Official MIPS FAQ

1. **If patients that drop off don't count against us, how do they know they dropped off if we won't be reporting functional codes beginning in January?**

Functional Limitation Reporting as a program is being phased out by Medicare as of January 1st, 2019. Commercial insurances that adopted the program will need to be checked on individually. The MIPS program is entirely different than FLR. With MIPS, you are completing quality measures during evaluation and re-evaluation visits. The only time you are reporting on measures at discharge are with the FOTO-specific outcome measures. In these instances, if a patient were to not return for treatment, they would be considered a denominator exclusion and would not count against your score for that particular measure.

2. **What if the patient doesn't know the dosage of their medications? This happens a lot.**

According to the official measure specifications, "… the provider attests to having documented a list of current medications **utilizing all immediate resources available** at the time of the encounter." Our interpretation of this is that if you have exhausted all available resources to obtain the information, then you would have successfully completed the measure. If you do not know the dosage, we would recommend documenting that in the comments section and then asking the patient to follow up on that dosage during their next visit.

3. **Can we use FOTO for Outcome Assessment standardized tool?**

Yes. FOTO is an outcome tool that would serve as both a pain and outcome assessment. Make sure that the FOTO functional test within TheraOffice is linked to both pain and outcome, and it will work for both those measures.

4. **Will you ever be able to enter the patient's medications, and will that list carry over to a new case?**

Yes, but it requires copying the previous case's evaluation when you are creating the new evaluation for the new case. Doing so will copy the entire evaluation, including the medication list.

5. **How many measures do you have to report on for each patient?**

Should you decide to participate, there are four process measures to choose from along with Outcome measures that are applicable based on the body part of the injury. We recommend doing all four process measures for all patients, as well as the Outcome measures if you are utilizing FOTO's tests.

6. **Can old Eval/Re-Eval Codes (97001 & 97002) be deleted from TO so they are not accidently used?**

We will not be deleting these codes through the update, as they are still possibly linked within templates. However, the treatments section will continue to require an update to those codes utilizing the more specific evaluation complexity codes. You are welcome to updating your evaluation templates to include the updated code, though we recommend still reviewing the evaluations for complexity.

7. **Will the TO wizard allow us to select a few providers to require MIPS?**

If you are only selecting a few providers for enrollment into MIPS, documentation for all providers will be updated. The piece of the wizard that allows you to enforce a performance met requirement on all measures is one that would extend to all users, which means it would not work for Individual, select submission. In this case, these select providers would still receive a pop-up telling them of their performance on the measures, though they would not be required to meet the performance before locking.

8. **Is the BMI calculator using CDC guidelines?**

The BMI Calculator was created using the MIPS Quality Measure Specification documents. In these documents from CMS, the calculation and follow-up types are specifically outlined.

9. **So if we are only 4 physical therapists and 1 PTA, are we considered the special designation group for a small practice?**

Most likely, yes. A practice is considered "small" by Medicare if there are 15 or less NPIs linked to that TIN during the determination period. If you currently have 5 providers, but over the last year, have shifted in and out more than 15 NPIs, you would lose that small practice designation. To know whether or not you have this designation for certain, we recommend checking the participation lookup found here.

10. **How are we impacted if we bring in a PT without any MIPS history?**

PTs will bring their MIPS score and MIPS eligibility with them into the payment adjustment year. If you were to hire a PT in 2021, payments received towards that PT's service will be impacted by their MIPS score from 2019, even if it was with a different company. If they were required to participate in that year and did not, they will receive a penalty. If they were not required and did not participate in 2019, they will not receive any payment adjustment.

11. **I thought you were going to have a wizard that would tell us whether we needed to participate or could only opt-in?**

Yes, this is coming in the .11 update.

12. **Will the MIPS wizard allow us to lock an eval without info if the patient is under 18 years old?**

Yes. When locking a note, TheraOffice will determine if the patient would be included in the Denominator of the MIPS equation, which includes looking at the patient's age.

13. Will the FOTO questionnaire count as an assessment tool?

Yes. The standard FOTO tests look at functional outcome and pain, so therefore will count towards both of those quality measures.

14. **Will the FOTO outcome measures be included in the cost of the registry, or will we need to continue paying for FOTO as well?**

The cost of the TheraOffice registry is completely separate from any FOTO related costs. The TheraOffice registry is intended as a means of data submission to Medicare for the MIPS program. It is not intended in any way to replace FOTO's base offering.

15. Do I need FOTO to do the outcome measures at discharge?

The functional status change measures were stewarded by FOTO, and do require a risk adjusted outcome test to complete. The TheraOffice registry will be supporting these measures through the use of the FOTO test.

16. What happens if you don't have FOTO?

If you are not testing patients with a risk-adjusted outcome test, you will not be able to submit on the functional status measures. This won't prevent you from participating in the program, but it will constrain your success in the program, most likely preventing you from reaching the exceptional performance bonus threshold.

17. I keep clouding up mentally on the 10th visit rule and reevaluations. I thought that re-evals were only when there was a marked change in the patient's condition. I was under the thought process that you have to

report every tenth visit. If both are true, then you would need a reevaluation on the tenth visit whether or not there is a marked change in the patient's condition.

Always happy to help on this and it is a common misunderstanding. The difference has to do with progress reporting periods versus re-evaluations. There are 4 situations for submitting Functional Reporting Codes:

- Onset of Care (DOS for initial therapy service)
- At every progress reporting period (which is often confused with a progress note). This occurs at least once every 10 treatment days
- At the DOS that an evaluative or re-evaluative procedure code is submitted on the claim
- At the time of Discharge for the therapy episode (unless discharge data is unavailable)

Depending on practice policies, re-evaluations are typically only used to document a significant change to the plan of care, or when a more thorough assessment of the patient is needed. So more than likely you would be updating the FLR based on a progress reporting period, which would not have the re-evaluation codes. During progress reporting period the FLR code just needs to be submitted (reported) once every 10 treatment days. If that happens because of a re-evaluation was performed on that day or you just updated the FLR score you will meet the above criterion.

With the MIPS program, you will need to report on a few of the MIPS measures during re-evaluations, but never because you did a progress note.

18. **Do we need to have a written response to the VAS scale or can we just record what the patient verbally tells us?**

Recording what the patient said is fine.

19. **If our clinic does not qualify as mandatory reporting because of a low Medicare population, can we choose not to participate in 2019 but then change our mind and decide to participate in 2020?**

Every year of MIPS is separate from every other year. Deciding to participate or not for 2019 has no impact on your participation in 2020, other than the gained experience.

20. Patients seen for non-pain cases (Parkinson's; balance disorders; fall prevention) are considered "non-eligible" for pain documentation, right?

CMS defines “not eligible” for the pain assessment as one of the following two reasons: A) Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example, cases where pain cannot be accurately assessed through use of a national recognized standardized pain assessment tools OR B) Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient’s health status.

Given this definition, I would guess that your described scenario would not qualify as non-eligible. I highly recommend reaching out to CMS directly for verification.

21. If there is reporting required at the time of discharge, how do we handle patients who may be MIA (due to any number of reasons that may interrupt care)? Do we just rely on initial data, or make estimations based on the last visit seen?

The only reporting that is required at discharge is for the functional status outcome measures. In these instances, there is a denominator exception when the patient does not come back for their last visit.

22. Do we need documentation of actual nutrition or exercise counseling given if BMI is above normal?

You only need to document the type of follow-up recommendation given to the patient. Details of the recommendation are up to you. The example CMS gave was:

The documented follow-up plan must be based on the most recent documented BMI, outside of normal parameters, example: “Patient referred to nutrition counseling for BMI above or below normal parameters”.

The follow-up options available in the BMI section of TheraOffice Documentation match with the follow-up examples provided by CMS.

23. For the 4 quality measures, does all this have to be collected daily, like pain? How often does a therapist assistant have to input on the note?

All four are required when you submit an evaluation CPT code. Current Medications, Pain Assessment, and Outcome Assessment are also due when utilizing a re-evaluation CPT code.

24. Did you say that there is a flat fee of $299.00 for individual and group is custom if we go through your registry? What about claims, is there any cost for a small practice and does it include PTAs?

Yes, and those fees are one time for the 2019 reporting year. There are no costs to submitting through claims. This option is only available to small practices, so be careful not to submit through claims if you are above 15 providers. Also, we recommend going the registry path for everyone, as there are more controls to ensure your success in the program.

25. For those patients that will still be on PQRS and are still in care when MIPS is initiated, is there a process in place to convert existing patients to the MIPS program?

Only if the provider bills an evaluation or re-evaluation code for those patients. At that time, the measures would be required regardless of when they started treatment.

26. Have you calculated the breakeven point if one chooses to enter into the registry? I have a small private practice (less than 15 PT's). Not positive yet if any individual is required to be part of this program. If we voluntarily decide to report as a group, then I would have 5 PT's whose data would need to be submitted. (One only works 4 hours per week, so could I leave her out of the group?)

There are a lot of factors that go into figuring out whether or not the program is worth it for you to participate. Payer mix, average payment per visit for Medicare patients, whether or not you plan on submitting on the functional status measures, your success on the process measures, and the scoring thresholds that get set by the rest of the healthcare industry. A few good rules of thumb that I recommend:

- If any provider is considered to be required, you should participate in the program.
- If you are a FOTO user, you should participate in the program.
- If you are a small practice and previously found success with the PQRS program, you should consider participating.
- If you are over 40% Medicare payer mix, you should consider participating even if individually no one is required.

Also, if you need help in making the decision, we recommend reaching out to us for a consultation on where you currently stand and what your options are.

27. If using the override - how does that effect pnt inclusion in MIPS data? Is FOTO a separate service, are you recommending we purchase it for use in TheraOffice's registry?

The impact on patient inclusion depends on your override selection. Some of the options allow for a patient exclusion like "Pain assessment documented as positive, follow-up plan not documented, documentation the patient is not eligible at the time of the encounter." Some selections will flag you as performance not being met such as "No documented of pain assessment, reason not given."

Signing up with FOTO is not required to participate in the program, but it is definitely helpful in reaching the exceptional performance bonus threshold for MIPS. The purpose behind the MIPS program is to shift us to pay-for-performance, so naturally, use of an outcomes system lines up with the goals of that program. It is not required, but it definitely helps.

28. **We are a small practice with 6 providers. All therapists are eligible/required to do MIPS, so we need to participate as a group. However, we treat a good percentage of Medicaid patients where we get paid a very little amount. I wonder what we should choose – claims-based reporting or registry-based and for all insurances or Medicare only?**

If you are submitting through the TheraOffice registry, you will have the option of reporting as a group or as individuals. Basically, should everyone be scored together or separately.

The largest benefit to submitting through claims is that you only have to do the measures on Medicare patients. That being said, this can also be considered a negative. Given the scoring methodology of the measures, you really do not want to miss out on a single patient. If you are filtering your actions based on the patient's insurance, there is the additional opportunity where that Medicare insurance isn't entered into TheraOffice before the evaluation, and the required measures getting missed because of this. If you are going to be doing claims-based submission, we recommend making sure insurance entry is managed carefully.

29. **The idea of submitting via registry versus claims is a new concept to us. If we are using a "Free Claims" service currently are we submitting via claims? Will MIPS information be collected and reported on claims automatically? Will MIPS data be printed on our reports as in IE, re-eval, etc? Where is the information located for the "Registry"?**

When a note is locked, charges are automatically sent over to the Accounting module, and then batched for claim submission. It is during this note locking that we will also be sending over the MIPS charges, so they are included on the claim. If you chose the registry option in the MIPS wizard, we will instead send those MIPS charges into a separate table where they will be stored until our registry picks them up.

30. What if someone starts with claims-based MIPS reporting and later switches to registry based?

You can submit using multiple methods. When it comes time for CMS to score your TIN/NPI, they will take the best scoring between the submission methods. That being said, for consistency sake, we do not recommend shifting between claims and registry in the middle of a reporting year.