SPECIAL eBULLETIN

FOR PROFESSIONAL PROVIDERS

OCTOBER 7, 2019

EFFECTIVE NOV. 22, 2019: MULTIPLE PROCEDURE PAYMENT REDUCTION (MPPR) CHANGE FOR THERAPY SERVICES FOR MEDICARE ADVANTAGE

We appreciate your support and the high-quality, cost-effective care you provide our members and your patients. Just as you do everything in your power to deliver the best care for your patients, we do everything in ours to ensure practices and hospitals are appropriately reimbursed for that care. That's why we've developed programs and policies dedicated to ensuring services are clinically appropriate and all claims are accurately reimbursed.

Highmark's new reimbursement policy for multiple procedure payment reduction (MPPR) for therapy services for Medicare Advantage is in alignment with Centers for Medicare & Medicaid Services (CMS) guidelines. Highmark will pay 100 percent (100%) for therapy services or units that are identified within its MPPR reimbursement policy with the highest Relative Value Units (RVU) practice expense. All subsequent services or units will have a 50 percent (50%) reduction applied to the payment when performed for the same member during the same session, or on the same calendar day, by the same provider or provider practice.

For therapy services provided within a group practice, the MPPR applies to all services provided to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines (e.g., physical therapy, occupational therapy, and/or speech-language therapy).

This policy change is effective for claims with dates of service on or after Nov. 22, 2019, and applies only to professional Medicare Advantage claims.

For more information, please see the new Highmark Reimbursement Policy Bulletin RP-051: Multiple Procedure Payment Reduction for Therapy Services, which is now available on the Provider Resource Center to provide time for reviewing prior to the effective date.

To access and view Highmark's reimbursement policies on the Provider Resource Center, select **CLAIMS, PAYMENT & REIMBURSEMENT** from the left menu options, and then click on **Reimbursement Policy**.

REIMBURSEMENT GUIDELINES

- Includes “always” therapy services, including those furnished in office and facility settings/place of services. Therapy services that are deemed to be “always” therapy are identified by a multiple procedure indicator of five (5) on the on the Medicare Physician Fee Schedule (MPFS).
- Many therapy services are time-based codes per their description, meaning multiple units may be billed for a single procedure. In cases where multiple units are reported for the same service code, Highmark will pay 100 percent (100%) of the Plan allowance for the first unit and apply a 50 percent (50%) reduction to the practice expense for all additional units of service reported, when performed for the same member during the same session, or on the same calendar day, by the same provider or provider practice.

  Note: See the table below for how to report time-based codes.

TIME-BASED CODES

Highmark follows Medicare’s method of counting minutes for timed therapy codes for professional services for our commercial plans. When more than one service represented by 15-minute timed codes is performed in a single day, the total number of minutes of service determines the number of timed units billed.

Based on the work value of these codes, the expectation is that the provider’s direct patient contact time for each unit will average fifteen (15) minutes in length. If only one service is provided in a day, providers should not bill for the services performed for less than eight (8) minutes.

For any single timed CPT code in the same day measured in 15-minute units, providers bill a single 15-minute unit for treatment greater than or equal to eight (8) minutes through and including twenty-two (22) minutes. If the duration of a single modality or procedure, in a day, is greater than or equal to twenty-three (23) minutes, through and including thirty-seven (37) minutes, then two (2) units should be billed. The pattern remains the same for treatment times in excess of the chart below.

Timed intervals for one (1) through eight (8) units are as follows:

Minutes	Units
8 - 22	1
23 - 37	2
38 - 52	3
53 - 67	4
68 - 82	5
83 - 97	6
98 - 112	7
113 - 127	8

EXAMPLE 1:

- 7 Minutes of neuromuscular re-education (97112)
- 7 Minutes therapeutic exercise (97110)
- 7 Minutes manual therapy (97140)
- **21 Total Timed Minutes**

  Result: Appropriate billing is for one (1) unit. The qualified professional would select one Appropriate CPT code (97112, 97110, or 97140) to bill since each code was performed for the same amount of time and only one unit is allowed based on the total timed minutes.

EXAMPLE 2:

- 18 Minutes therapeutic exercise (97110)
- 13 Minutes of manual therapy (97140)
- 10 Minutes of gait training (97116)
- 8 Minutes of ultrasound (97035)
- **49 Total Timed Minutes**

  Result: Appropriate billing is for three (3) units. Bill the procedures you spent the most time providing. You would have one (1) unit each of 97110, 97116, and 97140. You are unable to bill for the ultrasound because the total time of timed units that can be billed is constrained by the total timed code treatment minutes (e.g., you may not bill four units for less than 53 minutes total time regardless of how many services were performed). You would still document the ultrasound in the notes.

Note: The Centers for Medicare & Medicaid Services (CMS) claims processing Publication 100-04 can be referenced for additional details.

DEFINITIONS

RVU Practice Expense: The portion of the Total Relative Value Units that account for the non-physician clinical and nonclinical labor of the practice, as well as expenses for building space, equipment, and office supplies.

(MPFS) Multiple Procedure Indicator 5: Special reduction rule for the practice expense component for certain therapy services.

RELATED HIGHMARK POLICIES

Refer to the following Medical Policies for additional information:

- Commercial Policy Y-9: Manipulation Services
- Commercial Policy Y-2: Occupational Therapy
- Commercial Policy V-16: Speech Therapy
- Medical Advantage Policy Y-1: Therapy and Rehabilitation Services (PT, OT)
- Medical Advantage Policy Y-14: Speech-Language Pathology Services

ADDITIONAL BILLING INFORMATION AND GUIDELINES

- The Centers for Medicare & Medicaid Services (CMS); Claims Processing Publication 100-04, Chapter 12.
- Multiple Procedure Payment Reduction (MPPR) for Selected Therapy Services, MLN Matters Number: MM8206, April 1, 2013, Centers for Medicare & Medicaid Services (CMS).