Good Samaritan
Direct Health

Commercial Plans
CODING FACT SHEET

Procedure-to-Procedure (Unbundling) Edits

Description:

These edits identify claim lines containing procedure codes typically not reimbursed when submitted with certain other procedure codes by the same provider, for the same member, on the same date of service.

A code may be denied for reimbursement because it is:

- **incidental** to another procedure (a procedure is performed in conjunction with another procedure as a component of the overall service)
- **mutually exclusive** to another procedure (two procedures differ in technique or approach but lead to the same outcome)
- **medically impossible or improbable** to be performed with another procedure

ClaimsXten™ bases these edits on:

- Centers for Medicare and Medicaid (CMS) National Corrective Coding Initiative (NCCI) code pair data files found at https://www.cms.gov/Medicare/Coding/NCCI-Coding-Edits; and
- Code pairs Change Healthcare creates internally through ongoing review of AMA/CPT coding guidelines, specialty academy guidelines, and common medical practice in consultation with health plan medical directors and industry coding experts

Modifiers:

To expedite payment, submit codes with valid modifiers where the medical record demonstrates they are appropriate.

For many code pairs, modifiers may be submitted to prevent possible denials. For example, if the medical record demonstrates that a procedure is payable as a 'separate and distinct' service, modifiers (e.g., -59, -XE, -XS, -XP, -XU, -25, etc.) are allowable.

Modifiers are not allowed for all codes. For example, CMS NCCI code pair edits can be overridden only if the CMS data file includes a 'modifier allowed' value = 1.

Examples:

For illustration purposes only; codes subject to change

CODE 1		CODE 2		Result
Code	**Description**	**Code**	**Description**	
36415	Collection of venous blood by venipuncture	80053	Comprehensive metabolic panel	Code 36415 denies as incidental to code 80053
93010	Electrocardiogram, routine ECG with at least 12 leads, interpretation and report only	99291	Critical care evaluation and management of a critically ill or critically injured patient; first 30-74 minutes	Code 93010 denies as incidental to code 99291
81000	Urinalysis by dip stick or tablet reagent for bilirubin GL	99221	Initial hospital care per day for the evaluation and management of a patient …	Code 81000 denies as mutually exclusive to code 99221
99173	Screening test for visual acuity	99214	Office or other outpatient visit for the evaluation and management of an established patient …	Code 99173 denies as mutually exclusive to code 99214
76815	Ultrasound, pregnant uterus, real time with image documentation, limited …	99218	Initial observation care, per day, for the evaluation and management of a patient …	Code 76815 denies as incidental to 99218

Providers are responsible for accurately reporting services with the correct CPT and/or HCPCS codes and for appending applicable modifiers as appropriate based on medical record review. Providers should be familiar with AMA/CPT coding instructions as well as CMS code editing logic and submit claims that comply with existing guidelines.