

Payment Policy: Multiple CPT Code Replacement

Reference Number: LA.PP.033

Product Types: ALL

Effective Date: 08/2020

Last Review Date: 07/2023

**Coding Implications
Revision Log**

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview

When a single, more comprehensive procedure code exists to describe multiple services, the single more comprehensive code should be used versus multiple CPT codes. This is known as unbundling. Louisiana Healthcare Connections will not reimburse the multiple procedure codes, but instead will make a recommendation to reimburse the single, most comprehensive code. This determination is based on the CPT code description for each code billed.

Application

- Professional claims
- Same provider
- Within the same claim
- Claims with the same date of service
- Will review historical claims

Reimbursement

Louisiana Healthcare Connections code editing software identifies when two or more codes have been billed to represent a service, instead of the single, most comprehensive code. The following claims processing scenarios will occur based on how the services were billed:

Examples

Multiple component codes billed on claim instead of the most comprehensive code, 85027:

	DOS	Procedure Code	Quantity	Charge Amount	Allow Amount	Deny Amount	Pay	EX code
200	5/3/2016	85014	1	\$9.69	\$3.50	\$3.50	\$0.00	xa
300	5/3/2016	85018	1	\$9.69	\$3.50	\$3.50	\$0.00	xa
400	5/3/2016	85041	1	\$11.79	\$5.50	\$5.50	\$0.00	xa
500	5/3/2016	85048	1	\$10.38	\$4.50	\$4.50	\$0.00	xa
600	5/3/2016	85049	1	\$18.33	\$12.25	\$12.25	\$0.00	xa
↓Added Line				\$59.88	\$29.25	\$29.25		
700	5/3/2016	85027	1	\$59.88	\$8.51	\$0.00	\$8.51	92

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CPT Code	Description
85014	Blood Count; Hematocrit (HCT)
85018	Blood Count; Hemoglobin (HGB)
85041	Blood Count, Red Blood Cell (RBC), Automated
85048	Blood Count, Leukocyte (WBC), Automated
85049	Blood Count; Platelet, Automated
85027	Blood Count; Complete (CBC), Automated, (HGB, HCT, RBC, WBC and Platelet Count)

The following automated steps were taken to correct the claim and reimburse the provider correctly:

1. The health plan’s automated code editing software analyzed each service line, the CPT code billed and its description.
2. A total of 5 component codes were billed on service lines 0200-0600.
3. The software analyzed the service lines and determined that the most comprehensive CPT code had not been billed (85027).
4. The software denied each component service line with the denial code (EX code) “xa”
5. As a courtesy to the provider, the software added a new service line to reflect the most comprehensive code.
6. Total billed charges for the component codes is \$59.88
7. The total denied amount for the component codes is \$29.25
8. The total allowed amount for the most comprehensive code, 85027 is \$8.51
9. Total cost avoidance = \$20.74.

This edit does not change how a provider originally billed, but instead, as a courtesy to the provider, adds a new service line with the correct, payable quantity. All originally billed service lines remain on the claim.

Multiple component codes billed AND the most comprehensive code is billed:

	DOS	Procedure Code	Quantity	Charge Amount	Allow Amount	Deny Amount	Pay	EX code
200	5/3/2016	85014	1	\$9.69	\$3.50	\$3.50	\$0.00	xa
300	5/3/2016	85018	1	\$9.69	\$3.50	\$3.50	\$0.00	xa
400	5/3/2016	85041	1	\$11.79	\$5.50	\$5.50	\$0.00	xa
500	5/3/2016	85048	1	\$10.38	\$4.50	\$4.50	\$0.00	xa
600	5/3/2016	85049	1	\$18.33	\$12.25	\$12.25	\$0.00	xa
700	5/3/2016	85027	1	\$59.88	\$8.51	\$0.00	\$8.51	92

In the above example, all component service lines are denied with the denial EX code “xa”, however, the most comprehensive code billed on service line 0700 is paid. The allowed amount is \$8.51.

Definitions

1. *Unbundling*: Coding two or more bundled procedures separately instead of the single, most comprehensive code. This practice results in incorrect provider payments.
2. *Bundled procedures*: Procedures that are included as part of a more extensive procedure.

References

1. *Current Procedural Terminology (CPT®)*, 2022
2. *HCPCS Level II*, 2022
3. *International Classification of Diseases*, Tenth Revision, Clinical Modification (ICD-10-CM), 2022
4. *ICD-10-CM Official Draft Code Set*, 2022

Revision History	Revision Date	Approval Date
Converted corporate to local policy.	08/15/2020	
Annual Review; Update: dates and links in the reference section from 2019 to 2021 Removed clinical and added payment policy in “Important Reminder” section"	08/30/2022	
Annual review; updated the date in the reference section	07/26/2023	9/12/23

Important Reminder

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

The purpose of this 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 payment policy is effective as of the date determined by LHCC. 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

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regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this payment policy, and additional clinical 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 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 payment policy is the property of LHCC. 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.

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 _____

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