CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2328	**Date: October 27, 2011**
	Change Request 7564

SUBJECT: Claim Adjustment Reason Code (CARC) Used for Therapy Claims Subject to the Multiple Procedure Payment Reduction

I. SUMMARY OF CHANGES: This Change Request revises the remittance advice coding used when claim payments are subject to a multiple procedure payment reduction. The new code will make payment adjustments more easily recognized by providers on their remittance advices.

EFFECTIVE DATE: January 1, 2011
IMPLEMENTATION DATE: April 2, 2012

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	5/Table of Contents
N	5/10.6/Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Business Requirements
Manual Instruction
**Unless otherwise specified, the effective date is the date of service.*

Attachment – Business Requirements

Pub. 100-04	Transmittal: 2328	Date: October 27, 2011	Change Request: 7564

SUBJECT: Claim Adjustment Reason Code (CARC) Used for Therapy Claims Subject to the Multiple Procedure Payment Reduction

Effective Date: **January 1, 2011**
Implementation Date: April 2, 2012

I. GENERAL INFORMATION

A. Background: The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 7050, "Multiple Procedure Payment Reduction (MPPR) for Selected Therapy Services," on December 21, 2010. CR 7050 implemented a MPPR to the practice expense (PE) payment of select therapy services paid under the Medicare physician fee schedule.

This CR instructed contractors to use Claim Adjustment Reason Code (CARC 45), which is defined "Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement" for service lines for which the MPPR policy applied. However, CMS learned that this CARC message also appears for other reductions. This means that, if both MPPR and another reduction apply to the same line item, then CARC 45 would not distinguish the line item as subject to the MPPR.

This would make it more difficult for Medicare providers to understand the payments reflected on their remittance advices. To correct this, contractors shall instead use CARC 59, which is defined "Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia)" to identify service lines affected by the MPPR. When processing professional claims affected by the MPPR, Medicare contractors could change the CARC code locally and contractors were instructed to do so via a Technical Direction Letter. For institutional claims, this change required a modification to the Fiscal Intermediary Shared System (FISS), which is described by the requirement below.

B. Policy: This CR contains no new policy. The requirements improve the implementation of the MPPR for therapy services. The CR also updates the Medicare Claims Processing Manual to reflect CR 7050. Other than the CARC change described here, the instructions in CR 7050 remain in effect for all contractors.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7564.1	Contractors shall use the following CARC on the remittance advice for service lines for which they have applied the MPPR reduction described in CR 7050: 59 Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)	X		X		X	X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7564.2	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X		X					

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

X-Ref Requirement Number	Recommendations or other supporting information:
	None

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Wil Gehne, 410-786-6148, wilfried.gehne@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs)*:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Claims Processing Manual
Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services

Table of Contents
(Rev.2328, 10-27-11)

10.6 - Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services

(Rev. 2328, Issued: 10-27-11, Effective:01-01-11, Implementation: 04-02-12)

Medicare applies a multiple procedure payment reduction (MPPR) to the practice expense (PE) payment of select therapy services. The reduction applies to the HCPCS codes contained on the list of "always therapy" services (see section 20), excluding carrier-priced, bundled and add-on codes, regardless of the type of provider or supplier that furnishes the services.

Medicare applies 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. Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The MPPR applies to all therapy 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.

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 is made for the PE for services submitted on professional claims (any claim submitted using the 837 Professional electronic format or the CMS-1500 paper claim form) and 75 percent payment is made for the PE for services submitted on institutional claims (any claim submitted using the 837 Institutional electronic format or the UB-04 paper claim form).

To determine which services will receive the MPPR, contractors shall rank services according to the applicable PE relative value units (RVU) and price the service with the highest PE RVU at 100% and apply the appropriate MPPR to the remaining services. When the highest PE RVU applies to more than one of the identified services, contractors shall additionally sort and rank these services according to highest total fee schedule amount, and price the service with the highest total fee schedule amount at 100% and apply the appropriate MPPR to the remaining services.

The full fee schedule payments and the MPPR payments are summarized below in the following example for services on in an institutional claim (Note: on professional claims, the reduction percentage is 20 percent).

	Procedure 1 Unit 1	***Procedure 1 Unit 2***	***Procedure 2***	***Full MPFS Payment***	***MPPR 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) + (.5 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)*

The therapy payment amount that has been reduced by the MPPR is applied toward the therapy caps described in section 10.2. As a result, the MPPR may increase the amount of medically necessary therapy services a beneficiary may receive before exceeding the caps. The reduced amount is also used to calculate the beneficiary's coinsurance and deductible amounts.

Contractors indicate services have been subject to the MPPR using the following coding on the provider's remittance advice:

- *Group code CO and*
- *Claim adjustment reason code 59 - Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)*

Contractors shall use the following message on Medicare Summary Notices for claims subject to the MPPR:

- *30.1 The approved amount is based on a special payment method, or*
- *30.1 La cantidad aprobada está basada en un método especial de pago.*