Bundled Services

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Important Note About This Policy

Oscar's reimbursement policies serve as a guide to assist providers with accurate claims submission and outline the basis for reimbursement if the service is a covered benefit. Coverage does not guarantee reimbursement; services must meet authorization and medical necessity guidelines for the procedure, diagnosis, and member's state of residence.

Our policies provide general reference for described services and do not cover every aspect of reimbursement. Other factors may supplement, modify, or supersede this policy, including legislative mandates, provider contracts, member benefit documents, and/or other reimbursement, medical, or drug policies. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

Providers are responsible for submission of accurate documentation of services performed. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing Editor, American Medical Association, Current Procedural Terminology, CPT® Assistant, Healthcare Common Procedure Coding System, ICD-10 CM and PCS, National Drug Codes, Diagnosis Related Group guidelines, Centers for Medicare and Medicaid Services National Correct Coding Initiative Policy Manual, CCI table edits and other CMS guidelines. If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may deny the claim and/or recoup claim payment.

Oscar routinely updates reimbursement policies, and new versions are published on this website. If you print a copy of this policy, please be aware that the policy may be updated later. Oscar communicates policy updates to providers via update notifications.

Description

The Centers for Medicare and Medicaid Services (CMS) classifies services utilizing status indicators within the Physician Fee Schedule (PFS) and under the Hospital Outpatient Prospective Payment System (OPPS). These status indicators also define codes considered to be bundled. CMS also developed the National Correct Coding Initiative (NCCI) edits to prevent payment when incorrect code combinations are reported. Additionally, the American Medical Association (AMA) Current Procedural Terminology (CPT) codebook guidelines and code descriptions often contain information about services that are bundled and not separately reportable.

Policy

Oscar considers payment for certain services to be already factored into the reimbursement for other services. Oscar will not make a separate payment for the bundled service when conducted by the same provider in the same session. Oscar follows industry guidance including, but not limited to, Medicare NCCI standards, PFS and OPPS status indicators, as well as CPT codebook information for determining bundled services that are not separately reimbursable for professional and facility claims.

For the purpose of this policy, "same provider" is defined as any group of physicians and/or other healthcare professionals who bill under the same National Provider Identifier (NPI).

Reimbursement Guidelines

Oscar bundles payment for services based on industry guidance including, but not limited to, Medicare NCCI standards, PFS and OPPS status indicators, as well as CPT codebook information as detailed below. This is not an exhaustive list, therefore, there may be additional scenarios where services are considered bundled.

Status Indicators

Oscar aligns with CMS on the definition and reimbursement on certain status indicators. CMS assigns codes a status indicator that describes how the service will be reimbursed. These indicators can be found within the PFS and in the OPPS files. Codes assigned indicators that categorize the service as bundled or packaged are not separately payable. These indicators are as follows:

- Status Indicator B - This status indicator in the PFS defines codes where the service is always bundled into payment for other services. No separate payment is made for these services whether billed alone or with another service.
- Status Indicator N - This status indicator in the OPPS defines codes which are always packaged into payment for other services. There is no separate APC payment for these codes.
- Status Indicator P - This status indicator in the PFS defines bundled/excluded codes. The services are incidental to other payable services and are not separately payable.
- Status Indicator T - This status indicator in the PFS defines codes where the service is always bundled into payment for other services. These codes are only considered for payment when there are no other services billed on the same date.

NCCI Procedure-to-Procedure (PTP)

Oscar aligns with CMS on the application of NCCI PTP edits. The CMS NCCI PTP files detail codes that should not be reported together on a service date. Codes are paired and assigned as either Column One or Column Two within that pair where Column One is the code eligible for payment and Column Two is often a component of the more comprehensive code and not separately payable unless it meets certain requirements. The code pairs are based on rationale including, but not limited to, the following:

- CPT Manual or CMS manual coding instruction
- HCPCS/CPT procedure code definition
- CPT Separate procedure definition
- Standards of medical/surgical practice
- Mutually exclusive procedures
- Misuse of Column Two code with Column One code

NCCI PTP code pairs are assigned a Correct Coding Modifier Indicator (CCMI) that defines whether PTP-associated modifiers can be used when appropriate to override the pairing. The CCMIs are as follows:

- 0 - Indicates that NCCI PTP-associated modifiers cannot be used to bypass the edit
- 1 - Indicates that NCCI PTP associated modifiers may be used to bypass an edit under appropriate circumstances
- 9 - Indicates that the use of NCCI PTP-associated modifiers is not specified

Modifiers used to override PTP edits should be appropriate for the services rendered and should be supported by medical records. Oscar may verify modifier appendage by requesting medical records, review of diagnosis, and claim history to ensure that included modifiers adhere to the standards outlined by CMS and AMA.

The NCCI policy manual does specify that “the edits and policies do not include all possible combinations of correct coding edits or types of unbundling that exist. Providers/suppliers are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination.” Therefore, NCCI PTP edits are not the sole indicator as to whether services are inclusive of another or if a modifier should be used with services.

Incidental/Inherent/Inclusive Services and Supplies

Oscar considers certain services and supplies as incidental/inherent/inclusive to the procedure or facility charges on a claim. These services and supplies may not fall into the categories above, however, are still considered bundled and not separately payable due to industry standards, coding guidance, or are essential in completing other services. Examples include, but are not limited to:

- Services or supplies, such as imaging, that are incidental to a procedure
- Nursing care services that are incidental to room and board charges
- Floor stock supplies that are routine and incidental to room and board charges
- Tissue markers are inherent to placement of localization device procedures
- Chronic care management, complex chronic care management, and transitional care management are considered incidental to all other E/M services

Appending modifier 25, modifier 59, an X{EPSU} modifier, or another modifier does not independently establish eligibility for separate reimbursement when the underlying service is considered incidental, inherent, or inclusive to another service or does not otherwise meet applicable requirements for separate reporting.

Related Policies

Correct Coding Guidelines
Modifier Guidelines
Routine Services, Supplies, and Equipment

References

1. American Medical Association, Current Procedural Terminology (CPT®)
2. Healthcare Common Procedure Coding System (HCPCS)
3. Centers for Medicare and Medicaid Services, Status Indicators
4. Centers for Medicare and Medicaid Services, ADDENDUM D1.—PROPOSED OPPS PAYMENT STATUS INDICATORS
5. Centers for Medicare and Medicaid Services, MLN Matters, Hospital Outpatient Prospective Payment System: January 2026 Update
6. Centers for Medicare and Medicaid Services, Medicare NCCI Policy Manual
7. Centers for Medicare and Medicaid Services, Medicare NCCI Procedure to Procedure (PTP) Edits
8. Centers for Medicare and Medicaid Services, Medicare NCCI FAQ Library

Publication History

Date	Action/Description
04/01/2017	Original Documentation
04/20/2017	Approval and inclusion in Oscar Provider Manual
08/29/2018	Policy Updated
04/01/2025	Removed venipuncture statement of “Routine Venipuncture is bundled into any other rendered service” as a new self-titled policy was created for venipuncture reimbursement guidelines.
06/08/2026	Annual Review. Added Date section for quick reference; Added disclaimer; Added Description Section; Updated Policy Section to remove individualized statements of bundled services and replaced with standards by which the statements were based (status indicators, NCCI, etc.), Deleted Coding Section as it only served for definition of the individualized statements that were also removed; Added Related Policies Section; Added References Section.
10/12/2026	Off-Cycle Update. Relocated chronic care management, complex chronic care management, and transitional care management stance from Evaluation and Management Services policy tc this policy; Adjusted the layout of the Incidental/Inherent/Inclusive Services and Supplies subsection to fit the care management information and added the previous bundled example

	of tissue markers back into the policy; Added clarification about modifier application to the items that fall under Incidental/Inherent/Inclusive Services and Supplies.