Reimbursement Policy
Bundling/Incidental Services: Professional Reimbursement
Committee Approval Date: **01/06/2022**
These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by the member's plan. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with CPT codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record. Unless otherwise noted within the policy, our policies apply to both participating and non-participating providers and facilities. If appropriate coding/billing guidelines or current reimbursement policies are not followed, MHHP may reject/deny claim, recover/recoup payment or adjust the reimbursement to reflect the appropriate services and/or procedures performed. These policies may be superseded by mandates in provider contracts, or state, federal or CMS requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, MHHP strives to minimize these variations.
References: https://www.cms.gov/files/document/medicare-claims-processing-manual-chapter-12

Policy Statement

Services considered unbundled, incidental, mutually exclusive or integral to the primary service rendered are not eligible for separate reimbursement. Definitions for incidental, mutually exclusive and integral services are as follows:

Incidental Procedures

An incidental procedure is carried out at the same time as a more complex primary procedure. These procedures require little additional provider resources and are generally not considered necessary to the performance of the primary procedure. For example, the removal of an asymptomatic appendix is considered an incidental procedure when done during hysterectomy surgery. An incidental procedure is not reimbursed separately on a claim.

Example- specimen collection by any method is considered incidental to Evaluation and Management services.

Mutually Exclusive Procedures

Mutually exclusive procedures are two or more procedures that are usually not performed on the same patient on the same date of service. Mutually exclusive rules may also include different procedure code descriptions for the same type of procedures for which the provider should be submitting only one of the procedure codes. Only the most clinically intense procedure will be allowed. Generally, an open procedure and a closed procedure in the same anatomic site are not both reimbursed. If both codes accomplish the same results, the clinically more intense procedure supersedes and the comparative code is denied as mutually exclusive.

Integral Procedures

Procedures considered integral occur in the multiple surgery situations when one or more of the procedures are included in the major or principle procedure. These codes should not be reported in addition to the code for the total procedure or service of which it is considered an integral component.

Bundling Guidelines

The National Correct Coding Initiative (NCCI or CCI) was developed by CMS to control improper coding leading to inappropriate payment. CMS developed coding policies based on coding conventions defined in the AMA CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. CMS NCCI edits are a nationally recognized and widely used standard industry source to determine relationships between codes. MHHP uses the "Column One/Column Two" NCCI edits to determine whether CPT and/or HCPCS codes reported together by the same physician for the same member on the same date of service are eligible for separate reimbursement.

Status "B" codes:

CMS designates the status of HCPCS and CPT codes in the Medicare Physician Fee Schedule Database. Status B codes are bundled. Payment for these services is always included in payment for other related services and will not be separately payable. Status B code edits are applied to professional and outpatient facility claims. Separate payment is not made for those codes. Reference the MPFS for corresponding date of service because Medicare periodically updates code status.

Summary

Services considered to be mutually exclusive, incidental to or integral to the primary service rendered are not allowed additional payment. Claims editing for bundling guidelines will apply to professional and facility claims unless otherwise stated.

Memorial Hermann *Advantage* HMO is provided by Memorial Hermann Health Plan, Inc., a Medicare Advantage organization with a Medicare contract. Enrollment in this plan depends on contract renewal.

Memorial Hermann *Advantage* complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Please contact Customer Service at 855.645.8448 (TTY711) between 8 a.m. to 8 p.m. CT, 7 days a week.

- 8 a.m. to 8 p.m. CT, 7 days a week from Oct. 1 – March 31.
- 8 a.m. to 8 p.m. CT, Monday – Friday from April 1 – Sep. 30.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 855.645.8448 (TTY 711).