Historical Medicare Physician Fee Schedule Database (MPFSDB) Layouts

The MPFSDB includes the fee schedule amount, related component parts, and payment policy indicators. The MPFSDB record layout with the field descriptions and indicator definitions can be found on the CMS website in the Internet-Only Manual (IOM), Publication 100-04, Chapter 23, Addendum - MPFSDB File Record Layout and Field Descriptions, at the link below:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf

The IOM used to include the MPFSDB File Record Layouts for each year from 2001 to 2018. Beginning with the 2019 MPFSDB, and thereafter, the MPFSDB File Record Layout in the IOM will no longer be revised annually for the sole purpose of changing the calendar year, but will only be revised when there is a change to a field.

For historical reference, the MPFSDB file layouts for 2001 to 2018 that were removed from the IOM are below:

2001 File Layout

FIELD # & ITEM	LENGTH & PIC
1 File Year This field displays the effective year of the file.	4 Pic x(4)
2 A/B MAC (B) Number This field represents the 5-digit number assigned to the A/B MAC (B).	5 Pic x(5)
3 Locality This 2-digit code identifies the pricing locality used.	2 Pic x(2)
4 HCPCS Code This field represents the procedure code. Each A/B MAC (B) Procedural Terminology (CPT) code and alphanumeric HCPCS codes other than B, E, K and L codes and services representing anesthesia services will be included. The standard sort for this field is blanks, alpha, and numeric in ascending order.	5 Pic x(5)
5 Modifier For diagnostic tests, a blank in this field denotes the global service and the following modifiers identify the components: 26 = Professional component	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
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 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. Any other codes billed with modifier -53 are subject to A/B MAC (B) medical review and priced by individual consideration. 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.	
6 Descriptor This field will include a brief description of each procedure code.	50 Pic x(50)
7 Code Status This 1 position field provides the status of each code under the full fee schedule. Each status code is explained in §30.2.3.	1 Pic x(1)
8 Conversion Factor This field displays the multiplier which transforms relative values into payment amounts. The file will contain the 2001 conversion factor which will reflect all adjustments.	8 Pic 9(4)v9999
9 Update Factor This update factor has been included in the conversion factor in Field 8.	6 Pic 9(2)v9999
10 Work Relative Value Unit This field displays the unit value for the physician work RVU.	9 Pic 9(7)v99
11 Base Practice Expense Relative Value Unit For 2000 and beyond, this field is not applicable and will be zero filled. For 1999, this field displayed the unit value for the base practice expense RVU.	9 Pic 9(7)v99
12 Malpractice Relative Value Unit	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
This field displays the unit value for the malpractice expense RVU.	
13 Work Geographic Practice Cost Indices (GPCIs) This field displays a work geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
14 Practice Expense GPCI This field displays a practice expense geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
15 Malpractice GPCI This field displays a malpractice expense geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
16 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. 090 = Major surgery with a 1day 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 (B) 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.	3 Pic x(3)
17 Preoperative Percentage (Modifier 56)	6 Pic 9v9(5)

FIELD # & ITEM	LENGTH & PIC
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 0.1000. The total of fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	
18 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 0.6300. The total of fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
19 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 0.1700. The total of fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
20 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.	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
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 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 A/B MACs (B) 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.	

FIELD # & ITEM	LENGTH & PIC
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 = Physician 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.	
21 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 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 or 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 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,	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
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 field 31G. Apply the multiple endoscopy rules to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). 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 = Indicator is reserved for possible future use. 9 = Concept does not apply.	

22 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. If procedure is reported with modifier 50 or with modifiers RT and LT, base 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 and XXXXX-RT with an actual charge of $100. Payment would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The 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 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 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. If 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 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 amount for a single code. Example: The fee schedule amount for code YYYYY is $125. The physician reports code YYYYYLT with an actual charge of $100 and YYYYYRT with an actual charge of $100. Payment would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The RVUs are based on a bilateral procedure because: (a) the code descriptor specifically states that the procedure is bilateral; (b) the code descriptor states that the procedure may be performed either	1 Pic x(1)

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 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 payment for each side or organ or site of a paired organ on the lower of: (a) the actual charge for each side or (b) 100% of the fee schedule amount for each side. If procedure is reported as a bilateral procedure and with other procedure codes on the same day, 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 procedures. 9 = Concept does not apply.	
23	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
Assistant at Surgery This field provides an indicator for services where an assistant at surgery is never paid for per MCM. 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.	
24 CoSurgeons (Modifier 62) This field provides an indicator for services for which two surgeons, each in a different specialty, may be paid. 0 = Cosurgeons not permitted for this procedure. 1 = Cosurgeons could be paid; supporting documentation required to establish medical necessity of two surgeons for the procedure. 2 = Cosurgeons permitted; no documentation required if two specialty requirements are met. 9 = Concept does not apply.	1 Pic x(1)
25 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)
26 Billable Medical Supplies This field provides an indicator for services subject to special payment rules for supplies/administration. 0 = Cannot be separately billed with this service. 1 = Code in related procedure code field can be paid separately when billed with these codes when service is performed in the physicians office. 9 = Concept does not apply.	1 Pic x(1)
27	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
Site of Service Differential For 1998, this field provides an indicator for services with differential payments based on site of service. 0 = Differential does not apply to this service. 1 = Applies due to a 50 percent reduction in practice expense RVUs. 2 = Applies due to the site of service practice expense RVUs. 3 = Applies due to a 50 percent reduction in the site of service practice expense RVUs. 9 = Concept does not apply. For 1999 and beyond, the site of service differential no longer applies. The following definitions will apply for all years after 1998: 0 = Facility pricing does not apply. 1 = Facility pricing applies	
28 Non-Facility Fee Schedule Amount This field shows the fee schedule amount for the non-facility setting. This amount equals Field 34. Non-Facility Pricing Amount [(Work RVU * Work GPCI) + (Transitioned Non-Facility PE RB RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor	9 Pic 9(7)v99
29 Facility Fee Schedule Amount This field shows the fee schedule amount for the facility setting. This amount equals Field 35. Facility Pricing Amount [(Work RVU * Work GPCI) + (Transitioned Facility PE RB RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor Place of service codes to be used to identify facilities. 21 - Inpatient Hospital 22 - Outpatient Hospital 23 - Emergency Room - Hospital 24 - Ambulatory Surgical Center 31 - Skilled Nursing Facility 53 - Community Mental Health Center 51 - Inpatient Psychiatric Facility 61 - Comprehensive Inpatient Rehabilitation Facility 62 - Comprehensive Outpatient Rehabilitation Facility	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
30 Number of Related Codes This field defines the number of related procedure codes (see Field 31).	2 Pic 99
31 Related Procedure Codes This field identifies the number of times that a related code occurs.	65 Pic x(5) - Occurs 13 times
31A Physician Supervision of Diagnostic Procedures This field is for informational use only for post payment review. 1 = Procedure must be performed under the general supervision of a physician. 2 = Procedure must be performed under the direct supervision of a physician. 3 = Procedure must be performed under the personal supervision of a physician. 4 = Physician supervision policy does not apply when procedure personally furnished by a qualified, independent psychologist or a clinical psychologist; otherwise must be performed under the general supervision of a physician. 5 = Physician supervision policy does not apply when procedure personally furnished by a qualified audiologist; otherwise must be performed under the general supervision of a physician. 6 = Procedure must be personally performed by a physician OR a physical therapist who is certified by the American Board of Physical Therapy Specialties as a qualified electrophysiologic clinical specialist AND is permitted to provide the service under State law. 7 = Procedure must be personally performed by a physical therapist who is certified by the American Board of Physical Therapy Specialties as a qualified electrophysiologic clinical specialist AND is permitted to provide the service under State law OR performed under the direct supervision of a physician. 8 = For future use. 9 = Concept does not apply. P = Decision pending.	1 Pic x(1)
31B Filler Reserved for future use.	1 Pic x(1)
31C	9 Pic(7)v99

FIELD # & ITEM	LENGTH & PIC
Transitioned Facility Setting Practice Expense Relative Value Units	
31D Transitioned NonFacility Setting Practice Expense Relative Value Units	9 Pic(7)v99
31E Base Site of Service Practice Expense Relative Value Units	9 Pic(7)v99
31F Filler Reserved for future use.	1 Pic x(1)
31G Endoscopic Base Codes This field identifies an endoscopic base code for each code with a multiple surgery indicator of 3.	5 Pic x(5)
32A 1996 Transition/Fee Schedule Amount This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
32B 1996 Transition/Fee Schedule This field is no longer Indicator applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
32C 1996 Transition/Fee Schedule Amount When Site or Service Differential Applies This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
33A Units Payment Rule Indicator Reserved for future use. 9 = Concept does not apply.	1 Pic x(1)
33B Mapping Indicator This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
33C Medicare+Choice Encounter Pricing Locality NOT FOR A/B MAC (B) USE: These Medicare+Choice encounter pricing localities are for EDS purposes only. The locality values	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
were developed to facilitate centralized processing of encounter data by the Medicare+Choice organizations (M+COs).	
33D National Level Future Expansion This field is being provided for future expansion at the national level	7 Pic x(7)
34 Non-Facility Transition/Fee Schedule Amount* Since this field has historically been used to obtain the pricing amount, this field will replicate Field 28.	9 Pic 9(7)v99
35 Facility Transition/Fee Schedule Payment Amount* Since this field has historically been used to obtain the pricing amount, this field will replicate Field 29.	9 Pic 9(7)v99
36 Transition Calculation Indicator* In 2001, this field is not populated. 2001 Non-Facility Pricing Amount [(Work RVU * Work GPCI) + (Transitioned Non-Facility PE RB RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor 2001 Facility Pricing Amount [(Work RVU * Work GPCI) + (Transitioned Facility PE RB RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor	1 Pic x(1)
37 Future Local Level Expansion** The Updated 1992 Transition Amount was previously stored in this field. A/B MACs (B) can continue to maintain the updated transition amount in this field.	7 Pic x(7)
38A Future Local Level Expansion** The adjusted historical payment basis (AHPB) was previously stored in this field. A/B MACs (B) can continue to maintain the AHPB in this field.	7 Pic x(7)
38B Filler This field was originally established for 15 spaces. Since AHPB data will only use 7 of the 15 spaces, A/B MACs (B) have 8 remaining spaces for their purposes.	8 Pic x(8)

* These fields will be provided by the Program Development and Information Group in the 2001 Medicare Fee Schedule Database for codes with status code indicator of A and T, as well as, indicators D and R with associated RVUs. A/B MACs (B) will be responsible for calculating the 2001 payment amounts for codes with status code indicator of C, L, and R for codes without associated RVUs.

** These fields will be appended by each A/B MAC (B) at the local level.

2002 File Layout

HEADER RECORD

FIELD #	DATA ELEMENT NAME	LOCATION	PIC
1	Header ID	1-4	x(4) Value “Head"
2	Header Number	5	x(1)
3	Data Set Name	6-50	x(45)
4	Record Length	51-53	x(3)
5	Filler	54-54	x(1)
6	Block size	55-58	x(4)
7	Filler	59-59	x(1)
8	Number of Records Number does not include this header record	60-69	9(10)
9	Date Created	70-77	x(8) YYYYMMDD
10	Blanks	78-345	x(268)

FILE LAYOUT

FIELD # & ITEM	LENGTH & PIC
1 File Year This field displays the effective year of the file.	4 Pic x(4)
2 A/B MAC (B) Number This field represents the 5-digit number assigned to the A/B MAC (B).	5 Pic x(5)
3 Locality This 2-digit code identifies the pricing locality used.	2 Pic x(2)
4 HCPCS Code	5 Pic x(5)

FIELD # & ITEM	LENGTH & PIC
This field represents the procedure code. Each A/B MAC (B) Procedural Terminology (CPT) code and alphanumeric HCPCS codes other than B, E, K and L codes and services representing anesthesia services will be included. The standard sort for this field is blanks, alpha, and numeric in ascending order.	
5 Modifier For diagnostic tests, a blank in this field denotes the global service and the following modifiers identify the components: 26 = Professional component TC = Technical component For services other than those with a professional and/or technical component, a blank will appear in this field with one exception: the presence of CPT modifier 53 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. Any other codes billed with modifier -53 are subject to A/B MAC (B) 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)
6 Descriptor This field will include a brief description of each procedure code.	50 Pic x(50)
7 Code Status This 1 position field provides the status of each code under the full fee schedule. Each status code is explained in §30.2.3.	1 Pic x(1)
8 Conversion Factor This field displays the multiplier which transforms relative values into payment amounts. The file will contain the 2002 conversion factor which will reflect all adjustments.	8 Pic 9(4)v9999
9 Update Factor	6 Pic 9(2)v9999

FIELD # & ITEM	LENGTH & PIC
This update factor has been included in the conversion factor in Field 8.	
10 Work Relative Value Unit This field displays the unit value for the physician work RVU.	9 Pic 9(7)v99
11 Filler	9 Pic 9(7)v99
12 Malpractice Relative Value Unit This field displays the unit value for the malpractice expense RVU.	9 Pic 9(7)v99
13 Work Geographic Practice Cost Indices (GPCIs) This field displays a work geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
14 Practice Expense GPCI This field displays a practice expense geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
15 Malpractice GPCI This field displays a malpractice expense geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
16 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. 090 = Major surgery with a 1day preoperative period and 90 day postoperative period included in the fee schedule payment amount.	3 Pic x(3)

FIELD # & ITEM	LENGTH & PIC
MMM = Maternity codes; usual global period does not apply. XXX = Global concept does not apply YYY = A/B MAC (B) 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.	
17 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 0.1000. The total of fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
18 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 0.6300. The total of fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
19 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 0.1700. The total of fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
20 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 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
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 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.	

FIELD # & ITEM	LENGTH & PIC
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 A/B MACs (B) 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.	
21 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 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 or 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	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
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 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 field 31G. Apply the multiple endoscopy rules to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). 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 = Indicator is reserved for possible future use. 9 = Concept does not apply.	
22 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. If procedure is reported with modifier 50 or with modifiers RT and LT, base 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 and XXXXX-RT with an actual charge of $100. Payment would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200).	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
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 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 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 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. If 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 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 amount for a single code. Example: The fee schedule amount for code YYYYY is $125. The physician reports code YYYYYLT with an actual charge of $100 and YYYYYRT with an actual charge of $100. Payment would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The RVUs are based on a bilateral procedure because: (a) the code descriptor specifically states that the procedure is bilateral; (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally; or (c) the procedure is usually performed as a bilateral procedure. 3 = The usual payment adjustment for bilateral procedures does not apply. If 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 payment for each side or organ or site of a paired organ on the lower of: (a) the actual charge for each side or (b) 100% of the fee schedule amount for each side. If procedure is reported as a bilateral procedure and with other procedure codes on the same day, determine the fee schedule amount for a bilateral procedure before applying any applicable multiple procedure rules.	

FIELD # & ITEM	LENGTH & PIC
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. 9 = Concept does not apply.	
23 Assistant at Surgery This field provides an indicator for services where an assistant at surgery is never paid for per MCM. 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)
24 Co-Surgeons (Modifier 62) This field provides an indicator for services for which two surgeons, each in a different specialty, may be paid. 0 = Cosurgeons not permitted for this procedure. 1 = Cosurgeons could be paid; supporting documentation required to establish medical necessity of two surgeons for the procedure. 2 = Cosurgeons permitted; no documentation required if two specialty requirements are met. 9 = Concept does not apply.	1 Pic x(1)
25 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)
26 Filler	1 Pic x(1)
27 Site of Service Differential	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
For 1999 and beyond, the site of service differential no longer applies. The following definitions will apply for all years after 1998: 0 = Facility pricing does not apply. 1 = Facility pricing applies.	
28 Non-Facility Fee Schedule Amount This field shows the fee schedule amount for the non-facility setting. This amount equals Field 34. Non-Facility Pricing Amount [(Work RVU * Work GPCI) + (Non-Facility PE RB RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor	9 Pic 9(7)v99
29 Facility Fee Schedule Amount This field shows the fee schedule amount for the facility setting. This amount equals Field 35. Facility Pricing Amount [(Work RVU * Work GPCI) + (Facility PE RB RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor Place of service codes to be used to identify facilities. 21 - Inpatient Hospital 22 - Outpatient Hospital 23 - Emergency Room - Hospital 24 - Ambulatory Surgical Center - ASC is only treated as a facility setting when an ASC list procedure is performed in an ASC. 31 - Skilled Nursing Facilit 53 - Community Mental Health Center 51 - Inpatient Psychiatric Facility 61 - Comprehensive Inpatient Rehabilitation Facility	9 Pic 9(7)v99
30 Number of Related Codes This field defines the number of related procedure codes (see Field 31).	2 Pic 99
31 Related Procedure Codes This field identifies the number of times that a related code occurs.	65 Pic x(5) Occurs 13 times
31A	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
Physician Supervision of Diagnostic Procedures This field is for use in post payment review. 1 = Procedure must be performed under the general supervision of a physician. 2 = Procedure must be performed under the direct supervision of a physician. 3 = Procedure must be performed under the personal supervision of a physician. 4 = Physician supervision policy does not apply when procedure is furnished by a qualified, independent psychologist or a clinical psychologist; otherwise must be performed under the general supervision of a physician. 5 = Physician supervision policy does not apply when procedure is furnished by a qualified audiologist; otherwise must be performed under the general supervision of a physician. 6 = Procedure must be performed by a physician or a physical therapist (PT) who is certified by the American Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiologic clinical specialist and is permitted to provide the procedure under State law. 21 = Procedure may be performed by a technician with certification under general supervision of a physician; otherwise must be performed under direct supervision of a physician. 22 = May be performed by a technician with on-line real-time contact with physician. 66 = May be performed by a physician or by a physical therapist with ABPTS certification and certification in this specific procedure. 6a = Supervision standards for level 66 apply; in addition, the PT with ABPTS certification may supervise another PT, but only the PT with ABPTS certification may bill. 77 = Procedure must be performed by a PT with ABPTS certification or by a PT without certification under direct supervision of a physician, or by a technician with certification under general supervision of a physician. 7a = Supervision standards for level 77 apply; in addition, the PT with ABPTS certification may supervise another PT, but only the PT with ABPTS certification may bill. 9 = Concept does not apply.	
31B This filed has been deleted to allow for the expansion of field 31A.	
31C	9 Pic(7)v99

FIELD # & ITEM	LENGTH & PIC
Facility Setting Practice Expense Relative Value Units	
31D Non-Facility Setting Practice Expense Relative Value Units	9 Pic(7)v99
31E Filler	9 Pic(7)v99
31F Filler Reserved for future use.	1 Pic x(1)
31G Endoscopic Base Codes This field identifies an endoscopic base code for each code with a multiple surgery indicator of 3.	5 Pic x(5)
32A 1996 Transition/Fee Schedule Amount This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
32B 1996 Transition/Fee Schedule This field is no longer Indicator applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
32C 1996 Transition/Fee Schedule Amount When Site or Service Differential Applies This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
33A Units Payment Rule Indicator Reserved for future use. 9 = Concept does not apply.	1 Pic x(1)
33B Mapping Indicator This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
33C Medicare+Choice Encounter Pricing Locality NOT FOR A/B MAC (B) USE: These Medicare+Choice encounter pricing localities are for EDS purposes only. The locality values were developed to facilitate centralized processing	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
of encounter data by the Medicare+Choice organizations (M+COs).	
33D National Level Future Expansion This field is being provided for future expansion at the national level.	7 Pic x(7)
34 Non-Facility Fee Schedule Amount This field replicates field 28.	9 Pic 9(7)v99
35 Facility Fee Schedule Amount This field replicates field 29.	9 Pic 9(7)v99
36 Filler	1 Pic x(1)
37 Future Local Level Expansion** The Updated 1992 Transition Amount was previously stored in this field. A/B MACs (B) can continue to maintain the updated transition amount in this field.	7 Pic x(7)
38A Future Local Level Expansion** The adjusted historical payment basis (AHPB) was previously stored in this field. A/B MACs (B) can continue to maintain the AHPB in this field.	7 Pic x(7)
38B Filler This field was originally established for 15 spaces. Since AHPB data will only use 7 of the 15 spaces, A/B MACs (B) have 8 remaining spaces for their purposes.	8 Pic x(8)

* These fields will be provided by the Program Development and Information Group in the 2002 Medicare Fee Schedule Database for codes with status code indicator of A and T, as well as, indicators D and R with associated RVUs. A/B MACs (B) will be responsible for calculating the 2002 payment amounts for codes with status code indicator of C, L, and R for codes without associated RVUs.

** These fields will be appended by each A/B MAC (B) at the local level.

2003 File Layout

HEADER RECORD

FIELD #	DATA ELEMENT NAME	LOCATION	PIC
1	Header ID	1-4	x(4) Value "Head"
2	Header Number	5	x(1)
3	Data Set Name	6-50	x(45)
4	Record Length	51-53	x(3)
5	Filler	54-54	x(1)
6	Block size	55-58	x(4)
7	Filler	59-59	x(1)
8	Number of Records Number does not include this header record.	60-69	9(10)
9	Date Created	70-77	x(8) YYYYMMDD
10	Blanks	78-345	x(268)

FILE LAYOUT

FIELD # & ITEM	LENGTH & PIC
1 File Year This field displays the effective year of the file.	4 Pic x(4)
2 A/B MAC (B) Number This field represents the 5-digit number assigned to the A/B MAC (B).	5 Pic x(5)
3 Locality This 2-digit code identifies the pricing locality used.	2 Pic x(2)
4 HCPCS Code This field represents the procedure code. Each A/B MAC (B) Procedural Terminology (CPT) code and alpha-numeric HCPCS codes other than B, C, E, K and L codes and services representing anesthesia services will be included. The standard sort for this field is blanks, alpha, and numeric in ascending order.	5 Pic x(5)
5 Modifier For diagnostic tests, a blank in this field denotes the global service and the following modifiers identify the components: 26 = Professional component	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
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. Any other codes billed with modifier -53 are subject to A/B MAC (B) 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.	
6 Descriptor This field will include a brief description of each procedure code.	50 Pic x(50)
7 Code Status This 1 position field provides the status of each code under the full fee schedule. Each status code is explained in §30.2.3.	1 Pic x(1)
8 Conversion Factor This field displays the multiplier which transforms relative values into payment amounts. The file will contain the 2003 conversion factor which will reflect all adjustments.	8 Pic 9(4)v9999
9 Update Factor This update factor has been included in the conversion factor in Field 8.	6 Pic 9(2)v9999
10 Work Relative Value Unit This field displays the unit value for the physician work RVU.	9 Pic 9(7)v99
11 Filler	9 Pic 9(7)v99
12 Malpractice Relative Value Unit This field displays the unit value for the malpractice expense RVU.	9 Pic 9(7)v99
13	5 Pic 99v999

FIELD # & ITEM	LENGTH & PIC
Work Geographic Practice Cost Indices (GPCIs) This field displays a work geographic adjustment factor used in computing the fee schedule amount.	
14 Practice Expense GPCI This field displays a practice expense geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
15 Malpractice GPCI This field displays a malpractice expense geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
16 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. 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 (B) 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.)	3 Pic x(3)
17 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	6 Pic 9v9(5)

FIELD # & ITEM	LENGTH & PIC
will be shown as 0.1000. The total of fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	
18 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 0.6300. The total of fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
19 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 0.1700. The total of fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
20 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 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.	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
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 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 A/B MACs (B) 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.	

FIELD # & ITEM	LENGTH & PIC
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.	
21 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 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, or 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 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 field 31G.	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
Apply the multiple endoscopy rules to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). 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 = Indicator is reserved for possible future use. 9 = Concept does not apply.	
22 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. If procedure is reported with modifier -50 or with modifiers RT and LT, base 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 and XXXXX-RT with an actual charge of $100. Payment would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The 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 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 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. If procedure is reported with modifier -50 or is reported twice on the same day by any other means (e.g., with RT	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
and LT modifiers 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 amount 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 would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The RVUs are based on a bilateral procedure because: (a) the code descriptor specifically states that the procedure is bilateral; (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally; or (c) the procedure is usually performed as a bilateral procedure. 3 = The usual payment adjustment for bilateral procedures does not apply. If 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 payment for each side or organ or site of a paired organ on the lower of: (a) the actual charge for each side or (b) 100% of the fee schedule amount for each side. If procedure is reported as a bilateral procedure and with other procedure codes on the same day, 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 procedures. 9 = Concept does not apply.	
23 Assistant at Surgery This field provides an indicator for services where an assistant at surgery is never paid for per MCM. 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
24	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
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.	
25 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
26 Filler	1 Pic (x)1
27 Site of Service Differential For 1999 and beyond, the site of service differential no longer applies. The following definitions will apply for all years after 1998: 0 = Facility pricing does not apply. 1 = Facility pricing applies.	1 Pic (x)1
28 Non-Facility Fee Schedule Amount This field shows the fee schedule amount for the non-facility setting. This amount equals Field 34. Non-Facility Pricing Amount [(Work RVU * Work GPCI) + (Non-Facility PE RB RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor	9 Pic 9(7)v99
29 Facility Fee Schedule Amount This field shows the fee schedule amount for the facility setting. This amount equals Field 35.	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
Facility Pricing Amount [(Work RVU * Work GPCI) + (Facility PE RB RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor Place of service codes to be used to identify facilities. 21 - Inpatient Hospital 22 - Outpatient Hospital 23 - Emergency Room - Hospital 24 - Ambulatory Surgical Center - ASC is only treated as a facility setting when an ASC list procedure is performed in an ASC. 26 - Military Treatment Facility 31 - Skilled Nursing Facility 34 - Hospice 41 - Ambulance - Land 42 - Ambulance Air or Water 51 - Inpatient Psychiatric Facility 52 - Psychiatric Facility Partial Hospitalization 53 - Community Mental Health Center 56 - Psychiatric Residential Treatment Facility 61 - Comprehensive Inpatient Rehabilitation Facility	
30 Number of Related Codes This field defines the number of related procedure codes (see Field 31).	2 Pic 99
31 Related Procedure Codes This field identifies the number of times that a related code occurs.	65 Pic x(5) - Occurs 13 times
31A	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
Physician Supervision of Diagnostic Procedures This field is for use in post payment review. 01 = Procedure must be performed under the general supervision of a physician. 02 = Procedure must be performed under the direct supervision of a physician. 03 = Procedure must be performed under the personal supervision of a physician. 04 = Physician supervision policy does not apply when procedure is furnished by a qualified, independent psychologist or a clinical psychologist; otherwise must be performed under the general supervision of a physician. 05 = Physician supervision policy does not apply when procedure is furnished by a qualified audiologist; otherwise must be performed under the general supervision of a physician. 06 = Procedure must be performed by a physician or a physical therapist (PT) who is certified by the American Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiologic clinical specialist and is permitted to provide the procedure under State law. 21 = Procedure may be performed by a technician with certification under general supervision of a physician; otherwise must be performed under direct supervision of a physician. 22 = May be performed by a technician with on-line real-time contact with physician. 66 = May be performed by a physician or by a physical therapist with ABPTS certification and certification in this specific procedure. 6A = Supervision standards for level 66 apply; in addition, the PT with ABPTS certification may supervise another PT, but only the PT with ABPTS certification may bill. 77 = Procedure must be performed by a PT with ABPTS certification or by a PT without certification under direct supervision of a physician, or by a technician with certification under general supervision of a physician. 7A = Supervision standards for level 77 apply; in addition, the PT with ABPTS certification may supervise another PT, but only the PT with ABPTS certification may bill. 09 = Concept does not apply.	
31B This filed has been deleted to allow for the expansion of field 31A.	
31C	9 Pic(7)v99

FIELD # & ITEM	LENGTH & PIC
Facility Setting Practice Expense Relative Value Units	
31D Non-Facility Setting Practice Expense Relative Value Units	9 Pic(7)v99
31E Filler	9 Pic(7)v99
31F Filler Reserved for future use.	1 Pic x(1)
31G Endoscopic Base Codes This field identifies an endoscopic base code for each code with a multiple surgery indicator of 3.	5 Pic x(5)
32A 1996 Transition/Fee Schedule Amount This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
32B 1996 Transition/Fee Schedule This field is no longer Indicator applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
32C 1996 Transition/Fee Schedule Amount When Site or Service Differential Applies This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
33A Units Payment Rule Indicator Reserved for future use. 9 = Concept does not apply.	1 Pic x(1)
33B Mapping Indicator This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
33C Medicare+Choice Encounter Pricing Locality NOT FOR A/B MAC (B) USE: These Medicare+Choice encounter pricing localities are for EDS purposes only. The locality values	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
were developed to facilitate centralized processing of encounter data by the Medicare+Choice organizations (M+COs).	
33D National Level Future Expansion This field is being provided for future expansion at the national level.	7 Pic x(7)
34 Non-Facility Fee Schedule Amount This field replicates field 28.	9 Pic 9(7)v99
35 Facility Fee Schedule Amount This field replicates field 29.	9 Pic 9(7)v99
36 Filler	1 Pic x(1)
37 Future Local Level Expansion** The Updated 1992 Transition Amount was previously stored in this field. A/B MACs (B) can continue to maintain the updated transition amount in this field.	7 Pic x(7)

2004 File Layout

HEADER RECORD

FIELD #	**DATA ELEMENT NAME**	**LOCATION**	**PIC**
1	Header ID	1-4	x(4) Value “Head"
2	Header Number	5	x(1)
3	Data Set Name	6-50	x(45)
4	Record Length	51-53	x(3)
5	Filler	54-54	x(1)
6	Block size	55-58	x(4)
7	Filler	59-59	x(1)
8	Number of Records Number does not include this header record.	60-69	9(10)
9	Date Created	70-77	x(8) YYYYMMDD
10	Blanks	78-345	x(268)

FILE LAYOUT

FIELD # & ITEM	**LENGTH & PIC**
1 File Year This field displays the effective year of the file.	4 Pic x(4)
2 A/B MAC (B) Number This field represents the 5-digit number assigned to the A/B MAC (B).	5 Pic x(5)
3 Locality This 2-digit code identifies the pricing locality used.	2 Pic x(2)
4 HCPCS Code This field represents the procedure code. Each A/B MAC (B) Procedural Terminology (CPT) code and alpha-numeric HCPCS codes other than B, C, E, K and L codes and services representing anesthesia services will be included. The standard sort for this field is blanks, alpha, and numeric in ascending order.	5 Pic x(5)
5 Modifier For diagnostic tests, a blank in this field denotes the global service and the following modifiers identify the components: 26 = Professional component	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
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. Any other codes billed with modifier -53 are subject to A/B MAC (B) 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.	
6 Descriptor This field will include a brief description of each procedure code.	50 Pic x(50)
7 Code Status This 1 position field provides the status of each code under the full fee schedule. Each status code is explained in §30.2.3.	1 Pic x(1)
8 Conversion Factor This field displays the multiplier which transforms relative values into payment amounts. The file will contain the 2004 conversion factor which will reflect all adjustments.	8 Pic 9(4)v9999
9 Update Factor This update factor has been included in the conversion factor in Field 8.	6 Pic 9(2)v9999
10 Work Relative Value Unit This field displays the unit value for the physician work RVU.	9 Pic 9(7)v99
11 Filler	9 Pic 9(7)v99
12 Malpractice Relative Value Unit This field displays the unit value for the malpractice expense RVU.	9 Pic 9(7)v99
13	5 Pic 99v999

FIELD # & ITEM	LENGTH & PIC
Work Geographic Practice Cost Indices (GPCIs) This field displays a work geographic adjustment factor used in computing the fee schedule amount.	
14 Practice Expense GPCI This field displays a practice expense geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
15 Malpractice GPCI This field displays a malpractice expense geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
16 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. 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 (B) 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.)	3 Pic x(3)
17 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	6 Pic 9v9(5)

FIELD # & ITEM	LENGTH & PIC
will be shown as 0.1000. The total of fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	
18 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 0.6300. The total of fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
19 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 0.1700. The total of fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
20 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 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.	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
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 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 A/B MACs (B) 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.	

FIELD # & ITEM	LENGTH & PIC
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.	
21 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 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, or 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 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 field 31G.	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
Apply the multiple endoscopy rules to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). 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 = Indicator is reserved for possible future use. 9 = Concept does not apply.	
22 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. If procedure is reported with modifier -50 or with modifiers RT and LT, base 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 and XXXXX-RT with an actual charge of $100. Payment would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The 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 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 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. If procedure is reported with modifier -50 or is reported twice on the same day by any other means (e.g., with RT	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
and LT modifiers 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 amount 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 would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The RVUs are based on a bilateral procedure because: (a) the code descriptor specifically states that the procedure is bilateral; (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally; or (c) the procedure is usually performed as a bilateral procedure. 3 = The usual payment adjustment for bilateral procedures does not apply. If 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 payment for each side or organ or site of a paired organ on the lower of: (a) the actual charge for each side or (b) 100% of the fee schedule amount for each side. If procedure is reported as a bilateral procedure and with other procedure codes on the same day, 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 procedures. 9 = Concept does not apply.	
23 Assistant at Surgery This field provides an indicator for services where an assistant at surgery is never paid for per MCM. 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
24	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
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.	
25 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
26 Filler	1 Pic (x)1
27 Site of Service Differential For 1999 and beyond, the site of service differential no longer applies. The following definitions will apply for all years after 1998: 0 = Facility pricing does not apply. 1 = Facility pricing applies.	1 Pic (x)1
28 Non-Facility Fee Schedule Amount This field shows the fee schedule amount for the non-facility setting. This amount equals Field 34. Non-Facility Pricing Amount [(Work RVU * Work GPCI) + (Non-Facility PE RB RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor	9 Pic 9(7)v99
29 Facility Fee Schedule Amount This field shows the fee schedule amount for the facility setting. This amount equals Field 35.	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
Facility Pricing Amount [(Work RVU * Work GPCI) + (Facility PE RB RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor Place of service codes to be used to identify facilities. 21 - Inpatient Hospital 22 - Outpatient Hospital 23 - Emergency Room - Hospital 24 - Ambulatory Surgical Center - ASC is only treated as a facility setting when an ASC list procedure is performed in an ASC. 26 - Military Treatment Facility 31 - Skilled Nursing Facility 34 - Hospice 41 - Ambulance - Land 42 - Ambulance Air or Water 51 - Inpatient Psychiatric Facility 52 - Psychiatric Facility Partial Hospitalization 53 - Community Mental Health Center 56 - Psychiatric Residential Treatment Facility 61 - Comprehensive Inpatient Rehabilitation Facility	
30 Number of Related Codes This field defines the number of related procedure codes (see Field 31).	2 Pic 99
31 Related Procedure Codes This field identifies the number of times that a related code occurs.	65 Pic x(5) - Occurs 13 times
31A	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
Physician Supervision of Diagnostic Procedures This field is for use in post payment review. 01 = Procedure must be performed under the general supervision of a physician. 02 = Procedure must be performed under the direct supervision of a physician. 03 = Procedure must be performed under the personal supervision of a physician. 04 = Physician supervision policy does not apply when procedure is furnished by a qualified, independent psychologist or a clinical psychologist; otherwise must be performed under the general supervision of a physician. 05 = Physician supervision policy does not apply when procedure is furnished by a qualified audiologist; otherwise must be performed under the general supervision of a physician. 06 = Procedure must be performed by a physician or a physical therapist (PT) who is certified by the American Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiologic clinical specialist and is permitted to provide the procedure under State law. 21 = Procedure may be performed by a technician with certification under general supervision of a physician; otherwise must be performed under direct supervision of a physician. 22 = May be performed by a technician with on-line real-time contact with physician. 66 = May be performed by a physician or by a physical therapist with ABPTS certification and certification in this specific procedure. 6A = Supervision standards for level 66 apply; in addition, the PT with ABPTS certification may supervise another PT, but only the PT with ABPTS certification may bill. 77 = Procedure must be performed by a PT with ABPTS certification or by a PT without certification under direct supervision of a physician, or by a technician with certification under general supervision of a physician. 7A = Supervision standards for level 77 apply; in addition, the PT with ABPTS certification may supervise another PT, but only the PT with ABPTS certification may bill. 09 = Concept does not apply.	
31B This filed has been deleted to allow for the expansion of field 31A.	
31C	9 Pic(7)v99

FIELD # & ITEM	LENGTH & PIC
Facility Setting Practice Expense Relative Value Units	
31D Non-Facility Setting Practice Expense Relative Value Units	9 Pic(7)v99
31E Filler	9 Pic(7)v99
31F Filler Reserved for future use.	1 Pic x(1)
31G Endoscopic Base Codes This field identifies an endoscopic base code for each code with a multiple surgery indicator of 3.	5 Pic x(5)
32A 1996 Transition/Fee Schedule Amount This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
32B 1996 Transition/Fee Schedule This field is no longer Indicator applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
32C 1996 Transition/Fee Schedule Amount When Site or Service Differential Applies This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
33A Units Payment Rule Indicator Reserved for future use. 9 = Concept does not apply.	1 Pic x(1)
33B Mapping Indicator This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
33C Medicare+Choice Encounter Pricing Locality NOT FOR A/B MAC (B) USE: These Medicare+Choice encounter pricing localities are for EDS purposes only. The locality values	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
were developed to facilitate centralized processing of encounter data by the Medicare+Choice organizations (M+COs).	
33D National Level Future Expansion This field is being provided for future expansion at the national level.	7 Pic x(7)
34 Non-Facility Fee Schedule Amount This field replicates field 28.	9 Pic 9(7)v99
35 Facility Fee Schedule Amount This field replicates field 29.	9 Pic 9(7)v99
36 Filler	1 Pic x(1)
37 Future Local Level Expansion** The Updated 1992 Transition Amount was previously stored in this field. A/B MACs (B) can continue to maintain the updated transition amount in this field.	7 Pic x(7)

2005 File Layout

HEADER RECORD

FIELD #	DATA ELEMENT NAME	LOCATION	PIC
1	Header ID	1-4	x(4) Value “Head"
2	Header Number	5	x(1)
3	Data Set Name	6-50	x(45)
4	Record Length	51-53	x(3)
5	Filler	54-54	x(1)
6	Block size	55-58	x(4)
7	Filler	59-59	x(1)
8	Number of Records Number does not include this header record.	60-69	9(10)
9	Date Created	70-77	x(8) YYYYMMDD
10	Blanks	78-345	x(268)

FILE LAYOUT

FIELD # & ITEM	**LENGTH & PIC**
1 File Year This field displays the effective year of the file.	4 Pic x(4)
2 A/B MAC (B) Number This field represents the 5-digit number assigned to the A/B MAC (B).	5 Pic x(5)
3 Locality This 2-digit code identifies the pricing locality used.	2 Pic x(2)
4 HCPCS Code This field represents the procedure code. Each A/B MAC (B) Procedural Terminology (CPT) code and alpha-numeric HCPCS codes other than B, C, E, K and L codes and services representing anesthesia services will be included. The standard sort for this field is blanks, alpha, and numeric in ascending order.	5 Pic x(5)
5 Modifier For diagnostic tests, a blank in this field denotes the global service and the following modifiers identify the components:	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
26 = Professional component TC = Technical component For services other than those with a professional and/or technical component, a blank will appear in this field with one exception: the presence of 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 A/B MAC (B) 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.	
6 Descriptor This field will include a brief description of each procedure code.	50 Pic x(50)
7 Code Status This 1 position field provides the status of each code under the full fee schedule. Each status code is explained in §30.2.2.	1 Pic x(1)
8 Conversion Factor This field displays the multiplier which transforms relative values into payment amounts. The file will contain the **2005** conversion factor which will reflect all adjustments.	8 Pic 9(4)v9999
9 Update Factor This update factor has been included in the conversion factor in Field 8.	6 Pic 9(2)v9999
10 Work Relative Value Unit This field displays the unit value for the physician work RVU.	9 Pic 9(7)v99
11 Filler	9 Pic 9(7)v99
12 Malpractice Relative Value Unit	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
This field displays the unit value for the malpractice expense RVU.	
13 Work Geographic Practice Cost Indices (GPCIs) This field displays a work geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
14 Practice Expense GPCI This field displays a practice expense geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
15 Malpractice GPCI This field displays a malpractice expense geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
16 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. 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 (B) 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.)	3 Pic x(3)
17	6 Pic 9v9(5)

FIELD # & ITEM	LENGTH & PIC
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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	
18 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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
19 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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
20 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	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
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 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 A/B MACs (B) 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	

FIELD # & ITEM	LENGTH & PIC
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.	
21 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 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, or 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 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.,	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
another endoscopy that has the same base procedure). The base procedure for each code with this indicator is identified in field 31G. Apply the multiple endoscopy rules to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). 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 = Indicator is reserved for possible future use. 9 = Concept does not apply.	
22 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. If procedure is reported with modifier -50 or with modifiers RT and LT, base 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 and XXXXX-RT with an actual charge of $100. Payment would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The 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 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 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.	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
2 = 150 percent payment adjustment for bilateral procedure does not apply. RVUs are already based on the procedure being performed as a bilateral procedure. If 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 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 amount 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 would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The RVUs are based on a bilateral procedure because: (a) the code descriptor specifically states that the procedure is bilateral; (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally; or (c) the procedure is usually performed as a bilateral procedure. 3 = The usual payment adjustment for bilateral procedures does not apply. If 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 payment for each side or organ or site of a paired organ on the lower of: (a) the actual charge for each side or (b) 100% of the fee schedule amount for each side. If procedure is reported as a bilateral procedure and with other procedure codes on the same day, 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 procedures. 9 = Concept does not apply.	
23	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
Assistant at Surgery This field provides an indicator for services where an assistant at surgery is never paid for per IOM. 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.	
24 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
25 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
26 Filler	1 Pic (x)1
27 Site of Service Differential For 1999 and beyond, the site of service differential no longer applies. The following definitions will apply for all years after 1998: 0 = Facility pricing does not apply. 1 = Facility pricing applies.	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
28 Non-Facility Fee Schedule Amount This field shows the fee schedule amount for the non-facility setting. This amount equals Field 34. **Note**: Field 33 D indicates if an additional adjustment should be applied to this formula. Non-Facility Pricing Amount [(Work RVU * Work GPCI) + (Non-Facility PE RB RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor	9 Pic 9(7)v99
29 Facility Fee Schedule Amount This field shows the fee schedule amount for the facility setting. This amount equals Field 35. **Note:** Field 33D indicates if an additional adjustment should be applied to this formula. Facility Pricing Amount [(Work RVU * Work GPCI) + (Facility PE RB RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor Place of service codes to be used to identify facilities. 21 - Inpatient Hospital 22 - Outpatient Hospital 23 - Emergency Room - Hospital 24 - Ambulatory Surgical Center - ASC is only treated as a facility setting when an ASC list procedure is performed in an ASC. 26 - Military Treatment Facility 31 - Skilled Nursing Facility 34 - Hospice 41 - Ambulance - Land 42 - Ambulance Air or Water 51 - Inpatient Psychiatric Facility 52 - Psychiatric Facility Partial Hospitalization 53 - Community Mental Health Center 56 - Psychiatric Residential Treatment Facility 61 - Comprehensive Inpatient Rehabilitation Facility	9 Pic 9(7)v99
30	2 Pic 99

FIELD # & ITEM	**LENGTH & PIC**
Number of Related Codes This field defines the number of related procedure codes (see Field 31).	
31 Related Procedure Codes This field identifies the number of times that a related code occurs.	65 Pic x(5) - Occurs 13 times
31A	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
Physician Supervision of Diagnostic Procedures This field is for use in post payment review. 01 = Procedure must be performed under the general supervision of a physician. 02 = Procedure must be performed under the direct supervision of a physician. 03 = Procedure must be performed under the personal supervision of a physician. 04 = Physician supervision policy does not apply when procedure is furnished by a qualified, independent psychologist or a clinical psychologist; otherwise must be performed under the general supervision of a physician. 05 = Physician supervision policy does not apply when procedure is furnished by a qualified audiologist; otherwise must be performed under the general supervision of a physician. 06 = Procedure must be performed by a physician or a physical therapist (PT) who is certified by the American Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiologic clinical specialist and is permitted to provide the procedure under State law. 21 = Procedure may be performed by a technician with certification under general supervision of a physician; otherwise must be performed under direct supervision of a physician. 22 = May be performed by a technician with on-line real-time contact with physician. 66 = May be performed by a physician or by a physical therapist with ABPTS certification and certification in this specific procedure. 6A = Supervision standards for level 66 apply; in addition, the PT with ABPTS certification may supervise another PT, but only the PT with ABPTS certification may bill. 77 = Procedure must be performed by a PT with ABPTS certification or by a PT without certification under direct supervision of a physician, or by a technician with certification under general supervision of a physician. 7A = Supervision standards for level 77 apply; in addition, the PT with ABPTS certification may supervise another PT, but only the PT with ABPTS certification may bill. 09 = Concept does not apply.	
31B This field has been deleted to allow for the expansion of field 31A.	
31C	9 Pic(7)v99

FIELD # & ITEM	LENGTH & PIC
Facility Setting Practice Expense Relative Value Units	
31D Non-Facility Setting Practice Expense Relative Value Units	9 Pic(7)v99
31E Filler	9 Pic(7)v99
31F Filler Reserved for future use.	1 Pic x(1)
31G Endoscopic Base Codes This field identifies an endoscopic base code for each code with a multiple surgery indicator of 3.	5 Pic x(5)
32A 1996 Transition/Fee Schedule Amount This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
32B 1996 Transition/Fee Schedule This field is no longer Indicator applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
32C 1996 Transition/Fee Schedule Amount When Site or Service Differential Applies This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
33A Units Payment Rule Indicator Reserved for future use. 9 = Concept does not apply.	1 Pic x(1)
33B Mapping Indicator This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
33C Medicare+Choice Encounter Pricing Locality NOT FOR A/B MAC (B) USE: These Medicare+Choice encounter pricing localities are for EDS purposes only. The locality values	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
were developed to facilitate centralized processing of encounter data by the Medicare+Choice organizations (M+COs).	
33D Calculation Flag **This field is informational only; the SSMs do not need to add this field.** The intent is to assist A/B MACs (B) to understand how the fee schedule amount in fields 28 and 29 are calculated. The MMA mandates an additional adjustment to selected HCPCS codes. A value of "1" indicates an additional fee schedule adjustment of 1.32 in 2004 and 1.03 in 2005. A value of "0" indicates no additional adjustment needed.	1 Pic x(1)
33E National Level Future Expansion This field is being provided for future expansion at the national level.	6 Pic x (6)
34 Non-Facility Fee Schedule Amount This field replicates field 28.	9 Pic 9(7)v99
35 Facility Fee Schedule Amount This field replicates field 29.	9 Pic 9(7)v99
36 Filler	1 Pic x(1)
37 Future Local Level Expansion** The Updated 1992 Transition Amount was previously stored in this field. A/B MACs (B) can continue to maintain the updated transition amount in this field.	7 Pic x(7)
38A Future Local Level Expansion** The adjusted historical payment basis (AHPB) was previously stored in this field. A/B MACs (B) can continue to maintain the AHPB in this field.	7 Pic x(7)
38 B	8 Pix x(8)

FIELD # & ITEM	**LENGTH & PIC**
Filler This field was originally established for 15 spaces. Since AHPB data will only use 7 of the 15 spaces, A/B MACs (B) have 8 remaining spaces for their purposes. ** These fields will be appended by each A/B MAC (B) at the local level.	

2006 File Layout

HEADER RECORD

FIELD #	DATA ELEMENT NAME	LOCATION	PIC
1	Header ID	1-4	x(4) Value "Head"
2	Header Number	5	x(1)
3	Data Set Name	6-50	x(45)
4	Record Length	51-53	x(3)
5	Filler	54-54	x(1)
6	Block size	55-58	x(4)
7	Filler	59-59	x(1)
8	Number of Records Number does not include this header record.	60-69	9(10)
9	Date Created	70-77	x(8) YYYYMMDD
10	Blanks	78-345	x(268)

FILE LAYOUT

FIELD # & ITEM	LENGTH & PIC
1 File Year This field displays the effective year of the file.	4 Pic x(4)
2 A/B MAC (B) Number This field represents the 5-digit number assigned to the A/B MAC (B).	5 Pic x(5)
3 Locality This 2-digit code identifies the pricing locality used.	2 Pic x(2)
4 HCPCS Code This field represents the procedure code. Each A/B MAC (B) Procedural Terminology (CPT) code and alpha-numeric HCPCS codes other than B, C, E, K and L codes and services representing anesthesia services will be included. The standard sort for this field is blanks, alpha, and numeric in ascending order.	5 Pic x(5)
5 Modifier For diagnostic tests, a blank in this field denotes the global service and the following modifiers identify the components:	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
26 = Professional component TC = Technical component For services other than those with a professional and/or technical component, a blank will appear in this field with one exception: the presence of 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 A/B MAC (B) 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.	
6 Descriptor This field will include a brief description of each procedure code.	50 Pic x(50)
7 Code Status This 1 position field provides the status of each code under the full fee schedule. Each status code is explained in §30.2.2.	1 Pic x(1)
8 Conversion Factor This field displays the multiplier which transforms relative values into payment amounts. The file will contain the **2006** conversion factor which will reflect all adjustments.	8 Pic 9(4)v9999
9 Update Factor This update factor has been included in the conversion factor in Field 8.	6 Pic 9(2)v9999
10 Work Relative Value Unit This field displays the unit value for the physician work RVU.	9 Pic 9(7)v99
11 Filler	9 Pic 9(7)v99
12 Malpractice Relative Value Unit	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
This field displays the unit value for the malpractice expense RVU.	
13 Work Geographic Practice Cost Indices (GPCIs) This field displays a work geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
14 Practice Expense GPCI This field displays a practice expense geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
15 Malpractice GPCI This field displays a malpractice expense geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
16 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. 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 (B) 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.)	3 Pic x(3)
17	6 Pic 9v9(5)

FIELD # & ITEM	LENGTH & PIC
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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	
18 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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
19 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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
20 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	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
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 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 A/B MACs (B) 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	

FIELD # & ITEM	LENGTH & PIC
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.	
21 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 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 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.,	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
another endoscopy that has the same base procedure). The base procedure for each code with this indicator is identified in field 31G. Apply the multiple endoscopy rules to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). 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 = Indicator is reserved for possible future use. 9 = Concept does not apply.	
22 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. If procedure is reported with modifier -50 or with modifiers RT and LT, base 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 and XXXXX-RT with an actual charge of $100. Payment would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The 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 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 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.	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
2 = 150 percent payment adjustment for bilateral procedure does not apply. RVUs are already based on the procedure being performed as a bilateral procedure. If 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 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 amount 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 would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The RVUs are based on a bilateral procedure because: (a) the code descriptor specifically states that the procedure is bilateral; (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally; or (c) the procedure is usually performed as a bilateral procedure. 3 = The usual payment adjustment for bilateral procedures does not apply. If 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 payment for each side or organ or site of a paired organ on the lower of: (a) the actual charge for each side or (b) 100% of the fee schedule amount for each side. If procedure is reported as a bilateral procedure and with other procedure codes on the same day, 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 procedures. 9 = Concept does not apply.	
23	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
Assistant at Surgery This field provides an indicator for services where an assistant at surgery is never paid for per IOM. 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.	
24 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
25 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
26 Filler	1 Pic (x)1
27 Site of Service Differential For 1999 and beyond, the site of service differential no longer applies. The following definitions will apply for all years after 1998: 0 = Facility pricing does not apply. 1 = Facility pricing applies.	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
28 Non-Facility Fee Schedule Amount This field shows the fee schedule amount for the non-facility setting. This amount equals Field 34. **Note**: Field 33 D indicates if an additional adjustment should be applied to this formula. Non-Facility Pricing Amount [(Work RVU * Work GPCI) + (Non-Facility PE RB RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor	9 Pic 9(7)v99
29 Facility Fee Schedule Amount This field shows the fee schedule amount for the facility setting. This amount equals Field 35. **Note:** Field 33D indicates if an additional adjustment should be applied to this formula. Facility Pricing Amount [(Work RVU * Work GPCI) + (Facility PE RB RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor Place of service codes to be used to identify facilities. 21 - Inpatient Hospital 22 - Outpatient Hospital 23 - Emergency Room - Hospital 24 - Ambulatory Surgical Center - ASC is only treated as a facility setting when an ASC list procedure is performed in an ASC. 26 - Military Treatment Facility 31 - Skilled Nursing Facility 34 - Hospice 41 - Ambulance - Land 42 - Ambulance Air or Water 51 - Inpatient Psychiatric Facility 52 - Psychiatric Facility Partial Hospitalization 53 - Community Mental Health Center 56 - Psychiatric Residential Treatment Facility 61 - Comprehensive Inpatient Rehabilitation Facility	9 Pic 9(7)v99
30	2 Pic 99

FIELD # & ITEM	LENGTH & PIC
Number of Related Codes This field defines the number of related procedure codes (see Field 31).	
31 Related Procedure Codes This field identifies the number of times that a related code occurs.	65 Pic x(5) - Occurs 13 times
31A	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
Physician Supervision of Diagnostic Procedures This field is for use in post payment review. 01 = Procedure must be performed under the general supervision of a physician. 02 = Procedure must be performed under the direct supervision of a physician. 03 = Procedure must be performed under the personal supervision of a physician. 04 = Physician supervision policy does not apply when procedure is furnished by a qualified, independent psychologist or a clinical psychologist; otherwise must be performed under the general supervision of a physician. 05 = Physician supervision policy does not apply when procedure is furnished by a qualified audiologist; otherwise must be performed under the general supervision of a physician. 06 = Procedure must be performed by a physician or a physical therapist (PT) who is certified by the American Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiologic clinical specialist and is permitted to provide the procedure under State law. 21 = Procedure may be performed by a technician with certification under general supervision of a physician; otherwise must be performed under direct supervision of a physician. 22 = May be performed by a technician with on-line real-time contact with physician. 66 = May be performed by a physician or by a physical therapist with ABPTS certification and certification in this specific procedure. 6A = Supervision standards for level 66 apply; in addition, the PT with ABPTS certification may supervise another PT, but only the PT with ABPTS certification may bill. 77 = Procedure must be performed by a PT with ABPTS certification or by a PT without certification under direct supervision of a physician, or by a technician with certification under general supervision of a physician. 7A = Supervision standards for level 77 apply; in addition, the PT with ABPTS certification may supervise another PT, but only the PT with ABPTS certification may bill. 09 = Concept does not apply.	
31B This field has been deleted to allow for the expansion of field 31A.	
31C Facility Setting Practice Expense Relative Value Units	9 Pic(7)v99
31D	9 Pic(7)v99

FIELD # & ITEM	LENGTH & PIC
Non-Facility Setting Practice Expense Relative Value Units	
31E Filler	9 Pic(7)v99
31F Filler Reserved for future use.	1 Pic x(1)
31G Endoscopic Base Codes This field identifies an endoscopic base code for each code with a multiple surgery indicator of 3.	5 Pic x(5)
32A 1996 Transition/Fee Schedule Amount This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
32B 1996 Transition/Fee Schedule This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
32C 1996 Transition/Fee Schedule Amount When Site or Service Differential Applies This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
33A Units Payment Rule Indicator Reserved for future use. 9 = Concept does not apply.	1 Pic x(1)
33B Mapping Indicator This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
33 Medicare+Choice Encounter Pricing Locality NOT FOR A/B MAC (B) USE: These Medicare+Choice encounter pricing localities are for EDS purposes only. The locality values were developed to facilitate centralized processing of encounter data by the Medicare+Choice organizations (M+COs).	2 Pic x(2)
33D	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
Calculation Flag This field is informational only; the SSMs do not need to add this field. The intent is to assist A/B MACs (B) to understand how the fee schedule amount in fields 28 and 29 are calculated. The MMA mandates an additional adjustment to selected HCPCS codes. A value of "1" indicates an additional fee schedule adjustment of 1.32 in 2004 and 1.03 in 2005. A value of "0" indicates no additional adjustment needed.	
33E National Level Future Expansion This field is being provided for future expansion at the national level.	6 Pic x (6)
34 Non-Facility Fee Schedule Amount This field replicates field 28.	9 Pic 9(7)v99
35 Facility Fee Schedule Amount This field replicates field 29.	9 Pic 9(7)v99
36 Filler	1 Pic x(1)
37 Future Local Level Expansion** The Updated 1992 Transition Amount was previously stored in this field. A/B MACs (B) can continue to maintain the updated transition amount in this field.	7 Pic x(7)
38A Future Local Level Expansion** The adjusted historical payment basis (AHPB) was previously stored in this field. A/B MACs (B) can continue to maintain the AHPB in this field.	7 Pic x(7)
38 B Filler This field was originally established for 15 spaces. Since AHPB data will only use 7 of the 15 spaces, A/B MACs (B) have 8 remaining spaces for their purposes. **These fields will be appended by each A/B MAC (B) at the local level.	8 Pix x(8)

2007 File Layout

HEADER RECORD

FIELD #	DATA ELEMENT NAME	LOCATION	PIC
1	Header ID	1-4	x(4) Value "Head"
2	Header Number	5	x(1)
3	Data Set Name	6-50	x(45)
4	Record Length	51-53	x(3)
5	Filler	54-54	x(1)
6	Block size	55-58	x(4)
7	Filler	59-59	x(1)
8	Number of Records Number does not include this header record.	60-69	9(10)
9	Date Created	70-77	x(8) YYYYMMDD
10	Blanks	78-345	x(268)

FILE LAYOUT

FIELD # & ITEM	LENGTH & PIC
1 File Year This field displays the effective year of the file.	4 Pic x(4)
2 A/B MAC (B) Number This field represents the 5-digit number assigned to the A/B MAC (B).	5 Pic x(5)
3 Locality This 2-digit code identifies the pricing locality used.	2 Pic x(2)
4 HCPCS Code This field represents the procedure code. Each A/B MAC (B) Procedural Terminology (CPT) code and alpha-numeric HCPCS codes other than B, C, E, K and L codes will be included. The standard sort for this field is blanks, alpha, and numeric in ascending order.	5 Pic x(5)
5 Modifier For diagnostic tests, a blank in this field denotes the global service and the following modifiers identify the components: 26 = Professional component	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
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 A/B MAC (B) 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.	
6 Descriptor This field will include a brief description of each procedure code.	50 Pic x(50)
7 Code Status This 1 position field provides the status of each code under the full fee schedule. Each status code is explained in §30.2.2.	1 Pic x(1)
8 Conversion Factor This field displays the multiplier which transforms relative values into payment amounts. The file will contain the **2007** conversion factor which will reflect all adjustments.	8 Pic 9(4)v9999
9 Update Factor This update factor has been included in the conversion factor in Field 8.	6 Pic 9(2)v9999
10 Work Relative Value Unit This field displays the unit value for the physician work RVU.	9 Pic 9(7)v99
11 Filler	9 Pic 9(7)v99
12 Malpractice Relative Value Unit	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
This field displays the unit value for the malpractice expense RVU.	
13 Work Geographic Practice Cost Indices (GPCIs) This field displays a work geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
14 Practice Expense GPCI This field displays a practice expense geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
15 Malpractice GPCI This field displays a malpractice expense geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
16 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. 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 (B) 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.)	3 Pic x(3)
17	6 Pic 9v9(5)

FIELD # & ITEM	LENGTH & PIC
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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	
18 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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
19 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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
20 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	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
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 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 A/B MACs (B) 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	

FIELD # & ITEM	LENGTH & PIC
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.	
21 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 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 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.,	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
another endoscopy that has the same base procedure). The base procedure for each code with this indicator is identified in field 31G. Apply the multiple endoscopy rules to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). 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 25% reduction of the TC diagnostic imaging (effective for services January 1, 2006 thru December 31, 2006)** **4 = Subject to 50% reduction of the TC diagnostic imaging reduction (effective for services January 1, 2007 and after)** 9 = Concept does not apply.	
22 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. If procedure is reported with modifier -50 or with modifiers RT and LT, base 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 and XXXXX-RT with an actual charge of $100. Payment would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The 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 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 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.	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
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. If 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 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 amount 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 would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The RVUs are based on a bilateral procedure because: (a) the code descriptor specifically states that the procedure is bilateral; (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally; or (c) the procedure is usually performed as a bilateral procedure. 3 = The usual payment adjustment for bilateral procedures does not apply. If 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 payment for each side or organ or site of a paired organ on the lower of: (a) the actual charge for each side or (b) 100% of the fee schedule amount for each side. If procedure is reported as a bilateral procedure and with other procedure codes on the same day, 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 procedures. 9 = Concept does not apply.	
23	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
Assistant at Surgery This field provides an indicator for services where an assistant at surgery is never paid for per IOM. 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.	
24 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
25 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
26 Filler	1 Pic (x)1
27 Site of Service Differential For 1999 and beyond, the site of service differential no longer applies. The following definitions will apply for all years after 1998: 0 = Facility pricing does not apply.	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
1 = Facility pricing applies.	
28 Non-Facility Fee Schedule Amount This field shows the fee schedule amount for the non-facility setting. This amount equals Field 34. **Note**: Field 33 D indicates if an additional adjustment should be applied to this formula. Non-Facility Pricing Amount [(Work RVU * Work GPCI) + (Non-Facility PE RB RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor	9 Pic 9(7)v99
29 Facility Fee Schedule Amount This field shows the fee schedule amount for the facility setting. This amount equals Field 35. **Note:** Field 33D indicates if an additional adjustment should be applied to this formula. Facility Pricing Amount [(Work RVU * Work GPCI) + (Facility PE RB RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor Place of service codes to be used to identify facilities. 21 - Inpatient Hospital 22 - Outpatient Hospital 23 - Emergency Room - Hospital 24 - Ambulatory Surgical Center - ASC is only treated as a facility setting when an ASC list procedure is performed in an ASC. 26 - Military Treatment Facility 31 - Skilled Nursing Facility 34 - Hospice 41 - Ambulance - Land 42 - Ambulance Air or Water 51 - Inpatient Psychiatric Facility 52 - Psychiatric Facility Partial Hospitalization 53 - Community Mental Health Center 56 - Psychiatric Residential Treatment Facility 61 - Comprehensive Inpatient Rehabilitation Facility	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
30 Number of Related Codes This field defines the number of related procedure codes (see Field 31).	2 Pic 99
31 Related Procedure Codes This field identifies the number of times that a related code occurs.	65 Pic x(5) - Occurs 13 times
31A Physician Supervision of Diagnostic Procedures This field is for use in post payment review. 01 = Procedure must be performed under the general supervision of a physician. 02 = Procedure must be performed under the direct supervision of a physician. 03 = Procedure must be performed under the personal supervision of a physician. 04 = Physician supervision policy does not apply when procedure is furnished by a qualified, independent psychologist or a clinical psychologist; otherwise must be performed under the general supervision of a physician. 05 = Physician supervision policy does not apply when procedure is furnished by a qualified audiologist; otherwise must be performed under the general supervision of a physician. 06 = Procedure must be performed by a physician or a physical therapist (PT) who is certified by the American Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiologic clinical specialist and is permitted to provide the procedure under State law. 21 = Procedure may be performed by a technician with certification under general supervision of a physician; otherwise must be performed under direct supervision of a physician. 22 = May be performed by a technician with on-line real-time contact with physician. 66 = May be performed by a physician or by a physical therapist with ABPTS certification and certification in this specific procedure. 6A = Supervision standards for level 66 apply; in addition, the PT with ABPTS certification may supervise another PT, but only the PT with ABPTS certification may bill. 77 = Procedure must be performed by a PT with ABPTS certification or by a PT without certification under direct supervision	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
of a physician, or by a technician with certification under general supervision of a physician. 7A = Supervision standards for level 77 apply; in addition, the PT with ABPTS certification may supervise another PT, but only the PT with ABPTS certification may bill. 09 = Concept does not apply.	
31B This field has been deleted to allow for the expansion of field 31A.	
31C Facility Setting Practice Expense Relative Value Units	9 Pic(7)v99
31D Non-Facility Setting Practice Expense Relative Value Units	9 Pic(7)v99
31E Filler	9 Pic(7)v99
31F Filler Reserved for future use.	1 Pic x(1)
31G Endoscopic Base Codes This field identifies an endoscopic base code for each code with a multiple surgery indicator of 3.	5 Pic x(5)
32A 1996 Transition/Fee Schedule Amount This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
32B 1996 Transition/Fee Schedule This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
32C 1996 Transition/Fee Schedule Amount When Site or Service Differential Applies This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
33A Units Payment Rule Indicator Reserved for future use.	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
9 = Concept does not apply.	
33B Mapping Indicator This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
33C Medicare+Choice Encounter Pricing Locality NOT FOR A/B MAC (B) USE: These Medicare+Choice encounter pricing localities are for EDS purposes only. The locality values were developed to facilitate centralized processing of encounter data by the Medicare+Choice organizations (M+COs).	2 Pic x(2)
33D Calculation Flag This field is informational only; the SSMs do not need to add this field. The intent is to assist A/B MACs (B) to understand how the fee schedule amount in fields 28 and 29 are calculated. The MMA mandates an additional adjustment to selected HCPCS codes. A value of "1" indicates an additional fee schedule adjustment of 1.32 in 2004 and 1.03 in 2005. A value of "0" indicates no additional adjustment needed.	1 Pic x(1)
33 E **Diagnostic Imaging Family Indicator** **01 = Family 1 Ultrasound (Chest/Abdomen/Pelvis - Non Obstetrical** **02 = Family 2 CT and CTA (Chest/Thorax/Abd/Pelvis)** **03 = Family 3 CT and CTA (Head/Brain/Orbit/Maxillofacial/Neck)** **04 = Family 4 MRI and MRA (Chest/Abd/Pelvis)** **05 = Family 5 MRI and MRA (Head/Brain/Neck)** **06 = Family 6 MRI and MRA (spine)** **07 = Family 7 CT (spine)** **08 = Family 8 MRI and MRA (lower extremeties)** **09 = Family 9 CT and CTA (lower extremeties)** **10 = Family 10 Mr and MRI (upper extremeties and joints)** **11 = Family 11 CT and CTA (upper extremeties)**	**2Pic x(2)**
33F **Performance Payment Indicator** **(For future use)**	**1 Pic x (1)**

FIELD # & ITEM	LENGTH & PIC
33G **National Level Future Expansion**	**3 Pic x (3)**
34 Non-Facility Fee Schedule Amount This field replicates field 28.	9 Pic 9(7)v99
35 Facility Fee Schedule Amount This field replicates field 29.	9 Pic 9(7)v99
36 Filler	1 Pic x(1)
37 Future Local Level Expansion** The Updated 1992 Transition Amount was previously stored in this field. A/B MACs (B) can continue to maintain the updated transition amount in this field.	7 Pic x(7)
38A Future Local Level Expansion** The adjusted historical payment basis (AHPB) was previously stored in this field. A/B MACs (B) can continue to maintain the AHPB in this field.	7 Pic x(7)
38 B Filler This field was originally established for 15 spaces. Since AHPB data will only use 7 of the 15 spaces, A/B MACs (B) have 8 remaining spaces for their purposes. **These fields will be appended by each A/B MAC (B) at the local level.	8 Pix x(8)

2008 File Layout

HEADER RECORD

FIELD #	DATA ELEMENT NAME	LOCATION	PIC
1	Header ID	1-4	x(4) Value "Head"
2	Header Number	5	x(1)
3	Data Set Name	6-50	x(45)
4	Record Length	51-53	x(3)
5	Filler	54-54	x(1)
6	Block size	55-58	x(4)
7	Filler	59-59	x(1)
8	Number of Records Number does not include this header record.	60-69	9(10)
9	Date Created	70-77	x(8) YYYYMMDD
10	Blanks	78-345	x(268)

FILE LAYOUT

FIELD # & ITEM	LENGTH & PIC
1 File Year This field displays the effective year of the file.	4 Pic x(4)
2 A/B MAC (B) Number This field represents the 5-digit number assigned to the A/B MAC (B).	5 Pic x(5)
3 Locality This 2-digit code identifies the pricing locality used.	2 Pic x(2)
4 HCPCS Code This field represents the procedure code. Each A/B MAC (B) Procedural Terminology (CPT) code and alpha-numeric HCPCS codes other than B, C, E, K and L codes will be included. The standard sort for this field is blanks, alpha, and numeric in ascending order.	5 Pic x(5)
5 Modifier For diagnostic tests, a blank in this field denotes the global service and the following modifiers identify the components: 26 = Professional component	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
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 A/B MAC (B) 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.	
6 Descriptor This field will include a brief description of each procedure code.	50 Pic x(50)
7 Code Status This 1 position field provides the status of each code under the full fee schedule. Each status code is explained in §30.2.2.	1 Pic x(1)
8 Conversion Factor This field displays the multiplier which transforms relative values into payment amounts. The file will contain the **2008** conversion factor which will reflect all adjustments.	8 Pic 9(4)v9999
9 Update Factor This update factor has been included in the conversion factor in Field 8.	6 Pic 9(2)v9999
10 Work Relative Value Unit This field displays the unit value for the physician work RVU.	9 Pic 9(7)v99
11 Filler	9 Pic 9(7)v99
12 Malpractice Relative Value Unit	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
This field displays the unit value for the malpractice expense RVU.	
13 Work Geographic Practice Cost Indices (GPCIs) This field displays a work geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
14 Practice Expense GPCI This field displays a practice expense geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
15 Malpractice GPCI This field displays a malpractice expense geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
16 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. 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 (B) 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.)	3 Pic x(3)
17	6 Pic 9v9(5)

FIELD # & ITEM	LENGTH & PIC
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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	
18 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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
19 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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
20 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	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
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 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 A/B MACs (B) 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	

FIELD # & ITEM	LENGTH & PIC
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.	
21 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 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 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.,	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
another endoscopy that has the same base procedure). The base procedure for each code with this indicator is identified in field 31G. Apply the multiple endoscopy rules to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). 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 25% reduction of the TC diagnostic imaging (effective for services January 1, 2006 and after). 9 = Concept does not apply.	
22 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. If procedure is reported with modifier -50 or with modifiers RT and LT, base 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 and XXXXX-RT with an actual charge of $100. Payment would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The 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 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 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.	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
2 = 150 percent payment adjustment for bilateral procedure does not apply. RVUs are already based on the procedure being performed as a bilateral procedure. If 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 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 amount 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 would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The RVUs are based on a bilateral procedure because: (a) the code descriptor specifically states that the procedure is bilateral; (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally; or (c) the procedure is usually performed as a bilateral procedure. 3 = The usual payment adjustment for bilateral procedures does not apply. If 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 payment for each side or organ or site of a paired organ on the lower of: (a) the actual charge for each side or (b) 100% of the fee schedule amount for each side. If procedure is reported as a bilateral procedure and with other procedure codes on the same day, 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 procedures. 9 = Concept does not apply.	
23	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
Assistant at Surgery This field provides an indicator for services where an assistant at surgery is never paid for per IOM. 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.	
24 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
25 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
26 Filler	1 Pic (x)1
27 Site of Service Differential For 1999 and beyond, the site of service differential no longer applies. The following definitions will apply for all years after 1998: 0 = Facility pricing does not apply.	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
1 = Facility pricing applies.	
28 Non-Facility Fee Schedule Amount This field shows the fee schedule amount for the non-facility setting. This amount equals Field 34. **Note**: Field 33 D indicates if an additional adjustment should be applied to this formula. Non-Facility Pricing Amount **[((Work RVU * Budget Neutrality Adjustor** **(0.8994)) (round product to two decimal places)** *** Work GPCI) +** **(Transitioned Non-Facility PE RVU * PE GPC) +** **(MP RVU * MP GPCI)] * Conversion Factor**	9 Pic 9(7)v99
29 Facility Fee Schedule Amount This field shows the fee schedule amount for the facility setting. This amount equals Field 35. **Note:** Field 33D indicates if an additional adjustment should be applied to this formula. Facility Pricing Amount **[((Work RVU * Budget Neutrality Adjustor** **(0.8994)) (round product to two decimal places)** *** Work GPCI) +** **(Transitioned Facility PE RVU * PE GPCI) +** **(MP RVU * MP GPCI)] * Conversion Factor** Place of service codes to be used to identify facilities. 21 - Inpatient Hospital 22 - Outpatient Hospital 23 - Emergency Room - Hospital 24 - Ambulatory Surgical Center - ASC is only treated as a facility setting when an ASC list procedure is performed in an ASC. 26 - Military Treatment Facility 31 - Skilled Nursing Facility 34 - Hospice 41 - Ambulance - Land 42 - Ambulance Air or Water 51 - Inpatient Psychiatric Facility	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
52 - Psychiatric Facility Partial Hospitalization 53 - Community Mental Health Center 56 - Psychiatric Residential Treatment Facility 61 - Comprehensive Inpatient Rehabilitation Facility	
30 Number of Related Codes This field defines the number of related procedure codes (see Field 31).	2 Pic 99
31 Related Procedure Codes This field identifies the number of times that a related code occurs.	**45** Pic x(5) - Occurs **9** times
31DD **Filler**	**1Pic x(1)**
31CC **Imaging Cap Indicator** **A value of "1" means subject to OPPS payment cap.** **A value of "9" means not subject to OPPS payment cap.**	**1Pic x(1)**
31BB **Non-Facility Imaging Payment Amount**	**9Pic(7)v99**
33AA **Facility Imaging Payment Amount**	**9Pic(7)v99**
31A	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
Physician Supervision of Diagnostic Procedures This field is for use in post payment review. 01 = Procedure must be performed under the general supervision of a physician. 02 = Procedure must be performed under the direct supervision of a physician. 03 = Procedure must be performed under the personal supervision of a physician. 04 = Physician supervision policy does not apply when procedure is furnished by a qualified, independent psychologist or a clinical psychologist; otherwise must be performed under the general supervision of a physician. 05 = Physician supervision policy does not apply when procedure is furnished by a qualified audiologist; otherwise must be performed under the general supervision of a physician. 06 = Procedure must be performed by a physician or a physical therapist (PT) who is certified by the American Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiologic clinical specialist and is permitted to provide the procedure under State law. 21 = Procedure may be performed by a technician with certification under general supervision of a physician; otherwise must be performed under direct supervision of a physician. 22 = May be performed by a technician with on-line real-time contact with physician. 66 = May be performed by a physician or by a physical therapist with ABPTS certification and certification in this specific procedure. 6A = Supervision standards for level 66 apply; in addition, the PT with ABPTS certification may supervise another PT, but only the PT with ABPTS certification may bill. 77 = Procedure must be performed by a PT with ABPTS certification or by a PT without certification under direct supervision of a physician, or by a technician with certification under general supervision of a physician. 7A = Supervision standards for level 77 apply; in addition, the PT with ABPTS certification may supervise another PT, but only the PT with ABPTS certification may bill. 09 = Concept does not apply.	
31B This field has been deleted to allow for the expansion of field 31A.	
31C	9 Pic(7)v99

FIELD # & ITEM	LENGTH & PIC
Facility Setting Practice Expense Relative Value Units	
31D Non-Facility Setting Practice Expense Relative Value Units	9 Pic(7)v99
31E Filler	9 Pic(7)v99
31F Filler Reserved for future use.	1 Pic x(1)
31G Endoscopic Base Codes This field identifies an endoscopic base code for each code with a multiple surgery indicator of 3.	5 Pic x(5)
32A 1996 Transition/Fee Schedule Amount This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
32B 1996 Transition/Fee Schedule This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
32C 1996 Transition/Fee Schedule Amount When Site or Service Differential Applies This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
33A Units Payment Rule Indicator Reserved for future use. 9 = Concept does not apply.	1 Pic x(1)
33B Mapping Indicator This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
33C Medicare+Choice Encounter Pricing Locality NOT FOR A/B MAC (B) USE: These Medicare+Choice encounter pricing localities are for EDS purposes only. The locality values	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
were developed to facilitate centralized processing of encounter data by the Medicare+Choice organizations (M+COs).	
33D Calculation Flag This field is informational only; the SSMs do not need to add this field. The intent is to assist A/B MACs (B) to understand how the fee schedule amount in fields 28 and 29 are calculated. The MMA mandates an additional adjustment to selected HCPCS codes. A value of "1" indicates an additional fee schedule adjustment of 1.32 in 2004 and 1.03 in 2005. A value of "0" indicates no additional adjustment needed.	1 Pic x(1)
33 E Diagnostic Imaging Family Indicator 01 = Family 1 Ultrasound (Chest/Abdomen/Pelvis - Non Obstetrical 02 = Family 2 CT and CTA (Chest/Thorax/Abd/Pelvis) 03 = Family 3 CT and CTA (Head/Brain/Orbit/Maxillofacial/Neck) 04 = Family 4 MRI and MRA (Chest/Abd/Pelvis) 05 = Family 5 MRI and MRA (Head/Brain/Neck) 06 = Family 6 MRI and MRA (spine) 07 = Family 7 CT (spine) 08 = Family 8 MRI and MRA (lower extremities) 09 = Family 9 CT and CTA (lower extremities) 10 = Family 10 Mr and MRI (upper extremities and joints) 11 = Family 11 CT and CTA (upper extremities)	2Pic x(2)
33F Performance Payment Indicator (For future use)	1 Pic x (1)
33G National Level Future Expansion	3 Pic x (3)
34 Non-Facility Fee Schedule Amount This field replicates field 28.	9 Pic 9(7)v99
35 Facility Fee Schedule Amount This field replicates field 29.	9 Pic 9(7)v99
36 Filler	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
37 Future Local Level Expansion** The Updated 1992 Transition Amount was previously stored in this field. A/B MACs (B) can continue to maintain the updated transition amount in this field.	7 Pic x(7)
38A Future Local Level Expansion** The adjusted historical payment basis (AHPB) was previously stored in this field. A/B MACs (B) can continue to maintain the AHPB in this field.	7 Pic x(7)
38 B Filler This field was originally established for 15 spaces. Since AHPB data will only use 7 of the 15 spaces, A/B MACs (B) have 8 remaining spaces for their purposes. ** These fields will be appended by each A/B MAC (B) at the local level.	8 Pix x(8)

2009 File Layout

HEADER RECORD

FIELD #	DATA ELEMENT NAME	LOCATION	PIC
1	Header ID	1-4	x(4) Value “Head"
2	Header Number	5	x(1)
3	Data Set Name	6-50	x(45)
4	Record Length	51-53	x(3)
5	Filler	54-54	x(1)
6	Block size	55-58	x(4)
7	Filler	59-59	x(1)
8	Number of Records Number does not include this header record.	60-69	9(10)
9	Date Created	70-77	x(8) YYYYMMDD
10	Blanks	78-345	x(268)

FILE LAYOUT

FIELD # & ITEM	LENGTH & PIC
1 File Year This field displays the effective year of the file.	4 Pic x(4)
2 A/B MAC (B) Number This field represents the 5-digit number assigned to the A/B MAC (B).	5 Pic x(5)
3 Locality This 2-digit code identifies the pricing locality used.	2 Pic x(2)
4 HCPCS Code This field represents the procedure code. Each A/B MAC (B) Procedural Terminology (CPT) code and alpha-numeric HCPCS codes other than B, C, E, K and L codes will be included. The standard sort for this field is blanks, alpha, and numeric in ascending order.	5 Pic x(5)
5 Modifier For diagnostic tests, a blank in this field denotes the global service and the following modifiers identify the components: 26 = Professional component	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
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 A/B MAC (B) 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.	
6 Descriptor This field will include a brief description of each procedure code.	50 Pic x(50)
7 Code Status This 1 position field provides the status of each code under the full fee schedule. Each status code is explained in §30.2.2.	1 Pic x(1)
8 Conversion Factor This field displays the multiplier which transforms relative values into payment amounts. The file will contain the **2009** conversion factor which will reflect all adjustments.	8 Pic 9(4)v9999
9 Update Factor This update factor has been included in the conversion factor in Field 8.	6 Pic 9(2)v9999
10 Work Relative Value Unit This field displays the unit value for the physician work RVU.	9 Pic 9(7)v99
11 Filler	9 Pic 9(7)v99
12 Malpractice Relative Value Unit	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
This field displays the unit value for the malpractice expense RVU.	
13 Work Geographic Practice Cost Indices (GPCIs) This field displays a work geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
14 Practice Expense GPCI This field displays a practice expense geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
15 Malpractice GPCI This field displays a malpractice expense geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
16 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. 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 (B) 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.)	3 Pic x(3)
17	6 Pic 9v9(5)

FIELD # & ITEM	LENGTH & PIC
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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	
18 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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
19 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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
20 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	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
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 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 A/B MACs (B) 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	

FIELD # & ITEM	LENGTH & PIC
laboratory physician interpretation codes include values for physician work, practice expense and malpractice expense. 7 = Private practice therapist's service: Payment may not be made if the service is provided to either a hospital outpatient or a hospital inpatient by a physical therapist, occupational therapist, or speech-language pathologist in private practice. 8 = Physician interpretation codes: This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for 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.	
21 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 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 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.	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
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 field 31G. Apply the multiple endoscopy rules to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). 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 25% reduction of the TC diagnostic imaging (effective for services January 1, 2006 and after). 9 = Concept does not apply.	
22 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. If procedure is reported with modifier -50 or with modifiers RT and LT, base 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 and XXXXX-RT with an actual charge of $100. Payment would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The 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 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 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.	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
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. If 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 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 amount 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 would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The RVUs are based on a bilateral procedure because: (a) the code descriptor specifically states that the procedure is bilateral; (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally; or (c) the procedure is usually performed as a bilateral procedure. 3 = The usual payment adjustment for bilateral procedures does not apply. If 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 payment for each side or organ or site of a paired organ on the lower of: (a) the actual charge for each side or (b) 100% of the fee schedule amount for each side. If procedure is reported as a bilateral procedure and with other procedure codes on the same day, 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 procedures. 9 = Concept does not apply.	
23	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
Assistant at Surgery This field provides an indicator for services where an assistant at surgery is never paid for per IOM. 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.	
24 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
25 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
26 Filler	1 Pic (x)1
27 Site of Service Differential For 1999 and beyond, the site of service differential no longer applies. The following definitions will apply for all years after 1998: 0 = Facility pricing does not apply.	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
1 = Facility pricing applies.	
28 Non-Facility Fee Schedule Amount This field shows the fee schedule amount for the non-facility setting. This amount equals Field 34. **Note**: Field 33 D indicates if an additional adjustment should be applied to this formula. Non-Facility Pricing Amount for 2009 [(Work RVU * Work GPCI) + (Transitioned Non-Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor Non-Facility Fee Schedule Amount for 2007 and 2008 This field shows the fee schedule amount for the non-facility setting. This amount equals Field 34. **Note**: Field 33 D indicates if an additional adjustment should be applied to this formula. Non-Facility Pricing Amount for 2007 and 2008 [(Work RVU * Budget Neutrality Adjustor) (round product to two decimal places) * Work GPCI) + (Transitioned Non-Facility PE RVU * PE GPC) + (MP RVU * MP GPCI)] * Conversion Factor **Budget Neutrality Adjustor** **2007 = .8994** **2008 = .8806**	9 Pic 9(7)v99
29 Facility Fee Schedule Amount This field shows the fee schedule amount for the facility setting. This amount equals Field 35. **Note:** Field 33D indicates if an additional adjustment should be applied to this formula. Facility Pricing Amount for 2009 [(Work RVU * Work GPCI) + (Transitioned Facility PE RVU * PE GPCI) +	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
(MP RVU * MP GPCI)] * Conversion Factor Facility Pricing Amount for 2007 and 2008 [(Work RVU * Budget Neutrality Adjustor) (round product to two decimal places) * Work GPCI) + (Transitioned Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor **Budget Neutrality Adjustor** **2007 = .8994** **2008 = .8806** Place of service codes to be used to identify facilities. 21 - Inpatient Hospital 22 - Outpatient Hospital 23 - Emergency Room - Hospital **24 - Ambulatory Surgical Center - In a Medicare approved ASC, for an approved procedure on the ASC list, Medicare pays the lower facility fee to physicians. Beginning with dates of service January 1, 2008, in a Medicare approved ASC, for procedures NOT on the ASC list of approved procedures,** A/B MACs (B) **will also pay the lower facility fee to physicians.** 26 - Military Treatment Facility 31 - Skilled Nursing Facility 34 - Hospice 41 - Ambulance - Land 42 - Ambulance Air or Water 51 - Inpatient Psychiatric Facility 52 - Psychiatric Facility Partial Hospitalization 53 - Community Mental Health Center 56 - Psychiatric Residential Treatment Facility 61 - Comprehensive Inpatient Rehabilitation Facility	
30 Number of Related Codes This field defines the number of related procedure codes (see Field 31).	2 Pic 99
31 Related Procedure Codes This field identifies the number of times that a related code occurs.	45 Pic x(5) - Occurs **9** times

FIELD # & ITEM	LENGTH & PIC
31DD Filler	1Pic x(1)
31CC Imaging Cap Indicator A value of “1” means subject to OPPS payment cap **determination**. A value of “9” means not subject to OPPS payment cap **determination**.	1Pic x(1)
31BB Non-Facility Imaging Payment Amount	9Pic(7)v99
33AA Facility Imaging Payment Amount	9Pic(7)v99
31A	2 Pic x(2)

Physician Supervision of Diagnostic Procedures This field is for use in post payment review. 01 = Procedure must be performed under the general supervision of a physician. 02 = Procedure must be performed under the direct supervision of a physician. 03 = Procedure must be performed under the personal supervision of a physician. 04 = Physician supervision policy does not apply when procedure is furnished by a qualified, independent psychologist or a clinical psychologist; otherwise must be performed under the general supervision of a physician. 05 = Physician supervision policy does not apply when procedure is furnished by a qualified audiologist; otherwise must be performed under the **direct** supervision of a physician. 06 = Procedure must be personally performed by a physician or a physical therapist (PT) who is certified by the American Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiologic clinical specialist and is permitted to provide the procedure under State law. Procedure may also be performed by a PT with ABPTS certification without physician supervision. 21 = Procedure may be performed by a technician with certification under general supervision of a physician; otherwise must be performed under direct supervision of a physician. Procedure may also be performed by a PT with ABPTS certification without physician supervision. 22 = May be performed by a technician with on-line real-time contact with physician. 66 = May be personally performed by a physician or by a physical therapist with ABPTS certification and certification in this specific procedure. 6A = Supervision standards for level 66 apply; in addition, the PT with ABPTS certification may personally supervise another PT, but only the PT with ABPTS certification may bill. 77 = Procedure must be performed by a PT with ABPTS certification (TC & PC) or by a PT without certification under direct supervision of a physician (TC & PC), or by a technician with certification under general supervision of a physician (TC only; PC always physician). 7A = Supervision standards for level 77 apply; in addition, the PT with ABPTS certification may personally supervise another PT, but only the PT with ABPTS certification may bill. 09 = Concept does not apply.	

FIELD # & ITEM	LENGTH & PIC
31B This field has been deleted to allow for the expansion of field 31A.	
31C Facility Setting Practice Expense Relative Value Units	9 Pic(7)v99
31D Non-Facility Setting Practice Expense Relative Value Units	9 Pic(7)v99
31E Filler	9 Pic(7)v99
31F Filler Reserved for future use.	1 Pic x(1)
31G Endoscopic Base Codes This field identifies an endoscopic base code for each code with a multiple surgery indicator of 3.	5 Pic x(5)
32A 1996 Transition/Fee Schedule Amount This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
32B 1996 Transition/Fee Schedule This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
32C 1996 Transition/Fee Schedule Amount When Site or Service Differential Applies This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
33A Units Payment Rule Indicator Reserved for future use. 9 = Concept does not apply.	1 Pic x(1)
33B Mapping Indicator This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
33C Medicare+Choice Encounter Pricing Locality NOT FOR A/B MAC (B) USE: These Medicare+Choice encounter pricing localities are for EDS purposes only. The locality values were developed to facilitate centralized processing of encounter data by the Medicare+Choice organizations (M+COs).	2 Pic x(2)
33D Calculation Flag This field is informational only; the SSMs do not need to add this field**.** The intent is to assist A/B MACs (B) to understand how the fee schedule amount in fields 28 and 29 are calculated. The MMA mandates an additional adjustment to selected HCPCS codes. A value of "1" indicates an additional fee schedule adjustment of 1.32 in 2004 and 1.03 in 2005. A value of "0" indicates no additional adjustment needed. **A value of "2" indicates an additional fee schedule adjustment of 1.05 effective 7/1/2008.**	1 Pic x(1)
33 E Diagnostic Imaging Family Indicator 01 = Family 1 Ultrasound (Chest/Abdomen/Pelvis - Non Obstetrical 02 = Family 2 CT and CTA (Chest/Thorax/Abd/Pelvis) 03 = Family 3 CT and CTA (Head/Brain/Orbit/Maxillofacial/Neck) 04 = Family 4 MRI and MRA (Chest/Abd/Pelvis) 05 = Family 5 MRI and MRA (Head/Brain/Neck) 06 = Family 6 MRI and MRA (spine) 07 = Family 7 CT (spine) 08 = Family 8 MRI and MRA (lower extremities) 09 = Family 9 CT and CTA (lower extremities) 10 = Family 10 Mr and MRI (upper extremities and joints) 11 = Family 11 CT and CTA (upper extremities) **99 = Concept Does Not Apply**	2Pic x(2)
33F Performance Payment Indicator (For future use)	1 Pic x (1)
33G National Level Future Expansion	3 Pic x (3)
34 Non-Facility Fee Schedule Amount This field replicates field 28.	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
35 Facility Fee Schedule Amount This field replicates field 29.	9 Pic 9(7)v99
36 Filler	1 Pic x(1)
37 Future Local Level Expansion** The Updated 1992 Transition Amount was previously stored in this field. A/B MACs (B) can continue to maintain the updated transition amount in this field.	7 Pic x(7)
38A Future Local Level Expansion** The adjusted historical payment basis (AHPB) was previously stored in this field. A/B MACs (B) can continue to maintain the AHPB in this field.	7 Pic x(7)
38 B Filler This field was originally established for 15 spaces. Since AHPB data will only use 7 of the 15 spaces, A/B MACs (B) have 8 remaining spaces for their purposes. ** These fields will be appended by each A/B MAC (B) at the local level.	8 Pix x(8)

2010 File Layout

HEADER RECORD

FIELD #	DATA ELEMENT NAME	LOCATION	PIC
1	Header ID	1-4	x(4) Value “Head"
2	Header Number	5	x(1)
3	Data Set Name	6-50	x(45)
4	Record Length	51-53	x(3)
5	Filler	54-54	x(1)
6	Block size	55-58	x(4)
7	Filler	59-59	x(1)
8	Number of Records Number does not include this header record.	60-69	9(10)
9	Date Created	70-77	x(8) YYYYMMDD
10	Blanks	78-345	x(268)

FILE LAYOUT

FIELD # & ITEM	LENGTH & PIC
1 File Year This field displays the effective year of the file.	4 Pic x(4)
2 A/B MAC (B) Number This field represents the 5-digit number assigned to the A/B MAC (B).	5 Pic x(5)
3 Locality This 2-digit code identifies the pricing locality used.	2 Pic x(2)
4 HCPCS Code This field represents the procedure code. Each A/B MAC (B) Procedural Terminology (CPT) code and alpha-numeric HCPCS codes other than B, C, E, K and L codes will be included. The standard sort for this field is blanks, alpha, and numeric in ascending order.	5 Pic x(5)
5 Modifier For diagnostic tests, a blank in this field denotes the global service and the following modifiers identify the components: 26 = Professional component	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
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 A/B MAC (B) 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.	
6 Descriptor This field will include a brief description of each procedure code.	50 Pic x(50)
7 Code Status This 1 position field provides the status of each code under the full fee schedule. Each status code is explained in §30.2.2.	1 Pic x(1)
8 Conversion Factor This field displays the multiplier which transforms relative values into payment amounts. The file will contain the **2010** conversion factor which will reflect all adjustments.	8 Pic 9(4)v9999
9 Update Factor This update factor has been included in the conversion factor in Field 8.	6 Pic 9(2)v9999
10 Work Relative Value Unit This field displays the unit value for the physician work RVU.	9 Pic 9(7)v99
11 Filler	9 Pic 9(7)v99
12 Malpractice Relative Value Unit	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
This field displays the unit value for the malpractice expense RVU.	
13 Work Geographic Practice Cost Indices (GPCIs) This field displays a work geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
14 Practice Expense GPCI This field displays a practice expense geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
15 Malpractice GPCI This field displays a malpractice expense geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
16 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. 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 (B) 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.)	3 Pic x(3)
17	6 Pic 9v9(5)

FIELD # & ITEM	LENGTH & PIC
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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	
18 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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
19 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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
20 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	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
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 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 A/B MACs (B) 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	

FIELD # & ITEM	LENGTH & PIC
laboratory physician interpretation codes include values for physician work, practice expense and malpractice expense. 7 = Private practice therapist's service: Payment may not be made if the service is provided to either a hospital outpatient or a hospital inpatient by a physical therapist, occupational therapist, or speech-language pathologist in private practice. 8 = Physician interpretation codes: This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for 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.	
21 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 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 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.	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
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 field 31G. Apply the multiple endoscopy rules to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). 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 25% reduction of the TC diagnostic imaging (effective for services January 1, 2006 and after). 9 = Concept does not apply.	
22 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. If procedure is reported with modifier -50 or with modifiers RT and LT, base 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 and XXXXX-RT with an actual charge of $100. Payment would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The 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 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 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.	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
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. If 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 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 amount 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 would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The RVUs are based on a bilateral procedure because: (a) the code descriptor specifically states that the procedure is bilateral; (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally; or (c) the procedure is usually performed as a bilateral procedure. 3 = The usual payment adjustment for bilateral procedures does not apply. If 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 payment for each side or organ or site of a paired organ on the lower of: (a) the actual charge for each side or (b) 100% of the fee schedule amount for each side. If procedure is reported as a bilateral procedure and with other procedure codes on the same day, 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 procedures. 9 = Concept does not apply.	
23	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
Assistant at Surgery This field provides an indicator for services where an assistant at surgery is never paid for per IOM. 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.	
24 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
25 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
26 Filler	1 Pic (x)1
27 Site of Service Differential For 1999 and beyond, the site of service differential no longer applies. The following definitions will apply for all years after 1998: 0 = Facility pricing does not apply.	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
1 = Facility pricing applies.	
28 Non-Facility Fee Schedule Amount This field shows the fee schedule amount for the non-facility setting. This amount equals Field 34. **Note**: Field 33 D indicates if an additional adjustment should be applied to this formula. Non-Facility Pricing Amount for 2009 [(Work RVU * Work GPCI) + (Non-Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor **A** Budget Neutrality Adjustor **was applied to the work RVU for years 2007 and 2008:** 2007 = .8994 2008 = .8806	9 Pic 9(7)v99
29 Facility Fee Schedule Amount This field shows the fee schedule amount for the facility setting. This amount equals Field 35. **Note:** Field 33D indicates if an additional adjustment should be applied to this formula. Facility Pricing Amount **for 2009** [(Work RVU * Work GPCI) + (Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor **A** Budget Neutrality Adjustor **was applied to the work RVU for years 2007 and 2008:** **2007 = .8994** **2008 = .8806** Place of service codes to be used to identify facilities. 21 - Inpatient Hospital 22 - Outpatient Hospital 23 - Emergency Room - Hospital 24 - Ambulatory Surgical Center - In a Medicare approved ASC, for an approved procedure on the ASC list, Medicare pays the lower	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
facility fee to physicians. Beginning with dates of service January 1, 2008, in a Medicare approved ASC, for procedures NOT on the ASC list of approved procedures, A/B MACs (B) will also pay the lower facility fee to physicians. 26 - Military Treatment Facility 31 - Skilled Nursing Facility 34 - Hospice 41 - Ambulance - Land 42 - Ambulance Air or Water 51 - Inpatient Psychiatric Facility 52 - Psychiatric Facility Partial Hospitalization 53 - Community Mental Health Center 56 - Psychiatric Residential Treatment Facility 61 - Comprehensive Inpatient Rehabilitation Facility	
30 Number of Related Codes This field defines the number of related procedure codes (see Field 31).	2 Pic 99
31 Related Procedure Codes This field identifies the number of times that a related code occurs.	45 Pic x(5) - Occurs **9** times
31DD Filler	1Pic x(1)
31CC Imaging Cap Indicator A value of “1” means subject to OPPS payment cap determination. A value of “9” means not subject to OPPS payment cap determination.	1Pic x(1)
31BB Non-Facility Imaging Payment Amount	9Pic(7)v99
33AA Facility Imaging Payment Amount	9Pic(7)v99
31A	2 Pic x(2)

Physician Supervision of Diagnostic Procedures This field is for use in post payment review. 01 = Procedure must be performed under the general supervision of a physician. 02 = Procedure must be performed under the direct supervision of a physician. 03 = Procedure must be performed under the personal supervision of a physician. 04 = Physician supervision policy does not apply when procedure is furnished by a qualified, independent psychologist or a clinical psychologist; otherwise must be performed under the general supervision of a physician. 05 = Not subject to supervision when furnished personally by a qualified audiologist, physician or nonphysician practitioner. When a technical component is furnished in part by a qualified technician, some part of the technical component must be furnished either by or under the personal supervision of an audiologist, physician or nonphysician practitioner. The part of a service that is not furnished by or under the personal supervision of a qualified audiologist, physician or nonphysician practitioner must be furnished by a qualified technician under the direct supervision of an audiologist, physician or nonphysician practitioner. 06 = Procedure must be personally performed by a physician or a physical therapist (PT) who is certified by the American Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiological clinical specialist and is permitted to provide the procedure under State law. Procedure may also be performed by a PT with ABPTS certification without physician supervision. 21 = Procedure may be performed by a technician with certification under general supervision of a physician; otherwise must be performed under direct supervision of a physician. Procedure may also be performed by a PT with ABPTS certification without physician supervision. 22 = May be performed by a technician with on-line real-time contact with physician. 66 = May be personally performed by a physician or by a physical therapist with ABPTS certification and certification in this specific procedure. 6A = Supervision standards for level 66 apply; in addition, the PT with ABPTS certification may personally supervise another PT, but only the PT with ABPTS certification may bill. 77 = Procedure must be performed by a PT with ABPTS certification (TC & PC) or by a PT without certification under direct supervision of a physician (TC & PC), or by a technician with	

FIELD # & ITEM	LENGTH & PIC
certification under general supervision of a physician (TC only; PC always physician). 7A = Supervision standards for level 77 apply; in addition, the PT with ABPTS certification may personally supervise another PT, but only the PT with ABPTS certification may bill. 09 = Concept does not apply.	
31B This field has been deleted to allow for the expansion of field 31A.	
31C Facility Setting Practice Expense Relative Value Units	9 Pic(7)v99
31D Non-Facility Setting Practice Expense Relative Value Units	9 Pic(7)v99
31E Filler	9 Pic(7)v99
31F Filler Reserved for future use.	1 Pic x(1)
31G Endoscopic Base Codes This field identifies an endoscopic base code for each code with a multiple surgery indicator of 3.	5 Pic x(5)
32A 1996 Transition/Fee Schedule Amount This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
32B 1996 Transition/Fee Schedule This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
32C 1996 Transition/Fee Schedule Amount When Site or Service Differential Applies This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
33A Units Payment Rule Indicator Reserved for future use.	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
9 = Concept does not apply.	
33B Mapping Indicator This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
33C **Purchased Diagnostic Locality—Informational Use—Locality used for reporting utilization of purchased diagnostic services.** NOT FOR A/B MAC (B) USE: These Medicare+Choice encounter pricing localities are for EDS purposes only. The locality values were developed to facilitate centralized processing of encounter data by the Medicare+Choice organizations (M+COs).	2 Pic x(2)
33D Calculation Flag This field is informational only; the SSMs do not need to add this field**.** The intent is to assist A/B MACs (B) to understand how the fee schedule amount in fields 28 and 29 are calculated. The MMA mandates an additional adjustment to selected HCPCS codes. A value of "1" indicates an additional fee schedule adjustment of 1.32 in 2004 and 1.03 in 2005. A value of "0" indicates no additional adjustment needed. A value of "2" indicates an additional fee schedule adjustment of 1.05 effective 7/1/2008.	1 Pic x(1)
33 E Diagnostic Imaging Family Indicator 01 = Family 1 Ultrasound (Chest/Abdomen/Pelvis - Non Obstetrical 02 = Family 2 CT and CTA (Chest/Thorax/Abd/Pelvis) 03 = Family 3 CT and CTA (Head/Brain/Orbit/Maxillofacial/Neck) 04 = Family 4 MRI and MRA (Chest/Abd/Pelvis) 05 = Family 5 MRI and MRA (Head/Brain/Neck) 06 = Family 6 MRI and MRA (spine) 07 = Family 7 CT (spine) 08 = Family 8 MRI and MRA (lower extremities) 09 = Family 9 CT and CTA (lower extremities) 10 = Family 10 Mr and MRI (upper extremities and joints) 11 = Family 11 CT and CTA (upper extremities) 99 = Concept Does Not Apply	2Pic x(2)
33F Performance Payment Indicator	1 Pic x (1)

FIELD # & ITEM	LENGTH & PIC
(For future use)	
33G National Level Future Expansion	3 Pic x (3)
34 Non-Facility Fee Schedule Amount This field replicates field 28.	9 Pic 9(7)v99
35 Facility Fee Schedule Amount This field replicates field 29.	9 Pic 9(7)v99
36 Filler	1 Pic x(1)
37 Future Local Level Expansion** The Updated 1992 Transition Amount was previously stored in this field. A/B MACs (B) can continue to maintain the updated transition amount in this field.	7 Pic x(7)
38A Future Local Level Expansion** The adjusted historical payment basis (AHPB) was previously stored in this field. A/B MACs (B) can continue to maintain the AHPB in this field.	7 Pic x(7)
38 B Filler This field was originally established for 15 spaces. Since AHPB data will only use 7 of the 15 spaces, A/B MACs (B) have 8 remaining spaces for their purposes. ** These fields will be appended by each A/B MAC (B) at the local level.	8 Pix x(8)

2011 File Layout

HEADER RECORD

FIELD #	DATA ELEMENT NAME	LOCATION	PIC
1	Header ID	1-4	x(4) Value "Head"
2	Header Number	5	x(1)
3	Data Set Name	6-50	x(45)
4	Record Length	51-53	x(3)
5	Filler	54-54	x(1)
6	Block size	55-58	x(4)
7	Filler	59-59	x(1)
8	Number of Records Number does not include this header record.	60-69	9(10)
9	Date Created	70-77	x(8) YYYYMMDD
10	Blanks	78-345	x(268)

FILE LAYOUT

FIELD # & ITEM	LENGTH & PIC
1 File Year This field displays the effective year of the file.	4 Pic x(4)
2 A/B MAC (B) Number This field represents the 5-digit number assigned to the A/B MAC (B).	5 Pic x(5)
3 Locality This 2-digit code identifies the pricing locality used.	2 Pic x(2)
4 HCPCS Code This field represents the procedure code. Each A/B MAC (B) Procedural Terminology (CPT) code and alpha-numeric HCPCS codes other than B, C, E, K and L codes will be included. The standard sort for this field is blanks, alpha, and numeric in ascending order.	5 Pic x(5)
5 Modifier For diagnostic tests, a blank in this field denotes the global service and the following modifiers identify the components: 26 = Professional component	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
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 A/B MAC (B) 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.	
6 Descriptor This field will include a brief description of each procedure code.	50 Pic x(50)
7 Code Status This 1 position field provides the status of each code under the full fee schedule. Each status code is explained in §30.2.2.	1 Pic x(1)
8 Conversion Factor This field displays the multiplier which transforms relative values into payment amounts. The file will contain the **2011** conversion factor which will reflect all adjustments.	8 Pic 9(4)v9999
9 Update Factor This update factor has been included in the conversion factor in Field 8.	6 Pic 9(2)v9999
10 Work Relative Value Unit This field displays the unit value for the physician work RVU.	9 Pic 9(7)v99
11 Filler	9 Pic 9(7)v99
12 Malpractice Relative Value Unit	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
This field displays the unit value for the malpractice expense RVU.	
13 Work Geographic Practice Cost Indices (GPCIs) This field displays a work geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
14 Practice Expense GPCI This field displays a practice expense geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
15 Malpractice GPCI This field displays a malpractice expense geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
16 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. 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 (B) 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.)	3 Pic x(3)
17	6 Pic 9v9(5)

FIELD # & ITEM	LENGTH & PIC
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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	
18 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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
19 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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
20 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	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
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 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 A/B MACs (B) 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	

FIELD # & ITEM	LENGTH & PIC
laboratory physician interpretation codes include values for physician work, practice expense and malpractice expense. 7 = Private practice therapist's service: Payment may not be made if the service is provided to either a hospital outpatient or a hospital inpatient by a physical therapist, occupational therapist, or speech-language pathologist in private practice. 8 = Physician interpretation codes: This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for 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.	
21 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 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 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.	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
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 field 31G. Apply the multiple endoscopy rules to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). 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 25% reduction of the TC diagnostic imaging (effective for services January 1, 2006 **through June 30, 2010**). **Subject to 50% reduction of the TC diagnostic imaging (effective for services July 1, 2010 and after).** **5 = Subject to 20% reduction of the practice expense component for certain therapy services (effective for services January 1, 2011 and after).** 9 = Concept does not apply.	
22 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. If procedure is reported with modifier -50 or with modifiers RT and LT, base 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 and XXXXX-RT with an actual charge of $100. Payment would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The 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 or is reported twice on the same day by any other means (e.g., with RT and LT modifiers or	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
with a 2 in the units field), 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. If 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 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 amount 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 would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The RVUs are based on a bilateral procedure because: (a) the code descriptor specifically states that the procedure is bilateral; (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally; or (c) the procedure is usually performed as a bilateral procedure. 3 = The usual payment adjustment for bilateral procedures does not apply. If 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 payment for each side or organ or site of a paired organ on the lower of: (a) the actual charge for each side or (b) 100% of the fee schedule amount for each side. If procedure is reported as a bilateral procedure and with other procedure codes on the same day, 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 procedures. 9 = Concept does not apply.	
23	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
Assistant at Surgery This field provides an indicator for services where an assistant at surgery is never paid for per IOM. 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.	
24 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
25 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
26 Filler	1 Pic (x)1
27 Site of Service Differential For 1999 and beyond, the site of service differential no longer applies. The following definitions will apply for all years after 1998: 0 = Facility pricing does not apply.	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
1 = Facility pricing applies.	
28 Non-Facility Fee Schedule Amount This field shows the fee schedule amount for the non-facility setting. This amount equals Field 34. **Note**: Field 33 D indicates if an additional adjustment should be applied to this formula. Non-Facility Pricing Amount for **2011** [(Work RVU * Work GPCI) + (Non-Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor	9 Pic 9(7)v99
29 Facility Fee Schedule Amount This field shows the fee schedule amount for the facility setting. This amount equals Field 35. **Note:** Field 33D indicates if an additional adjustment should be applied to this formula. Facility Pricing Amount for **2011** [(Work RVU * Work GPCI) + (Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor Place of service codes to be used to identify facilities. 21 - Inpatient Hospital 22 - Outpatient Hospital 23 - Emergency Room - Hospital 24 - Ambulatory Surgical Center - In a Medicare approved ASC, for an approved procedure on the ASC list, Medicare pays the lower facility fee to physicians. Beginning with dates of service January 1, 2008, in a Medicare approved ASC, for procedures NOT on the ASC list of approved procedures, A/B MACs (B) will also pay the lower facility fee to physicians. 26 - Military Treatment Facility 31 - Skilled Nursing Facility 34 - Hospice 41 - Ambulance - Land 42 - Ambulance Air or Water 51 - Inpatient Psychiatric Facility 52 - Psychiatric Facility Partial Hospitalization	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
53 - Community Mental Health Center 56 - Psychiatric Residential Treatment Facility 61 - Comprehensive Inpatient Rehabilitation Facility	
30 Number of Related Codes This field defines the number of related procedure codes (see Field 31).	2 Pic 99
31 Related Procedure Codes This field identifies the number of times that a related code occurs.	**3**5 Pic x(5) - Occurs **7** times
31EE **Reduced therapy fee schedule amount**	**9Pic(7)v99**
31DD Filler	1Pic x(**2**)
31CC Imaging Cap Indicator A value of “1” means subject to OPPS payment cap determination. A value of “9” means not subject to OPPS payment cap determination.	1Pic x(1)
31BB Non-Facility Imaging Payment Amount	9Pic(7)v99
33AA Facility Imaging Payment Amount	9Pic(7)v99
31A	2 Pic x(2)

Physician Supervision of Diagnostic Procedures This field is for use in post payment review. 01 = Procedure must be performed under the general supervision of a physician. 02 = Procedure must be performed under the direct supervision of a physician. 03 = Procedure must be performed under the personal supervision of a physician. 04 = Physician supervision policy does not apply when procedure is furnished by a qualified, independent psychologist or a clinical psychologist; otherwise must be performed under the general supervision of a physician. 05 = Not subject to supervision when furnished personally by a qualified audiologist, physician or non physician practitioner. **Direct supervision by a physician is required for those parts of the test that may be furnished by a qualified technician when appropriate to the circumstances of the test.** 06 = Procedure must be personally performed by a physician or a physical therapist (PT) who is certified by the American Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiological clinical specialist and is permitted to provide the procedure under State law. Procedure may also be performed by a PT with ABPTS certification without physician supervision. 21 = Procedure may be performed by a technician with certification under general supervision of a physician; otherwise must be performed under direct supervision of a physician. Procedure may also be performed by a PT with ABPTS certification without physician supervision. 22 = May be performed by a technician with on-line real-time contact with physician. 66 = May be personally performed by a physician or by a physical therapist with ABPTS certification and certification in this specific procedure. 6A = Supervision standards for level 66 apply; in addition, the PT with ABPTS certification may personally supervise another PT, but only the PT with ABPTS certification may bill. 77 = Procedure must be performed by a PT with ABPTS certification (TC & PC) or by a PT without certification under direct supervision of a physician (TC & PC), or by a technician with certification under general supervision of a physician (TC only; PC always physician).	

FIELD # & ITEM	LENGTH & PIC
7A = Supervision standards for level 77 apply; in addition, the PT with ABPTS certification may personally supervise another PT, but only the PT with ABPTS certification may bill. 09 = Concept does not apply.	
31B This field has been deleted to allow for the expansion of field 31A.	
31C Facility Setting Practice Expense Relative Value Units	9 Pic(7)v99
31D Non-Facility Setting Practice Expense Relative Value Units	9 Pic(7)v99
31E Filler	9 Pic(7)v99
31F Filler Reserved for future use.	1 Pic x(1)
31G Endoscopic Base Codes This field identifies an endoscopic base code for each code with a multiple surgery indicator of 3.	5 Pic x(5)
32A 1996 Transition/Fee Schedule Amount This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
32B 1996 Transition/Fee Schedule This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
32C 1996 Transition/Fee Schedule Amount When Site or Service Differential Applies This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
33A Units Payment Rule Indicator Reserved for future use. 9 = Concept does not apply.	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
33B Mapping Indicator This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
33C Purchased Diagnostic Locality—Informational Use—Locality used for reporting utilization of purchased diagnostic services. NOT FOR A/B MAC (B) USE: These Medicare+Choice encounter pricing localities are for EDS purposes only. The locality values were developed to facilitate centralized processing of encounter data by the Medicare+Choice organizations (M+COs).	2 Pic x(2)
33D Calculation Flag This field is informational only; the SSMs do not need to add this field. The intent is to assist A/B MACs (B) to understand how the fee schedule amount in fields 28 and 29 are calculated. The MMA mandates an additional adjustment to selected HCPCS codes. A value of "1" indicates an additional fee schedule adjustment of 1.32 in 2004 and 1.03 in 2005. A value of "0" indicates no additional adjustment needed. A value of "2" indicates an additional fee schedule adjustment of 1.05 effective 7/1/2008.	1 Pic x(1)
33 E Diagnostic Imaging Family Indicator **For services effective January 1, 2011, and after, family indicators 01 - 11 will not be populated.** 01 = Family 1 Ultrasound (Chest/Abdomen/Pelvis - Non Obstetrical 02 = Family 2 CT and CTA (Chest/Thorax/Abd/Pelvis) 03 = Family 3 CT and CTA (Head/Brain/Orbit/Maxillofacial/Neck) 04 = Family 4 MRI and MRA (Chest/Abd/Pelvis) 05 = Family 5 MRI and MRA (Head/Brain/Neck) 06 = Family 6 MRI and MRA (spine) 07 = Family 7 CT (spine) 08 = Family 8 MRI and MRA (lower extremities) 09 = Family 9 CT and CTA (lower extremities) 10 = Family 10 Mr and MRI (upper extremities and joints) 11 = Family 11 CT and CTA (upper extremities) **88 = Subject to the reduction of the TC diagnostic imaging (effective for services January 1, 2011, and after).** 99 = Concept Does Not Apply	2Pic x(2)

FIELD # & ITEM	LENGTH & PIC
33F Performance Payment Indicator (For future use)	1 Pic x (1)
33G National Level Future Expansion	3 Pic x (3)
34 Non-Facility Fee Schedule Amount This field replicates field 28.	9 Pic 9(7)v99
35 Facility Fee Schedule Amount This field replicates field 29.	9 Pic 9(7)v99
36 Filler	1 Pic x(1)
37 Future Local Level Expansion** The Updated 1992 Transition Amount was previously stored in this field. A/B MACs (B) can continue to maintain the updated transition amount in this field.	7 Pic x(7)
38A Future Local Level Expansion** The adjusted historical payment basis (AHPB) was previously stored in this field. A/B MACs (B) can continue to maintain the AHPB in this field.	7 Pic x(7)
38 B Filler This field was originally established for 15 spaces. Since AHPB data will only use 7 of the 15 spaces, A/B MACs (B) have 8 remaining spaces for their purposes. ** These fields will be appended by each A/B MAC (B) at the local level.	8 Pix x(8)

2012 File Layout

HEADER RECORD

FIELD #	DATA ELEMENT NAME	LOCATION	PIC
1	Header ID	1-4	x(4) Value "Head"
2	Header Number	5	x(1)
3	Data Set Name	6-50	x(45)
4	Record Length	51-53	x(3)
5	Filler	54-54	x(1)
6	Block size	55-58	x(4)
7	Filler	59-59	x(1)
8	Number of Records Number does not include this header record.	60-69	9(10)
9	Date Created	70-77	x(8) YYYYMMDD
10	Blanks	78-345	x(268)

FILE LAYOUT

FIELD # & ITEM	LENGTH & PIC
1 File Year This field displays the effective year of the file.	4 Pic x(4)
2 A/B MAC (B) Number This field represents the 5-digit number assigned to the A/B MAC (B).	5 Pic x(5)
3 Locality This 2-digit code identifies the pricing locality used.	2 Pic x(2)
4 HCPCS Code This field represents the procedure code. Each A/B MAC (B) Procedural Terminology (CPT) code and alpha-numeric HCPCS codes other than B, C, E, K and L codes will be included. The standard sort for this field is blanks, alpha, and numeric in ascending order.	5 Pic x(5)
5 Modifier For diagnostic tests, a blank in this field denotes the global service and the following modifiers identify the components: 26 = Professional component	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
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 A/B MAC (B) 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.	
6 Descriptor This field will include a brief description of each procedure code.	50 Pic x(50)
7 Code Status This 1 position field provides the status of each code under the full fee schedule. Each status code is explained in §30.2.2.	1 Pic x(1)
8 Conversion Factor This field displays the multiplier which transforms relative values into payment amounts. The file will contain the **2012** conversion factor which will reflect all adjustments.	8 Pic 9(4)v9999
9 Update Factor This update factor has been included in the conversion factor in Field 8.	6 Pic 9(2)v9999
10 Work Relative Value Unit This field displays the unit value for the physician work RVU.	9 Pic 9(7)v99
11 Filler	9 Pic 9(7)v99
12 Malpractice Relative Value Unit	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
This field displays the unit value for the malpractice expense RVU.	
13 Work Geographic Practice Cost Indices (GPCIs) This field displays a work geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
14 Practice Expense GPCI This field displays a practice expense geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
15 Malpractice GPCI This field displays a malpractice expense geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
16 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. 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 (B) 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.)	3 Pic x(3)
17	6 Pic 9v9(5)

FIELD # & ITEM	LENGTH & PIC
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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	
18 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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
19 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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
20 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	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
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 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 A/B MACs (B) 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	

FIELD # & ITEM	LENGTH & PIC
laboratory physician interpretation codes include values for physician work, practice expense and malpractice expense. 7 = Private practice therapist's service: Payment may not be made if the service is provided to either a hospital outpatient or a hospital inpatient by a physical therapist, occupational therapist, or speech-language pathologist in private practice. 8 = Physician interpretation codes: This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for 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.	
21 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 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 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.	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
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 field 31G. Apply the multiple endoscopy rules to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). 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 25% reduction of the TC diagnostic imaging (effective for services January 1, 2006 through June 30, 2010). Subject to 50% reduction of the TC diagnostic imaging (effective for services July 1, 2010 and after). 5 = Subject to 20% reduction of the practice expense component for certain therapy services (effective for services January 1, 2011 and after). 9 = Concept does not apply.	
22 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. If procedure is reported with modifier -50 or with modifiers RT and LT, base 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 and XXXXX-RT with an actual charge of $100. Payment would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The 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 or is reported twice on the same day by any other means (e.g., with RT and LT modifiers or	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
with a 2 in the units field), 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. If 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 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 amount 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 would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The RVUs are based on a bilateral procedure because: (a) the code descriptor specifically states that the procedure is bilateral; (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally; or (c) the procedure is usually performed as a bilateral procedure. 3 = The usual payment adjustment for bilateral procedures does not apply. If 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 payment for each side or organ or site of a paired organ on the lower of: (a) the actual charge for each side or (b) 100% of the fee schedule amount for each side. If procedure is reported as a bilateral procedure and with other procedure codes on the same day, 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 procedures. 9 = Concept does not apply.	
23	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
Assistant at Surgery This field provides an indicator for services where an assistant at surgery is never paid for per IOM. 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.	
24 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
25 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
26 Filler	1 Pic (x)1
27 Site of Service Differential For 1999 and beyond, the site of service differential no longer applies. The following definitions will apply for all years after 1998: 0 = Facility pricing does not apply.	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
1 = Facility pricing applies.	
28 Non-Facility Fee Schedule Amount This field shows the fee schedule amount for the non-facility setting. This amount equals Field 34. **Note**: Field 33 D indicates if an additional adjustment should be applied to this formula. Non-Facility Pricing Amount for **2012** [(Work RVU * Work GPCI) + (Non-Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor	9 Pic 9(7)v99
29 Facility Fee Schedule Amount This field shows the fee schedule amount for the facility setting. This amount equals Field 35. **Note:** Field 33D indicates if an additional adjustment should be applied to this formula. Facility Pricing Amount for **2012** [(Work RVU * Work GPCI) + (Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor Place of service codes to be used to identify facilities. 21 - Inpatient Hospital 22 - Outpatient Hospital 23 - Emergency Room - Hospital 24 - Ambulatory Surgical Center - In a Medicare approved ASC, for an approved procedure on the ASC list, Medicare pays the lower facility fee to physicians. Beginning with dates of service January 1, 2008, in a Medicare approved ASC, for procedures NOT on the ASC list of approved procedures, A/B MACs (B) will also pay the lower facility fee to physicians. 26 - Military Treatment Facility 31 - Skilled Nursing Facility 34 - Hospice 41 - Ambulance - Land 42 - Ambulance Air or Water 51 - Inpatient Psychiatric Facility 52 - Psychiatric Facility Partial Hospitalization	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
53 - Community Mental Health Center 56 - Psychiatric Residential Treatment Facility 61 - Comprehensive Inpatient Rehabilitation Facility	
30 Number of Related Codes This field defines the number of related procedure codes (see Field 31).	2 Pic 99
31 Related Procedure Codes This field identifies the number of times that a related code occurs.	35 Pic x(5) - Occurs 7 times
31EE Reduced therapy fee schedule amount	9Pic(7)v99
31DD Filler	1Pic x(2)
31CC Imaging Cap Indicator A value of “1” means subject to OPPS payment cap determination. A value of “9” means not subject to OPPS payment cap determination.	1Pic x(1)
31BB Non-Facility Imaging Payment Amount	9Pic(7)v99
33AA Facility Imaging Payment Amount	9Pic(7)v99
31A	2 Pic x(2)

Physician Supervision of Diagnostic Procedures This field is for use in post payment review. 01 = Procedure must be performed under the general supervision of a physician. 02 = Procedure must be performed under the direct supervision of a physician. 03 = Procedure must be performed under the personal supervision of a physician. 04 = Physician supervision policy does not apply when procedure is furnished by a qualified, independent psychologist or a clinical psychologist; otherwise must be performed under the general supervision of a physician. 05 = Not subject to supervision when furnished personally by a qualified audiologist, physician or non physician practitioner. Direct supervision by a physician is required for those parts of the test that may be furnished by a qualified technician when appropriate to the circumstances of the test. 06 = Procedure must be personally performed by a physician or a physical therapist (PT) who is certified by the American Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiological clinical specialist and is permitted to provide the procedure under State law. Procedure may also be performed by a PT with ABPTS certification without physician supervision. 21 = Procedure may be performed by a technician with certification under general supervision of a physician; otherwise must be performed under direct supervision of a physician. Procedure may also be performed by a PT with ABPTS certification without physician supervision. 22 = May be performed by a technician with on-line real-time contact with physician. 66 = May be personally performed by a physician or by a physical therapist with ABPTS certification and certification in this specific procedure. 6A = Supervision standards for level 66 apply; in addition, the PT with ABPTS certification may personally supervise another PT, but only the PT with ABPTS certification may bill. 77 = Procedure must be performed by a PT with ABPTS certification (TC & PC) or by a PT without certification under direct supervision of a physician (TC & PC), or by a technician with certification under general supervision of a physician (TC only; PC always physician).	

FIELD # & ITEM	LENGTH & PIC
7A = Supervision standards for level 77 apply; in addition, the PT with ABPTS certification may personally supervise another PT, but only the PT with ABPTS certification may bill. 09 = Concept does not apply.	
31B This field has been deleted to allow for the expansion of field 31A.	
31C Facility Setting Practice Expense Relative Value Units	9 Pic(7)v99
31D Non-Facility Setting Practice Expense Relative Value Units	9 Pic(7)v99
31E Filler	9 Pic(7)v99
31F Filler Reserved for future use.	1 Pic x(1)
31G Endoscopic Base Codes This field identifies an endoscopic base code for each code with a multiple surgery indicator of 3.	5 Pic x(5)
32A 1996 Transition/Fee Schedule Amount This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
32B 1996 Transition/Fee Schedule This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
32C 1996 Transition/Fee Schedule Amount When Site or Service Differential Applies This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
33A Units Payment Rule Indicator Reserved for future use. 9 = Concept does not apply.	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
33B Mapping Indicator This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
33C Purchased Diagnostic Locality—Informational Use—Locality used for reporting utilization of purchased diagnostic services. NOT FOR A/B MAC (B) USE: These Medicare+Choice encounter pricing localities are for EDS purposes only. The locality values were developed to facilitate centralized processing of encounter data by the Medicare+Choice organizations (M+COs).	2 Pic x(2)
33D Calculation Flag This field is informational only; the SSMs do not need to add this field. The intent is to assist A/B MACs (B) to understand how the fee schedule amount in fields 28 and 29 are calculated. The MMA mandates an additional adjustment to selected HCPCS codes. A value of "1" indicates an additional fee schedule adjustment of 1.32 in 2004 and 1.03 in 2005. A value of "0" indicates no additional adjustment needed. A value of "2" indicates an additional fee schedule adjustment of 1.05 effective 7/1/2008.	1 Pic x(1)
33 E Diagnostic Imaging Family Indicator For services effective January 1, 2011, and after, family indicators 01 - 11 will not be populated. 01 = Family 1 Ultrasound (Chest/Abdomen/Pelvis - Non Obstetrical 02 = Family 2 CT and CTA (Chest/Thorax/Abd/Pelvis) 03 = Family 3 CT and CTA (Head/Brain/Orbit/Maxillofacial/Neck) 04 = Family 4 MRI and MRA (Chest/Abd/Pelvis) 05 = Family 5 MRI and MRA (Head/Brain/Neck) 06 = Family 6 MRI and MRA (spine) 07 = Family 7 CT (spine) 08 = Family 8 MRI and MRA (lower extremities) 09 = Family 9 CT and CTA (lower extremities) 10 = Family 10 Mr and MRI (upper extremities and joints) 11 = Family 11 CT and CTA (upper extremities) 88 = Subject to the reduction of the TC diagnostic imaging (effective for services January 1, 2011, and after). 99 = Concept Does Not Apply	2Pic x(2)

FIELD # & ITEM	LENGTH & PIC
33F Performance Payment Indicator (For future use)	1 Pic x (1)
33G National Level Future Expansion	3 Pic x (3)
34 Non-Facility Fee Schedule Amount This field replicates field 28.	9 Pic 9(7)v99
35 Facility Fee Schedule Amount This field replicates field 29.	9 Pic 9(7)v99
36 Filler	1 Pic x(1)
37 Future Local Level Expansion** The Updated 1992 Transition Amount was previously stored in this field. A/B MACs (B) can continue to maintain the updated transition amount in this field.	7 Pic x(7)
38A Future Local Level Expansion** The adjusted historical payment basis (AHPB) was previously stored in this field. A/B MACs (B) can continue to maintain the AHPB in this field.	7 Pic x(7)
38 B Filler This field was originally established for 15 spaces. Since AHPB data will only use 7 of the 15 spaces, A/B MACs (B) have 8 remaining spaces for their purposes. ** These fields will be appended by each A/B MAC (B) at the local level.	8 Pix x(8)

2013 File Layout

HEADER RECORD

FIELD #	DATA ELEMENT NAME	LOCATION	PIC
1	Header ID	1-4	x(4) Value “Head"
2	Header Number	5	x(1)
3	Data Set Name	6-50	x(45)
4	Record Length	51-53	x(3)
5	Filler	54-54	x(1)
6	Block size	55-58	x(4)
7	Filler	59-59	x(1)
8	Number of Records Number does not include this header record.	60-69	9(10)
9	Date Created	70-77	x(8) YYYYMMDD
10	Blanks	78-345	x(268)

FILE LAYOUT

FIELD # & ITEM	LENGTH & PIC
1 File Year This field displays the effective year of the file.	4 Pic x(4)
2 A/B MAC (B) Number This field represents the 5-digit number assigned to the A/B MAC (B).	5 Pic x(5)
3 Locality This 2-digit code identifies the pricing locality used.	2 Pic x(2)
4 HCPCS Code This field represents the procedure code. Each A/B MAC (B) Procedural Terminology (CPT) code and alpha-numeric HCPCS codes other than B, C, E, K and L codes will be included. The standard sort for this field is blanks, alpha, and numeric in ascending order.	5 Pic x(5)
5 Modifier For diagnostic tests, a blank in this field denotes the global service and the following modifiers identify the components: 26 = Professional component	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
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 A/B MAC (B) 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.	
6 Descriptor This field will include a brief description of each procedure code.	50 Pic x(50)
7 Code Status This 1 position field provides the status of each code under the full fee schedule. Each status code is explained in §30.2.2.	1 Pic x(1)
8 Conversion Factor This field displays the multiplier which transforms relative values into payment amounts. The file will contain the **2013** conversion factor which will reflect all adjustments.	8 Pic 9(4)v9999
9 Update Factor This update factor has been included in the conversion factor in Field 8.	6 Pic 9(2)v9999
10 Work Relative Value Unit This field displays the unit value for the physician work RVU.	9 Pic 9(7)v99
11 Filler	9 Pic 9(7)v99
12 Malpractice Relative Value Unit	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
This field displays the unit value for the malpractice expense RVU.	
13 Work Geographic Practice Cost Indices (GPCIs) This field displays a work geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
14 Practice Expense GPCI This field displays a practice expense geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
15 Malpractice GPCI This field displays a malpractice expense geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
16 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. 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 (B) 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.)	3 Pic x(3)
17	6 Pic 9v9(5)

FIELD # & ITEM	LENGTH & PIC
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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	
18 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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
19 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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
20 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	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
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 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 A/B MACs (B) 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	

FIELD # & ITEM	LENGTH & PIC
laboratory physician interpretation codes include values for physician work, practice expense and malpractice expense. 7 = Private practice therapist's service: Payment may not be made if the service is provided to either a hospital outpatient or a hospital inpatient by a physical therapist, occupational therapist, or speech-language pathologist in private practice. 8 = Physician interpretation codes: This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for 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.	
21 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 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 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.	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
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 field 31G. Apply the multiple endoscopy rules to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). 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 25% reduction of the TC diagnostic imaging (effective for services January 1, 2006 through June 30, 2010). Subject to 50% reduction of the TC diagnostic imaging (effective for services July 1, 2010 and after). **Subject to 25% reduction of the PC of diagnostic imaging (effective for services January 1, 2012 and after)**. 5 = Subject to 20% reduction of the practice expense component for certain therapy services (effective for services January 1, 2011 and after). 9 = Concept does not apply.	
22 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. If procedure is reported with modifier -50 or with modifiers RT and LT, base 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 and XXXXX-RT with an actual charge of $100. Payment would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The 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 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
1 = 150 percent payment adjustment for bilateral procedures applies. If 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 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. If 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 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 amount 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 would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The RVUs are based on a bilateral procedure because: (a) the code descriptor specifically states that the procedure is bilateral; (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally; or (c) the procedure is usually performed as a bilateral procedure. 3 = The usual payment adjustment for bilateral procedures does not apply. If 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 payment for each side or organ or site of a paired organ on the lower of: (a) the actual charge for each side or (b) 100% of the fee schedule amount for each side. If procedure is reported as a bilateral procedure and with other procedure codes on the same day, 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 procedures. 9 = Concept does not apply.	
23	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
Assistant at Surgery This field provides an indicator for services where an assistant at surgery is never paid for per IOM. 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.	
24 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
25 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
26 Filler	1 Pic (x)1
27 Site of Service Differential For 1999 and beyond, the site of service differential no longer applies. The following definitions will apply for all years after 1998: 0 = Facility pricing does not apply.	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
1 = Facility pricing applies.	
28 Non-Facility Fee Schedule Amount This field shows the fee schedule amount for the non-facility setting. This amount equals Field 34. **Note**: Field 33 D indicates if an additional adjustment should be applied to this formula. Non-Facility Pricing Amount for **2013** [(Work RVU * Work GPCI) + (Non-Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor	9 Pic 9(7)v99
29 Facility Fee Schedule Amount This field shows the fee schedule amount for the facility setting. This amount equals Field 35. **Note:** Field 33D indicates if an additional adjustment should be applied to this formula. Facility Pricing Amount for **2013** [(Work RVU * Work GPCI) + (Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor Place of service codes to be used to identify facilities. 21 - Inpatient Hospital 22 - Outpatient Hospital 23 - Emergency Room - Hospital 24 - Ambulatory Surgical Center - In a Medicare approved ASC, for an approved procedure on the ASC list, Medicare pays the lower facility fee to physicians. Beginning with dates of service January 1, 2008, in a Medicare approved ASC, for procedures NOT on the ASC list of approved procedures, A/B MACs (B) will also pay the lower facility fee to physicians. 26 - Military Treatment Facility 31 - Skilled Nursing Facility 34 - Hospice 41 - Ambulance - Land 42 - Ambulance Air or Water 51 - Inpatient Psychiatric Facility 52 - Psychiatric Facility Partial Hospitalization	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
53 - Community Mental Health Center 56 - Psychiatric Residential Treatment Facility 61 - Comprehensive Inpatient Rehabilitation Facility	
30 Number of Related Codes This field defines the number of related procedure codes (see Field 31).	2 Pic 99
31 Related Procedure Codes This field identifies the number of times that a related code occurs.	35 Pic x(5) - Occurs 7 times
31EE Reduced therapy fee schedule amount	9Pic(7)v99
31DD Filler	1Pic x(2)
31CC Imaging Cap Indicator A value of "1" means subject to OPPS payment cap determination. A value of "9" means not subject to OPPS payment cap determination.	1Pic x(1)
31BB Non-Facility Imaging Payment Amount	9Pic(7)v99
33AA Facility Imaging Payment Amount	9Pic(7)v99
31A	2 Pic x(2)

Physician Supervision of Diagnostic Procedures This field is for use in post payment review. 01 = Procedure must be performed under the general supervision of a physician. 02 = Procedure must be performed under the direct supervision of a physician. 03 = Procedure must be performed under the personal supervision of a physician. 04 = Physician supervision policy does not apply when procedure is furnished by a qualified, independent psychologist or a clinical psychologist; otherwise must be performed under the general supervision of a physician. 05 = Not subject to supervision when furnished personally by a qualified audiologist, physician or non physician practitioner. Direct supervision by a physician is required for those parts of the test that may be furnished by a qualified technician when appropriate to the circumstances of the test. 06 = Procedure must be personally performed by a physician or a physical therapist (PT) who is certified by the American Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiological clinical specialist and is permitted to provide the procedure under State law. Procedure may also be performed by a PT with ABPTS certification without physician supervision. 21 = Procedure may be performed by a technician with certification under general supervision of a physician; otherwise must be performed under direct supervision of a physician. Procedure may also be performed by a PT with ABPTS certification without physician supervision. 22 = May be performed by a technician with on-line real-time contact with physician. 66 = May be personally performed by a physician or by a physical therapist with ABPTS certification and certification in this specific procedure. 6A = Supervision standards for level 66 apply; in addition, the PT with ABPTS certification may personally supervise another PT, but only the PT with ABPTS certification may bill. 77 = Procedure must be performed by a PT with ABPTS certification (TC & PC) or by a PT without certification under direct supervision of a physician (TC & PC), or by a technician with certification under general supervision of a physician (TC only; PC always physician).	

FIELD # & ITEM	LENGTH & PIC
7A = Supervision standards for level 77 apply; in addition, the PT with ABPTS certification may personally supervise another PT, but only the PT with ABPTS certification may bill. 09 = Concept does not apply.	
31B This field has been deleted to allow for the expansion of field 31A.	
31C Facility Setting Practice Expense Relative Value Units	9 Pic(7)v99
31D Non-Facility Setting Practice Expense Relative Value Units	9 Pic(7)v99
31E Filler	9 Pic(7)v99
31F Filler Reserved for future use.	1 Pic x(1)
31G Endoscopic Base Codes This field identifies an endoscopic base code for each code with a multiple surgery indicator of 3.	5 Pic x(5)
32A 1996 Transition/Fee Schedule Amount This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
32B 1996 Transition/Fee Schedule This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
32C 1996 Transition/Fee Schedule Amount When Site or Service Differential Applies This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
33A Units Payment Rule Indicator Reserved for future use. 9 = Concept does not apply.	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
33B Mapping Indicator This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
33C Purchased Diagnostic Locality—Informational Use—Locality used for reporting utilization of purchased diagnostic services. NOT FOR A/B MAC (B) USE: These Medicare+Choice encounter pricing localities are for EDS purposes only. The locality values were developed to facilitate centralized processing of encounter data by the Medicare+Choice organizations (M+COs).	2 Pic x(2)
33D Calculation Flag This field is informational only; the SSMs do not need to add this field**.** The intent is to assist A/B MACs (B) to understand how the fee schedule amount in fields 28 and 29 are calculated. The MMA mandates an additional adjustment to selected HCPCS codes. A value of "1" indicates an additional fee schedule adjustment of 1.32 in 2004 and 1.03 in 2005. A value of "0" indicates no additional adjustment needed. A value of "2" indicates an additional fee schedule adjustment of 1.05 effective 7/1/2008.	1 Pic x(1)
33 E Diagnostic Imaging Family Indicator For services effective January 1, 2011, and after, family indicators 01 - 11 will not be populated. 01 = Family 1 Ultrasound (Chest/Abdomen/Pelvis - Non Obstetrical 02 = Family 2 CT and CTA (Chest/Thorax/Abd/Pelvis) 03 = Family 3 CT and CTA (Head/Brain/Orbit/Maxillofacial/Neck) 04 = Family 4 MRI and MRA (Chest/Abd/Pelvis) 05 = Family 5 MRI and MRA (Head/Brain/Neck) 06 = Family 6 MRI and MRA (spine) 07 = Family 7 CT (spine) 08 = Family 8 MRI and MRA (lower extremities) 09 = Family 9 CT and CTA (lower extremities) 10 = Family 10 Mr and MRI (upper extremities and joints) 11 = Family 11 CT and CTA (upper extremities) 88 = Subject to the reduction of the TC diagnostic imaging (effective for services January 1, 2011, and after). **Subject to the reduction of**	2Pic x(2)

FIELD # & ITEM	LENGTH & PIC
the PC diagnostic imaging (effective for services January 1, 2012 and after). 99 = Concept Does Not Apply	
33F Performance Payment Indicator (For future use)	1 Pic x (1)
33G National Level Future Expansion	3 Pic x (3)
34 Non-Facility Fee Schedule Amount This field replicates field 28.	9 Pic 9(7)v99
35 Facility Fee Schedule Amount This field replicates field 29.	9 Pic 9(7)v99
36 Filler	1 Pic x(1)
37 Future Local Level Expansion** The Updated 1992 Transition Amount was previously stored in this field. A/B MACs (B) can continue to maintain the updated transition amount in this field.	7 Pic x(7)
38A Future Local Level Expansion** The adjusted historical payment basis (AHPB) was previously stored in this field. A/B MACs (B) can continue to maintain the AHPB in this field.	7 Pic x(7)
38 B Filler This field was originally established for 15 spaces. Since AHPB data will only use 7 of the 15 spaces, A/B MACs (B) have 8 remaining spaces for their purposes. ** These fields will be appended by each A/B MAC (B) at the local level.	8 Pix x(8)

2014 File Layout

HEADER RECORD

FIELD #	DATA ELEMENT NAME	LOCATION	PIC
1	Header ID	1-4	x(4) Value "Head"
2	Header Number	5	x(1)
3	Data Set Name	6-50	x(45)
4	Record Length	51-53	x(3)
5	Filler	54-54	x(1)
6	Block size	55-58	x(4)
7	Filler	59-59	x(1)
8	Number of Records Number does not include this header record.	60-69	9(10)
9	Date Created	70-77	x(8) YYYYMMDD
10	Blanks	78-345	x(268)

FILE LAYOUT

FIELD # & ITEM	LENGTH & PIC
1 File Year This field displays the effective year of the file.	4 Pic x(4)
2 A/B MAC (B) Number This field represents the 5-digit number assigned to the A/B MAC (B).	5 Pic x(5)
3 Locality This 2-digit code identifies the pricing locality used.	2 Pic x(2)
4 HCPCS Code This field represents the procedure code. Each A/B MAC (B) Procedural Terminology (CPT) code and alpha-numeric HCPCS codes other than B, C, E, K and L codes will be included. The standard sort for this field is blanks, alpha, and numeric in ascending order.	5 Pic x(5)
5 Modifier For diagnostic tests, a blank in this field denotes the global service and the following modifiers identify the components:	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
26 = Professional component TC = Technical component For services other than those with a professional and/or technical component, a blank will appear in this field with one exception: the presence of 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 A/B MAC (B) 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.	
6 Descriptor This field will include a brief description of each procedure code.	50 Pic x(50)
7 Code Status This 1 position field provides the status of each code under the full fee schedule. Each status code is explained in §30.2.2.	1 Pic x(1)
8 Conversion Factor This field displays the multiplier which transforms relative values into payment amounts. The file will contain the 2014 conversion factor which will reflect all adjustments.	8 Pic 9(4)v9999
9 Update Factor This update factor has been included in the conversion factor in Field 8.	6 Pic 9(2)v9999
10 Work Relative Value Unit This field displays the unit value for the physician work RVU.	9 Pic 9(7)v99
11 Filler	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
12 Malpractice Relative Value Unit This field displays the unit value for the malpractice expense RVU.	9 Pic 9(7)v99
13 Work Geographic Practice Cost Indices (GPCIs) This field displays a work geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
14 Practice Expense GPCI This field displays a practice expense geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
15 Malpractice GPCI This field displays a malpractice expense geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
16 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. 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 (B) 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	3 Pic x(3)

FIELD # & ITEM	LENGTH & PIC
associated with intra-service time and in some instances the post service time.)	
17 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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
18 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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
19 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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
20 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.	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
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 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 A/B MACs (B) 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.	

FIELD # & ITEM	LENGTH & PIC
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 = Private practice therapist's service: Payment may not be made if the service is provided to either a hospital outpatient or a hospital inpatient by a physical therapist, occupational therapist, or speech-language pathologist in private practice. 8 = Physician interpretation codes: This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for 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.	
21 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 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.	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
2 = Standard payment adjustment rules for multiple procedures apply. If 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 field 31G. Apply the multiple endoscopy rules to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). 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 25% reduction of the TC diagnostic imaging (effective for services January 1, 2006 through June 30, 2010). Subject to 50% reduction of the TC diagnostic imaging (effective for services July 1, 2010 and after). Subject to 25% reduction of the PC of diagnostic imaging (effective for services January 1, 2012 and after). 5 = Subject to 20% reduction of the practice expense component for certain therapy services furnished in office and other non-institutional settings, and 25% reduction of the practice expense component for certain therapy services furnished in institutional settings (effective for services January 1, 2011 and after). Subject to 50% reduction of the practice expense component for certain therapy services furnished in both institutional and non-institutional settings (effective for services April 1, 2013 and after). 6 = Subject to 25% reduction of the TC diagnostic cardiovascular services (effective for services January 1, 2013 and after). 7 = Subject to 20% reduction of the TC diagnostic ophthalmology services (effective for services January 1, 2013 and after). 9 = Concept does not apply.	
22 Bilateral Surgery Indicator (Modifier 50) This field provides an indicator for services subject to a payment adjustment.	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
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 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 and XXXXX-RT with an actual charge of $100. Payment would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The 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 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 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. If 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 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 amount 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 would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The RVUs are based on a bilateral procedure because: (a) the code descriptor specifically states that the procedure is bilateral; (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally; or (c) the procedure is usually performed as a bilateral procedure.	

FIELD # & ITEM	LENGTH & PIC
3 = The usual payment adjustment for bilateral procedures does not apply. If 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 payment for each side or organ or site of a paired organ on the lower of: (a) the actual charge for each side or (b) 100% of the fee schedule amount for each side. If procedure is reported as a bilateral procedure and with other procedure codes on the same day, 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 procedures. 9 = Concept does not apply.	
23 Assistant at Surgery This field provides an indicator for services where an assistant at surgery is never paid for per IOM. 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
24 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
25 Team Surgeons (Modifier 66)	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
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.	
26 Filler	1 Pic (x)1
27 Site of Service Differential For 1999 and beyond, the site of service differential no longer applies. The following definitions will apply for all years after 1998: 0 = Facility pricing does not apply. 1 = Facility pricing applies.	1 Pic (x)1
28 Non-Facility Fee Schedule Amount This field shows the fee schedule amount for the non-facility setting. This amount equals Field 34. **Note**: Field 33 D indicates if an additional adjustment should be applied to this formula. Non-Facility Pricing Amount for 2014 [(Work RVU * Work GPCI) + (Non-Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor	9 Pic 9(7)v99
29 Facility Fee Schedule Amount This field shows the fee schedule amount for the facility setting. This amount equals Field 35. **Note:** Field 33D indicates if an additional adjustment should be applied to this formula. Facility Pricing Amount for 2014 [(Work RVU * Work GPCI) + (Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor Place of service codes to be used to identify facilities.	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
21 - Inpatient Hospital 22 - Outpatient Hospital 23 - Emergency Room - Hospital 24 - Ambulatory Surgical Center - In a Medicare approved ASC, for an approved procedure on the ASC list, Medicare pays the lower facility fee to physicians. Beginning with dates of service January 1, 2008, in a Medicare approved ASC, for procedures NOT on the ASC list of approved procedures, A/B MACs (B) will also pay the lower facility fee to physicians. 26 - Military Treatment Facility 31 - Skilled Nursing Facility 34 - Hospice 41 - Ambulance - Land 42 - Ambulance Air or Water 51 - Inpatient Psychiatric Facility 52 - Psychiatric Facility Partial Hospitalization 53 - Community Mental Health Center 56 - Psychiatric Residential Treatment Facility 61 - Comprehensive Inpatient Rehabilitation Facility	
29A Purchased Diagnostic Test Indicator This field providers an indicator for Purchased Diagnostic Test HCPCS codes: '1' = Purchased Diagnostic Test HCPCS. '9' = Concept does not apply.	1 Pic x
30 Effective Date This field identifies the effective date for the MPFSDB record for each HCPCS. The field is in YYYYMMDD format.	8 Pic x(8)
31 Filler	28 Pic x(28)
31EE Reduced therapy fee schedule amount	9Pic(7)v99
31DD Filler	1Pic x(2)
31CC	1Pic x(1)

FIELD # & ITEM	LENGTH & PIC
Imaging Cap Indicator A value of “1” means subject to OPPS payment cap determination. A value of “9” means not subject to OPPS payment cap determination.	
31BB Non-Facility Imaging Payment Amount	9Pic(7)v99
31AA Facility Imaging Payment Amount	9Pic(7)v99
31A	2 Pic x(2)

Physician Supervision of Diagnostic Procedures This field is for use in post payment review. 01 = Procedure must be performed under the general supervision of a physician. 02 = Procedure must be performed under the direct supervision of a physician. 03 = Procedure must be performed under the personal supervision of a physician. 04 = Physician supervision policy does not apply when procedure is furnished by a qualified, independent psychologist or a clinical psychologist; otherwise must be performed under the general supervision of a physician. 05 = Not subject to supervision when furnished personally by a qualified audiologist, physician or non physician practitioner. Direct supervision by a physician is required for those parts of the test that may be furnished by a qualified technician when appropriate to the circumstances of the test. 06 = Procedure must be personally performed by a physician or a physical therapist (PT) who is certified by the American Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiological clinical specialist and is permitted to provide the procedure under State law. Procedure may also be performed by a PT with ABPTS certification without physician supervision. 21 = Procedure may be performed by a technician with certification under general supervision of a physician; otherwise must be performed under direct supervision of a physician. Procedure may also be performed by a PT with ABPTS certification without physician supervision. 22 = May be performed by a technician with on-line real-time contact with physician. 66 = May be personally performed by a physician or by a physical therapist with ABPTS certification and certification in this specific procedure. 6A = Supervision standards for level 66 apply; in addition, the PT with ABPTS certification may personally supervise another PT, but only the PT with ABPTS certification may bill. 77 = Procedure must be performed by a PT with ABPTS certification (TC & PC) or by a PT without certification under direct supervision of a physician (TC & PC), or by a technician with certification under general supervision of a physician (TC only; PC always physician).	

FIELD # & ITEM	LENGTH & PIC
7A = Supervision standards for level 77 apply; in addition, the PT with ABPTS certification may personally supervise another PT, but only the PT with ABPTS certification may bill. 09 = Concept does not apply.	
31B This field has been deleted to allow for the expansion of field 31A.	
31C Facility Setting Practice Expense Relative Value Units	9 Pic(7)v99
31D Non-Facility Setting Practice Expense Relative Value Units	9 Pic(7)v99
31E Filler	9 Pic(7)v99
31F Filler Reserved for future use.	1 Pic x(1)
31G Endoscopic Base Codes This field identifies an endoscopic base code for each code with a multiple surgery indicator of 3.	5 Pic x(5)
32A 1996 Transition/Fee Schedule Amount This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
32B 1996 Transition/Fee Schedule This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
32C 1996 Transition/Fee Schedule Amount When Site or Service Differential Applies This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
33A Units Payment Rule Indicator Reserved for future use. 9 = Concept does not apply.	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
33B Mapping Indicator This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
33C Purchased Diagnostic Locality—Informational Use—Locality used for reporting utilization of purchased diagnostic services. NOT FOR A/B MAC (B) USE: These Medicare+Choice encounter pricing localities are for EDS purposes only. The locality values were developed to facilitate centralized processing of encounter data by the Medicare+Choice organizations (M+COs).	2 Pic x(2)
33D Calculation Flag This field is informational only; the SSMs do not need to add this field. The intent is to assist A/B MACs (B) to understand how the fee schedule amount in fields 28 and 29 are calculated. The MMA mandates an additional adjustment to selected HCPCS codes. A value of "1" indicates an additional fee schedule adjustment of 1.32 in 2004 and 1.03 in 2005. A value of "0" indicates no additional adjustment needed. A value of "2" indicates an additional fee schedule adjustment of 1.05 effective 7/1/2008.	1 Pic x(1)
33 E Diagnostic Imaging Family Indicator For services effective January 1, 2011, and after, family indicators 01 - 11 will not be populated. 01 = Family 1 Ultrasound (Chest/Abdomen/Pelvis - Non Obstetrical 02 = Family 2 CT and CTA (Chest/Thorax/Abd/Pelvis) 03 = Family 3 CT and CTA (Head/Brain/Orbit/Maxillofacial/Neck) 04 = Family 4 MRI and MRA (Chest/Abd/Pelvis) 05 = Family 5 MRI and MRA (Head/Brain/Neck) 06 = Family 6 MRI and MRA (spine) 07 = Family 7 CT (spine) 08 = Family 8 MRI and MRA (lower extremities) 09 = Family 9 CT and CTA (lower extremities) 10 = Family 10 Mr and MRI (upper extremities and joints) 11 = Family 11 CT and CTA (upper extremities) 88 = Subject to the reduction of the TC diagnostic imaging (effective for services January 1, 2011, and after). Subject to the reduction of	2Pic x(2)

FIELD # & ITEM	LENGTH & PIC
the PC diagnostic imaging (effective for services January 1, 2012 and after). 99 = Concept Does Not Apply	
33F Performance Payment Indicator (For future use)	1 Pic x (1)
33G National Level Future Expansion	3 Pic x (3)
34 Non-Facility Fee Schedule Amount This field replicates field 28.	9 Pic 9(7)v99
35 Facility Fee Schedule Amount This field replicates field 29.	9 Pic 9(7)v99
36 Filler	1 Pic x(1)
37 Future Local Level Expansion** The Updated 1992 Transition Amount was previously stored in this field. A/B MACs (B) can continue to maintain the updated transition amount in this field.	7 Pic x(7)
38A Future Local Level Expansion** The adjusted historical payment basis (AHPB) was previously stored in this field. A/B MACs (B) can continue to maintain the AHPB in this field.	7 Pic x(7)
38 B Filler This field was originally established for 15 spaces. Since AHPB data will only use 7 of the 15 spaces, A/B MACs (B) have 8 remaining spaces for their purposes. ** These fields will be appended by each A/B MAC (B) at the local level.	8 Pix x(8)

2015 File Layout

HEADER RECORD

FIELD #	DATA ELEMENT NAME	LOCATION	PIC
1	Header ID	1-4	x(4) Value "Head"
2	Header Number	5	x(1)
3	Data Set Name	6-50	x(45)
4	Record Length	51-53	x(3)
5	Filler	54-54	x(1)
6	Block size	55-58	x(4)
7	Filler	59-59	x(1)
8	Number of Records Number does not include this header record.	60-69	9(10)
9	Date Created	70-77	x(8) YYYYMMDD
10	Blanks	78-345	x(268)

FILE LAYOUT

FIELD # & ITEM	LENGTH & PIC
1 File Year This field displays the effective year of the file.	4 Pic x(4)
2 A/B MAC (B) Number This field represents the 5-digit number assigned to the A/B MAC (B).	5 Pic x(5)
3 Locality This 2-digit code identifies the pricing locality used.	2 Pic x(2)
4 HCPCS Code This field represents the procedure code. Each A/B MAC (B) Procedural Terminology (CPT) code and alpha-numeric HCPCS codes other than B, C, E, K and L codes will be included. The standard sort for this field is blanks, alpha, and numeric in ascending order.	5 Pic x(5)
5 Modifier For diagnostic tests, a blank in this field denotes the global service and the following modifiers identify the components:	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
26 = Professional component TC = Technical component For services other than those with a professional and/or technical component, a blank will appear in this field with one exception: the presence of 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 A/B MAC (B) 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.	
6 Descriptor This field will include a brief description of each procedure code.	50 Pic x(50)
7 Code Status This 1 position field provides the status of each code under the full fee schedule. Each status code is explained in §30.2.2.	1 Pic x(1)
8 Conversion Factor This field displays the multiplier which transforms relative values into payment amounts. The file will contain the **2015** conversion factor which will reflect all adjustments.	8 Pic 9(4)v9999
9 Update Factor This update factor has been included in the conversion factor in Field 8.	6 Pic 9(2)v9999
10 Work Relative Value Unit This field displays the unit value for the physician work RVU.	9 Pic 9(7)v99
11 Filler	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
12 Malpractice Relative Value Unit This field displays the unit value for the malpractice expense RVU.	9 Pic 9(7)v99
13 Work Geographic Practice Cost Indices (GPCIs) This field displays a work geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
14 Practice Expense GPCI This field displays a practice expense geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
15 Malpractice GPCI This field displays a malpractice expense geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
16 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. 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 (B) 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	3 Pic x(3)

FIELD # & ITEM	LENGTH & PIC
associated with intra-service time and in some instances the post service time.)	
17 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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
18 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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
19 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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
20 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.	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
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 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 A/B MACs (B) 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.	

FIELD # & ITEM	LENGTH & PIC
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 = Private practice therapist's service: Payment may not be made if the service is provided to either a hospital outpatient or a hospital inpatient by a physical therapist, occupational therapist, or speech-language pathologist in private practice. 8 = Physician interpretation codes: This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for 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.	
21 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 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.	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
2 = Standard payment adjustment rules for multiple procedures apply. If 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 field 31G. Apply the multiple endoscopy rules to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). 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 25% reduction of the TC diagnostic imaging (effective for services January 1, 2006 through June 30, 2010). Subject to 50% reduction of the TC diagnostic imaging (effective for services July 1, 2010 and after). Subject to 25% reduction of the PC of diagnostic imaging (effective for services January 1, 2012 and after). 5 = Subject to 20% reduction of the practice expense component for certain therapy services furnished in office and other non-institutional settings, and 25% reduction of the practice expense component for certain therapy services furnished in institutional settings (effective for services January 1, 2011 and after). Subject to 50% reduction of the practice expense component for certain therapy services furnished in both institutional and non-institutional settings (effective for services April 1, 2013 and after). 6 = Subject to 25% reduction of the TC diagnostic cardiovascular services (effective for services January 1, 2013 and after). 7 = Subject to 20% reduction of the TC diagnostic ophthalmology services (effective for services January 1, 2013 and after). 9 = Concept does not apply.	
22 Bilateral Surgery Indicator (Modifier 50) This field provides an indicator for services subject to a payment adjustment.	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
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 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 and XXXXX-RT with an actual charge of $100. Payment would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The 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 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 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. If 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 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 amount 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 would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The RVUs are based on a bilateral procedure because: (a) the code descriptor specifically states that the procedure is bilateral; (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally; or (c) the procedure is usually performed as a bilateral procedure.	

FIELD # & ITEM	LENGTH & PIC
3 = The usual payment adjustment for bilateral procedures does not apply. If 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 payment for each side or organ or site of a paired organ on the lower of: (a) the actual charge for each side or (b) 100% of the fee schedule amount for each side. If procedure is reported as a bilateral procedure and with other procedure codes on the same day, 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 procedures. 9 = Concept does not apply.	
23 Assistant at Surgery This field provides an indicator for services where an assistant at surgery is never paid for per IOM. 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
24 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
25 Team Surgeons (Modifier 66)	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
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.	
26 Filler	1 Pic (x)1
27 Site of Service Differential For 1999 and beyond, the site of service differential no longer applies. The following definitions will apply for all years after 1998: 0 = Facility pricing does not apply. 1 = Facility pricing applies. 9 = Concept does not apply.	1 Pic (x)1
28 Non-Facility Fee Schedule Amount This field shows the fee schedule amount for the non-facility setting. This amount equals Field 34. **Note**: Field 33 D indicates if an additional adjustment should be applied to this formula. Non-Facility Pricing Amount for **2015** [(Work RVU * Work GPCI) + (Non-Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor	9 Pic 9(7)v99
29 Facility Fee Schedule Amount This field shows the fee schedule amount for the facility setting. This amount equals Field 35. **Note:** Field 33D indicates if an additional adjustment should be applied to this formula. Facility Pricing Amount for **2015** [(Work RVU * Work GPCI) + (Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
Place of service codes to be used to identify facilities. 21 - Inpatient Hospital 22 - Outpatient Hospital 23 - Emergency Room - Hospital 24 - Ambulatory Surgical Center - In a Medicare approved ASC, for an approved procedure on the ASC list, Medicare pays the lower facility fee to physicians. Beginning with dates of service January 1, 2008, in a Medicare approved ASC, for procedures NOT on the ASC list of approved procedures, A/B MACs (B) will also pay the lower facility fee to physicians. 26 - Military Treatment Facility 31 - Skilled Nursing Facility 34 - Hospice 41 - Ambulance - Land 42 - Ambulance Air or Water 51 - Inpatient Psychiatric Facility 52 - Psychiatric Facility Partial Hospitalization 53 - Community Mental Health Center 56 - Psychiatric Residential Treatment Facility 61 - Comprehensive Inpatient Rehabilitation Facility	
29A Purchased Diagnostic Test Indicator This field providers an indicator for Purchased Diagnostic Test HCPCS codes: '1' = Purchased Diagnostic Test HCPCS. '9' = Concept does not apply.	1 Pic x
30 Effective Date This field identifies the effective date for the MPFSDB record for each HCPCS. The field is in YYYYMMDD format.	8 Pic x(8)
31 Filler	28 Pic x(28)
31EE Reduced therapy fee schedule amount	9Pic(7)v99
31DD Filler	1Pic x(2)

FIELD # & ITEM	LENGTH & PIC
31CC Imaging Cap Indicator A value of “1” means subject to OPPS payment cap determination. A value of “9” means not subject to OPPS payment cap determination.	1Pic x(1)
31BB Non-Facility Imaging Payment Amount	9Pic(7)v99
31AA Facility Imaging Payment Amount	9Pic(7)v99
31A	2 Pic x(2)

Physician Supervision of Diagnostic Procedures This field is for use in post payment review. 01 = Procedure must be performed under the general supervision of a physician. 02 = Procedure must be performed under the direct supervision of a physician. 03 = Procedure must be performed under the personal supervision of a physician. 04 = Physician supervision policy does not apply when procedure is furnished by a qualified, independent psychologist or a clinical psychologist; otherwise must be performed under the general supervision of a physician. 05 = Not subject to supervision when furnished personally by a qualified audiologist, physician or non physician practitioner. Direct supervision by a physician is required for those parts of the test that may be furnished by a qualified technician when appropriate to the circumstances of the test. 06 = Procedure must be personally performed by a physician or a physical therapist (PT) who is certified by the American Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiological clinical specialist and is permitted to provide the procedure under State law. Procedure may also be performed by a PT with ABPTS certification without physician supervision. 21 = Procedure may be performed by a technician with certification under general supervision of a physician; otherwise must be performed under direct supervision of a physician. Procedure may also be performed by a PT with ABPTS certification without physician supervision. 22 = May be performed by a technician with on-line real-time contact with physician. 66 = May be personally performed by a physician or by a physical therapist with ABPTS certification and certification in this specific procedure. 6A = Supervision standards for level 66 apply; in addition, the PT with ABPTS certification may personally supervise another PT, but only the PT with ABPTS certification may bill. 77 = Procedure must be performed by a PT with ABPTS certification (TC & PC) or by a PT without certification under direct supervision of a physician (TC & PC), or by a technician with certification under general supervision of a physician (TC only; PC always physician).	

FIELD # & ITEM	LENGTH & PIC
7A = Supervision standards for level 77 apply; in addition, the PT with ABPTS certification may personally supervise another PT, but only the PT with ABPTS certification may bill. 09 = Concept does not apply.	
31B This field has been deleted to allow for the expansion of field 31A.	
31C Facility Setting Practice Expense Relative Value Units	9 Pic(7)v99
31D Non-Facility Setting Practice Expense Relative Value Units	9 Pic(7)v99
31E Filler	9 Pic(7)v99
31F Filler Reserved for future use.	1 Pic x(1)
31G Endoscopic Base Codes This field identifies an endoscopic base code for each code with a multiple surgery indicator of 3.	5 Pic x(5)
32A 1996 Transition/Fee Schedule Amount This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
32B 1996 Transition/Fee Schedule This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
32C 1996 Transition/Fee Schedule Amount When Site or Service Differential Applies This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
33A Units Payment Rule Indicator Reserved for future use. 9 = Concept does not apply.	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
33B Mapping Indicator This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
33C Purchased Diagnostic Locality—Informational Use—Locality used for reporting utilization of purchased diagnostic services. NOT FOR A/B MAC (B) USE: These Medicare+Choice encounter pricing localities are for EDS purposes only. The locality values were developed to facilitate centralized processing of encounter data by the Medicare+Choice organizations (M+COs).	2 Pic x(2)
33D Calculation Flag This field is informational only; the SSMs do not need to add this field**.** The intent is to assist A/B MACs (B) to understand how the fee schedule amount in fields 28 and 29 are calculated. The MMA mandates an additional adjustment to selected HCPCS codes. A value of "1" indicates an additional fee schedule adjustment of 1.32 in 2004 and 1.03 in 2005. A value of "0" indicates no additional adjustment needed. A value of "2" indicates an additional fee schedule adjustment of 1.05 effective 7/1/2008.	1 Pic x(1)
33 E Diagnostic Imaging Family Indicator For services effective January 1, 2011, and after, family indicators 01 - 11 will not be populated. 01 = Family 1 Ultrasound (Chest/Abdomen/Pelvis - Non Obstetrical 02 = Family 2 CT and CTA (Chest/Thorax/Abd/Pelvis) 03 = Family 3 CT and CTA (Head/Brain/Orbit/Maxillofacial/Neck) 04 = Family 4 MRI and MRA (Chest/Abd/Pelvis) 05 = Family 5 MRI and MRA (Head/Brain/Neck) 06 = Family 6 MRI and MRA (spine) 07 = Family 7 CT (spine) 08 = Family 8 MRI and MRA (lower extremities) 09 = Family 9 CT and CTA (lower extremities) 10 = Family 10 Mr and MRI (upper extremities and joints) 11 = Family 11 CT and CTA (upper extremities) 88 = Subject to the reduction of the TC diagnostic imaging (effective for services January 1, 2011, and after). Subject to the reduction of	2Pic x(2)

FIELD # & ITEM	LENGTH & PIC
the PC diagnostic imaging (effective for services January 1, 2012 and after). 99 = Concept Does Not Apply	
33F Performance Payment Indicator (For future use)	1 Pic x (1)
33G National Level Future Expansion	3 Pic x (3)
34 Non-Facility Fee Schedule Amount This field replicates field 28.	9 Pic 9(7)v99
35 Facility Fee Schedule Amount This field replicates field 29.	9 Pic 9(7)v99
36 Filler	1 Pic x(1)
37 Future Local Level Expansion** The Updated 1992 Transition Amount was previously stored in this field. A/B MACs (B) can continue to maintain the updated transition amount in this field.	7 Pic x(7)
38A Future Local Level Expansion** The adjusted historical payment basis (AHPB) was previously stored in this field. A/B MACs (B) can continue to maintain the AHPB in this field.	7 Pic x(7)
38 B Filler This field was originally established for 15 spaces. Since AHPB data will only use 7 of the 15 spaces, A/B MACs (B) have 8 remaining spaces for their purposes. ** These fields will be appended by each A/B MAC (B) at the local level.	8 Pix x(8)

2016 File Layout

HEADER RECORD

FIELD #	DATA ELEMENT NAME	LOCATION	PIC
1	Header ID	1-4	x(4) Value “Head"
2	Header Number	5	x(1)
3	Data Set Name	6-50	x(45)
4	Record Length	51-53	x(3)
5	Filler	54-54	x(1)
6	Block size	55-58	x(4)
7	Filler	59-59	x(1)
8	Number of Records Number does not include this header record.	60-69	9(10)
9	Date Created	70-77	x(8) YYYYMMDD
10	Blanks	78-345	x(268)

FILE LAYOUT

FIELD # & ITEM	LENGTH & PIC
1 File Year This field displays the effective year of the file.	4 Pic x(4)
2 A/B MAC (B) Number This field represents the 5-digit number assigned to the A/B MAC (B).	5 Pic x(5)
3 Locality This 2-digit code identifies the pricing locality used.	2 Pic x(2)
4 HCPCS Code This field represents the procedure code. Each A/B MAC (B) Procedural Terminology (CPT) code and alpha-numeric HCPCS codes other than B, C, E, K and L codes will be included. The standard sort for this field is blanks, alpha, and numeric in ascending order.	5 Pic x(5)
5 Modifier For diagnostic tests, a blank in this field denotes the global service and the following modifiers identify the components:	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
26 = Professional component TC = Technical component For services other than those with a professional and/or technical component, a blank will appear in this field with one exception: the presence of 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 through stoma code 44388, 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.	
6 Descriptor This field will include a brief description of each procedure code.	50 Pic x(50)
7 Code Status This 1 position field provides the status of each code under the full fee schedule. Each status code is explained in §30.2.2.	1 Pic x(1)
8 Conversion Factor This field displays the multiplier which transforms relative values into payment amounts. The file will contain the **2016** conversion factor which will reflect all adjustments.	8 Pic 9(4)v9999
9 Update Factor This update factor has been included in the conversion factor in Field 8.	6 Pic 9(2)v9999
10 Work Relative Value Unit This field displays the unit value for the physician work RVU.	9 Pic 9(7)v99
11	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
Filler	
12 Malpractice Relative Value Unit This field displays the unit value for the malpractice expense RVU.	9 Pic 9(7)v99
13 Work Geographic Practice Cost Indices (GPCIs) This field displays a work geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
14 Practice Expense GPCI This field displays a practice expense geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
15 Malpractice GPCI This field displays a malpractice expense geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
16 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. 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 (B) determines whether global concept applies and establishes postoperative period, if appropriate, at time of pricing.	3 Pic x(3)

FIELD # & ITEM	LENGTH & PIC
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.)	
17 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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
18 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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
19 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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
20 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.	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
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 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 A/B MACs (B) for these services when they are provided to hospital inpatients or patients in a hospital	

FIELD # & ITEM	LENGTH & PIC
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 = Private practice therapist's service: Payment may not be made if the service is provided to either a hospital outpatient or a hospital inpatient by a physical therapist, occupational therapist, or speech-language pathologist in private practice. 8 = Physician interpretation codes: This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for 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.	
21 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 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	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
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 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 field 31G. Apply the multiple endoscopy rules to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). 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 25% reduction of the TC diagnostic imaging (effective for services January 1, 2006 through June 30, 2010). Subject to 50% reduction of the TC diagnostic imaging (effective for services July 1, 2010 and after). Subject to 25% reduction of the PC of diagnostic imaging (effective for services January 1, 2012 and after). 5 = Subject to 20% reduction of the practice expense component for certain therapy services furnished in office and other non-institutional settings, and 25% reduction of the practice expense component for certain therapy services furnished in institutional settings (effective for services January 1, 2011 and after). Subject to 50% reduction of the practice expense component for certain therapy services furnished in both institutional and non-institutional settings (effective for services April 1, 2013 and after). 6 = Subject to 25% reduction of the TC diagnostic cardiovascular services (effective for services January 1, 2013 and after). 7 = Subject to 20% reduction of the TC diagnostic ophthalmology services (effective for services January 1, 2013 and after). 9 = Concept does not apply.	
22 Bilateral Surgery Indicator (Modifier 50)	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
This field provides an indicator for services subject to a payment adjustment. 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 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 and XXXXX-RT with an actual charge of $100. Payment would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The 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 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 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. If 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 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 amount 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 would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The RVUs are based on a bilateral procedure because: (a) the code descriptor specifically states that the procedure is bilateral; (b) the code descriptor states that the procedure may be performed either	

FIELD # & ITEM	LENGTH & PIC
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 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 payment for each side or organ or site of a paired organ on the lower of: (a) the actual charge for each side or (b) 100% of the fee schedule amount for each side. If procedure is reported as a bilateral procedure and with other procedure codes on the same day, 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 procedures. 9 = Concept does not apply.	
23 Assistant at Surgery This field provides an indicator for services where an assistant at surgery is never paid for per IOM. 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
24 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
25	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
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.	
26 Filler	1 Pic (x)1
27 Site of Service Differential For 1999 and beyond, the site of service differential no longer applies. The following definitions will apply for all years after 1998: 0 = Facility pricing does not apply. 1 = Facility pricing applies. 9 = Concept does not apply.	1 Pic (x)1
28 Non-Facility Fee Schedule Amount This field shows the fee schedule amount for the non-facility setting. This amount equals Field 34. **Note**: Field 33 D indicates if an additional adjustment should be applied to this formula. Non-Facility Pricing Amount for **2016** [(Work RVU * Work GPCI) + (Non-Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor	9 Pic 9(7)v99
29 Facility Fee Schedule Amount This field shows the fee schedule amount for the facility setting. This amount equals Field 35. **Note:** Field 33D indicates if an additional adjustment should be applied to this formula. Facility Pricing Amount for **2016** [(Work RVU * Work GPCI) + (Facility PE RVU * PE GPCI) +	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
(MP RVU * MP GPCI)] * Conversion Factor Place of service codes to be used to identify facilities. 19 – Off Campus-Outpatient Hospital 21 - Inpatient Hospital 22 – On Campus-Outpatient Hospital 23 - Emergency Room - Hospital 24 - Ambulatory Surgical Center – In a Medicare approved ASC, for an approved procedure on the ASC list, Medicare pays the lower facility fee to physicians. Beginning with dates of service January 1, 2008, in a Medicare approved ASC, for procedures NOT on the ASC list of approved procedures, contractors will also pay the lower facility fee to physicians. 26 - Military Treatment Facility 31 - Skilled Nursing Facility 34 - Hospice 41 - Ambulance - Land 42 - Ambulance Air or Water 51 - Inpatient Psychiatric Facility 52 - Psychiatric Facility Partial Hospitalization 53 - Community Mental Health Center 56 - Psychiatric Residential Treatment Facility 61 - Comprehensive Inpatient Rehabilitation Facility	
29A Purchased Diagnostic Test Indicator This field providers an indicator for Purchased Diagnostic Test HCPCS codes: ‘1’ = Purchased Diagnostic Test HCPCS. ‘9’ = Concept does not apply.	1 Pic x
30 Effective Date This field identifies the effective date for the MPFSDB record for each HCPCS. The field is in YYYYMMDD format.	8 Pic x(8)
31 Filler	28 Pic x(28)
31EE Reduced therapy fee schedule amount	9Pic(7)v99
31DD	1Pic x(2)

FIELD # & ITEM	**LENGTH & PIC**
Filler	
31CC Imaging Cap Indicator A value of "1" means subject to OPPS payment cap determination. A value of "9" means not subject to OPPS payment cap determination.	1Pic x(1)
31BB Non-Facility Imaging Payment Amount	9Pic(7)v99
31AA Facility Imaging Payment Amount	9Pic(7)v99
31A	2 Pic x(2)

Physician Supervision of Diagnostic Procedures This field is for use in post payment review. 01 = Procedure must be performed under the general supervision of a physician. 02 = Procedure must be performed under the direct supervision of a physician. 03 = Procedure must be performed under the personal supervision of a physician. 04 = Physician supervision policy does not apply when procedure is furnished by a qualified, independent psychologist or a clinical psychologist; otherwise must be performed under the general supervision of a physician. 05 = Not subject to supervision when furnished personally by a qualified audiologist, physician or non physician practitioner. Direct supervision by a physician is required for those parts of the test that may be furnished by a qualified technician when appropriate to the circumstances of the test. 06 = Procedure must be personally performed by a physician or a physical therapist (PT) who is certified by the American Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiological clinical specialist and is permitted to provide the procedure under State law. Procedure may also be performed by a PT with ABPTS certification without physician supervision. 21 = Procedure may be performed by a technician with certification under general supervision of a physician; otherwise must be performed under direct supervision of a physician. Procedure may also be performed by a PT with ABPTS certification without physician supervision. 22 = May be performed by a technician with on-line real-time contact with physician. 66 = May be personally performed by a physician or by a physical therapist with ABPTS certification and certification in this specific procedure. 6A = Supervision standards for level 66 apply; in addition, the PT with ABPTS certification may personally supervise another PT, but only the PT with ABPTS certification may bill. 77 = Procedure must be performed by a PT with ABPTS certification (TC & PC) or by a PT without certification under direct supervision of a physician (TC & PC), or by a technician with certification under general supervision of a physician (TC only; PC always physician).	

FIELD # & ITEM	LENGTH & PIC
7A = Supervision standards for level 77 apply; in addition, the PT with ABPTS certification may personally supervise another PT, but only the PT with ABPTS certification may bill. 09 = Concept does not apply.	
31B This field has been deleted to allow for the expansion of field 31A.	
31C Facility Setting Practice Expense Relative Value Units	9 Pic(7)v99
31D Non-Facility Setting Practice Expense Relative Value Units	9 Pic(7)v99
31E Filler	9 Pic(7)v99
31F Filler Reserved for future use.	1 Pic x(1)
31G Endoscopic Base Codes This field identifies an endoscopic base code for each code with a multiple surgery indicator of 3.	5 Pic x(5)
32A 1996 Transition/Fee Schedule Amount This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
32B 1996 Transition/Fee Schedule This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
32C 1996 Transition/Fee Schedule Amount When Site or Service Differential Applies This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
33A Units Payment Rule Indicator Reserved for future use. 9 = Concept does not apply.	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
33B Mapping Indicator This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
33C Purchased Diagnostic Locality—Informational Use—Locality used for reporting utilization of purchased diagnostic services. NOT FOR A/B MAC (B): These Medicare+Choice encounter pricing localities are for EDS purposes only. The locality values were developed to facilitate centralized processing of encounter data by the Medicare+Choice organizations (M+COs).	2 Pic x(2)
33D Calculation Flag This field is informational only; the SSMs do not need to add this field. The intent is to assist A/B MACs (B) to understand how the fee schedule amount in fields 28 and 29 are calculated. The MMA mandates an additional adjustment to selected HCPCS codes. A value of "1" indicates an additional fee schedule adjustment of 1.32 in 2004 and 1.03 in 2005. A value of "0" indicates no additional adjustment needed. A value of "2" indicates an additional fee schedule adjustment of 1.05 effective 7/1/2008.	1 Pic x(1)
33 E Diagnostic Imaging Family Indicator For services effective January 1, 2011, and after, family indicators 01 - 11 will not be populated. 01 = Family 1 Ultrasound (Chest/Abdomen/Pelvis – Non Obstetrical 02 = Family 2 CT and CTA (Chest/Thorax/Abd/Pelvis) 03 = Family 3 CT and CTA (Head/Brain/Orbit/Maxillofacial/Neck) 04 = Family 4 MRI and MRA (Chest/Abd/Pelvis) 05 = Family 5 MRI and MRA (Head/Brain/Neck) 06 = Family 6 MRI and MRA (spine) 07 = Family 7 CT (spine) 08 = Family 8 MRI and MRA (lower extremities) 09 = Family 9 CT and CTA (lower extremities) 10 = Family 10 Mr and MRI (upper extremities and joints) 11 = Family 11 CT and CTA (upper extremities) 88 = Subject to the reduction of the TC diagnostic imaging (effective for services January 1, 2011, and after). Subject to the reduction of	2Pic x(2)

FIELD # & ITEM	LENGTH & PIC
the PC diagnostic imaging (effective for services January 1, 2012 and after). 99 = Concept Does Not Apply	
33F Performance Payment Indicator (For future use)	1 Pic x (1)
33G National Level Future Expansion	3 Pic x (3)
34 Non-Facility Fee Schedule Amount This field replicates field 28.	9 Pic 9(7)v99
35 Facility Fee Schedule Amount This field replicates field 29.	9 Pic 9(7)v99
36 Filler	1 Pic x(1)
37 Future Local Level Expansion** The Updated 1992 Transition Amount was previously stored in this field. A/B MACs (B) can continue to maintain the updated transition amount in this field.	7 Pic x(7)
38A Future Local Level Expansion** The adjusted historical payment basis (AHPB) was previously stored in this field. A/B MACs (B) can continue to maintain the AHPB in this field.	7 Pic x(7)
38 B Filler This field was originally established for 15 spaces. Since AHPB data will only use 7 of the 15 spaces, A/B MACs (B) have 8 remaining spaces for their purposes. ** These fields will be appended by each A/B MAC (B) at the local level.	8 Pix x(8)

2017 File Layout

HEADER RECORD

FIELD #	DATA ELEMENT NAME	LOCATION	PIC
1	Header ID	1-4	x(4) Value “Head"
2	Header Number	5	x(1)
3	Data Set Name	6-50	x(45)
4	Record Length	51-53	x(3)
5	Filler	54-54	x(1)
6	Block size	55-58	x(4)
7	Filler	59-59	x(1)
8	Number of Records Number does not include this header record.	60-69	9(10)
9	Date Created	70-77	x(8) YYYYMMDD
10	Blanks	78-345	x(268)

FILE LAYOUT

FIELD # & ITEM	LENGTH & PIC
1 File Year This field displays the effective year of the file.	4 Pic x(4)
2 A/B MAC (B) Number This field represents the 5-digit number assigned to the A/B MAC (B).	5 Pic x(5)
3 Locality This 2-digit code identifies the pricing locality used.	2 Pic x(2)
4	5 Pic x(5)

FIELD # & ITEM	LENGTH & PIC
HCPCS Code This field represents the procedure code. Each A/B MAC (B) Procedural Terminology (CPT) code and alpha-numeric HCPCS codes other than B, C, E, K and L codes will be included. The standard sort for this field is blanks, alpha, and numeric in ascending order.	
5 Modifier For diagnostic tests, a blank in this field denotes the global service and the following modifiers identify the components: 26 = Professional component TC = Technical component For services other than those with a professional and/or technical component, a blank will appear in this field with one exception: the presence of 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 through stoma code 44388, 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)
6 Descriptor This field will include a brief description of each procedure code.	50 Pic x(50)
7 Code Status This 1 position field provides the status of each code under the full fee schedule. Each status code is explained in §30.2.2.	1 Pic x(1)
8 Conversion Factor	8 Pic 9(4)v9999

FIELD # & ITEM	LENGTH & PIC
This field displays the multiplier which transforms relative values into payment amounts. The file will contain the 2017 conversion factor which will reflect all adjustments.	
9 Update Factor This update factor has been included in the conversion factor in Field 8.	6 Pic 9(2)v9999
10 Work Relative Value Unit This field displays the unit value for the physician work RVU.	9 Pic 9(7)v99
11 Filler	9 Pic 9(7)v99
12 Malpractice Relative Value Unit This field displays the unit value for the malpractice expense RVU.	9 Pic 9(7)v99
13 Work Geographic Practice Cost Indices (GPCIs) This field displays a work geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
14 Practice Expense GPCI This field displays a practice expense geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
15 Malpractice GPCI This field displays a malpractice expense geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
16 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.	3 Pic x(3)

FIELD # & ITEM	LENGTH & PIC
010 = Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during this 10-day postoperative period generally not payable. 090 = Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule payment amount. MMM = Maternity codes; usual global period does not apply. XXX = Global concept does not apply. YYY = A/B MAC (B) 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.)	
17 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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
18 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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
19 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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
20 Professional Component (PC)/Technical Component (TC) Indicator 0 = Physician service codes: This indicator identifies codes that describe physician services. Examples include visits, consultations,	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
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 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	

FIELD # & ITEM	LENGTH & PIC
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 A/B MACs (B) 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 = Private practice therapist's service: Payment may not be made if the service is provided to either a hospital outpatient or a hospital inpatient by a physical therapist, occupational therapist, or speech-language pathologist in private practice. 8 = Physician interpretation codes: This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for 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.	
21 Multiple Procedure (Modifier 51) Indicator indicates which payment adjustment rule for multiple procedures applies to the service.	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
0 = No payment adjustment rules for multiple procedures apply. If 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 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 field 31G. Apply the multiple endoscopy rules to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). 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 25% reduction of the TC diagnostic imaging (effective for services January 1, 2006 through June 30, 2010). Subject to 50% reduction of the TC diagnostic imaging (effective for services July 1, 2010 and after). Subject to 25% reduction of the PC of diagnostic imaging (effective for services January 1, 2012 through December 31, 2016). Subject to 5% reduction of the PC of diagnostic imaging (effective for services January 1, 2017 and after). 5 = Subject to 20% reduction of the practice expense component for certain therapy services furnished in office and other non-institutional settings, and 25% reduction of the practice expense component for certain therapy services furnished in institutional settings (effective for	

FIELD # & ITEM	LENGTH & PIC
services January 1, 2011 and after). Subject to 50% reduction of the practice expense component for certain therapy services furnished in both institutional and non-institutional settings (effective for services April 1, 2013 and after). 6 = Subject to 25% reduction of the TC diagnostic cardiovascular services (effective for services January 1, 2013 and after). 7 = Subject to 20% reduction of the TC diagnostic ophthalmology services (effective for services January 1, 2013 and after). 9 = Concept does not apply.	
22 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. If procedure is reported with modifier -50 or with modifiers RT and LT, base 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 and XXXXX-RT with an actual charge of $100. Payment would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The 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 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 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. If procedure is reported with modifier -50 or is reported twice on the same day by any other means (e.g., with RT	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
and LT modifiers 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 amount 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 would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The RVUs are based on a bilateral procedure because: (a) the code descriptor specifically states that the procedure is bilateral; (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally; or (c) the procedure is usually performed as a bilateral procedure. 3 = The usual payment adjustment for bilateral procedures does not apply. If 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 payment for each side or organ or site of a paired organ on the lower of: (a) the actual charge for each side or (b) 100% of the fee schedule amount for each side. If procedure is reported as a bilateral procedure and with other procedure codes on the same day, 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 procedures. 9 = Concept does not apply.	
23 Assistant at Surgery This field provides an indicator for services where an assistant at surgery is never paid for per IOM. 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
24	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
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.	
25 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
26 Filler	1 Pic (x)1
27 Site of Service Differential For 1999 and beyond, the site of service differential no longer applies. The following definitions will apply for all years after 1998: 0 = Facility pricing does not apply. 1 = Facility pricing applies. 9 = Concept does not apply.	1 Pic (x)1
28 Non-Facility Fee Schedule Amount This field shows the fee schedule amount for the non-facility setting. This amount equals Field 34. **Note**: Field 33 D indicates if an additional adjustment should be applied to this formula. Non-Facility Pricing Amount for 2017 [(Work RVU * Work GPCI) + (Non-Facility PE RVU * PE GPCI) +	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
(MP RVU * MP GPCI)] * Conversion Factor	
29 Facility Fee Schedule Amount This field shows the fee schedule amount for the facility setting. This amount equals Field 35. **Note:** Field 33D indicates if an additional adjustment should be applied to this formula. Facility Pricing Amount for 2017 [(Work RVU * Work GPCI) + (Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor Place of service codes to be used to identify facilities. 19 – Off Campus-Outpatient Hospital 21 - Inpatient Hospital 22 – On Campus-Outpatient Hospital 23 - Emergency Room - Hospital 24 - Ambulatory Surgical Center – In a Medicare approved ASC, for an approved procedure on the ASC list, Medicare pays the lower facility fee to physicians. Beginning with dates of service January 1, 2008, in a Medicare approved ASC, for procedures NOT on the ASC list of approved procedures, contractors will also pay the lower facility fee to physicians. 26 - Military Treatment Facility 31 - Skilled Nursing Facility 34 - Hospice 41 - Ambulance - Land 42 - Ambulance Air or Water 51 - Inpatient Psychiatric Facility 52 - Psychiatric Facility Partial Hospitalization 53 - Community Mental Health Center 56 - Psychiatric Residential Treatment Facility 61 - Comprehensive Inpatient Rehabilitation Facility	9 Pic 9(7)v99
29A	1 Pic x

FIELD # & ITEM	LENGTH & PIC
Purchased Diagnostic Test Indicator This field providers an indicator for Purchased Diagnostic Test HCPCS codes: ‘1’ = Purchased Diagnostic Test HCPCS. ‘9’ = Concept does not apply.	
30 Effective Date This field identifies the effective date for the MPFSDB record for each HCPCS. The field is in YYYYMMDD format.	8 Pic x(8)
31 Filler	28 Pic x(28)
31EE Reduced therapy fee schedule amount	9Pic(7)v99
31DD Filler	1Pic x(2)
31CC Imaging Cap Indicator A value of “1” means subject to OPPS payment cap determination. A value of “9” means not subject to OPPS payment cap determination.	1Pic x(1)
31BB Non-Facility Imaging Payment Amount	9Pic(7)v99
31AA Facility Imaging Payment Amount	9Pic(7)v99
31A	2 Pic x(2)

Physician Supervision of Diagnostic Procedures This field is for use in post payment review. 01 = Procedure must be performed under the general supervision of a physician. 02 = Procedure must be performed under the direct supervision of a physician. 03 = Procedure must be performed under the personal supervision of a physician. 04 = Physician supervision policy does not apply when procedure is furnished by a qualified, independent psychologist or a clinical psychologist; otherwise must be performed under the general supervision of a physician. 05 = Not subject to supervision when furnished personally by a qualified audiologist, physician or non physician practitioner. Direct supervision by a physician is required for those parts of the test that may be furnished by a qualified technician when appropriate to the circumstances of the test. 06 = Procedure must be personally performed by a physician or a physical therapist (PT) who is certified by the American Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiological clinical specialist and is permitted to provide the procedure under State law. Procedure may also be performed by a PT with ABPTS certification without physician supervision. 21 = Procedure may be performed by a technician with certification under general supervision of a physician; otherwise must be performed under direct supervision of a physician. Procedure may also be performed by a PT with ABPTS certification without physician supervision. 22 = May be performed by a technician with on-line real-time contact with physician. 66 = May be personally performed by a physician or by a physical therapist with ABPTS certification and certification in this specific procedure. 6A = Supervision standards for level 66 apply; in addition, the PT with ABPTS certification may personally supervise another PT, but only the PT with ABPTS certification may bill. 77 = Procedure must be performed by a PT with ABPTS certification (TC & PC) or by a PT without certification under direct supervision of a physician (TC & PC), or by a technician with certification under general supervision of a physician (TC only; PC always physician).	

FIELD # & ITEM	LENGTH & PIC
7A = Supervision standards for level 77 apply; in addition, the PT with ABPTS certification may personally supervise another PT, but only the PT with ABPTS certification may bill. 09 = Concept does not apply.	
31B This field has been deleted to allow for the expansion of field 31A.	
31C Facility Setting Practice Expense Relative Value Units	9 Pic(7)v99
31D Non-Facility Setting Practice Expense Relative Value Units	9 Pic(7)v99
31E Filler	9 Pic(7)v99
31F Filler Reserved for future use.	1 Pic x(1)
31G Endoscopic Base Codes This field identifies an endoscopic base code for each code with a multiple surgery indicator of 3.	5 Pic x(5)
32A 1996 Transition/Fee Schedule Amount This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
32B 1996 Transition/Fee Schedule This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
32C 1996 Transition/Fee Schedule Amount When Site or Service Differential Applies This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
33A Units Payment Rule Indicator Reserved for future use. 9 = Concept does not apply.	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
33B Mapping Indicator This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
33C Purchased Diagnostic Locality—Informational Use—Locality used for reporting utilization of purchased diagnostic services. NOT FOR A/B MAC (B) USE: These Medicare Advantage encounter pricing localities are for EDS purposes only. The locality values were developed to facilitate centralized processing of encounter data by the Medicare Advantage organizations.	2 Pic x(2)
33D Calculation Flag This field is informational only; the SSMs do not need to add this field**.** The intent is to assist A/B MACs (B) to understand how the fee schedule amount in fields 28 and 29 are calculated. The MMA mandates an additional adjustment to selected HCPCS codes. A value of "1" indicates an additional fee schedule adjustment of 1.32 in 2004 and 1.03 in 2005. A value of "0" indicates no additional adjustment needed. A value of "2" indicates an additional fee schedule adjustment of 1.05 effective 7/1/2008.	1 Pic x(1)
33 E Diagnostic Imaging Family Indicator For services effective January 1, 2011, and after, family indicators 01 - 11 will not be populated. 01 = Family 1 Ultrasound (Chest/Abdomen/Pelvis – Non Obstetrical 02 = Family 2 CT and CTA (Chest/Thorax/Abd/Pelvis) 03 = Family 3 CT and CTA (Head/Brain/Orbit/Maxillofacial/Neck) 04 = Family 4 MRI and MRA (Chest/Abd/Pelvis) 05 = Family 5 MRI and MRA (Head/Brain/Neck) 06 = Family 6 MRI and MRA (spine) 07 = Family 7 CT (spine) 08 = Family 8 MRI and MRA (lower extremities) 09 = Family 9 CT and CTA (lower extremities) 10 = Family 10 Mr and MRI (upper extremities and joints) 11 = Family 11 CT and CTA (upper extremities) 88 = Subject to the reduction of the TC diagnostic imaging (effective for services January 1, 2011, and after). Subject to the reduction of	2Pic x(2)

FIELD # & ITEM	**LENGTH & PIC**
the PC diagnostic imaging (effective for services January 1, 2012 and after). 99 = Concept Does Not Apply	
33F Performance Payment Indicator (For future use)	1 Pic x (1)
33G National Level Future Expansion	3 Pic x (3)
34 Non-Facility Fee Schedule Amount This field replicates field 28.	9 Pic 9(7)v99
35 Facility Fee Schedule Amount This field replicates field 29.	9 Pic 9(7)v99
36 Filler	1 Pic x(1)
37 Future Local Level Expansion** The Updated 1992 Transition Amount was previously stored in this field. A/B MACs (B) can continue to maintain the updated transition amount in this field.	7 Pic x(7)
38A Future Local Level Expansion** The adjusted historical payment basis (AHPB) was previously stored in this field. A/B MACs (B) can continue to maintain the AHPB in this field.	7 Pic x(7)
38 B Filler This field was originally established for 15 spaces. Since AHPB data will only use 7 of the 15 spaces, A/B MACs (B) have 8 remaining spaces for their purposes. ** These fields will be appended by each A/B MAC (B) at the local level.	8 Pix x(8)

2018 File Layout

HEADER RECORD

FIELD #	DATA ELEMENT NAME	LOCATION	PIC
1	Header ID	1-4	x(4) Value “Head"
2	Header Number	5	x(1)
3	Data Set Name	6-50	x(45)
4	Record Length	51-53	x(3)
5	Filler	54-54	x(1)
6	Block size	55-58	x(4)
7	Filler	59-59	x(1)
8	Number of Records Number does not include this header record.	60-69	9(10)
9	Date Created	70-77	x(8) YYYYMMDD
10	Blanks	78-345	x(268)

FILE LAYOUT

FIELD # & ITEM	LENGTH & PIC
1 File Year This field displays the effective year of the file.	4 Pic x(4)
2 A/B MAC (B) Number This field represents the 5-digit number assigned to the A/B MAC (B).	5 Pic x(5)
3 Locality This 2-digit code identifies the pricing locality used.	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
4 HCPCS Code This field represents the procedure code. Each A/B MAC (B) Procedural Terminology (CPT) code and alpha-numeric HCPCS codes other than B, C, E, K and L codes will be included. The standard sort for this field is blanks, alpha, and numeric in ascending order.	5 Pic x(5)
5 Modifier For diagnostic tests, a blank in this field denotes the global service and the following modifiers identify the components: 26 = Professional component TC = Technical component For services other than those with a professional and/or technical component, a blank will appear in this field with one exception: the presence of 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 through stoma code 44388, 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)
6 Descriptor This field will include a brief description of each procedure code.	50 Pic x(50)
7 Code Status This 1 position field provides the status of each code under the full fee schedule. Each status code is explained in §30.2.2.	1 Pic x(1)
8 Conversion Factor	8 Pic 9(4)v9999

FIELD # & ITEM	LENGTH & PIC
This field displays the multiplier which transforms relative values into payment amounts. The file will contain the 2018 conversion factor which will reflect all adjustments.	
9 Update Factor This update factor has been included in the conversion factor in Field 8.	6 Pic 9(2)v9999
10 Work Relative Value Unit This field displays the unit value for the physician work RVU.	9 Pic 9(7)v99
11 Filler	9 Pic 9(7)v99
12 Malpractice Relative Value Unit This field displays the unit value for the malpractice expense RVU.	9 Pic 9(7)v99
13 Work Geographic Practice Cost Indices (GPCIs) This field displays a work geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
14 Practice Expense GPCI This field displays a practice expense geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
15 Malpractice GPCI This field displays a malpractice expense geographic adjustment factor used in computing the fee schedule amount.	5 Pic 99v999
16 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.	3 Pic x(3)

FIELD # & ITEM	LENGTH & PIC
010 = Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during this 10-day postoperative period generally not payable. 090 = Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule payment amount. MMM = Maternity codes; usual global period does not apply. XXX = Global concept does not apply. YYY = A/B MAC (B) 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.)	
17 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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
18 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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
19 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 fields 17, 18, and 19 will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)
20 Professional Component (PC)/Technical Component (TC) Indicator 0 = Physician service codes: This indicator identifies codes that describe physician services. Examples include visits, consultations,	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
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 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	

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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 A/B MACs (B) 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 = Private practice therapist's service: Payment may not be made if the service is provided to either a hospital outpatient or a hospital inpatient by a physical therapist, occupational therapist, or speech-language pathologist in private practice. 8 = Physician interpretation codes: This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for 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.	
21 Multiple Procedure (Modifier 51) Indicator indicates which payment adjustment rule for multiple procedures applies to the service.	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
0 = No payment adjustment rules for multiple procedures apply. If 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 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 field 31G. Apply the multiple endoscopy rules to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). 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 25% reduction of the TC diagnostic imaging (effective for services January 1, 2006 through June 30, 2010). Subject to 50% reduction of the TC diagnostic imaging (effective for services July 1, 2010 and after). Subject to 25% reduction of the PC of diagnostic imaging (effective for services January 1, 2012 through December 31, 2016). Subject to 5% reduction of the PC of diagnostic imaging (effective for services January 1, 2017 and after). 5 = Subject to 20% reduction of the practice expense component for certain therapy services furnished in office and other non-institutional settings, and 25% reduction of the practice expense component for certain therapy services furnished in institutional settings (effective for	

FIELD # & ITEM	LENGTH & PIC
services January 1, 2011 and after). Subject to 50% reduction of the practice expense component for certain therapy services furnished in both institutional and non-institutional settings (effective for services April 1, 2013 and after). 6 = Subject to 25% reduction of the TC diagnostic cardiovascular services (effective for services January 1, 2013 and after). 7 = Subject to 20% reduction of the TC diagnostic ophthalmology services (effective for services January 1, 2013 and after). 9 = Concept does not apply.	
22 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. If procedure is reported with modifier -50 or with modifiers RT and LT, base 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 and XXXXX-RT with an actual charge of $100. Payment would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The 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 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 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. If procedure is reported with modifier -50 or is reported twice on the same day by any other means (e.g., with RT	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
and LT modifiers 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 amount 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 would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The RVUs are based on a bilateral procedure because: (a) the code descriptor specifically states that the procedure is bilateral; (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally; or (c) the procedure is usually performed as a bilateral procedure. 3 = The usual payment adjustment for bilateral procedures does not apply. If 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 payment for each side or organ or site of a paired organ on the lower of: (a) the actual charge for each side or (b) 100% of the fee schedule amount for each side. If procedure is reported as a bilateral procedure and with other procedure codes on the same day, 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 procedures. 9 = Concept does not apply.	
23 Assistant at Surgery This field provides an indicator for services where an assistant at surgery is never paid for per IOM. 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
24	1 Pic (x)1

FIELD # & ITEM	LENGTH & PIC
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.	
25 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
26 Filler	1 Pic (x)1
27 Site of Service Differential For 1999 and beyond, the site of service differential no longer applies. The following definitions will apply for all years after 1998: 0 = Facility pricing does not apply. 1 = Facility pricing applies. 9 = Concept does not apply.	1 Pic (x)1
28 Non-Facility Fee Schedule Amount This field shows the fee schedule amount for the non-facility setting. This amount equals Field 34. **Note**: Field 33 D indicates if an additional adjustment should be applied to this formula. Non-Facility Pricing Amount for 2018 [(Work RVU * Work GPCI) + (Non-Facility PE RVU * PE GPCI) +	9 Pic 9(7)v99

FIELD # & ITEM	LENGTH & PIC
(MP RVU * MP GPCI)] * Conversion Factor	
29 Facility Fee Schedule Amount This field shows the fee schedule amount for the facility setting. This amount equals Field 35. **Note:** Field 33D indicates if an additional adjustment should be applied to this formula. Facility Pricing Amount for 2018 [(Work RVU * Work GPCI) + (Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor Place of service codes to be used to identify facilities. 02 – Telehealth – Medicare pays telehealth services at the facility rate. 19 – Off Campus-Outpatient Hospital 21 - Inpatient Hospital 22 – On Campus-Outpatient Hospital 23 - Emergency Room - Hospital 24 - Ambulatory Surgical Center – In a Medicare approved ASC, for an approved procedure on the ASC list, Medicare pays the lower facility fee to physicians. Beginning with dates of service January 1, 2008, in a Medicare approved ASC, for procedures NOT on the ASC list of approved procedures, contractors will also pay the lower facility fee to physicians. 26 - Military Treatment Facility 31 - Skilled Nursing Facility 34 - Hospice 41 - Ambulance - Land 42 - Ambulance Air or Water 51 - Inpatient Psychiatric Facility 52 - Psychiatric Facility Partial Hospitalization 53 - Community Mental Health Center 56 - Psychiatric Residential Treatment Facility 61 - Comprehensive Inpatient Rehabilitation Facility	9 Pic 9(7)v99
29A	1 Pic x

FIELD # & ITEM	LENGTH & PIC
Purchased Diagnostic Test Indicator This field providers an indicator for Purchased Diagnostic Test HCPCS codes: ‘1’ = Purchased Diagnostic Test HCPCS. ‘9’ = Concept does not apply.	
30 Effective Date This field identifies the effective date for the MPFSDB record for each HCPCS. The field is in YYYYMMDD format.	8 Pic x(8)
31 Filler	28 Pic x(28)
31EE Reduced therapy fee schedule amount	9Pic(7)v99
31DD Filler	1Pic x(2)
31CC Imaging Cap Indicator A value of “1” means subject to OPPS payment cap determination. A value of “9” means not subject to OPPS payment cap determination.	1Pic x(1)
31BB Non-Facility Imaging Payment Amount	9Pic(7)v99
31AA Facility Imaging Payment Amount	9Pic(7)v99
31A	2 Pic x(2)

Physician Supervision of Diagnostic Procedures This field is for use in post payment review. 01 = Procedure must be performed under the general supervision of a physician. 02 = Procedure must be performed under the direct supervision of a physician. 03 = Procedure must be performed under the personal supervision of a physician. 04 = Physician supervision policy does not apply when procedure is furnished by a qualified, independent psychologist or a clinical psychologist; otherwise must be performed under the general supervision of a physician. 05 = Not subject to supervision when furnished personally by a qualified audiologist, physician or non physician practitioner. Direct supervision by a physician is required for those parts of the test that may be furnished by a qualified technician when appropriate to the circumstances of the test. 06 = Procedure must be personally performed by a physician or a physical therapist (PT) who is certified by the American Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiological clinical specialist and is permitted to provide the procedure under State law. Procedure may also be performed by a PT with ABPTS certification without physician supervision. 21 = Procedure may be performed by a technician with certification under general supervision of a physician; otherwise must be performed under direct supervision of a physician. Procedure may also be performed by a PT with ABPTS certification without physician supervision. 22 = May be performed by a technician with on-line real-time contact with physician. 66 = May be personally performed by a physician or by a physical therapist with ABPTS certification and certification in this specific procedure. 6A = Supervision standards for level 66 apply; in addition, the PT with ABPTS certification may personally supervise another PT, but only the PT with ABPTS certification may bill. 77 = Procedure must be performed by a PT with ABPTS certification (TC & PC) or by a PT without certification under direct supervision of a physician (TC & PC), or by a technician with certification under general supervision of a physician (TC only; PC always physician).	

FIELD # & ITEM	LENGTH & PIC
7A = Supervision standards for level 77 apply; in addition, the PT with ABPTS certification may personally supervise another PT, but only the PT with ABPTS certification may bill. 09 = Concept does not apply.	
31B This field has been deleted to allow for the expansion of field 31A.	
31C Facility Setting Practice Expense Relative Value Units	9 Pic(7)v99
31D Non-Facility Setting Practice Expense Relative Value Units	9 Pic(7)v99
31E Filler	9 Pic(7)v99
31F Filler Reserved for future use.	1 Pic x(1)
31G Endoscopic Base Codes This field identifies an endoscopic base code for each code with a multiple surgery indicator of 3.	5 Pic x(5)
32A 1996 Transition/Fee Schedule Amount This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
32B 1996 Transition/Fee Schedule This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
32C 1996 Transition/Fee Schedule Amount When Site or Service Differential Applies This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.	9 Pic 9(7)v99
33A Units Payment Rule Indicator Reserved for future use. 9 = Concept does not apply.	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
33B Mapping Indicator This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.	1 Pic x(1)
33C Purchased Diagnostic Locality—Informational Use—Locality used for reporting utilization of purchased diagnostic services. NOT FOR A/B MAC (B) USE: These Medicare Advantage encounter pricing localities are for EDS purposes only. The locality values were developed to facilitate centralized processing of encounter data by the Medicare Advantage organizations.	2 Pic x(2)
33D Calculation Flag This field is informational only; the SSMs do not need to add this field. The intent is to assist A/B MACs (B) to understand how the fee schedule amount in fields 28 and 29 are calculated. The MMA mandates an additional adjustment to selected HCPCS codes. A value of “1” indicates an additional fee schedule adjustment of 1.32 in 2004 and 1.03 in 2005. A value of “0” indicates no additional adjustment needed. A value of “2” indicates an additional fee schedule adjustment of 1.05 effective 7/1/2008.	1 Pic x(1)
33 E Diagnostic Imaging Family Indicator For services effective January 1, 2011, and after, family indicators 01 - 11 will not be populated. 01 = Family 1 Ultrasound (Chest/Abdomen/Pelvis – Non Obstetrical 02 = Family 2 CT and CTA (Chest/Thorax/Abd/Pelvis) 03 = Family 3 CT and CTA (Head/Brain/Orbit/Maxillofacial/Neck) 04 = Family 4 MRI and MRA (Chest/Abd/Pelvis) 05 = Family 5 MRI and MRA (Head/Brain/Neck) 06 = Family 6 MRI and MRA (spine) 07 = Family 7 CT (spine) 08 = Family 8 MRI and MRA (lower extremities) 09 = Family 9 CT and CTA (lower extremities) 10 = Family 10 Mr and MRI (upper extremities and joints) 11 = Family 11 CT and CTA (upper extremities) 88 = Subject to the reduction of the TC diagnostic imaging (effective for services January 1, 2011, and after). Subject to the reduction of	2Pic x(2)

FIELD # & ITEM	LENGTH & PIC
the PC diagnostic imaging (effective for services January 1, 2012 and after). 99 = Concept Does Not Apply	
33F Performance Payment Indicator (For future use)	1 Pic x (1)
33G National Level Future Expansion	3 Pic x (3)
34 Non-Facility Fee Schedule Amount This field replicates field 28.	9 Pic 9(7)v99
35 Facility Fee Schedule Amount This field replicates field 29.	9 Pic 9(7)v99
36 Filler	1 Pic x(1)
37 Future Local Level Expansion** The Updated 1992 Transition Amount was previously stored in this field. A/B MACs (B) can continue to maintain the updated transition amount in this field.	7 Pic x(7)
38A Future Local Level Expansion** The adjusted historical payment basis (AHPB) was previously stored in this field. A/B MACs (B) can continue to maintain the AHPB in this field.	7 Pic x(7)
38 B Filler This field was originally established for 15 spaces. Since AHPB data will only use 7 of the 15 spaces, A/B MACs (B) have 8 remaining spaces for their purposes. ** These fields will be appended by each A/B MAC (B) at the local level.	8 Pix x(8)