Payment Policy: Unbundled Professional Services

Reference Number: CC.PP.043
Product Types: ALL
Effective Date: 01/01/2014
Last Review Date: 12/06/2024

Coding Implications
Revision Log

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

Policy Overview
To determine payments and distribute benefits, the national code pair edit relationships payment criteria are outlined in this policy.

Certain procedure codes are not reimbursed individually when billed on the same service date. The coding standards for each medical profession are reflected in the code pair connections that these national specialty society organizations have established. Their members can utilize them as publicly available guidelines for the appropriate application of procedure codes in a particular medical specialty.

Application
Any physician and non-physician practitioner services rendered by the same provider on the same service day are covered by this policy. Claims from the past and present are reviewed.

Policy Description
The health plan utilizes automated claims code editing software to verify coding scenarios, ensure compliance to industry coding standards, and expedite correct claim payment. These rules originate from the Centers for Medicare and Medicaid Services (CMS) coding guidelines and the American Medical Association's Current Procedural Terminology (CPT®) coding recommendations.

In addition to using Current Procedural Terminology (CPT®) coding guidelines, National Medical Specialty Society Organizations create rules for their area of specialty. The regulations provide guidelines on procedure codes that should not be invoiced in tandem, by the same provider, for the same member, on the same service day. These regulations cover comprehensive services, which may comprise several component services; as a result, separate reimbursement for component services is not allowed. Only the comprehensive code—which is included in the reimbursement for the comprehensive procedure—is reimbursable when this coding combination is found. Unbundling edits is another name for these guidelines.

Each of the national medical specialty society can develop coding rules that are used for that specialty. Examples of some of the national medical specialty society organizations that develop coding rules include:

- American College of Obstetricians and Gynecologists (ACOG)
- American Academy of Orthopedic Surgeons (AAOS)
- American College of Radiology (ACR)
- American College of Surgeons (ACS)
- American College of Cardiology (ACC)

- American College of Pediatrics (AAP)
- American College of Rheumatology (ACR)

The specialty society organizations review the CMS Physician's Relative Value File (RVU) and procedure code description before creating an unbundling edit to determine the resources required for the service. Procedure codes are divided into comprehensive services and their component procedures based on this information.

Additionally, this method reveals operations that are mutually exclusive or those that cannot be not reasonably performed for the same member, at the same time, for the same encounter, at the same anatomic site, etc.

The CMS National Correct Coding Initiative (NCCI) edits are separate and distinct from the national specialty society unbundling 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.

The code editing program will recommend a denial if any of the preceding situations are applicable. Prior to making a decision about denial, the following factors are considered:

- Modifier 25
- Modifier 57
- Modifier 59
- Modifier 51
- Laterality specific modifiers, for example left and right (but not limited to RT/LT)

Documentation Requirements

Modifier 25
Modifier 25 is to be used to indicate that a service being provided is a significant, separately identifiable evaluation and management (E/M) service that goes above and beyond the services that are associated with another procedure or service being reported by the same physician or other qualified health care professional (QHP) on the *same* date of service

The following guidelines are used to determine whether modifier 25 was used appropriately. If any of the following conditions is met, reimbursement for the E/M service is recommended.

- The E/M is the first time the provider has seen the patient or evaluated a major condition
- A diagnosis on the claim indicates that a separate medical condition was treated in addition to the procedure that was performed
- The patient's condition is worsening as evidenced by diagnostic procedures being performed on or around the date of service.
- A provider bills supplies/equipment on the same date that are unrelated to the procedure performed but would require an E/M service to determine the patient's need

Modifier 57

The usage of modifier 57 indicates that the decision to perform surgery was driven by this Evaluation and Management visit. Modifier 57 is only used to indicate that the decision for the surgery was made, either the day before the surgery or the day of the surgery. This applies to major surgical procedure that have a 90-day global period. Claim lines billed with Modifier 57 appended to the E/M CPT are subject to prepayment clinical claims validation.

The analysis identifies whether the initial decision to perform surgery occurred the day before or the day of a major surgery by looking at diagnosis codes, procedure codes, E/M and surgical dates of service, and other claim information. The E/M service is separately reimbursed if the documentation supports the initial decision to perform surgery; otherwise, the E/M is denied.

Modifier 59

Modifier 59 is used to report non-E/M services and procedures that are not typically reported together. It indicates that a different treatment or service was rendered on the same day as other procedures or services for the same member by the same provider. Since these methods are frequently combined, the distinction needs to be explained by modifier -59.

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.

The proper application of a Modifier 59 different session; different procedure or surgery; different site or organ system; second initial injection procedure when protocol requires two separate sites or when the patient must return for a separately identifiable service; differential lesion or injury (or area in injury in extensive injuries) not commonly encountered or performed on the same day by the same individual

Coding and Modifier Information

This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. 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
Coding Editing Overview	CC.PP.011
Clinical Validation of Modifier -25	CC.PP.013
Clinical Validation of Modifier -59	CC.PP.014

Related Documents or Resources
https://www.cms.gov/files/document/proper-use-modifiers-59-xepsu.pdf

References
1. Current Procedural Terminology (CPT®), 2025
2. HCPCS Level II, 2025
3. CMS Medicaid National Correct Coding Initiative Policy Manual 2025 https://www.cms.gov/files/document/medicaid-ncci-policy-manual-2024-chapter-1.pdf
4. CMS Medicare National Correct Coding Initiative Policy Manual 2025 https://www.cms.gov/files/document/2025nccimedicarepolicymanualcompletepdf.pdf
5. AMA Reporting Modifier 25 Aug. 2023 https://www.ama-assn.org/system/files/reporting-CPT-modifier-25.pdf

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
11/03/2023	Annual review completed, no major updates to the policy. Reviewed and updated dates from 2022 to 2023
02/22/2024	Annual review completed; Updated Modifier 25 policy verbiage to make policy clear on dates to use Modifier 25 as the same day. Added additional NCCI links for current year; updated additional Coding Societies that could set their own coding guidelines; Updated links for accuracy and year on the policy.

12/06/2024	Annual review completed; Updated the CMS NCCI Medicare link.

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.

 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.