If a conflict arises between a Clinical Payment and Coding Policy and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a Clinical Payment and Coding Policy 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. Blue Cross and Blue Shield of Illinois may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSIL 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 approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing Editor, American Medical Association, Current Procedural Terminology, CPT® Assistant, Healthcare Common Procedure Coding System, ICD-10 CM and PCS, National Drug Codes, Diagnosis Related Group guidelines, Centers for Medicare and Medicaid Services National Correct Coding Initiative 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.

Unbundling Policy-Professional Provider

Policy Number: CPCP034

Version 1.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date: Oct. 13, 2025

Plan Effective Date: Jan. 19, 2026

Description

The purpose of this policy is to provide information for professional and ancillary providers who submit claims using the CMS-1500 claim form or its electronic equivalent for healthcare services, equipment, and supplies. 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.

Reimbursement Information

Codes which most comprehensively describe the services performed should be submitted. The plan may bundle submitted codes if 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. Failure to adhere to coding and billing policies may impact claims processing and reimbursement.

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

Terms, Examples, and Applicable Information

1. **Contaminated, Not Utilized or Considered Waste**

Items such as supplies or equipment that are presumed contaminated, considered waste, and/or not utilized during the provisioned services on the member are not eligible for reimbursement.

Examples include, but not limited to:

- Any items or supplies that were prepared or opened during a procedure or service but were **not** used or implanted into the member (e.g., surgical trays);
- Items or supplies that were opened by mistake;
- Unused items or supplies resulting from the provider's change of mind;
- Equipment failure and/or technical difficulties;
- Cancellation; and
- Large packages of items, supplies, and/or implants when more appropriate packaging can be purchased.

2. **Disposable and/or Reusable Supplies and Items**

Furnished to members in both inpatient and outpatient settings and are ineligible for separate reimbursement. Disposable and/or reusable supplies and

items include, but are not limited to blood pressure cuffs, thermometers, syringes, needles, blood and/or urine testing supplies, sheaths, bags, elastic garments, stockings, bandages, garter belts, gauze, and replacement batteries.

3. **Equipment**

Commonly available to members in a particular setting or during the course of treatment, even if the equipment is rented, is considered routine and ineligible for separate reimbursement and therefore should not be billed separately.

4. **Global Allowance**

The global surgical package, also referred to as global surgery, includes all the related services and supplies that are routine and necessary to the procedure, rendered by a provider or by another physician or other QHP within the same group and/or same specialty and sub-specialty for preoperative, intra-operative, and post-operative services to the procedure. The global surgical package applies in any setting including inpatient hospital, outpatient hospital, Ambulatory Surgery Center (ASC), and a professional health care provider's office.

5. **Incidental Services**

The Plan excludes the cost of incidental services when performed with the primary service as it is integral to the successful outcome of the primary service, including technical charges for equipment and its purchase, rental, and maintenance. Charges for such incidental services should not be billed separately.

6. **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.

7. **Routine Supplies**

Routine supplies are included in the general charge where services are being rendered. Additional charges during an office visit or office procedure for supplies commonly furnished or usually a part of a surgical/medical 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.

Bundled or Included in the Basic Allowance of Another Service

The list below includes **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 and/or reusable 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 and alcohol swabs
  - Items used to obtain a specimen or complete a diagnostic or therapeutic procedure
  - Tape
  - Syringes
  - Needles
  - Bandages
  - Gauze

- **Nursing Services**
  - Collecting medical documentation
  - Patient education
  - Vitals

- **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
- Television
- Telehealth/telemedicine digital devices

Billing and Coding

When billing for a drug, supply, service or procedure, providers should select the CPT or HCPCS code that accurately describes the administered drug(s), service(s) or procedure(s) performed. If and only if no code exists, providers should report the appropriate unlisted code. Unlisted codes are used as a last resort and only when there is not a more appropriate code. Providers should submit medical records timely to support unlisted codes, as requested by the plan.

Appending Appropriate Modifiers

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 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.

Additional Resources

Clinical Payment and Coding Policy

CPCP002 Inpatient/Outpatient Unbundling Policy- Facility

CPCP010 Anesthesia Information

CPCP014 Global Surgical Package-Professional Provider

CPCP017 Wasted/Discarded Drugs and Biologicals Policy

CPCP023 Modifier Reference Policy

CPCP024 Evaluation and Management (E/M) Coding- Professional Provider

References

Healthcare Common Procedure Coding System (HCPCS)

CMS Medicare Claims Processing Manual, Chapter 12, Sections 20.3, 20.4.4. Accessed May 16, 2025.

CMS Medicare Claims Processing Manual, Chapter 26, Section 10.5. Accessed May16, 2025.

Policy Update History

Approval Date	Description
08/04/2021	New policy
04/05/2022	Annual Review
05/04/2023	Annual Review
06/17/2024	Annual Review
10/13/2025	Annual Review; Grammatical and formatting updates, including items listed under *Terms, Examples, and Applicable Information*: 1, 2, 3, 4, 5, and 7; Additional examples added under *Bundled or Included in the Basic Allowance of Another Service*; References updated.