Commercial Reimbursement Policy

Subject: **Bundled Services and Supplies - Professional**	
Policy Number: **C-08003**	Policy Section: **Coding**
Last Approval Date: **09/03/2025**	Effective Date: **12/01/2025**

Policy

The health plan considers certain services and supplies to be ineligible for separate reimbursement when reported by a professional provider, unless provider, state, or federal contracts and/or requirements indicate otherwise. 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 CPT® and 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 for separate reimbursement when performed with any other procedure, service or supply. Modifiers 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

Definitions

Bundled Services	Items or services that are not eligible for separate reimbursement and considered to incident to another service rendered on the same date of service.
General Reimbursement Policy Definitions	

References and Research Materials

This policy has been developed through consideration of the following:

- Business decision
- CMS
- Optum EncoderPro 2024

Related Policies and Materials

Bundled Services and Supplies - Facility
Incident to Services and Billing - Professional
Modifiers 25 and 57: Evaluation and Management with Global Procedures - Professional
Modifiers 59, XE, XP, XS, XU: Distinct Procedural Services - Professional

Policy History

09/03/2025	Review approved 09/03/2025 and effective 12/01/2025: updated code lists • Section 1: ○ Added categories for existing always bundled services ○ Removed *specific codes related to the categories* ○ Added new categories: ▪ CMS MPFS RVU Status M Indicator codes ▪ HCPCS H Codes ○ Added new codes G9038, Q0521, 0902T, 0903T, 0904T, 0905T, 0945T ○ Removed deleted codes *99339, 99340, Q0516-Q0520* • Section 2: ○ Removed Telehealth originating site facility fee (Q3014) when reported with an E&M code in place of service 11 this is included in the Virtual Visits (C-08002) ○ Removed deleted codes 74710, 95950, 99224-99226, 99318, 99324-99328, 99334-99337, 99339-99340, 99354-99357, 99363-99364, 99420, 99444, J2001

	○ Removed J3490 when billed in place of service 19, 21, 22, 23, 24, 25, 31, 32, 33, 51, 52, 61, 62 and 65 captured in language of Place of Service- Professional C-09001 (C-24004) ○ Removed deleted code J2001 and added new 2025 code J2004 "when reported with injection, aspiration and needle and catheter placement" and added new 2025 codes 64466-64469, 64473-64474
11/26/2024	Review approved 11/26/2024 and effective 03/01/2025: Section 1: • Added G0310-G0315 • Removed G0453 and moved to Intraoperative Neuromonitoring- Professional (C-24002) • Removed *98966, 98967, 98968, 99441, 99442, and 99443* included in Virtual Visits - Professional and Facility (C-08002) Section 2: • Removed *95940 when reported with 95941* and moved to Intraoperative Neuromonitoring – Professional (C-24002) • Removed *95937 when reported with 95940, 95941 or G0453* and moved to Intraoperative Neuromonitoring – Professional (C-24002)
08/18/2023	Review approved 08/18/2023 and effective 12/01/2023: updated coding lists: Section 1 • Added code G2212- removed from Prolonged Services (C-08011) • Added codes G0316- G0318 • Added codes M0001-M0005, M1150-M1210 • Added codes HCPCS codes G2212, G0316-G0318, M0001-M0005, and M1150-M1210 • Added HCPCS codes S0353 and S0354 -these codes were removed from the Cancer Treatment and Planning retired policy (C-13005) • Removed deleted codes 99217-99220, 99241 and 99251 and consultation codes 99242-99245, 99252-99255 from 69209 and 69210 code pair. • Removed codes 76604, 76705-76706, 76770, 76775-76776, 76815 from the 99281-99285 and 99221-99233 code pair (FAST ultrasounds allow separate reimbursement also removed from Distinct Procedural Services (C-09006)). • Removed deleted codes 99217-99220, 99241 and 99251 and consultation codes 99242-99245, 99252-99255 from 69209 and 69210 code pair and codes 76604, 76705-76706, 76770, 76775-76776, 76815 from the 99281-99285 and 99221-99233 code pair

12/27/2022	Review approved 12/27/2022 and effective 7/1/2023: Section 1 Added HCPCS codes G0310, G0311, G0312, G0313, G0314, G0315
11/16/2022	Review approved 11/16/2022 and effective 03/01/2023: Section 1 ○ Removed codes 99000, 99001 and H0048 were removed from the Bundled Services and Supplies Section 1 coding professional policy and added to the Laboratory and Venipuncture Services – Professional & Facility Review approved 11/16/2022: ○ Removed e-consult Behavior Health codes 99484, 99447-99449 ○ Removed code S2900 and moved to Robotic Assisted Surgery Policy ○ Removed C9032 (deleted 01/01/2019)
06/18/2021	Review approved and effective 10/01/2021: ○ Added telehealth originating site facility fee (Q3014) when reported with an E&M code in place of service 11 ○ Added code G2221 to section 1 always bundle ○ Added 99072 to Section 1(new code 9/8/2020) ○ Added G0453 and S9088 to Section I ○ Removed interprofessional codes 99446, 99451, and 99452 and allow reimbursement ○ HCPCS code S0189. Code will be managed by precertification ○ Added paraoesophageal hernia codes to bundle with bariatric surgery codes ○ Added 76942 when reported with procedure codes 20550, 20551, 20552 and 20553
01/25/2019	Revision approved: Added codes 99451 and 99452 to Section 1 description and code list
09/15/2020	Review approved: removed deleted codes, updated codes and code pairs, and updated market exemptions
08/07/2020	Review approved: added to section 2: paraesophageal hernia codes to bundle with bariatric surgery codes
05/27/2020	Review approved: code list updated to include S9088 in Section I
02/25/2019	Review approved: remove HCPCS code S0189 from Section 1 bundling. Code will be managed by precert
01/25/2019	Review approved: add interprofessional procedure codes 99451 and 99452 to Section 1 description and code list; exemption added for California and Medicare Advantage allows reimbursement.
08/03/2018	Review approved: 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	Review approved: • Section 1

	○ Added language for X-ray DVD or film
12/15/2017	Review approved: moved policy reference section to end of the policy • Section 1 ○ Removed 99495 and 99496 transitional care
08/01/2017	Review approved: Expanded care management to allow these services for PCPs • Section 1 ○ Removed codes *G0502, G0503, G0504*
07/11/2017	Review approved: updated and moved bullet for drug testing • Section 1 ○ G0477-G0479 deleted 1/1/17 • Section 2 ○ Added 76942 when reported with 20552 and 20553 ○ Update moved nonvascular extremity ultrasound when reported with ultrasonic guidance- for needle placement from #49 to #35
06/06/2017	Review approved: • Section 1 ○ Added 99446-99449 ○ Added exemption for Medicare Advantage allows reimbursement for 99446-99449 • Section 2 ○ Added 29822 when billed with 29819, 29820, 29824, 29825, 29827 ○ Added 29823 when billed with 29806, 29807, 29819, 29820, 29821, 29825 ○ 29837 and 29838 when billed with 29834, 29835, 29836 ○ Added A4281, A4282, A4283, A4284, A4285 when billed with E0602, E0603, E0604
04/04/2017	Review approved: • Section 1 ○ Deleted codes 80300-80304 ○ Added codes 80305-80307 ○ Deleted G0477-G0479 ○ Added G0659 ○ Deleted codes 82541, 82543, and 82544 • Section 2 ○ Added G0480-G0483 when reported with G0659 ○ Delete 22614 when reported with 22600, 22610, 22612, 22630 ○ Added 22614 when reported with 22633
02/07/2017	Review approved: • Section 2 ○ Removed deleted codes for spinal injections

	○ Added 62320, 62321, 62322, 62323, 62324, 62325, 62326, and 62327 when reported with image guidance or hospital management service ○ Updated date of code list to match policy date
12/06/2016	Review approved: updated policy date to match 2017 code changes • Section 1 ○ Added codes G0500, G0501, G0502-G0507 ○ Deleted codesT1040 and T1041 ○ Deleted codes 80300-80304, 80305-80307, G0477-G0479 ○ Deleted code GMMM1 ○ Added code G0500
10/04/2016	Review approved: Section 1 code list created as separate document • Section 1: ○ Added codes 80305-80307 ○ Added codes G0477, G0478 and G0479 ○ Added code G0498 ○ Removed codes 80300-80304 • Section 2: ○ Added codes 99151, 99152, 99153, 99155, 99156, and 99157 when reported with codes previously listed in Appendix G of the CPT codebook by the provider rendering the service and the sedation ○ Added codes 88141-88155, 88164-88167when reported with 88174-88175 ○ Added codes 95937 when reported with 95940, 95941, or G0453 ○ Added 22614 when reported with 22600, 22610, 22612, 22630 and 22633 ○ Added 76942 when reported with 76881
09/06/2016	Review approved: • Section 2 ○ Added code 63048 when reported with 22633 ○ Added code 82542 when reported with 91065 ○ Added code G0101, S0610 and S0612 when reported with preventive/annual or problem oriented E/M service ○ Added code 22558 when reported with 63081-63088
08/02/2016	Review approved: • Section 2 ○ Added code 95957 when billed with 95951, 95953, 95954, 95956 on same date if service ○ Added code 95957 when billed with 95950, 95951, 95953, 95954, 95955,95956 on subsequent dates of service ○ Added codes 76942, 77002, 77003, 77012, 77021 when billed with 62310, 62311, 62319, 62319
04/05/2016	Review approved: • Section 1

	○ Added codes G9481-G9490and G9678 ○ Updated language on bullet #39 • Section 2 ○ G0402 when reported with 99381-99397 ○ G0438 and G0439 when reported with preventive CPT codes ○ 69209, 69210, G0268 when reported on the same day as audiologic function testing; no modifier
02/02/2016	Review approved: • Section 1 ○ Added G0180 d ○ Added T2002 ○ Added 99360 ○ Removed for cancer treatment planning • Section 2 ○ Added A4556 when reported with A4558 ○ Added 69209, 69210 when reported with evaluation and management services ○ Added supply codes when reported with 99601and 99602
01/05/2016	Review approved: minor language updates • Section 1 ○ Added CPT codes 803XX ○ Removed G0431 and G0434 • Section 2 ○ Added 29876 when reported with 29879 ○ Added 29880-29887 when reported with arthroscopic knee surgeries without an approved American Academy of Orthopedic Surgeons diagnosis ○ Added 82570 and 83986 when reported with G0480-G0483
12/01/2015	Review approved: • Section 1 ○ Removed code C9257 ○ Added HCPCS “G” or “Q” codes performed in the home or hospice setting • Section 2 ○ Added 82570 and 83986 when reported with 80300-80377 & 83992
11/03/2015	Review approved: • Section 1 ○ Added 99415 and 99416
10/06/2015	Review approved: • Section 1 ○ Added S0310 and S0315-S0317; codes inadvertently dropped off coding table • Section 2

	○ Added S0395, A4580 and A4590 when reported with L3000, L3010, L3020 and L3030 ○ Added 95940 when reported with 95941 ○ Added 77014 when reported with 77280, 77285, and 77290
07/07/2015	Review approved: code list updated • Section 1 ○ Added 98960, 9896, 98962 ○ Added Q9977 ○ Added S5000 and S5001 ○ Added S8262 • Section 2 ○ Added 43235 when reported with 43770, 43771, 43772, 43773, 43774, and/or 43775 ○ Added 36000 when reported with 96360, 96365, 96374, 96375, 96376, 96405, 96406, 96409, 96413, 96416, 96440, 96446, 96450, and/or 96542 ○ Added A4648 when reported with 19081-19101 and/or 19281-19288
06/02/2015	Review approved: Updated code lists • Section 1 ○ Added S9992 ○ Remove codes 77061, 77062, 77063 & G0279 • Section 2 ○ Added codes 82541 – 82544 when reported with 80300, 80301, 80302, 80303, 80304, 80320 – 80377 ○ 76499 medical policy to handle (see also 3D Radiology policy)
04/07/2015	Review approved: added X{EPSU} modifiers to Section 1 • Added codes S9208, S9480, S9484, S9485, S9992, S9999 to Section 1 • Added codes to Section 2 ○ G0438, G0439 when billed with preventive exams ○ A4215 with 97810-97814 ○ Updated information on coding for electrodes and electric stimulator supplies ○ Corrected typo for bullet 16 to S0610-S0613
02/03/2015	Review approved: updated • Section 1 ○ revised language DME 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”;

	○ Added 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."; ○ Added codes 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; ○ Added codes G0276, G0431, G0434, G0466-G0470 ○ updated G code range to G0913-G0918 due to deleted codes ○ Adding digital breast tomosynthesis to the last bullet of always bundled 3D imaging services ○ Added codes 77061, 77062, 77063, G0279 ○ Bullet #40--Removing "Quality Measure codes, and HCPCS Functional Limitation codes" language; duplicative with language in #36 • Section 2: updated Policy section descriptions ○ Added modifiers XE, XP, XS, and XU to policy cross-reference for Modifier 59 policy ○ updated language to #5 regarding unspecified code for digital breast tomosynthesis is bundled to mammographies or breast MRIs; ○ Updated #9 to make catheter care an example of per diem home infusion therapy since additional HIT codes were added to the edit ○ Added urine test or reagent strips or tablets are bundled with urinalysis tests (#23) ○ Added the codes for supplies and services included with the per diem HIT codes ○ Under bullet #22, only 76942 is not eligible when reported with CPT codes listed in the CPT parenthetical statement" ○ Add bullet #23 codesA4250 when billed with with 81000-81003 • Section 3 added the "X" modifiers in the description

11/04/2014	Review approved:
	• Section 2
	  ○ Added A4556, A4557 when reported with A4595 on the same date of service and/or within 30 days
	  ○ Added S9810, E0776 when reported with S5497

01/08/2013	Review approved: added 98966-98968, 98969, 99441-99443 to Section 1 code list
11/21/2010	Review approved: added to Section 2: 93010, 93042 when reported with an E/M service 99202-99215, 99221-99233, 99281-99285 and no longer allows modifier to override
10/21/2008	Review approved: removed “Always” from the title; divided policy to 2 sections (always bundled, and code pairs); added no modifier 59 override to Section 1 codes.
03/10/2008	Initial approval and effective

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 a member’s benefit plan. The determination that a service, procedure, or item is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must also meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member’s state of residence.

Ensure that you use proper billing and submission guidelines, including 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, we 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.

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.