# Vanishing Reimbursement:
## Bundling & Packaging

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Medical and surgical procedures, services, and supplies performed on patients are defined by CPT® and HCPCS Level II codes. Once the service has been completed and documented, medical coding staff review the patient's medical record and translate the services rendered into procedure, supply, and drug codes. Some procedure codes are very specific and define a single service, while others define comprehensive services that may consist of many separate steps or processes.

In addition, CPT and HCPCS Level II code descriptors provided in coding manuals typically do not list all of the components included in a procedure. There are often services inherent in a procedure or group of procedures that may not be part of the official code definition. For example, drug administration services include local anesthesia, starting the IV or accessing a port or catheter, flush at the conclusion of treatment, and standard supplies. In another example, radiation treatment management includes completing documentation, writing prescriptions, application of topical medication, nutrition, skin care, and inpatient hospital care during the course of therapy.

In an effort to prevent improper payment, the Centers for Medicare & Medicaid Services (CMS) and other payers have implemented edits and bundled payment policies for certain services. Non-governmental payers may refer to unbundled billing as fragmented charging, which means the use of more than one procedure code to bill for a procedure or service that may be adequately described by a lesser number of codes. In this scenario, inappropriately fragmented procedures are considered to be part of the reimbursement for the major procedure or service performed.

The reimbursement concept of bundling is not new; the Office of Inspector General (OIG) published a report titled "Fragmented Physician Claims" in September 1992, when CMS was still known as HCFA (the Health Care Finance Administration).[1] This report primarily addressed fragmented surgical billing, and states:

*The most important coding issue discussed in this report is what is called "fragmentation." Even the simplest surgical procedure involves many steps, from the preparation of the skin, to the incision, to the control of bleeding and eventual suture of the incision. All of these steps are integral to the procedure itself; other, less obvious, links exist between the major procedure being performed and other minor procedures which, when performed alone, can be coded separately.*

Although many healthcare providers use the terms interchangeably, there are very important billing and payment differences between "packaged" services and "bundled" services. Knowing the difference in these terms may help to avoid incorrect coding practices and prevent potential revenue loss for the healthcare organization.

### Bundling

The term "bundling" refers to the application of coding rules to ensure that the procedure codes submitted on the claim accurately reflect the services provided. The bundling concept applies to all practice settings, including hospitals, freestanding cancer centers, and oncology practices. CMS utilizes the National Correct Coding Initiative (NCCI), which provides an overall set of guidelines that define how multiple procedure codes will be reimbursed if submitted for the same patient on the same date of service.[2] NCCI includes three types of edits:

1. NCCI Procedure-to-Procedure (PTP) Edits
2. Medically Unlikely Edits (MUE)
3. Add-on Code Edits.

The National Correct Coding Policy Manual for 2016 accompanies the PTP edits and states:

*Procedures should be reported with the most comprehensive CPT code that describes the services performed. Physicians must not unbundle the services described by a HCPCS/CPT code.*

*In this Manual many policies are described utilizing the term "physician." Unless indicated differently, this usage term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules.*

*NCCI PTP edits are utilized by Medicare claims processing contractors to adjudicate provider claims for physician services, outpatient hospital services, and outpatient therapy services.*

*Since the NCCI is a CMS program, its policies and edits represent CMS national policy.*

Other insurance payers may employ the same NCCI edits or develop separate payer-specific bundling guidelines. For example, BlueCross BlueShield of Tennessee

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states that it applies bundling rules based on guidelines from the NCCI, American Medical Association (AMA), CMS, American Academy of Orthopaedic Surgeons (AAOS), American College of Obstetricians and Gynecologists (ACOG), and its own in-house clinical experts.[3] Cigna uses software called ClaimsXten™ that edits submitted claims for adherence to its medical coverage polices[4] and Humana includes an online search function to view its bundling edits.[5] A provider who has a signed participation agreement or contract with an insurer has generally agreed to accept its payer-specific bundling edits, which may be different from those applied by Medicare.

Unbundling is defined as the billing of multiple procedure codes for a group of procedures that are covered by a single comprehensive code. There are two types of unbundling: 1) unintentional, resulting from a misunderstanding of coding and 2) intentional, when an entity manipulates code assignment in order to inappropriately maximize payment. Following are examples of unbundling:

- Coding component parts of a procedure with separate procedure codes (e.g., billing the supervision, handling, and loading service in addition to remote afterloading brachytherapy treatments; or billing hydration codes for infusions provided solely to maintain line patency, in the absence of medically necessary fluid replacement).
- Reporting separate codes for related services when the code for the primary procedure includes all related services (e.g., separately reporting replacement fluid administration with a therapeutic phlebotomy).
- Down-coding a service in order to use an additional code when a single higher level, more comprehensive code is appropriate (e.g., coding multiple units of the complex treatment device code instead of a single unit of the IMRT device code).
- Separately billing the components of a procedure when one procedure code exists to accurately describe the service performed (e.g., billing image-guided localization in addition to stereotactic radiosurgery or stereotactic body radiation therapy; or billing "keep open" fluid administration between units of blood transfusion).
- Coding a unilateral service twice instead of reporting a single bilateral code (e.g., billing two simulation charges for treatment to the right and left breast, when the complex simulation includes simulating three or more separate treatment areas).

CMS has repeatedly stated that bundled services should *not* be billed to Medicare; the physician, practice, or facility should apply all bundling edits prior to issuing a claim. However, under certain circumstances, it may be appropriate to bypass the bundling edits to indicate that a procedure or service was distinct or independent from other services performed on the same day. It is important to remember that just because an edit *can* be bypassed does not mean that it *should* always be bypassed. It is essential to review each coding situation to ensure compliance.

**Modifier 59** (distinct service) or HCPCS **modifiers XE** (separate encounter), **XS** (separate structure), **XP** (separate provider), or **XU** (unusual, non-overlapping service) indicate that the ordinarily bundled code represents a service performed at a different anatomic site or at a different patient encounter on the same date.

In addition to publishing a list of current bundling edits, the CMS National Correct Coding Policy Manual provides specific examples of correct and incorrect coding. For example:

*The column one/column two code edit with column one CPT code 38221 (bone marrow biopsy) and column two CPT code 38220 (bone marrow, aspiration only) includes two distinct procedures when performed at separate anatomic sites or separate patient encounters. In these circumstances, it would be acceptable to use modifier 59. However, if both 38221 and 38220 are performed through the same skin incision at the same patient encounter, which is the usual practice, modifier 59 should NOT be used. Although CMS does not allow separate payment for CPT code 38220 with CPT code 38221 when bone marrow aspiration and biopsy are performed through the same skin incision at a single patient encounter, CMS does allow separate payment for HCPCS level II code G0364 (bone marrow aspiration performed with bone marrow biopsy through same incision on the same date of service) with CPT code 38221 under these circumstances.*

## Packaging

On Aug. 1, 2000, CMS implemented the Outpatient Prospective Payment System (OPPS) to pay for designated hospital outpatient services. In most cases, the unit of payment under the OPPS is the Ambulatory Payment Classification (APC), and CMS assigns individual procedure codes to APCs based on similar costs and clinical characteristics. Packaging is a critical feature of the OPPS; APCs generally include payment for the primary procedure plus dependent, ancillary, supportive, and adjunctive items and services.[6]

Packaging is a reimbursement term—not a coding concept—which relates only to outpatient hospital services. Packaging refers to the practice of making a single payment that includes payment for a significant procedure, as well as the "minor, ancillary services" generally associated with the procedure. Even though CMS may not provide separate payment, the codes for packaged services *should still be reported on the claim* unless contraindicated by authoritative coding guidance or superseded by bundling edits. It is especially important that hospitals continue to charge for packaged services so that CMS can collect accurate cost data for individual procedures. Also, not all payers follow Medicare payment policies, and some may provide payment in situations where CMS does not.

Examples of services that are typically packaged include:

- Supplies
- Ancillary services
- Anesthesia
- Operating and recovery room use
- Clinical diagnostic laboratory tests
- Procedures described by add-on codes
- Implantable medical devices (such as pacemakers)
- Inexpensive drugs under a per-day drug threshold packaging amount
- Drugs, biologicals, and radiopharmaceuticals that function as supplies (including diagnostic radiopharmaceuticals, contrast agents, stress agents, implantable biologicals, and skin substitutes)
- Guidance services
- Image processing services
- Intraoperative services
- Imaging supervision and interpretation services
- Observation services.

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For example, imaging guidance codes (with limited exceptions) are unconditionally packaged—that is, separate payment will *never* be made by Medicare contractors for any imaging guidance service. Instead, payment for the image guidance is included in the payment for the associated procedure. This means that Medicare reimbursement for radiation treatment delivery in the hospital (codes **77402-77412**) includes payment for all image guidance and motion tracking performed (code **77387**). The hospital continues to charge separately for image guidance and Medicare tracks this cost, but there is no separate payment for image guidance codes. In another example, the procedure code for a concurrent infusion (**96368**) is billed separately by the hospital, but is packaged by Medicare into other infusion services performed during the same encounter. The use of modifiers does not impact payment for packaged services. Applying any modifier, including **modifier 59** (distinct service), will not provide separate reimbursement for a packaged service.

Effective Jan. 1, 2014, Medicare packaged clinical laboratory charges into any other payable outpatient service performed on the same day for hospital billing. The following are exceptions to this packaging decision, but these exceptions would typically not apply to oncology patients:[7]

1. Non-patient referred specimen
2. A hospital collects a specimen and furnishes only the outpatient labs on a given date of service (a "specimen only" service)
3. A hospital conducts outpatient lab tests that are clinically unrelated to other hospital outpatient services furnished the same day. "Unrelated" means the laboratory test is ordered by a different practitioner than the practitioner who ordered the other hospital outpatient services, for a different diagnosis.

In other words, the hospital will only be paid separately for laboratory tests when it functions as an independent reference laboratory. Should this ever be the case, the hospital uses a special bill type for these non-patients to report that the patient is not present at the hospital.

Effective Jan. 1, 2015, CMS established comprehensive APCs (C-APCs) to provide all-inclusive payments for certain procedures. This policy packages payment for all items and services performed as part of the primary service into a single payment amount and includes stereotactic radiosurgery and intraoperative radiation treatment.

## Going Forward

Review the Medicare bundling edits and National Correct Coding Initiative Policy Manual, in addition to non-governmental payer contracts and participation agreements. Also, when negotiating any type of payer agreement, make sure to obtain as much information about bundling edits as possible. Remember, once the contract is signed, the healthcare organization has generally agreed to the payer's bundling guidelines.

Services should never be unbundled, fragmented, or inappropriately unpackaged and billed to any insurer. Medicare considers this practice to be an abusive one that can easily cross the line to perceived fraudulent behavior. In addition, based on the bundling mechanism employed, the healthcare provider could actually lose reimbursement dollars. Remember, it is not only Medicare that can institute an audit—all commercial payers have a Special Investigations Unit or Department that monitors billing for unusual or aberrant behavior.

Bundling is allowable because in many instances it's the accurate means for coding an encounter. If there's one comprehensive major procedure code existing that encompasses two or more services that took place during the same encounter, it's only proper to use the more significant inclusive code. If the provider wants to track bundled services included in a single reimbursement, a "no-charge" code can be used for tracking purposes. And remember, the patient cannot be billed for unbundled or packaged services, even by non-participating Medicare providers. The National Correct Coding Policy Manual states:

*CPT codes representing services denied based on NCCI PTP edits may not be billed to Medicare beneficiaries. Since these denials are based on incorrect coding rather than medical necessity, the provider cannot utilize an "Advanced Beneficiary Notice" (ABN) form to seek payment from a Medicare beneficiary. Furthermore, since the denials are based on incorrect coding rather than a legislated Medicare benefit exclusion, the provider cannot seek payment from the beneficiary with or without a "Notice of Exclusions from Medicare Benefits" (NEMB) form.* OI

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