# Payment Policy: Unbundled Professional Services

Reference Number: CC.PP.043
Product Types: ALL
Effective Date: 01/01/2014
Last Review Date: 12/01/2022

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**
Physician and Non-physician Practitioner Services for the same member, on the same date of service, with the same provider. Current and historical claims are reviewed.

**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 evaluates 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 (E/M) service 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. The following are taken into consideration prior to 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 are used to determine whether modifier -25 was used appropriately. If any one of the following conditions is met, then reimbursement for the E/M service is recommended.

1. 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. The 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 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). Claim lines billed with modifier -57 appended to the E/M are subject to prepayment clinical claims validation. The analysis includes 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 documentation supports the initial decision to perform surgery, the E/M service is separately reimbursed; otherwise, the E/M is denied.

**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, modifier -59 is needed to explain the distinction.

1. 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, all applicable diagnosis and procedure codes should be assigned using all applicable anatomical modifiers designating which areas of the body were treated.

## 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 2022, 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.

## Related Policies

| 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/files/document/proper-use-modifiers-59-xepsu.pdf

**References**

1. *Current Procedural Terminology (CPT®)*, 2022
2. *HCPCS Level II*, 2022

| 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. |
| 11/01/2019 | Annual Review completed |
| 11/01/2020 | Annual Review completed |
| 11/30/2021 | Annual review completed; sourcing and link for modifier 59 info updated |
| 12/01/2022 | Annual review completed; code tables removed since this information can be found in CPT resources |

**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 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.

This payment policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

**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.