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 HCPC 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/HCPC 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, if covered. There will be RVU's and payment amounts for codes with this status. The presence of an A indicator doesn't mean that Medicare has made a national coverage determination regarding this service; MACs remain responsible for coverage decisions in the absence of a national Medicare policy.

B. **B = Bundled Code.** Payment for covered services are always bundled into payment for other services not specified.

a. In accordance with CMS, when a claim is submitted with a CPT or HCPC 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.** MACs will establish RVUs and payment amounts for these services, generally on an individual case-by-case basis following review of documenatation such as an operative report.

D. **E = Excluded from physician fee schedule by regulation.** These codes are for items or services that CMS chose to exclude from the fee schedule payment by regulation. No RVUs or payment amounts are shown, and no payment may be made 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. Code NOT subject to a 90-day grace period.)

F. **M = Measurement codes**. Used for reporting purposes only.

G. **N = Non-covered services.**

H. **P = Bundled and excluded codes.** There are no RVUs and no payment amounts for these services. No separate payment is made for them under the fee schedule. If the item or service is covered as incident to a physician service and is given on the same day as a physician service, payment for it is bundeld into the payment for the physician service to which it is incident (an example is an elastic bandage furnished by a physician incident to a physician service). If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (for example, colostomy supplies) and is paid under the other payment provision of the Social Security Act.

    a. In accordance with CMS, when a claim is submitted with a CPT or HCPC 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.** These codes are paid only if there are no other services payable under the physician fee schedule billed on the same day by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the physician services for which payment is made.

L. **X = Statutory exclusion.** These codes represent an item or service that isn't in the statutory definition of physician services for fee schedule payment purposes. No RVUs or payment amounts are shown for these codes and no payment may be made under the physician fee schedule. (Examples are ambulance services and clinical diagnostic laboratory services.)

Definitions:

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 idicators indicating whether the code is included in the fee schedule and/or separately payable.

PFS - Physician Fee Schedule

Regulatory Citations:

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

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