Payment Policy: Status "P" Bundled Services

Reference Number: CC.PP.049
Product Types: ALL
Effective Date: 03/15/2017
Last Review Date: 12/01/2022

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
The Centers for Medicare and Medicaid Services (CMS) classifies certain procedure codes as always bundled when billed on the same claim or a historical claim containing another procedure code or codes to which the bundled code shares an incidental relationship. An incidental procedure is one that is carried out at the same time as a more complex primary procedure. These procedures require minimal additional provider resources and are considered not necessary to the performance of the primary procedure.

The purpose of this policy is to define payment criteria for covered services designated by CMS as always bundled to another physician's procedure or service to be used in making payment decisions and administering benefits.

Application
Physician and Non-physician Practitioner Services and Outpatient Institutional Claims

Policy Description
If an item or service is considered incidental to a physician's service and is provided on the same day as a physician's service, the payment is bundled into the payment for the physician's service to which it is incidental. The CMS Physician Fee Schedule Relative Value File (RVU) designates these incidental procedures with a status indicator of "P." If the procedure code is listed with a status indicator of "P," then payment for the procedure code is always subsumed by the payment for other physician's services to which they are incidental, and which are not designated as a status "P" procedure or service. Status "P" procedures are primarily categorized as supply codes.

Reimbursement
1. Code editing software evaluates the claim line billed with procedure codes designated as status "P" and compares to other current and historical claim lines.
2. Claims are reviewed for same member, same provider ID and same date of service.
3. If another procedure is found that is not indicated as a status "P" code, the service line with the status "P" code is denied.
4. Payment for the status "P" code is considered subsumed by the payment for the other services without the status "P" designation.
5. Procedure codes designated as status "P" are paid when billed alone.
6. Procedure codes designated as status "P" are paid when billed with another procedure code that also bears the status "P" designation.

Coding and Modifier Information

This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2022, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

References

1. *Centers for Medicare and Medicaid Services (CMS. National Physician Fee Schedule Relative Value File).* *https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/pfs-relative-value-files*

Revision History	
11/23/2016	Initial Policy Draft Created
04/27/2017	Change the Effective Date to 03/15/2017
04/24/2019	Conducted review, verified codes and updated policy
11/01/2019	Annual Review completed
11/01/2020	Annual Review completed
11/30/2021	Annual review completed; no major updates required
12/01/2022	Annual review completed; code list removed from policy as this information can be referenced in the current CMS RVU file; removed definitions section to eliminate content redundancy

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains

the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

This payment policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.