UniCare Professional Reimbursement Policy

Subject: Bundled Services and Supplies

Policy #: UniCare – 0008  Committee Approval: 06/01/2018  Effective: 11/01/2018

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Description
UniCare 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:
- 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, whether they are reported with another service or 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. See also our Modifiers 59 and XE, XP, XS, & XU Reimbursement Policy for additional information.
- 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 UniCare’s position on bundled services and supplies for CMS-1500 submitters.

Policy Section 1: Services and supplies 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, & 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. coronary therapeutic services and procedures add-on codes
11. costs to perform participating provider agreement requirements, such as prior authorizations, appeals, notices of non-coverage
12. definitive drug testing CPT codes (providers must report definitive drug testing by using the HCPCS “G” codes in lieu of the CPT codes)
13. delivery, instruction, and/or set up fees for durable medical equipment (DME)
14. determination of venous pressure
15. disease management programs that are not approved by UniCare
16. 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”)
17. 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®)
18. global fee for urgent care centers
19. handling and/or conveyance fees
20. Health Plan non-approved drugs, programs, services, and supplies identified by certain HCPCS “S” codes including, but not limited to, disease management programs, or when another CPT®′ or HCPCS code exists
21. heparin lock flush solution or kit for non-therapeutic use
22. hospital mandated on-call service
23. implantable device for fallopian tube occlusion
24. insertion of a Bakri balloon for treatment of post-partum hemorrhage
25. insertion of a pain pump by the operating physician during a surgical procedure
26. internal spinal fixation by wiring of spinous processes
27. monitoring feature or device, stand-alone or integrated, any type, including all accessories, components and electronics
28. online assessment and management by a qualified nonphysician health care professional
29. outpatient HCPCS “C” codes
    **exception: C9257 for injection, bevacizumab (Avastin), 0.25 mg
30. patient care planning services UniCare 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, etc.
31. peak expiratory flow rate
32. pharmacy and other dispensing services and/or supply fees, etc.
33. photography
34. physician interpretation and report of molecular pathology procedures
35. placement of an occlusive device into a venous or arterial access site, post op/procedural
36. postoperative follow up visit during the global period for reasons related to the original surgery
37. preparation of fecal microbiota for instillation, including assessment of donor specimen
38. prescriptions, electronic, fax or hard copy, new and renewal, including early renewal
39. programs, services, and supplies identified by certain HCPCS “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 CPT or other HCPCS code exists
   **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 physician in-patient service
42. prolonged E/M service before and after direct patient care
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 not eligible for separate reimbursement.**
To reference the listing of code examples UniCare 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 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. See also our Modifiers 59 and XE, XP, XS, & XU 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 arthrodosis, 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 esophagogastroduodenoscopy (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 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 fluoroscopic guidance for needle placement when reported with spinal injection described as with imaging

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
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. moderate (conscious) sedation services when reported by the same provider with the diagnostic or therapeutic codes previously identified in Appendix G of the 2016 CPT codebook
33. needles when reported with acupuncture services
34. neuromuscular junction testing when reported with continuous intraoperative neurophysiology monitoring
35. nonvascular extremity ultrasound when reported with ultrasonic guidance for needle placement
36. 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.)
37. open capsulectomy when reported with delayed insertion of breast prosthesis
38. preventive medicine counseling when reported with a routine comprehensive preventive medical examination
39. radiological supervision and interpretation of transcatheter therapy when reported with injection of sclerosing solution
40. regional or local anesthesia when administered in a physician’s office
41. removal of impacted cerumen when reported with audiologic function testing
42. removal of impacted cerumen by irrigation/lavage or by instrumentation when reported with evaluation and management services
43. replacement soft interface material, with continuous passive motion device
44. syringes and infusion supplies when reported with home infusion/specialty drug administration
45. therapeutic behavioral services, per 15 minutes when reported with therapeutic behavioral services, per diem
46. therapeutic, prophylactic, and diagnostic injections and infusions when reported with nuclear medicine testing
47. tissue marker when reported with breast biopsy with placement of breast localization device(s) and/or percutaneous placement of breast localization device(s)
48. ultrasonic guidance for needle placement when reported with CPT parenthetical identified procedures
49. ultrasonic guidance when reported with tendon, ligament, aponeurosis (i.e. fascia), or trigger point injections
50. urine creatinine or urine pH when reported with presumptive and/or definitive drug testing codes to validate accuracy of test results
51. urine test or reagent strips or tablets when reported with urinalysis
52. 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 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 pair 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 S9201-99215
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, 99221-99233, 99241-99255) other than a laboratory service
9. 82542 reported with 80305-80307, 80320-80377, 83992, G0480-G0483, G0659 or 91065
10. 77014 reported with 77280, 77285, and/or 77290
11. 01996 reported with 62320, 62321, 62322, 62323, 62324, 62325, 62326, and 62327
12. 96110 reported with 99201
13. 43235 reported with 43770, 43771, 43772, 43773, 43774, and/or 43775
14. 95957 reported with 95951, 95953, 95954 and 95956 on the same date of service
15. 95957 reported on subsequent dates of service of 95950, 95951, 95953, 95954, 95955 and 95956
16. G0102 reported with preventive and problem oriented E/M codes such as 99381-99397 and 99201-99215
17. G0480-G0483 reported with G0659
18. A4556 reported with services such as 93000, 93015, 95805, 95812, 97014, 97032, 97033, 97813, and 97814
19. A4556 and A4557 reported with A4595 on the same date of service and/or within 30 days
20. A4556 reported with A4558
21. 77002 reported with 62321, 62323, 62325, and 62327
22. A4221, A4222, E0776, E0781, and S9810 reported with any per diem home infusion therapy (HIT) codes such as S5492-S5502, S9061, S9325-S9379, S9490-S9504, S9537-S9590
23. 76942, 77002, 77003, 77012, and 77021 reported with 62320, 62322, 62324, and 62326
24. 93010, 93042, reported with E/M codes such as 99201-99215, 99221-99233, and 99281-99285
25. 93018 and 0180T reported with ER codes 99281-99285
26. 700XX-788XX, G01XX-G03XX, S8035-S8092, and S9024 (these code ranges include applicable radiology interpretation codes as well as radiology codes which modifier 26 would be added to identify the professional component only) reported with 99281-99285 and/or 99221-99223
27. 36000 reported with 96360, 96365, 96374, 96375, 96376, 96405, 96406, 96409, 96413, 96416, 96440, 96446, 96450, and/or 96542
28. 63048 reported with 22633
29. 29876 reported with 29878 and 29880-29887
30. 99151, 99152, 99153, 99155, 99156, and 99157 reported by the same provider with codes previously listed in Appendix G of the 2016 CPT codebook (See our Moderate (Conscious) Sedation reimbursement policy for code list.)
31. A4215 reported with 97810-97814
32. 95937 reported with 95940, 95941, or G0453
33. 76882 reported with 76942
34. Q0091 reported with preventive, problem-oriented E/M, and/or annual gynecological exam codes such as 99381-99397, G0101, S0610-S0613, and S9201-99215
35. 19371 reported with 19342
36. 99401-99404 and 99411-99412 reported with preventive medicine service codes such as 99381-99397
37. 75894 reported with 36471
38. J2001 or when reported as J3490 with office surgery/procedure codes
39. 69209, 69210, or G0268 reported with audiologic function tests such as 92550-92558, 92561-92588, 92596
40. 75894 reported with 36471
42. 69209 and/or 69210 reported with 99201-99205, 99211-99215, 99217-99226, 99231-99236, 99238, 99239, 99241-99245, 99251-99255, 99281-99285, 99288, 99291, 99292, 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337, 99339-99345, 99347-99350, 99354-99360, 99363, 99364, 99366-99368, 99374, 99375, 99377-99387, 99391-99397, 99401-99404, 99406-99409, 99411, 99412, 99420, 99441-99444, 99446-99450, 99455, 99456, 99460-99469, 99471, 99472, 99475-99480, 99485-99487, 99489, 99490, 99495, 99496, 99496, G0466-G0470

43. E1820 reported with E0935-E0936

44. A4206, A4207, A4208, A4209, A4212, A4213, A4215, A4216, A4217, A4221, A4222, A4223, A4244, A4245, A4246, A4247, A4248, A4248, A4550, A4649, A4657, and A4930 reported with 99601 and/or 99602

45. H2019 reported with H2020

46. 96365, 96369, 96372, 96373, 96374, and 96379 reported with 78012-79999

47. A4648 reported with 19081-19101 and/or 19281-19288

48. 76942 reported with CPT codes listed in the CPT parenthetical statement

49. 76942 reported with 20550, 20551, 20552, and 20553

50. 82570 and/or 83986 reported with 80305-80307, 80320-80377, 83992, G0480-G0483, or G0659

51. A4250 reported with 81000-81003

52. 63081-63088 reported with 22551, 22552, 22554, 22558 and 22561; and 63090-63091 reported with 22612, 22614, 22558, 22585, and 22634

**Policy Section 3: Services not eligible for separate reimbursement when reported with any other procedure, service, or supply.**

Modifiers S9, 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 stand-alone 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.

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<th>Added language to Section 1 bullet that copies of test results that are “always bundled” also include x-ray DVD or films.</th>
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Policy History

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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.

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