



Policy Information

Policy Title	Unbundling and Overbilling	Current Version Publish Date	12/2025
Policy Manual	Reimbursement Policy Manual	Original Effective Date	12/2025
Policy Number	18	Next Review Date	Annual

Policy Applicability (LOB)

<input checked="" type="checkbox"/> Medicare Inc	<input checked="" type="checkbox"/> Commercial IA	<input checked="" type="checkbox"/> Commercial IL	<input checked="" type="checkbox"/> Health Choices
<input checked="" type="checkbox"/> Medicare WI	<input checked="" type="checkbox"/> Commercial WI	<input checked="" type="checkbox"/> CPPHP (Kansas)	

Policy Statement and Purpose

This policy addresses unbundling and overbilling as it relates to reimbursements for services and supplies. The stipulations herein are based on CMS coding and payment requirements. CMS updates these files quarterly. It is the provider’s responsibility to follow the guidelines for the date of service that services were rendered. If coding is inconsistent with CMS guidelines, payment may be denied. Where CMS is silent, industry standards have been applied. Adhering to these guidelines does not imply payment, only eligibility for reimbursement. Actual payment for services will be guided by the services documented in the medical record and the coverage criteria in the patient’s contracted medical plan for whom the services are rendered.

This policy is expressly incorporated into and made a part of all reimbursement agreements and will provide context and clarity to the extent there is ambiguity in payment terms and notwithstanding contrary claims with regard to industry standards or practices.

Policy Definitions

Add-on Code (AOC): Describes a service or procedure performed in addition to a primary service. Add-on Codes must be paired with a primary procedure code.

Bilateral Procedure: The same procedure performed on both sides of the body during the same operative session.

CMS: Centers for Medicare and Medicaid Services.

CPT: Current Procedural Terminology. A medical code set maintained by the American Medical Association (AMA) that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations. CPT is included in Level I Healthcare Common Procedure Coding System (HCPCS).

Downcoding: The practice of assigning a lower-level code to a medical service or procedure than what was actually performed or documented.

E/M: Evaluation and Management

Fragmenting: Also known as unbundling, refers to the practice of billing separate, individual procedures or services that are typically bundled into a single procedure code.

HCPCS: Healthcare Common Procedure Coding System.

Healthcare Common Procedure Coding System (HCPCS): A standardized coding system used in the United States to report medical procedures, services, supplies, and products for billing and insurance claim processing.

Incidental Procedure: A procedure performed at the same time as a more complex primary procedure.

Integral Procedure: One or more of the procedures are included in the principal procedure.

MDM: Medical decision making.

Medical Decision Making (MDM): Defined by CMS is the complexity of establishing a diagnosis and/or selecting a management option, measured by three key elements: the number and complexity of problems addressed, the amount and complexity of data reviewed and analyzed, and the risk of complications, morbidity, or mortality associated with the patient's condition or management options.

Mutually Exclusive Procedure: Two or more procedures that are generally not performed on the same patient on the same date of service because they are either medically impossible, improbable, or represent conflicting approaches to the same clinical issue.

Provider: Physicians and health care practitioners, corporation, LLC. Partnership or other legal entity duly licensed or authorized to practice in the state, that are employed by, affiliated with or contracted with the legal entity.

Unbundling: The practice of using multiple CPT (Current Procedural Terminology) codes to bill separately for individual components of a procedure that are normally covered under a single, comprehensive code.

UOS: Units of service.

Upcoding: The practice of assigning a higher-level billing code to a medical service or procedure than what was actually provided.

Policy Provisions and Required Procedures

Providers must bill for procedures, drugs and supplies correctly. Drugs, supplies and procedures must be reported with the most comprehensive HCPCS/CPT code that describes the item or service(s) performed. Providers must not unbundle a procedure/drug/supply, fragment a procedure/drug/supply or report multiple HCPCS/CPT codes when a single comprehensive code describes the drug, supply or procedure. Below are examples of proper and improper coding.

UNBUNDLING/FRAGMENTING

- A vaginal hysterectomy on a uterus weighing less than 250 grams with bilateral salpingo-oophorectomy was performed.
 - Correct coding: CPT code 58262 (*Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)*).
 - Incorrect coding: CPT code 58260 (*Vaginal hysterectomy, for uterus 250 g or less;*) plus CPT code 58720 (*Salpingo-oophorectomy, complete or partial, unilateral, or bilateral (separate procedure)*)

- A laparoscopic cholecystectomy with intraoperative cholangiography was performed.
 - Correct coding: CPT code 47563 (*Laparoscopic cholecystectomy with intraoperative cholangiography*).
 - Incorrect coding: CPT 47562 (*Cholecystectomy*) plus CPT 47564 (*Cholangiography*)

- A bilateral mammography is performed.
 - Correct coding: CPT code 77066 (*Diagnostic mammography... bilateral*).
 - Incorrect coding:
 - CPT code 77065 (*Diagnostic mammography... unilateral*) with 2 UOS
 - CPT code 77065 LT plus 77065 RT

BIOPSIES

- Biopsies are eligible for separate reimbursement when:
 - Pathologic examination results in a decision to immediately proceed with a more extensive procedure (e.g., excision, destruction, removal) on the same lesion
 - Performed on a separate lesion.
- Biopsies are NOT separately reimbursable when the biopsy is to:
 - Assess resection margins
 - Verify resectability
 - Perform and submit for pathologic evaluation after performing the more extensive procedure

INTEGRAL PROCEDURES

- When HCPCS/CPT codes include services that are integral to them, the integral services should not be separately charged even when there is a separate code for a service.
 - Example: CPT code 36000 (*Introduction of needle or intra-catheter, vein*) is integral to all nuclear medicine procedures requiring injection of a radiopharmaceutical into a vein. CPT code 36000 is not separately reportable even though there is a separate code for the introduction of a needle into the vein.

ADD-ON CODES (AOCs) vs. INCIDENTAL SERVICES

- **Add-on Codes (AOCs):** AMA coding guidelines designate some CPT as Add-on Codes. AOCs describe a significant supplemental service that can only be reported in addition to a primary procedure. Coding guidelines specify the primary procedure code(s) for most AOCs. AOCs are not eligible for separate reimbursement when charged separately or as a supplemental service for codes not listed as a primary code.
- **Incidental Services:** Services that are necessary to accomplish the primary procedure are not separately reportable. For example, control of bleeding during an invasive procedure is considered an incidental part of the procedure and is eligible for separate reimbursement.

MUTUALLY EXCLUSIVE PROCEDURES

- Multiple approaches to the same procedure are mutually exclusive of one another and should not be reported separately.
 - Example: A hysterectomy that can be performed by two different methods, vaginally or abdominally. Only one method is eligible for reimbursement.

SEQUENTIAL PROCEDURES

- Some surgical procedures can be performed by different surgical approaches. The procedures for these approaches usually have different CPT codes. If an initial surgical approach to a procedure fails and a second surgical approach is used during the same patient encounter, the two procedures are considered “*sequential*” and only the HCPCS/CPT code corresponding to the second surgical approach is eligible for separate reimbursement.
 - Example: A surgeon may begin a cholecystectomy using a laparoscopic approach (*CPT 47562*) and have to convert to an open abdominal approach (*CPT 47600*). Only the CPT code for the open cholecystectomy (*CPT 47600*) is eligible for reimbursement. The CPT code for the failed laparoscopic cholecystectomy (*CPT 47562*) is not reimbursable.

UPCODING

- A procedure or service is eligible for reimbursement only if **all** services described by that code have been performed.
 - Example: A physician performs a superficial axillary lymphadenectomy
 - Correct coding: CPT code 38740 (*Superficial axillary lymphadenectomy*)
 - Incorrect coding: CPT code 38745 (*Axillary lymphadenectomy; complete*)

DOWNCODING

- A procedure or service is eligible for reimbursement if the code level assigned is supported by the medical record. Charging for a lower level of care than what was actually performed in an effort to circumvent audits or reduce the chance of investigation should not be attempted. MAHP reimburses services, drugs and supplies based on the medical records. Billing that is not supported by the medical record may be denied.
 - Example: A physician performed a Level 4 E/M visit (CPT 99214) for a patient with severe COPD exacerbation. The MD ordered testing and a pulmonary consult providing moderate complexity medical decision-making (MDM).
 - Correct coding: Level 4 CPT code 99214
 - Incorrect coding: Level 3 CPT code 99213 low complexity medical decision-making (MDM)

Related Policies	https://www.mahealthplans.com/app/files/public/23ec1d09-1e74-498e-ba84-33ceceb26145/MAHP_Provider/Billing%20and%20Claims%20Administration%20Policy.pdf
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Related Training/ Job Aids	
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NCQA Standard	
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References	2025 Medicare NCCI Policy Manual – Chapter 1 REVISED FINAL 1995 DOCUMENTATION GUIDELINES FOR EVALUATION AND MANAGEMENT SERVICES MGMA: Medical Decision Making and Why it is Important CMS Publication 100-04, Medicare Claims Processing Manual AAPC (License Required)
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Exhibits	
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Policy Owners / Reviewers

Department Owner	Lisa Kuhls	Date Reviewed	12/3/2025
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Department Reviewer	Network Strategy Committee	Date Reviewed	12/9/2025
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Approving Committee if applicable	<input type="checkbox"/> Compliance <input checked="" type="checkbox"/> UMC <input type="checkbox"/> QIC <input checked="" type="checkbox"/> Board of Directors <input type="checkbox"/> Other: _____	Date Approved	2/2026 3/2026
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History

Date of revision	<i>Summary of changes</i> <u>Prior Reviews:</u> Revised: Reviewed:
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