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## unbundling the confusion about “unbundling” of charges

**Payers often seem to be looking for ways to give new meanings to their provider contracts—meanings that were never addressed during the contract’s negotiation and are not included in its language.**

### AT A GLANCE

Rejecting service codes on the basis that they have been unbundled has become a popular way for payers to reduce total billed charges. However, the contract between the hospital and the payer, and not Medicare or some hastily manufactured and inconsistent industry standard, controls the obligation to pay for healthcare services.

One approach gaining popularity is to reject individual chargemaster service codes billed by a hospital for services furnished to a *commercial* patient because the separate billing of this item, and thus the existence of this service code on the chargemaster, constitutes “unbundling” under *Medicare’s* billing rules.

This service code rejection strategy affects payment only in contracts with percentage-of-charges rates. By rejecting service codes, payers reduce total billed charges. Depending on the rate structure of the contract, this can bring the total billed charges of some claims below the stop-loss threshold and keep payment at relatively low per diems or case rates. In other instances, it may simply reduce the total billed charges to which the contract’s percentage rate of payment is applied.

A limited number of service codes have been rejected on this basis for years during medical record audits as contingency-paid audit companies attempted to increase the payer’s “savings” upon which the auditors were paid. Because audits are expensive and typically performed on only a small percentage of claims, the strategy of rejecting service codes has now moved in-house and is applied at the claims adjudication stage. As moderation in the pursuit of underpayments is no virtue for a payer, the volume of service codes rejected on this basis has increased. Of course, this service code rejection upsets the financial basis on which the contract was made. If a hospital had structured its chargemaster to include the rejected service code X in service code Y, service code Y would have had a higher price because it then would have included the cost and markup for the items and services represented by service code X. However, because the hospital chose to bill for the health care represented by service code X separately, the costs and markup for these services were not included anywhere else in the chargemaster.

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Indeed, both parties relied on the existence of the rejected service codes during contract negotiations. In the payer's financial modeling during negotiations, it accepted the historical charges that included the total costs and markup of the charges it now rejects to estimate what the payer would owe under the contract's rates. This shows that the real goal of the payer is not to bring the hospital's chargemaster into conformity with any Medicare "rule," but to obtain services for free.

#### **"Unbundling" Is Not a Sin Unless a Rule Requires That the Item Be "Bundled"**

We start with the simple premise that it cannot be a bad thing to unbundle something unless there is first a rule that requires that thing to be bundled. For example, the Department of Health and Human Services Office of Inspector General says, "'Unbundling' is the practice of submitting bills piecemeal or in fragmented fashion to maximize the reimbursement for various tests or procedures that are *required* to be billed together and therefore at a reduced cost."<sup>a</sup> If the cost to the payer is the same whether items A, B, and C are billed together under code "88888" or each is billed separately under its own individual code, there simply is no unbundling.

Most references to unbundling concern the Current Procedural Terminology coding system copyrighted by the American Medical Association and adopted by Medicare. The best case law illustration of unbundling

is in *United States v. Metzinger*, which concerned the separate billing of the components of a lab test panel.<sup>b</sup> The court said, "'Unbundling' occurs under circumstances in which the Medicare program prescribes a special reimbursement rate for a group of laboratory procedures that commonly are ordered together. 'Unbundling' means billing separately for each component, as opposed to billing at the special rate."

As *Metzinger* shows, unbundling is a breach of contract. Every hospital that participates in Medicare has a provider agreement with Medicare. The Medicare fee schedule defines some of the rates under that agreement and establishes the "special rate" for the particular combination of lab tests. That contract rate is breached by the hospital's unbundling. Unbundling is thus not a circular concept that elevates form over substance. It is a term of art in the healthcare industry that developed from the detailed and precise CPT coding system which, when married to a fee schedule, results in precise contract rates for precisely identified groupings of services.

Of course, managed care contracts never control the content of the hospital's chargemaster. The chargemaster must be applied to thousands of patients and scores of payers; therefore, for budgetary, regulatory, and practical reasons, there cannot be numerous customized chargemasters in use, each of which conforms to the specific rules of different payers.

However, contracts can address the *effect of changes* to a chargemaster. For example, a recent trend is to include downward adjustments to the percentage-of-charges contract rate when chargemaster prices annually rise above specified increments. Here, the hospital retains its discretion to set its prices, but the parties agree on the impact these price increases may have on the contracting payer.

#### **Contracts Do Not Permit Service Code Rejection**

The contract between the hospital and the payer shows the mutual intent of the parties at the time of

a. *Compliance Program Guidance for Hospitals*, February 1998, fn. 20. Emphasis added.

b. *CCH Medicare & Medicaid Guide*, ¶ 44,669 (USDC E.D. Pa., 1996), 1996 WL 530002.

contracting concerning the structure of the chargemaster. If the contract has a percentage-of-charges rate, it is likely stated as a percentage of "billed charges" or "covered billed charges," with no exception for certain types of charges. This alone should be persuasive. If the service code rejection is being applied to an existing contract that was earlier performed on the basis of all the provider's billed charges, this practical interpretation by both parties will be significant in proving that the parties did not mutually intend to allow service code rejection. If the contract is new, the course of dealing between the parties under earlier contracts will have a similar effect.

By rejecting service codes, the real goal of the payer is not to bring the hospital's chargemaster into conformity with any Medicare "rule," but to obtain services for free.

**Medicare Does Not Control the Structure of a Hospital's Chargemaster**

In the absence of any specific billing rules in the contract, a payer will argue that the Medicare cost apportionment guidelines, which address a distinction between routine and ancillary charges, set an industry standard by which hospitals must set up their chargemasters—and thus an industry standard of what ancillary charges may be billed separately to commercial payers. This argument ignores the language and effect of the cited Medicare rule.

The relevant Medicare cost apportionment "rules" are not found in statutes or regulations, but in Medicare's *Provider Reimbursement Manual*. PRM section 2203 ("Provider Charge Structure as Basis for Apportionment") limits the cost apportionment procedures to Medicare cost apportionment: "While the Medicare program cannot dictate to a provider what its charges or charge structure may be, the program may determine whether or not the charges are allowable for use in apportioning costs under the program."<sup>c</sup>

This is not a new position; these Medicare cost apportionment manual provisions were published in the 1970s.<sup>d</sup> Thus, it was common knowledge in the health-care industry since the early 1970s that not only did these cost apportionment manual provisions exist, but also that by their own words Medicare disavowed any ability or intent to "dictate to a provider what its charges or charge structure may be."

These PRM sections also are not intended to eliminate service codes from the chargemaster so that they may be obtained for free. The purpose of the Medicare cost apportionment process is to ensure that costs generated by Medicare patients are not shifted to non-Medicare patients and vice versa. Whether Medicare considers a charge as ancillary (and thus separately billable) or routine (and thus one that should have been included in a routine charge) affects only the methodology by which Medicare attributes the cost of those types of services that were consumed by Medicare patients. Unlike the private payer's application of this rule to its commercial contracts, Medicare does not cause the cost of an ancillary charge that it thinks should have been included in a routine charge to disappear.

The "industry standard" argument also suffers from the same circularity of reasoning as the "unbundling" argument. If a Medicare rule did create an industry standard, then the interpretation and application of that standard would be for the Medicare program to define and apply. In fact, most if not all of the charges the payer rejects because they violate the Medicare

c. See also the following statement in Medicare Intermediary Letter No. 399 (Sept. 1, 1969), *CCH Medicare & Medicaid Guide*, ¶ 26,024: "The Medicare program cannot dictate to a provider what its charges or charge structure may be. The provider is free to set its charges and charge its private-paying patients, and others, in any way it sees fit. The Medicare program, however, may determine whether the charges are allowable for use in apportioning costs under the program."

d. PRM § 2206 ("Routine Services") was adopted in March 1971, and amended by transmittals in September 1972, July 1975, June 1976, and October 1976. *CCH Medicare & Medicaid Guide*, ¶ 6095. PRM § 2202.8 ("Ancillary Services") was also adopted in March 1971, and amended by transmittals in September 1972 and June 1976. *CCH Medicare & Medicaid Guide*, ¶ 6105. PRM § 2203 ("Provider Charge Structure as Basis for Apportionment") was adopted in September 1972, and amended by transmittals in May 1975 and June 1996. The June 1996 amendment did not add or amend the quoted language. *CCH Medicare & Medicaid Guide*, ¶ 6153.

"rule" have never been reclassified or rejected by the hospital's Medicare fiscal intermediary in the cost apportionment process. Yet the same payer who rejects a service code because it does not meet this "industry standard" deputizes itself—and under its logic every other payer—to privately police how Medicare "should" be applying its rules. This is not done through the adjudicative processes of the Medicare program and the federal courts so that a truly uniform result can be achieved, but in a series of arbitrations, whose results will remain private and will set no precedent, with the likelihood of conflicting decisions, all without the participation of Medicare—which has the only legal authority to make these decisions.

Simply put, there cannot be two contradictory "industry standards." In an industry where a contract rate based on a percentage of a hospital's covered billed

charges is a standard term, there cannot also be a standard whereby every payer has the right to tell the hospital how to restructure its charges.

In sum, once the tangled confusion of the payer's "unbundling" position is itself unbundled, it is clear that the contract between the hospital and the payer, and not Medicare or some hastily manufactured and inconsistent industry standard, controls the obligation to pay for healthcare services. As with so many other underpayment issues, hospitals should not hesitate to enforce the bargain they made in their contracts. ●

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#### UNBUNDLING TO MAKE A BUNDLE OFF MEDICARE?

In version 11.3 of its *National Correct Coding Initiative Policy Manual for Medicare Services*, the Centers for Medicare and Medicaid Services gives the following definition and examples of different types of unbundling:

Unbundling occurs when multiple procedure codes are billed for a group of procedures that are covered by a single comprehensive code. Two types of practices lead to unbundling. The first is unintentional and results from a misunderstanding of coding. The second is intentional and is used by providers to manipulate coding in order to maximize payment....

Examples of unbundling are described below:

- > Fragmenting one service into component parts and coding each component part as if it were a separate service. For example, the correct CPT comprehensive code to use for upper gastrointestinal endoscopy with biopsy of stomach is CPT code 43239. Separating the service into two component parts, using CPT code 43235 for upper gastrointestinal endoscopy and CPT code 43600 for biopsy of stomach, is inappropriate.
- > Reporting separate codes for related services when one comprehensive code includes all related services. An example of this type is coding a total abdominal hysterectomy with or without removal of tubes, with or without removal of ovaries (CPT code 58150) plus salpingectomy (CPT code 58700) plus oophorectomy (CPT code 58940) rather than using the comprehensive CPT code 58150 for all three related services.
- > Breaking out bilateral procedures when one code is appropriate. For example, bilateral mammography is coded correctly using CPT code 76091 rather than incorrectly submitting CPT code 76090-RT for right mammography and CPT code 76090-LT for left mammography.
- > Separating a surgical approach from a major surgical service. For example, a provider should not bill CPT code 49000 for exploratory laparotomy and CPT code 44150 for total abdominal colectomy for the same operation because the exploration of the surgical field is included in the CPT code 44150.