

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4131	Date: September 14, 2018
	Change Request 10926

SUBJECT: Updates to Chapter 23 Fee File Instructions

I. SUMMARY OF CHANGES: This Change Request removes outdated instructions about distributing fee files to State agencies. It also updates instructions for manually loading procedure codes when a code is not present on the Payment Indicator File.

EFFECTIVE DATE: December 17, 2018

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: December 17, 2018

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	23/30.3.2/A/B MAC (A), (B), or (HHH) Furnishing Physician Fee Schedule Data for National Codes
R	23/50.6/Physician Fee Schedule Payment Policy Indicator File Record Layout

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

**Business Requirements
Manual Instruction**

Attachment - Business Requirements

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I. GENERAL INFORMATION

A. Background: After consultation with the Medicare Administrative Contractors (MACs), CMS has determined that instructions in the Medicare Claims Processing Manual which require MACs to provide fee schedule files to State agencies are outdated. These files are available on the CMS website and State agencies have been accessing the files directly from the web for some time. This Change Request (CR) updates the manual to remove the outdated information.

Additionally, CR 10644 instructed contractors to add to their systems Current Procedural Terminology (CPT) Category III codes 0506T, 0507T, and 0508T. When A/B MACs (A) attempted to load the codes into the Fiscal Intermediary Shared System (FISS), they were unable to do so. FISS does not recognize the multiple procedure indicator of 7, which applies to these codes, as a valid value since it is not contained in the CMS payment indicator file. As a workaround, CMS instructed A/B MACs (A) to use multiple procedure indicator of 0 instead. This CR documents this process in the manual so the MACs have standing instructions in case similar situations arise in the future.

B. Policy: The MACs shall direct State Agencies to the appropriate pages on the CMS website to download Medicare Physician Fee Schedule data directly. When loading CPT or HCPCS codes with multiple procedure indicators that are not on the CMS payment indicator file, A/B MACs (A) shall enter an indicator of 0.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
10926.1	The contractors shall update their procedures to reflect the revisions to Chapter 23 of Pub. 100-04.	X	X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility

		A/B MAC			D M E	C E D I
		A	B	H H H	M A C	
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
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Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Wil Gehne, wilfried.gehne@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

30.3.2 - A/B MAC (A), (B), or (HHH) Furnishing Physician Fee Schedule Data for National Codes

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

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

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

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

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

50.6 – Physician Fee Schedule Payment Policy Indicator File Record Layout

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

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

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

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
<p>been established for procedures which the physician terminated before completion. This modifier is used only with colonoscopy code 45378 and screening colonoscopy codes G0105 and G0121. Any other codes billed with modifier -53 are subject to medical review and priced by individual consideration.</p> <p>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.</p>		
<p>Code Status</p> <p>This 1 position field provides the status of each code under the full fee schedule. Each status code is explained in Pub. 100-04, Chapter 23, §30.2.2.</p>	1 Pic x(1)	12
<p>Global Surgery</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>090 = Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule payment amount.</p> <p>MMM = Maternity codes; usual global period does not apply.</p> <p>XXX = Global concept does not apply.</p> <p>YYY = A/B MAC (A) determines whether global concept applies and establishes postoperative period, if appropriate, at time of pricing.</p>	3 Pic x(3)	13-15

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
<p>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.)</p>		
<p>Preoperative Percentage (Modifier 56)</p> <p>This field contains the percentage (shown in decimal format) for the preoperative portion of the global package. For example, 10 percent will be shown as 010000. The total of the preoperative percentage, intraoperative percentage, and the postoperative percentage fields will usually equal one. Any variance is slight and results from rounding.</p>	6 Pic 9v9(5)	16-21
<p>Intraoperative Percentage (Modifier 54)</p> <p>This field contains the percentage (shown in decimal format) for the intraoperative portion of the global package including postoperative work in the hospital. For example, 63 percent will be shown as 063000. The total of the preoperative percentage, intraoperative percentage, and the postoperative percentage fields will usually equal one. Any variance is slight and results from rounding.</p>	6 Pic 9v9(5)	22-27
<p>Postoperative Percentage (Modifier 55)</p> <p>This field contains the percentage (shown in decimal format) for the postoperative portion of the global package that is provided in the office after discharge from the hospital. For example, 17 percent will be shown as 017000. The total of the preoperative percentage, intraoperative percentage, and the postoperative percentage fields will usually equal one. Any variance is slight and results from rounding.</p>	6 Pic 9v9(5)	28-33
<p>Professional Component (PC)/Technical Component (TC) Indicator</p> <p>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.</p> <p>1 = Diagnostic tests or radiology services: This indicator identifies codes that describe diagnostic tests, e.g., pulmonary function tests, or therapeutic</p>	1 Pic x(1)	34

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
<p>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.</p> <p>The total RVUs for codes reported with a 26 modifier include values for physician work, practice expense, and malpractice expense.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>The total RVUs for technical component only codes include values for practice expense and malpractice expense only.</p> <p>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</p>		

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>9 = Concept of a professional/technical component does not apply</p>		
<p>Multiple Procedure (Modifier 51) Indicator indicates which payment adjustment rule for multiple procedures applies to the service.</p> <p>0 = No payment adjustment rules for multiple</p>	1 Pic (x)1	35

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
<p>procedures apply. If the procedure is reported on the same day as another procedure, base payment on the lower of: (a) the actual charge or (b) the fee schedule amount for the procedure.</p> <p>1 = Standard payment adjustment rules in effect before January 1, 1996, for multiple procedures apply. In the 1996 MPFSDB, this indicator only applies to codes with procedure status of "D." If a procedure is reported on the same day as another procedure with an indicator of 1,2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 25 percent, 25 percent, 25 percent, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage.</p> <p>2 = Standard payment adjustment rules for multiple procedures apply. If the procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 50 percent, 50 percent, 50 percent, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage.</p> <p>3 = Special rules for multiple endoscopic procedures apply if procedure is billed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure). The base procedure for each code with this indicator is identified in the endoscopic base code field.</p> <p>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).</p> <p>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.</p> <p>4 = Subject to MPPR reduction.</p> <p>9 = Concept does not apply.</p> <p><i>Codes with RVUs equal to zero are not included in the payment indicator file. These codes may have</i></p>		

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
<i>multiple procedure indicators not shown. See note below this table for instructions on these codes.</i>		
<p>Bilateral Surgery Indicator (Modifier 50) This field provides an indicator for services subject to a payment adjustment.</p> <p>0 = 150 percent payment adjustment for bilateral procedures does not apply.</p> <p>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.</p> <p>1 = 150 percent payment adjustment for bilateral procedures applies. If code is billed with the bilateral modifier base payment for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides, or (b) 150 percent of the fee schedule amount for a single code.</p> <p>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.</p> <p>2 = 150 percent payment adjustment for bilateral procedure does not apply. RVUs are already based on the procedure being performed as a bilateral procedure.</p> <p>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.</p> <p>3 = The usual payment adjustment for bilateral procedures does not apply.</p> <p>Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral procedures. If a procedure is billed with the 50 modifier, base payment on the lesser of the total actual charges for each side or 100% of the fee schedule amount for each side.</p> <p>9 = Concept does not apply.</p>	1 Pic (x)1	36
<p>Assistant at Surgery (Modifiers AS, 80, 81 and 82)</p>	1 Pic (x)1	37

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
<p>This field provides an indicator for services where an assistant at surgery may be paid:</p> <p>0 = Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.</p> <p>1 = Statutory payment restriction for assistants at surgery applies to this procedure. Assistant at surgery may not be paid.</p> <p>2 = Payment restriction for assistants at surgery does not apply to this procedure. Assistant at surgery may be paid.</p> <p>9 = Concept does not apply.</p>		
<p>Co-Surgeons (Modifier 62)</p> <p>This field provides an indicator for services for which two surgeons, each in a different specialty, may be paid.</p> <p>0 = Co-surgeons not permitted for this procedure.</p> <p>1 = Co-surgeons could be paid; supporting documentation required to establish medical necessity of two surgeons for the procedure.</p> <p>2 = Co-surgeons permitted; no documentation required if two specialty requirements are met.</p> <p>9 = Concept does not apply.</p>	1 Pic (x)1	38
<p>Team Surgeons (Modifier 66)</p> <p>This field provides an indicator for services for which team surgeons may be paid.</p> <p>0 = Team surgeons not permitted for this procedure.</p> <p>1 = Team surgeons could be paid; supporting documentation required to establish medical necessity of a team; pay by report.</p> <p>2 = Team surgeons permitted; pay by report.</p> <p>9 = Concept does not apply.</p>	1 Pic (x)1	39
<p>Endoscopic Base Codes</p> <p>This field identifies an endoscopic base code for each code with a multiple surgery indicator of 3.</p>	5 Pic (x) 5	40-44
<p>Performance Payment Indicator (For future use)</p>	1 Pic x (1)	45
<p>Diagnostic Imaging Family Indicator</p>	2 Pic x (2)	46-47

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
88 = Subject to the reduction for diagnostic imaging (effective for services January 1, 2011, and after). 99 = Concept Does Not Apply		
Effective Date This field displays the effective date of the file in YYYYMMDD format.	8 Pic x(8)	48 - 55
Filler	30 Pic x(30)	56 -75

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

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