PAYMENT POLICY ID NUMBER 10-022

Original Effective Date: 10/1/2014

Revised: 05/08/2025

T-Status Codes

THIS PAYMENT POLICY IS NOT AN AUTHORIZATION, CERTIFICATION, EXPLANATION OF BENEFITS, OR A GUARANTEE OF PAYMENT, NOR DOES IT SUBSTITUTE FOR OR CONSTITUTE MEDICAL ADVICE. ALL MEDICAL DECISIONS ARE SOLELY THE RESPONSIBILITY OF THE PATIENT AND PHYSICIAN. BENEFITS ARE DETERMINED BY THE GROUP CONTRACT, MEMBER BENEFIT BOOKLET, AND/OR INDIVIDUAL SUBSCRIBER CERTIFICATE IN EFFECT AT THE TIME SERVICES WERE RENDERED. THIS PAYMENT POLICY APPLIES TO ALL LINES OF BUSINESS AND PROVIDERS OF SERVICE. IT DOES NOT ADDRESS ALL POTENTIAL ISSUES RELATED TO PAYMENT FOR SERVICES PROVIDED TO FLORIDA BLUE MEMBERS AS LEGISLATIVE MANDATES, PROVIDER CONTRACT DOCUMENTS OR THE MEMBER'S BENEFIT COVERAGE MAY SUPERSEDE THIS POLICY.

DESCRIPTION:

This policy describes the reimbursement of procedure codes with a status of "T" as defined by the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Scheduled (PFS).

This policy applies to billing for services on a CMS-1500 or equivalent claim form. Same provider for the purposes of this policy includes all physicians and/or other health care professionals reporting under the same Federal Tax Identification number.

REIMBURSEMENT INFORMATION:

T status codes are defined by CMS as follows:

> 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.

Florida Blue considers procedure codes with a status indicator of "T" bundled into any other service provided, on the same date, by the same individual physician or other health care professional, for which payment is made. No modifier overrides will exempt "T" status codes from bundling into the services for which payment is made.

Appeals to override this policy will not be accepted.

BILLING/CODING INFORMATION:

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

REFERENCES:

1. American Medical Association, *Current Procedural Terminology (CPT®), Professional Edition.*
2. CMS, Medicare Physician Fee Schedule Relative Value File: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html

GUIDELINE UPDATE INFORMATION:

10/01/2014	Initial Publication
05/15/2016	Annual Review – no changes
05/11/2017	Annual Review
05/17/2018	Annual Review
05/16/2019	Annual Review
05/14/2020	Annual Review
05/13/2021	Annual Review
05/12/2022	Annual Review
05/11/2023	Annual Review – Reference reviewed and updated
05/09/2024	Annual Review – Reference reviewed and updated
05/08/2025	Annual Review – Clarifying language added to indicate this policy applies to billing for services on a CMS-1500 or equivalent claim form. Reference reviewed and updated