UnitedHealthcare®

UnitedHealthcare® Medicare Advantage
Reimbursement Policy
CMS 1500
Policy Number 2020R9032A

Rebundling and NCCI Edits Policy, Professional

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

This policy is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

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 Medicare Advantage reimbursement policies 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 (CMS 1450). 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 resource regarding UnitedHealthcare's Medicare Advantage reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Medicare Advantage 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 Medicare Advantage 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, and/or the enrollee's benefit coverage documents**. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Medicare Advantage due to programming or other constraints; however, UnitedHealthcare Medicare Advantage strives to minimize these variations.

UnitedHealthcare Medicare Advantage may modify this reimbursement policy at any time to comply with changes in CMS policy and other national standard coding guidelines by publishing a new version of the reimbursement policy on this website. However, the information presented in this reimbursement policy is accurate and current as of the date of publication. UnitedHealthcare Medicare Advantage encourages physicians and other health care professionals to keep current with any CMS policy changes and/or billing requirements by referring to the CMS or your local carrier website regularly. Physicians and other health care professionals can sign up for regular distributions for policy or regulatory changes directly from CMS and/or your local carrier. UnitedHealthcare's Medicare Advantage reimbursement policies do not include notations regarding prior authorization requirements.

** For more information on a specific enrollee's benefit coverage, please call the customer service number on the back of the member ID card.

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. UnitedHealthcare Medicare Advantage 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.

Reimbursement Guidelines

NCCI
UnitedHealthcare Medicare Advantage uses this policy to administer the "Column One/Column Two" National Correct Coding Initiative (NCCI) edits not otherwise addressed in UnitedHealthcare Medicare Advantage reimbursement policies to 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.

When reported with a column one code, UnitedHealthcare Medicare Advantage will not separately reimburse a column two code unless the edit pair is assigned an NCCI modifier indicator of "1" and the column two code is appropriately appended with one of the designated modifiers as outlined in the modifier section below.

Each CMS NCCI edit has a modifier indicator assigned to it:

- A modifier indicator of "0" indicates there are no modifiers associated with NCCI that are allowed to be used with this code pair and there are no circumstances in which both procedures of the code pair should be paid.
- A modifier indicator of "1" indicates that the modifiers associated with NCCI are allowed with this code pair when appropriate.
- A modifier indicator of "9" means that an NCCI edit does not apply to this code pair. The edit for this code pair was deleted retroactively.

The edits administered by this policy may be found by accessing the Medicare National Correct Coding Initiative (NCCI) Edits page on the CMS website.

Modifiers offer specific information and should be clearly documented in the medical record and used appropriately. For example, by definition, Modifier 91 (Repeat Clinical Diagnostic Laboratory Test) would be used to repeat the same laboratory test on the same day for the same patient.

According to the CPT book, modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under certain circumstances. Per the NCCI Medicare Policy manuals, the purpose of modifier 59 is to indicate that two or more procedures at different anatomic sites or patient encounters are performed. Information describing additional usage of modifier 59 can be found on the CMS Medicare NCCI, or CMS MLN Matters websites.

Consistent with CMS, effective for claims date of service July 1, 2019 and after, UnitedHealthcare Medicare Advantage will consider separate reimbursement of a column two code when reported with a column one code and modifiers 59, XE, XS, XP, or XU are appropriately appended to the column one or two code for a procedure or service rendered to the same patient, on the same date of service and by the Same Individual Physician or Other Qualified Health Care Professional, and there is an NCCI modifier indicator of "1".

Rebundling
Unbundling occurs when multiple procedure codes are billed for a group of procedures that are covered by a single comprehensive code. UnitedHealthcare Medicare Advantage 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 Medicare Advantage 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 Medicare Advantage 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 (NCCI) 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 healthcare 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 NCCI designated modifiers under this reimbursement policy for Medicare NCCI and Medicaid PTP edits:
24, 25, 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 and XU.

As it relates to the use of anatomical modifiers: 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, and F9, code pair edits may be bypassed only if the two procedures reported are submitted with different anatomical modifiers.

Please refer to the “Modifiers” section of this policy for a complete listing of acceptable modifiers UnitedHealthcare Medicare Advantage recognizes.

Modifiers offer specific information and should be used appropriately. It is inappropriate to use modifier 76 to indicate repeat laboratory services. Modifiers 59 or 91 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	Description
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.
59	UnitedHealthcare Medicare Advantage 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 MLN Matters website: Medicare Learning Network (MLN) Proper Use of 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.

Definitions

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.
Ipsilateral	Belonging to or occurring on the same side of the body.
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:** When should modifier 59 be used? **A:** Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under certain circumstances. Some examples of when it may be used are: identifying a different session, different procedure or surgery, separate lesion.

2	**Q:** When should modifier 25 be used? **A:** Modifier 25 is used when 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 evaluation and management (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. It should not be used to report an E/M service that resulted in a decision to perform surgery.
3	**Q:** Since the CCI Editing 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 including, but not limited to, the CPT and HCPCS books, and CMS NCCI Policy Manual which address situations in which a modifier applies. While the CCI Editing policy recognizes many modifiers, modifiers only apply when they are used according to correct coding guidelines. For example, CMS considers the shoulder to be a single anatomic structure. An NCCI procedure to procedure edit code pair consisting of two codes describing two shoulder procedures should never be bypassed with an NCCI-associated modifier when performed on the ipsilateral (same side) shoulder. In this case, procedure 23700 is billed with modifier LT, *Manipulation under anesthesia, shoulder joint, including application of fixation apparatus (dislocation excluded)* and is performed at the same encounter as procedure 29823 with modifier LT, *Arthroscopy, shoulder surgical: debridement, extensive.* Since both services were performed on the same (left) shoulder, only one procedure would be allowed. If the two procedures are performed on contralateral (opposite) shoulders (23700 with modifier LT and 29823 with modifier RT) then the CCI edit would not apply.

Codes	
Modifiers	
24	Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period (NCCI)
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 (Rebundling)
57	Decision for Surgery
58	Staged or Related Procedure or Service by the Same Physician 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	Upper left, eyelid
E2	Lower left, eyelid
E3	Upper right, eyelid

E4	Lower right, eyelid
XE	Separate Encounter: A service that is distinct because it occurred during a separate encounter. (Effective 01/01/2015)
XP	Separate Practitioner: A service that is distinct because it was performed by a different practitioner (Effective 01/01/2015)
XS	Separate Structure: A service that is distinct because it was performed on a separate organ/structure (Effective 01/01/2015)
XU	Unusual Non-Overlapping Service: The use of a service that is distinct because it does not overlap usual components of the main service (Effective 01/01/2015)
F1	Left hand, second digit
F2	Left hand, third digit
F3	Left hand, fourth digit
F4	Left hand, fifth digit
F5	Right hand, thumb
F6	Right hand, second digit
F7	Right hand, third digit
F8	Right hand, fourth digit
F9	Right hand, fifth digit
FA	Left hand, thumb
LC	Left circumflex coronary artery
LD	Left anterior descending coronary artery
LM	Left main coronary artery
LT	Left side
RC	Right coronary artery
RI	Ramus intermedius
RT	Right side
T1	Left foot, second digit
T2	Left foot, third digit
T3	Left foot, fourth digit
T4	Left foot, fifth digit
T5	Right foot, great toe
T6	Right foot, second digit
T7	Right foot, third digit
T8	Right foot, fourth digit
T9	Right foot, fifth digit
TA	Left foot, great toe

Resources

www.cms.gov
Medicare National Correct Coding Initiative (NCCI) Edits
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

History

04/30/2020	Policy Version Change • Reimbursement Guidelines: Modifiers: Updated language for ipsilateral anatomical modifiers. • Definitions: Added ipsilateral definition. • Questions and Answers: Added Q&A #3.
10/4/2019	Annual Anniversary Date and Version Change Reimbursement Guidelines: Updated modifier language.
8/23/2019	Policy Version Change Reimbursement Guidelines: Updated language for modifier editing effective July 1, 2019. History Section: Entries prior to 3/8/2017 archived
11/14/2018	Annual Policy Approval Date and Version Change History Section: Entries prior to 1/1/2017 archived
8/31/2018	Policy number changed from 2017R0056B (new version) Added the word 'Professional' to the policy title
11/8/2017	Annual Review (new version) Updated Overview Updated Preamble Changed UnitedHealthcare Medicare and Retirement to UnitedHealthcare Medicare Advantage
10/08/2014	New Policy
08/09/2012	Policy Implemented

