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Procedure 1208- Unbundling

Lines of Business: All

Purpose: This guideline provides an overview of how Network Health addresses coding relationships through rebundling edits. This guideline applies to the services reported on the Centers for Medicare and Medicaid Services (CMS) 1500 Claim Form and the UB Claim Form or its electronic equivalents.

Procedure: It is standard industry practice to review code usage in billing for medical services and supplies. Network Health sources its bundling edits based on the claims editing system which apply methodologies both used and recognized by third party authorities. Those methodologies can be definitive or interpretive.

A **definitive source** is one that is based on very specific instructions from the given source.

An **interpreted source** is one that is based on an interpretation of instructions from the identified source.

Some source examples Network Health uses to determine if a bundling edit is appropriate are: Current Procedural Terminology book (CPT) from the American Medical Association (AMA); CMS National Correct Coding Initiative (NCCI) edits; CMS Policy and Physician specialty societies (for example, American Academy of Orthopaedic Surgeons (AAOS), American College of Obstetricians and Gynecologists (ACOG), and American College of Cardiology (ACC).

According to CMS, medical and surgical procedures should be reported with the CPT or Healthcare Common Procedure Coding System (HCPCS) codes that most comprehensively describe the services performed. Unbundling occurs when multiple procedure codes are billed for a group of procedures that are covered by a single comprehensive code.

Note: E/M services as well as procedures/services of physicians and other health care professionals of the same specialty within the same group with the same federal tax identification number are considered as having been performed by the same physician/provider.

When Network Health processes a claim and determines that the billed service is bundled into payment for other services, the denial ANSI code will be 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.

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

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.

Unbundling- Unbundling 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.

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.

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.

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:

- The services cannot reasonably be done in the same session
- The coding combination represents two methods of performing the same service

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.”

Lab Panels: Network Health’s Claims Editing System will not allow lab panels to be unbundled regardless of where the lab components are performed. The modifier to reference outside laboratory added to one or more of the labs included in the panel will not allow for an exception to be reimbursed separately.

Note: Modifiers offer specific information and should be used appropriately on laboratory and pathology CPT codes. It is inappropriate to use the modifier which indicates 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.

Distinct Procedural Service Modifier: Network Health follows CPT guidelines for the use of this modifier. According to the CPT book, distinct procedural service modifier is used to identify procedures/services (other than Evaluation and Management (E/M) services) that are not normally reported together, but are appropriate under the circumstances. The use of this modifier may represent a:

- Different session/patient encounter
- Different procedure or surgery
- Different site or organ system
- Separate incision/excision
- Separate lesion
- Separate injury (or area of injury in extensive injuries)

The above points apply to procedures/services that are not ordinarily encountered or performed on the same day by the same physician.

According to the CPT book, the distinct procedural service modifier should only be used when a more descriptive modifier is not available.

Significant, separately identifiable E/M Modifier: Network Health follows CPT guidelines for the use of this modifier. The CPT book indicates that this modifier can be appended when the patient's condition requires a significant, separately identifiable E/M service above and beyond the procedure/service provided or the E/M service was provided above and beyond the usual preoperative and postoperative care associated with the procedure/service that was performed.

Network Health will reimburse when using the significant, separately identifiable E/M modifier, provided the use of the modifier meets the above requirements. Network Health will monitor modifier usage and frequency for appropriate billing of the modifier.

Services/Procedures/Supplies always bundled: Network Health considers the following services/procedures to be included in the overall management of a patient and 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:

- Alcohol and/or other drug testing: collection and handling only, specimens other than blood
- Collection of capillary blood specimen
- Collection of venous blood by venipuncture
- Implantable external access catheter
- Initial preventive physician examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment
- Permanent, long-term, nondissolvable lacrimal duct implant
- Postoperative follow-up visit
- Prostate cancer screening, digital rectal examination
- Services provided in an urgent care center (services listed in addition to the code for the urgent care service provided)
- Specimen handling and/or conveyance of specimen for transfer from the office to a laboratory
- Specimen handling and/or conveyance of specimen for transfer from the patient in other than an office to a laboratory
- Surgical trays
- Visual acuity screen

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