PROVIDER REIMBURSEMENT GUIDANCE			
Re-bundling and NCCI Edits			
Original Date Approved	**Effective Date SCO/ICO**	**Effective Date MAPD***	**Revision Date**
02/10/2022	04/01/2022	04/01/2022	02/01/2022

Scope: Commonwealth Care Alliance (CCA) Product Lines

☒ Senior Care Options (MA)
☒ One Care (MA)
☒ CCA Medicare Preferred – (PPO) MA*
☒ CCA Medicare Value - (PPO) MA*
☒ CCA Medicare Preferred – (PPO) RI*
☒ CCA Medicare Value - (PPO) RI*
☒ Medicare Maximum – (HMO DNSP) RI*

PAYMENT POLICY SUMMARY:

According to the Centers for Medicare and Medicaid Services (CMS), medical and surgical procedures should be reported with the Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) codes that most comprehensively describe the services performed. CCA Medicare Advantage uses this Re-bundling policy to determine whether CPT and/or HCPCS codes reported together by the Same Individual Physician or Other Qualified Health Care Professional for the same member on the same date of service are eligible for separate reimbursement.

REIMBURSEMENT REQUIREMENTS:

When the same provider submits two or more procedure codes for the same member on the same date of service, the codes will be compared. If any of the codes are considered to be a factor of the other code, only the most comprehensive procedure code will be reimbursed. These edits are based on a variety of sources including but not limited to:

- CMS's NCCI edits which are intended to promote consistent and correct coding and reduce incorrect and inappropriate payment
- CPT language which includes "separate procedure"
- Analysis of standard medical and surgical practice including input from specialty groups/societies

Under certain situations codes may be reimbursed when appended with the proper modifier if the criteria are met. Since modifiers do not bypass bundling edits in every circumstance, it is important that the modifiers only be used when appropriate and documentation in the medical record must reflect this.

BILLING AND CODING GUIDELINES:

CCA will not reimburse services determined to be Incidental, Mutually Exclusive, Transferred, or Unbundled to a more comprehensive service unless the codes are reported with an appropriate modifier.

CCA sources its re-bundling edits to methodologies used and recognized by third party authorities. Those methodologies can be Definitive or Interpretive. A Definitive source is one that is based on extremely specific instructions from the given source. An Interpreted source is one that is based on an interpretation of instructions from the identified source.
The sources used to determine if a re-bundling edit is appropriate are as follows:

- Current Procedural Terminology book (CPT) from the American Medical Association (AMA)
- CMS National Correct Coding Initiative (NCCI) edits
- CMS Policy and Specialty Societies (e.g., American Academy of Orthopedic Surgeons (AAOS), American Congress of Obstetricians and Gynecologists (ACOG), American College of Cardiology (ACC), and Society of Cardiovascular Interventional Radiology (SCIR).

Modifiers

Under proper circumstances, modifiers should be used to classify unusual circumstances, staged or related procedures, distinct procedural services, or separate anatomical location(s). CCA recognizes the following NCCI designated modifiers under this reimbursement policy:

24, 25, 57, 58, 59, 78, 79, 91, E1, E2, E3, E4, LC, LD, LM, LT, RC, RI, RT, TA, T1, T2, T3, T4, T5, T6, T7, T8, T9, FA, F1, F2, F3, F4, F5, F6, F7, F8, F9, XE, XP, XS and XU

Pertaining to the use of anatomical modifiers: E1, E2, E3, E4, LC, LD, LM, LT, RC, RI, RT, TA, T1, T2, T3, T4, T5, T6, T7, T8, T9, FA, F1, F2, F3, F4, F5, F6, F7, F8, and F9, code pair edits may be bypassed only if the two procedures reported are submitted with different anatomical modifiers.

In addition, note the following modifier criteria:

- It is incorrect to use modifier 76 to indicate repeat laboratory services.
- According to CMS and AMA, Modifiers 59 or 91 should be used to indicate repeat or distinct laboratory services
- Separate consideration for reimbursement will not be given to laboratory codes reported with modifier 76.

DISCLAIMER:

As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization, and utilization management guidelines when applicable and adherence to plan policies, procedures, and claims editing logic. CCA has the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that your office/facility did not comply with this payment policy, CCA has the right to expect your office/facility to refund all payments related to non-compliance.

REFERENCES:

Centers for Medicare and Medicaid Services (CMS)

American Medical Association, Current Procedural Terminology (CPT®)

Healthcare Common Procedure Coding System (HCPCS)

Medicare Claims Processing Manual - Chapter 12 - Physicians/Nonphysician Practitioners: Section 30

Medicare Claims Processing Manual - Chapter 23 - Fee Schedule Administration and Coding Requirements: Section 20.9 National Correct Coding Initiative (NCCI) Edits

Payment Policies:
Massachusetts / Rhode Island

Provider Manuals:
Massachusetts / Rhode Island

Prior Authorization Forms:
Massachusetts / Rhode Island

POLICY TIMELINE DETAILS

1. Drafted November 2021 for MAPD