PREMERA BLUE CROSS
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Payment Policy

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Title	**Medicare Indicator 'Status B, Status P and Status T' Services Reimbursement**		
Number	**CP.PP.366.v2.9**		
Last Approval Date	01/08/25	**Original Effective Date**	11/17/08
Cross Reference	*Personal Protective Equipment (PPE)*		

Coverage of any service is determined by a member's eligibility, benefit limits for the service or services rendered and the application of the Plan's Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the **Plan's professional or facility services claims coding policies**. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.

Purpose	To define how the Plan manages services designated on the current CMS National Physician Fee Schedule (NPFS) Relative Value file with a Status B, Status P or Status T indicator for medical and surgical services and supplies that are submitted on a CMS 1500 paper claim or 837P electronic claim form.
Scope	Applies to all Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, LifeWise Health Plan of Washington, LifeWise Assurance Company, and Premera Blue Cross HMO lines of business and products.
Definitions	**Status Indicator:** A code classification within the National Physician Fee Schedule (NPFS) as maintained by the Centers for Medicare and Medicaid Services (CMS). **Status Indicator B codes:** Indicates a code that is always bundled into the payment for other services. **Status Indicator P Codes:** Indicates a code that is bundled/excluded when rendered on the same day as a physician service. There are no Relative Value Units (RVUs) for these services. No separate payment is made for these services under the physician fee schedule when billed on the same day as a physician service. **Status Indicator T Codes**: Indicates a code that is only paid if there are no other payable services billed on the same date of service by the same provider.
Policy	The Plan uses the current CMS National Physician Fee Schedule (NPFS) Relative Value file to identify those procedure codes identified with a Status Indicator of "B", "P", or "T". Status Indicator B codes describe a service which is included/integral in the reimbursement for another service and is not eligible for reimbursement, whether billed alone or with another service. Status Indicator T codes are not reimbursed when submitted with other payable services billed on the same date of service by the same provider for the same member whether billed on the same claim or multiple claims. When a Status Indicator T code is billed alone and no other **payable services** are billed on the same claim or multiple claims for the same member on the same date of service by the same provider, the Status Indicator T code is reimbursable.

	Effective for claim with dates of service on and after October 6, 2024**,** Status Indicator P codes may no longer be reimbursed when submitted **with other payable services on the same date of service by the same provider for the same members whether on the same claim or multiple claims.** If the Status Indicator P item or service is incident to a physician service and is provided on the same day as a physician service, payment for the Status Indicator P code is bundled into the payment for the physician service to which it is incident to (e.g., elastic bandages furnished by a physician incident to a physician service). If the Status Indicator P item or service is provided **without any other physician service or is not an incident to service,** the Status Indicator P code is reimbursable. The Plan's payment policy is based upon the current published list of Status Indicator B, P, and T designations from CMS in the NPFS file applicable to the date of service on the claim. A complete and current list of Status Indicator B, P, and T codes can be obtained on the CMS website by selecting the NPFS Relative Value file release applicable for the date of service on the claim by using this link (LINK).
Codes/Coding Guidelines	
Violations of Policy	Violations of this policy by any party that enters into a written arrangement with the Plan may result in increased auditing and monitoring, performance guarantee contractual penalties and/or termination of the contract. Disciplinary actions will be determined at the Plan's sole discretion. Violations of this policy may be grounds for corrective action, up to and including termination of employment.
Exceptions	Exceptions to policy criteria include the following: ***Code 96040* - *Medical genetics and genetic counseling services, each 30 minutes face to face with patient/family.*** (Code terminated effective December 31, 2024) ***Code 96041* – *Medical genetics and genetic counseling services, each 30 minutes of total time provided by the genetic counselor on the date of the encounter*** (Code effective January 1, 2025) • Code 96041 will be reimbursable **ONLY** when this service is provided by **trained genetic counselors,** according to the CPT Codebook coding guidelines. • Do not report 96041 for less than 16 minutes or genetic counseling time. • Genetic counseling and education provided to an individual by a physician or other qualified healthcare professional who may report evaluation and management (E&M) services must use the appropriate E&M service code, per the CPT Codebook coding guidelines. **Code 99072: *Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency, as defined by law, due to respiratory-transmitted infectious disease*.**

	• Effective for claims with dates of service on and after **July 8, 2023**, procedure code 99072 reverted to being a Status Indicator B code and no reimbursement will be made for ALL providers and all claim submissions per policy criteria. ***Code G2211 Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)*** • Code G2211 is considered a bundled code and not separately reimbursable effective for claim dates of service on and after October 6, 2024. ***Code V2520 - Contact lens, hydrophilic, spherical, per lens*** Code V2520 is exempt from Status Indicator P policy criteria and will continue to be allowed reimbursement. **DME Agencies and DME Suppliers** • DME agencies and suppliers who submit DME Status Indicator P supplies without any other physician service on the same claim are exempt from Status Indicator P policy criteria.
Laws, Regulations & Standards	
References	• The Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS) Relative Value File • Current Procedural Terminology (CPT) Codebook, Professional Edition, American Medical Association (AMA)

Policy Owner Review	Payment Integrity Oversight Committee	
Contact	Any questions regarding the contents of this policy or its application should be directed to the Payment Integrity Department.	
Annual Review Dates	01/08/25; 06/13/24; 02/05/24; 03/13/23; 04/08/22; 05/27/21; 04/28/21; 11/04/20; 12/04/19; 12/06/18; 04/19/18; 07/18/17; 08/08/16; 08/10/15; 08/10/14; 01/12/14; 01/13/13; 01/26/12; 01/27/11; 03/04/10; 10/09/09	
Version History	04/19/18	Annual review; no changes made
	12/06/18	Added new section in the Policy section to identify "Code Exceptions" to address code 96040 for genetic counseling provided by a genetic counselor effective with dates of service on and after January 4, 2019, will be reimbursed
	12/04/19	Annual review; no changes
	11/04/20	• Clarified the Purpose statement to indicate that the policy pertains to Professional services billed on a CMS-1500 or 837P claim forms.

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		• In the Policy section, identified where the Status B indicators come from/located and clarified to pull the file version appropriate for the date of service billed. • Minor revisions made to the Code Exception section to make it easier to read.
	04/28/21	• Created a new section titled "Codes/Coding Guidelines. • Moved the Code Exception section into the Codes/Coding Guideline Section. • Added code 99072 (PPE) as an exception for the duration of the federally declared public health emergency.
	05/27/21	Additional clarification added to the Code/Coding Guidelines and Exception sections for CPT code 99072 when submitted by Washington Dentists and Pharmacists.
	04/08/22	Rewrote the last paragraph in the Policy section and embedded a link to the CMS NPFS Relative Value files
	03/13/23	• Modified the Policy title to include "Status T" codes. • In the Definitions section, added a definition for Status Indicator T codes. • Revised the Policy section to include references to Status Indicator T codes which will no longer be reimbursed effective with dates of service on and after July 8, 2023. • In the Codes/Coding Guidelines section, for code 99072, added the first bullet indicating that the code would return to being a non-reimbursable Status Indicator B code effective with claim dates of service on and after July 8, 2023, due to the termination of the PHE as declared by the federal government.
	02/05/24	In the Policy section, paragraph three, added further clarification on when a Status T code is/is not reimbursed.
	06/13/24	• The Title of the policy was revised to include Status P codes. • In the Definitions section, added a definition for Status P codes. • In the Policy section, added the fourth, fifth and sixth paragraphs to indicate that effective with claim dates of service on and after October 6, 2024, Status P codes will be considered bundled codes and may no longer be separately reimbursable when submitted incident to other physician services on the same date of service but reimbursable when billed with no other physician services on the same date of service by the same provider. • In the Exceptions section, the following exceptions are added to the policy criteria: o Code G2211 will be considered a bundled service effective with dates of service on and after October 6, 2024 o Code V2520 is exempt from Status P policy criteria and will continue to be reimbursed o Agency and Supplier providers who submit DME Status P supplies without any other physician services on the same claim are exempt from Status P policy criteria
	01/08/25	In the Definitions section of the policy, added a new definition for "Status Indicator" and revised the definitions for Status Indicator B, P and T codes.

		In the Codes/Coding Guideline section of the policy: • Moved codes 96040 and 99072 into the Exceptions section of the policy • Removed the following information related to code 99072 since the PHE has been declared over: o Effective with claims received with **dates of service on or after April 16, 2021, through July 7, 2023**, a code exception is being made **for the duration of the federally declared coronavirus public health emergency (PHE) for** PPE code 99072. o In compliance with Washington State Senate Bill 5169 (2021), code 99072 will be reimbursed to Washington state healthcare providers only whose member's benefits allow reimbursement for this service. o One unit will be reimbursed for code 99072 per Washington provider, per member, per date of service. o This exception also applies to Washington Dentists, which submit **medical services** billed on a CMS-1500 paper or 837P electronic professional claim forms. **This exception does not apply to Washington Dentists that bill PPE that is worn as part of a dental visit for dental plan services since it is considered part of the practice expense included in the main dental procedure rendered.** o This exception applies to Washington Pharmacists that submit **medical services** billed on a CMS-1500 paper or 837P electronic professional claim forms. **This exception does not apply to Washington Pharmacists that bill PPE that is worn as part of a Pharmacy visit since it is considered part of the practice expense included in the main Pharmacy service rendered.** o All other providers not specifically called out as an exception will continue to be subject to the policy criteria and the submission of code 99072 will continue to be denied as a Medicare Status B code. o When the federally declared PHE is terminated, code 99072 will return to being a non-reimbursable code per policy criteria for ALL providers and all submissions. In the Exceptions section of the policy: • Added the termination date to code 96040 which was December 31, 2024 • Added new code 96041 which became effective January 1, 2025, and added coding guidelines from the CPT Codebook • Added code 99072 which reverted to Status Indicator B status effective with dates of service on and after July 8, 2023 • Revised the paragraph on DME agencies and suppliers