HIGHMARK.

Reimbursement Policy

Title: Associated Services

Policy Number: RP-059

Version Number: 2026.11.9

Medicare Advantage:	PA, WV, DE, NY	Version Effective:	November 9, 2026
Commercial:	PA, WV, DE, NY	Originally Effective:	January 15, 2021
Claim Type:	CMS 1500 and UB04	History Versions:	Click Here → History

Disclosure: *The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan and ensure you are reimbursed based on the codes that correctly describe the health care services provided. Reimbursement Policies do not provide guidance on whether a service is a covered benefit under the members' contract. Benefit determinations are based in all cases on the applicable benefit plan contract language and applicable medical policies. Should there be any conflicts between Reimbursement Policy and the member's benefit plan, the member's benefit plan will prevail. Additionally, health care providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Reimbursement Policy is not intended to impact care decisions or medical practice. This Reimbursement Policy is intended to serve as a guide as to how the plan pays for covered services, however, other factors may influence payment and, in some cases, may supersede this policy. The provider should consult their network provider agreement for further details of their contractual obligations. The policy is applicable to designated markets either entirely, or partially, as indicated within the policy. Policy designation of claim type is based on how the provider is contracted with the Plan.*

Description:

This policy establishes reimbursement guidelines for services that are provided in connection with, supplied for, or integral to a principal medical or surgical service that is denied or not covered under the member's benefit plan. When the principal service is denied, directly related professional and facility services may also be denied or subject to payment recoupment.

Reimbursement Guidelines:

COMMERCIAL REIMBURSEMENT GUIDELINES:

This policy provides guidelines on the denial of, or recoupment of, reimbursement for services related to, associated with, or specifically supplied for the purpose of providing a medical or surgical service or integral to the performance of a medical or surgical service ("Associated Services") when the medical or surgical service is denied by the member's benefits including denials based on medical necessity. This policy applies to professional, and facility claims.

If the principal procedure, visit, or service is denied by the member's benefit Plan as a non-covered service including not medically necessary denials, all Associated Services (e.g., anesthesia, laboratory procedures, evaluation and management services, hospital services supplies, and medications) to the denied principal service will also be denied. In addition, the Plan will not allow providers or members to retain reimbursement for these Associated Services claims. This applies to both professional and facility claim types, regardless of how the denied principal procedure, visit, or service was submitted.

Note: If other services are provided not related to the denied procedure, but billed in conjunction with the denied service, the Plan will carefully consider and separate those services during the review process to ensure eligible services are paid or remain paid.

Associated Services will not be eligible for reimbursement when billed:

- by the same or different provider, or
- on the same or different claim

The following Associates Services to denied principal services will not be eligible for reimbursement:

1. **Anesthesia services** provided on the same date of service as a denied surgical service (refer to commercial medical policy A-1 Anesthesia Provided in Conjunction with Non-covered Services)
2. **Assistant Surgery, Co-Surgery, Team Surgery services** reported with modifiers 80, 81, 82, AS, 62 and 66, on the same date of service as a denied surgical service
3. **Evaluation and management (E&M) services** reported for the sole purpose of providing E&M services related to a denied service
4. **Pathology claims** reported with the same diagnosis as the denied service
5. **Radiology services** directly related to a denied medical or surgical service
6. **Facility services** used to provide the denied surgical or medical service
7. **Laboratory and/or diagnostic medical procedures** directly related to the denied medical or surgical service
8. **Office, facility, or DME supplies** provided and directly related to a denied service
9. **Injection/infusion** services provided and directly related to a denied service

10. **Contrast media** expenses/services provided and directly related to a denied service
11. **Drugs** provided pre-operatively, intra-operatively, or post-operatively and directly related to a denied surgery or drugs provided for the purpose of providing a denied treatment

The Plan may deny, or recoup payment made for Associated Services based on the criteria outlined above.

Note: Associated Services outlined in this reimbursement policy are considered non-covered services and not billable to the member (balance billing). **A network provider can only bill the member for the non-covered service(s) if the provider obtains advance written notice (signed consent) informing the member that the primary procedure and the dependent associated service(s) are non-covered by the Plan.** The member **must** be provided with a written estimate of the cost of the non-covered service(s) **prior to** delivery of those services. The member must agree in writing to assume financial responsibility in advance of receiving the services if the service is a non-covered benefit. The signed agreement is required to be maintained in the member's records and delivered to the Plan upon request.

MEDICARE ADVANTAGE REIMBURSEMENT GUIDELINES:

The Plan follows and adheres to guidelines as directed by the Centers for Medicare and Medicaid Services (CMS) in relation to services associated with a Medicare non-covered service. See Medicare Benefit Policy Manual Claims Chapter 1, section 120.

Coding:

N/A

Definitions:

N/A

References:

- Centers for Medicare and Medicaid Services; Medicare Benefit Policy Manual Claims Chapter 1, section 120. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c01.pdf

Related Plan Policies:

Refer to the following Commercial Medical Policies for additional information:

- A-1: Anesthesia Provided in Conjunction with Non-covered Services
- Z-67: Experimental / Investigational Services

Refer to the following Reimbursement Policies for additional information:

- RP-001: Assistant Surgery
- RP-002: Co-Surgery
- RP-035: Correct Coding Guidelines
- RP-037: Emergency E&M Services
- RP-052: Surgical Team

Policy Update History:

06 / 2023	Administrative policy review with no changes in policy direction
08 / 2025	Updated policy direction to include primary procedure medical necessity details
11 / 2026	Administrative policy review with no changes in policy and applied to new policy template

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-059		
Subject:	Associated Services		
Effective Date:	January 15, 2021	**End Date:**	
Issue Date:	August 25, 2025	**Revised Date:**	August 2025
Date Reviewed:	May 2025		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☒	**1500**	☒				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility applications is based on how the provider is contracted with the Plan.

History

COMMERCIAL REIMBURSEMENT GUIDELINES:

This policy provides guidelines on the denial of, or recoupment of, reimbursement for services related to, associated with, or specifically supplied for the purpose of providing a medical or surgical service or integral to the performance of a medical or surgical service ("Associated Services") when the medical or surgical service is denied by the member's benefits including denials based on medical necessity. This policy applies to professional, and facility claims.

If the principal procedure, visit, or service is denied by the member's benefit Plan as a non-covered service including not medically necessary denials, all Associated Services (e.g., anesthesia, laboratory procedures, evaluation and management services, hospital services supplies, and medications) to the denied principal service will also be denied. In addition, the Plan will not allow providers or members to retain reimbursement for these Associated Services claims. This applies to both professional and facility claim types, regardless of how the denied principal procedure, visit, or service was submitted.

Note: If other services are provided not related to the denied procedure, but billed in conjunction with the denied service, the Plan will carefully consider and separate those services during the review process to ensure eligible services are paid or remain paid.

Associated Services will not be eligible for reimbursement when billed:

- by the same or different provider, or
- on the same or different claim

The following Associates Services to denied principal services will not be eligible for reimbursement:

1. **Anesthesia services** provided on the same date of service as a denied surgical service (refer to commercial medical policy A-1 Anesthesia Provided in Conjunction with Non-covered Services)
2. **Assistant Surgery, Co-Surgery, Team Surgery services** reported with modifiers 80, 81, 82, AS, 62 and 66, on the same date of service as a denied surgical service
3. **Evaluation and management (E&M) services** reported for the sole purpose of providing E&M services related to a denied service
4. **Pathology claims** reported with the same diagnosis as the denied service
5. **Radiology services** directly related to a denied medical or surgical service
6. **Facility services** used to provide the denied surgical or medical service
7. **Laboratory and/or diagnostic medical procedures** directly related to the denied medical or surgical service
8. **Office, facility, or DME supplies** provided and directly related to a denied service
9. **Injection/infusion** services provided and directly related to a denied service
10. **Contrast media** expenses/services provided and directly related to a denied service
11. **Drugs** provided pre-operatively, intra-operatively, or post-operatively and directly related to a denied surgery or drugs provided for the purpose of providing a denied treatment

The Plan may deny, or recoup payment made for Associated Services based on the criteria outlined above.

Note: Associated Services outlined in this reimbursement policy are considered non-covered services and not billable to the member (balance billing). **A network provider can only bill the member for the non-covered service(s) if the provider obtains advance written notice (signed consent) informing the member the primary procedure and the dependent associated service(s) are non-covered by the Plan.** The member **must** be provided with a written estimate of the cost of the non-covered service(s) **prior to** delivery of those services. The member must agree in writing to assume financial responsibility in advance of receiving the services if the service is a non-covered benefit. The signed agreement is required to be maintained in the member's records and delivered to the Plan upon request.

HISTORY

MEDICARE ADVANTAGE REIMBURSEMENT GUIDELINES:

The Plan follows and adheres to guidelines as directed by the Centers for Medicare and Medicaid Services (CMS) in relation to services associated with a Medicare non-covered service. See Medicare Benefit Policy Manual Claims Chapter 1, section 120.

REFERENCES:

- Centers for Medicare and Medicaid Services; Medicare Benefit Policy Manual Claims Chapter 1, section 120. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c01.pdf

RELATED POLICIES:

Refer to the following Commercial Medical Policies for additional information:

- A-1: Anesthesia Provided in Conjunction with Non-covered Services
- Z-67: Experimental / Investigational Services

Refer to the following Reimbursement Policies for additional information:

- RP-001: Assistant Surgery
- RP-002: Co-Surgery
- RP-035: Correct Coding Guidelines
- RP-037: Emergency E&M Services
- RP-052: Surgical Team

POLICY UPDATE HISTORY INFORMATION:

1 / 2021	Implementation
11 / 2021	Added NY region applicable to the policy
1 / 2022	Added Delaware Medicare Advantage applicable to the policy
6 / 2023	Administrative policy review with no changes in policy direction
8 / 2025	Updated policy direction to include primary procedure medical necessity denials

HISTORY

Highmark Reimbursement Policy Bulletin

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HISTORY VERSION

Bulletin Number:	RP-059		
Subject:	Associated Services		
Effective Date:	January 15, 2021	**End Date:**	
Issue Date:	June 12, 2023	**Revised Date:**	June 2023
Date Reviewed:	May 2023		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☒	**1500**	☒				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

HISTORY

PURPOSE:

This policy provides guidelines on the denial of, or recoupment of, reimbursement for services related to, or associated with, services denied by the member's benefits. This policy applies to professional, and facility claims.

COMMERCIAL REIMBURSEMENT GUIDELINES:

If the principal procedure, visit, or service is denied by the member's benefit Plan as a non-covered service, all related or associated services to the denied principal service will also be denied. In addition, we will not allow providers or members to retain reimbursement from the Plan for these associated claims. This applies to both professional and facility claim types, regardless of how the original denied service was submitted.

Any service provided in relationship to the denied surgery will also be denied (e.g., anesthesia, laboratory procedures, evaluation and management services, hospital services supplies, and medications).

Note: If other services are provided not related to the denied procedure, but billed in conjunction with the denied service, the Plan will carefully consider and separate those services during the review process to ensure eligible services are paid or remain paid.

Services deemed to be related, or specifically supplied for the purpose of providing a denied medical or surgical service will not be eligible for reimbursement when billed:

- by the same or different provider, or
- on the same or different claim

The following services deemed to be related or associated to the denied services will not be eligible for reimbursement:

1. **Anesthesia services** provided on the same date of service as a denied surgical service (refer to commercial medical policy A-1 Anesthesia Provided in Conjunction with Non-covered Services)
2. **Assistant Surgery, Co-Surgery, Team Surgery services** reported with modifiers 80, 81, 82, AS, 62 and 66, on the same date of service as a denied surgical service
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8. **Office, facility, or DME supplies** provided and directly related to a denied service
9. **Injection/infusion** services provided and directly related to a denied service
10. **Contrast media** expenses/services provided and directly related to a denied service
11. **Drugs** provided pre-operatively, intra-operatively, or post-operatively and directly related to a denied surgery or drugs provided for the purpose of providing a denied treatment

The Plan may deny or recoup prior payment made for services deemed to be related to a denied medical or surgical service, based on the criteria outlined above.

Note: Associated services outlined in this reimbursement policy are considered non-covered services and not billable to the member (balance billing). **A network provider can only bill the member for the non-covered service(s) if the provider obtains advance written notice (signed consent) informing the member the primary procedure and the dependent associated service(s) are non-covered by the Plan.** The member **must** be provided with a written estimate of the cost of the non-covered service(s) **prior to** the delivery of those services. The member must agree in writing to assume financial responsibility in advance of receiving the services if the service is a non-covered benefit. The signed agreement is required to be maintained in the member's records and delivered to the Plan upon request.

HISTORY

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REFERENCES:

- Centers for Medicare and Medicaid Services; Medicare Benefit Policy Manual Claims Chapter 1, section 120. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c01.pdf

RELATED POLICIES:

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