

## 2009 Paper MPFSDB Layout

This appendix contains the RVUs and other information for each HCPCS code in level 1 (CPT) and level 2 (alpha-numeric HCPCS) except for alpha-numeric codes beginning with B (enteral and parenteral therapy), E (durable medical equipment), K or L (orthotics).

**HCPCS**--This is the CPT or level 2 HCPCS procedure code for the service.

**MOD (Modifier If One Applies)** --For diagnostic tests, a blank in this field denotes the global service and the following modifiers identify the components:

**26 = Professional component**

**TC = Technical component**

For services other than those with a professional and/or technical component, a blank will appear in this field with one exception: the presence of modifier CPT 53 indicates that separate RVUs and a fee schedule amount have been established for procedures which the physician terminated before completion.

**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. This modifier is used only with colonoscopy codes G0105, G0121 and 45378. Any other codes billed with modifier 53 are subject to carrier medical review and priced by individual consideration.

**PROC STAT (Status Code)**--This indicator provides the status of each code under the fee schedule.

- A** = **Active code.** These codes are separately paid under physician fee schedule if covered. There are RVUs for codes with this status. The presence of an "A" indicator does not mean that Medicare has made a national coverage determination regarding the service. The carrier is responsible for coverage decisions in the absence of a national Medicare policy.
- B** = **Bundled code.** Payment for covered services is always bundled into payment for other services not specified. There are no RVUs or payment amount for these codes and no separate payment is 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** = **Carriers price the code.** Carriers will establish payment amounts for these services, generally on an individual case basis following review of documentation such as an operative report.
- E** = **Excluded from physician fee schedule by regulation.** These codes are for items and/or services that CMS chose to exclude from 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, generally continues under reasonable charge methodology or other current payment rules.

- I** = **Not valid for Medicare purposes.** Medicare uses another code for reporting of, and payment for, these services.
- J** = **Anesthesia services.** (There are no relative value units or payment amounts for anesthesia codes on the database, only used to facilitate the identification of anesthesia services.)
- M** = **Measurement Codes.** These codes are used for reporting purposes only.
- N** = **Noncovered service.** These codes are 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 (e.g., colostomy supplies) and is paid under the other payment provisions of the Act.
- R** = **Restricted coverage.** Special coverage instructions apply.
- T** = There are RVUs and payment amounts for these services, but they are only paid when 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 service(s) 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. When they are covered, payment continues under the current payment methodology. (Examples are ambulance services and clinical diagnostic laboratory services)

**DESCRIPTION**--This is a short narrative description of the code.

**RVU WRK**--This is the relative value unit (RVU) for the physician work in the service.

**TRANS NONFAC PE**--This field displays the resource-based practice expense RVUs for non-facility settings.

**FULL NONFAC PE**--This field displays the fully implemented resource-based practice expense RVUs for non-facility settings.

**TRANS FAC PE** --This field displays the resource-based practice expense RVUs for facility settings.

**FULL FAC PE** --This field displays the fully implemented resource-based practice expense RVUs for facility settings.

**RVU MP**--This is the RVU for the malpractice expense for the service.

**PC/TC (Professional Component/Technical Component)**--This field indicates if the service is professional or technical in nature. Indicators in this column identify technical component (TC) and professional component (PC) for these services, among other things. An explanation of the indicators follows.

- 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 and TC may not be used with these codes.
- 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 may be used with these codes.
- 2** = **Professional component only.** This indicator identifies stand alone codes that describe the physician work portion of selected diagnostic tests for which there is an associated code that describes the technical component of the diagnostic test only and another associated code that describes the global test. An example of a professional component only code is 93010, Electrocardiogram; interpretation and report. Modifiers 26 and TC cannot be used with these codes.
- 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 test only. An example of a technical component only 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.
- 4** = **Global test only codes.** This indicator identifies stand-alone codes that describe selected diagnostic tests for which there are associated codes that describe either the professional component of the test only or the technical component of the test only. Modifiers 26 and TC cannot be used with these codes.
- 5** = **"Incident to" codes.** This indicator identifies codes that describe services covered incident to a physician's service when they are provided by auxiliary personnel employed by the physician and working under his or her direct supervision. No payment may be made for these services when they are provided to hospital inpatients or outpatients. Modifiers 26 and TC cannot be used with these codes.

- 6** = **Laboratory physician interpretation codes.** This indicator identifies clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made. Actual performance of the tests is paid for under the lab fee schedule. Modifier 26 will always appear with these codes. Modifier TC may not be used with these codes.
- 7** = **Physical therapy services codes.** This indicator identifies physical therapy codes for which payment may not be made if the services are provided to hospital inpatients or hospital outpatients by an independently practicing physical or occupational therapist.
- 8** = **Physician interpretation codes.** This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for hospital inpatient. This applies to code 85060. No TC billing is recognized because payment for the underlying clinical laboratory test is made to the hospital, generally through the PPS rate. No payment is recognized for code 85060 furnished to hospital outpatients or non-hospital patients. The physician interpretation is paid through the clinical laboratory fee schedule payment for the clinical laboratory test.
- 9** = **Concept of a professional/technical component does not apply.**

**SOS (Site of Service Differential).**—For 1999 and beyond, the site of service differential no longer applies. The following definitions will apply to this field for 1999 and after.

- 9** = **Facility pricing does not apply.**
- 1** = **Facility pricing applies.**

Place of service codes to be used to identify facilities:

- 21 - Inpatient Hospital
- 22 - Outpatient Hospital
- 23 - Emergency Room - Hospital
- 24 - Ambulatory Surgical Center – *(beginning in 2009 for dates of service 1/1/08 and after, the facility fee applies regardless of whether the code is on an ASC approved list).*
- 26 - Military Treatment Facility
- 31 - Skilled Nursing Facility
- 34 - Hospice
- 41 - Ambulance
- 42 - Ambulance Air or Water
- 51 - Inpatient Psychiatric Facility
- 52 - Psychiatric Facility Partial Hospitalization
- 53 - Community Mental Health Center
- 56 - Psychiatric Residential Treatment Facility
- 61 - Comprehensive Inpatient Rehabilitation Facility

**GLOB (Global Fee Period).**--This indicator 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 pre-op and post-op relative values on the day of the procedure only included in the fee schedule payment amount; E & M services on the day of the procedure generally not payable.**
- 010 = minor procedure with pre-op relative values on the day of the procedure and post-op relative values during a 10 day post-op period included in the fee schedule amount; E & M services on the day of the procedure and during the 10-day post-op period generally not payable.**
- 090 = major surgery with a 1-day pre-op period and 90-day post-op period included in the fee schedule payment amount.**
- MMM = maternity codes; usual global period does not apply.**
- XXX = The global concept does not apply to the code.**
- YYY = The global period is set by the carrier at the time of pricing (e.g., unlisted surgery codes).**
- ZZZ = The code is related to another service and is always included in the global period of the other service.**

**PRE OP (Preoperative Care).**--This field shows the percentage for the preoperative portion of the global package.

**INTRA OP (Intraoperative Care).**--This field shows the percentage for the intraoperative portion of the global package.

**POST OP (Postoperative Care).**--This field shows the percentage for the postoperative portion of the global package.

**MULT SURG (Multiple Surgery).**-- This indicator shows which payment adjustment rule for multiple procedures applies to the service. They are as follows:

- 0 = Payment adjustment rules for multiple procedures do not apply.** If procedure is reported on the same day as another procedure, payment is based on the lower of: (a) the actual charge or (b) the fee schedule amount for the procedure.
- 2 = Standard payment adjustment rules for multiple procedures apply.** If a procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, the procedures are ranked by fee schedule amount and the appropriate reduction is applied to the code (100%, 50%, 50%, 50%, 50% and by report). Payment is based on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage
- 3 = The special rule for multiple endoscopic procedures applies if this service is billed with another endoscopy in the same family.** The base procedure for each code with this indicator is identified in the ENDO BASE field. If an endoscopic procedure is reported with only its base procedure, carriers do not pay separately for

the base procedure. Payment for the base procedure is included in the payment for the other endoscopy.

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).

- 4 = **Services subject to the 25% reduction of the TC diagnostic imaging reduction.**  
(see CMS CR5141)
- 9 = **Concept does not apply.**

**BILT SURG (Bilateral Surgery).**--This field identifies services subject to a payment adjustment.

- 0 = **Payment adjustment for bilateral procedures does not apply.** Bilateral modifier is inappropriate for reasons such as (a) physiology or anatomy; (b) code descriptor specifically states it is a unilateral procedure and there is an existing code for the bilateral procedure.
- 1 = **Payment adjustment applies for bilateral procedures** (payment is based on the lower of: (a) the total actual charge for both sides or (b) 150% of the fee schedule amount for a single code.
- 2 = **Payment adjustment does not apply.** The RVUs are already based on a bilateral procedure because: (a) code descriptor states that the procedure is bilateral; (b) code descriptor states the procedure may be performed either unilaterally or bilaterally; (c) the procedure is usually performed as a bilateral procedure.
- 3 = **Usual payment adjustment for bilateral procedures does not apply.** Services in this category are generally radiology or other diagnostic tests, which are not subject to the special payment rules for other bilateral procedures.
- 9 = **Concept does not apply.**

**ASST SURG (Assistant at Surgery).**--This indicator identifies services for which an assistant at surgery is never paid per MCM.

- 0 = **Payment restriction for assistants at surgery applies unless medical necessity is established with documentation.**
- 1 = **Statutory payment restriction for assistant at surgery applies to this procedure. Assistant at surgery may not be paid.**
- 2 = **Payment restriction does not apply to this procedure. Assistant at surgery may be paid.**
- 9 = **Concept does not apply.**

**CO SURG (Co-Surgeons)**--This indicator identifies services for which two surgeons, each in a different specialty, may be paid.

- 0 = Co-surgeons not permitted for this procedure.**
- 1 = Co-surgeons may be paid if supporting documentation is supplied to establish medical necessity.**
- 2 = Co-surgeons permitted. No documentation is required if two-specialty requirement is met.**
- 9 = Concept does not apply.**

**TEAM SURG (Team Surgeons)**--This indicator identifies services for which team surgeons may be paid.

- 0 = Team surgeons not permitted for this procedure.**
- 1 = Team surgeons may 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.**

**ENDO BASE**--This field provides the base endoscopy code for each code with a multiple surgery indicator of 3.

**DIAG SUPV (Physician Supervision of Diagnostic Procedures)**-- This field is for informational use only for 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.**
- 04 = Physician supervision policy does not apply when procedure personally furnished by a qualified, independent psychologist or a clinical psychologist; otherwise must be performed under the general supervision of a physician.**
- 05 = Physician supervision policy does not apply when procedure is furnished by a qualified audiologist; otherwise must be performed under the general supervision of a physician.**
- 06 = Procedure must be performed by a physician or a physical therapist who is certified by the American Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiologic clinical specialist and is permitted to provide the procedure under State law.**

- 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.
- 22 = May be performed by a technician with on-line real-time contact with physician.
- 66 = May be performed by a physician or by a physical therapist with ABPTS certification and certification in this specific procedure.
- 6A = Supervision standards for level 66 apply; in addition, the PT with ABPTS certification may supervise another PT, but only the PT with ABPTS certification may bill.
- 77 = Procedure must be performed by a PT with ABTS certification or by a PT without certification under direct supervision of a physician, or by a technician with certification under general supervision of a physician.
- 7A = Supervision standards for level 77 apply; in addition, the PT with ABPTS certification may supervise another PT, but only the PT with ABPTS certification may bill.
- 09 = Concept does not apply.

**NON FAC PE FOR OPPTS CAP**—Non-facility practice expense RVU’s used to calculate the OPPTS payment cap.

**FACPE FOR OPPTS CAP**—Facility practice expense RVU’s used to calculate the OPPTS payment cap.

**MP FOR OPPTS CAP**—Malpractice practice expense RVU’s used to calculate the OPPTS payment cap.