Status B Bundled Codes

Policy REIMB-003

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Disclaimer:

1. Policies are subject to change in accordance with State and Federal notice requirements.
2. Policies outline coverage determinations for U of U Health Plans Commercial, CHIP and Healthy U (Medicaid) plans. Refer to the "Policy" section for more information.
3. Services requiring prior-authorization may not be covered, if prior-authorization is not obtained.
4. This Medical Policy does not guarantee coverage or payment of the service. The service must be a benefit in the member's plan and the member must be eligible for coverage at the time of service. Additional payment guidelines may be applied that are not included in this policy.

Description:

Surgical and medical supplies are used in the course of services/care provided by physicians and other professional providers in the office or clinic setting, inpatient hospital, outpatient hospital, ambulatory surgery center (ASC), and multiple other outpatient settings. Supplies used in conjunction with care provided in physician's office/clinic or other outpatient setting generally may not be separately reported and are not eligible for separate reimbursement based on industry standard guidelines. The procedure codes for professional services include reimbursement for the supply items needed to perform those services.

Status Indicator B (bundled codes) are a code classification data element found on the National Physician Fee Schedule (NPFS), as maintained by The Center for Medicare & Medicaid Services (CMS). This data element indicates a code that is always bundled into payment for other services. The claim editing logic within this rule identifies all-inclusive procedure and supply codes that are not eligible for reimbursement even if reported alone. The Medicare Physician Fee Schedule Database (MPFSDB), also known as the National Physician Fee Schedule Relative Value File, indicates these procedures/supplies with a status code indicator of "B." According to the MPFSDB, "payment for covered services is always bundled into payment for other services not specified. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident."

Policy Statement and Criteria

1. Commercial Plans/CHIP

U of U Health Plans does not cover any procedure codes with a Status Indicator B (Bundled code), as they are not eligible for separate reimbursement according to the Medicare Physician Fee Schedule Database (MPFSDB) and are considered an integral part of another service.

Status B codes submitted with any modifier including, but not limited to Modifier -59 cannot be used to override the Status B code. These Status B codes/services will be denied regardless of modifier use.

2. Medicaid Plans

Coverage is determined by the State of Utah Medicaid program; if Utah State Medicaid has no published coverage position and InterQual criteria are not available, the U of U Health Plans Commercial criteria will apply. For the most up-to-date Medicaid policies and coverage, please visit their website at: http://health.utah.gov/medicaid/manuals/directory.php or the Utah Medicaid code Look-Up tool

CPT/HCPCS codes covered by Utah State Medicaid may still require further evaluation to determine medical necessity for coverage.

Clinical Rationale

The Centers for Medicare and Medicaid Services (CMS) editing rules state procedure codes with a status code indicator of "B" are not eligible for separate reimbursement, whether billed alone or with other services as these codes are considered an integral part of another service. All procedure codes with a status code indicator of "B" can be found on the CMS National Professional Fee Schedule Relative Value File (PPRVU). Status "B" codes payment for these services are always included in payment for other services not specified, whether billed alone or with another service. Status B code edits are applied to professional and outpatient facility claims. Status B codes are bundled. In the definition of these status indicators, CMS has indicated reimbursement for these codes is bundled into the allowance (RVU) for the physician service with which it is associated or connected ("incident to").

Applicable Coding

Below is a list of codes assigned a status code "B" *(may not be all inclusive)*

CPT Codes

15851	Removal of sutures or staples requiring anesthesia (ie, general anesthesia, moderate sedation)
20930	Allograft, morselized, or placement of osteopromotive material, for spine surgery only (List separately in addition to code for primary procedure)

20936	Autograft for spine surgery only (includes harvesting the graft); local (eg, ribs, spinous process, or laminar fragments) obtained from same incision (List separately in addition to code for primary procedure)
22811	Exploration of spinal fusion
34839	Physician planning of a patient-specific fenestrated visceral aortic endograft requiring a minimum of 90 minutes of physician time
36000	Introduction of needle or intracatheter, vein
36416	Collection of capillary blood specimen (eg, finger, heel, ear stick)
38204	Management of recipient hematopoietic progenitor cell donor search and cell acquisition
90885	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes
90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient
90889	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other individuals, agencies, or insurance carriers
92352	Fitting of spectacle prosthesis for aphakia; monofocal
92353	; multifocal
92354	Fitting of spectacle mounted low vision aid; single element system
92355	; telescopic or other compound lens system
92358	Prosthesis service for aphakia, temporary (disposable or loan, including materials)
92371	Repair and refitting spectacles; spectacle prosthesis for aphakia
92531	Spontaneous nystagmus, including gaze
92532	Positional nystagmus test
92533	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes 4 tests)
92534	Optokinetic nystagmus test
92605	Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour
92606	Therapeutic service(s) for the use of non-speech-generating device, including programming and modification

92618	Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)
92921	Percutaneous transluminal coronary angioplasty; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)
92925	Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)
92929	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)
92934	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)
92938	Percutaneous transluminal revascularization of or through coronary artery graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft (List separately in addition to code for primary procedure)
92944	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (List separately in addition to code for primary procedure)
93740	Temperature gradient studies
93770	Determination of venous pressure
94005	Home ventilator management care plan oversight of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living) requiring review of status, review of laboratories and other studies and revision of orders and respiratory care plan (as appropriate), within a calendar month, 30 minutes or more
94150	Vital capacity, total (separate procedure)
96902	Microscopic examination of hairs plucked or clipped by the examiner (excluding hair collected by the patient) to determine telogen and anagen counts, or structural hair shaft abnormality
97010	Application of a modality to 1 or more areas; hot or cold packs
97602	Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (eg, wet-to-moist dressings, enzymatic, abrasion, larval

	therapy), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session
98960	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient
98961	; 2-4 patients
98962	; 5-8 patients
99000	Handling and/or conveyance of specimen for transfer from the office to a laboratory
99001	Handling and/or conveyance of specimen for transfer from the patient in other than an office to a laboratory (distance may be indicated)
99002	Handling, conveyance, and/or any other service in connection with the implementation of an order involving devices (eg, designing, fitting, packaging, handling, delivery or mailing) when devices such as orthotics, protectives, prosthetics are fabricated by an outside laboratory or shop but which items have been designed, and are to be fitted and adjusted by the attending physician or other qualified health care professional
99024	Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure
99050	Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service
99051	Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service
99053	Service(s) provided between 10:00 PM and 8:00 AM at 24-hour facility, in addition to basic service
99056	Service(s) typically provided in the office, provided out of the office at request of patient, in addition to basic service
99058	Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service
99060	Service(s) provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic service
99070	Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)

99071 Educational supplies, such as books, tapes, and pamphlets, for the patient's education at cost to physician or other qualified health care professional

99072 Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other nonfacility service(s), when performed during a Public Health Emergency, as defined by law, due to respiratory-transmitted infectious disease

99078 Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (eg, prenatal, obesity, or diabetic instructions)

99080 Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form

99100 Anesthesia for patient of extreme age, younger than 1 year and older than 70 (List separately in addition to code for primary anesthesia procedure)

99116 Anesthesia complicated by utilization of total body hypothermia (List separately in addition to code for primary anesthesia procedure)

99135 Anesthesia complicated by utilization of controlled hypotension (List separately in addition to code for primary anesthesia procedure)

99140 Anesthesia complicated by emergency conditions (specify) (List separately in addition to code for primary anesthesia procedure)

99288 Physician or other qualified health care professional direction of emergency medical systems (EMS) emergency care, advanced life support

99437 Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each additional 30 minutes by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

99491 ; first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month.

99366 Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional

99367 ; patient and/or family not present, 30 minutes or more; participation by physician

99368 ; patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional

99374 Supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes

99377 Supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes

99379 Supervision of a nursing facility patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes

99380 ; 30 minutes or more

99485 Supervision by a control physician of interfacility transport care of the critically ill or critically injured pediatric patient, 24 months of age or younger, includes two-way communication with transport team before transport, at the referring facility and during the transport, including data interpretation and report; first 30 minutes

99486 ; each additional 30 minutes (List separately in addition to code for primary procedure)

HCPCS Codes

A4262 Temporary, absorbable lacrimal duct implant, each

A4263 Permanent, long-term, nondissolvable lacrimal duct implant, each

A4270	Disposable endoscope sheath, each
A4300	Implantable access catheter, (e.g., venous, arterial, epidural subarachnoid, or peritoneal, etc.) external access
A4550	Tape, nonwaterproof, per 18 sq in
G0269	Placement of occlusive device into either a venous or arterial access site, postsurgical or interventional procedure (e.g., angioseal plug, vascular plug)
G0501	Resource-intensive services for patients for whom the use of specialized mobility-assistive technology (such as adjustable height chairs or tables, patient lift, and adjustable padded leg supports) is medically necessary and used during the provision of an office/outpatient, evaluation and management visit (list separately in addition to primary service)
Q3031	Collagen skin test
R0076	Transportation of portable EKG to facility or location, per patient

References:

1. American Medical Association (AMA) CPT® and HCPCS® (2024).
2. Centers for Medicare and Medicaid Services (CMS). Medicare Claims Processing Manual. "Addendum D1.--Proposed Payment Status Indicators". Accessed: December 21, 2023. Available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/downloads/CMS1392P_Addendum_D1.pdf
3. Centers for Medicare and Medicaid Services (CMS). National Correct Coding Initiative Policy Manual. Chapter 1 General Correct Coding Policies. Accessed: December 21, 2023. Available at: https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-policy-manual
4. Optum® "EncoderPro.com for Payers Professional" (2024).