

Hospital Outpatient Laboratory and Pathology Services Rebundling Policy

Type	Hospital Reimbursement	
Number	002	
Approved by		Approval Date
National Reimbursement Forum		May 13, 2009

Description

This policy describes reimbursement for hospital outpatient laboratory and pathology services reimbursed according to the UnitedHealthcare Facility Laboratory and Pathology Fee Schedule. Effective October 1, 2011, this policy also applies when any Laboratory or Pathology outpatient service category is contracted using the Per Unit payment method.

Audience

Targeted Population	This policy applies to participating hospitals contracted under the UHC Facility Laboratory and Pathology Fee Schedule. Effective October 1, 2011, this policy also applies when any Laboratory or Pathology outpatient service category is contracted using the Per Unit payment method.
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Policy

Overview	According to the Centers for Medicare and Medicaid Services (CMS), laboratory and pathology procedures/services should be reported with the CPT/HCPCS code(s) 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.
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Edit Sources

UnitedHealthcare sources its hospital outpatient laboratory and pathology rebundling edits to methodologies used and recognized by third party authorities. The definitive sources used to determine if a rebundling edit is appropriate are as follows:

Current Procedural Terminology book (CPT) from the American Medical Association (AMA) and

CMS National Correct Coding Initiative (CCI) edits

Modifiers

As specified by CMS and CPT, United Healthcare will accept the following modifiers for laboratory and pathology service reporting:

-59, -76, -77, -90, -91 and -92

Modifier -59 Instructions:

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 or patient encounter,
- different procedure or service on the same day,
- different site or organ **system**,
- separate incision/excision,
- separate lesion, or
- separate **injury** (or area of injury in extensive injuries).

According to the CPT book, modifier 59 should only be used when a more descriptive modifier is not available.

Definitions

CMS CCI Definitive Edit	An edit sourced to specific billing guidelines from the General Correct Coding Policies contained in the National Correct Coding Policy Manual published by CMS.
CPT Definitive Edit	An edit sourced to specific CPT coding book direction related to the reporting of exact codes or modifiers.

References and Resources

References

1. American Medical Association, *Current Procedural Terminology (CPT), Professional Edition*
2. Centers for Medicare and Medicaid Services (CMS)

Questions and Answers


Q1. Which version of the Correct Coding Initiative (CCI) edits does United Healthcare apply to hospital outpatient laboratory and pathology claims?
A1. In accordance with CMS, United Healthcare applies the hospital version of the CCI edits that are applicable to the date of service as loaded in the Medicare Outpatient Code Editor (OCE).

History/Updates

May, 2009	Publication of Policy
October 1, 2011	Change in Scope to include Per Unit methodology for applicable contracts

Attachments

Mutually Exclusive Laboratory/Pathology Code List	Mutually Exclusive Services that may or may not be allowed with appropriate modifier(s) CMS National Correct Coding Initiative (NCCI)
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Comprehensive Codes (Column1/Column 2) Laboratory/Pathology Code List:	Comprehensive/Component Codes that may or may not be allowed with appropriate modifier(s). CMS National Correct Coding Initiative (NCCI)
	

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