CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1717	**Date: April 24, 2009**
	Change Request 6381

SUBJECT: Speech-Language Pathology Private Practice Payment Policy

I. SUMMARY OF CHANGES: Contractors are advised that enrolled speech-language pathologists may bill for services provided on or after July 1, 2009.

New / Revised Material
Effective Date: July 1, 2009
Implementation Date: July 6, 2009

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

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	5/10/Part B Outpatient Rehabilitation and Comprehensive Outpatient Rehabilitation Facility (CORF) Services - General
R	23/30/Services Paid Under the Medicare Physician's Fee Schedule
R	23/Addendum

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:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1717	Date: April 24, 2009	Change Request: 6381

SUBJECT: Speech-Language Pathology Private Practice Payment Policy

Effective Date: July 1, 2009
Implementation Date: July 6, 2009

I. GENERAL INFORMATION

A. Background: Section 143 of the Medicare Improvements for Patients and Provider's Act of 2008 (MIPPA) authorizes the Centers for Medicare & Medicaid Services (CMS) to enroll speech-language pathologists (SLP) as suppliers of Medicare services and for SLPs to begin billing Medicare for outpatient speech-language pathology services furnished in private practice beginning July 1, 2009. Enrollment will allow SLPs in private practice to bill Medicare and receive direct payment for their services. Previously, the Medicare program could only pay SLP services if an institution, physician or nonphysician practitioner billed them.

B. Policy: SLPs in private practice may begin the Medicare enrollment process on June 2, 2009. Once enrolled, CMS will accept claims for services submitted by SLPs in private practice for services furnished on or after July 1, 2009.

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	
6381.1	Contractors shall process claims submitted on behalf of an enrolled SLP in private practice for services furnished on or after July 1, 2009.	X			X						
6381.2	Contractors shall ensure that they have appropriately applied coverage and payment policies to claims for services rendered by speech language pathologists in private practice. Contractors shall refer to Pub. 100-02, chapter 15, sections 220 and 230; Pub. 100-04 Chapter 5, section 10, and all other relevant manuals and policies regarding therapy services, speech language pathology services, and speech language pathologists in private practice.	X			X						
6381.3	Contractors shall ensure that they appropriately apply therapy caps and exceptions to speech language pathology services rendered by speech language pathologists in private practice.	X			X						
6381.4	Contractors shall observe and appropriately apply the revised description for the PC/TC indicator 7 in the	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	
	Medicare Physician Fee Schedule Database (Pub 100-04, Chapter 23, Addendum) to all edits and processes which use this indicator.										

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	
6381.5	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X			X						

IV. SUPPORTING INFORMATION

Section 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:

Section B: For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): For policy: Dorothy Shannon, 410-786-3396; for professional claims processing: Claudette Sikora 410-786-5618

Post-Implementation Contact(s): Payment Policy: Medicare Contractors

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Intermediaries (RHHIs):*

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.

10 - Part B Outpatient Rehabilitation and Comprehensive Outpatient Rehabilitation Facility (CORF) Services - General

(Rev.1717, Issued: 04-24-09, Effective: 07-01-09, Implementation: 07-06-09)

Language in this section is defined or described in Pub. 100-02, chapter 15, sections 220 and 230.

Section 4541(a)(2) of the Balanced Budget Act (BBA) (P.L. 105-33), which added §1834(k)(5) to the Social Security Act (the Act), required that all claims for outpatient rehabilitation, certain audiology services and comprehensive outpatient rehabilitation facility (CORF) services, be reported using a uniform coding system. The CMS chose HCPCS (Healthcare Common Procedure Coding System) as the coding system to be used for the reporting of these services. This coding requirement is effective for all claims for outpatient rehabilitation services including certain audiology services and CORF services submitted on or after April 1, 1998.

The BBA also required payment under a prospective payment system for outpatient rehabilitation services including audiology and CORF services. Effective for claims with dates of service on or after January 1, 1999, the Medicare Physician Fee Schedule (MPFS) became the method of payment for outpatient therapy services furnished by:

- Comprehensive *o*utpatient *r*ehabilitation *f*acilities (CORFs);
- Outpatient *p*hysical *t*herapy *p*roviders (OPTs);
- Other *r*ehabilitation *f*acilities (ORFs);
- Hospitals (to outpatients and inpatients who are not in a covered Part A stay);
- Skilled *n*ursing *f*acilities (SNFs) (to residents not in a covered Part A stay and to nonresidents who receive outpatient rehabilitation services from the SNF); and
- Home *h*ealth *a*gencies (HHAs) (to individuals who are not homebound or otherwise are not receiving services under a home health plan of care (POC)).

NOTE: *No provider or supplier other than the SNF will be paid for therapy services during the time the beneficiary is in a covered SNF Part A stay. For information regarding SNF consolidated billing see chapter 6, section 10 of this manual.*

Similarly, under the HH prospective payment system, HHAs are responsible to provide, either directly or under arrangements, all outpatient rehabilitation therapy services to beneficiaries receiving services under a home health POC. No other provider or supplier will be paid for these services during the time the beneficiary is in a covered Part A stay. For information regarding HH consolidated billing see chapter10, section 20 of this manual.

Section 143 of the Medicare Improvements for Patients and Provider's Act of 2008 (MIPPA) authorizes the Centers for Medicare & Medicaid Services (CMS) to enroll speech-language pathologists (SLP) as suppliers of Medicare services and for SLPs to begin billing Medicare for outpatient speech-language pathology services furnished in private practice beginning July 1, 2009. Enrollment will allow SLPs in private practice to bill Medicare and receive direct payment for their services. Previously, the Medicare program could only pay SLP services if an institution, physician or nonphysician practitioner billed them.

In Chapter 23, as part of the CY 2009 Medicare Physician Fee Schedule Database, the descriptor for PC/TC indicator "7", as applied to certain HCPCS/CPT codes, is described as specific to the services of privately practicing therapists. 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.

The MPFS is used as a method of payment for outpatient rehabilitation services furnished under arrangement with any of these providers.

In addition, the MPFS is used as the payment system for audiology and CORF services identified by the HCPCS codes in §20. Assignment is mandatory.

The Medicare **allowed charge** for the services is the lower of the actual charge or the MPFS amount. The Medicare payment for the services is 80 percent of the allowed charge after the Part B deductible is met. Coinsurance is made at 20 percent of the lower of the actual charge or the MPFS amount. The general coinsurance rule (20 percent of the actual charges) does not apply when making payment under the MPFS. This is a final payment.

The MPFS does **not** apply to outpatient rehabilitation services furnished by critical access hospitals (CAHs). CAHs are to be paid on a reasonable cost basis.

Contractors process outpatient rehabilitation claims from hospitals, including CAHs, SNFs, *HHAs,* CORFs, outpatient rehabilitation agencies, and outpatient physical therapy providers for which they have received a tie in notice from the RO. *These provider types submit their claims to the contractors using the 837 Institutional electronic claim format or the UB-04 paper form when permissible. Contractors also* process claims from physicians, certain nonphysician practitioners (NPPs), *therapists in private practices (TPPs), (which are limited to* physical and occupational therapists*, and speech-language pathologists* in private practice*s), and* physician-directed clinic*s* that bill for services furnished incident to a physician's service (see *c*hapter 15 in Pub. 100-02, Medicare Benefit Policy Manual for a definition of "incident to"). *These provider types submit their claims to the contractor using the 837 Professional electronic claim format or the CMS-1500 paper form when permissible.*

There are different fee rates for nonfacility and facility services. Chapter 23 describes the differences in these two rates. (See fields 28 and 29 of the record therein described).

Facility rates apply to professional services performed in a facility other than the professional's office. Nonfacility rates apply when the service is performed in the professional's office. The nonfacility rate (that is paid when the provider performs the services in its own facility) accommodates overhead and indirect expenses the provider incurs by operating its own facility. Thus it is somewhat higher than the facility rate.

Contractors pay the nonfacility rate *on institutional claims* for services performed in the provider's facility. *Contractor*s may pay *professional claims using* the facility or nonfacility rate depending upon where the service is performed (place of service on the claim), and the provider specialty.

Contractors pay the codes in §20 under the MPFS *on professional claims* regardless of whether they may be considered rehabilitation services. However, *contractors* must use this list *for institutional claims* to determine whether to pay under outpatient rehabilitation rules or whether payment rules for other types of service may apply, e.g., OPPS for hospitals, reasonable costs for CAHs.

Note that because a service is considered an outpatient rehabilitation service does not automatically imply payment for that service. Additional criteria, including coverage, plan of care and physician certification must also be met. These criteria are described in Pub. 100-02, Medicare Benefit Policy Manual, *c*hapters 1 and 15.

Payment for rehabilitation services provided to Part A inpatients of hospitals or SNFs is included in the respective PPS rate. Also, for SNFs (but not hospitals), if the beneficiary has Part B, but not Part A coverage (e.g., Part A benefits are exhausted), the SNF must bill for any rehabilitation service (*but not* audiologic function services).

*A*udiologists *in private practice using a professional claim* may bill directly for services rendered to Part B Medicare entitled beneficiaries residing in a SNF, but not in a SNF Part A covered stay. Payment is made based on the MPFS, whether *on an institutional* or *professional claim*. For beneficiaries not in a covered Part A SNF stay, who are sometimes referred to as beneficiaries in a Part B SNF stay, audiologic function tests are payable under Part B when billed by the SNF on *an institutional claim* as type of bill 22X, or when billed directly by the provider or supplier of the service *on a professional claim*. For tests that include both a professional component and technical component, the SNF may elect to bill the technical component *on an institutional claim*, but is not required to bill the service. (The professional component of a service is the direct patient care provided by the physician or audiologist, e.g., the interpretation of a test *when the test is valued by the American Medical Association to include interpretation in the professional component*.)

Payment for rehabilitation *therapy* services provided by home health agencies under a home health plan of care is included in the home health PPS rate. HHAs may submit bill type 34X and be paid under the MPFS if there are no home health services billed under a home health plan of care at the same time, and there is a valid rehabilitation POC (e.g., the patient is not homebound).

An institutional employer (other than a SNF) of the *TPPs*, or physician performing outpatient services, (e.g., hospital, CORF, etc.), or a clinic billing on behalf of the physician or therapist may bill the *contractor* on *a professional claim*.

The MPFS is the basis of payment for outpatient rehabilitation services furnished by *TPPs*, physicians, and certain nonphysician practitioners or for diagnostic tests provided incident to the services of such physicians or nonphysician practitioners. (See Pub. 100-02, Medicare Benefit Policy Manual, *c*hapter 15, for a definition of "incident to*, therapist, therapy and related instructions*.") Such services are billed to the *contractor on the professional claim format*. Assignment is mandatory.

The following table identifies the provider *and supplier* types, *and identifies* which *claim format* they may *use to* submit bills *to the contractor*.

"Provider/*Supplier* Service" Type	***Format***	**Bill Type**	**Comment**
Inpatient hospital Part A	*Institutional*	11X	Included in PPS
Inpatient SNF Part A	*Institutional*	21X	Included in PPS
Inpatient hospital Part B	*Institutional*	12X	Hospital may obtain services under arrangements and bill, or rendering provider may bill.
Inpatient SNF Part B except for audiology function tests.	*Institutional*	22X	SNF must provide and bill, or obtain under arrangements and bill.
Inpatient SNF Part B audiology function tests only.	*Institutional*	22X	SNF may *bill the contractor using the institutional claim format or the supplier of services may bill the contractor using the professional claim form*.
Outpatient hospital	*Institutional*	13X	Hospital may provide and bill or obtain under arrangements and bill, or rendering provider may bill.
Outpatient SNF	*Institutional*	23X	SNF must provide and bill or obtain under arrangements and bill.

"Provider/*Supplier* Service" Type	***Format***	**Bill Type**	**Comment**
HHA billing for services rendered under a Part A or Part B home health plan of care.	*Institutional*	32X	Service is included in PPS rate. CMS determines whether payment is from Part A or Part B trust fund.
HHA billing for services not rendered under a Part A or Part B home health plan of care, but rendered under a therapy plan of care.	*Institutional*	34X	Service not under home health plan of care.
Other Rehabilitation Facility (ORF)	*Institutional*	74X	Paid MPFS for outpatient rehabilitation services effective January 1, 1999, and all other services except drugs effective July 1, 2000. Starting April 1, 2002, drugs are paid 95% of the AWP. For claims with dates of service on or after July 1, 2003, drugs and biologicals do not apply in an OPT setting. Therefore, FIs are to advise their OPTs not to bill for them.
Comprehensive Outpatient Rehabilitation Facility (CORF)	*Institutional*	75X	Paid MPFS for outpatient rehabilitation services effective January 1, 1999, and all other services except drugs effective July 1, 2000. Starting April 1, 2002, drugs are paid 95% of the AWP.
Physician, NPPs, *TPPs*, and, for diagnostic tests only, audiologists (service in hospital or SNF)	*Professional*	See Chapter 26 for place of service, and type of service coding.	Payment may not be made for therapy services to Part A inpatients of hospitals or SNFs, or for Part B SNF residents. Otherwise, *suppliers bill to the contractor using the professional claim format.* Note that *services of a* physician/ NPP/*TPP* employee of *a* facility may *be billed by*

"Provider/*Supplier* Service" Type	***Format***	**Bill Type**	**Comment**
			the facility to *a contractor.*
Physician/NPP/*TPPs* office, independent clinic or patient's home	*Professional*	See Chapter 26 for place of service, and type of service coding.	Paid via Physician fee schedule.
Practicing audiologist for services defined as diagnostic tests only	*Professional*	See Chapter 26 for place of service, and type of service coding.	Some audiologists tests provided in hospitals are considered other diagnostic tests and are subject to OPPS instead of MPFS for outpatient therapy fee schedule.
Critical Access Hospital - inpatient Part A	*Institutional*	*11X*	Rehabilitation services are paid cost.
Critical Access Hospital - inpatient Part B	*Institutional*	85X	Rehabilitation services are paid cost.
Critical Access Hospital – outpatient Part B	*Institutional*	85X	Rehabilitation services are paid cost.

Complete Claim form completion requirements are contained in *c*hapters 25 and 26.

For a list of the outpatient rehabilitation HCPCS codes see §20.

If *a contractor* receives *an institutional* claim for one of these HCPCS codes with dates of service on or after July 1, 2003, that does not appear on the supplemental file it currently uses to pay the therapy claims, it contacts its *professional claims area* to obtain the *non-facility* price in order to pay the claim.

NOTE: The list of codes in §20 contains commonly utilized codes for outpatient rehabilitation services. *Contractors* may consider other codes *on institutional claims* for payment under the MPFS as outpatient rehabilitation services to the extent that such codes are determined to be medically reasonable and necessary and could be performed within the scope of practice of the therapist providing the service.

30 - Services Paid Under the Medicare Physician's Fee Schedule

(Rev.1717, Issued: 04-24-09, Effective: 07-01-09, Implementation: 07-06-09)

Following is a general description of services paid under the Medicare Physicians' Fee Schedule (MPFS).

A. Physician's Services

Effective with services furnished on or after January 1, 1992, carriers pay for physicians' services based on the MPFS. The Medicare allowed charge for such physicians' services is the lower of the actual charge or the fee schedule amount. The Medicare payment is 80 percent of the allowed charge after the deductible is met for most services paid based on the fee schedule. Exceptions to the rule, e.g., services for which deductible is not applicable, are specifically identified for the service where the exception applies.

The Physicians Fee Schedule is used when paying for the following physicians' services.

- Professional services (including attending physicians' services furnished in teaching settings) of doctors of medicine and osteopathy (including osteopathic practitioners), doctors of optometry, doctors of podiatry, doctors of dental surgery and dental medicine, and chiropractors;

- Services covered incident to physicians' services other than certain drugs covered as incident to services;

- Physical and occupational therapy*, and speech-language pathology services* furnished by physical therapists, occupational therapists*, and speech-language pathologists in private* practices;

- Diagnostic tests other than clinical laboratory tests. See *c*hapter 16 for payment for clinical diagnostic laboratory tests;

- Radiology services; and

- Monthly capitation payment (MCP) for physicians' services associated with the continuing medical management of end stage renal disease (ESRD) services.

The fee schedule is not used to pay for direct medical and surgical services of teaching physicians in hospitals that have elected cost payment under §1861(b)(7) of the Act.

When processing a claim, carriers continue to determine if a service is reasonable and necessary to treat illness or injury. If a service is not reasonable and necessary to treat illness or injury for any reason (including lack of safety and efficacy because it is an experimental procedure, etc.), carriers consider the service noncovered notwithstanding the presence of a payment amount for the service in the Medicare fee schedule. The presence of a payment amount in the MPFS and the Medicare physician fee schedule

database (MPFSDB) does not imply that CMS has determined that the service may be covered by Medicare. The nature of the status indicator in the database does not control coverage except where the status is N for noncovered.

Carriers pay the above-mentioned physician services according to the physician fee schedule when billed by the following entities:

- A physician or physician group including optometrists, dentists, oral and maxillofacial surgeons, podiatrists, and chiropractors;
- A privately practicing physical therapist, (for outpatient physical therapy services);
- *A privately practicing* speech-language pathologist (for outpatient speech-language services);
- A privately practicing occupational therapist (for outpatient occupational therapy services);
- A nonphysician practitioner including a nurse practitioner, a physician assistant, and a clinical nurse specialist beginning January 1, 1998, with respect to services these practitioners are authorized to furnish under state law: payment is equal to 85 percent of the participating physician fee schedule amount for the same service;
- A nurse midwife: *p*ayment is equal to 65 percent of the participating physician fee schedule amount for the same service;
- A registered dietitian or nutrition professional, for medical nutrition therapy services provided as of January 1, 2002: payment is equal to 85 percent of the participating physician fee schedule amount for the same service;
- An audiologist, for services rendered to beneficiaries not in a *s*killed *n*ursing *f*acility (SNF) Part A covered stay;
- A clinical psychologist who renders services in community mental health centers (CMHCs) on or after July 1, 1988, and in all settings on or after July 1, 1990;
- A clinical social worker: The fee schedule for CSW services is set at 75 percent of the fee schedule for comparable services furnished by clinical psychologists;
- Another entity that furnishes outpatient physical therapy, occupational therapy, and speech- language pathology services. This could be a rehabilitation agency, a public health agency, a clinic, a skilled nursing facility, a home health agency (for beneficiaries who are not eligible for home health benefits because they are not home bound beneficiaries entitled to home health benefits), hospitals (when such

services are provided to an outpatient or to a hospital inpatient who is entitled to benefits under Part A but who has exhausted benefits during a spell of illness, or who is not entitled to Part A benefits) and comprehensive outpatient rehabilitation facilities (CORFs). The fee schedule also applies to outpatient rehabilitation services furnished under an arrangement with any of the enumerated entities that are to be paid on the basis of the physician fee schedule;

- The supplier of the technical component of any radiology or diagnostic service;
- An independent laboratory doing anatomic pathology services; and
- Services billed by entities authorized to bill for physicians, suppliers, etc. under the reassignment rules.

B. Hospice Services

The Physicians Fee Schedule is used when paying for *h*ospice physician's services by the regional home health intermediary (RHHI). Regular *h*ospice services are paid under the hospice rate schedule (see *c*hapter 11.)

C. Outpatient Rehabilitation Services

Effective with services furnished on or after January 1, 1999, intermediaries pay for outpatient rehabilitation services based on the MPFS. Services included are physical therapy, speech-language pathology, occupational therapy, and certain audiology and CORF services.

Effective with services furnished on or after July 1, 2000, intermediaries pay for all CORF services under the MPFS.

Effective with claims with dates of service on or after July 1, 2003, OPTs/Outpatient Rehabilitation Facilities (ORFs), (74X bill type) are required to report all their services utilizing HCPCS. Intermediaries are required to make payment for these services under the MPFS unless the item or service is currently being paid under the orthotic fee schedule or the item is a drug, biological, supply or vaccine.

The MPFS applies when these services are furnished by rehabilitation agencies, (outpatient physical therapy providers and CORFs), hospitals (to outpatients and inpatients who are not in a covered Part A stay), SNFs (to residents not in a covered Part A stay and to nonresidents who receive outpatient rehabilitation services from the SNF), and HHAs (to individuals who are not homebound or otherwise are not receiving services under a home health plan of treatment). The MPFS is used as a method of payment for outpatient rehabilitation services furnished under arrangement with any of these providers. The MPFS allowed charge for these services is the lower of the actual charge or the fee schedule amount. The Medicare payment for the services is 80 percent of the allowed charge after the Part B deductible is met. This is a final payment. The MPFS

does not apply to outpatient rehabilitation services furnished by critical access hospitals (CAHs). CAHs are paid on a reasonable cost basis.

Application of the Outpatient Mental Health Treatment Limitation (Intermediaries)

In accordance with §1833 of the Act, payment is made at 62½ percent of the approved amount for outpatient mental health treatment services. This provision will continue to be implemented in accordance with the Act when these services are furnished to beneficiaries by CORFs. Therefore, make payment at 62½ percent of 80 percent of the approved amount (or in effect 50 percent) for outpatient mental health treatment services.

D. SNF Services

Effective with services furnished on or after April 1, 2001, intermediaries pay for Part B services furnished to SNF Part B inpatients and outpatients (22X and 23X types of bill) under the MPFS and other applicable fee schedules. Thus, where a fee schedule exists for the type of service, the fee amount (or charge if less than the applicable fee amount) is paid. Fee schedules made effective for SNF on this date include: Therapy, Lab, and DMEPOS.

Effective for services furnished by a SNF on and after January 1, 2002, intermediaries pay SNFs for radiology, other diagnostic, and other services under the MPFS. Payment is the lower of billed charges or the fee schedule amount. In either case, any applicable deductible and coinsurance amounts are subtracted from the payment amount prior to payment. Coinsurance is calculated on the Medicare payment amount after the subtraction of any applicable deductible amount.

If there is no fee schedule for the service or item being billed, FIs are to make payment based on cost. Consequently, all services billed under Part B are to be billed using HCPCS codes, whether the beneficiary resides in a certified bed or a noncertified bed.

Addendum - MPFSDB Record Layouts

(Rev.1717, Issued: 04-24-09, Effective: 07-01-09, Implementation: 07-06-09)

The CMS MPFSDBs include the total fee schedule amount, related component parts, and payment policy indicators.

2009 File Layout

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)

FILE LAYOUT

FIELD # & ITEM	LENGTH & PIC
1 File Year This field displays the effective year of the file.	4 Pic x(4)
2 Carrier Number This field represents the 5-digit number assigned to the carrier.	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 Carrier Procedural Terminology (CPT) code and alpha-numeric HCPCS codes other than B, C, E, K and L codes will be included. The standard sort for this field is blanks, alpha, and numeric in ascending order.	5 Pic x(5)
5	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
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 code 45378 and screening colonoscopy codes G0105 and G0121. Any other codes billed with modifier -53 are subject to carrier 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.	
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 **2009** conversion factor which will reflect all adjustments.	8 Pic 9(4)v9999
9 Update Factor This update factor has been included in the conversion factor in Field 8.	6 Pic 9(2)v9999
10 Work Relative Value Unit This field displays the unit value for the physician work RVU.	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
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. 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 = Carrier 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	3 Pic x(3)

FIELD # & ITEM	LENGTH & PIC
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 = 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	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
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. 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 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	

FIELD # & ITEM	LENGTH & PIC
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 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	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
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 31G. 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 and after). 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	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
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). 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	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
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.	
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
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.	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 34.*	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
***Note**: Field 33 D indicates if an additional adjustment should be applied to this formula.* *Non-Facility Pricing Amount for 2009* *[(Work RVU * Work GPCI) +* *(Transitioned Non-Facility PE RVU * PE GPCI) +* *(MP RVU * MP GPCI)] * Conversion Factor* Non-Facility Fee Schedule Amount *for 2007 and 2008* This field shows the fee schedule amount for the non-facility setting. This amount equals Field 34. **Note**: Field 33 D indicates if an additional adjustment should be applied to this formula. Non-Facility Pricing Amount *for 2007 and 2008* [(Work RVU * Budget Neutrality Adjustor) (round product to two decimal places) * Work GPCI) + (Transitioned Non-Facility PE RVU * PE GPC) + (MP RVU * MP GPCI)] * Conversion Factor **Budget Neutrality Adjustor** **2007 = .8994** **2008 = .8806**	
29 Facility Fee Schedule Amount This field shows the fee schedule amount for the facility setting. This amount equals Field 35. **Note:** Field 33D indicates if an additional adjustment should be applied to this formula. *Facility Pricing Amount for 2009* *[(Work RVU * Work GPCI) +* *(Transitioned Facility PE RVU * PE GPCI) +* *(MP RVU * MP GPCI)] * Conversion Factor* Facility Pricing Amount *for 2007 and 2008* [(Work RVU * Budget Neutrality Adjustor) (round product to two decimal places)	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
* Work GPCI) + (Transitioned Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor **Budget Neutrality Adjustor** **2007 = .8994** **2008 = .8806** Place of service codes to be used to identify facilities. 21 - Inpatient Hospital 22 - 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 Number of Related Codes This field defines the number of related procedure codes (see Field 31).	2 Pic 99
31 Related Procedure Codes This field identifies the number of times that a related code occurs.	45 Pic x(5) – Occurs **9** times
31DD Filler	1Pic x(1)
31CC Imaging Cap Indicator	1Pic x(1)

FIELD # & ITEM	LENGTH & PIC
A value of "1" means subject to OPPS payment cap **determination**. A value of "9" means not subject to OPPS payment cap **determination**.	
31BB Non-Facility Imaging Payment Amount	9Pic(7)v99
33AA Facility Imaging Payment Amount	9Pic(7)v99
31A 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. 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. 05 = Physician supervision policy does not apply when procedure is furnished by a qualified audiologist; otherwise must be performed under the **direct** supervision of a physician. 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 electrophysiologic 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	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
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.	
31B This field has been deleted to allow for the expansion of field 31A.	
31C Facility Setting Practice Expense Relative Value Units	9 Pic(7)v99
31D Non-Facility Setting Practice Expense Relative Value Units	9 Pic(7)v99
31E Filler	9 Pic(7)v99
31F Filler Reserved for future use.	1 Pic x(1)
31G Endoscopic Base Codes This field identifies an endoscopic base code for each code with a multiple surgery indicator of 3.	5 Pic x(5)
32A 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
32B 1996 Transition/Fee Schedule This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
32C 1996 Transition/Fee Schedule Amount When Site or Service Differential Applies This field is no longer applicable since transitioning ended in 1996.	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
This field will contain a zero.	
33A Units Payment Rule Indicator Reserved for future use. 9 = Concept does not apply.	1 Pic x(1)
33B Mapping Indicator This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
33C Medicare+Choice Encounter Pricing Locality NOT FOR CARRIER USE: These Medicare+Choice encounter pricing localities are for EDS purposes only. The locality values were developed to facilitate centralized processing of encounter data by the Medicare+Choice organizations (M+COs).	2 Pic x(2)
33D Calculation Flag This field is informational only; the SSMs do not need to add this field**.** The intent is to assist carriers 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.**	1 Pic x(1)
33 E Diagnostic Imaging Family Indicator 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)	2Pic x(2)

FIELD # & ITEM	LENGTH & PIC
99 = Concept Does Not Apply	
33F Performance Payment Indicator (For future use)	1 Pic x (1)
33G National Level Future Expansion	3 Pic x (3)
34 Non-Facility Fee Schedule Amount This field replicates field 28.	9 Pic 9(7)v99
35 Facility Fee Schedule Amount This field replicates field 29.	9 Pic 9(7)v99
36 Filler	1 Pic x(1)
37 Future Local Level Expansion** The Updated 1992 Transition Amount was previously stored in this field. Carriers can continue to maintain the updated transition amount in this field.	7 Pic x(7)
38A Future Local Level Expansion** The adjusted historical payment basis (AHPB) was previously stored in this field. Carriers can continue to maintain the AHPB in this field.	7 Pic x(7)
38 B Filler This field was originally established for 15 spaces. Since AHPB data will only use 7 of the 15 spaces, carriers have 8 remaining spaces for their purposes. ** These fields will be appended by each carrier at the local level.	8 Pix x(8)