PROVIDER REIMBURSEMENT GUIDANCE			
T Status Codes			
Original Date Approved	Effective Date Senior Care Options/One Care	Effective Date Medicare Advantage*	Revision Date
09/01/2022	11/01/2022	11/01/2022	

Scope: Commonwealth Care Alliance (CCA) Product Lines

- ☐ Senior Care Options MA
- ☐ One Care MA
- ☐ Medicare Preferred – (PPO) MA*
- ☐ Medicare Value - (PPO) MA*
- ☐ Medicare Preferred – (PPO) RI*
- ☐ Medicare Value - (PPO) RI*
- ☐ Medicare Maximum – (HMO DNSP) RI*

PAYMENT POLICY SUMMARY:

Commonwealth Care Alliance® (CCA) reimburses on T Status Codes if the status indicates whether the code is separately payable as published on the National Physician Fee Schedule (NPFS) by the Centers for Medicare and Medicaid Services (CMS).

AUTHORIZATION REQUIREMENTS:

Applicable CCA referral, notification and authorization policies and procedures apply. For more information on prior authorizations, please refer to the Prior Authorization Requirements in the plan specific Provider Manual.

REIMBURSEMENT GUIDELINES:

CCA considers CPT® and HCPCS codes with a status indicator of T bundled into any other service provided, on the same date by the same individual physician or other qualified health care professional, when reimbursement is applicable. No modifier overrides will exempt codes with a status indicator of T from bundling into the services for which reimbursement is made.

CMS assigns Relative Value Units (RVU) and reimbursement amounts for these services, but they are only paid 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 reimbursement is made.

REIMBURSEMENT GUIDELINES (cont.):

Status Indicator	Descriptor	Comment
A	Active Code	Paid separately under the physician fee schedule, if covered. There will be RVUs 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."
R	Restricted Coverage	Special coverage instructions apply. If covered, the service is carrier priced. (**NOTE:** The majority of codes to which this indicator will be assigned are the alpha-numeric dental codes, which begin with "D". Indicator is assigned to a limited number of CPT codes which represent services that are covered only in unusual circumstances.)
T	No Additional Service	There are RVUs and payment amounts for these services, but they are only paid 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.

BILLING and CODING GUIDELINES:

According to CMS NPFS file the codes with a status indicator of T Status codes are as follows:

HCPCS Codes	Description
36591	Collection of blood specimen from a completely implantable venous access device
36592	Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified
36598	Contrast injection(s) for radiologic evaluation of existing central venous access device, including fluoroscopy, image documentation and report
94760	Noninvasive ear or pulse oximetry for oxygen saturation; single determination
94761	Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations (e.g., during exercise)
96523	Irrigation of implanted venous access device for drug delivery systems
G0117	Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist
G0118	Glaucoma screening for high risk patients furnished under the direct supervision of an optometrist or ophthalmologist

RELATED SERVICE POLICIES:

Re-bundling and NCCI Edits Payment Policy

AUDIT and DISCLAIMER:

As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization, and utilization management guidelines when applicable and adherence to plan policies, procedures, and claims editing logic. CCA has the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that your office/facility did not comply with this payment policy, CCA has the right to expect your office/facility to refund all payments related to non-compliance.

REFERENCES:

- AMA CPT/HCPCS
- CCA Website
- CMS, Medicare Physician Fee Schedule Relative Value
- PFS Relative Value Files
- Provider Manuals: Massachusetts / Rhode Island
- Prior Authorization Forms: Massachusetts / Rhode Island

POLICY TIMELINE DETAILS:

1. Effective 11/01/2022