Reimbursement Policy

Associated Services and Related Claims

REIMBURSEMENT POLICY NUMBER: 9

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SCOPE AND APPLICATION..... 1
POLICY STATEMENT..... 1
POLICY GUIDELINES..... 5
CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) 6
CROSS REFERENCES..... 9
REFERENCES..... 9
POLICY REVISION HISTORY..... 10

INSTRUCTIONS FOR USE: Company reimbursement policies serve as guidance for the administration of plan benefits, reimbursement methodologies, and acceptable billing practices, intended to help health care providers submit claims accurately in order to reduce delays and ensure more accurate claim adjudication. Reimbursement policies do not constitute a guarantee of coverage. They allow for the consistent application of our member contracts, provider contracts, clinical edits, and medical policies. In the event of a conflict between one of these documents and a reimbursement policy, these documents will take precedent over the reimbursement policy. If contracts and policies are silent, the Company may defer to guidance from the Centers for Medicare & Medicaid Services (CMS) when available and applicable. In addition to correct billing practices, in order to qualify for reimbursement, all services, items, and procedures must be covered member benefits and must also meet applicable authorization and medical necessity guidelines. Company reimbursement policies are reviewed annually. The Companies reserve the right to determine the application of reimbursement policies and make revisions to reimbursement policies at any time.

SCOPE AND APPLICATION

Provider Type:

☒ Professional Claims

☒ DMEPOS Suppliers

☒ Facilities

Plan Product:

☒ Commercial

☒ Medicare

☐ Medicaid/Oregon Health Plan (OHP)

POLICY STATEMENT

SCOPE: Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as "Company" and collectively as "Companies").

NOTE: This policy does not replace or supersede established bundling practices or clinical edits, including but not limited to, the use of Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) edits, CMS Medically Unlikely Edits (MUEs) and established global period bundling. This means even if a service is determined to be a medically necessary, *unrelated* service, it may still be denied separate reimbursement if an NCCI edit or global period denial applies, or the number of units eligible for reimbursement may be reduced based on CMS MUEs.

I. For the purposes of this policy, terms or phrases such as "denied," "non-covered services," "non-covered procedures," or "non-covered items" refers to any service, procedure, or item denied with any of the following denial reasons: Not medically necessary, not a covered benefit or a member benefit exclusion, a benefit limit (maximum) has been reached, investigational, cosmetic, or provider or supplier contract exclusion. However, denial reasons may not be limited to this list alone and other scenarios at the discretion of the Company when upon review of medical records, it is determined that charges are associated with non-covered services.

Non-Medicare Plan Members

II. If the principal or primary procedure, service, drug, product, or equipment is denied by the Company, all associated services and claims/charges **related to**, **or integral to, the performance of** (hence, "associated with") the denied primary service will **also be denied and will not be allowed reimbursement**. Examples of these situations include, but are not limited to, the following (A.-H.):

A. **For *non-covered services, surgeries, or procedures***, the following are common examples of "associated services" or related charges:
   i. Preoperative professional services such as a history and physical (e.g., services or charges incurred in preparation for a non-covered service or procedure).
   ii. Preoperative laboratory, cardiology and radiology testing.
   iii. Surgeon, assistant surgeon, co-surgeon and team surgeon charges.
   iv. Facility charges.
   v. Supporting professional care (e.g., anesthesiologist, pathologist, radiologist charges, etc.).
   vi. Postoperative laboratory, cardiology and radiology testing when directly related to the non-covered surgery.
   vii. Supplies, drugs or DME used as part of operative or postoperative care.
   viii. Contrast media expenses/services provided and directly related to or required for a denied/non-covered radiology service.

B. **For *non-covered durable medical equipment, prosthetic or orthotic devices***, the following are common examples of "associated services" or related charges:
   i. Accessories and supplies, billed by the same DME provider or supplier.
   ii. Accessories and supplies, billed by a different DME provider or supplier.

C. **For *non-covered drugs, biologicals, or other products/implants***, the following are common examples of "associated services" or related charges:
   i. Charges for the administration, application or implantation of the non-

covered drug/product/implant.

Complications (Non-Medicare)

I. **For non-Medicare plan members**, for complications following a non-covered procedure or service, see the member benefit handbook.

Medicare Plan Members

III. The Company follows guidelines set by the Centers for Medicare and Medicaid Services (CMS) regarding services associated with a non-covered service.[1-4]

A. Services **related to** a non-covered service are also not covered services. Examples of non-covered services or items include, but are not limited to, the following (i.-v.):

i. Related services on the same claim or performed during the same encounter or same hospital stay. Examples include but may not be limited to the following (1.-3.):
   1. A non-covered injectable substance will result in denial of the administration charges.
   2. A denied surgery will result in the denial of hospital and anesthesia charges related to the non-covered surgery.
   3. Non-covered durable medical equipment, prosthetics or orthotics will result in the non-coverage of related supplies, accessories, fittings, fabrication, etc.

ii. Services related to follow-up care when expected to have been incorporated into the global follow-up days (e.g., postoperative visits to the surgeon for evaluating patient progress).

iii. Complications of non-covered services which require treatment *during* the hospital stay in which the non-covered service was performed.

iv. If a drug or other product is non-covered, the administration or application of that drug/product will also be denied. In addition, any other service which was primarily for the purposes of administering a non-covered injection will also be denied as an "associated" or related service.

Complications (Medicare)

IV. **For Medicare plan members**, complications which arise and services required *after discharge* from a hospital stay in which the non-covered service was performed are not subject to this policy.

A. Complications which arise at a later date following a non-covered procedure when they are otherwise considered medically necessary and covered benefits. The following (i.-iv.) are examples, but are not meant to represent an all-inclusive list:

i. Reversal or reoperation of a non-covered bariatric surgery when required for medically necessary reasons (e.g., bleeding, infection, obstruction, prolapse, etc.). *(When a relevant medical policy exists for a procedure, the medical policy will be used determine medical necessity for such situations.)*
ii. Complications following a cosmetic surgery (i.e., hematoma, bruising, seroma formation, nerve damage, infection, scarring and contracture, blood loss, pain, complications of anesthesia, deep vein thrombosis, and pulmonary embolism).
iii. Treatment of an infection as the result of a non-covered transplant that occurred **following discharge** from the hospital or facility.

(See the CMS section below)

All Plan Members

V. This policy applies to any service that is considered non-covered, even in any of the following situations:

A. The primary non-covered service was paid for by the member out-of-pocket; **or**
B. The non-covered service was rendered prior to member enrollment with the Company (or was provided while the member was under another insurance company); **or**
C. A CPT/HCPCS code for the non-covered service, item or product was not submitted to the plan.

VI. Charges for procedures, services, drugs, products, or equipment which are **unrelated** to (aka, **not related to**) a non-covered item, procedure, or service may be eligible for coverage and/or separate reimbursement when they are otherwise considered medically necessary covered benefits (i.e., they are a covered benefit, they are not statutorily excluded, they meet any applicable Medicare or Company medical policy criteria requirements, etc.). *(This may include services performed on the same date and billed on the same claim or during the same inpatient hospital stay, **if** those services are not related to or integral to the performance of the non-covered procedure.)* Examples that might warrant consideration of coverage for services rendered on the same claim **or** during the same inpatient stay as a non-covered procedure include, but are not limited to, the following situations:

A. A medically necessary breast reconstruction procedure, during which a non-covered (not medically necessary) skin or tissue substitute is utilized. While the HCPCS code for the skin substitute *product* is not covered, and the CPT code for the *application* of the skin substitute product would also be denied as a related service under this policy, since the application of the skin substitute is not the primary procedure rendered, other breast reconstruction procedures may be considered separately for coverage.
B. A member delivers a baby, and while in the hospital, has a non-covered (not

medically necessary) fetal genetic test. Since the genetic test is not the primary procedure rendered, charges for the labor and delivery would not be subject to this policy as they would not be considered "related services."

C. A member has a medically necessary coronary angiogram and stent placement, but during the same operative session, also undergoes a coronary lithotripsy, which is non-covered. While all codes representing the coronary lithotripsy components will be non-covered as not medically necessary, since the lithotripsy is not the primary procedure, the angiogram and stent placement may be considered separately for coverage.

***NOTE**: If services are denied as an associated service, an appeal or reconsideration request can be submitted for the charges they feel are **not related to** the non-covered service and which should be considered for payment or coverage.*

VII. Treatment of unsatisfactory or suboptimal results from non-covered or cosmetic procedures are not considered medical or surgical complications. Therefore, services performed for the purpose of achieving satisfactory results would be considered non-covered services as well.

*Note: This exclusion applies regardless of whether the unsatisfactory outcome is the result of **either** patient non-compliance with post-procedural instructions (e.g., activity restrictions, use of compression garments, surgical site protection, smoking cessation, avoidance of sun exposure, etc.) **or** poor performance by the rendering provider.*

VIII. If payment is made inadvertently, recovery efforts may be made to recoup the erroneous payment.

POLICY GUIDELINES

BACKGROUND

The Company will consider services associated with non-covered services (e.g., services denied as investigational, cosmetic, not medically necessary, not a covered member benefit, etc.) to also be non-covered. This applies to all services and claim types.

We will not allow providers or members to retain reimbursement from us for these associated claims. Therefore, if payment is made inadvertently, recovery efforts may be made to recoup the erroneous payment. Responsibility for the costs associated with these claims will be assigned to the provider or member depending on the denial type.

Examples include:

- Surgeon claim, hospital claim, and anesthesiologist claim: The surgeon claim is considered the primary claim, while the claims from the hospital and anesthesiologist are considered the related or associated claims. If the surgery is not covered, then in addition to the surgeon claim being non-covered, all related or associated claims will also be considered non-covered.
- Durable medical equipment (DME) and related supplies: If medical equipment is non-covered, then any supplies (e.g., batteries) and services (e.g., set-up, maintenance services, etc.) that may be required for the use of the non-covered equipment, as well as replacement of the non-covered equipment will also be considered non-covered.

Note: If other services are provided and billed in conjunction with the denied service, but are not related to the non-covered and denied service, the Company will review those services for consideration of coverage and reimbursement.

COMPLICATIONS

Medicare

Medicare regulations state that some services may be allowed coverage, even if they are related to a prior non-covered procedure. In particular, if a member has a non-covered surgery or procedure while admitted as an inpatient in a hospital, if after discharge from the hospital they experience complications which require medical treatment, coverage may be allowed. See the CMS references noted in the policy for more details.

Non-Medicare and Non-Medicaid

Reimbursement for complications following a non-covered procedure or service vary by member benefit contract and some plans have direct member benefit exclusions for complications of a non-covered procedure. Therefore, the member benefit handbook will need to be referenced to determine how to apply coverage or reimbursement rules.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

GENERAL

The following Centers for Medicare & Medicaid Services (CMS) guidance was identified which addresses services related to and required as a result of a non-covered service:

- Medicare Benefit Policy Manual, Chapter 16, §180 - Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare
- Medicare Benefit Policy Manual, Chapter 1, §120 - Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare
- Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services, §110.3 - Coverage of Supplies and Accessories
- Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services, §50.4.3 - Examples of Not Reasonable and Necessary, 3. Excessive Medications

- Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services, §50.4.7 - Denial of Medicare Payment for Compounded Drugs Produced in Violation of Federal Food, Drug, and Cosmetic Act
- Noridian Healthcare Solutions, Inc. Anesthesia. webpage (states anesthesia services for non-covered surgical procedures are non-covered)

General Medicare Guideline

Medicare Benefit Policy Manual, Chapter 16 - General Exclusions From Coverage, §180 - Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare

> "Medical and hospital services are sometimes required to treat a condition that arises as a result of services that are not covered because they are determined to be not reasonable and necessary or because they are excluded from coverage for other reasons. Services "related to" non-covered services (e.g., cosmetic surgery, non-covered organ transplants, non-covered artificial organ implants, etc.), including services related to follow-up care and complications of non-covered services which require treatment during a hospital stay in which the non-covered service was performed, are not covered services under Medicare. Services "not related to" non-covered services are covered under Medicare."

This CMS reference further clarifies:

> "…After a beneficiary has been discharged from the hospital stay in which the beneficiary received non-covered services, medical and hospital services required to treat a condition or complication that arises as a result of the prior non-covered services may be covered when they are reasonable and necessary in all other respects. Thus, coverage could be provided for subsequent inpatient stays or outpatient treatment ordinarily covered by Medicare, even if the need for treatment arose because of a previous non-covered procedure. Some examples of services that may be found to be covered under this policy are the reversal of intestinal bypass surgery for obesity, complications from cosmetic surgery, removal of a non-covered bladder stimulator, or treatment of any infection at the surgical site of a non-covered transplant that occurred following discharge from the hospital.
>
> "However, any subsequent services that could be expected to have been incorporated into a global fee are not covered. Thus, where a patient undergoes cosmetic surgery and the treatment regimen calls for a series of postoperative visits to the surgeon for evaluating the patient's progress, these visits are not covered."

Application to Durable Medical Equipment Supplies and Accessories

Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services, §110.3 - Coverage of Supplies and Accessories

> "Payment may be made for supplies, e.g., oxygen, that are necessary for the effective use of durable medical equipment. Such supplies include those drugs and biologicals which must be

put directly into the equipment in order to achieve the therapeutic benefit of the durable medical equipment or to assure the proper functioning of the equipment, e.g., tumor chemotherapy agents used with an infusion pump or heparin used with a home dialysis system. **However, the coverage of such drugs or biologicals does not preclude the need for a determination that the drug or biological itself is reasonable and necessary for treatment of the illness or injury or to improve the functioning of a malformed body member.**"

In addition to this CMS manual, various LCDs and LCAs also state that if medical necessity criteria are not met for the base equipment, then related supplies and accessories will also be denied as not medically necessary. Coverage of supplies and accessories requires the primary equipment to be considered medically necessary and covered. Examples include, but are not limited to, the LCD for *External Infusion Pumps* (L33794), *Hospital Beds and Accessories* (L33820), and *Wheelchair Options/Accessories* (L33792).

Application to Hospital Services

Medicare Benefit Policy Manual, Chapter 1 - Inpatient Hospital Services Covered Under Part A, §120 - Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare

"Medical and hospital services are sometimes required to treat a condition that arises as a result of services that are not covered because they are determined to be not reasonable and necessary or because they are excluded from coverage for other reasons. Services "related to" non-covered services (e.g., cosmetic surgery, non-covered organ transplants, non-covered artificial organ implants, etc.), including services related to follow-up care and complications of non-covered services which require treatment during a hospital stay in which the non-covered service was performed, are not covered services under Medicare. Services "not related to" non-covered services are covered under Medicare."

Application to Services Associated with Mediations or Drugs

Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services, §50.4.3 - Examples of Not Reasonable and Necessary, 3. Excessive Medications

"If a medication is determined not to be reasonable and necessary for diagnosis or treatment of an illness or injury according to these guidelines, the A/B MAC (B) or DME MAC excludes the entire charge (i.e., for both the drug and its administration). Also, A/B MACs (B) exclude from payment any charges for other services (such as office visits) which were primarily for the purpose of administering a noncovered injection (i.e., an injection that is not reasonable and necessary for the diagnosis or treatment of an illness or injury)."

Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services, §50.4.7 - Denial of Medicare Payment for Compounded Drugs Produced in Violation of Federal Food, Drug, and Cosmetic Act

"Section 1862(a)(1)(A) of the Act requires that drugs must be reasonable and necessary in order to by covered under Medicare. This means, in the case of drugs, the FDA must approve them for marketing. Section 50.4.1 instructs A/B MACs (A) and (B)to deny coverage for drugs that have

not received final marketing approval by the FDA, unless instructed otherwise by CMS. The Medicare Benefit Policy Manual, Chapter 16, "General Exclusions from Coverage," §180, instructs A/B MACs (B) to deny coverage of services related to the use of noncovered drugs as well. Hence, if DME or a prosthetic device is used to administer a noncovered drug, coverage is denied for both the nonapproved drug and the DME or prosthetic device."

Other Services Not Previously Called Out

Additional local coverage determination (LCD) references and other Medicare instruction may be available for specific services, but the above citations demonstrate the general CMS regulation and will be applied to all services, items and procedures.

CROSS REFERENCES

Medical Policies

- Company: Durable Medical Equipment Prosthetics Orthotics and Supplies (DMEPOS), MP142
- Medicare: Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), MP302

Coding Policies

- Global Surgical Package, CP12.0
- Modifiers 58, 78, and 79, CP72.0

The full Company portfolio of current Reimbursement Policies is available online and can be accessed here.

REFERENCES

1. Centers for Medicare & Medicaid Services (CMS). Medicare Benefit Policy Manual, Chapter 16 - General Exclusions From Coverage, §180 - Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c16.pdf. Accessed 6/30/2026.
2. CMS. Medicare Benefit Policy Manual, Chapter 1 - Inpatient Hospital Services Covered Under Part A, §120 - Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c01.pdf. Accessed 6/30/2026.
3. CMS. Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services, §110.3 - Coverage of Supplies and Accessories. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c15.pdf. Accessed 6/30/2026.
4. CMS. Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services, §50.4.3 - Examples of Not Reasonable and Necessary. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c15.pdf. Accessed 6/30/2026.
5. CMS. Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services, §50.4.7 - Denial of Medicare Payment for Compounded Drugs Produced in Violation of Federal Food, Drug, and Cosmetic Act. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c15.pdf. Accessed 6/30/2026.

6. Noridian Healthcare Solutions, Inc. (Noridian). Anesthesia. Last updated: 1/13/2025. https://med.noridianmedicare.com/web/jfb/specialties/anesthesia-pain-management. Accessed 6/30/2026.

POLICY REVISION HISTORY

Date	Revision Summary
8/2024	New Reimbursement Policy
11/2025	Annual review; no changes to policy position statements
11/2026	Annual review; no changes to policy position statements