CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 13912	**Date: September 14, 2026**
	Change Request 14560

SUBJECT: Internet-Only Manual (IOM) Update(s) to Publication 100-04, Chapter 23, Section(s) 20.3, 20.4, 20.8 and Addendum - Medicare Physician Fee Schedule Database (MPFSDB) File Record Layout and Field Descriptions

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the IOM to clarify that all Healthcare Common Procedure Coding System (HCPCS) Level II codes remain effective until otherwise announced, and to revise the MPFSDB File Layout to accommodate two different conversion factors as a result of the implementation of the Quality Payment Program (QPP).

EFFECTIVE DATE: November 16, 2026
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: November 16, 2026

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	23/20/20.3/Use and Acceptance of HCPCS Codes and Modifiers.
R	23/20/20.4/Deleted HCPCS Codes/Modifiers.
R	23/20/20.8/Payment, Utilization Review (UR), and Coverage Information on CMS quarterly HCPCS Codes Update File.
R	23/Addendum-MPFSDB File Record Layout and Field Descriptions

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

Pub. 100-04	Transmittal: 13912	Date: September 14, 2026	Change Request: 14560

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II. GENERAL INFORMATION

A. Background: This CR clarifies that HCPCS Level II codes are not designated as "temporary" or "permanent." All HCPCS Level II codes remain effective until CMS announces otherwise.

Effective January 2026, CMS implemented bifurcated MPFS payments under the QPP, requiring revisions to the MPFSDB file layout.

B. Policy: The Health Insurance Portability and Accountability Act (HIPAA) required the Secretary of the Department of Health and Human Services (HHS) to adopt standards for coding systems used in reporting health care transactions. Pursuant to this requirement, regulations were published in the Federal Register on August 17, 2000 (65 FR 50312), to implement standardized coding systems under HIPAA. Under the authority granted by HIPAA, the Secretary of HHS has delegated authority to the American Medical Association (AMA) and CMS to maintain and distribute HCPCS Level I and Level II codes, respectively.

Section 1848(d)(1) of the Act provides for the application of two different MPFS conversion factors depending on whether the services are furnished by an eligible clinician who is a Qualifying Alternative Payment Model (APM) Participant (QP) for the respective year.

III. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
14560.1	The Medicare Contractors shall be aware of the manual updates in Pub 100-04: chapter 23, section(s) 20.3, 20.4, 20.8 and the addendum.	X	X							

IV. PROVIDER EDUCATION

Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.

Impacted Contractors: A/B MAC Part B

V. 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:

Section B: All other recommendations and supporting information: N/A

VI. CONTACTS

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

VII. 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

Medicare Claims Processing Manual

Chapter 23 - Fee Schedule Administration and Coding Requirements

Table of Contents

(Rev. 13912; Issued: 09-14-26)

Transmittals for Chapter 23

20.3 - Use and Acceptance of HCPCS Codes and Modifiers

(Rev. 13912; Issued: 09-14-26; Effective: 11-16-26; Implementation: 11-16-26)

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

An updated list of the HCPCS codes for Durable Medical Equipment Medicare Administrative Contractors (DME MAC) and A/B MAC (B) jurisdictions is updated quarterly to reflect codes that have been added or discontinued (deleted) during each year. A recurring update notification will be published to notify the DME MACs and A/B MACs (B) that the list has been updated and is available on the CMS Web site. *https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system/quarterly-update.*

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

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

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

HCPCS Level II codes assigned by CMS through the HCPCS Level II coding process are subject to the standard code maintenance processes and are active unless otherwise announced.

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

20.4 - Deleted HCPCS Codes/Modifiers

(Rev. 13912; Issued: 09-14-26; Effective: 11-16-26; Implementation: 11-16-26)

Claims for services in a prior year are reported and processed using the HCPCS codes/modifiers in effect during that year. For example, a claim for a service furnished in November 2019 but received by an A/B MAC (A), (B), or (HHH), or DME MAC in 2020, should contain codes/modifiers valid in 2019 and is processed using the prior year's pricing files.

HCPCS codes (Level I CPT-4 and Level II alpha-numeric) are updated on a quarterly basis. Each quarter (January, April, July and October), CMS releases the HCPCS file to A/B MACs (A), (B), (HHH), and DME MACs. The HCPCS file contains the CPT-4 and the alpha-numeric updates. All MACs are notified of the release date via a one-time notification instruction. The file contains new, deleted, and revised HCPCS codes which are effective for the upcoming quarter.

The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets must be date of service compliant.

Providers can purchase the American Medical Association's CPT-4 coding book that is published each October that contains new, revised, and discontinued CPT-4 codes for the upcoming year. In addition, CMS posts on its Web site the alpha-numeric HCPCS file. Providers are encouraged to access CMS web site to see the new, revised, and discontinued alpha-numeric codes. The CMS web site to view the HCPCS update is *https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system/quarterly-update*.

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

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

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

(Rev. 13912; Issued: 09-14-26; Effective: 11-16-26; Implementation: 11-16-26)

The file CMS provides for the quarterly update of HCPCS codes contains fields for payment, UR, and coverage information to assist in developing front-end edit screens. Coverage information is not all inclusive, but should be used mainly as a guide in establishing specific review limits. A/B MACs (B) must establish reasonable developmental guidelines, review screens, and relative value units, as appropriate. A/B MACs (B) must assure that their system processes claims in accordance with CMS policies and procedures, including changes that may occur between HCPCS codes updates.

CMS *may determine* that *national HCPCS* codes/modifiers are needed to implement policy/legislation between HCPCS codes updates. Questions may arise in updating that require A/B MAC (B) staff to refer to a physician's or supplier's pricing history. Therefore, keep an electronic backup of HCPCS codes for the two prior years with linkages to pricing profiles. Perform required computer analysis as necessary.

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

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

Addendum-MPFSDB File Record Layout and Field Descriptions

(Rev. 13912; Issued: 09-14-26; Effective: 11-16-26; Implementation: 11-16-26)

HEADER RECORD

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

DATA RECORD

FIELD # & ITEM	LENGTH & PIC
1 File Year This field displays the effective year of the file.	4 Pic x(4)

2 A/B MAC (B) Number This field represents the 5-digit number assigned to the A/B MAC (B).	5 Pic x(5)
3 Locality This 2-digit code identifies the pricing locality used.	2 Pic x(2)
4 HCPCS Code This field represents the procedure code. Each A/B MAC (B) Current Procedural Terminology (CPT) code (other than codes for	5 Pic x(5)

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

6 Descriptor This field will include a brief description of each procedure code.	50 Pic x(50)
7 Code Status This 1 position field provides the status of each code under the full fee schedule. Each status code is explained in §30.2.2.	1 Pic x(1)
8 Conversion Factor This field displays the multiplier which transforms relative values into payment amounts. The file will contain the conversion factor for the File Year which will reflect all adjustments.	8 Pic 9(4)v9999
9	6 Pic 9(2)v9999

FIELD # & ITEM	**LENGTH & PIC**
Update Factor This update factor has been included in the conversion factor in Field 8.	
10 Work Relative Value Unit This field displays the unit value for the physician work RVU.	9 Pic 9(7)v99
11 Filler	9 Pic 9(7)v99
12 Malpractice Relative Value Unit This field displays the unit value for the malpractice expense RVU.	9 Pic 9(7)v99
13 Work Geographic Practice Cost Indices (GPCIs) This field displays a work geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
14 Practice Expense GPCI This field displays a practice expense geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999

15 Malpractice GPCI This field displays a malpractice expense geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
16 Global Surgery This field provides the postoperative time frames that apply to payment for each surgical procedure or another indicator that describes the applicability of the global concept to the service. 000 = Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; evaluation and management services on the day of the procedure generally not payable. 010 = Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during this 10-day postoperative period generally not payable.	3 Pic x(3)

FIELD # & ITEM	**LENGTH & PIC**
090 = Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule payment amount. MMM = Maternity codes; usual global period does not apply. XXX = Global concept does not apply. YYY = A/B MAC (B) determines whether global concept applies and establishes postoperative period, if appropriate, at time of pricing. ZZZ = Code related to another service and is always included in the global period of the other service. (Note: Physician work is associated with intra-service time and in some instances the post service time.)	

17 Preoperative Percentage (Modifier 56) This field contains the percentage (shown in decimal format) for the preoperative portion of the global package. For example, 10 percent will be shown as 010000. The total of fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
18 Intraoperative Percentage (Modifier 54) This field contains the percentage (shown in decimal format) for the intraoperative portion of the global package including postoperative work in the hospital. For example, 63 percent will be shown as 063000. The total of fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
19 Postoperative Percentage (Modifier 55) This field contains the percentage (shown in decimal format) for the postoperative portion of the global package that is provided in the office after discharge from the hospital. For example, 17 percent will be shown as 017000. The total of fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
20 Professional Component (PC)/Technical Component (TC) Indicator 0 = Physician service codes: This indicator identifies codes that describe physician services. Examples include visits, consultations, and surgical procedures. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. Modifiers 26 & TC cannot be used with these codes. The total Relative Value Units (RVUs) include values for physician work, practice expense and malpractice expense. There are some codes with no work RVUs.	1 Pic x(1)

FIELD # & ITEM	**LENGTH & PIC**

1 = Diagnostic tests or radiology services: This indicator identifies codes that describe diagnostic tests, e.g., pulmonary function tests, or therapeutic radiology procedures, e.g., radiation therapy. These codes generally have both a professional and technical component. Modifiers 26 and TC can be used with these codes. The total RVUs for codes reported with a 26 modifier include values for physician work, practice expense, and malpractice expense. The total RVUs for codes reported with a TC modifier include values for practice expense and malpractice expense only. The total RVUs for codes reported without a modifier equals the sum of RVUs for both the professional and technical component. 2 = Professional component only codes: This indicator identifies stand alone codes that describe the physician work portion of selected diagnostic tests for which there is an associated code that describes the technical component of the diagnostic test only and another associated code that describes the global test. An example of a professional component only code is 93010, Electrocardiogram; interpretation and report. Modifiers 26 and TC cannot be used with these codes. The total RVUs for professional component only codes include values for physician work, practice expense, and malpractice expense. 3 = Technical component only codes: This indicator identifies stand alone codes that describe the technical component (i.e., staff and equipment costs) of selected diagnostic tests for which there is an associated code that describes the professional component of the diagnostic tests only. An example of a technical component code is 93005, Electrocardiogram, tracing only, without interpretation and report. It also identifies codes that are covered only as diagnostic tests and therefore do not have a related professional code. Modifiers 26 and TC cannot be used with these codes. The total RVUs for technical component only codes include values for practice expense and malpractice expense only. 4 = Global test only codes: This indicator identifies stand alone codes for which there are associated codes that describe: a) the professional component of the test only and b) the technical component of the test only. Modifiers 26 and TC cannot be used with these codes. The total RVUs for global procedure only codes 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.	

FIELD # & ITEM	LENGTH & PIC
5 = Incident to codes: This indicator identifies codes that describe services covered incident to a physicians service when they are provided by auxiliary personnel employed by the physician and working under his or her direct supervision. Payment may not be made by A/B MACs (B) for these services when they are provided to hospital inpatients or patients in a hospital outpatient department. Modifiers 26 and TC cannot be used with these codes. 6 = Laboratory physician interpretation codes: This indicator identifies clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made. Actual performance of the tests is paid for under the lab fee schedule. Modifier TC cannot be used with these codes. The total RVUs for laboratory physician interpretation codes include values for physician work, practice expense and malpractice expense. 7 = Private practice therapist's service: Payment may not be made if the service is provided to either a hospital outpatient or a hospital inpatient by a physical therapist, occupational therapist, or speech-language pathologist in private practice. 8 = Physician interpretation codes: This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for hospital inpatient. This applies only to code 85060. No TC billing is recognized because payment for the underlying clinical laboratory test is made to the hospital, generally through the PPS rate. No payment is recognized for code 85060 furnished to hospital outpatients or non-hospital patients. The physician interpretation is paid through the clinical laboratory fee schedule payment for the clinical laboratory test. 9 = Concept of a professional/technical component does not apply.	

21 Multiple Procedure (Modifier 51) Indicator indicates which payment adjustment rule for multiple procedures applies to the service. 0 = No payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure, base payment on the lower of: (a) the actual charge or (b) the fee schedule amount for the procedure. 1 = Standard payment adjustment rules in effect before January 1, 1996, for multiple procedures apply. In the 1996 MPFSDB, this indicator only applies to codes with procedure status of "D." If a procedure is reported on the same day as another procedure with an	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
indicator of 1,2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 25 percent, 25 percent, 25 percent, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage. 2 = Standard payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 50 percent, 50 percent, 50 percent, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage. 3 = Special rules for multiple endoscopic procedures apply if procedure is billed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure). The base procedure for each code with this indicator is identified in field *44*. Apply the multiple endoscopy rules to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). If an endoscopic procedure is reported with only its base procedure, do not pay separately for the base procedure. Payment for the base procedure is included in the payment for the other endoscopy. 4 = Subject to 25% reduction of the TC diagnostic imaging (effective for services January 1, 2006 through June 30, 2010). Subject to 50% reduction of the TC diagnostic imaging (effective for services July 1, 2010 and after). Subject to 25% reduction of the PC of diagnostic imaging (effective for services January 1, 2012 through December 31, 2016). Subject to 5% reduction of the PC of diagnostic imaging (effective for services January 1, 2017 and after). 5 = Subject to 20% reduction of the practice expense component for certain therapy services furnished in office and other non-institutional settings, and 25% reduction of the practice expense component for certain therapy services furnished in institutional settings (effective for services January 1, 2011 and after). Subject to 50% reduction of the practice expense component for certain therapy services furnished in both institutional and non-institutional settings (effective for services April 1, 2013 and after). 6 = Subject to 25% reduction of the TC diagnostic cardiovascular services (effective for services January 1, 2013 and after). 7 = Subject to 20% reduction of the TC diagnostic ophthalmology services (effective for services January 1, 2013 and after).	

FIELD # & ITEM	LENGTH & PIC
9 = Concept does not apply.	
22 Bilateral Surgery Indicator (Modifier 50) This field provides an indicator for services subject to a payment adjustment. 0 = 150 percent payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier -50 or with modifiers RT and LT, base payment for the two sides on the lower of: (a) the total actual charge for both sides or (b) 100 percent of the fee schedule amount for a single code. Example: The fee schedule amount for code XXXXX is $125. The physician reports code XXXXX-LT with an actual charge of $100 and XXXXX-RT with an actual charge of $100. Payment would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The bilateral adjustment is inappropriate for codes in this category because of (a) physiology or anatomy or (b) because the code descriptor specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure. 1 = 150 percent payment adjustment for bilateral procedures applies. If code is billed with the bilateral modifier or is reported twice on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base payment for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides or (b) 150 percent of the fee schedule amount for a single code. If code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any applicable multiple procedure rules. 2 = 150 percent payment adjustment for bilateral procedure does not apply. RVUs are already based on the procedure being performed as a bilateral procedure. If procedure is reported with modifier -50 or is reported twice on the same day by any other means (e.g., with RT and LT modifiers with a 2 in the units field), base payment for both sides on the lower of (a) the total actual charges by the physician for both sides or (b) 100 percent of the fee schedule amount for a single code. Example: The fee schedule amount for code YYYYY is $125. The physician reports code YYYYY-LT with an actual charge of $100 and YYYYY-RT with an actual charge of $100. Payment would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200).	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
The RVUs are based on a bilateral procedure because: (a) the code descriptor specifically states that the procedure is bilateral; (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally; or (c) the procedure is usually performed as a bilateral procedure. 3 = The usual payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier -50 or is reported for both sides on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base payment for each side or organ or site of a paired organ on the lower of: (a) the actual charge for each side or (b) 100% of the fee schedule amount for each side. If procedure is reported as a bilateral procedure and with other procedure codes on the same day, determine the fee schedule amount for a bilateral procedure before applying any applicable multiple procedure rules. Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral procedures. 9 = Concept does not apply.	
23 Assistant at Surgery This field provides an indicator for services where an assistant at surgery is never paid for per IOM. 0 = Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity. 1 = Statutory payment restriction for assistants at surgery applies to this procedure. Assistant at surgery may not be paid. 2 = Payment restriction for assistants at surgery does not apply to this procedure. Assistant at surgery may be paid. 9 = Concept does not apply.	1 Pic (x)1
24 Co-Surgeons (Modifier 62) This field provides an indicator for services for which two surgeons, each in a different specialty, may be paid. 0 = Co-surgeons not permitted for this procedure. 1 = Co-surgeons could be paid; supporting documentation required to establish medical necessity of two surgeons for the procedure. 2 = Co-surgeons permitted; no documentation required if two specialty requirements are met. 9 = Concept does not apply.	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
25 Team Surgeons (Modifier 66) This field provides an indicator for services for which team surgeons may be paid. 0 = Team surgeons not permitted for this procedure. 1 = Team surgeons could be paid; supporting documentation required to establish medical necessity of a team; pay by report. 2 = Team surgeons permitted; pay by report. 9 = Concept does not apply.	1 Pic (x)1
26 Filler	1 Pic (x)1
27 Site of Service Differential For 1999 and beyond, the site of service differential no longer applies. The following definitions will apply for all years after 1998: 0 = Facility pricing does not apply. 1 = Facility pricing applies. 9 = Concept does not apply.	1 Pic (x)1
28 Non-Facility Fee Schedule Amount This field shows the fee schedule amount for the non-facility setting. This amount equals Field *55*. **Note**: Field *51* indicates if an additional adjustment should be applied to this formula. Non-Facility Pricing Amount for the File Year [(Work RVU * Work GPCI) + (Non-Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor	9 Pic 9(7)v99
29 Facility Fee Schedule Amount This field shows the fee schedule amount for the facility setting. This amount equals Field *56*. **Note:** Field *51* indicates if an additional adjustment should be applied to this formula. Facility Pricing Amount for the File Year [(Work RVU * Work GPCI) + (Facility PE RVU * PE GPCI) +	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
(MP RVU * MP GPCI)] * Conversion Factor Place of service codes to be used to identify facilities. 02 – Telehealth-Provided Other than in Patient's Home. 19 – Off Campus-Outpatient Hospital 21 - Inpatient Hospital 22 – On Campus-Outpatient Hospital 23 - Emergency Room - Hospital 24 - Ambulatory Surgical Center – In a Medicare approved ASC, for an approved procedure on the ASC list, Medicare pays the lower facility fee to physicians. Beginning with dates of service January 1, 2008, in a Medicare approved ASC, for procedures NOT on the ASC list of approved procedures, contractors will also pay the lower facility fee to physicians. 26 - Military Treatment Facility 31 - Skilled Nursing Facility 34 - Hospice 41 - Ambulance - Land 42 - Ambulance Air or Water 51 - Inpatient Psychiatric Facility 52 - Psychiatric Facility Partial Hospitalization 53 - Community Mental Health Center 56 - Psychiatric Residential Treatment Facility 61 - Comprehensive Inpatient Rehabilitation Facility	
30 Anti-markup Test Indicator This field providers an indicator for Anti-markup Test HCPCS codes: '1' = Anti-markup Test HCPCS. '9' = Concept does not apply.	1 Pic x
31 Record Effective Date This field identifies the effective date for the MPFSDB record for each HCPCS. The field is in YYYYMMDD format. NOTE: This is not the date the HCPCS code was created. It is the date the code was updated or added to the MPFSDB file for the current file year. This field is set to January 1 for all codes during the annual update process.	8 Pic x(8)

FIELD # & ITEM	LENGTH & PIC
32 Filler	28 Pic x(28)
33 Reduced therapy fee schedule amount	9Pic(7)v99
34 *Pricing Indicator* *This field provides an indicator for codes eligible for differential payment. For 2026 and beyond, the differential payment applies for qualifying providers.* *1 = QPP indicator applies to qualifying providers.* *9 = Concept does not apply.*	1Pic x*(1)*
35 *Filler*	*1Pic x(1)*
36 Imaging Cap Indicator A value of "1" means subject to OPPS payment cap determination. A value of "9" means not subject to OPPS payment cap determination.	1Pic x(1)
37 Non-Facility Imaging Payment Amount	9Pic(7)v99
38 Facility Imaging Payment Amount	9Pic(7)v99

39 Physician Supervision of Diagnostic Procedures This field is for use in post payment review. 01 = Procedure must be performed under the general supervision of a physician. 02 = Procedure must be performed under the direct supervision of a physician. 03 = Procedure must be performed under the personal supervision of a physician. (Diagnostic imaging procedures performed by a Registered Radiologist Assistant (RRA) who is certified and registered by The American Registry of Radiologic Technologists (ARRT) or a Radiology Practitioner Assistant (RPA) who is certified by the Certification Board for Radiology Practitioner Assistants (CBRPA), and is authorized to furnish the procedure under state law, may be performed under direct supervision.) 04 = Physician supervision policy does not apply when procedure is furnished by a qualified, independent psychologist or a clinical psychologist; otherwise must be performed under the general supervision of a physician.	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
05 = Not subject to supervision when furnished personally by a qualified audiologist, physician or non physician practitioner. Direct supervision by a physician is required for those parts of the test that may be furnished by a qualified technician when appropriate to the circumstances of the test. 06 = Procedure must be personally performed by a physician or a physical therapist (PT) who is certified by the American Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiological clinical specialist and is permitted to provide the procedure under State law. Procedure may also be performed by a PT with ABPTS certification without physician supervision. 21 = Procedure may be performed by a technician with certification under general supervision of a physician; otherwise must be performed under direct supervision of a physician. Procedure may also be performed by a PT with ABPTS certification without physician supervision. 22 = May be performed by a technician with on-line real-time contact with physician. 66 = May be personally performed by a physician or by a physical therapist with ABPTS certification and certification in this specific procedure. 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.	
40 Facility Setting Practice Expense Relative Value Units	9 Pic(7)v99
41 Non-Facility Setting Practice Expense Relative Value Units	9 Pic(7)v99
42 Filler	9 Pic(7)v99

FIELD # & ITEM	LENGTH & PIC
43 Filler Reserved for future use.	1 Pic x(1)
44 Endoscopic Base Codes This field identifies an endoscopic base code for each code with a multiple surgery indicator of 3.	5 Pic x(5)
45 1996 Transition/Fee Schedule Amount This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
46 1996 Transition/Fee Schedule This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
47 1996 Transition/Fee Schedule Amount When Site or Service Differential Applies This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
48 Units Payment Rule Indicator Reserved for future use. 9 = Concept does not apply.	1 Pic x(1)
49 Mapping Indicator This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
50 Anti-markup Locality—Informational Use—Locality used for reporting utilization of anti-markup services. NOT FOR A/B MAC (B) USE: These Medicare Advantage encounter pricing localities are for Shared System Maintainer purposes only. The locality values were developed to facilitate centralized processing of encounter data by the Medicare Advantage organizations.	2 Pic x(2)
51	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
Calculation Flag This field is informational only; the SSMs do not need to add this field. The intent is to assist A/B MACs (B) to understand how the fee schedule amount in fields 28 and 29 are calculated. The MMA mandates an additional adjustment to selected HCPCS codes. A value of "1" indicates an additional fee schedule adjustment of 1.32 in 2004 and 1.03 in 2005. A value of "0" indicates no additional adjustment needed. A value of "2" indicates an additional fee schedule adjustment of 1.05 effective 7/1/2008.	
52 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 Mr and MRI (upper extremities and joints) 11 = Family 11 CT and CTA (upper extremities) 88 = Subject to the reduction of the TC diagnostic imaging (effective for services January 1, 2011, and after). Subject to the reduction of the PC diagnostic imaging (effective for services January 1, 2012 and after). 99 = Concept Does Not Apply	2Pic x(2)
53 Performance Payment Indicator (For future use)	1 Pic x (1)
54 National Level Future Expansion	3 Pic x (3)
55 Non-Facility Fee Schedule Amount This field replicates field 28.	9 Pic 9(7)v99
56	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
Facility Fee Schedule Amount This field replicates field 29.	
57 Filler	1 Pic x(1)
58 Future Local Level Expansion** The Updated 1992 Transition Amount was previously stored in this field. A/B MACs (B) can continue to maintain the updated transition amount in this field.	7 Pic x(7)
59 Future Local Level Expansion** The adjusted historical payment basis (AHPB) was previously stored in this field. A/B MACs (B) can continue to maintain the AHPB in this field.	7 Pic x(7)
60 Filler This field was originally established for 15 spaces. Since AHPB data will only use 7 of the 15 spaces, A/B MACs (B) have 8 remaining spaces for their purposes. ** These fields will be appended by each A/B MAC (B) at the local level.	8 Pix x(8)

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