



September 11, 2023

Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, MD 21244-1850

***Submitted electronically***

**RE: Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program (CMS-1784-P)**

Dear Administrator Brooks-LaSure:

On behalf of the almost 4,000 members of APTA Private Practice, a Section of the 100,000+ member American Physical Therapy Association (APTA), I write to provide feedback on the Centers for Medicare and Medicaid Services' (CMS) 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; (CMS-1784-P) proposed rule. APTA Private Practice is an organization of physical therapists in private practice who use our expertise to restore function, improve mobility, relieve pain, and prevent or limit permanent physical disabilities in patients with injury or disease. The rehabilitative, maintenance, and habilitative care that we provide restores, maintains, and promotes overall fitness and health across the age span to a range of patient types.

Please find below our comments on the proposed rule.

**Medicare Physician Fee Schedule Reform**

APTA Private Practice urges CMS to identify and implement solutions to the recurring and crushing payment cuts under the Medicare physician fee schedule. Since the initial proposal to overhaul payment for evaluation/management codes in 2019, the agency has received tens of thousands of comments imploring it to take action to preserve payment for the dozens of provider types forced to foot the bill for the policy. While Congress has intervened three times to provide relief from the agency's policies, CMS has not mitigated long-term damage to the health system from low payment rates. During this time, Medicare providers have provided high quality care to their patients in spite of the COVID-19 pandemic, the opioid crisis, and extreme healthcare shortages. The agency continues to proceed with its annual updates without recognition of the reality we live in: CMS chooses to rely on Congress to mend these systemic issues, or it severely underestimates the significance of what these cuts mean to the health care system in the United States. Year after year, CMS hears from a chorus of clinicians, patient advocates, and other stakeholders urging the agency to focus on increasing access to care but continues to

implement policies that widen the disconnect between payment and the costs of operating a clinical practice. We must act before it is too late: after physical therapy practices have stopped accepting Medicare patients, moved to other settings, or simply closed their doors.

### *Impact on Physical Therapy*

Medicare's inadequate reimbursement rates are felt by dozens of types of providers, but physical therapists have been subject to some of the worst reductions in payment in recent years. Low rates were compounded by the lowest Medicare utilization of any type of provider practice during the pandemic. See exhibit 4 on page 11 of <https://www.ama-assn.org/system/files/2020-prp-covid-impact-medicare-physician-spending.pdf>. This report shows that during the height of the pandemic, physical therapy practices lost 28% of Medicare revenue; a far higher percentage than any other practice type.

By examining the most common CPT codes used by physical therapists, the compounding of the dire payment landscape is illustrated:

HCPSCS	Description	2014 Payment	2024 Payment	Change
97110	Therapeutic exercises	\$32.24	\$28.82	-11%
97112	Neuromuscular reeducation	\$33.67	\$33.08	-2%
97116	Gait training therapy	\$28.66	\$28.82	1%
97140	Manual therapy 1/> regions	\$30.09	\$26.53	-12%
97530	Therapeutic activities	\$35.11	\$36.02	3%

The five codes in the table above represent some of the most frequently used codes for physical therapy. This marked reduction in payment for physical therapy services is unjustifiable given that a dollar ten years ago has [the same buying power as \\$1.31 does today](#). Further, the relative value units of these codes have increased for three out of five of the codes listed. It is the conversion factor, and CMS' continued reduction in payment generally, that is driving the downward trend in payment. This calculation also does not include reductions from the multiple procedure payment reduction policy, the physical therapist assistant differential, and sequestration. **Physical therapists will be paid significantly less by Medicare in 2024 than they were in 2014.**

### *PT Wages and Staffing*

The constant downward pressure on reimbursement has had a significant impact on physical therapist and physical therapist assistant wages. APTA's [A Physical Therapy Profile: Wages Earned in the Profession, 2021-22](#), notes that between 2004 and 2013, PT and PTA annual wages matched or exceeded cost-of-living increases, but between 2016 and 2021, wages either met or began to lag behind the rate of inflation in all geographic regions except the West North Central region for PTs and the Middle Atlantic and New England regions for PTAs. These issues are compounded by the Report's illustration of relative wages by practice type: private practice settings are among the lowest reimbursed. Put another way, when comparing settings, the report noted that private outpatient office or group practice PT, the setting paid under the fee schedule, had the second lowest wages, with only PTs in K-12 school systems paid less (APTA, 2023)). In addition, private outpatient office or group practice has had the lowest rate of wage growth of all settings with only a 6.2% increase in wages from 2016 to 2021.

The data above is consistent with another [APTA Benchmark Report: Hiring Challenges in Outpatient Physical Therapy Practices](#). This report sought to better understand what physical therapy leaders had known anecdotally: that clinics were facing significant challenges employing and retaining physical therapists and physical therapist assistants. The survey quantified that struggle, noting three key points: First, outpatient physical therapy practices have significant vacancy rates. The vast majority of practices have openings of at least 5%, with a 16% total vacancy rate across all employee categories — physical therapists, physical therapist assistants, and support personnel. There are more openings for PTs than for PTAs and support personnel.

Second, hiring challenges are worsening. Most practices have more staffing openings now compared with December 2019, and many practices (40.8%) are facing higher turnover rates now than they were two years ago. While the report sought to identify the impact of the pandemic on staffing, CMS' action in the same time period makes it difficult to ascertain if the pandemic or payment policy had a larger consequence.

The following events have been managed by the average physical therapy clinic owner:

- 2019: - Medicare begins telegraphing an 8% cut to physical therapy services in its 2020 PFS.
- 2020: - The cut is increased to 9% in the 2021 PFS; later reduced to 3.3% by Congress.
- 2021: - The 2022 PFS includes a 3.75% cut; later reduced to 1.2% by Congress.
- 2022: - The 2023 PFS includes a 4.46% cut; later reduced to 2% by Congress.
  - 15% reduction in reimbursement for services delivered in whole or in part by a PTA.
  - Phase-in of 2% sequestration.
- 2023: - Proposed 3.3% reduction in payment.

It's no wonder that private practices have been unable to increase wages. The constant threat of reductions in reimbursement, with only the hope of Congress mitigating the damage at the last minute has left practices struggling to predict their financial solvency for the following year, let alone budget cost-of-living wage increases for their staff.

Accordingly, the third take away from the report is hardly surprising: pay was a primary reason for the vacancies. Of the various reasons respondents ranked why a staff person left their position 25.4% of respondents indicated pay was the primary reason, but 63.5% of respondents placed it within the top three reasons. Only relocation was ranked as a higher cause. Despite the ongoing public health emergency, concern over COVID-19 was ranked as the primary reason for leaving by only 1.7% of respondents, and only 11.9% of respondents placed it within the top three.

### *Administrative Burden*

APTA's report also identified a significant factor frequently overlooked in the payment equation: administrative burden and its impact on a provider's well-being. The third most cited reason staff left their position was work-life balance (reduction of hours/stress). We have no doubt that onerous regulatory requirements motivate clinicians to leave the field because they prevent providers from treating patients: the very purpose of pursuing their advanced training, and the core of their mission as medical professionals. Instead, many requirements, which have no meaningful connection to patient safety or program integrity force providers to spend hours upon hours documenting irrelevant information, tracking down signatures or completing other tedious tasks.



Distributed in the fall of 2022, the [APTA Administrative Burden Survey](#) received responses from 773 APTA members across various facility and institutional settings and sought to collect measurable survey results that offer insight into how administrative burden impacts patient clinical outcomes.

The survey noted that 86.3% of providers agree or strongly agree that administrative burden contributes to burnout. Nearly 3/4 of respondents indicated that prior authorization requirements delay access to medically necessary care by more than 25%. Further, when asked what policy changes would most reduce administrative burden, the second most reported request was elimination of the Medicare plan of care signature and recertification. Physical therapists met with CMS on this issue in early 2022 and 2023. We are disappointed the agency has not attempted any policy change on the signed plan of care issue, which could have such significant and immediate administrative relief for the physical therapy profession.

Currently, CMS does not require a referral or order for a physical therapist to treat a Medicare patient. CMS also does not require a physician's signature on the plan of care for a physical therapist to begin treatment. However, CMS does require a physician sign the patient's plan of care in order for the physical therapist to be paid for the services. A physician's signature on the plan of care is not required by statute. In fact, the statute indicates that the "plan for furnishing such services has been established by a physician or by the qualified physical therapist or qualified occupational therapist, respectively, providing such services and is periodically reviewed by a physician." 42 U.S.C. 1395n (a)(C).

APTA Private Practice recognizes the value of collaborating with physicians. We are supportive of interdisciplinary care and welcome the input of primary care providers on physical therapy plans of care. However, the specific requirement of obtaining a signature clearly harms patients and is preventing them from accessing timely and necessary services. Although a signature on a plan of care may seem like a small burden, physicians – primary care providers especially, are already overwhelmed with unnecessary paperwork. Our members have reported spending months trying to obtain signatures from physicians' offices, contacting them via phone, email and fax more than 30 times, to obtain one signature.

By clinging to the signed plan of care policy, CMS may be assuming that the physician's signature ensures that the plan of care is appropriate for the patient, and so it provides a check to ensure patient safety. But CMS allows treatment to begin before the signature is obtained, meaning patient safety is not a legitimate justification for the requirement. Failure to obtain the signature simply means the physical therapist will not be paid for any services they deliver. Instead of being justified by patient safety concerns, the certification requirement forces physical therapists to make a choice: begin treatment in the best interests of the patient, or delay care to ensure that payment can be obtained. The policy is flawed.

**Reimbursement for physical therapy services should be determined by the medical necessity of the service and whether the physical therapist has completed their statutory and regulatory requirements – not whether another provider has rubber stamped the plan of care with a signature.** Physical therapists have no control over whether a physician will or will not sign a document; it should not be a factor in physical therapist payment.

Alternatively, there are several ways this administrative burden might be relieved without sacrificing the physician's role in physical therapy. For instance, in cases where the patient has an order or referral on file, the statutory requirement that the patient be under the care of a physician is not only satisfied but documented. CMS should in these situations allow for documentation of delivery of the plan of care to the physician to satisfy the requirement and remove the problematic component of the requirement that a signature be returned. APTA Private Practice would echo its support for CMS to require proof the plan

was delivered, e.g. a fax log confirming the plan was sent. Most EMR's retain a fax log and clinicians have been logging this information for years. Maintaining this record allows physicians the opportunity to provide input on the plan of care but patient care will not be harmed because the physician fails to return the plan of care. Physical therapists are already permitted to begin treatment before obtaining the signature, so timing is not a concern in this situation. Further, because these patients have an order or referral on file, any specific instructions the physician needs to communicate will have already been delivered. Similarly, if a patient has an order or referral, or if the original plan of care has been delivered then the same requirements should apply to re-certification of the plan of care.

This type of simple regulatory change can significantly increase access to high quality, low cost physical therapy services, improve patient care, and save taxpayer funds. Multiple studies<sup>1, 2, 3</sup> show that early access to physical therapy correlates with better outcomes and decreased need for services. Allowing physical therapists to treat patients immediately without risking their reimbursement would benefit Medicare patients and Medicare as a whole.

#### *Removal of Work GPCI 1.0 floor at the end of 2024*

For 2024, CMS is not making any proposed changes to the calculation of GPICs. The rule notes, however, that the legislation establishing a 1.0 floor on the work GPCI will expire at the end of 2023, so the GPICs and summarized geographic adjustment factors for each locality that are displayed in Addenda D and E of the rule do not reflect the work GPCI floor. The rule also notes that policies affecting the locality definitions for California which were finalized in 2023 rulemaking will be operationalized in 2024. We urge CMS to reconsider the implications of this policy on rural practices. The removal of this policy only exacerbates the need to increase staffing flexibility and decrease administrative burden. If costs continue to rise, and reimbursement continues to decline, clinics will not be able to provide access to underserved communities by closing, decreasing staff, or decreasing hours of operation.

#### *The Future of Physical Therapy and Medicare*

We echo APTA data on wages, staffing and administrative burden to focus CMS' attention and to underscore the relationship between Medicare reimbursement, wages, beneficiary access to care, provider well-being, and staffing shortages. Ultimately, CMS is creating – and has continued to implement over nearly six years – a payment landscape that will ultimately leave many Medicare beneficiaries without providers.

APTA Private Practice is well aware that CMS is bound to maintain budget neutrality in the Medicare Physician Fee Schedule through several mechanisms, primarily adjustment of the conversion factor. Historically, this process has ensured that the Medicare trust fund is protected from annual adjustments that exceed \$20,000,000 as required by Section 1848(c)(2)(B)(ii)(II) of the Act. Should any changes in payment or coverage be implemented by CMS, the costs of those policies can be offset by reducing the CF, which reduces payment for all services under the PFS and maintains budget neutrality.

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<sup>1</sup> Sun, E., Moshfegh, J., & Rishel, C. A. 2018. JAMA Open Network Original Investigation. Anesthesiology. Accessed at: <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2718095>

Stevens, J. & Lee, R. 2018. American Journal of Prevention Medicine. The Potential to Reduce Falls and Avert Costs by Clinically Managing Fall Risk. Accessed at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6103639/>

<sup>2</sup> Phillips, C., Akif Baktir, M., Das, D., Lin, B., & Salehi, A. 2015. Physical Therapy and Rehabilitation Journal. The Linke Between Physical Activity and Cognitive Dysfunction in Alzheimer Disease. Accessed at: <https://academic.oup.com/ptj/article/95/7/1046/2686491>

We firmly believe that CMS has relied too much on reductions to the conversion factor to pay for sweeping policy changes that benefit one provider group without regard to the damage, even if unintended, this decision causes other providers. Many physical therapists no longer believe CMS harbors concern for patients whose care providers do not bill E/M services. Accordingly, most professional societies look to Congress to reform the fee schedule. The American Occupational Therapy Association, American Physical Therapy Association, American Speech-Language-Hearing Association, and APTA Private Practice have released [Policy Principles for Outpatient Therapy Reform under the Medicare Physician Fee Schedule](#). APTA Private Practice strongly supports the critical changes outlined in the principles.

The principles center around 5 key reforms needed to ensure rehabilitation therapy services remain available for Medicare beneficiaries:

1. Eliminate multiple procedure payment reduction for therapy services.
2. Allow PTs, OTs, and SLPs to opt-out of Medicare.
3. Provide flexibilities to the plan of care certification requirement.
4. Change PTA and OTA supervision in private practice from direct to general.
5. Reform MACRA and the quality payment program.

While these principles are intended for Congress, some of the reforms including plan of care certification flexibilities and PTA supervision requirements are currently within CMS' power to implement.

We also wish to note that constant reduction in payment for physical therapy services has become so unsustainable that APTA has undertaken the effort to pass legislation that would allow physical therapists to opt-out of Medicare. Currently, physicians have the authority to opt out of the Medicare program and privately contract with Medicare beneficiaries. Medicare allows other practitioners, including physician assistants, dentists, podiatrists, optometrists, social workers, psychologists, nurse midwives, dieticians, and other eligible providers to do so as well. While these providers are barred from providing services to Medicare beneficiaries for two years, they at least have the option to refuse Medicare's burdensome billing process and inequitable payment. Physical therapists currently do not even have this limited choice. They must enroll in Medicare or else they cannot provide Medicare covered services to Medicare beneficiaries.

Accordingly, APTA has supported legislation that would provide physical therapists with the ability to opt-out of Medicare, privately contract with patients, remove the two-year bar on treating Medicare beneficiaries, and allow beneficiaries to submit out-of-network claims for reimbursement.

By highlighting this bill for the agency's attention, we seek to stress the seriousness of the payment inequity under Medicare. APTA Private Practice echoes support for a robust, efficient, and effective Medicare program wherein beneficiaries are not burdened by having to seek out-of-network care and submit claims themselves. However, for many physical therapy practices, accepting Medicare reimbursement rates as they currently stand, not to mention that they will continue to be reduced under current policy, would put the financial health of their practice at risk. Out-of-network practices are easier to access than nonexistent clinics. While we encourage APTA Private Practice members to participate in Medicare and support CMS' efforts to sustain the program, it is ultimately better for patients to utilize out-of-network care than to access no care at all.

Accordingly, we strongly urge CMS to take action. The agency receives tens of thousands of comments annually decrying the reduction in payment since first proposing the E/M policy in 2018, yet it has not mitigated the policy's damage. Either by revising the E/M policy, or by some other means, the agency must act to support providers and ensure that Medicare beneficiaries can continue to access them. Payment, clinician workforce, and patient access are inextricably linked, and no clinical specialty operates in a vacuum. Clearly CMS understands this. The agency's efforts to encourage care coordination, interoperability, and value-based payment are evidence of its understanding. Unfortunately, the the knife's edge balance upon which PTs and others operate is not sustainable. Support for some specialties without adequate support for others is inequitable and undermines the foundation for safe, quality care. Choosing winners and losers results in breakdowns in care coordination, and it results in physical therapists providing care only until they can no longer afford to do so. This situation is preventable. Until CMS works establishes a permanent solution to ensure true payment adequacy for all providers under the system, all of those involved in the health care system will continue to suffer, including providers and patients alike. It is clear that under the PFS, these issues are magnified exponentially for physical therapists, who are treated to the same cuts as their physician counterparts, but with a payment baseline and operating margins that are not comparable. The windfalls that exist for physicians do not exist for physical therapists; our practices feel these cuts more acutely, and our ability to operate and serve the Medicare population is threatened at a more rapid pace.

#### **Office/Outpatient (O/O) E/M Visit Complexity Add-on Implementation**

APTA strongly recommends that CMS revisit its policy on the HCPCS code G2211. We express support for the comments submitted by The American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC) as well as numerous other stakeholders who have questioned the need and valuation for such a code. Given the significant impact to the conversion factor and payment to other providers, CMS must not implement this code given the legitimate and profound questions experts, like the AMA RUC has posed to the agency. At a minimum, CMS should delay implementation of this code until it can adequately respond to these concerns.

#### **Misvalued Codes**

APTA Private Practice thanks CMS for accepting the nomination submitted to the American Occupational Therapy Association of 19 therapy codes as potentially misvalued and recommending the AMA/Specialty Society RVS Update Committee (RUC) Practice Expense Subcommittee recommendations from January 2017 be re-reviewed. We believe a significant underpayment of physical therapy services has occurred over the last 5 years and are appreciative of CMS' acknowledgement of this potential mistake.

In the Medicare Physician Fee Schedule for 2017, CMS indicated that they were seeking information regarding appropriate valuation for the following codes: 97032, 97035, 97110, 97112, 97113, 97116, 97140, 97530, 97535 and G0283. The remaining codes were added as part of this family of services and reviewed for work and practice expense. At the 2017AMA RUC meeting, the family of Physical Medicine and Rehabilitation codes was presented by APTA and AOTA for re-valuation. During the presentation to the Practice Expense Subcommittee the associations were asked to confirm that multiple units or codes are billed in a session. Based on that confirmation the PE Subcommittee adjusted the clinical staff time to account for MPPR. The result of this action on the part of the subcommittee was a 50% reduction in clinical labor recommendations by the RUC. Since MPPR results in an additional 50% reduction when a claim is submitted, the cumulative result is a 75% overall reduction in clinical labor inputs even in cases where there is no duplication of the clinical labor time such as in cleaning equipment after a procedure.



For the 19 PM&R codes, the associations recommended and presented clinical labor practice expense inputs. The RUC Practice Expense Subcommittee reduced these recommended values by 1/2 or 1/3rd to address potential duplication of practice expense based on applying the statutory MPPR calculation. The application and calculation of the MPPR policy is conducted by the Medicare program at the time of claims processing, and is not the stated role of the AMA RUC during code valuation. At the April RUC 2023 Practice Expense Subcommittee Meeting it was expressly stated that if MPPR does not apply the subcommittee needs to consider overlapping inputs, but if MPPR applies, the subcommittee should not. Since MPPR applies to all codes listed above, the inputs should not have been adjusted by the PE Subcommittee. APTA Private Practice believes confusion arose during the PE subcommittee meeting because they had not been subject to MPPR when the codes were previously reviewed and valued in 2013.

These modifications have resulted in a cumulative devaluation of the practice expense for codes routinely billed by physical therapists and occupational therapists. Accordingly, we thank CMS for directing the AMA RUC PE Subcommittee to reconsider its clinical staff practice expense recommendations for these codes.

In addition, APTA Private Practice urges CMS to place a pause on MPPR for the 19 misvalued codes until the AMA RUC PE Subcommittee has a chance to review. This could easily be accomplished by switching the 19 codes from “Always Therapy” to “Sometimes Therapy” codes, and we urge CMS to use its authority to do so.

### **Payment for Caregiver Training Services**

APTA appreciates CMS’ recognition of the importance of caregiver training without the patient present for certain patients and/or under certain conditions. APTA also appreciates CMS acceptance of the RUC recommended values for these codes. As it relates to specific information in the proposed rule related to these codes APTA Private Practice echoes APTA’s comments.

We support the definition of a caregiver as an individual who is assisting or acting as a proxy for a patient with an illness or condition of short or long-term duration (not necessarily chronic or disabling); involved on an episodic, daily, or occasional basis and that a caregiver would include but not be limited to a legal guardian. Our position is that a caregiver should include a layperson assisting the patient in carrying out components of a treatment plan and that caregivers should be trained in strategies and specific activities that improve symptoms, functioning, and adherence to treatment. APTA agrees that caregiver understanding and competence in assisting and implementing these interventions and activities is critical for patients with functional limitations resulting from various conditions.

APTA Private Practice reiterates advice that CMS include rehabilitative therapy care in addition to complex health care and assistive technology activities at home as a management component for caregiver training. APTA also echoes advice that CMS add qualified healthcare professional as a provider who would establish a treatment plan in addition to the treating physician or practitioner to ensure inclusion of physical therapists, occupational therapists, and speech language pathologists. Finally, we repeat advice that training could apply to primary clinical diagnoses and contributing conditions, complexities or comorbidities, and that the techniques or strategies the caregiver should be trained in may apply to the performance of a prescribed home exercise or self-management plan in addition to activities of daily living.



As it relates to patient permission for the training of a caregiver without the patient present, this requirement should be satisfied by documentation in the clinical record by the physician, practitioner, or qualified healthcare professional that the patient has consented, or evidence that the caregiver is the legal guardian or healthcare proxy for the patient. CMS should not require formal signed consent, or any additional administrative burden as it relates to the provision of these services. Physical therapists routinely engage caregivers in the therapeutic intervention model and consistently meet HIPPA requirements as a standard of their practice.

Finally, we urge CMS to add these codes to the Category 3 Telehealth List of CPT Codes. These codes are extremely well suited for telehealth given the fact that the patient is not present. Further, many patients who are dependent on their caregivers face challenges in travelling to therapy appointments, and caregivers may face challenges finding the time to receive training given their responsibilities to the patient. Accordingly, to not preclude receipt of these services by the most vulnerable Medicare beneficiaries, we strongly encourage CMS to make this service available via telehealth, at least as long as other therapy services are available.

## **Telehealth**

### *Place of Service for Medicare Telehealth Services*

CMS proposes that for 2024, providers will no longer bill telehealth claims with Modifier '95' along with the POS code that would have applied had the service been furnished in person, and telehealth claims will instead be billed with the POS indicators "02" - Telehealth Provided Other than in Patient's Home or "10" - Telehealth Provided in Patient's Home. CMS has further proposed that services billed with POS "02" will be paid at the facility rate and services billed with POS "10" will be paid at the non-facility rate. APTA Private Practice includes members that are licensed as Rehabilitation Agencies. Other members may contract with a hospital or SNF setting to provide therapy services. As a result, we have several concerns with how this policy might be applied to therapy services.

Since 1999, Medicare has paid all outpatient therapy providers the same non-facility fee schedule rate. (63 FR 58860). Payment has been at the same rate regardless of whether the therapist was working in a private practice or facility, including rehabilitation agencies, skilled nursing facilities, hospital outpatient departments, home health agencies, or other facilities. The Medicare Claims Processing Manual, Chapter 12 Section 20.4.2 states:

Nonfacility rates are applicable to outpatient rehabilitative therapy procedures, including those relating to physical therapy, occupational therapy and speech-language pathology, regardless of whether they are furnished in facility or nonfacility settings. Nonfacility rates also apply to all comprehensive outpatient rehabilitative facility (CORF) services. In addition, payment is made at the nonfacility rate for physician services provided to CORF patients and appropriately billed using POS code 62 for CORF.

Under Medicare Part B, this approach to reimbursing at the same non-facility rate in all therapy settings is so ingrained that CMS' own Rule Addendum B Relative Value Units and Related Information, published annually along with the PFS, does not even contain facility PE RVUs for most therapy codes (See [Addendum B Relative Value Units and Related Information CY 2024 CMS 1784-P](#)).

However, with the implementation of the new POS codes, we have concerns that significant claims processing errors will occur in early 2024 in the following instances:

- For institutional billers using a UB-04 claim form, there is no field in which to document the POS code. If CMS policy continues, MACs must be prepared to process those claims as they have during the Public Health Emergency.
- It is unclear whether institutional therapy providers should continue to use the 95 modifier. We assume CMS would want to continue to track whether a service is performed via telehealth, and absent a POS code, these billers would be unable to indicate whether telehealth was used.
- Additionally, as described above, although institutional billers are “facilities” in the traditional sense, these billers have always been reimbursed at the non-facility rate. CMS should confirm that institutional billers of Part B therapy services will continue to be reimbursed at the non-facility rate.
- For private practices, which use the 1500 claim form and can document the POS code, the patient will occasionally be present at the clinic and the therapist will provide treatment via telehealth services from another location. In this scenario, the appropriate POS code would be POS “02” - Telehealth Provided Other than in Patient’s Home. However, CMS should confirm that payment in this scenario will be the non-facility rate given the fact that private practices are “non-facility” billers and therapy services are always reimbursed at the non-facility rate.

**We urge CMS to confirm that all outpatient therapy services under Medicare Part B will continue to be paid at the non-facility rate regardless of the POS code.** We also ask CMS to ensure that MACs are appropriately informed about therapy billing and reimbursement requirements to ensure that claims are processed smoothly in early 2024.

*Payment for Outpatient Therapy Services, Diabetes Self-Management Training, and Medical Nutrition Therapy when Furnished by Institutional Staff to Beneficiaries in Their Homes Through Communication Technology*

CMS proposes to continue to allow institutional therapy providers to bill for services when furnished remotely in the same manner they have during the PHE for COVID-19 through the end of CY 2024.

We appreciate CMS’ continued attention to this matter. While we disagreed with CMS’ initial interpretation of the Consolidated Appropriations Act, 2023 (Pub. L. 117-328, September 29, 2022) and the Hospitals Without Walls waiver, we are grateful that the agency continued to work with stakeholders to consider alternative interpretations that ensure Medicare beneficiaries retain access to rehabilitation services via telehealth regardless of the specific type of outpatient clinic from which they receive care. We strongly support this new policy which allows for institutional therapy providers to continue to furnish telehealth services until the end of 2024 along with private practices.

*Direct Supervision via Use of Two-way Audio/Video Communications Technology*

CMS proposes to maintain until the end of 2024 the new definition of “direct supervision” to allow the supervising professional to be immediately available through virtual presence using two-way, real-time audio/video technology, instead of requiring their physical presence. This updated definition was set to expire at the end of the year in which the PHE ends, but CMS has extended this flexibility to align with the CAA, 2023’s extension of telehealth flexibilities until the end of 2024. APTA Private Practice echoes strong support for this policy and encourages CMS to continue to examine ways it can increase access to



services and ease provider burden through these simple regulatory updates. APTA Private Practice thanks CMS for this important proposal.

### **Supervision of Outpatient Therapy Services in Private Practices**

*Remote therapeutic monitoring for physical therapists and occupational therapists in private practice.*

Current regulations at §§ 410.59(a)(3)(ii) and 410.60(a)(3)(ii) specify that all occupational and physical therapy services are performed by, or under the direct supervision of, the occupational or physical therapist, respectively, in private practice. While CMS amended the supervision standard for RTM services in last year's rule, it did not amend the regulations governing PTA and OTA supervision. Accordingly, this year CMS proposes to establish an RTM-specific general supervision policy at §§410.59(a)(3)(ii) and (c)(2) and 410.60(a)(3)(ii) and (c)(2) to allow OTPPs and PTPPs to provide general supervision only for RTM services furnished by their OTAs and PTAs, respectively.

We strongly support this revision. While we restate hope that CMS will move quickly to change supervision of PTAs and OTAs in private practice from direct to general and thereby create uniformity across all settings, as discussed below, we also appreciate CMS' recognition of RTM as a service particularly well suited for general supervision. APTA Private Practice thanks CMS for this important proposal.

#### *General Supervision for PTs and OTs in Private Practice Comment Solicitation*

CMS includes in the proposed rule a comment solicitation on the possibility of changing the supervision requirements of physical therapist assistants and occupational therapy assistants in private practice. Current regulations at §§ 410.59(c)(2) and 410.60(c)(2), require all services not performed personally by the physical therapist in private practice be performed under the direct supervision of the therapist by employees of the practice. However, other settings which provide outpatient therapy services under Medicare Part B are subject to a more flexible general supervision standard. This includes hospital outpatient clinics, skilled nursing facilities, rehabilitation agencies, comprehensive outpatient rehabilitation facilities, and even home health agencies. APTA has long sought a uniform supervision policy across Medicare settings and has had several meetings with the agency on the issue over the years.

We were pleased to see CMS request information on the implications of a general supervision policy for PTAs and OTAs in private practice. We [recognize the ability of PTAs to use general supervision](#) to perform at the top of their licensure as is consistent with the guidelines of the profession. APTA supports a minimum level of supervision required for the safe and effective delivery of physical therapy services and recognizes that a higher level of supervision may occur based on jurisdictional law, patient or client needs, the skills and abilities of personnel being supervised, as well as other factors.

We thank CMS for including this important comment solicitation in the proposed rule and echo comments from the American Physical Therapy Association, with emphasis on the following:

**Do State laws and policies allow a PTA or OTA to practice without a therapist in a therapy office or in a patient's home?**

PTAs are governed by state physical therapy licensure laws adopted by their states' physical therapy licensure board. A qualified PTA is a person who is licensed as a PTA and passed a national examination for PTAs. The Federation of State Boards of Physical Therapy furnishes the national examination for

PTAs, known as the National Physical Therapy Exam. The curriculum is provided by the Commission on Accreditation in Physical Therapy Education or by another credentialing body identified by APTA. Under 42 CFR 484.4, physical therapist assistants are either licensed or certified in all U.S. jurisdictions. Therefore, PTAs must pass the National Physical Therapy Exam to be eligible for state licensure or certification and must meet the continuing education and competency requirements in their state to maintain their licensure or certification. Requirements for transcripts, jurisprudence assessment, criminal background checks, and professional liability insurance [vary by state](#).

PTAs are also governed by corresponding regulations adopted by their state's physical therapy licensure board. These regulations often include supervision minimums that vary from state to state, but some states leave setting specific supervision requirements undefined. For a comprehensive list of state supervision laws, refer to the [Federation of State Boards of Physical Therapy](#). A summary of some of the trends in states' supervision requirements is below:

- 49 states have some form of general supervision.
- 44 states require general supervision in all settings.
- New York and the District of Columbia are the only jurisdictions that require on-site supervision of PTAs in all settings.

APTA is unaware of any state or jurisdiction having greater risk or complications due to their supervision levels. Accordingly, we believe that states are responsibly regulating supervision in their jurisdiction. If a state has deemed off-site supervision, or in-home care as appropriate, CMS should not impose additional standards.

Would a general supervision policy potentially cause a change in utilization? Would such a change in the supervision policy cause a difference in hiring actions by the PT or OT with respect to therapy assistants?

Utilization of therapy services is not expected to increase due to a change in supervision levels for PTAs. While this is a complex question, APTA is happy to provide reasoning and data to support this assertion. First, CMS must consider changes in utilization in two ways. First, general utilization of therapy services may change. Second, the ratio of services performed by PTs versus PTAs or OTs versus OTAs may change. APTA asserts that the general utilization of therapy services would remain the same, but therapy clinics would increase the ratio of services performed by PTAs versus PT which would result in savings to Medicare because PTA services are paid at a lower rate.

First, all patients must receive an evaluation from a PT and have a plan of care developed before a PTA can treat a patient. Accordingly, the current shortage of PTs previously discussed will continue to limit therapy utilization, as new patients will still need to wait for the availability of a PT. Changing supervision levels may result in modest increases in utilization due to the fact that PTs will be able to supervise PTAs in other locations, however, we believe this will have a greater impact on improving continuity of care, thereby reducing the average length of an episode of treatment. Private practices will continue to have a PT on site the majority of the time, but this flexibility will allow patients to continue to receive care in instances where the PT is unavailable due to illness, vacation, or other short-term scenarios. Currently, should the supervising PT leave a private practice, even for a short period of time, for instance to eat lunch or attend a personal errand, PTAs must stop treatment. This causes significant disruption to care and can result in patient setbacks and delayed visits.

APTA has data to support the fact that due to the PTA differential (due to which services delivered in whole or in part by a PTA, are paid at 85% of the fee schedule amount), Medicare stands to achieve significant savings from implementing a policy that replaces utilization of PTs with PTAs.

In 2022, the American Physical Therapy Association, American Health Care Association, American Occupational Therapy Association, Alliance for Physical Therapy Quality and Innovation, National Association of Rehabilitation Providers and Agencies, National Association for the Support of Long-Term Care, and the Private Practice Section of the American Physical Therapy Association commissioned Dobson DaVanzo & Associates to evaluate the financial impact and medical consequences of various provisions included in the “Stabilizing Medicare Access to Rehabilitation and Therapy” (SMART) Act, (H.R. 5536). One of those provisions was standardizing the supervision requirement for therapy assistants across all settings, a provision which has been re-introduced in the 118<sup>th</sup> Congress as the “Enabling More of the Physical and Occupational Workforce to Engage in Rehabilitation” Act, or EMPOWER Act, (H.R. 4878/S. 2459).

The [report](#) sought to predict whether a change in supervision would result in an increase in therapy utilization generally, and whether utilization of PTAs versus PTs will occur. The report examined utilization of PTA services in the two jurisdictions that require direct supervision by PTs across all settings (New York and District of Columbia) compared to states that do not have these requirements. Similarly, the report examined utilization of OTA services in the one state that requires direct supervision by OTs across all settings (Kentucky) compared to other states that do not have these requirements. The study found that the two states with direct supervision requirements utilized PTAs and OTAs substantially less than states with general supervision. (See [Report Exhibit 6. Percent of Medicare Physical/Occupational Therapy Services Performed by PTAs/OTAs by State in CY2021 Page 10](#)).

To determine whether reducing the supervision requirement could result in an increase in Medicare utilization of therapy services generally, the report examined utilization of physical therapy services by Medicare beneficiaries in the two jurisdictions that require direct supervision across all settings (New York and District of Columbia) compared to other states that do not have this requirement. Similarly, utilization of occupational therapy services by Medicare beneficiaries in the state that requires direct supervision across all settings (Kentucky) compared to other states that do not have this requirement was examined. The report found that states with direct supervision requirements had similar or higher utilization of Medicare therapy services compared to other states in their census region and nationally, even though the use of PTAs was lower in New York and the District of Columbia relative to the comparison areas and the use of OTAs was lower in Kentucky relative to the comparison areas. Thus, the analysis determined:

Based on observations of Medicare therapy utilization in New York, the District of Columbia, and Kentucky we assume that **reducing the supervision requirement will result in an increased use of therapy assistants but not a corresponding increase in total Medicare utilization of therapy services**. The increased use of therapy assistants that we assume will occur under a less stringent supervision requirement might free the therapist to focus on diagnosing patients and developing rehabilitation programs tailored to patient’s prognosis while allowing therapy assistants to execute rehabilitation plans. An increased number of therapy assistants in a practice would also require PTs or OTs to allocate additional supervision and administrative time. Thus, we assume that practices would substitute PTA or OTAs for certain services that would have been performed by a PT or OT but would not increase patient load or overall utilization of services. (Page 11)

The Report proves that Medicare stands to achieve *savings* by implementing this policy.

**Exhibit 11: Impact of Amending the Current Medicare Direct Supervision Requirements of Therapy Assistants in Private Practice Settings to General Supervision on Medicare Expenditures (2022 – 2031) in Millions of Dollars**

Provision	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2022-27	2022-31
Standardize the current Medicare <i>supervision</i> requirement across all settings + no exemption to payment differential	\$0.0	-\$7.3	-\$16.9	-\$20.6	-\$24.4	-\$29.2	-\$34.1	-\$40.1	-\$46.1	-\$52.7	-\$98.3	-\$271.3

Source: Dobson | DaVanzo estimates using Medicare Carrier and Outpatient Research Identifiable Files for 2021.

While the report analyzed a number of different scenarios based on various other provisions of the SMART Act, **the analysis of the impact of amending solely the current direct supervision requirements of PTAs demonstrated that Medicare spending would be reduced by \$271.3 million over ten years.** While this data assumed the policy would be implemented in January of 2023, Medicare still stands to recoup significant savings by implementing this policy.

A detailed Dobson DaVanzo report which includes data, assumptions, and methodology can be found [here](#).

**Clarifications for Remote Monitoring Services**

*Data collection requirements*

CMS notes that it is not extending beyond the end of the PHE the interim policy to permit billing for remote monitoring codes, which require data collection for at least 16 days in a 30-day period, when less than 16 days of data are collected within a given 30-day period.

CMS may have misconstrued the code descriptors for the various RTM codes. We would urge CMS to clarify that only codes 98975, 98976, 98977, and 98978 require 16 days of monitoring and are billed per a 30-day period. However, 98980 and 98981 are billed based on the amount of time spent in a calendar month inclusive of one synchronous interaction with the patient without requirement for a certain number of days of data collection. 98980 is billed when 20 minutes of monitoring and treatment management is provided in the calendar month and 98981 is billed when an additional 20 minutes is provided in a calendar month. It appears that CMS intends to require data collection for at least 16 days in a 30-day period for all RTM when only 98975, 98976, 98977, and 98978 have that requirement in the official code descriptor.

Accordingly, we encourage CMS to clarify that the 16-day data collection requirement only applies to 98975, 98976, 98977, and 98978 and does not apply to 98980 and 98981.

*New vs. established patient requirements*

CMS notes that it will require that RPM services be furnished only to an established patient. Patients who received initial remote monitoring services during PHE are considered established patients for purposes of the new patient requirements that are effective after the last day of the PHE for COVID-19.

We request that CMS clarify this requirement as the terms “new patient” and “established patient” are defined by CMS specifically as it relates to physicians and the billing of E/M codes. We urge CMS to

clarify that RTM services may be billed when provided under a physical therapy plan of care which is developed based on the completion of a physical therapy evaluation.

#### *Use of RPM and RTM in Conjunction with Other Services*

CMS proposes to clarify that RPM and RTM may not be billed together, so that no time is counted twice by billing for concurrent RPM and RTM services. CMS further states that in instances where the same patient receives RPM and RTM services, there may be multiple devices used for monitoring, and in these cases, CMS will apply our existing rules, meaning that the services associated with medical devices can be billed by only one practitioner, only once per patient, per 30-day period, and only when at least 16 days of data have been collected; and that the services must be reasonable and necessary (85 FR 84544 through 84545).

CMS should reconsider this position. As indicated by the descriptions of RPM and RTM, these services involve the analysis of different data for unique purposes. Additionally, different providers utilizing RPM or RTM would do so in the context of a specific plan of care and to support the achievement of unique goals. APTA supports the ability of multiple providers to bill for RPM and/or RTM services during the same period if the data being analyzed is not duplicative.

We would like to clarify that only 98975, 98976, 98977, and 98978 require 16 days of monitoring and are billed per a 30-day period. To ensure there is no confusion we would like to reinforce that 98980 and 98981 are billed based on the amount of time spent in a calendar month inclusive of one synchronous interaction with the patient without requirement for a certain number of days of data collection. 98980 is billed when 20 minutes of monitoring and treatment management is provided in the calendar month and 98981 is billed when an additional 20 minutes is provided in a calendar month.

It is important to note that RPM and RTM are two very distinct types of services, and it is reasonable for two different providers to bill for each service during the same time period. APTA Private Practice believes multiple providers should be able to bill RTM in the same time period if the services are for distinct therapeutic purposes and are not duplicative. We agree that a single provider should only be able to bill RTM services once in a time period.

#### *RTM Provided by 2 Different Disciplines on Same Medicare Beneficiary*

Beneficiaries receiving multiple therapy services at the same time (PT, OT, ST) may benefit from RTM services specific to each service that promote early activation and engagement of the patient in their therapeutic program. RTM services provide the opportunity for therapists to assess a patient's ability to carry over skills learned during a therapy session or exercises/activities prescribed by the therapist in real time and modify the plan of care as needed to optimize the therapy episode of care. RTM services provide the opportunity for patients to engage with their therapist without having to come into the clinic in between scheduled visits reducing demands on patients and caregivers and ensuring care plan adjustments are not delayed and patient's questions and concerns are answered in a timely manner.

CMS should reconsider its policy on only allowing one discipline to bill for RTM services provided to a Medicare beneficiary. There are circumstances where a Medicare beneficiary would require and benefit from concurrent RTM services. One example of a patient that often receives care from multiple clinicians in an outpatient therapy clinic is a beneficiary receiving therapy after a fall. For example, a Medicare beneficiary may fall and fracture both their hip and wrist. Following such a fall, that patient would be evaluated by a PT to establish a plan of care

for their hip fracture. Separately, that Medicare beneficiary may be evaluated by an OT that is also a certified hand therapist to establish a plan of care to address the beneficiary's wrist fracture. This is not an uncommon scenario in an outpatient therapy clinic. As the Medicare beneficiary proceeds through these two distinct plans of care, they are likely to respond differently to each plan of care. Therefore, the beneficiary would benefit from both their PT and OT providing RTM services. Unfortunately, if CMS does not allow for concurrent RTM services, therapists will be disincentivized from providing these valuable services, preventing Medicare beneficiaries from benefiting from the improved outcomes afforded by RTM services.

We urge CMS in the final rule to clearly state RTM services may be provided, billed, and reimbursed by the Medicare program for a Medicare beneficiary receiving concurrent RTM services from 2 different types of practitioners (e.g., physical therapist and occupational therapist) during the same 30-day period (98975, 98976, 98977 and 98978) or per calendar month (98980 and 98981).

#### *Other Clarifications for Appropriate Billing*

CMS also proposes to clarify that, in circumstances where an individual beneficiary may receive a procedure or surgery and related services which are covered under the payment for a global period, RPM services or RTM services (but not both RPM and RTM services concurrently) may be furnished separately to the beneficiary. In this scenario, the practitioner would receive payment for the RTM or RPM services separate from the global service payment, if other requirements for the global service and any other service during the global period are met. CMS further states that for an individual beneficiary who is currently receiving services during a global period, a practitioner may furnish RPM or RTM services (but not both RPM or RTM services) to the individual beneficiary. Here, the practitioner will receive separate payment, if the remote monitoring services are unrelated to the diagnosis for which the global procedure is performed. One other requirement to receive payment is that the purpose of the remote monitoring addresses an episode of care that is separate and distinct from the episode of care for the global procedure. This means that the remote monitoring services must address an underlying condition that is not linked to the global procedure or service.

We urge CMS to clarify that this policy does not apply when RTM is furnished as part of an outpatient physical therapy plan of care, and that RTM may be billed for a related diagnosis in this instance. CMS, in the 2022 physician fee schedule, noted that the primary billers of RTM would be physiatrists, NPs, and physical therapists. (86 FR 65115) As physical therapy is not included in the global period payment and is billed and paid for separately, RTM services should be treated similarly when furnished as part of a physical therapist's plan of care. Failing to make this clarification risks eliminating the RTM benefit for many post-operative Medicare beneficiaries.

*Do interested parties believe digital CBT could be billed using the existing remote therapeutic monitoring codes described by CPT codes 98975, 98980, and 98981?*

APTA Private Practice believes CBT could be billed using 98975, 98980, and 98981. CPT codes 98975, 98980, and 98981 are by definition not system-specific. Only 98986, 98977, and 98978 are system specific.

In the past, commenters generally supported the concept of a generic RTM device code, and offered a wide variety of possible use cases, including where FDA approved devices and devices that have gone through other premarket pathways exist for the purpose of monitoring various conditions that do not meet the current scope of the existing RTM codes.



*Under current practice models, are these products used as incident-to supplies or are they used independent of a patient visit with a practitioner?*

In the practice of physical therapy RTM devices and services are used as an adjunct to a patient visit with a practitioner but as an integrated aspect of the physical therapy plan of care. RTM in physical therapy and is utilized to essentially extend the reach of the therapist to assess and support the performance and progress of the patient outside of the therapy clinic or session.

*If used independently of a clinic visit, does a practitioner issue an order for the services?*

Physical therapists are required to include RTM services in the physical therapy plan of care when indicated.

### **Updates to the Definitions of Certified Electronic Health Record Technology (CEHRT)**

Private practice physical therapists are deeply concerned about the increasing gulf between providers who have and those who do not have certified EHR technology. This issue has never been more relevant as CMS proposes to end the exemption for physical therapists from reporting the Promoting Interoperability category of the Merit Based Incentive Payment System. As CMS is aware, physicians and hospitals were afforded funding through the former Meaningful Use incentive program (now the Promoting Interoperability category in MIPS) and adoption of EHRs was staged to enable them to learn how to successfully exchange patient information using CEHRT. Physical therapists in private practice, other non-physician health care professionals, and long-term and post-acute care facilities were ineligible to participate in the Meaningful Use program and have received little to no direction, time, or resources to support adoption and implementation of comprehensive, interoperable EHR systems.

Most independent practices use EHRs that are not standardized, making it that imperative that these providers, and their specific health information technology needs, are primary in health IT discussions. To ensure the future health care system is one that is equitable, patient-centric and dedicated to improving care quality and increasing patients' access to their information, all providers and other stakeholders across the continuum need and deserve financial and administrative support to help them implement CEHRT and adopt measures that give patients the ability to manage their health information. In addition, it is vitally important that patient information flows between various sectors of the care continuum, including physicians, hospitals, physical therapists in private practice, post-acute care and long-term care providers, and other health care providers.

The Office of National Coordinator for Health Information Technology's certification process has established standards and other criteria for structured data that EHRs must use. However, CEHRT requirements are designed for prescribing professionals and do not capture tasks performed by nonphysician professionals using different types of EHRs. Consequently, the vast majority of EHR technology developed for use by physical therapists and other nonphysician providers cannot fully satisfy the technology requirements outlined in 42 CFR 414.1305, therefore hindering these providers' ability to participate in the Promoting Interoperability category of MIPS, Advanced Alternative Payment Models, or other value-based payment programs.

Modifying and building upon the existing health information technology structure to satisfy future CEHRT requirements requires significant financial investment, is time-consuming, and is disruptive to workflow. To better leverage health IT functionality, as well as to incentivize physical therapist and other nonphysician provider participation in the Quality Payment Program (QPP) and other value-based models

in the future, it is critical that CMS recognize that much of the updated 2015 Edition certification criteria may not apply to physical therapist—and other nonphysician provider—practice, including:

CEHRT Category	CEHRT Criteria
Clinical Processes	Computerized provider order entry (CPOE) medications (prescribing) CPOE laboratory Drug-drug, drug allergy interaction checks for CPOE Drug-formulary and preferred drug list checks (CPOE) Implantable device list
Care Coordination	Electronic prescribing* (for medications)
Public Health	Transmission to immunization registries Transmission to public health agencies — syndromic surveillance Transmission to public health agencies — reportable laboratory tests and values/results Transmission to cancer registries Transmission to public health agencies — electronic case reporting Transmission to public health agencies — antimicrobial use and resistance reporting Transmission to public health agencies — health care surveys
*Electronic prescribing may be utilized for referrals and DME.	

It is critical that CMS work with ONC to offer financial and technical assistance to help nonphysician providers, including physical therapists, adopt and implement CEHRT. Moreover, to ensure that the CEHRT adoption process is equitable for all parties, we recommend that CMS set a date by which it expects all EHRs to achieve certification. To that end, we request that CMS afford EHR vendors and health care providers a transition period of three to five years to develop, adopt, and integrate certified products. We also recommend that CMS work with ONC to educate providers on the certification process in a manner that clearly conveys what providers need to know, actions to take, and the anticipated costs associated with adopting and implementing certified technology.

### Updates to the Quality Payment Program

#### *MVP Development, Maintenance, and Scoring*

#### Rehabilitative Support for Musculoskeletal Care

APTA Private Practice deeply appreciates CMS' inclusion of the new MIPS Value Pathway (MVPs) entitled the "Rehabilitative Support for Musculoskeletal Care MVP.". This landmark MVP is the first to allow a subset of physical therapists to meaningfully participate in the Quality Payment Program and be compared to their clinical peers.

APTA offers several specific comments across the quality measures and improvement activities below and notes the changes between the most recent round of MVP Candidate Feedback Process and this proposed rule. We believe that the MSK MVP can be improved to provide more meaningful participation by PTs.

- Quality Measures.** Compared to the most recent round of the MVP Candidate Feedback Process, CMS has proposed a similar measure set as identified in [the most recent draft](#). We appreciate that CMS accepted our recommendation for the inclusion of MIPS Measure Q487 (Screening for Social Drivers of Health). However, as proposed, CMS has removed the "Failure to Progress" IROMS measures from the available quality measures (IROMS12, IROMS14,

IROMS16, IROMS18, and IROMS20), leaving a limited pool of FOTO measures for participants to choose from.

- **FOTO Measures.** We remind CMS that the costs of participating in any part of the QPP, including the MSK MVP, is a challenge for PTs. While these measures can be reported via registry, seven of the ten total quality measures will require the use of FOTO. It is APTA's understanding that FOTO measures have historically required an annual subscription based on the practice's size. This means most physical therapists are not using FOTO measures and may not have access to them. Accordingly, this is yet another increased cost of participating, the sum of which will be challenging, if not impossible for PTs to earn back in program incentives. Practices that are not financially able to contract with FOTO are left with only 2-3 measures that they can report, making it impossible to report on the minimum four measures.
- **Removal of IROMS Measures.** The fact that IROMS measures were removed from the set without explanation exacerbates this, and we recommend at least including the IROMS measures. In our last comments on the MVP, we noted that since all but two measures were FOTO and IROMS measures, which are limited to specific body parts, it is conceivable that certain specialty practices may struggle to meet the four-measure minimum, creating avoidable barriers to participation. The proposed measure set, since it excludes IROMS, creates an even more narrow opportunity to participate. We ask CMS to include these measures in the final measure set.
- **CMS Should Include the Following Measures:** APTA suggests including several additional quality measures that would promote meaningful participation for physical therapists and other nonphysicians:
  - MIPS Measure 182 (Functional Outcome Assessment)
  - MIPS Measure 134 (Preventive Care and Screening: Screening for Depression and Follow-Up Plan)
  - MIPS Measure 226 (Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention)
  - MIPS Measure 431 (Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling)
- **Inclusion of PROMIS measures:** We urge CMS to include the option for physical therapy practices to include PROMIS measures associated with physical function, pain interference, and Global Health 10 or PROMIS 29. See <https://www.limberhealth.com/providers/qcdr>. More generally, the PROMIS measure set should be reconsidered for inclusion in future iterations of the MVP. Inclusion of PROMIS would create an important option that has already been in use in multiple cutting-edge facilities that are actively engaging in value-based care initiatives through systematic, transdisciplinary implementation of quality measures. The PROMIS measure set is used by the Cleveland Clinic, Washington University in St. Louis, the University of Rochester, Henry Ford hospital, and Duke University. The measure set is designed with a non-disease specific, whole-person (patient centered) orientation and allows for use independent of practice size, EHR system, and sophistication of practice. Administration with short forms is free and low-price options are available for using computer adaptive versions. CMS has repeatedly stated that the goal of MVPs is patient-centeredness and that patient-reported measures are a critical component of each MVP; the PROMIS measure set includes important patient-reported metrics and a focus on the patient's overall symptoms and function.
- **Improvement Activities:** CMS proposes significant additional improvement activities options from its most recent draft. The proposed rule includes the IA\_PSPA\_21 (Implementation of Falls

Screening and Assessment Programs), which we are pleased to see included in the measure set. APTA's previous comments noted the limited improvement activities for PTs; the inclusion of six additional options also offers several additional options that PTs may be able to use. These include IA\_BMH\_12 (Promoting Clinician Well Being) and IA\_EPA\_3 (Collection and Use of Patient Experience and Satisfaction Data). We encourage CMS to include additional IA options that PTs can use, including IA\_PM\_13: Chronic Care and Preventative Care Management for Empaneled Patients (Medium). We appreciate that CMS accepted several recommendations that were provided during the comment process and have proposed them in this rule.

- **Promoting Interoperability.** It is unclear how CMS anticipates that physical therapists will achieve interoperability requirements, particularly those associated with e-Prescribing and the Prescription Drug Monitoring Program (PDMP). While some flexibility exists in the PI category, these are required elements. Their presence in the MVP effectively lowers nonphysicians' ceiling in scoring on this category. Nonphysicians also have few (if any) CEHRT options available to them. As outlined below, CMS needs to maintain the reweighting of scoring for PTs in both traditional MIPS and MVPs. In relation to MVPs, CMS should ensure PTs are not scored on their performance in categories, such as e-prescribing in which they may not participate.

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

##### Promoting Interoperability Performance Category

We strongly oppose CMS' proposal to end physical therapists' automatic exemption from the Promoting Interoperability category of MIPS. Since their initial inclusion in the MIPS program, physical therapists have been subject to CMS' reweighting policy wherein it will assign a weight of zero to the Promoting Interoperability performance category in the MIPS final score. This is largely because physical therapists were not eligible to participate in the Medicare or Medicaid Promoting Interoperability Program (formerly known as Meaningful Use Program) and there are not sufficient CEHRT vendors or measures applicable and available to them under the Promoting Interoperability performance category.

As discussed above, the lack of CEHRT available for physical therapists is in large part due to the ONC certification standards which are designed for prescribing professionals and do not capture tasks performed by nonphysician professionals using different types of EHRs. Consequently, the vast majority of EHR technology developed for use by physical therapists and other nonphysician providers cannot fully satisfy the technology requirements outlined in 42 CFR 414.1305. This hinders physical therapists' capability to participate in the PI category of MIPS, MVPs, or Advanced Alternative Payment Models.

To our knowledge, no vendors of EHR designed for physical therapy have received ONC certification to date. Accordingly, physical therapists are unable to comply with the promoting interoperability reporting requirements.

Further, we understand that small practices are excepted from reporting promoting interoperability. Section 414.1380(c)(2)(C) provides MIPS clinicians with an exception to the Promoting Interoperability performance category where a significant hardship exists. The statute includes several criteria for obtaining the exception, one of which is:

- (4) The MIPS eligible clinician demonstrates through an application submitted to CMS that 50 percent or more of their outpatient encounters occurred in practice locations where they had no control over the availability of CEHRT. §414.1380(c)(2)(C)(4)



The [Quality Payment Program website](#) states that “Simply lacking the required CEHRT doesn't qualify you for reweighting,” but no additional information is provided as to how clinicians can prove CEHRT is not available. We request the agency provide more information on how an individual clinician would be able to demonstrate that no CEHRT is available, and we urge CMS to make it easy as possible for clinicians to prove this.

CMS has implemented a new administrative burden for PTs in the MIPS program if they are not able to easily indicate they meet the hardship exception. An exception that applies to all but requires even a short application for approval means that clinicians who file late or make an error on their application will be punished for these administrative errors, not for the quality of their services. CMS and the QPP should reward clinicians who deliver quality care and punish clinicians who deliver subpar care. They should not penalize clinicians who fail to submit burdensome paperwork for an exception which they should be granted automatically.

**Accordingly, we urge the agency to continue to exempt physical therapists from the Promoting Interoperability performance category for 2024 and beyond.**

#### *Low-Back Pain (LBP) Cost Measure*

The LBP cost measure is the first cost measure included in MIPS available to physical therapists. We strongly support inclusion of this measure in MIPS. PTs have extremely limited options to participate in any QPP track – this is primarily because there are so few PT inclusive measures. This means that the financial incentives available through these programs are generally less available to PTs. The opportunity to have PT-inclusive measures available in MIPS is the first step to improving PT participation in value-based payment.

While APTA is grateful for the development of this measure, the fact remains that only one cost measure will be available for physical therapists in 2024, seven years after the implementation of MACRA and the QPP. Ultimately, CMS must continue to improve the processes currently in place to review and introduce measures in MIPS, MVPs, and AAPMs. The challenges associated with developing an MVP or other measure proposals — cost, burden, overall complexity of quality measurement — are left almost entirely to the applicants; as such, we fear that these programs will never be able to meaningfully offer a framework under which PTs and other nonphysicians can participate that reflects the QPP's aim to shift healthcare toward a value-based model.

#### **Conclusion**

We thank CMS for the opportunity to provide feedback on the 2024 Medicare Physician Fee Schedule proposed rule.

Sincerely,

A handwritten signature in black ink that reads "Mike Horsfield". The signature is written in a cursive, flowing style.

Mike Horsfield, PT, MBA  
President, APTA Private Practice: a Section of the American Physical Therapy Association