



## BILLING POLICY No. 007

### DISTINCT UNBUNDLED MODIFIER

Effective date: Sept. 23, 2024

Review dates: 2/2025, 2/2026

Date of origin: July 2024

## APPLIES TO

All products

## DEFINITION

In support of correct coding and payment accuracy, Priority Health won't allow separate and distinct modifiers to bypass bundling claim edits for select services outlined in this policy.

## POLICY SPECIFIC INFORMATION

### Impacted services / procedures

#### Procedure codes 93798 & 93797

These codes are considered mutually exclusive and should not be billed together. Separate and distinct modifiers will no longer override this edit.

- **93798** – Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)
- **93797** – Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)

#### Procedure codes 93975 & 93976

These codes are considered mutually exclusive and should not be billed together. Separate and distinct modifiers will no longer override this edit.

- **93975** – Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study
- **93976** – Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; limited study

#### Procedure code 76942

This code is considered incidental when billed with transrectal ultrasound (76872) and prostate biopsy procedure (55700). Separate and distinct modifiers will no longer override this edit.

- **76942** – Ultrasonic guidance for needle placement (for example, biopsy, aspiration, injection or localization device), imaging supervision and interpretation
- **76872** – Ultrasound, transrectal

- **55700** – Biopsy, prostate; needle or punch, single or multiple, any approach

### **Hernia repair & bariatric surgery**

Hernia repair (43280, 43281, 43282, 43283, 43332, 43334, 43336, 49621) in bariatric surgery is considered incidental and not separately reimbursable. Separate and distinct modifiers won't override this edit.

### **Hernia**

- **43281** - Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh
- **43282** - Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh
- **43332** - Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; without implantation of mesh or other prosthesis
- **43334** - Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; with implantation of mesh or other prosthesis
- **43336** - Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; without implantation of mesh or other prosthesis
- **49621** - Repair of parastomal hernia, any approach (ie, open, laparoscopic, robotic), initial or recurrent, including implantation of mesh or other prosthesis, when performed; reducible

### **Bariatric procedures**

- **43644** - Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (Roux Limb 150 cm or less)
- **43645** - Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (Roux Limb 150 cm or less), with gastric bypass and small intestine reconstruction to limit absorption [laparoscopic gastric diversion with gastro-jejunal reconstruction]
- **43770** - Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components) [not covered if history of prior Roux-en-Y gastric bypass or sleeve gastrectomy] [not covered with gastric plication]
- **43842** - Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty
- **43843** -Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty [not covered for transoral gastroplasty (TG), vertical

sutured gastroplasty, endoluminal vertical gastroplasty, endoscopic sleeve gastroplasty] [not covered for open gastric banding]

- **43845** - Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)
- **43846** - Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy
- **43847** - Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy with small intestine reconstruction to limit absorption

## DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available [in our Provider Manual](#).

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## CHANGE / REVIEW HISTORY

Date	Revisions made
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Feb. 4, 2025	Added "Disclaimer" section
Feb 2026	Correction of typographical error 97975 to 93975