SIHO INSURANCE SERVICES

Commercial Plans
CODING FACT SHEET

Multi-code Rebundling Edits

Description:

These edits identify claims containing two or more procedure codes used to report a service when a single, more comprehensive procedure code more accurately represents the service performed. The rule audits procedure codes reported by the same service provider (or billing provider if service providers do not match), for the same member, on the same day of service.

Modifiers:

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

In many cases, 'separate and distinct' procedure modifiers (e.g. -59, -XE,- XS, -XP, -XU, etc.) and site-specific modifiers (e.g., -RT, -LT, etc.) may be used to override code rebundling.

Examples:

For illustration purposes only; codes subject to change

Claim #1

Line	Code	Description	Billed Amt	Result
1	85025	Blood count complete CBC …	30.00	Line denies
2	80053	Comprehensive metabolic panel	50.00	Line denies
3	84443	Thyroid stimulating TSH	90.00	Line denies
4	**80050**	**General health panel**	**170.00**	**Line ADDED.** Denied codes are replaced with a more comprehensive code; billed amount is total of denied lines.

If the medical record demonstrates that code 85025 is a separate and distinct procedure, adding modifier -59 will override re-bundling and allow all denied lines to pay.

Claim #2

Line	Code	Description	Billed Amt	Result
1	25500	Closed treatment of radial shaft fracture …	300.00	Line denies
2	25530	Closed treatment of ulnar shaft fracture	200.00	Line denies
3	**25560**	**Closed treatment of radial and ulnar shaft fractures …**	**500.00**	**Line ADDED.** Denied codes are replaced with a more comprehensive code; billed amount is total of denied lines.

If the medical record demonstrates that code 25500 is treatment for the right arm that should be paid separately, adding modifier -RT will override rebundling and allow all denied lines to pay.

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.