Commercial Reimbursement Policy

Subject: **Bundled Services and Supplies - Professional**	
Policy Number: **C-08003**	Policy Section: **Coding**
Last Approval Date: **04/01/2024**	Effective Date: **07/01/2024**

Disclaimer

These reimbursement 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 a member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

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 Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. These codes denote the services and/or procedures performed and when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

These reimbursement policies may be superseded by mandates in provider, state federal or Centers for Medicare and Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

The Health Plan considers certain services and supplies to be ineligible for separate reimbursement when reported by a professional provider. These services and/or supplies may be reported with a primary service or as a stand-alone service.

This policy is divided into 3 sections:

Policy Section 1: Services and Supplies not eligible for separate reimbursement

Section 1 provides a list and description of Current Procedural Terminology (CPT®) and Healthcare Common Procedural Coding System (HCPCS Level II) codes for those services and supplies not eligible for reimbursement when they are reported with another service or reported as a stand-alone service.

In most cases, services rendered without direct (face-to-face) patient contact are considered to be an integral component of the overall medical management service and are not eligible for separate reimbursement. In addition, modifiers will not override the denial for the always bundled services and/or supplies listed in the embedded document.

Policy Section 2: Procedures, Services and Supplies not eligible for separate reimbursement when reported with another specific procedure, service or supply
Section 2 provides a description and the code pair relationship for procedures that are not eligible for separate reimbursement when performed with another specific service or supply listed in the embedded document. In most cases, modifiers will not override the denial when reported with a specified service or supply.

Policy Section 3: Services not eligible for separate reimbursement when reported with any other procedure, service, or supply
Section 3 provides the code and description for services that are eligible for reimbursement when reported as a stand-alone service but are not eligible for separate reimbursement when performed with any other procedure, service or supply. Modifiers 59, XE, XP, XS or XU will not override the denial for the services when they are reported with any other procedure, service or supply.

Related Coding

Description	Coding Grids
Bundled Services Section 1	Services and Supplies not eligible for separate reimbursement
Bundled Services Section 2	Procedures, Services and Supplies not eligible for separate reimbursement when reported with another specific procedure, service or supply
Bundled Services Section 3	Policy Section 3: Services not eligible for separate reimbursement when reported with any other procedure, service, or supply

Policy History

04/01/2024	Review approved 04/01/2024 and effective 07/01/2024: updated coding lists Section 1: • Added codes G0310-G0318 • Added HCPCS code G2212 - removed from Prolonged Services (C-08011) • Added codes M0001-M0005, M1150-M1210 • Added HCPCS codes S0353 and S0354 - removed from the Cancer Treatment and Planning retired policy (C-13005) • Removed 99000, 99001 and H0048 (add to Laboratory and Venipuncture Services) Section 2 • Removed codes 99217-99220, 99241 and 99251 and consultation codes 99242-99245, 99252-99255 from 69209 and 69210 code pair

	• Removed codes 76604, 76705-76706, 76770, 76775-76776, 76815 from the 99281-99285 and 99221-99233 code pair (FAST ultrasounds allow separate reimbursement also removed from Distinct Procedural Services (C-09006))
10/01/2021	Review approved 10/01/2021 and effective 01/01/2022: added HCPCS code Q3014 to bundle when reported with an E&M code in place of service of 11 to section 2.
07/23/2021	Review approved and effective: Section 1: Removed code S2900- moved to Robotic Assisted Surgery Policy #C-12007; removed code C9032- this code was deleted 01/01/2019, removed e-consult Behavior Health codes 99484, 99447-99449

10/01/2020	Review approved 10/01/2021 and effective 01/01/2021:
	Revisions:
	• Add to section 1 code list:
	  ○ G0453
	  ○ 99451 and 99452
	  ○ 99072 (new code effective 9/8/2020)
	• Add to section 2 code list:
	• Add 22630 and 22633 as support codes to deny when reported with 63048
	• Add ultrasonic guidance (76942) when reported with tendon, ligament, aponeurosis (i.e. fascia) or trigger point injections (20550, 20551, 20552, 20553)
	• Add 22558 as support code that will deny 63081-63088
	• Add coding for shoulder and elbow arthroscopic debridement codes not allowed with arthroscopic surgery (shoulder: 29822 not allowed with 29819, 29820, 29824, 29825, 29827; 29823 not allowed with 29806, 29807, 29819, 29820, 29821, 29825; elbow: 29837 and 29838 not allowed with 29834, 29835, 29836) This is based on NCCI Policy Manual language; only allow site specific modifiers RT/LT to override when the codes are reported for different sides
	• Add column chromatography, includes mass spectrometry, if performed, non-drug analyte(s) not elsewhere specified, qualitative or quantitative, each specimen (82542) when reported with drug screening, confirmatory drug testing, or breath hydrogen or methane test (80320- 80377, 83992, G0480-G0483, G0659)
	• Add digital EEG analysis procedure 95957 to deny if billed on the same date of service as procedure codes 95954, 95700, 95705-95726

09/01/2019	New policy template: embedded section 1 code list and section 2 code pairs
10/05/2018	Allow reimbursement for HCPCS code C9032 (Luxturna)
08/03/2018	Revisions: Advanced care planning and chronic care management language removed. Also, removed codes 99487-99490 and 99497-99498 from the bundled services code list.

06/01/2018	Revision: Added language for X-ray DVD or film to Section 1 line #8 per request received
12/15/2017	Revision approved: • Add 20550 and 20551 (tendon injections) as support codes to the edit that 76942 (ultrasound guidance) is not eligible for separate reimbursement when reported with trigger point injections. Effective 1/1/18: CA will not deny 76942 when reported with 20552 and 20553. Effective 3/1/18: CA will not deny 76942 when reported with 20550 and 20551. • Moved other policy reference to end of policy • Remove reference in section 1 to transitional care mgmt./planning (the codes (99495 & 99496) were removed from the section 1 code list)
08/01/2017	• Revised: Update coding section 1 to remove from rule 25 codes to be eligible for reimbursement the following psych care management codes reported by primary care providers: ○ *G0502* (Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional) ○ *G0503* (Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities...) ○ *G0504* (Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities... use G0504 in conjunction with G0502, G0503) ▪ Bullet will now be G0505-G0507 • Part of Wave initiative #265; expanding care management to allow these services for PCPs; EPHC has agreed and from legal reviewed • These services differ enough from other care management services to warrant separate reimbursement • BH will monitor the utilization data ○ Only update to policy is date to match update to section 1 code list
07/11/2017	Revised: Update and move bullet for drug testing; now only definitive drug testing has “G” codes (G0480-G0483 and G0659), the presumptive testing “G” codes (G0477-G0479) were deleted 1/1/17 Update to section 2—move nonvascular extremity ultrasound when reported with ultrasonic guidance for needle placement from #49 to #35 to be in alpha order
06/06/2017	1. Section 1 coding: add 99446-99449 to document current edit 2. Add replacement breast pump supplies when reported on the same date of service that a breast pump is provided (A4281, A4282, A4283,

	A4284, A4285 will not be eligible for separate reimbursement when billed with E0602, E0603, E0604)
04/04/2017	Revised: 1) Updating section 2 coding (code-to-code) for the drug testing edits: a. For 2017 CPT deleted codes 80300-80304 and replaced with codes 80305-80307 for presumptive drug testing; for 2017 HCPCS deleted codes G0477-G0479 for presumptive drug testing (providers now report with 80305-80307) and added G0659 for definitive drug testing; removing deleted chromatography codes 82541, 82543, and 82544 b. G0480-G0483 are not allowed with G0659 2) Removing the edit that denies 22614 with CPT codes 22600, 22610, 22612, 22630 and leaving the edit between 22614 with 22633
02/07/2017	Revised: 1. Remove deleted codes for spinal injections from Section 2 (code pairs). 2. Add 2017 spinal injections codes 62320, 62321, 62322, 62323, 62324, 62325, 62326, and 62327 to Section 2 that image guidance or hospital management service will not be allowed with. 3. Code list date updated to match date of policy.
12/06/2016	Revised: Add codes to always bundled section 1code sheet: 1. G0500 2. G0501 3. G0502-G0507 4. T1040 and T1041 Deleted codes from section 1 coding: 1. 80300-80304 (CPT deleting 1/1/17) 2. 80305-80307 (HCPCS deleting G0477-G0479 1/1/17 therefore the CPT codes are to be used for presumptive drug testing and will not be added to rule 25) 3. GMMM1 (HCPCS replaced with G0500) Policy date updated to match changes in coding list.
10/04/2016	Revised: 1. Move section 1 code list from inside policy to separate document link. 2. Added to section 1: a. Presumptive drug testing codes eff 1/1/2017 80305-80307; providers should still use 2016 HCPCS codes G0477, G0478 and G0479 b. G0498 Chemotherapy administration...includes follow up office/other outpatient visit at the conclusion of the infusion c. Remove 80300-80304; deleted 1/1/17

	3. Added to section 2: a. 99151, 99152, 99153, 99155, 99156, and, 99157 when reported with codes previously listed in Appendix G of the CPT codebook by the provider rendering the service and the sedation; in 2017 CPT will allow separate reimbursement for moderate sedation for all services for same provider, same patient; this is based on changes to 2017 RVUs; each state will update based on when fee schedules move to 2017 RVUs b. Currently denying vaginal cytopathology 88141-88155, 88164-88167, and 88174-88175 when reported with preventive/annual or problem oriented E/M service ; add procedure codes G0402, G0438, G0439 G0101, S0610 and S0612 to the listing of support/pay codes associated with the edit; currently, only CPT E/M services are included in this edit; no modifier override c. Deny 95937 when reported with 95940, 95941, or G0453 d Deny 22614 when reported with procedures 22600, 22610, 22612, 22630 and 22633 and not allow any modifier e. Deny 76942 with 76881
09/16/2016	Revised: 1. Add an edit to Rule 26 to deny 63048 when reported with 22633 and do not allow any modifier override 2. Rule 26 - Deny 82542 (method) column chromatography as incidental to 91065 (test) hydrogen breath test and do not allow any modifier override 3. Currently denying vaginal cytopathology 88141-88155, 88164-88167, and 88174-88175 when reported with preventive/annual or problem oriented E/M service ; add procedure codes G0101, S0610 and S0612 to the listing of support/pay codes associated with the edit; currently, only CPT E/M services are included in this edit; no modifier override
08/02/2016	Revised: 1. Add 95957 (digital EEG analysis) not allowed with EEG services codes 95950, 95951, 95953, 95954, 95955 and 95956 on subsequent dates of service 2. Add [76942, 77002, 77003, 77012, 77021 when billed with codes 62310, 62311, 62319, 62319]; bracketed because not all states accepting at this time; supported in Federal Register – by CMS payment policy – not an NCCI edit.
04/05/2016	Revised: 1. Section 1, rule 25 (always bundled) – adding new codes eff 4/1/16 G9481-G9490 (Remote in-home visit for the evaluation and management of a new patient for use only in the Medicare-approved Comprehensive Care for Joint Replacement model) and G9678 (Oncology Care Model (OCM) Monthly Enhanced Oncology Services (MEOS)); these are codes developed by CMS to track Medicare programs therefore we should not see these codes on non-Medicare claims; current bullet #39 covers these codes

	2. Update language on current bullet #39 to read "preceding bullet" rather than specify a number since a bullet # is subject to change 3. Section 2, rule 26 code pairs – we are adding initial preventive visit HCPCS level II code G0402 to bullet #1 as not allowed with CPT preventive care codes 99381-99397 to document the edit in this policy; same logic that does not allow annual wellness HCPCS codes G0438 & G0439 with the preventive CPT codes; no modifier override; this information is currently documented in our Evaluation & Management and Modifiers 25 & 57 policy (2/2/16) 4. We will be adding 69209-removal of impacted cerumen by lavage to current edit which does not allow removal of impacted cerumen codes 69210 & G0268 when performed on same date of service as audiologic function testing; no modifier override
02/02/2016	Revised: Section #1 1) Adding G0180 (physician certification for Medicare covered home health services) (request from appeals) 2) Adding T2002 (per month case management code primarily used by Medicaid) These 2 codes covered in the bullet that patient care planning is always bundled 3) Listing 99360 separate from prolonged services codes 99356-99359 4) Removing the bullet and codes for cancer treatment planning; each state should have adopted by now Section #2 (description and corresponding coding) 1) Adding electrodes (A4556) reported with conductive gel or paste (A4558) 2) Adding removal impacted cerumen (69209 & 69210) when reported with any evaluation and management services (office visits, hospital visits, etc.); McKesson removing edit from their default, we are retaining (69209 is new for 2016) 3) Adding supply codes not payable with home infusion codes 99601 and 99602; McKesson removing edit from their default, we are retaining (this information will be included in our injection & infusion policy at a future review)
01/05/2016	Revised: 1. Section 1 (always bundled services) Along with cosmetic updates, we are: • Adding the presumptive and definitive drug testing CPT codes 803XX as always bundled (in agreement with CMS • Removing drug testing codes that CMS/HCPCS deleted 1/1/16: G0431 (qualitative) and G0434 (CLIA waived or moderate complexity) 2. Section 2 (code pairs)

	• Adding information to deny 29876 major arthroscopic knee synovectomy when reported procedure codes 29879 (abrasion arthroplasty) and 29880-29887 (arthroscopic meniscus surgeries) when reported with arthroscopic knee surgeries without an approved American Academy of Orthopedic Surgeons diagnosis; modifier 59 or the X modifiers will not override the denial • Add to bullet #33 82570 and 83986 not allowed with G0480-G0483; maintenance of existing logic to not allow validity testing with definitive drug testing CPT codes
12/01/2015	Revised: Section 1: 58. Code C9257 will be removed from our always bundled rule #25; adding a note for an exception to bullet #28 outpatient HCPCS "C" codes **exception: C9257 for injection, bevacizumab (Avastin), 0.25 mg 59. Adding a bullet that services identified by HCPCS "G" or "Q" codes performed in the home or hospice setting when reported on a CMS-1500 claim form will be always bundled Section 2: Adding urine creatinine (82570) or urine pH (83986) when reported with presumptive and/or definitive drug testing codes 80300-80377 & 83992 to validate accuracy of test results will not be eligible for reimbursement
11/03/2015	Revised: 1. Adding to section 1 as always bundled codes 99415 and 99416, which will be effective 01/01/2016 2. These codes represent prolonged clinical staff service (beyond the typical service time); we consider this service to be "incident to" or inclusive to the E/M service
10/06/2015	Revised: 1. Adding back to section 1 coding table S0310 (add on code for hospitalist service) and S0315-S0317 (disease mgmt.); codes inadvertently dropped off coding table 2. Adding to section 2: a. Deny procedures S0395 (casting), A4580 (cast supplies) and A4590 (special casting materials) as mutually exclusive when reported with L3000, L3010, L3020 and L3030 (custom foot orthotics); not being added to Modifier 59 policy because an override modifier will deny under Rule 8 for invalid use of modifier. b. 95940 (continuous intraoperative neurophysiology monitoring in the O/R, one on one, each 15 minutes) mutually exclusive to 95941 (continuous intraoperative neurophysiology monitoring, outside the O/R or more than one case, per hour) Add incidental edits to deny 77014 (CT guidance for placement of radiation therapy fields) when reported with 77280, 77285, and 77290 (therapeutic radiology simulation-aided field setting procedures)
07/07/2015	Revised: Additions to section 1 (always bundled):

	1) 98960 (education and training for patient self-management by a qualified, non-physician health care professional, individual); instructing the patient about the self-management of a condition is considered by the Health Plan to be part of the counseling included in an E/M service; considered part of the overall care of the patient and should not be separately reimbursed; codes 98961 (2-4 pts) and 98962 (5-8 pts) are currently always bundled services and identified in the policy (all are covered under bullet #29) 2) Q9977 (compounded drug, NOC) identified in new bullet #8 as compounded drugs that are not a part of Health Plan approved drugs, programs, services, or supplies 3) S5000 (prescription drug, generic), S5001 (prescription drug, brand name) (covered under bullet #19) 4) S8262 (Mandibular orthopedic repositioning device, each) (covered under bullet #19) Additions to section 2 (code pairs): 1) Diagnostic esophagogastroduodenoscopy (EGD) when performed with laparoscopy, surgical, gastric restrictive procedures--43235 reported with 43770, 43771, 43772, 43773, 43774, and/or 43775 (according to one of our NY medical directors, the EGD is being done to check for a leak from the bariatric surgery and, therefore, an integral part of the operation, and does not merit additional reimbursement; we are putting the edit back in that McKesson deleted in April 2) Introduction of needle or intracatheter, vein, when reported with injection and infusion services--36000 reported with 96360, 96365, 96374, 96375, 96376, 96405, 96406, 96409, 96413, 96416, 96440, 96446, 96450, and/or 96542 3) Tissue marker when reported with breast biopsies that include placement of breast localization device(s) and/or percutaneous placement of breast localization device(s)--A4648 reported with 19081-19101 and/or19281-19288
06/02/2015	Revised: 1) Adding S9992 to section 1 as an always bundled service even though the volume was minimal 2) Adding information to section 2 that column chromatograph/mass spectrometry non-drug analyte testing services (codes 82541 – 82544) are not eligible for separate reimbursement when reported with drug screening or definitive drug testing services (codes 80300, 80301, 80302, 80303, 80304, 80320 – 80377); there will be no modifier override therefore the codes are included in the Modifier 59 reimbursement policy 3) Remove information on digital breast tomosynthesis (DBT)—codes from section 1 (77061, 77062, 77063, & G0279) and language & coding from section 2 (76499); medical policy to handle (see also 3D Radiology policy)
04/07/2015	Revised:

	1) Under the description section and policy section #1, adding the X modifiers; these are new non-site specific modifiers for 2015 that could potentially override a bundled service 2) The project to add "S" codes to the always bundled edit has identified a few additional codes that will go into the policy—S9208, S9480, S9484, S9485, S9992, S9999; local plans will add if there are no exceptions 3) In section 2 we are adding a. annual wellness visits—G0438 and G0439--will bundle to preventive exams b. needles reported with acupuncture services—A4215 with 97810-97814 c. correcting information on coding for electrodes and electric stimulator supplies and the services they are bundled with d. also correcting typo for bullet 16 in coding section 2 (S0610-S0612 s/b S0610-S0613)
02/03/2015	Revised: • Section 1: 1) Revise bullet for DME that delivery, instruction, and/or set-up fees for DME are always bundled 2) Consolidate information for always bundled "S" codes to state: "Health Plan non-approved drugs, programs, services, and supplies identified by certain Healthcare Common Procedural Coding System (HCPCS Level II) "S" codes including, but not limited to, disease management programs, or when a corresponding national code exists"; additional "S" codes are being added to the code table as always bundled based on the ongoing "S" code review project—S0257, S1015, S1016, S3005, S4005, S4011, S4022, S4025, S4027, S4028, S4035, S4037, S4040, S4042, S8096, S8097, S8100, S8101, S8415, S9098, S9110, S9900, S9901 3) Consolidate information for always bundled patient care planning type services to state: "patient care planning services the Health Plan considers part of overall care responsibility including, but not limited to, advanced care planning, care coordination, care management, care planning oversight, education and training for patient self-management, medical home program, comprehensive care coordination and planning (initial and maintenance), physician care plan oversight, team conferences, transitional care management/planning, etc."; additional applicable codes added to the code table—34839, 98961 & 98962 (education and training for pt self mgmt), 99490, 99497 & 99498 (advanced care planning) 4) Consolidate information for always bundled "G" codes to state: "programs, services, and supplies identified by certain HCPCS Level "G" codes created for CMS use including, but not limited to, reporting codes (e.g., for functional limitation), Federally Qualified Health Center (FQHC) visits, quality measures, services related to CMS "coverage with evidence development (CED)" clinical trials, CMS

	demonstration programs, drug screen testing, etc. or when an alternate CPT code exists; additional G codes being added to the code table—G0276, G0431, G0434 (these two codes—G0431 & G0434 were previously used to identify drug screening with a frequency of 1 based on patient encounter however CPT has issued new codes for drug screening therefore these 2 G codes are no longer applicable for our reimbursement), G0466-G0470 5) There have been codes deleted in the G0908-G0922 range therefore the range has been updated to G0913-G0918 which are still active codes 6) Adding digital breast tomosynthesis to the last bullet of always bundled 3D imaging services along with the corresponding codes being added to the code table—77061, 77062, 77063, G0279 7) Bullet #40--Removing "Quality Measure codes, and HCPCS Functional Limitation codes" language; duplicative with language in #36 • Section 2: Policy section descriptions-- 1) Under the policy section 2 description, adding modifiers XE, XP, XS, and XU to policy cross-reference for Modifier 59 policy 2) Adding language to #5 regarding unspecified code for digital breast tomosynthesis is bundled to mammographies or breast MRIs; the code 76499 has been in the coding section just being a bit more definitive in the description for this scenario even though DBT has new codes for 2015 (see section #1) 3) Minor update to #9 to make catheter care an example of per diem home infusion therapy since additional HIT codes were added to the edit 4) Adding that urine test or reagent strips or tablets are bundled with urinalysis tests (#23) Coding section— 1) Adding the codes for supplies and services included with the per diem HIT codes 2) Under bullet #22, we will only reference that 76942 (u/s guidance) is not eligible when reported with CPT codes listed in the CPT parenthetical statement" rather than listing each of the parenthetical codes 3) Add bullet #23 A4250 u/a test supplies with u/a codes 81000-81003 Section 3 : Adding reference to the "X" modifiers in the description
11/04/2014	Revised: Adding the following code to code bundling to section 2 of the policy (rule 26): 1. Electrodes (A4556) and/or lead wires (A4557) reported with electrical stimulator supplies (A4595) on the same date of service and/or within 30 days will be denied; the electric stimulator supplies include the electrodes and wires

	2. Home infusion therapy professional pharmacy services, drug administration (S9810), equipment, and supplies (E0776 IV pole) when reported with per diem home infusion therapy catheter care/maintenance (S5497) a. S5497 is the per diem home infusion therapy care code that includes care and all necessary equipment and supplies b. Instructions for S9810 states “do not use this code with any per diem code” and code S5497 is identified as a “per diem” code
11/01/2013	Review approved
12/08/2012	Initial approval and effective

References and Research Materials

This policy has been developed through consideration of the following:

- American Medical Association (AMA)
- CMS
- Current Procedural Terminology (CPT®)
- 2018Healthcare Common Procedural Coding System (HCPCS Level II) 2017

Definitions

Bundled Services	Services that are not eligible for separate reimbursement and considered to be part of another service.
General Reimbursement Policy Definitions	

Related Policies and Materials

Distinct Procedural Services - Modifiers 59, XE, XP, XS, XU
Moderate Sedation
Modifiers 25 and 57
Screening Services with Evaluation and Management Services

Use of Reimbursement Policy

This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a member’s benefits on the date of service. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.