CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2395	**Date: January 26, 2012**
	Change Request 7684

SUBJECT: Multiple Procedure Payment Reduction (MPPR) for Physician Services for Certain Diagnostic Imaging Procedures in Critical Access Hospitals (CAH)

I. SUMMARY OF CHANGES: This instruction implements the MPPR for physician services for certain diagnostic imaging procedures in CAHs.

EFFECTIVE DATE: January 1, 2012
IMPLEMENTATION DATE: July 2, 2012

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	4/Table of Contents
R	4/250.2/Optional Method for Outpatient Services: Cost-Based Facility Services Plus 115 percent Fee Schedule Payment for Professional Services
N	4/250.16/Multiple Procedure Payment Reduction (MPPR) on Certain Diagnostic Imaging Procedures Rendered by Physicians

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

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

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2395	Date: January 26, 2012	Change Request: 7684

SUBJECT: Multiple Procedure Payment Reduction (MPPR) for Physician Services for Certain Diagnostic Imaging Procedures in Critical Access Hospitals (CAH)

Effective Date: **January 1, 2012**
Implementation Date: **July 2, 2012**

I. GENERAL INFORMATION

A. Background: Section 3134 of the Affordable Care Act (ACA) added section 1848(c)(2)(K) of the Social Security Act which specifies that the Secretary shall identify potentially misvalued codes by examining multiple codes that are frequently billed in conjunction with furnishing a single service. As a result of this examination, Medicare is making a change to the MPPR for physician services of certain diagnostic imaging procedures.

This instruction applies the MPPR to physician services of certain diagnostic imaging procedures billed by CAHs that have elected the optional method for outpatient billing. Payment is made to the CAH for physician services (revenue code (RC) 96X, 97X, or 98X) on bill type 85x based off the Medicare Physician Fee Schedule (MPFS) supplemental file.

B. Policy: The MPPR on diagnostic imaging applies when multiple physician services are furnished by the same physician to the same patient in the same session on the same day. Full payment is made for the service that yields the highest payment under the MPFS. Payment is made at 75 percent for the subsequent services furnished by the same physician to the same patient in the same session on the same day.

The current list of codes subject to the MPPR on diagnostic imaging is in Attachment 1.

Medicare uses the payment policy indicators on the MPFS to determine if a multiple procedure is authorized for a specific HCPCS/CPT code. The MPFS is located at: http://www.cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02_PFSsearch.asp. The fiscal intermediaries (FIs) and A/B Medicare Administrative Contractors (MACs) have access to the payment policy indicators via the Physician Fee Schedule Payment Policy Indicator File in the fiscal intermediary shared system.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7684.1	Contractors shall add a new field to the Physician Fee Schedule Payment Policy Indicator file as follows: Diagnostic Imaging Family Indicator – 2 PIC x(2) Position 46-47.						X				
7684.1.1	Contractors shall note manual section 250.2 in this instruction identifies the new field in the Physician Fee						X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	Schedule Payment Policy Indicator File layout.										
7684.2	Contractors shall display the Diagnostic Family Indicator on the Physician Fee Schedule Payment Policy Indicator screen.						X				
7684.3	Contractors shall be able to accept the updated Payment Policy Indicator abstract file to be identified in the recurring July 2012 MPFS Update.						X				
7684.4	Contractors shall identify TOB 85x with revenue codes 96x, 97x and/or 98x that contain more than one line item, same date of service with CPT/HCPCS codes assigned both a multiple procedure indicator equal to "4" and a Diagnostic Imaging Family indicator "88" on the PFS Payment Policy Indicator File.						X				
7684.5	Contractors shall continue to reimburse based on lesser of the fee amount or the provider submitted charges.						X				
7684.6	Contractors shall pay the service line that yields the highest reimbursement at 100%.						X				
7684.7	Contractors shall pay the additional service lines at 75%.						X				
7684.8	Contractors shall use the T/R indicator field on claim page 30 to identify service lines that have received the MPPR.						X				
7684.8.1	Contractors shall apply a "F" for the service line that yields the highest reimbursement.						X				
7684.8.2	Contractors shall apply a "M" for services that have been reduced for a multiple diagnostic imaging procedure.						X				
7684.9	Contractors shall apply the deductible and coinsurance based on the reduced amount.						X				
7684.10	Contractors shall continue to apply the 115% add on after the deductible and coinsurance for eligible services.						X				
7684.11	Contractors shall use the following claim adjustment reason code on the remittance advice notice for service lines for which they have applied the multiple surgery and/or special endoscopic payment methodologies. **59** - Processed based on the multiple or concurrent procedure rules.	X		X			X				
7684.12	Contractors shall use the group code "CO" contractual obligation, on the remittance advice notices when the multiple surgery and/or special endoscopic payment	X		X			X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	methodologies are applied.										
7684.13	Contractors shall use the following message on the Medicare Summary Notice for claims for which MPFS methodology was applied. 30.1 The approved amount is based on a special payment method. AND 30.1 La cantidad aprobada está basada en un método especial de pago.	X		X			X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7684.14	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X							

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:
	None.

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s):
Cindy Pitts at Cindy.Pitts@cms.hhs.gov or Jason Kerr at Jason.Kerr@cms.hhs.gov

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

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs)*:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:

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

ATTACHMENTS (1)

Attachment 1

Diagnostic Imaging Services Subject to the Multiple Procedure Payment Reduction

CPT/HCPCS Code	Short Descriptor
70336	Magnetic image jaw joint
70450	Ct head/brain w/o dye
70460	Ct head/brain w/dye
70470	Ct head/brain w/o & w/dye
70480	Ct orbit/ear/fossa w/o dye
70481	Ct orbit/ear/fossa w/dye
70482	Ct orbit/ear/fossa /o&w/dye
70486	Ct maxillofacial w/o dye
70487	Ct maxillofacial w/dye
70488	Ct maxillofacial w/o & w/dye
70490	Ct soft tissue neck w/o dye
70491	Ct soft tissue neck w/dye
70492	Ct sft tsue nck w/o & w/dye
70496	Ct angiography head
70498	Ct angiography neck
70540	Mri orbit/face/neck w/o dye
70542	Mri orbit/face/neck w/dye
70543	Mri orbt/fac/nck w/o & w/dye
70544	Mr angiography head w/o dye
70545	Mr angiography head w/dye
70546	Mr angiograph head w/o&w/dye
70547	Mr angiography neck w/o dye

70548	Mr angiography neck w/dye
70549	Mr angiograph neck w/o&w/dye
70551	Mri brain w/o dye
70552	Mri brain w/dye
70553	Mri brain w/o & w/dye
70554	Fmri brain by tech
71250	Ct thorax w/o dye
71260	Ct thorax w/dye
71270	Ct thorax w/o & w/dye
71275	Ct angiography, chest
71550	Mri chest w/o dye
71551	Mri chest w/dye
71552	Mri chest w/o & w/ dye
71555	Mri angio chest w/ or w/o dye
72125	Ct neck spine w/o dye
72126	Ct neck spine w/dye
72127	Ct neck spine w/o & w/dye
72128	Ct chest spine w/o dye
72129	Ct chest spine w/dye
72130	Ct chest spine w/o & w/dye
72131	Ct lumbar spine w/o dye
72132	Ct lumbar spine w/dye
72133	Ct lumbar spine w/o & w/dye
72141	Mri neck spine w/o dye
72142	Mri neck spine w/dye
72146	Mri chest spine w/o dye
72147	Mri chest spine w/dye
72148	Mri lumbar spine w/o dye

72149	Mri lumbar spine w/dye
72156	Mri neck spine w/o & w/dye
72157	Mri chest spine w/o & w/dye
72158	Mri lumbar spine w/o & w/dye
72159	Mr angio spine w/o&w/dye
72191	Ct angiograph pelv w/o&w/dye
72192	Ct pelvis w/o dye
72193	Ct pelvis w/dye
72194	Ct pelvis w/o & w/dye
72195	Mri pelvis w/o dye
72196	Mri pelvis w/dye
72197	Mri pelvis w/o & w/dye
72198	Mr angio pelvis w/o & w/dye
73200	Ct upper extremity w/o dye
73201	Ct upper extremity w/dye
73202	Ct uppr extremity w/o&w/dye
73206	Ct angio upr extrm w/o&w/dye
73218	Mri upper extremity w/o dye
73219	Mri upper extremity w/dye
73220	Mri uppr extremity w/o&w/dye
73221	Mri joint upr extrem w/o dye
73222	Mri joint upr extrem w/dye
73223	Mri joint upr extr w/o&w/dye
73225	Mr angio upr extr w/o&w/dye
73700	Ct lower extremity w/o dye
73701	Ct lower extremity w/dye
73702	Ct lwr extremity w/o&w/dye
73706	Ct angio lwr extr w/o&w/dye

73718	Mri lower extremity w/o dye
73719	Mri lower extremity w/dye
73720	Mri lwr extremity w/o&w/dye
73721	Mri jnt of lwr extre w/o dye
73722	Mri joint of lwr extr w/dye
73723	Mri joint lwr extr w/o&w/dye
73725	Mr ang lwr ext w or w/o dye
74150	Ct abdomen w/o dye
74160	Ct abdomen w/dye
74170	Ct abdomen w/o & w/dye
74175	Ct angio abdom w/o & w/dye
74176	Ct abd & pelvis
74177	Ct abd & pelv w/contrast
74178	Ct abd & pelv 1/> regns
74181	Mri abdomen w/o dye
74182	Mri abdomen w/dye
74183	Mri abdomen w/o & w/dye
74185	Mri angio abdom w orw/o dye
74261	Ct colonography dx
74262	Ct colonography dx w/dye
75557	Cardiac mri for morph
75559	Cardiac mri w/stress img
75561	Cardiac mri for morph w/dye
75563	Card mri w/stress img & dye
75571	Ct hrt w/o dye w/ca test
75572	Ct hrt w/3d image
75573	Ct hrt w/3d image congen
75574	Ct angio hrt w/3d image

75635	Ct angio abdominal arteries
76604	Us exam chest
76700	Us exam abdom complete
76705	Echo exam of abdomen
76770	Us exam abdo back wall comp
76775	Us exam abdo back wall lim
76776	Us exam k transpl w/doppler
76831	Echo exam uterus
76856	Us exam pelvic complete
76857	Us exam pelvic limited
76870	Us exam scrotum
77058	Mri one breast
77059	Mri both breasts

Medicare Claims Processing Manual

Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

Table of Contents

(Rev. 2395, Issued: 01-26-12)

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

(Rev. 2395, Issued: 01-26-12, Effective: 01-01-12, Implementation: 07-02-12)

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

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

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

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

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

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

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

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

    - The FI or A/B MAC uses the Medicare Physician Fee Schedule (MPFS) supplementary file, established for use by the CORF, and the CORF Abstract File, to pay for all the physician/nonphysician practitioner services rendered in a CAH that elected the optional method. The data in the supplemental file are in the same format as the abstract file. Payment is based on the lesser of the actual charge or the facility-specific MPFS amount less deductible and coinsurance times 1.15; and

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

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

        - If a nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA) renders a service, the “GF” modifier must be on the applicable line:

            - GF - Services rendered in a CAH by a nurse practitioner (NP), clinical nurse specialist (CNS), certified registered nurse (CRN) or physician assistant (PA). (The “GF” modifier is not to be used for CRNA services. If a claim is received and it has the “GF” modifier for certified registered nurse anesthetist (CRNA) services, the claim is returned to the provider.) Also, while this national “GF” modifier includes CRNs, there is no benefit under Medicare law that authorizes payment to CRNs for their services. Accordingly, if a claim is received and it has the “GF” modifier for CRN services, no Medicare payment should be made.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SUPPLEMENTAL FEE SCHEDULE
CRITICAL ACCESS HOSPITAL FEE SCHEDULE

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

This is the final physician fee schedule supplemental file.

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

Data Element Name	Location	Picture	Value
1 - HCPCS	1-5	X(05)	
2 - Modifier	6-7	X(02)	
3 - Filler	8-9	X(02)	
4 - Non-Facility Fee	10-16	9(05)V99	
5 - Filler	17-17	X(01)	
6 - PCTC Indicator	18-18	X(01)	This field is only applicable when pricing Critical Access Hospitals (CAHs) that have elected the optional method (Method 2) of payment.
7 - Filler	19	X(1)	
8 - Facility Fee	20-26	9(05)V99	
9 - Filler	27-30	X(4)	
10 - Carrier Number	31-35	X(05)	
11 - Locality	36-37	X(02)	
12 - Filler	38-40	X(03)	
13 - Fee Indicator	41-41	X(1)	Field not populated— filled with spaces.

14 - Outpatient Hospital	42-42	X(1)	Field not populated—Filled with spaces.
15 - Status Code	43-43	X(1)	Separate instructions will be issued for the use of this field at a later date. This field indicates whether the code is in the physician fee schedule and whether it's separately payable if the service is covered.
16 - Filler	44-60	X(17)	

Physician Fee Schedule Payment Policy Indicator File Record Layout

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

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
File Year This field displays the effective year of the file.	4 Pic x(4)	1-4
HCPCS Code This field represents the procedure code. Each Current Procedural Terminology (CPT) code and alpha-numeric HCPCS codes A, C, T, and some R codes that are currently returned on the MPFS supplemental file will be included. The standard sort for this field is blanks, alpha, and numeric in ascending order.	5 Pic x(5)	5-9
Modifier For diagnostic tests, a blank in this field denotes the global service and the following modifiers identify the components: 26 = Professional component; and TC = Technical component. For services other than those with a professional and/or technical component, a blank will appear in this field with one exception: the presence of CPT	2 Pic x(2)	10-11

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
modifier -53 which indicates that separate Relative Value Units (RVUs) and a fee schedule amount have been established for procedures which the physician terminated before completion. This modifier is used only with colonoscopy code 45378 and screening colonoscopy codes G0105 and G0121. Any other codes billed with modifier -53 are subject to medical review and priced by individual consideration. Modifier-53 = Discontinued Procedure - Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances, or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued.		
Code Status This 1 position field provides the status of each code under the full fee schedule. Each status code is explained in Pub. 100-04, Chapter 23, §30.2.2.	1 Pic x(1)	12
Global Surgery This field provides the postoperative time frames that apply to payment for each surgical procedure or another indicator that describes the applicability of the global concept to the service. 000 = Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; evaluation and management services on the day of the procedure generally not payable. 010 = Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during this 10-day postoperative period generally not payable.	3 Pic x(3)	13-15

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
090 = Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule payment amount. MMM = Maternity codes; usual global period does not apply. XXX = Global concept does not apply. YYY = Fiscal intermediary (FI) determines whether global concept applies and establishes postoperative period, if appropriate, at time of pricing. ZZZ = Code related to another service and is always included in the global period of the other service. (**NOTE**: Physician work is associated with intra-service time and in some instances the post service time.)		
Preoperative Percentage (Modifier 56) This field contains the percentage (shown in decimal format) for the preoperative portion of the global package. For example, 10 percent will be shown as 010000. The total of the preoperative percentage, intraoperative percentage, and the postoperative percentage fields will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)	16-21
Intraoperative Percentage (Modifier 54) This field contains the percentage (shown in decimal format) for the intraoperative portion of the global package including postoperative work in the hospital. For example, 63 percent will be shown as 063000. The total of the preoperative percentage, intraoperative percentage, and the postoperative percentage fields will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)	22-27
Postoperative Percentage (Modifier 55) This field contains the percentage (shown in decimal format) for the postoperative portion of the global	6 Pic 9v9(5)	28-33

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
package that is provided in the office after discharge from the hospital. For example, 17 percent will be shown as 017000. The total of the preoperative percentage, intraoperative percentage, and the postoperative percentage fields will usually equal one. Any variance is slight and results from rounding.		
Professional Component (PC)/Technical Component (TC) Indicator 0 = Physician service codes: This indicator identifies codes that describe physician services. Examples include visits, consultations, and surgical procedures. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. Modifiers 26 & TC cannot be used with these codes. The total Relative Value Units (RVUs) include values for physician work, practice expense and malpractice expense. There are some codes with no work RVUs. 1 = Diagnostic tests or radiology services: This indicator identifies codes that describe diagnostic tests, e.g., pulmonary function tests, or therapeutic radiology procedures, e.g., radiation therapy. These codes generally have both a professional and technical component. Modifiers 26 and TC can be used with these codes. The total RVUs for codes reported with a 26 modifier include values for physician work, practice expense, and malpractice expense. The total RVUs for codes reported with a TC modifier include values for practice expense and malpractice expense only. The total RVUs for codes reported without a modifier equals the sum of RVUs for both the professional and technical component. 2 = Professional component only codes: This indicator identifies stand alone codes that describe the physician work portion of selected diagnostic	1 Pic x(1)	34

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
tests for which there is an associated code that describes the technical component of the diagnostic test only and another associated code that describes the global test. An example of a professional component only code is 93010, Electrocardiogram; interpretation and report. Modifiers 26 and TC cannot be used with these codes. The total RVUs for professional component only codes include values for physician work, practice expense, and malpractice expense. 3 = Technical component only codes: This indicator identifies stand alone codes that describe the technical component (i.e., staff and equipment costs) of selected diagnostic tests for which there is an associated code that describes the professional component of the diagnostic tests only. An example of a technical component code is 93005, Electrocardiogram, tracing only, without interpretation and report. It also identifies codes that are covered only as diagnostic tests and therefore do not have a related professional code. Modifiers 26 and TC cannot be used with these codes. The total RVUs for technical component only codes include values for practice expense and malpractice expense only. 4 = Global test only codes: This indicator identifies stand alone codes for which there are associated codes that describe: a) the professional component of the test only and b) the technical component of the test only. Modifiers 26 and TC cannot be used with these codes. The total RVUs for global procedure only codes include values for physician work, practice expense, and malpractice expense. The total RVUs for global procedure only codes equals the sum of the total RVUs for the professional and technical components only codes combined. 5 = Incident to Codes: This indicator identifies codes		

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
that describe services covered incident to a physicians service when they are provided by auxiliary personnel employed by the physician and working under his or her direct supervision. Payment may not be made by carriers for these services when they are provided to hospital inpatients or patients in a hospital outpatient department. Modifiers 26 and TC cannot be used with these codes. 6 = Laboratory physician interpretation codes: This indicator identifies clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made. Actual performance of the tests is paid for under the lab fee schedule. Modifier TC cannot be used with these codes. The total RVUs for laboratory physician interpretation codes include values for physician work, practice expense and malpractice expense. 7 = Physical therapy service: Payment may not be made if the service is provided to either a hospital outpatient or inpatient by an independently practicing physical or occupational therapist. 8 = Physician interpretation codes: This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for hospital inpatient. This applies only to code 85060. No TC billing is recognized because payment for the underlying clinical laboratory test is made to the hospital, generally through the PPS rate. No payment is recognized for code 85060 furnished to hospital outpatients or non-hospital patients. The physician interpretation is paid through the clinical laboratory fee schedule payment for the clinical laboratory test. 9 = Concept of a professional/technical component does not apply		

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
Multiple Procedure (Modifier 51) Indicator indicates which payment adjustment rule for multiple procedures applies to the service. 0 = No payment adjustment rules for multiple procedures apply. If the procedure is reported on the same day as another procedure, base payment on the lower of: (a) the actual charge or (b) the fee schedule amount for the procedure. 1 = Standard payment adjustment rules in effect before January 1, 1996, for multiple procedures apply. In the 1996 MPFSDB, this indicator only applies to codes with procedure status of "D." If a procedure is reported on the same day as another procedure with an indicator of 1,2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 25 percent, 25 percent, 25 percent, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage. 2 = Standard payment adjustment rules for multiple procedures apply. If the procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 50 percent, 50 percent, 50 percent, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage. 3 = Special rules for multiple endoscopic procedures apply if procedure is billed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure). The base procedure for each code with this indicator is identified in the endoscopic base code field. Apply the multiple endoscopy rules to a family before ranking the family with other procedures	1 Pic (x)1	35

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). If an endoscopic procedure is reported with only its base procedure, do not pay separately for the base procedure. Payment for the base procedure is included in the payment for the other endoscopy. 4 = Subject to *MPPR reduction.* 9 = Concept does not apply.		
Bilateral Surgery Indicator (Modifier 50) This field provides an indicator for services subject to a payment adjustment. 0 = 150 percent payment adjustment for bilateral procedures does not apply. The bilateral adjustment is inappropriate for codes in this category because of: (a) physiology or anatomy, or (b) because the code descriptor specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure. 1 = 150 percent payment adjustment for bilateral procedures applies. If code is billed with the bilateral modifier base payment for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides or (b) 150 percent of the fee schedule amount for a single code. If code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any applicable multiple procedure rules. 2 = 150 percent payment adjustment for bilateral procedure does not apply. RVUs are already based on the procedure being performed as a bilateral	1 Pic (x)1	36

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
procedure. The RVUs are based on a bilateral procedure because: (a) the code descriptor specifically states that the procedure is bilateral; (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally; or (c) the procedure is usually performed as a bilateral procedure. 3 = The usual payment adjustment for bilateral procedures does not apply. Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral procedures. If a procedure is billed with the 50 modifier, base payment on the lesser of the total actual charges for **each** side or 100% of the fee schedule amount for **each** side. 9 = Concept does not apply.		
Assistant at Surgery (Modifiers AS, 80, 81 and 82) This field provides an indicator for services where an assistant at surgery may be paid: 0 = Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity. 1 = Statutory payment restriction for assistants at surgery applies to this procedure. Assistant at surgery may not be paid. 2 = Payment restriction for assistants at surgery does not apply to this procedure. Assistant at surgery may be paid. 9 = Concept does not apply.	1 Pic (x)1	37
Co-Surgeons (Modifier 62)	1 Pic (x)1	38

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
This field provides an indicator for services for which two surgeons, each in a different specialty, may be paid. 0 = Co-surgeons not permitted for this procedure. 1 = Co-surgeons could be paid; supporting documentation required to establish medical necessity of two surgeons for the procedure. 2 = Co-surgeons permitted; no documentation required if two specialty requirements are met. 9 = Concept does not apply.		
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.	1 Pic (x)1	39
Endoscopic Base Codes This field identifies an endoscopic base code for each code with a multiple surgery indicator of 3.	5 Pic (x) 5	40-44
Performance Payment Indicator (For future use)	1 Pic x (1)	45
Diagnostic Imaging Family Indicator *88 = Subject to the reduction for diagnostic imaging (effective for services January 1, 2011, and after).* *99 = Concept Does Not Apply*	2 Pic x (2)	46-47
Filler	30 Pic x(30)	48-75

Health Professional Shortage Area (HPSA) Incentive Payments for Physicians

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

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

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

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

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

250.16 – Multiple Procedure Payment Reduction (MPPR) on Certain Diagnostic Imaging Procedures Rendered by Physicians

(Rev. 2395, Issued: 01-26-12, Effective: 01-01-12, Implementation: 07-02-12)

Diagnostic imaging procedures rendered by a physician that has reassigned their billing rights to a Method II CAH are payable by Medicare when the procedures are eligible and billed on type of bill 85x with revenue code (RC) 096x, 097x and/or 098x.

The MPPR on diagnostic imaging applies when multiple services are furnished by the same physician to the same patient in the same session on the same day. Full payment is made for each service with the highest payment under the MPFS and payment is made at 75 percent for each subsequent service.