Blue Cross and Blue Shield of Georgia Inc, and Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. (hereinafter referred to collectively as "BCBSGA") Professional Reimbursement Policy

Subject: Bundled Services and Supplies		
Policy #: EPRP - 0008	**Effective:** 04/01/2014	

Coverage is subject to the terms, conditions, and limitations of an individual member's programs or products and policy criteria listed below.

Description

The Health Plan considers 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.

This policy is divided into 3 sections:

- The first section provides a description and coding grid for services and/or supplies not eligible for separate reimbursement. These services and/or supplies are not eligible for reimbursement whether they are reported with another service or as a stand-alone service.
- The second section provides a description and the code pair relationship for a number of procedures that are not eligible for separate reimbursement when performed with another specific service or item.
- The third section provides the code and description for services that are eligible for reimbursement when reported as a stand-alone service, but are not eligible for separate reimbursement when performed with any other procedure, service, or supply.

Policy Section 1: Services and supplies not eligible for separate reimbursement.

In most cases, services rendered without direct (face-to-face) patient contact are considered to be an integral component of the overall medical management service and are not eligible for separate reimbursement. In addition, modifier 59 will not override the denial for the bundled services and/or supplies listed below.

These bundled services and supplies may include, but are not limited to:

1. add-on code to identify services rendered by a hospitalist provider
2. administrative services requiring physician documentation (e.g., recertification, release forms, physical/camp/school/daycare forms, etc.)

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3. all practice overhead costs, such as heat, light, safe access, regulatory compliance including CDC and OSHA compliance, general supplies (paper, gauze, band aids, etc.), infection control supplies, insurance (including malpractice insurance), collections
4. application of hot or cold packs
5. Centers for Medicare & Medicaid Services' (CMS') Medicare Approved Bundled Payments for Care Improvement Initiative
6. collection/analysis of digitally/computer stored data
7. complex chronic care coordination services
8. copies of test results for patient
9. coronary therapeutic services and procedures add-on codes
10. costs to perform participating provider agreement requirements, such as prior authorizations, appeals, notices of non coverage
11. determination of venous pressure
12. disease management programs
13. DME and other delivery and/or set up fees
14. equipment and/or enhanced technology as part of a procedure, test, or treatment (e.g., robotic surgical systems, radiation oncology treatment tracking systems including "Clarity")
15. evaluation of cervicovaginal fluid for specific amniotic fluid protein(s) (eg, placental alpha microglobulin-1 [PAMG-1], placental protein 12 [PP12], alpha-fetoprotein), qualitative, each specimen (e.g., AmniSure®)
16. global fee for urgent care centers
17. handling and/or conveyance fees
18. heparin lock flush solution or kit for non therapeutic use
19. hospital mandated on-call service
20. implantable device for fallopian tube occlusion
21. insertion of a Bakri balloon for treatment of post-partum hemorrhage
22. insertion of a pain pump by the operating physician during a surgical procedure
23. medical home program, comprehensive care coordination and planning—initial and maintenance
24. monitoring feature or device, stand-alone or integrated, any type, including all accessories, components and electronics
25. online assessment and management by a qualified nonphysician health care professional
26. outpatient Healthcare Common Procedural Coding System (HCPCS Level II) "C" codes
27. peak expiratory flow rate
28. pharmacy and other dispensing services and/or supply fees, etc.
29. photography
30. physician care plan oversight
31. physician interpretation and report of molecular pathology procedures
32. placement of an occlusive device into a venous or arterial access site, post op/procedural
33. postoperative follow up visit during the global period for reasons related to the original surgery
34. preparation of fecal microbiota for instillation, including assessment of donor specimen
35. prescriptions, electronic, fax or hard copy, new and renewal, including early renewal
36. prolonged physician in-patient service
37. prolonged E/M service before and after direct patient care
38. pulse oximetry
39. qualitative drug screen testing (Refer to Qualitative Drug Screen Testing Policy)

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40. “Reporting only codes” including *Current Procedural Terminology* (CPT®′) Category II supplemental tracking codes for performance measurement, HCPCS Quality Measure codes, and HCPCS Functional Limitation codes
41. review of medical records
42. routine post surgical services such as dressing changes and suture removal
43. spinal surgery only graft (allograft, morselized)
44. spinal surgery only graft (autograft, same incision)
45. standby services
46. stat laboratory request
47. state or federal government agency supplied vaccines
48. sterile water, saline, and/or dextrose, 10 ml
49. surgical/procedural supplies and materials supplied by the provider rendering the primary service (e.g., surgical trays, syringes, needles, sterile water, etc.)
50. team conferences to coordinate patient care
51. telephone consultations with the patient, family members, or other health care professionals
52. transitional care management services
53. travel allowance for laboratory specimen pick-up
54. treatment planning and care coordination management for cancer treatment
55. 3D rendering of imaging studies

Coding Section 1: Services and supplies not eligible for separate reimbursement.

The following table identifies by code some examples of the procedures and supplies that are described above. The exclusion of a specific code does not indicate eligibility for reimbursement under all circumstances. This table is provided as an informational tool only, to help identify some of the procedures described in Policy Section 1 above.

0001F-0725F	90889	98967	99070	99374	A4216	A9901	P9603	S2900
0185T	92921	98968	99090	99377	A4218	C1300-C9899	P9604	S3600
15850	92925	98969	99091	99378	A4262	G0269	Q0511	S3601
20930	92929	99000	99339	99379	A4263	G0452	Q0512	S8110
20936	92934	99001	99340	99380	A4264	G0908-G0922	Q0513	S8301
44705	92938	99002	99356	99441	A4270	G8126-G8977	S0221	S9083
76376	92944	99024	99357	99442	A4300	G8978-G8999	S0280	
76377	93770	99026	99358	99443	A4470	G9140	S0281	
80100	94005	99027	99359	99487	A4480	G9158	S0302	
80101	94760	99053	99360	99488	A4550	G9186	S0310	
80104	94761	99056	99366	99489	A4649	G9187	S0315-S0317	
84112	97010	99058	99367	99495	A4650	H0048	S0353	
	98966	99060	99368	99496	A9279	J1642	S0354	

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Policy Section 2: Procedures, services, and supplies not eligible for separate reimbursement when reported with another specific procedure, service, or supply.

These bundled services and supplies may include, but are not limited to, the services and supplies listed below. Refer to Modifier 59 Policy for those instances where modifier 59 will not override the denial when reported with a specified service or supply.

1. cervical or vaginal cancer screening, pelvic and clinical breast examination when performed with preventive/annual or problem oriented E/M service (See also our Screening Services with Evaluation & Management Services reimbursement policy.)
2. cervical or vaginal cytopathology when performed with a preventive/annual or problem oriented E/M service
3. collection of blood specimen from a completely implantable venous access device or an established venous central or peripheral catheter when performed with any service (for example E/M services) other than a laboratory service
4. developmental screening when performed with administration and interpretation of health risk assessment instrument
5. digital breast imaging tomosynthesis reported with digital mammographies
6. digital rectal exam for prostate cancer screening when performed with a preventive or problem oriented E/M service (See also our Screening Services with Evaluation & Management Services reimbursement policy.)
7. electrodes and electrical stimulator supplies with other services (e.g., electrocardiogram (EKG), electroencephalogram (EEG), stress test, sleep study, electric stimulation modalities, acupuncture)
8. interpretation and report only of an EKG when performed with an E/M service
9. interpretation and report only of cardiovascular stress test or 64-lead EKG test when performed with an emergency room (ER) service
10. interpretation of a radiology tests when performed with an ER or inpatient E/M service
11. obtaining, preparing, and conveyance of cervical or vaginal PAP smear when performed with a preventive/annual or problem oriented E/M service (See also our Screening Services with Evaluation & Management Services reimbursement policy.)
12. open capsulectomy when performed with delayed insertion of breast prosthesis
13. preventive medicine counseling when performed with a routine comprehensive preventive medical examination
14. radiological supervision and interpretation of transcatheter therapy when performed with injection of sclerosing solution
15. regional or local anesthesia when administered in a physician's office
16. removal of impacted cerumen when performed with audiologic function testing
17. replacement soft interface material, with continuous passive motion device
18. therapeutic behavioral services, <u>per 15 minutes</u> when performed with therapeutic behavioral services, <u>per diem</u>
19. therapeutic, prophylactic, and diagnostic injections and infusions when performed with nuclear medicine testing
20. ultrasonic guidance for needle placement with CPT parenthetical identified procedures

Coding Section 2: Procedures, services, and supplies not eligible for separate reimbursement when reported with another specific procedure, service, or supply.

The following list identifies by code pair some examples of the procedures that are described above. The exclusion of a specific code does not indicate eligibility for reimbursement under all circumstances. These code relationships are provided as an informational tool only, to help

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identify some of the procedures described in Policy Section 2 above. They include, but are not limited to:

1. G0101 reported with Preventive, problem-oriented E/M, and annual gynecological exam codes such as 99381-99397, S0610, S0612, and 99201-99215
2. 88141-88155, 88164-88167, and 88174-88175 reported with Preventive and problem oriented E/M codes such as 99381-99397 and 99201-99215
3. 36591-36592 reported with any service (for example 99201-99215, 99221-99226, 99241-99255) other than a laboratory service
4. 96110 reported with 99420
5. 76499 (unlisted diagnostic radiographic procedure when reported as breast tomosynthesis) reported with G0202, G0204, and G0206
6. G0102 reported with Preventive and problem oriented E/M codes such as 99381-99397 and 99201-99215
7. A4556 and A4595 reported with services such as 93000, 93015, 95805, 95812, 97014, 97032, 97033, 97813, and 97814
8. 93010, 93042, reported with E/M codes such as 99201-99215, 99221-99233, and 99281-99285
9. 93018 and 0180T reported with ER codes 99281-99285
10. 700XX-788XX, G01XX-G03XX, S8035-S8092, and S9024 (these code ranges include applicable radiology interpretation codes as well as radiology codes which modifier 26 would be added to identify the professional component only) reported with 99221-99233 and 99281-99285
11. Q0091 reported with Preventive, problem-oriented E/M, and/or annual gynecological exam codes such as 99381-99397, G0101, S0610, S0612, and 99201-99215
12. 19371 reported with 19342
13. 99401-99404 & 99411-99412 reported with Preventive Medicine Service codes such as 99381-99397
14. 75894 reported with 36471
15. J2001 or when reported as J3490 with office surgery/procedure codes
16. 69210 reported with audiologic function tests such as 92551-92557 and 92561-92585
17. E1820 reported with E0935-E0936
18. H2019 reported with H2020
19. 96365, 96369, 96372, 96373, 96374, and 96379 reported with 78000-79999
20. 76942 reported with 10030, 19083, 19085, 27096, 32554, 32555, 32556, 32557, 37760, 37761, 43232, 43237, 43242, 45341, 45342, 64479-64484, 64490-64495, 76975, 0213T-0218T, 0228T-0231T, 0232T, 0249T, and 0301T

Policy Section 3: Services not eligible for separate reimbursement when reported with any other procedure, service, or supply.

Modifier 59 will not override the denial for the services listed below when they are reported with any other procedure, service, or supply even when the other procedure, service, or supply is denied. However, these services are eligible for reimbursement when reported as stand-alone services.**

- 94150 – vital capacity, total (separate procedure)
- 94664 – demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device
- 96523 – irrigation of implanted venous access device for drug delivery systems [Per CPT parenthetical coding guidelines]

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**Supplies are included in the RVUs for these codes and should not be reported separately.

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Policy History	
07/18/2008	New Policy
09/11/2012	Revised
05/07/2013	Revised
04/01/2014	Revised

Use of Reimbursement Policy:
This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a member's benefits on the date of service. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.

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