Bundling (Status B, P, T)

Reimbursement Policy ID: RPC.0022.01CH

Recent review date: 07/2026

Reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. The health plan may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy describes bundled payment status indicators in professional claims processing by the health plan.

The Centers for Medicare and Medicaid Services (CMS) bundles payment for services that are incidental to other services by the same provider. Any physician or other qualified health care professional from the same group practice under the same specialty and same tax identification number (TIN) is considered the same provider.

The health plan aligns with the Centers for Medicare and Medicaid Services (CMS) with regard to bundled payment criteria.

Exceptions

Any conflicting explicit state coverage provisions take precedence.

Reimbursement Guidelines

The health plan utilizes CMS Physician Fee Schedule (PFS) payment status indicators to classify bundled payments for services. No separate payment is made for procedure codes with CMS PFS status indicators of "B," "P," or "T":

- **B – Bundled Codes** represent services that are always considered as incidental to other services rendered by the same provider on the same date of service. Payment is bundled to those other services.
- **P – Bundled and Excluded Codes** represent services that are considered as incidental to other services rendered by the same provider on the same date of service, or services that are not payable to a professional provider.
- **T – Only Service Paid Codes** represent services that are considered as incidental to other services, represented by procedure codes with a CMS PFS status indicator of "A" or "R," for the same date of service by the same provider. Payment is bundled to those other services.

Refer to CPT/HCPS manuals for complete descriptions of procedures, CMS PFS files for status payment indicators, and state billing resources for fee schedules and billing guidelines.

Definitions

N/A

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. Centers for Medicare and Medicaid Services (CMS) Physician Fee Schedule Relative Value Files: https://www.cms.gov/medicare/medicare-fee-for-servicepayment/physicianfeesched/pfs-relative-
V. The National Correct Coding Initiative (NCCI)
VI. Corresponding health plans Clinical Policies.
VII. Applicable health plans provider manual.
VIII. Commonwealth of Pennsylvania Children's Health Insurance Program guidance.
IX. Commonwealth of Pennsylvania Medicaid Program fee schedule(s).

Attachments

N/A

Associated Policies

N/A

Policy History

09/2026	• Removed the next review date • Replaced the plan name with "the health plan"
07/2026	Reimbursement Policy Committee Approval
06/2026	Biennial review • No major changes

06/2025	Minor updates to formatting and syntax
05/2025	Reimbursement Policy Committee Approval