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Part B Insider (Multispecialty) Coding Alert

UNBUNDLING: Get to Know These Code Pairs That You Shouldn't Report Together Under Certain Circumstances

Follow the advice on these examples and it will lead the way to reporting your code combinations correctly.

The Correct Coding Initiative (CCI) offers guidance on which codes you shouldn't bill to Medicare together, and which you can report together with modifiers. But there are exceptions to every rule, and Medicare wants to make sure your coding doesn't fit one of these potential exceptions.

Medicare carriers routinely review claims to determine whether your physician reported codes together properly -- meaning that you should only report the most accurate codes, and you shouldn't bill "extra" codes just because CCI allows it.

Following are examples of common "unbundling" scenarios that Medicare carriers do not want you to report, along with rationale, courtesy of **Barbara J. Cobuzzi, MBA, CPC, CENTC, CPC-H, CPC-P, CPC-I, CHCC,** president of CRN Healthcare Solutions in Tinton Falls, N.J.

Bone marrow aspiration: If your physician performs bone marrow aspiration and a bone marrow biopsy during the same session, CCI will allow you to report both 38220 and 38221 -- but only if the physician performs the procedures at separate sites or during separate sessions.

"Separate sites include bone marrow aspiration and biopsy in different bones or two separate skin incisions over the same bones," the CCI manual indicates. "When both a bone marrow biopsy (38221) and a bone marrow aspiration (38220) are performed at the same site through the same skin incision, only the bone marrow biopsy (38221) should be reported."

Endoscopy/laryngoscopy: When you read the CCI edits, you'll note that a modifier such as 59 (Distinct procedural service) is allowable on the edit bundling 31231 (Nasal endoscopy, diagnostic...) and 31575 (Laryngoscopy, ... diagnostic). However, you can use the modifier to separate this bundle only if the physician performs the procedures during separate encounters. "The CCI edit bundling these codes assumes the physician is performing the procedures on separate sites,"Cobuzzi says.

Therefore, you should avoid billing these codes together unless the physician performed the procedures during separate sessions.

Discharge with OB codes:

Some ob-gyn coders believe that when a physician discharges an obstetric patient, he can report the discharge (e.g., 99238) along with the routine obstetric care code (e.g.,59510).

Reality: Code 59510 includes all routine antepartum care, the delivery, and all routine post partum care, so all daily visits in the hospital, including the day of discharge, are included in 59510. You should not try to unbundle this scenario with any modifiers.

Bottom line: Never bill Medicare for services that are considered bundled under the CCI guidelines unless they meet the pre-specified criteria allowable (e.g., separate encounter, separate location). Otherwise, your insurer could consider it fraudulent billing, even if the payer doesn't reimburse you for the charge.

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