Payment Policy: Unbundled Professional Services

Reference Number: LA.PP.043
Effective Date: 08/2020
Last Review Date: 07/2026

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
Louisiana Healthcare Connections 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
Louisiana Healthcare Connections 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 recommends denial of the service. 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 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
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).

Modifier -59
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.

Providers who do not adhere to the requirements above may be subject to a post payment medical record review and payment recoupment.

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 2025, 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-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.

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

Policy Name	Policy Number
"Code Editing Overview"	LA.PP.011
Clinical Validation of Modifier -59	LA.PP.014
Clinical Validation of Modifier -25	LA.PP.013

Related Documents or Resources
https://www.cms.gov/files/document/proper-use-modifiers-59-xepsu.pdf

References
1. *Current Procedural Terminology (CPT®)*, 2026
2. *HCPCS Level II*, 2026
3. CMS Medicaid National Correct Coding Initiative Policy Manual 2025
   https://www.cms.gov/files/document/medicaid-ncci-policy-manual-2024-chapter-1.pdf

4. CMS Medicare National Correct Coding Initiative Policy Manual 2025
   https://www.cms.gov/files/document/2025nccimedicarepolicymanualcompletepdf.pdf
5. AMA Reporting Modifier 25 Aug. 2023
https://www.ama-assn.org/system/files/reporting-CPT-modifier-25.pdf

Revision History	Revision Date	Approval Date	Effective Date
Converted corporate to local policy.	08/15/20		
Annual Review; Updated link and dates in the reference section from 2019 to 2021 Removed clinical and added payment policy in "Important Reminder" section	08/30/22		
Annual review; code tables removed, since this information can be found in CPT resources	08/01/23	1/9/24	
Annual review; Remove prepayment clinical review verbiage and added a statement, "providers may be subject to post payment review; Removed "clinical validation policies" under related policies, as they are retired. Updated links and dates for accuracy.	8/26/24	1/3/25	2/5/25
Annual review; references and dates updated	7/25	7/29/25	8/21/25
Annual review; reference dates updated	7/26	7/28/26	

Important Reminder
This payment 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 payment 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 payment policy. This payment policy is consistent with standards of medical practice current at the time that this payment policy was approved.

The purpose of this payment policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions 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 LHCC administrative policies and procedures.

This payment policy is effective as of the date determined by LHCC. 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. LHCC retains the right to change, amend or withdraw this payment policy, and additional clinical 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 recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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