Part B Extract Summary System (BESS) Carrier Data File

Introduction
Readme File 2007

The readme file is designed to help you learn about the data provided on the CD. The data was derived from the Medicare Part B Extract Summary System (BESS). BESS is a menu-driven query system that provides access to non-beneficiary specific physician/supplier claims data that have been summarized at the procedure code Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) level. The Physician Supplier Procedure Summary (PSPS) Master File is the source of data that supports BESS. This file is produced using the line items for all claims for physician and supplier services rendered to Medicare beneficiaries during the calendar year and processed by the Medicare carriers through June 30th of the following year. The PSPS file is also available for purchase at the following CMS website **http://www.cms.hhs.gov/NonIdentifiableDataFiles/**

The data sets are summarized at the carrier level by meaningful HCPCS/CPT code ranges. For ease of reference, included is a listing of the 2006 Medicare carriers arrayed by State. 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		3	$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. To obtain brief descriptions for individual alpha codes you may view the following CMS website:
http://www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS/list.asp

2006 Part B Carriers

00510	ALABAMA	00834	NEVADA
00511	GEORGIA	00835	OREGON
00512	MISSISSIPPI	00836	WASHINGTON
00520	ARKANSAS	00865	PENNSYLVANIA
00521	NEW MEXICO	00880	SOUTH CAROLINA
00522	OKLAHOMA	00882	RAILROAD
00523 *	MISSOURI	00883	OHIO
00524	RHODE ISLAND	00884	WEST VIRGINIA
00528	LOUISIANA	00885 +	SOUTH CAROLINA (REG C)
00590	FLORIDA	00900	TEXAS
00591	CONNECTICUT	00901	MARYLAND
00630	INDIANA	00902	DELAWARE
00635 +	INDIANA (REG B)	00903	DISTRICT OF COLUMBIA
00650	KANSAS	00904	VIRGINIA
00655	NEBRASKA	00951	WISCONSIN
00660	KENTUCKY	00952	ILLINOIS
00740 *	MISSOURI	00953	MICHIGAN
00751	MONTANA	00954	MINNESOTA
00801 *	WESTERN NEW YORK	00973	PUERTO RICO/VIRGIN ISLAND
00803 *	EMPIRE NEW YORK	05130	IDAHO
00805	NEW JERSEY	05440	TENNESSEE
00811 +	CONNECTICUT (REG A)	05535	NORTH CAROLINA
00820	NORTH/SOUTH DAKOTA	05655 +	TENNESSEE (REG D)
00823	UTAH	14330 *	GHI/NEW YORK
00824	COLORADO	31140 *	NORTHERN CALIFORNIA
00825	WYOMING	31142	MAINE
00826	IOWA	31143	MASSACHUSETTS
00831	ALASKA	31144	NEW HAMPSHIRE
00832	ARIZONA	31145	VERMONT
00833	HAWAII/GUAM	31146 *	SOUTHERN CALIFORNIA

* Multi Carrier State **BOLD** – New Carrier Number + DMERC

Numeric Code Ranges and Descriptions

00100 – 01999: Anesthesia (Displayed AA; AD; QK; Other; Total)

Anesthesia services are represented by the code range 00100-01999 plus modifier codes. 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.

10040-19499: Integumentary (Displayed SG; 80, 81, & 82 Summed; Other; Total)

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.

20000-29999: Musculoskeletal (Displayed AS; SG; 80, 81 & 82 Summed; Other; Total)

In the Musculoskeletal code range, 20000-29909, 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.

30000-32999: Respiratory (Displayed SG; 80, 81 & 82 Summed; Other; Total)

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.

33010-37799: Cardiovascular (Displayed SG; 80, 81 & 82 Summed; Other; Total)

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.

38100-38999: Lymphatic (Displayed SG; 80, 81, & 82 Summed; Other; Total)

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.

39000-39599: Mediastinum (Displayed SG; 80, 81, & 82 Summed; Other; Total)

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.

40490-49999: Digestive System (Displayed SG; 80, 81 & 82 Summed; Other; Total)

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.

50010-53899: Urinary (Displayed SG; 80, 81 & 82 Summed; Other; Total)

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.

54000-55899: Male Genital (Displayed SG; 80, 81 & 82 Summed; Other; Total)

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.

56405-58999: Female Genital (Displayed SG; 80, 81 & 82 Summed; Other; Total)

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.

59000-59899: Maternity (Displayed SG; 80, 81 & 82 Summed; Other; Total)

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.

60000-64999: Endocrine System (Displayed SG; 80, 81 & 82 Summed; Other; Total)

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.

65091-68899: Eye (Displayed SG; 80, 81 & 82 Summed; Other; Total)

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.

69000-69990: Ear (Displayed SG; 80, 81 & 82 Summed; Other; Total)

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.

70010-79999: Radiology (Displayed TC; Other; Total)

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.

80048-89399: Path/Lab (Displayed TC; Other; Total)

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.

90281-99199: Medicine (Displayed by Total Only)

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.

99201-99499: Evaluation and Management (Displayed by Total Only)

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. Most code ranges are broken down into subcategories, which designates the type of service that was performed and the approximate time involved to provide the services. In the Consultations category, subcategories include Initial Inpatient Consultations and Follow-Up Inpatient Consultations. These subcategories are further broken down into specific codes that designate the type of care administered.

99201-99499: Evaluation and Management by Specialty

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. Most code ranges are broken down into subcategories, which designates the type of service that was performed and the approximate time involved to provide the services. In the Consultations category, subcategories include Initial Inpatient Consultations and Follow-Up Inpatient Consultations. These subcategories are further broken down into specific codes that designate the type of care administered. The specialty code denotes the type of physician, practitioner or supplier providing the service.

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 assistant acting as an assistant at surgery.

QK

2-4 concurrent anesthesia procedures performed.

SG

ASC facility service charge

TC

Technical component.

Selected Reporting Elements

Reporting elements fall into three categories:

Allowed Services

A count of the number of services performed for a specific Part B procedure minus the denied services.

Allowed Charges

The allowed charge is the Medicare approved amount for the Part B procedure submitted by the physician or supplier. Medicare usually pays about 80% of the total allowed charge and the other 20% is the coinsurance share, which is paid by the beneficiary.

Payment Amount

The Medicare reimbursement amount is reflected under this reporting element.

Other Information

Carriers

A private company that has a contract with Medicare to pay your Medicare Part B bills.

Durable Medical Equipment Regional Carrier (DMERC)

A private company that contracts with Medicare to pay bills for durable medical equipment.

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. Level 1 = Numeric; Level 2 = Alpha; Level 3 = Local.

We want to caution you about the information we will be supplying you. Our internal validation of the BESS Files consists of basic consistency field edits. However, validation efforts do not preclude the presence of errors in the carrier's coding. To further insure the validity of all data submitted, we have initiated and will continue to do independent studies to verify that carriers have submitted properly coded data. We are concerned that because of problems that exist in the files (not all of which we are aware of), data may lead to misinterpreted or incorrect results and conclusions.

CPT codes (Current Procedural Technology)

CPT codes are systematic codes of procedures and services performed by a physician. Each procedure or service is assigned a specific code which is based on where and what type of procedure was performed. The five-digit numeric codes, descriptions, numeric modifiers, instructions, guidelines, and other material are copyright by the American Medical Association (AMA).