



"The searchable Medicare Physician Fee Schedule is a great tool to help my practice understand my Medicare payment!"



What is the Searchable Medicare Physician Fee Schedule (MPFS)?

Why Would a Health Care Professional, Supplier, or Provider Use the Searchable MPFS?

Background MPFS

How to Use and Locate the Searchable MPFS?

How to Use THE SEARCHABLE MEDICARE PHYSICIAN FEE SCHEDULE (MPFS)



To Learn More...

If you find this How to Use booklet helpful, then you may wish to review the other booklets in this series. Go to the MLN Products page at <http://www.cms.gov/MLNProducts> and search either the "MLN Products Catalog" or "MLN Publications" to locate these booklets.

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INTRODUCTION

What is the Searchable Medicare Physician Fee Schedule (MPFS)?

The Centers for Medicare & Medicaid Services (CMS) Physician Fee Schedule Search Tool provides Medicare payment information on more than 7,400 services, including pricing, the associated Relative Value Units (RVUs), and various payment policies.

Why Would a Health Care Professional, Supplier, or Provider Use the Searchable MPFS?

The MPFS is the primary method of payment for enrolled health care professionals. Specifically, Medicare uses this fee schedule when paying the following services:

- Professional services of physicians and other enrolled health care professionals in private practice;
- Services covered incident to physicians' services (other than certain drugs covered as incident to services);
- Diagnostic tests (other than clinical laboratory tests); and
- Radiology services.

In addition, suppliers such as Mammography Centers are paid according to the MPFS. Institutional providers such as hospitals, Comprehensive Outpatient Rehabilitation Facilities (CORFs), and Skilled Nursing Facilities (SNFs) are paid for some services under the MPFS depending on the institution type and service. For example, hospital outpatient departments are paid for screening mammographies and outpatient rehabilitation services under the MPFS.

The searchable MPFS allows health care professionals, suppliers, and institutional providers to find the Medicare payment amount for each code so they may calculate the beneficiary coinsurance amount. In addition, for those health care professionals/suppliers who choose to be nonparticipating, the MPFS provides the limiting charge.

PARTICIPATING HEALTH CARE PROFESSIONALS AND SUPPLIERS have enrolled in Medicare and have signed the Form CMS-460, "Medicare Participating Physician or Supplier Agreement," agreeing to charge no more than Medicare approved amounts and deductibles and coinsurance amounts. Participating professionals and suppliers submit assigned claims.

ASSIGNED CLAIMS are submitted by the health professional/supplier/provider on behalf of the beneficiary. Medicare issues payment to the submitter.

NONPARTICIPATING HEALTH CARE PROFESSIONALS AND SUPPLIERS enroll in Medicare but have decided not to sign the Form CMS-460. They accept assignment on a case-by-case basis. For services paid under the MPFS, there is a 5 percent reduction in the Medicare approved amounts for nonparticipants, and there is a limit on what the health care professional/supplier may charge the beneficiary (LIMITING CHARGE).

LIMITING CHARGE equals 115 percent of the fee schedule amount and is the maximum the nonparticipant may charge a beneficiary.

UNASSIGNED CLAIMS are submitted by a nonparticipating health care professional or supplier who is not accepting assignment on the claim. Medicare issues payment to the beneficiary.

The searchable MPFS is also an excellent way to learn if Healthcare Common Procedure Coding System (HCPCS) codes are affected by payment policies such as payment of assistant at surgery, applicability of certain modifiers, and physician supervision of diagnostic services.

Helpful Hint: Additional information about these and other payment policies are found in the CMS Internet-Only Manuals (IOMs). In addition, search the National Correct Coding Initiative (NCCI) at <http://www.cms.gov/NationalCorrectCodInitEd> to identify NCCI code pair edits and Medically Unlikely Edits (MUEs). Search the Medicare Coverage Database (MCD) at <http://www.cms.gov/medicare-coverage-database> to review national and local coverage determinations. The Medicare Learning Network® has created the “How to Use The National Correct Coding Initiative (NCCI) Tools” and “How to Use The Medicare Coverage Database” booklets to assist you.

Background

A fee schedule is a complete listing of fee maximums used by Medicare to pay physicians, other enrolled health care professionals, or providers/suppliers on a Fee-For-Service (FFS) basis. Medicare bases payment on whichever is less, the charge or MPFS amount. In addition to the MPFS, CMS develops fee schedules for ambulance services, clinical laboratory services, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS).

Some examples of adjustments to the fees shown in the MPFS are:

- For most codes, Medicare pays 80 percent of the amount listed and the beneficiary is responsible for 20 percent.
- Medicare has an outpatient mental health limitation (until 2014).
- Some physicians and other health care professionals might qualify for additional payment such as:
 - o Health Professional Shortage Area (HPSA) bonus payment and HSPA Surgical Incentive Payment (HSIP);
 - o Electronic Health Records Incentive Program;
 - o Physician Quality Reporting System; and
 - o Electronic Prescribing.
- Examples of reductions from the published MPFS amount include:
 - o Assistants at surgery receive 16 percent of the MPFS rate;
 - o Nurse practitioners, physician assistants, and clinical nurse specialists are paid 85 percent;
 - o Registered dietitians or nutrition professionals, for medical nutrition therapy services, are paid 85 percent; and
 - o Clinical social workers receive 75 percent.

Helpful Hint: Refer to Internet-Only Manual Publication (IOM Pub.) 100-04, “Medicare Claims Processing Manual,” Chapter 12, “Physicians/Nonphysician Practitioners,” at <http://www.cms.gov/manuals/downloads/clm104c12.pdf> for more information.

How Up-to-Date is the Searchable Medicare Physician Fee Schedule?

The searchable MPFS is updated quarterly. The PFS Update Status on the MPFS Overview page shows the date of the latest update.

How to Locate the Searchable Medicare Physician Fee Schedule

The searchable MPFS is located at

<http://www.cms.gov/apps/physician-fee-schedule/overview.aspx> and, because of its popularity, it is also one of the top 10 links featured as the Physician Fee Schedule Look-up on the CMS website home page.

SEARCHING THE MPFS

The searchable MPFS is designed to take the user through the selection steps prior to the display of the information so the user may customize searches of:

- Pricing amounts;
- Various payment policy indicators;
- Relative Value Unit (RVUs); and
- Geographic Practice Cost Indexes (GPCIs).

To begin a search from the MPFS Overview page, either click on 'Physician Fee Schedule Search' in the navigation bar at the top of the page or scroll down and select 'Start Search.' To continue, click 'Accept' to indicate you have read and agree to the License for Use of Current Procedural Terminology, Fourth Edition ("CPT®").

The MPFS Search Criteria screen will appear. A portion of this screen is shown in Figure 1.

Search Criteria

Begin your search below by selecting search criteria. Additional search criteria will appear depending on which selections you choose. Once your selections are complete, you will be asked to submit your criteria. All search criteria options displayed on this page are required.

Please select a year:

1

Type of Information:

2 ☐ Pricing Information

☐ Payment Policy Indicators

☐ Relative Value Units

☐ Geographic Practice Cost Index

☐ All

Figure 1: Search Criteria

To begin your search, select the following criteria:

- 1 Choose the year from the dropdown menu.

- 2 Then, select the Type of Information for the search from the following choices:
- **Pricing Information** - This search provides the maximum fee schedule amount by HCPCS code.
 - **Payment Policy Indicators** - This option provides only payment policy indicators information such as global surgery days, multiple surgery indicators, and applicability of professional and technical components.
 - **Relative Value Units (RVUs)** - For those interested in how the payment amount was calculated, this option provides RVU information for work, practice expense, and malpractice costs.
 - **Geographical Practice Cost Index (GPCI)** - A GPCI has been established for every Medicare payment locality for each of the three components of a procedure's RVU.
 - **All** - This option provides data for each of the above types of information.

Helpful Hint: If you are only interested in one of the above choices, there is a minor downside to choosing 'All' and that is, if you choose to print the results, you'll print more than what you need and will need to spend a little more time arranging the printing. Also, if you select one of the choices and then change your mind, you can easily switch from viewing only the default columns to all columns once your search results appear.

The remaining criteria options that are displayed vary based on the Type of Information selected for the search.

We will display the next steps of this search performing a Pricing Information Search and subsequently review the other choices of searches.

Pricing Information Search

- 1 Select **Pricing Information** for the Type of Information.
- 2 Select one of the following **Healthcare Common Procedure Coding System (HCPCS) Criteria** choices:
 - Single HCPCS Code**
Enter one procedure code.
 - List of HCPCS Codes**
Enter up to five codes.
 - Range of HCPCS Codes**
Enter a starting and ending procedure code to define the range.

The screenshot shows a web form titled "Pricing Information Search". It contains several sections with radio button options and input fields. Numbered callouts 1 through 5 point to specific elements: 1 points to the "Type of Information" section where "Pricing Information" is selected; 2 points to the "Select Healthcare Common Procedure Coding System (HCPCS) Criteria" section where "Single HCPCS Code" is selected; 3 points to the "Select Carrier/Medicare Administrative Contractor (MAC) Option" section where "National Payment Amount" is selected; 4 points to the "HCPCS Code" input field; and 5 points to the "Modifier" dropdown menu.

Type of Information:

- ☒ Pricing Information
- ☐ Payment Policy Indicators
- ☐ Relative Value Units
- ☐ Geographic Practice Cost Index
- ☐ All

Select Healthcare Common Procedure Coding System (HCPCS) Criteria:

- ☐ Single HCPCS Code
- ☐ List of HCPCS Codes
- ☐ Range of HCPCS Codes

Select Carrier/Medicare Administrative Contractor (MAC) Option:

- ☐ National Payment Amount
- ☐ Specific Carrier/MAC
- ☐ Specific Locality
- ☐ All Carriers/MACs

Pricing by Single HCPCS Code for All

Enter values for:

HCPCS Code:

Modifier:

Figure 2: Pricing Information and Search

Helpful Hint: The MPFS includes Level 1 Common Procedural Terminology CPT and Level 2 HCPCS codes.

- 3 Select one of the following choices for the Carrier/Medicare Administrative Contractor (MAC) criteria:

National Payment Amount

This option searches for information for only the national payment amount. The national payment amount is designated with a carrier locality code of "0000000."

Specific Carrier/MAC

This option searches for information by a number indicating a specific geographic area. If you choose this option, select an area from the dropdown menu at the bottom of the page.

Helpful Hint: A MAC will be comprised of more than one of these numbers. For example, the J1 MAC includes 01192-Southern California; 01102-Northern California; 01202-Hawaii, Guam, the Northern Mariana Islands and Samoa Islands; and 01302-Nevada.

Some of these areas, such as 01102, have multiple listings. To learn what, these numbers represent, reset the Search to Specific Locality.

Specific Locality

This search allows you to drill down to specific cities (for example, 0110205 - San Francisco) if payment varies within a carrier/MAC for specific localities. Notice the number for San Francisco starts with the Northern California number followed by 05.

All Carriers/MACs

This option searches for information for the entire nation. The results will include the national payment amount, as well as all carrier localities. This option is helpful for states with multiple payment localities because it groups all localities together for a carrier/MAC in case you are interested in how Medicare payment varies by locality within one carrier/MAC. However, this option does not provide locality names so it is necessary to know the carrier locality numbers, such as those provided in the Specific Locality option.

- 4 Enter the HCPCS code(s) for the search.
- 5 Select one of the following Modifier options from the dropdown menu:

- Global (Diagnostic Service) OR Physicians Professional Service where Professional/Technical concept does not apply;
- 26 Professional Component;
- 53 Procedures which the physician terminated before completion;
- TC Technical Component; and
- All Modifiers.

Helpful Hint: If you are uncertain as to which modifier to choose, select 'All Modifiers.' All means all of those modifiers listed above, not all modifiers in the AMA or HCPCS codebooks.

Click 'Submit' when all criteria have been selected to begin your Pricing search.

Pricing Search Using a List of Evaluation/Management Codes

In order to demonstrate the type of information found in a pricing search, this booklet first provides an example of a pricing search using a list of Evaluation/Management (E/M) codes and then shows how the results vary when performing a search using a code with a professional/technical component.

Figure 3 shows the top portion of the Search Results page after selecting or inputting the following information in this order:

- 2011;
- Pricing Information;
- List of HCPCS Codes;
- 00880 South Carolina as the Specific Carrier/MAC;
- 99214 and 99215 as a list of HCPCS Codes; and
- All Modifiers.

These selections are displayed. In addition, a brief descriptor of each code is provided.

Physician Fee Schedule Search

Search Results [2 Record(s)]

Selected Criteria:

Year: 2011 HCPCS: 99214 99215
Type of Info.: Pricing Information Modifier: All Modifiers
HCPCS Criteria: List of HCPCS Codes Carrier/MAC: 00880 SOUTH CAROLINA
Carrier/MAC Option: Specific Carrier/MAC

Update Results

Code	Description
99214	Office/outpatient visit est
99215	Office/outpatient visit est

Print Results **Download Results** **Email Results**

For your convenience, search results can be printed, downloaded or emailed.

Show Default Columns **Show All Columns**

View Items Per Page: 10 Go

Figure 3: Pricing Search Results for List of E/M Codes

Helpful Hint: If you wish to change the search criteria, type in a new code or other factor where your choices are indicated at the top of the page and then click on 'Update Results.' You may also print, download, or e-mail your search results by selecting one of these options.

In Figure 3, the 'Show Default Columns' view is automatically selected and only the columns related to the search are shown. To display all fields related to the information, you would select the 'Show All Columns' link.

In Figure 4, let's review the pricing information that is provided starting with the column on the left and moving towards the right:

1	2	3	4	5	6	7	8	9
HCPSC CODE ▲▼	MODIFIER ▲▼	PROC STAT ▲▼	CARRIER LOCALITY ▲▼	NON- FACILITY PRICE ▲▼	FACILITY PRICE ▲▼	NON- FACILITY LIMITING CHARGE ▲▼	FACILITY LIMITING CHARGE ▲▼	CONV FACT ▲▼
99214		A	0088001	\$98.21	\$72.98	\$107.29	\$79.73	33.9764
99215		A	0088001	\$132.20	\$103.09	\$144.43	\$112.63	33.9764

Figure 4: Pricing Search Results for List of E/M Codes

- HCPSC CODE** - 99214 and 99215 are each displayed on a separate row with the pricing information displayed under the columns to the right.

Helpful Hint: If the Single HCPCS Code option had been selected for the search, this column would not have appeared.

- MODIFIER** - There is nothing displayed in this column.

For services other than those codes with a professional and/or technical component, this field will be blank with one exception: when CPT modifier -53 is allowed, it will appear.

- PROC STAT** - This column includes the Procedure Status Code. In Figure 4, 'A' is listed in this column and indicates an Active Code, which means the code is paid if covered.

Helpful Hint: Refer to the "Medicare Claims Processing Manual," IOM Pub. 100-04, Chapter 23, Section 30.2.2, at <http://www.cms.gov/manuals/downloads/clm104c23.pdf> for full descriptions of all Procedure Status Codes or refer to the Appendix in the back of this booklet.

- CARRIER LOCALITY** - In Figure 4, 0088001 is displayed.

In this example, '0088001' represents South Carolina, and '01' as the last two digits indicates all of South Carolina's pricing is statewide. If this example was about Northern California, several rows would be displayed because pricing in California varies in several localities.

5

NON-FACILITY PRICE - In Figure 4, \$98.21 is displayed for 99214 and \$132.20 is displayed for 99215.

This column includes the fee schedule amount when a physician performs a procedure in a non-facility setting such as the office. (Non-facility fees are applicable to therapy procedures regardless of whether they are furnished in facility or non-facility settings.)

Occasionally, institutions such as hospitals are under the MPFS. When this occurs, they are paid at the non-facility (higher) rate. Although the terminology might seem confusing at first, the higher payment makes sense because here the facility is responsible for the cost of providing the staff and supplies.

Site of Service Differential

Under the MPFS, some procedures have a separate Medicare fee schedule for a physician's professional services when provided in a facility (such as a hospital) or a non-facility. Generally Medicare provides higher payments to physicians and other health care professionals for procedures performed in their offices because they are responsible for providing clinical staff, supplies, and equipment. This differential is viewed in the NON-FACILITY PRICE and FACILITY PRICE columns.

6

FACILITY PRICE - \$72.98 is shown for 99214 and \$103.09 for 99215.

This is the fee schedule amount when a physician provides this service in a facility setting, such as a hospital or Ambulatory Surgical Center (ASC).

7

NON-FACILITY LIMITING CHARGE - \$107.29 is shown for 99214 and \$144.43 for 99215.

This is the maximum amount a beneficiary can be charged for the service:

- By nonparticipating health care professionals;
- Who do not accept assignment; and
- When the service is performed in an office setting.

As explained on page 1 of this booklet, there is a 5 percent reduction in the approved amount for nonparticipating health care professionals and suppliers. In other words, the amounts in this column add up to 115 percent of 95 percent the amounts in column 5.

8

FACILITY LIMITING CHARGE - \$79.73 is shown for 99214 and \$112.63 for 99215.

This is the maximum amount a beneficiary can be charged for the service:

- By nonparticipating health care professionals;
- Who do not accept assignment; and
- When the service is performed in a facility setting.

9

CONV FACT - This column displays the Conversion Factor for this code, which we'll explain later in this booklet, when we discuss RVUs.

Pricing Search Using a Code with an Applicable Professional/Technical Component

Figure 5 below shows the additional pricing information that displays for codes that may be billed globally or with a professional/technical component. The selection criteria for this example were:

- 2011;
- Pricing Information;
- 77057 as the Single HCPCS Code;
- 00880 South Carolina as the Specific Carrier/MAC; and
- All Modifiers.

	MODIFIER ▲▼	PROC STAT ▲▼	CARRIER LOCALITY ▲▼	NON- FACILITY PRICE ▲▼	FACILITY PRICE ▲▼	NON- FACILITY LIMITING CHARGE ▲▼	FACILITY LIMITING CHARGE ▲▼
1		A	0088001	\$77.65	NA	\$84.83	NA
2	TC	A	0088001	\$43.83	NA	\$47.88	NA
3	26	A	0088001	\$33.82	\$33.82	\$36.95	\$36.95

Figure 5: Pricing Search Showing TC and 26

It is important to note that, although the search was only for one code (77057, screening mammogram), three rows are displayed because there are three ways to bill this code depending whether it is appropriate to bill a modifier.

- 1 The first row is blank in the modifier column in Figure 5. When a provider does not use a modifier with this code, it means this provider has performed both the technical and professional components of the procedure. The global pricing amount is \$77.65 for the **NON-FACILITY PRICE** and \$84.83 for the **NON-FACILITY LIMITING CHARGE**. (These amounts equal the sum of the amounts in the two other rows under these columns.) There is NA (Not Applicable) under both the **FACILITY PRICE** and **FACILITY LIMITING CHARGE** columns.
- 2 The second row displays the results if CPT Code 77057 is billed with HCPCS Level II modifier TC, Technical Component. TC indicates the claim was billed for the performance of the mammography only, not for the interpretation. \$43.83 is displayed under **NON-FACILITY PRICE** as the Medicare allowed amount for this code with a TC modifier, and \$47.88 is the maximum amount a nonparticipating professional may charge a beneficiary as the **NONFACILITY LIMITING CHARGE**. NA is shown under **FACILITY PRICE** and **FACILITY LIMITING CHARGE** because the facility does not receive payment for the technical component under the MPFS.
- 3 The third row provides information for CPT code 77057 submitted with modifier -26, which should be used when only the professional component of the procedure was performed. In this row there are prices listed in each column with \$33.82 in the two pricing columns and \$36.95 in the two limiting charge columns.

Payment Policy Indicator Search

Let's review the other information available in the searchable MPFS by now using the Payment Policy Indicators Search.

The Payment Policy Indicators include:

- Applicability of professional or technical modifiers;
- The number of post-operative days included in a procedure;
- Whether a code is paid by Medicare;
- The level of physician supervision required; and
- Whether the service can be billed bilaterally.

Payment Policy Indicators Search Using a Code with an Applicable Professional/Technical Component

In Figure 6 we'll search using a code for which there are applicable professional/technical modifiers and then in Figure 7 we'll discuss the information provided when a surgical code is inputted.

Figure 6 shows a portion of the Search results after selecting the following criteria:

- 2011;
- Payment Policy Indicators;
- Single HCPCS Code 77057; and
- All Modifiers.

We used the same code, 77057, as we just did in a pricing search to compare the information provided.

Helpful Hint: This payment policy search does not request a location or carrier/MAC selection because the policies shown are national. Learn more about these policies in the "Medicare Claims Processing Manual," IOM Pub 100-04, Chapter 23, "Fee Schedule Administration and Coding Requirements," at <http://www.cms.gov/manuals/downloads/clm104c23.pdf>. Remember, however, that carrier/MACs may have additional, local policies that you'll need to research on their websites or in the National Coverage Database at <http://www.cms.gov/medicare-coverage-database> on the CMS website.

1	2	3	4	5	6					
MODIFIER ▲▼	PROC STAT ▲▼	PCTC ▲▼	GLOBAL ▲▼	MULT SURG ▲▼	BILT SURG ▲▼	ASST SURG ▲▼	CO SURG ▲▼	TEAM SURG ▲▼	PHYS SUPV ▲▼	DIAG IMAGING FAMILY IND ▲▼
	A	1	XXX	0	2	9	0	0	09	99
26	A	1	XXX	0	2	9	0	0	09	99
TC	A	1	XXX	0	2	9	0	0	09	99

Figure 6: Payment Policy Indicators Search Results

- MODIFIER** – As in our pricing search for this code, the screen displays three rows, showing that code 77057, Mammography Screening, can be reported with no modifier, modifier -26, or a TC modifier.

All the other columns in this example display the same information for each row under the column heading.

- PROC STAT** - In this column, which shows Procedure Status Indicator, an 'A' is displayed as it was in the Pricing Search, meaning active code.
- PCTC** - This column complements the Modifier column by providing Professional Component/Technical Component Indicators. In our example, '1' is listed, which means the code is a diagnostic test or radiology service. Modifiers -26 and TC may be used when submitting this code on a claim.
- GLOBAL** - XXX appears in this example, which means the global surgery concept is not applicable to this code.
- MULT SURG** - There are zeros displayed in this column, which means no payment adjustment rules for multiple procedures apply.
- BILT SURG** - A '2' is displayed, which means the 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), payment is based 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.

For a complete listing of indicators, which might appear with other HCPCS code selections, refer to the "Medicare Claims Processing Manual," IOM Pub. 100-04, Chapter 23 at <http://www.cms.gov/manuals/downloads/clm104c23.pdf> and in the Addendum. Select the file layout for the applicable year (such as 2011) or refer to the Appendix in the back of this booklet. In addition, we'll also perform a payment policy search with a surgical example to explain more of these indicators.

All the other columns include indicators showing that these are not applicable or not permitted for code 77057. Let's now do a search using a surgical code to see what type of information may be conveyed in these columns.

Payment Policy Indicators Search Using a Surgical Code

Figure 7 below shows the MPFS search results when searching for CPT code 47480, incision of gallbladder.

Understanding the information in the columns displayed in these search results helps you understand policies such as bundled procedures or when using an appropriate CPT modifier with a code is necessary in order to be paid appropriately. This includes modifiers for assistant surgeons, bilateral surgery, and multiple procedures.

Search Results [1 Record(s)]

Selected Criteria:

Year: 2011

HCPSC: 47480

Type of Info.: Payment Policy Indicators

Modifier: All Modifiers

HCPSC Criteria: Single HCPSC Code

Update Results

Print Results

Download Results

Email Results

Code: 47480

Description: Incision of gallbladder

For your convenience, search results can be printed, downloaded or emailed.

1	2	3	4	5	6	7	8	9	10	Items Per Page: 10 Go
MODIFIER	PROC STAT	PCTC	GLOBAL	MULT SURG	BILT SURG	ASST SURG	CO SURG	TEAM SURG	PHYS SUPV	DIAG IMAGING FAMILY IND
▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼	▲▼
	A	0	90	2	0	2	1	0	09	99

Figure 7: Payment Policy Search Using a Surgical Code

- MODIFIER** - There is no information under the Modifier column.
- PROC STAT** - There is an 'A' in the column indicating this is a current code.
- PCTC** - There is a '0' in the column.

The '0' 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.

- GLOBAL** - This field provides the time frames that apply to payment for each surgical procedure or another indicator that describes the applicability of the global concept to the service (as XXX was explained in the previous mammography example).

In Figure 7, '90' is listed, which means code 47480 is major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule payment amount.

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THE MEDICARE PHYSICIAN FEE SCHEDULE Page 12

- 5 MULT SURG** - This column indicates which payment adjustment rule for multiple procedures (including certain physical therapy procedures) applies to the service. In Figure 7, a '2' indicates that standard payment adjustment rules for multiple procedures apply. Payment is based on the lower of the billed amount, or:
- 100 percent of the fee schedule amount for the highest valued procedure; and
 - 50 percent of the fee schedule amount for the second through the fifth highest valued procedures.

Additional procedures are reviewed and considered for payment.

Helpful Hint: When billing for multiple surgeries by the same professional (or physicians in the same group) on the same day, report the primary surgical procedure without modifier -51. Report additional surgical procedures performed by the same professional on the same day with modifier -51. Learn about multiple surgeries in Chapter 12 of IOM Pub. 100-04 and read about modifier -51 in the current CPT code book.

- 6 BILT SURGERY** - This field provides an indicator for bilateral services subject to a payment adjustment. Bilateral surgeries are procedures performed on both sides of the body during the same operative session or on the same day. In Figure 7, '0' is displayed, which means the 150 percent payment adjustment for bilateral procedures does not apply. If this procedure is reported with modifier -50 or with Modifiers RT and LT, Medicare bases 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.

Helpful Hint: Modifier -50 is a modifier indicating that the procedure was performed bilaterally at the same session. Learn more about billing for bilateral surgery in Chapter 12 of IOM Pub. 100-04 and read about modifier -50 in the current CPT code book.

- 7 ASST SURGERY** - This column indicates whether assistants at surgery may be paid. In Figure 7, '2' is displayed, which means payment restriction for assistants at surgery does not apply to this procedure.

Helpful Hint: Physicians are prohibited from billing a Medicare beneficiary for assistant at surgery services for procedure codes subject to the assistant at surgery limit. Learn more about assistant at surgery payment in Chapter 12 of IOM Pub. 100-04 and review modifiers -AS, -80, -81, and -82 by referring to the CPT/HCPCS code books.

- 8 CO SURG** - This field in Figure 7 includes an indicator '1', which means co-surgeons (each of a different specialty) could be paid. Supporting documentation is required to establish medical necessity of two surgeons for this procedure.

Helpful Hint: Learn more about co-surgeons in Chapter 12 of IOM Pub. 104 and read about modifier -62 in the current CPT code book.

- 9 TEAM SURG** - This field in Figure 7 provides indicator '0' indicating a team of surgeons (more than two surgeons of different specialties) is not permitted for this procedure.

Helpful Hint: Learn more teams of surgeons in Chapter 12 of IOM Pub. 104 and learn about modifier -66 in the CPT code book.

- 10** **PHYS SUPV** - Diagnostic tests, with certain exceptions, must be performed under the supervision of a physician. This field indicates the level of required supervision. In this example, '9' indicates that this concept does not apply.

Relative Value Unit (RVU) and Geographic Practice Cost Index (GPCI) Search

Prior to demonstrating the results of an RVU and GPCI search, it's important to understand what RVUs and GPCIs are. The pricing for each code in the MPFS is based on the following three components:

RVU - RVUs reflect the relative resources required to furnish a physician fee schedule service. Three separate RVUs are associated with the calculation of a payment under the MPFS:

- **Work RVUs** (reflect the relative time and intensity associated with providing a service and equal approximately 50 percent of the total payment);
- **Practice Expense (PE) RVUs** (reflect costs such as renting office space, buying supplies and equipment, and staff); and
- **Malpractice (MP) RVUs** (reflect the relative costs of purchasing malpractice insurance).

GPCI - To calculate the payment for every physician's service, the components of the fee schedule (physician work, PE, and MP RVUs) are adjusted by a GPCI. The GPCIs reflect the relative costs of physician work, practice expense, and malpractice expense in a specific area compared to the national average costs for each component.

Conversion Factor (CF) - Typically, the CF is updated on an annual basis. According to a formula specified by statute, the update for a year is equal to the Medicare Economic Index (MEI) adjusted up or down depending on how actual expenditures compare to a target rate called the Sustainable Growth Rate (SGR). RVUs are converted to dollar amounts through the application of a CF.

Further information about RVUs and GPCIs is available in the annual Medicare Physician Fee Schedule Rule or the file that can be accessed at

http://www.cms.gov/PhysicianFeeSched/01_Overview.asp on the CMS website. In addition, the Medicare Learning Network® has prepared a fact sheet explaining the RVU payment system. This publication is entitled "Medicare Physician Fee Schedule," and it can be located at

<http://www.cms.gov/MLNProducts/downloads/MedcrePhysFeeSchedfctsht.pdf> on the CMS website.

We'll first demonstrate a RVU search and then show a GPCI search.

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RVUs comprise the core of physician fees. CMS provides MACs/carriers with the fee schedule RVUs for all services except the following:

- Those with local codes;
- Those with national codes for which national relative values have not been established;
- Those requiring "By Report" payment or MAC/carrier pricing; and
- Those that are not included in the definition of physician services.

Review the Status Indicators in the Appendix for more information.

RVU Search

Using the Searchable MPFS, we selected:

- 2011;
- Relative Value Units for the Type of Information;
- 99214 for the Single HCPCS Code; and
- All Modifiers.

Figure 8 shows a portion of the screen displayed on the CMS website after making these selections. This figure shows only the following six columns from the many columns displayed on the website because these are the columns of interest to most health care professionals:

- In Figure 8, the **WORK RVU** column there is a 1.50.

Helpful Hint: If you searched for code 99215 instead of 99214, there would be a 2.11 in this column indicating a higher relative value. Looking back at the pricing search we did earlier in this booklet about these two codes, you'll see that the payment for 99215 is higher than for 99214. This helps you understand the impact of RVUs on the fee schedule amount.

Selected Criteria:

Year: HCPCS:

Type of Info.: Modifier:

HCPCS Criteria:

[Update Results](#)

[Print Results](#) [Download Results](#) [Email Results](#)

For your convenience, search results can be printed, downloaded or emailed.

1 View Items Per Page: Go

Code	Description	1	2	3	4	5
99214	Office/outpatient visit est					

WORK RVU ▲▼	NA FLAG FOR TRANS NON- FAC PE RVU ▲▼	1 TRANSITIONED NON-FAC PE RVU ▲▼	NA FLAG FOR FULLY IMP NON- FAC PE RVU ▲▼	2 FULLY IMPLEMENTED NON-FAC PE RVU ▲▼	NA FLAG FOR TRANS FACILITY PE RVU ▲▼	3 TRANSITIONED FACILITY PE RVU ▲▼	NA FLAG FOR FULLY IMP FAC PE RVU ▲▼	4 FULLY IMPLEMENTED FACILITY PE RVU ▲▼	5 MP RVU ▲▼	NON- FAC PE USED FOR OPPS PMT AMT ▲▼
1.50		1.41		1.48		0.63		0.71	0.10	\$0.00

Figure 8: RVU Search

The following Practice Expense (PE) RVUs are displayed in four columns:

- 1 1.41 under **TRANSITIONED NON-FAC PE RVU**;
- 2 1.48 under **FULLY IMPLEMENTED NON-FAC PE RVU**;
- 3 0.63 under **TRANSITIONED FACILITY PE RVU**; and
- 4 0.71 under **FULLY IMPLEMENTED FACILITY PE RVU**.

Helpful Hint: CMS has implemented a new methodology for determining resource-based PE RVUs and transitioned the new methodology over a 4 year period to be fully implemented for calendar 2013. Note the higher RVUs for non-facility rates and recall how the fee schedule amount was higher in the example we showed in Figure 4 earlier in this book.

5 MP RVU (Malpractice RVU) has a value of 0.10 in this example.

Helpful Hint: In order to see how MP RVUs vary, input a different code in an RVU search and compare to this result for 99214.

Chapter 23 of IOM Pub. 100-04, "Medicare Claims Processing," includes information on the other columns that are displayed on the CMS website when doing a RVU search.

GPCI Search

Finally, let's do a GPCI search for 2011. Remember, we do not input a HPCPCS code here because the same GPCI applies for all codes in an area. Our choices are whether we want a GPCI for:

- National Payment Amount;
- Specific Carrier/MAC;
- Specific Locality; or
- All Carriers/MACs.

Figure 9 displays a portion of the screen for GPCI's when choosing 'All Carriers/MACs.'

The screenshot shows the GPCI Search interface. Under 'Selected Criteria:', the 'Year' is set to 2011, 'Type of Info.' is Geographic Practice Cost Index, and 'Carrier/MAC Option' is All Carriers/MACs. An 'Update Results' button is visible. Below the criteria, there is a pagination bar showing 'Page 1 of 10' and a 'Go to page' input field. Navigation links for 'Prev' and 'Next' are present, along with a list of page numbers (1, 2, 3, 4, 5, 6, ...). The 'View Items Per Page' is set to 10. The main table displays results for two carrier/locality codes: 0000000 and 0051200. The table has four columns: CARRIER LOCALITY, GPCI WORK, GPCI PE, and GPCI MP. The values for 0000000 are 1.000, 1.000, and 1.000 respectively. The values for 0051200 are 1.000, 0.929, and 0.782 respectively.

CARRIER LOCALITY	GPCI WORK	GPCI PE	GPCI MP
0000000	1.000	1.000	1.000
0051200	1.000	0.929	0.782

Figure 9: GPCI Search

Remember that Carrier Locality 0000000 is national. There is value of '1.000' in each of the three GPCI columns: GPCI WORK, GPCI PE, and GPCI MP. For specific localities, any values higher or lower than '1.000' indicate higher or lower geographic classification values than the national average.

For our example, location 0051200 is displayed with a value of 1.000, 0.929, and 0.732 in these three respective columns.

Conclusion

In this booklet we've shown various types of searches using the searchable MPFS and explained the meaning of the indicators that are displayed as well as some of the policies that are relevant to understanding the information provided in these searches. To obtain further knowledge about the MPFS and related policies, other CMS web pages, provider education articles, and tools are listed in the Resources section of this booklet.

RESOURCES

Medicare Learning Network® Products

"How to Use The Medicare Coverage Database"

http://www.cms.gov/MLNProducts/downloads/MedicareCvrgeDatabase_ICN901346.pdf

This booklet was designed to provide education about how to use the Medicare Coverage Database (MCD). It includes an explanation of the database and how to use the search, indexes and reports, and downloads features.

"How to Use the National Correct Coding Initiative (NCCI) Tools"

<http://www.cms.gov/MLNProducts/downloads/How-To-Use-NCCI-Tools.pdf>

This booklet will help Medicare FFS providers navigate the CMS NCCI website. It explains how to look up Medicare code pair edits and Medically Unlikely Edits (MUEs). The NCCI tools can help providers avoid coding and billing errors and subsequent payment denials. If you want to become familiar with the "National Correct Coding Initiative Policy Manual for Medicare Services" and the tools on the NCCI website, this is the best resource.

"Medicare Physician Fee Schedule Fact Sheet"

<http://www.cms.gov/MLNProducts/downloads/MedcrePhysFeeSchedfctsht.pdf>

This fact sheet provides MPFS payment rates information, the MPFS payment rates formula, and MPFS resources.

Internet-Only Manuals

Internet-Only Manual (IOM) Pub. 100-02

"Medicare Benefit Policy Manual"

<http://www.cms.gov/manuals>

Chapter 15, "Covered Medical and Other Health Services," includes information on supervision for diagnostic x-ray, laboratory, and other diagnostic tests as well as information about other Medicare Part B covered services.

Internet-Only Manual (IOM) Pub. 100-04

"Medicare Claims Processing Manual"

<http://www.cms.gov/manuals>

Chapter 1, "General Billing Requirements," includes information on jurisdiction for claims, assignment, participation, termination of provider agreements, billing, and timely filing. This chapter provides information on payment for participating and non-participating providers based on the MPFS.

Chapter 4, "Part B Hospital (Including Inpatient Hospital Part B and OPPS)," explains physical therapy and diagnostic and screening mammography services are paid under the MPFS.

Chapter 12, "Physicians/Nonphysician Practitioners," includes information about how CMS updates the MPFS, adjustments to fee schedule components, correct coding policies, and other payment policies.

Chapter 23, “Fee Schedule Administration and Coding Requirements,” includes information about coding requirements, edits, and the MPFS. This chapter also identifies services that are paid at reasonable charge rather than based on a fee schedule and discusses the other fee schedules used by CMS, such as the clinical diagnostic laboratory and DMEPOS fee schedules.

CMS Web Pages

CMS Forms

<http://www.cms.gov/cmsforms>

The “Medicare Participating Physician or Supplier Agreement” (Form CMS-460) and other CMS forms can be downloaded from this web page.

Electronic Health Records (EHR) Incentive Program

http://www.cms.gov/EHRIncentivePrograms/01_Overview.asp

The Medicare and Medicaid EHR Incentive Programs will provide incentive payments to eligible professionals, eligible hospitals, and Critical Access Hospitals (CAHs) as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology.

Electronic Prescribing Incentive

<http://www.cms.gov/ERxIncentive>

This web page provides information on the electronic prescribing incentive program, which is in addition to the Physician Quality Reporting System incentive.

Health Professional (or Personnel) Shortage Area (HPSA) and HSPA Surgical Incentive Payment (HSIP)

<http://www.cms.gov/HPSAPSAPhysicianBonuses>

This web page provides information regarding bonuses for which certain physicians in certain areas may be eligible to receive in addition to the MPFS amount.

Medicare Coverage Database

<http://www.cms.gov/medicare-coverage-database>

The searchable Medicare Coverage Database (MCD) contains all National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs), local articles, and proposed NCD decisions.

National Correct Coding Initiatives (NCCI) Edits

<http://www.cms.gov/NationalCorrectCodInitEd>

CMS developed NCCI to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. CMS developed its coding policies based on coding conventions defined in the American Medical Association’s Current Procedural Terminology (CPT) manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. This web page offers a link to the “National Correct Coding Initiative (NCCI) Coding Policy Manual for Medicare Services” under the Downloads section.

Physician Fee Schedule

<http://www.cms.gov/PhysicianFeeSched>

This web page provides a link to the annual Physician Fee Schedule (PFS) final rule, files, and various reports. The rule includes annual updates to the relative weights of physician services.

Physician Quality Reporting System

<http://www.cms.gov/PQRS>

This web page provides information on the Medicare physician quality reporting system, including an incentive payment for eligible professionals who satisfactorily report data on quality measures for covered professional services furnished to Medicare.

Searchable MPFS

<http://www.cms.gov/apps/physician-fee-schedule/overview.aspx>

This CMS tool is designed to facilitate searches of information on services covered by the Medicare Physician Fee Schedule (MPFS). It provides more than 10,000 physician services, the associated relative value units, a fee schedule status indicator, and various payment policy indicators needed for payment adjustment.

APPENDIX

This information is from the "Medicare Claims Processing Manual," IOM Pub. 100-04, Chapter 23 at <http://www.cms.gov/manuals/downloads/clm104c23.pdf> on the CMS website. Select Addendum and the 2011 File Layout.

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/MACs 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/MACs price the code. 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.

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, continues under reasonable charge procedures.

F = Deleted/discontinued codes. (Code not subject to a 90 day grace period.) These codes are deleted effective with the beginning of the year and are never subject to a grace period. This indicator is no longer effective beginning with the 2005 fee schedule as of January 1, 2005.

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.) This indicator is no longer effective beginning with the 2005 fee schedule as of January 1, 2005.

H = *Deleted modifier. For 2000 and later years, 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.

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. (no relative value units or payment amounts for anesthesia codes on the database, only used to facilitate the identification of anesthesia services.)

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

M = Measurement codes, used for reporting purposes only.

N = Non-covered service.

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 = 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.

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.)

*Codes with these indicators had a 90 day grace period before January 1, 2005.

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/MAC 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. (Note: Physician work is associated with intra-service time and in some instances the post service time.)

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 and 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.

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/MACs 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 = Private practice therapist's service. Payment may not be made if the service is provided to either a hospital outpatient or a hospital inpatient by a physical therapist, occupational therapist, or speech-language pathologist in private practice.

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 a 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 Prospective Payment System (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.

Multiple Procedure (CPT Modifier -51)

This indicator indicates which payment adjustment rule for multiple procedures applies to the service.

0 = No payment adjustment rules for multiple procedures apply. If the procedure is reported on the same day as another procedure, payment is based 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, for multiple procedures apply. In the 1996 MPFSDB, this indicator only applied 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, Medicare ranks the procedures by fee schedule amount and the appropriate reduction to this code is applied (100 percent, 50 percent, 25 percent, 25 percent, 25 percent, and by report). Carriers/MACs 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 the procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, carriers/MACs 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). MACs base 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 field 31G of the Form CMS-1500 or its electronic equivalent claim. The multiple endoscopy rules apply 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, the base procedure is not separately paid. Payment for the base procedure is included in the payment for the other endoscopy.

4 = Subject to 25 percent reduction of the TC diagnostic imaging (effective for services January 1, 2006 through June 30, 2010). Subject to 50 percent reduction of the TC diagnostic imaging (effective for services July 1, 2010 and after).

5 = Subject to 20 percent reduction of the practice expense component for certain therapy services (effective for services January 1, 2011 and after).

9 = Concept does not apply.

Bilateral Surgery Indicator (CPT 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 a procedure is reported with modifier -50 or with modifiers RT and LT, Medicare bases 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 a 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), payment is based 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.

If code is reported as a bilateral procedure and is reported with other procedure codes on the same day, the bilateral adjustment is applied 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 a 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), payment is based 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), Medicare bases 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 percent 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, the fee schedule amount for a bilateral procedure is determined 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.

Assistants at Surgery

This field provides an indicator for services where an assistants at surgery is never paid.

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. Assistants at surgery may not be paid.

2 = Payment restriction for assistants at surgery does not apply to this procedure. Assistants at surgery may be paid.

9 = Concept does not apply.

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 is required to establish medical necessity of two surgeons for the procedure.

2 = Co-surgeons permitted. No documentation is required if two specialty requirements are met.

9 = Concept does not apply.

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 is required to establish medical necessity of a team; paid by report.

2 = Team surgeons permitted; paid by report.

9 = Concept does not apply.

Physician Supervision of Diagnostic Procedures

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 the procedure must be performed under the general supervision of a physician.

05 = Not subject to supervision when furnished personally by a qualified audiologist, physician, or non physician practitioner. Direct supervision by a physician is required for those parts of the test that may be furnished by a qualified technician when appropriate to the circumstances of the test.

06 = Procedure must be personally performed by a physician or a Physical Therapist (PT) who is certified by the American Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiological clinical specialist and is permitted to provide the procedure under State law. Procedure may also be performed by a PT with ABPTS certification without physician supervision.

21 = Procedure may be performed by a technician with certification under general supervision of a physician. Otherwise the procedure must be performed under direct supervision of a physician. Procedure may also be performed by a PT with ABPTS certification without physician supervision.

22 = May be performed by a technician with on-line real-time contact with a physician.

66 = May be personally performed by a physician or by a PT with ABPTS certification and certification in this specific procedure.

6A = Supervision standards for level 66 apply; in addition, the PT with ABPTS certification may personally supervise another PT, but only the PT with ABPTS certification may bill.

77 = Procedure must be performed by a PT with ABPTS certification (TC & PC) or by a PT without certification under direct supervision of a physician (TC & PC), or by a technician with certification under general supervision of a physician (TC only; PC always physician).

7A = Supervision standards for level 77 apply; in addition, the PT with ABPTS certification may personally supervise another PT, but only the PT with ABPTS certification may bill.

09 = Concept does not apply.

Diagnostic Imaging Family Indicator

For services effective January 1, 2011, and after, family indicators 01 - 11 will not be populated.

01 = Family 1 Ultrasound (Chest/Abdomen/Pelvis – Non Obstetrical)

02 = Family 2 CT and CTA (Chest/Thorax/Abd/Pelvis)

03 = Family 3 CT and CTA (Head/Brain/Orbit/Maxillofacial/Neck)

04 = Family 4 MRI and MRA (Chest/Abd/Pelvis)

05 = Family 5 MRI and MRA (Head/Brain/Neck)

06 = Family 6 MRI and MRA (Spine)

07 = Family 7 CT (Spine)

08 = Family 8 MRI and MRA (Lower Extremities)

09 = Family 9 CT and CTA (Lower Extremities)

10 = Family 10 Mr and MRI (Upper Extremities and Joints)

11 = Family 11 CT and CTA (Upper Extremities)

88 = Subject to the reduction of the TC diagnostic imaging (effective for services January 1, 2011, and after).

99 = Concept Does Not Apply

This booklet was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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