UnitedHealthcare®

Reimbursement Policy

Rebundling and NCCI Editing

Policy Number	CCR10082014RP	Approved By	UnitedHealthcare Medicare Reimbursement Policy Committee	Current Approval Date	10/08/2014

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

This policy is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

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 reimbursement policies use 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 (CMS 1450). 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 resource regarding UnitedHealthcare's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare 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 enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, and/or the enrollee's benefit coverage documents. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare due to programming or other constraints; however, UnitedHealthcare strives to minimize these variations.

UnitedHealthcare 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.

Table of Contents

Application

This reimbursement policy applies to services reported using the Health Insurance Claim Form CMS-1500 or its electronic equivalent or its successor form, and services reported using facility claim form CMS-1450 or its electronic equivalent or its successor form. This policy applies to all products, all network and non-network physicians, and other health care professionals.

The HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) edits. This policy does not take precedence over NCCI edits. Please refer to the NCCI for correct coding guidelines and specific applicable code combinations prior to billing UnitedHealthcare. It is not enough to link the procedure code to a correct, payable ICD-9-CM diagnosis code. The diagnosis must be present for the procedure to be paid. Compliance

with the provisions in this policy is subject to monitoring by pre-payment review and/or post-payment data analysis and subsequent medical review. The effective date of changes/additions/deletions to this policy is the committee meeting date unless otherwise indicated.

Summary

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.

Reimbursement Guidelines

NCCI

UnitedHealthcare uses this policy to administer the "Column One/Column Two" National Correct Coding Initiative (NCCI) edits not otherwise addressed in UnitedHealthcare Medicare and Retirement reimbursement policies to determine whether CPT and/or HCPCS codes reported together by the Same Individual Physician or Other Health Care Professional for the same member on the same date of service are eligible for separate reimbursement. When reported with a column one code, UnitedHealthcare Medicare and Retirement will not separately reimburse a column two code unless one of the designated modifiers is appended to the column two edit code for a procedure or service rendered to the same patient, on the same date of service and by the Same Individual Physician or Other Health Care Professional, and there is an NCCI modifier indicator of “1”, UnitedHealthcare will consider both services and/or procedures for reimbursement. Please refer to the “Modifiers” section of this policy for a complete listing of acceptable modifiers and the description of modifier indicators of “0”, “1” and “9”.

The edits administered by this policy may be found: Medicare National Correct Coding Initiative (NCCI) Edits

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).

Each CMS NCCI edit has a modifier indicator assigned to it. A modifier indicator of "0" indicates there are no modifiers associated with NCCI that are allowed to be used with this code pair and there are no circumstances in which both procedures of the code pair should be paid. A modifier indicator of "1" indicates that the modifiers associated with NCCI are allowed with this code pair when appropriate. A modifier indicator of “9” means that an NCCI edit does not apply to this code pair. The edit for this code pair was deleted retroactively.

UnitedHealthcare recognizes the following NCCI designated modifiers under this reimbursement policy for Medicare NCCI edits: 24, 25, 57, 58, 59, (XE, XS, XP, XU - Effective 1/1/2015), 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 and F9.

Please refer to the “Modifiers” section for a complete listing of modifiers and their descriptions.

Modifiers offer specific information and should be used appropriately. For example, by definition, Modifier 91 (Repeat Clinical Diagnostic Laboratory Test) would be used to repeat the same laboratory test on the same day for the same patient.

According to the CPT book, modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under certain circumstances. Per the NCCI Medicare Policy manuals, the purpose of modifier 59 is to indicate that two or more procedures at different anatomic sites or patient encounters are performed. Information describing additional usage of modifier 59 can be found on the CMS Medicare NCCI, or CMS MLN Matters websites.

Rebundling

Unbundling occurs when multiple procedure codes are billed for a group of procedures that are covered by a

Rebundling and NCCI Editing

single comprehensive code. UnitedHealthcare uses this policy to determine whether CPT and/or HCPCS codes reported together by the Same Individual Physician or Other Health Care Professional for the same member on the same date of service are eligible for separate reimbursement. UnitedHealthcare Medicare and Retirement 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 Medicare and Retirement 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 (NCCI) edits;
- CMS Policy; and
- Specialty Societies (e.g., American Academy of Orthopaedic Surgeons (AAOS), American Congress of Obstetricians and Gynecologists (ACOG), American College of Cardiology (ACC), and Society of Cardiovascular Interventional Radiology (SCIR)).

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 recognizes the following designated modifiers under this reimbursement policy: 5, 50, 57, 58, 59, (XE, XS, XP, XU - Effective 1/1/2015), 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 and F9.

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

Modifier	Description / Information
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: It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.
59	UnitedHealthcare follows CPT guidelines for the use of modifier 59. According to the CPT book, modifier 59 (distinct procedural service) is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. Use of the modifier 59 may represent 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) The above points apply to procedures/services that are not ordinarily encountered or performed on the same day by the same individual. Information describing additional usage of modifier 59 can be found on the CMS Medicare NCCI, Medicaid NCCI or CMS MLN Matters websites. CMS MLN Matters website: Medicare Learning Network (MLN) Proper Use of Modifier 59 According to the CPT book, modifier 59 should **only** be used when a more descriptive modifier is not available. Modifier 59 and designated modifiers should NOT be used to bypass an edit unless the proper criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required by any designated modifier that is used.

Modifiers

Code	Description
24	Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period ((NCCI))
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
50	Bilateral Procedure (Rebundling)
57	Decision for Surgery
58	Staged or Related Procedure or Service by the Same Physician During the Postoperative Period
59	Distinct Procedural Service
78	Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period
79	Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
91	Repeat Clinical Diagnostic Laboratory Test
E1	Upper left, eyelid
E2	Lower left, eyelid
E3	Upper right, eyelid
E4	Lower right, eyelid
XE	Separate Encounter: A service that is distinct because it occurred during a separate encounter. (Effective 1/1/2015)
XP	Separate Practitioner: A service that is distinct because it was performed by a different practitioner. (Effective 1/1/2015)
XS	Separate Structure: A service that is distinct because it was performed on a separate organ/structure. (Effective 1/1/2015)
XU	Unusual Non-Overlapping Service: The use of a service that is distinct because it does not overlap usual components of the main service. (Effective 1/1/2015)
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
LC	Left circumflex coronary artery
LD	Left anterior descending coronary artery
LM	Left main coronary artery
LT	Left side
RC	Right coronary artery
RI	Ramus intermedius
RT	Right side
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

Questions and Answers

1	**Q:**	When should modifier 59 be used?
	A:	Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under certain circumstances. Some examples of when it may be used are: identifying a different session, different procedure or surgery, separate lesion.
2	**Q:**	When should modifier 25 be used?
	A:	Modifier 25 is used when necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable evaluation and management (E/M) service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. It should not be used to report an E/M service that resulted in a decision to perform surgery.

References Included (but not limited to):

CMS Transmittals

Transmittal 1422, Change Request 8863, Dated 08/15/2014 (Specific Modifiers for Distinct Procedural Services)

MLN Matters

Article MM8863, Specific Modifiers for Distinct Procedural Services

Article SE1418, Proper Use of Modifier 59

Others

Medicare National Correct Coding Initiative (NCCI) Edits, CMS Website

History

Date	Revisions
10/08/2014	New Policy