Rebundling Policy, Professional

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare reimbursement policies may use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.*

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general reference resource regarding UnitedHealthcare's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, the enrollee's benefit coverage documents and/or other reimbursement, medical or drug policies. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare due to programming or other constraints; however, UnitedHealthcare strives to minimize these variations.

UnitedHealthcare may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

UnitedHealthcare uses a customized version of the Optum Claims Editing System known as iCES Clearinghouse to process claims in accordance with UnitedHealthcare reimbursement policies.

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Application

This reimbursement policy applies to services reported using the 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent

of charge contract physicians and other qualified health care professionals.

Policy

Overview

According to the Centers for Medicare and Medicaid Services (CMS), medical and surgical procedures should be reported with the Current Procedural Terminology (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. This policy does not apply to network home health services and supplies/home health agencies.

For the purpose of this policy, the Same Individual Physician or Other Qualified Health Care Professional is the same individual rendering health care services reporting the same Federal Tax Identification number.

Reimbursement Guidelines

Edit Sources

UnitedHealthcare uses this policy to determine whether CPT and/or HCPCS codes reported together by the Same Individual Physician or Other Qualified Health Care Professional for the same member on the same date of service are eligible for separate reimbursement. UnitedHealthcare will not reimburse services determined to be Incidental, Mutually Exclusive, Transferred, or Unbundled to a more comprehensive service unless the codes are reported with an appropriate modifier.

UnitedHealthcare sources its Rebundling edits to methodologies 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 (please see the Definitions section below for further explanations of these sources). The sources used to determine if a Rebundling edit is appropriate are as follows:

- *Current Procedural Terminology* book *(CPT)* from the American Medical Association (AMA);
- CMS National Correct Coding Initiative (CCI) edits;
- CMS Policy; and
- Specialty Societies (e.g., American Academy of Orthopaedic Surgeons (AAOS), American Congress of Obstetricians and Gynecologists (ACOG), American College of Cardiology (ACC), and Society of Cardiovascular Interventional Radiology (SCIR)).

Modifiers

Modifiers offer the physician or other qualified health care professional a way to identify that a service or procedure has been altered in some way. Under appropriate circumstances, modifiers should be used to identify unusual circumstances, staged or related procedures, distinct procedural services or separate anatomical location(s).

UnitedHealthcare recognizes the following designated modifiers under this reimbursement policy:
25, 50, 57, 58, 59, 78, 79, 91, E1, E2, E3, E4, LC, LD, LM, LT, RC, RI, RT, TA, T1, T2, T3, T4, T5, T6, T7, T8, T9, FA, F1, F2, F3, F4, F5, F6, F7, F8, F9, XE, XP, XS, XU

Modifiers offer specific information and should be used appropriately. It is inappropriate to use modifier 76 to indicate repeat laboratory services. Modifiers 59, 91, XE, XP, XS, or XU should be used to indicate repeat or distinct laboratory services, as appropriate, according to the AMA and CMS. Separate consideration for reimbursement will not be given to laboratory codes reported with modifier 76.

Modifier 25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service: It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.
Modifier 59	UnitedHealthcare follows CPT guidelines for the use of modifier 59. According to the CPT book, modifier 59 (distinct procedural service) is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. Use of the modifier 59 may represent a: • different session, • different procedure or surgery, • different site or organ system, • separate incision/excision, • separate lesion, or • 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 individual. Information describing additional usage of modifier 59 can be found on the CMS Medicare NCCI, Medicaid NCCI or CMS MLN Matters websites. CMS Medicare Learning Network (MLN) Proper Use of Modifier 59 There is a subset of modifiers (XE, XP, XS, and XU) to modifier 59 that may be reported to be more specific in identifying altering circumstances to a service or procedure. However, UnitedHealthcare will continue to recognize modifier 59. According to the CPT book, modifier 59 should only be used when a more descriptive modifier is not available. Modifier 59 and designated modifiers should NOT be used to bypass an edit unless the proper criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required by any designated modifier that is used.
Modifier XE	Separate encounter, a service that is distinct because it occurred during a separate encounter
Modifier XP	Separate practitioner, a service that is distinct because it was performed by a different practitioner
Modifier XS	Separate structure, a service that is distinct because it was performed on a separate organ/structure
Modifier XU	Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service

Edit Types and Frequency

Please refer to the Claim Estimator to review appropriate bundling of services under UnitedHealthcare reimbursement policies. The Claim Estimator can be found at the UnitedHealthcare website.

www.unitedhealthcareonline.com

Definitions	
Claim Estimator	Real-time online tool that allows the user to determine how UnitedHealthcare Rebundling edits would apply to any combination of codes prior to claim submission.
Definitive Source	Definitive sources contain the exact codes, modifiers or very specific instructions from the given source.
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. Incidental procedures are not separately reimbursable when performed with the primary procedure.
Interpretive Source	An edit source that includes guidelines; however, no exact or specific code or modifier information is listed. Therefore, an interpretation must be made as to what codes correlate to the guidelines. Additionally, an interpretation may be applied to surrounding or similar codes based on related Definitively Sourced edits.
Mutually Exclusive Services	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.
Rebundling	Rebundling is identifying and combining specific coding relationships into the most comprehensive and/or appropriate procedure code. Rebundling may occur when services are considered Incidental, Mutually Exclusive, Transferred, or Unbundled. Refer to these specific definitions for more detail.
Same Individual Physician or Other Qualified Health Care Professional	The same individual rendering health care services reporting the same Federal Tax Identification number.
Transferred Services	Refers to a situation where the coding combination may be more appropriately reported with another code combination or to a different CPT and/or HCPCS code(s).
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. For example, the correct CPT comprehensive code to use for upper gastrointestinal endoscopy with biopsy of stomach is CPT code 43239. Separating the service into two component parts, using CPT code 43235 for upper gastrointestinal endoscopy and CPT code 43600 for biopsy of stomach is inappropriate (per CMS National Correct Coding Policy Manual)

Questions and Answers	
1	**Q:** Are there other policies that deal with related information such as Laboratory Bundling, Evaluation and Management, and Anesthesia Services? How are those services considered? **A:** There are separate policies that encompass the Rebundling of Evaluation and Management (Global Days policy, Same Day/Same Service policy), Anesthesia Services, and Laboratory Bundling outside of the Rebundling Policy.

2	**Q:** How often are the Rebundling rules updated in each system? **A:** Rebundling edits are updated quarterly.
3	**Q:** Since the Rebundling policy recognizes many modifiers, do all modifiers bypass bundling edits in every situation? **A:** No. There are many coding guidelines provided within credible third-party sources such as the CPT and HCPCS books, CMS NCCI Policy Manual, etc. that address situations in which a modifier applies. While the Rebundling policy recognizes many modifiers, modifiers only apply when they are used according to correct coding guidelines. For example, a surgeon performs both 29866 and 29885 during the same operative session on the left knee in the same compartment. CPT parenthetical statement indicates, "Do not report 29866 in conjunction with…29885-29887 when performed in the same compartment." It would be inappropriate for the surgeon to report both 29866 and 29885 for the same date of service. However, if the surgeon performed 29885 in a distinct and separate compartment of the left knee or during a distinct and separate operative session, an override modifier 59, XE, or XS may be reported based on which modifier is the most appropriate to describe the situation. If the surgeon were to report a modifier LT on both 29866 and 29885 when performed in a distinct and separate compartment of the left knee or during a distinct and separate operative session, LT would be considered informational and bundling would still occur. LT is an informational modifier and does not distinguish a distinct and separate anatomic location.
4	**Q:** Will heparin sodium, (Heparin Lock Flush), per 10 units (HCPCS code J1642) be reimbursed separately? **A:** HCPCS code J1642 intended for the flushing of a vascular access catheter/port or as a solution used for reconstitution or dilution purposes, is included in the practice expense portion of the relative value unit for the medical or surgical service and are not separately reimbursed, in accordance with CMS.
5	**Q:** Will vision screenings be separately allowed with Evaluation and Management (E/M) codes? **A:** No, vision CPT code 99173 (screening test of visual acuity, quantitative, bilateral) is intended to be done within the same session as an E/M service and is not separately reimbursed, in accordance with CMS.
6	**Q:** How would the Rebundling edits handle the billing of a total abdominal hysterectomy (58150), salpingectomy (58700), and oophorectomy (58940)? **A:** 58700 and 58940 are not separately reportable services when submitted with 58150, as the descriptor of 58150 includes the services described in 58700 and 58940. The edit source is CCI.
7	**Q:** Are examination under general anesthesia services, 57410 (Pelvic examination under anesthesia) and 92502 (Otolaryngologic examination under general anesthesia), separately reimbursable services when submitted with a surgical procedure performed in the same anatomical area? **A:** In accordance with CMS, examinations under general anesthesia are an integral part of the related surgical procedure performed in the same anatomical area. For example, 57410 (Pelvic examination under anesthesia) is not a separately reimbursable service when reported with 57023 (Incision and drainage of vaginal hematoma; non-obstetrical).
8	**Q:** Will UnitedHealthcare separately reimburse HCPCS supply code A4550 (Surgical trays) when submitted with another Evaluation and Management (E/M) service and/or procedure code? **A:** UnitedHealthcare follows CMS guidelines with respect to reimbursement for surgical trays (supply). Office medical supplies including surgical trays are considered to be part of a physician's practice expense. Therefore, reimbursement for a surgical tray is included in the practice expense portion of the relative value unit for the medical or surgical service. HCPCS supply code A4550 is considered included in the Evaluation and Management (E/M) service and/or the procedure performed in the physician's or other qualified health care professional's office. Please see UnitedHealthcare's B Bundle policy for additional information regarding code A4550.
9	**Q:** Why are Evaluation and Management (E/M) services not reimbursed with certain codes in the CPT Medicine section when performed on the same date of service by the same individual provider? **A:** Consistent with CPT guidelines, E/M services will be considered included in many medicine codes in the 9xxxx section of CPT and will not be separately reimbursed. Modifier 25 should only be used to report a significant and separately identifiable E/M service that is above and beyond the other service provided.

10	**Q:** Why isn't the E/M service, 99211, allowed when reported with hydration, therapeutic, prophylactic, or diagnostic IV infusion or injections? **A:** According to CPT, hydration, therapeutic, prophylactic, or diagnostic IV infusion or injection services typically require direct physician supervision. Since 99211 may be reported by qualified health care professionals other than physicians, UnitedHealthcare does not allow 99211 to be reimbursed separately when reported with these services whether or not a modifier is appended.
11	**Q:** Are HCPCs codes G0442-G0447 and G0473 considered E/M codes? **A:** No, G0442-G0447 and G0473 are screening codes and are considered included in an E/M service.

Codes	
Modifiers	
25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service
50	Bilateral Procedure
57	Decision for Surgery
58	Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
59	Distinct Procedural Service
78	Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure 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
E1 – E4	Anatomic modifiers which are associated with the eyelid
FA, F1 – F9	Anatomic modifiers which are associated with the fingers
LC, LD, LM, RC, RI	Anatomic modifiers which are associated with the coronary arteries
LT	Left side
RT	Right side
TA, T1 – T9	Anatomic modifiers which are associated with the toes
XE	Separate encounter, a service that is distinct because it occurred during a separate encounter
XP	Separate practitioner, a service that is distinct because it was performed by a different practitioner
XS	Separate structure, a service that is distinct because it was performed on a separate organ/structure
XU	Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service

Resources
American Medical Association, *Current Procedural Terminology (*CPT®) and associated publications and services Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets

Centers for Medicare and Medicaid Services, National Correct Coding Initiative (NCCI) publications

Centers for Medicare and Medicaid Services, Physician Fee Schedule (PFS) Relative Value Files

Publications and services of the American Academy of Orthopedic Surgeons (AAOS)

Publications and services of the American College of Cardiology (ACC)

Publications and services of the American Congress of Obstetricians and Gynecologists (ACOG)

Publications and services of the American College of Surgeons (ACS)

Publications and services of the Society of Cardiovascular Interventional Radiology (SCIR)

History	
10/4/2019	Annual Anniversary Date and Version Change Definitions Section: Updated Unbundling
1/1/2019	Policy Version Change Policy Change: Q&A #5 changed. History Section: Entries prior to 1/1/2017 archived
11/14/2018 – 12/31/2018	Annual Policy Approval Date and Version Change Added 'Professional' to the policy title; removed reference to Community and State and Medicare and Retirement in the Application section. Definitions: Updated Same Individual Physician or Other Qualified Health Care Professional Added Q&A #11 History Section: Entries prior to 1/1/2016 archived
11/8/2017	Annual Policy Approval – no new version Logo, Preamble and Footer have been updated
1/1/2017 – 11/13/2018	Annual Policy Version Change Policy Approval Date Change History Section: Entries prior to 1/1/2015 archived