ANNUAL PHYSICIAN FEE SCHEDULE PAYMENT AMOUNT FILE
(DOWNLOADABLE VERSION)
CALENDAR YEAR 2016

Contents: This file contains locality-specific physician fee schedule payment amounts for services covered by the Medicare Physician Fee Schedule (MPFS).

File Organization: This file contains one record for each unique combination of carrier, locality, procedure code and modifier and is sorted in the above listed code sequence.

Initial Source: November 2015 Federal Register publications of Final Rule of Medicare Program's Fee Schedule for Physicians' Services for Calendar Year 2016.

Data Set Name: There is one file available: PFREV16D.ZIP contains the July updated pricing data for the entire country.

This is a self-extracting compressed file which when decompressed will contain two files:

(1) PF16PD (in Word (.doc) formats) contains the file's record layout and file documentation; and
(2) PFREV16D.TXT which is an ASCII text file containing the applicable physician fee schedule pricing information.

Update Schedule: The file is available for the forthcoming calendar year upon publication of the final rule in the Federal Register, which is usually in early November. Additionally, this file will be updated on a periodic schedule to incorporate mid-year changes. Updated files will be available on April 1, July 1, and October 1.

These changes will be provided in separate revision files; they are **not** overlay files. The following naming convention will be used to identify the revision files:

PFALL16A.ZIP	First revision release
PFREV16B.ZIP	Second revision release
PFREV16C.ZIP	Third revision release
PFREV16D.ZIP	Fourth revision release

NOTE:

ANNUAL PHYSICIAN FEE SCHEDULE PAYMENT AMOUNT FILE

DATA ELEMENT	LOCATION	COBOL PIC	DESCRIPTION
DATA RECORD			
Filler	1-1	x(1)	Value Quote
Year	2-5	x(4)	Effective Calendar Year for Payment Amounts
Filler	6-8	x(3)	Value Quote, Comma, Quote
Carrier Number	9-13	x(5)	HCFA-Assigned Identification Number
Filler	14-16	x(3)	Value Quote, Comma, Quote
Locality	17-18	x(2)	Identification of Pricing Locality
Filler	19-21	x(3)	Value Quote, Comma, Quote
HCPCS Code	22-26	x(5)	CPT or Level 2 HCPCS code number for the service. NOTE: See copyright statement on cover sheet.
Filler	27-29	x(3)	Value Quote, Comma, Quote
Modifier	30-31	x(2)	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 indicates that separate RVUs and a fee schedule amount have been established for procedures which the physician terminated before completion. In the 2004 MPFSDB, this modifier is used only with colonoscopy code 45378, G0105, and G0121. Any other codes billed with modifier –53 are subject to carrier medical review and priced by individual consideration.
Filler	32-34	x(3)	Value Quote, Comma, Quote

Non Facility Fee Schedule Amount	35-44	9(7).99	Pricing amount for the non-facility setting. If applicable, the payment amount has been capped at the level of the OPPS Payment Amount mandated by Section 5102(b) of the Deficit Reduction Act of 2005 (See column 107-116 for the OPPS Amounts that are to be used to reduce these payment amounts.). For a description of the computation of the full fee schedule amount, refer to the Federal Register Final Rule for the Medicare Physician Fee Schedule. The Medicare limiting charge is set by law at 115 percent of the payment amount for the service furnished by the nonparticipating physician. However, the law sets the payment amount for nonparticipating physicians at 95 percent of the payment amount for participating physicians (i.e. the full fee schedule amount). Calculating 95 percent of 115 percent of an amount is equivalent to multiplying the amount by a factor of 1.0925 (or 109.25 percent). Therefore, to calculate the Medicare limiting charge for a physician service for a locality, multiply the full fee schedule amount by a factor of 1.0925. The result is the Medicare limiting charge for that service for that locality to which the full fee schedule amount applies.
Filler	45-47	x(3)	Value Quote, Comma, Quote
Facility Fee Schedule Amount	48-57	9(7).99	Pricing amount for the facility setting. If applicable, the payment amount has been capped at the level of the OPPS Payment Amount mandated by Section 5102(b) of the Deficit Reduction Act of 2005 (See column 120-129 for the OPPS Amounts that are to be used to reduce these payment amounts.).
Filler	58-60	x(3)	Value Quote, Comma, Quote
Filler	61-61	x(1)	
Filler	62-64	x(3)	Value Quote, Comma, Quote
PCTC Indicator	65-65	x(1)	
Filler	66-68	x(3)	Value Quote, Comma, Quote
Status Code	69-69	x(1)	
Filler	70-72	x(3)	Value Quote, Comma, Quote
Multiple Surgery Indicator	73-73	x(1)	
Filler	74-76	x(3)	Value Quote, Comma, Quote
50% Therapy Reduction Amount	77-86	9(7).99	Pricing amount that reflects 50 percent payment for the PE for services furnished in office and other noninstitutional settings (services paid under section 1848 of the Act).

Filler	87-89	x(3)	Value Quote, Comma, Quote
50% Therapy Reduction Amount	90-99	9(7).99	Pricing amount that reflects 50 percent payment for the PE for services furnished in an institutional setting (services paid under section 1834 of the Act).
Filler	100-102	x(3)	Value Quote, Comma, Quote
OPPS Indicator	103-103	x(1)	
Filler	104-106	x(3)	Value Quote, Comma, Quote
OPPS Non Facility Fee Amount	107-116	9(7).99	Pricing amount for the non-facility setting that has been capped at the level of the OPPS Payment Amount mandated by Section 5102(b) of the Deficit Reduction Act of 2005.
Filler	117-119	x(3)	Value Quote, Comma, Quote
OPPS Facility Fee Amount	120-129	9(7).99	Pricing amount for the facility setting that has been capped at the level of the OPPS Payment Amount mandated by Section 5102(b) of the Deficit Reduction Act of 2005.
Filler	130-130	x(1)	Value Quote
TRAILER RECORD			
Filler	1-1	x(1)	Value Quote
Trailer Indicator	2-4	x(3)	Value TRL.
Copyright Statement	5-98	x(94)	

ATTACHMENT A

CARRIER	STATE ACRONYM	NAME
1010200	AL	ALABAMA
1020201	GA	ATLANTA, GA
1020299	GA	REST OF GEORGIA
0710213	AR	ARKANSAS
0421205	NM	NEW MEXICO
0431200	OK	OKLAHOMA
0530201	MO	METROPOLITAN ST. LOUIS, MO
0720201	LA	NEW ORLEANS, LA
0720299	LA	REST OF LOUISIANA
1210201	DE	DELAWARE
1220201	DC	DC + MD/VA SUBURBS
0910203	FL	FORT LAUDERDALE, FL
0910204	FL	MIAMI, FL
0910299	FL	REST OF FLORIDA
0810200	IN	INDIANA
0510200	IA	IOWA
0520200	KS	KANSAS
0540200	NE	NEBRASKA
1510200	KY	KENTUCKY
0530202	MO	METROPOLITAN KANSAS CITY, MO
0530299	MO	REST OF MISSOURI*
0320201	MT	MONTANA
1328299	NY1	REST OF NEW YORK
1320201	NY2	MANHATTAN, NY
1320202	NY2	NYC SUBURBS/LONG I., NY
1320203	NY2	POUGHKPSIE/N NYC SUBURBS, NY
1240201	NJ	NORTHERN NJ
1240299	NJ	REST OF NEW JERSEY
0330201	ND	NORTH DAKOTA
0340202	SD	SOUTH DAKOTA
0360221	WY	WYOMING
0240202	WA	SEATTLE (KING CNTY), WA
0240299	WA	REST OF WASHINGTON
0210201	AK	ALASKA
0310200	AZ	ARIZONA
0131200	NV	NEVADA
0411201	CO	COLORADO
0121201	HI	HAWAII/GUAM
0230201	OR	PORTLAND, OR
0230299	OR	REST OF OREGON
1250201	PA	METROPOLITAN PHILADELPHIA, PA
1250299	PA	REST OF PENNSYLVANIA
1441201	RI	RHODE ISLAND
1120201	SC	SOUTH CAROLINA
0441209	TX	BRAZORIA, TX

0441211	TX	DALLAS, TX
0441215	TX	GALVESTON, TX
0441218	TX	HOUSTON, TX
0441220	TX	BEAUMONT, TX
0441228	TX	FORT WORTH, TX
0441231	TX	AUSTIN, TX
0441299	TX	REST OF TEXAS
1230201	MD	BALTIMORE/SURR. CNTYS, MD
1230299	MD	REST OF MARYLAND
0350209	UT	UTAH
0630200	WI	WISCONSIN
0610212	IL	EAST ST. LOUIS, IL
0610215	IL	SUBURBAN CHICAGO, IL
0610216	IL	CHICAGO, IL
0610299	IL	REST OF ILLINOIS
0820201	MI	DETROIT, MI
0820299	MI	REST OF MICHIGAN
0920220	PRV	PUERTO RICO
0920250	PRV	VIRGIN ISLANDS
0118217	CA2	VENTURA, CA
0118218	CA2	LOS ANGELES, CA
0118226	CA2	ANAHEIM/SANTA ANA, CA
0118299	CA2	REST OF CALIFORNIA
0220200	ID	IDAHO
1030235	TN	TENNESSEE
1150200	NC	NORTH CAROLINA
1310200	CT	CONNECTICUT
0620200	MN	MINNESOTA
0730200	MS	MISSISSIPPI
1130200	VA	VIRGINIA
1329204	NY3	QUEENS, NY
1520200	OH	OHIO
1140216	WV	WEST VIRGINIA
0111203	CA1	MARIN/NAPA/SOLANO, CA
0111205	CA1	SAN FRANCISCO, CA
0111206	CA1	SAN MATEO, CA
0111207	CA1	OAKLAND/BERKELEY, CA
0111209	CA1	SANTA CLARA, CA
0111299	CA1	REST OF CALIFORNIA*
1411203	ME	SOUTHERN MAINE
1411299	ME	REST OF MAINE
1421201	MA	METROPOLITAN BOSTON
1421299	MA	REST OF MASSACHUSETTS
1431240	NH	NEW HAMPSHIRE
1451250	VT	VERMONT

ATTACHMENT B

STATUS CODE

A = Active Code. These codes are paid separately under the physician fee schedule, if covered. There will be RVUs 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. If RVUs are shown, they are not used for Medicare payment. If 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).

C = Carriers price the code. Carriers will establish RVUs and 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. These codes will not appear on the 2008 file as the grace period for deleted codes is no longer applicable.

E = Excluded from Physician Fee Schedule by regulation. These codes are for items and/or services that CMS chose to exclude from the fee schedule payment by regulation. No RVUs 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). These codes will not appear on the 2008 file as the grace period for deleted codes is no longer applicable.

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.) These codes will not appear on the 2008 file as the grace period for deleted codes is no longer applicable.

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". These codes will not appear on the 2008 file as the grace period for deleted codes is no longer applicable.

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.)

J = Anesthesia Services. There are no RVUs and no payment amounts for these codes. The intent of this value is to facilitate the identification of anesthesia services.

M = Measurement codes. Used for reporting purposes only.

N = Non-covered 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.

Q = Reporting Purposes Only. Used for nonpaying therapy measurement codes.

R = Restricted Coverage. Special coverage instructions apply. If no RVUs are shown, the service is carrier priced. (NOTE: The majority of codes to which this indicator will 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 RVUS and 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 RVUS or payment amounts are shown for these codes, and no payment may be made under the physician fee schedule. (Examples are ambulance services and clinical diagnostic laboratory services.)

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 CPT code **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 CPT code **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 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 to CPT codes 88141, 85060 and HCPCS code 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 CPT codes 88141, 85060 or HCPCS code 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.

Multiple Surgery 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 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 through June 30, 2010). Subject to 50% reduction of the TC diagnostic imaging (effective for services July 1, 2010 and after).

5 = Subject to 50% of the practice expense component for certain therapy services (effective for services April 1, 2013 and after).

6 = Subject to 25% reduction of the second highest and subsequent procedures to the TC of diagnostic cardiovascular services, effective for services January 1, 2013, and thereafter.

7 = Subject to 20% reduction of the second highest and subsequent procedures to the TC of diagnostic ophthalmology services, effective for services January 1, 2013, and thereafter.

9 = Concept does not apply.

OPPS Indicator	A value of “1” means subject to OPPS payment cap determination. A value of “9” means not subject to OPPS payment cap determination.