If a conflict arises between a Clinical Payment and Coding Policy (CPCP) and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. BCBSTX may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSTX has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act (HIPAA) approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing (UB) Editor, American Medical Association (AMA), Current Procedural Terminology (CPT®), CPT® Assistant, Healthcare Common Procedure Coding System (HCPCS), ICD-10 CM and PCS, National Drug Codes (NDC), Diagnosis Related Group (DRG) guidelines, Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

CPCP034 Unbundling Policy - Professional Providers

Policy Number: CPCP034

Version 2.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date: August 4, 2021

Plan Effective Date: November 12, 2021 (Blue Cross and Blue Shield of Texas Only)

Description

The purpose of this policy is to provide guidance for medical services, equipment and supplies that may or may not be eligible for separate reimbursement. Health care providers (physicians and other qualified health care professionals) are expected to exercise independent medical judgement in providing care to members. This policy is not intended to impact care decisions or medical practice. Additionally, this policy applies to In-Network and Out-of-Network professional/ancillary providers.

Reimbursement Information:

Appropriate coding to describe services and supplies that were performed or utilized should be submitted for eligible reimbursement. Codes submitted may be bundled if the plan identifies there is a more comprehensive code. Submission of any code should be fully supported in the medical documentation. The plan reserves the right to request supporting documentation if claim(s) do not adhere to coding and billing guidelines, which may result in a denial or reassigned payment rate. Claims may be reviewed on a case by case basis.

Services that are considered mutually exclusive, integral to, incidental or within the global period of a primary service are not eligible for additional reimbursement.

Global Allowance

The global surgical package includes all related services and supplies that are routine and necessary for a provider or by another same specialty provider within the same group before, during and after a procedure. The global surgical package applies in any setting including inpatient hospital, outpatient hospital, Ambulatory Surgery Center (ASC) or professional health care provider office.

Incidental Services

The plan excludes the cost of incidental services when performed with the primary procedure and is clinically integral to the successful outcome of the primary procedure, including technical charges for equipment and its purchase, rental and maintenance. Compensation for such incidental services may not be billed separately by Provider or another Provider or other entity.

Mutually Exclusive

Mutually exclusive procedures are those procedures that cannot reasonably be performed together or on the same patient on the same day based on the code definitions or anatomic considerations.

Bundled Routine Equipment and Supplies

Routine equipment and supplies are included in the general charge where services are being rendered. Additional charges for equipment and supplies that are commonly furnished or are a usual part of a surgical/medical procedure, during an office visit or office procedure are ineligible for separate reimbursement and should not be billed separately. For example, some HCPCS supply codes are not separately reimbursable as the cost of the supplies are incorporated into the Evaluation and Management (E/M) service or procedure code. Therefore, the plan will not separately reimburse the HCPCS supply codes if those supplies are utilized on the same day as the E/M service or procedure performed in a non-facility location or place of service by a provider.

Bundled or Included in the Basic Allowance of Another Service: The list below are examples of services, supplies and equipment that should not be billed separately. This is not an all-inclusive list:

- **Exam or treatment room**
  - Soap
  - Cotton balls, sterile or nonsterile
  - Kleenex tissues
  - Oral swabs
  - Pillows
  - Exam table coverings (sheet/paper)
- **Routine supplies**-Minor medical and surgical supplies that may be included in the basic allowance of the service (including disposable supplies), such as:
  - Drapes
  - Saline solutions (e.g. flush and irrigation)
  - Items such as gloves, gowns, socks/slippers, masks used by members or medical staff
  - Alcohol swabs
  - Items used to obtain a specimen or complete a diagnostic or therapeutic procedure
  - Tape
  - Syringes
  - Needles
  - Bandages
  - Gauze
- **Nursing Services**
- **Equipment**
  - Automatic thermometers & blood pressure machines
  - Digital recording equipment and printouts
  - Fans
  - IV pumps; poles; single and multiple lines; and tubing
  - Infusion pump
  - Nebulizers
  - Oximeters/Oxisensors-single use or continuous
  - Room furniture
  - Stethoscopes
  - Telephone
  - Televisions
  - Telehealth/telemedicine digital devices

Contaminated, Not Utilized or Considered Waste-Supplies

Supplies that are presumed contaminated, considered a waste and were not utilized during the provisioned services on the member may not be eligible for reimbursement, including but not limited to:

- Any items or supplies that were prepared or opened during a procedure or service but **not** used or implanted into the member (e.g., surgical trays);
- Items or supplies opened by mistake;

- Change of mind by the provider to use an item or supply for the member;
- Equipment failure/technical difficulties;
- Cancellation; and
- Large packages of items, supplies or implants when more appropriate packaging can be purchased.

Appending Appropriate Modifiers

Providers should append appropriate modifiers for services. Modifiers may be appended to CPT/HCPCS code(s) if the service or procedure is clinically supported for use of modifiers. A claim should be submitted with the correct modifier-to-procedure code combination. Modifiers should not be appended to CPT/HCPCS code(s) to circumvent a National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) edit if the service or procedure is not clinically supported for the use of a modifier. Claim submissions may be denied if a claim contains an inappropriate modifier-to-procedure code combination. Medical records or other documentation must support the use of the modifier submitted for reimbursement. For additional information on the appropriateness of appending a modifier, refer to the American Medical Association (AMA), CPT and/or HCPCS documents.

References:

Clinical Payment and Coding Policies

- **CPCP014** Global Surgical Package-Professional Providers
- **CPCP017** Wasted/Discarded Drugs and Biological Guidelines
- **CPCP023** Modifier Reference Guideline

American Medical Association, Current Procedural Terminology (CPT®)

Policy Update History:

8/4/2021	New policy