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 Community Plan reimbursement policies uses 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 Community Plan's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Community Plan 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 Community Plan enrollees.

Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors include, but are not limited to: federal &/or state regulatory requirements, 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 Community Plan due to programming or other constraints; however, UnitedHealthcare Community Plan strives to minimize these variations.

UnitedHealthcare Community Plan 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.

Application

This reimbursement policy applies to UnitedHealthcare Community Plan Medicaid products.

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.

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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. For the purpose of this policy, the same individual physician or health care professional is the same individual rendering health care services reporting the same Federal Tax Identification number.

Reimbursement Guidelines

Edit Sources

UnitedHealthcare Community Plan uses this policy to determine whether CPT and/or HCPCS codes reported together by the Same Individual Physician or Health Care Professional for the same member on the same date of service are eligible for separate reimbursement. UnitedHealthcare Community Plan 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 Community Plan 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 Orthopedic 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 Community Plan 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, and XU.

Modifiers offer specific information and should be used appropriately. It is inappropriate to use modifier 76 to indicate repeat laboratory services. Modifiers 59, XE, XP, XS, XU 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.

State Exceptions

Colorado	CPT codes 90791, 90832, 90834, 90837, 90846, and 90847 are reimbursable
Indiana	Indiana Medicaid considers G2211 and G0545 as a non-covered code
Kansas	Per state regulations: • CPT codes 90832, 90833 and HCPC code G2211 are separately reimbursable • HCPCS code G2211 is only separately reimbursable when the associated E/M visit (codes 99202-99205, 99211-99215) is billed without modifier 25

	• HCPCS codes S0610, S0612 and S0613 should not be considered E/M codes and therefore should be allowed for payment when billed with admins and E/M codes
Maryland	CPT code 99401 is reimbursable. The State of Maryland covers COVID-19 vaccine counseling. Per Maryland state requirements, code G2211 is allowed as separately reimbursable
Michigan	Code A4264 is payable when billed with code 58565 per State Regulations.
Nebraska	CPT codes 99406 and 99407 are reimbursable. The State of Nebraska covers counseling and certain drugs specifically approved to help members quit using tobacco.
North Carolina	CPT codes 99367 and 99368 are reimbursable.
Pennsylvania	CPT code 99080 is reimbursable. The State of Pennsylvania allows for incentive payment for EPSDT services on CPT 99080.
Tennessee	Rebundling edits do not apply to specific code combinations for place of service 53. See attachment section for Tennessee POS 53 code combinations list.
Texas	CPT code A4264 is reimbursable. A4264 is a supply code which is reimbursable in addition to the Essure sterilization procedure 58565.
Virginia	Per state fee schedule, HCPCS G2211 is separately reimbursable.
Washington	96164 is reimbursable in addition to the 96170. CPT codes 90832, 90834 and 90837 is reimbursable in addition to E&M codes and will not be rebundled in to the corresponding add on code. CPT codes 96110, 96127, 96160, and 96161 are reimbursable in addition to E/M codes and should not be rebundled.
Washington D.C.	Per state fee schedule, HCPCS G2211 is payable by DC Medicaid
Wisconsin	CPT code A4264 is reimbursable. A4264 is a supply code which is reimbursable in addition to the Essure sterilization procedure 58565. G2211 is allowed to be billed as an add on code to CPT codes 99205 and 99215

Definitions	
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.

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) or Preventive Medicine 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. Code 99173 is reimbursable with Preventive Service codes. See UnitedHealthcare Community Plan's "Preventive Medicine and Screening Policy" for additional information.
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 Community Plan separately reimburse HCPCS supply code A4550 (Surgical trays) when submitted with another Evaluation and Management (E/M) service and/or procedure code? **A:** UnitedHealthcare Community Plan 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 Community Plan'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 health care professionals other than physicians, UnitedHealthcare Community Plan does not allow 99211 to be reimbursed separately when reported with these services whether or not a modifier is appended.
11	**Q:** Will UnitedHealthcare Community Plan allow separate reimbursement for codes G2211 and G0545 for visit complexity when billed on the same date of service for the same patient by the same physician or Other QHP with an Evaluation and Management Service? **A:** No, visit complexity for services G2211 and G0545 are structured in the reimbursement for evaluation and management services and not paid separately.

Attachments

Tennessee POS 53 code combinations list	List of Tennessee POS 53 code combinations

Resources

Individual state Medicaid regulations, manuals & fee schedules

American Medical Association, *Current Procedural Terminology (CPT®) Professional Edition* 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

History

8/29/2025	Policy Version Change State Exceptions: Indiana updated
8/22/2025	Policy Version Change State Exceptions: Kansas updated
4/18/2025	Policy Version Change Question and Answers: Q&A 11 updated History section: Entries prior to 4/18/2023 archived
9/1/2024	Policy Version Change State Exceptions: Indiana added, Kansas updated, Maryland updated, Virginia added, Washington D.C. added, Wisconsin updated Question and Answers: Q&A 11 added History section: Entries prior to 9/1/2022 archived
7/14/2024	Policy Version Change State Exceptions: Washington updated
9/29/2023	Annual Anniversary Review Policy Version Change Header: Updated Branding History section: Entries prior to 9/29/2021 archived
11/14/2018	Policy Approval Date Change