Reimbursement Policy for NPFS Status Indicator T

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare's reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In a conflict, federal and state guidelines, as applicable, and the member's benefit plan document supersede the information in this policy. Also, to the extent of conflicts between this policy and the provider contract language, the Provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval. If there is a state exception, please refer to the state exception table listed below.

Policy Overview

This policy serves to detail the reimbursement protocols for healthcare services that are classified with a Status Indicator of 'T' according to the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS). The intention behind this document is to provide healthcare providers and qualified healthcare professionals with a comprehensive understanding of billing and reimbursement procedures related to these specific codes.

- ***CMS National Physician Fee Schedule (NPFS)***
  - The CMS National Physician Fee Schedule (NPFS) is an extensive compilation of Fee Schedule Status Codes. These codes function as indicators, specifying whether a given healthcare service code is incorporated into the fee schedule and is thus eligible for separate reimbursement, conditional on the service being covered under the Medicare program. For more information, you can refer to the CMS NPFS Database.
- ***Definition of 'T' Status Codes According to CMS***
  - In the realm of CMS regulations, a Status Indicator of 'T' is assigned to a healthcare service with allocated Relative Value Units (RVUs). It is critical to understand that reimbursement for services with a 'T' Status Code is available only under the condition that no other billable services are submitted on the same day by the same healthcare provider or other qualified healthcare professional under the physician fee schedule. This is in alignment with CMS guidelines, as delineated in the CMS Manual System, Pub 100-04, Medicare Claims Processing.
- ***Bundling of Services***
  - If a healthcare provider submits claims for additional services that qualify for reimbursement under the physician fee schedule on the same date, these services will be consolidated, or "bundled," into the physician services for which payment is subsequently made. This is in line with the CMS's "National Correct Coding Initiative" (NCCI) which is designed to promote accurate coding and control improper coding leading to inappropriate payment.
- ***Non-reimbursement for Unbundled Claims***
  - It is imperative for healthcare providers to note that any claims containing Status 'T' codes, which are unbundled and billed separately, will not be eligible for reimbursement. This is a strict policy, consistent with both federal and state Medicaid guidelines.

Reimbursement Guidelines

Molina Healthcare adheres to the following protocols for codes with a 'T' Status Indicator:

- These codes will be bundled into any other service provided on the same date by the same individual physician or healthcare professional.
- Payment will be processed according to the cumulative value of services, considering these codes as components of a single, comprehensive service.

Exceptions and Overrides

There will be no exceptions or overrides to this policy. Procedure codes with a 'T' Status Indicator will not be exempt from bundling, and they will be included in the services that are covered by the payment.

This policy follows CMS guidelines, as well as relevant regulations from Medicare Administrative Contractors (MACs) and various state Medicaid programs. For further details or clarifications, providers are encouraged to consult the official CMS documentation and their state-specific Medicaid websites.

Supplemental Information

Definitions

Term	Definition
Bundled	A payment structure in which different health care providers treating a patient for the same or related conditions are paid an overall sum for taking care of the condition rather than being paid for each individual treatment, test, or procedure.
CMS	Center for Medicare and Medicaid
NPFS	National Physician Fee Schedule - The Medicare physician fee schedule database (MPFSDB) is the file layout for carriers. It includes the total fee schedule amount, related component parts, and payment policy indicators.
PFS	Physician Fee Schedule
RVU	Relative Value Unit

State Exceptions

State	Exception

Documentation History

Type	Date	Action
Published		
Revised Date		

References

Agency:	Reference links:
CMS	CMS MLN901344 - Physician Fee Schedule Look up tool overview CMS Manual System (Page 7) PFS Relative Value Files | CMS