

Corporate Reimbursement Policy

Code Bundling Rules Not Addressed in ClaimCheck® or Correct Coding Initiative

File Name: code_bundling_rules_not_addressed_in_claim_check
Origination: 6/2004
Last Review: 12/2017
Next Review: 12/2018

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, 9th Revision, Clinical Modifications (ICD-9-DM) or 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-9-CM or ICD-10-CM publications. Use of any CPT or HCPCS code should be fully supported in the medical documentation.

Inclusion of a code in CPT, HCPCS or ICD-9 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-9 or ICD-10 does not imply that it is covered or reimbursed by any health insurance coverage.

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.

Related Corporate Reimbursement Policies:

Bundling Guidelines

Co-Surgeon, Assistant Surgeon, Team Surgeon and Assistant-at-Surgery Guidelines

Modifier Guidelines

Policy

Services considered to be incidental to the primary service rendered are not allowed additional payment. Participating providers cannot balance bill members for these services.

Code Bundling Rules not Addressed in Claim Check or Correct Coding Initiative

Anesthesia complicated by emergency conditions: (99140) is considered incidental to procedure/administration of anesthesia. Separate reimbursement is not provided for incidental services.

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

Care management services, which include complex chronic care management (99487, 99489) and transitional care management (99495, 99496) are not eligible for separate reimbursement.

Code Bundling Rules Not Addressed in ClaimCheck® or Correct Coding Initiative

Care management services for behavioral health conditions, G0507, is considered incidental to other evaluation and management services and not eligible for separate reimbursement.

Cognitive assessment and care plan services (99483, 99484) are not eligible for separate reimbursement.

Continuous intraoperative neurophysiology monitoring: codes 95940, 95941 and G0453 are 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 (sensory-evoked potentials, motor-evoked potentials, EEG monitoring)".

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").

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 and 99449 are considered incidental and not eligible for separate reimbursement.

"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.

Code Bundling Rules Not Addressed in ClaimCheck® or Correct Coding Initiative

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.

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) will be considered incidental to Evaluation and Management services, Surgical services, and Laboratory services. Separate reimbursement is not allowed for S9981 and S9982.

Miscellaneous Services: 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 separate reimbursement is not allowed.

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 separate reimbursement is not allowed.

Moderate (Conscious) Sedation: 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; under 5 years of age, first 15 minutes intra-service time (99151) is considered incidental to Evaluation and Management services, Surgical services, and Laboratory services and separate reimbursement is not allowed.

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; age 5 years or older, first 15 minutes intra-service time (99152) is considered incidental to Evaluation and Management services, Surgical services, and Laboratory services and separate reimbursement is not allowed.

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; each additional 15 minutes intra-service time (List separately in addition to code for primary service) (99153) is considered incidental to Evaluation and Management services, Surgical services, and Laboratory services and separate reimbursement is not allowed.

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. Separate reimbursement is not allowed for A9279.

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.

Code Bundling Rules Not Addressed in ClaimCheck® or Correct Coding Initiative

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.

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) is considered incidental to all evaluation and management services, surgical services and laboratory services. Separate reimbursement is not allowed for 99358.

Prolonged evaluation and management service before and/or after direct (face-to-face) patient care; each additional 30 minutes (List separately in addition to code for prolonged physician service). CPT 99359 is considered incidental to all evaluation and management services, surgical services and laboratory services. Separate reimbursement is not allowed for 99359. This is consistent with Medicare, which considers these codes to be “Status B” and not eligible for separate payment.

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.

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.

Robotic Surgical Systems: Surgical techniques requiring use of robotics surgical system (S2900) will be 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. Separate reimbursement is not allowed for the robotic surgical technique.

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, 99090, 99100, 99116, 99135, 99288, 99339, 99340, 99366, 99367, 99368, 99374, 99377, 99379, 99380.

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.

Code Bundling Rules Not Addressed in ClaimCheck® or Correct Coding Initiative

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.

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 (P9604) will be considered incidental to Evaluation and Management services, Surgical services, and Laboratory services. Separate reimbursement is not allowed for P9604.

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.

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

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 Administrative 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 codes: see the sections above

Policy Implementation/Update Information

6/10/04	Original policy issued.
4/07/05	Medical Policy Advisory Group reviewed policy on 03/10/2005. No changes to the policy required.
9/15/05	Added Cessation Counseling for Smoking and Tobacco Use.
12/15/05	Added Robotic Surgical Systems.
02/02/06	Added information regarding anesthesia complicated by emergency conditions.
02/16/06	Added information regarding Miscellaneous Services, Moderate (Conscious) Sedation, Therapeutic, Prophylactic, and Diagnostic Injections and Infusions because of new codes effective January 1, 2006.
3/30/06	Removed information and editing for Therapeutic, Prophylactic, and Diagnostic Injections and Infusions. System edits removed March 7, 2006.
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.
9/18/06	Removed the following statement from the Miscellaneous Services section: Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service (99051) is considered incidental to Evaluation and

Code Bundling Rules Not Addressed in ClaimCheck® or Correct Coding Initiative

Management services, Surgical services, and Laboratory services and separate reimbursement is not allowed.

- 3/26/07 Under the section, "Policy Statement" and "Policy Guidelines" added Blue Advantage. Under the section, "Hospital Mandated On Call Service" added verbiage "each hour" to the further clarify the code 99027 and 99026. Added the following to the "Policy Key Words" section: "Anesthesia Complicated by Emergency Conditions, Cessation Counseling for Smoking and Tobacco Use, Hospital Mandates On Call Service, Medical Records Copying Fee, Conscious Sedation, Robotic Surgical Systems, Travel Allowance and Venipuncture". Under the section, "Venipuncture" removed deleted code G0001. Under the section, "Policy Guidelines" remove the statement "BCBSNC claims systems process only one modifier per CPT code. Medical Policy reviewed by Senior Medical Director of Network Support.
- 08/27/07 Added information regarding Urgent Care Services.
- 01/28/08 Added the following statement, "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." under the section retitled from "Venipuncture" to Venipuncture and Other Central Venous Access". Removed code 36540 that was terminated on 12/31/2007. Removed the section, "Cessation Counseling for Smoking and Tobacco Use" because code G0375 and G0376 were terminated on of 12/31/2007.
- 05/05/08 Removed key words that are no longer related to policy. Policy reviewed 4/4/2008 by Vice President and Senior Medical Director of Provider Partnerships, Medical and Reimbursement Policy.
- 06/02/08 Added the following statements: 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. Separate reimbursement is not allowed for A9279
- 1/5/10 Added the following statements: 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) will be considered incidental to Evaluation and Management services, Surgical services, and Laboratory services. Separate reimbursement is not allowed for S0280 and S0281.
- 3/16/10 Information regarding prolonged care service 99358 and 99359 has been added to the policy.
- 6/22/10 Policy Number(s) removed (amw)
- 7/1/11 Added the phrase "correct coding initiative" throughout policy where appropriate. Notification given 7/1/11 for effective date 10/1/11. (adn)
- 3/30/12 Description section revised. **The following was noticed and will be effective 5/29/2012:**
"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

Code Bundling Rules Not Addressed in ClaimCheck® or Correct Coding Initiative

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 an auxiliary personnel performing a service in an inpatient or outpatient facility, documentation of this arrangement could be submitted for reconsideration. **Obstetrical ultrasound:** Ultrasound add-on codes indicating multiple gestation will be denied when the diagnosis code does not specify multiple gestation. **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. **Electromyography:** Nerve Conduction Tests and Reflex Tests with Evaluation and Management Services. Evaluation and Management service will be denied when billed the same date as electromyography, nerve conduction tests or reflex tests, unless the evaluation and management service consisted of a significant, separately identifiable service. **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. (adn)

- 9/18/12 The following was added to the Code Bundling Rules section; “**Health Risk Assessment Instrument:** A health risk assessment instrument (99420) is not reimbursed separately. It is considered incidental to the associated evaluation and management services. 99420 should not be used for developmental screening or testing. See policy entitled, Developmental Delay Screening and Testing Guidelines”. “**Real-time Intra-fraction Target Tracking:** Radiation therapy techniques requiring use of real-time intra-fraction target tracking (0197T) will be considered incidental to radiation treatment. Payment for new technology is based on the procedure rendered rather than the “technology” involved in the procedure. Separate reimbursement is not allowed for real-time intra-fraction target tracking.” Notification given 9/18/12. Policy Effective date 11/27/12. (btw)
- 12/11/12 Notification of policy updates. The following will be considered incidental to the primary service and not eligible for separate reimbursement: continuous intraoperative neurophysiology monitoring (95940, 95941 and G0453) and supervision by a control physician of interfacility transport care of the critically ill/injured pediatric patient (99485, 99486). **Notification given 12/11/12 for effective date of 2/12/2013.** (adn)
- 12/28/12 New code added for 2013. 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. (adn)
- 1/29/13 New codes added for 2013. Complex chronic care coordination services (99487-99489), continuous intraoperative neurophysiology monitoring (95940, 95941), interfacility transport care (99485, 99486), interactive complexity (90785), pharmacologic management (90863), transitional care management services (99495, 99496) are considered incidental and are not eligible for separate reimbursement. (adn)
- 2/26/13 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”). (adn)

Code Bundling Rules Not Addressed in ClaimCheck® or Correct Coding Initiative

- 7/1/13 Removed code 95941 from Continuous intraoperative neurophysiology monitoring. This section was revised to read: “codes 95940 and G0453 are 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. Continuous intraoperative neurophysiology monitoring of more than one case simultaneously, or when attention is not directed exclusively to one patient, is not eligible for reimbursement.” (adn)
- 1/1/2014 New codes added for Interprofessional Telephone/Internet Consultations. 99446, 99447, 99448 and 99449 are considered incidental and not eligible for separate reimbursement. (adn)
- 4/15/2014 The section regarding **Continuous intraoperative neurophysiology monitoring** has been revised to read: “codes 95940, 95941 and G0453 are 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 (sensory-evoked potentials, motor-evoked potentials, EEG monitoring).” (adn)
- 5/13/14 Policy category changed from “Corporate Medical Policy” to “Corporate Reimbursement Policy”. No changes to policy content. (adn)
- 12/30/14 Entry for Complex chronic care coordination services and transitional care management services combined into single entry titled “Care Management Services.” New code 99490 for chronic care management services added. Care management services: which include chronic care management (99490), complex chronic care management (99487, 99489), transitional care management (99495, 99496), and advance care planning (99497, 99498, S0257) are considered incidental to other evaluation and management services and not eligible for separate reimbursement. CPT 0197T deleted and replaced with 77387. (adn)
- 12/30/14 Counseling and discussion regarding advance directives or end of life care planning and decisions, with patient and/or surrogate (S0257) is considered incidental to other evaluation and management services and not eligible for separate reimbursement. **Notification given 12/30/14 for policy effective date of March 10, 2015.** (adn)
- 1/13/15 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. **Notification given 1/13/15 for policy effective date of March 31, 2015.** (adn)
- 3/31/15 Description section updated. HCPCS code G6017 added to statement regarding Real-time Intra-fraction Target Tracking. **Notification given 3/31/2015 for policy effective date of May 26, 2015.** (adn)
- 7/28/15 Description for Medical Home Program revised. S0280 and S0281 remain not covered services, but denial reason has changed from “incidental” to “not covered.” (adn)
- 7/28/15 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. 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, 99090, 99100, 99116, 99135, 99288, 99339, 99340, 99363, 99364, 99366, 99367, 99368, 99374, 99377, 99379, 99380. **Notification given 7/28/15 for effective date 10/1/2015.** (adn)
- 10/1/15 The use of corneal topography (92025) is considered incidental to ophthalmic services. Payment for technology is based on the outcome of the treatment rather than the

Code Bundling Rules Not Addressed in ClaimCheck® or Correct Coding Initiative

- “technology” involved in the procedure. Separate reimbursement is not allowed for corneal topography. **Notification given 10/1/15 for effective date 11/30/2015.** (adn)
- 2/29/16 Statement regarding real-time intra-fraction target tracking (codes 77387, G6017) deleted. (adn)
- 12/30/16 2017 Code Update. **New codes added:** G0501, G0502, G0503, G0504, G0507, 96160, 96161, 99151, 99152, 99153. **Codes deleted:** 99420, 99143, 99144, 99145. Care management services for behavioral health conditions, G0507, is considered incidental to other evaluation and management services. Health risk assessment, 96160, 96161 replace deleted code 99420 and are considered incidental. Moderate sedation codes 99151, 99152, 99153 are replacing codes 99143, 99144, 99145. Resource intensive services, code G0501 is considered incidental. Psychiatric collaborative care management codes G0502, G0503, G0504 are considered incidental. Incidental services are not eligible for separate reimbursement. (an)
- 1/27/17 In the section regarding Care Management Services: chronic care management (99490) and advance care planning (99497, 99498, S0257) were deleted from the list of non-covered services. (an)
- 3/31/17 The following section is deleted: A health risk assessment instrument (96160, 96161) is not reimbursed separately. It is considered incidental to the associated evaluation and management services. (an)
- 8/25/17 Section regarding Corneal Topography is deleted. See policy titled “Computerized Corneal Topography.” (an)
- 8/25/17 The following information is added to the section on **Status “B” codes:** Status B code edits are applied to professional and outpatient facility claims. **Notification given 8/25/17 for policy effective date of 10/27/17.** (an)
- 12/29/17 Status “B” Codes 99363, 99364 deleted from list. Codes added: anticoagulant management 93793; cognitive assessment and care plan services 99483, 99484; psychiatric collaborative care management services 99492, 99493, 99494. Codes G0502, G0503, G0504 were deleted. (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.