CLINICAL PAYMENT AND CODING POLICY

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.

Inpatient/Outpatient Unbundling Policy - Facility

Policy Number: CPCP002

Version: 1.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date: December 4, 2020

Plan Effective Date: March 18, 2021 (Blue Cross and Blue Shield of Texas Only)

Description:

The purpose of the Inpatient/Outpatient Unbundling Policy is to provide guidance for covered medical and surgical services and supplies. Health care providers (facilities, physicians and other qualified health care professionals) are expected to exercise independent medical judgment in providing care to members. The Inpatient/Outpatient Unbundling Policy is not intended to impact care decisions or medical practice. This policy applies to In-Network and Out-of-Network facilities.

Reimbursement Information:

A claim review conducted on an itemized statement involves an examination of that statement and the associated medical records for unbundling of charges and/or inappropriate charges whether the member's status is outpatient or inpatient.

For **In-Network providers**, all services provided during a member's admission to a facility for inpatient and outpatient services that are reimbursed under an all-inclusive payment method should be billed by the facility, and not by a third party. Services billed and provided by a third party while the member is admitted to said facility are the responsibility of that facility and may be denied by the plan.

Routine services are those services included by the provider in a daily service charge. Routine services are composed of two broad components: **(1) general routine service**, and **(2) special care units (SCU)**, including **coronary care units (CCU)** and **intensive care units (ICU)**.

Included in routine services are the regular room, dietary services, nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not applicable.

Equipment commonly available to members in a particular setting or ordinarily furnished to members during the course of a procedure, even though the equipment is rented by the hospital, is considered routine and ineligible for separate reimbursement and should not be billed separately. **Special Care Units** must be equipped or have available for immediate use, life-saving equipment necessary to treat critically ill members. The equipment necessary to treat critically ill members may include, but is not limited to, respiratory and cardiac monitoring equipment, respirators, cardiac defibrillators, and wall or canister oxygen and compressed air.

Disposable supplies furnished to members in both inpatient and outpatient settings are ineligible for separate reimbursement. Disposable supplies include, but are not limited to, the following: syringes, needles, blood or urine testing supplies (except as used in the treatment of diabetes), sheaths, bags, elastic garments, stockings, bandages, garter belts, gauze and replacement batteries.

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;
- Items or supplies opened by mistake;
- Change of mind by the surgeon to use an item or supply for the member;
- Equipment failure/technical difficulties;
- Surgery case cancellation; and
- Large packages of items, supplies or implants when more appropriate packaging can be purchased.

Routine Bundled Services and/or Supplies

Routine services and supplies are included by the provider in the general charge of the location where services are being rendered or the charge for the associated surgery or other procedures or services. A separate payment is never made for routine bundled services and supplies and therefore is ineligible for separate reimbursement and should not be billed separately. These are considered floor stock and are generally available to all members receiving services. Examples include drapes, saline solutions (e.g. flush and irrigation) and reusable items. The following guidelines may assist providers in identifying items, supplies, and services that are ineligible for separate reimbursement and should not be billed separately. This is not an all-inclusive list.

- Any supplies, items and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services in a specific location are considered routine services and or supplies and are ineligible for separate reimbursement and should not be billed separately in the inpatient and outpatient environments.
- Items and supplies that can be purchased over the counter may be ineligible for separate reimbursement and should not be billed separately, unless otherwise specified.
- All reusable items, supplies and equipment that are provided to all members during an inpatient or outpatient encounter are ineligible for separate reimbursement and should not be billed separately.
- All reusable items, supplies and equipment, such as pulse oximeter, blood pressure cuffs, bedside table, etc., that are provided to all members are ineligible for separate reimbursement and should not be billed separately.
- All reusable items, supplies and equipment that are provided to all members receiving the same service are ineligible for separate reimbursement and should not be billed separately.

The list below provides examples of items and services that should not be billed separately. Please note that the list is not all inclusive.

1. **Routine Supplies** - The hospital basic room and critical care area room (emergency department, observation, treatment room, cardiac, medical, surgical, pediatric, respiratory, burn, neonate (level III and IV), neurological, rehabilitative, post-anesthesia or recovery, and trauma) daily charge shall include all of the following services, personal care and supply items and equipment:

• Admission, hygiene, and or comfort kits • Soap • Alcohol swabs • Arterial blood gas kits • Baby powder • Band-aids • Basin • Bedpan, regular or fracture pan • Blood tubes • Cotton balls, sterile or nonsterile	• Mouthwash • Needles • Odor eliminator/ Room deodorizer • Oral Swabs • Oxygen masks • PICC (peripherally inserted central catheter) Line • Pillows • Preparation kits • Razors • Restraints

• Deodorant • Drapes • Emesis Basin • Gloves used by members or staff • Gowns used by members or staff • Heat light or heating pad • Ice packs • Interactive telecommunication or information technology devices • Irrigation solutions • Items used to obtain a specimen or complete a diagnostic or therapeutic procedure • IV (intravenous) arm boards • Kleenex tissues • Lemon glycerin swabs (flavored swabs) • Lotion • Lubricant Jelly • Masks/respirators used by members or staff • Meal Trays • Measuring pitcher • Mid-stream urine kits • Mouth care kits	• Reusable sheets, blankets, pillowcases, draw sheets, underpads, washcloths and towels • Saline solutions (e.g. flush and irrigation) • Shampoo • Sharps containers • Shaving Cream • Skin cleansing liquid • Socks/Slippers • Specipan • Sputum Trap • Syringes • Tape • Thermometers • Toilet tissue • Tongue depressors • Toothettes, oral swabs • Toothbrush • Toothpaste • Urinal • Water pitcher

The list of medical equipment below provides examples of items that should not be billed separately. Please note that the list is not all inclusive.

2. **Medical Equipment** - The hospital basic room and critical care area room (emergency department, observation, treatment room, cardiac, medical, surgical, pediatric, respiratory, burn, neonate (level III and IV), neurological, rehabilitative, post- anesthesia or recovery, and trauma) daily charge shall include all of the following services, personal care and supply items and equipment:

• Ambu bag • Aqua pad motor • Arterial pressure monitors (inclusive of Critical Care room charge only) • Auto Syringe Pump • Automatic thermometers and blood pressure machines • Bed scales • Bedside commodes • Blood pressure cuffs • Blood warmers • Cardiac monitors • CO2 monitors • Crash Cart • Defibrillator and paddles • Digital recording equipment and printouts • Dinamap • Emerson pumps • Fans • Feeding pumps • Flow meters • Footboard • Glucometers • Gomco pumps • Guest beds	• Heating or cooling pumps • Hemodynamic monitors (inclusive of Critical Care room charge only) • Humidifiers • Infant warmer • Injections (Therapeutic, prophylactic, or diagnostic) • IV pumps; poles; single and multiple line; tubing • Nebulizers • Overhead frames • Over-bed tables • Oximeters/Oxisensors- single use or continuous • Member room furniture; manual, electric, semi- electric beds • PCA pump • Penlight or other flashlight • PICC Line (reusable equipment associated with PICC Line placement) • Pill pulverizer • Pressure bags or pressure infusion equipment • Radiant warmer • Sitz baths • Stethoscopes • Telephone • Televisions • Traction equipment • Transport isolette • Wall Suction, continuous or intermittent

The list below provides examples of items and services that should not be billed separately. Please note that the list is not all inclusive.

3. **Facility Basic Charges** – The hospital basic room and critical care area room (emergency department, observation, treatment room, cardiac, medical, surgical, pediatric, respiratory, burn, neonate (level III and IV), neurological, rehabilitative, post- anesthesia or recover, and trauma) daily charge shall include all of the following services, personal care and supply items and equipment:

- Administration of blood or any blood product by nursing staff (does not include tubing, blood bank preparation, etc.)
- Administration or application of any medicine, chemotherapy, and/or IV fluids
- Arterial and Venipuncture
- Assisting members onto bedpan, bedside commode, or into bathroom
- Assisting physician or other licensed personnel in performing any type of procedure in the member's room, treatment room, surgical suite, endoscopy suite, cardiac catheterization lab; or x-ray
- Bathing of members
- Body preparation of deceased members
- Cardiopulmonary resuscitation
- Changing of dressing, bandages and/or ostomy appliances
- Changing of linens and member gowns
- Chest tube maintenance, dressing change, discontinuation
- Enemas
- Enterostomal services
- Feeding of members
- Incontinence care
- Injections (Therapeutic, prophylactic, or diagnostic)
- Insert, discontinue, and/or maintain nasogastric tubes
- Intubation
- Maintenance and flushing of J-tubes; PEG tubes; and feeding tubes of any kind
- Management or participation in cardiopulmonary arrest event. Obtaining and recording of blood pressure, temperature, respiration, pulse, pulse oximetry
- Medical record documentation
- Monitoring and maintenance of peripheral or central IV lines and sites – to include site care, dressing changes, and flushes
- Monitoring of cardiac monitors; CVP (central venous pressure) lines; Swan-Ganz lines/pressure readings; arterial lines/ readings; pulse oximeters; cardiac output; pulmonary arterial pressure
- Neurological status checks
- Nursing care
- Obtaining and recording of blood pressure, temperature, respiration, pulse, pulse oximetry
- Obtaining: finger-stick blood sugars; blood samples from either venous sticks or any type of central line catheter or PICC line; urine specimens; stool specimens; arterial draws; sputum specimens; or body fluid specimen
- Oral care
- Oxygen
- Member and family education and counseling
- PICC Line
- Preoperative care
- Set up and/or take-down of: IV pumps, suctions, flow meters, heating or cooling pumps, over-bed frames; oxygen; feeding pumps; TPN; traction equipment; monitoring equipment
- Shampoo hair
- Start and/or discontinue IV lines
- Suctioning or lavaging of members
- Telemetry
- Tracheostomy care and changing of cannulas
- Transporting, ambulating, range of motion, transfers to and from bed or chair
- Turning and weighing members
- Urinary catheterization

The list below provides examples of items and services that should not be billed separately. Please note that the list is not all inclusive.

4. Ancillary Personnel Providing Nursing or Technical Services

• Bedside Glucose monitoring, i.e. Accucheck • Maintenance of oxygen administration equipment • Mixing, preparation, or dispensing of any medications, IV fluids, total parenteral nutrition (TPN), or tube feedings	• No separate charges will be allowed for callback, emergency, standby, urgent attention, ASAP, stat, or portable fees • Single determination or continuous pulse oximetry monitoring

The list below provides examples of items and services that should not be unbundled. Please note that the list is not all inclusive.

5. Critical Care Units

• In addition to the above listed services, personal and supply items and equipment, if post-operative surgical or procedural recovery services are performed in any critical care room setting other than the Post-anesthesia Recovery Room), the critical care daily room charge will cover recovery service charges. • Intensive care nursing • PICC Line	• Respiratory Therapy Services • Ventilatory Support and management

The list below provides examples of items and services that should not be billed separately. Please note that the list is not all inclusive.

6. Surgical rooms and services – To include surgical suites, major and minor, treatment rooms, endoscopy labs, cardiac cath labs, X-ray, pulmonary and cardiology procedural rooms. The hospital's charge for surgical suites and services shall include the entire above listed nursing personnel services, supplies, and equipment (as included in the basic or critical care daily room charges). In addition, the following services and equipment will be included in the surgical rooms and service charges (Note: Please refer to any state specific guidelines):

• Air conditioning and filtration • All reusable instruments charged separately • All services rendered by RN's, LPN's, scrub technicians, surgical assistants, orderlies, and aides • Anesthesia equipment and monitors • Any automated blood pressure equipment • Cardiac monitors • Cardiopulmonary bypass equipment • CO2 monitors • Crash carts • Digital recording equipment and printouts • Dinamap • Fracture tables • Grounding pads • Hemochron • Hemoconcentrator • Laparoscopes, bronchoscopes, endoscopes and accessories	• Lights; Light handles; light cord, fiber optic Microscopes • Midas Rex • Monopolar and bipolar electrosurgical/bovie or cautery equipment • Obtaining laboratory specimens • Power equipment • Room heating and monitoring equipment • Room set-ups of equipment and supplies • Saline slush machine • Solution warmer • Surgeons' loupes or other visual assisting devices • Transport monitor • Video camera and tape • Wall suction equipment • X-ray film

Implant Revenue Codes 274-276 and 278

Inpatient/Outpatient Hospital Claim/ Billed charges for Revenue Code 274 Pros/Ortho devices, Revenue Code 275 Pacemaker, Revenue Code 276 Intraocular Lens, and Revenue Code 278 Other Implants

- If separately reimbursable, billed charges for revenue codes 274, 275, 276, and 278 may require a vendor's invoice to support supplies used that correspond to the services rendered unless otherwise agreed upon.
- These units must be clearly indicated on the vendor invoices submitted with the claim. If the units do not match or are not noted, the revenue codes 274, 275, 276, and 278 will be denied unless otherwise agreed upon.
- If supplies are purchased by the provider in bulk, the units that apply to the claim billed must be noted on the invoice or the revenue codes 274, 275, 276, and 278 will be denied unless otherwise agreed upon.
- Revenue code 0278 should not be billed for an item(s) that may be considered as a supply. If billed, these charges may be ineligible for separate reimbursement and should not be billed separately and considered unbundled under the language outlined in this policy.

References:

CMS Provider Reimbursement Manual, Determination of Cost of Services to Beneficiaries, Chapter 22, Section 2202.6

CMS, National Correct Coding Initiative Policy Manual for Medicare Services, Chapter 1, General Correct Coding Policies, Section A

CMS, Medicare Claims Processing Manual (Pub. 100-4), Chapter 12, Physicians/Non-Physician Practitioners

Medical Policy: SUR713.025 Intraocular Lens (IOLs) and Implantable Miniature Telescope (IMT)

Medical Policy: DME104.012 Lower Limb Prosthetics, Including Microprocessor Prosthetics

Medical Policy: DME104.001 Prosthetics, Except Lower Limb Prosthetics

Medical Policy: DME103.001 Orthotics

Clinical Payment and Coding Policies:
CPCP007 Implant Payment and Coding
CPCP017 Wasted/Discarded Drugs and Biological Guidelines

Policy Update History:

Approval Date	Description
03/30/2017	New policy
05/07/2018	Annual Review
06/11/2018	Verbiage updates
11/07/2018	Verbiage updates
04/01/2019	Verbiage updates and Annual Review
05/22/2019	Updated references
09/30/2019	Updated references
12/04/2020	Annual Review, Disclaimer Update, Verbiage Updates

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