ANNUAL PHYSICIAN FEE SCHEDULE PAYMENT AMOUNT FILE
(DOWNLOADABLE VERSION)
CALENDAR YEAR 2008

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 2007 Federal Register publications of Final Rule of Medicare Program's Fee Schedule for Physicians' Services for Calendar Year 2008 and the Medicare, Medicaid, and SCHIP Extension Act of 2007. **Effective for claims with dates of service January 1, 2008, through June 30, 2008, the update to the conversion factor will be 0.5%; and for claims with dates of service July 1, 2008 and after, will revert back to the previous payment methodology (the -10.1% update) that was outlined in the Final Rule, published in the Federal Register on November 27, 2007.)**

Data Set Name: There are two files available: PFALL08&.ZIP contains pricing data for the entire country and PF@@@08.ZIP contains pricing data for a single Medicare Part B carrier (usually corresponds to a state).
NOTE: '@@@' denotes the applicable state. '&' denotes the latest version of the file (see statement on Update Schedule below).

These are self-extracting compressed files which when decompressed will contain two files:

(1) PF08PC (in Word (.doc) formats) contains the file's record layout and file documentation; and
(2) PFALL08&.TXT or PF@@@08&.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:

PFREV08A.ZIP   First revision release
PFREV08B.ZIP   Second revision release
PFREV08C.ZIP   Third revision release
PFREV08D.ZIP   Fourth revision release

NOTE:

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DATA ELEMENT	LOCATION	COBOL PIC	DESCRIPTION
DATA RECORD			
Filler	1-1	x(1)	Value ΑQuote≅
Year	2-5	x(4)	Effective Calendar Year for Payment Amounts
Filler	6-8	x(3)	Value ΑQuote, Comma, Quote≅
Carrier Number	9-13	x(5)	HCFA-Assigned Identification Number
Filler	14-16	x(3)	Value ΑQuote, Comma, Quote≅
Locality	17-18	x(2)	Identification of Pricing Locality
Filler	19-21	x(3)	Value ΑQuote, 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 ΑQuote, 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 ΑQuote, 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. 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 participatin 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.
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	70-70	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)	

CARRIER	STATE ACRONYM	NAME
0051000	AL	ALABAMA
0051101	GA	ATLANTA, GA
0051199	GA	REST OF GEORGIA
0052013	AR	ARKANSAS
0052105	NM	NEW MEXICO
0052200	OK	OKLAHOMA
0052301	MO2	METROPOLITAN ST. LOUIS, MO
0052399	MO2	REST OF MISSOURI
0052801	LA	NEW ORLEANS, LA
0052899	LA	REST OF LOUISIANA
0090201	DE	DELAWARE
0090301	DC	DC + MD/VA SUBURBS
0059003	FL	FORT LAUDERDALE, FL
0059004	FL	MIAMI, FL
0059099	FL	REST OF FLORIDA
0063000	IN	INDIANA
0082600	IA	IOWA
0065000	KS	KANSAS
0065500	NE	NEBRASKA
0066000	KY	KENTUCKY
0074002	MO1	METROPOLITAN KANSAS CITY, MO
0074099	MO1	REST OF MISSOURI*
0320201	MT	MONTANA
0080199	NY1	REST OF NEW YORK
0080301	NY2	MANHATTAN, NY
0080302	NY2	NYC SUBURBS/LONG I., NY
0080303	NY2	POUGHKPSIE/N NYC SUBURBS, NY
0080501	NJ	NORTHERN NJ
0080599	NJ	REST OF NEW JERSEY
0330201	ND	NORTH DAKOTA
0340202	SD	SOUTH DAKOTA
0360221	WY	WYOMING
0083602	WA	SEATTLE (KING CNTY), WA
0083699	WA	REST OF WASHINGTON
0083101	AK	ALASKA
0310200	AZ	ARIZONA
0083400	NV	NEVADA
0082401	CO	COLORADO
0083301	HI	HAWAII/GUAM
0083501	OR	PORTLAND, OR
0083599	OR	REST OF OREGON
0086501	PA	METROPOLITAN PHILADELPHIA, PA
0086599	PA	REST OF PENNSYLVANIA
0052401	RI	RHODE ISLAND
0088001	SC	SOUTH CAROLINA

0090009	TX	BRAZORIA, TX
0090011	TX	DALLAS, TX
0090015	TX	GALVESTON, TX
0090018	TX	HOUSTON, TX
0090020	TX	BEAUMONT, TX
0090028	TX	FORT WORTH, TX
0090031	TX	AUSTIN, TX
0090099	TX	REST OF TEXAS
0090101	MD	BALTIMORE/SURR. CNTYS, MD
0090199	MD	REST OF MARYLAND
0350209	UT	UTAH
0095100	WI	WISCONSIN
0095212	IL	EAST ST. LOUIS, IL
0095215	IL	SUBURBAN CHICAGO, IL
0095216	IL	CHICAGO, IL
0095299	IL	REST OF ILLINOIS
0095301	MI	DETROIT, MI
0095399	MI	REST OF MICHIGAN
0097320	PRV	PUERTO RICO
0097350	PRV	VIRGIN ISLANDS
3114617	CA2	VENTURA, CA
3114618	CA2	LOS ANGELES, CA
3114626	CA2	ANAHEIM/SANTA ANA, CA
3114699	CA2	REST OF CALIFORNIA
0513000	ID	IDAHO
0544035	TN	TENNESSEE
0553500	NC	NORTH CAROLINA
0059100	CT	CONNECTICUT
0095400	MN	MINNESOTA
0051200	MS	MISSISSIPPI
0090400	VA	VIRGINIA
1433004	NY3	QUEENS, NY
0088300	OH	OHIO
0088416	WV	WEST VIRGINIA
3114003	CA1	MARIN/NAPA/SOLANO, CA
3114005	CA1	SAN FRANCISCO, CA
3114006	CA1	SAN MATEO, CA
3114007	CA1	OAKLAND/BERKELEY, CA
3114009	CA1	SANTA CLARA, CA
3114099	CA1	REST OF CALIFORNIA*
3114203	ME	SOUTHERN MAINE
3114299	ME	REST OF MAINE
3114301	MA	METROPOLITAN BOSTON
3114399	MA	REST OF MASSACHUSETTS
3114440	NH	NEW HAMPSHIRE
3114550	VT	VERMONT

ATTACHMENT A

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 <u>NOT</u> 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 = <u>Non-covered Services</u>. These services are not covered by Medicare.

P = <u>Bundled/Excluded Codes</u>. There are no RVUs and no payment amounts for these services. No separate payment should be made for them under the fee schedule.
     --If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident. (An example is an elastic bandage furnished by a physician incident to physician service.)
     --If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (i.e., colostomy supplies) and should be paid under the other payment provision of the Act.

R = <u>Restricted Coverage</u>. 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 = <u>Injections</u>. 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 <u>any</u> 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 =   <u>Physician Service Codes</u>--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 =   <u>Diagnostic Tests for Radiology Services</u>--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 =   <u>Professional Component Only Codes</u>--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 =   <u>Technical Component Only Codes</u>--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 =   <u>Global Test Only Codes</u>--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 =   <u>Incident To Codes</u>--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 =   <u>Laboratory Physician Interpretation Codes</u>--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 =   <u>Physical therapy service, for which payment may not be made</u>-- 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 =   <u>Physician interpretation codes:</u> 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 =   <u>Not Applicable</u>--Concept of a professional/technical component does not apply.