AmeriHealth Caritas Ohio

Multiple Procedure Payment Reduction

Reimbursement Policy ID: RPC.0033.7700

Recent review date: 11/2024

Next review date: 03/2026

AmeriHealth Caritas Ohio reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. AmeriHealth Caritas Ohio may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

Policy Overview

This policy addresses the provider payment reductions when multiple procedures that are specifically subject to the payment reduction are performed in the same episode of care. This includes surgeries, diagnostic radiology, and therapies performed on the same date.

Exceptions

N/A

Reimbursement Guidelines

Multiple Surgery Procedures

Reimburses the lesser of two amounts: the provider's summitted charge or the following multiple procedure payment reduction.

- A primary procedure (i.e., the procedure with the highest maximum amount listed in rule 5160-1-60 of the Ohio Administrative Code in appendix DD to that rule) is paid at 100%.
- A secondary procedure (i.e., the procedure with the next highest maximum amount listed in the Ohio Administrative Code) is paid at 50%.
- Additional procedures are paid at 25%.
- A bilateral procedure is paid at 150%.

Multiple Diagnostic Radiology Procedures

If more than one advanced imaging procedure (e.g., computed tomography, magnetic resonance imaging, ultrasound) is performed by the same provider or provider group for a patient in the same session, then the procedure with the highest payment amount in appendix DD of rule 5160-1-60 of the Ohio Administrative Code is considered to be the primary procedure. The payment amount for a covered advanced imaging procedure is the lesser of the submitted charge or a percentage of the amount specified in appendix DD, determined as stated below:

- A primary procedure is paid at 100%.
- Each additional procedure is paid at 50%.
- The technical component for each additional procedure is paid at 50%.
- The professional component for each additional procedure is paid at 95%.

Multiple Therapy Procedures

If more than one skilled therapy service is rendered by the same non-institutional provider or provider group to a member on the same date, then the service with the highest payment amount in appendix DD to rule 5160-1-60 of the Ohio Administrative Code is considered the primary procedure. Payment for a covered skilled therapy service is the lesser of the provider's submitted charge or a percentage of the amount in appendix DD to be determined in the following manner:

- For the first unit of a primary procedure, it is paid at 100%; or
- For each additional unit or procedure within the same therapy discipline, it is paid at 80%.

NOTE: Services reported on claims must correspond to the services documented in the treatment or maintenance plan.

Definitions

Advanced Diagnostic Imaging (ADI)
Advanced diagnostic procedures include, but are not limited to, magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine imaging procedures, such as positron emission tomography (PET). ADI procedures do not include x-ray, ultrasound, fluoroscopy procedures, or diagnostic and screening mammography.

Episode of Care
An episode of care includes care related to a defined medical event (e.g., a procedure or an acute condition), including the care for the event itself, any precursors to the event (such as diagnostic tests or pre-op visits) and follow-up care (such as medications, rehab, or readmission). Episodes, which are built from the perspective of a patient’s journey, offer a comprehensive view of the care involved in treating a condition for a patient.

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. Healthcare Common Procedure Coding System (HCPCS).
III. International Statistical Classification of Diseases and (ICD).
IV. Centers for Medicare and Medicaid Services (CMS).
V. Ohio Medicaid Fee Schedule(s).
VI. https://codes.ohio.gov/ohio-administrative-code/rule-5160-1-60

Attachments

N/A

Associated Policies

RPC.0006.7700 Bilateral Procedures

Policy History

11/2024	Reimbursement Policy Committee Approval
10/2024	Annual Review • No major updates
04/2024	Revised preamble
03/2024	Reimbursement Policy Committee Approval
08/2023	Removal of policy implemented by AmeriHealth Caritas Ohio from Policy History section
01/2023	Template revised • Preamble revised • Applicable Claim Types table removed • Coding section renamed to Reimbursement Guidelines • Associated Policies section added