities may not report the service. In selected instances, specific instructions may define a service as limited to professionals or limited to other entities (e.g., hospital or home health agency).” Additionally, CPT Professional xvi states: “In some cases alternative coding and procedural nomenclature as contained in other code sets may allow appropriate reporting of a more specific code. CPT references to use an unlisted procedure code do not preclude the reporting of an appropriate code that may be found in other code sets.”

The *AMA 2019 CPT Professional* xii defines a “physician or other qualified health care professional” as an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service. These professionals are distinct from “clinical staff.” A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service.”

Physical therapists are recognized as QHPs by the AMA. As stated on page 35 of the CPT Manual: “For team conferences where the patient is present for any part of the duration of the conference, nonphysician qualified health care professionals (e.g., speech-language pathologists, physical therapists, occupational therapists, social workers, dietitians) report the team conference face-to-face code 99366. CPT code 99366 is in the E/M section of the manual.”

CPT codes 99453, 99454, 99091, and 99457 describe services that are provided by physical therapists and other QHPs. They are the most descriptive and appropriate codes for these procedures. They are not E/M services. As stated in page 41 of the *CPT Manual*: “**If the services described by 99091 are provided on the same day the patient presents for an Evaluation and Management (E/M) service, these services should be considered part of the E/M service and not reported separately**” (emphasis added). This statement clarifies that the remote physiologic monitoring services are not billed with an E/M service, and therefore they are not an E/M service.

Further, it is worth noting that physical therapists report codes that are in the E/M section of the *CPT Manual* but are not necessarily codes to describe E/M services, a policy acknowledged by members of the AMA CPT Panel and in the *CPT Manual*. At the May 2018 CPT meeting, members of the CPT Panel, in response to concerns raised by APTA about the placement of these remote physiologic monitoring codes in the E/M section, indicated that placement of the codes in this section **would not** preclude their use by other QHPs and gave examples of codes in this section that are used by QHPs. **Panel members noted that the key consideration is whether the code description states that the codes could only be billed by professionals who may bill E/M services. There is no such statement in the description of the remote physiologic monitoring codes and remote physiologic monitoring treatment management services codes.**

Moreover, in a parenthetical related to the telephone services codes, a distinction is made between the codes to be used by physicians and the codes to be used by QHPs. However, in the remote physiologic monitoring and treatment code descriptions there is no such distinction. These codes are indicated for use by both physicians and other QHPs. Moreover, the language associated with the CPT codes at issue is consistent with the use of these codes by QHPs.

AMA also previously clarified that placement of a code in a specific section of the CPT Manual does not strictly classify the service or procedure. This was specific to the fact that codes in the surgical section do not necessarily describe surgery. Per the *CPT Professional Manual*: “It is equally important to recognize that as techniques in medicine and surgery have evolved, new types of services, including minimally invasive surgery, as well as endovascular, percutaneous, and endoscopic interventions have challenged the traditional distinction of Surgery vs Medicine. **Thus, the listing of a service or procedure in a specific section of this book should not be interpreted as strictly classifying the service or procedure as “surgery” or “not surgery” for insurance or other purposes.** The placement of a given service in a specific section of the book may reflect historical or other considerations (e.g., placement of the percutaneous peripheral vascular endovascular interventions in the Surgery/ Cardiovascular System section, while the percutaneous coronary interventions appear in the Medicine/Cardiovascular section).”

CMS has previously acknowledged that physical therapists can use remote patient monitoring. Per the 2019 Home Health PPS final rule, it is apparent that CMS is promoting innovation and modernization of home health care by now allowing the cost of remote patient monitoring to be reported by home health agencies as allowable costs on the Medicare cost report form. The agency expects this to result in more effective care planning, as data are shared among patients, their caregivers, and their providers. In the 2019 Home Health PPS final rule, CMS noted that commenters requested that CMS clarify whether the agency intends that all QHPs, specifically physical therapists, speech-language pathologists, and occupational therapists, acting within their scope of practice, may use remote patient monitoring to augment the plan of care during the home health episode. CMS responded, stating: “As therapy goals must be established by a qualified therapist in conjunction with the physician while determining the plan of care, **we believe therapists involved in care planning, as well as other skilled professionals acting within their scope of practice, may utilize remote patient monitoring to augment this process**” (emphasis added).

As noted above, CMS does not state that only professionals who bill E/M services can bill CPT codes 99453, 99454, 99091, and 99457. Rather, the agency defers to state law and the code descriptors included within AMA’s CPT codebook. The definition of QHP supports the interpretation that physical therapists are QHPs. While there should be no question that physical therapists may perform and bill for these services, some confusion remains. **Therefore, APTA respectfully requests that CMS clarify in final rulemaking that CPT codes 99453, 99454, 99091, and 99457 may be billed by QHPs, such as physical therapists, who meet all statutory requirements.**

## Therapy Services

### **Proposed Regulatory Revisions**

APTA supports CMS' proposal to revise regulation text to clarify that the specified amounts of annual per-beneficiary incurred expenses are no longer applied as limitations but as threshold amounts above which services require, as a condition of payment, inclusion of the KX modifier; and that use of the KX modifier confirms that the services are medically necessary as justified by appropriate documentation in the patient's medical record.

**There continue to be questions surrounding MPPR and nonparticipating providers. APTA requests that in the PFS final rulemaking CMS clarify whether nonparticipating providers' limiting charge includes MPPR in the calculation.**

**Example:** A nonparticipating provider in Arizona who does not accept assignment furnishes 3 units of CPT 97110 on January 2, 2019. If MPPR is not applied, the limiting charge is \$101.00. If the 50% MPPR is applied, the limiting charge is: \$85.71.

In this example, is the provider limited to charging the beneficiary \$85.71, which includes MPPR, or can they charge the beneficiary \$101.00, which does not include MPPR? Moreover, if MPPR is included in the calculation, we request that CMS clarify in final rulemaking how nonparticipating providers should conduct such calculation, given the complexity of MPPR.

### **Proposed Payment for Outpatient Physical Therapy and Occupational Therapy Services Furnished by PTAs and OTAs**

APTA's concerns and recommendations regarding this proposed policy are summarized below. For additional information, please refer to APTA's detailed comments submitted to CMS on August 28, 2019<sup>22</sup> responding to CMS' proposed application of the 10% de minimis standard to services furnished in whole or in part by a PTA or OTA.

Additionally, APTA disagrees with CMS' use of the term "concurrent" when discussing team-based therapy under this proposed policy. **CMS is using the confusing terms "concurrent" and "concurrently" to describe clinical scenarios where the PTA or OTA works alongside the respective physical therapist or occupational therapist to provide a "second set of hands" for safety or effectiveness purposes when an alternative term such as "in tandem" would be appropriate and create less confusion.** This usage describing a two-clinician to one patient scenario under this proposed Part B policy is the exact opposite of the existing and long-standing Medicare Part A SNF definition of "concurrent" therapy as depicted in this excerpt from page O-16 of the CMS Minimum Data Set Resident Assessment Instrument (MDS-RAI) Manual v1.17.1, October 2019:<sup>23</sup>

**Concurrent minutes**—Enter the total number of minutes of therapy that were provided on a concurrent basis in the last 7 days. Enter 0 if none were provided. Concurrent therapy is defined as

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<sup>22</sup> APTA Comments on CQ CO Modifier Policy 2020 PFS Proposed Rule Comments Final. <https://www.regulations.gov/document?D=CMS-2019-0111-2646> (Posted September 3, 2019).

<sup>23</sup> CMS MSD 3.0 RAI Manual Page O-16: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html>

the treatment of 2 residents at the same time, when the residents are not performing the same or similar activities, regardless of payer source, both of whom must be in line-of-sight of the treating therapist or assistant for Medicare Part A. When a Part A resident receives therapy that meets this definition, it is defined as concurrent therapy for the Part A resident regardless of the payer source for the second resident. For Part B, residents may not be treated concurrently: a therapist may treat one resident at a time, and the minutes during the day when the resident is treated individually are added, even if the therapist provides that treatment intermittently (first to one resident and then to another). For all other payers, follow Medicare Part A instructions.

**APTA recommends that for the purposes of this policy, CMS define the clinical scenario where a therapist and a therapist assistant are jointly furnishing services to a patient at the same time by using the term “in tandem” and not use the term “concurrent.”**

To summarize our comments submitted on August 28, 2019, the 2020 PFS proposed policy regarding the new modifiers for outpatient physical therapy and occupational therapy services represents an expanded application of the policy finalized in the 2019 PFS rule. We feel this new policy goes beyond the original intent of Congress in that it devalues therapy services provided by physical therapists and occupational therapists:

- 1. Concurrent services (In tandem therapy):** CMS is proposing that when a physical therapist (or occupational therapist) is furnishing care and requires the skilled assistance of a PTA or OTA, the entire service provided by the therapist will be subject to the 15% payment adjustment. When a therapist and assistant are jointly furnishing the services to a patient at the same time, and the therapist is fully engaged in the service during that time, the *service* during that time period should be identified as a therapist’s services and be allocated to the therapist. It is nonsensical to diminish reimbursement for services when safety precautions are implemented, and the overall value of the care is increased.  
**Summary:** We feel strongly that the entirety of care delivered by a physical therapist and occupational therapist should not be devalued because an assistant is providing care alongside the therapist. In this instance, the beneficiary is receiving skilled services from two skilled practitioners, yet under the 2020 rule, the entire service will be subject to a 15% payment adjustment.  
**Example: A physical therapist performs therapeutic activities, 97535, for 45 minutes. During that time, the physical therapist asks for the assistance of a PTA for 8 minutes to help position the patient for the activity. According to the 2020 proposed rule, the entire 45 minutes of service, (all three 15-minute units) would be subjected to the 15% reduction because the jointly furnished 8 minutes is 18% of 45 minutes.**
- 2. Same service furnished separately:** The 2020 PFS proposed rule proposes to apply the 15% payment adjustment (as determined by the 10% *de minimis* standard) to services provided by an occupational therapist or physical therapist when the assistant and the therapist each *separately* furnish units of the same service. In the 2020 rule, CMS is defining “service” for the purposes of the payment adjustment as the total of all treatment time that are billed under the same procedure code.  
**Difference from 2019 Rule:** This is in direct conflict with CMS’ response to comments in the 2019 PFS final rule (83 FR 59452) in which CMS explained how its claims

processing system allows for the *differentiation* of the same procedure code when the same service/procedure was furnished separately by the therapist and assistant. In 2019, the payment adjustment was calculated by each 15-minute unit billed, even when the same procedure code was billed.

**Summary:** Only those units of services provided “in whole or in part” by the assistant should be subject to the 10% *de minimis* standard and subsequently the 15% payment adjustment, not the entire therapy service.

**Example: A physical therapist performs therapeutic exercise, 97110, for 30 minutes.**

**The physical therapist leaves, and the PTA takes over the exercises, 97110, for another 15 minutes. According to the 2020 proposed rule, the entire 45 minutes of service (all three 15-minute units) would be subjected to the 15% reduction because 15 minutes is 33% of 45 minutes.**

- 3. Documentation requirements:** CMS is proposing that the outpatient therapy provider be required to add a statement in the medical record for *each* line of *every* claim to explain why the modifier was *used* or *not used*. The proposed documentation requirement associated with the new modifiers is burdensome and conflicts with CMS’ efforts to place “patients over paperwork.”

**Difference from 2019 Rule:** The 2019 rule did not require a separate documentation requirement to explain why the modifier was or was not used, nor does the statute require CMS to adopt new documentation requirements.

**Summary:** APTA has worked diligently with CMS to apply the 10% *de minimis* standard with as little administrative burden possible. Current policies already require extensive documentation and further notation would be redundant to the application of the modifier itself. The new narrative explanation is egregious given existing coding and documentation requirements. Per the *Medicare Benefit Policy Manual* Chapter 15 Section 220.3(E), documentation of each treatment is required to include the date of the treatment; identification of each specific intervention/modality provided and billed, for both timed and untimed codes, in language that can be compared with the billing on the claim to verify correct coding, and each service provided that is represented by a timed code must be documented, regardless of whether or not it is billed; total timed code treatment minutes and total treatment time in minutes; and the signature and professional identification of the qualified professional who furnished or supervised the services and a list of each person who contributed to that treatment.

### **Trigger Point Dry Needling (CPT Codes 205X1 and 205X2)**

#### **205X1**

APTA supports the comments of the Health Care Professionals Advisory Committee (HCPAC) and echoes the same comments and concerns here:

Based on a valid survey, the HCPAC recommends a work RVU of 0.45, the survey 25th percentile, for CPT code 205X1 *Needle insertion(s) without injection(s), 1 or 2 muscles*. CMS disagrees with the HCPAC’s recommendation because key reference service, CPT code 97140 *Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes* (work RVU = 0.43, 2 minutes preservice, 15 minutes intraservice and 2 minutes postservice time), has higher intraservice and total time and a lower work RVU.

The CMS proposal completely disregards all factors that go into the work value apart from time and minimizes the survey respondents' understanding of the service. The survey respondents selected a comparable service they are familiar with as the key reference, with the understanding that 205X1 is more intense and complex to perform because it is an invasive procedure rather than noninvasive manual therapy. 70% of survey respondents indicated that 205X1 requires more mental effort and judgment than noninvasive manual therapy, and 84% indicated that more physiological stress is involved. The intraservice work value per unit of time is appropriately aligned with the survey second key reference service, CPT code 97810 *Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient*, which is also an invasive needling service. These reference codes maintain relativity among other similar services, whereas the CMS crosswalk, CPT code 36600 *Arterial puncture, withdrawal of blood for diagnosis* (work RVU = 0.32), has the same intraservice time but was not selected as a key reference service by survey respondents. **APTA strongly recommends that CMS review the full HCPAC recommendations including surveyed time, but also intensity and complexity of the service and relativity to other similar services, rather than base the work value entirely on time. Also as recommended by the HCPAC, we urge CMS to accept a work RVU of 0.45 for CPT code 205X1.**

**Moreover, APTA strongly encourages CMS to recognize that CPT code 205X1 is not comparable to CMS' crosswalk to CPT code 36600.** First, there are significant differences in the required skills of the professional who may perform each procedure. Performing CPT code 205X1 requires the skills of a QHP to not only manipulate around the trigger point, but also to move around to identify other trigger points. Whereas, CPT code 36600 can be performed by a technician who may not be licensed or regulated by the state. Second, for a technician to perform CPT code 36600 requires a physician to order such procedure, while CPT code 205X1 does not.

**Further, CPT 205X1 is more complex than 97140 for the following reasons:** Manual therapy techniques that are described by the manual therapy CPT code (97140) are noninvasive techniques that do not have the same risks or skill requirement that procedures described by 205X1 involve. The QHP performing 205X1 must have higher levels of education, training, skill, and focus to monitor the patient during and following the procedure. The QHP also must have the skill, education, and focus to minimize risk of complications such as pneumothorax, nerve or vessel injury, and/or a vasovagal or sympathetic response. When performing 205X1, the QHP must manipulate each needle application within a region in order to elicit a response in the area of the trigger point. This is achieved through the "in and out technique" but involves scanning the needle around the area that was determined to be the target tissue in the preservice work. The effectiveness of this procedure depends on the acknowledgement of the intramuscular tension felt through the end of the needle tip and requires a higher level of skill and focus than required for 97140 to achieve the intended response.

## **205X2**

APTA supports the HCPAC's comments and echoes the same comments and concerns here as for 205X1:

Based on a valid survey, the HCPAC recommends a work RVU of 0.60, the survey 25th percentile, for CPT code 205X2. CMS starts with the value they have assigned to 205X1 and then selects crosswalk codes that match the intraservice time ratio between the codes in the

family. This is an erroneous methodology and if finalized will compromise the integrity of the resource-based relative value scale system. As with 205X1, the HCPAC compared 205X2 to the survey key reference service, CPT code 97140.

Also, as with 205X1, CMS' proposal completely disregards all factors that go into the work value apart from time and minimizes the survey respondents' understanding of the service. The survey respondents selected a comparable service they are familiar with as the key reference, with the understanding that 205X2 is more complex to perform because it is invasive needling, which is more intense than noninvasive manual therapy and patient therapy technique education. 71% of survey respondents indicated that 205X2 requires more mental effort and judgment, and 88% indicated that more physiological stress is involved. The intraservice work value per unit of time is appropriately aligned with the survey second key reference service, CPT code 97810, which is also an invasive needling service. These reference codes maintain relativity among other similar services, whereas the CMS crosswalk, CPT code 97113 *Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises* (work RVU = 0.48) and 97542 *Wheelchair management (e.g., assessment, fitting, training), each 15 minutes* (work RVU = 0.48), have the same intraservice time but were not selected as a key reference service code by survey respondents. **APTA strongly recommends that CMS review the full HCPAC recommendations including surveyed time, but also intensity and complexity of the service and relativity to other similar services, rather than base the work value entirely on time. Also as recommended by the HCPAC, APTA urges CMS to accept a work RVU of 0.60 for CPT code 205X2.**

**As stated in the comments for 205X1, 205X2 is more complex than 97140 and is not comparable to CMS' crosswalks 97113 and 97542 for the following reasons:** Manual therapy techniques that are described by the manual therapy CPT code (97140) are noninvasive techniques that do not have the same risks or skill requirement that procedures described by 205X1 involve. The QHP performing 205X1 must have higher levels of education, training, skill, and focus to monitor the patient during and following the procedure. The QHP also must have the skill, education, and focus to minimize risk of complications such as pneumothorax, nerve or vessel injury, and/or a vasovagal or sympathetic response. When performing 205X1, the QHP must manipulate each needle application within a region to elicit a response in the area of the trigger point. This is achieved through the "in and out technique" but involves scanning the needle around the area that was determined to be the target tissue in the preservice work. The effectiveness of this procedure depends on the acknowledgement of the intramuscular tension felt through the end of the needle tip and requires a higher level of skill and focus than required for 97113 or 97542 to achieve the intended response.

**Trigger point dry needling codes should be identified as "sometimes therapy" codes**  
APTA strongly recommends that CMS designate 205X1 and 205X2 as "sometimes therapy" procedures. First, these services may be performed by a wide range of professionals, including physicians, nurse practitioners, physician assistants, clinical nurse specialists, chiropractors, physical therapists, and occupational therapists. Second, it may not be appropriate to bill the service under a therapy plan of care. Third, assigning a designation of "always therapy" to these codes is inconsistent with CMS' designation of other CPT codes as "sometimes therapy" codes that could be appropriately provided either as therapy services or non-therapy services. CMS

used such rationale in the CY 2006 Hospital Outpatient Prospective Payment System final rule when the agency changed the designation of CPT codes 97602, 97605, and 97606 from “always therapy” to “sometimes therapy” services.

### **Online Digital Evaluation Service (e-Visit) (CPT Codes 98X00, 98X01, and 98X02)**

Within the rule, CMS discusses that CPT codes 98X00-98X02 are for practitioners who cannot independently bill E/M services. The statutory requirements that govern the Medicare benefit are specific regarding which practitioners may bill for E/M services. As such, when codes are established that describe E/M services that fall outside the Medicare benefit category of the practitioners who may bill for that service, CMS has typically created parallel HCPCS G-codes with descriptors that refer to the performance of an “assessment” rather than an “evaluation.” Thus, in the 2020 PFS proposed rule, CMS proposes to adopt three G-codes, GNPP1-GNPP3 with the following language “Qualified nonphysician health care professional online assessment for an established patient, for up to seven days, cumulative time during the 7 days: ....”

**APTA appreciates that CMS is proposing to allow qualified nonphysician health care professionals to perform and bill for online evaluations.** However, as communicated in HCPAC’s comments, the CPT Editorial Panel could have easily made an editorial change in time for the CPT 2020 publication and avoid the burden of having two sets of codes to describe the same service. We anticipate the CPT Editorial Panel will consider this editorial change for CPT 2021, so the CPT codes can be utilized, rather than G-codes, as intended.

**To that end, APTA recommends that CMS clarify in final rulemaking that these CPT codes may, in fact, be billed by nonphysician QHPs, such as physical therapists, who meet all statutory requirements.** Physical therapists are qualified nonphysician health care professionals under the definition put forth by the AMA. That is, a “physician or other qualified health care professional is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.”

**Moreover, as contained within the E/M section of the 2020 CPT code book, physical therapists are specifically identified as nonphysician QHPs:** “For team conferences where the patient is present for any part of the duration of the conference, nonphysician qualified health care professionals (e.g., speech-language pathologists, physical therapists, occupational therapists, social workers, dietitians) report the team conference face-to-face code 99366.” **The definition of QHP supports the interpretation that physical therapists are nonphysician QHPs.**

#### **98X00/GNPP1**

APTA supports CMS’ proposal to adopt a work RVU of 0.25 for CPT code GNPP1, which reflects the HCPAC recommended work RVU for CPT code 98X00.

#### **98X01/GNPP2**

As put forth by the HCPAC in their comments, APTA recommends that CMS accept the survey median work RVU of 0.50 for CPT code 98X01 because this maintains the same relativity as

equivalent physician codes, 9X0X1-9X0X3. CMS should focus on the relativity of these services, not the survey data point used. The work and time required by the physician or qualified nonphysician health care professional to provide these services are the same. The description of intra-service work for 98X01 and 9X0X2 is essentially the same. CPT code 98X01 should be valued at 0.50 work RVUs because it is similar to 98967 *Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion* (work RVU = 0.50).

The HCPAC noted that these services require the same QHP intraservice time to perform and deemed the survey conducted by the specialty society to be robust, with survey respondents consistently reporting the overall time/intensity of 98X01, and all the individual work components, as identical to or more intense than 98967 (the key reference service code). 98X01 is more intense than 98967 because the QHP response is documented in writing. There is a higher risk and challenge within the written response, as the QHP or patient may misinterpret something within the communication. Whereas, with a telephone call, any misinterpretations would be clarified with immediate feedback. Additionally, 98X01 is more complex because the QHP may review multiple images, some of which may be hard to decipher, and may engage in multiple communications over 7 days, which adds to the intensity of this service. **Therefore, APTA urges CMS to accept a work RVU of 0.50 for CPT code 98X01.**

### **98X02/GNPP3**

As put forth in the HCPAC comments, APTA recommends that CMS accept a work RVU of 0.80 for CPT code 98X02 because this maintains the same relativity as the equivalent physician codes 9X0X1-9X0X3. CMS should focus on the relativity of these services, not on the survey data point used. The work and time required by the physician or other QHP to provide these services are the same. The nonphysician health care professional work for this service is equivalent to the physician work for 9X0X3. CPT code 98X02 should be valued at 0.80 work RVUs because it is similar to CPT code 98968, *Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion* (work RVU = 0.75 and 25 minutes intra-service time, 36 minutes total time).

The HCPAC noted that 98X02 requires more qualified nonphysician health care professional work to perform and is more intense than 98968 because it describes 21 minutes or more, rather than a range of 21-30 minutes. The service will likely require more than 21 minutes, potentially much more. Additionally, the typical patient receiving 98X02 has more concerns than does the average patient. The HCPAC Review Board agreed that 98X02 is more intense than 98968 because the qualified nonphysician health care professional response is documented in writing with higher risk and challenges with multiple communications, not a verbal response with immediate clarifications as with CPT code 98X00. The HCPAC deemed the survey conducted by the specialty society to be robust, with survey respondents consistently reporting the overall

time/intensity of 98X02, and all the individual work components, as identical to or more intense than 98968 (the key reference service code). **Therefore, APTA recommends that CMS accept a work RVU of 0.80 for CPT code 98X02.**

### **Comment Solicitation on Opportunities for Bundled Payments Under the PFS**

APTA recommends that CMS place a high priority on the development of an alternative payment system that would ensure that Medicare beneficiaries receive medically necessary therapy services and that physical therapists are paid an amount that accurately reflects the resources needed to provide them. We also recommend that CMS pursue payment models that would replace the MPPR, which is an arbitrary across-the-board payment cut for outpatient therapy services. For example, CMS could consider a per-session bundled payment that would vary based on patient characteristics and the complexity of evaluation and treatment services furnished in the session. While this approach would involve the development of an entirely new coding/structure and system that therapists would need to learn, APTA supports the concept of moving toward per-session codes that would be based on the severity of the patient and the intensity of therapist clinical judgment and work involved in the provision of the therapy service. Such a system would be far more equitable than the MPPR policy, for example. We would be happy to work with CMS in the future to further develop this approach and others.

### **Opioid Treatment Programs**

APTA appreciates that to implement Section 2005 of the SUPPORT Act, CMS is proposing to establish rules to govern Medicare coverage of and payment for Opioid Use Disorder (OUD) treatment services furnished in opioid treatment programs (OTPs). We understand that CMS is proposing to establish a non-drug episode of care to provide a mechanism for OTPs to bill for non-drug services, including substance use counseling, individual and group therapy, and toxicology testing that are rendered during weeks when a medication is not administered. Further, CMS is proposing to define OUD treatment services as items and services that are specifically enumerated in Section 1861(jjj)(1) of the Social Security Act, including services that are furnished via telecommunications technology, and is seeking comment on any other items and services the agency might consider including as OUD treatment services under the discretion given to the Secretary.

**APTA encourages CMS to include physical therapy within the list of OUD treatment services.** Moreover, given that CMS is proposing to adjust the bundled payment rates through the use of an add-on code to account for instances in which effective treatment requires additional counseling or group or individual therapy to be furnished for a particular patient that substantially exceeds the amount specified in the patient's individualized treatment plan, **we recommend that CMS adjust the bundled payment rates to account for instances in which effective treatment requires physical therapy or other nonpharmacological treatment interventions.**

**Although SAMHSA certification standards do not require OTPs to furnish nonpharmacological therapies such as physical therapy, individuals with OUD need an integrated team approach that includes nonpharmacological interdisciplinary management**

**and interventions for acute pain to decrease the potentially disabling effects of chronic pain.** CMS should publicly support and promote OUD treatment approaches that include a focus on comprehensive nonpharmacological interdisciplinary pain management that includes physical therapy.

The adoption of interdisciplinary, comprehensive treatment plans that evaluate and treat the different factors influencing the presence of pain and the underlying causes of addiction, will enhance the effectiveness, efficiency, and safety of the care delivered. This approach may promote greater patient engagement and educate patients and providers on ways to address pain through increased movement, which can decrease the frequency of overuse of pain medication and prevent abuse. It also could improve outcomes among patients who receive treatment for mental and behavioral health conditions. CMS must ignite the much-needed paradigm shift away from opioid overutilization and toward safe and effective nonpharmacological treatments, when appropriate. Such actions will not only move this nation forward in its efforts to improve pain management but also foster and promote safe opioid prescribing.

Unfortunately, payment and coverage barriers to nonpharmacological care programs or treatments for chronic pain pose one of the greatest challenges in patient access. For example, barriers include patient attitudes toward pharmacological and nonpharmacological therapies, gaps in prescribers' knowledge, high copayments, and time and visit limits. This same sentiment was echoed in a letter from 37 attorneys general to America's Health Insurance Plans, in which they urged the organization to push its members to review and revise payment and coverage policies to encourage health care providers to prioritize nonopioid pain management options over opioids.

Moving forward, it is imperative that CMS acknowledge the important role that physical therapists and other nonphysician health care professionals play in the prevention and treatment of acute and chronic pain. While opioid addiction has affected all communities, rural and underserved areas have been disproportionately harmed. Given the seriousness of the opioid crisis (and, more broadly, the pain crisis), CMS should include nonpharmacological therapies within the list of OUD treatment services, as this likely will help to increase access in those medically underserved and rural communities and reduce the likelihood of future opioid addiction. **The solution requires more than limiting access to drugs. If CMS continues to remain silent on nonpharmacological treatment options that serve as an alternative to drugs, the agency only reinforces the idea that pharmaceuticals are the only option—an option with significant potential harm.**

#### **Revision(s) and Addition(s) to Denial and Revocation Reasons in §§ 424.530 and 424.535**

APTA appreciates CMS' concerns about instances of physician or other eligible professional misconduct and/or negligent or abusive behavior. We agree that it is important to ensure patient safety in all provider and supplier settings. However, it appears that CMS wants to be empowered with the discretion to determine whether the professional's conduct warrants revocation or denial, even when CMS has not been involved in the licensing board disciplinary process.

This new authority could result in CMS denying enrollment or revoking privileges due to action by the licensing board that includes administrative/monetary penalties or “any other reasons that CMS deems relevant to its determination.” We have concerns that this is an overreach by CMS into professional practice matters. Moreover, the new denial authority would impact far more physicians and professionals than the “high-risk” Medicare enrolled OTPs for whom these new revocation and denial bases were introduced. **Due to the impact this proposal may have on beneficiary access, APTA urges CMS not to finalize these proposed regulatory changes.**

### **Expanded Access to Medicare Intensive Cardiac Rehabilitation (ICR)**

APTA supports CMS’ proposal to modify the existing requirements under 42 CFR § 410.49(b) to implement the coverage changes specific to ICR.

### **Require Functional Ability and Level of Safety Screenings During Subsequent Annual Wellness Visit (AWV)**

APTA respectfully requests that CMS institute a regulatory change to the AWV to require functional ability and level of safety screenings during the subsequent AWV, in addition to the initial AWV. **Older adult falls are a critical public health problem that impacts millions of older adults each year. Requiring functional ability assessments that include an evaluation of falls risk during both the initial and subsequent AWV should help to reduce the personal and public costs associated with falls and injuries among older adults.**

Medicare covers an AWV providing personalized prevention plan services for beneficiaries who: 1) have been eligible for Medicare Part B benefits for more than 12 months; and 2) have not received an Initial Preventive Physical Examination (IPPE) or AWV within the past 12 months. During the initial AWV, the health care practitioner must review the beneficiary’s functional ability and level of safety using direct observation or select appropriate questions from various available screening questionnaires, or use standardized questionnaires recognized by national professional medical organizations to assess, at a minimum, the following topics: ability to successfully perform ADLs; fall risk; hearing impairment; and home safety.<sup>24,25</sup> In the subsequent AWV, the clinician is not required to review the beneficiary’s functional ability and level of safety to assess, at minimum, fall risk, among other topics.

CMS discussed its rationale for not requiring functional ability and level of safety screening elements in the subsequent AWV in the 2011 PFS final rule, stating they “agree that for certain individuals, functional status and safety assessments (for example, fall prevention) may be important to consider on a more routine basis. For the general Medicare population, there are no A or B recommendations by the USPSTF [US Preventive Services Task Force] in these areas and thus we have decided not to add functional status and safety assessments as universally required elements for the subsequent AWV. The AWV does allow for an individualized

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<sup>24</sup> “Initial Preventive Physical Examination,” *Medicare Learning Network*, August 2018. [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MPS\\_QRI\\_IPPE001a.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MPS_QRI_IPPE001a.pdf).

<sup>25</sup> “Annual Wellness Visit,” *Medicare Learning Network*, August 2018. [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AWV\\_Chart\\_ICN905706.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AWV_Chart_ICN905706.pdf).

approach with a personalized prevention plan. For certain individuals where these areas are determined to be priorities, specific evaluations may be voluntary parts of subsequent visits. Since we closely monitor the USPSTF recommendations for updates or changes, if specific new or revised recommendations come out in the future, we may consider modifications at that time.”<sup>26</sup>

We recognize that USPSTF has not published a formal recommendation regarding the frequency of falls screenings for Medicare beneficiaries. However, falls are the second leading cause of accidental or unintentional injury deaths worldwide, with an estimated 646,000 individuals dying from falls each year. According to the Centers for Disease Control and Prevention, 1 out of 5 falls causes a serious injury such as broken bones or a head injury.<sup>27</sup> In 2015, medical costs for falls totaled more than \$50 billion, with Medicare and Medicaid paying 75% of these costs.<sup>28</sup> **Given the high incidence of falls and the critical need for falls prevention, we strongly recommend that through formal rulemaking CMS require functional ability and level of safety screenings during the subsequent AWW.**

Falls and a fear of falling can diminish older Americans’ ability to lead a full and independent life. Although 1 in every 4 older adults falls each year, falling is not a part of normal aging. Unlike with other medical conditions, there is no single test that can predict a fall. As such, adults aged 65 years and older should be screened by a licensed health care provider, such as a physical therapist, on a yearly basis to help determine their risk for falling. In fact, both the American Geriatrics Society and the British Geriatrics Society recommend an annual screening for all adults aged 65 and older for a history of falls or balance impairment.<sup>29</sup>

As previously stated, physical therapists are movement experts with knowledge and skills in identifying, measuring and improving balance system deficits, functional limitations, and strength and flexibility deficits that have been shown to contribute to falls. **Accordingly, given the high incidence of falls and the critical need for falls prevention, we strongly recommend that through formal rulemaking CMS establish the requirement that functional ability and level of safety be screened during the subsequent AWW, in addition to the initial AWW.**

### **Telehealth Services**

**APTA requests that CMS clarify in final rulemaking whether it is legally permissible to hold a Medicare beneficiary financially liable for receipt of a service furnished as “telehealth” by a non-authorized telehealth provider and that is not on the list of Medicare-covered telehealth services, but which satisfies all other Medicare coverage criteria.** APTA recognizes that physical therapists are not currently recognized authorized providers of telehealth under the Section 1834(m) of the Social Security Act and none of the codes physical therapists use are on the [list](#) of Medicare-covered telehealth services. As such, the question has arisen as to

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<sup>26</sup> CY 2011 Physician Fee Schedule final rule. Page 73405. <https://www.govinfo.gov/content/pkg/FR-2010-11-29/pdf/2010-27969.pdf>

<sup>27</sup> “Important Facts about Falls,” *Centers for Disease Control and Prevention*. <https://www.cdc.gov/homeandrecreationalafety/falls/adultfalls.html>

<sup>28</sup> *Id.*

<sup>29</sup> Moncada, LVV, Mire, LG. Preventing falls in older persons. *Am Fam Physician*. 2017 Aug 15; 96(4): 240-247. <https://www.aafp.org/afp/2017/0815/p240.html>

whether a Medicare-enrolled physical therapist (or other nonauthorized telehealth provider) may accept cash as payment from a Medicare beneficiary for a service that satisfies all the Medicare coverage criteria but is furnished as a telehealth service. We encourage CMS to discuss in final rulemaking the rules surrounding charging cash when a telehealth service is not on the list of Medicare-covered telehealth services and it is furnished by a non-authorized telehealth provider, such as a physical therapist.

**APTA also requests that CMS clarify in final rulemaking whether it has the authority to enable Medicare Advantage (MA) plans to include physical therapy telehealth services as a basic benefit.** APTA would appreciate clarification as to whether CMS has the authority to enable MA plans to include physical therapy, occupational therapy, and speech-language pathology services furnished via telehealth as basic benefits pursuant to Section 50323 of the Bipartisan Budget Act (BBA) of 2018.

Section 50323 defines “additional telehealth benefits” as:

- (I) for which benefits are available under part B, including services for which payment is not made under section 1834(m) due to the conditions for payment under such section; and
- (II) that are identified for such year as clinically appropriate to furnish using electronic information and telecommunications technology when a physician (as defined in section 1861(r)) or practitioner (described in section 1842(b)(18)(C)) providing the service is not at the same location as the plan enrollee...

(3) REQUIREMENTS FOR ADDITIONAL TELEHEALTH BENEFITS.— The Secretary shall specify requirements for the provision or furnishing of additional telehealth benefits, including with respect to the following:

- (A) Physician or practitioner qualifications (other than licensure) and other requirements such as specific training.
- (B) Factors necessary for the coordination of such benefits with other items and services including those furnished in-person.
- (C) Such other areas as determined by the Secretary.

While the language in the BBA does appear to limit the “provision of additional telehealth services” to a physician and practitioner, the language included in the same section, below, would seem to grant CMS the regulatory authority to go beyond what is outlined in the BBA.

- (3) Requirements for additional telehealth benefits: (C) Such other areas as determined by the Secretary

Moreover, since physical therapy, occupational therapy, and speech-language pathology services **are** available under Part B but **are not** currently payable under Section 1834(m) of the Social Security Act, this language would seem to be consistent with the proposed rule. In the Contract Year 2020 MA and Part D flexibility proposed rule (83 FR 54982), CMS made no reference to the physician/practitioner terminology and proposed to define additional telehealth benefits as services that meet the following:

- (1) Are furnished by an MA plan for which benefits are available under Medicare Part B but which are not payable under section 1834(m) of the Act; and
- (2) Have been identified by the MA plan for the applicable year as clinically appropriate to furnish through electronic exchange.

CMS also stated in the proposed rule that Section 50323 of the BBA requires the “Secretary to solicit comment on what types of items and services should be considered to be additional telehealth benefits. Therefore, we are also soliciting comments on whether we should place any limitations on what types of Part B items and services...can be additional telehealth benefits provided under this authority.”

It appeared in the proposed rule that CMS was taking the broadest possible approach to this statute, which is supported by CMS stating that MA plans “are in the best position to identify each year whether additional telehealth benefits are clinically appropriate to furnish...”

**Accordingly, if a MA plan chose to cover telehealth furnished by physical therapists within its basic benefits package, APTA believes it would not be limited to services furnished solely by a physician or practitioner.**

Based on this analysis, APTA submitted comments in support of the CMS proposal to allow MA plans the flexibility to provide therapy services via telehealth as part of their “basic benefit” packages. However, in the CY 2020 MA final rule, CMS updated the definition of additional telehealth benefits to mimic the language of Section 50323 of the BBA:

42 CFR § 422.135 Additional telehealth benefits.

a. Definitions. For purposes of this section, the following definitions apply:  
Additional telehealth benefits mean services:

- (1) For which benefits are available under Medicare Part B but which are not payable under section 1834(m) of the Act; and
- (2) That have been identified by the MA plan for the applicable year as clinically appropriate to furnish through electronic exchange when the physician (as defined in section 1861(r) of the Act) or practitioner (described in section 1842(b)(18)(C) of the Act) providing the service is not in the same location as the enrollee.

It is clear that Congress intended to afford authority to CMS to include telehealth physical therapy services within the definition of additional telehealth benefits that can be part of the basic benefit package. However, given the definition of additional telehealth benefits finalized by CMS, we question whether CMS believes it has the statutory authority do so. **Therefore, we respectfully request that CMS clarify in final rulemaking, or through correspondence directly with APTA, the extent to which it has the authority to include physical therapy, occupational therapy, and speech-language pathology services furnished by licensed physical therapists, occupational therapists, and speech-language pathologists, respectively, within the definition of additional telehealth benefits that can be offered as a basic benefit by MA plans.**

## **Stark Law**

CMS proposes to ease certain restrictions regarding the types of advisory opinion requests that it may accept and the advisory opinions it may issue and seeks feedback.

**While outside the scope of CMS' request for feedback, APTA recommends that CMS add physical therapy to the list of services that trigger the disclosure requirement under the in-office ancillary services (IOAS) exception.**

### **Background**

Section 1877(b)(2) of the Social Security Act, entitled "IOAS," sets forth the exception that permits a physician in a solo or group practice to order and provide designated health services (DHS), other than most durable medical equipment and parenteral and enteral nutrients, in the office of the physician or group practice, provided that certain criteria are met. The requirements of the IOAS exception are described at 42 CFR § 411.355(b).

Section 6003 of the Affordable Care Act (ACA) amended Section 1877(b)(2) of the Social Security Act by creating a new disclosure requirement for the IOAS exception to the prohibition on physician self-referral. Specifically, Section 6003 of the ACA provided that, with respect to referrals for magnetic resonance imaging (MRI), computed tomography (CT), positron emission tomography (PET), and any other DHS specified under section 1877(h)(6)(D) of the Act that the Secretary determines appropriate, the referring physician inform a patient in writing at the time of the referral that the patient may obtain the service from a person other than the referring physician or someone in the physician's group practice and provide the patient with a list of suppliers who furnish the service in the area in which the patient resides.

In the CY 2011 PFS proposed rule (75 FR 40140), CMS proposed regulations to create a new disclosure requirement with respect to referrals for MRIs, CTs, and PETs. APTA submitted comments on the proposed rule, advocating that CMS exercise its administrative authority to address the increasing instances of physical therapy "referral for profit" models appearing across the country and expand the list of services subject to the disclosure requirement to include physical therapy.

In the CY 2011 PFS final rule (75 FR 73616), CMS finalized regulations related to Section 6003 of the ACA, which included applying the disclosure requirement to advanced imaging services only. CMS responded to stakeholders who had advocated that CMS expand the disclosure requirement to other DHS, including APTA, stating: "Section 6003 of the ACA does not grant the Secretary the authority to expand application of this disclosure requirement to DHS other than those in Section 1877(h)(6)(d)... The requested expansion to other DHS is beyond the Secretary's authority and cannot be accomplished via rulemaking."

### **Expanding the List of DHS Subject to the Disclosure Requirement**

**APTA disagrees with CMS' rationale and believes the agency has the authority to expand the list of DHS subject to the disclosure requirement through future rulemaking.** Congress has granted CMS broad authority and discretion to implement Section 1877 of the Social Security Act. Further, in accordance with Executive Order issued on June 24, 2019, this Administration seeks to enhance the ability of patients to *choose* the health care that is best for

them. “To make fully informed decisions about their healthcare, patients must know the price and quality of a good or service in advance... It is the policy of the Federal Government to ensure that patients are engaged with their healthcare decisions and have the information requisite for choosing the healthcare they want and need.”<sup>30</sup>

The IOAS exception is intended to improve coordination of care and promote patient convenience by allowing physicians to self-refer for designated health services integral to their primary care that are furnished in their group practices. However, physician referral to physical therapy services within his/her office, or to those with whom he/she may have a financial interest, limits the consumer’s right to choose his or her physical therapist. The consumer may not recognize this loss of choice, as no other option is offered.

Further, there is evidence that beneficiaries may receive higher-quality care—and therefore better outcomes—when self-referral is not involved. A study on LBP episodes of care, published in the July 2015 issue of the *Forum for Health Economics and Policies* by Jean Mitchell, PhD, of Georgetown University, found that non-self-referred episodes of care were far more likely to provide “active,” or hands-on, services than self-referral episodes—52% compared with 36%. This, according to the study’s authors, suggests the care delivered by physical therapists in non-self-referred episodes is more tailored to promote patient independence and a return to performing routine activities without pain. It is important to note that “passive” treatments, which are more likely found in self-referring episodes, can be performed by a person who is not a licensed physical therapist. The authors of this paper also cite evidence that these passive physical therapy modalities are “ineffective” in treating low back pain.

Adding physical therapy services to the list of DHS subject to the disclosure requirement would help to improve patient awareness of a potential conflict of interest and increase consumer choice, aiding CMS’ efforts to ensure patients can make well-informed decisions about their care. **Accordingly, we recommend that CMS add physical therapy to the list of DHS subject to the disclosure requirement.**

## QUALITY PAYMENT PROGRAM

### **Transforming MIPS: MIPS Value Pathways Request for Information**

CMS is proposing to apply a new MIPS Value Pathways (MVP) framework to future proposals beginning with the 2021 MIPS performance period/2023 MIPS payment year to simplify MIPS, improve value, reduce burden, help patients compare clinician performance, and better inform patient choice in selecting clinicians. The MVP framework would be implemented as early as feasible to produce a MIPS program that more effectively meets the 7 strategic objectives described in the CY 2018 QPP final rule (82 FR 53570) and drive continued progress and improvement. The MVP framework would connect measures and activities across the 4 MIPS performance categories, incorporate a set of administrative claims-based quality measures that focus on population health, provide data and feedback to clinicians, and enhance information

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<sup>30</sup> <https://www.whitehouse.gov/presidential-actions/executive-order-improving-price-quality-transparency-american-healthcare-put-patients-first/>

provided to patients. CMS is proposing to apply this MVP framework to future proposals beginning with the 2021 MIPS performance period rather than the 2020 MIPS performance period, so that the agency can seek necessary feedback on the details of implementing this transformative approach and address additional details of the methodology in next year's rulemaking cycle. These MVPs would remove barriers to APM participation and create a cohesive and meaningful participation experience for clinicians moving away from siloed activities towards an aligned set of measures. CMS is proposing to apply the new MVPs framework to future proposals beginning with the 2021 MIPS Performance Year (PY).

CMS proposes 4 guiding principles to define MVPs:

1. MVPs should consist of limited sets of measures and activities that are meaningful to clinicians, which will reduce or eliminate clinician burden related to selection of measures and activities, simplify scoring, and lead to sufficient comparative data.
2. MVPs should include measures and activities that would result in providing comparative performance data that is valuable to patients and caregivers in evaluating clinician performance and making choices about their care.
3. MVPs should include measures that encourage performance improvements in high priority areas.
4. MVPs should reduce barriers to APM participation by including measures that are part of APMs where feasible, and by linking cost and quality measurement.

**Conceptually, APTA supports the move to a more consolidated reporting structure in MIPS and believes there are benefits to patients and clinicians in moving toward the proposed MVP model.** Further, while we support the guiding principles, we recommend that principle number 1 be more clearly articulated as it relates to how CMS would define a “limited set of measures.” We also support the idea of a system that provides a more streamlined experience than the current version of MIPS, but have several concerns about the shift to MVPs, as discussed in more detail below.

#### **Feedback on MVP Approach, Definition, Development, Specification, and Examples**

CMS states that MVPs can be created with significant input from clinicians and specialty societies, to ensure that measures and activities within MVPs are relevant and important to clinician practices. CMS envisions that eventually all MIPS eligible clinicians would no longer be able to select quality measures or improvement activities from a single inventory. Instead, measures and activities in an MVP would be connected around a clinician specialty or condition. CMS intends that a population health measure/administrative claims-based measures would be layered into measuring the quality performance category and applied whenever there is a sufficient case minimum.

**APTA agrees that MVPs need to be created with significant input from clinicians and specialty societies. However, as clinicians who have just entered MIPS for the first time in 2019, physical therapists find themselves behind their physician colleagues in years of experience in the program and, more importantly, the number of measures and categories available. A shift to MVPs in the immediate future may have negative financial and administrative consequences on physical therapists unless CMS begins to address measure**

**deficiencies in the immediate future.** Currently, physical therapists have no applicable cost measures because measure attribution methodologies focus on E/M codes, which physical therapists are not permitted to use. Further, physical therapists do not receive administrative claims data on cost, and they do not receive information on the episode cost measures.

APTA has been actively engaged in the creation of episode cost measures over the last several years; however, we are disappointed that physical therapists continue to be excluded from these measure methodologies. The move to value-based care requires information on both quality and cost, but currently our MIPS eligible clinicians receive feedback solely on quality. Physical therapists use the 97000 series codes for much of their billing. Thus, adapting applicable cost measures could be done by applying the existing definitions to the family of codes utilized by physical therapists.

Physical therapists would benefit from seeing the total therapy costs for relevant episodes of care. At least 2 measure methodologies could be considered for physical therapists: attribution to the evaluating physical therapist or attribution by the plurality of 97000 series codes billed during the episode. Of these 2 methodologies, APTA believes the second would be most appropriate. We welcome the opportunity to work with CMS staff or contractors to develop cost measures for physical therapists.

Additionally, at this time, the majority of electronic health records (EHRs) that physical therapists use in private practice are not certified electronic health record technology (CEHRT). For this reason, most physical therapists participating in MIPS will be reweighted in the Promoting Interoperability category in MIPS. APTA has met with and submitted comments to both the Office of National Coordinator for Health IT (ONC) and CMS over the last several years regarding this issue. We are seeking additional clarification on this topic, which we will address in our comments concerning promoting interoperability below.

MVPs would be beneficial to physical therapists if they could be scored across the 4 MIPS categories. **Given that most physical therapists are being scored in only 2 of the 4 MIPS categories, however, APTA is concerned that the move to MVPs will be detrimental to physical therapists unless we can work with CMS to create cost measures and achieve clarity around the use of CEHRT.**

**We envision the MVPs working 1 of 2 ways for our providers: condition-specific or specialty-specific.** As physical therapists are frequently a part of a larger care team, it would make sense for them to be included in condition-specific MVPs. In such a scenario, there would need to be measures relevant to physical therapists' practice; otherwise, physical therapists would be included in an MVP that includes measures mostly applicable to physicians.

Alternatively, CMS could consider adopting a specialty-specific MVP for physical therapists. As physical therapists treat patients with numerous types of diagnoses, CMS could refine the MVPs for specific subsets of physical therapists' patient populations that would benefit from including similar measures; for instance, a musculoskeletal rehabilitation MVP (see Table 1 for an example) or a neurologic rehabilitation MVP. This would help to limit the measures to only those that are most applicable and relevant.

**Table 1. Example of Musculoskeletal Rehabilitation MVP for Physical Therapists**

MVP Example	Musculoskeletal Rehabilitation (Physical Therapy)
Quality Measures <i>(select 6 with at least 1 outcome or high-priority)</i>	<ul style="list-style-type: none"> <li>• Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up (# 128)</li> <li>• Documentation and Verification of Current Medications in the Medical Record (#130)</li> <li>• Pain Assessment Prior to Initiation of Patient Treatment (# 131)</li> <li>• Screening for Clinical Depression and Follow-Up Plan (#134)</li> <li>• Functional Outcome Assessment (#182)</li> <li>• Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (#226)</li> <li>• Falls: Screening for Future Falls Risk (#318)</li> <li>• Functional Outcome (select at least 1)               <ul style="list-style-type: none"> <li>○ QCDR (IROMS 11-20)</li> <li>○ FOTO (#217-222)</li> </ul> </li> </ul>
Cost Measures*	<ul style="list-style-type: none"> <li>• Knee Arthroplasty</li> <li>• Elective Primary Hip Arthroplasty</li> <li>• Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels</li> </ul>
Improvement Activities	<ul style="list-style-type: none"> <li>• Promotion of use of Patient-Reported Outcome Tools (#IA_AHE_3)</li> <li>• Implementation of formal quality improvement methods, practice changes or other practice improvement processes (#IA_PSPA_19)</li> <li>• Evidenced-based techniques to promote self-management into usual care (#IA_BE_16)</li> </ul>
Promoting Interoperability**	<ul style="list-style-type: none"> <li>• Health information exchange</li> <li>• Patient-to-provider exchange</li> </ul>
* If modified for physical therapists as discussed in our comments	
**If clarification on CEHRT for physical therapists occurs as discussed in our comments	

As it is CMS’ goal to use MVPs as a bridge to alternative payment models (APMs), we feel compelled to highlight to CMS the additional issues that will impact this transition and therefore the creation and assignment of MVPs to providers.

**Given the volume threshold for APM participation, both dollar amount and beneficiaries, to qualify for Qualifying APM Participant (QP) status in an Advanced APM, it is very difficult, if not impossible, for certain providers to meet or exceed the threshold. Thus, APTA struggles to see how physical therapists will make this transition in the current environment. While two Medicare Advanced APMs are applicable to physical therapy providers (Comprehensive Care for Joint Replacement Model and Bundled Payment for**

Care Improvements Advanced Model), a typical physical therapist practice would never see the volume of a single condition, such as joint replacement, to be able to achieve QP or Partial QP status in such model. This holds true for most condition-specific models; therefore, physical therapists would need to be in multiple models to even have a chance to achieve these ever-growing thresholds. Unfortunately, as noted above, there are very few Advanced APMs that physical therapists are eligible to participate in. CMS must recognize that these types of issues can and will prevent the movement and adoption of APMs, leaving physical therapists and other similar providers dependent on the MIPS track of the QPP.

#### **Feedback on Selection of Measures and Activities for MVPs**

**APTA recommends that MVPs include a finite list of quality measures that are relevant to the provider and patient. When feasible, we suggest that CMS allow clinicians to have the freedom to select relevant quality measures to report based on the patient's characteristics.** As outlined in Table 1, we recommend that providers report 6 quality measures with 1 outcome measure; if an outcome is not available, we recommend the use of a high-priority measure in its place. We included relevant QCDR measures in the list, as we feel that these are representative and relevant to this patient population.

**APTA also recommends that CMS consider how the requirements around improvement activities might evolve in MVPs. For instance, a provider or group selecting fewer activities, but performing them throughout the year.** In such instance, a provider or group reporting a high-level activity or 2 medium activities the entire year could achieve a full 40 points. This would allow providers to focus on activities that would improve their practice and the care of patients and be more in line with CMS' goals to incorporate quality improvement into practice.

**Additionally, as illustrated in Table 1, we recommend that QCDR measures be included in MVPs to encourage the use of evidence-based specialty specific measures to drive quality of care for Medicare beneficiaries.** Without inclusion of QCDR measures in these models, CMS will undermine the ability of new measures developed by specialty societies to move forward into the program and potentially halt the evolution of specialty-specific measures that may benefit patients and the Medicare program. APTA has significant concerns about the continued lack of incentives to utilize newly developed QCDR measures, given the significant financial and administrative resources required to develop these measures (discussed in more detail below). A clear path of support for inclusion of these measures is important to the program and directly impacts the quality of care delivered by our providers.

**For the reasons outlined above, and to ensure that MVPs exist for all clinician types, APTA recommends that CMS work directly with specialty societies to develop the MVPs.** While we appreciate that a "call for MVPs" may be easier for CMS, this should not be the primary strategy used to develop MVPs in the initial years. CMS should seek partners for the relevant MVPs in order to ensure appropriate MVP transition for all providers participating in MIPS. By engaging specialty groups in development and education efforts, CMS would promote greater adoption of MVPs. We also suggest that CMS solicit MVP suggestions by specialty via the QPP website, again working with the professional societies to understand which MVPs might be most applicable to their providers.

## **MVP Assignment**

**APTA recommends that CMS allow voluntary assignment of providers to MVPs during the first several years following their implementation.** Depending on the type of specialty, a clinician may wish to be included in a specialty-specific MVP and an applicable condition(s)-specific MVP(s). It may be possible in later years to assign MVPs once CMS has a better understanding of which providers use the MVPs.

**APTA also recommends that CMS institute a clear transition plan for the move to MVPs and that the transitional time period is limited.** Our providers view MIPS as a complex program that is difficult to navigate, and our association has a limited amount of resources to dedicate to assist our providers in navigating the program. These resources will be stretched thin if we are required to understand, explain, and support traditional MIPS **and** MVPs over a long period of time. However, as previously stated, there are benefits to transitioning to MVPs **if** the issues raised above are addressed.

## **MIPS Performance Category Measures and Activities**

### **Physical and Occupational Therapy Specialty Measure Set**

**APTA is pleased to see the expansion of the PT/OT measure set includes measures that our association advocated for during the specialty measure set comment process.** We believe this proposed updated measure set will allow our providers to more easily navigate and choose measures that are appropriate to their practice. **APTA supports the addition of physical therapy codes to measures #134 (depression screening), #181 (elder maltreatment screening), and #226 (tobacco screening).**

**APTA opposes the removal of measure #131: Pain assessment and follow up.** CMS has stated as its rationale for removal:

“We propose the removal of this measure (finalized in 81 FR 77558 through 77675) as a quality measure from the MIPS program due to the controversy surrounding the potential correlation between assessment of pain and increase in prescriptions for opioid medications. After consideration of previous stakeholder feedback, we believe this measure may have the unintended consequence of encouraging excessive prescribing of pharmacologic therapies to assist with pain management.”

**APTA disagrees with CMS’ rationale. The justification offered by CMS does not support the removal of measure #131; instead, it further indicates the need for provider education on nonpharmacological interventions that are available to patients with pain.** Further, we were unable to identify any recent literature that suggests a correlation between a pain assessment and the prescription of opioids. **This measure should promote the referral of patients to other programs and providers, such as physical therapists, to address pain. Physical therapists prevent, treat, and manage pain with nonpharmacological interventions, and physical therapy is one of the safest and most effective solutions for patients with pain.** Addressing pain is important to patients, as pain impacts their quality of life

and their ability to participate in activities. The assessment of pain is an essential component of the physical therapy examination.<sup>31</sup>

### **Data completeness**

**APTA supports CMS' proposal to increase the data completeness requirement from 60% to 70%.** We believe that many providers are reporting 100% of their data at this point, with some exceptions. Increasing data completeness will continue to convey the importance of quality reporting on all patients and potentially help to establish benchmarks for new measures that are being introduced into the program.

### **Cost**

Currently, physical therapists are not included in any of the episode-specific or broad-based cost measures in the MIPS program. As discussed in our comments above, if CMS intends providers to transition into MVPs to better promote the shift to true value-based payment, which requires both quality and cost to be accounted for, then the agency needs to address the lack of cost measures for physical therapists. Physical therapists in private practice provide care for more than 2.5 million Medicare beneficiaries and are part of the care team for many conditions. As such, they would benefit from feedback on the cost of their services in a given episode of care.

**Because CMS considers physical therapists to be a “specialty” provider and does not at this time recognize them as primary care providers for beneficiaries, physical therapists should not be included in the broad-based cost measures of Total Per Capita Cost and Medicare Spending Per Beneficiary Clinician.** Current measures methodologies appropriately exclude physical therapists from the measures' attributions of these 2 cost measures. However, several of the episodic cost measures could be revised to be relevant to our providers. APTA has been actively involved in the creation of the MIPS episode cost measures. **Several care episodes have been developed that are relevant to our providers, including: Knee Arthroplasty, Intracranial Hemorrhage or Cerebral Infarction, Elective Primary Hip Arthroplasty, and Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels.**

As discussed above, CMS should create a modified definition and measures attribution methodology for these measures to provide physical therapists with feedback on their costs in these episodes. The methodologies should be focused on the 97000 series CPT codes, which physical therapists use for most of their billing. All services covered under a physical therapy plan of care will be further designated using the GP modifier. **To that end, we recommend that the total amount of physical therapy services (billing of 97000 series codes with a GP modifier) could be attributed to the physical therapist who billed the plurality of the 97000 series codes billed with the GP modifier during each care episode.**

**We welcome the opportunity to work with CMS staff or CMS contractors on developing cost measures for physical therapists.**

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<sup>31</sup> Guide to Physical Therapist Practice. Version 3.0. American Physical Therapy Association.  
<http://guidetoptpractice.apta.org/>.

## **Improvement Activities**

APTA supports CMS' proposal to increase the group reporting threshold from at least 1 clinician to at least 50% of the group beginning with PY 2020. APTA also supports the proposal to require that at least 50% of a group's National Provider Identifiers (NPIs) perform the same activity for the same continuous 90 days in the performance period beginning with PY 2020. **This proposal should promote increased improvement activity participation by group practice clinicians.**

## **Promoting Interoperability**

CMS proposes to continue the existing policy of reweighting the Promoting Interoperability performance category for physical therapists, occupational therapists, qualified speech-language pathologists, qualified audiologists, clinical psychologists, and registered dietitians or nutrition professionals for the performance period in 2020. APTA supports the reweighting of this category for physical therapists and other newly eligible clinicians, as currently, there are very few physical therapists using CEHRT.

APTA's goal is to help the industry, through our advocacy efforts, adopt more CEHRT products for our providers. However, given that several of the 2015 Edition certification criteria do not apply to physical therapists, it is unclear how APTA and physical therapy-specific EHR vendors can successfully move forward in obtaining CEHRT products. The ONC certification process has established standards and other criteria for structured data that EHRs must use; however, several of the criteria are not applicable to physical therapists and other nonphysician professionals. Accordingly, vendors that develop and offer EHRs for physical therapists and other rehabilitation providers are not attempting to certify their products, due to their understanding that their EHRs do not encompass the necessary components to satisfy the certification criteria.

In a recent review of the previous rules, specifically the *Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 3 and Modifications to Meaningful Use in 2015 Through 2017*, we found the following CMS statement:

### Defining CEHRT for 2018 and Subsequent Years

#### Comment:

“Some commenters requested clarification on if a provider would be required to be certified to technology needed for measures the provider does not intend to use for attestation or if there is a specific certification requirement for certain specialties.”

#### Response:

“ONC certifies products not by specialty, but by each specific functionality. In some cases, intended inpatient or ambulatory use may be a factor in the product a provider chooses to possess. Beyond this distinction, the definition of CEHRT includes the requirements specific to each measure which may be independently certified, and a provider may not be required to obtain and use functions for which they do not intend to attest.”<sup>32</sup>

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<sup>32</sup> Pages 62874-62875 <https://www.federalregister.gov/documents/2015/10/16/2015-25595/medicare-and-medicaid-programs-electronic-health-record-incentive-program-stage-3-and-modifications>

We recognize that there are multiple permutations that could lead to a successful attestation under the EHR Incentive Programs. For example, a provider may decide to attest to the modified Stage 2 or Stage 3 Public Health measure using reporting options other than syndromic surveillance reporting. In such instance, the provider would not need to possess technology certified to ONC’s “Transmission to Public Health Agencies—Syndromic Surveillance Criterion.” In contrast, in Stage 3, some objectives require a provider to attest to all 3 measures but only successfully meet the thresholds of 2 of them. For such objectives, a provider would need to possess certified technology for all 3 measures for purposes of attesting.

**We further note that in the case of a provider that meets the exclusions of a measure, the provider is not required to possess technology to meet that measure. APTA cautions physical therapy providers to carefully make determinations regarding the technology they will need to attest to promoting interoperability [meaningful use] and encourages them to work closely with their EHR developers to ensure that the technology they possess will meet their attestation needs.**

In the same rule, CMS states:

“Please refer to Tables 11 through 16, which we have developed in conjunction with ONC of the technology requirements that support the CEHRT definition and each measure in section II.B.3.(d). of this final rule with comment period. We also note that the CEHRT definition provides a baseline of functionality, but a provider may choose to possess technology that goes beyond the requirements of this CEHRT definition. We encourage providers to review products available to meet their needs and to review the Certified Health IT Products List that is available online at [www.healthit.gov](http://www.healthit.gov).”<sup>33</sup>

We interpret this section of the rule to mean that CMS intended for EHR vendors to move forward with certification as it pertains to the providers they serve. **To that end, in order to move physical therapy and rehabilitation specific EHRs toward CEHRT, we request that CMS clarify in final rulemaking the following:**

- 1. Should physical therapy EHR vendors be certifying their EHRs?**
- 2. Can vendors for physical therapists and other nonphysician providers satisfy the definition of CEHRT, even if they can satisfy only a subset of certification criteria?**

**Further, if our vendors were to seek certification, we believe there are Promoting Interoperability measures that would apply to our providers should they use CEHRT.**

**These include:**

- Health Information Exchange**
  - Support Electronic Referral Loops by Receiving and Incorporating Health Information: For at least 1 electronic summary of care record received for patient encounters during the performance period for which a MIPS eligible clinician was

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<sup>33</sup> Pages 62874-62875 <https://www.federalregister.gov/documents/2015/10/16/2015-25595/medicare-and-medicaid-programs-electronic-health-record-incentive-program-stage-3-and-modifications>.

the receiving party of a transition of care or referral, or for patient encounters during the performance period in which the clinician has never before encountered the patient, the clinician conducts clinical information reconciliation for medication, medication allergy, and current problem list.

- Support Electronic Referral Loops by Sending Health Information: For at least 1 transition of care or referral to a provider of care other than a MIPS eligible clinician, the clinician creates a summary of care record using CEHRT and electronically exchanges the summary of care record.
- **Patient-to-provider exchange**
  - Provide Patients Electronic Access to Their Health Information: For at least 1 unique patient seen by a MIPS eligible clinician: (1) The patient (or the patient-authorized representative) is provided timely access to view online, download, and transmit his or her health information; and (2) The clinician ensures that the patient's health information is available for the patient (or patient-authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the Application Programming Interface in the clinician's CEHRT.

**Categories that do not apply to physical therapy providers and for which these providers would need to take exclusions include: e-prescribing, public health, and clinical data exchange.**

#### **Additional Concerns: Facility-Based Billing Under Medicare Part B**

As CMS is aware, physical therapists in private practice were strong participants in the Physician Quality Reporting System (PQRS). However, many physical therapists who work in facility-based settings and bill under Medicare Part B were unable to participate in PQRS, given their inability to independently bill in such settings. Continuing to exclude this large swath of facility-based providers from QPP leaves a significant number of providers outside of the evolving value-based payment systems. APTA encourages CMS to explore the possibility of adding these providers to MIPS in future years. Facility-based physical therapists could participate in MIPS under the group reporting option; however, due to current billing practices, we realize this may pose a challenge. One potential solution is to allow facility-based groups with rehabilitation providers to report in MIPS as a group using the revenue code to identify services.

**Should CMS add facility-based physical therapists to the program in the future, we encourage the agency to consider allowing providers in facilities to report measures relevant to their respective settings, as do their physician colleagues.** For example, physical therapists billing Part B in SNFs may wish to report the same functional measures they report under the SNF Quality Reporting Program. This would enable CMS to begin to align the new Improving Medicare Post-Acute Care Transformation (IMPACT) Act measures with the MIPS program. APTA welcomes the opportunity to work with CMS to determine how to add facility-based providers to both MIPS and Advanced APMs in future years.

## **MIPS Performance Threshold**

CMS proposes a performance threshold increase of 15 points for the next 2 payment years of the program, with a performance threshold of 45 points for the 2022 MIPS payment year and 60 points for the 2023 payment year. The exceptional performance threshold would increase to 80 points and 85 points respectively in the 2022 and 2023 payment years. **While APTA conceptually supports these gradual 15-point increases for the MIPS program, we find that most of our providers are only gaining these points in 2 of the 4 categories, given the lack of CEHRT in the rehabilitation industry and the unavailability of cost measures for physical therapists.** With each incremental increase, gaining points from a limited number of categories will become increasingly challenging for physical therapists, again placing them at a disadvantage. In addition, we find ourselves faced with several quality measure challenges that are impacting physical therapists' ability to maximize their points in the Quality category, which accounts for 85% of their total score (resulting from the reweighting of the Cost and Promoting Interoperability categories; the Improvement Activities category counts for the remaining 15%).

Currently, the ability to earn points for quality measures is based on 3 components: meeting the case minimum; meeting the data completeness requirement; and the CMS benchmark. While providers can generally control the ability to meet the case minimum by selecting appropriate quality measures and can satisfy data completeness by ensuring consistent reporting, providers have little control over CMS established benchmarks. Providers also have little to no control over the availability of measures, in large part driven by measure developers and CMS. For this reason, CMS must consider strategies that will increase the likelihood that quality measures have benchmarks.

One such strategy is to begin to encourage providers to report on fewer, but more multidisciplinary, measures. MVPs have the potential to achieve this goal. However, for many specialty groups, such as physical therapists, QCDR measures are gaining popularity as clinicians find these to be more clinically relevant and meaningful. **Unfortunately, for new, non-benchmarked QCDR measures, the point scoring may be prohibitive to providers, such as physical therapists, who have an increasing performance threshold and lack of MIPS performance categories.** To illustrate these issues, APTA has created Table 2a and Examples 1, 2, and 3a: Best performer of QPP measures (Example 1); average performer of QPP measures (Example 2); and best performer using QCDR measures (Example 3a). As illustrated below, the best performer using only non-benchmarked QCDR measures has the same score as the average performer and just meets the proposed threshold for MIPS PY 2022. Given the low number of points earned by providers using new, non-benchmarked QCDR measures, the MIPS scoring policies are disincentivizing the development of these types of measures and undermining their use due to their low valuation in the program. As QCDR measures are largely driven by specialty societies and the most recent clinical practice guidelines, CMS may inadvertently be impeding the drive to improve quality and clinical practice through the creation of new quality measures that would benefit the Medicare program and the patients it serves.

**Table 2a. Quality Measures Scoring for Different Providers**

Measure #	Measures Name	Best Performer	Average Performer	QCDR Best Performer
128	BMI	10	4	
130	Medication documentation*	7	3	
134	Depression	10	4	
154	Falls Screening*	7	4	
155	Falls Plan of Care*	7	3	
182	Functional Assessment*	3	3	
QCDR	IROMS 13**			3
QCDR	IROMS 14**			3
QCDR	IROMS 15**			3
QCDR	IROMS 16**			3
QCDR	IROMS 17**			3
QCDR	IROMS 18**			3
	Point subtotal (X)	44	21	18
	Bonus points (Y)	3	3	6
	Quality points (X+Y)	47	24	24
	Performance Score ((X+Y)*100)	78%	40%	40%
*High priority measure **Outcome measure				

**Example 1: Best Performer QPP Measures**

Performance Category	Performance Score (B)	Category Weight (C)	Earned Points ([B]*[C]*100)
Quality	78%	85%	66
Performance Category	Performance Score (B)	Category Weight (C)	Earned Points ([B]*[C]*100)
Cost	NA	0% Reweighted to Quality	0
Improvement Activities	100%	15%	15
Promoting Interoperability	NA	0% Reweighted to Quality	0
Subtotal			81
Complex Patient bonus			0
Final Score			81

**Example 2: Average Performer QPP Measures**

Performance Category	Performance Score (B)	Category Weight (C)	Earned Points ([B]*[C]*100)
Quality	40%	85%	34
Cost	NA	0% Reweighted to Quality	0
Improvement Activities	100%	15%	15
Promoting Interoperability	NA	0% Reweighted to Quality	0
Subtotal			49
Complex Patient bonus			0
Final Score			49

**Example 3a: QCDR Best Performer**

Performance Category	Performance Score (B)	Category Weight (C)	Earned Points ([B]*[C]*100)
Quality	35%	85%	34
Cost	NA	0% Reweighted to Quality	0
Improvement Activities	100%	15%	15
Promoting Interoperability	NA	0% Reweighted to Quality	0
Subtotal			49
Complex Patient bonus			0
Final Score			49

With the current outlined scoring methodologies, physical therapists will knowingly be taking a penalty in the 2023 payment year with a threshold score of 60 points should they still only be in 2 MIPS categories and choose to report 6 new, non-benchmarked QCDR measures. This will force our providers to begin gaming the points and potentially selecting quality measures that are less relevant to clinical practice but of high valuation in the program.

**For this reason, APTA recommends that CMS consider scoring QCDR measures in the first 2 years to incentivize reporting to establish benchmarks. APTA recommends that CMS award earned bonus points for the new, non-benchmarked QCDR measures but not count these bonus points toward the 10% cap on bonus points, thus allowing clinicians to earn full bonus points on these new QCDR measures in the first 2 years that they are in the program. In doing so, CMS would fully award 2 additional points for each new non-benchmarked QCDR outcome measure and 1 additional point for each new non-benchmarked QCDR high-priority measure.**

We have applied this logic in Table 2b and Example 3b below. Incentivizing the reporting of new QCDR measures will encourage the ongoing development of new measures that can improve the quality of care.

**Table 2b. Quality Measures Scoring for Different Providers**

Measure #	Measures Name	Best Performer	Average Performer	QCDR Best Performer
128	BMI	10	4	
130	Medication documentation*	7	3	
134	Depression	10	4	
154	Falls Screening*	7	4	
155	Falls Plan of Care*	7	3	
182	Functional Assessment*	3	3	
QCDR	IROMS 13**			3
QCDR	IROMS 14**			3
QCDR	IROMS 15**			3
QCDR	IROMS 16**			3
QCDR	IROMS 17**			3
QCDR	IROMS 18**			3
	Point subtotal (X)	44	21	18
	Bonus points (Y)	3	3	<b>12</b>
	Quality points (X+Y)	47	24	<b>30</b>
	Performance Score $([X+Y]*100)$	78%	40%	<b>50%</b>
*High priority measure **Outcome measure				

**Example 3b: QCDR Best Performer**

Performance Category	Performance Score (B)	Category Weight (C)	Earned Points $([B]*[C]*100)$
Quality	50%	85%	<b>42.5</b>
Cost	NA	0% Reweighted to Quality	0
Improvement Activities	100%	15%	15
Promoting Interoperability	NA	0% Reweighted to Quality	0
Subtotal			<b>57.5</b>
Complex Patient bonus			0
Final Score			<b>57.5</b>

Allowing all new non-benchmarked QCDR measures to earn bonus points in the first 2 years of reporting that are exempt from calculation of the bonus point cap (10%) would incentivize

clinicians to report these measures in the first 2 years and increase the likelihood of establishing benchmarks.

### **Qualified Clinical Data Registry**

#### **Data Requirement for QCDRs to Support All 3 Performance Categories Where Data Submission Is Required**

**APTA supports CMS' proposal to require QCDRs and qualified registries to support 3 performance categories: Quality, Improvement Activities, and Promoting Interoperability.** Registries should be supporting these categories to allow their clients to better track and manage their performance in the program, as this will become increasingly necessary with the move to MVPs.

#### **Requirement for QCDRs to Engage in Activities that will Foster Improvement in the Quality of Care**

APTA supports CMS' proposal that beginning with the 2023 MIPS payment year, QCDRs must foster services to clinicians and groups to improve the quality of care provided to patients by providing educational services in quality improvement and leading quality improvement initiatives. Quality improvement services may be broad, and they do not necessarily have to be specific toward an individual clinical process. For example, the QCDR could provide reports and education to clinicians on areas of improvement for patient populations by clinical condition for specific clinical care criteria. CMS also proposes to require QCDRs to describe the quality improvement services they intend to support in their self-nomination for CMS review and approval. APTA intends to include the QCDR's approved quality improvement services in the qualified posting for each approved QCDR.

**APTA's Physical Therapy Outcomes Registry currently engages in educational services with its clients to improve the quality of care provided to patients.** We believe that these activities not only are beneficial to the clients and the patients they serve but also distinguish our registry from others in the physical therapy industry. As the national association representing the physical therapy profession, it is our intent for the registry to do more than MIPS reporting; in fact, MIPS reporting is secondary to our goal of supporting physical therapists and PTAs in delivering the best care to the patients they serve. Many other specialty societies are engaged in these efforts as well, and CMS' proposed requirement further enhances the changes to the QCDR definition that were finalized for 2020.

#### **Enhanced Performance Feedback Requirement**

**APTA supports CMS' proposal, beginning with the 2023 MIPS payment year, to require that QCDRs provide performance feedback to their clinicians and groups at least 4 times a year, including how they compare with other clinicians who have submitted data on a given measure within the QCDR.** Currently the Physical Therapy Outcomes Registry offers far more than 4 reports per reporting year, with quality dashboards being available to our clients throughout the entire reporting year. CMS would like to see, and therefore encourages QCDRs to provide, timely feedback more than 4 times a year. We agree that receipt of more frequent feedback will help clinicians and groups make more timely changes to their practice to ensure the highest quality of care is being provided to patients.

**APTA disagrees with CMS’ suggestion to require MIPS eligible clinicians, groups, and virtual groups that utilize a QCDR to submit data throughout the performance period, and prior to the close of the performance period (i.e., December 31). While the proposal is well-intentioned, it is likely to cause increased burden to registries and their clients.** While most of the Physical Therapy Outcomes Registry’s clients report data throughout the year, some use manual data entry and have more unpredictable data entry patterns. APTA has devoted significant time and resources to educating our clients and encouraging data entry early and often; however, enforcing early data entry is simply not feasible with some clients.

### **QCDR Measure Availability**

CMS proposes that beginning with the 2020 performance period, after the self-nomination period closes each year, CMS will review newly self-nominated and previously approved QCDR measures. In instances in which multiple, similar QCDR measures exist that warrant approval, CMS states that it may provisionally approve the individual QCDR measures for 1 year with the condition that QCDRs address certain areas of duplication with other approved QCDR measures in order to be considered for the program in subsequent years.

**APTA supports CMS’ proposal, as this would encourage harmonization and collaboration among QCDRs. This is a better approach to pushing harmonization and collaboration than requiring QCDRs to enter into a licensure agreement with CMS as was proposed but not finalized in last year’s rule.**

### **QCDRs Measures Meeting Benchmarking Thresholds**

Beginning with the 2020 performance period, CMS proposes to place greater preference on QCDR measures that meet case minimum and reporting volumes required for benchmarking after being in the program for 2 consecutive performance periods. Those that do not may not continue to be approved. CMS proposes to implement, beginning with the 2021 performance period, 2-year QCDR measure approvals (at its discretion) for QCDR measures that attain approval status by meeting the QCDR measure considerations and requirements described above. However, as part of this proposal, CMS, upon review, may revoke the second year’s approval if a QCDR measure approved for 2 years:

- Tops out
- Duplicates a more robust measure
- Reflects an outdated clinical guideline
- Requires measure harmonization
- Was self-nominated by a QCDR that is no longer in good standing

CMS also proposes that when a QCDR believes the low-reported QCDR measure that did not meet benchmarking thresholds is still important and relevant to a specialist’s practice, the QCDR may develop and submit a QCDR measure participation plan for CMS’ consideration. For example, a QCDR measure participation plan could include one or more of the following:

- Development of an education and communication plan
- Updating the QCDR measure’s specification with changes to encourage broader participation (which would require review and approval by CMS)
- Required reporting on the QCDR measure as a condition of reporting through the QCDR

**APTA supports CMS' proposal to approve QCDR measures for 2 years, as this change will help providers feel more stable in the program. However, we strongly recommend that CMS consider modifying its scoring policy for new QCDR measures in these first years to encourage clinicians to report on such measures, for example, by increasing the points for reporting a new QCDR measure in the first 2 years in the program.** As demonstrated in Example 3a, clinicians who choose to report new QCDR measures typically would be scored as an average performer of QPP measures. CMS must work with QCDRs to incentivize reporting of new measures in this critical 2-year window.

**As stated earlier, APTA recommends that CMS allow all new non-benchmarked QCDR measures to earn bonus points in the first 2 years of reporting that are exempt from calculation of the bonus point cap (10%). In doing so, CMS would fully award 2 additional points for each new non-benchmarked QCDR outcome measure and 1 additional point for each new non-benchmarked QCDR high-priority measure.** We have applied this logic in Table 1b and Example 3b. Incentivizing the reporting of new QCDR measures will encourage the ongoing development of new measures that can improve the quality of care.

### **QCDR Measure Requirements**

CMS proposes that beginning with the 2020 performance period to require QCDR measures to include the following:

- Measures that are beyond the measure concept phase of development
- Measures that address significant variation in performance

Beginning with the 2021 performance period and future years, CMS proposes that for a QCDR measure to be considered for use in the program, all QCDR measures submitted at the time of self-nomination must be fully developed with completed testing results at the clinician level, as defined by the CMS Blueprint for the CMS Measures Management System<sup>34</sup> and as used in the testing of MIPS quality measures prior to the submission of those measures to the Call for Measures. CMS also proposes to require QCDRs to collect data on the potential QCDR measure. For a QCDR measure to be considered for use in the program, CMS proposes that, beginning with the 2021 performance period and future years, QCDRs will be required to collect data on a QCDR measure, appropriate to the measure type, prior to submitting the QCDR measure for CMS consideration during the self-nomination period. CMS suggests that QCDRs should collect data for as many months as possible and strongly encourages QCDRs to collect data for 12 months prior to submitting the QCDR measure for CMS' consideration at the time of self-nomination. Because quality reporting requires 12 months of data, collecting data for 12 months prior to submitting the measure for consideration will increase the chance that the measure can be benchmarked.

**APTA agrees conceptually with these requirements; however, it would be extremely beneficial if CMS incentivized the use of these new measures in the first 2 years of use in MIPS.** This would help to support the justification of the resource requirements and costs of measure development efforts described above. As CMS is aware, the work to fully develop

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<sup>34</sup> <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/Blueprint.pdf>.

measures is time and resource intensive. Although there is increased interoperability across the health care continuum, extensive efforts continue to be required in order to extract data from EHRs. Each revision to QCDR requirements may result in changes to documentation and data abstraction from EHRs. This work is essential to increase the quality of care for patients, but these measures also are used to determine payment. If providers cannot hit the threshold using QCDR measures in the first 2 years, then regardless of the clinical value of the measure, they will not be reported.

**APTA supports CMS' proposal that beginning with the 2021 performance period, QCDRs must identify a linkage between their QCDR measures and at least 1 of the following, at the time of self-nomination: (a) cost measure; (b) Improvement Activity; or (c) CMS-developed MVPs. If the potential QCDR measure otherwise meets the QCDR measure requirements but does not have a clear link to a cost measure, improvement activity, or MVP, CMS would consider exceptions for measures that otherwise meet the QCDR measure requirements. APTA also supports CMS' proposal to, beginning with the 2020 performance period, reject QCDR measures if the QCDR measures are duplicative of or identical to other measures, etc.**

**Finally, aligning the Quality, Improvement Activities, Promoting Interoperability, and Cost categories will create a more meaningful reporting experience for providers. This alignment also has the potential to simplify the program for clinicians. We further support CMS' rationale for rejecting measures.**

#### **QCDR Randomized Audit**

In the 2020 PFS/QPP proposed rule and during recent CMS qualified registry (QR)/QCDR vendor support calls, CMS has expressed that the intent of its language included in the 2017 final rule was that all randomized audits and subsequent detailed audits be completed for *all* performance categories supported by a QR/QCDR, not just the Quality category, and that all audits occur prior to submission of data to CMS. CMS also has indicated that while they have not enforced audits for PY 2017 and 2018 data validation reports, adherence to both criteria will be required beginning with PY 2019.

CMS states in the 2020 PFS proposed rule “As described in the CY 2017 Quality Payment Program final rule, the full self-nomination process requires the submission of basic information, a description of the process the qualified registry will use for completion of a randomized audit of a subset of data prior to submission, and the provision of a data validation plan along with the results of the executed data validation plan by May 31 of the year following the performance period (81 FR 77383 through 77384).”

CMS also reiterated during the July 23, 2019 QCDR support call (page 8 of the minutes): “In addition, your organization is required to submit a data validation execution report to CMS by 5/31 of the year following the PY (i.e., 5/31/19 for the 2018 PY). For the purposes of participation, we do not require that you provide a written report on Promoting Interoperability or IA, as our primary focus is Quality.”

While we applaud CMS for working to ensure the accuracy of the data being submitted for MIPS, we have concerns with feasibility and the excessive burden being placed on QRs/QCDRs to validate *all* performance category data prior to CMS submission. **Therefore, we recommend that CMS postpone the mandatory randomized audit for *all* MIPS performance categories prior to CMS data submission until PY 2020. Additionally, if CMS is now shifting to a model in which QRs/QCDRs will be responsible for the Improvement Activities audit, we request that this be postponed until PY 2021.**

Quality data validation for clients who are manually entering data may be difficult to audit, as many clinicians and practices do not complete data entry until late in the fourth quarter of the PY. Thus, it would be challenging to include this data as part of the randomized audit prior to the close of the year. To ensure timely completion prior to CMS submission, QRs/QCDRs will need to initiate these activities early in the fourth quarter. While QRs/QCDRs encourage all clinicians to enter data often and in a timely manner to ensure they can identify quality improvement opportunities early on, clinicians are busy during the day treating patients, and may have not yet incorporated this activity into their daily or weekly workflow.

The guidance issued to date by CMS regarding what constitutes appropriate documentation for each Improvement Activity has been very limited. The CMS fact sheet (as noted above) states, “CMS will validate data.” We believe the request by CMS for QRs/QCDRs to validate the Improvement Activities puts an undue burden on QRs/QCDRs to perform an activity that CMS has openly stated it will perform. Moreover, CMS has not provided QRs/QCDRs with appropriate guidance to complete such an audit.

**Therefore, we respectfully request that CMS clearly define what constitutes “primary source documentation” for each individual Improvement Activity.** Putting forth additional guidance will help (1) ensure that all eligible clinicians understand what will be required of them during an Improvement Activities audit, and (2) provide clear direction to QRs/QCDRs for what documentation CMS will find appropriate. Implementing an Improvement Activities audit for PY 2019 and PY 2020 will require QRs/QCDRs to undertake a completely manual process. Contacting clinicians and practices, describing what documentation is needed, and reviewing and confirming documentation (see comment above regarding the need to define “primary source documentation” for each individual Improvement Activity) would place an undue burden on QRs/QCDRs.

Given that this “primary source documentation” is currently unavailable and QRs/QCDRs have not been given enough time to automate the collection of Improvement Activities documentation, we respectfully request that CMS postpone implementation of this until PY 2021. This delay would allow CMS to develop and disseminate appropriate guidance by the PY 2021 self-nomination deadline to ensure that all QRs/QCDRs clearly understand the CMS expectation and know what they are committing to prior to submission of the 2021 QR/QCDR self-nominations. This delay also would allow QRs/QCDRs to automate the collection of the Improvement Activities documentation, thereby reducing the burden imposed on clinicians and practices when performing an audit.

## **Physician Compare**

**It is APTA's position that MIPS data should be shared on the Physician Compare website.** Therefore, APTA supports CMS' proposal to publicly report on Physician Compare: (1) aggregate MIPS data, including the minimum and maximum MIPS performance category and final scores earned by MIPS eligible clinicians, beginning with Year 2 (CY 2018 data, available starting in late CY 2019), as technically feasible; and (2) an indicator on the profile page or in the downloadable database that displays if a MIPS eligible clinician is scored using facility-based measurement, as technically feasible.

## **Partial QP Status**

APTA appreciates that CMS is proposing that, beginning in the 2020 QP performance period, Partial QP status applies only to the TIN/NPI combination(s) through which Partial QP status is attained, so that an eligible clinician who is a Partial QP for only 1 TIN/NPI combination may still be a MIPS eligible clinician and report under MIPS for other TIN/NPI combinations. Clinicians determined to be Partial QPs, however, have agreed to take on significant risk when entering into agreements with APM Entities, fully expecting to satisfy the QP threshold, and are proactively working to improve patient care. **Therefore, as CMS works toward finalizing APM policies in 2020 and beyond, we encourage the agency to bear in mind the risks facing physical therapists and, consequently, their needs, which may differ from those of other providers.**

Additionally, APTA continues to have concerns that the current methodology to make a QP determination makes it extremely difficult for physical therapists to ever satisfy either the Partial QP or QP threshold. Further, as the Partial QP and QP thresholds increase over time, it will become impossible for physical therapists, as well as other providers, to achieve Partial QP or QP status. Thus, without being able to meaningfully participate in any Medicare Advanced APMs and achieve either threshold, physical therapists will be forced to participate in MIPS, which seems contrary to the agency's efforts to move more providers into value-based payment models. **We request that CMS discuss within final rulemaking whether there are any alternative QP methodologies for specialty providers that CMS is permitted to explore.**

## **Conclusion**

APTA thanks CMS for the opportunity to provide comments on the CY 2020 PFS proposed rule. We look forward to working with the agency in revising the proposed policies in this rule prior to its finalization to ensure that Medicare beneficiaries have access to medically necessary physical therapy services in the outpatient setting.

Should you have any questions regarding our comments, please contact Kara Gainer, director of regulatory affairs, at [karagainer@apta.org](mailto:karagainer@apta.org) or 703/706-8547, or Heather Smith, director of quality, at [heathersmith@apta.org](mailto:heathersmith@apta.org) or 703/706-3140.

Thank you for your consideration.

Sincerely,

A handwritten signature in black ink that reads "Sharon L. Dunn". The signature is written in a cursive, flowing style.

Sharon L. Dunn, PT, PhD  
Board-Certified Clinical Specialist in Orthopaedic Physical Therapy  
President

SLD: krg, hls