CMS released the CY 2020 Medicare Physician Fee Schedule Final Rule on Friday, November 1, 2019. This Rule finalizes 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).

PAYMENT UPDATE:

CMS finalized a slight Fee Schedule rate increase of 0.14% for CY 2020 (the conversion factor will be 36.0896 vs. 36.0391 in 2019) due to the budget neutrality adjustment. (Recall, that by law, there are no annual statutory increases to the Medicare Physician Fee Schedule for 2020 through 2025.)

CMS also finalized changes to increase the reimbursement for the outpatient/office physician evaluation and management (E/M) CPT codes in CY 2021 (as proposed by the AMA) which will result in an approximately 8% cut in payment for outpatient PT and OT services, effective 1/1/2021 (despite receiving more than 10,000 comments against this proposal). Thirty-six (36) different specialties face cuts in 2021 (including PT/OT, opthamology, chiropractors, audiology, and clinical social workers) with the increase in payment for the physician E/M codes. However, CMS has not determined the actual cuts to each code yet. (Note: This will be a major focus for advocacy efforts by the APTA, AOTA, NASL, and NARA over the next year.)

THERAPY THRESHOLD:

CMS finalized regulatory language changes related to the therapy cap repeal in regulation text (§410.59 and §410.60), including:

- Changed verbiage referencing a therapy “limit” to “threshold amount”
- Application of the KX modifier over this threshold amount to indicate continued medical necessity
- Continued targeted manual medical review for services provided over $3000 until 2028
- Continued accrual of therapy services furnished by critical access hospitals (CAHs) based on fee schedule rates

The annual therapy threshold amount for 2020 is $2080 for PT/SLP and $2080 for OT.

THERAPIST ASSISTANT MODIFIERS:

The Bipartisan Budget Act of 2018 directed the Secretary of HHS to create modifiers signifying services were provided by a PTA or OTA, and indicated that services provided “in whole or in part” by a therapist assistant would be reimbursed at 85% of the Fee Schedule rate beginning in 2022. (Note**:** This payment reduction applies to services reimbursed via the Medicare Physician Fee Schedule only – i.e., Medicare Part B. In the Final Rule, CMS clarifies that the reduction *does not apply* to CAHs as they are not reimbursed via the fee schedule.)

In the CY 2019 Final Rule, CMS established two 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 CQ/CO modifiers are described as "payment modifiers" and are to be applied alongside, or in addition to, the GP and GO modifiers which indicate services are provided as part of a physical or occupational therapy plan of care (e.g., 97110GPCQ; 97535GOCO).

CMS also finalized a *de minimis* standard in last year's Final Rule for defining services provided "in whole or in part" by an assistant. 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 Final Rule, CMS changed its position on a couple of key points related to the assistant modifiers (after receiving almost 9000 comments!).

CMS revised the definition of "service" to mean the *de minimis* standard will be applied to untimed CPT/HCPCS codes and to each 15-minute unit of codes timed in 15-minute increments.

CMS finalized that they will NOT count time the therapist and assistant furnish services to the same patient at the same time (i.e., concurrently or as a team) for purposes of assessing whether the *de minimis* standard has been met. Meaning, only time the assistant spends independently treating the patient will be subject to the de minimis (10%) calculation and therefore, the application of the CO/CQ modifier.

To apply the *de minimis* standard under which a "service" is considered to be furnished in whole or in part by the PTA or OTA (i.e., >10% of the service), CMS finalized that providers 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 this is not billable, skilled time.

CMS revised the definition of "service" to mean the *de minimis* standard will be applied to untimed CPT/HCPCS codes and to each 15-minute unit of codes timed in 15-minute increments.

CMS also is revising their policy to allow separate reporting, on two different claim lines, of the number of 15-minute units of a code to which the modifiers do not apply and the number of 15-minute units of a code to which the modifiers do apply.

CMS offered two ways to compute whether the 10% standard was exceeded in the Proposed Rule and did not change this calculation methodology in the Final Rule, except to clarify that a service is now defined as "each 15 minute unit" for codes timed in 15-minute increments and that services provided concurrently (or as a therapist/assistant team) do not count toward calculating the 10% *de minimis* standard for modifier application.

The two methods, as described in detail in the Proposed Rule, are as follows:

1. Divide PTA/OTA minutes by the total minutes for the service, where total minutes are defined as:
   a. ~~The therapist's total time when the PTA/OTA minutes are furnished concurrently with the therapist, or~~ *(This is no longer applicable per the Final Rule.)*
   b. The sum of the PTA/OTA and therapist minutes when the assistant's services are furnished separately from the therapist.

   Then multiply this number by 100 to calculate the percentage of the service involving the PTA/OTA.

2. Divide the total time for the service by 10 to identify the 10% de minimis standard, and then add one minute to identify the number of minutes of service by the PTA/OTA that would be needed to exceed the 10% standard. (CMS calls this the "simple method" as outlined in the table below.)

TABLE 25: Simple Method for Determining when CQ/CO Modifiers Apply

METHOD TWO: Simple Method to apply 10% de minimis standard			
Total Time* examples using typical Service Total Times	Determine 10% standard by dividing service Total Time by 10	Round 10% standard to next whole integer	PTA/OTA minutes needed to exceed – Apply CQ/CO
10	1.0	1.0	2.0
15	1.5	2.0	3.0
20	2.0	2.0	3.0
30	3.0	3.0	4.0
45	4.5	5.0	6.0
60	6.0	6.0	7.0
75	7.5	8.0	9.0

*Total Time equals total therapy minutes plus any PTA/OTA independent minutes: Concurrent minutes: When PTA/OTA's minutes are furnished concurrently with the therapist, total time equals the total minutes of the therapist's service. Separate minutes: When the PTA/OTA's minutes are furnished separately from the minutes furnished by the therapist, total time equals the sum of the minutes of the service furnished by the PT/OT plus the minutes of the service furnished separately by the PTA/OTA.

CMS provided several examples and clinical scenarios to demonstrate application of the *de minimis* standard using both timed and untimed (i.e., evaluative, group, unattended modality) codes in the CY 2020 Proposed Rule. CMS did not offer any new examples in the Final Rule, but rather, stated that the examples in the Proposed Rule "generally applied," except for instances where the CO/CQ modifiers were applied when services were provided by the therapist and assistant at the same time ("concurrently" or as a team), and those examples where each timed CPT code was treated as one service – e.g., 10 min of 97110 delivered by PTA; 15 min by PT and the modifier applied to both units. With the clarification offered in the Final Rule, the above scenario would result in one unit 97110 billed with the modifier and one unit billed without the modifier, on separate claim lines. (For the scenarios and examples provided by CMS in the 2020 Proposed Rule, click **Here**.)

CMS also decided NOT to finalize their proposal 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. CMS states, "…we would expect the documentation in the medical record to be sufficient to know whether a specific service was furnished independently by a therapist or therapist assistant, or was furnished "in part" by a therapist assistant, in sufficient detail to permit the determination of whether the 10% standard was exceeded."

CPT CODE UPDATES:

In the Final Rule, CMS finalized changes to the work RVUs (relative value units) for several CPT/HCPCS codes applicable to therapy services.

Dry Needling

For CY 2020, two new CPT codes have been released by the American Medical Association (AMA) to represent trigger point dry needling:

- **20560** – Needle insertion(s) without injection(s), 1 or 2 muscles
- **20561** – Needle insertion(s) without injection(s), 3 or more muscles

Despite finalizing a work RVU of 0.32 for 20560 and 0.48 for 20561, **CMS will not pay for these codes in 2020**, "unless otherwise specified" in a National Coverage Determination (NCD). CMS has assigned these codes a non-covered status in 2020.

Cognitive Function Intervention

Effective with dates of service on and after January 1, 2020, CPT 97127 and HCPCS code G0515 have been deleted and will be replaced by two new CPT codes representing cognitive function intervention, initial 15 minutes and each additional 15 minutes:

- **97129** – 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*
- **97130** – 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 finalized the work RVUs of 0.50 for 97129 and 0.48 for 97130 and will designate these as "sometimes therapy" codes, meaning the multiple procedure payment reduction (MPPR) does not apply to these codes.

Biofeedback

CPT 90911 (Biofeedback training) is also being deleted effective January 1, 2020, and is being replaced with two new codes, again representing the initial 15 minutes of treatment and each additional 15 minutes:

- **90912** – Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry when performed; *initial 15 minutes* of one-on-one patient contact
- **90913** – 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 finalized the work RVU of 0.90 for 90912 and 0.50 for 90913 and will designate these codes as "sometimes therapy" codes, therefore MPPR does NOT apply.

Wound Care

CMS finalized the reweighting of CPT codes 97597 and 97598 (debridement, open wound) and increased the work RVU over the current value for both codes – 97597 will be 0.77 in 2020 (was 0.52); 97598 will be 0.50 in 2020 (was 0.24).

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 will assign "active" status to these codes and apply the work RVU of 0.41 for 97607 and 0.46 for 97608.

CPT 97610 (low frequency, non-contact, non-thermal ultrasound) has been resurveyed due to increased utilization and the work RVU has been adjusted for 2020 and finalized at 0.40.

Manual Muscle Testing

Effective with date of service on or after January 1, 2020, **CPT codes 95831, 95832, 95833, 95834 are being deleted.**

CARDIAC REHABILITATION:

Background: 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

CR is a structured, physician-supervised exercise program. ICR is a “lifestyle modification” program which includes exercise and cardiac risk modification, lipid, blood pressure, and stress reduction, smoking cessation, diet change, weight loss, etc.

In February 2014, CMS expanded coverage of CR to patients with stable chronic (or congestive) heart failure (CHF). The Bipartisan Budget Act of 2018 directed CMS to expand the list of covered conditions for ICR. In this rule, **CMS finalized the addition of stable CHF to the list of covered conditions for ICR.**

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS):

PT, OT, and SLP eligibility for participation in MIPS continues into the 2020 performance year (i.e., the 2022 payment year). Many aspects of MIPS remain the same in 2020 as they were in 2019. Modifications to the program going into 2020 are outlined below.

MIPS Value Pathways (MVPs)

In an effort to further transform the MIPS program by empowering patients and simplifying MIPS to improve value and reduce burden, **CMS will begin to apply a new MIPS Value Pathway (MVP) framework beginning with the 2021 MIPS performance year** (the 2023 payment year). The MVP framework will 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 believes this MVP framework will reduce the complexity of the program and the burden to participate and will balance flexibility with standardization to allow for better comparisons across providers/clinicians.

Quality Category

To meet reporting thresholds for Quality in CY 2020, eligible clinicians participating in MIPS must continue to report at least 6 measures, including at least 1 outcome measure, **on ≥ 70% of all eligible patients**, ***regardless of payer*****,** if using a reporting method other than via the claim (such as a Qualified Registry or QCDR). If utilizing Medicare Part B claims reporting (again, available to small practices of ≤ 15 clinicians only), data must be submitted on ≥ 70% of eligible Medicare Part B patients.

The Final Rule outlines the following changes to the MIPS Quality Measures for PTs and OTs in 2020:

The PT/OT Specialty Set (Appendix B.33):

Measure	Description	Measure	Description
126	Diabetic Foot/Ankle Care, Peripheral Neuropathy – Neurological Evaluation	217	Functional Status Change for Patient w/ Knee Impairments using FOTO Patient Reported Outcome Measurement
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
134	Screening for Depression & Follow-up	221	…Shoulder Impairments using FOTO PROM
154	Falls: Risk Assessment	222	… Elbow/Wrist/Hand Impairments using FOTO PROM
155	Falls: Plan of Care	478	…Neck Impairments using FOTO PROM
181	Elder Maltreatment Screen & Follow-up Plan	281	Dementia: Cognitive Assessment
182	Functional Outcome Assessment	282	Dementia: Functional Status Assessment
226	Tobacco Use: Screening & Cessation Intervention	288	Dementia: Education & Support of Caregivers for Patients with Dementia
		318	Falls: Screening for Future Fall Risk

The Physical Medicine Specialty Set measures applicable to PT/OT (Appendix B.15):

Measure	Description	Measure	Description
128	BMI Screening and Follow-up	182	Functional Outcome Assessment
130	Documentation of Current Meds	226	Tobacco Use: Screening and Cessation Intervention
154	Falls: Risk Assessment	402	Tobacco Use and Help with Quitting Among Adolescents
155	Falls: Plan of Care	431	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

The Final Rule lists the following measures in a new **specialty set for SLP** (Appendix B.43):

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

CMS finalized the removal of measures 131, Pain Assessment and Follow-up, and 223, Functional Status Change for Patients with General Orthopedic Impairments, from the MIPS program (from all measures sets) in 2020.

(Note: Several measures have been revised for 2020 to include changes to the measure numerator and/or denominator and to therapy disciplines to which the measures apply. These modifications will be described in detail in the final measure specifications to be released by CMS prior to the end of the year.)

For the 2022 payment year, CMS finalized the same 3-point floor for each quality measure that can be reliably scored against a benchmark based on a baseline period. (CMS states they will revisit this as they move toward MVPs.) Scoring remains essentially the same as for the 2021 payment year (the 2019 performance year), except for Class 3 measures, which currently receive 1 point – or 3 points for small practices.

TABLE 50: Quality Performance Category: Scoring Policies for the CY 2020 MIPS Performance Period

Measure Type	Description	Scoring Rules
Class 1	Measures submitted or calculated that meet all of the following criteria: 1) Has a benchmark; 2) Has at least 20 cases; and 3) Meets the data completeness standard (generally, 70% for 2020)	3 to 10 points based on performance compared to the benchmark
Class 2	Measures that are submitted and meet data completeness, but do not have either of the following: 1) A benchmark 2) At least 20 cases	3 points
Class 3	Measures that are submitted, but do not meet data completeness threshold, even if they have a measure benchmark and/or meet the case minimum	MIPS eligible clinicians other than small practices will receive zero points; small practices – 3 points

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 a continuous 90-day period during the 12-month performance period.

Activities continue to be categorized as “high-weighted” or “medium-weighted” based on the amount of time and resources it takes to implement and complete the activity.

CMS finalized modifications to the Improvement Activities inventory for 2020, including the removal, modification, and addition of activities. In addition, CMS finalized the adoption of

improvement activity removal factors which reflect those established for quality measure removal in the CY 2019 Final Rule.

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

1. **Increased 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 any continuous 90 days* in the performance period beginning in 2020**

(Note**:** Currently, if at least one clinician within the group performs the activity for a continuous 90 days in the performance period, the entire group may report that activity. And, all MIPS eligible clinicians reporting as a group receive the same score.)

MIPS Category Weighting

For the 2022 payment year (the 2020 performance year), CMS finalized weighting of 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 finalized a performance threshold of 45 points for the 2022 payment year (the 2020 performance year), and 60 points for 2023. The "additional performance threshold" – or exceptional performance benchmark – will be 85 points for both payment years 2022 and 2023.

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**.

For more information, access the **CMS Fact Sheet**.

Access the **2020 Quality Payment Program Final Rule Overview Fact Sheet**.

Access the **CY 2020 Medicare Physician Fee Schedule Final Rule**.