

Payment Policy: Unbundled Surgical Procedures

Reference Number: CC.PP.045

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 surgical 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 surgical code pair edit relationships to be used in making payment decisions and administering benefits.

Application

Outpatient Institutional Claims billed for the same member, by the same provider, on the same date of service. Applicable to the current claim and across claims history.

Policy Description

The health plan uses code editing software to verify coding scenarios, ensure compliance with industry coding standards and facilitate accurate claims payment. Software edits 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 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 into the comprehensive procedure. This is known as unbundling.

Examples of national medical specialty societies that develop coding rules are as follows:

- American College of Obstetricians and Gynecologists (ACOG)
- American Academy of Orthopedic Surgeons (AAOS)
- American College of Surgeons (ACS)

Prior to establishing an unbundling edit, 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.

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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, etc.

As these are national specialty society unbundling edits, they are separate and distinct from the CMS National Correct Coding Initiative (NCCI) edits and are not sourced from the Column 1/Column 2 edit tables.

Reimbursement

The health plan's code editing software evaluates service lines billed with a surgical procedure code that is not separately reimbursable when billed with one of the following:

1. A more comprehensive procedure
2. Procedures considered impossible to perform together during the same operative session

If any of the above conditions exist, the software recommends denial of the service. Specific modifiers are taken into consideration prior to denial determination:

- Modifier -59 & -X{EPSU}
- Site-specific modifiers (i.e., left, right)

Modifier Use and Documentation

The Health Plan conducts a prepayment review of all claims billed with Modifier -59, -X{EPSU}, and site-specific anatomic modifiers in accordance with the documentation requirements listed below.

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, all applicable diagnosis and procedure codes should be assigned using all applicable anatomic 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.

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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

References

1. *Current Procedural Terminology (CPT®)*, 2022
2. *HCPCS Level II*, 2022
3. <https://www.cms.gov/files/document/proper-use-modifiers-59-xepsu.pdf>

Revision History	
11/13/2016	Initial Policy Draft Created
01/23/2017	Revisions After Payment Integrity Review
03/01/2018	Reviewed and revised policy; started surgery HCPCS codes w 10021 instead of 10000 per 2018 code book
03/30/2019	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 links for modifier 59 info updated
12/01/2022	Annual review completed; added –X{EPSU} to modifier 59 section; removed definition tables to eliminate content redundancies; removed code tables as this information can be found in CPT resources; combined modifier sections

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

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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.

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