

Payment Policy: Unbundled Professional Services

Reference Number: CC.PP.043

Product Types: ALL

Effective Date: 01/01/2014

Last Review Date: 03/01/2019

[Coding Implications](#)
[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Policy Overview

Certain procedure codes when billed together on the same date of service are not separately reimbursable. These code pair relationships are established by national specialty society organizations and reflect coding guidelines for their area of medical specialty. They are available for use by their membership as public-domain (published) guidance for the correct use of procedure codes within a specific area of medical specialty.

The purpose of this policy is to define payment criteria for national specialty society code pair edit relationships to be used in making payment decisions and administering benefits.

Application

1. Physician and Non-physician Practitioner Services
2. Same member
3. Same provider
4. Claims with the same date of service
5. Rule reviews the current claim and across claims in history

Policy Description

The health plan uses automated claims code editing software to verify coding scenarios, ensure compliance with industry coding standards and facilitate accurate claims payment. These rules are based on coding conventions described by the Centers for Medicare and Medicaid Services (CMS), and the American Medical Association's Current Procedural Terminology (CPT®) coding guidelines.

Additionally, national medical specialty society organizations develop Current Procedural Terminology (CPT®) coding rules for their area of specialty. These rules establish guidance on procedure codes that may not appropriately be billed together, on the same date of service, by the same provider and for the same member. These rules describe comprehensive services that may include several component services and therefore the component services are not allowed for separate reimbursement. When this coding combination is identified, only the comprehensive code is reimbursable; reimbursement for the component code is subsumed in the reimbursement allotted for the comprehensive procedure. These rules are otherwise known as unbundling edits.

Examples of national medical specialty society organizations that develop coding rules are as follows:

- American College of Obstetricians and Gynecologists (ACOG)
- American Academy of Orthopedic Surgeons (AAOS)
- American College of Radiology (ACR)

- American College of Surgeons (ACS)

Prior to establishing an unbundling edit, these specialty society organizations reference the procedure code definition and CMS Physician's Relative Value File (RVU) to determine the necessary resources associated with the service. Based on this information, procedure codes are categorized into comprehensive services and their component procedures.

This process also identifies mutually exclusive procedures or those that cannot reasonably be performed for the same member, at the same time, same encounter, same anatomic site and etc.

As these are national specialty society unbundling edits, they are separate and distinct from the CMS National Correct Coding Initiative (NCCI) edits. As such, code pairs that are included in this rule are *not* sourced from the CMS Column 1/Column 2 NCCI edit tables.

Reimbursement

The health plan's code editing software will evaluate claim service lines billed with a procedure code that is not separately reimbursable when billed with one of the following:

1. A more comprehensive procedure
2. A procedure that results in overlapping services
3. Procedures that are considered impossible to be performed together during the same operative session
4. An evaluation and management service that is billed on the same date as a surgical procedure

If any of the above conditions exist, the code editing software will make a denial recommendation. Specific edits are taken into consideration prior to the denial determination:

- Modifier -25
- Modifier -57
- Modifier -59
- Site-specific modifiers (i.e., left, right)

Documentation Requirements

Modifier 25 –

Modifier -25 should only be used to indicate that a “significant, separately identifiable Evaluation and Management service (was provided) by the same physician on the same day of the procedure or other service.” The following guidelines will be used to determine whether or not modifier 25 was used appropriately. If any one of the following conditions is met, then reimbursement for the E/M service is recommended:

1. If the E/M service is the first time the provider has seen the patient or evaluated a major condition.
2. A diagnosis on the claim indicates that a separate medical condition was treated in

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- addition to the procedure that was performed
3. The patient's condition is worsening as evidenced by diagnostic procedures being performed on or around the date of services
 4. If a provider bills supplies or equipment, on or around the same date of service, that are unrelated to the procedure performed but would have required E/M services to determine the patient's need.

Modifier -57

The modifier -57 indicates that an Evaluation and Management service (E&M) resulted in the decision to perform surgery. This modifier is only used to indicate that the decision for surgery was made either the day before or the day of a major surgical procedure (90-day global period).

1. Claim lines billed with the modifier -57 appended to the E&M are subject to prepayment *clinical claims validation* by a registered nurse who is also a certified coder. The nurse will analyze E&M and surgical dates of service, diagnosis codes, procedure codes and other claim information to determine if the *initial decision* to perform surgery occurred on the day before or the day of a major surgery. If the claim documentation supports the initial decision to perform surgery; the E&M service is separately reimbursed, otherwise the E&M is denied.

Modifier – 59

The modifier -59 is used to designate that a distinct procedure or service was performed by the same provider, for the same member, on the same day as other procedures or services. Since these procedures are commonly bundled together, the modifier -59 is needed to explain the distinction.

1. The diagnosis codes on the claim indicate multiple conditions or sites were treated or are likely to be treated.
2. Claim history for the patient indicates that diagnostic testing was performed on multiple body sites or areas which would result in procedures being performed on multiple body areas and sites.
3. To avoid incorrect denials providers should assign to the claim all applicable diagnosis and procedure codes using all applicable anatomical modifiers designating which areas of the body were treated.

Site-Specific Modifiers Examples (this list is not all inclusive)

1. Left, Right
2. Eyelids (E1-E4)
3. Fingers (F1-F9), FA
4. Toes (T1-T9)
5. Left Foot Great Toe (TA)

Coding and Modifier Information

This payment policy references Current Procedural Terminology (CPT[®]). CPT[®] is a registered trademark of the American Medical Association. All CPT[®] codes and descriptions are copyrighted 2018, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-

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inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT/HCPCS Code	Descriptor
99201-99499	Evaluation and Management
00100-01999	Anesthesia
10021-69990	Surgery
70010-79999	Radiology
80047-89398	Laboratory and Pathology
90281-99140; 99151-99199, 99500-99607	Medicine Codes
Category III	Emerging Technology

Modifier	Descriptor
Left	Left side
Right	Right Side
E1	Upper left eyelid
E2	Lower left eyelid
E3	Upper right eyelid
E4	Lower right eyelid
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
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

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Modifier	Descriptor
-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
-57	Decision for Surgery: An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service
-59	Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support 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) not ordinarily encountered or performed on the same day by the same individual

ICD-10 Codes	Descriptor
NA	Not applicable

Definitions

- **Comprehensive Procedure Codes**
 CPT® codes that represent a total service. Several component procedure codes are best represented by one all-inclusive code.
- **Component Procedure Codes**
 An individual procedure code that by definition is also included in a more comprehensive procedure code.
- **Relative Value Units**
 The resources necessary to perform a designated service. This is a Medicare reimbursement formula that is used to measure the value of a physician’s services.
- **Mutually Exclusive Procedure**
 Two procedures that cannot be performed during the same patient encounter on the same date of service, at the same time because of procedure code definitions (i.e., limited/complete, partial/total, single/multiple, unilateral/bilateral, initial/subsequent, simple/complex, superficial/deep, with/without) or anatomic considerations. For example a vaginal hysterectomy and an abdominal hysterectomy.
- **Unbundling**
 Billing separately for individual procedure codes that are included in a single, more comprehensive code.

Related Policies

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Policy Name	Policy Number
“Clinical Validation of Modifier -25”	CC.PP.013
“Clinical Validation of Modifier -59”	CC.PP.014
“Code Editing Overview”	CC.PP.011

Related Documents or Resources

<https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/downloads/modifier59.pdf>

References

1. *Current Procedural Terminology (CPT®)*, 2018
2. *HCPCS Level II*, 2018

Revision History	
11/13/2016	Initial Policy Draft Created
01/23/2017	Revisions to Policy after PI Review
03/01/2018	Reviewed and revised policy; started Surgery at 10021 instead of 10000; started Radiology w 70010 instead of 70000; started Lab and Pathology w 80047 instead of 80000; added 99100-99140 of Medicine per the 2018 code book
04/01/2019	Conducted review and updated policy.

Important Reminder

For the purposes of this payment policy, “Health Plan” means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan’s affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to

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recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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