Anthem Blue Cross and Blue Shield
Commercial Professional Reimbursement Policy

**Subject:** Bundled Services and Supplies

| ME Policy: C-08003 | Committee Approval: 10/05/2018 | Effective: 03/01/2019 |

Coverage is subject to the terms, conditions, and limitations of an individual member’s programs or products and policy criteria listed below. This reimbursement policy also applies to Employer Group Retiree Medicare Advantage programs.

**Description**
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 standalone service.

This policy is divided into 3 sections:
- Section 1 provides a description and a list of examples 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.
- Section 2 provides a description and the code pair relationship for a number of procedures that are not eligible for separate reimbursement when performed with another specific service or item.
- 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.

This policy documents the Health Plan’s position on bundled services and supplies for CMS-1500 submitters.

**Policy Section 1: Services and supplies that are not eligible for separate reimbursement.**
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 59, XE, XP, XS, or XU will not override the denial for the bundled services and/or supplies listed below.

These bundled services and supplies may include, but are not limited to:
1. add-on code to identify services rendered by a hospitalist provider
2. administrative services requiring physician documentation (e.g., recertification, release forms, physical/camp/school/daycare forms, etc.)
3. all practice overhead costs, such as heat, light, safe access, regulatory compliance including CDC and OSHA compliance, general supplies (paper, gauze, band aids, etc.), infection control supplies, insurance (including malpractice insurance), collections
4. application of hot or cold packs
5. bioelectrical impedance analysis whole body composition assessment, supine position, with interpretation and report
6. Centers for Medicare & Medicaid Services’ (CMS’) Medicare Approved Bundled Payments for Care Improvement Initiative
7. collection/analysis of digitally/computer stored data
8. compounded drugs that are not a part of Health Plan approved drugs, programs, services, or supplies
9. copies of test results, X-ray DVD or films for patient
10. costs to perform participating provider agreement requirements, such as prior authorizations, appeals, notices of non-coverage
11. definitive drug testing CPT codes (providers must report definitive drug testing by using the HCPCS “G” codes in lieu of the CPT codes)
12. delivery, instruction, and/or set up fees for durable medical equipment (DME)
13. determination of venous pressure
14. disease management programs that are not approved by the Health Plan
15. equipment and/or enhanced technology as part of a procedure, test, or treatment (e.g., robotic surgical systems, radiation oncology treatment tracking systems including “Clarity”)
16. evaluation of cervicovaginal fluid for specific amniotic fluid protein(s) (e.g., placental alpha microglobulin-1 [PAMG-1], placental protein 12 [PP12], alpha-fetoprotein), qualitative, each specimen (e.g., AmniSure®)
17. global fee for urgent care centers
18. handling and/or conveyance fees
19. heparin lock flush solution or kit for non-therapeutic use
20. hospital mandated on-call service
21. implantable device for fallopian tube occlusion
22. insertion of a Bakri balloon for treatment of post-partum hemorrhage
23. insertion of a pain pump by the operating physician during a surgical procedure
24. internal spinal fixation by wiring of spinous processes
25. monitoring feature or device, stand-alone or integrated, any type, including all accessories, components and electronics
26. online assessment and management by a qualified non-physician health care professional
27. outpatient HCPCS Level II “C” codes
   **exception: C9257 for injection, bevacizumab (Avastin), 0.25 mg and C9032 for injection, voretigene neparvovec-rzyl, 1 billion vector genome (Luxturna).**
28. patient care planning services the Health Plan considers part of overall care responsibility including, but not limited to, care coordination, education and training for patient self-management, medical home program, comprehensive care coordination and planning (initial and maintenance), physician care plan oversight, team conferences, etc.
29. peak expiratory flow rate
30. pharmacy and other dispensing services and/or supply fees, etc.
31. photography
32. physician interpretation and report of molecular pathology procedures
33. placement of an occlusive device into a venous or arterial access site, post op/procedural
34. postoperative follow up visit during the global period for reasons related to the original surgery
35. preparation of fecal microbiota for instillation, including assessment of donor specimen
36. prescriptions, electronic, fax or hard copy, new and renewal, including early renewal
37. 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, or when a current definitive CPT or definitive HCPCS code exists that describes the service
Anthem Blue Cross and Blue Shield
Commercial Professional Reimbursement Policy

** exception: report definitive drug testing with HCPCS “G” codes in lieu of the CPT codes for definitive drug testing
40. prolonged clinical staff service (beyond the typical service time)
41. prolonged E/M service before and after direct patient care
42. prolonged physician in-patient service
43. pulse oximetry
44. “Reporting only codes” including CPT Category II supplemental tracking codes for performance measurement
45. review of medical records
46. routine post-surgical services such as dressing changes and suture removal
47. services identified by HCPCS “G” or “Q” codes performed in the home or hospice setting when reported on a CMS-1500 claim form
48. spinal surgery only graft (allograft, morselized; autograft, same incision)
49. standby services
50. stat laboratory request
51. state or federal government agency supplied vaccines
52. sterile water, saline, and/or dextrose, 10 ml
53. surgical/procedural/testing supplies and materials supplied by the provider rendering the primary service (e.g., surgical trays, syringes, needles, sterile water, etc.)
54. telephone consultations with the patient, family members, or other health care professionals
55. trauma response team associated with hospital critical care service
56. travel allowance for laboratory specimen pick-up
57. 3D rendering of imaging studies

Coding Section 1: Services and supplies that are not eligible for separate reimbursement.
To reference the listing of code examples the Health Plan has designated as “always bundled” and not eligible for separate reimbursement please close out of this policy and refer to the separate document under Bundled Services and Supplies titled “Bundled Services and Supplies Section 1 Coding.”

Policy Section 2: Procedures, services, and supplies that are not eligible for separate reimbursement when reported with another specific procedure, service, or supply.
These bundled services and supplies may include, but are not limited to, the services and supplies listed below. For example, see also our Modifiers 59 and XE, XP, XS, & XU (Distinct Procedural/Separate/Unusual Service) and Evaluation and Management Services and Related Modifiers -25 & -57 reimbursement policies for those instances when bypass modifiers will not override the denial when reported with a specified service or supply.

1. annual wellness or initial preventive visits when reported with preventive medicine evaluation and management services
2. arthroscopic debridement when reported with same joint arthroscopic surgery of the shoulder or elbow
3. arthrodesis, posterior or posterolateral technique, single level, each additional, reported with arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar
4. breast pump replacement supplies when reported on the same date of service as the breast pump
5. cast supplies, special casting materials, and/or impression casting of a foot reported by a practitioner other than the manufacturer of the orthotic reported with custom foot orthotics
6. cervical or vaginal cancer screening, pelvic and clinical breast examination when reported with preventive/annual or problem oriented E/M service (See also our Screening Services with Evaluation & Management Services reimbursement policy.)
7. cervical or vaginal cytopathology when reported with a preventive/annual or problem oriented E/M service
8. collection of blood specimen from a completely implantable venous access device or an established venous central or peripheral catheter when reported with any service (for example E/M services) other than a laboratory service
9. column chromatography, includes mass spectrometry, if performed, non-drug analyte(s) not elsewhere specified, qualitative or quantitative, each specimen when reported with drug screening, confirmatory drug testing, or breath hydrogen or methane test
10. computed tomography guidance for placement of radiation therapy fields when reported with therapeutic radiology simulation-aided field setting procedures
11. continuous intraoperative neurophysiology monitoring in the O/R, one on one, each 15 minutes reported with continuous intraoperative neurophysiology monitoring, outside the O/R or more than one case, per hour
12. daily hospital management of epidural or subarachnoid continuous drug administration for postoperative pain management reported with a therapeutic or diagnostic spinal injection described as without or with imaging
13. developmental screening when reported with administration and interpretation of health risk assessment instrument
14. diagnostic esophagogastrroduodenoscopy (EGD) when reported with laparoscopy, surgical, gastric restrictive procedures
15. digital analysis of electroencephalogram (EEG) when separately reported with EEG recording and interpretation services on the same date of service
16. digital analysis of electroencephalogram (EEG) when separately reported on subsequent dates of service of EEG recording and interpretation services
17. digital rectal exam for prostate cancer screening when reported with a preventive or problem oriented E/M service (See also our Screening Services with Evaluation & Management Services reimbursement policy.)
18. drug test(s), definitive...qualitative or quantitative, all sources, includes specimen validity testing, per day; 1-7 or 8-14 or 15-21 or 22 or more drug class(es), including metabolite(s) if performed when reported with drug test(s), definitive...qualitative or quantitative, all sources, includes specimen validity testing, per day, any number of drug classes
19. electrical stimulator supplies with electric stimulation modalities
20. electrodes with other services such as electrocardiogram (EKG), electroencephalogram (EEG), stress test, sleep study, electric stimulation modalities, acupuncture
21. electrodes and lead wires reported with electrical stimulator supplies on the same date of service and/or within 30 days
22. electrodes reported with conductive gel or paste
23. fluoroscopic guidance for needle placement when reported with spinal injection described as with imaging
24. home infusion therapy professional pharmacy services, drug administration, equipment, and/or supplies when reported with any per diem home infusion therapy (HIT) service (e.g., catheter care/maintenance)
25. imaging guidance (fluoroscopic, CT, or MRI) when reported with a therapeutic or diagnostic spinal injection described as without imaging
26. interpretation and report only of an EKG when reported with an E/M service
27. interpretation and report only of cardiovascular stress test or 64-lead EKG test when reported with an emergency room (ER) service
28. interpretation of radiology tests when reported with an ER or inpatient E/M service
29. introduction of needle or intracatheter, vein, when reported with injection and infusion services
Anthem Blue Cross and Blue Shield
Commercial Professional Reimbursement Policy

30. laminectomy, facetectomy and foraminotomy, each additional segment, when reported with arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar
31. major arthroscopic knee synovectomy (two or more compartments) when reported with arthroscopic knee surgeries without an approved American Academy of Orthopaedic Surgeons diagnosis
32. needles when reported with acupuncture services
33. neuromuscular junction testing when reported with continuous intraoperative neurophysiology monitoring
34. nonvascular extremity ultrasound when reported with ultrasonic guidance for needle placement
35. obtaining, preparing, and conveyance of cervical or vaginal PAP smear when reported with a preventive/annual or problem oriented E/M service (See also our Screening Services with Evaluation & Management Services reimbursement policy.)
36. open capsulectomy when reported with delayed insertion of breast prosthesis
37. preventive medicine counseling when reported with a routine comprehensive preventive medical examination
38. radiological supervision and interpretation of transcatheter therapy when reported with injection of sclerosing solution
39. regional or local anesthesia when administered in a physician’s office
40. removal of impacted cerumen when reported with audioligic function testing
41. removal of impacted cerumen by irrigation/lavage or by instrumentation when reported with evaluation and management services
42. replacement soft interface material, with continuous passive motion device
43. syringes and infusion supplies when reported with home infusion/specialty drug administration
44. therapeutic behavioral services, per 15 minutes when reported with therapeutic behavioral services, per diem
45. therapeutic, prophylactic, and diagnostic injections and infusions when reported with nuclear medicine testing
46. tissue marker when reported with breast biopsy with placement of breast localization device(s) and/or percutaneous placement of breast localization device(s)
47. ultrasonic guidance for needle placement when reported with CPT parenthetical identified procedures
48. ultrasonic guidance when reported with tendon, ligament, aponeurosis (i.e. fascia) trigger point injections
49. urine creatinine or urine pH when reported with presumptive and/or definitive drug testing codes to validate accuracy of test results
50. urine test or reagent strips or tablets when reported with urinalysis
51. vertebral corpectomies when reported with spinal arthrodesis codes unless limited circumstances are met, such as spinal fracture, spinal infection, or spinal tumor

Coding Section 2: Procedures, services, and supplies that are not eligible for separate reimbursement when reported with another specific procedure, service, or supply.
The following list identifies by code pair some examples of the procedures that are described above. The exclusion of a specific code does not indicate eligibility for reimbursement under all circumstances. These code relationships are provided as an informational tool only, to help identify some of the procedures described in Policy Section 2 above. They include, but are not limited to:
1. G0438, G0439, or G0402 with preventive E/M codes 99381-99397
2. 29822 reported with 29819, 29820, 29824, 29825, and 29827; 29823 reported with 29806, 29807, 29819, 29820, 29821, and 29825; 29837 and 29838 reported with 29834, 29835, and 29836
3. 22614 when reported with 22633
4. A4281, A4282, A4283, A4284, and A4285 when reported with E0602, E0603, and E0604
5. A4580, A4590, and/or S0395 reported with L3000, L3010, L3020, and/or L3030
6. G0101 reported with preventive, problem-oriented E/M, and annual gynecological exam codes such as 99381-99397, S0610, S0612, and 99201-99215
7. 88141-88155, 88164-88167, and 88174-88175 reported with preventive and problem oriented E/M codes such as 99381-99397, 99201-99215, G0101, G0402, G0438, G0439, S0610, and S0612
8. 36591-36592 reported with any service (for example 99201-99215, 99221-99226, 99231-99236, 99238, 99239, 99241-99245, 99251-99255, 99281-99285, 99288, 99291, 99292, 99304-99310, 99315, 99316, 99318,
Policy Section 3: Services that are not eligible for separate reimbursement when reported with any other procedure, service, or supply.

Modifiers 59, XE, XP, XS, or XU will not override the denial for the services listed below when they are reported with any other procedure, service, or supply even when the other procedure, service, or supply is denied. However, these services are eligible for reimbursement when reported as standalone services.**

- 92531 – spontaneous nystagmus, including gaze
- 92532 – positional nystagmus test
- 94150 – vital capacity, total (separate procedure)
- 94664 – demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device
- 96523 – irrigation of implanted venous access device for drug delivery systems (Per CPT parenthetical coding guidelines)

**Supplies are included in the RVUs for these codes and should not be reported separately.

Related Policies
Modifier 59, XE, XP, XS and XU
Evaluation and Management Services and Related Modifiers 25 & 57
Screening Services with Evaluation and Management Services
Moderate Sedation

References and Research Materials
This policy has been developed through consideration of the following:
- CMS
- Healthcare Common Procedural Coding System (HCPCS Level II)
### Policy History

<table>
<thead>
<tr>
<th>Date</th>
<th>Committee Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/01/2019</td>
<td>Committee Approved 10/05/2018:</td>
</tr>
<tr>
<td></td>
<td>• Add G0453 (Continuous intraoperative neurophysiology monitoring, from outside</td>
</tr>
<tr>
<td></td>
<td>the operating room (remote or nearby), per patient, (attention directed</td>
</tr>
<tr>
<td></td>
<td>exclusively to one patient) each 15 minutes (list in addition to primary</td>
</tr>
<tr>
<td></td>
<td>procedure)) to the Section 1 bundled services code list.</td>
</tr>
<tr>
<td></td>
<td>• Policy number updated.</td>
</tr>
<tr>
<td>02/23/2019</td>
<td>Committee Date 08/03/2018 Revisions:</td>
</tr>
<tr>
<td></td>
<td>• Advanced care planning and chronic care management language removed from</td>
</tr>
<tr>
<td></td>
<td>Section 1, bullet #30.</td>
</tr>
<tr>
<td></td>
<td>• Removed codes 99487-99490 and 99497-99498 from the bundled services code list.</td>
</tr>
<tr>
<td>11/01/2018</td>
<td>Committee Approved 10/05/2018:</td>
</tr>
<tr>
<td></td>
<td>• Add information to Section 1 that HCPCS code C9032 is an exception to the “C</td>
</tr>
<tr>
<td></td>
<td>codes always bundled” edit.</td>
</tr>
<tr>
<td>11/01/2018</td>
<td>Committee Approved 06/01/2018:</td>
</tr>
<tr>
<td></td>
<td>• Added language to Section 1 bullet that copies of test results that are “always</td>
</tr>
<tr>
<td></td>
<td>bundled” also include x-ray DVD or films.</td>
</tr>
</tbody>
</table>

### 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.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from Anthem Blue Cross and Blue Shield.

©2019 Anthem Blue Cross and Blue Shield