



Physician Services Version

KEY CONCEPTS OUTLINE

Module 5: Tools for Understanding and Predicting Medicare Reimbursement: Overview of the RBRVS

I. Background

- A. In 1992, Medicare replaced its charge-based payment system for professional services with a new payment system based on a national “physician fee schedule” (the “Fee Schedule”). The Fee Schedule is based on a resource-based relative value scale (“RBRVS”) which assigns each service included in the Fee Schedule a series of “relative values” based on the projected resources required to furnish the service. The Fee Schedule contains relative values for three resource components: physician work, practice expense and malpractice insurance.
- B. The actual fee schedule payment made for a particular service furnished in a particular area is based on the relative values assigned to the service, local “geographic practice cost indices” adjustment factors and a national “conversion factor.”

II. Payment Under the Physician Fee Schedule

A. Relative Value Units (RVUs) In General

1. Overview

- a. The RVUs assigned to each service reflect the relative value of the resources required to furnish the particular service as compared to the other services included in the fee schedule. <42 C.F.R. § 414.22 (a)>
 - (i) For example, a service that has a total relative value of 2.0 would require twice the resources of a service with a total relative value of 1.0.
- b. The total RVUs for each service included in the fee schedule is based on three different RVUs – the physician work RVU, the practice expense RVU, and the malpractice expense RVU.
- c. On average, for each service, the physician work RVU makes up about 52.5% of the total RVU, the practice expense RVU makes up about 43.6% of the RVU

and the malpractice expense RVU makes up about 3.9%. <42 C.F.R. § 414.22 (a)>

2. The Three RVUs

a. Physician Work RVUs ("Work")

(i) The "physician work" RVUs are intended to reflect the physician/practitioner work required to furnish a service. The physician work RVUs reflect:

- (a) the physician/practitioner's time,
- (b) the technical difficulty of the procedure,
- (c) the average severity of illness among patients receiving the procedure, and
- (d) the degree of physical and mental effort required to furnish the procedure. <42 C.F.R. 414.22(a); 69 Fed. Reg. 66,370>

(ii) Method of Determining Physician Work RVUs

(a) Most of the physician work RVUs were originally determined based on a study of physician work performed by a group of Harvard University researchers. <69 Fed. Reg. 66,370>

- (1) The physician work RVUs for radiology services were originally determined based on a relative value scale developed by the American College of Radiology. <42 C.F.R. 414.22(a)(2); 69 Fed. Reg. 66,370>
- (2) The physician work RVUs for anesthesiology services were based on relative values developed by the American Society of Anesthesiology. <42 C.F.R. 414.22(a)(2); 69 Fed. Reg. 66,370>

b. Practice Expense RVUs ("PE")

(i) The practice expense RVUs are intended to reflect the practice costs inherent in furnishing a service. <42 C.F.R. 414.22(b); 73 Fed. Reg. 69,730>

(ii) Method of Determining Practice Expense RVUs

- (a) The practice expense RVUs were originally determined based on CMS's analysis of two data sources – the Clinical Practice Expert Panel ("CPEP") data and the American Medical Association's Socioeconomic Monitoring System ("SMS") data. <73 Fed. Reg. 69,730>
- (b) A practice expense per hour (PE/HR) value was calculated using information from the Physician Practice Information Survey (PPIS) conducted by the American Medical Association. The PPIS is a multi-specialty, nationally representative, PE survey of both physicians and non-physician practitioners using a survey instrument. A four-year transition period, in which 2013 was the final year, was used in transitioning RVUs adjustments under this methodology. <77 Fed. Reg. 68,896>
- (c) The practice expense RVUs reflect both direct costs (e.g., clinical labor, medical supplies, medical equipment) and indirect costs (e.g., administrative labor, office expenses, etc.) <73 Fed. Reg. 69,730>

(iii) Facility versus Non-Facility Practice Expense RVUs

- (a) For most services, CMS has established two practice expense RVUs – a facility practice expense RVU and a non-facility practice expense RVU. The facility practice expense RVU applies when a service is furnished in a "facility" setting and the non-facility RVU applies when a service is furnished in a "non-facility" setting. <42 C.F.R. 414.22(b)(5)(i); Medicare Claims Processing Manual, Chapter 12 § 20.4.2>
 - (1) CMS sometimes refers to the payment difference between the facility and non-facility settings (based on the differences in the practice expense RVUs) as the "site of service" differential. <Medicare Claims Processing Manual, Chapter 12 § 20.4.2>
 - a. The site of service differential is discussed in more detail in the "Claims" module later in this course.

c. Malpractice Expense RVUs ("MP")

- (i) The malpractice expense RVUs are intended to reflect the malpractice costs inherent in furnishing a service. <42 C.F.R. 414.22(c); 73 Fed. Reg. 69,730>

(ii) Method of Determining Malpractice Expense RVUs

- (a) The malpractice expense RVUs are determined based on CMS's analysis of malpractice premium data for the various medical specialties. <73 Fed. Reg. 69,370>

B. Geographic Practice Cost Indices ("GPCIs")

1. Overview

- a. The GPCIs are numerical values that reflect relative differences in costs between geographic areas. There are separate GPCIs for each RVU component (i.e., physician work, practice expense and malpractice expense). <73 Fed. Reg. 69,740>
- (i) The GPCIs reflect cost differences in each locality as compared to national average costs. <73 Fed. Reg. 69,740>
- (a) For example, renting 1500 sq. ft. of medical office space in New York City is more expensive than renting 1500 sq. ft. of medical office space in Brookston, Indiana.
- b. GPCIs are reviewed and, if necessary, adjusted at least every three years. <73 Fed. Reg. 69,740>
- c. A permanent 1.0 work floor is applied to the Work GPCI for the frontier states only starting January 1, 2011. <77 Fed. Reg. 68,945>
- (i) The frontier states consist of Montana, Nevada, North Dakota, South Dakota, and Wyoming.
- d. Starting January 1, 2009, Alaska has a permanent Work GPCI floor of 1.5 applied. <73 Fed. Reg. 69,740>
- e. The Coronavirus Aid, Relief and Economic Security Act (CARES ACT), signed into law on March 27 extended the extends a provision raising the Work GPCI to 1.000 for all localities that currently have a Work GPCI of less than 1.000 through December 31, 2023, has expired.
- (i) The CY 2024 work GPCIs do not reflect the 1.0 work floor.
- (a) When reviewing the GPIC files in the PFS files, work GPCIs are listed for both CYs 2023 and 2024.

C. The Conversion Factor (CF)

1. The Conversion Factor is a national dollar amount used to convert the relative values into the Fee Schedule amounts.
2. The 2024 Medicare Physician Fee Schedule (PFS) Conversion Factors
 - a. From January 1 – March 8, 2024 - \$32.74
 - b. March 9 – December 31, 2024 - \$33.29
3. *Note: CMS published the updated CY 2024 physician fee schedule conversion factor, due to the 2024 Consolidated Appropriations Act which included a partial fix for the Medicare cuts imposed by the 2024 Medicare Physician Fee Schedule.*
4. There is a separate conversion factor for anesthesia services.
 - a. The national 2024 anesthesia conversion factor for dates of service from January 1 – March 8, 2024 - \$20.43 <88 Federal Register 79467 Table 117 >
 - b. The national 2024 anesthesia conversion factor for dates of service from March 8 – through December 31, 2024, is \$20.77
 - c. The anesthesia conversion factor is adjusted by locality.
 - d. For example, the 2021 anesthesia conversion factor in Chicago, Illinois is \$22.12. The national 2023 anesthesia conversion factor was \$22.32.
5. Budget Neutrality Adjustment
 - a. Changes to the fee schedule must be implemented in an environment of budget neutrality.
 - (i) CMS's definition of budget neutrality is met when adjustments in RVUs for a year do not cause total PFS payments to differ by more than \$20 million from what they would have been if the adjustments were not made. <73 Fed. Reg. 69,730>
 - (ii) If changes to the physician fee schedule are expected to exceed the \$20 million threshold, adjustments are made to the RVUs to preserve budget neutrality. <77 Fed. Reg. 69,344>
 - b. The 2023 budget neutrality adjustment

- (i) January 1 – March 8, 2024, is -2.20 percent. <88 *Fed. Reg.* 79467, Table 116>
- (ii) March 9 – December 31, 2024, is -2.18 percent <88 *Fed. Reg.* 79467, Table 116>

D. Fee Schedule Calculation

- 1. The participating Fee Schedule amount for a service is calculated based on the RVUs for the service, the applicable GPCIs for the area, and the conversion factor. <73 *Fed. Reg.* 69,731>
 - a. Fee Schedule Amount Formula
 - (i) See Attachment A
- 2. Special Rule for Anesthesia Services

E. In addition to the RVUs, GPCIs and anesthesia-specific conversion factor, the calculation of the Fee Schedule amount for anesthesia services takes in consideration anesthesia “time units.” <42 *C.F.R.* § 414.46(b)(1)>Allowable Amount; Coinsurance

- 1. For services payable under the Fee Schedule, the allowable is the lower of the charge or the fee schedule amount for the service. <Medicare Claims Processing Manual, Chapter 12 § 20>
 - a. For most services, Contractors pay 80% of the allowable after the deductible is met. <Medicare Claims Processing Manual, Chapter 12 § 20>
 - (i) The remaining 20% coinsurance is the beneficiary’s responsibility.

F. Deductibles

- 1. Medicare Part B Deductible – Full Coverage
 - a. Before payment is made under Medicare Part B for most (but not all) services, the beneficiary must meet his/her annual deductible. The annual Part B deductible is applied in the order in which the claims are processed by the Medicare program. <42 *C.F.R.* § 410.160; Medicare General Information, Eligibility and Entitlement Manual, Chapter 3 § 20.2>
 - (i) For 2024, the Part B deductible for full coverage is \$240 a year. <CMS Fact Sheet, 2024 Medicare Parts A & B Premiums and Deductibles>

- (ii) For 2023, the Part B deductible for full coverage is \$226 a year. <CMS Fact Sheet, 2024 Medicare Parts A & B Premiums and Deductibles>
- (iii) The full amount of the deductible is imposed regardless of when during the year the beneficiary enrolled in Part B (i.e., if a beneficiary is entitled to benefits for only half the year, s/he must still meet the full annual deductible amount). <42 C.F.R. § 410.160; Medicare General Information, Eligibility and Entitlement Manual, Chapter 3 § 20.2>

G. Premiums

1. Part B Full Coverage Premium

- a. Part B full coverage premium is based on beneficiary income parameters considering if it is a single or two-income household. <Medicare General Information, Eligibility and Entitlement Manual, Chapter 3 § 20.6>
- b. For 2024, the standard monthly premium is \$174.70 an increase of \$9.80 from \$164.90 in 2023. <CMS Fact Sheet, 2024 Medicare Parts A & B Premiums and Deductibles>
- c. A special rule called the “hold harmless provision” protects the Social Security benefit payment from decreasing due to an increase in the Medicare Part B premium.
 - (i) Individuals that do not qualify for the ‘hold harmless’ provision are those not collecting Social Security benefits, those who will enroll in Part B for the first time in 2024, dual eligible beneficiaries who have their premiums paid by Medicaid, and beneficiaries who pay an additional income-related premium. These beneficiaries have a standard premium of \$174.40, and a maximum premium of \$594.00.
- d. Medicare Part B Premium – Part B Immunosuppressive Drug Benefit
- e. The Consolidated Appropriations Act of 2021, amended section 1836(B) of the Social Security Act and added Limited Part B coverage for eligible individuals whose entitlement to Medicare based on End-Stage Renal Disease (ESRD) ends the 36th month after the month in which the individuals receive a successful kidney transplant. <Medicare Benefit Policy Manual, Chapter 15 § 50.5.1>
- f. The limited Part B premium is based on beneficiary income parameters considering if it is a single or two-income household.
 - (a) For 2024, the standard immunosuppressive drug premium is \$103.00.

III. The National Physician Fee Schedule Relative Value File (the "Relative Value File")

A. What is the Relative Value File?

1. The Relative Value File contains the Relative Value Units (RVUs) and certain "payment policy indicators" for each HCPCS code, including both HCPCS Level I codes (i.e., CPT codes) and HCPCS Level II codes. There is one record (i.e., line) in the Relative Value File for each HCPCS code.
 - a. CMS updates the Relative Value File on a quarterly basis. Typically, the updates are released for January 1, April 1, July 1, and October 1 of each year.

B. Key Fields < *Medicare Claims Processing Manual*, Chapter 23 Addendum, MPFSDB Record Layout >

1. Modifier

- a. For diagnostic tests, this field indicates whether CMS treats the test as divisible into separate professional and technical components (as discussed in the "Diagnostic Testing" module later in the course).
- b. For any other service, this field will either be blank or contain the -53 modifier.
 - (i) The -53 modifier indicates the relative values and payment policy indicators applicable when the code is furnished as a discontinued procedure.
 - (a) The only discontinued procedures recognized by the relative value file are three colonoscopy procedures. The Fee Schedule amount for any other discontinued procedure is determined by the carrier based on individual consideration.

2. Status Code

- a. Indicates whether the code is separately payable under the Fee Schedule if the service is covered. A description of each status code is set forth in the Medicare Claims Processing Manual, Chapter 23 § 30.2.2.
 - (i) A service that is not payable under the Fee Schedule (e.g., certain services with a status code of "E," "P," or "X") may still be payable under some other Medicare payment methodology.
- b. The status codes can often be used to determine if and how a particular service is payable under the Fee Schedule.

- c. The status code does not necessarily indicate national coverage policy. Rather, the status codes indicate how payment will be made by the Contractor **if the service is covered**. While there are some national coverage policies, CMS often leaves coverage decisions to the local Contractors.
3. Not Used for Medicare Payment Purposes
 - a. A "+" in this field indicates that the RVUs are not used for Medicare payment purposes.
 - (i) This field should be used in conjunction with the "status code" field.
 4. Work RVU
 - a. This field provides the physician work RVU for the service.
 5. Non-Facility Practice Expense RVU
 - a. This field provides the practice expense RVU for the service when furnished in a non-facility setting for the current year.
 6. Non-Facility NA Indicator
 - a. An "NA" in this field indicates that the service is rarely or never furnished by a physician/practitioner in a non-facility setting.
 7. Facility Practice Expense RVU
 - a. This field provides the practice expense RVU for the service when furnished in a facility setting for the current year.
 8. Facility NA Indicator
 - a. An "NA" in this field indicates that this service is rarely or never furnished by a physician/practitioner in a facility setting.
 - (i) Example
 - (a) 71046-TC (Chest x-ray, technical component) – the technical component of a chest x-ray performed in a hospital would typically be furnished by the hospital rather than a physician.
 9. Malpractice RVU
 - a. This field provides the malpractice expense RVU for the service.

10. Non-Facility Total

- a. This field provides the total RVUs for the service furnished in a non-facility setting.
 - (i) The total RVUs is determined by adding together the work, practice expense and malpractice expense RVUs.

11. Facility Total

- a. This field provides the total RVUs for the service furnished in a facility setting.

12. PC/TC Indicator

- a. This field indicates whether CMS treats the HCPCS code as divisible into separate professional and technical components (as discussed in the "Diagnostic Testing" module later in the course).
 - (i) There is some overlap between the information provided by this field and the information provided by the "modifier" field discussed above.

13. Global Days

- a. This field is discussed in the "Surgical Services" module later in the course.

14. Preoperative Percentage

- a. This field is discussed in the "Surgical Services" module later in the course.

15. Intraoperative Percentage

- a. This field is discussed in the "Surgical Services" module later in the course.

16. Postoperative Percentage

- a. This field is discussed in the "Surgical Services" module later in the course.

17. Multiple Procedures (Modifier -51)

- a. This field is discussed in the "Surgical Services" module later in the course.

18. Bilateral Surgery (Modifier -50)

- a. This field is discussed in the "Surgical Services" module later in the course.

19. Assistant at Surgery

a. This field is discussed in the "Surgical Services" module later in the course.

20. Co-Surgeons (Modifier -62)

a. This field is discussed in the "Surgical Services" module later in the course.

21. Team Surgery (Modifier -66)

a. This field is discussed in the "Surgical Services" module later in the course.

22. Endoscopic Base Code

a. This field is discussed in the "Surgical Services" module later in the course.

23. Conversion Factor

a. This is the national conversion factor.

24. Physician Supervision of Diagnostic Procedures

a. This field is used to indicate the level of physician supervision required for the service (as discussed in the "Diagnostic Testing" module later in the course).

25. Imaging Family

a. This field is discussed in the "Diagnostic Testing" module later in the course.

IV. Unusual Circumstances (Modifiers "-22" and "-52") Background

1. CPT contains two "unusual circumstances" modifiers.

a. Modifier -22 – Unusual Procedural Services

(i) This modifier is typically reported when a service requires an unusually high level of work effort or practice expense.

b. Modifier -52 – Reduced Services

(i) This modifier is typically reported when a service requires a reduced level of work effort or practice expense.

2. Medicare Payment for Services Reported with the Unusual Services Modifiers

a. CMS leaves payment adjustments for unusual services to the discretion of the Contractors. However, the Contractors are instructed not to increase or decrease payment except under "very unusual circumstances" based upon the

Contractor's review of medical records and other documentation. <Medicare Claims Processing Manual, Chapter 12 § 20.4.6>

Version 04/25/2024
Check for Updates

Attachment A

Fee Schedule Amount Formula

Fee Schedule Amount =

$$(\text{Work RVU} \times \text{Work GPCI}) + (\text{PE RVU} \times \text{PE GPCI}) + (\text{MP RVU} \times \text{MP GPCI})$$

x

Conversion Factor

Version 04/25/2024
Check for Updates

Intentionally

Blank

Version 04/26/2024
Check for Updates

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-01 Medicare General Information, Eligibility, and Entitlement	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12307	Date: October 19, 2023
	Change Request 13365

SUBJECT: Update to Medicare Deductible, Coinsurance and Premium Rates for Calendar Year (CY) 2024

I. SUMMARY OF CHANGES: The purpose of this recurring Change Request (CR) is to provide instructions for Medicare contractors to update the claims processing system with the new Calendar Year (CY) 2024 Medicare rates.

This recurring update notification applies to Chapter 3, Sections 10.3, 20.2 and 20.6 of the Medicare General Information, Eligibility, and Entitlement manual.

EFFECTIVE DATE: January 1, 2024

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: January 2, 2024

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	3/ 10.3/ Basis for Determining the Part A Coinsurance Amounts
R	3/ 20.2/ Part B Annual Deductible
R	3/ 20.6/ Part B Premium

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Attachment - Recurring Update Notification

Pub. 100-01	Transmittal: 12307	Date: October 19, 2023	Change Request: 13365
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SUBJECT: Update to Medicare Deductible, Coinsurance and Premium Rates for Calendar Year (CY) 2024

EFFECTIVE DATE: January 1, 2024

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: January 2, 2024

I. GENERAL INFORMATION

A. Background: Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements. A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital, for inpatient hospital services furnished in a spell of illness. When a beneficiary receives such services for more than 60 days during a spell of illness, he or she is responsible for a coinsurance amount equal to one-fourth of the inpatient hospital deductible per-day for the 61st - 90th day spent in the hospital. A beneficiary has 60 lifetime reserve days of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible. A beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of Skilled Nursing Facility (SNF) services furnished during a spell of illness.

Most individuals age 65 and older, and many disabled individuals under age 65, are insured for Health Insurance (HI) benefits without a premium payment. The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly premium. Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30 - 39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a 10 percent penalty is assessed for 2 years for every year they could have enrolled and failed to enroll in Part A.

Under Part B of the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. When Part B enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent 10 percent increase in the premium for each year the beneficiary could have enrolled and failed to enroll.

B. Policy: 2024 PART A - HOSPITAL INSURANCE (HI)

Part A Deductible

- \$1,632.00

Part A Coinsurance

- \$408.00 a day for 61st-90th day
- \$816.00 a day for 91st-150th day (lifetime reserve days)
- \$204.00 a day for 21st-100th day (Skilled Nursing Facility (SNF) coinsurance)

Part A Base Premium (BP)

- \$505.00 a month

Part A BP with 10% surcharge

- \$555.50 a month

Part A BP with 45% reduction

- \$278.00 a month (for those who have 30-39 quarters of coverage)

Part A BP with 45% reduction and 10% surcharge

- \$305.80 a month

2024 PART B - SUPPLEMENTARY MEDICAL INSURANCE (SMI)

Part B Standard Premium

- \$174.70 a month

Part B Deductible

- \$240.00 a year

Pro Rata Data Amount

- \$161.71 1st month
- \$78.29 2nd month

Coinsurance

- 20 percent

See Attachment A: “Income Parameters for Determining Part B Premium”

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13365.1	Contractors shall update the 2024 Medicare Part A inpatient deductible rate to \$1,632.00 per benefit period.	X				X			X	
13365.1.1	The CMS shall update the hospital inpatient limit to \$1,632.00 in the Outpatient Prospective Payment System	X				X				OPPS Pricer

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	(OPPS) Pricer. (This is used as a threshold amount for which the national coinsurance may not exceed).									
13365.2	Contractors shall update the 2024 Medicare Part A coinsurance rate to \$408.00 a day for days 61-90 in each period.	X				X			X	
13365.3	Contractors shall update the 2024 Medicare Part A coinsurance rate to \$816.00 a day for days 91-150 for each "Lifetime Reserve" day used.	X				X			X	
13365.4	Contractors shall update the 2024 Medicare Part A coinsurance to \$204.00 per day in a Skilled Nursing Facility for days 21-100 in each benefit period.	X				X			X	
13365.5	Contractors shall update the 2024 Medicare Part B deductible to \$240.00 per year.	X	X		X	X	X		X	
13365.6	The CWF shall make changes to incorporate the 2024 Pro-Rata Data amounts of \$161.71 for the 1st month and \$78.29 for the 2nd month.								X	
13365.7	Contractors shall update their Interactive Voice Response scripts with information provided in the above requirements (as applicable).	X	X		X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
13365.8	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the “MLN Connects” listserv to get MLN content notifications. You don’t need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.	X	X		X	

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

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

V. CONTACTS

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

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 1

Attachment A: Income Parameters for Determining Part B Premium

Listed below are the 2024 Part B monthly premium rates to be paid by beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow(er) with dependent child, or married filing separately who lived apart from their spouse for the entire taxable year) or a joint tax return.

Beneficiaries who file an individual tax return with income:	Beneficiaries who file a joint tax return with income:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to \$103,000	Less than or equal to \$206,000	\$0.00	\$174.70
Greater than \$103,000 and less than or equal to \$129,000	Greater than \$206,000 and less than or equal to \$258,000	69.90	244.60
Greater than \$129,000 and less than or equal to \$161,000	Greater than \$258,000 and less than or equal to \$322,000	174.70	349.40
Greater than \$161,000 and less than or equal to \$193,000	Greater than \$322,000 and less than or equal to \$386,000	279.50	454.20
Greater than \$193,000 and less than or equal to \$500,000	Greater than \$386,000 and less than or equal to \$750,000	384.30	559.00
Greater than or equal to \$500,000	Greater than or equal to \$750,000	419.30	594.00

In addition, the monthly premium rates to be paid by beneficiaries who are married and lived with their spouse at any time during the taxable year, but file a separate tax return from their spouse, are listed below.

Beneficiaries who are married and lived with their spouse at any time during the year, but file a separate tax return from their spouse:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to \$103,000	\$0.00	\$174.70
Greater than \$103,000 and less than \$397,000	384.30	559.00
Greater than or equal to \$397,000	419.30	594.00

Individual Income = Beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow(er) with dependent child, or married filing separately who lived apart from their spouse for the entire taxable year)

Joint Income (Married) = Beneficiaries who are married and lived with their spouse at any time during the taxable year, and also file a joint tax return.

Married filing Separate = Beneficiaries who are married and lived with their spouse at any time during the taxable year, but file a separate tax return from their spouse.

Medicare General Information, Eligibility, and Entitlement

Chapter 3 - Deductibles, Coinsurance Amounts, and Payment Limitations

10.3 - Basis for Determining the Part A Coinsurance Amounts

(Rev.12307; Issued: 10-19-23; Effective: 01-01-24; Implementation: 01-02-24)

The applicable inpatient deductible is the one in effect during the calendar year in which the patient's benefit period begins (i.e., in most cases, the year in which the first inpatient hospital services are furnished in the benefit period). Except for 1989, the coinsurance amount is based on the deductible applicable for the calendar year in which the coinsurance days occur.

When Deductible and/or Coinsurance Are Applicable for Part A

Inpatient Hospital- First 60 Days	Deductible applicable equal to national average cost per day
Inpatient Hospital- 61st thru 90th Day	Coinsurance per day always equal to 1/4 of inpatient hospital deductible
Inpatient Hospital- 60 Lifetime Reserve Days (nonrenewable) - 91st thru 150th day	Coinsurance always equal to 1/2 of inpatient hospital deductible
Skilled Nursing Facility 21st thru 100th Day	Coinsurance always equal to 1/8 of inpatient hospital deductible
Home Health Agency	No Deductible No Coinsurance (except for 20 percent coinsurance for DME and prosthetics/ orthotics)
Blood	1st 3 pints (or equivalent units of packed red blood cells) in a calendar year - combined Part A and B
Hospice * a. Drugs and Biologicals b. Respite Care	a. 5 percent of the cost determined by the drug copayment schedule (may not exceed \$5 per prescription) b. 5 percent of the payment for a respite care day

*Hospices may charge coinsurance for two services only, drugs and biologicals, and respite care. The amount of coinsurance for each prescription may not exceed \$5.00. The amount for respite care may not exceed the inpatient deductible for the year in which the hospital coinsurance period began.

Deductible and Coinsurance Amounts

Year	Part A Deductible, 1st 60 Days	Part A Coinsurance, 61st- 90th Days	Part A Coinsurance, 60 Lifetime Reserve Days	Part A SNF Coinsurance 21st- 100th Days
1986	\$492	123	246	61.50
1987	520	130	260	65.00
1988	540	135	270	67.50
1989	560	0 (1)	0 (1)	0(2)
1990	592	148	296	74.00

1991	628	157	314	78.50
1992	652	163	326	81.50
1993	676	169	338	84.50

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1994	696	174	348	87.00
1995	716	179	358	89.50
1996	736	184	368	92.00
1997	760	190	380	92.00
1998	764	191	382	95.50
1999	768	192	384	96.00
2000	776	194	388	97.00
2001	792	198	396	99.00
2002	812	203	406	101.50
2003	840	210	420	105.00
2004	876	219	438	109.50
2005	912	228	456	114.00
2006	952	238	476	119.00
2007	992	248	496	124.00
2008	1,024	256	512	128.00
2009	1,068	267	534	133.50
2010	1,100	275	550	137.50
2011	1,132	283	566	141.50
2012	1,156	289	578	144.50
2013	1,184	296	592	148.00
2014	1,216	304	608	152.00
2015	1,260	315	630	157.50
2016	1,288	322	644	161.00
2017	1,316	329	658	164.50
2018	1,340	335	670	167.50
2019	1,364	341	682	170.50
2020	1,408	352	704	176.00
2021	1,484	371	742	185.50
2022	1,556	389	778	194.50
2023	1,600	400	800	200.00
2024	1,632	408	816	204.00

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1. Coinsurance was not charged for inpatient hospital care in CY 1989 due to Catastrophic Coverage. The deductible was applied.

2. Under Catastrophic Coverage, a coinsurance payment of \$25.50 was due for days 1-8 of SNF care. No SNF coinsurance was due after day 8 in 1989.

20.2 - Part B Annual Deductible

(Rev.12307; Issued: 10-19-23; Effective: 01-01-24; Implementation: 01-02-24)

In each calendar year, a cash deductible must be satisfied before payment can be made under SMI. (See 20.4 of this chapter for exceptions.)

Calendar Year	Deductible
1966 – 1972	\$50
1973 – 1981	\$60
1982 – 1990	\$75
1991 – 2004	\$100
2005	\$110
2006	\$124
2007	\$131
2008	\$135
2009	\$135
2010	\$155
2011	\$162
2012	\$140

2013	\$147
2014	\$147
2015	\$147
2016	\$166
2017	\$183
2018	\$183
2019	\$185
2020	\$198
2021	\$203
2022	\$233
2023	\$226
<i>2024</i>	<i>\$240</i>

Expenses count toward the deductible on the basis of incurred, rather than paid expenses, and are based on Medicare allowed amounts. Non-covered expenses do not count toward the deductible. Even though an individual is not entitled to Part B benefits for the entire calendar year (i.e., insurance coverage begins after the first month of a year or the individual dies before the last month of the year), he or she is still subject to the full deductible for that year. Medical expenses incurred in the portion of the year preceding entitlement to medical insurance are not credited toward the deductible.

The date of service generally determines when expenses were incurred, but expenses are allocated to the deductible in the order in which the bills are received. Services not subject to the deductible cannot be used to satisfy the deductible.

Pro Rata Amounts

Pro Rata Amounts		
	First Month	Second Month
2012	\$100.20	\$39.80
2013	\$103.95	\$43.05
2014	\$114.99	\$32.01
2015	\$114.99	\$32.01
2016	\$118.86	\$47.14
2017	\$125.73	\$57.27
2018	\$126.88	\$56.12
2019	\$133.57	\$51.43
2020	\$140.46	\$57.54
2021	\$145.31	\$57.69
2022	\$150.66	\$82.34
2023	\$154.95	\$71.05
<i>2024</i>	<i>\$161.71</i>	<i>\$78.29</i>

The Part B deductible is split into pro rata amounts. The purpose of the pro rata amount is to provide beneficiaries who are enrolled in managed care plans the benefit of assuming they have paid their deductible as if they were not enrolled in a managed care plan. The pro rata amount does not apply only to just the first two months of the year but rather for the number of months after first enrollment in a managed care plan that is necessary to cover the Part B deductible. Each year starts the deduction for the pro rata amount over again.

20.6 – Part B Premium

(Rev.12307; Issued: 10-19-23; Effective: 01-01-24; Implementation: 01-02-24)

The Centers for Medicare and Medicaid Services (CMS) updates the Part B premium each year. These adjustments are made according to formulas set by statute. By law, the monthly Part B premium must be sufficient to cover 25 percent of the program's costs, including the costs of maintaining a reserve against unexpected spending increases. The federal government pays the remaining 75 percent.

Below are the annual Part B premium amounts from Calendar Year (CY) 1996 to 2006. For these years, and years prior to 1996, the Part B premium is a single established rate for all beneficiaries.

Year	Part B Premium
1996	\$42.50
1997	\$43.80
1998	\$43.80
1999	\$45.50
2000	\$45.50
2001	\$50.00
2002	\$54.00
2003	\$58.70
2004	\$66.60
2005	\$78.20
2006	\$88.50

Beginning on January 1, 2007, the Part B premium is based on the income of the beneficiary. See the following Change Requests (CRs) for more information.

For 2008, see CR 5345 at <http://www.cms.hhs.gov/transmittals/downloads/R41GI.pdf>

For 2008, see CR 5830 at <http://www.cms.hhs.gov/transmittals/downloads/R49GI.pdf>

For 2009, see CR 6258 at <http://www.cms.hhs.gov/transmittals/downloads/R56GI.pdf>

For 2010, see CR 6690 found on the "2009 Transmittals" page at <http://www.cms.hhs.gov/Transmittals/2009Trans/list.asp>

For 2011, see CR 7224 found on the "2010 Transmittals" page at <http://www.cms.gov/Transmittals/2010Trans/list.asp>

For 2012, see CR 7567 found on the "2011 Transmittals" page at <http://www.cms.gov/Transmittals/2011Trans/list.asp>

For 2013, see CR 8052 found on the "2012 Transmittals" page at <http://www.cms.gov/Transmittals/2012Trans/list.asp>

For 2014, see CR 8527 found on the "2013 Transmittals" page at <http://www.cms.gov/Transmittals/2013Trans/list.asp>

For 2015, see CR 8982 found on the "2014 Transmittals" page at <http://www.cms.gov/Transmittals/2014Trans/list.asp>

For 2016, see CR 9410 found on the "2015 Transmittals" page at <http://www.cms.gov/Transmittals/2015Trans/list.asp>

For 2017, see CR 9902 found on the "2016 Transmittals" page at <http://www.cms.gov/Transmittals/2016Trans/list.asp>

For 2018, see CR 10405 found on the "2017 Transmittals" page at <http://www.cms.gov/Transmittals/2017Trans/list.asp>

For 2019, see CR 11025 found on the "2018 Transmittals" page at <http://www.cms.gov/Transmittals/2018Trans/list.asp>

For 2020, see CR 11542 found on the "2019 Transmittals" page at <http://www.cms.gov/Transmittals/2019Trans/list.asp>

For 2021, see CR 12024 found on the "2020 Transmittals" page at <http://www.cms.gov/Transmittals/2020Trans/list.asp>

For 2022, see CR 12507 found on the "2021 Transmittals" page at <http://www.cms.gov/Transmittals/2021Trans/list.asp>

For 2023, see CR 12903 found on the "2022 Transmittals" page at <http://www.cms.gov/Transmittals/2022Trans/list.asp>

For 2024, see CR 13365 found on the "2023 Transmittals" page at <http://www.cms.gov/Transmittals/2023Trans/list.asp>

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 **50.5.1 - Immunosuppressive Drugs**

(Rev.11764, Issued: 12-22-2022; Effective: 01-01-2023; Implementation: 01-01-2023)

Until January 1, 1995, immunosuppressive drugs were covered under Part B for a period of one year following discharge from a hospital for a Medicare covered organ transplant. The CMS interpreted the 1-year period after the date of the transplant procedure to mean 365 days from the day on which an inpatient is discharged from the hospital. Beneficiaries are eligible to receive additional Part B coverage **within** 18 months after the discharge date for drugs furnished in 1995; **within** 24 months for drugs furnished in 1996; **within** 30 months for drugs furnished in 1997; and **within** 36 months for drugs furnished after 1997.

For immunosuppressive drugs furnished on or after December 21, 2000, this time limit for coverage is eliminated.

 The Consolidated Appropriations Act of 2021 amended section 1836(b) of the Social Security Act to add a new form of coverage that provides solely for coverage of immunosuppressive drugs beginning January 1, 2023, for eligible individuals whose entitlement to Medicare based on End-Stage Renal Disease (ESRD) ends the 36th month after the month in which the individuals receive a successful kidney transplant. This new benefit is referred to as the Part B immunosuppressive drug benefit or “Part B-ID.” Refer to Pub. 100-01, Chapter 2, Section 40.9 for more information on Part B-ID.

Covered drugs include those immunosuppressive drugs that have been specifically labeled as such and approved for marketing by the FDA. (This is an exception to the standing drug policy which permits coverage of FDA approved drugs for **nonlabeled** uses, where such uses are found to be reasonable and necessary in an individual case.)

Covered drugs also include those prescription drugs, such as prednisone, that are used in conjunction with immunosuppressive drugs as part of a therapeutic regimen reflected in FDA approved labeling for immunosuppressive drugs. Therefore, antibiotics, hypertensives, and other drugs that are not directly related to rejection are not covered.

The FDA has identified and approved for marketing the following specifically labeled immunosuppressive drugs. They are:

 Sandimmune (cyclosporine), Sandoz Pharmaceutical;
 Imuran (azathioprine), Burroughs Wellcome;
 Atgam (antithymocyte globulin), Upjohn;
 Orthoclone OKT3 (Muromonab-CD3), Ortho Pharmaceutical;
 Prograf (tacrolimus), Fujisawa USA, Inc;
 Celicept (mycophenolate mofetil, Roche Laboratories;
 Daclizumab (Zenapax);
 Cyclophosphamide (Cytosan);
 Prednisone; and
 Prednisolone.

The CMS expects contractors to keep informed of FDA additions to the list of the immunosuppressive drugs.

50.5.2 - Erythropoietin (EPO)

(Rev. 1, 10-01-03)

A3-3112.4.B.4, HO-230.4.B.4

The statute provides that EPO is covered for the treatment of anemia for patients with chronic renal failure who are on dialysis. Coverage is available regardless of whether the drug is administered by the patient or the patient’s caregiver. EPO is a biologically engineered protein which stimulates the bone marrow to make new red blood cells.

Medicare Claims Processing Manual Chapter 4

Excerpt

30.2 - MPFSDB Record Layout

(Rev. 4298, Issued: 05-03-19, Effective: 01-01-19, Implementation 10-07-19)

The CMS MPFSDB includes the total fee schedule amount, related component parts, and payment policy indicators. The record layout is provided in the Addendum below.



30.2.1 - Payment Concerns While Updating Codes

(Rev. 1, 10-01-03)

The following instructions apply in situations where the CMS CO does NOT provide pricing guidance via the Medicare Physician Fee Schedule Database (MPFSDB) for physicians' services.

If a new code appears, A/B MACs (B) make every effort to determine whether the procedure, drug or supply has a pricing history and profile. If there is a pricing history, map the new code to previous customary and prevailing charges or fee schedule amounts to ensure continuity of pricing.

Since there are different kinds of coding implosions and explosions, the way the principle is applied varies. For example, when the code for a single procedure is exploded into several codes for the components of that procedure, the total of the separate relative value unit or other charge screens established for the components must not be higher than the relative value units or other charge screens for the original service. However, when there is a single code that describes two or more distinct complete services (e.g., two different but related or similar surgical procedures), and separate codes are subsequently established for each, continue to apply the payment screens that applied to the single code to each of the services described by the new codes.

If there is no pricing history or coding implosion and explosion, A/B MACs (B) must make an individual consideration determination for pricing and payment of a covered service.

Conversely, when the codes for the components of a single service are combined in a single global code, A/B MACs (B) establish the payment screens for the new code by totaling the screens used for the components (i.e., use the total of the customary charges for the components as the customary charge for the global code; use the total of the prevailing charges for the components adjusted for multiple surgical rules if applicable as the prevailing charge for the global code, etc.). However, when the codes for several different services are imploded into a single code, A/B MACs (B) set the payment screens at the average (arithmetic mean), weighted by frequency, of the payment screens for the formerly separate codes.



30.2.2 - MPFSDB Status Indicators

(Rev. 4418, Issued: 10-18-19, Effective: 01-01-20 Implementation: 11-19-19)

A =	Active code. These codes are separately paid under the physician fee schedule if covered. There will be RVUs and payment amounts for codes with this status. The presence of an “A” indicator does not mean that Medicare has made a national coverage determination regarding the service; A/B MACs (B) remain responsible for coverage decisions in the absence of a national Medicare policy.
B =	Payment for covered services are always bundled into payment for other services not specified. There will be no RVUs or payment amounts for these codes and no separate payment is ever made. When these services are covered, payment for them is subsumed by the payment for the services to which they are incident (an example is a telephone call from a hospital nurse regarding care of a patient).
C =	A/B MACs (B) price the code. A/B MACs (B) will establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation such as an operative report.
D =*	Deleted/discontinued codes.
E =	Excluded from physician fee schedule by regulation. These codes are for items and/or services that CMS chose to exclude from the fee schedule payment by regulation. No RVUs or payment amounts are shown and no payment may be made under the fee schedule for these codes. Payment for them, when covered, continues under reasonable charge procedures.
F =	Deleted/discontinued codes. (Code not subject to a 90 day grace period.) These codes are deleted effective with the beginning of the year and are never subject to a grace period. This indicator is no longer effective beginning with the 2005 fee schedule as of January 1, 2005.
G =	Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. (Code subject to a 90 day grace period.) This indicator is no longer effective beginning with the 2005 fee schedule as of January 1, 2005.
H =*	Deleted modifier. For 2000 and later years, either the TC or PC component shown for the code has been deleted and the deleted component is shown in the data base with the H status.
I =	Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. (Code NOT subject to a 90 day grace period.)
J=	Anesthesia services (no relative value units or payment amounts for anesthesia codes on the database, only used to facilitate the identification of anesthesia services.)

L =	Local codes. A/B MACs (B) will apply this status to all local codes in effect on January 1, 1998 or subsequently approved by central office for use. A/B MACs (B) will complete the RVUs and payment amounts for these codes.
M=	Measurement codes, used for reporting purposes only.
N =	Non-covered service. These codes are carried on the HCPCS tape as noncovered services.
P =	Bundled/excluded codes. There are no RVUs and no payment amounts for these services. No separate payment is made for them under the fee schedule. If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident (an example is an elastic bandage furnished by a physician incident to a physician service). If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (for example, colostomy supplies) and is paid under the other payment provision of the Act.
Q =	Therapy functional information code (used for required reporting purposes only). This indicator is no longer effective beginning with the 2020 fee schedule as of January 1, 2020.
R =	Restricted coverage. Special coverage instructions apply.
T =	There are RVUs and payment amounts for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the physician services for which payment is made.
X =	Statutory exclusion. These codes represent an item or service that is not in the statutory definition of “physician services” for fee schedule payment purposes. No RVUs or payment amounts are shown for these codes and no payment may be made under the physician fee schedule. (Examples are ambulance services and clinical diagnostic laboratory services.)

*Codes with these indicators had a 90 day grace period before January 1, 2005

30.3 - Furnishing Pricing Files (Rev. 1, 10-01-03)

The CMS provides a schedule for activities related to furnishing these pricing files in advance each year. The CMS will provide the completed physician fee schedule, the Durable Medical Equipment and Prosthetics and Orthotics and Supplies (DMEPOS) fee schedules and clinical lab data to United Mine Workers and Indian Health Services. A/B

Medicare Claims Processing Manual -Chapter 23 Addendum

MPFSDB File Record Layout and Field Description

- a. If a single HCPCS code for an item is divided into two or more HCPCS codes for the components of that item, the sum of the single payment amounts for the new HCPCS codes will equal the single payment amount for the original item. In accordance with instructions provided in future recurring update notifications, the payment amounts for the HCPCS codes for the components will be established based on the corresponding fee schedule amounts for these codes that are established in accordance with section 60.3 of chapter 23 of the Claims Processing Manual. These amounts for the components of the item will then be adjusted by the same percentage to the level where the sum of the payment amounts for the HCPCS codes for the components equals the single payment amount for the item.
- b. If a single HCPCS code is divided into two or more separate HCPCS codes for different but similar items, the single payment amount for each of the new separate HCPCS codes is equal to the single payment amount applied to the original, single HCPCS code.
- c. If the HCPCS codes for components of an item are merged into a single HCPCS code for the item, the single payment amount for the new HCPCS code is equal to the total of the separate single payment amounts for the components.
- d. If multiple HCPCS codes for different but similar items are merged into a single HCPCS code, the items to which the new HCPCS codes apply may be furnished by any supplier that has a valid Medicare billing number. Payment for the new code will be based on the fee schedule methodology, even if single payment amounts were established for the discontinued multiple HCPCS codes. The old codes will be considered invalid and no longer included in the competitive bidding program for the remainder of the contract term.

Contract suppliers must furnish the item(s) described by the new HCPCS code(s) in scenarios (a) through (c) above and submit claims using the new codes. Notification of a competitive bidding HCPCS code change will occur through program instruction.

Addendum - MPFSDB File Record Layout and Field Descriptions

(Rev. 10356, Issued: 09-18-2020, Effective Date: 10-19-2020, Implementation Date: 10-19-2020)



The CMS MPFSDB includes the total fee schedule amount, related component parts, and payment policy indicators. The record layout is provided below. Beginning with the 2019 MPFSDB, and thereafter, the MPFSDB File Record Layout will no longer be revised annually in this section for the sole purpose of changing the calendar year, but will only be revised when there is a change to a field. Previous MPFSDB file layouts (for 2018 and prior) can be found on the CMS web site on the Physician Fee Schedule web page at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html>.

MPFSDB File Layout

HEADER RECORD

FIELD #	DATA ELEMENT NAME	LOCATION	PIC
1	Header ID	1-4	x(4) Value "Head"
2	Header Number	5	x(1)
3	Data Set Name	6-50	x(45)
4	Record Length	51-53	x(3)
5	Filler	54-54	x(1)
6	Block size	55-58	x(4)
7	Filler	59-59	x(1)
8	Number of Records Number does not include this header record.	60-69	9(10)
9	Date Created	70-77	x(8) YYYYMMDD
10	Blanks	78-345	x(268)

DATA RECORD

FIELD # & ITEM	LENGTH & PIC
1 File Year This field displays the effective year of the file.	4 Pic x(4)
2 A/B MAC (B) Number This field represents the 5-digit number assigned to the A/B MAC (B).	5 Pic x(5)
3 Locality This 2-digit code identifies the pricing locality used.	2 Pic x(2)
4 HCPCS Code This field represents the procedure code. Each A/B MAC (B) Current Procedural Terminology (CPT) code (other than codes for	5 Pic x(5)



FIELD # & ITEM	LENGTH & PIC
<p>Multianalyte Assays with Algorithmic Analyses (MAAA) and Proprietary Laboratory Analyses (PLA)) and alpha-numeric HCPCS codes other than B, C, E, K, L and U codes will be included. The standard sort for this field is blanks, alpha, and numeric in ascending order. Note: MAAA and PLA are alpha-numeric CPT codes.</p>	
<p>5 Modifier</p> <p>For diagnostic tests, a blank in this field denotes the global service and the following modifiers identify the components:</p> <p>26 = Professional component TC = Technical component</p> <p>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 through stoma code 44388, 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.</p> <p>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.</p>	2 Pic x(2)
<p>6 Descriptor</p> <p>This field will include a brief description of each procedure code.</p>	50 Pic x(50)
<p>7 Code Status</p> <p>This 1 position field provides the status of each code under the full fee schedule. Each status code is explained in §30.2.2.</p>	1 Pic x(1)
<p>8 Conversion Factor</p> <p>This field displays the multiplier which transforms relative values into payment amounts. The file will contain the conversion factor for the File Year which will reflect all adjustments.</p>	8 Pic 9(4)v9999
<p>9</p>	6 Pic 9(2)v9999



FIELD # & ITEM	LENGTH & PIC
<p>Update Factor This update factor has been included in the conversion factor in Field 8.</p>	
<p>10 Work Relative Value Unit This field displays the unit value for the physician work RVU.</p>	9 Pic 9(7)v99
<p>11 Filler</p>	9 Pic 9(7)v99
<p>12 Malpractice Relative Value Unit This field displays the unit value for the malpractice expense RVU.</p>	9 Pic 9(7)v99
<p>13 Work Geographic Practice Cost Indices (GPCIs) This field displays a work geographic adjustment factor used in computing the fee schedule amount.</p>	5 Pic 99v999
<p>14 Practice Expense GPCI This field displays a practice expense geographic adjustment factor used in computing the fee schedule amount.</p>	5 Pic 99v999
<p>15 Malpractice GPCI This field displays a malpractice expense geographic adjustment factor used in computing the fee schedule amount.</p>	5 Pic 99v999
<p>16 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.</p>	3 Pic x(3)

FIELD # & ITEM	LENGTH & PIC
<p>090 = Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule payment amount.</p> <p>MMM = Maternity codes; usual global period does not apply.</p> <p>XXX = Global concept does not apply.</p> <p>YYY = A/B MAC (B) determines whether global concept applies and establishes postoperative period, if appropriate, at time of pricing.</p> <p>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.)</p>	
<p>17</p> <p>Preoperative Percentage (Modifier 56)</p> <p>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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.</p>	6 Pic 9v9(5)
<p>18</p> <p>Intraoperative Percentage (Modifier 54)</p> <p>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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.</p>	6 Pic 9v9(5)
<p>19</p> <p>Postoperative Percentage (Modifier 55)</p> <p>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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.</p>	6 Pic 9v9(5)
<p>20</p> <p>Professional Component (PC)/Technical Component (TC) Indicator</p> <p>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.</p>	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
<p>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.</p> <p>The total RVUs for codes reported with a 26 modifier include values for physician work, practice expense, and malpractice expense.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>The total RVUs for technical component only codes include values for practice expense and malpractice expense only.</p> <p>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.</p>	

FIELD # & ITEM	LENGTH & PIC
<p>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.</p> <p>Payment may not be made by A/B MACs (B) 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.</p> <p>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.</p> <p>7 = Private practice therapist's service: Payment may not be made if the service is provided to either a hospital outpatient or a hospital inpatient by a physical therapist, occupational therapist, or speech-language pathologist in private practice.</p> <p>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.</p> <p>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.</p> <p>9 = Concept of a professional/technical component does not apply.</p>	
<p>21</p> <p>Multiple Procedure (Modifier 51)</p> <p>Indicator indicates which payment adjustment rule for multiple procedures applies to the service.</p> <p>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.</p> <p>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</p>	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
<p>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.</p> <p>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.</p> <p>3 = Special rules for multiple endoscopic procedures apply if procedure is billed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure). The base procedure for each code with this indicator is identified in field 31G. Apply the multiple endoscopy rules to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure).</p> <p>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.</p> <p>4 = Subject to 25% reduction of the TC diagnostic imaging (effective for services January 1, 2006 through June 30, 2010). Subject to 50% reduction of the TC diagnostic imaging (effective for services July 1, 2010 and after). Subject to 25% reduction of the PC of diagnostic imaging (effective for services January 1, 2012 through December 31, 2016). Subject to 5% reduction of the PC of diagnostic imaging (effective for services January 1, 2017 and after).</p> <p>5 = Subject to 20% reduction of the practice expense component for certain therapy services furnished in office and other non-institutional settings, and 25% reduction of the practice expense component for certain therapy services furnished in institutional settings (effective for services January 1, 2011 and after). Subject to 50% reduction of the practice expense component for certain therapy services furnished in both institutional and non-institutional settings (effective for services April 1, 2013 and after).</p> <p>6 = Subject to 25% reduction of the TC diagnostic cardiovascular services (effective for services January 1, 2013 and after).</p> <p>7 = Subject to 20% reduction of the TC diagnostic ophthalmology services (effective for services January 1, 2013 and after).</p>	

FIELD # & ITEM	LENGTH & PIC
9 = Concept does not apply.	
<p>22</p> <p>Bilateral Surgery Indicator (Modifier 50)</p> <p>This field provides an indicator for services subject to a payment adjustment.</p> <p>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.</p> <p>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).</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Example: The fee schedule amount for code YYYYYY is \$125. The physician reports code YYYYYY-LT with an actual charge of \$100 and YYYYYY-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).</p>	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
<p>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.</p> <p>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.</p> <p>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.</p> <p>9 = Concept does not apply.</p>	
<p>23</p> <p>Assistant at Surgery</p> <p>This field provides an indicator for services where an assistant at surgery is never paid for per IOM.</p> <p>0 = Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.</p> <p>1 = Statutory payment restriction for assistants at surgery applies to this procedure. Assistant at surgery may not be paid.</p> <p>2 = Payment restriction for assistants at surgery does not apply to this procedure. Assistant at surgery may be paid.</p> <p>9 = Concept does not apply.</p>	<p>1 Pic (x)1</p>
<p>24</p> <p>Co-Surgeons (Modifier 62)</p> <p>This field provides an indicator for services for which two surgeons, each in a different specialty, may be paid.</p> <p>0 = Co-surgeons not permitted for this procedure.</p> <p>1 = Co-surgeons could be paid; supporting documentation required to establish medical necessity of two surgeons for the procedure.</p> <p>2 = Co-surgeons permitted; no documentation required if two specialty requirements are met.</p> <p>9 = Concept does not apply.</p>	<p>1 Pic (x)1</p>

FIELD # & ITEM	LENGTH & PIC
<p>25 Team Surgeons (Modifier 66) This field provides an indicator for services for which team surgeons may be paid. 0 = Team surgeons not permitted for this procedure. 1 = Team surgeons could be paid; supporting documentation required to establish medical necessity of a team; pay by report. 2 = Team surgeons permitted; pay by report. 9 = Concept does not apply.</p>	<p>1 Pic (x)1</p>
<p>26 Filler</p>	<p>1 Pic (x)1</p>
<p>27 Site of Service Differential For 1999 and beyond, the site of service differential no longer applies. The following definitions will apply for all years after 1998: 0 = Facility pricing does not apply. 1 = Facility pricing applies. 9 = Concept does not apply.</p>	<p>1 Pic (x)1</p>
<p>28 Non-Facility Fee Schedule Amount This field shows the fee schedule amount for the non-facility setting. This amount equals Field 34. Note: Field 33 D indicates if an additional adjustment should be applied to this formula. Non-Facility Pricing Amount for the File Year [(Work RVU * Work GPCI) + (Non-Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor</p>	<p>9 Pic 9(7)v99</p>
<p>29 Facility Fee Schedule Amount This field shows the fee schedule amount for the facility setting. This amount equals Field 35. Note: Field 33D indicates if an additional adjustment should be applied to this formula. Facility Pricing Amount for the File Year [(Work RVU * Work GPCI) + (Facility PE RVU * PE GPCI) +</p>	<p>9 Pic 9(7)v99</p>

FIELD # & ITEM	LENGTH & PIC
<p>(MP RVU * MP GPCI)] * Conversion Factor</p> <p>Place of service codes to be used to identify facilities.</p> <p>02 – Telehealth-Medicare pays telehealth services at the facility rate.</p> <p>19 – Off Campus-Outpatient Hospital</p> <p>21 - Inpatient Hospital</p> <p>22 – On Campus-Outpatient Hospital</p> <p>23 - Emergency Room - Hospital</p> <p>24 - Ambulatory Surgical Center – In a Medicare approved ASC, for an approved procedure on the ASC list, Medicare pays the lower facility fee to physicians. Beginning with dates of service January 1, 2008, in a Medicare approved ASC, for procedures NOT on the ASC list of approved procedures, contractors will also pay the lower facility fee to physicians.</p> <p>26 - Military Treatment Facility</p> <p>31 - Skilled Nursing Facility</p> <p>34 - Hospice</p> <p>41 - Ambulance - Land</p> <p>42 - Ambulance Air or Water</p> <p>51 - Inpatient Psychiatric Facility</p> <p>52 - Psychiatric Facility Partial Hospitalization</p> <p>53 - Community Mental Health Center</p> <p>56 - Psychiatric Residential Treatment Facility</p> <p>61 - Comprehensive Inpatient Rehabilitation Facility</p>	
<p>29A</p> <p>Anti-markup Test Indicator</p> <p>This field provides an indicator for Anti-markup Test HCPCS codes:</p> <p>‘1’ = Anti-markup Test HCPCS.</p> <p>‘9’ = Concept does not apply.</p>	<p>1 Pic x</p>
<p>30</p> <p>Record Effective Date</p> <p>This field identifies the effective date for the MPFSDB record for each HCPCS. The field is in YYYYMMDD format.</p> <p>NOTE: This is not the date the HCPCS code was created. It is the date the code was updated or added to the MPFSDB file for the current file year. This field is set to January 1 for all codes during the annual update process.</p>	<p>8 Pic x(8)</p>

FIELD # & ITEM	LENGTH & PIC
31 Filler	28 Pic x(28)
31EE Reduced therapy fee schedule amount	9Pic(7)v99
31DD Filler	1Pic x(2)
31CC Imaging Cap Indicator A value of "1" means subject to OPPS payment cap determination. A value of "9" means not subject to OPPS payment cap determination.	1Pic x(1)
31BB Non-Facility Imaging Payment Amount	9Pic(7)v99
31AA Facility Imaging Payment Amount	9Pic(7)v99
31A Physician Supervision of Diagnostic Procedures This field is for use in post payment review. 01 = Procedure must be performed under the general supervision of a physician. 02 = Procedure must be performed under the direct supervision of a physician. 03 = Procedure must be performed under the personal supervision of a physician. (Diagnostic imaging procedures performed by a Registered Radiologist Assistant (RRA) who is certified and registered by The American Registry of Radiologic Technologists (ARRT) or a Radiology Practitioner Assistant (RPA) who is certified by the Certification Board for Radiology Practitioner Assistants (CBRPA), and is authorized to furnish the procedure under state law, may be performed under direct supervision.) 04 = Physician supervision policy does not apply when procedure is furnished by a qualified, independent psychologist or a clinical psychologist; otherwise must be performed under the general supervision of a physician.	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
<p>05 = Not subject to supervision when furnished personally by a qualified audiologist, physician or non physician practitioner. Direct supervision by a physician is required for those parts of the test that may be furnished by a qualified technician when appropriate to the circumstances of the test.</p> <p>06 = Procedure must be personally performed by a physician or a physical therapist (PT) who is certified by the American Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiological clinical specialist and is permitted to provide the procedure under State law. Procedure may also be performed by a PT with ABPTS certification without physician supervision.</p> <p>21 = Procedure may be performed by a technician with certification under general supervision of a physician; otherwise must be performed under direct supervision of a physician. Procedure may also be performed by a PT with ABPTS certification without physician supervision.</p> <p>22 = May be performed by a technician with on-line real-time contact with physician.</p> <p>66 = May be personally performed by a physician or by a physical therapist with ABPTS certification and certification in this specific procedure.</p> <p>6A = Supervision standards for level 66 apply; in addition, the PT with ABPTS certification may personally supervise another PT, but only the PT with ABPTS certification may bill.</p> <p>77 = Procedure must be performed by a PT with ABPTS certification (TC & PC) or by a PT without certification under direct supervision of a physician (TC & PC), or by a technician with certification under general supervision of a physician (TC only; PC always physician).</p> <p>7A = Supervision standards for level 77 apply; in addition, the PT with ABPTS certification may personally supervise another PT, but only the PT with ABPTS certification may bill.</p> <p>09 = Concept does not apply.</p>	
<p>31B This field has been deleted to allow for the expansion of field 31A.</p>	
<p>31C Facility Setting Practice Expense Relative Value Units</p>	9 Pic(7)v99
<p>31D Non-Facility Setting Practice Expense Relative Value Units</p>	9 Pic(7)v99
<p>31E Filler</p>	9 Pic(7)v99

FIELD # & ITEM	LENGTH & PIC
31F Filler Reserved for future use.	1 Pic x(1)
31G Endoscopic Base Codes This field identifies an endoscopic base code for each code with a multiple surgery indicator of 3.	5 Pic x(5)
32A 1996 Transition/Fee Schedule Amount This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
32B 1996 Transition/Fee Schedule This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
32C 1996 Transition/Fee Schedule Amount When Site or Service Differential Applies This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
33A Units Payment Rule Indicator Reserved for future use. 9 = Concept does not apply.	1 Pic x(1)
33B Mapping Indicator This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
33C Anti-markup Locality—Informational Use—Locality used for reporting utilization of anti-markup services. NOT FOR A/B MAC (B) USE: These Medicare Advantage encounter pricing localities are for Shared System Maintainer purposes only. The locality values were developed to facilitate centralized processing of encounter data by the Medicare Advantage organizations.	2 Pic x(2)
33D	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
<p>Calculation Flag</p> <p>This field is informational only; the SSMs do not need to add this field. The intent is to assist A/B MACs (B) to understand how the fee schedule amount in fields 28 and 29 are calculated. The MMA mandates an additional adjustment to selected HCPCS codes. A value of “1” indicates an additional fee schedule adjustment of 1.32 in 2004 and 1.03 in 2005. A value of “0” indicates no additional adjustment needed. A value of “2” indicates an additional fee schedule adjustment of 1.05 effective 7/1/2008.</p>	
<p>33 E</p> <p>Diagnostic Imaging Family Indicator</p> <p>For services effective January 1, 2011, and after, family indicators 01 - 11 will not be populated.</p> <p>01 = Family 1 Ultrasound (Chest/Abdomen/Pelvis – Non Obstetrical)</p> <p>02 = Family 2 CT and CTA (Chest/Thorax/Abd/Pelvis)</p> <p>03 = Family 3 CT and CTA (Head/Brain/Orbit/Maxillofacial/Neck)</p> <p>04 = Family 4 MRI and MRA (Chest/Abd/Pelvis)</p> <p>05 = Family 5 MRI and MRA (Head/Brain/Neck)</p> <p>06 = Family 6 MRI and MRA (spine)</p> <p>07 = Family 7 CT (spine)</p> <p>08 = Family 8 MRI and MRA (lower extremities)</p> <p>09 = Family 9 CT and CTA (lower extremities)</p> <p>10 = Family 10 Mr and MRI (upper extremities and joints)</p> <p>11 = Family 11 CT and CTA (upper extremities)</p> <p>88 = Subject to the reduction of the TC diagnostic imaging (effective for services January 1, 2011, and after). Subject to the reduction of the PC diagnostic imaging (effective for services January 1, 2012 and after).</p> <p>99 = Concept Does Not Apply</p>	<p>2Pic x(2)</p>
<p>33F</p> <p>Performance Payment Indicator</p> <p>(For future use)</p>	<p>1 Pic x (1)</p>
<p>33G</p> <p>National Level Future Expansion</p>	<p>3 Pic x (3)</p>
<p>34</p> <p>Non-Facility Fee Schedule Amount</p> <p>This field replicates field 28.</p>	<p>9 Pic 9(7)v99</p>
<p>35</p>	<p>9 Pic 9(7)v99</p>

FIELD # & ITEM	LENGTH & PIC
Facility Fee Schedule Amount This field replicates field 29.	
36 Filler	1 Pic x(1)
37 Future Local Level Expansion** The Updated 1992 Transition Amount was previously stored in this field. A/B MACs (B) can continue to maintain the updated transition amount in this field.	7 Pic x(7)
38A Future Local Level Expansion** The adjusted historical payment basis (AHPB) was previously stored in this field. A/B MACs (B) can continue to maintain the AHPB in this field.	7 Pic x(7)
38 B Filler This field was originally established for 15 spaces. Since AHPB data will only use 7 of the 15 spaces, A/B MACs (B) have 8 remaining spaces for their purposes. ** These fields will be appended by each A/B MAC (B) at the local level.	8 Pix x(8)

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 Check for Updates