Massachusetts | Commercial

Commercial Reimbursement Policy

Subject: **Bundled Services and Supplies - Facility**	
Policy Number: **C-23001**	Policy Section: **Facilities**
Last Approval Date: **06/12/2024**	Effective Date: **11/01/2024**

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a Wellpoint member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. These codes denote the services and/or procedures performed and when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Wellpoint may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

Wellpoint considers certain services and supplies to be ineligible for separate reimbursement when reported by a facility, unless provider, state, federal contract and/or requirements indicate otherwise.

Services considered integral to the primary service, or included in the facility fee, will not be allowed for separate reimbursement when billed by a facility provider. The categories below are including, but not limited to the following:

- DME; set-up, delivery, and accessories
- Facility personnel services
- Feeding kits and supplies
- Flushes and diluents
- Nursing services
- Pharmacy services
- Pulse oximetry
- Routine supplies and equipment

The Health Plan will not allow separate reimbursement when billed on the same date of service as a room or facility fee, or a procedure other than the administration service by a facility provider for the following categories:

- Chemotherapy administration
- Infusion Drug administration

The Related Coding section lists and describes the Current Procedural Terminology (CPT®) and Healthcare Common Procedural Coding System (HCPCS Level II) codes that are considered always bundled and not eligible for reimbursement when they are reported as a stand-alone service, or with another service. No modifiers will override the denial for the always bundled services and/or supplies listed.

Related Coding

Code	Description	Comments
15851	Removal of sutures or staples requiring anesthesia (ie, general anesthesia, moderate sedation)	Not eligible for reimbursement
87913	Infectious agent genotype analysis by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]), mutation identification in targeted region(s)	Not eligible for reimbursement
97010	Application of a modality to 1 or more areas; hot or cold packs	Not eligible for reimbursement
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)	Not eligible for reimbursement
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	Not eligible for reimbursement
G2211	Visit complexity inherent to evaluation and management associated with medical care services that serve as the	Not eligible for reimbursement

	continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition.	
G0498	Chemotherapy administration, intravenous infusion technique; initiation of infusion in the office/clinic setting using office/clinic pump/supplies, with continuation of the infusion in the community setting (e.g., home, domiciliary, rest home or assisted living) using a portable pump provided by the office/clinic, includes follow up office/clinic visit at the conclusion of the infusion	Not eligible for reimbursement
K1034	Provision of COVID-19 test, nonprescription self-administered and self-collected use, FDA approved, authorized or cleared, one test count	Not eligible for reimbursement
T1040	Medicaid certified community behavioral health clinic services, per diem	Not eligible for reimbursement

Policy History

06/12/2024	Review approved 06/12/2024 and effective 11/01/2024:
	• Added categories that will not be allowed for separate reimbursement when billed by a facility provider:
	  ○ DME, set-up, delivery, and accessories
	  ○ Facility personnel services
	  ○ Feeding kits and supplies
	  ○ Flushes and diluents
	  ○ Nursing services
	  ○ Pharmacy services
	  ○ Pulse oximetry
	  ○ Routine supplies and equipment
	• Added categories not allowed for separate reimbursement for facility providers on the same date of service with a room or facility fee
	  ○ Chemotherapy administration
	  ○ Infusion Drug administration
	• Related Coding section:
	  ○ Added code G2211
	  ○ Deleted codes 94760-94762, A4206-A4262, A4265-A9300, A9900-A9901, A9999

03/22/2023	Initial approval and effective 08/01/2023

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- Business decision
- Optum EncoderPro 2024

Definitions

Bundled Services	Services that are not eligible for separate reimbursement and considered to be part of another service.
General Reimbursement Policy Definitions	

Related Policies and Materials

Expenses Included in Facility Services - Professional
Modifier Usage - Facility

Use of Reimbursement Policy

State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, take precedence over Reimbursement Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.