

## Multiple Procedure Payment Reduction (MPPR) for Therapy Services Policy, Professional

### **IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY**

This policy is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage reimbursement policies use Current Procedural Terminology (CPT®\*), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms (CMS 1450). Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general resource regarding UnitedHealthcare's Medicare Advantage reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Medicare Advantage may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Medicare Advantage enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, and/or the enrollee's benefit coverage documents\*\*. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Medicare Advantage due to programming or other constraints; however, UnitedHealthcare Medicare Advantage strives to minimize these variations.

UnitedHealthcare Medicare Advantage may modify this reimbursement policy at any time to comply with changes in CMS policy and other national standard coding guidelines by publishing a new version of the reimbursement policy on this website. However, the information presented in this reimbursement policy is accurate and current as of the date of publication. UnitedHealthcare Medicare Advantage encourages physicians and other health care professionals to keep current with any CMS policy changes and/or billing requirements by referring to the CMS or your local carrier website regularly. Physicians and other health care professionals can sign up for regular distributions for policy or regulatory changes directly from CMS and/or your local carrier. UnitedHealthcare's Medicare Advantage reimbursement policies do not include notations regarding prior authorization requirements.

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*\*\* For more information on a specific enrollee's benefit coverage, please call the customer service number on the back of the member ID card.*

### **Application**

This reimbursement policy applies to services reported using the 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

### **Policy**

#### **Overview**

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.

The Act states that the MPPR applies to services identified as “always” therapy and applies to the second and subsequent therapy services furnished by a single provider to a beneficiary on a single date of service. This policy will apply to all outpatient therapy services paid under Part B, including those furnished in office and facility settings.

### Reimbursement Guidelines

As a step in implementing this provision, Medicare is applying a new MPPR to the Practice Expense (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. In compliance with CMS, UnitedHealthcare Medicare Advantage is applying a MPPR to the PE 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 at 50 percent payment for the PE for services furnished in both office settings and 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 Healthcare Common Procedure Coding System (HCPCS) codes contained on the list of “always therapy” services that are paid under the physician fee schedule, 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.)

- **For professional claims**, the MPPR applies to the procedures with a Multiple Procedure value of “5” on the Medicare Fee Schedule Database (MFSDB).

When applying the 50 percent reduction in non-facility PE Relative Value Units (RVUs), UnitedHealthcare Medicare Advantage will use the fee schedule amounts.

In addition, UnitedHealthcare Medicare Advantage will retrieve the non-facility PE RVUs from the physician fee schedule database in order to rank services according to non-facility PE RVU and appropriately apply the MPPR methodology.

When the highest non-facility PE RVU applies to more than one of the identified services, UnitedHealthcare Medicare Advantage will additionally sort and rank these services according to highest fee schedule amount, with the highest of these being priced at 100 percent of the non-facility PE RVU, and the others priced at 50 percent of the non-facility PE RVU for professional claims.

The following UnitedHealthcare Medicare Advantage reimbursement guidelines will apply to the MPPR for Therapy Services Policy:

- The multiple procedure value of “5,” the beneficiary’s health insurance claim number (HIC), the billing provider National Provider Identifier (NPI) tax identification number (TIN) and date of service to identify therapy services subject to the MPPR.
- The MPPR will apply to claims for two or more services identified by the multiple procedure value of 5, for the same beneficiary HIC, same billing provider NPI (TIN) and same date of service
- The services will be sorted according to the highest non-facility PE RVU amount such that the service with the highest non-facility PE RVU is ranked first.
- In performing the sort, consideration for both non-facility PE RVUs for units for procedures billed in multiple time units, and non-facility PE RVUs for procedures not billed based on time, including both in the ranking such that the highest ranked non-facility PE RVU could be either that for a single time unit of a service or a non-time based service for a beneficiary receiving both types of services on a given date of service through the same billing provider.
- If the sort results in the highest ranked non-facility PE RVU applying to two or more services, then these highest non-

facility PE RVU services will additionally be sorted according to highest total fee schedule non facility amount, with the service with the highest fee schedule amount ranked first.

- In performing the additional sort according to the full fee schedule amount, the full fee schedule amount applicable to 1 unit for those services billed in units will be utilized.
- When the service ranked highest according to the sorts is billed in units, and multiple units were reported, the first unit will be ranked as that having the highest non-facility PE RVU.
- Reimbursement for the lower of the billed or total fee schedule amount for the service ranked highest according to the sorts described above.
- Reimbursement for the lower of the billed or the amount in field 31EE (Reduced Therapy Fee Schedule Amount) for those services ranked below the first ranked service identified through the sorts described above.
- The current CMS RVU values will be utilized to administer this policy for claims submitted with a date of service on or after March 1, 2012. These values will be reviewed and updated quarterly to align with CMS when changes are needed.
- The MPPR methodology will be applied as described above to therapy services meeting all of the criteria described in this policy, but billed on different days (i.e., coming in on separate claims for the same beneficiary HIC, billing provider NPI (TIN) and date of service).

### Definitions

Allowable Amount	The dollar amount eligible for reimbursement to the physician or health care professional on the claim. Contracted rate, reasonable charge, or billed charges are examples of allowable amounts. For percent of charge or discount contracts, the allowable amount is determined as the billed amount, less the discount.
Practice Expense Relative Value Units (PE RVU)	The portion of the Total Relative Value Units assigned to a particular CPT or HCPCS code for maintaining a practice, including rent, equipment, supplies and nonphysician staff costs.
Same Individual Physician or Other Health Care Professional	The same individual rendering health care services reporting the same Federal Tax Identification number
Total Relative Value Units, Total RVU	The assigned unit value of a particular CPT or HCPCS code that consists of the sum of the Work Relative Value Units, the Practice Expense Relative Value Units and the Malpractice Relative Value Units.

### Questions and Answers

1	<p><b>Q:</b> How is the PE portion of a service determined?</p> <p><b>A:</b> The PE portion of a service is determined by calculating the ratio of PE RVU to Total RVU. This ratio is applied to the Allowable Amount of each charge to determine the PE portion in dollars.</p>
2	<p><b>Q:</b> If a provider group includes several specialty providers (physical, occupational, speech-language therapists), how will their services provided to a single patient on a single date of service be reduced?</p> <p><b>A:</b> All Multiple Therapy Reducible Codes reported for a single patient on a single date of service by all providers sharing the same TIN are considered reported by the Same Group Physician and/or Other Health Care Professional and will be viewed together for ranking and reduction purposes. The single code with the highest PE RVU will be ranked primary and will not be reduced. All remaining codes subject to this policy from all other providers in the same group, regardless of specialty, will be ranked as secondary, tertiary and so on and the PE portion of those services will be reduced by the appropriate percentage, depending on the date the service was performed. See the Reimbursement section for information about reduction percentages.</p>
3	<p><b>Q:</b> Other Physical Medicine &amp; Rehabilitation policies allow the reporting of timed codes with modifiers GO, GN or GP to distinguish the type of specialty provider who is performing services. Should these modifiers still be reported when they apply?</p> <p><b>A:</b> Yes. Continue to report modifiers that are appropriate and that communicate information that may be used in</p>

	policies other than this one. The use of these distinguishing modifiers will not exempt reducible codes from multiple therapy reduction when reported by the Same Group Physician and/or Other Health Care Professional for the same member on the same day. However, claims are edited against all applicable policies, so the modifiers should be reported when appropriate to ensure accurate reimbursement under policies other than Multiple Therapy Reduction.
4	<p><b>Q:</b> If a single provider group with the same TIN reports several Multiple Therapy Reducible Codes on a single date of service on separate claims at different times, how will these codes be reimbursed?</p> <p><b>A:</b> The claims editing system reviews all codes for a single date of service as if they were reported on a single claim, regardless of when they are reported. When codes for services provided to a single patient on a single date of service that are subject to multiple therapy reduction are submitted on different claims at different times, adjustments will be made to ensure that the code with the highest PE RVU is considered primary (that is, not subject to reduction) and that the remaining codes are correctly ranked and reduced.</p>
5	<p><b>Q:</b> If several Multiple Therapy Reducible Codes that share the same PE RVU are reported on the same date of service, how are they ranked?</p> <p><b>A:</b> If the sort results in the highest ranked non-facility PE RVU applying to two or more services, then these highest non-facility PE RVU services will additionally be sorted according to highest total fee schedule non facility amount, with the service with the highest fee schedule amount ranked first.</p>
6	<p><b>Q:</b> Will all services provided on the same date as Multiple Therapy Reducible Codes be reduced?</p> <p><b>A:</b> No. The only services that are subject to this policy are those on the Multiple Therapy Reducible Codes list. However, all codes reported on the same date of service, both reducible and non-reducible, will be subject to all other reimbursement policies that apply.</p>

<b>Codes</b>	
<b>CPT code section</b>	
<a href="#">National Physician Fee Schedule Relative Value File</a>	

<b>Resources</b>	
<a href="http://www.cms.gov">www.cms.gov</a>	
Centers for Medicare and Medicaid Services, National Physician Fee Schedule (NPF) Relative Value Files	

<b>History</b>	
03/01/2020	Annual Policy Review <ul style="list-style-type: none"> <li>Policy number changed from 2019R9022A to 2020R9022A</li> </ul>
3/1/2019	Annual Anniversary Date and Version Change Archived history prior to 3/1/2017
9/4/2018	Policy Version Change Policy number changed from 2018R0121A to 2018R9022A Added the word 'Professional' to the policy title
3/14/2018	Annual Policy (Version Change) Q&As & Definitions inserted Policy Reimbursement Overview & Guidelines Section: Verbiage updated Preamble Updated
3/8/2017	Policy Approval Date Change (no new version)



UnitedHealthcare® Medicare Advantage  
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