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National Government Services

2022 NGS Medicare Spring Virtual Conference **Medicare for You**

Medicare Physician Fee Schedule Database

5/11/2022

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

- Christine Obergfell, CPC, CPC-I
  - J6 Provider Outreach and Education
- Carleen Parker, Consultant
  - JK Provider Outreach and Education

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- Attendees/providers are **never** permitted to record (tape record or **any** other method) our educational events
  - This applies to our webinars, teleconferences, live events and any other type of National Government Services educational events

Objectives

- Assist providers in understanding the MPFSDB, how to access the database files and use the information found in the searchable database **prior** to submitting Medicare Part B claims

Agenda

- Provided by CMS Annually
- Updated Quarterly
- Pricing and Coverage
- NGS Physician Fee Schedule Tool

Why Use the Searchable Database?

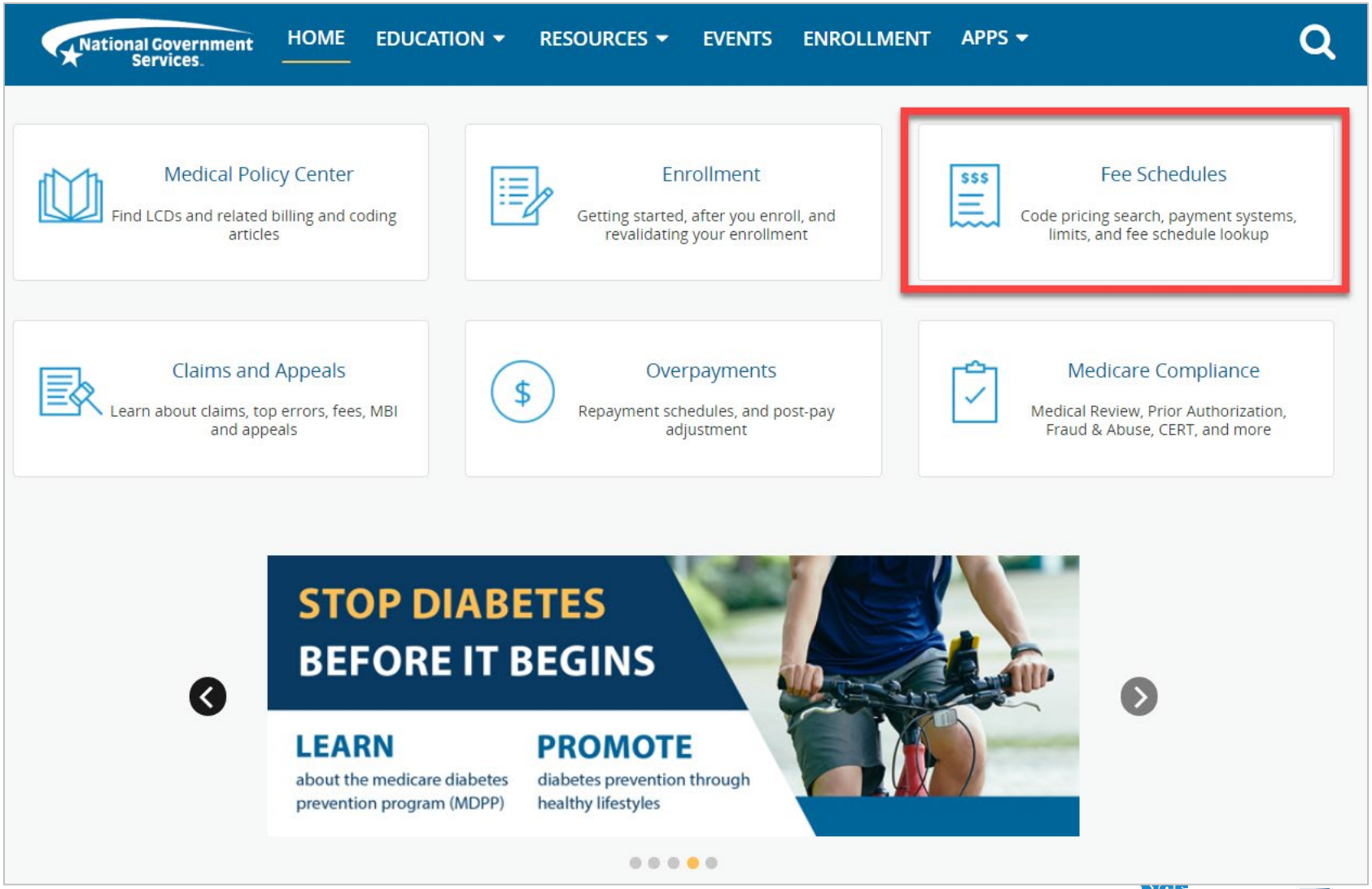
- Find Medicare payment amounts
- Learn if codes to be billed are affected by payment policies
  - Pricing amounts
  - Payment policy indicators
  - RVUs
  - GPCIs

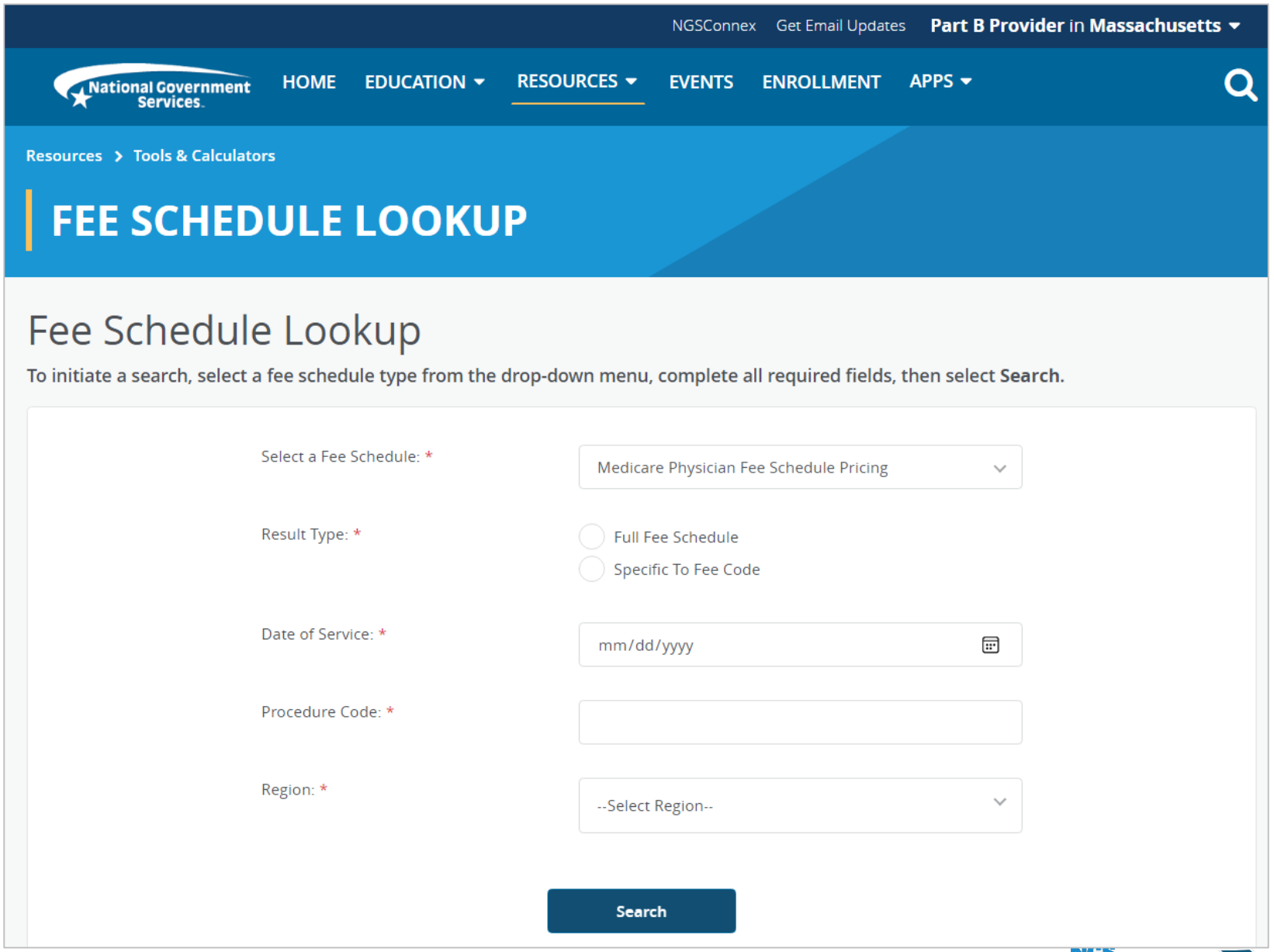
NGS Fee Schedule Lookup Tool

Searching Payment Policy Indicators

- Allowance amount
- If a code is payable by Medicare
- Professional/technical modifiers
- Global surgery days
- Preoperative intraoperative and postoperative
- If a service may be billed bilaterally
- If an assistance at surgery may be billed
- If cosurgery may be billed
- If team surgery may be billed

Medicare Physician Fee Schedule

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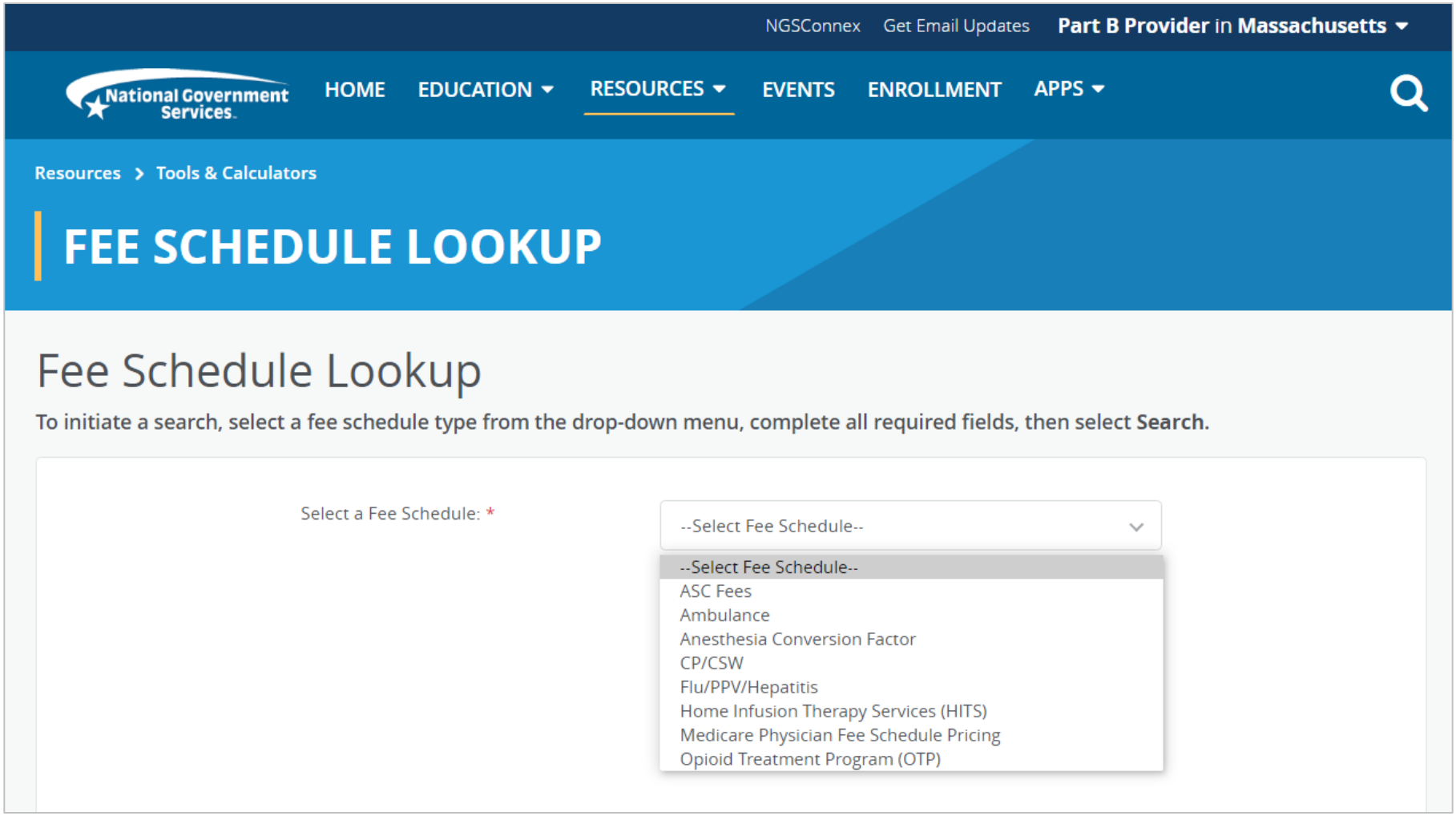
FEE SCHEDULE LOOKUP
Fee Schedule Lookup
To initiate a search, select a fee schedule type from the drop-down menu, complete all required fields, then select Search.
Select a Fee Schedule: *
Medicare Physician Fee Schedule Pricing
Result Type: *
Full Fee Schedule
Specific To Fee Code
Date of Service: *
mm/dd/yyyy
Procedure Code: *
Region: *
--Select Region--
Search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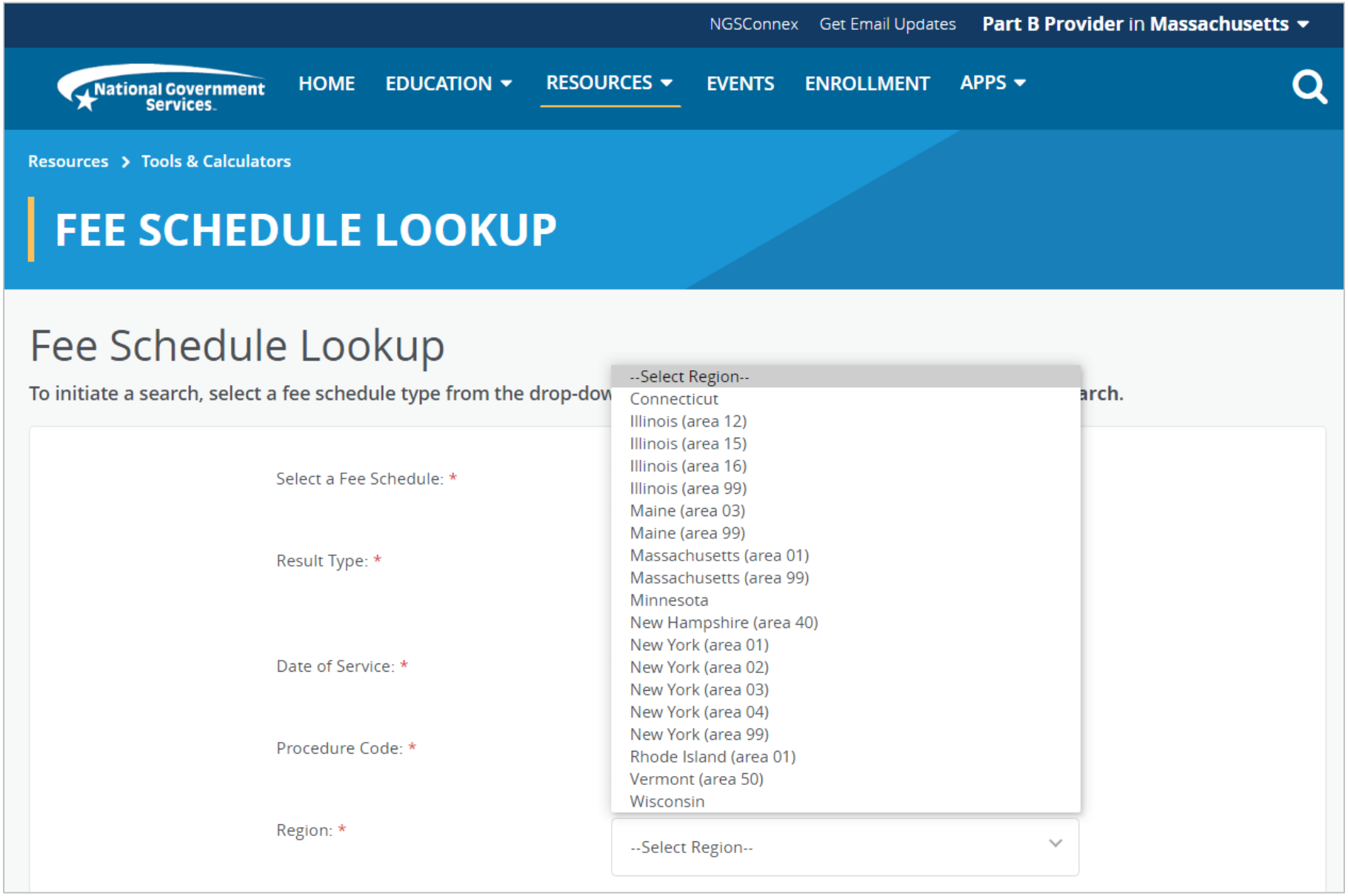
Select a Fee Schedule: *
--Select Fee Schedule--
--Select Fee Schedule--
ASC Fees
Ambulance
Anesthesia Conversion Factor
CP/CSW
Flu/PPV/Hepatitis
Home Infusion Therapy Services (HITS)
Medicare Physician Fee Schedule Pricing
Opioid Treatment Program (OTP)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To initiate a search, select a fee schedule type from the drop-dow
arch.
Select a Fee Schedule: *
Result Type: *
Date of Service: *
Procedure Code: *
Region: *
--Select Region--
--Select Region--
Connecticut
Illinois (area 12)
Illinois (area 15)
Illinois (area 16)
Illinois (area 99)
Maine (area 03)
Maine (area 99)
Massachusetts (area 01)
Massachusetts (area 99)
Minnesota
New Hampshire (area 40)
New York (area 01)
New York (area 02)
New York (area 03)
New York (area 04)
New York (area 99)
Rhode Island (area 01)
Vermont (area 50)
Wisconsin

Locality Lookup

State: * New York

County: * -Select-

-Select-
Albany
Allegany
Bronx
Brooklyn
Broome
Cattaraugus
Cayuga
Chautauqua
Chemung
Chenango
Clinton
Columbia
Cortland
Delaware
Dutchess
Erie
Essex
Franklin
Fulton

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Illinois Locality/Area and County Information

Locality/Area	Counties
12	Bond, Calhoun, Clinton, Jersey, Macoupin, Madison, Monroe, Montgomery, Randolph, St. Clair, Washington
15	DuPage, Kane, Lake, Will
16	Cook
99	All Other Counties

Maine and Massachusetts, Locality/Area and County Information

Locality/Area	State	Counties
01	MA	Middlesex, Norfolk, and Suffolk
99	MA	All Other Counties
03	ME	York and Cumberland
99	ME	All Other Counties

New York Locality/Area and County Information

Locality/Area	Counties
01	Manhattan
02	Bronx, Brooklyn, Nassau, Rockland, Staten Island, Suffolk, Westchester
03	Columbia, Delaware, Dutchess, Greene, Orange, Putnam, Sullivan, Ulster
04	Queens
99	Albany, Oneida, Allegany, Onondaga, Broome, Ontario, Cattaraugus, Orleans, Cayuga, Oswego, Chautauqua, Otsego, Chemung, Rensselaer, Chenango, Saratoga, Clinton, Schenectady, Cortland, Schoharie, Erie, Schuyler, Essex, Seneca, Franklin, Steuben, Fulton, St. Lawrence, Genesee, Tioga, Hamilton, Tompkins, Herkimer, Warren, Jefferson, Washington, Lewis, Wayne, Livingston, Wyoming, Madison, Yates, Monroe Montgomery, Niagara

Procedure Status Indicators

- Field indicates whether the code is in the fee schedule and whether it is separately payable if the service is covered
- Presence of an active (or valid) status code does not mean the service is covered by Medicare
- Service may be valid according to the list but may not be considered covered due to other criteria such as medical necessity or global surgery rules

Policy Indicator	Description
A	**Active code:** These codes are separately paid under the physician fee schedule if covered. There will be RVUs and payment amounts for codes with this status. The presence of an "A" indicator does not mean that Medicare has made a national coverage determination regarding the service; carriers remain responsible for coverage decisions in the absence of a national Medicare policy.
B	**Bundled code:** Payment for covered services is always bundled into payment for other services not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for is subsumed by the payment for the services to which they are incident. (An example is a telephone call from a hospital nurse regarding care of a patient.)
C	**Carriers price the code:** Carriers will establish RVUs and payment amounts for these services, generally on an individual case basis, following review of documentation such as an operative report.
E	**Excluded from Physician Fee Schedule by regulation:** These codes are for items and/or services that the CMS chose to exclude from the fee schedule payment by regulation. No RVUs are shown and no payment may be made under the fee schedule for these codes. Payment for them, when covered, generally continues under reasonable charge 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).
N	**Noncovered Services:** These services are not covered by Medicare.
R	**Restricted Coverage:** Special coverage instructions apply.

PC/TC Indicator

- Indicator describes physician services that have global concept, professional or technical components
- These include diagnostic and therapeutic radiology services, certain diagnostic tests that involve a physician's interpretation and physician pathology services
- Indicators identify TC for technical component and 26 professional component (PC)

Policy Indicator	Description
0	Physician Service Codes: Identifies codes that describe physician services. Examples include visits, consultations and surgical procedures. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. **Modifiers 26 and TC cannot be used with these codes**. The total RVUs include values for physician work, practice expense and malpractice expense. There are some codes with no work RVUs.
1	Diagnostic Tests for Radiology Services: Identifies codes that describe diagnostic tests. Examples are pulmonary function tests or therapeutic radiology procedures, e.g., radiation therapy. These codes 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 include values for physician work, practice expense and malpractice expense.
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 CPT code 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 test only. An example of a technical component only code is CPT code 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 includes values for practice expense and malpractice expense only.
4	**Global Test Only Codes:** This indicator identifies stand-alone codes that describe selected diagnostic tests 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.

Global Surgery

- Indicator provides postoperative time frames that apply to payment for each surgical procedure or another indicator that describes applicability of global concept to service
- Global surgery, includes all necessary services normally furnished by surgeon before, during, and after procedure
- Medicare payment for surgical procedure includes preoperative, intra-operative, and post-operative services routinely performed by the surgeon or by members of same group with same specialty
- Physicians in same group practice who are in same specialty must bill and be paid as though they were single physician

Policy Indicator	Description
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 the 10-day postoperative period generally not payable**.
090	Major surgery with a **one-day preoperative period and 90-day postoperative period** included in the fee schedule payment amount.

Multiple Procedure (Modifier 51)

- Indicator for which payment adjustment rule for multiple surgical procedures applies
- Multiple surgeries are separate procedures performed by single physician or physicians in same group practice on same patient at same operative session or on same day for which separate payment may be allowed and reduced
- Providers do not use modifier 51

Policy Indicator	Description
0	**No payment adjustment rules for multiple procedures apply.** If procedure is reported on the same day as another procedure, base the 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 1/1/1996, for multiple procedures apply. In the 1996 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 percent, 50 percent, 25 percent, 25 percent, 25 percent 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 percent, 50 percent, 50 percent, 50 percent, 50 percent 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 on 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 nonendoscopic procedure). If an endoscopic procedure is reported with only its base procedure, the base procedure is not separately paid. Payment for the base procedure is included in the payment for the other endoscopy.

Bilateral Surgery (Modifier 50)

- Indicates services subject to payment adjustment
- Bilateral services are procedures that can be performed on both sides of body during same session or on same day by same physician or other qualified health care professional

Policy Indicator	Description
0	**150 percent payment adjustment for bilateral procedures does not apply.** If procedure is reported with modifier 50 or with modifiers RT and LT, base the payment for the two sides on the lower of: (a) the total actual charge for both sides or (b) 100 percent of the fee schedule amount for a single code. Example: The fee schedule amount for code XXXXX is $125. The physician reports code XXXXX-LT with an actual charge of $100. Payment should be based on the fee schedule amount of $125 since it is lower than the total actual charges for the left and right sides ($200). The bilateral adjustment is inappropriate for codes in this category (a) because of physiology or anatomy, or (b) because the code description 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 procedure applies.** If the code is billed with the bilateral modifier or is reported twice on the same day by any other means (e.g., with RT and LT modifiers, or with a 2 in the units field), base the 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 the 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 does not apply**. RVUs are already based on the procedure being performed as a bilateral procedure. If the procedure is reported with modifier 50 or is reported twice on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base payment for both sides on the lower of (a) the total actual charges by the physician for both sides, or (b) 100 percent of the fee schedule for a single code. Example: The fee schedule amount for code YYYYY is $125. The physician reports code YYYYY-LT with an actual charge of $100 and YYYYY-RT with an actual charge of $100. Payment should 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 the 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**. If the procedure is reported with modifier 50 or is reported for both sides on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base the 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 percent of the fee schedule amount for each side. If the procedure is reported as a bilateral procedure and with other procedure codes on the same day, determine the fee schedule amount for a bilateral procedure before applying any applicable multiple procedure rules. Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral surgeries.

Assistant at Surgery

- Indicates services where assistant at surgery may be paid
- An assistant surgeon is defined as a physician who actively assists the operating surgeon
  - Assistant may be necessary because of the complex nature of procedure(s) or the patient's condition
  - Assistant is usually trained in same specialty
  - Assistant-at-surgery may be physician assistant, nurse practitioner or nurse midwife acting under the direct supervision of a physician, where physician acts as surgeon and the assistant-at-surgery as an assistant
- Assistant at surgery modifiers include
  - 80 for services by MD or DO
  - AS for services by NP, PA, or CNS

Policy Indicator	Description
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.

Co-surgeons (Modifier 62)

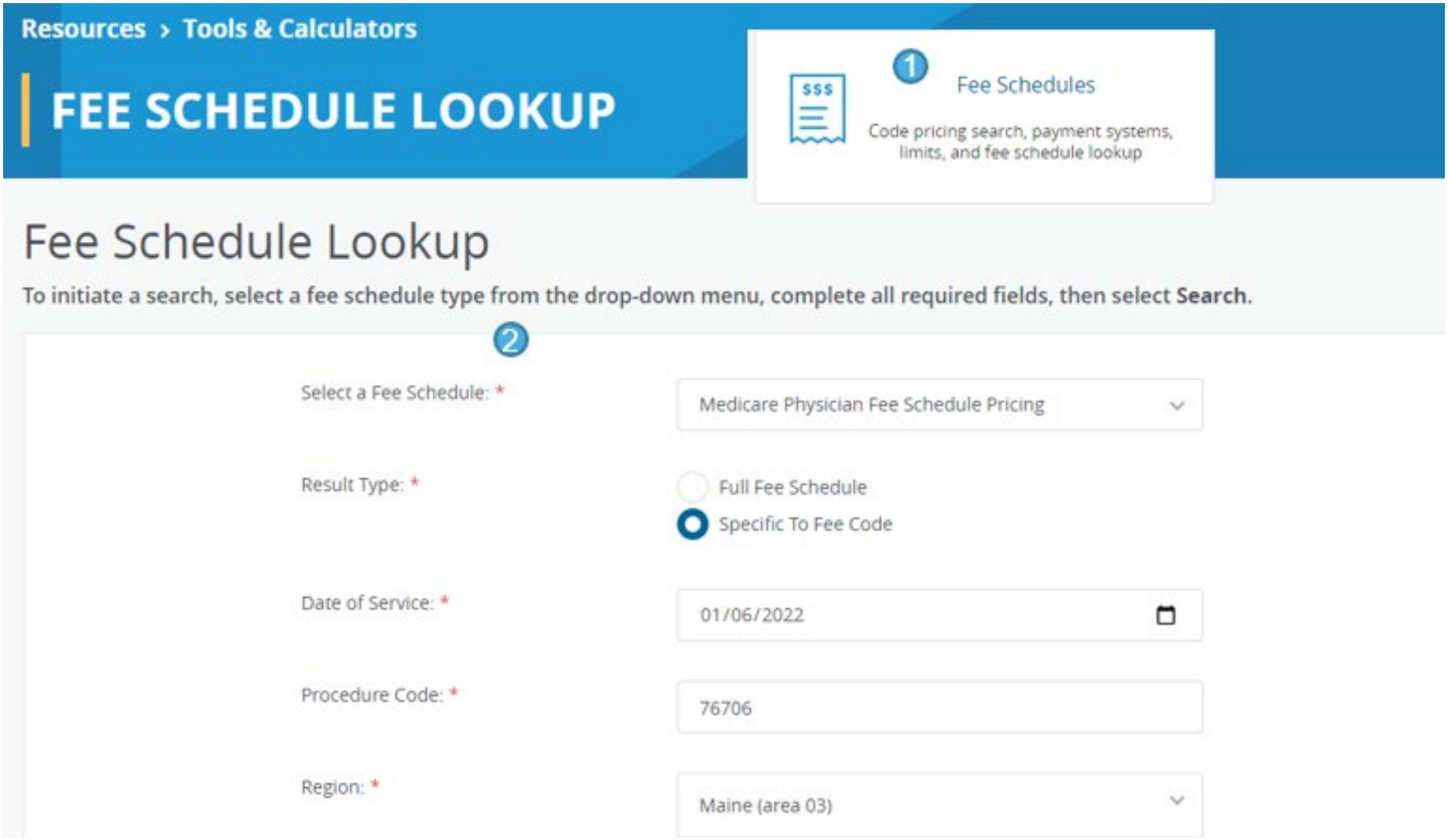
- Indicator for services that two surgeons, each in different specialty
- Cosurgeons are defined as two or more surgeons, where the skills of both surgeons are necessary to perform distinct parts of a specific operative procedure
- Cosurgery is always performed during the same operative session

Policy Indicator	Description
0	Co-surgeons **not permitted for this procedure.**
1	Co-surgeons **could be paid**, **though supporting documentation** is required to establish the medical necessity of two surgeons for the procedure.
2	Co-surgeons **permitted and no documentation** required if the two-specialty requirement is met.
9	Concept does not apply.

Team Surgery (Modifier 66)

- Indicator for services for which team surgeons may be paid
- Under some circumstances, highly complex procedures may require the services of a surgical team, consisting of several physicians, often of different specialties, plus other highly skilled, specially trained personnel and complex equipment
- Benefits are allowed for medically necessary procedures and allowance(s) will be determined on an individual consideration basis

Policy Indicator	Description
0	Team surgeons **not permitted for this procedure.**
1	Team surgeons **could be paid,** though **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.


Resources › Tools & Calculators
FEE SCHEDULE LOOKUP
1
Fee Schedules
Code pricing search, payment systems, limits, and fee schedule lookup
Fee Schedule Lookup
To initiate a search, select a fee schedule type from the drop-down menu, complete all required fields, then select Search.
2
Select a Fee Schedule: *
Medicare Physician Fee Schedule Pricing
Result Type: *
Full Fee Schedule
Specific To Fee Code
Date of Service: *
01/06/2022
Procedure Code: *
76706
Region: *
Maine (area 03)

Medicare Physician Fee Schedule Pricing

Procedure Code	Effective Date	State/Territory	Locality	Short Description
76706	01/01/2022	14112	03	Us abdl aorta screen aaa

Non-OPPS Capped Payment Rates (NON-OPPS)

Modifier	NON FAC PAR	NON FAC NON PAR	NON FAC LC	FAC PAR	FAC NON PAR	FAC LC
(Details)	110.21	104.70	120.41	110.21	104.70	120.41
26 (Details)	26.49	25.17	28.95	26.49	25.17	28.95
TC (Details)	83.72	79.53	91.46	83.72	79.53	91.46

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Medicare Physician Fee Schedule Pricing

Procedure Code	Effective Date	State/Territory	Locality	Short Description
76706	01/01/2022	14112	03	Us abdl aorta screen aaa

Non-OPPS Capped Payment Rates (NON-OPPS)

Modifier	NON FAC PAR	NON FAC NON PAR	NON FAC LC	FAC PAR	FAC NON PAR	FAC LC
(Details) 4	110.21	104.70	120.41	110.21	104.70	120.41
26 (Details)	26.49	25.17	28.95	26.49	25.17	28.95
TC (Details)	83.72	79.53	91.46	83.72	79.53	91.46

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CPT Code 76706

Modifier Selected: (blank)

Status	Conversion Factor	Update Factor	Work RVU	FAC PE RVU	NON FAC PE RVU
A	34.6062	0.9990	0.55	2.61	2.61
Malpractice RVU	**Work GPCI**	**Practice GPCI**	**Malpractice GPCI**	**Reduced Therapy Amt**	**Endoscopic Base**
0.05	1.000	0.997	0.652	0.00	
Global Surgery	**Facility Pricing**	**PC/TC**	**Preoperative Percentage**	**Interoperative Percentage**	**Postoperative Percentage**
XXX	1	1	00.00%	00.00%	00.00%
Multiple Surgery	**Bilateral Surgery**	**Assistant At Surgery**	**Two Surgeons**	**Team Surgery**	
0	0	0	0	0	

Medicare Physician Fee Schedule Pricing

Procedure Code	Effective Date	State/Territory	Locality	Short Description
47480	01/01/2022	14112	03	Incision of gallbladder

Non-OPPS Capped Payment Rates (NON-OPPS)

Modifier	NON FAC PAR	NON FAC NON PAR	NON FAC LC	FAC PAR	FAC NON PAR	FAC LC
(Details)	866.36	823.04	946.50	866.36	823.04	946.50

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CPT Code 47480

Non-OPPS Capped Payment Rates (NON-OPPS)

Modifier	NON FAC PAR	NON FAC NON PAR	NON FAC LC	FAC PAR	FAC NON PAR	FAC LC
(Details)	866.36	823.04	946.50	866.36	823.04	946.50

Modifier Selected: (blank)

Status	Conversion Factor	Update Factor	Work RVU	FAC PE RVU	NON FAC PE RVU
A	34.6062	0.9990	13.25	9.78	9.78

Malpractice RVU	Work GPCI	Practice GPCI	Malpractice GPCI	Reduced Therapy Amt	Endoscopic Base
3.12	1.000	0.997	0.652	0.00	

Global Surgery	Facility Pricing	PC/TC	Preoperative Percentage	Interoperative Percentage	Postoperative Percentage
090	1	0	09.00%	81.00%	10.00%

Multiple Surgery	Bilateral Surgery	Assistant At Surgery	Two Surgeons	Team Surgery
2	0	2	1	0

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CPT Code 33935

Non-OPPS Capped Payment Rates (NON-OPPS)

Modifier	NON FAC PAR	NON FAC NON PAR	NON FAC LC	FAC PAR	FAC NON PAR	FAC LC
(Details)	4742.58	4505.45	5181.27	4742.58	4505.45	5181.27

Modifier Selected: (blank)

Status	Conversion Factor	Update Factor	Work RVU	FAC PE RVU	NON FAC PE RVU
R	34.6062	0.9990	91.78	31.36	31.36

Malpractice RVU	Work GPCI	Practice GPCI	Malpractice GPCI	Reduced Therapy Amt	Endoscopic Base
21.47	1.000	0.997	0.652	0.00	

Global Surgery	Facility Pricing	PC/TC	Preoperative Percentage	Interoperative Percentage	Postoperative Percentage
090	1	0	09.00%	84.00%	07.00%

Multiple Surgery	Bilateral Surgery	Assistant At Surgery	Two Surgeons	Team Surgery
2	0	2	1	2

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CPT Code 99397

Non-OPPS Capped Payment Rates (NON-OPPS)

Modifier	NON FAC PAR	NON FAC NON PAR	NON FAC LC	FAC PAR	FAC NON PAR	FAC LC
(Details)	0.00	0.00	0.00	0.00	0.00	0.00

Modifier Selected: (blank)

Status	Conversion Factor	Update Factor	Work RVU	FAC PE RVU	NON FAC PE RVU
N	0.0000	0.0000	0.00	0.00	0.00
Malpractice RVU	Work GPCI	Practice GPCI	Malpractice GPCI	Reduced Therapy Amt	Endoscopic Base
0.00	1.000	0.997	0.652	0.00	
Global Surgery	Facility Pricing	PC/TC	Preoperative Percentage	Interoperative Percentage	Postoperative Percentage
XXX	9	9	00.00%	00.00%	00.00%

Multiple Surgery	Bilateral Surgery	Assistant At Surgery	Two Surgeons	Team Surgery
9	9	9	9	9

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CPT/HCPCS Code Ranges

- Anesthesia: 00000–09999
- Surgery: 10000–69999
- Radiology: 70000–79999
- Pathology/laboratory: 80000–89999
- Medicine: 90000–99999
- Ambulance: A0000–A9999
- Drugs: J0000–J9999

Not Otherwise Classified or Unlisted Codes

- An unlisted code represents an item, service, or procedure for which there is no specific CPT or Level II alphanumeric HCPCS code
- Unlisted codes should be reported only if no other specific codes adequately describe the procedure or service
- Consider finding a CPT code that best describes service/procedure using the reduced service modifier 52

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Documentation for NOC and Unlisted Codes

- Service/procedure(s) should be adequately documented in your medical record and submitted with each claim
  - Paper or electronic media claims
- Medicare allowable amounts are not established; therefore, allowance is based on the supporting documentation

Resources

- NGS Fee Schedule Lookup Tool
- Fee Schedule Assistance page
- Locality and county information
- CMS website
- Overview of the Physician Fee Schedule Search

Interactive Scenarios

Fee Schedule Allowance

- What is the fee schedule allowance for 33216 in Illinois locality 12 non facility par?
- $402.95
- $204.59

Fee Schedule Assistance

- Is 33216 a minor or major procedure?
- Minor
- Major

Fee Schedule Database: Assistant at Surgery

- Can assistant at surgery be paid for 33216?
- Yes
- No

Fee Schedule Database: Cosurgery

- Can cosurgery be paid for 33216?
- Yes
- No

Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?

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