Physician Supplier Procedure Summary (PSPS) on IDR File Layout

AS OF: 08/29/2010

NAME LENGTH BEG END CONTENTS

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1. HCPCS Code

5 1 5 The Health Care Common Procedure Coding

System (HCPCS) is a collection of codes that

represent procedures, supplies, products and

services which may be provided to Medicare

beneficiaries and to individuals enrolled in

private health insurance programs. The codes

are divided into three levels, or groups as

described below:

Level I

Codes and descriptors copyrighted by the American

Medical Association's Current Procedural

Terminology, Fourth Edition (CPT-4). These are

5 position numeric codes representing physician

and nonphysician services.

\*\*\*\* Note: \*\*\*\*

CPT-4 codes including both long and short

descriptions shall be used in accordance with the

CMS/AMA agreement. Any other use violates the

AMA copyright.

Level II

Includes codes and descriptors copyrighted by

the American Dental Association's Current Dental

Terminology, Third Edition (CDT-3). These are

5 position alpha-numeric codes comprising

the D series. All other level II codes and

descriptors are approved and maintained jointly

by the alpha-numeric editorial panel (consisting

of CMS, the Health Insurance Association of

America, and the Blue Cross and Blue Shield

Association). These are 5 position alpha-

numeric codes representing primarily items and

nonphysician services that are not

represented in the level I codes.

Level III

Codes and descriptors developed by Medicare

carriers for use at the local (carrier) level.

These are 5 position alpha-numeric codes in the

W, X, Y or Z series representing physician

and nonphysician services that are not

represented in the level I or level II codes.

2. HCPCS Initial Modifier Code

2 6 7 A first modifier to the HCPCS procedure code

to enable a more specific procedure

identification for the line item service

on the noninstitutional claim.

3. Provider Specialty Code

2 8 9 CMS specialty code used for pricing the

line item service on the noninstitutional

claim.

4. Carrier Number

5 10 14 The identification number assigned by CMS to a

carrier authorized to process claims from a

physician or supplier.

5. Pricing Locality Code

2 15 16 Code denoting the carrier-specific locality

used for pricing the service for this line

item on the carrier claim (non-DMERC).

For DMERCs, this field contains the beneficiary SSA

State Code

6. Type of Service Code

1 17 17 Code indicating the type of service, as defined

in the CMS Medicare Carrier Manual, for this

line item on the non-institutional claim.

7. Place of Service Code

2 18 19 The code indicating the place of service, as

defined in the Medicare Carrier Manual, for

this line item on the noninstitutional claim.

8. HCPCS Second Modifier Code

2 20 21 A second modifier to the HCPCS procedure code to

make it more specific than the first modifier

code to identify the line item procedures for

this claim.

9. Physician/Supplier Procedure Summary (PSPS) Submitted Service Count

14 22 35

The count of the total number of submitted services.

Format: 9999999999.999

10. Physician/Supplier Procedure Summary (PSPS) Submitted Charge Amount

13 36 48

The amount of charges submitted by the provider to

Medicare.

Format: +999999999.99

11. Physician/Supplier Procedure Summary (PSPS) Allowed Charge Amount

13 49 61

The amount that is approved (allowed) for Medicare.

Format: +999999999.99

12. Physician/Supplier Procedure Summary (PSPS) Denied Services Count

14 62 75

The count of the number of submitted services that

are denied by Medicare.

Format: 9999999999.999

13. Physician/Supplier Procedure Summary (PSPS) Denied Charge Amount

13 76 88

The amount of submitted charges for which Medicare

payment was denied.

Format: +999999999.99

14. Physician/Supplier Procedure Summary (PSPS) Assigned Services Count

14 89 102

The count of the number of services from providers

accepting Medicare assignment.

Format: 9999999999.999

15. Physician/Supplier Procedure Summary (PSPS) NCH Payment Amount

13 103 115

The amount of payment made from the trust fund (after

deductible and coinsurance amounts have been paid).

Format: +999999999.99

16. Physician/Supplier Procedure Summary (PSPS) HCPCS ASC Indicator Code

1 116 116

A Y/N code used to indicate whether the procedure

is approved to be performed in an Ambulatory Surgical

Center (ASC).

17. Physician Supplier Procedure Summary (PSPS) Error Indicator Code

2 117 118

The code used to indicate combinations of errors on key fields.

18. HCPCS Berenson-Eggers Type of Service Code (BETOS)

3 119 121

This field is valid beginning with 2003 data.

The Berenson-Eggers Type of Service (BETOS) for the

procedure code based on generally agreed upon clinically

meaningful groupings of procedures and services.