Payment Policy: Multiple CPT Code Replacement

Reference Number: CC.PP.033
Product Types: ALL
Effective Date: 01/01/2014
Last Review Date: 12/01/2022

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 rather than multiple CPT codes. This is known as unbundling. The health plan will not reimburse multiple procedure codes, but instead reimburses the single most comprehensive code. This determination is based on the CPT code description for each code billed.

Application
This policy applies to professional claims when billed by the same provider for the same member and on the same date of service. It is applicable to services billed on the same claim and across claim history.

Reimbursement
The health plan's code editing software identifies when two or more codes are billed to represent a service instead of the single, most comprehensive code. Please see the following example claims processing scenarios based on various services billed:

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

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 determined that the most comprehensive CPT code was not 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. Total denied amount for the component codes is $29.25
8. Total allowed amount for the most comprehensive code is $8.51

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.

Additional Information
Some health plan provider fee schedules are reimbursed at a rate lower than allowed for the most comprehensive code; in these instances, the provider or health plan will be excluded from the edit logic.

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	
02/28/2018	Converted to revised template and conducted review
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; no major updates required
12/01/2022	Annual review completed; removed definitions to eliminate redundancies

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.

This payment policy is the property of Centene Corporation. 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.

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.