

ADDENDUM A: EXPLANATION AND USE OF ADDENDUM B

Addendum B contains the following information for each CPT code and alpha-numeric HCPCS code, except for: alpha-numeric 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 "Nonfacility PE RVUs" column of Addendum B means that we have not developed a PE RVU in the nonfacility 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 nonfacility 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 under 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 hospital outpatient prospective payment system or bundled into the hospital inpatient prospective payment system payment. In some cases, these services may be paid in a facility setting at the PFS rate (for example, therapy services), but there would be no payment made to the practitioner under the PFS in these situations.

1. *CPT/HCPCS code.* This is the CPT or alpha-numeric HCPCS number for the service. Alpha-numeric 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 included in the PFS and whether it is separately payable if the service is covered. An explanation of types of status indicators follows:

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. Contractors 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 (for example, a telephone call from a hospital nurse regarding care of a patient).

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

E = Excluded from the PFS by regulation. These codes are for items and services that CMS chose to exclude from the PFS 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.

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.)

M = Measurement codes, used for reporting purposes only. There are no RVUs and no payment amounts for these codes. CMS 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 contractor-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, (for

example, ambulance services and clinical diagnostic laboratory services.)

4. *Description of code.* This is the code's short descriptor, which is an abbreviated version of the narrative description of the code.

5. *Physician work RVUs.* These are the RVUs for the physician work in CY 2012.

6. *Fully implemented nonfacility PE RVUs.* These are the fully implemented resource-based PE RVUs for nonfacility settings.

7. *CY 2012 transitional nonfacility PE RVUs.* These are the CY 2012 resource-based PE RVUs for nonfacility settings.

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

9. *CY 2012 Transitional facility PE RVUs.* These are the CY 2012 resource-based PE RVUs for facility settings.

10. *Malpractice expense RVUs.* These are the RVUs for the malpractice expense for CY 2012.

Note: The BN reduction resulting from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

11. *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 ante partum care, delivery, and postpartum care. The usual global surgical concept does not apply. See the Physicians' Current Procedural Terminology for specific

definitions.

XXX = The global concept does not apply.

YYY = The global period is to be set by the contractor (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, with the post-service time.)