BUNDLING GUIDELINES

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Description

Professional services are identified with Current Procedure Terminology (CPT®) codes, Healthcare Common Procedure Coding System (HCPCS Level II) codes, and International Classification of Diseases, 10th Revision, Clinical Modifications (ICD-10-CM). These codes enable the accurate identification of the service or procedure. All claims submitted by a provider must be in accordance with the reporting guidelines and instructions contained in the most current CPT®, HCPCS and ICD-10-CM publications.

Inclusion of a code in CPT ®, HCPCS, or ICD-10 does not represent endorsement of any given diagnostic or therapeutic procedure by the bodies that develop the codes (AMA, CMS, and the CDC). The inclusion of the code in CPT®, HCPCS, or ICD-10 does not imply that it is covered or reimbursed by any health insurance coverage.

Use of any CPT®, HCPCS, or ICD-10-CM code should be fully supported in the medical documentation.

Claims are reviewed to determine eligibility for payment. Blue Cross Blue Shield North Carolina (Blue Cross NC) uses several reference guidelines in developing its claims adjudication logic for services and procedures, including, but not limited to the American Medical Association's Current Procedural Terminology (CPT®) manual, the CMS Correct Coding Initiative (CCI), and Medicare (CMS) guidelines. These reference guidelines were developed for varying populations and benefit structures, and are not uniformly consistent with each other.

Services considered incidental, mutually exclusive, integral to the primary service rendered, or part of a global allowance, are not eligible for separate reimbursement. Definitions for incidental, mutually exclusive, integral, or global procedures or services are as follows:

A. Incidental Procedures
An incidental procedure is carried out at the same time as a more complex primary procedure. These procedures require little additional provider resources and are generally not considered essential to the performance of the primary procedure. For example, the removal of an asymptomatic appendix is considered an incidental procedure when done during hysterectomy surgery. An incidental procedure is not reimbursed separately.

B. Mutually Exclusive Procedures
Mutually exclusive procedures are two or more procedures that are usually not performed on the same patient on the same date of service. Mutually exclusive rules may also include different procedure code descriptions for the same type of procedures for which the provider should be submitting only one of the procedure codes. Only the most clinically intense procedure will be allowed. Generally, an open procedure and a closed procedure in the same anatomic site are not both reimbursed. If both codes accomplish the same result, the clinically more intense procedure supersedes, and the comparative code is denied as mutually exclusive.

C. Integral Procedures

Procedures considered integral occur in multiple surgery situations when one or more of the procedures are

included in the major or principal procedure. Integral procedures are those commonly carried out as part of a total service and do not meet all the criteria listed under the policy "Multiple Surgical Procedure Guidelines." Some of the procedures or services listed in the CPT® manual that are commonly carried out as an integral component of a total service or procedure have been identified by the term "separate procedure." These codes should not be reported in addition to the code for the total procedure or service of which it is considered an integral component.

D. Global Allowance
Most medical and surgical procedures include pre-procedure, intra-procedure, and post-procedure work. Reimbursement for these services is based on a global allowance. Claims for services considered to be directly related to pre-procedure, intra-procedure, and post-procedure work are included in the global reimbursement and will not be paid separately.

The pre- and post-operative global days are based on CMS standards. The global period is defined as the period of time during which claims for related services will be denied as an unbundled component of the total surgical package. Major procedures have a global period of 90 days. Minor procedures have a global period of 10 or 0 days.

The global surgical package includes all necessary services normally furnished by the surgeon before, during and after a surgical procedure. The global period also includes Evaluation and Management services that are related to the procedure. Payment for related medical or surgical services performed the day prior to, the day of, or within 90 days of a major surgical procedure is included in global allowance. Payment for related medical or surgical services performed the same day as a minor surgical procedure, as well as medical or surgical services performed within 10 days of a 10 day procedure, is included in the global allowance. Global surgery guidelines also apply to facility claims.

Policy

Services Blue Cross NC considers to be mutually exclusive, incidental to, integral to, or within the global period of the primary service rendered are not allowed additional payment. Participating providers cannot balance bill members for these services. Claims editing for bundling guidelines will apply to professional and facility claims unless otherwise stated.

Reimbursement Guidelines

The guidelines addressed in this policy are not an all-inclusive listing.

Ambulance Supplies:
The ambulance is medically equipped to include all supplies and services to provide the patient with the quality and care consistent with the transport level of care. These essential items and supplies provided by the ambulance are not separately reimbursable and are considered incidental when reported with an ambulance transportation service.

Care Plan Oversight and Coordination Services:
Care plan oversight and care coordination services are not eligible for separate reimbursement when billed within the same calendar month of a monthly ESRD service.

Dialysis Routine Supplies and Services:
Routine laboratory services, drugs and biologicals, equipment, and supplies are included in the dialysis inclusive rate and are not eligible for separate reimbursement. Please refer to provider contract, provider manual, and CMS' consolidated billing list for code specifics.

DME Bundling:
The items listed in the CMS DME Unbundled Column I/Column II document are considered incidental to/included in the allowance for the item listed in Column I, therefore separate reimbursement will not be provided for the items in Column II when provided in association with the item(s) in Column I.

"Incident to" Services:
CMS defines "incident to" services as those services furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of a condition. A physician may be reimbursed directly for "incident to" services performed by auxiliary personnel only when an employer relationship exists between the physician and the auxiliary personnel, and when the place of service code indicates the service was performed at a location typical for such an employer relationship (typically a physician office or other non-facility clinic). When the place of service code indicates the service was performed at a location not typical of a physician employer relationship (such as, but not limited to, inpatient or outpatient hospital), the service is considered an "incident to" service and is not eligible for separate reimbursement. In the unusual circumstance when an employer relationship exists between the physician and auxiliary personnel performing a service in an inpatient or outpatient facility, documentation of this arrangement could be submitted for reconsideration.

Injection and Infusion:
Infusion supplies and equipment, such as standard tubing and syringes, are included in the payment for infusion and injection services and will be denied as not separately reimbursed when billed with therapeutic, prophylactic, and diagnostic injection and infusion services by the same provider or same group practice.

Interprofessional Telephone/Internet Consultations:
This service is provided by a consulting physician at the request of the patient's primary or treating physician to assist in the diagnosis and/or management of the patient's problem without a face-to-face encounter with the consultant. 99446, 99447, 99448, 99449, 99451, 99452 are considered incidental and not eligible for separate reimbursement.

Moderate (Conscious) Sedation:
G0500 (Moderate sedation services provided by the same physician or other qualified health care professional performing a gastrointestinal endoscopy service) will be denied when a gastrointestinal endoscopic procedure has not been reported by the same physician for the same date of service.

Specimen Collection:
Specimen collection by any method (venipuncture, central venous access, nasal/throat swab, etc.) is considered incidental to Evaluation and Management services, Surgical services, and Laboratory services regardless of place of service. Separate reimbursement is not allowed for 36400, 36405, 36406, 36410, 36415, 36416, 36420, 36425, 36600, G2023, G2024, and S9529.

Rationale

The guidelines addressed in this policy are not an all-inclusive listing.

For global payment of diagnostic tests and radiology services, total payment will be based on no more than the equivalent global service regardless of whether the billing is from the same or different provider. If one provider bills for the global service and the same or different provider also bills for either the technical or professional component for the same test or service, then the first claim processed will be processed normally. The second claim processed will either be denied (if the first claim processed was for the global service) or will have the remaining component service appended to the global (if the first claim processed was for either the technical or professional component.

Out of Sequence claims are claims involving procedures where unique CPT® codes have been established for two or more components of a procedure as well as the more comprehensive procedure. In most situations, there are three separate codes, two each addressing distinct components of the procedure and a third addressing the comprehensive procedure. When all components are performed on the same date of service and are billed together, services are recoded into the more comprehensive procedure. When all components are performed on the same date of service and are billed on multiple claims at different times, the subsequent services will be denied if inclusive to the service already billed or recoded to the remaining portion of the service.

Billing and Coding

Applicable codes are for reference only and may not be all inclusive. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross NC web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Related policy

Evaluation and Management Services

Modifier Guidelines

Outpatient Code Editor (OCE) Edits

References

Healthcare Common Procedure Coding System

American Medical Association, *Current Procedural Terminology* (CPT®)

Centers for Disease Control and Prevention, International Classification of Diseases, 10th Revision

Centers for Medicare & Medicaid Services, CMS Manual System, and Medicare Claims Processing Manual 100-04

CMS National Correct Coding Initiative edits homepage:
http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html

Medicare Claims Processing Manual (cms.gov) -Ambulance Ch. 15

History

6/1/22	New policy developed. Medical Director approved. **Notification on 3/31/2022 for effective date 6/1/2022**. (eel)
12/31/2022	Routine Policy Review. Removed Care Management Section. (cjw)
12/31/2022	Added Ambulance bullet under Reimbursement Guidelines. Medical Director Approved. **Notification on 12/31/2022 for effective date 3/1/2022**. (cjw)
4/1/2023	Added Dialysis Routine Services and Supplies Section. Medical Director Approved. **Notification on 4/1/2023 for effective date 6/1/2023.** (cjw)
9/12/2023	Added DME Bundling section. Medical Director Approved. **Notification on 9/12/2023 for effective date 11/12/2023.** (tlc)

Application

These reimbursement requirements apply to all Blue Medicare HMO, Blue Medicare PPO, Blue Medicare Rx members, and members of any third-party Medicare plans supported by Blue Cross NC through administrative or operational services.

This policy relates only to the services or supplies described herein. Please refer to the Member's Evidence of Coverage (EOC) for availability of benefits. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this policy.

Legal

Reimbursement policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing, and Blue Cross NC reserves the right to review and revise its medical and reimbursement policies periodically.