

the service. Carriers remain responsible for coverage decisions in the absence of a national Medicare policy.

B = Bundled code. Payment for covered services is 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 = Carrier-priced code. Carriers will establish RVUs and payment amounts for these services, generally on a case-by-case basis following review of documentation, such as an operative report.

D = Deleted code. These codes are deleted effective with the beginning of the calendar year.

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

F = Deleted/discontinued codes. Code not subject to a 90-day grace period.

G = Code not valid for Medicare purposes. Medicare does not recognize codes assigned this status. Medicare uses another code for reporting of, and payment for, these services.

H = Deleted modifier. Either the TC or PC component shown for the code has been deleted, and the deleted component is shown in the data base with the H status indicator. (Code subject to a 90-day grace period.)

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

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

P = Bundled or excluded code. There are no RVUs for these services. No separate payment should be made for them under the physician fee schedule.

—If the item or service is covered as incident to a physician's service and is furnished on the same day as a physician's service, payment for it is bundled into the payment for the physician's service to which it is incident (an example is an elastic bandage furnished by a physician incident to a physician's service).

—If the item or service is covered as other than incident to a physician's service, it is excluded from the physician fee schedule (for example, colostomy supplies) and is paid under the other payment provisions of the Act.

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

T = Injections. There are RVUs 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 service(s) for which payment is made.

X = Exclusion by law. These codes represent an item or service that is not within the definition of "physicians' services" for physician fee schedule payment purposes. No RVUs 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.)

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 2003. Codes that are not used for Medicare payment are identified with a "+".

6. *Facility practice expense RVUs.* These are the fully implemented resource-based practice expense RVUs for facility settings.

7. *Non-facility practice expense RVUs.* These are the fully implemented resource-based practice expense RVUs for non-facility settings.

8. *Malpractice expense RVUs.* These are the RVUs for the malpractice expense for the service for 2003.

9. *Facility total.* This is the sum of the work, fully implemented facility practice expense, and malpractice expense RVUs.

10. *Non-facility total.* This is the sum of the work, fully implemented non-facility practice expense, and malpractice expense RVUs.

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 = The 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 practice expense are associated with intra-service time and in some instances the post-service time.)

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION

CPT ¹ / HCPCS ²	MOD	Status	Description	Physician work RVUs ³	Non-facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility total	Global
0001T	C	Endovas repr abdo ao aneurys	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0002T	D	endo repair abd aa aorto uni	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0003T	C	Cervicography	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0005T	C	Perc cath stent/brain cv art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0006T	C	Perc cath stent/brain cv art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0007T	C	Perc cath stent/brain cv art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0008T	C	Upper gi endoscopy w/suture	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0009T	C	Endometrial cryoablation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0010T	C	Tb test, gamma interferon	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0012T	C	Osteochondral knee autograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0013T	C	Osteochondral knee allograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0014T	C	Meniscal transplant, knee	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0016T	C	Thermotx choroid vasc lesion	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0017T	C	Photocoagulat macular drusen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0018T	C	Transcranial magnetic stimul	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0019T	I	Extracorp shock wave tx, ms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0020T	C	Extracorp shock wave tx, ft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0021T	C	Fetal oximetry, trnsvag/cerv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0023T	C	Phenotype drug test, hiv 1	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0024T	C	Transcath cardiac reduction	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0025T	D	Ultrasonic pachymetry	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0026T	C	Measure remnant lipoproteins	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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² Copyright 2003 American Dental Association. All rights reserved.

³ +Indicates RVUs are not used for Medicare payment.