



## How to Use the PFS Look-Up Tool



### [Physician Fee Schedule Look-Up Tool overview](#)

Substantive content changes are in dark red.

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### What's Changed?

- Updated instructions and screenshot for searching the PFS, pages 7-9
- Added new screenshots and prices for the instructions for the various searches, pages 9-23
- Added 2023 Conversion Factor, page 21
- Added 2023 Practice Expense (PE) RVUs, page 21
- Added 2023 GPCI WORK, GPCI PE, and GPCI Malpractice (MP) values for Northern California, page 23
- Changed the referral to MLN Matters Article in the callout box to MM9647, page 28
- Updated percentage of the MPPR reduction to the professional component for certain diagnostic imaging services to 5%, page 28
- Updated the instructions in the PFS Quick Reference Search Guide, pages 32-34

### To Learn More...

If you find this How to booklet helpful, then you may review the other booklets in this series. To find these booklets, go to the [MLN Publications](#) webpage, and search “how to.”

This booklet explains the Physician Fee Schedule (PFS) Look-Up Tool. You'll learn how to search:

- Pricing amounts
- Payment policy indicators
- Relative Value Units (RVUs)
- Geographic practice cost indices (GPCIs)
- The national payment amount
- A specific Medicare Administrative Contractor (MAC)
- A specific MAC locality

## What is the PFS Look-Up Tool?

The CMS PFS Look-Up Tool gives Medicare payment information on more than 10,000 services, including:

- Pricing
- Associated RVUs
- Payment policies

The tool doesn't display carrier priced codes or Medicare Part B non-payable codes.

## Why Would a Health Care Provider or Supplier Use the PFS Look-Up Tool?

The PFS is the primary method of payment for enrolled health care providers. Specifically, Medicare uses the PFS when paying the following services:

- Professional services of physicians and other enrolled health care providers in private practice
- Services covered incident to physicians' services (Other than certain drugs covered as incident to services)
- Diagnostic tests (Other than clinical laboratory tests)
- Radiology services

Medicare also pays suppliers like mammography centers, according to the PFS. Medicare pays institutional providers like hospitals, comprehensive outpatient rehabilitation facilities (CORFs), and skilled nursing facilities (SNFs) for services under the PFS, depending on the kind of institution and service. For example, Medicare pays hospital outpatient departments for screening mammographies and outpatient rehabilitation services under the PFS.

The PFS Look-Up Tool helps providers and suppliers find Medicare payment amounts for each code so they can calculate the patient coinsurance amount. The PFS gives the limiting charge for nonparticipating providers and suppliers who treat Medicare patients.

**Participating Medicare Providers and Suppliers** enroll in Medicare and sign the Form CMS-460, Medicare Participating Physician or Supplier Agreement, agreeing to charge no more than Medicare-approved amounts and deductibles and coinsurance amounts. Participating providers and suppliers send in assigned claims.

Providers and suppliers send in **Assigned Claims** on behalf of the patient. Medicare issues payment to the sender.

**Nonparticipating Providers and Suppliers** who enroll in Medicare but decide not to sign the Form CMS-460 accept assignment on a case-by-case basis.

Medicare reduces the Medicare-approved amounts for nonparticipants by 5% for services paid under the PFS. Also, Medicare limits what you or the supplier may charge the patient (Limiting Charge) when you choose not to accept assignment on the claim.

**Limiting Charge** equals 115% of the nonparticipating fee schedule amount and is the most the nonparticipant may charge a patient on an unassigned claim. The nonparticipating fee schedule amount is equal to 95% of the PFS.

Nonparticipating providers or suppliers who don't accept the assignment on the claim, send in **Unassigned Claims**. Medicare issues payment to the patient. Use the PFS Look-Up Tool to learn if payment policies such as payment of assistant at surgery services, applicability of certain modifiers, and physician supervision of diagnostic services affect HCPCS codes.

Using the PFS is an excellent way to check if the following payment policies affect HCPCS codes:

- Payment of assistant at surgery services
- Applicability of certain modifiers
- Physician supervision of diagnostic services

### Tip

Print out the PFS Quick Reference Search Guide on page 32 of this booklet for a step-by-step summary of how to use the PFS Look-Up Tool.

Find a full list of HCPCS codes on the [PFS Relative Value Files](#) webpage.

### Tip

- Find more information about these and other payment policies in the CMS manuals
- Search the [Medicare National Correct Coding Initiative \(NCCI\) Edits](#) webpage to find NCCI code pair edits and medically unlikely edits (MUEs)
- Search the [Medicare Coverage Database \(MCD\)](#) to review national and local coverage determinations
- Visit the [Medicare Learning Network® \(MLN\) Publications](#) webpage to review other booklets in the How to series:
  - How to Use the Medicare National Correct Coding Initiative (NCCI) Tools
  - How to Use the Medicare Coverage Database

## Background

Medicare Part B pays for physician services based on the Medicare PFS, which lists the more than 10,000 unique codes and their payment rates. Physicians' services include:

- Office visits
- Surgical procedures
- Anesthesia services
- A range of other diagnostic and therapeutic services

Physicians provide services in all settings, including:

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>• Physicians' offices</li> <li>• Hospitals</li> <li>• Ambulatory Surgical Centers</li> <li>• SNFs and other post-acute care settings</li> </ul> | <ul style="list-style-type: none"> <li>• Hospices</li> <li>• Outpatient dialysis facilities</li> <li>• Clinical laboratories</li> <li>• Patients' homes</li> </ul> |
|--|--|

## PFS Payment Rates

Medicare uses the PFS payment rates formula to decide a service's payment rate. There's a description for each part below the formula.

### Medicare PFS Payment Rates Formula



Figure 1: Arithmetic graphic of the parts added and multiplied together to show how Medicare decides the PFS payment rate for services

## Relative Value Units (RVUs)

The PFS uses 3 separate RVUs to calculate a payment:

1. **The Work RVU** shows the Medicare PFS service's relative time and intensity
2. **The Practice Expense (PE) RVU** shows the costs of supporting a practice (like renting office space, buying supplies and equipment, and staff costs)
3. **The Malpractice (MP) RVU** shows the costs of malpractice insurance

## Geographic Practice Cost Indices (GPCIs)

Medicare adjusts each of the 3 RVUs to account for geographic variations in the costs of practicing medicine in different areas of the country. Each kind of RVU has a related GPCI adjustment.

## Conversion Factor (CF)

To decide the payment rate for a service, CMS systems multiply the sum of the geographically adjusted RVUs by a CF in dollars. The statute specifies the formula Medicare uses to update the CF every year.

Medicare uses a fee schedule, a complete listing of fees, to pay doctors or other providers and suppliers. We use this comprehensive listing of fee maximums to pay a physician or other providers and suppliers on a Fee-for-Service (FFS) basis. Medicare bases payment on whichever is less, the charge or PFS amount. CMS also develops fee schedules for ambulance services, clinical laboratory services, and DMEPOS.

For most codes, Medicare pays 80% of the allowed amount and the patient pays 20%. Examples of reductions from the published PFS amount include:

- Assistants at surgery get 16% of the PFS rate
- Medicare pays nurse practitioners, physician assistants, and clinical nurse specialists 85%
- Medicare pays physical and occupational therapy assistants 85%
- Medicare pays registered dietitians or nutrition providers for medical nutrition therapy services 85%
- Clinical social workers get 75%

### Tip

See Sections 110.2 and 120 of the Medicare Claims Processing Manual, [Chapter 12](#), for more information.

## How Up to Date is the PFS?

CMS updates the PFS quarterly. The Data Updated statement on the [PFS Overview](#) page shows the date of the latest update.

## Searching the PFS

The Overview page of the [PFS Look-Up Tool](#) tells you the information you can search for with the tool. The site allows you to search:

- Pricing amounts
- Various payment policy indicators
- Relative Value Units
- Geographic Practice Cost Indices

You have **2** ways to manage your search results once completed:

1. Download CSV
2. Copy link

You'll see these buttons below your search results table.

To download an Excel file of your search results:

- Click the Download CSV button
- A box will pop up at the top right of your screen asking if you want to open the file
- If you click on the Open button, you'll get your search results in an Excel spreadsheet



To save a file with your search results:

- Click on the folder icon to the right of the Open button
- Choose where you'd like to save your file on your computer

To delete your search results:

- Click on the trash can icon to the right of the folder icon

To copy a link to your search results:

- Click on the Copy link button below your search results table
- You'll see a green check box to the right of the button and a message that says Link copied to clipboard
- Right click and select paste to paste the link in an email, a browser search bar, or to any document you choose

To start a search from the Overview page of the PFS Look-Up Tool:

- Click on the Begin Search button
- Accept to show you've read and agree to the licensing agreement

The Search the Physician Fee Schedule webpage appears. **Figure 2** shows part of this screen. To start your search, choose the following criteria:

**1**

**2**

**Figure 2:** Search Criteria



1 Choose the year from the dropdown menu.

2 Then, choose the Type of Information for the search from the following choices:

- **Pricing Information** - Search the maximum fee schedule amount by HCPCS code
- **Payment Policy Indicators** - This choice gives information such as global surgery days, multiple surgery indicators, and applicability of professional and technical components
- **Relative Value Units (RVUs)** - For those interested in how the PFS tool calculates the payment amount, this choice gives RVU information for work, practice expense, and malpractice costs
- **Geographic Practice Cost Index (GPCI)** – Medicare set up a GPCI for every Medicare payment locality for each of the 3 parts of a procedure’s RVU
- **All** - This choice gives data for each of the above types of information

### Tip

The downside to choosing All is if you choose to print the results, you’ll print more than what you need and spend a little more time arranging the printing. Also, if you select 1 of the choices and then change your mind, you can easily switch from viewing only the default columns to all columns once your search results appear.

The rest of the search limits and choices shown change based on the Type of Information chosen for the search. We’ll show the next steps of this search doing a Pricing Information Search and review the other choices of searches.

## Pricing Information Search

1 Choose Pricing Information for the Type of Information

2 Choose 1 of the following **HCPCS Criteria**:

- **Single HCPCS Code**
  - Enter 1 procedure code
- **List of HCPCS Codes**
  - Enter up to 5 codes
- **Range of HCPCS Codes**
  - Enter a starting and ending procedure code to define the range
  - You can search for up to 300 codes at a time

### Tip

The PFS includes Level I CPT and Level II HCPCS codes.

Figure 3: Pricing Information Search

3 Choose 1 of the following choices for the Medicare Administrative Contractor (MAC) criteria:

- **National Payment Amount**  
This choice searches for information for only the national payment amount. A MAC locality code of 0000000 shows for the national payment amount.
- **Specific MAC**  
Providers use a MAC locality code to search for information showing a specific geographic area.

If you choose this alternative, choose an area from the dropdown menu at the bottom of the page.

A few of these areas, such as 01112, have multiple listings. To learn what these numbers mean, reset the search to Specific Locality.

- **Specific Locality**  
This search allows you to drill down to specific cities (for example, 0111205 - San Francisco) if payment varies within a MAC for specific localities. Notice the number for San Francisco starts with the Northern California number followed with a 05.
- **All MACs**  
This choice searches for information for the entire nation. The results include the national payment amount and all MAC localities. This choice is helpful for states with multiple payment localities because it groups all localities together for a MAC. Medicare payment may vary within 1 MAC. But this choice doesn't give locality names. You must know the MAC locality codes, like those given in the Specific Locality choice.

**Tip**

MACs have more than 1 of these locality codes. For example, the JE MAC includes 01182-Southern California; 01112-Northern California; 01212-Hawaii, Guam, American Samoa, and the Northern Mariana Islands; and 01312-Nevada.

Select search parameters.

**Year**  
 2023

**Type of Information**  
 Pricing Information

Select Healthcare Common Procedural Coding System (HCPCS) criteria.

**HCPCS Criteria**      **HCPCS Code**  
 Single HCPCS Code     

**Modifier**  
 All Modifiers

Select Medicare Administrative Contractor (MAC) option.

**MAC Option**  
 All MACs  
 National Payment Amount  
 Specific MAC  
 Specific Locality  
 All MACs

**Downloads**  
[Physician Fee Schedule Guide \(PDF\)](#)

3

Figure 4: Pricing Information Search

- 4 Enter the HCPCS code(s) for the search.
- 5 Choose 1 of the following Modifier alternatives from the dropdown menu:
  - Global (Diagnostic Service) or Physicians Professional Service where the Professional or Technical concept doesn't apply
  - 26 Professional Component
  - 53 Procedures which the physician ended before completion
  - TC Technical Component
  - All Modifiers

**Tip**

If you don't know which modifier to choose, choose All Modifiers. This choice brings up all the modifiers listed above, not all modifiers in the AMA or HCPCS code books.

Year  
2023 [See notes for selected year](#)

Type of Information  
Pricing Information

Select Healthcare Common Procedural Coding System (HCPCS) criteria.

HCPCS Criteria  
List of HCPCS Codes

HCPCS Code HCPCS Code HCPCS Code HCPCS Code HCPCS Code

Modifier  
All Modifiers

Select Medicare Administrative Contractor (MAC) option.

MAC Option  
National Payment Amount

**Search fees**

Figure 5: Pricing Information Search

Click Search fees after you choose the criteria to start your pricing search.

## Pricing Search Using a List of Evaluation and Management Codes

We'll start with an example of a pricing search using a list of Evaluation and Management (E/M) codes. We'll then show how search results vary when using a code with a professional or technical component.

Figure 5 shows the top part of the Search Results page after choosing or inputting the following information in this order:

- 2023 Pricing Information
- List of HCPCS Codes
- 99214 and 99215 as a list of HCPCS Codes
- All Modifiers
- 11202 South Carolina as the Specific MAC

### Tip

To change the search criteria, type in a new code or other factor at the top of the page and then click on Search fees.

See the results from our search below. The PFS Look-Up Tool explains each code under the Short Description column.

In **Figure 6**, let's review the pricing information given starting with the column on the left:

1	2	3	4	5	6	7	8	9	10
HCPCS Code ▲	Modifier ▲	Short Description ▼	Proc Stat ▲	Mac Locality ▲	Non-Facility Price ▼	Facility Price ▼	Non-Facility Limiting Charge ▼	Facility Limiting Charge ▼	Conv Fact ▼
99214		Office o/p est mod 30-39 min	A	1120201	\$121.88	\$93.88	\$133.16	\$102.57	33.8872
99215		Office o/p est hi 40-54 min	A	1120201	\$171.09	\$137.85	\$186.91	\$150.61	33.8872

Figure 6: Pricing Search Results for List of E/M Codes

- 1 **HCPCS Code** – The PFS Look-Up Tool displays 99214 and 99215 on separate rows with the pricing information shown to the right.
- 2 **Modifier** - There's nothing displayed in this column. This field stays blank for services other than those codes with a professional or technical component (or both), with 1 exception: When allowed, CPT modifier 53 appears in this column.
- 3 **Short Description** – This column shows a short description of the code and time a physician would spend during an exam.
- 4 **Proc Stat** - This column includes the Procedure Status Code. A is listed in this column for Active Code. This means the physician fee schedule pays this code separately, if covered.
- 5 **MAC Locality** - In **Figure 6**, the search shows 1120201. In this example, 1120201 is South Carolina, and 01 as the last 2 digits means that all of South Carolina's pricing is statewide. If you use Northern California as an example, the Look-Up Tool shows several rows because pricing in California varies in several localities.
- 6 **Non-Facility Price** - **Figure 6** displays **\$121.88** for 99214 and **\$171.09** for 99215. This column includes the fee schedule amount when you do a procedure in a non-facility setting like the office. (Non-facility fees apply to therapy procedures regardless of whether the physician provides them in facility or non-facility settings.)

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Occasionally, Medicare pays institutions like hospitals under the PFS. When this occurs, Medicare pays them at the non-facility (higher) rate. Although the terminology might seem confusing at first, the higher payment makes sense because the facility handles the cost of supplying the staff and supplies.

**7** **Facility Price** - **\$93.88** shows for 99214 and **\$137.85** for 99215. This is the fee schedule amount when a physician provides this service in a facility setting, like a hospital or ambulatory surgical center (ASC).

**8** **Non-Facility Limiting Charge** - **\$133.16** shows for 99214 and **\$186.91** for 99215.

This is the most the providers listed below may charge a patient for the service:

- Nonparticipating health care providers
- Providers who don't accept assignment
- Providers who do the service in an office setting

#### Site of Service Differential

Under the PFS, some procedures have a separate Medicare fee schedule for a physician's professional services when provided in a facility (like a hospital) or a non-facility. Generally, Medicare pays more for procedures done in an office because you must supply clinical staff, supplies, and equipment. View this differential in the Non-Facility Price and Facility Price columns.

On [page 4](#) of this booklet, we explain that Medicare reduces the Medicare-approved amounts 5% for nonparticipating providers and suppliers. In other words, the amounts in this column add up to 115% of 95% of the amounts in column 5.

**9** **Facility Limiting Charge** – Figure 6 shows **\$102.57** for 99214 and **\$150.61** for 99215.

- This is the most the providers listed below may charge a patient for the service:
  - Nonparticipating health care providers
  - Providers who don't accept assignment
  - Providers who do the service in a facility setting

**10** **Conv Fact** - This column displays the Conversion Factor for this code. We'll explain this later when we discuss RVUs.

## Pricing Search Using a Code with an Applicable Professional or Technical Component

Figure 7 below shows other pricing information that displays for codes providers may bill globally or with a professional or technical component. Use the following information for this example:

- 2023
- Pricing Information
- 76706 as the Single HCPCS Code
- 11202 South Carolina as the Specific MAC
- All Modifiers

HCPCS Code ▲	Modifier ▲	Short Description ◄	Proc Stat ▲	Mac Locality ▲	Non-Facility Price ◄	Facility Price ◄	Non-Facility Limiting Charge ◄	Facility Limiting Charge ◄	Conv Fact ◄
76706		Us abdl aorta screen aaa	A	1120201	\$100.23	NA	\$109.50	NA	33.8872
76706	26	Us abdl aorta screen aaa	A	1120201	\$25.51	\$25.51	\$27.87	\$27.87	33.8872
76706	TC	Us abdl aorta screen aaa	A	1120201	\$74.72	NA	\$81.63	NA	33.8872

Figure 7: Pricing Search Showing Modifiers 26 and TC

1 In Figure 7, the first row is blank in the modifier column. When a provider doesn't use a modifier with this code, it means this provider did both the technical and professional components of the procedure. The **Non-Facility Price** pricing amount is **\$100.23**, **NA** for the **Facility Price** and **\$109.50** for the **Non-Facility Limiting Charge**. When you add the amounts for the professional component (modifier 26) and the technical component (TC), in the Non-Facility Limiting Charge column, they equal the amount in row 1.

Under the **Facility Limiting Charge**, the search results show **NA**.

2 The second row gives information for CPT code 76706 submitted with modifier 26, which providers use when they perform only the professional component of the procedure. The search results display **\$25.51** for the **Non-Facility Price and Facility Price** and **\$27.87** for the **Non-Facility Limiting Charge** and **\$27.87** under the **Facility Limiting Charge**.

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- 3 The third row displays the results if you bill CPT code 76706 with HCPCS Level II modifier TC, Technical Component. TC means the provider billed for performing the ultrasound only, not for the interpretation. The search results display **\$74.72** under the **Non-Facility Price**, **NA** under the **Facility Price**, and **\$81.63** under Non-Facility Limiting Charge.

Under the **Facility Limiting Charge**, the search results show **NA**.

## Payment Policy Indicators Search

Let's use the Payment Policy Indicators Search to review the other information available in the PFS Look-Up Tool.

The Payment Policy Indicators include:

- Professional or technical modifiers if they apply
- The number of post-operative days included in a procedure
- Whether Medicare pays a code
- The level of physician supervision needed
- Whether you bill the service as a bilateral procedure

## Payment Policy Indicators Search Using a Code with an Applicable Professional or Technical Component

In **Figure 8**, we'll search using a code with related professional or technical modifiers and then, in **Figures 9-1** and **9-2**, we'll discuss the information given when you use a surgical code.

**Figure 8** shows a part of the Search results after choosing the following criteria:

- 2023
- Payment Policy Indicators
- Single HCPCS Code 76706
- All Modifiers

We used the same code, 76706, as we just did in a pricing search to compare the information given.

### Tip

You don't have to include a location or choose a MAC for the payment policy search because the policies shown are national. Learn more about these policies in the Medicare Claims Processing Manual, [Chapter 23](#). Remember that MACs may have other local policies that you'll need to research on their websites or in the [Medicare Coverage Database](#).

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**Tip**

For the technical component of certain diagnostic imaging procedures, Medicare bases payment on the lower of the Outpatient Prospective Payment System (OPPS) cap or fee schedule amount. The PFS search results don't show payment adjustments. The PFS Look-Up Tool displays full payments as well as OPPS payments. Also, the PFS Look-Up Tool can't display multiple procedures payment reductions (MPPRs) since too many combinations of HCPCS codes exist. For more information about MPPR, refer to the [MLN Matters® Articles List](#).

1	2	3	4	5	6					
HCPCS Code ▲	Modifier ▲	Short Description ▼	Proc Stat ▲	PCTC ▼	Global ▼	MULT SURG ▼	BILT SURG ▼	ASST SURG ▼	CO SURG ▼	Team SURG ▼
76706		Us abdl aorta screen aaa	A	1	XXX	0	0	0	0	0
76706	26	Us abdl aorta screen aaa	A	1	XXX	0	0	0	0	0
76706	TC	Us abdl aorta screen aaa	A	1	XXX	0	0	0	0	0

Figure 8: Payment Policy Indicators Search Results

- 1 **Modifier** – As in our pricing search for this code, the screen displays 3 rows, showing that providers can report code 76706, abdominal aorta ultrasound, with no modifier, modifier 26, or a TC modifier.

All the other columns in this example display the same information for each row under the column heading.

- 2 **Proc Stat** – This column, which shows Procedure Status Indicator, shows an A, meaning an active code in the Pricing Search.
- 3 **PCTC** – This column shows the Professional Component and Technical Component Indicators. In our example, 1 shows, which means the code is a diagnostic test or radiology service. You can use Modifiers 26 and TC when sending in this code on a claim.
- 4 **Global** – XXX shows in this example, which means the global surgery concept isn't applicable to this code.
- 5 **MULT SURG** – This column displays zeros, which means no payment adjustment rules for multiple procedures apply.

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- 6 BILT SURG** – This column displays zeros, which means the 150% payment adjustment for bilateral procedure doesn't apply. The PFS bases RVUs on the procedure done as a bilateral procedure. If you report the procedure with modifier 50 or report it twice on the same day (for example, with RT and LT modifiers with a 2 in the units field), Medicare bases payment for both sides on the lower of:
- The total actual charges for both sides
  - 100% of the fee schedule amount for a single code

All the other columns include the figure 0 or letters XXX showing that these indicators don't apply, or Medicare doesn't allow them for code 76706. Let's now do a search using a surgical code to see what information shows in these columns.

### Payment Policy Indicators Search Using a Surgical Code

Figure 9-1 below shows the PFS search results when searching for CPT code 47480, Incision of gallbladder.

Understanding information shown in these search results helps you understand policies such as bundled procedures or whether you need a CPT modifier with a code to get paid. This includes modifiers for assistant surgeons, bilateral surgery, and multiple procedures.

1	2	3	4	5	6	7	8	
HCPSC Code ▲	Modifier ▲	Short Description ▼	Proc Stat ▲	PCTC ▼	Global ▼	MULT SURG ▼	BILT SURG ▼	ASST SURG ▼
47480		Incision of gallbladder	A	0	090	2	0	2

Figure 9.1: Payment Policy Indicators Search Using a Surgical Code

- 1 Modifier** – The Modifier column has no information listed.
- 2 Short Description** – This column shows a short description of the code.
- 3 Proc Stat** – This column displays an A showing this code is active.
- 4 PCTC** – This column displays a 0. The 0 indicator refers to codes that describe physician services. Examples include visits, consultations, and surgical procedures. The concept of PC and TC don't apply since the PFS doesn't split physician services into professional and technical components.
- 5 Global** – This field gives the time frames that apply to payment for each surgical procedure or another indicator that says whether it applies to the global concept of the service.

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Figure 9-1 lists 090 which means code 47480 is major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule payment amount.

**6 MULT SURG** – This column shows which payment adjustment rule for multiple procedures (including certain physical therapy procedures) applies to the service. In Figure 9-1, a 2 shows 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
- 50% of the fee schedule amount for the second through the fifth highest valued procedures

For a complete listing of indicators, refer to the Medicare Claims Processing Manual, Chapter 23. Review the Addendum in [Chapter 23](#), Section 50.6 for the latest information or refer to the Appendix in the back of this booklet.

Because Medicare only updates Chapter 23 every year, it's important to also review MLN Matters® articles and other information from CMS.

For Medicare Physician Fee Schedule Database (MPFSDB) file layout information for years before 2018, choose the [Historical MPFSDB Layouts](#) link from the Downloads section of the [Physician Fee Schedule](#) webpage

The Medicare system reviews other procedures and considers them for payment.

**7 BILT SURG** – This field gives an indicator for bilateral services subject to a payment adjustment. CMS defines Bilateral surgeries as procedures done on both sides of the body during the same operative session or on the same day. In Figure 9-1, we see 0, which means the 150% payment adjustment for bilateral procedures doesn't apply. If you report this procedure with modifier 50 or with modifiers RT and LT, Medicare bases payment for the 2 sides on the lower of:

- The total actual charge for both sides
- 100% of the fee schedule amount for a single code

**8 ASST SURG** – This column shows whether the PFS pays assistants at surgery. Figure 9-1 shows a 2, which means payment restriction for assistants at surgery doesn't apply to this procedure.

9	10	11				
BILT SURG	ASST SURG	CO SURG	Team SURG	PHYS SUPV	DIAG Imaging Family IND	
0	2	1	0	09	99	

Figure 9.2: Payment Policy Indicators Search Using a Surgical Code

- 9 **CO SURG** – This field in Figure 9-2 includes an indicator 1, which means the PFS pays co-surgeons (each of a different specialty). Medicare needs supporting documentation to prove the medical necessity of 2 surgeons for this procedure.
- 10 **Team SURG** – This field in Figure 9-2 shows indicator 0, meaning Medicare rules don't allow a team of surgeons (more than 2 surgeons of different specialties) for this procedure.
- 11 **PHYS SUPV** – Health care providers must do diagnostic tests, with certain exceptions, under the supervision of a physician. This field shows the level of supervision needed. In this example, 09 means that this concept doesn't apply.

## Relative Value Unit (RVU) & Geographic Practice Cost Index (GPCI) Search

Before starting an RVU or GPCI search, it's important to understand the definition of RVUs and GPCIs. The PFS bases the pricing for each code on the following 3 parts:

- 1.) **RVU** – RVUs show the resources needed to provide a physician fee schedule service. The PFS uses 3 separate RVUs to calculate payment under:
  - Work RVUs show the time and intensity associated with providing a service and equal about 50% of the total payment
  - Practice Expense (PE) RVUs show costs like renting office space, buying supplies and equipment, and staff
  - Malpractice (MP) RVUs show the relative costs of purchasing malpractice insurance

**Tip**

If you search for code 99215 instead of 99214, you'll see a 2.80 in the Work RVU column, showing a higher relative value. Look back at the pricing search we did earlier in this booklet with these 2 codes. You'll see that the payment for 99215 is higher than for 99214. This helps you understand the impact of RVUs on the fee schedule amount.

- 2.) **GPCI** – To calculate the payment for every provider's service, the Medicare system adjusts parts of the fee schedule (physician work, PE, and MP RVUs) with a GPCI. The GPCIs show the costs of physician work, practice expense, and malpractice expense in a specific area compared to the national average costs for each part.

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- 3.) **Conversion Factor (CF)** – Typically, CMS updates the CF each year. Until 2015, CMS used the Medicare Economic Index (MEI) adjusted up or down to calculate the annual update, depending on how actual expenditures compared to a target rate called the sustainable growth rate (SGR). The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repealed the SGR update formula for payments under the PFS. Effective January 1, **2023**, the Physician Fee Schedule update factor is 0.00% and the CF is **33.0607**. The application of the CF converts RVUs to dollar amounts.

Find more information about RVUs and GPCIs in the annual [Medicare Physician Fee Schedule Final Rule](#). We'll first show an RVU search and then show a GPCI search.

### RVU Search

Using the PFS Look-Up Tool, we chose:

- **2023**
- Relative Value Units for the Type of Information
- 99214 for the Single HCPCS Code
- All Modifiers

Figure 10 shows a part of the screen displayed after making these choices. This figure shows the following 5 columns (from the many columns displayed on the website) that interest most providers:

id	Work RVU	NA Flag for Trans Non-FAC PE RVU	Transitioned Non-FAC PE RVU	NA Flag for Fully IMP Non-FAC PE RVU	Fully Implemented Non-FAC PE RVU	NA Flag for Trans Facility PE RVU	Transitioned Facility PE RVU	NA Flag for Fully IMP FAC PE RVU	Fully Implemented Facility PE RVU	MP RVU
	1.92		1.73		1.73		0.82		0.82	0.14

Figure 10: RVU Search

The PFS Look-Up Tool shows the following Practice Expense (PE) RVUs displayed in 5 columns:

- 1 **1.73** under **Transitioned Non-FAC PE RVU**
- 2 **1.73** under **Fully Implemented Non-FAC PE RVU**

- 3 0.82 under **Transitioned Facility PE RVU**
- 4 0.82 under **Fully Implemented Facility PE RVU**
- 5 **MP RVU** (Malpractice RVU) has a value of **0.14** in this example.

In **Figure 10**, the **Work RVU** column is 1.92.

[Chapter 23](#) of the Medicare Claims Processing Manual includes information on the other columns displayed in an RVU search.

**Tip**

To see how MP RVUs vary, enter a different code in an RVU search and compare to this result for 99214.

**GPCI Search**

Finally, let's do a GPCI search for **2023**. Remember, we don't enter a HCPCS code here because the same GPCI applies for all codes in an area. We'll decide whether we want a GPCI for:

- National Payment Amount
- Specific MAC
- Specific Locality
- All MACs

**Figure 11** shows the screen for GPCIs when choosing All MACs.

MAC Locality ^	MAC Description ⇅	Locality Description ⇅	GPCI Work ⇅	GPCI PE ⇅	GPCI MP ⇅
0000000	NATIONAL	NATIONAL	1.000	1.000	1.000
0111205	NORTHERN CALIFORNIA	SAN FRANCISCO-OAKLAND-BERKELEY (SAN FRANCISCO CNTY)	1.082	1.374	0.452
0111206	NORTHERN CALIFORNIA	SAN FRANCISCO-OAKLAND-BERKELEY (SAN MATEO CNTY)	1.082	1.374	0.452
0111207	NORTHERN CALIFORNIA	SAN FRANCISCO-OAKLAND-BERKELEY (ALAMEDA/CONTRA COSTA CNTY)	1.082	1.374	0.452
0111209	NORTHERN CALIFORNIA	SAN JOSE-SUNNYVALE-SANTA CLARA (SANTA CLARA CNTY)	1.098	1.409	0.417
0111251	NORTHERN CALIFORNIA	NAPA	1.051	1.265	0.513
0111252	NORTHERN CALIFORNIA	SAN FRANCISCO-OAKLAND-BERKELEY (MARIN CNTY)	1.082	1.374	0.487
0111253	NORTHERN CALIFORNIA	VALLEJO	1.051	1.265	0.487
0111254	NORTHERN CALIFORNIA	BAKERSFIELD	1.027	1.079	0.694
0111255	NORTHERN CALIFORNIA	CHICO	1.021	1.079	0.579

**Figure 11:** GPCI Search



Remember that MAC Locality 0000000 is national (see [Figure 11](#)). The value of 1.000 shows in each of the 3 GPCI columns: GPCI WORK, GPCI PE, and GPCI MP. For specific localities, any values higher or lower than 1.000 mean higher or lower geographic classification values than the national average.

For our example, location 0111205 shows a value of **1.082**, **1.374**, and **0.452** in these 3 separate columns.

## Conclusion

In this booklet, we've shown several searches using the PFS Look-Up Tool. For more information, see the Resources section on page 33.

Print out the Physician Fee Schedule (PFS) Quick Reference Search Guide on page 32 of this booklet for a step-by-step summary of how to use the PFS Look-Up Tool.

## Appendix

This information is from the Medicare Claims Processing Manual, [Chapter 23](#). For Medicare Physician Fee Schedule Database (MPFSDB) file layout information for years before 2018, choose the [Historical MPFSDB Layouts](#) link from the Downloads section of the [Physician Fee Schedule](#) webpage.

### Tip

Because Medicare only updates Chapter 23 every year, it's important to also review MLN Matters® articles and other information from CMS.

## Status Indicators

**A** = Active code. Medicare pays these codes separately under the physician fee schedule (PFS), if covered. Codes with this status include RVUs and payment amounts. The presence of an A indicator doesn't mean that Medicare has made a national coverage determination about the service. A/B MACs (B) stay responsible for coverage decisions in the absence of a national Medicare policy.

**B** = The PFS always bundles payment for covered services into payment for other services not specified. No RVUs or payment amounts exist for these codes and Medicare never makes separate payment. When Medicare covers these services, we include payment for them in the payment for the services to which they're incident. An example is a telephone call from a hospital nurse about the care of a patient.

**C** = A/B MACs (B) price the code. A/B MACs (B) set up RVUs and payment amounts for these services, generally on an individual case-by-case basis following review of documentation such as an operative report.

**E** = Excluded from physician fee schedule by regulation. CMS excludes these codes for items or services from the fee schedule payment by regulation. The PFSDB Status Indicators table doesn't show any RVUs or payment amounts and makes no payment under the fee schedule for these codes. Payment for them, when covered, continues under reasonable charge procedures.

**I** = Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. This code isn't 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 help with the identification of anesthesia services.)

**L** = Local codes. A/B MACs (B) will apply this status to all local codes in effect on January 1, 1998, or those later approved by central office for use. A/B MACs (B) will complete the RVUs and payment amounts for | these codes.

**M** = Measurement codes. Used for reporting purposes only.

**N** = Non-covered service. Medicare carries these codes on the HCPCS tape as noncovered services.

**P** = Bundled and excluded codes. No RVUs exist for these services. Medicare doesn't make separate payment for them under the fee schedule. If we cover the item or service as incident to a physician service and you provide it on the same day as a physician service, we bundle payment for it into the payment for the physician service to which it's incident. An example is an elastic bandage a physician provided incident to a physician service. If Medicare covers the item or service as other than incident to a physician service, we exclude it from the fee schedule (for example, colostomy supplies) and pay it under the other payment provision of the Social Security Act.

**Q** = Therapy functional information code. Used for reporting purposes only. This indicator is no longer effective starting with the 2020 fee schedule as of January 1, 2020.

**R** = Restricted coverage. Special coverage instructions apply.

**T** = RVUs and payment amounts exist for these services. Medicare only pays these codes if no other services are payable under the physician fee schedule (PFS) billed on the same date by the same provider. If Medicare pays the same provider for any other services billed on the same date under the PFS, we bundle these services into the physician services.

**X** = Statutory exclusion. These codes stand for an item or service that isn't in the legal definition of physician services for fee schedule payment purposes. The PFSDB Status Indicators table shows no RVUs or payment amounts for these codes and makes no payment under the PFS. Examples: Medicare excludes ambulance services and clinical diagnostic laboratory services.

## Global Surgery

This field gives the postoperative timeframes that apply to payment for each surgical procedure or another indicator that describes how the global concept applies to the service.

**000** = Medicare includes endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only in the fee schedule payment amount. Medicare doesn't generally pay evaluation and management (E/M) services on the day of the procedure.

**010** = Medicare includes minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period in the fee schedule amount. Medicare doesn't generally pay E/M services on the day of the procedure and during this 10-day postoperative period.

**090** = Medicare includes 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 doesn't apply.

**XXX** = Global concept doesn't apply.

**YYY** = A/B MAC decides whether global concept applies and establishes postoperative period at time of pricing.

**ZZZ** = Code related to another service. Medicare always includes it in the global period of the other service.

**Note:** Physician work is associated with intra-service time and sometimes the post service time.

## Preoperative Percentage (Modifier 56)

This field has the percentage (shown in decimal format) for the preoperative part of the global package. For example, 10% shows as 010000. The total of the preoperative percentage, intraoperative percentage, and the postoperative percentage fields will usually equal 1. Any variance is slight and results from rounding.

## Intraoperative Percentage (Modifier 54)

This field has the percentage (shown in decimal format) for the intraoperative part of the global package including postoperative work in the hospital. For example, 63% shows as 063000. The total of the preoperative percentage, intraoperative percentage, and the postoperative percentage fields will usually equal 1. Any variance is slight and results from rounding.

## Postoperative Percentage (Modifier 55)

This field has the percentage (shown in decimal format) for the postoperative part of the global package that's provided in the office after discharge from the hospital. For example, 17% shows as 017000. The total of the preoperative percentage, intraoperative percentage, and the postoperative percentage fields will usually equal 1. Any variance is slight and results from rounding.

## Professional Component (PC) or Technical Component (TC) Indicator

**0** = Physician service codes. This indicator describes physician service codes. Examples include visits, consultations, and surgical procedures. The concept of PC or TC doesn't apply since Medicare doesn't split physician services into professional and technical components. You can't use Modifiers 26 and TC with these codes. The total Relative Value Units (RVUs) include values for physician work, practice expense, and malpractice expense. Medicare includes physician service codes with no work RVUs.

**1** = Diagnostic tests or radiology services. This indicator describes diagnostic tests codes (for example, pulmonary function tests or therapeutic radiology procedures such as radiation therapy). These codes generally have both a professional and technical component. You can use Modifiers 26 and TC 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 part of chosen diagnostic tests for which there's 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. You can't use modifiers 26 and TC 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 describes stand-alone codes that describe the technical component (like staff and equipment costs) of chosen diagnostic tests for which there's 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 describes codes that Medicare covers only as diagnostic tests and don't have a related professional code. You can't use Modifiers 26 and TC 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 describes stand-alone codes that have associated codes naming:

- The professional component of the test only
- The technical component of the test only

You can't use modifiers 26 and TC 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 equal the sum of the total RVUs for the professional and technical components only codes together.

**5** = Incident to codes. This indicator describes codes for services covered incident to a physician's service when auxiliary personnel the physician employs and who work under their direct supervision provides them.

MACs may not make payment for these services when auxiliary personnel provide them to hospital inpatients or patients in a hospital outpatient department. You can't use modifiers 26 and TC with these codes.

**6** = Laboratory physician interpretation codes. This indicator describes clinical laboratory codes for interpretations by laboratory physicians. Medicare pays separately for these services. Medicare pays the laboratory physician for doing the tests under the lab fee schedule. You can't use modifier TC 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. Medicare may not make payment if an independently practicing physical therapist or occupational therapist provided the service to a hospital outpatient or inpatient.

**8** = Physician interpretation codes. This indicator describes the professional component of clinical laboratory codes. Medicare may make separate payment only if the physician interprets an abnormal smear for a hospital inpatient. This applies only to code 85060. Medicare doesn't recognize TC billing because we make payment for the underlying clinical laboratory test to the hospital, generally through the Prospective Payment System (PPS) rate. Medicare doesn't make payment for code 85060 provided to hospital outpatients or non-hospital patients. Medicare pays the physician interpretation through the clinical laboratory fee schedule (CLFS) payment for the clinical laboratory test.

**9** = Concept of a professional or technical component doesn't apply.

### Multiple Procedure (CPT Modifier 51)

This indicator shows which payment adjustment rule for multiple procedures applies to the service.

**0** = No payment adjustment rules for multiple procedures apply. If you report the procedure on the same day as another procedure, payment is based on the lower of:

- The actual charge
- 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 applied 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, Medicare ranks the procedures by the fee schedule amount and applies the correct reduction to this code (100%, 50%, 25%, 25%, 25%, and by report). MACs base payment on the lower of:

- The actual charge
- The fee schedule amount reduced by the right percentage

**2** = Standard payment adjustment rules for multiple procedures apply. If you report the procedure on the same day as another procedure with an indicator of 1, 2, or 3, MACs rank the procedures by fee schedule amount and apply the reduction to this code (100%, 50%, 50%, 50%, 50%, and by report). MACs base payment on the lower of:

- The actual charge
- The fee schedule amount reduced by the correct percentage

**3** = Special rules for multiple endoscopic procedures apply if you bill the procedure with another endoscopy in the same family (that is, another endoscopy that has the same base procedure). You show the base procedure for each code with this indicator in the endoscopic base code field. The multiple endoscopy rules apply to a family before ranking the family with other procedures done on the same day (for example, if you report multiple endoscopies in the same family on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). If you report an endoscopic procedure with only its base procedure, Medicare doesn't pay the base procedure separately. We include payment for the base procedure in the payment for the other endoscopy.

**4** = Diagnostic imaging services subject to the MPPR. TC of diagnostic imaging services subject to a 50% reduction of the second and subsequent imaging services furnished by the same physician (or by multiple physicians in the same group practice, for example, same group National Provider Identifier [NPI]) to the same patient on the same day, effective for services July 1, 2010, and after. PC of diagnostic imaging services are subject to a 5% payment reduction of the second and subsequent imaging services effective January 1, 2017.

Medicare doesn't include multiple procedure indicator 5 in this file, since the indicator stands for the therapy multiple procedure payment reduction which never applies to professional service revenue codes. Medicare doesn't include multiple procedure indicators 6 and 7 in this file, since in these cases the reduction only applies to technical component services. On CAH claims, Medicare pays technical components on a cost basis, and they aren't subject to the reductions.

### Tip

Refer to [MLN Matters® Article MM9647](#) about the 5% reduction to the PC for certain diagnostic imaging procedures.

**9** = Concept doesn't apply.

The payment Indicator file doesn't include codes with RVUs equal to zero. These codes may have multiple procedure indicators not shown.

### Bilateral Surgery Indicator (CPT Modifier 50)

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

**0** = 150% payment adjustment for bilateral procedures doesn't apply. The bilateral adjustment isn't right for codes in this category because of:

- Physiology or anatomy
- The code descriptor specifically states that it's a unilateral procedure and there's an existing code for the bilateral procedure

**1** = 150% payment adjustment for bilateral procedures applies. If you bill a code with the bilateral modifier, Medicare bases payment for these codes (when reported as bilateral procedures) on the lower of:

- The total actual charge for both sides
- 150% of the fee schedule amount for a single code

If you report a code as a bilateral procedure with other procedure codes on the same day, Medicare applies the bilateral adjustment before applying any applicable multiple procedure rules.

**2** = 150% payment adjustment for bilateral procedure doesn't apply. Medicare bases RVUs on the procedure providers do as a bilateral procedure. Medicare bases RVUs on a bilateral procedure because:

- The code descriptor specifically states that the procedure is bilateral
- The code descriptor states that the procedure may be performed either unilaterally or bilaterally
- You usually do the procedure as a bilateral procedure

**3** = The usual payment adjustment for bilateral procedures doesn't apply. Services in this category are generally radiology procedures or other diagnostic tests which aren't subject to the special payment rules for other bilateral procedures. If you bill the procedure with modifier 50, Medicare bases payment on the lesser of:

- The actual charge for each side
- 100% of the fee schedule amount for each side

If you report a procedure as a bilateral procedure and with other procedure codes on the same day, the fee schedule amount for a bilateral procedure is determined before applying any applicable multiple procedure rules.

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

**9** = Concept doesn't apply.

### **Assistant at Surgery (Modifiers AS, 80, 81 and 82)**

This field gives an indicator for services where Medicare never pays an assistant at surgery.

**0** = Payment restriction for assistants at surgery applies to this procedure unless you send in supporting documentation to prove medical necessity.

**1** = Statutory payment restriction for assistants at surgery applies to this procedure. Medicare may not pay assistants at surgery.

**2** = Payment restriction for assistants at surgery don't apply to this procedure. Medicare may not pay assistants at surgery.

**9** = Concept doesn't apply.

### **Co-Surgeons (Modifier 62)**

This field gives an indicator for services for which Medicare may pay 2 surgeons, each in a different specialty.

**0** = Co-surgeons not allowed for this procedure.



**1** = Co-surgeons could be paid. Medicare requires supporting documentation to prove medical necessity of 2 surgeons for the procedure.

**2** = Co-surgeons allowed. Medicare doesn't require documentation if you meet the 2 specialty requirements.

**9** = Concept doesn't apply.

### Team Surgeons (Modifier 66)

This field gives an indicator for services for which Medicare may pay team surgeons.

**0** = Team surgeons not allowed for this procedure.

**1** = Team surgeons could be paid. Medicare requires supporting documentation to prove medical necessity of a team. Paid by report.

**2** = Team surgeons allowed. Pay by report.

**9** = Concept doesn't apply.

### Endoscopic Base Codes

This field shows an endoscopic base code for each code with a multiple surgery indicator of 3.

### Diagnostic Imaging Family Indicator

**88** = Subject to the reduction for diagnostic imaging (effective for services January 1, 2011, and after).

**99** = Concept doesn't apply.

### Physician Supervision of Diagnostic Procedures

Medicare uses this field in post payment review.

**01** = Procedure must be furnished under the general supervision of a physician.

**02** = Procedure must be furnished under the direct supervision of a physician.

**03** = Procedure must be furnished under the personal supervision of a physician. A registered radiologist assistant (RRA) who's certified and registered by The American Registry of Radiologic Technologists (ARRT) or a radiology practitioner assistant (RPA) certified by the Certification Board for Radiology Practitioner Assistants (CBRPA), can do diagnostic imaging procedures under direct supervision. State law must authorize the RRA or RPA to provide the procedure.

**04** = Physician supervision policy doesn't apply when a qualified, independent psychologist or a clinical psychologist furnishes a procedure. Otherwise, a physician must generally supervise the procedure.

**05** = Not subject to supervision when a qualified audiologist, physician, or nonphysician practitioner furnishes the procedure personally. A physician must directly supervise those parts of the test that a qualified technician may provide when proper.

**06** = A physician or physical therapist (PT) certified by the American Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiological clinical specialist and allowed to provide the procedure under state law, must personally do the procedure. A PT with ABPTS certification may also do the procedure without physician supervision.

**21** = Procedure may be furnished by a technician with certification under general supervision of a physician. Otherwise, a physician must directly supervise the procedure. A PT with ABPTS certification may also do the procedure without physician supervision.

**22** = May be furnished by a technician with on-line real-time contact with a physician.

**66** = May be personally furnished by a physician or by a PT with ABPTS certification and certification in this specific procedure.

**6A** = Supervision standards for level 66 apply. Also, the PT with ABPTS certification may personally supervise another PT, but only the PT with ABPTS certification may bill.

**77** = Procedure must be furnished 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. Also, the PT with ABPTS certification may personally supervise another PT, but only the PT with ABPTS certification may bill.

**09** = Concept doesn't apply.

### Diagnostic Imaging Family Indicator

For services effective January 1, 2011, and after, family indicators 01 - 11 won't populate.

**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 doesn't apply.

## Physician Fee Schedule (PFS) Quick Reference Search Guide

[Search the Physician Fee Schedule](#) and follow the steps below to complete the search process.

### Step 1: Begin Search

Click [Begin Search](#)

### Step 2: Year

Choose the PFS year for your search

### Step 3: Type of Information

Choose 1 of the following 5 types of information related to your search:

- Pricing Information
- Payment Policy Indicators
- Relative Value Units (RVUs)
- Geographic Practice Cost Index (GPCI)
- All

#### Tip

If you choose Payment Policy Indicators from the Type of Information dropdown menu, no MAC drop down menu appears.

#### Step 4: HCPCS Criteria

Choose 1 of the following 3 alternatives (This step won't appear if you chose the GPCI Type of Information in step 2 above):

- Single HCPCS Code – Click on Single HCPCS Code and type the code in the HCPCS Code field that appears at the bottom of the page
- List of HCPCS Codes – Click on List of HCPCS Codes and enter up to 5 codes in the HCPCS Code fields that appear at the bottom of the page
- Range of HCPCS Codes – Click on Range of HCPCS Codes and enter starting and ending procedure codes for the code range in the HCPCS Code fields that appear at the bottom of the page

Then, choose a modifier value from the Modifier dropdown menu at the bottom of the page.

#### Tip

We recommend using a small range of codes. It takes longer for a larger range to populate.

#### Step 5: Medicare Administrative Contractor (MAC)

Choose 1 of the following 4 alternatives (This step only appears if you choose Pricing Information, GPCI, or All for the Type of Information in step 2):

- National Payment Amount – Shown with a MAC locality code of 0000000.
- Specific MAC – Click Specific MAC, then start typing the name of the region or state you'd like. Once you start typing, MAC regions will appear below the box. Choose your MAC from the list that appears below the box.
- Specific Locality – Click Specific Locality, then start typing the name of the region or state you'd like. Once you start typing, MAC localities will appear below the box. Choose your locality from the list that appears below the box.
- All MACs – Displays information for the entire nation. Results include the national payment amount, as well as all MAC localities.

#### Step 6: Click **Search Fees** to see your search results

## Resources

- [PFS Federal Regulation Notices](#)
- [Physician Fee Schedule](#)
- [CMS Forms List](#)
- [How to Use the Medicare Coverage Database](#) educational tool
- [How to Use the Medicare National Correct Coding Initiative \(NCCI\) Tools](#) booklet
- [Medicare Benefit Policy Manual, Chapter 15](#)
- [Medicare Claims Processing Manual, Chapter 4](#)

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