

NATIONAL PHYSICIAN FEE SCHEDULE RELATIVE VALUE FILE CALENDAR YEAR 2005

Contents:

This file contains information on services covered by the Medicare Physician Fee Schedule (MPFS) in 2005. For more than 10,000 physician services, the file contains the associated relative value units, 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 1999, the practice expense relative value units are based on 75 percent of the charge-based system and 25 percent of the resource-based system. In 2001, they are based on 50 percent of the charge-based system and 50 percent of the resource-based system. In 2002, they are based on 25 percent of the charge-based system and 75 percent of the resource-based system. In 2002 and beyond, the practice expense relative value units are based entirely on the resource-based system.

Under the charge-based system, we had a policy that reduces the practice expense relative value units for certain services by 50 percent when they are performed in a facility setting. Under the resource-based system, this policy is no longer applicable because, where appropriate, we have developed practice expense relative value units specific to the facility and non-facility settings.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. Note: A procedure performed in an ASC that is not on the ASC list is reimbursed on the basis of the non-facility practice expense relative value units. Outpatient rehabilitation services usually will be reimbursed on the basis of the non-facility practice

expense relative value units.

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 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 payment formula for 2005 is as follows:

$$\begin{aligned} \text{2005 Non-Facility Pricing Amount} = & \\ & [(\text{Work RVU} * \text{Work GPCI}) + \\ & (\text{RB Non-Facility PE RVU} * \text{PE GPCI}) + \\ & (\text{MP RVU} * \text{MP GPCI})] * \text{Conversion Factor} \end{aligned}$$

$$\begin{aligned} \text{2005 Facility Pricing Amount} = & \\ & [(\text{Work RVU} * \text{Work GPCI}) + \\ & (\text{RB Facility PE RVU} * \text{PE GPCI}) + \\ & (\text{MP RVU} * \text{MP GPCI})] * \text{Conversion Factor} \end{aligned}$$

NOTE: If the Calculation Flag has a value of '1', then the 2005 Fee Schedule amount is adjusted by 1.03.

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 15, 2004 Federal Register publication of the Fee Schedule for Physicians' Services for CY 2005

Data Set Name: RVU05.ZIP will contain five files:
(1) RVUPUF05 (in Word (.doc) format) contains the file's record layout and file documentation;

- (2) The RVUs and policy indicators associated with the physician fee schedule in ASCII text(.txt), EXCEL (.xls) and comma delimited format (.csv);
- (3) GPCI05 (in Excel (.xls), ASCII text (.prn) and comma delimited (.csv) formats) provides each Geographic Practice Cost Index (GPCI) component for each carrier/locality for 2005; and
- (4) 05LOCCO (in Excel (.xls), ASCII text (.prn) and comma delimited (.csv) formats) contains the locality/county crosswalk.
- (5) ANES2005 (in Excel (.xls), ASCII text (.TXT) and comma delimited (.csv) formats) contains the 2005 Anesthesia conversion factors.

Length of Record: 180 Characters

Update Schedule: This file will be updated on a periodic schedule to incorporate mid-year changes. Updated 2005 files will be available on April 1, July 1 and October 1. The following naming convention will be used to identify each:

- RVU05_A.EXE: January 2005 release
- RVU05_B.EXE: April 2005 release
- RVU05_C.EXE: July 2005 release
- RVU05_D.EXE: October 2005 release

NOTE:

- CPT codes and descriptions only are copyright 2004 American Medical Association. All rights reserved. Applicable FARS/DFARS apply.
- All dental codes copyright 2002 American Dental Association, all rights reserved.

**NATIONAL PHYSICIAN FEE SCHEDULE RELATIVE VALUE FILE
CALENDAR YEAR 2005**

<u>DATA ELEMENT</u>	<u>LOCATIO N</u>	<u>COBOL PIC</u>	<u>DESCRIPTION</u>
<u>HEADER RECORD</u>			
Header Indicator	1-3	x(3)	Value "HDR".
Filler	4-4	x(1)	
Copyright Statement	5-50	x(46)	
Filler	51-150	x(100)	
<u>DATA RECORD</u>			
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)	<p>For diagnostic tests, a blank in this field denotes the global service and the following modifiers identify the components:</p> <p>--26 = Professional component</p> <p>--TC = Technical component</p> <p>--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 code 45378, G0105 and G0121. Any other codes billed with modifier -53 are subject to carrier medical review and priced by individual consideration.</p> <p>--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.</p>
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.
Not Used for Medicare Payment Purposes Indicator	59-59	x(1)	An "+" in this field Indicates that the relative value units are not used for Medicare payment purposes.
Work RVU	60-65	999.99	Relative Value Unit (RVU) for the physician work in the service as published in the 11/15/04 <u>Federal Register</u> Fee Schedule for Physicians Services for CY 2005.
Fully Implemented Non-Facility Practice Expense RVU	72-77	999.99	Relative Value Unit (RVU) for the fully-implemented resource based practice expense for the non-facility setting, as published in the 11/15/04 Federal Register Fee Schedule for Physicians Services for CY 2005.

Non-Facility NA Indicator	78-79	X(2)	An "NA" in this field indicates that this procedure is rarely or never performed in the non-facility setting.
Filler	80-84	X(5)	
Fully Implemented Facility Practice Expense RVU	92-97	999.99	Relative Value Unit (RVU) for the fully implemented resource based practice expense for the facility setting, as published in the 11/15/04 Federal Register Fee Schedule for Physicians Services for CY 2005.
Filler	98-100	X(3)	
Facility NA Indicator	101-102	X(2)	An "NA" in this field indicates that this procedure is rarely or never performed in the facility setting.
Malpractice RVU	104-109	999.99	RVU for the malpractice expense for the service as published in the 11/15/04 <u>Federal Register</u> Fee Schedule for Physicians' Services for CY 2005.
Total Fully Implemented Non-Facility RVUs	110-115	999.99	Sum of work, fully implemented non-facility practice expense, and malpractice expense RVUs.
Filler	117-122	X(6)	
Total Fully Implemented Facility RVUs	124-129	999.99	Sum of work, fully implemented based facility practice expense, and malpractice RVUs.
Filler	131-136	X(6)	
PC/TC Indicator	139-139	x(1)	See Attachment A for description of values.
Global Surgery	140-142	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 always included in the global period of the other service.

Preoperative Percentage	143-145	.99	Percentage for preoperative portion of global package.
Intraoperative Percentage	146-148	.99	Percentage for intraoperative portion of global package, including postoperative work in the hospital.
Postoperative Percentage	149-151	.99	Percentage for postoperative portion of global package that is provided in the office after discharge from the hospital.
Multiple Procedure (Modifier 51)	152-152	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%, 25%, 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.

9=Concept does not apply.

Bilateral Surgery
(Modifier 50)

153-153

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 or (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	154-154	x(1)
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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)	155-155	x(1)
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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)

156-156

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

157-157

x(1)

Filler

158-158

x(1)

This field used to contain the Billable Medical Supplies indicator. Under resource based practice expense, all billable medical supplies have been incorporated into the practice expense relative values of individual services.

Filler

159-163

x(5)

Endoscopic Base Code	164-168	x(5)	Code which identifies an endoscopic base code for each code with a multiple surgery indicator of 3.
Conversion Factor	169-176	999.9999	This is the multiplier that transforms relative values into payment amounts. This conversion factor reflects the MEI update adjustment. For 2002 and beyond, there is a single conversion factor for all services.

Physician Supervision of
Diagnostic Procedures

178-179

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 a physician.

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 electrophysiologic 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

180

X(1)

A Value of '1' indicates that an adjustment of 1.03 should be applied to the 2005 fee schedule amount

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; carriers 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. There will be no RVUs or payment amount for these codes, and no separate payment is 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 Codes. These codes are deleted effective with the beginning of the applicable year. These codes will not appear on the 2005 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 or payment amounts 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 2005 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 2005 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 2005 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.)
- N = Noncovered 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 carrier 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 **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 **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 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.

- 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 codes 88141, 85060 and P3001-26. 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 codes 88141, 85060 or P3001-26 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.