

Corporate Medical Policy

Bundling Guidelines

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Next Review: 4/2009

Discussion Related to Blue Advantage, Blue Care, Blue Choice, Blue Options, and Classic Blue Products

Professional services are identified with Current Procedure Terminology (CPT) codes or Healthcare Common Procedure Coding System (HCPCS) codes. These codes are the language that is utilized to communicate fully the services and/or procedures that have taken place. It enables the accurate identification of the service or procedure.

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

Use of any CPT or HCPCS code should be fully supported in the office notes

Claims are filed utilizing CPT or HCPCS codes. These claims are reviewed to determine eligibility for payment. If services are considered incidental, mutually exclusive, integral to the primary service rendered, or part of a global allowance, they 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. However, the incidental procedure requires little additional physician resources and/or is clinically integral to the performance of the primary procedure. For these reasons, an incidental procedure is not reimbursed separately on a claim. Procedures that are considered incidental when billed with related primary procedures on the same date of service will be denied.

B. Mutually Exclusive Procedures

Mutually exclusive procedures are two or more procedures that are usually not performed during the same patient encounter 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 physician 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 will not both be reimbursed. If both codes accomplish the same result, the clinically more intense procedure generally survives 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 considered an integral part of the major or principle procedure. Integral procedures are considered to be those commonly carried out as part of a total service which do not meet all the criteria listed under the policy Multiple Procedure Guidelines, or according to the CPT manual need not be listed separately.

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D. Global Allowance

Reimbursement for certain services is based on a global allowance. Claims for services considered to be directly related to a procedure's global allowance will be considered integral to that service and will not be allowed.

The pre- and postoperative global days are based on CMS standards. Medical visits rendered within this time frame and related to the procedure will be denied as an unbundled component of the total surgical package. Minor surgical procedures have either 0 or 10 day(s) post-op time frame. Major surgical procedures have a 1 day pre-op and 90 day(s) post-op time frame regarding medical visits.

- E. 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.

Policy Statement for Bundling Guidelines relating to Blue Advantage, Blue Care, Blue Choice, Blue Options, and Classic Blue Products

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

Topics of Frequent Interest Related to Blue Advantage, Blue Care, Blue Choice, Blue Options, and Classic Blue Products

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.

After Hours Care - After Hours, Sunday & Holiday, and 10pm to 8am care is considered mutually exclusive to an ER visit. Separate reimbursement is not allowed for mutually exclusive services.

Allergen Immunotherapy - Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular (90772) is considered mutually exclusive to 95115 - 95117. Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intra-arterial (90773) is considered mutually exclusive to 95115 - 95117. Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug (90774) is considered mutually exclusive to 95115 - 95117. Separate reimbursement is not allowed for mutually exclusive services.

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

Anesthesia complicated by emergency conditions - See new policy entitled Code Bundling Rules Not Addressed in Claim Check, Policy Number ADM9028.

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. Separate reimbursement is not allowed for incidental services.

Cardiac Stress Test - Generation of automated data (78890) is considered incidental to a cardiovascular stress test (93015). Separate reimbursement is not provided for incidental services. 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. It does not warrant 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 treat-

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ment 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, hexcilitite 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.

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.

Critical Care Services - Codes 36000, 36410, 36415, 36600, 71010, 71020, 91105, 92953, 93010, 93042, 93561, 93562, 94660, 94662, 99090 are considered incidental to Critical Care Services 99291 and 99292. Critical care service procedures will be denied as incidental when submitted with Neonatal Intensive Care service procedures as these services are considered overlapping. Separate reimbursement is not allowed for incidental services.

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.

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. Separate reimbursement is not provided for ECGs which are considered incidental.

An ECG is considered mutually exclusive to Physician services for cardiac rehabilitation (93797). Separate reimbursement is not provided for ECGs which are considered mutually exclusive.

Lab Tests - Lab codes 80048 - 80076 are lab panels that were developed for coding purposes. When the labs performed on a particular patient constitute one of the listed panels, the panel should be reported. The individual labs are rebundled back 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, 15570-15770. Simple wound repair procedures, 12001 through 12021, will be found incidental to excision of lesions, unless the excision is a Mohs' procedure.

Neonatal Intensive Care Services - Codes 36000, 36400, 36405, 36406, 36415, 36416, 36420, 36510, 36600, 36620, 36660, 62270, 92950, 93010, 93042, 93561, 93562, 94660, 94662, 94760, 94761, 94762, 99291, and 99292 will be considered incidental to Neonatal Intensive Care services 99293, 99294, 99295, 99296 and 99298. Separate reimbursement is not allowed for incidental services.

New Visit Frequency - When a claim is received reporting a New patient Evaluation and Management service more than once within a three year period, the New patient Evaluation and Management service will be replaced with the equivalent Established Evaluation and Management service if one is available.

Office Visits - Office services provided on an emergency basis (99058) are considered mutually exclusive to

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the primary services provided. Office visit (99211) is considered mutually exclusive to 95115-95117 (allergen immunotherapy). Separate reimbursement is not allowed for mutually exclusive services.

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 29) for clinical interpretation of laboratory results will be allowed for codes 83020, 83912, 84165, 84166, 84181, 84182, 85060, 85390, 85576, 86255, 86256, 86320, 86325, 86327, 86334, 86335, 87164, and 87207. Pathology interpretation of all other codes in the 80002-87999 range is considered integral to the laboratory test. Separate reimbursement is not allowed for integral services.

Pulse Oximetry - Pulse oximeters are considered incidental to office visits or procedures. Separate reimbursement is not provided for incidental procedures.

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. Separate reimbursement is not provided for mutually exclusive services.

Robotic Surgical Systems - 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.

Specimen Handling and/or Conveyance - Service 99000 handling and/or conveyance of specimen is eligible for payment when the laboratory service is not performed in the provider's office and the independent laboratory bills BCBSNC directly for the test.

STAT or After Hours Laboratory Charges - Additional charges for STAT or after hours laboratory services are considered an integral part of the laboratory charge.

Surgical Supplies - Surgical supplies 99070 will be considered incidental to Surgical, Laboratory, Inpatient Medical Evaluation and Management, and Consultation services. Surgical trays A4550 and miscellaneous surgical supplies A4649 are generally considered incidental to all medical, chemotherapy, surgery, and radiology services, including those performed in the office setting.

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

Ultrasonic Guidance for Needle Biopsy - Separate reimbursement is allowed for 76942 (Ultrasonic Guidance for Needle Biopsy) when submitted with 76872 (Transrectal, Echography).

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).

Venipuncture - See policy entitled Code Bundling Rules Not Addressed in Claim Check, Policy Number ADM9028.

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.

Vision Services - Determination of refractive state (92015) will be allowed with Evaluation and Management services as well as the General Ophthalmological services 92002, 92004, 92012, and 92014 when specific E&M services are provided and documented. Procedure 92015 will also be allowed with surgical services.

X-Rays - When single view and double view chest X-Rays are billed together (71010 and 71020), only the double view X-Ray is allowed. When the entire spine, survey study is billed (72010) with cervical spine films (72040), thoracic spine films (72070) or lumbosacral spine films (72100) 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

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one technical component is allowable per X-Ray.

Policy Guidelines

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

This policy relates to Blue Advantage, Blue Care, Blue Choice, Blue Options, and Classic Blue products.

BCBSNC claims systems process only one modifier per CPT code.

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.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Applicable Code:

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

Policy Key Words

Key Words: *ADM9202, bundling, mutually exclusive, incidental, integral, global, allowance, after hours care, anesthesia, cardiac stress test, casting, strapping, chemotherapy, critical care, ear wax removal, electrical stimulation, electrodes, electrocardiogram, lesion biopsy, lesion excision, lesion closure, maternity, neonatal intensive care services, office visits, pap smears, pathologist, preoperative, postoperative, pulse oximeter, robotic surgical systems, sedation, specimen handling, conveyance, starred procedures, STAT laboratory charges, after hours laboratory charges, surgical supplies, transvaginal ultrasound, ultrasonic guidance for needle biopsy, venipuncture, visual acuity, screening, vision, X-Ray, X-Rays*

Medical Term Definitions

Not Applicable

Scientific Background and Reference Sources

Medical Policy Advisory Group - 10/2003

Medical Policy Advisory Group - 03/10/2005

Medical Policy Advisory Group - 03/24/2006

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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, 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 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.

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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 new 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).

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."

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- 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 “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.

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.