UnitedHealthcare®

Reimbursement Policy

Medicare Physician Fee Schedule Status Indicator

Policy Number	MPFS04012008RP	Approved By	UnitedHealthcare Medicare Reimbursement Policy Committee	Current Approval Date	09/24/2014

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 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 reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare 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 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 due to programming or other constraints; however, UnitedHealthcare strives to minimize these variations.

UnitedHealthcare may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

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Application

This reimbursement policy applies to services reported using the Health Insurance Claim Form CMS-1500 or its electronic equivalent or its successor form, and services reported using facility claim form CMS-1450 or its electronic equivalent or its successor form. This policy applies to all products, all network and non-network physicians, and other health care professionals.

The HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits. This policy does not take

precedence over CCI edits. Please refer to the CCI for correct coding guidelines and specific applicable code combinations prior to billing UnitedHealthcare. It is not enough to link the procedure code to a correct, payable ICD-9-CM diagnosis code. The diagnosis must be present for the procedure to be paid. Compliance with the provisions in this policy is subject to monitoring by pre-payment review and/or post-payment data analysis and subsequent medical review. The effective date of changes/additions/deletions to this policy is the committee meeting date unless otherwise indicated.

Summary

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 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 will identify codes being used exclusively for functional reporting of therapy services. These functional G-codes have been added to the MPFSDB with the new "Q" status indicator. Because these are non-payable G-codes, there will be 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).

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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. (NOTE: This is a change from the previous definition, which states that injection services are bundled into any other services billed on the same date.)

Overview for Outpatient Therapy Functional Reporting

For therapy claims, with dates of service on and after January 1, 2013, processed on and after April 1, 2013, through June 30, 2013, contractors will send alerts reminding you to include the new functional limitation G-codes (from the list of 42) and the appropriate severity/complexity modifier on future specified therapy claims through a new RA message.

Reimbursement Guidelines for Outpatient Therapy Functional Reporting

Beginning July 1, 2013, claims will be returned or rejected using a new RA message when non-compliance with these reporting requirements occurs. Contractors will alert providers, who submit claims containing any of the following CPT evaluation/re-evaluation therapy codes 92506, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 96125, 97001, 97002, 97003, 97004 without functional information, that these codes require functional G-code(s) and appropriate severity/complexity modifier (s), and effective July 1, 2013, claims that do not include required functional reporting information will be returned or rejected. The following CARC and RARC will be used as the alert message:

- RC 246- "This non-payable code is for required reporting only." And
- RARC N566- "Alert: This procedure code requires functional reporting. Future claims containing this procedure code must include an applicable non-payable code and appropriate modifiers for the claim to be processed."" when CPT codes 92506, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 97001, 97002, 97003, or 97004 are submitted without the nonpayable HCPCS codes G8978 to G8999, G9158 to G9176, or G9186 and the appropriate modifier (CH – CN).

Please reference the Multiple Procedure Payment Reduction (MPPR) For Therapy Services Reimbursement Policy for further details.

CPT/HCPCS Codes

Code	Description
2012	http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/RVU12D.zip
2013	http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/RVU13D.zip
2014	http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/RVU14D.zip

Modifiers

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

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CN	100 percent impaired, limited or restricted **(Used for Functional Reporting Requirement Initiative ONLY)**

Questions and Answers

1	**Q:**	What if CMS has labeled some codes with a non-covered status but the member has extended benefits for them?
	A:	Codes identified as supplemental benefits for our members will be carved out of the non-covered status and bypassed from the global denial.
2	**Q:**	If a code with status indicator of B, I, M, P or Q is billed for a member, whose liability is the denied service?
	A:	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.

References Included (but not limited to):

CMS Claims Processing Manual

Chapter 23; § 30.2.2 MPFSDB Status Indicators

CMS Transmittals

Transmittal 165, Change Request 8005, Dated 12/21/2012 (Implementing the Claims-Based Data Collection Requirement for Outpatient Therapy Services -- Section 3005(g) of the Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) of 2012)

Transmittal 2622, Change Request 8005, Dated 12/21/2012 (Implementing the Claims-Based Data Collection Requirement for Outpatient Therapy Services -- Section 3005(g) of the Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) of 2012)

Transmittal 2695, Change Request 8286, Dated 05/02/2013 (Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - July 2013 Update)

Transmittal 2718, Change Request 8338, Dated 06/07/2013 (July 2013 Update of the Hospital Outpatient Prospective Payment System (OPPS))

Transmittal 2971, Change Request 8776, Dated 05/23/2014 (July 2014 Update of the Hospital Outpatient Prospective Payment System (OPPS))

UnitedHealthcare Medicare Advantage Coverage Summaries

Wound Treatments

UnitedHealthcare Reimbursement Policies

Multiple Procedure Payment Reduction (MPPR) For Therapy Services

MLN Matters

Article MM8005, Implementing the Claims-Based Data Collection Requirement for Outpatient Therapy Services — Section 3005(g) of the Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) of 2012

Article MM8166, Outpatient Therapy Functional Reporting Non-Compliance Alerts

Article MM8291, July Update to the Calendar Year (CY) 2013 Medicare Physician Fee Schedule Database (MPFSDB)

Article MM8664, April Update to the Calendar Year (CY) 2014 Medicare Physician Fee Schedule Database (MPFSDB)

Article MM8773, July Update to the Calendar Year (CY) 2014 Medicare Physician Fee Schedule Database (MPFSDB)

Article MM8888, October Update to the CY 2014 Medicare Physician Fee Schedule Database (MPFSDB)

Others

Medicare Learning Network Handout-ICN 901344: How to Use the Searchable Medicare Physician Fee Schedule (MPFS),January 2012, CMS Website

Medicare Learning Network Fact Sheet-ICN 006814: Medicare Physician Fee Schedule; April 2013, CMS Website

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History	
Date	**Revisions**
09/24/2014	Administrative updates
07/29/2014	Administrative updates
06/25/2014	Administrative updates
04/23/2014	• Administrative updates • Next review will occur July 2014
02/26/2014	• Administrative updates • More info located in the Multiple Procedure Payment Reduction (MPPR) For Therapy Services reimbursement policy
02/21/2014	Administrative updates
01/17/2014	Administrative updates
01/08/2014	Administrative updates
10/23/2013	Administrative updates
08/01/2013	Administrative updates
03/13/2013	• Policy re-reviewed and approved • Administrative updates
02/08/2012	Policy developed

