CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1574	**Date: August 12, 2008**
	Change Request 6013

NOTE: Transmittal 1508, dated May 16, 2008 is rescinded and replaced with Transmittal 1574, dated August 12, 2008 because a calculation error was made in the record layout. Attachment I in the Business Requirements and §250.2 in Chapter 4 of Pub.100-04, are updated to correct the length and PIC of the Filler field on the Physician Fee Schedule Payment Policy Indicator File record layout. All other information remains the same.

SUBJECT: Physician Fee Schedule Payment Policy Indicator File Record Layout for Use in Processing Method II Critical Access Hospital (CAH) Claims for Professional Services

I. SUMMARY OF CHANGES: The files used for pricing professional services submitted by a Method II Critical Access Hospital (CAH) do not contain the endoscopic base codes, payment policy indicators, global surgery indicator or the preoperative, intraoperative and postoperative percentages that are needed to determine if payment adjustment rules apply to a specific CPT/HCPCS code and the associated pricing modifier(s). To ensure that the fiscal intermediary standard system (FISS) can identify CPT/HCPCS codes subject to the payment adjustment rules and calculate the correct payment amount, a new record layout has been developed that will enable FISS to identify the CPT/HCPCS codes impacted.

New / Revised Material
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

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

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

R/N/D	Chapter / Section / Subsection / Title
R	4/250/250.2/Optional Method for Outpatient Services: Cost-Based Facility Services Plus 115 Percent Fee Schedule Payment for Professional Services

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: 1574	Date: August 12, 2008	Change Request: 6013

NOTE: Transmittal 1508, dated May 16, 2008 is rescinded and replaced with Transmittal 1574, dated August 12, 2008 because a calculation error was made in the record layout. Attachment I in the Business Requirements and §250.2 in Chapter 4 of Pub.100-04, are updated to correct the length and PIC of the Filler field on the Physician Fee Schedule Payment Policy Indicator File record layout. All other information remains the same.

SUBJECT: Physician Fee Schedule Payment Policy Indicator File Record Layout for Use in Processing Method II Critical Access Hospital (CAH) Claims for Professional Services

Effective Date: October 1, 2008

Implementation Date: October 6, 2008

I. GENERAL INFORMATION

A. Background: Physicians and non-physician practitioners billing on type of bill 85X for professional services rendered in a Method II CAH have the option of reassigning their billing rights to the CAH. When the billing rights are reassigned to the Method II CAH, payment is made to the CAH for professional services (revenue codes 96X, 97X or 98X) based on the Medicare Physician Fee Schedule (MPFS) supplemental file. The file used for Method II CAH claims does not contain the endoscopic base codes, payment policy indicators, global surgery indicator or the preoperative, intraoperative and postoperative percentages that are needed to determine if payment adjustment rules apply to a specific CPT/HCPCS code and the associated pricing modifier(s). To ensure that the fiscal intermediary standard system (FISS) can identify CPT/HCPCS codes subject to the payment adjustment rules and calculate the correct payment amount, a new record layout has been developed that will enable FISS to identify the CPT/HCPCS codes impacted.

This Change Request (CR) addresses the new record layout and the display of the fields on the record layout only. Future CRs will further address the payment adjustment rules.

Information on retrieving the new file will be included on the CR titled, “Descriptions for Retrieving the 2009 Pricing and HCPCS Data Files through CMS Mainframe Telecommunications System” that is released by CMS in mid-November. The Physician Fee Schedule Policy Indicator File will be released on an annual basis and on a quarterly basis if any updates are made during the quarter.

B. Policy: There are no changes to existing policy.

II. BUSINESS REQUIREMENTS TABLE

Use“Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an “X” in each applicable column)						
		A /	D M	F I	C A	R H	Shared-System Maintainers	OTHER

							FISS	MCS	VMS	CWF	
6013.1	Contractors shall implement the Physician Fee Schedule Payment Policy Indicator File record layout in Attachment 1.						X				
6013.2	Contractors shall be aware that more than one payment policy indicator may be associated with a CPT/HCPCS code.						X				
6013.3	Contractors shall code systems to display online 7 years of CPT/HCPCS codes, modifiers and their associated payment policy indicators. Note: The modifiers are: AS – Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist services for assistant at surgery, 50 – Bilateral procedure, 51 – Multiple procedures, 53 – Discontinued procedure, 54 – Surgical care only, 55 – Postoperative management only, 56 – Preoperative management only, 62 – Two surgeons, 66 – Surgical team, 80 – Assistant surgeon, 81 – Minimum Assistant surgeon, and 82 – Assistant surgeon (when qualified resident surgeon not available).						X				
6013.3.1	Contractors shall drop the earliest years after 7 years of updates to the CPT/HCPCS codes, modifiers and their associated payment policy indicators have been made.						X				
6013.4	Contractors shall code systems to display online 7 years of CPT/HCPCS codes and their associated global surgery indicators.						X				
6013.4.1	Contractors shall drop the earliest years after 7 years of updates to the CPT/HCPCS codes and global surgery indicators have been made.						X				
6013.5	Contractors shall code systems to display online 7 years of CPT/HCPCS code and their associated preoperative percentages.						X				
6013.5.1	Contractors shall drop the earliest years after 7 years of updates to the CPT/HCPCS codes and preoperative percentages have been made.						X				
6013.6	Contractors shall code systems to display online 7 years of CPT/HCPCS code and their associated intraoperative percentages.						X				
6013.6.1	Contractors shall drop the earliest years after 7 years of updates to the CPT/HCPCS codes and intraoperative percentages have been made.						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	
6013.7	Contractors shall code systems to display online 7 years of CPT/HCPCS codes and their associated postoperative percentages.						X				
6013.7.1	Contractors shall drop the earliest years after 7 years of updates to the CPT/HCPCS codes and postoperative percentages have been made.						X				
6013.8	Contractors shall code systems to display online 7 years of CPT/HCPCS code and the associated endoscopic base code for all CPT/HCPCS codes with a multiple procedure indicator of '3'. **NOTE**: 3 – Special rules for multiple endoscopic procedures apply if the procedure is billed with another endoscopy in the same family.						X				
6013.8.1	Contractors shall drop the earliest years after 7 years of updates to the CPT/HCPCS codes and the associated endoscopic base code have been made.						X				
6013.9	Contractors shall hold dropped files in history in an accessible manner should it be necessary to process earlier claims.						X				EDC
6013.10	Contractors shall be notified through e-mail in mid-July 2008 of the availability of a test file for the Physician Fee Schedule Policy Indicator File.						X				
6013.11	Contractors shall generate a report for the Physician Fee Schedule Policy Indicator File.						X				

III. PROVIDER EDUCATION TABLE

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

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

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: N/A

V. CONTACTS

Pre-Implementation Contact(s): Susan Guerin at susan.guerin@cms.hhs.gov or 410-786-6138

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs) 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.

ATTACHMENT: Physician Fee Schedule File Payment Policy Indicator File

Attachment I

PHYSICIAN FEE SCHEDULE PAYMENT POLICY INDICATOR FILE

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 A, C, T, and some R codes that are currently returned on the MPFS supplemental file will be included. 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* *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 well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued.*	*2 Pic x(2)*	*10-11*
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*	*3 Pic x(3)*	*13-15*

FIELD NAME & DESCRIPTION	***LENGTH & PIC***	***Position***
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 = Fiscal intermediary (FI) 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.)*		
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 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)*	*16-21*
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,*	*6 Pic 9v9(5)*	*28-33*

FIELD NAME & DESCRIPTION	***LENGTH & PIC***	***Position***
intraoperative percentage, and the postoperative percentage fields will usually equal one. Any variance is slight and results from rounding.		
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 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*	*1 Pic x(1)*	*34*

FIELD NAME & DESCRIPTION	***LENGTH & PIC***	***Position***
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 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.*		

FIELD NAME & DESCRIPTION	*LENGTH & PIC*	*Position*
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 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.* *4 = Subject to 25% reduction of the TC diagnostic imaging (effective for services January 1, 2006 and after). Note: The 4 will be changed to a 9 because the 4 does not apply to Method II CAH claims for professional services processed by the FI.* *9 = Concept does not apply.*	*1 Pic (x)1*	*35*
Bilateral Surgery Indicator (Modifier 50)	*1 Pic (x)1*	*36*

FIELD NAME & DESCRIPTION	***LENGTH & PIC***	***Position***
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 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*		

FIELD NAME & DESCRIPTION	***LENGTH & PIC***	***Position***
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.*		
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.* *2 = Payment restriction for assistants at surgery does not apply to this procedure. Assistant at surgery may be paid.* *9 = Concept does not apply.*	*1 Pic (x)1*	*37*
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.*	*1 Pic (x)1*	*39*

FIELD NAME & DESCRIPTION	***LENGTH & PIC***	***Position***
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.*		
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*
Filler	*30 Pic x(30)*	*46-75*

250.2 - Optional Method for Outpatient Services: Cost-Based Facility Services Plus 115 percent Fee Schedule Payment for Professional Services

(Rev.1574, Issued: 08-12-08, Effective: 10-01-08, Implementation: 10-06-08)

The BIPA legislation on payment for professional services at 115 percent of what would otherwise be paid under the fee schedule is effective for services furnished on or after July 1, 2001. A CAH may elect to be paid for outpatient services in any cost reporting period under this method by filing a written election with the intermediary on an annual basis at least 30 days before start of the Cost Reporting period to which the election applies. An election of this payment method, once made for a cost reporting period, remains in effect for all of that period for the CAH.

However, the Medicare Prescription Drugs, Improvement, and Modernization Act (MMA) of 2003, changes the requirement that each practitioner rendering a service at a CAH that has elected the optional method, reassign their billing rights to that CAH. This provision allows each practitioner to choose whether to reassign billing rights to the CAH or file claims for professional services through their carrier. The reassignment will remain in affect for that entire cost reporting period.

The individual practitioner must certify, using the Form CMS 855R, if he/she wishes to reassign their billing rights. The CAH must then forward a copy of the 855R to the intermediary and the appropriate carrier, must have the practitioner sign an attestation that clearly states that the practitioner will not bill the carrier for any services rendered at the CAH once the reassignment has been given to the CAH. This “attestation” will remain at the CAH.

For CAHs that elected the optional method before November 1, 2003, the provision is effective beginning on or after July 1, 2001. For CAHs electing the optional method on or after November 1, 2003, the provision is effective for cost reporting periods beginning on or after July 1, 2004. Under this election, a CAH will receive payment from their intermediary for professional services furnished in that CAH’s outpatient department. Professional services are those furnished by all licensed professionals who otherwise would be entitled to bill the carrier under Part B.

Payment to the CAH for each outpatient visit (reassigned billing) will be the sum of the following:

- For facility services, not including physician or other practitioner services, payment will be based on 101 percent of the reasonable costs of the services. On the ANSI X12N 837 I, list the facility service(s) rendered to outpatients using the appropriate revenue code. The FI will pay the amount equal to the lesser of 80 percent of 101 percent of the reasonable costs of its outpatient services, or the 101 percent of the outpatient services less applicable Part B deductible and coinsurance amounts, plus:

- On a separate line, list the professional services, along with the appropriate HCPCS code (physician or other practitioner) in one of the following revenue codes - 096X, 097X, or 098X.

    - The FI uses the Medicare Physician Fee Schedule (MPFS) supplementary file, established for use by the CORF, and the CORF Abstract File, to pay for all the physician/professional services rendered in a CAH that elected the all-inclusive method. The data in the supplemental file are in the same format as the abstract file. The FI will pay 115 percent of whatever Medicare would pay of the physician fee schedule. (The fee schedule amount, after applicable deductions, will be multiplied by 1.15 percent.) Payment for non physician practitioners will be 115 percent of 85 percent of the allowable amount under the physician fee schedule; and

      For a non-participating physician service, a CAH must place modifier AK on the claim. The intermediary should pay 95 percent of the payment amount for non-participating physician services. Calculating 95 percent of 115 percent of an amount is equivalent to multiplying the amount by a factor of 1.0925. To calculate the Medicare limiting charge for a physician service for a locality, multiply the fee schedule amount by a factor of 1.0925.

      Payment for non-physician practitioners will be 115 percent of the allowable amount under the physician fee schedule.

      If a non-physician practitioner renders a service, one of the following modifiers must be on the applicable line:

      GF - Services rendered in a CAH by a nurse practitioner (NP), clinical nurse specialist (CNS), certified registered nurse (CRN) or physician assistant (PA). (The "GF" modifier is not to be used for CRNA services. If a claim is received and it has the "GF" modifier for CRNA services, the claim is returned to the provider.)

      SB - Services rendered in a CAH by a nurse midwife.

      AH - Services rendered in a CAH by a clinical psychologist.

      AE - Services rendered in a CAH by a nutrition professional/registered dietitian.

    - Outpatient services, including ASC type services, rendered in an all-inclusive rate provider should be billed using the 85X type of bill (TOB). Non-patient laboratory specimens are billed on TOB 14X.

      The (MPFS) supplemental file is used for payment of all physician/professional services rendered in a CAH that has elected the optional method. If a HCPCS has a facility rate and a non-facility rate, pay the facility rate.

SUPPLEMENTAL FEE SCHEDULE
CRITICAL ACCESS HOSPTIAL FEE SCHEDULE

DATA SET NAMES: MU00.@BF12390.MPFS.CY05.SUPL.V1122.FI

This is the final physician fee schedule supplemental file.

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

Data Element Name	Location	Picture	Value
1 - HCPCS	1-5	X(05)	
2 - Modifier	6-7	X(02)	
3 - Filler	8-9	X(02)	
4 - Non-Facility Fee	10-16	9(05)V99	
5 - Filler	17-17	X(01)	
6 - PCTC Indicator	18-18	X(01)	This field is only applicable when pricing Critical Access Hospitals (CAHs) that have elected the optional method (Method 2) of payment.
7 - Filler	19	X(1)	
8 - Facility Fee	20-26	9(05)V99	
9 - Filler	27-30	X(4)	
10 - Carrier Number	31-35	X(05)	
11 - Locality	36-37	X(02)	
12 - Filler	38-40	X(03)	
13 - Fee Indicator	41-41	X(1)	Field not populated— filled with spaces.
14 - Outpatient Hospital	42-42	X(1)	Field not populated—Filled with spaces.
15 - Status Code	43-43	X(1)	Separate instructions will be issued for the use of this field at a later date. This field indicates whether the code is in the physician fee schedule and whether it's separately payable if the service is covered.
14 - Filler	44-60	X(17)	

Physician Fee Schedule Payment Policy Indicator File Record Layout

The information on the Physician Fee Schedule Payment Policy Indicator file record layout is used to identify endoscopic base codes, payment policy indicators, global surgery indicators or the preoperative, intraoperative and postoperative percentages that are needed to determine if payment adjustment rules apply to a specific CPT code and the associated pricing modifier(s). See Chapter 12 of Pub. 100-04 for more information on payment policy indicators and payment adjustment rules.

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 A, C, T, and some R codes that are currently returned on the MPFS supplemental file will be included. 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.*	*2 Pic x(2)*	*10-11*

FIELD NAME & DESCRIPTION	***LENGTH & PIC***	***Position***
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.		
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.*	*3 Pic x(3)*	*13-15*

FIELD NAME & DESCRIPTION	***LENGTH & PIC***	***Position***
YYY = Fiscal intermediary (FI) 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.)*		
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 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)*	*16-21*
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*

FIELD NAME & DESCRIPTION	*LENGTH & PIC*	*Position*
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 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*	*1 Pic x(1)*	*34*

FIELD NAME & DESCRIPTION	***LENGTH & PIC***	***Position***
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*		

FIELD NAME & DESCRIPTION	*LENGTH & PIC*	*Position*
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 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*	*1 Pic (x)1*	*35*

FIELD NAME & DESCRIPTION	*LENGTH & PIC*	*Position*
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*		

FIELD NAME & DESCRIPTION	***LENGTH & PIC***	***Position***
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). Note: The 4 will be changed to a 9 because the 4 does not apply to Method II CAH claims for professional services processed by the fiscal intermediary.* *9 = Concept does not apply.*		
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*	*1 Pic (x)1*	*36*

FIELD NAME & DESCRIPTION	*LENGTH & PIC*	*Position*
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. 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*		

FIELD NAME & DESCRIPTION	***LENGTH & PIC***	***Position***
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.*		

FIELD NAME & DESCRIPTION	*LENGTH & PIC*	*Position*
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.* *2 = Payment restriction for assistants at surgery does not apply to this procedure. Assistant at surgery may be paid.* *9 = Concept does not apply.*	*1 Pic (x)1*	*37*
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.*	*1 Pic (x)1*	*39*

FIELD NAME & DESCRIPTION	*LENGTH & PIC*	*Position*
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.*		
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*
Filler	*30 Pic x(30)*	*46-75*

Health Professional Shortage Area (HPSA) Incentive Payments for Physicians

Section 1833 (m) of the Social Security Act, provides incentive payments for physicians who furnish services in areas designated as HPSAs under section 332(a)(1)(A) of the Public Health Service (PHS) Act. This statute recognizes geographic-based, primary medical care and mental health HPSAs, are areas for receiving a 10 percent bonus payment. The Health Resources and Services Administration (HRSA), within the Department of Health & Human Services, is responsible for designating shortage areas.

Physicians, including psychiatrists, who provide covered professional services in a primary medical care HPSA, are entitled to an incentive payment. In addition, psychiatrists furnishing services in mental health HPSAs are eligible to receive bonus payments. The bonus is payable for psychiatric services furnished in either a primary care HPSA, or a mental health HPSA. Dental HPSAs remain ineligible for the bonus payment.

Physicians providing services in either rural or urban HPSAs are eligible for a 10percent incentive payment. It is not enough for the physician merely to have his/her office or primary service location in a HPSA, nor must the beneficiary reside in a HPSA, although, frequently, this will be the case. The key to eligibility is where the service is actually provided (place of service). For example, a physician providing a service in his/her office, the patient's home, or in a hospital, qualifies for the incentive payment as long as the specific location of the service provision is within an area designed as a HPSA. On the other hand, a physician may have an office in a HPSA, but go outside the office (and

the designated HPSA area) to provide the service. In this case, the physician would not be eligible for the incentive payment.

If the CAH electing the Optional Method (Method II) is located within a primary medical care HPSA, and/or mental health HPSA, the physicians providing (outpatient) professional services in the CAH are eligible for HPSA physician incentive payments. Therefore, payments to such a CAH for professional services of physicians in the outpatient department will be 115 percent **times** the amount payable under fee schedule **times** 110 percent. An approved Optional Method CAH that is located in a HPSA County should notify you of its HPSA designation **in writing**. Once you receive the information, place an indicator on the provider file showing the effective date of the CAH's HPSA status. The CMS will furnish quarterly lists of mental health HPSAs to intermediaries.

The HPSA incentive payment is 10 percent of the amount actually paid, not the approved amount. Do not include the incentive payment in each claim. Create a utility file so that you can run your paid claims file for a quarterly log. From this log you will send a quarterly report to the CAHs for each physician payment, one month following the end of each quarter. The sum of the "10% of line Reimbursement" column should equal the payment sent along with the report to the CAH. If any of the claims included on the report are adjusted, be sure the adjustment also goes to the report If an adjustment request is received after the end of the quarter, any related adjustment by the FI will be included on next quarter's report. The CAHs must be sure to keep adequate records to permit distribution of the HPSA bonus payment when received. If an area is designated as both a mental health HPSA and a primary medical care HPSA, only one 10 percent bonus payment shall be made for a single service.