

HOW TO USE THE SEARCHABLE MEDICARE PHYSICIAN FEE SCHEDULE (MPFS)



Target Audience: Medicare Fee-For Service Program (also known as Original Medicare)

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

To Learn More...

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INTRODUCTION

WHAT IS THE SEARCHABLE MEDICARE PHYSICIAN FEE SCHEDULE (MPFS)?

The Centers for Medicare & Medicaid Services (CMS) Physician Fee Schedule Search Tool provides Medicare payment information on more than 10,000 services, including pricing, the associated Relative Value Units (RVUs), and various payment policies.

WHY WOULD A HEALTH CARE PROFESSIONAL, SUPPLIER, OR PROVIDER USE THE SEARCHABLE MPFS?

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

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

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

For example, hospital outpatient departments are paid for screening mammographies and outpatient rehabilitation services under the MPFS.

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

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

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

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

LIMITING CHARGE equals 115

percent of the nonparticipating fee schedule amount and is the maximum the nonparticipant may charge a beneficiary on an unassigned claim. The nonparticipating fee schedule amount is equal to 95 percent of the Medicare Physician Fee Schedule.

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

Print out the “Medicare Physician Fee Schedule (MPFS) Quick Reference Search Guide” on page 31 of this booklet for a step-by-step summary of how to use the MPFS Search Tool.

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

HELPFUL HINT

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

BACKGROUND

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

For most codes, Medicare pays 80 percent of the amount listed and the beneficiary is responsible for 20 percent.

Examples of reductions from the published MPFS amount include:

- Assistants at surgery receive 16 percent of the MPFS rate
- Nurse practitioners, physician assistants, and clinical nurse specialists are paid 85 percent
- Registered dietitians or nutrition professionals, for medical nutrition therapy services, are paid 85 percent
- Clinical social workers receive 75 percent

HELPFUL HINT

Refer to IOM Publication (Pub.) 100-04, “Medicare Claims Processing Manual,” Chapter 12, “Physicians/ Nonphysician Practitioners,” at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf> for more information.

HOW UP-TO-DATE IS THE SEARCHABLE MEDICARE PHYSICIAN FEE SCHEDULE?

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

HOW TO LOCATE THE SEARCHABLE MEDICARE PHYSICIAN FEE SCHEDULE

The searchable MPFS is located at <https://www.cms.gov/apps/physician-fee-schedule/overview.aspx>.

SEARCHING THE MPFS

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

- Pricing amounts
- Various payment policy indicators
- Relative Value Units (RVUs)
- Geographic Practice Cost Indices (GPCIs)

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

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

To begin your search, select the following criteria:

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

HELPFUL HINT

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

The remaining criteria options that are displayed vary based on the Type of Information selected for the search. We will display the next steps of this search performing a Pricing Information Search and subsequently review the other choices of searches.

PRICING INFORMATION SEARCH

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

HELPFUL HINT

The MPFS includes Level I Current Procedural Terminology (CPT) and Level II HCPCS codes.

3. Select one of the following choices for the Medicare Administrative Contractor (MAC) criteria:
 - **National Payment Amount**
 - This option searches for information for only the national payment amount. The national payment amount is designated with a MAC locality code of '0000000.'
 - **Specific MAC**
 - This option searches for information by a number indicating a specific geographic area. If you choose this option, select an area from the dropdown menu at the bottom of the page.

Some of these areas, such as 01112, have multiple listings. To learn what these numbers represent, reset the search to Specific Locality.

- **Specific Locality**
 - This search allows you to drill down to specific cities (for example, 0111205 - San Francisco) if payment varies within a MAC for specific localities. Notice the number for San Francisco starts with the Northern California number followed by 05.
- **All MACs**
 - This option searches for information for the entire nation. The results will include the national payment amount, as well as all MAC localities. This option is helpful for states with multiple payment localities because it groups all localities together for a MAC in case you are interested in how Medicare payment varies by locality within one MAC. However, this option does not provide locality names so it is necessary to know the MAC locality numbers, such as those provided in the Specific Locality option.

HELPFUL HINT

A MAC will be comprised of more than one of these numbers. For example, the JE MAC includes 01182-Southern California; 01112-Northern California; 01212-Hawaii, Guam, American Samoa, and the Northern Mariana Islands; and 01312-Nevada.

4. Enter the HCPCS code(s) for the search.
5. Select one of the following Modifier options from the dropdown menu:
 - Global (Diagnostic Service) OR Physicians Professional Service where Professional/Technical concept does not apply
 - 26 Professional Component
 - 53 Procedures which the physician terminated before completion
 - TC Technical Component
 - All Modifiers

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

HELPFUL HINT

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

Pricing Search Using a List of Evaluation/Management Codes

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

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

- 2017
- Pricing Information
- List of HCPCS Codes
- 11202 South Carolina as the Specific MAC
- 99214 and 99215 as a list of HCPCS Codes
- All Modifiers

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

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

HELPFUL HINT

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

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

1. **HCPCS CODE** - 99214 and 99215 are each displayed on a separate row with the pricing information displayed under the columns to the right.
2. **MODIFIER** - There is nothing displayed in this column.
 - For services other than those codes with a professional and/or technical component, this field will be blank with one exception: when CPT modifier -53 is allowed, it will appear.
3. **PROC STAT** - This column includes the Procedure Status Code. In Figure 4, 'A' is listed in this column and indicates an Active Code, which means the code is separately paid under the physician fee schedule if covered.

HELPFUL HINT

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

4. **MAC LOCALITY** - In Figure 4, 1120201 is displayed.
 - In this example, '1120201' represents South Carolina, and '01' as the last two digits indicates all of South Carolina's pricing is statewide. If this example were about Northern California, several rows would be displayed because pricing in California varies in several localities.
5. **NON-FACILITY PRICE** - In Figure 4, \$102.91 is displayed for 99214 and \$138.71 is displayed for 99215.
 - This column includes the fee schedule amount when a physician performs a procedure in a non-facility setting such as the office. (Non-facility fees are applicable to therapy procedures regardless of whether they are furnished in facility or non-facility settings.)

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

6. **FACILITY PRICE** - \$76.40 is shown for 99214 and \$107.94 for 99215.
 - This is the fee schedule amount when a physician provides this service in a facility setting, such as a hospital or Ambulatory Surgical Center (ASC).

SITE OF SERVICE DIFFERENTIAL

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

7. NON-FACILITY LIMITING CHARGE - \$112.43 is shown for 99214 and \$151.54 for 99215

- This is the maximum amount a beneficiary can be charged for the service:
 - By nonparticipating health care professionals
 - Who do not accept assignment
 - When the service is performed in an office setting

As explained on page 3 of this booklet, there is a 5 percent reduction in the approved amount for nonparticipating health care professionals and suppliers. In other words, the amounts in this column add up to 115 percent of 95 percent of the amounts in column 5.

8. FACILITY LIMITING CHARGE - \$83.47 is shown for 99214 and \$117.93 for 99215.

- This is the maximum amount a beneficiary can be charged for the service:
 - By nonparticipating health care professionals
 - Who do not accept assignment
 - When the service is performed in a facility setting

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

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

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

- 2017
- Pricing Information
- 76706 as the Single HCPCS Code
- 11202 South Carolina as the Specific MAC
- All Modifiers

It is important to note that, although the search was only for one code (76706, ultrasound, abdominal aorta), three rows are displayed because there are three ways to bill this code depending whether it is appropriate to bill a modifier.

1. In Figure 5, the first row is blank in the modifier column. When a provider does not use a modifier with this code, it means this provider has performed both the technical and professional components of the procedure. The global pricing amount is \$88.40 for the NON-FACILITY PRICE and FACILITY PRICE and \$96.58 for the NON-FACILITY LIMITING CHARGE. NA is shown for the FACILITY LIMITING CHARGE. (These amounts equal the sum of the amounts in the two other rows under these columns.)
2. The second row provides information for CPT code 76706 submitted with modifier -26, which should be used when only the professional component of the procedure was performed. \$27.29 is displayed for the NON-FACILITY PRICE and FACILITY PRICE and \$29.82 is shown for the NON-FACILITY LIMITING CHARGE and the FACILITY LIMITING CHARGE.

3. The third row displays the results if the CPT code 76706 is billed with HCPCS Level II modifier TC, Technical Component. TC indicates the claim was billed for the performance of the ultrasound only, not for the interpretation. \$61.11 is displayed under NON-FACILITY PRICE and FACILITY PRICE and \$66.76 is shown under NON-FACILITY LIMITING CHARGE. NA is shown for the FACILITY LIMITING CHARGE.

HELPFUL HINT

For the technical component of certain diagnostic imaging procedures, Medicare payment is based on the lower of the Outpatient Prospective Payment System (OPPS) cap or fee schedule amount; however, payment adjustments are not reflected in the MPFS search results. Full payments are displayed as well as OPPS payments. Also, Multiple Procedures Payment Reductions (MPPRs) cannot be displayed since there are too many combinations of HCPCS codes to consider. For additional information about MPPR, refer to the MLN Matters® articles included in the Resources section on page 18.

PAYMENT POLICY INDICATORS SEARCH

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

The Payment Policy Indicators include:

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

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

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

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

- 2017
- Payment Policy Indicators
- Single HCPCS Code 76706
- All Modifiers

We used the same code, 76706, as we just did in a pricing search to compare the information provided.

HELPFUL HINT

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

1. **MODIFIER** – As in our pricing search for this code, the screen displays three rows, showing that code 76706, abdominal aorta ultrasound, can be reported with no modifier, modifier -26, or a TC modifier.
 - All the other columns in this example display the same information for each row under the column heading.
2. **PROC STAT** – In this column, which shows Procedure Status Indicator, an ‘A’ is displayed as it was in the Pricing Search, meaning active code.
3. **PCTC** – This column complements the Modifier column by providing Professional Component/Technical Component Indicators. In our example, ‘1’ is listed, which means the code is a diagnostic test or radiology service. Modifiers -26 and TC may be used when submitting this code on a claim.
4. **GLOBAL** – XXX appears in this example, which means the global surgery concept is not applicable to this code.
5. **MULT SURG** – There are zeros displayed in this column, which means no payment adjustment rules for multiple procedures apply.
6. **BILT SURG** – A ‘0’ is displayed, which means the 150 percent payment adjustment for bilateral procedure does not apply. RVUs are already based on the procedure being performed as a bilateral procedure. If the procedure is reported with modifier -50 or is reported twice on the same day by any other means (for example, with RT and LT modifiers with a 2 in the units field), payment is based for both sides on the lower of (a) the total actual charges by the physician for both sides or (b) 100 percent of the fee schedule amount for a single code.

All the other columns include indicators showing that these are not applicable or not permitted for code 76706. Let’s now do a search using a surgical code to see what type of information may be conveyed in these columns.

Payment Policy Indicators Search Using a Surgical Code

Figure 7 below shows the MPFS search results when searching for CPT code 47480, Incision of gallbladder. Understanding the information in the columns displayed in these search results helps you understand policies such as bundled procedures or when using an appropriate CPT modifier with a code is necessary in order to be paid appropriately. This includes modifiers for assistant surgeons, bilateral surgery, and multiple procedures.

1. **MODIFIER** – There is no information under the Modifier column.
2. **PROC STAT** – There is an ‘A’ in the column indicating this is an active code.

3. **PCTC** – There is a ‘0’ in the column. The ‘0’ indicator identifies codes that describe physician services. Examples include visits, consultations, and surgical procedures. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components.
4. **GLOBAL** – This field provides the time frames that apply to payment for each surgical procedure or another indicator that describes the applicability of the global concept to the service (as XXX was explained in the previous mammography example).

In Figure 7, ‘090’ is listed, which means code 47480 is major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule payment amount.

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

Additional procedures are reviewed and considered for payment.

HELPFUL HINT

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

6. **BILT SURGERY** – This field provides an indicator for bilateral services subject to a payment adjustment. Bilateral surgeries are procedures performed on both sides of the body during the same operative session or on the same day. In Figure 7, ‘0’ is displayed, which means the 150 percent payment adjustment for bilateral procedures does not apply. If this procedure is reported with modifier -50 or with modifiers RT and LT, Medicare bases payment for the two sides on the lower of: (a) the total actual charge for both sides or (b) 100 percent of the fee schedule amount for a single code.

HELPFUL HINT

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

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

HELPFUL HINT

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

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

HELPFUL HINT

Learn more about co-surgeons in Chapter 12 of IOM Pub. 100-04 and read about modifier -62 in the current CPT code book.

9. **TEAM SURG** – This field in Figure 7 provides indicator ‘0’ indicating a team of surgeons (more than two surgeons of different specialties) is not permitted for this procedure.
10. **PHYS SUPV** – Diagnostic tests, with certain exceptions, must be performed under the supervision of a physician. This field indicates the level of required supervision. In this example, ‘9’ indicates that this concept does not apply.

RELATIVE VALUE UNIT (RVU) AND GEOGRAPHIC PRACTICE COST INDEX (GPCI) SEARCH

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

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

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

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

- Those with national codes for which national relative values have not been established
- Those requiring “By Report” payment or MAC pricing
- Those that are not included in the definition of physician services

Review the Status Indicators in the Appendix for more information.

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

Conversion Factor (CF) – Typically, the CF is updated on an annual basis. Until 2015, the annual update was equal to the Medicare Economic Index (MEI) adjusted up or down depending on how actual expenditures compared to a target rate called the Sustainable Growth Rate (SGR). The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repealed the Medicare sustainable growth rate (SGR) update formula for payments under the Medicare Physician Fee Schedule. For 2017, the Physician Fee Schedule update factor is 0.5 percent and the CF is 35.8887. RVUs are converted to dollar amounts through the application of the CF.

Further information about RVUs and GPCIs is available in the annual Medicare Physician Fee Schedule Final Rule or the file that can be accessed at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html>. In addition, the Medicare Learning Network® has prepared a fact sheet explaining the RVU payment system. This publication is entitled “Medicare Physician Fee Schedule,” and it can be located at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243670.html>.

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

RVU Search

Using the Searchable MPFS, we selected:

- 2017
- Relative Value Units for the Type of Information
- 99214 for the Single HCPCS Code
- All Modifiers

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

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

HELPFUL HINT

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

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

1. 1.43 under TRANSITIONED NON-FAC PE RVU
2. 1.43 under FULLY IMPLEMENTED NON-FAC PE RVU
3. 0.62 under TRANSITIONED FACILITY PE RVU
4. 0.62 under FULLY IMPLEMENTED FACILITY PE RVU
5. MP RVU (Malpractice RVU) has a value of 0.10 in this example

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

HELPFUL HINT

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

GPCI Search

Finally, let's do a GPCI search for 20176. Remember, we do not input a HCPCS code here because the same GPCI applies for all codes in an area. Our choices are whether we want a GPCI for:

- National Payment Amount
- Specific MAC
- Specific Locality
- All MACs

Figure 9 displays a portion of the screen for GPCIs when choosing 'All MACs.'

Remember that MAC Locality 0000000 is national. There is value of '1.000' in each of the three GPCI columns: GPCI WORK, GPCI PE, and GPCI MP. For specific localities, any values higher or lower than '1.000' indicate higher or lower geographic classification values than the national average. For our example, location 0111205 is displayed with a value of 1.077, 1.357, and 0.439 in these three respective columns.

Conclusion

In this booklet we've shown various types of searches using the searchable MPFS and explained the meaning of the indicators that are displayed as well as some of the policies that are relevant to understanding the information provided in these searches. To obtain further knowledge about the MPFS and related policies, other CMS webpages, provider education articles, and tools are listed in the Resources section of this booklet. You can also print out the "Medicare Physician Fee Schedule (MPFS) Quick Reference Search Guide" on page 33 of this booklet for a step-by-step summary of how to use the MPFS Search Tool.

RESOURCES

Medicare Learning Network® Products

FOR MORE INFORMATION	RESOURCE
<p>All Available MLN Products</p>	<p>http://go.cms.gov/mln-catalog The MLN Catalog contains brief descriptions of offerings from the Medicare Learning Network, which include publications and educational tools, web-based training courses and more. The downloadable Catalog products have hyperlinked titles. This allows you to view products or get more information as you browse. All MLN products and services are free.</p>
<p>“How to Use the Medicare Coverage Database” Booklet</p>	<p>https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1247078.html Learn about navigating the Medicare Coverage Database; searching indexes and reports; and download features.</p>
<p>“How to Use the Medicare National Correct Coding Initiative (NCCI) Tools” Booklet</p>	<p>https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243274.html Learn about navigating the CMS NCCI webpages, Medicare code pair edits, Medicare code pair edits, medically unlikely edits, and avoiding coding and billing errors.</p>
<p>“Medicare Physician Fee Schedule” Fact Sheet</p>	<p>https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243670.html Learn about physician services; Medicare Physician Fee Schedule payment rates; and Quality Payment Program.</p>
<p>MLN Matters® Article MM7442 “Multiple Procedure Payment Reduction (MPPR) on Certain Diagnostic Imaging Procedures”</p>	<p>https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7442.pdf This article explains that CMS is applying the MPPR to the Professional Component (PC) services as well as to Technical Component (TC) services.</p>
<p>MLN Matters® Article MM7703 “Interaction of the Multiple Procedure Payment Reduction (MPPR) on Imaging Procedures and the Outpatient Prospective Payment System (OPPS) Cap on the Technical Component (TC) of Imaging Procedures”</p>	<p>https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7703.pdf This article explains that Medicare implemented the MPPR rule on the Technical Component (TC) of certain diagnostic imaging procedures effective January 1, 2006. The MPPR also applies to the Professional Component (PC) of such services effective January 1, 2012.</p>

FOR MORE INFORMATION	RESOURCE
<p>MLN Matters® Article MM7747 “Application of the Multiple Procedure Payment Reduction (MPPR) on Imaging Services to Physicians in the Same Group Practice”</p>	<p>https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7747.pdf This article explains that CMS is expanding the MPPR on the Professional Component (PC) and Technical Component (TC) of imaging services by applying it to physicians in the same group practice who furnish multiple services to the same patient, in the same session, on the same day.</p>
<p>MLN Matters® Article MM7848 “Multiple Procedure Payment Reduction (MPPR) on the Technical Component (TC) of Diagnostic Cardiovascular and Ophthalmology Procedures”</p>	<p>https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7848.pdf This article explains that CMS is expanding the MPPR policy by applying MPPRs to the TC of diagnostic cardiovascular and ophthalmology procedures.</p>
<p>MLN Matters® Article MM8206 “Multiple Procedure Payment Reduction (MPPR) for Selected Therapy Services”</p>	<p>https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM8206.pdf This article explains that the MPPR on selected therapy services increased to 50 percent for both office and institutional settings for claims with dates of service on or after April 1, 2013.</p>
<p>MLN Matters® Article MM8278 “Applying Multiple Procedure Payment Reductions to Therapy Cap Amounts for Critical Access Hospital (CAH) Claims”</p>	<p>https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8278.pdf This article is based on Change Request (CR) 8278 which revises the amount applied toward a beneficiary’s therapy cap amounts when therapy services are provided in a Critical Access Hospital (CAH).</p>

FOR MORE INFORMATION	RESOURCE
<p>MLN Matters® Article MM9081 “Emergency Update to the Calendar Year (CY) 2015 Medicare Physician Fee Schedule Database (MPFSDB)”</p>	<p>https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9081.pdf This article is based on Change Request (CR) 9081, to announce an emergency update to payment files issued to contractors based on the CY 2015 MPFS Final Rule. CR9081 amends those payment files, including an updated conversion factor for services furnished between January 1, 2015, and March 31, 2015, consistent with the Protecting Access to Medicare Act of 2014 that provides for a zero percent update from CY 2014 rates.</p>
<p>MLN Guided Pathways Provider Specific Medicare Resources</p>	<p>https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN903543.html Learn about the type of resources available for the health care community; including webpages; training materials and guides available for multiple specialty pathways designed for Medicare FFS Physicians, Other Enrolled Health Care Professionals, Suppliers, Providers, and Hospitals; resources on enrollment; accreditation standards/survey and certification; coverage; billing; claims processing and reimbursement; beneficiary notices; and quality.</p>

Internet-Only Manuals

FOR MORE INFORMATION	RESOURCE
<p>Internet-Only Manual (IOM) Pub. 100-02 “Medicare Benefit Policy Manual”</p>	<p>https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html Chapter 15, “Covered Medical and Other Health Services,” includes information on supervision for diagnostic x-ray, laboratory, and other diagnostic tests as well as information about other Medicare Part B covered services.</p>

FOR MORE INFORMATION	RESOURCE
<p>Internet-Only Manual (IOM) Pub. 100-04 “Medicare Claims Processing Manual”</p>	<p>https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms018912.html</p> <p>Chapter 1, “General Billing Requirements,” includes information on jurisdiction for claims, assignment, participation, termination of provider agreements, billing, and timely filing. This chapter provides information on payment for participating and non-participating providers based on the MPFS.</p> <p>Chapter 4, “Part B Hospital (Including Inpatient Hospital Part B and OPPS),” explains physical therapy and diagnostic and screening mammography services are paid under the MPFS.</p> <p>Chapter 12, “Physicians/Nonphysician Practitioners,” includes information about how CMS updates the MPFS, adjustments to fee schedule components, correct coding policies, and other payment policies.</p> <p>Chapter 23, “Fee Schedule Administration and Coding Requirements,” includes information about coding requirements, edits, and the MPFS. This chapter also identifies services that are paid at reasonable charge rather than based on a fee schedule and discusses the other fee schedules used by CMS, such as the clinical diagnostic laboratory and DMEPOS fee schedules.</p>

CMS Webpages

FOR MORE INFORMATION	RESOURCE
<p>CMS Forms List</p>	<p>https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html</p> <p>The “Medicare Participating Physician or Supplier Agreement” (Form CMS-460) and other CMS forms can be downloaded from this webpage.</p>
<p>Medicare Coverage Database</p>	<p>https://www.cms.gov/medicare-coverage-database</p> <p>The searchable Medicare Coverage Database (MCD) contains all National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs), local articles, and proposed NCD decisions.</p>

FOR MORE INFORMATION	RESOURCE
<p>Medicare Physician Fee Schedule Federal Regulation Notices</p>	<p>https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html This webpage lists yearly proposed and final regulations for the MPFS.</p>
<p>National Correct Coding Initiatives (NCCI) Edits</p>	<p>https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html CMS developed NCCI to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. CMS developed its coding policies based on coding conventions defined in the American Medical Association’s Current Procedural Terminology (CPT) manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. This webpage offers a link to the “NCCI Coding Policy Manual for Medicare Services” under the Downloads section.</p>
<p>Physician Fee Schedule</p>	<p>https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html This webpage provides a link to the annual Physician Fee Schedule (PFS) final rule, files, and various reports. The rule includes annual updates to the relative weights of physician services.</p>
<p>Searchable MPFS</p>	<p>https://www.cms.gov/apps/physician-fee-schedule/overview.aspx This CMS tool is designed to facilitate searches of information on services covered by the MPFS. It provides Medicare payment information on more than 10,000 physician services, the associated relative value units, a fee schedule status indicator, and various payment policy indicators needed for payment adjustment.</p>

APPENDIX

This information is from the “Medicare Claims Processing Manual,” IOM Pub. 100-04, Chapter 23 at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf>. Select the File Layout for the applicable year from the Addendum.

HELPFUL HINT

Because this chapter is only updated on an annual basis, it is important to also review MLN Matters® articles and other information from CMS.

Status Indicators

A = Active code. These codes are separately paid under the physician fee schedule, if covered. There will be RVUs and payment amounts for codes with this status. The presence of an ‘A’ indicator does not mean that Medicare has made a national coverage determination regarding the service; MACs remain responsible for coverage decisions in the absence of a national Medicare policy.

B = Bundled code. Payment for covered services are always bundled into payment for other services not specified. There will be no RVUs or payment 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 beneficiary).

C = MACs priced code. MACS will establish RVUs and payment amounts for these services, generally on an individual case-by-case basis following review of documentation such as an operative report.

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.

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.)

M = Measurement codes. Used for reporting purposes only.

N = Non-covered service.

P = Bundled/excluded codes. There are no RVUs and no payment amounts for these services. No separate payment is made for them under the fee schedule. If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident (an example is an elastic bandage furnished by a physician incident to a physician service). If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (for example, colostomy supplies) and is paid under the other payment provision of the Social Security Act.

Q = Therapy functional information code. Used for required reporting purposes only.

R = Restricted coverage. Special coverage instructions apply.

T = Paid as only service. These codes are paid only if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the physician services for which payment is made.

X = Statutory exclusion. These codes represent an item or service that is not in the statutory definition of 'physician services' for fee schedule payment purposes. No RVUs or payment amounts are shown for these codes and no payment may be made under the physician fee schedule. (Examples are ambulance services and clinical diagnostic laboratory services.)

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 = MAC determines whether global concept applies and establishes postoperative period, if appropriate, at time of pricing.

ZZZ = Code related to another service and is always included in the global period of the other service. (Note: Physician work is associated with intra-service time and in some instances the post service time.)

Professional Component (PC)/Technical Component (TC) Indicator

0 = Physician service codes. This indicator identifies codes that describe physician services. Examples include visits, consultations, and surgical procedures. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. Modifiers -26 and TC cannot be used with these codes. The total Relative Value Units (RVUs) include values for physician work, practice expense, and malpractice expense. There are some codes with no work RVUs.

1 = Diagnostic tests or radiology services. This indicator identifies codes that describe diagnostic tests (for example, pulmonary function tests or therapeutic radiology procedures such as 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 (such as 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 physician's 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 MACs for these services when they are provided to hospital inpatients or patients in a hospital outpatient department. Modifiers -26 and TC cannot be used with these codes.

6 = Laboratory physician interpretation codes. This indicator identifies clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made. Actual performance of the tests is paid for under the lab fee schedule. Modifier TC cannot be used with these codes. The total RVUs for laboratory physician interpretation codes include values for physician, work, practice expense, and malpractice expense.

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

8 = Physician interpretation codes. This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for a hospital inpatient. This applies only to code 85060. No TC billing is recognized because payment for the underlying clinical laboratory test is made to the hospital, generally through the Prospective Payment System (PPS) rate. No payment is recognized for code 85060 furnished to hospital outpatients or non-hospital patients. The physician interpretation is paid through the clinical laboratory fee schedule payment for the clinical laboratory test.

9 = Concept of a professional/technical component does not apply.

Multiple Procedure (CPT Modifier -51)

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

0 = No payment adjustment rules for multiple procedures apply. If the procedure is reported on the same day as another procedure, payment is based on the lower of: (a) the actual charge or (b) the fee schedule amount for the procedure.

1 = Standard payment adjustment rules in effect before January 1, 1996, for multiple procedures apply.

In the 1996 Medicare Physician Fee Schedule Database (MPFSDB), this indicator only applied to codes with procedure status of 'D.' If a procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, Medicare ranks the procedures by the fee schedule amount and the appropriate reduction to this code is applied (100 percent, 50 percent, 25 percent, 25 percent, 25 percent, and by report). MACs base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage.

2 = Standard payment adjustment rules for multiple procedures apply. If the procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, MACs rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 50 percent, 50 percent, 50 percent, and by report). MACs base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage.

3 = Special rules for multiple endoscopic procedures apply if procedure is billed with another endoscopy in the same family (that is, another endoscopy that has the same base procedure). The base procedure for each code with this indicator is identified in field 31G of the Form CMS-1500 or its electronic equivalent claim. The multiple endoscopy rules apply to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). If an endoscopic procedure is reported with only its base procedure, the base procedure is not separately paid. Payment for the base procedure is included in the payment for the other endoscopy.

4 = Diagnostic imaging services subject to MPPR methodology. TC of diagnostic imaging services subject to a 50 percent reduction of the second and subsequent imaging services furnished by the same physician (or by multiple physicians in the same group practice, for example, same group National Provider Identifier [NPI]) to the same beneficiary on the same day, effective for services July 1, 2010, and after. PC of diagnostic imaging services are subject to a 25 percent payment reduction of the second and subsequent imaging services effective January 1, 2012.

HELPFUL HINT

Refer to MLN Matters® article MM7442 for information about the 2012 implementation of the 25 percent reduction to the PC for certain diagnostic imaging procedures.

5 = Selected therapy services subject to MPPR methodology. Subject to 20 percent of the practice expense component for certain therapy services furnished in office or other non-institutional settings, and 25 percent reduction of the practice expense component for certain therapy services furnished in institutional settings (effective for services January 1, 2011, and after). Subject to 50 percent reduction of the practice expense component for certain therapy services furnished in both institutional and non-institutional settings (effective for services April 1, 2013, and after).

6 = Diagnostic cardiovascular services subject to the MPPR methodology. Full payment is made for the TC service with the highest payment under the MPFS. Payment is made at 75 percent for subsequent TC services furnished by the same physician (or by multiple physicians in the same group practice, that is, same group National Provider Identifier [NPI]) to the same beneficiary on the same day (effective for services January 1, 2013, and after).

7 = Diagnostic ophthalmology services subject to the MPPR methodology. Full payment is made for the TC service with the highest payment under the MPFS. Payment is made at 80 percent for subsequent TC services furnished by the same physician (or by multiple physicians in the same group practice, that is, same group NPI) to the same beneficiary on the same day (effective for services January 1, 2013, and after).

9 = Concept does not apply.

Bilateral Surgery Indicator (CPT Modifier -50)

This field provides an indicator for services subject to a payment adjustment.

0 = 150 percent payment adjustment for bilateral procedures does not apply. If a procedure is reported with modifier -50 or with modifiers RT and LT, Medicare bases payment for the two sides on the lower of: (a) the total actual charge for both sides or (b) 100 percent of the fee schedule amount for a single code. Example: The fee schedule amount for code XXXXX is \$125. The physician reports code XXXXX-LT with an actual charge of \$100 and XXXXX-RT with an actual charge of \$100.

Payment would be based on the fee schedule amount (\$125) since it is lower than the total actual charges for the left and right sides (\$200). The bilateral adjustment is inappropriate for codes in this category because of (a) physiology or anatomy or (b) because the code descriptor specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure.

1 = 150 percent payment adjustment for bilateral procedures applies. If a code is billed with the bilateral modifier or is reported twice on the same day by any other means (such as with RT and LT modifiers or with a 2 in the units field), payment is based for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides or (b) 150 percent of the fee schedule amount for a single code.

If code is reported as a bilateral procedure and is reported with other procedure codes on the same day, the bilateral adjustment is applied before applying any applicable multiple procedure rules.

2 = 150 percent payment adjustment for bilateral procedure does not apply. RVUs are already based on the procedure being performed as a bilateral procedure. If a procedure is reported with modifier -50 or is reported twice on the same day by any other means (such as with RT and LT modifiers with a 2 in the units field), payment is based for both sides on the lower of (a) the total actual charges by the physician for both sides or (b) 100 percent of the fee schedule amount for a single code. Example: The fee schedule amount for code YYYYY is \$125. The physician reports code YYYYY-LT with an actual charge of \$100 and YYYYY-RT with an actual charge of \$100.

Payment would be based on the fee schedule amount (\$125) since it is lower than the total actual charges for the left and right sides (\$200). The RVUs are based on a bilateral procedure because: (a) the code descriptor specifically states that the procedure is bilateral; (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally; or (c) the procedure is usually performed as a bilateral procedure.

3 = The usual payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier -50 or is reported for both sides on the same day by any other means (such as with RT and LT modifiers or with a 2 in the units field), Medicare bases payment for each side or organ or site of a paired organ on the lower of: (a) the actual charge for each side or (b) 100 percent of the fee schedule amount for each side. If procedure is reported as a bilateral procedure and with other procedure codes on the same day, the fee schedule amount for a bilateral procedure is determined before applying any applicable multiple procedure rules.

Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral procedures.

9 = Concept does not apply.

Assistant at Surgery

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

0 = Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.

1 = Statutory payment restriction for assistants at surgery applies to this procedure. Assistants at surgery may not be paid.

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

9 = Concept does not apply.

Co-Surgeons (Modifier -62)

This field provides an indicator for services for which two surgeons, each in a different specialty, may be paid.

0 = Co-surgeons not permitted for this procedure.

1 = Co-surgeons could be paid. Supporting documentation is required to establish medical necessity of two surgeons for the procedure.

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

9 = Concept does not apply.

Team Surgeons (Modifier -66)

This field provides an indicator for services for which team surgeons may be paid.

0 = Team surgeons not permitted for this procedure.

1 = Team surgeons could be paid. Supporting documentation is required to establish medical necessity of a team; paid by report.

2 = Team surgeons permitted; pay by report.

9 = Concept does not apply.

Physician Supervision of Diagnostic Procedures

This field is for use in post payment review.

01 = Procedure must be performed under the general supervision of a physician.

02 = Procedure must be performed under the direct supervision of a physician, independent psychologist or a clinical psychologist.

03 = Procedure must be performed under the personal supervision of a physician.

04 = Physician supervision policy does not apply when procedure is furnished by a qualified, independent psychologist or a clinical psychologist. Otherwise the procedure must be performed under the general supervision of a physician.

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

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

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

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

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

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

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

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

09 = Concept does not apply.

Diagnostic Imaging Family Indicator

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

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

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

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

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

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

06 = Family 6 MRI and MRA (Spine)

07 = Family 7 CT (Spine)

08 = Family 8 MRI and MRA (Lower Extremities)

09 = Family 9 CT and CTA (Lower Extremities)

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

11 = Family 11 CT and CTA (Upper Extremities)

88 = Subject to the reduction of the TC diagnostic imaging (effective for services January 1, 2011, and after).
Subject to the reduction of the PC diagnostic imaging (effective for services January 1, 2012, and after).

99 = Concept Does Not Apply.

MEDICARE PHYSICIAN FEE SCHEDULE (MPFS) QUICK REFERENCE SEARCH GUIDE

Locate the MPFS Search Tool at <https://www.cms.gov/apps/physician-fee-schedule/overview.aspx> and follow the steps below to complete the MPFS search process.

Step 1: Year

Select the MPFS year for your search.

Step 2: Type of Information

Select one of the following five types of information relevant to your search:

- Pricing Information
- Payment Policy Indicators
- Relative Value Units (RVUs)
- Geographic Practice Cost Index (GPCI)
- All

Step 3: Healthcare Common Procedure Coding System (HCPCS) Criteria

Select one of the following three options (this step will not appear if the GPCI Type of Information option was selected in step 2 above):

- Single HCPCS Code – After selecting this option, indicate the code in the HCPCS Code field that will appear at the bottom of the page;
- List of HCPCS Codes – After selecting this option, enter up to five codes in the HCPCS Code fields that will appear at the bottom of the page; or
- Range of HCPCS Codes – After selecting this option, enter starting and ending procedure codes for the code range in the HCPCS Code fields that will appear at the bottom of the page. Note: Using a small range of codes is recommended. The response time will be slower for a larger range.

Then, select a modifier value from the Modifier dropdown menu at the bottom of the page.

Step 4: Medicare Administrative Contractor (MAC)

Select one of the following four options (this step will only appear if Pricing Information, GPCI, or All was selected for the Type of Information in step 2):

- National Payment Amount – This amount is designated with a MAC locality code of ‘0000000’
- Specific MAC – After selecting this option, indicate the MAC of your interest from the MAC dropdown menu that will appear at the bottom of the page
- Specific Locality – After selecting this option, select the locality of your interest from the MAC Locality dropdown menu that will appear at the bottom of the page
- All MACs – Displays information for the entire nation (results will include the national payment amount, as well as all MAC localities)

Step 5: Click Submit to view your search results.

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