Payment Policy: Status "B" Bundled Services

Reference Number: CC.PP.046
Product Types: ALL
Effective Date: 01/01/2014
Last Review Date: 11/01/2019

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
The Centers for Medicare and Medicaid Services (CMS) classifies certain procedure codes as always bundled when billed on the same claim with another procedure code or codes to which the bundled code shares an incidental relationship.

The purpose of this policy is to define payment criteria for covered services designated by CMS as always bundled to another procedure or service to be used in making payment decisions and administering benefits.

Application
1. Physician and Non-physician Practitioner Services
2. Outpatient Institutional Claims

Policy Description
CMS defines certain procedures or services as "always bundled" to another procedure or service when billed with another procedure code or codes to which the bundled code shares an incidental relationship. The CMS National Physician Fee Schedule Relative Value File (RVU) designates the always bundled procedures with a status indicator of "B." If the procedure code is listed with a status indicator of "B", then payment for the procedure code (if covered by the Health Plan) is always subsumed by the payment for other procedures or services billed to which they are incidental and which are not designated as a status "B" procedure or service.

Reimbursement
1. The Health Plan's code editing software evaluates the current claim and historical claim lines that are billed with procedure codes designated as status "B" and compare to other procedures billed on the claim.
2. This rule reviews claims for same member, same provider ID and same date of service.
3. If another procedure(s) is found that is ***not*** indicated as a status "B" code, the service line with the status "B" code is denied.
4. Payment for the status "B" code is considered subsumed by the payment for the other services without the status "B" designation.
5. Procedure codes designated as status "B" will always pay when billed alone.
6. Procedure codes designated as status "B" will always pay when billed with another procedure code that also bears the status "B" designation.

Documentation Requirements
Not applicable

Coding and Modifier Information

This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT/HCPCS Code	Descriptor
A4262	Temporary tear duct plug
A4263	Permanent tear duct plug
A4270	Disposable endoscope sheath
A4300	Implantable access catheter,
A4550	Surgical stockings below knee length, each
G0269	Occlusive device in vein art
G0501	Resource-inten svc during ov
Q3031	Collagen skin test
R0076	Transport portable ekg
15850	Remove sutures same surgeon
20930	Sp bone algrft morsel add-on
20936	Sp bone agrft local add-on
22841	Insert spine fixation device
34839	Plnning pt spec fenest graft
36000	Place needle in vein
36416	Capillary blood draw
38204	Bl donor search management
90885	Psy evaluation of records
90887	Consultation with family
90889	Preparation of report
92352	Fit aphakia spectcl monofocl
92353	Fit aphakia spectcl multifoc
92354	Fit spectacles single system
92355	Fit spectacles compound lens
92358	Aphakia prosth service temp
92371	Repair & adjust spectacles
92531	Spontaneous nystagmus study
92532	Positional nystagmus test
92533	Caloric vestibular test
92534	Optokinetic nystagmus test
92605	Ex for nonspeech device rx
92606	Non-speech device service

92618	Ex for nonspeech dev rx add
92921	Prq cardiac angio addl art
92925	Prq card angio/athrect addl
92929	Prq card stent w/angio addl
92934	Prq card stent/ath/angio
92938	Prq revasc byp graft addl
92944	Prq card revasc chronic addl
93740	Temperature gradient studies
93770	Measure venous pressure
94005	Home vent mgmt supervision
94150	Vital capacity test
96040	Genetic counseling 30 min
96902	Trichogram
97010	Hot or cold packs therapy
97602	Wound(s) care non-selective
98960	Self-mgmt educ & train 1 pt
98961	Self-mgmt educ/train 2-4 pt
98962	Self-mgmt educ/train 5-8 pt
99000	Specimen handling office-lab
99001	Specimen handling pt-lab
99002	Device handling phys/qhp
99024	Postop follow-up visit
99050	Medical services after hrs
99051	Med serv eve/wkend/holiday
99053	Med serv 10pm-8am 24 hr fac
99056	Med service out of office
99058	Office emergency care
99060	Out of office emerg med serv
99070	Special supplies phys/qhp
99071	Patient education materials
99078	Group health education
99080	Special reports or forms
99090	Computer data analysis
99091	Collect/review data from pt
99100	Special anesthesia service
99116	Anesthesia with hypothermia
99135	Special anesthesia procedure
99140	Emergency anesthesia
99288	Direct advanced life support
99339	Domicil/r-home care supervis
99340	Domicil/r-home care supervis
99366	Team conf w/pat by hc prof
99367	Team conf w/o pat by phys

99368	Team conf w/o pat by hc pro
99374	Home health care supervision
99377	Hospice care supervision
99379	Nursing fac care supervision
99380	Nursing fac care supervision
99446	Interprof phone/online 5-10
99447	Interprof phone/online 11-20
99448	Interprof phone/online 21-30
99449	Interprof phone/online 31/>
99485	Suprv interfacilty transport
99486	Suprv interfac trnsport addl

Modifier	Descriptor
NA	NA

ICD-10 Codes	Descriptor
NA	Not applicable

Definitions

Incidental Procedure
An incidental procedure is one that is carried out at the same time as a more complex primary procedure. These procedures require minimal additional provider resources and are considered not necessary to the performance of the primary procedure.

Bundled Service
Procedure codes designated by the CMS National Physician Fee Schedule Relative Value File with a status indicator of "B." CMS defines these codes as "Payment for covered services is always bundled into payment for other services not specified."

Additional Information
Not applicable.

Related Documents or Resources
https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/pfs-relative-value-files.html

References
1. *Centers for Medicare and Medicaid Services (CMS. National Physician Fee Schedule Relative Value File). https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/pfs-relative-value-files.html*

Revision History	
11/07/2016	Initial Policy Draft Created
11/23/2016	Draft Revised with HCPCS codes and Title Change
03/10/2018	Reviewed and revised policy. Removed duplicate codes. Removed deleted coded 99363 and 99364
03/30/2019	Conducted review and updated policy
11/01/2019	Annual Review completed

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.