Multiple Procedure Payment Reduction Policy

What Is MPPR?

The Multiple Procedure Payment Reduction Policy, MPPR, was first implemented in 2011 and applies to physical therapy, occupational therapy, and speech-language pathology services provided under Medicare Part B.

Because of MPPR, when therapists bill more than one "always therapy" service (identified by CPT code) on the same day for the same patient, all therapy services beyond the first service provided are subject to a reduction in the practice expense portion of that code. The practice expense portion accounts for approximately 45% of a CPT code's value.

Under this policy, the therapy service with the highest practice expense value is reimbursed at its full value, but the practice expense values for all subsequent therapy services, provided by all therapy providers, are reduced by 50%. The work and malpractice components of the therapy service payment are not reduced.

Background

In the 2011 Medicare Physician Fee Schedule, CMS first proposed the implementation of a 25% MPPR across therapy services. Congress reduced this reduction amount to 20% in the Physician Payment and Therapy Relief Act of 2010 (H.R. 5712). This 20% MPPR was in place from Jan. 1, 2011, to March 31, 2013. Without any further analysis demonstrating a need to increase the MPPR, Congress enacted a permanent 50% MPPR in the American Taxpayer Relief Act of 2012, which was implemented by CMS on April 1, 2013. The sole reason Congress implemented MPPR in 2013 was not based on data or evidence but as a pay-for to address the Sustainable Growth Rate, or SGR, which was repealed through the Medicare Access and CHIP Reauthorization Act of 2015. As a result, the average payment per therapy claim in 2013 (after MPPR) was 8.5% less than the average therapy claim in 2010 (before MPPR), despite the fact that the SGR is no longer used, and that the applied reduction percentage has no evidentiary basis.

An Inherently Flawed Policy

The American Occupational Therapy Association, the American Physical Therapy Association, and the American Speech-Language-Hearing Association have opposed the MPPR policy since its inception. In addition to its other shortcomings, MPPR is also inherently flawed given that the American Medical Association RVS Update Committee, which assigns values to CPT codes, reduces all of the practice expense for therapy codes including those expenses that are unique to a specific procedure. Certain efficiencies that occur when multiple therapy services are provided in a single session have been and continue to be explicitly taken into account when relative values are established for these codes. As such the application of MPPR at claims processing represents a duplicative reduction so that the value of the code fails to cover the cost of providing the procedure.

Simply stated, the reduction to these codes occurs both during the valuation of the code and during claims processing. As such, the application of MPPR to the "always therapy" codes results in an excessive and duplicative reduction of these codes and has a significant impact on the financial viability of therapy practices — ultimately impacting access to vital therapy services. The percentage of payment reduction was arbitrarily decided and does not reflect actual utilization data regarding how many units of a therapy service are typically delivered in a treatment session, and it does not recognize that OT, PT, and SLP interventions are separate and distinct from each other.

Other factors support that MPPR is not appropriate because it applies a reduction where clinical staff activities are simply not duplicative between services. Notably, when CMS first proposed MPPR, they purposefully did not consider how therapy services are provided in facility-based settings, even stating that it does "not believe it would have been appropriate for us to consider institutional patterns of care." With the potential exception of greeting the patient, clinical staff activities that are elements of the practice expense are not duplicative in nature and should not be reduced in value, especially when delivering different services during the therapy session, however the RUC has slashed all elements of practice expense including those that are non-duplicative in the code valuation process.

CMS Recognizes MPPR Is a Problem

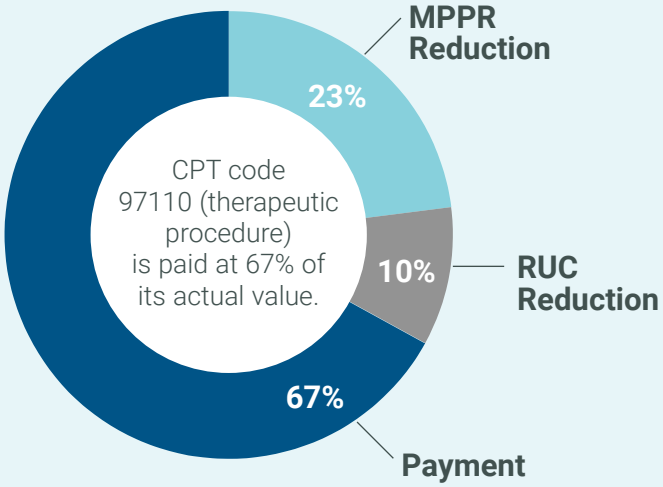
"As discussed in the proposed rule, we reviewed the clinical labor time entries for these 19 therapy codes. We noted that we did not believe a payment reduction should have been applied to the 19 nominated therapy codes' clinical labor time entries since the payment valuation reduction would be duplicative of the MPPR we apply during claims processing."

(Medicare Physician Fee Schedule Final Rule, Nov. 2, 2023)

Last updated: May 2025

Clinical Example

In this clinical example if a patient receives one unit of self-care retraining in the kitchen (CPT code 97535), followed by therapeutic exercises (CPT code 97110) using exercise equipment and a treatment mat, then the equipment, supplies, and clinical staff activities are entirely separate for each of these procedures. Each requires its own set-up, clean-up, disinfection, patient positioning, etc., before and after the procedure. Under the current policy, despite those services being separate and distinct, and having a separate and distinct practice expense, payment for the second unit (CPT 97110) is reduced even though the values of the two codes do not include any duplicative cost and despite the fact the RUC has already reduced the practice expense inputs based on therapists generally billing multiple procedures during a treatment session.



MPPR Negatively Impacts Multidisciplinary Practice

MPPR also inappropriately applies across therapy disciplines (physical therapy, occupational therapy, speech-language pathology) delivered on the same date regardless of the distinct services and supplies provided to the patient. While the first therapy discipline would receive payment under MPPR at 100% for the first unit and 50% of the practice expense for all other units, a second or third discipline delivering services on that date, would have all provided service units reduced. This occurs even though the equipment, clinical staff, and supplies utilized for one therapy service have no overlap with the other services provided. This policy penalizes providers when scheduling multiple therapies on the same date which disproportionately affects beneficiaries in rural and underserved communities where transportation issues may require therapy services to be delivered on the same day to reduce the need for repeat visits to the clinic.

Solution

Congress and CMS must repeal the inherently flawed policy of MPPR that unfairly penalizes therapy providers under the Medicare Physician Fee Schedule.

The Economic Value of Physical Therapy in the United States

A September 2023 report from the American Physical Therapy Association outlines the cost-effectiveness and economic value of physical therapist services for a broad range of common conditions. "The Economic Value of Physical Therapy in the United States" reinforces the importance of physical therapists and physical therapist assistants in improving patient outcomes and decreasing downstream costs. Policymakers should use this report to inform legislative and regulatory efforts for health care delivery and payment under Medicare, Medicaid, and commercial payers. **Review the findings at ValueofPT.com.**

American Physical Therapy Association

The American Physical Therapy Association is a national organization representing 100,000 physical therapists, physical therapist assistants, and students of physical therapy. Our mission is to build a community that advances the profession of physical therapy to improve the health of society.

For more information and contact information for APTA Government Affairs staff, scan here or visit apta.org/position-paper.

APTA American Physical Therapy Association