

Corporate Reimbursement Policy

Bundling Guidelines

File Name:	bundling_guidelines
Origination:	1/2000
Last Review:	12/2018
Next Review:	12/2019

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. BCBSNC uses several reference guidelines in developing its claims adjudication logic for services and procedures, including the American Medical Association's Current Procedural Terminology (CPT) manual, the CMS Correct Coding Initiative (CCI), Medicare (CMS) guidelines, and ClaimCheck®. 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 necessary 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 on a claim.

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 principle procedure. Integral procedures are those commonly carried out as part of a total service and do not meet all the criteria listed under the

Bundling Guidelines

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.

See also, “Guidelines for Global Maternity Reimbursement.”

Related Policies:

ECG Reimbursement

Guidelines for Global Maternity Reimbursement

Immunization Guidelines

Intraoperative Neurophysiologic Monitoring

Modifier Guidelines

Surgical Treatment of Sinus Disease

Policy

Services considered 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.

Topics of Frequent Interest

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

Administration Fee for injectable(s) - In accordance with CPT guidelines the administration fee for injectable(s) 96372 – 96377 will be covered in addition to the cost of the drug(s), which are eligible for coverage.

After Hours Care - Services provided on weekends or holidays, or between 10pm to 8am at a facility that normally provides 24-hour services are considered mutually exclusive to an ER visit.

A facility credentialed and contracted as an urgent care center cannot submit claims for after hours care. CPT codes 99050 and 99051 are considered mutually exclusive to any service(s) provided at an urgent care center.

Bundling Guidelines

Service(s) provided between 10:00 PM and 8:00 AM at a 24-hour facility, in addition to basic service (99053), is considered incidental to Evaluation and Management services, Surgical services, and Laboratory services and are not eligible for separate reimbursement.

Office services provided on an emergency basis (99058) are considered mutually exclusive to the primary services provided.

Service(s) provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic service (99060) is considered incidental to Evaluation and Management services, Surgical services, and Laboratory services and are not eligible for separate reimbursement.

Anesthesia - Anesthesia provided by the operating physician is considered incidental to the surgical procedure. This includes sedation given for endoscopic procedures including, but not limited to, colonoscopy.

Anesthesia complicated by emergency conditions – (Add-on code 99140) is considered incidental to the procedure/administration of anesthesia.

Anticoagulant management for a patient taking warfarin (93793) is not eligible for separate reimbursement.

Balloon Sinuplasty – Balloon sinuplasty (codes 31295, 31296, 31297) performed in conjunction with functional endoscopic sinus surgery (FESS) within the same sinus cavity, is considered incidental to the major service and not eligible for separate reimbursement. Refer to policy “Surgical Treatment of Sinus Disease.”

Bone Marrow or Stem Cell Services/Procedures - Codes 38204, 38207, 38208, 38209, 38210, 38211, 38212, 38213, 38214 and 38215 are considered incidental to 38240, 38241 and 38242.

Cardiac Stress Test - A stress test may require the administration of pharmacological agents. An IV injection of a pharmacological agent is considered an integral component of the stress test and does not warrant separate reimbursement.

Care Management Services – which include complex chronic care management (99487, 99489), chronic care management (99490, 99491, G0506), transitional care management (99495, 99496), cognitive assessment and care plan services (99483, 99484), psychiatric collaborative care management (99492, 99493, 99494) are not eligible for separate reimbursement.

Casting Application and Strapping - Separate reimbursement is allowed for an initial Evaluation and Management code when billed with a casting/strapping code. In a situation where a separate, identifiable evaluation and management service is provided in addition to the casting/strapping service, such as treatment of an acute/chronic illness, modifier 25 should be used when billing. In these cases, further review of the claim and supporting documentation may be necessary to make the appropriate reimbursement decision.

Separate reimbursement will be allowed for A4590, special casting materials, hexcilit and light cast, when submitted with casting and strapping procedures 29000-29799. Due to the significantly greater cost of fiberglass, it is considered over and above what is included in standard casting application.

Casting/strapping services 29000-29799 are considered integral to surgical procedures. Established Evaluate and Management services will be denied when billed with casting/strapping services.

Reapplication and supplies necessary for casting/strapping during the follow-up period are eligible for separate reimbursement. The office visit is considered to be within the global period of the original fracture repair.

Bundling Guidelines

Chemotherapy - Evaluation and Management services will generally be denied when submitted on the same date of service as a chemotherapy administration code. If a significant, separately identifiable service is performed, modifier 25 is used. Office notes must document the significant, separately identifiable service.

Intravenous infusion codes are not allowed in addition to intravenous chemotherapy administration services unless the intravenous infusion represents a treatment apart from chemotherapy administration. The reason for a separate intravenous infusion should be noted in the medical record, and the service code modifier for a distinct procedure appended to the procedure code for intravenous infusion.

Clinical photography - for documentation/record-keeping purposes photography is considered to be an integral part of an evaluation and management (E&M) service or procedure and not eligible for separate reimbursement consideration.

Critical Care Services - Codes 36000, 36410, 36415, 36591, 36600, 43752, 43753, 71010, 71015, 71020, 92953, 93561, 93562, 94002, 94003, 94004, 94660, 94662, 94760, 94761, 94762, and are considered incidental to 99291 and 99292(Critical Care Services). Critical care service procedures will be denied as incidental when submitted with Neonatal and Pediatric Critical Care services (99466, 99467, 99468, 99469, 99471, 99472, 99475, 99476). The critical care service procedures are included in the pediatric and neonatal critical care codes.

Continuous intraoperative neurophysiology monitoring in the operating room – (95940, 95941, G0453) is considered incidental to the surgeon's or anesthesiologist's primary service and not eligible for separate reimbursement when performed and billed by the surgeon or anesthesiologist. HCPCS Code G0453 will not be allowed when billed during the same operative session as 95940 or 95941. See also Corporate Medical Policy titled, "Intraoperative Neurophysiologic Monitoring".

Electrical Stimulation Electrodes - The supply of electrodes is considered incidental to electrical stimulation. Separate reimbursement is not allowed for incidental supplies.

Electrocardiogram - Electrocardiograms are considered incidental to a stress test, a cardiac test which includes an ECG as part of the test, and as part of initial hospital care. A 3 lead ECG is considered incidental to a 12 lead ECG.

An ECG is considered mutually exclusive to provider services for cardiac rehabilitation (93797, 93798). Separate reimbursement is not provided for ECGs which are considered mutually exclusive. See also policy titled, "ECG Reimbursement."

Electromyography, Nerve Conduction Tests and Reflex Tests with Evaluation and Management Services: Evaluation and Management service will be denied when billed on the same date as electromyography, nerve conduction tests or reflex tests, unless the evaluation and management service consisted of a significant, separately identifiable service.

Hospital Mandated On Call Service: Hospital mandated on call service; in hospital, each hour (99026) and hospital mandated on call service; out of hospital, each hour (99027) will be considered incidental to Evaluation and Management services, Surgical services and Laboratory services. Separate reimbursement is not allowed for 99026 and 99027.

Immunization Administration: Evaluation and Management services will not be reimbursed separately when billed with immunization administration codes 90460 – 90474. If a significant, separately identifiable evaluation and management service is performed in addition to immunization administration, the 25 modifier must be used. The 25 modifier is not required with Preventive Medicine Services 99381 – 99397. (See also Corporate Medical Policy titled "Immunization Guidelines").

"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

Bundling Guidelines

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.

Interactive complexity: (90785) is an add-on code reported in conjunction with codes for diagnostic psychiatric evaluation and psychotherapy. It is considered incidental to the main service and is not eligible for separate reimbursement.

Interfacility transport care: supervision by a control physician of interfacility transport care of the critically ill/injured pediatric patient (99485, 99486) is considered incidental to the professional services provided on that day and is not eligible for separate reimbursement.

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.

Intraoperative use of kinetic balance sensor for implant stability during knee replacement arthroplasty (0396T) is considered incidental to the primary procedure being performed and is not eligible for separate reimbursement.

Intraoperative visual axis identification using patient fixation (0514T) is considered incidental to the primary procedure being performed and is not eligible for separate reimbursement.

Lab Tests - Lab codes 80047 - 80081 are lab panels that were developed for coding purposes. When the lab tests performed on a particular patient constitute one of the listed panels, the panel should be reported. The individual lab tests are rebundled into the lab panel code for reimbursement. Individual lab codes which constitute a panel are considered mutually exclusive to the lab panel.

Lesion Biopsy - Lesion biopsy of separate anatomical sites will be allowed in addition to surgical procedures such as removal of skin tags/ lesions and closure.

Lesion Excision and Closure - Separate reimbursement is allowed for the excision of lesion procedures when submitted with intermediate, complex, or reconstructive closures; 12031-12057, 13100-13160, 14000-14350, 15002 - 15261, and 15570-15770. Simple wound repair procedures, 12001 through 12021, will be found incidental to excision of lesions, unless the excision is a Mohs’ procedure.

Lumbar Laminectomy, Facetectomy or Foraminotomy reported with a Lumbar Spinal Fusion - When a lumbar laminectomy, facetectomy or foraminotomy is performed in conjunction with a posterior approach for a lumbar spinal fusion procedure, the laminectomy, facetectomy or foraminotomy is generally incidental, and should be bundled with the fusion. Modifiers 58, 59, 78 and 79 (or XE, XS, XP, XU) will not allow additional payment when appended to CPT codes 63005, 63012, 63017, 63030, 63035, 63042, 63044, 63047 and 63048 and when performed in conjunction with 22630, 22632, 22633, and/or 22634. Based on the most common clinical scenario, it is expected that when a lumbar laminectomy, facetectomy, and/or foraminotomy is billed with a lumbar arthrodesis, posterior interbody technique, the procedures are being performed on the same level. In the unusual clinical circumstance when the procedures are

Bundling Guidelines

performed at different vertebral levels, clinical information will be required to be submitted on appeal.

Medical Home Program: Medical home program, comprehensive care coordination and planning, initial plan (S0280) and Medical home program, comprehensive care coordination and planning, maintenance of plan (S0281) are not covered services. Separate reimbursement is not allowed for S0280 and S0281.

Medical Records Copying Fee: Medical records copying fee, administrative (S9981) and medical records copying, per page (S9982) are considered incidental to Evaluation and Management services, Surgical services, and Laboratory services and not eligible for separate reimbursement.

Moderate (Conscious) Sedation (99151, 99152, 99153) - moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status is considered incidental to Evaluation and Management services, Surgical services, and Laboratory services and is not eligible for separate reimbursement.

Monitoring feature/device: Monitoring feature/device, stand-alone or integrated, any type, includes all accessories, components and electronics, not otherwise classified (A9279) is considered incidental to all monitoring systems and not eligible for separate reimbursement.

Myocardial strain imaging (0399T) – the quantitative assessment of myocardial mechanics using image-based analysis of local myocardial dynamics for the detection of myocardial malformation is considered incidental to the primary procedure being performed and is not eligible for separate reimbursement.

New Visit Frequency – BCBSNC does not automatically reassign or reduce the code level of Evaluation and Management codes billed for covered services, with the exception of the new visit frequency editing as described here. When a claim is received reporting a new patient evaluation and management service more than once within a 3 year period, the new patient evaluation and management service code will be replaced with the equivalent established patient evaluation and management code if one is available. Otherwise the claim will be denied.

BCBSNC will replace a code billed for a subsequent office or other outpatient consultation within 6 months of the initial office or other outpatient consultation by the same provider for the same member with the appropriate level of established office visit. The crosswalk is as follows:

99241 to 99212
99242 to 99212
99243 to 99213
99244 to 99214
99245 to 99215

Observation services: By their CPT definition, the initial observation care codes and codes that include the initial observation care are for the first day of treatment. Therefore, the subsequent day of treatment should be billed with another code, such as an observation care discharge, observation follow up, or an initial hospital visit. Initial observation care and codes that include the initial observation care will be denied the day following another initial observation care code for up to three consecutive days.

Obstetrical ultrasound: Ultrasound add-on codes indicating multiple gestation will be denied when the diagnosis code does not specify multiple gestation.

First trimester obstetrical ultrasound (76801) is considered to be incidental to obstetrical ultrasound with first trimester fetal nuchal translucency measurement (76813) unless there is a separate medical necessity indication for 76801.

Bundling Guidelines

Office visit (99211) is considered mutually exclusive to 95115-95117(allergen immunotherapy) and not eligible for separate reimbursement..

Pap Smears - Obtaining a pap smear is integral to the office visit. This includes both preventive and routine office visits. Separate reimbursement is not allowed for Q0091.

Pathologists - Claims submitted by pathologists (provider specialty code 22) for clinical interpretation of laboratory results will be allowed for codes 83020, 84165, 84166, 84181, 84182, 85060, 85097, 85390, 85576, 86077, 86078, 86255, 86256, 86320, 86325, 86327, 86334, 86335, 87164, 87207 and 88333. Pathology interpretation of all other codes in the 80047-89398 range is considered integral to the laboratory test. Separate reimbursement is not allowed for integral services.

Pediatric and Neonatal Critical Care - Codes 36000, 36140, 36620, 36510, 36555, 36400, 36405, 36406, 36420, 36600, 31500, 94002, 94003, 94004, 94375, 94610, 94660, 94760, 94761, 94762, 36430, 36440, 43752, 51100, 51701, 51702 and 62270 are considered incidental to 99468, 99471 and 99475(Inpatient Neonatal and Pediatric Critical Care). The critical care procedure codes listed as a part of 99291 and 99292 are included in the Pediatric Neonatal Critical care and are considered incidental. Separate reimbursement is not allowed for incidental services.

Pharmacologic Management: (90863) including prescription and review of medication, when performed with psychotherapy services is considered incidental and is not eligible for separate reimbursement.

Physician documentation of face-to-face visit for durable medical equipment determination performed by nurse practitioner, physician assistant or clinical nurse specialist (G0454) is considered incidental to the evaluation and management service and is not eligible for separate reimbursement.

Prolonged Evaluation and Management Service: Prolonged evaluation and management service before and/or after direct (face-to-face) patient care; first hour (99358) and each additional 30 minutes (99359) is considered incidental to all evaluation and management services, surgical services and laboratory services and not eligible for separate reimbursement.

Psychiatric collaborative care management services in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (99492, 99493, 99494) are considered incidental to the evaluation and management service and are not eligible for separate reimbursement.

Pulse Oximetry - Pulse oximetry is considered incidental to office visits or procedures and not eligible for separate reimbursement.

Remote monitoring of physiologic parameter(s) and remote physiologic monitoring treatment management services (99453, 99454, 99457) are considered incidental services and are not eligible for separate reimbursement.

Resource intensive services for patients for whom the use of specialized mobility-assistive technology (such as adjustable height chairs or tables, patient lift, and adjustable padded leg supports) is medically necessary and used during the provision of an office/outpatient, evaluation and management visit. Code G0501 is considered incidental to the evaluation and management service and is not eligible for separate reimbursement.

Respiratory Treatments - Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device is considered mutually exclusive to an office visit and is not eligible for separate reimbursement.

Bundling Guidelines

Robotic Surgical Systems - Surgical techniques requiring use of robotics surgical system (S2900) is considered incidental to surgical services. Payment for new technology is based on the outcome of the treatment rather than the “technology” involved in the procedure. Additional reimbursement is not provided for the robotic surgical technique.

STAT or After Hours Laboratory Charges - Additional charges for STAT or after hours laboratory services are considered an integral part of the laboratory charge and not eligible for separate reimbursement.

Status “B” codes: CMS designates the status of HCPCS and CPT codes in the Medicare Physician Fee Schedule Database. Status B codes are bundled. Payment for these services is always included in payment for other services not specified. Status B code edits are applied to professional and outpatient facility claims. Separate payment is not made for the following codes: A4262, A4263, A4270, A4300, A4550, G0269, Q3031, 15850, 20930, 20936, 22841, 36000, 38204, 92352, 92353, 92354, 92355, 92358, 92371, 92531, 92532, 92533, 92605, 92606, 92618, 93740, 93770, 94005, 94150, 94150 –TC, 94150 -26, 96902, 97010, 97602, 99000, 99001, 99002, 99058, 99070, 99080, , 99100, 99116, 99135, 99288, 99339, 99340, 99366, 99367, 99368, 99374, 99377, 99379, 99380.

Surgical Supplies - Surgical supplies will be considered incidental to Surgical; Laboratory; Inpatient, Outpatient or Office Medical Evaluation and Management; and Consultation services.

Surgical dressings applied in the provider’s office are considered incidental to the professional services of the health care practitioner and are not separately payable. Surgical dressings billed in the provider’s office (place of service 11) will be denied.

Surgical trays and miscellaneous medical and/or surgical supplies are generally considered incidental to all medical, chemotherapy, surgery, and radiology services, including those performed in the office setting.

Supplies (except those related to splinting and casting) are considered components of the 0, 10, and 90-day global surgical package, and are not separately billable on the same date of service as the 0, 10, or 90-day procedure.

Supplies are not covered when they do not require a prescription and can be purchased by the member over-the-counter or when they are given to the member as take-home supplies. Medical and/or surgical supplies, such as dressings and packings, used during the course of an office visit are generally considered incidental to the office visit.

Anti-embolism stockings (TED hose), elastic stockings, support hose, foot coverings, leotards, knee supports, surgical leggings, gauntlets, and pressure garments for the arms and hands are examples of items that are not ordinarily covered.

Supplies and Equipment Provided in the Facility Setting: Supplies and equipment services billed in a facility setting are not reimbursable as professional services and will be denied when billed with inpatient or facility places of service.

Transvaginal Ultrasound - Transvaginal ultrasound (76830) is considered mutually exclusive to a hysterosonography with or without color flow Doppler (76831).

Travel Allowance: Travel allowance one way in connection with medically necessary laboratory specimen collection drawn from home bound or nursing home bound patient; prorated miles actually travelled (P9603) or prorated trip charge (P9604) is considered incidental to Evaluation and Management services, Surgical services, and Laboratory services and not eligible for separate reimbursement.

Urgent Care Services: Additional reimbursement will not be allowed for S9088 - Services provided in an urgent center (list in addition to code for service). This code is considered incidental to the primary service(s) rendered.

Bundling Guidelines

Venipuncture and Other Central Venous Access: Venipuncture for collection of specimens will be considered incidental to Evaluation and Management services, Surgical services, and Laboratory services. Separate reimbursement is not allowed for 36400, 36405, 36406, 36410, 36415, 36416, 36420, 36425 and S9529. Other Central Venous Access procedures for collection of blood specimens from a completely implantable venous access device (36591) and collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified (36592) will be considered incidental to Evaluation and Management services, Surgical services and Laboratory services.

Vision Services - Determination of refractive state (92015) performed incidental to a medical eye exam is permissible and may be covered when performed outside of any global allowance and subject to member benefits.

X-Rays - When the entire spine, survey study is billed (72082, 72083, 72084) with cervical spine films (72040, 72050, 72052), thoracic spine films (72070, 72072, 72074) or lumbosacral spine films (72100, 72110, 72114, 72120) only the entire spine, survey study code is allowed. When a single view X-Ray code is billed with a multiple view X-Ray code, only the multiple view X-Ray code is allowed (e.g., 72020 with 72040, 72070, or 72100). Only one professional and one technical component are allowed per X-Ray.

Benefits Application

This policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet 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.

Policy Guidelines

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).

The National Correct Coding Initiative (NCCI or CCI) was developed by the Centers for Medicare & Medicaid Services (CMS) to control improper coding leading to inappropriate payment. CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. CMS NCCI edits are a nationally recognized and widely used standard industry source to determine relationships between codes. BCBSNC uses the "Column One/Column Two" NCCI edits to determine whether CPT and/or HCPCS codes reported together by the same physician for the same member on the same date of service are eligible for separate reimbursement.

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

Bundling Guidelines

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/Coding/Physician Documentation Information

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Reimbursement Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcsnc.com. They are listed in the Category Search on the Medical Policy search page.

Applicable service codes: not applicable

Reference Sources

Medical Policy Advisory Group - 10/2003

Medical Policy Advisory Group - 03/10/2005

Medical Policy Advisory Group - 03/24/2006

Senior Medical Director – 6/23/2010

Senior Medical Director Review – 5/26/2011

Medical Director review – 3/2012

Medical Director review 5/2013

CMS National Correct Coding Initiative edits homepage:

<http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html>

Medical Director review 7/2015

RPOC review 5/2018

Policy Implementation/Update Information

1/00	Implementation
3/00	Removed Blue Edge references.
5/00	Corrected specimen handling paragraph to state will be covered. Stipulation "when performed in the provider's office and the independent laboratory (not the provider) submits claims for tests performed" has been deleted. Added to Policy Guideline section, "The guidelines addressed in this policy are not an all-inclusive listing."
9/01	Medical Policy Advisory Group review. No change in policy.
11/01	Coding format change.
5/02	Added the following codes: 87620, 87621, and 87622 (Human papillomavirus HPV) as eligible codes for pathologists. Removed the Starred procedures section from this policy. Corrected Ultrasonic Guidance for Needle Biopsy paragraph to state will be covered when services are rendered on the same day by the same provider.
12/02	Policy reformatted. Additional key words added. Additional information added regarding bundling guidelines. Coding changes.
02/03	The following statements were added "Bone Marrow or Stem Cell Services/Procedures - Codes 38204, 38207, 38208, 38209, 38210, 38211, 38212, 38213, 38214, 38215, G0265, G0266 and G0267 are considered incidental to 38240, 38241 and 38242. Separate reimbursement is not allowed for incidental services." Added the new 2003 cpt code

Bundling Guidelines

- 36416 to the Venipuncture section of the policy. Added new 2003 HCPCS code G0268 to Ear Wax Removal section of the policy.
- 4/03 This policy applies to Blue Care, Blue Choice, Blue Options, and Classic Blue products only. Clarified this point in the policy.
- 11/03 Medical Policy Advisory Group review. Policy updated with bundling edits.
- 02/04 Reference to HCFA revised to CMS.
- 3/04 The following statement added to the Injection Procedures section of the policy "Injection procedure 90782 and 90784 is considered incidental to 99211. Separate reimbursement is not allowed for incidental services." New Visit Frequency was added to this policy under the Topic of Frequent Interest section.
- 6/10/04 Removed bundling guideline for Venipuncture. Please see new policy entitled: Code Bundling Rules Not Addressed in Claim Check, Policy ADM9028 with an effective date of 6/10/04.
- 6/11/04 Effective 07/01/04. Revisions under the "Topic of Frequent Interest" section of the policy, Fluoroscopic Guidance "Fluoroscopic Guidance- In general, fluoroscopic guidance is considered incidental to the procedure being done. However, code 76005 will be allowed separately when reported with 27096, 62270-62282, 62310-62319, 64470-64484, 64622-64627. 76005 will be considered incidental to 72275 - Epidurography, radiological supervision and interpretation."
- Ear Wax Removal- Ear wax removal (69210 and G0268) is considered incidental to medical or surgical services. Separate reimbursement is not provided for ear wax removal. Notification date 04/ 22/04. Effective date 07/01/04.
- 4/07/05 Medical Policy Advisory Group reviewed policy on 03/10/2005. Removed the following statements as they no longer apply: "**Starred Procedures**- Established patient Evaluation and Management services will not be allowed unless submitted with a -25 modifier, indicating a significant, separately identifiable service. As always, office notes should document the additional services."
- 5/19/05 Revised "Voiding Pressure Studies" to "Voiding pressure (VP) (51795) studies any technique are considered incidental to intra-abdominal voiding pressure (AP) (51797) studies.
- 12/15/05 Added "Robotic Surgical Systems" to indicate that payment for new technology is based on the outcome of the treatment rather than the "technology" involved in the procedure. Additional reimbursement is not provided for the robotic surgical technique.
- 02/02/06 Removed the bundling guidelines for Anesthesia complicated by emergency conditions. See policy entitled Code Bundling Rules Not Addressed in Claim Check, **Policy Number ADM9028**.
- 02/16/06 Added the following statements under **Injection Procedures**: December 31, 2005 CPT deleted code 90782, 90783, 90784 and 90788. New January 1, 2006, CPT codes are reference in policy "Code Bundling Rules Not Addressed in Claim Check".
- Removed the following statements from Injection Procedures: Injection procedure 90788 is allowed in addition to all other medical, surgical, and chemotherapy services. Injection procedures 90782 and 90784 will be considered incidental to surgery, radiology, and anesthesia services. Injection procedures 90782 and 90784 are considered incidental to 99211. Separate reimbursement is not allowed for incidental services. Injection procedure 90783 will be considered incidental to anesthesia services. A therapeutic, prophylactic or diagnostic injection (90782) is considered mutually exclusive to professional services for allergen immunotherapy (95115-95134).

Bundling Guidelines

- Added the following information to **Introduction of Needle or Intracatheter into a Vein:** Removed December 31, 2005 deleted CPT codes 90780, 90781, 90782, and 90784. Added new 2006 CPT codes 90760, 90761, 90765, 90766, 90767, 90768, 90772, 90773, 90774, and 90775.
- 3/30/06 Added section for Allergen Immunotherapy. Added to the section Ultrasonic Guidance for Needle Biopsy - "Separate reimbursement is allowed for 76942 (Ultrasonic Guidance for Needle Biopsy) when submitted with 76645 (Ultrasound, Breast(s) (unilateral or bilateral), B-scan and or real time with image documentation). Removed the bundling guidelines for Hot or Cold Packs. Removed the bundling guidelines for Introduction of Needle or Intracatheter. Section contained information for CPT codes effective January 1, 2006. Removed the bundling guidelines under Casting Application and Strapping - "A4580, 'cast supplies (e.g., plaster),' will be considered incidental to casting/strapping codes 29000-29799. The cost of the cast or splint is included in the basic value of the application and its corresponding code and does not provide separate reimbursement."
- 5/8/06 Medical Policy Advisory Group review 3/24/06 including revisions noted above. No additional changes required to policy criteria. Policy number added to the Key Words Section.
- 6/5/06 Revised guidelines to be consistent with Medicare for reimbursement to pathologists for interpretation of clinical labs with an effective date of August 18, 2006. Notification given 06/05/2006. Live Date 8/21/2006.
- 8/21/06 Removed statement "**Injection Procedures** - December 31, 2005 CPT deleted code 90782, 90783, 90784 and 90788. New January 1, 2006, CPT codes are reference in policy "Code Bundling Rules Not Addressed in Claim Check". Removed the following CPT codes from "**Pathologists**" statement; 80500, 80502, 85060, 85097, 86077, 86078, 86079, 86499, 86510, 86580, 86585, 87620, 87621, and 87622. Added CPT codes 84166 and 86355 to "**Pathologists**" statement.
- 10/16/06 "Specimen Handling and/or Conveyance or Implementation of Orders for Devices" to "Specimen Handling and/or Conveyance." and clarified reimbursement policy for 99000. Combined statements related to Therapeutic, prophylactic or diagnostic injection (Allergen Immunotherapy) and statements related Office Visit(s). Removed "Routine office visits provided in addition to preventive health office visits are considered mutually exclusive to the preventive health office visit."
- 11/05/07 In the Pathologist section added code 85060 to the list of codes eligible for clinical interpretation. Changed the wording from "Pathology interpretation of all other codes in the 80002-87999 range is considered an integral service." to "Pathology interpretation of all other codes in the 80002-87999 range is considered an integral to the laboratory test." Changed the words "mutually exclusive" to "incidental" in the Cardiac Stress Test section. Removed code 93000 and 93040 because the incidental logic no longer applies to 99291 and 99292 in the Critical Care section. Code 93798 removed from the Electrocardiograms section. Removed code 82800, 82805, 82810, 93000, 93040 and 94640 because the incidental logic no longer applies to codes 99296, 99294, 99295, 99296 and 99298 in the Neonatal Intensive Care Services. Changed the word from "incidental" to "mutually exclusive" in the Transvaginal Ultrasound section. Removed the Maldistribution of Inspired Gas, Chlamydia Testing by Direct or Amplified Probe Technique, Fluoroscopic Guidance and Voiding Pressure Studies section. Removed any deleted codes. Policy reviewed 10/26/07 by Senior Medical Director of Provider Partnerships, Medical and Reimbursement Policy.
- 12/03/07 Preoperative and Postoperative section was removed from "Topics of Frequent Interest Related to Blue Care, Blue Choice, Blue Options, and Classic Blue Products" and added to

Bundling Guidelines

“Discussion Related to Blue Care, Blue Choice, Blue Options, and Classic Blue Products.”
Added “Administration Fee for Injectable(s): In accordance with CPT guidelines the administration fee for injectable(s) (90772 - 90775) will be covered in addition to the cost of the drug(s), which are eligible for coverage. Removed “an” from “Pathology interpretation of all other codes in the 80002-87999 range is considered an integral to the laboratory test. Added “for” to “Separate reimbursement is not allowed integral services.” Reference added to clarify that “Blue Advantage” applies to this policy.

05/05/08 Added BCBSNC does not automatically reassign or reduce the code level of evaluation and management codes billed for covered services, with the exception of the new visit frequency editing as described below. Removed any key words or deleted codes which are no longer relevant to this policy. Policy reviewed 4/4/2008 by Vice President and Senior Medical Director of Provider Partnerships, Medical and Reimbursement Policy.

6/22/10 Policy Number(s) removed (amw)

7/1/10 Added guidelines for **Balloon Sinuplasty**. If Balloon Sinuplasty is performed in conjunction with FESS it will be considered incidental to the major service and not eligible for separate reimbursement. Refer to policy titled, "Balloon Sinuplasty for Treatment of Chronic Sinusitis".

Added “**Clinical photography** - for documentation/record-keeping purposes is considered to be an integral part of an evaluation and management (E&M) service or procedure and is, therefore, not eligible for separate reimbursement consideration.”

Removed the following statement; “**Ear Wax Removal** - Ear wax removal (69210 and G0268) is considered incidental to medical or surgical services. Separate reimbursement is not provided for ear wax removal.” Refer to policy, Removal of Impacted Cerumen. Senior Medical Director review 6/23/2010. (btw)

1/18/2011 Added CPT codes 31295, 31296 and 31297 to Balloon Sinuplasty in the section “Topics of Frequent Interest.” (adn)

3/15/2011 **Lumbar Laminectomy, Facetectomy or Foraminotomy reported with a Lumbar Spinal Fusion** - When a lumbar laminectomy, facetectomy or foraminotomy is performed with a posterior approach for a lumbar spinal fusion procedure, the laminectomy is generally incidental, and should be bundled with the fusion. When a claim is submitted reporting a posterior lumbar spinal fusion (22630/ 22632) and one of the following laminectomy procedures, 63005, 63012, 63017, 63030, 63035, 63042, 63044, 63047 and 63048, the laminectomy will be denied as incidental to the primary procedure, even if the 59 modifier is appended. New 2011 CPT codes added to Critical Care Services and Neonatal Intensive Care sections. Allergen Immunotherapy and Ultrasonic Guidance for Needle Biopsy sections were removed as they do not apply to this policy any longer. Notification 3/15/2011 with an Effective date of 6/19/2011. (dpe)

6/7/2011 Further defined “When a lumbar laminectomy, facetectomy or foraminotomy is performed in conjunction with a lumbar spinal fusion procedure, the lumbar laminectomy, facetectomy or foraminotomy will be considered incidental to the lumbar spinal fusion.” Notification 3/15/2011 with an Effective date of 6/19/2011. (dpe)

Policy implementation information from 3/30/2006-05/05/2008 restored.

Added information regarding After Hours Care and Specimen Handling. “After Hours Care - Reimbursement is not provided for CPT codes 99050 and 99051 for a facility credentialed and contracted as an urgent care center” and “CPT codes 99000 and 99001, the handling and/or conveyance of specimen, are eligible for payment to the provider’s office when the laboratory service is not performed in the provider’s office and the independent laboratory bills BCBSNC directly for the test. The independent laboratory/reference laboratory will not be reimbursed for 99000 and 99001.” Removed the following information from Topics

Bundling Guidelines

of Frequent Interest Related to Blue Care, Blue Choice, Blue Options, and Classic Blue Products as not longer applicable : “**Visual Acuity Screening** - Visual acuity screening (99173) is considered incidental to routine office visits and preventive health visits. Separate reimbursement is not allowed for incidental services.” Notification given 6/7/2011 for effective date of 9/1/2011. (adn)

- 3/30/12 Added information to the Discussion section, Item D, regarding Global Allowance. The global surgical package includes all necessary services normally furnished by the surgeon before, during, and after a surgical procedure. **The following was noticed and will be effective 5/29/2012:** Supplies (except those related to splinting and casting) are considered components of the 0, 10, and 90-day global surgical package, and are not separately billable on the same date of service as the 0, 10, or 90-day procedure. 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). Claims for surgical dressings billed in the provider’s office (place of service 11) will be denied, because they are considered part of the professional/procedural service. Supplies and materials furnished by the provider (drugs, trays, and materials) above and beyond those usually included with the procedure(s) performed should be separately reported by the provider. Professional radiology services in the inpatient or outpatient hospital setting are not eligible for payment unless the provider is an anesthesiologist, neurologist, obstetrician/gynecologist, emergency medicine specialist, physical medicine specialist, radiologist, or radiation oncologist. The intent of this edit is to avoid duplicate payment for services that were performed by another provider. Normally, the radiology group associated with the hospital will bill these procedures because they performed the official interpretation; an additional allowance for a second provider’s interpretation of the test results will not be allowed. (A specific exception to this policy is made for supervision and interpretation of angiography). In the unusual situation where a provider not included among the above specialties furnishes the sole interpretation of the professional radiology service, documentation of this circumstance could be submitted for reconsideration.

In the Topics of Frequent Interest section, the following statement was added under subtitle for Chemotherapy: Intravenous infusion codes are not allowed in addition to intravenous chemotherapy administration services unless the intravenous infusion represents a treatment apart from chemotherapy administration. The reason for a separate intravenous infusion should be noted in the medical record, and the service code modifier for a distinct procedure appended to the procedure code for intravenous infusion. Added description of “out of sequence” claims to Policy Guidelines section.

Added new CPT codes 22633 and 22634 to subtitled section on Lumbar Laminectomy. (adn)

- 10/1/12 Topics of Frequent Interest. The following statement was **deleted** from the section regarding Surgical Supplies: “Supplies and materials furnished by the provider (drugs, trays, and materials) above and beyond those usually included with the procedure(s) performed are reported separately.” HCPCS codes removed from description. The remaining statements in that section are unchanged. (adn)
- 11/13/12 Revisions made to “Surgical Supplies” section under Topics of Frequent Interest for clarity. The following statements were added: “Supplies are not covered when they do not require a prescription and can be purchased by the member over-the-counter or when they are given to the member as take-home supplies. Medical and/or surgical supplies, such as dressings and packings, used during the course of an office visit are generally considered

Bundling Guidelines

- incidental to the office visit. Compression/pressure garments, elastic stockings, support hose, foot coverings, leotards, knee supports, surgical leggings, gauntlets, and pressure garments for the arms and hands are examples of items that are not ordinarily covered.” (adn)
- 12/11/12 Revision to Topics of Frequent Interest. Section regarding Balloon Sinuplasty deleted. Refer to corporate medical policy titled “Balloon Sinuplasty for Treatment of Chronic Sinusitis” for information on this procedure. (adn)
- 2/26/13 CPT code removed from list in the section on “Pathologists.” CPT 83912 was deleted as of 12/31/12. (adn)
- 5/14/13 Added the following to Topics of Frequent Interest: “**Balloon Sinuplasty** – Balloon sinuplasty (codes 31295, 31296, 31297) performed in conjunction with FESS is considered incidental to the major service and not eligible for separate reimbursement. Refer to policy “Balloon Sinuplasty for Treatment of Chronic Sinusitis.” (sk)
- 8/13/13 The following statement was added to the subsection regarding New Visit Frequency: “BCBSNC will replace a code billed for a subsequent office or other outpatient consultation within 6 months of the initial office or other outpatient consultation by the same provider for the same member with the appropriate level of established office visit.” Code equivalents for crosswalk also added. Notification given 8/13/13 for effective date 10/15/13. (adn)
- 5/13/14 Policy category changed from “Corporate Medical Policy” to “Corporate Reimbursement Policy”. Removed this statement from the Description section, item A., Incidental Procedures: “Procedures that are considered incidental when billed with related primary procedures on the same date of service will be denied.” Added the following statement related to New Visit Frequency: [claims will be recoded from New to Established evaluation and management codes if one is available] “Otherwise the claim will be denied.” Removed the statement from the Policy Guidelines that read: “BCBSNC claims systems process only one modifier per CPT code.” (adn)
- 7/28/15 Description section updated. In the Topics of Frequent Interest section, codes in the “Lab Tests” were expanded to include all lab panels 80047 – 80076. The statement in the Policy Guidelines section regarding professional radiology services in the inpatient or outpatient hospital setting was removed. Information regarding National Correct Coding Initiative added to Policy Guidelines section. (adn)
- 12/30/15 CPT Code 72010 deleted, replaced with 72082. New codes for January, 2016 added: 0396T (intra-operative use of kinetic balance sensor for implant stability during knee replacement arthroplasty) and 0399T (myocardial strain imaging) are considered incidental to the primary procedure being performed and are not eligible for separate reimbursement. Section related to specimen handling and convenience was deleted. 99000 and 99001 are not a covered service. Refer to policy titled “Code Bundling Rules Not Addressed in Claimcheck or Correct Coding Initiative.” (adn)
- 2/29/16 Deleted information regarding Vision Services. Statement revised to read: please refer to CEC's bundling guidelines related to routine vision services. **Notification given 2/29/2016 for policy effective date 5/1/2016.** (adn)
- 12/30/16 In the Topics of Frequent Interest section, code range for Administration Fee for injectable(s) was expanded to include CPT code 96377. (an)

Bundling Guidelines

- 2/24/17 Deleted information regarding Vision Services. Statement revised to read: Determination of refractive state (92015) performed incidental to a medical eye exam is permissible and may be covered when performed outside of any global allowance and subject to member benefits. (an)
- 9/29/17 Added modifiers to section regarding Lumbar Laminectomy, Facetectomy or Foraminotomy reported with Lumbar Spinal Fusion. Modifiers 58, 59, 78 and 79 (or XE, XS, XP, XU) will not allow additional payment when appended to CPT codes 63005, 63012, 63017, 63030, 63035, 63042, 63044, 63047 and 63048 and when performed in conjunction with 22630, 22632, 22633, and/or 22634. Chronic Care Management Services (99490, G0506) are considered incidental to other evaluation and management services and not eligible for separate reimbursement. **Notification given 9/29/17 for policy effective date 11/28/17.** (an)
- 12/29/17 Routine review. No change to current policy. (an)
- 1/12/18 Policy correction. Information for 9/29/17 update with notifications effective 11/28/17 was inadvertently left off the 12/29/17 version. (an)
- 5/25/18 Extensive revisions to policy. All guidelines listed in Corporate Reimbursement Policy titled "Code Bundling Rules Not Addressed in ClaimCheck or Correct Coding Initiative" have been combined with this policy and the Code Bundling Rules policy is being archived. Clarification to Balloon Sinuplasty, bundling occurs within the same sinus cavity. Codes updated throughout the policy where necessary. (an)
- 9/7/18 Added code 85097, 86077, 86078 and 88333 to the subsection titled "**Pathologists.**" These codes are allowed when submitted by pathologists for clinical interpretation of laboratory results. (an)
- 12/31/18 Pathologist specialty code corrected, replaced 29 with 22. Deleted code 99090. Added code 99491 (chronic care management). Added codes 99451, 99452 to section regarding Interprofessional Telephone/Internet Consultations. Added section regarding intraoperative visual axis identification (0514T). Added section regarding remote monitoring of physiologic parameters (99453, 99454, 99457). Removed statement regarding Medicare Status "B" from section on Prolonged Evaluation and Management Service. (an)

Medical 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 BCBSNC reserves the right to review and revise its medical policies periodically.