| CMS Manual System | **Department of Health & Human Services (DHHS)** |
|---|---|
| Pub 100-04 Medicare Claims Processing | **Centers for Medicare & Medicaid Services (CMS)** |
| **Transmittal 2643** | **Date: January 31, 2013** |
| | **Change Request 8128** |

**SUBJECT: Streamlining the Process for Updating the Abstract Files Used to Price Institutional Claims**

**I. SUMMARY OF CHANGES:** Legislation changing fee schedule amounts has become more frequent. As a result, the current process for updates has become too cumbersome. To streamline it, CMS will only issue full versions of the abstract files as part of the January annual updates. All mid-year changes will be provided as update files (.i.e., files containing only the codes and fees that are changing). If a particular file is not affected by new legislation or policy, that file will not be re-issued (currently all files are re-issued in all cases). Additionally, an effective date will be added to each record in the files so that separate files for different dates are unnecessary.

**EFFECTIVE DATE: July 1, 2013**
**IMPLEMENTATION DATE: July 1, 2013**

***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 | 4/250.2/Optional Method for Outpatient Services: Cost-Based Facility Services Plus 115 percent Fee Schedule Payment for Professional Services |
| R | 23/30.3.1/RESERVED |
| R | 23/40/Clinical Diagnostic Laboratory Fee Schedule |
| R | 23/40.1/Access to Clinical Diagnostic Lab Fee Schedule Files |
| R | 23/40.3/Institutional Claim Record Layout for Clinical Laboratory Fee Schedule |
| R | 23/50/Fee Schedules Used by Medicare Contractors Processing Institutional Claims |
| R | 23/50.1/Institutional Claim Record Layout for Hospice, Radiology and Other Diagnostic Prices and Local HCPCS Codes |
| R | 23/50.2/Institutional Claim Record Layout for the Durable Medical Equipment, Prosthetic, Orthotic and Supply Fee Schedule |
| R | 23/50.3/Institutional Claim Record Layout for the Outpatient Rehabilitation and CORF Services Fee Schedule |
| R | 23/50.4/Institutional Claim Record Layout for the Skilled Nursing Facility Fee Schedule |
| R | 23/50.5/RESERVED |
| R | 23/50.6/Physician Fee Schedule Payment Policy Indicator File Record Layout |
| R | 23/50.7/Institutional Claim Record Layout for the Mammography Fee Schedule |
| R | 23/50.8/Institutional Claim Record Layout for the Ambulance Fee Schedule |

**III. FUNDING:**

**For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):**

No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

**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 obliged 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: 2643 | Date: January 31, 2013 | Change Request: 8128 |
|---|---|---|---|

**SUBJECT: Streamlining the Process for Updating the Abstract Files Used to Price Institutional Claims**

**EFFECTIVE DATE: July 1, 2013**
**IMPLEMENTATION DATE: July 1, 2013**

## I. GENERAL INFORMATION

**A. Background:** Over time, as a series of changes to the law required Original Medicare to pay institutional claims based on fee schedules, a number of files were created to provide the fee amounts to the Fiscal Intermediary Shared System (FISS). These files, known as abstract files, contained subsets of fee amounts from various fee schedules needed to implement the laws. These files are issued each January to reflect calendar year updates to the fee schedules. Whenever changes to the fee amounts are needed during a calendar year, the changes are provided to FISS and the Medicare Administrative Contractors (MACs) in full replacement files (i.e. all fees are re-issued even if only a few of them have changed). Additionally, separate files are needed if the effective dates of fees change mid-year.

Legislation changing fee schedule amounts has become more frequent. As a result, CMS had found this process to be too cumbersome. To streamline it, CMS will only issue full versions of the abstract files as part of the January annual updates. All mid-year changes will be provided as update files (.i.e., filed containing only the codes and fees that are changing). If a particular file is not affected by new legislation or policy, that file will not be re-issued (currently all files are re-issued in all cases). Additionally, an effective date will be added to each record in the files so that separate files for different dates are unnecessary.

CMS also identified a redundancy in the current abstract files. The fee information contained in the 'Supplemental' abstract file is the same as the information contained in the 'RHHI' abstract file. The 'Supplemental' file is used to provide certain professional component fees and is otherwise a reference file. The 'RHHI' file is use to pay attending physician services on hospice claims. These purposes can be met by a single file, which CMS will rename the 'HHH' (home health and hospice) file.

**B. Policy:** This Change Request contains no new policy. The requirements that follow streamline the implementation of existing policy.

## II. BUSINESS REQUIREMENTS TABLE

*Use "Shall" to denote a mandatory requirement.*

| Number | Requirement | Responsibility | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | Other |
| | | Part A | Part B | | | | | FISS | MCS | VMS | CWF | |
| 8128.1 | Medicare contractors shall use update-only abstract files to load fee amount changes that occur during the | X | | | X | | X | X | | | | EDCs |

| Number | Requirement | Responsibility | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | Other |
| | | Part A | Part B | | | | | FISS | MCS | VMS | CWF | |
| | calendar year. | | | | | | | | | | | |
| 8128.2 | Medicare contractors shall apply fee amount changes to the date of service on institutional claims using the effective date contained in the abstract files.<br><br>**NOTE:** The revised record layouts for the abstract files are contained in the attachments. The ambulance file is not shown because it currently contains an effective date. | X | | | X | | X | X | | | | EDCs |
| 8128.3 | Medicare contractors shall use the 'HHH' file to load all fees previously loaded from the SUPL and the RHHI files. | X | | | X | | X | X | | | | EDCs |

## III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | DME MAC | FI | CARRIER | RHHI | Other |
| | | Part A | Part B | | | | | |
| | None | | | | | | | |

## IV. SUPPORTING INFORMATION

**Section A: Recommendations and supporting information associated with listed requirements:**
*Use "Should" to denote a recommendation.*

| X-Ref Requirement Number | Recommendations or other supporting information: |
|---|---|
| 8128.3 | The 'RHHI' abstract file is renamed the 'HHH' file to reflect Medicare contracting reform changes. |

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

## V. CONTACTS

**Pre-Implementation Contact(s):** Wil Gehne, wilfried.gehne@cms.hhs.gov (Institutional Claims Processing) , Chuck Campbell, charles.campbell@cms.hhs.gov (Abstract Files)

**Post-Implementation Contact(s):** Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

## VI. FUNDING

**Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):**
No additional funding will be provided by CMS; Contractors activities are to be carried out with 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 do 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 (4)**

## Attachment A

## Institutional Claim Record Layout for the Clinical Laboratory Fee Schedule (CLAB File)

Record Length = 60
Record Format = FB
Block Size = 6000
Character Code = EBCDIC
Sort Sequence = Carrier, Locality, HCPCS Code

**Header Record**

| Data Element Name | Picture | Location | Comment |
|---|---|---|---|
| 1-Label | X(03) | 1 - 3 | Value = Lab |
| 2-Filler | X(07) | 4 - 10 | |
| 3-Filler | X(08) | 11 - 15 | |
| 4-Filler | X(04) | 16 - 22 | |
| 5-Date Fee Update | X(08) | 23 - 30 | YYYYMMDD |
| 6-Filler | X(22) | 31 - 52 | |
| 7-Date File Created | X(08) | 53 - 60 | YYYYMMDD |

**Data Record**

| Data Element Name | Picture | Location | Comment |
|---|---|---|---|
| 1-HCPCS | X(05) | 1 – 5 | |
| 2-Filler | X(04) | 6 – 9 | |
| 3-60% Fee | 9(05)V99 | 10 - 16 | |
| 4-62% Fee | 9(05)V99 | 17 - 23 | |
| 5-Filler | X(07) | 24 - 30 | |
| 6-Carrier Number | X(05) | 31 - 35 | |
| 7-Carrier Locality | X(02) | 36 - 37 | 00 = Single State Carrier<br>01 = North Dakota<br>02 = South Dakota<br>20 = Puerto Rico |
| 8-State Locality | X(02) | 38 - 39 | Separate instructions will be used for the use of this field at a later date. |
| 9-Filler | X(02) | 40 – 41 | |
| 10-Effective Date | X(08) | 42 – 49 | Update effective date (YYYYMMDD) |
| 11-Filler | X(11) | 50 – 60 | |

## Attachment B

## Institutional Claim Record Layout for Hospice, Radiology and Other Diagnostic Prices and Local HCPCS Codes (HHH file)

| | | |
|---|---|---|
| Record Length | - | 60 |
| Record Format | - | FB |
| Block Size | - | 6000 |
| Character Code | - | EBCDIC |
| Sort Sequence | - | Carrier, Locality, HCPCS Code, Modifier |

| Data Element Name | Picture | Location | Comment |
|---|---|---|---|
| 1-HCPCS | X(05) | 1 - 5 | |
| 2-Modifier | X(02) | 6 - 7 | |
| 3-Non-Facility Fee | 9(05)V99 | 8 - 14 | |
| 4-PCTC Indicator | X(01) | 15 - 15 | This field is only applicable when pricing Critical Access Hospitals (CAHs) that have elected the optional method (Method 2) of payment. |
| 5-Facility Fee | 9(05)V99 | 16 - 22 | |
| 6-Effective Date | X(08) | 23 - 30 | |
| 7-Carrier Number | X(05) | 31 - 35 | |
| 8-Locality | X(02) | 36 - 37 | |
| 9-**Label** | X(03) | 38 – 40 | HPH = Hospice Physician Services<br>ODX = Other Diagnostic Services<br>PRF = Portable Radiology<br>RAD = Radiology |
| 10-Filler | X(2) | 41 – 42 | |
| 11-Status Code | X(1) | 43 – 43 | Separate instructions will be used 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 is separately payable if the service is covered. |
| 12-Multiple Surgery | X(01) | 44 – 44 | Indicator indicates which payment adjustment rule for multiple procedures apply to the service. |
| 13-Non Facility PE | 9(05)V99 | 45 – 51 | Non-facility practice expense RVU |
| 14-Filler | X(01) | 52 – 52 | |
| 15-FI Therapy Reduction | 9(05)V99 | 53 – 59 | Reduces payment amount for multiple surgery |
| 16-Filler | X(01) | 60 - 60 | |

## Attachment C

## Institutional Claim Record Layout for Durable Medical Equipment, Prosthetic, Orthotic and Supply Fee Schedule (DMEPOS file)

| | | |
|---|---|---|
| Record Length | - | 60 |
| Record Format | - | FB |
| Block Size | - | 6000 |
| Character Code | - | EBCDIC |
| Sort Sequence | - | Label, HCPCS Code, MOD, State |

| Data Element Name | Picture | Location | Comment |
|---|---|---|---|
| 1-HCPCS | X(05) | 1 - 5 | |
| 2-MOD | X(02) | 6 – 7 | |
| 3-MOD 2 | X(02) | 8 – 9 | |
| 4-Fee Schedule Amt | 9(05)V99 | 10 - 16 | |
| 5-Filler | X(14) | 17 - 30 | |
| 6-State | X(02) | 31 - 32 | |
| 7-Filler | X(05) | 33 - 37 | |
| 8-*Label* | X(3) | 38 - 40 | DME = Durable Medical Equipment (other than oxygen)<br>OXY = Oxygen<br>P/O = Prosthetic/Orthotic<br>S/D = Surgical Dressings |
| 9-Filler | X(4) | 41 - 44 | |
| 10-*Pricing Change Indicator | X(1) | 45 - 45 | 0 = No change to Update Fee Schedule Amount since previous release<br>1 = A change has occurred to the Update Fee Schedule Amount since the previous release.<br>NOTE: In the initial release of the annual update, this field is initialized to >0’ |
| 11-Filler | X(02) | 46 – 47 | |
| 12-Effective Date | X(08) | 48 – 55 | Update effective date (YYYYMMDD) |
| 13-Filler | X(05) | 56 – 60 | |

## Attachment D

## Institutional Claim Record Layout for the Outpatient Rehabilitation and CORF Services Fee Schedule (ABSTR file)

| | | |
|---|---|---|
| Record Length | - | 60 |
| Record Format | - | FB |
| Block Size | - | 6000 |
| Character Code | - | EBCDIC |
| Sort Sequence | - | Carrier, Locality HCPCS Code, Modifier |

| Data Element Name | Picture | Location | Comment |
|---|---|---|---|
| 1-HCPCS | X(05) | 1 – 5 | |
| 2-Modifier | X(02) | 6 – 7 | |
| 3-Non-Facility Fee | 9(05)V99 | 8 - 14 | |
| 4-PCTC Indicator | X(01) | 15 - 15 | This field is only applicable when pricing Critical Access Hospitals (CAHs) that have elected the optional method (Method 2) of payment. |
| 5-Facility Fee | 9(05)V99 | 12 – 22 | |
| 6-Effective Date | X(08) | 23 – 30 | Update effective date |
| 7-Carrier Number | X(05) | 31 – 35 | |
| 8-Locality | X(02) | 36 - 37 | |
| 9-Filler | X(03) | 38 - 40 | |
| 10-Fee Indicator | X(1) | 41 - 41 | R = Rehab/Audiology function test/CORF services |
| 11-Outpatient Hospital | X(1) | 42 – 42 | 0 = Fee applicable in hospital outpatient setting<br>1 = Fee not applicable in hospital outpatient setting |
| 12-Status Code | X(1) | 43 – 43 | Separate instructions will be used 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 is separately payable if the service is covered. |
| 12-Multiple Surgery | X(01) | 44 – 44 | Indicator indicates which payment adjustment rule for multiple procedures apply to the service. |
| 13-Non Facility PE | 9(05)V99 | 45 – 51 | Non-facility practice expense RVU |
| 14-Filler | X(01) | 52 – 52 | |
| 15-FI Therapy Reduction | 9(05)V99 | 53 – 59 | Reduces payment amount for multiple surgery |
| 16-Filler | X(01) | 60 - 60 | |

# Medicare Claims Processing Manual
## Chapter 4 - Part B Hospital
## (Including Inpatient Hospital Part B and OPPS)

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*(Rev.2643, Issued: 01-31-13)*

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

***(Rev. 2643, Issued: 01-31-13, Effective: 07-01-13, Implementation: 07-01-13)***

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.

Effective for cost reporting periods beginning on or after October 1, 2010 if a CAH elected the optional method for its most recent cost reporting period beginning before October 1, 2010 or chooses to elect the optional method on or after October 1, 2010, that election remains in place until it is terminated, an annual election is no longer required. If a CAH elects the optional method on or after October 1, 2010, it must submit its request in writing to its fiscal intermediary or A/B MAC at least 30 days before the start of the first cost reporting period for which the election is effective. That election will not terminate unless the CAH submits a termination request to its fiscal intermediary or A/B MAC at least 30 days before the start of its next cost reporting period.

The Medicare Prescription Drugs, Improvement, and Modernization Act (MMA) of 2003, changed 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 effect 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 Form CMS-855R to the intermediary or A/B MAC, and the appropriate carrier or A/B MAC, must have the practitioner sign an attestation that clearly states that the practitioner will not bill the carrier or A/B MAC 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 or A/B MAC 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 or A/B MAC 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 or A/B MAC will pay 101 percent of the reasonable costs for 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 or A/B MAC uses the Medicare Physician Fee Schedule (MPFS) *amounts* to pay for all the physician/nonphysician practitioner services rendered in a CAH that elected the optional

method. Payment is based on the lesser of the actual charge or the facility-specific MPFS amount less deductible and coinsurance times 1.15; and

For a non-participating physician service, a CAH must place modifier AK on the claim. Payment is based on the lesser of the actual charge or a reduced fee schedule amount of 95 percent. Payment is calculated as follows:

- [(facility-specific MPFS amount times the non-participating physician reduction (0.95) minus (deductible and coinsurance] times 1.15.

- If a nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA) renders a service, the "GF" modifier 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 certified registered nurse anesthetist (CRNA) services, the claim is returned to the provider.) Also, while this national "GF" modifier includes CRNs, there is no benefit under Medicare law that authorizes payment to CRNs for their services. Accordingly, if a claim is received and it has the "GF" modifier for CRN services, no Medicare payment should be made.

    - Services billed with the "GF" modifier are paid based on the lesser of the actual charge or a reduced fee schedule amount of 85 percent. Payment is calculated **as follows:**

        - [(facility-specific MPFS amount times the nonphysician practitioner services reduction (0.85) minus (deductible and coinsurance)] times 1.15.

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

- For dates of service prior to January 1, 2011, certified nurse-midwife services billed with the "SB" modifier are paid based on the lesser of the actual charge or a reduced fee schedule amount of 65 percent. Payment is calculated **as follows:**

    - [(facility-specific MPFS amount times the certified nurse-midwife reduction (0.65) minus (deductible and coinsurance)] times 1.15.

    - For dates of service on or after January 1, 2011, Medicare covers the services of a certified nurse-midwife. The "SB" modifier is used to bill for the services and payment is based on the lesser of the actual charge or 100 percent of the MPFS. MPFS Payment is calculated **as follows**:

    - [(facility-specific MPFS amount) minus (deductible and coinsurance)] times 1.15.

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

- Payment for the services of a clinical psychologist is based on the lesser of the actual charge or 100 percent of the MPFS. Payment is calculated **as follows:**

- [(facility-specific MPFS amount) minus (deductible and coinsurance)] times 1.15.

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

- Services billed with the "AE" modifier are paid based on the lesser of the actual charge or a reduced fee schedule amount of 85 percent. Payment is calculated **as follows:**

  - [(facility-specific MPFS amount times the registered dietitian reduction (0.85) minus (deductible and coinsurance)] times 1.15.

o 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.

MPFS *rates contained* in the *HHH abstract file are* used for payment of all physician/professional services rendered in a CAH that has elected the optional method. If a HCPCS code has a facility rate and a non-facility rate, the facility rate is paid. *See Chapter 23 of Pub. 100-04, section 50.1 for the record layout for the HHH abstract file.*

**Physician Fee Schedule Payment Policy Indicator File**

The information on the Physician Fee Schedule Payment Policy Indicator file is used to identify endoscopic base codes, payment policy indicators, global surgery indicators, diagnostic imaging family 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. *See Chapter 23 of Pub. 100-04, section 50.6 for the record layout of the Payment Policy Indicator file.*

**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 10 percent 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.

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

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***(Rev. Rev.2643, Issued: 01-31-13)***



## 30.3.1 - *RESERVED*
**(Rev. 2643, Issued: 01-31-13, Effective: 07-01-13, Implementation: 07-01-13)**

## 40 - Clinical Diagnostic Laboratory Fee Schedule
**(Rev. 2643, Issued: 01-31-13, Effective: 07-01-13, Implementation: 07-01-13)**

The Medicare Claims Processing Manual, Chapter 16, “Laboratory Services From Independent Labs, Physicians, and Providers,” provides background and additional information for payment of laboratory services.

Clinical diagnostic laboratory tests - whether performed in a physician's office, by an independent laboratory, or by a hospital laboratory for its outpatients - are paid based on fee schedules. This section sets out rules for use of these schedules.
The fee schedule amounts are adjusted annually to reflect changes in the Consumer Price Index (CPI) for all Urban Consumers (U.S. city average), or as otherwise specified by legislation. Adjustments are applied and amounts are determined by CMS and published for contractor use and also on CMS Web site. Contractors are notified when and where updates are published.
For a cervical or vaginal smear test (pap smear), payment is the lesser of the local fee or the national limitation amount, but not less than the national minimum payment amount. However, in no case may payment for these tests exceed actual charges. The Part B deductible and coinsurance do not apply.
Regardless of whether a diagnostic laboratory test is performed in a physician's office, by an independent laboratory, or by a hospital laboratory for its outpatients or nonpatients, it is considered a laboratory service. When a hospital laboratory performs diagnostic laboratory tests for nonhospital patients, the laboratory is functioning as an independent laboratory.
National minimum limitation amounts are established each year for cervical or vaginal smear clinical laboratory tests. These payment amounts are published each year in *a Recurring Update Notification* issued by CMS. The affected CPT laboratory test codes for the national minimum payment amount are also identified in the annual *Recurring Update Notification*. National maximum limitation amounts may also be established for certain services and are also published each year *this Recurring Update Notification*.
*Medicare contractors* pay the lowest of the applicable current fee schedule, the actual charge, or the NLA. This applies to all clinical diagnostic laboratory tests except:

- Laboratory tests furnished to a hospital inpatient whose stay is covered under Part A;
- Laboratory tests performed by a Skilled Nursing Facility (SNF) for its own SNF inpatients and reimbursed under Part A or Part B and any laboratory tests furnished under arrangements to an SNF inpatient with Part A coverage. (The only covered source for laboratory services furnished under Part A is the SNF itself or a hospital with which the facility has a transfer agreement in effect.) ;
- Laboratory tests furnished by hospital-based or independent ESRD dialysis facilities that are included under the ESRD composite rate payment;
- Laboratory tests furnished by hospitals in States or areas which have been granted demonstration waivers of Medicare reimbursement principles for outpatient services. The State of Maryland has been granted such demonstration waivers;
- Laboratory tests furnished to inpatients of a hospital with a waiver under §602(k) of the 1983 Amendments to the Act. This section of the Act provides that an outside supplier may bill under Part B for laboratory and other nonphysician services furnished to inpatients that are otherwise paid only though the hospital;
- Laboratory tests furnished to patients of rural health clinics (RHCs) under an all inclusive rate;
- Laboratory tests provided by a participating health maintenance organization (HMO) or health care prepayment plan (HCPP) to an enrolled member of the plan; and
- Laboratory tests furnished by a hospice.

## 40.1 - Access to Clinical Diagnostic Lab Fee Schedule Files

**(Rev. 2643, Issued: 01-31-13, Effective: 07-01-13, Implementation: 07-01-13)**

The annual laboratory fee schedule data file should be retrieved electronically through CMS' mainframe telecommunications system.
For each test code, if the contractor's system retains only the pricing amount, they should load the data from the field named "60% Pricing Amt." For each test code, if the contractor's system has been developed to retain the local fee and the NLA, they may load the data from the fields named "60% Local Fee Amt" and "60% Natl Limit Amt" to use to determine payment. For clinical laboratory test codes for cervical or vaginal smear tests (listed in Chapter 16, "Laboratory Services from Independent Labs, Physicians, and Providers," §80.3) load the data from the field named "60% Pricing Amt" to reflect the lower of the local fee or the NLA, but not less than the national minimum payment amount. The fields named "62% Local Fee

Amt," "62% Natl Limit Amt," and "62% Pricing Amt" should be used by intermediaries for payment of clinical laboratory tests performed by a sole community hospital's qualified laboratory.
*The* annual laboratory fee schedule data is available *via the CMS website*. It is available in multiple formats: Excel, text, and comma delimited.

## 40.3 – *Institutional Claim* Record Layout for Clinical Laboratory Fee Schedule

**(Rev. 2643, Issued: 01-31-13, Effective: 07-01-13, Implementation: 07-01-13)**

*The CMS will provide the specific file names when the prices are released. The file name will contain the label CLAB.*

Record Length = 60
Record Format = FB
Block Size = 6000
Character Code = EBCDIC
Sort Sequence = Carrier, Locality, HCPCS Code

Header Record

| Data Element Name | Picture | Location | Comment |
|---|---|---|---|
| 1-Label | X(03) | 1 - 3 | Value = Lab |
| 2-Filler | X(07) | 4 - 10 | |
| 3-Filler | X(08) | 11 - 15 | |
| 4-Filler | X(04) | 16 - 22 | |
| 5-Date Fee Update | X(08) | 23 - 30 | YYYYMMDD |
| 6-Filler | X(22) | 31 - 52 | |
| 7-Date File Created | X(08) | 53 - 60 | YYYYMMDD |

Data Record

| Data Element Name | Picture | Location | Comment |
|---|---|---|---|
| 1-HCPCS | X(05) | 1 – 5 | |
| 2-Filler | X(04) | 6 – 9 | |
| 3-60% Fee | 9(05)V99 | 10 - 16 | |
| 4-62% Fee | 9(05)V99 | 17 - 23 | |
| 5-Filler | X(07) | 24 - 30 | |
| 6-Carrier Number | X(05) | 31 - 35 | |
| 7-Carrier Locality | X(02) | 36 - 37 | 00 = Single State Carrier<br>01 = North Dakota<br>02 = South Dakota<br>20 = Puerto Rico |
| 8-State Locality | X(02) | 38 - 39 | Separate instructions will be used for the use of this field at a later date. |
| *9-Filler* | *X(02)* | *40 – 41* | |
| *10-Effective Date* | *X(08)* | *42 – 49* | *Update effective date (YYYYMMDD)* |
| *11-Filler* | *X(11)* | *50 – 60* | |

## 50 - Fee Schedules Used by *Medicare Contractors Processing Institutional Claims*

**(Rev. 2643, Issued: 01-31-13, Effective: 07-01-13, Implementation: 07-01-13)**

*Medicare Contractors Processing Institutional Claims* retrieve multiple files from CMS mainframe telecommunications system. The HCPCS data files include deleted codes for the upcoming year. *Contractors* need to identify deleted codes using the HCPCS files because they are not identifiable solely from the fee schedules. HCPCS files are also obtained from CMS annually. New fee schedules are effective for dates of service on and after January 1 of each year. Quarterly and emergency updates to the

fee schedules are also sometimes released. *In that case, contractors* implement them according to the instructions *accompanying the release.*
Two HCPCS files are furnished by CMS. They are:

- The annual HCPCS file update including procedure and modifier codes and deleted codes; and
- A print file of the new year HCPCS codes.

The following fee schedules are furnished by CMS for use *in processing institutional claims:*

- Fees for *hospice claims* for Part B services *provided by the hospice beneficiart's attending physician*;
- *Medicare* Physician Fee Schedule;
- Clinical Laboratory Fee Schedule discussed in §40.3 above;
- Durable Medical Equipment, Prosthetics/Orthotics and Supplies (DMEPOS) Fee Schedule. *Contractors with home health workloads* retrieve data from all categories on this file. *All contractors* retrieve data from categories prosthetic/orthotics and surgical dressings;
- Outpatient Rehabilitation (Therapy) and CORF Services Fee Schedule Payment Amounts (Therapy/CORF Abstract File);
- CORF, outpatient Critical Access Hospital (CAH and Indian Health Services not part of the Outpatient Rehabilitation (therapy) file; *and*
- Skilled Nursing Facility (SNF) extract *file* for radiology, other diagnostic and other SNF services.

## 50.1 - *Institutional Claim Record Layout* for Hospice, Radiology and Other Diagnostic Prices and Local HCPCS Codes

**(Rev. 2643, Issued: 01-31-13, Effective: 07-01-13, Implementation: 07-01-13)**

*This file contains hospice* fee schedule prices extracted from the Physician Fee schedule. This file contains pricing data for carrier-priced and local HCPCS codes for radiology, other diagnostic services, and hospice services paid under the physician fee schedule. This file contains some high volume services such as portable x-rays. *The file is also used to pay claims for Critical Access Hospitals that have elected the optional method. The CMS will provide the specific file names when the prices are released. The file name will contain the label HHH.*

| | | |
|---|---|---|
| Record Length | - | 60 |
| Record Format | - | FB |
| Block Size | - | 6000 |
| Character Code | - | EBCDIC |
| Sort Sequence | - | Carrier, Locality, HCPCS Code, Modifier |

| Data Element Name | Picture | Location | Comment |
|---|---|---|---|
| 1-HCPCS | X(05) | 1 - 5 | |
| 2-Modifier | X(02) | 6 - 7 | |
| *3-Non-Facility Fee* | *9(05)V99* | *8 - 14* | |
| *4-PCTC Indicator* | *X(01)* | *15 - 15* | *This field is only applicable when pricing Critical Access Hospitals (CAHs) that have elected the optional method (Method 2) of payment.* |
| *5-Facility Fee* | *9(05)V99* | *16 - 22* | |
| *6-Effective Date* | *X(08)* | *23 - 30* | |
| *7-*Carrier Number | X(05) | 31 - 35 | |
| *8-*Locality | X(02) | 36 - 37 | |
| *9-***Label** | X(03) | 38 – 40 | HPH = Hospice Physician Services<br>ODX = Other Diagnostic Services<br>PRF = Portable Radiology |

| Data Element Name | Picture | Location | Comment |
|---|---|---|---|
| | | | RAD = Radiology |
| *10*-Filler | X(2) | 41 – 42 | |
| *11*-Status Code | X(1) | 43 – 43 | Separate instructions will be used 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 is separately payable if the service is covered. |
| *12-Multiple Surgery* | *X(01)* | *44 – 44* | *Indicator indicates which payment adjustment rule for multiple procedures apply to the service.* |
| *13-Non Facility PE* | *9(05)V99* | *45 – 51* | *Non-facility practice expense RVU* |
| *14-Filler* | *X(01)* | *52 – 52* | |
| *15-FI Therapy Reduction* | *9(05)V99* | *53 – 59* | *Reduces payment amount for multiple surgery* |
| *16-Filler* | *X(01)* | *60 - 60* | |

## 50.2 - *Institutional Claim Record Layout* for the Durable Medical Equipment, Prosthetic, Orthotic and Supply Fee Schedule

**(Rev. 2643, Issued: 01-31-13, Effective: 07-01-13, Implementation: 07-01-13)**

This file contains services subject to national Floors and Ceilings under the DMEPOS Fee Schedules including Surgical Dressings. *The CMS will provide the specific file names when the prices are released. The file name will contain the label DMEPOS.*

| | | |
|---|---|---|
| Record Length | - | 60 |
| Record Format | - | FB |
| Block Size | - | 6000 |
| Character Code | - | EBCDIC |
| Sort Sequence | - | Label, HCPCS Code, MOD, State |

| Data Element Name | Picture | Location | Comment |
|---|---|---|---|
| 1-HCPCS | X(05) | 1 - 5 | |
| 2-MOD | X(02) | 6 – 7 | |
| 3-MOD 2 | X(02) | 8 – 9 | |
| 4-Fee Schedule Amt | 9(05)V99 | 10 - 16 | |
| 5-Filler | X(14) | 17 - 30 | |
| 6-State | X(02) | 31 - 32 | |
| 7-Filler | X(05) | 33 - 37 | |
| 8-*Label* | X(3) | 38 - 40 | DME = Durable Medical Equipment (other than oxygen)<br>OXY = Oxygen<br>P/O = Prosthetic/Orthotic<br>S/D = Surgical Dressings |
| 9-Filler | X(4) | 41 - 44 | |
| 10-*Pricing Change Indicator | X(1) | 45 - 45 | 0 = No change to Update Fee Schedule Amount since previous release<br>1 = A change has occurred to the Update Fee Schedule Amount since the previous release.<br>NOTE: In the initial release of the annual update, this field is initialized to |

| Data Element Name | Picture | Location | Comment |
|---|---|---|---|
| | | | >0’ |
| *11-Filler* | *X(02)* | *46 – 47* | |
| *12-Effective Date* | *X(08)* | *48 – 55* | *Update effective date (YYYYMMDD)* |
| *13-Filler* | *X(05)* | *56 – 60* | |

## 50.3 - *Institutional Claim Record Layout for the* Outpatient Rehabilitation and CORF Services Fee Schedule

**(Rev. 2643, Issued: 01-31-13, Effective: 07-01-13, Implementation: 07-01-13)**

This is a physician fee schedule abstract file for outpatient rehabilitation and CORF services payment. *The CMS will provide the specific file names when the prices are released. The file name will contain the label ABSTR.*

| | | |
|---|---|---|
| Record Length | - | 60 |
| Record Format | - | FB |
| Block Size | - | 6000 |
| Character Code | - | EBCDIC |
| Sort Sequence | - | Carrier, Locality HCPCS Code, Modifier |

| Data Element Name | Picture | Location | Comment |
|---|---|---|---|
| 1-HCPCS | X(05) | 1 – 5 | |
| 2-Modifier | X(02) | 6 – 7 | |
| *3-Non-Facility Fee* | *9(05)V99* | *8 - 14* | |
| *4-PCTC Indicator* | *X(01)* | *15 - 15* | *This field is only applicable when pricing Critical Access Hospitals (CAHs) that have elected the optional method (Method 2) of payment.* |
| *5-Facility Fee* | *9(05)V99* | *12 – 22* | |
| *6-Effective Date* | *X(08)* | *23 – 30* | *Update effective date* |
| *7*-Carrier Number | X(05) | 31 – 35 | |
| *8*-Locality | X(02) | 36 - 37 | |
| *9*-Filler | X(03) | 38 - 40 | |
| *10*-Fee Indicator | X(1) | 41 - 41 | R = Rehab/Audiology function test/CORF services |
| *11*-Outpatient Hospital | X(1) | 42 – 42 | 0 = Fee applicable in hospital outpatient setting<br>1 = Fee not applicable in hospital outpatient setting |
| *12*-Status Code | X(1) | 43 – 43 | Separate instructions will be used 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 is separately payable if the service is covered. |
| *13-Multiple Surgery* | *X(01)* | *44 – 44* | *Indicator indicates which payment adjustment rule for multiple procedures apply to the service.* |
| *14-Non Facility PE* | *9(05)V99* | *45 – 51* | *Non-facility practice expense RVU* |
| *15-Filler* | *X(01)* | *52 – 52* | |
| *16-FI Therapy* | *9(05)V99* | *53 – 59* | *Reduces payment amount for multiple* |

| Data Element Name | Picture | Location | Comment |
|---|---|---|---|
| *Reduction* | | | *surgery* |
| *17-Filler* | *X(01)* | *60 - 60* | |

## 50.4 - *Institutional Claim Record Layout for the* Skilled Nursing Facility Fee Schedule

**(Rev. 2643, Issued: 01-31-13, Effective: 07-01-13, Implementation: 07-01-13)**

This section contains the record layout for the SNF extract for radiology Services, other diagnostic services, and other SNF services priced on the MPFS. *The CMS will provide the specific file names when the prices are released. The file name will contain the label SNF.*

| | | |
|---|---|---|
| Record Length | - | 60 |
| Record Format | - | FB |
| Block Size | - | 6000 |
| Character Code | - | EBCDIC |

| Data Element Name | Picture | Location | Comment |
|---|---|---|---|
| 1-HCPCS | X(05) | 1 – 5 | |
| 2-Modifier | X(02) | 6 – 7 | |
| *3-Non-Facility Fee* | *9(05)V99* | *8 - 14* | *The SNF fee schedule amount is based on the "non-facility rate" which is the fee that physicians may receive if performing the service in the physician's office.* |
| *4-PCTC Indicator* | *X(01)* | *15 - 15* | |
| *5-Facility Fee* | *9(05)V99* | *16 – 22* | |
| *6-Effective Date* | *X(08)* | *23 – 30* | *Update effective date* |
| *7-Carrier Number* | *X(05)* | *31 – 35* | |
| *8*-Locality | X(02) | 36 – 37 | |
| *9*-Filler | X(05) | 38 - 42 | |
| *10*-Status Code | X(1) | 43 - 43 | Separate instructions will be used 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 is separately payable if the service is covered. |
| *11-Multiple Surgery* | *X(01)* | *44 – 44* | *Indicator indicates which payment adjustment rule for multiple procedures apply to the service.* |
| *12-Non Facility PE* | *9(05)V99* | *45 – 51* | *Non-facility practice expense RVU* |
| *13-Filler* | *X(01)* | *52 – 52* | |
| *14-FI Therapy Reduction* | *9(05)V99* | *53 – 59* | *Reduces payment amount for multiple surgery* |
| *15-Filler* | *X(01)* | *60 - 60* | |

## 50.5 – *RESERVED*

**(Rev. 2643, Issued: 01-31-13, Effective: 07-01-13, Implementation: 07-01-13)**

## 50.6 – Physician Fee Schedule Payment Policy Indicator File Record Layout

**(Rev. 2643, Issued: 01-31-13, Effective: 07-01-13, Implementation: 07-01-13)**

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***<br>*This field displays the effective year of the file.* | *4 Pic x(4)* | *1-4* |
| ***HCPCS Code***<br><br>*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***<br><br>*For diagnostic tests, a blank in this field denotes the global service and the following modifiers identify the components:*<br>*26 = Professional component; and*<br>*TC = Technical component.*<br><br>*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.*<br>*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***<br><br>*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***<br><br>*This field provides the postoperative time frames that apply to payment for each surgical procedure or another indicator that describes the applicability of* | *3 Pic x(3)* | *13-15* |

| FIELD NAME & DESCRIPTION | LENGTH & PIC | Position |
|---|---|---|
| *the global concept to the service.*<br><br>*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.*<br><br>*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.*<br><br>*090 = Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule payment amount.*<br><br>*MMM = Maternity codes; usual global period does not apply.*<br><br>*XXX = Global concept does not apply.*<br><br>*YYY = Fiscal intermediary (FI) determines whether global concept applies and establishes postoperative period, if appropriate, at time of pricing.*<br><br>*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)***<br><br>*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)***<br><br>*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,* | *6 Pic 9v9(5)* | *22-27* |

| 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.* | | |
| ***Postoperative Percentage (Modifier 55)***<br><br>*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***<br><br>*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.*<br><br>*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.*<br><br>*The total RVUs for codes reported with a 26 modifier include values for physician work, practice expense, and malpractice expense.*<br><br>*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.*<br><br>*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* | *1 Pic x(1)* | *34* |

| FIELD NAME & DESCRIPTION | LENGTH & PIC | Position |
|---|---|---|
| *test only and another associated code that describes the global test.*<br><br>*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.*<br><br>*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.*<br><br>*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.*<br><br>*The total RVUs for technical component only codes include values for practice expense and malpractice expense only.*<br><br>*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.*<br><br>*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.*<br><br>*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.* | | |

| *FIELD NAME & DESCRIPTION* | *LENGTH & PIC* | *Position* |
|---|---|---|
| *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.*<br><br>*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.*<br><br>*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.*<br><br>*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.*<br>*9 = Concept of a professional/technical component does not apply* | | |
| ***Multiple Procedure (Modifier 51)***<br>*Indicator indicates which payment adjustment rule for multiple procedures applies to the service.*<br><br>*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.*<br><br>*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* | *1 Pic (x)1* | *35* |

| FIELD NAME & DESCRIPTION | LENGTH & PIC | Position |
|---|---|---|
| *report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage.*<br><br>*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.*<br><br>*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.*<br><br>*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).*<br><br>*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.*<br><br>*4 = Subject to MPPR reduction.*<br><br>*9 = Concept does not apply.* | | |
| ***Bilateral Surgery Indicator (Modifier 50)***<br>*This field provides an indicator for services subject to a payment adjustment.*<br><br>*0 = 150 percent payment adjustment for bilateral procedures does not apply.*<br><br>*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 Pic (x)1* | *36* |

| ***FIELD NAME & DESCRIPTION*** | ***LENGTH & PIC*** | ***Position*** |
|---|---|---|
| *1 = 150 percent payment adjustment for bilateral 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.*<br><br>*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.*<br><br>*2 = 150 percent payment adjustment for bilateral procedure does not apply. RVUs are already based on the procedure being performed as a bilateral procedure.*<br><br>*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.*<br><br>*3 = The usual payment adjustment for bilateral procedures does not apply.*<br><br>*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.*<br><br>*9 = Concept does not apply.* | | |
| ***Assistant at Surgery (Modifiers AS, 80, 81 and 82)***<br><br>*This field provides an indicator for services where an assistant at surgery may be paid:*<br><br>*0 = Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.*<br><br>*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.*<br><br>*9 = Concept does not apply.* | | |
| ***Co-Surgeons (Modifier 62)***<br><br>*This field provides an indicator for services for which two surgeons, each in a different specialty, may be paid.*<br><br>*0 = Co-surgeons not permitted for this procedure.*<br><br>*1 = Co-surgeons could be paid; supporting documentation required to establish medical necessity of two surgeons for the procedure.*<br><br>*2 = Co-surgeons permitted; no documentation required if two specialty requirements are met.*<br><br>*9 = Concept does not apply.* | *1 Pic (x)1* | *38* |
| ***Team Surgeons (Modifier 66)***<br><br>*This field provides an indicator for services for which team surgeons may be paid.*<br><br>*0 = Team surgeons not permitted for this procedure.*<br><br>*1 = Team surgeons could be paid; supporting documentation required to establish medical necessity of a team; pay by report.*<br><br>*2 = Team surgeons permitted; pay by report.*<br>*9 = Concept does not apply.* | *1 Pic (x)1* | *39* |
| ***Endoscopic Base Codes***<br><br>*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***<br>*(For future use)* | *1 Pic x (1)* | *45* |
| ***Diagnostic Imaging Family Indicator***<br><br>*88 = Subject to the reduction for diagnostic imaging (effective for services January 1, 2011, and after).*<br>*99 = Concept Does Not Apply* | *2 Pic x (2)* | *46-47* |
| ***Filler*** | *30 Pic x(30)* | *48-75* |

## 50.7 - *Institutional Claim Record Layout for the* Mammography Fee Schedule

**(Rev. 2643, Issued: 01-31-13, Effective: 07-01-13, Implementation: 07-01-13)**

This is a physician fee schedule abstract file for mammography services payment. *The CMS will provide the specific file names when the prices are released. The file name will contain the label MAMMO.*

| | | |
|---|---|---|
| Record Length | - | 60 |
| Record Format | - | FB |
| Block Size | - | 6000 |
| Character Code | - | EBCDIC |
| Sort Sequence | - | Carrier, Locality HCPCS Code, Modifier |

| Data Element Name | Picture | Location | Comment |
|---|---|---|---|
| 1-HCPCS | X(05) | 1 – 5 | |
| 2-Modifier | X(02) | 6 – 7 | |
| *3-Non-Facility Fee* | *9(05)V99* | *8 - 14* | |
| *4-PCTC Indicator* | *X(01)* | *15 - 15* | *This field is only applicable when pricing Critical Access Hospitals (CAHs) that have elected the optional method (Method 2) of payment.* |
| *5-Facility Fee* | *9(05)V99* | *16 – 22* | |
| *6-Effective Date* | *X(08)* | *23 – 30* | *Update effective date* |
| *7-*Carrier Number | X(05) | 31 – 35 | |
| *8-*Locality | X(02) | 36– 37 | |
| *9-*Filler | X(05) | 38– 42 | |
| *10-*Status Code | X(1) | 43– 43 | Separate instructions will be used 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 is separately payable if the service is covered. |
| *11-Multiple Surgery* | *X(01)* | *44 – 44* | *Indicator indicates which payment adjustment rule for multiple procedures apply to the service.* |
| *12-Non Facility PE* | *9(05)V99* | *45 – 51* | *Non-facility practice expense RVU* |
| *13-Filler* | *X(01)* | *52 – 52* | |
| *14-FI Therapy Reduction* | *9(05)V99* | *53 – 59* | *Reduces payment amount for multiple surgery* |
| *15-Filler* | *X(01)* | *60 - 60* | |

## 50.8 - *Institutional Claim Record Layout for the* Ambulance Fee Schedule

**(Rev. 2643, Issued: 01-31-13, Effective: 07-01-13, Implementation: 07-01-13)**

This is a physician fee schedule abstract file for ambulance services payment. *The CMS will provide the specific file names when the prices are released. The file name will contain the label AMBFS.*

| | | |
|---|---|---|
| Record Length | - | 80 |
| Record Format | - | FB |
| Block Size | - | 27920 |
| Character Code | - | EBCDIC |
| Sort Sequence | - | HCPCS, Carrier, Locality |

| Field Name | Format | Position | Description |
|---|---|---|---|

| Field Name | Format | Position | Description |
|---|---|---|---|
| 1-HCPCS | X(05) | 1 – 5 | HCFA Common Procedure Coding System |
| 2-Carrier Number | X(05) | 6 – 10 | |
| 3-Locality Code | X(02) | 11–12 | |
| 4-Base RVU | 9(4)v99 | 13 – 18 | Relative Value Unit |
| 5-Non-Facility PE GPCI | 9v9(3) | 19 – 22 | Geographic Adjustment Factor |
| 6-Conversion Factor | 9(5)v99 | 23 – 29 | Conversion Factor |
| 7-Urban Mileage | 9(5)v99 | 30 – 36 | Urban payment rate or base rate mileage rate (determined by HCPCS) |
| 8-Rural Mileage | 9(5)v99 | 37 – 43 | Rural payment rate or base rate mileage rate (determined by HCPCS) |
| 9-Current Year | 9(04) | 44– 47 | YYYY |
| 10-Current Quarter | 9(01) | 48 | Calendar Quarter-value 1-4 |
| 11-Effective Date | 9(8) | 49– 56 | Effective date of fee schedule file |
| 12-Filler | X(24) | 57 - 80 | Future Use |