ADDENDUM A: EXPLANATION OF ADDENDUM B AND C

Addenda B and C contain 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. Below we explain the information provided in each column.

CPT/HCPCS code. This is the CPT or alpha-numeric HCPCS code for the service. Alpha-numeric HCPCS codes are included at the end of Addendum B.

Mod. If a pre-determined payment amount is made for a code and if a modifier is used, the modifier is shown in this column. When 53 is shown, it indicates the rate for a discontinued procedure. A modifier is shown in this column to indicate the technical component (TC) or a professional component (26) for the service. For a global service, this column will not include a TC or 26. When a practitioner furnishes both the PC and TC, the code is billed without a modifier.

Status. The indicators in this column show whether the CPT/HCPCS code is included in the PFS and if it is covered whether it is separately payable. An explanation of each status indicator follows:

A = Active code. These codes are separately payable under the PFS. 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 local 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, which are not specified. If these services are covered,

payment for them is subsumed in the payment for the services to which they are bundled (for example, telephone calls to patients to convey information following a service or procedure). If RVUs are shown, they are not used for Medicare payment.

C = Contractor-priced code. Contractors establish RVUs and payment amounts for these services.

E = Excluded from the PFS by regulation. These codes are for items and services that CMS has excluded from the PFS by regulation. No payment may be made under the PFS for these codes and generally, no RVUs are shown.

I = Not valid for Medicare purposes. Medicare uses another code for the reporting of and the payment for these services.

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.

N = Noncovered service. These codes are noncovered services. Medicare payment is not made for these codes. If RVUs are shown, they are not used for Medicare payment.

P = Bundled/excluded codes. There are no RVUs and no payment amounts for these services. No separate payment is made for them under the fee schedule. If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident (an example is an elastic bandage furnished by a physician incident to a physician service). If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (for example, colostomy supplies) and is paid under the other payment provision of the Act.

Q = Therapy functional limitation code, used for required reporting purposes only. No separate payment is made.

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

T = Paid as only service. These codes are paid only if there are no other services payable under the PFS billed on the same date by the same practitioner. If any other services payable under the PFS are billed on the same date by the same practitioner, 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 (for example, ambulance services). No payment may be made under the PFS and generally, no RVUs are shown for these codes.

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

Work RVUs. These are the RVUs for the work in CY 2016.

Nonfacility PE RVUs. These are the resource-based PE RVUs for nonfacility settings. An "NA" in this column means that we have not developed a PE RVU in the nonfacility setting for the service because it is typically furnished in the hospital (for example, open heart surgery is generally furnished in the hospital setting and not a physician's office). If there is an "NA" in this column and the contractor determines that this service can be furnished in the nonfacility setting, the service will be paid at the facility PE RVU rate.

Facility PE RVUs. These are the resource-based PE RVUs for facility settings. Services that have an "NA" in this column are typically not paid under the PFS when

furnished 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.

Malpractice RVUs. These are RVUs for the malpractice expense for CY 2016.

Global. 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 = 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 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.)