UniCare Professional Reimbursement Policy

Subject: Bundled Services and Supplies

| Policy #: UniCare – 0008 | Adopted: 03/10/2008 | Effective: 02/07/2017 |

Coverage is subject to the terms, conditions, and limitations of an individual member’s programs or products and policy criteria listed below.

**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 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. 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 UniCare
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. 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
20. heparin lock flush solution or kit for non-therapeutic use
21. hospital mandated on-call service
22. implantable device for fallopian tube occlusion
23. insertion of a Bakri balloon for treatment of post-partum hemorrhage
24. insertion of a pain pump by the operating physician during a surgical procedure
25. internal spinal fixation by wiring of spinous processes
26. monitoring feature or device, stand-alone or integrated, any type, including all accessories, components and electronics
27. online assessment and management by a qualified nonphysician health care professional
28. outpatient HCPCS “C” codes
   **exception: C9257 for injection, bevacizumab (Avastin), 0.25 mg
29. 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, transitional care management/planning, etc.
30. peak expiratory flow rate
31. pharmacy and other dispensing services and/or supply fees, etc.
32. photography
33. physician interpretation and report of molecular pathology procedures
34. placement of an occlusive device into a venous or arterial access site, post op/procedural
35. postoperative follow up visit during the global period for reasons related to the original surgery
36. preparation of fecal microbiota for instillation, including assessment of donor specimen
37. prescriptions, electronic, fax or hard copy, new and renewal, including early renewal
38. presumptive and definitive drug testing CPT codes (providers must now report using the HCPCS “G” codes approved by CMS effective January 1, 2016 for presumptive and definitive drug testing in lieu of the CPT codes)
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: presumptive and definitive drug testing HCPCS “G” codes as referenced in the preceding bullet

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. arthrodesis, posterior or posterolateral technique, single level, each additional, reported with cervical, thoracic, or lumbar arthrodesis, posterior or posterolateral technique with or without laminectomy and/or discectomy
3. 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
4. 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 Services reimbursement policy.)
5. cervical or vaginal cytopathology when reported with a preventive/annual or problem oriented E/M service
6. 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
7. 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
8. computed tomography guidance for placement of radiation therapy fields when reported with therapeutic radiology simulation-aided field setting procedures
9. 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
10. 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
11. developmental screening when reported with administration and interpretation of health risk assessment instrument
12. diagnostic esophagogastroduodenoscopy (EGD) when reported with laparoscopy, surgical, gastric restrictive procedures
13. digital analysis of electroencephalogram (EEG) when separately reported with EEG recording and interpretation services on the same date of service
14. digital analysis of electroencephalogram (EEG) when separately reported on subsequent dates of service of EEG recording and interpretation services
15. 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.)
16. electrical stimulator supplies with electric stimulation modalities
17. electrodes with services such as electrocardiogram (EKG), electroencephalogram (EEG), stress test, sleep study, electric stimulation modalities, acupuncture
18. electrodes and lead wires reported with electrical stimulator supplies on the same date of service and/or within 30 days
19. electrodes reported with conductive gel or paste
20. fluoroscopic guidance for needle placement when reported with spinal injection described as with imaging
21. 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)
22. imaging guidance (fluoroscopic, CT, or MRI) when reported with a therapeutic or diagnostic spinal injection described as without imaging
23. interpretation and report only of an EKG when reported with an E/M service
24. interpretation and report only of cardiovascular stress test or 64-lead EKG test when reported with an emergency room (ER) service
25. interpretation of radiology tests when reported with an ER or inpatient E/M service
26. introduction of needle or intracatheter, vein, when reported with injection and infusion services
27. laminectomy, facetectomy and foraminotomy, each additional segment, when reported with arthodesis, 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
28. major arthroscopic knee synovectomy (two or more compartments) when reported with arthroscopic knee surgeries without an approved American Academy of Orthopaedic Surgeons diagnosis
29. 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
30. needles when reported with acupuncture services
31. neuromuscular junction testing when reported with continuous intraoperative neurophysiology monitoring
32. 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.)
33. open capsulectomy when reported with delayed insertion of breast prosthesis
34. preventive medicine counseling when reported with a routine comprehensive preventive medical examination
35. radiological supervision and interpretation of transcatheter therapy when reported with injection of sclerosing solution
36. regional or local anesthesia when administered in a physician’s office
37. removal of impacted cerumen when reported with audioligic function testing
38. removal of impacted cerumen by irrigation/lavage or by instrumentation when reported with evaluation and management services
39. replacement soft interface material, with continuous passive motion device
40. syringes and infusion supplies when reported with home infusion/specialty drug administration
41. therapeutic behavioral services, per 15 minutes when reported with therapeutic behavioral services, per diem
42. therapeutic, prophylactic, and diagnostic injections and infusions when reported with nuclear medicine testing
43. tissue marker when reported with breast biopsy with placement of breast localization device(s) and/or percutaneous placement of breast localization device(s)
44. ultrasonic guidance for needle placement when reported with CPT parenthetical identified procedures
45. nonvascular extremity ultrasound when reported with ultrasonic guidance for needle placement
46. urine creatinine or urine pH when reported with presumptive and/or definitive drug testing codes to validate accuracy of test results
47. urine test or reagent strips or tablets when reported with urinalysis
48. 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. 22614 when reported with 22600, 22610, 22612, 22630 and 22633
3. A4580, A4590, and/or S0395 reported with L3000, L3010, L3020, and/or L3030
4. G0101 reported with preventive, problem-oriented E/M, and annual gynecological exam codes such as 99381-99397, S0610, S0612, and 99201-99215
5. 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
6. 36591-36592 reported with any service (for example 99201-99215, 99221-99226, 99241-99255) other than a laboratory service
7. 82542 reported with 80300–80304, 80320–80377, or 91065
8. 77014 reported with 77280, 77285, and/or 77290
9. 95940 reported with 95941
10. 01996 reported with 62320, 62321, 62322, 62323, 62324, 62325, 62326, and 62327
11. 96110 reported with 99420
12. 43235 reported with 43770, 43771, 43772, 43773, 43774, and/or 43775
13. 95957 reported with 95951, 95953, 95954 and 95956 on the same date of service
14. 95957 reported on subsequent dates of service of 95950, 95951, 95953, 95954, 95955 and 95956
15. G0102 reported with preventive and problem oriented E/M codes such as 99381-99397 and 99201-99215
16. A4595 with 97014 and 97032
17. A4556 reported with services such as 93000, 93015, 95805, 95812, 97014, 97032, 97033, 97813, and 97814
18. A4556 and A4557 reported with A4595 on the same date of service and/or within 30 days
19. A4556 reported with A4558
20. 77002 reported with 62321, 62323, 62325, and 62327
21. 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
22. 76942, 77002, 77003, 77012, and 77021 reported with 62320, 62322, 62324, and 62326
23. 93010, 93042, reported with E/M codes such as 99201-99215, 99221-99233, and 99281-99285
24. 93018 and 0180T reported with ER codes 99281-99285
25. 700XX-788XX, G01XX-G03XX, S8035-S8092, and S9024 reported with 99281-99285 and/or 99221-99233
26. 63048 reported with 96405, 96409, 96413, 96416, 96440, 96446, 96450, and/or 96542
27. 63048 reported with 22633
28. 29876 reported with 29879 and 29880-29887
29. 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.)
30. A4215 reported with 97810-97814
31. 95937 when reported with 95940, 95941, or G0453
32. Q0091 reported with preventive, problem-oriented E/M, and/or annual gynecological exam codes such as 99381-99397, G0101, S0610-S0613, and 99201-99215
33. 19371 reported with 19342
34. 99401-99404 and 99411-99412 reported with preventive medicine service codes such as 99381-99397
35. 75894 reported with 36471
36. J2001 or when reported as J3490 with office surgery/procedure codes
37. 69209, 69210, or G0268 reported with audiologic function tests such as 92550-92558, 92561-92588, 92596
39. E1820 reported with E0935-E0936
40. A4206, A4207, A4208, A4209, A4212, A4213, A4215, A4216, A4217, A4221, A4222, A4223, A4244, A4245, A4246, A4247, A4248, A4550, A4649, A4657, and A4930 reported with 99601 and/or 99602
41. H2019 reported with H2020
42. 96365, 96369, 96372, 96373, 96375, and 96379 reported with 78012-79999
43. A4648 reported with 19081-19101 and/or 19281-19288
44. 76942 reported with CPT codes listed in the CPT parenthetical statement
45. 76882 reported with 76942
46. 82570 and/or 83986 reported with 80300-80377, 83992, and G0480-G0483
47. A4250 reported with 81000-81003
48. 63081-63088 reported with 22551, 22552, 22554, 22558 and 22585; and 63090-63091 reported with 22612, 22614, 22558, 22585, 22633, and 22634
**Policy Section 3: Services 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 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>Policy History</th>
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