

TITLE:	MULTIPLE PROCEDURE PAYMENT REDUCTION
DEPARTMENT:	PAYMENT POLICY
ORIGINAL EFF. DATE:	09/22/2026
REVISION DATE:	N/A

1. PURPOSE

This Payment Policy outlines clear and consistent reimbursement guidelines to ensure compliant, transparent, and timely payment for medically necessary, cost-effective care.

2. SCOPE

This policy applies to the reimbursement of covered services for all members and providers. Curative will allow reimbursement for services according to the criteria outlined in this policy, unless modified or superseded by contractual language.

3. DEFINITIONS

The following terms are defined as follows regarding this policy.

- 3.1. **Endoscopic Adjustment Rule** Allows the full allowable amount for the highest Relative Value Unit endoscopy code and reduces any additional endoscopy codes within the same family based on the value of the NPFS, National Physician Fee Schedule designated Endoscopic Base Code.
- 3.2. **Endoscopic Base Code** The most basic, least complex form of the endoscopic procedure within an endoscopic family based on anatomy and approach, usually designated as diagnostic.
- 3.3. **Relative Value Units (RVU)** The assigned unit value of a particular CPT or HCPCS code. The associated RVU is sourced to either the CMS NPFS Non-Facility Total value or Facility Total value.
- 3.4. **Same Individual Provider** The same individual Physician or Other Qualified Health Care Professional rendering health care services reporting the same Federal Tax Identification number.
- 3.5. **Same Specialty Provider** Physicians and/or Other Qualified Health Care Professionals of the same group and same primary specialty reporting the same Federal Tax Identification number.

4. POLICY

Disclaimer: These Payment Policies serve as a comprehensive guide for all providers, assisting in submitting accurate claims and outlining the essential framework for reimbursement. The determination that a service, procedure, or item is covered under a Curative member's benefit plan does not constitute a guarantee of payment. Services must meet medical necessity and authorization guidelines appropriate to the procedure and diagnosis and, where mandated, the members state of residence. Services rendered must be within the legal scope of practice for the specific type of provider and align with the professional credentials and training in the state where the care is furnished.

To ensure proper processing, providers are required to adhere to industry-standard, compliant codes and follow proper coding, billing, and submission guidelines. To ensure accurate reimbursement and proper claims adjudication, all services provided to the same member, by the same provider, and on the same date of service must be reported on a single claim. Current Procedure Terminology (CPT®*) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or relevant revenue codes must be used for billing. Codes submitted must be fully supported by corresponding documentation in the medical record. Unless noted otherwise within a policy, these payment policies apply to both participating and non-participating providers and facilities.

Curative reserves the right to take corrective action, which may include the rejection or denial of the claim, or the recovery and/or recoupment of any previous claim payment if proper coding, billing guidelines, or these established payment policies are not followed. Providers may refer to the Provider Manual for guidance on addressing such actions, including the formal claim reconsideration, appeals, and dispute resolution processes.

These policies may be superseded by mandates within provider contracts, state or federal laws, or requirements issued by the Centers for Medicare & Medicaid Services (CMS). Curative retains the right to revise these policies as deemed necessary and will publish the most current version on the Curative website.

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Reimbursement Guidelines

When the Same Individual Provider or Same Specialty Provider performs several procedures for the same patient on the same date, payment for any services performed after the primary procedure are reduced. Reimbursement at the full rate for each would result in duplicate reimbursement for shared administrative and clinical tasks.

Curative utilizes the CMS National Physician Fee Schedule (NPFS) to identify which services qualify for these reductions and ranks procedures based on their Relative Value Units (RVUs). The total RVU amount contains components for the work RVU, practice expense (PE) RVU and malpractice (MP) RVU. The procedure code with the highest RVU is reimbursed at 100% of the allowable rate, while subsequent procedures are discounted.

Multiple Procedure Indicators utilized from the NPFS:

- **Indicator 2** - Standard Reductions: Applies a 50% reduction to subsequent general surgical or medical services.
- **Indicator 3** - Endoscopic Rules): Applies specialized logic for endoscopic procedures performed within the same "family" (sharing a common base code).

For endoscopic procedures, the highest-valued endoscopy in a family is reimbursed at 100% of the allowable amount and additional endoscopies from that same family are reimbursed at a reduced rate. The amount is calculated by subtracting the value of the "base" endoscopy code to avoid duplicate payment for the initial access/scope insertion. If a provider performs both endoscopic and non-endoscopic surgeries on the same day, the claims may be reimbursed with both types of reductions.

- **Indicator 4** - Diagnostic Imaging: Applies a 50% reduction to the technical portion and a 5% reduction to the professional portion of the subsequent tests.

- **Indicator 5** - Therapy Services: Applies a 50% reduction to the practice expense (PE) RVU of the subsequent “always therapy” designated procedure codes. The highest practice expense RVU across all therapy disciplines (Physical Therapy, Occupational Therapy, Speech-Language Therapy) is allowed at 100% while the subsequent “always therapy” codes receive a 50% reduction to the practice expense RVU. The “MPPR Rate File” can be found on the CMS Therapy Services site.
- **Indicator 6** - Diagnostic Cardiovascular Procedures: Applies a 25% reduction only to the technical (modifier TC) component of the subsequent procedure codes.
- **Indicator 7** - Diagnostic Ophthalmology Procedures: Applies a 20% reduction to technical components (modifier TC) of the subsequent procedure codes.

Reimbursement may be subject to the application of other Curative policies.

5. REFERENCE DOCUMENTS AND MATERIALS

- 5.1. American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services
- 5.2. Centers for Medicare and Medicaid Services (CMS), Physician Fee Schedule (PFS) Relative Value Files
- 5.3. Centers for Medicare and Medicaid Services (CMS), CMS Manual System, Medicare Claims Processing Manual 100-04, Chapter 13 Radiology Services and Other Diagnostic Procedures, Section
- 5.4. Centers for Medicare and Medicaid Services (CMS), CMS Manual System, Medicare Claims Processing Manual 100-04, Chapter 5 Part B Outpatient Rehabilitation and CORF/OPT Services, Section 10.7 Multiple Procedure Payment Reduction (MPPR) for Selected Therapy Services
- 5.5. Centers for Medicare and Medicaid Services (CMS), CMS.gov - Multiple Procedure Payment Reduction File (based on the dates of service), Diagnostic Cardiovascular Services Subject to the Multiple Procedure Payment Reduction (MPPR)
- 5.6. Centers for Medicare and Medicaid Services (CMS), CMS Manual System, Medicare Claims Processing Manual 100-04, Chapter 23 Fee Schedule Administration and Coding Requirements, Section 50.6 Physician Fee Schedule Payment Policy Indicator File Record Layout

6. COLLABORATING DEPARTMENTS

- 6.1. Claims
- 6.2. Compliance
- 6.3. Medical Management
- 6.4. Network
- 6.5. System Configuration

7. POLICY & PROCEDURE CONTROL

This Policy will be reviewed at least annually and as necessary.

REVISION HISTORY			
Date	Author	Version	Comments
09- 22 -2026	CJW	001	Initial Version