Medicare’s MPPR Policy and Professional Component Reporting

The Centers for Medicare and Medicaid Services (CMS) has expanded its multiple procedure payment reduction (MPPR) policy that currently applies to the technical component (TC) of certain advanced imaging services to the professional component (PC). Effective January 1, 2012, a 25 percent reduction will be applied to the PC of subsequent advanced imaging services when multiple services are furnished by the same physician to the same patient in the same session on the same day.

As noted in the November/December 2011 ACR Radiology Coding Source, Medicare will make the full PC payment for the procedure with the highest payment under the Medicare Physician Fee Schedule (PFS), and then pay 75 percent for subsequent PC services. There has been no change in 2012 to the MPPR policy for the technical component (TC). Medicare will continue to make full TC payment for the procedure with the highest payment under the PFS, and then 50 percent for subsequent TC services.

A listing of the advanced imaging services to which the new PC MPPR policy applies is noted in Addendum F of the November 28, 2011 Final Rule.

The implementation of the MPPR for the PC has led to much confusion and many questions have been received by the ACR. The following Q&As are ACR’s interpretation of the rules based on what has been printed in the Final Rule, Change Request R9950TN, and MedLearn Matters #7442. This guidance is provided to ensure radiology practices are coding accurately and radiologists are being reimbursed appropriately for their services. The ACR will publish continued guidance on the MPPR policy as CMS provides additional guidance.

How does CMS define a session as it applies to the MPPR?

The term “session,” as applied in the MPPR, is defined differently for the professional and technical components of diagnostic imaging services. A session as it applies to the professional component is defined by when the studies are interpreted by the radiologist. A session as it applies to the technical component is based on when the images are acquired.

The only reference to what CMS considers a separate session for the PC is listed in the Final Rule, “For purposes of the MPPR on the PC, scans interpreted at widely different times...would constitute separate sessions.”

However, CMS does not define “widely” or provide any additional insight, and acknowledges that there may be instances “where the physician demonstrates the medical necessity for furnishing interpretations in separate sessions.”

Can a session cross modalities?

A session may cross modalities for both the professional and technical components.

CMS notes in the Final Rule: We further recognize that in some cases, imaging tests utilizing different modalities may be conducted in separate sessions for the TC service, such as when the patient must be moved to another floor of the hospital; however, the PC services in such cases may, or may not, be furnished in separate sessions.
When the patient is in the same scanner for two or more exams performed sequentially at the same appointment, is this considered the same session for both the professional and technical components?

When the patient is in the same scanner for two or more exams performed sequentially at the same appointment, it would be considered the same session as far as the technical component MPPR is concerned. However, it may or may not be considered the same session for the professional component. If the same physician interprets these scans during the same session, the MPPR would apply to the professional component as well.

CMS notes the following in the Final Rule, As a general policy, when multiple scans are conducted on a patient in the same session, we would generally consider the interpretations of those scans to be furnished in the same session...the physician will need to exercise judgment. For purposes of the MPPR on the PC, scans interpreted at widely different times...would constitute separate sessions, even though the scans themselves were conducted in the same session and the MPPR on the TC would apply.

How is the MPPR applied to group practice billings?

The Final Rule states that due to operational considerations, CMS is not applying the imaging MPPR to group practices at this time. This means that the MPPR policy does not apply when two or more physicians within the same group practice interpret different studies performed on the same patient on the same day.

However, the MPPR does apply to individual physicians in a group practice who bill under the Medicare Physician Fee Schedule (PFS) and interpret MPPR-applicable studies on the same patient on the same day during the same session.

In addition, the MPPR applies to all sites of service, whether the multiple procedures are performed in the hospital, physician office and/or independent diagnostic facility. Medicare contractors have been instructed to apply the reduction to applicable procedures billed on the same date of service based on the rendering physician’s National Provider Identifier. [CR7442.2]

Is it okay if members of my practice only interpret one study per patient?

If it is currently the practice that different sub-specialized physicians read different types of studies, the ACR recommends that you continue this practice. For example, if it has been typical that a chest radiologist, ultrasound specialist and body imager interpreted those respective types of studies, that practice should continue and each of these individual physicians should be able to bill and be reimbursed for the studies they interpret independent of the professional component MPPR. In other settings it may be more expedient for different radiologists to interpret different exams for patient care reasons. Again, if that is the case, then this practice should continue.

However, it would be considered inappropriate if physicians were purposefully assigned different studies to read for the purpose of bypassing the MPPR policy. CMS intends to monitor access to care and patterns of delivery for imaging services, with particular attention focused on identifying any changes in the delivery of same day imaging services that may be clinically inappropriate.

How does one know if the MPPR has been applied to a submitted claim?

The Medicare Administrative Contractor will assign Claim Adjustment Reason Code 59 to designate that the claim has been processed based on multiple or concurrent procedure rules. (CR7442.5.3)
If we are currently billing globally, do we have to split the claim into professional and technical components?

The claim detail does not need to be split into professional and technical components if you are currently billing globally. The Medicare administrative contractors will determine the PC and TC service with the highest payment under the Medicare Physician Fee Schedule in order to calculate the reductions for globally billed services (CR7442.3).

How does Medicare apply the payment reduction for the PC and TC when billed globally?

The following table is the example used by CMS to explain how the MPPR will be applied to global charges (CR7442, B, para 2):

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</thead>
<tbody>
<tr>
<td>PC</td>
<td>68</td>
<td>$102</td>
<td>$170</td>
<td>$153</td>
<td>$102 + (.75 x $68)</td>
</tr>
<tr>
<td>TC</td>
<td>476</td>
<td>$340</td>
<td>$646</td>
<td>$646</td>
<td>$476 + (.50 x $340)</td>
</tr>
<tr>
<td>Global</td>
<td>544</td>
<td>$442</td>
<td>$816</td>
<td>$799</td>
<td>$102 + (.75 x $68) + $476 + (.50 x $340)</td>
</tr>
</tbody>
</table>

*A 50 percent reduction applied to the technical component in 2011.

How does the interpreting physician indicate on the patient claim form that multiple procedures were performed on the same patient on the same day, but were interpreted at different sessions and, therefore, not subject to the professional component MPPR?

When a physician determines that multiple studies were interpreted in separate sessions, a 59 modifier should be appended to the second and subsequent studies to denote that the studies were interpreted at separate sessions. When a 59 modifier is appended to a code on the MPPR listing, the professional component MPPR policy will not be applied and the professional component for both studies would be eligible for full payment under the Medicare Physician Fee Schedule.

The Final Rule states, In cases where the physician demonstrates the medical necessity for furnishing interpretations in separate sessions, use of the -59 modifier would be appropriate. We recognize that it may not always be a simple matter to determine whether a service was furnished in the “same” session, particularly in the case of the PC. The physician will need to exercise judgment to determine when it is appropriate to use the -59 modifier indicating separate sessions. We do not expect use of the modifier to be a frequent occurrence.

If a session is defined as when the studies are interpreted and not when the images are acquired, how are global billings handled when the TC is performed during the same session, but the PC is interpreted at different sessions?

CMS Medicare Administrative Contractors will have to determine how to apply the Multiple Procedure Payment Reduction (MPPR) policy appropriately to the professional and technical
components when billed as a global charge, i.e., whether or not to apply a 50 percent reduction on the technical component and/or a 25 percent reduction on the professional component when modifier 59 is appended to a global charge. Be sure to review your payments to ensure you are being reimbursed appropriately.

If the MPPR and National Correct Coding Initiative (CCI) edit coding guidelines are at odds on the use of the 59 modifier, should we follow the CCI or MPPR guidelines?

Radiology practices should follow the National Correct Coding Initiative (CCI) edit guidelines and apply the 59 modifier in order to bypass the CCI edits when appropriate and to ensure payment for distinct services. When certain procedure code combinations have a CCI edit modifier indicator of 1 (modifier), it is appropriate and necessary to report a modifier 59 to bypass the CCI edit, as the 59 indicates a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.²

However, when a 59 modifier is used to override a CCI edit, the MPPR policy may also be bypassed as well. Medicare contractors will need to determine whether appropriate use of the 59 for CCI edit purposes will also apply to the MPPR PC. This may hinge on whether the contractor believes that interpretation of both studies would occur in the same session.

For example, when an MRA head and MRI brain on the same patient are interpreted at the same professional session, a 59 modifier would not be used for the purpose of bypassing the MPPR. However, according to CCI edit guidelines, when a full and complete brain MRI is performed separate from a full and complete MRA examination (separate data set acquisition) it would be appropriate to report both the MRI and MRA codes, and a 59 modifier should be added to designate that separate and distinct studies were performed.

² CPT 2012 Professional Codebook, p. 568.

A comparison study is done later in the day due to a change in the patient’s condition. How is this reported for the professional component?

The MPPR policy would be applied to the professional component (PC) based on when the study was interpreted. If the initial study and comparison study are interpreted by the same physician during the same session, the MPPR would be applied. If the interpretation of the initial study was performed, and at a widely different time during the same day a comparison study is interpreted by the same physician, it would be considered two separate PC sessions and a 59 modifier should be appended to the second study to denote a separate session.

CMS’ guidance thus far does not define “widely different times,” so physicians must decide what constitutes a “widely different time” within the specific clinical scenario and be able to provide documentation of medical necessity if challenged by Medicare contractors. Physicians should anticipate that imaging claims with a 59 modifier will be closely scrutinized by Medicare contractors and they should document for, and be prepared to defend, their use of this modifier to bypass the MPPR.

Can you give some additional examples of when it is appropriate to use the 59 modifier to bypass the MPPR?

Some additional examples of when to apply a 59 modifier to denote a separate session and to bypass the MPPR include:

- Physician interprets multiple diagnostic examinations at different times over the course of the day on the same patient
Abdominal US ordered for abnormal liver function studies is interpreted in the morning. An abdominal CT on the same patient is performed based on the results of the US and interpreted that same afternoon. For these examinations, interpreted at widely different times, it would be appropriate to append a -59 modifier to the second study to designate that it was interpreted at different sessions and the MPPR should not be applied.

Can you give some additional examples of when it is not appropriate to use the 59 modifier to bypass the MPPR?

Some additional examples of when NOT to apply a 59 modifier include:

- Interpretations done during the same PC session
  - Head CT and cervical spine CT acquired at the same technical session and interpreted by the same physician in the same session
  - Abdominal CT and abdominal ultrasound ordered at the same time and performed sequentially to evaluate for abdominal pain are interpreted by the physician at the same time in a single session

To summarize, the MPPR is now being applied to the professional component of certain CT, MR and US studies performed by the same physician for the same patient on the same date of service during the same session. This policy crosses modalities when applicable CT, MR, and ultrasound studies are interpreted by the same physician during the same session. Although the MPPR does not apply when multiple physicians within the same group practice interpret different studies on the same patient for the same date of service, it does apply to each individual physician within the group who bills under the PFS.

Physicians should continue to submit codes as they have been doing and use the appropriate modifiers as dictated by CPT and CCI guidelines. Medicare administrative contractors will determine when to apply the MPPR based on the codes submitted by the same physician for the same date of service.

Little guidance has been provided by CMS thus far. The ACR will continue to request clarification from CMS and will publish updates when available.