Payment Policy: Status "B" Bundled Services

Reference Number: LA.PP.046
Product Types: ALL
Effective Date: 08/2020
Last Review Date: 08/2023

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) 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. Louisiana Healthcare Connections 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 2022, 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.

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.

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*

Revision Log	Revision Date	Approval Date
Converted corporate to local policy.	8/15/2020	
Annual Review; Links updated	8/31/2022	
Annual review; code tables removed	8/1/2023	12/15/2023

Important Reminder
This payment policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this payment policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this payment policy. This payment policy is consistent with standards of medical practice current at the time that this payment policy was approved.

The purpose of this payment policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions 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 LHCC administrative policies and procedures.

This payment policy is effective as of the date determined by LHCC. 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. LHCC retains the right to change, amend or withdraw this payment policy, and additional clinical 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 payment policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.

This payment policy is the property of LHCC. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, Centene's P&P management software, is considered equivalent to an actual signature on paper.

Senior Director of Network Accounts: _____Electronic Signature on File_

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