Dynamic Chiropractic

BILLING / FEES / INSURANCE

Multi-Therapy Payment Reduction

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Q: I recently noticed my fees being reduced by several payers. I inquired about the reductions, and the payers stated that it is a "multi-procedure" reduction. What does this mean and is it legal for them to reduce my fees in this manner?

A: This policy payment is based on a protocol Medicare implemented for physical medicine and rehabilitation services in January 2011. The Centers for Medicare & Medicaid Services (CMS) initiated a new multiple-procedure payment reduction program to reduce the practice expense portion of certain physical medicine and rehabilitation procedures by 20 percent when these procedures are the secondary and/or subsequent procedures reported on a single date of service for the same patient. These procedures are identified with an MP (multiple procedure) indicator 5 on the CMS National Physician Fee Schedule.

CMS gathered data on therapy procedures that are frequently reported together during the same therapy session and determined that there is duplication of the practice expense components among commonly performed procedures. These redundant elements include: cleaning the room and equipment; education; instruction; counseling and coordinating home care; greeting the patient and providing the gown; obtaining measurements (e.g., range of motion); and post-therapy patient assistance.

In essence – similar to the chiropractic adjustment having a pre-service, intra-service, and post-service evaluation imbedded into the overall cost – payers are determining that physical medicine services have a similar value imbedded into each as well. Therefore, when doing multiple services in one visit, such as chiropractic manipulation with physical medicine services, the payment of the full fee for each service would include a payment for a portion of each of the subsequent service(s) that were included in the previous or primary service done on that date.

Currently, CMS has established RVUs (relative value units) for each component of a procedure. There are three types of components: work expense, practice expense, and malpractice expense. When the system processes a claim with certain multiple therapy procedures, it will rank the procedures by the largest amount of practice expense RVUs. The procedure with the largest practice expense RVU will not be reduced, but the second and subsequent procedures will have a 20 percent reduction applied to the portion of the allowed dollars for the practice expense component only.

This process has been in place in Medicare for physical therapy for several years, but of course, had no impact on chiropractic claims, as doctors of chiropractic are not reimbursed by Medicare for any services other than spinal manipulation.

In your question, you did not indicate what insurer was making this reduction, but this style of payment is currently being done by UnitedHealthcare plans. UnitedHealthcare will pay the primary or highest valued service at 100 percent and the subsequent services at 80 percent.

This policy was initiated in March 2012 for plans under UnitedHealthcare that paid a fee per service under Optum Health. However, it had no effect on UnitedHealthcare providers who are being paid a flat rate per diem (generally physical therapists and not doctors of chiropractic). The policy does affect all providers, not just doctors of chiropractic.

Additionally, Blue Shield of California has also implemented a similar policy for chiropractic claims. On Sept. 10, 2012, it added language to its Chiropractic Care Payment Policy stating that the policy limits the maximum services or units per visit to three and pays the highest valued at 100 percent, the second at 60 percent and the third at 40 percent. This policy does have one positive change, in that the insurer's prior policy would not allow multiple units of any service.

Although the current BS of California policy does limit it to three, it does allow multiple units of a single service. I have also heard rumors that some Aetna plans are following similar protocols, but have no direct confirmation or evidence of such.

It is not illegal for an insurer to have such a policy in place, as it is a contract the insurer has with the patient and the insurer makes payments based upon this contract. Furthermore, if the provider is a member of the plan as well, payments by the insurer and copayments that may be collected from the patient are limited to this arrangement. If you are not a contracted member, the patient is liable for any unpaid amounts. This policy only relates to physical medicine services and chiropractic manipulative treatment. Consequently, exams and X-rays are exempt from this reduction provision.

As a point of reference, this style of reduction has been in place in many states' worker's compensation systems. For example, California, Vermont and Arizona are three such states that make a cascade or reduction in payment of subsequent services billed on the same date of service.

Feel free to submit billing questions to Mr. Collins at sam@hjrossnetwork.com. Your question may be the subject of a future column.

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