Medicare
Carriers Manual
Part 3 - Claims Process

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 1820 **Date: SEPTEMBER 26, 2003**

CHANGE REQUEST 2898

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents – Chapter 15	15-1 – 15-2 (2 pp.)	15-1 – 15-2 (2 pp.)
15900.2 (Cont.) – 15902 (Cont.)	15-116.37–15-118 (16 pp.)	15-116.25–15-116.40(16 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: January 1, 2004*
IMPLEMENTATION DATE: January 1, 2004

Section 15900.4 Medicare Physician Fee Schedule Database (MPFSDB) 2004 File Layout, provides the file layout for 2004. Thee are no substantive changes.

Section 15902, Maintenance Process for the Medicare Physician Fee Schedule Database (MPFSDB), revises all references to the Division of Health Plan and Provider Data (DHPPD) is changed to the Division of Data Systems (DDS).

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

CHAPTER XV
FEE SCHEDULE FOR PHYSICIANS' SERVICES

FIELD # & ITEM	LENGTH & PIC

32B 1 Pic x(1)

1996 Transition/Fee Schedule
This field is no longer Indicator applicable since transitioning ended in 1996. This field will contain spaces.

32C 9 Pic 9(7)v99

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This field is no longer applicable since transitioning ended in 1996.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.

33A 1 Pic x(1)

Units Payment Rule Indicator
Reserved for future use.

9 = Concept does not apply.

33B 1 Pic x(1)

Mapping Indicator
This field is no longer applicable since transitioning ended in 1996. This field will contain spaces.

33C 2 Pic x(2)

Medicare+Choice Encounter Pricing Locality
NOT FOR CARRIER USE: These Medicare+Choice encounter pricing localities are for electronic data systems purposes **only**. The locality values were developed to facilitate centralized processing of encounter data by the Medicare+Choice organizations (M+COs).

33D 7 Pic x(7)

National Level Future Expansion
This field is being provided for future expansion at the national level.

34 9 Pic 9(7)v99

Non-Facility Fee Schedule Amount
This field replicates field 28.

35 9 Pic 9(7)v99

Facility Fee Schedule Amount
This field replicates field 29.

36

Filler 1 Pic x(1)

37 7 Pic x(7)

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.

38A 7 Pic x(7)

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.

38B 8 Pic x(8)

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 provided by the Program Development and Information Group in the 2003 Medicare Fee Schedule Database for codes with status code indicator of A and T, as well as, indicators D and R with associated RVUs. Carriers will be responsible for calculating the 2003 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 carrier at the local level.

15900.4 Medicare Physician Fee Schedule Database (MPFSDB) 2004 File Layout.--The CMS MPFSDB includes the total fee schedule amount, related component parts, and payment policy indicators.

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	4 Pic x(4)

File Year
This field displays the effective year of the file.

2	5 Pic x(5)

Carrier Number
This field represents the 5-digit number assigned to the carrier.

3	2 Pic x(2)

Locality
This 2-digit code identifies the pricing locality used.

4	5 Pic x(5)

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 and services representing anesthesia services will be included. The standard sort for this field is blanks, alpha, and numeric in ascending order.

5	2 Pic x(2)

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 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	50 Pic x(50)

Descriptor
This field will include a brief description of each procedure code.

FIELD # & ITEM	LENGTH & PIC
7	1 Pic x(1)

Code Status
This 1 position field provides the status of each code under the full fee schedule. Each status code is explained in §15901.

8	8 Pic 9(4)v9999

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.

9	6 Pic 9(2)v9999

Update Factor
This update factor has been included in the conversion factor in Field 8.

10	9 Pic 9(7)v99

Work Relative Value Unit (RVU)
This field displays the unit value for the physician work RVU.

11	9 Pic 9(7)v99

Filler

12	9 Pic 9(7)v99

Malpractice Relative Value Unit
This field displays the unit value for the malpractice expense RVU.

13	5 Pic 99v999

Work Geographic Practice Cost Indices (GPCIs)
This field displays a work geographic adjustment factor used in computing the fee schedule amount.

14	5 Pic 99v999

Practice Expense GPCI
This field displays a practice expense geographic adjustment factor used in computing the fee schedule amount.

15	5 Pic 99v999

Malpractice GPCI
This field displays a malpractice expense geographic adjustment factor used in computing the fee schedule amount.

16	3 Pic x(3)

Global Surgery
This field provides the post-operative time frames that apply to payment for each surgical procedure or another indicator that describes the applicability of the global concept to the service.

FIELD # & ITEM LENGTH & PIC

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.)

17 6 Pic 9v9(5)

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.

18 6 Pic 9v9(5)

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.

19 6 Pic 9v9(5)

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.

20 1 Pic x(1)

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

FIELD # & ITEM LENGTH & PIC

20 (Cont.)

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 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.

FIELD # & ITEM LENGTH & PIC

20 (Cont.)

Payment may not be made by carriers for these services when they are provided to hospital inpatients or patients in a hospital outpatient department. Modifiers 26 and TC cannot be used with these codes.

6 = Laboratory physician interpretation codes: This indicator identifies clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made. Actual performance of the tests is paid for under the lab fee schedule. Modifier TC cannot be used with these codes. The total RVUs for laboratory physician interpretation codes include values for physician work, practice expense, and malpractice expense.

7 = Physical therapy service: Payment may not be made if the service is provided to either a hospital outpatient or inpatient by an independently practicing physical or occupational therapist.

8 = Physician interpretation codes: This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for a 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, 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 the procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 50 percent, 50 percent, 50 percent, and by report). Base payment on the lower of: (a) The actual charge, or (b) The fee schedule amount reduced by the appropriate percentage.

FIELD # & ITEM LENGTH & PIC

21 (Cont.)

3 = Special rules for multiple endoscopic procedures apply if the 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 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 the 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. The RVUs are already based on the procedure being performed as a bilateral procedure. If the procedure is reported with modifier -50 or is reported twice on the same day by any other means (e.g., with RT and LT modifiers 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.

FIELD # & ITEM LENGTH & PIC

22 (Cont.)

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 percent of the fee schedule amount for each side. If the procedure is reported as a bilateral procedure and with other procedure codes on the same day, determine the fee schedule amount for a bilateral procedure before applying any applicable multiple procedure rules.

Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral procedures.

9 = Concept does not apply.

23 1 Pic x(1)

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 1 Pic x(1)

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.

FIELD # & ITEM LENGTH & PIC

24 (Cont.)

9 = Concept does not apply.

25 1 Pic x(1)

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 1 Pic x(1)

Filler

27 1 Pic x(1)

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.

28 9 Pic 9(7)v99

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

29 9 Pic 9(7)v99

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

FIELD # & ITEM	LENGTH & PIC

29 (Cont.)

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
- 49 – Independent Clinic
- 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 — 2 Pic 99

Number of Related Codes
This field defines the number of related procedure codes (see Field 31).

31 — 65 Pic x(5) - Occurs 13 times

Related Procedure Codes
This field identifies the number of times that a related code occurs.

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 the 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 the 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.

FIELD # & ITEM LENGTH & PIC

31A (Cont.)

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

Facility Setting Practice Expense Relative Value Units

31D 9 Pic(7)v99

Non-Facility Setting Practice Expense Relative Value Units

31E 9 Pic(7)v99

Filler

31F 1 Pic x(1)

Filler
Reserved for future use.

31G 5 Pic x(5)

Endoscopic Base Codes
This field identifies an endoscopic base code for each code with a multiple surgery indicator of 3.

32A 9 Pic 9(7)v99

1996 Transition/Fee Schedule Amount
This field is no longer applicable since transitioning ended in 1996. This field will contain a zero.

FIELD # & ITEM	LENGTH & PIC
32B	1 Pic x(1)

1996 Transition/Fee Schedule
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32C	9 Pic 9(7)v99

1996 Transition/Fee Schedule Amount When Site or Service Differential Applies
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33A	1 Pic x(1)

Units Payment Rule Indicator
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33B	1 Pic x(1)

Mapping Indicator
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National Level Future Expansion
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Facility Fee Schedule Amount
This field replicates field 29.

36	
Filler	1 Pic x(1)
37	7 Pic x(7)

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.

38A 7 Pic x(7)

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.

38B 8 Pic x(8)

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 provided by the Division of Data Systems (DDS) in the 2004 Medicare Fee Schedule Database for codes with status code indicator of A and T, as well as, indicators D and R with associated RVUs. Carriers will be responsible for calculating the 2004 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 carrier at the local level.

15901. MPFSDB STATUS INDICATORS

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. These codes are deleted effective with the beginning of the year and are always subject to a 90 day grace period.

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 was effective with the 2002 fee schedule as of January 1, 2002.

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.)

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. (Code subject to a 90 day grace period.)

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.)

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.

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.)

15902. MAINTENANCE PROCESS FOR THE MEDICARE PHYSICIAN FEE SCHEDULE DATABASE (MPFSDB)

The Division of Data Systems (DDS) calculates the fee schedule payment amounts and releases them to the carriers in the Medicare Physician Fee Schedule Database (MPFSDB). Carriers will implement those payment amounts on January 1 for that year. DDS will maintain the payment files centrally and will be responsible for recalculating any revised payment amounts. Any revisions initiated by Central Office (fee schedule amounts or payment policy indicators) will be issued to the carriers on a quarterly basis through a program memorandum.

The information for the ongoing maintenance of the MPFSDB is stated below.

- The DDS will calculate the new fee schedule amounts. The DDS will also issue the revised data to the ROs in the same format of the MPFSDB.

o Carriers will receive a file containing data with revisions for the quarter. This file will be release electronically.

o Carriers should give providers 30 days notification before revised payment amounts are implemented. The revised payment amounts should be implemented by the beginning of the following quarter.

o The DDS will furnish the recalculated payment amounts to the carriers in data files to ensure accuracy. If carriers overlay these files into their existing file, the potential for errors will be eliminated.

o Carriers should make adjustments on those claims that were processed incorrectly if the adjustment is requested by the biller. Adjustments should be made retroactively to January 1 of the current year, unless otherwise specified. This directive will apply in all instances unless the situation requires special consideration. In those instances, instructions on handling adjustments will be provided on a case by case basis.

o Separate instructions will be issued describing the data exchange for the fiscal intermediaries (FIs). In summary, FIs will receive the revised payment amounts two to three weeks after the carriers receive the data from DHPPD. FIs should not implement the revised payment amounts prior to the carriers' implementation date.

o Carriers will be required to furnish the revised payment information to the State Medicaid Agencies upon their request one month following receipt of the data from DHPPD. Those State agencies with Internet access capability should download the data directly from the CMS Home Page.

15903. HEARING AID EXCLUSION

Section 1862(a)(7) of the Social Security Act states that no payment may be made under part A or part B for any expenses incurred for items or services "where such expenses are for . . hearing aids or examinations therefore. . . " This policy is further reiterated at 42 CFR 411.15(d) which specifically states that "hearing aids or examination for the purpose of prescribing, fitting, or changing hearing aids" are excluded from coverage.

At the time of passage of the hearing aid exclusion, all hearing aids utilized functional air and/or bone conduction pathways to facilitate hearing. We are clarifying that any device that does not produce as its output an electrical signal that directly stimulates the auditory nerve is a hearing aid for the purposes of Medicare payment policy. Examples of hearing aids are devices that produce air-conducted sound into the external auditory canal, devices that produce sound by mechanically vibrating bone, or devices that produce sound by vibrating the cochlear fluid through stimulation of the round window. Devices such as cochlear implants, which produce as their output an electrical signal that directly stimulates the auditory nerve, are not considered to be hearing aids for purposes of Medicare payment policy. (See Coverage Issues Manual §65-14).

Medicare contractors are to deny payment for an item or service that is associated with any hearing aid as defined above. This clarification is not meant to change policy for the medically necessary treatment of complications of implantable hearing aids, such as medically necessary removals of implantable hearing aids due to infection. See §2300.1 of Part 3 of the Medicare Carrier Manual.