

Addendum A: Explanation and Use of Addendum B

The addenda on the following pages provide various data pertaining to the Medicare fee schedule for physicians' services furnished in 2010. Addendum B contains the RVUs for work, nonfacility practice expense (PE), facility PE, and malpractice expense, and other information for all services included in the PFS.

In previous years, we have listed many services in Addendum B that are not paid under the PFS. To avoid publishing as many pages of codes for these services, we are not including clinical laboratory codes or the alphanumeric codes (Healthcare Common Procedure Coding System (HCPCS) codes not included in CPT) not paid under the PFS in Addendum B. Addendum B contains the following information for each CPT code and alphanumeric HCPCS code, except for: alphanumeric codes beginning with B (enteral and parenteral therapy), E (durable medical equipment), K (temporary codes for nonphysicians' services or items), or L (orthotics); and codes for anesthesiology. Please also note the following:

□ An "NA" in the "Non-facility PE RVUs" column of Addendum B means that CMS has not developed a PE RVU in the non-facility setting for the service because it is typically performed in the hospital (for example, an open heart surgery is generally performed in the hospital setting and not a physician's office). If there is an "NA" in the nonfacility PE RVU column, and the contractor determines that this service can be performed in the non-facility setting, the service will be paid at the facility PE RVU rate.

□ Services that have an "NA" in the "Facility PE RVUs" column of Addendum B are typically not paid using the PFS when provided in a facility setting. These services (which include "incident to" services and the technical portion of diagnostic tests) are generally paid under either the outpatient hospital prospective payment system or bundled into the hospital inpatient prospective payment system payment.

1. CPT/HCPCS code. This is the CPT or alphanumeric HCPCS number for the

service. Alphanumeric HCPCS codes are included at the end of this addendum.

2. Modifier. A modifier is shown if there is a technical component (modifier TC) and a professional component (PC) (modifier-26) for the service. If there is a PC and a TC for the service, Addendum B contains three entries for the code. A code for: the global values (both professional and technical); modifier-26 (PC); and, modifier TC. The global service is not designated by a modifier, and physicians must bill using the code without a modifier if the physician furnishes both the PC and the TC of the service.

Modifier-53 is shown for a discontinued procedure, for example a colonoscopy that is not completed.

There will be RVUs for a code with this modifier.

3. Status indicator. This indicator shows whether the CPT/HCPCS code is in the PFS and whether it is separately payable if the service is covered.

A = Active code. These codes are separately payable under the PFS 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.

B = Bundled code. Payments for covered services are always bundled into payment for other services not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident (an example is a telephone call from a hospital nurse regarding care of a patient).

C = Carriers price the code. Carriers will establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation, such as an operative report.

D = Deleted/discontinued code.

E = Excluded from the PFS by regulation. These codes are for items and services that CMS chose to exclude from the fee schedule payment by regulation. No RVUs are shown, and no payment may be made under the PFS for these codes. Payment for them, when covered, continues under reasonable charge procedures.

F = Deleted/discontinued codes. (Code not subject to a 90-day grace period.) These codes are deleted effective with the beginning of the year and are never subject to a grace period. This indicator is no longer effective beginning with the 2005 fee schedule as of January 1, 2005.

G = Code not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. (Codes subject to a 90-day grace period.) This indicator is no longer effective with the 2005 PFS as of January 1, 2005.

H = Deleted modifier. For 2000 and later years, either the TC or PC component shown for the code has been deleted and the deleted component is shown in the database with the H status indicator.

I = Not valid for Medicare purposes. Medicare uses another code for the reporting of, and the payment for these services. (Codes not subject to a 90-day grace period.)

L = Local codes. Carriers will apply this status to all local codes in effect on January 1, 1998 or subsequently approved by central office for use. Carriers will complete the RVUs and payment amounts for these codes.

M = Measurement codes, used for reporting purposes only. There are no RVUs and no payment amounts for these codes. Medicare uses them to aid with performance measurement. No separate payment is made. These codes should be billed with a zero ((\$0.00) charge and are denied) on the MPFSDB.

N = Non-covered service. These codes are noncovered services. Medicare payment may not be made for these codes. If RVUs are shown, they are not used for Medicare payment.

R = Restricted coverage. Special coverage instructions apply. If the service is covered and no RVUs are shown, it is carrier-priced.

T = There are RVUs for these services, but they are only paid if there are no other services payable under the PFS billed on the same date by the same provider. If any other services payable under the PFS are billed on the same date by the same provider, these services are bundled into the service(s) for which payment is made.

X = Statutory exclusion. These codes represent an item or service that is not within the statutory definition of "physicians' services" for PFS payment

purposes. No RVUs are shown for these codes, and no payment may be made under the PFS. (Examples are ambulance services and clinical diagnostic laboratory services.)

4. Description of code. This is an abbreviated version of the narrative description of the code.

5. Physician work RVUs. These are the RVUs for the physician work for this service in 2010.

6. Fully implemented non-facility PE RVUs. These are the fully implemented resource-based practice PE RVUs for non-facility settings.

7. 2010 Transitional non-facility PE RVUs. These are the 2010 resourcebased PE RVUs for non-facility settings.

8. Fully implemented facility PE RVUs. These are the fully implemented resource-based practice PE RVUs for facility settings.

9. 2010 Transitional facility PE RVUs. These are the 2010 resource-based PE RVUs for facility settings.

10. Malpractice expense RVUs. These are the RVUs for the malpractice expense for the service for 2010.

9. Global period. This indicator shows the number of days in the global period for the code (0, 10, or 90 days). An explanation of the alpha codes follows:

MMM = Code describes a service furnished in uncomplicated maternity cases including antepartum care, delivery, and postpartum care. The usual global surgical concept does not apply. See the 1999 Physicians' Current Procedural Terminology for specific definitions.

XXX = The global concept does not apply.

YYY = The global period is to be set by the carrier (for example, unlisted surgery codes).

ZZZ = Code related to another service that is always included in the global period of the other service. (Note: Physician work and PE are associated with intra service time and in some instances in the post service time.