Medicare
Carriers Manual
Part 3 - Claims Process

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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CHANGE REQUEST 1301

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents - Chapter XV	15-1 - 15-2 (2 pp.)	15-1 - 15-2 (2 pp.)
15900.1 - 15901	15-115 - 15-116.14 (14 pp.)	15-115 - 15-116 (2 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: January 1, 2001*
IMPLEMENTATION DATE: January 1, 2001

Section 15900.1, Medicare Physician Fee Schedule Database (MPFSDB) 2001 File Layout, provides the complete file layout for 2001. There are no substantive changes to the database. This new manual section will allow the 2000 version to stay intact in §15900 for historical perspective.

These instructions should be implemented within your current operating budget.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previous published in the manual and is only being reprinted.

CHAPTER XV

FEE SCHEDULE FOR PHYSICIANS' SERVICES

CHAPTER XV

FIELD # & ITEM	LENGTH & PIC

36 (Cont.)

1999 Non-Facility Pricing Amount
[(Work RVU * Work GPCI) +
(Non-Facility PE RB RVU * 1 * PE GPCI) +
(MP RVU * MP GPCI)] * Conversion Factor

1999 Facility Pricing Amount
[(Work RVU * Work GPCI) +
(Facility PE RB RVU * 1 * PE GPCI) +

(MP RVU * MP GPCI)] * Conversion Factor

9 = Concept does not apply.

37 7 Pic x(7)

Future Local Level Expansion**
The Updated 1992 Transition Amount was previously stored in this field. Carriers can continue to maintain the updated transition amount in this field.

38A 7 Pic x(7)

Future Local Level Expansion**
The adjusted historical payment basis (AHPB) was previously stored in this field. Carriers can continue to maintain the AHPB in this field.

38B 8 Pic x(8)

Filler
This field was originally established for 15 spaces. Since AHPB data will only use 7 of the 15 spaces, carriers have 8 remaining spaces for their purposes.

* These fields will be provided by the Program Development and Information Group in the 2000 Medicare Fee Schedule Database for codes with status code indicator of A and T, as well as, indicators D and R with associated RVUs. Carriers will be responsible for calculating the 2000 payment amounts for codes with status code indicator of C, L, and R for codes without associated RVUs.

** These fields will be appended by each carrier at the local level.

15900.1 Medicare Physician Fee Schedule Database (Mpfsdb) 2001 File Layout.--The HCFA MPFSDB includes the total fee schedule amount, related component parts, and payment policy indicators. The record layout of the 2001 file is provided below.

FIELD # & ITEM	LENGTH & PIC
1	4 Pic x(4)
File Year This field displays the effective year of the file.	
2	5 Pic x(5)
Carrier Number This field represents the 5-digit number assigned to the carrier.	
3	2 Pic x(2)
Locality This 2-digit code identifies the pricing locality used.	
4	5 Pic x(5)
HCPCS Code This field represents the procedure code. Each Carrier Procedural Terminology (CPT) code and alpha-numeric HCPCS codes other than B, E, K and L codes and services representing anesthesia services will be included. The standard sort for this field is blanks, alpha, and numeric in ascending order.	
5	2 Pic x(2)
Modifier 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 Relative Value Units (RVUs) and a fee chedule amount have been established for procedures which the physician terminated before completion. This modifier is used only with colonoscopy code 45378. Any other codes billed with modifier -53 are subject to carrier medical review and priced by individual consideration.	

FIELD # & ITEM	LENGTH & PIC
5 (Cont.) Modifier -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.	
6 Descriptor This field will include a brief description of each procedure code.	50 Pic x(50)
7 Code Status This 1 position field provides the status of each code under the full fee schedule. Each status code is explained in §15901.	1 Pic x(1)
8 Conversion Factor This field displays the multiplier which transforms relative values into payment amounts. The file will contain the 2001 conversion factor which will reflect all adjustments.	8 Pic 9(4)v9999
9 Update Factor This update factor has been included in the conversion factor in Field 8.	6 Pic 9(2)v9999
10 Work Relative Value Unit This field displays the unit value for the physician work RVU.	9 Pic 9(7)v99
11 **Base** Practice Expense Relative Value Unit For 2000 and beyond, this field is not applicable and will be zero filled. For 1999, this field displayed the unit value for the **base** practice expense RVU.	9 Pic 9(7)v99
12 Malpractice Relative Value Unit This field displays the unit value for the malpractice expense RVU.	9 Pic 9(7)v99
13 Work Geographic Practice Cost Indices (GPCIs) This field displays a work geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999

FIELD # & ITEM	LENGTH & PIC
14	5 Pic 99v999

Practice Expense GPCI
This field displays a practice expense geographic adjustment factor used in computing the fee schedule amount.

15	5 Pic 99v999

Malpractice GPCI
This field displays a malpractice expense geographic adjustment factor used in computing the fee schedule amount.

16	3 Pic x(3)

Global Surgery
This field provides the postoperative time frames that apply to payment for each surgical procedure or another indicator that describes the applicability of the global concept to the service.

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 this 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 payment amount.

MMM = Maternity codes; usual global period does not apply.

XXX = Global concept does not apply

YYY = Carrier determines whether global concept applies and establishes postoperative period, if appropriate, at time of pricing.

ZZZ = Code related to another service and is always included in the global period of the other service.

17	6 Pic 9v9(5)

Preoperative Percentage (Modifier 56)
This field contains the percentage (shown in decimal format) for the preoperative portion of the global package. For example, 10 percent will be shown as 0.1000. The total of fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.

FIELD # & ITEM	LENGTH & PIC
18	6 Pic 9v9(5)

Intraoperative Percentage (Modifier 54)
This field contains the percentage (shown in decimal format) for the intraoperative portion of the global package including postoperative work in the hospital. For example, 63 percent will be shown as 0.6300. The total of fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.

19	6 Pic 9v9(5)

Postoperative Percentage (Modifier 55)
This field contains the percentage (shown in decimal format) for the postoperative portion of the global package that is provided in the office after discharge from the hospital. For example, 17 percent will be shown as 0.1700. The total of fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.

20	1 Pic x(1)

Professional Component (PC)/Technical Component (TC) Indicator

0 = Physician service codes: This indicator 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 & TC cannot be used with these codes.

The total Relative Value Units (RVUs) include values for physician work, practice expense and malpractice expense. There are some codes with no work RVUs.

1 = Diagnostic tests or radiology services: This indicator identifies codes that describe diagnostic tests, e.g., pulmonary function tests, or therapeutic radiology procedures, e.g., radiation therapy. These codes generally 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 equals the sum of RVUs for both the professional and technical component.

FIELD # & ITEM LENGTH & PIC

20 (Cont.)

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 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 tests only. An example of a technical component code is 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 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 physicians service when they are provided by auxiliary personnel employed by the physician and working under his or her direct supervision.

Payment may not be made by carriers 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.

FIELD # & ITEM LENGTH & PIC

20 (Cont.)

7 = Physician therapy service: Payment may not be made if the service is provided to either a hospital outpatient or inpatient 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 only to code 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 code 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 = Concept of a professional/technical component does not apply.

21 1 Pic (x)1

Multiple Procedure (Modifier 51)
Indicator indicates which payment adjustment rule for multiple procedures applies to the service.

0 = No payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure, base 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, 1996 or multiple procedures apply. In the 1996 MPFSDB, this indicator only applies to codes with procedure status of "D." If a 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 percent, 50 percent, 25 percent, 25 percent, 25 percent, and by report). Base 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 percent, 50 percent, 50 percent, 50 percent, 50 percent, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage.

FIELD # & ITEM LENGTH & PIC

21 (Cont.)

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 field 31G.

Apply the multiple endoscopy rules to a family before ranking the family with 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 = Indicator is reserved for possible future use.

9 = Concept does not apply.

22 1 Pic x(1)

Bilateral Surgery Indicator (Modifier 50)
This field provides an indicator for services subject to a payment adjustment.

0 = 150 percent payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier -50 or with modifiers RT and LT, base payment for the two sides on the lower of: (a) the total actual charge for both sides or (b) 100 percent 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 would 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 because of (a) physiology or anatomy or (b) because the code descriptor specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure.

1 = 150 percent payment adjustment for bilateral procedures applies. If 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 payment for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides or (b) 150 percent of the fee schedule amount for a single code.

FIELD # & ITEM LENGTH & PIC

22 (Cont.)

If 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 applicable multiple procedure rules.

2 = 150 percent payment adjustment for bilateral procedure does not apply. RVUs are already based on the procedure being performed as a bilateral procedure. If 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 with a 2 in the units field), base payment for both sides on the lower of (a) the total actual charges by the physician for both sides or (b) 100 percent of the fee schedule amount 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 would 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 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 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 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 applicable 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 procedures.

9 = Concept does not apply.

23 1 Pic x(1)

Assistant at Surgery
This field provides an indicator for services where an assistant at surgery is never paid for per MCM.

0 = Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.

FIELD # ITEM — LENGTH & PIC

23 (Cont.)

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.

24 — 1 Pic x(1)

Co-Surgeons (Modifier 62)
This field provides an indicator for 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; supporting documentation required to establish medical necessity of two surgeons for the procedure.

2 = Co-surgeons permitted; no documentation required if two specialty requirements are met.

9 = Concept does not apply.

25 — 1 Pic x(1)

Team Surgeons (Modifier 66)
This field provides an indicator for services for which team surgeons may be paid.

0 = Team surgeons not permitted for this procedure.

1 = Team surgeons could be paid; 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.

26 — 1 Pic x(1)

Billable Medical Supplies
This field provides an indicator for services subject to special payment rules for supplies/administration.

0 = Cannot be separately billed with this service.

1 = Code in related procedure code field can be paid separately when billed with these codes when service is performed in the physician's office.

FIELD # ITEM	LENGTH & PIC

26 (Cont.)

9 = Concept does not apply.

27 — 1 Pic x(1)

Site of Service Differential
For 1998, this field provides an indicator for services with differential payments based on site of service.

0 = Differential does not apply to this service.

1 = Applies due to a 50 percent reduction in practice expense RVUs.

2 = Applies due to the site of service practice expense RVUs.

3 = Applies due to a 50 percent reduction in the site of service practice expense RVUs.

9 = Concept does not apply.

For 1999 and beyond, the site of service differential no longer applies. The following definitions will apply for all years after 1998:

0 = Facility pricing does not apply.

1 = Facility pricing applies

28 — 9 Pic 9(7)v99

Non-Facility Fee Schedule Amount
This field shows the fee schedule amount for the non-facility setting. This amount equals Field 34.

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

29 — 9 Pic 9(7)v99

Facility Fee Schedule Amount
This field shows the fee schedule amount for the facility setting. This amount equals Field 35.

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

FIELD # ITEM	LENGTH & PIC
29 (Cont.) Place of service codes to be used to identify facilities. 21 - Inpatient Hospital 22 - Outpatient Hospital 23 - Emergency Room - Hospital 24 - Ambulatory Surgical Center 31 - Skilled Nursing Facility 53 - Community Mental Health Center 51 - Inpatient Psychiatric Facility 61 - Comprehensive Inpatient Rehabilitation Facility 62 - Comprehensive Outpatient Rehabilitation Facility	
30 Number of Related Codes This field defines the number of related procedure codes (see Field 31).	2 Pic 99
31 Related Procedure Codes This field identifies the number of times that a related code occurs.	65 Pic x(5) - Occurs 13 times
31A Physician Supervision of Diagnostic Procedures This field is for informational use only for post payment review. 1 = Procedure must be performed under the general supervision of a physician. 2 = Procedure must be performed under the direct supervision of a physician. 3 = Procedure must be performed under the personal supervision of a physician. 4 = Physician supervision policy does not apply when procedure personally furnished by a qualified, independent psychologist or a clinical psychologist; otherwise must be performed under the general supervision of a physician. 5 = Physician supervision policy does not apply when procedure personally furnished by a qualified audiologist; otherwise must be performed under the general supervision of a physician. 6 = Procedure must be personally performed by a physician OR a physical therapist who is certified by the American Board of Physical Therapy Specialties as a qualified electrophysiologic clinical specialist AND is permitted to provide the service under State law.	1 Pic x(1)

FIELD # & ITEM	LENGTH& PIC
31A (Cont.) 7 = Procedure must be personally performed by a physical therapist who is certified by the American Board of Physical Therapy Specialities as a qualified electrophysiologic clinical specialist AND is permitted to provide the service under State law OR performed under the direct supervision of a physician. 8 = For future use. 9 = Concept does not apply. P = Decision pending.	
31B Filler Reserved for future use.	1 Pic x(1)
31C **Transitioned Facility Setting** Practice Expense Relative Value Units	9 Pic(7)v99
31D **Transitioned Non-Facility Setting** Practice Expense Relative Value Units	9 Pic(7)v99
31E **Base** Site of Service Practice Expense Relative Value Units	9 Pic(7)v99
31F Filler Reserved for future use.	1 Pic x(1)
31G Endoscopic Base Codes This field identifies an endoscopic base code for each code with a multiple surgery indicator of 3.	5 Pic x(5)
32A 1996 Transition/Fee Schedule Amount This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
32B 1996 Transition/Fee Schedule This field is no longer Indicator applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
32C	9 Pic 9(7)v99
1996 Transition/Fee Schedule Amount When Site or Service Differential Applies This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	
33A	1 Pic x(1)
Units Payment Rule Indicator Reserved for future use. 9 = Concept does not apply.	
33B	1 Pic x(1)
Mapping Indicator This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	
33C	2 Pic x(2)
Medicare+Choice Encounter Pricing Locality **NOT FOR CARRIER USE**: These Medicare+Choice encounter pricing localities are for EDS purposes **only**. The locality values were developed to facilitate centralized processing of encounter data by the Medicare+Choice organizations (M+COs).	
33D	7 Pic x(7)
National Level Future Expansion This field is being provided for future expansion at the national level	
34	9 Pic 9(7)v99
Non-Facility Transition/Fee Schedule Amount* Since this field has historically been used to obtain the pricing amount, this field will replicate Field 28.	
35	9 Pic 9(7)v99
Facility Transition/Fee Schedule Payment Amount* Since this field has historically been used to obtain the pricing amount, this field will replicate Field 29.	

FIELD # & ITEM	LENGTH & PIC
36	1 Pic x(1)

Transition Calculation Indicator*
In 2001, this field is not populated.

2001 Non-Facility Pricing Amount
[(Work RVU * Work GPCI) +
(Transitioned Non-Facility PE RB RVU * PE GPCI) +
(MP RVU * MP GPCI)] * Conversion Factor

2001 Facility Pricing Amount
[(Work RVU * Work GPCI) +
(Transitioned Facility PE RB RVU * PE GPCI) +
(MP RVU * MP GPCI)] * Conversion Factor

37	7 Pic x(7)

Future Local Level Expansion**
The Updated 1992 Transition Amount was previously stored in this field. Carriers can continue to maintain the updated transition amount in this field.

38A	7 Pic x(7)

Future Local Level Expansion**
The adjusted historical payment basis (AHPB) was previously stored in this field. Carriers can continue to maintain the AHPB in this field.

38B	8 Pic x(8)

Filler
This field was originally established for 15 spaces. Since AHPB data will only use 7 of the 15 spaces, carriers have 8 remaining spaces for their purposes.

* These fields will be provided by the Program Development and Information Group in the 2001 Medicare Fee Schedule Database for codes with status code indicator of A and T, as well as, indicators D and R with associated RVUs. Carriers will be responsible for calculating the 2001 payment amounts for codes with status code indicator of C, L, and R for codes without associated RVUs.

** These fields will be appended by each carrier at the local level.

15901. MPFSDB STATUS INDICATORS

A = Active code. These codes are separately paid under the physician fee schedule if covered. There will be RVUs and payment amounts 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; carriers remain responsible for coverage decisions in the absence of a national Medicare policy.

B = Payment for covered services are always bundled into payment for other services not specified. There will be no RVUs or payment amounts for these codes and no separate payment is ever made. When 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 = Carriers price the code. Carriers 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/discontinued codes. These codes are deleted effective with the beginning of the year and are always subject to a 90 day grace period.

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

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.)

H = Deleted modifier. This code had a TC and/or PC in 1999. For 2000, 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.

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.)

L = Local codes. Carriers will apply this status to all local codes in effect on January 1, 1998 or subsequently approved by central office for use. Carriers will complete the RVUs and payment amounts for these codes.

N = Non-covered service. These codes are carried on the HCPCS tape as noncovered services.

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.

R = Restricted coverage. Special coverage instructions apply.

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.