Medicare Claims Processing Manual

Chapter 23 - Fee Schedule Administration and Coding Requirements

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10 - ICD-9-CM Diagnosis and Procedure Codes

(Rev. 1, 10-01-03)

B3-4020.2 Item 21, A3-3604, PM-01-144, CMS Medlearn Web site for diagnosis codes, A3-3632, HO-230.8, B3-15021.1, B-03-028

ICD-9-CM and its "Official ICD-9-CM Guidelines for Coding and Reporting" have been selected as the approved coding set for entities covered under the Health Insurance Portability and Accountability Act (HIPAA) for reporting diagnoses and inpatient procedures. This requires the use of ICD-9-CM and its official coding and reporting guidelines by most health plans (including Medicare) by October 16, 2002. The Administrative Simplification Act of 2001, however, permits plans and providers to apply for an extension until October 16, 2003.

The "Official ICD-9-CM Guidelines for Coding and Reporting" provides guidance on coding. The "ICD-9-CM Coding Guidelines for Outpatient Services," which is part of the "Official ICD-9-CM Guidelines for Coding and Reporting," provides guidance on diagnosis coding specific to outpatient facilities and physician offices.

Proper coding is necessary on Medicare claims because codes are generally used to assist in determining coverage and payment amounts.

A - ICD-9-CM Diagnosis Codes

The CMS accepts only ICD-9-CM diagnostic and procedural codes that use definitions contained in DHHS Publication No. (PHS) 89-1260 or CMS approved errata and supplements to this publication. The CMS approves only changes issued by the Federal ICD-9-CM Coordination and Maintenance Committee. Diagnosis codes must be full ICD-9-CM diagnoses codes, including all five digits where applicable

Diagnosis coding changes for Volume 1 and 2 are approved annually by a Federal committee. The changes take effect each year October 1. Volume 3 is revised annually by CMS. Updates include:

- Addition of new codes;
- Deletion of old codes; and
- Revisions to descriptions of codes.

Rules for reporting diagnosis codes on the claim are:

- Use the ICD-9-CM code that describes the patient's diagnosis, symptom, complaint, condition or problem. Do not code suspected diagnosis.
- Use the ICD-9-CM code that is chiefly responsible for the item or service provided.

- Assign codes to the highest level of specificity. Use the fourth and fifth digits where applicable.
- Code a chronic condition as often as applicable to the patient's treatment.
- Code all documented conditions that coexist at the time of the visit that require or affect patient care or treatment. (Do not code conditions that no longer exist.)

Claims submitted to the carrier on Form CMS-1500 or its electronic equivalent must have a diagnosis code to identify the patient's diagnosis/condition (item 21). All physician and nonphysician specialties (e.g., PA, NP, CNS, CRNA) must use an ICD-9-CM code number and code to the highest level of specificity. Up to four codes may be submitted in priority order (primary, secondary condition). An independent laboratory is required to enter a diagnosis only for limited coverage procedures.

All narrative diagnoses for nonphysician specialties must be submitted on an attachment.

Inpatient claims submitted to the intermediary on Form CMS-1450 or its electronic equivalent must have a principal diagnosis. For inpatient claims, the provider reports the principal diagnosis in FL 67. 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 DRG and an overpayment to a hospital under PPS.

The physician should code the ICD-9-CM code that provides the highest degree of accuracy and completeness. In the context of ICD-9-CM coding, the "highest degree of specificity" refers to assigning the most precise ICD-9-CM code that most fully explains the narrative description of the symptom or diagnosis. Concerning level of specificity, ICD-9-CM codes contain either 3, 4, or 5-digits. If a 3-digit code has 4-digit codes which further describe it, then the 3-digit code is not acceptable for claim submission. If a 4-digit code has 5-digit codes which further describe it, then the 4-digit code is not acceptable for claim submission.

For electronically submitted DMEPOS claims, a valid diagnosis code, which most fully explains the patient's diagnosis, is required. 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.

For outpatient claims, providers report the full ICD-9-CM code for the diagnosis shown to be chiefly responsible for the outpatient services in FL 67. 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 (786.2). If, during the course

of the outpatient evaluation and treatment, a definitive diagnosis is made (e.g., acute bronchitis), the definitive diagnosis is reported (466.0). 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 an ICD-9-CM code for "Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations" (V70-V82). Examples include:

- Routine general medical examination (V70.0);
- General medical examination without any working diagnosis or complaint, patient not sure if the examination is a routine checkup (V70.9); or
- Examination of ears and hearing (V72.1).

Other diagnoses codes are required on inpatient claims and are used in determining the appropriate Diagnosis Related Group (DRG). The provider reports the full ICD-9-CM codes for up to eight 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 it is duplicated, intermediaries should eliminate it before GROUPER. Proper installation of the Medicare Code Editor (MCE) identifies situations where the principal diagnosis is duplicated.

For outpatient claims, providers report the full ICD-9-CM codes for up to eight 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 an other diagnosis.

Form Locator 76 on the Form CMS-1450 is defined as Admitting Diagnosis/Patient's Reason for Visit is required for inpatient hospital claims subject to PRO 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 is defined as Patient's Reason for Visit and is not required by Medicare but may be used by providers for nonscheduled visits for outpatient bills.

Additional information and training is available in Medlearn on CMS Web site: http://cms.hhs.gov/medlearn/cbt%5Ficd9.asp

B - ICD-9-CM Procedure Codes

ICD-9-CM 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. The principal procedure is the procedure performed for definitive treatment rather than for diagnostic or exploratory purposes, or which was necessary to take care of a complication. It is also the procedure most closely related to the principal diagnosis. The provider enters the

ICD-9-CM code for the inpatient principal procedure on the Form CMS-1450 FL 80 titled Principal Procedure Code and Date. This includes incision, excision, amputation, introduction, repair, destructions, endoscopy, suture, and manipulation.

The principal procedure code shown on the bill **must** be the full ICD-9-CM, Volume 3, procedure code, including all 4-digit codes where applicable.

Other procedure codes are reported using the full ICD-9-CM, Volume 3, procedure codes, including all four digits where applicable. Up to five significant procedures other than the principal procedure may be reported.

ICD-9-CM diagnosis and procedure codes are available on CMS Web site: http://cms.hhs.gov/paymentsystems/icd9/

10.1 - ICD-9-CM Coding for Diagnostic Tests

(Rev. 1, 10-01-03)

PM AB-01-144, PM B-01-61, A3-3632, HO-230.8, B3-15021.1,

The CMS requires following the ICD-9-CM Coding Guidelines for Outpatient Services (hospital-based and physician office). These guides instruct physicians to report diagnoses based on test results, if available. The Coding Clinic for ICD-9-CM confirms this longstanding coding guideline.

Contractors, physicians, hospitals, and other health care providers must comply with the following instructions in determining the appropriate ICD-9-CM diagnoses code for diagnostic test results. These instructions simplify coding for diagnostic tests consistent with the ICD-9-CM Guidelines for Outpatient Services (hospital-based and physician office).

10.1.1 - Determining the Appropriate Primary ICD-9-CM Diagnosis Code for Diagnostic Tests Ordered Due to Signs and/or Symptoms

(Rev. 1, 10-01-03)

A3-3632, HO-230.8, B3-15021.1

A - Confirmed Diagnosis Based on Results of Test

If the physician has confirmed a diagnosis based on the results of the diagnostic test, the physician interpreting the test should code that diagnosis. The signs and/or symptoms that prompted ordering the test may be reported as additional diagnoses if they are not fully explained or related to the confirmed diagnosis.

EXAMPLE 1: A surgical specimen is sent to a pathologist with a diagnosis of "mole." The pathologist personally reviews the slides made from the specimen and makes a diagnosis of "malignant melanoma." The pathologist should report a diagnosis of "malignant melanoma" as the primary diagnosis.

EXAMPLE 2: A patient is referred to a radiologist for an abdominal CT scan with a diagnosis of abdominal pain. The CT scan reveals the presence of an abscess. The radiologist should report a diagnosis of "intra-abdominal abscess."

EXAMPLE 3: A patient is referred to a radiologist for a chest x-ray with a diagnosis of "cough." The chest x-ray reveals 3 cm. peripheral pulmonary nodule. The radiologist should report a diagnosis of "pulmonary nodule" and may sequence "cough" as an additional diagnosis.

B - Signs or Symptoms

If the diagnostic test did not provide a diagnosis or was normal, the interpreting physician should code the sign(s) or symptom(s) that prompted the treating physician to order the study.

EXAMPLE 1: A patient is referred to a radiologist for a spine x-ray due to complaints of "back pain." The radiologist performs the x-ray, and the results are normal. The radiologist should report a diagnosis of "back pain" since this was the reason for performing the spine x-ray.

EXAMPLE 2: A patient is seen in the ER for chest pain. An EKG is normal, and the final diagnosis is chest pain due to suspected gastroesophageal reflux disease (GERD). The patient was told to follow up with his primary care physician for further evaluation of the suspected GERD. The primary diagnosis code for the EKG should be chest pain. Although the EKG was normal, a definitive cause for the chest pain was not determined.

C - Diagnosis Preceded by Words that Indicate Uncertainty

If the results of the diagnostic test are normal or nondiagnostic and the referring physician records a diagnosis preceded by words that indicate uncertainty (e.g., probably, suspected, questionable, rule out, or working), then the interpreting physician should not code the referring diagnosis. Rather the interpreting physician should report the sign(s) or symptom(s) that prompted the study. Diagnoses labeled as uncertain are considered by the ICD-9-CM Coding Guidelines as unconfirmed and should not be reported. This is consistent with the requirement to code the diagnosis to the highest degree of certainty.

EXAMPLE: A patient is referred to a radiologist for a chest x-ray with a diagnosis of "rule out pneumonia." The radiologist performs a chest x-ray, and the results are normal. The radiologist should report the sign(s) or symptom(s) that prompted the test (e.g., cough).

10.1.2 - Instructions to Determine the Reason for the Test

(Rev. 1, 10-01-03)

A3-3632, HO-230.8, B3-15021.1,

The Balanced Budget Act (BBA) §4317(b) requires referring physicians to provide diagnostic information to the testing entity at the time the test is ordered. As further indicated in 42 CFR 410.32 all diagnostic tests "must be ordered by the physician who is treating the beneficiary. An "order" is a communication from the treating physician/practitioner requesting that a diagnostic test be performed for a beneficiary. An order may include the following forms of communication:

- A written document signed by the treating physician/practitioner, which is hand-delivered, mailed, or faxed to the testing facility;
- A telephone call by the treating physician/practitioner or his/her office to the testing facility; or
- An electronic mail by the treating physician/practitioner or his/her office to the testing facility.

NOTE: If the order is communicated via telephone, both the treating physician/practitioner or his/her office and the testing facility must document the telephone call in their respective copies of the beneficiary's medical records.

A. On the rare occasion when the interpreting physician does not have diagnostic information as to the reason for the test and the referring physician is unavailable to provide such information, it is appropriate to obtain the information directly from the patient or the patient's medical record if it is available. However, an attempt should be made to confirm any information obtained from the patient by contacting the referring physician.

EXAMPLE: A patient is referred to a radiologist for a gastrograffin enema to rule out appendicitis. However, the referring physician does not provide the reason for the referral and is unavailable at the time of the study. The patient is queried, indicates that he/she saw the physician for abdominal pain, and was referred to rule out appendicitis. The radiologist performs the x-ray, and the results are normal. The radiologist should report the abdominal pain as the primary diagnosis.

B. If the physician's interpretation of the test result is not clear or is ambiguously stated in the patient's medical record, either the attending physician or the physician that performed that test should be contacted for clarification. This may result in the reporting of symptoms or a confirmed diagnosis.

C. If the test (e.g., lab test) has been performed and the results are back, but the patient's physician has not yet reviewed them to make a diagnosis, or there is no physician interpretation, code the symptom or the diagnosis provided by the referring physician.

D. If the individual responsible for reporting the codes for the testing facility or the physician's office does not have the report of the physician interpretation at the time of billing, the individual responsible for reporting the codes for the testing facility or the physician's office should code what they know at the time of billing. Sometimes reports of the physician's interpretation of diagnostic tests may not be available until several days later, which could result in delay of billing. Therefore, in such instances, the individual responsible for reporting the codes for the testing facility or the physician's office should code based on the information/reports available to them, or what they know, at the time of billing.

10.1.3 - Incidental Findings

(Rev. 1, 10-01-03)

A3-3632, HO-230.8, B3-15021.1

Incidental findings should never be listed as primary diagnoses. If reported, incidental findings may be reported as secondary diagnoses by the physician interpreting the diagnostic test.

EXAMPLE 1: A patient is referred to a radiologist for an abdominal ultrasound due to jaundice. After review of the ultrasound, the interpreting physician discovers that the patient has an aortic aneurysm. The interpreting physician reports jaundice as the primary diagnosis and may report the aortic aneurysm as a secondary diagnosis because it is an incidental finding.

EXAMPLE 2: A patient is referred to a radiologist for a chest x-ray because of wheezing. The x-ray is normal except for scoliosis and degenerative joint disease of the thoracic spine. The interpreting physician reports wheezing as the primary diagnosis since it was the reason for the patient's visit and may report the other findings (scoliosis and degenerative joint disease of the thoracic spine) as additional diagnoses.

EXAMPLE 3: A patient is referred to a radiologist for a magnetic resonance imaging (MRI) of the lumbar spine with a diagnosis of L-4 radiculopathy. The MRI reveals degenerative joint disease at L1 and L2. The radiologist reports radiculopathy as the primary diagnosis and may report degenerative joint disease of the spine as an additional diagnosis.

10.1.4 - Unrelated Coexisting Conditions/Diagnoses

(Rev. 1, 10-01-03)

B3-3632, HO-230.8, B3-15021.1

Unrelated and coexisting conditions/diagnoses may be reported as additional diagnoses by the physician interpreting the diagnostic test.

EXAMPLE A patient is referred to a radiologist for a chest x-ray because of a cough. The result of the chest x-ray indicates the patient has pneumonia. During the performance of the diagnostic test, it was determined that the patient has hypertension and diabetes mellitus. The interpreting physician reports a primary diagnosis of pneumonia. The interpreting physician may report the hypertension and diabetes mellitus as secondary diagnoses.

10.1.5 - Diagnostic Tests Ordered in the Absence of Signs and/or Symptoms

(Rev. 1, 10-01-03)

A3-3632, HO-230.8, A3-3632, R1891.A.3, B.3-15021.1, R1807.B.3

When a diagnostic test is ordered in the absence of signs/symptoms or other evidence of illness or injury, the testing facility or the physician interpreting the diagnostic test should report the screening code as the primary diagnosis code. Any condition discovered during the screening should be reported as a secondary diagnoses.

10.1.6 - Use of ICD-9-CM to the Greatest Degree of Accuracy and Completeness

(Rev. 1, 10-01-03)

A3-3632, HO-230.8, B3-15021.1

The following longstanding coding guidelines are part of “Official ICD-9-CM Guidelines for Coding and Reporting.”

The testing facility or the interpreting physician should code the ICD-9-CM code that provides the highest degree of accuracy and completeness for the diagnosis resulting from test, or for the sign(s)/ symptom(s) that prompted the ordering of the test.

The "highest degree of specificity means assigning the most precise ICD-9-CM code that most fully explains the narrative description in the medical chart of the symptom or diagnosis.

EXAMPLE 1: A chest x-ray reveals a primary lung cancer in the left lower lobe. The interpreting physician should report the ICD-9-CM code as 162.5 for malignancy of the left "lower lobe, bronchus or lung," not the code for a malignancy of "other parts of bronchus or lung" (162.8) or the code for "bronchus and lung unspecified" (162.9).

EXAMPLE 2: If a sputum specimen is sent to a pathologist and the pathologist confirms growth of "streptococcus, type B" which is indicated in the patient's medical record, the pathologist should report a primary diagnosis as 482.32 (Pneumonia due to streptococcus, Group B). However, if the pathologist is unable to specify the organism, then the pathologist should report the primary diagnosis as 486 (Pneumonia, organism unspecified).

In order to report the correct number of digits when using ICD-9-CM, refer to the following instructions:

ICD-9-CM diagnosis codes are composed of codes with three, four, or five digits. Codes with three digits are included in ICD-9-CM as the heading of a category of codes that may be further subdivided by the use of fourth and fifth digits to provide greater specificity. Assign 3-digit codes only if there are no 4-digit codes within that code category. Assign 4-digit codes only if there is no 5-digit subclassification for that category. Assign the 5-digit subclassification code for those categories where it exists.

EXAMPLE 3: A patient is referred to a physician with a diagnosis of diabetes mellitus. However, there is no indication that the patient has diabetic complications or that the diabetes is out of control. It would be incorrect to assign code 250 since all codes in this series have five digits. Reporting only three digits of a code that has five digits would be incorrect. One must add two more digits to make it complete. Because the type (adult onset/juvenile) of diabetes is not specified, and there is no indication that the patient has a complication or that the diabetes is out of control, the correct ICD-9-CM code would be 250.00. The fourth and fifth digits of the code would vary depending on the specific condition of the patient. One should be guided by the codebook.

For the latest ICD-9-CM coding guidelines, please refer to the following Web site: http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm guide.

10.1.7 - Coding Questions and Answers for Diagnostic Tests

(Rev. 1, 10-01-03)

A3-3632, HO-230.8, B3-15021.1, R1769b3

The following is from the "Coding Clinic for ICD-9-CM," copyright 2000 by the American Hospital Association. All rights reserved. Reprint is granted with permission from the American Hospital Association.

Question 1: A skin lesion of the cheek is surgically removed and submitted to the pathologist for analysis. The surgeon writes on the pathology order, "skin lesion." The pathology report comes back with the diagnosis of "basal cell carcinoma." A laboratory billing consultant is recommending that the ordering physician's diagnosis be reported instead of the final diagnosis obtained by the pathologist. In addition, an insurance carrier is also suggesting this case be coded to "skin lesion" since the surgeon did not know the nature of the lesion at the time the tissue was sent to pathology. Which code should the pathologist use to report his claim?

Answer 1: The pathologist is a physician and if a diagnosis is made it can be coded. It is appropriate for the pathologist to code what is known at the time of code assignment. For example, if the pathologist has made a diagnosis of basal cell carcinoma, assign code 173.3, Other malignant neoplasm of skin, skin of other and unspecified parts of face. If the pathologist had not come up with a definitive diagnosis, it would be appropriate to code the reason why the specimen was submitted, in this instance, the skin lesion of the cheek.

Question 2: A patient presents to the hospital for outpatient x-rays with a diagnosis on the physician's orders of questionable stone. The abdominal x-ray diagnosis per the Radiologist is "bilateral nephrolithiasis with staghorn calculi." No other documentation is available. Is it correct to code this as 592.0, Calculus of kidney, based on the radiologist's diagnosis?

Answer 2: The radiologist is a physician and he/she diagnosed the nephrolithiasis. Therefore, it is appropriate to code this case as 592.0, Calculus of kidney based on the radiologist's diagnosis.

Question 3: A patient undergoes outpatient surgery for removal of a breast mass. The pre- and post-operative diagnosis is reported as "breast mass." The pathological diagnosis is fibroadenoma. How should the hospital outpatient coder code this? Previous "Coding Clinic" advice has precluded us from assigning codes based on laboratory findings. Does

the same advice apply to pathological reports?

Answer 3: Previously published advice has warned against coding from laboratory results alone, without physician interpretation. However, the pathologist is a physician and the pathology report serves as the pathologist's interpretation and a microscopic confirmatory report regarding the morphology of the tissue excised. Therefore, a pathology report provides greater specificity. Assign code 217, Benign neoplasm of breast, for the fibroadenoma of the breast. It is appropriate for coders to code based on the physician documentation available at the time of code assignment.

Question 4: A referring physician sent a urine specimen to the cytology lab for analysis with a diagnosis of "hematuria" (code 599.7). However, a cytology report authenticated by the pathologist revealed abnormal cells consistent with transitional cell carcinoma of the bladder. Although the referring physician assigned code 599.7, Hematuria, the laboratory reported code 188.9, Malignant neoplasm of bladder, Bladder, part unspecified. For reporting purposes, what would be the appropriate diagnosis code for the laboratory and the referring physician?

Answer 4: The laboratory should report code 188.9, Malignant neoplasm of bladder, Bladder, part unspecified. It is appropriate to code the carcinoma, in this instance, because the cytology report was authenticated by the pathologist and serves as confirmation of the cell type, similar to a pathology report. The referring physician should report code 599.7, Hematuria, if the result of the cytological analysis is not known at the time of code assignment.

Question 5: A patient presents to the physician's office with complaints of urinary frequency and burning. The physician ordered a urinalysis and the findings were positive for bacteria and increased WBCs in the urine. Based on these findings a urine culture was ordered and was positive for urinary tract infection. Should the lab report the "definitive diagnosis," urinary tract infection, or is it more appropriate for the lab to report the signs and symptoms when submitting the claim?

Answer 5: Since this test does not have physician interpretation, the laboratory (independent or hospital-based) should code the symptoms (e.g., urinary frequency and burning).

Question 6: The physician refers a patient for chest x-ray to outpatient radiology with a diagnosis of weakness and chronic myelogenous leukemia (CML). The

radiology report demonstrated no acute disease and moderate hiatal hernia. For reporting purposes, which codes are appropriate for the facility to assign?

Answer 6: Assign code 780.79, Other malaise and fatigue, and code 205.10, Myeloid leukemia, without mention of remission, for this encounter. It is not necessary to report code 553.3, Diaphragmatic hernia, for the hiatal hernia because it is an incidental finding.

For CMS purposes, the primary diagnosis would be reported as 780.79 (Other malaise and fatigue), and the secondary diagnosis as 205.10 (Myeloid leukemia, without mention of remission, for this encounter.

Question 7: The physician A patient presents to the doctor's office with a complaint of fatigue. The physician orders a complete blood count (CBC). The CBC reveals a low hemoglobin and hematocrit. Should the lab report the presenting symptom fatigue (code 780.79) or the finding of anemia (code 285.9)?

Answer 7: The laboratory (independent or hospital-based) should code the symptoms, because no physician has interpreted the results. Assign code 780.79, Other malaise and fatigue, unless the lab calls the physician to confirm the diagnosis of anemia.

10.2 - Relationship of ICD-9-CM Codes and Date of Service

(Rev. 1, 10-01-03)

PM B-02-027 (CR-2108), B-02-063, B-02-064, B-03-002

Diagnosis codes must be reported based on the date of service on the claim and not the date the claim is prepared or received. Medicare contractors are required to be able to edit claims on this basis, including providing for annual updates each October. The effective date for this requirement is:

- Claims to DMERCs - April 1, 2003;
- Claims to carriers - October 1, 2002; and
- Claims to intermediaries - October 1, 1983.

Shared systems must establish 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 ICD-9-CM updates. During implementation, for codes already established on the shared system files, the effective date could be defaulted to January 1, 1990. Any codes on claims to carriers and DMERCs currently identified as no longer effective upon implementation could be considered to have an end date of

December 31, 2001. Thereafter, any additions or terminations must have the actual effective and end date.

A 90-day grace period applies. Medicare carriers and intermediaries accept old and new ICD-9 codes for dates of service October 1 through December 31, except inpatient hospital claims may not contain deleted diagnoses.

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

(Rev. 1, 10-01-03)

B3-4501, A3-3627, B3-4540, AB-01-127, AB-01-162, HO-442, CMS HCPCS Code Web site

Background

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.

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.

The CMS monitors the system to ensure uniformity.

Local Codes

Level III now contains local codes needed by contractors or Medicaid State agencies to process Medicare and Medicaid claims. They are used for services that are not contained in either Level I or Level II. Level III codes (procedure codes and modifiers) are scheduled for discontinuance by December 31, 2003.

The local codes are also alpha-numeric, but are restricted to the series beginning with W, X, Y, and Z. Local codes and other Level III codes are to be phased out in connection with implementation of HCPCS as a standard identifier under HIPAA (e.g., a Level I or Level II codes, as appropriate, will be assigned what was formerly coded as a Level III code).

Nonspecific or Nonclassified Codes

In addition to codes for specific services, there are codes for each type of service that may be used for claims processing where there is not a code that specifically describes the service. These codes are defined as "not otherwise classified" or "not otherwise specified" codes. Processing systems cannot make coverage and/or payment determinations automatically for these, but claims can be billed and paid for covered services with these codes where there is no currently available code to describe the service.

Tracking Codes for New and Emerging Technologies

Effective January 1, 2002, the AMA established a new category of CPT codes, called CPT Category III Tracking Codes. The CPT tracking codes were developed by the AMA to track new and emerging technologies. These codes consist of four numeric digits and one alpha character at the end, e.g., 0001T. Some of these codes are carrier priced and others may be noncovered. The Medicare Physician Fee Schedule Data Base for January 1, 2002, and thereafter contains the correct status indicators.

For laboratory tests, the new Category III Tracking Codes represent emerging technologies that may not be performed by many laboratories and may not yet have been approved by the Food and Drug Administration. Review of emerging technology codes will be made by the CPT Editorial Panel as part of its procedures to annually update CPT codes. The CPT Editorial Panel will determine if a temporary emerging technology code should be converted to a permanent existing technology Category I CPT code or if a new emerging technology code should be established. These codes are not included in the 2002 laboratory fee schedule data file because they can be covered and priced only at carrier discretion. More information on the use of emerging technology codes can be accessed at the AMA's Web page http://www.ama-assn.org.

Modifiers

HCPCS also contains Levels I, II, and III modifiers. Modifiers in the WA through ZZ range, with the exception of YY (second opinion) and ZZ (third opinion), are reserved for local assignment. Modifiers Q, K, and G modifiers are reserved for CMS. The remainder of the alpha-numeric and numeric series is reserved for national modifiers and AMA modifiers, respectively.

Noncovered Codes

There are certain HCPCS codes that are not used by Medicare. These may be codes that describe services that are not covered or may be codes that describe both covered and

noncovered services. In the latter case, the Level I codes are not used by Medicare, but Medicare makes payment using Level II codes instead. This is because the definition of the Level I code can be broader than CMS coverage policy, which is based on law and regulation pertaining to specific services, not on code assignment. These codes are identified in files that CMS makes available to contractors in connection with code updates.

If unacceptable codes are reported, carriers and intermediaries deny the line item as noncovered. The appropriate denial message must be identified on the Remittance Advice to the provider and to the crossover record sent to any subsequent payer.

If intermediaries receive HCPCS codes not used by Medicare on a claim with other services that are covered, they also move the charges to noncovered.

Intermediaries do not return to the provider (RTP) the claim unless the provider has failed to also include covered codes. If covered and unacceptable codes are submitted, the intermediary notifies the provider to correct the unacceptable codes in order to obtain payment.

Buying Codebooks

Level I (CPT-4) codes/modifiers can be purchased in hardcopy form or electronic medium from:

American Medical Association
P.O. Box 10946
Chicago, IL 60610-0946
AMA Customer Service Telephone 1-800-621-8335

http://www.amapress.org

Level II (non-CPT-4) codes/modifiers can be purchased in hardcopy form from:

Superintendent of Documents
U.S. Government Printing Office
Washington, DC 20402

Telephone (202) 783-3238

FAX: (202) 512-2250

Level II codes/modifiers are also available on computer tape from the National Technical Information Services (NTIS). Their address is:

National Technical Information Service
5285 Port Royal Road
Springfield, VA 22161

Sales Desk: (703) 487-4650,

Subscriptions: (703) 487-4630,

TDD (hearing impaired only): (703) 487-4639,

RUSH Service (available for an additional fee):

1-800-553-NTIS, Fax: (703) 321-8547, and

E-Mail: orders@ntis.fedworld.gov

HCPCS code information is also published on CMS Web site at http://cms.hhs.gov/medicare/hcpcs/ under the Plans and Providers page. Alpha-numeric codes are also available at: http://cms.hhs.gov/providers/pufdownload/anhcpcdl.asp.

Contractors are to supply physicians, suppliers, and providers current HCPCS local code/modifiers (alpha-numeric W-Z). 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.

For information on making suggestions for the establishment of new HCPCS codes, see the document titled "HCPCS Level II Code Modification Process" at http://cms.hhs.gov/medicare/hcpcs/. There are separate processes for Level I, Level II, and Medicaid. All three processes are available on this HCPCS Code Web site.

20.1 - Use and Maintenance of CPT-4 in HCPCS

(Rev. 1, 10-01-03)

B3-4506, SNF-530.1, A3-3627.1, PM-AB-01-127, HO-442.1

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 Medicare contractors and Medicaid State agencies annually.

It is the contractor'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.

Contractors may edit and abridge CPT-4 terminology within their claims processing area. However, contractors 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. Contractors 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, contractors do not need to show the copyright legend. Contractors may also print the code and approved narrative description in development requests relating to individual cases.

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

paper documentation cover memorandum, HCPCS tape characteristics and record layout, and transaction list printouts are mailed to each contractor annually.

20.2 - Local Codes

(Rev. 1, 10-01-03)

B3-4507, B3-4507.1, A3-3627.2, HO-442.2, AB-02-005 (to be added), A3-3644.G

Approved local codes must be discontinued by December 31, 2003. Unapproved local codes are discontinued December 31, 2002 for carriers and March 31, 2003 for intermediaries.

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., contractor 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.

Contractors 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, contractors assign a local HCPCS code for the combination of services. Contractors establish local codes for blood administration sets and filters and set reasonable charge amounts for independent facilities.

Contractors 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, contractors send a copy to the HCPCS Coordinator in the RO.

Under the outpatient prospective payment system (OPPS), intermediaries 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. 1, 10-01-03)

B3-4508, A3-3627.3, 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 contractors 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. Contractors 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.

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. Carriers and DMERCs 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. Intermediaries 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 contractors to delete them. All active "Q," "K," and "G" codes at the time of update will be included on the update file for contractors. 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 Medicare Carrier 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. 1, 10-01-03)

B3-4509.3, 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 a carrier/DMERC/intermediary in 2003, should contain codes/modifiers valid in 2002 and is processed using the prior year's pricing files.

Claims for services furnished in the current year, which are billed using codes/modifiers deleted by the most recent HCPCS update, can be processed with these deleted codes/modifiers for a three calendar month "grace period" after each HCPCS update. The grace period applies to claims received prior to April 1 of the current year, which contain dates of service for the current year and are billed using the prior years' HCPCS code (which is now a deleted code for the current year). Fee schedule claims with deleted codes that are acceptable during the grace period are priced and paid by using the prior year's rate, updated by the applicable update methodology. Annual update files provided to contractors by CMS, e.g., the Medicare fee schedule database (MFSDB) clinical diagnostic lab fee schedules include the deleted codes and are already updated by CMS to reflect the correct grace period fees for deleted codes.

Carriers compute updated customary and prevailing charges for deleted codes for services paid under the reasonable charge methodology during the grace period (e.g., for the 2002 update use actual charge data from July 1, 2000, through June 30, 2001, to

compute 2002 customary and prevailing charges for deleted codes) and perform the required inflation indexed charge (IIC) calculations.

See the Medicare Claims Processing Manual, Chapter 22, “Remittance Notices to Providers,” for remittance remarks when prior to April 1, the carrier receives an assigned claim which includes a deleted HCPCS code for a service furnished in the current year.

Carriers do not use any special Medicare Summary Notice (MSN) messages in this situation.

Carriers must reject services for deleted codes received on or after April 1 (e.g., after expiration of the 3-month grace period). If there are other services on the same claim that are valid codes, process those line items for coverage and payment determinations. Advise physicians/suppliers/providers and beneficiaries when a service billed under a deleted code is rejected. **NOTE:** Intermediaries return to the provider (RTP) claims containing deleted codes.

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

Message 16.13 is included on the beneficiary MSN when deleted codes are rejected.

> 16.13 - The code(s) your provider used is/are not valid for the date of service billed.

20.5 - The HCPCS Codes Training

(Rev. 1, 10-01-03)

B3-4552, A3-3627.7, 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, contractors must schedule the sessions in conjunction with the State medical records association or the State hospital or medical/physician associations. Contractors should schedule sessions in the major population centers of their service area.

Contractors should use the following guidelines in planning training sessions.

- Limit the training sessions to a manageable size to encourage questions and answers.
- Carriers 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 contractor schedules a visit to provide the specific training needed. Training is the carriers'/intermediaries' responsibility.

20.6 - Professional/Public Relations for HCPCS

(Rev. 1, 10-01-03)

B3-4551, A3-3627.6, A3-3627.4, B3-4540.A

Contractors 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.

- Carriers should share Level III codes/modifiers with the Medicaid State agency in the carrier'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

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

- Intermediaries and carriers 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 on Contractors' Web Sites

(Rev. 1, 10-01-03)

PM AB-00-126 (CR1415)

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 CPT codes, descriptions, and other materials on contractors' Web sites and in other electronic media. (For purposes of this manual, electronic media is defined as tapes, disk, or CD-ROM.) Contractors must follow the requirements and guidelines below for any new or revised material used on the Web sites and electronic media.

20.7.1 - Displaying Material With CPT Codes

(Rev. 1, 10-01-03)

The CPT code information may be used on contractors 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 contractors provide any electronic media to other State and Federal agencies, any CPT coding contained in the publication(s) must conform to these requirements. Contractors 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 contractors 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 contractors 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. Contractors may use as many CPT codes, or CPT codes and short descriptions as necessary.

Contractors 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 contractor 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, contractors 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. Contractors 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)

Contractors 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, contractors 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, contractors 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 contractor'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."

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For electronic media such as tapes, diskettes, and CD ROMs, contractors must include either a point and click license which can be embedded in the diskettes or CD-ROM and

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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 contractor'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 an 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.

Contractors 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.

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The AMA/CMS Amendment can be viewed at:
http://www.cms.hhs.gov/states/letters/smd07051.pdf.

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

Section	Code Range First	Code Range Last	Subsection	Code Count
	99374	99380	Care Plan Oversight Services	6
	99381	99429	Preventive Medicine Services	22
	99431	99440	Newborn Care	6
	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

Section	Code Range First	Code Range Last	Subsection	Code Count
	01810	01860	Forearm, Wrist, and Hand	10
	01905	01933	Radiological Procedures	11
	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

Section	Code Range		Subsection	Code Count
	First	Last		
	69000	69979	Auditory System	97
	69990	69990	Operating Microscope	1
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

Section	Code Range First	Code Range Last	Subsection	Code Count
	88230	88299	Cytogenetic Studies	27
	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}.**"

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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).

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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

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.

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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

HCPCS/ CPT	Description	Status Code	Work RVU
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
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)

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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)

B3-4509.2

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. Carriers must establish reasonable developmental guidelines, review screens, and relative value units, as appropriate. Carriers 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 carrier 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.

Intermediaries also develop editing screens using HCPCS based on payment and coverage policies from CMS. Intermediaries must assure that system claims processing complies with CMS policy and procedures.

20.9 - Correct Coding Initiative (CCI)

(Rev. 1, 10-01-03)

PM B-01-67, PM-A-00-69, B3-4630

The CMS developed the Correct Coding Initiative (CCI) 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, 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 CCI can be found on CMS Web site, Medlearn Page at http://cms.hhs.gov/medlearn/ncci.asp. The CMS will e-mail an updated version of the CCI Coding Policy Manual to the ROs for distribution to the carriers. The Coding Policy Manual should be utilized by carriers as a general reference tool that explains the rationale for CCI edits.

Carriers implemented CCI edits within their claim processing systems for dates of service on or after January 1, 1996.

CCI edits are incorporated within the outpatient code editor (OCE).

The purpose of the CCI edits is to ensure the most comprehensive groups of codes are billed rather than the component parts. Additionally, CCI edits check for mutually exclusive code pairs. These edits were implemented to ensure that only appropriate codes are grouped and priced. The unit-of-service edits determine the maximum allowed number of services for each HCPCS code.

The official method for providers to receive the CCI edits is through National Technical Information Service (NTIS) Department of Commerce. The CMS has designated NTIS as the sole distributor of the CCI edits. The narrative introduction of the NTIS product is considered public domain and may be freely reproduced. However, the specific CPT code combinations may **not** be reproduced. However, neither the narrative introduction nor the narrative portion of each chapter is intended to supersede any current Medicare policy. Anyone wishing to receive the CCI edits must purchase them through NTIS.

To purchase the CCI edits, call the National Technical Information Service:

- To receive the information by fax, call (703) 605-6880.

- To order subscriptions, call (703) 605-6060 or (800) 363-2068.

Ordering and product information are also available via the World Wide Web at www.ntis.gov/product/correct-coding.htm

The following CCI instructions also apply to claims for Ambulatory Surgical Center (ASC) Facilities services. However, carriers do not pay an ASC facility fee for an approved code under CCI unless that code is on the list of Medicare-covered ASC procedures.

Standard language was developed for use in correspondence concerning questions related to specific code combinations or reductions in payment due to specific codes billed. The standard language and examples of edits are found in the Medicare Contractor Correspondence Manual.

A - MSN Messages

The following message is displayed on the beneficiary's Medicare Summary Notice (MSN) for assigned claims submitted to carriers for CCI editing on the same claim:

> "Payment is included in another service received on the same day."
> (MSN message 16.8)

Display the following message on the beneficiary's MSN for assigned claims for CCI editing on different claims:

> "This allowance has been reduced by the amount previously paid for a related procedure." (MSN message 16.9)

The following message should be displayed on the beneficiary's MSN for unassigned claims for CCI editing on the same claim:

> "Payment is included in another service received on the same day." (MSN message 16.8)
>
> "Your doctor did not accept assignment for this service. Under Federal law, your doctor cannot charge more than ($_____). If you have already paid more than this amount, you are entitled to a refund from the provider."

(**NOTE:** this message should print on all unassigned service lines for which the billed amount exceeds the Medicare limiting charge. Carriers do not print when the amount that the limiting charge is exceeded is less than any threshold established by CMS.)

Display the following message on the beneficiary's MSN for unassigned claims for CCI editing on different claims:

> "This allowance has been reduced by the amount previously paid for a related procedure." (MSN message 16.9)

B - Remittance Notice Messages

When either MSN messages 16.8 or 30.3 apply, use claim adjustment reason code B15.

> "Claim/service denied/reduced because this service/procedure is not paid separately."

at the service level on the provider remittance notice. Also, carriers use remark code M80:

> "We cannot pay for this when performed during the same session as another approved service for this beneficiary."

with the same service on the same provider remittance notice.

When either MSN messages 16.30 or 16.9 apply, carriers use claim adjustment reason code B10

> "Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test."

at the service level on the provider remittance notice.

Also, carriers use remark code M80

> "We cannot pay for this when performed during the same session as another approved service for this beneficiary."

with the same service on the same provider remittance notice.

20.9.1 - Correct Coding Modifier Indicators and HCPCS Codes Modifiers

(Rev. 1, 10-01-03)

The Correct Coding File Formats continue to include a Correct Coding Modifier (CCM) indicator (carrier only) for both the Comprehensive/Component Table and the Mutually Exclusive Table. This indicator determines whether a CCM causes the code pair to bypass the edit. This indicator will be either a "0," "1," or a "9." The definitions of each is:

0 = A CCM is not allowed and will not bypass the edits.

1 = A CCM is allowed and will bypass the edits.

9 = The use of 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 (Carriers Only)

(Rev. 1, 10-01-03)

B3-4508.1

A - General

Carriers subject all line items with identical modifiers to the CCI edit.

All line items with identical modifiers must be subjected to the CCI edit. Line items with the modifiers listed below are NOT subject to the CCI edit. However, they are subject to additional edits based on the specific use of the modifier as defined in other instructions issued by CMS.

E1 - E4	FA	F1 - F9	TA	T1 - T9	LT	RT
-25	-58	-59	-78	-79	LC	LD
RC	-91					

B - Modifier "-59"

Definition - The "-59" modifier is used to indicate a distinct procedural service. The physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. This may represent a different session or patient encounter, different procedure or surgery, different site, or organ system, separate incision/excision, or separate injury (or area of injury in extensive injuries).

Rationale - Multiple services provided to a patient on one day by the same provider may appear to be incorrectly coded, when in fact the services may have been performed as reported. Because these circumstances cannot be easily identified, a modifier was established to permit claims of such a nature to bypass correct coding edits. The addition of this modifier to a procedure code indicates that the procedure represents a distinct procedure or service from others billed on the same date of service. In other words, this may represent a different session, different surgery, different anatomical site or organ system, separate incision/excision, different agent, different lesion, or different injury or area of injury (in extensive injuries).

Instruction - The secondary, additional, or lesser procedure(s) or service(s) must be identified by adding the modifier "-59".

Following are examples of appropriate use of the "-59" modifier:

EXAMPLE 1: CPT codes describing chemotherapy administration include codes for the administration of chemotherapeutic agents by multiple routes, the most common being the intravenous route. For a given agent, only one intravenous route (push or infusion) is appropriate at a given session. It is recognized that frequently combination chemotherapy is provided by different routes at the same session. When this is the case, using the CPT codes 96408, 96410, and 96414, the "-59" modifier (different substance) should be attached to the lesser valued technique indicating that separate agents were administered by different techniques.

EXAMPLE 2: When a recurrent incisional or ventral hernia requires repair, the appropriate recurrent incisional or ventral hernia repair code is billed. A code for initial incisional hernia repair is not billed in addition to the recurrent incisional or ventral hernia repair unless a medically necessary initial incisional hernia repair is performed at a different site. In this case, the "-59" modifier should be attached to the initial incisional hernia repair code.

Modifier "-59" may not be used with the following codes:

77427	Radiation treatment management, five treatments
99201 - 99499	Evaluation and management services

When a provider submits a claim for any of the codes specified above with the "-59" modifier, the carrier must process the claim as if the modifier were not present. In addition to those messages specified in §20.9.A above, carriers convey the following message on the provider remittance notice:

> "The procedure code is inconsistent with the modifier used, or a required modifier is missing." (ANSI 4)

No additional message should be conveyed on the beneficiary's MSN.

C - Modifier "-91"

Definition - The "-91" modifier is used to indicate a repeat laboratory procedural service on the same day to obtain subsequent reportable test values. The physician may need to indicate that a lab procedure or service was distinct or separate from other lab services performed on the same day. This may indicate that a repeat clinical diagnostic laboratory test was distinct or separate from a lab panel or other lab services performed on the same day, and was performed to obtain subsequent reportable test values.

Rationale - Multiple laboratory services provided to a patient on one day by the same provider may appear to be incorrectly coded, when in fact the services may have been performed as reported. Because these circumstances cannot be easily identified, a modifier "-91" was established to permit claims of such a nature to bypass correct coding edits. The addition of this modifier to a laboratory procedure code indicates a repeat test or procedure on the same day.

Instruction - The additional or repeat laboratory procedure(s) or service(s) must be identified by adding the modifier "-91".

EXAMPLE 1: When cytopathology codes are billed, the appropriate CPT code to bill is that which describes, to the highest level of specificity, what services were rendered. Accordingly, for a given specimen, only one code from a family of progressive codes (subsequent codes include services described in the previous CPT code, e.g., 88104-88107, 88160-88162) is to be billed. If multiple services on different specimens are billed, the "-91" modifier should be used to indicate that different levels of service were provided for different specimens. This should be reflected in the cytopathologic reports.

D - Professional Component Modifier

Modifier 26 is used when reporting the physician component of a service separately. If this modifier is used with a Column II code that is reported with a Column I code, carriers deny the Column II code with the modifier.

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

Effective January 1, 2002, new modifiers were developed to allow practitioners and suppliers to bill Medicare for items and services that are statutorily non-covered or do not meet the definition of a Medicare benefit and items and services not considered reasonable and necessary by Medicare. The following three codes and one modifier were therefore deemed obsolete and were discontinued.

A9160 - Non-covered service by podiatrist
A9170 - Non-covered service by chiropractor
A9190 - Personal comfort item, (non-covered by Medicare statute)
GX - Service not covered by Medicare

1. Definitions of the GA, GY, and GZ Modifiers

The modifiers are defined below:

GA - Waiver of liability statement on file.
GY - Item or service statutorily excluded or does not meet the definition of any Medicare benefit.
GZ - Item or service expected to be denied as not reasonable and necessary.

2. Use of the GA, GY, and GZ Modifiers for Services Billed to Local Carriers

The GY modifier must be used when physicians, practitioners, or suppliers want to indicate that the item or service is statutorily non-covered or is not a Medicare benefit.

The GZ modifier must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they have not had an Advance Beneficiary Notification (ABN) signed by the beneficiary.

The GA modifier must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they do have on file an ABN signed by the beneficiary. (See http://www.cms.hhs.gov/medlearn/refabn.asp for additional information on use of the GA modifier and ABNs.)

The GY and GZ modifiers should be used with the specific, appropriate HCPCS code when one is available. In cases where there is no specific procedure code to describe services, a "not otherwise classified code" (NOC) must be used with either the GY or GZ modifier.

3. Use of the GA, GY, and GZ Modifiers for Items and Supplies Billed to DMERCs

The GY modifier must be used when suppliers want to indicate that the item or supply is statutorily non-covered or is not a Medicare benefit.

The GZ modifier must be used when suppliers want to indicate that they expect that Medicare will deny an item or supply as not reasonable and necessary and they have not had an Advance Beneficiary Notification (ABN) signed by the beneficiary.

The GA modifier must be used when suppliers want to indicate that they expect that Medicare will deny an item or supply as not reasonable and necessary and they do have on file an ABN signed by the beneficiary.

The GY and GZ modifiers should be used with the specific, appropriate HCPCS code when one is available. In cases where there is no specific procedure code to describe items or supplies, an NOC must be used with either the GY or GZ modifiers.

4. Use of the A9270

Effective January 1, 2002, the A9270, Noncovered item or service, under no circumstances will be accepted for services or items billed to local carriers. 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 DMERCs for statutorily non-covered items and items that do not meet the definition of a Medicare benefit.

5. Claims Processing Instructions

At carrier and DMERC 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.

20.9.2 - Limiting Charge and CCI edits.

(Rev. 1, 10-01-03)

B3-4630.E

Medicare does not make separate payment for procedures that are part of a more comprehensive group of services, nor does it make payment for services that cannot be performed at the same time. These are not medical necessity denials. Instead, payment for the comprehensive procedure includes any separately identified component parts of the procedure. The limitation on liability protections in §1879 of the Act are not a consideration nor are the physician refund protections in §1842(l) of the Act a consideration. The maximum a provider may bill a Medicare beneficiary is whatever the limiting charge is for the comprehensive (Column I) service. This policy has been in effect since January 1, 1991.

The limiting charge provisions of the law apply to those services that are submitted on unassigned claims and are paid under the physician fee schedule, with the exclusion of those which have a Medicare Fee Schedule Data Base status code indicator of:

- “"B” (bundled code);
- “G” (not valid for Medicare purposes);
- “I” (not valid for Medicare purposes);
- “N” (noncovered service);
- “X” (statutory exclusion);
- “P” (bundled/excluded Code); and
- “R” (restricted coverage), if the service is deemed noncovered.

Procedure codes that are listed in the correct coding initiative and are component parts of other procedures or cannot be performed at the same time are not separately payable when billed with the principal service. In addition, these are subject to the charge limits, if the unbundled service is identified with a status code subject to Medicare charge limits. These instances are limiting charge violations and must be included on the affected providers’ Limiting Charge Exception.

20.9.3 - Appeals

(Rev. 1, 10-01-03)

B3-4630.F

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, carriers must include the more detailed explanation of the correct coding initiative edit which can be found in the standard correspondence language for Part B Medicare carriers in the Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 1.

20.9.4 - Savings Report

(Rev. 1, 10-01-03)

B3-4630.G

Carriers must provide a quarterly report of savings generated by the CCI edits. These quarterly reports are due on the 20th day of the month following the end of the quarter, e.g., April 20, July 20, October 20, and January 20. The savings files must be in an Extended Binary Code Decimal Interchange Code (EBCDIC) format. The files are to be submitted using the Network Data Mover. In addition, the following rules for submission must be met:

- Multiple files will not be accepted;
- Record all data in EBCDIC and display mode; and
- Do not submit compressed data.

Carriers must use the following sample Job Control Language (JCL) for sending the savings files to CMS via Network Data Mover (NDM):

Sample NDM JCL

```
/*****************************************************************/
/*  NDM process to transfer files from carrier or FI to CMS                    */
/*      - replace XXXXX with your carrier ID number                            */
/*      - replace FROM DSN name with the file name you are sending to CMS      */
/*      - USERID,PASSWORD refers to your NDM userid assigned to their facility */
/*****************************************************************/

TESTPROC   PROCESS   SNODEID=(USERID,PASSWORD)
STEPUS01   COPY FROM (DSN=TWxx.@AAA0000.CORRCODE.FILE-
           DISP=SHR
           PNODE)
           TO  (DSN=MU00.@BF12372.CXXXXX,
                DISP=(NEW,CATLG,DELETE))
                CKPT=200K
                COMPRESS
STEPUS02   IF (STEPUS01 = 0) THEN
     RUN JOB (DSN=MU00.@BF12372.CLIST(CXXXXX)) SNODE
     EIF
/*
//
```

20.9.4.1 - Savings Record Format

(Rev. 1, 10-01-03)

Use the following record format to report savings:

Field	**Type**	**Record Position**	**Length**
Carrier Number	Numeric	1	5
Comprehensive Column 1 Code or Mutually Exclusive Column 1 code	Character	6	5
Modifier I	Character	11	2
Modifier II	Character	13	2
Component Column 2 Code or Mutually Exclusive column 2 Code	Character	15	5
Modifier I	Character	20	2
Modifier II	Character	22	2
Provider Specialty	Character	24	2
HCPCS Frequency	Numeric	26	10
HCPCS Savings	Numeric	36	12
Savings Type Indicator Edit “1” CCE “2” Mutually Exclusive (Recommended, but not required)	Numeric	48	1

Submit these reports to:

Centers for Medicare & Medicaid Services
Program Development and Information Group
Division of Health Plan and Provider Data
7500 Security Blvd
Mail Stop: C4-14-21
Baltimore, Maryland 21244-1850

20.9.5 - Adjustments

(Rev. 1, 10-01-03)

B3-4630.I

Carriers 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, carriers 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)

B3-4630.M

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

Carrier/Shared Systems Record Format

Field	Type	Record Position	Length
Comprehensive Column 1 Code or	Character	1	5
Mutually Exclusive Column 1 Code			
Component Column 2 Code or	Character	6	5
Mutually Exclusive Column 2 Code			
Prior Rebundled Code Indicator	Character	11	1
"*" rebundled prior to 1996 edits			
" " rebundled 1/1/1996 or later			

Field	Type	Record Position	Length
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	Numeric	38	1
"0" No CCE modifier allowed			
"1" CCE modifier acceptable			
"9" Use of CCE modifier not specified			
Savings Type Indicator Edit	Character	39	1
"1" CCE			
"2" Mutually Exclusive			

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

(Rev. 1, 10-01-03)

B3-15000, B3- 15002, B3-15004, AB-98-63, AB-00-08, A-00-88, AB-01-33, A-01-45, A-01-94, A-01-119, A-03-011

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, carriers 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 furnished by physical therapists and occupational therapists in independent 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, carriers 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.), carriers 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.

Carriers 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, including a speech-language pathologist (for outpatient physical therapy and 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 Regional Home Health Intermediary (RHHI). 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, intermediaries pay for outpatient rehabilitation services based on the MPFS. Services included are physical therapy (which includes outpatient speech-language pathology), occupational therapy, and certain audiology and Comprehensive Outpatient Rehabilitation Facility (CORF) services.

Effective with services furnished on or after July 1, 2000, intermediaries 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. Intermediaries 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 (Intermediaries)

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, intermediaries 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, intermediaries 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, FIs 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)

B3-15902

The CMS calculates the fee schedule payment amounts and releases them to the carriers in the Medicare Physician Fee Schedule Database (MPFSDB). Carriers 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 carriers 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.

- Carriers receive a file containing data with revisions for the quarter. This file is released electronically via CMS' Mainframe Telecommunications System.

- Carriers 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 carriers in data files to ensure accuracy. Carriers overlay these files into their existing file, to eliminate the potential for errors.

- Carriers 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 fiscal intermediaries (FIs). In summary, FIs receive the revised payment amounts two to three weeks after the carriers receive the data from CMS. FIs do not implement the revised payment amounts prior to the carriers' implementation date.

- Carriers 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 contractors.

30.2 - MPFSDB Record Layout

(Rev. 1, 10-01-03)

B3-15900.1, 2, and 3

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

30.2.1 - Payment Concerns While Updating Codes

(Rev. 1, 10-01-03)

B3-4509.1

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, carriers 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, carriers 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, carriers 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, carriers 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. 1, 10-01-03)

A =	Active code. These codes are separately paid under the physician fee schedule if covered. There will be RVUs and payment amounts for codes with this status. The presence of an "A" indicator does not mean that Medicare has made a national coverage determination regarding the service; carriers remain responsible for coverage decisions in the absence of a national Medicare policy.
B =	Payment for covered services are always bundled into payment for other services not specified. There will be no RVUs or payment amounts for these codes and no separate payment is ever made. When these services are covered, payment for them is subsumed by the payment for the services to which they are incident (an example is a telephone call from a hospital nurse regarding care of a patient).
C =	Carriers price the code. Carriers will establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation such as an operative report.
D =	Deleted/discontinued codes. These codes are deleted effective with the beginning of the year and are always subject to a 90 day grace period.
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 was effective with the 2002 fee schedule as of January 1, 2002.
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.)
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. (Code subject to a 90 day grace period.)

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

30.3 - Furnishing Pricing Files

(Rev. 1, 10-01-03)

B3-4620

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. Carriers and intermediaries are informed where to access the files for FTP (File Transfer Protocol) download.

30.3.1 - Carrier Furnishing Physician Fee Schedule Data for Local and Carrier Priced Codes to CMS

(Rev. 1, 10-01-03)

B3-4620.1

Prices for some codes in the MPFSDB must be developed by carriers. The CMS informs carriers of these codes each year, and carriers must develop and inform CMS of these prices as described in §30.3.1.

Carriers must provide to CMS the payment amounts for all local and carrier priced codes for physician services (MPFSDB status codes of L, C, and R) by the date specified in the schedule. Payment amounts are required only for those carrier priced status codes C and R without associated Relative Value Units (RVUs), and for local codes for which payment amounts have been developed.

After receipt of carrier data, CMS will furnish the payment amounts for local and carrier priced codes to the intermediaries, Palmetto GBA, Indian Health Services, and United Mine Workers.

Carriers should follow the steps identified below.

1. Create a file that includes all the fields from the MPFSDB for local and carrier priced codes covered under the physician fee schedule for which the carrier has developed the payment amounts. Complete the fields with the appropriate data for the local and carrier priced codes.

2. Zero fill fields that do not contain entries.

3. If the carrier has not developed payment amounts for local or carrier priced codes covered under the physician fee schedule, complete the record transmittal form indicating that a file does not need to be submitted.

4. Detailed record specifications are updated annually in §30.2.

    - If HCPCS is a radiology procedure (e.g., 70000-79999, or appropriate “Q” or “G” code), then designate “RAD” for label.

    - If HCPCS is a portable radiology procedure (appropriate “R,” “Q,” or “G” code), then designate “PRF” for label.

    - If PCTC = 1, 2, 3, 4, 6, 8 and service is not radiology or portable x-ray, then designate “ODX” as label.

- All other codes should be considered hospice services and the appropriate label should be “HPH.”

5. Files can be submitted either electronically via e-mail, on diskette, or on tape/cartridge.

   If the file is transmitted electronically or on diskette, follow these instructions:

   - Files must be in ASCII format.
   - If sent electronically, send to Mary Anne Stevenson (MStevenson or Mstevenson@cms.hhs.gov).
   - A backup file must be maintained until the file is approved.

   If the file is transmitted on tape/cartridge, follow these instructions:

   - Prepare file as an IBM standard label file. Additionally, a trailer record follows the data record. The trailer record is discussed below.
   - Assure that an external label is placed on each tape or cartridge.
   - IBM standard label, data records, trailer record, and a standard IBM end of file.
   - IBM standard Label - Data set name: UH5585.PSAB.PPR.LOCAL
   - Tape configuration of a 3480 cartridge or a 9 track.
   - 1600/6250 round tape.
   - Block data records 8970.
   - Record all data in EBCDIC and in display mode. A data set name other than the file above will result in automatic return of the file. A backup file must be maintained until the file is approved.
   - DO NOT SUBMIT COMPRESSED DATA.

6. Trailer Record (Last Record on File)

Columns	Data	Description
1-7 (7)		The word “trailer"
8-15 (8)	Total number of records.	The number of records on the file. Do not include the trailer record. Right justify, zero fill.
16-345 (330)	Blank fill trailer record	

7. Ship the File To:

   Centers for Medicare & Medicaid Services
   Program Development and Information Group,
   Mail Stop C4-15-25
   7500 Security Blvd.
   Baltimore, MD. 21224-1850

8. Carriers forward the MPFSDB Local codes file with the record transmittal that was used in submitting previous years’ files. Ship the magnetic tape(s) to CMS by mail. However, carriers in close proximity to CMS Central Office may use other delivery service options if faster and/or more economical.

30.3.2 - Contractor Furnishing Physician Fee Schedule Data for National Codes

(Rev. 1, 10-01-03)

B3-4620.2

Carriers and intermediaries are responsible for furnishing fee schedules to related providers, suppliers, physicians, and practitioners with billing relationships.

Carriers and intermediaries must also be prepared to release the entire MPFSDB file in the same format as received from CMS, which will include the payment policy indicators, to the State Agencies upon their request. The data will be available on the CMS Home Page and those State Agencies with Internet access capability will be able 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 intermediaries, Palmetto GBA (Railroad Retirement Board), the Indian Health Services, and the United Mine Workers. CONTRACTORS DO NOT NEED TO SEND FILES TO THOSE ENTITIES.

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

To furnish the Medicare physician fee schedule for national codes to the State Agencies follow the steps identified below.

1. Create a file to include an extract for status codes A, T and associated RVUs; and carrier and local codes as in §30.3.1. NOTE: All fields may not be necessary to the entity receiving the file. The State Agencies should extract only the fields that apply to their particular applications.

2. To release to the State Agencies, contact the regional office to obtain the name and mailing address of the individual to receive the file.

3. Refer to §30.3.1 for the physical file specifications and blocking factor.

4. Header Type Specifications

Field No.	Field Name	Size	Picture	Field Specs	Remarks
1	Label	3	X(3)	L	a
2	Filler	7	X(7)	L	
3	Carrier #	5	9(5)	L	
4	Filler	1	X(1)		

a - Use the following label: MPFS - Medicare Physician Fee Schedule

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

(Rev. 1, 10-01-03)

B3-4620.3

Carriers 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 (RRB), Fiscal Intermediaries, State Agencies, Indian Health Services, and United Mine Workers.

Carriers furnish statewide (or carrier-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, carriers furnish Palmetto GBA (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 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., carrier, intermediary, RRB, 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 Durable Medical Equipment Regional Carriers (DMERCs), local carriers, and intermediaries must download and implement the DMEPOS fee schedules for the items and services within their jurisdiction. DMERCs 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 DMERCs, carriers and intermediaries 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	Carrier #	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
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	Carrier #	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

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

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. RHHIs 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

30.4 - Localities for Pricing

(Rev. 1, 10-01-03)

PM A-01-104, B3-15012

The localities listed below are used to make Medicare payments for services paid under the physician fee schedule or linked to the physician fee schedule (e.g., hospital, radiology, and other diagnostic services). Carriers use the locality for the geographic area where the service is rendered.

Contractors may not make any changes to localities. Changes may only be made by CMS. These localities apply to services paid under or linked to the physician fee schedule. They do not affect services paid under the lab or DMEPOS fee schedules.

LOCALITIES

Carrier Number	Locality Number	Locality Name
00510	00	Alabama
00831	01	Alaska
00832	00	Arizona
00520	13	Arkansas
31146	26	Anaheim/Santa Ana, CA
31146	18	Los Angeles, CA
31140	03	Marin/Napa/Solano, CA
31140	07	Oakland/Berkeley, CA
31140	05	San Francisco, CA
31140	06	San Mateo, CA
31140	09	Santa Clara, CA
31146	17	Ventura, CA
31146	99	Rest of California*
31140	99	Rest of California*
00824	01	Colorado

Carrier Number	Locality Number	Locality Name
00591	00	Connecticut
00902	01	Delaware
00903	01	DC + MD/VA Suburbs
00590	03	Fort Lauderdale, FL
00590	04	Miami, FL
00590	99	Rest of Florida
00511	01	Atlanta, GA
00511	99	Rest of Georgia
00833	01	Hawaii/Guam
05130	00	Idaho
00952	16	Chicago, IL
00952	12	East St. Louis, IL
00952	15	Suburban Chicago, IL
00952	99	Rest of Illinois
00630	00	Indiana
00826	00	Iowa
00650	00	Kansas
00740	04	Johnson and Wyandotte, Kansas*
00660	00	Kentucky
00528	01	New Orleans, LA
00528	99	Rest of Louisiana
31142	03	Southern Maine
31142	99	Rest of Maine

Carrier Number	Locality Number	Locality Name
00901	01	Baltimore/Surr. CNTYS, MD
00901	99	Rest of Maryland
31143	01	Metropolitan Boston
31143	99	Rest of Massachusetts
00953	01	Detroit, MI
00953	99	Rest of Michigan
00954	00	Minnesota
00512	00	Mississippi
00740	02	Metropolitan Kansas City, MO
00523	01	Metropolitan St. Louis, MO
00740	99	Rest of Missouri*
00523	99	Rest of Missouri*
00751	01	Montana
00655	01	Nebraska
00834	00	Nevada
31144	40	New Hampshire
00805	01	Northern NJ
00805	99	Rest of New Jersey
00521	05	New Mexico
00803	01	Manhattan, NY
00803	02	NYC Suburbs/Long I., NY
00803	03	Poughkpsie/N NYC Suburbs, NY
14330	04	Queens, NY

Carrier Number	Locality Number	Locality Name
00801	99	Rest of New York
05535	00	North Carolina
00820	01	North Dakota
16360	00	Ohio
00522	00	Oklahoma
00835	01	Portland, OR
00835	99	Rest of Oregon
00865	01	Metropolitan Philadelphia, Pa
00865	99	Rest of Pennsylvania
00973	20	Puerto Rico
00870	01	Rhode Island
00880	01	South Carolina
00820	02	South Dakota
05440	35	Tennessee
00900	31	Austin, TX
00900	20	Beaumont, TX
00900	09	Brazoria, TX
00900	11	Dallas, TX
00900	28	Fort Worth, TX
00900	15	Galveston, TX
00900	18	Houston, TX
00900	99	Rest of Texas
00910	09	Utah
31145	50	Vermont

Carrier Number	Locality Number	Locality Name
00973	50	Virgin Islands
00904	00	Virginia
00836	02	Seattle (king CNTY), WA
00836	99	Rest of Washington
16510	16	West Virginia
00951	00	Wisconsin
00825	21	Wyoming

* - Payment locality is serviced by two carriers.

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 carrier is required to determine the payment amounts for its geographic areas.

The CMS has not established specific criteria that carriers should use in determining the payment amounts they establish for “carrier 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 carrier believes such adjustments are appropriate. Such an appropriation provides carriers with the flexibility to take into account local factors affecting the level of resources required to perform this service.

Carriers 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 carrier-priced services. Such periodic reviews for carrier priced services would be consistent with statutory requirements. If portable x-ray transportation suppliers request such a review, carriers 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. 1, 10-01-03)

B3-5114, B3-5114.1, A3-3628, AB-01-162, AB-02-163

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 contractor use and also on CMS Web site. Contractors 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 Program Memoranda issued by CMS. The affected CPT laboratory test codes for the national minimum payment amount are also identified in the annual Program Memorandum.

National maximum limitation amounts may also be established for certain services and are also published each year in Program Memoranda issued by CMS.

Carriers and Intermediaries 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. 1, 10-01-03)

AB - 01-162

The annual laboratory fee schedule data file should be retrieved electronically through CMS' mainframe telecommunications system, formerly referred to as the National Data Mover.

For each test code, if the contractor'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 contractor'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 intermediaries for payment of clinical laboratory tests performed by a sole community hospital's qualified laboratory.

The 3-month grace period for deleted codes is defined in the above in §20.4 and begins January 1.

Internet access to annual laboratory fee schedule data is available at the following CMS Web address: http://www.cms.hhs.gov/clia/clsites.asp or http://www.cms.hhs.gov/paymentsystems/. It is available in multiple formats: Excel, text, and comma delimited.

40.2 - Carrier 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	
Carrier Number	X(05)	6-10	
Locality	X(02)	11-12	00 = Denotes Single Carrier 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	

Data Element Name	Picture	Location	Comment
Gap - Fill Indicator	X(01)	55 - 55	0 = No Gap-fill Required 1 = Carrier 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 - Intermediary and Regional Home Health Intermediary (RHHI) Record Layout for Clinical Laboratory Fee Schedule

(Rev. 1, 10-01-03)

PM AB-01-162, A-01-104, AB-02-163

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

Record Length = 60

Record Format = FB

Block Size = 6000

Character Code = EDBCIC

Sort Sequence = Carrier, Locality, HCPCS Code

Header Record

Data Element Name	Picture	Location	Comment
Label	X(03)	1 - 3	Value = Lab
Filler	X(07)	4 - 10	
Filler	X(08)	11 - 15	
Filler	X(04)	16 - 22	
Date Fee Update	X(08)	23 - 30	YYYYMMDD

Data Element Name	Picture	Location	Comment
Filler	X(22)	31 - 52	
Date File Created	X(08)	53 - 60	YYYYMMDD

Data Record

Data Element Name	Picture	Location	Comment
HCPCS	X(05)	1 - 5	
Filler	X(04)	6 - 9	
60% Pricing Amt	9(05)V99	10 - 16	
62% Pricing Amt	9(05)V99	17 - 23	
Filler	X(07)	24 - 30	
Carrier Number	X(05)	31 - 35	
Locality	X(02)	36 - 37	00 = Denotes Single State Carrier
			01 = North Dakota
			02 = South Dakota
			20 = Puerto Rico
			40 = New Hampshire
			50 = Vermont
Filler	X(23)	38 - 60	

40.4 - Gap-Filled Fees Submitted to CMS by Carriers

(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 carriers 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, carriers establish and use these payment amounts; they may be revised in the course of the year. Also during this period, carriers 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 carriers 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. Carriers 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 carrier in establishing a gap-fill amount, carriers' 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, carriers should not determine a gap-fill amount by crosswalking to the payment amount for another test code.

After determining a gap-fill amount, a carrier may consider if a least costly alternative to a new test exists. If a carrier determines a least costly alternative test exists, the carrier 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 carrier must report two payment amounts, the gap-fill amount prior to

determination of a least costly alternative and the payment amount that the carrier has determined to be the least costly alternative.

Carriers should also communicate the gap-fill amounts to corresponding intermediaries. Carriers can seek assistance from RO staff to facilitate communication of the gap-fill amounts to intermediaries. The list of codes which carriers are required to gap-fill each year are communicated in the annual instructions..

Carriers 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. Carriers 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 carrier 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	
Carrier Number	X(5)	12 - 16	
Locality	X(2)	17 - 18	00 = Denotes Single State Carrier 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 - Carriers Forward HCPCS Gap Fill Amounts to Fiscal Intermediaries

(Rev. 1, 10-01-03)

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

Any carrier that establishes a HCPCS gap fill payment rate for its own use, or at the request of an FI, must forward the information to the contacts at all FIs/RHHIs with providers in the carrier service area.

Carriers that establish HCPCS gap-fill payment rates for their own needs should forward the information to FI/RHHIs as soon as practicable. FIs are to contact the appropriate carrier 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. Carriers must provide the payment rate to the requesting FI/RHHI (and all other FI/RHHIs with providers in that common jurisdiction) within 10 working days of receipt of the request.

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

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

It is the FI's responsibility to ascertain the amount or consult with the carrier, CCMS-CM, or BFE timely. Intermediary 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 carrier 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 FI 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 carrier replied at least five days before the expiration of the payment floor, CC 15 requests will **not** be honored.

50 - Fee Schedules Used by All Intermediaries and Regional Home Health Intermediaries (RHHIs)

(Rev. 1, 10-01-03)

PM A- 01-104, PM AB-02-112

Intermediaries and RHHIs retrieve multiple files from CMS mainframe telecommunications system (CMSTS). The HCPCS data files include deleted codes for the upcoming year (following the grace period). Intermediaries and RHHIs 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 each case the Carriers and Intermediaries should implement them according to the Program Memorandum instructions from which they are announced.

Two HCPCS files are furnished by CMS. They are:

- The annual HCPCS file update including procedure and modifier codes and deleted codes for the upcoming grace period; and
- A print file of the new year HCPCS codes.

The following fee schedules are furnished by CMS for intermediary use.

- Fees for Hospice for Part B services used by RHHIs;
- Physician Fee Schedule for Intermediaries and RHHIs;
- Clinical Laboratory Fee Schedule discussed in §40.3 above;
- Durable Medical Equipment, Prosthetics/Orthotics and Supplies (DMEPOS) Fee Schedule. RHHIs retrieve data from all categories on this file. Regular intermediaries only need to 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;
- Skilled Nursing Facility (SNF) extract from the MPFSDB for radiology, other diagnostic and other SNF services; and
- There is an additional supplemental file that will contain all physician fee schedule services for CORFs and their related prices. Since this supplemental file

contains approximately a million records, CMS does not anticipate that FIs would incorporate it into their operational systems, but instead use it as a resource to extract pricing data as needed. The data in the supplemental file will be in the same format as the MPFS abstract file, but the fields defining the fee and outpatient hospital indicators will not be populated, instead they will be filled in with spaces. See §50.3 for the format of the record layout. (Therapy/CORF Supplemental File).

50.1 - RHHI Fees for Hospice, Radiology and Other Diagnostic Prices and Local HCPCS Codes

(Rev. 1, 10-01-03)

PM A-01-104, A-02-090

The Hospice fee schedule contains prices extracted from the Physician Fee schedule. This file contains pricing data for carrier-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.

Record Length	-	60
Record Format	-	FB
Block Size	-	6000
Character Code	-	EBCDIC
Sort Sequence	-	Carrier, Locality, HCPCS Code, Modifier

Data Element Name	Picture	Location	Comment
HCPCS	X(05)	1 - 5	
Modifier	X(02)	6 - 7	
Filler	X(02)	8 - 9	
Fee	9(05)V99	10 - 16	
Filler	X(07)	17 - 23	
Filler	X(07)	24 - 30	
Carrier Number	X(05)	31 - 35	

Data Element Name	Picture	Location	Comment
Locality	X(02)	36 - 37	See §30.4 for localities.
Label	X(03)	38 - 40	HPH = Hospice Physician Services
			ODX = Other Diagnostic Services
			PRF = Portable Radiology
			RAD = Radiology

50.2 - Intermediary Format for Durable Medical Equipment, Prosthetic, Orthotic and Supply Fee Schedule

(Rev. 1, 10-01-03)

A-01-104, A-02-090

This file contains services subject to national Floors and Ceilings under the DMEPOS Fee Schedules including Surgical Dressings. RHHIs retrieve data from all DME categories contained in this file. Regular intermediaries retrieve prices for prosthetics, orthotics and surgical dressings. Also, new services that were gapped-filled by DMERCs or local Part B Carriers contain the same format with a different file name. The CMS will provide the specific file names when the prices are released.

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

Data Element Name	Picture	Location	Comment
HCPCS	X(05)	1 - 5	
Modifier	X(02)	6 - 7	
Filler	X(02)	8 - 9	
Fee Schedule Amt	9(05)V99	10 - 16	

Data Element Name	Picture	Location	Comment
Filler	X(14)	17 - 30	
State	X(02)	31 - 32	
Filler	X(05)	33 - 37	
Label	X(3)	38 - 40	DME = Durable Medical Equipment (other than oxygen OXY = Oxygen P/O = Prosthetic/Orthotic S/D = Surgical Dressings
Filler	X(20)	41 - 60	

50.3 - Intermediary Outpatient Rehabilitation and CORF Services Fee Schedule

(Rev. 1, 10-01-03)

A-01-104, A-02-090

This is a physician fee schedule abstract file for outpatient rehabilitation and CORF services payment for intermediaries. A separate file name with the same record layout is also available containing HCPCS codes that are needed to price services provided in a CORF, an outpatient Critical Access Hospital (CAH) and Indian Health Services that are not part of the abstract file.

NOTE: Fields 10 (Fee Indicator) and 11 (Outpatient Hospital) will not be used for the CORF/CAH/IHS supplemental file.

Data Element Name	Picture	Location	Comment
HCPCS	X(05)	1 - 5	
Modifier	X(02)	6 - 7	
Filler	X(02)	8 - 9	
Non-Facility Fee	9(05)V99	10 - 16	
Filler	X(07)	17 - 23	

Data Element Name	Picture	Location	Comment
Filler	X(07)	24 - 30	
Carrier Number	X(05)	31 - 35	
Locality	X(02)	36 - 37	Identical to radiology/diagnostic fees
Filler	X(03)	38 - 40	
Fee Indicator	X(1)	41 - 41	“R” = Rehab/Audiology function test/CORF services
Outpatient Hospital	X(1)	42 - 42	“0” = Fee applicable in hospital outpatient setting. “1” = Fee not applicable in hospital outpatient setting.
Filler	X(18)	43 - 60	

50.4 - Intermediary Format for Skilled Nursing Facility Fee Schedule

(Rev. 1, 10-01-03)

A-02-090

This section contains the record layout for the SNF Extract from the MPFSDB 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.

Record Length - 60

Record Format - FB

Block Size - 6000

Character Code - EBCDIC

Data Element Name	Picture	Location	Comment
HCPCS	X(05)	1 - 5	
Modifier	X(02)	6 - 7	

Data Element Name	Picture	Location	Comment
Filler	X(02)	8 - 9	
Non-Facility Fee	9(05)V99	10 - 16	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.
Filler	X(01)	17 - 17	
PCTC Indicator	X(01)	18 - 18	0 = Physician Service Codes 1 = Diagnostic Tests for Radiology Services 2 = Professional Component Only Codes 3 = Technical Component Only Codes 4 = Global Test Only Codes 5 = Incident To Codes 6 = Laboratory Physician Interpretation Codes 7 = Physical Therapy Service, for which payment may not be made 8 = Physician Interpretation Codes 9 = Not Applicable
Filler	X(05)	19 - 23	
Filler	X(07)	24 - 30	
Carrier Number	X(05)	31 - 35	
Locality	X(02)	33 - 37	Identical to other Physician Fee Schedule Abstract Files, (i.e. Therapy/Hospice)
Filler	X(03)	38 - 40	

Data Element Name	Picture	Location	Comment
Filler	X(01)	41 - 41	
Filler	X(01)	42 - 42	
Filler	X(18)	43 - 60	

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

(Rev. 1, 10-01-03)

AB-01-126, AB-02-152, AB-03-071

The CMS issues instructions for implementing an annual fee schedule and/or updating payment amounts quarterly for DMEPOS. The DMEPOS fee schedule is provided to DMERCs, the Statistical Analysis Durable Medical Equipment Carrier (SADMERC), and local carriers via CMS' mainframe telecommunication system.

The DMEPOS fee schedules are calculated by CMS. A separate DMEPOS Fee Schedule file is release to the intermediaries, regional home health intermediaries, Railroad Retirement Board (RRB), Indian Health Service and United Mine Workers. This fee schedule is also available through CMS homepage for interested parties like the State Medicaid agencies and managed care organizations. The fee schedule for parenteral and enteral nutrition (PEN) is released to the SADMERC and DMERCs 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.

The CMS also provides a list of new items that will be subject to the DME, prosthetics and orthotics, surgical dressings, or PEN fee schedules for which carriers/DMERCS must gap-fill base fee schedule amounts. The CMS identifies which codes apply to carrier or DMERC for gap-filling. Carriers submit the base fees for new codes to CMS CO. Once carriers submit base fees for a given code, they do not have to resubmit those base fees. Carriers are notified when and where to submit the base fees.

The gap-filled codes are contained in the annual 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 and release an addendum file to contractors. Local Part B carriers should note that the DDS files will not contain fee schedule amounts for noncontinental areas under local carrier jurisdiction. Local carriers must update their fee schedules using the appropriate covered item updates.

Upon successful receipt of the file(s), contractors send notification of receipt via E-MAIL stating the name of the file received and the entities for which they were received (e.g., contractor name and FI/RHHI number. Address e-mail to Mary Anne Stevenson at CMS at (Mstevenson@cms.hhs.gov).

60.1 - Record Layout for DMEPOS Fee Schedule

(Rev. 1, 10-01-03)

AB-02-152

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 = DMERC Jurisdiction
			L = Local Part B Carrier jurisdiction
			J = Joint DMERC/Local Carrier 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

Field Name	Pic	Position	Comment
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.
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 that 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. For these codes, this field will be filled with zeros

Field Name	Pic	Position	Comment
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 that 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. For these codes, this field will be filled with zeros.
Updated Fee Schedule Amount	9(5)V99	43 - 49	Amount used for pricing.
Gap-Fill Indicator	X	50	0 = No Gap-filling required. 1 = Carrier 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.
Filler	X(9)	52 - 60	Set to spaces

60.2 – Quarterly Update Schedule for DMEPOS Fee Schedule

(Rev. 1, 10-01-03)

AB-01-126, AB-02-152, AB-03-071

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

- DMERCs and the SADMERC identify instances where base year fees are incorrect and forward requests for revisions to their regional offices. The DMERCs 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. Contractors 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) in CBC,

Attention: Mary Anne Stevenson. (Those transmissions must occur within the timeframes established by CMS.

- Requests for revisions must be accompanied by a narrative description. This description must be forwarded via e-mail to Mary Anne Stevenson (Mstevenson@cms.hhs.gov) in DDS and Joel Kaiser (Jkaiser@cms.hhs.gov) in the Division of Community Post-Acute Care (DCPC) in the Center for Medicare Management.

- 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 DMERCs, SADMERC, and local carriers 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. DCPC (Joel Kaiser) must also receive a copy of the corrected fees.

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

- DMERCs and local carriers should give providers 30 days notice before revised payment amounts are implemented. Dates for implementation are provided by CMS.

- Carriers 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.

- Separate instructions are issued each year describing the data exchange for fiscal intermediaries (FIs). In summary, FIs will receive the revised payment amounts two to three weeks after the carriers receive the data from CMS. FIs may not implement the revised payment amounts prior to the carrier implementation date.

- CMS will furnish the revised payment amounts to RRB, Indian Health Service and United Mine Workers. DMERCs and local Part B carriers must provide the data to the State Medicaid Agencies.

- Fee Schedule Disclaimer: Whenever the carriers 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. 1, 10-01-03)

B3-5102.2, AB-01-126, AB-02-152, AB-03-071

DMERCs and local carriers must gap-fill the DMEPOS fee schedule for items for which charge data were unavailable during the previous database period using the fee schedule amounts for comparable equipment, using properly calculated fee schedule amounts from a neighboring carrier, or using supplier price lists with prices in effect during the database year. Mail order catalogs are particularly suitable sources of price information for items such as urological and ostomy supplies which require constant replacement. DMERCs 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 2002 deflation factors for gap-filling purposes are:

- .613 for Capped Rental DME (CR);
- .609 for Oxygen (OX);
- .614 for Inexpensive of Routinely Purchased DME (IN), Frequently Serviced DME (FS), Ostomy, Tracheostomy, or Urological Supply (OS), and Prosthetics and Orthotics (PO); and
- .779 for Surgical Dressings (SD).

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 carrier 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 carrier area without a sales tax. Likewise, if the gap-filled amount is calculated from another carrier's fees where a

sales tax is imposed, adjust the gap-filled amount to reflect the applicable local sales tax circumstances.

DMERCs and local carriers 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 an addendum file to contractors in mid December each year and during the quarterly updates.

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

(Rev. 1, 10-01-03)

AB-02-152

The DMERCs and SADMERC identifies instances where revisions to DMEPOS fees are needed and forwards 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 Mary Anne Stevenson (Mstevenson@cms.hhs.gov) and Joel Kaiser (Jkaiser@cms.hhs.gov). If the files are mailed, they must be mailed to the following address:

Centers for Medicare & Medicaid Management
Mary Anne Stevenson
Division of Health Plans and Provider Data/CBC
7500 Security Blvd.
C4-14-21
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	
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 Inherent Reasonableness (IR) Indicator	X(1)	28	For Capped Rental Services Only: 0 - IR not applied to original base fee, base fee is subject to rebasing adjustment 1 - IR applied to original base fee, 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

Field Name	PIC	Position	Comment
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.

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 DMERCs 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 DMERCs and the SADMERC via CMS' mainframe telecommunication system.

70.1- Record Layout for PEN Fee Schedule

(Rev. 1, 10-01-03)

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

Field Name	Pic	Position	Comment
1st Modifier	XX	10 - 11	
2nd Modifier	XX	12 - 13	
Jurisdiction	X	14	D = DMERC 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.
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 = Carrier 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.
Filler	X(9)	52 - 60	

80 - Reasonable Charges as Basis for Carrier/DMERC 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, carriers 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, carriers 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. Carriers compute each year's IIC screen, by increasing the appropriate previous year's screen by the percentage amount specified in annual Program Memorandum instructions. Carriers 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. Carriers/DMERCs have the primary responsibility for determining reasonable charges. The following guidelines are intended to assure overall consistency among carriers/DMERCs 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 contractor 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 contractor 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 carriers 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

Carriers/DMERCS 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.

Carriers/DMERCS 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, contractors may also ask physicians or other persons for their charges for services rendered to the public in general. Contractors should validate any information on charges obtained from sources against claims.

A - Charges for Rare or Unusual Procedures

Carriers 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 carrier, 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.

Carriers 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

Contractors 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 contractor 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 contractor 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, contractors 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 contractor 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

Carriers/DMERCS 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.

Carriers/DMERCS 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 carrier 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.)

Carriers/DMERCs 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 a carrier service area.

If it is necessary to establish customary charges using price lists, carriers/DMERCs use these customary charges to also establish the required prevailing charges. (See §80.3.1.) If the carrier/DMERC 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 carrier/DMERC 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 carrier service area and by specialty or group of specialties;

3 Prevailing charge by locality without regard to specialty;

4 Prevailing charge by carrier 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 carriers. Use another carrier 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, carriers should use their best judgment based on the available data to resolve the issue.

The CMS publishes carrier and DMERC 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

Carrier 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 carrier'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 carrier 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 carrier 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 Carrier 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,

carriers/DMERCs must use one of the following gap-filling methods to establish the needed screen.

A - Gaps in Customary Charge Screens

Carriers/DMERCs 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.

Carriers/DMERCs 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 carriers/DMERCs 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 carrier has not been able to establish a prevailing charge for a service based on the prevailing charge screen procedures, then carriers 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

$$C/F = \frac{\frac{CHG_1}{RVU_l} \times SVC_l + \frac{CHG_2}{RVU_2} \times SVC_2 . \frac{CHG_n}{RVU_n} \times SVC_n}{SIGMA\ SVC_{1\text{-}n}}$$

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

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

(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. 1, 10-01-03)

B3-5025

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 nonphysician services. Nonphysician 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, Intraocular Lenses);
- Blood products and transfusion medicine;
- Certain medical supplies used in connection with home dialysis; and
- Ambulance services (2001 and prior)

B - Calculation

The IIC is the lowest of the reasonable charge screens for the previous fee screen year (FSY) updated by an inflation adjustment factor. The reasonable charge screens include the prevailing charge, customary charge and the IIC. The inflation adjustment factor is based on the current change in the Consumer Price Index for all Urban Consumers (CPI-U) for the 12-month period ending June 30. The CMS issues the CPI to carriers and DMERCs annually.

C - Application of IIC

For all claims for nonphysician services subject to reasonable charge, the IIC is used as an additional limit in determining the reasonable charge. The customary charge, prevailing charge and LCL amount (if applicable) is updated annually in accordance with §80.3 and §80.4. The actual charge is compared against the customary charge, prevailing charge, LCL, and the IIC. The reasonable charge is calculated as the lowest of the above amounts.

D - Special Consideration for Calculating the IIC

The IIC is calculated based on the lowest of the reasonable charge screens in effect on September 30 of the prior FSY. Where, however, the customary charge in the prior FSY was based on the 50th percentile of the array of charges (see §80.5), such customary charge does not enter into the IIC calculation. Similarly, an IIC is not based on customary or prevailing charges calculated through conversion factors or price list data. (See §§80.4.) These limitations on the application of the IIC assure that the IIC is constructed only from true reasonable charge screens

While the IIC does not directly apply to reasonable charges constructed off price list data, contractors use their authority to assure that reasonable charges so derived are inherently reasonable. Thus, if there are increases in prices substantially in excess of the CPI, absent satisfactory evidence to the contrary, such excessive charge increases may be found unreasonable and need not be recognized. However, note that price list data are not routinely used to construct reasonable charge screens in other than unusual circumstances.

80.7 - Determination of Comparable Circumstances

(Rev. 1, 10-01-03)

B3-5026

Contractors 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 contractor would be obligated to pay. Under certain circumstances, some carriers 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 a carrier’s private health plan refer to the payment screens that are presently in effect, e.g., payment levels actually being used in the carrier’s private business for settling claims submitted by its policy holders or subscribers. Carriers 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 a carrier’s private health plan allowances are later revised, it will be necessary for the carrier 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 a carrier’s program has comparability will fall upon the carrier in reporting pertinent information about its programs to CMS. When the pertinent information has been reported, CMS will advise the carrier 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 carrier should exercise judgment so that its reasonable charge determinations are realistic and equitable. Carriers 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.

Addendum - MPFSDB Record Layouts

(Rev. 1, 10-01-03)

The CMS MPFSDBs include the total fee schedule amount, related component parts, and payment policy indicators. The record layout of the 2001, 2002, and 2003 files are provided below.

2001 File Layout

FIELD # & ITEM	LENGTH & PIC
1 File Year This field displays the effective year of the file.	4 Pic x(4)
2 Carrier Number This field represents the 5-digit number assigned to the carrier.	5 Pic x(5)
3 Locality This 2-digit code identifies the pricing locality used.	2 Pic x(2)
4 HCPCS Code This field represents the procedure code. Each Carrier Procedural Terminology (CPT) code and alphanumeric HCPCS codes other than B, E, K and L codes and services representing anesthesia services will be included. The standard sort for this field is blanks, alpha, and numeric in ascending order.	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 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 code 45378. Any other codes billed with modifier -53 are subject to carrier medical review and priced by individual consideration.	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
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.	
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 §30.2.3.	1 Pic x(1)
8 Conversion Factor This field displays the multiplier which transforms relative values into payment amounts. The file will contain the 2001 conversion factor which will reflect all adjustments.	8 Pic 9(4)v9999
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 Base Practice Expense Relative Value Unit For 2000 and beyond, this field is not applicable and will be zero filled. For 1999, this field displayed the unit value for the base practice expense RVU.	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	5 Pic 99v999

FIELD # & ITEM	LENGTH & PIC
Practice Expense GPCI This field displays a practice expense geographic adjustment factor used in computing the fee schedule amount.	
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 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 1day preoperative period and 90-day postoperative period included in the fee schedule payment amount. MMM = Maternity codes; usual global period does not apply. XXX = Global concept does not apply. YYY = Carrier 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.	3 Pic x(3)
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 0.1000. 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	6 Pic 9v9(5)

FIELD # & ITEM	LENGTH & PIC
intraoperative portion of the global package including postoperative work in the hospital. For example, 63 percent will be shown as 0.6300. The total of fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	
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 0.1700. 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 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	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
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 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 = Physician 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	

FIELD # & ITEM	LENGTH & PIC
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) 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 or 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.	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
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 = Indicator is reserved for possible future use. 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. 2 = 150 percent payment adjustment for bilateral procedure does not apply. RVUs are already based on the procedure being performed as	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
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 YYYYYLT with an actual charge of $100 and YYYYYRT 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 Assistant at Surgery This field provides an indicator for services where an assistant at surgery is never paid for per MCM. 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.	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
9 = Concept does not apply.	
24 CoSurgeons (Modifier 62) This field provides an indicator for services for which two surgeons, each in a different specialty, may be paid. 0 = Cosurgeons not permitted for this procedure. 1 = Cosurgeons could be paid; supporting documentation required to establish medical necessity of two surgeons for the procedure. 2 = Cosurgeons 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 Billable Medical Supplies This field provides an indicator for services subject to special payment rules for supplies/administration. 0 = Cannot be separately billed with this service. 1 = Code in related procedure code field can be paid separately when billed with these codes when service is performed in the physicians office. 9 = Concept does not apply.	1 Pic x(1)
27 Site of Service Differential For 1998, this field provides an indicator for services with differential payments based on site of service. 0 = Differential does not apply to this service. 1 = Applies due to a 50 percent reduction in practice expense RVUs. 2 = Applies due to the site of service practice expense RVUs. 3 = Applies due to a 50 percent reduction in the site of service	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
practice expense RVUs. 9 = Concept does not apply. 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 = Facility pricing applies	
28 Non-Facility Fee Schedule Amount This field shows the fee schedule amount for the non-facility setting. This amount equals Field 34. Non-Facility Pricing Amount [(Work RVU * Work GPCI) + (Transitioned Non-Facility PE RB 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. Facility Pricing Amount [(Work RVU * Work GPCI) + (Transitioned Facility PE RB RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor Place of service codes to be used to identify facilities. 21 - Inpatient Hospital 22 - Outpatient Hospital 23 - Emergency Room - Hospital 24 - Ambulatory Surgical Center 31 - Skilled Nursing Facility 53 - Community Mental Health Center 51 - Inpatient Psychiatric Facility 61 - Comprehensive Inpatient Rehabilitation Facility 62 - Comprehensive Outpatient Rehabilitation Facility	9 Pic 9(7)v99
30 Number of Related Codes This field defines the number of related procedure codes (see Field 31).	2 Pic 99

FIELD # & ITEM	LENGTH & PIC
31 Related Procedure Codes This field identifies the number of times that a related code occurs.	65 Pic x(5) - Occurs 13 times
31A Physician Supervision of Diagnostic Procedures This field is for informational use only for post payment review. 1 = Procedure must be performed under the general supervision of a physician. 2 = Procedure must be performed under the direct supervision of a physician. 3 = Procedure must be performed under the personal supervision of a physician. 4 = Physician supervision policy does not apply when procedure personally furnished by a qualified, independent psychologist or a clinical psychologist; otherwise must be performed under the general supervision of a physician. 5 = Physician supervision policy does not apply when procedure personally furnished by a qualified audiologist; otherwise must be performed under the general supervision of a physician. 6 = Procedure must be personally performed by a physician OR a physical therapist who is certified by the American Board of Physical Therapy Specialties as a qualified electrophysiologic clinical specialist AND is permitted to provide the service under State law. 7 = Procedure must be personally performed by a physical therapist who is certified by the American Board of Physical Therapy Specialties as a qualified electrophysiologic clinical specialist AND is permitted to provide the service under State law OR performed under the direct supervision of a physician. 8 = For future use. 9 = Concept does not apply. P = Decision pending.	1 Pic x(1)
31B Filler Reserved for future use.	1 Pic x(1)
31C Transitioned Facility Setting Practice Expense Relative Value Units	9 Pic(7)v99
31D	9 Pic(7)v99

FIELD # & ITEM	LENGTH & PIC
Transitioned NonFacility Setting Practice Expense Relative Value Units	
31E Base Site of Service Practice Expense Relative Value Units	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 Indicator applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
32C 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.	9 Pic 9(7)v99
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 Medicare+Choice Encounter Pricing Locality NOT FOR CARRIER USE: These Medicare+Choice encounter pricing localities are for EDS purposes only. The locality values	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
were developed to facilitate centralized processing of encounter data by the Medicare+Choice organizations (M+COs).	
33D National Level Future Expansion This field is being provided for future expansion at the national level	7 Pic x(7)
34 Non-Facility Transition/Fee Schedule Amount* Since this field has historically been used to obtain the pricing amount, this field will replicate Field 28.	9 Pic 9(7)v99
35 Facility Transition/Fee Schedule Payment Amount* Since this field has historically been used to obtain the pricing amount, this field will replicate Field 29.	9 Pic 9(7)v99
36 Transition Calculation Indicator* In 2001, this field is not populated. 2001 Non-Facility Pricing Amount [(Work RVU * Work GPCI) + (Transitioned Non-Facility PE RB RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor 2001 Facility Pricing Amount [(Work RVU * Work GPCI) + (Transitioned Facility PE RB RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor	1 Pic x(1)
37 Future Local Level Expansion** The Updated 1992 Transition Amount was previously stored in this field. Carriers 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. Carriers can continue to maintain the AHPB in this field.	7 Pic x(7)
38B Filler	8 Pic x(8)

FIELD # & ITEM	LENGTH & PIC
This field was originally established for 15 spaces. Since AHPB data will only use 7 of the 15 spaces, carriers have 8 remaining spaces for their purposes.	

* These fields will be provided by the Program Development and Information Group in the 2001 Medicare Fee Schedule Database for codes with status code indicator of A and T, as well as, indicators D and R with associated RVUs. Carriers will be responsible for calculating the 2001 payment amounts for codes with status code indicator of C, L, and R for codes without associated RVUs.

** These fields will be appended by each carrier at the local level.

2002 File Layout

(Rev. 1, 10-01-03)

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)

FILE LAYOUT

FIELD # & ITEM	LENGTH & PIC
1 File Year This field displays the effective year of the file.	4 Pic x(4)
2 Carrier Number This field represents the 5-digit number assigned to the carrier.	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 Carrier Procedural Terminology (CPT) code and alphanumeric HCPCS codes other than B, E, K and L codes and services representing anesthesia services will be included. The standard sort for this field is blanks, alpha, and numeric in ascending order.	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 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 code 45378. Any other codes billed with modifier -53 are subject to carrier 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 §30.2.3.	1 Pic x(1)
8 Conversion Factor This field displays the multiplier which transforms relative values into payment amounts. The file will contain the 2002 conversion factor which will reflect all adjustments.	8 Pic 9(4)v9999

FIELD # & ITEM	LENGTH & PIC
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 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;	3 Pic x(3)

FIELD # & ITEM	LENGTH & PIC
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 1day preoperative period and 90 day postoperative period included in the fee schedule payment amount. MMM = Maternity codes; usual global period does not apply. XXX = Global concept does not apply YYY = Carrier 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.	
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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 0.6300. 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 0.1700. 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 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	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
cannot be used with these codes. The total Relative Value Units (RVUs) include values for physician work, practice expense and malpractice expense. There are some codes with no work RVUs. 1 = Diagnostic tests or radiology services: This indicator identifies codes that describe diagnostic tests, e.g., pulmonary function tests, or therapeutic radiology procedures, e.g., radiation therapy. These codes generally have both a professional and technical component. Modifiers 26 and TC can be used with these codes. The total RVUs for codes reported with a 26 modifier include values for physician work, practice expense, and malpractice expense. The total RVUs for codes reported with a TC modifier include values for practice expense and malpractice expense only. The total RVUs for codes reported without a modifier equals the sum of RVUs for both the professional and technical component. 2 = Professional component only codes: This indicator identifies stand alone codes that describe the physician work portion of selected diagnostic tests for which there is an associated code that describes the technical component of the diagnostic test only and another associated code that describes the global test. An example of a professional component only code is 93010, Electrocardiogram; interpretation and report. Modifiers 26 and TC cannot be used with these codes. The total RVUs for professional component only codes include values for physician work, practice expense, and malpractice expense. 3 = Technical component only codes: This indicator identifies stand alone codes that describe the technical component (i.e., staff and equipment costs) of selected diagnostic tests for which there is an associated code that describes the professional component of the diagnostic tests only. An example of a technical component code is 93005, Electrocardiogram, tracing only, without interpretation and report. It also identifies codes that are covered only as diagnostic tests and therefore do not have a related professional code. Modifiers 26 and TC cannot be used with these codes. The total RVUs for technical component only codes include values for practice expense and malpractice expense only. 4 = Global test only codes: This indicator identifies stand alone codes for which there are associated codes that describe: a) the professional component of the test only and b) the technical component of the test only. Modifiers 26 and TC cannot be used with these codes. The total RVUs for global procedure only codes	

FIELD # & ITEM	LENGTH & PIC
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 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.	
21 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 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

FIELD # & ITEM	LENGTH & PIC
1 = Standard payment adjustment rules in effect before January 1, 1996 or 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 = Indicator is reserved for possible future use. 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	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
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 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. 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 YYYYYLT with an actual charge of $100 and YYYYYRT 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	

FIELD # & ITEM	LENGTH & PIC
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 Assistant at Surgery This field provides an indicator for services where an assistant at surgery is never paid for per MCM. 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)
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 = Cosurgeons not permitted for this procedure. 1 = Cosurgeons could be paid; supporting documentation required to establish medical necessity of two surgeons for the procedure. 2 = Cosurgeons 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.	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
2 = Team surgeons permitted; pay by report. 9 = Concept does not apply.	
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 = Facility pricing applies	1 Pic x(1)
28 Non-Facility Fee Schedule Amount This field shows the fee schedule amount for the non-facility setting. This amount equals Field 34. Non-Facility Pricing Amount [(Work RVU * Work GPCI) + (Non-Facility PE RB 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. Facility Pricing Amount [(Work RVU * Work GPCI) + (Facility PE RB RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor Place of service codes to be used to identify facilities. 21 - Inpatient Hospital 22 - Outpatient Hospital 23 - Emergency Room - Hospital 24 - Ambulatory Surgical Center – ASC is only treated as a facility setting when an ASC list procedure is performed in an ASC. 31 - Skilled Nursing Facility 53 - Community Mental Health Center 51 - Inpatient Psychiatric Facility	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
61 - Comprehensive Inpatient Rehabilitation Facility	
30 Number of Related Codes This field defines the number of related procedure codes (see Field 31).	2 Pic 99
31 Related Procedure Codes This field identifies the number of times that a related code occurs.	65 Pic x(5) Occurs 13 times
31A Physician Supervision of Diagnostic Procedures This field is for use in post payment review. 1 = Procedure must be performed under the general supervision of a physician. 2 = Procedure must be performed under the direct supervision of a physician. 3 = Procedure must be performed under the personal supervision of a physician. 4 = 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. 5 = Physician supervision policy does not apply when procedure is furnished by a qualified audiologist; otherwise must be performed under the general supervision of a physician. 6 = Procedure must be performed by a physician or a physical therapist (PT) who is certified by the American Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiologic clinical specialist and is permitted to provide the procedure under State law. 21 = Procedure may be performed by a technician with certification under general supervision of a physician; otherwise must be performed under direct supervision of a physician. 22 = May be performed by a technician with on-line real-time contact with physician. 66 = May be performed by a physician or by a physical therapist with ABPTS certification and certification in this specific procedure. 6a = Supervision standards for level 66 apply; in addition, the PT with ABPTS certification may supervise another PT, but only the	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
PT with ABPTS certification may bill. 77 = Procedure must be performed by a PT with ABPTS certification or by a PT without certification under direct supervision of a physician, or by a technician with certification under general supervision of a physician. 7a = Supervision standards for level 77 apply; in addition, the PT with ABPTS certification may supervise another PT, but only the PT with ABPTS certification may bill. 9 = Concept does not apply.	
31B This filed 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 Indicator applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
32C 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.	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
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 Medicare+Choice Encounter Pricing Locality NOT FOR CARRIER USE: These Medicare+Choice encounter pricing localities are for EDS purposes only. The locality values were developed to facilitate centralized processing of encounter data by the Medicare+Choice organizations (M+COs).	2 Pic x(2)
33D National Level Future Expansion This field is being provided for future expansion at the national level.	7 Pic x(7)
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. Carriers 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. Carriers can continue to maintain the AHPB in this field.	7 Pic x(7)
38B	8 Pic 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, carriers have 8 remaining spaces for their purposes.	

* These fields will be provided by the Program Development and Information Group in the 2002 Medicare Fee Schedule Database for codes with status code indicator of A and T, as well as, indicators D and R with associated RVUs. Carriers will be responsible for calculating the 2002 payment amounts for codes with status code indicator of C, L, and R for codes without associated RVUs.

** These fields will be appended by each carrier at the local level.

2003 File Layout

(Rev. 1, 10-01-03)

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)

FILE LAYOUT

FIELD # & ITEM	LENGTH & PIC
1 File Year This field displays the effective year of the file.	4 Pic x(4)
2 Carrier Number This field represents the 5-digit number assigned to the carrier.	5 Pic x(5)
3 Locality This 2-digit code identifies the pricing locality used.	2 Pic x(2)
4 HCPCS Code This field represents the procedure code. Each Carrier Procedural Terminology (CPT) code and alpha-numeric HCPCS codes other than B, C, E, K and L codes and services representing anesthesia services will be included. The standard sort for this field is blanks, alpha, and numeric in ascending order.	5 Pic x(5)
5 Modifier	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
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 code 45378. Any other codes billed with modifier -53 are subject to carrier 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.	
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 §30.2.3.	1 Pic x(1)
8 Conversion Factor This field displays the multiplier which transforms relative values into payment amounts. The file will contain the 2003 conversion factor which will reflect all adjustments.	8 Pic 9(4)v9999
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	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
Filler	
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 management services on the day of the procedure generally not payable. 010 = Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during this 10-day postoperative period generally not payable. 090 = Major surgery with a 1?day preoperative period and 90-day postoperative period included in the fee schedule payment amount. MMM = Maternity codes; usual global period does not apply. XXX = Global concept does not apply. YYY = Carrier 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	3 Pic x(3)

FIELD # & ITEM	LENGTH & PIC
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 0.1000. 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 0.6300. 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 0.1700. 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 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	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
values for practice expense and malpractice expense only. The total RVUs for codes reported without a modifier equals the sum of RVUs for both the professional and technical component. 2 = Professional component only codes: This indicator identifies stand alone codes that describe the physician work portion of selected diagnostic tests for which there is an associated code that describes the technical component of the diagnostic test only and another associated code that describes the global test. An example of a professional component only code is 93010, Electrocardiogram; interpretation and report. Modifiers 26 and TC cannot be used with these codes. The total RVUs for professional component only codes include values for physician work, practice expense, and malpractice expense. 3 = Technical component only codes: This indicator identifies stand alone codes that describe the technical component (i.e., staff and equipment costs) of selected diagnostic tests for which there is an associated code that describes the professional component of the diagnostic tests only. An example of a technical component code is 93005, Electrocardiogram, tracing only, without interpretation and report. It also identifies codes that are covered only as diagnostic tests and therefore do not have a related professional code. Modifiers 26 and TC cannot be used with these codes. The total RVUs for technical component only codes include values for practice expense and malpractice expense only. 4 = Global test only codes: This indicator identifies stand alone codes for which there are associated codes that describe: a) the professional component of the test only and b) the technical component of the test only. Modifiers 26 and TC cannot be used with these codes. The total RVUs for global procedure only codes include values for physician work, practice expense, and malpractice expense. The total RVUs for global procedure only codes equals the sum of the total RVUs for the professional and technical components only codes combined. 5 = Incident to codes: This indicator identifies codes that describe services covered incident to a physicians service when they are provided by auxiliary personnel employed by the physician and working under his or her direct supervision. Payment may not be made by carriers 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	

FIELD # & ITEM	LENGTH & PIC
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.	
21 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 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, or 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	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
(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 = Indicator is reserved for possible future use. 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	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
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. 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.	

FIELD # & ITEM	LENGTH & PIC
23 Assistant at Surgery This field provides an indicator for services where an assistant at surgery is never paid for per MCM. 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
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	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
1998: 0 = Facility pricing does not apply. 1 = Facility pricing applies.	
28 Non-Facility Fee Schedule Amount This field shows the fee schedule amount for the non-facility setting. This amount equals Field 34. Non-Facility Pricing Amount [(Work RVU * Work GPCI) + (Non-Facility PE RB 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. Facility Pricing Amount [(Work RVU * Work GPCI) + (Facility PE RB RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor Place of service codes to be used to identify facilities. 21 - Inpatient Hospital 22 - Outpatient Hospital 23 - Emergency Room - Hospital 24 - Ambulatory Surgical Center - ASC is only treated as a facility setting when an ASC list procedure is performed in an ASC. 26 - Military Treatment Facility 31 - Skilled Nursing Facility 34 - Hospice 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	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
30 Number of Related Codes This field defines the number of related procedure codes (see Field 31).	2 Pic 99
31 Related Procedure Codes This field identifies the number of times that a related code occurs.	65 Pic x(5) - Occurs 13 times
31A Physician Supervision of Diagnostic Procedures This field is for use in post payment review. 01 = Procedure must be performed under the general supervision of a physician. 02 = Procedure must be performed under the direct supervision of a physician. 03 = Procedure must be performed under the personal supervision of a physician. 04 = Physician supervision policy does not apply when procedure is furnished by a qualified, independent psychologist or a clinical psychologist; otherwise must be performed under the general supervision of a physician. 05 = Physician supervision policy does not apply when procedure is furnished by a qualified audiologist; otherwise must be performed under the general supervision of a physician. 06 = Procedure must be performed by a physician or a physical therapist (PT) who is certified by the American Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiologic clinical specialist and is permitted to provide the procedure under State law. 21 = Procedure may be performed by a technician with certification under general supervision of a physician; otherwise must be performed under direct supervision of a physician. 22 = May be performed by a technician with on-line real-time contact with physician. 66 = May be performed by a physician or by a physical therapist with ABPTS certification and certification in this specific procedure. 6A = Supervision standards for level 66 apply; in addition, the PT with ABPTS certification may supervise another PT, but only the PT with ABPTS certification may bill. 77 = Procedure must be performed by a PT with ABPTS	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
certification or by a PT without certification under direct supervision of a physician, or by a technician with certification under general supervision of a physician. 7A = Supervision standards for level 77 apply; in addition, the PT with ABPTS certification may supervise another PT, but only the PT with ABPTS certification may bill. 09 = Concept does not apply.	
31B This filed 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 Indicator applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
32C 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.	9 Pic 9(7)v99
33A Units Payment Rule Indicator	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
Reserved for future use. 9 = Concept does not apply.	
33B Mapping Indicator This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
33C Medicare+Choice Encounter Pricing Locality NOT FOR CARRIER USE: These Medicare+Choice encounter pricing localities are for EDS purposes only. The locality values were developed to facilitate centralized processing of encounter data by the Medicare+Choice organizations (M+COs).	2 Pic x(2)
33D National Level Future Expansion This field is being provided for future expansion at the national level.	7 Pic x(7)
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. Carriers can continue to maintain the updated transition amount in this field.	7 Pic x(7)