UnitedHealthcare® Medicare Advantage
Reimbursement Policy
CMS 1500
UB04
Policy Number 2025R9032A

Rebundling and NCCI Edits Policy, Professional and Facility

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

This policy is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage reimbursement policies use Current Procedural Terminology (CPT®*), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

This reimbursement policy applies to all health care services billed on UB04 forms (CMS 1450) and to those billed on CMS 1500 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general resource regarding UnitedHealthcare's Medicare Advantage reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Medicare Advantage may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Medicare Advantage enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the facility or other provider contracts, the enrollee's benefit coverage documents**, and/or other reimbursement, medical or drug policies. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Medicare Advantage due to programming or other constraints; however, UnitedHealthcare Medicare Advantage strives to minimize these variations.

UnitedHealthcare Medicare Advantage may modify this reimbursement policy at any time to comply with changes in CMS policy and other national standard coding guidelines by publishing a new version of the reimbursement policy on this website. However, the information presented in this reimbursement policy is accurate and current as of the date of publication. UnitedHealthcare Medicare Advantage encourages physicians and other health care professionals to keep current with any CMS policy changes and/or billing requirements by referring to the CMS or your local carrier website regularly. Facilities can sign up for regular distributions for policy or regulatory changes directly from CMS and/or your local carrier. UnitedHealthcare's Medicare Advantage reimbursement policies do not include notations regarding prior authorization requirements.

** For more information on a specific enrollee's benefit coverage, please call the customer service number on the back of the member ID card.

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CMS 1500
UB04
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Application

This reimbursement policy applies to all Medicare Advantage products and for network provider services reported using the UB04 and CMS 1500 form or its electronic equivalent or its successor form.

Policy

Overview

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. UnitedHealthcare Medicare Advantage uses this 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 Guidelines

Edit Sources

UnitedHealthcare Medicare Advantage uses this policy to determine whether CPT and/or HCPCS codes reported together by the Same Individual Physician or Health Care Professional for the same member on the same date of service are eligible for separate reimbursement. UnitedHealthcare Medicare Advantage 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.

UnitedHealthcare Medicare Advantage sources its Rebundling 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 very specific instructions from the given source. An Interpreted source is one that is based on an interpretation of instructions from the identified source (please see the Definitions section below for further explanations of these sources). The sources used to determine if a Rebundling 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 Orthopaedic Surgeons (AAOS), American Congress of Obstetricians and Gynecologists (ACOG), American College of Cardiology (ACC), and Society of Cardiovascular Interventional Radiology (SCIR).

Modifiers

Modifiers offer the physician or healthcare professional a way to identify that a service or procedure has been altered in some way. Under appropriate circumstances, modifiers should be used to identify unusual circumstances, staged or related procedures, distinct procedural services or separate anatomical location(s).

UnitedHealthcare Medicare Advantage 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.

As it relates 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.

An NCCI PTP edit code pair consisting of two codes describing two shoulder arthroscopy procedures, CPT codes ranging from 29805-29828, shall not be separately reimbursable when performed on the ipsilateral shoulder even when an NCCI PTP-associated modifier is present. These services may be considered for separate reimbursement with an NCCI PTP-associated modifier only if the two procedures are performed on contralateral shoulders.

The following CPT codes will be considered for separate reimbursement when submitted in addition to code 29823 if extensive debridement is completed in a different area of the same shoulder: 29824, 29827 and 29828.
Modifiers offer specific information and should be used appropriately. It is inappropriate to use modifier 76 to indicate repeat laboratory services. Modifiers 59 or 91 should be used to indicate repeat or distinct laboratory services, as appropriate, according to the AMA and CMS. Separate consideration for reimbursement will not be given to laboratory codes reported with modifier 76.

Definitions	
Incidental Services	Includes procedures that can be performed along with the primary procedure but are not essential to complete the procedure. They do not typically have a significant impact on the work and time of the primary procedure. Incidental procedures are not separately reimbursable when performed with the primary procedure.
Ipsilateral	Belonging to or occurring on the same side of the body.
Mutually Exclusive Services	When Mutually Exclusive procedures are submitted together, the coding combination is considered submitted in error and only one of the services is allowed. One or more of the following criteria may be used to determine what constitutes a Mutually Exclusive relationship: • The services cannot reasonably be done in the same session. • The coding combination represents two methods of performing the same service. The edits that may be assigned to this category are those edits derived from directives provided in CPT that do not meet criteria for either the Incidental or Unbundle service category.
Rebundling	Rebundling is identifying and combining specific coding relationships into the most comprehensive and/or appropriate procedure code. Rebundling may occur when services are considered Incidental, Mutually Exclusive, Transferred, or Unbundled. Refer to these specific definitions for more detail.
Same Individual Physician or Other Qualified Health Care Professional	The same individual rendering health care services reporting the same Federal Tax Identification number.
Transferred Services	Refers to a situation where the coding combination may be more appropriately reported with another code combination or to a different CPT and/or HCPCS code(s).
Unbundling	Unbundling occurs when multiple procedure codes are submitted for a group of procedures that are described by a single comprehensive code. An example of Unbundling would be fragmenting one service into component parts and coding each component as if it were a separate service.

Questions and Answers	
1	**Q:** When should modifier 59 be used?

	A: Modifier 59 is used to identify procedures/services that are not normally reported together but are appropriate under certain circumstances. Some examples of when it may be used are: identifying a different session, different procedure or surgery, separate lesion.
2	**Q:** When should modifier 25 be used? **A:** Modifier 25 is used when necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable evaluation and management (E/M) service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. It should not be used to report an E/M service that resulted in a decision to perform surgery.
3	**Q:** Since the CCI Editing policy recognizes many modifiers, do all modifiers bypass bundling edits in every situation? **A:** No. There are many coding guidelines provided within credible third-party sources including, but not limited to, the CPT and HCPCS books, and CMS NCCI Policy Manual which address situations in which a modifier applies. While the CCI Editing policy recognizes many modifiers, modifiers only apply when they are used according to correct coding guidelines. For example, CMS considers the shoulder to be a single anatomic structure. An NCCI procedure to procedure edits code pair consisting of two codes describing two shoulder procedures should never be bypassed with an NCCI-associated modifier when performed on the Ipsilateral (same side) shoulder. In this case, procedure 23700 is billed with modifier LT and is performed at the same encounter as procedure 29823 with modifier LT. Since both services were performed on the same (left) shoulder, only one procedure would be allowed. If the two procedures are performed on contralateral (opposite) shoulders (23700 with modifier LT and 29823 with modifier RT) then the CCI edit would not apply.
4	**Q:** Under what circumstances will UnitedHealthcare Medicare Advantage separately reimburse a NCCI Column two CPT/HCPCS when billed without a PTP associated modifier? **A**: When reported with a column one code, UnitedHealthcare Medicare Advantage will not separately reimburse a column two code unless the edit pair is assigned a Correct Coding Modifier Indicator (CCMI) of "1" and a NCCI PTP-associated modifier is appropriately appended to ***one*** of the codes. If the two codes of a code pair edit have the same NCCI PTP-associated anatomic modifier, the edit will not be bypassed unless an additional NCCI PTP-associated modifier is appended to one of the codes indicating the reason to bypass the edit. The use of modifiers that are not NCCI PTP-associated modifiers shall not bypass an NCCI PTP edit. NCCI PTP-associated modifiers are the following: Anatomic modifiers: E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD, RC, LM, RI Global surgery modifiers: 24, 25, 57, 58, 78, 79 Other modifiers: 27, 59, 91, XE, XS, XP, XU.

Resources

www.cms.gov

American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services

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

History

2/1/2025	Policy Version Change

	Add Facility to the title of the policy. Application Section: Updated Modifier section: Updated policy language History Section: Entries prior to 2/1/2023 archived
10/1/2024	Policy Version Change
10/1/2023	Policy Version Change Logo Updated History Section: Entries prior to 10/1/2021 archived
10/8/2014	New Policy
8/9/2012	Policy Implemented