PAYMENT POLICY ID NUMBER 18-063

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Unbundled, Incidental, and Mutually Exclusive Services

THIS PAYMENT POLICY IS NOT AN AUTHORIZATION, CERTIFICATION, EXPLANATION OF BENEFITS, A GUARANTEE OF PAYMENT, NOR DOES IT SUBSTITUTE FOR OR CONSTITUTE MEDICAL ADVICE. ALL MEDICAL DECISIONS ARE SOLELY THE RESPONSIBILITY OF THE PATIENT AND PHYSICIAN. BENEFITS ARE DETERMINED BY THE GROUP CONTRACT, MEMBER BENEFIT BOOKLET, AND/OR INDIVIDUAL SUBSCRIBER CERTIFICATE IN EFFECT AT THE TIME SERVICES WERE RENDERED. THIS PAYMENT POLICY APPLIES TO ALL LINES OF BUSINESS AND PROVIDERS OF SERVICE. IT DOES NOT ADDRESS ALL POTENTIAL ISUES RELATED TO PAYMENT FOR SERVICES PROVIDED TO FLORIDA BLUE MEMBERS AS LEGISLATIVE MANDATES, PROVIDER CONTRACT DOCUMENTS OF THE MEMBER'S BENEFIT COVERAGE MAY SUPERSEDE THIS POLICY.

DESCRIPTION:

Medical and surgical procedures should be reported with the Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT®) codes that most comprehensively describe the services performed. Providers/Suppliers must not unbundle the services described by a HCPCS/CPT® code. Unbundling occurs when multiple procedure codes are billed for a group of procedures that are covered by a single comprehensive code. Services that are considered incidental, mutually exclusive, integral to the primary service rendered, or part of a global allowance are not separately reportable.

The Unbundled, Incidental, and Mutually Exclusive Services payment policy describes services that are not eligible for separate reimbursement when reported by the same provider/supplier for the same member on the same date of service.

This policy applies to professional services reported on a CMS-1500 claim or its electronic equivalent.

REIMBURSEMENT INFORMATION:

Unbundling

Unbundling occurs when multiple procedure codes are used to report a procedure covered by a single comprehensive HCPCS/CPT® code. Services integral to HCPCS/CPT® code defined procedures are included in those procedures based on the standards of medical/surgical practice. Some of these integral services have specific HCPCS/CPT® codes for reporting the service when not performed as an integral part of another procedure; other integral services do not have specific codes. **Services that are integral to a more comprehensive service are not eligible for separate reimbursement.**

Below are several examples in which a service or procedure is considered bundled and not eligible for separate reimbursement.

- Reporting integral services that have specific HCPCS/CPT® codes for reporting the service.
    - For example, CPT® code 36000 (introduction of needle or intracatheter into a vein) is integral to all nuclear medicine procedures requiring injection of a radiopharmaceutical into a vein.

- Reporting integral services that do not have specific HCPCS/CPT® codes for reporting the service.
    - For example, wound irrigation is integral to the treatment of all wounds and does not have a HCPCS/CPT® code.

- Reporting multiple HCPCS/CPT® codes when a single comprehensive code describes these services.
    - For example, if a physician performs a vaginal hysterectomy on a uterus weighing less than 250 grams with bilateral salpingo-oophorectomy, the provider/supplier shall report CPT® code 58262 (Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)). The provider/supplier shall not report CPT® code 58260 (Vaginal hysterectomy, for uterus 250 g or less;) plus code 58720 [Salpingo-oophorectomy, complete or partial, unilateral, or bilateral (separate procedure)].

- Fragmenting a procedure into its component parts and coding each component as if it were a separate procedure.
    - For example, if a physician performs an anal endoscopy with biopsy, the provider/supplier shall report CPT® code 46606 (Anoscopy; with biopsy, single or multiple). It is improper to unbundle this procedure and report CPT® code 46600 (Anoscopy; diagnostic,…) plus CPT® code 45100 (Biopsy of anorectal wall, anal approach...). The latter code is not intended to be utilized with an endoscopic procedure code.

- Unbundling a bilateral procedure code into two unilateral procedure codes.
    - For example, if a provider/supplier performs bilateral mammography, the provider/supplier shall report CPT® code 77066 (Diagnostic mammography... bilateral). The provider/supplier shall not report CPT® code 77065 (Diagnostic mammography... unilateral) with two units of service or 77065 LT plus 77065 RT.

- Unbundling services that are integral to a more comprehensive procedure.
    - For example, surgical access is integral to a surgical procedure. A provider/supplier shall not report CPT® code 49000 (Exploratory laparotomy,...) when performing an open abdominal procedure such as a total abdominal colectomy (For example, CPT® code 44150).

Incidental Services

An incidental procedure is carried out at the same time as a more complex primary procedure. These procedures require little additional provider resources. Incidental services that are necessary to accomplish the primary procedure (For example, lysis of adhesions in the course of an open cholecystectomy) are not separately reportable. In addition, incidental services that are performed along with the primary procedure but are not considered necessary to the performance of the primary procedure are not separately reportable (For example, the removal of an asymptomatic appendix is considered an incidental procedure when done during hysterectomy surgery).

Mutually Exclusive Procedures

Many procedure codes cannot be reported together because they are mutually exclusive of each other. Mutually exclusive procedures cannot reasonably be performed at the same anatomic site or same patient encounter. When Mutually Exclusive procedures are submitted together, the coding combination is considered submitted in error and only one of the services is allowed. An example of a mutually exclusive situation is the repair of an organ that can be performed by two different methods. Only one method can be chosen.

Modifier

Centers for Medicare & Medicaid Services (CMS) National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) edits are a nationally recognized and widely used standard industry source to determine relationships between codes. Under appropriate circumstances, modifiers should be used to identify unusual circumstances, staged or related procedures, distinct procedural services, or separate anatomical location(s).

Florida Blue applies the NCCI Procedure to Procedure (PTP) coding edits. It is important to understand, however, that the NCCI does not include all possible combinations of correct coding edits or types of unbundling that exist. Providers are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination.

Florida Blue will not reimburse services determined to be Unbundled, Incidental, or Mutually Exclusive unless the codes are reported with an appropriate modifier. If both codes are clinically appropriate and an appropriate NCCI-associated modifier is used, supporting documentation must be in the member's medical record.

BILLING/CODING INFORMATION:

CPT®/HCPCS Coding/Modifiers:

Modifiers that may be used under appropriate clinical circumstances to bypass an unbundled edit:

Anatomic modifiers:	E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD, RC, LM, RI
Other modifiers:	59, XE, XS, XP, XU

Providers are required to include an anatomical modifier that identifies the area or part of the body for procedures performed when appropriate. Claims may be returned for correction if the anatomical modifier is not included. Claims can then be resubmitted with the appropriate modifier.

Below are several examples of procedures/services not eligible for separate reimbursement when reported with another procedure/service.

- **Counseling Risk Factor Reduction:** CPT® states "Codes 99381-99397 include counseling/anticipatory guidance/risk factor reduction interventions which are provided at the time of the initial or periodic comprehensive preventive medicine examination." The individual counseling codes 99401-99404 would be reported when the counseling or risk factor reduction guidance are provided at a separate encounter. Procedure code 99401-99404 will not be separately payable when billed with procedure codes 99381-99397.

- **Robotic Surgical Systems:** Additional reimbursement is not provided for the robotic surgical technique (HCPCS code S2900). Reimbursement is based on the treatment provided rather than the technology involved in the procedure.
- **Screening Codes:** G codes are often created by CMS for use in the Medicare program in order to report screening or wellness services that are covered under the program because the comprehensive preventive medicine CPT® codes (99381 - 99397) are non-covered under the program. Since these G codes represent a component of the comprehensive preventive medicine CPT® code, separate reimbursement is not allowed for the G code on the same day. Examples of screenings include, but are not limited to, glaucoma and alcohol misuse.
- **Urgent Care Centers:** Code S9083 is a temporary national code representing a global fee for urgent care centers. Florida Blue does not have a reimbursement method for urgent care centers based upon a global fee reported with code S9083. Urgent care centers should report appropriate CPT® evaluation and management (E/M) service codes, as well as other codes that represent the services performed during the urgent care center encounter. Code S9088 is a temporary national code representing services provided in an urgent care center (list in addition to code for service). This code reports the location of service and does not describe additional services provided. Therefore, S9088 should not be reported in addition to an E/M service. Florida Blue will deny procedure S9083 and S9088 when submitted with CPT® E/M service codes 99202-99205 and 99211-99215.
- **Venipuncture and Other Central Venous Access:** Venipuncture for the collection of specimens will be considered incidental when submitted with a lab procedure that requires venipuncture, e.g., 80050 – general health panel. Other Central Venous Access procedures for collection of blood specimens from a completely implantable venous access device (36591) and collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified (36592) will be considered incidental to E/M services, surgical services and laboratory services.
- **Visual Acuity Testing:** CPT® code 99173, visual acuity screening test, is not separately reimbursable when submitted with preventive office visits (CPT® codes 99381-99397).

Modifier 59, XE, XP, XS or XU will not override the denial for the bundled services listed below. This list is not an all-inclusive list.

- **3D Rendering of Tomographic Modalities:** Florida Blue considers 3D rendering of imaging studies to be a technology and technique improvement that represents an aid to the physician via computer generated real-time study interpretation and decision support. Separate visual enhancements reported with CPT® codes 76376 and 76377 are not eligible for separate reimbursement.
- **Pulse Oximetry:** Pulse oximetry (CPT® code 94760) is considered incidental to office visits or procedures and not eligible for separate reimbursement.
- **Medical Nutrition Therapy:** Medical nutrition therapy procedures 97802, 97803, & G0270 are considered part of a comprehensive Preventive Medicine E/M service and will not be separately reimbursed. Modifier 25 appended to the Preventive Medicine E/M codes (99381-99397) will also not override the denial.
- **Screening Papanicolaou Smear Q0091 and Cervical or vaginal cancer screening; pelvic and clinical breast examination G0101:** A Screening Pap Smear (HCPCS code Q0091) and/or the Cervical or Vaginal Cancer Screening (G0101) are considered part of a Preventive Medicine E/M service and will not be separately reimbursed. Modifier 25 appended to the Preventive Medicine E/M codes (99381-99397) will not override the denial.
- **Shoulder Arthroscopy Debridement**: Limited or extensive arthroscopic shoulder debridement procedures 29822 and 29823 are included in more extensive arthroscopic surgical procedures when performed on the same shoulder. Modifiers will not override this edit. Extensive debridement procedure 29823 may be allowed with 29824 (Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface), 29827 (Arthroscopy, shoulder, surgical; with rotator cuff repair), and 29828 (Arthroscopy, shoulder, surgical; biceps tenodesis) when performed on a different area of the same shoulder and reported with modifier 59.

- **Hip Arthroscopy Debridement**: It is not appropriate to report either code 29862 or 29863 in addition to codes 29914-29916 for arthroscopic femoroacetabular impingement (FAI) surgery because the reconstructive procedures described by codes 29914-29916 also involve the articular cartilage and/or labrum. CPT® codes 29862 and 29863 are for arthroscopic surgery on the articular cartilage, labrum, and/or synovium of the hip joint. Codes 29862 and 29863 will be denied when billed with 29914-29916. Modifiers will not override this edit.
- **Spinal Procedures:** When the following code combinations are billed to Florida Blue, the spinal cord decompression, laminectomy, facetectomy and/or foraminotomy procedure will be denied when performed at the same level.

Spinal Cord Decompression Procedures	
63056/22630	63057/22630
63056/22632	63057/22632
63056/22633	63057/22633
63056/22634	63057/22634
Laminectomy, Facetectomy and Foraminotomy Procedures	
63047/22633	63048/22633
63047/22634	63048/22634

- **Supplies:** Supplies, including, but not limited to, syringes, non-needle injection devices, maintenance supplies for drug infusions, electrodes, mouthpiece, bandages, etc. are considered an integral component in the performance of a diagnostic, surgical and/or therapeutic procedure**.** For example, separate reimbursement is not allowed for HCPCS codes A4206, A4207, A4208, A4209, A4210, A4213, A4215, A4221, A4222, A4556, A4617, and A6448 in office setting and/or when utilized as part of a diagnostic, surgical or therapeutic procedure.
- **Pelvic Examination (99459):** When a pelvic examination is performed in conjunction with a gynecologic procedure, as a necessary part of the procedure or as a confirmatory examination, the add-on code for pelvic examination is not separately reportable. The pelvic pack and pre-procedure evaluation time has already been accounted for in the practice expense relative value assigned to the gynecologic procedures. Therefore, add on code 99459 should not be reported when an E&M service is provided on the same date of service as a gynecological procedure.

Clear Claim Connection (C3)

Clear Claim Connection (C3) is a free online reference tool that mirrors the logic behind Florida Blue's code-auditing software* ClaimsXten™. Providers use C3 to determine how coding combinations on a particular claim may be evaluated during the adjudication process.

It is important to note that C3 does not contain all the claim edits and processes used by Florida Blue in adjudicating claims and the results from use of the C3 tool are not a guarantee of the final claim determination.

*ClaimsXten is a code auditing tool developed by Lyric Healthcare.

Florida Blue's **Self-Service Section** of the **Manual for Physicians and Providers** provides detailed instructions on accessing Clear Claim Connection. Below is a link to the Manual for Physicians and Providers.

Manual for Physicians and Providers

RELATED MEDICAL COVERAGE GUIDELINES OR PAYMENT POLICIES:

3D Rendering of Tomographic Modalities 10-001
Anatomical Modifier Requirement Policy 23-081
B-Status Codes – 10-004
Global Surgery Package – 10-009
Laboratory Panels and Components – 15-040
National Correct Coding Initiative (NCCI) Edits – 10-006
Robotic Assisted Surgery – 10-030

REFERENCES:

1. American Medical Association, Current Procedural Terminology (CPT®), Professional Edition
2. Centers for Medicare and Medicaid Services, "National Correct Coding Initiative Edits", https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html

GUIDELINE UPDATE INFORMATION:

11/08/2018	New Payment Policy
11/12/2020	Annual Review- Added Medical Nutrition Therapy, Shoulder Arthroscopy Debridement, and Supplies to the list of bundled services that do not allow a modifier override.
09/16/2021	Revision – Clarifications added to the Venipuncture/Other Central Venous Access and Shoulder Arthroscopy Debridement sections of the policy.
11/11/2021	Annual Review –E/M service code range revised to remove 99201
11/10/2022	Annual Review – Manual for Physicians and Providers link updated.
11/09/2023	Annual Review: Added Hip Arthroscopy Debridement to the list of bundled services that do not allow a modifier override. Anatomical Modifier Requirement Policy added to Related Payment Policies section. References reviewed and updated.
10/17/2024	Annual Review: Removed effective date for spinal procedures. Added clarifying language to Supplies. Added Pelvic Examination (99459) to the list of bundled services that do not allow a modifier override. References reviewed and updated