Reimbursement Policy for Multiple Procedure Payment Reduction

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 operative 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.

Documentation History

Type	Date	Action
Published		
Revised Date		

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.

References

State/Agency	Link/Document
CMS	Section 40.6, C, 11
CGS	Multiple Procedure Payment Reduction
AZ	Multiple Procedure Payment Reduction
CA	Multiple Procedure Payment Reduction
FI	Multiple Procedure Payment Reduction
ID	Multiple Procedure Payment Reduction
KY	Multiple Procedure Payment Reduction
MI	Multiple Procedure Payment Reduction
MS	Multiple Procedure Payment Reduction
SC	Multiple Procedure Payment Reduction
TX	Multiple Procedure Payment Reduction
UT	Multiple Procedure Payment Reduction
VA	Multiple Procedure Payment Reduction
MAC Novitas	Multiple Procedure Payment Reduction
MAC Noridan	Multiple Procedure Payment Reduction