



Dear *Medicare RBRVS 2023: The Physicians' Guide* Customer:

Thank you for purchasing the American Medical Association's (AMA's) electronic book (eBook), *Medicare RBRVS 2023: The Physicians' Guide*, in which the CPT RVUs 2023 and GPCIs 2023 tables are now part of the downloadable CPT RVUs-GPCIs 2023 Microsoft Excel file. Please read the following to assist you in using the file.

The Excel file, which includes the 2023 payment information available as of January 6, 2023, has three tabs: the CPT RVU Data Table, CPT Search | Locality Payment and 2023 GPCIs.

The Excel file provides a data table with CPT® and Healthcare Common Procedure Coding System (HCPCS) codes' short, medium, and long descriptors plus relative value units (RVUs) for the three components of each physician's service (work RVUs, practice expense (PE) RVUs, and professional liability insurance component (PLI) RVUs) covered by the Medicare program. The file also includes the global period covered by the payment, the total facility and non-facility RVUs, the Medicare facility and non-facility national average payment rates, the Medicare status code, and the Medicare payment policy indicators. Note that the CPT RVUs 2023 table does not list anesthesia base units for anesthesia services or payment rates for any services paid under the clinical lab fee schedule (CLFS); it only includes national Medicare payment rates for services that have RVUs.

The CPT Search | Locality Payment tab provides a search field for CPT and HCPCS codes, which allows you to sort by code number. The code-search field includes a smart-search feature in that once you enter at least one digit or character, all the matching codes will be displayed in the spreadsheet. This tab also includes a dropdown menu in which you can select either the national or state geographic practice cost index (GPCI); once selected, the table will automatically display the non-facility and facility payment rates. GPCIs are indices reflecting differences across geographic areas in physicians' resource costs relative to the national average. Payments under the Medicare Physician Payment Schedule (MFS) are adjusted geographically for three factors (physician work, PE, and PLI) to reflect differences in the cost of resources needed to "produce" physician services. The three distinct GPCI factors are used to calculate the payment schedule amount for a service in a Medicare locality. In addition, in this tab when the conversion factor (CF) is changed, the payment rates will adjust accordingly. The CF is a dollar amount used by most physician payment schedules that is multiplied by the RVUs and GPCIs to derive the payment rate for a given service. Unlike the CPT RVUs table in the first tab, this table does not include the legislative adjustment from the Deficit Reduction Act of 2005 for advanced imaging services in the payment rates.

The third tab in the spreadsheet, ie, the 2023 GPCIs tab, simply lists the work, PE, and PLI GPCIs for every Medicare Administrative Contractor (MAC) and Medicare locality.

This spreadsheet includes Medicare physician payment amounts under MFS only and may not reflect the true cost of the services provided. It does not provide payment information for anesthesia MFS services (CPT codes 00100-01999), clinical lab MFS services, or HCPCS supply codes. Note that private sector payments will vary. For more information about the MFS, see the Medicare and Medicaid section at <https://www.ama-assn.org/practice-management/medicare-medicaid>.

FILE NAMES

Medicare RBRVS 2023_CPT RVUs-GPCIs 2023.xlsx: 17,080 records.

USING COMPATIBLE SOFTWARE

This table was created using Microsoft Office Excel 365 in December of 2022. The tables in the first or third tabs are accessible with all versions of Microsoft Excel after 2007. However, the underlying Excel formulas that are used in the second tab may not be compatible with versions of Excel earlier than Excel 2016.

Data Record Definitions for CPT RVUs 2023 Table:

Field	Description
CPT Code/ HCPCS Code	CPT or HCPCS code
Modifier	Modifier 26 (professional only), Modifier 53 (discontinued procedure), and TC (technical component)
Short Descriptor	CPT or HCPCS abbreviated descriptions up to 27 characters in length
Medium Descriptor	CPT or HCPCS abbreviated description up to 48 characters in length
Long Descriptor	CPT or HCPCS full, unabbreviated descriptions
Medicare Status	<ul style="list-style-type: none">• A = Active Code. These codes are paid separately under MFS, if covered. There will be RVUs for codes with this status.• 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.• 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 at the beginning of the applicable year.• E = Excluded from MFS by regulation. These codes are for items and/or services that CMS chose to exclude from MFS payment by regulation.• F = Deleted/Discontinued Codes. (Code not subject to a 90 day grace period).• G = Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services.• 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.)• J = Anesthesia Services. There are no RVUs and no payment amounts for these codes. The intent of this value is to facilitate the identification of anesthesia services.• M = Measurement codes. Used for reporting purposes only.• N = Non-covered Services. These services are not covered by Medicare.• R = Restricted Coverage. Special coverage instructions apply. If covered, the service is carrier priced.• T = Injections. There are RVUs and payment amounts for these services, but they are only paid if there are no other services payable under MFS billed on the same date by the same provider.• X = Statutory Exclusion. These codes represent an item or service that is not in the statutory definition of "physician services" for MFS payment purposes.• Q = Therapy functional information code (used for required reporting purposes only).
Work RVU	RVUs for the physician work component
Non-Facility PE RVU	RVUs for the practice expense component for services performed in the nonfacility setting
Facility PE RVU	RVUs for the practice expense component for services performed in the facility setting
PLI RVU	RVUs for the professional liability insurance component
Non-Facility Total RVU	Total RVUs for services performed in the non-facility setting

Medicare Non-Facility Payment	National average Medicare non-facility payment amount calculated by adding the work RVU to the practice expense and malpractice RVUs and multiplied by the 2023 Medicare conversion factor \$33.8872). The Non-Facility Payment amount in the first tab may be capped or limited to the Hospital Outpatient Prospective Payment amount through the Deficit Reduction Act. If this cap may apply, “DRA” will be shown in the Payment Flag indicator.
Facility Total RVU	Total RVUs for services performed in the facility setting
Medicare Facility Payment	National average Medicare facility payment amount calculated by adding the Work RVU to the practice expense and malpractice RVUs and multiplied by the 2023 Medicare conversion factor \$33.8872).
Payment Policy Indicators	<p>The payment policy indicators include Medicare’s supervision requirements, including:</p> <ul style="list-style-type: none"> • Assistant-at-Surgery services are not payable for those codes where an “A” appears in the Payment Policy Indicator column. • An “A+” indicates this payment restriction applies unless medical necessity is established. • A “B” indicates that the payment adjustment for a bilateral procedure does apply. • A “C” indicates that payment for a co-surgeon is allowed, while a C+ indicates that documentation establishing medical necessity is required before payment for the co-surgeon would be allowed. • A “T” indicates that payment for a surgical team is allowed and paid on a by-report basis. • A “T+” indicates team surgeons are payable if medical necessity is established and are paid on a by-report basis. • An “M” indicates that Medicare’s standard multiple surgery rule applies. • A “Me” indicates that special Medicare rules apply if the procedure is billed with another endoscopy in the same family (ie, another endoscopy that has the same base procedure). • An Mtc indicates that special Medicare rules apply if the procedure is billed with another diagnostic imaging procedure in the same family. • A “DRA” indicates the service is subjected to the Deficit Reduction Act payment limit. Codes with these initials are capped at the OPPS rate if the normal payment exceeds this rate for the technical portion of the service. <p>Other Policy Indicators include:</p> <ul style="list-style-type: none"> • General supervision (GS): The physician is not required to be on premises but is responsible for overall quality of the service performed. • Direct supervision (DS): The physician is required to be on premises and immediately available in the office suite, but not required to have direct contact with the patient. • Personal supervision (PS): The physician must be in direct contact with the patient.
Global Period	The number of postoperative days of care that are included in the payment for a global surgical package

Should you have questions regarding the CPT RVUs 2023 and GPCIs 2023 tables, please call the AMA Unified Service Center at (800) 621-8335.

Sincerely,

AMA Customer Service