PD'd 03/30/2023

Commercial Reimbursement Policy

Subject: **Bundled Services and Supplies - Professional**	
Policy Number: **C-08003**	Policy Section: **Coding**
Last Approval Date: **02/22/2023**	Effective Date: **07/01/2023**

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by an Anthem Blue Cross and Blue Shield (Anthem) member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. These codes denote the services and/or procedures performed and when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

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:

Policy Section 1: Services and Supplies not eligible for separate reimbursement

Section 1 provides a list and description of Current Procedural Terminology (CPT®) and Healthcare Common Procedural Coding System (HCPCS Level II) codes for those services and supplies not eligible for reimbursement when they are reported with another service or reported as a stand-alone service.

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, modifiers will not override the denial for the always bundled services and/or supplies listed in the embedded document.

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

Section 2 provides a description and the code pair relationship for procedures that are not eligible for separate reimbursement when performed with another specific service or supply listed in the embedded document. In most cases, modifiers will not override the denial when reported with a specified service or supply.

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

Section 3 provides the code and description for services that are eligible for reimbursement when reported as a stand-alone service but are not eligible or separate reimbursement when performed with any other procedure, service or supply. Modifier 59, XE, XP, XS or XU will not override the denial for the services when they are reported with any other procedure, service or supply.

Related Coding

Description	Coding Grids
Bundled Services Section 1 coding	Services and Supplies not eligible for separate reimbursement

Bundled Services Section 2 code pairs	Procedures, Services and Supplies not eligible for separate reimbursement when reported with another specific procedure, service or supply
Bundled Services Section 3 coding	Services not eligible for separate reimbursement when reported with any other procedure, service, or supply

Exemptions

Colorado	Allows reimbursement for HCPCS codes S9208 and S9480
Connecticut	Allows reimbursement for HCPCS codes S9208, S4042, S9480, S9484 and S9485
Georgia	Allows reimbursement for HCPCS codes S4042 and S9208
Indiana	• Allows reimbursement for HCPCS codes S4015, S4016, S4022, S4027, S4040, S5000 and S5001 • Allow reimbursement for HCPCS code S9475 for Behavioral Health providers
Kentucky	• Allows reimbursement for HCPCS codes S4015, S4016, S4022, S4027, S4042, S5000 and S5001 • Allow reimbursement for HCPCS code S9475 for Behavioral Health providers
Maine	Allows reimbursement for HCPCS codes S9480, S9484 and S9485
Missouri	Allows reimbursement for HCPCS codes S4015, S4016, S4022, S4027, S4040, S5000 and S5001
Nevada	Allows reimbursement for HCPCS codes S9208 and S9480
New Hampshire	• Allows reimbursement for HCPCS codes S9480 and S9485 • Allows reimbursement for procedure code 90899 • Allows reimbursement for HCPCS code S0201

Policy History

12/27/2022	Review approved 12/27/2022 and effective 07/01/2023: added codes G0310, G0311, G0312, G0313, G0314, G0315 to Section 1 code list
09/14/2022	Review approved 09/14/2022 and effective 03/01/2023: added codes 87913 and K1034 to Policy Section 1: Services and Supplies not eligible for separate reimbursement coding list; Colorado effective 03/15/2023

12/22/2021	Review approved: codes 99000, 99001, H0048, P9603 and P9604 were removed from the Bundled Services and Supplies Section 1 coding professional policy and added to the Laboratory and Venipuncture Services – Professional & Facility effective 10/01/2022
10/13/2021	Georgia exemption removed: effective 04/01/2022: Section 2 codes 88141-88155, 88164-88167, and 88174-88175 when reported with 99381-99397, 99201-99215 will bundle
07/23/2021	Review approved and effective 07/23/2021: Section 1: Removed code S2900 - moved to Robotic Assisted Surgery Policy #C-12007; removed code C9032- this code was deleted 01/01/2019, removed e-consult Behavior Health codes 99484, 99447-99449
12/16/2020	Review approved: added code G2211 to section 1 always bundle; Removed code 99201 from section 2 code pair edits. Code 99201 was deleted 12/31/2020. Effective 01/01/2021.
11/25/2020	Review approved: Bundle CPT code 99072. Code is treated as a supply code. Added exemption for NH. NH allows reimbursement for procedure code 90899
10/30/2020	Review approved: Section 1 Coding list updated to remove interprofessional codes 99446, 99451, and 99452 and allow reimbursement. New Hampshire will allow reimbursement in July 2021.
09/15/2020	Review approved: Removed deleted codes, updated codes and code pairs, and updated market exemptions
08/28/2020	Telehealth originating site facility fee (Q3014) when reported with an E&M code in Place of Service 11
08/07/2020	Added to section 2: paraesophageal hernia codes to bundle with bariatric surgery codes WAVE# 441598
05/27/2020	Code list updated to include S9088 in Section I
11/26/2019	• Added NH exemption to allow reimbursement for HCPCS S0201 • Added GA exemption: Allows separate reimbursement for procedure codes 88141-88155, 88164-88167, and 88174-88175 when reported with 99381-99397, 99201-99215 but

	continues to not allow separate reimbursement for HCPCS codes G0101, G0402, G0438, G0439, S0610 and S0612
06/01/2019	New policy template: embedded section 1 code list, section 2 code pairs and section 3 code list
05/24/2019	Allow reimbursement for HCPCS code S9475 for OBOT program for WI, IN. Edit effective 9/1/2019
01/25/2019	Added interprofessional procedure codes 99451 and 99452 to section 1 description and code list; exemption added for Medicare Advantage.
10/05/2018	• Effective 10/05/2018: Allow reimbursement for HCPCS code S9475 for KY, OH and VA. These markets have contracted with Behavioral Health providers for peer support services on Opioid abuse treatment and are advised to bill HCPCS code S9475. A post review will be done to ensure other providers are not billing HCPCS code S9475 inappropriately. • Allow reimbursement for HCPCS code C9032 (Luxturna) • Added G0453 to nonreimbursable bundled code list. This is supported by Policy Section 1 #39; Effective 03/01/19 for all markets except VA. The Effective date for VA is 09/01/19.
08/03/2018	Revisions: • Advanced care planning and chronic care management language removed. Also, removed codes 99487-99490 and 99497-99498 from the bundled services code list.
06/01/2018	Revision: • Added language for X-ray DVD or film to Section 1 line#8 per request received
12/15/2017	Revision approved: • Add 20550 and 20551 (tendon injections) as support codes to the edit that 76942 (ultrasound guidance) is not eligible for separate reimbursement when reported with trigger point injections. Effective 1/1/18: CA and VA will not deny 76942 when reported with 20552 and 20553. Effective 3/1/18: CA and CA will not deny 76942 when reported with 20550 and 20551. • Moved other policy reference to end of policy

	• Remove reference in section 1 to transitional care mgmt./planning (the codes (99495 & 99496) were removed from the section 1 code list)

08/01/2017	• Revised: Update coding section 1 to remove from rule 25 codes to be eligible for reimbursement the following psych care management codes reported by primary care providers:
	  ○ *G0502* (Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional)
	  ○ *G0503* (Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities...)
	  ○ *G0504* (Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities... use G0504 in conjunction with G0502, G0503)
	  ▪ Bullet will now be G0505-G0507
	• Part of Wave initiative #265; expanding care management to allow these services for PCPs; EPHC has agreed and from legal reviewed
	• These services differ enough from other care management services to warrant separate reimbursement
	• BH will monitor the utilization data
	  ○ Only update to policy is date to match update to section 1 code list

07/11/2017	Revised: Update and move bullet for drug testing; now only definitive drug testing has “G” codes (G0480-G0483 and G0659), the presumptive testing “G” codes (G0477-G0479) were deleted 1/1/17 Add to section 2 code pair to deny U/S guidance 76942 when reported with trigger point injections 20552 and 20553

	Update to section 2—move nonvascular extremity ultrasound when reported with ultrasonic guidance for needle placement from #49 to #35 to be in alpha order
06/06/2017	Section 1 coding: add 99446-99449 to document current edit Section 2: 1. Add coding for shoulder and elbow arthroscopic debridement codes not allowed with arthroscopic surgery and no modifier override (shoulder: 29822 not allowed with 29819, 29820, 29824, 29825, 29827; 29823 not allowed with 29806, 29807, 29819, 29820, 29821, 29825; elbow: 29837 and 29838 not allowed with 29834, 29835, 29836) This is based on NCCI Policy Manual language; only allow site specific modifiers RT/LT to override when the codes are reported for different sides. 2. Add replacement breast pump supplies when reported on the same date of service that a breast pump is provided (A4281, A4282, A4283, A4284, A4285 will not be eligible for separate reimbursement when billed with E0602, E0603, E0604)
04/04/2017	Revised: 1) Updating section 2 coding (code-to-code) for the drug testing edits: a. For 2017 CPT deleted codes 80300-80304 and replaced with codes 80305-80307 for presumptive drug testing; for 2017 HCPCS deleted codes G0477-G0479 for presumptive drug testing (providers now report with 80305-80307) and added G0659 for definitive drug testing; removing deleted chromatography codes 82541, 82543, and 82544 b. G0480-G0483 are not allowed with G0659 2) Removing the edit that denies 22614 with CPT codes 22600, 22610, 22612, 22630 and leaving the edit between 22614 with 22633
02/07/2017	Revised: 1. Remove deleted codes for spinal injections from Section 2 (code pairs).

	2. Add 2017 spinal injections codes 62320, 62321, 62322, 62323, 62324, 62325, 62326, and 62327 to Section 2 that image guidance or hospital management service will not be allowed with. 3. Code list date updated to match date of policy.
12/06/2016	Revised: Add codes to always bundled section 1code sheet: G0500 G0501 G0502-G0507 T1040 and T1041 Deleted codes from section 1 coding: 80300-80304 (CPT deleting 1/1/17) 80305-80307 (HCPCS deleting G0477-G0479 1/1/17 therefore the CPT codes are to be used for presumptive drug testing and will not be added to rule 25) GMMM1 (HCPCS replaced with G0500) Policy date updated to match changes in coding list.
10/04/2016	Revised: 1. Move section 1 code list from inside policy to separate document link. 2. Added to section 1: a. Presumptive drug testing codes eff 1/1/2017 80305-80307; providers should still use 2016 HCPCS codes G0477, G0478 and G0479 b. G0498 Chemotherapy administration...includes follow up office/other outpatient visit at the conclusion of the infusion c. Remove 80300-80304; deleted 1/1/17 3. Added to section 2: a. G0402, G0438, G0439 are support (allowed) codes for cervical and vaginal cytopathology deny codes 88141-88155, 88164-88167, and 88174-88175 b. Deny 95937 when reported with 95940, 95941, or G0453 c. Deny 22614 when reported with procedures 22600, 22610, 22612, 22630 and 22633 and not allow any modifier override d. Deny 76942 with 76881

09/06/2016	Revised: 1. Add an edit to Rule 26 to deny 63048 when reported with 22633 and do not allow any modifier override 2. Rule 26 - Deny 82542 (method) column chromatography as incidental to 91065 (test) hydrogen breath test and do not allow any modifier override 3. Currently denying vaginal cytopathology 88141-88155, 88164-88167, and 88174-88175 when reported with preventive/annual or problem oriented E/M service; add procedure codes G0101, S0610 and S0612 to the listing of support/pay codes associated with the edit; currently, only CPT E/M services are included in this edit; no modifier override 4. Add 22558 as support code that will deny 63081-63088
08/02/2016	Revised: 1. Add digital EEG analysis procedure 95957 to deny if billed on the same date of service as procedure codes 95951, 95953, 95954 and 95956 2. Add 95957 (digital EEG analysis) not allowed with EEG services codes 95950, 95951, 95953, 95954, 95955 and 95956 on subsequent dates of service 3. Add [76942, 77002, 77003, 77012, 77021 when billed with codes 62310, 62311, 62319, 62319]; bracketed because not all states accepting at this time; supported in Federal Register – by CMS payment policy – not an NCCI edit.
04/05/2016	Revised: 1. Section 1, rule 25 (always bundled) – adding new codes eff 4/1/16 G9481-G9490 (Remote in-home visit for the evaluation and management of a new patient for use only in the Medicare-approved Comprehensive Care for Joint Replacement model) and G9678 (Oncology Care Model (OCM) Monthly Enhanced Oncology Services (MEOS)); these are codes developed by CMS to track Medicare programs therefore we should not see these codes on non-Medicare claims; current bullet #39 covers these codes

	2. Update language on current bullet #39 to read “preceding bullet” rather than specify a number since a bullet # is subject to change 3. Section 2, rule 26 code pairs – we are adding initial preventive visit HCPCS level II code G0402 to bullet #1 as not allowed with CPT preventive care codes 99381-99397 to document the edit in this policy; same logic that does not allow annual wellness HCPCS codes G0438 & G0439 with the preventive CPT codes; no modifier override; this information is currently documented in our Evaluation & Management and Modifiers 25 & 57 policy (2/2/16) 4. We will be adding 69209-removal of impacted cerumen by lavage to current edit which does not allow removal of impacted cerumen codes 69210 & G0268 when performed on same date of service as audiologic function testing; no modifier override
02/02/2016	Revised: Section #1 • Adding G0180 (physician certification for Medicare covered home health services) (request from appeals) • Adding T2002 (per month case management code primarily used by Medicaid) These 2 codes covered in the bullet that patient care planning is always bundled • Listing 99360 separate from prolonged services codes 99356-99359 • Removing the bullet and codes for cancer treatment planning; each state should have adopted by now Section #2 (description and corresponding coding) • Adding electrodes (A4556) reported with conductive gel or paste (A4558) • Adding removal impacted cerumen (69209 & 69210) when reported with any evaluation and management services (office visits, hospital visits, etc.); McKesson removing edit from their default, we are retaining (69209 is new for 2016)

	• Adding supply codes not payable with home infusion codes 99601 and 99602; McKesson removing edit from their default, we are retaining (this information will be included in our injection & infusion policy at a future review)
01/05/2016	Revised: 1. Section 1 (always bundled services) Along with cosmetic updates, we are: • Adding the presumptive and definitive drug testing CPT codes 803XX as always bundled (in agreement with CMS • Removing drug testing codes that CMS/HCPCS deleted 1/1/16: G0431 (qualitative) and G0434 (CLIA waived or moderate complexity) 2. Section 2 (code pairs) • Adding information to deny 29876 major arthroscopic knee synovectomy when reported procedure codes 29879 (abrasion arthroplasty) and 29880-29887 (arthroscopic meniscus surgeries) when reported with arthroscopic knee surgeries without an approved American Academy of Orthopedic Surgeons diagnosis; modifier 59 or the X modifiers will not override the denial • Add to bullet #33 82570 and 83986 not allowed with G0480-G0483; maintenance of existing logic to not allow validity testing with definitive drug testing CPT codes
12/01/2015	Revised: Section 1: • Code C9257 will be removed from our always bundled rule #25; adding a note for an exception to bullet #28 outpatient HCPCS “C” codes **exception: C9257 for injection, bevacizumab (Avastin), 0.25 mg • Adding a bullet that services identified by HCPCS “G” or “Q” codes performed in the home or hospice setting when reported on a CMS-1500 claim form will be always bundled Section 2: • Adding urine creatinine (82570) or urine pH (83986) when reported with presumptive and/or definitive drug testing codes 80300-80377 & 83992 to validate accuracy of test results will not be eligible for reimbursement

11/03/2015	Revised: • Adding to section 1 as always bundled codes 99415 and 99416, which will be effective 01/01/2016 • These codes represent prolonged clinical staff service (beyond the typical service time); we consider this service to be “incident to” or inclusive to the E/M service
10/06/2015	Revised: • Adding back to section 1 coding table S0310 (add on code for hospitalist service) and S0315-S0317 (disease mgmt.); codes inadvertently dropped off coding table • Adding to section 2: ○ Deny procedures S0395 (casting), A4580 (cast supplies) and A4590 (special casting materials) as mutually exclusive when reported with L3000, L3010, L3020 and L3030 (custom foot orthotics); not being added to Modifier 59 policy because an override modifier will deny under Rule 8 for invalid use of modifier. ○ 95940 (continuous intraoperative neurophysiology monitoring in the O/R, one on one, each 15 minutes) mutually exclusive to 95941 (continuous intraoperative neurophysiology monitoring, outside the O/R or more than one case, per hour) Add incidental edits to deny 77014 (CT guidance for placement of radiation therapy fields) when reported with 77280, 77285, and 77290 (therapeutic radiology simulation-aided field setting procedures)
07/07/2015	Revised: Additions to section 1 (always bundled): • 98960 (education and training for patient self-management by a qualified, non-physician health care professional, individual); instructing the patient about the self-management of a condition is considered by the Health Plan to be part of the counseling included in an E/M service; considered part of the overall care of the patient and should not be separately reimbursed; codes 98961 (2-4 pts) and 98962 (5-8 pts) are currently always bundled services and identified in the policy (all are covered under bullet #29)

	• Q9977 (compounded drug, NOC) identified in new bullet #8 as compounded drugs that are not a part of Health Plan approved drugs, programs, services, or supplies • S5000 (prescription drug, generic), S5001 (prescription drug, brand name) (covered under bullet #19) • S8262 (Mandibular orthopedic repositioning device, each) (covered under bullet #19) Additions to section 2 (code pairs): • Diagnostic esophagogastroduodenoscopy (EGD) when performed with laparoscopy, surgical, gastric restrictive procedures--43235 reported with 43770, 43771, 43772, 43773, 43774, and/or 43775 (according to one of our NY medical directors, the EGD is being done to check for a leak from the bariatric surgery and, therefore, an integral part of the operation, and does not merit additional reimbursement; • Introduction of needle or intracatheter, vein, when reported with injection and infusion services--36000 reported with 96360, 96365, 96374, 96375, 96376, 96405, 96406, 96409, 96413, 96416, 96440, 96446, 96450, and/or 96542 Tissue marker when reported with breast biopsies that include placement of breast localization device(s) and/or percutaneous placement of breast localization device(s)--A4648 reported with 19081-19101 and/or19281-19288
06/02/2015	Revised: • Adding S9992 to section 1 as an always bundled service even though the volume was minimal • Adding information to section 2 that column chromatograph/mass spectrometry non-drug analyte testing services (codes 82541 – 82544) are not eligible for separate reimbursement when reported with drug screening or definitive drug testing services (codes 80300, 80301, 80302, 80303, 80304, 80320 – 80377); there will be no modifier override therefore the codes are included in the Modifier 59 reimbursement policy • Remove information on digital breast tomosynthesis (DBT)—codes from section 1 (77061, 77062, 77063, & G0279) and

	language & coding from section 2 (76499); medical policy to handle (see also 3D Radiology policy)
04/07/2015	Revised: • Under the description section and policy section #1, adding the X modifiers; these are new non-site specific modifiers for 2015 that could potentially override a bundled service • The project to add "S" codes to the always bundled edit has identified a few additional codes that will go into the policy—S9208, S9480, S9484, S9485, S9992, S9999; local plans will add if there are no exceptions • In section 2 we are adding ○ annual wellness visits—G0438 and G0439--will bundle to preventive exams ○ needles reported with acupuncture services—A4215 with 97810-97814 ○ correcting information on coding for electrodes and electric stimulator supplies and the services they are bundled with ○ also correcting typo for bullet 16 in coding section 2 (S0610-S0612 s/b S0610-S0613)
02/03/2015	Revised: • Section 1: ○ Revise bullet for DME that delivery, instruction, and/or set-up fees for DME are always bundled ○ Consolidate information for always bundled "S" codes to state: "Health Plan non-approved drugs, programs, services, and supplies identified by certain Healthcare Common Procedural Coding System (HCPCS Level II) "S" codes including, but not limited to, disease management programs, or when a corresponding national code exists"; additional "S" codes are being added to the code table as always bundled based on the ongoing "S" code review project—S0257, S1015, S1016, S3005, S4005, S4011, S4022, S4025, S4027, S4028, S4035, S4037, S4040, S4042, S8096, S8097, S8100, S8101, S8415, S9098, S9110, S9900, S9901

	○ Consolidate information for always bundled patient care planning type services to state: "patient care planning services the Health Plan considers part of overall care responsibility including, but not limited to, advanced care planning, care coordination, care management, care planning oversight, education and training for patient self-management, medical home program, comprehensive care coordination and planning (initial and maintenance), physician care plan oversight, team conferences, transitional care management/planning, etc."; additional applicable codes added to the code table—34839, 98961 & 98962 (education and training for pt self mgmt), 99490, 99497 & 99498 (advanced care planning) ○ Consolidate information for always bundled "G" codes to state: "programs, services, and supplies identified by certain HCPCS Level "G" codes created for CMS use including, but not limited to, reporting codes (e.g., for functional limitation), Federally Qualified Health Center (FQHC) visits, quality measures, services related to CMS "coverage with evidence development (CED)" clinical trials, CMS demonstration programs, drug screen testing, etc. or when an alternate CPT code exists; additional G codes being added to the code table—G0276, G0431, G0434 (these two codes—G0431 & G0434 were previously used to identify drug screening with a frequency of 1 based on patient encounter however CPT has issued new codes for drug screening therefore these 2 G codes are no longer applicable for our reimbursement), G0466-G0470 ○ There have been codes deleted in the G0908-G0922 range therefore the range has been updated to G0913-G0918 which are still active codes ○ Adding digital breast tomosynthesis to the last bullet of always bundled 3D imaging services along with the corresponding codes being added to the code table—77061, 77062, 77063, G0279

	○ Bullet #40--Removing “Quality Measure codes, and HCPCS Functional Limitation codes” language; duplicative with language in #36 • Section 2: Policy section descriptions-- ○ Under the policy section 2 description, adding modifiers XE, XP, XS, and XU to policy cross-reference for Modifier 59 policy ○ Adding language to #5 regarding unspecified code for digital breast tomosynthesis is bundled to mammographies or breast MRIs; the code 76499 has been in the coding section just being a bit more definitive in the description for this scenario even though DBT has new codes for 2015 (see section #1) ○ Minor update to #9 to make catheter care an example of per diem home infusion therapy since additional HIT codes were added to the edit ○ Adding that urine test or reagent strips or tablets are bundled with urinalysis tests (#23) Coding section— • Adding the codes for supplies and services included with the per diem HIT codes • Under bullet #22, we will only reference that 76942 (u/s guidance) is not eligible when reported with CPT codes listed in the CPT parenthetical statement” rather than listing each of the parenthetical codes • Add bullet #23 A4250 u/a test supplies with u/a codes 81000-81003 Section 3 : Adding reference to the “X” modifiers in the description
11/04/2014	Revised: Adding the following code to code bundling to section 2 of the policy (rule 26): • Electrodes (A4556) and/or lead wires (A4557) reported with electrical stimulator supplies (A4595) on the same date of service and/or within 30 days will be denied; the electric stimulator supplies include the electrodes and wires

	• Home infusion therapy professional pharmacy services, drug administration (S9810), equipment, and supplies (E0776 IV pole) when reported with per diem home infusion therapy catheter care/maintenance (S5497) ○ S5497 is the per diem home infusion therapy care code that includes care and all necessary equipment and supplies ○ Instructions for S9810 states "do not use this code with any per diem code" and code S5497 is identified as a "per diem" code
10/21/2008	Revised: "Always" was eliminated from the title of the policy. The policy was divided into 2 sections to distinguish "Option #1" codes from relationship services not eligible for separate reimbursement when reported with specific other services. Also it was clarified that the 59 mod will not override section 1 codes.
03/10/2008	Initial policy approval and effective date

References and Research Materials

This policy has been developed through consideration of the following:

- Business Decision
- Centers for Medicare and Medicaid (CMS)

Definitions

Bundled Services	Services that are not eligible for separate reimbursement and considered to be part of another service.
General Reimbursement Policy Definitions	

Related Policies and Materials

Evaluation and Management Services and Related Modifiers 25 & 57 - Professional
Distinct Procedural Services Modifier 59 and XE, XP, XS and XU - Professional

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.