CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 10320	**Date: August 28, 2020**
	Change Request 11941

SUBJECT: Updates to Chapter 23 - Fee Schedule Administration and Coding Requirements

I. SUMMARY OF CHANGES: This change request updates Chapter 23 to reflect the quarterly update process for HCPCS files. It also removes outdated instructions from the chapter.

EFFECTIVE DATE: December 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: December 1, 2020

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	23/Table of Contents
R	23/20/Description of Healthcare Common Procedure Coding System (HCPCS)
R	23/20.1/Use and Maintenance of CPT-4 in HCPCS
R	23/20.2/Local Codes
R	23/20.3/Use and Acceptance of HCPCS Codes and Modifiers
R	23/20.4/Deleted HCPCS Codes/Modifiers
R	23/20.8/Payment, Utilization Review (UR), and Coverage Information on CMS Quarterly HCPCS Codes Update File
R	23/50.6/Physician Fee Schedule Payment Policy Indicator File Record Layout

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

regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 10320	Date: August 28, 2020	Change Request: 11941

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I. GENERAL INFORMATION

A. Background: Recently, original Medicare implemented changes to allow Medicare Administrative Contractors (MACs) and shared system maintainers to systematically load Healthcare Common Procedure Coding System (HCPCS) files on a quarterly basis. CMS systems are now constructed such that all quarterly updates of the HCPCS code set can occur using the complete HCPCS file as it is updated and released to the Medicare contractors. This Change Request (CR) makes conforming changes to Publication (Pub.)100-04, Medicare Claims Processing Manual, to reflect quarterly rather than annual file updates.

This change request also updates the manual to remove outdated references to local codes and HCPCS grace periods. These processes are not compliant with Health Insurance Portability and Accountability Act of 1996 (HIPAA) transaction and code set regulations and have not been in effect for many years. It also corrects a detail error in a record layout.

B. Policy: This change request contains no new policy. It updates Medicare manuals to more accurately reflect current policies.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11941.1	Contractors shall be aware of the manual updates in Pub. 100-04, Chapter 23 contained in this CR.	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Wil Gehne, wilfried.gehne@cms.hhs.gov

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

VI. FUNDING

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

ATTACHMENTS: 0

Medicare Claims Processing Manual
Chapter 23 - Fee Schedule Administration and Coding Requirements

Table of Contents
(Rev. 10320, Issued: 08-28-2020)

20 - Description of Healthcare Common Procedure Coding System (HCPCS)

(Rev.10320, Issued: 08-28-2020, Effective: 12-01-2020, Implementation: 12-01-2020)

The HCPCS has been *adopted* as the *code* set for *use in* Health Insurance Portability and Accountability Act (HIPAA) *transactions*, for reporting outpatient procedures*, items, and services*.

The HCPCS *originated from* the American Medical Association's (AMA) "Physicians' Current Procedural Terminology, Fourth Edition" (CPT-4). It includes *two* levels of codes and modifiers. Level I contains only the AMA's CPT-4 codes. This level consists of all numeric codes. Level II contains alpha-numeric codes primarily for items and nonphysician services not included in CPT-4, e.g., ambulance, DME, orthotics, and prosthetics. These are alpha-numeric codes maintained by CMS.

The CMS monitors the system to ensure uniformity.

20.1 - Use and Maintenance of CPT-4 in HCPCS

(Rev.10320, Issued: 08-28-2020, Effective: 12-01-2020, Implementation: 12-01-2020)

There are over 7,000 service codes, plus titles and modifiers, in the CPT-4 section of HCPCS, which is copyrighted by the AMA. The AMA and CMS have entered into an agreement that permits the use of HCPCS codes and describes the manner in which they may be used. See §20.7 below.

- The AMA permits CMS, its agents, and other entities participating in programs administered by CMS to use CPT-4 codes/modifiers and terminology as part of HCPCS;

- CMS shall adopt and use CPT-4 in connection with HCPCS for the purpose of reporting services under Medicare and Medicaid;

- CMS agrees to include a statement in HCPCS that participants are authorized to use the copies of CPT-4 material in HCPCS only for purposes directly related to participating in CMS programs, and that permission for any other use must be obtained from the AMA;

- HCPCS shall be prepared in format(s) approved in writing by the AMA, which include(s) appropriate notice(s) to indicate that CPT-4 is copyrighted material of the AMA;

- Both the AMA and CMS will encourage health insurance organizations to adopt CPT-4 for the reporting of physicians' services in order to achieve the widest possible acceptance of the system and the uniformity of services reporting;

- The AMA recognizes that CMS and other users of CPT-4 may not provide payment under their programs for certain procedures identified in CPT-4. Accordingly, CMS and other health insurance organizations may independently establish policies and procedures governing the manner in which the codes are used within their operations; and

- The AMA's CPT-4 Editorial Panel has the sole responsibility to revise, update, or modify CPT-4 codes.

The AMA updates and republishes CPT-4 annually and provides CMS with the updated data. The CMS updates the alpha-numeric (Level II) portion of HCPCS and incorporates the updated AMA material to create the HCPCS code file. The CMS provides the file to A/B MACs (A), (B), (HHH), and DME MACs and Medicaid State agencies. *The file is also available via the CMS website.*

It is the MAC's responsibility to develop payment screens and limits within Federal guidelines and to implement CMS' issuances. The coding system is one of the tools used to achieve national consistency in claims processing.

MACs may edit and abridge CPT-4 terminology within their claims processing area. However, MACs are not allowed to publish, edit, or abridge versions of CPT-4 for distribution outside of the claims processing structure. This would violate copyright laws. MACs may furnish providers/suppliers AMA and CMS Internet addresses, and may issue newsletters with codes and approved narrative descriptions that instruct physicians, suppliers and providers on the use of certain codes/modifiers when reporting services on claims forms, e.g., need for documentation of services, handling of unusual circumstances. The CMS acknowledges that CPT is a trademark of the AMA, and the newsletter must show the following statement in close proximity to listed codes and descriptors:

> *"CPT Copyright 2017 American Medical Association. All rights reserved.*
> *CPT® is a registered trademark of the American Medical Association."*
>
> *(Please note that the use or reprinting of CPT content in any product or publication requires a license. For more information about the licenses available, see CPT License Information.)*
>
> *Applicable FARS/DFARS Restrictions Apply to Government Use*
>
> *Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.*

If only a small portion of the terminology is used, MACs do not need to show the copyright legend. MACs may also print the code and approved narrative description in development requests relating to individual cases.

The CMS provides MACs *a quarterly* update file of HCPCS codes and instructions to retrieve the update via CMS mainframe telecommunication system.

20.2 - *RESERVED*

20.3 - Use and Acceptance of HCPCS Codes and Modifiers

(Rev.10320, Issued: 08-28-2020, Effective: 12-01-2020, Implementation: 12-01-2020)

The HCPCS is updated *quarterly* to reflect changes in the practice of medicine and provision of health care. The CMS provides a file containing the updated HCPCS codes to A/B MACs (A), (B), (HHH), and DME MACs and Medicaid State agencies 60 to 90 days in advance of the implementation of *each* update. Distribution consists of an electronic file of the updated HCPCS codes, file characteristics, record layout, and a listing of *added, revised and deleted* codes. MACs are required to update their HCPCS codes file and map all new, *revised, and* deleted codes to appropriate payment information.

An updated list of the HCPCS codes for Durable Medical Equipment Medicare Administrative Contractors (DME MAC) and A/B MAC (B) jurisdictions is updated *quarterly* to reflect codes that have been added or discontinued (deleted) during each year. A recurring update notification will be published to notify the

DME MACs and A/B MACs (B) that the list has been updated and is available on the CMS Web site. https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html.

Both the DME MACs and the A/B MACs (B) publish this list to educate providers on which MAC they should bill for codes provided on this list.

Physicians and suppliers must use HCPCS codes on the Form CMS-1500 or its electronic equivalent and providers must use HCPCS codes on the Form CMS-1450 or its electronic equivalent for most outpatient services. The *procedure, item, or* service can be further described by using 2-position modifiers contained in HCPCS.

Modifiers to HCPCS Level I codes for medicine, anesthesia, surgery, radiology, and pathology are on the HCPCS codes file from CMS. Modifiers for Level II alpha-numeric codes are with the Level II codes published by CMS. Alpha-numeric and CPT-4 modifiers may be used with either alpha-numeric or CPT-4 codes. A/B MACs *(A, B and HHH)* and DME MACs are required to accept *up to four* 2-position numeric or alpha modifiers and process both modifiers completely through the claims processing system (including any manual portion) as far as payment history. It is not acceptable merely to be able to accept multiple modifiers and then drop one before complete systems processing. Dropping of a modifier leads to incomplete and inaccurate pricing profiles.

Series "Q," "K," and "G" in the Level II coding are reserved for CMS assignment. "Q," "K," and "G" codes are **temporary** national codes for items or services requiring uniform national coding between one year's update and the next. Sometimes "temporary" codes remain for more than one update. If "Q," "K," or "G" codes are not converted to permanent codes in the Level I or Level II series in the following update, they will remain active until converted or until CMS notifies MACs to delete them. All active "Q," "K," and "G" codes at the time of update will be included on the update file for MACs. In addition, deleted codes are retained on the file for informational purposes, with a deleted indicator, for four years.

Series "S" Level II codes are reserved for use by the BCBSA and *other private insurers*. These codes provide for reporting needs unique to those organizations. Each State defines its own Medicaid coverage, payment, and utilization levels. The CMS does not impose Medicare requirements on Medicaid programs. The HCPCS simply provides a system for identifying services that can be expanded to meet everyone's needs.

20.4 - Deleted HCPCS Codes/Modifiers

(Rev.10320, Issued: 08-28-2020, Effective: 12-01-2020, Implementation: 12-01-2020)

Claims for services in a prior year are reported and processed using the HCPCS codes/modifiers in effect during that year. For example, a claim for a service furnished in November *2019* but received by an A/B MAC (A), (B), or (HHH), or DME MAC in *2020*, should contain codes/modifiers valid in *2019* and is processed using the prior year's pricing files.

HCPCS codes (Level I CPT-4 and Level II alpha-numeric) are updated on *a quarterly* basis. Each *quarter (January, April, July and October)*, CMS releases the HCPCS file to A/B MACs (A), (B), (HHH), and DME MACs. The HCPCS file contains the CPT-4 and the alpha-numeric updates. All MACs are notified of the release date via a one-time notification instruction. The file contains new, deleted, and revised HCPCS codes which are effective *for the upcoming quarter*.

The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets must be date of service compliant.

Providers can purchase the American Medical Association's CPT-4 coding book that is published each October that contains new, revised, and discontinued CPT-4 codes for the upcoming year. In addition, CMS posts on its Web site the alpha-numeric HCPCS file. Providers are encouraged to access CMS web site to

see the new, revised, and discontinued alpha-numeric codes. The CMS web site to view the HCPCS update is https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html.

A/B MACs (B) and DME MACs must reject services submitted with discontinued HCPCS codes. A/B MACs (A) and (HHH) must return to the provider (RTP) claims containing deleted codes.

See the Medicare Claims Processing Manual, Chapter 22, "Remittance Notices to Providers."

20.8 - Payment, Utilization Review (UR), and Coverage Information on CMS *Quarterly* HCPCS Codes Update File

(Rev.10320, Issued: 08-28-2020, Effective: 12-01-2020, Implementation: 12-01-2020)

The file CMS provides for the *quarterly* update of HCPCS codes contains fields for payment, UR, and coverage information to assist in developing front-end edit screens. Coverage information is not all inclusive, but should be used mainly as a guide in establishing specific review limits. A/B MACs (B) must establish reasonable developmental guidelines, review screens, and relative value units, as appropriate. A/B MACs (B) must assure that their system processes claims in accordance with CMS policies and procedures, including changes that may occur between HCPCS codes updates.

Where CMS determines that nationally uniform temporary codes/modifiers are needed to implement policy/legislation between HCPCS codes updates, the codes/modifiers, definitions and policy are issued as Level II codes/modifiers prefixed with "Q" or "K" or "G." Questions may arise in updating that require A/B MAC (B) staff to refer to a physician's or supplier's pricing history. Therefore, keep an electronic backup of HCPCS codes for the two prior years with linkages to pricing profiles. Perform required computer analysis as necessary.

The HCPCS terminology seldom includes a place of service designation. Where place of service affects pricing, pricing is obtained from the place of service field on the claim record.

A/B MACs (A) and (HHH) also develop editing screens using HCPCS based on payment and coverage policies from CMS. A/B MACs (A) and (HHH) must assure that system claims processing complies with CMS policy and procedures.

50.6 – Physician Fee Schedule Payment Policy Indicator File Record Layout

(Rev.10320, Issued: 08-28-2020, Effective: 12-01-2020, Implementation: 12-01-2020)

The information on the Physician Fee Schedule Payment Policy Indicator file record layout is used for processing Method II CAH professional services with revenue codes 96X, 97X or 98X.

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 that are currently returned on the MPFS supplemental file will be included *when the MPFS Status Indicator is A, C, T, and some with R*. The standard sort for this field is blanks, alpha, and numeric in ascending order.	5 Pic x(5)	5-9

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
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 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.	2 Pic x(2)	10-11
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 = A/B MAC (A) 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 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.	6 Pic 9v9(5)	28-33
Professional Component (PC)/Technical Component (TC) Indicator 0 = Physician service codes: This indicator identifies	1 Pic x(1)	34

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
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 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		

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
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 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.		

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
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		
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 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	1 Pic (x)1	35

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
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 *multiple procedure payment reduction (MPPR).* 9 = Concept does not apply. Codes with RVUs equal to zero are not included in the payment indicator file. These codes may have multiple procedure indicators not shown. See note below this table for instructions on these codes.		
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 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.	1 Pic (x)1	36

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
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) 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.	1 Pic (x)1	38
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 Pic (x)1	39

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
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.		
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
Effective Date This field displays the effective date of the file in YYYYMMDD format.	8 Pic x(8)	48 - 55
Filler	30 Pic x(30)	56 -75

Multiple procedure indicator 5 is not 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 are not 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 are not subject to the reductions.

There may be cases when A/B MACs (A) must manually load a HCPCS code that is contractor priced which has a multiple procedure indicator that is not on the payment indicator file. In these cases, the MAC enters a multiple procedure indicator of 0.