

Multiple Procedure Payment Reduction

This policy affects many codes that are relevant to retinal practices.

BY STEPHEN A. KAMENETZKY, MD

MPPR is the latest acronym identifying another change in payment policy that takes more money out of physicians' pockets. What does it stand for, and what do the changes mean for ophthalmology as a specialty and for retina specialists in particular?

MPPR stands for multiple procedure payment reduction. This term defines a payment reduction that the Centers for Medicare & Medicaid Services (CMS) will be making in 2013 for certain ophthalmologic testing procedures that are performed on a patient on the same day. CMS considers this to be a logical extension of the current payment rules for second and subsequent surgical procedures performed by the same surgeon or physician group on the same patient, on the same day, and in the same setting (the familiar -51 multiple procedure modifier). The reduced payment for additional procedures is based on the concept that, when services are rendered together, there are efficiencies that occur that would result in duplicate payment of practice expenses and pre- and post-procedure work if all procedures were paid in full. MPPR extends the concept to certain diagnostic testing.

AFFECTED SPECIALTIES AND SERVICES

Fortunately, ophthalmology is late to the reduction-of-payment-for-testing-services game. In 1995, CMS initially applied this concept to nuclear medicine diagnostic procedures. Ten years later, the policy was extended to certain combinations of diagnostic imaging procedures performed in a single session, imposing a reduction in payment for clinical labor and supplies. Reduction in clinical labor time also results in reduction of payment for indirect practice costs and equipment usage. In 2011, this policy was extended to therapy services.

The Government Accountability Office and the Medicare Payment Advisory Commission encouraged CMS to expand the MPPR policy to other diagnostic services when performed together. Ophthalmology was chosen as one of the specialties to be reviewed. Twenty-seven codes from CPT series 76510-76529 and 92002-92371 were selected, and

TABLE 1. DIAGNOSTIC OPHTHALMOLOGY SERVICES SUBJECT TO MPPR¹

Codes			
76510	92060	92134	92270
76511	92081	92136	92283
76512	92082	92235	92284
76513	92083	92240	92285
76514	92132	92250	92286
76516	92133	92265	

CMS' analysis of code pairs frequently performed together revealed evidence of duplicate payment for many activities. For example, greeting the patient, taking his or her history, and collating data were not performed separately for each test, but physicians were being paid as though they were.

Initial evaluation of ophthalmology code pair frequency in 2011 ranged from 4193 to 553 502. CMS analysis indicated that this duplication of payment resulted in an average volume-adjusted excess payment of 32% for clinical labor. To compensate, CMS suggested that the technical payment for second and subsequent codes be reduced by 25%. The American Academy of Ophthalmology (AAO) provided extensive documentation detailing the ways that CMS overestimated the true effect of efficiencies obtained when these tests were performed together. CMS considered these comments and others and revised the volume-adjusted average effect to +22%. This resulted in CMS reducing the MPPR reduction for ophthalmology from 25% to 20%.

The list of codes affected by this policy includes many that are relevant to retinal practices (Table 1). These codes have the general characteristic that the technical component of payment is a major part of the total payment. This can have a significant impact on revenue for code pairs performed at high volume.

UNAFFECTED SERVICES

Let us clarify what is not affected by these changes before considering a specific example of how this will work. Evaluation and management services (eye visit codes

TABLE 2. SAMPLE OPHTHALMOLOGY PAYMENT REDUCTION*1

<i>Unilateral FA and fundus photos</i>					
	Code 92235	Code 92250	Total 2012 Payment	Total 2013 Payment	Payment Calculation
PC	\$46.00	\$23.00	\$69.00	\$69.00	No reduction
TC	\$92.00	\$53.00	\$145.00	\$134.40	$\$92 + (.80 \times \$53)$
Global	\$138.00	\$76.00	\$214.00	\$203.40	$\$69 + \$92 (.80 \times \$53)$
*Dollar amounts are for illustrative purposes and do not reflect actual payment amounts. PC = professional component; TC = technical component.					

or EM series) are not considered a test, so combining an office exam with a test does not result in a reduction of payment due to MPPR. The payment for the professional component of physician work for each test is not reduced when 2 or more tests are performed at the same time. Supply costs related to multiple tests are not reduced. The code with the largest technical component is still paid at 100%. Only the technical component of the second and all subsequent codes is reduced by 20%.

EXAMPLE OF MPPR

Looking at the common example for pairing of fluorescein angiography (FA) and fundus photos in Table 2, the process is pretty easy to understand. For unilateral cases, FA (92235) has the higher technical component (TC) when compared with fundus photos (92250). Therefore, both professional components are paid in full, the technical component for 92235 is paid in full, and the technical component of 92250 (the smaller of the 2) is reduced by 20%. In this example, there is an overall reduction of about 5%.

If there is pathology in both eyes, it is a bit more complex because FA is a unilateral code and photos are inherently bilateral. In this instance the technical component of FA is paid in full for the first eye but is reduced by 20% for the second eye. The technical component of 92250 is also reduced by 20%. Professional fees and supplies for all tests are still paid in full. Using the same values from Table 2, the payment for 2013 would be \$323 for both eyes compared to \$352 in 2012 (about 9% less).

Modifiers are not required. Medicare intermediaries will automatically make the correction.

Check with your local Medicare carrier for the exact values in your area for 2013.

DON'T TRY TO GET CUTE

So, you might ask, why not simply bring patients back more often so that all codes are paid in full? Don't even consider going there. This is important enough that I am going to quote the specific language in the Final Rule:

"We would not expect the adoption of an MPPR for the TC of diagnostic ... ophthalmology services to result

in services being furnished on separate days by 1 physician merely so that the physician may garner increased payment. ...such an unprofessional response on the part of practitioners would be inefficient and inappropriate care for the beneficiary. We will monitor access to care and patterns of delivery for ... ophthalmology services to beneficiaries, with particular attention focused on identifying any clinically inappropriate changes in timing of the delivery of such services."¹

CONCLUSION

These dollars do not vanish. They are reallocated to the overall practice expense pool, so there is no net savings to Medicare from the policy. But this emphasis on getting the payment right (at least from CMS' point of view) is the tip of the iceberg as the overall scrutiny of physician payment methods increases. New payment models such as a true bundling of payment for services frequently performed together are being evaluated. Reduction of the professional component for every code subject to MPPR has been proposed. A fixed payment for all care for a patient with a given diagnosis such as macular degeneration or diabetic retinopathy might become part of the process.

The relentless drive to reduce costs in the Medicare program will certainly not spare physicians. Ophthalmology is an attractive target because we care for so many patients in the Medicare age group and use many imaging tests to manage treatment. ■

Stephen A. Kamenetzky, MD, is currently the AAO Advisor to the AMA Relative Value Update Committee (RUC) and a consultant to the AAO Health Policy Committee. He is a Medical Director for Anthem Blue Cross and Blue Shield of Missouri and Clinical Professor of Ophthalmology and Visual Science at Washington University School of Medicine, St. Louis, MO. Dr. Kamenetzky states that he has no financial relationships to disclose. He may be reached kamen1@mindspring.com.

1. Final Rule [CMS-1590-FC]. Centers for Medicare & Medicaid Services. November 16, 2012. Pages 68891-69380. <http://www.gpo.gov/fdsys/pkg/FR-2012-11-16/html/2012-26900.htm>. Accessed January 9, 2012.