Priority Health	BILLING POLICY No. 024
PROFESSIONAL STATUS INDICATOR	
Date of origin: Apr. 2024	**Review dates: 2/2025**

APPLIES TO

- Physician and non-physician practitioners related services for all products (unless otherwise specified)
- Exceptions to this policy may be stated in other policies or outlined in member benefits

DEFINITION

This policy defines payment criteria for covered services as designated by the Centers for Medicare and Medicaid Services (CMS) and adopted for Priority Health reimbursement purposes. Priority Health may define a service as covered, but this doesn't guarantee reimbursement is assigned to these services. This may be due to bundling, informational/reporting codes or codes that may not be reimbursed in defined settings. In addition, CMS has defined specific exclusions that may be CMS policy related, codes not recognized for traditional Medicare or services CMS identified as falling outside of what is classified as physician services.

The CMS Physician Fee Schedule Relative Value (PFSRV) file defines payment status indicators for codes listed within the physician fee schedule. These status indicators classify codes into specific categories indicating how they'll be handled in claims processing and whether they'll be reimbursed. PFSRV updates are released quarterly and may be used in making payment decisions and administering benefits. Priority Health will update in alignment with these releases.

POLICY SPECIFIC INFORMATION

Bundled indicators

Items or services are considered inclusive or bundled into another physician service when minimal additional resources are necessary in addition to the primary services performed on the same date of service. These services are always bundled or inclusive to the more complex service.

Status Indicator B

- Defined as services that are always bundled and not assigned relative value units (RVUs) or payment. These services are always bundled into reimbursement for other services, or a separate payment is never made for these services. Although these services may be defined as "covered" services, there's no defined reimbursement.
- Services designated as status B aren't reimbursed even when billed alone.

Status Indicator P

- Defined for services that are always considered inclusive to other physician services (which don't have P status designation) performed on the same date of service. These services are commonly characterized as supply codes.
- Services designated as status P will be reimbursed when billed alone or with another service with the same designation.

Status Indicator T

- Defined for injection services that are considered inclusive to any payable physician services when performed on the same date by the same provider.
- Reimbursement is made only if no other services defined within the physician fee schedule are performed.

Exclusion indicators

Status Indicator E

- Defined as codes for items and/or services that CMS chose to exclude from the fee physician 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 these codes, when covered, continues under reasonable charge procedures.
- Exclusions for pharmacy drugs or biologicals defined for medical benefits may exist. These will be detailed in the Provider Manual.

Status Indicator I

- Defined for codes reported that are invalid.
- The provider is responsible to report the most accurate code for services rendered.
- Inaccurate codes will need to be returned as a denial and will require claim resubmission.

Status Indicator N

- Defines services that CMS has defined as non-covered under traditional Medicare.
- Exclusions for enhanced/supplemental benefits as defined in the Provider Manual or outlined in a member's Explanation of Coverage or Certificate of Coverage.
- Applies to Medicare products only.

Status Indicator X

- Defines items or services that are considered statutory exclusions.
- These services or items fall outside of what is classified as physician services according to the CMS physician fee schedule.
- Services have no RVU or fees assigned under the physician fee schedule.
- Services may be defined within another fee schedule aligned to a provider or provider group. Reference specific contractual language and/or policies in the Provider Manual for these guidelines.
- Exclusions for pharmacy, enhanced/supplemental benefits as defined in the Provider Manual or outlined in a member's Explanation of Coverage or Certificate of Coverage.
- Applies to Medicare products only.

Informational indicators

Status Indicator M

- Defined for services that are reporting only and typically have no fee assigned. These identify measurement(s) associated with a defined performance measurement or set measured criteria.
- Services are only payable if defined through an eligible initiative detailed in the Provider Manual.

Place of Service indicators

Status Indicator NA

- Defines items or services that are rarely or never reimbursed when performed in a non-facility setting.
- Defines items or services that aren't paid in a facility setting based on the physician fee schedule.
- Exceptions to reimbursement of services based on setting are defined in the Provider Manual.

REFERENCE

Centers for Medicare and Medicaid Services, Physician Fee Schedule (PFS) Relative Value Files

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for

coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Feb. 5, 2025	Added "Disclaimer" section