n05732

Un-Bundling Policy

Values

Accountability ● Integrity ● Service Excellence ● Innovation ● Collaboration

Abstract Purpose:

This reimbursement policy outlines Network Health's process, for all lines of business, when addressing coding relationships through re-bundling edits; as well as applying National Correct Coding Initiative (NCCI) edits.

Policy Detail:

I. It is industry standard to review claims to ensure correct coding and billing practices are followed. Network Health's Claims Editing System utilizes the coding policies from the following sources for analysis of standard medical and surgical practices and review of current coding practices:

A. Centers for Medicare and Medicaid Services (CMS)
B. Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) guidelines
C. Local Coverage Articles (LCA)
D. Local and National Coverage Determinations (LCD and NCD)

II. Medical and surgical procedures should be reported with the CPT or HCPCS code(s) that most comprehensively describe the services performed. These services apply to the same individual physician or other health care professional rendering health care services using the same Federal Tax Identification (TIN) number.

III. <u>Unbundling:</u>

A. Network Health sources its bundling edits based on the Claims Editing System which applies methodologies used and recognized by third party authorities. These methodologies can be definitive or interpretive.

1. A **definitive source** is one that is based on very specific instructions from the given source.
2. An **interpretive source** is one that is based on an interpretation of instructions from the identified source.

B. Network Health utilizes the following sources to determine if a bundling edit is appropriate:

1. Current Procedural Terminology (CPT) book from the American Medical Association (AMA)
2. Centers for Medicare and Medicaid Services (CMS)

3. National Correct Coding Initiative (NCCI) edits
4. CMS policy and physician specialty societies

    a. Example: American Academy of Orthopaedic Surgeons (AAOS), American College of Obstetricians and Gynecologists (ACOG), and American College of Cardiology (ACC).

C. Unbundling occurs when multiple procedure codes are billed for a group of procedures that are covered by a single comprehensive code.

D. Modifiers offer physicians and other health care professionals a way to provide additional information about the medical procedure, service, or supply involved without changing the meaning of the code. Modifiers offer specific information and should be appended appropriately.

E. When Network Health processes a claim and determines the billed service is bundled into payment for other services, the line(s) will be denied with Claims Adjustment Reason Code (CARC) 97 *"The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated."* Providers cannot balance bill members for these services.

IV. Services/Procedures/Supplies always bundled:

A. Network Health considers the following services/procedures/supplies to be included in the overall management of a patient, and they are not separately reimbursable when submitted with another code, or when submitted as the only code on a claim for the same date of service. These services include but are not limited to:

1. 36415 - Collection of venous blood by venipuncture
2. 36416 - Collection of capillary blood specimen
3. 99000 - Specimen handling and/or conveyance of specimen for transfer from the office to a laboratory
4. 99001 - Specimen handling and/or conveyance of specimen for transfer from the patient in other than an office to a laboratory
5. 99024 - Postoperative follow-up visit
6. 99173 - Visual acuity screening
7. A4263 - Permanent, long-term, non-dissolvable lacrimal duct implant
8. A4300 - Implantable external access catheter
9. A4550 - Surgical trays
10. J3490/J3590 - Unclassified drugs and Unclassified biologics for local anesthetics (injectable lidocaine, Marcaine, Bupivacaine) when claims are submitted with Place of Service (POS) 11 (office)
11. H0048 - Alcohol and/or other drug testing: collection and handling only, specimens other than blood
12. S9088 - Services provided in an urgent care center (services listed in addition to the code for the urgent care service provided)

V. CCI Editing:

A. CMS developed the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) edits to prevent inappropriate payment of services that should not be reported together.

B. Edits are divided into Column One and Column Two procedure (CPT/HCPCS) codes. These NCCI PTP edits determine whether CPT and/or HCPCS codes reported together by the same individual physician or other health care professional for the same member on the same date of service are eligible for separate reimbursement.

1. When billed with a Column One code, Network Health will not separately reimburse a Column Two code unless the codes are appropriately reported with one of the NCCI PTP-designated modifiers recognized by Network Health under this policy.

2. Each NCCI code pair is designated with a superscript of "0" or "1".

C. When one of the distinct procedural service modifiers is appended to either the Column One or Column Two code(s) rendered to the same patient, on the same date of service, and by the same individual provider or other health care professional, and there is an NCCI superscript of "1", Network Health will consider both services and/or procedures for reimbursement.

Superscript	Description
0	A "0" superscript appended to a code pair indicates that in no circumstance may a modifier be used to override that edit.
1	A "1" superscript appended to a code pair indicates that an appropriate modifier may be used to override the edit.

VI. Modifiers:

A. In order to override an edit, it is imperative the conditions of the submitted modifier are met, and the documentation clearly reflects appropriate use of the modifier.

B. Below is the current list of modifiers recognized under this reimbursement policy.

Modifier	Description
24	Unrelated evaluation and management service by the same physician or other qualified health care professional during a postoperative period.
25	Significiant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same date of the procedure or other service.
59	Distinct procedural service.
76	Repeat procedure or service by same physician or other qualified health care professional.
77	Repeat procedure or service by another physician or other qualified health care professional.
78	Unplanned return to the operating/procedure room by the same physician or other qualified health care professional during the postoperative period.
79	Unrelated procedure or service by the same physician or other qualified health care professional during the postoperative period.
91	Repeat clinical diagnostic laboratory test.
XE	Separate encounter, a service that is distinct because it occurred during a separate encounter.
XS	Separate structure, a service that is distinct because it was performed on a separate organ/structure.
XP	Separate practitioner, a service that is distinct because it was performed by a different practitioner.
XU	Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual componemnts of the main service.

VII. Definitions:

A. Incidental services: Includes procedures that can be performed along with the primary procedure but are not essential to complete the procedure. They do not typically have a significant impact on the work and time of the primary procedure. These incidental procedures are not separately reimbursable when performed with the primary procedure.

B. Integral services: Services that are considered to be those carried out as part of a more complex major or primary procedure. These integral procedures are not separately reimbursable when performed with the primary procedure

C. Lab Panels: Network Health's Claims Editing System will not allow lab panels to be unbundled regardless of where the lab components are performed. Adding a modifier to reference outside laboratory to one or more of the labs included in the panel will not warrant an exception for separate reimbursement.

Note: Modifiers offer specific information and should be used appropriately on laboratory and pathology CPT codes. It is inappropriate to use modifier "76"/repeat procedure or service by the same physician or other qualified health care professional for repeat laboratory or pathology services. According to the AMA and CMS, there are more appropriate modifiers to indicate repeat clinical diagnostic laboratory test or distinct procedural services, and these should be considered.

D. Mutually Exclusive Services/Inappropriate Coding Combinations: When mutually exclusive procedures are submitted together, the coding combination is considered submitted in error and only one of the services is allowed. One or more of the following criteria may be used to determine what constitutes a mutually exclusive relationship:

1. The services cannot reasonably be done in the same session.
2. The coding combination represents two methods of performing the same service.
3. The edits that may be assigned to this category are those edits derived from directives provided in CPT that do not meet criteria for either the Incidental or Unbundle service category. These edits are also referred to as "inappropriate coding combinations."

E. Re-bundling: Includes identifying and combining specific coding relationships into the most comprehensive and/or appropriate procedure. Re-bundling may occur when services are considered either incidental, mutually exclusive, transferred, or unbundled.

F. Transferred services: Refers to situations where the coding combination may be more appropriately reported with another code combination or a different CPT and/or HCPCS code.

G. Unbundling: This occurs when multiple procedure codes are submitted for a group of procedures that are described by a single comprehensive code. An example of unbundling would be fragmenting one service into component parts and coding each component as if it were a separate service.

Regulatory Citations:

Centers for Medicare and Medicaid Services (CMS)

Related Policies:

Claim Submission Policy
Status Code Policy

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