CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11630	**Date: October 6, 2022**
	Change Request 12871

SUBJECT: Instructions to the Fiscal Intermediary Shared System [FISS] to Add Additional Multiple Procedure Indicators 6 and 7 Into the Physician Fee Schedule Payment Policy Indicator File Record Layout

I. SUMMARY OF CHANGES: In the past, CMS instructed contractors to add to their systems Current Procedural Terminology (CPT) Category III codes with multiple procedure indicators 6 and 7. These codes are payable on professional claims on a fee schedule basis and on institutional claims for Critical Access Hospital (CAH) services on a cost basis. Multiple procedure indicators 6 and 7 apply a reduction to the technical component of these services when paid on a fee schedule basis.

When A/B MACs (A) attempted to load the codes into the Fiscal Intermediary Shared System (FISS), they were unable to do so. Currently, FISS does not recognize the multiple procedure indicators of 6 and 7, which apply to these codes, as a valid value since it is not contained in the CMS payment indicator file.

The purpose of this Change Request (CR) is to instruct the FISS to add additional multiple procedure indicators 6 and 7 into the Physician Fee Schedule Payment Policy Indicator File Record Layout. This will allow codes to be loaded, but will not affect the cost-based payment on CAH claims. In addition, this CR updates Pub 100-04, Medicare Claims Processing Manual, Chapter 23, Section 50.6.

EFFECTIVE DATE: April 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 3, 2023

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	23/50.6 Physician Fee Schedule Payment Policy Indicator File Record Layout

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not

obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 11630	Date: October 6, 2022	Change Request: 12871

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I. GENERAL INFORMATION

A. Background: In the past, CMS instructed contractors to add to their systems Current Procedural Terminology (CPT) Category III codes with multiple procedure indicators 6 and 7. These codes are payable on professional claims on a fee schedule basis and on institutional claims for Critical Access Hospital (CAH) services on a cost basis. Multiple procedure indicators 6 and 7 apply a reduction to the technical component of these services when paid on a fee schedule basis.

When A/B MACs (A) attempted to load the codes into the Fiscal Intermediary Shared System (FISS), they were unable to do so. Currently, FISS does not recognize the multiple procedure indicators of 6 and 7, which apply to these codes, as a valid value since it is not contained in the CMS payment indicator file.

The purpose of this Change Request (CR) is to instruct the FISS to add additional multiple procedure indicators 6 and 7 into the Physician Fee Schedule Payment Policy Indicator File Record Layout. This will allow codes to be loaded, but will not affect the cost-based payment on CAH claims. In addition, this CR updates Pub 100-04, Medicare Claims Processing Manual, Chapter 23, Section 50.6.

B. Policy: This CR does not implement new policy. This is a system enhancement to allow MACs to enforce existing policy.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12871.1	The contractor shall add additional multiple procedure indicators 6 and 7 to the Physician Fee Schedule Payment Policy Indicator File Record Layout as shown Pub 100-04, Medicare Claims Processing Manual, Chapter 23, Section 50.6.					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12871.2	The contractor shall load HCPCS codes with additional multiple procedure indicators 6 or 7 when they are present in the HCPCS file.					X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Will Gehne, wilfried.gehne@cms.hhs.gov , Kajol Balani, Kajol.Balani@cms.hhs.gov

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

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not

obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Claims Processing Manual
Chapter 23 - Fee Schedule Administration and Coding Requirements

Table of Contents
(Rev.11630; Issued: 10-06-2022)

50.6 – Physician Fee Schedule Payment Policy Indicator File Record Layout
(Rev. 11630; Issued: 10-06-2022; Effective: 04-01-2023, Implementation; 04-03-2023)

The information on the Physician Fee Schedule Payment Policy Indicator file record layout is used for processing Method II CAH professional services with revenue codes 96X, 97X or 98X.

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
File Year This field displays the effective year of the file.	4 Pic x(4)	1-4
HCPCS Code This field represents the procedure code. Each Current Procedural Terminology (CPT) code and alpha-numeric HCPCS codes that are currently returned on the MPFS supplemental file will be included when the MPFS Status Indicator is A, C, T, and some with R. The standard sort for this field is blanks, alpha, and numeric in ascending order.	5 Pic x(5)	5-9
Modifier For diagnostic tests, a blank in this field denotes the global service and the following modifiers identify the components: 26 = Professional component; and 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 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	2 Pic x(2)	10-11

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued.		
Code Status This 1 position field provides the status of each code under the full fee schedule. Each status code is explained in Pub. 100-04, Chapter 23, §30.2.2.	1 Pic x(1)	12
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 = A/B MAC (A) determines whether global concept applies and establishes postoperative period, if appropriate, at time of pricing. ZZZ = Code related to another service and is always included in the global period of the other service. (**NOTE**: Physician work is associated with intra-service time and in some instances the post service time.)	3 Pic x(3)	13-15
Preoperative Percentage (Modifier 56)	6 Pic 9v9(5)	16-21

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
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 the preoperative percentage, intraoperative percentage, and the postoperative percentage fields will usually equal one. Any variance is slight and results from rounding.		
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 the preoperative percentage, intraoperative percentage, and the postoperative percentage fields will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)	22-27
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 the preoperative percentage, intraoperative percentage, and the postoperative percentage fields will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)	28-33
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	1 Pic x(1)	34

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

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
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 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: Payment may not be made if the service is provided to either a hospital outpatient or inpatient 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 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		
Multiple Procedure (Modifier 51) Indicator indicates which payment adjustment rule	1 Pic (x)1	35

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
for multiple procedures applies to the service. 0 = No payment adjustment rules for multiple procedures apply. If the procedure is reported on the same day as another procedure, 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 the 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 the endoscopic base code field. 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.		

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
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 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*		

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
through June 30, 2010). Subject to 50% reduction of the TC diagnostic imaging (effective for services July 1, 2010 and after). Subject to 25% reduction of the PC of diagnostic imaging (effective for services January 1, 2012 through December 31, 2016). Subject to 5% reduction of the PC of diagnostic imaging (effective for services January 1, 2017 and after). *5 = Subject to 20% reduction of the practice expense component for certain therapy services furnished in office and other non-institutional settings, and 25% reduction of the practice expense component for certain therapy services furnished in institutional settings (effective for services January 1, 2011 and after). Subject to 50% reduction of the practice expense component for certain therapy services furnished in both institutional and non-institutional settings (effective for services April 1, 2013 and after).* *6 = Subject to 25% reduction of the TC diagnostic cardiovascular services (effective for services January 1, 2013 and after).* *7 = Subject to 20% reduction of the TC diagnostic ophthalmology services (effective for services January 1, 2013 and after).* 9 = Concept does not apply. Codes with RVUs equal to zero are not included in the payment indicator file. These codes may have multiple procedure indicators not shown. See note below this table for instructions on these codes.		
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. 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	1 Pic (x)1	36

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
procedures applies. If code is billed with the bilateral modifier base payment for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides, or (b) 150 percent of the fee schedule amount for a single code. If code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any applicable multiple procedure rules. 2 = 150 percent payment adjustment for bilateral procedure does not apply. RVUs are already based on the procedure being performed as a bilateral procedure. 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. 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. If a procedure is billed with the 50 modifier, base payment on the lesser of the total actual charges for **each** side or 100% of the fee schedule amount for **each** side. 9 = Concept does not apply.		
Assistant at Surgery (Modifiers AS, 80, 81 and 82) This field provides an indicator for services where an assistant at surgery may be paid: 0 = Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity. 1 = Statutory payment restriction for assistants at surgery applies to this procedure. Assistant at surgery may not be paid.	1 Pic (x)1	37

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
2 = Payment restriction for assistants at surgery does not apply to this procedure. Assistant at surgery may be paid. 9 = Concept does not apply.		
Co-Surgeons (Modifier 62) This field provides an indicator for services for which two surgeons, each in a different specialty, may be paid. 0 = Co-surgeons not permitted for this procedure. 1 = Co-surgeons could be paid; supporting documentation 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	38
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	39
Endoscopic Base Codes This field identifies an endoscopic base code for each code with a multiple surgery indicator of 3.	5 Pic (x) 5	40-44
Performance Payment Indicator (For future use)	1 Pic x (1)	45
Diagnostic Imaging Family Indicator 88 = Subject to the reduction for diagnostic imaging (effective for services January 1, 2011, and after). 99 = Concept Does Not Apply	2 Pic x (2)	46-47
Effective Date This field displays the effective date of the file in YYYYMMDD format.	8 Pic x(8)	48 - 55
Filler	30 Pic x(30)	56 -75

Multiple procedure indicator 5 is not included in this file, since the indicator represents the therapy multiple procedure payment reduction which never applies to professional service revenue codes. Multiple procedure indicators 6 and 7 are not included in this file, since in these cases the reduction only applies to technical component services. On CAH claims, technical components are paid on a cost basis and so are not subject to the reductions.

There may be cases when A/B MACs (A) must manually load a HCPCS code that is contractor priced which has a multiple procedure indicator that is not on the payment indicator file. In these cases, the MAC enters a multiple procedure indicator of 0.