

n05707
Status Code Policy

Values

Accountability • Integrity • Service Excellence • Innovation • Collaboration

Abstract Purpose:

This reimbursement policy outlines Network Health's process, for all lines of business, when professional claims are submitted with a CPT or HCPCS Code with a Status Code B or P.

Policy Detail:

- I. The National Physician Fee Schedule Relative Value File assigns a unique Status Code for each CPT/HCPCS code listed within the fee schedule. These code(s) provide additional information as determined by the Centers for Medicare and Medicaid Services (CMS).

- II. **Status Indicators:**
 - A. **A = Active Code.** These codes are separately payable under the physician fee schedule (PFS), if covered. Codes with this status include Relative Value Units (RVU's) and payment amounts. The presence of an A indicator doesn't mean that Medicare has made a national coverage determination about the service. A/B MACs (B) Medicare Administrative Contractors stay responsible for coverage decisions in the absence of a national Medicare policy.

 - B. **B = Bundled Code.** The PFS always bundles payment for covered services into payment for other services not specified. No RVUs or payment amounts exist for these codes and Medicare never makes separate payment. When Medicare covers these services, they include payment for them in the payment for the services to which they are incident. An example is a telephone call from a hospital nurse about the care of a patient.
 - a. In accordance with CMS, when a claim is submitted with a CPT or HCPCS code that carries a Status Code of B per the current year National Physician Fee Schedule Relative Value File, the service will be denied with Claim Adjustment Reason Code (CARC) 97/"*The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.*"

 - C. **C = MACs priced code.** A/B MACs (B) price the code. A/B MAC's (B) set up RVUs and payment amounts for these services, generally on an individual case-by-case basis following review of documentation such as an operative

report.

- D. **E = Excluded from physician fee schedule by regulation.** CMS excludes these codes for items or services from the fee schedule payment by regulation. The Physician Fee Schedule Data Base (PFSDB) Status Indicators table doesn't show any RVUs or payment amounts and makes no payment under the fee schedule for these codes. Payment for them, when covered, continues under reasonable charge procedures.
- E. **I = Not valid for Medicare purposes.** Medicare uses another code for reporting of, and payment for, these services. This code is not subject to a 90-day grace period.
- F. **M = Measurement codes.** Used for reporting purposes only.
- G. **N = Non-covered service.** Medicare carries these codes on the HCPCS tape as non-covered services.
- H. **P = Bundled and excluded codes.** No RVUs exist for these services. Medicare doesn't make separate payment for them under the fee schedule. If they cover the item or service as incident to a physician service and it is provided on the same day as a physician service, the payment is bundled into the payment for the physician service to which it is incident. An example is an elastic bandage a physician provided incident to a physician service. If Medicare covers the item or service as other than incident to a physician service, they exclude it from the fee schedule (for example, colostomy supplies) and pay it under the other payment provision of the Social Security Act.
 - a. In accordance with CMS, when a claim is submitted with a CPT or HCPCS code that carries a Status Code of P per the current year National Physician Fee Schedule Relative Value File, the service will be denied with Claim Adjustment Reason Code (CARC) 97/"*The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.*"
- I. **Q = Therapy functional information codes.** Used for required reporting purposes only. This indicator is no longer effective beginning with the 2020 fee schedule as of January 1, 2020.
- J. **R = Restricted coverage.** Special coverage instructions apply.
- K. **T = Paid as only service.** RVUs and payment amounts exist for these services. Medicare only pays these codes if there are no other services payable under the physician fee schedule (PFS) billed on the same day by the same provider. If Medicare pays the same provider for any other services billed on the same date under the PFS, charges are bundled into the physician services for which payment is made.
- L. **X = Statutory exclusion.** These codes stand for an item or service that isn't in the legal definition of physician services for fee schedule payment purposes. The PFSDB Status Indicators table shows no RVUs or payment amounts for these codes and makes no payment under the physician fee schedule. Examples: Medicare excludes ambulance services and clinical diagnostic

laboratory services.

Definitions:

Medicare Administrative Contractor (MAC) – MACs are companies that process claims and perform other administrative duties for the Medicare fee-for-service program (Original Medicare) within a specific geographic area or jurisdiction.

National Physician Fee Schedule Relative Value File – This file provides information on services covered under the Medicare Physician Fee Schedule. The fee schedule contains associated Relative Value Units (RVUs) and status indicators indicating whether the code is included in the fee schedule and/or separately payable.

PFS – The Physician Fee Schedule is a system used by Medicare to pay for services provided by physicians and other healthcare suppliers. It includes payment rates for over 10,000 services like office visits, diagnostic tests, and surgeries.

Physician Fee Schedule Data Base (PFSDB) – This is a comprehensive list of payment rates for services provided by physicians and other healthcare providers to Medicare beneficiaries. This database is used by Medicare to determine payments for a wide range of services such as office visits, diagnostic tests and surgeries. It includes the payment rates and the relative value units (RVUs) that factor into the calculations for each service, covering work, practice expense, and malpractice insurance.

Regulatory Citations:

Centers for Medicare and Medicaid Services (CMS)
Current Year CMS PFS Relative Value File

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