CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1381	**Date: NOVEMBER 23, 2007**
	Change Request 5814

Subject: File Descriptions for Retrieving the 2008 Pricing and HCPCS Data Files through CMS Mainframe Telecommunications System

I. SUMMARY OF CHANGES: This transmittal gives contractors that process institutional claims the new file names and dates for retrieving the 2008 pricing files for various benefits.

New / Revised Material
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

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
N/A	

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: 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:

Recurring Update Notification

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

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 1381	Date: November 23, 2007	Change Request: 5814

SUBJECT: File Descriptions for Retrieving the 2008 Pricing and HCPCS Data Files through CMS' Mainframe Telecommunications System

Effective Date: January 1, 2008

Implementation Date: January 7, 2008

I. GENERAL INFORMATION

A. Background: Attached are the file descriptions and instructions for retrieving the 2008 Pricing and HCPCS Data Files through CMS' Mainframe Telecommunications System (MTS). CMS' Division of Data Systems (DDS) will release the fee schedules files on the dates indicated. You must use these files for pricing HCPCS codes for dates of service beginning January 1, 2008.

B. Policy: This Recurring Update Notification replaces CR 5330, dated October 27, 2006.

Section 5102(b) of the Deficit Reduction Act requires payment for imaging services to be limited to the Medicare OPD fee schedule amount established under the prospective payment system for hospital outpatient department services. To the extent possible, this limit is reflected in the fees contained in these files. However, carrier priced services are not included in these files. For any imaging services that are carrier priced, fiscal intermediaries will need to ensure this limit is implemented when the fee is obtained from the carrier.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5814.1	Medicare contractors shall download the 2008 HCPCS file and its companion print file with the following names from the CMS MTS on October 24, 2007 after 8:00 PM EST: P@HCP.@AAA2360.HCPC2008.CONTR and	X		X							

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	P@HCP.@AAA2360.HCPC2008.PRINT										
5814.2	Medicare contractors shall download the 2008 fee amounts for Part B hospice claims with the following name from the CMS MTS on November 13, 2007 after 8:00 PM EST: MU00.@BF12390.MPFS.CY08.ALL.V1113.RHHI See attachment B for description and file layout.					X					
5814.3	Medicare contractors shall download the 2008 fee amounts for carrier priced and local HCPCS with the following name from the CMS MTS on December 7, 2008 after 8:00 PM EST: MU00.@BF12390.MPFS.CY08.LOC.V1207.FI See attachment B for description and file layout.	X		X							
5814.4	Medicare contractors shall download the 2008 fee amounts for clinical diagnostic laboratory services with the following name from the CMS MTS on November 16, 2007 after 8:00 PM EST: MU00.@BF12394.CLAB.CY08.V1116.FI See attachment C for description and file layout.	X		X							
5814.5	Medicare contractors shall download the 2008 fee amounts for DMEPOS with the following name from the CMS MTS on November 15, 2007 after 8:00 PM EST: MU00.@BF12393.DMEPOS.T080101.V1115.FI See attachment D for description and file layout.	X		X		X					
5814.5.1	MACs and FIs shall retrieve from the following DMEPOS categories as appropriate: OS, P/O and S/D	X		X							
5814.5.2	The RHHIs shall retrieve as appropriate from all DMEPOS categories except T/S.					X					
5814.6	Medicare contractors shall download the 2008 physician fee schedule abstract fee amounts for outpatient rehabilitation and CORF services with the following name from the CMS MTS on November 13, 2007 after 8:00 PM EST:	X		X							

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	MU00.@BF12390.MPFS.CY08.ABSTR.V1113.FI See attachment E for description and file layout.										
5814.7	Medicare contractors shall download the 2008 fee amounts for outpatient rehabilitation, CORF, SNF and CAH services with the following name from the CMS MTS on November 13, 2007 after 8:00 PM EST: MU00.@BF12390.MPFS.CY08.SUPL.V1113.FI See attachment F for description and file layout.	X		X							
5814.8	Medicare contractors shall download the 2008 fee amounts for the new digital mammography technology and regular screening mammography services with the following name from the CMS MTS on November 13, 2007 after 8:00 PM EST: MU00.@BF12390.MPFS.CY08.MAMMO.V1113.FI See attachment G for description and file layout.	X		X							
5814.9	Medicare contractors shall download the 2008 fee amounts for Part B SNF claims with the following name from the CMS MTS on November 13, 2007 after 8:00 PM EST: MU00.@BF12390.MPFS.CY08.SNF.V1113.FI See attachment H for description and file layout.	X		X							
5814.10	Medicare contractors shall download the 2008 Anesthesia conversion factor fee amounts for CAH services from the CMS MTS on November 13, 2007. **NOTE:** The date set name for this file will be provided in email from OIS later.	X		X							
5814.11	Medicare contractors shall download the 2008 ambulance fee amounts by locality for all localities with the following name from the CMS MTS on November 8, 2007 after 8:00 PM EST: MU00.@AAA2390.AMBFS.FINAL.V71 See attachment I for description and file layout.	X		X							
5814.12	Medicare contractors shall use the locality structure in Attachment J to identify the carrier associated with the locality name and number.	X		X							
5814.13	Medicare contractors shall treat pricing data confidential and shall not release data until notification is received from	X		X							

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	CMS (publication of the final rule implementing the fee schedule for physician services for 2008).										
5814.14	Medicare contractors shall price claims with dates of service on and after January 1, 2008, with codes and fee rates furnished in the 2008 files.	X		X		X					
5814.15	For each file referenced above, notification of successful receipt shall be sent via e-mail to price_file_receipt@cms.hhs.gov stating the name of the file received and the entity for which it was received (fiscal intermediary name and number).	X		X		X					
5814.16	Medicare contractors shall compare selected carrier priced imaging service fees to the outpatient PPS amount in their system for the same service and load the lower amount for payment.	X		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None.										

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
5814.1 – 5814.13	See Attachments for file layouts and file descriptions.

B. For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Wil Gehne, (410) 786-6148, wilfried.gehne@cms.hhs.gov

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

A. *For Fiscal Intermediaries and Carriers*:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

B. *For Medicare Administrative Contractors (MAC)*:
The Medicare Administrative Contractor (MAC) is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as changes to the MAC Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified 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.

ATTACHMENT A

INSTRUCTIONS FOR RECEIVING
2008 PART B PRICING FILES
VIA CMS' MAINFRAME TELECOMMUNICATIONS SYSTEM

Listed below are instructions for receiving the 2008 Part B Pricing Files via CMS' mainframe telecommunications system. In order not to incur additional transmission cost, transmission must occur during the evening hours, specifically after 8:00 P.M. Eastern Standard Time (EST).

Listed below are the most common problems encountered when carriers/intermediaries receive data via CMS' mainframe telecommunications system:

o Receipt was performed in interactive mode, rather than batch. If transmission is performed interactively, it is impossible for DHPPD to access the CMS' mainframe telecommunications system log to verify transmission success/failure.

o Omission or change of NEWNAME parameter. Omission of this parameter makes it extremely difficult and cumbersome for DHPPD to access CMTS log to verify transmission success/failure. See the following NEWNAME parameters:

-- ***DMEPOS*** for services priced under the durable medical equipment, prosthetics, orthotic and supply fee schedule

-- ***CLAB*** for services priced under the clinical diagnostic laboratory fee schedule

-- **MPFS** for the radiology and other diagnostic services priced under the physician fee Schedule

-- ***HCPCS*** for procedure coding information required for claims processing

o Omission or change of STARTT parameter. This parameter establishes the starting time for the batch job. As stated earlier, transmission must occur during the evening hours. Setting the STARTT to 20:00:00 hours assures that transmission will not commence prior to 8:00 PM EST.

The following is the JCL required for setting up a CMTS transmission of the 2008 Part B Pricing Files file from the HCFA Data Center.

****

```
//UID#DMEP JOB (ACCTNG),'NAME',MSGCLASS=A,CLASS=C,
//       MSGLEVEL=(1,1)
//DMBATCH EXEC PGM=DMBATCH,REGION=512K,PARM=(YYSLYNN)
//DMPUBLIB  DD DSN= NDM.PROCESS.LIBRARY,DISP=SHR
//DMMSGFIL  DD DSN= NDM.MESSAGE.LIBRARY,DISP=SHR
//DMNETMAP  DD DSN= NDM.NETWORK.MAP,DISP=SHR
//DMPRINT   DD SYSOUT=*
//NDMCMDS   DD SYSOUT=*
//SYSUDUMP  DD SYSOUT=*
//SYSPRINT  DD SYSOUT=*
//SYSIN     DD *
  SIGNON USERID=(NDM USERID)  -
                 NODE= NDM NODE ID  -
              NETMAP= NDM NETWORK MAP
   SUBMIT DSN= PROCESS LIBRARY MEMBER  -
           STARTT=(,20:00:00) -
       NEWNAME=DMEPOS or CLAB or MPFS or HCPCS
  SIGNOFF
/*
//
**********
```

Prior to submitting this job, supply the following parameters particular to your job site:

UID#	= Your system User-ID
ACCTNG	= Accounting Information, if applicable
NAME	= Programmer's Name
NDM.PROCESS.LIBRARY	= NDM Process Library for your system
NDM.MESSAGE.LIBRARY	= NDM Message Library for your system
NDM.NETWORK.MAP	= NDM Network Map File for your system
NDM USERID	= NDM Userid for your system
NDM NODE	= NDM Node ID for your system
PROCESS LIBRARY MEMBER	= Member where the code for the NDM COPY (see next page) is stored

The following code should be placed in your process library. This code will be executed from within CMTS to perform the copying of the 2008 Part B pricing data from a file at the CMS Data Center to a file at your processing site.

****

```
DMEPOS PROCESS  PNODE= NDM NODE  -
                SNODE=NDM.CMS  -
                SNODEID=(TWXX, PASSWD)  -
                PACCT= 'ACCTNG'  -
                 &DSN= DATASET NAME
STEP01  COPY  -
       FROM  -
         (DSN=CMS FILE
          DISP=SHR  -
          SNODE)  -
       TO  -
         (DSN=&DSN  -
          DISP=(,CATLG,DELETE)  -
          UNIT= UNIT ID     -
          PNODE)
```

****

Supply the following parameters particular to your job site:

NDM NODE	= NDM Node ID for your system
TWXX	= NDM User ID for CMS' system
PASSWD	= Password to access NDM at CMS
ACCTNG	= Accounting Information (if required)
DATASET NAME	= File to receive HCFA data transmission
CMS FILE	= ***APPROPRIATE DATA SET NAME***
UNIT ID	= Unit Identifier for your system

The submission of this JCL will enter this job in the MTS queue. In order not to incur additional transmission line costs, the job must not run before 8:00 P.M. (EST) of the day it is submitted.

ATTACHMENT B

MEDICARE PHYSICIAN FEE SCHEDULE FILE CHARACTERISTICS

DATA SET NAMES: **MU00.@BF12390.MPFS.CY08.ALL.V1113.RHHI**

This file is to be used only by regional home health intermediaries (RHHIs) to process hospice claims for Part B services and it will be labeled HPH. Included are fees for all radiology and other diagnostic services, even those that are not subject to payment limitations. All available fees (global, professional, and technical) are transmitted. Codes subject to the grossing up formula are not grossed-up on the HPH file.

Date Available: November 13, 2007

Or

MU00.@BF12390.MPFS.CY08.LOC.V1207.FI

This file contains pricing data for carrier-priced and local HCPCS codes for radiology, other diagnostic, and hospice services paid under the physician fee schedule, including some high volume services such as portable X-rays.

Date Available: December 7, 2007

RECORD LENGTH: 60
RECORD FORMAT: FB
BLOCK SIZE: 6000
CHARACTER CODE: EBCDIC
SORT SEQUENCE: CARRIER, LOCALITY, HCPCS CODE, MODIFIER

Data Element Name	Location	Picture	
1--HCPCS	1-5	X(05)	
2--Modifier	6-7	X(02)	
3--Filler	8-9	X(02)	
4--Non-Facility Fee	10-16	9(05)V99	
5--Filler	17-17	X(01)	
6--PCTC Indicator	18-18	X(01)	This field is only applicable when pricing Critical Access Hospitals (CAHs) that have elected the optional method (Method 2) of payment. See Attachment L for a description of values.
7--Filler	19-30	X(12)	
8--Carrier Number	31-35	X(05)	
9-- Locality	36-37	X(02)	See Attachment J
10**--Label**	38-40	X(03)	
11-- Filler	41-42	X(2)	
12--Status Code	43-43	X(1)	Separate instructions will be used for the use of this field at a later date. This field indicates whether the code is in the physician fee schedule and whether it is separately payable if the service is covered. See Attachment K for a description of values.
13—Filler	44-60	X(17)	

**Label:
HPH -- Hospice Physician Services
ODX -- Other Diagnostic Services
PRF -- Portable Radiology
RAD -- Radiology

ATTACHMENT C

CLINICAL DIAGNOSTIC LABORATORY FEE SCHEDULE FILE CHARACTERISTICS

This file contains pricing data priced under the clinical diagnostic lab fee schedule. The file will also include HCPCS codes for clinical lab services that must be gap-filled. The fee field transmitted for these codes will contain a zero.

DATA SET NAME: **MU00.@BF12394.CLAB.CY08.V1116.FI**

Date Available: November 16, 2007

RECORD LENGTH: 60
RECORD FORMAT: FB
BLOCK SIZE: 6000
CHARACTER CODE: EBCDIC
SORT SEQUENCE: CARRIER, LOCALITY, HCPCS CODE

Data Element Name	Cobol Location	Picture	
HEADER RECORD:			
1--Label	1-3	X(03)	Value = LAB
2--Filler	4-10	X(07)	
3--Filler	11-15	X(08)	
4--Filler	16-22	X(04)	
5--Date Fee Update	23-30	X(08)	YYYYMMDD
6--Filler	31-52	X(22)	
7--Date File Created	53-60	X(08)	YYYYMMDD
DATA RECORD:			
1--HCPCS	1-5	X(05)	
2--Filler	6-9	X(04)	
3--60% Fee	10-16	9(05)V99	
4--62% Fee	17-23	9(05)V99	
5--Filler	24-30	X(07)	
6--Carrier Number	31-35	X(05)	
7--Carrier Locality	36-37	X(02)	00--Single State Carrier 01--North Dakota 02--South Dakota 20--Puerto Rico
8--State Locality	38-39	X(02)	Separate instructions will be used for the use of this field at a later date. See Attachment C2 for a description of values.
9--Filler	4+0-60	X(21)	

ATTACHMENT C2

CarrierLocality/StateLocality Map

Carrier/Loc 0051000=StateLoc 01 (ALABAMA)
Carrier/Loc 0051100=StateLoc 02 (GEORGIA)
Carrier/Loc 0051200=StateLoc 03 (MISSISSIPPI)
Carrier/Loc 0052000=StateLoc 04 (ARKANSAS)
Carrier/Loc 0052100=StateLoc 05 (NEW MEXICO)
Carrier/Loc 0052200=StateLoc 06 (OKLAHOMA)
Carrier/Loc 0052300=StateLoc 07 (MISSOURI GENERAL AMERICAN)
Carrier/Loc 0052800=StateLoc 08 (LOUISIANA)
Carrier/Loc 0059000=StateLoc 09 (FLORIDA)
Carrier/Loc 0059100=StateLoc 10 (CONNECTICUT)
Carrier/Loc 0063000=StateLoc 11 (INDIANA)
Carrier/Loc 0065000=StateLoc 12 (KANSAS)
Carrier/Loc 0065500=StateLoc 13 (NEBRASKA)
Carrier/Loc 0066000=StateLoc 14 (KENTUCKY)
Carrier/Loc 0074000=StateLoc 15 (MISSOURI)
Carrier/Loc 0003202=StateLoc 16 (MONTANA)
Carrier/Loc 0080100=StateLoc 17(WESTERN NEW YORK)
Carrier/Loc 0080300=StateLoc 18 (EMPIRE NEW YORK)
Carrier/Loc 0080500=StateLoc 19 (NEW JERSEY)
Carrier/Loc 0003202=StateLoc 20 (NORTH DAKOTA)
Carrier/Loc 0003402=StateLoc 21(SOUTH DAKOTA)
Carrier/Loc 0082400=StateLoc 22 (COLORADO)
Carrier/Loc 0003602=StateLoc 23 (WYOMING)
Carrier/Loc 0082600=StateLoc 24 (IOWA)
Carrier/Loc 0083100=StateLoc 25 (ALASKA)
Carrier/Loc 0003102=StateLoc 26 (ARIZONA)
Carrier/Loc 0083300=StateLoc 27 (HAWAII)
Carrier/Loc 0083400=StateLoc 28 (NEVADA)
Carrier/Loc 0083500=StateLoc 29 (OREGON)
Carrier/Loc 0083600=StateLoc 30 (WASHINGTON STATE)
Carrier/Loc 0086500=StateLoc 31 (PENNSYLVANIA)
Carrier/Loc 0052400=StateLoc 32 (RHODE ISLAND)
Carrier/Loc 0088000=StateLoc 33 (SOUTH CAROLINA)
Carrier/Loc 0088300=StateLoc 34 (OHIO)
Carrier/Loc 0088400=StateLoc 35 (WEST VIRGINIA)
Carrier/Loc 0090000=StateLoc 36 (TEXAS)
Carrier/Loc 0090100=StateLoc 37 (MARYLAND)
Carrier/Loc 0090200=StateLoc 38 (DELAWARE)
Carrier/Loc 0090300=StateLoc 39 (DISTRICT OF COLUMBIA)
Carrier/Loc 0090400=StateLoc 40 (VIRGINIA)
Carrier/Loc 0003502=StateLoc 41 (UTAH)
Carrier/Loc 0095100=StateLoc 42 (WISCONSIN)
Carrier/Loc 0095200=StateLoc 43 (ILLINOIS)
Carrier/Loc 0095300=StateLoc 44 (MICHIGAN)
Carrier/Loc 0095400=StateLoc 45 (MINNESOTA)
Carrier/Loc 0097320=StateLoc 46 (PUERTO RICO)
Carrier/Loc 0513000=StateLoc 47 (IDAHO)
Carrier/Loc 0544000=StateLoc 48 (TENNESSEE)

Carrier/Loc 0553500=StateLoc 49 (NORTH CAROLINA)
Carrier/Loc 1433000=StateLoc 50 (NEW YORK GHI)
Carrier/Loc 3114000=StateLoc 51 (NORTHERN CALIFORNIA)
Carrier/Loc 3114200=StateLoc 52 (MAINE)
Carrier/Loc 3114300=StateLoc 53 (MASSACHUSETTS)
Carrier/Loc 3114400=StateLoc 54 (NEW HAMPSHIRE)
Carrier/Loc 3114500=StateLoc 55 (VERMONT)
Carrier/Loc 3114600=StateLoc 56 (SOUTHERN CALIFORNIA OCCIDENTAL)

ATTACHMENT D

DURABLE MEDICAL EQUIPMENT, PROSTHETIC, ORTHOTIC AND SUPPLY FEE SCHEDULE FILE CHARACTERISTICS

DATA SET NAME: MU00.@BF12393.DMEPOS.T080101.V1115.FI

Date Available: November 15, 2007

This file contains HCPCS codes and related prices subject to the DMEPOS fee schedule. This file will include only those services, which are subject to the DMEPOS national floors and ceilings. It will NOT include services which are priced by carriers (e.g., customized services) or services priced under reasonable charges. These pricing amounts will continue to be provided by the Part B carriers.

The nine DMEPOS categories have been mapped to extraction labels as follows:

- IN = Inexpensive/routinely purchased...DME;
- FS = Frequency Service...DME;
- CR = Capped Rental... DME;
- OX = Oxygen and Oxygen Equipment... OXY;
- OS = Ostomy, Tracheostomy and Urologicals...O/S;
- S/D = Surgical Dressings...S/D;
- P/O = Prosthetics and Orthotics...P/O;
- SU = Supplies...DME; and
- TE = TENS...DME,
- T/S = Therapeutic Shoes…T/S

The new T/S category **does not** have to be retrieved by the FIs or RHHIs. RHHIs will need to retrieve data from all of the above categories, except T/S. Regular intermediaries only need to retrieve data from categories OS, P/O, S/D.

RECORD LENGTH: 60
RECORD FORMAT: FB
BLOCK SIZE: 6000
CHARACTER CODE: EBCDIC
SORT SEQUENCE: LABEL, HCPCS, MOD, STATE

Data Element Name	Location	Cobol Picture
DATA RECORD		
1--HCPCS	1-5	X(05)
2--MOD	6-7	X(02)
3--MOD 2	8-9	X(02)
4--Fee Schedule Amt	10-16	9(05)V99
5--Filler	17-30	X(14)
6--State	31-32	X(02)
7--Filler	33-37	X(05)
8*--Label*	38-40	X(3)
9--Filler	41-44	X(4)
10*--Pricing change indicator	45-45	X(1)
11—Filler	46-60	X(15)

**Label: DME--Durable Medical Equipment (other than oxygen)
OXY--Oxygen
P/O--Prosthetic/Orthotic
S/D--Surgical Dressings

*Pricing change indicator: 0—No change to Update Fee Schedule Amount since previous release
1—A change has occurred to the Update Fee Schedule Amount since the previous release.
NOTE: In the initial release of the annual update, this field is initialized to >0’

ATTACHMENT E

OUTPATIENT REHABILITATION and CORF SERVICES FEE SCHEDULE

This is a final physician fee schedule abstract file for outpatient rehabilitation and CORF services payment.

DATA SET NAMES: **MU00.@BF12390.MPFS.CY08.ABSTR.V1113.FI**

Date Available: November 13, 2007

RECORD LENGTH: 60
RECORD FORMAT: FB
BLOCK SIZE: 6000
CHARACTER CODE: EBCDIC
SORT SEQUENCE: Carrier, Locality HCPCS Code, Modifier

Data Element Name	Location	Picture	Value
1--HCPCS	1-5	X(05)	
2--Modifier	6-7	X(02)	
3--Filler	8-9	X(02)	
4--Non-Facility Fee	10-16	9(05)V99	
5--Filler	17-17	X(01)	
6—PCTC Indicator	18-18	X(01)	This field is only applicable when pricing Critical Access Hospitals (CAHs) that have elected the optional method (Method 2) of payment. See Attachment L for a description of values.
7--Filler	19-30	X(12)	
8--Carrier Number	31-35	X(05)	
9--Locality	36-37	X(02)	See Attachment J
10--Filler	38-40	X(03)	
11--Fee Indicator	41-41	X(1)	R-- Rehab/Audiology function test/CORF services
12--Outpatient Hospital	42-42	X(1)	0 -- Fee applicable in hospital outpatient setting 1 -- Fee not applicable in hospital outpatient setting
13--Status Code	43-43	X(1)	Separate instructions will be used for the use of this field at a later date. This field indicates whether the code is in the physician fee schedule and whether it is separately payable if the service is covered. See Attachment K for a description of values.
14—Filler	44-60	X(17)	

ATTACHMENT F

CORF SERVICES SUPPLEMENTAL and CRITICAL ACCESS HOSPITAL FEE SCHEDULE

This is the final physician fee schedule supplemental file.

DATA SET NAMES: **MU00.@BF12390.MPFS.CY08.SUPL.V1113.FI**

Date Available: November 13, 2007

RECORD LENGTH: 60
RECORD FORMAT: FB
BLOCK SIZE: 6000
CHARACTER CODE: EBCDIC
SORT SEQUENCE: Carrier, Locality HCPCS Code, Modifier

Data Element Name	Location	Picture Value	
1--HCPCS	1-5	X(05)	
2--Modifier	6-7	X(02)	
3--Filler	8-9	X(02)	
4--Non-Facility Fee	10-16	9(05)V99	
5--Filler	17-17	X(01)	
6—PCTC Indicator	18-18	X(01)	This field is only applicable when pricing Critical Access Hospitals (CAHs) that have elected the optional method (Method 2) of payment. See Attachment L for a description of values.
7--Filler	19	X(1)	
8—Facility Fee	20-26	9(05)V99	
9--Filler	27-30	X(4)	
10—Carrier Number	31-35	X(05)	See attachment J
11—Locality	36-37	X(02)	
12—Filler	38-40	X(03)	
13—Fee Indicator	41-41	X(1)	
14—Outpatient Hosptial	42-420	X(1)	
15 – Status Code	43-43	X(1)	Separate instructions will be used for the use of this field at a later date. This field indicates whether the code is in the physician fee schedule and whether it is separately payable if the service is covered. See Attachment K for a description of values.
16 – Filler	44-60	X(1)	

ATTACHMENT G

MAMMOGRAPHY FEE SCHEDULE

DATA SET NAMES: MU00.@BF12390.MPFS.CY08.MAMMO.V1113.FI

Date Available: November 13, 2007

RECORD LENGTH: 60
RECORD FORMAT: FB
BLOCK SIZE: 6000
CHARACTER CODE: EBCDIC
SORT SEQUENCE: Carrier, Locality HCPCS Code, Modifier

Data Element Name	Location	Picture Value	
1--HCPCS	1-5	X(05)	
2--Modifier	6-7	X(02)	
3--Filler	8-9	X(02)	
4--Non-Facility Fee	10-16	9(05)V99	
5--Filler	17-17	X(01)	
6—PCTC Indicator	18-18	X(01)	This field is only applicable when pricing Critical Access Hospitals (CAHs) that have elected the optional method (Method 2) of payment. See Attachment L for a description of values.
7--Filler	19-30	X(12)	
8--Carrier Number	31-35	X(05)	
9--Locality	36-37	X(02)	See Attachment J
10--Filler	38-42	X(05)	
13--Status Code	43-43	X(1)	Separate instructions will be used for the use of this field at a later date. This field indicates whether the code is in the physician fee schedule and whether it is separately payable if the service is covered. See Attachment K for a description of values.
14—Filler	44-60	X(17)	

ATTACHMENT H

Record Layout for the SNF Extract from the MPFSDB Fee Schedule for Radiology Services, Other Diagnostic Services, and Other Services Priced on the MPFS Data Set Name:

Data Set Name: MU00.@BF12390.MPFS.CY08.SNF.V1113.FI

Date Available: November 13, 2007

RECORD LENGTH: 60
RECORD FORMAT: FB
BLOCK SIZE: 6000
CHARACTER CODE: EBCDIC

Data Element Name	Location	Picture	Value
1--HCPCS	1-5	X(05)	
2--Modifier	6-7	X(02)	
3--Filler	8-9	X(02)	
4--Non-Facility Fee	10-16	9(05)V99	The SNF fee schedule amount is based on the "nonfacility rate" which is the fee that physicians may receive if performing the service in the physician's office.
5--Filler	17-17	X(01)	
6--PCTC Indicator	18-18	X(01)	See Attachment L
7--Filler	19-30	X(12)	
8--Carrier Number	31-35	X(05)	
9--Locality	36-37	X(02)	See Attachment J
10--Filler	38-42	X(05)	
11--Status Code	43-43	X(1)	Separate instructions will be used for the use of this field at a later date. This field indicates whether the code is in the physician fee schedule and whether it is separately payable if the service is covered. See Attachment K for a description of values.
12—Filler	44-60	X(17)	

ATTACHMENT I

Record Layout for the Ambulance Fee Schedule

Data Set Name: **MU00.@AAA2390.AMBFS.FINAL.V71**

Date Available: November 18, 2007

RECORD LENGTH: 80
RECORD FORMAT: FB
BLOCK SIZE: 27920
CHARACTER CODE: EBCDIC
SORT SEQUENCE: HCPCS, Carrier, Locality

Field Name	Position	Format	Description
1. HCPCS	1-5	X(05)	HCFA Common Procedure Coding System
2. Carrier Number	6-10	X(05)	
3. Locality Code	11-12	X(02)	
4. Base RVU	13-18	s9(4)v99	Relative Value Unit
5. Non-Facility PE GPCI	19-22	s9v9(3)	Geographic Adjustment Factor
6. Conversion Factor	23-27	s9(3)v99	Conversion Factor
7. Urban Mileage/	28-34	s9(5)v99	Urban Payment rate or Base Rate Mileage rate (determined By HCPCS)
8. Rural Mileage/	35-41	s9(5)v99	Rural Payment rate or Base Rate Mileage rate (determined By HCPCS)
9. Current Year	42-45	9(04)	YYYY
10. Current Quarter	46	9(01)	Calendar Quarter – value 1-4
11. Filler	47-80	X(34)	Future use

2008 PRICING AREA

Carrier Number	Locality Number	Locality Name
00510	00	ALABAMA
00831	01	ALASKA
03102	00	ARIZONA
00520	13	ARKANSAS
31146	26	ANAHEIM/SANTA ANA, CA
31146	18	LOS ANGELES, CA
31140	03	MARIN/NAPA/SOLANO, CA
31140	07	OAKLAND/BERKELEY, CA
31140	05	SAN FRANCISCO, CA
31140	06	SAN MATEO, CA
31140	09	SANTA CLARA, CA
31146	17	VENTURA, CA
31146	99	REST OF CALIFORNIA*
31140	99	REST OF CALIFORNIA*
00824	01	COLORADO
00591	00	CONNECTICUT
00902	01	DELAWARE
00903	01	DC + MD/VA SUBURBS
00590	03	FORT LAUDERDALE, FL
00590	04	MIAMI, FL
00590	99	REST OF FLORIDA
00511	01	ATLANTA, GA
00511	99	REST OF GEORGIA
00833	01	HAWAII/GUAM
05130	00	IDAHO
00952	16	CHICAGO, IL
00952	12	EAST ST. LOUIS, IL
00952	15	SUBURBAN CHICAGO, IL
00952	99	REST OF ILLINOIS
00630	00	INDIANA

00826	00	IOWA
00650	00	KANSAS*
00740	04	KANSAS*-
00660	00	KENTUCKY
00528	01	NEW ORLEANS, LA
00528	99	REST OF LOUISIANA
31142	03	SOUTHERN MAINE
31142	99	REST OF MAINE
00901	01	BALTIMORE/SURR. CNTYS, MD
00901	99	REST OF MARYLAND
31143	01	METROPOLITAN BOSTON
31143	99	REST OF MASSACHUSETTS
00953	01	DETROIT, MI
00953	99	REST OF MICHIGAN
00954	00	MINNESOTA
00512	00	MISSISSIPPI
00740	02	METROPOLITAN KANSAS CITY, MO
00523	01	METROPOLITAN ST. LOUIS, MO
00740	99	REST OF MISSOURI*
00523	99	REST OF MISSOURI*
03202	01	MONTANA
00655	00	NEBRASKA
00834	00	NEVADA
31144	40	NEW HAMPSHIRE
00805	01	NORTHERN NJ
00805	99	REST OF NEW JERSEY
00521	05	NEW MEXICO
00803	01	MANHATTAN, NY
00803	02	NYC SUBURBS/LONG I., NY
00803	03	POUGHKPSIE/N NYC SUBURBS, NY
14330	04	QUEENS, NY
00801	99	REST OF NEW YORK
05535	00	NORTH CAROLINA
03302	01	NORTH DAKOTA
00883	00	OHIO
00522	00	OKLAHOMA
00835	01	PORTLAND, OR

00835	99	REST OF OREGON
00865	01	METROPOLITAN PHILADELPHIA, PA
00865	99	REST OF PENNSYLVANIA
00973	20	PUERTO RICO
00524	01	RHODE ISLAND
00880	01	SOUTH CAROLINA
03402	02	SOUTH DAKOTA
05440	35	TENNESSEE
00900	31	AUSTIN, TX
00900	20	BEAUMONT, TX
00900	09	BRAZORIA, TX
00900	11	DALLAS, TX
00900	28	FORT WORTH, TX
00900	15	GALVESTON, TX
00900	18	HOUSTON, TX
00900	99	REST OF TEXAS
03502	09	UTAH
31145	50	VERMONT
00973	50	VIRGIN ISLANDS
00904	00	VIRGINIA
00836	02	SEATTLE (KING CNTY), WA
00836	99	REST OF WASHINGTON
00884	16	WEST VIRGINIA
00951	00	WISCONSIN
03602	21	WYOMING

*Payment locality is serviced by two carriers.

ATTACHMENT K

STATUS CODE

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

B =Bundled Code. Payment for covered services are always bundled into payment for other services not specified. There will be no payment amount for these codes, and no separate payment is made. When these services are covered, payment for them is subsumed by the payment for the services to which they are incident. (An example is a telephone call from a hospital nurse regarding care of a patient). The beneficiary cannot be billed.

C =Carriers price the code. Carriers will establish payment amounts for these services, generally on an individual case basis following review of documentation such as an operative report.

D =Deleted Codes. These codes are deleted effective with the beginning of the applicable year.

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 payment amounts are shown and no payment may be made under the fee schedule for these codes. Payment for them, when covered, generally continues under reasonable charge procedures.

F =Deleted/Discontinued Codes. (Code not subject to a 90 day grace period).

G =Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. (Code subject to a 90 day grace period.)

H =Deleted Modifier. This code had an associated TC and/or 26 modifier in the previous year. For the current year, the TC or 26 component shown for the code has been deleted, and the deleted component is shown with a status code of "H".

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.)

N =Noncovered Services. These services are not covered by Medicare.

P =Bundled/Excluded Codes. There are no RVUs and no payment amounts for these services. No separate payment should be 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 physician service.)
--If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (i.e., colostomy supplies) and should be paid under the other payment provision of the Act.

R =Restricted Coverage. Special coverage instructions apply. If covered, the service is carrier priced. (NOTE: The majority of codes to which this indicator wil be assigned are the alpha-numeric dental codes, which begin with "D". We are assigning the indicator to a limited number of CPT codes which represent services that are covered only in unusual circumstances.)

T =Injections. There are payment amounts for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider.
If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the physician services for which payment is made. (NOTE: This is a change from the previous definition, which states that injection services are bundled into any other services billed on the same date.)

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 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.)

PC/TC INDICATOR

0 = Physician Service Codes--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 RVUS include values for physician work, practice expense and malpractice expense. There are some codes with no work RVUs.

1 = Diagnostic Tests for Radiology Services--Identifies codes that describe diagnostic tests. Examples are pulmonary function tests or therapeutic radiology procedures, e.g., radiation therapy. These codes 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 include values for physician work, practice expense, and malpractice expense.

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 test only. An example of a technical component only 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 that describe selected diagnostic tests 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 personal supervision. Payment may not be made by carriers for these services when they are provided to hospital inpatients or patients in a hospital outpatient department. Modifiers 26 and TC cannot be used with these codes.

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

7 = Physical therapy service, for which payment may not be made--Payment may not be made if the service is provided to either a patient in a hospital outpatient department or to an inpatient of the hospital by an independently practicing physical or occupational therapist.

8 = Physician interpretation codes: This indicator identifies the processional 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 to codes 88141, 85060 and P3001-26. 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 codes 88141, 85060 or P3001-26 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 = Not Applicable--Concept of a professional/technical component does not apply.