CY 2020 MPFS Proposed Rule Summary

On Monday, July 29, 2019, CMS released the CY 2020 Medicare Physician Fee Schedule Proposed Rule. This rule proposes several items relevant to therapy services, including payment updates for services paid via the Physician Fee Schedule, instructions for application of the CQ and CO modifiers for services provided by physical and occupational therapist assistants beginning January 1, 2020, CPT/HCPCS coding updates, and updates to the Merit-based Incentive Payment System (MIPS). The comment period closes September 27, 2019.

Payment Update

CMS proposes a very **slight Physician Fee Schedule rate increase of 0.14% for calendar year (CY) 2020** due to the budget neutrality adjustment. (By law, there are no annual statutory increases to the Medicare fee schedule for 2020 through 2025.) The estimated impact of this increase for physical and occupational therapy is zero percent.

Therapy Threshold

CMS proposes to codify the changes from the Bipartisan Budget Act (BBA) of 2018 related to the therapy cap repeal in regulation text (§410.59 and §410.60), including:

- Changing verbiage referencing a therapy "limit" to "threshold amount"
- Application of the KX modifier over this threshold amount (which will be determined for 2020 in the final rule) to indicate continued medical necessity
- Continued manual medical review for services provided over $3,000 until 2028
- Continued accrual of therapy services furnished by critical access hospitals (CAHs) based on fee schedule rates

Therapist Assistant Modifiers

The BBA of 2018 directed the Secretary of HHS to create modifiers indicating services were provided by a physical therapist assistant (PTA) or occupational therapy assistant (OTA), and indicated that services provided "in whole or in part" by an assistant would be reimbursed at 85% of the fee schedule rate beginning in 2022. (*Note:* This payment reduction applies to Medicare Part B (i.e., outpatient) services only.)

In the CY 2019 final rule, CMS established two new modifiers to identify services provided by a PTA or OTA. These modifiers will be required beginning January 1, 2020.

- **CQ: Services provided in whole or in part by a PTA**
- **CO: Services provided in whole or in part by an OTA**

The assistant modifiers are described as "payment modifiers" and are to be applied "alongside" the existing GP and GO modifiers which indicate services provided as part of a physical or occupational therapy plan of care (e.g., 97110GPCQ or 97535GOCO).

Last year, CMS also finalized a *de minimis* standard for defining services provided "in whole or in part" by an assistant (meaning a minimal standard or the minimum amount of service that constitutes "in

part"). Under this standard, **a service is considered furnished in whole or in part by a PTA/OTA when more than 10% of the service is furnished by the assistant.**

In the CY 2020 proposed rule, CMS offers further clarification of this de minimis standard and defines "service" to mean a specific procedure code (CPT or HCPCS code) that describes a PT or OT service (e.g., 97110, 97535, G0283, 97166).

T**o apply the de minimis standard under which a service, or procedure code, is considered to be furnished in whole or in part by the PTA or OTA, CMS proposes to make the 10% calculation based on the respective "therapeutic minutes" of time spent by the therapist and the PTA/OTA, rounded to the nearest whole minute.** Time spent on "administrative" or "non-therapeutic" tasks (i.e., non-skilled services) is not considered in this calculation as it is not billable, skilled time.

CMS provides several examples and clinical scenarios to demonstrate application of the de minimis standard using both timed and untimed codes. For more information on calculating the 10% standard, including clinical scenarios as outlined in the proposed rule, click **here**.

CMS also proposes to require that, beginning January 1, 2020, the treatment notes explain, "via a short phrase or statement," the application or non-application of the CQ/CO modifier for each service furnished that day. This documentation requirement would be included in subsection 220.3.E (treatment notes) in Chapter 15 of the Medicare Benefit Policy Manual. This requirement would apply to timed and untimed services.

CMS is seeking comments on whether it would be appropriate to require documentation of the minutes as part of the CQ/CO modifier explanation as a means to avoid possible "additional burden associated with a contractor's medical review process conducted for these services." And CMS states they are interested in "hearing from therapists and therapy providers about current burden" with the medical review process based on current policy that does not require times for individual services to be documented.

CMS reiterates that, as discussed in the CY 2019 proposed and final rules, the reduced payment rate (i.e., services paid at 85% of the Fee Schedule) for outpatient (OP) services furnished in whole or in part by therapy assistants which becomes effective January 1, 2022, does not apply to OP services furnished in CAHs.

CPT Code Updates

CMS discusses updates to the valuation for newly created and revised CPT codes for CY 2020. CMS considers the recommendations of the American Medical Association's (AMA's) Relative Value Scale Update Committee (RUC) and the Health Care Professionals Advisory Commission (HCPAC), then completes their own analysis, and finally proposes changes to the "work relative value unit," or work RVU, portion of the value (i.e., the fee schedule rate) of a given CPT or HCPCS code. The work RVU represents the portion of the resources used in furnishing a given service that reflects physician "time and intensity, or in the case of services furnished by therapists, the therapist's time and intensity. Adjustments, whether positive or negative, to the work RVU changes the fee schedule reimbursement for the specific CPT/HCPCS code.

In this proposed rule, CMS outlines changes to the work RVU (and hence the payment rates) for several CPT/HCPCS codes applicable to therapy services and other CPT code changes that would go into effect January 1, 2020.

Dry Needling

For CY 2020, two new CPT codes will be released by the AMA to represent trigger point dry needling:

- **205X1 – Needle insertion(s) without injection(s), 1 or 2 muscles**
- **205X2 – Needle insertion(s) without injection(s), 3 or more muscles**

CMS is proposing to classify these as "always therapy" codes, meaning they will count toward the annual therapy dollar threshold (for application of the KX modifier) and the multiple procedure payment reduction (MPPR) will apply. CMS proposes a work RVU of 0.32 for 205X1 and 0.48 for 205X2 (vs. the 0.45 and 0.60 proposed by HCPAC).

Cognitive Function Intervention

Effective with dates of service on and after January 1, 2020, CPT 97127 has been deleted and will be replaced by two new CPT codes:

- **971XX – Therapeutic interventions that focus on cognitive function** (e.g., attention, memory, reasoning, executive function, problem solving and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing and sequencing tasks), direct (one-to-one) patient contact; ***initial 15 minutes***
- **9XXX0 – Therapeutic interventions that focus on cognitive function** (e.g., attention, memory, reasoning, executive function, problem solving and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing and sequencing tasks), direct (one-to-one) patient contact; ***each additional 15 minutes*** (list separately in addition to code for primary procedure)

CMS is proposing the RUC-recommended work RVUs of 0.50 for 971XX and 0.48 for 9XXX0 and will designate these as "sometimes therapy" codes.

<u>Biofeedback</u>

CPT 90911 (Biofeedback training) is also being deleted effective January 1, 2020, and is being replaced with two new codes to describe biofeedback training for the initial 15 minutes and each additional 15 minutes of one-on-one intervention:

- **908XX – Biofeedback training,** perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry when performed; ***initial 15 minutes*** of one-on-one patient contact
- **909XX – Biofeedback training,** perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry when performed; ***each additional 15 minutes*** of one-on-one patient contact

CMS proposes the RUC-recommended work RVU of 0.90 for 908XX and 0.50 for 909XX and will designate these codes as "sometimes therapy" codes.

Wound Care

CMS is proposing to reweight CPT codes 97597 and 97598 (debridement, open wound) and increase the work RVU over the current value for both codes.

Currently, CPT codes 97607 and 97608 (negative pressure wound therapy using disposable, non-durable medical equipment) are not payable by Medicare. Beginning with dates of service January 1, 2020, CMS is proposing to assign "active" status to these codes and apply the work RVUs recommended by the RUC.

CPT 97610 (low frequency, non-contact, non-thermal ultrasound) has been resurveyed due to increased utilization and the work RVU is being adjusted accordingly.

Cardiac Rehabilitation

Currently, Medicare Part B covers cardiac rehab (CR) and intensive cardiac rehab (ICR) program services for beneficiaries who have experienced one or more of the following:

1. An acute myocardial infarction within the preceding 12 months
2. Coronary artery bypass surgery
3. Current stable angina pectoris
4. Heart valve repair or placement
5. Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting
6. Heart or heart-lung transplant

In February 2014, CMS expanded coverage of CR to patients with stable chronic (or congestive) heart failure (CHF). The BBA of 2018 directed CMS to expand the list of covered conditions for ICR. In this rule, CMS is proposing to add stable CHF to the list of covered conditions for ICR.

Merit-based Incentive Payment System (MIPS)

As confirmed in the CY 2019 final rule, physical therapists (PTs), occupational therapists (OTs), speech-language pathologists (SLPs), clinical psychologists, dietitians and audiologists were added as eligible clinicians for the 2019 MIPS performance year (i.e., the 2021 payment year). **Therapist eligibility for participation in MIPS continues into the 2020 performance year (i.e., the 2022 payment year) for therapists in private practice** – that is, those who bill on a CMS 1500 (or 827p) claim form.

For the 2020 performance year, several elements of MIPS remain the same as in 2019:

- The low-volume threshold
- Eligible clinician types
- Opt-in policy
- MIPS determination period
- Collection types
- Submitter types
- Submission types
- CEHRT requirements

- Topped out measures
- Measure, activity and performance category scoring methodologies
- 3-point Floor for scored quality measures
- Improvement scoring
- Bonus points
- Scoring for improvement activities

Additional information on these unchanged elements can be found at the **CMS Quality Payment Program website** and in the **CY 2019 Final Rule**.

MIPS Value Pathways (MVPs) Request for Information

In an effort to further transform the MIPS program by empowering patients and simplifying MIPS to improve value and reduce burden, CMS is proposing to apply a new MIPS Value Pathway (MVP) framework to future proposals beginning with the 2021 MIPS performance year (i.e., the 2023 payment year). This MVP framework would connect measures and activities across the four MIPS categories, incorporate a set of administrative claims-based quality measures that focus on population health, provide data and feedback to clinicians, and enhance the information provided to patients.

CMS is seeking public comments on the following issues:

1. How to construct MVPs, including approach, definition, development, specifications, and examples
2. How to select measures and activities
3. How to determine MVP assignment
4. How to transition to MVPs

Quality Category

To meet reporting thresholds for Quality in performance year 2020, eligible clinicians participating in MIPS must continue to **report at least six measures**, including at least one outcome measure, **on 70% or more of all eligible patients, *regardless of payer*, if using a reporting method other than via the claim**. If utilizing Medicare Part B claims reporting, data must be submitted on at least 70% of eligible Medicare Part B patients.

The proposed rule discusses the following changes to the MIPS Quality Measures Specialty Set for PTs and OTs in 2020 (added measures in teal):

Measure	Description	Measure	Description
126	Diabetic Foot/Ankle Care, Peripheral Neuropathy – Neurological Evaluation	217	Functional Status Change for Patient with Knee Impairments using FOTO Patient Reported Outcome Measurement (PROM)
127	Diabetic Foot/Ankle Care, Ulcer Prevention – Eval of Footwear	218	…Hip Impairments using FOTO PROM
128	BMI Screening and Follow-up	219	…Foot/Ankle Impairments using FOTO PROM
130	Documentation of Current Meds	220	…Lumbar Impairments using FOTO PROM
~~131~~	~~Pain Assessment and Follow-up~~ (Proposed to be deleted in 2020)	221	…Shoulder Impairments using FOTO PROM
134	Screening for Depression & Follow-up	222	… Elbow/Wrist/Hand Impairments using FOTO PROM
154	Falls: Risk Assessment	~~223~~	~~… Other General Ortho Impairments using FOTO (PROM)~~ (Proposed to be deleted in 2020)
155	Falls: Plan of Care	TBD	…Neck Impairments using FOTO PROM
181	Elder Maltreatment Screen and Follow-up Plan	226	Tobacco Use: Screening and Cessation Intervention
182	Functional Outcome Assessment	281	Dementia: Cognitive Assessment
		318	Falls: Screening for Future Fall Risk

The proposed rule lists the following measures in a specialty set for Speech Language Pathology:

Measure	Description	Measure	Description
130	Documentation of Current Meds	182	Functional Outcome Assessment
181	Elder Maltreatment Screen & Follow-up Plan	226	Tobacco Use: Screening and Cessation Intervention

Improvement Activities Category

In addition to the Quality category, MIPS-eligible PTs, OTs, and SLPs must continue to report Improvement Activities in 2020. Eligible clinicians or groups must attest to completing improvement activities for at least a continuous 90-day period during the 12-month performance period (CY 2020).

CMS proposes to remove 15 activities, modify 7, and add 2 new activities for 2020, and to adopt improvement activity removal factors which reflect those finalized for quality measure removal in the CY 2019 final rule.

CMS proposes two changes to the group reporting requirement for the improvement activities category:

1. Increase the group reporting threshold from at least one clinician to at least 50% of the group beginning with the 2020 performance year

2. At least 50% of a group's NPIs must perform the same activity for the same continuous 90 days in the performance period beginning in 2020

MIPS Category Weighting

For the 2022 payment year (the 2020 performance year), CMS proposes to weight the four MIPS categories as follows:

MIPS Category	2020 Weight	2020 Weight for PT/OT/SLP
Quality	45%	85%
Cost	15%	0%
Improvement Activities	15%	15%
Promoting Interoperability	25%	0%

PTs, OTs, and SLPs will continue to have the cost and promoting interoperability categories reweighted to the quality category in 2020.

MIPS Scoring

CMS proposes a performance threshold of 45 points for the 2022 payment year (i.e., the 2020 performance year), and 60 points for 2023. And, the "additional performance threshold," or exceptional performance benchmark, is proposed to be 80 points for payment year 2022 and 85 for payment year 2023. This means, participating clinicians and groups must achieve more than 45 points in the program to receive a positive payment adjustment, and participants who achieve 80 or more points are eligible for an additional incentive.

The maximum payment adjustment for 2022 is +/- 9%. The MIPS program remains budget neutral, however, such that incentives are paid based on penalties incurred. Incentive percentages are based on a "scaling factor" that increases as the number (and amount) of penalties increase. More MIPS eligible clinicians with scores above the performance threshold means the scaling factor decreases; more clinicians below the performance threshold means the scaling factor increases. As the scaling factor increases, the incentive percentage increases.

For more information on MIPS in 2020, click **here**.

Requests for Information (RFIs)

In addition to CMS's RFI for the MIPS Value Program, the proposed rule contains multiple requests for stakeholder feedback and input on topics including, but not limited to the following:

- A metric to improve efficiency of providers within electronic health records (EHRs)
- Provider to patient exchange – CMS is moving toward a system where patients have immediate access to their health information and can be assured their health information will follow them as they move throughout a health care system from provider to provider and payer to payer. To this end, CMS requests input on the following:

- Immediate access
- Persistent access and standards-based application programming interfaces (APIs)
- Available data
- Patient matching

- Integration of patient-generated health data into EHRs using certified electronic health record technology (CEHRT)
- Engaging in activities that promote the safety of the EHR

For more information, access CMS's Fact Sheets:

Proposed Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2020

2020 Quality Payment Program Proposed Rule Overview Factsheet with Request for Information for 2021

CY 2020 Proposed Rule