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.

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. This code had TC and PC components in 1995. For 1996, these components are deleted.

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

 \dot{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 service and is furnished 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 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 "physician 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 1996. Codes that are not used for Medicare payment are identified with a "#."

6. *Practice expense RVUs.* These are the RVUs for the practice expense for the service for 1996. Codes that are subject to the OBRA 1993 practice expense reduction are identified by an asterisk in this column.

7. *Malpractice expense RVUs.* These are the RVUs for the malpractice expense for the service for 1996.

8. *Total RVUs.* This is the sum of the work, practice expense, and malpractice expense RVUs for 1996.

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 = 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 1996 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 = The code is part of another service and falls within the global period for the other service.

10. Update indicator. This column indicates whether the update for surgical procedures, primary care services, or other nonsurgical services applies to the CPT/ HCPCS code in column 1. A "0" appears in this field for codes that are deleted in 1996 or are not paid under the physician fee schedule. A "P" in this column indicates that the update and CF for primary care services applies to this code. An "N" in this column indicates that the update and CF for other nonsurgical services applies to this code. An "S" in this column indicates that the separate update and CF for surgical procedures applies.

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

			1				,		
CPT ¹ / HCPCS ²	MOD	Status	Description	Physi- cian work RVUs ³	Practice expense RVUs ⁴	Mal- practice RVUs	Total	Global period	Update
10040		А	Acne surgery of skin abscess	1.34	0.32	0.03	1.69	010	S
10060		A	Drainage of skin abscess	1.12	0.44	0.04	1.60	010	S
10061		A	Drainage of skin abscess	2.48	0.64	0.06	3.18	010	S
10080		А	Drainage of pilonidal cyst	1.62	0.50	0.05	2.17	010	N
10081		А	Drainage of pilonidal cyst	2.40	1.11	0.16	3.67	010	S
10120		А	Remove foreign body	1.19	0.46	0.05	1.70	010	S
10121		А	Remove foreign body	2.64	1.00	0.12	3.76	010	S
10140		А	Drainage of hematoma/fluid	1.48	0.48	0.05	2.01	010	S
10160		А	Puncture drainage of lesion	1.15	0.38	0.05	1.58	010	S
10180		А	Complex drainage, wound	2.20	1.05	0.18	3.43	010	S
11000		А	Surgical cleansing of skin	0.91	0.40	0.04	1.35	000	S
11001		А	Additional cleansing of skin	0.45	0.26	0.02	0.73	ZZZ	S
11040		А	Surgical cleansing, abrasion	0.50	0.40	0.04	0.94	000	S
11041		A	Surgical cleansing of skin	0.82	0.56	0.06	1.44	000	S
11042		А	Cleansing of skin/tissue	1.12	0.65	0.08	1.85	000	S
11043		А	Cleansing of tissue/muscle	1.83	1.81	0.34	3.98	010	S
11044		А	Cleansing tissue/muscle/bone	2.28	2.82	0.49	5.59	010	S
11050		А	Trim skin lesion	0.43	0.37	0.03	0.83	000	S
11051		A	Trim 2 to 4 skin lesions	0.66	0.50	0.05	1.21	000	S
11052		A	Trim over 4 skin lesions	0.86	0.41	0.04	1.31	000	S
11100		A	Biopsy of skin lesion	0.81	0.51	0.04	1.36	000	S
11101		A	Biopsy, each added lesion	0.41	0.29	0.02	0.72	ZZZ	S
11200		A	Removal of skin tags	0.69	0.43	0.04	1.16	010	S
11201		A	Removal of added skin tags	0.26	0.17	0.02	0.45	ZZZ	S
11300		А	Shave skin lesion	0.51	0.53	0.05	1.09	000	S
11301		A	Shave skin lesion	0.85	0.67	0.06	1.58	000	S

¹ All CPT codes and descriptors copyright 1995 American Medical Association.

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3# Indicates RVUs are not used for Medicare payment.

^{4*} Indicates reduction of Practice Expense RVUs as a result of OBRA 1993.