2019 MEDICARE PHYSICIAN FEE SCHEDULE (MPFS) INDICATOR DESCRIPTORS

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Here is an overview of the layout. Use the key on the following pages to interpret indicators. CPT codes and modifiers begin with a numeric character and HCPCS codes and modifiers begin with an alpha character. All Current Procedural Terminology (CPT) codes and descriptors are copyrighted 2018 by the American Medical Association.

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MPFS DESCRIPTORS

These codes explain the labels and notes on the Medicare Physician Fee Download files.

Indicator	Descriptor
Note - #	Service Performed in Facility Setting.
Note - C	Payment for Technical Component is Capped at OPPS Amount.
Procedure/Mod	CPT/HCPCS code and Modifier (26, TC, 53).
Par Amount	Participating Physician Fee.
Non-Par Amount	Non-Participating Physician Fee.
Limiting Charge	Limiting Charge for Non-Participating Physician.

INDICATOR LIST DESCRIPTORS

These codes explain the labels and notes on the Medicare Physician Fee Indicator Download files.

Indicator	Descriptor
Code	CPT/HCPCS code
MOD	Modifier (CPT Modifiers 26 and 53, HCPCS Modifier TC)
Status	Status
Effective Date	Effective Date. Formatted YYYYDDMM
Global Days	Global Days
Pre-Op%	Pre-Operative % (CPT Modifier 56 represents Pre-Operative care; however the Medicare processing system does not recognize modifier 56 for payment. Pre-Operative care is paid with Intra-Operative code under modifier 54.)
Intra-Op%	Intra-Operative % (When CPT Modifier 54 is billed, the Medicare payment is based on both the Pre-OP and Intra-Op percentages. When CPT modifier 78 is billed, the payment is based on the Intra-Op %.)
Post Op%	Post-Operative % (When CPT Modifier 55 is billed, the Medicare payment depends on the number of post-op days of care provided.)
SOS Differential	As of 01-01-1999, the site of service differential no longer applies. However, this indicates if facility pricing applies.
Prof/Tech Comp.	Professional/Technical Component Rules (CPT Modifier 26 and HCPCS Modifier TC)
Mult Proc	Multiple Procedure (CPT Modifier 51.) Modifier 51 is not required to be reported when billing multiple procedures. The Medicare claims processing system will automatically append Modifier 51 as needed for claims processing.
Bilat Surg	Bilateral Surgery (Modifier 50)
Assist Surg	Assistant at Surgery (Modifier 80, 81, 82 and AS.) This field provides an indicator for services where an assistant at surgery is never paid for per IOM.
Co-Surg	Co Surgeons (CPT Modifier 62)
Team Surg	Team Surgeons (CPT Modifier 66)
Purch Diag Test Ind	Purchased Diagnostic Test Indicator
Image Cap Ind	Imaging Indicator
PSDP	Physician Supervision of Diagnostic Procedures
Endo Base	Endoscopic Base Code
Diag Imag Fam Ind	Diagnostic Imaging Family Indicator.
Work RVU	The unit value for the Physician Relative Value Unit (RVU.)
Malpractice RVU	The unit value for the malpractice expense RVU.
Facility Setting RVU	The unit value for the practice expense RVU when service is rendered in a facility setting.

Non-Facility Setting RVU	The unit value for the practice expense RVU when service is rendered in a non-facility setting.
Work Expense GPCI	The work expense geographic adjustment factor used in computing the fee schedule amount.
Malpractice Expense GPCI	The malpractice expense geographic adjustment factor used in computing the fee schedule amount.
Practice Expense GPCI	The practice expense geographic adjustment factor used in computing the fee schedule amount.
Conversion Factor	The multiplier which transforms relative values into payment amounts for the fee screen year.
Update Factor	The update factor is included in the conversion factor and can also be used to index carrier priced fees from year to year.

S - STATUS

This field provides the status of each code under the full fee schedule.

Indicator	Descriptor
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. Carriers may also gap-fill payment based on a comparable code(s) or value of multiple codes. When this occurs, RVUs are not maintained for these codes; instead, the carrier fee is indexed each year using the MPFSDB update factor. The update factor is located on the display screen and on the MPFSDB Indicator Download file.
D	Deleted/discontinued codes. Codes with this indicator had a 90 day grace period before January 1, 2005.
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. Codes with this indicator had a 90 day grace period before January 1, 2005.
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.
Q	Therapy functional information code (used for required reporting purposes only.)
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.)

SITE OF SERVICE

For 1999 and beyond, the site of service differential no longer applies. The following definitions will apply for all years after 1998:

Indicator	Descriptor

1	Facility pricing applies.
9	Facility pricing does not apply.

P/T - PROFESSIONAL/TECHNICAL COMPONENT (MODIFIER 26 AND HCPCS MODIFIER TC)

This field provides an indicator identifying when the Professional (modifier 26) and Technical (modifier TC) Component applies.

Indicator	Descriptor
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, 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	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.

M - MULTIPLE PROCEDURE (MODIFIER 51)

Indicator indicates which payment adjustment rule for multiple procedures applies to the service. Modifier 51 is not required to be reported when billing multiple procedures. The Medicare claims processing system will automatically append Modifier 51 as needed for claims processing.

Indicator	Descriptor
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 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 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.

B - BILATERAL SURGERY (MODIFIER 50)

This field provides an indicator for services subject to a payment adjustment.

Indicator	Descriptor
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.
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.

A - ASSISTANT AT SURGERY (MODIFIERS 80, 81, 82 AND AS)

This field provides an indicator for services where an assistant at surgery is never paid for per IOM.

Indicator	Descriptor
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.

T - TEAM SURGEONS (MODIFIER 66)

This field provides an indicator for services for which team surgeons may be paid.

Indicator	Descriptor
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.

C - CO SURGEONS (MODIFIER 62)

This field provides an indicator for services for which two surgeons, each in a different specialty, may be paid.

Indicator	Descriptor
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.

PSDP - PHYSICIAN SUPERVISION OF DIAGNOSTIC PROCEDURES

This field is for use in post payment review.

Indicator	Descriptor
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. (Diagnostic imaging procedures performed by a Registered Radiologist Assistant (RRA) who is certified and registered by The American Registry of Radiologic Technologists (ARRT) or a Radiology Practitioner Assistant (RPA) who is certified by the Certification Board for Radiology Practitioner Assistants (CBRPA), and is authorized to furnish the procedure under state law, may be performed under direct supervision).
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).

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.

GLB - GLOBAL DAYS

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.

Indicator	Descriptor
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.)

PREOP - PRE-OPERATIVE % (MODIFIER 56)

This field contains the percentage for the preoperative portion of the global package. The total of the Pre-Operative %, Intra-Operative%, and Post-Operative % fields will usually equal 100%. Any variance is slight and results from rounding.

INTRAOP - INTRA-OPERATIVE % (MODIFIER 54)

This field contains the percentage for the intraoperative portion of the global package including postoperative work in the hospital. The total of the Pre-Operative %, Intra-Operative%, and Post-Operative % fields will usually equal 100%. Any variance is slight and results from rounding.

POSTOP - POST-OPERATIVE % (MODIFIER 55)

This field contains the percentage for the postoperative portion of the global package that is provided in the office after discharge from the hospital. The total of the Pre-Operative %, Intra-Operative%, and Post-Operative % fields will usually equal 100%. Any variance is slight and results from rounding.

ENDOSCOPIC BASE CODE

This field identifies an endoscopic base code for each code with a multiple surgery indicator of 3. Special rules for multiple endoscopic procedure apply if procedure is billed with another endoscopy in the same family. Select Display Indicator Descriptor Page link located next to the Indicators title on the Display Procedure Code Page.

DIAGNOSTIC IMAGING INDICATOR

For services effective January 1, 2011, and after, family indicators 01 - 11 will not be populated.

Indicator	Descriptor
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 the

	PC diagnostic imaging (effective for services January 1, 2012 and after.)
99	Concept Does Not Apply.

CONVERSION FACTOR

This field displays the multiplier which transforms relative values into payment amounts.

UPDATE FACTOR

This update factor is included in the conversion factor for the current fee screen year. This factor is used to index forward carrier priced fees from the previous year.

ICI - IMAGING CAP INDICATOR

This field identifies codes that are subject to CMS payment limitations based on the OPPS payment cap.

Indicator	Descriptor
1	Subject to OPPS Payment Cap determination.
9	Not Subject to OPPS Payment Cap determination.

P4P INDICATOR

(For future use)

PURCHASED DIAGNOSTIC TEST INDICATOR

This field providers an indicator for Purchased Diagnostic Test HCPCS codes

Indicator	Descriptor
1	Purchased Diagnostic Test HCPCS.
9	Concept does not apply.