Multiple Procedure Payment Reduction Policy

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare's reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In a conflict, federal and state guidelines, as applicable, and the member's benefit plan document supersede the information in this policy. Also, to the extent of conflicts between this policy and the provider contract language, the Provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval. If there is a state exception, please refer to the state exception table listed below.

Policy Overview

Molina Healthcare is committed to providing fair and transparent reimbursement practices in accordance with federal and state regulations. To that end, Molina Healthcare utilizes the Multiple Procedure Payment Reduction (MPPR) methodology when adjudicating claims that involve multiple surgical or diagnostic procedures performed by the same healthcare professional within a single operative session on the same day. This policy is in alignment with Multiple Procedure Indicator 2, which adheres to the standard payment adjustment rules set forth by the Centers for Medicare & Medicaid Services (CMS).

Reimbursement Guidelines

Scope of Policy

Molina Healthcare adheres to the Multiple Procedure Payment Reduction (MPPR) methodology as defined by CMS and augmented by specific state Medicaid programs. This policy serves as a guideline for determining reimbursement rates for multiple procedures conducted by the same provider on the same day, during a single operating session.

Reimbursement Rates

The following reimbursement structure is applied under this policy:

- The primary procedure will be reimbursed at 100% of the allowable rate as per the relevant fee schedule.
- The secondary procedure will be reimbursed at 50% of its allowable rate.

For any additional procedures performed, reimbursement rates will be guided by either state-specific Medicaid regulations or CMS guidelines, whichever is applicable.

Fee Schedules and Contractual Agreements

Reimbursement calculations are based on the applicable fee schedules and any supplementary contractual arrangements between Molina Healthcare and the healthcare provider.

Compliance Requirements

It is of paramount importance that healthcare providers comply with the billing and documentation guidelines as stipulated by the specific state Medicaid program and/or CMS. Providers must ensure that

all necessary indicators and supporting documentation are included when submitting claims.

Consequences of Non-Compliance

Failure to adhere to these guidelines may lead to delays in claims processing, denials, or even trigger audits. Such actions can have significant financial implications and may require corrective measures to resolve.

Supplemental Information

Definitions

Term	Definition
MAC	A Medicare Administrative Contractor (MAC) is a private health insurance company that processes Medicare Part A and Part B medical claims, as well as durable medical equipment (DME) claims, for Medicare Fee-for-Service (FFS) beneficiaries. They act as the main operational link between the Medicare program and healthcare providers. MACs are multi-state, regional contractors responsible for administering both Medicare Part A and Part B claims for a defined geographic area.
Noridian	Noridian is a Medicare Administrative Contractor (MAC) that handles claims processing and related services for Medicare Parts A and B in Jurisdiction E (JE) and Jurisdiction F (JF). They are contracted by the Centers for Medicare & Medicaid Services (CMS) to support healthcare providers and beneficiaries within these jurisdictions.
Novitas	Novitas is a Medicare Administrative Contractor (MAC) that handles claims processing and related services for Medicare Parts A and B in Jurisdiction H (JH) and Jurisdiction L (JL). They are contracted by the Centers for Medicare & Medicaid Services (CMS) to support healthcare providers and beneficiaries within these jurisdictions.

State Exceptions

State	Exception
California	MediCal Only: Medical policies have been established for certain multiple surgeries when billed for a recipient, by the same provider, for the same date of service. Note the following information: • Tubal ligations performed at the time of a cesarean section or other intra- abdominal surgery are reimbursable only when billed with CPT code 58611. For more information, refer to the Hysterectomy and Sterilization sections in this manual. • A salpingectomy or oophorectomy (CPT codes 58700, 58720, 58900 thru 58943) billed on the same date of service as a hysterectomy (CPT codes 58150 thru 58285) is not separately reimbursable. • A vaginal delivery (CPT codes 59400, 59409, 59610 or 59612) billed on the same date of service as a cesarean section (CPT codes 59510, 59514, 59618 or 59620) is not reimbursable unless the claim indicates a multiple pregnancy – one child delivered vaginally and one by cesarean section. • Policy for intra-ocular lens with cataract surgery is in the Surgery: Eye and Ocular Adnexa section of the provider manual.

	• Insertion of a non-indwelling or temporary indwelling bladder catheter (CPT codes 51701 and 51702) is not separately reimbursable when billed with CPT codes 10021 thru 69979. • CPT procedure code 36000 (introduction of needle or intracatheter, vein) is not reimbursable when billed by the same provider for the same recipient on the same date of service with any CPT procedure code within the ranges 00100 thru 69999 and 96360 thru 96549.

Documentation History

Type	Date	Action
Initial Creation Date	10/23/2023	New Policy
Revised Date	12/16/2024	Updated Template
Revised Date	08/06/2025	Updated the templated, verified links, removed SC link
Revised Date	08/21/2025	Added page number and PI number; changed Coding Disclaimer from 9 point to 10 point; updated entire document to 10 point; added Definitions.

References

This policy was developed using:

- CMS
- State Medicaid Regulatory Guidance
- State Contracts

Reference	Link
CMS	Medicare Claims Processing Manual Ch 12 Pricing Multiple Surgical Procedures (Non-Endoscopic)
Noridian	Multiple Procedure Payment Reduction (MPPR) on Certain Diagnostic Imaging Procedures - JF Part B - Noridian
Novitas	Multiple Procedure Payment Reduction
AZ	FFS_Chap10.pdf
CA	Workbook_Medi-Cal Provider Training 2024: Allied Health & Medical Services (ah_2024)
FL	Statewide Medicaid Managed Care (SMMC) Policy Transmittal 14-15
ID	General Billing Instructions ID Medicaid Provider Handbook
KY	Ambulatory Surgical Center (ASC) Services - PT (36) - Cabinet for Health and Family Services
MI	MI Medicaid Provider Manual
MS	MS Multiple Surgery Reduction Letter
TX	Texas Medicaid Provider Procedures Manual — August 2025
UT	September2022-MIB.pdf

***CODING DISCLAIMER**. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does guarantee coverage.*

Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.