Understanding and Using the Medicare Physician Fee Schedule Database

Presented by
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January 13, 2016

Disclaimer
The speaker has no financial relationship to any products or services referenced in this program. The program is intended to be informational only. The speaker is not an authoritative source by law. Attendees are advised to reference payor specific provider manuals, on-line or otherwise, for verification prior to making changes to their coding, documentation and/or billing practices.
Objectives for this session

In this interactive session, Ms. Reed will address what the MPFSDB (Ma-phys-da-buh) is and does. She will show the importance of the information on the database, including the Relative Value Units for all CPT codes and the payment policy indicators and what they mean. Included in this discussion will be status of codes, global periods, modifiers, as well as various payment concepts that are included in the database. The Medicare Physician Fee Schedule Database is not the Medicare Fee Schedule. They are very different. It is a national database used by MACs to assure consistent claims processing nationally and is continuously updated by CMS. Correct use of the MPFSDB is key to clean, correct, claim submission the first time. This tool is a resource often overlooked in the practice. During the session the specific concerns of the audience will be addressed on best practices for use.

I hear, I know, I see, I remember, I do, I understand

Confucius  551-479 BC
Slides and Information

Please be aware that not all slides will be discussed in detail during this presentation. Some of the slides are informational only.

If you see something that is just being referred to and you have a question please ask.

Presentation Style

- Ms. Reed prefers an interactive presentation style. She will try to address questions as they occur unless time is limited.

- Thank you in advance for your consideration of others in the audience by not talking amongst yourselves.

- Please silence your phone during this session, thank you.
Disclaimer

The information provided today pertains to Medicare. It is current as of the date these slides were submitted to the AAPC in January 2016.

Any changes since that time will be added or discussed by the presenter.

The MPFSDB

(Ma-phys-da-buh)
What is the MPFSDB?

- Medicare Physician Fee Schedule Data Base
- Contains the Relative Value Units (RVUs) for each CPT code
- Contains the Payment Policy Indicators for:
  - Status of CPT codes
  - Appropriate modifiers
  - Global period
  - Various payment concepts
  - And much more

The MPFSDB is not the Physician Fee Schedule!

- It IS a national database used by MACs to assure consistent claims processing nationally
  - Continuously updated
- The Physician Fee Schedule (PFS) is carrier specific and lists the fees (per year) based on locality and procedure codes
- Note-These tools are created for use by government payors; however more and more private insurances are turning to them for coding clarification.
The MPFSDB is used as a tool to discover details about codes and how they are used to provide payment for services. The more you understand how to use and interpret it, the more beneficial it becomes when structuring not only payor contracts but provider contracts for employment.

- When a payor says they use the Medicare or CMS billing and coding rules, they use the MFS and the MPFSDB.

Where and How Do I Find the MPFSDB?
- Go to [www.cms.hhs.gov](http://www.cms.hhs.gov) and click on Medicare.
- Scroll down to “Medicare Fee for Service Payment”, click on “Physician Fee Schedule”
- Click on “PFS Relative Value Files”
- Find and click on the year you need access to
- Open the zipped Excel file for the year and quarter
Medicare Fee-for-Service Payment

Under this option you will see several choices referring to the fee schedule:

- Fee Schedules-General Information
- Physician Fee Schedule
- Physician Fee Schedule Look-Up Tool

The best way to find what you are looking for is to click on the Physician Fee Schedule.
You can change the order of the years by clicking on the Calendar Year.

The RVU files are designated with a number and letter. The number represents the year, the letter represents the quarter.
Before we open the MPFSDB we need to discuss another link on slide 12. It gives you the option to the **Medicare Physician Fee Schedule Look Up Tool**. The following pages illustrate and discuss how valuable this tool can be.
This is the same step as 3 on slide 14. However it is a different choice. I recommend you download this tool and save it. This way it's easier to open when you are on the live MFS or MPFSDB.

This Tool is a Life-saver ...

Physician Fee Schedule Look-Up Tool

To start your search, go to the Medicare Physician Fee Schedule Look-up Tool.

To read more about the MPFS search tool, go to the MLN® booklet, How to Use The Searchable Medicare Physician Fee Schedule Booklet April 2016 (PDF; 248K).
Medicare Physician Fee Schedule Look-up Tool

- This tool will clarify questions on the MPFSDB
- It explains terminology used on the tool
- Helps all of us to further explain the rules to providers
- Shows methods for understanding Medicare payments

In this era of being tech savvy and using websites, I will confess to having downloaded and printed a copy. My rationale is that I have a perfect place for all my notes and short cuts. I would recommend it to all of you.

*The next two slides are examples of what is in the tool.*
Back to our study of the MPFSDB
This is the unzipped file, open the most recent excel worksheet

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The MPFSDB

- Columns A-C are codes and descriptions, D is the status of the code
- Columns F-N represent Relative Value Units (RVUs)
Codes and Descriptions

- Column A  Code number (number or combination code)
- Column B  Description from manual
- Column D  Status of the code (discussed later in the presentation)

All codes are listed, not just the ones that are active and paid by government payors.

RBRVS and Relative Value Units

Resource Based Relative Value Scale, adopted by Medicare in 1992

- Three components to the Relative Value Units:
  1. Physician Work (column F)
  2. Practice Expense (columns G and I)
  3. Malpractice Expense (column K)
- When combined, they equal the Total RVU’s per code (columns L and M). There are differences in the two columns since one represents Facility and the other Non-Facility
Relative Value Units
Difference between Non-Facility and Facility

- Note the difference between Non-Facility and Facility Practice Expense.
- That difference reflects the variance between Non-Facility and Facility total RVUs for the codes.

Codes That are the Exception

59400 Routine obstetric care including antepartum care, vaginal delivery (with or without episotomy, and/or forceps) and postpartum care

The code shown above has the same RVU’s for both Non-Facility and Facility. Rationale indicates the malpractice is the same no matter the location. There are some codes that are the exception, and according to the RUC (Relative Value Scale Update Committee) it is due to risk factors involved. The RUC further states that these codes are reviewed for valuation more often than others.
RVU Comparison

- 99214 is worth 3.02 Total RVUs Non-Facility
- 99214 is worth 2.21 Total RVUs Facility

- 59400 is worth 60.31 Total RVUs both Non-Facility and Facility

So in other words 59400 is worth approximately Twenty (20) 99214 Non-Facility Visits and Twenty-seven (27) Facility Visits.

This comparison is good to use when discussing the value of the procedure to providers.
Column N

- PCTC is the code for the Professional/Technical Component. These are represented on claims with -26 and TC modifiers.
- This column complements the Modifier column by providing Professional Component/Technical Component Indicators.
- Indicates codes that can or cannot accept modifiers -26 and –TC.
- Indicates codes that are either global, professional, or technical by CPT definition.
- Identifies other “incident to” services that are not payable in the hospital inpatient or outpatient departments.

Column N - PC/TC Indicators

- 0 = Physician Service, Modifier TC & 26 do not apply
- 1 = Diagnostic Service, Modifiers TC & 26 apply
- 2 = Professional Component by definition, Modifiers TC & 26 do not apply
- 3 = Technical Component by definition, Modifiers TC & 26 do not apply
- 4 = Global by definition, Modifiers TC & 26 do not apply
Column N- PC/TC Indicators continued

- 5 = Incident to code – not a physician service by definition, modifiers TC & 26 do not apply
- 9 = Concept of professional/technical does not apply
Column D-Status Codes

- A = Active code and separately paid under the physician fee schedule if covered
- B = Bundled code. Payment for covered services are always bundled into payment for other services not specified
- C = Carriers/MACs price the code
- D = Deleted/discontinued codes
- E = Excluded from physician fee schedule by regulation
- F = Deleted/discontinued codes
- G = Not valid for Medicare purposes

Column D-Status Codes continued

- H = Deleted modifier
- I = Not valid for Medicare purposes
- J = Anesthesia services
- M = Measurement codes
- N = Non-covered service
- P = Bundled/excluded codes
- Q = Therapy functional information code
- R = Restricted coverage
- T = Injections
- X = Statutory exclusion
Duration of Global Period

- 0 days for endoscopies or certain minor procedures for when the physician visits the patient on the same day as the procedure
- 10 days for most minor surgeries
- 90 days for major surgeries

Column O Global Days

- 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
Column O-Global Days continued

- 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/MAC 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.)

Columns P-Q-R Global Surgery Indicators

- Column P: Pre-operative percentage (modifier 56)
- Column Q: Inter-operative percentage (modifier 54)
- Column R: Post-operative percentage (modifier 55)

If treatment of a major procedure (90 day global) is co-managed, then the modifiers are applied to the procedure code and the reimbursement is split based upon the work performed and reported.

EXAMPLE: 69400   P= 0.07   Q= 0.79   R= 0.14
Columns S Multiple Surgery

- This column indicates which payment adjustment rule for multiple procedures (including certain physical therapy procedures) applies to the service. In column S, a ‘2’ indicates that standard payment adjustment rules for multiple procedures apply.
  - Payment is based on the lower of the billed amount, or:
    - 100% of the fee schedule amount for the highest valued procedure; and
    - 50% percent of the fee schedule amount for the second through the fifth highest valued procedures.
- Additional procedures are reviewed independently and considered for payment.

Helpful Hints for Multiple Surgery

- When billing for multiple surgeries by the same professional (or physicians in the same group) on the same day:
  - Report the primary surgical procedure without modifier -51.
  - Report additional surgical procedures performed by the same professional on the same day with modifier -51.
- Learn about multiple surgeries in Chapter 12 of IOM Pub. 100-04 and read about modifier -51 in the current CPT code book.
- Note: Not all payors want you to add the -51. Be sure you check contracts and local carrier requirements.
Column T Bilateral Surgery

- This field provides an indicator for bilateral services subject to a payment adjustment. Bilateral surgeries are procedures performed on opposite sides of the body, during the same operative session, or on the same day. In column T, you’ll find 0,1,2,3 or 9 displayed, which tells you if the code is considered bilateral and how it is paid.

Definitions of the indicators are on the following two slides

Bilateral Surgery Indicators

0 = 150% payment adjustment does not apply. If billed with modifiers RT & LT, or with two units, 100% allowed for each procedure.

1 = 150% payment adjustment applies. If billed with modifiers RT & LT, or with two units, 1st procedure paid at 100%, 2nd procedure paid at 50%.

2 = 150% payment adjustment does not apply. The code is always bilateral by definition and RVUs are based upon the procedure being performed bilaterally.
Bilateral Indicators continued

3 = 150% payment adjustment does not apply. If billed with modifiers RT & LT, or with two units, 100% allowed for each procedure.

9 = Bilateral concept does not apply

Helpful Hints Bilateral Surgery

Modifier -50 is a modifier indicating that the procedure was performed bilaterally at the same session. Learn more about billing for bilateral surgery in Chapter 12 of IOM Pub. 100-04 and read about modifier -50 in the current CPT code book.
Column U Assistant Surgeon

- This column indicates whether assistants at surgery may be paid. In column U you’ll find 0,1,2, displayed, which means payment is allowed or not allowed.

  0 = Payment restrictions 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 restrictions for assistants at surgery does not apply to this procedure. Assistant at Surgery may be paid.

Helpful Hints Assistant at Surgery

Physicians are prohibited from billing a Medicare beneficiary for assistant surgeon charges for procedure codes subject to the assistant at surgery limit. Learn more about assistant at surgery payment in Chapter 12 of IOM Pub. 100-04 and review modifiers -AS, -80, -81, and -82 by referring to the CPT/HCPCS code books.

Definition

- An "assistant at surgery" is a physician who actively assists the physician in charge of a case in performing a surgical procedure. The assistant provides more than just ancillary services.
Column V Co-Surgeon

- Column V includes indicators of 0, 1, or 2, indicating if co-surgeons are allowed on the procedure.

Co-Surgery Indicators
- 0 = Co-surgeons not permitted for this procedure
  - Medicare will not allow payment
- 1 = Co-surgeons may be paid if supporting documentation is supplied to establish medical necessity
- 2 = Co-surgeons permitted. No documentation is required when the two specialty rule is met

- When the indicator is "1", the second claim will suspend for additional documentation and review regardless of whether the first claim contained Modifier 62.

- Global Surgery rules apply to each of the physicians.

Helpful Hints Co-Surgeon

Appropriate Use
- Two surgeons (each in a different specialty) are required to perform a specific procedure for the patient.
- Two surgeons (same or different specialty) are each performing parts of the same procedure simultaneously, such as heart transplants, or bilateral knee replacements.
- Both physicians bill the same procedure code appending modifier 62.

Inappropriate Use
- One surgeon is acting as an assistant surgeon.
- Rare situations, usually in trauma cases, where both surgeons are acting simultaneously, but not performing the same procedure.
- There are more than two primary surgeons.
Column W Team Surgery

- Column W displays 0,1, or 2 indicating a team of surgeons (more than two surgeons of different specialties) is or is not permitted for this procedure.

Team Indicators
0 = Team surgeons not permitted for this procedure.
1 = Team surgeons may be paid if supporting documentation is supplied to establish medical necessity of a team. Paid by report.
2 = Team surgeons may be paid. Paid by report.

Helpful Hints Team Surgery

- If a team of surgeons (more than two surgeons of different specialties) is required to perform a specific procedure, each surgeon bills for the procedure with a modifier "66." Each surgeon is required to provide a separate operative report showing his or her role and work during the operative session.

Facts
- Global surgery rules apply to each of the physicians participating in a team surgery.
- Reimbursement is determined "By Report."
Column X Endoscopic Base

- Column X identifies endoscopic base codes that determine payment when multiple endoscopic procedures are performed.

- If multiple endoscopies are billed, special rules for multiple endoscopic procedures apply. Medicare contractors will perform the following actions when multiple HCPCS/CPT codes with a payment policy indicator of ‘3’ (Special rules for multiple endoscopic procedures), with the same date of service, are present:
  1. Identify if the billed codes share the same Endoscopic Base Code (using the Physician Fee Schedule Payment Policy Indicator File).
  2. Pay the full value of the highest valued endoscopy (if the same base is shared), plus the difference between the next highest and the base endoscopy.

Endoscopy Rules

- Two unrelated endoscopies (e.g., 46606 and 43217)
  - Apply the usual multiple surgery rules.

- Two sets of unrelated endoscopies (e.g., 43202 and 43217; 46606 and 46608)
  - Apply the special endoscopy rules to each series, then
  - Apply the multiple surgery rules. (Consider the total payment for each set of endoscopies as one service)
Endoscopy Rules

- Two unrelated endoscopies and a third, unrelated procedure.
  - Apply the multiple surgery rules.
- Two related endoscopies and a third, unrelated procedure
  - Apply the special endoscopic rules to the related endoscopies, then
  - Apply the multiple surgery rules. (Consider the total payment for the related endoscopies as one service and the unrelated endoscopy as another service.)

MLN Matters® Number: MM7387
Column Y

- RVUs are multiplied by a conversion factor to determine payment.

- Payments are calculated by multiplying the combined RVUs of a service by a conversion factor (a monetary amount that is determined by the Centers for Medicare and Medicaid Services). Payments are also adjusted for geographical differences in resource costs.

- CY 2016 MPFS conversion factor is $35.8279, reflecting the budget neutrality adjustment of -0.02%, the 0.5% update factor specified under Medicare Access and CHIP Reauthorization Act (MACRA), and the 0.77% target recapture amount required under ABLE Act.

Column Z

- Physician Supervision of Diagnostic Procedures
- Medicare requires a specific level of physician supervision in order to bill certain diagnostic services in radiology, cardiology, and pulmonology.
- There are three levels of physician supervision
  - General Supervision (1)
  - Direct Supervision (2)
  - Personal Supervision (3)
Physician Supervision of Diagnostic Procedures

- 01=Procedure performed under general supervision
- 02=Procedure performed under direct supervision
- 03=Procedure personally performed or personally supervised by the physician
- 09=Supervision concept does not apply

Definition of Supervision

- General Supervision

  - Such procedures are furnished under the physician’s overall direction and control but the physician’s presence is not required.
  
  - The training of non-physician personnel and the maintenance of the equipment are the responsibility of the physician.
Definition of Supervision

• Direct Supervision

• The physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure.

• It does not mean that the physician must be present in the room when the procedure is performed.

• Personal Supervision

• The physician must be in attendance in the room during the performance of the procedure.
Conclusions

- Further details of the MPFSDB are on your carrier website in the form of educational tools, modifier definitions and fact sheets.
- Some of the carriers also have a link to the MPFSDB on their websites.
- As you study the tool we have reviewed you will also want to look at any MLM that pertains to the code or area you are studying.
- If you are not signed up for your carrier newsletters you need to do this as a continual source of educational updates.
- CMS also has several list serves and newsletters that apply to the MPFSDB tool and general updates. You would be wise to sign up for these as well.

Conclusions

- As we said at the start of this session these tools are reviewed and updated constantly by CMS.
- If you download the reports or tools be sure each time you go to review the information that you check CMS to see if anything has changed.
- If you ask questions about issues on this tool in a forum or list serve be sure you validate any and all answers you get.
Acknowledgements

- Much of the ideas and information for this presentation came from the CMS and MAC websites.
- Tracy Bird and Brenda Edwards, my peeps, who had the original concept for this presentation were kind enough to share it.
- Angela Jordan who never let me give up with my snip tool!
- Cathy Jennings for the new tech skills in slide making.
- My colleagues at Medical Revenue Solutions, LLC for all their help and support, especially Linda Duckworth and Sandra Soerries for technical review of this presentation.

QUESTIONS

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