Reimbursement Policy:

Bundled Services

(Commercial and Medicare)

POLICY NUMBER	EFFECTIVE DATE:	APPROVED BY
RPC20220031	1/01/2018	RPC (Reimbursement Policy Committee)

Reimbursement Guideline Disclaimer: We have policies in place that reflect billing or claims payment processes unique to our health plans. Current billing and claims payment policies apply to all our products, unless otherwise noted. We will inform you of new policies or changes in policies through postings to the applicable Reimbursement Policies webpages on emblemhealth.com and connecticare.com. Further, we may announce additions and changes in our provider manual and/or provider newsletters which are available online and emailed to those with a current and accurate email address on file. The information presented in this policy is accurate and current as of the date of this publication.

The information provided in our policies is intended to serve only as a general reference resource for services described and is not intended to address every aspect of a reimbursement situation. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to, legislative mandates, physician or other provider contracts, the member's benefit coverage documents and/or other reimbursement, and medical or drug policies. Finally, this policy may not be implemented the same way on the different electronic claims processing systems in use due to programming or other constraints; however, we strive to minimize these variations.

We follow coding edits that are based on industry sources, including, but not limited to, CPT® guidelines from the American Medical Association, specialty organizations, and CMS including NCCI and MUE. In coding scenarios where there appears to be conflicts between sources, we will apply the edits we determine are appropriate. We use industry-standard claims editing software products when making decisions about appropriate claim editing practices. Upon request, we will provide an explanation of how we handle specific coding issues. If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may deny the claim and/or recoup claim payment.

Overview:

The purpose of this policy is to define payment criteria for covered services designated by CMS as always bundled to another physician's procedure or service to be used in making payment decisions and administering benefits. The Centers for Medicare and Medicaid Services (CMS) classifies certain procedure codes as always bundled when billed on the same claim or a historical claim containing another procedure code or codes to which the bundled code shares an incidental relationship.

Policy Statement:

This policy applies to Physician and Non-physician Practitioner Services when billed on CMS-1500 Professional Claims. This policy does not apply to Ambulance, DME, Home Infusion, and Home Care providers.

Reimbursement Guidelines:

The Center for Medicare and Medicaid Services (CMS) maintains the National Physician Fee Schedule (NPFS) which contains CPT and HCPCS procedure codes. Each of these codes has a Status Indicator code. The status code indicates whether the code is separately payable if the service is covered.

Additionally, CMS has guidance for procedure codes that are listed as in the Hospital Outpatient Prospective Payment System (OPPS) Fee Schedule. Codes for procedures/services with OPSI status "N" that are also and not payable under the physician fee schedule (explicitly NPFS Status "X" or "E" codes; because those codes that are either statutorily excluded or excluded from the physician fee schedule due to regulation) are also addressed in this policy.

EmblemHealth/ConnectiCare have aligned with CMS and consider certain services and supplies to be ineligible for separate reimbursement when reported by a professional provider. These services and/or supplies may be reported with a primary service or as a stand-alone service.

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This policy applies to those CPT/HCPCS codes with following CMS Status Indicators:

CMS Status Indicator	Description
Status “A”	**Active Code**: These codes are paid separately under the physician fee schedule, if covered. There will be RVUs for codes with this status. The presence of an "A" indicator does not mean that Medicare has made a national coverage determination regarding the service; carriers remain responsible for coverage decisions in the absence of a national Medicare policy.
Status “B”	**Bundled Code:** “Payment for covered services are always bundled into payment for other services not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident. (An example is a telephone call from a hospital nurse regarding care of a patient)."
Status “E”	**Excluded from physician fee schedule by regulation**. CMS excludes these codes for items or services from the fee schedule payment by regulation. The PFSDB Status Indicators table doesn’t show any RVUs or payment amounts and makes no payment under the fee schedule for these codes.
Status “P”	**Bundled/Excluded Codes:** There are no RVUs and no payment amounts for these services. No separate payment should be made for them under the fee schedule. • If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident (an example is an elastic bandage furnished by a physician incident to a physician service). • If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (for example, colostomy supplies) and would be paid under the other payment provisions of the act.
Status “R”	**Restricted Coverage**. Special coverage instructions apply. If covered, the service is carrier priced. (NOTE: The majority of codes to which this indicator will be assigned are the alpha-numeric dental codes, which begin with "D". We are assigning the indicator to a limited number of CPT codes which represent services that are covered only in unusual circumstances.)
Status “T”	There are RVUS and payment amounts for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the physician services for which payment is made. (NOTE: This is a change from the previous definition, which states that injection services are bundled into any other services billed on the same date.)
Status “X”	**Statutory exclusion**. These codes stand for an item or service that isn’t in the legal definition of physician services for fee schedule payment purposes. The PFSDB Status Indicators table shows no RVUs or payment amounts for these codes and makes no payment under the PFS.

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Definitions:

Term	Description
Incidental Procedure	An incidental procedure is one that is carried out at the same time as a more complex primary procedure. These procedures require minimal additional provider resources and are considered not necessary to the performance of the primary procedure.

Status B (Bundled Codes)

EmblemHealth/ConnectiCare have aligned with CMS and will not separately reimburse for certain CPT/HCPCS codes identified by the Centers for Medicare and Medicare Services (CMS) National Physician Fee Schedule (NPFS) Relative Value File with a designated status of "B" indicating a bundled procedure. **Modifiers will not override the denial for the always bundled services and/or supplies.**

*The table below is based upon the most current published list or update of **Status B** designations from CMS in the NPFS. The following codes are included below for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply coverage or provider reimbursement.*

Status "B" CPT/HCPCS Codes (Commercial)											
0537T	0538T	0539T	15850	20930	20936	22841	34839	38204	90889	92354	92355
92358	92371	92531	92532	92533	92534	92605	92606	92618	92921	92925	92929
92934	92938	92944	93740	93770	94005	94150	96902	97602	99000	99001	99002
99024	99051	99053	99060	99070	99071	99072	99080	99100	99116	99135	99140
99288	99339	99340	99366	99367	99368	99377	99379	99380	99485	99486	A4262
A4263	A4270	A4300	A4550	A4560	G0269	Q3031	R0076				

Status "B" CPT/HCPCS Codes (Medicare)											
0537T	0538T	0539T	15850	20930	20936	22841	34839	36000	36416	38204	90885
90887	90889	92352	92353	92354	92355	92358	92371	92531	92532	92533	92534
92605	92606	92618	92921	92925	92929	92934	92938	92944	93740	93770	94005
94150	96040	96902	97602	98960	98961	98962	99000	99001	99002	99024	99050
99051	99053	99056	99058	99060	99070	99071	99072	99078	99080	99100	99116
99135	99140	99288	99339	99340	99366	99367	99368	99374	99377	99379	99380
99485	99486	A4262	A4263	A4270	A4300	A4550	A4560	G0269	G0501	Q3031	R0076

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Status P (Bundled/Excluded Codes:)

EmblemHealth/ConnectiCare have aligned with CMS and will not separately reimburse for certain CPT/HCPCS codes identified by the Centers for Medicare and Medicare Services (CMS) National Physician Fee Schedule (NPFS) Relative Value File with a designated status of "P". *Status "P" procedures are primarily categorized as supply codes.*

If the procedure code is listed with a status indicator of "P," then payment for the procedure code is always included in the payment for other physician's services to which they are incidental and which are not designated as a status "P" procedure or service.

Reimbursement:

1. EmblemHealth/ConnectiCare code editing software will evaluate the current claim and historical claim lines that are billed with procedure codes designated as status "P" and compare to other procedures billed on the claims.
2. This rule reviews claims for same member, same individual physician or other health care professional and same date of service.
3. If another procedure(s) is found that is not indicated as a status "P" code, the service line with the status "P" code is denied.
4. Payment for the status "P" code is considered subsumed by the payment for the other services without the status "P" designation.
5. Procedure codes designated as status "P" will always pay when billed alone.
6. Procedure codes designated as status "P" will always pay when billed with another procedure code that also bears the status "P" designation.

*The table below is based upon the most current published list or update of **Status P** designations from CMS in the NPFS. The following codes are included below for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply coverage or provider reimbursement.*

Status "P" CPT/HCPCS Codes (Commercial and Medicare)											
A4220	A4265	A4301	A4305	A4306	A4310	A4311	A4312	A4313	A4314	A4315	A4316
A4320	A4322	A4326	A4327	A4328	A4330	A4335	A4338	A4340	A4344	A4346	A4351
A4352	A4354	A4355	A4356	A4357	A4358	A4361	A4362	A4364	A4367	A4398	A4399
A4400	A4402	A4404	A4436	A4437	A4455	A4465	A4470	A4480	A4556	A4557	A4558
A4649	A5051	A5052	A5053	A5054	A5055	A5061	A5062	A5063	A5071	A5072	A5073
A5081	A5082	A5093	A5102	A5105	A5112	A5113	A5114	A5121	A5122	A5126	A5131
A6154	A6196	A6197	A6198	A6199	A6203	A6204	A6205	A6206	A6207	A6208	A6209
A6210	A6211	A6212	A6213	A6214	A6215	A6216	A6217	A6218	A6219	A6220	A6221

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Status "P" CPT/HCPCS Codes (Commercial and Medicare)											
A6222	A6223	A6224	A6228	A6229	A6230	A6234	A6235	A6236	A6237	A6238	A6239
A6240	A6241	A6242	A6243	A6244	A6245	A6246	A6247	A6248	A6250	A6251	A6252
A6253	A6254	A6255	A6256	A6257	A6258	A6259	A6260	A6261	A6262	A6266	A6402
A6403	A6404										

Status T (Bundled/Excluded Codes:)

EmblemHealth/ConnectiCare have aligned with CMS and consider CPT® and HCPCS codes assigned a status indicator of T according to the CMS NPFS bundled into services assigned a status indicator of A or R provided on the same date of service by the Same Individual Physician or Other Health Care Professional, for which payment is made. **Modifier overrides will not prevent codes with a status indicator of T from bundling into other services.**

In some instances, a code assigned a status indicator of T is considered payable when reported alone or in the case of two codes assigned a status indicator of T being billed together with no additional service, on the same date of service by the Same Individual Physician or Other Health Care Professional. EmblemHealth/ConnectiCare will bundle the code with the lower relative value unit (RVU) into the code with the higher RVU.

*The table below is based upon the most current published list or update of **Status T** designations from CMS in the NPFS. The following codes are included below for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply coverage or provider reimbursement.*

Status "T" CPT/HCPCS Codes (Commercial and Medicare)								
36591	36592	36598	94760	94761	96523	G0117	G0118	

Anesthetic Drugs – Bundled Drugs

EmblemHealth/ConnectiCare have aligned with CMS and consider the HCPCS codes below as bundled and will not allow separate payment for these drugs when a medical or surgical procedure is performed.

Anesthetic "Caine" Drugs (Commercial and Medicare)						
J0665	J0670	J2001 *Code Deleted 10/1/2024*	J2002 *Code effective 10/1/2024*	J2003 *Code effective 10/1/2024*	J2004 *Code effective 10/1/2024*	J2402

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Status "N" Outpatient Hospital (OPPS Fee Schedule)

EmblemHealth/ConnectiCare follow the Centers for Medicare and Medicaid (CMS) Hospital Outpatient Prospective Payment System (OPPS) Fee Schedule for all codes that are covered. Codes with OPSI status indicator of "N" on Addendum B *that are also not payable under the national physician fee schedule (NPFS)* (codes with PFS status 'E' or 'X') will not be separately reimbursed.

Services Included Under OPPS:

- Designated hospital outpatient services
- Certain Medicare Part B services furnished to hospital inpatients who do not have Part A coverage.
- Partial hospitalization services furnished by hospitals or Community Mental Health Centers (CMHC)
- Hepatitis B vaccines and their administration, splints, casts, and antigens furnished by a Home Health Agency (HHA) to patients who are not under an HHA plan of treatment or to hospice patients for treatment of non-terminal illness.
- An initial preventive physical examination (IPPE) performed within the first 12 months of Medicare Part B coverage.

Services Excluded from Payment under OPPS:

- Clinical diagnostic laboratory services
- Outpatient therapy services
- Screening and diagnostic mammography

CMS Status Indicator	Description
CMS OPPS payment indicator "N"	Items or services packaged into APC rates; paid under CMS Outpatient Prospective Payment System (OPPS); payment is packaged into payment for other services. Therefore, there is no separate APC payment.

The table below is based upon the most current published list or update of CMS Addendum B – Status 'N" designations from CMS in the OPPS that are also not payable under the national physician fee schedule (NPFS) (codes with PFS status 'E' or 'X').

The following codes are included below for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply coverage or provider reimbursement.

OPPS Status "N" CPT/HCPCS Codes (Commercial and Medicare)											
99459	A4206	A4207	A4208	A4209	A4213	A4215	A4216	A4217	A4218	A4221	A4222
A4223	A4224	A4225	A4230	A4231	A4244	A4245	A4246	A4247	A4248	A4255	A4280
A4290	A4321	A4331	A4332	A4333	A4334	A4336	A4337	A4349	A4353	A4360	A4366

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OPPS Status "N" CPT/HCPCS Codes (Commercial and Medicare)											
A4368	A4369	A4371	A4372	A4373	A4375	A4376	A4377	A4378	A4379	A4380	A4381
A4382	A4383	A4435	A4453	A4458	A4459	A4461	A4463	A4481	A4483	A4559	A4560
A4561	A4565	A4595	A4596	A4604	A4605	A4606	A4608	A4614	A4615	A4616	A4617
A4618	A4619	A4620	A4623	A4624	A4625	A4626	A4628	A4629	A4634	A4648	A4650
A4660	A4663	A4680	A4690	A4706	A4707	A4708	A4709	A4714	A4719	A4720	A4721
A4722	A4723	A4724	A4725	A4726	A4730	A4736	A4737	A4740	A4750	A4755	A4760
A4765	A4766	A4770	A4771	A4773	A4774	A4802	A4860	A4870	A4911	A4913	A4918
A4927	A4928	A4929	A4930	A4931	A4932	A5510	A6025	A6410	A6411	A6501	A6502
A6503	A6504	A6505	A6506	A6507	A6508	A6509	A6510	A6511	A6512	A6531	A6532
A6545	A7025	A7040	A7041	A7047	A7048	A7501	A7502	A7503	A7504	A7505	A7506
A7507	A7508	A7509	A7520	A7521	A7522	A7523	A7524	A7525	A7526	A7527	A9156
A9268	A9269	A9284	A9583	A9584	A9597	A9598	A9603	A9697	A9698	C9150	J7505
J7599	P9615	Q0163	Q0164	Q0166	Q0169	Q0173	Q0175	Q0177	Q0180	Q0181	Q4134
Q4135	Q4136	Q4272	Q4273	Q4274	Q4275	Q4277	Q4284	V2630	V2631	V2632	V2790
A6444	A6445	A6446	A6447	A6448	A6449	A6450	A6451	A6452	A6453	A6454	A6455
A6456	A6457	A6460	A6461	A6501	A6502	A6503	A6504	A6505	A6506	A6507	A6508
A6509	A6510	A6511	A6512	A6531	A6532	A6545	A6550	A7023	A7025	A7040	A7041
A7047	A7048	A7501	A7502	A7503	A7504	A7505	A7506	A7507	A7508	A7509	A7520
A7521	A7522	A7523	A7524	A7525	A7526	A7527	A9156	A9268	A9269	A9284	A9515
A9520	A9573	A9575	A9576	A9577	A9578	A9579	A9581	A9582	A9583	A9584	A9585
A9587	A9588	A9589	A9597	A9598	A9603	A9697	A9698	C9150	J7030	J7040	J7042
J7050	J7060	J7070	J7120	J7121	J7500	J7505	J7509	J7510	J7599	P9615	Q0163
Q0164	Q0166	Q0167	Q0169	Q0173	Q0175	Q0177	Q0180	Q0181	Q4132	Q4133	Q4134
Q4135	Q4136	Q4186	Q4187	Q4272	Q4273	Q4274	Q4275	Q4276	Q4277	Q4278	Q4280
Q4281	Q4282	Q4283	Q4284	Q4287	Q4288	Q4304	V2630	V2631	V2632	V2790	

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References:

- American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services
- Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
- Centers for Medicare and Medicaid Services, Physician Fee Schedule (PFS) Relative Value Files https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files
- CMS Internet Only Manual (IOM), Publication 100-04, Medicare Claims Processing Manual, Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS
- CMS Addendum A and B Updates reflect OPPS Pricer changes that are part of quarterly OPPS recurring update notification transmittals.
- National Government Services, CPT 99459 Pelvic Examination Billing for Medicare
- Centers for Medicare and Medicaid Services, Physician Fee Schedule (PFS) Status Indicators https://www.cms.gov/status-indicators

Revision History

Company(ies)	DATE	REVISION
EmblemHealth ConnectiCare	**10/1/2024**	• **Commercial and Medicare** – Updated "Anesthetic "Caine" Drugs" table: ○ Indicated code J2001 as deleted **effective 10/1/2024.** ○ Added new codes J2002, J2003, and J2004 **effective 10/1/2024**
EmblemHealth ConnectiCare	**8/7/2024**	• Updated to include clarifying language on inclusion of OPSI Status "N" codes in this policy. • No changes to criteria or corresponding effective dates previously captured in Revision History
EmblemHealth ConnectiCare	**5/31/2024**	• **Commercial and Medicare-** Added CPT code 99459 to "Status "N" CPT/HCPCS Codes" table **effective 1/1/2024**
EmblemHealth ConnectiCare	**3/25/2024**	• **Commercial and Medicare-** Removed code V2520 from "Status "P" CPT/HCPCS Codes" table

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Company(ies)	DATE	REVISION
EmblemHealth ConnectiCare	**1/12/2024**	• **Commercial and Medicare -** Added Following New HCPCS Codes **effective 1/1/2024:** ○ Status N: A4457, A4468, A4540, and A7023 • **Commercial and Medicare**- Removed deleted code C9156 from "Status "N" CPT/HCPCS Codes" tables **effective 1/1/2024.** • **Commercial and Medicare-** Added codes J7030, J7040, J7042, J7050, J7060, J7070, J7120 and J7121 to "Status "N" CPT/HCPCS Codes" tables **effective 4/15/2024**
EmblemHealth ConnectiCare	**12/13/2023**	• **Commercial and Medicare**- Removed code G2211 from "Status "B" CPT/HCPCS Codes" tables **effective 1/1/2024**
EmblemHealth ConnectiCare	**10/27/2023**	• Updated to clarify that policy does not apply to Ambulance, DME, Home Infusion, and Home Care providers
EmblemHealth ConnectiCare	**9/29/2023**	• **Commercial and Medicare** - Added Following New HCPCS Codes effective 10/1/2023: ○ Status N: A9156, A9268, A9269, A9573, A9603, A9697, & C9156
EmblemHealth ConnectiCare	**7/31/2023**	• Updated policy statement to clarify applicable bill type as CMS-1500
EmblemHealth ConnectiCare	**7/27/2023**	• **Commercial and Medicare-** Removed code G0378 from "OPPS Status "N" CPT/HCPCS Codes" table
EmblemHealth ConnectiCare	**7/10/2023**	• **Commercial and Medicare** – Updated "Anesthetic "Caine" Drugs" table: • Indicated code S0020 as deleted **effective 7/1/2023.** • Added new code J0665 **effective 7/1/2023**
EmblemHealth ConnectiCare	**6/21/2023**	• **Commercial and Medicare - Added Following New HCPCS Codes effective 7/1/2023:** ○ Status N: C9150, Q4272, Q4273, Q4274, Q4275, Q4276, Q4277, Q4278, Q4280, Q4281, Q4282, Q4283, Q4284

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EmblemHealth ConnectiCare	**6/14/2023**	• **Commercial and Medicare** – Updated to include Anesthetic "Caine" Drugs Bundled Services **effective 1/1/2023**. • Indicated CPT Code S0020 as deleted **effective 7/1/2023.**
EmblemHealth ConnectiCare	**5/18/2023**	• **Commercial and Medicare** – Updated to include Outpatient Hospital (CMS OPPS Status "N") Bundled Services **effective 10/01/2023.** • Policy Statement updated to include Physician and Non-physician Practitioner Services and Outpatient Institutional Claims
EmblemHealth ConnectiCare	**5/2/2023**	• **Commercial and Medicare** – Added New HCPCS Code **effective 4/01/2023**: ○ Status B: A4560
EmblemHealth ConnectiCare	**12/2022**	• **Commercial** - Added Following CPT/HCPCS Codes **effective 3/01/2023**: ○ Status P: A4305, A4306, A4310, A4465, A4557, A4558, A4649, A5055, A5061, A5062, A5063, A5071, A6214, A6215, A6217, A6222, A6224, A6260 and A6261 • **Commercial and Medicare** - Added Following CPT/HCPCS Codes **effective 3/01/2023**: • Status B: A4270 and A4550 • Status T: 36591, 36592, 36598, 94760, 94761, 96523, G0117 and G0118 • Reformatted and reorganized policy, transferred content to new template with new Reimbursement Policy Number