



Administrator Action Brief

Refining MPPR to Improve Medicare Beneficiary Access While Preserving Budget Neutrality

The Issue

CMS's current application of the Multiple Procedure Payment Reduction (MPPR) for outpatient therapy assumes practice expense efficiencies across distinct services and disciplines that often do not exist. This approach unintentionally undervalues medically necessary therapy, discourages coordinated care, and contributes to reduced beneficiary access, particularly in rural and underserved communities.

Why This Matters Now

Outpatient therapy providers continue to face sustained payment pressure while demand for rehabilitation services rises with an aging Medicare population. Without refinement, current MPPR methodology risks further contraction in therapy availability, delayed care, and higher downstream Medicare spending driven by preventable hospitalizations, falls, imaging, opioid utilization, and surgical interventions.

The Opportunity

CMS has clear regulatory discretion to refine its claims processing methodology so that practice expense reductions apply only where genuine cost overlap occurs. Targeted refinement would better align reimbursement with actual resource utilization while maintaining statutory compliance and supporting value based care delivery.

Fiscal Impact

These refinements are expected to remain budget neutral because efficiency assumptions are already embedded within established code valuation methodology. Expanded access to timely outpatient therapy is associated with substantial downstream savings through reduced acute care utilization and improved functional outcomes. Even modest increases in therapy utilization and completion rates could generate significant long term Medicare savings while advancing prevention focused care.

CMS Authority

CMS has historically exercised sub regulatory discretion when refining MPPR ordering logic and aggregation methodologies in other service categories. Similar action can be implemented through rulemaking or claims processing guidance without statutory change.

The Request

UPTA respectfully urges CMS to include MPPR refinement in the CY 2027 Physician Fee Schedule proposed rule and adopt a methodology that limits reductions to circumstances where measurable efficiencies exist.

UPTA Support

The United Physical Therapy Association stands ready to provide claims level modeling, technical expertise, and stakeholder collaboration to assist CMS in evaluating and implementing these refinements.

Recommended Actions

- Apply the MPPR practice expense reduction only to additional units of the identical CPT code furnished on the same date of service.
- Do not aggregate services delivered under separate therapy plan of care modifiers (GP, GO, GN) when determining second and subsequent procedures.



United Physical Therapy Association (UPTA)
Petition for Rulemaking to Refine CMS’s Implementation
of the Statutory Therapy MPPR

February 3, 2026

Dr. Mehmet Oz

Administrator, Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Petition for Rulemaking Under 5 U.S.C. § 553(e) Regarding CMS’s Application of the Statutory Multiple Procedure Payment Reduction (MPPR) for Outpatient Therapy Services

Dear Administrator Oz:

The United Physical Therapy Association (UPTA) respectfully requests that the Centers for Medicare & Medicaid Services (CMS) initiate rulemaking to refine its implementation of the statutory Multiple Procedure Payment Reduction (MPPR) as applied to outpatient therapy services under the Medicare Physician Fee Schedule (PFS). A slight change in how CMS applies MPPR will alleviate its current disproportionate impact that unintentionally undervalues distinct therapy services, reduces beneficiary access to care and conflicts with CMS’ own valuation framework.

Under MPPR, Congress required CMS to apply a **50 percent practice expense (PE)** for subsequent therapy (physical, occupational and speech) services furnished by the same provider to the same beneficiary on the same date of service. However, Congress gave CMS discretion for how to achieve the PE cost reduction on therapy services considered “second and subsequent.” Unfortunately, CMS’ implementation of MPPR has disproportionately gutted therapy reimbursement by treating all therapy across disciplines the same and over-estimating the actual expense savings.

This petition requests CMS to exercise its delegated discretion to modify its implementation of MPPR to be more consistent with Congress’ instructions and to ensure MPPR is applied to reduce the PE only where genuine expense efficiencies exist.



Executive Summary

- **CMS Discretion:** CMS has the discretion to review and adjust its application of the 50 percent PE reduction to payment for subsequent services in a manner that focuses on reducing therapy reimbursement only where the assumed practice expense reductions actually occur.
- **CMS's Current Methodology Exceeds Congress' Mandate:** The current application of MPPR exceeds the statutory mandate by incorrectly assuming practice expense reductions occur regardless of the type of therapy provided. Practice expenses account for 55 – 65% of therapy reimbursement, but that assumes the same cost inputs apply to subsequent therapy services. Practice expense savings are not realized in clinics that provide multiple types of therapy services since each require different practitioners, equipment, space, etc. The end result is a real reduction in therapy reimbursement of up to 30% for therapy services even when the assumed cost savings are not realized..
- **Duplicative Reductions:** As CMS has already acknowledged in the CY 2024 PFS, MPPR duplicates expense reduction calculations that are already embedded in the valuation of outpatient therapy services and leads to the undervaluation of therapy codes by 10-15%. A separate study contends that duplicative reductions undervalue subsequent therapy services by 23%.
- **Impact on Rural Care:** Rural communities have substantially fewer therapists and MedPAC has repeatedly identified access to outpatient therapy as a concern, especially for beneficiaries with mobility restrictions. MedPAC estimates that rural beneficiaries have 25% higher unmet therapy needs. The payment reductions due to the over-estimation of PE savings, has reduced therapy availability in rural communities.
- **Requested Change:** To correct the underpayment of therapy services while achieving Congress' mandate to apply a 50% PE reduction for subsequent therapy services, UPTA requests CMS:
 - Apply the MPPR PE reduction only to additional units of the same CPT code;
 - Not apply the MPPR PE reduction to outpatient therapy services provided under different plan-of-care modifiers (i.e. by different types of therapists).
- **The requested refinements are budget-neutral and consistent with CMS's own valuation framework:** Increasing access to outpatient therapy services decreases



utilization of higher acuity and more expensive clinical interventions.

REQUESTED ACTION

For the reasons provided in this briefing memo, CMS should revise its implementation of the therapy MPPR to ensure the statutorily required 50 percent PE reduction is applied in a manner consistent with actual resource use. Specifically, CMS should:

- 1. Apply the MPPR practice expense reduction only to additional units of the identical CPT code** billed on the same date of service for the same beneficiary. When multiple units of the same therapy CPT code are furnished, the PE reduction would apply only to the second and subsequent units of that identical code. The reduction would not apply to other distinct therapy CPT codes furnished on the same date of service. This refinement would not alter existing time-based unit billing rules, 8-minute rule application, or documentation requirements, and would not permit artificial unbundling or code proliferation .
- 2. Do not aggregate therapy services billed under different therapy plan-of-care modifiers** when determining “second and subsequent” services. Services billed under GP (physical therapy), GO (occupational therapy), and GN (speech-language pathology) modifiers should be treated as separate services for MPPR ordering purposes and should not be combined to trigger additional reductions.

CMS has previously exercised similar discretion in defining ordering logic and aggregation rules for MPPR in other service categories, such as diagnostic imaging, demonstrating clear authority to refine implementation without statutory change.

Additionally, CMS should disclose and explain the current claims-processing methodology, including ordering logic, aggregation rules across distinct codes and disciplines, and treatment of therapy modifiers, to enable informed public comment. These changes preserve the statutory MPPR requirement while correcting aspects of CMS’s implementation that extend the PE reduction beyond circumstances where efficiencies plausibly exist.

Alternative Implementation Option for CMS Consideration

If CMS elects not to adopt the above refinements in full, UPTA respectfully proposes an alternative implementation option:



- a. Maintain the current MPPR structure, but
- b. Apply the PE reduction **only when at least 25 percent of PE inputs overlap** between services, using existing RUC practice expense input data.

This approach preserves CMS flexibility, aligns reductions with measurable efficiencies, and avoids over-application where inputs are demonstrably distinct. CMS could implement this approach through sub-regulatory claims-processing guidance or phased testing prior to full rulemaking adoption.

DATA-DRIVEN RATIONALE SUPPORTING RULEMAKING

1. MPPR Duplicates Efficiencies Already Embedded in Therapy Code Valuation:

Outpatient therapy CPT codes are valued through the American Medical Association (AMA) Relative Value Scale Update Committee (RUC) process, which explicitly incorporates assumptions regarding pre-service, intra-service, and post-service efficiencies. The RUC methodology assumes 50-75% efficiencies in pre- and post-service work for therapy codes, as detailed in the AMA RUC Database (2023-2024).

CMS has acknowledged this overlap in recent PFS rulemaking. In the CY 2024 PFS Final Rule (CMS-1784-F), CMS declined to reduce clinical labor time for 19 therapy codes after determining that such reductions would be duplicative because MPPR already applies at the claims-processing level. CMS's analysis in the CY 2024 PFS Proposed Rule (88 FR 52262) estimated that broad MPPR application leads to undervaluation by 10-15% for distinctly different codes. An American Physical Therapy Association (APTA) study (2023) further quantifies this, showing MPPR overlaps with RUC valuations by up to 23% for common code pairs.

Applying MPPR broadly across distinctly different “always therapy” CPT codes produces payment levels that no longer align with CMS's own valuation methodology.

2. Quantified Financial Impact on Therapy Services:

CMS utilization data show that most outpatient therapy visits include multiple distinct CPT codes, triggering MPPR in approximately **80 percent of therapy encounters**.



Key data points include:

- Practice expense accounts for approximately 55–65 percent of total RVUs for most therapy CPT codes (CMS PFS Relative Value Files, CY 2024; e.g., ~60% for 97110).
- A 50 percent PE reduction therefore equates to an effective 25–30 percent reduction in payment for affected services, as calculated by APTA and Clinicient analyses.
- Analyses by professional organizations estimate that MPPR reduces total payment per therapy visit by approximately 6–7 percent on average, depending on code mix (APTA Position Paper on MPPR, 2023).
- Post-MPPR implementation (2011-2013), average therapy claim payments fell 8.5% (APTA, 2023).
- Between 2010 and 2024, inflation-adjusted Medicare payment for outpatient therapy services declined by approximately 30 percent, based on CMS conversion factor history (from \$36.87 in 2010 to \$32.74 in 2024, a nominal 11% cut) adjusted using Bureau of Labor Statistics (BLS) Consumer Price Index for All Urban Consumers (CPI-U) data (cumulative inflation ~50% over the period). Broader physician payments have declined 33% from 2001-2025 when adjusted for inflation (AMA, 2024).
- During 2020-2024, physical therapy practices saw a 34% drop in PFS spending during the early pandemic, with MPPR exacerbating recovery (Medicare Payment Advisory Commission [MedPAC] Report to Congress, June 2024).
- Rising costs: Practice expenses increased 15-20% post-pandemic (e.g., staffing and equipment), per BLS Producer Price Index for Health Care (2021-2024).

When combined with the statutory 15 percent payment differential for services furnished by physical therapist assistants (CQ/CO modifiers), these reductions materially constrain the financial capacity of practices to maintain staffing levels, visit duration, and service availability, leading to 7-20% total revenue losses (APTQI, 2024). This penalizes providers by improperly applying MPPR to distinct "always therapy" codes.

3. Illustrative Example of Current MPPR Impact

To illustrate the impact of the current blanket MPPR application on distinct codes, consider a common therapy session with 2 units of 97530 (therapeutic activities), 1 unit of 97110 (therapeutic exercises), and 1 unit of 97112 (neuromuscular re-education). Using CY 2026 RVU values (similar to CY 2024 as no major changes were adopted for



these codes in the final rule), the table below shows the calculation without and with MPPR. The conversion factor used is the CY 2026 non-qualifying APM factor of \$33.40 for estimation. Note that MPPR treats each unit as a separate procedure, ranking them by PE RVU, paying the highest full PE, and reducing subsequent PE by 50%, even for distinct codes with different RVUs and clinical purposes.

Code	Units	Work RVU	PE RVU (Full)	MP RVU	Total RVU (Full)	Adjusted PE RVU (MPPR)	Adjusted Total RVU (MPPR)	Payment Without MPPR	Payment With MPPR
97530	1	0.50	0.50	0.02	1.02	0.50 (highest, full)	1.02	\$34.07	\$34.07
97530	1	0.50	0.50	0.02	1.02	0.25	0.77	\$34.07	\$25.72
97112	1	0.50	0.48	0.02	1.00	0.24	0.76	\$33.40	\$25.38
97110	1	0.45	0.45	0.02	0.92	0.225	0.695	\$30.73	\$23.21
Total	4	1.95	1.93	0.08	3.96	1.215	3.255	\$132.27	\$108.38

This example demonstrates an ~18% overall reduction (\$23.89 loss), despite the codes being distinct with varying RVUs, clinical objectives, and resource use. The blanket reduction assumes efficiencies that do not exist across different interventions, leading to undervaluation. If services are performed by a Physical Therapist Assistant, or Occupational Therapist Assistant, another 15% reduction is applied to final payment.

4. Disproportionate Impact on Rural and Underserved Communities

Multiple CMS and MedPAC reports document that rural communities have significantly fewer rehabilitation providers per capita than urban areas and that rural practices operate with lower patient volumes and higher per-visit fixed costs. Relevant data include:

- Rural counties have substantially fewer physical therapists per capita than metropolitan areas—only 8.5 PTs per 10,000 residents in rural areas versus 19.7 in urban (Health Resources and Services Administration [HRSA] Area Health Resource Files, 2024).



- Urban areas have 2.3 times more physical therapists per capita than rural communities (HRSA, 2023).
- MedPAC has repeatedly identified access to outpatient therapy as a concern for rural Medicare beneficiaries, particularly those with mobility limitations, noting that 17% of beneficiaries are rural with documented therapy access gaps (MedPAC Reports to Congress, multiple years, including 2024 and 2025).
- 15-20% of rural practices are at risk of closure due to PFS cuts, including MPPR (MedPAC, 2025).
- Rural Medicare users have 25% higher unmet therapy needs (CMS Rural-Urban Disparities in Health Care in Medicare, 2024).
- Government Accountability Office (GAO) and CMS analyses show that Medicare beneficiaries in rural areas travel longer distances for outpatient services—averaging 30+ miles for therapy, leading to 10-15% higher no-show rates (GAO Medicare Access and Rural Health Care Reports, 2023).

MPPR discourages same-day provision of clinically appropriate combinations of therapy services by reducing payment for each additional service, increasing patient travel burden and delaying care in communities with limited provider availability. This exacerbates rural disparities, as many practices will not see a patient on the same day for both PT and OT services due to the MPPR reduction on each discipline, even though they are distinct with separate providers, plans of care, and resources.

These provider-side constraints disproportionately affect rural patients, who already face geographic isolation, lower socioeconomic status, and higher rates of chronic conditions requiring therapy (e.g., from agricultural work, aging populations, or conditions like arthritis and knee osteoarthritis). For instance, rural Medicare beneficiaries are less likely to receive physical therapy for knee osteoarthritis or rehabilitation evaluations after hip fracture surgery, leading to delayed treatment and poorer recovery outcomes. Studies indicate that limited PT access in rural areas contributes to 25% higher unmet therapy needs, resulting in worsened mobility, increased fall risks (with 50% higher emergency visits for unmanaged falls), higher opioid reliance (up to 28% more without timely PT), and 20-30% elevated hospitalization rates for preventable complications. Rural patients, often older, sicker, and poorer than urban counterparts, may forgo care altogether due to prohibitive travel costs and time, perpetuating cycles of chronic pain, reduced quality of life, and greater overall Medicare expenditures through avoidable downstream interventions.



Payment policies like MPPR amplify these disparities by straining rural practices, forcing closures or reduced services, and ultimately denying equitable access to essential therapy for vulnerable populations.

5. **Barriers to Coordinated, Multidisciplinary Care**

CMS's aggregation of therapy services across disciplines for MPPR purposes creates incentives to fragment care by avoiding same-day scheduling of physical therapy, occupational therapy, and speech-language pathology services. 40-50% of practices avoid same-day PT/OT to evade MPPR, per an APTA survey (2024). There is no evidence that therapy services across disciplines share duplicative practice expense inputs—distinct codes and modifiers show less than 5% shared PE inputs (RUC data, 2023).

These services involve:

- Different providers
- Different plans of care
- Different clinical objectives
- Different equipment, tools, and testing instruments.

Applying MPPR across disciplines therefore lacks an empirical basis and runs counter to CMS priorities related to care coordination, prevention, and efficient outpatient management. Peer-reviewed literature consistently demonstrates that timely, complete courses of outpatient therapy reduce downstream utilization, including hospitalizations and surgical interventions, particularly for musculoskeletal and neurologic conditions. For example:

- A completed physical therapy course saves an average of \$13,540 per patient across eight common conditions (e.g., low back pain, falls), potentially avoiding \$380 billion in annual U.S. healthcare costs through prevention (APTA Economic Value Report, 2024).
- For falls: Physical therapy after a fall reduces emergency room and hospital visits by 50%, saving over \$10 billion annually if increased among Medicare patients prone to falls (APTQI Analysis, 2023).
- For low back pain: Physical therapy as first-line treatment saves 19% versus injections (\$11,151 vs. \$13,606 per year) and 54% versus surgery (\$11,151 vs. \$36,772) (Health Services Research, 2017; confirmed in 2023 updates).
- Timely physical therapy reduces opioid use by 28% and imaging by 15% for musculoskeletal conditions (JAMA Network Open, 2022).



Payment policies that discourage appropriate service delivery undermine these cost-saving effects.

6. Potential Cost Neutrality and System-Wide Savings

The proposed refinements would promote access without compromising budget neutrality, as therapy efficiencies are already captured in RUC valuations. By encouraging coordinated care, these changes could enhance system-wide savings: physical therapy's preventive role avoids downstream costs like hospitalizations (e.g., \$380 billion potential annual savings nationally, per APTA, 2024). CMS's own data shows undervalued therapy leads to higher overall Medicare expenditures through delayed interventions, countering goals for value-based care.

Encouraging appropriate, coordinated therapy services reduces downstream utilization, hospitalizations, opioid use, and surgical interventions—advancing CMS value-based objectives.

Conclusion

This petition does not seek repeal of the statutorily mandated therapy MPPR, nor does it challenge Congress's authority to require a practice expense reduction. Rather, it requests a targeted, data-driven refinement of CMS's implementation, so that the required PE reduction is applied only where genuine efficiencies exist, along with disclosure and explanation of the current claims-processing methodology to support informed public input. Refining MPPR application to limit reductions to duplicate units of the same CPT code and to avoid aggregation across therapy disciplines would:

- Improve alignment with CMS's valuation framework
- Support beneficiary access, particularly in rural and underserved areas
- Preserve statutory compliance
- Advance CMS goals related to prevention, coordination, and value



UPTA respectfully requests that CMS:

- Include this issue in the **CY 2027 PFS Proposed Rule** for public comment, and
- Implement any finalized refinements **effective January 1, 2027**, consistent with annual PFS timelines.

Thank you for your consideration.

Sincerely,

A handwritten signature in black ink, appearing to read 'S. Gardner', is positioned below the word 'Sincerely,'. The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Scott Gardner, PT, DPT President
United Physical Therapy Association



Appendix A

References

1. Centers for Medicare & Medicaid Services. (2024). Physician Fee Schedule Relative Value Files (CY 2024). <https://www.cms.gov/medicare/payment/physicianfeesched/pfs-relative-value-files>
2. Centers for Medicare & Medicaid Services. (2023). Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule (Final Rule, CMS-1784-F). Federal Register, 88(220), 78818-80103. <https://www.govinfo.gov/content/pkg/FR-2023-11-16/pdf/2023-24184.pdf>
3. Centers for Medicare & Medicaid Services. (2023). CY 2024 PFS Proposed Rule (88 FR 52262). <https://www.federalregister.gov/documents/2023/08/07/2023-14624/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other>
4. Medicare Payment Advisory Commission (MedPAC). (2024). Report to the Congress: Medicare Payment Policy (June 2024). <https://www.medpac.gov/document/june-2024-report-to-the-congress-medicare-payment-policy/>
5. Medicare Payment Advisory Commission (MedPAC). (2025). Medicare's Measurement of Rural Provider Quality (June 2025 Report, Chapter 6). <https://www.medpac.gov/document/june-2025-report-to-the-congress-medicare-and-the-health-care-delivery-system/>
6. Bureau of Labor Statistics. (2024). Consumer Price Index for All Urban Consumers (CPI-U). <https://www.bls.gov/cpi/>
7. Bureau of Labor Statistics. (2024). Producer Price Index for Health Care Services (2021-2024 Data). <https://www.bls.gov/ppi/>
8. Health Resources and Services Administration (HRSA). (2024). Area Health Resource Files. <https://data.hrsa.gov/topics/health-workforce/ahrf>
9. Health Resources and Services Administration (HRSA). (2023). Area Health Resource Files (Previous Year Update). <https://data.hrsa.gov/topics/health-workforce/ahrf>



10. Centers for Medicare & Medicaid Services. (2024). Rural-Urban Disparities in Health Care in Medicare. <https://www.cms.gov/files/document/rural-urban-disparities-health-care-medicare-2024.pdf>
11. Government Accountability Office (GAO). (2023). Medicare Access and Rural Health Care Reports. <https://www.gao.gov/products/gao-23-105408>
12. American Physical Therapy Association (APTA). (2023). Multiple Procedure Payment Reduction Policy Position Paper. <https://www.apta.org/contentassets/20fd56498ab446949c89517f546e4fb3/apta-positionpaper-mppr-final.pdf>
13. American Physical Therapy Association (APTA). (2024). Economic Value of Physical Therapy in the United States. https://www.valueofpt.com/globalassets/value-of-pt/economic_value_pt_u.s._report_from_apta-policy_paper-policymakers.pdf
14. American Physical Therapy Association (APTA). (2024). Survey on Practice Impacts of MPPR and PFS Cuts. <https://www.apta.org/your-practice/payment/medicare-payment/coding-billing/mppr>
15. Alliance for Physical Therapy Quality and Innovation (APTQI). (2024). Impact of PFS Cuts on Therapy Providers. <https://www.aptqi.com/resources/>
16. Alliance for Physical Therapy Quality and Innovation (APTQI). (2023). Increased Use of Physical Therapy Among Medicare Patients Prone to Falls. <https://www.aptqi.com/news/analysis-increased-use-of-physical-therapy-among-medicare-patients-prone-to-falls-could-reduce-healthcare-spending-by-10-billion/>
17. Alliance for Physical Therapy Quality and Innovation (APTQI). (2025). Annual Economic Impact Estimate of MPPR on Therapy Providers. <https://www.aptqi.com/resources/>
18. American Medical Association (AMA). (2024). 2025 Medicare Updates Compared to Inflation. <https://www.ama-assn.org/system/files/2025-medicare-updates-inflation-chart.pdf>
19. American Medical Association (AMA). (2023-2024). RUC Database and Methodology. <https://www.ama-assn.org/about/rvs-update-committee-ruc/ruc-database>



20. Fritz JM et al. (2017). Physical Therapy for Low Back Pain and Health Care Utilization. Health Services Research, 52(5), 1628-1650. DOI: 10.1111/1475-6773.12564
21. Horn ME et al. (2022). Association of Physical Therapy Interventions With Opioid Use and Imaging in Musculoskeletal Conditions. JAMA Network Open, 5(7), e2221487. DOI: 10.1001/jamanetworkopen.2022.21487