Status Indicator Flag B Bundled Codes

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

The Center for Medicare and Medicaid Services (CMS) maintains the National Physician Fee Schedule (NPFS), which contains CPT and HCPCS procedure codes. Each of these codes has a Status Indicator flag that classifies the code into a specific category, indicating how it will be handled in claims processing and whether it will be reimbursed. Status Indicator B signifies a service that is always bundled into another service.

Reimbursement for this service is included in the payment for another service, regardless of whether the code is billed on the same date of service as a primary code or billed separately on a different date or claim.

Bundled codes refer to a group of medical procedure codes or services that are combined or packaged together for reimbursement by healthcare payers, such as insurance companies or government programs like Medicare and Medicaid. When codes are bundled, they are not paid separately; instead, their payment is included in the payment for another primary service or procedure.

This bundling process streamlines billing and reimbursement, prevents double payments for overlapping services, and promotes efficiency in healthcare delivery. The primary service that includes bundled codes is generally considered the most comprehensive or significant in each medical encounter. For example, if a surgeon performs a surgical procedure that involves inserting a medical implant, the cost of the implant may be bundled with the payment for the surgical procedure rather than being reimbursed separately.

Bundled codes are often identified through specific coding guidelines and rules set by healthcare payers, which can vary depending on the payer and the specific medical procedure or service being performed. Understanding bundled codes is important for healthcare providers and billing professionals to ensure accurate and compliant billing and reimbursement processes.

Reimbursement Guidelines

Procedure codes assigned a CMS status Indicator flag 'B' are not eligible for separate reimbursement. Payment for these covered services is always integrated into the payment for other unspecified services. If Relative Value Units (RVUs) are provided, they are not considered for Medicare reimbursement. Instead, payment for these services is included within the payment for the related services to which they are associated. For example, a telephone call from a hospital nurse regarding patient care is one such instance. Molina Healthcare adheres to state and federal regulations by not providing separate reimbursement for procedure codes bearing a status Indicator flag 'B'.

Supplemental Information

Definitions

Term	Definition
CMS	the Centers for Medicare & Medicaid Services. It is a federal agency within the United States Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program (CHIP), and health insurance portability standards.
CPT	stands for Current Procedural Terminology. It is a set of medical codes used by physicians, allied health professionals, nonphysician practitioners, hospitals, outpatient facilities, and laboratories to describe the procedures and services they perform
HCPCS	Healthcare Common Procedure Coding System. It is a standardized coding system that Medicare and other health insurance programs use to identify services and procedures that medical professionals provide.
NPFS	NPFS stands for National Physician Fee Schedule. It is a list of fees used by Medicare to pay doctors or other providers/suppliers. The NPFS is updated annually and contains the relative value units (RVUs) and payment amounts for each CPT code.
Status Indicator Flag	A status indicator flag is a classification of a CPT or HCPCS procedure code into a specific category indicating how it will be handled in claims processing and whether it will be reimbursed. The Center for Medicare and Medicaid Services (CMS) maintains the National Physician Fee Schedule (NPFS) which contains CPT and HCPCS procedure codes
RVU's	RVUs stands for Relative Value Units. It is a measure of value used in the Medicare reimbursement formula for physician services. The RVU is a measure of the relative resources required to provide a service, including physician work, practice expense, and malpractice expense

State Exceptions

State	Exception

Documentation History

Type	Date	Action
Effective Date	09/08/2023	New Policy
Revised Date	12/17/2024	Updated the language and the policy template

References

This policy was developed using.

- CMS
- State Medicaid Regulatory Guidance
- State Contracts

State/Agency	Document Name/Description	Link/Document
All	**PFS Relative Value Files/ The National Phys Fee Schedule that shows the payment indicators (if codes are Status B-codes (bundled), and PDF**	PFS Relative Value Files | CMS
All	**Medicare NCCI 2022 Coding Policy Manual/Explains the purpose of the NCCI PTP database-Starting on Page 6**	Medicare NCCI 2022 Coding Policy Manual – Chap1-GeneralPolicies (cms.gov)
All	**Medicare NCCI FAQ Library page/Reference bullet# under the heading national Correct Coding Initiative (NCCI) Policy Manual which state to whom the NCCI rules apply**	https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci/ncci-medicare/medicare-ncci-faq-library
All	**CMS MLN Fact Sheet/Proper Use of Modifiers (Reference starting on Page 15)**	MLN1783722 - Proper Use of Modifiers 59, XE, XP, XS, and XU (cms.gov)
All Medicaid	**Medicaid National Correct Coding Initiative Policy Manual/ Reference Page 5 – Use of Manual section**	https://www.cms.gov/files/document/medicaid-ncci-policy-manual-2023-introduction.pdf
CMS	**Medicaid NCCI 2023 Coding Policy Manual – Chapter 10/ Page 6 Bullet C – Lab Panel Unbundling Modifiers**	https://www.cms.gov/files/document/medicaid-ncci-policy-manual-2023-chapter-10.pdf

***CODING DISCLAIMER**. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.*