Rebundling Policy (CES)

Policy Number: ADMINISTRATIVE 292.1 T0
Effective Date: August 1, 2021

Instructions for Use

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Related Policies
None

Applicable Lines of Business/Products

This policy applies to Oxford Commercial plan membership.

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.

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

Oxford 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. Oxford 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.

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Oxford 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 (refer to the Definitions section 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 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).

Oxford recognizes the following designated modifiers under this reimbursement policy:

Modifiers											
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.

CMS Medicare Learning Network (MLN) Proper Use of Modifier 59

Edit Types and Frequency

Refer to the Claims Tool to review appropriate bundling of services under UnitedHealthcare reimbursement policies. The Claims Tool can be found at the UnitedHealthcare website. www.uhcprovider.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.

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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.

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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 Oxford separately reimburse HCPCS supply code A4550 (Surgical trays) when submitted with another Evaluation and Management (E/M) service and/or procedure code?
	A:	Oxford 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. Refer to Oxford'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.
12	Q:	Can an open or laparoscopic repair of a reducible incisional or ventral hernia be reported when performed at the same time as another intra-abdominal procedure?
	A:	Open or laparoscopic repair of a reducible incisional or ventral hernia, codes 49560, 49565, 49652, 49654 and 49656, is considered incidental to a more definitive intra-abdominal operative service performed at the same site. The same site may be an abdominal scar from a previous surgery that developed a hernia, which is used as the incision access point for a new intra-abdominal procedure. Appending a distinct procedural modifier to the ventral/incisional repair codes 49560, 49565, 49652, 49654 or 49656 when submitted with an intra-abdominal operative service identifies a distinct procedural service performed at a separate site. The modifier indicates the procedure is more extensive than simply incising an existing scar or ventral hernia during an open intra-abdominal procedure and that the hernia is in a different site.

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13	Q:	Can an appendectomy be reported when performed at the same time as another intra-abdominal procedure?
	A:	Appendectomy procedure code 44950 and laparoscopic appendectomy code 44970 are included in other more extensive intra-abdominal or laparoscopic operative services performed at the same time. It is an error to report 44970 for laparoscopic removal of a diseased appendix at the same time as another intra-abdominal laparoscopic procedure. The AMA states there is no CPT code to report a laparoscopic appendectomy when done for an indicated purpose at time of another major procedure. This would be reported using 44979, Unlisted laparoscopy procedure. No modifiers override the edits between CPT code 44950 or 44970 and intra-abdominal laparoscopic operative services.

References

The foregoing Oxford policy has been adapted from an existing UnitedHealthcare national policy that was researched, developed, and approved by UnitedHealthcare Reimbursement Policy Oversight Committee. [*2021R0056C~~B~~*]

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 College of Surgeons (ACS)

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

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

Policy History/Revision Information

Date	Summary of Changes
08/01/2021	New Reimbursement Policy

Instructions for Use

The services described in Oxford policies are subject to the terms, conditions and limitations of the member's contract or certificate. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members. Oxford reserves the right, in its sole discretion, to modify policies as necessary without prior written notice unless otherwise required by Oxford's administrative procedures or applicable state law. The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies.

Certain policies may not be applicable to Self-Funded members and certain insured products. Refer to the member specific benefit plan document or Certificate of Coverage to determine whether coverage is provided or if there are any exclusions or benefit limitations applicable to any of these policies. If there is a difference between any policy and the member specific benefit plan document or Certificate of Coverage, the member specific benefit plan document or Certificate of Coverage will govern.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The InterQual® criteria are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

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