CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1005	Date: JULY 21, 2006
	Change Request 5206

Subject: Medicare Physician Fee Schedule Database (MPFSDB) 2007 File Layout

I. SUMMARY OF CHANGES: Provides the annual file layout for 2007 for Medicare carriers and also updates several MPFSDB status indicators. There are two MPFSDB status indicators that have been added: J and M. Also, Field 21 of the file layout has been expanded and Field 33E has been changed to 33F and a new Field 33E has been created.

New / Revised Material
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

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

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

R/N/D	Chapter / Section / Subsection / Title
R	23/30.2.2 MPFSDB Status Indicators 23/Addendum

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007

IV. ATTACHMENTS:

Recurring Update Notification
Manual Instruction

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

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 1005	Date: July 21, 2005	Change Request 5206

SUBJECT: Medicare Physician Fee Schedule Database (MPFSDB) 2007 File Layout

I.   GENERAL INFORMATION

A.   Background: The Medicare physician fee schedule database (MPFSDB) is the file layout for carriers. It includes the total fee schedule amount, related component parts, and payment policy indicators.

B.   Policy: This is the annual file layout for 2007. The instruction also updates the MPFSDB status indicators. The MPFSDB indicators that have been added are J and M. Also, field 21 of the file layout has been expanded and field 33E has been changed to 33F and a new field 33E has been created.

II.   BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		F I	R H H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
5206.1	Contractors **shall** recognize the changes made to the MPFSDB status indicators and fields.			x			x			
5206.2	Contractors **shall** recognize the 2007 MPFSDB file layout.			x			x			
5206.3	Contractors **shall** use the 2007 HCPCS file to view discontinued codes.			x			x			

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	None.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 1, 2007 **Implementation Date:** January 2, 2007 **Pre-Implementation Contact(s):** Vera A. Dillard (410) 786-6149 **Post-Implementation Contact(s):** Vera A. Dillard (410) 786-6149	**No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.**

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

Medicare Claims Processing Manual

Chapter 23 - Fee Schedule Administration and Coding Requirements

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(Rev.1005, 07-21-06)

30.2.2 - MPFSDB Status Indicators

(Rev. 1005, Issued: 07-21-05; Effective Date: 01-01-07; Implementation Date: 01-02-07)

A =	Active code. These codes are separately paid under the physician fee schedule if covered. There will be RVUs and payment amounts for codes with this status. The presence of an "A" indicator does not mean that Medicare has made a national coverage determination regarding the service; carriers remain responsible for coverage decisions in the absence of a national Medicare policy.
B =	Payment for covered services are always bundled into payment for other services not specified. There will be no RVUs or payment amounts for these codes and no separate payment is ever made. When these services are covered, payment for them is subsumed by the payment for the services to which they are incident (an example is a telephone call from a hospital nurse regarding care of a patient).
C =	Carriers price the code. Carriers will establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation such as an operative report.
D =*	Deleted/discontinued codes.
E =	Excluded from physician fee schedule by regulation. These codes are for items and/or services that CMS chose to exclude from the fee schedule payment by regulation. No RVUs or payment amounts are shown and no payment may be made under the fee schedule for these codes. Payment for them, when covered, continues under reasonable charge procedures.
F =	Deleted/discontinued codes. (Code not subject to a 90 day grace period.) These codes are deleted effective with the beginning of the year and are never subject to a grace period. This indicator is no longer effective beginning with the 2005 fee schedule as of January 1, 2005.
G =	Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. (Code subject to a 90 day grace period.) This indicator is no longer effective beginning with the 2005 fee schedule as of January 1, 2005.
H =*	Deleted modifier. For 2000 and later years, either the TC or PC component shown for the code has been deleted and the deleted component is shown in the data base with the H status.
I =	Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. (Code NOT subject to a 90 day grace period.)
J=	*Anesthesia services (no relative value units or payment amounts for anesthesia codes on the database, only used to facilitate the identification of anesthesia*

	services.)
L =	Local codes. Carriers will apply this status to all local codes in effect on January 1, 1998 or subsequently approved by central office for use. Carriers will complete the RVUs and payment amounts for these codes.
M=	*Measurement codes, used for reporting purposes only.*
N =	Non-covered service. These codes are carried on the HCPCS tape as noncovered services.
P =	Bundled/excluded codes. There are no RVUs and no payment amounts for these services. No separate payment is made for them under the fee schedule. If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident (an example is an elastic bandage furnished by a physician incident to a physician service). If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (for example, colostomy supplies) and is paid under the other payment provision of the Act.
R =	Restricted coverage. Special coverage instructions apply.
T =	There are RVUs and payment amounts for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the physician services for which payment is made.
X =	Statutory exclusion. These codes represent an item or service that is not in the statutory definition of "physician services" for fee schedule payment purposes. No RVUs or payment amounts are shown for these codes and no payment may be made under the physician fee schedule. (Examples are ambulances services and clinical diagnostic laboratory services.)

*Codes with these indicators had a 90 day grace period before January 1, 2005.

Addendum - MPFSDB Record Layouts

(Rev. 1005, Issued: 07-21-05; Effective Date: 01-01-07; Implementation Date: 01-02-07)

The CMS MPFSDBs include the total fee schedule amount, related component parts, and payment policy indicators.

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 Carrier Number This field represents the 5-digit number assigned to the carrier.	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 Carrier 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	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
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 carrier 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* *This field displays the unit value for the malpractice expense RVU.*	*9 Pic 9(7)v99*
13 *Work Geographic Practice Cost Indices (GPCIs)*	*5 Pic 99v999*

FIELD # & ITEM	LENGTH & PIC
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 = Carrier 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 will be shown as 010000. The total of fields 17, 18, and 19 will usually equal one. Any variance is slight and results from	6 Pic 9v9(5)

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

FIELD # & ITEM	LENGTH & PIC
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 carriers for these services when they are provided to hospital inpatients or patients in a hospital outpatient department. Modifiers 26 and TC cannot be used with these codes.* *6 = Laboratory physician interpretation codes: This indicator identifies clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made. Actual performance of the tests is paid for under the lab fee schedule. Modifier TC cannot be used with these codes. The total RVUs for laboratory physician interpretation codes include values for physician work, practice expense and malpractice expense.* *7 = Physical therapy service: Payment may not be made if the service is provided to either a hospital outpatient or inpatient by an independently practicing physical or occupational therapist.* *8 = Physician interpretation codes: This indicator identifies the*	

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

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

FIELD # & ITEM	LENGTH & PIC
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.	

FIELD # & ITEM	LENGTH & PIC
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)* *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

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 of a physician, or by a technician with certification under general supervision of a physician.	2 Pic x(2)

FIELD # & ITEM	LENGTH & PIC
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. 9 = Concept does not apply.	1 Pic x(1)
33B Mapping Indicator This field is no longer applicable since transitioning ended in 1996.	1 Pic x(1)

FIELD # & ITEM	LENGTH & PIC
This field will contain spaces.	
33C Medicare+Choice Encounter Pricing Locality NOT FOR CARRIER 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 carriers 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)
33G National Level Future Expansion	3 Pic x (3)

FIELD # & ITEM	LENGTH & PIC
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. Carriers 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. Carriers 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, carriers have 8 remaining spaces for their purposes. ** These fields will be appended by each carrier at the local level.	8 Pix x(8)