ADDENDUM A: Explanation and Use of Addendum B

Addendum B contains the 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.

1. 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 this Addendum.

2. Mod. A modifier is shown in this column if there is a technical component (modifier TC) or 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. One entry for the PC (modifier-26); one for the TC (TC) and one for the global service (PC and TC). The global service is not designated by a modifier. When a practitioner furnishes both the PC and TC, the code is billed without a modifier. When modifier-53 is shown, it indicates the rate for a discontinued procedure.

3. Status indicator. This column shows whether the CPT/HCPCS code is included and covered in the PFS and whether it is separately payable. An explanation of types of status indicators 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 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 bundled (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.

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

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. These codes should be billed with a zero (($0.00) charge and are denied.

N = Non-covered 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.

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 RVUs are shown for these codes and no payment may be made under the PFS.

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 proposed RVUs for the physician work in CY 2013.

6. 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 performed in the hospital (for example, open heart surgery is generally performed 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 performed in the nonfacility setting, the service will be paid at the facility PE RVU rate.

7. 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 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.

8. Malpractice RVUs. These are the proposed RVUs for the malpractice expense for CY 2013.

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 = 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.)