2000 Limitations for the Physician/Supplier Procedure Summary Master File (PSPSMF)

Produced by Members of the:
Division of Health Plan and Provider Data
Demonstrations and Data Analysis Group
Center for Beneficiary Choices

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INTRODUCTION

The 2000 Physician Supplier Procedure Summary Master File (PSPSMF) includes data from all Medicare Part B carriers. A list of the 2000 carriers is included in **Appendix 1**; **Appendix 2** provides a history of Part B carriers. This file represents procedure-specific billing data for all (i.e., 100 percent) physician/supplier services rendered to all Medicare beneficiaries during calendar year (CY) 2000 and processed by the carriers through June 30, 2001.

Part B charge and utilization data for institutional services (hospital outpatient departments, home health agencies, comprehensive outpatient rehabilitation facilities, end-stage renal disease facilities, and rural health clinics) are processed by Medicare Part A fiscal intermediaries and are not included in these data. Data for services rendered to beneficiaries enrolled in risk-based Health Maintenance Organizations (HMOs) are also not included.

The quality of data is measured by processing each carrier's data through a computerized edit program. This program generates a listing of errors for each carrier. The data are edited for:

- Invalid HCFA Common Procedure Coding System (HCPCS) codes
- Invalid specialty codes
- Invalid type of service codes
- Invalid place of service codes
- Invalid combinations of Miles, Time, Units or Services (MTUS) and MTUS indicator code
- Invalid combinations of HCPCS code, specialty code, type of service code, and place of service code

Tolerances are set for records from each carrier. Records which fall outside the tolerances shown below are subject to investigation:

- Up to 2 percent of total records in error for any edit listed above
- Up to 5 percent of total records in error for all edits
- Up to 2 percent of total allowed charges occurring in records with errors

This document provides information on errors and/or reporting inconsistencies that have been noted at this time. Due to the volume, scope, and nature of the data, the review process is inexact; users are cautioned to be alert for undetected problems.

This document should be used in conjunction with the PSPSMF Record Description, which provides definitions of all data elements.

GENERAL COMMENTS

Carriers report services using the HCPCS codes in effect at the time the services are rendered; that is, services rendered in CY 2000 are reported with 2000 HCPCS codes. You should be aware of the 90-day grace period, which permits carriers to use the prior year's HCPCS codes for services performed in the first 3 months (90 days) of the report year. This means that carriers were permitted to use 1999 HCPCS codes to report services rendered in the first 3 months (90 days) of CY 2000.

For a variety of reasons, some carriers also use their own local procedure and modifier codes. These codes begin with the letters W, X, Y, or Z (but do not include YY or ZZ, which are national modifiers).

Occasionally, carriers report services using obsolete procedure and modifier codes. These codes are considered invalid and result in the records appearing in the Errant Records Report.

Determining the number of services for surgical procedures can be confusing. **Appendix 3** describes the methodology that should be followed in order to obtain accurate service counts for these procedures.

ERRANT RECORDS

Records that are identified in the edit process as being incorrect (errant) are included in the user files, but are annotated as errant.

Records are considered errant if they contain an:

- Invalid HCPCS procedure code
- Invalid specialty code
- Invalid type of service code
- Invalid place of service code
- Invalid locality code

Appendix 4 displays, for each carrier, the total allowed charges, the errant allowed charges, and the percent of errant allowed charges to the total allowed charges.

2000 LIMITATIONS FOR THE PHYSICIAN/SUPPLIER PROCEDURE SUMMARY MASTER FILE (2000 PSPSMF)

Carrier Jurisdiction Change

When Part B Contractors (carriers) changed after an incurred service year has begun, it is our practice to use the old number for the remainder of the PSPSMF incurred year, e.g. carrier 10230 (Connecticut) changed to 00591 on or about 09/30/2000. Since most of the data for this carrier was already aggregated into the 2000 PSPSMF under the old number 10230, 2000 claims received under the new number will be converted to the old number for the 2000 PSPSMF. The new number will be used for the next year's PSPSMF.

Carriers changing to a new number during 2000 are:

Connecticut (00591 was 10230), Minnesota (00954 was 10240), Mississippi (00512 was 10250), Virginia (00904 was 10490), Railroad (00882 was 10071), DMERC (RegA) (00811 was 10555) and So. California (31146 was 02050).

See Appendix 1 for a list of carrier numbers used in the 2000 PSPSMF.

Administrative Denials

Administrative denials result when non-covered or bundled services are submitted to the carriers. Since these submissions are always denied, they never produce allowed services, and consequently, are not included in the PSPSMF.

Number of Services

Total services represent the number of times a procedure has been performed or rendered; they include the count of denied services. Services are represented by different units of measurement, referred to as "pricing units." **Appendix 5** provides the methodology for calculating the number of services in the PSPSMF. Service count problems have been identified for the following procedure codes:

> **E1400 – E1404 --** Normally services are reported as units of one for most durable medical equipment. We have, however, noticed that some claims for Oxygen Concentrators have been overweighted with services greater than one. Approximately 99.1 % of all services reported for these HCPCs have a service count of 1 per line item. Approximately .9% are reporting service counts that are not reasonable, e.g. 20, 50, 300. The allowed charge for these overweighted services appear to indicate only 1 service was rendered. This small percentage of misreported concentrators will cause a slightly lower average allowed charge, but will not affect the total allowed charges or payment amounts.

R0075 -- 2000 claims contain inflated service counts for procedure code R0075 (Transportation of portable X-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one patient seen, per patient). Instructions require carriers to prorate the fee schedule amount established for this carrier-priced code among all patients seen on a given trip. For example, if two patients are X-rayed at the same location, the carrier should allow one-half of the fee schedule amount for each patient. To administer the payment policy, carriers have told providers to report in the units field on a claim's line item the total number of patients seen during a single trip.

Eighteen of the 47 carriers reporting utilization for R0075 reported the total units (patients) shown on the provider's claim, thus inflating the number of services for this procedure code, although not affecting either the actual number of services allowed by the carrier or the allowed charges for this procedure code.

Carriers should report a service count that is consistent with the prorated allowed charge.

For services incurred January 1, 1997 and later, the number of services reported for R0075 will be converted to one (1) in the PSPSMF if more than one service is reported on the claim.

77419-77430 -- The reporting of certain radiation therapy services in 2000 resulted in unusually low average allowed charges for HCPCS codes 77419 through 77430. The 77419 to 77430 range identifies weekly radiation therapy management services. The Medicare Carriers Manual (MCM) indicates that five fractions or treatment sessions are equal to one weekly unit of radiation therapy management, regardless of the amount of time between each of the five fractions (i.e., the five fractions are not required to occur in consecutive days). The MCM further states that billing entities should report the number of fractions for which payment is sought (e.g., 5) rather than the pricing unit for the weekly radiation therapy management service (e.g., 1). As a result, the number of services were inflated, thereby producing deflated average allowed charges. In order to avoid understating the average allowed charge for these HCPCS codes, the PSPSMF has assumed that where five services are reported, only one weekly unit of radiation therapy management has been performed.

83520 – The reporting of this procedure in North Carolina with unusually high service counts will yield a lower than national average allowed charge for this service. The carrier has been notified to contact this provider to correct the problem. The payments are accurate, but the unit of pricing reported by a provider in this carrier do not reflect the true services rendered.

90918-90921 -- The reporting of certain end stage renal disease (ESRD) services in 2000 resulted in unusually low average allowed charges for HCPCS codes 90918 through 90921. This code range identifies ESRD monitoring per full month. Carriers 00640 (Iowa) and 05440 (Tennessee) reported days in the service count field. As a result, the

number of services were inflated, thereby producing deflated average allowed charges. In order to avoid understating the average allowed charge for these HCPCS codes, the PSPSMF has assumed that where more than 12 (assuming 12 months in a year) services are reported, only one month will be assumed in the service count field.

Type of Service

Effective in 1998, the mammography screening service (HCPC 76092) is no longer reported with a type of service B (high risk screening) or C (low risk screening). Prior to 1998 this service was paid annually when a beneficiary's diagnosis indicated a high risk condition and every two years when the diagnosis indicated low risk condition. This screening service is now covered annually regardless of condition. Therefore, this procedure is now reported under type of service 1 (medical care).

Place of Service

A problem was discovered in reporting the Place of Service (POS) for procedure code 88331 (Pathology consultation during surgery; with frozen section(s), single specimen). This code is subject to the Medicare Physician Fee Schedule and, on that fee schedule, is assigned a "PCTC Indicator" of 1, which means the Part B claims for this procedure should only be for the professional component and, therefore, should be submitted with modifier 26 (professional component).

The majority of claims for procedure code 88331 from Arkansas Blue Shield were being reported as a global procedure (i.e., without a 26 or a TC [technical component] modifier) with a POS code of 21 (Inpatient hospital), 22 (Outpatient hospital), or 23 (Emergency room hospital). Because the Medicare Physician Fee Schedule requires that this code be submitted as a professional component through Part B when the POS is a hospital, a modifier of 26 is appended when the line item is summarized in the PSPSMF.

The carrier explained that its practice of billing 88331 as a global procedure was correct, as that is the manner in which the services were being priced. The carrier stated that a majority of its hospital laboratories were run by groups of physicians who bill the global service through Part B. No hospital bill is submitted. The carrier felt it was inappropriate for modifier 26 to be appended to these services in the PSPSMF.

Appropriate staff have been notified of this problem, and a solution is being worked out.

Pricing Localities

In the 1997 Physician Fee Schedule Final Rule, HCFA reduced the number of Physician Fee Schedule pricing localities from 210 to 92, effective for services provided on or after January 1, 1997.

Several carriers are reporting some physician services in their carrier wide/Statewide locality 00. This is not a valid physician pricing locality for these carriers. The carriers are 00511 (Georgia), 00523 (Missouri), 00590 (Florida), 00835 (Oregon) and 00836 (Washington State). Appropriate HCFA Staff have been notified of this problem, and the carriers have been notified to stop this practice.

For durable medical equipment (DME) claims, the locality code field contains the beneficiary residence State code. It indicates where the service was priced. The provider State code determines where the service was performed. When the beneficiary and DME provider State codes are the same, the locality field is then both the pricing and performing location. The assumption is that this occurs for a high percentage of claims.

For 100 percent accuracy in determining the pricing and performing location, use the Decision Support Access Facility (DSAF) DME claims level data (RIC M) Standard Analytical Files (available as Public Use Files) and use both the beneficiary residence State code for the pricing location and the provider State code for the performing location. For non-DME services, the locality code is both the performing and pricing location.

Specialty Code Reporting Errors by Durable Medical Equipment Regional Carriers (DMERCs)

99 (Unknown Physician Specialty) - This specialty code was reported on an inordinately large number of claims from DMERCs. Physician claims should not be processed by DMERCs. We suspect these claims should instead have carried specialty code 88 (Unknown Supplier / Provider). The problem was reported to the Provider Purchasing and Administration Group (PPAG) in CHPP in March 1996 and again in June 1998. Although the problem has been corrected for many of the suppliers, there are still suppliers reporting this specialty for claims processed by the DMERCs.

Anesthesia Time Units (MTUS Field – MTU Indicator Value 2)

For anesthesia services (HCPCS 00100-01996), time units are entered into the miles, time, units or services (MTUS) field on the PSPS record. The field should contain one implied decimal for time units. We have noticed that several carriers are reporting two decimal places in this field. They are: 00510 (Alabama), 00630 (Indiana), 00650 (Kansas), 00655 (Nebraska), 00660 (Kentucky), 00740 (Missouri), 00803 (Empire New York), 00880 (South Carolina), 00973 (Puerto Rico/Virgin Island), 02050 (Trans-Occid/California), 05130 (Idaho), 05440 (Tennessee), 05535 (North Carolina) and 14330 (GHI/New York).

APPENDIX 1

2000 PART B CARRIERS

00510	ALABAMA	00880	SOUTH CAROLINA
00511	GEORGIA	00885+	SOUTH CAROLINA (REG C)
00520	ARKANSAS	00900	TEXAS
00521	NEW MEXICO	00901	MARYLAND
00522	OKLAHOMA	00902	DELEWARE
00523 *	MISSOURI	00903	DISTRICT OF COLUMBIA
00528	LOUISIANA	00910	UTAH
00590	FLORIDA	00951	WISCONSIN
00630	INDIANA	00952	ILLINOIS
00635 +	INDIANA (REG B)	00953	MICHIGAN
00650	KANSAS	00973	PUERTO RICO/VIRGIN ISLANDS
00655	NEBRASKA	02050*	TRANS-OCCID/CALIFORNIA
00660	KENTUCKY	05130	IDAHO
00740 *	MISSOURI	05440	TENNESSEE
00751	MONTANA	05535	NORTH CAROLINA
00801 *	WESTERN NEW YORK	05655+	TENNESSEE (REG D)
00803 *	EMPIRE NEW YORK	10071	RAILROAD
00805	**NEW JERSEY**	10230	CONNECTICUT
00820	NORTH/SOUTH DAKOTA	10240	MINNESOTA
00824	COLORADO	10250	MISSISSIPPI
00825	WYOMING	10490	VIRGINIA
00826	IOWA	10555+	CONNECTICUT (REG A)
00831	ALASKA	14330*	GHI/NEW YORK
00832	ARIZONA	16360	OHIO
00833	HAWAII/GUAM	16510	WEST VIRGINIA
00834	NEVADA	31140	NORTHERN CALIFORNIA
00835	OREGON	31142	MAINE
00836	WASHINGTON	31143	MASSACHUSETTS
00865	PENNSYLVANIA	31144	NEW HAMPSHIRE
00870	RHODE ISLAND	31145	VERMONT

*- Multi Carrier State ** - New Carrier Number + - DMERC

APPENDIX 2

HISTORY OF PART B CARRIERS

Sorted by State X=Active

STATE	CARRIER	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	00	CARRIER
AK	00831														X	X	X	00831
AK	01020	X	X	X	X	X	X	X	X	X	X	X	X	X				01020
AL	00510	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	00510
AR	00520	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	00520
AZ	00832														X	X	X	00832
AZ	01030	X	X	X	X	X	X	X	X	X	X	X	X	X				01030
CA(N)*	00542	X	X	X	X	X	X	X	X	X	X	X	X					00542
CA(N)*	31140													X	X	X	X	31140
CA(T)*	02050	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	02050
CO	00550	X	X	X	X	X	X	X	X	X	X							00550
CO	00824											X	X	X	X	X	X	00824
CT	03070	X																03070
CT	10230		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	10230
DC	00580	X	X	X	X	X	X	X	X	X	X	X	X	X				00580
DC	00903														X	X	X	00903
DE	00570	X	X	X	X	X	X	X	X	X	X	X	X	X				00570
DE	00902														X	X	X	00902
FL	00590	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	00590
GA	00511														X	X	X	00511
GA	01040				X	X	X	X	X	X	X	X	X	X				01040
GA	13110	X	X	X														13110
HI	00833														X	X	X	00833
HI	01120	X	X	X	X	X	X	X	X	X	X	X	X	X				01120
IA	00640	X	X	X	X	X	X	X	X	X	X	X	X	X	X			00640
IA	00826															X	X	00826
ID	05130	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	05130
IL	00621	X	X	X	X	X	X	X	X	X	X	X	X	X	X			00621
IL	00952															X	X	00952
IN	00630	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	00630
KS	00650	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	00650
KY	00660	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	00660
LA	00528	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	00528
LA	08190																	08190
MA	00700	X	X	X	X	X	X	X	X	X	X	X	X	X				00700
MA	31143														X	X	X	31143
MD	00690	X	X	X	X	X	X	X	X	X	X							00690
MD	00901											X	X	X	X	X	X	00901
ME	21200	X	X	X	X	X	X	X	X	X	X	X	X	X				21200

STATE	CARRIER	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	00	CARRIER
ME	31142														X	X	X	31142
MI	00623											X	X	X	X			00623
MI	00710	X	X	X	X	X	X	X	X	X	X							00710
MI	00953															X	X	00953
MN*	00720	X	X	X	X	X	X	X	X	X	X	X						00720
MN*	10240	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	10240
MO*	00740	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	00740
MO*	00523															X	X	00523
MO*	11260	X	X	X	X	X	X	X	X	X	X	X	X	X	X			11260
MS	10250	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	10250
MT	00751	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	00751
N/SD	00820	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	00820
NC	05535				X	X	X	X	X	X	X	X	X	X	X	X	X	05535
NC	13340	X	X	X														13340
NE	00645	X	X	X														00645
NE	00655				X	X	X	X	X	X	X	X	X	X	X	X	X	00655
NE	12280																	12280
NH/VT	00770																	00770
NH/VT	00780	X	X	X	X	X	X	X	X	X	X	X	X	X				00780
NH	31144														X	X	X	31144
NJ **	00805																X	00805
NJ	00860				X	X	X	X	X	X	X	X	X	X	X	X		00860
NJ	13310	X	X	X														13310
NM	00521														X	X	X	00521
NM	01360		X	X	X	X	X	X	X	X	X	X	X	X				01360
NM	05320	X																05320
NV	00834														X	X	X	00834
NV	01290	X	X	X	X	X	X	X	X	X	X	X	X	X				01290
NY(E)*	00803	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	00803
NY(G)*	14330	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	14330
NY(W)*	00801	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	00801
OH	16360	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	16360
OK	00522														X	X	X	00522
OK	01370	X	X	X	X	X	X	X	X	X	X	X	X	X				01370
OR	00835														X	X	X	00835
OR	01380	X	X	X	X	X	X	X	X	X	X	X	X	X				01380
PA	00865	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	00865
PR/VI	00973	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	00973
Reg B(IN)+	00635									X	X	X	X	X	X	X	X	00635
RegA(CT)+	10555									X	X	X	X	X	X	X	X	10555

STATE	CARRIER	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	00	CARRIER
RegC(SC) +	00885									X	X	X	X	X	X	X	X	00885
RegD(TN) +	05655									X	X	X	X	X	X	X	X	05655
RI	00870	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	00870
RR	10071	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	10071
SC	00880	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	00880
TN	05440	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	05440
TX	00900	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	00900
UT	00910	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	00910
VA	10490	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	10490
VT	31145														X	X	X	31145
WA	00836														X	X	X	00836
WA	00930	X	X	X	X	X	X	X	X									00930
WA	00932									X								00932
WA	01390										X	X	X	X				01390
WI	00951	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	00951
WV	16510	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	16510
WY	00825						X	X	X	X	X	X	X	X	X	X	X	00825
WY	05530	X	X	X	X	X												05530

HISTORY OF PART B CARRIERS

Sorted by Carrier X=Active

STATE	CARRIER	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	00	CARRIER
AL	00510	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	00510
GA	00511														X	X	X	00511
AR	00520	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	00520
NM	00521														X	X	X	00521
OK	00522														X	X	X	00522
MO*	00523															X	X	00523
LA	00528	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	00528
CA(N)*	00542	X	X	X	X	X	X	X	X	X	X	X	X					00542
CO	00550	X	X	X	X	X	X	X	X	X	X							00550
DE	00570	X	X	X	X	X	X	X	X	X	X	X	X	X				00570
DC	00580	X	X	X	X	X	X	X	X	X	X	X	X	X				00580
FL	00590	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	00590
IL	00621	X	X	X	X	X	X	X	X	X	X	X	X	X	X			00621
MI	00623											X	X	X	X			00623
IN	00630	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	00630
Reg B(IN)+	00635									X	X	X	X	X	X	X	X	00635
IA	00640	X	X	X	X	X	X	X	X	X	X	X	X	X	X			00640
NE	00645	X	X	X														00645
KS	00650	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	00650
NE	00655				X	X	X	X	X	X	X	X	X	X	X	X	X	00655
KY	00660	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	00660
MD	00690	X	X	X	X	X	X	X	X	X	X							00690
MA	00700	X	X	X	X	X	X	X	X	X	X	X	X	X				00700
MI	00710	X	X	X	X	X	X	X	X	X	X							00710
MN*	00720	X	X	X	X	X	X	X	X	X	X	X						00720
MO	00740	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	00740
MT	00751	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	00751
NH/VT	00770																	00770
NH/VT	00780	X	X	X	X	X	X	X	X	X	X	X	X	X				00780
NY(W)*	00801	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	00801
NY(E)*	00803	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	00803
NJ **	**00805**																**X**	**00805**
N/SD	00820	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	00820
CO	00824											X	X	X	X	X	X	00824
WY	00825					X	X	X	X	X	X	X	X	X	X	X	X	00825
IA	00826															X	X	00826
AK	00831														X	X	X	00831

STATE	CARRIER	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	00	CARRIER
AZ	00832														X	X	X	00832
HI	00833														X	X	X	00833
NV	00834														X	X	X	00834
OR	00835														X	X	X	00835
WA	00836														X	X	X	00836
NJ	00860				X	X	X	X	X	X	X	X	X	X	X	X		00860
PA	00865	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	00865
RI	00870	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	00870
SC	00880	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	00880
RegC(SC)+	00885									X	X	X	X	X	X	X	X	00885
TX	00900	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	00900
MD	00901											X	X	X	X	X	X	00901
DE	00902														X	X	X	00902
DC	00903														X	X	X	00903
UT	00910	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	00910
WA	00930	X	X	X	X	X	X	X	X									00930
WA	00932									X								00932
WI	00951	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	00951
IL	00952															X	X	00952
MI	00953															X	X	00953
PR/VI	00973	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	00973
AK	01020	X	X	X	X	X	X	X	X	X	X	X	X	X				01020
AZ	01030	X	X	X	X	X	X	X	X	X	X	X	X	X				01030
GA	01040				X	X	X	X	X	X	X	X	X	X				01040
HI	01120	X	X	X	X	X	X	X	X	X	X	X	X	X				01120
NV	01290	X	X	X	X	X	X	X	X	X	X	X	X	X				01290
NM	01360		X	X	X	X	X	X	X	X	X	X	X	X				01360
OK	01370	X	X	X	X	X	X	X	X	X	X	X	X	X				01370
OR	01380	X	X	X	X	X	X	X	X	X	X	X	X	X				01380
WA	01390										X	X	X	X				01390
CA(T)*	02050	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	02050
CT	03070	X																03070
ID	05130	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	05130
NM	05320	X																05320
TN	05440	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	05440
WY	05530	X	X	X	X	X												05530
NC	05535				X	X	X	X	X	X	X	X	X	X	X	X	X	05535
RegD(TN)+	05655									X	X	X	X	X	X	X	X	05655
LA	08190																	08190
RR	10071	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	10071
CT	10230		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	10230

STATE	CARRIER	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	00	CARRIER
MN*	10240	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	10240
MS	10250	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	10250
VA	10490	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	10490
RegA(CT)+	10555									X	X	X	X	X	X	X	X	10555
MO	11260	X	X	X	X	X	X	X	X	X	X	X	X	X	X			11260
NE	12280																	12280
GA	13110	X	X	X														13110
NJ	13310	X	X	X														13310
NC	13340	X	X	X														13340
NY(G)*	14330	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	14330
OH	16360	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	16360
WV	16510	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	16510
ME	21200	X	X	X	X	X	X	X	X	X	X	X	X	X				21200
CA(N)*	31140													X	X	X	X	31140
ME	31142														X	X	X	31142
MA	31143														X	X	X	31143
NH	31144														X	X	X	31144
VT	31145														X	X	X	31145

APPENDIX 3

METHODOLOGY FOR DETERMINING NUMBER (FREQUENCY) OF SURGERIES AND PAYMENT AMOUNTS AND ALLOWED CHARGES (HCFA-1500 CLAIMS)

The following methodology describes how the number (frequency) of services should be counted and how the payment amounts and allowed charges should be tabulated for surgeries (i.e., procedure codes falling in the CPT 4 range of 10000-69999).

(1) Of the claims or procedure summary records with the codes above, include only those with Type of Service (TOS) code = 2 (surgery).

(2) In order to avoid counting claims in addition to the global procedure and other claims which could erroneously inflate the frequency (i.e., there may be more than one TOS = 2 claim associated with the same surgery), the following exclusions need to be made for the claims counted in Step (1) above:

(A) Specialty Code 05 (Anesthesiology)

Exclude from the count the claims with Specialty Code 05 for Anesthesiology.

(B) Modifier 50 (Bilateral Procedure)

The bilateral modifier is used to indicate cases in which a procedure that can be performed on both sides of the body was, in fact, performed on both sides of the body on the same day. This modifier will not result in double payment for the procedure. The payment will be based on 150 percent of the global fee. Only one claim should be submitted for these services. The total number of services for such claims should be multiplied by 2 to avoid under-counting the services. The payment amounts and allowed charges for all such claims would not be altered.

©Modifier 55 (Post-Operative Care Only)

Exclude from the count the claims with modifier 55 (post-operative care). These claims represent post-operative care associated with the original surgery and, therefore, should not be included in the count. The payment amounts and allowed charges for these services, however, should be counted because they comprise a percentage of the global fee payment package (effective 1/92 with the Medicare Physician Fee Schedule).

(D) Modifier 56 (Pre-Operative Care Only)

Exclude from the count the claims with modifier 56 (pre-operative care). Similar to (B) above, these claims represent pre-operative care associated with the

upcoming surgery and, therefore, should not be included in the count. The payment amounts and allowed charges for these services should be counted because they comprise a percentage of the global fee payment package (effective 1/92 with the Medicare Physician Fee Schedule).

(E) Modifier 62 (Two Surgeons)

You may want to include modifier 62 claims, counting the payment amount and allowed charges but dividing the services by 2. Such claims represent a circumstance where the skills of two surgeons (usually with different skills) may be required in the management of a specific surgical procedure. Since two claims would be submitted, each showing one service, the total number of services for such claims would be divided by 2 to avoid double-counting the services. The payment amounts and allowed charges for all such claims would be counted. (Each surgeon is paid for his/her services, but one payment is a percentage of the other. To divide the payment amounts/allowed charges in half would seriously under count the payment amounts/allowed charges.)

(F) Modifier 66 (Surgical Team)

Modifier 66 is used by physicians submitting claims for highly complex procedures (requiring the concomitant services of several physicians, often of different specialties) which are carried out under the "surgical team" concept. It is our understanding that all physicians involved in a team surgery submit individual claims for the team surgery. Because a surgical team may consist of any number of surgeons, we have no way of computing the number of services. Because all team surgeons could receive payment for team surgery, the payment amounts and allowed charges for all claims would be counted if modifier 66 claims are used in counting surgeries.

APPENDIX 4

2000 PHYSICIAN AND SUPPLIER PROCEDURE SUMMARY FILE
ERRANT ALLOWED CHARGES AS A PERCENT OF TOTAL ALLOWED CHARGES

CARRIER	TOTAL ALLOWED CHARGES	ERRANT ALLOWED CHARGES	% OF ERRANT TO TOTAL
00510 - ALABAMA B/S	1,072,488,284	0	0.00
00511 - GEORGIA	1,484,669,530	20,089	0.00
00520 - ARKANSAS B/S	632,581,165	0	0.00
00521 - NEW MEXICO	215,026,496	6,908	0.00
00522 - OKLAHOMA	696,458,287	757	0.00
00523 - MISSOURI (ARKANSAS B/S)	877,479,549	8,364	0.00
00528 - LOUISIANA B/S	923,862,143	0	0.00
00590 - FLORIDA B/S	5,513,498,390	187,022	0.00
00630 - INDIANA B/S	1,249,343,449	0	0.00
00635 - DMERC B- ASSOCIATED INSURANCE	1,475,998,620	424,837	0.03
00650 - KANSAS B/S	444,396,895	0	0.00
00655 - NEBRASKA B/S	344,270,889	7,545	0.00
00660 - KENTUCKY B/S	908,469,391	0	0.00
00740 - WESTERN MISSOURI(KANSAS B/S)	430,020,114	2,352	0.00
00751 - MONTANA B/S	168,978,119	0	0.00
00801 - WESTERN NEW YORK B/S	1,245,462,142	1,537	0.00
00803 - GREATER NEW YORK B/S	3,239,890,818	0	0.00
00805 - NEW JERSEY (EMPIRE B/S)	2,509,597,116	0	0.00
00820 - NORTH/SOUTH DAKOTA (ND B/S)	325,110,843	0	0.00
00824 - COLORADO	441,746,560	0	0.00
00825 - WYOMING B/S	62,377,798	0	0.00
00826 - IOWA (NORTH DAKOTA B/S)	592,741,972	1,885	0.00
00831 - ALASKA	48,967,597	41	0.00
00832 - ARIZONA	862,740,455	0	0.00
00833 - HAWAII	169,815,502	0	0.00
00834 - NEVADA	338,155,129	0	0.00
00835 - OREGON	404,514,965	15,044	0.00
00836 - WASHINGTON	869,553,919	13,050	0.00
00865 - PENN. (HGSADMINISTRATORS)	2,924,253,746	0	0.00
00870 - RHODE ISLAND B/S	205,019,317	0	0.00
00880 - SOUTH CAROLINA B/S	879,382,415	0	0.00
00885 - DMERC C- BC/BS SOUTH CAROLINA	3,250,762,991	475,547	0.01
00900 - TEXAS B/S	3,761,013,073	6,515	0.00
00901 - MARYLAND (TEXAS B/S)	849,502,392	0	0.00
00902 - DELAWARE (TEXAS B/S)	200,144,792	0	0.00
00903 - DISTRICT OF COLUMBIA (TX B/S)	696,644,155	0	0.00
00910 - UTAH B/S	275,207,247	6,135	0.00
00951 - WISCONSIN B/S	1,012,540,319	0	0.00
00952 - ILLINOIS (WISC PHY SERV)	2,280,371,532	462,864	0.02
00953 - MICHIGAN (WISC PHYS SERV)	2,467,764,509	734	0.00
00973 - PUERTO RICO B/S	625,964,142	0	0.00
02050 - S. CALIFORNIA - OCCIDENTAL	2,894,662,517	284	0.00
05130 - IDAHO - EQUICOR	172,781,361	0	0.00
05440 - TENNESSEE - EQUICOR	1,414,794,723	0	0.00
05535 - NORTH CAROLINA -EQUICOR	1,709,896,084	0	0.00
05655 - DMERC D- CIGNA	1,262,380,457	394,773	0.03
10071 - RRB TRAVELERS	900,435,652	0	0.00
10230 - CONNECTICUT - TRAVELERS	854,197,549	0	0.00
10240 - MINNESOTA - TRAVELERS	755,310,972	13,704	0.00
10250 - MISSISSIPPI -TRAVELERS	590,059,134	0	0.00
10490 - VIRGINIA - TRAVELERS	1,088,871,175	0	0.00
10555 - DMERC A - TRAVELERS	1,077,149,854	511,520	0.05
14330 - NEW YORK GROUP HEALTH	327,819,180	0	0.00
16360 - OHIO - NATIONWIDE	2,359,464,354	0	0.00
16510 - WEST VIRGINIA - NATIONWIDE	436,801,551	0	0.00
31140 - N. CALIFORNIA B/S	2,250,246,557	4,352	0.00
31142 - MAINE	295,837,950	0	0.00
31143 - MASSACHUSETTS	1,402,281,995	0	0.00
31144 - NEW HAMPSHIRE	228,239,469	8,059	0.00
31145 - VERMONT	106,725,481	4,314	0.00
	67,104,742,782	2,578,232	0.17

APPENDIX 5

METHODOLOGY FOR CODING NUMBER OF SERVICES, MILES/TIME/UNITS/SERVICES (MTUS) AND MTUS INDICATOR FIELDS

The following instructions should be used as a guide for coding the number of services, Miles/Time/Units/Services (MTUS) and MTUS indicator fields on the Part B Physician/Supplier Claim. These fields are documented in the HCFA National Claims History Data Dictionary as CWFB_SRVC_CNT, CWFB_MTUS_CNT, and CWFB_MTUS_IND_CD, respectively. Services not falling into examples A, B, D, or E should be coded as shown in example C (services/pricing units).

A. Ambulance Miles - (CWFB_MTUS_IND_CD = 1)

For procedures reporting ambulance services in miles, the following example should be used to code the line item:

A total of 1 allowed service (1 trip) was reported for HCPCS code A0020: Ambulance service, per mile, loaded, one way. The trip was for 10 miles.

Number of services: 1
MTUS (miles): 10
MTUS indicator: 1

B. Anesthesia Time Units - (CWFB_MTUS_IND_CD = 2)

For procedures reporting anesthesia time units in 15-minute periods or fractions of 15-minute periods, the following example should be used to code the line item:

A total of 1 allowed service is reported for HCPCS code 00142: Anesthesia for procedures on eye; lens surgery. The anesthesiologist attended the patient for 35 minutes.

Number of services: 1
MTUS (time units): 23 (decimal point implied) *****
MTUS indicator: 2

***** 2 15-minute periods + 1/3 of a 15-minute period equals 2.3

C. Services/Pricing Units - (CWFB_MTUS_IND_CD = 3)

For procedures reported as a service or pricing unit, the following examples should be used to code the line item:

A total of 2 visits were reported for HCPCS code 99211: Office or other outpatient visit for the management of an established patient.

Number of services: 2
MTUS (services): 2
MTUS indicator: 3

A total of 500 milligrams was administered for HCPCS code J0120: Injection, Tetracycline, up to 250 mg.

NOTE: The number of milligrams should not be reported in the service or MTUS fields. Instead, report the number of pricing units. In this case, up to 250 mg equals 1 unit/service. Thus, 500 mg equals 2 units/services.

Number of services: 2
MTUS (services): 2
MTUS indicator: 3

A total of 24 cans were purchased, each containing 300 calories for HCPCS code B4150: Enteral Formulae, 100 calories.

NOTE: The number of calories should not be reported in the services or MTUS fields. Instead, report the number of pricing units. In this case, 100 calories equals 1 unit/service. Thus, 24 cans * 300 calories / 100 calories equals 72 units/services.

Example: 24 cans * 300 calories per can / 100 (pricing unit) = 72 pricing units

Number of service: 72
MTUS (services): 72
MTUS indicator: 3

A total of 2 visits were reported for HCPCS code 99211: Office or other outpatient visit for the management of an established patient. **Both services were denied.**

Number of services: 2 (furnished)
MTUS (services): 0 (allowed)
MTUS indicator: 0

OTHER TYPES OF PROCEDURES IN CATEGORY C ARE:

HCPCS*	DESCRIPTION	PRICING UNITS
A codes	Kits Syringes Ostomy supplies Bandages Etc.	Each
B codes	Enteral Formulae Parenteral Nutrition	Number of calories=1 unit Number of milliliters=1 unit
J codes	Dosages	Number of milligrams=1 unit Number of milliliters=1 unit
K codes	Tablets Dressings Gauze pads Etc.	Each, milliliters, ounces

* Not all codes in these ranges are reported as these pricing units. Refer to the HCPCS description of the code to determine pricing unit.

D. Oxygen Services - (CWFB_MTUS_IND_CD = 4)

For procedures reporting oxygen units, the following example should be used to code the line item:

A total of 1 allowed service was reported for HCPCS code E0400: Oxygen contents, gaseous, per cubic foot. The claim reported 37 cubic feet of oxygen.

Number of services: 1
MTUS (cubic feet): 37
MTUS indicator: 4

E. Blood Services - (CWFB_MTUS_IND_CD = 5)

For procedures reporting blood units, the following example should be used to code the line item:

A total of 6 units of blood (services) were furnished for HCPCS code P9010: Blood (whole), for transfusion, per unit. **Two units were denied.**

Number of services: 6 (furnished)
MTUS (units): 4 (allowed)
MTUS indicator: 5