Payment Policy: Multiple Procedure Payment Reduction (MPPR) for Therapeutic Services

Reference Number: CC.PP.068
Product Types: ALL
Last Review Date: 08-18-20

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
Physical, Occupational, and Speech Therapy services are timed-based procedure codes and therefore multiple units may be billed for a single procedure. However, certain practice expense services are not repeated when more than one unit or procedure is provided to the same patient on the same day. The MPPR for therapeutic procedures applies to multiple units and procedures.

Physical medicine and rehabilitation therapy services are frequently performed together on the same date of service. Reimbursement for these procedures includes payment for practice expense services such as 1) greeting the patient, 2) gowning the patient, 3) cleaning the room and equipment, 4) providing education and instruction, 5) counseling and coordinating home care, 6) obtaining measurements, and 7) post-therapy patient assistance; the multispecialty visit pack.

When the same provider or provider group practice provides multiple therapeutic services for the same patient, the practice expense procedures are not performed twice. Therefore, payment at 100% for the practice expense of secondary and subsequent therapeutic procedures would represent duplicative components of the primary procedure.

The Centers for Medicare and Medicaid Services (CMS) establishes reimbursement guidelines for MPPR when the same provider or provider group practice furnishes multiple procedures to the same patient on the same day. When this occurs, full payment is made for the unit or procedure with the highest allowed amount and subsequent procedures/units are reduced by an established percent.

This policy is based on CMS reimbursement methodologies for MPPR and applies a multiple procedure payment reduction to therapeutic procedures assigned a multiple procedure indicator (**MPI) of 5 on the CMS National Physician Fee Schedule (NPFS)**. When multiple procedures/units are billed, full payment (100%) is made for the unit or procedure with the highest value and payment for subsequent procedures/units is reimbursed at 90% of the allowance.

This reduction applies to all therapy services furnished on the same day, regardless of whether the services were provided in one therapy discipline or multiple disciplines, such as physical therapy, occupational therapy, or speech-language pathology.

Application

- Commercial, Marketplace, Medicare, Medicaid
- Physicians and non-physician providers
- In office and other non-institutional settings (i.e., home health agencies)
- Institutional settings (i.e., Comprehensive Outpatient Rehabilitation Facilities)

Reimbursement

The Plan uses the **CMS NPFS MPI of 5** to determine which therapeutic (Physical, Occupational and Speech) services are eligible for the multiple procedure payment reduction for therapeutic procedures.

When multiple (two or more) "always therapy" procedures with an MPI of **5** are performed by the same provider, or by providers within the same group practice, on the same day, the Plan will allow 100% of the maximum allowance for the therapeutic procedure with the **highest cost per unit** and 90% of the allowance for each subsequent therapeutic procedure.

Furthermore, a single therapeutic procedure billed in multiple units is also subject to the MPPR for therapeutic services. Reimbursement for a single procedure billed with multiple units will be reimbursed at 100% of the maximum allowance. Subsequent units will be reimbursed at 90% of the maximum allowance. The claim paid amount is divided by the units billed.

The health plan's prepayment (after services are rendered, but prior to claims payment), automated claims review system will evaluate provider claims that are eligible for multiple procedure payment reduction for selected therapy services.

	Example Therapeutic Procedure Payment Reduction: Single Unit				
CPT Code	**Units**	**Billed Amt**	**Paid Amt**	**Calculation**	**Final Paid**
97140	**1**	**$61.75**	**$22.56**	**100% for highest paid unit**	**$22.56**
97035	1	$29.75	$9.70	2nd procedure @ 90% $9.705x.90)	$8.73 (90% of $9.70)

Example Therapeutic Procedure Payment Reduction: Multiple Units					
CPT Code	**Units**	**Billed Amt**	**Paid Amt**	**Calculation**	**Final Paid**
97110	2	$134.00	$48.78	1st unit @ 90%; ($24.39 x.90) second unit @ 90%	$43.90
97112	**1**	**$67.50**	**$25.43**	**100% for highest paid unit**	**$25.43**
97140	1	$48.00	$20.31	$18.28 (90% of $20.31)	$18.28

Documentation Requirements

Coding and Modifier Information

This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not

guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.
.

CPT/HCPCS Code	Descriptor
G0281	Elec stim unattend for press
G0283	Elec stim other than wound
G0329	Electromagntic tx for ulcers
92507	Speech/hearing therapy
92508	Speech/hearing therapy
92521	Evaluation of speech fluency
92522	Evaluate speech production
92523	Speech sound lang comprehen
92524	Behavral qualit analys voice
92526	Oral function therapy
92597	Oral speech device eval
92607	Ex for speech device rx 1hr
92609	Use of speech device service
96125	Cognitive test by hc pro
97012	Mechanical traction therapy
97016	Vasopneumatic device therapy
97018	Paraffin bath therapy
97022	Whirlpool therapy
97024	Diathermy eg microwave
97026	Infrared therapy
97028	Ultraviolet therapy
97032	Electrical stimulation
97033	Electric current therapy
97034	Contrast bath therapy
97035	Ultrasound therapy
97036	Hydrotherapy
97110	Therapeutic exercises
97112	Neuromuscular reeducation
97113	Aquatic therapy/exercises
97116	Gait training therapy
97124	Massage therapy
97140	Manual therapy 1/> regions
97150	Group therapeutic procedures
97161	Pt eval low complex 20 min
97162	Pt eval mod complex 30 min
97163	Pt eval high complex 45 min
97164	Pt re-eval est plan care

97165	Ot eval low complex 30 min
97166	Ot eval mod complex 45 min
97167	Ot eval high complex 60 min
97168	Ot re-eval est plan care
97530	Therapeutic activities
97533	Sensory integration
97535	Self care mngment training
97537	Community/work reintegration
97542	Wheelchair mngment training
97750	Physical performance test
97755	Assistive technology assess
97760	Orthotic mgmt&traing 1st enc
97761	Prosthetic traing 1st enc
97763	Orthc/prostc mgmt sbsq enc

Modifier	Descriptor
NA	NA

ICD-10 Codes	Descriptor
NA	NA

Definitions:

Occupational Therapy
A form of therapy for those recuperating from physical or mental illness that encourages rehabilitation through the performance of activities required in daily life. For example, self-care skills, education, work, or social interaction.

Physical Therapy
Therapy for the preservation, enhancement or restoration of movement and physical function impaired or threatened by disease, injury or disability. Physical Therapy uses therapeutic exercise, physical modalities (such as massage and electrotherapy) assistive devices, and patient education and therapy.

Practice Expense
Non-physician labor costs, office rental, equipment, supplies and miscellaneous

Same Group Physician and/or Other Health Care Professional: All physicians and/or other health care professionals of the same group reporting the same Federal Tax Identification number.

Speech Therapy
The therapeutic treatment of impairments and disorders of speech, voice, language, communication and swallowing.

Time-Based Therapy Codes
Procedures codes defined by the face-to-face time the physician or other qualified health professional spends with the patient.

Additional Information
NA

Related Documents or Resources
NA

References
1. *Current Procedural Terminology (CPT®)*, 2019
2. *Centers for Medicare and Medicaid Services,* CMS Manual System and other CMS publications and services.
3. *https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-relative-value-files/2020*

Revision History	
08/18/2020	Initial Policy Draft

Important Reminder
For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

This payment policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.