



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



Target Audience: Medicare-Fee-For-Service Providers

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

[Physician Fee Schedule look-up tool overview](#)

To Learn More...

If you find this How to booklet helpful, then you may wish to review the other booklets in this series. To locate these booklets, go to the [MLN Publications](#) webpage and search for items containing the words “how to.”

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TABLE OF CONTENTS

INTRODUCTION	3
What is the Searchable Medicare Physician Fee Schedule (MPFS)?	3
Why Would a Health Care Professional, Supplier, or Provider Use the Searchable MPFS?	3
Background	4
How Up to Date is the Searchable Medicare Physician Fee Schedule?	6
SEARCHING THE MPFS	7
Pricing Information Search	9
Pricing Search Using a List of Evaluation/Management Codes	11
Pricing Search Using a Code with an Applicable Professional/Technical Component	14
Payment Policy Indicators Search	15
Payment Policy Indicators Search Using a Code with an Applicable Professional/Technical Component	15
Payment Policy Indicators Search Using a Surgical Code	17
Relative Value Unit (RVU) and Geographic Practice Cost Index (GPCI) Search	19
RVU Search	20
GPCI Search	21
Conclusion	22
Resources	23
Internet-Only Manuals	25
CMS Webpages	25
APPENDIX	27
Status Indicators	27
Global Surgery	28
Professional Component (PC)/Technical Component (TC) Indicator	29
Multiple Procedure (CPT Modifier -51)	30
Bilateral Surgery Indicator (CPT Modifier -50)	31
MEDICARE PHYSICIAN FEE SCHEDULE (MPFS) QUICK REFERENCE SEARCH GUIDE	35

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.

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.

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.

HELPFUL HINT

Print out the Medicare Physician Fee Schedule (MPFS) Quick Reference Search Guide on page 35 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 affected 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)
- Search the [National Correct Coding Initiative \(NCCI\) Edits](#) webpage to identify NCCI code pair edits and Medically Unlikely Edits (MUEs)
- Search the [Medicare Coverage Database \(MCD\)](#) to review national and local coverage determinations
- Visit the [Medicare Learning Network® \(MLN\) Publications](#) webpage to review other booklets in the How to series:
 - How to Use the Medicare National Correct Coding Initiative (NCCI) Tools
 - How to Use the Medicare Coverage Database booklets to assist you

BACKGROUND

Medicare Part B pays for physician services based on the Medicare PFS, which lists the more than 7,000 unique codes and their payment rates. Physicians' services include:

- Office visits
- Surgical procedures
- Anesthesia services
- A range of other diagnostic and therapeutic services

Physicians' services are furnished in all settings, including:

- Physicians' offices
- Hospitals
- Ambulatory Surgical Centers
- Skilled Nursing Facilities and other post-acute care settings
- Hospices
- Outpatient dialysis facilities
- Clinical laboratories
- Beneficiaries' homes

MEDICARE PFS PAYMENT RATES

The Medicare PFS payment rates formula shows how a payment rate for an individual service is determined, and we provide a description for each component below the formula.

Medicare PFS Payment Rates Formula

(arithmetic graphic of components added and multiplied together to make up the PFS payment rate)



1) Relative Value Units (RVUs)

Three separate RVUs are associated with calculating a payment under the Medicare PFS:

The Work RVU reflects the relative time and intensity associated with furnishing a Medicare PFS service

The Practice Expense (PE) RVU reflects the costs of maintaining a practice (such as renting office space, buying supplies and equipment, and staff costs)

The Malpractice (MP) RVU reflects the costs of malpractice insurance

2) Geographic Practice Cost Indices (GPCIs)

Each of the three RVUs are adjusted to account for geographic variations in the costs of practicing medicine in different areas within the country. These adjustments are called GPCIs, and each kind of RVU component has a corresponding GPCI adjustment.

3) Conversion Factor (CF)

To determine the payment rate for a particular service, the sum of the geographically adjusted RVUs is multiplied by a CF in dollars. The statute specifies the formula by which the CF is updated on an annual basis.

QPP

Effective January 1, 2017, the Medicare Access and CHIP Reauthorization Act of 2015 repealed the previous formula to update the Medicare PFS and replaced it with several years of increases to overall payments for PFS services. In conjunction with that change, the law created the QPP, which rewards the delivery of high-quality and cost-efficient patient care.

You may choose from these tracks:

- Advanced Alternative Payment Models to earn an incentive payment for participation.
- The Merit-based Incentive Payment System to earn a performance-based adjustment to your Medicare payment. It consolidates the components of the Physician Quality Reporting System (PQRS), Physician Value-based Payment (VBP) Modifier, and Medicare Electronic Health Record (EHR) Incentive Program for Eligible Professionals.

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 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.

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:

Figure 1: Search 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.' If you choose to print the results, you'll print more than what you need and will 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

Search Criteria

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

Please select a year (see 'Notes for Selected Year' box for details):

Type of Information:

1 Pricing Information
 Payment Policy Indicators
 Relative Value Units
 Geographic Practice Cost Index
 All

Select Healthcare Common Procedure Coding System (HCPCS) Criteria:

2 Single HCPCS Code
 List of HCPCS Codes
 Range of HCPCS Codes

Select Medicare Administrative Contractor (MAC) Option:

3 National Payment Amount
 Specific MAC
 Specific Locality
 All MACs

Pricing by Single HCPCS Code for All
 Enter values for:
 4 HCPCS Code:

5 **Modifier:**

[RESET SELECTION CRITERIA](#)

[Back to Top](#)

NOTES FOR SELECTED YEAR

2020: The Medicare Physician Fee Schedule update factor for 2020 is 0.00% and the conversion factor is 36.0896.

PFS UPDATE STATUS

Data last updated: 02/05/2020

Figure 2: 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

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.

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

PRICING SEARCH USING A LIST OF EVALUATION/MANAGEMENT CODES

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

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

- 2020 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.

The screenshot displays the 'Physician Fee Schedule Search' interface. At the top, there are navigation tabs: 'OVERVIEW', 'PHYSICIAN FEE SCHEDULE SEARCH' (active), and 'DOCUMENTATION FILES'. A 'Tool Help' icon is in the top right. Below the tabs, a link for 'Back to Search Criteria' is visible. The main heading is 'Physician Fee Schedule Search'. A section titled 'Search Results [2 Record(s)]' contains the search criteria: Year (2020), Type of Info. (Pricing Information), HCPCS Criteria (List of HCPCS Codes), MAC Option (Specific MAC), HCPCS (99214, 99215), Modifier (All Modifiers), and MAC (11202 SOUTH CAROLINA). An 'Update Results' button is present. Below the criteria is a table titled 'List of HCPCS Codes' with two rows: 99214 (Office/outpatient visit est) and 99215 (Office/outpatient visit est). To the right of the table are buttons for 'Print Results', 'Download Results', and 'Email Results', along with a note: 'For your convenience, search results can be printed, downloaded or emailed.' Below the table are 'Show Default Columns' and 'Show All Columns' buttons. At the bottom, there is a pagination indicator '1' and a 'View Items Per Page' dropdown set to '10' with a 'Go' button. A partial table header is visible at the bottom right with columns for 'NA FLAG' and 'NA FLG FOR'.

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

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 towards the right:

1	2	3	4	5	6	7	8	9	NA FLAG FOR TRANS NON-FAC PE RVU	NA FLG FOR FULLY IMP NON-FAC PE RVU	NA FLAG FOR TRANS FACILITY PE RVU	NA FL FOR FU IM FA PE RVU
HCPCS CODE	MODIFIER	PROC STAT	MAC LOCALITY	NON-FACILITY PRICE	FACILITY PRICE	NON-FACILITY LIMITING CHARGE	FACILITY LIMITING CHARGE	CONV FACT				
99214		A	1120201	\$104.07	\$76.91	\$113.70	\$84.02	36.0896				
99215		A	1120201	\$140.08	\$108.66	\$153.04	\$118.71	36.0896				

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

- 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.
- 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 was about Northern California, several rows would be displayed because pricing in California varies in several localities.

HELPFUL HINT

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

5 NON-FACILITY PRICE - In Figure 4, \$104.07 is displayed for 99214 and \$140.08 is displayed for 99215.

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

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

SITE OF SERVICE DIFFERENTIAL

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

6 FACILITY PRICE - \$76.91 is shown for 99214 and \$108.66 for 99215.

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

7 NON-FACILITY LIMITING CHARGE - \$113.70 is shown for 99214 and \$153.04 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 1 of this booklet, there is a 5 percent reduction in the approved amount for nonparticipating health care professionals and suppliers. In other words, the amounts in this column add up to 115 percent of 95 percent of the amounts in column 5.

8 FACILITY LIMITING CHARGE - \$84.02 is shown for 99214 and \$118.71 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:

- 2020
- Pricing Information
- 76706 as the Single HCPCS Code
- 11202 South Carolina as the Specific MAC
- All Modifiers

MODIFIER	PROC STAT	MAC LOCALITY	NON-FACILITY PRICE	FACILITY PRICE	NON-FACILITY LIMITING CHARGE	FACILITY LIMITING CHARGE	CONV FACT	NA FLAG FOR TRANS NON-FAC PE RVU	NA FLG FOR FULLY IMP NON-FAC PE RVU	NA FLAG FOR TRANS FACILITY PE RVU	NA FLAG FOR FULLY IMP FAC PE RVU	NO FOI ME	
1		A	1120201	\$106.51	\$106.51	\$116.36	NA	36.0896			NA		
2	26	A	1120201	\$27.07	\$27.07	\$29.58	\$29.58	36.0896					
3	TC	A	1120201	\$79.44	\$79.44	\$86.79	NA	36.0896			NA		

Figure 5: Pricing Search Showing TC and 26

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 **NON-FACILITY PRICE** pricing amount is \$106.51, \$106.51 for the **FACILITY PRICE** and \$116.36 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. \$27.07 is displayed for the **NON-FACILITY PRICE** and **FACILITY PRICE** and \$29.58 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. \$79.44 is displayed under **NON-FACILITY PRICE** and **FACILITY PRICE** and \$86.79 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 23.

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:

- 2020
- 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,. Remember, however, that MACs may have additional, local policies that you'll need to research on their websites or in the [Medicare Coverage Database](#).

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

Figure 6: Payment Policy Indicators Search Results

- 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.

For a complete listing of indicators which might appear with other HCPCS code selections, refer to the Medicare Claims Processing Manual, IOM Pub. 100-04, [Chapter 23](#). In the Addendum, select the layout for the applicable year (such as 2019) or refer to the Appendix in the back of this booklet. In addition, we'll also perform a payment policy search with a surgical example to explain more of these indicators.

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.

Physician Fee Schedule Search

Search Results [1 Record(s)]

Selected Criteria:
 Year: 2020 | HCPCS: 47480
 Type of Info.: Payment Policy Indicators | Modifier: All Modifiers
 HCPCS Criteria: Single HCPCS Code

Single HCPCS Code

Code	Description
47480	Incision of gallbladder

Print Results | Download Results | Email Results

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

1 MODIFIER	2 PROC STAT	3 PCTC	4 GLOBAL	5 MULT SURG	6 BILT SURG	7 ASST SURG	8 CO SURG	9 TEAM SURG	10 PHYS SUPV	DIAG IMAGING FAMILY IND
	A	0	090	2	0	2	1	0	09	99

View Items Per Page: 10 | Go

Figure 7: Payment Policy Indicators Search Using Surgical Code

- 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.

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.

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.

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.

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 GPICs 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 GPICs 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. Effective January 1, 2020, the Physician Fee Schedule update factor is 0.00 percent and the CF is 36.09. RVUs are converted to dollar amounts through the application of the CF.

Further information about RVUs and GPICs is available in the annual [Medicare Physician Fee Schedule Final Rule](#).

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

RVU SEARCH

Using the Searchable MPFS, we selected:

- 2020
- 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 health care 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 about these two codes; you'll see that the payment for 99215 is higher than for 99214. This helps you understand the impact of RVUs on the fee schedule amount.

Selected Criteria:

Year: HCPCS:

Type of Info.: Modifier:

HCPCS Criteria:

Single HCPCS Code

Code	Description
99214	Office/outpatient visit est

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

WORK RVU	NA FLAG FOR TRANS NON-FAC PE RVU	TRANSITIONED NON-FAC PE RVU	NA FLAG FOR FULLY IMP NON-FAC PE RVU	FULLY IMPLEMENTED NON-FAC PE RVU	NA FLAG FOR TRANS FACILITY PE RVU	TRANSITIONED FACILITY PE RVU	NA FLAG FOR FULLY IMP FAC PE RVU	FULLY IMPLEMENTED FACILITY PE RVU	MP RVU	NON-FAC PE USED FOR OPPTS PMT AMT
1.50		1.45		1.45		0.62		0.62	0.11	0.00

Figure 8: RVU Search

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

- 1 1.45 under **TRANSITIONED NON-FAC PE RVU**
- 2 1.45 under **FULLY IMPLEMENTED NON-FAC PE RVU**
- 3 0.62 under **TRANSITIONED FACILITY PE RVU**
- 3 0.62 under **FULLY IMPLEMENTED FACILITY PE RVU**
- 5 **MP RVU** (Malpractice RVU) has a value of 0.11 in this example.

HELPFUL HINT

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

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

GPCI SEARCH

Finally, let's do a GPCI search for 2020. 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 or
- All MACs

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

Search Results [113 Record(s)]

Selected Criteria:
 Year: 2020
 Type of Info.: Geographic Practice Cost Index
 MAC Option: All MACs

Update Results

Print Results | Download Results | Email Results

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

Page 1 of 12 | Go to page | Prev | 1 2 3 4 5 6 ... | Next | View Items Per Page: 10 | Go

MAC LOCALITY	GPCI WORK	GPCI PE	GPCI MP
0000000	1.000	1.000	1.000
0111205	1.076	1.327	0.440
0111206	1.076	1.327	0.440
0111207	1.076	1.327	0.440

Figure 9: GPCI Search

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 1.076, 1.327, and 0.440 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 35 of this booklet for a step-by-step summary of how to use the MPFS Search Tool.

RESOURCES

Medicare Learning Network® Products

Visit the [MLN Publications](#) webpage to see all Available MLN Products

The [MLN Catalog](#) contains brief descriptions and links to educational resources. The Centers for Medicare & Medicaid Services (CMS) works with clinicians, billing experts, and CMS subject matter experts to prepare these free MLN resources. They cover CMS programs, policies, and initiatives in detail, giving you the information to make the best decisions for your patients and your practice. Resources identified by a star symbol also offer Continuing Education Units (CEUs) and Continuing Medical Education (CME) credits.

FOR MORE INFORMATION ABOUT...	RESOURCE
How to Use the Medicare Coverage Database Booklet	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1247078 Learn how to navigate the database; search indexes and download reports.
How to Use the Medicare National Correct Coding Initiative (NCCI) Tools Booklet	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243274 Learn about navigating the CMS NCCI webpages; Medicare code pair edit; Medicare code pair edits; medically unlikely edits; and avoiding coding and billing errors.
MLN Matters® Article MM6993 Multiple Procedure Payment Reduction (MPPR) on the Technical Component (TC) of Certain Diagnostic Imaging Procedures	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6993.pdf This article explains that CMS is applying the MPPR to the Professional Component (PC) services as well as to Technical Component (TC) services.
MLN Matters® Article MM7442 Multiple Procedure Payment Reduction (MPPR) on Certain Diagnostic Imaging Procedures	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.

FOR MORE INFORMATION ABOUT...	RESOURCE
<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>
<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>

INTERNET-ONLY MANUALS

Internet-Only Manual (IOM) Pub. 100-02 Medicare Benefit Policy Manual

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf>

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

Internet-Only Manual (IOM) Pub. 100-04 Medicare Claims Processing Manual

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf>

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.

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf>

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.

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf>

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.

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf>

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

CMS WEBPAGES

CMS Forms List

<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List>

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

Medicare Coverage Database

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

The searchable Medicare Coverage Database (MCD) contains all National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs), local articles, and proposed NCD decisions. Medicare Physician Fee Schedule Federal Regulation Notices

MPFS Federal Regulation Notices

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/MPFS-Federal-Regulation-Notices>

This webpage lists yearly proposed and final regulations for the MPFS.

National Correct Coding Initiatives (NCCI) Edits

<https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index>

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.

Physician Fee Schedule

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index>

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.

Searchable MPFS

<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.

APPENDIX

This information is from the Medicare Claims Processing Manual, IOM Pub. 100-04, [Chapter 23](#) at. 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. This indicator is no longer effective beginning with the 2020 fee schedule as of January 1, 2020.

R = Restricted coverage. Special coverage instructions apply.

T = 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.

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.

9 = Concept does not apply.

Codes with RVUs equal to zero are not included in the payment indicator file. These codes may have multiple procedure indicators not shown.

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 YYYYYY is \$125. The physician reports code YYYYYY-LT with an actual charge of \$100 and YYYYYY-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.

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

(Diagnostic imaging procedures performed by a Registered Radiologist Assistant (RRA) who is certified and registered by The American Registry of Radiologic Technologists (ARRT) or a Radiology Practitioner Assistant (RPA) who is certified by the Certification Board for Radiology Practitioner Assistants (CBRPA), and is authorized to furnish the procedure under state law, may be performed under direct supervision.)

04 = Physician supervision policy does not apply when procedure is furnished by a qualified, independent psychologist or a clinical psychologist. Otherwise 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 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 or
- 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.**[Medicare Learning Network® Content Disclaimer, Product Disclaimer, and Department of Health & Human Services Disclosure](#)**

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