Diminishing Rates of Return

Multiple Procedure Payment Reductions

By Franklin J. Rooks Jr, PT, MBA, Esq.

Background

RECENTLY, SEVERAL THERAPISTS CONtacted the Private Practice Section about the current payment environment for participating providers. Their questions were prompted by the changes in Medicare payments and the trickle-down effect to the payment schemes of other insurers. In particular, the therapists raised concerns about the cascading reimbursement under the Multiple Procedure Payment Reduction (MPPR) paradigm and the impact it has on the viability of their practices. To provide some context, it is important to first review how Medicare calculates the allowable fee. Each therapy service has three relative value units (RVUs): (1) a practice expense component, (2) a work component, and (3) a malpractice component. The three RVUs for a given service are each multiplied by a unique geographic practice cost index (GPCI). The general formula for calculating Medicare payment amounts is expressed as the (Work RVU multiplied by the Work GPCI) *plus* (Practice Expense RVU multiplied by the Practice Expense GPCI) *plus* (Malpractice RVU multiplied by the Malpractice GPCI). The sum of this is the Total RVU. The Medicare payment is the Total RVU multiplied by the Calendar Year Conversion Factor.

The MPPR reduces the amount that Medicare pays providers. The MPPR is an ominous concept crafted by the Centers for Medicare & Medicaid Services (CMS). In 2011, CMS adopted the MPPR in the final Medicare physician fee schedule rule. The MPPR is applicable to certain Part B outpatient therapy services. The MPPR applies only to the practice expense component of therapy services. Effective for claims with dates of service on or after April 1, 2013, Medicare pays the therapy procedure, with the highest allowable paid at 100%. That is, CMS authorizes full payment for all three of the relative value units comprising that fee's allowable amount. For subsequent units and procedures, CMS allows 50% payment for the practice expense component, furnished to the same patient on the same day.[1] The work and malpractice components are unaffected. In plain English, the MPPR functions to reduce the allowable amount of multiple medical procedures that are performed during the same session by the same provider.[2] Some insurance carriers, such as Aetna, have modeled their reimbursement on this CMS policy and implemented their own versions of the MPPR.[3] The MPPR has its criticisms, namely, the payment is not commensurate with the education, skill, and value that the physical therapist delivers.

Same Service, Less Payment

The MPPR's financial impact is obvious. The American Physical Therapy Association (APTA) has estimated that the MPPR policy will reduce Medicare reimbursement by approximately 6% to 7%.[4] This reduction estimate does not consider the additional 1.6% sequestration reduction implemented by the Budget Control Act of 2011. The financial impact is harder to quantify with other payers. Aetna, for example, has its version of the MPPR, which varies slightly from the CMS version. CMS has only 1 payment rate and payment structure in a given geographic area. Aetna, on the other hand, may

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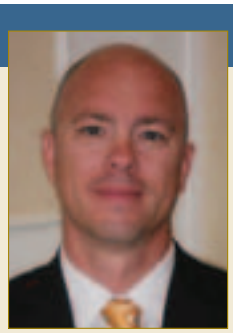

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have several different types of payment structures in the same area.[5] Accordingly, the physical therapist is likely to face difficulty when trying to quantity the payment losses for this payer.

Under the MPPR, physical therapists will perform the same service and receive less payment. Prior to April 1, 2013, the MPPR reduced the practice expense component by 25% for the second procedure. After April 1, 2013, MPPR reduced the practice expense component by 50%, instead of 25%, for the very same procedure.[6] The practice expense component of the Medicare allowable is intended to cover overhead and other indirect costs associated with providing treatment. The MPPR policy assumes that there are redundancies in the practice expense component when multiple services or procedures are performed for the same patient on the same day. Any private practice owner would assuredly challenge that assumption.

Diminishing Returns

Economic theory has a law of "diminishing returns." In its simplest sense, this law postulates that, in a production process, additional units of output will at some point yield lower per-unit returns. With diminishing returns, the increase in production is not proportional to the additional investment needed to produce that additional unit. In treating a patient, each additional unit of time (15 minutes) spent with the patient (i.e., additional labor input) yields a return that is less than the return from the first unit of time spent with the patient. This is clearly true of the MPPR. The first unit yields 100% of the allowable amount, with successive units generating a reduced reimbursement amount.

The law of diminishing returns, relative to the MPPR, is patient-specific. The additional per-unit return decreases with each successive unit billed to *that* patient. The clock is reset for each additional patient seen. That is, with patient "A," the first unit is paid at 100% of the allowable, and then successive units are reduced by the MPPR. When the therapist begins treatment for patient "B," the first unit billed to this patient is paid at 100% of the allowable, and then successive units are reduced by the MPPR.

Some enterprising physical therapists have discovered that they can counter the law of diminishing returns and minimize the impact of the MPPR. Consider the illustration below, which uses payment amounts taken from an Aetna explanation of benefits for services rendered in April 2013.

Each example in the illustration above encompasses 3 hours of treatment time. In Scenario I, 3 patients are treated, and receive 4 units each. In Scenario II, 4 patients are treated, and receive 3 units each. The same number of units (12) are delivered in each scenario. In Scenario II, delivering 3 units to each patient results in higher payment for the 3-hour period. As expected, the marginal return for each

Example of benefits for services rendered in April 2013

Scenario I: 4 Units of Skilled Service Performed						
Patient	**Unit 1 CPT 97112 (100%)**	**Unit 2 CPT 97112 (Reduced by MPPR)**	**Unit 3 CPT 97110 (Reduced by MPPR)**	**Unit 4 CPT 97140 (Reduced by MPPR)**	**Total Reimbursement**	**Total Time**
Patient A	$24.48	$21.88	$21.00	$19.85	$87.21	60 min
Patient B	$24.48	$21.88	$21.00	$19.85	$87.21	60 min
Patient C	$24.48	$21.88	$21.00	$19.85	$87.21	60 min
					$261.63	3 hours

Scenario II: 3 Units of Skilled Service Performed						
Patient	**Unit 1 CPT 97112 (100%)**	**Unit 2 CPT 97112 (Reduced by MPPR)**	**Unit 3 CPT 97110 (Reduced by MPPR)**		**Total Reimbursement**	**Total Time**
Patient A	$24.48	$21.88	$21.00		$67.36	45 min
Patient B	$24.48	$21.88	$21.00		$67.36	45 min
Patient C	$24.48	$21.88	$21.00		$67.36	45 min
Patient D	$24.48	$21.88	$21.00		$67.36	45 min
					$269.44	3 hours

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unit decreases. In light of the declining payment, several therapists have inquired with the Private Practice Section on whether they can, as a matter of policy, schedule patients who are subject to the MPPR for 45-minute treatment slots.

Ethical and Legal Concerns

A cursory review of APTA's Code of Ethics for the Physical Therapist (the Code) makes the analysis moot.[7] Many physical therapists accept non-Medicare insurance plans, which pay less than the cost of doing business. The Code states that "[p]hysical therapists shall seek remuneration as is deserved and reasonable for physical therapist services." [8] Therefore, it would appear that not all practitioners adhere to all of the provisions set forth in the Code. Nevertheless, some tenets are worth mentioning.

Altering the procedures performed during the patient's treatment based on financial concerns, rather than medical necessity, runs afoul of the Code. "Physical therapists shall not engage in conflicts of interest that interfere with professional judgment." [9] By participating with the insurance carrier, the practice owner has agreed to the payment terms. Altering the payment terms should occur at the bargaining table, not in the treatment room. "Physical therapists shall be trustworthy and compassionate in addressing the rights and needs of patients/clients."[10]

It is unclear how the patient's needs can be met when the treatment is not being driven by a clinical presentation. "Physical therapists shall demonstrate independent and objective professional judgment in the patient's/client's best interest in all practice settings."[11] There is nothing that offends the Code by establishing a payment program or different payment rates after the patient has exhausted his or her benefits. However, to vary the treatment duration and procedures, based solely on economic parameters that the physical therapist has agreed to under a participation agreement, shortchanges the patient.

Aside from ethical concerns, potential legal issues should further discourage discriminatory treatment programs predicated on the patient's payer source. This practice would likely offend the participating provider contract. Consider the following excerpt:

> Group Provider shall not discriminate and shall ensure that its Providers shall not discriminate against any Beneficiary in the provision of Covered Services hereunder, whether on the basis of the Beneficiary's coverage under a Benefit Program, age, sex, race, color, religion, ancestry, national origin, disability, handicap, health status, amount of reimbursement by [*insurance carrier name redacted*], utilization of medical or mental health services or supplies or other unlawful basis including, without limitation, the filing by such Beneficiary of any complaint, grievance or legal action against Group Provider, Provider or [*insurance carrier name redacted*]. (emphasis added)

The practice that discriminates against the patient on the basis of payment is likely in breach of the contract. The physical therapist has a duty to the patient to provide appropriate treatment. The provider's failure to deliver medically necessary care could result in negligence claims as well.

Conclusion

For the therapists making the inquiry on scheduling patients relative to a payer's MPPR policy, the rationale and motivation is purely economic. Treating patients for 45 minutes, where an MPPR policy is in effect, will generate better returns than treating them for 60 minutes. The physical therapists' inquiries were directed at the legality of such discriminatory scheduling and treatment policies. The issue of legality, however, need not be reached. The ethical considerations raised by this should preempt any discussion on any legal issues. In the meantime, physical therapists would be well advised to voice their concerns to their legislators and provider representatives. The law of diminishing returns is here to stay, at least for the time being. ■

References

[1] http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM8206.pdf

[2] See http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7050.pdf

[3] See http://www.uhc.com/legal/payment_of_out_of_network_benefits.htm

[4] http://www.apta.org/Payment/Medicare/2013/Changes/

[5] http://www.apta.org/PTinMotion/NewsNow/2012/4/13/Aetna/

[6] http://www.apta.org/PTinMotion/NewsNow/2013/1/4/MPFSFAQ/

[7] http://www.apta.org/uploadedFiles/APTAorg/About_US/Policies/HOD/Ethics/Codeofethics.pdf

[8] See Principle #7B of the American Physical Therapy Associations Code of Ethics for the Physical Therapist.

[9] See Principle #3D of the American Physical Therapy Associations Code of Ethics for the Physical Therapist.

[10] See Principle #2 of the American Physical Therapy Associations Code of Ethics for the Physical Therapist.

[11] See Principle #3A of the American Physical Therapy Associations Code of Ethics for the Physical Therapist.