Part B Carrier Summary Data File
Introduction
Readme File

The readme file is designed to help you learn about the data provided in the datasets. This file containing aggregated 2016 Part B data is being used as an example. It was 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
https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Part-B-Carrier-Summary-Data-File/Overview.html

The file name is Medicare Carrier Summary Data File. It was originally known as the Part B Extract Summary System (BESS) Carrier Data File until the BESS system was retired. The data sets are summarized at the carrier level by meaningful HCPCS/CPT code ranges. For ease of reference, a listing of the Medicare carriers arrayed by state is included. The data set name contains the year for which data is being reported followed by the associated carrier number (ex. Y2016_10102.xlsx). Brief descriptions for the code ranges and modifiers are provided at the end of this 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 for Part B is shown below. The examples are also taken from the 2016 data file.

Part B Data for Completed Year 2016 Carrier 10102

DESCRIPTION	HCPCS	MODIFIER	ALLOWED SERVICES	ALLOWED CHARGES	PAYMENT
Carrier 00510	00100	AA	N/A	$1,157.29	$907.32
ANESTHESIA	00100	AD	N/A	$249.60	$167.91
ANESTHESIA	00100	QK	162	$24,024.73	$18,048.87
ANESTHESIA	00100	QZ	N/A	$2,789.53	$2,056.85
ANESTHESIA	00100	OTHER	175	$26,841.61	$20,860.31
ANESTHESIA	00100	**TOTAL**	**352**	**$55,062.76**	**$42,041.26**

The allowed services less than 11 are not displayed and show as N/A in these reports but are calculated for total summary.

These reports only illustrate the modifiers when more than one bill can be submitted for the same procedure. The Surgeon, ASC and Assistant at Surgery can all bill separately for the same procedure using the same HCPCS/CPT code. 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 the example below for surgery code 66984 (Cataract Surgery w/IOL), the primary surgical procedures are grouped together in the modifier field labeled "OTHER". The Allowed Services count billed to primary surgical procedures was 73,117. In order to get an estimate of the average cost of billed surgical procedures, averages should be calculated by dividing the total allowed charges or total payments by the "OTHER" service counts.

Total Allowed Charges / Other Allowed Services = Average Allowed Charge

$42,242,419.26 / 73,117 = **$**577.73

Total Payment / Other Allowed Services = Average Payment

$32,540,802.14 / 73,117 = **$**445.05

The modifier SG in the report below represents the ASC facility allowed services count. It is an individual modifier that can only apply to services performed at an Ambulatory Surgical Center* (ASC) facility. Averages may also be calculated for individual modifiers.

Modifier SG

DESCRIPTION	HCPCS	MODIFIER	ALLOWED SERVICES	ALLOWED CHARGES	PAYMENT
EYE	66984	SG	563	$474,103.47	$356,505.68
EYE	66984	OTHER	73,117	$42,242,419.26	$32,540,802.14
EYE	66984	**TOTAL**	**73,680**	**$42,716,522.73**	**$32,897,307.82**

The example below shows radiology code 71010 (Chest X-ray). The primary technical and professional service codes are global codes that are grouped on the report under the modifier category GLOBL. The 26 modifier represents the professional component for a procedure code and can be used to show the number of times the professional component billed separately. The TC modifier represents the technical component for a procedure code and can be used to show the number of times the technical component billed separately.

Radiology Code 71010 (Chest X-ray)

DESCRIPTION	HCPCS	MODIFIER	ALLOWED SERVICES	ALLOWED CHARGES	PAYMENT
RADIOLOGY	71010	26	381,088	$3,379,828.37	$2,555,768.40
RADIOLOGY	71010	TC	421	$4,871.74	$3,367.88
RADIOLOGY	71010	GLOBL	17,629	$359,493.20	$257,807.10
RADIOLOGY	71010	**TOTAL**	**399,138**	**$3,744,193.31**	**$2,816,943.38**

GLOBL modifier category averages:

Total Allowed Charges / Other Allowed Services = Average Allowed Charge

$359,493.20 / 17,629 = $20.39

Total Payment / Other Allowed Services = Average Payment

$257,807.10 / 17,629 = $14.62

Services for medicine, radiology, pathology and laboratory appear in the respective numeric 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/02_HCPCS_Quarterly_Update.asp

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 (2) 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 (2) 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 (2) 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 (4) 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 (4) 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.

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

Modifier Codes and Descriptions

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.

AA Anesthesia services performed personally by anesthesiologist

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

AS Physician assistant acting as an assistant at surgery

QK Medically directed by a physician: two, three, or four concurrent procedures

QY Anesthesiologist medically directs one CRNA

QX CRNA service: with medical direction by a physician

QZ CRNA service: without medical direction by a physician

QS Monitored anesthesia care service. Can be reported in the 2nd position under appropriate circumstances in addition to one of the previous anesthesia modifiers

SG Ambulatory surgical center (ASC) facility service

TC The technical component for a procedure code

23 Unusual anesthesia. Can be reported in the 2nd position under appropriate circumstances in addition to one of the previous anesthesia modifiers.

26 The professional component for a procedure code

80 Codes with the modifier 80 indicates that an assistant surgeon aided with 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

Grouped Modifier Categories

OTHER Used for the HCPCS/CPT code ranges 00000 – 09999 and 45378.
If modifier codes other than AA, AD, QK or Q2 are used with code ranges 00000 – 09999, the modifiers are grouped together and displayed as 'OTHER'. If modifier codes other than 53 are used with CPT code 45378, the modifiers are grouped together and displayed as 'OTHER'.

GLOBL Used for the HCPCS/CPT code ranges 70000 – 79999, 80000 – 89999, G0000 – G9999 and individual codes G0105 and G0121. Modifier codes are grouped together and displayed as the modifier category code 'GLOBL' under the following circumstances:

1. When the combination of modifier codes 26 and TC appear in Modifier 1 and Modifier 2 for the same HCPCS code on a given claim.
2. When modifier codes other than 53 are used with CPT codes G0105 or G0121.

80S Used for the HCPCS/CPT code ranges 10000 – 69999.

If any combination of modifier codes 80, 81, 82 or AS are used in Modifier 1 and Modifier 2 codes for this HCPCS/CPT code range, the modifiers are grouped together and displayed as '80S.'

Selected Reporting Elements

Reporting elements fall into three (3) 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 Medicare Carrier Summary Data 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).

Carrier Numbers (as of 7/1/2016)

STATE	CARRIER
ALABAMA	10102
ALASKA	02102
ARIZONA	03102
ARKANSAS	07102
N. CALIFORNIA	01112
S. CALIFORNIA	01182
COLORADO	04112
CONNECTICUT	13102
DC	12202
DELAWARE	12102
DMAC A	16013
DMAC B	17013
DMAC C	18003
DMAC D	19003
FLORIDA	09102
GEORGIA	10202
HAWAII	01212
(Including American Samoa, Guam & Northern Mariana Islands)	
IDAHO	02202
ILLINOIS	06102
INDIANA	08102
IOWA	05102
KANSAS	05202
KANSAS (Kansas City, KS)	05202/00
KENTUCKY	15102
LOUISIANA	07202
MAINE	14112
MARYLAND	12302
MASSACHUSETTS	14212
MICHIGAN	08202

MINNESOTA	06202
MISSISSIPPI	07302
MISSOURI (Kansas City, MO)	05302/02
MISSOURI	05302/99
E. MISSOURI	05302
W. MISSOURI	05302
MONTANA	03202
NEBRASKA	05402
NEVADA	01312
NEW HAMPSHIRE	14312
NEW MEXICO	04212
NEW YORK	13282
NEW JERSEY	12402
NORTH CAROLINA	11502
NORTH DAKOTA	03302
OHIO	15202
OKLAHOMA	04312
OREGON	02302
PENNSYLVANIA	12502
PUERTO RICO	09202
RHODE ISLAND	14412
SOUTH CAROLINA	11202
SOUTH DAKOTA	03402
TENNESSEE	10302
TEXAS	04412
UTAH	03502
VERMONT	14512
VIRGIN ISLANDS	09302
VIRGINIA	11302
WEST VIRGINIA	11402
WASHINGTON	02402
WISCONSIN	06302
WYOMING	03602

Note: Carrier Numbers are subject to change over time.