NATIONAL PHYSICIAN FEE SCHEDULE RELATIVE VALUE FILE CALENDAR YEAR 2027

Contents: This file contains information on services covered by the Medicare Physician Fee Schedule (MPFS) in 2027. For more than 10,000 physician services, the file contains the associated relative value units (RVUs), a fee schedule status indicator, and various payment policy indicators needed for payment adjustment (i.e., payment of assistant at surgery, team surgery, bilateral surgery, etc.).

The Medicare Physician Fee Schedule amounts are adjusted to reflect the variation in practice costs from area to area. A geographic practice cost index (GPCI) has been established for every Medicare payment locality for each of the three components of a procedure's relative value unit (i.e., the RVUs for work, practice expense, and malpractice). The GPCIs are applied in the calculation of a fee schedule payment amount by multiplying the RVU for each component times the GPCI for that component.

For informational purposes, changes from the previous year's documentation file are in bold font to facilitate their identification.

Section 121 of the Social Security Act Amendments of 1994 required CMS to replace the existing charge-based practice expense relative value units for all Medicare Physician Fee Schedule services with new resource-based ones. The Balanced Budget Act of 1997 requires a four-year transition from the existing charge-based system to the new resource-based system beginning on January 1, 1999. In 2002 and beyond, the practice expense relative value units are based entirely on the resource-based system. Beginning with CY 2007, we will use a bottom–up methodology for direct costs, use supplementary survey data for indirect costs, and eliminate the nonphysician workpool in order to calculate the practice expense RVUs. The nonphysician workpool was a special method that has been used to calculate practice expense RVUs for services with no physician work.

Under the resource-based system, we have developed practice expense relative value units specific to the facility and non-facility settings. Generally, under the resource-based system, the facility practice expense RVUs will be used for services performed in inpatient or outpatient hospital settings, emergency rooms, skilled nursing facilities, or ambulatory surgical centers (ASCs). The non-facility practice expense relative value units will be used for services furnished in all other settings. We did not develop non-facility practice expense relative value units for some services which, either by definition or in practice, are never (or rarely) performed in a non-facility setting. For example, by definition, the initial hospital care codes (CPT codes 99221-99223) are provided only in the hospital inpatient setting. Also, many major surgical procedures with a 90-day global period are almost always performed in the hospital inpatient setting. These facility-only codes are identified by a "NA" in the "NA Indicator" field.

The formula for 2027 physician fee schedule payment amount is as follows:

Non-Facility Pricing Amount =
[(Work RVU * Work GPCI) +
(Non-Facility PE RVU * PE GPCI) +
(MP RVU * MP GPCI)] * Conversion Factor (CF)

Facility Pricing Amount =
[(Work RVU * Work GPCI) +
(Facility PE RVU * PE GPCI) +
(MP RVU * MP GPCI)] * Conversion Factor

Certain therapy codes will receive a 50 percent reduction to the PE.

Section 5102(b) of the Deficit Reduction Act of 2005 requires a payment cap on the technical component (TC) of certain diagnostic imaging procedures and the TC portions of the global diagnostic imaging services. This cap is based on the Outpatient Prospective Payment System (OPPS) payment. To implement this provision, the physician fee schedule amount is compared to the OPPS payment amount and the lower amount is used in the formula below to calculate payment.

OPPS Non-Facility Payment Amount =
[(Work RVU * Work GPCI) + (OPPS Non-Facility PE RVU * PE GPCI) +
(OPPS MP RVU * MP GPCI)] * Conversion Factor

OPPS Facility Payment Amount =
[Work RVU * Work GPCI) + (OPPS Facility PE RVU * PE GPCI) +
(OPPS MP RVU * MP GPCI)] * Conversion Factor

We are attaching/including the locality-specific anesthesia conversion factors (CFs) and they are calculated from the national anesthesia CF whose calculation is described in the CY 2027 final physician fee schedule regulation.

The Medicare limiting charge is set by law at 115 percent of the payment amount for the service furnished by the nonparticipating physician. However, the law sets the payment amount for nonparticipating physicians at 95 percent of the payment amount for participating physicians (i.e., the fee schedule amount). Calculating 95 percent of 115 percent of an amount is equivalent to multiplying the amount by a factor of 1.0925 (or 109.25 percent). Therefore, to calculate the Medicare limiting charge for a physician service for a locality, multiply the fee schedule amount by a factor of 1.0925. The result is the Medicare limiting charge for that service for that locality to which the fee schedule amount applies.

File Organization: The file contains one record for each unique combination of procedure code and modifier and is sorted in the above listed code sequence.

Initial Source: November 2026 Federal Register publication of the Fee Schedule for Physicians' Services for CY 2027

Data Set Name: RVU27A.Zip will contain six files:

(1) RVU27A (in Word (.docx) format) contains the file's record layout and file documentation;
(2) PPRRVU27 contains the RVUs and policy indicators associated with the physician fee schedule in ASCII text (.txt), EXCEL (.xls) and comma delimited format (.csv);
(3) GPCI2027 (in Excel (.xls), ASCII text (.prn) and comma delimited (.csv) formats) provides each Geographic Practice Cost Index (GPCI) component for each carrier/locality
(4) 27LOCCO (in Excel (.xls), ASCII text (.prn) and comma delimited (.csv) formats) contains the locality/county crosswalk;
(5) ANES2027 (in Excel (.xls), ASCII text (.TXT) and comma delimited (.csv) formats) contains the Anesthesia conversion factors; and
(6) OPPSCAP (in Excel (.xls), and comma delimited (.csv) formats) contains the payment amounts after the application of the OPPS based payment caps, except for carrier priced codes. For carrier price codes, the field only contains the OPPS based payment caps. Carrier prices cannot exceed the OPPS based payment caps.

Length of Record: 200 Characters

Update Schedule: This file will be updated on a periodic schedule to incorporate mid-year changes. Updated 2027 files will be available on April 1, July 1 and October 1. The following naming convention will be used to identify each:

RVU27A: January 2027 release
RVU27AR: January 2027 release – Correction Notice (If required)
RVU27B: April 2027 release
RVU27C: July 2027 release
RVU27D: October 2027 release

NOTE:

- CPT codes and descriptions only are copyright 2027 American Medical Association. All rights reserved. Applicable FARS/DFARS apply.

- All dental codes copyright 2027 American Dental Association, all rights reserved.

NATIONAL PHYSICIAN FEE SCHEDULE RELATIVE VALUE FILE
CALENDAR YEAR 2027

DATA ELEMENT	LOCATION	COBOL PIC	DESCRIPTION
HEADER RECORD			
Header Indicator	1-3	x(3)	Value “HDR”.
Filler	4-4	x(1)	
Copyright Statement	5-50	x(46)	
Filler	51-150	x(100)	

DATA RECORD

HCPCS Code	1-5	X(5)	CPT or Level 2 HCPCS number for the service. NOTE: See copyright statement on cover sheet.
Modifier	6-7	X(2)	For diagnostic tests, a blank in this field denotes the global service and the following modifiers identify the components: --26 = Professional component --TC = Technical component --For services other than those with a professional and/or technical component, a blank will appear in this field with one exception: the presence of CPT modifier -53 indicates that separate RVUs and a fee schedule amount have been established for procedures which the physician terminated before completion. This modifier is used only with colonoscopy CPT codes 44388 and 45378, or with G0105 and G0121. Any other codes billed with modifier -53 are subject to carrier medical review and priced by individual consideration. --53 = Discontinued Procedure - Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances, or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued.
Description	8-57	X(50)	
Status Code	58-58	X(1)	Indicates whether the code is in the fee schedule and whether it is separately payable if the service is covered. See Attachment A for description of values. Only RVUs associated with status codes of "A", "R", or "T", are used for Medicare payment.
Work RVU	60-65	999.99	Relative Value Unit (RVU) for the physician work in the service as

			published in the Federal Register Fee Schedule for Physicians Services for CY 2027
Non-Facility Practice Expense RVU	67-72	999.99	Relative Value Unit (RVU) for the resource-based practice expense for the non-facility setting, as published in the Federal Register Fee Schedule for Physicians Services for CY 2027
Non-Facility NA Indicator	73-74	X(2)	An “NA” in this field indicates that this procedure is rarely or never performed in the non-facility setting.
Facility Practice Expense RVU	76-81	999.99	Relative Value Unit (RVU) for the resource-based practice expense for the facility setting, as published in the Federal Register Fee Schedule for Physicians Services for CY 2027
Facility NA Indicator	82-83	X(2)	An “NA” in this field indicates that this procedure is rarely or never performed in the facility setting.
Malpractice RVU	85-89	99.99	RVU for the malpractice expense for the service as published in the Federal Register Fee Schedule for Physicians' Services for CY 2027
Total Non-Facility RVUs	91-96	999.99	Sum of work, non-facility practice expense, and malpractice expense RVUs.
Total Facility RVUs	97-102	999.99	Sum of work, facility practice expense, and malpractice expense RVUs.

PC/TC Indicator	103-103	x(1)	See Attachment A for description of values.
Global Surgery	104-106	XXX	Provides time frames that apply to each surgical procedure. 000=Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; evaluation and management services on the day of the procedure generally not payable. 010=Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10 day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during the 10-day postoperative period generally not payable. 090=Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule amount. MMM=Maternity codes; usual global period does not apply. XXX=The global concept does not apply to the code. YYY=The carrier is to determine whether the global concept applies and establishes postoperative period, if appropriate, at time of pricing. ZZZ=The code is related to another service and is <u>always</u> included in the global period of the other service.
Preoperative Percentage	107-109	.99	Percentage for preoperative portion of global package.
Intraoperative Percentage	110-112	.99	Percentage for intraoperative portion of global package, including postoperative work in the hospital.
Postoperative	113-115	.99	Percentage for postoperative portion of global package that is provided

Percentage			in the office after discharge from the hospital.
Multiple Procedure (Modifier 51)	116-116	x(1)	Indicates applicable payment adjustment rule for multiple procedures: 0=No payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure, base the payment on the lower of (a) the actual charge, or (b) the fee schedule amount for the procedure. 1=Standard payment adjustment rules in effect before January 1, 1995 for multiple procedures apply. In the 1995 file, this indicator only applies to codes with a status code of "D". If procedure is reported on the same day as another procedure that has an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100%, 50%, 25%, and by report). Base the payment on the lower of (a) the actual charge, or (b) the fee schedule amount reduced by the appropriate percentage. 2=Standard payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100%, 50%, 50%, 50%, 50% and by report). Base the payment on the lower of (a) the actual charge, or (b) the fee schedule amount reduced by the appropriate percentage. 3=Special rules for multiple endoscopic procedures apply if procedure is billed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure). The base procedure for each code with this indicator is identified in the Endobase field of this file. Apply the multiple endoscopy rules to a family before ranking the family with the other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). If an endoscopic procedure is reported with

only its base procedure, do not pay separately for the base procedure. Payment for the base procedure is included in the payment for the other endoscopy.

4=Special rules for the technical component (TC) of diagnostic imaging procedures apply if procedure is billed with another diagnostic imaging procedure in the same family (per the diagnostic imaging family indicator, below). If procedure is reported in the same session on the same day as another procedure with the same family indicator, rank the procedures by fee schedule amount for the TC. Pay 100% for the highest priced procedure, and 50% for each subsequent procedure. Base the payment for subsequent procedures on the lower of (a) the actual charge, or (b) the fee schedule amount reduced by the appropriate percentage. Subject to 50% reduction of the TC diagnostic imaging (effective for services July 1, 2010 and after). Subject to 25% reduction of the PC of diagnostic imaging (effective for services January 1, 2012 through December 31, 2016). Subject to 5% reduction of the PC of diagnostic imaging (effective for services January 1, 2017 and after).

5=Subject to 50% of the practice expense component for certain therapy services.

6=Subject to 25% reduction of the second highest and subsequent procedures to the TC of diagnostic cardiovascular services, effective for services January 1, 2013, and thereafter.

7=Subject to 20% reduction of the second highest and subsequent procedures to the TC of diagnostic ophthalmology services, effective for services January 1, 2013, and thereafter.

			9=Concept does not apply.
Bilateral Surgery (Modifier 50)	117-117	x(1)	Indicates services subject to payment adjustment. 0=150% payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier -50 or with modifiers RT and LT, base the payment for the two sides on the lower of: (a) the total actual charge for both sides and (b) 100% of the fee schedule amount for a single code. Example: The fee schedule amount for code XXXXX is $125. The physician reports code XXXXX-LT with an actual charge of $100 and XXXXX-RT with an actual charge of $100. Payment should be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The bilateral adjustment is inappropriate for codes in this category (a) because of physiology or anatomy, or (b) because the code description specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure. 1=150% payment adjustment for bilateral procedures applies. If the code is billed with the bilateral modifier or is reported twice on the same day by any other means (e.g., with RT and LT modifiers, or with a 2 in the units field), base the payment for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides or (b) 150% of the fee schedule amount for a single code. If the code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any multiple procedure rules. 2=150% payment adjustment does not apply. RVUs are already based on the procedure being performed as a bilateral procedure. If the procedure is reported with modifier -50 or is reported twice on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base the payment for both sides on the lower of (a) the total actual charge by the physician for both sides, or (b) 100% of the

			fee schedule for a single code. Example: The fee schedule amount for code YYYYY is $125. The physician reports code YYYYY-LT with an actual charge of $100 and YYYYY-RT with an actual charge of $100. Payment should be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The RVUs are based on a bilateral procedure because (a) the code descriptor specifically states that the procedure is bilateral, (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally, or (c) the procedure is usually performed as a bilateral procedure. 3=The usual payment adjustment for bilateral procedures does not apply. If the procedure is reported with modifier -50 or is reported for both sides on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base the payment for each side or organ or site of a paired organ on the lower of (a) the actual charge for each side or (b) 100% of the fee schedule amount for each side. If the procedure is reported as a bilateral procedure and with other procedure codes on the same day, determine the fee schedule amount for a bilateral procedure before applying any multiple procedure rules. Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral surgeries. 9=Concept does not apply.
Assistant at Surgery	118-118	x(1)	Indicates services where an assistant at surgery is never paid for per Medicare Claims Manual. 0=Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity. 1=Statutory payment restriction for assistants at surgery applies to this

			procedure. Assistant at surgery may not be paid. 2=Payment restriction for assistants at surgery does not apply to this procedure. Assistant at surgery may be paid. 9=Concept does not apply.
Co-surgeons (Modifier 62)	119-119	x(1)	Indicates services for which two surgeons, each in a different specialty, may be paid. 0=Co-surgeons not permitted for this procedure. 1=Co-surgeons could be paid, though supporting documentation is required to establish the medical necessity of two surgeons for the procedure. 2=Co-surgeons permitted and no documentation required if the two-specialty requirement is met. 9=Concept does not apply.
Team Surgery (Modifier 66)	120-120	x(1)	Indicates services for which team surgeons may be paid. 0=Team surgeons not permitted for this procedure.1=Team surgeons could be paid, though supporting documentation required to establish medical necessity of a team; pay by report. 2=Team surgeons permitted; pay by report. 9=Concept does not apply.
Filler	121-126	x(6)	

Endoscopic Base Code	127-131	X(5)	Code which identifies an endoscopic base code for each code with a multiple surgery indicator of 3.
Physician Supervision of Diagnostic Procedures	132-133	X(2)	This field is for use in post payment review. 01 = Procedure must be performed under the general supervision of a physician. 02 = Procedure must be performed under the direct supervision of a physician. 03 = Procedure must be performed under the personal supervision of physician. (Diagnostic imaging procedures performed by a Registered Radiologist Assistant (RRA) who is certified and registered by The American Registry of Radiologic Technologists (ARRT) or a Radiology Practitioner Assistant (RPA) who is certified by the Certification Board for Radiology Practitioner Assistants (CBRPA), and is authorized to furnish the procedure under state law, may be performed under direct supervision.) 04 = Physician supervision policy does not apply when procedure is furnished by a qualified, independent psychologist or a clinical psychologist; otherwise must be performed under the general supervision of a physician. 05 = Physician supervision policy does not apply when procedure is furnished by a qualified audiologist; otherwise must be performed under the general supervision of a physician. 06 = Procedure must be performed by a physician or a physical Therapist (PT) who is certified by the American Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiological clinical specialist and is permitted to provide the procedure under State law. 21 = Procedure may be performed by a technician with certification

			under general supervision of a physician; otherwise must be performed under direct supervision of a physician. 22 = May be performed by a technician with on-line real-time contact with physician. 66 = May be performed by a physician or by a physical therapist with ABPTS certification and certification in this specific procedure. 6A= Supervision standards for level 66 apply; in addition, the PT with ABPTS certification may supervise another PT, but only the PT with ABPTS certification may bill. 77 = Procedure must be performed by a PT with ABPTS certification or by a PT without certification under direct supervision of a physician, or by a technician with certification under general supervision of a physician. 7A = Supervision standards for level 77 apply; in addition, the PT with ABPTS certification may supervise another PT, but only the PT with ABPTS certification may bill. 09 = Concept does not apply.
Calculation Flag	134-134	X(1)	As of July 1, 2014 the value for the Calculation Flag for all HCPCS is "0".
Diagnostic Imaging Family Indicator	136-137	X(2)	This field identifies the applicable diagnostic service family for that HCPCS codes with a multiple procedure indicator of '4'. *For services effective January 1, 2011 and after, family indicators 01 – 11 will not be populated.* The values are: 01=Ultrasound (Chest/Abdomen/Pelvis-Non-Obstetrical) 02=CT and CTA (Chest/Thorax/Abd/Pelvis) 03=CT and CTA (Head/Brain/Orbit/Maxillofacial/Neck) 04=MRI and MRA (Chest/Abd/Pelvis) 05=MRI and MRA (Head/Brain/Neck) 06=MRI and MRA (Spine) 07=CT (Spine) 08=MRI and MRA (Lower Extremities) 09=CT and CTA (Lower Extremities) 10=MR and MRI (Upper Extremities and Joints) 11=CT and CTA (Upper Extremities) 88 = Subject to the reduction of the TC diagnostic imaging (effective for services January 1, 2011 and after). Subject to the reduction of the PC diagnostic imaging (effective for services January 1, 2012, and after)

			99=Concept does not apply
Filler	138-141	X(4)	
Conversion Factor	142-149	999.9999	This is the standard multiplier that transforms relative values into payment amounts. This conversion factor reflects the MEI update adjustment.
Non-Facility Practice Expense Used for OPPS Payment Amount	150-155	999.99	The OPPS Payment Amount calculated using these values is compared to the Medicare Physician Fee Schedule to determine applicability of the OPPS Imaging Cap mandated by Section 5102(b) of the Deficit Reduction Act of 2005.
Facility Practice Expense Used for OPPS Payment Amount	156-161	999.99	The OPPS Payment Amount calculated using these values is compared to the Medicare Physician Fee Schedule to determine applicability of the OPPS Imaging Cap mandated by Section 5102(b) of the Deficit Reduction Act of 2005.
Malpractice Used for OPPS Payment Amount	162-167	999.99	The OPPS Payment Amount calculated using these values is compared to the Medicare Physician Fee Schedule to determine applicability of the OPPS Imaging Cap mandated by Section 5102(b) of the Deficit Reduction Act of 2005.
QPP Conversion Factor	168-175	999.9999	This is the multiplier that transforms relative values into payment amounts for eligible participants in the qualifying payment program. This conversion factor reflects the MEI update adjustment.
QPP Non-Facility Practice Expense Used for OPPS Payment Amount	176-181	999.99	The OPPS Payment Amount calculated using these values is compared to the Medicare Physician Fee Schedule to determine applicability of the OPPS Imaging Cap mandated by Section 5102(b) of the Deficit Reduction Act of 2005.
QPP Facility Practice Expense Used for OPPS Payment Amount	182-187	999.99	The OPPS Payment Amount calculated using these values is compared to the Medicare Physician Fee Schedule to determine applicability of the OPPS Imaging Cap mandated by Section 5102(b) of the Deficit Reduction Act of 2005.
QPP Malpractice Used for OPPS Payment Amount	188-193	999.99	The OPPS Payment Amount calculated using these values is compared to the Medicare Physician Fee Schedule to determine applicability of the OPPS Imaging Cap mandated by Section 5102(b) of the Deficit Reduction Act of 2005.

ATTACHMENT A

STATUS CODE A = Active Code. These codes are paid separately under the physician fee schedule, 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; A/B MACs (B) remain responsible for coverage decisions in the absence of a national Medicare policy.

B = Bundled Code. Payment 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 = Contractors price the code. A/B MACs (B) 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 Codes. These codes are deleted effective with the beginning of the applicable year. These codes will not appear on the 2006 file as the grace period for deleted codes is no longer applicable.

E = Excluded from Physician Fee Schedule by regulation. These codes are for items and/or 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 fee schedule for these codes. Payment for them, when covered, generally continues under reasonable charge procedures.

F = Deleted/Discontinued Codes. (Code not subject to a 90 day grace period). These codes will not appear on the 2006 file as the grace period for deleted codes is no longer applicable.

G = Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. (Code subject to a 90 day grace period.) These codes will not appear on the 2006 file as the grace period for deleted codes is no longer applicable.

H = Deleted Modifier. This code had an associated TC and/or 26 modifier in the previous year. For the current year, the TC or 26 component shown for the code has been deleted, and the deleted component is shown with a status code of "H". These codes will not appear on the 2006 file as the grace period for deleted codes is no longer applicable.

I = Not valid for Medicare purposes. Medicare uses another code for

reporting of, and payment for, these services. (Code NOT subject to a 90 day grace period.)

J = Anesthesia Services. There are no RVUs and no payment amounts for these codes. The intent of this value is to facilitate the identification of anesthesia services.

M = Measurement codes. Used for reporting purposes only.

N = Non-covered Services. These services are not covered by Medicare.

P = Bundled/Excluded Codes. There are no RVUs and no payment amounts for these services. No separate payment should be 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 physician service.)

--If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (i.e., colostomy supplies) and should be paid under the other payment provision of the Act.

R = Restricted Coverage. Special coverage instructions apply. If covered, the service is contractor priced. (NOTE: The majority of codes to which this indicator will be assigned are the alpha-numeric dental codes, which begin with "D". We are assigning the indicator to a limited number of CPT codes which represent services that are covered only in unusual circumstances.)

T = Injections. 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. (NOTE: This is a change from the previous definition, which states that injection services are bundled into any other services billed on the same date.)

X = Statutory Exclusion. These codes represent an item or service that is not in the statutory definition of "physician services" for fee schedule payment purposes. No RVUS or payment amounts are shown for these codes, and no payment may be made under the physician fee schedule. (Examples are ambulance services and clinical diagnostic laboratory services.)

PC/TC INDICATOR

0 = Physician Service Codes--Identifies codes that describe physician services. Examples include visits, consultations, and surgical procedures. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. Modifiers 26 and TC cannot be used with these codes. The RVUS include values for physician work, practice expense and malpractice expense. There are some codes with no work RVUs.

1 = Diagnostic Tests for Radiology Services--Identifies codes that describe diagnostic tests. Examples are pulmonary function tests or therapeutic radiology procedures, e.g., radiation therapy. These codes have both a professional and technical component. Modifiers 26 and TC can be used with these codes. The total RVUs for codes reported with a 26 modifier include values for physician work, practice expense, and malpractice expense. The total RVUs for codes reported with a TC modifier include values for practice expense and malpractice expense only. The total RVUs for codes reported without a modifier include values for physician work, practice expense, and malpractice expense.

2 = Professional Component Only Codes--This indicator identifies stand-alone codes that describe the physician work portion of selected diagnostic tests for which there is an associated code that describes the technical component of the diagnostic test only and another associated code that describes the global test. An example of a professional component only code is CPT code **93010--Electrocardiogram**; Interpretation and Report. Modifiers 26 and TC cannot be used with these codes. The total RVUs for professional component only codes include values for physician work, practice expense, and malpractice expense.

3 = Technical Component Only Codes--This indicator identifies stand- alone codes that describe the technical component (i.e., staff and equipment costs) of selected diagnostic tests for which there is an associated code that describes the professional component of the diagnostic test only. An example of a technical component only code is CPT code **93005--Electrocardiogram**; Tracing Only, **without interpretation and report**. It also identifies codes that are covered only as diagnostic tests and therefore do not have a related professional code. Modifiers 26 and TC cannot be used with these codes. The total RVUs for technical component only codes include values for practice expense and malpractice expense only.

4 = Global Test Only Codes--This indicator identifies stand-alone codes that describe selected diagnostic tests for which there are associated codes that describe (a) the professional component

of the test only, and (b) the technical component of the test only. Modifiers 26 and TC cannot be used with these codes. The total RVUs for global procedure only codes include values for physician work, practice expense, and malpractice expense. The total RVUs for global procedure only codes equals the sum of the total RVUs for the professional and technical components only codes combined.

5 = Incident To Codes--This indicator identifies codes that describe services covered incident to a physician's service when they are provided by auxiliary personnel employed by the physician and working under his or her direct personal supervision. Payment may not be made by A/B MACs (B) for these services when they are provided to hospital inpatients or patients in a hospital outpatient department. Modifiers 26 and TC cannot be used with these codes.

6 = Laboratory Physician Interpretation Codes--This indicator identifies clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made. Actual performance of the tests is paid for under the lab fee schedule. Modifier TC cannot be used with these codes. The total RVUs for laboratory physician interpretation codes include values for physician work, practice expense, and malpractice expense.

7 = Physical therapy service, for which payment may not be made--Payment may not be made if the service is provided to either a patient in a hospital outpatient department or to an inpatient of the hospital by an independently practicing physical or occupational therapist.

8 = Physician interpretation codes: This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for hospital inpatient. This applies to CPT codes 85060. No TC billing is recognized because payment for the underlying clinical laboratory test is made to the hospital, generally through the PPS rate.

No payment is recognized for CPT codes 85060 furnished to hospital outpatients or non-hospital patients. The physician interpretation is paid through the clinical laboratory fee schedule payment for the clinical laboratory test.

9 = Not Applicable--Concept of a professional/technical component does not apply