

## Medicare Physician Fee Schedule Status Indicator Policy, Professional

### **IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY**

This policy is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage reimbursement policies use Current Procedural Terminology (CPT®\*), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms (CMS 1450). Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general resource regarding UnitedHealthcare's Medicare Advantage reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Medicare Advantage may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Medicare Advantage enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, and/or the enrollee's benefit coverage documents\*\*. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Medicare Advantage due to programming or other constraints; however, UnitedHealthcare Medicare Advantage strives to minimize these variations.

UnitedHealthcare Medicare Advantage may modify this reimbursement policy at any time to comply with changes in CMS policy and other national standard coding guidelines by publishing a new version of the reimbursement policy on this website. However, the information presented in this reimbursement policy is accurate and current as of the date of publication. UnitedHealthcare Medicare Advantage encourages physicians and other health care professionals to keep current with any CMS policy changes and/or billing requirements by referring to the CMS or your local carrier website regularly. Physicians and other health care professionals can sign up for regular distributions for policy or regulatory changes directly from CMS and/or your local carrier. UnitedHealthcare's Medicare Advantage reimbursement policies do not include notations regarding prior authorization requirements.

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*\*\* For more information on a specific enrollee's benefit coverage, please call the customer service number on the back of the member ID card.*

### **Application**

This reimbursement policy applies to services reported using the 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

### **Policy**

#### **Overview**

A fee schedule is a complete listing of fees used by Medicare to pay doctors or other providers/suppliers. This comprehensive listing of fee maximums is used to reimburse a physician and/or other providers on a fee-for-service basis. CMS develops fee schedules for physicians, ambulance services, clinical laboratory services, and durable medical

equipment, prosthetics, orthotics, and supplies.

This policy addresses Medicare Physician Fee Schedule status codes B, I, M, N, P, Q, & T. Status indicator B represents “Bundled” codes, status code I represents “Invalid” codes, status code M represents “Measurement” codes, status code N represents “Noncovered” codes, P represents “Bundled/Excluded” codes, Q represents “Therapy Information Code”, and T represents “Injection” codes.

### Reimbursement Guidelines

- B** – “Bundled” Codes - Payment for covered services are always bundled into payment for other services not specified. If Relative Value Units (RVUs) are shown on the fee schedule, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident. (An example is a telephone call from a hospital nurse regarding care of a patient).
- 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.)
- M** – “Measurement” codes. Used for reporting purposes only.
- N** – “Non-covered” Services. These services are not covered by Medicare.
- P** – “Bundled/Excluded” Codes. There are no RVUs and no payment amounts for these services. No separate payment should be made for them under the fee schedule.
- If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident. (An example is an elastic bandage furnished by a physician incident to physician service.)
  - If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (i.e., colostomy supplies) and should be paid under the other payment provision of the Act.
- Q** – “Therapy functional information code, used for required reporting purposes only.”
- On January 1, 2013, a new status indicator of “Q” was created for the Medicare Physician Fee Schedule Database (MPFSDB). This new status indicator identifies codes used exclusively for functional reporting of therapy services. These functional G-codes were added to the MPFSDB with the new “Q” status indicator. Because these are non-payable G-codes, there are no Relative Value Units or payment amounts for these codes.
  - The reporting and collection requirements of beneficiary functional data apply to all claims for services furnished under the Medicare Part B outpatient therapy benefit and the PT, OT, and SLP services furnished under the Comprehensive Outpatient Rehabilitation Facility (CORF) benefit. They also apply to the therapy services furnished incident to the service of a physician and certain Non-Physician Practitioners (NPPs), including, as applicable, Nurse Practitioners (NPs), Certified Nurse Specialists (CNSs), and Physician Assistants (PAs).
  - CMS and UnitedHealthcare Medicare Advantage will no longer require the functional status reporting for dates of service on or after January 1, 2019.
  - Beginning January 1, 2020, MPFSDB status indicator Q is no longer being used.
- T** – “Injections”. There are RVUs and payment amounts for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date 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.

### Reimbursement Guidelines for Outpatient Therapy Functional Reporting

Claims with dates of service prior to January 1, 2019 will be returned or rejected when non-compliant with these reporting requirements. Claims containing any of the following CPT evaluation/re-evaluation therapy codes 92521, 92522, 92523, 92524, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 96125, 97161, 97162, 97163, 97164, 97165, 97166, 97167, or 97168 require functional information. Claims that do not include required functional reporting information will be returned or rejected and may be corrected and resubmitted.

- CPT codes 92521, 92522, 92523, 92524, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 97161, 97162, 97163, 97164, 97165, 97166, 97167, and 97168 must be submitted with the nonpayable HCPCS codes G8978 to G8999, G9158 to G9176, or G9186 and the appropriate modifier (CH – CN).
- Claims with dates of service on or after January 1, 2019 will no longer require the functional status G-code(s) or

severity/complexity modifier (s).

### Definitions

|   |   |
|---|---|
| <b>Relative Value Unit (RVU)</b>              | The assigned unit value of a particular CPT or HCPCS code. The associated RVU is either from the CMS NPFS Non-Facility Total value or Facility Total value.   |
| <b>Medicare Physician Fee Schedule (MPFS)</b> | A fee schedule is a complete listing of fee maximums used by Medicare to pay physicians, other enrolled health care professionals, or providers/suppliers on a Fee-For-Service (FFS) basis. Medicare bases payment on whichever is less, the charge or MPFS amount. |

### Questions and Answers

|          |   |
|----------|---|
| <b>1</b> | <p><b>Q:</b> What if CMS has labeled some codes with a non-covered status but the member has extended benefits for them?</p> <p><b>A:</b> Codes identified as supplemental benefits for our members will be carved out of the non-covered status and bypassed from the global denial.</p>   |
| <b>2</b> | <p><b>Q:</b> If a code with status indicator of B, I, M, P or Q is billed for a member, whose liability is the denied service?</p> <p><b>A:</b> If one of the codes with these status indicators is billed by a PAR or Non-Par Provider, the Provider will be held liable for the denied service. The member will be held harmless.</p> |

### Codes

At the PFS Relative Value File CMS website, the files are grouped by calendar year of release. The files are updated quarterly by CMS. The file name indicates which year and quarter the physician fee schedule is for. All files begin with "RVU", next two digits are the year, and the next digit represents the quarterly release. "A" = January, "B" = April, "C" = July, "D" = October. If there is an "R" after the quarter code, this will indicate a revision was made. Look up the MPFS for your date of service. Example for 05/01/2015 you would use RVU15B.  
 Medicare Physician Fee Schedule is found at: [National Physician Fee Schedule Relative Value File](#)

### Modifiers

| Code      | Description  |
|-----------|--|
| <b>CH</b> | 0 percent impaired, limited or restricted <b>(Used for Functional Reporting Requirement Initiative ONLY)</b>                                     |
| <b>CI</b> | At least 1 percent but less than 20 percent impaired, limited or restricted <b>(Used for Functional Reporting Requirement Initiative ONLY)</b>   |
| <b>CJ</b> | At least 20 percent but less than 40 percent impaired, limited or restricted <b>(Used for Functional Reporting Requirement Initiative ONLY)</b>  |
| <b>CK</b> | At least 40 percent but less than 60 percent impaired, limited or restricted <b>(Used for Functional Reporting Requirement Initiative ONLY)</b>  |
| <b>CL</b> | At least 60 percent but less than 80 percent impaired, limited or restricted <b>(Used for Functional Reporting Requirement Initiative ONLY)</b>  |
| <b>CM</b> | At least 80 percent but less than 100 percent impaired, limited or restricted <b>(Used for Functional Reporting Requirement Initiative ONLY)</b> |
| <b>CN</b> | 100 percent impaired, limited or restricted <b>(Used for Functional Reporting Requirement Initiative ONLY)</b>                                   |

### Resources

[www.cms.gov](http://www.cms.gov)

[HCPCS Release & Code Sets](#)

[National Physician Fee Schedule Relative Value Files](#)

### History

|           |   |
|-----------|---|
| 1/1/2020  | Annual Policy Version Change <ul style="list-style-type: none"> <li>Update for Transmittal 4418 advising effective 01/01/2020 status indicator Q is no longer being used by CMS</li> </ul>            |
| 1/1/2019  | Annual Policy Version Change <ul style="list-style-type: none"> <li>Template update</li> <li>Remove the requirement of the functional status G-code(s) and severity/complexity modifier(s)</li> </ul> |
| 9/7/2018  | <ul style="list-style-type: none"> <li>Title change to add Professional (no new version)</li> <li>Archive history prior to 9/1/2016</li> </ul>  |
| 7/10/2018 | Definition Corrections (no new version)   |
| 3/14/2018 | Annual Policy Version Change <ul style="list-style-type: none"> <li>Preamble update</li> <li>Codes updated</li> <li>Resource update</li> <li>History past 1/1/2016 archived</li> </ul>                |
| 3/8/2017  | Policy Approval Date Change (no new version)  |
| 1/1/2017  | Annual Policy Version Change  |
| 2/8/2012  | Policy developed and approved by committee  |