



POLICY INFORMATION			
Policy Number:	POL-PP- 231	Original Effective Date:	7/1/2022
Version Number:	006	Revision Date:	7/1/2025
Policy Status:	Active	Next Revision Date:	7/1/2026

NOTICE

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Blue KC reserves the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to: <https://providers.bluekc.com/ContactUs/PaymentPolicies>.

PROVIDER/ENTITY IMPACTED					
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PROFESSIONAL	FACILITY	DME	AMBULATORY SURGERY	LAB	OTHER

LINES OF BUSINESS IMPACTED						
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
COMMERCIAL	BLUE MEDICARE ADVANTAGE	ACA QHP¹	SMALL GROUP ACA	JAA²	FEP³	DENTAL

¹ ACA QHP: Affordable Care Act Qualified Health Plan for Individual/Family ² JAA: Joint Administrative Account ³ FEP: Federal Employee Program

Disclaimer

Blue KC has developed Provider Payment Policies to provide guidance on payment methodologies as they pertain to submitted claims. These policies are written following industry standard recommendations from sources such as:

- Current Procedural Terminology
- Centers for Medicare and Medicaid
- American Medical Association
- National Correct Coding Initiative
- Other professional organizations and societies

Coverage of any service is determined by date of service, a member's eligibility and benefit limits for the service or services rendered, all terms of the Provider Service Agreement, and other standards of coding rules and guidelines.

Final payment is subject to the application of claims adjudication and edits common to the industry.

For confirmation of which services may be eligible for coverage and description of when medical services are considered medically necessary, not medically necessary, or investigational, please contact:

- Blue KC Provider Hotline for Commercial lines of Business 816-395-3929
- Affordable Care Act Provider Hotline 866-859-3822
- Blue Medicare Advantage Provider Hotline 866-508-7140

In the event of a conflict between any policies, the Member's coverage document will govern.



Description/Application

The Medicare Physician Fee Schedule (PFS) uses status indicators to classify codes and determine how they are paid. These status indicators help determine whether a code is eligible for separate payment, whether it is bundled with another code, or if it is simply not covered. They are essential for accurately billing and receiving payment for services rendered.

Policy

Medicare Physician Fee Schedule

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.

CMS develops fee schedules for physicians, ambulance services, clinical laboratory services, and durable medical equipment, prosthetics, orthotics, and supplies.

Status indicator, or "SI," is a payment indicator that identifies whether a service represented by a CPT or HCPCS code is payable under the Outpatient Prospective Payment System/Ambulatory Payment Classification or another payment system.

Only one status indicator is assigned to each CPT or HCPCS code.

Status Indicator	Descriptor
A	Active code. These codes are separately paid under the physician fee schedule if covered. There will be RVUs, and payment amounts for codes with this status. The presence of an "A" indicator does not mean that Medicare has made a national coverage determination regarding the service; carriers remain responsible for coverage decisions in the absence of a national Medicare policy.
B	Bundled code. Payment for a covered service is always bundled into payment for other services not specified. There will be no RVUs, or payment amounts for these codes and no separate payment is ever made. When 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 beneficiary).
C	Carriers/MACs priced code. Carriers/MACs will establish RVUs, and payment amounts for these services, on an individual case-by-case basis following review of documentation such as an operative report.
E	Excluded from physician fee schedule by regulation. These codes are for items and/or services that CMS chose to exclude from the fee 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 them, when covered, continues under reasonable charge procedures.
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 service.



P	Bundled/excluded codes. There are no RVUs, and no payment amounts for these services. No separate payment is 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 a physician service). If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (for example, colostomy supplies) and is paid under the other payment provision of the Act.
R	Restricted coverage. Special coverage instructions apply.
T	Paid as only service. These codes are paid only 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.
X	Statutory exclusion. These codes represent an item or service that is not in the statutory definition of "physician services" for fee schedule payment purposes. No RVUs or payment amounts are shown for these codes, and no payment may be made under the physician fee schedule. (Examples are ambulances services and clinical diagnostic laboratory services.)

Coding

For code specific information, please go to <https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/pfs-relative-value-files>

References and Resources

CMS Physician Fee Schedule
Blue KC Provider Reference Guide

Related Documents

N/A

Revision History

Date	Summary of Revisions
7/1/2022	New Policy
7/1/2023	Annual review, no updates, or changes were made
7/1/2024	Annual review, no updates, or changes were made
7/1/2025	Annual review, no updates, or changes were made