COMMERCIAL REIMBURSEMENT POLICY

Laboratory Rebundling

Active

Policy Number: Lab/Path – 001
Policy Title: Laboratory Rebundling
Section: Lab/Path
Effective Date: 06/05/23

Description

This policy addresses coding and reimbursement for laboratory rebundled services.

Definitions

Unbundling: The submission of multiple procedure codes for a group of specific procedures that are components of a single comprehensive code.

Rebundling: The identification and combination of specific coding relationships into the most comprehensive and/or appropriate procedure code.

Policy Statement

Blue Cross and Blue Shield of Minnesota (Blue Cross) requires laboratory services to be ordered by a physician or other qualified healthcare professional (QHP).

Laboratory procedures should be submitted using the Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT®) code that describes the procedure performed to the greatest specificity possible. Multiple HCPCS/CPT codes should not be submitted if a single HCPCS/CPT code exists that describes the services. This type of unbundling is incorrect coding.

The tests listed under each organ or disease-oriented panel (80047- 80081) identify the defined components of that panel, and *all* tests listed must be performed to bill for that panel. Tests performed in addition to those specifically indicated for a particular panel can be billed separately in addition to the panel code.

If a panel is submitted and one of the lab procedures/tests is repeated, that single repeat component may be billed with the individual service code and modifier 91.

Lab panels should be reported as 1 line item with 1 unit per panel.

Do not report two or more panel codes comprising the same tests; report the panel with the highest number of tests to meet the definition of the code and report the remaining tests individually.

Procedure Code Unbundling/Replacement

Procedure code unbundling is the submission of multiple procedure codes for a group of specific procedures that are components of a single comprehensive code. Procedure unbundling may occur in one of two ways:

- A professional claim could be submitted that has procedure codes for both the individual components, and the procedure code for the comprehensive procedure. Blue Cross will rebundle the individual component codes into the comprehensive procedure code for payment.

- Procedure unbundling could also occur when a professional claim is submitted with only the individual components of the comprehensive code. In this situation, the system will recognize the relationship between the comprehensive code and its individual components. Then, it will automatically add the comprehensive code to the claim and rebundle the individual components into that comprehensive code for payment.

Documentation Submission

The medical record must show the tests and/or panels ordered. If repeat tests included in a panel are done, documentation should indicate and support the necessity of ordering the repeated test.

Coverage

Eligible services will be subject to the subscriber benefits, the applicable fee schedule amount, and any coding edits.

The following applies to all claim submissions.

All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria, policies found in the Provider Policy and Procedure Manual sections, Reimbursement Policies and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be paid according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

The following codes are included below for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply subscriber coverage or provider reimbursement.

CPT/HCPCS Modifier: 91
ICD-10 Diagnosis: N/A

ICD-10 Procedure: N/A

CPT/HCPCS: 80047 80048 80050 80051 80053 80055 80061 80069 80074 80076 80081

Revenue Codes: N/A

Cross Reference

Cross Reference: N/A

Resources

Current Procedural Terminology (CPT®)
National Correct Coding Initiative (NCCI)

Policy History

12/02/2014	Initial Committee Approval Date
04/03/2018	Annual Policy Review and Code Update
01/07/2019	Annual Policy Review
01/26/2021	Annual Policy Review
05/24/2022	Annual Policy Review
03/28/2023	Annual Policy Review