

## REBUNDLING OF PROCEDURE CODES

ISSUE DATE: September 25, 1991

AUTHORITY: [32 CFR 199.9\(b\)](#) and [\(c\)](#)

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### I. APPLICABILITY

**THE USE OF TRICARE CLAIMCHECK TO DETECT UNBUNDLING IS MANDATORY FOR THE CURRENT MANAGED CARE CONTRACTS AND UNTIL THOSE CONTRACTS EXPIRE.**

### II. ISSUE

What is “fragmentation” or “unbundling”? How should these claims be adjudicated?

### III. DESCRIPTION

“Fragmentation” or “unbundling” is separately reporting the component parts of a procedure instead of reporting a single code which includes the entire comprehensive procedure. This is distinguished from multiple surgery which involves performing more than one procedure at the same operative session. “Unbundling” or “fragmenting the bill” is believed responsible for a major portion of escalating health care costs. It encompasses surgery, pathology and lab charges, radiology and medical services. Coding manipulations are often used to inappropriately increase claim reimbursements.

### IV. POLICY

A. Rebundling. “Fragmentation” or “unbundling” reflects improper reporting of procedures. The allowable charge determination will be based upon the single comprehensive code which includes the entire procedure. The component parts of the procedure are to be denied as already included within the allowable charge for the single procedure. This process is referred to as “rebundling”.

EXAMPLE:

| PROPER BILLING        |                        | UNBUNDLED BILLING     |                        |
|-----------------------|------------------------|-----------------------|------------------------|
| CPT <sup>1</sup> CODE | SHORT DESCRIPTION      | CPT <sup>1</sup> CODE | SHORT DESCRIPTION      |
| 58120                 | DILATION AND CURETTAGE | 57410                 | PELVIC EXAMINATION     |
|                       |                        | 57505                 | ENDOCERVICAL CURETTAGE |
|                       |                        | 58120                 | DILATION AND CURETTAGE |

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NOTE: In the above example, only CPT<sup>1</sup> procedure code 58120 would be allowed. CPT<sup>1</sup> procedure codes 57410 and 57505 would be denied as they are already included in the comprehensive CPT<sup>1</sup> procedure code 58120.

B. Allowable Charge Determination. Claims that are rebundled are allowable charge determinations and must be treated as such. Rebundling which results in reductions to the billed amount are not subject to the formal appeals process, and providers that agree to participate are NOT permitted to bill the beneficiary for amounts disallowed for the component parts of the comprehensive procedure. Participating providers and beneficiaries do have the right, however, to question the amount allowed and request a review.

C. Balance Billing Limitation. Since rebundling combines component parts into a single comprehensive code and base reimbursement on that single code, there is only one allowable charge determination for the services. Therefore, for non-participating providers, the balance billing limitation applies to all of the services and the provider's billed charge for all the services is limited to 115 percent of the allowable amount for the single comprehensive code (see [Chapter 5, Section 2, paragraph III.F.2.](#)).

D. Improper Billing Practices - Unassigned and Assigned Claims. Providers with a pattern of billing fragmented claims (participating or non-participating) are to be advised that such practice represents improper billing practices. Providers that bill in such a way as to misrepresent the services rendered, whether participating or nonparticipating, should be cautioned that "unbundling", "fragmenting", or "code gaming" in order to manipulate the CPT codes as a means of increasing reimbursement is considered an improper billing practice and a misrepresentation of the services rendered. Such a practice can be considered fraudulent and abusive. Fraudulent actions can result in criminal or civil penalties. Either fraudulent or abusive activities may result in administrative sanctions of suspension or exclusion as an authorized provider.

## V. EFFECTIVE DATE

For claims received on or after January 1, 1992.

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