Impact of the Professional Component MPPR Policy on Interdivisional Finances in an Academic Radiology Department

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Abstract

Purpose: The professional component (PC) Multiple Procedure Payment Reduction (MPPR) policy reduces reimbursement for two or more imaging services rendered by the same group practice for a single patient in a single session. The purpose of this study was to analyze the impact of the PC MPPR on interdivisional finances in an academic radiology department.

Methods: A retrospective analysis of Medicare collections from imaging services rendered by a single academic radiology department in a tertiary care medical center for calendar year 2014 was performed. The impact of the PC MPPR on each division was calculated as the fraction of the total departmental PC MPPR, and as the proportion of the divisional revenue.

Results: The total decrease in Medicare collections as a result of the PC MPPR was 5.35%. The impact of the PC MPPR on each division as a fraction of the total departmental PC MPPR was: abdominal division (16.63%); thoracic division (23.56%); breast division (0.03%); musculoskeletal division (11.92%); neuroradiology division (34.40%); and noninvasive cardiovascular division (13.46%). The impact of the PC MPPR on each division as a fraction of the divisional revenue was: abdominal (2.82%); thoracic (11.83%); breast (0.66%); musculoskeletal (6.01%); neuroradiology (5.31%); and noninvasive cardiovascular (5.85%).

Conclusions: The PC MPPR differentially affects divisions within an academic radiology department. The neuroradiology and thoracic divisions of our department were the most adversely affected, owing to the high frequency of combined examinations. We speculate that this impact has implications for divisional self-sufficiency, interdivisional relationships, and resident decision making regarding subspecialty training.

Key Words: Multiple procedure payment reduction, MPPR, interdivisional finances, academic radiology department

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INTRODUCTION

In 2006, CMS implemented the Multiple Procedure Payment Reduction (MPPR) policy for certain advanced imaging (CT, MRI, and ultrasound) and surgical services [1,2]. The assertion was put forward that the technical component was more efficient when multiple services were performed on a patient in a single day's session. For example, a technician's time preparing a patient for multiple simultaneous examinations was incurred only once [3]. Under the MPPR policy, the full technical component payment was made for the highest-priced service, and a 25% reduced technical component payment was made for each subsequent contiguous examination to account for these efficiencies [4]. This policy reduced Medicare reimbursement by approximately $96 million in 2006 [3]. The MPPR technical component reimbursement was increased from 25% to 50% by the Patient Protection and Affordable Care Act of 2010, and was applied to noncontiguous parts of the body across various imaging modalities in the 2011 Medicare Physician Fee Schedule final rule [1].

In a 2009 report [3], *Medicare Physician Payments: Fees Could Better Reflect Efficiencies Achieved When Services Are Provided Together*, the US Government Accountability Office (GAO) recommended that CMS further reduce Medicare payments under the MPPR policy. The GAO argued that the MPPR had underestimated overall

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efficiencies because it did not reflect physician work efficiencies occurring in the professional component of imaging services, nor did it include nonimaging and nonsurgical services [3]. The GAO suggested that a systematic 25% MPPR be applied on the physician work component, with an exemption for the savings from the budget neutrality requirement, which would have required that the savings be redistributed by increasing fees for all other services [3]. Despite opposition by the AMA and the ACR, the Medicare Payment Advisory Commission (MedPAC) used the GAO report to recommend that the MPPR be extended to include the professional component [5,6]. In 2011, CMS applied a 25% MPPR to the entire professional component (ie, not just the physician work component) for multiple services performed by the same physician in the same session in the same day [1]. In the 2013 Medicare Physician Fee Schedule final rule, this application was broadened to include one or more physicians in the same group practice [2,4]. The meaning of "separate sessions" was never clearly defined; the CMS indicated that "for the purposes of the MPPR on the PC, scans interpreted at widely different times…would constitute separate sessions, even though the scans themselves were conducted in the same session" [1].

Although the professional component MPPR is just one of multiple reimbursement cuts to the specialty of medical imaging over the past decade, it has the disruptive potential of altering interdivisional finances by affecting certain divisions more than others. For example, some of the most commonly ordered same-patient, same-session examinations include those for trauma and metastatic disease. These combined examinations are heavily discounted by the MPPR, which offers full payment on only the most expensive examination and discounts the others. The purpose of this study was to analyze the impact of the PC MPPR on interdivisional finances in an academic radiology department.

METHODS

A retrospective analysis of Medicare collections from imaging services rendered by a single academic radiology department in a tertiary care medical center for calendar year 2014 (January 1, 2014 to October 6, 2014) was performed. A list of the diagnostic studies subject to the PC MPPR is available [7]. The studies were divided into the following categories: abdominal, thoracic, breast, musculoskeletal, neuroradiology, and noninvasive cardiovascular. Spine studies were divided between the musculoskeletal and neuroradiology division; non-neurological CT angiography and MR angiography studies were assigned to the noninvasive cardiovascular division. Nuclear medicine and interventional radiology were excluded from our analysis because they were not affected by the MPPR at all (ie, no nuclear medicine or interventional radiology Current Procedural Terminology codes were affected by the MPPR). Pediatrics was excluded for a similar reason—in our preliminary analysis, pediatric studies contributed <0.3% of all MPPR reductions. The revenue was annualized; all Medicare invoices were assumed to be resolved.

The divisional PC MPPR in dollars, and the divisional revenue in dollars was calculated for each division. The divisional PC MPPR as a fraction of the total departmental PC MPPR was calculated by dividing the divisional PC MPPR by the total departmental PC MPPR. The divisional PC MPPR as a fraction of the divisional revenue was calculated by dividing the divisional PC MPPR by the sum of the divisional revenue and divisional PC MPPR.

RESULTS

The relative impact of the PC MPPR on each division as a fraction of the total departmental PC MPPR was as follows: abdominal (16.63%); thoracic (23.56%); breast (0.03%); musculoskeletal (11.92%); neuroradiology (34.40%); and noninvasive cardiovascular (13.46%). The relative impact of the PC MPPR on each division as a fraction of the divisional revenue was as follows: abdominal (2.82%); thoracic (11.83%); breast (0.66%); musculoskeletal (6.01%); neuroradiology (5.31%); and noninvasive cardiovascular (5.85%). These results are summarized in Table 1 and Figures 1 and 2. The neuroradiology division had the greatest loss as a fraction of the overall MPPR reduction, whereas the thoracic division had the greatest loss as a fraction of the divisional revenue. The number of pediatric studies affected by the PC MPPR was minimal and not included in the analysis. No nuclear medicine or interventional radiology studies were affected by the PC MPPR. The total departmental loss as a fraction of the total departmental revenue was 5.35%. The overall payer mix was 40.0% Medicare.

The imaging examinations most commonly affected by the PC MPPR include trauma work-ups (which typically included a nonenhanced CT head, CT angiography chest, contrast-enhanced CT abdomen/pelvis, and CT spine reconstructions) and metastatic work-ups (for example: MRI brain, contrast-enhanced CT chest, and