PAYMENT POLICY ID NUMBER: 10-038

Original Effective Date: 08/01/2014

Revised: 08/10/2023

Multiple Therapy Procedure Reduction

THIS PAYMENT POLICY IS NOT AN AUTHORIZATION, CERTIFICATION, EXPLANATION OF BENEFITS, OR A GUARANTEE OF PAYMENT, NOR DOES IT SUBSTITUTE FOR OR CONSTITUTE MEDICAL ADVICE. ALL MEDICAL DECISIONS ARE SOLELY THE RESPONSIBILITY OF THE PATIENT AND PHYSICIAN. BENEFITS ARE DETERMINED BY THE GROUP CONTRACT, MEMBER BENEFIT BOOKLET, AND/OR INDIVIDUAL SUBSCRIBER CERTIFICATE IN EFFECT AT THE TIME SERVICES WERE RENDERED. THIS PAYMENT POLICY APPLIES TO ALL LINES OF BUSINESS AND PROVIDERS OF SERVICE. IT DOES NOT ADDRESS ALL POTENTIAL ISSUES RELATED TO PAYMENT FOR SERVICES PROVIDED TO FLORIDA BLUE MEMBERS AS LEGISLATIVE MANDATES, PROVIDER CONTRACT DOCUMENTS OR THE MEMBER'S BENEFIT COVERAGE MAY SUPERSEDE THIS POLICY.

DESCRIPTION:

This policy describes the reimbursement when certain physical medicine and rehabilitative procedures are reported on the same date of service for the same patient.

As defined by the Centers for Medicare and Medicaid Services (CMS), some elements that comprise these services, known as Practice Expense Relative Value Units (PE RVUs), are duplicated when multiple procedures are performed on a single day. Duplicated components cited by CMS included cleaning the room and equipment, greeting the patient, educating, instructing, and counseling the patient, coordinating home care, obtaining measurements, providing post-treatment patient assistance and duplicated supply items. CMS implemented its reduction policy for therapy procedures in January 2011 based upon instructions in the Affordable Care Act that required CMS to identify potentially misvalued codes by examining multiple codes that are frequently billed together. This multiple procedure reduction policy seeks to align with CMS' findings and appropriately account for this duplication of value when multiple services are performed on the same day.

This reduction is similar to those Florida Blue applies to multiple surgical procedures, multiple imaging procedures, and multiple evaluation and management services.

This policy applies to billing for therapy services on a CMS-1500 or equivalent claim form. Same provider for the purposes of this policy includes all physicians and/or other health care professionals reporting under the same Federal Tax Identification number.

REIMBURSEMENT INFORMATION:

Therapy codes subject to the reduction policy are defined by the CMS Medicare Physician Fee Schedule. The procedure codes with a MULT PROC value of "5" will be considered under this policy.

When multiple therapy procedures are performed, the primary procedure is allowed at 100 percent. However, allowances for secondary and all subsequent procedures are reduced by 25 percent when performed on the same date of service. The primary procedure is identified as the one with the highest total RVU as published by CMS. Additionally, when the primary procedure is billed with multiple units, the first unit will allow at 100 percent and each subsequent unit will be allowed at 75 percent.

The percent at which the primary line is reduced is shown in the table below.

Primary Procedure		
Unit	**Percent Allowed**	**Example of Fee Schedule Allowance**
1	100%	$22.00
2	87.5%	$22.00 x 2 x 87.5% = $38.50
3	83.3%	$22.00 x 3 x 83.3% = $54.98
4	81.3%	$22.00 x 4 x 81.3% = $71.54
5	80.0%	$22.00 x 5 x 80.0% = $88.00
6	79.2%	$22.00 x 6 x 79.2% = $104.54
7	78.6%	$22.00 x 7 x 78.6% =$121.04
8	78.1%	$22.00 x 8 x 78.1% = $137.46
*Percent allowed rounded to 3 digits		

Note: Additional units are subject to the appropriate percent allowed.

The following examples illustrate possible scenarios:

Example 1:

Line	Procedure	Units	Fee Sch. Allowance	RVU	Rank	Final Allowance
1	A	1	$22.00	0.92	1	$22.00 (100%)
2	B	1	$20.00	0.85	2	$15.00 ($20x75%)
3	C	1	$10.00	0.36	3	$7.50 ($10x75%)

Example 2:

Line	Procedure	Units	Fee Sch. Allowance	RVU	Rank	Final Allowance
1	A	3	$66.00 ($22.00x3)	0.92	1	54.98 [($22.00x3) x 83.3%]
2	B	1	$20.00	0.85	2	$15.00 ($20x75%)

Other payment policies, such as National Correct Coding Initiative, may also apply.

BILLING/CODING INFORMATION:

CPT®/HCPCS codes subject to Multiple Therapy Procedure Reduction are identified in the Medicare Physician Fee Schedule (PFS) Relative Value File with a value of "5" in the MULT PROC field. The file can be located in the References section below.

REFERENCES:

1. American Medical Association, Current Procedural Terminology (CPT®), Professional Edition.
2. CMS, Medicare Physician Fee Schedule Relative Value File: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html
3. CMS, MLN Matters MM8206: Multiple Procedure Payment Reduction (MPPR) for Selected Therapy Services, February 22, 2013: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2013-Transmittals-Items/R1194OTN
4. CMS, Final Rule with Comment Period, Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2011, November 29, 2010: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS1240932.html

GUIDELINE UPDATE INFORMATION:

08/01/2014	New Payment Policy
08/04/2016	Annual Review – no material changes
08/17/2017	Annual Review – examples refreshed
08/16/2018	Annual Review, no changes
08/15/2019	Annual Review
08/13/2020	Annual Review- Removed "For service dates beginning with August 1, 2014" from the Reimbursement Information section of the policy.
08/12/2021	Annual Review – no changes
03/17/2022	Revision – Table added to the "Reimbursement Information" section to illustrate the percent reduction on the primary procedure.
08/11/2022	Annual Review – no changes
08/10/2023	Annual Review – References reviewed and updated.