

How to Use the MPFS Look-Up Tool



[Physician Fee Schedule Look-Up Tool overview](#)

What's Changed?

- Added verbiage for Short Description display in MPFS Look-Up Tool on page 10 and 15
- Added 2021 MPFS figures on pages 6, 7, 8, 18, 19 and 22
- Added new screenshots with instructions for the updated MPFS Look-Up Tool on pages 7, 9, 10, 11, 12, 13, 14, 16, 17, 18, 20, 21 and 22

You'll find substantive content updates in dark red font.

To Learn More...

If you find this How to booklet helpful, then you may wish to review the other booklets in this series. To locate these booklets, go to the [MLN Publications](#) webpage and search for items containing the words "how to."

Introduction

This booklet will help providers and suppliers understand the Medicare Physician Fee Schedule (MPFS) Look-Up Tool. You'll learn:

- How to search pricing amounts
- Payment policy Indicators
- Relative Value Units (RVUs)
- Geographic Practice
- Cost Indices (GPCIs)
- How to search for the: National payment amount
- A specific Medicare Administrative
- Contractor (MAC)
- Specific MAC locality

What is the MPFS Look-Up Tool?

The CMS MPFS Look-Up Tool provides Medicare payment information on more than 10,000 services, including:

- Pricing
- Associated Relative Value Units (RVUs),
- Payment policies

Why Would a Health Care Professional, Supplier, or Provider Use the MPFS Look-Up Tool?

The MPFS is the primary method of payment for enrolled health care professionals. Specifically, Medicare uses the MPFS when paying the following services:

- Professional services of physicians and other enrolled health care professionals in private practice
- Services covered incident to physicians' services (other than certain drugs covered as incident to services)
- Diagnostic tests (other than clinical laboratory tests)
- Radiology services

Medicare also pays suppliers like Mammography Centers according to the MPFS. Medicare pays Institutional providers like hospitals, Comprehensive Outpatient Rehabilitation Facilities (CORFs), and Skilled Nursing Facilities (SNFs) for some services under the MPFS, depending on the institution type and service. For example, Medicare pays hospital outpatient departments for screening mammographies, and outpatient rehabilitation services, under the MPFS.

The MPFS Look-Up Tool helps health care professionals, suppliers, and institutional providers find Medicare payment amounts for each code so they can calculate the beneficiary coinsurance amount. The MPFS gives the limiting charge for nonparticipating health care professionals and suppliers who treat Medicare beneficiaries.

The MPFS is an excellent way to learn if HCPCS codes are affected by payment policies like:

- Payment of assistant at surgery services
- Applicability of certain modifiers
- Physician supervision of diagnostic services

Participating Health Care Professionals and Suppliers enrolled in Medicare and signed the Form CMS-460, Medicare Participating Physician or Supplier Agreement, agreeing to charge no more than Medicare-approved amounts and deductibles and coinsurance amounts. Participating professionals and suppliers submit assigned claims.

Health professionals, suppliers and providers submit **Assigned Claims** on behalf of the beneficiary. Medicare issues payment to the submitter.

Nonparticipating Health Care Professionals and Suppliers enrolled in Medicare but decided not to sign the Form CMS-460. They accept assignment on a case-by-case basis. For services paid under the MPFS, Medicare reduces (5%) the Medicare-approved amounts for nonparticipants. Also, Medicare limits what the health care professional or supplier may charge the beneficiary (Limiting Charge) when they choose not to accept assignment on the claim.

Limiting Charge equals 115% of the nonparticipating fee schedule amount and is the maximum the nonparticipant may charge a beneficiary on an unassigned claim. The nonparticipating fee schedule amount is equal to 95% of the Medicare Physician Fee Schedule.

Nonparticipating health care professionals or suppliers not accepting assignment on the claim submit **Unassigned Claims**. Medicare issues payment to the beneficiary. Use the MPFS Look-Up Tool to learn if payment policies such as payment of assistant at surgery services, applicability of certain modifiers, and physician supervision of diagnostic services affect HCPCS codes.

Helpful Hint

Print out the MPFS Quick Reference Search Guide on page 27 of this booklet for a step-by-step summary of how to use the MPFS Look-Up Tool.

Helpful Hint

- Find additional information about these and other payment policies in the CMS Internet-Only Manuals (IOMs)
- Search the [National Correct Coding Initiative \(NCCI\) Edits](#) webpage to identify NCCI code pair edits and Medically Unlikely Edits (MUEs)
- Search the [Medicare Coverage Database \(MCD\)](#) to review national and local coverage determinations
- Visit the [Medicare Learning Network® \(MLN\) Publications](#) webpage to review other booklets in the How to series:
 - How to Use the Medicare National Correct Coding Initiative (NCCI) Tools
 - How to Use the Medicare Coverage Database

Background

Medicare Part B pays for physician services based on the Medicare PFS, which lists the more than 7,000 unique codes and their payment rates. Physicians' services include:

- Office visits
- Surgical procedures
- Anesthesia services
- A range of other diagnostic and therapeutic services

Physicians provide services in all settings, including:

- Physicians' offices
- Hospitals
- Ambulatory Surgical Centers
- Skilled Nursing Facilities and other post-acute care settings
- Hospices
- Outpatient dialysis facilities
- Clinical laboratories
- Beneficiaries' homes

MPFS Payment Rates

The MPFS payment rates formula shows how a payment rate for an individual service is determined, there's a description for each component below the formula.

Medicare PFS Payment Rates Formula

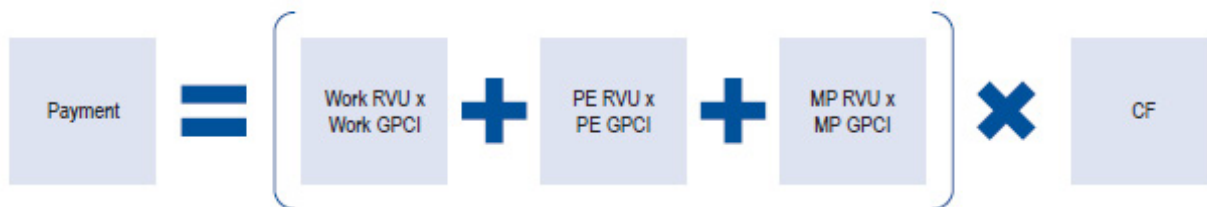


Figure 1: Arithmetic graphic of components added and multiplied together to make up the PFS payment rate

1) Relative Value Units (RVUs)

The MPFS uses 3 separate RVUs to calculate a payment:

1. **The Work RVU** reflects the relative time and intensity associated with furnishing a Medicare PFS service
2. **The Practice Expense (PE) RVU** reflects the costs of maintaining a practice (such as renting office space, buying supplies and equipment, and staff costs)
3. **The Malpractice (MP) RVU** reflects the costs of malpractice insurance

2) Geographic Practice Cost Indices (GPCIs)

Medicare adjusts each of the 3 RVUs to account for geographic variations in the costs of practicing medicine in different areas of the country. Each kind of RVU component has a corresponding GPCI adjustment.

3) Conversion Factor (CF)

To determine the payment rate for a service, CMS systems multiply the sum of the geographically adjusted RVUs by a CF in dollars. The statute specifies the formula by which the CF is updated on an annual basis.

QPP

Effective January 1, 2017, the Medicare Access and CHIP Reauthorization Act of 2015 repealed the previous formula to update the Medicare PFS and replaced it with several years of increases to overall payments for PFS services. In conjunction with that change, the law created the QPP, which rewards the delivery of high-quality and cost-efficient beneficiary care.

You may choose from these tracks:

- Advanced Alternative Payment Models to earn an incentive payment for participation.
- The Merit-based Incentive Payment System to earn a performance-based adjustment to your Medicare payment. It consolidates the components of the Physician Quality Reporting System (PQRS), Physician Value-based Payment (VBP) Modifier, and Medicare Electronic Health Record (EHR) Incentive Program for Eligible Professionals.

Medicare uses a fee schedule (a complete listing of fees) to pay doctors or other providers and suppliers to pay physicians, other enrolled health care professionals, or providers and suppliers on a Fee-For-Service (FFS) basis. Medicare bases payment on whichever is less, the charge or MPFS amount. In addition to the MPFS, CMS develops fee schedules for ambulance services, clinical laboratory services, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS).

For most codes, Medicare pays 80% of the amount listed and the beneficiary is responsible for 20%. Examples of reductions from the published MPFS amount include:

- Assistants at surgery get 16% of the MPFS rate
- Medicare pays nurse practitioners, physician assistants, and clinical nurse specialists 85%
- Medicare pays registered dietitians or nutrition professionals for medical nutrition therapy services 85%
- Clinical social workers get 75%

Helpful Hint

Refer to IOM Publication (Pub.) 100-04, Medicare Claims Processing Manual, [Chapter 12](#), Sections 110.2, 120 for more information.

How Up to Date is the MPFS?

CMS updates the MPFS quarterly. The PFS Update Status on the [MPFS Overview page](#) shows the date of the latest update.

Searching the MPFS

The Overview page of the [MPFS Look-Up Tool](#) takes the user through the selection steps prior to displaying the information, so the user can customize searches of:

- Pricing amounts
- Various payment policy indicators
- Relative Value Units (RVUs)
- Geographic Practice Cost Indices (GPCIs)

To begin a search from the Overview page of the MPFS Look-Up Tool:

- Click on the Begin Search button
- Accept to indicate you have read and agree to the License for Use of Current Procedural Terminology, Fourth Edition (CPT®).

The Search the Physician Fee Schedule screen will appear. A portion of this screen is shown in [Figure 2](#).

To begin your search, select the following criteria:

Figure 2: Search Criteria

1 Choose the year from the dropdown menu.

2 Then, select the Type of Information for the search from the following choices:

- **Pricing Information** - Search the maximum fee schedule amount by HCPCS code.
- **Payment Policy Indicators** - This option gives information such as global surgery days, multiple surgery indicators, and applicability of professional and technical components.
- **Relative Value Units (RVUs)** - For those interested in how the MPFS tool calculates the payment amount, this option gives RVU information for work, practice expense, and malpractice costs.
- **Geographic Practice Cost Index (GPCI)** - A GPCI has been established for every Medicare payment locality for each of the 3 components of a procedure's RVU.
- **All** - This option gives data for each of the above types of information.

The remaining search parameters and criteria options displayed, vary based on the Type of Information selected for the search. We will display the next steps of this search performing a Pricing Information Search and review the other choices of searches.

Helpful Hint

If you are only interested in 1 of the above choices, there is a minor downside to choosing All. If you choose to print the results, you'll print more than what you need and will spend a little more time arranging the printing. Also, if you select 1 of the choices and then change your mind, you can easily switch from viewing only the default columns to all columns once your search results appear.

Pricing Information Search

- 1 Select Pricing Information for the Type of Information.
- 2 Select 1 of the following **HCPCS Criteria** choices:
 - **Single HCPCS Code**
 - Enter 1 procedure code
 - **List of HCPCS Codes**
 - Enter up to 5 codes
 - **Range of HCPCS Codes**
 - Enter a starting and ending procedure code to define the range

Figure 3: Pricing Information Search

- 3 Select 1 of the following choices for the Medicare Administrative Contractor (MAC) criteria:
 - **National Payment Amount**

This option searches for information for only the national payment amount. The national payment amount is designated with a MAC locality code of 0000000.
 - **Specific MAC**

Providers use a MAC locality code to search for information indicating a specific geographic area. If you choose this option, select an area from the dropdown menu at the bottom of the page.

Some of these areas, such as 01112, have multiple listings. To learn what these numbers represent, reset the search to Specific Locality.

- **Specific Locality**

This search allows you to drill down to specific cities (for example, 0111205 - San Francisco) if payment varies within a MAC for specific localities. Notice the number for San Francisco starts with the Northern California number followed with a 05.

- **All MACs**

This option searches for information for the entire nation. The results include the national payment amount, and all MAC localities. This option is helpful for states with multiple payment localities because it groups all localities together for a MAC. Medicare payment may vary within 1 MAC. However, this option doesn't give locality names. You must know the MAC locality codes, such as those given in the Specific Locality option.

Figure 4: Pricing Information Search

4 Enter the HCPCS code(s) for the search.

5 Select 1 of the following Modifier options from the dropdown menu:

- Global (Diagnostic Service) OR Physicians Professional Service where the Professional or Technical concept doesn't apply
- 26 Professional Component
- 53 Procedures which the physician terminated before completion
- TC Technical Component
- All Modifiers

5

Figure 5: Pricing Information Search

Click Search fees after you select the criteria to begin your Pricing search.

Helpful Hint

The MPFS includes Level I CPT and Level II HCPCS codes.

Helpful Hint

MACs have more than 1 of these locality codes. For example, the JE MAC includes 01182-Southern California; 01112-Northern California; 01212-Hawaii, Guam, American Samoa, and the Northern Mariana Islands; and 01312-Nevada.

Helpful Hint

Providers who are uncertain as to which modifier to choose can select All Modifiers. All means all of those modifiers listed above, not all modifiers in the AMA or HCPCS code books.

Pricing Search Using a List of Evaluation and Management Codes

To demonstrate the type of information found in a pricing search, this booklet first gives an example of a pricing search using a list of Evaluation and Management (E/M) codes and then shows how the results vary when performing a search using a code with a professional or technical component.

Figure 5 shows the top portion of the Search Results page after selecting or inputting the following information in this order:

- 2021 Pricing Information
- List of HCPCS Codes
- 11202 South Carolina as the Specific MAC
- 99214 and 99215 as a list of HCPCS Codes
- All Modifiers

See the results from our selections below. The PFS search gives a brief descriptor of each code under the Short Description column.

Helpful Hint

If you wish to change the search criteria, type in a new code or other factor at the top of the page and then click on Search fees. To download, or copy the link for your search results, select 1 of these options below the Search Results table.

In **Figures 6-1** and **6-2**, let's review the pricing information given starting with the column on the left and moving towards the right:

1 HCPCS Code ▲	2 Modifier ▲	3 Short Description ⇅	4 Proc Stat ▲	5 Mac Locality ▲	6 Non-Facility Price ⇅	7 Facility Price ⇅	8 Non-Facility Limiting Charge
99214		Office o/p est mod 30-39 min	A	1120201	\$123.95	\$96.23	\$135.42
99215		Office o/p est hi 40-54 min	A	1120201	\$173.37	\$141.55	\$189.41

Figure 6-1: Pricing Search Results for List of E/M Codes

- 1 **HCPCS Code** – The MPFS Look-Up Tool displays 99214 and 99215 on separate rows with the pricing information displayed to the right.
- 2 **Modifier** - There is nothing displayed in this column. This field stays blank for services other than those codes with a professional or technical component (or both), with 1 exception: when CPT modifier 53 is allowed, it will appear.
- 3 **Short Description** – This column displays an abbreviated description of the code and time a physician would spend during an exam.
- 4 **Proc Stat** - This column includes the Procedure Status Code. In Figure 6-1, A is listed in this column and indicates an Active Code, which means the physician fee schedule pays this code separately, if covered.
- 5 **MAC Locality** - In Figure 6-1, the search shows 1120201. In this example, 1120201 represents South Carolina, and 01 as the last 2 digits indicates all of South Carolina’s pricing is statewide. If you use Northern California as an example, the Look-Up Tool will show several rows because pricing in California varies in several localities.
- 6 **Non-Facility Price** - In Figure 6-1, \$123.95 is displayed for 99214 and \$173.37 is displayed for 99215. This column includes the fee schedule amount when a physician performs a procedure in a non-facility setting such as the office. (Non-facility fees apply to therapy procedures regardless of whether the physician gives them in facility or non-facility settings.)

Occasionally, Medicare pays institutions like hospitals, under the MPFS. When this occurs, Medicare pays them at the non-facility (higher) rate. Although the terminology might seem confusing at first, the higher payment makes sense because here the facility is responsible for the cost of supplying the staff and supplies.

7 Facility Price - \$96.23 is shown for 99214 and \$141.55 for 99215. This is the fee schedule amount when a physician gives this service in a facility setting, such as a hospital or Ambulatory Surgical Center (ASC).

8 Non-Facility Limiting Charge - \$135.42 is shown for 99214 and \$189.41 for 99215.

This is the maximum amount the providers listed below may charge a beneficiary for the service:

- Nonparticipating health care professionals
- Providers who don't accept assignment
- Providers who perform the service in an office setting

On [page 3](#) of this booklet, we explain that Medicare reduces the Medicare-approved amounts for nonparticipating health care professionals and suppliers by 5%. In other words, the amounts in this column add up to 115% of 95% of the amounts in column 5.

9 **10**

Showing 1 - 2 of 2

Facility Limiting Charge	Conv Fact	NA Flag for Trans Non-FAC PE RVU	NA Flag for Fully IMP Non-FAC PE RVU	NA Flag for Trans facility PE RVU	NA Flag for Fully IMP FAC PE RVU	Not Used for Medicare	Opps Non-Facility Payment Amount ¹	Opps Facility Payment Amount ¹
\$105.13	34.8931						NA	NA
\$154.64	34.8931						NA	NA

Figure 6-2: Pricing Search Results for List of E/M Codes

9 Facility Limiting Charge - \$105.13 is shown for 99214 and \$154.64 for 99215.

- This is the maximum amount the providers listed below may charge a beneficiary for the service:
 - Nonparticipating health care professionals
 - Providers who don't accept assignment
 - Providers who perform the service in a facility setting

10 Conv Fact - This column displays the Conversion Factor for this code. We'll explain later in this booklet when we discuss RVUs.

Site of Service Differential

Under the MPFS, some procedures have a separate Medicare fee schedule for a physician's professional services when given in a facility (such as a hospital) or a non-facility. Generally, Medicare gives higher payments to physicians and other health care professionals for procedures performed in their offices because they must supply clinical staff, supplies, and equipment. View this differential in the Non-Facility Price and Facility Price columns.

Pricing Search Using a Code with an Applicable Professional or Technical Component

Figures 7-1 and 7-2 below show the additional pricing information that displays for codes providers may bill globally or with a professional or technical component. Use the following selection criteria for this example:

- 2021
- Pricing Information
- 76706 as the Single HCPCS Code
- 11202 South Carolina as the Specific MAC
- All Modifiers

Showing 1 - 3 of 3

HCPCS Code ▲	Modifier ▲	Short Description ◆	Proc Stat ▲	Mac Locality ▲	Non-Facility Price ◆	Facility Price ◆	Non-Facility Limiting Charge ◆
1 76706		Us abdl aorta screen aaa	A	1120201	\$102.96	NA	\$112.48
2 76706	26	Us abdl aorta screen aaa	A	1120201	\$26.46	\$26.46	\$28.91
3 76706	TC	Us abdl aorta screen aaa	A	1120201	\$76.49	NA	\$83.57

Figure 7-1: Pricing Search Showing TC and Modifier 26

Showing 1 - 3 of 3

Charge ◆	Facility Limiting Charge ◆	Conv Fact ◆	NA Flag for Trans Non-FAC PE RVU ◆	NA Flag for Fully IMP M
NA		34.8931		
\$28.91		34.8931		
NA		34.8931		

Figure 7-2: Pricing Search Showing TC and Modifier 26

It is important to note that, although we searched for only 1 code (76706, ultrasound, abdominal aorta), the MPFS Look-Up Tool displays 3 rows because providers may bill this code 3 different ways, depending on whether it's appropriate to bill a modifier.

- 1 In Figure 7-1, the first row is blank in the modifier column. When a provider doesn't use a modifier with this code, it means this provider performed both the technical and professional components of the procedure. The Non-Facility Price pricing amount is \$102.96, NA for the Facility Price and \$112.48 for the Non-Facility Limiting Charge. In Figure 7-2, under the Facility Limiting Charge, the search results show NA. (These amounts equal the sum of the amounts in the 2 other rows under these columns.)
- 2 The second row gives information for CPT code 76706 submitted with modifier 26, which providers use when they perform only the professional component of the procedure. The search results display \$26.46 for the Non-Facility Price and Facility Price and \$28.91 for the Non-Facility Limiting Charge and in

Figure 7-2, NA under the [Facility Limiting Charge](#)

3 The third row displays the results if the CPT code 76706 is billed with HCPCS Level II modifier TC, Technical Component. TC indicates the provider billed for performing the ultrasound only, not for the interpretation. The search results display \$76.49 under [Non-Facility Price and Facility Price](#) and \$83.57 under [Non-Facility Limiting Charge](#). In [Figure 7-2](#), under the [Facility Limiting Charge](#), the search results show NA.

Helpful Hint

For the technical component of certain diagnostic imaging procedures, Medicare bases payment on the lower of the Outpatient Prospective Payment System (OPPS) cap or fee schedule amount; however, the MPFS search results don't reflect payment adjustments. The MPFS Look-Up Tool displays full payments as well as OPPS payments. Also, the MPFS Look-Up Tool can't display Multiple Procedures Payment Reductions (MPPRs) since too many combinations of HCPCS codes exist. For additional information about MPPR, refer to the [MLN Matters® Articles List](#).

Payment Policy Indicators Search

Let's use the Payment Policy Indicators Search to review the other information available in the MPFS Look-Up Tool.

The Payment Policy Indicators include:

- Applicability of professional or technical modifiers
- The number of post-operative days included in a procedure
- Whether Medicare pays a code
- The level of physician supervision required
- Whether you bill the service as a bilateral procedure

Payment Policy Indicators Search Using a Code with an Applicable Professional or Technical Component

In [Figure 8](#) we'll search using a code with applicable professional or technical modifiers and then, in [Figures 9-1 and 9-2](#), we'll discuss the information given when you input a surgical code.

[Figure 8](#) shows a portion of the Search results after selecting the following criteria:

- 2021
- Payment Policy Indicators
- Single HCPCS Code 76706
- All Modifiers

We used the same code, 76706, as we just did in a pricing search to compare the information given.

Helpful Hint

You don't have to include a location or MAC selection for the payment policy search because the policies shown are national. Learn more about these policies in the Medicare Claims Processing Manual, IOM Pub 100-04, [Chapter 23](#), Fee Schedule Administration and Coding Requirements,. Remember, however, that MACs may have additional, local policies that you'll need to research on their websites or in the [Medicare Coverage Database](#).

1	2	3	4	5	6		
HCPCS Code ▲	Modifier ▲	Short Description ⇅	Proc Stat ▲	PCTC ⇅	Global ⇅	MULT SURG ⇅	BILT SURG ⇅
76706		Us abdl aorta screen aaa	A	1	XXX	0	0
76706	26	Us abdl aorta screen aaa	A	1	XXX	0	0
76706	TC	Us abdl aorta screen aaa	A	1	XXX	0	0

Figure 8: Payment Policy Indicators Search Results

- 1 **Modifier** – As in our pricing search for this code, the screen displays 3 rows, showing that providers can report code 76706, abdominal aorta ultrasound, with no modifier, modifier 26, or a TC modifier. All the other columns in this example display the same information for each row under the column heading.
- 2 **Proc Stat** – In this column, which shows Procedure Status Indicator, an A is displayed meaning an active code in the Pricing Search.
- 3 **PCTC** – This column shows the Professional Component and Technical Component Indicators. In our example, 1 is listed, which means the code is a diagnostic test or radiology service. Providers may use Modifiers 26 and TC when submitting this code on a claim.
- 4 **Global** – XXX appears in this example, which means the global surgery concept isn't applicable to this code.
- 5 **MULT SURG** – This column displays zeros, which means no payment adjustment rules for multiple procedures apply.
- 6 **BILT SURG** – This column displays a 0, which means the 150% payment adjustment for bilateral procedure doesn't apply. The MPFS bases RVUs on the procedure providers perform as a bilateral procedure. If you report the procedure with modifier 50 or report it twice on the same day (for example, with RT and LT modifiers with a 2 in the units field), Medicare bases payment for both sides on the lower of (a) the total actual charges for both sides or (b) 100% of the fee schedule amount for a single code.

All the other columns include indicators showing that these don't apply, or Medicare doesn't permit them for code 76706. Let's now do a search using a surgical code to see what type of information is conveyed in these columns.

For a complete listing of indicators which might appear with other HCPCS code selections, refer to the Medicare Claims Processing Manual, IOM Pub. 100-04, [Chapter 23](#). Review the Addendum in Chapter 23, Section 50.6 for the latest information or refer to the Appendix in the back of this booklet. In addition, we'll also perform a payment policy search with a surgical example to explain more of these indicators.

Payment Policy Indicators Search Using a Surgical Code

Figure 9-1 below shows the MPFS search results when searching for CPT code 47480, Incision of gallbladder.

Understanding the information displayed in the columns in these search results helps you understand policies such as bundled procedures or if using an appropriate CPT modifier with a code is necessary to get paid correctly. This includes modifiers for assistant surgeons, bilateral surgery, and multiple procedures.

1	2	3	4	5	6	7	8	
HCPCS Code ▲	Modifier ▲	Short Description ▼	Proc Stat ▲	PCTC ▼	Global ▼	MULT SURG ▼	BILT SURG ▼	ASST SURG
47480		Incision of gallbladder	A	0	090	2	0	2

Figure 9-1: Payment Policy Indicators Search Using a Surgical Code

9	10	11							
Proc Stat ▲	PCTC ▼	Global ▼	MULT SURG ▼	BILT SURG ▼	ASST SURG ▼	CO SURG ▼	Team SURG ▼	PHYS SUPV ▼	DIAG Imaging Family IND ▼
	0	090	2	0	2	1	0	9	99

Figure 9-2: Payment Policy Indicators Search Using a Surgical Code

- 1 **Modifier** – The Modifier column has no information listed.
- 2 **Short Description** – This column displays an abbreviated description of the code and time a physician would spend during an exam
- 3 **Proc Stat** – This column displays an A indicating this code is active.
- 4 **PCTC** – This column displays a 0.

The 0 indicator identifies codes that describe physician services. Examples include visits, consultations, and surgical procedures. The concept of PC and TC don't apply since the MPFS doesn't split physician services into professional and technical components.

- 5 **Global** – This field gives the time frames that apply to payment for each surgical procedure or another indicator that describes the applicability of the global concept to the service.

In Figure 9-1, 090 is listed, which means code 47480 is major surgery with a 1-day preoperative period

and 90-day postoperative period included in the fee schedule payment amount.

6 MULT SURG – This column indicates which payment adjustment rule for multiple procedures (including certain physical therapy procedures) applies to the service. In [Figure 9-1](#), a 2 indicates that standard payment adjustment rules for multiple procedures apply. Payment is based on the lower of the billed amount, or:

- 100% of the fee schedule amount for the highest valued procedure
- 50% of the fee schedule amount for the second through the fifth highest valued procedures

The Medicare system reviews additional procedures and considered them for payment.

7 BILT SURG – This field gives an indicator for bilateral services subject to a payment adjustment. CMS defines Bilateral surgeries as procedures performed on both sides of the body during the same operative session or on the same day. In [Figure 9-1](#), 0 is displayed, which means the 150% payment adjustment for bilateral procedures doesn't apply. If this procedure is reported with modifier 50 or with modifiers RT and LT, Medicare bases payment for the 2 sides on the lower of: (a) the total actual charge for both sides or (b) 100% of the fee schedule amount for a single code.

8 ASST SURG – This column indicates whether the MPFS pays assistants at surgery. In [Figure 9-1](#), 2 is displayed, which means payment restriction for assistants at surgery doesn't apply to this procedure.

9 CO SURG – This field in [Figure 9-2](#) includes an indicator 1, which means the MPFS pays co-surgeons (each of a different specialty). Supporting documentation is required to establish medical necessity of 2 surgeons for this procedure.

10 Team SURG – This field in [Figure 9-2](#) gives indicator 0 indicating a team of surgeons (more than 2 surgeons of different specialties) isn't permitted for this procedure.

11 PHYS SUPV – Health care personnel must perform diagnostic tests, with certain exceptions, under the supervision of a physician. This field indicates the level of required supervision. In this example, 9 indicates that this concept doesn't apply.

Relative Value Unit (RVU) and Geographic Practice Cost Index (GPCI) Search

Prior to demonstrating the results of an RVU and GPCI search, it's important to understand the definition of RVUs and GPCIs. The MPFS bases the pricing for each code on the following 3 components:

RVU – RVUs reflect the relative resources required to furnish a physician fee schedule service. The MPFS uses 3 separate RVUs to calculate payment under:

- **Work RVUs** (reflect the relative time and intensity associated with providing a service and equal approximately 50% of the total payment)
- **Practice Expense (PE) RVUs** (reflect costs such as renting office space, buying supplies and equipment, and staff)
- **Malpractice (MP) RVUs** (reflect the relative costs of purchasing malpractice insurance)

GPCI – To calculate the payment for every physician's service, the Medicare system adjusts components of the fee schedule (physician work, PE, and MP RVUs) with a GPCI. The GPCIs reflect the relative costs of physician work, practice expense, and malpractice expense in a specific area compared to the national average costs for each component.

Conversion Factor (CF) – Typically, CMS updates the CF on an annual basis. Until 2015, CMS used the Medicare Economic Index (MEI) adjusted up or down to calculate the annual update, depending on how actual expenditures compared to a target rate called the Sustainable Growth Rate (SGR). The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repealed the Medicare sustainable growth rate (SGR) update formula for payments under the Medicare Physician Fee Schedule. Effective January 1, 2020, the Physician Fee Schedule update factor is 0.00% and the CF is 36.09. The application of the CF converts RVUs to dollar amounts.

Find more information about RVUs and GPCIs in the annual [Medicare Physician Fee Schedule Final Rule](#). We'll first demonstrate an RVU search and then show a GPCI search.

RVUs include the core of physician fees. CMS gives MACs the fee schedule RVUs for all services except the following:

- Those with national codes for which national relative values have not been established
- Those requiring By Report payment or MAC pricing
- Those not included in the definition of physician services

Review the Status Indicators in the Appendix for more information.

RVU Search

Using the MPFS Look-Up Tool, we selected:

- 2021
- Relative Value Units for the Type of Information
- 99214 for the Single HCPCS Code
- All Modifiers

Figure 10 shows a portion of the screen displayed on the CMS website after making these selections. This figure shows only the following 5 columns (from the many columns displayed on the website) that interest most health care professionals:

In Figure 10, the Work RVU column is 1.92.

HCPCS Code	Modifier	Short Description	Proc Stat	PCTC	Not Used for Medicare	Work RVU	NA Flag for Trans Non-FAC PE RVU
99214		Office o/p est mod 30-39 min	A	0		1.92	

Figure 10: RVU Search

In **Figure 11**, the MPFS Look-Up Tool shows the following Practice Expense (PE) RVUs displayed in 5 columns:

- 1** 1.70 under **Transitioned Non-FAC PE RVU**
- 2** 1.70 under **Fully Implemented Non-FAC PE RVU**
- 3** 0.82 under **Transitioned Facility PE RVU**
- 4** 0.82 under **Fully Implemented Facility PE RVU**
- 5** **MP RVU** (Malpractice RVU) has a value of **0.14** in this example.

The screenshot shows a table with the following columns and values:

Transitioned Non-FAC PE RVU	NA Flag for Fully Implemented Non-FAC PE RVU	Fully Implemented Non-FAC PE RVU	NA Flag for Trans Facility PE RVU	Transitioned Facility PE RVU	NA Flag for Fully Implemented Facility PE RVU	Fully Implemented Facility PE RVU	MP RVU
1.70		1.70		0.82		0.82	0.14

Figure 11: RVU Search

[Chapter 23](#) of IOM Pub. 100-04, Medicare Claims Processing Manual, includes information on the other columns displayed when doing an RVU search.

Helpful Hint

If you searched for code 99215 instead of 99214, there would be a 2.80 in the Work RVU column indicating a higher relative value. Look back at the pricing search we did earlier in this booklet about these two codes; you'll see that the payment for 99215 is higher than for 99214. This helps you understand the impact of RVUs on the fee schedule amount.

Helpful Hint

To see how MP RVUs, vary, input a different code in an RVU search and compare to this result for 99214.

GPCI Search

Finally, let's do a GPCI search for 2021. Remember, we don't input a HCPCS code here because the same GPCI applies for all codes in an area. We'll decide whether we want a GPCI for:

- National Payment Amount
- Specific MAC
- Specific Locality or
- All MACs

Figures 12-1 and 12-2 display a portion of the screen for GPCIs when choosing All MACs.

MAC Locality	MAC Description	Locality Description	
0000000	NATIONAL	NATIONAL	1
0111205	NORTHERN CALIFORNIA	SAN FRANCISCO-OAKLAND-HAYWARD (SAN FRANCISCO CNTY)	1
0111206	NORTHERN CALIFORNIA	SAN FRANCISCO-OAKLAND-HAYWARD (SAN MATEO CNTY)	1
0111207	NORTHERN CALIFORNIA	SAN FRANCISCO-OAKLAND-HAYWARD (ALAMEDA/CONTRA COSTA CNTY)	1
0111209	NORTHERN CALIFORNIA	SAN JOSE-SUNNYVALE-SANTA CLARA (SANTA CLARA CNTY)	1
0111251	NORTHERN CALIFORNIA	NAPA	1
0111252	NORTHERN CALIFORNIA	SAN FRANCISCO-OAKLAND-HAYWARD (MARIN CNTY)	1
0111253	NORTHERN CALIFORNIA	VALLEJO-FAIRFIELD	1
0111254	NORTHERN CALIFORNIA	BAKERSFIELD	1
0111255	NORTHERN CALIFORNIA	CHICO	1

Figure 12-1: GPCI Search

Remember that MAC Locality 0000000 is national (see Figure 12-1). The value of 1.000 shows (see Figure 12-2) in each of the 3 GPCI columns: GPCI WORK, GPCI PE, and GPCI MP. For specific localities, any values higher or lower than 1.000 indicate higher or lower geographic classification values than the national average.

Locality Description	GPCI Work	GPCI PE	GPCI MP
NATIONAL	1.000	1.000	1.000
SAN FRANCISCO-OAKLAND-HAYWARD (SAN FRANCISCO CNTY)	1.077	1.329	0.458
SAN FRANCISCO-OAKLAND-HAYWARD (SAN MATEO CNTY)	1.077	1.329	0.458
SAN FRANCISCO-OAKLAND-HAYWARD (ALAMEDA/CONTRA COSTA CNTY)	1.077	1.329	0.458
SAN JOSE-SUNNYVALE-SANTA CLARA (SANTA CLARA CNTY)	1.096	1.383	0.414
NAPA	1.044	1.220	0.504
SAN FRANCISCO-OAKLAND-HAYWARD (MARIN CNTY)	1.071	1.311	0.504
VALLEJO-FAIRFIELD	1.044	1.220	0.504
BAKERSFIELD	1.035	1.065	0.704
CHICO	1.027	1.065	0.597

Figure 12-2: GPCI Search

For our example, in Figure 12-2, location 0111205 is displayed with a value of 1.077, 1.329, and 0.458 in these 3 respective columns.

Conclusion

In this booklet we’ve shown various types of searches using the MPFS Look-Up Tool and explained the meaning of the indicators displayed as well as some of the policies relevant to understanding the information given in these searches. For more information about the MPFS and related policies, other CMS webpages, and tools see the Resources section below. Print out the Medicare Physician Fee Schedule (MPFS) Quick Reference Search Guide on page 27 of this booklet for a step-by-step summary of how to use the MPFS Look-Up Tool.

Appendix

This information is from the Medicare Claims Processing Manual, IOM Pub. 100-04, [Chapter 23](#). For MPFSDB file layout information for years prior to 2018, select the [Historical MPFSDB Layouts](#) link from the Downloads section of the [Physician Fee Schedule](#) webpage.

Helpful Hint

Because this chapter is only updated on an annual basis, it is important to also review MLN Matters® articles and other information from CMS.

Status Indicators

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 doesn't mean that Medicare has made a national coverage determination regarding the service; MACs remain responsible for coverage decisions in the absence of a national Medicare policy.

B = Bundled code. Payment for covered services are always bundled into payment for other services not specified. 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 beneficiary).

C = MACs priced code. MACs will establish RVUs and payment amounts for these services, generally on an individual case-by-case basis following review of documentation such as an operative report.

E = Excluded from physician fee schedule by regulation. These codes are for items 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.

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.)

M = Measurement codes. Used for reporting purposes only.

N = Non-covered service.

P = Bundled and 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 given 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 Social Security 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 = Paid as only service. These codes are paid only 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 isn't 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.)

Global Surgery

This field gives the postoperative time frames that apply to payment for each surgical procedure or another indicator that describes the applicability of the global concept to the service.

000 = Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount, evaluation and management services on the day of the procedure generally not payable.

010 = Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during this 10-day postoperative period generally not payable.

090 = Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule payment amount.

MMM = Maternity codes; usual global period doesn't apply.

XXX = Global concept doesn't apply.

YYY = MAC determines whether global concept applies and establishes postoperative period, if appropriate, at time of pricing.

ZZZ = Code related to another service and is always included in the global period of the other service. (Note: Physician work is associated with intra-service time and in some instances the post service time.)

Professional Component (PC) or Technical Component (TC) Indicator

0 = Physician service codes. This indicator identifies codes that describe physician services. Examples include visits, consultations, and surgical procedures. The concept of PC or TC doesn't apply since physician services can't be split into professional and technical components. Modifiers 26 and TC can't be used with these codes. The total Relative Value Units (RVUs) include values for physician work, practice expense, and malpractice expense. There are some codes with no work RVUs.

1 = Diagnostic tests or radiology services. This indicator identifies codes that describe diagnostic tests (for example, pulmonary function tests or therapeutic radiology procedures such as radiation therapy). These codes generally have both a professional and technical component. Modifiers 26 and TC can be used with these codes. The total RVUs for codes reported with a 26 modifier include values for physician work, practice expense, and malpractice expense. The total RVUs for codes reported with a TC modifier include values for practice expense and malpractice expense only.

The total RVUs for codes reported without a modifier equals the sum of RVUs for both the professional and technical component.

2 = Professional component only codes. This indicator identifies stand alone codes that describe the physician work portion of selected diagnostic tests for which there is an associated code that describes the technical component of the diagnostic test only and another associated code that describes the global test. An example of a professional component only code is 93010, Electrocardiogram, interpretation, and report. Modifiers 26 and TC can't be used with these codes. The total RVUs for professional component only codes include values for physician work, practice expense, and malpractice expense.

3 = Technical component only codes. This indicator identifies stand alone codes that describe the technical component (such as staff and equipment costs) of selected diagnostic tests for which there is an associated code that describes the professional component of the diagnostic tests only. An example of a technical component code is 93005, Electrocardiogram, tracing only, without interpretation and report. It also identifies codes that are covered only as diagnostic tests and therefore don't have a related professional code. Modifiers 26 and TC can't be used with these codes. The total RVUs for technical component only codes include values for practice expense and malpractice expense only.

4 = Global test only codes. This indicator identifies stand alone codes for which there are associated codes that describe:

a) the professional component of the test only and b) the technical component of the test only. Modifiers 26 and TC can't 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 equal the sum of the total RVUs for the professional and technical components only codes combined.

5 = Incident to codes. This indicator identifies codes that describe services covered incident to a physician's service when they are given by auxiliary personnel employed by the physician and working under his or her direct supervision.

Payment may not be made by MACs for these services when they are given to hospital inpatients or patients in a hospital outpatient department. Modifiers 26 and TC can't be used with these codes.

6 = Laboratory physician interpretation codes. This indicator identifies clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made. Actual performance of the tests is paid for under the lab fee schedule. Modifier TC can't be used with these codes. The total RVUs for laboratory physician interpretation codes include values for physician, work, practice expense, and malpractice expense.

7 = Private practice therapist's service. Payment may not be made if the service is given to either a beneficiary in a hospital outpatient department or to an inpatient of the hospital by a physical therapist, occupational therapist, or speech-language pathologist in private practice.

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 a 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 Prospective Payment System (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 or technical component doesn't apply.

Multiple Procedure (CPT Modifier 51)

This indicator indicates which payment adjustment rule for multiple procedures applies to the service.

0 = No payment adjustment rules for multiple procedures apply. If the procedure is reported on the same day as another procedure, payment is based on the lower of: (a) the actual charge or (b) the fee schedule amount for the procedure.

1 = Standard payment adjustment rules in effect before January 1, 1996, for multiple procedures apply. In the 1996 Medicare Physician Fee Schedule Database (MPFSDB), this indicator only applied to codes with procedure status of D. If a procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, Medicare ranks the procedures by the fee schedule amount and the appropriate reduction to this code is applied (100%, 50%, 25%, 25%, 25%, and by report). MACs base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage.

2 = Standard payment adjustment rules for multiple procedures apply. If the procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, MACs rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100%, 50%, 50%, 50%, 50%, and by report). MACs base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage.

3 = Special rules for multiple endoscopic procedures apply if procedure is billed with another endoscopy in the same family (that is, another endoscopy that has the same base procedure). The base procedure for each code with this indicator is identified in field 31G of the Form CMS-1500 or its electronic equivalent claim. The multiple endoscopy rules apply to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). If an endoscopic procedure is reported with only its base procedure, the base procedure isn't separately paid. Payment for the base procedure is included in the payment for the other endoscopy.

4 = Diagnostic imaging services subject to MPPR methodology. TC of diagnostic imaging services subject to a 50% reduction of the second and subsequent imaging services furnished by the same physician (or by multiple physicians in the same group practice, for example, same group National Provider Identifier [NPI]) to the same beneficiary on the same day, effective for services July 1, 2010, and after. PC of diagnostic imaging services are subject to a 25% payment reduction of the second and subsequent imaging services effective January 1, 2012.

Helpful Hint

Refer to MLN Matters® article [MM7442](#) for information about the 2012 implementation of the 25% reduction to the PC for certain diagnostic imaging procedures.

Multiple procedure indicator 5 isn't included in this file, since the indicator represents the therapy multiple procedure payment reduction which never applies to professional service revenue codes. Multiple procedure indicators 6 and 7 aren't included in this file, since in these cases the reduction only applies to technical component services. On CAH claims, technical components are paid on a cost basis and so aren't subject to the reductions.

9 = Concept doesn't apply.

Codes with RVUs equal to zero aren't included in the payment indicator file. These codes may have multiple procedure indicators not shown.

Bilateral Surgery Indicator (CPT Modifier 50)

This field gives an indicator for services subject to a payment adjustment.

0 = 150% payment adjustment for bilateral procedures doesn't apply. If a procedure is reported with modifier 50 or with modifiers RT and LT, Medicare bases payment for the 2 sides on the lower of:

(a) the total actual charge for both sides or (b) 100% of the fee schedule amount for a single code. Example: The fee schedule amount for code XXXXX is \$125. The physician reports code XXXXX-LT with an actual charge of \$100 and XXXXX-RT with an actual charge of \$100.

Payment would be based on the fee schedule amount (\$125) since it's lower than the total actual charges for the left and right sides (\$200). The bilateral adjustment is inappropriate for codes in this category because of (a) physiology or anatomy or (b) because the code descriptor specifically states that it's a unilateral procedure and there is an existing code for the bilateral procedure.

1 = 150% payment adjustment for bilateral procedures applies. If a code is billed with the bilateral modifier or is reported twice on the same day by any other means (such as with RT and LT modifiers or with a 2 in the units field), payment is based for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides or (b) 150% of the fee schedule amount for a single code.

If code is reported as a bilateral procedure and is reported with other procedure codes on the same day, the bilateral adjustment is applied before applying any applicable multiple procedure rules.

2 = 150% payment adjustment for bilateral procedure doesn't apply. RVUs are already based on the procedure providers perform as a bilateral procedure. If a procedure is reported with modifier 50 or is reported twice on the same day by any other means (such as with RT and LT modifiers with a 2 in the units field), payment is based for both sides on the lower of (a) the total actual charges by the physician for both sides or (b) 100% of the fee schedule amount for a single code. 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). The RVUs are based on a bilateral procedure because: (a) the code descriptor specifically states that the procedure is bilateral; (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally; or (c) the procedure is usually performed as a bilateral procedure.

3 = The usual payment adjustment for bilateral procedures doesn't apply. If procedure is reported with modifier 50 or is reported for both sides on the same day by any other means (such as with RT and LT modifiers or with a 2 in the units field), Medicare bases 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, the fee schedule amount for a bilateral procedure is determined before applying any applicable multiple procedure rules.

Services in this category are generally radiology procedures or other diagnostic tests which aren't subject to the special payment rules for other bilateral procedures.

9 = Concept doesn't apply.

Assistant at Surgery

This field gives an indicator for services where an assistant at surgery is never paid.

0 = Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.

1 = Statutory payment restriction for assistants at surgery applies to this procedure. Assistants at surgery may not be paid.

2 = Payment restriction for assistants at surgery don't apply to this procedure. Assistants at surgery may be paid.

9 = Concept doesn't apply.

Co-Surgeons (Modifier 62)

This field gives an indicator for services for which 2 surgeons, each in a different specialty, may be paid.

0 = Co-surgeons not permitted for this procedure.

1 = Co-surgeons could be paid. Supporting documentation is required to establish medical necessity of 2 surgeons for the procedure.

2 = Co-surgeons permitted. No documentation is required if 2 specialty requirements are met.

9 = Concept doesn't apply.

Team Surgeons (Modifier 66)

This field gives 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 is required to establish medical necessity of a team; paid by report.

2 = Team surgeons permitted; pay by report.

9 = Concept doesn't apply.

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 doesn't apply when procedure is furnished by a qualified, independent psychologist or a clinical psychologist. Otherwise the procedure must be performed under the general supervision of a physician.

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.

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.

21 = Procedure may be performed by a technician with certification under general supervision of a physician. Otherwise the procedure must be performed under direct supervision of a physician. Procedure may also be performed by a PT with ABPTS certification without physician supervision

22 = May be performed by a technician with on-line real-time contact with a physician.

66 = May be personally performed by a physician or by a PT with ABPTS certification and certification in this specific procedure.

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.

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).

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.

09 = Concept doesn't apply.

Diagnostic Imaging Family Indicator

For services effective January 1, 2011, and after, family indicators 01 - 11 won't be populated.

01 = Family 1 Ultrasound (Chest/Abdomen/Pelvis – Non Obstetrical) 02 = Family 2 CT and CTA (Chest/Thorax/Abd/Pelvis)

03 = Family 3 CT and CTA (Head/Brain/Orbit/Maxillofacial/Neck)

04 = Family 4 MRI and MRA (Chest/Abd/Pelvis)

05 = Family 5 MRI and MRA (Head/Brain/Neck)

06 = Family 6 MRI and MRA (Spine)

07 = Family 7 CT (Spine)

08 = Family 8 MRI and MRA (Lower Extremities)

09 = Family 9 CT and CTA (Lower Extremities)

10 = Family 10 MRI and MRI (Upper Extremities and Joints)

11 = Family 11 CT and CTA (Upper Extremities)

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)

99 = Concept Doesn't Apply.

Medicare Physician Fee Schedule (MPFS) Quick Reference Search Guide

Locate the [MPFS Look-Up Tool](#) and follow the steps below to complete the MPFS search process.

Step 1: Year

Select the MPFS year for your search.

Step 2: Type of Information

Select one of the following 5 types of information relevant to your search:

- Pricing Information
- Payment Policy Indicators
- Relative Value Units (RVUs)
- Geographic Practice Cost Index (GPCI)
- All

NOTE: If you select Payment Policy Indicators from the Type of Information drop down menu, no MAC drop down menu will appear.

Step 3: HCPCS Criteria

Select 1 of the following 3 options (this step won't appear if you selected the GPCI Type of Information option in step 2 above):

- Single HCPCS Code – After selecting this option, indicate the code in the HCPCS Code field that will appear at the bottom of the page.
- List of HCPCS Codes – After selecting this option, enter up to 5 codes in the HCPCS Code fields that will appear at the bottom of the page.
- Range of HCPCS Codes – After selecting this option, enter starting and ending procedure codes for the code range in the HCPCS Code fields that will appear at the bottom of the page. Note: Using a small range of codes is recommended. The response time will be slower for a larger range.

Then, select a modifier value from the Modifier dropdown menu at the bottom of the page.

Step 4: Medicare Administrative Contractor (MAC)

Select 1 of the following 4 options (this step will only appear if you select Pricing Information, GPCI, or All for the Type of Information in step 2):

- National Payment Amount – This amount is designated with a MAC locality code of 0000000
- Specific MAC – After selecting this option, indicate the MAC of your interest from the MAC dropdown menu that will appear at the bottom of the page
- Specific Locality – After selecting this option, select the locality of your interest from the MAC Locality dropdown menu that will appear at the bottom of the page or
- All MACs – Displays information for the entire nation (results will include the national payment amount, as well as all MAC localities)

Step 5: Click Submit to view your search results.

Resources

- [PFS Federal Regulation Notices](#)
- [Physician Fee Schedule](#)
- [CMS Forms List](#)
- [How to Use the Medicare Coverage Database booklet](#)
- [How to Use the Medicare National Correct Coding Initiative \(NCCI\) Tools booklet](#)
- [Internet-Only Manual \(IOM\) Pub. 100-02 Medicare Benefit Policy Manual, Chapter 15](#)
- [Internet-Only Manual \(IOM\) Pub. 100-04 Medicare Claims Processing Manual, Chapter 4](#)

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