UnitedHealthcare®

Reimbursement Policy

Multiple Procedure Payment Reduction (MPPR) For Therapy Services

Policy Number	MPPR08012011RP	Approved By	UnitedHealthcare Medicare Reimbursement Policy Committee	Current Approval Date	02/26/2014

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

This policy is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare reimbursement policies use Current Procedural Terminology (CPT®*), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms (CMS 1450). Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general resource regarding UnitedHealthcare's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, and/or the enrollee's benefit coverage documents. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare due to programming or other constraints; however, UnitedHealthcare strives to minimize these variations.

UnitedHealthcare may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

Table of Contents

Application

This reimbursement policy applies to services reported using the Health Insurance Claim Form CMS-1500 or its electronic equivalent or its successor form, and services reported using facility claim form CMS-1450 or its electronic equivalent or its successor form. This policy applies to all products, all network and non-network physicians, and other health care professionals.

Multiple Procedure Payment Reduction (MPPR) For Therapy Services

Summary

Overview

Section 3134 of The Affordable Care Act added section 1848(c)(2)(K) of The Social Security Act, which specifies that the Secretary of Health and Human Services shall identify potentially misvalued codes by examining multiple codes that are frequently billed in conjunction with furnishing a single service. UnitedHealthcare is adopting a multiple procedure payment reduction (MPPR) policy for therapy services in order to more appropriately recognize the efficiencies when combinations of therapy services are furnished together.

Effective for claims with dates of service April 1, 2013, and after, Section 633 of the American Taxpayer Relief Act of 2012 revised the reduction to 50 percent for all settings. The Act states that the MPPR applies to services identified as "always" therapy and applies to the second and subsequent therapy services furnished by a single provider to a beneficiary on a single date of service. This policy will apply to all outpatient therapy services paid under Part B, including those furnished in office and facility settings.

Reimbursement Guidelines

As a step in implementing this provision, Medicare is applying a new MPPR to the PE component of payment of select therapy services paid under the MPFS. The reduction will be similar to that currently applied to multiple surgical procedures and to diagnostic imaging procedures. This policy is discussed in the CY 2011 MPFS final rule.

Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. In compliance with CMS, UnitedHealthcare is applying a MPPR to the practice expense payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Full payment is made for the unit or procedure with the highest PE payment. For subsequent units and procedures, furnished to the same patient on the same day, full payment is made at 50 percent payment for the PE for services furnished in both office settings and institutional settings.

For therapy services furnished by a group practice or "incident to" a physician's service, the MPPR applies to all services furnished to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines; for example, physical therapy, occupational therapy, or speech-language pathology.

The reduction applies to the Healthcare Common Procedure Coding System (HCPCS) codes contained on the list of "always therapy" services that are paid under the physician fee schedule, regardless of the type of provider or supplier that furnishes the services (e.g., hospitals, Home Health Agencies (HHAs), and Comprehensive Outpatient Rehabilitation Facilities (CORFs), etc.)

- **For professional claims**, the MPPR applies to the procedures with a Multiple Procedure (Field 21) value of "5" on the Medicare Fee Schedule Database (MFSDB).
- **For institutional claims**, the MPPR apples to procedures with a Multiple Services Indicator (field labeled

MULTSURG) value of "5" on the therapy abstract file. Note that these services are paid with a non-facility PE.

When applying the 50 percent reduction in non-facility PE RVUs, UnitedHealthcare will use the fee schedule amounts.

In addition, UnitedHealthcare will retrieve the non-facility PE RVUs from the physician fee schedule database in order to rank services according to non-facility PE RVU and appropriately apply the MPPR methodology. When the highest non-facility PE RVU applies to more than one of the identified services, UnitedHealthcare will additionally sort and rank these services according to highest fee schedule amount, with the highest of these being priced at 100 percent of the non-facility PE RVU, and the others priced at 50 percent of the non-facility PE RVU for professional claims.

- UnitedHealthcare will use the multiple procedure value of "5," the beneficiary's HIC, the billing provider NPI (TIN) and date of service to identify therapy services subject to the MPPR.
- UnitedHealthcare will apply the MPPR to claims for two or more services identified by the multiple procedure value of 5, for the same beneficiary HIC, same billing provider NPI (TIN) and same date of service
- UnitedHealthcare will sort the services according to the highest non-facility PE RVU amount such that the service with the highest non-facility PE RVU is ranked first.
- In performing the sort, UnitedHealthcare will consider both non-facility PE RVUs for units for procedures billed in multiple time units, and non-facility PE RVUs for procedures not billed based on time, including both in the ranking such that the highest ranked non-facility PE RVU could be either that for a single time unit of a service or a non-time based service for a beneficiary receiving both types of services on a given date of service through the same billing provider.
- If the sort results in the highest ranked non-facility PE RVU applying to two or more services, UnitedHealthcare will additionally sort these highest non-facility PE RVU services according to highest total fee schedule non facility amount, with the service with the highest fee schedule amount ranked first.
- In performing the additional sort according to the full fee schedule amount, UnitedHealthcare will use the full fee schedule amount applicable to 1 unit for those services billed in units.
- When the service ranked highest according to the sorts is billed in units, and multiple units were reported, UnitedHealthcare will rank the first unit as that having the highest non-facility PE RVU.
- UnitedHealthcare will pay the lower of the billed or total fee schedule amount for the service ranked highest according to the sorts described above.
- UnitedHealthcare will pay the lower of the billed or the amount in field 31EE (Reduced Therapy Fee Schedule Amount) for those services ranked below the first ranked service identified through the sorts described above.
- UnitedHealthcare will utilize the current CMS RVU values to administer this policy for claims submitted with a date of service on or after March 1, 2012. These values will be reviewed and updated quarterly to align with CMS when changes are needed.
- UnitedHealthcare will apply the MPPR methodology described above to therapy services meeting all of the criteria described in this policy, **but billed on different days** (i.e., coming in on separate claims for the same beneficiary HIC, billing provider NPI (TIN) and date of service).

Overview for Outpatient Therapy Functional Reporting

CMS implemented a new claims-based data submission requirement for outpatient therapy services, effective January 1, 2013. (Testing Period 01/01/13-06/30/13) It requires reporting with 42 new non-payable functional Healthcare Common Procedure Coding System (HCPCS) G-codes and 7 new severity/complexity modifiers on claims for Physical Therapy (PT), Occupational Therapy (OT), and Speech-Language Pathology (SLP) services from 07/01/13.

Reimbursement Guidelines for Outpatient Therapy Functional Reporting

In order to implement use of these G-codes for reporting function data on January 1, 2013, a new status indicator of "Q" has been created for the Medicare Physician Fee Schedule Database (MPFSDB). This new

status indicator will identify codes being used exclusively for functional reporting of therapy services. These functional G-codes will be added to the MPFSDB with the new "Q" status indicator. Because these are non-payable G-codes, there will be no Relative Value Units or payment amounts for these codes. The new "Q" status code indicator reads, as follows: "Status Code Indicator "Q" –"Therapy functional information code, used for required reporting purposes only." Therapy Services billed without the "G" Code(s) and Severity/Complexity Modifier(s) will be denied/rejected. The following CPT Evaluation/Re-evaluation therapy codes require the functional reporting and severity/complexity modifiers: 92506, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 96125, 97001, 97002, 97003, 97004.

Beginning July 1, 2013, claims will be returned or rejected using a new RA message when non-compliance with these reporting requirements occur. Contractors will alert providers, who submit claims containing any of the following CPT evaluation/re-evaluation therapy codes 92506, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 96125, 97001, 97002, 97003, 97004 without functional information, that these codes require functional G-code(s) and appropriate severity/complexity modifier (s), and effective July 1, 2013, claims that do not include required functional reporting information will be returned or rejected. The following CARC and RARC will be used as the alert message:

- CARC 246- "This non-payable code is for required reporting only"; and
- RARC N566- "Alert: This procedure code requires functional reporting. Future claims containing this procedure code must include an applicable non-payable code and appropriate modifiers for the claim to be processed." **When CPT codes 92506, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 97001, 97002, 97003, or 97004 are submitted without the nonpayable HCPCS codes G8978 to G8999, G9158 to G9176, or G9186 and the appropriate modifier (CH – CN).**

CPT/HCPCS Codes

Code	Description
92506	Evaluation of speech, language, voice, communication, and/or auditory processing (expired effective 12/31/2013; see replacement codes 92521-92524)
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals
92521	Evaluation of speech fluency (eg, stuttering, cluttering) (new code effective 01/01/2014)
92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria) (new code effective 01/01/2014)
92523	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language) (new code effective 01/01/2014)
92524	Behavioral and qualitative analysis of voice and resonance (new code effective 01/01/2014)
92526	Treatment of swallowing dysfunction and/or oral function for feeding
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech
92606	Therapeutic service(s) for the use of non-speech-generating device, including programming and modification (Used for Institutional Claim Billing ONLY)
92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour
92608	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure) (Used for Institutional Claim Billing ONLY)
92609	Therapeutic services for the use of speech-generating device, including programming and modification

Multiple Procedure Payment Reduction (MPPR) For Therapy Services

92610	Evaluation of oral and pharyngeal swallowing function (Used for Functional Reporting Requirement Initiative ONLY)
92611	Motion fluoroscopic evaluation of swallowing function by cine or video recording (Used for Functional Reporting Requirement Initiative ONLY)
92612	Flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording (Used for Functional Reporting Requirement Initiative ONLY)
92614	Flexible fiberoptic endoscopic evaluation, laryngeal sensory testing by cine or video recording (Used for Functional Reporting Requirement Initiative ONLY)
92616	Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording (Used for Functional Reporting Requirement Initiative ONLY)
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour (Used for Functional Reporting Requirement Initiative ONLY)
92618	Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure) (Used for Institutional Claim Billing ONLY)
96125	Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report
97001	Physical therapy evaluation
97002	Physical therapy re-evaluation
97003	Occupational therapy evaluation
97004	Occupational therapy re-evaluation
97010	Application of a modality to 1 or more areas; hot or cold packs (Used for Institutional Claim Billing ONLY)
97012	Application of a modality to 1 or more areas; traction, mechanical
97016	Application of a modality to 1 or more areas; vasopneumatic devices
97018	Application of a modality to 1 or more areas; paraffin bath
97022	Application of a modality to 1 or more areas; whirlpool
97024	Application of a modality to 1 or more areas; diathermy (eg, microwave)
97026	Application of a modality to 1 or more areas; infrared
97028	Application of a modality to 1 or more areas; ultraviolet
97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes
97033	Application of a modality to 1 or more areas; iontophoresis, each 15 minutes
97034	Application of a modality to 1 or more areas; contrast baths, each 15 minutes
97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes
97036	Application of a modality to 1 or more areas; Hubbard tank, each 15 minutes
97039	Unlisted modality (specify type and time if constant attendance) (Used for Institutional Claim Billing ONLY)
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

Multiple Procedure Payment Reduction (MPPR) For Therapy Services

97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113	Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises
97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)
97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97139	Unlisted therapeutic procedure (specify) (Used for Institutional Claim Billing ONLY)
97140	Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97150	Therapeutic procedure(s), group (2 or more individuals)
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes
97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
97537	Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes
97542	Wheelchair management (e.g., assessment, fitting, training), each 15 minutes
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes
97755	Assistive technology assessment (e.g., to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes
97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes
97762	Checkout for orthotic/prosthetic use, established patient, each 15 minutes
97799	Unlisted physical medicine/rehabilitation service or procedure (Used for Institutional Claim Billing ONLY)
G0281	Electrical stimulation, (unattended), to one or more areas, for chronic Stage III and Stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care
G0283	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care
G0329	Electromagnetic therapy, to one or more areas for chronic Stage III and Stage IV pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care as part of a therapy plan of care

Multiple Procedure Payment Reduction (MPPR) For Therapy Services

G8978	Mobility: walking and moving around functional limitation, current status, at therapy episode outset and at reporting intervals (Used for Functional Reporting Requirement Initiative ONLY)
G8979	Mobility: walking and moving around functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting (Used for Functional Reporting Requirement Initiative ONLY)
G8980	Mobility: walking and moving around functional limitation, discharge status, at discharge from therapy or to end reporting (Used for Functional Reporting Requirement Initiative ONLY)
G8981	Changing and maintaining body position functional limitation, current status, at therapy episode outset and at reporting intervals (Used for Functional Reporting Requirement Initiative ONLY)
G8982	Changing and maintaining body position functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting (Used for Functional Reporting Requirement Initiative ONLY)
G8983	Changing and maintaining body position functional limitation, discharge status, at discharge from therapy or to end reporting (Used for Functional Reporting Requirement Initiative ONLY)
G8984	Carrying, moving and handling objects functional limitation, current status, at therapy episode outset and at reporting intervals (Used for Functional Reporting Requirement Initiative ONLY)
G8985	Carrying, moving and handling objects, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting (Used for Functional Reporting Requirement Initiative ONLY)
G8986	Carrying, moving and handling objects functional limitation, discharge status, at discharge from therapy or to end reporting (Used for Functional Reporting Requirement Initiative ONLY)
G8987	Self care functional limitation, current status, at therapy episode outset and at reporting intervals (Used for Functional Reporting Requirement Initiative ONLY)
G8988	Self care functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting (Used for Functional Reporting Requirement Initiative ONLY)
G8989	Self care functional limitation, discharge status, at discharge from therapy or to end reporting (Used for Functional Reporting Requirement Initiative ONLY)
G8990	Other physical or occupational therapy primary functional limitation, current status, at therapy episode outset and at reporting intervals (Used for Functional Reporting Requirement Initiative ONLY)
G8991	Other physical or occupational therapy primary functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting (Used for Functional Reporting Requirement Initiative ONLY)
G8992	Other physical or occupational therapy primary functional limitation, discharge status, at discharge from therapy or to end reporting (Used for Functional Reporting Requirement Initiative ONLY)
G8993	Other physical or occupational therapy subsequent functional limitation, current status, at therapy episode outset and at reporting intervals (Used for Functional Reporting Requirement Initiative ONLY)
G8994	Other physical or occupational therapy subsequent functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting (Used for Functional Reporting Requirement Initiative ONLY)
G8995	Other physical or occupational therapy subsequent functional limitation, discharge status, at discharge from therapy or to end reporting (Used for Functional Reporting Requirement Initiative ONLY)

Multiple Procedure Payment Reduction (MPPR) For Therapy Services

G8996	Swallowing functional limitation, current status at therapy episode outset and at reporting intervals (Used for Functional Reporting Requirement Initiative ONLY)
G8997	Swallowing functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting (Used for Functional Reporting Requirement Initiative ONLY)
G8998	Swallowing functional limitation, discharge status, at discharge from therapy or to end reporting (Used for Functional Reporting Requirement Initiative ONLY)
G8999	Motor speech functional limitation, current status at therapy episode outset and at reporting intervals (Used for Functional Reporting Requirement Initiative ONLY)
G9158	Motor speech functional limitation, discharge status, at discharge from therapy or to end reporting (Used for Functional Reporting Requirement Initiative ONLY)
G9159	Spoken language comprehension functional limitation, current status at therapy episode outset and at reporting intervals (Used for Functional Reporting Requirement Initiative ONLY)
G9160	Spoken language comprehension functional limitation, projected goal status at therapy episode outset, at reporting intervals, and at discharge from or to end reporting (Used for Functional Reporting Requirement Initiative ONLY)
G9161	Spoken language comprehension functional limitation, discharge status, at discharge from therapy or to end reporting (Used for Functional Reporting Requirement Initiative ONLY)
G9162	Spoken language expression functional limitation, current status at therapy episode outset and at reporting intervals (Used for Functional Reporting Requirement Initiative ONLY)
G9163	Spoken language expression functional limitation, projected goal status at therapy episode outset, at reporting intervals, and at discharge from or to end reporting (Used for Functional Reporting Requirement Initiative ONLY)
G9164	Spoken language expression functional limitation, discharge status at discharge from therapy or to end reporting (Used for Functional Reporting Requirement Initiative ONLY)
G9165	Attention functional limitation, current status at therapy episode outset and at reporting intervals (Used for Functional Reporting Requirement Initiative ONLY)
G9166	Attention functional limitation, projected goal status at therapy episode outset, at reporting intervals, and at discharge from or to end reporting (Used for Functional Reporting Requirement Initiative ONLY)
G9167	Attention functional limitation, discharge status at discharge from therapy or to end reporting (Used for Functional Reporting Requirement Initiative ONLY)
G9168	Memory functional limitation, current status at therapy episode outset and at reporting intervals (Used for Functional Reporting Requirement Initiative ONLY)
G9169	Memory functional limitation, projected goal status at therapy episode outset, at reporting intervals, and at discharge from or to end reporting (Used for Functional Reporting Requirement Initiative ONLY)
G9170	Memory functional limitation, discharge status at discharge from therapy or to end reporting (Used for Functional Reporting Requirement Initiative ONLY)
G9171	Voice functional limitation, current status at therapy episode outset and at reporting intervals (Used for Functional Reporting Requirement Initiative ONLY)
G9172	Voice functional limitation, projected goal status at therapy episode outset, at reporting intervals, and at discharge from or to end reporting (Used for Functional Reporting Requirement Initiative ONLY)
G9173	Voice functional limitation, discharge status at discharge from therapy or to end reporting (Used for Functional Reporting Requirement Initiative ONLY)

Multiple Procedure Payment Reduction (MPPR) For Therapy Services

G9174	Other speech language pathology functional limitation, current status at therapy episode outset and at reporting intervals (Used for Functional Reporting Requirement Initiative ONLY)
G9175	Other speech language pathology functional limitation, projected goal status at therapy episode outset, at reporting intervals, and at discharge from or to end reporting (Used for Functional Reporting Requirement Initiative ONLY)
G9176	Other speech language pathology functional limitation, discharge status at discharge from therapy or to end reporting (Used for Functional Reporting Requirement Initiative ONLY)
G9186	Motor speech functional limitation, projected goal status at therapy episode outset, at reporting intervals, and at discharge from or to end reporting (Used for Functional Reporting Requirement Initiative ONLY)

Modifiers

The following modifiers are used for functional reporting requirement initiative **only**.

Code	Description
CH	0 percent impaired, limited or restricted
CI	At least 1 percent but less than 20 percent impaired, limited or restricted
CJ	At least 20 percent but less than 40 percent impaired, limited or restricted
CK	At least 40 percent but less than 60 percent impaired, limited or restricted
CL	At least 60 percent but less than 80 percent impaired, limited or restricted
CM	At least 80 percent but less than 100 percent impaired, limited or restricted
CN	100 percent impaired, limited or restricted

References Included (but not limited to):

CMS Transmittals

Transmittal 826, Change Request 7050, Dated 12/21/2010 (Multiple Procedure Payment Reduction (MPPR) for Selected Therapy Services)

MLN Matters

Article MM7050, Multiple Procedure Payment Reduction (MPPR) for Selected Therapy Services

Article MM8166, Outpatient Therapy Functional Reporting Non-Compliance Alerts

Article MM8206, Multiple Procedure Payment Reduction (MPPR) for Selected Therapy Services

Others

Functional Reporting: PT, OT, and SLP Services Frequently Asked Questions (FAQs); CMS Website

History

Date	Revisions
03/19/2014	FAQ source (rec'd from Payment Integrity) added to Resource section
02/26/2014	• Re-review presented to MRPC for approval • Policy content modified per recommendation of MRPC
02/20/2014	Administrative updates
01/17/2014	Administrative updates
11/01/2013	Administrative updates
04/25/2013	Administrative updates
03/27/2013	Administrative updates
02/22/2013	• MLN Matters MM8206 released to communicate the change to MPPR for therapy services to 50 percent reduction for **all** settings effective April 1, 2013 • Since implementation of this policy, *previous direction for reductions had been*: The

	Physician Payment and Therapy Relief Act of 2010 modified the reduction from the initial 25 percent of the practice expense (PE) payment for all settings to 25 percent when furnished in the hospital outpatient department and other facilities that are paid under section 1834(k) of the Social Security Act and to 20 percent for services furnished in clinicians' offices and other settings that are paid under section 1848 of the Act
02/13/2013	• New template implemented, re-review presented to MRPC • Motion passed and policy was approved
08/21/2012	Administrative updates
05/10/2012	Administrative updates
12/28/2011	Administrative updates
07/23/2011	Policy developed and approved