healthfirst
Health Insurance for New Yorkers

Reimbursement Policy

Subject:	Medicare Physician Fee Schedule Status Indicators		
Policy Number:	PO-RE-129v1		
Effective Date:	05/01/2025	**Last Approval Date:**	2/24/2025

I. Policy Description

The purpose of this reimbursement policy is to define the payment criteria for covered services as designated by the Centers for Medicare and Medicaid Services (CMS), particularly those classified as "always bundled" when billed alongside another physician's procedure or service. This policy will serve as a guideline for making payment decisions and administering benefits effectively.

The information below applies to the following lines of business:

- Medicare Advantage
- Managed Long-Term Care (MLTC)
  - Medicaid Advantage Plus (CompleteCare)
  - Senior Health Partners (SHP)
- Medicare PPO

Policy Scope

This policy applies to all healthcare providers and organizations that submit claims for services covered under Medicare. It encompasses all procedure codes that CMS classify with various status indicators, detailing the reimbursement criteria associated with each. The policy aims to ensure compliance with CMS regulations and to facilitate accurate and efficient claims processing.

Reimbursement Guidelines

The Center for Medicare and Medicaid Services (CMS) maintains the National Physician Fee Schedule (NPFS), which contains Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) procedure codes. Each of these codes has a Status Indicator code that indicates whether the code is separately payable if the service is covered. Additionally, CMS has guidance for procedure codes listed under the Hospital Outpatient Prospective Payment System (OPPS) Fee Schedule.

Codes with OPPS status “N” that are not payable under the physician fee schedule (specifically NPFS Status “X” or “E” codes) are addressed in this policy. Healthfirst aligns with CMS and considers certain

services and supplies ineligible for separate reimbursement when reported by a professional provider. These services and/or supplies may be reported with a primary service or as a stand-alone service.

Status B (Bundled Codes):
Healthfirst has aligned with CMS and will not separately reimburse for certain CTP/HCPSC codes identified by Centers for Medicare and Medicaid Services (CMS), National Physician Fee Schedule (NPFS), Relative Value File with designated status of “B” indicating a bundled procedure. Modifiers will not override the denial for these always bundled services and/or supplies.

Status P (Bundled/Excluded Codes):
Healthfirst have aligned with CMS and will not separately reimburse certain CPT/HCPCS codes identified by the Centers for Medicare and Medicare Services (CMS), National Physician Fee Schedule (NPFS), Relative Value File with a designated status of "P". Status “P” procedures are primarily categorized as supply codes. If the procedure code is listed with a status indicator of “P,” then payment for the procedure code is always included in the payment for other physician’s services to which they are incidental, and which are not designated as a status “P” procedure or service.

- Healthfirst code editing software will evaluate the current claim and historical claim lines that are billed with procedure codes designated as status “P” and compare to other procedures billed on the claims.
- This rule reviews claims for the same member, same individual physician or other health care professional and same date of service.
- If another procedure(s) is found that is not indicated as a status “P” code, the service line with the status “P” code is denied.
- Payment for the status “P” code is considered subsumed by the payment for the other services without the status “P” designation.
- Procedure codes designated as status “P” will always pay when billed alone.
- Procedure codes designated as status “P” will always pay when billed with another procedure code that also bears the status “P” designation.

This policy applies to those CPT/HCPCS codes with the following CMS Status Indicators:

CMS Status Indicator	Description	Healthfirst's Stance
Status “A”	Active code. Medicare pays these codes separately under the physician fee schedule (PFS), if covered. Codes with this status include RVUs 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) stay responsible for coverage decisions in the absence of a national Medicare policy.	Providers should submit claims for these codes as they will receive separate payment if covered.

Status “B”	The Physician Fee Schedule (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, we include payment for them in the payment for the services to which they’re incident. An example is a telephone call from a hospital nurse about the care of a patient.	Payment will be included in the payment for the primary service. Providers should not expect separate reimbursement.
Status “C”	A/B MACs (B) price the code. A/B MACs (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.	Claim will deny on initial submission. For consideration and potential reimbursement decision, providers must submit necessary documentation.
Status “E”	Excluded from the physician fee schedule by regulation. CMS excludes these codes for items or services from the fee schedule payment by regulation. The 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.	No payment will be made under the fee schedule; claims will be processed under reasonable charge procedures.
Status “I”	Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for these services. This code isn’t subject to a 90-day grace period.	Non-covered codes: reimbursement decisions will be made on a case-by-case basis.
Status “J”	Anesthesia services: no relative value units or payment amounts for anesthesia codes on the database, only used to help with the identification of anesthesia services.	Covered but not separately reimbursed.
Status “L”	Local codes. A/B MACs (B) will apply this status to all local codes in effect on January 1, 1998, or those later approved by the central office for use. A/B MACs (B) will complete the RVUs, and payment amounts for these codes.	Claims should be submitted for reimbursement based on local determinations.
Status “M”	Measurement codes. Used for reporting purposes only.	No reimbursement available; informational only.
Status “N”	Non-covered service. Medicare carries these codes on the HCPCS tape as noncovered services.	No reimbursement will be provided.

Status “P”	Bundled and excluded codes. No RVUs exist for these services. Medicare doesn’t make separate payment for them under the fee schedule. If we cover the item or service as incident to a physician service and you provide it on the same day as a physician service, we bundle payment for it into the payment for the physician service to which it’s 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, we exclude it from the fee schedule (for example, colostomy supplies) and pay it under the other payment provision of the Social Security Act.	Payment will be bundled with the physician service payment; separate reimbursement will not be issued.
Status “Q”	Therapy functional information code. Used for reporting purposes only. This indicator is no longer effective starting with the 2020 fee schedule as of January 1, 2020.	Not applicable for reimbursement
Status “R”	Restricted coverage. Special coverage instructions apply.	Further research is needed to establish a separate policy for these codes.
Status “T”	RVUs and payment amounts exist for these services. Medicare only pays for these codes if no other services are payable under the physician fee schedule (PFS) billed on the same date by the same provider. If Medicare pays the same provider for any other services billed on the same date under PFS, we bundle these services into the physician services.	Payment will be bundled; providers should be aware of this when submitting claims.
Status “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 PFS. Examples: Medicare excludes ambulance services and clinical diagnostic laboratory services.	No payment will be made under the PFS.

Adjudication and Appeal Process

1. Services that are classified as bundled will not be eligible for separate reimbursement. This determination is based on the above status indicators, and all bundled services must be billed together on a single claim. Providers are advised to ensure that claims for bundled services reflect the complete package to avoid discrepancies in reimbursement.

2. Reimbursement for services will be based on the provider's contract with Healthfirst or at the Healthfirst Standard Fee Schedule rate.

3. Claims submissions will be subject to timely filing requirements, as set forth in the provider contract with Healthfirst and in the Healthfirst Provider Manual. *Refer to: Healthfirst Provider Manual Subsection 17.6, "Claims Inquiries, Corrected Claims, Claim Reconsideration, and Appeal Process" in this section.*

II. Applicable Codes

Code	Description	Comment

III. Definitions

Term	Meaning

IV. Related Policies

Policy Number	Policy Description
N/A	N/A

Procedure codes appearing in Reimbursement Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.

V. Reference Materials

Status Indicators | CMS

VI. Revision History

Revision Date	Summary of Changes

Disclaimer

Healthfirst's claim edits follow national industry standards aligned with CMS standards that include, but are not limited to, the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst's coding edits incorporate industry-accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles, National Uniform Billing Editor's revenue coding guidelines, CPT Assistant guidelines, New York State-specific coding, billing, and payment policies, as well as national physician specialty academy guidelines (coding and clinical). Failure to follow proper coding, billing, and/or reimbursement policy guidelines could result in the denial and/or recoupment of the claim payment.

This policy is intended to serve as a resource for providers to use in understanding reimbursement guidelines for professional and institutional claims. This information is accurate and current as of the date of publication. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for the services outlined. Reimbursement decisions are based on the terms of the applicable evidence of coverage, state and federal requirements or mandates, and the provider's participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.