Massachusetts | Commercial

Commercial Reimbursement Policy

Subject: **Bundled Services and Supplies - Professional**	
Policy Number: **C-08003**	Policy Section: **Coding**
Last Approval Date: **06/12/2024**	Effective Date: **06/12/2024**

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 Wellpoint 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, Wellpoint 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These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements.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

Wellpoint 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

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

Policy History

06/12/2024	Review approved 06/12/2024 and effective 08/01/2024: removed codes based on updated coding requirements in new policy titled Intraoperative Neuromonitoring – Professional (C-24002); Section 1 • Removed code G0453 Section 2: • Removed codes 95940 when reported with 95941

	• Removed codes 95937 when reported with 95940, 95941, and G0453
04/24/2024	Review approved and effective 04/24/2024: Section 1 • Removed codes 98966, 98967, 98968 (allowed virtual visits) • Removed codes 99441, 99442, 99443 (allowed virtual visits)
04/06/2023	Review approved 04/06/2023 and effective (see dates below): updated coding lists; Section 1 effective 09/01/2023 • Added code G2212- removed from Prolonged Services (C-08011) • Added codes G0316- G0318 • Added codes M0001-M0005, M1150-M1210 Section 2 • Removed deleted codes 99217-99220, 99241 and 99251 and consultation codes 99242-99245, 99252-99255 from 69209 and 69210 code pair effective 12/31/2022. • 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)) effective 04/06/2023
03/22/2023	Review approved and effective: Section 1 • Added HCPCS codes S0353 and S0354 -these codes were removed from the Cancer Treatment and Planning retired policy (C-13005)
12/27/2022	Review approved 12/27/2022 and effective 07/01/2023: Section 1 • Added HCPCS codes G0310, G0311, G0312, G0313, G0314, G0315
09/14/2022	Review approved and effective 01/01/2023: Section 1 • Added CPT code 87913 effective February 21, 2022, • Added HCPCS code K1034 effective April 22, 2022
12/22/2021	Review approved: Section 1 Removed CPT codes 99000, 99001 and H0048 and added to the Laboratory and Venipuncture Services – Professional & Facility (C-21010)
07/23/2021	Review approved and effective: Section 1 • Removed HCPCS code S2900- moved to Robotic Assisted Surgery Policy (C-12007) • Removed deleted HCPCS code C9032 • Removed CPT codes 99484, 99447-99449
12/16/2020	Review approved effective 01/01/2021: Section 1 • Added HCPCS code G2211 Section 2 Removed CPT code 99201 from all section 2 code pair edits.
11/25/2020	Review approved and effective 09/08/2020: Section 1

	• Added CPT code 99072
10/30/2020	Review approved: Section 1 • Removed CPT code 99446, 99451 and 99452
09/15/2020	Review approved: Removed deleted codes, updated codes and code pairs, and updated market exemptions
08/28/2020	Review approved: Section 2 • Added HCPCS code Q3014 when reported with an E&M code in place of service of 11
08/07/2020	Revision approved: Section 2 • Added 43281, 43282, 43283, 43332, 43333 when reported with 43644, 43645, 43770, 43771, 43772, 43773, 43774, 43775, 43842, 43843, 43845, 43846, 43847, 43848, 43886, 43887 and 43888
05/27/2020	Revision approved: Section 1 • Added HCPCS code S9088
09/01/2019	Review approved: Section 1 • Removed language about transitional care mgmt. • Removed CPT codes 99495 & 99496
06/01/2019	Revision approved: updated policy section, embedded code lists into policy
05/24/2019	Review approved: • Added exemption to allow S9475 for OBOT program for Wellpoint
03/15/2019	Review approved: • Added exemption to allow CPT code 90887 for Wellpoint
02/25/2019	Review approved: Section 1 • Removed HCPCS code S0189
01/25/2019	Review approved: Section 1 • Added CPT codes 99451 and 99452
10/05/2018	Review approved effective 03/01/2019: Section 1 • Removed HCPCS code C0932 • Added HCPCS code G0453
08/03/2018	Review approved: Section 1 • Removed Advanced care planning and chronic care management language. • Removed CPT codes 99487-99490 and 99497-99498
06/01/2018	Review approved: Section 1 • Added language for X-ray DVD or film to line #8
12/15/2017	Revision approved effective 01/01/2018: Policy Reference section moved to the end of the policy;

	Section 1 • Removed language about transitional care management • Removed CPT codes 99495 and 99496 Section 2 • Added CPT code 76942 when reported with 20550 and 20551
08/01/2017	Revision approved: Section 1 • Removed HCPCS codes G0502, G0503, G0504 • HCPCS codes G0505-G0507 to remain
07/11/2017	Review approved: Section 2 • Updated and move bullet for drug testing • Updated and moved nonvascular extremity ultrasound when reported with ultrasonic guidance- for needle placement from #49 to #35 to be in alpha order • Added CPT code 76942 when reported with 20552 and 20553
06/06/2017	Review approved: Section 1 • Added CPT codes 99446-99449 Section 2 • Added CPT code 29822 when reported with 29819, 29820, 29824, 29825, and 29827 • Added CPT code 29823 when reported with 29806, 29807, 29819, 29820, 29821, and 29825 • Added CPT code 29837 and 29838 when reported with 29834, 29835, and 29836 • Added HCPCS codes A4281, A4282, A4283, A4284, A4285 when reported with E0602, E0603, E0604
04/04/2017	Review approved: Section 2 • Removed CPT codes 80300-80304 and replaced with 80305-80307 for presumptive drug testing • Removed HCPCS codes G0477-G0479 for presumptive drug testing • Added HCPCS code G0659 for definitive drug testing • Removed CPT codes 82541, 82543 and 82544 • Added HCPCS codes G0480-G0483 when reported with G0659 • Removed CPT code 22614 when reported with 22600, 22610, 22612, 22630; line item will now be CPT code 22614 when reported with 22633
02/07/2017	Review approved: Section 2 • Added CPT codes 62320, 62321, 62322, 62323, 62324, 62325, 62326, 62327 when reported with image guidance or hospital management service • Removed codes for spinal injections
12/06/2016	Review approved: Section 1 • Added HCPCS codes G0500, G0501, G0502-G0507 • Added HCPCS codes T1040 and T1041 • Removed CPT codes 80300-80304, 80305-80307

	• Removed HCPCS code GMMM1
10/04/2016	Review approved and effective 01/01/2017: • Moved section 1 code list from inside policy to separate document link. Section 1 • Added CPT codes 80305-80307 ○ providers should still use 2016 HCPCS codes G0477, G0478 and G0479 • Added HCPCS code G0498 • Removed CPT codes 80300-80304 Section 2 • Added CPT codes 99151, 99152, 99153, 99155, 99156, and, 99157 when reported with codes previously listed in Appendix G of the CPT codebook • Added HCPCS codesG0402, G0438, G0439 when reported with 88141-88155, 88164-88167, and 88174-88175 • Added CPT Code 95937 when reported with 95940, 95941, or G0453 • Added CPT coded 22614 when reported with 22600, 22610, 22612, 22630 and 22633 • Added CPT code 76942 when reported with 76881
09/06/2016	Revision approved: Section 2 • Added CPT code 63048 when reported with 22633 • Added CPT code 82542 when reported with 91065 • Added HCPCS codes G0101, G0610, and G0612 to 88141-88155, 88164-88167, and 88174-88175 when reported with preventive/annual or problem-oriented E/M • Added CPT code 22558 when reported with 63081-63088
08/02/2016	Review approved: Section 2 • Added CPT code 95957 when reported with 95951, 95953, 95954 and 95956 • Added CPT 95957 when reported with 95950, 95951, 95953, 95954, 95955 and 95956 on subsequent dates of service • Added CPT codes 76942, 77002, 77003, 77012, 77021 when reported with 62310, 62311, 62319, 62319
04/05/2016	Review approved: Section 1 • Added HCPCS Codes G9481-G9490 and • Update language on current bullet #39 to read “preceding bullet” Section 2 • Added HCPCS code G0402, G0438 and G0439 when reported with 99381-99397 • Added CPT code 69209, 69210 and G0268 when reported on the same date of service as audiologic function testing
02/02/2016	Review approved: Section 1 • Added HCPCS code G0180 • Added HCPCS code T2002

	• Added CPT code 99360 separate from prolonged services codes 99356-99359 • Removed S0353, S0354 for cancer treatment planning Section 2 • Added HCPCS code A4556 when reported with A4558 • Added CPT codes 69209 & 69210 when reported with any evaluation and management services • Added supply codes not payable with home infusion codes 99601 and 99602
01/05/2016	Review approved: Section 1 • Added the presumptive and definitive drug testing CPT codes 803XX • Removed HCPCS codes G0431 and G0434 Section 2 • Added CPT codes 29876, 29879 and 29880-29887 when reported with arthroscopic knee surgeries without an approved American Academy of Orthopedic Surgeons diagnosis • Added procedure codes 82570 and 83986 when reported with G0480-G0483
12/01/2015	Review approved: Section 1 • Removed HCPCS Code C9257 • Added a note for an exception to bullet #28 outpatient HCPCS “C” codes **exception: C9257 for injection, bevacizumab (Avastin), 0.25 mg • Added language that 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: • Added 82570, 83986 when reported with 80300-80377 & 83992
11/03/2015	Review approved and effective 01/01/2016: Section 1 • Added CPT codes 99415 and 99416
10/06/2015	Review approved: Section 1 • Added S0310 and S0315-S0317 codes inadvertently dropped off coding table Section 2 • Added HCPCS codes S0395, A4580 and A4590 when reported with L3000, L3010, L3020, and L3030 • Added CPT codes 95940 when reported with 95941 • Added CPT codes 77014 when reported with 77280, 77285, and 77290
07/07/2015	Revised approved: Section 1 • Added CPT codes 98960, 98961 and 98962 • Added HCPCS code Q9977 • Added HCPCS codes S5000, S5001 • Added HCPCS code S8262 Section 2

	• Added CPT code 43235 when reported with 43770, 43771, 43772, 43773, 43774, and/or 43775 • Added CPT code 36000 when reported with 96360, 96365, 96374, 96375, 96376, 96405, 96406, 96409, 96413, 96416, 96440, 96446, 96450, and/or 96542 • Added procedure codes A4648 when reported with 19081-19101 and/or 19281-19288
06/02/2015	Revision approved: Section 1: • Added S9992 • Removed 77061, 77062, 77063, G0279 and 76499 Section 2: • Added codes 82541 – 82544 when reported with drug 80300, 80301, 80302, 80303, 80304, 80320 – 80377
04/07/2015	Revision approved: Section 1: • Added modifiers XE, XP, XS, XU to section 1 description section • Added S9208, S9480, S9484, S9485, S9992, S9999 Section 2: • Added G0438 and G0439 when reported with preventive exams • Added A4215 when reported with 97810-97814 • correcting information on coding for electrodes and electric stimulator supplies and the services they are bundled with • also correcting typo for bullet 16 in coding section 2 (S0610-S0612 s/b S0610-S0613)
02/03/2015	Revised: Section 1: • Revise bullet for DME that delivery, instruction, and/or set-up fees for DME are always bundled • 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 • 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) • 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 • There have been codes deleted in the G0908-G0922 range therefore the range has been updated to G0913-G0918 which are still active codes. • 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. • Bullet #40--Removing "Quality Measure codes, and HCPCS Functional Limitation codes" language; duplicative with language in #36 Section 2: Policy section descriptions-- • Under the policy section 2 description, adding modifiers XE, XP, XS, and XU to policy cross-reference for Modifier 59 policy • 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) • 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 • Adding that urine test or reagent strips or tablets are bundled with urinalysis tests (#23) Coding section— • Adding the codes for supplies and services included with the per diem HIT codes • 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. • 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	Revision approved: Section 2: • Added A4556 and/or A4557 when reported with A4595 on the same date of service and/or within 30 days will be denied. • Added S9810 and E0776 when report with S5497
01/08/2013	Revision approved: Section 1: • Added codes 98966-98968, and 98969 • Added codes 99441-99443
10/21/2008	Revised: "Always" was eliminated from the title of the policy; the policy was divided into 2 sections to distinguish "Option #1" codes from relationship services not eligible for separate reimbursement when reported with specific other services; added language Modifier 59 will not override section 1 codes.

03/10/2008	Initial approval and effective

References and Research Materials

This policy has been developed through consideration of the following:

- Business decision
- CMS
- Optum EncoderPro 2024

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

Modifiers 25 and 57: Evaluation and Management Services and Related - Professional
Modifier 59 and XE, XP, XS and XU: Distinct Procedural/Separate/Unusual Service - Professional

Use of Reimbursement Policy
State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, take precedence over Reimbursement Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.