

TABLE OF CODES APPENDIX  
FROM CA REPOSITORY RIF REPORT

AS OF: 08/01/2011

BENE\_CWF\_LOC\_TB

Beneficiary Common Working File Location Table

B = Mid-Atlantic  
C = Southwest  
D = Northeast  
E = Great Lakes  
F = Great Western  
G = Keystone  
H = Southeast  
I = South  
J = Pacific

BENE\_IDENT\_TB

Beneficiary Identification Code (BIC) Table

Social Security Administration:

A = Primary claimant  
B = Aged wife, age 62 or over (1st  
claimant)  
B1 = Aged husband, age 62 or over (1st  
claimant)  
B2 = Young wife, with a child in her care  
(1st claimant)  
B3 = Aged wife (2nd claimant)  
B4 = Aged husband (2nd claimant)  
B5 = Young wife (2nd claimant)  
B6 = Divorced wife, age 62 or over (1st  
claimant)  
B7 = Young wife (3rd claimant)  
B8 = Aged wife (3rd claimant)

B9 = Divorced wife (2nd claimant)  
BA = Aged wife (4th claimant)  
BD = Aged wife (5th claimant)  
BG = Aged husband (3rd claimant)  
BH = Aged husband (4th claimant)  
BJ = Aged husband (5th claimant)  
BK = Young wife (4th claimant)  
BL = Young wife (5th claimant)  
BN = Divorced wife (3rd claimant)  
BP = Divorced wife (4th claimant)  
BQ = Divorced wife (5th claimant)  
BR = Divorced husband (1st claimant)  
BT = Divorced husband (2nd claimant)  
BW = Young husband (2nd claimant)  
BY = Young husband (1st claimant)  
C1-C9,CA-CZ = Child (includes minor, student  
                  or disabled child)  
D = Aged widow, 60 or over (1st claimant)  
D1 = Aged widower, age 60 or over (1st  
      claimant)  
D2 = Aged widow (2nd claimant)  
D3 = Aged widower (2nd claimant)  
D4 = Widow (remarried after attainment of  
      age 60) (1st claimant)  
D5 = Widower (remarried after attainment of  
      age 60) (1st claimant)  
D6 = Surviving divorced wife, age 60 or over  
      (1st claimant)  
D7 = Surviving divorced wife (2nd claimant)  
D8 = Aged widow (3rd claimant)  
D9 = Remarried widow (2nd claimant)  
DA = Remarried widow (3rd claimant)  
DD = Aged widow (4th claimant)  
DG = Aged widow (5th claimant)  
DH = Aged widower (3rd claimant)  
DJ = Aged widower (4th claimant)  
DK = Aged widower (5th claimant)  
DL = Remarried widow (4th claimant)  
DM = Surviving divorced husband (2nd  
      claimant)

DN = Remarried widow (5th claimant)  
DP = Remarried widower (2nd claimant)  
DQ = Remarried widower (3rd claimant)  
DR = Remarried widower (4th claimant)  
DS = Surviving divorced husband (3rd  
claimant)  
DT = Remarried widower (5th claimant)  
DV = Surviving divorced wife (3rd claimant)  
DW = Surviving divorced wife (4th claimant)  
DX = Surviving divorced husband (4th  
claimant)  
DY = Surviving divorced wife (5th claimant)  
DZ = Surviving divorced husband (5th  
claimant)  
E = Mother (widow) (1st claimant)  
E1 = Surviving divorced mother (1st  
claimant)  
E2 = Mother (widow) (2nd claimant)  
E3 = Surviving divorced mother (2nd  
claimant)  
E4 = Father (widower) (1st claimant)  
E5 = Surviving divorced father (widower)  
(1st claimant)  
E6 = Father (widower) (2nd claimant)  
E7 = Mother (widow) (3rd claimant)  
E8 = Mother (widow) (4th claimant)  
E9 = Surviving divorced father (widower)  
(2nd claimant)  
EA = Mother (widow) (5th claimant)  
EB = Surviving divorced mother (3rd  
claimant)  
EC = Surviving divorced mother (4th  
claimant)  
ED = Surviving divorced mother (5th  
claimant)  
EF = Father (widower) (3rd claimant)  
EG = Father (widower) (4th claimant)  
EH = Father (widower) (5th claimant)  
EJ = Surviving divorced father (3rd  
claimant)

EK = Surviving divorced father (4th  
claimant)  
EM = Surviving divorced father (5th  
claimant)  
F1 = Father  
F2 = Mother  
F3 = Stepfather  
F4 = Stepmother  
F5 = Adopting father  
F6 = Adopting mother  
F7 = Second alleged father  
F8 = Second alleged mother  
J1 = Primary prouty entitled to HIB  
(less than 3 Q.C.) (general fund)  
J2 = Primary prouty entitled to HIB  
(over 2 Q.C.) (RSI trust fund)  
J3 = Primary prouty not entitled to HIB  
(less than 3 Q.C.) (general fund)  
J4 = Primary prouty not entitled to HIB  
(over 2 Q.C.) (RSI trust fund)  
K1 = Prouty wife entitled to HIB (less than  
3 Q.C.) (general fund) (1st claimant)  
K2 = Prouty wife entitled to HIB (over 2  
Q.C.) (RSI trust fund) (1st claimant)  
K3 = Prouty wife not entitled to HIB (less  
than 3 Q.C.) (general fund) (1st  
claimant)  
K4 = Prouty wife not entitled to HIB (over  
2 Q.C.) (RSI trust fund) (1st  
claimant)  
K5 = Prouty wife entitled to HIB (less than  
3 Q.C.) (general fund) (2nd claimant)  
K6 = Prouty wife entitled to HIB (over 2  
Q.C.) (RSI trust fund) (2nd claimant)  
K7 = Prouty wife not entitled to HIB (less  
than 3 Q.C.) (general fund) (2nd  
claimant)  
K8 = Prouty wife not entitled to HIB (over  
2 Q.C.) (RSI trust fund) (2nd  
claimant)

K9 = Prouty wife entitled to HIB (less than  
3 Q.C.) (general fund) (3rd claimant)  
KA = Prouty wife entitled to HIB (over 2  
Q.C.) (RSI trust fund) (3rd claimant)  
KB = Prouty wife not entitled to HIB (less  
than 3 Q.C.) (general fund) (3rd  
claimant)  
KC = Prouty wife not entitled to HIB (over  
2 Q.C.) (RSI trust fund) (3rd  
claimant)  
KD = Prouty wife entitled to HIB (less than  
3 Q.C.) (general fund) (4th claimant)  
KE = Prouty wife entitled to HIB (over 2 Q.C.  
(4th claimant)  
KF = Prouty wife not entitled to HIB (less  
than 3 Q.C.) (4th claimant)  
KG = Prouty wife not entitled to HIB (over  
2 Q.C.) (4th claimant)  
KH = Prouty wife entitled to HIB (less than  
3 Q.C.) (5th claimant)  
KJ = Prouty wife entitled to HIB (over 2  
Q.C.) (5th claimant)  
KL = Prouty wife not entitled to HIB (less  
than 3 Q.C.) (5th claimant)  
KM = Prouty wife not entitled to HIB (over  
2 Q.C.) (5th claimant)  
M = Uninsured-not qualified for deemed HIB  
M1 = Uninsured-qualified but refused HIB  
T = Uninsured-entitled to HIB under deemed  
or renal provisions  
TA = MQGE (primary claimant)  
TB = MQGE aged spouse (first claimant)  
TC = MQGE disabled adult child (first claimant)  
TD = MQGE aged widow(er) (first claimant)  
TE = MQGE young widow(er) (first claimant)  
TF = MQGE parent (male)  
TG = MQGE aged spouse (second claimant)  
TH = MQGE aged spouse (third claimant)  
TJ = MQGE aged spouse (fourth claimant)  
TK = MQGE aged spouse (fifth claimant)

TL = MQGE aged widow(er) (second claimant)  
TM = MQGE aged widow(er) (third claimant)  
TN = MQGE aged widow(er) (fourth claimant)  
TP = MQGE aged widow(er) (fifth claimant)  
TQ = MQGE parent (female)  
TR = MQGE young widow(er) (second claimant)  
TS = MQGE young widow(er) (third claimant)  
TT = MQGE young widow(er) (fourth claimant)  
TU = MQGE young widow(er) (fifth claimant)  
TV = MQGE disabled widow(er) fifth claimant  
TW = MQGE disabled widow(er) first claimant  
TX = MQGE disabled widow(er) second claimant  
TY = MQGE disabled widow(er) third claimant  
TZ = MQGE disabled widow(er) fourth claimant  
T2-T9 = Disabled child (second to ninth  
claimant)  
W = Disabled widow, age 50 or over (1st  
claimant)  
W1 = Disabled widower, age 50 or over (1st  
claimant)  
W2 = Disabled widow (2nd claimant)  
W3 = Disabled widower (2nd claimant)  
W4 = Disabled widow (3rd claimant)  
W5 = Disabled widower (3rd claimant)  
W6 = Disabled surviving divorced wife (1st  
claimant)  
W7 = Disabled surviving divorced wife (2nd  
claimant)  
W8 = Disabled surviving divorced wife (3rd  
claimant)  
W9 = Disabled widow (4th claimant)  
WB = Disabled widower (4th claimant)  
WC = Disabled surviving divorced wife (4th  
claimant)  
WF = Disabled widow (5th claimant)  
WG = Disabled widower (5th claimant)  
WJ = Disabled surviving divorced wife (5th  
claimant)  
WR = Disabled surviving divorced husband  
(1st claimant)

WT = Disabled surviving divorced husband  
(2nd claimant)

Railroad Retirement Board:

NOTE:

Employee: a Medicare beneficiary who is  
still working or a worker who  
died before retirement  
Annuitant: a person who retired under the  
railroad retirement act on or  
after 03/01/37  
Pensioner: a person who retired prior to  
03/01/37 and was included in the  
railroad retirement act

10 = Retirement - employee or annuitant  
80 = RR pensioner (age or disability)  
14 = Spouse of RR employee or annuitant  
(husband or wife)  
84 = Spouse of RR pensioner  
43 = Child of RR employee  
13 = Child of RR annuitant  
17 = Disabled adult child of RR annuitant  
46 = Widow/widower of RR employee  
16 = Widow/widower of RR annuitant  
86 = Widow/widower of RR pensioner  
43 = Widow of employee with a child in her care  
13 = Widow of annuitant with a child in her care  
83 = Widow of pensioner with a child in her care  
45 = Parent of employee  
15 = Parent of annuitant  
85 = Parent of pensioner  
11 = Survivor joint annuitant  
(reduced benefits taken to insure benefits  
for surviving spouse)

BENE\_MDCR\_STUS\_TB

CWF Beneficiary Medicare Status Table

10 = Aged without ESRD  
11 = Aged with ESRD  
20 = Disabled without ESRD  
21 = Disabled with ESRD  
31 = ESRD only

BENE\_PRMRY\_PYR\_TB

Beneficiary Primary Payer Table

A = Working aged bene/spouse with employer  
group health plan (EGHP)  
B = End stage renal disease (ESRD) beneficiary  
in the 18 month coordination period with  
an employer group health plan  
C = Conditional payment by Medicare; future  
reimbursement expected  
D = Automobile no-fault (eff. 4/97; Prior  
to 3/94, also included any liability  
insurance)  
E = Workers' compensation  
F = Public Health Service or other federal  
agency (other than Dept. of Veterans  
Affairs)  
G = Working disabled bene (under age 65  
with LGHP)  
H = Black Lung  
I = Dept. of Veterans Affairs  
J = Any liability insurance  
(eff. 3/94 - 3/97)  
L = Any liability insurance (eff. 4/97)  
(eff. 12/90 for carrier claims and 10/93  
for FI claims; obsoleted for all claim  
types 7/1/96)  
M = Override code: EGHP services involved  
(eff. 12/90 for carrier claims and 10/93  
for FI claims; obsoleted for all claim  
types 7/1/96)



N = Override code: non-EGHP services involved  
(eff. 12/90 for carrier claims and 10/93  
for FI claims; obsoleted for all claim  
types 7/1/96)

BLANK = Medicare is primary payer (not sure  
of effective date: in use 1/91, if  
not earlier)

\*\*\*Prior to 12/90\*\*\*

Y = Other secondary payer investigation  
shows Medicare as primary payer

Z = Medicare is primary payer

NOTE: Values C, M, N, Y, Z and BLANK  
indicate Medicare is primary payer.  
(values Z and Y were used prior to  
12/90. BLANK was suppose to be  
effective after 12/90, but may have  
been used prior to that date.)

BENE\_RACE\_TB

Beneficiary Race Table

0 = Unknown  
1 = White  
2 = Black  
3 = Other  
4 = Asian  
5 = Hispanic  
6 = North American Native

BENE\_SEX\_IDENT\_TB

Beneficiary Sex Identification Table

1 = Male

2 = Female  
0 = Unknown

BETOS\_TB

BETOS Table

M1A = Office visits - new  
M1B = Office visits - established  
M2A = Hospital visit - initial  
M2B = Hospital visit - subsequent  
M2C = Hospital visit - critical care  
M3 = Emergency room visit  
M4A = Home visit  
M4B = Nursing home visit  
M5A = Specialist - pathology  
M5B = Specialist - psychiatry  
M5C = Specialist - opthamology  
M5D = Specialist - other  
M6 = Consultations  
P0 = Anesthesia  
P1A = Major procedure - breast  
P1B = Major procedure - colectomy  
P1C = Major procedure - cholecystectomy  
P1D = Major procedure - turp  
P1E = Major procedure - hysterectomy  
P1F = Major procedure - explor/decompr/excisdisc  
P1G = Major procedure - Other  
P2A = Major procedure, cardiovascular-CABG  
P2B = Major procedure, cardiovascular-Aneurysm repair  
P2C = Major Procedure, cardiovascular-Thromboendarterectomy  
P2D = Major procedure, cardiovascularr-Coronary angioplasty (PTCA)  
P2E = Major procedure, cardiovascular-Pacemaker insertion  
P2F = Major procedure, cardiovascular-Other  
P3A = Major procedure, orthopedic - Hip fracture repair  
P3B = Major procedure, orthopedic - Hip replacement  
P3C = Major procedure, orthopedic - Knee replacement  
P3D = Major procedure, orthopedic - other  
P4A = Eye procedure - corneal transplant  
P4B = Eye procedure - cataract removal/lens insertion

P4C = Eye procedure - retinal detachment  
P4D = Eye procedure - treatment of retinal lesions  
P4E = Eye procedure - other  
P5A = Ambulatory procedures - skin  
P5B = Ambulatory procedures - musculoskeletal  
P5C = Ambulatory procedures - inguinal hernia repair  
P5D = Ambulatory procedures - lithotripsy  
P5E = Ambulatory procedures - other  
P6A = Minor procedures - skin  
P6B = Minor procedures - musculoskeletal  
P6C = Minor procedures - other (Medicare fee schedule)  
P6D = Minor procedures - other (non-Medicare fee schedule)  
P7A = Oncology - radiation therapy  
P7B = Oncology - other  
P8A = Endoscopy - arthroscopy  
P8B = Endoscopy - upper gastrointestinal  
P8C = Endoscopy - sigmoidoscopy  
P8D = Endoscopy - colonoscopy  
P8E = Endoscopy - cystoscopy  
P8F = Endoscopy - bronchoscopy  
P8G = Endoscopy - laparoscopic cholecystectomy  
P8H = Endoscopy - laryngoscopy  
P8I = Endoscopy - other  
P9A = Dialysis services (medicare fee schedule)  
P9B = Dialysis services (non-medicare fee schedule)  
I1A = Standard imaging - chest  
I1B = Standard imaging - musculoskeletal  
I1C = Standard imaging - breast  
I1D = Standard imaging - contrast gastrointestinal  
I1E = Standard imaging - nuclear medicine  
I1F = Standard imaging - other  
I2A = Advanced imaging - CAT/CT/CTA: brain/head/neck  
I2B = Advanced imaging - CAT/CT/CTA: other  
I2C = Advanced imaging - MRI/MRA: brain/head/neck  
I2D = Advanced imaging - MRI/MRA: other  
I3A = Echography/ultrasonography - eye  
I3B = Echography/ultrasonography - abdomen/pelvis  
I3C = Echography/ultrasonography - heart  
I3D = Echography/ultrasonography - carotid arteries  
I3E = Echography/ultrasonography - prostate, transrectal

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I3F = Echography/ultrasonography - other
I4A = Imaging/procedure - heart including cardiac
      catheterization
I4B = Imaging/procedure - other
T1A = Lab tests - routine venipuncture (non Medicare
      fee schedule)
T1B = Lab tests - automated general profiles
T1C = Lab tests - urinalysis
T1D = Lab tests - blood counts
T1E = Lab tests - glucose
T1F = Lab tests - bacterial cultures
T1G = Lab tests - other (Medicare fee schedule)
T1H = Lab tests - other (non-Medicare fee schedule)
T2A = Other tests - electrocardiograms
T2B = Other tests - cardiovascular stress tests
T2C = Other tests - EKG monitoring
T2D = Other tests - other
D1A = Medical/surgical supplies
D1B = Hospital beds
D1C = Oxygen and supplies
D1D = Wheelchairs
D1E = Other DME
D1F = Prosthetic/Orthotic devices
D1G = Drugs Administered through DME
O1A = Ambulance
O1B = Chiropractic
O1C = Enteral and parenteral
O1D = Chemotherapy
O1E = Other drugs
O1F = Hearing and speech services
O1G = Immunizations/Vaccinations
Y1 = Other - Medicare fee schedule
Y2 = Other - non-Medicare fee schedule
Z1 = Local codes
Z2 = Undefined codes

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CARR CLM ENTRY TB

Carrier Claim Entry Table

- 1 = Original debit; void of original debit  
(If CLM\_DISP\_CD = 3, code 1 means  
voided original debit)
- 3 = Full credit
- 5 = Replacement debit
- 9 = Accrete bill history only (internal;  
effective 2/22/91)

CARR\_CLM\_HOSPC\_OVRD\_IND\_TB                      Carrier Claim Hospice Override Indicator Table

- 0 = No Investigation
- 1 = Hospice investigation shown not applicable  
to this claim.

CARR\_CLM\_MCO\_OVRD\_IND\_TB                      Carrier Claim MCO Override Indicator Table

- 0 = No Investigation
- 1 = MCO Investigation does not apply to this  
claim.

CARR\_CLM\_PMT\_DNL\_TB                              Carrier Claim Payment Denial Table

Valid values effective 1/2011 (2-byte values are  
replacing the character values)

- 0 = Denied
- 1 = Physician/supplier
- 2 = Beneficiary
- 3 = Both physician/supplier and beneficiary
- 4 = Hospital (hospital based physicians)
- 5 = Both hospital and beneficiary
- 6 = Group practice prepayment plan
- 7 = Other entries (e.g. Employer, union)
- 8 = Federally funded
- 9 = PA service

A = Beneficiary under limitation of liability  
B = Physician/supplier under limitation of liability  
D = Denied due to demonstration involvement (eff. 5/97)  
E = MSP cost avoided IRS/SSA/HCFA Data Match (eff. 7/3/00)  
F = MSP cost avoided HMO Rate Cell (eff. 7/3/00)  
G = MSP cost avoided Litigation Settlement (eff. 7/3/00)  
H = MSP cost avoided Employer Voluntary Reporting (eff. 7/3/00)  
J = MSP cost avoided Insurer Voluntary Reporting (eff. 7/3/00)  
K = MSP cost avoided Initial Enrollment Questionnaire (eff. 7/3/00)  
P = Physician ownership denial (eff 3/92)  
Q = MSP cost avoided - (Contractor #88888) voluntary agreement (eff. 1/98)  
T = MSP cost avoided - IEQ contractor (eff. 7/96) (obsolete 6/30/00)  
U = MSP cost avoided - HMO rate cell adjustment (eff. 7/96) (obsolete 6/30/00)  
V = MSP cost avoided - litigation settlement (eff. 7/96) (obsolete 6/30/00)  
X = MSP cost avoided - generic  
Y = MSP cost avoided - IRS/SSA data match project (obsolete 6/30/00)  
00= MSP cost avoided - COB Contractor  
12= MSP cost avoided - BC/BS Voluntary Agreements  
13= MSP cost avoided - Office of Personnel Management  
14= MSP cost avoided - Workman's Compensation (WC) Datamatch  
15= MSP cost avoided - Workman's Compensation Insurer Voluntary Data Sharing Agreements (WC VDSA) (eff. 4/2006)  
16= MSP cost avoided - Liability Insurer VDSA (eff.4/2006)  
17= MSP cost avoided - No-Fault Insurer VDSA (eff.4/2006)  
18= MSP cost avoided - Pharmacy Benefit Manager Data Sharing Agreement (eff.4/2006)

21= MSP cost avoided - MIR Group Health Plan (eff.1/2009)  
22= MSP cost avoided - MIR non-Group Health Plan (eff.1/2009)  
25= MSP cost avoided - Recovery Audit Contractor - California  
(eff.10/2005)  
26= MSP cost avoided - Recovery Audit Contractor - Florida  
(eff.10/2005)

NOTE: Effective 4/1/02, the Carrier claim payment denial code was expanded to a 2-byte field. The NCH instituted a crosswalk from the 2-byte code to a 1-byte character code. Below are the character codes (found in NCH & NMUD). At some point, NMUD will carry the 2-byte code but NCH will continue to have the 1-byte character code.

! = MSP cost avoided - COB Contractor ('00' 2-byte code)  
@ = MSP cost avoided - BC/BS Voluntary Agreements  
( '12' 2-byte code)  
# = MSP cost avoided - Office of Personnel Management  
( '13' 2-byte code)  
\$ = MSP cost avoided - Workman's Compensation (WC) Datamatch  
( '14' 2-byte code)  
\* = MSP cost avoided - Workman's Compensation Insurer  
Voluntary Data Sharing Agreements (WC VDSA)  
( '15' 2-byte code) (eff. 4/2006)  
( = MSP cost avoided - Liability Insurer VDSA  
( '16' 2-byte code) (eff. 4/2006)  
) = MSP cost avoided - No-Fault Insurer VDSA  
( '17' 2-byte code) (eff. 4/2006)  
+ = MSP cost avoided - Pharmacy Benefit Manager Data  
Sharing Agreement ( '18' 2 -byte code) (eff. 4/2006)  
< = MSP cost avoided - MIR Group Health Plan  
( '21' 2-byte code) (eff. 1/2009)  
> = MSP cost avoided - MIR non-Group Health Plan  
( '22' 2-byte code) (eff. 1/2009)  
% = MSP cost avoided - Recovery Audit Contractor -  
- California ( '25' 2-byte code) (eff. 10/2005)  
& = MSP cost avoided - Recovery Audit Contractor -  
Florida ( '26' 2-byte code) (eff. 10/2005)

A = Assigned claim  
N = Non-assigned claim

CARR\_LINE\_CLIA\_ALERT\_IND\_TB                      Carrier Line CLIA Alert Indicator Code Table

(EFFECTIVE 9/92 BUT NOT STORED UNTIL 10/93)

0 = NO ALERT  
1 = 77X9  
2 = 77XA  
3 = 77X5  
4 = 77X6  
5 = 77X7  
6 = 77X8  
7 = 77XB

CARR\_LINE\_HPSA\_SCRCTY\_IND\_TB                      Carrier Line HPSA/Scarcity Indicator Code Table

1 = Health Professional Shortage Areas (HPSA)  
2 = PSA (Scarcity)  
3 = HPSA and PSA  
4 = HPSA Surgical Incentive Payment Program (HSIP) eff. 1/2011  
5 = HPSA and HSIP  
6 = Primary Care Incentive Payment Program (PCIP) eff. 1/2011  
7 = HPSA and PCIP  
Space = Not applicable

CARR\_LINE\_MTUS\_IND\_TB                              Carrier Line Miles/Time/Units Indicator Table

0 = Values reported as zero (no allowed  
    activities)  
1 = Transportation (ambulance) miles



- 2 = Anesthesia time units
- 3 = Services
- 4 = Oxygen units
- 5 = Units of blood
- 6 = Anesthesia base and time units (prior to 1991; from BMAD)

CARR\_LINE\_PRVDR\_TYPE\_TB

Carrier Line Provider Type Table

For Physician/Supplier (RIC O) Claims:

- 0 = Clinics, groups, associations, partnerships, or other entities
- 1 = Physicians or suppliers reporting as solo practitioners
- 2 = Suppliers (other than sole proprietorship)
- 3 = Institutional provider
- 4 = Independent laboratories
- 5 = Clinics (multiple specialties)
- 6 = Groups (single specialty)
- 7 = Other entities

For DMERC (RIC M) Claims - PRIOR TO VERSION H:

- 0 = Clinics, groups, associations, partnerships, or other entities for whom the carrier's own ID number has been assigned.
- 1 = Physicians or suppliers billing as solo practitioners for whom SSN's are shown in the physician ID code field.
- 2 = Physicians or suppliers billing as solo practitioners for whom the carrier's own physician ID code is shown.
- 3 = Suppliers (other than sole proprietorship) for whom EI numbers are used in coding the ID field.
- 4 = Suppliers (other than sole proprietorship)

for whom the carrier's own code has been shown.

- 5 = Institutional providers and independent laboratories for whom EI numbers are used in coding the ID field.
- 6 = Institutional providers and independent laboratories for whom the carrier's own ID number is shown.
- 7 = Clinics, groups, associations, or partnerships for whom EI numbers are used in coding the ID field.
- 8 = Other entities for whom EI numbers are used in coding the ID field or proprietorship for whom EI numbers are used in coding the ID field.

CARR\_LINE\_RDCD\_PHYSN\_ASTNT\_TB      Carrier Line Part B Reduced Physician Assistant Table

BLANK = Adjustment situation (where CLM\_DISP\_CD equal 3)

0 = N/A

1 = 65%

A) Physician assistants assisting in surgery

B) Nurse midwives

2 = 75%

A) Physician assistants performing services in a hospital (other than assisting surgery)

B) Nurse practitioners and clinical nurse specialists performing services in rural areas

C) Clinical social worker services

3 = 85%

A) Physician assistant services for other than assisting surgery

B) Nurse practitioners services

CARR\_NUM\_TB

Carrier Number/MAC Table

00510 = Alabama - CAHABA (eff. 1983)  
(replaced by MAC #10102 -- see below)  
00511 = Georgia - CAHABA (eff. 1998)  
(replaced by MAC #10202 -- see below)  
00512 = Mississippi - CAHABA (eff. 2000)  
00520 = Arkansas BC/BS (eff. 1983)  
00521 = New Mexico - Arkansas BC/BS (eff. 1998; term. 2008)  
(replaced by MAC #04202 -- see below)  
00522 = Oklahoma - Arkansas BC/BS (eff. 1998; term. 2008)  
(replaced by MAC #04302 -- see below)  
00523 = Missouri East - Arkansas BC/BS (eff. 1999; term. 2008)  
(replaced by MAC #05392 -- see below)  
00524 = Rhode Island - Arkansas BC/BS (eff. 2004)  
(replaced by MAC #14402 -- see below)  
00528 = Louisiana - Arkansas BS (eff. 1984)  
00542 = California BS (eff. 1983; term. 1996)  
00550 = Colorado BS (eff. 1983; term. 1994)  
00570 = Delaware - Pennsylvania BS (eff. 1983;  
term. 1997)  
00580 = District of Columbia - Pennsylvania BS  
(eff. 1983; term. 1997)  
00590 = Florida - First Coast (eff. 1983)  
(replaced by MAC #09102 -- see below)  
00591 = Connecticut - First Coast (eff. 2000)  
(replaced by MAC #13102 -- see below)  
00621 = Illinois BS - HCSC (eff. 1983; term. 1998)  
00623 = Michigan - Illinois Blue Shield (eff. 1995)  
(term. 1998)  
00630 = Indiana - Administar (eff. 1983)  
00635 = DMERC-B - Administar (eff. 1993)  
(replaced by MAC #17003 -- see below)  
00640 = Iowa - Wellmark, Inc. (eff. 1983; term. 1998)  
00645 = Nebraska - Iowa BS (eff. 1985; term. 1987)  
00650 = Kansas BCBS (eff. 1983) (term. 2008)  
(replaced by MAC #05202 -- see below)  
00655 = Nebraska - Kansas BC/BS (eff. 1988; term. 2008)

(replaced by MAC #05402 -- see below)  
00660 = Kentucky - Administar (eff. 1983)  
00690 = Maryland BS (eff. 1983; term. 1994)  
00700 = Massachusetts BS (eff. 1983; term. 1997)  
00710 = Michigan BS (eff. 1983; term. 1994)  
00720 = Minnesota BS (eff. 1983; term. 1995)  
00740 = Western Missouri - Kansas BS (eff. 1983; term.2008)  
(replaced by MAC #05302 -- see below)  
00751 = Montana BC/BS (eff. 1983)  
(replaced by MAC # 03202 -- see below)  
00770 = New Hampshire/Vermont Physician Services  
(eff. 1983; term. 1984)  
00780 = New Hampshire/Vermont - Massachusetts BS  
(eff. 1985; term. 1997)  
00801 = New York - Healthnow (eff. 1983)  
(replaced by MAC #13282 -- see below)  
00803 = New York - Empire BS (eff. 1983)  
(replaced by MAC #13202 -- see below)  
00805 = New Jersey - Empire BS (eff. 3/99)  
(replaced by MAC # 12402 -- see below)  
00811 = DMERC (A) - Healthnow (eff. 2000)  
(replaced by MAC #16003 -- see below)  
00820 = North Dakota - Noridian (eff. 1983)  
(replaced by MAC #03302 -- see below)  
00823 = Utah - Noridian (eff. 12/1/2005)  
(replaced by MAC #03502 -- see below)  
00824 = Colorado - Noridian (eff. 1995)  
(term. 2008)  
(replaced by MAC #04102 -- see below)  
00825 = Wyoming - Noridian (eff. 1990)  
(replaced by MAC #03602 -- see below)  
00826 = Iowa - Noridian (eff. 1999) (term. 2008)  
(replaced by MAC #05102 -- see below)  
00831 = Alaska - Noridian (eff. 1998)  
00832 = Arizona - Noridian (eff. 1998)  
(replaced by MAC # 03102 -- see below)  
00833 = Hawaii - Noridian (eff. 1998)  
(replaced by MAC # 01202 -- see below)  
00834 = Nevada - Noridian (eff. 1998)  
(replaced by MAC # 01302 -- see below)

00835 = Oregon - Noridian (eff. 1998)  
00836 = Washington - Noridian (eff. 1998)  
00860 = New Jersey - Pennsylvania BS (eff. 1988;  
term. 1999)  
00865 = Pennsylvania - Highmark (eff. 1983)  
(replaced by MAC # 12502 -- see below)  
00870 = Rhode Island BS (eff. 1983; term. 2004)  
00880 = South Carolina - Palmetto (eff. 1983)  
00882 = RRB - South Carolina PGBA (eff. 2000)  
00883 = Ohio - Palmetto (eff. 2002)  
00884 = West Virginia - Palmetto (eff. 2002)  
00885 = DMERC C - Palmetto (eff. 1993)  
(replaced by MAC #18003 -- see below)  
00889 = South Dakota - Noridian (eff. 4/1/2006)  
(replaced by MAC # 03402 -- see below)  
00900 = Texas - Trailblazer (eff. 1983; term. 2008)  
(replaced by MAC # 04402 -- see below)  
00901 = Maryland - Trailblazer (eff. 1995)  
(replaced by MAC # 12302 -- see below)  
00902 = Delaware - Trailblazer (eff. 1998)  
(replaced by MAC # 12102 -- see below)  
00903 = District of Columbia - Trailblazer (eff. 1998)  
(replaced by MAC # 12202 -- see below)  
00904 = Virginia - Trailblazer (eff. 2000)  
(replaced by MAC # 11302 -- see below)  
00910 = Utah BS (eff. 1983)  
00951 = Wisconsin - Wisconsin Phy Svc (eff. 1983)  
00952 = Illinois - Wisconsin Phy Svc (eff. 1999)  
00953 = Michigan - Wisconsin Phy Svc (eff. 1999)  
00954 = Minnesota - Wisconsin Phy Svc (eff. 2000)  
00973 = Puerto Rico - Triple S, Inc. (eff. 1983)  
(replaced by MAC # 09202 -- see below)  
00974 = Triple-S, Inc. - Virgin Islands  
01020 = Alaska - AETNA (eff. 1983; term. 1997)  
01030 = Arizona - AETNA (eff. 1983; term. 1997)  
01040 = Georgia - AETNA (eff. 1988; term. 1997)  
01120 = Hawaii - AETNA (eff. 1983; term. 1997)  
01290 = Nevada - AETNA (eff. 1983; term. 1997)  
01360 = New Mexico - AETNA (eff. 1986; term. 1997)  
01370 = Oklahoma - AETNA (eff. 1983; term. 1997)

01380 = Oregon - AETNA (eff. 1983; term. 1997)  
01390 = Washington - AETNA (eff. 1994; term. 1997)  
02050 = California - TOLIC (eff. 1983; term. 2000)  
03070 = Connecticut General Life Insurance Co.  
(eff. 1983; term. 1985)  
05130 = Idaho - CIGNA (eff. 1983)  
05302 = Western Missouri (eff. 3/2008)  
05320 = New Mexico - Equitable Insurance  
(eff. 1983; term. 1985)  
05440 = Tennessee - CIGNA (eff. 1983)  
(replaced by MAC #10302 - see below)  
05530 = Wyoming - Equitable Insurance (eff. 1983)  
(term. 1989)  
05535 = North Carolina - CIGNA (eff. 1988)  
05655 = DMERC-D Alaska - CIGNA (eff. 1993)  
(replaced by MAC #19003 -- see below)  
10071 = Railroad Board Travelers (eff. 1983)  
(term. 2000)  
10230 = Connecticut - Metra Health (eff. 1986)  
(term. 2000)  
10240 = Minnesota - Metra Health (eff. 1983)  
(term. 2000)  
10250 = Mississippi - Metra Health (eff. 1983)  
(term. 2000)  
10490 = Virginia - Metra Health (eff. 1983)  
(term. 2000)  
10555 = DMERC A - Travelers Insurance Co.  
(eff. 1993) (term. 2000)  
11260 = General American Life of Missouri  
(eff. 1983; term. 1998)  
14330 = New York - GHI (eff. 1983)  
(replaced by MAC #13292 -- see below)  
16360 = Ohio - Nationwide Insurance Co. (eff. 1983)  
(term. 2002)  
16510 = West Virginia - Nationwide Insurance Co.  
(eff. 1983) (term. 2002)  
21200 = Maine - Massachusetts BS  
(eff. 1983) (term. 1998)  
31140 = N. California - National Heritage Ins.  
(eff. 1997) (replaced by MAC #01102 -- see below)

31142 = Maine - National Heritage Ins.  
    (eff. 1998) (replaced with MAC # 14102 - see below)  
31143 = Massachusetts - National Heritage Ins.  
    (eff. 1998) (replaced with MAC # 14202 - see below)  
31144 = New Hampshire - National Heritage Ins.  
    (eff. 1998) (replaced with MAC # 14302 - see below)  
31145 = Vermont - National Heritage Ins.  
    (eff. 1998)  
31146 = So. California - NHIC (eff. 2000)  
80884 = Contractor ID for Physician Risk Adjust-  
    ment Data (data not sent through CWF;  
    but through Palmetto)

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Medicare Administrative Contractors (MACs)

JURISDICTION 1 -- Part B MACs

01102 = California (eff. 9/1/08)  
    (replaces carrier #00832)  
01202 = Hawaiiia (eff. 8/1/08)  
    (replaces carrier #00833)  
01302 = Nevada (eff. 8/1/08)  
    (replaces carrier #00834)

JURISDICTION 3 -- Part B MACs

03102 = Arizona (eff. 12/1/06)  
    (replaces carrier #00832)  
03202 = Montana (eff. 12/1/06)  
    (replaces carrier #00751)  
03302 = N. Dakota (eff. 12/1/06)  
    (replaces carrier #00820)  
03402 = S. Dakota (eff. 12/1/06)  
    (replaces carrier #00889)  
03502 = Utah (eff. 12/1/06)  
    (replaces carrier #00823)  
03602 = Wyoming (eff. 12/1/06)  
    (replaces carrier #00825)

JURISDICTION 4 -- Part B MACs

04102 = Colorado (eff. 3/24/08)  
         (replaces carrier #00824)  
04202 = New Mexico (eff. 3/1/08  
         (replaces carrier #00521)  
04302 = Oklahoma (eff. 3/1/08)  
         (replaces carrier #00522)  
04402 = Texas (eff. 6/13/08)  
         (replaces carrier #00900)

JURISDICTION 5 -- Part B MACs

05102 = Iowa (eff.2/1/08)  
         (replaces carrier #00826)  
05202 = Kansas (eff. 3/1/08)  
         (replaces carrier #00650)  
05302 = W. Missouri (eff. 3/1/08)  
         (replaces carrier #00651 or 00740)  
05392 = E. Missouri (eff. 6/1/08)  
         (replaces carrier #00523)  
05402 = Nebraska (eff. 3/1/08)  
         (replaces carrier #00655)

JURISDICTION 9 -- Part B MACs

09102 = Florida (eff.2/1/08)  
         (replaces carrier #00590)  
09202 = Puerto Rico/Virgin Island (eff.3/1/00)  
         (replaces carrier #00973)

JURISDICTION 10 -- Part B MACs

10102 = Alabama (eff.5/4/09)  
         (replaces carrier #00510)  
10202 = Georgia (eff.8/3/09)  
         (replaces carrier #00511)  
10302 = Tennessee (eff.9/1/09)  
         (replaces carrier #05440)



JURISDICTION 11 -- Part B MACs

11302 = Virginia (eff. 3/21/11)  
(replaces carrier #00904)

JURISDICTION 12 -- Part B MACs

12102 = New Jersey (eff. 7/11/2008)  
(replaces carrier # 00902)  
12202 = District of Columbia (eff. 7/11/2008)  
(replaces carrier # 00903)  
NOTE: Includes Montgomery & Prince Georges  
Counties in Maryland and Fairfax  
Counties and the City of Alexandria, VA  
12302 = Maryland (eff. 7/11/2008)  
(replaces carrier # 00901)  
12402 = New Jersey (eff. 11/14/2008)  
(replaces carrier # 00805)  
12502 = Pennsylvania (eff. 12/8/2008)  
(replaces carrier # 00865)

JURISDICTION 13 -- Part B MACs

13102 = Connecticut (eff. 8/1/2008)  
(replaces carrier # 00591)  
13202 = E. New York (eff. 7/18/2008)  
(replaces carrier # 00803)  
13282 = W. New York (eff. 9/1/2008)  
(replaces carrier # 00801)  
13292 = New York (Queens) (eff. 7/18/2008)  
(replaces carrier # 14330)

JURISDICTION 14 -- Part B MACs

14102 = Maine (eff. 6/1/2009)  
(replaces carrier # 31142)  
14202 = Massachusetts (eff. 6/1/2009)  
(replaces carrier # 31143)  
14302 = N. Hampshire (eff. 6/1/2009)  
(replaces carrier # 31144)

14402 = Rhode Island (eff. 5/1/2009)  
(replaces carrier # 00524)  
14502 = Vermont (eff. 6/1/2009)  
(replaces carrier # 31145)

Durable Medical Equipment (DME) MACs

16003 = National Heritage Insurance  
Company (NHIC) (eff. 7/1/06)  
(replaces carrier #00811)  
  
17003 = Administar Federal, Inc. (eff. 7/1/06)  
(replaces carrier # 00635)  
  
18003 = Palmetto GBA, LLC (eff. 6/1/07)  
(replaces carrier #00885)  
  
19003 = Noridan Administrative Services  
(eff. 10/1/06) (replaces carrier  
#05655)

CLM\_ADMTG\_DGNS\_VRSN\_TB

Claim Admitting Diagnosis Version Code Table

Valid Values:

9 = ICD-9  
0 = ICD-10

CLM\_BILL\_TYPE\_TB

Claim Bill Type Table

11 = Hospital-inpatient (Part A)  
12 = Hospital-inpatient or home health visits (Part B only)  
13 = Hospital-outpatient (HHA-A also) (under OPPS 13X  
must be used for ASC claims submitted for OPPS  
payment -- eff. 7/00)  
14 = Hospital-Laboratory Services Provided to

Non-patients

- 15 = Hospital-intermediate care - level I (obsolete)
- 16 = Hospital-intermediate care - level II (obsolete)
- 17 = Hospital-intermediate care - level III (obsolete)
- 18 = Hospital-swing beds
- 19 = Reserved for national assignment
- 21 = SNF-inpatient (including Part A)
- 22 = SNF-inpatient or home health visits (Part B only)
- 23 = SNF-outpatient (HHA-A also)
- 24 = SNF-other (Part B) - (obsolete)
- 25 = SNF-intermediate care - level I (obsolete)
- 26 = SNF-intermediate care - level II (obsolete)
- 27 = SNF-intermediate care - level III (obsolete)
- 28 = SNF-swing beds
- 29 = SNF-reserved for national assignment
- 31 = HHA-inpatient (including Part A) (obsolete)
- 32 = HHA-inpatient (plan of treatment under Part B only)
- 33 = HHA-outpatient (plan of treatment under Part A,  
including DME under Part A)
- 34 = HHA-other (for medical and surgical services not  
under a plan of treatment)
- 35 = HHA-intermediate care - level I (obsolete)
- 36 = HHA-intermediate care - level II (obsolete)
- 37 = HHA-intermediate care - level III (obsolete)
- 38 = HHA-swing beds (obsolete)
- 39 = HHA-reserved for national assignment
- 41 = Religious Nonmedical Health Care Institution (RNHCI)  
hospital-inpatient (including Part A) (all references  
to Christian Science (CS) is obsolete eff. 8/00 and  
replaced with RNHCI)
- 42 = RNHCI hospital-inpatient or home health visits (Part B only)
- 43 = RNHCI hospital-outpatient (HHA-A also)
- 44 = RNHCI hospital-other (Part B) - (obsolete)
- 45 = RNHCI hospital-intermediate care - level I (obsolete)
- 46 = RNHCI hospital-intermediate care - level II (obsolete)
- 47 = RNHCI hospital-intermediate care - level III (obsolete)
- 48 = RNHCI hospital-swing beds (obsolete)
- 49 = RNHCI hospital-reserved for national assignment
- 51 = CS extended care-inpatient (including Part A) OBSOLETE  
eff. 7/00 - implementation of Religious Nonmedical

Health Care Institutions (RNHCI)

- 52 = RNHCI extended care-inpatient or home health visits  
(Part B only) (eff. 7/00) - OBSOLETE; prior to 7/00  
Christian Science (CS)
- 53 = RNHCI extended care-outpatient (HHA-A also) (eff. 7/00);  
OBSOLETE - prior to 7/00 referenced CS
- 54 = RNHCI extended care-other (Part B) (eff. 7/00)- OBSOLETE;  
prior to 7/00 referenced CS
- 55 = RNHCI extended care-intermediate care - level I (eff. 7/00)  
OBSOLETE - prior to 7/00 referenced CS
- 56 = RNHCI extended care-intermediate care - level II (eff. 7/00)  
OBSOLETE - prior to 7/00 referenced CS
- 57 = RNHCI extended care-intermediate care - level III (eff. 7/00)  
OBSOLETE - prior to 7/00 referenced CS
- 58 = RNHCI extended care-swing beds (eff. 7/00)- OBSOLETE  
prior to 7/00 referenced CS
- 59 = RNHCI extended care-reserved for national assignment  
(eff. 7/00) - OBSOLETE; prior to 7/00 referenced CS
- 61 = Intermediate care-inpatient (including Part A)  
OBSOLETE
- 62 = Intermediate care-inpatient or home health visits (Part B only)  
OBSOLETE
- 63 = Intermediate care-outpatient (HHA-A also) - OBSOLETE
- 64 = Intermediate care-other (Part B)- OBSOLETE
- 65 = Intermediate care-intermediate care - level I
- 66 = Intermediate care-intermediate care - level II
- 67 = Intermediate care-intermediate care - level III - OBSOLETE
- 68 = Intermediate care-swing beds - OBSOLETE
- 69 = Reserved for national assignment
- 71 = Clinic-rural health
- 72 = Clinic-hospital based or independent renal dialysis facility
- 73 = Clinic-Freestanding
- 74 = Clinic-ORF only (eff 4/97);  
ORF and CMHC (10/91 - 3/97)
- 75 = Clinic-CORF
- 76 = Clinic-CMHC (eff 4/97)
- 77 = Clinic-Federally Qualified Health Center (FQHC)  
eff. 4/2010
- 78 = Clinic-reserved for national assignment
- 79 = Clinic-other

|                                                          |       |
|----------------------------------------------------------|-------|
| 81 = Hospice (non-hospital based)                        |       |
| 82 = Hospice (hospital based)                            |       |
| 83 = Ambulatory Aurgical Center                          |       |
| (Discontinued for Hospitals Subject to Outpatient PPS;   |       |
| hospitals must use 13X for ASC claims submitted for OPPS |       |
| payment -- eff. 7/00)                                    |       |
| 84 = Freestanding Birthing Center                        |       |
| 85 = Critical Access Hospital                            | 0/94) |
| 86 = Residential Facility (eff. 4/1/2010)                |       |
| 87 = Reserved for national assignment                    |       |
| 88 = Reserved for national assignment                    |       |
| 89 = Special facility or ASC surgery-other               |       |
| 91 = Reserved for national assignment                    |       |
| 92 = Reserved for national assignment                    |       |
| 93 = Reserved for national assignment                    |       |
| 94 = Reserved for national assignment                    |       |
| 95 = Reserved for national assignment                    |       |
| 96 = Reserved for national assignment                    |       |
| 97 = Reserved for national assignment                    |       |
| 98 = Reserved for national assignment                    |       |
| 99 = Reserved for national assignment                    |       |

|                  |                                    |
|------------------|------------------------------------|
| CLM_DGNS_VRSN_TB | Claim Diagnosis Version Code Table |
|------------------|------------------------------------|

Valid Values:

9 = ICD-9  
0 = ICD-10

|             |                         |
|-------------|-------------------------|
| CLM_DISP_TB | Claim Disposition Table |
|-------------|-------------------------|

01 = Debit accepted  
02 = Debit accepted (automatic adjustment)  
    applicable through 4/4/93  
03 = Cancel accepted  
61 = \*Conversion code: debit accepted  
62 = \*Conversion code: debit accepted

(automatic adjustment)  
63 = \*Conversion code: cancel accepted

\*Used only during conversion period:  
1/1/91 - 2/21/91

CLM\_EXCPTD\_NEXCPTD\_TRTMT\_TB                      Claim Excepted/Nonexcepted Treatment Table

0 = No Entry  
1 = Excepted  
2 = Nonexcepted

CLM\_FAC\_TYPE\_TB                                      Claim Facility Type Table

1 = Hospital  
2 = Skilled nursing facility (SNF)  
3 = Home health agency (HHA)  
4 = Religious Nonmedical (Hospital)  
    (eff. 8/1/00); prior to 8/00 referenced Christian  
    Science (CS)  
5 = Religious Nonmedical (Extended Care)  
    (eff. 8/1/00); prior to 8/00 referenced CS  
    (discontinued effective 10/1/05)  
6 = Intermediate care  
7 = Clinic or hospital-based renal dialysis facility  
8 = Special facility or ASC surgery  
9 = Reserved

CLM\_FREQ\_TB                                              Claim Frequency Table

0 = Non-payment/zero claims  
1 = Admit thru discharge claim  
2 = Interim - first claim  
3 = Interim - continuing claim (not valid for

PPS claims)

- 4 = Interim - last claim (not valid for PPS claims)
- 5 = Late charge(s) only claim
- 6 = Reserved for national assignment; Adjustment of prior claim. Obsolete
- 7 = Replacement of prior claim;  
    eff 10/93, provider debit
- 8 = Void/cancel prior claim  
    eff 10/93, provider cancel
- 9 = Final claim -- used in an HH PPS  
    episode to indicate the claim  
    should be processed like debit/  
    credit adjustment to RAP (initial  
    claim) (eff. 10/00)
- A = Admission election notice - used when hospice  
    or Religious Nonmedical Health Care Institution  
    is submitting the HCFA-1450 as an  
    admission notice - hospice NOE only
- B = Hospice/Medicare Coordinated Care Demonstration/  
    RNCHI - Termination/Revocation Notice - hospice  
    NOE only (eff 9/93)
- C = Hospice change of provider notice  
    - hospice NOE only (eff 9/93)
- D = Hospice/Medicare Coordinated Care Demonstration/  
    RNHCI - void/cancel  
    - hospice NOE only (eff 9/93)
- E = Hospice change of ownership  
    - hospice NOE only (eff 1/97)
- F = Beneficiary initiated adjustment claim  
    (eff 10/93)
- G = CWF initiated adjustment claim (eff 10/93)
- H = CMS initiated adjustment claim (eff 10/93)
- I = Intermediary adjustment claim (other than PRO  
    or provider) - used to identify a  
    debit adjustment initiated by CMS or  
    an intermediary (other than QIO or Provider)  
    - eff 10/93, used to identify intermediary  
    initiated adjustment only
- J = Other adjustment request (eff 10/93)
- K = OIG initiated adjustment (eff 10/93)
- M = MSP initiated adjustment (eff 10/93)

N = Reserved for national assignment  
O = Nonpayment/Zero claims  
P = Adjustment required by Quality Improvement  
Organization (QIO) -- formerly Peer Review  
Organization (PRO)  
Q = Claim Submitted for Reconsideration Outside of  
Timely Limits  
X = Replacement of Prior Abbreviated Encounter Submission  
(used by Medicare Advantage contractor or other plan  
required to submit encounter data);  
Special adjustment processing - used for QA editing (eff 8/92)  
Obsolete  
Z = New Abbreviated Encounter Submission (TOB '11Z') used  
for MCO enrollee hospital discharges 7/1/97 - 12/31/98;  
not stored in the NCH. Exception: Problem in  
startup months may have resulted in this abbreviated  
UB-92 being erroneously stored in the NCH.

CLM\_HHA\_LUPA\_IND\_TB      Claim HHA Low Utilization Payment Adjustment (LUPA) Indicator Code Table

L = LUPA claim  
BLANK = Not a LUPA claim

CLM\_HHA\_RFRL\_TB                      Claim Home Health Referral Table

1 = Physician referral - The patient was  
admitted upon the recommendation of  
a personal physician.  
2 = Clinic referral - The patient was  
admitted upon the recommendation of  
this facility's clinic physician.  
3 = HMO referral - The patient was admitted  
upon the recommendation of an health  
maintenance organization (HMO)  
physician.  
4 = Transfer from hospital - The patient



was admitted as an inpatient transfer from an acute care facility.

- 5 = Transfer from a skilled nursing facility (SNF) - The patient was admitted as an inpatient transfer from a SNF.
- 6 = Transfer from another health care facility - The patient was admitted as a transfer from a health care facility other than an acute care facility or SNF.
- 7 = Emergency room - The patient was admitted upon the recommendation of this facility's emergency room physician.
- 8 = Court/law enforcement - The patient was admitted upon the direction of a court of law or upon the request of a law enforcement agency's representative.
- 9 = Information not available - The means by which the patient was admitted is not known.
- A = Transfer from a Critical Access Hospital - patient was admitted/referred to this facility as a transfer from a Critical Access Hospital.
- B = Transfer from another HHA - Beneficiaries are permitted to transfer from one HHA to another unrelated HHA under HH PPS. (eff. 10/00)
- C = Readmission to same HHA - If a beneficiary is discharged from an HHA and then re-admitted within the original 60-day episode, the original episode must be closed early and a new one created.  
NOTE: the use of this code will permit the agency to send a new RAP allowing all claims to be accepted by Medicare. (eff. 10/00)

CLM\_HIPPS\_TB

Claim SNF, HHA & IRF Health Insurance PPS Table

\*\*\*\*\* SNF PPS HIPPS \*\*\*\*\*

\*\*\*\*\*1st 3 positions (RUGS-III group)\*\*\*\*\*

AAA = Default: No assessment

BA1,BA2,BB1,BB2 = Behavior only problems (e.g.,  
physical/verbal abuse)

CA1,CA2,CB1,CB2 = Clinically-complex conditions  
CC1,CC2 (e.g., chemo, dialysis)

IA1,IA2,IB1,IB2 = Impaired cognition (e.g., im-  
paired cognition (e.g., short term memory)

PA1,PA2,PB1,PB2 = Reduced physical functions  
PC1,PC2,PD1,PD2  
PE1,PE2

RHA,RHB,RHC,RHL,RHX, RLA = Low/medium/high rehabilitation  
RLB,RLX,RMA,RMB,RMC,RML,RMX  
NOTE: (Codes RHL, RHX, RLX, RML, RMX are effective 1/3/06)

RUA,RUB,RUC,RUL,RUX,RVA = Very high/ultra high rehabilita-  
RVB,RVC,RVL,RVX tion: highest level  
NOTE: (Codes RUL, RUX, RVL, RVx are effective 1/3/06)

SE1,SE2,SE3 = Extensive services; e.g.; IV feed  
trach care

SSA,SSB,SSC = Special care; e.g.; coma, burns

\*\*\*\*\*Positions 4 & 5 represent HIPPS modifier/\*\*\*\*\*  
\*\*\*\*\* assessment type indicator \*\*\*\*\*

00 = No assessment completed

01 = Medicare 5-day full required assessment/not an

initial admission assessment  
02 = Medicare 30-day full required assessment  
03 = Medicare 60-day full required assessment  
04 = Medicare 90-day full required assessment  
05 = Medicare Readmission/Return required assessment  
(eff. 10/2000)  
07 = Medicare 14-day full or comprehensive assessment/  
not an initial admission assessment  
08 = Off-cycle Other Medicare Required Assessment (OMRA)  
11 = Admission assessment AND Medicare 5-day (or readmission/  
return) assessment  
17 = Medicare 14-day required assessment AND initial  
admission assessment (eff. 10/2000)  
18 = OMRA replacing Medicare 5-day required assessment  
(eff. 10/2000)  
19 = Special payment situation - 5 day assessment  
(eff. 7/1/2002)  
28 = OMRA replacing Medicare 30-day required assessment  
(eff. 10/2000)  
29 = Special payment situation - 30 day assessment  
(eff. 7/1/2002)  
30 = Off-cycle significant change assessment (outside  
assessment window) (eff. 10/2000)  
31 = Significant change assessment replaces Medicare  
5-day assessment (eff. 10/2000)  
32 = Significant change assessment replaces Medicare  
30-day assessment  
33 = Significant change assessment replaces Medicare  
6--day assessment  
34 = Significant change assessment replaces Medicare  
90-day assessment  
35 = Significant change assessment replaces a Medicare  
readmission/return assessment  
37 = Significant change assessment replaces Medicare  
14-day assessment  
38 = OMRA replacing Medicare 60-day required  
assessment  
39 = Special payment situation - 60 day assessment  
(eff. 7/1/2002)  
40 = Off-cycle significant correction assessment of a

prior assessment (outside assessment window)  
(eff. 10/2000)  
41 = Significant correction of prior full assessment  
replaces a Medicare 5-day assessment  
42 = Significant correction of prior full assessment  
replaces a Medicare 30-day assessment  
43 = Significant correction of prior full assessment  
replaces a Medicare 60-day assessment  
44 = Significant correction of prior full assessment  
replaces a Medicare 90-day assessment  
45 = Significant correction of a prior assessment  
replaces a readmission/return assessment  
(eff. 10/2000)  
47 = Significant correction of prior full assessment  
replaces a Medicare 14-day required assessment  
48 = OMRA replacing Medicare 90-day required assessment  
49 = Special payment situation - 90 day assessment  
(eff. 7/1/2002)  
54 = Quarterly review assessment - Medicare 90-day  
full assessment  
78 = OMRA replacing a Medicare 14-day assessment  
(eff. 10/2000)  
79 = Special payment situation - 14 day assessment  
(eff. 7/1/2002)

\*\*\*\*\*  
\*\*\*\*\*

\*\*\*\*\*Claim Home Health PPS HIPPS Table\*\*\*\*\*

\*\*\*\*\* KEY \*\*\*\*\*

Position 1 = 'H'  
Position 2 = Clinical (A, B, C, D)  
Position 3 = Functional (E, F, G, H, I)  
Position 4 = Service (J, K, L, M)  
Position 5 = identifies which elements of the code were  
computed or derived:  
1 = 2nd, 3rd, 4th positions computed  
2 = 2nd position derived  
3 = 3rd position derived

4 = 4th position derived  
5 = 2nd & 3rd positions derived  
6 = 3rd & 4th positions derived  
7 = 2nd & 4th positions derived  
8 = 2nd, 3rd, 4th positions derived

\*\*\*\*\*

\*\*HHRG = C0F0S0/Clinical = Min, Functional = Min, Service = Min\*\*

HAEJ1  
HAEJ2  
HAEJ3  
HAEJ4  
HAEJ5  
HAEJ6  
HAEJ7  
HAEJ8

\*\*HHRG = C0F0S1/Clinical = Min, Functional = Min, Service = Low\*\*

HAEK1  
HAEK2  
HAEK3  
HAEK4  
HAEK5  
HAEK6  
HAEK7  
HAEK8

\*\*HHRG = C0F0S2/Clinical = Min, Functional = Min, Service = Mod\*\*

HAEL1  
HAEL2  
HAEL3  
HAEL4  
HAEL5  
HAEL6  
HAEL7  
HAEL8

\*\*HHRG = C0F0S3/Clinical = Min, Functional = Min, Service = High\*\*

HAEM1  
HAEM2  
HAEM3  
HAEM4  
HAEM5

HAEM6  
HAEM7  
HAEM8  
\*\*HHRG = C0F1S0/Clinical = Min, Functional = Low, Service = Min\*\*  
HAFJ1  
HAFJ2  
HAFJ3  
HAFJ4  
HAFJ5  
HAFJ6  
HAFJ7  
HAFJ8  
\*\*HHRG = C0F1S1/Clinical = Min, Functional = Low, Service = Low\*\*  
HAFK1  
HAFK2  
HAFK3  
HAFK4  
HAFK5  
HAFK6  
HAFK7  
HAFK8  
\*\*HHRG = C0F1S2/Clinical = Min, Functional = Low, Service = Mod\*\*  
HAFL1  
HAFL2  
HAFL3  
HAFL4  
HAFL5  
HAFL6  
HAFL7  
HAFL8  
\*\*HHRG = C0F1S3/Clinical = Min, Functional = Low, Service = High\*\*  
HAFM1  
HAFM2  
HAFM3  
HAFM4  
HAFM5  
HAFM6  
HAFM7  
HAFM8  
\*\*HHRG = C0F2S0/Clinical = Min, Functional = Mod, Service = Min\*\*

HAGJ1  
HAGJ2  
HAGJ3  
HAGJ4  
HAGJ5  
HAGJ6  
HAGJ7  
HAGJ8  
\*\*HHRG = C0F2S1/Clinical = Min, Functional = Mod, Service = Low\*\*  
HAGK1  
HAGK2  
HAGK3  
HAGK4  
HAGK5  
HAGK6  
HAGK7  
HAGK8  
\*\*HHRG = C0F2S2/Clinical = Min, Functional = Mod, Service = Mod\*\*  
HAGL1  
HAGL2  
HAGL3  
HAGL4  
HAGL5  
HAGL6  
HAGL7  
HAGL8  
\*\*HHRG = C0F2S3/Clinical = Min, Functional = Mod, Service = High\*\*  
HAGM1  
HAGM2  
HAGM3  
HAGM4  
HAGM5  
HAGM6  
HAGM7  
HAGM8  
\*\*HHRG = C0F3S0/Clinical = Min, Functional = High, Service = Min\*\*  
HAHJ1  
HAHJ2  
HAHJ3  
HAHJ4

HAHJ5  
HAHJ6  
HAHJ7  
HAHJ8  
\*\*HHRG = C0F3S1/Clinical = Min, Functional = High, Service = Low\*\*  
HAHK1  
HAHK2  
HAHK3  
HAHK4  
HAHK5  
HAHK6  
HAHK7  
HAHK8  
\*\*HHRG = C0F3S2/Clinical = Min, Functional = High, Service = Mod\*\*  
HAHL1  
HAHL2  
HAHL3  
HAHL4  
HAHL5  
HAHL6  
HAHL7  
HAHL8  
\*\*HHRG = C0F3S3/Clinical = Min, Functional = High, Service = High\*\*  
HAHM1  
HAHM2  
HAHM3  
HAHM4  
HAHM5  
HAHM6  
HAHM7  
HAHM8  
\*\*HHRG = C0F4S0/Clinical = Min, Functional = Max, Service = Min\*\*  
HAIJ1  
HAIJ2  
HAIJ3  
HAIJ4  
HAIJ5  
HAIJ6  
HAIJ7  
HAIJ8



```
**HHRG = C0F4S1/Clinical = Min, Functional = Max, Service = Low**  
HAIK1  
HAIK2  
HAIK3  
HAIK4  
HAIK5  
HAIK6  
HAIK7  
HAIK8  
**HHRG = C0F4S2/Clinical = Min, Functional = Max, Service = Mod**  
HAIL1  
HAIL2  
HAIL3  
HAIL4  
HAIL5  
HAIL6  
HAIL7  
HAIL8  
**HHRG = C0F4S3/Clinical = Min, Functional = Max, Service = High**  
HAIM1  
HAIM2  
HAIM3  
HAIM4  
HAIM5  
HAIM6  
HAIM7  
HAIM8  
**HHRG = C1F0S0/Clinical = Low, Functional = Min, Service = Min**  
HBEJ1  
HBEJ2  
HBEJ3  
HBEJ4  
HBEJ5  
HBEJ6  
HBEJ7  
HBEJ8  
**HHRG = C1F0S1/Clinical = Low, Functional = Min, Service = Low**  
HBEK1  
HBEK2  
HBEK3
```

HBEK4  
HBEK5  
HBEK6  
HBEK7  
HBEK8  
\*\*HHRG = C1F0S2/Clinical = Low, Functional = Min, Service = Mod\*\*  
HBEL1  
HBEL2  
HBEL3  
HBEL4  
HBEL5  
HBEL6  
HBEL7  
HBEL8  
\*\*HHRG = C1F0S3/Clinical = Low, Functional = Min, Service = High\*\*  
HBEM1  
HBEM2  
HBEM3  
HBEM4  
HBEM5  
HBEM6  
HBEM7  
HBEM8  
\*\*HHRG = C1F1S0/Clinical = Low, Functional = Low, Service = Min\*\*  
HBFJ1  
HBFJ2  
HBFJ3  
HBFJ4  
HBFJ5  
HBFJ6  
HBFJ7  
HBFJ8  
\*\*HHRG = C1F1S1/Clinical = Low, Functional = Low, Service = Low\*\*  
HBFK1  
HBFK2  
HBFK3  
HBFK4  
HBFK5  
HBFK6  
HBFK7

HBFK8  
\*\*HHRG = C1F1S2/Clinical = Low, Functional = Low, Service = Mod\*\*  
HBFL1  
HBFL2  
HBFL3  
HBFL4  
HBFL5  
HBFL6  
HBFL7  
HBFL8  
\*\*HHRG = C1F1S3/Clinical = Low, Functional = Low, Service = High\*\*  
HBFM1  
HBFM2  
HBFM3  
HBFM4  
HBFM5  
HBFM6  
HBFM7  
HBFM8  
\*\*HHRG = C1F2S0/Clinical = Low, Functional = Mod, Service = Min\*\*  
HBGJ1  
HBGJ2  
HBGJ3  
HBGJ4  
HBGJ5  
HBGJ6  
HBGJ7  
HBGJ8  
\*\*HHRG = C1F2S1/Clinical = Low, Functional = Mod, Service = Low\*\*  
HBGK1  
HBGK2  
HBGK3  
HBGK4  
HBGK5  
HBGK6  
HBGK7  
HBGK8  
\*\*HHRG = C1F2S2/Clinical = Low, Functional = Mod, Service = Mod\*\*  
HBGL1  
HBGL2

HBGL3  
HBGL4  
HBGL5  
HBGL6  
HBGL7  
HBGL8  
\*\*HHRG = C1F2S3/Clinical = Low, Functional = Mod, Service = High\*\*  
HBGM1  
HBGM2  
HBGM3  
HBGM4  
HBGM5  
HBGM6  
HBGM7  
HBGM8  
\*\*HHRG = C1F3S0/Clinical = Low, Functional = High, Service = Min\*\*  
HBHJ1  
HBHJ2  
HBHJ3  
HBHJ4  
HBHJ5  
HBHJ6  
HBHJ7  
HBHJ8  
\*\*HHRG = C1F3S1/Clinical = Low, Functional = High, Service = Low\*\*  
HBHK1  
HBHK2  
HBHK3  
HBHK4  
HBHK5  
HBHK6  
HBHK7  
HBHK8  
\*\*HHRG = C1F3S2/Clinical = Low, Functional = High, Service = Mod\*\*  
HBHL1  
HBHL2  
HBHL3  
HBHL4  
HBHL5  
HBHL6

HBHL7  
HBHL8  
\*\*HHRG = C1F3S3/Clinical = Low, Functional = High, Service = High\*\*  
HBHM1  
HBHM2  
HBHM3  
HBHM4  
HBHM5  
HBHM6  
HBHM7  
HBHM8  
\*\*HHRG = C1F4S0/Clinical = Low, Functional = Max, Service = Min\*\*  
HBIJ1  
HBIJ2  
HBIJ3  
HBIJ4  
HBIJ5  
HBIJ6  
HBIJ7  
HBIJ8  
\*\*HHRG = C1F4S1/Clinical = Low, Functional = Max, Service = Low\*\*  
HBIK1  
HBIK2  
HBIK3  
HBIK4  
HBIK5  
HBIK6  
HBIK7  
HBIK8  
\*\*HHRG = C1F4S2/Clinical = Low, Functional = Max, Service = Mod\*\*  
HBIL1  
HBIL2  
HBIL3  
HBIL4  
HBIL5  
HBIL6  
HBIL7  
HBIL8  
\*\*HHRG = C1F4S3/Clinical = Low, Functional = Max, Service = High\*\*  
HBIM1

HBIM2  
HBIM3  
HBIM4  
HBIM5  
HBIM6  
HBIM7  
HBIM8  
\*\*HHRG = C2F0S0/Clinical = Mod, Functional = Min, Service = Min\*\*  
HCEJ1  
HCEJ2  
HCEJ3  
HCEJ4  
HCEJ5  
HCEJ6  
HCEJ7  
HCEJ8  
\*\*HHRG = C2F0S1/Clinical = Mod, Functional = Min, Service = Low\*\*  
HCEK1  
HCEK2  
HCEK3  
HCEK4  
HCEK5  
HCEK6  
HCEK7  
HCEK8  
\*\*HHRG = C2F0S2/Clinical = Mod, Functional = Min, Service = Mod\*\*  
HCEL1  
HCEL2  
HCEL3  
HCEL4  
HCEL5  
HCEL6  
HCEL7  
HCEL8  
\*\*HHRG = C2F0S3/Clinical = Mod, Functional = Min, Service = High\*\*  
HCEM1  
HCEM2  
HCEM3  
HCEM4  
HCEM5

HCEM6  
HCEM7  
HCEM8  
\*\*HHRG = C2F1S0/Clinical = Mod, Functional = Low, Service = Min\*\*  
HCFJ1  
HCFJ2  
HCFJ3  
HCFJ4  
HCFJ5  
HCFJ6  
HCFJ7  
HCFJ8  
\*\*HHRG = C2F1S1/Clinical = Mod, Functional = Low, Service = Low\*\*  
HCFK1  
HCFK2  
HCFK3  
HCFK4  
HCFK5  
HCFK6  
HCFK7  
HCFK8  
\*\*HHRG = C2F1S2/Clinical = Mod, Functional = Low, Service = Mod\*\*  
HCFL1  
HCFL2  
HCFL3  
HCFL4  
HCFL5  
HCFL6  
HCFL7  
HCFL8  
\*\*HHRG = C2F1S3/Clinical = Mod, Functional = Low, Service = High\*\*  
HCFM1  
HCFM2  
HCFM3  
HCFM4  
HCFM5  
HCFM6  
HCFM7  
HCFM8  
\*\*HHRG = C2F2S0/Clinical = Mod, Functional = Mod, Service = Min\*\*

HCGJ1  
HCGJ2  
HCGJ3  
HCGJ4  
HCGJ5  
HCGJ6  
HCGJ7  
HCGJ8  
\*\*HHRG = C2F2S1/Clinical = Mod, Functional = Mod, Service = Low\*\*  
HCGK1  
HCGK2  
HCGK3  
HCGK4  
HCGK5  
HCGK6  
HCGK7  
HCGK8  
\*\*HHRG = C2F2S2/Clinical = Mod, Functional = Mod, Service = Mod\*\*  
HCGL1  
HCGL2  
HCGL3  
HCGL4  
HCGL5  
HCGL6  
HCGL7  
HCGL8  
\*\*HHRG = C2F2S3/Clinical = Mod, Functional = Mod, Service = High\*\*  
HCGM1  
HCGM2  
HCGM3  
HCGM4  
HCGM5  
HCGM6  
HCGM7  
HCGM8  
\*\*HHRG = C2F3S0/Clinical = Mod, Functional = High, Service = Min\*\*  
HCHJ1  
HCHJ2  
HCHJ3  
HCHJ4



HCHJ5  
HCHJ6  
HCHJ7  
HCHJ8  
\*\*HHRG = C2F3S1/Clinical = Mod, Functional = High, Service = Low\*\*  
HCHK1  
HCHK2  
HCHK3  
HCHK4  
HCHK5  
HCHK6  
HCHK7  
HCHK8  
\*\*HHRG = C2F3S2/Clinical = Mod, Functional = High, Service = Mod\*\*  
HCHL1  
HCHL2  
HCHL3  
HCHL4  
HCHL5  
HCHL6  
HCHL7  
HCHL8  
\*\*HHRG = C2F3S3/Clinical = Mod, Functional = High, Service = High\*\*  
HCHM1  
HCHM2  
HCHM3  
HCHM4  
HCHM5  
HCHM6  
HCHM7  
HCHM8  
\*\*HHRG = C2F4S0/Clinical = Mod, Functional = Max, Service = Min\*\*  
HCIJ1  
HCIJ2  
HCIJ3  
HCIJ4  
HCIJ5  
HCIJ6  
HCIJ7  
HCIJ8

```
**HHRG = C2F4S1/Clinical = Mod, Functional = Max, Service = Low**
HCIK1
HCIK2
HCIK3
HCIK4
HCIK5
HCIK6
HCIK7
HCIK8
**HHRG = C2F4S2/Clinical = Mod, Functional = Max, Service = Mod**
HCIL1
HCIL2
HCIL3
HCIL4
HCIL5
HCIL6
HCIL7
HCIL8
**HHRG = C2F4S3/Clinical = Mod, Functional = Max, Service = High**
HCIM1
HCIM2
HCIM3
HCIM4
HCIM5
HCIM6
HCIM7
HCIM8
**HHRG = C3F0S0/Clinical = High, Functional = Min, Service = Min**
HDEJ1
HDEJ2
HDEJ3
HDEJ4
HDEJ5
HDEJ6
HDEJ7
HDEJ8
**HHRG = C3F0S1/Clinical = High, Functional = Min, Service = Low**
HDEK1
HDEK2
HDEK3
```

HDEK4  
HDEK5  
HDEK6  
HDEK7  
HDEK8  
\*\*HHRG = C3F0S2/Clinical = High, Functional = Min, Service = Mod\*\*  
HDEL1  
HDEL2  
HDEL3  
HDEL4  
HDEL5  
HDEL6  
HDEL7  
HDEL8  
\*\*HHRG = C3F0S3/Clinical = High, Functional = Min, Service = High\*\*  
HDEM1  
HDEM2  
HDEM3  
HDEM4  
HDEM5  
HDEM6  
HDEM7  
HDEM8  
\*\*HHRG = C3F1S0/Clinical = High, Functional = Low, Service = Min\*\*  
HDFJ1  
HDFJ2  
HDFJ3  
HDFJ4  
HDFJ5  
HDFJ6  
HDFJ7  
HDFJ8  
\*\*HHRG = C3F1S1/Clinical = High, Functional = Low, Service = Low\*\*  
HDFK1  
HDFK2  
HDFK3  
HDFK4  
HDFK5  
HDFK6  
HDFK7

HDFK8  
\*\*HHRG = C3F1S2/Clinical = High, Functional = Low, Service = Mod\*\*  
HDFL1  
HDFL2  
HDFL3  
HDFL4  
HDFL5  
HDFL6  
HDFL7  
HDFL8  
\*\*HHRG = C3F1S3/Clinical = High, Functional = Low, Service = High\*\*  
HDFM1  
HDFM2  
HDFM3  
HDFM4  
HDFM5  
HDFM6  
HDFM7  
HDFM8  
\*\*HHRG = C3F2S0/Clinical = High, Functional = Mod, Service = Min\*\*  
HDGJ1  
HDGJ2  
HDGJ3  
HDGJ4  
HDGJ5  
HDGJ6  
HDGJ7  
HDGJ8  
\*\*HHRG = C3F2S1/Clinical = High, Functional = Mod, Service = Low\*\*  
HDGK1  
HDGK2  
HDGK3  
HDGK4  
HDGK5  
HDGK6  
HDGK7  
HDGK8  
\*\*HHRG = C3F2S2/Clinical = High, Functional = Mod, Service = Mod\*\*  
HDGL1  
HDGL2

HDGL3  
HDGL4  
HDGL5  
HDGL6  
HDGL7  
HDGL8  
\*\*HHRG = C3F2S3/Clinical = High, Functional = Mod, Service = High\*\*  
HDGM1  
HDGM2  
HDGM3  
HDGM4  
HDGM5  
HDGM6  
HDGM7  
HDGM8  
\*\*HHRG = C3F3S0/Clinical = High, Functional = High, Service = Min\*\*  
HDHJ1  
HDHJ2  
HDHJ3  
HDHJ4  
HDHJ5  
HDHJ6  
HDHJ7  
HDHJ8  
\*\*HHRG = C3F3S1/Clinical = High, Functional = High, Service = Low\*\*  
HDHK1  
HDHK2  
HDHK3  
HDHK4  
HDHK5  
HDHK6  
HDHK7  
HDHK8  
\*\*HHRG = C3F3S2/Clinical = High, Functional = High, Service = Mod\*\*  
HDHL1  
HDHL2  
HDHL3  
HDHL4  
HDHL5  
HDHL6

HDHL7  
HDHL8  
\*\*HHRG = C3F3S3/Clinical = High, Functional = High, Service = High\*\*  
HDHM1  
HDHM2  
HDHM3  
HDHM4  
HDHM5  
HDHM6  
HDHM7  
HDHM8  
\*\*HHRG = C3F4S0/Clinical = High, Functional = Max, Service = Min\*\*  
HDIJ1  
HDIJ2  
HDIJ3  
HDIJ4  
HDIJ5  
HDIJ6  
HDIJ7  
HDIJ8  
\*\*HHRG = C3F4S1/Clinical = High, Functional = Max, Service = Low\*\*  
HDIK1  
HDIK2  
HDIK3  
HDIK4  
HDIK5  
HDIK6  
HDIK7  
HDIK8  
\*\*HHRG = C3F4S2/Clinical = High, Functional = Max, Service = Mod\*\*  
HDIL1  
HDIL2  
HDIL3  
HDIL4  
HDIL5  
HDIL6  
HDIL7  
HDIL8  
\*\*HHRG = C3F4S3/Clinical = High, Functional = Max, Service = High\*\*  
HDIM1

HDIM2  
HDIM3  
HDIM4  
HDIM5  
HDIM6  
HDIM7  
HDIM8

\*\*\*\*\*  
\*\*\*\*\*

\*\*\*\*\*Claim IRF PPS HIPPS Table\*\*\*\*\*  
\*\*\*\*\*1st position\*\*\*\*\*

A = CMG is defined as without comorbidity  
B = CMG is defined as with comorbidity for Tier 1  
C = CMG is defined as with comorbidity for Tier 2  
D = CMG is defined as with comorbidity for Tier 3

\*\*\*\*\*2nd/3rd & 4th/5th positions\*\*\*\*\*  
The 2nd & 3rd positions represent the Rehabilitation Impair-  
ment Code (RIC).

The 3rd & 4th positions represent the sequential number  
system within the RIC.

0101 = Stroke with motor score from 69-84 and cognitive score  
from 23-35

0102 = Stroke with motor score from 59-68 and cognitive score  
from 23-35

0103 = Stroke with motor score from 59-64 and cognitive score  
from 5-22

0104 = Stroke with motor score from 53-58

0105 = Stroke with motor score from 47-52

0106 = Stroke with motor score from 42-46

0107 = Stroke with motor score from 39-41

0108 = Stroke with motor score from 34-38 and patient is  
83 years old or older

0109 = Stroke with motor score from 34-38 and patient is  
82 years old or older

0110 = Stroke with motor score from 12-33 and patient is  
89 years old or older

0111 = Stroke with motor score from 27-33 and patient is  
82 and 88 years old. (discontinued 10/2005)

0112 = Stroke with motor score from 12-26 and patient is  
82 and 88 years old. (discontinued 10/2005)

0113 = Stroke with motor score from 27-33 and patient is  
81 years old or younger. (discontinued 10/2005)

0114 = Stroke with motor score from 12-26 and patient is  
81 years old or younger. (discontinued 10/2005)

0201 = Traumatic brain injury with motor score from  
52-84 and cognitive score from 24-35

0202 = Traumatic brain injury with motor score from  
40-51 and cognitive score from 24-35

0203 = Traumatic brain injury with motor score from  
40-84 and cognitive score from 5-23

0204 = Traumatic brain injury with motor score from  
30-39

0205 = Traumatic brain injury with motor score from  
12-29

0206 = Traumatic brain injury with motor score > 22.05 &  
motor score < 28.75 (eff. 10/2005)



0207 = Traumatic brain injury with motor score < 22.05  
(eff. 10/2005)

0301 = Non-traumatic brain injury with motor score from  
51-84

0302 = Non-traumatic brain injury with motor score from  
41-50

0303 = Non-traumatic brain injury with motor score from  
25-40

0304 = Non-traumatic brain injury with motor score from  
12-24

0401 = Traumatic spinal cord injury with motor score  
50-84

0402 = Traumatic spinal cord injury with motor score  
36-49

0403 = Traumatic spinal cord injury with motor score  
19-35

0404 = Traumatic spinal cord injury with motor score  
12-18

0405 = Traumatic spinal cord injury with motor score  
< 10.05 & age < 63.5 (eff. 10/2005)

0501 = Non-traumatic spinal cord injury with motor score  
51-84 and cognitive score from 30-35

0502 = Non-traumatic spinal cord injury with motor score  
51-84 and cognitive score from 5-29

0503 = Non-traumatic spinal cord injury with motor score  
41-50

0504 = Non-traumatic spinal cord injury with motor score

34-40

0505 = Non-traumatic spinal cord injury with motor score  
12-33

0506 = Non-traumatic spinal cord injury with motor score  
< 23.75 (eff. 10/2005)

0601 = Neurological with motor score from 56-84

0602 = Neurological with motor score from 47-55

0603 = Neurological with motor score from 36-46

0604 = Neurological with motor score from 12-35

0701 = Fracture of lower extremity with motor score  
from 52-84

0702 = Fracture of lower extremity with motor score  
from 46-51

0703 = Fracture of lower extremity with motor score  
from 42-45

0704 = Fracture of lower extremity with motor score  
from 38-41

0705 = Fracture of lower extremity with motor score  
from 12-37 (discontinued 10/2005)

0801 = Replacement of lower extremity joint with motor  
score from 58-84

0802 = Replacement of lower extremity joint with motor  
score from 55-57

0803 = Replacement of lower extremity joint with motor  
score from 47-54

0804 = Replacement of lower extremity joint with motor score from 12-46 and cognitive score from 32-35

0805 = Replacement of lower extremity joint with motor score from 40-46 and cognitive score from 5-31

0806 = Replacement of lower extremity joint with motor score from 12-39 and cognitive score from 5-31

0901 = Other orthopedic with motor score from 54-84

0902 = Other orthopedic with motor score from 47-53

0903 = Other orthopedic with motor score from 38-46

0904 = Other orthopedic with motor score from 12-37

1001 = Amputation, lower extremity with motor score from 61-84

1002 = Amputation, lower extremity with motor score from 52-60

1003 = Amputation, lower extremity with motor score from 46-51

1004 = Amputation, lower extremity with motor score from 39-45 (discontinued 10/2005)

1005 = Amputation, lower extremity with motor score from 12-38 (discontinued 10/2005)

1101 = Amputation, non-lower extremity with motor score from 52-84

1102 = Amputation, non-lower extremity with motor score from 38-51

1103 = Amputation, non-lower extremity with motor score from 12-37 (discontinued 10/2005)

1201 = Osteoarthritis with motor score from 55-84 and  
cognitive score from 34-35

1202 = Osteoarthritis with motor score from 55-84 and  
cognitive score from 5-33

1203 = Osteoarthritis with motor score from 48-54

1204 = Osteoarthritis with motor score from 39-47  
(discontinued 10/2005)

1205 = Osteoarthritis with motor score from 12-38  
(discontinued 10/2005)

1301 = Rheumatoid, other arthritis with motor score  
from 54-84

1302 = Rheumatoid, other arthritis with motor score  
from 47-53

1303 = Rheumatoid, other arthritis with motor score  
from 36-46

1304 = Rheumatoid, other arthritis with motor score  
from 12-35 (discontinued 10/2005)

1401 = Cardiac with motor score from 56-84

1402 = Cardiac with motor score from 48-55

1403 = Cardiac with motor score from 38-47

1404 = Cardiac with motor score from 12-37

1501 = Pulmonary with motor score from 61-84

1502 = Pulmonary with motor score from 48-60

1503 = Pulmonary with motor score from 36-47

1504 = Pulmonary with motor score from 12-35

1601 = Pain syndrome with motor score from 45-84

1602 = Pain syndrome with motor score from 12-44

1603 = Pain syndrome with motor score < 26.75  
(eff. 10/2005)

1701 = Major multiple trauma without brain or spinal  
cord injury with motor score from 46-84

1702 = Major multiple trauma without brain or spinal  
cord injury with motor score from 33-45

1703 = Major multiple trauma without brain or spinal  
cord injury with motor score from 12-32

1704 = Major multiple trauma without brain or spinal  
cord injury with motor score < 25.55  
(eff. 10/2005)

1801 = Major multiple trauma with brain or spinal cord  
injury with motor score from 45-84 and cognitive  
score from 33-35

1802 = Major multiple trauma with brain or spinal cord  
injury with motor score from 45-84 and cognitive  
score from 5-32

1803 = Major multiple trauma with brain or spinal cord  
injury with motor score from 26-44

1804 = Major multiple trauma with brain or spinal cord  
injury with motor score from 12-25  
(discontinued 10/2005)

1901 = Guillian Barre with motor score from 47-84

1902 = Guillian Barre with motor score from 31-46

1903 = Guillian Barre with motor score from 12-30

2001 = Miscellaneous with motor score from 54-84

2002 = Miscellaneous with motor score from 45-53

2003 = Miscellaneous with motor score from 33-44

2004 = Miscellaneous with motor score from 12-32  
and patient is 82 years old or older

2005 = Miscellaneous with motor score from 12-32  
and patient is 81 years old or younger  
(discontinued 10/2005)

2101 = Burns with motor score from 46-84

2102 = Burns with motor score from 12-45  
(discontinued 10/2005)

NOTE: The following codes are ONLY prefixed with an 'A':

5001 = Short-stay cases, length of stay is 3 days or  
fewer

5101 = Expired, orthopedic, length of stay is 13 days  
or fewer

5102 = Expired, orthopedic, length of stay is 14 days  
or more

5103 = Expired, orthopedic, length of stay is 15 days  
or fewer

5104 = Expired, orthopedic, length of stay is 16 days  
or more

- 0 = Blank
- 1 = Emergency - The patient required immediate medical intervention as a result of severe, life threatening, or potentially disabling conditions. Generally, the patient was admitted through the emergency room.
- 2 = Urgent - The patient required immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient was admitted to the first available and suitable accommodation.
- 3 = Elective - The patient's condition permitted adequate time to schedule the availability of suitable accommodations.
- 4 = Newborn - Necessitates the use of special source of admission codes.
- 5 = Trauma Center - visits to a trauma center/hospital as licensed or designated by the State or local government authority authorized to do so, or as verified by the American College of Surgeons and involving a trauma activation.
- 6 THRU 8 = Reserved
- 9 = Unknown - Information not available.

CLM\_MCO\_PD\_TB

Claim MCO Paid Switch Code Table

- 1 = MCO has paid the provider for a claim
- BLANK or 0 = MCO has not paid the provider for a claim

CLM\_MDCR\_NPMT\_RSN\_TB

Claim Medicare Non-Payment Reason Table

Valid Values effective 1/2011 (2-byte values are replacing the character values)

A = Covered worker's compensation (Obsolete)  
B = Benefit exhausted  
C = Custodial care - noncovered care  
    (includes all 'beneficiary at fault'  
    waiver cases) (Obsolete)  
E = HMO out-of-plan services not emergency  
    or urgently needed (Obsolete)  
E = MSP cost avoided - IRS/SSA/HCFR Data  
    Match (eff. 7/00)  
F = MSP cost avoid HMO Rate Cell (eff. 7/00)  
G = MSP cost avoided Litigation Settlement  
    (eff. 7/00)  
H = MSP cost avoided Employer Voluntary  
    Reporting (eff. 7/00)  
J = MSP cost avoid Insurer Voluntary  
    Reporting (eff. 7/00)  
K = MSP cost avoid Initial Enrollment  
    Questionnaire (eff. 7/00)  
N = All other reasons for nonpayment  
P = Payment requested  
Q = MSP cost avoided Voluntary Agreement  
    (eff. 7/00)  
R = Benefits refused, or evidence not  
    submitted  
T = MSP cost avoided - IEQ contractor  
    (eff. 9/76) (obsolete 6/30/00)  
U = MSP cost avoided - HMO rate cell  
    adjustment (eff. 9/76) (Obsolete 6/30/00)  
V = MSP cost avoided - litigation  
    settlement (eff. 9/76) (Obsolete 6/30/00)  
W = Worker's compensation (Obsolete)  
X = MSP cost avoided - generic  
Y = MSP cost avoided - IRS/SSA data  
    match project (obsolete 6/30/00)  
Z = Zero reimbursement RAPs -- zero reimbursement  
    made due to medical review intervention or  
    where provider specific zero payment has been



determined. (effective with HHPPS - 10/00)

- 00 = MSP cost avoided - COB Contractor
- 12 = MSP cost avoided - BCBS Voluntary Agreements
- 13 = MSP cost avoided - Office of Personnel Management
- 14 = MSP cost avoided - Workman's Compensation (WC) Datamatch
- 15 = MSP cost avoided - Workman's Compensation Insurer Voluntary Data Sharing Agreements (WC VDSA) (eff. 4/2006)
- 16 = MSP cost avoided - Liability Insurer VDSA (eff. 4/2006)
- 17 = MSP cost avoided - No-Fault Insurer VDSA (eff. 4/2006)
- 18 = MSP cost avoided - Pharmacy Benefit Manager Data Sharing Agreement (eff. 4/2006)
- 21 = MSP cost avoided - MIR Group Health Plan (eff. 1/2009)
- 22 = MSP cost avoided - MIR non-Group Health Plan (eff. 1/2009)
- 25 = MSP cost avoided - Recovery Audit Contractor - California (eff. 10/2005)
- 26 = MSP cost avoided - Recovery Audit Contractor - Florida (eff. 10/2005)

Prior to 1/2011, the character values below were used to represent the 2-byte values

NOTE: Effective 4/1/02, the Medicare nonpayment reason code was expanded to a 2-byte field. The NCH instituted a crosswalk from the 2-byte code to a 1-byte character code. Below are the character codes (found in NCH & NMUD). At some point, NMUD will carry the 2-byte code but NCH will continue to have the 1-byte character code.

- ! = MSP cost avoided - COB Contractor ('00' 2-byte code)
- @ = MSP cost avoided - BC/BS Voluntary Agreements ('12' 2-byte code)
- # = MSP cost avoided - Office of Personnel Management ('13' 2-byte code)
- \$ = MSP cost avoided - Workman's Compensation (WC) Datamatch ('14' 2-byte code)
- \* = MSP cost avoided - Workman's Compensation Insurer Voluntary Data Sharing Agreements (WC VDSA) ('15' 2-byte code) (eff. 4/2006)
- ( = MSP cost avoided - Liability Insurer VDSA

('16' 2-byte code) (eff. 4/2006)  
 ) = MSP cost avoided - No-Fault Insurer VDSA  
 ('17' 2-byte code) (eff. 4/2006)  
 + = MSP cost avoided - Pharmacy Benefit Manager Data  
 Sharing Agreement ('18' 2-byte code) (eff. 4/2006)  
 < = MSP cost avoided - MIR Group Health Plan  
 ('21' 2-byte code) (eff. 1/2009)  
 > = MSP cost avoided - MIR non-Group Health Plan  
 ('22' 2-byte code) (eff. 1/2009)  
 % = MSP cost avoided - Recovery Audit Contractor -  
 - California ('25' 2-byte code) (eff. 10/2005)  
 & = MSP cost avoided - Recovery Audit Contractor -  
 Florida ('26' 2-byte code) (eff. 10/2005)

CLM\_OCRNC\_SPAN\_TB

Claim Occurrence Span Table

70 = Qualifying Stay Dates for SNF Use  
 Only - the from/through dates of at  
 least a 3-day inpatient hospital stay  
 that qualifies the resident for Medicare  
 payment of SNF services billed. Code  
 can only be used by SNF for billing.  
 71 = Hospital prior stay dates - the from/  
 thru dates of any hospital stay that  
 ended within 60 days of this hospital  
 or SNF admission.  
 72 = First/last visit - the dates of the  
 first and last visits occurring in this  
 billing period if the dates are different  
 from those in the statement covers period.  
 73 = Benefit eligibility period - the  
 inclusive dates during which CHAMPUS  
 medical benefits are available to a  
 sponsor's bene as shown on the  
 bene's ID card.  
 74 = Non-covered level of care - The from/  
 thru dates of a period at a noncovered  
 level of care in an otherwise

covered stay, excluding any period reported with occurrence span code 76, 77, or 79.

- 75 = The from/thru dates of SNF level of care during IP hospital stay. Shows PRO approval of patient remaining in hospital because SNF bed not available. not applicable to swing bed cases. PPS hospitals use in day outlier cases only.
- 76 = Patient liability - From/thru dates of period of noncovered care for which hospital may charge bene. The FI or PRO must have approved such charges in advance. patient must be notified in writing 3 days prior to noncovered period
- 77 = Provider liability (utilization charged) - The from/thru dates of period of noncovered care for which the provider is liable. Eff 3/92, applies to provider liability where bene is charged with utilization and is liable for deductible/coinsurance
- 78 = SNF prior stay dates - The from/thru dates of any SNF stay that ended within 60 days of this hospital or SNF admission.
- 79 = Provider Liability (non-utilization) (Payer code) - Eff 3/92, from/thru dates of period of noncovered care where bene is not charged with utilization, deductible, or coinsurance. and provider is liable. Eff 9/93, noncovered period of care due to lack of medical necessity.
- 80 = Prior Same-SNF Stay Dates for Payment Ban Purposes - the from/thru dates of a prior same-SNF stay indicating a patient resided in the SNF prior to, and if applicable, during a payment ban period

up until their discharge to a hospital.  
81 - 99 = Reserved for state assignment  
M0 = QIO/UR approved stay dates - Eff 10/93,  
the first and last days that were  
approved where not all of the stay was  
approved.  
M1 = Provider Liability-No Utilization -- from/  
thru dates of a period of noncovered care  
that is denied due to lack of medical  
necessity or custodial care for which the  
provider is liable. (eff. 10/01)  
M2 = Dates of Inpatient Respite Care -- from/thru  
dates of a period of inpatient respite care  
for hospice patients. (eff. 10/00)  
M3 = ICF Level of Care -- the from/through dates  
of a period of intermediate level of care  
during an inpatient hospital stay.  
M4 = Residential Level of Care - The from/through  
dates of a period of residential level of  
care during an inpatient hospital stay.

CLM\_OP\_ESRD\_MTHD\_REIMBSMT\_TB      Claim Outpatient ESRD Method of Reimbursement Table

0 = Not ESRD  
1 = Method 1 - Home supplies purchased  
through a facility  
2 = Method 2 - Home supplies purchased  
from a supplier.

CLM\_OP\_RFRL\_TB      Claim Outpatient Referral Table

\* For Outpatient Claims: Effective 3/91 \*

1 = Non-Health Care Facility Point of Origin  
(Physician Referral) - The patient presents  
to this facility an order from a physician

for services or seeks scheduled services for which an order is not required (e.g. mammography). Includes non-emergent self referrals. NOTE: Includes patients coming from home, a physician's office or work-place.

- 2 = Clinical referral - The patient was referred to this facility for outpatient or referenced diagnostic services by this facility's clinic or other outpatient department physician
- 3 = Reserved for national assignment. (eff. 10/1/07).  
Prior to 10/1/07, HMO referral - The patient referenced diagnostic services by a HMO physician.
- 4 = Transfer from a hospital (Different Facility) - The patient was admitted to this facility as a hospital transfer from an acute care facility where he or she was an outpatient. NOTE: Excludes Transfers from Hospital Inpatient in the same facility (see code D).
- 5 = Transfer from a SNF for Intermediate Care Facility (ICF) - The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of the SNF or ICF where he or she was a resident.
- 6 = Transfer from another health care facility - The patient was referred to this facility for services by (a physician of) another type of health care facility not defined elsewhere in this code list where he or she was an outpatient.
- 7 = Emergency room - The patient received unscheduled services in this facility's emergency department and discharged without an inpatient admission. Includes self referrals in emergency situations that

require immediate medical attention.

OBSOLETE - 7/1/10

- 8 = Court/law enforcement - The patient was referred to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative for outpatient or referenced diagnostic services.
- 9 = Information not available - For Medicare outpatient claims this is not a valid code.
- A = Reserved for National Assignment. (eff. 10/1/07)  
Prior to 10/07, defined as: Transfer from a Critical Access Hospital (CAH) -- The patient was referred to this facility for outpatient or referenced diagnostic services by (a physician of) the CAH where the patient is an inpatient.
- B = Transfer from Another Home Health Agency - The patient was admitted to this home health agency as a transfer from another home health agency. Discontinued 7/1/10 - replaced with condition code 47.
- C = Readmission to Same Home Health Agency - The patient was readmitted to this home health agency as a transfer from another home health agency. Discontinued 7/1/10
- D = Transfer from hospital inpatient in the same facility resulting in separate claim to the payer.
- E = Transfer from Ambulatory Surgery Center - The patient received outpatient services in this facility for outpatient or referenced diagnostic services from an ambulatory surgery center.
- F = Transfer from Hospice and is under a Hospice plan of care or enrolled in a Hospice program - the patient was referred to this facility for outpatient or referenced diagnostic services from a hospice.

## CLM\_OP\_SRVC\_TYPE\_TB

## Claim Outpatient Service Type Table

- 0 = Blank
- 1 = Emergency - The patient required immediate medical intervention as a result of severe, life threatening, or potentially disabling conditions. Generally, the patient was admitted through the emergency room.
- 2 = Urgent - The patient required immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient was admitted to the first available and suitable accommodation.
- 3 = Elective - The patient's condition permitted adequate time to schedule the availability of suitable accommodations.
- 5 THRU 8 = Reserved.
- 9 = Unknown - Information not available.

## CLM\_OP\_TRANS\_TYPE\_TB

## Claim Outpatient Transaction Type Table

- A = Outpatient Psychiatric Hospital
- B = Outpatient TB Hospital
- C = Outpatient General Care Hospital
- D = Outpatient SNF
- E = Home Health Agency
- F = Comprehensive Health Care
- G = Clinical Rehab Agency
- H = Rural Health Clinic
- I = Satellite Dialysis Facility
- J = Limited Care Facility
- 0 = Christian Science SNF
- 1 = Psychiatric Hospital Facility

2 = TB Hospital Facility  
3 = General Care Hospital  
4 = Regularly SNF  
Spaces = Home Health/Hospice

CLM\_POA\_IND\_TB

Claim Present on Admission (POA)

Indicator Table

Y = Diagnosis was present at the time of inpatient admission.  
CMS will pay the CC/MCC DRG for those selected HACs that  
are coded as 'Y' for the POA Indicator.

N = Diagnosis was not present at the time of inpatient admission.  
CMS will not pay the CC/MCC DRG for those selected HACs that  
are coded as 'N' for the POA Indicator.

U = Documentation is insufficient to determine if the  
condition was present at the time of inpatient admission.  
CMS will not pay the CC/MCC DRG for those selected HACs that  
are coded as 'U' for the POA Indicator. NOTE: From 4/15/10 to  
12/31/10, the MQR process assigned a 'U' to those POAs that came  
in blank. They did this because of the POA/DGNS issue.

W = Clinically undetermined. Provider is unable to clinically determine  
whether condition was present at the time of inpatient admission.  
CMS will pay the CC/MCC DRG for those selected HACs that  
are coded as 'W' for the POA Indicator.

1 = Unreported/not used - diagnosis codes exempt from POA reporting --  
This code is equivalent to a blank on the UB-04, however,  
it was determined that blanks are undesirable when submitting  
this data via the 4010A.  
CMS will not pay the CC/MCC DRG for those selected HACs that  
are coded as '1' for the POA Indicator. The '1' POA Indicator  
should not be applied to any codes on the HAC list.  
Obsolete eff. 1/3/11

Z = Denotes the end of the POA indicators (obsolete 1/2011).



X = Denotes the end of the POA indicators in special data processing situations that may be identified by CMS in the future (obsolete 1/2011).

Blank = identifies diagnosis codes that are exempt from the POA reporting requirements (replaces the '1'). NOTE: NCH/NMUD will carry a '0' in place of a blank.

CLM\_PPS\_IND\_TB

Claim PPS Indicator Table

\*\*\*Effective NCH weekly process date 10/3/97 - 5/29/98\*\*\*

0 = not PPS bill (claim contains no PPS indicator)  
2 = PPS bill (claim contains PPS indicator)

\*\*\*Effective NCH weekly process date 6/5/98\*\*\*

0 = not applicable (claim contains neither PPS nor deemed insured MQGE status indicators)  
1 = Deemed insured MQGE (claim contains deemed insured MQGE indicator but not PPS indicator)  
2 = PPS bill (claim contains PPS indicator but no deemed insured MQGE status indicator)  
3 = Both PPS and deemed insured MQGE (contains both PPS and deemed insured MQGE indicators)

CLM\_PRCR\_VRSN\_TB

Claim Procedure Version Code Table

Valid Values:

9 = ICD-9  
0 = ICD-10

CLM\_PRCR\_RTRN\_TB

Claim Pricer Return Code Table

\*\*\*\*\*Home Health Pricer Return Codes\*\*\*\*\*  
\*\*\*\*\*TOB 32X or 33X, DOS 10/1/2000 and after\*\*\*\*\*

Home Health Payment Return Codes:

00 = Final payment where no outlier applies  
01 = Final payment where outlier applies  
03 = Initial percentage payment, 0%  
04 = Initial percentage payment, 50%  
05 = Initial percentage payment, 60%  
06 = LUPA payment only  
07 = Final payment, SCIC  
08 = Final payment, SCIC with outlier  
09 = Final payment, PEP  
11 = Final payment, PEP with outlier  
12 = Final payment, SCIC within PEP  
13 = Final payment, SCIS within PEP with outlier

Home Health Error Return Codes:

10 = Invalid TOB  
15 = Invalid PEP Days  
16 = Invalid HRG Days, >60  
20 = PEP indicator invalid  
25 = Med review indicator invalid  
30 = Invalid MSA code  
35 = Invalid Initial Payment Indicator  
40 = Dates < October 1, 2000 or invalid  
70 = Invalid HRG Code  
75 = No HRG present in 1st occurrence  
80 = Invalid Revenue code  
85 = No revenue code present on HH final claim/  
adjustment

\*\*\*\*\*Hospice Pricer Return Codes\*\*\*\*\*  
\*\*\*\*\*TOB 81X or 82X\*\*\*\*\*

Hospice Payment Return Codes:

00 = Home rate returned

Hospice Error Return Codes:

10 = Bad units

20 = Bad units2 < 8  
30 = Bad MSA code  
40 = Bad hospice wage index from MSA file  
50 = Bad bene wage index from MSA file  
51 = Bad provider number

\*\*\*\*\*SNF Pricer Return Codes\*\*\*\*\*  
\*\*\*\*\*TOB 21X\*\*\*\*\*

SNF Payment return codes:  
00 = RUG III group rate returned

SNF Error return codes:  
20 = Bad RUG code  
30 = Bad MSA code  
40 = Thru date < July 1, 1998 or invalid  
50 = Invalid Federal blend for that year  
60 = Invalid Federal blend  
61 = Federal blend = 0 and SNF thru date < January  
1, 2000

\*\*\*Inpatient Hospital Pricer Return Codes\*\*\*  
\*\*\*\*\*TOB 11X\*\*\*\*\*

Inpatient Hospital Payment return codes:  
00 = Paid normal DRG payment  
01 = Paid as a day outlier (Note: day outlier no longer  
being paid as of 10/1/97)  
02 = Paid as a cost outlier  
03 = Transfer paid on a per diem basis up to and  
including the full DRG  
05 = Transfer paid on a per diem basis up to and  
including the full DRG which also qualified  
for a cost outlier payment  
06 = Provider refused cost outlier  
10 = DRG is 209, 210, or 211 and post-acute transfer  
12 = Post-acute transfer with specific DRGs. The  
following DRG's: 14, 113, 236, 263, 264, 429,  
483  
14 = Paid normal DRG payment with per diem days =

or > GM ALOS  
16 = Paid as a cost outlier with per diem days = or  
> GM ALOS

Inpatient Hospital Error return codes:

51 = No provider specific information found  
52 = Invalid MSA# in provider file  
53 = Waiver state - not calculated by PPS  
54 = DRG < 001 or > 511, or = 214, 215, 221, 222, 438,  
456, 457, 458  
55 = Discharge date < provider effective start date or  
discharge date < MSA effective start date for PPS  
56 = Invalid length of stay  
57 = Review code invalid (Not 00, 03, 06, 07, 09)  
58 = Total charges not numeric  
61 = Lifetime reserve days not numeric or BILL-LTR-DAYS  
> 60  
62 = Invalid number of covered days  
65 = PAY-CODE not = A, B or C on provider specific file  
for capital  
67 = Cost outlier with LOS > covered days

\*\*\*\*\*Outpatient PPS Pricer Return Codes\*\*\*\*\*

Outpatient PPS Payment return codes:

01 = Line processed to payment  
20 = Line processed but payment = 0 bene deductible  
= > adjusted payment

Outpatient PPS Error return codes:

30 = Missing, deleted or invalid APC  
38 = Missing or invalid discount factor  
40 = Invalid service indicator passed by the OCE  
41 = Service indicator invalid for OPPS PRICER  
42 = APC = '00000' or (packaging flag = 1 or 2)  
43 = Payment indicator not = to 1 or 5 thru 9  
44 = Service indicator = 'H' but payment indicator  
not = to 6  
45 = Packaging flag not = to 0  
46 = Line item denial/reject flag not = to 0

or line item denial/reject flag = to 1 and (APC  
not = 0033 or 0034 or 0322 or 0323 or 0324 or 0325  
or 0373 or 0374)) or line item action flag not = to  
1  
47 = Line item action flag = 2 or 3  
48 = Payment adjustment flag not valid  
49 = Site of service flag not = to 0 or (APC 0033 is not  
on the claim and service indicator = 'P' or APC =  
0322, 0325, 0373, 0374)  
50 = Wage index not located  
51 = Wage index equals zero  
52 = Provider specific file wage index reclassification  
code invalid or missing  
53 = Service from date not numeric or < 20000801  
54 = Service from date < provider effective date  
or service from date > provider termination date

\*\*\*Inpatient Rehab Facility (IRF) Pricer Return Codes\*\*\*

IRF Payment return codes:

00 = Paid normal CMG payment without outlier  
01 = Paid normal CMG payment with outlier  
02 = Transfer paid on a per diem basis without outlier  
03 = Transfer paid on a per diem basis with outlier  
04 = Blended CMG payment -- 2/3 Federal PPS rate +  
1/3 provider specific rate -- without outlier  
05 = Blended CMG payment -- 2/3 Federal PPS rate +  
1/3 provider specific rate -- with outlier  
06 = Blended transfer payment -- 2/3 Federal PPS  
transfer rate + 1/3 provider specific rate --  
without outlier  
07 = Blended transfer payment -- 2/3 Federal PPS  
transfer rate + 1/3 provider specific rate --  
with outlier  
10 = Paid normal CMG payment with penalty without  
outlier  
11 = Paid normal CMG payment with penalty with  
outlier  
12 = Transfer paid on a per diem basis with penalty  
without outlier

- 13 = Transfer paid on a per diem basis with penalty  
with outlier
- 14 = Blended CMG payment -- 2/3 Federal PPS rate +  
1/3 provider specific rate -- with penalty  
without outlier
- 15 = Blended CMG payment -- 2/3 Federal PPS rate +  
1/3 provider specific rate -- with penalty  
with outlier
- 16 = Blended transfer payment -- 2/3 Federal PPS  
transfer rate + 1/3 provider specific rate --  
with penalty without outlier
- 17 = Blended transfer payment -- 2/3 Federal PPS  
transfer rate + 1/3 provider specific rate --  
with penalty with outlier

IRF Error return codes:

- 50 = Provider specific rate not numeric
- 51 = Provider record terminated
- 52 = Invalid wage index
- 53 = Waiver state - not calculated by PPS
- 54 = CMG on claim not found in table
- 55 = Discharge date < provider effective start  
date or discharge date < MSA effective start  
date for PPS
- 56 = Invalid length of stay
- 57 = Provider specific rate zero when blended payment  
requested
- 58 = Total covered charges not numeric
- 59 = Provider specific record not found
- 60 = MSA wage index record not found
- 61 = Lifetime reserve days not numeric or  
BILL-LTR-DAYS > 60
- 62 = Invalid number of covered days
- 65 = Operating cost-to-charge ratio not numeric
- 67 = Cost outlier with LOS > covered days or cost  
outlier threshold calculation
- 72 = Invalid blend indicator (not 3 or 4)
- 73 = Discharged before provider FY begin date
- 74 = Provider FY begin date not in 2002

\*Long Term Care Hospital (LTCH) Pricer Return Codes\*

LTCH Payment return codes:

- 00 = Normal DRG payment without outlier
- 01 = Normal DRG payment with outlier
- 02 = Short stay payment without outlier
- 03 = Short stay payment with outlier
- 04 = Blend year 1 - 80% facility rate plus 20%  
normal DRG payment without outlier
- 05 = Blend year 1 - 80% facility rate plus 20%  
normal DRG payment with outlier
- 06 = Blend year 1 - 80% facility rate plus 20%  
short stay payment without outlier
- 07 = Blend year 1 - 80% facility rate plus 20%  
short stay payment with outlier
- 08 = Blend year 2 - 60% facility rate plus 40%  
normal DRG payment without outlier
- 09 = Blend year 2 - 60% facility rate plus 40%  
normal DRG payment with outlier
- 10 = Blend year 2 - 60% facility rate plus 40%  
short stay payment without outlier
- 11 = Blend year 2 - 60% facility rate plus 40%  
short stay payment with outlier
- 12 = Blend year 3 - 40% facility rate plus 60%  
normal DRG payment without outlier
- 13 = Blend year 3 - 40% facility rate plus 60%  
normal DRG payment with outlier
- 14 = Blend year 3 - 40% facility rate plus 60%  
short stay payment without outlier
- 15 = Blend year 3 - 40% facility rate plus 60%  
short stay payment with outlier
- 16 = Blend year 4 - 20% facility rate plus 80%  
normal DRG payment without outlier
- 17 = Blend year 4 - 20% facility rate plus 80%  
normal DRG payment with outlier
- 18 = Blend year 4 - 20% facility rate plus 80%  
short stay payment without outlier
- 19 = Blend year 4 - 20% facility rate plus 80%  
short stay payment with outlier

LTCH Error return codes:

- 50 = Provider specific rate not numeric
- 51 = Provider record terminated
- 52 = Invalid wage index
- 53 = Waiver state - not calculated by PPS
- 54 = DRG on claim not found in table
- 55 = Discharge date < provider effective start date  
or discharge date < MSA effective start date  
for PPS
- 56 = Invalid length of stay
- 57 = Provider specific rate zero when blended payment  
requested
- 58 = Total covered charges not numeric
- 59 = Provider specific record not found
- 60 = MSA wage index record not found
- 61 = Lifetime reserve days not numeric or BILL-LTR-DAYS  
> 60
- 62 = Invalid number of covered days
- 65 = Operating cost-to-charge ratio not numeric
- 67 = Cost outlier with LOS > covered days or cost  
outlier threshold calculation
- 72 = Invalid blend indicator (not 1 thru 5)
- 73 = Discharged before provider FY begin date
- 74 = Provider FY begin date not in 2002

\*\*\*End Stage Renal Disease (ESRD) Pricer Return Codes\*\*\*

ESRD Payment return codes:

- 00 = ESRD PPS payment calculated
- 01 = ESRD facility rate > zero

ESRD Error return codes:

- 50 = ESRD facility rate not numeric
- 52 = Provider type not = '40' or '41'
- 53 = Special payment indicator not = '1'  
or blank
- 54 = Date of birth not numeric or = zero
- 55 = Patient weight not numeric or = zero
- 56 = Patient height not numeric or = zero
- 57 = Revenue center code not in range



58 = Condition code not = '73' or '74' or blank  
60 = MSA wage adjusted rate record not found  
98 = Claim through date before 4/1/2005 or not numeric

CLM\_PTNT\_RSN\_VISIT\_VRSN\_TB                      Claim Patient Reason for Visit Version Code Table

Valid Values:

9 = ICD-9  
0 = ICD-10

CLM\_PWK\_TB                                              Claim Paperwork Code Table

P1 = one iteration is present  
P2 = two iterations are present  
P3 = three iterations are present  
P4 = four iterations are present  
P5 = five iterations are present  
P6 = six iterations are present  
P7 = seven iterations are present  
P8 = eight iterations are present  
P9 = nine iterations are present  
P0 = ten iterations are present

CLM\_QUERY\_TB                                              Claim Query Table

0 = Credit adjustment  
1 = Interim bill  
2 = Home Health Agency (HHA) benefits  
    exhausted (obsolete 7/98)  
3 = Final bill  
4 = Discharge notice (obsolete 7/98)  
5 = Debit adjustment

CLM\_RAC\_ADJSTMT\_TB                      Recovery Audit Contractor (RAC) Adjustment Indicator Table

R = RAC adjusted claim  
Spaces

CLM\_RLT\_COND\_TB

Claim Related Condition Table

- 01 = Military service related - Medical condition incurred during military service.
- 02 = Employment related - Patient alleged that the medical condition causing this episode of care was due to environment/ events resulting from employment.
- 03 = Patient covered by insurance not reflected here - Indicates that patient or patient representative has stated that coverage may exist beyond that reflected on this bill.
- 04 = Information Only Bill - Health Maintenance Organization (HMO) enrollee - Medicare beneficiary is enrolled in an HMO. Eff 9/93, hospital must also expect to receive payment from HMO.
- 05 = Lien has been filed - Provider has filed legal claim for recovery of funds potentially due a patient as a result of legal action initiated by or on behalf of the patient.
- 06 = ESRD patient in 1st 30 months of entitlement covered by employer group health insurance - indicates Medicare may be secondary insurer. Eff 3/1/96, ESRD patient in 1st 30 months of entitlement covered by employer group health insurance.
- 07 = Treatment of nonterminal condition for hospice patient - The patient is a hospice enrollee, but the provider is

- not treating a terminal condition and is requesting Medicare reimbursement.
- 08 = Beneficiary would not provide information concerning other insurance coverage.
- 09 = Neither patient nor spouse is employed  
- Code indicates that in response to development questions, the patient and spouse have denied employment.
- 10 = Patient and/or spouse is employed but no EGHP coverage exists or (eff 9/93) other employer sponsored/provided health insurance covering patient.
- 11 = The disabled beneficiary and/or family member has no group coverage from a LGHP or (eff 9/93) other employer sponsored/provided health insurance covering patient.
- 12 = Payer code - Reserved for internal use only by third party payers. CMS will assign as needed. Providers will not report them.
- 13 = Payer code - Reserved for internal use only by third party payers. CMS will assign as needed. Providers will not report them.
- 14 = Payer code - Reserved for internal use only by third party payers. CMS will assign as needed. Providers will not report them.
- 15 = Payer code - reserved for internal use only by third party payers. CMS will assign as needed. Providers will not report them. Prior to 3/07, clean claim (eff 10/92) OBSOLETE
- 16 = Payer code - reserved for internal use only by third party payers. CMS will assign as needed. Providers will not report them. Prior to 3/07. SNF transition exemption - An exemption from the post-hospital requirement applies

- for this SNF stay for the qualifying stay dates are more than 30 days prior to the admission date. OBSOLETE
- 17 = Patient is homeless (eff. 3/07). Prior to 3/07, code indicated Patient is over 100 years old - patient was over 100 years old at the date of admission.
- 18 = Maiden name retained - A dependent spouse entitled to benefits who does not use her husband's last name.
- 19 = Child retains mother's name - A patient who is a dependent child entitled to CHAMPVA benefits that does not have father's last name.
- 20 = Bene requested billing - Provider realizes the services on this bill are at a noncovered level of care or otherwise excluded from coverage, but the bene has requested formal determination
- 21 = Billing for denial notice - The SNF or HHA realizes services are at a noncovered level of care or excluded, but requests a Medicare denial in order to bill medicaid or other insurer
- 22 = Patient on multiple drug regimen - A patient who is receiving multiple intravenous drugs while on home IV therapy
- 23 = Homecaregiver available - The patient has a caregiver available to assist him or her during self-administration of an intravenous drug
- 24 = Home IV patient also receiving HHA services - the patient is under care of HHA while receiving home IV drug therapy services
- 25 = Patient is Non-U.S. resident
- 26 = VA eligible patient chooses to receive services in Medicare certified facility rather than a VA facility (eff 3/92)

- 27 = Patient referred to a sole community hospital for a diagnostic laboratory test - (sole community hospital only). (eff 9/93)
- 28 = Patient and/or spouse's EGHP is secondary to Medicare - Qualifying EGHP for employers who have fewer than 20 employees. (eff 9/93)
- 29 = Disabled beneficiary and/or family member's LGHP is secondary to Medicare - Qualifying LGHP for employer having fewer than 100 full and part-time employees
- 30 = Qualifying Clinical Trials - Non-research services provided to all patients, including managed care enrollees, enrolled in a Qualified Clinical Trial.
- 31 = Patient is student (full time - day) - Patient declares that he or she is enrolled as a full time day student.
- 32 = Patient is student (cooperative/work study program)
- 33 = Patient is student (full time - night) - Patient declares that he or she is enrolled as a full time night student.
- 34 = Patient is student (part time) - Patient declares that he or she is enrolled as a part time student.
- 36 = General care patient in a special unit - Patient is temporarily placed in special care unit bed because no general care beds were available.
- 37 = Ward accommodation is patient's request - Patient is assigned to ward accommodations at patient's request.
- 38 = Semi-private room not available - Indicates that either private or ward accommodations were assigned because semi-private accommodations were not available.

- 39 = Private room medically necessary -  
Patient needed a private room for  
medical reasons.
- 40 = Same day transfer - Patient  
transferred to another facility  
before midnight of the day of admission.
- 41 = Partial hospitalization - Eff 3/92,  
indicates claim is for partial  
hospitalization services. For OP  
services, this includes a variety  
of psych programs.
- 42 = Continuing Care Not Related to Inpatient  
Admission - continuing care not related  
to the condition or diagnosis for which  
the beneficiary received inpatient  
hospital services. (eff. 10/01)
- 43 = Continuing Care Not Provided Within  
Prescribed Postdischarge Window -  
continuing care was related to the  
inpatient admission but the prescribed  
care was not provided within the post-  
discharge window. (eff. 10/01)
- 44 = Inpatient Admission Changed to Outpatient -  
For use on outpatient claims only, when the  
physician ordered inpatient services, but  
upon internal review performed before the  
claim was initially submitted, the hospital  
determined the services did not meet its  
inpatient criteria. (eff. 4/1/04)
- 45 = Ambiguous Gender Category - claim indicates  
patient has ambiguous gender characteristics  
(e.g. transgendered or hermaphrodite).
- 46 = Nonavailability statement on file for  
CHAMPUS claim for nonemergency IP care  
for CHAMPUS bene residing within the  
catchment area (usually a 40 mile  
radius) of a uniform services hospital.
- 47 = Transfer from another Home Health Agency.  
(eff. 7/1/10)
- 48 = Psychiatric Residential Treatment Centers for

Children and Adolescents (RTCs)

- 49 = Product Replacement within Product Lifecycle- replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly (eff. 4/2006)
- 50 = Product Replacement for Known Recall of a Product - Manufacturer or FDA has identified the product for recall and therefore replacement. (eff. 4/2006)
- 51 = Reserved for national assignment.
- 52 = Reserved for national assignment.
- 53 = Reserved for national assignment.
- 54 = Reserved for national assignment.
- 55 = SNF bed not available - The patient's SNF admission was delayed more than 30 days after hospital discharge because a SNF bed was not available.
- 56 = Medical appropriateness - Patient's SNF admission was delayed more than 30 days after hospital discharge because physical condition made it inappropriate to begin active care within that period
- 57 = SNF readmission - Patient previously received Medicare covered SNF care within 30 days of the current SNF admission.
- 58 = Payment of SNF claims for beneficiaries disenrolling from terminating M+C plans plans who have not met the 3-day hospital stay requirement (eff. 10/1/00)
- 59 = Non-primary ESRD facility - code indicates that ESRD beneficiary received non-scheduled or emergency dialysis services at a facility other than his/her primary ESRD dialysis facility.
- 60 = Operating cost day outlier - A hospital being paid under a prospective payment system (PPS) is reporting this stay as a day outlier.

- 61 = Operating cost cost outlier - A hospital is being paid under a prospective payment system (PPS) is requesting additional payment for this stay as a cost outlier.
- 62 = Payer Code - providers do not report this code. PIP bill - This bill is a periodic interim payment bill. Obsolete
- 63 = Payer Code - providers do not report this code. PRO denial received before batch clearance report - The HCSSACL receipt date is used on PRO adjustment if the PRO's notification is before orig bill's acceptance report. (Payer only code eff 9/93)
- 64 = Payer Code - providers do not report this code. Other than clean claim - the claim is not a 'clean claim'. Obsolete
- 65 = Payer Code - Providers do not report this code. Non-PPS code - The bill is not a prospective payment system bill. Obsolete
- 66 = Outlier not claimed - Bill may meet the criteria for cost outlier, but the hospital did not claim the cost outlier (PPS)
- 67 = Beneficiary elects not to use LTR days
- 68 = Beneficiary elects to use LTR days
- 69 = IME/DGME/N&AH Payment Only - providers request for supplemental IME/DGME/N&AH payment for each discharge of MCO enrollee, beginning 1/1/98, from teaching hospitals (facilities with approved medical residency training program); not stored in NCH. Exception: problem in startup year may have resulted in this special IME payment request being erroneously stored in NCH. If present, disregard claim as condition code '69' is not valid NCH claim.
- 70 = Self-administered EPO - Billing is for a home dialysis patient who self administers EPO.
- 71 = Full care in unit - Billing is for a



- patient who received staff assisted dialysis services in a hospital or renal dialysis facility.
- 72 = Self care in unit - Billing is for a patient who managed his own dialysis services without staff assistance in a hospital or renal dialysis facility.
- 73 = Self care training - Billing is for special dialysis services where the patient and helper (if necessary) were learning to perform dialysis.
- 74 = Home - Billing is for a patient who received dialysis services at home.
- 75 = Home 100% reimbursement -  
(not to be used for services after 4/15/90)  
The billing is for home dialysis patient using a dialysis machine that was purchased under the 100% program.
- 76 = Back-up facility - Billing is for a patient who received dialysis services in a back-up facility.
- 77 = Provider accepts or is obligated/required due to contractual agreement or law to accept payment by a primary payer as payment in full - Medicare pays nothing.
- 78 = New coverage not implemented by HMO - eff 3/92, indicates newly covered service under Medicare for which HMO does not pay.
- 79 = CORF services provided off site - Code indicates that physical therapy, occupational therapy, or speech pathology services were provided off site.
- 80 = Home Dialysis - Nursing Facility - Home dialysis furnished in a SNF or nursing facility. (eff. 4/4/05)
- 81 - 99 = Reserved for state assignment.
- A0 = TRICARE External Partnership Program -  
This code identifies TRICARE claims submitted

under the External Partnership Program.

A0 = Special Zip Code Reporting - five digit  
zip code of the location from which the  
beneficiary is initially placed on board  
the ambulance. (eff. 9/01) Obsolete

A0 = CHAMPUS external partnership program  
special program indicator code. (eff 10/93)  
(obsolete)

A1 = EPSDT/CHAP - Early and periodic  
screening diagnosis and treatment  
special program indicator code. (eff 10/93)

A2 = Physically handicapped children's  
program - Services provided receive  
special funding through Title 8 of  
the Social Security Act or the CHAMPUS  
program for the handicapped. (eff 10/93)

A3 = Special federal funding - Designed for  
uniform use by state uniform billing  
committees.  
Special program indicator code (eff 10/93)

A4 = Family planning - Designed for  
uniform use by state uniform billing  
committees.  
Special program indicator code (eff 10/93)

A5 = Disability - Designed for uniform  
use by state uniform billing  
committees.  
Special program indicator code (eff 10/93)

A6 = PPV/Medicare 100% Payment - Identifies that  
pneumococcal pneumonia 100% payment  
vaccine (PPV) services should be  
reimbursed under a special Medicare  
program provision.  
Special program indicator code (eff 10/93)

A7 = Induced abortion to avoid danger to  
woman's life.  
Special program indicator code (eff 10/93)

A8 = Induced abortion - Victim of rape/  
incest.  
Special program indicator code (eff 10/93)

A9 = Second opinion surgery - Services requested to support second opinion on surgery. Part B deductible and coinsurance do not apply. Special program indicator code (eff 10/93)

AA = Abortion Performed due to Rape (eff. 10/1/02)

AB = Abortion Performed due to Incest (eff. 10/1/02)

AC = Abortion Performed due to Serious Fetal Genetic Defect, Deformity or Abnormality (eff. 10/1/02)

AD = Abortion Performed due to a Life Endangering Physical Condition Caused by, arising from or exacerbated by the Pregnancy itself (eff. 10/1/02)

AE = Abortion Performed due to physical health of mother that is not life endangering (eff. 10/1/02)

AF = Abortion Performed due to emotional/psychological health of mother (eff. 10/1/02)

AG = Abortion performed due to social economic reasons (eff. 10/1/02)

AH = Elective Abortion (eff. 10/1/02)

AI = Sterilization (eff. 10/1/02)

AJ = Payer Responsible for copayment (4/1/03)

AK = Air Ambulance Required - For ambulance claims. Time needed to transport poses a threat. (eff. 10/16/03)

AL = Specialized Treatment/bed Unavailable - For ambulance claims. Specialized treatment bed unavailable. Transported to alternate facility. (eff. 10/16/03)

AM = Non-emergency Medically Necessary Stretcher Transport Required - For ambulance claims. Non-emergency medically necessary stretcher transport required. (eff. 10/16/03)

AN = Preadmission Screening Not Required - person meets the criteria for an exemption from preadmission screening. (eff. 1/1/04)

B0 = Medicare Coordinated Care Demonstration Program - patient is a participant in

a Medicare Coordinated Care Demonstration  
(eff. 10/01)

- B1 = Beneficiary ineligible for demonstration program (eff. 1/02).
  - B2 = Critical Access Hospital Ambulance Attestation - Attestation by CAH that it meets the criteria for exemption from the Ambulance Fee Schedule
  - B3 = Pregnancy Indicator - Indicates the patient is pregnant. Required when mandated by law. (eff. 10/16/03)
  - B4 = Admission Unrelated to Discharge - Admission unrelated to discharge on same day. This code is for discharges starting on January 1, 2004.
  - B5 = Special program indicator  
Reserved for national assignment.
  - B6 = Special program indicator  
Reserved for national assignment.
  - B7 = Special program indicator  
Reserved for national assignment.
  - B8 = Special program indicator  
Reserved for national assignment.
  - B9 = Special program indicator  
Reserved for national assignment.
  - BP = Gulf Oil Spill of 2010 - The code identifies claims where the provision of all services on the claim are related, in whole or in part, to an illness, injury, or condition that was caused by or exacerbated by the effects, direct or indirect, of the 2010 oil spill in the Gulf of Mexico and/or circumstances related to such spill, including but not limited to subsequent clean-up activities.
  - C0 = Reserved for national assignment.
  - C1 = Approved as billed - The services provided for this billing period have been reviewed by the QIO/UR or intermediary and are fully approved including any day or cost outlier. (eff 10/93)
- NOTE: Beginning July 2005, this code is

- relevant to type of bills other than inpatient  
(18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).
- C2 = Automatic approval as billed based on  
focused review. (No longer used for  
Medicare)  
QIO approval indicator services (eff 10/93)  
NOTE: Beginning July 2005, this code is  
relevant to type of bills other than inpatient  
(18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).
- C3 = Partial approval - The services  
provided for this billing period have  
been reviewed by the QIO/UR or  
intermediary and some portion has been  
denied (days or services). (eff 10/93)  
NOTE: Beginning July 2005, this code is  
relevant to type of bills other than inpatient  
(18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).
- C4 = Admission/services denied - Indicates  
that all of the services were denied  
by the QIO/UR.  
QIO approval indicator services (eff 10/93)  
NOTE: Beginning July 2005, this code is  
relevant to types of bill other than inpatient  
(18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).
- C5 = Postpayment review applicable - QIO/UR  
review to take place after payment.  
QIO approval indicator services (eff 10/93)  
NOTE: Beginning July 2005, this code is  
relevant to types of bill other than inpatient  
(18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).
- C6 = Admission preauthorization - The  
QIO/UR authorized this admission/  
service but has not reviewed the  
services provided.  
QIO approval indicator services (eff 10/93)  
NOTE: Beginning July 2005, this code is  
relevant to types of bill other than inpatient  
(18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).
- C7 = Extended authorization - the QIO has  
authorized these services for an

extended length of time but has not reviewed the services provided.

QIO approval indicator services (eff 10/93)

NOTE: Beginning July 2005, this code is relevant to types of bill other than inpatient (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).

C8 = Reserved for national assignment.

QIO approval indicator services (eff 10/93)

C9 = Reserved for national assignment.

QIO approval indicator services (eff 10/93)

D0 = Changes to service dates.

Change condition (eff 10/93)

D1 = Changes in charges.

Change condition (eff 10/93)

D2 = Changes in revenue codes/HCPCS/HIPPS

Rate Code

Change condition (eff 10/93)

D3 = Second or subsequent interim

PPS bill.

Change condition (eff 10/93)

D4 = Change in ICD-9-CM diagnosis and/or procedure code

Change condition (eff 10/93)

D5 = Cancel only to correct a beneficiary claim account number or provider identification number.

change condition (eff 10/93)

D6 = Cancel only to repay a duplicate

payment or OIG overpayment (includes cancellation of an OP bill containing services required to be included on the IP bill). Change condition eff 10/93.

D7 = Change to make Medicare the secondary payer.

Change condition (eff 10/93)

D8 = Change to make Medicare the primary payer.

Change condition (eff 10/93)

D9 = Any other change.

Change condition (eff 10/93)

DR = Disaster Relief (eff. 10/2005) - Code used to facilitate claims processing and track services and items provided to victims of Hurricane Katrina and any future disasters.

E0 = Change in patient status.  
Change condition (eff 10/93)

EY = National Emphysema Treatment Trial (NETT) or Lung Volume Reduction Surgery (LVRS) clinical study (eff. 11/97) Obsolete

G0 = Multiple medical visits occur on the same day in the same revenue center but visits are distinct and constitute independent visits (allows for payment under outpatient PPS -- eff. 7/3/00).

H0 = Delayed Filing, Statement of Intent Submitted -- statement of intent was submitted within the qualifying period to specifically identify the existence of another third party liability situation. (eff. 9/01)

H2 = Discharge by a Hospice Provider for Cause (eff. 1/1/09).

M0 = Reserved for national assignment.

M0 = All inclusive rate for outpatient services. (payer only code). Obsolete

M1 = Reserved for national assignment.

M1 = Roster billed influenza virus vaccine. (payer only code)  
Eff 10/96, also includes pneumococcal pneumonia vaccine (PPV) Obsolete

M2 = Reserved for national assignment.

M2 = HH override code - home health total reimbursement exceeds the \$150,000 cap or the number of total visits exceeds the 150 limitation. (eff 4/3/95) Obsolete (payer only code)

P1 = Do Not Resuscitate Order (DNR) - for public health reporting only - code indicates that a DNR order was written at the time of or within the first 24 hours

of the patient's admission to the hospital and is clearly documented in the patient's medical record.

- P7 = Direct Inpatient Admission from Emergency Room - for public health reporting only when required by state or federal law or regulations. Code indicates that patient was admitted directly from this facility's emergency room department. (eff. 7/1/10)
- W0 = United Mine Workers of America (UMWA) SNF demonstration indicator (eff 1/97); but no claims transmitted until 2/98)
- W2 = Duplicate of Original Bill - code indicates bill is exact duplicate of the original bill submitted. (eff. 10/1/08)
- W3 = Level I Appeal - code indicates bill is submitted for reconsideration; the Level of appeal/reconsideration (I) is specified/defined by the payer. (eff. 10/1/08)
- W4 = Level II Appeal - Code indicates bill is submitted for reconsideration; the Level of appeal/reconsideration (II) is specified/defined by the payer. (eff. 10/1/08)
- W5 = Level III Appeal - Code indicates bill is submitted for reconsideration; the Level of appeal/reconsideration (III) is specified/defined by the payer. (eff. 10/1/08)
- XX = Transgender/Hermaphrodite Beneficiaries (eff. 1/2/07) Obsolete

CLM\_RLT\_OCRNC\_TB

Claim Related Occurrence Table

01 THRU 09 = Accident  
10 THRU 19 = Medical condition  
20 THRU 39 = Insurance related  
40 THRU 69 = Service related  
A1-A3 = Miscellaneous

=====



- 01 = Auto accident - The date of an auto accident.
- 02 = No-fault insurance involved, including auto accident/other - The date of an accident where the state has applicable no-fault liability laws, (i.e., legal basis for settlement without admission or proof of guilt).
- 03 = Accident/tort liability - The date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no-fault liability.
- 04 = Accident/employment related - The date of an accident relating to the patient's employment.
- 05 = Accident/No medical liability coverage - code indicating accident related injury for which there is no medical payment or third party liability coverage. Provide the date of accident/injury.
- 05 = Other accident - The date of an accident not described by the codes 01 thru 04. (obsolete)
- 06 = Crime victim - Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties.
- 07 = Reserved for national assignment.
- 08 = Reserved for national assignment.
- 09 = Start of Infertility Treatment Cycle - code indicating the start date of infertility treatment cycle.
- 10 = Last Menstrual Period - code indicating the date of the last menstrual period; ONLY applies when patient is being treated for maternity related conditions.
- 11 = Onset of symptoms/illness - The date

the patient first became aware of  
symptoms/illness.

- 12 = Date of onset for a chronically  
dependent individual - Code indicates  
the date the patient/bene became  
a chronically dependent individual.
- 13 = Reserved for national assignment.
- 14 = Reserved for national assignment.
- 15 = Reserved for national assignment.
- 16 = Date of Last Therapy - code denotes  
last day of therapy services (e.g.,  
physical therapy, occupational therapy,  
speech therapy).
- 17 = Date outpatient occupational therapy  
plan established or last reviewed -  
Code indicating the date an occupational  
therapy plan was established or  
last reviewed (eff 3/93)
- 18 = Date of retirement (patient/bene)  
- Code indicates the date of retirement  
for the patient/bene.
- 19 = Date of retirement spouse -  
Code indicates the date of retirement  
for the patient's spouse.
- 20 = Guarantee of payment began - The date  
on which the provider began claiming  
Medicare payment under the guarantee  
of payment provision.
- 21 = UR notice received - Code indicating  
the date of receipt by the hospital & SNF  
of the UR committee's finding that the  
admission or future stay was not  
medically necessary.
- 22 = Active care ended - The date on which  
a covered level of care ended in a SNF  
or general hospital, or date active care  
ended in a psychiatric or tuberculosis  
hospital or date on which patient was  
released on a trial basis from a resi-  
dential facility. Code is not required

- if code "21" is used.
- 23 = Cancellation of Hospice benefits - The date the RHHI cancelled the hospice benefit. (eff. 10/00). NOTE: this will be different than the revocation of the hospice benefit by beneficiaries.  
Benefits exhausted - The last date for which benefits can be paid. (term 9/30/93; replaced by code A3)
- 24 = Date insurance denied - The date the insurer's denial of coverage was received by a higher priority payer.
- 25 = Date benefits terminated by primary payer - The date on which coverage (including worker's compensation benefits or no-fault coverage) is no longer available to the patient.
- 26 = Date skilled nursing facility (SNF) bed available - The date on which a SNF bed became available to a hospital inpatient who required only SNF level of care.
- 27 = Date of Hospice Certification or Re-Certification -- code indicates the date of certification or recertification of the hospice benefit period, beginning with the first two initial benefit periods of 90 days each and the subsequent 60-day benefit periods. (eff. 9/01)
- 27 = Date home health plan established or last reviewed - Code indicating the date a home health plan of treatment was established or last reviewed. (Obsolete) not used by hospital unless owner of facility
- 28 = Date comprehensive outpatient rehabilitation plan established or last reviewed - Code indicating the date a comprehensive outpatient rehabilitation plan was established or last reviewed. not used by hospital unless owner of facility

- 29 = Date OPT plan established or last reviewed - the date a plan of treatment was established for outpatient physical therapy.  
Not used by hospital unless owner of facility
- 30 = Date speech pathology plan treatment established or last reviewed - The date a speech pathology plan of treatment was established or last reviewed.  
Not used by hospital unless owner of facility
- 31 = Date bene notified of intent to bill (accommodations) - The date of the notice provided to the patient by the hospital stating that he no longer required a covered level of IP care.
- 32 = Date bene notified of intent to bill (procedures or treatment) - The date of the notice provided to the patient by the hospital stating requested care (diagnostic procedures or treatments) is not considered reasonable or necessary.
- 33 = First day of the Medicare coordination period for ESRD bene - During which Medicare benefits are secondary to benefits payable under an EGHP.  
Required only for ESRD beneficiaries.
- 34 = Date of election of extended care facilities - The date the guest elected to receive extended care services (used by Religious Nonmedical Health Care Institutions only).
- 35 = Date treatment started for physical therapy - Code indicates the date services were initiated by the billing provider for physical therapy.
- 36 = Date of discharge for the IP hospital stay when patient received a transplant procedure  
- Hospital is billing for immunosuppressive drugs.

- 37 = The date of discharge  
for the IP hospital stay when  
patient received a noncovered  
transplant procedure - Hospital  
is billing for immunosuppressive drugs.
- 38 = Date treatment started for home IV  
therapy - Date the patient was first  
treated in his home for IV therapy.
- 39 = Date discharged on a continuous  
course of IV therapy - Date the patient  
was discharged from the hospital on a  
continuous course of IV therapy.
- 40 = Scheduled date of admission - The  
date on which a patient will be admitted  
as an inpatient to the hospital.  
(This code may only be used on an  
outpatient claim.)
- 41 = Date of First Test for Pre-admission  
Testing - The date on which the first  
outpatient diagnostic test was  
performed as part of a pre-admission  
testing (PAT) program. This code may  
only be used if a date of admission  
was scheduled prior to the administration  
of the test(s). (eff. 10/01)
- 42 = Date of discharge/termination of hospice  
care - for the final bill for hospice  
care. Eff 5/93, definition revised to  
apply only to date patient revoked  
hospice election.
- 43 = Scheduled Date of Canceled Surgery -  
date which ambulatory surgery was  
scheduled. (eff. 9/01)
- 44 = Date treatment started for occupational  
therapy - Code indicates the date  
services were initiated by the billing  
provider for occupational therapy.
- 45 = Date treatment started for speech  
therapy - Code indicates the date  
services were initiated by the billing

- provider for speech therapy.
- 46 = Date treatment started for cardiac rehabilitation - Code indicates the date services were initiated by the billing provider for cardiac rehabilitation.
- 47 = Date Cost Outlier Status Begins - code indicates that this is the first day the cost outlier threshold is reached. For Medicare purposes, a bene must have regular coinsurance and/or lifetime reserve days available beginning on this date to allow coverage of additional daily charges for the purpose of making cost outlier payments. (eff. 9/01)
- 48 = Payer code - Code reserved for internal use only by third party payers. HCFA assigns as needed for your use. Providers will not report it.
- 49 = Payer code - Code reserved for internal use only by third party payers. HCFA assigns as needed for your use. Providers will not report it.
- 50 = Assessment Date - code indicating an assessment date as defined by the assessment instrument applicable to this provider type (e.g. Minimum Data Set (MDS) for skilled nursing). eff. 1/1/11
- 51 = Date of Last Kt/V Reading - for in-center hemodialysis patients, this is the date of the last reading taken during the billing period. For peritoneal dialysis patients (and home hemodialysis patients), this date may be before the current billing period but should be within 4 months of the date of service. eff. 7/1/10
- 52 = Medical Certification/recertification date - the date of the most recent non-hospice medical certification or recertification of the patient. Use occurrence

code 27 for Date of Hospice Certification  
or Recertification. eff. 1/1/11

54 = Physician Follow-up Date - Last date of a  
physician follow-up with the patient.  
eff. 1/1/11

A1 = Birthdate, Insured A - The birthdate of  
the individual in whose name the insurance  
is carried. (Eff 10/93)

A2 = Effective date, Insured A policy - A  
code indicating the first date insurance  
is in force. (eff 10/93)

A3 = Benefits exhausted - Code indicating  
the last date for which benefits are  
available and after which no payment  
can be made to payer A. (eff 10/93)

A4 = Split Bill Date - date patient became  
eligible due to medically needy spend  
down (sometimes referred to as "Split  
Bill Date").

B1 = Birthdate, Insured B - The birthdate of  
the individual in whose name the insurance  
is carried. (eff 10/93)

B2 = Effective date, Insured B policy - A  
code indicating the first date insurance  
is in force. (eff 10/93)

B3 = Benefits exhausted - code indicating  
the last date for which benefits are  
available and after which no payment  
can be made to payer B. (eff 10/93)

C1 = Birthdate, Insured C - The birthdate of  
the individual in whose name the insurance  
is carried. (eff 10/93)

C2 = Effective date, Insured C policy - A  
code indicating the first date insurance  
is in force. (eff 10/93) Obsolete

C3 = Benefits exhausted - Code indicating  
the last date for which benefits are  
available and after which no payment  
can be made to payer C. (eff 10/93)  
Obsolete

\*\*For Inpatient/SNF Claims:\*\*

- 0 = ANOMALY: invalid value, if present,  
translate to '9'
- 1 = Non-Health Care Facility Point of Origin  
(Physician Referral) - The patient was  
admitted to this facility upon an order  
of a physician.
- 2 = Clinic referral - The patient was  
admitted upon the recommendation of  
this facility's clinic physician.
- 3 = HMO referral - Reserved for national  
assignment. (eff. 3/08)  
Prior to 3/08, HMO referral - The patient  
was admitted upon the recommendation of  
an health maintenance organization (HMO)  
physician.
- 4 = Transfer from hospital (Different Facility) -  
The patient was admitted to this facility  
as a hospital transfer from an acute care  
facility where he or she was an inpatient.
- 5 = Transfer from a skilled nursing  
facility (SNF) or Intermediate Care Facility  
(ICF) - The patient was admitted to this  
facility as a transfer from a SNF or ICF  
where he or she was a resident.
- 6 = Transfer from another health care  
facility - The patient was admitted  
to this facility as a transfer from  
another type of health care facility  
not defined elsewhere in this code list  
where he or she was an inpatient.
- 7 = Emergency room - The patient was  
admitted to this facility after receiving



- services in this facility's emergency room department. Obsolete - eff. 7/1/10
- 8 = Court/law enforcement - The patient was admitted upon the direction of a court of law or upon the request of a law enforcement agency's representative. Includes transfers from incarceration facilities.
- 9 = Information not available - The means by which the patient was admitted is not known.
- A = Reserved for National Assignment. (eff. 3/08)  
Prior to 3/08 defined as: Transfer from a Critical Access Hospital - patient was admitted/referred to this facility as a transfer from a Critical Access Hospital.
- B = Transfer from Another Home Health Agency -  
The patient was admitted to this home health agency as a transfer from another home health agency. (Discontinued July 1, 2010- See Condition Code 47)
- C = Readmission to Same Home Health Agency -  
The patient was readmitted to this home health agency within the same home health episode period. (Discontinued July 1, 2010)
- D = Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer - The patient was admitted to this facility as a transfer from hospital inpatient within this facility resulting in a separate claim to the payer.

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\*\*For Newborn Type of Admission\*\*

- 1 = Normal delivery - A baby delivered with out complications. Obsolete eff. 10/1/07
- 2 = Premature delivery - A baby delivered with time and/or weight factors qualifying it for premature status. Obsolete eff. 10/1/07

- 3 = Sick baby - A baby delivered with medical complications, other than those relating to premature status. Obsolete eff. 10/1/07
- 4 = Extramural birth - A baby delivered in a nonsterile environment. Obsolete eff. 10/1/07
- 5 = Born Inside this Hospital - eff. 10/1/07
- 6 = Born Outside of this Hospital - eff. 10/1/07
- 7-9 = Reserved for national assignment.

CLM\_SRVC\_CLSFCTN\_TYPE\_TB

Claim Service Classification Type Table

For facility type code 1 thru 6, and 9

- 1 = Inpatient (including Part A)
- 2 = Hospital based or Inpatient (Part B only) or home health visits under Part B
- 3 = Outpatient (HHA-A also)
- 4 = Other (Part B) -- (Includes HHA medical and other health services not under a plan of treatment, hospital or SNF for diagnostic clinical laboratory services for "nonpatients," and referenced diagnostic services. For HHAs under PPS, indicates an osteoporosis claim.)
- 5 = Intermediate care - level I
- 6 = Intermediate care - level II
- 7 = Subacute Inpatient (revenue code 019X required) (formerly Intermediate care - level III)  
NOTE: 17X & 27X are discontinued effective 10/1/05.
- 8 = Swing beds (used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement)
- 9 = Reserved for national assignment

For facility type code 7

- 1 = Rural Health Clinic (RHC)
- 2 = Hospital based or independent renal

- dialysis facility
- 3 = Free-standing provider based federally qualified health center (FQHC) (eff 10/91)
  - 4 = Other Rehabilitation Facility (ORF) and Community Mental Health Center (CMHC) (eff 10/91 - 3/97); ORF only (eff. 4/97)
  - 5 = Comprehensive Rehabilitation Center (CORF)
  - 6 = Community Mental Health Center (CMHC) (eff 4/97)
  - 7-8 = Reserved for national assignment
  - 9 = Other

For facility type code 8

- 1 = Hospice (non-hospital based)
- 2 = Hospice (hospital based)
- 3 = Ambulatory surgical center in hospital outpatient department
- 4 = Freestanding birthing center
- 5 = Critical Access Hospital (eff. 10/99) formerly Rural primary care hospital (eff. 10/94)
- 6-8 = Reserved for national use
- 9 = Other

CLM\_TRANS\_TB

Claim Transaction Table

- 0 = Religious NonMedical Health Care Institutions (RNHCI) bill (prior to 8/00, Christian Science bill), SNF bill, or state buy-in
- 1 = Psychiatric hospital facility bill or dummy psychiatric
- 2 = Tuberculosis hospital facility bill
- 3 = General care hospital facility bill or dummy LRD
- 4 = Regular SNF bill
- 5 = Home health agency bill (HHA)
- 6 = Outpatient hospital bill
- C = CORF bill - type of OP bill in the HHA bill format (obsoleted 7/98)

H = Hospice bill

CLM\_VAL\_TB

Claim Value Table

- 01 = Most Common Semi-Private Rate - to provide for the recording of hospital's most common semi-private rate.
- 02 = Hospital Has No Semi-Private Rooms - Entering this code requires \$0.00 amount.
- 03 = Reserved for national assignment.
- 04 = Inpatient professional component charges which are combined billed - For use only by some all inclusive rate hospitals. (Eff 9/93)
- 05 = Professional component included in charges and also billed separately to carrier - For use on Medicare and Medicaid bills if the state requests this information.
- 06 = Medicare blood deductible - Total cash blood deductible (Part A blood deductible).
- 07 = Medicare cash deductible (term 9/30/93) Reserved for national assignment.
- 08 = Medicare Part A lifetime reserve amount in first calendar year - Lifetime reserve amount charged in the year of admission. (not stored in NCH until 2/93)
- 09 = Medicare Part A coinsurance amount in the first calendar year - Coinsurance amount charged in the year of admission. (not stored in NCH until 2/93)
- 10 = Medicare Part A lifetime reserve amount in the second calendar year - Lifetime reserve amount charged in the year of discharge where the bill spans two calendar years.

(in NCH until 2/93)

- 11 = Medicare Part A coinsurance amount in the second calendar year - Coinsurance amount charged in the year of discharge where the bill spans two calendar years (not stored in NCH until 2/93)
- 12 = Amount is that portion of higher priority EGHP insurance payment made on behalf of aged bene provider applied to Medicare covered services on this bill. Six zeroes indicate provider claimed conditional Medicare payment.
- 13 = Amount is that portion of higher priority EGHP insurance payment made on behalf of ESRD bene provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional Medicare payment.
- 14 = That portion of payment from higher priority no fault auto/other liability insurance made on behalf of bene provider applied to Medicare covered services on this bill. Six zeroes indicate provider claimed conditional payment
- 15 = That portion of a payment from a higher priority WC plan made on behalf of a bene that the provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional Medicare payment.
- 16 = That portion of a payment from higher priority PHS or other federal agency made on behalf of a bene the provider applied to Medicare covered services on this bill. Six zeroes indicate provider claimed conditional Medicare payment.

- 17 = Operating Outlier amount - Providers do not report this. For payer internal use only. Indicates the amount of day or cost outlier payment to be made. (Do not include any PPS capital outlier payment in this entry). Obsolete
- 18 = Operating Disproportionate share amount - Providers do not report this. For payer internal use only. Indicates the disproportionate share amount applicable to the bill. Use the amount provided by the disproportionate share field in PRICER. (Do not include any PPS capital DSH adjustment in this entry). Obsolete
- 19 = Operating Indirect medical education amount - Providers do not report this. For payer internal use only. Indicates the indirect medical education amount applicable to the bill. (Do not include PPS capital IME adjustment in this entry). Obsolete
- 20 = Total payment sent provider for capital under PPS, including HSP, FSP, outlier, old capital, DSH adjustment, IME adjustment, and any exception amount. (used 10/1/91 - 3/1/92 for provider reporting. Payer only code eff 9/93.) Obsolete
- 21 = Catastrophic - Medicaid - Eligibility requirements to be determined at state level. (Medicaid specific/deleted 9/93)
- 22 = Surplus - Medicaid - Eligibility requirements to be determined at state level. (Medicaid specific/deleted 9/93)
- 23 = Recurring monthly income - Medicaid - Eligibility requirements to be determined at state level. (Medicaid specific/deleted 9/93)
- 24 = Medicaid rate code - Medicaid - Eligibility requirements to be determined at state level. (Medicaid

specific/deleted 9/93)

- 25 = Offset to the Patient Payment Amount  
(Prescription Drugs) - Prescription  
drugs paid for out of a long-term  
care facility resident/patient's fund  
in the billing period submitted (State-  
ment Covers Period).
- 26 - Prescription Drugs Offset to Patient  
(Payment Amount - Hearing and Ear Services)  
Hearing and ear services paid for out of  
a long term care facility resident/patient's  
funds in the billing period submitted  
(Statement covers period).
- 27 = Offset to the Patient (Payment Amount - Vision  
and Eye Services) - Vision and eye services paid  
for out of a long term care facility resident/  
patient's funds in the billing period submitted  
(Statement Covers Period).
- 28 = Offset to the Patient (Payment Amount - Dental  
Services) - Dental services paid for out of a  
long term care facility resident/patient's funds  
in the billing period submitted (Statement  
Covers Period).
- 29 = Offset to the Patient (Payment Amount - Chiro-  
practic Services) - Chiropractic services paid  
for out of a long term care facility resident/  
patient's funds in the billing period submitted  
(Statement Covers Period).
- 30 = Preadmission Testing - the code used to reflect  
the charges for preadmission outpatient diag-  
nostic services in preparation for a previously  
scheduled admission.
- 31 = Patient liability amount - Amount  
shown is that which you or the PRO  
approved to charge the bene for  
noncovered accommodations, diagnostic  
procedures or treatments.
- 32 = Multiple patient ambulance transport -  
The number of patients transported during  
one ambulance ride to the same destination.

(eff. 4/1/2003)

- 33 = Offset to the Patient Payment Amount (Podiatric Services) -- Podiatric services paid out of a long-term care facility resident/patient's funds in the billing period submitted.
- 34 = Offset to the Patient Payment Amount (Medical Services) -- Other medical services paid out of a long-term care facility resident/patient's funds in the billing period submitted.
- 35 = Offset to the Patient Payment Amount (Health Insurance Premiums) -- Other medical services paid out of a long-term care facility resident/patient's funds in the billing period submitted.
- 37 = Pints of blood furnished - Total number of pints of whole blood or units of packed red cells furnished to the patient. (eff 10/93)
- 38 = Blood deductible pints - The number of unreplaced pints of whole blood or units of packed red cells furnished for which the patient is responsible. (eff 10/93)
- 39 = Pints of blood replaced - The total number of pints of whole blood or units of packed red cells furnished to the patient that have been replaced by or on behalf of the patient. (eff 10/93)
- 40 = New coverage not implemented by HMO - amount shown is for inpatient charges covered by HMO (eff 3/92).  
(use this code when the bill includes inpatient charges for newly covered services which are not paid by HMO.)
- 41 = Amount is that portion of a payment from higher priority Black Lung federal program made on behalf of bene the provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional Medicare



- payment.
- 42 = Amount is that portion of a payment from higher priority VA made on behalf of bene the provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional Medicare payment.
- 43 = Disabled bene under age 65 with LGHP - Amount is that portion of a payment from a higher priority LGHP made on behalf of a disabled Medicare bene the provider applied to Medicare covered services on this bill.
- 44 = Amount provider agreed to accept from primary payer when amount less than charges but more than payment received - When a lesser amount is received and the received amount is less than charges, a Medicare secondary payment is due.
- 45 = Accident Hour - The hour the accident occurred that necessitated medical treatment.
- 46 = Number of grace days - Following the date of the PRO/UR determination, this is the number of days determined by the PRO/UR to be necessary to arrange for the patient's post-discharge care. (eff 10/93)
- 47 = Any liability insurance - Amount is that portion from a higher priority liability insurance made on behalf of Medicare bene the provider is applying to Medicare covered services on this bill. (Eff 9/93)
- 48 = Hemoglobin reading - The patient's most recent hemoglobin reading taken before the start of the billing period (eff. 1/3/2006). Prior to 1/3/2006 defined as the latest hemoglobin reading taken during the billing cycle.

- 49 = Hematocrit reading - The patient's most recent hematocrit reading taken before the start of the billing period (eff. 1/3/2006). Prior to 1/3/2006 defined as hematocrit reading taken during the billing cycle.
- 50 = Physical therapy visits - Indicates the number of physical therapy visits from onset (at billing provider) through this billing period.
- 51 = Occupational therapy visits - Indicates the number of occupational therapy visits from onset (at the billing provider) through this billing period.
- 52 = Speech therapy visits - Indicates the number of speech therapy visits from onset (at billing provider) through this billing period.
- 53 = Cardiac rehabilitation - Indicates the number of cardiac rehabilitation visits from onset (at billing provider) through this billing period.
- 54 = New birth weight in grams - Actual birth weight or weight at time of admission for an extramural birth. Required on all claims with type of admission of '4' and on other claims as required by law.
- 55 = Eligibility Threshold for Charity Care - code identifies the corresponding value amount at which a health care facility determines the eligibility threshold of charity care.
- 56 = Hours skilled nursing provided - The number of hours skilled nursing provided during the billing period. Count only hours spent in the home.
- 57 = Home health visit hours - The number of home health aide services provided during the billing period. Count only the hours spent in the home.
- 58 = Arterial blood gas - Arterial blood gas value at beginning of each reporting

period for oxygen therapy. This value or value 59 will be required on the initial bill for oxygen therapy and on the fourth month's bill.

59 = Oxygen saturation - Oxygen saturation at the beginning of each reporting period for oxygen therapy. This value or value 58 will be required on the initial bill for oxygen therapy and on the fourth month's bill.

60 = HHA branch MSA - MSA in which HHA branch is located.

61 = Location of HHA service or hospice service - the balanced budget act (BBA) requires that the geographic location of where the service was provided be furnished instead of the geographic location of the provider.

NOTE: HHA claims with a thru date on or before 12/31/05, the value code amount field reflects the MSA code (followed by zeroes to fill the field). HHA claims with a thru date after 12/31/05, the value code amount field reflects the CBSA code.

62 = Number of Part A home health visits accrued during a period of continuous care - necessitated by the change in payment basis under HH PPS (eff. 10/00)

63 = Number of Part B home health visits accrued during a period of continuous care - necessitated by the change in payment basis under HH PPS (eff. 10/00)

64 = Amount of home health payments attributed to the Part A trust fund in a period of continuous care - necessitated by the change in payment basis under HH PPS (eff. 10/00)

65 = Amount of home health payments attributed

to the Part B trust fund in a period  
of continuous care - necessitated by the  
change in payment basis under HH PPS  
(eff. 10/00)

- 66 = Medicare Spend-down Amount -- The dollar  
amount that was used to meet the recipient's  
spend-down liability for this claim.
- 67 = Peritoneal dialysis - The number of  
hours of peritoneal dialysis provided  
during the billing period (only the  
hours spent in the home).  
(eff. 10/97)
- 68 = EPO drug - Number of units of EPO  
administered relating to the billing  
period.
- 69 = State Charity Care Percent - code  
indicates the percentage of charity  
care eligibility for the patient.
- 70 = Interest amount - (Providers do not  
report this.) Report the amount  
applied to this bill.
- 71 = Funding of ESRD networks - (Providers  
do not report this.) Report the  
amount the Medicare payment was  
reduced to help fund the ESRD networks.
- 72 = Flat rate surgery charge - Code  
indicates the amount of the charge for  
outpatient surgery where the hospital  
has such a charging structure.
- 73 = Drug deductible - (For internal use by  
third party payers only). Report the  
amount of the drug deductible to be  
applied to the claim.
- 74 = Drug coinsurance - (For internal use  
by third party payers only). Report  
the amount of drug coinsurance to be  
applied to the claim.
- 75 = Gramm/Rudman/Hollings - (Providers do  
not report this.) Report the amount of  
the sequestration applied to this bill.

- 76 = Report provider's percentage of billed charges interim rate during billing period. Applies to OP hospital, SNF and HHA claims where interim rate is applicable. Report to left of dollar/cents delimiter. (TP payers internal use only)
- 77 = New Technology Add-on Payment Amount - Amount of payments made for discharges involving approved new technologies. If the total covered costs of the discharge exceed the DRG payment for the case (including adjustments for IME and disproportionate share hospitals (DSH) but excluding outlier payments) an add-on amount is made indicating a new technology was used in the treatment of the beneficiary. (eff. 4/1/03, under Inpatient PPS)
- 78 = Payer code - This codes is set aside for payer use only. Providers do not report these codes.
- 79 = Payer code - This code is set aside for payer use only. Providers do not report these codes.
- 80 = Covered days - the number of days covered by the primary payer as qualified by the payer.
- 81 = Non-covered Days - days of care not covered by the primary payer.
- 82 = Co-insurance Days - The inpatient Medicare days occurring after the 60th day and before the 91st day or inpatient SNF/Swing bed days occurring after the 20th and before the 101st day in a single spell of illness.
- 83 = Lifetime Reserve Days - Under Medicare, each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days of inpatient hospital services during a spell of illness.
- 84 - 99 = Reserved for national assignment.
- A0 = Special Zip Code Reporting - five digit

zip code of the location from which the beneficiary is initially placed on board the ambulance. (eff. 9/01)

- A1 = Deductible Payer A - The amount assumed by the provider to be applied to the patient's deductible amount to the involving the indicated payer. (eff. 10/93)  
- Prior value 07
- A2 = Coinsurance Payer A - The amount assumed by the provider to be applied to the patient's Part B coinsurance amount involving the indicated payer. (eff 10/93)
- A3 = Estimated Responsibility Payer A - The amount estimated by the provider to be paid by the indicated payer.
- A4 = Self-administered drugs administered in an emergency situation - Ordinarily the only noncovered self-administered drug paid for under Medicare in an emergency situation is insulin administered to a patient in a diabetic coma. (eff 7/97)
- A5 = Covered self-administered drugs -- The amount included in covered charges for self-administrable drugs administered to the patient because the drug was not self-administered in the form and situation in which it was furnished to the patient.
- A6 = Covered self-administered drugs -Diagnostic study and Other --- the amount included in covered charges for self-administrable drugs administered to the patient because the drug was necessary for diagnostic study or other reasons. For use with Revenue Center 0637.
- A7 = Copayment A -- The amount assumed by the provider to be applied toward the patient's copayment amount involving the indicated payer.
- A8 = Patient Weight -- Weight of patient in kilograms. Report this data only when the health plan has a predefined change in reimbursement that is affected by weight.

A9 = Patient Height - Height of patient in centimeters  
Report this data only when the health plan has  
a predefined change in reimbursement that is  
affected by height.

AA = Regulatory Surcharges, Assessments, Allowances  
or Health Care Related Taxes (Payer A) -- The  
amount of regulatory surcharges, assessments,  
allowances or health care related taxes per-  
taining to the indicated payer (eff. 10/2003).

AB = Other Assessments or Allowances (Payer A) --  
The amount of other assessments or allowances  
pertaining to the indicated payer. (eff. 10/2003).

B1 = Deductible Payer B - The amount  
assumed by the provider to be applied  
to the patient's deductible amount  
involving the indicated payer. (eff 10/93)  
- Prior value 07

B2 = Coinsurance Payer B - the amount assumed  
by the provider to be applied to the  
patient's Part B coinsurance amount  
involving the indicated payer. (eff 10/93)

B3 = Estimated Responsibility Payer B - The  
amount estimated by the provider to be  
paid by the indicated payer.

B7 = Copayment B -- The amount assumed by the pro-  
vider to be applied toward the patient's co-  
payment amount involving the indicated payer.

BA = Regulatory Surcharges, Assessments, Allowances  
or Health Care Related Taxes (Payer B) -- The  
amount of regulatory surcharges, assessments,  
allowances or health care related taxes per-  
taining to the indicated payer (eff. 10/2003).

BB = Other Assessments or Allowances (Payer B) --  
The amount of other assessments or allowances  
pertaining to the indicated payer. (eff. 10/2003).

C1 = Deductible Payer C - The amount  
assumed by the provider to be applied  
to the patient's deductible amount  
involving the indicated payer. (eff 10/93)  
- Prior value 07

C2 = Coinsurance Payer C - The amount assumed by the provider to be applied to the patient's Part B coinsurance amount involving the indicated payer. (eff 10/93)

C3 = Estimated Responsibility Payer C - The

C7 = Copayment C -- The amount assumed by the provider to be applied toward the patient's copayment amount involving the indicated payer.

CA = Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes (Payer C) -- The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer (eff. 10/2003).

CB = Other Assessments or Allowances (Payer C) -- The amount of other assessments or allowances pertaining to the indicated payer. (eff. 10/2003).

D3 = Estimated Responsibility Patient - The amount estimated by the provider to be paid by the indicated patient.

D4 = Clinical Trial Number Assigned by NLM/NIH - Eight digit numeric National Library of Medicine/National Institute of Health clinical trial registry number or a default number of '99999999' if the trial does not have an 8-digit registry number. (Eff. 10/1/07)

D5 = Last Kt/V Reading - result of last Kt/V reading. For in-center hemodialysis patients, this is the last reading taken during the billing period. For peritoneal dialysis patients (and home hemodialysis patients), this may be before the current billing period but should be within 4 months of the date of service. (eff. 7/1/10)

G8 = Facility Where Inpatient Hospice Service Is Delivered - MSA or Core Based Statistical Area (CBSA) number (or rural state code) of the facility where inpatient hospice is delivered. (Eff. 1/1/08)

XX = Total Charge Amount for all Part A visits on RIC 'U' claims - for Home Health claims



containing both Part A and Part B services  
this code identifies the total charge amount  
for the Part A visits (based on revenue  
center codes 042X, 043X, 044X, 055X, 056X,  
& 057X). Code created internally in the  
CWFMQA system (eff. 10/31/01 with HHPPS).

XY = Total Charge Amount for all Part B visits  
on RIC 'U' claims - for Home Health claims  
containing both Part A and Part B services  
this code identifies the total charge amount  
for the Part B visits (based on revenue  
center codes 042X, 043X, 044X, 055X, 056X,  
& 057X). Code created internally in the  
CWFMQA system (eff. 10/31/01 with HHPPS).

XZ = Total Charge Amount for all Part B non-  
visit charges on the RIC 'U' claims - for  
Home Health claims containing both Part A  
& Part B services, this code identifies the  
total charge amount for the Part B non-visit  
charges. Code created internally in the  
CWFMQA system (eff. 10/31/01 with HHPPS).

Y1 = Part A demo payment - Portion of the  
payment designated as reimbursement for  
Part A services under the demonstration.  
This amount is instead of the traditional  
prospective DRG payment (operating and  
capital) as well as any outlier payments  
that might have been applicable in the  
absence of the demonstration. No deductible  
or coinsurance has been applied. Payments  
for operating IME and DSH which are pro-  
cessed in the traditional manner are also  
not included in this amount.

Y2 = Part B demo payment - Portion of the  
payment designated as reimbursement for  
Part B services under the demonstration.  
No deductible or coinsurance has been  
applied.

Y3 = Part B coinsurance - Amount of Part B

coinsurance applied by the intermediary to this demo claim. For demonstration claims this will be a fixed copayment unique to each hospital and DRG (or DRG/procedure group).

Y4 = Conventional Provider Payment Amount for Non-Demonstration Claims - This the amount Medicare would have reimbursed the provider for Part A services if there had been no demonstration. This should include the prospective DRG payment (both capital as well as operational) as well as any outlier payment, which would be applicable. It does not include any pass through amounts such as that for direct medical education nor interim payments for operating IME and DSH.

CLM\_WC\_IND\_TB

Workers' Compensation Indicator Table

Y = The diagnosis codes on the claims are related to the diagnosis codes on the MSP auxiliary file in CWF.

Spaces

CMS\_PRVDR\_SPCLTY\_TB

CMS Provider Specialty Table

00 = Carrier wide  
01 = General practice  
02 = General surgery  
03 = Allergy/immunology  
04 = Otolaryngology  
05 = Anesthesiology  
06 = Cardiology  
07 = Dermatology

08 = Family practice  
09 = Interventional Pain Management (IPM) (eff. 4/1/03)  
09 = Gynecology (osteopaths only)  
    (discontinued 5/92 use code 16)  
10 = Gastroenterology  
11 = Internal medicine  
12 = Osteopathic manipulative therapy  
13 = Neurology  
14 = Neurosurgery  
15 = Obstetrics (osteopaths only)  
    (discontinued 5/92 use code 16)  
16 = Obstetrics/gynecology  
17 = Ophthalmology, otology, laryngology,  
    rhinology (osteopaths only)  
    (discontinued 5/92 use codes 18 or 04  
    depending on percentage of practice)  
18 = Ophthalmology  
19 = Oral surgery (dentists only)  
20 = Orthopedic surgery  
21 = Pathologic anatomy, clinical  
    pathology (osteopaths only)  
    (discontinued 5/92 use code 22)  
22 = Pathology  
23 = Peripheral vascular disease, medical  
    or surgical (osteopaths only)  
    (discontinued 5/92 use code 76)  
24 = Plastic and reconstructive surgery  
25 = Physical medicine and rehabilitation  
26 = Psychiatry  
27 = Psychiatry, neurology (osteopaths  
    only) (discontinued 5/92 use code 86)  
28 = Colorectal surgery (formerly  
    proctology)  
29 = Pulmonary disease  
30 = Diagnostic radiology  
31 = Roentgenology, radiology (osteopaths  
    only) (discontinued 5/92 use code 30)  
32 = Anesthesiologist Assistants (eff. 4/1/03--previously  
    grouped with Certified Registered Nurse Anesthetists  
    (CRNA))

- 32 = Radiation therapy (osteopaths only)  
(discontinued 5/92 use code 92)
- 33 = Thoracic surgery
- 34 = Urology
- 35 = Chiropractic
- 36 = Nuclear medicine
- 37 = Pediatric medicine
- 38 = Geriatric medicine
- 39 = Nephrology
- 40 = Hand surgery
- 41 = Optometry (revised 10/93 to  
mean optometrist)
- 42 = Certified nurse midwife (eff 1/87)
- 43 = CRNA (eff. 1/87) (Anesthesiologist Assistants  
were removed from this specialty 4/1/03)
- 44 = Infectious disease
- 45 = Mammography screening center
- 46 = Endocrinology (eff 5/92)
- 47 = Independent Diagnostic Testing Facility  
(IDTF) (eff. 6/98)
- 48 = Podiatry
- 49 = Ambulatory surgical center  
(formerly miscellaneous)
- 50 = Nurse practitioner
- 51 = Medical supply company with  
certified orthotist (certified by  
American Board for Certification in  
Prosthetics And Orthotics)
- 52 = Medical supply company with  
certified prosthetist  
(certified by American Board for  
Certification In Prosthetics And  
Orthotics)
- 53 = Medical supply company with  
certified prosthetist-orthotist  
(certified by American Board for  
Certification in Prosthetics  
and Orthotics)
- 54 = Medical supply company not included  
in 51, 52, or 53. (Revised 10/93)

to mean medical supply company for DMERC)

55 = Individual certified orthotist

56 = Individual certified prosthetist

57 = Individual certified prosthetist-orthotist

58 = Individuals not included in 55, 56, or 57,  
(revised 10/93 to mean medical supply company  
with registered pharmacist)

59 = Ambulance service supplier, e.g.,  
private ambulance companies, funeral homes, etc.

60 = Public health or welfare agencies  
(federal, state, and local)

61 = Voluntary health or charitable agencies (e.g.  
National Cancer Society, National Heart  
Association, Catholic Charities)

62 = Psychologist (billing independently)

63 = Portable X-ray supplier

64 = Audiologist (billing independently)

65 = Physical therapist (private practice added 4/1/03)  
(independently practicing removed 4/1/03)

66 = Rheumatology (eff 5/92)  
Note: during 93/94 DMERC also used this to mean  
medical supply company with  
respiratory therapist

67 = Occupational therapist (private practice added 4/1/03)  
(independently practicing removed 4/1/03)

68 = Clinical psychologist

69 = Clinical laboratory (billing independently)

70 = Multispecialty clinic or group practice

71 = Registered Dietician/Nutrition Professional (eff. 1/1/02)

72 = Pain Management (eff. 1/1/02)

73 = Mass Immunization Roster Biller (eff. 4/1/03)

74 = Radiation Therapy Centers (added to differentiate  
them from Independent Diagnostic Testing Facilities  
(IDTF --eff. 4/1/03)

74 = Occupational therapy (GPPP)  
(not to be assigned after 5/92)

75 = Slide Preparation Facilities (added to differentiate  
them from Independent Diagnostic Testing Facilities  
(IDTFs -- eff. 4/1/03)

75 = Other medical care (GPPP) (not to assigned after 5/92)  
76 = Peripheral vascular disease (eff 5/92)  
77 = Vascular surgery (eff 5/92)  
78 = Cardiac surgery (eff 5/92)  
79 = Addiction medicine (eff 5/92)  
80 = Licensed clinical social worker  
81 = Critical care (intensivists) (eff 5/92)  
82 = Hematology (eff 5/92)  
83 = Hematology/oncology (eff 5/92)  
84 = Preventive medicine (eff 5/92)  
85 = Maxillofacial surgery (eff 5/92)  
86 = Neuropsychiatry (eff 5/92)  
87 = All other suppliers (e.g. drug and department stores) (note: DMERC used 87 to mean department store from 10/93 through 9/94; recoded eff 10/94 to A7; NCH cross-walked DMERC reported 87 to A7.  
88 = Unknown supplier/provider specialty (note: DMERC used 87 to mean grocery store from 10/93 - 9/94; recoded eff 10/94 to A8; NCH cross-walked DMERC reported 88 to A8.  
89 = Certified clinical nurse specialist  
90 = Medical oncology (eff 5/92)  
91 = Surgical oncology (eff 5/92)  
92 = Radiation oncology (eff 5/92)  
93 = Emergency medicine (eff 5/92)  
94 = Interventional radiology (eff 5/92)  
95 = Competative Acquisition Program (CAP) Vendor (eff. 07/01/06). Prior to 07/01/06, known as Independent physiological laboratory (eff. 5/92)  
96 = Optician (eff 10/93)  
97 = Physician assistant (eff 5/92)  
98 = Gynecologist/oncologist (eff 10/94)  
99 = Unknown physician specialty  
A0 = Hospital (eff 10/93) (DMERCs only)

A1 = SNF (eff 10/93) (DMERCs only)  
 A2 = Intermediate care nursing facility  
     (eff 10/93) (DMERCs only)  
 A3 = Nursing facility, other (eff 10/93)  
     (DMERCs only)  
 A4 = HHA (eff 10/93) (DMERCs only)  
 A5 = Pharmacy (eff 10/93) (DMERCs only)  
 A6 = Medical supply company with respiratory  
     therapist (eff 10/93) (DMERCs only)  
 A7 = Department store (for DMERC use:  
     eff 10/94, but cross-walked from  
     code 87 eff 10/93)  
 A8 = Grocery store (for DMERC use:  
     eff 10/94, but cross-walked from  
     code 88 eff 10/93)  
 A9 = Indian Health Service (IHS), tribe and  
     tribal organizations (non-hospital or  
     non-hospital based facilities. DMERCs shall  
     process claims submitted by IHS, tribe and  
     non-tribal organizations for DMEPOS and drugs  
     covered by the DMERCs. (eff. 1/2005)  
 B1 = Supplier of oxygen and/or oxygen related  
     equipment (eff. 10/2/07)  
 B2 = Pedorthic Personnel (eff. 10/2/07)  
 B3 = Medical Supply Company with Pedorthic Personnel  
     (eff. 10/2/07)  
 B4 = Rehabilitation Agency (eff. 10/2/07)

CMS\_TYPE\_SRVC\_TB

CMS Type of Service Table

1 = Medical care  
 2 = Surgery  
 3 = Consultation  
 4 = Diagnostic radiology  
 5 = Diagnostic laboratory  
 6 = Therapeutic radiology  
 7 = Anesthesia  
 8 = Assistant at surgery

9 = Other medical items or services  
0 = Whole blood only eff 01/96,  
whole blood or packed red cells before 01/96  
A = Used durable medical equipment (DME)  
B = High risk screening mammography  
(obsolete 1/1/98)  
C = Low risk screening mammography  
(obsolete 1/1/98)  
D = Ambulance (eff 04/95)  
E = Enteral/parenteral nutrients/supplies  
(eff 04/95)  
F = Ambulatory surgical center (facility  
usage for surgical services)  
G = Immunosuppressive drugs  
H = Hospice services (discontinued 01/95)  
I = Purchase of DME (installment basis)  
(discontinued 04/95)  
J = Diabetic shoes (eff 04/95)  
K = Hearing items and services (eff 04/95)  
L = ESRD supplies (eff 04/95)  
(renal supplier in the home before 04/95)  
M = Monthly capitation payment for dialysis  
N = Kidney donor  
P = Lump sum purchase of DME, prosthetics,  
orthotics  
Q = Vision items or services  
R = Rental of DME  
S = Surgical dressings or other medical supplies  
(eff 04/95)  
T = Psychological therapy (term. 12/31/97)  
outpatient mental health limitation (eff. 1/1/98)  
U = Occupational therapy  
V = Pneumococcal/flu vaccine (eff 01/96),  
Pneumococcal/flu/hepatitis B vaccine (eff 04/95-12/95),  
Pneumococcal only before 04/95  
W = Physical therapy  
Y = Second opinion on elective surgery  
(obsoleted 1/97)  
Z = Third opinion on elective surgery  
(obsoleted 1/97)



CTGRY\_EQTBL\_BENE\_IDENT\_TB      Category Equatable Beneficiary Identification Code (BIC) Table

| NCH BIC<br>----- | SSA Categories<br>-----                                                       |
|------------------|-------------------------------------------------------------------------------|
| A                | = A;J1;J2;J3;J4;M;M1;T;TA                                                     |
| B                | = B;B2;B6;D;D4;D6;E;E1;K1;K2;K3;K4;W;W6;<br>TB (F) ;TD (F) ;TE (F) ;TW (F)    |
| B1               | = B1;BR;BY;D1;D5;DC;E4;E5;W1;WR;TB (M)<br>TD (M) ;TE (M) ;TW (M)              |
| B3               | = B3;B5;B9;D2;D7;D9;E2;E3;K5;K6;K7;K8;W2<br>W7;TG (F) ;TL (F) ;TR (F) ;TX (F) |
| B4               | = B4;BT;BW;D3;DM;DP;E6;E9;W3;WT;TG (M)<br>TL (M) ;TR (M) ;TX (M)              |
| B8               | = B8;B7;BN;D8;DA;DV;E7;EB;K9;KA;KB;KC;W4<br>W8;TH (F) ;TM (F) ;TS (F) ;TY (F) |
| BA               | = BA;BK;BP;DD;DL;DW;E8;EC;KD;KE;KF;KG;W9<br>WC;TJ (F) ;TN (F) ;TT (F) ;TZ (F) |
| BD               | = BD;BL;BQ;DG;DN;DY;EA;ED;KH;KJ;KL;KM;WF<br>WJ;TK (F) ;TP (F) ;TU (F) ;TV (F) |
| BG               | = BG;DH;DQ;DS;EF;EJ;W5;TH (M) ;TM (M) ;TS (M)<br>TY (M)                       |
| BH               | = BH;DJ;DR;DX;EG;EK;WB;TJ (M) ;TN (M) ;TT (M)<br>TZ (M)                       |
| BJ               | = BJ;DK;DT;DZ;EH;EM;WG;TK (M) ;TP (M) ;TU (M)<br>TV (M)                       |
| C1               | = C1;TC                                                                       |
| C2               | = C2;T2                                                                       |
| C3               | = C3;T3                                                                       |
| C4               | = C4;T4                                                                       |
| C5               | = C5;T5                                                                       |
| C6               | = C6;T6                                                                       |
| C7               | = C7;T7                                                                       |
| C8               | = C8;T8                                                                       |
| C9               | = C9;T9                                                                       |
| F1               | = F1;TF                                                                       |
| F2               | = F2;TQ                                                                       |

F3-F8 = Equatable only to itself (e.g., F3 IS  
equatable to F3)  
CA-CZ = Equatable only to itself. (e.g., CA is  
only equatable to CA)

-----  
RRB Categories

10 = 10  
11 = 11  
13 = 13;17  
14 = 14;16  
15 = 15  
43 = 43  
45 = 45  
46 = 46  
80 = 80  
83 = 83  
84 = 84;86  
85 = 85

DMERC\_LINE\_DCSN\_IND\_TB

DMERC Line Decision Indicator Table

O = Original MR determination  
R = MR determination after reversal  
of original decision

DMERC\_LINE\_MTUS\_IND\_TB

DMERC Line Miles/Time/Units Indicator Table

0 = Values reported as zero  
3 = Number of services  
4 = Oxygen volume units  
6 = Drug dosage -- since early 1994 this value has  
incorrectly been placed on DMERC claims. The DMERCs  
were overriding the MTUS indicator with a '6' if the  
claim was submitted with an NDC code.

NOTE: It was recently discovered that this problem has been corrected -- no date on when the correction became effective.

DMERC\_LINE\_SCRN\_RSLT\_IND\_TB

DMERC Line Screen Result Indicator Table

A = Denied for lack of medical necessity;  
highest level of review was automated  
level I review

B = Reduced (partially denied) for lack  
of medical necessity; highest level  
of review was automated level I review

C = Denied as statutorily noncovered;  
highest level of review was automated  
level I review

D = Reserved for future use

E = Paid after automated level I review

F = Denied for lack of medical necessity;  
highest level of review was manual  
level I review

G = Reduced (partially denied) for lack  
of medical necessity; highest level  
of review was manual level I review

H = Denied as statutorily noncovered;  
highest level of review was manual  
level I review

I = Denied for coding/unbundling reasons;  
highest level of review was manual  
level I review

J = Paid after manual level I review

K = Denied for lack of medical necessity;  
highest level of review was manual  
level II review

L = Reduced (partially denied) for lack  
of medical necessity; highest level  
of review was manual level II review

M = Denied as statutorily noncovered;  
highest level of review was manual

level II review  
N = Denied for coding/unbundling reasons;  
highest level of review was manual  
level II review  
O = Paid after manual level II review  
P = Denied for lack of medical necessity;  
highest level of review was manual  
level III review  
Q = Reduced (partially denied) for lack  
of medical necessity; highest level  
of review was manual level III review  
R = Denied as statutorily noncovered;  
highest level of review was manual  
level III review  
S = Denied for coding/unbundling reasons;  
highest level of review was manual  
level III review  
T = Paid after manual level III review

DMERC\_LINE\_SCRN\_SUSPNSN\_IND\_TB                      DMERC Line Screen Suspension Indicator Table

MUXX = Mandated unbundling screens  
UXXX = Local unbundling screens  
CXXX = Statutorily noncovered screens  
M1XX = Mandate CAT I screens  
1XXX = Local CAT I screens  
M2XX = Mandate CAT II screens  
2XXX = Local CAT II screens  
M3XX = Mandate CAT III screens  
3XXX = Local CAT III screens

DMERC\_LINE\_SUPLR\_TYPE\_TB                              DMERC Line Supplier Type Table

0 = Clinics, groups, associations,  
partnerships, or other entities  
for whom the carrier's own ID number

has been assigned.

- 1 = Physicians or suppliers billing as solo practitioners for whom SSN's are shown in the physician ID code field.
- 2 = Physicians or suppliers billing as solo practitioners for whom the carrier's own physician ID code is shown.
- 3 = Suppliers (other than sole proprietorship) for whom EI numbers are used in coding the ID field.
- 4 = Suppliers (other than sole proprietorship) for whom the carrier's own code has been shown.
- 5 = Institutional providers and independent laboratories for whom EI numbers are used in coding the ID field.
- 6 = Institutional providers and independent laboratories for whom the carrier's own ID number is shown.
- 7 = Clinics, groups, associations, or partnerships for whom EI numbers are used in coding the ID field.
- 8 = Other entities for whom EI numbers are used in coding the ID field or proprietorship for whom EI numbers are used in coding the ID field.

DRG\_OUTLIER\_STAY\_TB

Diagnosis Related Group Outlier Patient Stay Table

- 0 = No outlier
- 1 = Day outlier (condition code 60)
- 2 = Cost outlier, (condition code 61)

\*\*\* Non-PPS Only \*\*\*

- 6 = Valid diagnosis related groups (DRG) received from the intermediary
- 7 = CMS developed DRG

8 = CMS developed DRG using patient status  
code

9 = Not groupable

END\_REC\_TB

End of Record Code Table

EOR = End of record/segment

EOC = End of claim

FI\_CLM\_ACTN\_TB

Fiscal Intermediary Claim Action Table

1 = Original debit action (includes non-  
adjustment RTI correction items) - it  
will always be a 1 in regular bills.

2 = Cancel by credit adjustment - used  
only in credit/debit pairs (under HHPPS,  
updates the RAP).

3 = Secondary debit adjustment - used only  
in credit/debit pairs (under HHPPS, would  
be the final claim or an adjustment on  
a LUPA).

4 = Cancel only adjustment (under HHPPS,  
RAP/final claim/LUPA).

5 = Force action code 3

6 = Force action code 2

8 = Benefits refused (for inpatient bills,  
an 'R' nonpayment code must also be  
present

9 = Payment requested (used on bills that  
replace previously-submitted benefits-  
refused bills, action code 8. In such  
cases a debit/credit pair is not re-  
quired. For inpatient bills, a 'P'  
should be entered in the nonpayment  
code.)

FI\_NUM\_TB

Fiscal Intermediary Number /

Medicare Administrative Contractor Table

00010 = Alabama BC - Alabama  
(replaced with MAC #10101 -- see below)  
00011 = Alabama BC - Iowa  
replaced by MAC # 03401 -- see below)  
00012 = Iowa  
replaced by MAC # 05101 -- see below)  
00020 = Arkansas BC - Arkansas  
00021 = Arkansas BC - Rhode Island  
00030 = Arizona BC (replaced by MAC #  
03101 -- see below)  
00040 = California BC (term. 12/00)  
00050 = New Mexico BC/CO (term. 06/89)  
00060 = Connecticut BC (term. 06/99)  
00070 = Delaware BC - terminated 2/98  
00080 = Florida BC (term. 03/88)  
00090 = Florida BC  
(replaced with MAC #09101 -- see below)  
00101 = Georgia BC  
(replaced with MAC #10201 -- see below)  
00121 = Illinois - HCSC (term. 08/98)  
00123 = Michigan - HCSC (term. 08/98)  
00130 = Indiana BC/Administar Federal  
00131 = Illinois - Administar  
00140 = Iowa - Wellmark (term. 6/2000)  
00150 = Kansas BC (term. 2008)  
(replaced with MAC # 05201 -- see below)  
00160 = Kentucky/Administar  
(replaced with MAC # 15101 -- see below)  
00180 = Maine BC  
(replaced with MAC #14004 & 14101 -- see below)  
00181 = Maine BC - Massachusetts  
00190 = Maryland BC (term. 9/2005)  
00200 = Massachusetts BC (term. 7/97)  
00210 = Michigan BC (term. 9/94)  
00220 = Minnesota BC (term. 07/99)  
00230 = Mississippi BC

00231 = Mississippi BC/LA (term. 09/92)  
00232 = Mississippi BC  
00241 = Missouri BC (term. 9/92)  
00242 = Missouri  
    (replaced with MAC # 05301 --see below)  
00250 = Montana BC (replaced by MAC #  
    03201 -- see below)  
00260 = Nebraska BC (term. 2007)  
    (replaced with MAC # 05401 --see below)  
00270 = New Hampshire BC  
    (replaced with MAC #14501 -- see below)  
00280 = New Jersey BC (term. 8/2000)  
00290 = New Mexico BC - terminated 11/95  
00308 = New York - Empire BC  
    (replaced with MAC # 12101, 13201 & 13101 -- see below)  
00310 = North Carolina BC (term. 01/02)  
00320 = North Dakota BC - North Dakota  
    (replaced with MAC # 03301 -- see  
    below)  
00322 = North Dakota BC - Washington & Alaska  
00323 = North Dakota BC - Idaho, Oregon & Utah  
    (replaced with MAC # 03501 --see below)  
00332 = Ohio-Administar  
00340 = Oklahoma BC (term. 2008)  
    (replaced with MAC # 04301 -- see below)  
00350 = Oregon BC  
00351 = Oregon BC/ID. (term. 09/88)  
00355 = Oregon-CWF  
00362 = Independence BC - terminated 8/97  
00363 = Pennsylvania/Highmark - Veritus  
00366 = Highmark (MD & DC) - Part A (eff. 10/2005)  
00370 = Rhode Island BC  
    (replaced with MAC #14401 - see below)  
00380 = South Carolina BC - South Carolina  
    (replaced with MAC #11004 & 11201 - see below)  
00382 = South Carolina BC - North Carolina  
    (replaced with MAC #11501 - see below)  
00390 = Tennessee BC/Riverbend  
    (replaced with MAC # 12001 & 10301 -- see below)  
00400 = Texas BC



(replaced with MAC #04101, 04201, 04401 -- see below)  
00410 = Utah BC (term. 09/00)  
00423 = Virginia BC; Trigon (term. 08/99)  
00430 = Washington/Alaska BC  
00450 = Wisconsin BC - Wisconsin  
00452 = Wisconsin BC - Michigan  
00453 = Wisconsin BC - Virginia & West Virginia  
(replaced with MAC #11301 & 11401 - see below)  
00454 = Wisconsin BC - California  
(replaced by MAC #01101, 01201 & 01301 -- see below)  
00460 = Wyoming BC  
(replaced by MAC # 03601 -- see below)  
00468 = N Carolina BC/CPRTIVA  
00993 = BC/BS Assoc.  
17120 = Hawaii Medical Service (term. 06/99)  
50333 = Travelers; Connecticut United Healthcare  
(terminated - date unknown)  
51051 = Aetna California - terminated 6/97  
51070 = Aetna Connecticut - terminated 6/97  
51100 = Aetna Florida - terminated 6/97  
51140 = Aetna Illinois - terminated 6/97  
51390 = Aetna Pennsylvania - terminated 6/97  
52280 = NE - Mutual of Omaha  
57400 = Puerto Rico - Cooperativa  
(replaced with MAC # 09201)  
61000 = Aetna (term. 06/97)  
80883 = Contractor ID for Inpatient & Outpatient  
Risk Adjustment Data (data not sent through  
CWF; but through Palmetto)

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#### Medicare Administrative Contractor Numbers

#### JURISDICTION 1 - PART A MACs

01101 = California (eff. 8/15/2008)  
(replaces FI #00454)  
01201 = Hawaii (eff. 8/15/2008)  
(replaces FI #00454)  
01301 = Nevada (eff. 8/15/2008)

(replaces FI #00454)

JURISDICTION 3 - Part A MACs

03101 = Arizona (eff. 10/1/2006)  
(replaces FI #00030)  
03201 = Montana (eff. 12/1/2006)  
(replaces FI #00250)  
03301 = N. Dakota (eff. 12/1/2006)  
(replaces FI #00320)  
03401 = S. Dakota (eff. 3/1/2007)  
(replaces FI #00011)  
03501 = Utah (eff. 12/1/2006)  
(replaces FI #00323)  
03601 = Wyoming (eff. 11/1/2006)  
(replaces FI #00460)

JURISDICTION 4 - Part A MACs

04101 = Colorado (eff. 6/16/2008)  
(replaces FI #00400)  
04201 = New Mexico (eff. 6/16/2008)  
(replaces FI #00400)  
04301 = Oklahoma (eff. 3/1/2008)  
(replaces FI #00340)  
04401 = Texas (eff. 6/16/2008)  
(replaces FI #00400)

JURISDICTION 5 - Part A MACs

05101 = Iowa (eff. 5/1/2008)  
(replaces FI #00012)  
05201 = Oklahoma (eff. 3/1/2008)  
(replaces FI #00150)  
05301 = Missouri (eff. 5/1/2008)  
(replaces FI #00242)  
05401 = Nebraska (eff. 12/1/2007)  
(replaces FI #00260)

JURISDICTION 9 - PART A MACs

09101 = Florida (eff. 2/13/2009)  
    (replaces FI #00090)  
09201 = PR/VI (eff. 03/1/2009)  
    (replaces FI #57400)

JURISDICTION 10 - PART A MACs

10101 = Alabama (eff. 5/18/2009)  
    (replaces FI #00010)  
10201 = Georgia (eff. 8/3/2009)  
    (replaces FI #00101)  
10301 = Tennessee (eff. 8/3/2009)  
    (replaces FI #00390)

JURISDICTION 11 - PART A MACs

11004 = Region C (eff. 1/24/2011)  
    (replaces FI #00380)  
11201 = South Carolina (eff. 1/24/2011)  
    (replaces FI #00380)  
11301 = Virginia (eff. 5/16/2011)  
    (replaces FI #00453)  
11401 = West Virginia (eff. 5/16/2011)  
    (replaces FI #00453)  
11501 = North Carolina (eff. 9/30/2010)  
    (replaces FI #00390)

JURISDICTION 12 - PART A MACs

12001 = New Jersey (eff. 9/1/2008)  
    (replaces FI # 00390)  
12101 = Delaware (eff. 11/14/2008)  
    (replaces FI # 00308)

JURISDICTION 13 - PART A MACs

13101 = Connecticut (eff. 11/4/2008)  
    (replaces FI #00308)  
13201 = New Yort (eff. 11/4/2008)

(replaces FI #00308)

JURISDICTION 14 - PART A MACs

14004 = Region A (eff.5/15/2009)  
(replaces FI #00180)  
14101 = Maine (eff. 5/15/2009)  
(replaces FI #00180)  
14201 = Massachusetts (eff. 5/15/2009)  
(replaces FI #00181)  
14401 = Rhode Island (eff. 6/1/2009)  
(replaces FI #00370)  
14301 = New Hampshire (eff. 6/5/2009)  
(replaces FI #00270)  
14501 = Vermont (eff. 6/5/2009)  
(replaces FI #00270)

JURISDICTION 15 - PART A MACs

15101 = Kentucky (eff.4/30/2011)  
(replaces FI #00160)

FI\_RQST\_CLM\_CNCL\_RSN\_TB

Claim Cancel Reason Code Table

C = Coverage Transfer  
D = Duplicate Billing  
H = Other or blank  
L = Combining two beneficiary master records  
P = Plan Transfer  
S = Scramble  
\*\*\*\*\*For Action Code 4 \*\*\*\*\*  
\*\*\*\*\*Effective with HHPPS - 10/00\*\*\*\*\*  
A = RAP/Final claim/LUPA is cancelled by Interme-  
diary. Does not delete episode. Do not set  
cancellation indicator.  
B = RAP/Final claim/LUPA is cancelled by Interme-  
diary. Does not delete episode. Set  
cancellation indicator to 1.

E = RAP/Final claim/LUPA is cancelled by Intermediary. Remove episode.  
F = RAP/Final claim/LUPA is cancelled by Provider. Remove episode.

GEO\_SSA\_STATE\_TB

State Table

01 = Alabama  
02 = Alaska  
03 = Arizona  
04 = Arkansas  
05 = California  
06 = Colorado  
07 = Connecticut  
08 = Delaware  
09 = District of Columbia  
10 = Florida  
11 = Georgia  
12 = Hawaii  
13 = Idaho  
14 = Illinois  
15 = Indiana  
16 = Iowa  
17 = Kansas  
18 = Kentucky  
19 = Louisiana  
20 = Maine  
21 = Maryland  
22 = Massachusetts  
23 = Michigan  
24 = Minnesota  
25 = Mississippi  
26 = Missouri  
27 = Montana  
28 = Nebraska  
29 = Nevada  
30 = New Hampshire  
31 = New Jersey

32 = New Mexico  
33 = New York  
34 = North Carolina  
35 = North Dakota  
36 = Ohio  
37 = Oklahoma  
38 = Oregon  
39 = Pennsylvania  
40 = Puerto Rico  
41 = Rhode Island  
42 = South Carolina  
43 = South Dakota  
44 = Tennessee  
45 = Texas  
46 = Utah  
47 = Vermont  
48 = Virgin Islands  
49 = Virginia  
50 = Washington  
51 = West Virginia  
52 = Wisconsin  
53 = Wyoming  
54 = Africa  
55 = California  
56 = Canada & Islands  
57 = Central America and West Indies  
58 = Europe  
59 = Mexico  
60 = Oceania  
61 = Philippines  
62 = South America  
63 = U.S. Possessions  
64 = American Samoa  
65 = Guam  
66 = Commonwealth of the Northern Marianas Islands  
67 = Texas  
68 = Florida (eff. 10/2005)  
69 = Florida (eff. 10/2005)  
70 = Kansas (eff. 10/2005)  
71 = Louisiana (eff. 10/2005)

72 = Ohio (eff. 10/2005)  
73 = Pennsylvania (eff. 10/2005)  
74 = Texas (eff. 10/2005)  
80 = Maryland (eff. 8/2000)  
97 = Northern Marianas  
98 = Guam  
99 = With 000 county code is American Samoa;  
otherwise unknown

LINE\_ADDTNL\_CLM\_DCMTN\_IND\_TB            Line Additional Claim Documentation Indicator Table

0 = No additional documentation  
1 = Additional documentation submitted for  
non-DME EMC claim  
2 = CMN/prescription/other documentation submitted  
which justifies medical necessity  
3 = Prior authorization obtained and approved  
4 = Prior authorization requested but not approved  
5 = CMN/prescription/other documentation submitted  
but did not justify medical necessity  
6 = CMN/prescription/other documentation submitted  
and approved after prior authorization rejected  
7 = Recertification CMN/prescription/other  
documentation

LINE\_CNSLDTD\_BLG\_TB                    Line Consolidated Billing Indicator Table

1 = Home Health Consolidated Billing Override Code  
2 = SNF Consolidated Billing Override Code

LINE\_DGNS\_VRSN\_TB                    Line Diagnosis Version Code Table

Valid Values:  
9 = ICD-9

0 = ICD-10

LINE\_DUP\_CLM\_CHK\_IND\_TB

Line Duplicate Claim Check Indicator Table

1 = Exact duplicate review performed-service  
determined not to be a duplicate and is  
approved for payment

2 = Suspected duplicate review performed-service  
determined not to be a duplicate and is  
approved for payment

Blank = not applicable or the line item or service  
is being denied as a duplicate

LINE\_HCT\_HGB\_TYPE\_TB

Line Hematocrit/Hemoglobin Test Type

Code

R1 = Hemoglobin Test

R2 = Hematocrit Test

LINE\_PMT\_80\_100\_TB

Line Payment 80%/100% Table

0 = 80%

1 = 100%

3 = 100% Limitation of liability only

4 = 75% Reimbursement

LINE\_PRCSG\_IND\_TB

Line Processing Indicator Table

A = Allowed

B = Benefits exhausted

C = Noncovered care

D = Denied (existed prior to 1991; from  
BMAD)



I = Invalid data  
L = CLIA (eff 9/92)  
M = Multiple submittal--duplicate line item  
N = Medically unnecessary  
O = Other  
P = Physician ownership denial (eff 3/92)  
Q = MSP cost avoided (contractor #88888) -  
voluntary agreement (eff. 1/98)  
R = Reprocessed--adjustments based on  
subsequent reprocessing of claim  
S = Secondary payer  
T = MSP cost avoided - IEQ contractor  
(eff. 7/76)  
U = MSP cost avoided - HMO rate cell  
adjustment (eff. 7/96)  
V = MSP cost avoided - litigation  
settlement (eff. 7/96)  
X = MSP cost avoided - generic  
Y = MSP cost avoided - IRS/SSA data  
match project  
Z = Bundled test, no payment  
(eff. 1/1/98)  
00= MSP cost avoided - COB Contractor  
12= MSP cost avoided - BC/BS Voluntary Agreements  
13= MSP cost avoided - Office of Personnel Management  
14= MSP cost avoided - Workman's Compensation (WC) Datamatch  
15= MSP cost avoided - Workman's Compensation Insurer Voluntary  
Data Sharing Agreements (WC VDSA) (eff. 4/2006)  
16= MSP cost avoided - Liability Insurer VDSA (eff.4/2006)  
17= MSP cost avoided - No-Fault Insurer VDSA (eff.4/2006)  
18= MSP cost avoided - Pharmacy Benefit Manager Data Sharing  
Agreement (eff.4/2006)  
21= MSP cost avoided - MIR Group Health Plan (eff.1/2009)  
22= MSP cost avoided - MIR non-Group Health Plan (eff.1/2009)  
25= MSP cost avoided - Recovery Audit Contractor - California  
(eff.10/2005)  
26= MSP cost avoided - Recovery Audit Contractor - Florida  
(eff.10/2005)

NOTE: Effective 4/1/02, the Line Processing Indicator

code was expanded to a 2-byte field. The NCH instituted a crosswalk from the 2-byte code to a 1-byte character code. Below are the character codes (found in NCH & NMUD). At some point, NMUD will carry the 2-byte code but NCH will continue to have the 1-byte character code.

! = MSP cost avoided - COB Contractor ('00' 2-byte code)  
@ = MSP cost avoided - BC/BS Voluntary Agreements ('12' 2-byte code)  
# = MSP cost avoided - Office of Personnel Management ('13' 2-byte code)  
\$ = MSP cost avoided - Workman's Compensation (WC) Datamatch ('14' 2-byte code)  
\* = MSP cost avoided - Workman's Compensation Insurer Voluntary Data Sharing Agreements (WC VDSA) ('15' 2-byte code) (eff. 4/2006)  
( = MSP cost avoided - Liability Insurer VDSA ('16' 2-byte code) (eff. 4/2006)  
) = MSP cost avoided - No-Fault Insurer VDSA ('17' 2-byte code) (eff. 4/2006)  
+ = MSP cost avoided - Pharmacy Benefit Manager Data Sharing Agreement ('18' 2 -byte code) (eff. 4/2006)  
< = MSP cost avoided - MIR Group Health Plan ('21' 2-byte code) (eff. 1/2009)  
> = MSP cost avoided - MIR non-Group Health Plan ('22' 2-byte code) (eff. 1/2009)  
% = MSP cost avoided - Recovery Audit Contractor - California ('25' 2-byte code) (eff. 10/2005)  
& = MSP cost avoided - Recovery Audit Contractor - Florida ('26' 2-byte code) (eff. 10/2005)

LINE\_PRVDR\_PRTCPTG\_IND\_TB

Line Provider Participating Indicator Table

1 = Participating  
2 = All or some covered and allowed  
    expenses applied to deductible Participating  
3 = Assignment accepted/non-participating

- 4 = Assignment not accepted/non-participating
- 5 = Assignment accepted but all or some covered and allowed expenses applied to deductible Non-participating.
- 6 = Assignment not accepted and all covered and allowed expenses applied to deductible non-participating.
- 7 = Participating provider not accepting assignment.

LINE\_SRVC\_DDCTBL\_IND\_TB

Line Service Deductible Indicator Switch Code Table

- 0 = SERVICE SUBJECT TO DEDUCTIBLE
- 1 = SERVICE NOT SUBJECT TO DEDUCTIBLE

MCO\_OPTN\_TB

MCO Option Table

\*\*\*\*\*For lock-in beneficiaries\*\*\*\*\*

- A = HCFA to process all provider bills
- B = MCO to process only in-plan
- C = MCO to process all Part A and Part B bills

\*\*\*\*\* For non-lock-in beneficiaries\*\*\*\*\*

- 1 = HCFA to process all provider bills
- 2 = MCO to process only in-plan Part A and Part B bills
- 4 = Cost Plan-Chronic Care Organizations (eff. 10/2005)

NCH\_CLM\_BIC\_MDFY\_TB

NCH Claim BIC Modify H Code Table

- H = BIC submitted by CWF = HA, HB or HC
- blank = No HA, HB or HC BIC present

NCH\_CLM\_TYPE\_TB

NCH Claim Type Table

10 = HHA claim  
20 = Non swing bed SNF claim  
30 = Swing bed SNF claim  
40 = Outpatient claim  
50 = Hospice claim  
60 = Inpatient claim  
61 = Inpatient 'Full-Encounter' claim  
62 = Medicare Advantage IME/GME Claims  
63 = Medicare Advantage (no-pay) claims  
64 = Medicare Advantage (paid as FFS) claims  
71 = RIC O local carrier non-DMEPOS claim  
72 = RIC O local carrier DMEPOS claim  
81 = RIC M DMERC non-DMEPOS claim  
82 = RIC M DMERC DMEPOS claim

NOTE: In the data element NCH\_CLM\_TYPE\_CD  
(derivation rules) the numbers for these claim  
types need to be changed - dictionary reflects  
61 for all three.

NCH\_COND\_TRLR\_IND\_TB

NCH Condition Trailer Indicator Table

C = Condition code trailer present

NCH\_DEMO\_TRLR\_IND\_TB

NCH Demonstration Trailer Indicator Table

D = Demo trailer present

NCH\_DGNS\_E\_TRLR\_IND\_TB

NCH Diagnosis E Trailer Indicator Code Table

Valid Value:

W = NCH Diagnosis E Code trailer

NCH\_DGNS\_TRLR\_IND\_TB

NCH Diagnosis Trailer Indicator Table

Y = Diagnosis code trailer present

NCH\_EDIT\_DISP\_TB

NCH Edit Disposition Table

00 = No MQA errors  
10 = Possible duplicate  
20 = Utilization error  
30 = Consistency error  
40 = Entitlement error  
50 = Identification error  
60 = Logical duplicate  
70 = Systems duplicate

NCH\_EDIT\_TB

NCH EDIT TABLE

A0X1 = (C) PHYSICIAN-SUPPLIER ZIP CODE  
A000 = (C) REIMB > \$100,000 OR UNITS > 150  
A002 = (C) CLAIM IDENTIFIER (CAN)  
A003 = (C) BENEFICIARY IDENTIFICATION (BIC)  
A004 = (C) PATIENT SURNAME BLANK  
A005 = (C) PATIENT 1ST INITIAL NOT-ALPHABETIC  
A006 = (C) DATE OF BIRTH IS NOT NUMERIC  
A007 = (C) INVALID GENDER (0, 1, 2)  
A008 = (C) INVALID QUERY-CODE (WAS CORRECTED)  
A009 = (C) TYPE OF BILL RECEIVED IS 41A, 41B, OR 41D  
A010 = (C) DISPOSITION CODE VS. ACTION/ENTRY CODE  
A023 = (C) PORTABLE X-RAY WITHOUT MODIFIER  
A025 = (C) FOR OV 4, TOB MUST = 13,83,85,73  
A031 = (C) HOSPITAL CLAIMS--CLAIM SHOWS SERVICES WERE PAID  
BY AN HMO AND CODITION CODE '04' IS NOT PRESENT.

(TOB '11' & '12')

A041 = (C) HHA CLAIMS--TOB 32X OR 33X WITH >4 VISITS; DATE  
OF SERVICE > 9/30/00 AND LUPA IND IS PRESENT.  
BYPASS FOR NON-PAYMENT CODE B, C, Q, T-Y.

A1X1 = (C) PERCENT ALLOWED INDICATOR

A1X2 = (C) DT>97273,DG1=7611,DG<>103,163,1589

A1X3 = (C) DT>96365,DIAG=V725

A1X4 = (C) INVALID DIAGNOSTIC CODES

C050 = (U) HOSPICE - SPELL VALUE INVALID

D102 = (C) DME DATE OF BIRTH INVALID

D2X2 = (C) DME SCREEN SAVINGS INVALID

D2X3 = (C) DME SCREEN RESULT INVALID

D2X4 = (C) DME DECISION IND INVALID

D2X5 = (C) DME WAIVER OF PROV LIAB INVALID

D3X1 = (C) DME NATIONAL DRUG CODE INVALID

D4X1 = (C) DME BENE RESIDNC STATE CODE INVALID

D4X2 = (C) DME OUT OF DMERC SERVICE AREA

D4X3 = (C) DME STATE CODE INVALID

D5X1 = (C) TOS INVALID FOR DME HCPCS

D5X2 = (C) DME HCPCS NOC & NOC DESCRIP MISSING

D5X3 = (C) DME INVALID USE OF MS MODIFIER

D5X4 = (C) TOS9 NDC REQD WHEN HCPCS OMITTED

D5X5 = (C) TOS9 NDC REQD FOR Q0127-130 HCPCS

D5X6 = (C) TOS9 NDC/DIAGNOSIS CODE INVALID

D5X7 = (C) ANTI-EMETIC/ANTI-CANCER DRUG W/0 CANCER  
DIAGNOSIS

D5X8 = (C) TWO ANTI-EMETIC DRUGS PRESENT ON SAME CLAIM  
WITH IDENTICAL DATES OF SERVICE.

D6X1 = (C) DME SUPPLIER NUMBER MISSING

D7X1 = (C) DME PURCHASE ALLOWABLE INVALID

D919 = (C) CAPPED/PEN PUMPS,NUM OF SRVCS > 1

D921 = (C) SHOE HCPC W/O MOD RT,LT REQ U=2/4/6

D922 = (C) THERAPEUTIC SHOE CODES 'A5505-A5501'  
W/MODIFIER 'LT' OR 'RT' MUST HAVE  
UNITS = '001'

XXXX = (D) SYS DUPL: HOST/BATCH/QUERY-CODE

Y001 = (C) HCPCS R0075/UNITS>1/SERVICES=1

Y002 = (C) HCPCS R0075/UNITS=1/SERVICES>1

Y003 = (C) HCPCS R0075/UNITS=SERVICES

Y010 = (C) TOB=13X/14X AND T.C.>\$7,500

Y011 = (C) INP CLAIM/REIM > \$350,000  
 Z001 = (C) RVNU 820-859 REQ COND CODE 71-76  
 Z002 = (C) CC M2 PRESENT/REIMB > \$150,000  
 Z003 = (C) CC M2 PRESENT/UNITS > 150  
 Z004 = (C) CC M2 PRESENT/UNITS & REIM < MAX  
 Z005 = (C) REIMB>99999 AND REIMB<150000  
 Z006 = (C) UNITS>99 AND UNITS<150  
 Z007 = (C) TOB VS TOTAL CHARGE  
 Z008 = (C) TOB VS TOTAL CHARGE W/O 20/21  
           CONDITION CODE  
 Z237 = (E) HOSPICE OVERLAP - DATE ZERO  
 0011 = (C) ACTION CODE INVALID  
 0012 = (C) IME/GME CLAIM -- '04' OR '69'  
           CONDITION CODE  
 0013 = (C) CABG/PCOE/MPPD AND INVALID ADMIT DATE  
 0014 = (C) DEMO NUM INVALID  
 0015 = (C) ESRD PLAN VS DEMO NUM  
 0016 = (C) INVALID VA CLAIM  
 0017 = (C) DEMO=38 W/O CONTRACTOR #80881/80882  
 0018 = (C) DEMO=31,ACT CD<>1/5 OR ENT CD<>1/5  
 0019 = (C) DEMO 07/08 WITH CONDITION CODE B1  
 0020 = (C) CANCEL ONLY CODE INVALID  
 0021 = (C) DEMO COUNT > 1  
 0022 = (C) TOB '32X' OR '33X' W/DATES OF SERVICE >9/30/00  
           AND HAS CANCEL ONLY CODE OTHER THAN A,B,E,F  
 0023 = (C) DEMO '46' AND HCPCS INCONSISTENT  
 0301 = (C) INVALID HI CLAIM NUMBER  
 0302 = (C) BENE IDEN CDE (BIC) INVAL OR BLK  
 04A1 = (C) PATIENT SURNAME BLANK (PHYS/SUP)  
 04B1 = (C) PATIENT 1ST INITIAL NOT-ALPHABETIC  
 0401 = (C) BILL TYPE/PROVIDER INVALID  
 0402 = (C) BILL TYPE/REV CODE/PROVR RANGE  
 0403 = (C) TOB '41X'/PRVDR # 1990-1999) OR TOB '51X'/  
           PRVDR #6990-6999, TRANS CODE SHOULD BE  
           '0' OR '3'  
 0406 = (C) MAMMOGRAPHY WITH NO HCPCS 76092 OR SEX NOT F  
 0407 = (C) RESPITE CARE BILL TYPE NOT 34X,NO REV 66  
 0408 = (C) REV CODE 403 /TYPE 71X/ PROV3800-974  
 041A = (C) TOB '11A' OR '11D' AND DEMO #'07' OR '08'  
           NOT PRESENT

0410 = (C) IMMUNO DRUG OCCR-36,NO REV-25 OR 636  
0412 = (C) BILL TYPE XX5 HAS ACCOM. REV. CODES  
0413 = (C) CABG/PCOE BUT TOB = HHA,OUT,HOS  
0414 = (C) VALU CD 61,MSA AMOUNT MISSING  
0415 = (C) HOME HEALTH INCORRECT ALPHA RIC  
0416 = (C) REVENUE CENTER '0022', TOB MUST BE  
          '18X' OR '21X'  
0417 = (C) REVENUE CENTER '0023', TOB MUST BE '32X'  
          OR '33X'  
0418 = (C) HHA--TOB '3X5' AND DATES OF SERVICE  
          >9/30/00  
0419 = (C) HHA--RIC 'W' MUST HAVE VALUE CODE '63'/  
          RIC 'V' MUST HAVE VALUE CODE '62' AND  
          RIC 'U' MUST HAVE VALUE CODES '62' AND  
          '63' PRESENT FOR DATES OF SERVICE >  
          9/30/00.  
0420 = (C) HHA W/O REVENUE CODE '0023'  
0421 = (C) START DATE MISSING  
0422 = (C) COB VS. OVERRIDE CODE  
05X4 = (C) UPIN REQUIRED FOR TYPE-OF-SERVICE  
05X5 = (C) UPIN REQUIRED FOR DME  
0501 = (C) REFFERING UPIN REQUIRED FOR CLINICAL LAB  
0502 = (C) REFERRING UPIN INVALID  
0601 = (C) GENDER INVALID  
0701 = (C) CONTRACTOR/POS 1-2 PROVIDER NUM INVALID  
0702 = (C) PROVIDER NUMBER VS. TOB  
0703 = (C) MAMMOGRAPHY FOR NOT FEMALE  
0704 = (C) INVALID CONT FOR CABG DEMO  
0705 = (C) INVALID CONT FOR PCOE DEMO  
0706 = (C) REVENUE CENTER CODE MAMMOGRAPHY AND  
          BENEFICIARY <35  
0901 = (C) INVALID DISP CODE OF 02  
0902 = (C) INVALID DISP CODE OF SPACES  
0903 = (C) INVALID DISP CODE  
1001 = (C) PROF REVIEW/ACT CODE/BILL TYPE  
13X2 = (C) MULTIPLE ITEMS FOR SAME SERVICE  
1301 = (C) LINE COUNT NOT NUMERIC OR > 13  
1302 = (C) RECORD LENGTH INVALID  
1401 = (C) INVALID MEDICARE STATUS CODE  
1501 = (C) ADMIT DATE/START DATE/ENTRY CODE INVALID



1502 = (C) ADMIT DATE/START CARE DATE > STAY FROM DATE  
1503 = (C) ADMIT DATE INVALID WITH THRU DATE  
1504 = (C) ADM/FROM/THRU DATE > TODAYS DATE  
1505 = (C) HCPCS W SERVICE DATES > 09-30-94  
1601 = (C) INVESTIGATION IND INVALID  
1701 = (C) SPLIT IND INVALID  
1801 = (C) PAY-DENY CODE INVALID  
1802 = (C) HEADER AMT/LINE ITEMS DENIED  
1803 = (C) MSP COST AVD/ALL MSP LI NOT SAME  
1901 = (C) AB CROSSOVER IND INVALID  
2001 = (C) HOSPICE OVERRIDE INVALID  
2101 = (C) HMO-OVERRIDE/PATIENT-STAT INVALID  
2102 = (C) PATIENT STATUS VS. TOB  
2103 = (C) HIPPS RATE/CMG CODE VS. PATIENT STATUS  
2201 = (C) FROM DATE/HCPCS YR INVALID  
2202 = (C) STAY-FROM DATE > THRU-DATE  
2203 = (C) THRU DATE INVALID  
2204 = (C) FROM DATE BEFORE EFFECTIVE DATE  
2205 = (C) DATE YEARS DIFFERENT ON OUTPAT  
2207 = (C) MAMMOGRAPHY BEFORE 1991  
2208 = (C) TOB '21X', REV CODE 0022 FROM DATE  
< 06-03-98  
2209 = (C) HHA WITH OVERLAPPING DATES JUNE/JULY,  
SEPT/OCT  
2210 = (C) TOB 41X, SERVICE DATES 6/30/00,  
EXCEP/NONEXCEP IND = 1,2  
2212 = (C) TOB 51X WITH SERVICE DATES >6/30/00  
2213 = (C) TOB 32X OR 33X, SERVICE >9/30/00 DAYS  
CAN NOT = 60  
2215 = (C) DEMO 37 WITH VALUE CODES 'A2', 'B2', 'C2'  
2216 = (C) DEMO 37 OR CONDITION CODE 78 AND CHARGES  
SUB TO DED > 0  
2301 = (C) DOCUMENT CNTL OR UTIL DYS INVALID  
2302 = (C) COVERED DAYS INVALID OR INCONSIST  
2303 = (C) COST REPORT DAYS > ACCOMIDATION  
2304 = (C) UTIL DAYS = ZERO ON PATIENT BILL  
2305 = (C) LATE CHARGE BILL WITH DATA FIELD PRESENT  
2306 = (C) UTIL DYS/NOPAY/REIMB INCONSISTENT  
2307 = (C) COND=40,UTL DYS >0/VAL CDE A1,08,09  
2308 = (C) NOPAY = R WHEN UTIL DAYS = ZERO

2401 = (C) NON-UTIL DAYS INVALID  
 2501 = (C) CLAIM RCV DT OR COINSURANCE INVAL  
 2502 = (C) COIN+LR>UTIL DAYS/RCPT DTE>CUR DTE  
 2503 = (C) COIN/TR TYP/UTIL DYS/RCPT DTE>PD/DEN  
 2504 = (C) COINSURANCE AMOUNT EXCESSIVE  
 2505 = (C) COINSURANCE RATE > ALLOWED AMOUNT  
 2506 = (C) COINSURANCE DAYS/AMOUNT INCONSIST  
 2507 = (C) COIN+LR DAYS > TOTAL DAYS FOR YR  
 2508 = (C) COINSURANCE DAYS INVALID FOR TRAN  
 2601 = (C) CLAIM PAID DT INVALID OR LIFE RES  
 2602 = (C) LR-DAYS, NO VAL 08,10/PD/DEN>CUR+27  
 2603 = (C) LIFE RESERVE > RATE FOR CAL YEAR  
 2604 = (C) PPS BILL, NO DAY OUTLIER  
 2605 = (C) LIFE RESERVE RATE > DAILY RATE AVR.  
 28XA = (C) UTIL DAYS > FROM TO BENEF EXH  
 28XB = (C) BENEFITS EXH DATE > FROM DATE  
 28XC = (C) BENEFITS EXH DATE/INVALID TRANS TYPE  
 28XD = (C) OCCUR 23 WITH SPAN 70 ON INPAT HOSP  
 28XE = (C) MULTI BENE EXH DATE (OCCR A3,B3,C3)  
 28XF = (C) ACE DATE ON SNF (NOPAY =B, C, N, W)  
 28XG = (C) SPAN CD 70+4+6+9 NOT = NONUTIL DAYS  
 28XM = (C) OCC CD 42 DATE NOT = SRVCE THRU DTE  
 28XN = (C) INVALID OCC CODE  
 28XO = (C) AN 'N' NO-PAY CODE IS PRESENT AND OCCURRENCE  
 CODE '23' OR '42' IS NOT PRESENT AND THE  
 DATE ASSOCIATED WITH CODE IS MISSING OR NOT  
 EQUAL TO THRU DATE.  
 28XP = (C) THE OCCURRENCE CODE 23 DATE DOES NOT EQUAL THE  
 THRU DATE  
 28X0 = (C) BENE EXH DATE OUTSIDE SERVICE DATES  
 28X1 = (C) OCCUR DATE INVALID  
 28X2 = (C) OCCUR = 20 AND TRANS = 4  
 28X3 = (C) OCCUR 20 DATE < ADMIT DATE  
 28X4 = (C) OCCUR 20 DATE > ADMIT + 12  
 28X5 = (C) OCCUR 20 AND ADMIT NOT = FROM  
 28X6 = (C) OCCUR 20 DATE < BENE EXH DATE  
 28X7 = (C) OCCUR 20 DATE+UTIL-COIN>COVERAGE  
 28X8 = (C) OCCUR 22 DATE < FROM OR > THRU  
 28X9 = (C) UTIL > FROM - THRU LESS NCOV  
 33X1 = (C) QUAL STAY DATES INVALID (SPAN=70)

33X2 = (C) QS FROM DATE NOT < THRU (SPAN=70)  
33X3 = (C) QS DAYS/ADMISSION ARE INVALID  
33X4 = (C) QS THRU DATE > ADMIT DATE (SPAN=70)  
33X5 = (C) SPAN 70 INVALID FOR DATE OF SERVICE  
33X6 = (C) TOB=18/21/28/51,COND=WO,HMO<>90091  
33X7 = (C) TOB<>18/21/28/51,COND=WO  
33X8 = (C) TOB=18/21/28/51,CO=WO,ADM DT<97001  
33X9 = (C) TOB=32X SPAN 70 OR OCCR BO PRESENT  
33#A = (C) MULTIPLE PET SCANS  
33#B = (C) MULTIPLE PET SCANS W/O MODIFIER 26  
OR TC  
3401 = (C) DEMO ID = 04 AND RIC NOT = 1 OR 2  
34X2 = (C) DEMO ID = 04 AND COND WO NOT SHOWN  
34#3 = (C) CONDITION CODE = W0 AND DEMO NOT = 04  
35X1 = (C) 60, 61, 66 & NON-PPS / 65 & PPS  
35X2 = (C) COND = 60 OR 61 AND NO VALU 17  
35X3 = (C) PRO APPROVAL COND C3,C7 REQ SPAN M0  
35#3 = (C) (SECOND CONDITION) CONDITION CODE = C3  
REQUIRES SPAN CODE 76 OR 77  
35#4 = (C) CONDITION CODE = 69 AND TOB NOT 11X  
36X1 = (C) SURG DATE < STAY FROM/ > STAY THRU  
36#1 = (C) SURGICAL DATE = ZEROES OR < FROM OR >  
THRU DATES  
3701 = (C) ASSIGN CODE INVALID  
3705 = (C) 1ST CHAR OF IDE# IS NOT ALPHA  
3706 = (C) INVALID IDE NUMBER-NOT IN FILE  
3710 = (C) NUM OF IDE# > REV 0624  
3715 = (C) NUM OF IDE# < REV 0624  
3720 = (C) IDE AND LINE ITEM NUMBER > 2  
3801 = (C) AMT BENE PD INVALID  
3XA/ = (C) COLORECTAL/PROSTATE SCREENING BILLED  
MULTIPLE TIMES  
4001 = (C) BLOOD PINTS FURNISHED INVALID  
4002 = (C) BLOOD FURNISHED/REPLACED INVALID  
4003 = (C) BLOOD FURNISHED/VERIFIED/DEDUCT  
4201 = (C) BLOOD PINTS UNREPLACED INVALID  
4202 = (C) BLOOD PINTS UNREPLACED/BLOOD DED  
4203 = (C) INVALID CPO PROVIDER NUMBER  
4301 = (C) BLOOD DEDUCTABLE INVALID  
4302 = (C) BLOOD DEDUCT/FURNISHED PINTS

4303 = (C) BLOOD DEDUCT > UNREPLACED BLOOD  
4304 = (C) BLOOD DEDUCT > 3 - REPLACED  
4501 = (C) PRIMARY DIAGNOSIS INVALID  
4502 = (C) SERVICE DATES > CURRENT DATE  
46#A = (C) MSP VET AND VET AT MEDICARE  
46#B = (C) MULTIPLE COIN VALU CODES (A2,B2,C2)  
46#C = (C) COIN VALUE (A2,B2,C2) ON INP/SNF  
46#G = (C) VALU CODE 20 INVALID  
46#L = (C) BLOOD FURNISHED < BLOOD REPLACED  
46#N = (C) VALUE CODE 37,38,39 INVALID  
46#O = (C) VALUE CDE 37,38,39 AMOUNT NOT > 00  
46#P = (C) BLD UNREP VS REV CDS AND/OR UNITS  
46#Q = (C) VALUE CDE 37=39 AND 38 IS PRESENT  
46#R = (C) BLD FIELDS VS REV CDE 380,381,382  
46#S = (C) VALU CODE 39, AND 37 IS NOT PRESENT  
46#T = (C) CABG/PCOE/MPPD,VC<>Y1,Y2,Y3,Y4,VA NOT>0  
46#U = (C) MSP VALUES ON CABG/PCOE/MPPD (INP)  
TOB '32X'/'33X' MUST HAVE VALUE 62/64  
OR 63/65 (HHA)  
46#V = (C) TOB '32X'/'33X' VISITS IN 62/63 NOT =  
REVENUE CODE 42X-44X, 55X-57X  
46#W = (C) CONDITION CODE =30/78 AND WITH VALUE  
CODE = A1, B1, C1  
46#1 = (C) VALUE AMOUNT INVALID  
46#2 = (C) VALU 06 AND BLD-DED-PTS IS ZERO  
46#3 = (C) VALU 06 AND TTL-CHGS=NC-CHGS(001)  
46#4 = (C) VALU (A1,B1,C1): AMT > DEDUCT  
46#5 = (C) DEDUCT VALUE (A1,B1,C1) ON SNF BILL  
46#6 = (C) VALU 17 AND NO COND CODE 60 OR 61  
46#7 = (C) OUTLIER(VAL 17) > REIMB + VAL6-16  
46#8 = (C) MULTI CASH DED VALU CODES (A1,B1,C1)  
46X9 = (C) DEMO ID=03,REQUIRED HCPCS NOT SHOWN  
4600 = (C) CAPITAL TOTAL NOT = CAP VALUES  
4601 = (C) CABG/PCOE, MSP CODE PRESENT  
4603 = (C) DEMO ID = 03 AND RIC NOT=6,7  
4604 = (C) DEMO = 03 WITH DATES OF SERVICE  
> 09/31/01  
4901 = (C) PCOE/CABG,DEN CD NOT D  
4902 = (C) PCOE/CABG BUT DME  
50#1 = (C) RVCD=54,TOB<>13,23,32,33,34,83,85

50#2 = (C) REV CD=054X,MOD NOT = QM,QN  
5051 = (E) EDB: NOMATCH ON 3 CHARACTERISTICS  
5052 = (E) EDB: NOMATCH ON MASTER-ID RECORD  
5053 = (E) EDB: NOMATCH ON CLAIM-NUMBER  
51#A = (C) HCPCS EYEWARE & REV CODE NOT 274  
51#C = (C) HCPCS REQUIRES DIAG CODE OF CANCER  
51#D = (C) HCPCS REQUIRES UNITS > ZERO  
51#E = (C) HCPCS REQUIRES REVENUE CODE 636/294  
51#F = (C) INV BILL TYP/ANTI-CAN DRUG HCPCS  
51#G = (C) HCPCS REQUIRES DIAG OF HEMOPHILL1A  
51#H = (C) TOB 21X/P82=2/3/4;REV CD<9001,>9044  
51#I = (C) TOB 21X/P82<>2/3/4:REV CD>8999<9045  
51#J = (C) TOB 21X/REV CD: SVC-FROM DT INVALID  
51#K = (C) TOB 21X/P82=2/3/4,REV CD = NNX  
51#L = (C) REV 0762/UNT>48,TOB NOT=12,13,85,83  
51#M = (C) 21X,RC>9041/<9045,RC<>4/234  
51#N = (C) 21X,RC>9032/<9042,RC<>4/234  
51#O = (C) TWO ANTI-EMETIC/ANTI-CANCER DRUGS  
ON SAME CLAIM  
51#P = (C) HHA/OUTPATIENT RC DATE OF SRVC MISSING  
51#Q = (C) NO RC 0636 OR DTE INVALID  
51#R = (C) DEMO ID=01,RIC NOT=2  
51#S = (C) DEMO ID=01,RUGS<>2,3,4 OR BILL<>21  
51#V = (C) TOB 72X W HCPCS 'J1955' MISSING REVENUE  
CENTER 636  
51#W = (C) TOB 12X, 13X, 22X, 23X, 34X, 74X, 75X,  
83X, HCPCS '97504', '97116', PRESENT  
ON SAME DAY  
51#X = (C) TOB '32X-34X' REQUIRE HCPCS FOR REVENUE  
CODE '29X', '60X', '636'  
51X0 = (C) REV CENTER CODE INVALID  
51X1 = (C) REV CODE CHECK  
51X2 = (C) REV CODE INCOMPATIBLE BILL TYPE  
51X3 = (C) UNITS MUST BE > 0  
51X4 = (C) INP:CHGS/YR-RATE,ETC; OUTP:PSYCH>YR  
51X5 = (C) REVENUE NON-COVERED > TOTAL CHRGE  
51X6 = (C) REV TOTAL CHARGES EQUAL ZERO  
51X7 = (C) REV CDE 403 WTH NO BILL 14 23 71 85  
51X8 = (C) MAMMOGRAPHY SUBMISSION INVALID  
51X9 = (C) HCPCS/REV CODE/BILL TYPE

5100 = (U) TRANSITION SPELL / SNF  
5160 = (U) LATE CHG HSP BILL STAY DAYS > 0  
5166 = (U) PROVIDER NE TO 1ST WORK PRVDR  
5167 = (U) PROVIDER 1 NE 2: FROM DT < START DT  
5168 = (E) CLAIM IN HOSPICE WITH 2ND START DATE  
PRESENT  
5169 = (U) PROVIDER NE TO WORK PROVIDER  
5170 = (E) OCCURRENCE CODE = 42 AND < DOLBA  
5177 = (U) PROVIDER NE TO WORK PROVIDER  
5178 = (U) HOSPICE BILL THRU < DOLBA  
5181 = (U) HOSP BILL OCCR 27 DISCREPANCY  
5200 = (E) ENTITLEMENT EFFECTIVE DATE  
5201 = (U) HOSP DATE DIFFERENCE NE 60 OR 90  
5202 = (E) ENTITLEMENT HOSPICE EFFECTIVE DATE  
5202 = (U) HOSPICE TRAILER ERROR  
5203 = (E) ENTITLEMENT HOSPICE PERIODS  
5203 = (U) HOSPICE START DATE ERROR  
5204 = (U) HOSPICE DATE DIFFERENCE NE 90  
5205 = (U) HOSPICE DATE DISCREPANCY  
5206 = (U) HOSPICE DATE DISCREPANCY  
5207 = (U) HOSPICE THRU > TERM DATE 2ND  
5208 = (U) HOSPICE PERIOD NUMBER BLANK  
5209 = (U) HOSPICE DATE DISCREPANCY  
5210 = (E) ENTITLEMENT FRM/TRU/END DATES  
5211 = (E) ENTITLEMENT DATE DEATH/THRU  
5212 = (E) ENTITLEMENT DATE DEATH/THRU  
5213 = (E) ENTITLEMENT DATE DEATH MBR  
5220 = (E) ENTITLEMENT FROM/EFF DATES  
5225 = (E) ENT INP PPS SPAN 70 DATES  
5232 = (E) ENTL HMO NO HMO OVERRIDE CDE  
5233 = (E) ENTITLEMENT HMO PERIODS  
5234 = (E) ENTITLEMENT HMO NUMBER NEEDED  
5235 = (E) ENTITLEMENT HMO HOSP+NO CC07  
5236 = (E) ENTITLEMENT HMO HOSP + CC07  
5237 = (E) ENTITLEMENT HOSP OVERLAP  
5238 = (U) HOSPICE CLAIM OVERLAP > 90  
5239 = (U) HOSPICE CLAIM OVERLAP > 60  
524Z = (E) HOSP OVERLAP NO OVD NO DEMO  
5240 = (U) HOSPICE DAYS STAY+USED > 90  
5241 = (U) HOSPICE DAYS STAY+USED > 60

5242 = (C) INVALID CARRIER FOR RRB  
5243 = (C) HMO=90091, INVALID SERVICE DTE  
5244 = (E) DEMO CABG/PCOE MISSING ENTL  
5245 = (C) INVALID CARRIER FOR NON RRB  
525Z = (E) HMO/HOSP 6/7 NO OVD NO DEMO  
5250 = (U) HOSPICE DOEBA/DOLBA  
5255 = (U) HOSPICE DAYS USED  
5256 = (U) HOSPICE DAYS USED > 999  
526Y = (E) HMO/HOSP DEMO 5/15 REIMB > 0  
526Z = (E) HMO/HOSP DEMO 5/15 REIMB = 0  
5270 = (C) CONDITION CODE = 30 AND HMO REQUIRES  
MODIFIER = 'QV' OR 'KZ'/DED IND  
5271 = (C) RISK HMO NOT PRESENT AND MOD 'KZ'/  
OR CONDITION CODE 78 PRESENT  
527Y = (E) HMO/HOSP DEMO OVD=1 REIMB > 0  
527Z = (E) HMO/HOSP DEMO OVD=1 REIMB = 0  
5299 = (U) HOSPICE PERIOD NUMBER ERROR  
52#K = (C) HCPCS VS DIAGNOSIS  
52#L = (C) HCPCS VS MODIFIER  
52#M = (C) HCPCS VS DATES OF SERVICE  
52#N = (C) TOB '71X' OR '73X' WITH REVENUE  
CENTER CODE 0403 MISSING REVENUE  
CENTER CODE 0521  
52#O = (C) REVENUE CENTER CODE 0022/0024 WITH  
CHARGES >0  
52#P = (C) REVENUE CENTER CODE 010X-021X MINUS  
18X <> 0022  
52#Q = (C) REVENUE CENTER CODE 0022 AND HIPPS  
MISSING  
52#R = (C) REVENUE CENTER CODE 0022 MISSING DATE  
OF SERVICE  
52#T = (C) REVENUE CENTER CODE 0022 MISSING REVENUE  
CENTER CODE 042X-044X  
5320 = (U) BILL > DOEBA AND IND-1 = 2  
5350 = (U) HOSPICE DOEBA/DOLBA SECONDARY  
5355 = (U) HOSPICE DAYS USED SECONDARY  
5362 = (C) MAMMOGRAPHY AND BENE <35  
5378 = (C) SERVICE DATE < AGE 50  
5379 = (C) HCPCS 'G0160' PRESENT MORE THAN  
ONCE

5381 = (C) HCPCS 'G0161' PRESENT MORE THAN  
ONCE  
5382 = (C) HCPCS 'G0102-03' AND BENE <50  
538Q = (C) SERVICE DATES WITHIN ALIEN RECORD  
5397 = (C) DEMO '37' AND NOT CAT 74  
5398 = (C) HCPCS 'G9001-G9005 & G9009-G9011 >1  
OR 2 ARE PRESENT  
5399 = (U) HOSPICE PERIOD NUM MATCH  
539A = (C) HCPCS 'G9008' PRESENT MORE THAN ONCE  
539C = (C) HCPCS 'G9013-G9015' PRESENT MORE THAN  
ONCE OR 2 PRESENT  
5410 = (U) INPAT DEDUCTABLE  
5425 = (U) PART B DEDUCTABLE CHECK  
5430 = (U) PART B DEDUCTABLE CHECK  
5450 = (U) PART B COMPARE MED EXPENSE  
5460 = (U) PART B COMPARE MED EXPENSE  
5499 = (U) MED EXPENSE TRAILER MISSING  
5500 = (U) FULL DAYS/SNF-HOSP FULL DAYS  
5510 = (U) COIN DAYS/SNF COIN DAYS  
5515 = (U) FULL DAYS/COIN DAYS  
5516 = (U) SNF FULL DAYS/SNF COIN DAYS  
5520 = (U) LIFE RESERVE DAYS  
5530 = (U) UTIL DAYS/LIFE PSYCH DAYS  
5540 = (U) HH VISITS NE AFT PT B TRLR  
5550 = (E) SNF LESS THAN PT A EFF DATE  
5600 = (D) LOGICAL DUPE, COVERED  
5601 = (D) LOGICAL DUPE, QRY-CDE, RIC 123  
5602 = (D) LOGICAL DUPE, PANDE C, E OR I  
5603 = (D) LOGICAL DUPE, COVERED  
5604 = (D) LOGICAL DUPE, DATES  
5605 = (D) POSS DUPE, OUTPAT REIMB  
5606 = (D) POSS DUPE, HOME HEALTH COVERED U  
5623 = (U) NON-PAY CODE IS P  
57X1 = (C) PROVIDER SPECIALITY CODE INVALID  
57X2 = (C) PHYS THERAPY/PROVIDER SPEC INVAL  
57X3 = (C) PLACE/TYPE/SPECIALTY/REIMB IND  
57X4 = (C) SPECIALTY CODE VS. HCPCS INVALID  
57X5 = (C) HCPCS 98940-2 MODIFIER NOT = 'AT'  
5700 = (U) LINKED TO THREE SPELLS  
5701 = (C) DEMO ID=02,RIC NOT = 5



5702 = (C) DEMO ID=02,INVALID PROVIDER NUM  
58X1 = (C) PROVIDER TYPE INVALID  
58X9 = (C) TYPE OF SERVICE INVALID  
5802 = (C) REIMB > \$150,000  
5803 = (C) UNITS/VISITS > 150  
5804 = (C) UNITS/VISITS > 99  
5805 = (C) OUTPATIENT CHARGE > \$150,000  
5806 = (C) REVENUE CENTER CODE '042X-044X'  
WITHOUT MODIFIER 'GN-GP'  
58#4 = (C) REVENUE CENTER CODE MISSING REQUIRED  
HCPCS OR MODIFIER  
59XA = (C) PROST ORTH HCPCS/FROM DATE  
59XB = (C) HCPCS/FROM DATE/TYPE P OR I  
59XC = (C) HCPCS Q0036,37,42,43,46/FROM DATE  
59XD = (C) HCPCS Q0038-41/FROM DATE/TYPE  
59XE = (C) HCPCS/MAMMOGRAPHY-RISK/ DIAGNOSIS  
59XG = (C) INVALID TOS FOR DME  
59XH = (C) HCPCS E0620/TYPE/DATE  
59XI = (C) HCPCS E0627-9/ DATE < 1991  
59XJ = (C) GLOBAL HCPCS TOS MUST = 2  
59XK = (C) HCPCS PEN PUMP AND TOS <>9  
59XL = (C) HCPCS 00104 - TOS/POS  
59X1 = (C) INVALID HCPCS/TOS COMBINATION  
59X2 = (C) ASC IND/TYPE OF SERVICE INVALID  
59X3 = (C) TOS INVALID TO MODIFIER  
59X4 = (C) KIDNEY DONOR/TYPE/PLACE/REIMB  
59X5 = (C) MAMMOGRAPHY FOR MALE  
59X6 = (C) DRUG AND NON DRUG BILL LINE ITEMS  
59X7 = (C) CAPPED-HCPCS/FROM DATE  
59X8 = (C) FREQUENTLY MAINTAINED HCPCS  
59X9 = (C) HCPCS E1220/FROM DATE/TYPE IS R  
5901 = (U) ERROR CODE OF Q  
5A#1 = (C) DEMO=37, UNITS >1 FOR 'G9001-05'  
'G9007-11', G9013-G9015'  
60X1 = (C) ASSIGN IND INVALID  
6000 = (U) ADJUSTMENT BILL SPELL DATA  
6020 = (U) CURRENT SPELL DOEBA < 1990  
6030 = (U) ADJUSTMENT BILL SPELL DATA  
6035 = (U) ADJUSTMENT BILL THRU DTE/DOLBA  
61X1 = (C) PAY PROCESS IND INVALID

61X2 = (C) DENIED CLAIM/NO DENIED LINE  
61X3 = (C) PAY PROCESS IND/ALLOWED CHARGES  
61X4 = (C) RATE MISSING OR NON-NUMERIC  
61#E = (C) PROVIDER PAYMENT INCONSISTENCIES  
61#F = (C) BENEFICIARY PAYMENT INCONSISTENCIES  
61#G = (C) PATIENT RESPONSIBILITY INCONSISTENCIES  
61#H = (C) MEDICARE PAYMENT INCONSISTENCIES  
61#I = (C) LINE DATE OF SERVICE < FROM DATE  
          > THRU DATE  
61#J = (C) DUPLICATE HCPCS CODE '55873'  
61#K = (C) HCPCS 'G0117-8' >2 OR BOTH PRESENT  
61#L = (C) REVENUE CENTER CODE 0024 > 2  
61#M = (C) REVENUE CENTER CODE 0024 VS PROVIDER  
          NUMBER  
61#N = (C) REVENUE CENTER CODE 0024 REQUIRES  
          VALID HIPPS RATE CMG CODE  
61#R = (C) HCPCS/TOB/REVENUE CENTER CODE  
61#S = (C) HCPCS 'G0247' REQUIRES 'G0245-6' TO  
          BE COVERED  
61#T = (C) HCPCS CODE '0245-0246' PRESENT MULTIPLE  
          TIMES  
61#0 = (C) REVENUE CENTER CODE VS SPAN CODE '74'  
61#6 = (C) PAYMENT METHOD INVALID  
61#7 = (C) ANSI CODE MISSING  
61#8 = (C) BLOOD CASH DEDUCTIBLE INCONSISTENCIES  
61#9 = (C) CASH DEDUCTIBLE INCONSISTENCIES  
6100 = (C) REV 0001 NOT PRESENT ON CLAIM  
6101 = (C) REV COMPUTED CHARGES NOT=TOTAL  
6102 = (C) REV COMPUTED NON-COVERED/NON-COV  
6103 = (C) REV TOTAL CHARGES < PRIMARY PAYER  
6105 = (C) REVE CODE 0001 > 1  
6106 = TOB 3X2 REVENUE CENTER CODE 0023 NOT =  
          TOTAL CHARGE  
6109 = (C) REIMBURSEMENT > 4 OR 6 TIMES  
62XA = (C) PSYC OT PT/REIM/TYPE  
62XC = (C) DEMO 37 WITH REIMBURSEMENT/DED IND  
          <>1  
62X1 = (C) DME/DATE/100% OR INVAL REIMB IND  
62X6 = (C) RAD PATH/PLACE/TYPE/DATE/DED  
62X8 = (C) KIDNEY DONO/TYPE/100%

62X9 = (C) PNEUM VACCINE/TYPE/100%  
6201 = (C) TOTAL DEDUCT > CHARGES/NON-COV  
6203 = (U) HOSPICE ADJUSTMENT PERIOD/DATE  
6204 = (U) HOSPICE ADJUSTMENT THRU>DOLBA  
6260 = (U) HOSPICE ADJUSTMENT STAY DAYS  
6261 = (U) HOSPICE ADJUSTMENT DAYS USED  
6265 = (U) HOSPICE ADJUSTMENT DAYS USED  
6269 = (U) HOSPICE ADJUSTMENT PERIOD# (MAIN)  
63X1 = (C) DEDUCT IND INVALID  
63X2 = (C) DED/HCFA COINS IN PCOE/CABG  
6365 = (U) HOSPICE ADJUSTMENT SECONDARY DAYS  
6369 = (U) HOSPICE ADJUSTMENT PERIOD# (SECOND)  
64X1 = (C) PROVIDER IND INVALID  
6430 = (U) PART B DEDUCTABLE CHECK  
65X1 = (C) PAYSCREEN IND INVALID  
66?? = (D) POSS DUPE, CR/DB, DOC-ID  
66XX = (D) POSS DUPE, CR/DB, DOC-ID  
66X1 = (C) UNITS AMOUNT INVALID  
66X2 = (C) UNITS IND > 0; AMT NOT VALID  
66X3 = (C) UNITS IND = 0; AMT > 0  
66X4 = (C) MT INDICATOR/AMOUNT  
66X7 = (C) DEMO 37/HCPCS/UNITS  
6600 = (U) ADJUSTMENT BILL FULL DAYS  
6610 = (U) ADJUSTMENT BILL COIN DAYS  
6620 = (U) ADJUSTMENT BILL LIFE RESERVE  
6630 = (U) ADJUSTMENT BILL LIFE PSYCH DYS  
67X1 = (C) UNITS INDICATOR INVALID  
67X2 = (C) CHG ALLOWED > 0; UNITS IND = 0  
67X3 = (C) TOS/HCPCS=ANEST, MTU IND NOT = 2  
67X4 = (C) HCPCS = AMBULANCE, MTU IND NOT = 1  
67X6 = (C) INVALID PROC FOR MT IND 2, ANEST  
67X7 = (C) INVALID UNITS IND WITH TOS OF BLOOD  
67X8 = (C) INVALID PROC FOR MT IND 4, OXYGEN  
6700 = (U) ADJUSTMENT BILL FULL/SNF DAYS  
6710 = (U) ADJUSTMENT BILL COIN/SNF DAYS  
68XA = (C) HCPCS G0117-8 >1 OR BOTH PRESENT  
68XB = (C) HCPCS CODE G0245-46 > 1  
68X1 = (C) INVALID HCPCS CODE  
68X2 = (C) MAMMOGRAPY/DATE/PROC NOT 76092  
68X3 = (C) TYPE OF SERVICE = G /PROC CODE

68X4 = (C) HCPCS NOT VALID FOR SERVICE DATE  
68X5 = (C) MODIFIER NOT VALID FOR HCPCS, ETC  
68X6 = (C) TYPE SERVICE INVALID FOR HCPCS, ETC  
68X7 = (C) ZX MOD REQ FOR THER SHOES/INS/MOD.  
68X8 = (C) ANTI-EMETIC WITHOUT ANTI-CANCER DRUG  
6812 = (C) DEMO 37 WITH PRIMARY PAYER CODE  
69XA = (C) MODIFIER NOT VALID FOR HCPCS/GLOBAL  
69XB = (C) HCPCS CODE 97504/97116 PRESENT ON  
SAME DAY  
69XC = (C) HCPCS CODE VS PAY PROCESS INDICATOR  
69X3 = (C) PROC CODE MOD = LL / TYPE = R  
69X6 = (C) PROC CODE MOD/NOT CAPPED  
69X8 = (C) SPEC CODE NURSE PRACT, MOD INVAL  
69X9 = (C) NURSE PRACTITIONER, MOD INVALID  
6901 = (C) KRON IND AND UTIL DYS EQUALS ZERO  
6902 = (C) KRON IND AND NO-PAY CODE B OR N  
6903 = (C) KRON IND AND INPATIENT DEDUCT = 0  
6904 = (C) KRON IND AND TRANS CODE IS 4  
6910 = (C) REV CODES ON HOME HEALTH  
6911 = (C) REV CODE 274 ON OUTPAT AND HH ONLY  
6912 = (C) REV CODE INVAL FOR PROSTH AND ORTHO  
6913 = (C) REV CODE INVAL FOR OXYGEN  
6914 = (C) REV CODE INVAL FOR DME  
6915 = (C) PURCHASE OF RENT DME INVAL ON DATES  
6916 = (C) PURCHASE OF RENT DME INVAL ON DATES  
6917 = (C) PURCHASE OF LIFT CHAIR INVAL > 91000  
6918 = (C) HCPCS INVALID ON DATE RANGES  
6919 = (C) DME OXYGEN ON HH INVAL BEFORE 7/1/89  
6920 = (C) HCPCS INVAL ON REV 270/BILL 32-33  
6921 = (C) HCPCS ON REV CODE 272 BILL TYPE 83X  
6922 = (C) HCPCS ON BILL TYPE 83X -NOT REV 274  
6923 = (C) RENTAL OF DME CUSTOMIZE AND REV 291  
6924 = (C) INVAL MODIFIER FOR CAPPED RENTAL  
6925 = (C) HCPCS ALLOWED ON BILL TYPES 32X-34X  
6929 = (U) ADJUSTMENT BILL LIFE RESERVE  
6930 = (U) ADJUSTMENT BILL LIFE PSYCH DYS  
7000 = (U) INVALID DOEBA/DOLBA  
7002 = (U) LESS THAN 60/61 BETWEEN SPELLS  
7010 = (E) TOB 85X/ELECTN PRD: COND CD 07 REQD  
71X1 = (C) SUBMITTED CHARGES INVALID

71X2 = (C) MAMMOGRPY/PROC CODE MOD TC,26/CHG  
71X3 = (C) HCPCS 76092 PAY INDICATOR <> A,R,S  
& 76085 PAY INDICATOR A,R,S  
72X1 = (C) ALLOWED CHGS INVALID  
72X2 = (C) ALLOWED/SUBMITTED CHARGES/TYPE  
72X3 = (C) DENIED LINE/ALLOWED CHARGES  
7230 = (C) FRAMES >1, LENSES >2  
73X1 = (C) SS NUMBER INVALID  
73X2 = (C) CARRIER ASSIGNED PROV NUM MISSING  
74X1 = (C) LOCALITY CODE INVAL FOR CONTRACT  
76X1 = (C) PL OF SER INVAL ON MAMMOGRAPHY BILL  
77X1 = (C) PLACE OF SERVICE INVALID  
77X2 = (C) PHYS THERAPY/PLACE  
77X3 = (C) PHYS THERAPY/SPECIALTY/TYPE  
77X4 = (C) ASC/TYPE/PLACE/REIMB IND/DED IND  
77X6 = (C) TOS=F, PL OF SER NOT = 24  
7701 = (C) INCORRECT MODIFIER  
7777 = (D) POSS DUPE, PART B DOC-ID  
78XA = (C) MAMMOGRAPHY BEFORE 1991  
78XB = (C) ANTI-CANCER BEFORE 01/01/1998  
78X1 = (C) FROM DATE IMPOSSIBLE  
78X2 = (C) FROM DATE > CURRENT DATE OR  
< 07/01/1966  
78X3 = (C) FROM DATE GREATER THAN THRU DATE  
78X4 = (C) FROM DATE > RCVD DATE/PAY-DENY  
78X5 = (C) FROM DATE > PAID DATE/TYPE/100%  
78X7 = (C) LAB EDIT/TYPE/100%/FROM DATE  
79X1 = (C) THRU DATE IMPOSSIBLE  
79X2 = (C) THRU DATE > CURRENT DATE  
79X3 = (C) THRU DATE>RECD DATE/NOT DENIED  
79X4 = (C) THRU DATE>PAID DATE/NOT DENIED  
8000 = (U) MAIN & 2NDARY DOEBA < 01/01/90  
8028 = (E) NO ENTITLEMENT  
8029 = (U) HH BEFORE PERIOD NOT PRESENT  
8030 = (U) HH BILL VISITS > PT A REMAINING  
8031 = (U) HH PT A REMAINING > 0  
8032 = (U) HH DOLBA+59 NOT GT FROM-DATE  
8050 = (U) HH QUALIFYING INDICATOR = 1  
8051 = (U) HH # VISITS NE AFT PT B APPLIED  
8052 = (U) HH # VISITS NE AFT TRAILER

8053 = (U) HH BENEFIT PERIOD NOT PRESENT  
8054 = (U) HH DOEBA/DOLBA NOT > 0  
8060 = (U) HH QUALIFYING INDICATOR NE 1  
8061 = (U) HH DATE NE DOLBA IN AFT TRLR  
8062 = (U) HH NE PT-A VISITS REMAINING  
81X1 = (C) NUM OF SERVICES INVALID  
83X1 = (C) DIAGNOSIS INVALID  
8301 = (C) HCPCS/GENDER DIAGNOSIS  
8302 = (C) HCPCS G0101 V-CODE/SEX CODE  
8303 = (C) HCPCS/GENDER  
8304 = (C) BILL TYPE INVALID FOR G0123/4  
8305 = (C) HCPCS/SERVICE DATES/GENDER  
84X1 = (C) PAP SMEAR/DIAGNOSIS/GENDER/PROC  
84X2 = (C) INVALID DME START DATE  
84X3 = (C) INVALID DME START DATE W/HCPCS  
84X4 = (C) HCPCS G0101 V-CODE/SEX CODE  
84X5 = (C) HCPCS CODE WITH INV DIAG CODE  
84X6 = (C) HCPCS/GENDER  
84X7 = (C) HCPCS/SERVICE DATES/GENDER  
84X8 = (C) DUPLICATE HCPCS  
86X1 = (C) CLINICAL LAB HCPCS W/O CLINICAL  
LAB ID  
86X2 = (C) NON-WAIVER HCPCS/PAY DENIAL CODE/  
MODIFIER  
86X8 = (C) CLIA REQUIRES NON-WAIVER HCPCS  
88XX = (D) POSS DUPE, DOC-ID, UNITS, ENT, ALWD  
9000 = (U) DOEBA/DOLBA CALC  
9005 = (U) FULL/COINS HOSP DAYS CALC  
9010 = (U) FULL/COINS SNF DAYS CALC  
9015 = (U) LIFE RESERVE DAYS CALC  
9020 = (U) LIFE PSYCH DAYS CALC  
9030 = (U) INPAT DEDUCTABLE CALC  
9040 = (U) DATA INDICATOR 1 SET  
9050 = (U) DATA INDICATOR 2 SET  
91X1 = (C) PATIENT REIMB/PAY-DENY CODE  
92X1 = (C) PATIENT REIMB INVALID  
92X2 = (C) PROVIDER REIMB INVALID  
92X3 = (C) LINE DENIED/PATIENT-PROV REIMB  
92X4 = (C) MSP CODE/AMT/DATE/ALLOWED CHARGES  
92X5 = (C) CHARGES/REIMB AMT NOT CONSISTANT

92X7 = (C) REIMB/PAY-DENY INCONSISTANT  
9201 = (C) UPIN REF NAME OR INITIAL MISSING  
9202 = (C) UPIN REF FIRST 3 CHAR INVALID  
9203 = (C) UPIN REF LAST 3 CHAR NOT NUMERIC  
93X1 = (C) CASH DEDUCTABLE INVALID  
93X2 = (C) DEDUCT INDICATOR/CASH DEDUCTIBLE  
93X3 = (C) DENIED LINE/CASH DEDUCTIBLE  
93X4 = (C) FROM DATE/CASH DEDUCTIBLE  
93X5 = (C) TYPE/CASH DEDUCTIBLE/ALLOWED CHGS  
9300 = (C) UPIN OTHER, NOT PRESENT  
9301 = (C) UPIN NME MIS/DED TOT LI>0 FR DEN CLM  
9302 = (C) UPIN OPERATING, FIRST 3 NOT NUMERIC  
9303 = (C) UPIN L 3 CH NT NUM/DED TOT LI>YR DED  
9351 = (C) OTHER UPIN PRESENT/MISSING OTHER FIELDS  
9352 = (C) OTHER UPIN INVALID  
9353 = (C) OTHER UPIN INVALID  
94A1 = (C) NON-COVERED FROM DATE INVALID  
94A2 = (C) NON-COVERED FROM > THRU DATE  
94A3 = (C) NON-COVERED THRU DATE INVALID  
94A4 = (C) NON-COVERED THRU DATE > ADMIT  
94A5 = (C) NON-COVERED THRU DATE/ADMIT DATE  
94C1 = (C) PR-PSYCH DAYS INVALID  
94C3 = (C) PR-PSYCH DAYS > PROVIDER LIMIT  
94F1 = (C) REIMBURSEMENT AMOUNT INVALID  
94F2 = (C) REIMBURSE AMT NOT 0 FOR HMO PAID  
94G1 = (C) NO-PAY CODE INVALID  
94G2 = (C) NO-PAY CODE SPACE/NON-COVERD=TOTL  
94G3 = (C) NO-PAY/PROVIDER INCONSISTANT  
94G4 = (C) NO PAY CODE = R & REIMB PRESENT  
94X1 = (C) BLOOD LIMIT INVALID  
94X2 = (C) TYPE/BLOOD DEDUCTIBLE  
94X3 = (C) TYPE/DATE/LIMIT AMOUNT  
94X4 = (C) BLOOD DED/TYPE/NUMBER OF SERVICES  
94X5 = (C) BLOOD/MSP CODE/COMPUTED LINE MAX  
9401 = (C) BLOOD DEDUCTIBLE AMT > 3  
9402 = (C) BLOOD FURNISHED > DEDUCTIBLE  
9403 = (C) DATE OF BIRTH MISSING ON PRO-PAY  
9404 = (C) INVALID GENDER CODE ON PRO-PAY  
9407 = (C) INVALID DIAGNOSIS  
9408 = (C) INVALID DRG NUMBER (GLOBAL)

9409 = (C) HCFA DRG<>DRG ON BILL  
940X = (C) INVALID DRG  
9410 = (C) CABG/PCOE, INVALID DRG  
95X1 = (C) MSP CODE G/DATE BEFORE 1/1/87  
95X2 = (C) MSP AMOUNT APPLIED INVALID  
95X3 = (C) MSP AMOUNT APPLIED > SUB CHARGES  
95X4 = (C) MSP PRIMARY PAY/AMOUNT/CODE/DATE  
95X5 = (C) MSP CODE = G/DATE BEFORE 1987  
95X6 = (C) MSP CODE = X AND NOT AVOIDED  
95X7 = (C) MSP CODE VALID, CABG/PCOE  
96X1 = (C) OTHER AMOUNTS INVALID  
96X2 = (C) OTHER AMOUNTS > PAT-PROV REIMB  
97X1 = (C) OTHER AMOUNTS INDICATOR INVALID  
97X2 = (C) GRUDMAN SW/GRUDMAN AMT NOT > 0  
98X1 = (C) COINSURANCE INVALID  
98X3 = (C) MSP CODE/TYPE/COIN AMT/ALLOW/CSH  
98X4 = (C) DATE/MSP/TYPE/CASH DED/ALLOW/COI  
98X5 = (C) DATE/ALLOW/CASH DED/REIMB/MSP/TYP  
9801 = (C) REV CENTER CODE 0910 WITH SERVICE  
DATE > 10/15/2004  
99XX = (D) POSS DUPE, PART B DOC-ID  
9901 = (C) REV CODE INVALID OR TRAILER CNT=0  
9902 = (C) ACCOMMODATION DAYS/FROM/THRU DATE  
9903 = (C) NO CLINIC VISITS FOR RHC  
9904 = (C) INCOMPATIBLE DATES/CLAIM TYPE  
991X = (C) NO DATE OF SERVICE  
9910 = (C) BLOOD DEDUCTIBLE NON NUMERIC  
9911 = (C) BLOOD DEDUCTIBLE PRESENT WITHOUT  
BLOOD FURNISHED  
9920 = (C) CASH DEDUCTIBLE INVALID  
9930 = (C) COINSURANCE INVALID  
9931 = (C) OUTPAT COINSURANCE VALUES  
9933 = (C) RATE EXCEDES MAMMOGRAPHY LIMIT  
9934 = (C) HCPCS 76092 NON COVERED/76085 COVERED  
9940 = (C) PROVIDER PAYMENT INVALID  
9941 = (C) REIMBURSEMENT AMOUNT/COND/NON-PAYMENT/  
PRIMARY PAYER  
9942 = (C) PATIENT DISTRIBUTION INVALID  
9944 = (C) STAY FROM>97273, DIAG<>V103,163,7612  
9945 = (C) HCPCS INVALID FOR SERVICE DATES



9946 = (C) TOB INVALID FOR HCPCS  
9947 = (C) INVALID DATE FOR HCPCS  
9948 = (C) STAY FROM>96365,DIAG=V725  
9960 = (C) MED CHOICE BUT HMO DATA MISSING  
9965 = (C) HMO PRESENT BUT MED CHOICE MISSING  
9968 = (C) MED CHOICE NOT= HMO PLAN NUMBER  
9999 = (U) MAIN SPELL TRAILER NUMBER DOES NOT MATCH SPELL

NCH\_EDIT\_TRLR\_IND\_TB

NCH Edit Trailer Indicator Table

E = Edit code trailer present

NCH\_IP\_PRO\_APRVL\_TYPE\_TB

NCH Inpatient Peer Review Organization Approval Type Table

- 1 = Approved by the PRO as billed - Code indicates that the claim has been reviewed by the PRO and has been fully approved including any day or cost outliers.
- 2 = Automatic approval - Does not apply to Medicare claim.
- 3 = Partial approval - Code indicates the bill has been reviewed by the PRO, and some portion (days or services) has been denied. The from/thru dates of the approved portion of the stay, excluding grace days and any period at a noncovered level of care are shown on the bill.
- 4 = Admission denied - Code indicates the patient's need for inpatient services was reviewed upon admission and the PRO found that the stay was not medically necessary.
- 5 = Post payment review - Code indicates that any medical review will be

completed after the claim is paid.  
The bill may be a day outlier, part of  
the sample review, or may not be  
reviewed.

6 = Pre-admission authorization - Pre-  
admission authorization obtained, but  
services not reviewed by the PRO.

7 THRU 9 = Reserved.

NCH\_LINE\_TRLR\_IND\_TB

NCH Line Item Trailer Indicator Table

L = Line Item trailer present

Blank = No trailer present

NCH\_MCO\_TRLR\_IND\_TB

NCH Managed Care Organization (MCO) Trailer Indicator Table

M = MCO trailer present

NCH\_MQA\_QUERY\_PATCH\_TB

NCH MQA Query Patch Table

Y = MQA changed bill query code on a action  
code 6 (force action code 2)  
bill to a zero. (Eff. 10/12/93)

Z = MQA changed bill query code on a action  
code 4 (cancel only adjustment)  
bill to zero. (Eff. 5/16/94)

NCH\_MQA\_RIC\_TB

NCH MQA Record Identification Code Table

1 = Inpatient

2 = SNF

3 = Hospice

- 4 = Outpatient
- 5 = Home Health Agency
- 6 = Physician/Supplier
- 7 = Durable Medical Equipment

NCH\_NEAR\_LINE\_REC\_VRSN\_TB

NCH Near Line Record Version Table

- A = Record format as of January 1991
- B = Record format as of April 1991
- C = Record format as of May 1991
- D = Record format as of January 1992
- E = Record format as of March 1992
- F = Record format as of May 1992
- G = Record format as of October 1993
- H = Record format as of September 1998
- I = Record format as of July 2000
- J = Record format as of January 2011

NCH\_NEAR\_LINE\_RIC\_TB

NCH Near-Line Record Identification Code Table

- O = Part B physician/supplier claim  
record (processed by local carriers;  
can include DMEPOS services)
- V = Part A institutional claim record  
(inpatient (IP), skilled nursing  
facility (SNF), christian science  
(CS), home health agency (HHA), or  
hospice)
- W = Part B institutional claim record  
(outpatient (OP), HHA)
- U = Both Part A and B institutional home  
health agency (HHA) claim records --  
due to HHPPS and HHA A/B split.  
(effective 10/00)
- M = Part B DMEPOS claim record (processed  
by DME Regional Carrier) (effective 10/93)

NCH\_OCRNC\_TRLR\_IND\_TB

NCH Occurrence Trailer Indicator Table

0 = Occurrence code trailer present

NCH\_PATCH\_TB

NCH Patch Table

- 01 = RRB Category Equatable BIC - changed (all claim types) -- applied during the Nearline 'G' conversion to claims with NCH weekly process date before 3/91. Prior to Version 'H', patch indicator stored in redefined Claim Edit Group, 3rd occurrence, position 2.
- 02 = Claim Transaction Code made consistent with NCH payment/edit RIC code (OP and HHA) -- effective 3/94, CWFMQA began patch. During 'H' conversion, patch applied to claims with NCH weekly process date prior to 3/94. Prior to version 'H', patch indicator stored in redefined Claim Edit Group, 4th occurrence, position 1.
- 03 = Garbage/nonnumeric Claim Total Charge Amount set to zeroes (Instnl) -- during the Version 'G' conversion, error occurred in the derivation of this field where the claim was missing revenue center code = '0001'. In 1994, patch was applied to the OP and HHA SAFs only. (This SAF patch indicator was stored in the redefined Claim Edit Group, 4th occurrence, position 2). During the 'H' conversion, patch applied to Nearline claims where garbage or nonnumeric values.
- 04 = Incorrect bene residence SSA standard county code '999' changed (all claim types) -- applied during the Nearline 'G' conversion and ongoing through 4/21/94, calling EQSTZIP

- routine to claims with NCH weekly process date prior to 4/22/94. Prior to Version 'H' patch indicator stored in redefined Claim Edit Group, 3rd occurrence, position 4.
- 05 = Wrong century bene birth date corrected (all claim types) -- applied during Nearline 'H' conversion to all history where century greater than 1700 and less than 1850; if century less than 1700, zeroes moved.
- 06 = Inconsistent CWF bene medicare status code made consistent with age (all claim types) -- applied during Nearline 'H' conversion to all history and patched ongoing. Bene age is calculated to determine the correct value; if greater than 64, 1st position MSC = '1'; if less than 65, 1st position MSC = '2'.
- 07 = Missing CWF bene medicare status code derived (all claim types) -- applied during Nearline 'H' conversion to all history and patched ongoing, except claims with unknown DOB and/or Claim From Date='0' (left blank). Bene age is calculated to determine missing value; if greater than 64, MSC='10'; if less than 65, MSC = '20'.
- 08 = Invalid NCH primary payer code set to blanks (Instnl) -- applied during Version 'H' conversion to claims with NCH weekly process date 10/1/93-10/30/95, where MSP values = invalid '0', '1', '2', '3' or '4' (caused by erroneous logic in HCFA program code, which was corrected on 11/1/95).
- 09 = Zero CWF claim accretion date replaced with NCH weekly process date (all claim types) -- applied during Version 'H' conversion to Instnl and DMERC claims; applied during Version 'G' conversion to non-institutional (non-DMERC) claims. Prior to Version 'H', patch indicator stored in redefined claim edit group, 3rd occurrence, position 1.
- 10 = Multiple Revenue Center 0001 (Outpatient,

HHA and Hospice) -- patch applied to 1998 & 1999 Nearline and SAFs to delete any revenue codes that followed the first '0001' revenue center code. The edit was applied across all institutional claim types, including Inpatient/SNF (the problem was only found with OP/HHA/Hospice claims). The problem was corrected 6/25/99.

- 11 = Truncated claim total charge amount in the fixed portion replaced with the total charge amount in the revenue center 0001 amount field -- service years 1998 & 1999 patched during quarterly merge. The 1998 & 1999 SAFs were corrected when finalized in 7/99. The patch was done for records with NCH Daily Process Date 1/4/99 - 5/14/99.
- 12 = Missing claim-level HHA Total Visit Count -- service years 1998, 1999 & 2000 patch applied during Version 'I' conversion of both the Nearline and SAFs. Problem occurs in those claims recovered during the missing claims effort.
- 13 = Inconsistent Claim MCO Paid Switch made consistent with criteria used to identify an inpatient encounter claim -- if MCO paid switch equal to blank or '0' and ALL conditions are met to indicate an inpatient encounter claim (bene enrolled in a risk MCO during the service period), change the switch to a '1'. The patch was applied during the Version 'I' conversion, for claims back to 7/1/97 service thru date.
- 14 = SNF claims incorrectly identified as Inpatient Encounter claims -- SNF claims matching the Inpatient encounter data criteria were incorrectly identified as Inpatient encounter claims (claim type code = '61' instead of '20' or '30'). NOTE: if the SNF claims were identified the MCO paid switch was set to '1'. The patch was applied to correctly identify these claims as a '20' or '30'. The MCO paid switch will be set to '0' as there is no way to recover the original

value. The problem occurred in claims with an NCH Weekly Process Date ranging from 7/7/2000 - 1/26/2001. The patch applied date is 03/30/2001.

- 15 = HHA Part A claims with overlaid revenue center lines - During the Version 'I' conversion, NCH made each segment of a claim contains a maximum of 45 revenue lines. During the month of June 2000 our CWFMQA had to be ready to except the new expanded format, but the NCH was not ready. CWFMQA converted these 'I' claims back to Version 'H', a typo in the code caused the additional revenue lines to overlay some of the revenue lines on the base/initial record/segment. The problem occurred in claims with NCH Weekly Process dates from 6/16/00, 6/23/00, 6/30/00 and 7/7/00 (both Version 'H' & 'I' files).

In the Version 'I' files, the annual service year 2000 files, service year 1999 and 1998 trickles were patched. The 18-month service year 1999 was also patched (the service year 2000 SAF was created after the fix was applied).

The patch applied date is 06/29/2001.

NCH\_PATCH\_TRLR\_IND\_TB

NCH Patch Trailer Indicator Table

P = Patch code trailer present

NCH\_POA\_DGNS\_TRLR\_IND\_TB

NCH POA Diagnosis Trailer Indicator Code Table

Valid Value:

A = NCH POA Diagnosis Code trailer

NCH\_PRCDR\_TRLR\_IND\_TB

NCH Procedure Trailer Indicator Table

Z = Procedure code trailer present

NCH\_PTNT\_STUS\_IND\_TB

NCH Patient Status Indicator Table

A = Discharged

B = Died

C = Still patient

NCH\_REV\_TRLR\_IND\_TB

NCH Revenue Center Trailer Indicator Table

R = Revenue code trailer present

NCH\_SPAN\_TRLR\_IND\_TB

NCH Span Trailer Indicator Table

S = Span code trailer present

NCH\_STATE\_SGMT\_TB

NCH State Segment Table

NCH State Segment

State Codes

B =

01;02;03;04;06;07;08;09;  
12;13;16;17;19;20;21;25;  
27;28;29;30;32;35;37;38;  
40;41;42;43;44;46;47;48;  
50;51;53-99

C =

11;14;15;18;24;26;49;52

D =

11;14;15;18;24;26;31;34;  
45;49;52



E =	22;23;31;34;36;45
F =	10;22;23;31;34;36;45
G =	10;22;23;36;39
H =	05;10;22;23;39
I =	05;10;39
J =	05;10;33;39
K =	05;33;39
L =	05;33;39
M =	05;33
N =	05;33
O =	33
P =	33
Q =	33
R =	33

NCH\_VAL\_TRLR\_IND\_TB

NCH Value Trailer Indicator Table

V = Value code trailer present

PMT\_EDIT\_RIC\_TB

Payment And Edit Record Identification Code Table

C = Inpatient hospital, SNF

D = Outpatient  
 E = Religious Nonmedical Health Care Institutions (eff. 8/00);  
     Christian Science, prior to 7/00  
 F = Home Health Agency (HHA)  
 G = Discharge notice  
     (obsoleted 7/98)  
 I = Hospice

PRVDR\_NUM\_TB

Provider Number Table

- First two positions are the GEO SSA State Code.
- Positions 3 and sometimes 4 are used as a category identifier. The remaining positions are serial numbers. The following blocks of numbers are reserved for the facilities indicated (NOTE: may have different meanings dependent on the Type of Bill (TOB)):

0001-0879	Short-term (general and specialty) hospitals where TOB = 11X; ESRD clinic where TOB = 72X
0880-0899	Reserved for hospitals participating in ORD demonstration projects where TOB = 11X; ESRD clinic where TOB = 72X
0900-0999	Multiple hospital component in a medical complex (numbers retired) where TOB = 11X; ESRD clinic where TOB = 72X
1000-1199	Reserved for future use
1200-1224	Alcohol/drug hospitals (excluded from PPS-numbers retired) where TOB = 11X; ESRD clinic where TOB = 72X
1225-1299	Medical assistance facilities (Montana project); ESRD clinic where TOB = 72X

1300-1399	Rural Primary Care Hospital (RCPH) - eff. 10/97 changed to Critical Access Hospitals (CAH)
1400-1499	Continuation of 4900-4999 series (CMHC)
1500-1799	Hospices
1800-1989	Federally Qualified Health Centers (FQHC) where TOB = 73X; SNF (IP PTB) where TOB = 22X; HHA where TOB = 32X, 33X, 34X
1990-1999	Christian Science Sanatoria (hospital services) - eff. 7/00 changed to Religious Nonmedical Health Care Institutions (RNHCI)
2000-2299	Long-term hospitals
2300-2499	Chronic renal disease facilities (hospital based)
2500-2899	Non-hospital renal disease treatment centers
2900-2999	Independent special purpose renal dialysis facility (1)
3000-3024	Formerly tuberculosis hospitals (numbers retired)
3025-3099	Rehabilitation hospitals
3100-3199	Continuation of Subunits of Nonprofit and Proprietary Home Health Agencies (7300-7399) Series (3) (eff. 4/96)
3200-3299	Continuation of 4800-4899 series (CORF)
3300-3399	Children's hospitals (excluded from PPS) where TOB = 11X; ESRD clinic where TOB = 72X
3400-3499	Continuation of rural health clinics (provider-based) (3975-3999)
3500-3699	Renal disease treatment centers (hospital satellites)
3700-3799	Hospital based special purpose renal dialysis facility (1)
3800-3974	Rural health clinics (free-standing)
3975-3999	Rural health clinics (provider-based)
4000-4499	Psychiatric hospitals
4500-4599	Comprehensive Outpatient

Rehabilitation Facilities (CORF)

4600-4799 Community Mental Health Centers (CMHC);  
9/30/91 - 3/31/97 used for clinic OPT  
where TOB = 74X

4800-4899 Continuation of 4500-4599 series (CORF)  
(eff. 10/95)

4900-4999 Continuation of 4600-4799 series (CMHC)  
(eff. 10/95); 9/30/91 - 3/31/97 used for  
clinic OPT where TOB = 74X

5000-6499 Skilled Nursing Facilities

6500-6989 CMHC / Outpatient physical therapy services  
where TOB = 74X; CORF where TOB =  
75X

6990-6999 Christian Science Sanatoria (skilled  
nursing services) - eff. 7/00 Numbers  
Reserved (formerly CS)

7000-7299 Home Health Agencies (HHA) (2)

7300-7399 Subunits of 'nonprofit' and  
'proprietary' Home Health Agencies (3)

7400-7799 Continuation of 7000-7299 series

7800-7999 Subunits of state and local governmental  
Home Health Agencies (3)

8000-8499 Continuation of 7400-7799 series (HHA)

8500-8899 Continuation of rural health  
center (provider based) (3400-3499)

8900-8999 Continuation of rural health  
center (free-standing) (3800-3974)

9000-9799 Continuation of 8000-8499 series (HHA)  
(eff. 10/95)

9800-9899 Transplant Centers (eff. 10/1/07)

9900-9999 Reserved for future use (eff. 8/1/98)  
NOTE: 10/95-7/98 this series was  
assigned to HHA's but rescinded - no  
HHA's were ever assigned a number  
from this series.

Exception:

P001-P999 Organ procurement organization

- (1) These facilities (SPRDFS) will be assigned the same provider number whenever they are recertified.
- (2) The 6400-6499 series of provider numbers in Iowa (16), South Dakota (43) and Texas (45) have been used in reducing acute care costs (RACC) experiments.
- (3) In Virginia (49), the series 7100-7299 has been reserved for statewide subunit components of the Virginia state home health agencies.
- (4) Parent agency must have a number in the 7000-7299, 7400-7799 or 8000-8499 series.

NOTE:

There is a special numbering system for units of hospitals that are excluded from prospective payment system (PPS) and hospitals with SNF swing-bed designation. An alpha character in the third position of the provider number identifies the type of unit or swing-bed designation as follows:

M = Psychiatric Unit in Critical Access Hospital  
R = Rehabilitation Unit in Critical Access Hospital  
S = Psychiatric unit (excluded from PPS)  
T = Rehabilitation unit (excluded from PPS)  
U = Swing-Bed Hospital Designation for Short-Term Hospitals  
V = Alcohol drug unit (prior to 10/87 only)  
W = Swing-Bed Hospital Designation for Long Term Care Hospitals  
Y = Swing-Bed Hospital Designation for Rehabilitation Hospitals  
Z = Swing Bed Designation for Critical Access Hospitals

There is also a special numbering system for

assigning emergency hospital identification numbers (non participating hospitals). The sixth position of the provider number is as follows:

E = Non-federal emergency hospital  
F = Federal emergency hospital

PTNT\_DSCHRG\_STUS\_TB

Patient Discharge Status Table

- 01 = Discharged to home/self care (routine charge).
- 02 = Discharged/transferred to other short term general hospital for inpatient care.
- 03 = Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care -- (For hospitals with an approved swing bed arrangement, use Code 61 - swing bed. For reporting discharges/transfers to a non-certified SNF, the hospital must use Code 04 - ICF).
- 04 = Discharged/transferred to a facility that provides custodial or supportive care (includes intermediate care facilities (ICF)). Also used to designate patients that are discharged/transferred to a nursing facility with neither Medicare nor Medicaid certification and for discharges/transfers to Assisted Living Facilities.
- 05 = Discharged/transferred to a designated cancer center or children's hospital (eff. 10/09). Prior to 10/1/09, discharged/transferred to another type of institution for inpatient care (including distinct parts). NOTE: Effective 1/2005, psychiatric hospital or psychiatric distinct part unit of a hospital will no longer be identified by this code. New code is '65'.
- 06 = Discharged/transferred to home care of

- organized home health service organization  
in anticipation of covered skilled care.
- 07 = Left against medical advice or discontinued  
care.
- 08 = Discharged/transferred to home under  
care of a home IV drug therapy provider.  
(discontinued effective 10/1/05)
- 09 = Admitted as an inpatient to this  
hospital (effective 3/1/91). In situa-  
tions where a patient is admitted before  
midnight of the third day following the  
day of an outpatient service, the out-  
patient services are considered inpatient.
- 20 = Expired
- 21 = Discharged/transferred to Court/Law  
Enforcement.
- 30 = Still patient.
- 40 = Expired at home (Hospice claims only).
- 41 = Expired in a medical facility such as  
hospital, SNF, ICF, or freestanding  
hospice. (Hospice claims only)
- 42 = Expired - place unknown (Hospice claims  
only)
- 43 = Discharged/transferred to a federal hospital  
(eff. 10/1/03). Discharges and transfers to a  
government operated health facility such as a  
Department of Defense hospital, a Veteran's  
Administration hospital or a Veteran's Administration  
nursing facility. To be used whenever the destination  
at discharge is a federal health care facility,  
whether the patient lives there or not.
- 50 = Hospice - home (eff. 10/96)
- 51 = Hospice - medical facility (certified) providing  
hospice level of care
- 61 = Discharged/transferred within this insti-  
tution to a hospital-based Medicare  
approved swing bed (eff. 9/01)
- 62 = Discharged/transferred to an inpatient  
rehabilitation facility including distinct  
parts units of a hospital.

- (eff. 1/2002)
- 63 = Discharged/transferred to a Medicare certified long term care hospital. (eff. 1/2002)
- 64 = Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare (eff. 10/2002)
- 65 = Discharged/Transferred to a psychiatric hospital or psychiatric distinct unit of a hospital (these types of hospitals were pulled from patient/discharge status code '05' and given their own code). (eff. 1/2005).
- 66 = Discharged/transferred to a Critical Access Hospital (CAH) (eff. 1/1/06)
- 70 = Discharged/transferred to another type of health care institution not defined elsewhere in code list.
- 71 = Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care (eff. 9/01) (discontinued effective 10/1/05)
- 72 = Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care (eff. 9/01) (discontinued effective 10/1/05)

REV\_CNTR\_ANSI\_TB

Revenue Center ANSI Code Table

\*\*\*\*\*EXPLANATION OF CLAIM ADJUSTMENT GROUP CODES\*\*\*\*\*

\*\*\*\*\*POSITIONS 1 & 2 OF ANSI CODE\*\*\*\*\*

CO = Contractual Obligations -- this group code should be used when a contractual agreement between the payer and payee, or a regulatory requirement, resulted in an adjustment. Generally, these adjustments are considered a write-off for the provider and are not billed to the patient.

CR = Corrections and Reversals -- this group code should be used for correcting a prior claim. It applies



when there is a change to a previously adjudicated claim.

OA = Other Adjustments -- this group code should be used when no other group code applies to the adjustment.

PI = Payer Initiated Reductions -- this group code should be used when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer (i.e., medical review or professional review organization adjustments).

PR = Patient Responsibility -- this group should be used when the adjustment represents an amount that should be billed to the patient or insured. This group would typically be used for deductible and copay adjustments.

\*\*\*\*\*Claim Adjustment Reason Codes\*\*\*\*\*  
\*\*\*\*\*POSITIONS 3 through 5 of ANSI CODE\*\*\*\*\*

- 1 = Deductible Amount
- 2 = Coinsurance Amount
- 3 = Co-pay Amount
- 4 = The procedure code is inconsistent with the modifier used or a required modifier is missing.
- 5 = The procedure code/bill type is inconsistent with the place of service.
- 6 = The procedure code is inconsistent with the patient's age.
- 7 = The procedure code is inconsistent with the patient's gender.
- 8 = The procedure code is inconsistent with the provider type.
- 9 = The diagnosis is inconsistent with the patient's age.
- 10 = The diagnosis is inconsistent with the patient's gender.
- 11 = The diagnosis is inconsistent with the procedure.
- 12 = The diagnosis is inconsistent with the provider type.

13 = the date of death precedes the date of service.  
14 = The date of birth follows the date of service.  
15 = Claim/service adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.  
16 = Claim/service lacks information which is needed for adjudication.  
17 = Claim/service adjusted because requested information was not provided or was insufficient/incomplete.  
18 = Duplicate claim/service.  
19 = Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.  
20 = Claim denied because this injury/illness is covered by the liability carrier.  
21 = Claim denied because this injury/illness is the liability of the no-fault carrier.  
22 = Claim adjusted because this care may be covered by another payer per coordination of benefits.  
23 = Claim adjusted because charges have been paid by another payer.  
24 = Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.  
25 = Payment denied. Your Stop loss deductible has not been met.  
26 = Expenses incurred prior to coverage.  
27 = Expenses incurred after coverage terminated.  
28 = Coverage not in effect at the time the service was provided.  
29 = The time limit for filing has expired.  
30 = Claim/service adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.  
31 = Claim denied as patient cannot be identified as our insured.  
32 = Our records indicate that this dependent is not an eligible dependent as defined.  
33 = Claim denied. Insured has no dependent coverage.  
34 = Claim denied. Insured has no coverage for newborns.  
35 = Benefit maximum has been reached.

36 = Balance does not exceed copayment amount.  
37 = Balance does not exceed deductible amount.  
38 = Services not provided or authorized by designated (network) providers.  
39 = Services denied at the time authorization/pre-certification was requested.  
40 = Charges do not meet qualifications for emergency/urgent care.  
41 = Discount agreed to in Preferred Provider contract.  
42 = Charges exceed our fee schedule or maximum allowable amount.  
43 = Gramm-Rudman reduction.  
44 = Prompt-pay discount.  
45 = Charges exceed your contracted/legislated fee arrangement.  
46 = This (these) service(s) is(are) not covered.  
47 = This (these) diagnosis(es) is(are) not covered, missing, or are invalid.  
48 = This (these) procedure(s) is(are) not covered.  
49 = These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.  
50 = These are non-covered services because this is not deemed a 'medical necessity' by the payer.  
51 = These are non-covered services because this a pre-existing condition.  
52 = The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.  
53 = Services by an immediate relative or a member of the same household are not covered.  
54 = Multiple physicians/assistants are not covered in this case.  
55 = Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.  
56 = Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by payer.  
57 = Claim/service adjusted because the payer deems the information submitted does not support this level of service, this many services, this length of service, or

this dosage.

58 = Claim/service adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.

59 = Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.

60 = Charges for outpatient services with the proximity to inpatient services are not covered.

61 = Charges adjusted as penalty for failure to obtain second surgical opinion.

62 = Claim/service denied/reduced for absence of, or exceeded, precertification/authorization.

63 = Correction to a prior claim. INACTIVE

64 = Denial reversed per Medical Review. INACTIVE

65 = Procedure code was incorrect. This payment reflects the correct code. INACTIVE

66 = Blood Deductible.

67 = Lifetime reserve days. INACTIVE

68 = DRG weight. INACTIVE

69 = Day outlier amount.

70 = Cost outlier amount.

71 = Primary Payer amount.

72 = Coinsurance day. INACTIVE

73 = Administrative days. INACTIVE

74 = Indirect Medical Education Adjustment.

75 = Direct Medical Education Adjustment.

76 = Disproportionate Share Adjustment.

77 = Covered days. INACTIVE

78 = Non-covered days/room charge adjustment.

79 = Cost report days. INACTIVE

80 = Outlier days. INACTIVE

81 = Discharges. INACTIVE

82 = PIP days. INACTIVE

83 = Total visits. INACTIVE

84 = Capital adjustments. INACTIVE

85 = Interest amount. INACTIVE

86 = Statutory adjustment. INACTIVE

87 = Transfer amounts.

88 = Adjustment amount represents collection against receivable created in prior overpayment.

89 = Professional fees removed from charges.  
90 = Ingredient cost adjustment.  
91 = Dispensing fee adjustment.  
92 = Claim paid in full. INACTIVE  
93 = No claim level adjustment. INACTIVE  
94 = Process in excess of charges.  
95 = Benefits adjusted. Plan procedures not followed.  
96 = Non-covered charges.  
97 = Payment is included in allowance for another service/procedure.  
98 = The hospital must file the Medicare claim for this inpatient non-physician service. INACTIVE  
99 = Medicare Secondary Payer Adjustment Amount. INACTIVE  
100 = Payment made to patient/insured/responsible party.  
101 = Predetermination: anticipated payment upon completion of services or claim adjudication.  
102 = Major medical adjustment.  
103 = Provider promotional discount (i.e. Senior citizen discount).  
104 = Managed care withholding.  
105 = Tax withholding.  
106 = Patient payment option/election not in effect.  
107 = Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.  
108 = Claim/service reduced because rent/purchase guidelines were not met.  
109 = Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.  
110 = Billing date predates service date.  
111 = Not covered unless the provider accepts assignment.  
112 = Claim/service adjusted as not furnished directly to the patient and/or not documented.  
113 = Claim denied because service/procedure was provided outside the United States or as a result of war.  
114 = Procedure/PROduct not approved by the Food and Drug Administration.  
115 = Claim/service adjusted as procedure postponed or canceled.  
116 = Claim/service denied. The advance indemnification notice signed by the patient did not comply with

requirements.

117 = Claim/service adjusted because transportation is only covered to the closest facility that can provide the necessary care.

118 = Charges reduced for ESRD network support.

119 = Benefit maximum for this time period has been reached.

120 = Patient is covered by a managed care plan. INACTIVE

121 = Indemnification adjustment.

122 = Psychiatric reduction.

123 = Payer refund due to overpayment. INACTIVE

124 = Payer refund amount - not our patient. INACTIVE

125 = Claim/service adjusted due to a submission/billing error(s).

126 = Deductible - Major Medical.

127 = Coinsurance - Major Medical.

128 = Newborn's services are covered in the mother's allowance.

129 = Claim denied - prior processing information appears incorrect.

130 = Paper claim submission fee.

131 = Claim specific negotiated discount.

132 = Prearranged demonstration project adjustment.

133 = The disposition of this claim/service is pending further review.

134 = Technical fees removed from charges.

135 = Claim denied. Interim bills cannot be processed.

136 = Claim adjusted. Plan procedures of a prior payer were not followed.

137 = Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.

138 = Claim/service denied. Appeal procedures not followed or time limits not met.

139 = Contracted funding agreement - subscriber is employed by the provider of services.

140 = Patient/Insured health identification number and name do not match.

141 = Claim adjustment because the claim spans eligible and ineligible periods of coverage.

142 = Claim adjusted by the monthly Medicaid patient liability amount.

A0 = Patient refund amount  
A1 = Claim denied charges.  
A2 = Contractual adjustment.  
A3 = Medicare Secondary Payer liability met. INACTIVE  
A4 = Medicare Claim PPS Capital Day Outlier Amount.  
A5 = Medicare Claim PPS Capital Cost Outlier Amount.  
A6 = Prior hospitalization or 30 day transfer requirement not met.  
A7 = Presumptive Payment Adjustment.  
A8 = Claim denied; ungroupable DRG.  
B1 = Non-covered visits.  
B2 = Covered visits. INACTIVE  
B3 = Covered charges. INACTIVE  
B4 = Late filing penalty.  
B5 = Claim/service adjusted because coverage/program guidelines were not met or were exceeded.  
B6 = This service/procedure is adjusted when performed/billed by this type of provider, by this type of facility, or by a provider of this specialty.  
B7 = This provider was not certified/eligible to be paid for this procedure/service on this date of service.  
B8 = Claim/service not covered/reduced because alternative services were available, and should have been utilized.  
B9 = Services not covered because the patient is enrolled in a Hospice.  
B10 = Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.  
B11 = The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.  
B12 = Services not documented in patients' medical records.  
B13 = Previously paid. Payment for this claim/service may have been provided in a previous payment.  
B14 = Claim/service denied because only one visit or consultation per physician per day is covered.

B15 = Claim/service adjusted because this procedure/  
 service is not paid separately.  
 B16 = Claim/service adjusted because 'New Patient'  
 qualifications were not met.  
 B17 = Claim/service adjusted because this service was  
 not prescribed by a physician, not prescribed  
 prior to delivery, the prescription is incomplete,  
 or the prescription is not current.  
 B18 = Claim/service denied because this procedure code/  
 modifier was invalid on the date of service or  
 claim submission.  
 B19 = Claim/service adjusted because of the finding of a  
 Review Organization. INACTIVE  
 B20 = Charges adjusted because procedure/service was  
 partially or fully furnished by another provider.  
 B21 = The charges were reduced because the service/care  
 was partially furnished by another physician.  
 INACTIVE  
 B22 = This claim/service is adjusted based on the  
 diagnosis.  
 B23 = Claim/service denied because this provider has  
 failed an aspect of a proficiency testing program.  
 W1 = Workers Compensation State Fee Schedule Adjustment.

REV\_CNTR\_APC\_BUFR\_TB      Revenue Center Ambulatory Payment Classification (APC) Buffer Code Table

00      =      N/A in this case  
 01-99 =      1st composite - 99th composite  
 A1-A9 =    100th composite - 108th composite  
 B1-B9 =    109th composite - 117th composite  
 C1-C9 =    118th composite - 126th composite  
 D1-D9 =    127th composite - 135th composite  
 E1-E9 =    136th composite - 144th composite  
 F1-F9 =    145th composite - 153rd composite  
 G1-G9 =    154th composite - 162nd composite  
 H1-H9 =    163rd composite - 171st composite  
 I1-I9 =    172nd composite - 180th composite  
 J1-J9 =    181st composite - 189th composite



K1-K9 = 190th composite - 198th composite  
L1-L9 = 199th composite - 207th composite  
M1-M9 = 208th composite - 216th composite  
N1-N9 = 217th composite - 225th composite  
O1-O9 = 226th composite - 234th composite  
P1-P9 = 235th composite - 243rd composite  
Q1-Q9 = 244th composite - 252nd composite  
R1-R9 = 253rd composite - 261st composite  
S1-S9 = 262nd composite - 270th composite  
T1-T9 = 271st composite - 279th composite  
U1-U9 = 280th composite - 288th composite  
V1-V9 = 289th composite - 297th composite  
W1-W9 = 298th composite - 306th composite  
X1-X9 = 307th composite - 315th composite  
Y1-Y9 = 316th composite - 324th composite  
Z1-Z9 = 325th composite - 333rd composite

AA-AZ = 334th composite - 359th composite  
BA-BZ = 360th composite - 385th composite  
CA-CZ = 386th composite - 411th composite  
DA-DZ = 412th composite - 437th composite  
EA-EZ = 438th composite - 463rd composite  
FA-FZ = 464th composite - 489th composite  
GA-GZ = 490th composite - 515th composite  
HA-HZ = 516th composite - 541st composite  
IA-IZ = 542nd composite - 567th composite  
JA-JZ = 568th composite - 593rd composite  
KA-KZ = 594th composite - 619th composite  
LA-LZ = 620th composite - 645th composite  
MA-MZ = 646th composite - 671st composite  
NA-NZ = 672nd composite - 697th composite  
OA-OZ = 698th composite - 723rd composite  
PA-PZ = 724th composite - 749th composite  
QA-QZ = 750th composite - 775th composite  
RA-RZ = 776th composite - 801st composite  
SA-SZ = 802nd composite - 827th composite  
TA-TZ = 828th composite - 853rd composite  
UA-UZ = 854th composite - 879th composite  
VA-VZ = 880th composite - 905th composite  
WA-WZ = 906th composite - 931st composite

XA-XZ = 932nd composite - 957th composite  
ZA-ZZ = 958th composite - 983rd composite

REV\_CNTR\_APC\_TB

Revenue Center Ambulatory Payment Classification (APC)

0000 = Code used when Payment Method Indicator  
equals 'N9'  
0001 = Photochemotherapy  
0002 = Fine needle Biopsy/Aspiration  
0003 = Bone Marrow Biopsy/Aspiration  
0004 = Level I Needle Biopsy/ Aspiration Except  
Bone Marrow  
0005 = Level II Needle Biopsy /Aspiration Except  
Bone Marrow  
0006 = Level I Incision & Drainage  
0007 = Level II Incision & Drainage  
0008 = Level III Incision & Drainage  
0009 = Nail Procedures  
0010 = Level I Destruction of Lesion  
0011 = Level II Destruction of Lesion  
0012 = Level I Debridement & Destruction  
0013 = Level II Debridement & Destruction  
0014 = Level III Debridement & Destruction  
0015 = Level IV Debridement & Destruction  
0016 = Level V Debridement & Destruction  
0017 = Level VI Debridement & Destruction  
0018 = Biopsy Skin, Subcutaneous Tissue or Mucous Membrane  
0019 = Level I Excision/ Biopsy  
0020 = Level II Excision/ Biopsy  
0021 = Level III Excision/ Biopsy  
0022 = Level IV Excision/ Biopsy  
0023 = Exploration Penetrating Wound  
0024 = Level I Skin Repair  
0025 = Level II Skin Repair  
0026 = Level III Skin Repair  
0027 = Level IV Skin Repair  
0028 = Level I Incision/Excision Breast  
0029 = Incision/Excision Breast (obsolete 12/00);

Level II Incision/Excision Breast (effective 1/01)  
0030 = Breast Reconstruction/Mastectomy  
0031 = Hyperbaric Oxygen (obsolete 1/01)  
0032 = Placement Transvenous Catheters/Arterial Cutdown  
0033 = Partial Hospitalization  
0040 = Arthrocentesis & Ligament/Tendon Injection  
0041 = Arthroscopy  
0042 = Arthroscopically-Aided Procedures  
0043 = Closed Treatment Fracture Finger/Toe/Trunk  
0044 = Closed Treatment Fracture/Dislocation Except  
Finger/Toe/Trunk  
0045 = Bone/Joint Manipulation Under Anesthesia  
0046 = Open/Percutaneous Treatment Fracture or Dislocation  
0047 = Arthroplasty without Prosthesis  
0048 = Arthroplasty with Prosthesis  
0049 = Level I Musculoskeletal Procedures Except Hand  
and Foot  
0050 = Level II Musculoskeletal Procedures Except Hand  
and Foot  
0051 = Level III Musculoskeletal Procedures Except Hand  
and Foot  
0052 = Level IV Musculoskeletal Procedures Except Hand  
and Foot  
0053 = Level I Hand Musculoskeletal Procedures  
0054 = Level II Hand Musculoskeletal Procedures  
0055 = Level I Foot Musculoskeletal Procedures  
0056 = Level II Foot Musculoskeletal Procedures  
0057 = Bunion Procedures  
0058 = Level I Strapping and Cast Application  
0059 = Level II Strapping and Cast Application  
0060 = Manipulation Therapy  
0070 = Thoracentesis/Lavage Procedures  
0071 = Level I Endoscopy Upper Airway  
0072 = Level II Endoscopy Upper Airway  
0073 = Level III Endoscopy Upper Airway  
0074 = Level IV Endoscopy Upper Airway  
0075 = Level V Endoscopy Upper Airway  
0076 = Endoscopy Lower Airway  
0077 = Level I Pulmonary Treatment  
0078 = Level II Pulmonary Treatment

0079 = Ventilation Initiation and Management  
0080 = Diagnostic Cardiac Catheterization  
0081 = Non-Coronary Angioplasty or Atherectomy  
0082 = Coronary Atherectomy  
0083 = Coronary Angioplasty  
0084 = Level I Electrophysiologic Evaluation  
0085 = Level II Electrophysiologic Evaluation  
0086 = Ablate Heart Dysrhythm Focus  
0087 = Cardiac Electrophysiologic Recording/Mapping  
0088 = Thrombectomy  
0089 = Level I Implantation/Removal/Revision of  
Pacemaker, AICD Vascular Device (obsolete 12/00);  
Insertion/Replacement of Permanent Pacemaker and  
Electrodes (eff. 1/01)  
0090 = Level II Implantation/Removal/Revision of  
Pacemaker AICD Vascular Device (obsolete 12/00);  
Insertion/Replacement of Permanent Pacemaker  
and Pulse Generator  
0091 = Level I Vascular Ligation  
0092 = Level II Vascular Ligation  
0093 = Vascular Repair/Fistula Construction  
0094 = Resuscitation and Cardioversion  
0095 = Cardiac Rehabilitation  
0096 = Non-Invasive Vascular Studies  
0097 = Cardiovascular Stress Test (obsolete 12/00);  
Cardiac Monitoring for 30 days (eff. 1/01)  
0098 = Injection of Sclerosing Solution  
0099 = Continuous Cardiac Monitoring (obsolete 12/00);  
Electrocardiograms (eff. 1/01)  
0100 = Stress test and continuous ECG  
0101 = Tilt Table Evaluation  
0102 = Electronic Analysis of Pacemakers/other Devices  
0103 = Miscellaneous Vascular Procedures (eff. 1/01)  
0104 = Transcatheter Placement of Intracoronary Stents  
(eff. 1/01)  
0105 = Revision/Removal of Pacemakers, AICD or Vascular  
(eff. 1/01)  
0106 = Insertion/Replacement/Repair of Pacemaker  
Electrode (eff. 1/01)  
0107 = Insertion of Cardioverter-Defibrillator

(eff. 1/01)

0108 = Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads (eff. 1/01)

0109 = Bone Marrow Harvesting and Bone Marrow/Stem Cell Transplant (obsolete 12/00); Removal of Implanted Devices (eff. 1/01)

0110 = Transfusion

0111 = Blood PRODUCT Exchange

0112 = Extracorporeal Photopheresis

0113 = Excision Lymphatic System

0114 = Thyroid/Lymphadenectomy Procedures

0115 = Cannula/Access Device Procedures

(eff. 1/01)

0116 = Chemotherapy Administration by Other Technique Except Infusion

0117 = Chemotherapy Administration by Infusion Only

0118 = Chemotherapy Administration by Both Infusion and Other Technique

0119 = Implantation of Devices (eff. 1/01)

0120 = Infusion Therapy Except Chemotherapy

0121 = Level I Tube changes and Repositioning

0122 = Level II Tube changes and Repositioning

0123 = Bone Marrow Harvesting and Bone Marrow/Stem Cell Transplant

0124 = Revision of Implanted Infusion Pump

(eff. 1/01)

0130 = Level I Laparoscopy

0131 = Level II Laparoscopy

0132 = Level III Laparoscopy

0140 = Esophageal Dilation without Endoscopy

0141 = Upper GI Procedures

0142 = Small Intestine Endoscopy

0143 = Lower GI Endoscopy

0144 = Diagnostic Anoscopy

0145 = Therapeutic Anoscopy

0146 = Level I Sigmoidoscopy

0147 = Level II Sigmoidoscopy

0148 = Level I Anal/Rectal Procedure

0149 = Level II Anal/Rectal Procedure

0150 = Level III Anal/Rectal Procedure

0151 = Endoscopic Retrograde Cholangio-Pancreatography (ERCP)  
0152 = Percutaneous Biliary Endoscopic Procedures  
0153 = Peritoneal and Abdominal Procedures  
0154 = Hernia/Hydrocele Procedures  
0157 = Colorectal Cancer Screening: Barium Enema  
(Not subject to National coinsurance)  
0158 = Colorectal Cancer Screening: Colonoscopy  
Not subject to National coinsurance. Minimum  
unadjusted coinsurance is 25% of the payment rate.  
Payment rate is lower of the HOPD payment rate or  
the Ambulatory Surgical Center payment.  
0159 = Colorectal Cancer Screening: Flexible Sigmoidoscopy  
Not subject to National coinsurance. Minimum  
unadjusted coinsurance is 25% of the payment rate.  
Payment rate is lower of the HOPD payment rate or  
the Ambulatory Surgical Center payment.  
0160 = Level I Cystourethroscopy and other Genitourinary  
Procedures  
0161 = Level II Cystourethroscopy and other Genitourinary  
Procedures  
0162 = Level III Cystourethroscopy and other Genitourinary  
Procedures  
0163 = Level IV Cystourethroscopy and other Genitourinary  
Procedures  
0164 = Level I Urinary and Anal Procedures  
0165 = Level II Urinary and Anal Procedures  
0166 = Level I Urethral Procedures  
0167 = Level II Urethral Procedures  
0168 = Level III Urethral Procedures  
0169 = Lithotripsy  
0170 = Dialysis for Other Than ESRD Patients  
0180 = Circumcision  
0181 = Penile Procedures  
0182 = Insertion of Penile Prosthesis  
0183 = Testes/Epididymis Procedures  
0184 = Prostate Biopsy  
0190 = Surgical Hysteroscopy  
0191 = Level I Female RePRODuctive Procedures  
0192 = Level II Female RePRODuctive Procedures  
0193 = Level III Female RePRODuctive Procedures

0194 = Level IV Female RePROductive Procedures  
0195 = Level V Female RePROductive Procedures  
0196 = Dilatation & Curettage  
0197 = Infertility Procedures  
0198 = Pregnancy and Neonatal Care Procedures  
0199 = Vaginal Delivery  
0200 = Therapeutic Abortion  
0201 = Spontaneous Abortion  
0210 = Spinal Tap  
0211 = Level I Nervous System Injections  
0212 = Level II Nervous System Injections  
0213 = Extended EEG Studies and Sleep Studies  
0214 = Electroencephalogram  
0215 = Level I Nerve and Muscle Tests  
0216 = Level II Nerve and Muscle Tests  
0217 = Level III Nerve and Muscle Tests  
0220 = Level I Nerve Procedures  
0221 = Level II Nerve Procedures  
0222 = Implantation of Neurological Device  
0223 = Level I Revision/Removal Neurological Device  
(obsolete 12/00); Implantation of Pain  
Management Device (eff. 1/01)  
0224 = Level II Revision/Removal Neurological Device  
(obsolete 12/00); Implantation of Reservoir/  
Pump/Shunt (eff. 1/01)  
0225 = Implantation of Neurostimulator Electrodes  
0226 = Implantation of Drug Infusion Reservoir  
(eff. 1/01)  
0227 = Implantation of Drug Infusion Device  
(eff. 1/01)  
0228 = Creation of Lumbar Subarachnoid Shunt  
(eff. 1/01)  
0229 = Transcatheter Placement of Intravascular Shunts  
(eff. 1/01)  
0230 = Level I Eye Tests  
0231 = Level II Eye Tests  
0232 = Level I Anterior Segment Eye  
0233 = Level II Anterior Segment Eye  
0234 = Level III Anterior Segment Eye Procedures  
0235 = Level I Posterior Segment Eye Procedures

0236 = Level II Posterior Segment Eye Procedures  
0237 = Level III Posterior Segment Eye Procedures  
0238 = Level I Repair and Plastic Eye Procedures  
0239 = Level II Repair and Plastic Eye Procedures  
0240 = Level III Repair and Plastic Eye Procedures  
0241 = Level IV Repair and Plastic Eye Procedures  
0242 = Level V Repair and Plastic Eye Procedures  
0243 = Strabismus/Muscle Procedures  
0244 = Corneal Transplant  
0245 = Cataract Procedures without IOL Insert  
0246 = Cataract Procedures with IOL Insert  
0247 = Laser Eye Procedures Except Retinal  
0248 = Laser Retinal Procedures  
0250 = Nasal Cauterization/Packing  
0251 = Level I ENT Procedures  
0252 = Level II ENT Procedures  
0253 = Level III ENT Procedures  
0254 = Level IV ENT Procedures  
0256 = Level V ENT Procedures  
0257 = Implantation of Cochlear Device (obsolete 1/01)  
0258 = Tonsil and Adenoid Procedures  
0260 = Level I Plain Film Except Teeth  
0261 = Level II Plain Film Except Teeth Including Bone  
Density Measurement  
0262 = Plain Film of Teeth  
0263 = Level I Miscellaneous Radiology Procedures  
0264 = Level II Miscellaneous Radiology Procedures  
0265 = Level I Diagnostic Ultrasound Except Vascular  
0266 = Level II Diagnostic Ultrasound Except Vascular  
0267 = Vascular Ultrasound  
0268 = Guidance Under Ultrasound  
0269 = Echocardiogram Except Transesophageal  
0270 = Transesophageal Echocardiogram  
0271 = Mammography  
0272 = Level I Fluoroscopy  
0273 = Level II Fluoroscopy  
0274 = Myelography  
0275 = Arthrography  
0276 = Level I Digestive Radiology  
0277 = Level II Digestive Radiology



0278 = Diagnostic Urography  
0279 = Level I Diagnostic Angiography and Venography  
Except Extremity  
0280 = Level II Diagnostic Angiography and Venography  
Except Extremity  
0281 = Venography of Extremity  
0282 = Level I Computerized Axial Tomography  
0283 = Level II Computerized Axial Tomography  
0284 = Magnetic Resonance Imaging  
0285 = Positron Emission Tomography (PET)  
0286 = Myocardial Scans  
0290 = Standard Non-Imaging Nuclear Medicine  
0291 = Level I Diagnostic Nuclear Medicine Excluding  
Myocardial Scans  
0292 = Level II Diagnostic Nuclear Medicine Excluding  
Myocardial Scans  
0294 = Level I Therapeutic Nuclear Medicine  
0295 = Level II Therapeutic Nuclear Medicine  
0296 = Level I Therapeutic Radiologic Procedures  
0297 = Level II Therapeutic Radiologic Procedures  
0300 = Level I Radiation Therapy  
0301 = Level II Radiation Therapy  
0302 = Level III Radiation Therapy  
0303 = Treatment Device Construction  
0304 = Level I Therapeutic Radiation Treatment  
Preparation  
0305 = Level II Therapeutic Radiation Treatment  
Preparation  
0310 = Level III Therapeutic Radiation Treatment  
Preparation  
0311 = Radiation Physics Services  
0312 = Radioelement Applications  
0313 = Brachytherapy  
0314 = Hyperthermic Therapies  
0320 = Electroconvulsive Therapy  
0321 = Biofeedback and Other Training  
0322 = Brief Individual Psychotherapy  
0323 = Extended Individual Psychotherapy  
0324 = Family Psychotherapy  
0325 = Group Psychotherapy

0330 = Dental Procedures  
0340 = Minor Ancillary Procedures  
0341 = Immunology Tests  
0342 = Level I Pathology  
0343 = Level II Pathology  
0344 = Level III Pathology  
0345 = Transfusion Laboratory Procedures Level I  
(eff. 1/01)  
0346 = Transfusion Laboratory Procedures Level II  
(eff. 1/01)  
0347 = Transfusion Laboratory Procedures Level III  
(eff. 1/01)  
0348 = Fertility Laboratory Procedures  
(eff. 1/01)  
0349 = Miscellaneous Laboratory Procedures  
(eff. 1/01)  
0354 = Administration of Influenza Vaccine (Not  
subject to national coinsurance)  
0355 = Level I Immunizations  
0356 = Level II Immunizations  
0357 = Level III Immunizations (obsolete 1/01)  
0358 = Level IV Immunizations (obsolete 1/01)  
0359 = Injections  
0360 = Level I Alimentary Tests  
0361 = Level II Alimentary Tests  
0362 = Fitting of Vision Aids  
0363 = Otorhinolaryngologic Function Tests  
0364 = Level I Audiometry  
0365 = Level II Audiometry  
0366 = Electrocardiogram (ECG) (obsolete 1/01)  
0367 = Level I Pulmonary Test  
0368 = Level II Pulmonary Test  
0369 = Level III Pulmonary Test  
0370 = Allergy Tests  
0371 = Allergy Injections  
0372 = Therapeutic Phlebotomy  
0373 = Neuropsychological Testing  
0374 = Monitoring Psychiatric Drugs  
0600 = Low Level Clinic Visits  
0601 = Mid Level Clinic Visits

0602 = High Level Clinic Visits  
0603 = Interdisciplinary Team Conference (obsolete 1/01)  
0610 = Low Level Emergency Visits  
0611 = Mid Level Emergency Visits  
0612 = High Level Emergency Visits  
0620 = Critical Care  
0701 = Strontium (eligible for pass-through payments)  
(obsolete 12/00); SR 89 chloride, per mCi  
(eff. 1/01)  
0702 = Samarium (eligible for pass-through payments)  
(obsolete 12/00); SM 153 lexidronam, 50 mCi  
(eff. 1/01)  
0704 = IN 111 Satumomab Pendetide (eligible for pass-through payments)  
0705 = Tc99 Tetrofosmin (eligible for pass-through payments)  
0725 = Leucovorin Calcium (eligible for pass-through payments)  
0726 = Dextrazoxane Hydrochloride (eligible for pass-through payments)  
0727 = Injection, Etidronate Disodium (eligible for pass-through payments)  
0728 = Filgrastim (G-CSF) (eligible for pass-through payments)  
0730 = Pamidronate Disodium (eligible for pass-through payments)  
0731 = Sargramostim (GM-CSF) (eligible for pass-through payments)  
0732 = Mesna (eligible for pass-through payments)  
0733 = Non-ESRD Epoetin Alpha (eligible for pass-through payments)  
0750 = Dolasetron Mesylate 10 mg (eligible for pass-through payments)  
0754 = Metoclopramide HCL (eligible for pass-through payments)  
0755 = Thiethylperazine Maleate (eligible for pass-through payments)  
0761 = Oral Substitute for IV Antiemetic (eligible for pass-through payments)  
0762 = Dronabinol (eligible for pass-through payments)

0763 = Dolasetron Mesylate 100 mg Oral (eligible for pass-through payments)  
0764 = Granisetron HCL, 100 mcg (eligible for pass-through payments)  
0765 = Granisetron HCL, 1mg Oral (eligible for pass-through payments)  
0768 = Ondansetron Hydrochloride per 1 mg Injection (eligible for pass-through payments)  
0769 = Ondansetron Hydrochloride 8 mg oral (eligible for pass-through payments)  
0800 = Leuprolide Acetate per 3.75 mg (eligible for pass-through payments)  
0801 = Cyclophosphamide (eligible for pass-through payments)  
0802 = Etoposide (eligible for pass-through payments)  
0803 = Melphalan (eligible for pass-through payments)  
0807 = Aldesleukin single use vial (eligible for pass-through payments)  
0809 = BCG (Intravesical) one vial (eligible for pass-through payments)  
0810 = Goserelin Acetate Implant, per 3.6 mg (eligible for pass-through payments)  
0811 = Carboplatin 50 mg (eligible for pass-through payments)  
0812 = Carmustine 100 mg (eligible for pass-through payments)  
0813 = Cisplatin 10 mg (eligible for pass-through payments)  
0814 = Asparaginase, 10,000 units (eligible for pass-through payments)  
0815 = Cyclophosphamide 100 mg (eligible for pass-through payments)  
0816 = Cyclophosphamide, Lyophilized 100 mg (eligible for pass-through payments)  
0817 = Cytrabine 100 mg (eligible for pass-through payments)  
0818 = Dactinomycin 0.5 mg (eligible for pass-through payments)  
0819 = Dacarbazine 100 mg (eligible for pass-through payments)

0820 = Daunorubicin HCl 10 mg (eligible for pass-through payments)  
0821 = Daunorubicin Citrate, Liposomal Formulation, 10 mg (eligible for pass-through payments)  
0822 = Diethylstilbestrol Diphosphate 250 mg (eligible for pass-through payments)  
0823 = Docetaxel 20 mg (eligible for pass-through payments)  
0824 = Etoposide 10 mg (eligible for pass-through payments)  
0826 = Methotrexate Oral 2.5 mg (eligible for pass-through payments)  
0827 = Floxuridine injection 500mg  
0828 = Gemcitabine HCL 200 mg (eligible for pass-through payments)  
0830 = Irinotecan 20 mg (eligible for pass-through payments)  
0831 = Ifosfamide injection 1 gm (eligible for pass-through payments)  
0832 = Idarubicin HCL injection 5 mg (eligible for pass-through payments)  
0833 = Interferon Alfacon-1, 1 mcg (eligible for pass-through payments)  
0834 = Interferon, Alfa-2A, Recombinant 3 million units (eligible for pass-through payments)  
0836 = Interferon, Alfa-2B, Recombinant, 1 million units (eligible for pass-through payments)  
0838 = Interferon, Gamma 1-B injection, 3 million units (eligible for pass-through payments)  
0839 = Mechlorethamine HCL injection 10 mg (eligible for pass-through payments)  
0840 = Melphalan HCL 50 mg (eligible for pass-through payments)  
0841 = Methotrexate sodium injection 5 mg (eligible for pass-through payments)  
0842 = Fludarabine Phosphate injection 50 mg (eligible for pass-through payments)  
0843 = Pegaspargase, single dose vial (eligible for pass-through payments)  
0844 = Pentostatin injection, 10 mg (eligible for pass-

through payments)  
0847 = Doxorubicin HCL 10 mg (eligible for pass-through payments)  
0849 = Rituximab, 100 mg (eligible for pass-through payments)  
0850 = Streptozocin injection, 1 gm (eligible for pass-through payments)  
0851 = Thiotepa injection, 15 mg (eligible for pass-through payments)  
0852 = Topotecan 4 mg (eligible for pass-through payments)  
0853 = Vinblastine Sulfate injection, 1 mg (eligible for pass-through payments)  
0854 = Vincristine Sulfate 1 mg (eligible for pass-through payments)  
0855 = Vinorelbine Tartrate per 10 mg (eligible for pass-through payments)  
0856 = Porfimer Sodium 75 mg (eligible for pass-through payments)  
0857 = Bleomycin Sulfate injection 15 units (eligible for pass-through payments)  
0858 = Cladribine, 1mg (eligible for pass-through payments)  
0859 = Fluorouracil injection 500 mg  
0860 = Plicamycin (mithramycin) injection, 2.5 mg  
0861 = Leuprolide Acetate 1 mg (eligible for pass-through payments)  
0862 = Mitomycin, 5mg (eligible for pass-through payments)  
0863 = Paclitaxel, 30mg (eligible for pass-through payments)  
0864 = Mitoxantrone HCL, per 5mg (eligible for pass-through payments)  
0865 = Interferon alfa-N3, 250,000 IU (eligible for pass-through payments)  
0884 = Rho (D) Immune Globulin, Human one dose pack (eligible for pass-through payments)  
0886 = Azathioprine, 50 mg oral  
(Not subject to national coinsurance)  
0887 = Azathioprine, Parenteral 100 mg, 20 ml each injection  
(Not subject to national coinsurance)  
0888 = Cyclosporine, Oral 100 mg  
(Not subject to national coinsurance)  
0889 = Cyclosporine, Parenteral

(Not subject to national coinsurance)  
0890 = Lymphocyte Immune Globulin 250 mg  
(Not subject to national coinsurance)  
0891 = Tacrolimus per 1 mg oral  
(Not subject to national coinsurance)  
0892 = Daclizumab, Parenteral, 25 mg (obsolete 1/01)  
(eligible for pass-through payments)  
0900 = Injection, Alglucerase per 10 units  
(eligible for pass-through payments)  
0901 = Alpha I, Proteinase Inhibitor, Human per 10mg  
(eligible for pass-through payments)  
0902 = Botulinum Toxin, Type A per unit  
(eligible for pass-through payments)  
0903 = CMV Immune Globulin (obsolete 12/00);  
Cytomegalovirus imm IV, vial  
(eligible for pass-through payments) (eff. 1/01)  
0905 = Immune Globulin per 500 mg  
(eligible for pass-through payments)  
0906 = RSV-ivig 50 mg  
(eligible for pass-through payments)  
0907 = Ganciclovir Sodium 500 mg injection  
(Not subject to national coinsurance)  
0908 = Tetanus Immune Globulin, injection up to 250 units  
(Not subject to national coinsurance)  
0909 = Interferon Beta - 1a 33 mcg (eligible for pass-through payments)  
0910 = Interferon Beta - 1b 0.25 mg (eligible for pass-through payments)  
0911 = Streptokinase per 250,000 iu  
(Not subject to national coinsurance)  
0913 = Ganciclovir long act implant 4.5 mg (eligible for pass-through payments)  
0914 = Reteplase, 37.6 mg  
(Not subject to national coinsurance)  
0915 = Alteplase injection, recombinant, 10mg  
(Not subject to national coinsurance)  
0916 = Imiglucerase per unit (eligible for pass-through payments)  
0917 = Dipyridamole, 10mg / Adenosine 6MG  
(Not subject to national coinsurance) (obsolete 1/01)

Pharmalogic stresses (eff. 1/01)  
0918 = Brachytherapy Seeds, Any type, Each (eligible  
for pass-through payments) (obsolete 4/01)  
0925 = Factor VIII (Antihemophilic Factor, Human) per iu  
(eligible for pass-through payments)  
0926 = Factor VIII (Antihemophilic Factor, Porcine) per iu  
(eligible for pass-through payments)  
0927 = Factor VIII (Antihemophilic Factor, Recombinant)  
per iu (eligible for pass-through payments)  
0928 = Factor IX, Complex (eligible for pass-through  
payments)  
0929 = Other Hemophilia Clotting Factors per iu (eligible  
for pass-through payments) (obsolete 1/01)  
Anti-inhibitor per iu (eff. 1/01)  
0930 = Antithrombin III (Human) per iu (eligible for pass-  
through payments)  
0931 = Factor IX (Antihemophilic Factor, Purified, Non-  
Recombinant) (eligible for pass-through payments)  
0932 = Factor IX (Antihemophilic Factor, Recombinant)  
(eligible for pass-through payments)  
0949 = Plasma, Pooled Multiple Donor, Solvent/Detergent  
Treated, Frozen (not subject to national coinsurance)  
0950 = Blood (Whole) For Transfusion (not subject to  
national coinsurance)  
0952 = Cryoprecipitate (not subject to national coinsurance)  
0953 = Fibrinogen Unit (not subject to national coinsurance)  
0954 = Leukocyte Poor Blood (not subject to national  
coinsurance)  
0955 = Plasma, Fresh Frozen (not subject to national  
coinsurance)  
0956 = Plasma Protein Fraction (not subject to national  
coinsurance)  
0957 = Platelet Concentrate (not subject to national  
coinsurance)  
0958 = Platelet Rich Plasma (not subject to national  
coinsurance)  
0959 = Red Blood Cells (not subject to national coinsurance)  
0960 = Washed Red Blood Cells (not subject to national  
coinsurance)  
0961 = Infusion, Albumin (Human) 5%, 500 ml



(not subject to national coinsurance)  
0962 = Infusion, Albumin (Human) 25%, 50 ml  
(not subject to national coinsurance)  
0970 = New Technology - Level I (\$0 - \$50)  
(not subject to national coinsurance)  
0971 = New Technology - Level II (\$50 - \$100)  
(not subject to national coinsurance)  
0972 = New Technology - Level III (\$100 - \$200)  
(not subject to national coinsurance)  
0973 = New Technology - Level IV (\$200 - \$300)  
(not subject to national coinsurance)  
0974 = New Technology - Level V (\$300 - \$500)  
(not subject to national coinsurance)  
0975 = New Technology - Level VI (\$500 - \$750)  
(not subject to national coinsurance)  
0976 = New Technology - Level VII (\$750 - \$1000)  
(not subject to national coinsurance)  
0977 = New Technology - Level VIII (\$1000 - \$1250)  
(not subject to national coinsurance)  
0978 = New Technology - Level IX (\$1250 - \$1500)  
(not subject to national coinsurance)  
0979 = New Technology - Level X (\$1500 - \$1750)  
(not subject to national coinsurance)  
0980 = New Technology - Level XI (\$1750 - \$2000)  
(not subject to national coinsurance)  
0981 = New Technology - Level XII (\$2000 - \$2500)  
(not subject to national coinsurance)  
0982 = New Technology - Level XIII (\$2500 - \$3500)  
(not subject to national coinsurance)  
0983 = New Technology - Level XIV (\$3500 - \$5000)  
(not subject to national coinsurance)  
0984 = New Technology - Level XV (\$5000 - \$6000)  
(not subject to national coinsurance)  
0987 = New Device Technology - Level I (\$0 - \$250)  
(eff. 1/01)  
0988 = New Device Technology - Level II (\$250 - \$500)  
(eff. 1/01)  
0989 = New Device Technology - Level III (\$500 - \$750)  
(eff. 1/01)  
0990 = New Device Technology - Level IV (\$750 - \$1000)

(eff. 1/01)  
0991 = New Device Technology - Level V (\$1000 - \$1500)  
(eff. 1/01)  
0992 = New Device Technology - Level VI (\$1500 - \$2000)  
(eff. 1/01)  
0993 = New Device Technology - Level VII (\$2000 - \$3000)  
(eff. 1/01)  
0994 = New Device Technology - Level VIII (\$3000 - \$4000)  
(eff. 1/01)  
0995 = New Device Technology - Level IX (\$4000 - \$5000)  
(eff. 1/01)  
0996 = New Device Technology - Level X (\$5000 - \$7000)  
(eff. 1/01)  
0997 = New Device Technology - Level XI (\$7000 - \$9000)  
(eff. 1/01)  
1000 = Perclose Closer Prostar Arterial Vascular  
Closure (eff. 1/01)  
1001 = AcuNav-diagnostic ultrasound ca (eff. 1/01)  
1002 = Cochlear Implant System (eff. 1/01)  
1003 = Cath, ablation, livewire TC (eff. 1/01)  
1004 = Fast-Cath, Swartz, SAFL, CSTA (eff. 1/01)  
1006 = ARRAY post chamb IOL (eff. 1/01)  
1007 = Ams 700 penile prosthesis (eff. 1/01)  
1008 = Urolume-implant urethral stent (eff. 1/01)  
1009 = Plasma, cryoprecipitate-reduced, unit  
(eff. 1/01)  
1010 = Blood, L/R CMV-neg (eff. 1/01)  
1011 = Platelets, L/R, CMV-neg (eff. 1/01)  
1012 = Platelet concentrate, L/R, irradiated, unit  
(eff. 1/01)  
1013 = Platelet concentrate, L/R, unit (eff. 1/01)  
1014 = Platelets, aph/pher, L/R, unit (eff. 1/01)  
1016 = Blood, L/R, froz/deglycerol/washed (eff. 1/01)  
1017 = Platelets, aph/pher, L/R CMV-neg, unit  
(eff. 1/01)  
1018 = Blood, L/R, irradiated (eff. 1/01)  
1019 = Platelets, aph/pher, L/R, irradiated, unit  
(eff. 1/01)  
1024 = Quinupristin 150 mg/dalfopriston 350 mg  
(eff. 1/01)

1025 = Marinr CS catheter (eff. 1/01)  
1026 = RF Perfrmr cath 5F RF Marinr (eff. 1/01)  
1027 = Magic x/short, radius 14m (eff. 1/01)  
1028 = Prcis Twst trnsvg anch sys (eff. 1/01)  
1029 = CRE guided balloon dil cath (eff. 1/01)  
1030 = Cthtr:Mrshal, Blu Max Utr Dmnd (eff. 1/01)  
1033 = Sonicath mdl 37-410 (eff. 1/01)  
1034 = SURPASS, Long30 SURPASS-cath (eff. 1/01)  
1035 = Cath, Ultra ICE (eff. 1/01)  
1036 = R port/reservior impl dev (eff. 1/01)  
1037 = Vaxcelchronic dialysis cath (eff. 1/01)  
1038 = UltraCross Imaging Cath (eff. 1/01)  
1039 = Wallstent/RP:Trach (eff. 1/01)  
1040 = Wallstent/RP TIPS -- 20/40/60 (eff. 1/01)  
1042 = Wallstent, UltraFlex: Bil (eff. 1/01)  
1045 = I-131 MIBG (ioben-sulfate) 0.5mCi  
(eff. 1/01)  
1047 = Navi-Star, Noga-Star cath (eff. 1/01)  
1048 = NeuroCyberneticPros: gen (eff. 1/01)  
1051 = Oasis Thrombectomy Cath (eff. 1/01)  
1053 = EnSite 3000 catheter (eff. 1/01)  
1054 = Hydrolyser Thromb Cath 6/7F (eff. 1/01)  
1055 = Transesoph 210, 210-S Cath (eff. 1/01)  
1056 = Thermachoice II Cath (eff. 1/01)  
1057 = Micromark Tissue Marker (eff. 1/01)  
1059 = Carticel, auto cult-chndr cyte (eff. 1/01)  
1060 = ACS multi-link tristor stent (eff. 1/01)  
1061 = ACS Viking Guiding cath (eff. 1/01)  
1063 = EndoTak Endurance EZ,RX leads (eff. 1/01)  
1067 = Megalink biliary stent (eff. 1/01)  
1068 = Pulsar DDD pmkr (eff. 1/01)  
1069 = Discovery DR, pmaker  
1071 = Pulsar Max, Pulsar SR pmkr (eff. 1/01)  
1072 = Guidant: blln dil cath (eff. 1/01)  
1073 = Gynecare Morcellator (eff. 1/01)  
1074 = RX/OTW Viatrac-peri dil cath (eff. 1/01)  
1075 = Guidant: lead (eff. 1/01)  
1076 = Ventak minisc defib (eff. 1/01)  
1077 = Ventak VR Prizm VR, sc defib (eff. 1/01)  
1078 = Ventak: Prizm, AVIIIDR defib

1079 = CO 57/58 0.5 mCi (eff. 1/01)  
1084 = Denileukin diftitox, 300 mcg (eff. 1/01)  
1086 = Temozolomide, 5 mg (eff. 1/01)  
1087 = I-123 per uCi capsule (eff. 1/01)  
1089 = CO 57, 0.5 mCi (eff. 1/01)  
1090 = IN 111 Chloride, per mCi (eff. 1/01)  
1091 = IN 111 Oxyquinoline, per 5 mCi (eff. 1/01)  
1092 = IN 111 Pentetate, per 1.5 mCi (eff. 1/01)  
1094 = TC 99M Albumin aggr, per vial  
1095 = TC 99M Depreotide, per vial (eff. 1/01)  
1096 = TC 99M Exametazime, per dose (eff. 1/01)  
1097 = TC 99M Mebrofenin, per vial (eff. 1/01)  
1098 = TC 99M Pentetate, per vial (eff. 1/01)  
1099 = TC 99M Pyrophosphate, per vial (eff. 1/01)  
1100 = Medtronic AVE GT1 guidewire (eff. 1/01)  
1101 = Medtronic AVE, AVE Z2 cath (eff. 1/01)  
1102 = Synergy Neurostim Genrtr (eff. 1/01)  
1103 = Micro Jewell Defibrillator (eff. 1/01)  
1104 = RF ConductorAblative Cath (eff. 1/01)  
1105 = Sigman 300VDD pacmkr (eff. 1/01)  
1106 = SynergyEZ Pt Progmr (eff. 1/01)  
1107 = Torqr, Solist cath (eff. 1/01)  
1108 = Reveal Cardiac Recorder (eff. 1/01)  
1109 = Implantable anchor: Ethicon (eff. 1/01)  
1110 = Stable Mapper, cath electrd (eff. 1/01)  
1111 = AneuRx Aort-Uni-llicstnt & cath (eff. 1/01)  
1112 = AneuRx Stent graft/del cath (eff. 1/01)  
1113 = Tlnt Endo Sprng Stnt Grft Sys (eff. 1/01)  
1114 = TalntSprgStnt + Graf endo pros (eff. 1/01)  
1115 = 5038S, 5038, 5038L pace lead (eff. 1/01)  
1116 = CapSureSP pacing lead (eff. 1/01)  
1117 = Ancure Endograft Del Sys (eff. 1/01)  
1118 = Sigma300DR LegIIDR, pacemkr (eff. 1/01)  
1119 = Sprint6932, 6943 defib lead (eff. 1/01)  
1120 = Sprint6942, 6945 defi lead (eff. 1/01)  
1121 = Gem defibrillator (eff. 1/01)  
1122 = TC 99M arcitumomab per dose (eff. 1/01)  
1123 = Gem II VR defibrillator (eff. 1/01)  
1124 = InterStim Test Stim Kit (eff. 1/01)  
1125 = Kappa 400SR, Ttopaz II SR pmkr (eff. 1/01)

1126 = Kappa 700 DR pacemkr (eff. 1/01)  
1127 = Kappa 700SR, pmkr sgl chamber (eff. 1/01)  
1128 = Kappa 700D, Ruby IID pmkr (eff. 1/01)  
1129 = Kappa 700VDD, pacmkr (eff. 1/01)  
1130 = Sigma 200D, LGCY IID sc pmkr (eff. 1/01)  
1131 = Sigma 200DR pmker (eff. 1/01)  
1132 = Sigma 200SR Leg II:sc pac (eff. 1/01)  
1133 = Sigma SR, Vita SR, pmaker (eff. 1/01)  
1134 = Sigma 300D pmker (eff. 1/01)  
1135 = Entity DR 5326L/R, DC, pmkr (eff. 1/01)  
1136 = Affinity DR 5330L/R, DC, pmkr (eff. 1/01)  
1137 = CardioSEAL implant syst (eff. 1/01)  
1143 = AddVent mod 2060BL, VDD (eff. 1/01)  
1144 = Afnty SP 5130, Integrity SR, pmkr (eff. 1/01)  
1145 = Angio-Seal 6fr, 8fr (eff. 1/01)  
1147 = AV Plus DX 1368: lead (eff. 1/01)  
1148 = Contour MD sc defib (eff. 1/01)  
1149 = Entity DC 5226R-pmker (eff. 1/01)  
1151 = Passiveplus DXlead, 10mdls (eff. 1/01)  
1152 = LifeSite Access System (eff. 1/01)  
1153 = Regency SC+ 2402L pmkr (eff. 1/01)  
1154 = SPL:SPOI, 0204- defib lead (eff. 1/01)  
1155 = Repliform 8 sq cm (eff. 1/01)  
1156 = Tr 1102TrSR+ 2260L, 2264L, 5131 (eff. 1/01)  
1157 = Trilogy DCT 23/8L pmkr (eff. 1/01)  
1158 = TVL lead SV01, SV02, SV04 (eff. 1/01)  
1159 = TVL RV02, RV06, RV07: lead (eff. 1/01)  
1160 = TVL-ADX 1559: lead (eff. 1/01)  
1161 = Tendril DX, 1338 pacing lead (eff. 1/01)  
1162 = TempoDr, TrilogyDR+ DC pmkr (eff. 1/01)  
1163 = Tendril SDX, 1488T pacing lead (eff. 1/01)  
1164 = Iodine-125 brachytx seed (eff. 1/01)  
1166 = Cytarabine liposomal, 10 mg (eff. 1/01)  
1167 = Epirubicin hcl, 2 mg (eff. 1/01)  
1171 = Autosuture site marker stple (eff. 1/01)  
1172 = Spacemaker dissect ballon (eff. 1/01)  
1173 = Cor stntS540, S670, o-wire stn (eff. 1/01)  
1174 = Bard brachytx needle (eff. 1/01)  
1178 = Busulfan IV, 6 mg (eff. 1/01)  
1180 = Vigor SR, SC, pmkr (eff. 1/01)

1181 = Meridian SSI, SC pmkr (eff. 1/01)  
1182 = Pulsar SSI, SC, pmkr (eff. 1/01)  
1183 = Jade IIS, Sigma 300S, SC, pmkr (eff. 1/01)  
1184 = Sigma 200S, SC, pmkr (eff. 1/01)  
1188 = I 131, per mCi (eff. 1/01)  
1200 = TC 99M Sodium Clucoheptonate, per vial  
(eff. 1/01)  
1201 = TC 99M succimer, per vial (eff. 1/01)  
1202 = TC 99M Sulfur Colloid, per dose (eff. 1/01)  
1203 = Verteporfin for Injection (eff. 1/01)  
1205 = TC 99M Disofenin, per vial (eff. 1/01)  
1207 = Octreotide acetate depot 1 mg (eff. 1/01)  
1302 = SQ01:lead (eff. 1/01)  
1303 = CapSure Fix 6940/4068-110, lead (eff. 1/01)  
1304 = Sonicath mdl 37-416,-418 (eff. 1/01)  
1305 = Apligraf (eff. 1/01)  
1306 = NeuroCyberneticsPros: lead (eff. 1/01)  
1311 = Trilogy DR + DAO pmkr (eff. 1/01)  
1312 = Magic WALLSTENT stent-mini (eff. 1/01)  
1313 = Magic medium, radius 31mm (eff. 1/01)  
1314 = Magic WALLSTENT stent-Long (eff. 1/01)  
1315 = Vigor DR, Meridian DR pmkr (eff. 1/01)  
1316 = Meridian DDD pmkr (eff. 1/01)  
1317 = Discovery SR, pmkr (eff. 1/01)  
1318 = Meridian SR pmkr (eff. 1/01)  
1319 = Wallstent/RP Enteral--60mm (eff. 1/01)  
1320 = Wallstent/RP lliac Del Sys (eff. 1/01)  
1325 = Pallidium - 103 seed (eff. 1/01)  
1326 = Angio-jet rheolytic thromb cath (eff. 1/01)  
1328 = ANS Renew NS trnsmt (eff. 1/01)  
1333 = PALMZA Corinthian bill stent (eff. 1/01)  
1334 = Crown, Mini-crown,CrossLC (eff. 1/01)  
1335 = Mesh, Prolene (eff. 1/01)  
1336 = Constant Flow Imp Pump (eff. 1/01)  
1337 = IsoMed 8472-20/35/60 (eff. 1/01)  
1348 = I 131 per mCi solution (eff. 1/01)  
1350 = Prosta/OncoSeed, RAPID strand, I-125 (eff. 1/01)  
1351 = CapSure (Fix) pacing lead (eff. 1/01)  
1352 = Gem II defib (eff. 1/01)  
1353 = Itrel Interstm neurostim + ext (eff. 1/01)

1354 = Kappa 400DR, Diamond II 820 DR (eff. 1/01)  
1355 = Kappa 600 DR, Vita DR (eff. 1/01)  
1356 = Profile MD V-186HV3 sc defib (eff. 1/01)  
1357 = Angstrom MD V-190HV3 sc defib (eff. 1/01)  
1358 = Affinity DC 5230R-Pacemaker (eff. 1/01)  
1359 = Pulsar, Pulsar Max DR, pmkr (eff. 1/01)  
1363 = Gem DR, DC, defib (eff. 1/01)  
1364 = Photon DR V-230HV3 DC defib (eff. 1/01)  
1365 = Guidewire, Hi-Torque 14/18/35 (eff. 1/01)  
1366 = Guidewire, PTCA, Hi-Torque (eff. 1/01)  
1367 = Guidewire, Hi-Torque Crosslt (eff. 1/01)  
1369 = ANS Renew Stim Sys recvr (eff. 1/01)  
1370 = Tension-Free Vaginal Tape (eff. 1/01)  
1371 = Symp Nitinol Transhep Bil Sys (eff. 1/01)  
1372 = Cordis Nitinol bil Stent (eff. 1/01)  
1375 = Stent, coronary, NIR (eff. 1/01)  
1376 = ANS Renew Stim Sys lead (eff. 1/01)  
1377 = Specify 3988 neuro lead (eff. 1/01)  
1378 = InterStim Tx 3080/3886 lead (eff. 1/01)  
1379 = Pisces-Quad 3887 lead (eff. 1/01)  
1400 = Diphenhydramine hcl 50 mg (eff. 1/01)  
1401 = Prochlorperazine maleate 5 mg (eff. 1/01)  
1402 = Promethazine hcl 12.5 mg oral (eff. 1/01)  
1403 = Chlorpromazine hcl 10mg oral (eff. 1/01)  
1404 = Trimethobenzamide hcl 250mg (eff. 1/01)  
1405 = Thiethylperazine maleate 10 mg (eff. 1/01)  
1406 = Perphenazine 4 mg oral (eff. 1/01)  
1407 = Hydroxyzine pamoate 25 mg (eff. 1/01)  
1409 = Factor via recombinant, per 1.2 mg (eff. 1/01)  
1410 = Prosorba column (eff. 1/01)  
1411 = Herculink, OTW SDS bil stent (eff. 1/01)  
1420 = StapleTac2 Bone w/Dermis (eff. 1/01)  
1421 = StapleTac2 Bone w/o Dermis (eff. 1/01)  
1450 = Orthosphere Arthroplasty (eff. 1/01)  
1451 = Orthosphere Arthroplasty Kity (eff. 1/01)  
1500 = Atherectomy sys, peripheral (eff. 1/01)  
1600 = TC 99M sestamibi, per syringe (eff. 1/01)  
1601 = TC 99M medronate, per dose (eff. 1/01)  
1602 = TC 99M apcitide, per vial (eff. 1/01)  
1603 = TL 201, mCi (eff. 1/01)

1604 = IN 111 capromab pendetide, per dose (eff. 1/01)  
1605 = Abciximab injection, 10 mg (eff. 1/01)  
1606 = Anistreplase, 30 u (eff. 1/01)  
1607 = Eptifibatide injection, 5 mg (eff. 1/01)  
1608 = Etanercept injection, 25 mg (eff. 1/01)  
1609 = Rho(D) Immune globulin h, sd 100 iu (eff. 1/01)  
1611 = Hylan G-F 20 injection, 16 mg (eff. 1/01)  
1612 = Daclizumab, parenteral, 25 mg (eff. 1/01)  
1613 = Trastuzumab, 10 mg (eff. 1/01)  
1614 = Valrubicin, 200 mg (eff. 1/01)  
1615 = Basiliximab, 20 mg (eff. 1/01)  
1616 = Histrelin Acetate, 0.5 mg (eff. 1/01)  
1617 = Lepirdin, 50 mg (eff. 1/01)  
1618 = Von Willebrand factor, per iu (eff. 1/01)  
1619 = Ga 67, per mCi (eff. 1/01)  
1620 = TC 99M Bicisate, per vial (eff. 1/01)  
1621 = Xe 133, per mCi (eff. 1/01)  
1622 = TC 99M Mertiatide, per vial (eff. 1/01)  
1623 = TC 99M Gluceptate (eff. 1/01)  
1624 = P32 sodium, per mCi (eff. 1/01)  
1625 = IN 111 Pentetreotide, per mCi (eff. 1/01)  
1626 = TC 99M Oxidronate, per vial (eff. 1/01)  
1627 = TC-99 labeled red blood cell, per test (eff. 1/01)  
1628 = P32 phosphate chromic, per mCi (eff. 1/01)  
1700 = Authen Mick TP brachy needle (eff. 1/01)  
(obsolete 4/01)  
1701 = Medtec MT-BT-5201-25 ndl (eff. 1/01)  
(obsolete 4/01)  
1702 = WWMT brachytx needle (eff. 1/01)  
(obsolete 4/01)  
1703 = Mentor Prostate Brachy (eff. 1/01)  
(obsolete 4/01)  
1704 = MT-BT-5001-25/5051-25 (eff. 1/01)  
(obsolete 4/01)  
1705 = Best Flexi Brachy Needle (eff. 1/01)  
(obsolete 4/01)  
1706 = Indigo Prostate Seeding Ndl (eff. 1/01)  
(obsolete 4/01)  
1707 = Varisource Implt Ndl (eff. 1/01)  
(obsolete 4/01)



1708 = UroMed Prostate Seed Ndl (eff. 1/01)  
(obsolete 4/01)  
1709 = Remington Brachytx Needle (eff. 1/01)  
(obsolete 4/01)  
1710 = US Biopsy Prostate Needle (eff. 1/01)  
(obsolete 4/01)  
1711 = MD Tech brachytx needle (eff. 1/01)  
(obsolete 4/01)  
1712 = Imagyn brachytx needle (eff. 1/01)  
(obsolete 4/01)  
1713 = Anchor/screw bn/bn,tis/bn (eff. 4/01)  
1714 = Cath, trans atherectomy, dir (eff. 4/01)  
1715 = Brachytherapy needle (eff. 4/01)  
1716 = Brachytx seed, Gold 198 (eff. 4/01)  
1717 = Brachytx seed, HDR Ir-192 (eff. 4/01)  
1718 = Brachytx seed, Iodine 125 (eff. 4/01)  
1719 = Brachytx seed, Non-HDR Ir-192 (eff. 4/01)  
1720 = Brachytx, Palladium 103 (eff. 4/01)  
1721 = AICD, dual chamber (eff. 4/01)  
1722 = AICD, single chamber (eff. 4/01)  
1723 = Cath, ablation, non-cardiac (eff. 4/01)  
1724 = Cath, trans atheroc, rotation (eff. 4/01)  
1725 = Cath, translumin non-laser (eff. 4/01)  
1726 = Cath, bal dil, non-vascular (eff. 4/01)  
1727 = Cath, bal tis, dis, nonvas (eff. 4/01)  
1728 = Cath, brachytx seed adm (eff. 4/01)  
1729 = Cath, drainage, biliary (eff. 4/01)  
1730 = Cath, EP, 19 or fewer elect (eff. 4/01)  
1731 = Cath, EP, 20 or more elect (eff. 4/01)  
1732 = Cath, EP, diag/abl, 3D/vect (eff. 4/01)  
1733 = Cath, EP, other than temp (eff. 4/01)  
1750 = Cath, hemodialysis, long-term (eff. 4/01)  
1751 = Cath, inf pr/cent/midline (eff. 4/01)  
1752 = Cath, hemodialysis, short-term (eff. 4/01)  
1753 = Cath, intravas ultrasound (eff. 4/01)  
1754 = Catheter, intradiscal (eff. 4/01)  
1755 = Catheter, intraspinal (eff. 4/01)  
1756 = Cath, pacing, transesoph (eff. 4/01)  
1757 = Cath, thrombectomy/embolect (eff. 4/01)  
1758 = Cath, ureteral (eff. 4/01)

1759 = Cath, intra echocardiography (eff. 4/01)  
1760 = Closure dev, vasc, imp/insert (eff. 4/01)  
1762 = Conn tiss, human (inc fascia) (eff. 4/01)  
1763 = Conn tiss, non-human (eff. 4/01)  
1764 = Event recorder, cardiac (eff. 4/01)  
1767 = Generator, neurostim, imp (eff. 4/01)  
1768 = Graft, vascular (eff. 4/01)  
1769 = Guide wire (eff. 4/01)  
1770 = Imaging coil, MR insertable (eff. 4/01)  
1771 = Rep dev, urinary , w/sling (eff. 4/01)  
1772 = Infusion pump, programmable (eff. 4/01)  
1773 = Retrieval dev, insert (eff. 4/01)  
1776 = Joint device (implantable) (eff. 4/01)  
1777 = Lead, AICD, endo single coil (eff. 4/01)  
1778 = Lead, neurostimulator (eff. 4/01)  
1779 = Lead, pmkr, transvenous VDD (eff. 4/01)  
1780 = Lens, intraocular (eff. 4/01)  
1781 = Mesh (implantable) (eff. 4/01)  
1782 = Morcellator (eff. 4/01)  
1784 = Ocular dev, intraop, det ret (eff. 4/01)  
1785 = Pmkr, dual, rate-resp (eff. 4/01)  
1786 = Pmkr, single, rate-resp (eff. 4/01)  
1787 = Patient progr, neurostim (eff. 4/01)  
1788 = Port, indwelling, imp (eff. 4/01)  
1789 = Prosthesis, breast, imp. (eff. 4/01)  
1790 = Iridium 192 HDR (eff. 1/01)  
(obsolete 4/01)  
1791 = OncoSeed, Rapid Strand I-125 (eff. 1/01)  
(obsolete 4/01)  
1792 = UroMed I-125 Brachy seed (eff. 1/01)  
(obsolete 4/01)  
1793 = Bard InterSource P-103 seed (eff. 1/01)  
(obsolete 4/01)  
1794 = Bard IsoSeed P-103 seed (eff. 1/01)  
(obsolete 4/01)  
1795 = Bard BrachySource I-125 (eff. 1/01)  
(obsolete 4/01)  
1796 = Source Tech Med I-125 (eff. 1/01)  
(obsolete 4/01)  
1797 = Draximage I-125 seed (eff. 1/01)

(obsolete 4/01)  
1798 = Syncor I-125 PharmaSeed (eff. 1/01)  
(obsolete 4/01)  
1799 = I-Plant I-125 Brachytx seed (eff. 1/01)  
(obsolete 4/01)  
1800 = Pd-103 brachytx seed (eff. 1/01)  
(obsolete 4/01)  
1801 = IoGold I-125 brachytx seed (eff. 1/01)  
(obsolete 4/01)  
1802 = Iridium 192 brachytx seed (eff. 1/01)  
(obsolete 4/01)  
1803 = Best Iodine 125 brachytx seeds (eff. 1/01)  
(obsolete 4/01)  
1804 = Best Palladium 103 seeds (eff. 1/01)  
(obsolete 4/01)  
1805 = IsoStar Iodine-125 seeds (eff. 1/01)  
(obsolete 4/01)  
1806 = Gold 198 (eff. 1/01)  
(obsolete 4/01)  
1810 = D114S Dilatation Cath (eff. 1/01)  
(obsolete 4/01)  
1811 = Surgical Dynamics Anchors (eff. 1/01)  
(obsolete 4/01)  
1812 = OBL Anchors (eff. 1/01)  
(obsolete 4/01)  
1813 = Prosthesis, penile, inflatab (eff. 4/01)  
1815 = Pros, urinary sph, imp (eff. 4/01)  
1816 = Receiver/transmitter, neuro (eff. 4/01)  
1817 = Septal defect imp sys (eff. 4/01)  
1850 = Repliform 14/21 sq cm (eff. 1/01)  
(obsolete 4/01)  
1851 = Repliform 24/28 sq cm (eff. 1/01)  
(obsolete 4/01)  
1852 = TransCyte, per 247 sq cm (eff. 1/01)  
(obsolete 4/01)  
1853 = Suspend, per 8/14 sq cm (eff. 1/01)  
(obsolete 4/01)  
1854 = Suspend, per 24/28 sq cm (eff. 1/01)  
(obsolete 4/01)  
1855 = Suspend, per 36 sq cm (eff. 1/01)

(obsolete 4/01)  
1856 = Suspend, per 48 sq cm (eff. 1/01)  
(obsolete 4/01)  
1857 = Suspend, per 84 sq cm (eff. 1/01)  
(obsolete 4/01)  
1858 = DuraDerm, per 8/14 sq cm (eff. 1/01)  
(obsolete 4/01)  
1859 = DuraDerm, per 21/24 sq cm (eff. 1/01)  
(obsolete 4/01)  
1860 = DuraDerm, per 48 sq cm (eff. 1/01)  
(obsolete 4/01)  
1861 = DuraDerm, per 36 sq cm (eff. 1/01)  
(obsolete 4/01)  
1862 = DuraDerm, per 72 sq cm (eff. 1/01)  
(obsolete 4/01)  
1863 = DuraDerm, per 84 sq cm (eff. 1/01)  
(obsolete 4/01)  
1864 = SpermaTex, per 13/44 sq cm (eff. 1/01)  
(obsolete 4/01)  
1865 = FasLata, per 8/14 sq cm (eff. 1/01)  
(obsolete 4/01)  
1866 = FasLata, per 24/28 sq cm (eff. 1/01)  
(obsolete 4/01)  
1867 = FasLata, per 36/48 sq cm (eff. 1/01)  
(obsolete 4/01)  
1868 = FasLata, per 96 sq cm (eff. 1/01)  
(obsolete 4/01)  
1869 = Gore Thyroplasty Dev (eff. 1/01)  
(obsolete 4/01)  
1870 = DermMatrix, per 16 sq cm (eff. 1/01)  
(obsolete 4/01)  
1871 = DermMatrix, 32 or 64 sq cm (eff. 1/01)  
(obsolete 4/01)  
1872 = Dermagraft, per 37.5 sq cm (eff. 1/01)  
(obsolete 4/01)  
1873 = Bard 3DMax Mesh (eff. 1/01)  
(obsolete 4/01)  
1874 = Stent, coated/cov w/del sys (eff. 4/01)  
1875 = Stent, coated/cov w/o del sys (eff. 4/01)  
1876 = Stent, non-coated/no-cov w/del (eff. 4/01)

1877 = Stent, non-coated/cov w/o del (eff. 4/01)  
1878 = Martl for vocal cord (eff. 4/01)  
1879 = Tissue marker, imp (eff. 4/01)  
1880 = Vena cava filter (eff. 4/01)  
1881 = Dialysis access system (eff. 4/01)  
1882 = AICD, other than sing/dual (eff. 4/01)  
1883 = Adapt/ext, pacing/neuro lead (eff. 4/01)  
1885 = Cath, translumin angio laser (eff. 4/01)  
1887 = Catheter, guiding (eff. 4/01)  
1891 = Infusion pump, non-prog, perm (eff. 4/01)  
1892 = Intro/sheath , fixed, peel-away (eff. 4/01)  
1893 = Intro/sheath, fixed, non-peel (eff. 4/01)  
1894 = Intro/sheath, non-laser (eff. 4/01)  
1895 = Lead, AICD, endo dual coil (eff. 4/01)  
1896 = Lead, AICD, non sing/dual (eff. 4/01)  
1897 = Lead, neurostim test kit (eff. 4/01)  
1898 = Lead, pmkr, other than trans (eff. 4/01)  
1899 = Lead, pmkr/AICD combination (eff. 4/01)  
1929 = Maverick PTCA Cath (eff. 1/01) (obsolete 4/01)  
1930 = Coyote Dil Cath, 20/30/40mm (eff. 1/01)  
(obsolete 4/01)  
1931 = Talon Dil Cath (eff. 1/01) (obsolete 4/01)  
1932 = Scimed remedy Dil Cath (eff. 1/01)  
(obsolete 4/01)  
1933 = Opti-Plast XL/Centurion Cath (eff. 1/01)  
(obsolete 4/01)  
1934 = Ultraverse 3.5F Bal Dil Cath (eff. 1/01)  
(obsolete 4/01)  
1935 = Workhorse PTA Bal Cath (eff. 1/01)  
(obsolete 4/01)  
1936 = Uromax Ultra Bal Dil Cath (eff. 1/01)  
(obsolete 4/01)  
1937 = Synergy Balloon Dil Cath (eff. 1/01)  
(obsolete 4/01)  
1938 = Uroforce Bal Dil Cath (eff. 1/01) (obsolete 4/01)  
1939 = Raptur, Ninja PTCA Dil Cath (eff. 1/01)  
(obsolete 4/01)  
1940 = PowerFlex, OPTA 5/LP Bal Cath (eff. 1/01)  
(obsolete 4/01)  
1941 = Jupiter PTA Dil Cath (eff. 1/01)

(obsolete 4/01)  
1942 = Cordis Maxi LD PTA Bal Cath (eff. 1/01)  
(obsolete 4/01)  
1943 = RXCrossSail OTW OpenSail (eff. 1/01)  
(obsolete 4/01)  
1944 = Rapid Exchange Bil Dil Cath (eff. 1/01)  
(obsolete 4/01)  
1945 = Savvy PTA Dil Cath (eff. 1/01)  
(obsolete 4/01)  
1946 = Rls Rapid Dil Cath (eff. 1/01)  
(obsolete 4/01)  
1947 = Gazelle Bal Dil Cath (eff. 1/01)  
(obsolete 4/01)  
1948 = Pursuit Balloon Cath (eff. 1/01)  
(obsolete 4/01)  
1949 = Oracle Megasonics Cath (eff. 1/01)  
(obsolete 4/01)  
1979 = Visions PV/Avanar US Cath (eff. 1/01)  
(obsolete 4/01)  
1980 = Atlantis SR Coronary Cath (eff. 1/01)  
(obsolete 4/01)  
1981 = PTCA Catheters (eff. 1/01)  
(obsolete 4/01)  
2000 = Orbiter ST Steerable Cath (eff. 1/01)  
(obsolete 4/01)  
2001 = Constellation Diag Cath (eff. 1/01)  
(obsolete 4/01)  
2002 = Irvine 5F Inquiry Diag EP Cath (eff. 1/01)  
(obsolete 4/01)  
2003 = Irvine 6F Inquiry Diag EP Cath (eff. 1/01)  
(obsolete 4/01)  
2004 = Biosense EP Cath -- Octapolar (eff. 1/01)  
(obsolete 4/01)  
2005 = Biosense EP Cath -- Hexapolar (eff. 1/01)  
(obsolete 4/01)  
2006 = Biosense EP Cath -- Decapolar (eff. 1/01)  
(obsolete 4/01)  
2007 = Irvine 6F Luma-Cath EP Cath (eff. 1/01)  
(obsolete 4/01)  
2008 = 7F Luma-Cath EP Cath 81910-15 (eff. 1/01)

(obsolete 4/01)  
2009 = Irvine 7F Luma-Cath EP Cath (eff. 1/01)  
(obsolete 4/01)  
2010 = Fixed Curve EP Cath (eff. 1/01)  
(obsolete 4/01)  
2011 = Deflectable Tip Cath--Quad (eff. 1/01)  
(obsolete 4/01)  
2012 = Celsius Abln Cath (eff. 1/01)  
(obsolete 4/01)  
2013 = Celsius Large Abln Cath (eff. 1/01)  
(obsolete 4/01)  
2014 = Celsius II Asym Abln Cath (eff. 1/01)  
(obsolete 4/01)  
2015 = Celsius II Sym Abln Cath (eff. 1/01)  
(obsolete 4/01)  
2016 = Navi-Star DS, Navi-Star Ther (eff. 1/01)  
(obsolete 4/01)  
2017 = Navi-Star Abln Cath (eff. 1/01)  
(obsolete 4/01)  
2018 = Polaris T Ablation Cath (eff. 1/01)  
(obsolete 4/01)  
2019 = EP Deflectable Cath (eff. 1/01)  
(obsolete 4/01)  
2020 = Blazer II XP Abln Cath (eff. 1/01)  
(obsolete 4/01)  
2021 = SilverFlex EP Cath (eff. 1/01)  
(obsolete 4/01)  
2022 = CP Chillli Cooled Abln Cath (eff. 1/01)  
(obsolete 4/01)  
2023 = Chillli Cld AblnCath-std, lg (eff. 1/01)  
(obsolete 4/01)  
2100 = CP CS Reference Cath (eff. 1/01)  
(obsolete 4/01)  
2102 = CP Radii 7F EP Cath (eff. 1/01)  
(obsolete 4/01)  
2103 = CP Radii 7F EP Cath w/Track (eff. 1/01)  
(obsolete 4/01)  
2104 = Lasso Deflectable Cath (eff. 1/01)  
(obsolete 4/01)  
2151 = Veripath Guiding Cath (eff. 1/01)

(obsolete 4/01)  
2152 = Cordis Vista Brite Tip Cath (eff. 1/01)  
(obsolete 4/01)  
2153 = Bard Viking Cath (eff. 1/01)  
(obsolete 4/01)  
2200 = Arrow-Trerotola PTD Cath (eff. 1/01)  
(obsolete 4/01)  
2300 = Varisource Stnd Catheters (eff. 1/01)  
(obsolete 4/01)  
2597 = Clinicath/kit 16/18 sgl/dbl (eff. 1/01)  
(obsolete 4/01)  
2598 = Clinicath 18/20/24-G single (eff. 1/01)  
(obsolete 4/01)  
2599 = Clinicath 16/18-G-double (eff. 1/01)  
(obsolete 4/01)  
2601 = Bard DL Ureteral Cath (eff. 1/01)  
(obsolete 4/01)  
2602 = Vitesse Laser Cath 1.4/1.7mm (eff. 1/01)  
(obsolete 4/01)  
2603 = Vitesse Laser Cath 2.0mm (eff. 1/01)  
(obsolete 4/01)  
2604 = Vitesse E Laser Cath 2.0mm (eff. 1/01)  
(obsolete 4/01)  
2605 = Extreme Laser Catheter (eff. 1/01)  
(obsolete 4/01)  
2606 = SpineCath XL Catheter (eff. 1/01)  
(obsolete 4/01)  
2607 = SpineCath Intradiscal Cath (eff. 1/01)  
(obsolete 4/01)  
2608 = Scimed 6F Wiseguide Cath (eff. 1/01)  
(obsolete 4/01)  
2609 = Flexima Bil Drainage Cath (eff. 1/01)  
(obsolete 4/01)  
2610 = FlexTipPlus Intraspinial Cath (eff. 1/01)  
(obsolete 4/01)  
2611 = AlgoLine Intraspinial Cath (eff. 1/01)  
(obsolete 4/01)  
2612 = InDura Catheter (eff. 1/01)  
(obsolete 4/01)  
2615 = Sealant, pulmonary, liquid (eff. 4/01)



2616 = Brachytx seed, Yttrium-90 (eff. 4/01)  
2617 = Stent, non-cor, tem w/o del (eff. 4/01)  
2618 = Probe, cryoablation (eff. 4/01)  
2619 = Pmkr, dual, non rate-resp (eff. 4/01)  
2620 = Pmkr, single, non rate-resp (eff. 4/01)  
2621 = Pmkr, other than single/dual (eff. 4/01)  
2622 = Prosthesis, penile, non-inf (eff. 4/01)  
2625 = Stent, non-cor , tem w/del sys (eff. 4/01)  
2626 = Infusion pump, non-prog, temp (eff. 4/01)  
2627 = Cath, suprapubic/cystoscopic (eff. 4/01)  
2628 = Catheter, occlusion (eff. 4/01)  
2629 = Intro/sheath, laser (eff. 4/01)  
2630 = Cath, EP, temp-controlled (eff. 4/01)  
2631 = Rep dev, urinary, w/o sling (eff. 4/01)  
2700 = MycroPhylax Plus CS defib (eff. 1/01)  
(obsolete 4/01)  
2701 = Phylax XM SC defib (eff. 1/01)  
(obsolete 4/01)  
2702 = Ventak Prizm 2VR Defib (eff. 1/01)  
(obsolete 4/01)  
2703 = Ventak Prizm VR HE Defib (eff. 1/01)  
(obsolete 4/01)  
2704 = Ventak Mini IV + Defib (eff. 1/01)  
(obsolete 4/01)  
2801 = Defender IV DR 612 DC defib (eff. 1/01)  
(obsolete 4/01)  
2802 = Phylax AV DC defib (eff. 1/01)  
(obsolete 4/01)  
2803 = Ventak Prizm DR HE Defib (eff. 1/01)  
(obsolete 4/01)  
2804 = Ventak Prizm 2 DR Defib (eff. 1/01)  
(obsolete 4/01)  
2805 = Jewel AF 7250 Defib (eff. 1/01)  
(obsolete 4/01)  
2806 = GEM VR 7227 Defib (eff. 1/01)  
(obsolete 4/01)  
2807 = Contak CD 1823 (eff. 1/01)  
(obsolete 4/01)  
2808 = Contak TR 1241 (eff. 1/01)  
(obsolete 4/01)

3001 = Kainox SL/RV defib lead (eff. 1/01)  
(obsolete 4/01)  
3002 = EasyTrak Defib Lead (eff. 1/01)  
(obsolete 4/01)  
3003 = Endotak SQ Array XP lead (eff. 1/01)  
(obsolete 4/01)  
3004 = Intervene Defib lead (eff. 1/01)  
(obsolete 4/01)  
3400 = Siltex Spectrum, Contour Prof (eff. 1/01)  
(obsolete 4/01)  
3401 = Saline-Filled Spectrum (eff. 1/01)  
(obsolete 4/01)  
3500 = Mentor alpha I Inf Penile Pros (eff. 1/01)  
(obsolete 4/01)  
3510 = AMS 800 Urinary Pros (eff. 1/01)  
(obsolete 4/01)  
3551 = Choice/PT Graphix/Luge/Trooper (eff. 1/01)  
(obsolete 4/01)  
3552 = Hi-Torque Whisper (eff. 1/01)  
(obsolete 4/01)  
3553 = Cordis guidewires (eff. 1/01)  
(obsolete 4/01)  
3554 = Jindo guidewire (eff. 1/01)  
(obsolete 4/01)  
3555 = Wholey Hi-Torque Plus GW (eff. 1/01)  
(obsolete 4/01)  
3556 = Wave/FlowWire Guidewire (eff. 1/01)  
(obsolete 4/01)  
3557 = HyTek guidewire (eff. 1/01)  
(obsolete 4/01)  
3800 = SynchroMed EL infusion pump (eff. 1/01)  
(obsolete 4/01)  
3801 = Arrow/Microject PCAQ Sys (eff. 1/01)  
(obsolete 4/01)  
3851 = Elastic UV IOL AA-4203T/TF/TL (eff. 1/01)  
(obsolete 4/01)  
4000 = Opus G 4621, 4624 SC pmkr (eff. 1/01)  
(obsolete 4/01)  
4001 = Opus S 4121/4124 SC pmkr (eff. 1/01)  
(obsolete 4/01)

4002 = Talent 113 SC pmkr (eff. 1/01)  
(obsolete 4/01)  
4003 = Kairos SR SC pmkr (eff. 1/01)  
(obsolete 4/01)  
4004 = Actros SR, Actros SLR SC pmkr (eff. 1/01)  
(obsolete 4/01)  
4005 = Philos SR/SR-B SC pmkr (eff. 1/01)  
(obsolete 4/01)  
4006 = Pulsar Max II SR pmkr (eff. 1/01)  
(obsolete 4/01)  
4007 = Marathon SR pmkr (eff. 1/01)  
(obsolete 4/01)  
4008 = Discovery II SSI pmkr (eff. 1/01)  
(obsolete 4/01)  
4009 = Discovery II SR pmkr (eff. 1/01)  
(obsolete 4/01)  
4300 = Integrity AFx DR 5342 pmkr (eff. 1/01)  
(obsolete 4/01)  
4301 = Integrity AFx DR 5346 pmkr (eff. 1/01)  
(obsolete 4/01)  
4302 = Affinity VDR 5430 DR (eff. 1/01)  
(obsolete 4/01)  
4303 = Brio 112 DC pmkr (eff. 1/01)  
(obsolete 4/01)  
4304 = Brio 212, Talent 213/223 DC pmkr (eff. 1/01)  
(obsolete 4/01)  
4305 = Brio 222 DC pmkr (eff. 1/01)  
(obsolete 4/01)  
4306 = Brio 220 DC pmkr (eff. 1/01)  
(obsolete 4/01)  
4307 = Kairos DR DC pmkr (eff. 1/01)  
(obsolete 4/01)  
4308 = Inos2, Inos2+ DC pmkr (eff. 1/01)  
(obsolete 4/01)  
4309 = Actros DR,D,DR-A, SLR DC pmkr (eff. 1/01)  
(obsolete 4/01)  
4310 = Actros DR-B DC pmkr (eff. 1/01)  
(obsolete 4/01)  
4311 = Philos DR/DR-B/SLR DC (eff. 1/01)  
(obsolete 4/01)

4312 = Pulsar Max II DR pmkr (eff. 1/01)  
(obsolete 4/01)  
4313 = Marathon DR pmkr (eff. 1/01)  
(obsolete 4/01)  
4314 = Momentum DR pmkr (eff. 1/01)  
(obsolete 4/01)  
4315 = Selection AFm pmkr (eff. 1/01)  
(obsolete 4/01)  
4316 = Discovery II DR (eff. 1/01)  
(obsolete 4/01)  
4317 = Discovery II DDD (eff. 1/01)  
(obsolete 4/01)  
4600 = Snynox, Polyrox, Elox, Retrox (eff. 1/01)  
(obsolete 4/01)  
4602 = Tendril SDX, 1488K pmkr lead (eff. 1/01)  
(obsolete 4/01)  
4603 = Oscan/Flexion pmkr lead (eff. 1/01)  
(obsolete 4/01)  
4604 = CrystallineActFix, CapsureFix (eff. 1/01)  
(obsolete 4/01)  
4605 = CapSure Epi pmkr lead (eff. 1/01)  
(obsolete 4/01)  
4606 = Flexend pmkr lead (eff. 1/01)  
(obsolete 4/01)  
4607 = FinelineII/EZ, ThinlineII/EZ (eff. 1/01)  
(obsolete 4/01)  
5000 = BX Velocity w/Hepacoat (eff. 1/01)  
(obsolete 4/01)  
5001 = Memotherm Bil Stent, sm, med (eff. 1/01)  
(obsolete 4/01)  
5002 = Memotherm Bil Stent, large (eff. 1/01)  
(obsolete 4/01)  
5003 = Memotherm Bil Stent, x-large (eff. 1/01)  
(obsolete 4/01)  
5004 = PalmazCorinthian IQ Bil Stent (eff. 1/01)  
(obsolete 4/01)  
5005 = PalmazCorinthian IQ Trans/Bil (eff. 1/01)  
(obsolete 4/01)  
5006 = PalmazTran Bil Stent Sys-Med (eff. 1/01)  
(obsolete 4/01)

5007 = PalmazTran XL Bil Stent--40mm (eff. 1/01)  
(obsolete 4/01)  
5008 = PalmazTran XL Bil Stent--50mm (eff. 1/01)  
(obsolete 4/01)  
5009 = VistaFlex Biliary Stent (eff. 1/01)  
(obsolete 4/01)  
5010 = Rapid Exchange Bil Stent Sys (eff. 1/01)  
(obsolete 4/01)  
5011 = IntraStent, IntraStent LP (eff. 1/01)  
(obsolete 4/01)  
5012 = IntraStent DoubleStrut LD (eff. 1/01)  
(obsolete 4/01)  
5013 = IntraStent DoubleStrut XS (eff. 1/01)  
(obsolete 4/01)  
5014 = AVE Bridge Stent Sys-10/17/28 (eff. 1/01)  
(obsolete 4/01)  
5015 = AVE/X3 Bridge Sys, 40-100 (eff. 1/01)  
(obsolete 4/01)  
5016 = Biliary stent single use cov (eff. 1/01)  
(obsolete 4/01)  
5017 = WallstentRP Bil--20/40/60/68mm (eff. 1/01)  
(obsolete 4/01)  
5018 = WallstentRP Bil--80/94mm (eff. 1/01)  
(obsolete 4/01)  
5019 = Flexima Bil Stent Sys (eff. 1/01)  
(obsolete 4/01)  
5020 = Smart Nitinol Stent--20mm (eff. 1/01)  
(obsolete 4/01)  
5021 = Smart Nitinol Stent--40/60mm (eff. 1/01)  
(obsolete 4/01)  
5022 = Smart Nitinol Stent--80mm (eff. 1/01)  
(obsolete 4/01)  
5023 = BX Velocity Stent--8/13mm (eff. 1/01)  
(obsolete 4/01)  
5024 = BX Velocity Stent 18mm (eff. 1/01)  
(obsolete 4/01)  
5025 = BX Velocity Stent 23 mm (eff. 1/01)  
(obsolete 4/01)  
5026 = BX Velocity Stent 28/33mm (eff. 1/01)  
(obsolete 4/01)

5027 = BX Velocity Stent w/Hep--8/13mm (eff. 1/01)  
(obsolete 4/01)  
5028 = BX Velocity Stent w/Hep--18mm (eff. 1/01)  
(obsolete 4/01)  
5029 = BX Velocity Stent w/Hep--23mm (eff. 1/01)  
(obsolete 4/01)  
5030 = Stent, coronary, S660 9/12mm (eff. 1/01)  
(obsolete 4/01)  
5031 = Stent, coronary, S660 15/18mm (eff. 1/01)  
(obsolete 4/01)  
5032 = Stent, coronary, S660 24/30mm (eff. 1/01)  
(obsolete 4/01)  
5033 = Niroyal Stent Sys, 9mm (eff. 1/01)  
(obsolete 4/01)  
5034 = Niroyal Stent Sys, 12/15mm (eff. 1/01)  
(obsolete 4/01)  
5035 = Niroyal Stent Sys, 18mm (eff. 1/01)  
(obsolete 4/01)  
5036 = Niroyal Stent Sys, 25mm (eff. 1/01)  
(obsolete 4/01)  
5037 = Niroyal Stent Sys, 31mm (eff. 1/01)  
(obsolete 4/01)  
5038 = BX Velocity Stent w/Raptor (eff. 1/01)  
(obsolete 4/01)  
5039 = IntraCoil Periph Stent--40mm (eff. 1/01)  
(obsolete 4/01)  
5040 = IntraCoil Periph Stent--60mm (eff. 1/01)  
(obsolete 4/01)  
5041 = BeStent Over-the-Wire 24/30mm (eff. 1/01)  
(obsolete 4/01)  
5042 = BeStent Over-the-Wire 18mm (eff. 1/01)  
(obsolete 4/01)  
5043 = BeStent Over-the-Wire 15mm (eff. 1/01)  
(obsolete 4/01)  
5044 = BeStent Over-the-Wire 9/12mm (eff. 1/01)  
(obsolete 4/01)  
5045 = Multilink Tetra Cor Stent Sys (eff. 1/01)  
(obsolete 4/01)  
5046 = Radius 20mm cor stent (eff. 1/01)  
(obsolete 4/01)

5047 = Niroyal Elite Cor Stent Sys (eff. 1/01)  
(obsolete 4/01)  
5048 = GR II Coronary Stent (eff. 1/01)  
(obsolete 4/01)  
5130 = Wilson-Cook Colonic Z-Stent (eff. 1/01)  
(obsolete 4/01)  
5131 = Bard Colorectal Stent-60mm (eff. 1/01)  
(obsolete 4/01)  
5132 = Bard Colorectal Stent-80mm (eff. 1/01)  
(obsolete 4/01)  
5133 = Bard Colorectal Stent-100mm (eff. 1/01)  
(obsolete 4/01)  
5134 = Enteral Wallstent-90mm (eff. 1/01)  
(obsolete 4/01)  
5279 = Contour/Percuflex Stent (eff. 1/01)  
(obsolete 4/01)  
5280 = Inlay Db1 Ureteral Stent (eff. 1/01)  
(obsolete 4/01)  
5281 = Wallgraft Trach Sys 70mm (eff. 1/01)  
(obsolete 4/01)  
5282 = Wallgraft Trach Sys 20/30/50 (eff. 1/01)  
(obsolete 4/01)  
5283 = Wallstent/RP TIPS--80mm (eff. 1/01)  
(obsolete 4/01)  
5284 = Wallstent TrachUltraFlex (eff. 1/01)  
(obsolete 4/01)  
5600 = Closure dev, VasoSeal ES (eff. 1/01)  
(obsolete 4/01)  
5601 = VasoSeal Model 1000 (eff. 1/01)  
(obsolete 4/01)  
6001 = Composix Mesh 8/21 in (eff. 1/01)  
(obsolete 4/01)  
6002 = Composix Mesh 32 in (eff. 1/01)  
(obsolete 4/01)  
6003 = Composix Mesh 48 in (eff. 1/01)  
(obsolete 4/01)  
6004 = Composix Mesh 80 in (eff. 1/01)  
(obsolete 4/01)  
6005 = Composix Mesh 140 in (eff. 1/01)  
(obsolete 4/01)

6006 = Composix Mesh 144 in (eff. 1/01)  
(obsolete 4/01)  
6012 = Pelvicol Collagen 8/14 sq cm (eff. 1/01)  
(obsolete 4/01)  
6013 = Pelvicol Collagen 21/24/28 sq cm (eff. 1/01)  
(obsolete 4/01)  
6014 = Pelvicol Collagen 36 sq cm (eff. 1/01)  
(obsolete 4/01)  
6015 = Pelvicol Collagen 48 sq cm (eff. 1/01)  
(obsolete 4/01)  
6016 = Pelvicol Collagen 96 sq cm (eff. 1/01)  
(obsolete 4/01)  
6017 = Gore-Tex DualMesh 75/96 sq cm (eff. 1/01)  
(obsolete 4/01)  
6018 = Gore-Tex DualMesh 150 sq cm (eff. 1/01)  
(obsolete 4/01)  
6019 = Gore-Tex DualMesh 285 sq cm (eff. 1/01)  
(obsolete 4/01)  
6020 = Gore-Tex DualMesh 432 sq cm (eff. 1/01)  
(obsolete 4/01)  
6021 = Gore-Tex DualMesh 600 sq cm (eff. 1/01)  
(obsolete 4/01)  
6022 = Gore-Tex DualMesh 884 sq cm (eff. 1/01)  
(obsolete 4/01)  
6023 = Gore-TexPlus 1mm, 75/96 sq cm (eff. 1/01)  
(obsolete 4/01)  
6024 = Gore-TexPlus 1mm, 150 sq cm (eff. 1/01)  
(obsolete 4/01)  
6025 = Gore-TexPlus 1mm, 285 sq cm (eff. 1/01)  
(obsolete 4/01)  
6026 = Gore-TexPlus 1mm, 432 sq cm (eff. 1/01)  
(obsolete 4/01)  
6027 = Gore-TexPlus 1mm, 600 sq cm (eff. 1/01)  
(obsolete 4/01)  
6028 = Gore-TexPlus 1mm, 884 sq cm (eff. 1/01)  
(obsolete 4/01)  
6029 = Gore-TexPlus 2mm, 150 sq cm (eff. 1/01)  
(obsolete 4/01)  
6030 = Gore-TexPlus 2mm, 285 sq cm (eff. 1/01)  
(obsolete 4/01)



6031 = Gore-TexPlus 2mm, 432 sq cm (eff. 1/01)  
(obsolete 4/01)  
6032 = Gore-TexPlus 2mm, 600 sq cm (eff. 1/01)  
(obsolete 4/01)  
6033 = Gore-TexPlus 2mm, 884 sq cm (eff. 1/01)  
(obsolete 4/01)  
6034 = Bard ePTFE: 150 sq cm-2mm  
(obsolete 4/01)  
6035 = Bard ePTFE: 150sqcm-1mm,75-2mm (eff. 1/01)  
(obsolete 4/01)  
6036 = Bard ePTFE: 50/75sqcm-1,2mm (eff. 1/01)  
(obsolete 4/01)  
6037 = Bard ePTFE: 300 sq cm-1,2mm (eff. 1/01)  
(obsolete 4/01)  
6038 = Bard ePTFE: 600 sq cm-1mm (eff. 1/01)  
(obsolete 4/01)  
6039 = Bard ePTFE: 884sq cm-1mm (eff. 1/01)  
(obsolete 4/01)  
6040 = Bard ePTFE: 600sq cm-2mm (eff. 1/01)  
(obsolete 4/01)  
6041 = Bard ePTFE: 884sq cm -2mm (eff. 1/01)  
(obsolete 4/01)  
6050 = Female Sling Sys w/wo Matr1 (eff. 1/01)  
(obsolete 4/01)  
6051 = Stratasis Sling, 20/40 cm (eff. 1/01)  
(obsolete 4/01)  
6052 = Stratasis Sling, 60 cm (eff. 1/01)  
(obsolete 4/01)  
6053 = Surgisis Soft Graft (eff. 1/01)  
(obsolete 4/01)  
6054 = Surgisis Enhanced Graft (eff. 1/01)  
(obsolete 4/01)  
6055 = Surgisis Enhanced Tissue (eff. 1/01)  
(obsolete 4/01)  
6056 = Surgisis Soft Tissue Graft (eff. 1/01)  
(obsolete 4/01)  
6057 = Surgisis Hernia Graft (eff. 1/01)  
(obsolete 4/01)  
6058 = SurgiPro Hernia Plug, med/lg (eff. 1/01)  
(obsolete 4/01)

6080 = Male Sling Sys w/wo Matrial (eff. 1/01)  
(obsolete 4/01)  
6200 = Exxcel Soft ePTFE vas graft (ef. 1/01)  
(obsolete 4/01)  
6201 = Impra Venaflo--10/20cm (eff. 1/01)  
(obsolete 4/01)  
6202 = Impra Venaflo--30/40 cm (eff. 1/01)  
(obsolete 4/01)  
6203 = Impra Venaflo--50 cm, vt45 (eff. 1/01)  
(obsolete 4/01)  
6204 = Impra Venaflo--stepped (eff. 1/01)  
(obsolete 4/01)  
6205 = Impra Carboflo--10cm (eff. 1/01)  
(obsolete 4/01)  
6206 = Impra Carboflo--20 cm (eff. 1/01)  
(obsolete 4/01)  
6207 = Impra Carboflo--30/35/40cm (eff. 1/01)  
(obsolete 4/01)  
6208 = Impra Carboflo--40/50cm (eff. 1/01)  
(obsolete 4/01)  
6209 = Impra Carboflo--ctrflex (eff. 1/01)  
(obsolete 4/01)  
6210 = Exxcel ePTFE vas graft (eff. 1/01)  
(obsolete 4/01)  
6300 = Vanguard III Endovas Graft (eff. 1/01)  
(obsolete 4/01)  
6500 = Preface Guiding Sheath (eff. 1/01)  
(obsolete 4/01)  
6501 = Soft Tip Sheaths (eff. 1/01)  
(obsolete 4/01)  
6502 = Perry Exchange Dilator (eff. 1/01)  
(obsolete 4/01)  
6525 = Spectranetics Laser Sheath (eff. 1/01)  
(obsolete 4/01)  
6600 = Micro Litho Flex Probes (eff. 1/01)  
(obsolete 4/01)  
6650 = Fast-Cath Guiding Introducer (eff. 1/01)  
(obsolete 4/01)  
6651 = Seal-Away Guding Introducer (eff. 1/01)  
(obsolete 4/01)

6652 = Bard Excalibur Introducer (eff. 1/01)  
(obsolete 4/01)  
6700 = Focal Seal-L (eff. 1/01)  
(obsolete 4/01)  
7000 = Amifostine, 500 mg (eligible for pass-through  
payments)  
7001 = Amphotericin B lipid complex, 50 mg, Inj  
(eligible for pass-through payments)  
7002 = Clonidine, HCl, 1 MG (eligible for pass-  
through payments) (obsolete 1/01)  
7003 = Epoprostenol, 0.5 MG, inj (eligible for pass-  
through payments)  
7004 = Immune globulin intravenous human 5g, inj  
(eligible for pass-through payments)  
7005 = Gonadorelin hCl, 100 mcg (eligible for pass-  
through payments)  
7007 = Milrinone lactate, per 5 ml, inj (not subject  
to national coinsurance)  
7010 = Morphine sulfate concentrate (preservative free)  
per 10 mg (eligible for pass-through payments)  
7011 = Oprelevakin, inj, 5 mg (eligible for pass-through  
payments)  
7012 = Pentamidine isethionate, 300 mg (eligible for  
pass-through payments) (obsolete 1/01)  
7014 = Fentanyl citrate, inj, up to 2 ml (eligible for  
pass-through payments)  
7015 = Busulfan, oral 2 mg (eligible for pass-through  
payments)  
7019 = Aprotinin, 10,000 kiu (eligible for pass-through  
payments)  
7021 = Baclofen, intrathecal, 50 mcg (eligible for pass-  
through payments) (obsolete 1/01)  
7022 = Elliotts B Solution, per ml (eligible for pass-  
through payments)  
7023 = Treatment for bladder calculi, I.e. Renacidin  
per 500 ml (eligible for pass-through payments)  
7024 = Corticorelin ovine triflutate, 0.1 mg  
(eligible for pass-through payments)  
7025 = Digoxin immune FAB (Ovine), 10 mg  
(eligible for pass-through payments)

7026 = Ethanolamine oleate, 1000 ml  
(eligible for pass-through payments)  
7027 = Fomepizole, 1.5 G  
(eligible for pass-through payments)  
7028 = Fosphenytoin, 50 mg  
(eligible for pass-through payments)  
7029 = Glatiramer acetate, 25 mg  
(eligible for pass-through payments)  
7030 = Hemin, 1 mg  
(eligible for pass-through payments)  
7031 = Octreotide Acetate, 500 mcg  
(eligible for pass-through payments)  
7032 = Sermorelin acetate, 0.5 mg  
(eligible for pass-through payments)  
7033 = Somatrem, 5 mg  
(eligible for pass-through payments)  
7034 = Somatropin, 1 mg  
(eligible for pass-through payments)  
7035 = Teniposide, 50 mg  
(eligible for pass-through payments)  
7036 = Urokinase, inj, IV, 250,000 I.U.  
(not subject to national coinsurance)  
7037 = Urofollitropin, 75 I.U.  
(eligible for pass-through payments)  
7038 = Muromonab-CD3, 5 mg  
(eligible for pass-through payments)  
7039 = Pegademase bovine inj 25 I.U.  
(eligible for pass-through payments)  
7040 = Pentastarch 10% inj, 100 ml  
(eligible for pass-through payments)  
7041 = Tirofiban HCL, 0.5 mg  
(not subject to national coinsurance)  
7042 = Capecitabine, oral 150 mg  
(eligible for pass-through payments)  
7043 = Infliximab, 10 MG (eligible for pass-through  
payments)  
7045 = Trimetrexate Glucoronate (eligible for pass-  
through payments)  
7046 = Doxorubicin Hcl Liposome (eligible for pass-  
through payments)

7047 = Droperidol/fentanyl inj (eff. 1/01)  
7048 = Alteplase, 1 mg (eff. 1/01)  
7049 = Filgrastim 480 mcg injection (eff. 1/01)  
7315 = Sodium hyaluronate, 20 mg (eff. 1/01)  
8099 = Spectranetics Lead Lock Dev (eff. 1/01)  
(obsolete 4/01)  
8100 = Adhesion barrier, ADCON-L (eff. 1/01)  
(obsolete 4/01)  
8102 = SurgiVision Esoph Coil (eff. 1/01)  
(obsolete 4/01)  
9000 = Na chromate Cr51, per 0.25mCi (eff. 1/01)  
9001 = Linezolid inj, 200mg (eff. 1/01)  
9002 = Tenecteplase, 50mg/vial (eff. 1/01)  
9003 = Palivizumab, per 50 mg (eff. 1/01)  
9004 = Gemtuzumab ozogamicin inj, 5mg (eff. 1/01)  
9005 = Reteplase inj, half-kit, 18.8 mg/vial (eff. 1/01)  
9006 = Tacrolimus inj, per 5 mg (1 amp) (eff. 1/01)  
9007 = Baclofen Intrathecal kit-1amp (eff. 1/01)  
9008 = Baclofen Refill Kit--500mcg (eff. 1/01)  
9009 = Baclofen Refill Kit--2000mcg (eff. 1/01)  
9010 = Baclofen Refill Kit--4000mcg (eff. 1/01)  
9011 = Caffeine Citrate, inj, 1ml (eff. 1/01)  
9012 = Arsenic Trioxide, 1mg/kg (eff. 4/01)  
9013 = Co 57 Cobaltous Cl, 1 ml (eff. 4/01)  
9100 = Iodinated I-131 Albumin (eff. 1/01)  
9102 = 51 Na chromate, 50mCi (eff. 1/01)  
9103 = Na lothalamate I-125, 10uCi (eff. 1/01)  
9104 = Anti-thymocyte globin, 25 mg (eff. 1/01)  
9105 = Hep B immun glob, per 1 ml (eff. 1/01)  
9106 = Sirolimus 1 mg/ml (eff. 1/01)  
9107 = Tinzaparin sodium, 2ml vial (eff. 1/01)  
9108 = Thyrotropin Alfa, 1.1 mg (eff. 1/01)  
9109 = Tirofiban hydrachloride 6.25 mg (eff. 1/01)  
9217 = Leuprolide acetate for depot suspension,  
7.5 mg (eff. 1/01)  
9500 = Platelets, irradi, ea unit (eff. 1/01)  
9501 = Platelets, pheresis, ea unit (eff. 1/01)  
9502 = Platelets, pher/irrad, ea unit (eff. 1/01)  
9503 = Fresh frozen plasma, ea unit (eff. 1/01)  
9504 = RBC, deglycerolized, ea unit (eff. 1/01)

9998 = Enoxaparin (eff. 1/01)

Revenue Center Consolidated Billing Table

2 = SNF Consolidated Billing Override Code

Revenue Center Deductible Coinsurance Code

4 = No charge or units associated with this revenue center code. (For multiple HCPCS per single revenue center code)

X = Override code: MSP cost avoided  
(eff 12/90 for non-institutional claims;  
10/93 for institutional claims)

Revenue Center Discount Indicator Table

\*DISCOUNTING FORMULAS\*

1 = 1.0  
2 =  $(1.0 + D(U - 1)) / U$   
3 =  $T / U$   
4 =  $(1 + D) / U$   
5 = D  
6 =  $TD / U$   
7 =  $D(1 + D) / U$   
8 =  $2.0 / U$

NOTE: VALUES D, U & T REPRESENT THE FOLLOWING:

D = Discounting fraction (currently 0.5)

U = Number of units

T = Terminated procedure discount (currently 0.5)

REV\_CNTR\_DUP\_CLM\_CHK\_IND\_TB                      Revenue Center Duplicate Claim Check Indicator Table

1 = Exact duplicate review performed-service  
determined not to be a duplicate and is  
approved for payment

2 =

2 = Suspected duplicate review performed-service  
determined not to be a duplicate and is  
approved for payment

Blank =  
denied

Blank = not applicable or the line item service  
is being denied as a duplicate

REV\_CNTR\_NDC\_QTY\_QLFR\_TB                      Revenue Center NDC Qualifier Code Table

Valid Values:

F2 = International Unit

GR = Gram

ML = Milliliter

UN = Unit

REV\_CNTR\_PACKG\_IND\_TB                      Revenue Center Packaging Indicator Table

- 0 = Not packaged
- 1 = Packaged service (service indicator N)
- 2 = Packaged as part of partial hospitalization  
per diem or daily mental health service  
per diem
- 3 = Artificial charges for surgical procedure  
(eff. 7/2004)

REV\_CNTR\_PMT\_MTHD\_IND\_TB

Revenue Center Payment Method Indicator Table

NOTE: Prior to 10/2005, this table contained the valid values for both the payment indicator and status indicator. Effective 10/2005, the payment indicator codes will remain in this table and the status indicator code values will be reflected in the new table: REV\_CNTR\_STUS\_IND\_TB. Both the payment indicator and status indicator values have been expanded to 2-btyes.

- 1 = Paid standard hospital OPPS amount  
(status indicators K, S,T,V,X)
- 2 = Services not paid under OPPS (status indicator A, or no HCPCS code and not certain revenue center codes)
- 3 = Not paid (status indicator M,W,Y,E) or not paid under OPPS (status indicator B,C & Z)
- 4 = Paid at reasonable cost (status indicator F,L)
- 5 = Additional payment for drug or biological  
(status indicator G)
- 6 = Additional payment for device (status indicator H)
- 7 = Additional payment for new drug or new biological (status indicator J)
- 8 = Paid partial hospitalization per diem



(status indicator P)  
9 = No additional payment, payment included  
in line items with APCs (status indicator  
N, or no HCPCS code and certain revenue  
center codes, or HCPCS codes G0176  
(activity therapy), G0129 (occupational  
therapy) or G0177 (partial hospitalization  
program services)

\*\*\*\*\*VALUES PRIOR TO 10/3/2005\*\*\*\*\*

\*\*\*\*\*Service Indicator\*\*\*\*\*

\*\*\*\*\* 1st position \*\*\*\*\*

A = Services not paid under OPPS  
C = Inpatient procedure  
E = Noncovered items or services  
F = Corneal tissue acquisition  
G = Current drug or biological pass-through  
H = Device pass-through  
J = New drug or new biological pass-through  
N = Packaged incidental service  
P = Partial hospitalization services  
S = Significant procedure not subject to  
multiple procedure discounting  
T = Significant procedure subject to multiple  
procedure discounting  
V = Medical visit to clinic or emergency  
department  
X = Ancillary service

\*\*\*\*\*Payment Indicator\*\*\*\*\*

\*\*\*\*\* 2nd position \*\*\*\*\*

1 = Paid standard hospital OPPS amount  
(service indicators S,T,V,X)  
2 = Services not paid under OPPS (service  
indicator A, or no HCPCS code and not  
certain revenue center codes)  
3 = Not paid (service indicators C & E)  
4 = Acquisition cost paid (service indica-  
tor F)

- 5 = Additional payment for current drug or biological (service indicator G)
- 6 = Additional payment for device (service indicator H)
- 7 = Additional payment for new drug or new biological (service indicator J)
- 8 = Paid partial hospitalization per diem (service indicator P)
- 9 = No additional payment, payment included in line items with APCs (service indicator N, or no HCPCS code and certain revenue center codes, or HCPCS codes Q0082 (activity therapy), G0129 (occupational therapy) or G0172 (partial hospitalization training))

REV\_CNTR\_PRICNG\_IND\_TB

Revenue Center Pricing Indicator Table

A = A valid HCPCS code not subject to a fee schedule payment. Reimbursement is calculated on provider submitted charges.

B = A valid HCPCS code subject to the fee schedule payment. for the provider billed charges. NOTE: There is an exception for Critical Access Hospitals (provider numbers XX1300-XX1399) with reimbursement method 'J' (all-inclusive method) and dates of service on or after 7/1/01. In these situations, reimbursement for professional services (revenue codes 96X, 97X, 98X) is always at the fee schedule amount of logic is not applicable.

C = Unlisted Rehabilitation Carrier Priced HCPCS

D = a valid radiology HCPCS code subject to the Radiology Pricer and the rate is reflected as zeroes on the HCPCS file and cost report. The Radiology Pricer treats this HCPCS as a non-covered service. Reimbursement is cal-

culated on provider submitted charges.

E = A valid ASC HCPCS code subject to the ASC Pricer. The rate is reflected as zeroes on the HCPCS file. The ASC Pricer determines the ASC payment rate and is reported on the cost report.

F = A valid ESRD HCPCS code subject to the parameter rate. Reimbursement is the lesser of provider submitted charges or the fee schedule amount for non-dialysis HCPCS. Reimbursement is calculated on the provider file rates for dialysis HCPCS.

NOTE: The ESRD Pricing Indicator is used when processing the ESRD claim. The non-ESRD pricing indicator is used only for Inpatient claims as follows: valid Hemophilia HCPCS for inpatient claim only and code is summed to parameter rate.

G = A valid HCPCS, code is subject to a fee schedule, but the rate is no longer present on the HCPCS file. Reimbursement is calculated on provider submitted charges.

H = A valid DME HCPCS, code is subject to a fee schedule. The rates are reflected under the DME segment. Reimbursement is calculated either on a fee schedule, provider submitted charges or the lesser of provider submitted, or the fee schedule depending on the category of DME.

I = A valid DME category 5 HCPCS, HCPCS is not found on the DME history record, but a match was found on HIC, category and generic code. Claim must be reviewed by Medical Review before payment can be calculated.

J = A valid DME HCPCS, no DME history is present, and a prescription is required before delivery. Claim must be reviewed by Medical Review.

K = A valid DME HCPCS, prescribed has been reviewed, and fee schedule payment is approved as prescription was present before delivery.

L = A valid TENS HCPCS, rental period is six months or greater and must be reviewed by Medical Review. This code will be automatically set by the system.

M = A valid TENS HCPCS, Medical Review has approved the rental charge in excess of five months. This must be set by Medical Review. This must be set by Medical Review when approved for payment.

N = Paid based on the fee amount for non ESRD TOB's.  
NOTE: Fee amount is paid regardless of charges.

Q = Manual pricing

R = A valid radiology HCPCS code and is subject to APC. The rate is reported on the cost report. Reimbursement is calculated on provider submitted charges.

S = Valid influenza/PPV HCPCS. A fee amount is not applicable. The amount payable is present in the covered charge field. This amount is not subject to the coinsurance and deductible. This charge is subject to the provider's reimbursement rate.

T = Valid HCPCS. A fee amount is present. The amount payable should be the lower of the billed charge or fee amount. The system should compute the fee amount by multiplying the covered units times the rate. The fee amount is not subject to coinsurance and deductible or provider's reimbursement rate.

U = Valid ambulance HCPCS. A fee amount is present. The amount payable is a blended amount based on a percentage of the fee schedule and a percentage of the reasonable cost. The fee amount is subject to

coinsurance and deductible.

X = Unclassified drug as subject to manual pricing.

REV\_CNTR\_STUS\_IND\_TB

Revenue Center Status Indicator Table

A = Services not paid under OPPS  
B = Non-allowed item or service for OPPS  
C = Inpatient procedure  
E = Non-allowed item or service  
F = Corneal tissue acquisition and certain CRNA services  
G = Drug/biological pass-through  
H = Device pass-through  
J = New drug or new biological pass-through  
K = Non pass-through drug/biological, radio-pharmaceutical agent, certain brachytherapy sources  
L = Flu/PPV vaccines  
M = Service not billable to FI  
N = Packaged incidental service  
S = Significant procedure not subject to multiple procedure discounting  
T = Significant procedure subject to multiple procedure discounting  
V = Medical visit to clinic or emergency department  
W = Invalid HCPCS or invalid revenue code with blank HCPCS  
X = Ancillary service  
Y = Non-implantable DME, Therapeutic shoes  
Z = Valid revenue with blank HCPCS and no other SI assigned

REV\_CNTR\_TB

Revenue Center Table

0001 = Total charge

0022 = SNF claim paid under PPS submitted as TOB 21X,  
effective for cost reporting periods begin-  
ning on or after 7/1/98 (dates of service after  
6/30/98). NOTE: This code may appear multiple  
times on a claim to identify different HIPPS  
Rate Code/assessment periods.

0023 = Home Health services paid under PPS submitted as  
TOB 32X and 33X, effective 10/00. This code may  
appear multiple times on a claim to identify  
different HIPPS/Home Health Resource Groups (HRG).

0024 = Inpatient Rehabilitation Facility services paid  
under PPS submitted as TOB 11X, effective for  
cost reporting periods beginning on or after  
1/1/2002 (dates of service after 12/31/01).  
This code may appear only once on a claim.

0100 = All inclusive rate-room and board plus ancillary

0101 = All inclusive rate-room and board

0110 = Private medical or general-general classification

0111 = Private medical or general-medical/surgical/GYN

0112 = Private medical or general-OB

0113 = Private medical or general-pediatric

0114 = Private medical or general-psychiatric

0115 = Private medical or general-hospice

0116 = Private medical or general-detoxification

0117 = Private medical or general-oncology

0118 = Private medical or general-rehabilitation

0119 = Private medical or general-other

0120 = Semi-private 2 bed (medical or general)  
general classification

0121 = Semi-private 2 bed (medical or general)  
medical/surgical/GYN

0122 = Semi-private 2 bed (medical or general)-OB

0123 = Semi-private 2 bed (medical or general)-pediatric

0124 = Semi-private 2 bed (medical or general)-psychiatric

0125 = Semi-private 2 bed (medical or general)-hospice

0126 = Semi-private 2 bed (medical or general)  
detoxification

0127 = Semi-private 2 bed (medical or general)-oncology

0128 = Semi-private 2 bed (medical or general)  
rehabilitation

0129 = Semi-private 2 bed (medical or general)-other  
0130 = Semi-private 3 and 4 beds-general classification  
0131 = Semi-private 3 and 4 beds-medical/surgical/GYN  
0132 = Semi-private 3 and 4 beds-OB  
0133 = Semi-private 3 and 4 beds-pediatric  
0134 = Semi-private 3 and 4 beds-psychiatric  
0135 = Semi-private 3 and 4 beds-hospice  
0136 = Semi-private 3 and 4 beds-detoxification  
0137 = Semi-private 3 and 4 beds-oncology  
0138 = Semi-private 3 and 4 beds-rehabilitation  
0139 = Semi-private 3 and 4 beds-other  
0140 = Private (deluxe)-general classification  
0141 = Private (deluxe)-medical/surgical/GYN  
0142 = Private (deluxe)-OB  
0143 = Private (deluxe)-pediatric  
0144 = Private (deluxe)-psychiatric  
0145 = Private (deluxe)-hospice  
0146 = Private (deluxe)-detoxification  
0147 = Private (deluxe)-oncology  
0148 = Private (deluxe)-rehabilitation  
0149 = Private (deluxe)-other  
0150 = Room&Board ward (medical or general)  
general classification  
0151 = Room&Board ward (medical or general)  
medical/surgical/GYN  
0152 = Room&Board ward (medical or general)-OB  
0153 = Room&Board ward (medical or general)-pediatric  
0154 = Room&Board ward (medical or general)-psychiatric  
0155 = Room&Board ward (medical or general)-hospice  
0156 = Room&Board ward (medical or general)-detoxification  
0157 = Room&Board ward (medical or general)-oncology  
0158 = Room&Board ward (medical or general)-rehabilitation  
0159 = Room&Board ward (medical or general)-other  
0160 = Other Room&Board-general classification  
0164 = Other Room&Board-sterile environment  
0167 = Other Room&Board-self care  
0169 = Other Room&Board-other  
0170 = Nursery-general classification  
0171 = Nursery-newborn  
level I (routine)

0172 = Nursery-premature  
newborn-level II (continuing care)  
0173 = Nursery-newborn-level III (intermediate care)  
(eff 10/96)  
0174 = Nursery-newborn-level IV (intensive care)  
(eff 10/96)  
0175 = Nursery-neonatal ICU (obsolete eff 10/96)  
0179 = Nursery-other  
0180 = Leave of absence-general classification  
0182 = Leave of absence-patient convenience charges  
billable  
0183 = Leave of absence-therapeutic leave  
0184 = Leave of absence-ICF mentally retarded-any reason  
0185 = Leave of absence-nursing home (hospitalization)  
0189 = Leave of absence-other leave of absence  
0190 = Subacute care - general classification  
(eff. 10/97)  
0191 = Subacute care - level I (eff. 10/97)  
0192 = Subacute care - level II (eff. 10/97)  
0193 = Subacute care - level III (eff. 10/97)  
0194 = Subacute care - level IV (eff. 10/97)  
0199 = Subacute care - other (eff 10/97)  
0200 = Intensive care-general classification  
0201 = Intensive care-surgical  
0202 = Intensive care-medical  
0203 = Intensive care-pediatric  
0204 = Intensive care-psychiatric  
0206 = Intensive care-post ICU; redefined as  
intermediate ICU (eff 10/96)  
0207 = Intensive care-burn care  
0208 = Intensive care-trauma  
0209 = Intensive care-other intensive care  
0210 = Coronary care-general classification  
0211 = Coronary care-myocardial infraction  
0212 = Coronary care-pulmonary care  
0213 = Coronary care-heart transplant  
0214 = Coronary care-post CCU; redefined as  
intermediate CCU (eff 10/96)  
0219 = Coronary care-other coronary care  
0220 = Special charges-general classification



0221 = Special charges-admission charge  
0222 = Special charges-technical support charge  
0223 = Special charges-UR service charge  
0224 = Special charges-late discharge, medically  
necessary  
0229 = Special charges-other special charges  
0230 = Incremental nursing charge rate-general  
classification  
0231 = Incremental nursing charge rate-nursery  
0232 = Incremental nursing charge rate-OB  
0233 = Incremental nursing charge rate-ICU (include  
transitional care)  
0234 = Incremental nursing charge rate-CCU (include  
transitional care)  
0235 = Incremental nursing charge rate-hospice  
0239 = Incremental nursing charge rate-other  
0240 = All inclusive ancillary-general classification  
0241 = All inclusive ancillary-basic  
0242 = All inclusive ancillary-comprehensive  
0243 = All inclusive ancillary-specialty  
0249 = All inclusive ancillary-other inclusive ancillary  
0250 = Pharmacy-general classification  
0251 = Pharmacy-generic drugs  
0252 = Pharmacy-nongeneric drugs  
0253 = Pharmacy-take home drugs  
0254 = Pharmacy-drugs incident to other diagnostic service-  
subject to payment limit  
0255 = Pharmacy-drugs incident to radiology-  
subject to payment limit  
0256 = Pharmacy-experimental drugs  
0257 = Pharmacy-non-prescription  
0258 = Pharmacy-IV solutions  
0259 = Pharmacy-other pharmacy  
0260 = IV therapy-general classification  
0261 = IV therapy-infusion pump  
0262 = IV therapy-pharmacy services (eff 10/94)  
0263 = IV therapy-drug supply/delivery (eff 10/94)  
0264 = IV therapy-supplies (eff 10/94)  
0269 = IV therapy-other IV therapy  
0270 = Medical/surgical supplies-general classification

(also see 062X)

0271 = Medical/surgical supplies-nonsterile supply  
0272 = Medical/surgical supplies-sterile supply  
0273 = Medical/surgical supplies-take home supplies  
0274 = Medical/surgical supplies-prosthetic/orthotic  
devices  
0275 = Medical/surgical supplies-pace maker  
0276 = Medical/surgical supplies-intraocular lens  
0277 = Medical/surgical supplies-oxygen-take home  
0278 = Medical/surgical supplies-other implants  
0279 = Medical/surgical supplies-other devices  
0280 = Oncology-general classification  
0289 = Oncology-other oncology  
0290 = DME (other than renal)-general classification  
0291 = DME (other than renal)-rental  
0292 = DME (other than renal)-purchase of new DME  
0293 = DME (other than renal)-purchase of used DME  
0294 = DME (other than renal)-related to and listed as DME  
0299 = DME (other than renal)-other  
0300 = Laboratory-general classification  
0301 = Laboratory-chemistry  
0302 = Laboratory-immunology  
0303 = Laboratory-renal patient (home)  
0304 = Laboratory-non-routine dialysis  
0305 = Laboratory-hematology  
0306 = Laboratory-bacteriology & microbiology  
0307 = Laboratory-urology  
0309 = Laboratory-other laboratory  
0310 = Laboratory pathological-general classification  
0311 = Laboratory pathological-cytology  
0312 = Laboratory pathological-histology  
0314 = Laboratory pathological-biopsy  
0319 = Laboratory pathological-other  
0320 = Radiology diagnostic-general classification  
0321 = Radiology diagnostic-angiocardiology  
0322 = Radiology diagnostic-arthrography  
0323 = Radiology diagnostic-arteriography  
0324 = Radiology diagnostic-chest X-ray  
0329 = Radiology diagnostic-other  
0330 = Radiology therapeutic-general classification

0331 = Radiology therapeutic-chemotherapy injected  
0332 = Radiology therapeutic-chemotherapy oral  
0333 = Radiology therapeutic-radiation therapy  
0335 = Radiology therapeutic-chemotherapy IV  
0339 = Radiology therapeutic-other  
0340 = Nuclear medicine-general classification  
0341 = Nuclear medicine-diagnostic  
0342 = Nuclear medicine-therapeutic  
0343 = Nuclear medicine-diagnostic radiopharmaceuticals  
0344 = Nuclear medicine-therapeutic radiopharmaceuticals  
0349 = Nuclear medicine-other  
0350 = Computed tomographic (CT) scan-general  
classification  
0351 = CT scan-head scan  
0352 = CT scan-body scan  
0359 = CT scan-other CT scans  
0360 = Operating room services-general classification  
0361 = Operating room services-minor surgery  
0362 = Operating room services-organ transplant,  
other than kidney  
0367 = Operating room services-kidney transplant  
0369 = Operating room services-other operating room  
services  
0370 = Anesthesia-general classification  
0371 = Anesthesia-incident to RAD and  
subject to the payment limit  
0372 = Anesthesia-incident to other diagnostic service  
and subject to the payment limit  
0374 = Anesthesia-acupuncture  
0379 = Anesthesia-other anesthesia  
0380 = Blood-general classification  
0381 = Blood-packed red cells  
0382 = Blood-whole blood  
0383 = Blood-plasma  
0384 = Blood-platelets  
0385 = Blood-leukocytes  
0386 = Blood-other components  
0387 = Blood-other derivatives (cryoprecipitates)  
0389 = Blood-other blood  
0390 = Blood storage and processing-general

classification  
0391 = Blood storage and processing-blood  
administration  
0399 = Blood storage and processing-other  
0400 = Other imaging services-general classification  
0401 = Other imaging services-diagnostic mammography  
0402 = Other imaging services-ultrasound  
0403 = Other imaging services-screening mammography  
(eff 1/1/91)  
0404 = Other imaging services-positron emission  
tomography (eff 10/94)  
0409 = Other imaging services-other  
0410 = Respiratory services-general classification  
0412 = Respiratory services-inhalation services  
0413 = Respiratory services-hyperbaric oxygen therapy  
0419 = Respiratory services-other  
0420 = Physical therapy-general classification  
0421 = Physical therapy-visit charge  
0422 = Physical therapy-hourly charge  
0423 = Physical therapy-group rate  
0424 = Physical therapy-evaluation or re-evaluation  
0429 = Physical therapy-other  
0430 = Occupational therapy-general classification  
0431 = Occupational therapy-visit charge  
0432 = Occupational therapy-hourly charge  
0433 = Occupational therapy-group rate  
0434 = Occupational therapy-evaluation or re-evaluation  
0439 = Occupational therapy-other (may include  
restorative therapy)  
0440 = Speech language pathology-general classification  
0441 = Speech language pathology-visit charge  
0442 = Speech language pathology-hourly charge  
0443 = Speech language pathology-group rate  
0444 = Speech language pathology-evaluation or  
re-evaluation  
0449 = Speech language pathology-other  
0450 = Emergency room-general classification  
0451 = Emergency room-emptala emergency medical screening  
services (eff 10/96)  
0452 = Emergency room-ER beyond emptala screening

(eff 10/96)

0456 = Emergency room-urgent care (eff 10/96)

0459 = Emergency room-other

0460 = Pulmonary function-general classification

0469 = Pulmonary function-other

0470 = Audiology-general classification

0471 = Audiology-diagnostic

0472 = Audiology-treatment

0479 = Audiology-other

0480 = Cardiology-general classification

0481 = Cardiology-cardiac cath lab

0482 = Cardiology-stress test

0483 = Cardiology-Echocardiology

0489 = Cardiology-other

0490 = Ambulatory surgical care-general classification

0499 = Ambulatory surgical care-other

0500 = Outpatient services-general classification  
(deleted 9/93)

0509 = Outpatient services-other

0510 = Clinic-general classification

0511 = Clinic-chronic pain center

0512 = Clinic-dental center

0513 = Clinic-psychiatric

0514 = Clinic-OB-GYN

0515 = Clinic-pediatric

0516 = Clinic-urgent care clinic (eff 10/96)

0517 = Clinic-family practice clinic (eff 10/96)

0519 = Clinic-other

0520 = Free-standing clinic-general classification

0521 = Free-standing clinic-Clinic visit by a  
member to RHC/FQHC (eff. 7/1/06). Prior to  
7/1/06 - Rural Health-Clinic

0522 = Free-standing clinic-Home visit by RHC/FQHC  
practitioner (eff. 7/1/06). Prior to  
7/1/06 - Rural Health-Home

0523 = Free-standing clinic-family practice

0524 = Free-standing clinic - visit by RHC/FQHC  
practitioner to a member in a covered Part  
A stay at the SNF. (eff. 7/1/06)

0525 = Free-standing clinic - visit by RHC/FQHC

practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility. (eff. 7/1/06)

0526 = Free-standing clinic-urgent care (eff 10/96)

0527 = Free-standing clinic-RHC/FQHC visiting nurse service(s) to a member's home when in a home health shortage area. (eff. 7/1/06)

0528 = Free-standing clinic-visit by RHC/FQHC practitioner to other non RHC/FQHC site (e.g. scene of accident). (eff. 7/1/06)

0529 = Free-standing clinic-other

0530 = Osteopathic services-general classification

0531 = Osteopathic services-osteopathic therapy

0539 = Osteopathic services-other

0540 = Ambulance-general classification

0541 = Ambulance-supplies

0542 = Ambulance-medical transport

0543 = Ambulance-heart mobile

0544 = Ambulance-oxygen

0545 = Ambulance-air ambulance

0546 = Ambulance-neo-natal ambulance

0547 = Ambulance-pharmacy

0548 = Ambulance-telephone transmission EKG

0549 = Ambulance-other

0550 = Skilled nursing-general classification

0551 = Skilled nursing-visit charge

0552 = Skilled nursing-hourly charge

0559 = Skilled nursing-other

0560 = Medical social services-general classification

0561 = Medical social services-visit charge

0562 = Medical social services-hourly charges

0569 = Medical social services-other

0570 = Home health aid (home health)-general classification

0571 = Home health aid (home health)-visit charge

0572 = Home health aid (home health)-hourly charge

0579 = Home health aid (home health)-other

0580 = Other visits (home health)-general classification (under HHPs, not allowed as covered charges)

0581 = Other visits (home health)-visit charge  
(under HHPPS, not allowed as covered charges)  
0582 = Other visits (home health)-hourly charge  
(under HHPPS, not allowed as covered charges)  
0589 = Other visits (home health)-other  
(under HHPPS, not allowed as covered charges)  
0590 = Units of service (home health)-general  
classification (under HHPPS, not allowed  
as covered charges)  
0599 = Units of service (home health)-other  
(under HHPPS, not allowed as covered charges)  
0600 = Oxygen/Home Health-general classification  
0601 = Oxygen/Home Health-stat or port equip/supply  
or count  
0602 = Oxygen/Home Health-stat/equip/under 1 LPM  
0603 = Oxygen/Home Health-stat/equip/over 4 LPM  
0604 = Oxygen/Home Health-stat/equip/portable add-on  
0609 = Oxygen/Home Health - Other  
0610 = Magnetic resonance technology (MRT)-general  
classification  
0611 = MRT/MRI-brain (including brainstem)  
0612 = MRT/MRI-spinal cord (including spine)  
0614 = MRT/MRI-other  
0615 = MRT/MRA-Head and Neck  
0616 = MRT/MRA-Lower Extremities  
0618 = MRT/MRA-other  
0619 = MRT/Other MRT  
0620 = Reserved (Use 0270 for general classification)  
0621 = Medical/surgical supplies-incident to radiology-  
subject to the payment limit - extension of 027X  
0622 = Medical/surgical supplies-incident to other  
diagnostic service-subject to the payment limit -  
extension of 027X  
0623 = Medical/surgical supplies-surgical dressings  
(eff 1/95) - extension of 027X  
0624 = Medical/surgical supplies-medical investigational  
devices and procedures with FDA approved IDE's  
(eff 10/96) - extension of 027X  
0630 = Reserved (eff. 1/98)  
0631 = Drugs requiring specific identification-single drug

source (eff 9/93)  
0632 = Drugs requiring specific identification-multiple drug  
source (eff 9/93)  
0633 = Drugs requiring specific identification-restrictive  
prescription (eff 9/93)  
0634 = Drugs requiring specific identification-EPO under  
10,000 units  
0635 = Drugs requiring specific identification-EPO 10,000  
units or more  
0636 = Drugs requiring specific identification-detailed  
coding (eff 3/92)  
0637 = Self-administered drugs administered in an  
emergency situation - not requiring detailed  
coding  
0640 = Home IV therapy-general classification  
(eff 10/94)  
0641 = Home IV therapy-nonroutine nursing  
(eff 10/94)  
0642 = Home IV therapy-IV site care, central line  
(eff 10/94)  
0643 = Home IV therapy-IV start/change peripheral line  
(eff 10/94)  
0644 = Home IV therapy-nonroutine nursing, peripheral line  
(eff 10/94)  
0645 = Home IV therapy-train patient/caregiver, central  
line (eff 10/94)  
0646 = Home IV therapy-train disabled patient, central  
line (eff 10/94)  
0647 = Home IV therapy-train patient/caregiver, peripheral  
line (eff 10/94)  
0648 = Home IV therapy-train disabled patient, peripheral  
line (eff 10/94)  
0649 = Home IV therapy-other IV therapy services  
(eff 10/94)  
0650 = Hospice services-general classification  
0651 = Hospice services-routine home care  
0652 = Hospice services-continuous home care-1/2  
  
0655 = Hospice services-inpatient care  
0656 = Hospice services-general inpatient care



(non-respite)  
0657 = Hospice services-physician services  
0658 = Hospice services-Hospice Room & Board -  
Nursing Facility  
0659 = Hospice services-other  
0660 = Respite care (HHA)-general classification  
(eff 9/93)  
0661 = Respite care (HHA)-hourly charge/skilled nursing  
(eff 9/93)  
0662 = Respite care (HHA)-hourly charge/home health aide/  
homemaker (eff 9/93)  
0663 = Respite care-daily respite care  
0669 = Respite care-other respite care  
0670 = OP special residence charges - general  
classification  
0671 = OP special residence charges - hospital based  
0672 = OP special residence charges - contracted  
0679 = OP special residence charges - other special  
residence charges  
0680 = Trauma Response-not used  
0681 = Trauma response-Level I Trauma  
0682 = Trauma response-Level II Trauma  
0683 = Trauma response-Level III Trauma  
0684 = Trauma response-Level IV Trauma  
0689 = Trauma response-Other trauma response  
0700 = Cast room-general classification  
0709 = Cast room-other  
0710 = Recovery room-general classification  
0719 = Recovery room-other  
0720 = Labor room/delivery-general classification  
0721 = Labor room/delivery-labor  
0722 = Labor room/delivery-delivery  
0723 = Labor room/delivery-circumcision  
0724 = Labor room/delivery-birthing center  
0729 = Labor room/delivery-other  
0730 = EKG/ECG-general classification  
0731 = EKG/ECG-Holter monitor  
0732 = EKG/ECG-telemetry (include fetal monitoring until  
9/93)  
0739 = EKG/ECG-other

0740 = EEG-general classification  
0749 = EEG (electroencephalogram)-other  
0750 = Gastro-intestinal services-general classification  
0759 = Gastro-intestinal services-other  
0760 = Treatment or observation room-general  
classification  
0761 = Treatment or observation room-treatment room  
(eff 9/93)  
0762 = Treatment or observation room-observation room  
(eff 9/93)  
0769 = Treatment or observation room-other  
0770 = Preventative care services-general classification  
(eff 10/94)  
0771 = Preventative care services-vaccine administration  
(eff 10/94)  
0779 = Preventative care services-other (eff 10/94)  
0780 = Telemedicine - general classification  
(eff 10/97)  
0789 = Telemedicine - telemedicine (eff 10/97)  
0790 = Lithotripsy-general classification  
0799 = Lithotripsy-other  
0800 = Inpatient renal dialysis-general classification  
0801 = Inpatient renal dialysis-inpatient hemodialysis  
0802 = Inpatient renal dialysis-inpatient peritoneal  
(non-CAPD)  
0803 = Inpatient renal dialysis-inpatient CAPD  
0804 = Inpatient renal dialysis-inpatient CCPD  
0809 = Inpatient renal dialysis-other inpatient dialysis  
0810 = Organ acquisition-general classification  
0811 = Organ acquisition-living donor (eff 10/94);  
prior to 10/94, defined as living donor kidney  
0812 = Organ acquisition-cadaver donor (eff 10/94);  
prior to 10/94, defined as cadaver donor kidney  
0813 = Organ acquisition-unknown donor (eff 10/94)  
prior to 10/94, defined as unknown donor kidney  
0814 = Organ acquisition - unsuccessful organ search-  
donor bank charges (eff 10/94); prior to 10/94,  
defined as other kidney acquisition  
0815 = Organ acquisition-cadaver donor-heart  
(obsolete, eff 10/94)

0816 = Organ acquisition-other heart acquisition  
(obsolete, eff 10/94)  
0817 = Organ acquisition-donor-liver  
(obsolete, eff 10/94)  
0819 = Organ acquisition-other donor (eff 10/94);  
prior to 10/94, defined as other  
0820 = Hemodialysis OP or home dialysis-general  
classification  
0821 = Hemodialysis OP or home dialysis-hemodialysis-  
composite or other rate  
0822 = Hemodialysis OP or home dialysis-home supplies  
0823 = Hemodialysis OP or home dialysis-home equipment  
0824 = Hemodialysis OP or home dialysis-maintenance/100%  
0825 = Hemodialysis OP or home dialysis-support services  
0829 = Hemodialysis OP or home dialysis-other  
0830 = Peritoneal dialysis OP or home-general  
classification  
0831 = Peritoneal dialysis OP or home-peritoneal-  
composite or other rate  
0832 = Peritoneal dialysis OP or home-home supplies  
0833 = Peritoneal dialysis OP or home-home equipment  
0834 = Peritoneal dialysis OP or home-maintenance/100%  
0835 = Peritoneal dialysis OP or home-support services  
0839 = Peritoneal dialysis OP or home-other  
0840 = CAPD outpatient-general classification  
0841 = CAPD outpatient-CAPD/composite or other rate  
0842 = CAPD outpatient-home supplies  
0843 = CAPD outpatient-home equipment  
0844 = CAPD outpatient-maintenance/100%  
0845 = CAPD outpatient-support services  
0849 = CAPD outpatient-other  
0850 = CCPD outpatient-general classification  
0851 = CCPD outpatient-CCPD/composite or other rate  
0852 = CCPD outpatient-home supplies  
0853 = CCPD outpatient-home equipment  
0854 = CCPD outpatient-maintenance/100%  
0855 = CCPD outpatient-support services  
0859 = CCPD outpatient-other  
0860 = Magnetoencephalography (MEG) - general  
classification

0861 = Magnetoencephalography (MEG) - MEG  
0880 = Miscellaneous dialysis-general classification  
0881 = Miscellaneous dialysis-ultrafiltration  
0882 = Miscellaneous dialysis-home dialysis aide visit  
(eff 9/93)  
0889 = Miscellaneous dialysis-other  
0890 = Other donor bank-general classification; changed to  
reserved for national assignment (eff 4/94)  
0891 = Other donor bank-bone; changed to  
reserved for national assignment (eff 4/94)  
0892 = Other donor bank-organ (other than kidney); changed  
to reserved for national assignment (eff 4/94)  
0893 = Other donor bank-skin; changed to  
reserved for national assignment (eff 4/94)  
0899 = Other donor bank-other; changed to  
reserved for national assignment (eff 4/94)  
0900 = Behavior Health Treatment/Services - general  
classification (eff. 10/2004); prior to  
10/2004 defined as Psychiatric/psychological  
treatments-general classification  
0901 = Behavior Health Treatment/Services - electroshock  
treatment (eff. 10/2004); prior to 10/2004  
defined as Psychiatric/psychological  
treatments-electroshock treatment  
0902 = Behavior Health Treatment/Services - milieu  
therapy (eff. 10/2004); prior to 10/2004  
defined as Psychiatric/psychological  
treatments-milieu therapy  
0903 = Behavior Health Treatment/Services - play  
therapy (eff. 10/2004); prior to 10/2004  
defined as Psychiatric/psychological  
treatments-play therapy  
0904 = Behavior Health Treatment/Services - activity  
therapy (eff. 10/2004); prior to 10/2004  
defined as Psychiatric/psychological  
treatments-activity therapy  
0905 = Behavior Health Treatment/Services - intensive  
outpatient services-psychiatric (eff. 10/2004)  
0906 = Behavior Health Treatment/Services - intensive  
outpatient services-chemical dependency

(eff. 10/2004)

0907 = Behavior Health Treatment/Services - community  
behavioral health program-day treatment  
(eff. 10/2004)

0909 = Reserved for National Use (eff. 10/2004); prior  
to 10/2004 defined as Psychiatric/psychological  
treatments-other

0910 = Behavioral Health Treatment/Services-Reserved for  
National Assignment (eff. 10/2004); prior to  
10/2004 defined as Psychiatric/psychological  
services-general classification

0911 = Behavioral Health Treatment/Services-rehabilitation  
(eff. 10/2004); prior to 10/2004 defined as  
Psychiatric/psychological services-rehabilitation

0912 = Behavioral Health Treatment/Services-partial  
hospitalization-less intensive (eff. 10/2004);  
prior to 10/2004 defined as Psychiatric/  
psychological services-less intensive

0913 = Behavioral Health Treatment/Services-partial  
hospitalization-intensive (eff. 10/2004);  
prior to 10/2004 defined as Psychiatric/  
psychological services-intensive

0914 = Behavioral Health Treatment/Services-indivi-  
dual therapy (eff. 10/2004); prior to  
10/2004 defined as Psychiatric/psychological  
services-individual therapy

0915 = Behavioral Health Treatment/Services-group  
therapy (eff. 10/2004); prior to 10/2004  
defined as Psychiatric/psychological services-  
group therapy

0916 = Behavioral Health Treatment/Services-family  
therapy (eff. 10/2004); prior to 10/2004  
defined as Psychiatric/psychological services-  
family therapy

0917 = Behavioral Health Treatment/Services-bio  
feedback (eff. 10/2004); prior to 10/2004  
defined as Psychiatric/psychological services-  
bio feedback

0918 = Behavioral Health Treatment/Services-testing  
(eff. 10/2004); prior to 10/2004 defined as

Psychiatric/psychological services-testing  
0919 = Behavioral Health Treatment/Services-other  
(eff. 10/2004); prior to 10/2004 defined as  
Psychiatric/psychological services-other  
0920 = Other diagnostic services-general classification  
0921 = Other diagnostic services-peripheral vascular lab  
0922 = Other diagnostic services-electromyelogram  
0923 = Other diagnostic services-pap smear  
0924 = Other diagnostic services-allergy test  
0925 = Other diagnostic services-pregnancy test  
0929 = Other diagnostic services-other  
0931 = Medical Rehabilitation Day Program - Half Day  
0932 = Medical Rehabilitation Day Program - Full Day  
0940 = Other therapeutic services-general classification  
0941 = Other therapeutic services-recreational therapy  
0942 = Other therapeutic services-education/training  
(include diabetes diet training)  
0943 = Other therapeutic services-cardiac rehabilitation  
0944 = Other therapeutic services-drug rehabilitation  
0945 = Other therapeutic services-alcohol  
rehabilitation  
0946 = Other therapeutic services-routine complex  
medical equipment  
0947 = Other therapeutic services-ancillary complex  
medical equipment (eff 3/92)  
0949 = Other therapeutic services-other  
0951 = Professional Fees-athletic training (extension  
of 094X)  
0952 = Professional Fees-kinesiotherapy (extension  
of 094X)  
0960 = Professional fees-general classification  
0961 = Professional fees-psychiatric  
0962 = Professional fees-ophthalmology  
0963 = Professional fees-anesthesiologist (MD)  
0964 = Professional fees-anesthetist (CRNA)  
0969 = Professional fees-other  
NOTE: 097X is an extension of 096X  
0971 = Professional fees-laboratory  
0972 = Professional fees-radiology diagnostic  
0973 = Professional fees-radiology therapeutic

0974 = Professional fees-nuclear medicine  
0975 = Professional fees-operating room  
0976 = Professional fees-respiratory therapy  
0977 = Professional fees-physical therapy  
0978 = Professional fees-occupational therapy  
0979 = Professional fees-speech pathology  
    NOTE: 098X is an extension of 096X & 097X  
0981 = Professional fees-emergency room  
0982 = Professional fees-outpatient services  
0983 = Professional fees-clinic  
0984 = Professional fees-medical social services  
0985 = Professional fees-EKG  
0986 = Professional fees-EEG  
0987 = Professional fees-hospital visit  
0988 = Professional fees-consultation  
0989 = Professional fees-private duty nurse  
0990 = Patient convenience items-general classification  
0991 = Patient convenience items-cafeteria/guest tray  
0992 = Patient convenience items-private linen service  
0993 = Patient convenience items-telephone/telecom  
0994 = Patient convenience items-tv/radio  
0995 = Patient convenience items-nonpatient room rentals  
0996 = Patient convenience items-late discharge charge  
0997 = Patient convenience items-admission kits  
0998 = Patient convenience items-beauty shop/barber  
0999 = Patient convenience items-other  
1000 = Behavioral Health Accommodations -  
    general classification  
1001 = Behavioral Health Accommodations -  
    residential treatment -Psychiatric  
1002 = Behavioral Health Accommodations -  
    residential treatment - chemical  
    dependency  
1003 = Behavioral Health Accommodations -  
    supervised living  
1004 = Behavioral Health Accommodations -  
    halfway house  
1005 = Behavioral Health Accommodations -  
    group home  
2100 = Alternative Therapy Services - general

classification

- 2101 = Alternative Therapy Services - Acupuncture
- 2102 = Alternative Therapy Services - Acupressure
- 2103 = Alternative Therapy Services - massage
- 2104 = Alternative Therapy Services - reflexology
- 2105 = Alternative Therapy Services - biofeedback
- 2106 = Alternative Therapy Services - hypnosis
- 2109 = Alternative Therapy Services - other alternative therapy service
- 3100 = Adult Care - Reserved
- 3101 = Adult Care - adult day care, medical and social hourly
- 3102 = Adult Care - adult day care, social-hourly
- 3103 = Adult Care - adult day care, medical and social - daily
- 3104 = Adult Care - adult day care, social - daily
- 3105 = Adult Care - adult foster care daily
- 3109 = Adult Care - other adult care

NOTE: Following Revenue Codes reported for NHCMQ (RUGS) demo claims effective 2/96.

- 9000 = RUGS-no MDS assessment available
- 9001 = Reduced physical functions- RUGS PA1/ADL index of 4-5
- 9002 = Reduced physical functions- RUGS PA2/ADL index of 4-5
- 9003 = Reduced physical functions- RUGS PB1/ADL index of 6-8
- 9004 = Reduced physical functions- RUGS PB2/ADL index of 6-8



9005 = Reduced physical functions-  
RUGS PC1/ADL index of 9-10  
9006 = Reduced physical functions-  
RUGS PC2/ADL index of 9-10  
9007 = Reduced physical functions-  
RUGS PD1/ADL index of 11-15  
9008 = Reduced physical functions-  
RUGS PD2/ADL index of 11-15  
9009 = Reduced physical functions-  
RUGS PE1/ADL index of 16-18  
9010 = Reduced physical functions-  
RUGS PE2/ADL index of 16-18  
9011 = Behavior only problems-  
RUGS BA1/ADL index of 4-5  
9012 = Behavior only problems-  
RUGS BA2/ADL index of 4-5  
9013 = Behavior only problems-  
RUGS BB1/ADL index of 6-10  
9014 = Behavior only problems-  
RUGS BB2/ADL index of 6-10  
9015 = Impaired cognition-  
RUGS IA1/ADL index of 4-5  
9016 = Impaired cognition-  
RUGS IA2/ADL index of 4-5  
9017 = Impaired cognition-  
RUGS IB1/ADL index of 6-10  
9018 = Impaired cognition-  
RUGS IB2/ADL index of 6-10  
9019 = Clinically complex-  
RUGS CA1/ADL index of 4-5  
9020 = Clinically complex-  
RUGS CA2/ADL index of 4-5d  
9021 = Clinically complex-  
RUGS CB1/ADL index of 6-10  
9022 = Clinically complex-  
RUGS CB2/ADL index of 6-10d  
9023 = Clinically complex-  
RUGS CC1/ADL index of 11-16  
9024 = Clinically complex-  
RUGS CC2/ADL index of 11-16d

9025 = Clinically complex-  
RUGS CD1/ADL index of 17-18  
9026 = Clinically complex-  
RUGS CD2/ADL index of 17-18d  
9027 = Special care-  
RUGS SSA/ADL index of 7-13  
9028 = Special care-  
RUGS SSB/ADL index of 14-16  
9029 = Special care-  
RUGS SSC/ADL index of 17-18  
9030 = Extensive services-  
RUGS SE1/1 procedure  
9031 = Extensive services-  
RUGS SE2/2 procedures  
9032 = Extensive services-  
RUGS SE3/3 procedures  
9033 = Low rehabilitation-  
RUGS RLA/ADL index of 4-11  
9034 = Low rehabilitation-  
RUGS RLB/ADL index of 12-18  
9035 = Medium rehabilitation-  
RUGS RMA/ADL index of 4-7  
9036 = Medium rehabilitation-  
RUGS RMB/ADL index of 8-15  
9037 = Medium rehabilitation-  
RUGS RMC/ADL index of 16-18  
9038 = High rehabilitation-  
RUGS RHA/ADL index of 4-7  
9039 = High rehabilitation-  
RUGS RHB/ADL index of 8-11  
9040 = High rehabilitation-  
RUGS RHC/ADL index of 12-14  
9041 = High rehabilitation-  
RUGS RHD/ADL index of 15-18  
9042 = Very high rehabilitation-  
RUGS RVA/ADL index of 4-7  
9043 = Very high rehabilitation-  
RUGS RVB/ADL index of 8-13  
9044 = Very high rehabilitation-  
RUGS RVC/ADL index of 14-18

\*\*\*Changes effective for providers entering\*\*\*  
\*\*RUGS Demo Phase III as of 1/1/97 or later\*\*

9019 = Clinically complex-  
RUGS CA1/ADL index of 11  
9020 = Clinically complex-  
RUGS CA2/ADL index of 11D  
9021 = Clinically complex-  
RUGS CB1/ADL index of 12-16  
9022 = Clinically complex-  
RUGS CB2/ADL index of 12-16D  
9023 = Clinically complex-  
RUGS CC1/ADL index of 17-18  
9024 = Clinically complex-  
RUGS CC2/ADL index of 17-18D  
9025 = Special care-  
RUGS SSA/ADL index of 14  
9026 = Special care-  
RUGS SSB/ADL index of 15-16  
9027 = Special care-  
RUGS SSC/ADL index of 17-18  
9028 = Extensive services-  
RUGS SE1/ADL index 7-18/1 procedure  
9029 = Extensive services-  
RUGS SE2/ADL index 7-18/2 procedures  
9030 = Extensive services-  
RUGS SE3/ADL index 7-18/3 procedures  
9031 = Low rehabilitation-  
RUGS RLA/ADL index of 4-13  
9032 = Low rehabilitation-  
RUGS RLB/ADL index of 14-18  
9033 = Medium rehabilitation-  
RUGS RMA/ADL index of 4-7  
9034 = Medium rehabilitation-  
RUGS RMB/ADL index of 8-14  
9035 = Medium rehabilitation-  
RUGS RMC/ADL index of 15-18  
9036 = High rehabilitation-  
RUGS RHA/ADL index of 4-7

9037 = High rehabilitation-  
RUGS RHB/ADL index of 8-12  
9038 = High rehabilitation-  
RUGS RHC/ADL index of 13-18  
9039 = Very High rehabilitation-  
RUGS RVA/ADL index of 4-8  
9040 = Very high rehabilitation-  
RUGS RVB/ADL index of 9-15  
9041 = Very high rehabilitation-  
RUGS RVC/ADL index of 16  
9042 = Very high rehabilitation-  
RUGS RUA/ADL index of 4-8  
9043 = Very high rehabilitation-  
RUGS RUB/ADL index of 9-15  
9044 = Ultra high rehabilitation-  
RUGS RUC/ADL index of 16-18

YES\_NO\_TB

Yes/No Table

Y = Yes  
N = No

08/01/2011

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