September 09, 2024

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 2025 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments (file code CMS-1807-P)

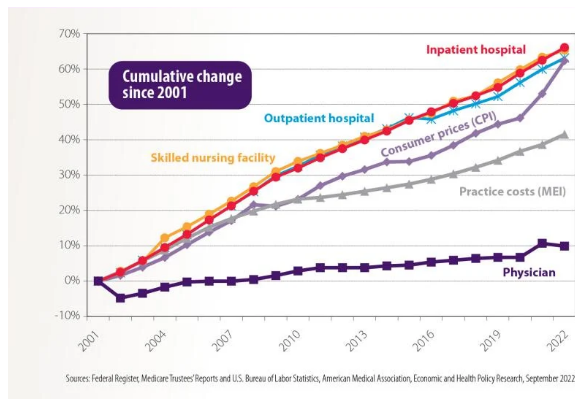
Dear Administrator Brooks-LaSure:
On behalf of the almost 4,000 members of APTA Private Practice, a Section of the 100,000+ member American Physical Therapy Association (APTA), I write to provide feedback on the Centers for Medicare and Medicaid Services' (CMS) 2054 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; (CMS-1807-P) proposed rule. APTA Private Practice is an organization of physical therapists (PTs) in private practice who use their 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 our comments on the proposed rule below.

<u>Medicare Physician Fee Schedule Reform</u>
We urge CMS to identify and implement solutions to the recurring and crushing payment cuts under the Medicare Physician Fee Schedule (MPFS). Over the last three years, rehabilitation therapy providers as a group have received some of the largest cuts of any health care providers because of the fee schedule's budget neutrality policies. In a survey of our membership this year, private practice PTs had to make difficult decisions to avoid complete financial ruin by doing the following: closing clinics, reducing clinic hours, and/or waitlisting patients. As physical therapy is not an acute service, patients with limited access may see further decline in their condition and may not easily be able to find a convenient alternative for ongoing care.

At the same time, physical therapists are subject to significant legacy reductions to payment for services that date back to the days of the sustainable growth rate formula, as well as excessive and burdensome administrative costs and barriers to participation in innovative and value-based programs. Patient access for some of the most vulnerable populations is being compromised.

Private practice physical therapists face an increasingly challenging environment in providing Medicare beneficiaries with access to timely and quality care, which is particularly important for underserved and rural areas. The medical community continues to contend with the residual impacts of the COVID-19 pandemic, record levels of burnout, workforce shortages, and ongoing reductions to Medicare Part B payment and, as a result, private payer reimbursement, which is often based on a percentage of Medicare rates. While Congress has taken action to address some of these fiscal challenges by mitigating some of the recent MPFS cuts, payment continues to decline.

According to an American Medical Association analysis of Medicare Trustees data, when adjusted for inflation, Medicare payments to clinicians have declined by 22% from 2001–2021. Additionally, the MPFS lacks an annual inflationary update, even though physical therapists in private practice — many of whom are small business owners — contend with a wide range of shifting economic factors, such as increasing administrative burdens, staff salaries and benefits, debt, office rent, and purchasing of essential technology when determining their ability to provide care to Medicare patients. The absence of an annual inflationary update, combined with statutory budget neutrality requirements, further compounds the difficulties our members face in managing resources to continue caring for patients in their communities.



These year-over-year cuts, combined with a paucity of available alternative payment and value-based care models, clearly demonstrate that the Medicare payment system is broken. While the incentives under the Quality Payment Program (QPP) were intended to bridge the payment gap following MACRA, they were generally designed for physician practices and do not adequately fit with the vast majority of physical therapy practices. As a result, the costs of participating in any part of the QPP, including the MSK MVP, is a challenge for PTs. Very few applicable measures are available for the specialty and compliant health information technology is almost non-existent. The inadequacy of value-based models in the context of physical therapy as well as other systemic issues outlined above will continue to generate significant instability for physical therapists in the future, threatening patient's timely access to essential physical therapy services.

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 access to physical therapy providers.

APTA Private Practice is well aware that CMS is bound to maintain budget neutrality in the MPFS through several mechanisms, primarily adjustment of the conversion factor (CF). 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 MPFS and maintains budget neutrality.

We firmly believe that CMS has relied too much on reductions to the CF 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, and we thank CMS for their work to implement the changes we have prioritized with Congress.

The constant reduction in payment for physical therapy services has become so unsustainable that we have urged Congress 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, we have 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. 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.

Finally, we urge CMS to support an update to the fee schedule based on the Medicare Economic Index (MEI). Physical therapists and most other Part B providers under the Medicare Physician Fee Schedule do not receive the annual inflationary update that virtually all other Medicare providers can rely on to better weather periods of fiscal uncertainty. The addition of an

inflationary update will provide budgetary stability as physical therapists – many of whom are small business owners – contend with a wide range of shifting economic factors, such as increasing administrative burdens, staff salaries, office rent, and costs of essential technology. Providing an annual inflation update equal to the MEI for fee schedule payments is essential to enabling practices to better absorb payment distributions triggered by budget neutrality rules, performance adjustments, and periods of high inflation. It will also help providers invest in their practices and implement new strategies to provide high-value care. Providing an annual adjustment based on MEI aligns with the Medicare Payment Advisory Commission recommendation that Congress increase 2024 Medicare payments above current law by linking the payment update to the MEI. Also, the Medicare Trustees Report recently said lawmakers should "expect access to Medicare-participating providers to become a significant issue in the long term" unless we take steps to bolster the payment system.

Value of Physical Therapy
We urge CMS decisionmakers to review the APTA report, "The Economic Value of Physical Therapy in the United States," which makes a compelling case for improved patient access to and coverage of physical therapist services. The report calculated the net benefits to patients and the U.S. health care system of choosing physical therapy over alternative treatments and underscores the high-value, lower-cost interventions physical therapy offers patients and the health care system.

In preparing the report, Nous, an international management consultant, examined the costs and benefits of eight condition-based physical therapist services, each of which was chosen based on the prevalence of the condition and its associated level of healthcare spending across the United States. The report presents the results of this analysis by synthesizing the available clinical research on services delivered for each of the eight conditions and drawing comparisons between physical therapist services and non-physical therapist treatments, based on the costs associated with providing care and the benefits generated within the American health care system. Physical therapy was found to have a net economic benefit over the alternative treatment for each of the conditions:

- The average net benefit of treating **carpal tunnel syndrome** with physical therapy is estimated to be $39,533 per episode of care.
- The average net benefit of treating **vascular claudication (resulting from peripheral arterial disease)** with monitored exercise plus optimal medical care relative to optimal medical care alone is estimated to be $24,125 per episode of care.
- The average net benefit of treating **osteoarthritis of the knee** with physical therapy is estimated to be $13,981 per episode of care.
- The average net benefit of treating **Lateral Epicondylitis (tennis elbow)** with physical therapy is estimated to be $10,739 per episode of care.
- The average net benefit of treating **stress urinary incontinence** with physical therapy is estimated to be $10,129 per episode of care.
- The average net benefit of treating **acute low back pain** with physical therapy is estimated to be $4,160 per episode of care.

- The average net benefit of **physical therapy-based cancer telerehabilitation** is estimated to be $3,514 per episode of care.

- The average net benefit of **physical therapy-based falls-prevention** exercise is estimated to be $2,144 per episode of care.

We strongly urge CMS to consider the insights provided in this report to support access to, coverage of, and payment for physical therapist services. Policies that help patients, employers, and payers realize the economic value of physical therapy will produce benefits that improve lives and reduce costs to the health care system.[BH4]

Physical Therapist Assistant Supervision

Last year, CMS included in the 2024 proposed rule a comment solicitation on the possibility of changing the supervision requirements of physical therapist assistants (PTAs) 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.

Physical therapists and physical therapist assistants are governed by their state's practice act and must follow their state licensure requirements if they are more stringent than Medicare's. However, 49 states permit "general supervision" of physical therapist assistants in outpatient practices, making Medicare's direct supervision requirement in that setting more burdensome than most state licensure requirements. In addition, on July 19, 2024, the District of Columbia changed the supervision requirements of a physical therapist assistant from direct supervision to general supervision.

PTAs play a crucial role in the PT-PTA team and help bridge the gap in providing access to care. The current direct supervision requirement makes it harder for this access to be provided and threatens physical therapy businesses, particularly in rural and underserved areas where beneficiaries are much more likely to receive therapy from a PTA. APTA Private Practice supports the EMPOWER Act (H.R. 4878/S. 2459) which would, if it were to become law, standardize the supervision requirement from direct to general for private practices, help ensure continued patient access to needed therapy services, and give practices more flexibility in meeting the needs of beneficiaries. This small modification, mirrored in the draft fee schedule, would better promote timely access to therapy services for millions of Americans experiencing challenges accessing these services in rural or underserved areas.

The requirement of direct supervision — meaning the physical therapist must physically be onsite with the assistant when care is being delivered— is outdated and does not reflect current practice requirements or workforce demands. The inconsistency of supervision policies between settings jeopardizes employment opportunities for PTAs as well as the needs of Medicare beneficiaries in medically underserved and rural communities that rely so heavily on their services. Standardizing the supervision requirement from direct to general for private practices will help ensure continued patient access to needed therapy services and give private practices more flexibility in meeting the needs of beneficiaries.

According to an independent report published by Dobson & Davanzo in September 2022, this change in supervision would also save up to an estimated $271 million over 10 years. As part of our advocacy, we would also urge government leaders to conduct an analysis of how the Medicare Part B 15% payment differential for services provided by PTAs has impacted access to therapy services in rural and medically underserved areas since its implementation in 2022. Physical therapists report that rural areas suffer significantly decreased access from the ongoing physical therapist and physical therapist assistant workforce shortage. A government-led report would provide greatly needed information and data regarding the impact of this payment differential on the therapy workforce and on access to care.

We are pleased to see that CMS has recognized the importance of this issue and is proposing to change its rule regarding supervision. **We strongly urge CMS to implement this policy in the final 2025 fee schedule. We support general supervision in the private practice setting for all outpatient therapy visits, either in-person or via telehealth**. We are also pleased that CMS is proposing this change because it will improve general access in underserved communities and access to specialty physical therapy services in rural areas. Consistency across settings and services should be maximized to support patient access. If this policy is implemented, CMS will be burnishing its commitment to improving health equity, which we strongly support.

Caregiver Training Proposals

APTA Private Practice supports CMS's proposal to add CPT codes 97550, 97551, and 97552 to the Medicare Telehealth List with provisional status. In addition, APTA Private Practice would strongly urge CMS to clarify in the final rule that the codes below be classified as "sometimes therapy" CPT codes that can be utilized by physical therapists.

- GCTD1 (Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound dressing changes, and infection control) (without the patient present), face-to-face; initial 30 minutes),

- GCTD2 (Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound dressing changes, and infection control) (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service) (Use GCTD2 in conjunction with GCTD1)), and

- GCTD3 (Group caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound dressing changes, and infection control) (without the patient present), face-to-face with multiple sets of caregivers))

Physical therapists provide education to caregivers without the patient present regarding the care of wounds, medication management and other procedures that are not specific to functional tasks.

In addition, APTA Private Practice also **asks CMS to confirm in the final rule that the codes currently holding provisional status will remain on the Medicare Telehealth Services List**

in calendar year 2025 as they have throughout the PHE in anticipation of Congress passing legislation to continue to allow outpatient physical therapy services to be delivered via telehealth.

__Delivery of Telehealth in 2025__

Currently, CMS requires 2-way audio/visual telecommunication availability when a Medicare beneficiary is receiving outpatient physical, occupational, and/or speech therapy services via telehealth. For 2025, CMS is proposing that

> an interactive telecommunications system may also include two-way, real-time audio-only communication technology for any telehealth service furnished to a beneficiary in their home if the distant site physician or practitioner is technically capable of using an interactive telecommunications system as defined as multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication, but the patient is not capable of, or does not consent to, the use of video technology.

We support this change, even though, if CMS keeps this provision in the final rule, modifier 93 will be appended to each CPT code on the claim form for all settings except Rural Health Centers and Federally Qualified Health Centers, which must append modifier FQ. We feel confident that if Congress adds physical therapy to the approved provider list, physical therapists will utilize this proposed allowance.

In addition, APTA Private Practice also **asks CMS to confirm in the final rule that the codes currently holding provisional status will remain on the Medicare Telehealth Services List in calendar year 2025 as they have throughout the PHE in anticipation of Congress passing legislation to continue to allow outpatient physical therapy services to be delivered via telehealth.**

__Certification of Therapy Plans of Care__

APTA Private Practice is a strong supporter of the Remove Duplicative Unnecessary Clerical Exchanges Act, or REDUCE Act (H.R. 7279), and CMS' policy to propose certification of therapy plans of care with an order/referral echoes its flexibilities, which we believe will be a boon for access to physical therapy services. We broadly support the CMS proposal to create an exception from the current duplicative and burdensome Plan of Care Signature requirement, but would recommend limited modifications.

Currently, Medicare Part B guidelines permit Medicare beneficiaries to access physical therapy services with or without a physician's order. The physical therapist may evaluate that patient, formulate a plan of care, and commence treatment without a physician order and prior to the plan of care being signed and dated by the referring physician or nonphysician practitioner (NPP). However, under current CMS plan of care certification requirements, physical therapists are required to send plans of care to the referring physician or NPP, who has 30 days to sign off on the physical therapy services that the referring physician or NPP initially ordered to be considered timely. If the 30-day deadline is approaching and the physician/NPP fails to return the signed plan of care, it is the physical therapist's responsibility to obtain the physician's/NPP's signature. Without the signature, the PT is faced with the prospect of stopping patient treatment or not getting paid by Medicare. This situation can and does result in interruptions to patient care simply due to delayed paperwork.

This clerical signature requirement creates unnecessary paperwork and stress for physical therapists as they often struggle to track down signatures before thirty days end. The time and

resources spent by PTs in procuring a timely signature adds unnecessary cost, potentially delays essential services, and fails to contribute to improved quality of care.

CMS is proposing that if a Medicare beneficiary presents to physical therapy with an appropriate order/referral that documents the type of therapy, is signed and dated by the physician, physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS), and the therapist has documented evidence that the plan of care has been delivered to the physician, NP, PA, or CNS within 30 days of completion of the initial evaluation, that this order/referral will serve as the initial certification. A separate signed and dated plan of care by the physician, PA, NP, or CNS will not be required. The above only applies to the initial certification and not to recertifications. The proposal applies to all outpatient therapy settings except for a Comprehensive Outpatient Rehabilitation Facility (CORF) since in a CORF, the therapy plan of care must be established by a physician.

If implemented, we are confident that the proposed modification to the plan of care signature requirement will reduce administrative burden. Under this policy, in those cases when outpatient therapy services are provided under a physician's order, the plan of care certification requirement will be deemed satisfied if the physical therapist simply submits the plan of care to the patient's referring physician within 30 days of the initial evaluation; PTs would no longer need to obtain a signed plan of care within 30 days from the physician who referred the patient.

Eliminating administrative burden is critical to efficient physical therapy practice. An APTA survey of members found that nearly 75% of respondents believe that administrative burdens negatively impact patient outcomes. More than 8 in 10 said that administrative burden contributes to burnout. Administrative burden is also costly: the survey found that more than 75% of facilities have added nonclinical staff to accommodate administrative burden. The new policy will eliminate an unnecessary administrative burden that increases costs and does nothing to improve outcomes. This small but critical change will save untold hours on an unnecessary mandate so that physical therapists can spend less time doing paperwork and more time treating Medicare beneficiaries.

CMS is soliciting comments to gather more information about the need for a regulation that would address the amount of time a physician or NPP should be granted for changes to plans of treatment established by a therapist. CMS has requested comment regarding its interpretation of the 10-day window for physician/NPP review of the plan of care. We support a 10-day window to modify the plan of care on the part of the physician/NPP; however, are requesting several clarifications and conditions below. We are confident that any underlying concern regarding the proposed policy's impact on the physician and their ability to modify the plan of care is misplaced. The 10-day calendar window is meant to assure payment without undue delay, but in no way will limit the physician's/NPP's authority to communicate changes to the plan. Based on anecdotal discussions, no members of APTA Private Practice have reported modifications to the plan of care by the referring clinician, and if physicians/NPPs ever do make modifications to the plan of care, we are confident that it occurs very rarely.

We urge CMS to recognize the value of certainty around payment within that 10-day period for any services that are rendered because the 10-day window can be a substantial portion of physical therapy treatment time. It would undercut the policy's effectiveness to create payment ambiguity by allowing those services not to be paid. If the physician is waiting until the end of the 10-day period to object to whether the proposed plan of care is improper for the patient for a clinical reason, payment must be assured for the services that were rendered prior to that objection. APTA Private Practice firmly believes that any services rendered during the proposed

ten-day review period and prior to a formal modification should presumptively meet the Medicare requirements for reimbursement. Once the physician indicates their specific modifications to the plan of care, it becomes incumbent on the PT to rework the treatment plan as necessary. If the PT continues with the established plan following notice of the modification, only those services should be denied under the policy.

Ultimately, the presence of a physician modification to the plan of care cannot and should not affect whether CMS pays for services that are provided prior to a modified plan of care. The care still meets Medicare's requirements: it is both medically necessary, and the patient is still under a physician's care as evidenced by the signed order. However, without assuring payment for services rendered during the review period, CMS risks creating the same situation it sought to avoid by creating this exception: the PT would still be required to choose between providing timely care or waiting to avoid a potential denial based on ANY modification from the physician, no matter how significant. Thus, the only change under the proposed policy would be that it limits the overall time required to wait for physician input to 10 days instead of indefinitely.

We also note that in the proposed rule, CMS uses the language "order/referral," which differs from the Benefit Policy Manual (MBPM) section 220.1, which specifically uses the word "order." We believe that the language in the Medicare benefit policy manual should conform to the language in the regulation, and we believe that a referral is broadly inclusive of the more specific term "order." For this reason, we urge CMS to modify the language in the final rule to use the word "referral" in place of the terms "order" or "order/referral" and that change also be explicitly made to the Medicare Benefit Policy Manual within a reasonable timeframe. Since PTs are expected to apply their clinical expertise and are free to develop an appropriate plan of care based on the patient's needs, an order and referral are effectively one in the same. Distinguishing these terms creates confusion that an order and referral are treated differently, when in fact they function the same under the proposed rule. By updating this language, PTs that rely on the MBPM to understand these requirements will be certain of their meaning. Again, an order is more prescriptive than a referral, and to effectively implement the policy, physicians should be required only to be engaged in the delivery of care decisions, which is demonstrated by a referral, not necessarily an order.

Additionally, the services rendered prior to modification of the plan of care may, in fact, be independently appropriate or remain appropriate under the modified plan, too. Therapists should not fear nonpayment for medically necessary services. For instance, in the example above, the PT provided five sessions prior to the physician modification on the overall length of treatment. Those five sessions would have been appropriate under either the original or modified plan of care since the physician change concerned only the overall duration of services, which at that point had not occurred. Similarly, many physician modifications concern extremely narrow issues, which should not serve as a barrier to otherwise medically necessary services performed prior to that objection.

It logically follows that these services were medically necessary (the purpose of the signature requirement), and that CMS should not deny payment for these services simply because the physician took an exceedingly long time to provide their feedback to the plan of care. This is especially true for situations where the modification does not materially impact CMS' assessment of whether the services rendered were medically necessary.

We predict that it will be critical for therapists to be conscientious about sending the plan of care as soon as it is completed. We recognize and pledge to work with CMS to educate physical therapists about this new policy once it is finalized. We recognize that the Medicare Benefit

Policy Manual requires that care not be initiated until the plan of care is drafted unless the evaluating provider is the one starting the treatment and will reiterate this policy to our members. We plan to strongly encourage member physical therapists to make sure that as soon as the plan of care is complete it is sent posthaste.

APTA Private Practice recommends CMS finalize this proposal with the following considerations and clarifications:

1. CMS should finalize the policy with the 10-business day review period under consideration. Physician/NPP silence during the 10-day business window would thus serve as agreement to the Plan of Care for payment purposes.
2. The initial plan of care established by the physical therapist is presumed to be medically necessary and takes precedence over the physician order/referral. If a physician/NPP recommends changes to the plan of care within the 10 business days, any therapy provided prior to that change is presumed to meet medical necessity by virtue of the physician/NPP referral and shall be reimbursed by the Medicare program.
3. Any modifications to the plan of care by the physician/NPP **shall not** be applied retroactively to physical therapy visits provided prior to the modification of the plan of care. Changes to the plan of care does not make the physical therapy services that were provided prior to the change not medically necessary.
4. If a physician/NPP modifies a PT plan of care within the 10 business days, we ask CMS to clarify in the final rule that the document sent by the physician/NPP modifying the plan of care meets the signature requirement since the physicians'/NPPs' changes have been incorporated into the plan of care by the physical therapist. To clarify, no other document is required to meet the initial plan of care certification requirements.
5. Additionally, we would respectfully urge that CMS explicitly confirm that facsimile logs or other electronic means will be accepted as proof that the plan of care was submitted for review by the referring physician.
6. We also urge that CMS modify the language in any final rule to use the word "referral" versus "order," and that change also be explicitly made to the Medicare Benefit Policy Manual within a reasonable timeframe. In practice, physical therapists will likely default to using the Medicare Benefit Policy Manual prior to researching and implementing the language of any final rule, and updating the manual to contain this clarification will be impactful. An order is more prescriptive than a referral, and to effectively implement the policy, physicians should be required only to be engaged in the delivery of care decisions, which is demonstrated by a referral, not necessarily an order. In the proposed rule CMS uses the language "order/slash" referral which is not ideal as the Benefits Policy Manual section 220.1 specifically uses the word "order."

CMS is also soliciting comments as to whether there should be a 90 calendar day time limit on the order/referral in cases where the order/referral is intended to be used in relation to the initial certification of the treatment plan at §424.24(c)(5). That 90-day limit would span from the order/referral date until the initial treatment by the physical therapist. CMS also seeks comments on whether there should be a time limit on the order or referral when it is intended to serve as the initial certification, specifically asking whether 90 days or a different time frame is appropriate.

APTA Private Practice urges CMS not to establish a limit to how long an order/referral can serve as a substitute for the PoC signature requirement. Workforce distribution creates variable staffing challenges throughout the country. For instance, in California, the ratio of therapists to residents is just 57 per 100,000, compared with the national ratio of 72 per 100,000—it is

possible in the state for PT clinics to have a backlog of referrals, necessitating that care is routinely scheduled months in advance. APTA believes that the 90-day limit would unnecessarily challenge the flexibility that certain clinics need in order to manage patient loads based on their staffing needs; for referrals that go beyond 90 days, these clinics would have the added challenge of hunting down physician signatures, and could benefit from the added flexibility of the policy. If the agency finds that a substantial portion of care is started beyond 90 days, it can refine the policy in future years.

Misvalued Codes

APTA Private Practice thanks CMS for accepting the nomination 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. The remaining codes were added as part of this family of services and reviewed for work and practice expense. The following codes continue to be misvalued: 97032, 97035, 97110, 97112, 97113, 97116, 97140, 97530, 97535 and G0283. We believe a significant underpayment of physical therapy services has occurred over the last 5 years and are appreciative of CMS' acknowledgement of this mistake.

In the 2024 Medicare Physician Final Rule, CMS stated:

> As discussed in the proposed rule, we reviewed the clinical labor time entries for these 19 therapy codes. We noted that we did not believe a payment reduction should have been applied to the 19 nominated therapy codes' clinical labor time entries (Table 10) since the payment valuation reduction would be duplicative of the MPPR we apply during claims processing. We proposed to nominate these 19 codes as potentially misvalued for CY 2024, as we believed that the valuation of these services would benefit from additional review through the AMA RUC HCPAC valuation process. … After consideration of the public comments for this issue, we are finalizing our proposal to consider the 19 therapy codes as potentially misvalued for CY 2024.

The RUC HCPAC recommendations for these codes continues to be based on a payment reduction that CMS does not believe should have been applied and is duplicative of the Multiple Procedure Payment Reduction (MPPR) policy. Although APTA and AOTA only addressed clinical labor in the reassessment of these codes based on CMS's specific directive related to clinical labor time entries, the RUC went further, and adjusted equipment minutes based on the duplicative reduction in clinical labor minutes. The follow-up discussion regarding equipment minutes that APTA and AOTA had with CMS was secondary to the primary consideration of clinical labor and has served to further exacerbate the duplicative reduction in direct practice expense inputs.

While CMS made it clear in the 2024 Final Rule that these codes should not be subject to clinical labor reductions, these reductions were again applied by the RUC. In the 2025 Proposed Rule CMS states:

> …to account for the MPPR, the HCPAC determined that 3.5 codes are billed per session, with the first paid at 100% and the second and subsequent units paid at half and so forth for PE (for example, 1.00 + 0.5 + 0.5 + 0.25 = 2.25). This resulted in the HCPAC recommending that many of the standard clinical labor times be divided by 2.25 to account for the MPPR, such as taking the standard 3 minutes for greeting and gowning the patient and dividing it by 2.25 to arrive at the recommended time of 1.33 minutes (1.33 + 0.67 + 0.67 + 0.34 = 3 minutes).

The RUC ignored the CMS directive, but CMS has adopted the RUC's valuation in the Proposed Rule. APTA requests that CMS clarify why it has echoed the RUC's devaluation of these services despite the clarity provided in the 2024 Final Rule.

We urge CMS to pay attention to its own Final Rule from last year and disallow MPPR being applied at the RUC and again during claims processing. If, for our first example, the standard for cleaning equipment is two minutes and equipment is procedure specific (therefore requiring two minutes for each procedure) the recommendation of one minute by the RUC, which then becomes .5 minutes for every procedure following the first based on MPPR, is not appropriate. There are few, if any, pieces of equipment used by a physical therapist that can be effectively cleaned in 30 seconds and the vast majority of procedures require multiple pieces of equipment. Contact time alone for most disinfectants ranges from 15 to 30 seconds. Even one minute is inadequate but 30 seconds (after MPPR) represents a significant underrepresentation of the time spent in cleaning equipment in a responsible and reasonable infection control manner.

As a second example, it is important to remember that for every procedure a physical therapist engages in, a patient must be positioned appropriately. Throughout the course of a session a patient may move from being supine, prone, and/or side lying on a mat to being safely and appropriately set up on a piece of exercise equipment, to working on a device to address balance. Based on the RUC recommendations, 1.33 minutes is allocated to position a patient for the first procedure and, after applying the MPPR, forty seconds is allocated to positioning a patient up for each subsequent procedure. Spending one and a third minutes is inadequate for most, if not all, procedures. In addition, spending only 40 seconds is not a realistic allocation of time to ensure that a patient is appropriately and safely positioned.

These are just two examples of how inappropriate the RUC recommendations are, but the same rules apply to all six of the clinical labor inputs. If the clinical labor inputs were correct, then the equipment minutes would also need to be addressed based on the formula applied at the January meeting.

In addition, APTA Private Practice strongly urges CMS to place a pause on MPPR for the 19 misvalued codes until the AMA RUC PE Subcommittee has a chance to again review the issue. 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.

<u>Billing for Remote Therapeutic Monitoring Services in the Hospital Outpatient Setting</u>

Private practice physical therapists can contract their services to hospital outpatient therapy departments and the billing for these services is completed by the hospital on a UB-04 claim form. Hospitals submit claims to their respective Medicare Administrative Contractor on a UB-04 claim form with a bill type of 12x or most commonly, bill type 13x, for outpatient therapy services.

It has been brought to our attention by our members that hospital outpatient therapy departments are not being reimbursed for CPT codes 98980 and 98981; however, are being reimbursed for CPT code 98975, 98976, and 98977. Upon investigation, APTA found that under OPPS, these 2 codes have a status indicator of B while 98975 is a status indicator of V and 98976 – 98978 a status indicator of Q1. For reference, the OPPS status indicators can be found here.

Since these codes when delivered by a PT under a PT plan of care with the GP modifier appended are considered physical therapy, they should have a status indicator of A like all other CPT codes billed by PT. APTA Private Practice requests that the status indicator for 98975, 98976, 98977, 98980, and 98981 be changed to A.

Additions to the List of Diagnostic Services by Physical Therapists
Consistent with the Physical Therapist scope of practice and state practice acts APTA respectfully requests that CMS add the diagnostic ultrasound codes below to the list of diagnostic codes performed by physical therapists.

- **76883:** US NRV&ACC STRUX 1 XTR COMPRE W/IMG PR EXTREMITY
- **76881:** US COMPL JOINT R-T W/IMAGE DOCUMENTATION
- **76882:** US LMTD JT/FCL EVAL NONVASC XTR STRUX R-T W/IMG
- **76883:** US NRV&ACC STRUX 1 XTR COMPRE W/IMG PR EXTREMITY

Value-based Payment
2025 Merit-based Incentive Payment System (MIPS). The track record of the MIPS program has been dismal for physical therapists to date, even as our practices have engaged with the program in good will. The implementation and structure of the program has been highly problematic due to the cost and the administrative burden of participation in relation to the low returns on that participation investment. For the 2023 MIPS Performance Year/2025 Payment Year, the highest positive payment adjustment is only 2.15%, nowhere near the "advertised" 9%. For the 2025 MIPS Performance Year/2027 Payment Year, CMS is projecting an approximate 2.25% percent positive payment adjustment for those providers that score 100 points. This program, similar to many others under Medicare that were intended to replace the Sustainable Growth Rate, is not working. For private practice physical therapists, the program does not improve care quality and its burdens offer very little return. In addition, the program does not come close to balancing the scales of cuts and losses that are being imposed by Medicare.

Nevertheless, physical therapy practices have participated in good faith, and many have scored in the upper echelon of quality in MIPS. As the CMS QPP report shows, the specialties with the highest proportion of clinicians receiving a positive payment adjustment were Obstetrics/ Gynecology, Physical Therapy and General Surgery. The payment adjustment percentages for physical therapists in 2024 were as follows:

- **Maximum -9% Payment Adjustment**: 380 PTs (1.91%)
- **-6.75 – 0% Payment Adjustment**: 2088 PTs (10.47%)
- **Neutral Payment Adjustment**: 381 PTs (1.91%)
- **0% – 1.25 Payment Adjustment**: 6,222 PTs (31.20%)
- **1.55% – 8.26% Payment Adjustment**: 10,871 PTs (54.51%)

Physical therapists have broadly participated. The aforementioned CMS report shows that, in 2022, there were 19,942 physical therapists (PTs) required to report to the MIPS program and only 523 PTs chose not to submit data. This means that only 2.62% of PTs who were required to submit MIPS data did not.

2025 MIPS Thresholds. CMS is proposing to maintain the performance threshold at 75 points for the 2025 MIPS Performance Year/2027 MIPS Payment Year. For the 2025 MIPS Performance Year, the scoring weight for each category are as follows: Quality: 30%; Cost: 30%; Promoting Interoperability: 25%; Improvement Activities: 15%. As to the Data Completeness Threshold, for the 2025 and 2026 MIPS Performance Years, CMS had already finalized the data completeness threshold at 75% of all eligible patients based on how Quality Measures are reported. In the proposed rule, CMS is proposing to maintain the data completeness threshold at 75% for the 2027 and 2028 MIPS Performance Years.

We support CMS' proposal to maintain the performance threshold at 75 points for the 2025 MIPS Performance Year/2027 MIPS Payment Year and to maintain the data completeness threshold at 75% for the 2027 and 2028 MIPS Performance Years.

Quality Measures. CMS is proposing substantive changes to the following quality measures that can be reported by physical therapists:

- **Quality Measure 130**: Documentation of Current Medications in the Medical Record
- **Quality Measure 155**: Falls: Plan of Care
- **Quality Measure 181**: Elder Maltreatment Screen and Follow-Up Plan
- **Quality Measure 182**: Functional Outcome Assessment
- **Quality Measure 291**: Assessment of Cognitive Impairment or Dysfunction for Patients with Parkinson's Disease
- **Quality Measure 498**: Connection to Community Service Provider

APTA Private Practice supports these changes and appreciates CMS adding physical therapy coding for Quality Measures 291 and 498.

Promoting Interoperability Category. CMS is proposing that if multiple data submissions for the Promoting Interoperability performance category are filed, a score will be calculated for each data submission received and assign the highest of the scores. We appreciate this flexibility offered by CMS and support this proposal if physical therapists are not exempt from this category for the 2025 MIPS Performance Year/2027 MIPS Payment Year.

Even with workarounds like this, private practice physical therapists are deeply concerned about the increasing gulf between providers who have and those who do not have certified electronic health record technology CEHRT). The issue has never been more relevant since CMS ended the promoting interoperability exemption for physical therapists beginning with the 2024 MIPS Performance Year. 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. Private practice physical therapists, 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 practices use EHRs that are not standardized, making it 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, 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 recognizes that much of the updated 2015 Edition certification criteria may not apply to private practice physical therapist—and other nonphysician provider—practice.

We urge CMS to work with ONC to offer financial and technical assistance to help nonphysician providers, including private practice 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 CEHRT.

No vendors of EHR designed for physical therapy have received ONC certification to date. Accordingly, physical therapists are unable to easily 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 as easy as possible for clinicians to prove this.

For these reasons, we urge the agency to exempt physical therapists from the Promoting Interoperability performance category for 2025 and beyond. We also urge CMS to analyze the number of PT providers who filed for and were granted the PI exception for the 2024 MIPS Performance Year since the majority would have done this by July 5, 2024.

Other Proposed Changes to the 2025 MIPS Performance Year
Quality and Improvement Activities Performance Categories. CMS is proposing the following:

- If multiple organizations (qualified registry, EHR vendor, practice administrator) submit

data on Quality Measures and Improvement Activities, CMS will calculate and score each submission received and assign the highest of the scores
- CMS is proposing that MIPS eligible clinicians participating in traditional MIPS would have to report two Improvement Activities and MIPS eligible clinicians who are categorized as a small practice, rural, in a provider-shortage area, or non-patient facing would now be required to report one activity to receive full credit for this category.
- If CMS receives multiple submissions from one or more submitters in the same organization, CMS will score the most recent submission

APTA Private Practice supports the first 2 proposals as proposed and asks CMS to finalize them in the final rule.

Regarding the third proposal, we ask CMS that if they receive multiple submissions from one or more submitters in the same organization, for CMS to calculate and score each submission received and assign the highest of the scores. An organization should not possibly be punished for submitting data more than once. An example could be an employee submits the data in February for the previous MIPS Performance Year and then that employee leaves that organization. Another employee who is now responsible for the MIPS program for that organization, unaware of what has been submitted previously, submits data in March for the previous MIPS Performance Year. This new employee, who may not be as proficient with the MIPS program, may not submit all of the data and now the organization will receive a lower score.

Why is CMS distinguishing a difference between multiple organizations submitting data on Quality Measures and Improvement Activities and one or more submitters in the same organization submitting Quality Measures and Improvement Activities?

The goal of the program is to have MIPS eligible clinicians successfully participate and report in the MIPS program. We ask that CMS **does not finalize** that if they receive multiple submissions from one or more submitters in the same organization, CMS will score the most recent submission. **Rather, we urge CMS to state the following in the final rule: If CMS receives multiple submissions from one or more submitters in the same organization, CMS will calculate and score each submission received and assign the highest of the scores.**

Topped Out Quality Measures. CMS acknowledges that some clinicians and specialty sets are being hindered by topped out quality measures and has adopted a topped out measure scoring cap. In this draft rule, CMS is proposing to publish a list in the Federal Register of topped out measures determined to be impacted by limited measure choice. Unfortunately, none of the proposed topped out measures impacted by limited measure choice and subject to defined topped out measure benchmark for the CY 2025 performance period/2027 MIPS Payment Year by Specialty Set are Quality Measures that would be reported by orthopaedic physical therapists.

For the 2025 MIPS Performance Year, the PT/OT Specialty Set will have three quality measures that can be reported via Medicare Part B claims and all 3 are topped out. For the 2025 MIPS Performance Year, the PT/OT Specialty set will have 16 quality measures, excluding the FOTO measures, that can be reported via a registry by physical therapists and 11 of the 16 are topped out. These topped out measures severely impact the ability of physical therapists participating in MIPS to achieve 10 quality measure points per quality measure reported and hence, achieve a performance score of 75 points or greater for the 2025 MIPS Performance Year. **We strongly urge CMS to include the topped out measures found in the**

PT/OT Specialty Set in the list to be published in the Federal Register.

In addition, to address this problem, we urge CMS to include PROMIS measures in the PT/OT Specialty Set as an option for reporting by physical therapists. PROMIS measures include those associated with physical function, pain interference, and Global Health 10 or PROMIS 29. See https://www.limberhealth.com/for-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.

In conclusion, APTA Private Practice urges CMS to add the following quality measures to the PT/OT Specialty Set for the 2025 MIPS Performance Year:

- **MSK1:** Patients Suffering From a Neck Injury Who Improve Physical Function
- **MSK2:** Patients Suffering From an Upper Extremity Injury Who Improve Physical Function
- **MSK3:** Patients Suffering From a Back Injury Who Improve Physical Function
- **MSK4:** Patients Suffering From a Lower Extremity Injury Who Improve Physical Function
- **MSK5:** Patients Suffering From a Knee Injury Who Improve Physical Function
- **MSK6**: Patients Suffering From a Neck Injury who Improve Pain
- **MSK7**: Patients Suffering From an Upper Extremity Injury Injury who Improve Pain
- **MSK8**: Patients Suffering From a Back Injury Injury who Improve Pain
- **MSK9**: Patients Suffering From a Lower Extremity Injury Injury who Improve Pain
- **MSK10:** Patients Suffering From a Knee Injury Who Improve Pain

Rehabilitative Care for Musculoskeletal Care (MSK) MVP. In 2024, CMS finalized the MSK MVP, which is being continued and slightly modified under the 2025 proposed rule. CMS proposes to add five additional quality measures including one for urinary incontinence, as well as four measures related to pain.

Quality Measures Proposed for Addition:

- **Measure 050**: Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older
- **MSK6**: Patients Suffering From a Neck Injury who Improve Pain
- **MSK7**: Patients Suffering From an Upper Extremity Injury Injury who Improve Pain
- **MSK8**: Patients Suffering From a Back Injury Injury who Improve Pain
- **MSK9**: Patients Suffering From a Lower Extremity Injury Injury who Improve Pain

APTA Private Practice appreciates and supports the addition of the 4 pain measures (MSK06-MSK09) and urinary incontinence measure and urges CMS to finalize these measures for the Rehabilitative Care for Musculoskeletal Care MVP.

In addition, APTA Private Practice urges CMS to add the following Quality Measures to the MSK MVP for the 2025 MIPS Performance Year:

- **MIPS Measure 134** (Preventive Care and Screening: Screening for Depression and Follow-Up Plan)
- **MIPS Measure 182** (Functional Outcome Assessment
- **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)
- **MSK1** Patients Suffering From a Neck Injury Who Improve Physical Function
- **MSK2** Patients Suffering From an Upper Extremity Injury Who Improve Physical Function
- **MSK3** Patients Suffering From a Back Injury Who Improve Physical Function
- **MSK4** Patients Suffering From a Lower Extremity Injury Who Improve Physical Function
- **MSK5** Patients Suffering From a Knee Injury Who Improve Physical Function
- **MSK10** Patients Suffering From a Knee Injury Who Improve Pain

We believe that the inclusion of MSK10, Knee Pain, is a critical oversight in the current Rehabilitative Support for Musculoskeletal Care MVP. We urge CMS to add the remaining MSK pain (knee pain, MSK10) and all five MSK functional measures (MSK01-MSK05) to the MSK quality measures in the MVP track as well as to the MIPS PT/OT Specialty Set.

CMS had requested that several of the largest registries collaborate and work on the MSK measure set. That work has been done successfully. Physical therapists across the country are using this measure set. By adding all five MSK functional measures (MSK01-MSK05) to the MSK quality measures in the MVP track, this will vastly increase the participation in the Rehabilitative Care Musculoskeletal Care MVP by including non-proprietary measures.

While the current functional measures included in the MSK MVP say they do not require proprietary software, multiple QCDRs have done outreach to receive the required Risk Adjustment files necessary to produce the predicted change scores required in the Numerators of quality measures 217, 218, 219, 220, 221, and 222, they have not been granted the necessary material to be able to use these measures. The MSK Measure set utilizes multiple types of Patient Reported Outcomes (PROs) widely used and freely available to organizations no matter their size or technical abilities. There are over fifty thousand Physical Therapy providers who currently utilize the legacy & PROMIS surveys in the MSK measures. These providers are small practices, rural physical therapy offices, and national physical therapy brands. They are the providers who have opted into MIPS utilizing the MSK measure structure since 2019. These organizations have chosen the evidence-based, widely utilized, and free reporting means offered in the MSK Measures to drive their quality improvement initiatives.

In conclusion, APTA Private Practice strongly urges CMS to move forward with finalizing the inclusion of these comprehensive MSK quality measures (MSK01-MSK10) into the Rehabilitative Care for Musculoskeletal Care MVP. This will strengthen the MIPS MVP track's ability to assess and report on quality in musculoskeletal rehabilitation and drive increased participation in the MVP and Quality Payment Programs.

Improvement Activities Proposed for Addition to Rehabilitative Care for Musculoskeletal Care MVP :

- **IA_ERP_6**: COVID-19 Vaccine Achievement for Practice Staff

Improvement Activities Proposed for Removal:

- **IA_CC_1**: Implementation of Use of Specialists Reports Back to Referring Clinician or Group to Close Referral Loop
- **IA_EPA_1**: Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient's Medical Record

Cost

APTA Private Practice also supports collecting data illustrating the impact to overall cost for patients in different groups focusing on which interventions they access first. APTA Private Practice would respectfully urge CMS to collect information regarding PT participation through the model as PTs are not alone in their ability to participate and it would be beneficial for orthopaedic physical therapists to review their performance versus their peers. In addition, the interoperability requirement is still highly problematic for orthopaedic physical therapists as few CEHRT options exist for our specialty. We also urge CMS to increase the resources it devotes to measure development and stewardship to allow for a more comprehensive quality measure set applicable to physical therapy.

We urge CMS to continue to invest in and refine both cost measures generally and the low back pain cost measure to apply to physical therapy more directly. As with the model as a whole, we would urge CMS to make available PT-specific data regarding participation. We are concerned that, like the MIPS program, PT will be under-represented, and thus have a low sample size. Our hope is that, over time, addressing CEHRT and building a more complete physical therapy measure set will improve. Another area for continued focus is the fact that in almost all states, patients enjoy direct access to physical therapy without the need for an initial physician referral. It would be very helpful to know how many patients visit their physical therapists first, as the real value of PT is in what interventions are avoided. One other problem, as mentioned above, is that PTs are not the only types of providers included and thus are not being evaluated vs one another.

CMS is also proposing the following changes for the MIPS MVP program:

- CMS is proposing to remove the requirement for an MVP Participant to select a population health measure at the time of MVP registration.
- For population health measures, beginning with the 2025 Performance Year, CMS will use the highest score of all available population health measures. If no population health measure has a benchmark or meets the case minimum requirement, then the population health measure is excluded from the MVP Participant's total measure achievement points and total available measure achievement points.
- For improvement activities, beginning with the 2025 MIPS Performance Year, CMS is proposing that MVP Participants would be required to submit one improvement activity to achieve 40 points, or full credit, or participation in a certified or recognized patient-centered medical home (PCMH), or comparable specialty practice as described at §414.1380(b)(3)(ii).

APTA Private Practice supports the above 3 changes and urges CMS to finalize them in the final rule.

Conclusion
We thank CMS for the opportunity to provide feedback on the 2025 Medicare Physician Fee Schedule proposed rule.

Sincerely,

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

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