CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 826	**Date: December 21, 2010**
	Change Request 7050

NOTE: Transmittal 800, dated November 3, 2010 is being rescinded and replaced by Transmittal 826, dated December 21, 2010, due to changes in the policy made by the Physician Payment and Therapy Relief Act of 2010. The reduction has been changed from 25 percent to 20 percent for therapy services furnished in office and other non-institutional settings. The reduction percentage remains at 25 percent for therapy services furnished in institutional settings. All other information remains the same.

SUBJECT: Multiple Procedure Payment Reduction (MPPR) for Selected Therapy Services

I. SUMMARY OF CHANGES: Section 3134 of the Affordable Care Act (ACA) added section 1848(c)(2)(K) of the Social Security Act which specifies that the Secretary 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 multiple procedure payment reduction (MPPR) to the practice expense (PE) payment of select therapy services paid under the physician fee schedule. 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 physician fee schedule proposed rule published on July 13, 2010. This advance notice is provided so contractors can begin making the necessary systems changes for the policy to go in effect January 1, 2011.

EFFECTIVE DATE: January 1, 2011
IMPLEMENTATION DATE: January 3, 2011

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
N/A	

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
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:

One-Time Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 826	Date: December 21, 2010	Change Request: 7050

NOTE: Transmittal 800, dated November 3, 2010 is being rescinded and replaced by Transmittal 826, date December 21, 2010 g, due to changes in the policy made by the Physician Payment and Therapy Relief Act of 2010. The reduction has been changed from 25 percent to 20 percent for therapy services furnished in office and other non-institutional settings. The reduction percentage remains at 25 percent for therapy services furnished in institutional settings. All other information remains the same.

SUBJECT: Multiple Procedure Payment Reduction (MPPR) for Selected Therapy Services

Effective Date: January 1, 2011

Implementation Date: January 3, 2011

I. GENERAL INFORMATION

A. Background: Section 3134 of the Affordable Care Act (ACA) added section 1848(c)(2)(K) of the Social Security Act which specifies that the Secretary 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 multiple procedure payment reduction (MPPR) to the practice expense (PE) payment of select therapy services paid under the physician fee schedule. The reduction is similar to that currently applied to multiple surgical procedures and to diagnostic imaging procedures. This policy is discussed in the CY 2011 physician fee schedule final rule published in the Federal Register on November 29, 2010. Subsequent to publication of the CY 2011 physician fee schedule final rule, section 3 of the Physician Payment and Therapy Relief Act of 2010 codified the therapy MPPR while modifying the reduction percentage in some settings.

B. Policy: Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. We are 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 for work and malpractice and 80 percent payment for the PE for services furnish in office settings and other non-institutional settings (services paid under section 1848 of the Act) and 75 percent payment for the PE for services furnished in institutional settings (service aid under section 1834).

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 physician fee schedule, regardless of the type of provider or supplier that furnishes the services (e.g. hospitals, home health agencies, and comprehensive outpatient rehabilitation facilities (CORFs), etc.) The MPPR applies to the procedures in Attachment 1. Note that these services are paid with a non-facility PE. The current and proposed payments are summarized below in the following example for services furnished in an institutional setting (Note: for office and other non-institutional settings, the reduction percentage is 20 percent).

	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)

To accommodate implementation of this new policy for professional claims, the 2011 Medicare Physician Fee Schedule layout will have some additional changes. The changes are:

1) A new Multiple Procedure (Field 21) value of '5' will denote those services subject to the MPPR methodology.
2) Field 31EE will contain the non-facility fee amounts reflecting the 20 percent reduction in non-facility PE RVUs. The format of the Medicare Physician Fee Schedule Data Base (MPFSDB) will change as follows:

31 Related Procedure Codes	35 Pic x(5) – Occurs 7 times
31EE Reduced Therapy Fee Schedule Amount	9Pic(7)v99
31DD Filler	1Pic x(2)

When applying the 20 percent reduction in non-facility PE RVUs, the contractors shall use the fee schedule amounts supplied in field 31EE.

In addition, contractors shall 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, contractors shall 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 80 percent of the non-facility PE RVU for professional claims.

To accommodate implementation of the 25 percent reduction in non-facility PE RVUs for services furnished in an institutional setting, the 2011 Therapy Abstract file layout will be changed. The changes are:

1) A new non-facility PE RVU field will be added to the file. This field will start in position 45 with a picture of 9(5)v99. This field will be labeled NFACPE.

2) A new reduced therapy fee schedule amount will be added to the file. This field will start in position 53 with a picture of 9(5)v99. This field will be labeled FITHERRED.

3) A new multiple services indicator will be added to the file. This field will start in position 44 with a picture of X(1). HCPCS codes that have a Multiple Services Indicator value of '5' are subject to the multiple therapy reduction policy. This field will be labeled MULTSURG.

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	
7050.1	Medicare contractors shall apply a multiple procedure payment reduction (MPPR) to certain therapy services when submitted on institutional claims.	X		X		X	X				
7050.1.1	Medicare contractors shall apply the MPPR to therapy services that meet the following criteria: • type of bill 12x, 13x, 22x, 23x, 34x, 74x or 75x, • revenue code 042x, 043x or 44x, • a HCPCS code with a multiple services indicator value of '5' and • the same date of service.	X		X		X	X				
7050.2	Medicare contractors shall load fee data from a revised therapy abstract (ABST) file for use in calculating the MPPR.	X		X		X	X				
7050.2.1	Medicare contractors shall load data from the following new fields in the ABST file for the HCPCS codes in Attachment 1: • non-facility PE RVU (field labeled NFACPE) • reduced therapy fee schedule (field labeled FITHERRED) and • multiple services indicator (field labeled MULTSURG).	X		X		X	X				
7050.3	When more than one service on an institutional claim meets the criteria in requirement 7050.1.1, Medicare contractors shall pay the full MPFS amount for the line with the highest value in the non-facility PE RVU field.	X		X		X	X				
7050.3.1	If, in determining the service to be paid the full MPFS amount, more than one service have the same non-facility PE RVU value, Medicare contractors shall pay the full MPFS amount for the service with both the highest non-facility PE RVU value and the highest total fee amount.	X		X		X	X				
7050.4	When more than one service on an institutional claim meets the criteria in requirement 7050.1.1, Medicare contractors shall pay the amount in the reduced therapy fee schedule field for those which	X		X		X	X				

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	
	do not have the highest non-facility PE RVU field amount.										
7050.5	When a service on an institutional claim which meets the criteria in requirement 7050.1.1 has multiple units, Medicare contractors shall pay the full MPFS amount for one unit and pay the amount in the reduced therapy fee schedule field for all additional units of the line.	X		X		X	X				
7050.6	When more than one service on an institutional claim meets the criteria in requirement 7050.1.1 and the line identified for full MPFS payment in requirement 7050.3 has multiple units, Medicare contractors shall pay the full MPFS amount for one unit on that line and pay the amount in the reduced therapy fee schedule field for all additional units of the line.	X		X		X	X				
7050.6.1	Contractors shall use the following claim adjustment reason code on the remittance advice notices for service lines for which they have applied the MPPR methodology as described in BRs 7050.4 –7050.6: 45 Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	X		X		X	X				
7050.6.2	Contractors shall use the group code "CO," contractual obligation, on remittance advice notices for claims for which MPPR methodology was applied as described in BRs 7050.4 –7050.6.	X		X		X	X				
7050.6.3	Contractors shall use the following message on the Medicare Summary Notices for claims for which MPPR methodology was applied as described in BRs 7050.4 –7050.6: 30.1 The approved amount is based on a special payment method. And 30.1 La cantidad aprobada está basada en un método especial de pago.	X		X		X	X				

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	
7050.7	Contractors shall apply a multiple procedure payment reduction (MPPR) to certain therapy services on professional claims.	X			X			X			
7050.8	Contractors shall recognize and use the multiple procedure (field 21) value of "5" to identify therapy services subject to the MPPR.	X			X			X			
7050.9	Contractors shall accommodate changes to the physician fee schedule layout to include the new field 31EE and changes to fields 31 and 31DD as follows: 31 Related Procedure Codes: 35 Pic x(5) – Occurs 7 times 31EE Reduced Therapy Fee Schedule Amount: 9Pic(7)v99 31DD Filler: 1Pic x(2)	X			X			X			
7050.10	Contractors shall recognize the new field 31EE Reduced Therapy Fee Schedule Amount and the fee amounts it contains.	X			X			X			
7050.11	Contractors shall use the multiple procedure value of "5," the beneficiary's HIC, the billing provider NPI, and date of service to identify therapy services subject to the MPPR.	X			X			X			
7050.12	Contractors shall apply the MPPR to claims for two or more services identified by the multiple procedure value of 5, for the same beneficiary HIC, same billing provider NPI, and same date of service	X			X			X			
7050.12.1	Contractors shall retrieve the non-facility PE RVU value when the services on the claim meet all of the conditions in BR 7050.12	X			X			X			
7050.12.2	Contractors shall sort the services meeting the conditions of BR 7050.12 according to the highest non-facility PE RVU amount such that the service with the highest non-facility PE RVU is ranked first.	X			X			X			
7050.12.2.1	In performing the sort described in BR 7050.12.2, contractors shall consider 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	X			X			X			

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	
	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.										
7050.12.3	If the sort described in BR 7050.12.2 results in the highest ranked non-facility PE RVU applying to two or more services, the contractors shall additionally sort these highest non-facility PE RVU services according to highest total fee schedule non facility amount, with the service with the highest fee schedule amount ranked first.	X			X			X			
7050.12.3.1	In performing the additional sort according to the full fee schedule amount described in BR 7050.12.3, contractors shall use the full fee schedule amount applicable to 1 unit for those services billed in units.	X			X			X			
7050.12.4	When the service ranked highest according to the sorts specified in BRs 7050.12.2 through 7050 12. 3 is billed in units, and multiple units were reported, contractors shall rank the first unit as that having the highest non-facility PE RVU.	X			X			X			
7050.12.5	Contractors shall pay the lower of the billed or total fee schedule amount for the service ranked highest according to the sorts performed in BRs 7050.12. 2 through 7050.12.4.	X			X			X			
7050.12.6	Contractors shall pay 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 of BR 7050 12.2 through 12.4.	X			X			X			
7050.12.7	Contractors shall apply the MPPR methodology described in 7050.12 to therapy services meeting all of the criteria described in BR 7050.11, but billed on different days (i.e., coming in on separate claims for the same beneficiary HIC, billing provider NPI, and date of service).	X			X			X			
7050.13	Contractors shall use the following claim adjustment reason code on the remittance advice notices for claims for which they have applied the MPPR methodology as described in BR 7050.12:	X			X			X			

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	
	45 Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.										
7050.14	Contractors shall use the group code "CO," contractual obligation, on remittance advice notices for claims for which MPPR methodology was applied as described in BR 7050.12	X			X			X			
7050.14.1	Contractors shall use the following message on the Medicare Summary Notices for claims for which MPPR methodology was applied as described in BR 7050.12: 30.1 The approved amount is based on a special payment method. And 30.1 La cantidad aprobada está basada en un método especial de pago.	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	
7050.15	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ **when this CR is no longer Sensitive and Controversial**. 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	X		X	X	X					

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	
	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.										

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:

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

V. CONTACTS

Pre-Implementation Contact(s): Ken Marsalek for payment policy issues on 410-786- 4502, Kenneth.Marsalek@cms.hhs.gov; Claudette Sikora for Part B claims processing issues, on 410-786-5618, Claudette.sikora@cms.hhs.gov, Wil Gehne for institutional claims processing issues on 410-786-6148, wilfried.gehne@cms.hhs.gov and Charles Campbell for MPFDB issues on 410-786-7290, charles.campbell@cms.hhs.gov

Post-Implementation Contact(s): Appropriate RO or MAC PO

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* use only one of the following statements:

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),*** **include the following statement:**

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.

Attachment

Attachment 1

List of Therapy Procedures Subject to the Multiple Procedure Payment Reduction

Code	Short Descriptor
92506	Speech/hearing evaluation
92507	Speech/hearing therapy
92508	Speech/hearing therapy
92526	Oral function therapy
92597	Oral speech device eval
92607	Ex for speech device rx, 1hr
92609	Use of speech device service
96125	Cognitive test by hc pro
97001	Pt evaluation
97002	Pt re-evaluation
97003	Ot evaluation
97004	Ot re-evaluation
97012	Mechanical traction therapy
97016	Vasopneumatic device therapy
97018	Paraffin bath therapy
97022	Whirlpool therapy
97024	Diathermy eg, microwave
97026	Infrared therapy
97028	Ultraviolet therapy
97032	Electrical stimulation
97033	Electric current therapy
97034	Contrast bath therapy
97035	Ultrasound therapy
97036	Hydrotherapy
97110	Therapeutic exercises
97112	Neuromuscular reeducation
97113	Aquatic therapy/exercises
97116	Gait training therapy
97124	Massage therapy
97140	Manual therapy
97150	Group therapeutic procedures
97530	Therapeutic activities
97533	Sensory integration
97535	Self care mngment training
97537	Community/work reintegration
97542	Wheelchair mngment training

97750	Physical performance test
97755	Assistive technology assess
97760	Orthotic mgmt and training
97761	Prosthetic training
97762	C/o for orthotic/prosth use
G0281	Elec stim unattend for press
G0283	Elec stim other than wound
G0329	Electromagntic tx for ulcers