Medicare Claims Processing Manual
Chapter 23 - Fee Schedule Administration and Coding Requirements

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(Rev. 4465, 11-15-19)

10 - Reporting ICD Diagnosis and Procedure Codes
(Rev. 3081, Issued: 09-26-14, Effective: Upon Implementation of ICD-10, Implementation: Upon Implementation of ICD-10)

Proper coding is necessary on Medicare claims because codes are generally used in determining coverage and payment amounts. CMS accepts only HIPAA approved ICD-9-CM or ICD-10-CM/ICD-10-PCS codes, depending on the date of service. The official ICD-9-CM codes which were updated annually through October 1, 2013 are posted at http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/codes.html

The official annual updates and effective dates for any changes to ICD-10-CM and ICD-10-PCS codes are posted at http://www.cms.gov/Medicare/Coding/ICD10/index.html .

See the following sections (10.1 - 10.6) for additional instructions about coding ICD diagnoses for inpatient, outpatient, and other services.

10.1 - General Rules for Diagnosis Codes
(Rev. 3081, Issued: 09-26-14, Effective: Upon Implementation of ICD-10, Implementation: Upon Implementation of ICD-10)

The Official ICD-9-CM Coding Guidelines can be found at http://www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm

The Official ICD-10-CM and ICD-10-PCS Coding Guidelines can be found with the annual ICD-10-CM and ICD-10-PCS updates at http://www.cms.gov/Medicare/Coding/ICD10/index.html

The CMS understands that physicians may not always provide suppliers of DMEPOS with the most specific diagnosis code, and may provide only a narrative description. In those cases, suppliers may choose to utilize a variety of sources to determine the most specific diagnosis code to include on the individual line items of the claim. These sources may include, but are not limited to: coding books and resources, contact with physicians or other health professionals, documentation contained in the patient's medical record, or verbally from the patient's physician or other healthcare professional.

Beneficiaries are not required to submit diagnosis codes on beneficiary-submitted claims. Beneficiary-submitted claims are filed on Form CMS-1490S. For beneficiary-submitted claims, the A/B MAC (B) must develop the claim to determine a current and valid diagnosis code and may enter the code on the claim.

10.2 - Inpatient Claim Diagnosis Reporting
(Rev. 3081, Issued: 09-26-14, Effective: Upon Implementation of ICD-10, Implementation: Upon Implementation of ICD-10)

On inpatient claims providers must report the principal diagnosis. The principal diagnosis is the condition established after study to be chiefly responsible for the admission. Even

though another diagnosis may be more severe than the principal diagnosis, the principal diagnosis, as defined above, is entered. Entering any other diagnosis may result in incorrect assignment of a Medicare Severity - Diagnosis Related Group (MS-DRG) and an incorrect payment to a hospital under PPS. See Chapter 25, Completing and Processing the Form CMS-1450 Data Set, for instructions about completing the claim.

Other diagnoses codes are required on inpatient claims and are used in determining the appropriate MS-DRG. The provider reports the full codes for up to twenty four additional conditions if they coexisted at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay.

The principal diagnosis should not under any circumstances be duplicated as an additional or secondary diagnosis. If the provider reports duplicate diagnoses they are eliminated in Medicare Code Editor (MCE) before GROUPER.

The Admitting Diagnosis Code is required for inpatient hospital claims subject to A/B MAC (A) review. The admitting diagnosis is the condition identified by the physician at the time of the patient's admission requiring hospitalization. For outpatient bills, the field defined as Patient's Reason for Visit is not required by Medicare but may be used by providers for nonscheduled visits for outpatient bills.

10.3 - Outpatient Claim Diagnosis Reporting

(Rev. 3081, Issued: 09-26-14, Effective: Upon Implementation of ICD-10, Implementation: Upon Implementation of ICD-10)

For outpatient claims, providers report the full diagnosis code for the diagnosis shown to be chiefly responsible for the outpatient services. For instance, if a patient is seen on an outpatient basis for an evaluation of a symptom (e.g., cough) for which a definitive diagnosis is not made, the symptom is reported. If, during the course of the outpatient evaluation and treatment, a definitive diagnosis is made (e.g., acute bronchitis), the definitive diagnosis is reported. If the patient arrives at the hospital for examination or testing without a referring diagnosis and cannot provide a complaint, symptom, or diagnosis, the hospital reports the encounter code that most accurately reflects the reason for the encounter.

Examples include:

- Z00.00 Encounter for general adult medical examination without abnormal findings
- Z00.01 Encounter for general adult medical examination with abnormal findings
- Z01.10 Encounter for examination of ears and hearing without abnormal findings
- Z01.118 Encounter for examination of ears and hearing with other abnormal findings

For outpatient claims, providers report the full diagnosis codes for up to 24 other diagnoses that coexisted in addition to the diagnosis reported as the principal diagnosis. For instance, if the patient is referred to a hospital for evaluation of hypertension and the medical record also documents diabetes, diabetes is reported as another diagnosis.

Additional information and training is available on CMS Web site:
http://www.cms.gov/Medicare/Coding/ICD10/index.html

10.4 - ICD Procedure Codes

(Rev. 3081, Issued: 09-26-14, Effective: Upon Implementation of ICD-10, Implementation: Upon Implementation of ICD-10)

ICD procedure codes are required for inpatient hospital Part A claims only. Healthcare Common Procedure Code System (HCPCS) codes are used for reporting procedures on other claim types. Inpatient hospital claims require reporting the principal procedure if a significant procedure occurred during the hospitalization. For information of the selection of the principal procedure, see the Official ICD-10-PCS coding guidelines posted with the annual updates to ICD-10-PCS posted at
http://www.cms.gov/Medicare/Coding/ICD10/index.html

The principal procedure code and other procedure codes shown on the bill **must** be the full ICD-9-CM, Volume 3, or ICD-10-PCS procedure code, including all applicable digits, up to seven digits.

Up to twenty four significant procedures other than the principal procedure may be reported.

10.5 - Coding for Outpatient Services and Physician Offices

(Rev. 3081, Issued: 09-26-14, Effective: Upon Implementation of ICD-10, Implementation: Upon Implementation of ICD-10)

The Official ICD-10-CM Coding Guidelines include a section for Outpatient Services (hospital-based and physician office). These guidelines can be found in the annual updates to ICD-10-CM posted at http://www.cms.gov/Medicare/Coding/ICD10/index.html

A/B MACs (A), (B), (HHH), and DME MACs, physicians, hospitals, and other health care providers must comply with the Official ICD-10-CM Coding Guidelines.

10.6 - Relationship of Diagnosis Codes and Date of Service

(Rev. 3081, Issued: 09-26-14, Effective: Upon Implementation of ICD-10, Implementation: Upon Implementation of ICD-10)

Diagnosis codes must be reported based on the date of service (including, when applicable, the date of discharge) on the claim and not the date the claim is prepared or received. A/B MACs (A), (B), (HHH), and DME MACs are required to edit claims on this basis, including providing for annual updates each October.

Shared systems must maintain date parameters for diagnosis editing. Use of actual effective and end dates is required when new diagnosis codes are issued or current codes become obsolete with the annual updates.

The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets must be date-of-service compliant. Since ICD diagnosis codes are a medical code set, effective for dates of service on and after October 1, 2004, CMS does not provide any grace period for providers to use in billing discontinued diagnosis codes on Medicare claims. The updated codes are published in the Federal Register each year as part of the Proposed Changes to the Hospital Inpatient Prospective Payment Systems in table 6 and effective each October 1.

All MACs will return claims containing a discontinued diagnosis code as unprocessable. For dates of service beginning October 1, 2004, physicians, practitioners, and suppliers must use the current and valid diagnosis code that is then in effect for the date of service. After the updated codes are published in the Federal Register, CMS places the new, revised and discontinued codes on the ICD-9 or ICD-10 Web site as applicable. http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/codes.html or http://www.cms.gov/Medicare/Coding/ICD10/index.html.

The CMS sends the updated codes to All MACs on an annual basis via a recurring update notification instruction. This is normally released to MACs each June, and contains the new, revised, and discontinued diagnosis codes which are effective for dates of service on and after October 1st.

20 - Description of Healthcare Common Procedure Coding System (HCPCS)

(Rev.2288, Issued: 08-26-11, Effective: 01-01-11, Implementation: 01-03-11)

HO-442, CMS HCPCS Code Web site

Background

The HCPCS has been selected as the approved coding set for entities covered under the Health Insurance Portability and Accountability Act (HIPAA), for reporting outpatient procedures.

The HCPCS is based upon the American Medical Association's (AMA) "Physicians' Current Procedural Terminology, Fourth Edition" (CPT-4). It includes three levels of codes and modifiers. Level I contains only the AMA's CPT-4 codes. This level consists of all numeric codes. Level II contains alpha-numeric codes primarily for items and nonphysician services not included in CPT-4, e.g., ambulance, DME, orthotics, and prosthetics. These are alpha-numeric codes maintained jointly by CMS, the Blue Cross and Blue Shield Association (BCBSA), and the Health Insurance Association of America (HIAA).

Normally Level I and Level II codes are updated annually, issued in October for January implementation. However, Level II codes also may be issued quarterly to provide for new or changed Medicare coverage policy for physicians' services as well as services normally

described in Level II. These codes may be temporary and be replaced by a Level I or Level II code in the related CPT or HCPCS code section, or may remain for a considerable time as "temporary" codes. Designation as temporary does not affect the coverage status of the service identified by the code. New temporary codes that have been approved will be issued in a Recurring Update Notification instruction quarterly.

New K or Q codes may be identified from time to time and, when they are, they will be announced in a Recurring Change Request issued on a quarterly basis.

The CMS monitors the system to ensure uniformity.

20.1 - Use and Maintenance of CPT-4 in HCPCS

(Rev. 3124, Issued: 11-13-14, Effective: 01-01-15, Implementation; 01-05-15)

There are over 7,000 service codes, plus titles and modifiers, in the CPT-4 section of HCPCS, which is copyrighted by the AMA. The AMA and CMS have entered into an agreement that permits the use of HCPCS codes and describes the manner in which they may be used. See §20.7 below.

- The AMA permits CMS, its agents, and other entities participating in programs administered by CMS to use CPT-4 codes/modifiers and terminology as part of HCPCS;

- CMS shall adopt and use CPT-4 in connection with HCPCS for the purpose of reporting services under Medicare and Medicaid;

- CMS agrees to include a statement in HCPCS that participants are authorized to use the copies of CPT-4 material in HCPCS only for purposes directly related to participating in CMS programs, and that permission for any other use must be obtained from the AMA;

- HCPCS shall be prepared in format(s) approved in writing by the AMA, which include(s) appropriate notice(s) to indicate that CPT-4 is copyrighted material of the AMA;

- Both the AMA and CMS will encourage health insurance organizations to adopt CPT-4 for the reporting of physicians' services in order to achieve the widest possible acceptance of the system and the uniformity of services reporting;

- The AMA recognizes that CMS and other users of CPT-4 may not provide payment under their programs for certain procedures identified in CPT-4. Accordingly, CMS and other health insurance organizations may independently establish policies and procedures governing the manner in which the codes are used within their operations; and

- The AMA's CPT-4 Editorial Panel has the sole responsibility to revise, update, or modify CPT-4 codes.

The AMA updates and republishes CPT-4 annually and provides CMS with the updated data. The CMS updates the alpha-numeric (Level II) portion of HCPCS and incorporates the updated AMA material to create the HCPCS code file. The CMS provides the file to A/B MACs (A), (B), (HHH), and DME MACs and Medicaid State agencies annually.

It is the MAC's responsibility to develop payment screens and limits within Federal guidelines and to implement CMS' issuances. The coding system is merely one of the tools used to achieve national consistency in claims processing.

MACs may edit and abridge CPT-4 terminology within their claims processing area. However, MACs are not allowed to publish, edit, or abridge versions of CPT-4 for distribution outside of the claims processing structure. This would violate copyright laws. MACs may furnish providers/suppliers AMA and CMS Internet addresses, and may issue newsletters with codes and approved narrative descriptions that instruct physicians, suppliers and providers on the use of certain codes/modifiers when reporting services on claims forms, e.g., need for documentation of services, handling of unusual circumstances. The CMS acknowledges that CPT is a trademark of the AMA, and the newsletter must show the following statement in close proximity to listed codes and descriptors:

> CPT codes, descriptors and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply.

If only a small portion of the terminology is used, MACs do not need to show the copyright legend. MACs may also print the code and approved narrative description in development requests relating to individual cases.

The CMS provides MACs an annual update file of HCPCS codes and instructions to retrieve the update via CMS mainframe telecommunication system.

20.2 - Local Codes
(Rev. 1, 10-01-03)

Approved local codes must be discontinued by December 31, 2003. Unapproved local codes are discontinued December 31, 2002 for A/B MACs (B) and March 31, 2003 for A/B MACs (A) and (HHH).

Until then, local codes/modifiers (Level III) may be used for items and services not covered by any Level I or Level II code/modifier. They are alpha-numeric and are restricted to the W, X, Y, and Z series. New local codes/modifiers can only be added with prior CO approval. If an item or service is not described by a Level I or Level II code/modifier for Part B Medicare and a local code/modifier is necessary, a request is submitted to the RO. The RO reviews the request to determine that the required documentation is provided and

whether a current code/modifier exists. If no current code/modifier is found, the RO forwards the submitted information and its recommendation for consideration of a local code/modifier assignment to the HCPCS Coordinator, Room C4-02-16, in CO. The request will be placed on CMS HCPCS Workgroup agenda for review and a final decision regarding the establishment of a new local code/modifier. The RO will be notified of the decision and, if approved, the new code/modifier will be added to the HCPCS codes database.

The RO and CO must receive written notification when local codes/modifiers are deleted and when there are changes to administrative data.

The request to add a new local code or modifier must include the following information:

- Identify the component making the request and its address, e.g., A/B MAC (A), (B), (HHH), or DME MAC name and number;

- Reason the code/modifier assignment is requested, e.g., new procedure, new product, received on claim, request from hospital, etc. This provides background that helps CMS in deciding whether or not a national code may be required;

- Exact nomenclature or terminology requested;

- Expected coverage, utilization, or payment limits placed upon the service;

- Nearest national HCPCS code/modifier with an explanation of why it cannot be used;

- If applicable, suggested Relative Value Unit (RVU) of the new local code,

- Expected annual billings in terms of services and charges;

- Purpose for which the code/modifier is needed, (e.g., administrative/statistical use);

- For modifiers only, a description of how the modifier will be used (e.g., to trigger MR, for informational purposes, to affect payment (how it impacts payment), or for internal processing only; and

- The RO and CO must receive written notification when local codes/modifiers are deleted and when there are changes to administrative data.

The CMS establishes reasonable criteria for code assignments, such as a minimum frequency of occurrence of a service. It is not appropriate to request assignment of codes for items rarely furnished. The occasional service is correctly reported in a miscellaneous code (usually ending in 49 or 99) generally referred to as “not otherwise classified” (NOC). Use discretion in requesting assignment of local codes, remembering that there are finite numbers of codes available for local assignment, that once issued a number cannot be

reused for a minimum of five years, and that all parties involved with the coding system have to maintain and update their systems to reflect current coding assignments.

MACs should not delay claims processing of affected claims prior to receiving a decision on the local code or modifier requested. Process the claims under a "not otherwise classified code" in the Level I or Level II code range that most closely represents the service, pending CMS CO approval/denial of the local code/modifier request.

An exception to this process is the creation of local codes for blood administration supplies. In some areas, blood banks group a number of services into one charge. For example, they may have one charge covering washed cells with a cross-match. There is one HCPCS code (P9022) for washed red blood cells, and there are others for typing and cross-matching. Have facilities use a combination of the available codes to reflect the one charge by the blood bank. However, if this skews the payment for independent facilities, MACs assign a local HCPCS code for the combination of services. MACs establish local codes for blood administration sets and filters and set reasonable charge amounts for independent facilities.

MACs report local codes established for blood administration, along with the definition and billing frequency, by the 15th of the month following the end of each quarter to:

Centers for Medicare & Medicaid Services
CMM
Room C4-02-16
7500 Security Blvd.
Baltimore, MD. 21244

Also, MACs send a copy to the HCPCS Coordinator in the RO.

Under the outpatient prospective payment system (OPPS), A/B MACs (A) make payment based on HCPCS codes as defined in standard national software. As a result, there is no mechanism for the pricing of local codes under OPPS, and a local code would serve no purpose. However, requests to add new local codes or modifiers for services not subject to the OPPS may continue to be made. Such requests must include the data listed above.

20.3 - Use and Acceptance of HCPCS Codes and Modifiers

(Rev. 1644, Issued: 12-05-09, Effective: 10-27-08/12-12-08 HCPCS code A4559, Implementation: 10-27-08/12-12-08 HCPCS code A4559)
SNF-530.2, HO-442.3

The HCPCS is updated annually to reflect changes in the practice of medicine and provision of health care. The CMS provides a file containing the updated HCPCS codes to A/B MACs (A), (B), (HHH), and DME MACs and Medicaid State agencies 60 to 90 days in advance of the implementation of the annual update. Distribution consists of an electronic file of the updated HCPCS codes, file characteristics, record layout, and a listing of changed and deleted codes. MACs are required to update their HCPCS codes file and

map all new or deleted codes to appropriate payment information no later than three months after receipt of the update.

A spreadsheet containing an updated list of the HCPCS codes for Durable Medical Equipment Medicare Administrative Contractors (DME MAC) and A/B MAC (B) jurisdictions is updated annually to reflect codes that have been added or discontinued (deleted) during each year. A recurring update notification will be published annually to notify the DME MACs and A/B MACs (B) that the list has been updated and is available on the CMS Web site.
https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html.

Both the DME MACs and the A/B MACs (B) publish this list to educate providers on which MAC they should bill for codes provided on this list.

In addition to the major annual update, CMS also updates HCPCS codes quarterly to reflect additional changes or corrections that are emergency in nature. Quarterly changes are issued by letter or memorandum for local implementation.

Physicians and suppliers must use HCPCS codes on the Form CMS-1500 or its electronic equivalent and providers must use HCPCS codes on the Form CMS-1450 or its electronic equivalent for most outpatient services. The service or procedure can be further described by using 2-position modifiers contained in HCPCS.

Modifiers to HCPCS Level I codes for medicine, anesthesia, surgery, radiology, and pathology are on the HCPCS codes file from CMS. Modifiers for Level II alpha-numeric codes are with the Level II codes published by CMS. Alpha-numeric and CPT-4 modifiers may be used with either alpha-numeric or CPT-4 codes. A/B MACs (B) and DME MACs are required to accept at least 2-position numeric or alpha modifiers and process both modifiers completely through the claims processing system (including any manual portion) as far as payment history. A/B MACs (A) or (HHH) must be able to accept at least five modifiers and process them completely through the system. It is not acceptable merely to be able to accept multiple modifiers and then drop one before complete systems processing. Dropping of a modifier leads to incomplete and inaccurate pricing profiles.

Series “Q,” “K,” and “G” in the Level II coding are reserved for CMS assignment. “Q,” “K,” and “G” codes are **temporary** national codes for items or services requiring uniform national coding between one year’s update and the next. Sometimes “temporary” codes remain for more than one update. If “Q,” “K,” or “G” codes are not converted to permanent codes in the Level I or Level II series in the following update, they will remain active until converted in following years or until CMS notifies MACs to delete them. All active “Q,” “K,” and “G” codes at the time of update will be included on the update file for MACs. In addition, deleted codes are retained on the file for informational purposes, with a deleted indicator, for four years.

Series “S” and Series “I” Level II codes are reserved for use by the BCBSA and the HIAA, respectively. These codes provide for reporting needs unique to those organizations. Each State defines its own Medicaid coverage, payment, and utilization levels. The CMS does not impose Medicare requirements on Medicaid programs. The HCPCS simply provides a system for identifying services that can be expanded to meet everyone’s needs.

If Level I and Level II codes/modifiers do not exist for services or items common to Medicare and Medicaid, a local HCPCS code/modifier in the W, X, Y, or Z series may be requested. Local code/modifier requests for services common to both Medicare and Medicaid should be coordinated between the A/B MAC (B) and the Medicaid State agency and submitted to CMS CO for approval through the RO. See the procedure outlined in §20.2 to request CMS CO approval for such codes.

20.4 - Deleted HCPCS Codes/Modifiers

(Rev. 89, 02-06-04)
HO-442.2

Claims for services in a prior year are reported and processed using the HCPCS codes/modifiers in effect during that year. For example, a claim for a service furnished in November 2002 but received by an A/B MAC (A), (B), or (HHH), or DME MAC in 2003, should contain codes/modifiers valid in 2002 and is processed using the prior year’s pricing files.

HCPCS codes (Level I CPT-4 and Level II alpha-numeric) are updated on an annual basis. Each October, CMS releases the annual HCPCS file to A/B MACs (A), (B), (HHH), and DME MACs. The HCPCS file contains the CPT-4 and the alpha-numeric updates. All MACs are notified of the release date via a one-time notification instruction. The file contains new, deleted, and revised HCPCS codes which are effective on January 1 of each year. With each annual HCPCS update, CMS had permitted a 90-day grace period for billing discontinued HCPCS codes for dates of service January 1 through March 31 that were submitted to MACs by April 1 of the current year.

The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets must be date of service compliant. Since HCPCS is a medical code set, effective January 1, 2005, CMS will no longer provide a 90-day grace period for providers to use in billing discontinued HCPCS codes. The elimination of the grace period applies to the annual HCPCS update and to any mid-year coding changes. Any codes discontinued mid-year will no longer have a 90-day grace period.

MACs must eliminate the 90-day grace period from their system effective with the January 1, 2005, HCPCS update. MACs will no longer accept discontinued HCPCS codes for dates of service January 1 through March 31. Providers can purchase the American Medical Association’s CPT-4 coding book that is published each October that contains new, revised, and discontinued CPT-4 codes for the upcoming year. In addition, CMS posts on its Web site the annual alpha-numeric HCPCS file for the upcoming year at the end of each October. Providers are encouraged to access CMS web site to see the new, revised, and

discontinued alpha-numeric codes for the upcoming year. The CMS web site to view the annual HCPCS update is https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html.

A/B MACs (B) and DME MACs must continue to reject services submitted with discontinued HCPCS codes. A/B MACs (A) and (HHH) must continue to return to the provider (RTP) claims containing deleted codes.

See the Medicare Claims Processing Manual, Chapter 22, "Remittance Notices to Providers."

20.5 - The HCPCS Codes Training

(Rev. 1, 10-01-03)
HO-442.5

A large number of changes to HCPCS codes may necessitate the training of physician, supplier and provider personnel. If this is necessary, MACs must schedule the sessions in conjunction with the State medical records association or the State hospital or medical/physician associations. All MACs should schedule sessions in the major population centers of their service area.

All MACs should use the following guidelines in planning training sessions.

- Limit the training sessions to a manageable size to encourage questions and answers.
- A/B MACs (B) should limit sessions to office staffs of homogenous medical specialties, e.g., do not include DME suppliers with staff from physicians' offices.
- Invite office personnel who complete bills and claims to attend.
- In conducting the training, emphasize the use of the new HCPCS/CPT-4 manuals and the proper completion of the claim forms using the new codes.

Be alert to a specific physician/supplier/provider having difficulty with HCPCS. Provide follow up training focused to the individual situation. Review and discuss specific billing problems over the phone or by mail. If many problems develop with a specific provider, the MAC schedules a visit to provide the specific training needed. Training is the A/B MACs (A)'s, (B)'s, (HHH)'s, and DME MACs' responsibility.

20.6 - Professional/Public Relations for HCPCS

(Rev. 1, 10-01-03)

A/B MACs (A), (B), (HHH), and DME MACs must perform the following professional/public relations activities:

- Designate a knowledgeable person as a focal point for physician, supplier and provider inquiries. This person must be able to address coding and payment questions.

- Notify physicians, suppliers and providers by newsletter and Web site at least 30 days before codes are changed, added or deleted. Also, notify them when general problems arise including coding issues.

- A/B MACs (B) should share Level III codes/modifiers with the Medicaid State agency in the A/B MAC (B)'s jurisdiction.

- Advise physicians and providers to obtain new copies of CPT-4 annually from the AMA. Orders can be placed by calling 1-800-621-8335 or order online at www.ama-assn.org/catalog

- A/B MACs (A) and (HHH) supply providers with CMS' alpha-numeric code updates and with any local codes. See §20 for sources. A/B MACs (B) supply the current HCPCS local codes/modifiers (alpha-numeric W-Z) since they are the only source.

- A/B MACs (A), (B), (HHH), and DME MACs inform physicians, suppliers, and providers when the annually and quarterly updated HCPCS codes become available and effective in the claims processing system.

- All codes/modifiers contained in the current version of the HCPCS will be recognized and processed unless they have been deleted or are indicated as not valid for Medicare.

- It is important for physicians, practitioners, suppliers, and providers to note that code/modifier recognition does not imply that a service is covered by Medicare. In addition, a separate code does not mean that the payment level will be different from similar services identified by different codes.

- Since local changes can occur throughout the year, continue professional relations activities to provide as much information as possible to providers.

20.7 - Use of the American Medical Association's (AMA's) Physicians' Current Procedural Terminology (CPT) Fourth Edition Codes, and Use of the American Dental Association's (ADA's) Current Dental Terminology-Fourth Edition (CDT) Codes, on A/B MACs (A)'s, (B)'s, (HHH)'s, and DME MACs' Web Sites and Other Electronic Media

(Rev. 323, Issued: 10-22-04, Effective: 08-01-04, Implementation: 11-22-04)

See Business Requirements at http://www.cms.hhs.gov/manuals/pm_trans/R43CP.pdf

The CMS and the AMA signed an amendment to the original 1983 Agreement on CMS' use of CPT coding. This amendment covers the use of the CPT codes, descriptions, and other materials on A/B MACs (A)'s, (B)'s, (HHH)'s, and DME MACs' Web sites and in other electronic media. (For purposes of this manual, electronic medial is defined as tapes, disk, or CD ROM.)

On August 18, 1999, the ADA and CMS entered into a license agreement regarding computer and print use of the ADA's Current Dental Terminology -Fourth Edition Codes. Additionally, the agreement was modified to provide for Internet and other electronic media use of dental codes. The amendment was recently renegotiated with minor updates in October 2003 and in August 2004. The new effective date of the renegotiated ADA/CMS amendment is August 1, 2004.

All MACs must follow the requirements and guidelines below for any new or revised material used on their Web sites and in electronic media.

20.7.1 - Displaying Material With CPT Codes
(Rev. 1, 10-01-03)

The CPT code information may be used on A/B MACs (A)'s, (B)'s, (HHH)'s, and DME MACs' Web sites and in electronic media in the following types of publications:

- Local Medical Review Policies (LMRPs);
- Bulletins/Newsletters;
- Program Memoranda and Instructions;
- Coverage Issues and Medicare Coding Policies;
- Program Integrity Bulletins and Information;
- Educational Training Materials, including Computer Basic Training Modules;
- Fee Schedules; and
- Special Mailings (containing information that would otherwise be included in the aforementioned publications, but due to time constraints requires expedited handling).

The above materials are referred to collectively as "publications" whether displayed on a Web site or included in electronic media.

Publications must be designed to convey Medicare specific information and not CPT coding advice. Publications must not be designed to substitute for the CPT Book with respect to codes, long descriptions, notes, or guidelines for any user.

In addition, when providing copies of publications in electronic media to any requesters in order to comply with Freedom of Information Act (FOIA) request, the publications released via FOIA that contain CPT codes must only contain short descriptions. CPT short descriptions mean CPT 5-digit identifying code numbers and abbreviated procedural descriptions that are no more than 28 characters long. When MACs provide any electronic media to other State and Federal agencies, any CPT coding contained in the publication(s)

must conform to these requirements. MACs must notify such Federal and State Agencies that their use is subject to the terms of the amendment.

20.7.2 - Use of CPT Codes With Long Descriptors
(Rev. 1, 10-01-03)

The CPT long descriptions mean CPT 5-digit identifying code numbers and complete procedural descriptions. The CPT codes are considered the Level I codes in HCPCS. The CPT codes are numeric and NOT alpha-numeric. The CPT codes and long descriptions can be used on Web sites as long as each document does not contain over 30 percent of a section (e.g., first level section heading in the CPT book "Table of Contents," e.g., "Surgery") or subsection (e.g., a second level heading in the "Table of Contents," e.g., "Surgery: Integumentary System") of the CPT-4 book. For example, in the CPT section "Surgery," subsection "Hemic and Lympathic Systems," the total codes in this subsection are 47. If A/B MACs (A), (B), (HHH), and DME MACs need to display the codes and long descriptions, they would be able to list only 14 codes and long descriptions (30 percent). For any subsection that contains less than 30 CPT codes, this requirement does NOT apply.

Some CPT sections have subsections with only a few codes. For these CPT sections, e.g., "Anesthesia, Evaluation and Management, and Pathology and Laboratory," the subsection limitation does not apply. The limit on the use of long descriptions is 30 percent of a total section.

Section 20.7.6.1 contains a list of sections and subsections of CPT and the number of codes in each subsection. This attachment will be updated by the AMA and supplied to all MACs by CMS on an annual basis. (Note that Attachment I is an Excel File and is included as a separate document.)

If necessary, over 30 percent of a section of codes with their long descriptions may be used if the long descriptions are integrated into narrative text. The codes and long descriptions cannot be presented in consecutive listings even if used to convey fee schedule or payment policy information. Section 20.7.6.2 provides an example of long descriptions and codes integrated into text.

Remember that the 30 percent rule applies only to CPT codes with long descriptions. MACs may use as many CPT codes, or CPT codes and short descriptions as necessary.

MACs are not permitted to use over 30 percent of a subsection of CPT-4 codes with long descriptions. AMA states that in doing so CMS is violating the AMA's copyright in CPT. As stated above, if over 30 percent of CPT-4 codes and long descriptions are used in a particular document, the long descriptions must be part of a narrative text (that are necessary for the presentation of information in that text and are not presented in consecutive listings) as in §20.7.6.2. There may be circumstances where the MAC believes the 30 percent rule should be waived. The CMS and the AMA will deal with these

situations on a case-by-case basis. If such a case occurs, MACs contact the regional office that will communicate the case to CMS CO for evaluation.

Fee schedules cannot include long descriptions. Only CPT short descriptions (28 characters or less) can be used in fee schedules.

20.7.3 - Distinguishing CPT and Non-CPT Material
(Rev. 1, 10-01-03)

The CPT and non-CPT information must be clearly distinguished. The CPT must be presented in such a way that it is clear to the reader what is CPT and what is not. Whenever practical, distinguish CPT by including the requirements of copyright notices, separation of CPT and non-CPT via distinct sections, formatting, font, or the like. Section 20.7.6.3 lists examples of formats developed by CMS to use when displaying CPT and non-CPT information or when distinguishing CPT and HCPCS Level II notes and guidelines. A/B MACs (A), (B), (HHH), and DME MACs may also develop other formats as long as they distinguish between CPT and non-CPT information and between CPT and HCPCS Level II notes or guidelines and meet the requirements of the amendment.

20.7.4 - Required Notices
(Rev. 1, 10-01-03)

20.7.4.1 - AMA Copyright Notice
(Rev. 1, 10-01-03)

A/B MACs (A), (B), (HHH), and DME MACs must display the AMA copyright notice on the first screen or Web page of any document containing one or more CPT codes immediately prior to the initial appearance or display of any CPT. The copyright notice must also appear on the first page of publications of downloaded materials that include CPT. In other words, where any CPT code is used in publications on the Web sites and other electronic media such as tape, disk or CD-ROM, whether short or long descriptions are used or only codes or ranges, MACs must display the AMA copyright notice. The copyright notice is:

> "CPT codes, descriptors, and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply."

NOTE: FARS/DFARS is defined as FARS - Federal Acquisition Regulation System and DFARS - Defense Federal Acquisition Regulation Supplement.

20.7.4.2 - Point and Click License
(Rev. 1, 10-01-03)

In addition, A/B MACs (A), (B), (HHH), and DME MACs must use a point and click license (a license that appears on a computer screen or Web page and includes a computer

program or Web page mechanism that requires users to indicate whether they accept the terms of the license by pointing their cursor and clicking to indicate that they accept the terms of the license prior to accessing a document containing CPT). Whenever publications containing CPT are used on the Internet, an end user agreement in the form of a point and click license is required. (See §20.7.6.4.) It is the MAC's option to use a point and click license prior to each document containing CPT codes, or before initial access to any pages containing CPT codes on the Web site section level. For example, the point and click license may be placed before the Local Medical Review Policies with the following statement:

> "Please read and accept the terms of the agreement below in order to proceed to the Policy Index and Policy Tests."

MAC may include additional terms in the point and click license as long as the additional terms do not conflict with these requirements.

MAC must use a point and click license before each downloaded file that contains CPT codes. See CMS' Web site as an example: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU14A.html.

The following statement must also appear on the Web page where the actual publication appears after the point and click license (e.g., as per https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html?redirect=/PhysicianFeeSched/).

> "**NOTE:** Should you have landed here as a result of a search engine (or other) link, be advised that these files contain material that is copyrighted by the American Medical Association. You are forbidden to download the files unless you read, agree to, and abide by the provisions of the copyright statement. Read the copyright statement now and you will be linked back to here."

Computer based training modules that function as software must include an embedded point and click license if the training material contains CPT codes, descriptions or CPT notes, and guidelines. The module must include a mechanism that requires the acceptance of the license before installation of the program.

For electronic media such as tapes, diskettes, and CD ROMs, MACs must include either a point and click license which can be embedded in the diskettes or CD-ROM and accepted by the requester before the requester can access the files or a shrink-wrap license (see §20.7.6.5.) Since a user does not sign a shrink-wrap license or take any other action like clicking acceptances as in the "point and click" license, a notice must be posted in a conspicuous location to encourage the reading of the agreement before opening the electronic media. The notice must read as follows:

> "Although this Publication is not copyrighted, it contains CPT, which is copyrighted by the American Medical Association (AMA). Carefully read the

following AMA terms and conditions before opening the Electronic Media Package. Opening this package acknowledges your acceptance of the AMA terms and conditions. If you do not agree with these provisions, you must, within a reasonable time, return the Electronic Media Package unused."

20.7.5 - Effective Dates for Compliance and Application of the Amendment

(Rev. 1, 10-01-03)

Compliance with this instruction is as follows:

- Any issued or revised LMRPs and other publications that are posted on a MAC's Web site must conform to the requirements of this instruction.

- Bulletins, and/or newsletters posted on a Web site prior to December 15, 2000, need NOT comply with this instruction as long as the applicable copyright notice is displayed.

- LMRPs and publications, other than bulletins or newsletters, posted on a Web site prior to December 15, 2000, must conform to these requirements.

- All end of year hard copy bulletins or newsletters that are issued containing the new, revised, or deleted CPT codes and long descriptions for the following new year must be edited to delete the long descriptions when putting these publications on a Web site.

- In no event may the publications be designed to substitute for the CPT book for any user.

MACs may not charge for distribution over the Internet for publications(s) that include over 30 percent of a section or subsection of CPT, except for training materials that include CPT distributed over the Internet may be distributed for no more than cost of the materials.

The amendment authorizes use of CPT only for purposes related to CMS programs. Electronic and Internet distribution of materials containing CPT codes and descriptions, notes, or guidelines that are unrelated to CMS programs, including but not limited to, incorporation of CPT into commercial products requires a separate license agreement with the AMA.

Upon written request by any MAC that entered into a prior agreement with the AMA regarding the use of CPT codes on their Medicare Web site, the AMA will cancel the agreement so that the MAC can follow the requirements of this instruction.

The AMA/CMS Amendment can be viewed at: https://www.cms.gov/apps/physician-fee-schedule/license-agreement.aspx

20.7.6 - Attachments for AMA-CMS CPT Agreement
(Rev. 1, 10-01-03)

20.7.6.1 - Attachment I - CPT 2000 and 2001 Section Counts
(Rev. 1, 10-01-03)

CPT 2002 Section Counts

Section	Code Range		Subsection	Code Count
	First	Last		
Evaluation and Management	99021	99499	Section Total	130
	99201	99215	Office or Other Outpatient Services	10
	99217	99220	Hospital Observation Services	4
	99221	99239	Hospital Inpatient Services	11
	99241	99275	Consultations	18
	99281	99288	Emergency Department Services	6
	99289	99290	Patient Transport	2
	99291	99292	Critical Care Services	2
	99295	99298	Neonatal Intensive Care	4
	99301	99316	Nursing Facility Services	8
	99321	99333	Domiciliary, Rest Home, Custodial Care Services	6
	99341	99350	Home Services	9
	99354	99360	Prolonged Services	7
	99361	99373	Case Management Services	5
	99374	99380	Care Plan Oversight Services	6
	99381	99429	Preventive Medicine Services	22
	99431	99440	Newborn Care	6

Section	Code Range		Subsection	Code Count
	First	Last		
	99450	99456	Special Evaluation and Management Services	3
	99499	99499	Other Evaluation and Management Services	1
Anesthesia	00100	01999	Section Total	259
	00100	00222	Head	30
	00300	00352	Neck	5
	00400	00474	Thorax (Chest Wall and Shoulder Girdle)	11
	00500	00580	Intrathoracic	20
	00600	00670	Spine and Spinal Cord	9
	00700	00797	Upper Abdomen	14
	00800	00882	Lower Abdomen	24
	00902	00952	Perineum	25
	01112	01190	Pelvis (Except Hip)	9
	01200	01274	Upper Leg (Except Knee)	15
	01320	01444	Knee and Popliteal Area	16
	01462	01522	Lower Leg (Below Knee, Includes Ankle and Foot)	14
	01610	01682	Shoulder and Axilla	15
	01710	01782	Upper Arm and Elbow	16
	01810	01860	Forearm, Wrist, and Hand	10
	01905	01933	Radiological Procedures	11

Section	Code Range		Subsection	Code Count
	First	Last		
	01951	01953	Burn Excisions or Debridement	3
	01960	01969	Obstetric	8
	01990	01999	Other Procedures	4
Surgery	10040	69990	Section Total	5073
	10021	10022	General	2
	10040	19499	Integumentary System	372
	20000	29999	Musculoskeletal System	1525
	30000	32999	Respiratory System	271
	33010	37799	Cardiovascular System	543
	38100	38999	Hemic and Lymphatic Systems	49
	39000	39599	Mediastinum and Diaphragm	18
	40490	49999	Digestive System	763
	50010	53899	Urinary System	302
	54000	55899	Male Genital System	143
	55970	55980	Intersex Surgery	2
	56405	58999	Female Genital System	180
	59000	59899	Maternity Care and Delivery	59
	60000	60699	Endocrine System	30
	61000	64999	Nervous System	449
	65091	68899	Eye and Ocular Adnexa	267
	69000	69979	Auditory System	97
	69990	69990	Operating Microscope	1

Section	Code Range		Subsection	Code Count
	First	Last		
Radiology	70010	79999	Section Total	674
	70010	76499	Diagnostic Radiology (Diagnostic Imaging)	397
	76506	76999	Diagnostic Ultrasound	51
	77261	77799	Radiation Oncology	67
	78000	79999	Nuclear Medicine	159
Pathology and Laboratory	80048	89399	Section Total	1156
	80048	80090	Organ or Disease Oriented Panels	10
	80100	80103	Drug Testing	4
	80150	80299	Therapeutic Drug Assays	32
	80400	80440	Evocative/Suppression Testing	24
	80500	80502	Consultations (Clinical Pathology)	2
	81000	81099	Urinalysis	11
	82000	84999	Chemistry	427
	85002	85999	Hematology and Coagulation	100
	86000	86849	Immunology	177
	86850	86999	Transfusion Medicine	38
	87001	87999	Microbiology	185
	88000	88099	Anatomic Pathology	16
	88104	88199	Cytopathology	31
	88230	88299	Cytogenetic Studies	27

Section	Code Range		Subsection	Code Count
	First	Last		
	88300	88399	Surgical Pathology	32
	88400	88400	Transcutaneous Procedures	1
	89050	89399	Other Procedures	39
Medicine	90281	99199	Section Total	793
	90281	90399	Immune Globulins	18
	90471	90474	Immunization Administration for Vaccines/Toxoids	4
	90476	90749	Vaccines, Toxoids	58
	90780	90781	Therapeutic or Diagnostic Infusions	2
	90782	90799	Therapeutic, Prophylactic or Diagnostic Infusions	5
	90801	90899	Psychiatry	44
	90901	90911	Biofeedback	2
	90918	90999	Dialysis	18
	91000	91299	Gastroenterology	19
	92002	92499	Ophthalmology	64
	92502	92599	Special Otorhinolaryngologic Services	65
	92950	93799	Cardiovascular	152
	93875	93990	Non-Invasive Vascular Diagnostic Studies	22
	94010	94799	Pulmonary	44
	95004	95199	Allergy and Clinical Immunology	34

Section	Code Range		Subsection	Code Count
	First	Last		
	95250	95250	Endocrinology	1
	95805	96004	Neurology and Neuromuscular Procedures	73
	96100	96117	Central Nervous System Assessments/Tests	6
	96150	96155	Health and Behavior Assessment/Intervention	6
	96400	96549	Chemotherapy Administration	19
	96567	96571	Photodynamic Therapy	3
	96900	96999	Special Dermatological Procedures	6
	97001	97799	Physical Medicine and Rehabilitation	47
	97802	97804	Medical Nutrition Therapy	3
	98925	98929	Osteopathic Manipulative Treatment	5
	98940	98943	Chiropractic Manipulative Treatment	4
	99000	99091	Special Services, Procedures and Reports	18
	99100	99140	Qualifying Circumstances for Anesthesia	4
	99141	99142	Sedation With or Without Analgesia	2
	99170	99199	Other Services and Procedures	12
	99500	99539	Home Health Procedures/Services	14
	99551	99569	Home Infusion Procedures	19

Section	Code Range		Subsection	Code Count
	First	Last		
Category III Codes	0001T	00026T	Section Total	22
Total				8107

20.7.6.2 - Attachment II - Example: CPT Long Descriptions Incorporated Into Narrative

(Rev. 1, 10-01-03)

Dialysis Shunt Maintenance Revised Medical Policy

CPT CODES

35475, 35476, 35903, 36005, 36140,36145, 36215, 36216, 36217, 35245, 36246, 36247, 36489, 36491, 36535, 36800, 36810, 36815, 36821, 36825, 36830, 36831, 36832, 36833, 36834, 36835, 36860, 36861, 37201, 37202, 37205, 37206, 37207, 37208, 37607, 37799, 75710, 75820, 75896, 75898, 75960, 75962, 75964, 75978, 76499, and 93900

Indications and Limitation of Coverage and/or Medical Necessity

Percutaneous interventions to enhance or reestablish patency of a hemodialysis AV fistula have proven useful in extending the life of the fistula and reducing the need for open repair, reconstruction, or replacement. The longevity and quality of the life of the end stage renal disease (ESRD) patient are positively impacted. Covered services are only indicated to correct a physiologically and functionally significant deficit of shunt performance. Percutaneous AV fistula declotting, maintenance, or reestablishment of appropriate and adequate flow may encompass the following procedures. These need not all be performed on every dysfunctional shunt. Each may, under unique circumstances, be considered reasonable and medically necessary.

Open surgical therapy for thrombosed dialysis cannula or hemodynamically significant flow impediment utilizes direct access to the conduit and contiguous vessels. Mechanical fragmentation and surgical removal of occlusive thrombotic material is effected under direct visualization. Adjunctive thrombolytic pharmacotherapy may be employed. Residual vascular stenoses or obstructive lesions are removed and corrected using standard vascular surgical techniques; “e.g., CPT Code 36832, Revision, arteriovenous fistula; without thrombectomy, autogenous or non-autogenous dialysis graft (separate procedure). 36834, Plastic repair arteriovenous aneurysm (separate procedure).”

20.7.6.3 - Attachment III Examples of Formats With CPT and Non-CPT Information
(Rev. 1, 10-01-03)

20.7.6.3.1 - Example 1: Separation of CPT and Non-CPT Information
(Rev. 1, 10-01-03)

Consultations

CPT CODES: 99241-99243, 99244-99255

The CMS concurs with American Medical Association "Current Procedural Terminology (CPT)" guidelines related to physician reporting of inpatient and outpatient consultation services 99241-99243, 99244-99255:

99241 Office consultation for a new or established patient, which requires these three key components:

- a problem focused history;
- a problem focused examination; and
- straightforward medical decision making

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

99242 Office consultation for a new or established patient, which requires these three key components:

- an expanded problem focused history;
- an expanded problem focused examination; and
- straightforward medical decision making

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

The CMS will pay a consultation fee when the service is provided by a physician at the request of the patient's attending physician when:

- All of the criteria for the use of a consultation code are met;
- The consultation is followed by treatment;
- The consultation is requested by members of the same group practice;
- The documentation for consultations has been met (written request from an appropriate source and a written report furnished the requesting physician);
- Pre-operative consultation for a new or established patient performed by any physician at the request of the surgeon; and
- A surgeon requests that another physician participate in post-operative care (provided that the physician did not perform a pre-operative consultation).

20.7.6.3.2 - Example 2: Distinguishing CPT and HCPCS Codes - Notes and Guidelines

(Rev. 1, 10-01-03)

Issues Related to Critical Care Policy and Use of the Critical Care CPT codes 99291 and 99292

A. Definition of Critical Illness or Injury

The AMA's CPT has redefined a critical illness or injury as follows:

> "A critical illness or injury acutely impairs one or more vital organ systems such that the patient's survival is jeopardized."

Please note that the term "unstable" is no longer used in the CPT definition to describe critically ill or injured patients.

B. Definition of Critical Care Services

The CPT 2000 has redefined critical care services as follows:

> "Critical care is the direct delivery by a physician(s) of medical care for a critically ill or injured patient...the care of such patients involves decision making of high complexity to assess, manipulate, and support central nervous system failure, circulatory failure, shock-like conditions, renal, hepatic, metabolic, or respiratory failure, postoperative complications, overwhelming infection, or other vial system functions to treat single or multiple vital organ system failure or to prevent further deterioration. It may require extensive interpretation of multiple databases and application of advanced technology to manage the patient. Critical care may be

provided on multiple days, even if no changes are made in the treatment rendered to the patient, provided that the patient's condition continues to require the level of physician attention described above.

"Critical care services include but are not limited to, the treatment or prevention of further deterioration of central nervous system failure, circulatory failure, shock-like conditions, renal, hepatic, metabolic or respiratory failure, post operative complications, or overwhelming infection. Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, pediatric intensive care unit, respiratory care unit, or the emergency care facility."

C. Guidelines for Use Whenever Medical Review is Performed in Relation to Critical Illness and Critical Care Service

A clarification of Medicare policy concerning both payment for and medical review of critical care services is warranted, given the CPT redefinition of both critical illness/injury and critical care services.

In order to reliably and consistently determine that delivery of critical care services rather than other evaluation and management services is medically necessary, both of the following medical review criteria must be met in addition to the CPT definitions.

Clinical Condition Criterion

There is a high probability of sudden, clinically significant, or life threatening deterioration in the patient's condition which requires the highest level of physician preparedness to intervene urgently.

Treatment Criterion

Critical care services require direct personal management by the physician. They are life and organ supporting interventions that require frequent, personal assessment and manipulation by the physician. Withdrawal of, or failure to initiate these interventions on an urgent basis would likely result in sudden, clinically significant, or life threatening deterioration in the patient's condition.

Claims for critical care services must be denied if the services are not reasonable and medically necessary. If the services are reasonable and medically necessary but they do not meet the criteria for critical care services, then the services should be re-coded as another appropriate evaluation and management (E/M) service (e.g., hospital visit).

Providing medical care to a critically ill patient should not be automatically determined to be a critical care service for the sole reason that the patient is critically ill. The physician service must be medically necessary and meet the definition of critical care services as described previously in order to be covered.

20.7.6.3.3 - Example 3: Separation of CPT and Non-CPT Codes and Short Descriptions in a Fee Schedule or Similar Listing

(Rev. 1, 10-01-03)

REVISED 2000 NATIONAL PHYSICIAN FEE SCHEDULE RELATIVE VALUE FILE

HCPCS/CPT	Description	Status Code	Work RVU
10040	Acne surgery of skin abscess	A	1.18
10060	Drainage of skin abscess	A	1.17
10061	Drainage of skin abscess	A	2.4
10080	Drainage of pilonidal cyst	A	1.17
10081	Drainage of pilonidal cyst	A	2.45
10120	Remove foreign body	A	1.22
10121	Remove foreign body	A	2.69
10140	Drainage of hematoma/fluid	A	1.53
10160	Puncture drainage of lesion	A	1.2
10180	Complex drainage, wound	A	2.25
11000	Debride infected skin	A	0.6
11001	Debride infected skin add-on	A	0.3
11010	Debride skin, fx	A	4.2
11011	Debride skin/muscle, fx	A	4.95
11012	Debride skin/muscle/bone, fx	A	6.88
11040	Debride skin, partial	A	0.5

HCPCS/CPT	Description	Status Code	Work RVU
11041	Debride skin, full	A	0.82
11042	Debride skin/tissue	A	1.12
11043	Debride tissue/muscle	A	2.38
11044	Debride tissue/muscle/bone	A	3.06
11055	Trim skin lesion	R	0.27
11056	Trim skin lesions, 2 to 4	R	0.39
11057	Trim skin lesions, over 4	R	0.5
11100	Biopsy of skin lesion	A	0.81
11101	Biopsy, skin add-on	A	0.41
11200	Removal of skin tags	A	0.77
V5299	Hearing service	R	0
V5336	Repair communication device	N	0
V5362	Speech screening	R	0
V5363	Language screening	R	0
V5364	Dysphagia screening	R	0

(Example shows separation of CPT codes from alpha-numeric codes)

20.7.6.4 - Attachment IV - License for Use of "Physicians' Current Procedural Terminology" (CPT) Fourth Edition

(Rev. 1, 10-01-03)

End User/Point and Click Agreement

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ACCEPT	DO NOT ACCEPT

20.7.6.5 - Attachment V - License for Use of "Physicians' Current Procedural Terminology" (CPT) Fourth Edition - (Shrink-Wrap License)

(Rev. 1, 10-01-03)

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20.7.7 - Reserved for Future Use
(Rev. 43, 12-19-03)

20.7.8 - Reserved for Future Use
(Rev. 43, 12-19-03)

20.7.9 - Reserved for Future Use
(Rev. 43, 12-19-03)

20.7.10 - Displaying Material With CDT Codes
(Rev. 323, Issued: 10-22-04, Effective: 08-01-04, Implementation: 11-22-04)

This section provides the criteria that must be followed in using CDT codes on MAC Web sites and other electronic media. The agreement and the subsequent amendments follow the format of the CMS/American Medical Association (AMA) Amendment. The actual ADA/CMS License Agreement can be viewed by going to https://www.cms.gov/medicare-coverage-database/license/cpt-license.aspx.

The following is a summation of the criteria contained in the ADA/CMS amendments.

- The ADA has developed a publication entitled Current Dental Terminology, (CDT), for use in dental offices for purposes of keeping patient records, reporting procedures on patients, and processing dental insurance claims.

- The ADA owns all rights, title, and interest (including all copyrights and other intellectual property rights) in CDT. The CMS, as a licensee of CDT, has no proprietary interest in CDT.

- The CMS has agreed that in using CDT codes, its Entities must place the copyright notice on certain materials that contain CDT and on certain printouts of CDT nomenclature and descriptors. The copyright notice may not be removed or obscured. On any printouts containing a portion of CDT, the parts of CDT must be identified as belonging to the ADA.

The CMS entities have the authority to include CDT codes, nomenclature, and descriptors on their web sites, and electronic media in the following documents:

- Local medical review policies (LMRP);
- Bulletins/newsletters;
- CMS Manual System and billing instructions;

- Coverage and coding policies;
- Program Integrity bulletins and correspondence;
- Educational/training materials;
- Special mailings containing information that would otherwise be included in the aforementioned publications but, due to time constraints require expedited handling;
- Fee schedules;
- Program/policy handbooks or manuals; and
- Computer-based training materials.

The above types of documents should be designed to convey Medicare specific information to providers and others in the program and not CDT coding advice. Documents should not be designed to substitute for the CDT book with respect to CDT codes, "nomenclature," "descriptors," notes, and/or guidelines for any user.

Document(s), when sent by entities to other Federal and State agencies, must include a statement advising the requesting agency that the documents contain CDT, which is copyrighted, and that use of CDT is governed by a licensing agreement with the ADA.

Entities may use CDT descriptors in the above identified documents, provided that use of the CDT descriptors does not exceed 15 percent of the total number of CDT descriptors in the defined Category of Service, e.g., Restorative. The 15 percent limitation on the use of CDT descriptors shall not apply if the subsection of CDT has less than 15 CDT codes. There may be other circumstances where the ADA may waive the 15 percent rule. The ADA and CMS will address requests for waivers on a case-by-case basis. The ADA will respond in writing to any requests for waivers.

The use of CDT is authorized only for purposes related to participating in CMS programs. Organizations or entities that wish to use CDT for other purposes must obtain a license agreement from the ADA. Distribution of materials containing CDT codes or descriptions that are unrelated to CMS programs or incorporate CDT into commercial products requires a separate license agreement with the ADA.

NOTE: CMS Medicaid entities use CDT codes more extensively than CMS MACs. However, since this agreement and its amendments apply to CMS entities, we wanted to make sure you are aware of the ADA criteria in using CDT codes on your Web sites and in other electronic media.

20.7.11 - Use of CDT Nomenclature and Descriptors

(Rev. 323, Issued: 10-22-04, Effective: 08-01-04, Implementation: 11-22-04)

CDT "nomenclature" is defined as CDT five-character alphanumeric code numbers and abbreviated procedural descriptions which are typeset in bold in the ADA’s CDT Users Manual. CDT "descriptors" are defined as CDT five-character alphanumeric code numbers, nomenclature, and procedural descriptions that include the complete procedural description.

EXAMPLE: CDT Code Nomenclature

D0102 - Periodic oral evaluation

EXAMPLE: CDT Code Descriptor

D0102 - An evaluation performed on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately.

For the purposes of calculating the amount of "use" of CDT descriptors as permitted, each distinct document is evaluated separately.

Fee schedules can include CDT codes and nomenclature but not CDT descriptors.

See Exhibit I for examples of formats that can be used to display CDT as directed in the Amendment.

20.7.12 - Required Notices
(Rev. 43, 12-19-03)

20.7.12.1 - ADA Copyright Notice
(Rev. 323, Issued: 10-22-04, Effective: 08-01-04, Implementation: 11-22-04)

The following copyright notice shall appear on the screen or Web page including or immediately prior to the initial appearance or display of any CDT codes:

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The term of this license agreement shall begin on October 22, 2003, and continue until terminated by either party (ADA or CMS). Either party may terminate this License Agreement by providing 60 days prior written notice to the other party.

The grant of this license is being provided at no charge to CMS or its entities.

The ADA reserves the right to modify or change CDT at any time.

20.7.12.2 - Point and Click License, and Shrink Wrap License
(Rev. 323, Issued: 10-22-04, Effective: 08-01-04, Implementation: 11-22-04)

When selected parts of CDT are made available by CMS Entities on Internet Web sites or electronic media, a "point and click" license must be used. This point and click license is similar to the one used when displaying the AMA CPT codes. Point and click license means a license that appears on a computer screen or Web page and includes a computer program or Web page mechanism that requires users to indicate whether they accept the terms of the license by pointing their cursor and signaling, by clicking, that they accept the terms of the license prior to access to CDT. An example of the point and click license is attached (see Exhibit II).

The point and click license must appear before initial access to any CDT containing pages at the entities' Web site (i.e., before a section of bulletins or LMRPs) or prior to each document at the entity's option and before each file download containing CDT.

You must include a point and click license in any electronic media that you distribute to users outside of your organization if such electronic media contains any documentation that includes CDT. However, electronic media containing a limited number of CDT codes (i.e., 6 CDT codes) need not contain a point and click notice. As in the AMA/CMS Amendment, if you are unable to use a point and click license in electronic media that you distribute to users outside your organization, you may use a shrink-wrap license. An example of the shrink-wrap license is attached (see Exhibit III).

E-mail communications containing a limited reference to CDT (e.g., 6 CDT codes) need not contain the copyright notice.

20.7.13 - Exhibits for ADA-CMS Agreement
(Rev. 43, 12-19-03)

20.7.13.1 - Exhibit I - Samples of CDT Nomenclature and Descriptors
(Rev. 323, Issued: 10-22-04, Effective: 08-01-04, Implementation: 11-22-04)

Sample CDT Descriptor in a Document

Guidelines for administering the dental benefit - Diagnostic Procedures

Clinical oral evaluations are covered diagnostic procedures that must be distinguished from preventive (e.g., dental prophylaxis) procedures. The following CDT procedure code is most common.

Periodic evaluation is an eligible procedure. Benefits are limited to twice annually for each covered member. The date of service should be the actual date of the examination.

*** D0120 Periodic oral evaluation**

An evaluation performed on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This includes periodontal screening and may require interpretation of information acquired

through additional diagnostic procedures. Report additional diagnostic procedures separately.

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Sample CDT Nomenclature In A Fee Schedule
Revised 2003 National Dental Diagnostic Procedures Fee Schedule

* CDT Code	* Nomenclature	Scheduled Amount
D0120	Periodic oral evaluation	40
D0140	Limited oral evaluation-problem focused	50
D0150	Comprehensive oral evaluation-new or established patient	65
D0160	Detailed and extensive oral evaluation - problem focused, by report	100
D0210	Intraoral-complete series (including bitewings)	95
D0220	Intraoral - periapical first film	22
D0230	Intraoral - periapical each additional film	15
D0272	Bitewings - two films	35
D0274	Bitewings - four films	49

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20.7.13.2 - Exhibit II - Point and Click License
(Rev. 323, Issued: 10-22-04, Effective: 08-01-04, Implementation: 11-22-04)

POINT AND CLICK LICENSE FOR USE OF "CURRENT DENTAL TERMINOLOGY", ("CDT")

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20.7.13.3 - Exhibit III - Shrink Wrap License

(Rev. 323, Issued: 10-22-04, Effective: 08-01-04, Implementation: 11-22-04)

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20.8 - Payment, Utilization Review (UR), and Coverage Information on CMS Annual HCPCS Codes Update File

(Rev. 1, 10-01-03)

The file CMS provides for the annual update of HCPCS codes contains fields for payment, UR, and coverage information to assist in developing front-end edit screens. Coverage information is not all inclusive, but should be used mainly as a guide in establishing specific review limits. A/B MACs (B) must establish reasonable developmental guidelines, review screens, and relative value units, as appropriate. A/B MACs (B) must assure that their system processes claims in accordance with CMS policies and procedures, including changes that may occur between HCPCS codes updates. Where CMS determines that nationally uniform temporary codes/modifiers are needed to implement policy/legislation between HCPCS codes updates, the codes/modifiers, definitions and policy are issued by CO as Level II codes/modifiers prefixed with "Q" or "K" or "G." Questions may arise in updating that require A/B MAC (B) staff to refer to a physician's or supplier's pricing history. Therefore, keep an electronic backup of HCPCS codes for the two prior years with linkages to pricing profiles. Perform required computer analysis as necessary.

The HCPCS terminology seldom includes a place of service designation. Where place of service affects pricing, pricing is obtained from the place of service field on the claim record.

A/B MACs (A) and (HHH) also develop editing screens using HCPCS based on payment and coverage policies from CMS. A/B MACs (A) and (HHH) must assure that system claims processing complies with CMS policy and procedures.

20.9 - National Correct Coding Initiative (CCI)

(Rev. 4465; Issued: 11-15-19, Effective: 01-30-19, Implementation: 01-30-19)

The CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. The CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT manual, CMS 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. An overview of the NCCI Program for both the Procedure-to-Procedure (PTP), Medically Unlikely Edits (MUE), Add-on Code Edits and additional information sources can be found on the following CMS NCCI Website
https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

The National Correct Coding Initiative Policy Manual for Medicare Services (also known as the Coding Policy Manual) shall be utilized by Medicare Administrative Contractors (MACs) as a general reference tool that explains the rationale for NCCI edits.

The purpose of the NCCI Procedure-to-Procedure (PTP) edits is to prevent improper payment when incorrect code combinations are reported. The NCCI contains one table of edits for physicians/practitioners and one table of edits for outpatient hospital services. The Column One/Column Two Correct Coding Edits table and the Mutually Exclusive Edits table have been combined into one table and include PTP code pairs that should not be reported together for a number of reasons explained in the Coding Policy Manual.

The purpose of the NCCI MUE program is to prevent improper payments when services are reported with incorrect units of service. The CMS developed Medically Unlikely Edits (MUEs) to reduce the paid claims error rate for Part B claims. An MUE for a Healthcare Common Procedure Coding System (HCPCS)/ Current Procedural Terminology (CPT) code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service.

An add-on code is a HCPCS/CPT code that describes a service that**, with one exception (see CR7501 for details),** is always performed in conjunction with another primary service. An add-on code **with one exception** is eligible for payment only if it is reported with an appropriate primary procedure performed by the same practitioner. An add-on code **with one exception** is never eligible for payment if it is the only procedure reported by a practitioner.

The Correspondence Language Manual for Medicare Services available on the CMS Web site has been written and maintained for utilization by the Medicare Contractors to answer routine correspondence inquiries about the NCCI procedure- to- procedure (PTP) and MUE edits. The general correspondence language paragraphs explain the rationale for the edits. The section-specific examples add further explanation to the PTP or MUE edits and are sorted by edit rationale and HCPCS/CPT code section (00000, 10000, 20000, etc.). Please refer to the Introduction of the Correspondence Language Manual for additional guidance about its use.

Inquiries about the NCCI program, including those related to NCCI (PTP, MUE and Add-On Code) edits, should be sent to the following email address: NCCIPTPMUE@cms.hhs.gov.

20.9.1 - Correct Coding Modifier Indicators and HCPCS Codes Modifiers

(Rev. 4465; Issued: 11-15-19, Effective: 01-30-19, Implementation: 01-30-19)

The National Correct Coding File Formats continue to include a Correct Coding Modifier Indicator (CCMI) for the Column One/ Column Two Correct Coding edit file. This indicator determines whether an NCCI-associated modifier causes the code pair to bypass the edit. The CCMI will be either a “0,” “1,” or a “9.” The definitions of each are:

0 = an NCCI-associated modifier is not allowed and will not bypass the edit.

1 = an NCCI-associated modifier is allowed and will bypass the edit.

9 = The use of NCCI-associated modifiers is not specified. This indicator is used for all code pairs that have a deletion date that is the same as the effective date. This indicator was created so that no blank spaces would be in the indicator field.

20.9.1.1 - Instructions for Codes With Modifiers (A/B MACs (B) Only)

(Rev. 4465; Issued: 11-15-19, Effective: 01-30-19, Implementation: 01-30-19)

A. General

MACs subject all line items for the same beneficiary, same NPI, and same date of service to NCCI edits.

All line items for the same beneficiary, same NPI, and same date of service shall be subject to NCCI procedure-to-procedure (PTP) edits. If the CCMI of a PTP edit is "0", the column two code is not eligible for payment even if an NCCI-associated modifier is appropriately appended to one of the codes. If the CCMI of a PTP edit is "1", the edit may be bypassed and the column two code of the edit may be eligible for payment if an NCCI-associated modifier is appropriately appended to one of the codes. If the two codes of a code pair edit have the same NCCI-associated anatomic modifiers, the edit should not be bypassed unless an additional NCCI-associated modifier is appended to one of the codes indicating the reason to bypass the edit.

The use of modifiers that are not NCCI-associated modifiers shall not bypass an NCCI PTP edit.

NCCI-associated modifiers are the following:

Anatomic modifiers: E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD, RC, LM, RI
Global surgery modifiers: 24, 25, 57, 58, 78, 79
Other modifiers: 27, 59, 91, XE, XS, XP, XU

B. Modifier "-59"

Modifier 59 and other NCCI-associated modifiers shall NOT be used to bypass a PTP edit unless the proper criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier that is used. Find further information on Modifier 59 in the Coding Policy Manual available on the CMS website.

Examples of appropriate use of the "-59" modifier can be found in the Modifier 59 Article, https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Downloads/modifier59.pdf

1. Modifier 59 is used appropriately for different anatomic sites during the same encounter only when procedures are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ.

2. Modifier 59 is used appropriately when the procedures are performed in different encounters on the same day.

3. Modifier 59 is used inappropriately if the basis for its use is that the narrative description of the two codes is different.

4. Other specific appropriate uses of modifier 59

There are three other limited situations in which two services may be reported as separate and distinct because they are separated in time and describe non-overlapping services even though they may occur during the same encounter.

a. Modifier 59 is used appropriately for two services described by timed codes provided during the same encounter only when they are performed sequentially. There is an appropriate use for modifier 59 that is applicable only to codes for which the unit of service is a measure of time (e.g., per 15 minutes, per hour). If two-timed services are provided in blocks of time that are separate and distinct (i.e., the same time block is not used to determine the unit of service for both codes), modifier 59 may be used to identify the services.

b. Modifier 59 is used appropriately for a diagnostic procedure, which precedes a therapeutic procedure only when the diagnostic procedure is the basis for performing the therapeutic procedure. When a diagnostic procedure precedes a surgical procedure or non-surgical therapeutic procedure and is the basis on which the decision to perform the surgical procedure is made, that diagnostic test may be considered to be a separate and distinct procedure as long as (a) it occurs before the therapeutic procedure and is not interspersed with services that are required for the therapeutic intervention; (b) it clearly provides the information needed to decide whether to proceed with the therapeutic procedure; (c) it does not constitute a service that would have otherwise been required during the therapeutic intervention; and d) it is not specifically prohibited. If the diagnostic procedure is an inherent component of the surgical procedure, it should not be reported separately.

c. Modifier 59 is used appropriately for a diagnostic procedure, which occurs subsequent to a completed therapeutic procedure only when the diagnostic procedure is not a common, expected, or necessary follow-up to the therapeutic procedure. When a diagnostic procedure follows the surgical procedure or non-surgical therapeutic procedure, that diagnostic procedure may be considered to be a separate and distinct procedure as long as (a) it occurs after the completion of the therapeutic procedure and is not interspersed with or otherwise commingled with services that are only required for the therapeutic intervention, and (b) it does not constitute a service that would have otherwise been required during the therapeutic intervention. If the post-procedure diagnostic procedure is an inherent component or otherwise included (or not separately payable) post-procedure service of the surgical procedure or non-surgical therapeutic procedure, it should not be reported separately.

Use of modifier 59 does not require a different diagnosis for each HCPCS/CPT coded procedure. Conversely, different diagnoses are not adequate criteria for use of modifier 59.

Modifier “-59” shall not be used with the following codes:

77427 Radiation treatment management, five treatments

Evaluation and management services

When a provider submits a claim for any of the codes specified above with the "-59" modifier, the A/B MAC must process the claim as if the modifier were not present. In addition to those messages specified in §20.9.A above, A/B MACs shall convey additional messaging.

C. Modifier "-91"

Modifier 91 may be appended to laboratory procedure(s) or service(s) to indicate a repeat test or procedure on the same day when appropriate. This modifier indicates to the Medicare contractors that the physician had to perform a repeat clinical diagnostic laboratory test that was distinct or separate from a lab panel or other lab services performed on the same day, and was performed to obtain medically necessary subsequent reportable test values. This modifier must not be used to report repeat laboratory testing due to laboratory errors, quality control, or confirmation of results.

For example, if a laboratory performs all tests included in a panel of laboratory tests and repeats one of these component tests as a medically reasonable and necessary service on the same date of service, the HCPCS code corresponding to the repeat laboratory test may be reported with modifier 91 appended.

D. Reserved for future use

E. Coding for Noncovered Services and Services Not Reasonable and Necessary

For information on this topic, see the Claims Processing Manual Chapter 1 and MLN Booklet: Medicare Advance Written Notices of Noncoverage ICN 006266 https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/abn_booklet_icn006266.pdf

Use of the A9270

A9270, Noncovered item or service, will not be accepted under any circumstances for services or items billed to A/B MACs. However, in cases where there is no specific procedure code for an item or supply and no appropriate NOC code available, the A9270 must continue to be used by suppliers to bill DME MACs for statutorily non-covered items or supplies and items or supplies that do not meet the definition of a Medicare benefit.

Claims Processing Instructions

At A/B MAC and DME MAC discretion, claims submitted using the GY modifier may be auto-denied. If the GZ and GA modifiers are submitted for the same item or service, treat the item or service as having an invalid modifier and therefore unprocessable.

Effective for dates of service on and after July 1, 2011, A/B MACs shall automatically deny claim line(s) items submitted with a GZ modifier. A/B MACs shall not perform complex medical review on claim line(s) items submitted with a GZ modifier. All MACs shall make all language published in educational outreach materials, articles, and on their

Web sites, consistent to state all claim line(s) items submitted with a GZ modifier shall be denied automatically and will not be subject to complex medical review.

20.9.2 - Reserved for future use
(Rev. 4465; Issued: 11-15-19, Effective: 01-30-19, Implementation: 01-30-19)

20.9.3 - Appeals
(Rev. 1, 10-01-03)

When a request for review is received as a result of an initial determination based on a correct coding initiative edit, and after determining that the reviews were coded correctly, the reviewer must come to the same conclusion as the initial determination (i.e., the review does not result in an increase in payment). If the review determines that a correct coding modifier not submitted with the initial claim could have been appended to either code of an edit code pair, the reviewer may change the initial determination only if the correct coding initiative edit has a modifier indicator of "1." If the correct coding initiative edit modifier indicator is a "0," the reviewer must come to the same conclusion as the initial determination. If the conclusion is the same as the initial determination, the review determination must repeat the generic language that appears in the MSN or remittance advice notice pertaining to the correct coding edit. In addition, A/B MACs (B) must include the more detailed explanation of the correct coding initiative edit which can be found in the standard correspondence language for A/B MACs (B) in the Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 1.

20.9.3.1- Procedure-to-Procedure Edits
(Rev. 4465; Issued: 11-15-19, Effective: 01-30-19, Implementation: 01-30-19)

All PTP edits have a "Correct Coding Modifier Indicator" (CCMI).

A denial of services due to a PTP edit is a coding denial, not a medical necessity denial. The presence of an Advance Beneficiary Notice (ABN) shall not shift liability to the beneficiary for UOS denied based on a PTP.

PTP edits with a CCMI of "0":

On appeal, if the CCMI is a "0", and the provider coded the claim correctly, there are no circumstances in which both procedures of the PTP code pair should be paid for the same beneficiary on the same day by the same provider. If the reviewer determines that the claim was coded incorrectly then, the review determination must repeat the generic language that appears in the MSN or remittance advice notice pertaining to the NCCI edit. In addition, MACs must include the more detailed explanation of the NCCI edit, which can be found in the standard correspondence language for MACs in the Correspondence Language Manual for Medicare Services.

PTP edits with a CCMI of "1":

On appeal, if the correct coding initiative edit modifier indicator is a “1”, the reviewer must determine whether the claim was coded correctly. For example, the reviewer should determine whether the provider reported an incorrect code, a medically unnecessary service, or simply neglected to use a modifier. The reviewer may change the initial determination only if the correct coding initiative edit has a modifier indicator of “1” and the reviewer determines that an NCCI-associated modifier could have been appended to either code of a correctly coded edit code pair. If the reviewer determines that the claim was coded incorrectly then, the review determination must repeat the generic language that appears in the MSN or remittance advice notice pertaining to the NCCI edit. In addition, MACs must include the more detailed explanation of the NCCI edit, which can be found in the standard correspondence language for MACs in the Correspondence Language Manual for Medicare Services.

20.9.3.2 Medically Unlikely Edits

All HCPCS codes with MUE values have an “MUE adjudication indicator” or “MAI”.

MUEs for HCPCS codes with an MAI of “1”:

MUEs for HCPCS codes with an MAI of “1” will be adjudicated as a claim line edit.

MUEs for HCPCS codes with an MAI of “2”:

MUEs for HCPCS codes with an MAI of “2”: MUEs for HCPCS codes with an MAI of “2” are absolute date of service edits. These are “per day edits based on policy”. HCPCS codes with an MAI of “2” have been rigorously reviewed and vetted within CMS and obtain this MAI designation because UOS on the same date of service (DOS) in excess of the MUE value would be considered contrary to statute, regulation, or subregulatory guidance. Subregulatory guidance includes clear correct coding policy that is binding on both providers and the MACs. As stated in CR 8853, while Qualified Independent Contractors (QICs) are not bound by subregulatory guidance, they should understand the policy nature of the MAI “2” indicator when considering whether to pay UOS in excess of the MUE value if claim denials based on these edits are appealed.

Limitations created by anatomical or coding restrictions are incorporated in correct coding policy, both in the Health Insurance Portability & Accountability Act of 1996 (HIPAA) mandated coding descriptors and CMS approved coding guidance as well as specific guidance in CMS and National Correct Coding Initiative Policy manuals. For example, it would be contrary to correct coding policy to report more than one unit of service for "ventilation assist and management . . . initial day" because such usage could not accurately describe two initial days of management occurring on the same DOS as would be required by the code descriptor.

CMS establishes edits with an MAI of 2 based directly on regulation, statute or subregulatory guidance.

MUEs for HCPCS codes with an MAI of “3”:

MUEs for HCPCS codes with an MAI of “3” are date of service edits. These are “per day edits based on clinical benchmarks”. If claim denials based on these edits are appealed, MACs may pay UOS in excess of the MUE value if there is adequate documentation of medical necessity of correctly reported units. If MACs have pre-payment evidence (e.g. medical review) that UOS in excess of the MUE value were actually provided, were correctly coded, and were medically necessary, the MACs may bypass the MUE for a HCPCS code with an MAI of “3” during claim processing, reopening, or redetermination, or in response to effectuation instructions from a reconsideration or higher level appeal.

General Instructions on MUEs

• MUEs are set high enough to allow for medically likely daily frequencies of services provided in most settings. Because MUEs are based on current coding instructions and practices, MUEs are prospective edits applicable to the time period for which the edit is effective. A change in an MUE is not retroactive and has no bearing on prior services unless specifically updated with a retroactive effective date. In the unusual case of a retroactive MUE change, MACs are not expected to identify claims but should reopen impacted claims that providers or suppliers bring to their attention.

• Since MUEs are auto-deny edits, denials may be appealed. Appeals shall be submitted to the appropriate MAC not the NCCI/MUE contractor. MACs adjudicating an appeal for a claim denial for a HCPCS code with an MAI of “1” or “3” may pay correctly coded correctly counted medically necessary UOS in excess of the MUE value.

• A denial of services due to an MUE is a coding denial, not a medical necessity denial. The presence of an Advance Beneficiary Notice (ABN) shall not shift liability to the beneficiary for UOS denied based on an MUE. If during reopening or redetermination medical records are provided with respect to an MUE denial for an edit with an MAI of “3”, MACs will review the records to determine if the provider actually furnished units in excess of the MUE, if the codes were used correctly, and whether the services were medically reasonable and necessary. If the units were actually provided but one of the other conditions is not met, a change in denial reason may be warranted (for example, a change from the MUE denial based on incorrect coding to a determination that the item/service is not reasonable and necessary under section 1862(a)(1)). This may also be true for certain edits with an MAI of “1.” CMS interprets the notice delivery requirements under Section1879 of the Social Security Act (the Act) as applying to situations in which a provider expects the initial claim determination to be a reasonable and necessary denial. Consistent with NCCI guidance, denials resulting from MUEs are not based on any of the statutory provisions that give liability protection to beneficiaries under section 1879 of the Social Security Act. Thus, ABN issuance based on an MUE is NOT appropriate. A provider/ supplier may not issue an ABN in connection with services denied due to an MUE and cannot bill the beneficiary for units of service denied based on an MUE.

• If a procedure is performed bilaterally and the HCPCS code descriptor does not state that it is a unilateral or bilateral procedure, report bilateral surgical procedures on a single claim line with modifier 50 and one (1) UOS. For specific instructions for Ambulatory Surgical Centers, refer to Chapter 14, Section 40.5 of the "Medicare Claims Processing Manual" at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c14.pdf on the CMS website. When modifier -50 is required by manual or coding instructions, claims submitted with two lines or two units and anatomic modifiers will be denied for incorrect coding. MACs may reopen or allow resubmission of those claims in accordance with their policies and with the policy in Chapter 34, Section 10.1, of the "Medicare Claims Processing Manual" at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c34.pdf on the CMS website. Clerical errors (which include minor errors and omissions) may be treated as reopenings.

• Providers or suppliers may change and resubmit their own claims where possible but during reopening MACs may, when necessary, correct the claim to modifier -50 from an equivalent 2 units of bilateral anatomic modifiers. The original submitted version of the claim is retained in the Medicare IDR (Integrated Data Repository).

• Providers or suppliers shall use anatomic modifiers (e.g. RT, LT, FA, F1-F9, TA, T1-T9, E1-E4) and report procedures with differing modifiers on individual claim lines when appropriate. Many MUEs are based on the assumption that correct modifiers are used.

• A/B MACs shall include with the review determination the more detailed explanation of the correct coding initiative edit, which can be found in the standard correspondence language for A/B MACs in the Correspondence Language Manual for Medicare Services.

• MACs shall assign MSN 15.6. CARC 151 with Group Code CO for claims that fail the MUE edits, when the UOS on the claim exceeds the MUE value, and deny the entire claim line(s) for the relevant Healthcare Common Procedure Coding System code.

- MACs shall assign CARC 236 with Group Code CO and MSN 16.8 for claims that fail the PTP edits, and deny when this procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements.

20.9.3.2- Medically Unlikely Edits

(Rev. 4465; Issued: 11-15-19, Effective: 01-30-19, Implementation: 01-30-19)

All HCPCS codes with MUE values have an “MUE adjudication indicator” or “MAI”.

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General Instructions on MUEs

• MUEs are set high enough to allow for medically likely daily frequencies of services provided in most settings. Because MUEs are based on current coding instructions and practices, MUEs are prospective edits applicable to the time period for which the edit is effective. A change in an MUE is not retroactive and has no bearing on prior services unless specifically updated with a retroactive effective date. In the unusual case of a

retroactive MUE change, MACs are not expected to identify claims but should reopen impacted claims that providers or suppliers bring to their attention.

• Since MUEs are auto-deny edits, denials may be appealed. Appeals shall be submitted to the appropriate MAC not the NCCI/MUE contractor. MACs adjudicating an appeal for a claim denial for a HCPCS code with an MAI of “1” or “3” may pay correctly coded correctly counted medically necessary UOS in excess of the MUE value.

• A denial of services due to an MUE is a coding denial, not a medical necessity denial. The presence of an Advance Beneficiary Notice (ABN) shall not shift liability to the beneficiary for UOS denied based on an MUE. If during reopening or redetermination medical records are provided with respect to an MUE denial for an edit with an MAI of “3”, MACs will review the records to determine if the provider actually furnished units in excess of the MUE, if the codes were used correctly, and whether the services were medically reasonable and necessary. If the units were actually provided but one of the other conditions is not met, a change in denial reason may be warranted (for example, a change from the MUE denial based on incorrect coding to a determination that the item/service is not reasonable and necessary under section 1862(a)(1)). This may also be true for certain edits with an MAI of “1.” CMS interprets the notice delivery requirements under Section1879 of the Social Security Act (the Act) as applying to situations in which a provider expects the initial claim determination to be a reasonable and necessary denial. Consistent with NCCI guidance, denials resulting from MUEs are not based on any of the statutory provisions that give liability protection to beneficiaries under section 1879 of the Social Security Act. Thus, ABN issuance based on an MUE is NOT appropriate. A provider/ supplier may not issue an ABN in connection with services denied due to an MUE and cannot bill the beneficiary for units of service denied based on an MUE.

• If a procedure is performed bilaterally and the HCPCS code descriptor does not state that it is a unilateral or bilateral procedure, report bilateral surgical procedures on a single claim line with modifier 50 and one (1) UOS. For specific instructions for Ambulatory Surgical Centers, refer to Chapter 14, Section 40.5 of the "Medicare Claims Processing Manual" at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c14.pdf on the CMS website. When modifier -50 is required by manual or coding instructions, claims submitted with two lines or two units and anatomic modifiers will be denied for incorrect coding. MACs may reopen or allow resubmission of those claims in accordance with their policies and with the policy in Chapter 34, Section 10.1, of the "Medicare Claims Processing Manual" at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c34.pdf on the CMS website. Clerical errors (which include minor errors and omissions) may be treated as reopenings.

• Providers or suppliers may change and resubmit their own claims where possible but during reopening MACs may, when necessary, correct the claim to modifier -50 from an equivalent 2 units of bilateral anatomic modifiers. The original submitted version of the claim is retained in the Medicare IDR (Integrated Data Repository).

• Providers or suppliers shall use anatomic modifiers (e.g. RT, LT, FA, F1-F9, TA, T1-T9, E1-E4) and report procedures with differing modifiers on individual claim lines when appropriate. Many MUEs are based on the assumption that correct modifiers are used.

• A/B MACs shall include with the review determination the more detailed explanation of the correct coding initiative edit, which can be found in the standard correspondence language for A/B MACs in the Correspondence Language Manual for Medicare Services.

• MACs shall assign MSN 15.6. CARC 151 with Group Code CO for claims that fail the MUE edits, when the UOS on the claim exceeds the MUE value, and deny the entire claim line(s) for the relevant Healthcare Common Procedure Coding System code.

- MACs shall assign CARC 236 with Group Code CO and MSN 16.8 for claims that fail the PTP edits, and deny when this procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements.

20.9.4 Reserved for future use
(Rev. 4465; Issued: 11-15-19, Effective: 01-30-19, Implementation: 01-30-19)

20.9.4.1 Reserved for future use
(Rev. 4465; Issued: 11-15-19, Effective: 01-30-19, Implementation: 01-30-19)

20.9.5 - Adjustments
(Rev. 1, 10-01-03)

A/B MACs (B) adjust for underpayment if the wrong, lower paying code is paid on the first of multiple claims submitted. If the wrong, higher paying code is paid on the first of multiple claims submitted, A/B MACs (B) pay the subsequent claim(s) and initiate recovery action on the previously paid claim(s).

20.9.6 - Correct Coding Edit (CCE) File Record Format
(Rev. 1, 10-01-03)

The following record layout for the Correct Coding Edit (CCE) File is available to the Shared Systems, A/B MACs (B), NTIS, and the Regional Offices via Network Data Mover and CMS Data Center.

A/B MAC (B)/Shared Systems Record Format

Field	Type	Record Position	Length
Comprehensive Column 1 Code or	Character	1	5

Field	Type	Record Position	Length
Mutually Exclusive Column 1 Code			
Component Column 2 Code or Mutually Exclusive Column 2 Code	Character	6	5
Prior Rebundled Code Indicator "*" rebundled prior to 1996 edits "•" rebundled 1/1/1996 or later	Character	11	1
Correspondence Language Reference	Character	12	12
Effective Date (4 position year followed by Julian day)	Numeric	24	7
Deletion Date (4 position year followed by Julian day)	Numeric	31	7
Modifier Indicators "0" No CCE modifier allowed "1" CCE modifier acceptable "9" Use of CCE modifier not specified	Numeric	38	1
Savings Type Indicator Edit "1" CCE "2" Mutually Exclusive	Character	39	1

20.9.7 - National Correct Coding Initiative (Edits) Quarterly Updates

(Rev. 4465; Issued: 11-15-19, Effective: 01-30-19, Implementation: 01-30-19)

MACs receive quarterly updates to National Correct Coding Initiative (NCCI) edits, indicating the version and the effective date, through a recurring update notification. At this time, the official method for providers or suppliers to receive the National Correct Coding Initiative (NCCI) edits is through the CMS website.

30 - Services Paid Under the Medicare Physician's Fee Schedule

(Rev. 1717, Issued: 04-24-09, Effective: 07-01-09, Implementation: 07-06-09)

Following is a general description of services paid under the Medicare Physicians' Fee Schedule (MPFS).

A. Physician's Services

Effective with services furnished on or after January 1, 1992, A/B MACs (B) pay for physicians' services based on the MPFS. The Medicare allowed charge for such physicians' services is the lower of the actual charge or the fee schedule amount. The Medicare payment is 80 percent of the allowed charge after the deductible is met for most services paid based on the fee schedule. Exceptions to the rule, e.g., services for which deductible is not applicable, are specifically identified for the service where the exception applies.

The Physicians Fee Schedule is used when paying for the following physicians' services.

- Professional services (including attending physicians' services furnished in teaching settings) of doctors of medicine and osteopathy (including osteopathic practitioners), doctors of optometry, doctors of podiatry, doctors of dental surgery and dental medicine, and chiropractors;

- Services covered incident to physicians' services other than certain drugs covered as incident to services;

- Physical and occupational therapy, and speech-language pathology services furnished by physical therapists, occupational therapists, and speech-language pathologists in private practices;

- Diagnostic tests other than clinical laboratory tests. See chapter 16 for payment for clinical diagnostic laboratory tests;

- Radiology services; and

- Monthly capitation payment (MCP) for physicians' services associated with the continuing medical management of end stage renal disease (ESRD) services.

The fee schedule is not used to pay for direct medical and surgical services of teaching physicians in hospitals that have elected cost payment under §1861(b)(7) of the Act.

When processing a claim, A/B MACs (B) continue to determine if a service is reasonable and necessary to treat illness or injury. If a service is not reasonable and necessary to treat illness or injury for any reason (including lack of safety and efficacy because it is an experimental procedure, etc.), A/B MACs (B) consider the service noncovered notwithstanding the presence of a payment amount for the service in the Medicare fee schedule. The presence of a payment amount in the MPFS and the Medicare physician fee schedule database (MPFSDB) does not imply that CMS has determined that the service may be covered by Medicare. The nature of the status indicator in the database does not control coverage except where the status is N for noncovered.

A/B MACs (B) pay the above-mentioned physician services according to the physician fee schedule when billed by the following entities:

- A physician or physician group including optometrists, dentists, oral and maxillofacial surgeons, podiatrists, and chiropractors;

- A privately practicing physical therapist, (for outpatient physical therapy services);

- A privately practicing speech-language pathologist (for outpatient speech-language services);

- A privately practicing occupational therapist (for outpatient occupational therapy services);

- A nonphysician practitioner including a nurse practitioner, a physician assistant, and a clinical nurse specialist beginning January 1, 1998, with respect to services these practitioners are authorized to furnish under state law: payment is equal to 85 percent of the participating physician fee schedule amount for the same service;

- A nurse midwife: payment is equal to 65 percent of the participating physician fee schedule amount for the same service;

- A registered dietitian or nutrition professional, for medical nutrition therapy services provided as of January 1, 2002: payment is equal to 85 percent of the participating physician fee schedule amount for the same service;

- An audiologist, for services rendered to beneficiaries not in a skilled nursing facility (SNF) Part A covered stay;

- A clinical psychologist who renders services in community mental health centers (CMHCs) on or after July 1, 1988, and in all settings on or after July 1, 1990;

- A clinical social worker: The fee schedule for CSW services is set at 75 percent of the fee schedule for comparable services furnished by clinical psychologists;

- Another entity that furnishes outpatient physical therapy, occupational therapy, and speech- language pathology services. This could be a rehabilitation agency, a public health agency, a clinic, a skilled nursing facility, a home health agency (for beneficiaries who are not eligible for home health benefits because they are not home bound beneficiaries entitled to home health benefits), hospitals (when such services are provided to an outpatient or to a hospital inpatient who is entitled to benefits under Part A but who has exhausted benefits during a spell of illness, or who is not entitled to Part A benefits) and comprehensive outpatient rehabilitation facilities (CORFs). The fee schedule also applies to outpatient rehabilitation services furnished under an arrangement with any of the enumerated entities that are to be paid on the basis of the physician fee schedule;

- The supplier of the technical component of any radiology or diagnostic service;
- An independent laboratory doing anatomic pathology services; and
- Services billed by entities authorized to bill for physicians, suppliers, etc. under the reassignment rules.

B. Hospice Services

The Physicians Fee Schedule is used when paying for hospice physician's services by the A/B MAC (HHH). Regular hospice services are paid under the hospice rate schedule (see chapter 11.)

C. Outpatient Rehabilitation Services

Effective with services furnished on or after January 1, 1999, A/B MACs (A) pay for outpatient rehabilitation services based on the MPFS. Services included are physical therapy, speech-language pathology, occupational therapy, and certain audiology and CORF services.

Effective with services furnished on or after July 1, 2000, A/B MACs (A) pay for all CORF services under the MPFS.

Effective with claims with dates of service on or after July 1, 2003, OPTs/Outpatient Rehabilitation Facilities (ORFs), (74X bill type) are required to report all their services utilizing HCPCS. A/B MACs (A) are required to make payment for these services under the MPFS unless the item or service is currently being paid under the orthotic fee schedule or the item is a drug, biological, supply or vaccine.

The MPFS applies when these services are furnished by rehabilitation agencies, (outpatient physical therapy providers and CORFs), hospitals (to outpatients and inpatients who are not in a covered Part A stay), SNFs (to residents not in a covered Part A stay and to nonresidents who receive outpatient rehabilitation services from the SNF), and HHAs (to individuals who are not homebound or otherwise are not receiving services under a home health plan of treatment). The MPFS is used as a method of payment for outpatient rehabilitation services furnished under arrangement with any of these providers. The MPFS allowed charge for these services is the lower of the actual charge or the fee schedule amount. The Medicare payment for the services is 80 percent of the allowed charge after the Part B deductible is met. This is a final payment. The MPFS does not apply to outpatient rehabilitation services furnished by critical access hospitals (CAHs). CAHs are paid on a reasonable cost basis.

Application of the Outpatient Mental Health Treatment Limitation (A/B MACs (A))

In accordance with §1833 of the Act, payment is made at 62½ percent of the approved amount for outpatient mental health treatment services. This provision will continue to be implemented in accordance with the Act when these services are furnished to beneficiaries by CORFs. Therefore, make payment at 62½ percent of 80 percent of the approved amount (or in effect 50 percent) for outpatient mental health treatment services.

D. SNF Services

Effective with services furnished on or after April 1, 2001, A/B MACs (A) pay for Part B services furnished to SNF Part B inpatients and outpatients (22X and 23X types of bill) under the MPFS and other applicable fee schedules. Thus, where a fee schedule exists for the type of service, the fee amount (or charge if less than the applicable fee amount) is paid. Fee schedules made effective for SNF on this date include: Therapy, Lab, and DMEPOS.

Effective for services furnished by a SNF on and after January 1, 2002, A/B MACs (A) pay SNFs for radiology, other diagnostic, and other services under the MPFS. Payment is the lower of billed charges or the fee schedule amount. In either case, any applicable deductible and coinsurance amounts are subtracted from the payment amount prior to payment. Coinsurance is calculated on the Medicare payment amount after the subtraction of any applicable deductible amount.

If there is no fee schedule for the service or item being billed, A/B MACs (A) and (HHH) are to make payment based on cost. Consequently, all services billed under Part B are to be billed using HCPCS codes, whether the beneficiary resides in a certified bed or a noncertified bed.

30.1 - Maintenance Process for the Medicare Physician Fee Schedule Database (MPFSDB)

(Rev. 1, 10-01-03)

The CMS calculates the fee schedule payment amounts and releases them to the A/B MACs (B) in the Medicare Physician Fee Schedule Database (MPFSDB). A/B MACs (B) implement those payment amounts on January 1 of each year. The CMS maintains the payment files centrally and is responsible for recalculating any revised payment amounts. Any revisions initiated by Central Office (fee schedule amounts or payment policy indicators) are issued to the A/B MACs (B) on a quarterly basis.

The information for the ongoing maintenance of the MPFSDB is stated below.

- CMS calculates the new fee schedule amounts. The CMS Central Office issues the revised data to the ROs in the same format of the MPFSDB.

- A/B MACs (B) receive a file containing data with revisions for the quarter. This file is released electronically via CMS' Mainframe Telecommunications System.

- A/B MACs (B) must allow providers 30 days notification before revised payment amounts are implemented. The revised payment amounts are implemented the beginning of the following quarter.

- CMS furnishes the recalculated payment amounts to the A/B MACs (B) in data files to ensure accuracy. A/B MACs (B) overlay these files into their existing file, to eliminate the potential for errors.

- A/B MACs (B) must make adjustments on those claims that were processed incorrectly if the adjustment is requested by the physician/supplier. Adjustments are made retroactively to January 1 of the current year, unless otherwise specified. This directive applies in all instances unless the situation requires special consideration. In those instances, instructions on handling adjustments will be provided on a case-by-case basis.

Separate instructions are issued describing the data exchange for the A/B MACs (A) and (HHH)

- .In summary, A/B MACs (A) and (HHH) receive the revised payment amounts two to three weeks after the A/B MACs (B) receive the data from CMS. A/B MACs (A) and (HHH) do not implement the revised payment amounts prior to the A/B MACs (B)'s implementation date.

- A/B MACs (B) are required to furnish the revised payment information to the State Medicaid Agencies upon their request one month following receipt of the data from CMS. Those State agencies with Internet access capability will download the data directly from CMS Web site.

The CMS publishes a schedule for Medicare Physician Fee Schedule updates and participation physician enrollment procedures annually for all MACs.

30.2 - MPFSDB Record Layout
(Rev. 4298, Issued: 05-03-19, Effective: 01-01-19, Implementation 10-07-19)

The CMS MPFSDB includes the total fee schedule amount, related component parts, and payment policy indicators. The record layout is provided in the Addendum below.

30.2.1 - Payment Concerns While Updating Codes
(Rev. 1, 10-01-03)

The following instructions apply in situations where the CMS CO does NOT provide pricing guidance via the Medicare Physician Fee Schedule Database (MPFSDB) for physicians' services.

If a new code appears, A/B MACs (B) make every effort to determine whether the procedure, drug or supply has a pricing history and profile. If there is a pricing history,

map the new code to previous customary and prevailing charges or fee schedule amounts to ensure continuity of pricing.

Since there are different kinds of coding implosions and explosions, the way the principle is applied varies. For example, when the code for a single procedure is exploded into several codes for the components of that procedure, the total of the separate relative value unit or other charge screens established for the components must not be higher than the relative value units or other charge screens for the original service. However, when there is a single code that describes two or more distinct complete services (e.g., two different but related or similar surgical procedures), and separate codes are subsequently established for each, continue to apply the payment screens that applied to the single code to each of the services described by the new codes.

If there is no pricing history or coding implosion and explosion, A/B MACs (B) must make an individual consideration determination for pricing and payment of a covered service.

Conversely, when the codes for the components of a single service are combined in a single global code, A/B MACs (B) establish the payment screens for the new code by totaling the screens used for the components (i.e., use the total of the customary charges for the components as the customary charge for the global code; use the total of the prevailing charges for the components adjusted for multiple surgical rules if applicable as the prevailing charge for the global code, etc.). However, when the codes for several different services are imploded into a single code, A/B MACs (B) set the payment screens at the average (arithmetic mean), weighted by frequency, of the payment screens for the formerly separate codes.

30.2.2 - MPFSDB Status Indicators

(Rev. 4418, Issued: 10-18- 19, Effective: 01-01- 20 Implementation: 11- 19 19)

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; A/B MACs (B) 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 =	A/B MACs (B) price the code. A/B MACs (B) will establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation such as an operative report.

D =*	Deleted/discontinued codes.
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. A/B MACs (B) will apply this status to all local codes in effect on January 1, 1998 or subsequently approved by central office for use. A/B MACs (B) will complete the RVUs and payment amounts for these codes.
M=	Measurement codes, used for reporting purposes only.
N =	Non-covered service. These codes are carried on the HCPCS tape as noncovered services.
P =	Bundled/excluded codes. There are no RVUs and no payment amounts for these services. No separate payment is made for them under the fee schedule. If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident (an example is an elastic bandage furnished by a physician incident to a physician service).

	If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (for example, colostomy supplies) and is paid under the other payment provision of the Act.
Q =	Therapy functional information code (used for required reporting purposes only). *This indicator is no longer effective beginning with the 2020 fee schedule as of January 1, 2020.*
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 ambulances services and clinical diagnostic laboratory services.)

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

30.3 - Furnishing Pricing Files
(Rev. 1, 10-01-03)

The CMS provides a schedule for activities related to furnishing these pricing files in advance each year. The CMS will provide the completed physician fee schedule, the Durable Medical Equipment and Prosthetics and Orthotics and Supplies (DMEPOS) fee schedules and clinical lab data to United Mine Workers and Indian Health Services. A/B MACs (A), (B), (HHH), and DME MACs are informed where to access the files for FTP (File Transfer Protocol) download.

30.3.1 - RESERVED
(Rev. 2643, Issued: 01-31-13, Effective: 07-01-13, Implementation: 07-01-13)

30.3.2 - A/B MAC (A), (B), or (HHH) Furnishing Physician Fee Schedule Data for National Codes
(Rev. 4131, Issued: 09-14-18, Effective: 12-17-18, Implementation: 12-17-18)

A/B MACs (A), (B), and (HHH) are responsible for furnishing fee schedules to related providers, suppliers, physicians, and practitioners with billing relationships.

A/B MACs (A), (B), and (HHH) may also receive requests for this information from the State Agencies. The data is available on the CMS website. The MACs shall direct State Agencies to the appropriate pages on the website to download the data directly.

The CMS will provide the Medicare physician, ambulance, DMEPOS, and clinical laboratory fee schedules and the zip code file to the A/B MACs (A) and (HHH), Palmetto GBA (the Specialty MAC or S MAC for Railroad Retirement Board), the Indian Health Services, and the United Mine Workers. MACs DO NOT NEED TO SEND FILES TO THOSE ENTITIES.

Fee schedules also are available for the public on the CMS Web site.

30.3.3 - Furnishing Other Fee Schedule, Prevailing Charge, and Conversion Factor Data

(Rev. 1, 10-01-03)
B3-4620.3

A/B MACs (B) use the file format in §30.3.5 to furnish fee schedule (Excluding Physician Fee Schedule), prevailing charge, and conversion factor information to Palmetto GBA (S MAC for RRB), A/B MACs (A) or (HHH), State Agencies, Indian Health Services, and United Mine Workers.

A/B MACs (B) furnish statewide (or A/B MAC (B)-wide for areas less than an entire State) pricing data for certified registered nurse anesthetist conversion factors. Furnish all fee schedules and conversion factors on tape unless the receiving entity agrees that a paper listing is acceptable.

Clinical Lab pricing files subject to national limitation amounts and DMEPOS pricing files subject to national floor and ceiling limitation amounts will be furnished by CMS to all entities except the State Medicaid Agencies. The Center for Medicaid and State Operations will provide those pricing files to the State Medicaid Agencies.

In addition to the above pricing files, A/B MACs (B) furnish Palmetto GBA (the S MAC for RRB) with a tape file of locality prevailing charges for ambulance services and inflation indexed prevailing charges for non-physician services subject to the IIC.

Send pricing files for the RRB S MAC to:

Medicare Systems RRB - AG-430
Palmetto GBA
Building One
2300 Springdale Drive
Camden, SC 29020

For Indian Health Services, send pricing files to:

IHS Contract Health Services
12800 Indian School Road North East
Albuquerque, NM 87112

For releasing nonphysician pricing files to State Agencies, contact the RO to obtain the name and mailing address of the individual to whom the file should be addressed.
For the United Mine Workers, send the pricing files to:

Government Programs Manager
UMWA Health and Retirement Funds
2121 K Street, NW
Washington, DC 20037, or
MedPricing@umwafunds.org

You may negotiate agreements with the receiving entity to use an alternate medium (e.g., paper, diskette) or a tape file format other than that specified in §30.3.5. However, such agreements must be in writing and signed by the affected entities (e.g., A/B MAC (A), (B), (HHH), or DME MAC, RRB S MAC, UMWA, etc.). Furnish your RO with a copy of written agreements for using mediums other than tape or tape file formats other than that in §30.3.5.

30.3.4 - Responsibility to Obtain and Implement Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedules

(Rev. 1, 10-01-03)
B3-4622

The A/B MACs (A), (B), (HHH), and DME MACs must download and implement the DMEPOS fee schedules for the items and services within their jurisdiction. DME MACs must also forward the DMEPOS fee schedule to Medicaid State Agencies. The CMS releases new fee schedules on an annual basis, with updates being issued quarterly, if needed. The CMS issues separate instructions for downloading and implementing fee schedule updates as appropriate. Central office (CO) will issue annual updates describing the maintenance process for each year. These instructions provide A/B MACs (A), (B), (HHH), and DME MACs the due dates. The instructions will also list the date the release will be made available and an implementation date for each release.

30.3.5 - File Specifications

(Rev. 1, 10-01-03)
B3-4621

The following guidelines are used to create the pricing files.

1. Recommended Physical File Specifications-Magnetic Tape - Tape characteristics-9 track, 8 2” to 10 2” reels with silver mylar reflector (standard reels) with write ring removed.

Parity – Odd

Recording Density - 6250 bytes per inch

Recording Code - Extended Binary Coded Decimal

File Label - IBM standard label. The tape must have an end of file mark. The first data record on the file identifies the submitter and the receiver and serves the function of a file label.

Physical Record Length - 60 characters

Blocking Factor - 100 records per block

The external label on the reel must appear as:

From

To

Reel number HCPCS (see footnote (a) below for entry) number (the unique number by which the tape is identified in your library).

Date (MMDDYYYY)

2. Record Specifications. The logical HCPCS record is made up of a series of 60 character physical records.

3. Blocking factor of 100 (100 records per data block).

4. Header Type Specifications

Field No.	**Field Name**	**Size**	**Picture**	**Specification**	**Field Remarks**
1	Label	3	X(3)	L	See Footnote (b)
2	Filler	7	X(7)	L	
3	A/B MAC (B) #	5	9(5)	L	
4	Filler	1	X(1)		
5	Interm. #	5	9(5)	L	
6	Filler	1	X(1)	L	
7	Date Fee Updated	8	X(8)	L	MMDDYYYY

Field No.	Field Name	Size	Picture	Specification	Field Remarks
8	Filler	22	X(22)		
9	Date File Created	8	X(8)	L	MMDDYYYY

5. Detail Record

Field No.	Field Name	Size	Picture	Specification	Field Remarks
1	HCPCS	5	X(5)	L	
2	Filler	2	XX	L	
3	Filler	2	XX	L	
4	Fee/CF/Prev.	7	9(5)V99	R	See Footnote (c) for applicable category
5	Fee	7	9(5)V99	R	See Footnote (d)
6	Fee	7	9(5)V99	R	See Footnote (e)
7	A/B MAC (B) #	5	X(5)	L	
8	Locality	2	99	L	
9	Filler	23	X(23)		

(a) Identify the type of information furnished:

- DME fee schedule (includes supplies, inexpensive/routinely purchased, frequency service, and capped rental);
- Surgical Dressings;
- Prevailing charges applicable to hospice physician services;
- Lab fee schedule;
- Other diagnostic service prevailing charges;
- Oxygen fee schedule;
- Prosthetic/orthotic fee schedule (includes ostomy, tracheostomy, and urologicals);
- Radiology conversion factors;
- Portable radiology fee schedule; or
- Certified registered nurse anesthetist conversion factors.

(b) Show the label for category as:

- DME - durable medical equipment;
- S/D - surgical dressings;
- HPH - prevailing charges for pricing hospice physician services;
- LAB - laboratory;
- ODX - other diagnostic services;
- OXY - oxygen;
- P/O - prosthetic/orthotic;
- RAD - radiology;
- PRF - portable radiology; or
- CNA - certified nurse anesthetist.

(c, d, e) DME

(c) purchase new

(d) purchase used

(e) monthly rental

NOTE: When a HCPCS code has multiple fees, list all the fees. A/B MACs (HHH) are not able to accept procedure codes with modifiers.

HPH

(c) locality prevailing charge for physician services

LAB

(c) fee schedule amount - 60%

(d) fee schedule amount - 62%

ODX

(c) locality prevailing charge amounts

OXY

(c) purchase new/purchased oxygen contents

(d) purchase used

(e) monthly rental

P/O

(c) purchase new

RAD

(c) conversion factors

NOTE: HCPCS codes are not necessary for radiology.

PRF

(c) fee schedule amount

CNA

(c) conversion factor - medically directed CRNA services

(d) conversion factor - non-medically directed CRNA services

30.5 - Payment Amounts for Portable X-Ray Transportation Services

(Rev. 1, 10-01-03)
B-02-075

Transportation for portable x-ray services (HCPCS code R0070) is paid under the Medicare physician fee schedule. There are no national values for this service. The CMS has not established national relative values for this service because there are no national data for these services and because there are significant differences in the delivery of this service in different geographic areas. Instead, each A/B MAC (B) is required to determine the payment amounts for its geographic areas.

The CMS has not established specific criteria that A/B MACs (B) should use in determining the payment amounts they establish for "A/B MAC (B) priced" services. The CMS has not established a specific annual update factor to be applied to these services. Mid-year adjustments are possible if the A/B MAC (B) believes such adjustments are appropriate. Such an appropriation provides A/B MACs (B) with the flexibility to take into account local factors affecting the level of resources required to perform this service.

A/B MACs (B) should periodically review (at least every five years, or more frequently if local conditions warrant) their locally determined payment amounts to determine whether the payment amounts reflect the relative resources (e.g., staff, equipment, supplies and general expenses) required to perform A/B MAC (B)-priced services. Such periodic reviews for A/B MAC (B) priced services would be consistent with statutory requirements. If portable x-ray transportation suppliers request such a review, A/B MACs (B) should work with the local suppliers to review the payment amounts for R0070, taking into account local factors and any data available regarding the resources required to provide these services.

40 - Clinical Diagnostic Laboratory Fee Schedule

(Rev. 2643, Issued: 01-31-13, Effective: 07-01-13, Implementation: 07-01-13)

The Medicare Claims Processing Manual, Chapter 16, "Laboratory Services From Independent Labs, Physicians, and Providers," provides background and additional information for payment of laboratory services.

Clinical diagnostic laboratory tests - whether performed in a physician's office, by an independent laboratory, or by a hospital laboratory for its outpatients - are paid based on fee schedules. This section sets out rules for use of these schedules.

The fee schedule amounts are adjusted annually to reflect changes in the Consumer Price Index (CPI) for all Urban Consumers (U.S. city average), or as otherwise specified by legislation. Adjustments are applied and amounts are determined by CMS and published for A/B MAC (A), (B), and (HHH) use and also on CMS Web site. A/B MACs (A), (B), and (HHH) are notified when and where updates are published.

For a cervical or vaginal smear test (pap smear), payment is the lesser of the local fee or the national limitation amount, but not less than the national minimum payment amount. However, in no case may payment for these tests exceed actual charges. The Part B deductible and coinsurance do not apply.

Regardless of whether a diagnostic laboratory test is performed in a physician's office, by an independent laboratory, or by a hospital laboratory for its outpatients or nonpatients, it is considered a laboratory service. When a hospital laboratory performs diagnostic laboratory tests for nonhospital patients, the laboratory is functioning as an independent laboratory.

National minimum limitation amounts are established each year for cervical or vaginal smear clinical laboratory tests. These payment amounts are published each year in a Recurring Update Notification issued by CMS. The affected CPT laboratory test codes for the national minimum payment amount are also identified in the annual Recurring Update Notification. National maximum limitation amounts may also be established for certain services and are also published each year this Recurring Update Notification.

A/B MACs (A), (B), and (HHH) pay the lowest of the applicable current fee schedule, the actual charge, or the NLA. This applies to all clinical diagnostic laboratory tests except:

- Laboratory tests furnished to a hospital inpatient whose stay is covered under Part A;

- Laboratory tests performed by a Skilled Nursing Facility (SNF) for its own SNF inpatients and reimbursed under Part A or Part B and any laboratory tests furnished under arrangements to an SNF inpatient with Part A coverage. (The only covered source for laboratory services furnished under Part A is the SNF itself or a hospital with which the facility has a transfer agreement in effect.)

- Laboratory tests furnished by hospital-based or independent ESRD dialysis facilities that are included under the ESRD composite rate payment;

- Laboratory tests furnished by hospitals in States or areas which have been granted demonstration waivers of Medicare reimbursement principles for outpatient services. The State of Maryland has been granted such demonstration waivers;

- Laboratory tests furnished to inpatients of a hospital with a waiver under §602(k) of the 1983 Amendments to the Act. This section of the Act provides that an outside

supplier may bill under Part B for laboratory and other nonphysician services furnished to inpatients that are otherwise paid only though the hospital;

- Laboratory tests furnished to patients of rural health clinics (RHCs) under an all inclusive rate;

- Laboratory tests provided by a participating health maintenance organization (HMO) or health care prepayment plan (HCPP) to an enrolled member of the plan; and

- Laboratory tests furnished by a hospice.

40.1 - Access to Clinical Diagnostic Lab Fee Schedule Files

(Rev. 2643, Issued: 01-31-13, Effective: 07-01-13, Implementation: 07-01-13)

The annual laboratory fee schedule data file should be retrieved electronically through CMS' mainframe telecommunications system.

For each test code, if the MAC's system retains only the pricing amount, they should load the data from the field named "60% Pricing Amt." For each test code, if the MAC's system has been developed to retain the local fee and the NLA, they may load the data from the fields named "60% Local Fee Amt" and "60% Natl Limit Amt" to use to determine payment. For clinical laboratory test codes for cervical or vaginal smear tests (listed in Chapter 16, "Laboratory Services from Independent Labs, Physicians, and Providers," §80.3) load the data from the field named "60% Pricing Amt" to reflect the lower of the local fee or the NLA, but not less than the national minimum payment amount. The fields named "62% Local Fee Amt," "62% Natl Limit Amt," and "62% Pricing Amt" should be used by A/B MACs (A) for payment of clinical laboratory tests performed by a sole community hospital's qualified laboratory.

The annual laboratory fee schedule data is available via the CMS website. It is available in multiple formats: Excel, text, and comma delimited.

40.2 - A/B MAC (B) Record Layout for Clinical Laboratory Fee Schedule

(Rev. 1, 10-01-03)
PM AB-01-162, AB-02-163

The instructions for each annual update contain the actual data set name for that year. The Data Set Name is included with each annual update instructions.

Data Element Name	Picture	Location	Comment
HCPCS Code	X(05)	1-5	
A/B MAC (B) Number	X(05)	6-10	

Data Element Name	Picture	Location	Comment
Locality	X(02)	11-12	00 = Denotes Single A/B MAC (B) State 01 = North Dakota 02 = South Dakota 20 = Puerto Rico 40 = New Hampshire 50 = Vermont
60% Local Fee	9(05)V99	13 - 19	
62% Local Fee	9(05)V99	20 - 26	
60% Natl Limit Amt	9(05)V99	27 - 33	
62% Natl Limit Amt	9(05)V99	34 - 40	
60% Pricing Amt	9(05)V99	41 - 47	
62% Pricing Amt	9(05)V99	48 - 54	
Gap - Fill Indicator	X(01)	55 - 55	0 = No Gap-fill Required 1 = A/B MAC (B) Gap-fill 2 = Special Instructions Apply
Modifier	X(02)	56 - 57	Where modifier is shown, QW denotes a CLIA waive test.
Filler	X(03)	58 - 60	

40.3 - Institutional Claim Record Layout for Clinical Laboratory Fee Schedule (Rev. 2643, Issued: 01-31-13, Effective: 07-01-13, Implementation: 07-01-13)

The CMS will provide the specific file names when the prices are released. The file name will contain the label CLAB.

Record Length = 60

Record Format = FB

Block Size = 6000

Character Code = EBCDIC

Sort Sequence = A/B MAC (B), Locality, HCPCS Code

Header Record

Data Element Name	Picture	Location	Comment
1-Label	X(03)	1 - 3	Value = Lab
2-Filler	X(07)	4 - 10	
3-Filler	X(08)	11 - 15	
4-Filler	X(04)	16 - 22	
5-Date Fee Update	X(08)	23 - 30	YYYYMMDD
6-Filler	X(22)	31 - 52	
7-Date File Created	X(08)	53 - 60	YYYYMMDD

Data Record

Data Element Name	Picture	Location	Comment
1-HCPCS	X(05)	1 - 5	
2-Filler	X(04)	6 - 9	
3-60% Fee	9(05)V99	10 - 16	
4-62% Fee	9(05)V99	17 - 23	
5-Filler	X(07)	24 - 30	
6- A/B MAC (B) Number	X(05)	31 - 35	
7- A/B MAC (B) Locality	X(02)	36 - 37	00 = Single State A/B MAC (B) 01 = North Dakota 02 = South Dakota 20 = Puerto Rico

Data Element Name	Picture	Location	Comment
8-State Locality	X(02)	38 - 39	Separate instructions will be used for the use of this field at a later date.
9-Filler	X(02)	40 - 41	
10-Effective Date	X(08)	42 - 49	Update effective date (YYYYMMDD)
11-Filler	X(11)	50 - 60	

40.4 - Gap-Filled Fees Submitted to CMS by A/B MACs (B)

(Rev. 1, 10-01-03)
AB-01-162, AB-02-163

In accordance with §531(b) of the Benefits Improvement and Protection Act of 2000 (BIPA), CMS solicits public comments on determining payment amounts for new laboratory tests. The CMS hosts an annual public meeting to allow parties the opportunity to provide input to the payment determination process. The CMS employs one of two approaches to establishing payment amounts for new laboratory test codes, crosswalking and gap-filling. After considering public input regarding the new test codes, CMS determines which approach is most appropriate for each new test code.

If the new test is comparable to an existing test, the new test is "crosswalked" to the existing test, and it is assigned the local fee for the existing test and the corresponding NLA. The new test code and payment amounts are included in the updated laboratory fee schedule annually.

If CMS determines that the laboratory fee schedule includes no sufficiently comparable test to permit crosswalking, CMS instructs A/B MACs (B) to "gap-fill" the payment amount for the new test code. Gap-filling is an empirical process of determining a payment amount in a locality using available information sources. Usually the period during which gap-filled payment amounts are instructed is the year following the introduction of a new code. During this period, A/B MACs (B) establish and use these payment amounts; they may be revised in the course of the year. Also during this period, A/B MACs (B) must report the gap-fill amounts to their ROs which are then forwarded to CMS CO. The CMS considers the gap-fill amounts and uses them to establish the fees for the new test code in the next update of the laboratory fee schedule.

In determining gap-fill amounts, the sources of information A/B MACs (B) should examine, if available, include: charges for the test and routine discounts to charges; resources required to perform the test; payment amounts determined by other payers; and charges, payment amounts, and resources required for other tests that may be comparable or otherwise relevant. A/B MACs (B) may consider other sources of information as

appropriate, including clinical studies and information provided by clinicians practicing in the area, manufacturers, or other interested parties. To assist each A/B MAC (B) in establishing a gap-fill amount, A/B MACs (B)' Medical Directors may meet and share information regarding the new test, though without reaching a formal consensus.

Establishing payment amounts for new laboratory tests is inherently difficult, precisely because these tests are new and as a result the types and extent of information available about them may be limited. Because the circumstances of different tests may vary significantly, specifying in detail a method of using the various information sources outlined above does not appear appropriate at this time. However, CMS designates a new test code for gap-filling in instances where no test code seems sufficiently similar to make a crosswalk approach appropriate. Accordingly, A/B MACs (B) should not determine a gap-fill amount by crosswalking to the payment amount for another test code.

After determining a gap-fill amount, an A/B MAC (B) may consider if a least costly alternative to a new test exists. If an A/B MAC (B) determines a least costly alternative test exists, the A/B MAC (B) may adopt the payment amount of the least costly alternative test as the gap-fill amount for the new test code. The least costly alternative amount will be considered the local fee, and CMS will use this payment amount in establishing the NLA. However in this case, the A/B MAC (B) must report two payment amounts, the gap-fill amount prior to determination of a least costly alternative and the payment amount that the A/B MAC (B) has determined to be the least costly alternative.

A/B MACs (B) should also communicate the gap-fill amounts to corresponding A/B MACs (A) and (HHH). A/B MACs (B) can seek assistance from RO staff to facilitate communication of the gap-fill amounts to A/B MACs (A) and (HHH). The list of codes which A/B MACs (B) are required to gap-fill each year are communicated in the annual instructions.

A/B MACs (B) provide their RO with gap-fill fees according to the date communicated by CMS (usually May), to be used by CMS-Central for the development of subsequent or later laboratory fee schedules. A/B MACs (B) submit the gap-fill fees in a right-justified format. These gap-fill data should be transmitted in an ASCII file with the following file specifications to MStevenson@cms.hhs.gov with a copy to Agreenberg@cms.hhs.gov to assist with coordinated collection of the gap-fill fees.

Data Set Name: CLXXXXX.TXT* (ASCII File)

(*Denotes A/B MAC (B) 5 - digit number)

Gap-filled Fees Record Layout

Data Element Name	Picture	Location	Comment
Year	X(4)	1 - 4	Set to Year (e.g., 2003)

HCPCS Code	X(5)	5 - 9	
Modifier	X(2)	10 - 11	
A/B MAC (B) Number	X(5)	12 - 16	
Locality	X(2)	17 - 18	00 = Denotes Single State A/B MAC (B) 01 = North Dakota 02 = South Dakota 20 = Puerto Rico 40 = New Hampshire 50 = Vermont
Gap-fill Amount	9(5)V99	19 - 25	Prior to any determination of a least costly alternative
Least Costly Alternative Amount	9(5)V99	26-32	
Least Costly Alternative Code	X(5)	33-37	

40.4.1 - A/B MACs (B) Forward HCPCS Gap Fill Amounts to A/B MACs (A) and (HHH)

(Rev. 1, 10-01-03)

CMS Memo 9-13-02 HCPCS Gap-fillR3.doc

Any A/B MAC (B) that establishes a HCPCS gap fill payment rate for its own use, or at the request of an A/B MAC (A) or (HHH), must forward the information to the contacts at all A/B MACs (A) or (HHH) with providers in the A/B MAC (B) service area.

A/B MACs (B) that establish HCPCS gap-fill payment rates for their own needs should forward the information to A/B MACs (A) and (HHH) as soon as practicable. A/B MACs (A) and (HHH) are to contact the appropriate A/B MAC (B) to request a gap fill payment rate with 5 working days of the suspension of claims containing HCPCS codes(s) for which payment rate is needed and has not been forwarded. A/B MACs (B) must provide the payment rate to the requesting A/B MAC (A) or (HHH) (and all other A/B MACs (A) or (HHH) with providers in that common jurisdiction) within 10 working days of receipt of the request.

Requests for policy clarification in A/B MAC (B) establishing the HCPCS gap fill payment rates or A/B MAC (A) or (HHH) procedures for the use thereof should be directed to the respective Regional Office HCPCS business function experts (BFE). Examples of the need for A/B MAC (A) or (HHH) consultation with the BFE are coverage questions and receipt of unresolved significant inconsistencies in fee amounts from different A/B MACs (B) for the same HCPCS. The A/B MAC (A) or (HHH) should consult the A/B MACs (B) with disparate fees before contacting the BFE.

An A/B MAC (A) or (HHH) experiencing delay in replies or nonresponses from an A/B MAC (B) should alert it respective Consortium Contractor Management Staff (CCMS) Contract Manager (CM). The CM will coordinate with his/her counterpart assigned to the A/B MAC (B) to achieve more timely action by the A/B MAC (B).

It is the A/B MAC (A)'s or (HHH)'s responsibility to ascertain the amount or consult with the A/B MAC (B), CCMS-CM, or BFE timely. A/B MAC (A or (HHH) requests to apply CC 15 to claims which are paid untimely solely because of a delay in ascertaining a HCPCS gap fill amount from the A/B MAC (B) should be addressed to the respective CM. The CM will contact the HCPCS BFE for a decision. Requests for application of CC 15 to claims for which the A/B MAC (A) or (HHH) did not request the gap fill payment rate within 5 working days of the claim suspension and/or did not seek timely advice from the RO BFE concerning application of gap fill amount will not be honored. Additionally, if the A/B MAC (B) replied at least five days before the expiration of the payment floor, CC 15 requests will not be honored.

50 - Fee Schedules Used by Medicare A/B MACs (A) and (HHH) Processing Institutional Claims

(Rev. 2643, Issued: 01-31-13, Effective: 07-01-13, Implementation: 07-01-13)

A/B MACs (A) and (HHH) processing institutional claims retrieve multiple files from the CMS mainframe telecommunications system. The HCPCS data files include deleted codes for the upcoming year. A/B MACs (A) and (HHH) need to identify deleted codes using the HCPCS files because they are not identifiable solely from the fee schedules. HCPCS files are also obtained from CMS annually. New fee schedules are effective for dates of service on and after January 1 of each year. Quarterly and emergency updates to the fee schedules are also sometimes released. In that case, A/B MACs (A) and (HHH) implement them according to the instructions accompanying the release.

Two HCPCS files are furnished by CMS. They are:

- The annual HCPCS file update including procedure and modifier codes and deleted codes; and

- A print file of the new year HCPCS codes.

The following fee schedules are furnished by CMS for use in processing institutional claims:

- Fees for hospice claims for Part B services provided by the hospice beneficiary's attending physician;

- Medicare Physician Fee Schedule;

- Clinical Laboratory Fee Schedule discussed in §40.3 above;

- Durable Medical Equipment, Prosthetics/Orthotics and Supplies (DMEPOS) Fee Schedule. A/B MACs (HHH) with home health workloads retrieve data from all categories on this file. All MACs retrieve data from categories prosthetic/orthotics and surgical dressings;

- Outpatient Rehabilitation (Therapy) and CORF Services Fee Schedule Payment Amounts (Therapy/CORF Abstract File);

- CORF, outpatient Critical Access Hospital (CAH and Indian Health Services not part of the Outpatient Rehabilitation (therapy) file; and

- Skilled Nursing Facility (SNF) extract file for radiology, other diagnostic and other SNF services.

50.1 - Institutional Claim Record Layout for Hospice, Radiology and Other Diagnostic Prices and Local HCPCS Codes

(Rev. 2643, Issued: 01-31-13, Effective: 07-01-13, Implementation: 07-01-13)

This file contains hospice fee schedule prices extracted from the Physician Fee schedule. This file contains pricing data for A/B MAC (B)-priced and local HCPCS codes for radiology, other diagnostic services, and hospice services paid under the physician fee schedule. This file contains some high volume services such as portable x-rays. The file is also used to pay claims for Critical Access Hospitals that have elected the optional method. The CMS will provide the specific file names when the prices are released. The file name will contain the label HHH.

Record Length	-	60
Record Format	-	FB
Block Size	-	6000
Character Code	-	EBCDIC
Sort Sequence	-	A/B MAC (B), Locality, HCPCS Code, Modifier

Data Element Name	Picture	Location	Comment
1-HCPCS	X(05)	1 - 5	
2-Modifier	X(02)	6 - 7	
3-Non-Facility Fee	9(05)V99	8 - 14	
4-PCTC Indicator	X(01)	15 - 15	This field is only applicable when pricing Critical Access Hospitals (CAHs) that have elected the optional method (Method 2) of payment.
5-Facility Fee	9(05)V99	16 - 22	
6-Effective Date	X(08)	23 - 30	
7- A/B MAC (B) Number	X(05)	31 - 35	
8-Locality	X(02)	36 - 37	
9-**Label**	X(03)	38 - 40	HPH = Hospice Physician Services ODX = Other Diagnostic Services PRF = Portable Radiology RAD = Radiology
10-Filler	X(2)	41 - 42	
11-Status Code	X(1)	43 - 43	Separate instructions will be used for the use of this field at a later date. This field indicates whether the code is in the physician fee schedule and whether it is separately payable if the service is covered.
12-Multiple Surgery	X(01)	44 - 44	Indicator indicates which payment adjustment rule for multiple procedures apply to the service.
13-Non Facility PE	9(05)V99	45 - 51	Non-facility practice expense RVU
14-Filler	X(01)	52 - 52	

Data Element Name	Picture	Location	Comment
15- A/B MAC (A) or (HHH) Therapy Reduction	9(05)V99	53 - 59	Reduces payment amount for multiple surgery
16-Filler	X(01)	60 - 60	

50.2 - Institutional Claim Record Layout for the Durable Medical Equipment, Prosthetic, Orthotic and Supply Fee Schedule

(Rev. 3350, Issued: 09-11-15, Effective: 01-01-16, Implementation: 01-04-16)

This file contains services subject to national Floors and Ceilings under the DMEPOS Fee Schedules including Surgical Dressings. The CMS will provide the specific file names when the prices are released. The file name will contain the label DMEPOS.

Record Length	-	60
Record Format	-	FB
Block Size	-	6000
Character Code	-	EBCDIC
Sort Sequence	-	Label, HCPCS Code, MOD, State

Data Element Name	Picture	Location	Comment
1-HCPCS	X(05)	1 - 5	
2-MOD	X(02)	6 – 7	
3-MOD 2	X(02)	8 – 9	
4-Fee Schedule Amt	9(05)V99	10 – 16	
5-Filler	X(01)	17	
6-Rural Fee Amt	9(05)v99	18 – 24	
7-Filler	X(01)	25	
8-Rural Fee indicator	X(01)	26-	R = Rural Fee is present
9-Filler	X(04)	27-30	
10-State	X(02)	31 - 32	
11-Filler	X(05)	33 - 37	
12-*Label*	X(3)	38 - 40	DME = Durable Medical Equipment (other than oxygen) OXY = Oxygen P/O = Prosthetic/Orthotic S/D = Surgical Dressings
13-Filler	X(4)	41 - 44	
14-*Pricing Change Indicator	X(1)	45 - 45	0 = No change to Update Fee Schedule Amount since previous release 1 = A change has occurred to the Update Fee Schedule Amount since the previous release.

Data Element Name	Picture	Location	Comment
			NOTE: In the initial release of the annual update, this field is initialized to >0’
15-Filler	X(02)	46 – 47	
16-Effective Date	X(08)	48 – 55	Update effective date (YYYYMMDD)
17-Filler	X(05)	56 – 60	

50.3 - Institutional Claim Record Layout for the Outpatient Rehabilitation and CORF Services Fee Schedule

(Rev. 2643, Issued: 01-31-13, Effective: 07-01-13, Implementation: 07-01-13)

This is a physician fee schedule abstract file for outpatient rehabilitation and CORF services payment. The CMS will provide the specific file names when the prices are released. The file name will contain the label ABSTR.

Record Length	-	60
Record Format	-	FB
Block Size	-	6000
Character Code	-	EBCDIC
Sort Sequence	-	A/B MAC (B), Locality HCPCS Code, Modifier

Data Element Name	Picture	Location	Comment
1-HCPCS	X(05)	1 - 5	
2-Modifier	X(02)	6 - 7	
3-Non-Facility Fee	9(05)V99	8 - 14	
4-PCTC Indicator	X(01)	15 - 15	This field is only applicable when pricing Critical Access Hospitals (CAHs) that have elected the optional method (Method 2) of payment.
5-Facility Fee	9(05)V99	12 - 22	
6-Effective Date	X(08)	23 - 30	Update effective date
7- A/B MAC (B) Number	X(05)	31 - 35	

Data Element Name	Picture	Location	Comment
8-Locality	X(02)	36 - 37	
9-Filler	X(03)	38 - 40	
10-Fee Indicator	X(1)	41 - 41	R = Rehab/Audiology function test/CORF services
11-Outpatient Hospital	X(1)	42 - 42	0 = Fee applicable in hospital outpatient setting 1 = Fee not applicable in hospital outpatient setting
12-Status Code	X(1)	43 - 43	Separate instructions will be used for the use of this field at a later date. This field indicates whether the code is in the physician fee schedule and whether it is separately payable if the service is covered.
13-Multiple Surgery	X(01)	44 - 44	Indicator indicates which payment adjustment rule for multiple procedures apply to the service.
14-Non Facility PE	9(05)V99	45 - 51	Non-facility practice expense RVU
15-Filler	X(01)	52 - 52	
16- A/B MAC (A) or (HHH) Therapy Reduction	9(05)V99	53 - 59	Reduces payment amount for multiple surgery
17-Filler	X(01)	60 - 60	

50.4 - Institutional Claim Record Layout for the Skilled Nursing Facility Fee Schedule

(Rev. 2643, Issued: 01-31-13, Effective: 07-01-13, Implementation: 07-01-13)

This section contains the record layout for the SNF extract for radiology Services, other diagnostic services, and other SNF services priced on the MPFS. The CMS will provide the specific file names when the prices are released. The file name will contain the label SNF.

Record Length - 60

Record Format	-	FB
Block Size	-	6000
Character Code	-	EBCDIC

Data Element Name	Picture	Location	Comment
1-HCPCS	X(05)	1 - 5	
2-Modifier	X(02)	6 - 7	
3-Non-Facility Fee	9(05)V99	8 - 14	The SNF fee schedule amount is based on the “non-facility rate” which is the fee that physicians may receive if performing the service in the physician’s office.
4-PCTC Indicator	X(01)	15 - 15	
5-Facility Fee	9(05)V99	16 - 22	
6-Effective Date	X(08)	23 - 30	Update effective date
7- A/B MAC (B) Number	X(05)	31 - 35	
8-Locality	X(02)	36 - 37	
9-Filler	X(05)	38 - 42	
10-Status Code	X(1)	43 - 43	Separate instructions will be used for the use of this field at a later date. This field indicates whether the code is in the physician fee schedule and whether it is separately payable if the service is covered.
11-Multiple Surgery	X(01)	44 - 44	Indicator indicates which payment adjustment rule for multiple procedures apply to the service.
12-Non Facility PE	9(05)V99	45 - 51	Non-facility practice expense RVU
13-Filler	X(01)	52 - 52	

Data Element Name	Picture	Location	Comment
14- A/B MAC (A) or (HHH) Therapy Reduction	9(05)V99	53 - 59	Reduces payment amount for multiple surgery
15-Filler	X(01)	60 - 60	

50.5 - RESERVED

(Rev. 2643, Issued: 01-31-13, Effective: 07-01-13, Implementation: 07-01-13)

50.6 – Physician Fee Schedule Payment Policy Indicator File Record Layout

(Rev. 4131, Issued: 09-14-18, Effective: 12-17-18, Implementation: 12-17-18)

The information on the Physician Fee Schedule Payment Policy Indicator file record layout is used for processing Method II CAH professional services with revenue codes 96X, 97X or 98X.

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
File Year This field displays the effective year of the file.	4 Pic x(4)	1-4
HCPCS Code This field represents the procedure code. Each Current Procedural Terminology (CPT) code and alpha-numeric HCPCS codes A, C, T, and some R codes that are currently returned on the MPFS supplemental file will be included. The standard sort for this field is blanks, alpha, and numeric in ascending order.	5 Pic x(5)	5-9
Modifier For diagnostic tests, a blank in this field denotes the global service and the following modifiers identify the components: 26 = Professional component; and TC = Technical component. For services other than those with a professional and/or technical component, a blank will appear in this field with one exception: the presence of CPT modifier -53 which indicates that separate Relative Value Units (RVUs) and a fee schedule amount have been established for procedures which the	2 Pic x(2)	10-11

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
physician terminated before completion. This modifier is used only with colonoscopy code 45378 and screening colonoscopy codes G0105 and G0121. Any other codes billed with modifier -53 are subject to medical review and priced by individual consideration. Modifier-53 = Discontinued Procedure - Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances, or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued.		
Code Status This 1 position field provides the status of each code under the full fee schedule. Each status code is explained in Pub. 100-04, Chapter 23, §30.2.2.	1 Pic x(1)	12
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.	3 Pic x(3)	13-15

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
MMM = Maternity codes; usual global period does not apply. XXX = Global concept does not apply. YYY = A/B MAC (A) 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.)		
Preoperative Percentage (Modifier 56) This field contains the percentage (shown in decimal format) for the preoperative portion of the global package. For example, 10 percent will be shown as 010000. The total of the preoperative percentage, intraoperative percentage, and the postoperative percentage fields will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)	16-21
Intraoperative Percentage (Modifier 54) This field contains the percentage (shown in decimal format) for the intraoperative portion of the global package including postoperative work in the hospital. For example, 63 percent will be shown as 063000. The total of the preoperative percentage, intraoperative percentage, and the postoperative percentage fields will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)	22-27
Postoperative Percentage (Modifier 55) This field contains the percentage (shown in decimal format) for the postoperative portion of the global package that is provided in the office after discharge from the hospital. For example, 17 percent will be shown as 017000. The total of the preoperative percentage, intraoperative percentage, and the postoperative percentage fields will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)	28-33

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
Professional Component (PC)/Technical Component (TC) Indicator 0 = Physician service codes: This indicator identifies codes that describe physician services. Examples include visits, consultations, and surgical procedures. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. Modifiers 26 & TC cannot be used with these codes. The total Relative Value Units (RVUs) include values for physician work, practice expense and malpractice expense. There are some codes with no work RVUs. 1 = Diagnostic tests or radiology services: This indicator identifies codes that describe diagnostic tests, e.g., pulmonary function tests, or therapeutic radiology procedures, e.g., radiation therapy. These codes generally have both a professional and technical component. Modifiers 26 and TC can be used with these codes. The total RVUs for codes reported with a 26 modifier include values for physician work, practice expense, and malpractice expense. The total RVUs for codes reported with a TC modifier include values for practice expense and malpractice expense only. The total RVUs for codes reported without a modifier equals the sum of RVUs for both the professional and technical component. 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	1 Pic x(1)	34

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
report. Modifiers 26 and TC cannot be used with these codes. The total RVUs for professional component only codes include values for physician work, practice expense, and malpractice expense. 3 = Technical component only codes: This indicator identifies stand alone codes that describe the technical component (i.e., staff and equipment costs) of selected diagnostic tests for which there is an associated code that describes the professional component of the diagnostic tests only. An example of a technical component code is 93005, Electrocardiogram, tracing only, without interpretation and report. It also identifies codes that are covered only as diagnostic tests and therefore do not have a related professional code. Modifiers 26 and TC cannot be used with these codes. The total RVUs for technical component only codes include values for practice expense and malpractice expense only. 4 = Global test only codes: This indicator identifies stand alone codes for which there are associated codes that describe: a) the professional component of the test only and b) the technical component of the test only. Modifiers 26 and TC cannot be used with these codes. The total RVUs for global procedure only codes include values for physician work, practice expense, and malpractice expense. The total RVUs for global procedure only codes equals the sum of the total RVUs for the professional and technical components only codes combined. 5 = Incident to Codes: This indicator identifies codes that describe services covered incident to a physicians service when they are provided by auxiliary personnel employed by the physician and working under his or her direct supervision. Payment may not be made by carriers for these services when they are provided to hospital		

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
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: Payment may not be made if the service is provided to either a hospital outpatient or inpatient by an independently practicing physical or occupational therapist. 8 = Physician interpretation codes: This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for hospital inpatient. This applies only to code 85060. No TC billing is recognized because payment for the underlying clinical laboratory test is made to the hospital, generally through the PPS rate. No payment is recognized for code 85060 furnished to hospital outpatients or non-hospital patients. The physician interpretation is paid through the clinical laboratory fee schedule payment for the clinical laboratory test. 9 = Concept of a professional/technical component does not apply		
Multiple Procedure (Modifier 51) Indicator indicates which payment adjustment rule for multiple procedures applies to the service. 0 = No payment adjustment rules for multiple procedures apply. If the procedure is reported on the same day as another procedure, base payment on the lower of: (a) the actual charge or (b) the fee schedule amount for the procedure.	1 Pic (x)1	35

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
1 = Standard payment adjustment rules in effect before January 1, 1996, for multiple procedures apply. In the 1996 MPFSDB, this indicator only applies to codes with procedure status of "D." If a procedure is reported on the same day as another procedure with an indicator of 1,2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 25 percent, 25 percent, 25 percent, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage. 2 = Standard payment adjustment rules for multiple procedures apply. If the procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 50 percent, 50 percent, 50 percent, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage. 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 endoscopic base code field. Apply the multiple endoscopy rules to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). If an endoscopic procedure is reported with only its base procedure, do not pay separately for the base procedure. Payment for the base procedure is included in the payment for the other endoscopy. 4 = Subject to MPPR reduction.		

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
9 = Concept does not apply. Codes with RVUs equal to zero are not included in the payment indicator file. These codes may have multiple procedure indicators not shown. See note below this table for instructions on these codes.		
Bilateral Surgery Indicator (Modifier 50) This field provides an indicator for services subject to a payment adjustment. 0 = 150 percent payment adjustment for bilateral procedures does not apply. The bilateral adjustment is inappropriate for codes in this category because of: (a) physiology or anatomy, or (b) because the code descriptor specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure. 1 = 150 percent payment adjustment for bilateral procedures applies. If code is billed with the bilateral modifier base payment for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides, or (b) 150 percent of the fee schedule amount for a single code. If code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any applicable multiple procedure rules. 2 = 150 percent payment adjustment for bilateral procedure does not apply. RVUs are already based on the procedure being performed as a bilateral procedure. 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.	1 Pic (x)1	36

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
3 = The usual payment adjustment for bilateral procedures does not apply. 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. If a procedure is billed with the 50 modifier, base payment on the lesser of the total actual charges for **each** side or 100% of the fee schedule amount for **each** side. 9 = Concept does not apply.		
Assistant at Surgery (Modifiers AS, 80, 81 and 82) This field provides an indicator for services where an assistant at surgery may be 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. 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.	1 Pic (x)1	37
Co-Surgeons (Modifier 62) This field provides an indicator for services for which two surgeons, each in a different specialty, may be paid. 0 = Co-surgeons not permitted for this procedure. 1 = Co-surgeons could be paid; supporting documentation required to establish medical necessity of two surgeons for the procedure.	1 Pic (x)1	38

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
2 = Co-surgeons permitted; no documentation 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 required to establish medical necessity of a team; pay by report. 2 = Team surgeons permitted; pay by report. 9 = Concept does not apply.	1 Pic (x)1	39
Endoscopic Base Codes This field identifies an endoscopic base code for each code with a multiple surgery indicator of 3.	5 Pic (x) 5	40-44
Performance Payment Indicator (For future use)	1 Pic x (1)	45
Diagnostic Imaging Family Indicator 88 = Subject to the reduction for diagnostic imaging (effective for services January 1, 2011, and after). 99 = Concept Does Not Apply	2 Pic x (2)	46-47
Effective Date This field displays the effective date of the file in YYYYMMDD format.	8 Pic x(8)	48 - 55
Filler	30 Pic x(30)	56 -75

Multiple procedure indicator 5 is not included in this file, since the indicator represents the therapy multiple procedure payment reduction which never applies to professional service revenue codes. Multiple procedure indicators 6 and 7 are not included in this file, since in these cases the reduction only applies to technical component services. On CAH claims, technical components are paid on a cost basis and so are not subject to the reductions.

There may be cases when A/B MACs (A) must manually load a HCPCS code that is contractor priced which has a multiple procedure indicator that is not on the payment indicator file. In these cases, the MAC enters a multiple procedure indicator of 0.

50.7 - Institutional Claim Record Layout for the Mammography Fee Schedule

(Rev. 2643, Issued: 01-31-13, Effective: 07-01-13, Implementation: 07-01-13)

This is a physician fee schedule abstract file for mammography services payment. The CMS will provide the specific file names when the prices are released. The file name will contain the label MAMMO.

Record Length	-	60
Record Format	-	FB
Block Size	-	6000
Character Code	-	EBCDIC
Sort Sequence	-	A/B MAC (B), Locality HCPCS Code, Modifier

Data Element Name	**Picture**	**Location**	**Comment**
1-HCPCS	X(05)	1 - 5	
2-Modifier	X(02)	6 - 7	
3-Non-Facility Fee	9(05)V99	8 - 14	
4-PCTC Indicator	X(01)	15 - 15	This field is only applicable when pricing Critical Access Hospitals (CAHs) that have elected the optional method (Method 2) of payment.
5-Facility Fee	9(05)V99	16 - 22	
6-Effective Date	X(08)	23 - 30	Update effective date
7- A/B MAC (B) Number	X(05)	31 - 35	
8-Locality	X(02)	36- 37	
9-Filler	X(05)	38- 42	
10-Status Code	X(1)	43- 43	Separate instructions will be used for the use of this field at a later date. This field indicates whether the code is in the physician fee schedule and whether it is separately payable if the service is covered.

Data Element Name	Picture	Location	Comment
11-Multiple Surgery	X(01)	44 - 44	Indicator indicates which payment adjustment rule for multiple procedures apply to the service.
12-Non Facility PE	9(05)V99	45 - 51	Non-facility practice expense RVU
13-Filler	X(01)	52 - 52	
14- A/B MAC (A) or (HHH) Therapy Reduction	9(05)V99	53 - 59	Reduces payment amount for multiple surgery
15-Filler	X(01)	60 - 60	

50.8 - Institutional Claim Record Layout for the Ambulance Fee Schedule

(Rev. 2643, Issued: 01-31-13, Effective: 07-01-13, Implementation: 07-01-13)

This is a physician fee schedule abstract file for ambulance services payment. The CMS will provide the specific file names when the prices are released. The file name will contain the label AMBFS.

Record Length	-	80
Record Format	-	FB
Block Size	-	27920
Character Code	-	EBCDIC
Sort Sequence	-	HCPCS, A/B MAC (B), Locality

Field Name	Format	Position	Description
1-HCPCS	X(05)	1 - 5	HCFA Common Procedure Coding System
2- A/B MAC (B) Number	X(05)	6 - 10	
3-Locality Code	X(02)	11-12	
4-Base RVU	9(4)v99	13 - 18	Relative Value Unit

Field Name	Format	Position	Description
1-HCPCS	X(05)	1 - 5	HCFA Common Procedure Coding System
5-Non-Facility PE GPCI	9v9(3)	19 - 22	Geographic Adjustment Factor
6-Conversion Factor	9(5)v99	23 - 29	Conversion Factor
7-Urban Mileage	9(5)v99	30 - 36	Urban payment rate or base rate mileage rate (determined by HCPCS)
8-Rural Mileage	9(5)v99	37 - 43	Rural payment rate or base rate mileage rate (determined by HCPCS)
9-Current Year	9(04)	44- 47	YYYY
10-Current Quarter	9(01)	48	Calendar Quarter-value 1-4
11-Effective Date	9(8)	49- 56	Effective date of fee schedule file
12-Filler	X(24)	57 - 80	Future Use

60 - Durable Medical Equipment Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

(Rev. 2902, Issued: 03-11-14, Effective: 04-01-14, Implementation: 04-07-14)

The CMS issues instructions for implementing and/or updating the DMEPOS fee schedule payment amounts on a semiannual basis (January and July), with quarterly updates as necessary (April and October). The DMEPOS fee schedule is provided to DME MACs, the Pricing, Data Analysis and Coding Contractor (PDAC), and A/B MACs (B) via CMS' mainframe telecommunication system.

The DMEPOS fee schedules are calculated by CMS. A separate DMEPOS Fee Schedule file is released to A/B MACs (A) and (HHH), Railroad Retirement Board (RRB) and RRB's Specialty MAC, Indian Health Service, and United Mine Workers. This fee schedule is also available on the CMS site (http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html) for other interested parties like the State Medicaid agencies and managed care organizations. The fee schedule for parenteral and enteral nutrition (PEN) is released to the PDAC and DME MACs in a separate file. All annual updates to fee schedules are to be implemented on January 1 for claims with dates of service on or after January 1.

As part of the annual or July update, the CMS provides a list of new items that will be subject to the DME, prosthetics and orthotics, surgical dressings, splints and casts, certain

intraocular lenses or PEN fee schedules for which A/B MACs (B) or DME MACs must gap-fill base fee schedule amounts. The CMS identifies which codes apply to A/B MAC (B) or DME MAC for gap-filling. A/B MACs (B) and DME MACs submit the base fees for new codes to CMS CO. Once MACs submit base fees for a given code, they do not have to resubmit those base fees. MACs are notified when and where to submit the base fees.

The codes to be gap-filled are contained in the DMEPOS Fee Schedule file and are identifiable by a gap-fill indicator of "1." These codes have associated pricing amounts of 0. For further information see section 60.3.

After receiving the gap-filled base fees, CMS Division of Data Systems (DDS) will develop national fee schedule floors and ceilings and fee schedule amounts for these codes. A/B MACs (B) should note that the DDS files will not contain fee schedule amounts for noncontinental areas under A/B MAC (B) jurisdiction. A/B MACs (B) must update their fee schedules using the appropriate covered item updates.

Upon successful receipt of the file(s), MACs send notification of receipt via E-MAIL to price_file_receipt@cms.hhs.gov stating the name of the file received and the entities for which they were received (e.g., MAC name and A/B MAC (A) or (HHH) number.

60.1 - Record Layout for DMEPOS Fee Schedule

(Rev. 3350, Issued: 09-11-15, Effective: 01-01-16, Implementation: 01-04-16)

Sort Sequence: Category, HCPCS, 1st Modifier, 2nd Modifier State

Field Name	Pic	Position	Comment
Year	X(4)	1 - 4	Applicable Update Year
HCPCS Code	X(5)	5 - 9	All current year active and deleted codes subject to DMEPOS floors and ceilings
1st Modifier	X(2)	10 - 11	
2nd Modifier	X(2)	12 - 13	
Jurisdiction	X	14	D = DME MAC Jurisdiction L = Local A/B MAC (B) jurisdiction J = Joint DME MAC/A/B MAC (B) jurisdiction
Category	X(2)	15 - 16	IN = Inexpensive/Routinely Purchased FS = Frequently Serviced CR = Capped Rental OX = Oxygen & Oxygen Equipment OS = Ostomy, Tracheostomy & Urologicals SD = Surgical Dressings PO = Prosthetics & Orthotics SU = Supplies TE = TENS TS = Therapeutic Shoes SC = Splints and Casts IL = Intraocular Lenses
HCPCS Action	X	17	Indicates active/delete status in HCPCS file A = Active Code D = Deleted Code, price provided for grace period processing only
Region	X(2)	18 - 19	This amount is not used for pricing claims. It is on file for informational purposes. 00 = For all non Prosthetic and Orthotic Services 01 - 10 = For Prosthetic and Orthotic Services only. This field denotes the applicable regional fee schedule.
State	X(2)	20 - 21	

Original Base Fee	9(5)V99	22 - 28	This amount is not used for pricing claims. It is on file for informational purposes. For capped rental services, this amount represents the base fee after adjustments for rebasing and statewide conversions. The base year for E0607 and L8603 is 1995. Since pricing amounts for E1405 and E1406 are developed by summing pricing amounts from source codes, they do not have a true base fee. For these codes, this field will be filled with zeros. Beginning January 1, 2016, this field will include the Competitive Bidding Rural Fee Amount for specific HCPCS codes. A new indicator field (RURAL FEE INDICATOR) shall be populated with a value of "R" when the Rural Fee is present in this field.
Ceiling	9(5)V99	29 - 35	This amount is not used for pricing claims. It is on file for informational purposes and could be integrated into other processes (i.e., IR review, validation, inquiries). **NOTE**: Since E0607 is priced via national IR, it is not priced using floors and ceilings. For E0607, this field will be filled with zeros. Since pricing amounts for E1405 and E1406 are developed by summing pricing amounts from source codes, they are not subject to ceilings and floors. Since non-mail order (no-KL) codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, and A4259 are priced using National Mail order single payment amounts, they are not subject to ceilings and floors. Splints, casts and intraocular lenses are national fee schedule amounts not subject to ceilings. For these codes, this field will be filled with zeros. Beginning January 1, 2016, this field will also be filled with zeros for codes whose fees are adjusted using DMEPOS competitive bid information.

Floor	9(5)V99	36 - 42	This amount is not used for pricing claims. It is on file for informational purposes and could be integrated into other processes (i.e., IR review, validation, inquiries). **NOTE**: Since E0607 is priced via national IR, it is not priced using floors and ceilings. For E0607, this field will be filled with zeros. Since pricing amounts for E1405 and E1406 are developed by summing pricing amounts from source codes, they are not subject to ceilings and floors. Since non-mail order (no-KL) codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, and A4259 are priced using National Mail order single payment amounts, they are not subject to ceilings and floors. Splints, casts and intraocular lenses are national fee schedule amounts not subject to floors. For these codes, this field will be filled with zeros. Beginning January 1, 2016, this field will also be filled with zeros for codes whose fees are adjusted using DMEPOS competitive bid information.
Updated Fee Schedule Amount	9(5)V99	43 - 49	Amount used for pricing.
Gap-Fill Indicator	X	50	0 = No Gap-filling required. 1 = A/B MAC (B) Needs to Gap-fill Original Base Year Amount.
Pricing Change Indicator	X	51	0 = No change to the updated fee schedule amount since previous release. 1 = A change has occurred to the updated fee schedule amount since the previous release.
Rural Fee Indicator	X(01)		R = Rural Fee is present in the Original Base Fee field
Filler	X(8)	53 - 60	Set to spaces

60.2 - Quarterly Update Schedule for DMEPOS Fee Schedule

(Rev. 2902, Issued: 03-11-14, Effective: 04-01-14, Implementation: 04-07-14)

Following is an approximate schedule for making additions (for new HCPCS codes) and corrections to base-year amounts for the DMEPOS fee schedule.

- The DME MACs identify instances where base year fees are incorrect and forward requests for revisions to their regional offices. The DME MACs also identify those instances where fee schedule amounts are replaced by inherent reasonableness (IR) limits/payment amounts, should the authority for making IR adjustments be restored. A/B MACs (B) and DME MACs must use the file layout in §60.1 above to submit all revisions. Regional offices will review those requests and, upon

concurrence, forward them to the Division of Data Systems (DDS) and the Division of DMEPOS Policy (DDP) in CMS Central Office. Those transmissions must occur within the timeframes established by CMS.

- Requests for revisions must be accompanied by a narrative description.

- For inherent reasonableness (IR) changes, the effective date of the revised payment amount must be provided. The format provides a field for those dates.

- DDS will recalculate the current year fee schedule amounts as appropriate.

- DDS will transmit the entire DMEPOS file to the DME MACs, PDAC, and A/B MACs using the file layout described in §60.1 above. An indicator in the record field will identify those instances where pricing amounts have changed. These transmissions must occur within the dates specified each year by CMS. DDP must also receive a copy of the corrected fees.

- Concurrently, DDP issues instructions for implementing the revised fee schedule amounts.

- DME MACs and A/B MACs should give providers 30 days' notice before revised payment amounts are implemented. Dates for implementation are provided by CMS.

- DME MACs and A/B MACs should make adjustments on those claims that were processed incorrectly if brought to their attention. Adjustments may be made retroactively to January 1 unless otherwise specified.

- CMS will furnish the revised payment amounts to RRB, Indian Health Service and United Mine Workers. DME MACs and A/B MACs (A), (B), and (HHH), shall provide the data to the State Medicaid Agencies.

- Fee Schedule Disclaimer: Whenever the MACs publish the DMEPOS fee schedule in their bulletins/notices, a disclaimer must be added. The disclaimer is, "Inclusion or exclusion of a fee schedule amount for an item or service does not imply any health insurance coverage."

- CMS will release specific timeframes for quarterly changes for DMEPOS Fees.

60.3 - Gap-filling DMEPOS Fees

(Rev. 4130, Issued: 09-14-18, Effective: 06-11-18, Implementation: 10-15-18)

The DME MACs and Part B MACs must gap-fill the DMEPOS fee schedule for items for which charge data were unavailable during the fee schedule data base year using the fee schedule amounts for comparable equipment, using properly calculated fee schedule amounts from a neighboring DME MAC or Part B MAC area, or using supplier price lists

with prices in effect during the fee schedule data base year. Data base "year" refers to the time period mandated by the statute and/or regulations from which Medicare allowed charge data is to be extracted in order to compute the fee schedule amounts for the various DMEPOS payment categories. For example, the fee schedule base year for inexpensive or routinely purchased durable medical equipment is the 12 month period ending June 30, 1987. Supplier price lists include catalogues and other retail price lists (such as internet retail prices) that provide information on commercial pricing for the item. Potential appropriate sources for such commercial pricing information can also include verifiable information from supplier invoices and non-Medicare payer data (e.g., fee schedule amounts comprised of the median of the commercial pricing information adjusted as described below). Mail order catalogs are particularly suitable sources of price information for items such as urological and ostomy supplies which require constant replacement. DME MACs will gap-fill based on current instructions released each year for implementing and updating the new year's payment amounts.

If the only available price information is from a period other than the base period, apply the deflation factors that are included in the current year implementation instructions against current pricing in order to approximate the base year price for gap-filling purposes.

The deflation factors for gap-filling purposes are:

Year*	**OX**	**CR**	**PO**	**SD**	**PE**	**SC**	**IL**
1987	0.965	0.971	0.974	n/a	n/a	n/a	n/a
1988	0.928	0.934	0.936	n/a	n/a	n/a	n/a
1989	0.882	0.888	0.890	n/a	n/a	n/a	n/a
1990	0.843	0.848	0.851	n/a	n/a	n/a	n/a
1991	0.805	0.810	0.813	n/a	n/a	n/a	n/a
1992	0.781	0.786	0.788	n/a	n/a	n/a	n/a
1993	0.758	0.763	0.765	0.971	n/a	n/a	n/a
1994	0.740	0.745	0.747	0.947	n/a	n/a	n/a
1995	0.718	0.723	0.725	0.919	n/a	n/a	n/a
1996	0.699	0.703	0.705	0.895	0.973	n/a	n/a
1997	0.683	0.687	0.689	0.875	0.951	n/a	n/a
1998	0.672	0.676	0.678	0.860	0.936	n/a	n/a
1999	0.659	0.663	0.665	0.844	0.918	n/a	n/a
2000	0.635	0.639	0.641	0.813	0.885	n/a	n/a
2001	0.615	0.619	0.621	0.788	0.857	n/a	n/a
2002	0.609	0.613	0.614	0.779	0.848	n/a	n/a
2003	0.596	0.600	0.602	0.763	0.830	n/a	n/a
2004	0.577	0.581	0.582	0.739	0.804	n/a	n/a
2005	0.563	0.567	0.568	0.721	0.784	n/a	n/a
2006	0.540	0.543	0.545	0.691	0.752	n/a	n/a
2007	0.525	0.529	0.530	0.673	0.732	n/a	n/a
2008	0.500	0.504	0.505	0.641	0.697	n/a	n/a
2009	0.508	0.511	0.512	0.650	0.707	n/a	n/a

2010	0.502	0.506	0.507	0.643	0.700	n/a	n/a
2011	0.485	0.488	0.490	0.621	0.676	n/a	n/a
2012	0.477	0.480	0.482	0.611	0.665	n/a	n/a
2013	0.469	0.472	0.473	0.600	0.653	n/a	0.983
2014	0.459	0.462	0.464	0.588	0.640	0.980	0.963
2015	0.459	0.462	0.463	0.588	0.639	0.978	0.962
2016	0.454	0.457	0.458	0.582	0.633	0.969	0.952
2017	0.447	0.450	0.451	0.572	0.623	0.953	0.937
2018	0.435	0.437	0.439	0.556	0.605	0.927	0.911

* Year price in effect

Payment Category Key:
OX Oxygen & oxygen equipment (DME)
CR Capped rental (DME)
IN Inexpensive/routinely purchased (DME)
FS Frequently serviced (DME)
SU DME supplies
PO Prosthetics & orthotics
SD Surgical dressings
OS Ostomy, tracheostomy, and urological supplies
PE Parental and enteral nutrition
TS Therapeutic Shoes
SC Splints and Casts
IL Intraocular Lenses inserted in a physician's office IN, FS, OS and SU category deflation factors=PO deflation factors

After deflation, the result must be increased by 1.7 percent and by the cumulative covered item update to complete the gap-filling (e.g., an additional .6 percent for a 2002 DME fee).

Note that when gap-filling for capped rental items, it is necessary to first gap-fill the purchase price then compute the base period fee schedule at 10 percent of the base period purchase price.

For used equipment, establish fee schedule amounts at 75 percent of the fee schedule amount for new equipment.

When gap-filling, for those DME MAC or Part B MAC areas where a sales tax was imposed in the base period, add the applicable sales tax, e.g., five percent, to the gap-filled amount where the gap-filled amount does not take into account the sales tax, e.g., where the gap-filled amount is computed from pre-tax price lists or from another DME MAC or Part B MAC area without a sales tax. Likewise, if the gap-filled amount is calculated from another DME MAC's or Part B MAC's fees where a sales tax is imposed, adjust the gap-filled amount to reflect the applicable local sales tax circumstances.

Contractors send their gap-fill information to CMS. After receiving the gap-filled base fees each year, CMS develops national fee schedule floors and ceilings and new fee schedule amounts for these codes and releases them as part of the July update file each year and during the quarterly updates.

60.3.1 - Payment Concerns While Updating Codes

(Rev. 2236, Issued: 06-03-11, Effective: 01-01-11, for implementation of fee schedule amounts for codes in effect on 01-01-11, 07- 01-11 for all others changes. Implementation Date: (07-05-11)

The instructions in section 30.2.1 of this chapter originally appeared in section 4509.1 of the Medicare Carriers Manual (HCFA-Pub. 14-3) and apply to all Part B items and services, including DMEPOS items and services. The language in section 30.2.1 was amended to address coding changes and continuity of pricing in the specific context of physician services and this was an error. The instructions should not have been revised to read as if they only applied to updated codes for physician services. These basic instructions have always applied, and continue to apply, to DMEPOS items and services as well as physician services and are repeated in this section so that it is clear that these instructions also apply to DMEPOS items and services.

The following instructions apply in situations where the CMS CO does NOT provide pricing guidance related to implementation of fee schedule for DMEPOS items and services.

Because a HCPCS code is new does not necessarily mean that Medicare payment on a fee schedule basis has never been made for the item and service described by the new code. If a new code appears, A/B MACs (B) make every effort to determine whether the item and service has a pricing history and profile. If there is a pricing history, map the new code to previous fee schedule amounts to ensure continuity of pricing.

Since there are different kinds of coding implosions and explosions, the way the principle is applied varies. For example, when the code for an item is exploded into several codes for the components of that item, the total of the separate fee schedule amounts established for the components must not be higher than the fee schedule amount for the original item. However, when there is a single code that describes two or more distinct complete items (e.g., two different but related or similar items), and separate codes are subsequently established for each, continue to apply the fee schedule amounts that applied to the single code to each of the items described by the new codes.

Conversely, when the codes for the components of a single item are combined in a single global code, A/B MACs (B) establish the fee schedule amounts for the new code by totaling the fee schedule amounts used for the components (i.e., use the total of the fee schedule amounts for the components as the fee schedule amount for the global code). However, when the codes for several different items are imploded into a single code, A/B

MACs (B) set the fee schedule amounts at the average (arithmetic mean), weighted by frequency, of the fee schedule amounts for the formerly separate codes.

60.4 - Process for Submitting Revisions to DMEPOS Fee Schedule to CMS

(Rev. 2006, Issued: 07-23-10, Effective: 01-01-10, Implementation: 10-04-10)

The DME MACs identify instances where revisions to DMEPOS fees are needed and forward requests for revisions to their regional offices (RO). The RO will review requests and upon concurrence, forward them to CMS Division of Data Systems (DDS). The revisions must be contained in an ASCII file. The requests for revisions must be accompanied by a narrative description. This narrative description must be forwarded via e-mail to Laura Ashbaugh (Laura.Ashbaugh@cms.hhs.gov) and Karen Jacobs (Karen.Jacobs@cms.hhs.gov). If the files are mailed, they must be mailed to the following address:

Centers for Medicare & Medicaid Management
Laura Ashbaugh
Division of Data Systems/CMM
7500 Security Blvd.
C4-10-07
Baltimore, MD 21244-1850

The following file specifications are 2003 examples, the actual file names may change each year:

Data Set Name	DMEREV1A.TXT	First Quarter Submission
	DMEREV1B.TXT	Second Quarter Submission
	DMEREV1C.TXT	Third Quarter Submission
	DMEREV1D.TXT	Fourth Quarter Submission

Record Format

Field Name	PIC	Position	Comment
HCPCS Code	X(5)	1 - 5	
Filler	X(1)	6 - 6	Set to Spaces
First Modifier	X(2)	7 - 8	
Filler	X(1)	9	Set to Spaces
Second Modifier	X(2)	10 - 11	

Field Name	PIC	Position	Comment
Filler	X(2)	12 - 13	Set to Spaces
State	X(3)	14 - 16	
Filler	X(1)	17	Set to Spaces
Revised Base Fee	S9(5)V99	18 - 26	1992 level for surgical dressings; 1989 for all other categories
Filler	X(1)	27	Set to Spaces
Capped Rental Rebasing Indicator	X(1)	28	For Capped Rental Services Only: 0 - IR not applied to original base fee and base fee in effect prior to 1991, base fee is subject to rebasing adjustment 1 - IR applied to original base fee or base fee not in effect prior to 1991, base fee is exempted from rebasing adjustment
Filler	X(1)	29	Set to Spaces
Nature of Fee Revision	X(1)	30	0 = Correction 1 = IR Revision 2 = Other - Please submit supporting documentation.
Filler	X(1)	31	Set to Spaces
IR - Effective Date	9(8)	32 - 39	Field is applicable only to those records where the fee has changed due to an inherent reasonableness decision and the previous field contains a value of "1." Format is YYYYMMDD

The CMS will recalculate current year fee schedule amounts as appropriate and release the entire file in the record layout described in §60.1. An indicator in the record field (Pricing Change Indicator) will identify those instances where pricing amounts have changed. The CMS will also issue instructions for implementing the revised fee schedule amounts with the fee schedule.

60.5 – Rural ZIP Code Claim Record Layout for Medicare Contractors Processing Rural DMEPOS Fee Schedule Claims

(Rev. 3350, Issued: 09-11-15, Effective: 01-01-16, Implementation: 01-04-16)

This file contains rural area, as defined in 42 CFR §414.202, ZIP codes within the contiguous United States for use processing claims subject to the adjusted fee schedule methodology required by Section1834(a)(1)(F) of the Social Security Act. The CMS will provide the specific file names when the rural ZIP code files are released.

Field Name	Pic	Position	Comment
Effective Date	9(8)	1 - 8	Effective date that ZIP code considered rural (CCYYMMDD).
Expiration Date	9(8)	9 - 16	Final date for considering a ZIP code rural. Field will be filled with 99999999s if an end-date has not been established. Discontinued rural ZIP codes will be end dated as of the end of the quarter it was last an active rural ZIP. File Format is CCYYMMDD.
ZIP Code	X(5)	17 - 21	5-digit ZIP code considered rural
State	X(2)	22 - 23	
Filler	X(17)	24 -40	Set to spaces

70 - Parenteral and Enteral Nutrition (PEN) Fee Schedule

(Rev. 1, 10-01-03)
PM B-01-54, AB-02-152

The Balanced Budget Act of 1997 §4315 authorized the Secretary to implement a fee schedule for parenteral and enteral nutrition (PEN) items and services. These items were previously paid on a reasonable charge basis. The DME MACs will make payment based on the new PEN fee schedule effective for claims with dates of service on or after January 1, 2002.

The file layout for the PEN fee schedule is consistent with that of the DMEPOS fee schedule in §60.1 above except that “Region,” “Ceiling,” and “Floor” fields are not applicable and will be zero filled.

The CMS issues instructions for implementing an annual PEN fee schedule along with the DMEPOS fee schedule instructions. The PEN fee schedule is provided to DME MACs and the Pricing, Data Analysis, and Coding Contractor (PDAC) via CMS’ mainframe telecommunication system.

70.1 - Record Layout for PEN Fee Schedule

(Rev. 3350, Issued: 09-11-15, Effective: 01-01-16, Implementation: 01-04-16)

Field Name	**Pic**	**Position**	**Comment**
Year	X(4)	1 - 4	Applicable Update Year

Field Name	Pic	Position	Comment
HCPCS Code	X(5)	5 - 9	All current year active and deleted codes
1st Modifier	XX	10 - 11	
2nd Modifier	XX	12 - 13	
Jurisdiction	X	14	D = DME MAC Jurisdiction
Category	XX	15 - 16	PE = Parenteral and Enteral Nutrition.
HCPCS Action	X	17	Indicates active/delete status in HCPCS file A = Active Code D = Deleted Code, price provided for grace period processing only
Filler	XX	18 - 19	Value = 00
State	XX	20 - 21	
Original Base Fee	9(5)V99	22 - 28	This amount is not used for pricing claims. It is on file for informational purposes. Beginning January 1, 2016, this field will include the Competitive Bidding Rural Fee Amount for specific HCPCS codes. A new indicator field (RURAL FEE INDICATOR) shall be populated with a value of "R" when the Rural Fee is present in this field.
Filler	9(5)V99	29 - 35	This field is zero filled.
Filler	9(5)V99	36 - 42	This field is zero filled.
Updated Fee Schedule Amount	9(5)V99	43 - 49	Amount used for pricing.
Gap-Fill Indicator	X	50	0 = No Gap-filling required. 1 = A/B MAC (B) Needs to Gap-fill Original Base Year Amount.
Pricing Change Indicator	X	51	0 = No change to the updated fee schedule amount since previous release. 1 = A change has occurred to the updated fee schedule amount since the previous release.
Rural Fee Indicator	X(01)	52	R = Rural Fee is present in the Original Base Fee field
Filler	X(8)	53 - 60	

80 - Reasonable Charges as Basis for A/B MAC (B)/DME MAC Payments

(Rev. 1, 10-01-03)
B3-5000, AB-01-118, AB-02-136, B-02-089

Effective with services furnished on or after January 1, 1992, A/B MACs (B) pay for physicians' services based on a fee schedule. Nonphysician services are also paid based on a percentage of fee schedule amounts depending on the type of nonphysician and service

rendered. Other services and supplies (e.g., DMEPOS) are paid under the fee schedule designed specifically for those services. Beginning in 1992, only the services listed below are paid under the reasonable charge methodology.

Where payment continues to be made on a reasonable charge basis for items and services, other than ambulance and laboratory services, A/B MACs (B) compute customary and prevailing charge updates at the beginning of each fee screen year (the 12-month period beginning January), using available statistics on charges for services from claims processed or services rendered during the 12 month period ending June 30 immediately preceding the start of the fee screen year. For example, the customary and prevailing charge rates established for fee screen year 2003 (January 1, 2003, through December 31, 2003) are based on the charges made from July 1, 2001, through June 30, 2002.

Instructions regarding payment for ambulance and for laboratory services still subject to reasonable charges are found in Medicare Claims Processing Manual, Chapter 15, "Ambulance," and Chapter 16, "Laboratory Services from Independent Labs, Physicians, and Providers." Additional instructions regarding payment for dialysis supplies and equipment are provided in the Medicare Claims Processing Manual, Chapter 8, "Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims."

See specific year Program Memorandum instructions for a list of codes that are subject to the inflation-indexed charge (IIC) each year. A/B MACs (B) compute each year's IIC screen, by increasing the appropriate previous year's screen by the percentage amount specified in annual Program Memorandum instructions. A/B MACs (B) must not compute IIC screens for items paid using gap-filled payment amounts in the previous year. See specific year Program Memorandum instructions for any variances to these rules and for each year's specific increase percentage.

Services paid on a reasonable charge basis continue to be paid for under the rules in this section. A/B MACs (B)/DME MACs have the primary responsibility for determining reasonable charges. The following guidelines are intended to assure overall consistency among A/B MACs (B)/DME MACs with respect to the concepts applied in making reasonable charge determinations.

80.1 - Criteria for Determining Reasonable Charge

(Rev. 1, 10-01-03)
B3-5002, B-03-007

There are two criteria in §1842 of the Act that must be considered in determining the reasonable charge for a service. They are:

- The customary charges for similar services generally made by the physician or other person furnishing such services; and

- The prevailing charges in the locality for similar services.

Therefore, the reasonable charge for a specific service in the absence of unusual medical complications or circumstances, may not exceed the lowest of:

- The customary charge for that service;
- The prevailing charge made for similar services in the locality; or
- The actual charge for the service. (See §80.8.)

The law also provides that the reasonable charge for a service not exceed the charge applicable for a comparable service under comparable circumstances to the contractor's policyholders or subscribers. (See §80.7.) The A/B MAC (B) or DME MAC also determines if the charge for the specific item or service is inherently reasonable.

The income of an individual patient may not be considered in determining the amount of the reasonable charge.

Public Law 96-499 requires that reasonable charge payments be based on customary and prevailing charge screens in effect on the date the service is rendered. However, if the service was rendered at any time prior to the current fee year, payment is based on the screens in effect during the preceding fee screen year.

To implement this provision, the A/B MAC (B) must complete the following activities:

- Retain the prior year's pricing files in the system so that reasonable charge pricing data is available for two years. As of July 1, 2003, all A/B MACs (B) operating the MCS system must retain at least five pricing files (current period plus four prior periods); and

- Price the service based on the date of service on the claim using pricing files in effect for the same year as the date of service.

80.2 - Updating Customary and Prevailing Charges

(Rev. 1, 10-01-03)
B3-5003

A/B MACs (B)/DME MACs update customary and prevailing charge limits at the beginning of each fee screen year (the 12-month period beginning January), using available statistics on charges for services from claims processed or services rendered during the 12-month period ending June 30 immediately preceding the start of the fee screen year. For example, the limits used during fee screen year 2003 (January 1, 2003, through December 31, 2003) were based on the charges made from July 1, 2001, through June 30, 2002.

Customary and prevailing charge screens for a fee screen year are not changed except for the following reasons:

- In individually identified and highly unusual situations where equity clearly indicates that the increases are warranted and requested by the entity furnishing the service;
- To correct erroneous calculations; or
- To establish screens for new services.

A/B MACs (B)/DME MACs must ensure that all data on the frequency of services, all data files and customary and prevailing charge files used to establish reasonable charge screens are retained and are available for use.

80.3 - The Customary Charge

(Rev. 1, 10-01-03)
B3-5010, B3-5205

The customary charge is the amount that best represents the actual charges made for a given medical service or by other persons who supply other medical and health services to the general public. Therefore, obtain information on the customary charges from the following sources:

- Physicians and other persons not only from the Medicare program;
- Any other available sources;
- Other contractor programs;
- Other insurance programs;
- Federal Employee Health Benefit Program;
- TriCare;
- Any studies conducted by State or local medical societies;
- From public agencies;
- Any data volunteered from other sources.

Where circumstances warrant, MACs may also ask physicians or other persons for their charges for services rendered to the public in general. MACs should validate any information on charges obtained from sources against claims.

A. Charges for Rare or Unusual Procedures

A/B MACs (B) may incur situations where a new or rare procedure is performed and information on customary and prevailing charges is difficult to obtain. In such situations, in order to make the reasonable charge determination:

a. Obtain data, if possible, on the charges made for the unusual or rare procedure in other areas similar to the locality in which the service was rendered; or

b. Consult with the local medical society regarding the appropriate charge to be made for this procedure.

A relative value scale may be used together with available information about the physician's customary charges and about the prevailing charges for more frequently performed services in the locality in order to fill gaps in the data available. Where there is insufficient information, consult with any medical authority that would be helpful, such as the medical personnel within the A/B MAC (B), the local or State medical society, or hospital medical personnel. In assessing the value of the procedure, the medical personnel should take into consideration:

a. Its complexity;
b. The time needed to perform the procedure; and
c. The prevailing charges in the locality for other procedures of comparable complexity.

A/B MACs (B) then determine reasonable charge for a given service on the best available medical opinion and information on customary and prevailing charges.

80.3.1 - Calculating Customary Charge

(Rev. 1, 10-01-03)
B3-5010.1, B3-5213

A/B MACs (B) and DME MACs use to the extent possible, the actual charges for services rendered during the year ending June 30 immediately preceding the start of the fee screen year. Use data either from claims processed or from claims for services rendered during that 12-month period.

The A/B MAC (B) or DME MAC arrays each charge the physician, supplier, or another entity made for a service in ascending order. The lowest actual charge which is high enough to include the median of the arrayed charge data is then selected as the physician's or other person's customary charge for the service. Include charges made to a class of patients (such as members of a Preferred Provider Organization) in the array of charges used to compute the customary charge.

Customary charges may be established using price lists when there is inadequate charge data. In this case, use only the fees charged and the price lists in effect as of December 31 of the data base year. The intent is to use a price list which reasonably replicates the median of the prices charged by the supplier for his items and services during the data base year.

Where the MAC permitted an increase in a customary charge under the equity provision (see §80.3.1.1 below), the increased amount is recognized as the customary charge for the next fee screen year if it exceeds the median of charges made by the physician or other person for the service during the 12 months ending June 30 immediately preceding the start of that fee screen year. The increased amount is the correct customary charge for use in the appropriate prevailing charge calculation(s).

A. Inclusion of Sales Taxes in Reasonable Charges

Sales taxes where appropriate were included in the calculation of reasonable charges computed. They were also accounted for in the calculation of the base fee schedules for DME and orthotic/prosthetic devices. The Consumer Price Index used to update fee schedules also accounts for sales tax. Therefore, MACs do not make any additional payment for sales taxes and do not make adjustments in fees to reflect local changes in tax rates.

80.3.1.1 - Equity Adjustments in Customary Charge Screens

(Rev. 1, 10-01-03)
B3-5010.2

Once the MAC establishes the customary charge screens for a fee screen year, further increases (other than to correct errors) are permitted only in individually identified and highly unusual situations where equity clearly indicates that the increases are warranted. Requests for revisions in customary charge profiles are initiated only by physicians or other persons furnishing covered services. Such requests are neither encouraged nor discouraged, and each request is handled on the basis of its own merits.

All of the following considerations are taken into account, as applicable, in determining whether unusual circumstances warrant a revision in a customary profile in a particular situation.

- Time elapsed since last change was made in customary charge
    - Identify if the last change made in a customary charge for the service was in the past two or three years. Generally, the more time that has elapsed since the last change the stronger the case is for recognizing the current charge.
    - Take into consideration that a physician or other entity did not increase fees charged for a service because of the government's request for restraint and this can be verified. This should be taken into account in determining whether unusual circumstances are present in a particular case.
- Consider the amount of the requested increase and the relationship of the new and old charges to the customary charges of other physicians or other persons in the locality for the service.
- Increases in Operating Expenses Used to Justify an Increase in Charges
    - The entity must specifically prove that increases in operating expenses are substantially above those resulting from general economic factors and the situation is unique.

80.3.2 - Customary Charge Profile

(Rev. 1, 10-01-03)
B3-5010.3

A/B MACs (B)/DME MACs establish and maintain adequate data on the customary charges for specific services and procedures made by individual physicians and other persons and organizations which render covered services. This data must be readily available. The customary charge record for each entity rendering covered services must include a minimum of the following data:

- Entity name, address, identification code, locality and specialty status;
- A continuing history of the entity's charges for specific services, supplies, etc;
- A customary charge for each specific service or item derived from the entity's history of charges for that service or item (and which is to be used as the basis for the determination of reasonable charges in conjunction with the prevailing charge criterion); and
- For a charge made under unusual circumstances, include a description of the circumstances.

A/B MACs (B)/DME MACs develop and include in the entity's profile a customary charge conversion factor for use with a relative value scale when there is insufficient data to establish the actual customary charge or when an infrequently performed service or item is involved.

80.4 - Prevailing Charge

(Rev. 1, 10-01-03)
B3-5020

Prevailing charges are those charges that fall within the range of charges most frequently and widely used in a locality for a particular procedure or service. The top of this range establishes an overall limitation on the charges that the A/B MAC (B) accepts as reasonable for a given procedure or service, except where unusual circumstances or medical complications warrant an additional charge.

For any fee screen year, the prevailing charge limit in a locality for a service must be calculated as the 75th percentile of the customary charges determined for that service. Array each customary charge for the service in ascending order and weight by how often the physician or other person rendered the service (as reflected by the charge data used to calculate the customary charge. The lowest customary charge which is high enough to include the customary charges of the physicians or other persons who rendered 75 percent of the cumulative services is then determined as the prevailing charge for the service. The proper procedure for establishing revised prevailing charge screens based on the 75th percentile is illustrated by the following example:

Customary Charge	Number of the item/ service rendered	Cumulative Services
$5	1402	1402
$6	1115	2517
$7	1680	4197
$8	803	5000
	Total 5000	

In the above example, 75 percent of the total of 5,000 services equals 3,750 services. The prevailing charge is, therefore, $7. (A total of 2,517 services were rendered with $5 and $6 customary charges, and an additional 1,680 services were rendered with $7 customary charges. The 3,750th service was thus rendered with a $7 customary charge.)

A/B MACs (B)/DME MACs establish four customary charges as the minimum number of customary charges for the same service needed to calculate the prevailing charge for a particular service in a locality or in an A/B MAC (B) service area.

If it is necessary to establish customary charges using price lists, A/B MACs (B)/DME MACs use these customary charges to also establish the required prevailing charges. (See §80.3.1.) If the A/B MAC (B)/DME MAC cannot derive precise data on the frequency of services from their records, they may use any information they have about the volume of business done by various suppliers in their area in order to weight the customary charges used to calculate the prevailing charges.

If the A/B MAC (B)/DME MAC has not established a locality prevailing charge for the service by specialty or group of specialties, they select the locality prevailing charge from the remaining sources of data (items 2 through 5 below inclusive). That sequence must be followed in strict order except as otherwise permitted by item 6. The first charge available in the sequence of sources of data is selected as the locality prevailing charge. Payments must be based on the fully adjusted locality prevailing charges.

Approved Sources of Data in the Required Sequence

1 Prevailing charge by locality and by specialty or group of specialties;

2 Prevailing charge by A/B MAC (B) service area and by specialty or group of specialties;

3 Prevailing charge by locality without regard to specialty;

4 Prevailing charge by A/B MAC (B) service area without regard to specialty; and

5 Array of actual charges - Where items 1 through 4 have not produced an acceptable prevailing charge and where at least four physicians or other persons in your service area (without regard to locality or specialty) have submitted charges for a service (but four “qualified customary charges” are not available), array all the available

actual charges for that service. Set the prevailing charge for that service at the 75th percentile of that array.

6 Item 4 may be omitted with RO approval from the sources of data listed above, e.g., because this simplifies claims processes and reduces the related expenses. Also, when there is insufficient charge data to establish valid prevailing charges for substantial numbers of services or items, request RO assistance in working out mergers of charge data with that from other A/B MACs (B). Use another A/B MAC (B)'s data that has a similar service area with regards to medical prices, and other economic and demographic characteristics. Such data mergers must receive prior approval from CMS.

The steps described above may not always achieve a perfect result. However, beneficiaries, physicians, and suppliers have the right to question the determination in a given case. In such instances, A/B MACs (B) should use their best judgment based on the available data to resolve the issue.

The CMS publishes A/B MAC (B) and DME MAC localities. These designations should be used in making reasonable charge determinations. Where appropriate, multiple localities may be used with respect to different types and levels of services. This may occur where there are not enough members of a specialty group in any one locality to establish a valid basis for deriving the prevailing charges for their services. Prior CO approval must be obtained when deviating from the established CMS localities.

80.4.1 - Rounding of Reasonable Charge Calculation

(Rev. 1, 10-01-03)
B3-5021

A/B MAC (B) screens should include both dollars and cents. Rounding of customary and prevailing charges should not normally take place with one exception.

Rounding is permitted in situations where the A/B MAC (B)'s customary charge calculation is clearly erroneous and results in a peculiar or odd cent amount, e.g., $8.33. In such an instance, rounding to the nearest l0 cents is permissible, pending the required correction of the calculation, where the data result in a customary charge that is not in 25-cent or 75-cent units. For other than the 25-cent or 75-cent amounts, fractional amounts ending in 5-cent increments should be rounded up to the nearest l0 cents. However, where the A/B MAC (B) knows the odd cents in a customary charge calculation are correct, e.g., because a sales tax is involved in the charges made by a physician, then no rounding of the odd cents should take place.

The above exception applies only to customary charge calculations, and not to prevailing charges. The exception is permissible only as an interim measure to deal with an immediate problem. The A/B MAC (B) should promptly identify the cause of the error and take appropriate corrective action.

There should be no need for rounding initial prevailing charge calculations since actual customary charges are used to establish these screens.

80.5 - Filling Gaps in A/B MAC (B) Reasonable Charge Screens
(Rev. 1, 10-01-03)
B3-5022, AB-02-136, B-02-089

Where there is insufficient actual charge data for determining the customary charge and/or the prevailing charge in the locality for a particular medical procedure or service, A/B MACs (B)/DME MACs must use one of the following gap-filling methods to establish the needed screen.

A. Gaps in Customary Charge Screens

A/B MACs (B)/DME MACs fill a gap in a customary charge screen:

1. By applying a conversion factor derived from the physician's (or supplier's) known customary charges for other services in the same category of service (medicine, surgery, etc.) to a relative value scale in the manner suggested in §§80.3, or

2. By using the 50th percentile in the array of customary charges (weighted by frequency) that was used to establish the prevailing charges for similar services for the physicians in the same specialty and locality.

A/B MACs (B)/DME MACs must ensure that, where a 50th percentile charge is used as a customary charge for payment purposes, the reasonable charge does not exceed either that amount or the locality prevailing charge. Also, all A/B MACs (B)/DME MACs that use 50th percentile charges to fill gaps in their customary charge data must retain the capacity to calculate and use conversion factors with relative value scales when this is appropriate.

B. Gaps in Prevailing Charge Screens

Where the A/B MAC (B) has not been able to establish a prevailing charge for a service based on the prevailing charge screen procedures, then A/B MACs (B) must gap-fill the payment amounts using a prevailing charge conversion factor (§80.5.1) and a relative value scale, manually if necessary. (See §80.3 regarding charges for rare or unusual procedures. This is to be used as a last resort.

80.5.1 - Use of Relative Value Scale and Conversion Factors for Reasonable Charge Gap-Filling
(Rev. 1, 10-01-03)
B3-5022.1

The relative value scales used to fill gaps in charge data for the Medicare program should, to the extent possible, be those that contractors use in their own programs. Relative value scales developed by contractors or by medical societies for States other than those in which

your Medicare service area is located should be carefully reviewed and validated before they are used. Ensure that a relative value scale, which is used to estimate customary charges or prevailing charges, accurately reflects charge patterns in the area you service. Similarly, the conversion factor used with the relative value scale should reflect the known customary charges of the physician or other person for whom a customary charge is being estimated, or the known prevailing charges for services in the locality, as appropriate.

As a result of consent agreements with the Federal Trade Commission (FTC), relative value scales formerly published by the American Academy of Orthopedic Surgeons, the American College of Obstetricians and Gynecologists, the American College of Radiology, and the California Medical Association have been withdrawn from circulation. The FTC consent agreements did not bar the use of the related procedural terminology and coding systems. However, do not use these four relative value scales to fill gaps in customary and prevailing charge data.

This does not mean that you must discontinue using relative value scales to fill gaps in customary charges or in determining prevailing charges. Instead use a system of relative value units that has not been the subject of a consent agreement, or develop your own system. A potential source of information in this regard is the relative value scale that has been included with the CMS HCPCS. This relative value scale is included with HCPCS as an informational item only. You may use it, revise it, or use some other relative value scale if you deem it more appropriate.

You may, if necessary develop a relative value scale for gap-filling purposes by dividing the unadjusted prevailing charges in a locality by a common denominator and filling the gaps in the resulting "relative value scale" by relying on medical staff judgment or on other persons with knowledge of the charging patterns and practices in your service area. Alternatively, you may use a service area wide approach and/or the unweighted average of the customary charges that have been made for a service, divided by a common denominator.

For radiology codes (codes beginning with 7, local radiology codes, and R-codes in HCPCS), you may use the national and local relative values used to make payment under the radiology fee schedule.

Customary and/or prevailing charge conversion factors used with relative value scales to fill gaps in reasonable charge screens should be calculated as outlined in A and B below. (Develop separate customary charge conversion factors for each physician or supplier from his known customary charges in the same category of services, e.g., medicine, surgery, radiology, etc. Similarly, separate prevailing charge conversion factors, by locality (and by specialty or groups of specialties as applicable), should be calculated based on the known prevailing charges, by locality and specialty, or groups of specialties within the same category of service. Customary charge conversion factors may only be calculated for a physician for a category of service if the physician has at least seven customary charges for services in that category of service upon which to base the conversion factor calculation. If a physician does not have sufficient customary charges to calculate a conversion factor in

one category of service, this does not preclude the calculation of his customary charge conversion factors for other categories of service for which he does have sufficient customary charges).

A. Customary Charge

Use the following formula for the calculation of a customary charge conversion factor:

C/F = Customary charge conversion factor

CHG = The physician's customary charge for a procedure

SVC = Number of times the physician performed the procedure

l-n = The different procedures the physician performed within a category of service

RVU = The relative value unit assigned to a procedure

SIGMA = Sum of

$$C/F = \frac{CHG_1}{RVU_l} \times SVC_l + \frac{CHG_2}{RVU_2} \times SVC_2 . \frac{CHG_n}{RVU_n} \times SVC_n$$

$$\text{SIGMA } SVC_{1\text{-}n}$$

EXAMPLE: Compute a customary charge conversion factor for a physician with the following charge history: (May be for medicine, surgery, radiology, pathology.)

Procedure	Frequency	Customary Charge	Relative Value
1	$ 3	5.00	1
2	7	12.00	2
3	5	35.00	4
4	4	20.00	3
5	6	8.00	1.5
	25		

Method

l. For each procedure, divide the customary charge by the relative value and multiply the result by the frequency of that procedure in the physician's charge history.

2. Add all the results of these computations.

3. Divide the result by the sum of all the frequencies.

Solution

$$\frac{(5x3)}{1} + \frac{(12x7)}{2} + \frac{(35x5)}{4} + \frac{(20x4)}{3} + \frac{(8x6}{1.5}$$ divided by 25=

(5 x 3) + (6 x 7) + (8.75 x 5) + (6.67 x 4) + (5.33 x 6) = 25
15 + 42 + 43.75 + 26.68 + 3l.98 = 25
159.41 = $6.40 (i.e., $6.38 rounded to the 25 nearest 10 cents)

To determine a physician's customary charge for a particular procedure where there is no reliable statistical basis, multiply the relative value of the procedure by the physician's customary charge conversion factor for the appropriate category of service (e.g., radiology, medicine, surgery).

B. Prevailing Charges

The prevailing charge conversion factors used with the appropriate relative value scale are developed from the same formula used for customary charge conversion factors, except that:

CHG = The fully adjusted locality prevailing charge for a procedure by locality and by specialty or group of specialties (regardless of the source of data from which the locality prevailing charge was developed).

SVC = The number of times the procedure was performed by all physicians in the same specialty or group of specialties and locality.

l-n = The different procedures within a category of service for which prevailing charges have been established by specialty or group of specialties and locality.

The conversion factors calculated for any fee screen year reflect customary and prevailing charges calculated on the basis of charge data for the year ending June 30 immediately preceding the start of the fee screen year. Also, reasonable charge screens established through the use of a relative value scale and conversion factors consist of two components. Consequently, the conversion factors must be recalculated when there is any change in the relative value units assigned to procedures (as may occur if you use a different or updated relative value scale) in order to assure that the change(s) in unit values do not violate the integrity of the reasonable charge screens. The economic index limitation, the no rollback provision, and the Administrative Savings Clause are not applied directly to prevailing charge conversion factors calculated in accordance with this section.

80.6 - Inflation Indexed Charge (IIC) for Nonphysician Services

(Rev. 2837, Issued: 12-13-13, Effective: 01-01-14 - payment reasonable charge basis/04-01-14 - payment national fee schedule basis, Implementation: 01-06-14 - payment reasonable charge basis/04-07-14 - payment national fee schedule basis)

A General

Effective for services rendered on or after October 1, 1985, an additional factor - the inflation indexed charge (IIC), is added to the factors taken into consideration in

determining reasonable charges for non-physician services. Non-physician services are defined as those Part B medical services, supplies, and equipment reimbursed on a reasonable charge basis and not subject to the application of the Medicare Economic Index (MEI).

Examples of items affected by the IIC are:

- Prosthetic and orthotic devices not subject to the fee schedules [Therapeutic Shoes (2005 and prior), Intraocular Lenses (2014 and prior)];
- Blood products and transfusion medicine;
- Certain medical supplies used in connection with home dialysis (2011 and prior); and
- Ambulance services (2001 and prior)

80.7 - Determination of Comparable Circumstances

(Rev. 1, 10-01-03)
B3-5026

A/B MACs (B) do not make a reasonable charge determination that would be higher than the charge upon which they would base payment to their own policyholders for a comparable service under comparable circumstances. The charge upon which payment is based does not mean the amount the A/B MAC (B) would be obligated to pay. Under certain circumstances, some A/B MACs (B) pay amounts on behalf of their policyholders, which are below the customary and prevailing charges physicians or other persons usually make to the general public. Payments under the medical insurance program are not limited to these lower amounts.

"Comparable circumstances" refers to the circumstances under which services are rendered to individuals and the nature of your health insurance programs, and the method used to determine the amounts of payment under these programs. Generally, comparability exists where:

- Payment is made under the contractor's own program on the customary charges of physicians or other persons, and on current prevailing charges in a locality, and
- The determination does not preclude recognition of factors such as specialty status and unusual circumstances that affect the amount charged for a service.

However, even where there is comparability, coverage limitations applicable under the contractor's own programs do not necessarily apply to reasonable charge determinations for Medicare purposes.

The “current” customary and/or prevailing charges of an A/B MAC (B)’s private health plan refer to the payment screens that are presently in effect, e.g., payment levels actually being used in the A/B MAC (B)’s private business for settling claims submitted by its policy holders or subscribers. A/B MACs (B) must, therefore, continue to apply the comparability limitation based upon their payment screens that are presently in effect, even where an update under their private insurance plans has been deferred. If an A/B MAC (B)’s private health plan allowances are later revised, it will be necessary for the A/B MAC (B) to reexamine the relationship of these new payment levels to those under the Medicare program an initiate the necessary changes through their routine maintenance operations.

Responsibility for determining whether an A/B MAC (B)’s program has comparability will fall upon the A/B MAC (B) in reporting pertinent information about its programs to CMS. When the pertinent information has been reported, CMS will advise the A/B MAC (B) whether any of its programs have comparability.

80.8 - Applying Criteria for Reasonable Charge Determinations

(Rev. 1, 10-01-03)
B3-5030, B3-5030.2

The reasonable charge determination for a covered service should be based on the actual charge for the service when that charge is no higher than the applicable customary and prevailing charges. The A/B MAC (B) should exercise judgment so that its reasonable charge determinations are realistic and equitable. A/B MACs (B) should take into account special factors in individual cases that might affect the reasonableness of charges. The special factors could involve travel, medical complications, or other unusual circumstances such as prolonged time and attention required by a patient’s condition.

Different services and supplies for which charges are made under Part B, may not be grouped together for the purpose of making one overall reasonable charge determination. Thus, in processing a claim for payment a separate reasonable charge determination must be made with respect to each item for which a charge is made.

80.8.1 - Waiver of Deductible and Coinsurance

(Rev. 1, 10-01-03)
B3-5220

Physicians or suppliers who routinely waive the collection of deductible or coinsurance from a beneficiary constitute a violation of the law pertaining to false claims and kickbacks. These situations should be referred to Program Integrity area for additional investigation according to the procedures in the Medicare Program Integrity Manual.

Deductible and coinsurance amounts are taken into account (included) in determining the reasonable charge for a service or item. In this regard, a billed amount that is not reasonably related to an expectation of payment is not considered the “actual” charge for the purpose of processing a claim or for the purpose of determining customary charges.

Where a physician/supplier makes a reasonable collection effort for the payment of coinsurance/deductibles, failure to collect payment is not considered a reduction in the physician's/supplier's charge. To be considered a reasonable collection effort, the effort to collect Medicare coinsurance/deductible amounts must be similar to the effort made to collect comparable amounts from non-Medicare patients. It must also involve the issuance of a bill to the beneficiary or to the party responsible for the patient's personal financial obligations. In addition, it may include other actions, such as subsequent billings, collection letters and telephone calls or personal contacts which constitute a genuine, rather than token, collection effort.

90 - Inherent Reasonableness Used for Payment of Nonphysician Services

(Rev. 1, 10-01-03)
B3-5246, AB-98-9 (Obsolete instructions)

Placeholder for instruction when current regulation is finalized.

100 - Competitive Bidding Durable Medical Equipment Prosthetics, Orthotics and Supplies (DMEPOS) Single Payment Amounts

(Rev. 2682, Issued: 04-05-13, Effective: 07-01-13, Implementation: 07-01-13)

Section 1847 (b)(5) of the Social Security Act mandates that a single payment amount be established for each item in each competitive bid area based on the bids submitted and accepted for that item. Section 1847(a)(6) of the Act requires that this payment basis be substituted for the fee schedule payment basis otherwise applied under section 1834(a) of the Act for DME, section 1834(h) of the Act for off-the-shelf orthotics, or section 1842(s) of the Act for enteral nutrients, equipment and supplies, as appropriate.

For the Round One Rebid, the DME MACs will make payment based on the new competitive bidding single payment amounts effective for claims with dates of service on or after January 1, 2011. The CMS issues instructions for implementing the single payment amounts and/or updating the payment amounts quarterly for competitive bidding items. The following files will be provided to the DME MACs and the Pricing, Data Analysis and Coding (PDAC) Contractor via CMS' mainframe telecommunication system in order to implement a competitive bidding round: a Healthcare Common Procedure Coding System (HCPCS) category file, a bid pricing file, a ZIP Code file, and a contract supplier file. All four files will contain data only for the current competitive bidding round.

The DME MACs will make manual updates to the competitive bidding files, as instructed through Recurring Update Notifications. The following files will be provided on a quarterly basis to the DME MACs and the Pricing, Data Analysis and Coding (PDAC) Contractor via CMS' mainframe telecommunication system: HCPCS category file, bid pricing file, and ZIP Code file. These files will only contain the changes for that quarter.

Upon successful receipt of the mainframe files, DME MACs will send notification of receipt via e-mail to price_file_receipt@cms.hhs.gov, stating the name of the files received and the entities for which they were received (e.g., DME MAC name).

Following program implementation and on an as needed basis, updates to the contract supplier file will be accomplished via an Excel file emailed directly from the Competitive Bidding Implementation Contractor (CBIC) to the DME MACs. Upon successful receipt of the files, the DME MACs will send notification of receipt via email stating the name of the file received and the entities for which they were received (e.g., DME MAC name) to the CBIC. E-mails should be sent to cbic.dmemac@palmettoGBA.com at the CBIC. The DME MACs shall manually update the contract supplier file with the changes by adding and/or end dating each supplier record.

Public use files containing the competitive bidding HCPCS categories, single payment amounts and ZIP Codes are available on the CBIC Website at http://www.dmecompetitivebid.com/palmetto/cbic.nsf.

100.1 - Record Layout for Competitive Bidding HCPCS Category File

(Rev. 2088, Issued: 11-05-10, Effective: 01-01-11, Implementation: 01-03-11)

Field Name	Pic	Position	Comment
CBA Bid Category Effective Date	X(8)	1 - 8	
Bid Product Category Effective Date- CC	9(2)	1 - 2	
Bid Product Category Effective Date-Year	9(2)	3 - 4	
Bid Product Category Effective Date -Month	9(2)	5 - 6	
Bid Product Category Effective-Day	9(2)	7 - 8	
Bid Category Expiration Date	X(8)	9 - 16	
Bid Product Category Expiration Date -CC	9(2)	9 - 10	
Bid Product Category Expiration Date - Year	9(2)	11 - 12	

Field Name	Pic	Position	Comment
Bid Product Category Expiration Date-Month	9(2)	13 - 14	
Bid Product Category Expiration Date - Day	9(2)	15 - 16	
HCPCS Procedure Codes	X(13)_	17 - 29	
HCPCS Procedure Code	X(5)	17 - 21	All Competitive Bidding Active Codes.
Modifier 1	X(2)	22 - 23	
Modifier 2	X(2)	24 - 25	
Modifier 3	X(2)	26 - 27	
Modifier 4	X(2)	28 - 29	

Field Name	Pic	Position	Comment
CBA Area	X(5)	30 - 34	16740 = Charlotte NC-SC 16741 = Charlotte NC-SC Mail Order 17140 = Cincinnati OH 17141 = Cincinnati OH Mail Order 17460 = Cleveland OH 17461 = Cleveland OH Mail Order 19100 = Dallas TX 19101 = Dallas TX Mail Order 28140 = Kansas MO-KS 28141 = Kansas MO- KS Mail Order 33100 = Miami FL 33101 = Miami FL Mail Order 36740 = Orlando FL 36741 = Orlando FL Mail Order 38300 = Pittsburgh PA 38301 = Pittsburgh PA Mail Order 40140 = Riverside CA 40141 = Riverside CA Mail Order
Bid Product Category Number	X(3)	35 - 37	001 = Oxygen Supplies & Equipment 002 = Standard Power Wheelchairs 003 = Complex Rehab Power Wheelchairs 004 = Mail Order Diabetic Supplies 005 = Enteral Nutrients, Equipment 006 = CPAPs, RADs and Related Supplies 007 = Hospital Beds & Related Supplies 009 = Walkers & Related Supplies 010 = Support Surfaces

Field Name	Pic	Position	Comment
Bid Business Rule 1	X(1)	38 - 38	When field contains “S”, permits non-contract physicians to bill selected CB items or “H”, permits Hospitals to bill selected CB items
Bid Business Rule 2	X(1)	39 - 39	When field contains “S”, permits non-contract physicians to bill selected CB items or “H”, permits Hospitals to bill selected CB items.
Bid Business Rule 3	X(1)	40 - 40	For future use
Bid Business Rule 4	X(1)	41- 41	For future use
Bid Business Rule 5	X(1)	42 - 42	For future use
Filler	X(8)	43 - 50	

100.2 - Record Layout for Competitive Bidding Pricing File

(Rev. 2088, Issued: 11-05-10, Effective: 01-01-11, Implementation: 01-03-11)

Field Name	Pic	Position	Comment
CBA Bid Round Effective Date	X(8)	1-8	
Bid Round Effective Date - CC	9(2)	1 -2	
Bid Round Effective Date -Year	9(2)	3-4	
Bid Round Effective Date - Month	9(2)	5 - 6	
Bid Round Effective Date - Day	9(2)	7 - 8	

Field Name	Pic	Position	Comment
Bid Round Expiration	X(8)	9-16	
Bid Round Expiration Date -CC	9(2)	9 - 10	
Bid Round Expiration Date - Year	9(2)	11 - 12	
Bid Round Expiration Date- Month	9(2)	13 - 14	
Bid Round Expiration Date - Day	9(2)	15 - 16	
HCPCS Procedure Code	X(5)	17 - 21	
Modifier 1	X(2)	22 - 23	
Modifier 2	X(2)	24 - 25	
Modifier 3	X(2)	26 - 27	
Modifier 4	X(2)	28 - 29	
DMEPOS Category	X(2)	30 - 31	IN = Inexpensive/Routinely Purchased FS = Frequently Serviced CR = Capped Rental OX = Oxygen & Oxygen Equipment OS = Ostomy, Tracheostomy & Urologicals SD = Surgical Dressings PO = Prosthetics & Orthotics SU = Supplies TE = TENS

Field Name	Pic	Position	Comment
CBA Area	X(5)	32 - 36	16740 = Charlotte NC-SC 16741 = Charlotte NC-SC Mail Order 17140 = Cincinnati OH 17141 = Cincinnati OH Mail Order 17460 = Cleveland OH 17461 = Cleveland OH Mail Order 19100 = Dallas TX 19101 = Dallas TX Mail Order 28140 = Kansas MO-KS 28141 = Kansas MO- KS Mail Order 33100 = Miami FL 33101 = Miami FL Mail Order 36740 = Orlando FL 36741 = Orlando FL Mail Order 38300 = Pittsburgh PA 38301 = Pittsburgh PA Mail Order 40140 = Riverside CA 40141 = Riverside CA Mail Order
Bid Price	9(6)V99.	37 - 44	Competitive Bidding Single Payment Amount for HCPCS code
Bid Price Effective Date	X(8)	45 - 52	
Bid Price Effective Date - CC	9(2)	45 - 46	
Bid Price Effective Date -Year	9(2)	47 - 48	
Bid Price Effective Date - Month	9(2)	49 - 50	
Bid Price Effective Date - Day	9(2)	51 - 52	

Field Name	Pic	Position	Comment
Bid Price Expiration Date	X(8)	53 - 60	
Bid Price Expiration Date -CC	9(2)	53 - 54	
Bid Price Expiration Date - Year	9(2)	55 - 56	
Bid Price Expiration Date- Month	9(2)	57 - 58	
Bid Price Expiration Date - Day	9(2)	59 - 60	
Price Change Indicator	X(1)	61 - 61	
Bid Product Category	X(3)	62 - 64	001 = Oxygen Supplies & Equipment 002 = Standard Power Wheelchairs 003 = Complex Rehab Power Wheelchairs 004 = Mail Order Diabetic Supplies 005 = Enteral Nutrients, Equipment 006 = CPAPs, RADs and Related Supplies 007 = Hospital Beds & Related Supplies 009 = Walkers & Related Supplies 010 = Support Surfaces
Filler	X(12)	65 - 76	

100.3 - Record Layout for Competitive Bidding ZIP Code File

(Rev. 2088, Issued: 11-05-10, Effective: 01-01-11, Implementation: 01-03-11)

Field Name	Pic	Position	Comment
CBA ZIP Code Effective Date	X(8)	1- 8	

Field Name	Pic	Position	Comment
Bid ZIP Code Effective Date- CC	9(2)	1 - 2	
Bid ZIP Code Effective Date-Year	9(2)	3-4	
Bid ZIP Code Effective Date -Month	9(2)	5 - 6	
Bid ZIP Code Effective Date - Day	9(2)	7- 8	
Bid ZIP Code Expiration Date	X(8)	9-16	
Bid ZIP Code Expiration Date -CC	9(2)	9 - 10	
Bid ZIP Code Expiration Date - Year	9(2)	11 - 12	
Bid ZIP Code Expiration Date- Month	9(2)	13 - 14	
Bid ZIP Code Expiration Date - Day	9(2)	15 - 16	
CBA ZIP Code	X(5)	17 - 21	ZIP Code for the CBA
CBA State	X(2)	22 - 23	

Field Name	Pic	Position	Comment
CBA Area	X(5)	24- 28	16740 = Charlotte NC-SC 16741 = Charlotte NC-SC Mail Order 17140 = Cincinnati OH 17141 = Cincinnati OH Mail Order 17460 = Cleveland OH 17461 = Cleveland OH Mail Order 19100 = Dallas TX 19101 = Dallas TX Mail Order 28140 = Kansas MO-KS 28141 = Kansas MO- KS Mail Order 33100 = Miami FL 33101 = Miami FL Mail Order 36740 = Orlando FL 36741 = Orlando FL Mail Order 38300 = Pittsburgh PA 38301 = Pittsburgh PA Mail Order 40140 = Riverside CA 40141 = Riverside CA Mail Order
Filler	X(12)	29 - 40	

100.4 - Record Layout for Competitive Bidding Contract Supplier File

(Rev. 2088, Issued: 11-05-10, Effective: 01-01-11, Implementation: 01-03-11)

Field Name	Pic	Position	Comment
Supplier NSC Number	X(10)	1 - 10	
Supplier NPI Number	X(10)	11 - 20	

Field Name	Pic	Position	Comment
CBA Area	X(5)	21 - 25	16740 = Charlotte NC-SC 16741 = Charlotte NC-SC Mail Order 17140 = Cincinnati OH 17141 = Cincinnati OH Mail Order 17460 = Cleveland OH 17461 = Cleveland OH Mail Order 19100 = Dallas TX 19101 = Dallas TX Mail Order 28140 = Kansas MO-KS 28141 = Kansas MO- KS Mail Order 33100 = Miami FL 33101 = Miami FL Mail Order 36740 = Orlando FL 36741 = Orlando FL Mail Order 38300 = Pittsburgh PA 38301 = Pittsburgh PA Mail Order 40140 = Riverside CA 40141 = Riverside CA Mail Order
Bid Effective Date	X(8)	26 - 33	
Bid Effective Date-CC	9(2)	26 - 27	
Bid Effective Date-Year	9(2)	28 - 29	
Bid Effective Date - Month	9(2)	30 - 31	
Bid Effective Date-Day	9(2)	32 - 33	
Bid Expiration Date	X(8)	34 - 41	
Bid Expiration Date - CC	9(2)	34 - 35	

Field Name	Pic	Position	Comment
Bid Expiration Date - Year	9(2)	36 - 37	
Bid Expiration Date- Month	9(2)	38 - 39	
Bid Expiration Date - Day	9(2)	40 - 41	
Bid Switches Occurs 500 Times	X(500)	42-541	The switch occurrence equates to the 500 Times Bid category; i.e., Bid Switch (1) denotes the supplier contract for category 001
Bid Switch (1)	X(1)	42 - 42	
Bid Switch (2)	X(1)	43 - 43	
Filler	X(59)	542 - 600	

100.5 - Adjustments to the Single Payment Amounts to Reflect Changes in HCPCS Codes

(Rev. 1535, Issued: 06-13-08, Effective: 07-01-08, Implementation: 07-07-08)

If new HCPCS codes are established following the start of a competitive bidding contract period that describe new technology items that did not previously fall under HCPCS codes for competitive bidding items, they will not be added to the competitive bidding HCPCS, CBA pricing and public use files.

If a HCPCS code descriptor for a competitive bidding item is revised to clarify the item described by that code after the competitive bidding contract period begins, a corresponding code descriptor change will be made in the competitive bidding HCPCS, CBA pricing and public use files.

Should a HCPCS code be deleted from the HCPCS after the competitive bidding contract period begins, the deleted code will be considered invalid for claims submission under the competitive bidding program and will be removed from the competitive bidding HCPCS, CBA pricing and public use files. Although the code is discontinued, as explained below, the items that previously fell under the code may continue to be subject to the competitive bidding program.

If a HCPCS code for a competitive bidding item is revised after the contract period for a competitive bidding program begins, CMS will adjust the single payment amount(s) for the item(s) on the CBA pricing file for that Round using one of the following methods:

a. If a single HCPCS code for an item is divided into two or more HCPCS codes for the components of that item, the sum of the single payment amounts for the new HCPCS codes will equal the single payment amount for the original item. In accordance with instructions provided in future recurring update notifications, the payment amounts for the HCPCS codes for the components will be established based on the corresponding fee schedule amounts for these codes that are established in accordance with section 60.3 of chapter 23 of the Claims Processing Manual. These amounts for the components of the item will then be adjusted by the same percentage to the level where the sum of the payment amounts for the HCPCS codes for the components equals the single payment amount for the item.

b. If a single HCPCS code is divided into two or more separate HCPCS codes for different but similar items, the single payment amount for each of the new separate HCPCS codes is equal to the single payment amount applied to the original, single HCPCS code.

c. If the HCPCS codes for components of an item are merged into a single HCPCS code for the item, the single payment amount for the new HCPCS code is equal to the total of the separate single payment amounts for the components.

d. If multiple HCPCS codes for different but similar items are merged into a single HCPCS code, the items to which the new HCPCS codes apply may be furnished by any supplier that has a valid Medicare billing number. Payment for the new code will be based on the fee schedule methodology, even if single payment amounts were established for the discontinued multiple HCPCS codes. The old codes will be considered invalid and no longer included in the competitive bidding program for the remainder of the contract term.

Contract suppliers must furnish the item(s) described by the new HCPCS code(s) in scenarios (a) through (c) above and submit claims using the new codes. Notification of a competitive bidding HCPCS code change will occur through program instruction.

Addendum - MPFSDB File Record Layout and Field Descriptions

(Rev. 4298, Issued: 05-03-19, Effective: 01-01-19, Implementation 10-07-19)

The CMS MPFSDB includes the total fee schedule amount, related component parts, and payment policy indicators. The record layout is provided below. Beginning with the 2019 MPFSDB, and thereafter, the MPFSDB File Record Layout will no longer be revised annually in this section for the sole purpose of changing the calendar year, but will only be revised when there is a change to a field. Previous MPFSDB file layouts (for 2018 and prior) can be found on the CMS web site on the Physician Fee Schedule web page at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html.

MPFSDB File Layout

HEADER RECORD

FIELD #	DATA ELEMENT NAME	LOCATION	PIC
1	Header ID	1-4	x(4) Value “Head"
2	Header Number	5	x(1)
3	Data Set Name	6-50	x(45)
4	Record Length	51-53	x(3)
5	Filler	54-54	x(1)
6	Block size	55-58	x(4)
7	Filler	59-59	x(1)
8	Number of Records Number does not include this header record.	60-69	9(10)
9	Date Created	70-77	x(8) YYYYMMDD
10	Blanks	78-345	x(268)

DATA RECORD

FIELD # & ITEM	LENGTH & PIC
1 File Year This field displays the effective year of the file.	4 Pic x(4)
2 A/B MAC (B) Number This field represents the 5-digit number assigned to the A/B MAC (B).	5 Pic x(5)
3 Locality This 2-digit code identifies the pricing locality used.	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
4 HCPCS Code This field represents the procedure code. Each A/B MAC (B) Current Procedural Terminology (CPT) code (other than codes for Multianalyte Assays with Algorithmic Analyses (MAAA) and Proprietary Laboratory Analyses (PLA)) and alpha-numeric HCPCS codes other than B, C, E, K and L codes will be included. The standard sort for this field is blanks, alpha, and numeric in ascending order. Note: MAAA and PLA are alpha-numeric CPT codes.	5 Pic x(5)
5 Modifier For diagnostic tests, a blank in this field denotes the global service and the following modifiers identify the components: 26 = Professional component TC = Technical component For services other than those with a professional and/or technical component, a blank will appear in this field with one exception: the presence of CPT modifier -53 which indicates that separate Relative Value Units (RVUs) and a fee schedule amount have been established for procedures which the physician terminated before completion. This modifier is used only with colonoscopy through stoma code 44388, colonoscopy code 45378 and screening colonoscopy codes G0105 and G0121. Any other codes billed with modifier -53 are subject to medical review and priced by individual consideration. Modifier-53 = Discontinued Procedure - Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances, or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued.	2 Pic x(2)
6 Descriptor This field will include a brief description of each procedure code.	50 Pic x(50)
7 Code Status This 1 position field provides the status of each code under the full fee schedule. Each status code is explained in §30.2.2.	1 Pic x(1)
8	8 Pic 9(4)v9999

FIELD # & ITEM	LENGTH & PIC
Conversion Factor This field displays the multiplier which transforms relative values into payment amounts. The file will contain the conversion factor for the File Year which will reflect all adjustments.	
9 Update Factor This update factor has been included in the conversion factor in Field 8.	6 Pic 9(2)v9999
10 Work Relative Value Unit This field displays the unit value for the physician work RVU.	9 Pic 9(7)v99
11 Filler	9 Pic 9(7)v99
12 Malpractice Relative Value Unit This field displays the unit value for the malpractice expense RVU.	9 Pic 9(7)v99
13 Work Geographic Practice Cost Indices (GPCIs) This field displays a work geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
14 Practice Expense GPCI This field displays a practice expense geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
15 Malpractice GPCI This field displays a malpractice expense geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
16 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	3 Pic x(3)

FIELD # & ITEM	LENGTH & PIC
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 = A/B MAC (B) 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.)	
17 Preoperative Percentage (Modifier 56) This field contains the percentage (shown in decimal format) for the preoperative portion of the global package. For example, 10 percent will be shown as 010000. The total of fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
18 Intraoperative Percentage (Modifier 54) This field contains the percentage (shown in decimal format) for the intraoperative portion of the global package including postoperative work in the hospital. For example, 63 percent will be shown as 063000. The total of fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
19 Postoperative Percentage (Modifier 55) This field contains the percentage (shown in decimal format) for the postoperative portion of the global package that is provided in the office after discharge from the hospital. For example, 17 percent will be shown as 017000. The total of fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
20 Professional Component (PC)/Technical Component (TC) Indicator	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
0 = Physician service codes: This indicator identifies codes that describe physician services. Examples include visits, consultations, and surgical procedures. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. Modifiers 26 & TC cannot be used with these codes. The total Relative Value Units (RVUs) include values for physician work, practice expense and malpractice expense. There are some codes with no work RVUs. 1 = Diagnostic tests or radiology services: This indicator identifies codes that describe diagnostic tests, e.g., pulmonary function tests, or therapeutic radiology procedures, e.g., radiation therapy. These codes generally have both a professional and technical component. Modifiers 26 and TC can be used with these codes. The total RVUs for codes reported with a 26 modifier include values for physician work, practice expense, and malpractice expense. The total RVUs for codes reported with a TC modifier include values for practice expense and malpractice expense only. The total RVUs for codes reported without a modifier equals the sum of RVUs for both the professional and technical component. 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	

FIELD # & ITEM	LENGTH & PIC
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 A/B MACs (B) 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 hospital inpatient. This applies only to code 85060. No TC billing is recognized because payment for the underlying clinical laboratory test is made to the hospital, generally through the PPS rate. No payment is recognized for code 85060 furnished to hospital outpatients or non-hospital patients. The physician interpretation is paid through the clinical laboratory fee schedule payment for the clinical laboratory test. 9 = Concept of a professional/technical component does not apply.	
21 Multiple Procedure (Modifier 51)	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
Indicator indicates which payment adjustment rule for multiple procedures applies to the service. 0 = No payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure, base payment on the lower of: (a) the actual charge or (b) the fee schedule amount for the procedure. 1 = Standard payment adjustment rules in effect before January 1, 1996, for multiple procedures apply. In the 1996 MPFSDB, this indicator only applies to codes with procedure status of "D." If a procedure is reported on the same day as another procedure with an indicator of 1,2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 25 percent, 25 percent, 25 percent, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage. 2 = Standard payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 50 percent, 50 percent, 50 percent, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage. 3 = Special rules for multiple endoscopic procedures apply if procedure is billed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure). The base procedure for each code with this indicator is identified in field 31G. Apply the multiple endoscopy rules to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). If an endoscopic procedure is reported with only its base procedure, do not pay separately for the base procedure. Payment for the base procedure is included in the payment for the other endoscopy. 4 = Subject to 25% reduction of the TC diagnostic imaging (effective for services January 1, 2006 through June 30, 2010). Subject to 50% reduction of the TC diagnostic imaging (effective for services July 1, 2010 and after). Subject to 25% reduction of the PC of diagnostic imaging (effective for services January 1, 2012 through December 31, 2016). Subject to 5% reduction of the PC of diagnostic imaging (effective for services January 1, 2017 and after).	

FIELD # & ITEM	LENGTH & PIC
5 = Subject to 20% reduction of the practice expense component for certain therapy services furnished in office and other non-institutional settings, and 25% reduction of the practice expense component for certain therapy services furnished in institutional settings (effective for services January 1, 2011 and after). Subject to 50% reduction of the practice expense component for certain therapy services furnished in both institutional and non-institutional settings (effective for services April 1, 2013 and after). 6 = Subject to 25% reduction of the TC diagnostic cardiovascular services (effective for services January 1, 2013 and after). 7 = Subject to 20% reduction of the TC diagnostic ophthalmology services (effective for services January 1, 2013 and after). 9 = Concept does not apply.	
22 Bilateral Surgery Indicator (Modifier 50) This field provides an indicator for services subject to a payment adjustment. 0 = 150 percent payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier -50 or with modifiers RT and LT, base payment for the two sides on the lower of: (a) the total actual charge for both sides or (b) 100 percent of the fee schedule amount for a single code. Example: The fee schedule amount for code XXXXX is $125. The physician reports code XXXXX-LT with an actual charge of $100 and XXXXX-RT with an actual charge of $100. Payment would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The bilateral adjustment is inappropriate for codes in this category because of (a) physiology or anatomy or (b) because the code descriptor specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure. 1 = 150 percent payment adjustment for bilateral procedures applies. If code is billed with the bilateral modifier or is reported twice on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base payment for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides or (b) 150 percent of the fee schedule amount for a single code. If code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any applicable multiple procedure rules.	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
2 = 150 percent payment adjustment for bilateral procedure does not apply. RVUs are already based on the procedure being performed as a bilateral procedure. If procedure is reported with modifier -50 or is reported twice on the same day by any other means (e.g., with RT and LT modifiers with a 2 in the units field), base payment for both sides on the lower of (a) the total actual charges by the physician for both sides or (b) 100 percent of the fee schedule amount for a single code. Example: The fee schedule amount for code YYYYY is $125. The physician reports code YYYYY-LT with an actual charge of $100 and YYYYY-RT with an actual charge of $100. Payment would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The RVUs are based on a bilateral procedure because: (a) the code descriptor specifically states that the procedure is bilateral; (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally; or (c) the procedure is usually performed as a bilateral procedure. 3 = The usual payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier -50 or is reported for both sides on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base payment for each side or organ or site of a paired organ on the lower of: (a) the actual charge for each side or (b) 100% of the fee schedule amount for each side. If procedure is reported as a bilateral procedure and with other procedure codes on the same day, determine the fee schedule amount for a bilateral procedure before applying any applicable multiple procedure rules. Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral procedures. 9 = Concept does not apply.	
23	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
Assistant at Surgery This field provides an indicator for services where an assistant at surgery is never paid for per IOM. 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.	
24 Co-Surgeons (Modifier 62) This field provides an indicator for services for which two surgeons, each in a different specialty, may be paid. 0 = Co-surgeons not permitted for this procedure. 1 = Co-surgeons could be paid; supporting documentation required to establish medical necessity of two surgeons for the procedure. 2 = Co-surgeons permitted; no documentation required if two specialty requirements are met. 9 = Concept does not apply.	1 Pic (x)1
25 Team Surgeons (Modifier 66) This field provides an indicator for services for which team surgeons may be paid. 0 = Team surgeons not permitted for this procedure. 1 = Team surgeons could be paid; supporting documentation required to establish medical necessity of a team; pay by report. 2 = Team surgeons permitted; pay by report. 9 = Concept does not apply.	1 Pic (x)1
26 Filler	1 Pic (x)1
27 Site of Service Differential For 1999 and beyond, the site of service differential no longer applies. The following definitions will apply for all years after 1998: 0 = Facility pricing does not apply.	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
1 = Facility pricing applies. 9 = Concept does not apply.	
28 Non-Facility Fee Schedule Amount This field shows the fee schedule amount for the non-facility setting. This amount equals Field 34. **Note**: Field 33 D indicates if an additional adjustment should be applied to this formula. Non-Facility Pricing Amount for the File Year [(Work RVU * Work GPCI) + (Non-Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor	9 Pic 9(7)v99
29 Facility Fee Schedule Amount This field shows the fee schedule amount for the facility setting. This amount equals Field 35. **Note:** Field 33D indicates if an additional adjustment should be applied to this formula. Facility Pricing Amount for the File Year [(Work RVU * Work GPCI) + (Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor Place of service codes to be used to identify facilities. 02 – Telehealth-Medicare pays telehealth services at the facility rate. 19 – Off Campus-Outpatient Hospital 21 - Inpatient Hospital 22 – On Campus-Outpatient Hospital 23 - Emergency Room - Hospital 24 - Ambulatory Surgical Center – In a Medicare approved ASC, for an approved procedure on the ASC list, Medicare pays the lower facility fee to physicians. Beginning with dates of service January 1, 2008, in a Medicare approved ASC, for procedures NOT on the ASC list of approved procedures, contractors will also pay the lower facility fee to physicians. 26 - Military Treatment Facility 31 - Skilled Nursing Facility 34 - Hospice	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
41 - Ambulance - Land 42 - Ambulance Air or Water 51 - Inpatient Psychiatric Facility 52 - Psychiatric Facility Partial Hospitalization 53 - Community Mental Health Center 56 - Psychiatric Residential Treatment Facility 61 - Comprehensive Inpatient Rehabilitation Facility	
29A Anti-markup Test Indicator This field providers an indicator for Anti-markup Test HCPCS codes: '1' = Anti-markup Test HCPCS. '9' = Concept does not apply.	1 Pic x
30 Record Effective Date This field identifies the effective date for the MPFSDB record for each HCPCS. The field is in YYYYMMDD format. NOTE: This is not the date the HCPCS code was created. It is the date the code was updated or added to the MPFSDB file for the current file year. This field is set to January 1 for all codes during the annual update process.	8 Pic x(8)
31 Filler	28 Pic x(28)
31EE Reduced therapy fee schedule amount	9Pic(7)v99
31DD Filler	1Pic x(2)
31CC Imaging Cap Indicator A value of "1" means subject to OPPS payment cap determination. A value of "9" means not subject to OPPS payment cap determination.	1Pic x(1)
31BB Non-Facility Imaging Payment Amount	9Pic(7)v99
31AA	9Pic(7)v99

FIELD # & ITEM	**LENGTH & PIC**
Facility Imaging Payment Amount	
31A	2 Pic x(2)

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. (Diagnostic imaging procedures performed by a Registered Radiologist Assistant (RRA) who is certified and registered by The American Registry of Radiologic Technologists (ARRT) or a Radiology Practitioner Assistant (RPA) who is certified by the Certification Board for Radiology Practitioner Assistants (CBRPA), and is authorized to furnish the procedure under state law, may be performed under direct supervision.) 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 = 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 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 physician. 66 = May be personally performed by a physician or by a physical therapist with ABPTS certification and certification in this specific procedure.	

FIELD # & ITEM	LENGTH & PIC
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.	
31B This field has been deleted to allow for the expansion of field 31A.	
31C Facility Setting Practice Expense Relative Value Units	9 Pic(7)v99
31D Non-Facility Setting Practice Expense Relative Value Units	9 Pic(7)v99
31E Filler	9 Pic(7)v99
31F Filler Reserved for future use.	1 Pic x(1)
31G Endoscopic Base Codes This field identifies an endoscopic base code for each code with a multiple surgery indicator of 3.	5 Pic x(5)
32A 1996 Transition/Fee Schedule Amount This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
32B 1996 Transition/Fee Schedule This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
32C	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
1996 Transition/Fee Schedule Amount When Site or Service Differential Applies This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	
33A Units Payment Rule Indicator Reserved for future use. 9 = Concept does not apply.	1 Pic x(1)
33B Mapping Indicator This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
33C Anti-markup Locality—Informational Use—Locality used for reporting utilization of anti-markup services. NOT FOR A/B MAC (B) USE: These Medicare Advantage encounter pricing localities are for Shared System Maintainer purposes only. The locality values were developed to facilitate centralized processing of encounter data by the Medicare Advantage organizations.	2 Pic x(2)
33D Calculation Flag This field is informational only; the SSMs do not need to add this field**.** The intent is to assist A/B MACs (B) to understand how the fee schedule amount in fields 28 and 29 are calculated. The MMA mandates an additional adjustment to selected HCPCS codes. A value of "1" indicates an additional fee schedule adjustment of 1.32 in 2004 and 1.03 in 2005. A value of "0" indicates no additional adjustment needed. A value of "2" indicates an additional fee schedule adjustment of 1.05 effective 7/1/2008.	1 Pic x(1)
33 E 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)	2Pic x(2)

FIELD # & ITEM	LENGTH & PIC
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). Subject to the reduction of the PC diagnostic imaging (effective for services January 1, 2012 and after). 99 = Concept Does Not Apply	
33F Performance Payment Indicator (For future use)	1 Pic x (1)
33G National Level Future Expansion	3 Pic x (3)
34 Non-Facility Fee Schedule Amount This field replicates field 28.	9 Pic 9(7)v99
35 Facility Fee Schedule Amount This field replicates field 29.	9 Pic 9(7)v99
36 Filler	1 Pic x(1)
37 Future Local Level Expansion** The Updated 1992 Transition Amount was previously stored in this field. A/B MACs (B) can continue to maintain the updated transition amount in this field.	7 Pic x(7)
38A Future Local Level Expansion** The adjusted historical payment basis (AHPB) was previously stored in this field. A/B MACs (B) can continue to maintain the AHPB in this field.	7 Pic x(7)
38 B	8 Pix x(8)

FIELD # & ITEM	LENGTH & PIC
Filler This field was originally established for 15 spaces. Since AHPB data will only use 7 of the 15 spaces, A/B MACs (B) have 8 remaining spaces for their purposes. ** These fields will be appended by each A/B MAC (B) at the local level.	

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R4465CP	11/15/2019	Medicare Claims Processing Manual Chapter 23 - Fee Schedule Administration and Coding Requirements	01/30/2019	10868
R4418CP	10/18/2019	Medicare Physician Fee Schedule Database (MPFSDB) Update to Status Indicators	11/19/2019	11453
R4298CP	05/03/2019	Medicare Physician Fee Schedule Database (MPFSDB) File Record Layout	10/07/2019	11191
R4188CP	12/28/2018	Medicare Claims Processing Manual Chapter 23 - Fee Schedule Administration and Coding Requirements- Rescinded and replaced by Transmittal 4465	01/30/2019	10868
R4131CP	09/14/2018	Updates to Chapter 23 Fee File Instructions	12/17/2018	10926
R4130CP	09/14/2018	Update to the Medicare Claims Processing Manual, Chapter 23, Section 60.3	10/15/2018	10924
R3931CP	12/01/2017	CY 2018 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule	01/02/2018	10395
R3903CP	11/03/2017	Annual Medicare Physician Fee Schedule (MPFS) Files Delivery and Implementation and Medicare Physician Fee Schedule Database (MPFSDB) 2018 File Layout Manual	01/02/2018	10218
R3876CP	10/06/2017	Decommission the MCS Maintained HBCRB081 Report (“Correct Coding Quarterly Savings Report”)	04/02/2018	10284
R3721CP	02/24/2017	Updates to Pub. 100-04, Chapters 12, 17 and 23 to Correct Remittance Advice Messages	05/25/2017	9906

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R3693CP	01/13/2017	Medicare Physician Fee Schedule Database (MPFSDB) 2017 File Layout Manual	01/03/2017	9784
R3671CP	12/05/2016	CY 2017 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule	01/03/2016	9854
R3613CP	09/16/2016	Medicare Physician Fee Schedule Database (MPFSDB) 2017 File Layout Manual – Rescinded and replaced by Transmittal 3693.	01/03/2017	9784
R3416CP	11/23/2015	CY 2016 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule	01/04/2016	9431
R3371CP	10/09/2015	Medicare Physician Fee Schedule Database (MPFSDB) 2016 File Layout Manual	01/04/2016	9346
R3350CP	09/11/2015	Implementation of Adjusted Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule Amounts Using Information from the National Competitive Bidding Program (CBP)	01/04/2016	9239
R3316CP	08/07/2015	Implementation of Adjusted Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule Amounts Using Information from the National Competitive Bidding Program (CBP) – Rescinded and replaced by Transmittal 3350	01/04/2016	9239
R3190CP	02/06/2015	CY 2015 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule	01/05/2015	8999
R3144CP	12/05/2014	Medicare Physician Fee Schedule Database (MPFSDB) 2015 File Layout Manual	01/05/2015	8958

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R3129CP	11/21/2014	CY 2015 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule – Rescinded and replaced by Transmittal 3190	01/05/2015	8999
R3124CP	11/13/2014	2015 Healthcare Common Procedure Coding System (HCPCS) Annual Update Reminder	01/05/2014	8975
R3100CP	10/24/2014	2015 Healthcare Common Procedure Coding System (HCPCS) Annual Update Reminder – Rescinded and replaced by Transmittal 3124	01/05/2014	8975
R3093CP	10/10/2014	Medicare Physician Fee Schedule Database (MPFSDB) 2015 File Layout Manual – Rescinded and replaced by Transmittal 3144	01/05/2015	8958
R3081CP	09/26/2014	Update to Pub. 100-04, Chapter 23 to Provide Language-Only Changes for Conversion to ICD-10	Upon Implementation of ICD-10	8692
R3020CP	08/08/2014	Update to Pub. 100-04, Chapter 23 to Provide Language-Only Changes for Conversion to ICD-10 – Rescinded and replaced by Transmittal 3081	Upon Implementation of ICD-10	8692
R2902CP	03/11/2014	April Quarterly Update for 2014 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule	04/07/2014	8645
R2893CP	02/28/2014	April Quarterly Update for 2014 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule	04/07/2014	8645
R2837CP	12/13/2013	Change to the Reasonable Charge Update for 2014 for Splints, Casts and Certain Intraocular Lenses	01/06/2014	8523

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R2836CP	01/06/2013	CY 2014 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule	01/06/2014	8531
R2790CP	09/20/2013	Medicare Physician Fee Schedule Database (MPFSDB) 2014 File Layout Manual	01/06/2014	8455
R2783CP	09/10/2013	Corrections to the Medicare Claims Processing Manual	09/17/2013	8343
R2725CP	06/14/2013	Corrections to the Medicare Claims Processing Manual – Rescinded and replaced by Transmittal 2783	09/17/2013	8343
R2709CP	05/17/2013	July Quarterly Update for 2013 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule	07/01/2013	8325
R2682CP	04/05/2013	Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP) - July 2013	07012013	8232
R2643CP	01/31/2013	Streamlining the Process for Updating the Abstract Files Used to Price Institutional Claims	07/01/2013	8128
R2632CP	01/11/2013	CY 2013 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule	01/07/2013	8133
R2608CP	12/07/2012	CY 2013 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule – Rescinded and replaced by Transmittal 2632	01/07/2013	8133
R2566CP	10/12/2012	Medicare Physician Fee Schedule Database (MPFSDB) 2013 File Layout Manual	01/07/2013	8064

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R2549CP	09/21/2012	Medicare Physician Fee Schedule Database (MPFSDB) 2013 File Layout Manual – Rescinded and replaced by Transmittal 2566	01/07/2013	8064
R2340CP	11/04/2011	CY 2012 Update for Durable Medical Equipment, Prosthetics. Orthotics and Supplies (DMEPOS) Fee Schedule	01/03/2012	7635
R2288CP	08/26/2011	Establishing a Quarterly Recurring Update Notification Process for Temporary “K” and “Q” Codes	01/03/2012	7493
R2287CP	08/26/2011	Medicare Physician Fee Schedule Database (MPFSDB) 2012 File Layout Manual	01/03/2012	7554
R2236CP	06/03/2011	July Quarterly Update for 2011 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule	07/05/2011	7416
R2148CP	02/04/2011	Auto Denial of Claim Line(s) Items Submitted With a GZ Modifier	07/05/2011	7228
R2119CP	12/14/2010	Medicare Physician Fee Schedule Database (MPFSDB) 2011 File Layout Manual	01/03/2011	7243
R2101CP	11/19/2010	Medicare Physician Fee Schedule Database (MPFSDB) 2011 File Layout Manual – Rescinded and replaced by Transmittal 2119	01/03/2011	7243
R2088CP	1105/2010	January 2011 Quarterly Update for the DMEPOS Competitive Bidding Program	01/03/2011	7181
R2006CP	07/23/2010	October Quarterly Update for 2010 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule	10/04/2010	7070

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R1853CP	11/13/2009	CY 2010 Fee Schedule Update for Durable Medical Equipment, Prosthetics. Orthotics and Supplies (DMEPOS) Fee Schedule	01/04/2010	6720
R1825CP	10/08/2009	Medicare Physician Fee Schedule Database (MPFSDB) 2010 File Layout	01/04/2010	6648
R1822CP	10/02/2009	Medicare Physician Fee Schedule Database (MPFSDB) 2010 File Layout – Rescinded and replaced by Transmittal 1825	01/04/2010	6648
R1717CP	04/24/2009	Speech-Language Pathology Practice Payment Policy	07/06/2009	6381
R1709CP	04/03/2009	Manualization of the Medicare Physician Fee Schedule (MPFS) Record Layouts for Contractors Processing Institutional Claims	07/06/2009	6443
R1644CP	12/05/2008	2008 Jurisdiction List for Durable Medical Equipment Prosthetics, Orthotics, and Supply Healthcare Common Procedure Coding System (HCPCS) Codes	10/27/2008 and 12/12/2008	6062
R1632CP	11/07/2008	Medicare Physician Fee Schedule Database (MPFSDB) 2009 File Layout	01/05/2009	6227
R1630CP	11/07/2008	Fee Schedule Update for 2009 for Durable Medical Equipment, Prosthetics, Orthotics and Supplies	01/05/2009	6270
R1605CP	09/26/2008	2008 Jurisdiction List for Durable Medical Equipment Prosthetics, Orthotics, and Supply Healthcare Common Procedure Coding System (HCPCS) Codes – Rescinded and replaced by Transmittal 1644	10/27/2008	6062
R1535CP	06/13/2008	July 2008 Quarterly Update for the DMEPOS Competitive Bidding Program	07/07/2008	6101
R1472CP	03/06/2008	Update of Institutional Claims References	04/07/2008	5893

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R1421CP	01/25/2008	Update of Institutional Claims References - Rescinded and Replaced by Transmittal 1472	04/07/2008	5893
R1358CP	10/26/2007	Medicare Physician Fee Schedule Database (MPFSDB) 2008 File	01/07/2008	5774
R1005CP	07/21/2006	Medicare Physician Fee Schedule Database (MPFSDB) 2007 File Layout	01/02/2007	5206
R823CP	02/01/2006	New Temporary Code for Battery for Power Mobility Devices	07/03/2006	4253
R614CP	07/22/2005	Medicare Physician Fee Schedule Database (MPFSDB) 2006 File Layout	01/03/2006	3889
R341CP	10/29/2004	Implementation of the Medicare Physician Fee Schedule (MPFS) National Abstract File for Purchased Diagnostic Tests and Interpretations	04/04/2005	3481
R323CP	10/22/2004	Update Regarding the Use of American Dental Association's (ADA) Current Dental Terminology (CDT) Codes on Medicare Contractors Web Sites and Other Electronic Media	11/22/2004	3499
R286CP	08/27/2004	Medicare Physician Fee Schedule Database (MPFSDB) 2005 File Layout	01/03/2005	3421
R283CP	08/27/2004	2005 Healthcare Common Procedure Coding System (HCPCS) Annual Update Reminder	01/03/2005	3422
R236CP	07/23/2004	2005 DMEPOS Pricing File Record Layout Expansion and New Pricing Procedures for Certain DMEPOS Items Based on Modifiers	01/03/2005	3300
R210CP	06/18/2004	CMS Annual Reminder to Contractors of The ICD-9-CM Update for October 1, 2004	10/04/2004	3303

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R127CP	03/26/2004	Annual Spreadsheet Containing an Updated List of HCPCS Codes for Durable Medical Equipment Regional Carrier (DMERC) and Part B Local Carrier Jurisdictions to Reflect Codes That Have Been Added or Discontinued (Deleted) During Each Year	05/26/2004	3139
R126CP	03/26/2004	ICD-9 Coding for Beneficiary Claims	N/A	2857
R095CP	02/06/2004	Eliminate The 90-Day Grace Period for Billing Discontinued ICD-9-CM Codes	10/01/2004	3094
R089CP	02/06/2004	Eliminating The 90-Day Grace Period for Billing Discontinued HCPCS Codes	07/06/2004	3093
R066CP	01/16/2004	Quarterly Update to Correct Coding Initiative (CCI) Edits, Version 10 1, Effective April 1, 2004	04/05/2004	2997
R050CP	12/19/2003	Clarification That Medicare Contractors Will Be Receiving Quarterly Updates for Temporary HCPCS Codes	04/05/2004	2967
R043CP	12/19/2003	Using the American Dental Association's (ADA's) Current Dental Terminology-Fourth Edition (CDT-4) Codes of Contractors Web Sites and Other Electronic Media.	01/20/2004	3003
R037CP	12/08/2003	Adding place of service (POS) code 42 to Field 29 of MFSDB; and 38B, and adding the year 2004 to field 8 Conversion Factor	01/05/2004	2970
R001CP	10/01/2003	Initial Publication of Manual	NA	NA

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