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ABSTRACT

SUMMARY: Multiple Procedure Payment Reduction currently applies to multiple diagnostic imaging services administered to the same patient during the same day and entails a 50% decrease in the technical component and a 25% decrease in the professional component reimbursement. This might change with time due to further legislation, so it is important to be up-to-date on these health policy developments.

ABBREVIATION: MPPR = Multiple Procedure Payment Reduction

The Multiple Procedure Payment Reduction (MPPR) has been a major challenge for radiology practice. Despite its criticality, there is a continued need to increase awareness regarding its implementation and resultant impact. This Health Care Reform Vignette aims to outline, in comprehensible terms, the effect of the MPPR on neuroradiologists and the specialty of radiology at large.

WHAT IS THE MULTIPLE PROCEDURE PAYMENT REDUCTION?

MPPR is a per-day Centers for Medicare and Medicaid Services reimbursement policy that applies across disciplines and across different practice settings. Imaging MPPRs apply to multiple diagnostic imaging services administered to the same patient on a single day. With an MPPR, Medicare fully reimburses the most expensive procedure; however, the second and all subsequent procedures are reduced by a specific percentage. Imaging-specific MPPRs are traditionally applied to advanced diagnostic imaging services, which the federal government defines as CT, MR imaging, and sonography.

As a result of the Balanced Budget Act of 2005,[1] the Centers for Medicare and Medicaid Services, through the 2006 Medicare Physician Fee Schedule Final Rule,[2] first applied an MPPR to the technical component of advanced diagnostic imaging services. The technical component of advanced diagnostic imaging represents reimbursement from Medicare for the cost of equipment, nonphysician personnel, and medical supplies in the office setting. In addition, the initial structure of the technical component MPPR policy applied to contiguous body parts within specific families of codes.

Congress and the Centers for Medicare and Medicaid Services continued to expand the scope of the technical component MPPR policy in subsequent years. In fact, the passage of the Patient Protection and Affordable Care Act[3] commonly referred to as "Health Care Reform," resulted in an increase in the technical component MPPR from 25% to 50%. In addition, the 2011 Medicare Physician Fee Schedule Final Rule expanded the scope of the technical component MPPR policy so that it applied to noncontiguous body parts, across different modalities. Although a small amount of efficiencies exist within the technical component when a single patient receives multiple advanced diagnostic imaging services, during the same session, on the same day, this amount is nowhere near 25%, to say nothing of 50%. The decision of the Supreme Court to uphold the constitutionality of the Patient Protection and Affordable Care Act ensured that the 50% technical component MPPR would remain in effect for multiple CT, MR imaging, and sonography procedures, including those services delivered on noncontiguous body parts across different modalities.

The concept of applying an MPPR to the professional component of advanced diagnostic imaging did not come under serious consideration by the federal government until 2011. The Medicare Payment Advisory Commission recommended that Congress apply a professional component MPPR to advanced diagnostic imaging services. The Medicare Payment Advisory Commission unanimously voted in favor of including the profes-

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sional component MPPR recommendation within the June 2011 Annual Report to Congress.[4]

In July 2011, the Centers for Medicare and Medicaid Services, citing the June 2011 Medicare Payment Advisory Commission recommendation, included provisions in the 2011 Medicare Physician Fee Schedule Proposed Rule to apply a 50% multiple-procedure payment reduction to the professional component of advanced diagnostic imaging services. As a result of the effort of organized radiology, the Centers for Medicare and Medicaid Services elected to lower the professional component MPPR reduction to 25% in the Medicare Physician Fee Schedule Final Rule.[5]

Although the Final Rule included a cut of 25% rather than 50%, the policy was expanded in January 2013 so that it now applied to 2 different physicians interpreting multiple images from the same patient, during the same session, on the same day.[6,7] The progression is noteworthy. The Balanced Budget Act of 2005 introduced the technical MPPR to address perceived efficiencies in obtaining imaging of contiguous body parts. These perceived efficiencies are likely overstated. The interpretive component of advanced imaging enjoys very limited efficiencies when a single reader provides these services[8] as described above. It is difficult to posit even a perceived efficiency when 2 different physicians, potentially in separate locations, interpret images of contiguous body parts in the same patient.

WHAT IS A PRACTICAL EXAMPLE OF APPLICATION OF MPPR?

As an example, a hypothetic patient presents to the emergency department with symptoms of a stroke. With an imaging strategy that helps to illustrate the MPPR point, a CT of the head/CT angiography of the neck and head followed perhaps by an MR imaging of the brain are performed on the same day. The MR imaging of the brain, which is the most expensive procedure, will be reimbursed at 100%; however, under the MPPR, the reimbursement of both the CTA and CT of the head will be decreased, the technical component by 50% and the professional component by 25%.

WHAT IS THE OBJECTIVE BASIS FOR MPPR?

It has been suggested that there is no scientific rationale behind the application of a professional component MPPR, especially because the radiologist is morally and professionally obliged to spend an equal amount of time, energy, and expertise interpreting multiple patient images, irrespective of technique or section of the body under review. On a more objective basis, a June 2011 peer-reviewed study published in *Journal of the American College of Radiology*[8] found that the gained efficiency in professional component interpretations under the MPPR rules only ranged from a minimum of 2.96% for CT to a maximum of 5.45% for sonography.[9]

The patients who undergo multiple imaging studies in a single session are often those with the most complex conditions seen by radiologists. These include patients with stroke, severe trauma, or suspicion of metastatic cancer. The effort required by radiologists when interpreting multiple imaging studies on the same patient, during the same session, on the same day, is often more intense, rather than less. Per above, it is difficult to comprehend what argument could be advanced to explain supposed efficiencies obtained by different radiologists interpreting contiguous body parts on the same day.

WHAT IS HR 4302?

HR 4302, the Protecting Access to Medicare Act, signed into law in April 2014, included provisions specifically addressing the 25% professional component Multiple Procedure Payment Reduction. HR 4302/S. 1020, the Diagnostic Imaging Services Access Protection Act, was bipartisan, bicameral legislation, which temporarily prevented the impending 24% cut associated with the flawed sustainable growth rate formula from going into effect for 12 months. With respect to the professional component MPPR, language was included in HR 4302 mandating that the Centers for Medicare and Medicaid Services disclose the specific data that were used in the 2012 Medicare Physician Fee Schedule Final Rule when the 25% reimbursement decrease was initially proposed.[9] Despite this being established law, the specific data have not been shared with organized radiology or the public yet. More recently, HR 6, the 21st Century Cures Act (Section 4003), unanimously passed out of the House Energy and Commerce Committee to repeal the professional component payment reduction of MPPR.

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