Laboratory Rebundling

Rules Committee Recommendation

Rebundling Procedure reporting rule

Context

Colorado enacted the Medical Clean Claims Transparency and Uniformity Act in 2010. The act established a task force of industry and government representatives to develop a standardized set of health care claim edits and payment rules to process medical claims. It requires the task force to submit to the General Assembly and Department of Health Care Policy & Financing a report and recommendations for a uniform, standardized set of payment rules and claim edits to be used by all payers and providers in Colorado.

The existing statute also requires that contracting providers be given information sufficient for them to determine the compensation or payment for health care services provided, including: the manner of payment (e.g., fee-for-service, capitation); the methodology used to calculate any fee schedule; the underlying fee schedule; and the effect of any payment rules and edits on payment or compensation, C.R.S. 25-37-103.

If the coding reported does not adhere to this rule, the payer may make a decision to deny the claim line. This will be communicated on an electronic remittance advice (ERA) with a HIPAA Claim Adjustment Reason Code (CARC) and as appropriate a Remittance Advice Remark Code (RARC) to explain the reason for the chosen action. If an ERA is not utilized, the payer may use a clearly defined payer adjustment code, on a paper remittance advice.

Modifier Involved

91: Repeat Clinical Diagnostic Laboratory Test: In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. **Note:** This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (eg, glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.[1]

Rebundling rule

Pathology And Laboratory

Organ or Disease-Oriented Panels

Do not report two or more panel codes that include any of the same constituent tests performed from the same patient collection. If a group of tests overlaps two or more panels, report the panel that incorporates the greater number of tests to fulfill the code definition and report the remaining tests using individual test codes (eg, do not report 80047 in conjunction with 80053). Reference

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the *Current Procedural Terminology (CPT®) manual* for a listing of codes in these panels.[2]

Coding and adjudication guidelines

The format of the CPT manual includes descriptions of procedures, which are, in order to conserve space, not listed in their entirety for all procedures. The partial description is indented under the main entry. The main entry then encompasses the portion of the description preceding the semicolon. The main entry applies to and is a part of all indented entries, which follow with their codes.

In the course of other procedure descriptions, the code definition specifies other procedures that are included in this comprehensive code. In addition, a code description may define a rebundling relationship where one code is a part of another based on the language used in the descriptor.

When components of a specific organ or disease oriented laboratory panel (e.g., codes 80061 and 80059) or automated multi-channel tests (e.g., codes 80002 - 80019) are billed separately, they must be bundled into the comprehensive panel or automated multi-channel test code as appropriate that includes the multiple component tests. The individual tests that make up a panel or can be performed on an automated multi-channel test analyzer are not to be separately billed.[3]

Correct coding example:

80047
82947 91

Incorrect coding example (no modifier):

80047
82947

OR billing all individual codes instead of a panel:

82947
84132
84295, etc

Rationale

The following rationale was used to formulate the Rule Committee Recommendation:

- The CPT coding guidelines and conventions and national medical specialty society coding guidelines were reviewed.
- The CPT descriptions were selected.
- The Centers for Medicare and Medicaid Services (CMS) pricing policy as identified in the MPFS and the Medicare Claims Processing Manual[4] were selected.
- CPT codes that were exceptions to the CMS pricing policy were identified and included in the Rule Committee Recommendation.

MCCTF comment

We recognize that public and private payers commonly have a reimbursement maximum in place

[2] Copyright 2013. All rights reserved. American Medical Association.
[3] CPT book, CPT Procedure Code Definition, Chapter 12, page 22.
[4] Chapter 12 – Physician/Nonphysician Practitioners, *Medicare Claims Processing Manual*, Publication # 100-04.

to limit the amount paid when individual components of a panel (but not all components) are billed separately. This type of payment edit is out of scope.

This edit identifies incorrect billing when components of a comprehensive multiple component blood test (i.e., organ or disease-oriented panel) are reported separately. If all components are billed separately, they will be combined into the appropriate single comprehensive code.

Edit/Modifier definitions

When two or more codes submitted together are better described by a single code or series of codes, transfer the original code combination into the more appropriate code or code combinations.

Indicator definitions

N/A

Federation outreach

- American Academy of Othopaedic Surgeons (AAOS)
- American Academy of Otolaryngology – Head and Neck Surgery
- American College of Radiology (ACR)
- American College of Surgeons (ACS)
- American Congress of Obstetricians and Gynecologists (ACOG)
- College of American Pathologists (CAP)
- The AMA Federation Payment Policy Workgroup