Title: Multiple Procedure Payment Reduction for Therapy Services

Policy Number: RP-051

Version Number: 2026.10.26

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| Medicare Advantage: | PA, WV, DE, NY | Version Effective: | October 26, 2026 |
| Commercial: | PA, WV, DE, NY | Originally Effective: | November 22, 2019 |
| Claim Type: | CMS 1500 | History Versions: | Click Here → History |

**Disclosure**: *The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan and ensure you are reimbursed based on the codes that correctly describe the health care services provided. Reimbursement Policies do not provide guidance on whether a service is a covered benefit under the members' contract. Benefit determinations are based in all cases on the applicable benefit plan contract language and applicable medical policies. Should there be any conflicts between Reimbursement Policy and the member's benefit plan, the member's benefit plan will prevail. Additionally, health care providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Reimbursement Policy is not intended to impact care decisions or medical practice. This Reimbursement Policy is intended to serve as a guide as to how the plan pays for covered services, however, other factors may influence payment and, in some cases, may supersede this policy. The provider should consult their network provider agreement for further details of their contractual obligations. The policy is applicable to designated markets either entirely, or partially, as indicated within the policy. Policy designation of claim type is based on how the provider is contracted with the Plan.*

## Description:

This policy provides the Plan's direction as it pertains to the reduction of reimbursement when multiple therapy services are performed by the same provider, or provider practice, in the same session or on the same calendar day. This is known as Multiple Procedure Payment Reduction or MPPR.

## Reimbursement Guidelines:

### Medicare Advantage

This policy applies to all outpatient "always" therapy services, including those furnished in office and facility settings/place of services. Therapy services that are deemed to be "always" therapy are identified by a multiple procedure indicator of five (5) on the on the Medicare Physician Fee Schedule (MPFS). For these therapy services, the Plan will pay 100% of the Plan allowance for the reported service with the highest Relative Value Units (RVU) practice expense. The Plan will apply a 50% reduction to the practice expense for all additional reported therapy services, when performed for the same member during the same session or on the same calendar day, by the same provider or provider practice.

Many therapy services are time-based codes per their description, meaning multiple units may be billed for a single procedure. In cases where multiple units are reported for the same service code, Plan will pay 100% of the Plan allowance for the first unit and apply a 50% reduction to the practice expense for all additional units of service reported, when performed for the same member during the same session or on the same calendar day, by the same provider or provider practice. Note: See the table below for how to report time-based codes. 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 (e.g., physical/occupational therapy, or speech-language pathology).

Time-based Codes

The Plan follows Medicare's method of counting minutes for timed therapy codes for professional services. When more than one service represented by 15-minute timed codes is performed in a single day, the total number of minutes of service determines the number of timed units billed. Based on the work value of these codes, the expectation is that the provider's direct patient contact time for each unit will average fifteen (15) minutes in length. If only one service is provided in a day, providers should not bill for the services performed for less than eight (8) minutes.

For any single timed CPT code in the same day measured in 15-minute units, providers bill a single 15-minute unit for treatment greater than or equal to eight (8) minutes through and including twenty-two (22) minutes. If the duration of a single modality or procedure, in a day, is greater than or equal to twenty-three (23) minutes, through and including thirty-seven (37) minutes, then two (2) units should be billed. The pattern remains the same for treatment times in excess of the chart below.

| **Minutes** | *Units* |
|---|---|
| 8 - 22 | 1 |
| 23 - 37 | 2 |

| **Minutes** | *Units* |
|---|---|
| 38 - 52 | 3 |
| 53 - 67 | 4 |

| **Minutes** | *Units* |
|---|---|
| 68 - 82 | 5 |
| 83 - 97 | 6 |

| **Minutes** | *Units* |
|---|---|
| 98 - 112 | 7 |
| 113 - 127 | 8 |

| | **Code** | **Service Time** |
|---|---|---|
| *Example 1* | 97112 | 10 minutes of neuromuscular re-education |
| | 97110 | 10 minutes of therapeutic exercise |
| | 97530 | 10 minutes of dynamic activities |
| | | **30 Total Timed Minutes** |

| | **Code** | **Service Time** |
|---|---|---|
| *Example 2* | 97110 | 15 minutes of therapeutic exercise |
| | 97116 | 15 minutes of gait training |
| | 97530 | 10 minutes of dynamic activities |
| | 97035 | 8 minutes of ultrasound |
| | | **48 Total Timed Minutes** |

*Example 1:* Appropriate billing is for two (2) units. The qualified professional would select one appropriate CPT code (97112, 97110, or 97530) to bill since each code was performed for the same amount of time and only one unit is allowed based on the total timed minutes.

*Example 2:* Appropriate billing is for three (3) units. Bill the procedures you spent the most time providing. You would have one (1) unit each of 97110, 97116, and 97530. You are unable to bill for the ultrasound because the total time of timed units that can be billed is constrained by the total timed code treatment minutes (e.g., you may not bill four units for less than 53 minutes total time regardless of how many services were performed). You would still document the ultrasound in the notes.

Note: MPPR reductions are not applicable in NY region.

Massage Therapy *(applicable to PA, WV, DE, NY regions)*

The Plan will not consider separate reimbursement for code 97124 when performed by a Physical Therapist, Chiropractor, Occupational Therapist, or Physiatrist. If code 97124 is billed, it will be denied as not separately reimbursed and non-billable to the member. Manual therapy (97140) should be reported only when the service meets the CPT definition for manual therapy techniques and is supported by documentation.

**Commercial**

Massage Therapy

The Plan will not consider separate reimbursement for code 97124 when performed by a Physical Therapist, Chiropractor, Occupational Therapist, or Physiatrist. If code 97124 is billed, it will be denied as not separately reimbursed and non-billable to the member. Manual therapy (97140) should be reported only when the service meets the CPT definition for manual therapy techniques and is supported by documentation.

## Coding: N/A

## Definitions:

| Term | Definition |
|---|---|
| RVU Practice Expense | The portion of the Total Relative Value Units that account for the non-physician clinical and nonclinical labor of the practice, as well as expenses for building space, equipment, and office supplies. |
| Multiple Procedure Indicator 5 | Special reduction rule for the practice expense component for certain outpatient “always” therapy services on the Medicare Physician Fee Schedule (MPFS). |

## References:


- The Centers for Medicare & Medicaid Services (CMS); Publication 100-04, Chapter 12.
- (CMS) Multiple Procedure Payment Reduction (MPPR) for Selected Therapy Services, MLN Matters Number: MM8278, April 1, 2013,


## Related Plan Policies:

Refer to the following Medicare Advantage Medical Policies for additional information:

- N-156: Therapy for Pulmonary Conditions – NCD 240.3.240.7
- N-174: Outpatient Physical Medicine and Rehabilitation Services, Physical Therapy and Occupational Therapy

Refer to the following Commercial Medical Policies for additional information:

- Y-1: Therapy and Rehabilitation Services (PT, OT)
- Y-9: Manipulation Services
- Y-14: Speech-Language Pathology Services
- Y-24: Respiratory Therapy
- V-23: Temporomandibular Joint (TMJ) Dysfunction

Refer to the following Reimbursement Policies for additional information:

- RP-035: Correct Coding Guidelines

## Policy Update History:

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|---|---|
| 7 / 2024 | Medicare Advantage applicable box unchecked for New York |
| 10 / 2026 | Added direction for code 97124 applicable to Commercial and Medicare Advantage with regional variances for MA noted |

# Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

| | | | |
|---|---|---|---|
| **Bulletin Number:** | RP-051 | | |
| **Subject:** | Multiple Procedure Payment Reduction for Therapy Services | | |
| **Effective Date:** | November 22, 2019 | **End Date:** | |
| **Issue Date:** | July 25, 2024 | **Revised Date:** | July 2024 |
| **Date Reviewed:** | June 2024 | | |
| **Source:** | Reimbursement Policy | | |

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|---|---|---|---|---|---|---|---|
| **Applicable Commercial Market** | **PA** | ☐ | **WV** | ☐ | **DE** | ☐ | **NY** ☐ |
| **Applicable Medicare Advantage Market** | **PA** | ☒ | **WV** | ☒ | **DE** | ☒ | **NY** ☐ |
| **Applicable Claim Type** | **UB** | ☐ | **1500** | ☒ | | | |

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

HISTORY

## PURPOSE:

This policy provides the Plan's direction as it pertains to the reduction of reimbursement when multiple therapy services are performed by the same provider, or provider practice, in the same session or on the same calendar day. This is known as Multiple Procedure Payment Reduction or MPPR.

## DEFINITIONS:

RVU Practice expense: The portion of the Total Relative Value Units that account for the non-physician clinical and nonclinical labor of the practice, as well as expenses for building space, equipment, and office supplies.

(MPFS) Multiple Procedure Indicator 5: Special reduction rule for the practice expense component for certain therapy services.

## REIMBURSEMENT GUIDELINES:

This policy applies to all outpatient "always" therapy services, including those furnished in office and facility settings/place of services. Therapy services that are deemed to be "always" therapy are identified by a multiple procedure indicator of five (5) on the on the Medicare Physician Fee Schedule (MPFS).

For these therapy services, the Plan will pay 100% of the Plan allowance for the reported service with the highest Relative Value Units (RVU) practice expense. The Plan will apply a 50% reduction to the practice expense for all additional reported therapy services, when performed for the same member during the same session or on the same calendar day, by the same provider or provider practice.

Many therapy services are time-based codes per their description, meaning multiple units may be billed for a single procedure. In cases where multiple units are reported for the same service code, Plan will pay 100% of the Plan allowance for the first unit and apply a 50% reduction to the practice expense for all additional units of service reported, when performed for the same member during the same session or on the same calendar day, by the same provider or provider practice.

**Note:** See the table below for how to report time-based codes.

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.

**Time-based Codes**

The Plan follows Medicare's method of counting minutes for timed therapy codes for professional services. When more than one service represented by 15-minute timed codes is performed in a single day, the total number of minutes of service determines the number of timed units billed.

Based on the work value of these codes, the expectation is that the provider's direct patient contact time for each unit will average fifteen (15) minutes in length. If only one service is provided in a day, providers should not bill for the services performed for less than eight (8) minutes.

For any single timed CPT code in the same day measured in 15-minute units, providers bill a single 15-minute unit for treatment greater than or equal to eight (8) minutes through and including twenty-two (22) minutes. If the duration of a single modality or procedure, in a day, is greater than or equal to twenty-three (23) minutes, through and including thirty-seven (37) minutes, then two (2) units should be billed. The pattern remains the same for treatment times in excess of the chart below.

Timed intervals for one (1) through eight (8) units are as follows:

| MINUTES | UNITS |
|---|---|
| 8 - 22 | 1 |
| 23 - 37 | 2 |
| 38 - 52 | 3 |
| 53 - 67 | 4 |
| 68 - 82 | 5 |
| 83 - 97 | 6 |
| 98 - 112 | 7 |
| 113 - 127 | 8 |

HISTORY

**Example 1**

7 Minutes of neuromuscular re-education (97112)
7 Minutes therapeutic exercise (97110)
7 Minutes manual therapy (97140)
**21 Total Timed Minutes**

*Appropriate billing is for one (1) unit.* The qualified professional would select one appropriate CPT code (97112, 97110, or 97140) to bill since each code was performed for the same amount of time and only one unit is allowed based on the total timed minutes.

**Example 2**

18 Minutes therapeutic exercise (97110)
13 Minutes of manual therapy (97140)
10 Minutes of gait training (97116)
8 Minutes of ultrasound (97035)
**49 Total Timed Minutes**

*Appropriate billing is for three (3) units.* Bill the procedures you spent the most time providing. You would have one (1) unit each of 97110, 97116, and 97140. You are unable to bill for the ultrasound because the total time of timed units that can be billed is constrained by the total timed code treatment minutes (e.g., you may not bill four units for less than 53 minutes total time regardless of how many services were performed). You would still document the ultrasound in the notes.

**Note:** The Centers for Medicare & Medicaid Services (CMS) claims processing Publication 100-04 can be referenced for additional details.

HISTORY

**RELATED POLICIES:**

Refer to the following Medicare Advantage Medical Policies for additional information:

- Y-1: Therapy and Rehabilitation Services (PT, OT)
- Y-14: Speech-Language Pathology Services

Refer to the following Reimbursement Policies for additional information:

- RP-035: Correct Coding Guidelines

**ADDITIONAL BILLING INFORMATION AND GUIDELINES:**

- The Centers for Medicare & Medicaid Services (CMS); Publication 100-04, Chapter 12.

- Multiple Procedure Payment Reduction (MPPR) for Selected Therapy Services, MLN Matters Number: MM8278, April 1, 2013, Centers for Medicare & Medicaid Services (CMS)

**POLICY UPDATE HISTORY INFORMATION:**

| | |
|---|---|
| 10 / 2019 | Implementation |
| 7 / 2021 | Added new policy header with expanded regional checkboxes |
| 3 / 2022 | Added policy applicable to Delaware Medicare Advantage |
| 5 / 2023 | Administrative policy review with no changes in policy direction |
| 7 / 2024 | NY Medicare Advantage box unchecked |

HISTORY