Payment Policy: Unbundled Surgical Procedures

Reference Number: LA.PP.045
Product Types: All
Effective Date: 08/2020 Coding Implications
Last Review Date: 08/2022~~0~~ 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
1. Outpatient Institutional Claims
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 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 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, etc.

As these are national specialty society surgical 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 s*urgical 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 perform 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 -59
- Site-specific modifiers (i.e., left, right)

Documentation Requirements
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.

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 2019, 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.

CPT/HCPCS Code	Descriptor
10021-69990	Surgery
HCPCS-Healthcare Common Procedure Coding System	Identifies products, supplies and services not included in CPT codes such as DME, ambulance services, prosthetics and orthotics

Modifier	Descriptor
LC	Left Circumflex Coronary Artery
LD	Left Anterior Descending Coronary Artery
LT	Left side
RC	Right Coronary Artery
RT	Right Side
E1	Upper left eyelid
E2	Lower left eyelid
E3	Upper right eyelid
E4	Lower right eyelid
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

Modifier	Descriptor
FA	Left hand, thumb
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
-59	Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support 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) not ordinarily encountered or performed on the same day by the same individual

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

Related Documents or Resources
~~https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/downloads/modifier59.pdf~~https://www.cms.gov/files/document/proper-use-modifiers-59-xepsu.pdf

References
1. *Current Procedural Terminology (CPT®)*, 20~~19~~21
2. *HCPCS Level II*, 20~~19~~21

Revision History	
08/15/2020	Converted corporate to local policy.
08/30/2022	Annual Review; Updated link and dates in the reference section from 2019 to 2021 Removed clinical and added payment policy in "Important Reminder" section

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

The purpose of this ~~clinical policy~~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 ~~clinical policy~~payment policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this ~~clinical policy~~payment policy. This ~~clinical policy~~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 ~~clinical policy~~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 ~~clinical policy~~payment policy, and additional clinical policies may be developed and adopted as needed, at any time.

This ~~clinical policy~~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 ~~clinical policy~~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 ~~clinical policy~~payment policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.

This ~~clinical policy~~payment policy is the property of LHCC. Unauthorized copying, use, and distribution of this ~~clinical policy~~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.

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, Centene's P&P management software, is considered equivalent to an actual signature on paper.

Senior Director of Network Accounts: _____Electronic Signature on File_