Payment Policy: Multiple CPT Code Replacement

Reference Number: LA.PP.033
Product Types: ALL
Effective Date: 08/2020
Last Review Date: 08/2020

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
When a single, more comprehensive procedure code exists to describe multiple services, the single more comprehensive code should be used versus multiple CPT codes. This is known as unbundling. Louisiana Healthcare Connections will not reimburse the multiple procedure codes, but instead will make a recommendation to reimburse the single, most comprehensive code. This determination is based on the CPT code description for each code billed.

Application
- Professional claims
- Same provider
- Within the same claim
- Claims with the same date of service
- Will review historical claims

Reimbursement
Louisiana Healthcare Connections code editing software identifies when two or more codes have been billed to represent a service, instead of the single, most comprehensive code. The following claims processing scenarios will occur based on how the services were billed:

Examples

Multiple component codes billed on claim instead of the most comprehensive code, 85027:

	DOS	Procedure Code	Quantity	Charge Amount	Allow Amount	Deny Amount	Pay	EX code
200	5/3/2016	85014	1	$9.69	$3.50	$3.50	$0.00	xa
300	5/3/2016	85018	1	$9.69	$3.50	$3.50	$0.00	xa
400	5/3/2016	85041	1	$11.79	$5.50	$5.50	$0.00	xa
500	5/3/2016	85048	1	$10.38	$4.50	$4.50	$0.00	xa
600	5/3/2016	85049	1	$18.33	$12.25	$12.25	$0.00	xa
↓Added Line				$59.88	$29.25	$29.25		
700	5/3/2016	85027	1	$59.88	$8.51	$0.00	$8.51	92

CPT Code	Description

85014	Blood Count; Hematocrit (HCT)
85018	Blood Count; Hemoglobin (HGB)
85041	Blood Count, Red Blood Cell (RBC), Automated
85048	Blood Count, Leukocyte (WBC), Automated
85049	Blood Count; Platelet, Automated
85027	Blood Count; Complete (CBC), Automated, (HGB, HCT, RBC, WBC and Platelet Count

The following automated steps were taken to correct the claim and reimburse the provider correctly:

1. The health plan's automated code editing software analyzed each service line, the CPT code billed and its description.
2. A total of 5 component codes were billed on service lines 0200-0600.
3. The software analyzed the service lines and determined that the most comprehensive CPT code had not been billed (85027).
4. The software denied each component service line with the denial code (EX code) "xa"
5. As a courtesy to the provider, the software added a new service line to reflect the most comprehensive code.
6. Total billed charges for the component codes is $59.88
7. The total denied amount for the component codes is $29.25
8. The total allowed amount for the most comprehensive code, 85027 is $8.51
9. Total cost avoidance = $20.74.

This edit does not change how a provider originally billed, but instead, as a courtesy to the provider, adds a new service line with the correct, payable quantity. All originally billed service lines remain on the claim.

Multiple component codes billed AND the most comprehensive code is billed:

	DOS	Procedure Code	Quantity	Charge Amount	Allow Amount	Deny Amount	Pay	EX code
200	5/3/2016	85014	1	$9.69	$3.50	$3.50	$0.00	xa
300	5/3/2016	85018	1	$9.69	$3.50	$3.50	$0.00	xa
400	5/3/2016	85041	1	$11.79	$5.50	$5.50	$0.00	xa
500	5/3/2016	85048	1	$10.38	$4.50	$4.50	$0.00	xa
600	5/3/2016	85049	1	$18.33	$12.25	$12.25	$0.00	xa
700	5/3/2016	85027	1	$59.88	$8.51	$0.00	$8.51	92

In the above example, all component service lines are denied with the denial EX code "xa", however, the most comprehensive code billed on service line 0700 is paid. The allowed amount is $8.51.

Definitions

1. *Unbundling*: Coding two or more bundled procedures separately instead of the single, most comprehensive code. This practice results in incorrect provider payments.
2. *Bundled procedures*: Procedures that are included as part of a more extensive procedure.

References

1. *Current Procedural Terminology (CPT®)*, 2019
2. *HCPCS Level II*, 2019
3. *International Classification of Diseases*, Tenth Revision, Clinical Modification (ICD-10-CM), 2019
4. *ICD-10-CM Official Draft Code Set*, 2019

Revision History	
08/15/2020	Converted corporate to local policy.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved.

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This clinical 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 clinical policy is not intended to

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

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POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, Centene's P&P management software, is considered equivalent to an actual signature on paper.

Senior Director of Network Accounts: _____Electronic Signature on File_____