

## **Part B National Summary Data File**

### **Information for Users**

The information in Part B National 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).

### **Healthcare Common Procedure Coding System (HCPCS) Coding Systems**

The HCPCS Coding System is divided into two principal subsystems, referred to as Level I and Level II codes.

Level I of the HCPCS coding system is comprised of Current Procedural Terminology (CPT) codes, a numeric coding system maintained by the AMA. The CPT code set 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 codes to identify services and procedures for which they bill public or private health insurance programs. Level I HCPCS codes (CPT codes), do 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 coding system is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) when used outside a physician's office. Because Medicare and other insurers cover a variety of services, supplies, and equipment that are not identified by CPT codes, the level II HCPCS codes were established for submitting claims for these items.

### **About the Datasets**

The data sets are summarized by meaningful HCPCS/CPT code ranges. Brief descriptions for the code ranges and modifiers are provided in this readme file (see Numeric and Alpha numeric Code Ranges and Descriptions sections below). The data set name contains the year followed by a five-character sequence code that is the HCPCS/CPT code. This HCPCS/CPT code corresponds to the first HCPCS/CPT in the selected code range of disciplines. 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. A sample data set is shown below:

#### **Code Range 00100 – 01999**

DESCRIPTION	HCPCS	MODIFIER	ALLOWED SERVICES	ALLOWED CHARGES	PAYMENT
ANESTHESIA	00100	AA	5,580	\$1,187,161.00	\$935,402.00
ANESTHESIA	00100	AD	168	\$13,287.00	\$9,996.00
ANESTHESIA	00100	QK	5,102	\$620,723.00	\$489,280.00
ANESTHESIA	00100	QZ	2,347	\$415,336.00	\$327,821.00
ANESTHESIA	00100	OTHER	5,944	\$654,184.00	\$518,378.00
ANESTHESIA	00100	<b>TOTAL</b>	<b>19,141</b>	<b>\$2,890,692.00</b>	<b>\$2,280,878.00</b>

Only certain modifiers are defined below in the 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 code(s). 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 1 below illustrating Surgery Code 66984 (Cataract Surgery w/iol), the primary surgeries are shown in the modifier field labeled “OTHER”. There were three allowed services billed by the assistant at surgery (modifier 80’s) 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 assistant reimbursement amounts 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: Surgery Code 66984 (Cataract Surgery w/iol)**

DESCRIPTION	HCPCS	MODIFIER	ALLOWED SERVICES	ALLOWED CHARGES	PAYMENT
EYE	66984	SG	934,343	\$884,906,157.00	\$702,786,098.00
EYE	66984	80’s	N/A	\$296.00	\$157.00
EYE	66984	OTHER	2,108,557	\$1,135,506,587.00	\$900,489,934.00
EYE	66984	<b>TOTAL</b>	<b>3,042,903</b>	<b>\$2,020,413,040.00</b>	<b>\$1,603,276,188.00</b>

Example 2 shows Radiology Code 71010 (chest x-ray). The global modifier (GLOBL) 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 those 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: Radiology Code 71010 (chest x-ray)**

DESCRIPTION	HCPCS	MODIFIER	ALLOWED SERVICES	ALLOWED CHARGES	PAYMENT
RADIOLOGY	71010	TC	369,430	\$6,374,489.00	\$4,855,156.00
RADIOLOGY	71010	26	16,700,762	\$150,052,259.00	\$117,355,518.00
RADIOLOGY	71010	GLOBL	634,622	\$15,965,081.00	\$11,850,757.00
RADIOLOGY	71010	<b>TOTAL</b>	17,704,814	\$172,391,829.00	\$134,061,430.00

## Numeric Code Ranges and Descriptions

**Anesthesia (00000 – 09999):** Anesthesia services are represented by the code range 00000-09999. 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.

**Surgery (10000 – 99999):** Descriptors displayed in Alpha Order on the spreadsheet as indicated below:

**Cardiovascular:** The Cardiovascular range 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.

**Digestive System:** The Digestive System range 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 and are then further noted by specific codes, which detail the procedure that was employed.

**Ear:** The Auditory system ranges 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.

**Endocrine System:** This code range is broken into two subcategories – (1) the Thyroid Gland and the Parathyroid and (2) Thymus, Adrenal Glands, and Carotid Body. These categories are divided into subcategories based on general procedures, and specific procedures are assigned a code.

**Evaluation and Management:** The Evaluation and Management codes are divided into broad categories. The broad categories range from office visits, hospital visits, consultations, prolonged services, nursing facility services, newborn care, etc.

**Eye:** These categories are divided into subcategories based on general procedures. Specific procedures in the subcategories are given a code.

**Female Genital:** 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.

**Integumentary:** 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.

**Lymphatic:** In the Lymphatic range 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.

**Male Genital:** 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.

**Maternity:** 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.

**Mediastinum:** The Mediastinum range 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.

**Medicine:** The Medicine range 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.

**Musculoskeletal:** The Musculoskeletal range 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.

**Path/Lab:** Pathology and Laboratory 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.

**Radiology:** 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.

**Respiratory:** The Respiratory ranges 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.

**Urinary:** 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.

## **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 with a modifier to denote what has been altered. Modifiers are two-digit codes and are categorized into two levels:

**1. Level I Modifiers:** Normally known as CPT Modifiers and consist of two numeric digits and are updated annually by AMA - American Medical Association.

**2. Level II Modifiers:** Normally known as HCPCS Modifiers and consist of two Alpha / Alphanumeric characters in the sequence AA through VP. These modifiers are annually updated by CMS.

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

**80** - Indicates that an assistant surgeon aided with the procedure

**81** - Indicates that a minimum surgical assistant was used during the procedure

**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 that are covered by Medicare.

**Allowed Charges:** The amount Medicare determines to be reasonable payment for a provider or covered service. Medicare participating providers have agreed to accept this amount as payment in full.

**Coinsurance:** The amount you may be required to pay for services after you pay any plan deductibles. In Original Medicare, this is usually 20% of the Medicare approved amount. Medicare pays the other 80%.

**Deductible:** The amount you must pay for health care or prescriptions before Original Medicare, your prescription drug plan, or other insurance begins to pay.

**Final Action Claim:** A final action claim is a claim for which all disputes and adjustments have been resolved and details clarified and was submitted for payment. A claim in final action status can be subsequently paid or denied.

**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:** For Original Medicare, this is the amount a doctor or supplier who 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 provides you with 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 media 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.