

TITLE:	BUNDLED SERVICES AND SUPPLIES
DEPARTMENT:	PAYMENT POLICY
ORIGINAL EFF. DATE:	09/01/2026
REVISION DATE:	N/A

1. PURPOSE

This Payment Policy outlines clear and consistent reimbursement guidelines to ensure compliant, transparent, and timely payment for medically necessary, cost-effective care.

2. SCOPE

This policy applies to the reimbursement of covered services for all members and providers. Curative will allow reimbursement for services according to the criteria outlined in this policy, unless modified or superseded by contractual language.

3. DEFINITIONS

The following terms are defined as follows regarding this policy.

- 3.1. **Same Individual Provider** The same individual Physician or Other Qualified Health Care Professional rendering health care services reporting the same Federal Tax Identification number.
- 3.2. **Same Specialty Provider** Physicians and/or Other Qualified Health Care Professionals of the same group and same primary specialty reporting the same Federal Tax Identification number.
- 3.3. **Global Surgical Package** The necessary pre-operative, intraoperative and postoperative services and supplies necessary to a surgery, rendered by a provider or a provider of the same group and same primary specialty in any setting.

4. POLICY

Disclaimer: These Payment Policies serve as a comprehensive guide for all providers, assisting in submitting accurate claims and outlining the essential framework for reimbursement. The determination that a service, procedure, or item is covered under a Curative member’s benefit plan does not constitute a guarantee of payment. Services must meet medical necessity and authorization guidelines appropriate to the procedure and diagnosis and, where mandated, the members state of residence. Services rendered must be within the legal scope of practice for the specific type of provider and align with the professional credentials and training in the state where the care is furnished.

To ensure proper processing, providers are required to adhere to industry-standard, compliant codes and follow proper coding, billing, and submission guidelines. To ensure accurate reimbursement and proper claims adjudication, all services provided to the same member, by the same provider, and on the same date of service must be reported on a single claim. Current Procedure Terminology (CPT®) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or relevant revenue codes must be used for billing. Codes submitted must be fully supported by corresponding documentation in the medical record. Unless noted otherwise within a policy, these payment policies apply to both participating and non-participating providers and facilities.

Curative reserves the right to take corrective action, which may include the rejection or denial of the claim, or the recovery and/or recoupment of any previous claim payment if proper coding, billing guidelines, or these established payment policies are not followed. Providers may refer to the Provider Manual for guidance on addressing such actions, including the formal claim reconsideration, appeals, and dispute resolution processes.

These policies may be superseded by mandates within provider contracts, state or federal laws, or requirements issued by the Centers for Medicare & Medicaid Services (CMS). Curative retains the right to revise these policies as deemed necessary and will publish the most current version on the Curative website.

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Reimbursement Guidelines

Curative follows industry standard guidelines and considers some CPT/HCPCS codes to be bundled, incidental, integral, or mutually exclusive, or unbundled from more comprehensive services. In these situations the codes are ineligible for reimbursement when reported on the same date of service for the same member by the Same Individual Provider or Same Specialty Provider.

Bundled Procedures Procedures referred to as "Bundled" represent codes assigned a status indicator of "B" within the National Physician Fee Schedule (NPFS) Relative Value File or are included in the CMS National Correct Coding Initiative (NCCI) or Outpatient Code Edits (OCE). These specific codes are not eligible for independent reimbursement. The bundled code is classified as an integral component of the primary, comprehensive service and will be denied unless an appropriate modifier is appended and clinically supported by medical record documentation.

Incidental Procedures Incidental procedures are procedures carried out during the same session as a more complex procedure but are not considered essential to the primary procedure. These services are not reimbursed separately. Example: If an asymptomatic appendix is removed during a hysterectomy, the appendectomy is classified as incidental and will not be reimbursed separately.

Integral Procedures Integral procedures are procedures considered a standard component of a more comprehensive primary service. These codes represent clinical steps necessary to complete a major procedure, such as the administration of local anesthesia, initial incision, or post-operative wound closure associated with a surgery. Integral actions are fundamental to the primary service, and will not be reimbursed separately. Some integral procedure descriptions contain "separate procedure" indicating the only time the code is considered for reimbursement is when it is performed alone.

Mutually Exclusive Procedures Mutually Exclusive are procedures that, under normal clinical circumstances, could not or should not be performed on the same patient, by the same provider, during the same session. One procedure either inherently includes the other or represents a clinically redundant method of achieving the same result—such as an "open" surgical approach versus a "closed" approach for the same repair.

Unbundled Procedures Unbundled procedures are codes reported separately but not considered for reimbursement due to code description and guidelines, being included in the National Correct Coding Initiative edits, NCCI, the Outpatient Code Edits, OCE, or clinical criteria.

Examples of specific services not separately reimbursed are below.

Allergen Immunotherapy

When allergy immunotherapy injections are reported, any Evaluation and Management visit code (99202-99215) is not eligible for separate reimbursement. The visit code is only eligible for reimbursement if modified to indicate it is significant and separately identifiable.

Cardiac Stress Test

Cardiac stress tests may include the administration of pharmacological agents. This administration is considered an integral component of the service. Separate codes for intravenous administration are not eligible for reimbursement.

Injection Administration

Codes representing the administration of drugs or substances by injection must be submitted on the same claim as the allowable drug or substance. If only the injection is being submitted due to the drug not being supplied by the provider, the line should still be present with a \$.00 or nominal, \$.01 billed amount.

Intravenous administration

Infusion and injection codes for the administration of drugs and substances considered integral to the procedure or service being performed are not separately reimbursable. If the administration being reported is in addition to the other service, the code must be identified as significant and separately identifiable with the appropriate modifier.

Intraoperative Neuromonitoring (IONM)

Intraoperative Neurophysiological Monitoring (IONM) services, represented by CPT codes 95940, 95941, and HCPCS code G0453, are classified as incidental to the primary procedure when performed by the operating surgeon or anesthesiologist. Reimbursement for IONM is only considered for qualified, third-party providers who are not part of the operative team. Facility-billed IONM charges are considered integral to the facility payment and are not eligible for separate reimbursement.

Laboratory Handling

Codes representing laboratory handling and conveyance of lab specimens are considered a component of the overall patient management of the service provided and are not separately reimbursable.

Pre-Screening Colonoscopy Consultation

The evaluation of an asymptomatic patient prior to a screening colonoscopy is considered an inherent and duplicative component of the subsequent procedural work and does not justify separate reimbursement for evaluation and management (E/M) services. Industry screening guidelines assume the member is asymptomatic; therefore, such visits lack clinical medical necessity beyond the standard pre-operative assessment included in the Global Surgical Package. HCPCS code S0285, representing a colonoscopy consultation performed prior to a screening colonoscopy, is classified as bundled into the primary colonoscopy service. In instances where the colonoscopy is not ultimately performed, the consultation code remains ineligible for reimbursement as a standalone screening service.

Robotic Assistance

Surgical techniques utilizing a robotic system (represented by code S2900) are classified as incidental to the primary surgical service. Because robotic assistance is considered a refinement of the surgical technique rather than a separate, standalone procedure, no additional reimbursement is provided for the use of robotic systems. The primary procedure's allowance includes all tools and methods used to complete the surgery.

Specimen Collection

The gathering of specimens, regardless of the technique used, is classified as incidental to Evaluation and Management (E/M), Surgical, and Laboratory services. This includes, but is not limited to, venipuncture, central venous access, and nasal or throat swabs. Only one specimen collection per type is allowed per individual provider per encounter.

Specimen collection from a completely implantable venous access device is considered incidental when performed with a National Physician Fee Schedule (NPFS) status indicator of A, R or T when performed on the same date of service and reported by the same provider.

Supplies

Specific HCPCS supply codes are not eligible for independent reimbursement, as the cost of these materials is classified as integral to the Evaluation and Management (E/M) service or procedure when rendered in a non-facility setting. These components are included in the allowance for the primary service.

Provisions including durable medical equipment (DME), orthotics, prosthetics, biologicals, and drugs are considered integral to the facility payment. Therefore, these items are ineligible for separate reimbursement when submitted on a CMS-1500 claim form for services performed in a facility setting.

Certain DME, orthotics, prosthetics, and associated supplies are considered included in the comprehensive payment to skilled nursing and nursing facilities. Such items will not be reimbursed separately when reported via a CMS-1500 claim form.

Medical and surgical supplies considered separate from another service must be submitted with the appropriate Level II HCPCS code. Non-specific CPT codes 99070 (representing supplies and materials provided by a physician or other qualified healthcare professional beyond those typically included in an office visit) and 99072 are not eligible for separate reimbursement in any setting.

Any outpatient disposable supply or device, including but not limited to bandages, testing supplies (except for diabetes) diapers, bedpans, support hose, compresses and other devices not intended for reuse are not eligible for separate reimbursement in any setting.

Visit Complexity

Curative does not reimburse separately for the visit complexity codes. The services described by codes G2211 and G0545 are considered bundled to the Evaluation and Management Service rendered.

5. REFERENCE DOCUMENTS AND MATERIALS

- 5.1. American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services
- 5.2. Centers for Medicare and Medicaid Services (CMS), CMS Manual System and other CMS publications and services
- 5.3. Centers for Medicare and Medicaid Services (CMS), National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services

5.4. National Uniform Billing Committee (NUBC)

6. COLLABORATING DEPARTMENTS

- 6.1. Claims
- 6.2. Compliance
- 6.3. Medical Management
- 6.4. Network
- 6.5. System Configuration

7. POLICY & PROCEDURE CONTROL

This Policy will be reviewed at least annually and as necessary.

REVISION HISTORY			
Date	Author	Version	Comments
09-01-2026	CJ Wisecarver	001	Initial Version