Present:

MIPS 2025 Reporting

May 7th, 2025

Welcome!

Today's Lunch & Learn session will provide OptimisPT users with:

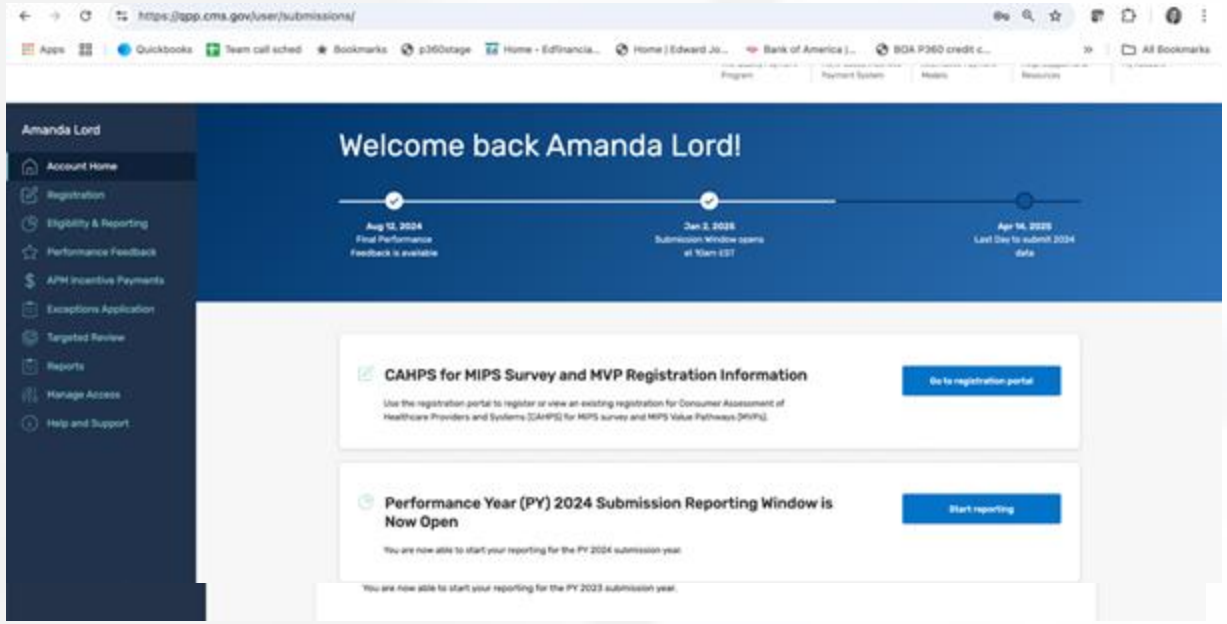
- Quick recap and 2024 stats
- MIPS 2025 policies
- Understanding eligibility for PTs and data completeness requirements
- PT measures & benchmarking
- Review of P360 & OptimisPT automation
- Demo
- Q & A

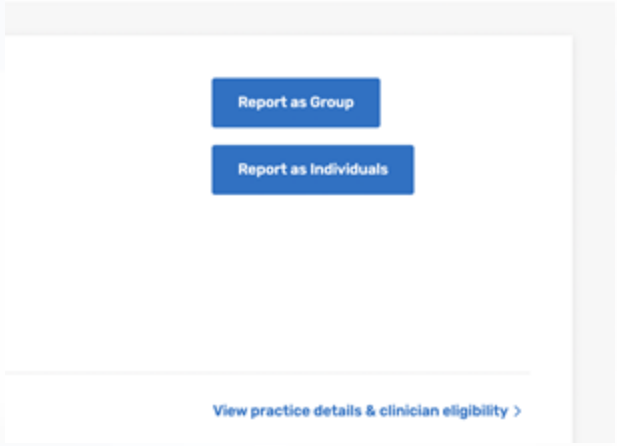
2024 Quick Results Overview

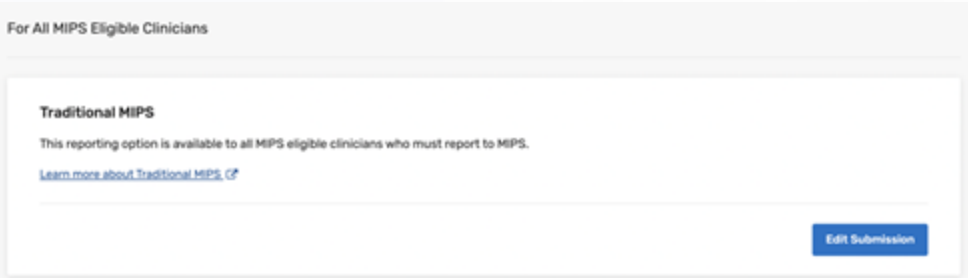
1. 9 groups and 14 individual OptimisPT clients successfully submitted their 2024 MIPS data to CMS via Patient360.
2. All TINs who submitted data for 2024 are projected to pass MIPS with 75 total points or higher pending final score release by CMS in summer of 2025. Most will receive a bonus.
3. The “preliminary” quality category average for all quality data submitted to CMS was 80.4.

2024 Submissions in QPP

How and where to view your 2024 submission in QPP: https://qpp.cms.gov/login
If you are a security official for your TIN, log into QPP
Issues with viewing the submission in QPP call this number: 1-866-288-8292







About Patient360

- Patient360 has been around since the days of PQRI- first data submissions to CMS back in 2009.
- Patient360 occupies both the Qualified Registry and QCDR space, supporting MIPS measures applicable to PT, as well as QCDR measures including MSK measures.
- Click here for more information on the benefits of QCDR reporting

2025 Policies & Changes

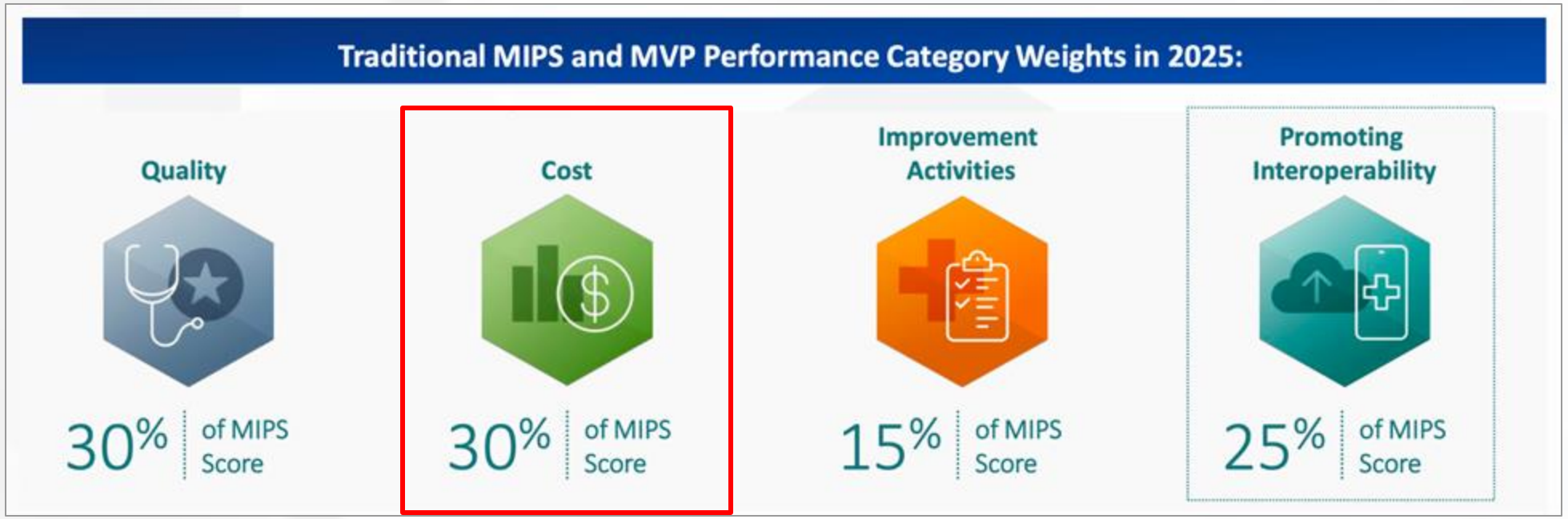
The requirements remain stringent for 2025:

2025 Final Rule Fact Sheet

1. Quality category continues to be worth only 30% of your score, and cost 30% per federal rulemaking.
2. You need 75 points minimum total across ALL categories to avoid negative payment adjustment and there is no more exceptional bonus.
3. Data completeness requirements remain at 75% in 2025.
4. 1- point floors were implemented for 2024 benchmarks and remain in place for 2025 for large practices (greater than 15 providers). However, large practices can still get 0 points if they don't meet case minimum for a measure.
5. Many measures are topped out, capped at 7 points, and/or don't have a benchmark

2025 Policies & Changes

2025 MIPS performance category weights (same percentages as 2024)



2025 Policies

Scoring Scenarios & Reweights for PTs

If you are a **small practice** (defined by CMS as fewer than 15 providers), your Promoting Interoperability (PI) category will continue to be automatically reweighted for 2025: QPP Special Statuses (unless you waive that option).

If you are a large practice (greater than 15) and unable to report the PI category, you can apply for a PI hardship here

Small Practice

There are a number of special scoring scenarios that apply to small practices:

- You only need to perform and attest to one **improvement activity**, whether reporting traditional MIPS or a MIPS Value Pathway.
- You'll receive 6 bonus points in the **quality** performance category if you submit at least one quality measure. These bonus points are available in all 3 MIPS reporting options.
- You'll continue to receive 3 points (instead of zero) for **quality** measures that don't meet data completeness or case minimum requirements, or that can't be reliably scored against a benchmark. This applies to all 3 MIPS reporting options.
- You qualify for automatic reweighting of the **Promoting Interoperability** performance category to 0%. This automatic reweighting applies to all 3 MIPS reporting options. The performance category weight will be redistributed to other performance categories unless you choose to submit Promoting Interoperability data.
- You also qualify for a different redistribution policy when the Promoting Interoperability performance category is reweighted.

Apply for a MIPS Promoting Interoperability Hardship Exception

The MIPS Promoting Interoperability Performance Category Hardship Exception application for the 2025 performance period will be available in spring of 2025. The application deadline is **8 p.m. ET on December 31, 2025**. Clinicians, groups, and virtual groups may submit a MIPS Promoting Interoperability Performance Category Hardship Exception application whether reporting traditional MIPS, an MVP, or the APP.

- **This application isn't available to APM Entities.**

Hardship exceptions are available for the following specified reasons:

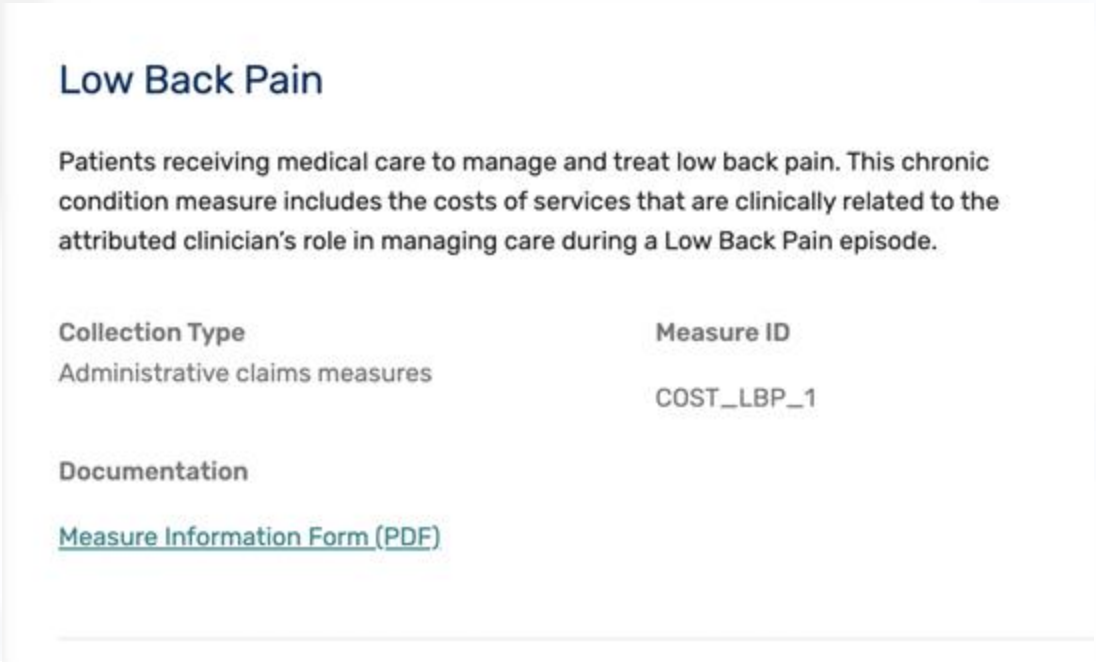
- You have decertified EHR technology (must be decertified under the Office of the National Coordinator for Health Information Technology's (ONC) Health IT Certification Program).
- You have insufficient internet connectivity.
- You face extreme and uncontrollable circumstances such as a disaster, practice closure, severe financial distress, or vendor issues.
- You lack control over the availability of CEHRT.

2025 Policies

Cost Category will apply for PTs!!!

Cost: Traditional MIPS Requirments

Cost is calculated BY CMS AFTER submissions are over during the summer. If you have at least 20 patients for the Low Back Pain Measure, cost will be calculated for your TIN



Low Back Pain

Patients receiving medical care to manage and treat low back pain. This chronic condition measure includes the costs of services that are clinically related to the attributed clinician's role in managing care during a Low Back Pain episode.

Collection Type
Administrative claims measures

Measure ID
COST_LBP_1

Documentation

Measure Information Form (PDF)

2025 Policies

Good News and a Success Tip:

Group AND Individual reporting: For group submissions, consider reporting as BOTH a group, AND report your very high scoring individuals as individuals too! CMS will take the higher of the two scores! Reach out to Patient360 if interested in this option and we will walk you through how to submit both ways in our platform.

Proactive Reporting

More Tips for Great MIPS Quality Scores in 2025:

1. Focus on the PT measures that OptimisPT has programmed for integration
2. Monitor performance in the Patient360 dashboard regularly and identify areas for improvement.
3. Make changes in clinical behavior & documentation to improve Quality Measure performance.
4. Be aware that measures 126, 127, 130, 134, 155, 182, & 226 are “topped out” and capped at 7 points.
5. Consider reporting the full set of PT specialty process measures in addition to reporting the MSK (formerly IROMS) measures- provides a good buffer

Proactive Reporting

Use the 2025 CMS Historical Benchmarks to strategize:

NOTE: practices with greater than 15 providers have a 1- point floor for all quality measures. Small practices still have a 3 point floor.

Use the QPP "Explore Measures" tool for 2025 to also select appropriate measures

Your Physical Therapy 2025 Measures

2025 Physical Therapy Specialty Measures Set:

MEASURE NAME	QUALITY ID	NQS DOMAIN	MEASURE TYPE	HIGH PRIORITY MEASURE
Urinary Incontinence: Assessment of Presence o	48	None	Process	FALSE
Urinary Incontinence: Plan of Care for Urinary In	50	None	Process	TRUE
Diabetes Mellitus: Diabetic Foot and Ankle Care	126	None	Process	FALSE
Diabetes Mellitus: Diabetic Foot and Ankle Care	127	None	Process	FALSE
Documentation of Current Medications in the M	130	None	Process	TRUE
Preventive Care and Screening: Screening for De	134	None	Process	FALSE
Falls: Plan of Care	155	None	Process	TRUE
Elder Maltreatment Screen and Follow-Up Plan	181	None	Process	TRUE
Functional Outcome Assessment	182	None	Process	TRUE
Functional Status Change for Patients with Knee	217	None	Patient Reported Outcome	TRUE
Functional Status Change for Patients with Hip I	218	None	Patient Reported Outcome	TRUE
Functional Status Change for Patients with Lowe	219	None	Patient Reported Outcome	TRUE
Functional Status Change for Patients with Low	220	None	Patient Reported Outcome	TRUE
Functional Status Change for Patients with Shou	221	None	Patient Reported Outcome	TRUE
Functional Status Change for Patients with Elbo	222	None	Patient Reported Outcome	TRUE
Preventive Care and Screening: Tobacco Use: Sc	226	None	Process	FALSE
Dementia: Cognitive Assessment	281	None	Process	FALSE
Dementia: Safety Concern Screening and Follow	286	None	Process	TRUE
Dementia: Education and Support of Caregivers	288	None	Process	TRUE
Assessment of Cognitive Impairment or Dysfunc	291	None	Process	FALSE
Falls: Screening for Future Fall Risk	318	None	Process	TRUE
Functional Status Change for Patients with Neck	478	None	Patient Reported Outcome	TRUE
Screening for Social Drivers of Health	487	None	Process	TRUE
Connection to Community Service Provider	498	None	Process	TRUE
Improvement or Maintenance of Functioning for	502	None	Patient Reported Outcome	TRUE
Gains in Patient Activation Measure (PAM) Score	503	None	Patient Reported Outcome	TRUE

QCDR Measures: Previously called IROMS, now called MSK

MSK1	Patients Suffering From a Neck Injury
MSK2	Patients Suffering From an Upper
MSK3	Patients Suffering From a Back Injury
MSK4	Patients Suffering From a Lower
MSK6	Patients Suffering From a Neck Injury
MSK7	Patients Suffering From an Upper
MSK8	Patients Suffering From a Back Injury
MSK9	Patients Suffering From a Lower
MSK5	Patients Suffering From a Knee Injury
MSK10	Patients Suffering From a Knee Injury

Your Physical Therapy 2025 Measures

2025 CMS Approved QCDRs

EAST TENNESSEE STATE UNIVERSITY | Limber

Advancing Musculoskeletal (MSK) Care and Rehabilitation QCDR »

View QCDR measures and specifications

EAST TENNESSEE STATE UNIVERSITY

Patient360 in collaboration with ETSU »

View QCDR measures and specifications

webpt

MSK and Rehabilitative Care Outcomes »

View QCDR measures and specifications

[2025 MSK (formerly IROMS) Measure Specifications]

Find your measures: [Here]

Harmonized MSK measure set (formerly IROMS) at-a-glance!

Instrument	MSK Measure ID	LMBR Measure ID	Keet Measure ID	Type	Description
NDI	MSK1	LMBR3	KEET01	Function	Patients Suffering From a Neck Injury who Improve Physical Fur
PROMIS PI					
QDASH	MSK2	LMBR5	IROMS19	Function	Patients Suffering From an Upper Extremity Injury who Improve
PROMIS UE					
MDQ	MSK3	LMBR2	IROMS17	Function	Patients Suffering From a Back Injury who Improve Physical Fur
PROMIS PI					
LEFS	MSK4	LMBR4	IROMS13	Function	Patients Suffering From a Lower Extremity Injury who Improve P
HOOS JR					
PROMIS PF					
KOS	MSK5	LMBR1	IROMS11	Function	Patients Suffering From a Knee Injury who Improve Physical Fur
KOOS JR					
PROMIS PF					
NPRS or NRS	MSK6	LMBR8	IROMS16	Pain	Patients Suffering From a Neck Injury who Improve Pain
NPRS or NRS	MSK7	LMBR10	IROMS20	Pain	Patients Suffering From an Upper Extremity Injury who Improve
NPRS or NRS	MSK8	LMBR7	IROMS18	Pain	Patients Suffering From a Back Injury who Improve Pain
NPRS or NRS	MSK9	LMBR9	IROMS14	Pain	Patients Suffering From a Lower Extremity Injury who Improve P
NPRS or NRS	MSK10	LMBR6	IROMS12	Pain	Patients Suffering From a Knee Injury who Improve Pain

How to Successfully Report MSK measures (IROMS)

- Understand denominator eligibility
- Report on ALL denominator eligible patients for each measure
- Report on at LEAST 75% numerator responses. This means you need to discharge at least 75% of your eligible patients prior to the end of the year (performance period ending December 31st, 2025) or determine if they are exclusions or exceptions. You cannot have more than 25% of your eligible patient population as "not reported."
- Denominator for ALL MSK measures:
    - The total number of all patients 18 years or older at the time of Initial Evaluation or start of care
    - with a [*specific body part**] injury
    - evaluated and treated by a PT, OT, or musculoskeletal provider or group

	**specific body part*
MSK1 & MSK6	neck
MSK2 & MSK7	upper extremity
MSK3 & MSK8	back
MSK4 & & MSK9	lower extremity
MSK5 & MSK10	knee

How to Successfully Report MSK measures (IROMS)

Remember, in 2025 REPORTING RATE can never be BELOW 75%. If you see too many of these toward the end of the year (last quarter), please discharge those patients:

MSK1	QCDR	Template	1	9	0	0	0	1	0.0%	0.0%	3.0
MSK10	QCDR	Template	53	12	0	1	4	48	9.43%	20.0%	3.0
MSK2	QCDR	Template	7	29	0	3	3	1	85.71%	50.0%	7.0
MSK3	QCDR	Template	4	31	0				100.0%	25.0%	7.0
MSK4	QCDR	Template	6	32	0				0.0%	0.0%	3.0
MSK5	QCDR	Template	7	31	0	1	2	4	42.86%	33.33%	3.0
MSK6	QCDR	Template	12	6	0	0	1	11	8.33%	0.0%	3.0
MSK7	QCDR	Template	52	23	0	6	8	38	26.92%	42.86%	3.0
MSK8	QCDR	Template	38	31	0	7	7	24	36.84%	50.0%	3.0
MSK9	QCDR	Template	47	27	0	2	4	41	12.77%	33.33%	3.0

Performance

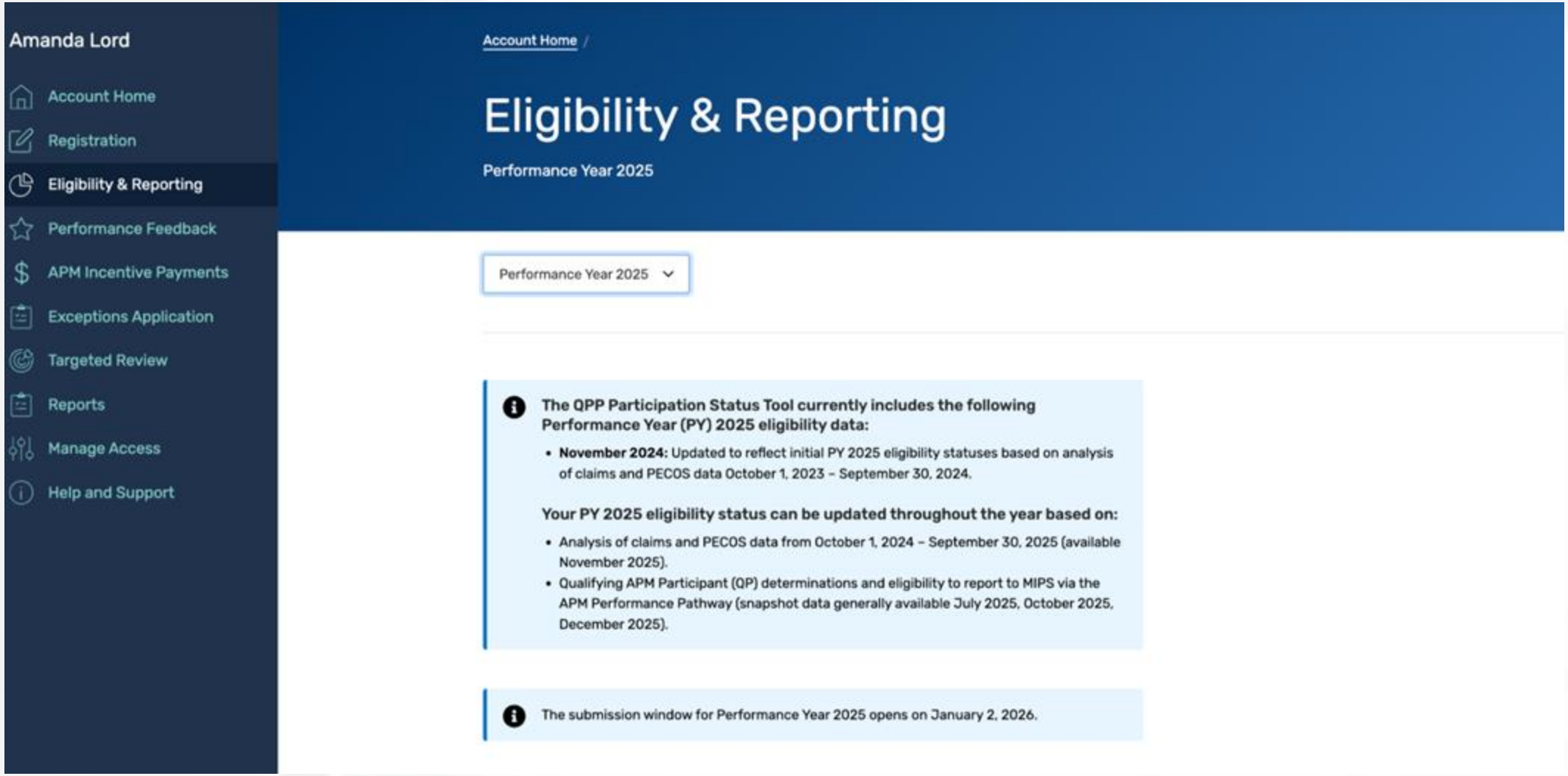
Not Reported

Workflow- Determine Eligibility

Determine your Eligibility by following these steps:

1. Log into https://qpp.cms.gov/login.
2. Choose Eligibility and Reporting on the left side navigation bar.
3. Choose View practice details & clinician eligibility link under your TIN for 2025.
4. Choose Download link under Connected Clinicians.
5. **Send the downloaded file to Patient360.**

Workflow- Determine Eligibility



Workflow- Getting Started w P360

1. Contract with Patient360.
2. Patient360 notifies OptimisPT.
3. OptimisPT begins pushing your quality measure data. If you sign up later than the beginning of the year, they will retroactively push your historical data from January 1st- present.
4. View and monitor your progress on the P360 dashboard early and often.
5. Discharge patients consistently throughout the year.

Note: The automation magic, or as we like to refer to it “automagic” doesn’t happen in a day. It takes some time for all the measures to be fully updated each year, validated, and then pushed over to P360.

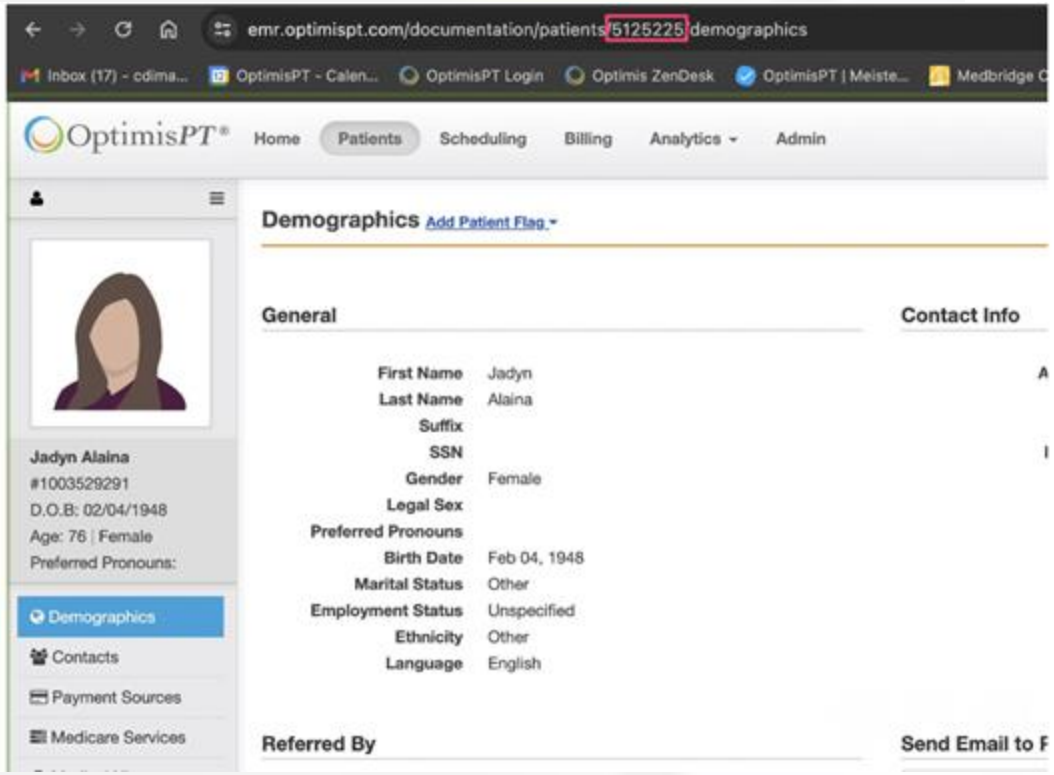
Measures in OptimisPT

OptimisPT has measure documentation requirements available for your practice

- Review which measures make the most sense for your practice to report.
- Review Measure Specifications in OptimisPT Manual (see resources page for link)
- How to do a patient lookup in OptimisPT if you need to go back in and review certain patients that are showing up in P360 as not met.

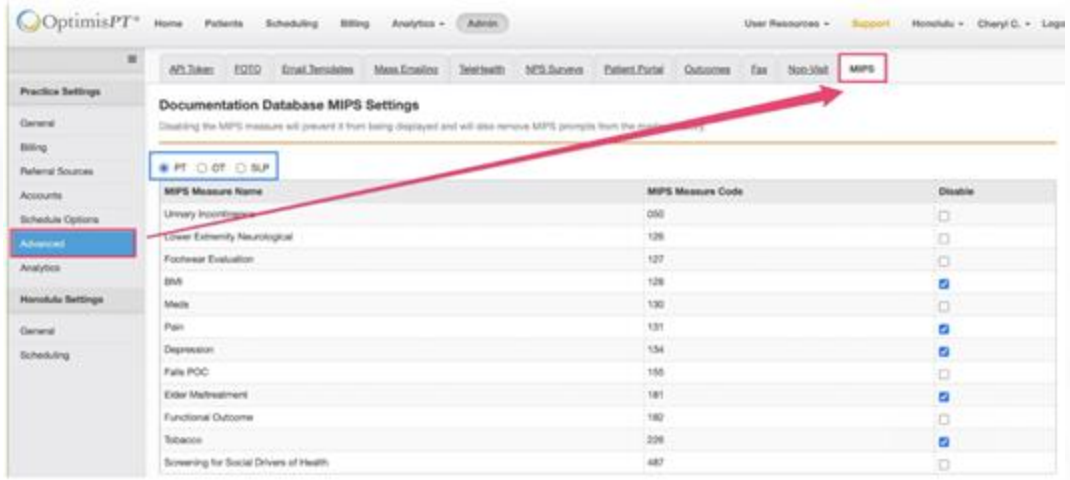
Patient Lookup in OptimisPT

The # in Patient360 is the Patient ID. You'll find it in the URL when you're in the demographics page. If you're in any patient chart, copy the Patient ID # from Patient360 and replace the number in the URL.



New Feature: *Each practice can choose the MIPS measures they want to focus on and hide the rest:*

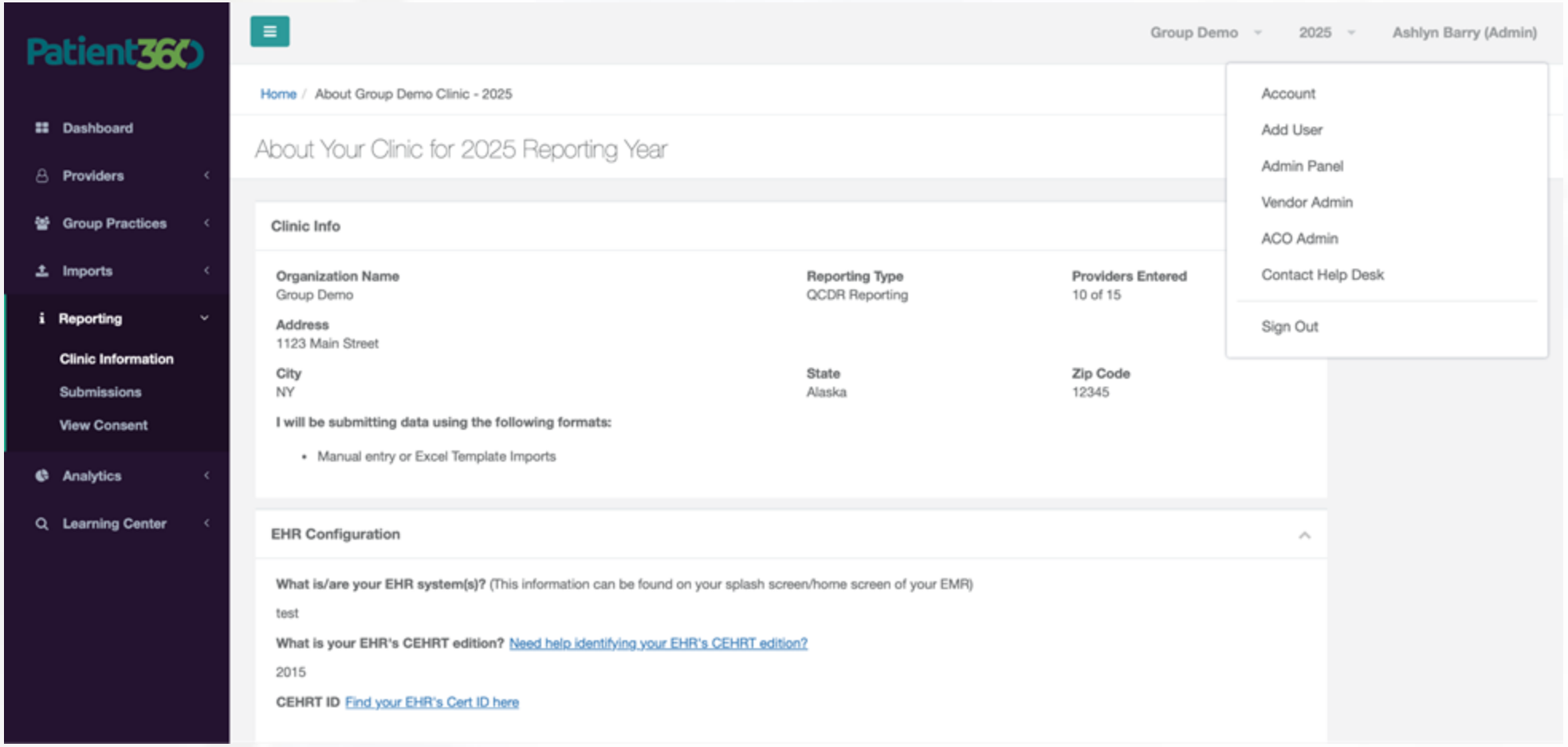
>> In the practice admin settings under "advanced," select the new MIPS tab to specify the measures for each discipline. Disable the ones you don't want to see.



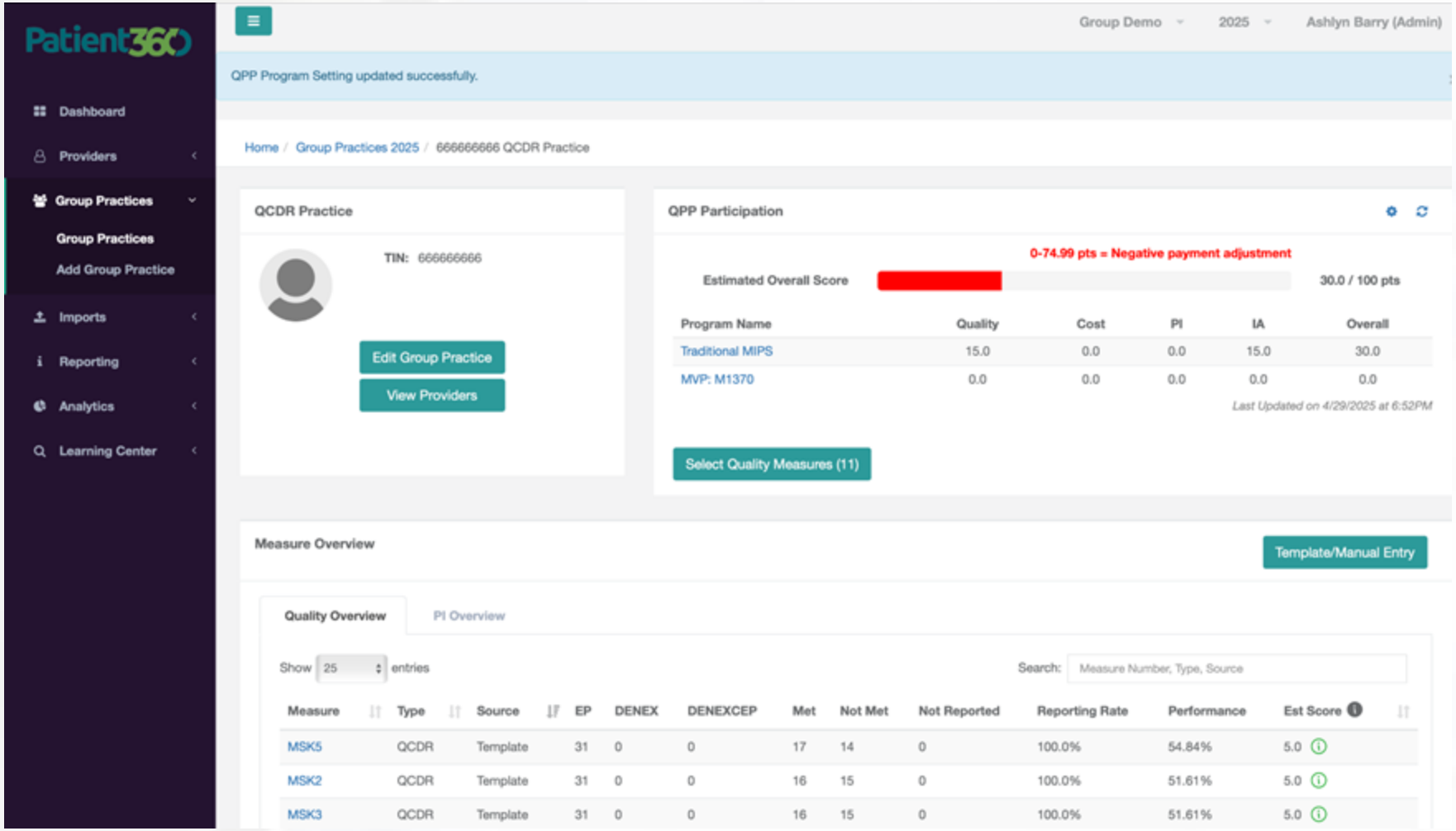
Demo

1. Clinic Information, main menu, setup, ticketing process
2. How and where to monitor your Quality data
3. How to make manual updates to your Quality data
4. How to select and attest to Improvement Activities (IAs)
5. Consent Agreements
6. Analytics tools

Demo- Clinic Info, Ticketing

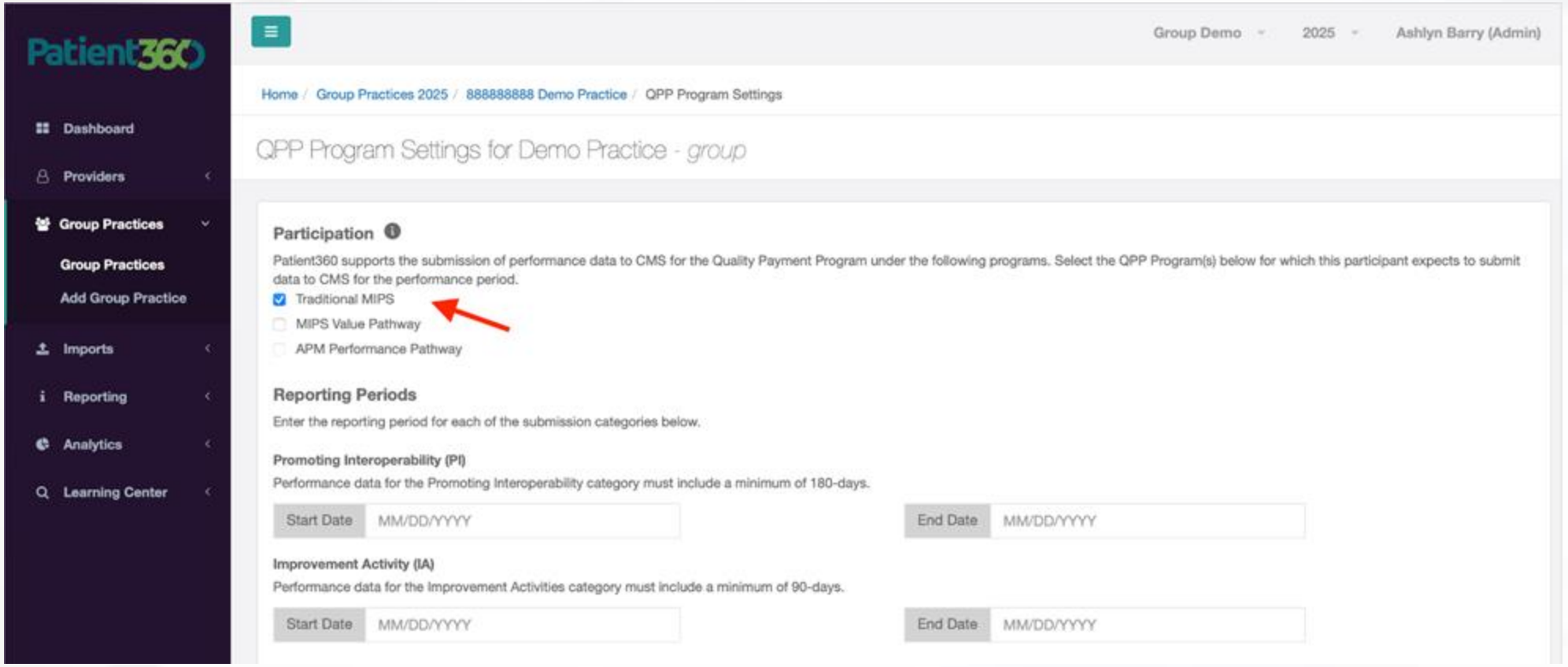


Demo



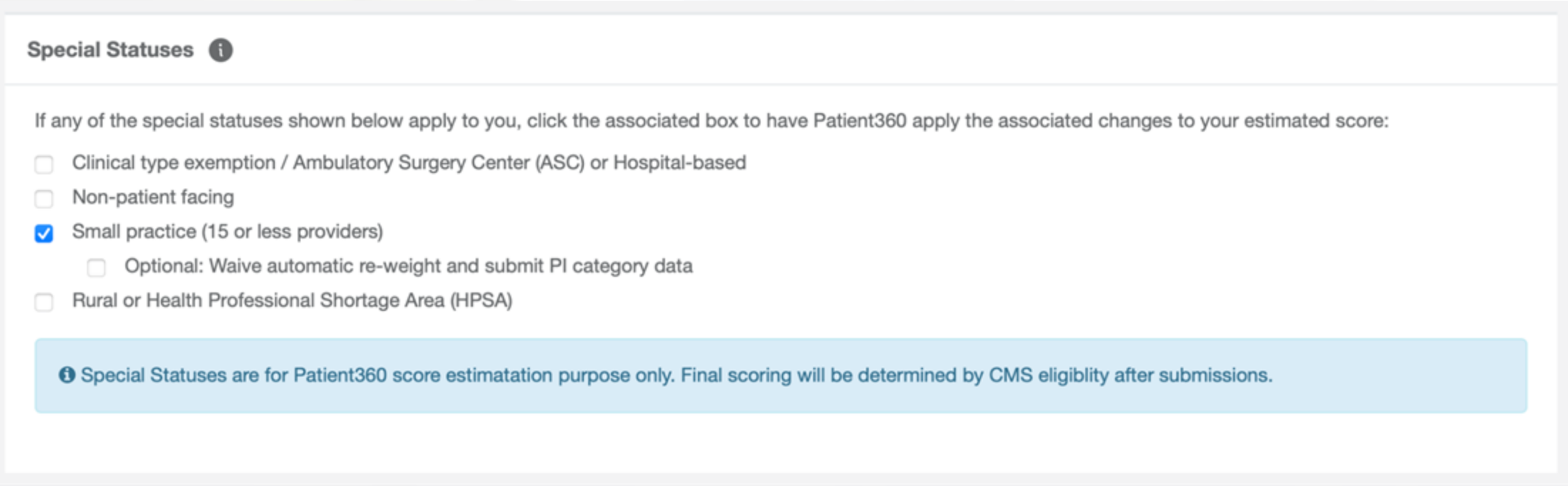
Selecting a Program

Select your QPP program by navigating to QPP Program Settings



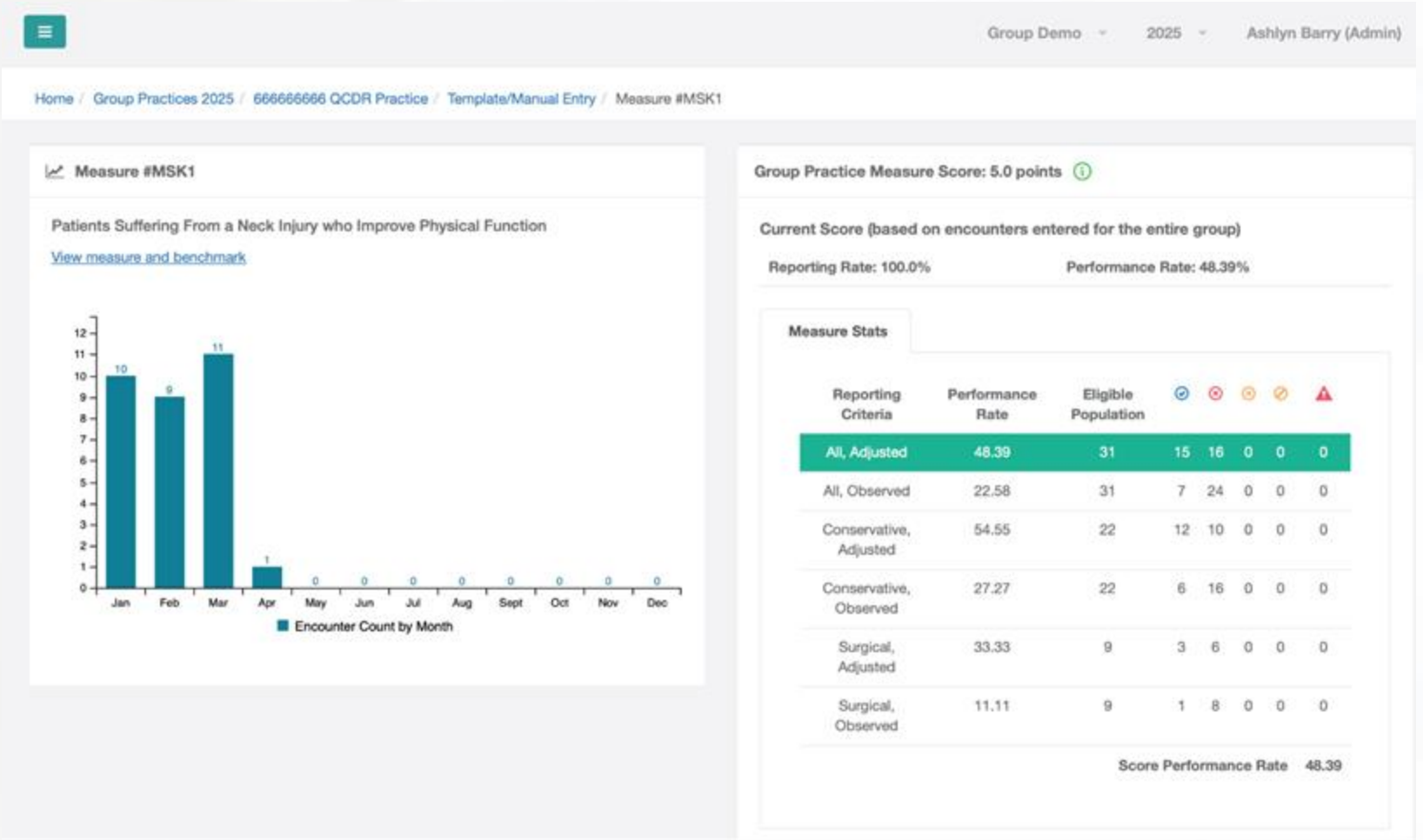
Special Statuses

Edit Clinic Information to check off the special status that applies to you.

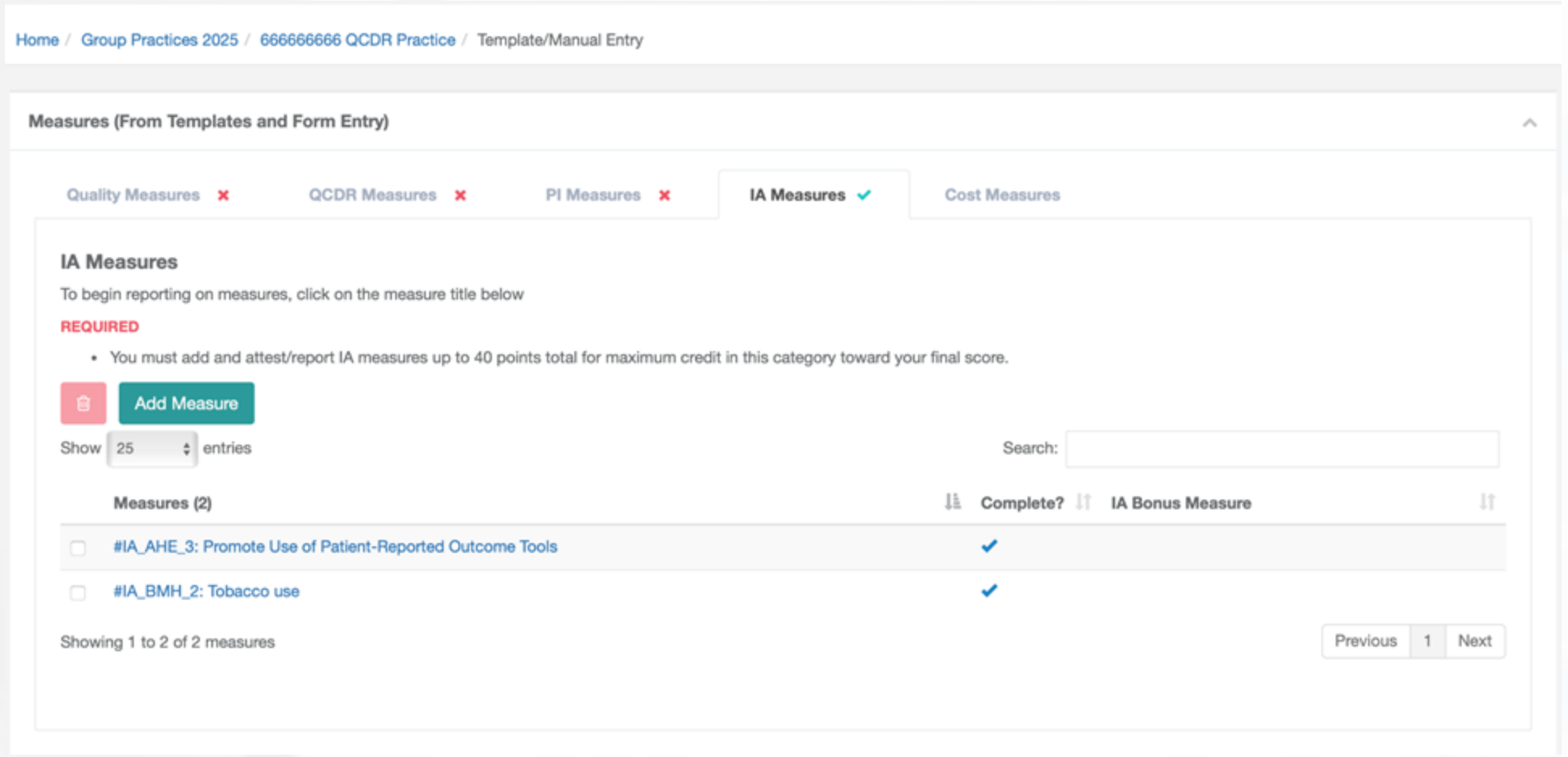


Checking off “Small Practice” will automatically remove the PI category from your estimated MIPS score unless you check off that you wish to waive the automatic PI re-weight and submit the PI category

Demo



Demo- IA category



Strategic Food For Thought:

Thinking about this in a budget neutral program. From CMS regarding payment adjustments in the past- direct quote from CMS:

"Given the relatively low performance threshold, the majority of negative MIPS payment adjustments to date have resulted from individually eligible clinicians who did not submit data.
· Under the automatic extreme and uncontrollable circumstances policy, we assigned these individual clinicians a neutral adjustment instead of the maximum negative payment adjustment.
· As a result, MIPS eligible clinicians with a final score between 30.01 – 74.99 points earned a 2021 payment adjustment of 0.00%.

· MIPS eligible clinicians with a final score above the performance threshold are eligible for an additional positive adjustment for exceptional performance. This additional positive payment adjustment is not subject to budget neutrality, **but we do apply a scaling factor to account for available funds. In 2019, clinicians with a final score above 75.00 points received a positive adjustment ranging from 0.09% to a maximum of 1.79%. For 2020, it was similar."**

*****In 2021, all groups who received a 100% performance rate received a bonus of +2.33%*****
*****In 2022, all groups who received a 100% performance rate received a bonus of +8.33%*****
*****In 2023, all groups who received a 100% performance rate received a bonus of +2.15%*****

Payment Adjustments

Where and how to view: Go to qpp.cms.gov. Log in and click on Performance Feedback in left menu.

How they are calculated: Payment Adjustment User Guide

2023 payment adjustments occur in 2025. 2024 payment adjustments occur in 2026. The payments are dispersed throughout the year.

The adjustment come back to you as the percentage earned per reimbursement. For examples, if you have one reimbursement at $100, then .06% of that $100 will be the incentive; if you get another reimbursement for $80, then .06% of that $80 will reimbursed, etc.

You can find the specific amount on any of the EOBs your practice receives this year. If you see the code “N807", that denotes it is a MIPS Payment Adjustment.

These will come on your EOBs. As stated above, “N807" shows it is for a MIPS adjustment. If you see the code “CARC 144", that means it is a positive adjustment. The incentive amount will be on each EOB with these two codes present.

Final Score	Payment Adjustment
0.00 – 18.75 points	-9% payment adjustment
18.76 – 74.99 points	Negative payment adjustment (greater than -9% and less than 0%)
75.00 points (Performance threshold)	Neutral payment adjustment (0%)
75.01 –100.00 points	Positive payment adjustment (scaling factor applied to meet statutory budget neutrality requirements)

Here in 2025, the performance threshold remains 75 points.

Payment Adjustments - In Real Life

Practice 1	Practice 2	Practice 3
150 Providers	25 Providers	5 Providers
$12,043,651 in Part B Claims in 2020	$2,672,866 in Part B Claims in 2020	$481,746 in Part B Claims in 2020
MIPS Impact = +/- **$240,873.00**	MIPS Impact = +/- **$53,457.00**	MIPS Impact = +/- **$9,634.00**

These figures are based on 2020 +/- 2% adjustment.

Payment Adjustments - In Real Life

Practice 1	Practice 2	Practice 3
150 Providers	25 Providers	5 Providers
$12,043,651 in Part B Claims in 2020	$2,672,866 in Part B Claims in 2020	$481,746 in Part B Claims in 2020
MIPS Impact = +/- **$1,083,928**	MIPS Impact = +/- **$240,557**	MIPS Impact = +/- **$43,357**

These figures are based on 2020 +/- 9% adjustment.

Data Submission Deadline **Feb 28, 2026**

All performance period data is due to be pushed to CMS 30 days prior to the CMS public deadline. This must always occur at the end of February. This is your contracted deadline with Patient360.

d) **Submission Format.** Customer must elect the desired submission format thirty (30) days prior to the Submission Deadline (Defined in this IV. (e)). Customer recognizes that modification of submission format after this time may result in failure to have requisite data received and approved by CMS. While Registry will work to amend changes taking place within thirty (30) days of the Submission Deadline, Customer recognizes such late notice may result in additional fees or a failed submission. As such, Customer releases Registry from liability and recognizes that paid fees are non-refundable regardless of data transfer mechanism/process selected by Customer.

e) **Submission Deadline.**

i) To meet requisite obligations for the Registry, Customer must upload/submit at least 50% of the reporting year's data by October 1st of the then current reporting year. Since CMS requires Registry to provide minimal interval reporting during the course of the reporting year, filing after this date mitigates Registry's ability to meet this federal obligation. Therefore, Customer's failure to meet this data submission deadline may result in additional fees or a failed submission. No refunds will be applied as a result of Customer's failure to meet this data submission deadline.

ii) Customer commits to meet the Submission Deadline (i.e., the date on which Registry requires all requisite data submitted). The Submission Deadline will be **thirty (30) days prior to the CMS official publicly posted deadline**) for the then current year, in accordance with the terms of this Agreement. Failure of the Customer to meet the Registry Submission Deadline, negates obligation of Registry to meet data submission requirements and the Customer agrees that any monies paid Registry are non-refundable; i.e., Customer recognizes failure to provide to the Registry requisite data by the Registry Submission Deadline is the sole responsibility of the Customer and Registry shall bear no financial or other responsibility and/or liability in this regard.

Thank You!

We are here to help. Connect with us now!

Amanda Lord Darbani

Patient360 COO, MIPS Subject Matter Expert

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Resources

Patient360 & OptimisPT Web Page: https://patient360.com/optimispt/

OptimisPT Support Page: For support, it's the orange button at the top, or:

support@optimispt.com

Quality Payment Program Page: qpp.cms.gov

Participation Lookup Page: qpp.cms.gov/participation-lookup

QPP Resource Library: qpp.cms.gov/about/resource-library

2025 Policies

COST category FAQs:

Is the cost comparison all of the expenses, from all of the providers, for a particular patient's episode of care?

CMS Answer * Cost comparison * The Low Back Pain cost measure represents how a MIPS eligible clinician performs relative to other MIPS clinicians managing and treating low back pain. The Low Back Pain measure includes the costs of services that are clinically related to the attributed clinician's role in managing care during a Low Back Pain episode. As such, the measure covers the costs of all clinically-related services regardless of which provider billed the service. Please refer to the full list of clinically-related services to Low Back Pain in the "Service_Assignment_AB" tab in the "2023-10-codes-list-low-back.xlsx" included in the 2024 Cost Measures Codes Lists (ZIP) <https://www.cms.gov/files/zip/2024-cost-measure-codes-list-zip.zip>. The measure calculation starts with a ratio of the actual ("observed") costs of these services occurring during each episode to the predicted (or > "expected") costs (as estimated through the risk adjustment model). That is, a ratio of observed over expected costs is calculated for each episode attributed to the clinician. The average episode cost ratio is then > calculated by taking the average of the observed over expected costs ratio across all of the episodes attributed to that clinician or group during the performance period (e.g., Calendar Year 2022). This ratio is multiplied by the national observed mean cost to generate a dollar figure for the cost measure score used in MIPS. More information on how scores for the Low Back Pain measure are calculated can be found in the "2023-06-methods-low-back" file included in the 2024 Cost Measure Information Forms (ZIP) <https://www.cms.gov/files/zip/2024-cost-measure-information-forms-zip.zip>.

2025 Policies

COST category FAQs:

PT has a triggering and re-affirming claim within 60 days which opens the 120 day attribution window. PT discharges patient. 90 days later patient sees MD and receives cortisone injection. Does that start the 120 window again even if PT never sees patient again?

CMS Answer: *Attribution window* The 120-day attribution window is the minimum time period used to calculate the measure score. The attribution window is only extended if a reaffirming service is billed during an open attribution window by the same clinician group that billed the trigger event to reaffirm that clinician group's responsibility for managing a patient's chronic condition. If a reaffirming service is provided 90 days after the trigger claim by the same clinician group, the attribution window is extended by an additional 120 days. The costs of any clinically related services provided during this extended attribution window will be included in the measure, regardless of which individual clinician provided the service. Please note that the measure will only be attributed to an individual clinician within the attributed clinician group if they billed at least 30% of the trigger or confirming codes on Part B Physician/Supplier claim lines during the episode. To review the full list of reaffirming services included in the measure, please refer to the "Service Assignment_AB" tab in the "2023-10-codes-list-low-back.xlsx" included in the 2024 Cost Measures Codes Lists (ZIP) > <https://www.cms.gov/files/zip/2024-cost-measure-codes-list-zip.zip>.

2025 Policies

COST category FAQs:

Where does information for subgroups, exclusions, and risk adjustment come from? PTs don't normally code those DGN. Will that be drawn from the other providers claims for the patient?

CMS Answer: *Codes included in the measure* The metrics for the Low Back Pain measure come from claims data from Medicare Parts A, B, and D that identify any clinically-related services provided to the patient during a given episode of care, regardless of which individual clinician billed the code. Similarly, other aspects of the measure, such as risk adjustment variables, sub-groups, and exclusion variables are constructed using Medicare claims data, not just codes billed by Physical Therapists.

In PT we often see patients for multiple complaints at once. If we are seeing patient for low back pain and shoulder pain, how are the costs related to the shoulder factored out of the cost measure? We aren't going to be forced to see the patient for low back pain one day and their shoulder a different day just to keep from being penalized on the cost measure, are we?

CMS Answer: *Service assignment* Clinically-related services are assigned to the Low Back Pain measure when also accompanied by a clinically-related diagnosis code. As such, the measure only accounts for costs of services billed with a diagnosis relevant to low back pain. To review the measure's service assignment rules, please refer to tab "Service_Assignment_AB" in the 2024 Cost Measure Codes Lists (ZIP) file. https://www.cms.gov/files/zip/2024-cost-measure-codes-list-zip.zip

2025 Policies

COST category FAQs:

Patient B DOS: 12/1/2023. Dx on claim form: M43.16 (low back) and M75.120 (shoulder) Charges: 97162 1 unit 97110 3 units 97140 1 unit The M43.16 and all of the CPT codes are triggering for Low Back Cost Measure. There is no way to split those on the claim as to which are for DX M43.16 and which are for M75.120. If the therapist was only treating M43.16 the charges may have just been 1 unit of 97110. Therefore, it will look like greater utilization of PT services because 2 conditions are being treated in 1 session unless there is a way this case is excluded because of the additional non-low back diagnosis. Please advise.

Example 2: If I'm billing for therEx and spent 15 min on the back and 30 on the shoulder, it combines 97110 to 3 units, but only 1 unit is specific to the low back, yet both diagnoses codes are attached to 97110. Does this mean Medicare is going to drill down the claim and see how much time for each unit is specific to the low back and calculate how much of 97110 will count toward the cost measure?

CMS Answer: You are correct in stating that the cost of physical therapy services for multiple diagnoses cannot be separately assessed within the same claim. In the scenario you described, the costs of the physical therapy services would be included in the measure calculation. Several aspects of measure construction mitigate the impact of such a scenario. First, the measure is risk adjusted to account for expected cost differences between patients with additional comorbidities and other patient-level factors. Second, measure excludes outlier cases, so episodes that are much costlier than expected will not be included in measure calculation. Third, the measure uses a 20-episode case minimum so any one episode is unlikely to significantly reduce overall measure performance. Additionally, the Low Back Pain measure includes many costs beyond physical therapy, including high cost services such as injections, imaging, and surgery; physical therapy costs are comparatively low cost and are less likely to independently drive poor measure performance.

2025 Policies

COST category FAQs:

What is the CMS stance on the fact that, all costs by all providers seeing that patient, are included in the cost of care? As admitted, the PT portion is such a small part of that, whether the PT manages the case well or not, will have minimal impact on the actual cost. So, PTs are totally at the mercy of the primary care and ortho docs' management of the case. How is this fair when assessing a MIPS score for a group of Physical Therapists submitting data? Please advise.

CMS Answer 6: The Low Back Pain measure was developed with the specific intent of including physical therapists in attribution, as physical therapists are an important part of the care team providing treatment and management for low back pain. The attribution logic, as well as the types of services assigned to the measure, were developed with a Clinician Expert Workgroup comprising several physical therapists including those with affiliations with the American Physical Therapy Association, along with many other specialists (e.g., neurosurgeons, chiropractors, occupational therapists). Additionally, CMS values stakeholder feedback and hosts several public comment opportunities for input on measure specifications for measures in development (such as national field testing periods), measures under consideration for use in programs (such as the Pre-Rulemaking Measure Review process and previously the Measure Applications Partnership), and the public comment periods associated with the notice-and-comment rulemaking process.

Regarding the costs included in the measure, not all services provided to a beneficiary are assigned to the episode. Instead, services are assigned following the service assignment rules outlined in the Measure Information Form and Measure Codes List. Costs of services are assigned to an episode only when clinically related to the low back pain care. These clinically-related services were determined with input by the Clinician Expert Workgroup as services where the attributed clinicians could reasonably influence the occurrence, frequency, and/or intensity. Like all MIPS cost measures, the Low Back Pain measure includes costs for clinically related services provided by the attributed provider and by other providers to capture a holistic picture of the episode costs. This also allows the measure to capture treatment costs, as well as costs of complications or consequences of care. Additionally, by assigning costs from other providers, the measure aims to encourage care coordination to improve the value of care provided to patients with low back pain.

For more information about the development of the Low Back Pain measure, we recommend taking a look at the following summaries of the Clinician Expert Workgroup meetings which are available on the CMS.gov QPP Cost Measures Information Page in the Prior Work section:

- **Summary of Wave 4 Workgroup Meetings**
- **Summary of Wave 4 Service Assignment & Refinement (SAR) Workgroup Meetings**
- **Summary of Wave 4 Post-Field Test Refinement (PFTR) Workgroup Meetings**