

	<i>Status Indicator B (Bundled) Codes</i>	
	Policy Number: POL-PP-206	Original Creation Date: 12/1/2021
	Version Number: 07	Version Effective Date: 12/1/2021
	Policy Status: Active	Next Review Date: 12/1/2026

NOTICE

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Blue KC reserves the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to: <https://providers.bluekc.com/ContactUs/PaymentPolicies>.

PROVIDER/ENTITY IMPACTED					
<input checked="" type="checkbox"/> PROFESSIONAL	<input checked="" type="checkbox"/> FACILITY	<input checked="" type="checkbox"/> DME	<input checked="" type="checkbox"/> AMBULATORY SURGERY	<input checked="" type="checkbox"/> LAB	<input type="checkbox"/> OTHER

LINES OF BUSINESS IMPACTED						
<input checked="" type="checkbox"/> COMMERCIAL	<input checked="" type="checkbox"/> BLUE MEDICARE ADVANTAGE	<input checked="" type="checkbox"/> ACA QHP¹	<input checked="" type="checkbox"/> SMALL GROUP ACA	<input checked="" type="checkbox"/> JAA²	<input checked="" type="checkbox"/> FEP³	<input type="checkbox"/> DENTAL

¹ ACA QHP: Affordable Care Act Qualified Health Plan for Individual/Family ² JAA: Joint Administrative Account ³ FEP: Federal Employee Program

Disclaimer

Blue KC has developed Provider Payment Policies to provide guidance on payment methodologies as they pertain to submitted claims. These policies are written following industry standard recommendations from sources such as:

- Current Procedural Terminology
- Centers for Medicare and Medicaid
- American Medical Association
- National Correct Coding Initiative
- Other professional organizations and societies

Coverage of any service is determined by date of service, a member's eligibility and benefit limits for the service or services rendered, all terms of the Provider Service Agreement, and other standards of coding rules and guidelines.

Final payment is subject to the application of claims adjudication and edits common to the industry.

For confirmation of which services may be eligible for coverage and description of when medical services are considered medically necessary, not medically necessary, or investigational, please contact:

- Blue KC Provider Hotline for Commercial lines of Business 816-395-3929
- Affordable Care Act Provider Hotline 866-859-3822
- Blue Medicare Advantage Provider Hotline 866-508-7140

In the event of a conflict between any policies, the Member's coverage document will govern.

Description/Application

Status Indicator B indicates a service that is always bundled into another service. Reimbursement of a status B service is included in the payment for another service, whether the code is billed on the same date of service as a primary code or billed alone on a different date or claim.

Policy

For claims filed with a date of service on or after 12/01/2020 Blue KC will not separately reimburse procedures identified on the National Physician Fee Schedule as status indicator “B”. When a status indicator B code is submitted, the procedure code line will be denied as a non-covered service. Providers will be held liable when a service is denied due to a status “B” indicator. Blue KC members will not be held responsible.

For more information go to <https://www.cms.gov/status-indicators>.

Coding

CPT/HCPC	Definition
A4262	Temporary, absorbable lacrimal duct implant, each
A4263	Permanent, long-term, non-dissolvable 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	Surgical trays
G0269	Placement of occlusive device into either a venous or arterial access site, postsurgical or interventional procedure (e.g., angioseal plug, vascular plug)
Q3031	Collagen skin test
R0076	Transportation of portable EKG to facility or location, per patient
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 (e.g., ribs, spinous process, or laminae fragments) obtained from same incision (List separately in addition to code for primary procedure)
22841	Internal spinal fixation by wiring of spinous processes (List separately in addition to code for primary procedure)
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 intra-catheter, vein
36416	Collection of capillary blood specimen (egg, finger, heel, ear stick)
38204	Management of recipient hematopoietic progenitor cell donor search and cell acquisition
38225	Chimeric antigen receptor T-cell (CAR-T) therapy; harvesting of blood-derived T lymphocytes for development of genetically modified autologous CAR-T cells, per day
38226	Chimeric antigen receptor T-cell (CAR-T) therapy; preparation of blood-derived T lymphocytes for transportation (e.g., cryopreservation, storage)
38227	Chimeric antigen receptor T-cell (CAR-T) therapy; receipt and preparation of CAR-T cells for administration
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	Fitting of spectacle prosthesis for aphakia; multifocal
92354	Fitting of spectacle mounted low vision aid; single element system

92355	Fitting of spectacle mounted low vision aid; 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 bypass 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 (e.g., 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)
96041	Medical genetics and genetic counseling services, each 30 minutes of total time provided by the genetic counselor on the date of the encounter
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 (e.g., 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 nonphysician qualified health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient
98961	Education and training for patient self-management by a nonphysician qualified health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients
98962	Education and training for patient self-management by a nonphysician qualified health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 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 (e.g., 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 (e.g., 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 non-facility 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 professionals qualified by education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (e.g., 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
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	Medical team conference with interdisciplinary team of health care professionals, patient, and/or family not present, 30 minutes or more; participation by physician
99368	Medical team conference with interdisciplinary team of health care professionals, 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 (e.g., 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) (e.g., 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) (e.g., 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) (e.g., 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	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) (e.g., 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; 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 transport, including data interpretation and report; first 30 minutes
99486	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; each additional 30 minutes (List separately in addition to code for primary procedure)

Related Documents

N/A

References

Center for Medicare and Medicaid Services
Blue KC Provider Reference Guide

Revision History

Version	Date	Summary of Revisions
001	12/1/2020	Initial version
002	8/12/2021	Update - ; CPT codes removed, see CPT and HCPCS manuals for correct coding.
003	2/20/2022	Update - Added examples of Status B codes
004	12/1/2022	Annual review, no updates, or changes were made to the policy
005	12/1/2023	Annual review, no updates, or changes were made to the policy
006	12/1/2024	Annual review, Link to CMS status indicators was added.
007	12/1/2025	Annual review, complete list of status indicator B codes added to policy