

2009

Part B Carrier Summary Data File

Information for Users

The information in Part B Carrier Summary Data Files is limited to Medicare Fee-For-Service (FFS) Part B Physician/Supplier data. It does not include information on physician/supplier services for beneficiaries in the managed care portion of the program (Medicare Advantage).

HCPCS Coding Systems

The HCPCS is divided into two principal subsystems, referred to as Level I and Level II of the HCPCS.

Level I of the HCPCS is comprised of CPT-4, a numeric coding system maintained by the AMA. The CPT-4 is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. These health care professionals use the CPT-4 to identify services and procedures for which they bill public or private health insurance programs. Level I of the HCPCS, the CPT-4 codes, does not include codes needed to separately report medical items or services that are regularly billed by suppliers other than physicians.

Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT-4 codes, such as ambulance services and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) when used outside a physician's office.

About the Datasets

The data sets are summarized at the carrier level by meaningful HCPCS/CPT code ranges. The data set name contains the year followed by a carrier number. Brief descriptions for the code ranges and modifiers are provided in the readme file (see Numeric and Alpha numeric Code Ranges and Descriptions sections below). Within each code range are, procedural, condition, or description subheadings. Each data set displays the allowed services, allowed charges, and payment amounts by HCPCS/CPT codes and prominent modifiers if applicable. A sample data set is shown below:

Part B Data for Completed Year 2004

Carrier 00510

HCPCS MODIFIER DESCRIPTION ALLOWED SERVICES ALLOWED CHARGES PAYMENT					
00100	AA	ANESTHESIA	5,580	\$1,187,161	\$935,402
	AD		168	\$13,287	\$9,996
	QK		5,102	\$620,723	\$489,280
	QZ		2,347	\$415,336	\$327,821
	OTHER		5,944	\$654,184	\$518,378
	TOTAL		19,141	\$2,890,692	\$2,280,878

Modifiers are defined at the end of this readme file. These reports only illustrate the modifiers when more than one bill can be submitted for one procedure. The surgeon, ASC, and assistant at surgery can all bill separately using the same HCPCS/CPT. Utilization for modifiers not affected by duplicative counting is collapsed into the other category on the reports. Therefore, not all CMS published modifiers are illustrated.

In example one below, surgery code 66984 (cataract surgery w/iol), the primary surgeries are shown in the modifier field labeled "other". The allowed services billed by the assistant at surgery (modifier 80's) were three and the ASC facility (modifier SG) billed a total of 934,343 allowed services. Averages should be calculated by dividing the total allowed charges or total payments by the "other" service counts, which represent the actual number of procedures. Averages may also be calculated by individual modifiers. The ASC and assistants reimbursement would be substantially lower than that of the surgeon.

Total allowed charges / Other allowed services = Average Allowed Charge
 \$2,020,413,040 / 2,108,557 = \$958

Total payment / Other allowed services = Average payment
 \$1,603,276,188 / 2,108,557 = \$760

Example 1:

Part B Data for Completed Year 2004

Carrier 00510

HCPCS MODIFIER DESCRIPTION ALLOWED SERVICES ALLOWED CHARGES PAYMENT

66984 SG	934,343	\$884,906,157	\$702,786,098
80'S	N/A	\$296	\$157
OTHER	2,108,557	\$1,135,506,587	\$900,489,934
TOTAL	3,042,903	\$2,020,413,040	\$1,603,276,188

Example two shows radiology code 71010 (chest x-ray). The global modifier includes both the technical and professional portion for the code, while the 26 modifier shows the frequency with which the professional component billed separately and the TC modifier shows the times the technical component billed separately. To establish a meaningful count of allowed services add the global count to the count for the 26 modifier. Do not include the allowed service counts for the TC modifier as these services are duplicative. The most appropriate averages are that of the global modifier.

Total allowed charges / Total allowed services = average allowed charge

\$15,965,081 / 634,622 = \$25

Total payments / Total allowed services = average payment

\$11,850,757 / 634,622 = \$19

Example 2:

Part B Data for Completed Year 2004

Carrier 00510

HCPCS MODIFIER DESCRIPTION	ALLOWED SERVICES	ALLOWED CHARGES	PAYMENT
71010 TC	369,430	\$6,374,489	\$4,855,156
26	16,700,762	\$150,052,259	\$117,355,518
GLOBL	634,622	\$15,965,081	\$11,850,757
TOTAL	17,704,814	\$172,391,829	\$134,061,430

Services for medicine, radiology, pathology and laboratory appear in the numeric respective code ranges, as well as some alpha numeric code ranges, specifically certain G, P and Q codes.

Numeric Code Ranges and Descriptions

Anesthesia (00100 – 01999): Anesthesia services are represented by the code range 00100-01999. The codes represent general and supplementation anesthesia, as well as any other procedure an anesthesiologist deems optimal. These services include preoperative and postoperative visits, care during the procedure, the administration of fluids, and the usual monitoring services.

Integumentary (10040-19499): Procedures and services to the Integumentary System, which specializes in skin and nails, are designated by the code range 10040-19499. The category is broken down into subcategories, such as Skin, Subcutaneous, and Accessory Structures; Nails; Repair; and Breast. These subcategories are further detailed into more specific locations or procedures, and then finally assigned a code that designates the specific procedure.

Musculoskeletal (20000-29999): In the Musculoskeletal code range, 20000-29999, categories are broken down into broad procedures, such as General; Neck (Soft Tissue) and Thorax; Spine; Upper Arm and Elbow; etc. These categories are again divided into more specific procedures, such as Incision under the Pelvis and Hip Joint category. The specific subcategories are separated into code ranges, which designate the type of procedure performed.

Respiratory (30000-32999): Respiratory code ranges run from 30000-32999 and are broken into the broad categories Nose, Accessory Sinuses, Larynx, Trachea and Bronchi, and Lungs and Pleura. These categories are divided into more specific procedures, which are broken into specific codes that denote the type of procedure completed and the place on the body it was performed.

Cardiovascular (33010-37799): The Cardiovascular code range, 33010-37799 is separated into two broad categories, Heart & Pericardium and Arteries & Veins. These categories are then further broken down into specific areas of the body on which the procedure was performed. Some subcategories are further divided, such as the subcategory Cardiac Valves, which was broken into smaller, more specific areas such as the Aortic Valves and Mitral Valve. Procedures in each subcategory are then assigned a specific code that reveals the type of procedure.

Lymphatic (38100-38999): In the Lymphatic code range, 38100-38999, the only category included is Spleen, which is divided into the three subcategories, Excision, Repair, and Laparoscopy. These subcategories are further separated into code ranges that denote the specific procedure.

Mediastinum (39000-39599): The Mediastinum code range, 39000-39599, is divided into two categories, Mediastinum and Diaphragm, which are broken down into more specific subcategories, such as Incision and Excision. In these subcategories, codes are assigned for specific procedures.

Digestive System (40490-49999): The Digestive System code range covers codes 40490-49999. Codes cover procedures relating, but not limited to Lips, Vestibule of Mouth, Palate, Tongue and floor of mouth, Esophagus, Tonsils, Intestines (excluding rectum), Appendix, Anus,

Abdomen, etc. These categories are broken down into subcategories describing a general procedure, then are further noted by specific codes, which detail the procedure that was employed.

Urinary (50010-53899): Codes relating to the urinary system run from 50010-53899. The codes are broken into categories, which include Kidney, Ureter, Bladder, Transurethral Surgery, and Urethra. These categories are further divided into subcategories, which describe general procedures. Procedures in the subcategories are broken into specific codes that describe the procedure performed.

Male Genital (54000-55899): The Male Genital code range runs from 54000-55899. The code range is divided into categories, which describe a general area where the procedure was performed. The categories are then divided into subcategories that describe general procedures; specific procedures in the subcategories are assigned codes that detail the course of action.

Female Genital (56405-58999): The Female Genital code range runs from 56405-58999. The code range is divided into categories, which describe a general area where the procedure was performed. The categories are then divided into subcategories that describe general procedures; specific procedures in the subcategories are assigned codes that detail the course of action. Code ranges also include In Vitro Fertilization.

Maternity (59000-59899): Maternity services are represented by five digit codes ranging from 59000-59899. The codes in this range correspond to services that are provided in uncomplicated maternity cases, including antepartum care, delivery services, and postpartum care. Any medical complications of pregnancy are listed in the Medicine or Evaluation & Management Sections. Surgical complications of pregnancy are included in the Surgery section.

Endocrine System (60000-64999): Code ranges for the Endocrine System run from 60000-64999. This code range is broken into two subcategories, the Thyroid Gland and the Parathyroid; Thymus, Adrenal Glands, and Carotid Body. These categories are divided into subcategories based on general procedures, and specific procedures are assigned a code.

Eye (65091-68899): The eye code range, which runs from 65091-68899, is broken down into categories based on the part of the eye. These categories are then divided into subcategories based on general procedures. Specific procedures in the subcategories are given a code.

Ear (69000-69990): The Auditory system code ranges run from 69000-69990 and are broken into four categories, External Ear, Middle Ear, Inner Ear, and Temporal Bone (Middle Fossa Approach). These four categories are divided into subcategories based on general procedures, and procedures in these subcategories are assigned a specific code.

Radiology (70010-79999): Radiology codes run from 70010-79999. In the radiology category, the procedures are divided into categories, Diagnostic Radiology, Diagnostic Ultrasound, Radiation Oncology, and Nuclear Medicine. These four categories are then divided into subcategories based on the part of the body, such as Gastrointestinal Tract and Abdomen. In the subcategories, the specific procedures are assigned an individual code.

Path/Lab (80048-89399): Pathology and Laboratory services are represented by a number in the code range 80048-89399; all services are administered by a physician or technicians under the supervision of a physician. Services provided in this code range include but are not limited to organ or disease panels, drug testing, evocative/suppression testing, consultations with a Clinical Pathologist, Urinalysis, Chemistry, Molecular Diagnostics, Anatomic Pathology, Microbiology Infectious Agent Detection, Infectious Agent Antibodies, Cytopathology, and Surgical Pathology.

Medicine (90281-99199): The Medicine code range, 90281-99199, is divided into types of treatment administered, such as Immune Globulins, Psychiatry, and Dialysis. The categories are then divided into the general type of service or where the procedure was performed (Inpatient, Residential, or Partial Hospital). Some subcategories are further divided to describe the general type of procedure performed. Specific procedures are then assigned a code that describes the type of services performed.

Evaluation and Management (99201-99499): The Evaluation and Management codes run from 99201-99499 and are divided into broad categories. The broad categories range from office visits, hospital visits, consultations, prolonged services, nursing facility services, newborn care, etc.

Alpha Numeric Code Ranges and Descriptions

A0000-A0999: Transportation Services including Ambulance

A4000-A8999: Medical and Surgical Supplies

A9000-A9999: Administrative, Miscellaneous and Investigational

B4000-B9999: Enteral and Parental Therapy

C00001-C9999: Not applicable

D0100-D9999: Dental Procedures

E0100-E9999: Durable Medical Equipment

G0000-G9999: Procedures/Professional Services

H0000-H9999: Not applicable

J0000-J8499: Drugs other than Chemotherapy

J8521-J9999: Chemotherapy Drugs

K0000-K9999: Durable Medical Equipment Regional (DMERCS)

L0100-L4999: Orthotic Procedures

L5000-L9999: Prosthetic Procedures

M0000-M0999: Services

P2000-P2999: Pathology/Lab Tests

Q0000-Q9999: National Codes Assigned by CMS on a Temporary Basis

R0000-R5999: Diagnostic Radiology Services

S0000-S9999: National Codes Established for Private Payer Use

V0000-V2799: Vision Services

V5000-V5299: CMS Assignment of Hearing Services

V5300-V5399: Speech-Language Pathology Services Miscellaneous Code Range Local Codes W, X, Y, Z, 10021, 10022 and Tracking Codes Note: all local codes deleted as of 12/31/04

Modifiers

Modifiers denote that a certain procedure/service has been altered by a particular circumstance, but not changed in its definition, therefore the same code is used and a modifier is added to denote what has been altered.

In the reports, the line item shown as 80's is a sum of services for modifiers 80, 81 and 82.

-80

Codes with the modifier –80 indicates that an assistant surgeon aided with the procedure.

-81

A code with an -81 modifier indicates that a minimum surgical assistant was used during the procedure.

-82

The modifier –82 designates that an assistant surgeon was used given that a qualified resident surgeon was not available during the procedure.

-26

Professional Component

AA

Anesthesia performed by an anesthesiologist.

AD

Medical supervision by a physician: more than four concurrent anesthesia procedures.

AS

Physician's assistant acting as an assistant at surgery

QK

2-4 concurrent anesthesia procedures performed.

SG

ASC facility service charge

TC

Technical component

Glossary of Terms

Allowed Services: A count of the number of services performed for a procedure.

Allowed Charges: The amount Medicare determines to be reasonable payment for a provider or service covered under Part B. This includes the coinsurance and deductible amounts.

Coinsurance: The amount you may be required to pay for services after you pay any plan deductibles. In Original Medicare, this is a percentage (like 20%) of the Medicare approved amount. You have to pay this amount after you pay the deductible for Part A and/or Part B. In a Medicare Prescription Drug Plan, the coinsurance will vary depending on how much you have spent.

Deductible: The amount you must pay for health care or prescriptions, before Original Medicare, your prescription drug plan, or other insurance begins to pay. For example, in Original Medicare, you pay a new deductible for each benefit period for Part A, and each year for Part B. These amounts can change every year.

Final Action Claim: A final action claim is a non-rejected claim for which a payment has been made. All disputes and adjustments have been resolved and details clarified.

HCPCS (*Healthcare Common Procedure Coding System*): The HCPCS is a coding system for all services performed by a physician or supplier. It is based on the American Medical Association Physicians Current Procedural Terminology (CPT) codes and is augmented with codes for physician and non-physician services (such as ambulance and durable medical equipment (DME), which are not included in CPTs.

Payment: In the Original Medicare Plan, this is the amount a doctor or supplier that accepts assignment can be paid. It includes what Medicare pays and any deductible, coinsurance, or copayment that the beneficiary must pay. It may be less than the actual amount a doctor or supplier charges.

Physician Services: Services provided by an individual licensed under state law to practice medicine or osteopathy. Physician services given while in the hospital that appear on the hospital bill are not included.

Supplier: Generally, any company, person, or agency that gives you a medical item or service, like a wheelchair or walker.

Data Quality and Timeliness

The summarized data created to produce the information in the Part B National Summary Data Files was generated from the Part B Analytic Reports (PBAR).

Data Disclaimer

CMS has no responsibility for the data after it has been converted, processed or otherwise altered. Data that has been manipulated or reprocessed by the user is the responsibility of the user. The user may not present data that has been altered in any way as CMS data. Any alteration of the original data, including conversion to other dia or other data formats, is the responsibility of the requestor.

Cell sizes less than 11 have been screened for privacy and replaced with N/A. A zero indicates there were no services or payments rendered for a particular code.