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Effective April 1, 2011, the Centers for Medicare & Medicaid Services (CMS) expects home health agencies and hospices have fully established internal processes to comply with the face-to-face encounter requirements mandated by the Affordable Care Act (ACA) for purposes of certification of a patient's eligibility for Medicare home health services and of recertification for Medicare hospice services. CMS will continue to address industry questions concerning the new requirements, and will update information at http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html on the CMS website.

MLN Matters® Number: MM7050
Related Change Request (CR) #: 7050
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Effective Date: January 1, 2011
Related CR Transmittal #: R826OTN
Implementation Date: January 3, 2011

Multiple Procedure Payment Reduction (MPPR) for Selected Therapy Services

Note: This article was revised on July 6, 2013, to add a reference to MLN Matters® article MM8278 (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8278.pdf), which announced that CR8278 revises the amount applied toward a beneficiary's therapy cap amounts when the therapy services are provided in a CAH. The stated requirements ensure that the MPPR is applied to these amounts. All other information remains unchanged.

Provider Types Affected

Physicians, non-physician practitioners, and providers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs) for therapy services provided to Medicare beneficiaries that are paid under the Medicare Physician Fee Schedule (MPFS).

Provider Action Needed

This article is based on Change Request (CR) 7050, which announces that Medicare is applying a new Multiple Procedure Payment Reduction (MPPR) to the Practice Expense (PE) component of payment of select therapy services paid

under the MPFS. Make sure your billing staff is aware of these payment reductions.

Background

Section 3134 of The Affordable Care Act added section 1848(c)(2)(K) of The Social Security Act, which specifies that the Secretary of Health and Human Services shall identify potentially misvalued codes by examining multiple codes that are frequently billed in conjunction with furnishing a single service. As a step in implementing this provision, Medicare is applying a new MPPR to the PE component of payment of select therapy services paid under the MPFS. The reduction will be similar to that currently applied to multiple surgical procedures and to diagnostic imaging procedures. This policy is discussed in the CY 2011 MPFS final rule.

Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The Centers for Medicare & Medicaid Services (CMS) is applying a MPPR to the practice expense payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Full payment is made for the unit or procedure with the highest PE payment. For subsequent units and procedures, furnished to the same patient on the same day, full payment is made for work and malpractice and 80 percent payment for the PE for services furnished in office settings and other non-institutional settings and at 75 percent payment for the PE services furnished in institutional settings.

For therapy services furnished by a group practice or "incident to" a physician's service, the MPPR applies to all services furnished to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines; for example, physical therapy, occupational therapy, or speech-language pathology.

The reduction applies to the HCPCS codes contained on the list of "always therapy" services that are paid under the MPFS, regardless of the type of provider or supplier that furnishes the services (e.g. hospitals, Home Health Agencies (HHAs), and Comprehensive Outpatient Rehabilitation Facilities (CORFs), etc.). The MPPR applies to the codes on the list of procedures included with CR7050 as Attachment 1. CR7050 is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R826OTN.pdf on the CMS website. Note that these services are paid with a non-facility PE. The current and proposed payments are summarized below in the following example based on the 75 percent reduction for institutional settings:

	Procedure 1 Unit 1	Procedure 1 Unit 2	Procedure 2	Current Total Payment	Proposed Total Payment	Proposed Payment Calculation
Work	$7.00	$7.00	$11.00	$25.00	$25.00	no reduction
PE	$10.00	$10.00	$8.00	$28.00	$23.50	$10 + (.75 x $10) + (.75 x $8)
Malpractice	$1.00	$1.00	$1.00	$3.00	$3.00	no reduction
Total	$18.00	$18.00	$20.00	$56.00	$51.50	$18 + ($18-$10) + (.75 x $10) +($20-$8) + (.75 x $8)

Where claims are impacted by the MPPR, Medicare will return a Claim Adjustment Reason Code of 45 (Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement) and a Group Code of Contractual Obligation (CO).

Additional Information

The official instruction, CR7050, issued to your carrier, FI, or A/B MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R826OTN.pdf on the CMS website. If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

You may want to review MM7564, which advises providers that CARC 59 (processed based on multiple or concurrent procedure rules) will replace CARC 45 to indicate that the claim payment is subject to the MPPR.

You may want to review MM8036 (http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM8206.pdf) which alerts providers that all requests for therapy services above $3,700 provided by speech language therapists, physical therapists, occupational therapists, and physicians must be approved in advance. This applies to: Part B Skilled Nursing Facilities, Comprehensive Outpatient Rehabilitation Facilities, rehabilitation agencies (Outpatient Rehabilitation Facilities (ORFs), private practices, home health agencies (TOB 34X), and hospital outpatient departments.

You may want to review MM8206 (http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM8206.pdf), which alerts providers that, effective April 1, 2013, Section 633 of the American Taxpayers Relief Act of 2012 revised the MPPR on selected therapy services to 50 percent for all settings.