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 CMS RIF REPORT  
 AS OF: 08/01/2011

NAME	LENGTH	BEG	END	CONTENTS
-----				
*** FI Inpatient SNF Claim Record (NCH)				
	VAR	1	16554	REC
				Fiscal intermediary inpatient/SNF claim record for version J of the NCH.
				STANDARD ALIAS : FI_IP_SNF_CLM_REC SYSTEM ALIAS : UTLIPSNJ
				LIMITATIONS :
				REFER TO :
				CHOICES_DEMO_LIM
				CLM_POA_IND_CD_LIM
				CLM_SNF_VRSN_I_REC_LIM
				CLM_TRANS_CD_LIM
				HHA_HCPCS_LIM
				IP_IME_GME_LIM
				MCO_PD_SW_LIM
				MLTPL_REV_CNTR_0001_CD_LIM
				PMT_AMT_EXCEDG_CHRG_AMT_LIM
				PPS_CPTL_DRG_WT_NUM_LIM
				PPS_CPTL_DSCHRG_FRCTN_PCT_LIM
				REV_CNTR_IDE_NDC_UPC_LIM
				REV_CNTR_TOT_CHRG_AMT_LIM
				TOT_CHRG_AMT_LIM
1. FI Inpatient SNF Claim Fixed Group				
	861	1	861	GRP
				Fixed portion of the fiscal intermediary inpatient/SNF claim record for version J of the NCH nearline file.
				STANDARD ALIAS : FI_IP_SNF_CLM_FIX_GRP
2. Claim Record Identification Group				
	8	1	8	GRP
				Effective with Version 'I' the record length, version code, record identification, code and NCH derived claim type code were moved

to this group for internal NCH processing.

STANDARD ALIAS : CLM\_REC\_IDENT\_GRP

3. Record Length Count

3 1 3

PACK

Effective with Version H, the count (in bytes)  
of the length of the claim record.

NOTE: During the Version H conversion this field  
was populated with data throughout history  
(back to service year 1991).

DB2 ALIAS : REC\_LNGTH\_CNT

SAS ALIAS : REC\_LEN

STANDARD ALIAS : REC\_LNGTH\_CNT

LENGTH : 5 SIGNED : Y

SOURCE : NCH

4. NCH Near-Line Record Version Code

1 4 4

CHAR

The code indicating the record version of the Nearline file  
where the institutional, carrier or DMERC claims data are  
stored.

DB2 ALIAS : NCH\_REC\_VRSN\_CD

SAS ALIAS : REC\_LVL

STANDARD ALIAS : NCH\_NEAR\_LINE\_REC\_VRSN\_CD

TITLE ALIAS : NCH\_VERSION

LENGTH : 1

COMMENTS :

Prior to Version H this field was named:

CLM\_NEAR\_LINE\_REC\_VRSN\_CD.

SOURCE : NCH

CODE TABLE : NCH\_NEAR\_LINE\_REC\_VRSN\_TB

5. NCH Near Line Record Identification Code

1 5 5

CHAR

A code defining the type of claim record being processed.

COMMON ALIAS : RIC

DB2 ALIAS : NEAR\_LINE\_RIC\_CD  
SAS ALIAS : RIC\_CD  
STANDARD ALIAS : NCH\_NEAR\_LINE\_RIC\_CD  
TITLE ALIAS : RIC

LENGTH : 1

COMMENTS :  
Prior to Version H this field was named:  
RIC\_CD.

SOURCE : NCH

CODE TABLE : NCH\_NEAR\_LINE\_RIC\_TB

6. NCH MQA RIC Code

1 6 6 CHAR

Effective with Version H, the code used (for internal editing purposes) to identify the record being processed through CMS' CWFMQA system.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : NCH\_MQA\_RIC\_CD  
SAS ALIAS : MQA\_RIC  
STANDARD ALIAS : NCH\_MQA\_RIC\_CD  
TITLE ALIAS : MQA\_RIC

LENGTH : 1

SOURCE : NCH QA PROCESS

CODE TABLE : NCH\_MQA\_RIC\_TB

7. NCH Claim Type Code

2 7 8 CHAR

The code used to identify the type of claim record being processed in NCH.

NOTE1: During the Version H conversion this field was populated with data throughout history (back to service year 1991).

NOTE2: During the Version I conversion this field was expanded to include inpatient 'full' encounter claims (for service dates after 6/30/97).

NOTE3: Effective with Version 'J', 3 new code values have been added to include a type code for the Medicare Advantage claims (IME/GME, no-pay and paid as FFS). During the Version 'J' conversion, these type codes were populated throughout history. With Version 'J', these claims are also being stored in NMUD. Prior to Version 'J' they were only in the NCH. No history was converted in NMUD.

DB2        ALIAS : NCH\_CLM\_TYPE\_CD  
SAS        ALIAS : CLM\_TYPE  
STANDARD ALIAS : NCH\_CLM\_TYPE\_CD  
TITLE     ALIAS : CLAIM\_TYPE

LENGTH        : 2

DERIVATIONS :

FFS CLAIM TYPE CODES DERIVED FROM:

NCH CLM\_NEAR\_LINE\_RIC\_CD  
NCH PMT\_EDIT\_RIC\_CD  
NCH CLM\_TRANS\_CD  
NCH PRVDR\_NUM

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:

(Pre-HDC processing -- AVAILABLE IN NCH)  
CLM\_MCO\_PD\_SW  
CLM\_RLT\_COND\_CD  
MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD  
MCO\_PRD\_EFCTV\_DT  
MCO\_PRD\_TRMNTN\_DT

DERIVATION RULES:

SET CLM\_TYPE\_CD TO 10 (HHA CLAIM) WHERE THE  
FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V','W' OR 'U'  
2. PMT\_EDIT\_RIC\_CD EQUAL 'F'  
3. CLM\_TRANS\_CD EQUAL '5'

SET CLM\_TYPE\_CD TO 20 (SNF NON-SWING BED CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'  
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'  
3. CLM\_TRANS\_CD EQUAL '0' OR '4'  
4. POSITION 3 OF PRVDR\_NUM IS NOT 'U', 'W', 'Y'  
OR 'Z'

SET CLM\_TYPE\_CD TO 30 (SNF SWING BED CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'
3. CLM\_TRANS\_CD EQUAL '0' OR '4'
4. POSITION 3 OF PRVDR\_NUM EQUAL 'U', 'W', 'Y' OR 'Z'

SET CLM\_TYPE\_CD TO 40 (OUTPATIENT CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'W'
2. PMT\_EDIT\_RIC\_CD EQUAL 'D'
3. CLM\_TRANS\_CD EQUAL '6'

SET CLM\_TYPE\_CD TO 50 (HOSPICE CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'
2. PMT\_EDIT\_RIC\_CD EQUAL 'I'
3. CLM\_TRANS\_CD EQUAL 'H'

SET CLM\_TYPE\_CD TO 60 (INPATIENT CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'
3. CLM\_TRANS\_CD EQUAL '1' '2' OR '3'

SET CLM\_TYPE\_CD TO 61 (INPATIENT 'FULL' ENCOUNTER  
CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 -  
12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_MCO\_PD\_SW = '1'
2. CLM\_RLT\_COND\_CD = '04'
3. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = 'C'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS

SET CLM\_TYPE\_CD TO 61 (INPATIENT 'FULL' ENCOUNTER  
CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE  
FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'
3. CLM\_TRANS\_CD EQUAL '1' '2' OR '3'
4. FI\_NUM = 80881

SET CLM\_TYPE\_CD TO 62 (Medicare Advantage IME/GME  
CLAIMS - 10/1/05 - FORWARD)

WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_MCO\_PD\_SW = '0'
2. CLM\_RLT\_COND\_CD = '04' & '69'
3. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = 'C'

CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS

SET CLM\_TYPE\_CD TO 63 (HMO NO-PAY CLAIMS)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
CLAIMS PROCESSED ON OR AFTER 10/6/08  
1. CLM\_THRU\_DT ON OR AFTER 10/1/06  
2. CLM\_MCO\_PD\_SW = '1'  
3. CLM\_RLT\_COND\_CD = '04'  
4. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = 'A', 'B' OR 'C'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS  
5. ZERO REIMBURSEMENT (CLM\_PMT\_AMT)

SET CLM\_TYPE\_CD TO 63 (HMO NO-PAY CLAIMS)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
CLAIMS PROCESSED PRIOR to 10/6/08  
1. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = 'A', 'B' OR 'C'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS  
2. ZERO REIMBURSEMENT (CLM\_PMT\_AMT)

SET CLM\_TYPE\_CD TO 64 (HMO CLAIMS PAID AS FFS)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
CLAIMS PROCESSED PRIOR to 10/6/08  
1. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = '1', '2' OR '4'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS

SET CLM\_TYPE\_CD TO 64 (HMO CLAIMS PAID AS FFS)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
CLAIMS PROCESSED on or after 10/6/08  
1. CLM\_RLT\_COND\_CD = '04'  
2. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = '1', '2' OR '4'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS

SET CLM\_TYPE\_CD TO 71 (RIC O non-DMEPOS CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'O'

2. HCPCS\_CD not on DMEPOS table

SET CLM\_TYPE\_CD TO 72 (RIC O DMEPOS CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'O'
2. HCPCS\_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).

SET CLM\_TYPE\_CD TO 81 (RIC M non-DMEPOS DMERC CLAIM)

WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'M'
2. HCPCS\_CD not on DMEPOS table

SET CLM\_TYPE\_CD TO 82 (RIC M DMEPOS DMERC CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'M'
2. HCPCS\_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).

SOURCE : NCH

CODE TABLE : NCH\_CLM\_TYPE\_TB

8. Fiscal Intermediary Claim Link Group  
125 9 133

GRP

Effective with Version 'I', this group contains those fields necessary to keep segments together (a claim may have up to 10 segments due to the increase in number of revenue center trailers (up to 450). It is also used to house fields necessary for sorting and the final action process.

STANDARD ALIAS : FI\_CLM\_LINK\_GRP

9. Claim Locator Number Group  
11 9 19

GRP

This number uniquely identifies the beneficiary in the NCH Nearline.

COMMON ALIAS : HIC

STANDARD ALIAS : CLM\_LCTR\_NUM\_GRP

TITLE ALIAS : HICAN

10. Beneficiary Claim Account Number  
9 9 17

CHAR

The number identifying the primary beneficiary under the SSA or RRB programs submitted.

COMMON ALIAS : CAN  
DB2 ALIAS : BENE\_CLM\_ACNT\_NUM  
SAS ALIAS : CAN  
STANDARD ALIAS : BENE\_CLM\_ACNT\_NUM  
TITLE ALIAS : CAN

LENGTH : 9

SOURCE : SSA,RRB

LIMITATIONS :  
RRB-issued numbers contain an overpunch in the first position that may appear as a plus zero or A-G. RRB-formatted numbers may cause matching problems on non-IBM machines.

11. NCH Category Equatable Beneficiary Identification Code  
2 18 19

CHAR

The code categorizing groups of BICs representing similar relationships between the beneficiary and the primary wage earner.

The equatable BIC module electronically matches two records that contain different BICs where it is apparent that both are records for the same beneficiary. It validates the BIC and returns a base BIC under which to house the record in the National Claims History (NCH) databases. (All records for a beneficiary are stored under a single BIC.)

COMMON ALIAS : NCH\_BASE\_CATEGORY\_BIC  
DB2 ALIAS : CTGRY\_EQTBL\_BIC  
SAS ALIAS : EQ\_BIC  
STANDARD ALIAS : NCH\_CTGRY\_EQTBL\_BIC\_CD  
TITLE ALIAS : EQUATED\_BIC

LENGTH : 2

COMMENTS :  
Prior to Version H this field was named:  
CTGRY\_EQTBL\_BENE\_IDENT\_CD.



				SOURCE	: BIC EQUATE MODULE
				CODE TABLE	: CTGRY_EQTBL_BENE_IDENT_TB
12.	Beneficiary Identification Code	2	20	21	CHAR
					The code identifying the type of relationship between an individual and a primary Social Security Administration (SSA) beneficiary or a primary Railroad Board (RRB) beneficiary.
				COMMON	ALIAS : BIC
				DA3	ALIAS : BENE_IDENT_CODE
				DB2	ALIAS : BENE_IDENT_CD
				SAS	ALIAS : BIC
				STANDARD	ALIAS : BENE_IDENT_CD
				TITLE	ALIAS : BIC
				LENGTH	: 2
				SOURCE	: SSA/RRB
				EDIT RULES :	
					EDB REQUIRED FIELD
				CODE TABLE	: BENE_IDENT_TB
13.	NCH State Segment Code	1	22	22	CHAR
					The code identifying the segment of the NCH Nearline file containing the beneficiary's record for a specific service year. Effective 12/96, segmentation is by CLM_LCTR_NUM, then final action sequence within residence state. (Prior to 12/96, segmentation was by ranges of county codes within the residence state.)
				DB2	ALIAS : NCH_STATE_SGMT_CD
				SAS	ALIAS : ST_SGMT
				STANDARD	ALIAS : NCH_STATE_SGMT_CD
				TITLE	ALIAS : NEAR_LINE_SEGMENT
				LENGTH	: 1
				COMMENTS :	
					Prior to Version H this field was named: BENE_STATE_SGMT_NEAR_LINE_CD.

SOURCE : NCH

CODE TABLE : NCH\_STATE\_SGMT\_TB

14. Beneficiary Residence SSA Standard State Code

2 23 24 CHAR

The SSA standard state code of a beneficiary's residence.

DA3 ALIAS : SSA\_STANDARD\_STATE\_CODE  
DB2 ALIAS : BENE\_SSA\_STATE\_CD  
SAS ALIAS : STATE\_CD  
STANDARD ALIAS : BENE\_RSDNC\_SSA\_STD\_STATE\_CD  
TITLE ALIAS : BENE\_STATE\_CD

LENGTH : 2

COMMENTS :

1. Used in conjunction with a county code, as selection criteria for the determination of payment rates for HMO reimbursement.
2. Concerning individuals directly billable for Part B and/or Part A premiums, this element is used to determine if the beneficiary will receive a bill in English or Spanish.
3. Also used for special studies.

SOURCE : SSA/EDB

EDIT RULES :

OPTIONAL: MAY BE BLANK

CODE TABLE : GEO\_SSA\_STATE\_TB

15. Claim From Date

8 25 32 NUM

The first day on the billing statement covering services rendered to the beneficiary (a.k.a. 'Statement Covers From Date').

NOTE: For Home Health PPS claims, the 'from' date and the 'thru' date on the RAP (initial claim) must always match.

DB2 ALIAS : CLM\_FROM\_DT  
SAS ALIAS : FROM\_DT  
STANDARD ALIAS : CLM\_FROM\_DT  
TITLE ALIAS : FROM\_DATE

				LENGTH	: 8	SIGNED : N
				SOURCE	: CWF	
				EDIT RULES :		
					YYYYMMDD	
16.	Claim Through Date	8	33	40	NUM	
					The last day on the billing statement covering services rendered to the beneficiary (a.k.a 'Statement Covers Thru Date').	
					NOTE: For Home Health PPS claims, the 'from' date and the 'thru' date on the RAP (initial claim) must always match.	
				DB2	ALIAS :	CLM_THRU_DT
				SAS	ALIAS :	THRU_DT
				STANDARD	ALIAS :	CLM_THRU_DT
				TITLE	ALIAS :	THRU_DATE
				LENGTH	: 8	SIGNED : N
				SOURCE	: CWF	
				EDIT RULES :		
					YYYYMMDD	
17.	NCH Weekly Claim Processing Date	8	41	48	NUM	
					The date the weekly NCH database load process cycle begins, during which the claim records are loaded into the Nearline file. This date will always be a Friday, although the claims will actually be appended to the database subsequent to the date.	
				DB2	ALIAS :	NCH_WKLY_PROC_DT
				SAS	ALIAS :	WKLY_DT
				STANDARD	ALIAS :	NCH_WKLY_PROC_DT
				TITLE	ALIAS :	NCH_PROCESS_DT
				LENGTH	: 8	SIGNED : N
				COMMENTS :		
					Prior to Version H this field was named: HCFA_CLM_PROC_DT.	

SOURCE : NCH

EDIT RULES :  
YYYYMMDD

18. CWF Claim Accretion Date

8 49 56 NUM

The date the claim record is accreted (posted/  
processed) to the beneficiary master record  
at the CWF host site and authorization for  
payment is returned to the fiscal interme-  
diary or carrier.

DB2 ALIAS : CWF\_CLM\_ACRTN\_DT  
SAS ALIAS : ACRTN\_DT  
STANDARD ALIAS : CWF\_CLM\_ACRTN\_DT  
TITLE ALIAS : ACCRETION\_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

19. CWF Claim Accretion Number

2 57 58 PACK

The sequence number assigned to the claim  
record when accreted (posted/processed) to  
the beneficiary master record at the CWF host  
site on a given date. This element indicates  
the position of the claim within that day's  
processing at the CWF host. \*\*(Exception: If  
the claim record is missing the accretion date  
CMS' CWFMQA system places a zero in the  
accretion number.

DB2 ALIAS : CWF\_CLM\_ACRTN\_NUM  
SAS ALIAS : ACRTN\_NM  
STANDARD ALIAS : CWF\_CLM\_ACRTN\_NUM  
TITLE ALIAS : ACCRETION\_NUMBER

LENGTH : 3 SIGNED : Y

SOURCE : CWF

20. FI Document Claim Control Number

	23	59	81	CHAR	
				Unique control number assigned by an intermediary to an institutional claim.	
				COMMON ALIAS : ICN	
				DB2 ALIAS : DOC_CLM_CNTL_NUM	
				SAS ALIAS : CLM_CNTL	
				STANDARD ALIAS : FI_DOC_CLM_CNTL_NUM	
				TITLE ALIAS : ICN	
				LENGTH : 23	
				SOURCE : CWF	
21. FI Original Claim Control Number	23	82	104	CHAR	
				Effective with Version G, the original intermediary control number (ICN) which is present on adjustment claims, representing the ICN of the original transaction now being adjusted.	
				COMMON ALIAS : ORIGINAL_ICN	
				DB2 ALIAS : ORIG_CLM_CNTL_NUM	
				SAS ALIAS : ORIGCNTL	
				STANDARD ALIAS : FI_ORIG_CLM_CNTL_NUM	
				TITLE ALIAS : ORIGINAL_ICN	
				LENGTH : 23	
				SOURCE : CWF	
22. Claim Query Code	1	105	105	CHAR	
				Code indicating the type of claim record being processed with respect to payment (debit/credit indicator; interim/final indicator).	
				DB2 ALIAS : CLM_QUERY_CD	
				SAS ALIAS : QUERY_CD	
				STANDARD ALIAS : CLM_QUERY_CD	
				TITLE ALIAS : QUERY_CD	
				LENGTH : 1	
				SOURCE : CWF	
				CODE TABLE : CLM_QUERY_TB	

23. Provider Number

6 106 111

CHAR

The identification number of the institutional provider certified by Medicare to provide services to the beneficiary.

NOTE: Effective October 1, 2007 the OSCAR Provider Number has been renamed the CMS Certification Number (CCN). The name was changed to avoid confusion with the National Provider Identifier (NPI). The CCN (OSCAR Provider Number) will continue to play a critical role in verifying that a provider has been Medicare certified and for what type of services.

DB2 ALIAS : PRVDR\_NUM  
SAS ALIAS : PROVIDER  
STANDARD ALIAS : PRVDR\_NUM  
TITLE ALIAS : PROVIDER\_NUMBER

LENGTH : 6

CODE TABLE : PRVDR\_NUM\_TB

24. NCH Daily Process Date

8 112 119

NUM

Effective with Version H, the date the claim record was processed by CMS' CWFMQA system (used for internal editing purposes).

Effective with Version I, this date is used in conjunction with the NCH Segment Link Number to keep claims with multiple records/ segments together.

NOTE1: With Version 'H' this field was populated with data beginning with NCH weekly process date 10/3/97. Under Version 'I' claims prior to 10/3/97, that were blank under Version 'H', were populated with a date.

DB2 ALIAS : NCH\_DAILY\_PROC\_DT  
SAS ALIAS : DAILY\_DT  
STANDARD ALIAS : NCH\_DAILY\_PROC\_DT  
TITLE ALIAS : DAILY\_PROCESS\_DT

LENGTH : 8 SIGNED : N

SOURCE : NCH

EDIT RULES :  
YYYYMMDD

25. NCH Segment Link Number

5 120 124 PACK

Effective with Version 'I', the system generated number used in conjunction with the NCH daily process date to keep records/segments belonging to a specific claim together. This field was added to ensure that records/segments that come in on the same batch with the same identifying information in the link group are not mixed with each other.

NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991).

DB2 ALIAS : NCH\_SGMT\_LINK\_NUM  
SAS ALIAS : LINK\_NUM  
STANDARD ALIAS : NCH\_SGMT\_LINK\_NUM  
TITLE ALIAS : LINK\_NUM

LENGTH : 9 SIGNED : Y

SOURCE : NCH

26. Claim Total Segment Count

2 125 126 NUM

Effective with Version I, the count used to identify the total number of segments associated with a given claim. Each claim could have up to 10 segments.

NOTE: During the Version I conversion, this field was populated with data throughout history (back to service year 1991). For institutional claims, the count for claims prior to 7/00 will be 1 or 2 (1 if 45 or less revenue center lines on a claim and 2 if more than 45 revenue center lines on a claim). For noninstitutional claims, the count will always be 1.

DB2 ALIAS : TOT\_SGMT\_CNT  
SAS ALIAS : SGMT\_CNT  
STANDARD ALIAS : CLM\_TOT\_SGMT\_CNT

				TITLE      ALIAS : SEGMENT_COUNT  LENGTH        : 2      SIGNED : N  SOURCE        : CWF
27. Claim Segment Number	2	127	128	NUM  Effective with Version I, the number used to identify an actual record/segment (1 - 10) associated with a given claim.  NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991). For institutional claims prior to 7/00, this number will be either 1 or 2. For noninstitutional claims, the number will always be 1.  DB2          ALIAS : CLM_SGMT_NUM SAS          ALIAS : SGMT_NUM STANDARD ALIAS : CLM_SGMT_NUM TITLE      ALIAS : SEGMENT_NUMBER  LENGTH        : 2      SIGNED : N  SOURCE        : CWF
28. Claim Total Line Count	3	129	131	NUM  Effective with Version I, the count used to identify the total number of revenue center lines associated with the claim.  NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991). Prior to Version 'I', the maximum line count will be no more than 58. Effective with Version 'I', the maximum line count could be 450.  DB2          ALIAS : TOT_LINE_CNT SAS          ALIAS : LINECNT STANDARD ALIAS : CLM_TOT_LINE_CNT TITLE      ALIAS : TOTAL_LINE_COUNT  LENGTH        : 3      SIGNED : N



				SOURCE	: CWF
29. Claim Segment Line Count	2	132	133	NUM	
				Effective with Version I, the count used to identify the number of lines on a record/segment.	
				NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991). The maximum line count per record/segment on the revenue center trailer is 45. The maximum number of lines on carrier and DMERC claims are 13.	
				DB2	ALIAS : SGMT_LINE_CNT
				SAS	ALIAS : SGMTLINE
				STANDARD	ALIAS : CLM_SGMT_LINE_CNT
				TITLE	ALIAS : SEGMENT_LINE_COUNT
				LENGTH	: 2 SIGNED : N
				SOURCE	: CWF
30. FI Claim Common Group	382	134	515	GRP	
				Information common to fiscal intermediary (FI) claims (inpatient/SNF, outpatient, HHA & hospice), for version J of NCH Nearline file.	
				STANDARD ALIAS : FI_CLM_CMN_GRP	
31. NCH Payment and Edit Record Identification Code	1	134	134	CHAR	
				The code used for payment and editing purposes that indicates the type of institutional claim record. Prior to Version H this field was named: PMT_EDIT_RIC_CD.	
				DB2	ALIAS : PMT_EDIT_RIC_CD
				SAS	ALIAS : PE_RIC
				STANDARD	ALIAS : NCH_PMT_EDIT_RIC_CD
				TITLE	ALIAS : NCH_PAYMENT_EDIT_RIC

				LENGTH	: 1
				SOURCE	: NCH QA Process
				CODE TABLE	: PMT_EDIT_RIC_TB
32. Claim Transaction Code	1	135	135	CHAR	
				The code derived by CWF to indicate the type of claim submitted by an institutional provider.	
				DB2	ALIAS : CLM_TRANS_CD
				SAS	ALIAS : TRANS_CD
				STANDARD	ALIAS : CLM_TRANS_CD
				TITLE	ALIAS : TRANSACTION_CODE
				LENGTH	: 1
				SOURCE	: CWF
				LIMITATIONS :	
				REFER TO :	
				CLM_TRANS_CD_LIM	
				CODE TABLE	: CLM_TRANS_TB
33. Claim Bill Type Group	2	136	137	GRP	
				Effective with Version H, the claim facility type code plus the claim service classification type code. (The first two positions of the ('type of bill')). During the Version H conversion, this grouping was created throughout history.	
				NOTE: Effective 4/1/2002, TOB code 'XX0' was implemented to identify those claims that are totally non-covered.	
				STANDARD ALIAS : CLM_BILL_TYPE_CD_GRP	
				CODE TABLE	: CLM_BILL_TYPE_TB
34. Claim Facility Type Code	1	136	136	CHAR	
				The first digit of the type of bill (TOB1) submitted on an institutional claim used to identify the type of facility	

that provided care to the beneficiary.

COMMON ALIAS : TOB1  
DB2 ALIAS : CLM\_FAC\_TYPE\_CD  
SAS ALIAS : FAC\_TYPE  
STANDARD ALIAS : CLM\_FAC\_TYPE\_CD  
TITLE ALIAS : TOB1

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM\_FAC\_TYPE\_TB

35. Claim Service Classification Type Code  
1 137 137

CHAR

The second digit of the type of bill (TOB2) submitted on an institutional claim record to indicate the classification of the type of service provided to the beneficiary.

COMMON ALIAS : TOB2  
DB2 ALIAS : SRVC\_CLSFCTN\_CD  
SAS ALIAS : TYPESRVC  
STANDARD ALIAS : CLM\_SRVC\_CLSFCTN\_TYPE\_CD  
TITLE ALIAS : TOB2

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM\_SRVC\_CLSFCTN\_TYPE\_TB

36. Claim Frequency Code  
1 138 138

CHAR

The third digit of the type of bill (TOB3) submitted on an institutional claim record to indicate the sequence of a claim in the beneficiary's current episode of care.

COMMON ALIAS : TOB3  
DB2 ALIAS : CLM\_FREQ\_CD  
SAS ALIAS : FREQ\_CD  
STANDARD ALIAS : CLM\_FREQ\_CD  
TITLE ALIAS : FREQUENCY\_CD

LENGTH : 1

SOURCE : CWF

				CODE TABLE	: CLM_FREQ_TB
37. FILLER	1	139	139	CHAR	
				DB2	ALIAS : FILLER
				LENGTH	: 1
38. NCH MQA Query Patch Code	1	140	140	CHAR	
					Effective with Version H, a code used (for internal editing purposes) to indicate that the CWFMQA process changed the query code submitted on the claim record.
					NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.
				DB2	ALIAS : MQA_QUERY_PATCH_CD
				SAS	ALIAS : MQAQUERY
				STANDARD	ALIAS : NCH_MQA_QUERY_PATCH_CD
				TITLE	ALIAS : MQA_QUERY_PATCH_IND
				LENGTH	: 1
				SOURCE	: NCH QA Process
				CODE TABLE	: NCH_MQA_QUERY_PATCH_TB
39. Claim Disposition Code	2	141	142	CHAR	
					Code indicating the disposition or outcome of the processing of the claim record.
				DB2	ALIAS : CLM_DISP_CD
				SAS	ALIAS : DISP_CD
				STANDARD	ALIAS : CLM_DISP_CD
				TITLE	ALIAS : DISPOSITION_CD
				LENGTH	: 2
				SOURCE	: CWF
				CODE TABLE	: CLM_DISP_TB
40. NCH Edit Disposition Code	2	143	144	CHAR	

Effective with Version H, a code used (for internal editing purposes) to indicate the disposition of the claim after editing in the CWFMQA process.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : NCH\_EDIT\_DISP\_CD  
SAS ALIAS : EDITDISP  
STANDARD ALIAS : NCH\_EDIT\_DISP\_CD  
TITLE ALIAS : NCH\_EDIT\_DISP

LENGTH : 2

SOURCE : NCH QA Process

CODE TABLE : NCH\_EDIT\_DISP\_TB

41. NCH Claim BIC Modify H Code  
1 145 145

CHAR

Effective with Version H, the code used (for internal editing purposes) to identify a claim record that was submitted with an incorrect HA, HB, or HC BIC.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : NCH\_BIC\_MDFY\_CD  
SAS ALIAS : BIC\_MDFY  
STANDARD ALIAS : NCH\_CLM\_BIC\_MDFY\_CD  
TITLE ALIAS : BIC\_MODIFY\_CD

LENGTH : 1

SOURCE : NCH QA Process

CODE TABLE : NCH\_CLM\_BIC\_MDFY\_TB

42. Beneficiary Residence SSA Standard County Code  
3 146 148 CHAR

The SSA standard county code of a beneficiary's residence.

DB2 ALIAS : BENE\_SSA\_CNTY\_CD  
SAS ALIAS : CNTY\_CD  
STANDARD ALIAS : BENE\_RSDNC\_SSA\_STD\_CNTY\_CD

TITLE ALIAS : BENE\_COUNTY\_CD

LENGTH : 3

SOURCE : SSA/EDB

EDIT RULES :  
OPTIONAL: MAY BE BLANK

43. FI Claim Receipt Date

8 149 156

NUM

The date the fiscal intermediary received the institutional claim from the provider.

DB2 ALIAS : FI\_CLM\_RCPT\_DT

SAS ALIAS : RCPT\_DT

STANDARD ALIAS : FI\_CLM\_RCPT\_DT

TITLE ALIAS : RECEIPT\_DT

LENGTH : 8 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
FICARR\_CLM\_RCPT\_DT.

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

44. FI Claim Scheduled Payment Date

8 157 164

NUM

The scheduled date of payment to the institutional provider, as reflected on the claim record transmitted to the CWF host. Note: This date is considered to be the date paid since no additional information as to the actual payment date is available.

DB2 ALIAS : FI\_SCHLD\_PMT\_DT

SAS ALIAS : SCHLD\_DT

STANDARD ALIAS : FI\_CLM\_SCHLD\_PMT\_DT

TITLE ALIAS : SCHEDULED\_PMT\_DT

LENGTH : 8 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:

FICARR\_CLM\_PMT\_DT.

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

45. CWF Forwarded Date

8 165 172

NUM

Effective with Version H, the date CWF forwarded the claim record to CMS (used for internal editing purposes).

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

DB2 ALIAS : CWF\_FRWRD\_DT  
SAS ALIAS : FRWRD\_DT  
STANDARD ALIAS : CWF\_FRWRD\_DT  
TITLE ALIAS : FORWARD\_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

46. FI Number

5 173 177

CHAR

The identification number assigned by CMS to a fiscal intermediary authorized to process institutional claim records.

Effective October 2006, the Medicare Administrative Contractors (MACs) began replacing the existing fiscal intermediaries and started processing institutional claim records for states assigned to its jurisdiction.

NOTE: The 5-position MAC number will be housed in the existing FI\_NUM field. During the transition from an FI to a MAC the FI\_NUM field could contain either a FI number or a MAC number. See the FI\_NUM table of codes to identify the new MAC numbers and their effective dates.

DB2 ALIAS : FI\_NUM

SAS ALIAS : FI\_NUM  
STANDARD ALIAS : FI\_NUM  
TITLE ALIAS : INTERMEDIARY

LENGTH : 5

COMMENTS :  
Prior to Version H this field was named:  
FICARR\_IDENT\_NUM.

SOURCE : CWF

CODE TABLE : FI\_NUM\_TB

47. CWF Claim Assigned Number  
8 178 185

CHAR

Effective with Version H, the number assigned  
to an institutional claim record by CWF (used  
for internal editing purposes).

NOTE: Beginning with NCH weekly process date  
10/3/97 this field was populated with  
data. Claims processed prior to 10/3/97  
will contain spaces in this field.

DB2 ALIAS : CWF\_CLM\_ASGN\_NUM  
SAS ALIAS : ASGN\_NUM  
STANDARD ALIAS : CWF\_CLM\_ASGN\_NUM  
TITLE ALIAS : ASSIGNED\_NUM

LENGTH : 8

SOURCE : CWF

48. CWF Transmission Batch Number  
4 186 189

CHAR

Effective with Version H, the number assigned  
to each batch of claims transactions sent from  
CWF(used for internal editing purposes).

NOTE: Beginning 11/98, this field will be  
populated with data. Claims processed  
prior to 11/98 will contain spaces in  
this field.

DB2 ALIAS : TRNSMSN\_BATCH\_NUM  
SAS ALIAS : FIBATCH  
STANDARD ALIAS : CWF\_TRNSMSN\_BATCH\_NUM



				TITLE	ALIAS : BATCH_NUM
				LENGTH	: 4
				SOURCE	: CWF
49.	Beneficiary Mailing Contact ZIP Code	9	190	198	CHAR
					The ZIP code of the mailing address where the beneficiary may be contacted.
				DB2	ALIAS : BENE_MLG_ZIP_CD
				SAS	ALIAS : BENE_ZIP
				STANDARD	ALIAS : BENE_MLG_CNTCT_ZIP_CD
				TITLE	ALIAS : BENE_ZIP
				LENGTH	: 9
				SOURCE	: EDB
50.	Beneficiary Sex Identification Code	1	199	199	CHAR
					The sex of a beneficiary.
				COMMON	ALIAS : SEX_CD
				DA3	ALIAS : SEX_CODE
				DB2	ALIAS : BENE_SEX_IDENT_CD
				SAS	ALIAS : SEX
				STANDARD	ALIAS : BENE_SEX_IDENT_CD
				TITLE	ALIAS : SEX_CD
				LENGTH	: 1
				SOURCE	: SSA,RRB,EDB
				EDIT RULES :	
					REQUIRED FIELD
				CODE TABLE	: BENE_SEX_IDENT_TB
51.	Beneficiary Race Code	1	200	200	CHAR
					The race of a beneficiary.
				DA3	ALIAS : RACE_CODE
				DB2	ALIAS : BENE_RACE_CD
				SAS	ALIAS : RACE

STANDARD ALIAS : BENE\_RACE\_CD  
TITLE ALIAS : RACE\_CD  
  
LENGTH : 1  
  
SOURCE : SSA  
  
CODE TABLE : BENE\_RACE\_TB

52. Beneficiary Birth Date

8 201 208

NUM

The beneficiary's date of birth.

COMMON ALIAS : DOB  
DA3 ALIAS : BIRTH\_DATE  
DB2 ALIAS : BENE\_BIRTH\_DT  
SAS ALIAS : BENE\_DOB  
STANDARD ALIAS : BENE\_BIRTH\_DT  
TITLE ALIAS : BENE\_BIRTH\_DATE

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

53. CWF Beneficiary Medicare Status Code

2 209 210

CHAR

The CWF-derived reason for a beneficiary's entitlement to Medicare benefits, as of the reference date (CLM\_THRU\_DT).

COBOL ALIAS : MSC  
COMMON ALIAS : MSC  
DB2 ALIAS : BENE\_MDCR\_STUS\_CD  
SAS ALIAS : MS\_CD  
STANDARD ALIAS : CWF\_BENE\_MDCR\_STUS\_CD  
TITLE ALIAS : MSC

LENGTH : 2

DERIVATIONS :  
CWF derives MSC from the following:  
1. Date of Birth  
2. Claim Through Date  
3. Original/Current Reasons for entitlement  
4. ESRD Indicator

5. Beneficiary Claim Number  
 Items 1,3,4,5 come from the CWF Beneficiary  
 Master Record; item 2 comes from the FI/Carrier  
 claim record. MSC is assigned as follows:

MSC	OASI	DIB	ESRD	AGE	BIC
10	YES	N/A	NO	65 and over	N/A
11	YES	N/A	YES	65 and over	N/A
20	NO	YES	NO	under 65	N/A
21	NO	YES	YES	under 65	N/A
31	NO	NO	YES	any age	T.

COMMENTS :  
 Prior to Version H this field was named:  
 BENE\_MDCR\_STUS\_CD. The name has been changed  
 to distinguish this CWF-derived field from the  
 EDB-derived MSC (BENE\_MDCR\_STUS\_CD).

SOURCE : CWF

CODE TABLE : BENE\_MDCR\_STUS\_TB

54. Claim Patient 6 Position Surname  
                                 6      211      216

CHAR

The first 6 positions of the Medicare patient's  
 surname (last name) as reported by the provider  
 on the claim.

NOTE1: Prior to Version H, this field was only  
 present on the IP/SNF claim record.  
 Effective with Version H, this field is  
 present on all claim types.

NOTE2: For OP, HHA, Hospice and all Carrier  
 claims, data was populated beginning  
 with NCH weekly process 10/3/97. Claims  
 processed prior to 10/3/97 will contain  
 spaces in this field.

COMMON ALIAS : PATIENT\_SURNAME  
 DB2 ALIAS : PTNT\_6\_PSTN\_SRNM  
 SAS ALIAS : SURNAME  
 STANDARD ALIAS : CLM\_PTNT\_6\_PSTN\_SRNM\_NAME  
 TITLE ALIAS : PATIENT\_SURNAME

LENGTH : 6

SOURCE : CWF

55. Claim Patient 1st Initial Given Name  
1 217 217

CHAR

The first initial of the Medicare patient's given name (first name) as reported by the provider on the claim.

NOTE1: Prior to Version H, this field was only present on the IP/SNF claim record. Effective with Version H, this field is present on all claim types.

NOTE2: For OP, HHA, Hospice and all Carrier claims, data was populated beginning with NCH weekly process date 10/3/97. Claims processed prior to 10/3/97 will contain spaces in this field.

COMMON ALIAS : PATIENT\_GIVEN\_NAME  
DB2 ALIAS : 1ST\_INITL\_GVN\_NAME  
SAS ALIAS : FRSTINIT  
STANDARD ALIAS : CLM\_PTNT\_1ST\_INITL\_GVN\_NAME  
TITLE ALIAS : PATIENT\_FIRST\_INITIAL

LENGTH : 1

SOURCE : CWF

56. Claim Patient First Initial Middle Name  
1 218 218

CHAR

The first initial of the Medicare patient's middle name as reported by the provider on the claim.

NOTE1: Prior to Version H, this field was only present on the IP/SNF claim record. Effective with Version H, this field is present on all claim types.

NOTE2: For OP, HHA, Hospice and all Carrier claims, data was populated beginning with NCH weekly process date 10/3/97. Claims processed prior to 10/3/97 will contain spaces in this field.

COMMON ALIAS : PATIENT\_MIDDLE\_NAME  
DB2 ALIAS : 1ST\_INITL\_MDL\_NAME  
SAS ALIAS : MDL\_INIT

				STANDARD ALIAS : CLM_PTNT_1ST_INITL_MDL_NAME
				TITLE ALIAS : PATIENT_MIDDLE_INITIAL
				LENGTH : 1
				SOURCE : CWF
57. Beneficiary CWF Location Code	1	219	219	CHAR
				The code that identifies the Common Working File (CWF) location (the host site) where a beneficiary's Medicare utilization records are maintained.
				COMMON ALIAS : CWF_HOST
				DB2 ALIAS : BENE_CWF_LOC_CD
				SAS ALIAS : CWFLOCCD
				STANDARD ALIAS : BENE_CWF_LOC_CD
				TITLE ALIAS : CWF_HOST
				LENGTH : 1
				SOURCE : CWF
				CODE TABLE : BENE_CWF_LOC_TB
58. Claim Principal Diagnosis Group	8	220	227	GRP
				Effective with Version 'J', the group used to identify the principal diagnosis code. This group contains the principal diagnosis code and the principal diagnosis version code.
				STANDARD ALIAS : CLM_PRNCPAL_DGNS_GRP
59. Claim Principal Diagnosis Version Code	1	220	220	CHAR
				Effective with Version 'J', the code used to indicate if the diagnosis is ICD-9 or ICD-10.
				NOTE: With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2013.
				DB2 ALIAS : UNDEFINED
				SAS ALIAS : PDVRSNCD

				LENGTH	: 1
				CODE TABLE	: CLM_DGNS_VRSN_TB
60.	Claim Principal Diagnosis Code	7	221	227	CHAR
					<p>The diagnosis code identifying the diagnosis, condition, problem or other reason for the admission/encounter/visit shown in the medical record to be chiefly responsible for the services provided.</p> <p>NOTE: Effective with Version H, this data is also redundantly stored as the first occurrence of the diagnosis trailer.</p> <p>NOTE1: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10.</p> <p>DB2 ALIAS : PRNCPAL_DGNS_CD</p> <p>SAS ALIAS : PDGNS_CD</p> <p>LENGTH : 7</p> <p>SOURCE : CWF</p> <p>EDIT RULES : ICD-9-CM</p>
61.	FILLER	1	228	228	CHAR
					<p>DB2 ALIAS : FILLER</p> <p>LENGTH : 1</p>
62.	Claim Medicare Non Payment Reason Code	2	229	230	CHAR
					<p>The reason that no Medicare payment is made for services on an institutional claim.</p> <p>NOTE1: This field was put on all institutional claim types but data did not start coming in on OP/HHA/Hospice until 4/1/02. Prior to 4/1/02, data only came in Inpatient/SNF claims.</p> <p>NOTE2: Effective 4/1/02, this field was also</p>

expanded to two bytes to accommodate new values.  
The NCH Nearline file did not expand the current  
1-byte field but instituted a crosswalk of the  
2-byte field to the 1-byte character value.  
See table of code for the crosswalk.

NOTE3: Effective with Version 'J', the field has been  
expanded on the NCH claim to 2 bytes. With this  
expansion the NCH will no longer use the character  
values to represent the official two byte values being  
sent in by CWF since 4/2002.

During the Version 'J' conversion, all character values  
were converted to the two byte values.

DB2 ALIAS : MDCR\_NPMT\_RSN\_CD  
SAS ALIAS : NOPAY\_CD

LENGTH : 2

CODE TABLE : CLM\_MDCR\_NPMT\_RSN\_TB

63. Claim Excepted/Nonexcepted Medical Treatment Code  
1 231 231 CHAR

Effective with Version I, the code used to identify  
whether or not the medical care or treatment received  
by a beneficiary, who has elected care from a  
Religious Nonmedical Health Care Institution (RNHCI),  
is excepted or nonexcepted. Excepted is medical care  
or treatment that is received involuntarily or is re-  
quired under Federal, State or local law. Nonexcepted is  
defined as medical care or treatment other than excepted.

DB2 ALIAS : EXCPTD\_NEXCPTD\_CD  
SAS ALIAS : TRTMT\_CD  
STANDARD ALIAS : CLM\_EXCPTD\_NEXCPTD\_TRTMT\_CD  
TITLE ALIAS : EXCPTD\_NEXCPTD\_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM\_EXCPTD\_NEXCPTD\_TRTMT\_TB

64. Claim Payment Amount  
6 232 237 PACK

Amount of payment made from the Medicare trust fund for the  
services covered by the claim record. Generally, the amount

is calculated by the FI or carrier; and represents what was paid to the institutional provider, physician, or supplier, with the exceptions noted below. \*\*NOTE: In some situations, a negative claim payment amount may be present; e.g., (1) when a beneficiary is charged the full deductible during a short stay and the deductible exceeded the amount Medicare pays; or (2) when a beneficiary is charged a coinsurance amount during a long stay and the coinsurance amount exceeds the amount Medicare pays (most prevalent situation involves psych hospitals who are paid a daily per diem rate no matter what the charges are.)

Under IP PPS, inpatient hospital services are paid based on a predetermined rate per discharge, using the DRG patient classification system and the PRICER program. On the IP PPS claim, the payment amount includes the DRG outlier approved payment amount, disproportionate share (since 5/1/86), indirect medical education (since 10/1/88), total PPS capital (since 10/1/91). After 4/1/03, the payment amount could also include a "new technology" add-on amount. It does NOT include the pass-thru amounts (i.e., capital-related costs, direct medical education costs, kidney acquisition costs, bad debts); or any beneficiary-paid amounts (i.e., deductibles and coinsurance); or any other payer reimbursement.

Under IRFPPS, inpatient rehabilitation services are paid based on a predetermined rate per discharge, using the Case Mix Group (CMG) classification system and the PRICER program. From the CMG on the IRF PPS claim, payment is based on a standard payment amount for operating and capital cost for that facility (including routine and ancillary services). The payment is adjusted for wage, the % of low-income patients (LIP), locality, transfers, interrupted stays, short stay cases, deaths, and high cost outliers. Some or all of these adjustments could apply. The CMG payment does NOT include certain pass-through costs (i.e. bad debts, approved education activities); beneficiary-paid amounts, other payer reimbursement, and other services outside of the scope of PPS.

Under LTCH PPS, long term care hospital services are paid based on a predetermined rate per discharge based on the DRG and the PRICER program. Payments are based on a single standard Federal rate for both inpatient operating and capital-related costs (including routine and ancillary services), but do NOT include certain pass-through costs (i.e. bad debts, direct medical education, new technologies and blood clotting factors). Adjustments to the payment may occur due to short-stay outliers, interrupted stays,



high cost outliers, wage index, and cost of living adjustments.

Under SNF PPS, SNFs will classify beneficiaries using the patient classification system known as RUGS III. For the SNF PPS claim, the SNF PRICER will calculate/return the rate for each revenue center line item with revenue center code = '0022'; multiply the rate times the units count; and then sum the amount payable for all lines with revenue center code '0022' to determine the total claim payment amount.

Under Outpatient PPS, the national ambulatory payment classification (APC) rate that is calculated for each APC group is the basis for determining the total claim payment. The payment amount also includes the outlier payment and interest.

Under Home Health PPS, beneficiaries will be classified into an appropriate case mix category known as the Home Health Resource Group. A HIPPS code is then generated corresponding to the case mix category (HHRG).

For the RAP, the PRICER will determine the payment amount appropriate to the HIPPS code by computing 60% (for first episode) or 50% (for subsequent episodes) of the case mix episode payment. The payment is then wage index adjusted.

For the final claim, PRICER calculates 100% of the amount due, because the final claim is processed as an adjustment to the RAP, reversing the RAP payment in full. Although final claim will show 100% payment amount, the provider will actually receive the 40% or 50% payment. The payment may also include outlier payments.

Exceptions: For claims involving demos and BBA encounter data, the amount reported in this field may not just represent the actual provider payment.

For demo Ids '01','02','03','04' -- claims contain amount paid to the provider, except that special 'differentials' paid outside the normal payment system are not included.

For demo Ids '05','15' -- encounter data 'claims' contain amount Medicare would have paid under FFS, instead of the actual payment to the MCO.

For demo Ids '06','07','08' -- claims contain actual provider payment but represent a special negotiated bundled payment for both Part A and Part B services.

To identify what the conventional provider Part A payment would have been, check value code = 'Y4'. The related noninstitutional (physician/supplier) claims contain what would have been paid had there been no demo.

For BBA encounter data (non-demo) -- 'claims' contain amount Medicare would have paid under FFS, instead of the actual payment to the BBA plan.

COMMON ALIAS : REIMBURSEMENT  
DB2 ALIAS : CLM\_PMT\_AMT  
SAS ALIAS : PMT\_AMT  
STANDARD ALIAS : CLM\_PMT\_AMT  
TITLE ALIAS : REIMBURSEMENT

LENGTH : 9.2 SIGNED : Y

COMMENTS :

Prior to Version H, the size of this field was S9(7)V99. Also, the noninstitutional claim records carried this field as a line item. Effective with Version H, this element is a claim level field across all claim types (and the line item field has been renamed.)

SOURCE : CWF

LIMITATIONS :

Prior to 4/6/93, on inpatient, outpatient, and physician/supplier claims containing a CLM\_DISP\_CD of '02', the amount shown as the Medicare reimbursement does not take into consideration any CWF automatic adjustments (involving erroneous deductibles in most cases). In as many as 30% of the claims (30% IP, 15% OP, 5% PART B), the reimbursement reported on the claims may be over or under the actual Medicare payment amount.

REFER TO :

PMT\_AMT\_EXCEDG\_CHRG\_AMT\_LIM

EDIT RULES :

\$\$\$\$\$\$\$\$CC

65. NCH Primary Payer Claim Paid Amount

6 238 243

PACK

The amount of a payment made on behalf of a Medicare beneficiary by a primary payer other than Medicare, that the

provider is applying to covered Medicare charges on an institutional, carrier, or DMERC claim.

DB2 ALIAS : PRMRY\_PYR\_PD\_AMT  
STANDARD ALIAS : NCH\_PRMRY\_PYR\_CLM\_PD\_AMT  
TITLE ALIAS : PRIMARY\_PAYER\_AMOUNT

LENGTH : 9.2 SIGNED : Y

COMMENTS :  
Prior to Version H this field was named:  
BENE\_PRMRY\_PYR\_CLM\_PMT\_AMT and the field size  
was S9(7)V99.

SOURCE : NCH

EDIT RULES :  
\$\$\$\$\$\$\$\$\$CC

66. NCH Primary Payer Code

1 244 244 CHAR

The code, on an institutional claim, specifying a federal non-Medicare program or other source that has primary responsibility for the payment of the Medicare beneficiary's health insurance bills.

DB2 ALIAS : NCH\_PRMRY\_PYR\_CD  
SAS ALIAS : PRPAY\_CD  
STANDARD ALIAS : NCH\_PRMRY\_PYR\_CD  
TITLE ALIAS : PRIMARY\_PAYER\_CD

LENGTH : 1

DERIVATIONS :  
DERIVED FROM:  
CLM\_VAL\_CD  
CLM\_VAL\_AMT

DERIVATION RULES

SET NCH\_PRMRY\_PYR\_CD TO 'A' WHERE THE  
CLM\_VAL\_CD = '12'

SET NCH\_PRMRY\_PYR\_CD TO 'B' WHERE THE  
CLM\_VAL\_CD = '13'

SET NCH\_PRMRY\_PYR\_CD TO 'C' WHERE THE  
CLM\_VAL\_CD = '16' and CLM\_VAL\_AMT is zeroes

SET NCH\_PRMRY\_PYR\_CD TO 'D' WHERE THE  
CLM\_VAL\_CD = '14'

SET NCH\_PRMRY\_PYR\_CD TO 'E' WHERE THE  
CLM\_VAL\_CD = '15'

SET NCH\_PRMRY\_PYR\_CD TO 'F' WHERE THE  
CLM\_VAL\_CD = '16' (CLM\_VAL\_AMT not  
equal to zeroes)

SET NCH\_PRMRY\_PYR\_CD TO 'G' WHERE THE  
CLM\_VAL\_CD = '43'

SET NCH\_PRMRY\_PYR\_CD TO 'H' WHERE THE  
CLM\_VAL\_CD = '41'

SET NCH\_PRMRY\_PYR\_CD TO 'I' WHERE THE  
CLM\_VAL\_CD = '42'

SET NCH\_PRMRY\_PYR\_CD TO 'L' (or prior to 4/97  
set code to 'J') WHERE THE CLM\_VAL\_CD = '47'

COMMENTS :  
Prior to Version H this field was named:  
BENE\_PRMRY\_PYR\_CD.

SOURCE : NCH

CODE TABLE : BENE\_PRMRY\_PYR\_TB

67. FI Requested Claim Cancel Reason Code  
1 245 245

CHAR

The reason that an intermediary requested cancelling  
a previously submitted institutional claim.

DB2 ALIAS : RQST\_CNCL\_RSN\_CD  
SAS ALIAS : CANCELCD  
STANDARD ALIAS : FI\_RQST\_CLM\_CNCL\_RSN\_CD  
TITLE ALIAS : CANCEL\_CD

LENGTH : 1

COMMENTS :  
Prior to Version H this field was named:  
INTRMDRY\_RQST\_CLM\_CNCL\_RSN\_CD.

SOURCE : CWF

CODE TABLE : FI\_RQST\_CLM\_CNCL\_RSN\_TB

68. FI Claim Action Code

1 246 246

CHAR

The type of action requested by the intermediary  
to be taken on an institutional claim.

DB2 ALIAS : FI\_CLM\_ACTN\_CD  
SAS ALIAS : ACTIONCD  
STANDARD ALIAS : FI\_CLM\_ACTN\_CD  
TITLE ALIAS : ACTION\_CD

LENGTH : 1

COMMENTS :  
Prior to Version H this field was named:  
INTRMDRY\_CLM\_ACTN\_CD.

SOURCE : CWF

CODE TABLE : FI\_CLM\_ACTN\_TB

69. FI Claim Process Date

8 247 254

NUM

The date the fiscal intermediary completes  
processing and releases the institutional  
claim to the CWF host.

DB2 ALIAS : FI\_CLM\_PROC\_DT  
SAS ALIAS : APRVL\_DT  
STANDARD ALIAS : FI\_CLM\_PROC\_DT  
TITLE ALIAS : FI\_PROCESS\_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

70. NCH Provider State Code

2 255 256

CHAR

Effective with Version H, the two position SSA state code  
where provider facility is located.

NOTE: During the Version H conversion this field was  
populated with data throughout history (back to service year  
1991).

```

DB2      ALIAS : NCH_PRVDR_STATE_CD
SAS      ALIAS : PRSTATE
STANDARD ALIAS : NCH_PRVDR_STATE_CD
TITLE    ALIAS : PROVIDER_STATE_CD

LENGTH      : 2

DERIVATIONS :
DERIVED FROM:
    NCH_PRVDR_NUM

DERIVATION RULES:

    SET NCH_PRVDR_STATE_CD TO
      PRVDR_NUM POS1-2.
    FOR PRVDR_NUM POS1-2 EQUAL '55' OR '75'
      SET NCH_PRVDR_STATE_CD TO '05'.
    FOR PRVDR_NUM POS1-2 EQUAL '67' OR '74'
      SET NCH_PRVDR_STATE_CD TO '45'.
    FOR PRVDR_NUM POS1-2 EQUAL '68' OR '69'
      SET NCH_PRVDR_STATE_CD TO '10'.
    FOR PRVDR_NUM POS1-2 EQUAL '78'
      SET NCH_PRVDR_STATE_CD TO '14'.
    FOR PRVDR_NUM POS1-2 EQUAL TO '76'
      SET NCH_PRVDR_STATE_CD TO '16'.
    FOR PRVDR_NUM POS1-2 EQUAL '70'
      SET NCH_PRVDR_STATE_CD TO '17'.
    FOR PRVDR_NUM POS1-2 EQUAL '71'
      SET NCH_PRVDR_STATE_CD TO '19'.
    FOR PRVDR_NUMBER POS1-2 EQUAL '77'
      SET NCH_PRVDR_STATE_CD TO '24'.
    FOR PRVDR_NUM POS1-2 EQUAL TO '72'
      SET NCH_PRVDR_STATE_CD TO '36'.
    FOR PRVDR_NUM POS1-2 EQUAL TO '73'
      SET NCH_PRVDR_STATE_CD TO '39'.

SOURCE      : NCH

CODE TABLE : GEO_SSA_STATE_TB

```

71. Organization NPI Number

10      257      266

CHAR

On an institutional claim, the National Provider Identifier (NPI) number assigned to uniquely identify the institutional provider certified by Medicare to provide services to the beneficiary.

NOTE: Effective May 2007, the NPI will become the national standard identifier for covered health care providers. NPIs will replace current OSCAR provider number, UPINs, NSC numbers, and local contractor provider identification numbers (PINs) on standard HIPPA claim transactions. (During the NPI transition phase (4/3/06 - 5/23/07) the capability was there for the NCH to receive NPIs along with an existing legacy number (UPIN, PIN, OSCAR provider number, etc.)).

NOTE1: CMS has determined that dual provider identifiers (old legacy numbers and new NPI) must be available in the NCH. After the 5/07 NPI implementation, the standard system maintainers will add the legacy number to the claim when it is adjudicated. We will continue to receive the OSCAR provider number and any currently issued UPINs. Effective May 2007, no NEW UPINs (legacy number) will be generated for NEW physicians (Part B and outpatient claims), so there will only be NPIs sent in to the NCH for those physicians.

DB2 ALIAS : ORG\_NPI\_NUM  
 SAS ALIAS : ORGNPINM  
 STANDARD ALIAS : ORG\_NPI\_NUM  
 TITLE ALIAS : ORG\_NPI

LENGTH : 10

SOURCE : CWF

72. Attending Physician ID Group  
     24      267      290

Name and identification numbers associated with the primary care physician.

STANDARD ALIAS : ATNDG\_PHYSN\_ID\_GRP

73. Claim Attending Physician UPIN Number  
     6      267      272

CHAR

On an institutional claim, the unique physician identification number (UPIN) of the physician who would normally be expected to certify and recertify the medical necessity of the services rendered and/or who has primary responsibility for

the beneficiary's medical care and treatment  
(attending physician).

COMMON ALIAS : ATTENDING\_PHYSICIAN\_UPIN  
DB2 ALIAS : ATNDG\_UPIN\_NUM  
SAS ALIAS : AT\_UPIN  
STANDARD ALIAS : CLM\_ATNDG\_PHYSN\_UPIN\_NUM  
TITLE ALIAS : ATTENDING\_PHYSICIAN

LENGTH : 6

COMMENTS :  
Prior to Version H this field was named:  
CLM\_PRMRY\_CARE\_PHYSN\_IDENT\_NUM and contained  
10 positions (6-position UPIN and 4-position  
physician surname).

SOURCE : CWF

74. Claim Attending Physician NPI Number  
10 273 282

CHAR

On an institutional claim, the national  
provider identifier (NPI) number assigned  
to uniquely identify the physician who has  
overall responsibility for the beneficiary's  
care and treatment.

NOTE: Effective May 2007, the NPI will be-  
come the national standard identifier for  
covered health care providers. NPIs will  
replace current OSCAR provider number, UPINs,  
NSC numbers, and local contractor provider  
identification numbers (PINs) on standard  
HIPPA claim transactions. (During the NPI  
transition phase (4/3/06 - 5/23/07) the  
capability was there for the NCH to receive NPIs  
along with an existing legacy number (UPIN,  
PIN, OSCAR provider number, etc.)).

NOTE1: CMS has determined that dual provider  
identifiers (old legacy numbers and new NPI)  
must be available in the NCH. After the 5/07  
NPI implementation, the standard system main-  
tainers will add the legacy number to the claim  
when it is adjudicated. We will continue to  
receive the OSCAR provider number and any currently  
issued UPINs. Effective May 2007, no NEW UPINs  
(legacy number) will be generated for NEW  
physicians (Part B and Outpatient claims),



so there will only be NPIs sent in to the NCH  
for those physicians.

COMMON ALIAS : ATTENDING\_PHYSICIAN\_NPI  
DB2 ALIAS : ATNDG\_NPI\_NUM  
SAS ALIAS : AT\_NPI  
STANDARD ALIAS : CLM\_ATNDG\_PHYSN\_NPI\_NUM  
TITLE ALIAS : ATNDG\_NPI

LENGTH : 10

SOURCE : CWF

75. Claim Attending Physician Surname  
6 283 288

CHAR

Effective with Version H, the last name of the  
attending physician (used for internal editing  
purpose in CMS' CWFMQA system.)

NOTE: Beginning with NCH weekly process date  
10/3/97 this field was populated with data.  
Claims processed prior to 10/3/97 will contain  
spaces in this field.

DB2 ALIAS : ATNDG\_SRNM  
SAS ALIAS : AT\_SRNM  
STANDARD ALIAS : CLM\_ATNDG\_PHYSN\_SRNM\_NAME  
TITLE ALIAS : ANDG\_PHYSN\_SURNAME

LENGTH : 6

SOURCE : CWF

76. Claim Attending Physician Given Name  
1 289 289

CHAR

Effective with Version H, the first name of the  
attending physician (used for internal editing  
purposes in CMS' CWFMQA system).

NOTE: Beginning with NCH weekly process date  
10/3/97 this field was populated with data.  
Claims processed prior to 10/3/97 will contain  
spaces in this field.

DB2 ALIAS : ATNDG\_GVN\_NAME  
SAS ALIAS : AT\_GVNNM  
STANDARD ALIAS : CLM\_ATNDG\_PHYSN\_GVN\_NAME  
TITLE ALIAS : ATNDG\_PHYSN\_FIRSTNAME

LENGTH : 1  
SOURCE : CWF

77. Claim Attending Physician Middle Initial Name

1 290 290 CHAR

Effective with Version H, the middle initial of the attending physician (used for internal editing purposes in CMS' CWFMQA system.)

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : ATNDG\_MI\_NAME  
SAS ALIAS : AT\_MDL  
STANDARD ALIAS : CLM\_ATNDG\_PHYSN\_MDL\_INITL\_NAME  
TITLE ALIAS : ATNDG\_PHYSN\_MI

LENGTH : 1  
SOURCE : CWF

78. Operating Physician ID Group

24 291 314

Name and identification numbers associated with the physician who performed the principal procedure.

STANDARD ALIAS : OPRTG\_PHYSN\_ID\_GRP

79. Claim Operating Physician UPIN Number

6 291 296 CHAR

On an institutional claim, the unique physician identification number (UPIN) of the physician who performed the principal procedure. This element is used by the provider to identify the operating physician who performed the surgical procedure.

DB2 ALIAS : OPRTG\_UPIN  
SAS ALIAS : OP\_UPIN  
STANDARD ALIAS : CLM\_OPRTG\_PHYSN\_UPIN\_NUM  
TITLE ALIAS : OPRTG\_UPIN

LENGTH : 6

COMMENTS :

Prior to Version H this field was named:  
CLM\_PRNCPL\_PRCDR\_PHYSN\_NUM and contained  
10 positions (6-position UPIN and 4-position  
physician surname.

NOTE: For HHA and Hospice formats beginning  
with NCH weekly process date 10/3/97 this field  
was populated with data. HHA and Hospice claims  
processed prior to 10/3/97 will contain spaces.

SOURCE : CWF

80. Claim Operating Physician NPI Number  
10 297 306

CHAR

On an institutional claim, the National Provider  
Identifier (NPI) number assigned to uniquely  
identify the physician with the primary  
responsibility for performing the surgical  
procedure(s).

NOTE: Effective May 2007, the NPI will become  
the national standard identifier for covered  
health care providers. NPIs will replace  
the current OSCAR provider number, UPINs, NSC  
numbers, and local contractor provider identi-  
fication numbers (PINs) on standard HIPPA claim  
transactions. (During the NPI transition phase  
(4/3/06 - 5/23/07) the capability was there  
for the NCH to receive NPIs along with an  
existing legacy number (UPIN, PIN, OSCAR provider  
number, etc.)).

NOTE1: CMS has determined that dual provider  
identifiers (old legacy number and new NPI)  
must be available in the NCH. After the 5/07  
NPI implementation, the standard system maint-  
ainers will add the legacy number to the claim  
when its adjudicated. We will continue to re-  
ceive the OSCAR provider number and any currently  
issued UPINs. Effective May 2007, no NEW UPINs  
(legacy numbers) will be generated for NEW  
physicians (Part B and outpatient claims), so  
there will only be NPIs sent in to the NCH  
for those physicians.

DB2 ALIAS : OPRTG\_NPI

SAS ALIAS : OP\_NPI  
STANDARD ALIAS : CLM\_OPRTG\_PHYSN\_NPI\_NUM  
TITLE ALIAS : OPRTG\_NPI

LENGTH : 10

SOURCE : CWF

81. Claim Operating Physician Surname  
6 307 312

CHAR

Effective with Version H, the last name of the operating physician (used for internal editing purposes in CMS' CWFMQA system.)

NOTE: Beginning with the NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : OPRTG\_SRNM  
SAS ALIAS : OP\_SRNM  
STANDARD ALIAS : CLM\_OPRTG\_PHYSN\_SRNM\_NAME  
TITLE ALIAS : OPRTG\_PHYSN\_SURNAME

LENGTH : 6

SOURCE : CWF

82. Claim Operating Physician Given Name  
1 313 313

CHAR

Effective with Version H, the first name of the operating physician (used for internal editing purposes in CMS' CWFMQA system.)

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : OPRTG\_GVN\_NAME  
SAS ALIAS : OP\_GVN  
STANDARD ALIAS : CLM\_OPRTG\_PHYSN\_GVN\_NAME  
TITLE ALIAS : OPRTG\_PHYSN\_FIRSTNAME

LENGTH : 1

SOURCE : CWF

83. Claim Operating Physician Middle Initial Name

1 314 314 CHAR

Effective with Version H, the middle initial of the operating physician (used for internal editing purposes in CMS' CWFMQA system.)

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : OPRTG\_MI\_NAME  
SAS ALIAS : OP\_MDL  
STANDARD ALIAS : CLM\_OPRTG\_PHYSN\_MDL\_INITL\_NAME  
TITLE ALIAS : OPRTG\_PHYSN\_MI

LENGTH : 1

SOURCE : CWF

84. Other Physician ID Group

24 315 338

Name and identification numbers associated with the other physician.

STANDARD ALIAS : OTHR\_PHYSN\_ID\_GRP

85. Claim Other Physician UPIN Number

6 315 320 CHAR

On an institutional claim, the unique physician identification number (UPIN) of the other physician associated with the institutional claim.

DB2 ALIAS : OTHR\_UPIN  
SAS ALIAS : OT\_UPIN  
STANDARD ALIAS : CLM\_OTHR\_PHYSN\_UPIN\_NUM  
TITLE ALIAS : OTH\_PHYSN\_UPIN

LENGTH : 6

COMMENTS :  
Prior to Version H this field was named:  
CLM\_OTHR\_PHYSN\_IDENT\_NUM and contained  
10 positions (6-position UPIN and 4-position  
other physician surname).

NOTE: For HHA and Hospice formats beginning with NCH weekly process date 10/3/97 this field was populated with data. HHA and Hospice claims processed prior to 10/3/97 will contain spaces.

SOURCE : CWF

86. Claim Other Physician NPI Number  
10 321 330

CHAR

On an institutional claim, the National Provider Identifier (NPI) number assigned to uniquely identify the other physician associated with the institutional claim.

NOTE: Effective May 2007, the NPI will become the national standard identifier for covered health care providers. NPIs will replace current OSCAR provider number, UPINs, NSC numbers, and local contractor provider identification numbers (PINs) on standard HIPPA claim transactions. (During the NPI transition phase (4/3/06 - 5/23/07) the capability was there for the NCH to receive NPIs along with an existing legacy number (UPIN, PIN, OSCAR provider number, etc.)).

NOTE1: CMS has determined that dual provider identifiers (old legacy numbers and new NPI) must be available in the NCH. After the 5/07 NPI implementation, the standard system maintainers will add the legacy number to the claim when it is adjudicated. We will continue to receive the OSCAR provider number and any currently issued UPINs. Effective May 2007, no NEW UPINs (legacy number) will be generated for NEW physicians (Part B AND outpatient claims), so there will only be NPIs sent in to the NCH for those physicians.

DB2 ALIAS : OTHR\_NPI  
SAS ALIAS : OT\_NPI  
STANDARD ALIAS : CLM\_OTHR\_PHYSN\_NPI\_NUM

LENGTH : 10

SOURCE : CWF

87. Claim Other Physician Surname  
6 331 336

CHAR

Effective with Version H, the last name of the other physician (used for internal editing purposes in CMS' CWFMQA system.)

NOTE: Beginning with the NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : OTHR\_SRNM  
SAS ALIAS : OT\_SRNM  
STANDARD ALIAS : CLM\_OTHR\_PHYSN\_SRNM\_NAME  
TITLE ALIAS : OTH\_PHYSN\_SURNAME

LENGTH : 6

SOURCE : CWF

88. Claim Other Physician Given Name  
1 337 337

CHAR

Effective with Version H, the first name of the other physician (used for internal editing purposes in CMS' CWFMQA system.)

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : OTHR\_GVN\_NAME  
SAS ALIAS : OT\_GVN  
STANDARD ALIAS : CLM\_OTHR\_PHYSN\_GVN\_NAME  
TITLE ALIAS : OTH\_PHYSN\_FIRSTNAME

LENGTH : 1

SOURCE : CWF

89. Claim Other Physician Middle Initial Name  
1 338 338

CHAR

Effective with Version H, the middle initial of the other physician (used for internal editing purposes in CMS' CWFMQA system.)

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain

spaces in this field.

DB2 ALIAS : OTHR\_MI\_NAME  
SAS ALIAS : OT\_MDL  
STANDARD ALIAS : CLM\_OTHR\_PHYSN\_MDL\_INITL\_NAME  
TITLE ALIAS : OTH\_PHYSN\_MI

LENGTH : 1

SOURCE : CWF

90. Medicaid Provider Identification Number  
13 339 351

CHAR

A unique identification number assigned to each provider by the state Medicaid agency. This unique provider number is used to ensure proper payment of providers and to maintain claims history on individual providers for surveillance and utilization review.

DB2 ALIAS : MDCD\_PRVDR\_NUM  
SAS ALIAS : MDCD\_PRV  
STANDARD ALIAS : MDCD\_PRVDR\_IDENT\_NUM  
TITLE ALIAS : MEDICAID\_PROVIDER

LENGTH : 13

COMMENTS :  
Prior to Version H the field size was X(12).

SOURCE : CWF

91. Claim Medicaid Information Code  
4 352 355

CHAR

Effective with Version G, code identifying Medicaid information supplied by the contractor to Medicaid.

DB2 ALIAS : CLM\_MDCD\_INFO\_CD  
SAS ALIAS : MDCDINFO  
STANDARD ALIAS : CLM\_MDCD\_INFO\_CD  
TITLE ALIAS : MEDICAID\_INFO

LENGTH : 4

SOURCE : CWF

92. Claim MCO Paid Switch  
1 356 356

CHAR



A switch indicating whether or not a Managed Care Organization (MCO) has paid the provider for an institutional claim.

COBOL ALIAS : MCO\_PD\_IND  
DB2 ALIAS : CLM\_MCO\_PD\_SW  
SAS ALIAS : MCOPDSW  
STANDARD ALIAS : CLM\_MCO\_PD\_SW  
TITLE ALIAS : MCO\_PAID\_SW

LENGTH : 1

COMMENTS :  
Prior to Version H this field was named:  
CLM\_GHO\_PD\_SW.

SOURCE : CWF

LIMITATIONS :

REFER TO :  
MCO\_PD\_SW\_LIM

CODE TABLE : CLM\_MCO\_PD\_TB

93. Claim Treatment Authorization Number  
18 357 374

CHAR

The number assigned by the medical reviewer and reported by the provider to identify the medical review (treatment authorization) action taken after review of the beneficiary's case. It designates that treatment covered by the bill has been authorized by the payer. This number is used by the intermediary and the Peer Review Organization.

NOTE: Under HH PPS this field will be used to link claims to the OASIS assessment used as the basis of payment. This eighteen character string consists of the start of care date, the OASIS assessment date and the two digit reason for assessment code.

COMMON ALIAS : TAN  
DB2 ALIAS : TRTMT\_AUTHRZTN\_NUM  
SAS ALIAS : AUTHRZTN  
STANDARD ALIAS : CLM\_TRTMT\_AUTHRZTN\_NUM  
TITLE ALIAS : TREATMENT\_AUTHORIZATION

				LENGTH	: 18
				SOURCE	: CWF
94. Patient Control Number	20	375	394	CHAR	
				The unique alphanumeric identifier assigned by the provider to the institutional claim to facilitate retrieval of individual case records and posting of payments.	
				DB2	ALIAS : PTNT_CNTL_NUM
				SAS	ALIAS : PTNTCNTL
				STANDARD	ALIAS : PTNT_CNTL_NUM
				TITLE	ALIAS : PATIENT_CONTROL_NUM
				LENGTH	: 20
				SOURCE	: CWF
95. Claim Medical Record Number	17	395	411	CHAR	
				The number assigned by the provider to the beneficiary's medical record to assist in record retrieval.	
				DB2	ALIAS : CLM_MDCL_REC_NUM
				SAS	ALIAS : MDCL_REC
				STANDARD	ALIAS : CLM_MDCL_REC_NUM
				TITLE	ALIAS : MEDICAL_RECORD_NUM
				LENGTH	: 17
				SOURCE	: CWF
96. Claim PRO Control Number	12	412	423	CHAR	
				Effective with Version G, the unique identifier assigned by the Peer Review Organization (PRO) for control purposes.	
				DB2	ALIAS : CLM_PRO_CNTL_NUM
				SAS	ALIAS : PRO_CNTL
				STANDARD	ALIAS : CLM_PRO_CNTL_NUM
				TITLE	ALIAS : PRO_CONTROL_NUM
				LENGTH	: 12

				SOURCE	: CWF
97.	Claim PRO Process Date	8	424	431	NUM
					Effective with Version H, the date the claim was used in the PRO review process.
					NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.
				DB2	ALIAS : CLM_PRO_PROC_DT
				SAS	ALIAS : PRO_DT
				STANDARD	ALIAS : CLM_PRO_PROC_DT
				TITLE	ALIAS : PRO_PROC_DT
				LENGTH	: 8 SIGNED : N
				SOURCE	: CWF
				EDIT RULES :	YYYYMMDD
98.	Patient Discharge Status Code	2	432	433	CHAR
					The code used to identify the status of the patient as of the CLM_THRU_DT.
				DB2	ALIAS : PTNT_DSCHRG_STUS
				SAS	ALIAS : STUS_CD
				STANDARD	ALIAS : PTNT_DSCHRG_STUS_CD
				TITLE	ALIAS : PTNT_DSCHRG_STUS_CD
				LENGTH	: 2
				COMMENTS :	Prior to Version H this field was named: CLM_STUS_CD.
				SOURCE	: CWF
				CODE TABLE	: PTNT_DSCHRG_STUS_TB
99.	Claim 1st Diagnosis E Code Group	8	434	441	GRP

Effective with Version 'J', the group used to identify the 1st diagnosis E code in the diagnosis E trailer. This group contains the 1st diagnosis E code and the 1st diagnosis E version code.

STANDARD ALIAS : CLM\_1ST\_DGNS\_E\_CD\_GRP

100. Claim 1st Diagnosis E Version Code  
1 434 434

CHAR

Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9 or ICD-10.

NOTE: With 5010, the diagnosis and procedure codes have been expanded to accomodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2013.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : E1VRSNCD

LENGTH : 1

CODE TABLE : CLM\_DGNS\_VRSN\_TB

101. Claim 1st Diagnosis E Code  
7 435 441

CHAR

The code used to identify the 1st external cause of injury, poisoning, or other adverse effect. This diagnosis E code is also stored as the 1st occurrence of the diagnosis E code trailer.

NOTE: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10.

DB2 ALIAS : CLM\_1ST\_DGNS\_E\_CD  
SAS ALIAS : DGNS\_E  
STANDARD ALIAS : CLM\_1ST\_DGNS\_E\_CD

LENGTH : 7

COMMENTS :  
Prior to version 'J', this field was named:  
CLM\_DGNS\_E\_CD.

SOURCE : CWF

EDIT RULES :

ICD-9-CM

102. Claim PPS Indicator Code

1 442 442

CHAR

Effective with Version H, the code indicating whether or not the (1) claim is PPS and/or (2) the beneficiary is a deemed insured Medicare Qualified Government Employee (MQGE).

NOTE: Beginning with NCH weekly process date 10/3/97 through 5/29/98, this field was populated with only the PPS indicator. Beginning with NCH weekly process date 6/5/98, this field was additionally populated with the deemed MQGE indicator. Claims processed prior to 10/3/97 will contain spaces.

COBOL ALIAS : PPS\_IND  
DB2 ALIAS : CLM\_PPS\_IND\_CD  
SAS ALIAS : PPS\_IND  
STANDARD ALIAS : CLM\_PPS\_IND\_CD  
TITLE ALIAS : PPS\_IND

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM\_PPS\_IND\_TB

103. Claim Total Charge Amount

6 443 448

PACK

Effective with Version G, the total charges for all services included on the institutional claim. This field is redundant with revenue center code 0001/total charges.

DB2 ALIAS : CLM\_TOT\_CHRG\_AMT  
SAS ALIAS : TOT\_CHRG  
STANDARD ALIAS : CLM\_TOT\_CHRG\_AMT  
TITLE ALIAS : CLAIM\_TOTAL\_CHARGES

LENGTH : 9.2 SIGNED : Y

COMMENTS :  
Prior to Version H the size of this field was S9(7)V99.

SOURCE : CWF

LIMITATIONS :

REFER TO :  
TOT\_CHRG\_AMT\_LIM

104. Claim Pricer Return Code

2 449 450

CHAR

Effective 1/1/2004 with the implementation of NCH/NMUD CR#1, the code used to identify various PPS payment adjustment types. This code identifies the payment return code or the error return code for every claim type calculated by a PRICER (Inpatient, Outpatient, SNF, Inpatient Rehab Facility (IRF), Home Health and Hospice).

The payment return code identifies the type of payment calculated by the PRICER software.

The error return code identifies a condition in a claim that prevents the PRICER software from calculating a correct payment.

NOTE: Prior to 10/2005 (implementation of NCH/NMUD CR#2), this data was stored in positions 443-444 (FILLER) on all institutional claim types.

DB2 ALIAS : CLM\_PRCR\_RTRN\_CD  
SAS ALIAS : PRCRRTRN  
STANDARD ALIAS : CLM\_PRCR\_RTRN\_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : CLM\_PRCR\_RTRN\_TB

105. Claim Business Segment Identifier Code

4 451 454

CHAR

Effective 10/1/2005 with the implementation of NCH/NMUD CR#2, the identifier that captures the 2-byte jurisdiction code (represents the USPS state/territory abbreviation (i.e. NY = New York) and the 2-byte modifier that identifies the type of Medicare FFS contract (intermediary, RHHI, carrier or DMERC). This 4-byte identifier along with the 5-byte FI/Carrier number comprises the Contractor Workload Identifier number. The business segment

identifier (BSI) is intended to help sort work-loads that may be redistributed with the implementation of contracting reform as required by MMA.

DB2 ALIAS : BUSNS\_SGMT\_ID\_CD  
SAS ALIAS : SGMT\_ID  
STANDARD ALIAS : CLM\_BUSNS\_SGMT\_ID\_CD

LENGTH : 4

SOURCE : CWF

106. Recovery Audit Contractor (RAC) Adjustment Indicator Code  
1 455 455 CHAR

Effective January 5, 2009 with the implementation of CR#4, the code used to identify a Recovery Audit Contractor (RAC) requested adjustment. This occurs as a result of post-payment review activities done by the RAC.

DB2 ALIAS : RAC\_ADJSTMT\_CD  
SAS ALIAS : RACINDCD  
STANDARD ALIAS : CLM\_RAC\_ADJSTMT\_IND\_CD

LENGTH : 1

CODE TABLE : CLM\_RAC\_ADJSTMT\_TB

107. Worker's Compensation Indicator Code  
1 456 456 CHAR

This indicator is used to determine whether the diagnosis codes on the claims are related to the diagnosis codes on the MSP auxiliary file in CWF.

DB2 ALIAS : CLM\_WC\_IND\_CD  
SAS ALIAS : WCINDCD

LENGTH : 1

CODE TABLE : CLM\_WC\_IND\_TB

LANGUAGE : C

108. Claim Service Facility Zip Code  
9 457 465 CHAR

Effective with Version 'J', the zip code used to identify the location of the facility where the service

was performed.

DB2 ALIAS : SRVC\_FAC\_ZIP\_CD  
SAS ALIAS : SRVCFAC  
STANDARD ALIAS : CLM\_SRVC\_FAC\_ZIP\_CD

LENGTH : 9

109. FILLER

50 466 515

CHAR

DB2 ALIAS : FILLER

LENGTH : 50

110. Inpatient/SNF NCH Edit Code Count

2 516 517

NUM

The count of the number of edit codes annotated to the inpatient/SNF claim during the HCFA's CWFMQA process. The purpose of this count is to indicate how many claim edit trailers are present.

DB2 ALIAS : IP\_NCH\_EDIT\_CD\_CNT  
SAS ALIAS : IPEDCNT  
STANDARD ALIAS : IP\_NCH\_EDIT\_CD\_CNT

LENGTH : 2 SIGNED : N

COMMENTS :

Prior to Version H this field was named: CLM\_EDIT\_CD\_CNT.

SOURCE : NCH

111. Inpatient/SNF NCH Patch Code Count

2 518 519

NUM

Effective with Version H, the count of the number of HCFA patch codes annotated to the inpatient/SNF claim during the Nearline maintenance process. The purpose of this count is to indicate how many NCH patch trailers are present.

NOTE1: During the Version H conversion this field was populated with data throughout history (back to service year 1991).



NOTE2: Effective with Version 'I' the number of possible occurrences was reduced to 30. Prior to Version 'I' the number of possible occurrences was 99).

DB2 ALIAS : IP\_PATCH\_CD\_CNT  
SAS ALIAS : IPPATCNT  
STANDARD ALIAS : IP\_NCH\_PATCH\_CD\_I\_CNT

LENGTH : 2 SIGNED : N

SOURCE : NCH

112. Inpatient/SNF MCO Period Count

1 520 520

NUM

Effective with Version H, the count of the number of Managed Care Organization (MCO) periods reported on an inpatient/SNF claim. The purpose of this count is to indicate how many MCO period trailers are present.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

DB2 ALIAS : IP\_MCO\_PRD\_CNT  
SAS ALIAS : IPMCOCNT  
STANDARD ALIAS : IP\_MCO\_PRD\_CNT

LENGTH : 1 SIGNED : N

SOURCE : NCH

EDIT RULES :  
RANGE: 0 TO 2

113. Inpatient/SNF Claim Dem

1 521 521

NUM

Effective with Version H, the count of the number of claim demonstration IDs reported on an inpatient/SNF claim. The purpose of this count is to indicate how many claim demonstration trailers are present.

NOTE: During the Version H conversion this field was populated with data where a demo was identifiable.

DB2 ALIAS : IP\_CLM\_DEMO\_ID  
SAS ALIAS : IPDEMCNT

```

LENGTH          : 1      SIGNED : N

114. Inpatient Claim POA Diagnosis Code Count
      2      522      523  NUM

Effective with Version 'J', the count of the number
of Present on Admission (POA) codes reported on the
Inpatient/SNF claim.
The purpose of this count is to indicate
how many claim POA diagnosis trailers are present.

DB2      ALIAS : CLM_POA_TRLR_CNT
SAS      ALIAS : IPPOACNT
STANDARD ALIAS : IP_CLM_POA_DGNS_CD_CNT

LENGTH          : 2      SIGNED : N

SOURCE          :

EDIT RULES :
      Range: 0 to 25

115. Inpatient Claim POA Diagnosis E Code Count
      2      524      525  NUM

Effective with Version 'J', the count of the number
of Present on Admission (POA) codes associated with
the diagnosis E codes reported on the Inpatient/SNF
claim. The purpose of this count is to indicate
how many claim POA diagnosis E trailers are present.

DB2      ALIAS : CLM_POA_E_TRLR_CNT
SAS      ALIAS : IPPECNT
STANDARD ALIAS : IP_CLM_POA_DGNS_E_CD_CNT

LENGTH          : 2      SIGNED : N

SOURCE          :

EDIT RULES :
      Range: 0 to 12

116. Inpatient/SNF Claim Diagnosis Code J Count
      2      526      527  NUM

The count of the number of diagnosis codes (both principal
and secondary) reported on an Inpatient/SNF claim. The
purpose of this count is to indicate how many claim
diagnosis code trailers are present. Prior to Version 'J',
this field was named: IP_CLM_DGNS_CD_CNT.

```

NOTE: Effective with Version 'J', the count of the number of diagnosis code trailers was expanded from 10 to 25.

DB2 ALIAS : IP\_CLM\_DGNS\_CD\_CNT  
SAS ALIAS : IPDGNCNT  
STANDARD ALIAS : IP\_CLM\_DGNS\_CD\_J\_CNT

LENGTH : 2 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
CLM\_OTHR\_DGNS\_CD\_CNT and the principal was  
not included in the count.

SOURCE : F

EDIT RULES :  
Range: 0 to 25

117. Inpatient Claim Diagnosis E Code Count  
2 528 529

NUM

Effective with Version 'J', the count of the number of diagnosis E codes reported on the Inpatient/SNF claim. The purpose of this count is to indicate how many diagnosis E trailers are present.

DB2 ALIAS : DGNS\_E\_TRLR\_CNT  
SAS ALIAS : IPDECNT  
STANDARD ALIAS : IP\_CLM\_DGNS\_E\_CD\_CNT

LENGTH : 2 SIGNED : N

SOURCE :

EDIT RULES :  
Range: 0 to 12

118. Inpatient/SNF Claim Procedure Code Count  
2 530 531

NUM

The count of the number of procedure codes (both principal and secondary) reported on an Inpatient/SNF claim. The purpose of this count is to indicate how many claim procedure trailers are present. Prior to Version 'J', this field was named: IP\_CLM\_PRCDR\_CD\_CNT.

NOTE: Effective with Version 'J', the count of the number

of procedure code trailers was expanded from 6 to 25.

DB2 ALIAS : IP\_PRCDR\_CD\_CNT  
SAS ALIAS : IPPRCNT  
STANDARD ALIAS : IP\_CLM\_PRCDR\_CD\_J\_CNT

LENGTH : 2 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
CLM\_PRCDR\_CD\_CNT.

SOURCE : CWF

EDIT RULES :  
RANGE: 0 TO 25

119. Inpatient/SNF Claim Related Condition Code Count  
2 532 533 NUM

The count of the number of condition codes reported on an inpatient/SNF claim. The purpose of this count is to indicate how many condition code trailers are present.

DB2 ALIAS : IP\_RLT\_COND\_CD\_CNT  
SAS ALIAS : IPCONCNT  
STANDARD ALIAS : IP\_CLM\_RLT\_COND\_CD\_CNT

LENGTH : 2 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
CLM\_RLT\_COND\_CD\_CNT.

SOURCE : CWF

EDIT RULES :  
RANGE: 0 TO 30

120. Inpatient/SNF Claim Related Occurrence Code Count  
2 534 535 NUM

The count of the number of occurrence codes reported on an inpatient/SNF claim. The purpose of this count is to indicate how many occurrence code trailers are present.

DB2 ALIAS : IP\_OCRNC\_CD\_CNT  
SAS ALIAS : IPOCRCNT  
STANDARD ALIAS : IP\_CLM\_RLT\_OCRNC\_CD\_CNT

LENGTH : 2 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
CLM\_RLT\_OCRNC\_CD\_CNT.

SOURCE : CWF

EDIT RULES :  
RANGE: 0 TO 30

121. Inpatient/SNF Claim Occurrence Span Code Count  
2 536 537 NUM

The count of the number of occurrence span codes reported on an inpatient/SNF claim. The purpose of the count is to indicate how many span code trailers are present.

DB2 ALIAS : IP\_OCRNC\_SPAN\_CNT  
SAS ALIAS : IPSPNCNT  
STANDARD ALIAS : IP\_CLM\_OCRNC\_SPAN\_CD\_CNT

LENGTH : 2 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
CLM\_OCRNC\_SPAN\_CD\_CNT.

SOURCE : CWF

122. Inpatient/SNF Claim Value Code Count  
2 538 539 NUM

The count of the number of value codes reported on an inpatient/SNF claim. The purpose of the count is to indicate how many value code trailers are present.

DB2 ALIAS : IP\_VAL\_CD\_CNT  
SAS ALIAS : IPVALCNT  
STANDARD ALIAS : IP\_CLM\_VAL\_CD\_CNT

LENGTH : 2 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
CLM\_VAL\_CD\_CNT.

SOURCE : CWF

EDIT RULES :  
RANGE: 0 TO 36

123. Inpatient/SNF Revenue Center Code Count  
2 540 541

NUM

The count of the number of revenue codes reported on an inpatient/SNF claim. The purpose of the count is to indicate how many revenue center trailers are present.

DB2 ALIAS : IP\_REV\_CNTR\_CD\_CNT  
SAS ALIAS : IPREVCNT  
STANDARD ALIAS : IP\_REV\_CNTR\_CD\_I\_CNT

LENGTH : 2 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
CLM\_REV\_CNTR\_CD\_CNT.

NOTE: During the Version 'I' conversion the number of occurrences changed to 45 (per segment - 450 total for claim). For claims prior to Version 'I' the number of occurrences was 58, but in the conversion we made all claims back to service year 1991 contain only 45 revenue center lines. It is possible that claims prior to 1991 will have 2 segments if they contained more than 45 revenue lines.

SOURCE : CWF

EDIT RULES :  
RANGE: 0 TO 45

124. FILLER

4 542 545

CHAR

DB2 ALIAS : FILLER

LENGTH : 4

125. FI Inpatient SNF Claim Specific Group  
316 546 861

GRP

Data pertaining only to fiscal intermediary inpatient

or SNF claims

STANDARD ALIAS : FI\_IP\_SNF\_CLM\_SPECF\_GRP

126. Claim Admission Date                   8     546     553     NUM

On an institutional claim, the date the beneficiary was admitted to the hospital, skilled nursing facility, or christian science sanitorium.

DB2         ALIAS : CLM\_ADMSN\_DT  
SAS         ALIAS : ADMSN\_DT

LENGTH                 : 8         SIGNED : N

SOURCE                 : CWF

EDIT RULES :  
              YYYYMMDD

127. Claim Inpatient Admission Type Code                   1     554     554     CHAR

The code indicating the type and priority of an inpatient admission associated with the service on an intermediary submitted claim.

DB2         ALIAS : IP\_ADMSN\_TYPE\_CD  
SAS         ALIAS : TYPE\_ADM  
STANDARD ALIAS : CLM\_IP\_ADMSN\_TYPE\_CD  
TITLE       ALIAS : IP\_ADMISSION\_TYPE

LENGTH                 : 1

SOURCE                 : CWF

CODE TABLE            : CLM\_IP\_ADMSN\_TYPE\_TB

128. Claim Source Inpatient Admission Code                   1     555     555     CHAR

The code indicating the source of the referral for the admission or visit.

DB2         ALIAS : SRC\_IP\_ADMSN\_CD  
SAS         ALIAS : SRC\_ADMS  
STANDARD ALIAS : CLM\_SRC\_IP\_ADMSN\_CD  
TITLE       ALIAS : IP\_ADMISSION\_SOURCE

			LENGTH	: 1
			SOURCE	: CWF
			CODE TABLE	: CLM_SRC_IP_ADMSN_TB
129. Claim Admitting Diagnosis Group	8	556	563	GRP
				Effective with Version 'J', the group used to identify the admitting diagnosis code on an Inpatient/SNF claim. This group contains the admitting diagnosis code and the admitting diagnosis version code.
				STANDARD ALIAS : CLM_ADMTG_DGNS_GRP
130. Claim Admitting Diagnosis Version Code	1	556	556	CHAR
				Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9 or ICD-10.
				NOTE: With 5010 the diagnosis and procedure codes have been expanded to accommodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2013.
			DB2	ALIAS : UNDEFINED
			SAS	ALIAS : ADVRSNCD
			LENGTH	: 1
			CODE TABLE	: CLM_ADMTG_DGNS_VRSN_TB
131. Claim Admitting Diagnosis Code	7	557	563	CHAR
				A diagnosis code on the institutional claim indicating the beneficiary's initial diagnosis at admission.
				NOTE1: Effective 1/1/2004 with the implementation of NCH/NMUD CR#1, the admitting diagnosis (also known as reason for patient visit) was added to the Outpatient claim. This data was stored in positions 572-576 (FILLER) until the implementation of NCH/NMUD CR#2. Prior to 1/1/2004, this field was only present on inpatient claims.
				Additional exception: Virgin Island hospitals and



hospitals that furnish only inpatient Part B services.

NOTE1: Effective with Version 'J' this field expanded from 5 bytes to 7 bytes.

DB2 ALIAS : CLM\_ADMTG\_DGNS\_CD  
SAS ALIAS : AD\_DGNS

LENGTH : 7

132. NCH Patient Status Indicator Code

1 564 564

CHAR

Effective with Version H, the code on an inpatient/SNF and Hospice claim, indicating whether the beneficiary was discharged, died or still a patient (used for internal CWFMQA editing purposes.)

NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).

DB2 ALIAS : NCH\_PTNT\_STUS\_IND  
SAS ALIAS : PTNTSTUS  
STANDARD ALIAS : NCH\_PTNT\_STUS\_IND\_CD  
TITLE ALIAS : NCH\_PATIENT\_STUS

LENGTH : 1

DERIVATIONS :

DERIVED FROM:

NCH\_PTNT\_DSCHRG\_STUS\_CD

DERIVATION RULES:

SET NCH\_PTNT\_STUS\_IND\_CD TO 'A' WHERE THE  
PTNT\_DSCHRG\_STUS\_CD NOT EQUAL TO '20' - '30'  
OR '40' - '42'.

SET NCH\_PTNT\_STUS\_IND\_CD TO 'B' WHERE THE  
PTNT\_DSCHRG\_STUS\_CD EQUAL TO '20' - '29'  
OR '40' - '42'.

SET NCH\_PTNT\_STUS\_IND\_CD TO 'C' WHERE THE  
PTNT\_DSCHRG\_STUS\_CD EQUAL TO '30'

SOURCE : NCH QA Process

CODE TABLE : NCH\_PTNT\_STUS\_IND\_TB

133. NCH Inpatient Pro Approval Type Code

1 565 565

CHAR

The Peer Review Organization (PRO) determination on the type of approval or denial of an inpatient claim.

DB2 ALIAS : IP\_PRO\_APRVL\_CD  
SAS ALIAS : APRVL\_CD  
STANDARD ALIAS : NCH\_IP\_PRO\_APRVL\_TYPE\_CD  
TITLE ALIAS : PRO\_IP\_APPROVAL\_CODE

LENGTH : 1

DERIVATIONS :  
Set based upon presence of condition code equal TO C1, C3, C4, C5, C6 OR C7.

COMMENTS :  
Prior to Version H this field was named:  
CLM\_IP\_PRO\_APRVL\_TYPE\_CD.

SOURCE : NCH

CODE TABLE : NCH\_IP\_PRO\_APRVL\_TYPE\_TB

134. NCH Inpatient PRO Approval Service From Date

8 566 573

NUM

On an institutional claim, the start date of service that has been approved by the Peer Review Organization (PRO).

DB2 ALIAS : IP\_PRO\_FROM\_DT  
SAS ALIAS : PRO\_FROM  
STANDARD ALIAS : NCH\_IP\_PRO\_SRVC\_FROM\_DT  
TITLE ALIAS : PRO\_FROM\_DT

LENGTH : 8 SIGNED : N

DERIVATIONS :  
DERIVED FROM:  
CLM\_OCRNC\_SPAN\_CD  
CLM\_OCRNC\_SPAN\_FROM\_DT

DERIVATION RULES:  
Based on the presence of occurrence span code equal to 'MO' move the corresponding occurrence span from date to the NCH\_IP\_PRO\_SRVC\_FROM\_DT.

COMMENTS :  
Prior to Version H this field was named:  
CLM\_PRO\_APRVL\_SRVC\_FROM\_DT.

SOURCE : NCH

EDIT RULES :  
YYYYMMDD

135. NCH Inpatient PRO Approval Service Thru Date  
8 574 581 NUM

On an institutional claim, the last day of  
service that has been approved by the Peer  
Review Organization (PRO).

DB2 ALIAS : IP\_PRO\_THRU\_DT  
SAS ALIAS : PRO\_THRU  
STANDARD ALIAS : NCH\_IP\_PRO\_SRVC\_THRU\_DT  
TITLE ALIAS : PRO\_THRU

LENGTH : 8 SIGNED : N

DERIVATIONS :  
DERIVED FROM:  
CLM\_OCRNC\_SPAN\_CD  
CLM\_OCRNC\_SPAN\_THRU\_DT

DERIVATION RULES:  
Based on the presence of occurrence span code  
equal to 'MO' move the corresponding occurrence  
span thru date to the NCH\_IP\_PRO\_SRVC\_THRU\_DT.

COMMENTS :  
Prior to Version H this field was named:  
CLM\_PRO\_APRVL\_SRVC\_THRU\_DT.

SOURCE : NCH

EDIT RULES :  
YYYYMMDD

136. NCH Inpatient PRO Approval Grace Day Count  
1 582 582 NUM

On an institutional claim, the number of days  
determined by a Peer Review Organization (PRO)  
to be necessary to arrange post-discharge care.

DB2 ALIAS : IP\_PRO\_GRC\_CNT

SAS ALIAS : GRC\_DAY  
STANDARD ALIAS : NCH\_IP\_PRO\_GRC\_DAY\_CNT  
TITLE ALIAS : GRACE\_DAYS

LENGTH : 1 SIGNED : N

DERIVATIONS :  
DERIVED FROM:  
CLM\_VAL\_CD  
CLM\_VAL\_AMT

DERIVATION RULES:  
Based on the presence of value code equal to '46'  
move the corresponding value amount to the  
NCH\_IP\_PRO\_GRC\_DAY\_CNT.

COMMENTS :  
Prior to Version H this field was named:  
CLM\_PRO\_APRVL\_GRC\_DAY\_CNT.

SOURCE : NCH

137. Claim Pass Thru Per Diem Amount  
6 583 588

PACK

The amount of the established reimbursable costs  
for the current year divided by the estimated  
Medicare days for the current year (all PPS  
claims), as calculated by the FI and reim-  
bursement staff. Items reimbursed as a pass  
through include capital-related costs; direct  
medical education costs; kidney acquisition  
costs for hospitals approved as RTCs; and  
bad debts (per Provider Reimbursement Manual,  
Part 1, Section 2405.2). \*\*Note: Pass throughs  
are not included in the Claim Payment Amount.

DB2 ALIAS : PASS\_THRU\_PER\_DIEM  
SAS ALIAS : PER\_DIEM  
STANDARD ALIAS : CLM\_PASS\_THRU\_PER\_DIEM\_AMT  
TITLE ALIAS : PER\_DIEM

LENGTH : 9.2 SIGNED : Y

COMMENTS :  
Prior to Version H the field size was:  
S9(5)V99.

SOURCE : CWF

138. NCH Beneficiary Inpatient Deductible Amount

6 589 594 PACK

The amount of the deductible the beneficiary paid for inpatient services, as originally submitted on the institutional claim.

DB2 ALIAS : BENE\_IP\_DDCTBL\_AMT  
SAS ALIAS : DED\_AMT  
STANDARD ALIAS : NCH\_BENE\_IP\_DDCTBL\_AMT  
TITLE ALIAS : BENE\_DED\_AMT

LENGTH : 9.2 SIGNED : Y

DERIVATIONS :  
DERIVED FROM:  
CLM\_VAL\_CD  
CLM\_VAL\_AMT

DERIVATION RULES:  
Based on the presence of value code equal to A1, B1, or C1 move the corresponding value amount to the NCH\_BENE\_IP\_DDCTBL\_AMT.

COMMENTS :  
Prior to Version H this field was named:  
BENE\_IP\_DDCTBL\_AMT and the field size was  
S9(5)V99).

SOURCE : NCH

139. NCH Beneficiary Part A Coinsurance Liability Amount

6 595 600 PACK

The amount of money for which the intermediary has determined that the beneficiary is liable for Part A coinsurance on the institutional claim.

DB2 ALIAS : PTA\_COINSRNC\_AMT  
SAS ALIAS : COIN\_AMT  
STANDARD ALIAS : NCH\_BENE\_PTA\_COINSRNC\_AMT  
TITLE ALIAS : BENE\_PTA\_COINSURANCE

LENGTH : 9.2 SIGNED : Y

DERIVATIONS :  
DERIVED FROM:  
CLM\_VAL\_CD  
CLM\_VAL\_AMT

DERIVATION RULES:  
Based on the presence of value code equal to  
8, 9, 10 or 11 move the corresponding value  
amount to the NCH\_BENE\_IP\_PTA\_COINSRC\_AMT.

COMMENTS :  
Prior to Version H this field was named:  
BENE\_PTA\_COINSRNC\_LBLTY\_AMT and the field size  
was S9(5)V99.

SOURCE : NCH

140. NCH Beneficiary Blood Deductible Liability Amount  
6 601 606 PACK

The amount of money for which the intermediary  
determined the beneficiary is liable for the blood  
deductible.

DB2 ALIAS : BLOOD\_DDCTBL\_AMT  
SAS ALIAS : BLDDDEDAM  
STANDARD ALIAS : NCH\_BENE\_BLOOD\_DDCTBL\_AMT  
TITLE ALIAS : BLOOD\_DEDUCTIBLE

LENGTH : 9.2 SIGNED : Y

DERIVATIONS :  
DERIVED FROM:  
CLM\_VAL\_CD  
CLM\_VAL\_AMT

DERIVATION RULES:  
Based on the presence of value code equal to  
'06' move the corresponding value amount to  
NCH\_BENE\_BLOOD\_DDCTBL\_AMT.

COMMENTS :  
Prior to Version H, this field was named:  
BENE\_BLOOD\_DDCTBL\_LBLTY\_AMT and the field  
size was S9(5)V99. Also, for OP claims, this  
field was stored in a blood trailer. Version  
H eliminated the OP blood trailer.

SOURCE : NCH QA PROCESS

141. NCH Blood Total Charge Amount  
6 607 612 PACK

Effective with Version H, the total charge for  
blood usage (for internal CWFMQA editing

purposes).

NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991).

DB2 ALIAS : BLOOD\_TOT\_CHRG\_AMT  
SAS ALIAS : BLDTCHRG  
STANDARD ALIAS : NCH\_BLOOD\_TOT\_CHRG\_AMT  
TITLE ALIAS : BLOOD\_CHARGES

LENGTH : 9.2 SIGNED : Y

DERIVATIONS :  
DERIVED FROM:  
REV\_CNTR\_CD  
REV\_CNTR\_TOT\_CHRG\_AMT

DERIVATION RULES:  
Based on the presence of revenue center codes  
0380 thru 0389 move the related total charge  
amount to the NCH\_BLOOD\_TOT\_CHRG\_AMT.

SOURCE : NCH QA Process

142. NCH Blood Non-Covered Charge Amount  
6 613 618

PACK

Effective with Version H, the total noncovered charges for blood usage (for internal CWFMQA editing purposes).

NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991).

DB2 ALIAS : BLOOD\_NCVR\_AMT  
SAS ALIAS : BLDNCHRG  
STANDARD ALIAS : NCH\_BLOOD\_NCOV\_CHRG\_AMT  
TITLE ALIAS : BLOOD\_NCV\_CHARGES

LENGTH : 9.2 SIGNED : Y

DERIVATIONS :  
DERIVED FROM:  
REV\_CNTR\_CD  
REV\_CNTR\_NCOV\_CHRG\_AMT

DERIVATION RULES:

Based on the presence of revenue center codes equal to 0380 thru 0389 move the related noncovered charges to NCH\_BLOOD\_NCOV\_CHRG\_AMT.

SOURCE : NCH QA Process

143. NCH Professional Component Charge Amount  
6 619 624

PACK

Effective with Version H, for inpatient and outpatient claims, the amount of physician and other professional charges covered under Medicare Part B (used for internal CWFMQA editing purposes and other internal processes (e.g. if computing interim payment these charges are deducted)).

NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991).

DB2 ALIAS : PROFNL\_CMPNT\_AMT  
SAS ALIAS : PCCHGAMT  
STANDARD ALIAS : NCH\_PROFNL\_CMPNT\_CHRG\_AMT  
TITLE ALIAS : PROFNL\_CMPNT\_CHARGES

LENGTH : 9.2 SIGNED : Y

DERIVATIONS :

1. IF INPATIENT - DERIVED FROM:

CLM\_VAL\_CD  
CLM\_VAL\_AMT

DERIVATION RULES:

Based on the presence of value code 04 or 05 move the related value amount to the NCH\_PROFNL\_CMPNT\_CHRG\_AMT.

2. IF OUTPATIENT - DERIVED FROM:

REV\_CNTR\_CD  
REV\_CNTR\_TOT\_CHRG\_AMT

DERIVATION RULES (Effective 10/98):

Based on the presence of revenue center codes 096X, 097X & 098X move the related total charge amount to NCH\_PROFNL\_CMPNT\_CHRG\_AMT.

NOTE1: During the Version H conversion, this field was populated with data throughout history BUT the derivation rule applied to the outpatient



claim was incomplete (i.e., revenue codes 0972, 0973, 0974 and 0979 were omitted from the calculation).

SOURCE : NCH QA Process

144. NCH Inpatient Noncovered Charge Amount  
6 625 630

PACK

Effective with Version H, the noncovered charges for all accommodations and services, reported on an inpatient claim (used for internal CWFMQA editing purposes).

NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991).

DB2 ALIAS : IP\_NCVR\_CHRG\_AMT  
SAS ALIAS : NCCHGAMT  
STANDARD ALIAS : NCH\_IP\_NCOV\_CHRG\_AMT  
TITLE ALIAS : IP\_NCOV\_CHARGES

LENGTH : 9.2 SIGNED : Y

DERIVATIONS :  
DERIVED FROM:  
REV\_CNTR\_CD  
REV\_CNTR\_NCVR\_CHRG\_AMT

DERIVATION RULES:  
Based on the presence of revenue center code equal to 0001 move the related noncovered charge amount to NCH\_IP\_NCOV\_CHRG\_AMT.

SOURCE : NCH QA Process

145. NCH Inpatient Total Deduction Amount  
6 631 636

PACK

Effective with Version H, the total Part A deductions reported on the Inpatient claim (used for internal CWFMQA editing purposes).

NOTE: During the Version H conversion this field was populated with data throughout history (back to 1991), but the derivation rule applied was incomplete for claims processed prior to 10/93. Disregard any data present in this field on claims with NCH weekly process date earlier than 10/93.

DB2 ALIAS : IP\_TOT\_DDCTN\_AMT  
SAS ALIAS : TDEDAMT  
STANDARD ALIAS : NCH\_IP\_TOT\_DDCTN\_AMT  
TITLE ALIAS : IP\_TOT\_DEDUCTIONS

LENGTH : 9.2 SIGNED : Y

DERIVATIONS :  
DERIVED FROM:  
CLM\_VAL\_CD  
CLM\_VAL\_AMT

DERIVATION RULES (Effective 10/93):  
Accumulate the value amounts associated with  
value codes equal to 06, 08 thru 11 and A1, B1  
or C1 and move to IP\_TOT\_DDCTN\_AMT.  
NOTE: Value codes 08-11 did not exist in the  
NCH prior to 2/93; values codes A1, B1, C1 did  
not exist prior to 10/93.

SOURCE : NCH QA Process

146. Claim Total PPS Capital Amount  
6 637 642

PACK

The total amount that is payable for capital  
PPS for the claim. This is the sum of the  
capital hospital specific portion, federal  
specific portion, outlier portion,  
disproportionate share portion, indirect  
medical education portion, exception payments,  
and hold harmless payments.

DB2 ALIAS : TOT\_PPS\_CPTL\_AMT  
SAS ALIAS : PPS\_CPTL  
STANDARD ALIAS : CLM\_TOT\_PPS\_CPTL\_AMT  
TITLE ALIAS : PPS\_CAPITAL

LENGTH : 9.2 SIGNED : Y

COMMENTS :  
Prior to Version H the size of this field was:  
S9(7)V99.

SOURCE : CWF

147. Claim PPS Capital HSP Amount  
6 643 648

PACK

Effective 3/2/92, the hospital specific portion  
of the PPS payment for capital.

DB2 ALIAS : PPS\_CPTL\_HSP\_AMT  
SAS ALIAS : CPTL\_HSP  
STANDARD ALIAS : CLM\_PPS\_CPTL\_HSP\_AMT  
TITLE ALIAS : PPS\_CAPITAL\_HSP

LENGTH : 9.2 SIGNED : Y

COMMENTS :  
Prior to Version H the size of this field was:  
S9(7)V99.

SOURCE : CWF

EDIT RULES :  
\$\$\$\$\$\$\$\$\$CC

148. Claim PPS Capital FSP Amount  
6 649 654

PACK

Effective 3/2/92, the amount of the federal specific  
portion of the PPS payment for capital.

DB2 ALIAS : PPS\_CPTL\_FSP\_AMT  
SAS ALIAS : CPTL\_FSP  
STANDARD ALIAS : CLM\_PPS\_CPTL\_FSP\_AMT  
TITLE ALIAS : PPS\_CAPITAL\_FSP

LENGTH : 9.2 SIGNED : Y

COMMENTS :  
Prior to Version H the size of this field was:  
S9(7)V99.

SOURCE : CWF

EDIT RULES :  
\$\$\$\$\$\$\$\$\$CC

149. Claim PPS Capital Outlier Amount  
6 655 660

PACK

Effective 3/2/92, the amount of the outlier portion  
of the PPS payment for capital.

DB2 ALIAS : PPS\_OUTLIER\_AMT  
SAS ALIAS : CPTLOUTL  
STANDARD ALIAS : CLM\_PPS\_CPTL\_OUTLIER\_AMT

TITLE ALIAS : PPS\_CPTL\_OUTLIER

LENGTH : 9.2 SIGNED : Y

COMMENTS :  
Prior to Version H the size of this field was:  
S9(7)V99.

SOURCE : CWF

EDIT RULES :  
\$\$\$\$\$\$\$\$\$CC

150. Claim PPS Capital Disproportionate Share Amount  
6 661 666 PACK

Effective 3/2/92, the amount of disproportionate  
share (rate reflecting indigent population served)  
portion of the PPS payment for capital.

DB2 ALIAS : PPS\_DSPRPRNT\_AMT  
SAS ALIAS : DISP\_SHR  
STANDARD ALIAS : CLM\_PPS\_CPTL\_DSPRPRNT\_SHR\_AMT  
TITLE ALIAS : PPS\_DISP\_SHR

LENGTH : 9.2 SIGNED : Y

COMMENTS :  
Prior to Version H the size of the field was:  
S9(7)V99.

SOURCE : CWF

EDIT RULES :  
\$\$\$\$\$\$\$\$\$CC

151. Claim PPS Capital IME Amount  
6 667 672 PACK

Effective 3/2/92, the amount of the indirect medical  
education (IME) (reimbursable amount for teaching  
hospitals only; an added amount passed by Congress  
to augment normal PPS payments for teaching  
hospitals to compensate them for higher patient  
costs resulting from medical education programs for  
interns and residents) portion of the PPS payment  
for capital.

DB2 ALIAS : PPS\_CPTL\_IME\_AMT  
SAS ALIAS : IME\_AMT

STANDARD ALIAS : CLM\_PPS\_CPTL\_IME\_AMT  
TITLE ALIAS : PPS\_CPTL\_IME

LENGTH : 9.2 SIGNED : Y

COMMENTS :  
Prior to Version H the size of this field was:  
S9(7)V99.

SOURCE : CWF

EDIT RULES :  
\$\$\$\$\$\$\$\$\$CC

152. Claim PPS Capital Exception Amount  
6 673 678

PACK

Effective 3/2/92, the capital PPS amount of exception payments provided for hospitals with inordinately high levels of capital obligations. Exception payments expire at the end of the 10-year transition period.

DB2 ALIAS : PPS\_EXCPTN\_AMT  
SAS ALIAS : CPTL\_EXP  
STANDARD ALIAS : CLM\_PPS\_CPTL\_EXCPTN\_AMT  
TITLE ALIAS : PPS\_CPTL\_EXCP

LENGTH : 9.2 SIGNED : Y

COMMENTS :  
Prior to Version H the size of this field was:  
S9(7)V99.

SOURCE : CWF

EDIT RULES :  
\$\$\$\$\$\$\$\$\$CC

153. Claim PPS Old Capital Hold Harmless Amount  
6 679 684

PACK

Effective 3/2/92, this amount is the hold harmless amount payable for old capital as computed by PRICER for providers with a payment code equal to 'A'. The hold harmless amount-old capital is 100 percent of the reasonable costs of old capital for sole community sole community hospitals, or 85 percent of the reasonable costs associated with old capital for all other hospitals, plus a payment for new capital.

DB2 ALIAS : PPS\_CPTL\_HRMLS\_AMT  
SAS ALIAS : HLDHRMLS  
STANDARD ALIAS : CLM\_PPS\_OLD\_CPTL\_HLD\_HRMLS\_AMT  
TITLE ALIAS : PPS\_CPTL\_HOLD\_HRMLS

LENGTH : 9.2 SIGNED : Y

COMMENTS :  
Prior to Version H the size of this field was:  
S9(7)V99.

SOURCE : CWF

EDIT RULES :  
\$\$\$\$\$\$\$\$CC

154. Claim PPS Capital Discharge Fraction Percent

3 685 687 PACK

Effective 3/2/92, the percent resulting from  
dividing the days by the average length of stay  
for capital PPS transfer cases (PRICER review  
codes 03, 05, 06) not to exceed 1.

DB2 ALIAS : PPS\_DSCHRG\_PCT  
SAS ALIAS : DSCHFRCT  
STANDARD ALIAS : CLM\_PPS\_CPTL\_DSCHRG\_FRCTN\_PCT  
TITLE ALIAS : PPS\_CAPITL\_DSCHRG\_FRACTION\_PCT

LENGTH : 1.4 SIGNED : Y

SOURCE : CWF

LIMITATIONS :

REFER TO :  
PPS\_CPTL\_DSCHRG\_FRCTN\_PCT\_LIM

155. Claim PPS Capital DRG Weight Number

4 688 691 PACK

Effective 3/2/92, the number used to determine  
a transfer adjusted case mix index for capital  
PPS. The number is determined by multiplying  
the DRG weight times the discharge fraction.

DB2 ALIAS : PPS\_DRG\_WT\_NUM  
SAS ALIAS : DRGWTAMT  
STANDARD ALIAS : CLM\_PPS\_CPTL\_DRG\_WT\_NUM

TITLE ALIAS : PPS\_CAPITAL\_DRG\_WEIGHT\_NUM

LENGTH : 3.4 SIGNED : Y

SOURCE : CWF

LIMITATIONS :

REFER TO :

PPS\_CPTL\_DRG\_WT\_NUM\_LIM

156. Claim Utilization Day Count  
2 692 693

PACK

On an institutional claim, the number of covered days of care that are chargeable to Medicare facility utilization that includes full days, coinsurance days, and lifetime reserve days. It excludes any days classified as non-covered, leave of absence days, and the day of discharge or death.

DB2 ALIAS : CLM\_UTLZTN\_DAY\_CNT

SAS ALIAS : UTIL\_DAY

STANDARD ALIAS : CLM\_UTLZTN\_DAY\_CNT

TITLE ALIAS : UTILIZATION\_DAYS

LENGTH : 3 SIGNED : Y

157. Claim Cost Report Days Count  
2 694 695

PACK

The number of days on an institutional claim which would have been Medicare covered days if another primary payer were not involved or if a beneficiary had fewer days available than were needed by a PPS bill.

DB2 ALIAS : CLM\_CR\_DAY\_CNT

SAS ALIAS : CR\_DAY

LENGTH : 3 SIGNED : Y

158. Beneficiary Total Coinsurance Days Count  
2 696 697

PACK

The count of the total number of coinsurance days involved with the beneficiary's stay in a facility.

DB2 ALIAS : COINSRNC\_DAY\_CNT

SAS ALIAS : COIN\_DAY  
STANDARD ALIAS : BENE\_TOT\_COINSRNC\_DAY\_CNT  
TITLE ALIAS : COINSRNC\_DAYS

LENGTH : 3 SIGNED : Y

SOURCE : CWF

159. Claim Coinsurance Year 1 Day Count  
2 698 699

PACK

Effective with Version H, the count of the number of coinsurance days during the first year of the bill (used for internal CWFMQA editing purposes).

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 should contain zeroes in this field. Exception: during the Version 'H' conversion invalid data may have been populated for prior periods. Disregard any data in this field on claims with NCH weekly process date earlier than 10/3/97.

DB2 ALIAS : COINS\_YR1\_DAY\_CNT  
SAS ALIAS : COYR1DAY  
STANDARD ALIAS : CLM\_COINSRNC\_YR\_1\_DAY\_CNT  
TITLE ALIAS : COINS\_YR1\_DAYS

LENGTH : 3 SIGNED : Y

SOURCE : CWF

160. NCH Coinsurance Year 1 Rate Amount  
6 700 705

PACK

Effective with Version H, the charge for each day of coinsurance during the first year in the bill (used for internal CWFMQA editing purposes).

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 should contain zeroes in this field. Exception: during the Version 'H' conversion invalid data may have been populated for prior periods. Disregard any data present in this field on claims with NCH weekly process date earlier than 10/3/97.

DB2 ALIAS : COINS\_YR1\_RATE\_AMT



SAS ALIAS : COYR1AMT  
STANDARD ALIAS : NCH\_COINSRNC\_YR\_1\_RATE\_AMT  
TITLE ALIAS : COINS\_YR1\_RATE

LENGTH : 9.2 SIGNED : Y

DERIVATIONS :  
DERIVED FROM:  
CLM\_VAL\_CD  
CLM\_VAL\_AMT  
CLM\_COINSRNC\_YR\_1\_DAY\_CNT

DERIVATION RULES:  
Divide the value amount associated with value code  
equal to 09 by the coinsurance year 1 days and move  
to NCH\_COINSRNC\_YR\_1\_RATE\_AMT.

SOURCE : NCH QA Process

161. Claim Coinsurance Year 2 Day Count  
2 706 707

PACK

Effective with Version H, the count of the  
number of coinsurance days during the second  
year of the bill which spans two years (used  
for internal CWFMQA editing purposes.)

NOTE: Beginning with NCH weekly process date  
10/3/97 this field was populated with data.  
Claims processed prior to 10/3/97 should contain  
zeroes in this field. Exception: during the  
Version 'H' conversion invalid data may have  
been populated for prior periods. Disregard  
any data in this field on claims with NCH  
weekly process date earlier than 10/3/97.

DB2 ALIAS : COINS\_YR2\_DAY\_CNT  
SAS ALIAS : COYR2DAY  
STANDARD ALIAS : CLM\_COINSRNC\_YR\_2\_DAY\_CNT  
TITLE ALIAS : COINS\_YR2\_DAYS

LENGTH : 3 SIGNED : Y

SOURCE : CWF

162. NCH Coinsurance Year 2 Rate Amount  
6 708 713

PACK

Effective with Version H, the charge for each  
day of coinsurance during the second year in a

bill which spans two years (used for internal  
CWFMQA editing purposes.)

NOTE: Beginning with NCH weekly process date  
10/3/97 this field was populated with data.  
Claims processed prior to 10/3/97 should contain  
zeroes in this field. Exception: during the  
Version 'H' conversion invalid data may have  
been populated for prior periods. Disregard  
any data in this field on claims with NCH  
weekly process date earlier than 10/3/97.

DB2 ALIAS : COINS\_YR2\_RATE\_AMT  
SAS ALIAS : COYR2AMT  
STANDARD ALIAS : NCH\_COINSRNC\_YR\_2\_RATE\_AMT  
TITLE ALIAS : COINS\_YR2\_RATE

LENGTH : 9.2 SIGNED : Y

DERIVATIONS :  
DERIVED FROM:  
CLM\_VAL\_CD  
CLM\_VAL\_AMT  
CLM\_COINSRNC\_YR\_2\_DAY\_CNT

DERIVATION RULES:  
Divide the value amount associated with value code  
equal to 11 by the coinsurance year 2 days and move  
to NCH\_COINSRNC\_YR\_2\_RATE\_AMT.

SOURCE : NCH QA Process

163. Beneficiary LRD Used Count  
2 714 715

PACK

The number of lifetime reserve days that the  
beneficiary has elected to use during the period  
covered by the institutional claim. Under Medicare,  
each beneficiary has a one-time reserve of sixty  
additional days of inpatient hospital coverage  
that can be used after 90 days of inpatient care  
have been provided in a single benefit period.  
This count is used to subtract from the total  
number of lifetime reserve days that a beneficiary  
has available.

DB2 ALIAS : BENE\_LRD\_USE\_CNT  
SAS ALIAS : LRD\_USE

LENGTH : 3 SIGNED : Y

164. Claim Non Utilization Days Count  
3 716 718

PACK

On an institutional claim, the number of days of care that are not chargeable to Medicare facility utilization.

DB2 ALIAS : NUTLZTN\_DAY\_CNT  
SAS ALIAS : NUTILDAY  
STANDARD ALIAS : CLM\_NUTLZTN\_DAY\_CNT  
TITLE ALIAS : NUTLZTN\_DAYS

LENGTH : 5 SIGNED : Y

SOURCE : CWF

165. Beneficiary Prior Psychiatric Day Count  
2 719 720

PACK

Effective with Version H, the number of days in a psychiatric hospital prior to the entitlement to Medicare.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

DB2 ALIAS : PRIOR\_PSYCH\_CNT  
SAS ALIAS : PSYCHDAY  
STANDARD ALIAS : BENE\_PRIOR\_PSYCH\_DAY\_CNT  
TITLE ALIAS : PRIOR\_PSYCH\_DAYS

LENGTH : 3 SIGNED : Y

SOURCE : CWF

166. NCH Blood Pints Furnished Quantity  
2 721 722

PACK

Number of whole pints of blood furnished to the beneficiary.

DB2 ALIAS : NCH\_BLOOD\_PT\_FRNSH  
STANDARD ALIAS : NCH\_BLOOD\_PT\_FRNSH\_QTY  
TITLE ALIAS : BLOOD\_PINTS\_FURNISHED

LENGTH : 3 SIGNED : Y

DERIVATIONS :  
DERIVED FROM:  
CLM\_VAL\_CD  
CLM\_VAL\_AMT

DERIVATION RULES:  
Based on the presence of value code equal to  
37 move the related value amount to the  
NCH\_BLOOD\_PT\_FRNSH\_QTY.

COMMENTS :  
Prior to Version H this field was named:  
CLM\_BLOOD\_PT\_FRNSH\_QTY. Also for outpatient  
claims this field was stored in a blood  
trailer. Version H eliminated the outpatient  
blood trailer.

SOURCE : NCH QA Process

EDIT RULES :  
NUMERIC

167. NCH Blood Pints Replaced Quantity  
2 723 724

PACK

Number of whole pints of blood replaced.

DB2 ALIAS : BLOOD\_PT\_RPLC\_QTY  
SAS ALIAS : BLD\_RPLC  
STANDARD ALIAS : NCH\_BLOOD\_PT\_RPLC\_QTY  
TITLE ALIAS : BLOOD\_PINTS\_REPLACED

LENGTH : 3 SIGNED : Y

DERIVATIONS :  
DERIVED FROM:  
CLM\_VAL\_CD  
CLM\_VAL\_AMT

DERIVATION RULES:  
Based on the presence of value code equal to  
39 move the related value amount to the  
NCH\_BLOOD\_PT\_RPLC\_QTY.

COMMENTS :  
Prior to Version H this field was named:  
CLM\_BLOOD\_PT\_RPLC\_QTY. Also for outpatient  
claims this field was stored in a blood  
trailer. Version H eliminated the outpatient  
blood trailer.

			SOURCE	: NCH QA Process
			EDIT RULES :	
			NUMERIC	
168.	NCH Blood Pints Not Replaced Quantity			
	2	725	726	PACK
				Number of whole pints of blood not replaced.
			DB2	ALIAS : BLOOD_PT_NRPLC_QTY
			SAS	ALIAS : BLDNRPLC
			STANDARD	ALIAS : NCH_BLOOD_PT_NRPLC_QTY
			TITLE	ALIAS : BLOOD_PINTS_NOT_REPLACED
			LENGTH	: 3 SIGNED : Y
			DERIVATIONS :	
			DERIVED FROM:	
			CLM_VAL_CD	
			CLM_VAL_AMT	
			DERIVATION RULES:	
				Subtract value code 39 amount from value code
				37 amount and move the result to
				NCH_BLOOD_PT_NRPLC_QTY.
			COMMENTS :	
				Prior to Version H this field was named:
				CLM_BLOOD_PT_NRPLC_QTY. Also for outpatient
				claims this field was stored in a blood
				trailer. Version H eliminated the outpatient
				blood trailer.
			SOURCE	: NCH QA Process
			EDIT RULES :	
			NUMERIC	
169.	NCH Blood Deductible Pints Quantity			
	2	727	728	PACK
				The quantity of blood pints applied (blood
				deductible).
			DB2	ALIAS : BLOOD_DDCTBL_QTY
			SAS	ALIAS : BLDDDEDPT

STANDARD ALIAS : NCH\_BLOOD\_DDCTBL\_PT\_QTY  
TITLE ALIAS : BLOOD\_PINTS\_DEDUCTIBLE

LENGTH : 3 SIGNED : Y

DERIVATIONS :  
DERIVED FROM:  
CLM\_VAL\_CD  
CLM\_VAL\_AMT

DERIVATION RULES:  
Based on the presence of value code equal to  
38 move the related value amount to the  
NCH\_BLOOD\_DDCTBL\_PT\_QTY.

COMMENTS :  
Prior to Version H this field was named:  
CLM\_BLOOD\_DDCTBL\_PT\_QTY. Also for outpatient  
claims this field was stored in a blood  
trailer. Version H eliminated the outpatient  
blood trailer.

SOURCE : NCH QA Process

EDIT RULES :  
NUMERIC

170. NCH Qualified Stay From Date  
8 729 736

NUM

Effective with Version H, the beginning date of  
the beneficiary's qualifying stay (used for internal  
CWFMQA editing purposes). For inpatient claims, the  
date relates to the PPS portion of the inlier for  
which there is no utilization to benefits. For  
SNF claims, the date relates to a qualifying stay  
from a hospital that is at least two days in a row  
if the source of admission is an 'A', or at least  
three days in a row if the source of admission  
is other than 'A'.

NOTE: During the Version H conversion this field  
was populated with data throughout history (back to  
service year 1991).

DB2 ALIAS : QLFY\_STAY\_FROM\_DT  
SAS ALIAS : QLFYFROM  
STANDARD ALIAS : NCH\_QLFY\_STAY\_FROM\_DT  
TITLE ALIAS : QLFYG\_STAY\_FROM\_DT

LENGTH : 8 SIGNED : N

DERIVATIONS :  
DERIVED FROM:  
CLM\_OCRNC\_SPAN\_CD  
CLM\_OCRNC\_SPAN\_FROM\_DT

DERIVATION RULES:  
Based on the presence of occurrence code 70  
move the related occurrence from date to  
NCH\_QLFY\_STAY\_FROM\_DT.

SOURCE : NCH QA Process

EDIT RULES :  
YYYYMMDD

171. NCH Qualify Stay Through Date  
8 737 744

NUM

Effective with Version H, the ending date of the beneficiary's qualifying stay (used for internal CWFMQA editing purposes.) For inpatient claims, the date relates to the PPS portion of the inlier for which there is no utilization to benefits. For SNF claims, the date relates to a qualifying stay from a hospital that is at least two days in a row if the source of admission is an 'A', or at least three days in a row if the source of admission is other than 'A'.

NOTE: During the Version H, conversion this field was populated with data throughout history (back to service year 1991).

DB2 ALIAS : QLFY\_STAY\_THRU\_DT  
SAS ALIAS : QLFYTHRU  
STANDARD ALIAS : NCH\_QLFY\_STAY\_THRU\_DT  
TITLE ALIAS : QLFYG\_STAY\_THRU\_DT

LENGTH : 8 SIGNED : N

DERIVATIONS :  
DERIVED FROM:  
CLM\_OCRNC\_SPAN\_CD  
CLM\_OCRNC\_SPAN\_THRU\_DT

DERIVATION RULES:  
Based on the presence of occurrence code 70

move the related occurrence thru date to  
NCH\_QLFY\_STAY\_THRU\_DT.

SOURCE : NCH QA Process

EDIT RULES :  
YYYYMMDD

172. NCH Verified Noncovered Stay From Date  
8 745 752

NUM

Effective with Version H, the beginning date of  
the beneficiary's noncovered stay (used for  
internal CWFMQA editing purposes.)

NOTE: During the Version H conversion this field  
was populated with data throughout history (back to  
service year 1991).

DB2 ALIAS : VRFY\_NCVR\_FROM\_DT  
SAS ALIAS : NCOVFROM  
STANDARD ALIAS : NCH\_VRFY\_NCOV\_STAY\_FROM\_DT  
TITLE ALIAS : VERIFIED\_NCOV\_FROM\_DT

LENGTH : 8 SIGNED : N

DERIVATIONS :  
DERIVED FROM:  
CLM\_OCRNC\_SPAN\_CD  
CLM\_OCRNC\_SPAN\_FROM\_DT

DERIVATION RULES:  
Based on the presence of occurrence code 74, 76,  
77 or 79 move the related occurrence from date to  
NCH\_VRFY\_NCOV\_STAY\_FROM\_DT.

SOURCE : NCH QA Process

EDIT RULES :  
YYYYMMDD

173. NCH Verified Noncovered Stay Through Date  
8 753 760

NUM

Effective with Version H, the ending date of  
the beneficiary's noncovered stay (used for  
internal CWFMQA editing purposes.)

NOTE: During the Version H conversion this field  
was populated with data throughout history (back to



service year 1991).

DB2 ALIAS : VRFY\_NCVR\_THRU\_DT  
SAS ALIAS : NCOVTHRU  
STANDARD ALIAS : NCH\_VRFY\_NCOV\_STAY\_THRU\_DT  
TITLE ALIAS : VERIFIED\_NCOV\_THRU\_DT

LENGTH : 8 SIGNED : N

DERIVATIONS :  
DERIVED FROM:  
CLM\_OCRNC\_SPAN\_CD  
CLM\_OCRNC\_SPAN\_THRU\_DT

DERIVATION RULES:  
Based on the presence of occurrence code 74, 76,  
77 or 79 move the related occurrence thru date to  
NCH\_VRFY\_NCOV\_STAY\_THRU\_DT.

SOURCE : NCH QA Process

EDIT RULES :  
YYYYMMDD

174. NCH Provider Guaranteed Payment Start Date  
8 761 768

NUM

The date that the guaranteed payment to the  
institutional provider started.

DB2 ALIAS : GUARNT\_PMT\_STRT\_DT  
SAS ALIAS : GURPMTDT  
STANDARD ALIAS : NCH\_PRVDR\_GUARNT\_PMT\_STRT\_DT  
TITLE ALIAS : GARNT\_PMT\_DT

LENGTH : 8 SIGNED : N

DERIVATIONS :  
DERIVED FROM:  
CLM\_RLT\_OCRNC\_CD  
CLM\_RLT\_OCRNC\_DT

DERIVATION RULES:  
Based on the presence of occurrence code 20  
move the related occurrence date to  
NCH\_PRVDR\_GUARNT\_PMT\_STRT\_DT.

COMMENTS :  
Prior to Version H this field was named:  
CLM\_PRVDR\_GUARNT\_PMT\_STRT\_DT.

SOURCE : NCH QA Process

EDIT RULES :  
YYYYMMDD

175. NCH Utilization Review Notice Received Date  
8 769 776

NUM

The date of receipt by the skilled nursing facility of a utilization review committee's finding that an admission or further stay was no longer medically necessary.

DB2 ALIAS : NCH\_UR\_NTC\_RCV\_DT  
SAS ALIAS : URNTCDT

LENGTH : 8 SIGNED : N

DERIVATIONS :  
DERIVED FROM:  
CLM\_RLT\_OCRNC\_CD  
CLM\_RLT\_OCRNC\_DT

DERIVATION RULES:  
Based on the presence of occurrence code 21  
move the related occurrence date to  
NCH\_UR\_NTC\_RCV\_DT.

COMMENTS :  
Prior to Version H this field was named:  
CLM\_UR\_NTC\_RCV\_DT.

SOURCE : NCH QA Process

EDIT RULES :  
YYYYMMDD

176. NCH Active or Covered Level Care Thru Date  
8 777 784

NUM

The date on a claim for which the covered level of care ended in a general hospital or the active care ended in a psychiatric/TB hospital.

DB2 ALIAS : ACTV\_CARE\_THRU\_DT  
SAS ALIAS : CARETHRU  
STANDARD ALIAS : NCH\_ACTV\_CVR\_LVL\_CARE\_THRU\_DT  
TITLE ALIAS : ACTIVE\_CARE\_THRU\_DT

LENGTH : 8 SIGNED : N

DERIVATIONS :  
DERIVED FROM:  
CLM\_RLT\_OCRNC\_CD  
CLM\_RLT\_OCRNC\_DT

DERIVATION RULES:  
Based on the presence of occurrence code 22  
move the related occurrence date to  
NCH\_ACTV\_CVR\_LVL\_CARE\_THRU\_DT.

COMMENTS :  
Prior to Version H this field was named:  
CLM\_ACTV\_CVR\_LVL\_CARE\_THRU\_DT.

SOURCE : NCH QA Process

EDIT RULES :  
YYYYMMDD

177. NCH Beneficiary Medicare Benefits Exhausted Date  
8 785 792 NUM

The last date for which the beneficiary has  
Medicare coverage. This is completed only where  
where benefits were exhausted before the date of  
discharge and during the billing period covered  
by this institutional claim.

DB2 ALIAS : MDCR\_BNFT\_EXHST\_DT  
SAS ALIAS : EXHST\_DT  
STANDARD ALIAS : NCH\_MDCR\_BNFT\_EXHST\_DT  
TITLE ALIAS : BENEFIT\_EXHST\_DT

LENGTH : 8 SIGNED : N

DERIVATIONS :  
DERIVED FROM:  
CLM\_RLT\_OCRNC\_CD  
CLM\_RLT\_OCRNC\_DT

DERIVATION RULES (Effective 10/93):  
Based on the presence of occurrence code A3,  
B3 or C3 move the related occurrence date to  
NCH\_MDCR\_BNFT\_EXHST\_DT. \*NOTE: Prior to  
10/93, the date associated with occurrence  
code 23 was moved to this field.

COMMENTS :

Prior to Version H this field was named:  
CLM\_MDCR\_BNFT\_EXHST\_DT.

SOURCE : NCH QA Process

EDIT RULES :  
YYYYMMDD

178. NCH Beneficiary Discharge Date  
8 793 800

NUM

Effective with Version H, on an inpatient and  
HHA claim, the date the beneficiary was discharged  
from the facility or died (used for internal CWFMQA  
editing purposes.)

NOTE: During the Version H conversion this field  
was populated with data throughout history (back to  
service year 1991.)

DB2 ALIAS : NCH\_BENE\_DSCHRG\_DT  
SAS ALIAS : DSCHRGDT  
STANDARD ALIAS : NCH\_BENE\_DSCHRG\_DT  
TITLE ALIAS : DISCHARGE\_DT

LENGTH : 8 SIGNED : N

DERIVATIONS :  
DERIVED FROM:  
NCH\_PTNT\_STUS\_IND\_CD  
CLM\_THRU\_DT

DERIVATION RULES:  
Based on the presence of patient discharge status  
code not equal to 30 (still patient), move the claim  
thru date to the NCH\_BENE\_DSCHRG\_DT.

SOURCE : NCH QA Process

EDIT RULES :  
YYYYMMDD

179. Claim Diagnosis Related Group Code  
3 801 803

CHAR

The diagnostic related group to which a hospital  
claim belongs for prospective payment purposes.

DB2 ALIAS : CLM\_DRG\_CD  
SAS ALIAS : DRG\_CD

LENGTH : 3

COMMENTS :

GROUPE is the software that determines the DRG from data elements reported by the hospital. Once determined, the DRG code is one of the elements used to determine the price upon which to base the reimbursement to the hospitals under prospective payment. Nonpayment claims (zero reimbursement) may not have a DRG present.

180. Claim Diagnosis Related Group Outlier Stay Code  
1 804 804 CHAR

On an institutional claim, the code that indicates the beneficiary stay under the prospective payment system which, although classified into a specific diagnosis related group, has an unusually long length (day outlier) or exceptionally high cost (cost outlier).

DB2 ALIAS : DRG\_OUTLIER\_CD  
SAS ALIAS : OUTLR\_CD  
STANDARD ALIAS : CLM\_DRG\_OUTLIER\_STAY\_CD  
TITLE ALIAS : DRG\_OUTLIER\_STAY\_CODE

LENGTH : 1

SOURCE : CWF

CODE TABLE : DRG\_OUTLIER\_STAY\_TB

181. NCH DRG Outlier Approved Payment Amount  
6 805 810 PACK

On an institutional claim, the additional payment amount approved by the Peer Review Organization due to an outlier situation for a beneficiary's stay under the prospective payment system, which has been classified into a specific diagnosis related group.

DB2 ALIAS : DRG\_OUTLIER\_AMT  
SAS ALIAS : OUTLRPMT  
STANDARD ALIAS : NCH\_DRG\_OUTLIER\_APRV\_PMT\_AMT  
TITLE ALIAS : DRG\_OUTLIER\_PMT

LENGTH : 9.2 SIGNED : Y

DERIVATIONS :  
DERIVED FROM:  
CLM\_VAL\_CD  
CLM\_VAL\_AMT

DERIVATION RULES:  
Based on the presence of value code equal  
to 17 move the related amount to  
NCH\_DRG\_OUTLIER\_APRV\_PMT\_AMT.

COMMENTS :  
Prior to Version H this field was named:  
CLM\_DRG\_OUTLIER\_APRV\_PMT\_AMT and field size  
was S9(7)V99.

SOURCE : NCH QA Process

182. Claim KRON Indicator Code  
1 811 811

CHAR

Effective with Version H, on inpatient claims  
only, the code indicating that the bill must force  
a new spell even if it is within 60 days of a  
prior spell.

NOTE: Beginning with NCH weekly process date  
10/3/97 this field was populated with data.  
Claims processed prior to 10/3/97 will contain  
spaces in this field.

DB2 ALIAS : CLM\_KRON\_IND\_CD  
SAS ALIAS : KRON\_IND

LENGTH : 1

183. FILLER  
50 812 861

CHAR

DB2 ALIAS : FILLER

LENGTH : 50

184. FI Inpatient SNF Claim Variable Group  
VAR 862 16554

GRP

Variable portion of the fiscal intermediary inpatient/  
SNF claim record for version I of the NCH.

				STANDARD ALIAS : FI_IP_SNF_CLM_VAR_GRP
185. NCH Edit Group	5	862	866	GRP
				The number of claim edit trailers is determined by the claim edit code count.
				STANDARD ALIAS : NCH_EDIT_GRP
				OCCURS MIN: 0 OCCURS MAX: 13
				DEPENDING ON : IP_NCH_EDIT_CD_CNT
186. NCH Edit Trailer Indicator Code	1	862	862	CHAR
				Effective with Version H, the code indicating the presence of an NCH edit trailer.
				NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).
				DB2 ALIAS : EDIT_TRLR_IND_CD
				SAS ALIAS : EDITIND
				STANDARD ALIAS : NCH_EDIT_TRLR_IND_CD
				LENGTH : 1
				SOURCE : NCH QA Process
				CODE TABLE : NCH_EDIT_TRLR_IND_TB
187. NCH Edit Code	4	863	866	CHAR
				The code annotated to the claim indicating the CWFMQA editing results so users will be aware of data deficiencies.
				NOTE: Prior to Version H only the highest priority code was stored. Beginning 11/98 up to 13 edit codes may be present.
				COMMON ALIAS : QA_ERROR_CODE
				DB2 ALIAS : NCH_EDIT_CD
				SAS ALIAS : EDIT_CD
				STANDARD ALIAS : NCH_EDIT_CD

				TITLE	ALIAS : QA_ERROR_CD
				LENGTH	: 4
				SOURCE	: NCH QA EDIT PROCESS
				CODE TABLE	: NCH_EDIT_TB
188. NCH Patch Group	11	1	11	GRP	
				STANDARD ALIAS	: NCH_PATCH_GRP
				OCCURS MIN:	0 OCCURS MAX: 30
				DEPENDING ON	: IP_NCH_PATCH_CD_I_CNT
189. NCH Patch Trailer Indicator Code	1	1	1	CHAR	
				Effective with Version H, the code indicating the presence of an NCH patch trailer.	
				NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).	
				DB2	ALIAS : PATCH_TRLR_IND_CD
				SAS	ALIAS : PATCHIND
				STANDARD ALIAS	: NCH_PATCH_TRLR_IND_CD
				LENGTH	: 1
				SOURCE	: NCH
				CODE TABLE	: NCH_PATCH_TRLR_IND_TB
190. NCH Patch Code	2	2	3	CHAR	
				Effective with Version H, the code annotated to the claim indicating a patch was applied to the record during an NCH Nearline record conversion and/or during current processing.	
				NOTE: Prior to Version H this field was located in the third and fourth occurrence of the CLM_EDIT_CD.	



				DB2	ALIAS : NCH_PATCH_CD
				SAS	ALIAS : PATCHCD
				STANDARD	ALIAS : NCH_PATCH_CD
				TITLE	ALIAS : NCH_PATCH
				LENGTH	: 2
				SOURCE	: NCH
				CODE TABLE	: NCH_PATCH_TB
191. NCH Patch Applied Date	8	4	11	NUM	
					Effective with Version H, the date the NCH patch was applied to the claim.
				DB2	ALIAS : NCH_PATCH_APPLY_DT
				SAS	ALIAS : PATCHDT
				STANDARD	ALIAS : NCH_PATCH_APPLY_DT
				TITLE	ALIAS : NCH_PATCH_DT
				LENGTH	: 8 SIGNED : N
				SOURCE	: NCH
				EDIT RULES :	YYYYMMDD
192. MCO Period Group	37	1	37	GRP	
					The number of managed care organization (MCO) period data trailers present is determined by the claim MCO period trailer count. This field reflects the two most current MCO periods in the CWF beneficiary history record. It may have no connection to the services on the claim.
				STANDARD	ALIAS : MCO_PRD_GRP
				OCCURS MIN:	0 OCCURS MAX: 2
				DEPENDING ON :	IP_MCO_PRD_CNT
193. NCH MCO Trailer Indicator Code	1	1	1	CHAR	

Effective with Version H, the code indicating the presence of a Managed Care Organization (MCO) trailer.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

COBOL ALIAS : MCO\_IND  
DB2 ALIAS : MCO\_TRLR\_IND\_CD  
SAS ALIAS : MCOIND  
STANDARD ALIAS : NCH\_MCO\_TRLR\_IND\_CD  
TITLE ALIAS : MCO\_INDICATOR

LENGTH : 1

SOURCE : NCH QA Process

CODE TABLE : NCH\_MCO\_TRLR\_IND\_TB

194. MCO Contract Number

5 2 6 CHAR

Effective with Version H, this field represents the plan contract number of the Managed Care Organization (MCO).

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : MCO\_CNTRCT\_NUM  
SAS ALIAS : MCONUM  
STANDARD ALIAS : MCO\_CNTRCT\_NUM  
TITLE ALIAS : MCO\_NUM

LENGTH : 5

SOURCE : CWF

195. MCO Option Code

1 7 7 CHAR

Effective with Version H, the code indicating Managed Care Organization (MCO) lock-in enrollment status of the beneficiary.

NOTE: Beginning with NCH weekly process date

10/3/97 this field was populated with data.  
Claims processed prior to 10/3/97 will contain  
spaces in this field.

DB2 ALIAS : MCO\_OPTN\_CD  
SAS ALIAS : MCOOPTN  
STANDARD ALIAS : MCO\_OPTN\_CD  
TITLE ALIAS : MCO\_OPTION\_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : MCO\_OPTN\_TB

196. MCO Period Effective Date  
8 8 15

NUM

Effective with Version H, the date the bene-  
ficiary's enrollment in the Managed Care  
Organization (MCO) became effective.

NOTE: Beginning with NCH weekly process date  
10/3/97 this field was populated with data.  
Claims processed prior to 10/3/97 will contain  
zeroes in this field.

DB2 ALIAS : MCO\_PRD\_EFCTV\_DT  
SAS ALIAS : MCOEFFDT  
STANDARD ALIAS : MCO\_PRD\_EFCTV\_DT  
TITLE ALIAS : MCO\_PERIOD\_EFF\_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

197. MCO Period Termination Date  
8 16 23

NUM

Effective with Version H, the date the bene-  
ficiary's enrollment in the Managed Care  
Organization (MCO) was terminated.

NOTE: Beginning with NCH weekly process date  
10/3/97 this field was populated with data.  
Claims processed prior to 10/3/97 will contain  
zeroes in this field.

DB2 ALIAS : MCO\_PRD\_TRMNTN\_DT  
SAS ALIAS : MCOTRMDT  
STANDARD ALIAS : MCO\_PRD\_TRMNTN\_DT  
TITLE ALIAS : MCO\_PERIOD\_TERM\_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

198. MCO Health PLANID Number

14 24 37 CHAR

A placeholder field (effective with Version H)  
for storing the Health PlanID associated with  
the Managed Care Organization (MCO). Prior to  
Version 'I' this field was named:  
MCO\_PAYERID\_NUM.

DB2 ALIAS : MCO\_PLANID\_NUM  
SAS ALIAS : MCOPLNID  
STANDARD ALIAS : MCO\_HLTH\_PLANID\_NUM  
TITLE ALIAS : MCO\_PLANID

LENGTH : 14

COMMENTS :  
Prior to Version I this field was named:  
MCO\_PAYERID\_NUM.

SOURCE : CWF

199. Claim Demonstration Identification Group

18 1 18 GRP

The number of demonstration identification  
trailers present is determined by the claim  
demonstration identification trailer count.

STANDARD ALIAS : CLM\_DEMO\_ID\_GRP

OCCURS MIN: 0 OCCURS MAX: 5

DEPENDING ON : IP\_CLM\_DEMO\_ID\_CNT

200. NCH Demonstration Trailer Indicator Code

1 1 1 CHAR

Effective with Version H, the code indicating the presence of a demo trailer.

NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).

COBOL ALIAS : DEMO\_IND  
DB2 ALIAS : NCH\_DEMO\_TRLR\_IND\_  
SAS ALIAS : DEMOIND  
STANDARD ALIAS : NCH\_DEMO\_TRLR\_IND\_CD  
TITLE ALIAS : DEMO\_INDICATOR

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH\_DEMO\_TRLR\_IND\_TB

201. Claim Demonstration Identification Number

2 2 3 CHAR

Effective with Version H, the number assigned to identify a demo. This field is also used to denote special processing (a.k.a. Special Processing Number, SPN).

NOTE: Prior to Version H, Demo ID was stored in the redefined Claim Edit Group, 4th occurrence, positions 3 and 4. During the H conversion, this field was populated with data throughout history (as appropriate either by moving ID on Version G or by deriving from specific demo criteria).

01 = Nursing Home Case-Mix and Quality: NHCMQ (RUGS) Demo -- testing PPS for SNFs in 6 states, using a case-mix classification system based on resident characteristics and actual resources used. The claims carry a RUGS indicator and one or more revenue center codes in the 9,000 series.

NOTE1: Effective for SNF claims with NCH weekly process date after 2/8/96 (and service date after 12/31/95) -- beginning 4/97, Demo ID '01' was derived in NCH based on presence of RUGS phase # '2','3' or '4' on incoming claim; since 7/97, CWF has been adding ID to claim.

NOTE2: During the Version H conversion, Demo ID '01' was populated back to NCH weekly process date 2/9/96 based on the RUGS phase indicator (stored in Claim Edit Group, 3rd occurrence, 4th position, in Version G).

02 = National HHA Prospective Payment Demo -- testing PPS for HHAs in 5 states, using two alternate methods of paying HHAs: per visit by type of HHA visit and per episode of HH care.

NOTE1: Effective for HHA claims with NCH weekly process date after 5/31/95 -- beginning 4/97, Demo ID '02' was derived in NCH based on HCFA/CHPP-supplied listing of provider # and start/stop dates of participants.

NOTE2: During the Version H conversion, Demo ID '02' was populated back to NCH weekly process date 6/95 based on the CHPP criteria.

03 = Telemedicine Demo -- testing covering traditionally noncovered physician services for medical consultation furnished via two-way, interactive video systems (i.e. teleconsultation) in 4 states. The claims contain line items with 'QQ' HCPCS code.

NOTE1: Effective for physician/supplier (nonDMERC) claims with NCH weekly process date after 12/31/96 (and service date after 9/30/96) -- since 7/97, CWF has been adding Demo ID '03' to claim.

NOTE2: During Version H conversion, Demo ID '03' was populated back to NCH weekly process date 1/97 based on the presence of 'QQ' HCPCS on one or more line items.

04 = United Mine Workers of America (UMWA) Managed Care Demo -- testing risk sharing for Part A services, paying special capitation rates for all UMWA beneficiaries residing in 13 designated counties in 3 states. Under the demo, UMWA will waive the 3-day qualifying hospital stay for a SNF admission. The claims contain TOB '18X', '21X', '28X' and '51X'; condition code = W0; claim MCO paid switch = not '0'; and MCO contract # = '90091'.

NOTE: Initially scheduled to be implemented for all SNF claims for admission or services on 1/1/97 or later, CWF did not transmit any Demo ID '04' annotated claims until on or about 2/98.

05 = Medicare Choices (MCO encounter data) demo -- testing expanding the type of Managed Care plans available and different payment methods at 16 MCOs in 9 states. The claims contain one of the specific MCO Plan Contract # assigned to the Choices Demo site.

NOTE1: Effective for all claim types with NCH weekly process date after 7/31/97 -- CWF adds Demo ID '05' to claim based on the presence of the MCO Plan Contract #. \*\*\*Demonstration was terminated 12/31/2000.\*\*\*

NOTE2: During the Version H conversion, Demo ID '05' was populated back to NCH weekly process date 8/97 based on the presence of the Choices indicator (stored as an alpha character cross-walked from MCO plan contract # in the Claim Edit Group, 4th occurrence, 2nd position, in Version 'G').

06 = Coronary Artery Bypass Graft (CABG) Demo -- testing bundled payment (all-inclusive global pricing) for hospital + physician services related to CABG surgery in 7 hospitals in 7 states. The inpatient claims contain a DRG '106' or '107'.

NOTE1: Effective for Inpatient claims and physician/supplier claims with Claim Edit Date no earlier than 6/1/91 (not all CABG sites started at the same time) -- on 5/1/97, CWF started transmitting Demo ID '06' on the claim. The FI adds the ID to the claim based on the presence of DRG '106' or '107' from specific providers for specified time periods; the carrier adds the ID to the claim based on receiving 'Daily Census List' from participating hospitals. \*\*\*Demo terminated in 1998.\*\*\*

NOTE2: During the Version H conversion, any claims where Medicare is the primary payer that were not already identified as Demo ID

'06' (stored in the redefined Claim Edit Group, 4th occurrence, positions 3 and 4, Version G) were annotated based on the following criteria: Inpatient - presence of DRG '106' or '107' and a provider number=220897, 150897, 380897,450897,110082,230156 or 360085 for specified service dates; noninstitutional - presence of HCPCS modifier (initial and/or second) = 'Q2' and a carrier number =00700/31143 00630,01380,00900,01040/00511,00710,00623, or 13630 for specified service dates.

07 = Virginia Cardiac Surgery Initiative (VCSI) (formerly referred to as Medicare Quality Partnerships Demo) -- this is a voluntary consortium of the cardiac surgery physician groups and the non-Veterans Administration hospitals providing open heart surgical services in the Commonwealth of Virginia. The goal of the demo is to share data on quality and process innovations in an attempt to improve the care for all cardiac patients. The demonstration only affects those FIs that process claims from hospitals in Virginia and the carriers that process claims from physicians providing inpatient services at those hospitals. The hospitals will be reimbursed on a global payment basis for selected cardiac surgical diagnosis related groups (DRGs). The inpatient claims will contain a DRG '104', '105', '106', '107', '109'; the related physician/supplier claims will contain the claim payment denial reason code = 'D'.

NOTE: The implementation date for this demo is 4/1/03. The FI will annotate the claim with the demo id add Demo ID '07' to claim. For carrier claims, the Standard Systems will annotate the claim with the '07' demo number.

08 = Provider Partnership Demo -- testing per-case payment approaches for acute inpatient hospitalizations, making a lump-sum payment (combining the normal Part A PPS payment with the Part B allowed charges into a single fee schedule) to a Physician/Hospital Organization for all Part A and Part B services associated with a hospital admission. From 3 to 6 hospitals in the Northeast and Mid-Atlantic regions may participate in the demo.

NOTE: The demo is on HOLD. The FI and carrier will



add Demo ID '08' to claim.

15 = ESRD Managed Care (MCO encounter data) -- testing open enrollment of ESRD beneficiaries and capitation rates adjusted for patient treatment needs at 3 MCOs in 3 States. The claims contain one of the specific MCO Plan Contract # assigned to the ESRD demo site.

NOTE: Effective 10/1/97 (but not actually implemented at a site until 1/1/98) for all claim types -- the FI and carrier add Demo ID '15' to claim based on the presence of the MCO plan contract #.

30 = Lung Volume Reduction Surgery (LVRS) or National Emphysema Treatment Trial (NETT) Clinical Study -- evaluating the effectiveness of LVRS and maximum medical therapy (including pulmonary rehab) for Medicare beneficiaries in last stages of emphysema at 18 hospitals nationally, in collaboration with NIH.

NOTE: Effective for all claim types (except DMERC) with NCH weekly process date after 2/27/98 (and service date after 10/31/97) -- the FI adds Demo ID '30' based on the presence of a condition code = EY; the participating physician (not the carrier) adds ID to the noninstitutional claim. DUE TO THE SENSITIVE NATURE OF THIS CLINICAL TRIAL AND UNDER THE TERMS OF THE INTERAGENCY AGREEMENT WITH NIH, THESE CLAIMS ARE PROCESSED BY CWF AND TRANSMITTED TO HCFA BUT NOT STORED IN THE NEARLINE FILE (access is restricted to study evaluators only).

31 = VA Pricing Special Processing (SPN) -- not really a demo but special request from VA due to court settlement; not Medicare services but VA inpatient and physician services submitted to FI 00400 and Carrier 00900 to obtain Medicare pricing -- CWF WILL PROCESS VA CLAIMS ANNOTATED WITH DEMO ID '31', BUT WILL NOT TRANSMIT TO HCFA (not in Nearline File).

37 = Medicare Coordinated Care Demonstration -- to test whether coordinated care services furnished to certain beneficiaries improves outcome of care and reduces Medicare expenditures under Part A and Part B. There will be at least 14 Coordinated

Care Entities (CCEs). The selected entities will be assigned a provider number specifically for the demonstration services.

NOTE: All claims will be processed by carriers; no FI processing (except for Georgetown site)

37 = Medicare Disease Management (DMD) -- the purpose of this demonstration is to study the impact on costs and health outcomes of applying disease management services supplemented with coverage for prescription drugs for certain Medicare beneficiaries with diagnosed, advanced-stage congestive heart failure, diabetes, or coronary heart disease. Three demonstration sites will be used for this demonstration and it will last for 3 years. (Effective 4/1/2003).

NOTE: All claims will be processed by NHIC-California (Carrier). FIs will only serve as a conduit for transmitting information to and from CWF about the NOEs.

38 = Physician Encounter Claims - the purpose of this demo id is to identify the physician encounter claims being processed at the HCFA Data Center (HDC). This number will help EDS in making the claim go through the appropriate processing logic, which differs from that for fee-for-service. \*\*NOT IN NCH.\*\*

NOTE: Effective October, 2000. Demo ids will not be assigned to Inpatient and Outpatient encounter claims.

39 = Centralized Billing of Flu and PPV Claims -- The purpose of this demo is to facilitate the processing carrier, Trailblazers, paying flu and PPV claims based on payment localities. Providers will be giving the shots throughout the country and transmitting the claims to Trailblazers for processing.

NOTE: Effective October, 2000 for carrier claims.

40 = Payment of Physician and Nonphysician Services in certain Indian Providers -- the purpose of this demo is to extend payment for services of physician and nonphysician practitioners furnished in hospitals and ambulatory care clinics. Prior to the legislation change in BIPA, reimbursement for Medicare services provided in IHS facilities was limited to services provided in hospitals and skilled nursing facilities. This

change will allow payment for IHS, Tribe and Tribal Organization providers under the Medicare physician fee schedule.

NOTE: Effective July 1, 2001 for institutional and carrier claims.

48 = Medical Adult Day-Care Services -- the purpose of this demonstration is to provide, as part of the episode of care for home health services, medical adult day care services to Medicare beneficiaries as a substitute for a portion of home health services that would otherwise be provided in the beneficiaries home. This demo would last approx. 3 years in not more than 5 sites. Payment for each home health service episode of care will be set at 95% of the amount that would otherwise be paid for home health services provided entirely in the home.

NOTE: Effective July 5, 2005 for HHA claims.

DB2 ALIAS : CLM\_DEMO\_ID\_NUM  
SAS ALIAS : DEMONUM  
STANDARD ALIAS : CLM\_DEMO\_ID\_NUM  
TITLE ALIAS : DEMO\_ID

LENGTH : 2

SOURCE : CWF

202. Claim Demonstration Information Text

15 4 18

CHAR

Effective with Version H, the text field that contains related demo information. For example, a claim involving a CHOICES demo id '05' would contain the MCO plan contract number in the first five positions of this text field.

NOTE: During the Version H conversion this field was populated with data throughout history.

DB2 ALIAS : CLM\_DEMO\_INFO\_TXT  
SAS ALIAS : DEMOTXT  
STANDARD ALIAS : CLM\_DEMO\_INFO\_TXT  
TITLE ALIAS : DEMO\_INFO

LENGTH : 15

DERIVATIONS :

DERIVATION RULES:

Demo ID = 01 (RUGS) -- the text field will contain a 2, 3 or 4 to denote the RUGS phase. If RUGS phase is blank or not one of the above the text field will reflect 'INVALID'. NOTE: In Version 'G', RUGS phase was stored in redefined Claim Edit Group, 3rd occurrence, 4th position.

Demo ID = 02 (Home Health demo) -- the text field will contain PROV#. When demo number not equal to 02 then text will reflect 'INVALID'.

Demo ID = 03 (Telemedicine demo) -- text field will contain the HCPCS code. If the required HCPCS is not shown then the text field will reflect 'INVALID'.

Demo ID = 04 (UMWA) -- text field will contain W0 denoting that condition code W0 was present. If condition code W0 not present then the text field will reflect 'INVALID'.

Demo ID = 05 (CHOICES) -- the text field will contain the CHOICES plan number, if both of the following conditions are met: (1) CHOICES plan number present and PPS or Inpatient claim shows that 1st 3 positions of provider number as '210' and the admission date is within HMO effective/termination date; or non-PPS claim and the from date is within HMO effective/termination date and (2) CHOICES plan number matches the HMO plan number. If either condition is not met the text field will reflect 'INVALID CHOICES PLAN NUMBER'. When CHOICES plan number not present, text will reflect 'INVALID'.

NOTE: In Version 'G', a valid CHOICES plan ID is stored as alpha character in redefined Claim Edit Group, 4th occurrence, 2nd position. If invalid, CHOICES indicator 'ZZ' displayed.

Demo ID = 15 (ESRD Managed Care) -- text field will contain the ESRD/MCO plan number. If ESRD/MCO plan number not present the field will reflect 'INVALID'.

Demo ID = 38 (Physician Encounter Claims) -- text field will contain the MCO plan number. When MCO plan number not present the field will

reflect 'INVALID'.

SOURCE : CWF

LIMITATIONS :

REFER TO :  
CHOICES\_DEMO\_LIM

203. Claim Present on Admission (POA) Diagnosis Group  
2 1 2 GRP

The number of claim POA trailers is determined by the claim POA diagnosis code count. This group contains those POA codes associated with the diagnosis (principal and other) codes (excluding diagnosis E codes). The POAs for the diagnosis E codes are stored in the POA diagnosis E trailer.

STANDARD ALIAS : CLM\_POA\_DGNS\_GRP

OCCURS MIN: 0 OCCURS MAX: 25

DEPENDING ON : IP\_CLM\_POA\_DGNS\_CD\_CNT

204. NCH POA Diagnosis Trailer Indicator Code  
1 1 1

CHAR

Effective with Version 'J', the code indicating the presence of a POA Diagnosis trailer.

NOTE: During the Version J conversion, this field was populated throughout history.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : PTRLRIND  
STANDARD ALIAS : NCH\_POA\_DGNS\_TRLR\_IND\_CD

LENGTH : 1

SOURCE :

CODE TABLE : NCH\_POA\_DGNS\_TRLR\_IND\_TB

205. Claim POA Diagnosis Indicator Code  
1 2 2

CHAR

Effective September 1, 2008, with the implementation

of CR#3, on Inpatient claims only, the code used to indicate a condition was present at the time the beneficiary was admitted to a general acute care facility.

NOTE: Prior to Version 'J', the POA indicators were housed in a 10 byte field. There could be up to 9 POA indicators for each diagnosis code reflected in the diagnosis trailer. The field also contained a 1 byte indicator ('Z' or 'X' to identify the end of the POA codes.

NOTE1: Effective with Version 'J', a POA trailer was created for both diagnosis codes and diagnosis 'E' codes. There is a POA diagnosis trailer (up to 25 occurrences) that is associated with the diagnosis trailer. There is also a POA diagnosis 'E' trailer (up to 12 occurrences) that is associated with the diagnosis 'E' trailer. \*\*Medicare requires a POA for 'E' codes in the regular diagnosis trailer but not for 'E' codes in the 'E' diagnosis trailer. However, 5010 has POA indicators as situational for 'E' codes in the 'E' code trailer, so a POA could be reported.

DB2 ALIAS : CLM\_POA\_IND\_CD  
SAS ALIAS : POAINDCD  
STANDARD ALIAS : CLM\_POA\_DGNS\_IND\_CD

LENGTH : 1

COMMENTS :

Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM\_POA\_IND\_CD.

SOURCE :

CODE TABLE : CLM\_POA\_IND\_TB

206. Claim Present on Admission (POA) Diagnosis E Group  
2 1 2 GRP

The number of claim POA diagnosis E trailers is determined by the claim POA diagnosis E code count. This group contains those POA codes associated with the diagnosis E codes.

STANDARD ALIAS : CLM\_POA\_DGNS\_E\_GRP

OCCURS MIN: 0 OCCURS MAX: 12

DEPENDING ON : IP\_CLM\_POA\_DGNS\_E\_CD\_CNT

207. NCH POA Diagnosis E Trailer Indicator Code

1 1 1 CHAR

Effective with Version 'J', the code indicating the presence of a POA Diagnosis E trailer.

NOTE: During the Version 'J' conversion, this field was populated throughout history.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : PETRLR  
STANDARD ALIAS : NCH\_POA\_DGNS\_E\_TRLR\_IND\_CD

LENGTH : 1

SOURCE :

208. Claim POA Diagnosis E Indicator Code

1 2 2 CHAR

Effective with Version 'J', the code used to identify the present on admission (POA) indicator code associated with the diagnosis E codes.

DB2 ALIAS : CLM\_POA\_IND\_CD  
SAS ALIAS : POAEIND  
STANDARD ALIAS : CLM\_POA\_DGNS\_E\_IND\_CD

LENGTH : 1

COMMENTS :

Prior to Version 'J', the POA indicators were stored in a 10-byte field in the fixed portion of the claim. The field was named: CLM\_POA\_IND\_CD.

SOURCE :

CODE TABLE : CLM\_POA\_IND\_TB

209. Claim Diagnosis Group

9 1 9 GRP

The number of claim diagnosis trailers is determined by the claim diagnosis code count. The principal diagnosis is the first occurrence.

The principal diagnosis is also stored (redundantly) in the fixed portion of the record.

NOTE:

Prior to Version H this group was named: CLM\_OTHR\_DGNS\_GRP and did not contain the CLM\_PRNCPAL\_DGNS\_CD.

STANDARD ALIAS : CLM\_DGNS\_GRP

OCCURS MIN: 0 OCCURS MAX: 25

DEPENDING ON : IP\_CLM\_DGNS\_CD\_J\_CNT

210. NCH Diagnosis Trailer Indicator Code  
1 1 1

CHAR

Effective with Version H, the code indicating the presence of a diagnosis trailer.

NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).

DB2 ALIAS : DGNS\_TRLR\_IND\_CD  
SAS ALIAS : DGNSIND  
STANDARD ALIAS : NCH\_DGNS\_TRLR\_IND\_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH\_DGNS\_TRLR\_IND\_TB

211. Claim Diagnosis Version Code  
1 2 2

CHAR

Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9 or ICD-10.

NOTE: With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2013.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : DVRSNCD

LENGTH : 1



				CODE TABLE	: CLM_DGNS_VRSN_TB
212. Claim Diagnosis Code	7	3	9	CHAR	
					<p>The diagnosis code identifying the beneficiary's principal or other diagnosis (including E code).</p> <p>NOTE:</p> <p>Prior to Version H, the principal diagnosis code was not stored with the 'OTHER' diagnosis codes. During the Version H conversion the CLM_PRNCPAL_DGNS_CD was added as the first occurrence.</p> <p>NOTE1: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10.</p> <p>NOTE2: Effective with Version 'J', the diagnosis E codes are stored in a separate trailer (CLM_DGNS_E_GRP).</p> <p>DB2 ALIAS : CLM_DGNS_CD</p> <p>SAS ALIAS : DGNS_CD</p> <p>LENGTH : 7</p> <p>EDIT RULES :</p> <p>ICD-9-CM</p>
213. Claim Diagnosis E Group	9	1	9	GRP	
					<p>The number of claim diagnosis E trailers is determined by the claim diagnosis E code count. This group contains the diagnosis E codes and the diagnosis E version code.</p> <p>STANDARD ALIAS : CLM_DGNS_E_GRP</p> <p>OCCURS MIN: 0 OCCURS MAX: 12</p> <p>DEPENDING ON : IP_CLM_DGNS_E_CD_CNT</p>
214. NCH Diagnosis E Trailer Indicator Code	1	1	1	CHAR	
					<p>Effective with Version 'J', the code indicating the</p>

presence of a diagnosis E trailer.

NOTE: During the Version 'J' conversion, this field was populated throughout history.

DB2 ALIAS : DGNS\_E\_TRLR\_IND\_CD  
SAS ALIAS : ETRLRIND

LENGTH : 1

SOURCE :

CODE TABLE : NCH\_DGNS\_E\_TRLR\_IND\_TB

215. Claim Diagnosis Version Code

1 2 2

CHAR

Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9 or ICD-10.

NOTE: With 5010, the diagnosis and procedure codes have been expanded to accomodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2013.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : EVRSNCD

LENGTH : 1

CODE TABLE : CLM\_DGNS\_VRSN\_TB

216. Claim Diagnosis E Code

7 3 9

CHAR

Effective with Version J, the code used to identify the external cause of injury, poisoning, or other adverse affect.

NOTE: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accomodate the future implementation of ICD-10.

During the Version 'J' conversion, all 'E' codes in the diagnosis trailer were moved to the diagnosis 'E' trailer.

With the implementation of Version 'J', diagnosis 'E' codes can also be found in the regular diagnosis trailer.

DB2 ALIAS : CLM\_DGNS\_E\_CD  
SAS ALIAS : EDGNSCD

				LENGTH	: 7
				SOURCE	: CWF
				EDIT RULES :	
				ICD-9-CM	
217. Claim Procedure Group	17	1	17	GRP	
					<p>The number of claim procedure trailers is determined by the claim procedure code count.  Effective with Version 'J', up to 25 occurrences may be reported on a claim.  Beginning 10/93, up to six occurrences (one principal; five others) may be reported.</p> <p>OCCURS MIN: 0 OCCURS MAX: 25</p> <p>DEPENDING ON : IP_CLM_PRCDR_CD_J_CNT</p>
218. NCH Procedure Trailer Indicator Code	1	1	1	CHAR	
					<p>Effective with Version H, the code indicating the presence of a procedure trailer.</p> <p>NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).</p> <p>DB2 ALIAS : NCH_PRCDR_TRLR_IND  SAS ALIAS : PRCDRIND  STANDARD ALIAS : NCH_PRCDR_TRLR_IND_CD</p> <p>LENGTH : 1</p> <p>SOURCE : NCH</p> <p>CODE TABLE : NCH_PRCDR_TRLR_IND_TB</p>
219. Claim Procedure Version Code	1	2	2	CHAR	
					<p>Effective with Version 'J', the code used to indicate if the surgical procedure code is ICD-9 or ICD-10.</p> <p>NOTE: With 5010, the diagnosis and procedure codes have</p>

been expanded to accommodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2013.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : PVRSNCD

LENGTH : 1

CODE TABLE : CLM\_PRCDR\_VRSN\_TB

220. Claim Procedure Code

7 3 9

CHAR

The code that indicates the principal or other procedure performed during the period covered by the institutional claim.

NOTE:

Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims. The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

NOTE1: Effective with Version 'J', the number of procedure code occurrences has expanded from 6 to 25.

DB2 ALIAS : CLM\_PRCDR\_CD  
SAS ALIAS : PRCDR\_CD

LENGTH : 7

DERIVATIONS :

DERIVED FROM:

NCH CLM\_PRCDR\_CD

IF FIELD CONTAINS 4 ALPHA-NUMERIC CHARACTERS OR  
OR 3 ALPHA-NUMERIC CHARACTERS FOLLOWED BY A  
SPACE, ASSUME CODE IS VALID  
OTHERWISE  
MOVE SPACES TO CLM\_PRCDR\_CD.

SOURCE : CWF

EDIT RULES :

ICD-9-CM

221. Claim Procedure Performed Date

8 10 17

NUM

On an institutional claim, the date on which  
the principal or other procedure was performed.

DB2 ALIAS : CLM\_PRCDR\_PRFRM\_DT  
SAS ALIAS : PRCDR\_DT  
STANDARD ALIAS : CLM\_PRCDR\_PRFRM\_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

222. Claim Related Condition Group  
3 1 3

GRP

The number of claim related condition trailers is  
determined by the claim related condition code count.  
Effective 10/93, up to 30 occurrences can be reported  
on an institutional claim. Prior to 10/93, up to  
10 occurrences could be reported.

STANDARD ALIAS : CLM\_RLT\_COND\_GRP

OCCURS MIN: 0 OCCURS MAX: 30

DEPENDING ON : IP\_CLM\_RLT\_COND\_CD\_CNT

223. NCH Condition Trailer Indicator Code  
1 1 1

CHAR

Effective with Version H, the code indicating  
the presence of a condition code trailer.

NOTE: During the Version H conversion this field  
was populated throughout history (back to service  
year 1991).

DB2 ALIAS : COND\_TRLR\_IND\_CD  
SAS ALIAS : CONDIND  
STANDARD ALIAS : NCH\_COND\_TRLR\_IND\_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH\_COND\_TRLR\_IND\_TB

224. Claim Related Condition Code  
2

2 3

CHAR

The code that indicates a condition relating to an institutional claim that may affect payer processing.

DB2 ALIAS : CLM\_RLT\_COND\_CD  
SAS ALIAS : RLT\_COND  
STANDARD ALIAS : CLM\_RLT\_COND\_CD  
TITLE ALIAS : RELATED\_CONDITION\_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : CLM\_RLT\_COND\_TB

225. Claim Related Occurrence Group  
11

1 11

GRP

The number of claim related occurrence trailers is determined by the claim related occurrence code count. Effective 10/93, up to 30 occurrences can be reported on an institutional claim. Prior to 10/93, up to 10 occurrences could be reported.

STANDARD ALIAS : CLM\_RLT\_OCRNC\_GRP

OCCURS MIN: 0 OCCURS MAX: 30

DEPENDING ON : IP\_CLM\_RLT\_OCRNC\_CD\_CNT

226. NCH Occurrence Trailer Indicator Code  
1

1 1

CHAR

Effective with Version H, the code indicating the presence of a occurrence code trailer.

NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).

DB2 ALIAS : OCRNC\_TRLR\_IND\_CD  
SAS ALIAS : OCRNCIND  
STANDARD ALIAS : NCH\_OCRNC\_TRLR\_IND\_CD

LENGTH : 1

			SOURCE	: NCH
			CODE TABLE	: NCH_OCRNC_TRLR_IND_TB
227. Claim Related Occurrence Code	2	3	CHAR	
			<p>The code that identifies a significant event relating to an institutional claim that may affect payer processing. These codes are claim-related occurrences that are related to a specific date.</p>	
			DB2	ALIAS : CLM_RLT_OCRNC_CD
			SAS	ALIAS : OCRNC_CD
			STANDARD	ALIAS : CLM_RLT_OCRNC_CD
			TITLE	ALIAS : OCCURRENCE_CD
			LENGTH	: 2
			SOURCE	: CWF
			CODE TABLE	: CLM_RLT_OCRNC_TB
228. Claim Related Occurrence Date	8	4	11	NUM
			<p>The date associated with a significant event related to an institutional claim that may affect payer processing.</p>	
			DB2	ALIAS : CLM_RLT_OCRNC_DT
			SAS	ALIAS : OCRNCDT
			STANDARD	ALIAS : CLM_RLT_OCRNC_DT
			TITLE	ALIAS : RLT_OCRNC_DT
			LENGTH	: 8      SIGNED : N
			SOURCE	: CWF
			<p>EDIT RULES :           YYYYMMDD</p>	
229. Claim Occurrence Span Group	19	1	19	GRP
			<p>The number of claim occurrence span trailers is determined by the claim occurrence span code count.</p>	

Up to 10 occurrences may be reported on an institutional claim.

STANDARD ALIAS : CLM\_OCRNC\_SPAN\_GRP

OCCURS MIN: 0 OCCURS MAX: 10

DEPENDING ON : IP\_CLM\_OCRNC\_SPAN\_CD\_CNT

230. NCH Span Trailer Indicator Code  
1 1 1

CHAR

Effective with Version H, the code indicating the presence of a span code trailer.

NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).

DB2 ALIAS : SPAN\_TRLR\_IND\_CD  
SAS ALIAS : SPANIND  
STANDARD ALIAS : NCH\_SPAN\_TRLR\_IND\_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH\_SPAN\_TRLR\_IND\_TB

231. Claim Occurrence Span Code  
2 2 3

CHAR

The code that identifies a significant event relating to an institutional claim that may affect payer processing. These codes are claim-related occurrences that are related to a time period (span of dates).

DB2 ALIAS : CLM\_OCRNC\_SPAN\_CD  
SAS ALIAS : SPAN\_CD  
STANDARD ALIAS : CLM\_OCRNC\_SPAN\_CD  
TITLE ALIAS : SPAN\_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : CLM\_OCRNC\_SPAN\_TB

232. Claim Occurrence Span From Date



	8	4	11	NUM	
					The from date of a period associated with an occurrence of a specific event relating to an institutional claim that may affect payer processing.
				DB2	ALIAS : OCRNC_SPAN_FROM_DT
				SAS	ALIAS : SPANFROM
				STANDARD	ALIAS : CLM_OCRNC_SPAN_FROM_DT
				TITLE	ALIAS : SPAN_FROM_DT
				LENGTH	: 8 SIGNED : N
				SOURCE	: CWF
				EDIT RULES :	YYYYMMDD
233. Claim Occurrence Span Through Date	8	12	19	NUM	
					The thru date of a period associated with an occurrence of a specific event relating to an institutional claim that may affect payer processing.
				DB2	ALIAS : OCRNC_SPAN_THRU_DT
				SAS	ALIAS : SPANTHRU
				STANDARD	ALIAS : CLM_OCRNC_SPAN_THRU_DT
				TITLE	ALIAS : SPAN_THRU_DT
				LENGTH	: 8 SIGNED : N
				SOURCE	: CWF
				EDIT RULES :	YYYYMMDD
234. Claim Value Group	9	1	9	GRP	
					The number of claim value data trailers present is determined by the claim value code count. Effective 10/93, up to 36 occurrences can be reported on an institutional claim. Prior to 10/93, up to 10 occurrences could be reported.
				STANDARD	ALIAS : CLM_VAL_GRP

OCCURS MIN: 0 OCCURS MAX: 36

DEPENDING ON : IP\_CLM\_VAL\_CD\_CNT

235. NCH Value Trailer Indicator Code

1 1 1

CHAR

Effective with Version H, the code indicating the presence of a value code trailer.

NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).

DB2 ALIAS : VAL\_TRLR\_IND\_CD

SAS ALIAS : VALIND

STANDARD ALIAS : NCH\_VAL\_TRLR\_IND\_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH\_VAL\_TRLR\_IND\_TB

236. Claim Value Code

2 2 3

CHAR

The code indicating the value of a monetary condition which was used by the intermediary to process an institutional claim.

DB2 ALIAS : CLM\_VAL\_CD

SAS ALIAS : VAL\_CD

STANDARD ALIAS : CLM\_VAL\_CD

TITLE ALIAS : VALUE\_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : CLM\_VAL\_TB

237. Claim Value Amount

6 4 9

PACK

The amount related to the condition identified in the CLM\_VAL\_CD which was used by the intermediary to process the institutional claim.

DB2 ALIAS : CLM\_VAL\_AMT  
SAS ALIAS : VAL\_AMT  
STANDARD ALIAS : CLM\_VAL\_AMT  
TITLE ALIAS : VALUE\_AMOUNT  
  
LENGTH : 9.2 SIGNED : Y  
  
SOURCE : CWF  
  
EDIT RULES :  
\$\$\$\$\$\$\$\$\$CC

238. Claim Revenue Center Group  
297 1 297 GRP

The number of claim revenue center data trailers is determined by the claim revenue center code count. Effective 7/7/00, up to 450 occurrences may be reported on an institutional claim. The increase in the number of revenue center lines causes each claim to be broken out into records/segments (up to 10). Each record can have up to 45 occurrences of revenue center lines. Prior to 7/7/00, up to 58 occurrences may be reported on an institutional claim. Claims submitted prior to 10/93, contained up to 28 occurrences.

STANDARD ALIAS : CLM\_REV\_CNTR\_GRP

OCCURS MIN: 0 OCCURS MAX: 45

DEPENDING ON : IP\_REV\_CNTR\_CD\_I\_CNT

239. NCH Revenue Center Trailer Indicator Code  
1 1 1

CHAR

Effective with Version H, the code identifying the revenue center trailer.

During the Version H conversion this field was populated with data throughout history (back to service year 1991).

DB2 ALIAS : REV\_CNTR\_TRLR\_CD  
SAS ALIAS : REVIND  
STANDARD ALIAS : NCH\_REV\_CNTR\_TRLR\_IND\_CD  
  
LENGTH : 1

				SOURCE	: NCH
				CODE TABLE	: NCH_REV_TRLR_IND_TB
240. Revenue Center Code	4	2	5	CHAR	
				<p>The provider-assigned revenue code for each cost center for which a separate charge is billed (type of accommodation or ancillary). A cost center is a division or unit within a hospital (e.g., radiology, emergency room, pathology).  EXCEPTION: Revenue center code 0001 represents the total of all revenue centers included on the claim.</p>	
				COBOL	ALIAS : REV_CD
				DB2	ALIAS : REV_CNTR_CD
				SAS	ALIAS : REV_CNTR
				STANDARD	ALIAS : REV_CNTR_CD
				TITLE	ALIAS : REVENUE_CENTER_CD
				LENGTH	: 4
				SOURCE	: CWF
				CODE TABLE	: REV_CNTR_TB
241. Revenue Center Date	8	6	13	NUM	
				<p>Effective with Version H, the date applicable to the service represented by the revenue center code. This field may be present on any of the institutional claim types. For home health claims the service date should be present on all bills with from date greater than 3/31/98. With the implementation of outpatient PPS, hospitals will be required to enter line item dates of service for all outpatient services which require a HCPCS.</p>	
				<p>NOTE1: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.</p>	
				<p>NOTE2: When revenue center code equals '0022' (SNF PPS) and revenue center HCPCS code not equal to 'AAA00' (default for no assessment), date represents the MDS RAI assessment reference date.</p>	
				<p>NOTE3: When revenue center code equals '0023'</p>	

(HHPPS), the date on the initial claim (RAP) must represent the first date of service in the episode. The final claim will match the '0023' information submitted on the initial claim. The SCIC (significant change in condition) claims may show additional '0023' revenue lines in which the date represents the date of the first service under the revised plan of treatment.

DB2 ALIAS : REV\_CNTR\_DT  
STANDARD ALIAS : REV\_CNTR\_DT  
TITLE ALIAS : REV\_CNTR\_DATE

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

242. Revenue Center 1st ANSI Code

5 14 18

CHAR

The first code used to identify the detailed reason an adjustment was made (e.g. reason for denial or reducing payment).

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.

DB2 ALIAS : REV\_CNTR\_ANSI1\_CD

SAS ALIAS : REVANSI1  
STANDARD ALIAS : REV\_CNTR\_ANSI\_1\_CD  
TITLE ALIAS : ANSI\_CD

LENGTH : 5

SOURCE : CWF

CODE TABLE : REV\_CNTR\_ANSI\_TB

243. Revenue Center 2nd ANSI Code

5 19 23

CHAR

The second code used to identify the detailed reason an adjustment was made (e.g. reason for denial or reducing payment).

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.

DB2 ALIAS : REV\_CNTR\_ANSI2\_CD  
SAS ALIAS : REVANSI2  
STANDARD ALIAS : REV\_CNTR\_ANSI\_2\_CD  
TITLE ALIAS : ANSI\_CD

LENGTH : 5

SOURCE : CWF

244. Revenue Center 3rd ANSI Code

5 24 28

CHAR

The third code used to identify the detailed reason an adjustment was made (e.g. reason for denial or reducing payment).

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.

DB2 ALIAS : REV\_CNTR\_ANSI3\_CD  
SAS ALIAS : REVANSI3  
STANDARD ALIAS : REV\_CNTR\_ANSI\_3\_CD  
TITLE ALIAS : ANSI\_CD

LENGTH : 5

SOURCE : CWF

245. Revenue Center 4th ANSI Code  
5

29

33

CHAR

The fourth code used to identify the detailed reason an adjustment was made (e.g. reason for denial or reducing payment).

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if

certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.

DB2 ALIAS : REV\_CNTR\_ANSI4\_CD  
SAS ALIAS : REVANSI4  
STANDARD ALIAS : REV\_CNTR\_ANSI\_4\_CD  
TITLE ALIAS : ANSI\_CD

LENGTH : 5

SOURCE : CWF

246. Revenue Center APC/HIPPS Code

5 34 38

CHAR

Effective with Version 'I', this field was created to house two pieces of data. The Ambulatory Payment Classification (APC) code and the HIPPS code. The APC is used to identify groupings of outpatient services. APC codes are used to calculate payment for services under OPPS. The APC is a four byte field. The HIPPS codes are used to identify patient classifications for SNFPPS, HHPPS and IREPPS that will be used to calculate payment. The HIPPS code is a five byte field.

NOTE1: The APC field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.



Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: Under SNFPPS, HHPPS & IRFPPS, HIPPS codes are stored in the HCPCS field. \*\*EXCEPTION: if a HHPPS HIPPS code is downcoded/upcoded the downcoded/upcoded HIPPS will be stored in this field.

NOTE3: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.

DB2 ALIAS : REV\_APC\_HIPPS\_CD S  
SAS ALIAS : APCHIPPS  
STANDARD ALIAS : REV\_CNTR\_APC\_HIPPS\_CD  
TITLE ALIAS : APC\_HIPPS

LENGTH : 5

SOURCE : CWF

CODE TABLE : REV\_CNTR\_APC\_TB

247. Revenue Center Healthcare Common Procedure Coding System Code

5 39 43 CHAR

Healthcare Common Procedure Coding System (HCPCS) is a collection of codes that represent procedures, supplies, products and services which may be provided to Medicare beneficiaries and to individuals enrolled in private health insurance programs. The codes are divided into three levels, or groups, as described below:

DB2 ALIAS : REV\_CNTR\_HCPCS\_CD  
STANDARD ALIAS : REV\_CNTR\_HCPCS\_CD  
TITLE ALIAS : HCPCS\_CD

LENGTH : 5

COMMENTS :

Prior to Version H this field was named: HCPCS\_CD. With Version H, a prefix was added to denote the location of this field on each claim type (institutional: REV\_CNTR and non-institutional: LINE).

NOTE: When revenue center code = '0022' (SNF PPS), '0023' (HH PPS), or '0024' (IRF PPS); this field contains the Health Insurance PPS (HIPPS) code.

The HIPPS code for SNF PPS contains the rate code/assessment type that identifies (1) RUG-III group the beneficiary was classified into as of the RAI MDS assessment reference date and (2) the type of assessment for payment purposes.

The HIPPS code for Home Health PPS identifies (1) the three case-mix dimensions of the HHRG system, clinical, functional and utilization, from which a beneficiary is assigned to one of the 80 HHRG categories and (2) it identifies whether or not the elements of the code were computed or derived. The HHRGs, represented by the HIPPS coding, will be the basis of payment for each episode.

The HIPPS code (CMG Code) for IRF PPS identifies the clinical characteristics of the beneficiary. The HIPPS rate/CMG code (AXXY - DXXYY) must contain five digits. The first position of the code is an A, B, C, or 'D'. The HIPPS code beginning with an 'A' in front of the CMG is defined as without comorbidity. The 'B' in front of the CMG is defined as with comorbidity for Tier 1. The 'C' is defined as comorbidity for Tier 2 and 'D' is defined as comorbidity for Tier 3. The 'XX' in the HIPPS rate code is the Rehabilitation Impairment Code (RIC). The 'YY' is the sequential number system within the RIC.

For SNF PPS, HH PPS & IRF PPS HIPPS values see CLM\_HIPPS\_TB.

#### Level I

Codes and descriptors copyrighted by the American Medical Association's Current Procedural Terminology, Fourth Edition (CPT-4). These are 5 position numeric codes representing physician and nonphysician services.

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

CPT-4 codes including both long and short descriptions shall be used in accordance with the HCFA/AMA agreement. Any other use violates the AMA copyright.

#### Level II

Includes codes and descriptors copyrighted by the American Dental Association's Current Dental Terminology, Second Edition (CDT-2). These are 5 position alpha-numeric codes comprising the D series. All other level II codes and descriptors are approved and maintained jointly by the alpha-numeric editorial panel (consisting of HCFA, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association). These are 5 position alpha-numeric codes representing primarily items and nonphysician services that are not represented in the level I codes.

#### Level III

Codes and descriptors developed by Medicare carriers for use at the local (carrier) level. These are 5 position alpha-numeric codes in the W, X, Y or Z series representing physician and nonphysician services that are not represented in the level I or level II codes.

#### LIMITATIONS :

REFER TO :  
HHA\_HCPCS\_LIM

CODE TABLE : CLM\_HIPPS\_TB

#### 248. Revenue Center HCPCS Initial Modifier Code

2 44 45 CHAR

A first modifier to the procedure code to enable a more specific procedure identification for the claim.

DB2 ALIAS : REV\_HCPCS\_MDFR\_CD  
STANDARD ALIAS : REV\_CNTR\_HCPCS\_INITL\_MDFR\_CD  
TITLE ALIAS : INITIAL\_MODIFIER

LENGTH : 2

#### COMMENTS :

Prior to Version H this field was named: HCPCS\_INITL\_MDFR\_CD. With Version H, a prefix was added to denote the location of this field on each claim type (institutional: REV\_CNTR and non-institutional: LINE).

SOURCE : CWF

EDIT RULES :  
Carrier Information File

249. Revenue Center HCPCS Second Modifier Code  
2 46 47

CHAR

A second modifier to the procedure code to make it more specific than the first modifier code to identify the procedures performed on the beneficiary for the claim.

DB2 ALIAS : REV\_HCPCS\_2ND\_CD  
STANDARD ALIAS : REV\_CNTR\_HCPCS\_2ND\_MDFR\_CD  
TITLE ALIAS : SECOND\_MODIFIER

LENGTH : 2

COMMENTS :  
Prior to Version H this field was named:  
HCPCS\_2ND\_MDFR\_CD. With Version H, a prefix  
was added to denote the location of this field  
on each claim type (institutional: REV\_CNTR and  
non-institutional: LINE).

SOURCE : CWF

EDIT RULES :  
CARRIER INFORMATION FILE

250. Revenue Center HCPCS Third Modifier Code  
2 48 49

CHAR

Effective with Version I, a third modifier to the procedure code to make it more specific than the second modifier code to identify the procedures performed on the beneficiary for the claim.

DB2 ALIAS : REV\_HCPCS\_3RD\_CD  
STANDARD ALIAS : REV\_CNTR\_HCPCS\_3RD\_MDFR\_CD  
TITLE ALIAS : THIRD\_MODIFIER

LENGTH : 2

COMMENTS :  
NOTE: Beginning with NCH weekly process date  
8/18/00, this field will be populated with data.  
Claims processed prior to 8/18/00 will contain  
spaces in this field.

SOURCE : CWF

EDIT RULES :  
CARRIER INFORMATION FILE

251. Revenue Center HCPCS Fourth Modifier Code  
2 50 51

CHAR

Effective with Version I, a fourth modifier to the procedure code to make it more specific than the third modifier code to identify the procedures performed on the beneficiary for the claim.

DB2 ALIAS : REV\_HCPCS\_4TH\_CD  
STANDARD ALIAS : REV\_CNTR\_HCPCS\_4TH\_MDFR\_CD  
TITLE ALIAS : FOURTH\_MODIFIER

LENGTH : 2

COMMENTS :

NOTE: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.

SOURCE : CWF

EDIT RULES :  
CARRIER INFORMATION FILE

252. Revenue Center HCPCS Fifth Modifier Code  
2 52 53

CHAR

Effective with Version I, a fifth modifier to the procedure code to make it more specific than the fourth modifier code to identify the procedures performed on the beneficiary for the claim.

DB2 ALIAS : REV\_HCPCS\_5TH\_CD  
SAS ALIAS : MDFR\_CD5  
STANDARD ALIAS : REV\_CNTR\_HCPCS\_5TH\_MDFR\_CD  
TITLE ALIAS : FIFTH\_MODIFIER

LENGTH : 2

COMMENTS :

NOTE: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.

SOURCE : CWF

EDIT RULES :  
CARRIER INFORMATION FILE

253. Revenue Center Payment Method Indicator Code

2 54 55 CHAR

Effective with Version 'I', the code used to identify how the service is priced for payment. This field is made up of two pieces of data, 1st position being the service indicator and the 2nd position being the payment indicator.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

NOTE3: Effective 10/2005, this field will no longer represent the service indicator and the payment indicator. This field will now house the 2-byte payment indicator. The status indicator will be housed in a new field named: REV\_CNTR\_STUS\_IND\_CD.

DB2 ALIAS : REV\_PMT\_MTHD\_CD  
SAS ALIAS : PMTMTHD

STANDARD ALIAS : REV\_CNTR\_PMT\_MTHD\_IND\_CD  
TITLE ALIAS : PMT\_MTHD

LENGTH : 2

SOURCE : CWF

CODE TABLE : REV\_CNTR\_PMT\_MTHD\_IND\_TB

254. Revenue Center Discount Indicator Code  
1 56 56

CHAR

Effective with Version 'I', this code represents a factor that specifies the amount of any APC discount. The discounting factor is applied to a line item with a service indicator (part of the REV\_CNTR\_PMT\_MTHD\_IND\_CD) of 'T'. The flag is applicable when more than one significant procedure is performed. \*\*If there is no discounting the factor will be 1.0.\*\*

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

NOTE3: VALUES D, U & T REPRESENT THE FOLLOWING:  
D = Discounting fraction (currently 0.5)  
U = Number of units  
T = Terminated procedure discount (currently 0.5)

DB2 ALIAS : REV\_DSCNT\_IND\_CD  
SAS ALIAS : DSCNTIND  
STANDARD ALIAS : REV\_CNTR\_DSCNT\_IND\_CD  
TITLE ALIAS : REV\_CNTR\_DSCNT\_IND\_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : REV\_CNTR\_DSCNT\_IND\_TB

255. Revenue Center Packaging Indicator Code  
1 57 57

CHAR

Effective with Version 'I', the code used to identify those services that are packaged/bundled with another service.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPBS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPBS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the



dates of service.

DB2 ALIAS : REV\_PACKG\_IND\_CD  
SAS ALIAS : PACKGIND  
STANDARD ALIAS : REV\_CNTR\_PACKG\_IND\_CD  
TITLE ALIAS : REV\_CNTR\_PACKG\_IND

LENGTH : 1

SOURCE : CWF

CODE TABLE : REV\_CNTR\_PACKG\_IND\_TB

256. Revenue Center Pricing Indicator Code  
2 58 59

CHAR

Effective with Version 'I', the code used to identify if there was a deviation from the standard method of calculating payment amount.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2        ALIAS : REV\_PRICNG\_IND\_CD  
SAS        ALIAS : PRICNG  
STANDARD ALIAS : REV\_CNTR\_PRICNG\_IND\_CD  
TITLE      ALIAS : REV\_CNTR\_PRICNG\_IND  
  
LENGTH        : 2  
  
SOURCE         : CWF  
  
CODE TABLE    : REV\_CNTR\_PRICNG\_IND\_TB

257. Revenue Center Obligation to Accept As Full (OTAF) Payment Code  
1        60        60        CHAR

Effective with Version 'j' the code used to indicate that the provider was obligated to accept as full payment the amount received from the primary (or secondary) payer.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2        ALIAS : REV\_OTAF\_IND\_CD  
SAS        ALIAS : OTAF

LENGTH : 1

SOURCE : CWF

EDIT RULES :

Y = provider is obligated to accept the payment  
as payment in full for the service.

N or blank = provider is not obligated to accept  
the payment, or there is no payment by a prior  
payer.

258. Revenue Center IDE, NDC, UPC Number  
24 61

84 CHAR

Effective with Version H, the exemption number assigned by the Food and Drug Administration (FDA) to an investigational device after a manufacturer has been approved by FDA to conduct a clinical trial on that device. HCFA established a new policy of covering certain IDE's which was implemented in claims processing on 10/1/96 (which is NCH weekly process 10/4/96) for service dates beginning 10/1/95. IDE's are always associated with revenue center code '0624'.

NOTE1: Prior to Version H a 'dummy' revenue center code '0624' trailer was created to store IDE's. The IDE number was housed in two fields: HCPCS code and HCPCS initial modifier; the second modifier contained the value 'ID'. There can be up to 7 distinct IDE numbers associated with an '0624' dummy trailer. During the Version H conversion IDE's were moved from the dummy '0624' trailer to this dedicated field.

NOTE2: Effective with Version 'I', this field was renamed to eventually accommodate the National Drug Code (NDC) and the Universal Product Code (UPC). This field could contain either of these 3 fields (there would never be an instance where more than one would come in on a claim). The size of this field was expanded to X(24) to accommodate either of the new fields (under Version 'H' it was X(7)). DATA ANAMOLY/LIMITATION: During an CWFMQA review an edit revealed the IDE was missing. The problem occurs in claim with an NCH weekly process dates of 6/9/00 through 9/8/00. During processing of the new format the program receives the IDE but then blanked out the data.

DB2 ALIAS : IDE\_NDC\_UPC\_NUM  
SAS ALIAS : IDENDC  
STANDARD ALIAS : REV\_CNTR\_IDE\_NDC\_UPC\_NUM  
TITLE ALIAS : IDE\_NDC\_UPC

LENGTH : 24

SOURCE : CWF

LIMITATIONS :

REFER TO :  
REV\_CNTR\_IDE\_NDC\_UPC\_LIM

259. Revenue Center NDC Quantity Qualifier Code  
2 85 86

CHAR

Effective with Version 'J', the code used to indicate the unit of measurement for the drug that was administered.

DB2 ALIAS : NDC\_QTY\_QLFR\_CD  
SAS ALIAS : QTYQLFR  
STANDARD ALIAS : REV\_CNTR\_NDC\_QTY\_QLFR\_CD

LENGTH : 2

CODE TABLE : REV\_CNTR\_NDC\_QTY\_QLFR\_TB

260. Revenue Center NDC Quantity  
6 87 92

PACK

Effective with Version 'J', the quantity dispensed for the drug reflected on the revenue center line item.

DB2 ALIAS : NDC\_QTY\_NUM  
SAS ALIAS : NDCQTY

LENGTH : 7.3 SIGNED : Y

261. Revenue Center Unit Count  
4 93 96

PACK

A quantitative measure (unit) of the number of times the service or procedure being reported was performed according to the revenue center/HCPSC code definition as described on an institutional claim.

Depending on type of service, units are measured by number of covered days in a particular accommodation, pints of blood, emergency room visits, clinic visits, dialysis

treatments (sessions or days), outpatient therapy visits, and outpatient clinical diagnostic laboratory tests.

NOTE1: When revenue center code = '0022' (SNF PPS) the unit count will reflect the number of covered days for each HIPPS code and, if applicable, the number of visits for each rehab therapy code.

DB2 ALIAS : REV\_CNTR\_UNIT\_CNT  
SAS ALIAS : REV\_UNIT  
STANDARD ALIAS : REV\_CNTR\_UNIT\_CNT  
TITLE ALIAS : UNITS

LENGTH : 7 SIGNED : Y

SOURCE : CWF

262. Revenue Center Rate Amount

6 97 102

PACK

Charges relating to unit cost associated with the revenue center code. Exception (encounter data only): If plan (e.g. MCO) does not know the actual rate for the accommodations, \$1 will be reported in the field.

NOTE1: For SNF PPS claims (when revenue center code equals '0022'), CMS has developed a SNF PRICER to compute the rate based on the provider supplied coding for the MDS RUGS III group and assessment type (HIPPS code, stored in revenue center HCPCS code field).

NOTE2: For OP PPS claims, CMS has developed a PRICER to compute the rate based on the Ambulatory Payment Classification (APC), discount factor, units of service and the wage index.

NOTE3: Under HH PPS (when revenue center code equals '0023'), CMS has developed a HHA PRICER to compute the rate. On the RAP, the rate is determined using the case mix weight associated with the HIPPS code, adjusting it for the wage index for the beneficiary's site of service, then multiplying the result by 60% or 50%, depending on whether or not the RAP is for a first episode.

On the final claim, the HIPPS code could change the payment if the therapy threshold is not met, or partial episode payment (PEP) adjustment or a

significant change in condition (SCIC) adjustment.  
In cases of SCICs, there will be more than one  
'0023' revenue center line, each representing the  
payment made at each case-mix level.

NOTE4: For IRF PPS claims (when revenue center  
code equals '0024'), CMS has developed a PRICER  
to compute the rate based on the HIPPS/CMG  
(HIPPS code, stored in revenue center HCPCS code  
field).

DB2 ALIAS : REV\_CNTR\_RATE\_AMT  
SAS ALIAS : REV\_RATE  
STANDARD ALIAS : REV\_CNTR\_RATE\_AMT  
TITLE ALIAS : CHARGE\_PER\_UNIT

LENGTH : 9.2 SIGNED : Y

COMMENTS :  
Prior to Version H the size of this field was:  
S9(7)V99.

SOURCE : CWF

263. Revenue Center Blood Deductible Amount  
6 103 108

PACK

Effective with Version 'I', the amount of money  
for which the intermediary determined the  
beneficiary is liable for the blood deductible  
for the line item service.

NOTE1: This field is populated for those claims  
that are required to process through Outpatient  
PPS Pricer. The type of bills (TOB) required to  
process through are: 12X, 13X, 14X (except Maryland  
providers, Indian Health Providers, hospitals located  
in American Samoa, Guam and Saipan and Critical  
Access Hospitals (CAH)); 76X; 75X and 34X if  
certain HCPCS are on the bill; and any outpatient  
type of bill with a condition code '07' and certain  
HCPCS. These claim types could have lines that are  
not required to price under OPPS rules so those  
lines would not have data in this field.

Additional exception: Virgin Island hospitals and  
hospitals that furnish only inpatient Part B services  
with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be

populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV\_BLOOD\_DDCTBL  
SAS ALIAS : REVBLOOD  
STANDARD ALIAS : REV\_CNTR\_BLOOD\_DDCTBL\_AMT  
TITLE ALIAS : BLOOD\_DDCTBL\_AMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

264. Revenue Center Cash Deductible Amount  
6 109 114

PACK

Effective with Version 'I' the amount of cash deductible the beneficiary paid for the line item service.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data

has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2        ALIAS : REV\_CASH\_DDCTBL  
SAS        ALIAS : REVDCTBL  
STANDARD ALIAS : REV\_CNTR\_CASH\_DDCTBL\_AMT  
TITLE     ALIAS : CASH\_DDCTBL

LENGTH            : 9.2        SIGNED : Y

SOURCE            : CWF

265. Revenue Center Coinsurance/Wage Adjusted Coinsurance Amount  
                                6    115    120    PACK

Effective with Version 'I', the amount of coinsurance applicable to the line item service defined by the revenue center and HCPCS codes. For those services subject to Outpatient PPS, the applicable coinsurance is wage adjusted.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. The above claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

NOTE2: This field will have either a zero (for services for which coinsurance is not applicable), a regular coinsurance amount (calculated on either charges or a fee schedule) or if subject to OP PPS the national coinsurance amount will be wage adjusted. The wage adjusted coinsurance is based on the MSA where the provider is located or assigned as a result of a reclassification.

NOTE3: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion



OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : ADJSTD\_COINSRNC  
SAS ALIAS : WAGEADJ  
STANDARD ALIAS : REV\_CNTR\_WAGE\_ADJSTD\_COINS\_AMT  
TITLE ALIAS : WAGE\_ADJSTD\_COINS

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

266. Revenue Center Reduced Coinsurance Amount  
6 121 126

PACK

Effective with Version 'I', for all services subject to Outpatient PPS, the amount of coinsurance applicable to the line for a particular service (HCPCS) for which the provider has elected to reduce the coinsurance amount.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: The reduced coinsurance amount cannot be lower than 20% of the payment rate for the APC line.

NOTE3: It has been discovered that this field may be

populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : RDCD\_COINSRNC  
SAS ALIAS : RDCDCOIN  
STANDARD ALIAS : REV\_CNTR\_RDCD\_COINS\_AMT  
TITLE ALIAS : REDUCED\_COINS

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

267. Revenue Center 1st Medicare Secondary Payer Paid Amount  
6 127 132 PACK

Effective with Version 'I', the amount paid by the primary payer when the payer is primary to Medicare (Medicare is secondary).

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data

```
DB2      ALIAS : REV_MSP1_PD_AMT
SAS      ALIAS : REV_MSP1
STANDARD ALIAS : REV_CNTR_MSP1_PD_AMT
TITLE    ALIAS : MSP_PAID_AMOUNT
```

SOURCE : CWF

Effective with Version 'I', the amount paid by the secondary payer when two payers are primary to Medicare (Medicare is the tertiary payer).

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV\_MSP2\_PD\_AMT  
SAS ALIAS : REV\_MSP2  
STANDARD ALIAS : REV\_CNTR\_MSP2\_PD\_AMT  
TITLE ALIAS : MSP PAID AMOUNT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

269. Revenue Center Provider Payment Amount  
6 139 144

PACK

Effective with Version 'I', the amount paid to the provider for the services reported on the line item.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

ANAMOLY: For dates of service August 1, 2000 to the present, the OPPS revenue center fields are being processed differently by FISS and APASS (standard systems). For more information on OPPS data problems for this time period see Limitations Appendix. The following is how each system handles this field:

FISS: populated correctly with provider payment amount

APASS: provider payment amount plus interest on 1st revenue center line (CMM will instruct APASS not to include interest)

Currently, the following FI numbers are under the APASS

system and all other FI numbers are under FISS. See  
FI\_NUM table of codes for all FI numbers.

52280 -- Mutual of Omaha (until 6/1/2003)  
00430 -- Washington/Alaska (until 11/1/2003)  
00310 -- North Carolina BC (until 12/1/2003)  
00370 -- Rhode Island (until 2/1/2004)  
00270 -- New Hampshire/Vermont (until 3/1/2004)  
00181 -- Maine/Massachusetts (until 5/1/2004)

NOTE2: It has been discovered that this field may be  
populated with data on claims with dates of service  
prior to 7/00 (implementation of Claim Line Expansion  
OPPS/HHPPS). The original understanding of the new  
revenue center fields was that data would be populated  
on claims with dates of service 7/00 and forward. Data  
has been found in claims with dates of service prior to  
7/00 because the Standard Systems have processed any  
claim coming in 7/00 and after, meeting the above criteria,  
through the Outpatient Code Editor (OCE) regardless of the  
dates of service.

DB2 ALIAS : REV\_PRVDR\_PMT\_AMT  
SAS ALIAS : RPRVDPMT  
STANDARD ALIAS : REV\_CNTR\_PRVDR\_PMT\_AMT  
TITLE ALIAS : REV\_PRVDR\_PMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

270. Revenue Center Beneficiary Payment Amount  
6 145 150

PACK

Effective with Version I, the amount paid  
to the beneficiary for the services reported  
on the line item.

NOTE1: This field is populated for those claims  
that are required to process through Outpatient  
PPS Pricer. The type of bills (TOB) required to  
process through are: 12X, 13X, 14X (except Maryland  
providers, Indian Health Providers, hospitals located  
in American Samoa, Guam and Saipan and Critical  
Access Hospitals (CAH)); 76X; 75X and 34X if  
certain HCPCS are on the bill; and any outpatient  
type of bill with a condition code '07' and certain  
HCPCS. These claim types could have lines that are  
not required to price under OPPS rules so those  
lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV\_BENE\_PMT\_AMT  
SAS ALIAS : RBENEPMT  
STANDARD ALIAS : REV\_CNTR\_BENE\_PMT\_AMT  
TITLE ALIAS : REV\_BENE\_PMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

271. Revenue Center Patient Responsibility Payment Amount  
6 151 156 PACK

Effective with Version I, the amount paid by the beneficiary to the provider for the line item service.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

ANAMOLY: For dates of service August 1, 2000 to present, the OPPS revenue center fields are being processed differently by FISS and APASS (standard systems). For more information on OPPS data problems for this time period see the Limitations Appendix. The following is how each system is handling this field:

FISS: populating correctly (sum of coinsurance and deductible)

APASS: not populating this field

Currently, the following FI numbers are under the APASS system and all other FI numbers are under FISS. See FI\_NUM table of codes for all FI numbers.

52280 -- Mutual of Omaha (until 6/1/2003)  
00430 -- Washington/Alaska (until 11/1/2003)  
00310 -- North Carolina BC (until 12/1/2003)  
00370 -- Rhode Island (until 2/1/2004)  
00270 -- New Hampshire/Vermont (until 3/1/2004)  
00181 -- Maine/Massachusetts (until 5/1/2004)

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV\_PTNT\_RESP\_AMT  
SAS ALIAS : PTNTRESP  
STANDARD ALIAS : REV\_CNTR\_PTNT\_RESP\_PMT\_AMT  
TITLE ALIAS : REV\_PTNT\_RESP

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

272. Revenue Center Payment Amount  
6 157 162

PACK

Effective with Version 'I', the line item Medicare payment amount for the specific revenue center.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

ANAMOLY: For dates of service August 1, 2000 to present, the OPPS revenue center fields are being processed differently by FISS and APASS (standard systems). For more information on OPPS data problems for this time period see the Limitations Appendix. The following is how each system is handling this field:

FISS: this field contains provider reimbursement.

APASS: provider payment amount plus coinsurance and deductible (should not include coinsurance and deductible). Users should rely on provider payment amount field for the trust fund payment.

Currently, the following FI numbers are under the APASS system and all other FI numbers are under FISS. See FI\_NUM table of codes for all FI numbers.

52280 -- Mutual of Omaha (until 6/1/2003)  
00430 -- Washington/Alaska (until 11/1/2003)  
00310 -- North Carolina BC (until 12/1/2003)  
00370 -- Rhode Island (until 2/1/2004)  
00270 -- New Hampshire/Vermont (until 3/1/2004)  
00181 -- Maine/Massachusetts (until 5/1/2004)

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data



has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV\_CNTR\_PMT\_AMT  
SAS ALIAS : REVPMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

EDIT RULES :  
\$\$\$\$\$\$\$CC

273. Revenue Center Total Charge Amount  
6 163 168

PACK

The total charges (covered and non-covered) for all accommodations and services (related to the revenue code) for a billing period before reduction for the deductible and coinsurance amounts and before an adjustment for the cost of services provided. NOTE: For accommodation revenue center total charges must equal the rate times units (days).

EXCEPTIONS:

(1) For SNF RUGS demo claims only (9000 series revenue center codes), this field contains SNF customary accommodation charge, (ie., charges related to the accommodation revenue center code that would have been applicable if the provider had not been participating in the demo).

(2) For SNF PPS (non demo claims), when revenue center code = '0022', the total charges will be zero.

(3) For Home Health PPS (RAPs), when revenue center code = '0023', the total charges will equal the dollar amount for the '0023' line.

(4) For Home Health PPS (final claim), when revenue center code = '0023', the total charges will be the sum of the revenue center code lines (other than '0023').

(5) For Inpatient Rehabilitation Facility (IFR) PPS, when the revenue center code = '0024', the total charges will be zero. For accommodation revenue codes (010X - 021X), total charges must equal the rate times the units.

(6) For encounter data, if the plan (e.g. MCO) does not know the actual charges for the accommodations the total charges will be \$1 (rate) times units (days).

DB2 ALIAS : REV\_TOT\_CHRG\_AMT  
SAS ALIAS : REV\_CHRG  
STANDARD ALIAS : REV\_CNTR\_TOT\_CHRG\_AMT  
TITLE ALIAS : REVENUE\_CENTER\_CHARGES

LENGTH : 9.2 SIGNED : Y

COMMENTS :  
Prior to Version H the size of this field was:  
S9(7)V99.

SOURCE : CWF

LIMITATIONS :

REFER TO :  
MLTPL\_REV\_CNTR\_0001\_CD LIM  
REV\_CNTR\_TOT\_CHRG\_AMT LIM

EDIT RULES :  
\$\$\$\$\$\$\$\$CC

274. Revenue Center Non-Covered Charge Amount  
6 169 174

PACK

The charge amount related to a revenue center code for services that are not covered by Medicare.

NOTE: Prior to Version H the field size was S9(7)V99 and the element was only present on the Inpatient/SNF format. As of NCH weekly process date 10/3/97 this field was added to all institutional claim types.

DB2 ALIAS : REV\_NCVR\_CHRG\_AMT  
SAS ALIAS : REV\_NCVR  
STANDARD ALIAS : REV\_CNTR\_NCVR\_CHRG\_AMT  
TITLE ALIAS : REV\_CENTER\_NONCOVERED\_CHARGES

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

EDIT RULES :  
\$\$\$\$\$\$\$\$CC

275. Revenue Center Deductible Coinsurance Code

1 175 175 CHAR

Code indicating whether the revenue center charges  
are subject to deductible and/or coinsurance.

DB2 ALIAS : DDCTBL\_COINSRNC\_CD  
SAS ALIAS : REVDEDCD  
STANDARD ALIAS : REV\_CNTR\_DDCTBL\_COINSRNC\_CD  
TITLE ALIAS : REVENUE\_CENTER\_DEDUCTIBLE\_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : REV\_CNTR\_DDCTBL\_COINSRNC\_TB

276. Revenue Center Consolidated Billing Code

1 176 176 CHAR

Effective 1/1/2004 with the implementation of NCH/NMUD  
CR#1, this code is reflected on outpatient claims only  
to identify those line item services (i.e. therapy  
and nonroutine supply services) that are subject  
to SNF and Home Health consolidated billing. If the  
line item service was paid by an intermediary prior  
to the submission of the SNF or home health claim  
an adjustment for the outpatient claim will be submitted  
identifying those services that are subject to  
consolidated billing.

NOTE1: Prior to 10/2005 (implementation of NCH/NMUD  
CR#2), this data was stored in position 175 (FILLER)  
in the revenue center trailer.

NOTE2: Effective July 2005, this data will no longer  
be coming into the NCH. This process is being handled  
in the new CWF override processing.

DB2 ALIAS : CNSLDTD\_BLG\_CD  
SAS ALIAS : RCNSLDTD  
STANDARD ALIAS : REV\_CNTR\_CNSLDTD\_BLG\_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : REV\_CNTR\_CNSLDTD\_BLG\_TB

277. Revenue Center Status Indicator Code

2 177 178 CHAR

Effective 10/3/2005 with the implementation of NCH/NMUD CR#2, the code used to identify the status of the line item service. This field along with the payment method indicator field is used to identify how the service was priced for payment.

NOTE1: This 2-byte indicator is being added due to an expansion of a field that currently exist on the revenue center trailer. The status indicator is currently the 1st position of the Revenue Center Payment Method Indicator Code. The payment method indicator code is being split into two 2-byte fields (payment indicator and status indicator). The expanded payment indicator will continue to be stored in the existing payment method indicator field. The split of the current payment method indicator field is due to the expansion of both pieces of data from 1-byte to 2-bytes.

NOTE2: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services.

DB2 ALIAS : REV\_STUS\_IND\_CD  
SAS ALIAS : RSTUSIND  
STANDARD ALIAS : REV\_CNTR\_STUS\_IND\_CD  
  
LENGTH : 2  
  
SOURCE : CWF  
  
CODE TABLE : REV\_CNTR\_STUS\_IND\_TB

278. Revenue Center Duplicate Claim Check Indicator Code  
1 179 179 CHAR

Effective 1/1/2009 with the implementation of NCH/NMUD

CR#4, the code used to identify an item or service that appeared to be a duplicate but has been reviewed by an FI or MAC and appropriately approved for payment.

DB2 ALIAS : DUP\_CLM\_CHK\_IND\_CD  
SAS ALIAS : DUP-CHK  
STANDARD ALIAS : REV\_CNTR\_DUP\_CLM\_CHK\_IND\_CD

LENGTH : 1

CODE TABLE : REV\_CNTR\_DUP\_CLM\_CHK\_IND\_TB

279. Revenue Center APC Buffer Code  
2 180 181

CHAR

APC - Ambulatory Payment Classification  
Effective 1/1/2009 with the implementation of CR#4, the code used to identify related line items that make up a composite APC group. This field is only applicable to outpatient PPS claims.

DB2 ALIAS : REV\_CNTR\_BUFR\_CD  
SAS ALIAS : APCBUFR  
STANDARD ALIAS : REV\_CNTR\_APC\_BUFR\_CD

LENGTH : 2

CODE TABLE : REV\_CNTR\_APC\_BUFR\_TB

280. Revenue Center Rendering Physician NPI Num  
10 182 191

CHAR

Effective with Version 'J', the NPI of the rendering physician who performed the service.

DB2 ALIAS : RNDRNG\_NPI\_NUM  
SAS ALIAS : REVNPI

LENGTH : 10

281. Revenue Center Rendering Physician Surname  
6 192 197

CHAR

Effective with Version 'J', the 6 position last name of the rendering physician who performed the service.

DB2 ALIAS : RNDRNG\_SRNM\_NAME  
SAS ALIAS : REVSRNM

LENGTH : 6

282. FILLER

100 198 297 CHAR  
DB2 ALIAS : FILLER  
LENGTH : 100

283. End of Record Code

3 1 3 CHAR  
Effective with Version 'I', the code used  
to identify the end of a record/segment or  
the end of the claim.  
DB2 ALIAS : END\_REC\_CD  
SAS ALIAS : EOR  
STANDARD ALIAS : END\_REC\_CD  
TITLE ALIAS : END\_OF\_REC  
LENGTH : 3  
COMMENTS :  
Prior to Version I this field was named:  
END\_REC\_CNSTNT.  
SOURCE : NCH  
CODE TABLE : END\_REC\_TB

\*\*\*\*\*

H3PM.R\_RIF\_MAIN\_Q,Q1,F

1

LIMITATIONS APPENDIX FOR RECORD: FI\_IP\_SNF\_CLM\_REC  
AS OF: 06/30/2011

CHOICES\_DEMO\_LIM

FULL NAME: Choices Demonstration Limitation  
DESCRIPTION :  
A programming error created an 'INVALID' indication  
in the demo text field for CHOICES claims.  
BACKGROUND :  
In 6/00, the CWFMQA front-end editing revealed that some  
CHOICES demo claims were coming in with a valid 'H'  
number in the fixed portion of the claims, but in the

first occurrence MCO trailer a numeric packed field (value hex '0100000C') was moved to the MCO Contract Number/Option Code fields. This created an invalid period check of number/code to MCO effective date, resulting in an INVALID indication in the demo info text field.

CORRECTIVE ACTION :

The problem was forwarded to the CWF BSOG staff for further investigation.

SOURCE:

CONTACT : OIS/EDG/DMUDD

CLM\_SNF\_VRSN\_I\_REC\_LIM

FULL NAME: Claim SNF Version 'I' Record Limitation

DESCRIPTION :

SNF Version 'I' claims were incorrectly identified in the NCH Nearline as Inpatient encounter claims.

BACKGROUND :

SNF claims matching the Inpatient encounter data criteria were incorrectly identified as Inpatient encounters (NCH Claim Type Code is '61', rather than '20' or '30'). If the SNF claims were identified as Inpatient encounters, the MCO Paid Switch was set to '1'.

CORRECTIVE ACTION :

The problem was corrected during the NCH quarterly update in March 2001. The NCH Claim Type was correctly identified as '20' or '30'. The MCO Paid Switch was changed to '0'. A patch code trailer was added to the record: Patch Code '14' and a patch apply date of '20010330'.

SOURCE:

ADMINISTRATIVE DATA:

START DATE : 07/07/00

END DATE : 01/26/01

CONTACT : OIS/EDG/DMUDD

CLM\_TRANS\_CD\_LIM

FULL NAME: Claim Transaction Code Limitation

DESCRIPTION :

Claim Transaction Code missing from 1999 inpatient records and there was also a problem identified in the May and June 2000 data.

BACKGROUND :

Users of the data discovered taht the claim transaction code was missing values 2 & 3 for service year 1999 and for the months of May and June, 2000. This information was confirmed and OIS/BSOG was notified.

CORRECTIVE ACTION :

In July 2000 the problem was fixed and the claim transaction code contained the correct values.

SOURCE:

CONTACT : OIS/EDG/DMUDD

HHA\_HCPCS\_LIM

FULL NAME: Home Health HCPCS Limitation

DESCRIPTION :

It was determined that providers were not complying with the 15-minute increment billing instructions for using the 'G' HCPCS codes.

BACKGROUND :

The instructions state that providers are to use the newly created 'G' codes to identify services of the six home health disciplines during an HH episode of care. These 'G' codes (G0151, G0152, G0153, G0154, G0155, G0156) are subject to 15-minute interval billing. As a result the user can not trust the 'G' codes for visit counting. For a more accurate accounting of services the user should rely on the revenue center codes rather than the HCPCS.

Currently there is a check that if the 15-minute increment 'G' codes appear, the revenue center code must be the corresponding HH discipline; however, there is no check to see if the discipline revenue center code appears and that the HCPCS contains the corresponding 'G' code.

CORRECTIVE ACTION :

The Standard Systems has put a fix in to correct this problem.

SOURCE:

CONTACT : OIS/EDG/DMUDD

IP\_IME\_GME\_LIM

FULL NAME: Inpatient IME/GME Limitation

DESCRIPTION :

Special payment records to reimburse teaching hospitals for direct/indirect graduate medical education costs (IME/GME payment records) were mistakenly put into the NCH.

BACKGROUND :

During the recovery from CWF history of NCH dropped claims, we were unaware that the files contained the IME/GME payment records. Normally, these claims are received in separate transmittals from the FFS claims and full UB-92 encounters; and are not stored in the NCH. The total number of IME/GMEs inserted was 181,693, representing \$57.76 million in reimbursement; involving service years 1998 and 1999.

To identify these claims, look for service years 1998 and 1999 inpatient claims with claim related condition codes 04 and 69. Condition code '69' is the identifying characteristic.



NOTE: There could be identical full inpatient encounter claims in history that match to these erroneous IME/GME records, except that they will not contain a condition code '69'. If the IME/GMEs are not deleted, it is possible when running the final action algorithm that the IME/GME record will remain and the full inpatient encounter claim could be dropped.

CORRECTIVE ACTION :

The IME/GME claims were not removed from the NCH, due to the impact it would have on the balancing counts. They were removed from the 1999 service year SAFs. The 1998 finalized SAFs were not rerun to incorporate the relevant dropped claims (only missing receipts for 6/18/99 and 6/25/99 weeks); the IME/GMEs are not in the 1998 SAFs.

SOURCE: NCH

CONTACT : OIS/EDG/DMUDD

MCO\_PD\_SW\_LIM

FULL NAME: Claim MCO Paid Switch Limitation

DESCRIPTION :

The MCO paid switch made consistent with criteria used to identify an inpatient encounter claim.

BACKGROUND :

During the NCH Version 'I' conversion, history was populated with an NCH Claim Type Code that will identify the record as an inpatient encounter claim. When applying the CWF logic to identify an inpatient encounter claim, it was discovered that when all the criteria was met the MCO paid switch was sometimes a blank or '0' (reflecting that the MCO did not pay the provider).

CORRECTIVE ACTION :

With the inception of the Version 'I' processing (7/00), if all the criteria for identifying an inpatient encounter claim is met but the MCO paid switch is a blank or '0' it is changed to a '1'.

A patch code = '13' was applied to all claims back to 7/1/97 service year thru date.

SOURCE:

CONTACT : OIS/EDG/DMUDD

MLTPL\_REV\_CNTR\_0001\_CD\_LIM

FULL NAME: Multiple Revenue Center '0001' Code Limitation

DESCRIPTION :

Multiple total charge '0001' revenue center codes appearing on outpatient, hospice and home health claim records.

BACKGROUND :

On outpatient, home health and hospice it appears that more than one '0001' revenue center code is showing

up on the claims. The first total charge line adds the revenue center codes above it correctly; the problem exists below the first total charge line where garbage may be present due to the FI Standard System not clearing out fields before processing the next claim. We believe the error began with the change-over to a different claims processing contractor in 1/98.

CORRECTIVE ACTION :

CWF created an edit to reject multiple '0001' revenue center codes, effective 6/28/99. EDG's CWFMQA process implemented an edit to drop any revenue center line items below the first total charge line. The NCH Nearline File, as well as the 1998 Standard Analytic Files (SAFs), have been patched/corrected to delete the multiple '0001' codes where present on any of the institutional claim types. Also, HCIS will be correcting the revenue center summaries during the next refresh.

The NCH\_PATCH\_CD field will reflect a value '10'.

SOURCE:

CONTACT : OIS/EDG/DMUDD

PMT\_AMT\_EXCEDG\_CHRG\_AMT\_LIM

FULL NAME: Claim Payment Amount Exceeding Total Charge Amount Limitation

DESCRIPTION :

Approximately 75 Inpatient claims had a reimbursement amount exceed \$500,000 which was at least 25 times the total charge amount. There were also claims where the reimbursement was less than \$500,000 but greater than the total charges.

BACKGROUND :

In November of 1999, it was brought to the attention of the HDUG that large reimbursement amounts were being paid in Pennsylvania. There were 75 inpatient claims provided where the reimbursement amount was over \$500,000 and at least 25 times the total charge amount. These claims were processed between 9/29/98 and 10/1/98. There were also claims identified with reimbursement less than \$500,000 but greater than total charge. It was later discovered that the source of the problem was an error in entering an MSA; the decimal point was off by 2 positions.

Because there were no changes in utilization, the claims were corrected and the correct payments distributed, but the new payment amounts were never sent to CWF (not in NCH). There is currently no requirement that FIs and carriers update CWF with final payment information by submitting payment only

adjustments. It was noted that there is no expectation that CWF will have final payment information for claims.

CORRECTIVE ACTION :

According to Veritus (FI), the problem was caught in their system using a pre-payment edit prior to sending out the payments. The erroneous MSA value was corrected and the claims were then sent to PRICER again and paid correctly.

The claims were corrected and correct payments were made but these new payment amounts were never sent to CWF and are not reflected in the NCH.

SOURCE:

CONTACT                      OIS/EDG/DMUDD

PPS\_CPTL\_DRG\_WT\_NUM\_LIM

FULL NAME: Claim PPS Capital DRG Weight                      Number Limitation  
DESCRIPTION :

Field erroneously blanked out on segments 2-10.

BACKGROUND :

During the Version 'I' conversion of all service years (1991-6/30/00) the following field was erroneously blanked out on segments 2-10.

During the Version 'I' planning process, it was decided that all codes, dates, numbers, names and percent fields would be populated on all segments of a claim; but amount, counts, and quantities would be zeroed out on segments 2-10 to eliminate the risk of overstating values.

CORRECTIVE ACTION :

This data can not be recovered.

SOURCE:

CONTACT                      : OIS/EDG/DMUDD

PPS\_CPTL\_DSCHRG\_FRCTN\_PCT\_LIM

FULL NAME: Claim PPS Capital Discharge Fraction                      Percent Limitation  
DESCRIPTION :

Field erroneously blanked out on segments 2-10.

BACKGROUND :

During the Version 'I' conversion of all service years (1991 through 6/30/00) the following field was erroneously blanked out on segments 2-10.

During the Version 'I' planning process, it was decided that all codes, dates, numbers, names and percent fields would be populated on all segments of a claim; but amount, counts, and quantities would be zeroed out on segments 2-10 to eliminate the risk of overstating values.

CORRECTIVE ACTION :

This data can not be recovered.

SOURCE:

CONTACT                      : OIS/EDG/DMUDD

REV\_CNTR\_IDE\_NDC\_UPC\_LIM

FULL NAME: Revenue Center IDE, NDC, UPC Limitation  
DESCRIPTION :  
Missing data in the REV\_CNTR\_IDE\_NDC\_UPC\_NUM  
field.  
BACKGROUND :  
Prior to Version 'I', this field housed only the 7-position  
exemption number assigned by the FDA to an investigational  
device after a manufacturer has been approved to conduct  
a clinical trial on that device. With Version 'I', this  
field expanded to 24 positions to accommodate the future  
receipt of the National Drug Code and the Uniform Product  
Code. The CWFMQA editing process was moving the IDE to  
the expanded field, but then incorrectly blanked it out  
(positions 8-24 should be blank).  
CORRECTIVE ACTION :  
CWFMQA fixed the code and the problem was corrected with  
claims processed with NCH weekly process date 9/15/00.  
SOURCE:  
ADMINISTRATIVE DATA:  
START DATE : 06/09/00  
END DATE : 09/08/00  
CONTACT : OIS/EDG/DMUDD

REV\_CNTR\_TOT\_CHRG\_AMT\_LIM

FULL NAME: Revenue Center Total Charge Amount Limitation  
DESCRIPTION :  
Revenue center total charge amount field being  
populated on segments 2-10 of the Version 'I'  
record.  
BACKGROUND :  
Under Version 'I', a decision was made that any  
amount, count and quantity field would be zeroed  
out to eliminate the risk of overstating values  
during an accumulation.  
CORRECTIVE ACTION :  
The CWFMQA front-end process was modified to zero  
out the total charge amount field in segments 2-10.  
SOURCE:  
ADMINISTRATIVE DATA:  
START DATE : 07/01/00  
END DATE : 02/02/01  
CONTACT : OIS/EDG/DMUDD

TOT\_CHRG\_AMT\_LIM

FULL NAME: Claim Total Charge Amount Limitation  
DESCRIPTION :  
The total charge amount field in the fixed portion was  
truncated on outpatient, hospice and home health claims.  
BACKGROUND :  
For outpatient, hospice and home health claims, the  
total charge amount field in the fixed portion was

truncated (the cents were dropped off; the decimal point was moved, making cents out of dollars) in the CWFMQA process beginning with data received from CWF 1/4/99 through 5/14/99. The problem occurred when CWF increased the size of the field.

CORRECTIVE ACTION :

The CWFMQA front-end was fixed. The Nearline was patched during the quarterly merge in 7/99 for service years 1998 and 1999. The NCH PACTCH CD field will be populated with a value '11'. The 1998 and 1999 SAFs were corrected when finalized in 7/99.

The patch involved moving the total charge amount in the revenue center trailer to the total charge amount field in the fixed portion, for records with NCH Daily Process Date 1/4/99 - 5/14/99.

SOURCE:

ADMINISTRATIVE DATA:

START DATE : 01/04/99  
END DATE : 05/14/99  
CONTACT : OIS/EDG/DMUDD

CLM\_POA\_IND\_CD\_LIM

FULL NAME: Claim Present on Admission Indicator Code Limitation

DESCRIPTION :

DESCRIPTION:

Missing present on admission (POA) indicators on the NCH claims.

BACKGROUND :

A problem has been discovered with the Inpatient claims received from CWF from July 6, 2009 through October 4, 2009. The claims received during this timeperiod have no POA indicators. The problem was a result of a defect in the conversion code used by CWF to convert the new 5010 record format back to the 4010 format for the NCH. The reason CWF was converting the claims to the 4010 format was because they implemented the 5010 format beginning in July 2009 but the NCH is still using the 4010 until 1/3/2011.

CORRECTIVE ACTION :

CORRECTIVE ACTION:

CWF will be sending in adjustment claims to correct the problem. The claims will come into the NCH the week of December 19, 2009. There were approximately 3 million claims missing the POA indicator.

SOURCE:

ADMINISTRATIVE DATA:

START DATE : 7/6/09  
END DATE : 10/5/09  
CONTACT  
CONTACT act: OIS/EDG/DIDPM

06/30/2011

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H3PM.R\_RIF\_LIM\_Q,F  
1  
CMS RIF REPORT  
AS OF: 07/01/2011

NAME	LENGTH	BEG	END	CONTENTS
*** FI Outpatient Claim Record (NCH)				
VAR	1	16292	REC	
				Fiscal intermediary outpatient claim record for version J of the NCH.
				STANDARD ALIAS : FI_OP_CLM_REC SYSTEM ALIAS : UTLOUTPJ
				LIMITATIONS :
				REFER TO :
				CHOICES_DEMO_LIM
				CLM_OPPS_LIM
				CLM_TRANS_CD_LIM
				HHA_HCPCS_LIM
				MCO_PD_SW_LIM
				MLTPL_REV_CNTR_0001_CD_LIM
				PMT_AMT_EXCEDG_CHRG_AMT_LIM
				REV_CNTR_IDE_NDC_UPC_LIM
				REV_CNTR_TOT_CHRG_AMT_LIM
				TOT_CHRG_AMT_LIM
1. FI Outpatient Claim Fixed Group				
673	1	673	GRP	
				Fixed portion of the fiscal intermediary outpatient claim record for version J of the NCH.
				STANDARD ALIAS : FI_OP_CLM_FIX_GRP
2. Claim Record Identification Group				
8	1	8	GRP	

Effective with Version 'I' the record length, version code, record identification, code and NCH derived claim type code were moved to this group for internal NCH processing.

STANDARD ALIAS : CLM\_REC\_IDENT\_GRP

3. Record Length Count

3 1 3

PACK

Effective with Version H, the count (in bytes) of the length of the claim record.

NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991).

DB2 ALIAS : REC\_LNGTH\_CNT  
SAS ALIAS : REC\_LEN  
STANDARD ALIAS : REC\_LNGTH\_CNT

LENGTH : 5 SIGNED : Y

SOURCE : NCH

4. NCH Near-Line Record Version Code

1 4 4

CHAR

The code indicating the record version of the Nearline file where the institutional, carrier or DMERC claims data are stored.

DB2 ALIAS : NCH\_REC\_VRSN\_CD  
SAS ALIAS : REC\_LVL  
STANDARD ALIAS : NCH\_NEAR\_LINE\_REC\_VRSN\_CD  
TITLE ALIAS : NCH\_VERSION

LENGTH : 1

COMMENTS :  
Prior to Version H this field was named:  
CLM\_NEAR\_LINE\_REC\_VRSN\_CD.

SOURCE : NCH

CODE TABLE : NCH\_NEAR\_LINE\_REC\_VRSN\_TB

5. NCH Near Line Record Identification Code

1 5 5

CHAR

A code defining the type of claim record being processed.

COMMON ALIAS : RIC  
DB2 ALIAS : NEAR\_LINE\_RIC\_CD  
SAS ALIAS : RIC\_CD  
STANDARD ALIAS : NCH\_NEAR\_LINE\_RIC\_CD  
TITLE ALIAS : RIC

LENGTH : 1

COMMENTS :  
Prior to Version H this field was named:  
RIC\_CD.

SOURCE : NCH

CODE TABLE : NCH\_NEAR\_LINE\_RIC\_TB

6. NCH MQA RIC Code

1 6 6 CHAR

Effective with Version H, the code used (for internal editing purposes) to identify the record being processed through CMS' CWFMQA system.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : NCH\_MQA\_RIC\_CD  
SAS ALIAS : MQA\_RIC  
STANDARD ALIAS : NCH\_MQA\_RIC\_CD  
TITLE ALIAS : MQA\_RIC

LENGTH : 1

SOURCE : NCH QA PROCESS

CODE TABLE : NCH\_MQA\_RIC\_TB

7. NCH Claim Type Code

2 7 8 CHAR

The code used to identify the type of claim record being processed in NCH.

NOTE1: During the Version H conversion this field was populated with data throughout history (back to service year 1991).



NOTE2: During the Version I conversion this field was expanded to include inpatient 'full' encounter claims (for service dates after 6/30/97).

NOTE3: Effective with Version 'J', 3 new code values have been added to include a type code for the Medicare Advantage claims (IME/GME, no-pay and paid as FFS). During the Version 'J' conversion, these type codes were populated throughout history. With Version 'J', these claims are also being stored in NMUD. Prior to Version 'J' they were only in the NCH. No history was converted in NMUD.

DB2        ALIAS : NCH\_CLM\_TYPE\_CD  
SAS        ALIAS : CLM\_TYPE  
STANDARD ALIAS : NCH\_CLM\_TYPE\_CD  
TITLE     ALIAS : CLAIM\_TYPE

LENGTH        : 2

DERIVATIONS :

FFS CLAIM TYPE CODES DERIVED FROM:

NCH\_CLM\_NEAR\_LINE\_RIC\_CD  
NCH\_PMT\_EDIT\_RIC\_CD  
NCH\_CLM\_TRANS\_CD  
NCH\_PRVDR\_NUM

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:

(Pre-HDC processing -- AVAILABLE IN NCH)

CLM\_MCO\_PD\_SW  
CLM\_RLT\_COND\_CD  
MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD  
MCO\_PRD\_EFCTV\_DT  
MCO\_PRD\_TRMNTN\_DT

DERIVATION RULES:

SET CLM\_TYPE\_CD TO 10 (HHA CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V', 'W' OR 'U'
2. PMT\_EDIT\_RIC\_CD EQUAL 'F'
3. CLM\_TRANS\_CD EQUAL '5'

SET CLM\_TYPE\_CD TO 20 (SNF NON-SWING BED CLAIM) WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'
3. CLM\_TRANS\_CD EQUAL '0' OR '4'
4. POSITION 3 OF PRVDR\_NUM IS NOT 'U', 'W', 'Y' OR 'Z'

SET CLM\_TYPE\_CD TO 30 (SNF SWING BED CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'  
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'  
3. CLM\_TRANS\_CD EQUAL '0' OR '4'  
4. POSITION 3 OF PRVDR\_NUM EQUAL 'U', 'W', 'Y'  
OR 'Z'

SET CLM\_TYPE\_CD TO 40 (OUTPATIENT CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'W'  
2. PMT\_EDIT\_RIC\_CD EQUAL 'D'  
3. CLM\_TRANS\_CD EQUAL '6'

SET CLM\_TYPE\_CD TO 50 (HOSPICE CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'  
2. PMT\_EDIT\_RIC\_CD EQUAL 'I'  
3. CLM\_TRANS\_CD EQUAL 'H'

SET CLM\_TYPE\_CD TO 60 (INPATIENT CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'  
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'  
3. CLM\_TRANS\_CD EQUAL '1' '2' OR '3'

SET CLM\_TYPE\_CD TO 61 (INPATIENT 'FULL' ENCOUNTER  
CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 -  
12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_MCO\_PD\_SW = '1'  
2. CLM\_RLT\_COND\_CD = '04'  
3. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = 'C'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS

SET CLM\_TYPE\_CD TO 61 (INPATIENT 'FULL' ENCOUNTER  
CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE  
FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'  
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'  
3. CLM\_TRANS\_CD EQUAL '1' '2' OR '3'  
4. FI\_NUM = 80881

SET CLM\_TYPE\_CD TO 62 (Medicare Advantage IME/GME  
CLAIMS - 10/1/05 - FORWARD)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_MCO\_PD\_SW = '0'

2. CLM\_RLT\_COND\_CD = '04' & '69'  
3. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = 'C'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS

SET CLM\_TYPE\_CD TO 63 (HMO NO-PAY CLAIMS)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
CLAIMS PROCESSED ON OR AFTER 10/6/08

1. CLM\_THRU\_DT ON OR AFTER 10/1/06  
2. CLM\_MCO\_PD\_SW = '1'  
3. CLM\_RLT\_COND\_CD = '04'  
4. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = 'A', 'B' OR 'C'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS  
5. ZERO REIMBURSEMENT (CLM\_PMT\_AMT)

SET CLM\_TYPE\_CD TO 63 (HMO NO-PAY CLAIMS)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
CLAIMS PROCESSED PRIOR to 10/6/08

1. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = 'A', 'B' OR 'C'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS  
2. ZERO REIMBURSEMENT (CLM\_PMT\_AMT)

SET CLM\_TYPE\_CD TO 64 (HMO CLAIMS PAID AS FFS)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
CLAIMS PROCESSED PRIOR to 10/6/08

1. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = '1', '2' OR '4'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS

SET CLM\_TYPE\_CD TO 64 (HMO CLAIMS PAID AS FFS)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
CLAIMS PROCESSED on or after 10/6/08

1. CLM\_RLT\_COND\_CD = '04'  
2. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = '1', '2' OR '4'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS

SET CLM\_TYPE\_CD TO 71 (RIC O non-DMEPOS CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'O'  
2. HCPCS\_CD not on DMEPOS table

SET CLM\_TYPE\_CD TO 72 (RIC O DMEPOS CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'O'  
2. HCPCS\_CD on DMEPOS table (NOTE: if one or  
more line item(s) match the HCPCS on the  
DMEPOS table).

SET CLM\_TYPE\_CD TO 81 (RIC M non-DMEPOS DMERC  
CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'M'  
2. HCPCS\_CD not on DMEPOS table

SET CLM\_TYPE\_CD TO 82 (RIC M DMEPOS DMERC CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'M'  
2. HCPCS\_CD on DMEPOS table (NOTE: if one or  
more line item(s) match the HCPCS on the  
DMEPOS table).

SOURCE : NCH

CODE TABLE : NCH\_CLM\_TYPE\_TB

8. Fiscal Intermediary Claim Link Group  
125 9 133

GRP

Effective with Version 'I', this group  
contains those fields necessary to keep  
segments together (a claim may have up to 10  
segments due to the increase in number of  
revenue center trailers (up to 450). It is  
also used to house fields necessary for sorting  
and the final action process.

STANDARD ALIAS : FI\_CLM\_LINK\_GRP

9. Claim Locator Number Group  
11 9 19

GRP

This number uniquely identifies the beneficiary in  
the NCH Nearline.

COMMON ALIAS : HIC  
STANDARD ALIAS : CLM\_LCTR\_NUM\_GRP  
TITLE ALIAS : HICAN

10. Beneficiary Claim Account Number  
9 9 17

CHAR

The number identifying the primary beneficiary  
under the SSA or RRB programs submitted.

COMMON ALIAS : CAN  
DB2 ALIAS : BENE\_CLM\_ACNT\_NUM  
SAS ALIAS : CAN  
STANDARD ALIAS : BENE\_CLM\_ACNT\_NUM  
TITLE ALIAS : CAN

LENGTH : 9

SOURCE : SSA,RRB

LIMITATIONS :  
RRB-issued numbers contain an overpunch in  
the first position that may appear as a plus  
zero or A-G. RRB-formatted numbers may  
cause matching problems on non-IBM machines.

11. NCH Category Equatable Beneficiary Identification Code  
2 18 19

CHAR

The code categorizing groups of BICs  
representing similar relationships between  
the beneficiary and the primary wage earner.

The equatable BIC module electronically matches  
two records that contain different BICs where  
it is apparent that both are records for the  
same beneficiary. It validates the BIC and  
returns a base BIC under which to house the  
record in the National Claims History (NCH)  
databases. (All records for a beneficiary  
are stored under a single BIC.)

COMMON ALIAS : NCH\_BASE\_CATEGORY\_BIC  
DB2 ALIAS : CTGRY\_EQTBL\_BIC  
SAS ALIAS : EQ\_BIC  
STANDARD ALIAS : NCH\_CTGRY\_EQTBL\_BIC\_CD  
TITLE ALIAS : EQUATED\_BIC

LENGTH : 2

COMMENTS :  
Prior to Version H this field was named:  
CTGRY\_EQTBL\_BENE\_IDENT\_CD.

SOURCE : BIC EQUATE MODULE

CODE TABLE : CTGRY\_EQTBL\_BENE\_IDENT\_TB

12. Beneficiary Identification Code  
2 20 21

CHAR

The code identifying the type of relationship between an individual and a primary Social Security Administration (SSA) beneficiary or a primary Railroad Board (RRB) beneficiary.

COMMON ALIAS : BIC  
DA3 ALIAS : BENE\_IDENT\_CODE  
DB2 ALIAS : BENE\_IDENT\_CD  
SAS ALIAS : BIC  
STANDARD ALIAS : BENE\_IDENT\_CD  
TITLE ALIAS : BIC

LENGTH : 2

SOURCE : SSA/RRB

EDIT RULES :  
EDB REQUIRED FIELD

CODE TABLE : BENE\_IDENT\_TB

13. NCH State Segment Code  
1 22 22

CHAR

The code identifying the segment of the NCH Nearline file containing the beneficiary's record for a specific service year. Effective 12/96, segmentation is by CLM\_LCTR\_NUM, then final action sequence within residence state. (Prior to 12/96, segmentation was by ranges of county codes within the residence state.)

DB2 ALIAS : NCH\_STATE\_SGMT\_CD  
SAS ALIAS : ST\_SGMT  
STANDARD ALIAS : NCH\_STATE\_SGMT\_CD  
TITLE ALIAS : NEAR\_LINE\_SEGMENT

LENGTH : 1

COMMENTS :

Prior to Version H this field was named:  
BENE\_STATE\_SGMT\_NEAR\_LINE\_CD.

SOURCE : NCH

CODE TABLE : NCH\_STATE\_SGMT\_TB

14. Beneficiary Residence SSA Standard State Code

2 23 24 CHAR

The SSA standard state code of a beneficiary's residence.

DA3 ALIAS : SSA\_STANDARD\_STATE\_CODE  
DB2 ALIAS : BENE\_SSA\_STATE\_CD  
SAS ALIAS : STATE\_CD  
STANDARD ALIAS : BENE\_RSDNC\_SSA\_STD\_STATE\_CD  
TITLE ALIAS : BENE\_STATE\_CD

LENGTH : 2

COMMENTS :

1. Used in conjunction with a county code, as selection criteria for the determination of payment rates for HMO reimbursement.
2. Concerning individuals directly billable for Part B and/or Part A premiums, this element is used to determine if the beneficiary will receive a bill in English or Spanish.
3. Also used for special studies.

SOURCE : SSA/EDB

EDIT RULES :

OPTIONAL: MAY BE BLANK

CODE TABLE : GEO\_SSA\_STATE\_TB

15. Claim From Date

8 25 32 NUM

The first day on the billing statement covering services rendered to the beneficiary (a.k.a. 'Statement Covers From Date').

NOTE: For Home Health PPS claims, the 'from' date and the 'thru' date on the RAP (initial claim) must always match.

DB2 ALIAS : CLM\_FROM\_DT  
SAS ALIAS : FROM\_DT

STANDARD ALIAS : CLM\_FROM\_DT  
TITLE ALIAS : FROM\_DATE  
  
LENGTH : 8 SIGNED : N  
  
SOURCE : CWF  
  
EDIT RULES :  
YYYYMMDD

16. Claim Through Date

8 33 40

NUM

The last day on the billing statement covering services rendered to the beneficiary (a.k.a 'Statement Covers Thru Date').

NOTE: For Home Health PPS claims, the 'from' date and the 'thru' date on the RAP (initial claim) must always match.

DB2 ALIAS : CLM\_THRU\_DT  
SAS ALIAS : THRU\_DT  
STANDARD ALIAS : CLM\_THRU\_DT  
TITLE ALIAS : THRU\_DATE

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

17. NCH Weekly Claim Processing Date

8 41 48

NUM

The date the weekly NCH database load process cycle begins, during which the claim records are loaded into the Nearline file. This date will always be a Friday, although the claims will actually be appended to the database subsequent to the date.

DB2 ALIAS : NCH\_WKLY\_PROC\_DT  
SAS ALIAS : WKLY\_DT  
STANDARD ALIAS : NCH\_WKLY\_PROC\_DT  
TITLE ALIAS : NCH\_PROCESS\_DT

LENGTH : 8 SIGNED : N



COMMENTS :  
Prior to Version H this field was named:  
HCFA\_CLM\_PROC\_DT.

SOURCE : NCH

EDIT RULES :  
YYYYMMDD

18. CWF Claim Accretion Date

8 49 56

NUM

The date the claim record is accreted (posted/  
processed) to the beneficiary master record  
at the CWF host site and authorization for  
payment is returned to the fiscal interme-  
diary or carrier.

DB2 ALIAS : CWF\_CLM\_ACRTN\_DT  
SAS ALIAS : ACRTN\_DT  
STANDARD ALIAS : CWF\_CLM\_ACRTN\_DT  
TITLE ALIAS : ACCRETION\_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

19. CWF Claim Accretion Number

2 57 58

PACK

The sequence number assigned to the claim  
record when accreted (posted/processed) to  
the beneficiary master record at the CWF host  
site on a given date. This element indicates  
the position of the claim within that day's  
processing at the CWF host. \*\*(Exception: If  
the claim record is missing the accretion date  
CMS' CWFMQA system places a zero in the  
accretion number.

DB2 ALIAS : CWF\_CLM\_ACRTN\_NUM  
SAS ALIAS : ACRTN\_NM  
STANDARD ALIAS : CWF\_CLM\_ACRTN\_NUM  
TITLE ALIAS : ACCRETION\_NUMBER

LENGTH : 3 SIGNED : Y

				SOURCE	: CWF
20.	FI Document Claim Control Number	23	59	81	CHAR
					Unique control number assigned by an intermediary to an institutional claim.
				COMMON	ALIAS : ICN
				DB2	ALIAS : DOC_CLM_CNTL_NUM
				SAS	ALIAS : CLM_CNTL
				STANDARD	ALIAS : FI_DOC_CLM_CNTL_NUM
				TITLE	ALIAS : ICN
				LENGTH	: 23
				SOURCE	: CWF
21.	FI Original Claim Control Number	23	82	104	CHAR
					Effective with Version G, the original intermediary control number (ICN) which is present on adjustment claims, representing the ICN of the original transaction now being adjusted.
				COMMON	ALIAS : ORIGINAL_ICN
				DB2	ALIAS : ORIG_CLM_CNTL_NUM
				SAS	ALIAS : ORIGCNTL
				STANDARD	ALIAS : FI_ORIG_CLM_CNTL_NUM
				TITLE	ALIAS : ORIGINAL_ICN
				LENGTH	: 23
				SOURCE	: CWF
22.	Claim Query Code	1	105	105	CHAR
					Code indicating the type of claim record being processed with respect to payment (debit/credit indicator; interim/final indicator).
				DB2	ALIAS : CLM_QUERY_CD
				SAS	ALIAS : QUERY_CD
				STANDARD	ALIAS : CLM_QUERY_CD
				TITLE	ALIAS : QUERY_CD
				LENGTH	: 1

				SOURCE	: CWF
				CODE TABLE	: CLM_QUERY_TB
23. Provider Number	6	106	111	CHAR	
				The identification number of the institutional provider certified by Medicare to provide services to the beneficiary.	
				NOTE: Effective October 1, 2007 the OSCAR Provider Number has been renamed the CMS Certification Number (CCN). The name was changed to avoid confusion with the National Provider Identifier (NPI). The CCN (OSCAR Provider Number) will continue to play a critical role in verifying that a provider has been Medicare certified and for what type of services.	
				DB2	ALIAS : PRVDR_NUM
				SAS	ALIAS : PROVIDER
				STANDARD	ALIAS : PRVDR_NUM
				TITLE	ALIAS : PROVIDER_NUMBER
				LENGTH	: 6
				CODE TABLE	: PRVDR_NUM_TB
24. NCH Daily Process Date	8	112	119	NUM	
				Effective with Version H, the date the claim record was processed by CMS' CWFMQA system (used for internal editing purposes).	
				Effective with Version I, this date is used in conjunction with the NCH Segment Link Number to keep claims with multiple records/ segments together.	
				NOTE1: With Version 'H' this field was populated with data beginning with NCH weekly process date 10/3/97. Under Version 'I' claims prior to 10/3/97, that were blank under Version 'H', were populated with a date.	
				DB2	ALIAS : NCH_DAILY_PROC_DT
				SAS	ALIAS : DAILY_DT
				STANDARD	ALIAS : NCH_DAILY_PROC_DT
				TITLE	ALIAS : DAILY_PROCESS_DT

LENGTH : 8 SIGNED : N

SOURCE : NCH

EDIT RULES :  
YYYYMMDD

25. NCH Segment Link Number

5 120 124

PACK

Effective with Version 'I', the system generated number used in conjunction with the NCH daily process date to keep records/segments belonging to a specific claim together. This field was added to ensure that records/segments that come in on the same batch with the same identifying information in the link group are not mixed with each other.

NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991).

DB2 ALIAS : NCH\_SGMT\_LINK\_NUM  
SAS ALIAS : LINK\_NUM  
STANDARD ALIAS : NCH\_SGMT\_LINK\_NUM  
TITLE ALIAS : LINK\_NUM

LENGTH : 9 SIGNED : Y

SOURCE : NCH

26. Claim Total Segment Count

2 125 126

NUM

Effective with Version I, the count used to identify the total number of segments associated with a given claim. Each claim could have up to 10 segments.

NOTE: During the Version I conversion, this field was populated with data throughout history (back to service year 1991). For institutional claims, the count for claims prior to 7/00 will be 1 or 2 (1 if 45 or less revenue center lines on a claim and 2 if more than 45 revenue center lines on a claim). For noninstitutional claims, the count will always be 1.

DB2 ALIAS : TOT\_SGMT\_CNT  
SAS ALIAS : SGMT\_CNT  
STANDARD ALIAS : CLM\_TOT\_SGMT\_CNT  
TITLE ALIAS : SEGMENT\_COUNT

LENGTH : 2 SIGNED : N

SOURCE : CWF

27. Claim Segment Number

2 127 128

NUM

Effective with Version I, the number used to identify an actual record/segment (1 - 10) associated with a given claim.

NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991). For institutional claims prior to 7/00, this number will be either 1 or 2. For noninstitutional claims, the number will always be 1.

DB2 ALIAS : CLM\_SGMT\_NUM  
SAS ALIAS : SGMT\_NUM  
STANDARD ALIAS : CLM\_SGMT\_NUM  
TITLE ALIAS : SEGMENT\_NUMBER

LENGTH : 2 SIGNED : N

SOURCE : CWF

28. Claim Total Line Count

3 129 131

NUM

Effective with Version I, the count used to identify the total number of revenue center lines associated with the claim.

NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991). Prior to Version 'I', the maximum line count will be no more than 58. Effective with Version 'I', the maximum line count could be 450.

DB2 ALIAS : TOT\_LINE\_CNT  
SAS ALIAS : LINECNT  
STANDARD ALIAS : CLM\_TOT\_LINE\_CNT

				TITLE	ALIAS : TOTAL_LINE_COUNT
				LENGTH	: 3 SIGNED : N
				SOURCE	: CWF
29.	Claim Segment Line Count	2	132	133	NUM
					Effective with Version I, the count used to identify the number of lines on a record/segment.
					NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991). The maximum line count per record/segment on the revenue center trailer is 45. The maximum number of lines on carrier and DMERC claims are 13.
				DB2	ALIAS : SGMT_LINE_CNT
				SAS	ALIAS : SGMTLINE
				STANDARD	ALIAS : CLM_SGMT_LINE_CNT
				TITLE	ALIAS : SEGMENT_LINE_COUNT
				LENGTH	: 2 SIGNED : N
				SOURCE	: CWF
30.	FI Claim Common Group	382	134	515	GRP
					Information common to fiscal intermediary (FI) claims (inpatient/SNF, outpatient, HHA & hospice), for version J of NCH Nearline file.
					STANDARD ALIAS : FI_CLM_CMN_GRP
31.	NCH Payment and Edit Record Identification Code	1	134	134	CHAR
					The code used for payment and editing purposes that indicates the type of institutional claim record. Prior to Version H this field was named: PMT_EDIT_RIC_CD.
				DB2	ALIAS : PMT_EDIT_RIC_CD
				SAS	ALIAS : PE_RIC

				STANDARD ALIAS : NCH_PMT_EDIT_RIC_CD
				TITLE ALIAS : NCH_PAYMENT_EDIT_RIC
				LENGTH : 1
				SOURCE : NCH_QA_Process
				CODE TABLE : PMT_EDIT_RIC_TB
32. Claim Transaction Code	1	135	135	CHAR
				The code derived by CWF to indicate the type of claim submitted by an institutional provider.
				DB2 ALIAS : CLM_TRANS_CD
				SAS ALIAS : TRANS_CD
				STANDARD ALIAS : CLM_TRANS_CD
				TITLE ALIAS : TRANSACTION_CODE
				LENGTH : 1
				SOURCE : CWF
				LIMITATIONS :
				REFER TO :
				CLM_TRANS_CD_LIM
				CODE TABLE : CLM_TRANS_TB
33. Claim Bill Type Group	2	136	137	GRP
				Effective with Version H, the claim facility type code plus the claim service classification type code. (The first two positions of the ('type of bill')). During the Version H conversion, this grouping was created throughout history.
				NOTE: Effective 4/1/2002, TOB code 'XX0' was implemented to identify those claims that are totally non-covered.
				STANDARD ALIAS : CLM_BILL_TYPE_CD_GRP
				CODE TABLE : CLM_BILL_TYPE_TB
34. Claim Facility Type Code	1	136	136	CHAR

The first digit of the type of bill (TOB1) submitted on an institutional claim used to identify the type of facility that provided care to the beneficiary.

COMMON ALIAS : TOB1  
DB2 ALIAS : CLM\_FAC\_TYPE\_CD  
SAS ALIAS : FAC\_TYPE  
STANDARD ALIAS : CLM\_FAC\_TYPE\_CD  
TITLE ALIAS : TOB1

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM\_FAC\_TYPE\_TB

35. Claim Service Classification Type Code  
1 137 137

CHAR

The second digit of the type of bill (TOB2) submitted on an institutional claim record to indicate the classification of the type of service provided to the beneficiary.

COMMON ALIAS : TOB2  
DB2 ALIAS : SRVC\_CLSFCTN\_CD  
SAS ALIAS : TYPESRVC  
STANDARD ALIAS : CLM\_SRVC\_CLSFCTN\_TYPE\_CD  
TITLE ALIAS : TOB2

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM\_SRVC\_CLSFCTN\_TYPE\_TB

36. Claim Frequency Code  
1 138 138

CHAR

The third digit of the type of bill (TOB3) submitted on an institutional claim record to indicate the sequence of a claim in the beneficiary's current episode of care.

COMMON ALIAS : TOB3  
DB2 ALIAS : CLM\_FREQ\_CD  
SAS ALIAS : FREQ\_CD  
STANDARD ALIAS : CLM\_FREQ\_CD  
TITLE ALIAS : FREQUENCY\_CD

LENGTH : 1



				SOURCE	: CWF
				CODE TABLE	: CLM_FREQ_TB
37. FILLER	1	139	139	CHAR	
				DB2 ALIAS	: FILLER
				LENGTH	: 1
38. NCH MQA Query Patch Code	1	140	140	CHAR	
				Effective with Version H, a code used (for internal editing purposes) to indicate that the CWFMQA process changed the query code submitted on the claim record.	
				NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.	
				DB2 ALIAS	: MQA_QUERY_PATCH_CD
				SAS ALIAS	: MQAQUERY
				STANDARD ALIAS	: NCH_MQA_QUERY_PATCH_CD
				TITLE ALIAS	: MQA_QUERY_PATCH_IND
				LENGTH	: 1
				SOURCE	: NCH QA Process
				CODE TABLE	: NCH_MQA_QUERY_PATCH_TB
39. Claim Disposition Code	2	141	142	CHAR	
				Code indicating the disposition or outcome of the processing of the claim record.	
				DB2 ALIAS	: CLM_DISP_CD
				SAS ALIAS	: DISP_CD
				STANDARD ALIAS	: CLM_DISP_CD
				TITLE ALIAS	: DISPOSITION_CD
				LENGTH	: 2
				SOURCE	: CWF
				CODE TABLE	: CLM_DISP_TB

## 40. NCH Edit Disposition Code

2 143 144

CHAR

Effective with Version H, a code used (for internal editing purposes) to indicate the disposition of the claim after editing in the CWFMQA process.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : NCH\_EDIT\_DISP\_CD  
SAS ALIAS : EDITDISP  
STANDARD ALIAS : NCH\_EDIT\_DISP\_CD  
TITLE ALIAS : NCH\_EDIT\_DISP

LENGTH : 2

SOURCE : NCH QA Process

CODE TABLE : NCH\_EDIT\_DISP\_TB

## 41. NCH Claim BIC Modify H Code

1 145 145

CHAR

Effective with Version H, the code used (for internal editing purposes) to identify a claim record that was submitted with an incorrect HA, HB, or HC BIC.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : NCH\_BIC\_MDFY\_CD  
SAS ALIAS : BIC\_MDFY  
STANDARD ALIAS : NCH\_CLM\_BIC\_MDFY\_CD  
TITLE ALIAS : BIC\_MODIFY\_CD

LENGTH : 1

SOURCE : NCH QA Process

CODE TABLE : NCH\_CLM\_BIC\_MDFY\_TB

## 42. Beneficiary Residence SSA Standard County Code

3 146 148

CHAR

The SSA standard county code of a beneficiary's residence.

DB2 ALIAS : BENE\_SSA\_CNTY\_CD  
SAS ALIAS : CNTY\_CD  
STANDARD ALIAS : BENE\_RSDNC\_SSA\_STD\_CNTY\_CD  
TITLE ALIAS : BENE\_COUNTY\_CD

LENGTH : 3

SOURCE : SSA/EDB

EDIT RULES :  
OPTIONAL: MAY BE BLANK

43. FI Claim Receipt Date

8 149 156 NUM

The date the fiscal intermediary received the institutional claim from the provider.

DB2 ALIAS : FI\_CLM\_RCPT\_DT  
SAS ALIAS : RCPT\_DT  
STANDARD ALIAS : FI\_CLM\_RCPT\_DT  
TITLE ALIAS : RECEIPT\_DT

LENGTH : 8 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
FICARR\_CLM\_RCPT\_DT.

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

44. FI Claim Scheduled Payment Date

8 157 164 NUM

The scheduled date of payment to the institutional provider, as reflected on the claim record transmitted to the CWF host. Note: This date is considered to be the date paid since no additional information as to the actual payment date is available.

DB2 ALIAS : FI\_SCHLD\_PMT\_DT  
SAS ALIAS : SCHLD\_DT  
STANDARD ALIAS : FI\_CLM\_SCHLD\_PMT\_DT  
TITLE ALIAS : SCHEDULED\_PMT\_DT

LENGTH : 8 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
FICARR\_CLM\_PMT\_DT.

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

45. CWF Forwarded Date

8 165 172 NUM

Effective with Version H, the date CWF forwarded the claim record to CMS (used for internal editing purposes).

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

DB2 ALIAS : CWF\_FRWRD\_DT  
SAS ALIAS : FRWRD\_DT  
STANDARD ALIAS : CWF\_FRWRD\_DT  
TITLE ALIAS : FORWARD\_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

46. FI Number

5 173 177 CHAR

The identification number assigned by CMS to a fiscal intermediary authorized to process institutional claim records.

Effective October 2006, the Medicare Administrative Contractors (MACs) began replacing the existing fiscal intermediaries and started processing institutional claim records for states assigned to its jurisdiction.

NOTE: The 5-position MAC number will be housed in the existing FI\_NUM field. During the transition from an FI to a MAC the FI\_NUM field could contain either a FI number or a MAC number. See the FI\_NUM table of codes to identify the new MAC

numbers and their effective dates.

DB2 ALIAS : FI\_NUM  
SAS ALIAS : FI\_NUM  
STANDARD ALIAS : FI\_NUM  
TITLE ALIAS : INTERMEDIARY

LENGTH : 5

COMMENTS :  
Prior to Version H this field was named:  
FICARR\_IDENT\_NUM.

SOURCE : CWF

CODE TABLE : FI\_NUM\_TB

47. CWF Claim Assigned Number  
8 178 185

CHAR

Effective with Version H, the number assigned  
to an institutional claim record by CWF (used  
for internal editing purposes).

NOTE: Beginning with NCH weekly process date  
10/3/97 this field was populated with  
data. Claims processed prior to 10/3/97  
will contain spaces in this field.

DB2 ALIAS : CWF\_CLM\_ASGN\_NUM  
SAS ALIAS : ASGN\_NUM  
STANDARD ALIAS : CWF\_CLM\_ASGN\_NUM  
TITLE ALIAS : ASSIGNED\_NUM

LENGTH : 8

SOURCE : CWF

48. CWF Transmission Batch Number  
4 186 189

CHAR

Effective with Version H, the number assigned  
to each batch of claims transactions sent from  
CWF(used for internal editing purposes).

NOTE: Beginning 11/98, this field will be  
populated with data. Claims processed  
prior to 11/98 will contain spaces in  
this field.

				DB2	ALIAS : TRNSMSN_BATCH_NUM
				SAS	ALIAS : FIBATCH
				STANDARD	ALIAS : CWF_TRNSMSN_BATCH_NUM
				TITLE	ALIAS : BATCH_NUM
				LENGTH	: 4
				SOURCE	: CWF
49.	Beneficiary Mailing Contact ZIP Code	9	190	198	CHAR
					The ZIP code of the mailing address where the beneficiary may be contacted.
				DB2	ALIAS : BENE_MLG_ZIP_CD
				SAS	ALIAS : BENE_ZIP
				STANDARD	ALIAS : BENE_MLG_CNTCT_ZIP_CD
				TITLE	ALIAS : BENE_ZIP
				LENGTH	: 9
				SOURCE	: EDB
50.	Beneficiary Sex Identification Code	1	199	199	CHAR
					The sex of a beneficiary.
				COMMON	ALIAS : SEX_CD
				DA3	ALIAS : SEX_CODE
				DB2	ALIAS : BENE_SEX_IDENT_CD
				SAS	ALIAS : SEX
				STANDARD	ALIAS : BENE_SEX_IDENT_CD
				TITLE	ALIAS : SEX_CD
				LENGTH	: 1
				SOURCE	: SSA,RRB,EDB
				EDIT RULES :	
					REQUIRED FIELD
				CODE TABLE	: BENE_SEX_IDENT_TB
51.	Beneficiary Race Code	1	200	200	CHAR
					The race of a beneficiary.

DA3 ALIAS : RACE\_CODE  
DB2 ALIAS : BENE\_RACE\_CD  
SAS ALIAS : RACE  
STANDARD ALIAS : BENE\_RACE\_CD  
TITLE ALIAS : RACE\_CD

LENGTH : 1

SOURCE : SSA

CODE TABLE : BENE\_RACE\_TB

52. Beneficiary Birth Date

8 201 208

NUM

The beneficiary's date of birth.

COMMON ALIAS : DOB  
DA3 ALIAS : BIRTH\_DATE  
DB2 ALIAS : BENE\_BIRTH\_DT  
SAS ALIAS : BENE\_DOB  
STANDARD ALIAS : BENE\_BIRTH\_DT  
TITLE ALIAS : BENE\_BIRTH\_DATE

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

53. CWF Beneficiary Medicare Status Code

2 209 210

CHAR

The CWF-derived reason for a beneficiary's entitlement to Medicare benefits, as of the reference date (CLM\_THRU\_DT).

COBOL ALIAS : MSC  
COMMON ALIAS : MSC  
DB2 ALIAS : BENE\_MDCR\_STUS\_CD  
SAS ALIAS : MS\_CD  
STANDARD ALIAS : CWF\_BENE\_MDCR\_STUS\_CD  
TITLE ALIAS : MSC

LENGTH : 2

DERIVATIONS :  
CWF derives MSC from the following:  
1. Date of Birth

2. Claim Through Date
3. Original/Current Reasons for entitlement
4. ESRD Indicator
5. Beneficiary Claim Number

Items 1,3,4,5 come from the CWF Beneficiary Master Record; item 2 comes from the FI/Carrier claim record. MSC is assigned as follows:

MSC	OASI	DIB	ESRD	AGE	BIC
10	YES	N/A	NO	65 and over	N/A
11	YES	N/A	YES	65 and over	N/A
20	NO	YES	NO	under 65	N/A
21	NO	YES	YES	under 65	N/A
31	NO	NO	YES	any age	T.

COMMENTS :  
Prior to Version H this field was named:  
BENE\_MDCR\_STUS\_CD. The name has been changed  
to distinguish this CWF-derived field from the  
EDB-derived MSC (BENE\_MDCR\_STUS\_CD).

SOURCE : CWF

CODE TABLE : BENE\_MDCR\_STUS\_TB

54. Claim Patient 6 Position Surname  
6 211 216

CHAR

The first 6 positions of the Medicare patient's  
surname (last name) as reported by the provider  
on the claim.

NOTE1: Prior to Version H, this field was only  
present on the IP/SNF claim record.  
Effective with Version H, this field is  
present on all claim types.

NOTE2: For OP, HHA, Hospice and all Carrier  
claims, data was populated beginning  
with NCH weekly process 10/3/97. Claims  
processed prior to 10/3/97 will contain  
spaces in this field.

COMMON ALIAS : PATIENT\_SURNAME  
DB2 ALIAS : PTNT\_6\_PSTN\_SRNM  
SAS ALIAS : SURNAME  
STANDARD ALIAS : CLM\_PTNT\_6\_PSTN\_SRNM\_NAME  
TITLE ALIAS : PATIENT\_SURNAME



LENGTH : 6

SOURCE : CWF

55. Claim Patient 1st Initial Given Name

1 217 217

CHAR

The first initial of the Medicare patient's given name (first name) as reported by the provider on the claim.

NOTE1: Prior to Version H, this field was only present on the IP/SNF claim record. Effective with Version H, this field is present on all claim types.

NOTE2: For OP, HHA, Hospice and all Carrier claims, data was populated beginning with NCH weekly process date 10/3/97. Claims processed prior to 10/3/97 will contain spaces in this field.

COMMON ALIAS : PATIENT\_GIVEN\_NAME  
DB2 ALIAS : 1ST\_INITL\_GVN\_NAME  
SAS ALIAS : FRSTINIT  
STANDARD ALIAS : CLM\_PTNT\_1ST\_INITL\_GVN\_NAME  
TITLE ALIAS : PATIENT\_FIRST\_INITIAL

LENGTH : 1

SOURCE : CWF

56. Claim Patient First Initial Middle Name

1 218 218

CHAR

The first initial of the Medicare patient's middle name as reported by the provider on the claim.

NOTE1: Prior to Version H, this field was only present on the IP/SNF claim record. Effective with Version H, this field is present on all claim types.

NOTE2: For OP, HHA, Hospice and all Carrier claims, data was populated beginning with NCH weekly process date 10/3/97. Claims processed prior to 10/3/97 will contain spaces in this field.

COMMON ALIAS : PATIENT\_MIDDLE\_NAME  
DB2 ALIAS : 1ST\_INITL\_MDL\_NAME  
SAS ALIAS : MDL\_INIT  
STANDARD ALIAS : CLM\_PTNT\_1ST\_INITL\_MDL\_NAME  
TITLE ALIAS : PATIENT\_MIDDLE\_INITIAL

LENGTH : 1

SOURCE : CWF

57. Beneficiary CWF Location Code  
1 219 219

CHAR

The code that identifies the Common Working File (CWF) location (the host site) where a beneficiary's Medicare utilization records are maintained.

COMMON ALIAS : CWF\_HOST  
DB2 ALIAS : BENE\_CWF\_LOC\_CD  
SAS ALIAS : CWFLOCCD  
STANDARD ALIAS : BENE\_CWF\_LOC\_CD  
TITLE ALIAS : CWF\_HOST

LENGTH : 1

SOURCE : CWF

CODE TABLE : BENE\_CWF\_LOC\_TB

58. Claim Principal Diagnosis Group  
8 220 227

GRP

Effective with Version 'J', the group used to identify the principal diagnosis code.  
This group contains the principal diagnosis code and the principal diagnosis version code.

STANDARD ALIAS : CLM\_PRNCPAL\_DGNS\_GRP

59. Claim Principal Diagnosis Version Code  
1 220 220

CHAR

Effective with Version 'J', the code used to indicate if the diagnosis is ICD-9 or ICD-10.

NOTE: With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2013.

				DB2	ALIAS : UNDEFINED
				SAS	ALIAS : PDVRSNCD
				LENGTH	: 1
				CODE TABLE	: CLM_DGNS_VRSN_TB
60.	Claim Principal Diagnosis Code	7	221	227	CHAR
					The diagnosis code identifying the diagnosis, condition, problem or other reason for the admission/encounter/visit shown in the medical record to be chiefly responsible for the services provided.
					NOTE: Effective with Version H, this data is also redundantly stored as the first occurrence of the diagnosis trailer.
					NOTE1: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10.
				DB2	ALIAS : PRNCPAL_DGNS_CD
				SAS	ALIAS : PDGNS_CD
				LENGTH	: 7
				SOURCE	: CWF
				EDIT RULES :	ICD-9-CM
61.	FILLER	1	228	228	CHAR
				DB2	ALIAS : FILLER
				LENGTH	: 1
62.	Claim Medicare Non Payment Reason Code	2	229	230	CHAR
					The reason that no Medicare payment is made for services on an institutional claim.
					NOTE1: This field was put on all institutional claim types but data did not start coming in on OP/HHA/Hospice until 4/1/02. Prior to 4/1/02,

data only came in Inpatient/SNF claims.

NOTE2: Effective 4/1/02, this field was also expanded to two bytes to accommodate new values. The NCH Nearline file did not expand the current 1-byte field but instituted a crosswalk of the 2-byte field to the 1-byte character value. See table of code for the crosswalk.

NOTE3: Effective with Version 'J', the field has been expanded on the NCH claim to 2 bytes. With this expansion the NCH will no longer use the character values to represent the official two byte values being sent in by CWF since 4/2002.

During the Version 'J' conversion, all character values were converted to the two byte values.

DB2 ALIAS : MDCR NPMT\_RSN\_CD  
SAS ALIAS : NOPAY\_CD

LENGTH : 2

CODE TABLE : CLM\_MDCR\_NPMT\_RSN\_TB

63. Claim Excepted/Nonexcepted Medical Treatment Code  
1 231 231 CHAR

Effective with Version I, the code used to identify whether or not the medical care or treatment received by a beneficiary, who has elected care from a Religious Nonmedical Health Care Institution (RNHCI), is excepted or nonexcepted. Excepted is medical care or treatment that is received involuntarily or is required under Federal, State or local law. Nonexcepted is defined as medical care or treatment other than excepted.

DB2 ALIAS : EXCPTD\_NEXCPTD\_CD  
SAS ALIAS : TRTMT\_CD  
STANDARD ALIAS : CLM\_EXCPTD\_NEXCPTD\_TRTMT\_CD  
TITLE ALIAS : EXCPTD\_NEXCPTD\_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM\_EXCPTD\_NEXCPTD\_TRTMT\_TB

64. Claim Payment Amount  
6 232 237 PACK

Amount of payment made from the Medicare trust fund for the services covered by the claim record. Generally, the amount is calculated by the FI or carrier; and represents what was paid to the institutional provider, physician, or supplier, with the exceptions noted below. \*\*NOTE: In some situations, a negative claim payment amount may be present; e.g., (1) when a beneficiary is charged the full deductible during a short stay and the deductible exceeded the amount Medicare pays; or (2) when a beneficiary is charged a coinsurance amount during a long stay and the coinsurance amount exceeds the amount Medicare pays (most prevalent situation involves psych hospitals who are paid a daily per diem rate no matter what the charges are.)

Under IP PPS, inpatient hospital services are paid based on a predetermined rate per discharge, using the DRG patient classification system and the PRICER program. On the IP PPS claim, the payment amount includes the DRG outlier approved payment amount, disproportionate share (since 5/1/86), indirect medical education (since 10/1/88), total PPS capital (since 10/1/91). After 4/1/03, the payment amount could also include a "new technology" add-on amount. It does NOT include the pass-thru amounts (i.e., capital-related costs, direct medical education costs, kidney acquisition costs, bad debts); or any beneficiary-paid amounts (i.e., deductibles and coinsurance); or any other payer reimbursement.

Under IRFPPS, inpatient rehabilitation services are paid based on a predetermined rate per discharge, using the Case Mix Group (CMG) classification system and the PRICER program. From the CMG on the IRF PPS claim, payment is based on a standard payment amount for operating and capital cost for that facility (including routine and ancillary services). The payment is adjusted for wage, the % of low-income patients (LIP), locality, transfers, interrupted stays, short stay cases, deaths, and high cost outliers. Some or all of these adjustments could apply. The CMG payment does NOT include certain pass-through costs (i.e. bad debts, approved education activities); beneficiary-paid amounts, other payer reimbursement, and other services outside of the scope of PPS.

Under LTCH PPS, long term care hospital services are paid based on a predetermined rate per discharge based on the DRG and the PRICER program. Payments are based on a single standard Federal rate for both inpatient operating and capital-related costs (including routine and ancillary services), but do NOT include certain pass-through costs

(i.e. bad debts, direct medical education, new technologies and blood clotting factors). Adjustments to the payment may occur due to short-stay outliers, interrupted stays, high cost outliers, wage index, and cost of living adjustments.

Under SNF PPS, SNFs will classify beneficiaries using the patient classification system known as RUGS III. For the SNF PPS claim, the SNF PRICER will calculate/return the rate for each revenue center line item with revenue center code = '0022'; multiply the rate times the units count; and then sum the amount payable for all lines with revenue center code '0022' to determine the total claim payment amount.

Under Outpatient PPS, the national ambulatory payment classification (APC) rate that is calculated for each APC group is the basis for determining the total claim payment. The payment amount also includes the outlier payment and interest.

Under Home Health PPS, beneficiaries will be classified into an appropriate case mix category known as the Home Health Resource Group. A HIPPS code is then generated corresponding to the case mix category (HHRG).

For the RAP, the PRICER will determine the payment amount appropriate to the HIPPS code by computing 60% (for first episode) or 50% (for subsequent episodes) of the case mix episode payment. The payment is then wage index adjusted.

For the final claim, PRICER calculates 100% of the amount due, because the final claim is processed as an adjustment to the RAP, reversing the RAP payment in full. Although final claim will show 100% payment amount, the provider will actually receive the 40% or 50% payment. The payment may also include outlier payments.

Exceptions: For claims involving demos and BBA encounter data, the amount reported in this field may not just represent the actual provider payment.

For demo Ids '01','02','03','04' -- claims contain amount paid to the provider, except that special 'differentials' paid outside the normal payment system are not included.

For demo Ids '05','15' -- encounter data 'claims' contain amount Medicare would have paid under FFS, instead of the actual payment to the MCO.

For demo Ids '06','07','08' -- claims contain actual provider payment but represent a special negotiated bundled payment for both Part A and Part B services. To identify what the conventional provider Part A payment would have been, check value code = 'Y4'. The related noninstitutional (physician/supplier) claims contain what would have been paid had there been no demo.

For BBA encounter data (non-demo) -- 'claims' contain amount Medicare would have paid under FFS, instead of the actual payment to the BBA plan.

COMMON ALIAS : REIMBURSEMENT  
DB2 ALIAS : CLM\_PMT\_AMT  
SAS ALIAS : PMT\_AMT  
STANDARD ALIAS : CLM\_PMT\_AMT  
TITLE ALIAS : REIMBURSEMENT

LENGTH : 9.2 SIGNED : Y

COMMENTS :

Prior to Version H, the size of this field was S9(7)V99. Also, the noninstitutional claim records carried this field as a line item. Effective with Version H, this element is a claim level field across all claim types (and the line item field has been renamed.)

SOURCE : CWF

LIMITATIONS :

Prior to 4/6/93, on inpatient, outpatient, and physician/supplier claims containing a CLM\_DISP\_CD of '02', the amount shown as the Medicare reimbursement does not take into consideration any CWF automatic adjustments (involving erroneous deductibles in most cases). In as many as 30% of the claims (30% IP, 15% OP, 5% PART B), the reimbursement reported on the claims may be over or under the actual Medicare payment amount.

REFER TO :

PMT\_AMT\_EXCEDG\_CHRG\_AMT\_LIM

EDIT RULES :

\$\$\$\$\$\$\$\$\$CC

65. NCH Primary Payer Claim Paid Amount

6 238 243

PACK

The amount of a payment made on behalf of a Medicare beneficiary by a primary payer other than Medicare, that the provider is applying to covered Medicare charges on an institutional, carrier, or DMERC claim.

DB2 ALIAS : PRMRY\_PYR\_PD\_AMT  
STANDARD ALIAS : NCH\_PRMRY\_PYR\_CLM\_PD\_AMT  
TITLE ALIAS : PRIMARY\_PAYER\_AMOUNT

LENGTH : 9.2 SIGNED : Y

COMMENTS :  
Prior to Version H this field was named:  
BENE\_PRMRY\_PYR\_CLM\_PMT\_AMT and the field size  
was S9(7)V99.

SOURCE : NCH

EDIT RULES :  
\$\$\$\$\$\$\$\$\$CC

66. NCH Primary Payer Code

1 244 244

CHAR

The code, on an institutional claim, specifying a federal non-Medicare program or other source that has primary responsibility for the payment of the Medicare beneficiary's health insurance bills.

DB2 ALIAS : NCH\_PRMRY\_PYR\_CD  
SAS ALIAS : PRPAY\_CD  
STANDARD ALIAS : NCH\_PRMRY\_PYR\_CD  
TITLE ALIAS : PRIMARY\_PAYER\_CD

LENGTH : 1

DERIVATIONS :  
DERIVED FROM:  
CLM\_VAL\_CD  
CLM\_VAL\_AMT

DERIVATION RULES

SET NCH\_PRMRY\_PYR\_CD TO 'A' WHERE THE  
CLM\_VAL\_CD = '12'

SET NCH\_PRMRY\_PYR\_CD TO 'B' WHERE THE  
CLM\_VAL\_CD = '13'



SET NCH\_PRMRY\_PYR\_CD TO 'C' WHERE THE  
CLM\_VAL\_CD = '16' and CLM\_VAL\_AMT is zeroes

SET NCH\_PRMRY\_PYR\_CD TO 'D' WHERE THE  
CLM\_VAL\_CD = '14'

SET NCH\_PRMRY\_PYR\_CD TO 'E' WHERE THE  
CLM\_VAL\_CD = '15'

SET NCH\_PRMRY\_PYR\_CD TO 'F' WHERE THE  
CLM\_VAL\_CD = '16' (CLM\_VAL\_AMT not  
equal to zeroes)

SET NCH\_PRMRY\_PYR\_CD TO 'G' WHERE THE  
CLM\_VAL\_CD = '43'

SET NCH\_PRMRY\_PYR\_CD TO 'H' WHERE THE  
CLM\_VAL\_CD = '41'

SET NCH\_PRMRY\_PYR\_CD TO 'I' WHERE THE  
CLM\_VAL\_CD = '42'

SET NCH\_PRMRY\_PYR\_CD TO 'L' (or prior to 4/97  
set code to 'J') WHERE THE CLM\_VAL\_CD = '47'

COMMENTS :  
Prior to Version H this field was named:  
BENE\_PRMRY\_PYR\_CD.

SOURCE : NCH

CODE TABLE : BENE\_PRMRY\_PYR\_TB

67. FI Requested Claim Cancel Reason Code  
1 245 245

CHAR

The reason that an intermediary requested cancelling  
a previously submitted institutional claim.

DB2 ALIAS : RQST\_CNCL\_RSN\_CD  
SAS ALIAS : CANCELCD  
STANDARD ALIAS : FI\_RQST\_CLM\_CNCL\_RSN\_CD  
TITLE ALIAS : CANCEL\_CD

LENGTH : 1

COMMENTS :  
Prior to Version H this field was named:  
INTRMDRY\_RQST\_CLM\_CNCL\_RSN\_CD.

				SOURCE	: CWF
				CODE TABLE	: FI_RQST_CLM_CNCL_RSN_TB
68. FI Claim Action Code	1	246	246	CHAR	
				The type of action requested by the intermediary to be taken on an institutional claim.	
				DB2	ALIAS : FI_CLM_ACTN_CD
				SAS	ALIAS : ACTIONCD
				STANDARD	ALIAS : FI_CLM_ACTN_CD
				TITLE	ALIAS : ACTION_CD
				LENGTH	: 1
				COMMENTS :	
				Prior to Version H this field was named: INTRMDRY_CLM_ACTN_CD.	
				SOURCE	: CWF
				CODE TABLE	: FI_CLM_ACTN_TB
69. FI Claim Process Date	8	247	254	NUM	
				The date the fiscal intermediary completes processing and releases the institutional claim to the CWF host.	
				DB2	ALIAS : FI_CLM_PROC_DT
				SAS	ALIAS : APRVL_DT
				STANDARD	ALIAS : FI_CLM_PROC_DT
				TITLE	ALIAS : FI_PROCESS_DT
				LENGTH	: 8 SIGNED : N
				SOURCE	: CWF
				EDIT RULES :	
				YYYYMMDD	
70. NCH Provider State Code	2	255	256	CHAR	
				Effective with Version H, the two position SSA state code where provider facility is located.	

NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991).

DB2 ALIAS : NCH\_PRVDR\_STATE\_CD  
 SAS ALIAS : PRSTATE  
 STANDARD ALIAS : NCH\_PRVDR\_STATE\_CD  
 TITLE ALIAS : PROVIDER\_STATE\_CD

LENGTH : 2

DERIVATIONS :  
 DERIVED FROM:  
 NCH\_PRVDR\_NUM

DERIVATION RULES:

SET NCH\_PRVDR\_STATE\_CD TO  
 PRVDR\_NUM POS1-2.  
 FOR PRVDR\_NUM POS1-2 EQUAL '55' OR '75'  
 SET NCH\_PRVDR\_STATE\_CD TO '05'.  
 FOR PRVDR\_NUM POS1-2 EQUAL '67' OR '74'  
 SET NCH\_PRVDR\_STATE\_CD TO '45'.  
 FOR PRVDR\_NUM POS1-2 EQUAL '68' OR '69'  
 SET NCH\_PRVDR\_STATE\_CD TO '10'.  
 FOR PRVDR\_NUM POS1-2 EQUAL '78'  
 SET NCH\_PRVDR\_STATE\_CD TO '14'.  
 FOR PRVDR\_NUM POS1-2 EQUAL TO '76'  
 SET NCH\_PRVDR\_STATE\_CD TO '16'.  
 FOR PRVDR\_NUM POS1-2 EQUAL '70'  
 SET NCH\_PRVDR\_STATE\_CD TO '17'.  
 FOR PRVDR\_NUM POS1-2 EQUAL '71'  
 SET NCH\_PRVDR\_STATE\_CD TO '19'.  
 FOR PRVDR\_NUMBER POS1-2 EQUAL '77'  
 SET NCH\_PRVDR\_STATE\_CD TO '24'.  
 FOR PRVDR\_NUM POS1-2 EQUAL TO '72'  
 SET NCH\_PRVDR\_STATE\_CD TO '36'.  
 FOR PRVDR\_NUM POS1-2 EQUAL TO '73'  
 SET NCH\_PRVDR\_STATE\_CD TO '39'.

SOURCE : NCH

CODE TABLE : GEO\_SSA\_STATE\_TB

71. Organization NPI Number

10 257 266 CHAR

On an institutional claim, the National Provider Identifier (NPI) number assigned to uniquely identify the institutional provider

certified by Medicare to provide services to the beneficiary.

NOTE: Effective May 2007, the NPI will become the national standard identifier for covered health care providers. NPIs will replace current OSCAR provider number, UPINs, NSC numbers, and local contractor provider identification numbers (PINs) on standard HIPPA claim transactions. (During the NPI transition phase (4/3/06 - 5/23/07) the capability was there for the NCH to receive NPIs along with an existing legacy number (UPIN, PIN, OSCAR provider number, etc.)).

NOTE1: CMS has determined that dual provider identifiers (old legacy numbers and new NPI) must be available in the NCH. After the 5/07 NPI implementation, the standard system maintainers will add the legacy number to the claim when it is adjudicated. We will continue to receive the OSCAR provider number and any currently issued UPINs. Effective May 2007, no NEW UPINs (legacy number) will be generated for NEW physicians (Part B and outpatient claims), so there will only be NPIs sent in to the NCH for those physicians.

DB2 ALIAS : ORG\_NPI\_NUM  
SAS ALIAS : ORGNPINM  
STANDARD ALIAS : ORG\_NPI\_NUM  
TITLE ALIAS : ORG\_NPI

LENGTH : 10

SOURCE : CWF

72. Attending Physician ID Group  
24 267 290

Name and identification numbers associated with the primary care physician.

STANDARD ALIAS : ATNDG\_PHYSN\_ID\_GRP

73. Claim Attending Physician UPIN Number  
6 267 272

CHAR

On an institutional claim, the unique physician identification number (UPIN) of the physician

who would normally be expected to certify and recertify the medical necessity of the services rendered and/or who has primary responsibility for the beneficiary's medical care and treatment (attending physician).

COMMON ALIAS : ATTENDING\_PHYSICIAN\_UPIN  
DB2 ALIAS : ATNDG\_UPIN\_NUM  
SAS ALIAS : AT UPIN  
STANDARD ALIAS : CLM\_ATNDG\_PHYSN\_UPIN\_NUM  
TITLE ALIAS : ATTENDING\_PHYSICIAN

LENGTH : 6

COMMENTS :  
Prior to Version H this field was named:  
CLM\_PRMRY\_CARE\_PHYSN\_IDENT\_NUM and contained  
10 positions (6-position UPIN and 4-position  
physician surname).

SOURCE : CWF

74. Claim Attending Physician NPI Number  
10 273 282

CHAR

On an institutional claim, the national provider identifier (NPI) number assigned to uniquely identify the physician who has overall responsibility for the beneficiary's care and treatment.

NOTE: Effective May 2007, the NPI will become the national standard identifier for covered health care providers. NPIs will replace current OSCAR provider number, UPINs, NSC numbers, and local contractor provider identification numbers (PINs) on standard HIPPA claim transactions. (During the NPI transition phase (4/3/06 - 5/23/07) the capability was there for the NCH to receive NPIs along with an existing legacy number (UPIN, PIN, OSCAR provider number, etc.)).

NOTE1: CMS has determined that dual provider identifiers (old legacy numbers and new NPI) must be available in the NCH. After the 5/07 NPI implementation, the standard system maintainers will add the legacy number to the claim when it is adjudicated. We will continue to receive the OSCAR provider number and any currently

issued UPINs. Effective May 2007, no NEW UPINs (legacy number) will be generated for NEW physicians (Part B and Outpatient claims), so there will only be NPIs sent in to the NCH for those physicians.

COMMON ALIAS : ATTENDING\_PHYSICIAN\_NPI  
DB2 ALIAS : ATNDG\_NPI\_NUM  
SAS ALIAS : AT\_NPI  
STANDARD ALIAS : CLM\_ATNDG\_PHYSN\_NPI\_NUM  
TITLE ALIAS : ATNDG\_NPI

LENGTH : 10

SOURCE : CWF

75. Claim Attending Physician Surname  
6 283 288

CHAR

Effective with Version H, the last name of the attending physician (used for internal editing purpose in CMS' CWFMQA system.)

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : ATNDG\_SRNM  
SAS ALIAS : AT\_SRNM  
STANDARD ALIAS : CLM\_ATNDG\_PHYSN\_SRNM\_NAME  
TITLE ALIAS : ANDG\_PHYSN\_SURNAME

LENGTH : 6

SOURCE : CWF

76. Claim Attending Physician Given Name  
1 289 289

CHAR

Effective with Version H, the first name of the attending physician (used for internal editing purposes in CMS' CWFMQA system).

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : ATNDG\_GVN\_NAME

SAS ALIAS : AT\_GVNNM  
STANDARD ALIAS : CLM\_ATNDG\_PHYSN\_GVN\_NAME  
TITLE ALIAS : ATNDG\_PHYSN\_FIRSTNAME

LENGTH : 1

SOURCE : CWF

77. Claim Attending Physician Middle Initial Name

1 290 290 CHAR

Effective with Version H, the middle initial of the attending physician (used for internal editing purposes in CMS' CWFMQA system.)

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : ATNDG\_MI\_NAME  
SAS ALIAS : AT\_MDL  
STANDARD ALIAS : CLM\_ATNDG\_PHYSN\_MDL\_INITL\_NAME  
TITLE ALIAS : ATNDG\_PHYSN\_MI

LENGTH : 1

SOURCE : CWF

78. Operating Physician ID Group

24 291 314

Name and identification numbers associated with the physician who performed the principal procedure.

STANDARD ALIAS : OPRTG\_PHYSN\_ID\_GRP

79. Claim Operating Physician UPIN Number

6 291 296 CHAR

On an institutional claim, the unique physician identification number (UPIN) of the physician who performed the principal procedure. This element is used by the provider to identify the operating physician who performed the surgical procedure.

DB2 ALIAS : OPRTG\_UPIN  
SAS ALIAS : OP\_UPIN

STANDARD ALIAS : CLM\_OPRTG\_PHYSN\_UPIN\_NUM  
TITLE ALIAS : OPRTG\_UPIN

LENGTH : 6

COMMENTS :

Prior to Version H this field was named:  
CLM\_PRNCPAL\_PRCDR\_PHYSN\_NUM and contained  
10 positions (6-position UPIN and 4-position  
physician surname.

NOTE: For HHA and Hospice formats beginning  
with NCH weekly process date 10/3/97 this field  
was populated with data. HHA and Hospice claims  
processed prior to 10/3/97 will contain spaces.

SOURCE : CWF

80. Claim Operating Physician NPI Number  
10 297 306

CHAR

On an institutional claim, the National Provider  
Identifier (NPI) number assigned to uniquely  
identify the physician with the primary  
responsibility for performing the surgical  
procedure(s).

NOTE: Effective May 2007, the NPI will become  
the national standard identifier for covered  
health care providers. NPIs will replace  
the current OSCAR provider number, UPINs, NSC  
numbers, and local contractor provider identi-  
fication numbers (PINs) on standard HIPPA claim  
transactions. (During the NPI transition phase  
(4/3/06 - 5/23/07) the capability was there  
for the NCH to receive NPIs along with an  
existing legacy number (UPIN, PIN, OSCAR provider  
number, etc.)).

NOTE1: CMS has determined that dual provider  
identifiers (old legacy number and new NPI)  
must be available in the NCH. After the 5/07  
NPI implementation, the standard system maint-  
ainers will add the legacy number to the claim  
when its adjudicated. We will continue to re-  
ceive the OSCAR provider number and any currently  
issued UPINs. Effective May 2007, no NEW UPINs  
(legacy numbers) will be generated for NEW  
physicians (Part B and outpatient claims), so  
there will only be NPIs sent in to the NCH



for those physicians.

DB2 ALIAS : OPRTG\_NPI  
SAS ALIAS : OP\_NPI  
STANDARD ALIAS : CLM\_OPRTG\_PHYSN\_NPI\_NUM  
TITLE ALIAS : OPRTG\_NPI

LENGTH : 10

SOURCE : CWF

81. Claim Operating Physician Surname  
6 307 312

CHAR

Effective with Version H, the last name of the operating physician (used for internal editing purposes in CMS' CWFMQA system.)

NOTE: Beginning with the NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : OPRTG\_SRNM  
SAS ALIAS : OP\_SRNM  
STANDARD ALIAS : CLM\_OPRTG\_PHYSN\_SRNM\_NAME  
TITLE ALIAS : OPRTG\_PHYSN\_SURNAME

LENGTH : 6

SOURCE : CWF

82. Claim Operating Physician Given Name  
1 313 313

CHAR

Effective with Version H, the first name of the operating physician (used for internal editing purposes in CMS' CWFMQA system.)

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : OPRTG\_GVN\_NAME  
SAS ALIAS : OP\_GVN  
STANDARD ALIAS : CLM\_OPRTG\_PHYSN\_GVN\_NAME  
TITLE ALIAS : OPRTG\_PHYSN\_FIRSTNAME

LENGTH : 1

SOURCE : CWF

83. Claim Operating Physician Middle Initial Name

1 314 314 CHAR

Effective with Version H, the middle initial of the operating physician (used for internal editing purposes in CMS' CWFMQA system.)

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : OPRTG\_MI\_NAME  
SAS ALIAS : OP\_MDL  
STANDARD ALIAS : CLM\_OPRTG\_PHYSN\_MDL\_INITL\_NAME  
TITLE ALIAS : OPRTG\_PHYSN\_MI

LENGTH : 1

SOURCE : CWF

84. Other Physician ID Group

24 315 338

Name and identification numbers associated with the other physician.

STANDARD ALIAS : OTHR\_PHYSN\_ID\_GRP

85. Claim Other Physician UPIN Number

6 315 320 CHAR

On an institutional claim, the unique physician identification number (UPIN) of the other physician associated with the institutional claim.

DB2 ALIAS : OTHR\_UPIN  
SAS ALIAS : OT\_UPIN  
STANDARD ALIAS : CLM\_OTHR\_PHYSN\_UPIN\_NUM  
TITLE ALIAS : OTH\_PHYSN\_UPIN

LENGTH : 6

COMMENTS :  
Prior to Version H this field was named:  
CLM\_OTHR\_PHYSN\_IDENT\_NUM and contained

10 positions (6-position UPIN and 4-position other physician surname).

NOTE: For HHA and Hospice formats beginning with NCH weekly process date 10/3/97 this field was populated with data. HHA and Hospice claims processed prior to 10/3/97 will contain spaces.

SOURCE : CWF

86. Claim Other Physician NPI Number  
10 321 330

CHAR

On an institutional claim, the National Provider Identifier (NPI) number assigned to uniquely identify the other physician associated with the institutional claim.

NOTE: Effective May 2007, the NPI will become the national standard identifier for covered health care providers. NPIs will replace current OSCAR provider number, UPINs, NSC numbers, and local contractor provider identification numbers (PINs) on standard HIPPA claim transactions. (During the NPI transition phase (4/3/06 - 5/23/07) the capability was there for the NCH to receive NPIs along with an existing legacy number (UPIN, PIN, OSCAR provider number, etc.)).

NOTE1: CMS has determined that dual provider identifiers (old legacy numbers and new NPI) must be available in the NCH. After the 5/07 NPI implementation, the standard system maintainers will add the legacy number to the claim when it is adjudicated. We will continue to receive the OSCAR provider number and any currently issued UPINs. Effective May 2007, no NEW UPINs (legacy number) will be generated for NEW physicians (Part B AND outpatient claims), so there will only be NPIs sent in to the NCH for those physicians.

DB2 ALIAS : OTHR\_NPI  
SAS ALIAS : OT\_NPI  
STANDARD ALIAS : CLM\_OTHR\_PHYSN\_NPI\_NUM

LENGTH : 10

SOURCE : CWF

## 87. Claim Other Physician Surname

6 331 336

CHAR

Effective with Version H, the last name of the other physician (used for internal editing purposes in CMS' CWFMQA system.)

NOTE: Beginning with the NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : OTHR\_SRNM  
SAS ALIAS : OT\_SRNM  
STANDARD ALIAS : CLM\_OTHR\_PHYSN\_SRNM\_NAME  
TITLE ALIAS : OTH\_PHYSN\_SURNAME

LENGTH : 6

SOURCE : CWF

## 88. Claim Other Physician Given Name

1 337 337

CHAR

Effective with Version H, the first name of the other physician (used for internal editing purposes in CMS' CWFMQA system.)

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : OTHR\_GVN\_NAME  
SAS ALIAS : OT\_GVN  
STANDARD ALIAS : CLM\_OTHR\_PHYSN\_GVN\_NAME  
TITLE ALIAS : OTH\_PHYSN\_FIRSTNAME

LENGTH : 1

SOURCE : CWF

## 89. Claim Other Physician Middle Initial Name

1 338 338

CHAR

Effective with Version H, the middle initial of the other physician (used for internal editing purposes in CMS' CWFMQA system.)

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : OTHR\_MI\_NAME  
SAS ALIAS : OT MDL  
STANDARD ALIAS : CLM\_OTHR\_PHYSN\_MDL\_INITL\_NAME  
TITLE ALIAS : OTH\_PHYSN\_MI

LENGTH : 1

SOURCE : CWF

90. Medicaid Provider Identification Number  
13 339 351

CHAR

A unique identification number assigned to each provider by the state Medicaid agency. This unique provider number is used to ensure proper payment of providers and to maintain claims history on individual providers for surveillance and utilization review.

DB2 ALIAS : MDCD\_PRVDR\_NUM  
SAS ALIAS : MDCD\_PRV  
STANDARD ALIAS : MDCD\_PRVDR\_IDENT\_NUM  
TITLE ALIAS : MEDICAID\_PROVIDER

LENGTH : 13

COMMENTS :  
Prior to Version H the field size was X(12).

SOURCE : CWF

91. Claim Medicaid Information Code  
4 352 355

CHAR

Effective with Version G, code identifying Medicaid information supplied by the contractor to Medicaid.

DB2 ALIAS : CLM\_MDCD\_INFO\_CD  
SAS ALIAS : MDCDINFO  
STANDARD ALIAS : CLM\_MDCD\_INFO\_CD  
TITLE ALIAS : MEDICAID\_INFO

LENGTH : 4

SOURCE : CWF

92. Claim MCO Paid Switch

1 356 356

CHAR

A switch indicating whether or not a Managed Care Organization (MCO) has paid the provider for an institutional claim.

COBOL ALIAS : MCO\_PD\_IND  
DB2 ALIAS : CLM\_MCO\_PD\_SW  
SAS ALIAS : MCOPDSW  
STANDARD ALIAS : CLM\_MCO\_PD\_SW  
TITLE ALIAS : MCO\_PAID\_SW

LENGTH : 1

COMMENTS :  
Prior to Version H this field was named:  
CLM\_GHO\_PD\_SW.

SOURCE : CWF

LIMITATIONS :

REFER TO :  
MCO\_PD\_SW\_LIM

CODE TABLE : CLM\_MCO\_PD\_TB

93. Claim Treatment Authorization Number

18 357 374

CHAR

The number assigned by the medical reviewer and reported by the provider to identify the medical review (treatment authorization) action taken after review of the beneficiary's case. It designates that treatment covered by the bill has been authorized by the payer. This number is used by the intermediary and the Peer Review Organization.

NOTE: Under HH PPS this field will be used to link claims to the OASIS assessment used as the basis of payment. This eighteen character string consists of the start of care date, the OASIS assessment date and the two digit reason for assessment code.

COMMON ALIAS : TAN  
DB2 ALIAS : TRTMT\_AUTHRZTN\_NUM  
SAS ALIAS : AUTHRZTN

				STANDARD ALIAS : CLM_TRTMT_AUTHRZTN_NUM
				TITLE ALIAS : TREATMENT_AUTHORIZATION
				LENGTH : 18
				SOURCE : CWF
94. Patient Control Number	20	375	394	CHAR
				The unique alphanumeric identifier assigned by the provider to the institutional claim to facilitate retrieval of individual case records and posting of payments.
				DB2 ALIAS : PTNT_CNTL_NUM
				SAS ALIAS : PTNTCNTL
				STANDARD ALIAS : PTNT_CNTL_NUM
				TITLE ALIAS : PATIENT_CONTROL_NUM
				LENGTH : 20
				SOURCE : CWF
95. Claim Medical Record Number	17	395	411	CHAR
				The number assigned by the provider to the beneficiary's medical record to assist in record retrieval.
				DB2 ALIAS : CLM_MDCL_REC_NUM
				SAS ALIAS : MDCL_REC
				STANDARD ALIAS : CLM_MDCL_REC_NUM
				TITLE ALIAS : MEDICAL_RECORD_NUM
				LENGTH : 17
				SOURCE : CWF
96. Claim PRO Control Number	12	412	423	CHAR
				Effective with Version G, the unique identifier assigned by the Peer Review Organization (PRO) for control purposes.
				DB2 ALIAS : CLM_PRO_CNTL_NUM
				SAS ALIAS : PRO_CNTL
				STANDARD ALIAS : CLM_PRO_CNTL_NUM

				TITLE	ALIAS : PRO_CONTROL_NUM
				LENGTH	: 12
				SOURCE	: CWF
97.	Claim PRO Process Date	8	424	431	NUM
					Effective with Version H, the date the claim was used in the PRO review process.
					NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.
				DB2	ALIAS : CLM_PRO_PROC_DT
				SAS	ALIAS : PRO_DT
				STANDARD	ALIAS : CLM_PRO_PROC_DT
				TITLE	ALIAS : PRO_PROC_DT
				LENGTH	: 8 SIGNED : N
				SOURCE	: CWF
				EDIT RULES :	YYYYMMDD
98.	Patient Discharge Status Code	2	432	433	CHAR
					The code used to identify the status of the patient as of the CLM_THRU_DT.
				DB2	ALIAS : PTNT_DSCHRG_STUS
				SAS	ALIAS : STUS_CD
				STANDARD	ALIAS : PTNT_DSCHRG_STUS_CD
				TITLE	ALIAS : PTNT_DSCHRG_STUS_CD
				LENGTH	: 2
				COMMENTS :	Prior to Version H this field was named: CLM_STUS_CD.
				SOURCE	: CWF
				CODE TABLE	: PTNT_DSCHRG_STUS_TB



99. Claim 1st Diagnosis E Code Group  
8 434 441

GRP

Effective with Version 'J', the group used to identify the 1st diagnosis E code in the diagnosis E trailer. This group contains the 1st diagnosis E code and the 1st diagnosis E version code.

STANDARD ALIAS : CLM\_1ST\_DGNS\_E\_CD\_GRP

100. Claim 1st Diagnosis E Version Code  
1 434 434

CHAR

Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9 or ICD-10.

NOTE: With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2013.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : E1VRSNCD

LENGTH : 1

CODE TABLE : CLM\_DGNS\_VRSN\_TB

101. Claim 1st Diagnosis E Code  
7 435 441

CHAR

The code used to identify the 1st external cause of injury, poisoning, or other adverse effect. This diagnosis E code is also stored as the 1st occurrence of the diagnosis E code trailer.

NOTE: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10.

DB2 ALIAS : CLM\_1ST\_DGNS\_E\_CD  
SAS ALIAS : DGNS\_E  
STANDARD ALIAS : CLM\_1ST\_DGNS\_E\_CD

LENGTH : 7

COMMENTS :  
Prior to version 'J', this field was named:  
CLM\_DGNS\_E\_CD.

SOURCE : CWF

EDIT RULES :  
ICD-9-CM

102. Claim PPS Indicator Code

1 442 442

CHAR

Effective with Version H, the code indicating whether or not the (1) claim is PPS and/or (2) the beneficiary is a deemed insured Medicare Qualified Government Employee (MQGE).

NOTE: Beginning with NCH weekly process date 10/3/97 through 5/29/98, this field was populated with only the PPS indicator. Beginning with NCH weekly process date 6/5/98, this field was additionally populated with the deemed MQGE indicator. Claims processed prior to 10/3/97 will contain spaces.

COBOL ALIAS : PPS\_IND  
DB2 ALIAS : CLM\_PPS\_IND\_CD  
SAS ALIAS : PPS\_IND  
STANDARD ALIAS : CLM\_PPS\_IND\_CD  
TITLE ALIAS : PPS\_IND

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM\_PPS\_IND\_TB

103. Claim Total Charge Amount

6 443 448

PACK

Effective with Version G, the total charges for all services included on the institutional claim. This field is redundant with revenue center code 0001/total charges.

DB2 ALIAS : CLM\_TOT\_CHRG\_AMT  
SAS ALIAS : TOT\_CHRG  
STANDARD ALIAS : CLM\_TOT\_CHRG\_AMT  
TITLE ALIAS : CLAIM\_TOTAL\_CHARGES

LENGTH : 9.2 SIGNED : Y

COMMENTS :  
Prior to Version H the size of this field was

S9(7)V99.

SOURCE : CWF

LIMITATIONS :

REFER TO :  
TOT\_CHRG\_AMT\_LIM

104. Claim Pricer Return Code

2 449 450 CHAR

Effective 1/1/2004 with the implementation of NCH/NMUD CR#1, the code used to identify various PPS payment adjustment types. This code identifies the payment return code or the error return code for every claim type calculated by a PRICER (Inpatient, Outpatient, SNF, Inpatient Rehab Facility (IRF), Home Health and Hospice).

The payment return code identifies the type of payment calculated by the PRICER software.

The error return code identifies a condition in a claim that prevents the PRICER software from calculating a correct payment.

NOTE: Prior to 10/2005 (implementation of NCH/NMUD CR#2), this data was stored in positions 443-444 (FILLER) on all institutional claim types.

DB2 ALIAS : CLM\_PRCR\_RTRN\_CD  
SAS ALIAS : PRCRRTN  
STANDARD ALIAS : CLM\_PRCR\_RTRN\_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : CLM\_PRCR\_RTRN\_TB

105. Claim Business Segment Identifier Code

4 451 454 CHAR

Effective 10/1/2005 with the implementation of NCH/NMUD CR#2, the identifier that captures the 2-byte jurisdiction code (represents the USPS state/territory abbreviation (i.e. NY = New York) and the 2-byte modifier that identifies the type of Medicare FFS contract (intermediary, RHHI, carrier or DMERC).

This 4-byte identifier along with the 5-byte FI/Carrier number comprises the Contractor Workload Identifier number. The business segment identifier (BSI) is intended to help sort workloads that may be redistributed with the implementation of contracting reform as required by MMA.

DB2 ALIAS : BUSNS\_SGMT\_ID\_CD  
SAS ALIAS : SGMT\_ID  
STANDARD ALIAS : CLM\_BUSNS\_SGMT\_ID\_CD

LENGTH : 4

SOURCE : CWF

106. Recovery Audit Contractor (RAC) Adjustment Indicator Code  
1 455 455 CHAR

Effective January 5, 2009 with the implementation of CR#4, the code used to identify a Recovery Audit Contractor (RAC) requested adjustment. This occurs as a result of post-payment review activities done by the RAC.

DB2 ALIAS : RAC\_ADJSTMT\_CD  
SAS ALIAS : RACINDCD  
STANDARD ALIAS : CLM\_RAC\_ADJSTMT\_IND\_CD

LENGTH : 1

CODE TABLE : CLM\_RAC\_ADJSTMT\_TB

107. Worker's Compensation Indicator Code  
1 456 456 CHAR

This indicator is used to determine whether the diagnosis codes on the claims are related to the diagnosis codes on the MSP auxiliary file in CWF.

DB2 ALIAS : CLM\_WC\_IND\_CD  
SAS ALIAS : WCINDCD

LENGTH : 1

CODE TABLE : CLM\_WC\_IND\_TB

LANGUAGE : C

108. Claim Service Facility Zip Code  
9 457 465 CHAR

Effective with Version 'J', the zip code used to identify the location of the facility where the service was performed.

DB2 ALIAS : SRVC\_FAC\_ZIP\_CD  
SAS ALIAS : SRVCFAC  
STANDARD ALIAS : CLM\_SRVC\_FAC\_ZIP\_CD

LENGTH : 9

109. FILLER

50 466 515

CHAR

DB2 ALIAS : FILLER

LENGTH : 50

110. Outpatient NCH Edit Code Count

2 516 517

NUM

The count of how many claim edit trailers present on an outpatient claim during the quality assurance process. The purpose of this count is to indicate how many claim edit trailers are present.

DB2 ALIAS : OP\_NCH\_EDIT\_CD\_CNT  
SAS ALIAS : OPEDCNT  
STANDARD ALIAS : OP\_NCH\_EDIT\_CD\_CNT

LENGTH : 2 SIGNED : N

SOURCE : NCH

111. Outpatient NCH Patch Code Count

2 518 519

NUM

Effective with Version H, the count of the number of HCFA patch codes annotated to the outpatient claim during the Nearline maintenance process. The purpose of this count is to indicate how many NCH patch trailers are present.

NOTE1: During the Version H conversion this field was populated with data throughout history (back to service year 1991).

NOTE2: Effective with Version 'I' the number

of possible occurrences was reduced to 30.  
Prior to Version 'I' the number of possible  
occurrences was 99.

DB2 ALIAS : OP\_PATCH\_CD\_CNT  
SAS ALIAS : OPPATCNT  
STANDARD ALIAS : OP\_NCH\_PATCH\_CD\_I\_CNT

LENGTH : 2 SIGNED : N

SOURCE : NCH

112. Outpatient MCO Period Count  
1 520 520

NUM

Effective with Version H, the count of the  
number of Managed Care Organization (MCO)  
periods reported on an outpatient claim.  
The purpose of this count is to indicate  
how many MCO period trailers are present.

NOTE: Beginning with NCH weekly process date  
10/3/97 this field was populated with data.  
Claims processed prior to 10/3/97 will contain  
zeroes in this field.

DB2 ALIAS : OP\_MCO\_PRD\_CNT  
SAS ALIAS : OPMCOCNT  
STANDARD ALIAS : OP\_MCO\_PRD\_CNT

LENGTH : 1 SIGNED : N

SOURCE : NCH

EDIT RULES :  
RANGE: 0 TO 2

113. Outpatient Claim Demonstration Id Count  
1 521 521

NUM

Effective with Version H, the count of the number  
of claim demonstration IDs reported on an  
outpatient claim. The purpose of this count  
is to indicate how many claim demonstration  
trailers are present.

NOTE: During the Version H conversion this field  
was populated with data where a demo was  
identifiable.

DB2 ALIAS : OP\_CLM\_DEMO\_ID\_CNT  
SAS ALIAS : OPDEMCNT  
STANDARD ALIAS : OP\_CLM\_DEMO\_ID\_CNT

LENGTH : 1 SIGNED : N

SOURCE : NCH

EDIT RULES :  
RANGE: 0 TO 5

114. FILLER

2 522 523

NUM

DB2 ALIAS : FILLER

LENGTH : 2 SIGNED : N

115. FILLER

2 524 525

NUM

DB2 ALIAS : FILLER

LENGTH : 2 SIGNED : N

116. Outpatient Claim Diagnosis Code Count

2 526 527

NUM

The count of the number of diagnosis codes (both principal and secondary) reported on an Outpatient claim. The purpose of this count is to indicate how many claim diagnosis code trailers are present. Prior to Version 'J', this field was named:OP\_CLM\_DGNS\_CD\_CNT.

NOTE: Effective with Version 'J', the count of the number of diagnosis code trailers was expanded from 10 to 25.

NOTE1: During the Version 'J' conversion, the diagnosis E codes were removed from the diagnosis trailer and put in the newly created diagnosis E code trailer. Effective with Version 'J', 'E' codes can be found in the diagnosis trailer as secondary diagnosis codes.

DB2 ALIAS : OP\_CLM\_DGNS\_CD\_CNT  
SAS ALIAS : OPDECNT  
STANDARD ALIAS : OP\_CLM\_DGNS\_CD\_J\_CNT

LENGTH : 2 SIGNED : N

COMMENTS :

Prior to Version H this field was named:  
CLM\_OTHR\_DGNS\_CD\_CNT and the principal was  
not included in the count.

SOURCE :

EDIT RULES :  
Range: 0 to 25

117. Outpatient Claim Diagnosis E Code Count  
2 528 529

NUM

Effective with Version 'J', the count of the number of  
diagnosis E codes reported on the outpatient claim.  
The purpose of this count is to indicate how many  
diagnosis E trailers are present.

DB2 ALIAS : DGNS\_E\_TRLR\_CNT  
SAS ALIAS : OPDECNT  
STANDARD ALIAS : OP\_CLM\_DGNS\_E\_CD\_CNT

LENGTH : 2 SIGNED : N

SOURCE :

EDIT RULES :  
Range: 0 to 12

118. Outpatient Claim Procedure Code Count  
2 530 531

NUM

The count of the number of procedure codes (both  
principal and other) reported on an outpatient  
claim. The purpose of this count is to indicate  
how many claim procedure trailers are present.  
Prior to Version 'J', this field was named:  
OP\_CLM\_PRCDR\_CD\_CNT.

NOTE: Effective with Version 'J', the count of the number of  
procedure code trailers was expanded from 6 to 25.

DB2 ALIAS : OP\_PRCDR\_CD\_CNT  
SAS ALIAS : OPDRJCNT  
STANDARD ALIAS : OP\_CLM\_PRCDR\_CD\_J\_CNT

LENGTH : 2 SIGNED : N

SOURCE : CWF

EDIT RULES :



RANGE: 0 TO 25

119. Outpatient Claim Related Condition Code Count

2 532 533 NUM

The count of the number of condition codes reported on an outpatient claim. The purpose of this count is to indicate how many condition code trailers are present.

DB2 ALIAS : OP\_CLM\_RLT\_COND\_CD  
SAS ALIAS : OPCONCNT  
STANDARD ALIAS : OP\_CLM\_RLT\_COND\_CD\_CNT

LENGTH : 2 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
CLM\_RLT\_COND\_CD\_CNT.

SOURCE : NCH

EDIT RULES :  
RANGE: 0 TO 30

120. Outpatient Claim Related Occurrence Code Count

2 534 535 NUM

The count of the number of occurrence codes reported on an outpatient claim. The purpose of this count is to indicate how many occurrence code trailers are present.

DB2 ALIAS : OP\_OCRNC\_CD\_CNT  
SAS ALIAS : OPOCRCNT  
STANDARD ALIAS : OP\_CLM\_RLT\_OCRNC\_CD\_CNT

LENGTH : 2 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
CLM\_RLT\_OCRNC\_CD\_CNT.

SOURCE : NCH

EDIT RULES :  
RANGE: 0 TO 30

121. Outpatient Claim Occurrence Span Code Count

2 536 537 NUM

The count of the number of occurrence span codes reported on an outpatient claim. The purpose of the count is to indicate how many span code trailers are present.

DB2 ALIAS : OP\_OCRNC\_SPAN\_CNT  
SAS ALIAS : OPSPNCNT  
STANDARD ALIAS : OP\_CLM\_OCRNC\_SPAN\_CD\_CNT

LENGTH : 2 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
CLM\_OCRNC\_SPAN\_CD\_CNT.

SOURCE : NCH

122. Outpatient Claim Value Code Count  
2 538 539

NUM

The count of the number of value codes reported on an outpatient claim. The purpose of the count is to indicate how many value code trailers are present.

DB2 ALIAS : OP\_CLM\_VAL\_CD\_CNT  
SAS ALIAS : OPVALCNT  
STANDARD ALIAS : OP\_CLM\_VAL\_CD\_CNT

LENGTH : 2 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
CLM\_VAL\_CD\_CNT.

SOURCE : NCH

EDIT RULES :  
RANGE: 0 TO 36

123. Outpatient Revenue Center Code Count  
2 540 541

NUM

The count of the number of revenue codes reported on an inpatient/SNF claim. The purpose of the count is to indicate how many revenue center trailers are present.

DB2 ALIAS : OP\_REV\_CNTR\_CD\_CNT

SAS ALIAS : OPREVCNT  
STANDARD ALIAS : OP\_REV\_CNTR\_CD\_I\_CNT

LENGTH : 2 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
CLM\_REV\_CNTR\_CD\_CNT.

NOTE: During the Version 'I' conversion the  
number of occurrences changed to 45 (per seg-  
ment - 450 total for claim). For claims prior  
to Version 'I' the number of occurrences was 58.

SOURCE : NCH

EDIT RULES :  
RANGE: 0 TO 45

124. FILLER

4 542 545

CHAR

DB2 ALIAS : FILLER

LENGTH : 4

125. FI Outpatient Claim Specific Group

128 546 673

GRP

Data pertaining only to fiscal intermediary  
outpatient claims.

STANDARD ALIAS : FI\_OP\_CLM\_SPECF\_GRP

126. Claim Outpatient Service Type Code

1 546 546

CHAR

Code indicating type and priority of outpatient  
service.

DB2 ALIAS : OP\_SRVC\_TYPE\_CD  
SAS ALIAS : OPSRVTYP  
STANDARD ALIAS : CLM\_OP\_SRVC\_TYPE\_CD  
TITLE ALIAS : OP\_SERVICE\_TYPE\_CODE

LENGTH : 1

CODE TABLE : CLM\_OP\_SRVC\_TYPE\_TB

127. Claim Outpatient Referral Code

1 547 547 CHAR

The code indicating the means by which the beneficiary was referred for outpatient services.

DB2 ALIAS : CLM\_OP\_RFRL\_CD  
SAS ALIAS : OP\_RFRL  
STANDARD ALIAS : CLM\_OP\_RFRL\_CD  
TITLE ALIAS : OP\_REFERRAL\_CODE

LENGTH : 1

SOURCE : CWF

128. NCH Beneficiary Blood Deductible Liability Amount

6 548 553 PACK

The amount of money for which the intermediary determined the beneficiary is liable for the blood deductible.

DB2 ALIAS : BLOOD\_DDCTBL\_AMT  
SAS ALIAS : BLDDDEDAM  
STANDARD ALIAS : NCH\_BENE\_BLOOD\_DDCTBL\_AMT  
TITLE ALIAS : BLOOD\_DEDUCTIBLE

LENGTH : 9.2 SIGNED : Y

DERIVATIONS :  
DERIVED FROM:  
CLM\_VAL\_CD  
CLM\_VAL\_AMT

DERIVATION RULES:  
Based on the presence of value code equal to '06' move the corresponding value amount to NCH\_BENE\_BLOOD\_DDCTBL\_AMT.

COMMENTS :  
Prior to Version H, this field was named: BENE\_BLOOD\_DDCTBL\_LBLTY\_AMT and the field size was S9(5)V99. Also, for OP claims, this field was stored in a blood trailer. Version H eliminated the OP blood trailer.

SOURCE : NCH QA PROCESS

129. NCH Beneficiary Part B Deductible Amount

6 554 559

PACK

The amount of money for which the intermediary or carrier has determined that the beneficiary is liable for the Part B cash deductible on the claim.

DB2 ALIAS : NCH\_PTB\_DDCTBL\_AMT  
SAS ALIAS : PTB\_DED  
STANDARD ALIAS : NCH\_BENE\_PTB\_DDCTBL\_AMT  
TITLE ALIAS : PTB\_DDCTBL

LENGTH : 9.2 SIGNED : Y

DERIVATIONS :  
DERIVED FROM:  
CLM\_VAL\_CD  
CLM\_VAL\_AMT

DERIVATION RULES (Effective 10/93):  
Based on the presence of value codes A1, B1 or C1 move the related value amount to the NCH\_BENE\_PTB\_DDCTBL\_AMT. \*NOTE: Prior to 10/93, this field was present on the claim transmitted by CWF.

COMMENTS :  
Prior to Version H this field was named: BENE\_PTB\_DDCTBL\_LBLTY\_AMT and field size was S9(5)V99.

SOURCE : NCH QA PROCESS

EDIT RULES :  
\$\$\$\$\$\$\$\$\$CC

130. NCH Beneficiary Part B Coinsurance Amount

6 560 565

PACK

The amount of money for which the intermediary has determined that the beneficiary is liable for Part B coinsurance on the institutional claim.

DB2 ALIAS : PTB\_COINSRNC\_AMT  
SAS ALIAS : PTB\_COIN  
STANDARD ALIAS : NCH\_BENE\_PTB\_COINSRNC\_AMT  
TITLE ALIAS : BENE\_PTB\_COINSURANCE\_AMT

LENGTH : 9.2 SIGNED : Y

DERIVATIONS :  
DERIVED FROM:  
CLM\_VAL\_CD  
CLM\_VAL\_AMT

DERIVATION RULES (Effective 10/93):  
Based on the presence of value codes A2, B2 or C2  
move the related value amount to the  
NCH\_BENE\_PTB\_COINSRNC\_AMT. \*NOTE: Prior to  
10/93, this field was present on the claim  
transmitted by CWF.

COMMENTS :  
Prior to Version H this field was named:  
BENE\_PTB\_COINSRNC\_LBLTY\_AMT and the field  
size was S9(5)V99.

SOURCE : NCH QA PROCESS

EDIT RULES :  
\$\$\$\$\$\$\$CC

131. NCH Professional Component Charge Amount  
6 566 571

PACK

Effective with Version H, for inpatient and out-  
patient claims, the amount of physician and other  
professional charges covered under Medicare Part B  
(used for internal CWFMQA editing purposes and other  
internal processes (e.g. if computing interim payment  
these charges are deducted)).

NOTE: During the Version H conversion this field  
was populated with data throughout history (back to  
service year 1991).

DB2 ALIAS : PROFNL\_CMPNT\_AMT  
SAS ALIAS : PCCHGAMT  
STANDARD ALIAS : NCH\_PROFNL\_CMPNT\_CHRG\_AMT  
TITLE ALIAS : PROFNL\_CMPNT\_CHARGES

LENGTH : 9.2 SIGNED : Y

DERIVATIONS :

1. IF INPATIENT - DERIVED FROM:  
CLM\_VAL\_CD  
CLM\_VAL\_AMT

DERIVATION RULES:

Based on the presence of value code 04 or 05  
move the related value amount to the  
NCH\_PROFNL\_CMPNT\_CHRG\_AMT.

2. IF OUTPATIENT - DERIVED FROM:  
REV\_CNTR\_CD  
REV\_CNTR\_TOT\_CHRG\_AMT

DERIVATION RULES (Effective 10/98):  
Based on the presence of revenue center codes  
096X, 097X & 098X move the related total charge  
amount to NCH\_PROFNL\_CMPNT\_CHRG\_AMT.

NOTE1: During the Version H conversion, this  
field was populated with data throughout history  
BUT the derivation rule applied to the outpatient  
claim was incomplete (i.e., revenue codes 0972,  
0973, 0974 and 0979 were omitted from the calcu-  
lation).

SOURCE : NCH QA Process

132. Claim Outpatient Beneficiary Interim Deductible Amount  
6 572 577 PACK

Effective with Version H, the amount paid by the  
beneficiary that is being applied to the  
deductible, as reported on the outpatient claim .

NOTE: Beginning with NCH weekly process date  
10/3/97 this field was populated with data.  
Claims processed prior to 10/3/97 will contain  
zeroes in this field.

DB2 ALIAS : INTRM\_DDCTBL\_AMT  
SAS ALIAS : INTRMDED  
STANDARD ALIAS : CLM\_OP\_BENE\_INTRM\_DDCTBL\_AMT  
TITLE ALIAS : INTRM\_DDCTBL

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

133. Claim Outpatient Provider Payment Amount  
6 578 583 PACK

Effective with Version H, the amount paid, from the  
Medicare trust fund, to the provider for the  
services reported on the outpatient claim.

NOTE: Beginning with NCH weekly process date  
10/3/97 this field was populated with data.  
Claims processed prior to 10/3/97 will contain  
zeroes in this field.

DB2 ALIAS : OP\_PRVDR\_PMT\_AMT  
SAS ALIAS : PRVDRPMT  
STANDARD ALIAS : CLM\_OP\_PRVDR\_PMT\_AMT  
TITLE ALIAS : OP\_PRVDR\_PMT

LENGTH : 9.2 SIGNED : Y

SOURCE : NCH

134. Claim Outpatient Beneficiary Payment Amount

6 584 589 PACK

Effective with Version H, the amount paid, from the  
Medicare trust fund, to the beneficiary for the  
services reported on the outpatient claim.

NOTE: Beginning with NCH weekly process date  
10/3/97 this field was populated with data.  
Claims processed prior to 10/3/97 will contain  
zeroes in this field.

DB2 ALIAS : OP\_BENE\_PMT\_AMT  
SAS ALIAS : BENEFMT  
STANDARD ALIAS : CLM\_OP\_BENE\_PMT\_AMT  
TITLE ALIAS : OP\_BENE\_PMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

135. NCH Blood Pints Furnished Quantity

2 590 591 PACK

Number of whole pints of blood furnished to the  
beneficiary.

DB2 ALIAS : NCH\_BLOOD\_PT\_FRNSH  
STANDARD ALIAS : NCH\_BLOOD\_PT\_FRNSH\_QTY  
TITLE ALIAS : BLOOD\_PINTS\_FURNISHED

LENGTH : 3 SIGNED : Y

DERIVATIONS :  
DERIVED FROM:  
CLM\_VAL\_CD



CLM\_VAL\_AMT

DERIVATION RULES:

Based on the presence of value code equal to 37 move the related value amount to the NCH\_BLOOD\_PT\_FRNSH\_QTY.

COMMENTS :

Prior to Version H this field was named: CLM\_BLOOD\_PT\_FRNSH\_QTY. Also for outpatient claims this field was stored in a blood trailer. Version H eliminated the outpatient blood trailer.

SOURCE : NCH QA Process

EDIT RULES :  
NUMERIC

136. NCH Blood Pints Replaced Quantity  
2 592 593

PACK

Number of whole pints of blood replaced.

DB2 ALIAS : BLOOD\_PT\_RPLC\_QTY

SAS ALIAS : BLD\_RPLC

STANDARD ALIAS : NCH\_BLOOD\_PT\_RPLC\_QTY

TITLE ALIAS : BLOOD\_PINTS\_REPLACED

LENGTH : 3 SIGNED : Y

DERIVATIONS :

DERIVED FROM:

CLM\_VAL\_CD

CLM\_VAL\_AMT

DERIVATION RULES:

Based on the presence of value code equal to 39 move the related value amount to the NCH\_BLOOD\_PT\_RPLC\_QTY.

COMMENTS :

Prior to Version H this field was named: CLM\_BLOOD\_PT\_RPLC\_QTY. Also for outpatient claims this field was stored in a blood trailer. Version H eliminated the outpatient blood trailer.

SOURCE : NCH QA Process

EDIT RULES :  
NUMERIC

137. NCH Blood Pints Not Replaced Quantity  
2 594 595

PACK

Number of whole pints of blood not replaced.

DB2 ALIAS : BLOOD\_PT\_NRPLC\_QTY  
SAS ALIAS : BLDNRPLC  
STANDARD ALIAS : NCH\_BLOOD\_PT\_NRPLC\_QTY  
TITLE ALIAS : BLOOD\_PINTS\_NOT\_REPLACED

LENGTH : 3 SIGNED : Y

DERIVATIONS :  
DERIVED FROM:  
CLM\_VAL\_CD  
CLM\_VAL\_AMT

DERIVATION RULES:  
Subtract value code 39 amount from value code  
37 amount and move the result to  
NCH\_BLOOD\_PT\_NRPLC\_QTY.

COMMENTS :  
Prior to Version H this field was named:  
CLM\_BLOOD\_PT\_NRPLC\_QTY. Also for outpatient  
claims this field was stored in a blood  
trailer. Version H eliminated the outpatient  
blood trailer.

SOURCE : NCH QA Process

EDIT RULES :  
NUMERIC

138. NCH Blood Deductible Pints Quantity  
2 596 597

PACK

The quantity of blood pints applied (blood  
deductible).

DB2 ALIAS : BLOOD\_DDCTBL\_QTY  
SAS ALIAS : BLDDDEDPT  
STANDARD ALIAS : NCH\_BLOOD\_DDCTBL\_PT\_QTY  
TITLE ALIAS : BLOOD\_PINTS\_DEDUCTIBLE

LENGTH : 3 SIGNED : Y

DERIVATIONS :  
DERIVED FROM:  
CLM\_VAL\_CD  
CLM\_VAL\_AMT

DERIVATION RULES:  
Based on the presence of value code equal to  
38 move the related value amount to the  
NCH\_BLOOD\_DDCTBL\_PT\_QTY.

COMMENTS :  
Prior to Version H this field was named:  
CLM\_BLOOD\_DDCTBL\_PT\_QTY. Also for outpatient  
claims this field was stored in a blood  
trailer. Version H eliminated the outpatient  
blood trailer.

SOURCE : NCH QA Process

EDIT RULES :  
NUMERIC

139. Claim Outpatient Transaction Type Code  
1 598 598

CHAR

Effective with Version H, the code derived  
at CWF based on type of bill and provider number  
to identify the outpatient transaction type.

NOTE: Beginning with NCH weekly process date  
10/3/97 this field was populated with data.  
Claims processed prior to 10/3/97 will contain  
spaces in this field.

DB2 ALIAS : OP\_TRANS\_TYPE\_CD  
SAS ALIAS : TRANTYPE  
STANDARD ALIAS : CLM\_OP\_TRANS\_TYPE\_CD  
TITLE ALIAS : OP\_TRANS\_TYPE

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM\_OP\_TRANS\_TYPE\_TB

140. Claim Outpatient ESRD Method of Reimbursement Code  
1 599 599

CHAR

Effective with Version H, the code denoting the method of reimbursement selected by the ESRD bene for home dialysis (i.e. whether home supplies are purchased through a facility or from a supplier.)

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : ESRD\_REIMBRSM\_T\_CD  
SAS ALIAS : ESRDMTHD  
STANDARD ALIAS : CLM\_OP\_ESRD\_MTHD\_REIMBRSM\_T\_CD  
TITLE ALIAS : ESRD\_REIMBRSM\_T\_MTHD

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM\_OP\_ESRD\_MTHD\_REIMBRSM\_T\_TB

141. Claim Patient for Visit Code Group

8 600 607

GRP

Effective with Version 'J', the group used to identify the patient's reason for visit diagnosis code on the outpatient claim. This group contains the reason for visit diagnosis code and the reason for visit diagnosis version code.

OCCURS MIN: 3 OCCURS MAX: 0

142. Claim Patient Reason for Visit Version Code

1 600 600

CHAR

Effective with Version 'J', the code used to indicate if the diagnosis code/patient reason for visit code is ICD-9 or ICD-10.

NOTE: With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2013.

DB2 ALIAS : PTNT\_RSN\_VRSN\_CD  
SAS ALIAS : PRSNVRSN

LENGTH : 1

				CODE TABLE	: CLM_PTNT_RSN_VISIT_VRSN_TB
143. Claim Patient Reason for Visit Code	7	601	607	CHAR	
					The diagnosis code used to identify the patient's reason for visit.
				DB2	ALIAS : PTNT_RSN_VISIT_CD
				SAS	ALIAS : PVISITCD
				LENGTH	: 7
				COMMENTS :	
					Prior to Version 'J', this field was :CLM_ADMTG_DGNS_CD.
					With Version 'J', the name has changed and there can be up to 3 occurrences of this group.
				SOURCE	:
144. FILLER	50	624	673	CHAR	
				DB2	ALIAS : FILLER
				LENGTH	: 50
145. FI Outpatient Claim Trailer Group	VAR	674	16292	GRP	
					Variable portion of the fiscal intermediary outpatient claim record for version J of the NCH.
				STANDARD ALIAS	: FI_OP_CLM_TRLR_GRP
146. NCH Edit Group	5	674	678	GRP	
					The number of claim edit trailers is determined by the claim edit code count.
				STANDARD ALIAS	: NCH_EDIT_GRP
				OCCURS MIN:	0 OCCURS MAX: 13
				DEPENDING ON	: OP_NCH_EDIT_CD_CNT
147. NCH Edit Trailer Indicator Code					

	1	674	674	CHAR	
				Effective with Version H, the code indicating the presence of an NCH edit trailer.	
				NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).	
				DB2 ALIAS : EDIT_TRLR_IND_CD	
				SAS ALIAS : EDITIND	
				STANDARD ALIAS : NCH_EDIT_TRLR_IND_CD	
				LENGTH : 1	
				SOURCE : NCH QA Process	
				CODE TABLE : NCH_EDIT_TRLR_IND_TB	
148. NCH Edit Code	4	675	678	CHAR	
				The code annotated to the claim indicating the CWFMQA editing results so users will be aware of data deficiencies.	
				NOTE: Prior to Version H only the highest priority code was stored. Beginning 11/98 up to 13 edit codes may be present.	
				COMMON ALIAS : QA_ERROR_CODE	
				DB2 ALIAS : NCH_EDIT_CD	
				SAS ALIAS : EDIT_CD	
				STANDARD ALIAS : NCH_EDIT_CD	
				TITLE ALIAS : QA_ERROR_CD	
				LENGTH : 4	
				SOURCE : NCH QA EDIT PROCESS	
				CODE TABLE : NCH_EDIT_TB	
149. NCH Patch Group	11	1	11	GRP	
				STANDARD ALIAS : NCH_PATCH_GRP	
				OCCURS MIN: 0 OCCURS MAX: 30	

DEPENDING ON : OP\_NCH\_PATCH\_CD\_I\_CNT

150. NCH Patch Trailer Indicator Code

1 1 1

CHAR

Effective with Version H, the code indicating the presence of an NCH patch trailer.

NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).

DB2 ALIAS : PATCH\_TRLR\_IND\_CD  
SAS ALIAS : PATCHIND  
STANDARD ALIAS : NCH\_PATCH\_TRLR\_IND\_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH\_PATCH\_TRLR\_IND\_TB

151. NCH Patch Code

2 2 3

CHAR

Effective with Version H, the code annotated to the claim indicating a patch was applied to the record during an NCH Nearline record conversion and/or during current processing.

NOTE: Prior to Version H this field was located in the third and fourth occurrence of the CLM\_EDIT\_CD.

DB2 ALIAS : NCH\_PATCH\_CD  
SAS ALIAS : PATCHCD  
STANDARD ALIAS : NCH\_PATCH\_CD  
TITLE ALIAS : NCH\_PATCH

LENGTH : 2

SOURCE : NCH

CODE TABLE : NCH\_PATCH\_TB

152. NCH Patch Applied Date

8 4 11

NUM

Effective with Version H, the date the NCH patch was applied to the claim.

DB2 ALIAS : NCH\_PATCH\_APPLY\_DT  
SAS ALIAS : PATCHDT  
STANDARD ALIAS : NCH\_PATCH\_APPLY\_DT  
TITLE ALIAS : NCH\_PATCH\_DT

LENGTH : 8 SIGNED : N

SOURCE : NCH

EDIT RULES :  
YYYYMMDD

153. MCO Period Group

37 1 37 GRP

The number of managed care organization (MCO) period data trailers present is determined by the claim MCO period trailer count. This field reflects the two most current MCO periods in the CWF beneficiary history record. It may have no connection to the services on the claim.

STANDARD ALIAS : MCO\_PRD\_GRP

OCCURS MIN: 0 OCCURS MAX: 2

DEPENDING ON : OP\_MCO\_PRD\_CNT

154. NCH MCO Trailer Indicator Code

1 1 1 CHAR

Effective with Version H, the code indicating the presence of a Managed Care Organization (MCO) trailer.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

COBOL ALIAS : MCO\_IND  
DB2 ALIAS : MCO\_TRLR\_IND\_CD  
SAS ALIAS : MCOIND  
STANDARD ALIAS : NCH\_MCO\_TRLR\_IND\_CD  
TITLE ALIAS : MCO\_INDICATOR

LENGTH : 1



				SOURCE	: NCH QA Process
				CODE TABLE	: NCH_MCO_TRLR_IND_TB
155. MCO Contract Number	5	2	6	CHAR	
					Effective with Version H, this field represents the plan contract number of the Managed Care Organization (MCO).
					NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.
				DB2	ALIAS : MCO_CNTRCT_NUM
				SAS	ALIAS : MCONUM
				STANDARD	ALIAS : MCO_CNTRCT_NUM
				TITLE	ALIAS : MCO_NUM
				LENGTH	: 5
				SOURCE	: CWF
156. MCO Option Code	1	7	7	CHAR	
					Effective with Version H, the code indicating Managed Care Organization (MCO) lock-in enrollment status of the beneficiary.
					NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.
				DB2	ALIAS : MCO_OPTN_CD
				SAS	ALIAS : MCOOPTN
				STANDARD	ALIAS : MCO_OPTN_CD
				TITLE	ALIAS : MCO_OPTION_CD
				LENGTH	: 1
				SOURCE	: CWF
				CODE TABLE	: MCO_OPTN_TB
157. MCO Period Effective Date					

8 8 15 NUM

Effective with Version H, the date the beneficiary's enrollment in the Managed Care Organization (MCO) became effective.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

DB2 ALIAS : MCO\_PRD\_EFCTV\_DT  
SAS ALIAS : MCOEFFDT  
STANDARD ALIAS : MCO\_PRD\_EFCTV\_DT  
TITLE ALIAS : MCO\_PERIOD\_EFF\_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

158. MCO Period Termination Date  
8

16 23 NUM

Effective with Version H, the date the beneficiary's enrollment in the Managed Care Organization (MCO) was terminated.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

DB2 ALIAS : MCO\_PRD\_TRMNTN\_DT  
SAS ALIAS : MCOTRMDT  
STANDARD ALIAS : MCO\_PRD\_TRMNTN\_DT  
TITLE ALIAS : MCO\_PERIOD\_TERM\_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

159. MCO Health PLANID Number

14 24 37 CHAR

A placeholder field (effective with Version H) for storing the Health PlanID associated with the Managed Care Organization (MCO). Prior to Version 'I' this field was named: MCO\_PAYERID\_NUM.

DB2 ALIAS : MCO\_PLANID\_NUM  
SAS ALIAS : MCOPLNID  
STANDARD ALIAS : MCO\_HLTH\_PLANID\_NUM  
TITLE ALIAS : MCO\_PLANID

LENGTH : 14

COMMENTS :  
Prior to Version I this field was named: MCO\_PAYERID\_NUM.

SOURCE : CWF

160. Claim Demonstration Identification Group  
18 1 18

GRP

The number of demonstration identification trailers present is determined by the claim demonstration identification trailer count.

STANDARD ALIAS : CLM\_DEMO\_ID\_GRP

OCCURS MIN: 0 OCCURS MAX: 5

DEPENDING ON : OP\_CLM\_DEMO\_ID\_CNT

161. NCH Demonstration Trailer Indicator Code  
1 1 1

CHAR

Effective with Version H, the code indicating the presence of a demo trailer.

NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).

COBOL ALIAS : DEMO\_IND  
DB2 ALIAS : NCH\_DEMO\_TRLR\_IND\_  
SAS ALIAS : DEMOIND  
STANDARD ALIAS : NCH\_DEMO\_TRLR\_IND\_CD  
TITLE ALIAS : DEMO\_INDICATOR

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH\_DEMO\_TRLR\_IND\_TB

162. Claim Demonstration Identification Number  
2 2 3

CHAR

Effective with Version H, the number assigned to identify a demo. This field is also used to denote special processing (a.k.a. Special Processing Number, SPN).

NOTE: Prior to Version H, Demo ID was stored in the redefined Claim Edit Group, 4th occurrence, positions 3 and 4. During the H conversion, this field was populated with data throughout history (as appropriate either by moving ID on Version G or by deriving from specific demo criteria).

01 = Nursing Home Case-Mix and Quality: NHCMQ (RUGS) Demo -- testing PPS for SNFs in 6 states, using a case-mix classification system based on resident characteristics and actual resources used. The claims carry a RUGS indicator and one or more revenue center codes in the 9,000 series.

NOTE1: Effective for SNF claims with NCH weekly process date after 2/8/96 (and service date after 12/31/95) -- beginning 4/97, Demo ID '01' was derived in NCH based on presence of RUGS phase # '2','3' or '4' on incoming claim; since 7/97, CWF has been adding ID to claim.

NOTE2: During the Version H conversion, Demo ID '01' was populated back to NCH weekly process date 2/9/96 based on the RUGS phase indicator (stored in Claim Edit Group, 3rd occurrence, 4th position, in Version G).

02 = National HHA Prospective Payment Demo -- testing PPS for HHAs in 5 states, using two alternate methods of paying HHAs: per visit by type of HHA visit and per episode of HH care.

NOTE1: Effective for HHA claims with NCH weekly process date after 5/31/95 -- beginning 4/97, Demo ID '02' was derived in NCH based on HCFA/

CHPP-supplied listing of provider # and start/stop dates of participants.

NOTE2: During the Version H conversion, Demo ID '02' was populated back to NCH weekly process date 6/95 based on the CHPP criteria.

03 = Telemedicine Demo -- testing covering traditionally noncovered physician services for medical consultation furnished via two-way, interactive video systems (i.e. teleconsultation) in 4 states. The claims contain line items with 'QQ' HCPCS code.

NOTE1: Effective for physician/supplier (nonDMERC) claims with NCH weekly process date after 12/31/96 (and service date after 9/30/96) -- since 7/97, CWF has been adding Demo ID '03' to claim.

NOTE2: During Version H conversion, Demo ID '03' was populated back to NCH weekly process date 1/97 based on the presence of 'QQ' HCPCS on one or more line items.

04 = United Mine Workers of America (UMWA) Managed Care Demo -- testing risk sharing for Part A services, paying special capitation rates for all UMWA beneficiaries residing in 13 designated counties in 3 states. Under the demo, UMWA will waive the 3-day qualifying hospital stay for a SNF admission. The claims contain TOB '18X', '21X', '28X' and '51X'; condition code = W0; claim MCO paid switch = not '0'; and MCO contract # = '90091'.

NOTE: Initially scheduled to be implemented for all SNF claims for admission or services on 1/1/97 or later, CWF did not transmit any Demo ID '04' annotated claims until on or about 2/98.

05 = Medicare Choices (MCO encounter data) demo -- testing expanding the type of Managed Care plans available and different payment methods at 16 MCOs in 9 states. The claims contain one of the specific MCO Plan Contract # assigned to the Choices Demo site.

NOTE1: Effective for all claim types with NCH weekly process date after 7/31/97 -- CWF adds Demo ID '05' to claim based on the presence of

the MCO Plan Contract #. \*\*\*Demonstration was terminated 12/31/2000.\*\*\*

NOTE2: During the Version H conversion, Demo ID '05' was populated back to NCH weekly process date 8/97 based on the presence of the Choices indicator (stored as an alpha character cross-walked from MCO plan contract # in the Claim Edit Group, 4th occurrence, 2nd position, in Version 'G').

06 = Coronary Artery Bypass Graft (CABG) Demo -- testing bundled payment (all-inclusive global pricing) for hospital + physician services related to CABG surgery in 7 hospitals in 7 states. The inpatient claims contain a DRG '106' or '107'.

NOTE1: Effective for Inpatient claims and physician/supplier claims with Claim Edit Date no earlier than 6/1/91 (not all CABG sites started at the same time) -- on 5/1/97, CWF started transmitting Demo ID '06' on the claim. The FI adds the ID to the claim based on the presence of DRG '106' or '107' from specific providers for specified time periods; the carrier adds the ID to the claim based on receiving 'Daily Census List' from participating hospitals. \*\*\*Demo terminated in 1998.\*\*\*

NOTE2: During the Version H conversion, any claims where Medicare is the primary payer that were not already identified as Demo ID '06' (stored in the redefined Claim Edit Group, 4th occurrence, positions 3 and 4, Version G) were annotated based on the following criteria: Inpatient - presence of DRG '106' or '107' and a provider number=220897, 150897, 380897, 450897, 110082, 230156 or 360085 for specified service dates; noninstitutional - presence of HCPCS modifier (initial and/or second) = 'Q2' and a carrier number =00700/31143 00630, 01380, 00900, 01040/00511, 00710, 00623, or 13630 for specified service dates.

07 = Virginia Cardiac Surgery Initiative (VCSI) (formerly referred to as Medicare Quality Partnerships Demo) -- this is a voluntary consortium of the cardiac surgery physician groups and the non-

Veterans Administration hospitals providing open heart surgical services in the Commonwealth of Virginia. The goal of the demo is to share data on quality and process innovations in an attempt to improve the care for all cardiac patients. The demonstration only affects those FIs that process claims from hospitals in Virginia and the carriers that process claims from physicians providing inpatient services at those hospitals. The hospitals will be reimbursed on a global payment basis for selected cardiac surgical diagnosis related groups (DRGs). The inpatient claims will contain a DRG '104', '105', '106', '107', '109'; the related physician/supplier claims will contain the claim payment denial reason code = 'D'.

NOTE: The implementation date for this demo is 4/1/03. The FI will annotate the claim with the demo id add Demo ID '07' to claim. For carrier claims, the Standard Systems will annotate the claim with the '07' demo number.

08 = Provider Partnership Demo -- testing per-case payment approaches for acute inpatient hospitalizations, making a lump-sum payment (combining the normal Part A PPS payment with the Part B allowed charges into a single fee schedule) to a Physician/Hospital Organization for all Part A and Part B services associated with a hospital admission. From 3 to 6 hospitals in the Northeast and Mid-Atlantic regions may participate in the demo.

NOTE: The demo is on HOLD. The FI and carrier will add Demo ID '08' to claim.

15 = ESRD Managed Care (MCO encounter data) -- testing open enrollment of ESRD beneficiaries and capitation rates adjusted for patient treatment needs at 3 MCOs in 3 States. The claims contain one of the specific MCO Plan Contract # assigned to the ESRD demo site.

NOTE: Effective 10/1/97 (but not actually implemented at a site until 1/1/98) for all claim types -- the FI and carrier add Demo ID '15' to claim based on the presence of the MCO plan contract #.

30 = Lung Volume Reduction Surgery (LVRS) or

National Emphysema Treatment Trial (NETT)  
Clinical Study -- evaluating the effectiveness of LVRS and maximum medical therapy (including pulmonary rehab) for Medicare beneficiaries in last stages of emphysema at 18 hospitals nationally, in collaboration with NIH.

NOTE: Effective for all claim types (except DMERC) with NCH weekly process date after 2/27/98 (and service date after 10/31/97) -- the FI adds Demo ID '30' based on the presence of a condition code = EY; the participating physician (not the carrier) adds ID to the noninstitutional claim. DUE TO THE SENSITIVE NATURE OF THIS CLINICAL TRIAL AND UNDER THE TERMS OF THE INTERAGENCY AGREEMENT WITH NIH, THESE CLAIMS ARE PROCESSED BY CWF AND TRANSMITTED TO HCFA BUT NOT STORED IN THE NEARLINE FILE (access is restricted to study evaluators only).

31 = VA Pricing Special Processing (SPN) -- not really a demo but special request from VA due to court settlement; not Medicare services but VA inpatient and physician services submitted to FI 00400 and Carrier 00900 to obtain Medicare pricing -- CWF WILL PROCESS VA CLAIMS ANNOTATED WITH DEMO ID '31', BUT WILL NOT TRANSMIT TO HCFA (not in Nearline File).

37 = Medicare Coordinated Care Demonstration -- to test whether coordinated care services furnished to certain beneficiaries improves outcome of care and reduces Medicare expenditures under Part A and Part B. There will be at least 14 Coordinated Care Entities (CCEs). The selected entities will be assigned a provider number specifically for the demonstration services.

NOTE: All claims will be processed by carriers; no FI processing (except for Georgetown site)

37 = Medicare Disease Management (DMD) -- the purpose of this demonstration is to study the impact on costs and health outcomes of applying disease management services supplemented with coverage for prescription drugs for certain Medicare beneficiaries with diagnosed, advanced-stage congestive heart failure, diabetes, or coronary heart disease. Three demonstration sites will be used for this demonstration and it will last for 3 years. (Effective 4/1/2003).



NOTE: All claims will be processed by NHIC-California (Carrier). FIs will only serve as a conduit for transmitting information to and from CWF about the NOEs.

38 = Physician Encounter Claims - the purpose of this demo id is to identify the physician encounter claims being processed at the HCFA Data Center (HDC). This number will help EDS in making the claim go through the appropriate processing logic, which differs from that for fee-for-service. \*\*NOT IN NCH.\*\*

NOTE: Effective October, 2000. Demo ids will not be assigned to Inpatient and Outpatient encounter claims.

39 = Centralized Billing of Flu and PPV Claims -- The purpose of this demo is to facilitate the processing carrier, Trailblazers, paying flu and PPV claims based on payment localities. Providers will be giving the shots throughout the country and transmitting the claims to Trailblazers for processing.

NOTE: Effective October, 2000 for carrier claims.

40 = Payment of Physician and Nonphysician Services in certain Indian Providers -- the purpose of this demo is to extend payment for services of physician and nonphysician practitioners furnished in hospitals and ambulatory care clinics. Prior to the legislation change in BIPA, reimbursement for Medicare services provided in IHS facilities was limited to services provided in hospitals and skilled nursing facilities. This change will allow payment for IHS, Tribe and Tribal Organization providers under the Medicare physician fee schedule.

NOTE: Effective July 1, 2001 for institutional and carrier claims.

48 = Medical Adult Day-Care Services -- the purpose of this demonstration is to provide, as part of the episode of care for home health services, medical adult day care services to Medicare beneficiaries as a substitute for a portion of home health services that would otherwise be provided in the beneficiaries home. This demo would last approx. 3 years in not more than 5 sites. Payment for each home health service episode of care will be set at 95% of the amount

that would otherwise be paid for home health services provided entirely in the home.

NOTE: Effective July 5, 2005 for HHA claims.

DB2 ALIAS : CLM\_DEMO\_ID\_NUM  
SAS ALIAS : DEMONUM  
STANDARD ALIAS : CLM\_DEMO\_ID\_NUM  
TITLE ALIAS : DEMO\_ID

LENGTH : 2

SOURCE : CWF

163. Claim Demonstration Information Text

15 4 18

CHAR

Effective with Version H, the text field that contains related demo information. For example, a claim involving a CHOICES demo id '05' would contain the MCO plan contract number in the first five positions of this text field.

NOTE: During the Version H conversion this field was populated with data throughout history.

DB2 ALIAS : CLM\_DEMO\_INFO\_TXT  
SAS ALIAS : DEMOTXT  
STANDARD ALIAS : CLM\_DEMO\_INFO\_TXT  
TITLE ALIAS : DEMO\_INFO

LENGTH : 15

DERIVATIONS :

DERIVATION RULES:

Demo ID = 01 (RUGS) -- the text field will contain a 2, 3 or 4 to denote the RUGS phase. If RUGS phase is blank or not one of the above the text field will reflect 'INVALID'. NOTE: In Version 'G', RUGS phase was stored in redefined Claim Edit Group, 3rd occurrence, 4th position.

Demo ID = 02 (Home Health demo) -- the text field will contain PROV#. When demo number not equal to 02 then text will reflect 'INVALID'.

Demo ID = 03 (Telemedicine demo) -- text field will contain the HCPCS code. If the required HCPCS is not shown then the text field will reflect

'INVALID'.

Demo ID = 04 (UMWA) -- text field will contain W0 denoting that condition code W0 was present. If condition code W0 not present then the text field will reflect 'INVALID'.

Demo ID = 05 (CHOICES) -- the text field will contain the CHOICES plan number, if both of the following conditions are met: (1) CHOICES plan number present and PPS or Inpatient claim shows that 1st 3 positions of provider number as '210' and the admission date is within HMO effective/termination date; or non-PPS claim and the from date is within HMO effective/termination date and (2) CHOICES plan number matches the HMO plan number. If either condition is not met the text field will reflect 'INVALID CHOICES PLAN NUMBER'. When CHOICES plan number not present, text will reflect 'INVALID'.

NOTE: In Version 'G', a valid CHOICES plan ID is stored as alpha character in redefined Claim Edit Group, 4th occurrence, 2nd position. If invalid, CHOICES indicator 'ZZ' displayed.

Demo ID = 15 (ESRD Managed Care) -- text field will contain the ESRD/MCO plan number. If ESRD/MCO plan number not present the field will reflect 'INVALID'.

Demo ID = 38 (Physician Encounter Claims) -- text field will contain the MCO plan number. When MCO plan number not present the field will reflect 'INVALID'.

SOURCE : CWF

LIMITATIONS :

REFER TO :  
CHOICES\_DEMO\_LIM

164. Claim Diagnosis Group

9 1 9 GRP

The number of claim diagnosis trailers is determined by the claim diagnosis code

count. The principal diagnosis is the first occurrence.  
The principal diagnosis is also  
stored (redundantly) in the fixed portion  
of the record.

NOTE:

Prior to Version H this group was named:  
CLM\_OTHR\_DGNS\_GRP and did not contain the  
CLM\_PRNCPAL\_DGNS\_CD.

STANDARD ALIAS : CLM\_DGNS\_GRP

OCCURS MIN: 0 OCCURS MAX: 25

DEPENDING ON : OP\_CLM\_DGNS\_CD\_J\_CNT

165. NCH Diagnosis Trailer Indicator Code

1 1 1

CHAR

Effective with Version H, the code indicating  
the presence of a diagnosis trailer.

NOTE: During the Version H conversion this field  
was populated throughout history (back to service  
year 1991).

DB2 ALIAS : DGNS\_TRLR\_IND\_CD

SAS ALIAS : DGNSIND

STANDARD ALIAS : NCH\_DGNS\_TRLR\_IND\_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH\_DGNS\_TRLR\_IND\_TB

166. Claim Diagnosis Version Code

1 2 2

CHAR

Effective with Version 'J', the code used to indicate if the  
diagnosis code is ICD-9 or ICD-10.

NOTE: With 5010, the diagnosis and procedure codes have been  
expanded to accommodate ICD-10, even though ICD-10 is not  
scheduled for implementation until 10/2013.

DB2 ALIAS : UNDEFINED

SAS ALIAS : DVRSNCD

LENGTH : 1

				CODE TABLE : CLM_DGNS_VRSN_TB
167. Claim Diagnosis Code	7	3	9	CHAR
				<p>The diagnosis code identifying the beneficiary's principal or other diagnosis (including E code).</p> <p>NOTE:</p> <p>Prior to Version H, the principal diagnosis code was not stored with the 'OTHER' diagnosis codes. During the Version H conversion the CLM_PRNCPAL_DGNS_CD was added as the first occurrence.</p> <p>NOTE1: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10.</p> <p>NOTE2: Effective with Version 'J', the diagnosis E codes are stored in a separate trailer (CLM_DGNS_E_GRP).</p> <p>DB2 ALIAS : CLM_DGNS_CD</p> <p>SAS ALIAS : DGNS_CD</p> <p>LENGTH : 7</p> <p>EDIT RULES : ICD-9-CM</p>
168. Claim Diagnosis E Group	9	1	9	GRP
				<p>The number of claim diagnosis E trailers is determined by the claim diagnosis E code count. This group contains the diagnosis E codes and the diagnosis E version code.</p> <p>STANDARD ALIAS : CLM_DGNS_E_GRP</p> <p>OCCURS MIN: 0 OCCURS MAX: 12</p> <p>DEPENDING ON : OP_CLM_DGNS_E_CD_CNT</p>
169. NCH Diagnosis E Trailer Indicator Code	1	1	1	CHAR

Effective with Version 'J', the code indicating the presence of a diagnosis E trailer.

NOTE: During the Version 'J' conversion, this field was populated throughout history.

DB2 ALIAS : DGNS\_E\_TRLR\_IND\_CD  
SAS ALIAS : ETRLRIND

LENGTH : 1

SOURCE :

CODE TABLE : NCH\_DGNS\_E\_TRLR\_IND\_TB

170. Claim Diagnosis Version Code  
1

2 2

CHAR

Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9 or ICD-10.

NOTE: With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2013.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : EVRSNCD

LENGTH : 1

CODE TABLE : CLM\_DGNS\_VRSN\_TB

171. Claim Diagnosis E Code

7 3 9

CHAR

Effective with Version J, the code used to identify the external cause of injury, poisoning, or other adverse affect.

NOTE: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10.

During the Version 'J' conversion, all 'E' codes in the diagnosis trailer were moved to the diagnosis 'E' trailer.

With the implementation of Version 'J', diagnosis 'E' codes can also be found in the regular diagnosis trailer.

DB2 ALIAS : CLM\_DGNS\_E\_CD

				SAS            ALIAS : EDGNSCD  LENGTH            : 7  SOURCE            : CWF  EDIT RULES : ICD-9-CM
172. Claim Procedure Group	17	1	17	GRP   The number of claim procedure trailers is determined by the claim procedure code count. Effective with Version 'J', up to 25 occurrences may be reported on a claim. Beginning 10/93, up to six occurrences (one principal; five others) may be reported.  OCCURS MIN: 0 OCCURS MAX: 25  DEPENDING ON : OP_CLM_PRCDR_CD_J_CNT
173. NCH Procedure Trailer Indicator Code	1	1	1	CHAR  Effective with Version H, the code indicating the presence of a procedure trailer.  NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).  DB2            ALIAS : NCH_PRCDR_TRLR_IND SAS            ALIAS : PRCDRIND STANDARD ALIAS : NCH_PRCDR_TRLR_IND_CD  LENGTH            : 1  SOURCE            : NCH  CODE TABLE       : NCH_PRCDR_TRLR_IND_TB
174. Claim Procedure Version Code	1	2	2	CHAR  Effective with Version 'J', the code used to indicate if the surgical procedure code is ICD-9 or ICD-10.

NOTE: With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2013.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : PVRSNCD

LENGTH : 1

CODE TABLE : CLM\_PRCDR\_VRSN\_TB

175. Claim Procedure Code

7 3 9

CHAR

The code that indicates the principal or other procedure performed during the period covered by the institutional claim.

NOTE:

Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims. The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

NOTE1: Effective with Version 'J', the number of procedure code occurrences has expanded from 6 to 25.

DB2 ALIAS : CLM\_PRCDR\_CD  
SAS ALIAS : PRCDR\_CD

LENGTH : 7

DERIVATIONS :

DERIVED FROM:

NCH CLM\_PRCDR\_CD

IF FIELD CONTAINS 4 ALPHA-NUMERIC CHARACTERS OR  
OR 3 ALPHA-NUMERIC CHARACTERS FOLLOWED BY A  
SPACE, ASSUME CODE IS VALID  
OTHERWISE  
MOVE SPACES TO CLM\_PRCDR\_CD.

SOURCE : CWF

EDIT RULES :

ICD-9-CM

176. Claim Procedure Performed Date



8 10 17 NUM

On an institutional claim, the date on which  
the principal or other procedure was performed.

DB2 ALIAS : CLM\_PRCDR\_PRFRM\_DT  
SAS ALIAS : PRCDR\_DT  
STANDARD ALIAS : CLM\_PRCDR\_PRFRM\_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

177. Claim Related Condition Group

3 1 3 GRP

The number of claim related condition trailers is  
determined by the claim related condition code count.  
Effective 10/93, up to 30 occurrences can be reported  
on an institutional claim. Prior to 10/93, up to  
10 occurrences could be reported.

STANDARD ALIAS : CLM\_RLT\_COND\_GRP

OCCURS MIN: 0 OCCURS MAX: 30

DEPENDING ON : OP\_CLM\_RLT\_COND\_CD\_CNT

178. NCH Condition Trailer Indicator Code

1 1 1 CHAR

Effective with Version H, the code indicating  
the presence of a condition code trailer.

NOTE: During the Version H conversion this field  
was populated throughout history (back to service  
year 1991).

DB2 ALIAS : COND\_TRLR\_IND\_CD  
SAS ALIAS : CONDIND  
STANDARD ALIAS : NCH\_COND\_TRLR\_IND\_CD

LENGTH : 1

SOURCE : NCH

				CODE TABLE	: NCH_COND_TRLR_IND_TB
179. Claim Related Condition Code	2	2	3	CHAR	
					The code that indicates a condition relating to an institutional claim that may affect payer processing.
				DB2	ALIAS : CLM_RLT_COND_CD
				SAS	ALIAS : RLT_COND
				STANDARD	ALIAS : CLM_RLT_COND_CD
				TITLE	ALIAS : RELATED_CONDITION_CD
				LENGTH	: 2
				SOURCE	: CWF
				CODE TABLE	: CLM_RLT_COND_TB
180. Claim Related Occurrence Group	11	1	11	GRP	
					The number of claim related occurrence trailers is determined by the claim related occurrence code count. Effective 10/93, up to 30 occurrences can be reported on an institutional claim. Prior to 10/93, up to 10 occurrences could be reported.
				STANDARD	ALIAS : CLM_RLT_OCRNC_GRP
				OCCURS MIN:	0 OCCURS MAX: 30
				DEPENDING ON	: OP_CLM_RLT_OCRNC_CD_CNT
181. NCH Occurrence Trailer Indicator Code	1	1	1	CHAR	
					Effective with Version H, the code indicating the presence of a occurrence code trailer.
				NOTE:	During the Version H conversion this field was populated throughout history (back to service year 1991).
				DB2	ALIAS : OCRNC_TRLR_IND_CD
				SAS	ALIAS : OCRNCIND
				STANDARD	ALIAS : NCH_OCRNC_TRLR_IND_CD

				LENGTH	: 1
				SOURCE	: NCH
				CODE TABLE	: NCH_OCRNC_TRLR_IND_TB
182. Claim Related Occurrence Code	2	2	3	CHAR	
				The code that identifies a significant event relating to an institutional claim that may affect payer processing. These codes are claim-related occurrences that are related to a specific date.	
				DB2	ALIAS : CLM_RLT_OCRNC_CD
				SAS	ALIAS : OCRNC_CD
				STANDARD	ALIAS : CLM_RLT_OCRNC_CD
				TITLE	ALIAS : OCCURRENCE_CD
				LENGTH	: 2
				SOURCE	: CWF
				CODE TABLE	: CLM_RLT_OCRNC_TB
183. Claim Related Occurrence Date	8	4	11	NUM	
				The date associated with a significant event related to an institutional claim that may affect payer processing.	
				DB2	ALIAS : CLM_RLT_OCRNC_DT
				SAS	ALIAS : OCRNCDT
				STANDARD	ALIAS : CLM_RLT_OCRNC_DT
				TITLE	ALIAS : RLT_OCRNC_DT
				LENGTH	: 8 SIGNED : N
				SOURCE	: CWF
				EDIT RULES : YYYYMMDD	
184. Claim Occurrence Span Group	19	1	19	GRP	
				The number of claim occurrence span trailers is	

determined by the claim occurrence span code count.  
Up to 10 occurrences may be reported on an  
institutional claim.

STANDARD ALIAS : CLM\_OCRNC\_SPAN\_GRP

OCCURS MIN: 0 OCCURS MAX: 10

DEPENDING ON : OP\_CLM\_OCRNC\_SPAN\_CD\_CNT

185. NCH Span Trailer Indicator Code

1 1 1

CHAR

Effective with Version H, the code indicating  
the presence of a span code trailer.

NOTE: During the Version H conversion this field  
was populated throughout history (back to service  
year 1991).

DB2 ALIAS : SPAN\_TRLR\_IND\_CD

SAS ALIAS : SPANIND

STANDARD ALIAS : NCH\_SPAN\_TRLR\_IND\_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH\_SPAN\_TRLR\_IND\_TB

186. Claim Occurrence Span Code

2 2 3

CHAR

The code that identifies a significant event  
relating to an institutional claim that may  
affect payer processing. These codes are  
claim-related occurrences that are related  
to a time period (span of dates).

DB2 ALIAS : CLM\_OCRNC\_SPAN\_CD

SAS ALIAS : SPAN\_CD

STANDARD ALIAS : CLM\_OCRNC\_SPAN\_CD

TITLE ALIAS : SPAN\_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : CLM\_OCRNC\_SPAN\_TB

## 187. Claim Occurrence Span From Date

8 4 11

NUM

The from date of a period associated with an occurrence of a specific event relating to an institutional claim that may affect payer processing.

DB2 ALIAS : OCRNC\_SPAN\_FROM\_DT  
SAS ALIAS : SPANFROM  
STANDARD ALIAS : CLM\_OCRNC\_SPAN\_FROM\_DT  
TITLE ALIAS : SPAN\_FROM\_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

## 188. Claim Occurrence Span Through Date

8 12 19

NUM

The thru date of a period associated with an occurrence of a specific event relating to an institutional claim that may affect payer processing.

DB2 ALIAS : OCRNC\_SPAN\_THRU\_DT  
SAS ALIAS : SPANTHRU  
STANDARD ALIAS : CLM\_OCRNC\_SPAN\_THRU\_DT  
TITLE ALIAS : SPAN\_THRU\_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

## 189. Claim Value Group

9 1 9

GRP

The number of claim value data trailers present is determined by the claim value code count. Effective 10/93, up to 36 occurrences can be reported on an institutional claim. Prior to 10/93, up to 10 occurrences could be reported.

STANDARD ALIAS : CLM\_VAL\_GRP

OCCURS MIN: 0 OCCURS MAX: 36

DEPENDING ON : OP\_CLM\_VAL\_CD\_CNT

190. NCH Value Trailer Indicator Code

1 1 1

CHAR

Effective with Version H, the code indicating the presence of a value code trailer.

NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).

DB2 ALIAS : VAL\_TRLR\_IND\_CD

SAS ALIAS : VALIND

STANDARD ALIAS : NCH\_VAL\_TRLR\_IND\_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH\_VAL\_TRLR\_IND\_TB

191. Claim Value Code

2 2 3

CHAR

The code indicating the value of a monetary condition which was used by the intermediary to process an institutional claim.

DB2 ALIAS : CLM\_VAL\_CD

SAS ALIAS : VAL\_CD

STANDARD ALIAS : CLM\_VAL\_CD

TITLE ALIAS : VALUE\_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : CLM\_VAL\_TB

192. Claim Value Amount

6 4 9

PACK

The amount related to the condition identified in the CLM\_VAL\_CD which was used by the intermediary to process the institutional

claim.

DB2 ALIAS : CLM\_VAL\_AMT  
SAS ALIAS : VAL\_AMT  
STANDARD ALIAS : CLM\_VAL\_AMT  
TITLE ALIAS : VALUE\_AMOUNT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

EDIT RULES :  
\$\$\$\$\$\$CC

193. Claim Revenue Center Group

297 1 297

GRP

The number of claim revenue center data trailers is determined by the claim revenue center code count. Effective 7/7/00, up to 450 occurrences may be reported on an institutional claim. The increase in the number of revenue center lines causes each claim to be broken out into records/segments (up to 10). Each record can have up to 45 occurrences of revenue center lines. Prior to 7/7/00, up to 58 occurrences may be reported on an institutional claim. Claims submitted prior to 10/93, contained up to 28 occurrences.

STANDARD ALIAS : CLM\_REV\_CNTR\_GRP

OCCURS MIN: 0 OCCURS MAX: 45

DEPENDING ON : OP\_REV\_CNTR\_CD\_I\_CNT

194. NCH Revenue Center Trailer Indicator Code

1 1 1

CHAR

Effective with Version H, the code identifying the revenue center trailer.

During the Version H conversion this field was populated with data throughout history (back to service year 1991).

DB2 ALIAS : REV\_CNTR\_TRLR\_CD  
SAS ALIAS : REVIND  
STANDARD ALIAS : NCH\_REV\_CNTR\_TRLR\_IND\_CD

LENGTH : 1

				SOURCE	: NCH
				CODE TABLE	: NCH_REV_TRLR_IND_TB
195. Revenue Center Code	4	2	5	CHAR	
				<p>The provider-assigned revenue code for each cost center for which a separate charge is billed (type of accommodation or ancillary). A cost center is a division or unit within a hospital (e.g., radiology, emergency room, pathology).  EXCEPTION: Revenue center code 0001 represents the total of all revenue centers included on the claim.</p>	
				COBOL	ALIAS : REV_CD
				DB2	ALIAS : REV_CNTR_CD
				SAS	ALIAS : REV_CNTR
				STANDARD	ALIAS : REV_CNTR_CD
				TITLE	ALIAS : REVENUE_CENTER_CD
				LENGTH	: 4
				SOURCE	: CWF
				CODE TABLE	: REV_CNTR_TB
196. Revenue Center Date	8	6	13	NUM	
				<p>Effective with Version H, the date applicable to the service represented by the revenue center code. This field may be present on any of the institutional claim types. For home health claims the service date should be present on all bills with from date greater than 3/31/98. With the implementation of outpatient PPS, hospitals will be required to enter line item dates of service for all outpatient services which require a HCPCS.</p>	
				<p>NOTE1: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.</p>	
				<p>NOTE2: When revenue center code equals '0022' (SNF PPS) and revenue center HCPCS code not equal to 'AAA00' (default for no assessment), date represents the MDS RAI assessment reference date.</p>	



NOTE3: When revenue center code equals '0023' (HHPPS), the date on the initial claim (RAP) must represent the first date of service in the episode. The final claim will match the '0023' information submitted on the initial claim. The SCIC (significant change in condition) claims may show additional '0023' revenue lines in which the date represents the date of the first service under the revised plan of treatment.

DB2 ALIAS : REV\_CNTR\_DT  
STANDARD ALIAS : REV\_CNTR\_DT  
TITLE ALIAS : REV\_CNTR\_DATE

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

197. Revenue Center 1st ANSI Code  
5

14

18

CHAR

The first code used to identify the detailed reason an adjustment was made (e.g. reason for denial or reducing payment).

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPSS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.

DB2 ALIAS : REV\_CNTR\_ANSI1\_CD  
SAS ALIAS : REVANSI1  
STANDARD ALIAS : REV\_CNTR\_ANSI\_1\_CD  
TITLE ALIAS : ANSI\_CD

LENGTH : 5

SOURCE : CWF

CODE TABLE : REV\_CNTR\_ANSI\_TB

198. Revenue Center 2nd ANSI Code  
5

19

23

CHAR

The second code used to identify the detailed reason an adjustment was made (e.g. reason for denial or reducing payment).

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.

DB2 ALIAS : REV\_CNTR\_ANSI2\_CD  
SAS ALIAS : REVANSI2  
STANDARD ALIAS : REV\_CNTR\_ANSI\_2\_CD  
TITLE ALIAS : ANSI\_CD

LENGTH : 5

SOURCE : CWF

199. Revenue Center 3rd ANSI Code

5        24        28        CHAR

The third code used to identify the detailed reason an adjustment was made (e.g. reason for denial or reducing payment).

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.

DB2        ALIAS : REV\_CNTR\_ANSI3\_CD  
SAS        ALIAS : REVANSI3  
STANDARD ALIAS : REV\_CNTR\_ANSI\_3\_CD  
TITLE      ALIAS : ANSI\_CD

LENGTH        : 5

SOURCE         : CWF

200. Revenue Center 4th ANSI Code

5        29        33        CHAR

The fourth code used to identify the detailed reason an adjustment was made (e.g. reason for denial or reducing payment).

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical

Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPFS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.

DB2 ALIAS : REV\_CNTR\_ANSI4\_CD  
 SAS ALIAS : REVANSI4  
 STANDARD ALIAS : REV\_CNTR\_ANSI\_4\_CD  
 TITLE ALIAS : ANSI\_CD

LENGTH : 5

SOURCE : CWF

201. Revenue Center APC/HIPPS Code

5 34 38

CHAR

Effective with Version 'I', this field was created to house two pieces of data. The Ambulatory Payment Classification (APC) code and the HIPPS code. The APC is used to identify groupings of outpatient services. APC codes are used to calculate payment for services under OPFS. The APC is a four byte field. The HIPPS codes are used to identify patient classifications for SNFPPS, HHPPS and IRFPPS that will be used to calculate payment. The HIPPS code is a five byte field.

NOTE1: The APC field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPFS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: Under SNFPSP, HHPPS & IRFPSP, HIPPS codes are stored in the HCPCS field. \*\*EXCEPTION: if a HHPPS HIPPS code is downcoded/upcoded the downcoded/upcoded HIPPS will be stored in this field.

NOTE3: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.

DB2 ALIAS : REV\_APC\_HIPPS\_CD S  
SAS ALIAS : APCHIPPS  
STANDARD ALIAS : REV\_CNTR\_APC\_HIPPS\_CD  
TITLE ALIAS : APC\_HIPPS

LENGTH : 5

SOURCE : CWF

CODE TABLE : REV\_CNTR\_APC\_TB

202. Revenue Center Healthcare Common Procedure Coding System Code  
5 39 43 CHAR

Healthcare Common Procedure Coding System (HCPCS) is a collection of codes that represent procedures, supplies, products and services which may be provided to Medicare beneficiaries and to individuals enrolled in private health insurance programs. The codes are divided into three levels, or groups, as described below:

DB2 ALIAS : REV\_CNTR\_HCPCS\_CD  
STANDARD ALIAS : REV\_CNTR\_HCPCS\_CD  
TITLE ALIAS : HCPCS\_CD

LENGTH : 5

COMMENTS :

Prior to Version H this field was named: HCPCS\_CD. With Version H, a prefix was added to denote the location of this field on each claim type (institutional: REV\_CNTR and non-institutional: LINE).

NOTE: When revenue center code = '0022' (SNF PPS), '0023' (HH PPS), or '0024' (IRF PPS); this field contains the Health Insurance PPS (HIPPS) code.

The HIPPS code for SNF PPS contains the rate code/assessment type that identifies (1) RUG-III group the beneficiary was classified into as of the RAI MDS assessment reference date and (2) the type of assessment for payment purposes.

The HIPPS code for Home Health PPS identifies (1) the three case-mix dimensions of the HHRG system, clinical, functional and utilization, from which a beneficiary is assigned to one of the 80 HHRG categories and (2) it identifies whether or not the elements of the code were computed or derived. The HHRGs, represented by the HIPPS coding, will be the basis of payment for each episode.

The HIPPS code (CMG Code) for IRF PPS identifies the clinical characteristics of the beneficiary. The HIPPS rate/CMG code (AXXXY - DXXYY) must contain five digits. The first position of the code is an A, B, C, or 'D'. The HIPPS code beginning with an 'A' in front of the CMG is defined as without comorbidity. The 'B' in front of the CMG is defined as with comorbidity for Tier 1. The 'C' is defined as comorbidity for Tier 2 and 'D' is defined as comorbidity for Tier 3. The 'XX' in the HIPPS rate code is the Rehabilitation Impairment Code (RIC). The 'YY' is the sequential number system within the RIC.

For SNF PPS, HH PPS & IRF PPS HIPPS values see CLM\_HIPPS\_TB.

#### Level I

Codes and descriptors copyrighted by the American Medical Association's Current Procedural Terminology, Fourth Edition (CPT-4). These are 5 position numeric codes representing physician and nonphysician services.

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

CPT-4 codes including both long and short descriptions shall be used in accordance with the HCFA/AMA agreement. Any other use violates the AMA copyright.

Level II

Includes codes and descriptors copyrighted by the American Dental Association's Current Dental Terminology, Second Edition (CDT-2). These are 5 position alpha-numeric codes comprising the D series. All other level II codes and descriptors are approved and maintained jointly by the alpha-numeric editorial panel (consisting of HCFA, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association). These are 5 position alpha-numeric codes representing primarily items and nonphysician services that are not represented in the level I codes.

Level III

Codes and descriptors developed by Medicare carriers for use at the local (carrier) level. These are 5 position alpha-numeric codes in the W, X, Y or Z series representing physician and nonphysician services that are not represented in the level I or level II codes.

LIMITATIONS :

REFER TO :

HHA\_HCPCS\_LIM

CODE TABLE : CLM\_HIPPS\_TB

203. Revenue Center HCPCS Initial Modifier Code

2 44 45

CHAR

A first modifier to the procedure code to enable a more specific procedure identification for the claim.

DB2 ALIAS : REV\_HCPCS\_MDFR\_CD

STANDARD ALIAS : REV\_CNTR\_HCPCS\_INITL\_MDFR\_CD

TITLE ALIAS : INITIAL\_MODIFIER

LENGTH : 2

COMMENTS :

Prior to Version H this field was named: HCPCS\_INITL\_MDFR\_CD. With Version H, a prefix was added to denote the location of this field on each claim type (institutional: REV\_CNTR and non-institutional: LINE).

SOURCE : CWF

EDIT RULES :  
Carrier Information File

204. Revenue Center HCPCS Second Modifier Code  
2 46 47

CHAR

A second modifier to the procedure code to make it more specific than the first modifier code to identify the procedures performed on the beneficiary for the claim.

DB2 ALIAS : REV\_HCPCS\_2ND\_CD  
STANDARD ALIAS : REV\_CNTR\_HCPCS\_2ND\_MDFR\_CD  
TITLE ALIAS : SECOND\_MODIFIER

LENGTH : 2

COMMENTS :  
Prior to Version H this field was named:  
HCPCS\_2ND\_MDFR\_CD. With Version H, a prefix  
was added to denote the location of this field  
on each claim type (institutional: REV\_CNTR and  
non-institutional: LINE).

SOURCE : CWF

EDIT RULES :  
CARRIER INFORMATION FILE

205. Revenue Center HCPCS Third Modifier Code  
2 48 49

CHAR

Effective with Version I, a third modifier to the procedure code to make it more specific than the second modifier code to identify the procedures performed on the beneficiary for the claim.

DB2 ALIAS : REV\_HCPCS\_3RD\_CD  
STANDARD ALIAS : REV\_CNTR\_HCPCS\_3RD\_MDFR\_CD  
TITLE ALIAS : THIRD\_MODIFIER

LENGTH : 2

COMMENTS :  
NOTE: Beginning with NCH weekly process date  
8/18/00, this field will be populated with data.  
Claims processed prior to 8/18/00 will contain  
spaces in this field.

SOURCE : CWF



EDIT RULES :  
CARRIER INFORMATION FILE

206. Revenue Center HCPCS Fourth Modifier Code  
2 50 51

CHAR

Effective with Version I, a fourth modifier to the procedure code to make it more specific than the third modifier code to identify the procedures performed on the beneficiary for the claim.

DB2 ALIAS : REV\_HCPCS\_4TH\_CD  
STANDARD ALIAS : REV\_CNTR\_HCPCS\_4TH\_MDFR\_CD  
TITLE ALIAS : FOURTH\_MODIFIER

LENGTH : 2

COMMENTS :

NOTE: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.

SOURCE : CWF

EDIT RULES :  
CARRIER INFORMATION FILE

207. Revenue Center HCPCS Fifth Modifier Code  
2 52 53

CHAR

Effective with Version I, a fifth modifier to the procedure code to make it more specific than the fourth modifier code to identify the procedures performed on the beneficiary for the claim.

DB2 ALIAS : REV\_HCPCS\_5TH\_CD  
SAS ALIAS : MDFR\_CD5  
STANDARD ALIAS : REV\_CNTR\_HCPCS\_5TH\_MDFR\_CD  
TITLE ALIAS : FIFTH\_MODIFIER

LENGTH : 2

COMMENTS :

NOTE: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.

SOURCE : CWF

EDIT RULES :  
CARRIER INFORMATION FILE

208. Revenue Center Payment Method Indicator Code

2 54 55 CHAR

Effective with Version 'I', the code used to identify how the service is priced for payment. This field is made up of two pieces of data, 1st position being the service indicator and the 2nd position being the payment indicator.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

NOTE3: Effective 10/2005, this field will no longer represent the service indicator and the payment indicator. This field will now house the 2-byte payment indicator. The status indicator will be housed in a new field named: REV\_CNTR\_STUS\_IND\_CD.

DB2 ALIAS : REV\_PMT\_MTHD\_CD

SAS ALIAS : PMTMTHD  
STANDARD ALIAS : REV\_CNTR\_PMT\_MTHD\_IND\_CD  
TITLE ALIAS : PMT\_MTHD

LENGTH : 2

SOURCE : CWF

CODE TABLE : REV\_CNTR\_PMT\_MTHD\_IND\_TB

209. Revenue Center Discount Indicator Code

1 56 56

CHAR

Effective with Version 'I', this code represents a factor that specifies the amount of any APC discount. The discounting factor is applied to a line item with a service indicator (part of the REV\_CNTR\_PMT\_MTHD\_IND\_CD) of 'T'. The flag is applicable when more than one significant procedure is performed. \*\*If there is no discounting the factor will be 1.0.\*\*

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

NOTE3: VALUES D, U & T REPRESENT THE FOLLOWING:  
D = Discounting fraction (currently 0.5)  
U = Number of units  
T = Terminated procedure discount (currently 0.5)

DB2 ALIAS : REV\_DSCNT\_IND\_CD  
SAS ALIAS : DSCNTIND  
STANDARD ALIAS : REV\_CNTR\_DSCNT\_IND\_CD  
TITLE ALIAS : REV\_CNTR\_DSCNT\_IND\_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : REV\_CNTR\_DSCNT\_IND\_TB

210. Revenue Center Packaging Indicator Code  
1 57 57

CHAR

Effective with Version 'I', the code used to identify those services that are packaged/bundled with another service.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria,

through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV\_PACKG\_IND\_CD  
SAS ALIAS : PACKGIND  
STANDARD ALIAS : REV\_CNTR\_PACKG\_IND\_CD  
TITLE ALIAS : REV\_CNTR\_PACKG\_IND

LENGTH : 1

SOURCE : CWF

CODE TABLE : REV\_CNTR\_PACKG\_IND\_TB

211. Revenue Center Pricing Indicator Code  
2 58 59

CHAR

Effective with Version 'I', the code used to identify if there was a deviation from the standard method of calculating payment amount.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV\_PRICNG\_IND\_CD  
SAS ALIAS : PRICNG  
STANDARD ALIAS : REV\_CNTR\_PRICNG\_IND\_CD  
TITLE ALIAS : REV\_CNTR\_PRICNG\_IND

LENGTH : 2

SOURCE : CWF

CODE TABLE : REV\_CNTR\_PRICNG\_IND\_TB

212. Revenue Center Obligation to Accept As Full (OTAF) Payment Code  
1 60 60 CHAR

Effective with Version 'j' the code used to indicate that the provider was obligated to accept as full payment the amount received from the primary (or secondary) payer.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV\_OTAF\_IND\_CD

SAS        ALIAS : OTAF

LENGTH        : 1

SOURCE        : CWF

EDIT RULES :

Y = provider is obligated to accept the payment  
as payment in full for the service.

N or blank = provider is not obligated to accept  
the payment, or there is no payment by a prior  
payer.

213. Revenue Center IDE, NDC, UPC Number  
24        61

84    CHAR

Effective with Version H, the exemption number assigned by the Food and Drug Administration (FDA) to an investigational device after a manufacturer has been approved by FDA to conduct a clinical trial on that device. HCFA established a new policy of covering certain IDE's which was implemented in claims processing on 10/1/96 (which is NCH weekly process 10/4/96) for service dates beginning 10/1/95. IDE's are always associated with revenue center code '0624'.

NOTE1: Prior to Version H a 'dummy' revenue center code '0624' trailer was created to store IDE's. The IDE number was housed in two fields: HCPCS code and HCPCS initial modifier; the second modifier contained the value 'ID'. There can be up to 7 distinct IDE numbers associated with an '0624' dummy trailer. During the Version H conversion IDE's were moved from the dummy '0624' trailer to this dedicated field.

NOTE2: Effective with Version 'I', this field was renamed to eventually accommodate the National Drug Code (NDC) and the Universal Product Code (UPC). This field could contain either of these 3 fields (there would never be an instance where more than one would come in on a claim). The size of this field was expanded to X(24) to accommodate either of the new fields (under Version 'H' it was X(7)). DATA ANAMOLY/LIMITATION: During an CWFMQA review an edit revealed the IDE was missing. The problem occurs in claim with an NCH weekly process dates of 6/9/00 through 9/8/00. During processing of the new format the program receives the IDE but then blanked out the data.

DB2 ALIAS : IDE\_NDC\_UPC\_NUM  
SAS ALIAS : IDENDC  
STANDARD ALIAS : REV\_CNTR\_IDE\_NDC\_UPC\_NUM  
TITLE ALIAS : IDE\_NDC\_UPC

LENGTH : 24

SOURCE : CWF

LIMITATIONS :

REFER TO :  
REV\_CNTR\_IDE\_NDC\_UPC\_LIM

214. Revenue Center NDC Quantity Qualifier Code  
2 85 86

CHAR

Effective with Version 'J', the code used to indicate the unit of measurement for the drug that was administered.

DB2 ALIAS : NDC\_QTY\_QLFR\_CD  
SAS ALIAS : QTYQLFR  
STANDARD ALIAS : REV\_CNTR\_NDC\_QTY\_QLFR\_CD

LENGTH : 2

CODE TABLE : REV\_CNTR\_NDC\_QTY\_QLFR\_TB

215. Revenue Center NDC Quantity  
6 87 92

PACK

Effective with Version 'J', the quantity dispensed for the drug reflected on the revenue center line item.

DB2 ALIAS : NDC\_QTY\_NUM  
SAS ALIAS : NDCQTY

LENGTH : 7.3 SIGNED : Y

216. Revenue Center Unit Count  
4 93 96

PACK

A quantitative measure (unit) of the number of times the service or procedure being reported was performed according to the revenue center/HCPSC code definition as described on an institutional claim.

Depending on type of service, units are measured by number of covered days in a particular accommodation, pints of



blood, emergency room visits, clinic visits, dialysis treatments (sessions or days), outpatient therapy visits, and outpatient clinical diagnostic laboratory tests.

NOTE1: When revenue center code = '0022' (SNF PPS) the unit count will reflect the number of covered days for each HIPPS code and, if applicable, the number of visits for each rehab therapy code.

DB2 ALIAS : REV\_CNTR\_UNIT\_CNT  
SAS ALIAS : REV\_UNIT  
STANDARD ALIAS : REV\_CNTR\_UNIT\_CNT  
TITLE ALIAS : UNITS

LENGTH : 7 SIGNED : Y

SOURCE : CWF

217. Revenue Center Rate Amount

6 97 102

PACK

Charges relating to unit cost associated with the revenue center code. Exception (encounter data only): If plan (e.g. MCO) does not know the actual rate for the accommodations, \$1 will be reported in the field.

NOTE1: For SNF PPS claims (when revenue center code equals '0022'), CMS has developed a SNF PRICER to compute the rate based on the provider supplied coding for the MDS RUGS III group and assessment type (HIPPS code, stored in revenue center HCPCS code field).

NOTE2: For OP PPS claims, CMS has developed a PRICER to compute the rate based on the Ambulatory Payment Classification (APC), discount factor, units of service and the wage index.

NOTE3: Under HH PPS (when revenue center code equals '0023'), CMS has developed a HHA PRICER to compute the rate. On the RAP, the rate is determined using the case mix weight associated with the HIPPS code, adjusting it for the wage index for the beneficiary's site of service, then multiplying the result by 60% or 50%, depending on whether or not the RAP is for a first episode.

On the final claim, the HIPPS code could change the payment if the therapy threshold is not met, or

partial episode payment (PEP) adjustment or a significant change in condition (SCIC) adjustment. In cases of SCICs, there will be more than one '0023' revenue center line, each representing the payment made at each case-mix level.

NOTE4: For IRF PPS claims (when revenue center code equals '0024'), CMS has developed a PRICER to compute the rate based on the HIPPS/CMG (HIPPS code, stored in revenue center HCPCS code field).

DB2 ALIAS : REV\_CNTR\_RATE\_AMT  
SAS ALIAS : REV\_RATE  
STANDARD ALIAS : REV\_CNTR\_RATE\_AMT  
TITLE ALIAS : CHARGE\_PER\_UNIT

LENGTH : 9.2 SIGNED : Y

COMMENTS :  
Prior to Version H the size of this field was:  
S9(7)V99.

SOURCE : CWF

218. Revenue Center Blood Deductible Amount  
6 103 108

PACK

Effective with Version 'I', the amount of money for which the intermediary determined the beneficiary is liable for the blood deductible for the line item service.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPSS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV\_BLOOD\_DDCTBL  
SAS ALIAS : REVBLOOD  
STANDARD ALIAS : REV\_CNTR\_BLOOD\_DDCTBL\_AMT  
TITLE ALIAS : BLOOD\_DDCTBL\_AMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

219. Revenue Center Cash Deductible Amount  
6 109 114

PACK

Effective with Version 'I' the amount of cash deductible the beneficiary paid for the line item service.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated

on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV\_CASH\_DDCTBL  
SAS ALIAS : REVDCTBL  
STANDARD ALIAS : REV\_CNTR\_CASH\_DDCTBL\_AMT  
TITLE ALIAS : CASH\_DDCTBL

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

220. Revenue Center Coinsurance/Wage Adjusted Coinsurance Amount

6 115 120 PACK

Effective with Version 'I', the amount of coinsurance applicable to the line item service defined by the revenue center and HCPCS codes. For those services subject to Outpatient PPS, the applicable coinsurance is wage adjusted.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. The above claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

NOTE2: This field will have either a zero (for services for which coinsurance is not applicable), a regular coinsurance amount (calculated on either charges or a fee schedule) or if subject to OP PPS the national coinsurance amount will be wage adjusted. The wage adjusted coinsurance is based on the MSA where the provider is located or assigned as a result of a reclassification.

NOTE3: It has been discovered that this field may be populated with data on claims with dates of service

prior to 7/00 (implementation of Claim Line Expansion OPPS/HPPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : ADJSTD\_COINSRNC  
SAS ALIAS : WAGEADJ  
STANDARD ALIAS : REV\_CNTR WAGE\_ADJSTD\_COINS\_AMT  
TITLE ALIAS : WAGE\_ADJSTD\_COINS

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

221. Revenue Center Reduced Coinsurance Amount  
6 121 126

PACK

Effective with Version 'I', for all services subject to Outpatient PPS, the amount of coinsurance applicable to the line for a particular service (HCPCS) for which the provider has elected to reduce the coinsurance amount.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: The reduced coinsurance amount cannot be lower than 20% of the payment rate for the APC line.

NOTE3: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : RDCD\_COINSRNC  
SAS ALIAS : RDCDCOIN  
STANDARD ALIAS : REV\_CNTR\_RDCD\_COINS\_AMT  
TITLE ALIAS : REDUCED\_COINS

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

222. Revenue Center 1st Medicare Secondary Payer Paid Amount  
6 127 132 PACK

Effective with Version 'I', the amount paid by the primary payer when the payer is primary to Medicare (Medicare is secondary).

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HPPS). The original understanding of the new revenue center fields was that data would be populated

on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV\_MSP1\_PD\_AMT  
SAS ALIAS : REV\_MSP1  
STANDARD ALIAS : REV\_CNTR\_MSP1\_PD\_AMT  
TITLE ALIAS : MSP PAID AMOUNT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

223. Revenue Center 2nd Medicare Secondary Payer Paid Amount  
6 133 138 PACK

Effective with Version 'I', the amount paid by the secondary payer when two payers are primary to Medicare (Medicare is the tertiary payer).

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the

dates of service.

DB2 ALIAS : REV\_MSP2\_PD\_AMT  
SAS ALIAS : REV\_MSP2\_  
STANDARD ALIAS : REV\_CNTR\_MSP2\_PD\_AMT  
TITLE ALIAS : MSP PAID AMOUNT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

224. Revenue Center Provider Payment Amount  
6 139 144

PACK

Effective with Version 'I', the amount paid to the provider for the services reported on the line item.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

ANAMOLY: For dates of service August 1, 2000 to the present, the OPPS revenue center fields are being processed differently by FISS and APASS (standard systems). For more information on OPPS data problems for this time period see Limitations Appendix. The following is how each system handles this field:

FISS: populated correctly with provider payment amount

APASS: provider payment amount plus interest on 1st revenue center line (CMM will instruct APASS not to include interest)



Currently, the following FI numbers are under the APASS system and all other FI numbers are under FISS. See FI\_NUM table of codes for all FI numbers.

52280 -- Mutual of Omaha (until 6/1/2003)  
00430 -- Washington/Alaska (until 11/1/2003)  
00310 -- North Carolina BC (until 12/1/2003)  
00370 -- Rhode Island (until 2/1/2004)  
00270 -- New Hampshire/Vermont (until 3/1/2004)  
00181 -- Maine/Massachusetts (until 5/1/2004)

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV\_PRVDR\_PMT\_AMT  
SAS ALIAS : RPRVDPMT  
STANDARD ALIAS : REV\_CNTR\_PRVDR\_PMT\_AMT  
TITLE ALIAS : REV\_PRVDR\_PMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

225. Revenue Center Beneficiary Payment Amount  
6 145 150

PACK

Effective with Version I, the amount paid to the beneficiary for the services reported on the line item.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those

lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV\_BENE\_PMT\_AMT  
SAS ALIAS : RBENEPMT  
STANDARD ALIAS : REV\_CNTR\_BENE\_PMT\_AMT  
TITLE ALIAS : REV\_BENE\_PMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

226. Revenue Center Patient Responsibility Payment Amount  
6 151 156 PACK

Effective with Version I, the amount paid by the beneficiary to the provider for the line item service.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

ANAMOLY: For dates of service August 1, 2000 to present, the OPPS revenue center fields are being processed differently by FISS and APASS (standard systems). For more information on OPPS data problems for this time period see the Limitations Appendix. The following is how each system is handling this field:

FISS: populating correctly (sum of coinsurance and deductible)

APASS: not populating this field

Currently, the following FI numbers are under the APASS system and all other FI numbers are under FISS. See FI\_NUM table of codes for all FI numbers.

52280 -- Mutual of Omaha (until 6/1/2003)  
00430 -- Washington/Alaska (until 11/1/2003)  
00310 -- North Carolina BC (until 12/1/2003)  
00370 -- Rhode Island (until 2/1/2004)  
00270 -- New Hampshire/Vermont (until 3/1/2004)  
00181 -- Maine/Massachusetts (until 5/1/2004)

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV\_PTNT\_RESP\_AMT  
SAS ALIAS : PTNTRESP  
STANDARD ALIAS : REV\_CNTR\_PTNT\_RESP\_PMT\_AMT  
TITLE ALIAS : REV\_PTNT\_RESP

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

227. Revenue Center Payment Amount

6 157 162

PACK

Effective with Version 'I', the line item Medicare payment amount for the specific

revenue center.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

ANAMOLY: For dates of service August 1, 2000 to present, the OPPS revenue center fields are being processed differently by FISS and APASS (standard systems). For more information on OPPS data problems for this time period see the Limitations Appendix. The following is how each system is handling this field:

FISS: this field contains provider reimbursement.

APASS: provider payment amount plus coinsurance and deductible (should not include coinsurance and deductible). Users should rely on provider payment amount field for the trust fund payment.

Currently, the following FI numbers are under the APASS system and all other FI numbers are under FISS. See FI\_NUM table of codes for all FI numbers.

52280 -- Mutual of Omaha (until 6/1/2003)  
00430 -- Washington/Alaska (until 11/1/2003)  
00310 -- North Carolina BC (until 12/1/2003)  
00370 -- Rhode Island (until 2/1/2004)  
00270 -- New Hampshire/Vermont (until 3/1/2004)  
00181 -- Maine/Massachusetts (until 5/1/2004)

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated

on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV\_CNTR\_PMT\_AMT  
SAS ALIAS : REVPMPT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

EDIT RULES :  
\$\$\$\$\$\$\$\$CC

228. Revenue Center Total Charge Amount  
6 163 168

PACK

The total charges (covered and non-covered) for all accommodations and services (related to the revenue code) for a billing period before reduction for the deductible and coinsurance amounts and before an adjustment for the cost of services provided. NOTE: For accommodation revenue center total charges must equal the rate times units (days).

EXCEPTIONS:

(1) For SNF RUGS demo claims only (9000 series revenue center codes), this field contains SNF customary accommodation charge, (ie., charges related to the accommodation revenue center code that would have been applicable if the provider had not been participating in the demo).

(2) For SNF PPS (non demo claims), when revenue center code = '0022', the total charges will be zero.

(3) For Home Health PPS (RAPs), when revenue center code = '0023', the total charges will equal the dollar amount for the '0023' line.

(4) For Home Health PPS (final claim), when revenue center code = '0023', the total charges will be the sum of the revenue center code lines (other than '0023').

(5) For Inpatient Rehabilitation Facility (IFR) PPS, when the revenue center code = '0024', the total charges will be zero. For accommodation revenue codes (010X - 021X), total charges must equal the rate times the units.

(6) For encounter data, if the plan (e.g. MCO) does not know the actual charges for the accommodations the total charges will be \$1 (rate) times units (days).

DB2 ALIAS : REV\_TOT\_CHRG\_AMT  
SAS ALIAS : REV\_CHRG  
STANDARD ALIAS : REV\_CNTR\_TOT\_CHRG\_AMT  
TITLE ALIAS : REVENUE\_CENTER\_CHARGES

LENGTH : 9.2 SIGNED : Y

COMMENTS :  
Prior to Version H the size of this field was:  
S9(7)V99.

SOURCE : CWF

LIMITATIONS :

REFER TO :  
MLTPL\_REV\_CNTR\_0001\_CD\_LIM  
REV\_CNTR\_TOT\_CHRG\_AMT\_LIM

EDIT RULES :  
\$\$\$\$\$\$\$\$CC

229. Revenue Center Non-Covered Charge Amount  
6 169 174

PACK

The charge amount related to a revenue center code for services that are not covered by Medicare.

NOTE: Prior to Version H the field size was S9(7)V99 and the element was only present on the Inpatient/SNF format. As of NCH weekly process date 10/3/97 this field was added to all institutional claim types.

DB2 ALIAS : REV\_NCVR\_CHRG\_AMT  
SAS ALIAS : REV\_NCVR  
STANDARD ALIAS : REV\_CNTR\_NCVR\_CHRG\_AMT  
TITLE ALIAS : REV\_CENTER\_NONCOVERED\_CHARGES

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

EDIT RULES :  
\$\$\$\$\$\$\$\$CC

230. Revenue Center Deductible Coinsurance Code

1 175 175 CHAR

Code indicating whether the revenue center charges are subject to deductible and/or coinsurance.

DB2 ALIAS : DDCTBL\_COINSRNC\_CD  
SAS ALIAS : REVDEDCD  
STANDARD ALIAS : REV\_CNTR\_DDCTBL\_COINSRNC\_CD  
TITLE ALIAS : REVENUE\_CENTER\_DEDUCTIBLE\_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : REV\_CNTR\_DDCTBL\_COINSRNC\_TB

231. Revenue Center Consolidated Billing Code

1 176 176 CHAR

Effective 1/1/2004 with the implementation of NCH/NMUD CR#1, this code is reflected on outpatient claims only to identify those line item services (i.e. therapy and nonroutine supply services) that are subject to SNF and Home Health consolidated billing. If the line item service was paid by an intermediary prior to the submission of the SNF or home health claim an adjustment for the outpatient claim will be submitted identifying those services that are subject to consolidated billing.

NOTE1: Prior to 10/2005 (implementation of NCH/NMUD CR#2), this data was stored in position 175 (FILLER) in the revenue center trailer.

NOTE2: Effective July 2005, this data will no longer be coming into the NCH. This process is being handled in the new CWF override processing.

DB2 ALIAS : CNSLDTD\_BLG\_CD  
SAS ALIAS : RCNSLDTD  
STANDARD ALIAS : REV\_CNTR\_CNSLDTD\_BLG\_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : REV\_CNTR\_CNSLDTD\_BLG\_TB

232. Revenue Center Status Indicator Code

2 177 178 CHAR

Effective 10/3/2005 with the implementation of NCH/NMUD CR#2, the code used to identify the status of the line item service. This field along with the payment method indicator field is used to identify how the service was priced for payment.

NOTE1: This 2-byte indicator is being added due to an expansion of a field that currently exist on the revenue center trailer. The status indicator is currently the 1st position of the Revenue Center Payment Method Indicator Code. The payment method indicator code is being split into two 2-byte fields (payment indicator and status indicator). The expanded payment indicator will continue to be stored in the existing payment method indicator field. The split of the current payment method indicator field is due to the expansion of both pieces of data from 1-byte to 2-bytes.

NOTE2: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services.

DB2 ALIAS : REV\_STUS\_IND\_CD  
SAS ALIAS : RSTUSIND  
STANDARD ALIAS : REV\_CNTR\_STUS\_IND\_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : REV\_CNTR\_STUS\_IND\_TB

233. Revenue Center Duplicate Claim Check Indicator Code

1 179 179 CHAR



Effective 1/1/2009 with the implementation of NCH/NMUD CR#4, the code used to identify an item or service that appeared to be a duuplicate but has been reviewed by an FI or MAC and appropriately approved for payment.

DB2 ALIAS : DUP\_CLM\_CHK\_IND\_CD  
SAS ALIAS : DUP-CHK  
STANDARD ALIAS : REV\_CNTR\_DUP\_CLM\_CHK\_IND\_CD

LENGTH : 1

CODE TABLE : REV\_CNTR\_DUP\_CLM\_CHK\_IND\_TB

234. Revenue Center APC Buffer Code  
2 180 181

CHAR

APC - Ambulatory Payment Classification  
Effective 1/1/2009 with the implementation of CR#4, the code used to identify related line items that make up a composite APC group. This field is only applicable to outpatient PPS claims.

DB2 ALIAS : REV\_CNTR\_BUFR\_CD  
SAS ALIAS : APCBUFR  
STANDARD ALIAS : REV\_CNTR\_APC\_BUFR\_CD

LENGTH : 2

CODE TABLE : REV\_CNTR\_APC\_BUFR\_TB

235. Revenue Center Rendering Physician NPI Num  
10 182 191

CHAR

Effective with Version 'J', the NPI of the rendering physician who performed the service.

DB2 ALIAS : RNDRNG\_NPI\_NUM  
SAS ALIAS : REVNPI

LENGTH : 10

236. Revenue Center Rendering Physician Surname  
6 192 197

CHAR

Effective with Version 'J', the 6 position last name of the rendering physician who performed the service.

DB2 ALIAS : RNDRNG\_SRNM\_NAME  
SAS ALIAS : REVSERNM

				LENGTH	: 6
237. FILLER	100	198	297	CHAR	
				DB2	ALIAS : FILLER
				LENGTH	: 100
238. End of Record Code	3	1	3	CHAR	
				Effective with Version 'I', the code used to identify the end of a record/segment or the end of the claim.	
				DB2	ALIAS : END_REC_CD
				SAS	ALIAS : EOR
				STANDARD	ALIAS : END_REC_CD
				TITLE	ALIAS : END_OF_REC
				LENGTH	: 3
				COMMENTS :	
				Prior to Version I this field was named: END_REC_CNSTNT.	
				SOURCE	: NCH
				CODE TABLE	: END_REC_TB

\*\*\*\*\*

H3PM.R\_RIF\_MAIN\_Q,Q1,F

1

LIMITATIONS APPENDIX FOR RECORD: FI\_OP\_CLM\_REC  
AS OF: 07/01/2011

CHOICES\_DEMO\_LIM

FULL NAME: Choices Demonstration Limitation  
DESCRIPTION :  
A programming error created an 'INVALID' indication in the demo text field for CHOICES claims.  
BACKGROUND :  
In 6/00, the CWFMQA front-end editing revealed that some CHOICES demo claims were coming in with a valid 'H'

number in the fixed portion of the claims, but in the first occurrence MCO trailer a numeric packed field (value hex '0100000C') was moved to the MCO Contract Number/Option Code fields. This created an invalid period check of number/code to MCO effective date, resulting in an INVALID indication in the demo info text field.

CORRECTIVE ACTION :

The problem was forwarded to the CWF BSOG staff for further investigation.

SOURCE:

CONTACT : OIS/EDG/DMUDD

CLM\_OPPTS\_LIM

FULL NAME: Claim Outpatient PPS Limitation

DESCRIPTION :

OPPS claims processed by FISS and APASS had a number of problems with the line item detail data.

BACKGROUND :

In July, 2001 a problem was discovered with the OPPTS claims processed by FISS with service dates greater than 8/1/00. Roughly 80% nationally did not have any line items except those that were assigned an APC code; there were also no charges or HCPCS for any services that were bundled into an APC.

It was later discovered that the data processed by FISS was also missing the APC code and that other fields may also be missing: (1) Discount and package flags were not being used; (2) revenue rate is only populated for non-PPS services (3) Revenue line Medicare payment amount field was not always populated and was not reliable. It was also discovered that other revenue center line payment amounts were not being populated correctly between the two Standard Systems (FISS & APASS).

The actual Medicare payment amount were correct and the claim-level data appeared to be accurate.

CORRECTIVE ACTION :

A fix (correcting the problem of missing data) was applied to production effective 8/6/01. A special utility was created to correct history (service dates 8/1/00-8/5/01).

Both the 2000 and 2001 OPPTS adjustments were loaded into the NCH in the October and November monthly files. The 2001 OP SAF was completed 1/15/02 and the 2000 OP SAF was completed 1/18/02 (updated through December 2001).

NOTE: The problems with the revenue center line payment amount fields have not been corrected. The correction to these fields is tentatively scheduled for 4/1/03 (it is likely that this date will slip).

SOURCE:

ADMINISTRATIVE DATA:

START DATE : 08/01/00  
END DATE : 01/15/01  
CONTACT : OIS/EDG/DMUDD

CLM\_TRANS\_CD\_LIM

FULL NAME: Claim Transaction Code Limitation

DESCRIPTION :

Claim Transaction Code missing from 1999 inpatient records and there was also a problem identified in the May and June 2000 data.

BACKGROUND :

Users of the data discovered taht the claim transaction code was missing values 2 & 3 for service year 1999 and for the months of May and June, 2000. This information was confirmed and OIS/BSOG was notified.

CORRECTIVE ACTION :

In July 2000 the problem was fixed and the claim transaction code contained the correct values.

SOURCE:

CONTACT : OIS/EDG/DMUDD

HHA\_HCPCS\_LIM

FULL NAME: Home Health HCPCS Limitation

DESCRIPTION :

It was determined that providers were not complying with the 15-minute increment billing instructions for using the 'G' HCPCS codes.

BACKGROUND :

The instructions state that providers are to use the newly created 'G' codes to identify services of the six home health disciplines during an HH episode of care. These 'G' codes (G0151, G0152, G0153, G0154, G0155, G0156) are subject to 15-minute interval billing. As a result the user can not trust the 'G' codes for visit counting. For a more accurate accounting of services the user should rely on the revenue center codes rather than the HCPCS.

Currently there is a check that if the 15-minute increment 'G' codes appear, the revenue center code must be the corresponding HH discipline; however, there is no check to see if the discipline revenue center code appears and that the HCPCS contains the corresponding 'G' code.

CORRECTIVE ACTION :

The Standard Systems has put a fix in to correct this problem.

SOURCE:

CONTACT : OIS/EDG/DMUDD

MCO\_PD\_SW\_LIM

FULL NAME: Claim MCO Paid Switch Limitation

DESCRIPTION :

The MCO paid switch made consistent with criteria used to identify an inpatient encounter claim.

BACKGROUND :

During the NCH Version 'I' conversion, history was populated with an NCH Claim Type Code that will identify the record as an inpatient encounter claim. When applying the CWF logic to identify an inpatient encounter claim, it was discovered that when all the criteria was met the MCO paid switch was sometimes a blank or '0' (reflecting that the MCO did not pay the provider).

CORRECTIVE ACTION :

With the inception of the Version 'I' processing (7/00), if all the criteria for identifying an inpatient encounter claim is met but the MCO paid switch is a blank or '0' it is changed to a '1'.

A patch code = '13' was applied to all claims back to 7/1/97 service year thru date.

SOURCE:

CONTACT : OIS/EDG/DMUDD

MLTPL\_REV\_CNTR\_0001\_CD\_LIM

FULL NAME: Multiple Revenue Center '0001' Code Limitation

DESCRIPTION :

Multiple total charge '0001' revenue center codes appearing on outpatient, hospice and home health claim records.

BACKGROUND :

On outpatient, home health and hospice it appears that more than one '0001' revenue center code is showing up on the claims. The first total charge line adds the revenue center codes above it correctly; the problem exists below the first total charge line where garbage may be present due to the FI Standard System not clearing out fields before processing the next claim. We believe the error began with the change-over to a different claims processing contractor in 1/98.

CORRECTIVE ACTION :

CWF created an edit to reject multiple '0001' revenue center codes, effective 6/28/99. EDG's CWFMQA process implemented an edit to drop any revenue center line items below the first total charge line. The NCH Nearline File, as well as the 1998 Standard Analytic

Files (SAFs), have been patched/corrected to delete the multiple '0001' codes where present on any of the institutional claim types. Also, HCIS will be correcting the revenue center summaries during the next refresh.

The NCH\_PATCH\_CD field will reflect a value '10'.

SOURCE:

CONTACT : OIS/EDG/DMUDD

PMT\_AMT\_EXCEDG\_CHRG\_AMT\_LIM

FULL NAME: Claim Payment Amount Exceeding Total Charge Amount Limitation

DESCRIPTION :

Approximately 75 Inpatient claims had a reimbursement amount exceed \$500,000 which was at least 25 times the total charge amount. There were also claims where the reimbursement was less than \$500,000 but greater than the total charges.

BACKGROUND :

In November of 1999, it was brought to the attention of the HDUG that large reimbursement amounts were being paid in Pennsylvania. There were 75 inpatient claims provided where the reimbursement amount was over \$500,000 and at least 25 times the total charge amount. These claims were processed between 9/29/98 and 10/1/98. There were also claims identified with reimbursement less than \$500,000 but greater than total charge. It was later discovered that the source of the problem was an error in entering an MSA; the decimal point was off by 2 positions.

Because there were no changes in utilization, the claims were corrected and the correct payments distributed, but the new payment amounts were never sent to CWF (not in NCH). There is currently no requirement that FIs and carriers update CWF with final payment information by submitting payment only adjustments. It was noted that there is no expectation that CWF will have final payment information for claims.

CORRECTIVE ACTION :

According to Veritus (FI), the problem was caught in their system using a pre-payment edit prior to sending out the payments. The erroneous MSA value was corrected and the claims were then sent to PRICER again and paid correctly.

The claims were corrected and correct payments were made but these new payment amounts were never sent to CWF and are not reflected in the NCH.

SOURCE:

CONTACT : OIS/EDG/DMUDD

REV\_CNTR\_IDE\_NDC\_UPC\_LIM

FULL NAME: Revenue Center IDE, NDC, UPC Limitation  
DESCRIPTION :  
Missing data in the REV\_CNTR\_IDE\_NDC\_UPC\_NUM  
field.  
BACKGROUND :  
Prior to Version 'I', this field housed only the 7-position  
exemption number assigned by the FDA to an investigational  
device after a manufacturer has been approved to conduct  
a clinical trial on that device. With Version 'I', this  
field expanded to 24 positions to accommodate the future  
receipt of the National Drug Code and the Uniform Product  
Code. The CWFMQA editing process was moving the IDE to  
the expanded field, but then incorrectly blanked it out  
(positions 8-24 should be blank).  
CORRECTIVE ACTION :  
CWFMQA fixed the code and the problem was corrected with  
claims processed with NCH weekly process date 9/15/00.  
SOURCE:  
ADMINISTRATIVE DATA:  
START DATE : 06/09/00  
END DATE : 09/08/00  
CONTACT : OIS/EDG/DMUDD

REV\_CNTR\_TOT\_CHRG\_AMT\_LIM

FULL NAME: Revenue Center Total Charge Amount Limitation  
DESCRIPTION :  
Revenue center total charge amount field being  
populated on segments 2-10 of the Version 'I'  
record.  
BACKGROUND :  
Under Version 'I', a decision was made that any  
amount, count and quantity field would be zeroed  
out to eliminate the risk of overstating values  
during an accumulation.  
CORRECTIVE ACTION :  
The CWFMQA front-end process was modified to zero  
out the total charge amount field in segments 2-10.  
SOURCE:  
ADMINISTRATIVE DATA:  
START DATE : 07/01/00  
END DATE : 02/02/01  
CONTACT : OIS/EDG/DMUDD

TOT\_CHRG\_AMT\_LIM

FULL NAME: Claim Total Charge Amount Limitation  
DESCRIPTION :  
The total charge amount field in the fixed portion was  
truncated on outpatient, hospice and home health claims.  
BACKGROUND :  
For outpatient, hospice and home health claims, the  
total charge amount field in the fixed portion was

truncated (the cents were dropped off; the decimal point was moved, making cents out of dollars) in the CWFMQA process beginning with data received from CWF 1/4/99 through 5/14/99. The problem occurred when CWF increased the size of the field.

CORRECTIVE ACTION :

The CWFMQA front-end was fixed. The Nearline was patched during the quarterly merge in 7/99 for service years 1998 and 1999. The NCH PACTCH\_CD field will be populated with a value '11'. The 1998 and 1999 SAFs were corrected when finalized in 7/99.

The patch involved moving the total charge amount in the revenue center trailer to the total charge amount field in the fixed portion, for records with NCH Daily Process Date 1/4/99 - 5/14/99.

SOURCE:

ADMINISTRATIVE DATA:

START DATE : 01/04/99  
END DATE : 05/14/99  
CONTACT : OIS/EDG/DMUDD

07/01/2011

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H3PM.R\_RIF\_LIM\_Q,F

1

CMS RIF REPORT  
AS OF: 06/30/2011

NAME	LENGTH	BEG	END	CONTENTS
*** FI HHA Claim Record (NCH)				
	VAR	1	15825	REC
				Fiscal intermediary home health agency claim record for Version J of the NCH.
				STANDARD ALIAS : FI_HHA_CLM_REC
				SYSTEM ALIAS : UTLHHAJ
				LIMITATIONS :
				REFER TO :
				CHOICES_DEMO_LIM



CLM\_TRANS\_CD\_LIM  
HHA\_AB\_SHIFT\_LIM  
HHA\_HCPCS\_LIM  
HHA\_MISG\_CLM\_LIM  
HHA\_PPS\_LUPA\_0023\_LINE\_LIM  
HHA\_PPS\_RIC\_CD\_ADJSTMT\_LIM  
HHA\_PTA\_OVRD\_TRLR\_LIM  
HHA\_RFRL\_CD\_LIM  
HHA\_TOT\_VISIT\_CNT\_LIM  
MCO\_PD\_SW\_LIM  
MLTPL\_REV\_CNTR\_0001\_CD\_LIM  
PMT\_AMT\_EXCEDG\_CHRG\_AMT\_LIM  
REV\_CNTR\_IDE\_NDC\_UPC\_LIM  
REV\_CNTR\_TOT\_CHRG\_AMT\_LIM  
TOT\_CHRG\_AMT\_LIM

1. FI HHA Claim Fixed Group  
631 1 631 GRP

Fixed portion of the fiscal intermediary home health agency claim record for Version 'J' of the NCH.

STANDARD ALIAS : FI\_HHA\_CLM\_FIX\_GRP

2. Claim Record Identification Group  
8 1 8 GRP

Effective with Version 'I' the record length, version code, record identification, code and NCH derived claim type code were moved to this group for internal NCH processing.

STANDARD ALIAS : CLM\_REC\_IDENT\_GRP

3. Record Length Count  
3 1 3 PACK

Effective with Version H, the count (in bytes) of the length of the claim record.

NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991).

DB2 ALIAS : REC\_LNGTH\_CNT  
SAS ALIAS : REC\_LEN  
STANDARD ALIAS : REC\_LNGTH\_CNT

				LENGTH	: 5	SIGNED : Y
				SOURCE	: NCH	
4.	NCH Near-Line Record Version Code	1	4	4	CHAR	
					The code indicating the record version of the Nearline file where the institutional, carrier or DMERC claims data are stored.	
				DB2	ALIAS : NCH_REC_VRSN_CD	
				SAS	ALIAS : REC_LVL	
				STANDARD	ALIAS : NCH_NEAR_LINE_REC_VRSN_CD	
				TITLE	ALIAS : NCH_VERSION	
				LENGTH	: 1	
				COMMENTS :	Prior to Version H this field was named: CLM_NEAR_LINE_REC_VRSN_CD.	
				SOURCE	: NCH	
				CODE TABLE	: NCH_NEAR_LINE_REC_VRSN_TB	
5.	NCH Near Line Record Identification Code	1	5	5	CHAR	
					A code defining the type of claim record being processed.	
				COMMON	ALIAS : RIC	
				DB2	ALIAS : NEAR_LINE_RIC_CD	
				SAS	ALIAS : RIC_CD	
				STANDARD	ALIAS : NCH_NEAR_LINE_RIC_CD	
				TITLE	ALIAS : RIC	
				LENGTH	: 1	
				COMMENTS :	Prior to Version H this field was named: RIC_CD.	
				SOURCE	: NCH	
				CODE TABLE	: NCH_NEAR_LINE_RIC_TB	
6.	NCH MQA RIC Code	1	6	6	CHAR	

Effective with Version H, the code used (for internal editing purposes) to identify the record being processed through CMS' CWFMQA system.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : NCH\_MQA\_RIC\_CD  
SAS ALIAS : MQA\_RIC  
STANDARD ALIAS : NCH\_MQA\_RIC\_CD  
TITLE ALIAS : MQA\_RIC

LENGTH : 1

SOURCE : NCH QA PROCESS

CODE TABLE : NCH\_MQA\_RIC\_TB

7. NCH Claim Type Code

2 7 8 CHAR

The code used to identify the type of claim record being processed in NCH.

NOTE1: During the Version H conversion this field was populated with data throughout history (back to service year 1991).

NOTE2: During the Version I conversion this field was expanded to include inpatient 'full' encounter claims (for service dates after 6/30/97).

NOTE3: Effective with Version 'J', 3 new code values have been added to include a type code for the Medicare Advantage claims (IME/GME, no-pay and paid as FFS). During the Version 'J' conversion, these type codes were populated throughout history. With Version 'J', these claims are also being stored in NMUD. Prior to Version 'J' they were only in the NCH. No history was converted in NMUD.

DB2 ALIAS : NCH\_CLM\_TYPE\_CD  
SAS ALIAS : CLM\_TYPE  
STANDARD ALIAS : NCH\_CLM\_TYPE\_CD  
TITLE ALIAS : CLAIM\_TYPE

LENGTH : 2

DERIVATIONS :

FFS CLAIM TYPE CODES DERIVED FROM:

NCH CLM\_NEAR\_LINE\_RIC\_CD  
NCH PMT\_EDIT\_RIC\_CD  
NCH CLM\_TRANS\_CD  
NCH PRVDR\_NUM

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:

(Pre-HDC processing -- AVAILABLE IN NCH)  
CLM\_MCO\_PD\_SW  
CLM\_RLT\_COND\_CD  
MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD  
MCO\_PRD\_EFCTV\_DT  
MCO\_PRD\_TRMNTN\_DT

DERIVATION RULES:

SET CLM\_TYPE\_CD TO 10 (HHA CLAIM) WHERE THE  
FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V', 'W' OR 'U'
2. PMT\_EDIT\_RIC\_CD EQUAL 'F'
3. CLM\_TRANS\_CD EQUAL '5'

SET CLM\_TYPE\_CD TO 20 (SNF NON-SWING BED CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'
3. CLM\_TRANS\_CD EQUAL '0' OR '4'
4. POSITION 3 OF PRVDR\_NUM IS NOT 'U', 'W', 'Y'  
OR 'Z'

SET CLM\_TYPE\_CD TO 30 (SNF SWING BED CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'
3. CLM\_TRANS\_CD EQUAL '0' OR '4'
4. POSITION 3 OF PRVDR\_NUM EQUAL 'U', 'W', 'Y'  
OR 'Z'

SET CLM\_TYPE\_CD TO 40 (OUTPATIENT CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'W'
2. PMT\_EDIT\_RIC\_CD EQUAL 'D'
3. CLM\_TRANS\_CD EQUAL '6'

SET CLM\_TYPE\_CD TO 50 (HOSPICE CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'
2. PMT\_EDIT\_RIC\_CD EQUAL 'I'
3. CLM\_TRANS\_CD EQUAL 'H'

SET CLM\_TYPE\_CD TO 60 (INPATIENT CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'  
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'  
3. CLM\_TRANS\_CD EQUAL '1' '2' OR '3'

SET CLM\_TYPE\_CD TO 61 (INPATIENT 'FULL' ENCOUNTER  
CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 -  
12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_MCO\_PD\_SW = '1'  
2. CLM\_RLT\_COND\_CD = '04'  
3. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = 'C'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS

SET CLM\_TYPE\_CD TO 61 (INPATIENT 'FULL' ENCOUNTER  
CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE  
FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'  
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'  
3. CLM\_TRANS\_CD EQUAL '1' '2' OR '3'  
4. FI\_NUM = 80881

SET CLM\_TYPE\_CD TO 62 (Medicare Advantage IME/GME  
CLAIMS - 10/1/05 - FORWARD)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_MCO\_PD\_SW = '0'  
2. CLM\_RLT\_COND\_CD = '04' & '69'  
3. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = 'C'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS

SET CLM\_TYPE\_CD TO 63 (HMO NO-PAY CLAIMS)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
CLAIMS PROCESSED ON OR AFTER 10/6/08  
1. CLM\_THRU\_DT ON OR AFTER 10/1/06  
2. CLM\_MCO\_PD\_SW = '1'  
3. CLM\_RLT\_COND\_CD = '04'  
4. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = 'A', 'B' OR 'C'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS  
5. ZERO REIMBURSEMENT (CLM\_PMT\_AMT)

SET CLM\_TYPE\_CD TO 63 (HMO NO-PAY CLAIMS)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
CLAIMS PROCESSED PRIOR to 10/6/08

1. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = 'A', 'B' OR 'C'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS
2. ZERO REIMBURSEMENT (CLM\_PMT\_AMT)

SET CLM\_TYPE\_CD TO 64 (HMO CLAIMS PAID AS FFS)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
CLAIMS PROCESSED PRIOR to 10/6/08

1. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = '1', '2' OR '4'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS

SET CLM\_TYPE\_CD TO 64 (HMO CLAIMS PAID AS FFS)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
CLAIMS PROCESSED on or after 10/6/08

1. CLM\_RLT\_COND\_CD = '04'
2. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = '1', '2' OR '4'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS

SET CLM\_TYPE\_CD TO 71 (RIC O non-DMEPOS CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'O'
2. HCPCS\_CD not on DMEPOS table

SET CLM\_TYPE\_CD TO 72 (RIC O DMEPOS CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'O'
2. HCPCS\_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).

SET CLM\_TYPE\_CD TO 81 (RIC M non-DMEPOS DMERC CLAIM)

WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'M'
2. HCPCS\_CD not on DMEPOS table

SET CLM\_TYPE\_CD TO 82 (RIC M DMEPOS DMERC CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE RIC CD EQUAL 'M'
2. HCPCS\_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).

SOURCE : NCH

CODE TABLE : NCH\_CLM\_TYPE\_TB

8. Fiscal Intermediary Claim Link Group  
125 9 133

GRP

Effective with Version 'I', this group contains those fields necessary to keep segments together (a claim may have up to 10 segments due to the increase in number of revenue center trailers (up to 450). It is also used to house fields necessary for sorting and the final action process.

STANDARD ALIAS : FI\_CLM\_LINK\_GRP

9. Claim Locator Number Group  
11 9 19

GRP

This number uniquely identifies the beneficiary in the NCH Nearline.

COMMON ALIAS : HIC  
STANDARD ALIAS : CLM\_LCTR\_NUM\_GRP  
TITLE ALIAS : HICAN

10. Beneficiary Claim Account Number  
9 9 17

CHAR

The number identifying the primary beneficiary under the SSA or RRB programs submitted.

COMMON ALIAS : CAN  
DB2 ALIAS : BENE\_CLM\_ACNT\_NUM  
SAS ALIAS : CAN  
STANDARD ALIAS : BENE\_CLM\_ACNT\_NUM  
TITLE ALIAS : CAN

LENGTH : 9

SOURCE : SSA,RRB

LIMITATIONS :  
RRB-issued numbers contain an overpunch in  
the first position that may appear as a plus  
zero or A-G. RRB-formatted numbers may  
cause matching problems on non-IBM machines.

11. NCH Category Equatable Beneficiary Identification Code  
2 18 19 CHAR

The code categorizing groups of BICs  
representing similar relationships between  
the beneficiary and the primary wage earner.

The equatable BIC module electronically matches  
two records that contain different BICs where  
it is apparent that both are records for the  
same beneficiary. It validates the BIC and  
returns a base BIC under which to house the  
record in the National Claims History (NCH)  
databases. (All records for a beneficiary  
are stored under a single BIC.)

COMMON ALIAS : NCH\_BASE\_CATEGORY\_BIC  
DB2 ALIAS : CTGRY\_EQTBL\_BIC  
SAS ALIAS : EQ\_BIC  
STANDARD ALIAS : NCH\_CTGRY\_EQTBL\_BIC\_CD  
TITLE ALIAS : EQUATED\_BIC

LENGTH : 2

COMMENTS :  
Prior to Version H this field was named:  
CTGRY\_EQTBL\_BENE\_IDENT\_CD.

SOURCE : BIC EQUATE MODULE

CODE TABLE : CTGRY\_EQTBL\_BENE\_IDENT\_TB

12. Beneficiary Identification Code  
2 20 21 CHAR

The code identifying the type of relationship between an  
individual and a primary Social Security Administration  
(SSA) beneficiary or a primary Railroad Board (RRB)  
beneficiary.

COMMON ALIAS : BIC  
DA3 ALIAS : BENE\_IDENT\_CODE  
DB2 ALIAS : BENE\_IDENT\_CD  
SAS ALIAS : BIC



STANDARD ALIAS : BENE\_IDENT\_CD  
TITLE ALIAS : BIC

LENGTH : 2

SOURCE : SSA/RRB

EDIT RULES :  
EDB REQUIRED FIELD

CODE TABLE : BENE\_IDENT\_TB

13. NCH State Segment Code

1 22 22 CHAR

The code identifying the segment of the NCH Nearline file containing the beneficiary's record for a specific service year. Effective 12/96, segmentation is by CLM\_LCTR\_NUM, then final action sequence within residence state. (Prior to 12/96, segmentation was by ranges of county codes within the residence state.)

DB2 ALIAS : NCH\_STATE\_SGMT\_CD  
SAS ALIAS : ST\_SGMT  
STANDARD ALIAS : NCH\_STATE\_SGMT\_CD  
TITLE ALIAS : NEAR\_LINE\_SEGMENT

LENGTH : 1

COMMENTS :  
Prior to Version H this field was named:  
BENE\_STATE\_SGMT\_NEAR\_LINE\_CD.

SOURCE : NCH

CODE TABLE : NCH\_STATE\_SGMT\_TB

14. Beneficiary Residence SSA Standard State Code

2 23 24 CHAR

The SSA standard state code of a beneficiary's residence.

DA3 ALIAS : SSA\_STANDARD\_STATE\_CODE  
DB2 ALIAS : BENE\_SSA\_STATE\_CD  
SAS ALIAS : STATE\_CD  
STANDARD ALIAS : BENE\_RSDNC\_SSA\_STD\_STATE\_CD  
TITLE ALIAS : BENE\_STATE\_CD

LENGTH : 2

COMMENTS :  
1. Used in conjunction with a county code, as selection criteria for the determination of payment rates for HMO reimbursement.  
2. Concerning individuals directly billable for Part B and/or Part A premiums, this element is used to determine if the beneficiary will receive a bill in English or Spanish.  
3. Also used for special studies.

SOURCE : SSA/EDB

EDIT RULES :  
OPTIONAL: MAY BE BLANK

CODE TABLE : GEO\_SSA\_STATE\_TB

15. Claim From Date

8 25 32

NUM

The first day on the billing statement covering services rendered to the beneficiary (a.k.a. 'Statement Covers From Date').

NOTE: For Home Health PPS claims, the 'from' date and the 'thru' date on the RAP (initial claim) must always match.

DB2 ALIAS : CLM\_FROM\_DT  
SAS ALIAS : FROM\_DT  
STANDARD ALIAS : CLM\_FROM\_DT  
TITLE ALIAS : FROM\_DATE

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

16. Claim Through Date

8 33 40

NUM

The last day on the billing statement covering services rendered to the beneficiary (a.k.a. 'Statement Covers Thru Date').

NOTE: For Home Health PPS claims, the 'from' date and the 'thru' date on the RAP (initial claim) must always match.

DB2 ALIAS : CLM\_THRU\_DT  
SAS ALIAS : THRU\_DT  
STANDARD ALIAS : CLM\_THRU\_DT  
TITLE ALIAS : THRU\_DATE

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

17. NCH Weekly Claim Processing Date  
8 41

48 NUM

The date the weekly NCH database load process cycle begins, during which the claim records are loaded into the Nearline file. This date will always be a Friday, although the claims will actually be appended to the database subsequent to the date.

DB2 ALIAS : NCH\_WKLY\_PROC\_DT  
SAS ALIAS : WKLY\_DT  
STANDARD ALIAS : NCH\_WKLY\_PROC\_DT  
TITLE ALIAS : NCH\_PROCESS\_DT

LENGTH : 8 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
HCFA\_CLM\_PROC\_DT.

SOURCE : NCH

EDIT RULES :  
YYYYMMDD

18. CWF Claim Accretion Date

8 49 56

NUM

The date the claim record is accreted (posted/processed) to the beneficiary master record at the CWF host site and authorization for payment is returned to the fiscal intermediary or carrier.

DB2 ALIAS : CWF\_CLM\_ACRTN\_DT  
SAS ALIAS : ACRTN\_DT

STANDARD ALIAS : CWF\_CLM\_ACRTN\_DT  
TITLE ALIAS : ACCRETION\_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

19. CWF Claim Accretion Number  
2 57 58

PACK

The sequence number assigned to the claim record when accreted (posted/processed) to the beneficiary master record at the CWF host site on a given date. This element indicates the position of the claim within that day's processing at the CWF host. \*(Exception: If the claim record is missing the accretion date CMS' CWFMQA system places a zero in the accretion number.

DB2 ALIAS : CWF\_CLM\_ACRTN\_NUM  
SAS ALIAS : ACRTN\_NM  
STANDARD ALIAS : CWF\_CLM\_ACRTN\_NUM  
TITLE ALIAS : ACCRETION\_NUMBER

LENGTH : 3 SIGNED : Y

SOURCE : CWF

20. FI Document Claim Control Number  
23 59 81

CHAR

Unique control number assigned by an intermediary to an institutional claim.

COMMON ALIAS : ICN  
DB2 ALIAS : DOC\_CLM\_CNTL\_NUM  
SAS ALIAS : CLM\_CNTL  
STANDARD ALIAS : FI\_DOC\_CLM\_CNTL\_NUM  
TITLE ALIAS : ICN

LENGTH : 23

SOURCE : CWF

21. FI Original Claim Control Number  
23 82 104

CHAR

Effective with Version G, the original intermediary control number (ICN) which is present on adjustment claims, representing the ICN of the original transaction now being adjusted.

COMMON ALIAS : ORIGINAL\_ICN  
DB2 ALIAS : ORIG\_CLM\_CNTL\_NUM  
SAS ALIAS : ORIGCNTL  
STANDARD ALIAS : FI\_ORIG\_CLM\_CNTL\_NUM  
TITLE ALIAS : ORIGINAL\_ICN

LENGTH : 23

SOURCE : CWF

22. Claim Query Code

1 105 105

CHAR

Code indicating the type of claim record being processed with respect to payment (debit/credit indicator; interim/final indicator).

DB2 ALIAS : CLM\_QUERY\_CD  
SAS ALIAS : QUERY\_CD  
STANDARD ALIAS : CLM\_QUERY\_CD  
TITLE ALIAS : QUERY\_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM\_QUERY\_TB

23. Provider Number

6 106 111

CHAR

The identification number of the institutional provider certified by Medicare to provide services to the beneficiary.

NOTE: Effective October 1, 2007 the OSCAR Provider Number has been renamed the CMS Certification Number (CCN). The name was changed to avoid confusion with the National Provider Identifier (NPI). The CCN (OSCAR Provider Number) will continue to play a critical role in verifying that a provider has been Medicare certified and for what type of services.

DB2 ALIAS : PRVDR\_NUM  
SAS ALIAS : PROVIDER  
STANDARD ALIAS : PRVDR\_NUM  
TITLE ALIAS : PROVIDER\_NUMBER

LENGTH : 6

CODE TABLE : PRVDR\_NUM\_TB

24. NCH Daily Process Date

8 112 119

NUM

Effective with Version H, the date the claim record was processed by CMS' CWFMQA system (used for internal editing purposes).

Effective with Version I, this date is used in conjunction with the NCH Segment Link Number to keep claims with multiple records/ segments together.

NOTE1: With Version 'H' this field was populated with data beginning with NCH weekly process date 10/3/97. Under Version 'I' claims prior to 10/3/97, that were blank under Version 'H', were populated with a date.

DB2 ALIAS : NCH\_DAILY\_PROC\_DT  
SAS ALIAS : DAILY\_DT  
STANDARD ALIAS : NCH\_DAILY\_PROC\_DT  
TITLE ALIAS : DAILY\_PROCESS\_DT

LENGTH : 8 SIGNED : N

SOURCE : NCH

EDIT RULES :  
YYYYMMDD

25. NCH Segment Link Number

5 120 124

PACK

Effective with Version 'I', the system generated number used in conjunction with the NCH daily process date to keep records/segments belonging to a specific claim together. This field was added to ensure that records/ segments that come in on the same batch with the same identifying information in the link group are not mixed with each other.

NOTE: During the Version I conversion this

field was populated with data throughout history (back to service year 1991).

DB2 ALIAS : NCH\_SGMT\_LINK\_NUM  
SAS ALIAS : LINK\_NUM  
STANDARD ALIAS : NCH\_SGMT\_LINK\_NUM  
TITLE ALIAS : LINK\_NUM

LENGTH : 9 SIGNED : Y

SOURCE : NCH

26. Claim Total Segment Count

2 125 126 NUM

Effective with Version I, the count used to identify the total number of segments associated with a given claim. Each claim could have up to 10 segments.

NOTE: During the Version I conversion, this field was populated with data throughout history (back to service year 1991). For institutional claims, the count for claims prior to 7/00 will be 1 or 2 (1 if 45 or less revenue center lines on a claim and 2 if more than 45 revenue center lines on a claim). For noninstitutional claims, the count will always be 1.

DB2 ALIAS : TOT\_SGMT\_CNT  
SAS ALIAS : SGMT\_CNT  
STANDARD ALIAS : CLM\_TOT\_SGMT\_CNT  
TITLE ALIAS : SEGMENT\_COUNT

LENGTH : 2 SIGNED : N

SOURCE : CWF

27. Claim Segment Number

2 127 128 NUM

Effective with Version I, the number used to identify an actual record/segment (1 - 10) associated with a given claim.

NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991). For institutional claims prior to 7/00,

this number will be either 1 or 2. For noninstitutional claims, the number will always be 1.

DB2 ALIAS : CLM\_SGMT\_NUM  
SAS ALIAS : SGMT\_NUM  
STANDARD ALIAS : CLM\_SGMT\_NUM  
TITLE ALIAS : SEGMENT\_NUMBER

LENGTH : 2 SIGNED : N

SOURCE : CWF

28. Claim Total Line Count

3 129 131

NUM

Effective with Version I, the count used to identify the total number of revenue center lines associated with the claim.

NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991). Prior to Version 'I', the maximum line count will be no more than 58. Effective with Version 'I', the maximum line count could be 450.

DB2 ALIAS : TOT\_LINE\_CNT  
SAS ALIAS : LINECNT  
STANDARD ALIAS : CLM\_TOT\_LINE\_CNT  
TITLE ALIAS : TOTAL\_LINE\_COUNT

LENGTH : 3 SIGNED : N

SOURCE : CWF

29. Claim Segment Line Count

2 132 133

NUM

Effective with Version I, the count used to identify the number of lines on a record/segment.

NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991). The maximum line count per record/segment on the revenue center trailer is 45. The maximum number of lines on carrier and DMERC claims are 13.



DB2 ALIAS : SGMT\_LINE\_CNT  
SAS ALIAS : SGMTLINE  
STANDARD ALIAS : CLM\_SGMT\_LINE\_CNT  
TITLE ALIAS : SEGMENT\_LINE\_COUNT  
  
LENGTH : 2 SIGNED : N  
  
SOURCE : CWF

30. FI Claim Common Group

382 134 515 GRP

Information common to fiscal intermediary (FI)  
claims (inpatient/SNF, outpatient, HHA & hospice),  
for version J of NCH Nearline file.

STANDARD ALIAS : FI\_CLM\_CMN\_GRP

31. NCH Payment and Edit Record Identification Code

1 134 134 CHAR

The code used for payment and editing purposes that  
indicates the type of institutional claim record.  
Prior to Version H this field was named:  
PMT\_EDIT\_RIC\_CD.

DB2 ALIAS : PMT\_EDIT\_RIC\_CD  
SAS ALIAS : PE\_RIC  
STANDARD ALIAS : NCH\_PMT\_EDIT\_RIC\_CD  
TITLE ALIAS : NCH\_PAYMENT\_EDIT\_RIC

LENGTH : 1

SOURCE : NCH QA Process

CODE TABLE : PMT\_EDIT\_RIC\_TB

32. Claim Transaction Code

1 135 135 CHAR

The code derived by CWF to indicate the type of claim  
submitted by an institutional provider.

DB2 ALIAS : CLM\_TRANS\_CD  
SAS ALIAS : TRANS\_CD  
STANDARD ALIAS : CLM\_TRANS\_CD  
TITLE ALIAS : TRANSACTION\_CODE

				LENGTH	: 1
				SOURCE	: CWF
				LIMITATIONS :	
				REFER TO :	
				CLM_TRANS_CD_LIM	
				CODE TABLE	: CLM_TRANS_TB
33.	Claim Bill Type Group	2	136	137	GRP
					Effective with Version H, the claim facility type code plus the claim service classification type code. (The first two positions of the ('type of bill')). During the Version H conversion, this grouping was created throughout history.
					NOTE: Effective 4/1/2002, TOB code 'XX0' was implemented to identify those claims that are totally non-covered.
					STANDARD ALIAS : CLM_BILL_TYPE_CD_GRP
					CODE TABLE : CLM_BILL_TYPE_TB
34.	Claim Facility Type Code	1	136	136	CHAR
					The first digit of the type of bill (TOB1) submitted on an institutional claim used to identify the type of facility that provided care to the beneficiary.
				COMMON	ALIAS : TOB1
				DB2	ALIAS : CLM_FAC_TYPE_CD
				SAS	ALIAS : FAC_TYPE
				STANDARD	ALIAS : CLM_FAC_TYPE_CD
				TITLE	ALIAS : TOB1
				LENGTH	: 1
				SOURCE	: CWF
				CODE TABLE	: CLM_FAC_TYPE_TB
35.	Claim Service Classification Type Code	1	137	137	CHAR

The second digit of the type of bill (TOB2) submitted on an institutional claim record to indicate the classification of the type of service provided to the beneficiary.

COMMON ALIAS : TOB2  
DB2 ALIAS : SRVC\_CLSFCTN\_CD  
SAS ALIAS : TYPESRVC  
STANDARD ALIAS : CLM\_SRVC\_CLSFCTN\_TYPE\_CD  
TITLE ALIAS : TOB2

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM\_SRVC\_CLSFCTN\_TYPE\_TB

36. Claim Frequency Code

1 138 138

CHAR

The third digit of the type of bill (TOB3) submitted on an institutional claim record to indicate the sequence of a claim in the beneficiary's current episode of care.

COMMON ALIAS : TOB3  
DB2 ALIAS : CLM\_FREQ\_CD  
SAS ALIAS : FREQ\_CD  
STANDARD ALIAS : CLM\_FREQ\_CD  
TITLE ALIAS : FREQUENCY\_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM\_FREQ\_TB

37. FILLER

1 139 139

CHAR

DB2 ALIAS : FILLER

LENGTH : 1

38. NCH MQA Query Patch Code

1 140 140

CHAR

Effective with Version H, a code used (for internal editing purposes) to indicate that the CWFMQA process changed the query code submitted on the claim record.

NOTE: Beginning with NCH weekly process date 10/3/97 this

field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : MQA\_QUERY\_PATCH\_CD  
SAS ALIAS : MQAQUERY  
STANDARD ALIAS : NCH\_MQA\_QUERY\_PATCH\_CD  
TITLE ALIAS : MQA\_QUERY\_PATCH\_IND

LENGTH : 1

SOURCE : NCH QA Process

CODE TABLE : NCH\_MQA\_QUERY\_PATCH\_TB

39. Claim Disposition Code

2 141 142 CHAR

Code indicating the disposition or outcome of the processing of the claim record.

DB2 ALIAS : CLM\_DISP\_CD  
SAS ALIAS : DISP\_CD  
STANDARD ALIAS : CLM\_DISP\_CD  
TITLE ALIAS : DISPOSITION\_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : CLM\_DISP\_TB

40. NCH Edit Disposition Code

2 143 144 CHAR

Effective with Version H, a code used (for internal editing purposes) to indicate the disposition of the claim after editing in the CWFMQA process.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : NCH\_EDIT\_DISP\_CD  
SAS ALIAS : EDITDISP  
STANDARD ALIAS : NCH\_EDIT\_DISP\_CD  
TITLE ALIAS : NCH\_EDIT\_DISP

LENGTH : 2

SOURCE : NCH QA Process

				CODE TABLE	: NCH_EDIT_DISP_TB
41.	NCH Claim BIC Modify H Code				
	1	145	145	CHAR	
					Effective with Version H, the code used (for internal editing purposes) to identify a claim record that was submitted with an incorrect HA, HB, or HC BIC.
					NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.
				DB2	ALIAS : NCH_BIC_MDFY_CD
				SAS	ALIAS : BIC_MDFY
				STANDARD	ALIAS : NCH_CLM_BIC_MDFY_CD
				TITLE	ALIAS : BIC_MODIFY_CD
				LENGTH	: 1
				SOURCE	: NCH QA Process
				CODE TABLE	: NCH_CLM_BIC_MDFY_TB
42.	Beneficiary Residence SSA Standard County Code				
	3	146	148	CHAR	
					The SSA standard county code of a beneficiary's residence.
				DB2	ALIAS : BENE_SSA_CNTY_CD
				SAS	ALIAS : CNTY_CD
				STANDARD	ALIAS : BENE_RSDNC_SSA_STD_CNTY_CD
				TITLE	ALIAS : BENE_COUNTY_CD
				LENGTH	: 3
				SOURCE	: SSA/EDB
				EDIT RULES :	
					OPTIONAL: MAY BE BLANK
43.	FI Claim Receipt Date				
	8	149	156	NUM	
					The date the fiscal intermediary received the institutional claim from the provider.
				DB2	ALIAS : FI_CLM_RCPT_DT
				SAS	ALIAS : RCPT_DT

STANDARD ALIAS : FI\_CLM\_RCPT\_DT  
TITLE ALIAS : RECEIPT\_DT

LENGTH : 8 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
FICARR\_CLM\_RCPT\_DT.

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

44. FI Claim Scheduled Payment Date  
8 157 164

NUM

The scheduled date of payment to the institutional provider, as reflected on the claim record transmitted to the CWF host. Note: This date is considered to be the date paid since no additional information as to the actual payment date is available.

DB2 ALIAS : FI\_SCHLD\_PMT\_DT  
SAS ALIAS : SCHLD\_DT  
STANDARD ALIAS : FI\_CLM\_SCHLD\_PMT\_DT  
TITLE ALIAS : SCHEDULED\_PMT\_DT

LENGTH : 8 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
FICARR\_CLM\_PMT\_DT.

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

45. CWF Forwarded Date  
8 165 172

NUM

Effective with Version H, the date CWF forwarded the claim record to CMS (used for internal editing purposes).

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

DB2 ALIAS : CWF\_FRWRD\_DT  
 SAS ALIAS : FRWRD\_DT  
 STANDARD ALIAS : CWF\_FRWRD\_DT  
 TITLE ALIAS : FORWARD\_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
 YYYYMMDD

46. FI Number

5 173 177 CHAR

The identification number assigned by CMS to a fiscal intermediary authorized to process institutional claim records.

Effective October 2006, the Medicare Administrative Contractors (MACs) began replacing the existing fiscal intermediaries and started processing institutional claim records for states assigned to its jurisdiction.

NOTE: The 5-position MAC number will be housed in the existing FI\_NUM field. During the transition from an FI to a MAC the FI\_NUM field could contain either a FI number or a MAC number. See the FI\_NUM table of codes to identify the new MAC numbers and their effective dates.

DB2 ALIAS : FI\_NUM  
 SAS ALIAS : FI\_NUM  
 STANDARD ALIAS : FI\_NUM  
 TITLE ALIAS : INTERMEDIARY

LENGTH : 5

COMMENTS :  
 Prior to Version H this field was named:  
 FICARR\_IDENT\_NUM.

SOURCE : CWF

CODE TABLE : FI\_NUM\_TB

47. CWF Claim Assigned Number

8 178 185 CHAR

Effective with Version H, the number assigned to an institutional claim record by CWF (used for internal editing purposes).

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : CWF\_CLM\_ASGN\_NUM  
SAS ALIAS : ASGN\_NUM  
STANDARD ALIAS : CWF\_CLM\_ASGN\_NUM  
TITLE ALIAS : ASSIGNED\_NUM

LENGTH : 8

SOURCE : CWF

48. CWF Transmission Batch Number  
4 186 189

CHAR

Effective with Version H, the number assigned to each batch of claims transactions sent from CWF(used for internal editing purposes).

NOTE: Beginning 11/98, this field will be populated with data. Claims processed prior to 11/98 will contain spaces in this field.

DB2 ALIAS : TRNSMSN\_BATCH\_NUM  
SAS ALIAS : FIBATCH  
STANDARD ALIAS : CWF\_TRNSMSN\_BATCH\_NUM  
TITLE ALIAS : BATCH\_NUM

LENGTH : 4

SOURCE : CWF

49. Beneficiary Mailing Contact ZIP Code  
9 190 198

CHAR

The ZIP code of the mailing address where the beneficiary may be contacted.

DB2 ALIAS : BENE\_MLG\_ZIP\_CD  
SAS ALIAS : BENE\_ZIP  
STANDARD ALIAS : BENE\_MLG\_CNTCT\_ZIP\_CD  
TITLE ALIAS : BENE\_ZIP



				LENGTH	: 9
				SOURCE	: EDB
50.	Beneficiary Sex Identification Code	1	199	199	CHAR
				The sex of a beneficiary.	
				COMMON	ALIAS : SEX_CD
				DA3	ALIAS : SEX_CODE
				DB2	ALIAS : BENE_SEX_IDENT_CD
				SAS	ALIAS : SEX
				STANDARD	ALIAS : BENE_SEX_IDENT_CD
				TITLE	ALIAS : SEX_CD
				LENGTH	: 1
				SOURCE	: SSA,RRB,EDB
				EDIT RULES :	
				REQUIRED FIELD	
				CODE TABLE	: BENE_SEX_IDENT_TB
51.	Beneficiary Race Code	1	200	200	CHAR
				The race of a beneficiary.	
				DA3	ALIAS : RACE_CODE
				DB2	ALIAS : BENE_RACE_CD
				SAS	ALIAS : RACE
				STANDARD	ALIAS : BENE_RACE_CD
				TITLE	ALIAS : RACE_CD
				LENGTH	: 1
				SOURCE	: SSA
				CODE TABLE	: BENE_RACE_TB
52.	Beneficiary Birth Date	8	201	208	NUM
				The beneficiary's date of birth.	
				COMMON	ALIAS : DOB
				DA3	ALIAS : BIRTH_DATE
				DB2	ALIAS : BENE_BIRTH_DT

SAS ALIAS : BENE\_DOB  
STANDARD ALIAS : BENE\_BIRTH\_DT  
TITLE ALIAS : BENE\_BIRTH\_DATE

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

53. CWF Beneficiary Medicare Status Code  
2 209 210

CHAR

The CWF-derived reason for a beneficiary's entitlement to Medicare benefits, as of the reference date (CLM\_THRU\_DT).

COBOL ALIAS : MSC  
COMMON ALIAS : MSC  
DB2 ALIAS : BENE\_MDCR\_STUS\_CD  
SAS ALIAS : MS\_CD  
STANDARD ALIAS : CWF\_BENE\_MDCR\_STUS\_CD  
TITLE ALIAS : MSC

LENGTH : 2

DERIVATIONS :  
CWF derives MSC from the following:

1. Date of Birth
2. Claim Through Date
3. Original/Current Reasons for entitlement
4. ESRD Indicator
5. Beneficiary Claim Number

Items 1,3,4,5 come from the CWF Beneficiary Master Record; item 2 comes from the FI/Carrier claim record. MSC is assigned as follows:

MSC	OASI	DIB	ESRD	AGE	BIC
10	YES	N/A	NO	65 and over	N/A
11	YES	N/A	YES	65 and over	N/A
20	NO	YES	NO	under 65	N/A
21	NO	YES	YES	under 65	N/A
31	NO	NO	YES	any age	T.

COMMENTS :  
Prior to Version H this field was named:  
BENE\_MDCR\_STUS\_CD. The name has been changed  
to distinguish this CWF-derived field from the

EDB-derived MSC (BENE\_MDCR\_STUS\_CD).

SOURCE : CWF

CODE TABLE : BENE\_MDCR\_STUS\_TB

54. Claim Patient 6 Position Surname  
6 211 216

CHAR

The first 6 positions of the Medicare patient's surname (last name) as reported by the provider on the claim.

NOTE1: Prior to Version H, this field was only present on the IP/SNF claim record. Effective with Version H, this field is present on all claim types.

NOTE2: For OP, HHA, Hospice and all Carrier claims, data was populated beginning with NCH weekly process 10/3/97. Claims processed prior to 10/3/97 will contain spaces in this field.

COMMON ALIAS : PATIENT\_SURNAME  
DB2 ALIAS : PTNT\_6\_PSTN\_SRNM  
SAS ALIAS : SURNAME  
STANDARD ALIAS : CLM\_PTNT\_6\_PSTN\_SRNM\_NAME  
TITLE ALIAS : PATIENT\_SURNAME

LENGTH : 6

SOURCE : CWF

55. Claim Patient 1st Initial Given Name  
1 217 217

CHAR

The first initial of the Medicare patient's given name (first name) as reported by the provider on the claim.

NOTE1: Prior to Version H, this field was only present on the IP/SNF claim record. Effective with Version H, this field is present on all claim types.

NOTE2: For OP, HHA, Hospice and all Carrier claims, data was populated beginning with NCH weekly process date 10/3/97. Claims processed prior to 10/3/97 will contain

spaces in this field.

COMMON ALIAS : PATIENT\_GIVEN\_NAME  
DB2 ALIAS : 1ST\_INITL\_GVN\_NAME  
SAS ALIAS : FRSTINIT  
STANDARD ALIAS : CLM\_PTNT\_1ST\_INITL\_GVN\_NAME  
TITLE ALIAS : PATIENT\_FIRST\_INITIAL

LENGTH : 1

SOURCE : CWF

56. Claim Patient First Initial Middle Name  
1 218 218

CHAR

The first initial of the Medicare patient's middle name as reported by the provider on the claim.

NOTE1: Prior to Version H, this field was only present on the IP/SNF claim record. Effective with Version H, this field is present on all claim types.

NOTE2: For OP, HHA, Hospice and all Carrier claims, data was populated beginning with NCH weekly process date 10/3/97. Claims processed prior to 10/3/97 will contain spaces in this field.

COMMON ALIAS : PATIENT\_MIDDLE\_NAME  
DB2 ALIAS : 1ST\_INITL\_MDL\_NAME  
SAS ALIAS : MDL\_INIT  
STANDARD ALIAS : CLM\_PTNT\_1ST\_INITL\_MDL\_NAME  
TITLE ALIAS : PATIENT\_MIDDLE\_INITIAL

LENGTH : 1

SOURCE : CWF

57. Beneficiary CWF Location Code  
1 219 219

CHAR

The code that identifies the Common Working File (CWF) location (the host site) where a beneficiary's Medicare utilization records are maintained.

COMMON ALIAS : CWF\_HOST  
DB2 ALIAS : BENE\_CWF\_LOC\_CD  
SAS ALIAS : CWFLOCCD

				STANDARD ALIAS : BENE_CWF_LOC_CD
				TITLE ALIAS : CWF_HOST
				LENGTH : 1
				SOURCE : CWF
				CODE TABLE : BENE_CWF_LOC_TB
58.	Claim Principal Diagnosis Group	8	220	227
				GRP
				Effective with Version 'J', the group used to identify the principal diagnosis code. This group contains the principal diagnosis code and the principal diagnosis version code.
				STANDARD ALIAS : CLM_PRNCPAL_DGNS_GRP
59.	Claim Principal Diagnosis Version Code	1	220	220
				CHAR
				Effective with Version 'J', the code used to indicate if the diagnosis is ICD-9 or ICD-10.
				NOTE: With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2013.
				DB2 ALIAS : UNDEFINED
				SAS ALIAS : PDVRSNCD
				LENGTH : 1
				CODE TABLE : CLM_DGNS_VRSN_TB
60.	Claim Principal Diagnosis Code	7	221	227
				CHAR
				The diagnosis code identifying the diagnosis, condition, problem or other reason for the admission/encounter/visit shown in the medical record to be chiefly responsible for the services provided.
				NOTE: Effective with Version H, this data is also redundantly stored as the first occurrence of the diagnosis trailer.

NOTE1: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10.

DB2 ALIAS : PRNCPAL\_DGNS\_CD  
SAS ALIAS : PDGNS\_CD

LENGTH : 7

SOURCE : CWF

EDIT RULES :  
ICD-9-CM

61. FILLER

1 228 228

CHAR

DB2 ALIAS : FILLER

LENGTH : 1

62. Claim Medicare Non Payment Reason Code

2 229 230

CHAR

The reason that no Medicare payment is made for services on an institutional claim.

NOTE1: This field was put on all institutional claim types but data did not start coming in on OP/HHA/Hospice until 4/1/02. Prior to 4/1/02, data only came in Inpatient/SNF claims.

NOTE2: Effective 4/1/02, this field was also expanded to two bytes to accommodate new values. The NCH Nearline file did not expand the current 1-byte field but instituted a crosswalk of the 2-byte field to the 1-byte character value. See table of code for the crosswalk.

NOTE3: Effective with Version 'J', the field has been expanded on the NCH claim to 2 bytes. With this expansion the NCH will no longer use the character values to represent the official two byte values being sent in by CWF since 4/2002.

During the Version 'J' conversion, all character values were converted to the two byte values.

DB2 ALIAS : MDCR\_NPMT\_RSN\_CD  
SAS ALIAS : NOPAY\_CD

LENGTH : 2

CODE TABLE : CLM\_MDCR\_NPMT\_RSN\_TB

63. Claim Excepted/Nonexcepted Medical Treatment Code  
1 231 231 CHAR

Effective with Version I, the code used to identify whether or not the medical care or treatment received by a beneficiary, who has elected care from a Religious Nonmedical Health Care Institution (RNHCI), is excepted or nonexcepted. Excepted is medical care or treatment that is received involuntarily or is required under Federal, State or local law. Nonexcepted is defined as medical care or treatment other than excepted.

DB2 ALIAS : EXCPTD\_NEXCPTD\_CD  
SAS ALIAS : TRTMT\_CD  
STANDARD ALIAS : CLM\_EXCPTD\_NEXCPTD\_TRTMT\_CD  
TITLE ALIAS : EXCPTD\_NEXCPTD\_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM\_EXCPTD\_NEXCPTD\_TRTMT\_TB

64. Claim Payment Amount  
6 232 237 PACK

Amount of payment made from the Medicare trust fund for the services covered by the claim record. Generally, the amount is calculated by the FI or carrier; and represents what was paid to the institutional provider, physician, or supplier, with the exceptions noted below. \*\*NOTE: In some situations, a negative claim payment amount may be present; e.g., (1) when a beneficiary is charged the full deductible during a short stay and the deductible exceeded the amount Medicare pays; or (2) when a beneficiary is charged a coinsurance amount during a long stay and the coinsurance amount exceeds the amount Medicare pays (most prevalent situation involves psych hospitals who are paid a daily per diem rate no matter what the charges are.)

Under IP PPS, inpatient hospital services are paid based on a predetermined rate per discharge, using the DRG patient classification system and the PRICER program. On the IP PPS claim, the payment amount includes the DRG outlier approved payment amount, disproportionate share (since

5/1/86), indirect medical education (since 10/1/88), total PPS capital (since 10/1/91). After 4/1/03, the payment amount could also include a "new technology" add-on amount. It does NOT include the pass-thru amounts (i.e., capital-related costs, direct medical education costs, kidney acquisition costs, bad debts); or any beneficiary-paid amounts (i.e., deductibles and coinsurance); or any other payer reimbursement.

Under IRFPPS, inpatient rehabilitation services are paid based on a predetermined rate per discharge, using the Case Mix Group (CMG) classification system and the PRICER program. From the CMG on the IRF PPS claim, payment is based on a standard payment amount for operating and capital cost for that facility (including routine and ancillary services). The payment is adjusted for wage, the % of low-income patients (LIP), locality, transfers, interrupted stays, short stay cases, deaths, and high cost outliers. Some or all of these adjustments could apply. The CMG payment does NOT include certain pass-through costs (i.e. bad debts, approved education activities); beneficiary-paid amounts, other payer reimbursement, and other services outside of the scope of PPS.

Under LTCH PPS, long term care hospital services are paid based on a predetermined rate per discharge based on the DRG and the PRICER program. Payments are based on a single standard Federal rate for both inpatient operating and capital-related costs (including routine and ancillary services), but do NOT include certain pass-through costs (i.e. bad debts, direct medical education, new technologies and blood clotting factors). Adjustments to the payment may occur due to short-stay outliers, interrupted stays, high cost outliers, wage index, and cost of living adjustments.

Under SNF PPS, SNFs will classify beneficiaries using the patient classification system known as RUGS III. For the SNF PPS claim, the SNF PRICER will calculate/return the rate for each revenue center line item with revenue center code = '0022'; multiply the rate times the units count; and then sum the amount payable for all lines with revenue center code '0022' to determine the total claim payment amount.

Under Outpatient PPS, the national ambulatory payment classification (APC) rate that is calculated for each APC group is the basis for determining the total claim payment. The payment amount also includes the outlier payment and interest.



Under Home Health PPS, beneficiaries will be classified into an appropriate case mix category known as the Home Health Resource Group. A HIPPS code is then generated corresponding to the case mix category (HHRG).

For the RAP, the PRICER will determine the payment amount appropriate to the HIPPS code by computing 60% (for first episode) or 50% (for subsequent episodes) of the case mix episode payment. The payment is then wage index adjusted.

For the final claim, PRICER calculates 100% of the amount due, because the final claim is processed as an adjustment to the RAP, reversing the RAP payment in full. Although final claim will show 100% payment amount, the provider will actually receive the 40% or 50% payment. The payment may also include outlier payments.

Exceptions: For claims involving demos and BBA encounter data, the amount reported in this field may not just represent the actual provider payment.

For demo Ids '01','02','03','04' -- claims contain amount paid to the provider, except that special 'differentials' paid outside the normal payment system are not included.

For demo Ids '05','15' -- encounter data 'claims' contain amount Medicare would have paid under FFS, instead of the actual payment to the MCO.

For demo Ids '06','07','08' -- claims contain actual provider payment but represent a special negotiated bundled payment for both Part A and Part B services. To identify what the conventional provider Part A payment would have been, check value code = 'Y4'. The related noninstitutional (physician/supplier) claims contain what would have been paid had there been no demo.

For BBA encounter data (non-demo) -- 'claims' contain amount Medicare would have paid under FFS, instead of the actual payment to the BBA plan.

COMMON	ALIAS : REIMBURSEMENT
DB2	ALIAS : CLM_PMT_AMT
SAS	ALIAS : PMT_AMT
STANDARD	ALIAS : CLM_PMT_AMT
TITLE	ALIAS : REIMBURSEMENT

LENGTH : 9.2 SIGNED : Y

COMMENTS :

Prior to Version H, the size of this field was S9(7)V99. Also, the noninstitutional claim records carried this field as a line item. Effective with Version H, this element is a claim level field across all claim types (and the line item field has been renamed.)

SOURCE : CWF

LIMITATIONS :

Prior to 4/6/93, on inpatient, outpatient, and physician/supplier claims containing a CLM\_DISP\_CD of '02', the amount shown as the Medicare reimbursement does not take into consideration any CWF automatic adjustments (involving erroneous deductibles in most cases). In as many as 30% of the claims (30% IP, 15% OP, 5% PART B), the reimbursement reported on the claims may be over or under the actual Medicare payment amount.

REFER TO :

PMT\_AMT\_EXCEDG\_CHRG\_AMT\_LIM

EDIT RULES :

\$\$\$\$\$\$\$\$\$CC

65. NCH Primary Payer Claim Paid Amount  
6 238 243

PACK

The amount of a payment made on behalf of a Medicare beneficiary by a primary payer other than Medicare, that the provider is applying to covered Medicare charges on an institutional, carrier, or DMERC claim.

DB2 ALIAS : PRMRY\_PYR\_PD\_AMT

STANDARD ALIAS : NCH\_PRMRY\_PYR\_CLM\_PD\_AMT

TITLE ALIAS : PRIMARY\_PAYER\_AMOUNT

LENGTH : 9.2 SIGNED : Y

COMMENTS :

Prior to Version H this field was named: BENE\_PRMRY\_PYR\_CLM\_PMT\_AMT and the field size was S9(7)V99.

SOURCE : NCH

EDIT RULES :

\$\$\$\$\$\$\$\$CC

66. NCH Primary Payer Code

1 244 244 CHAR

The code, on an institutional claim, specifying a federal non-Medicare program or other source that has primary responsibility for the payment of the Medicare beneficiary's health insurance bills.

DB2 ALIAS : NCH\_PRMRY\_PYR\_CD  
SAS ALIAS : PRPAY\_CD  
STANDARD ALIAS : NCH\_PRMRY\_PYR\_CD  
TITLE ALIAS : PRIMARY\_PAYER\_CD

LENGTH : 1

DERIVATIONS :

DERIVED FROM:

CLM\_VAL\_CD  
CLM\_VAL\_AMT

DERIVATION RULES

SET NCH\_PRMRY\_PYR\_CD TO 'A' WHERE THE  
CLM\_VAL\_CD = '12'

SET NCH\_PRMRY\_PYR\_CD TO 'B' WHERE THE  
CLM\_VAL\_CD = '13'

SET NCH\_PRMRY\_PYR\_CD TO 'C' WHERE THE  
CLM\_VAL\_CD = '16' and CLM\_VAL\_AMT is zeroes

SET NCH\_PRMRY\_PYR\_CD TO 'D' WHERE THE  
CLM\_VAL\_CD = '14'

SET NCH\_PRMRY\_PYR\_CD TO 'E' WHERE THE  
CLM\_VAL\_CD = '15'

SET NCH\_PRMRY\_PYR\_CD TO 'F' WHERE THE  
CLM\_VAL\_CD = '16' (CLM\_VAL\_AMT not  
equal to zeroes)

SET NCH\_PRMRY\_PYR\_CD TO 'G' WHERE THE  
CLM\_VAL\_CD = '43'

SET NCH\_PRMRY\_PYR\_CD TO 'H' WHERE THE  
CLM\_VAL\_CD = '41'

SET NCH\_PRMRY\_PYR\_CD TO 'I' WHERE THE

CLM\_VAL\_CD = '42'

SET NCH\_PRMRY\_PYR\_CD TO 'L' (or prior to 4/97  
set code to 'J') WHERE THE CLM\_VAL\_CD = '47'

COMMENTS :  
Prior to Version H this field was named:  
BENE\_PRMRY\_PYR\_CD.

SOURCE : NCH

CODE TABLE : BENE\_PRMRY\_PYR\_TB

67. FI Requested Claim Cancel Reason Code  
1 245 245

CHAR

The reason that an intermediary requested cancelling  
a previously submitted institutional claim.

DB2 ALIAS : RQST\_CNCL\_RSN\_CD  
SAS ALIAS : CANCELCD  
STANDARD ALIAS : FI\_RQST\_CLM\_CNCL\_RSN\_CD  
TITLE ALIAS : CANCEL\_CD

LENGTH : 1

COMMENTS :  
Prior to Version H this field was named:  
INTRMDRY\_RQST\_CLM\_CNCL\_RSN\_CD.

SOURCE : CWF

CODE TABLE : FI\_RQST\_CLM\_CNCL\_RSN\_TB

68. FI Claim Action Code  
1 246 246

CHAR

The type of action requested by the intermediary  
to be taken on an institutional claim.

DB2 ALIAS : FI\_CLM\_ACTN\_CD  
SAS ALIAS : ACTIONCD  
STANDARD ALIAS : FI\_CLM\_ACTN\_CD  
TITLE ALIAS : ACTION\_CD

LENGTH : 1

COMMENTS :  
Prior to Version H this field was named:  
INTRMDRY\_CLM\_ACTN\_CD.

				SOURCE	: CWF
				CODE TABLE	: FI_CLM_ACTN_TB
69. FI Claim Process Date	8	247	254	NUM	
				The date the fiscal intermediary completes processing and releases the institutional claim to the CWF host.	
				DB2	ALIAS : FI_CLM_PROC_DT
				SAS	ALIAS : APRVL_DT
				STANDARD	ALIAS : FI_CLM_PROC_DT
				TITLE	ALIAS : FI_PROCESS_DT
				LENGTH	: 8 SIGNED : N
				SOURCE	: CWF
				EDIT RULES :	
					YYYYMMDD
70. NCH Provider State Code	2	255	256	CHAR	
				Effective with Version H, the two position SSA state code where provider facility is located.	
				NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991).	
				DB2	ALIAS : NCH_PRVDR_STATE_CD
				SAS	ALIAS : PRSTATE
				STANDARD	ALIAS : NCH_PRVDR_STATE_CD
				TITLE	ALIAS : PROVIDER_STATE_CD
				LENGTH	: 2
				DERIVATIONS :	
				DERIVED FROM:	
					NCH PRVDR_NUM
				DERIVATION RULES:	
				SET NCH_PRVDR_STATE_CD TO	
				PRVDR_NUM POS1-2.	
				FOR PRVDR_NUM POS1-2 EQUAL '55' OR '75'	

```

SET NCH_PRVDR_STATE_CD TO '05'.
FOR PRVDR_NUM POS1-2 EQUAL '67' OR '74'
SET NCH_PRVDR_STATE_CD TO '45'.
FOR PRVDR_NUM POS1-2 EQUAL '68' OR '69'
SET NCH_PRVDR_STATE_CD TO '10'.
FOR PRVDR_NUM POS1-2 EQUAL '78'
SET NCH_PRVDR_STATE_CD TO '14'.
FOR PRVDR_NUM POS1-2 EQUAL TO '76'
SET NCH_PRVDR_STATE_CD TO '16'.
FOR PRVDR_NUM POS1-2 EQUAL '70'
SET NCH_PRVDR_STATE_CD TO '17'.
FOR PRVDR_NUM POS1-2 EQUAL '71'
SET NCH_PRVDR_STATE_CD TO '19'.
FOR PRVDR_NUMBER POS1-2 EQUAL '77'
SET NCH_PRVDR_STATE_CD TO '24'.
FOR PRVDR_NUM POS1-2 EQUAL TO '72'
SET NCH_PRVDR_STATE_CD TO '36'.
FOR PRVDR_NUM POS1-2 EQUAL TO '73'
SET NCH_PRVDR_STATE_CD TO '39'.

```

SOURCE : NCH

CODE TABLE : GEO\_SSA\_STATE\_TB

71. Organization NPI Number

10 257 266

CHAR

On an institutional claim, the National Provider Identifier (NPI) number assigned to uniquely identify the institutional provider certified by Medicare to provide services to the beneficiary.

NOTE: Effective May 2007, the NPI will become the national standard identifier for covered health care providers. NPIs will replace current OSCAR provider number, UPINs, NSC numbers, and local contractor provider identification numbers (PINs) on standard HIPPA claim transactions. (During the NPI transition phase (4/3/06 - 5/23/07) the capability was there for the NCH to receive NPIs along with an existing legacy number (UPIN, PIN, OSCAR provider number, etc.)).

NOTE1: CMS has determined that dual provider identifiers (old legacy numbers and new NPI) must be available in the NCH. After the 5/07 NPI implementation, the standard system maintainers will add the legacy number to the claim

when it is adjudicated. We will continue to receive the OSCAR provider number and any currently issued UPINs. Effective May 2007, no NEW UPINs (legacy number) will be generated for NEW physicians (Part B and outpatient claims), so there will only be NPIs sent in to the NCH for those physicians.

DB2 ALIAS : ORG\_NPI\_NUM  
SAS ALIAS : ORGNPINM  
STANDARD ALIAS : ORG\_NPI\_NUM  
TITLE ALIAS : ORG\_NPI

LENGTH : 10

SOURCE : CWF

72. Attending Physician ID Group  
24 267 290

Name and identification numbers associated with the primary care physician.

STANDARD ALIAS : ATNDG\_PHYSN\_ID\_GRP

73. Claim Attending Physician UPIN Number  
6 267 272

CHAR

On an institutional claim, the unique physician identification number (UPIN) of the physician who would normally be expected to certify and recertify the medical necessity of the services rendered and/or who has primary responsibility for the beneficiary's medical care and treatment (attending physician).

COMMON ALIAS : ATTENDING\_PHYSICIAN\_UPIN  
DB2 ALIAS : ATNDG\_UPIN\_NUM  
SAS ALIAS : AT\_UPIN  
STANDARD ALIAS : CLM\_ATNDG\_PHYSN\_UPIN\_NUM  
TITLE ALIAS : ATTENDING\_PHYSICIAN

LENGTH : 6

COMMENTS :

Prior to Version H this field was named: CLM\_PRMRY\_CARE\_PHYSN\_IDENT\_NUM and contained 10 positions (6-position UPIN and 4-position physician surname).

SOURCE : CWF

74. Claim Attending Physician NPI Number  
10 273 282

CHAR

On an institutional claim, the national provider identifier (NPI) number assigned to uniquely identify the physician who has overall responsibility for the beneficiary's care and treatment.

NOTE: Effective May 2007, the NPI will become the national standard identifier for covered health care providers. NPIs will replace current OSCAR provider number, UPINs, NSC numbers, and local contractor provider identification numbers (PINs) on standard HIPPA claim transactions. (During the NPI transition phase (4/3/06 - 5/23/07) the capability was there for the NCH to receive NPIs along with an existing legacy number (UPIN, PIN, OSCAR provider number, etc.)).

NOTE1: CMS has determined that dual provider identifiers (old legacy numbers and new NPI) must be available in the NCH. After the 5/07 NPI implementation, the standard system maintainers will add the legacy number to the claim when it is adjudicated. We will continue to receive the OSCAR provider number and any currently issued UPINs. Effective May 2007, no NEW UPINs (legacy number) will be generated for NEW physicians (Part B and Outpatient claims), so there will only be NPIs sent in to the NCH for those physicians.

COMMON ALIAS : ATTENDING\_PHYSICIAN\_NPI  
DB2 ALIAS : ATNDG\_NPI\_NUM  
SAS ALIAS : AT\_NPI  
STANDARD ALIAS : CLM\_ATNDG\_PHYSN\_NPI\_NUM  
TITLE ALIAS : ATNDG\_NPI

LENGTH : 10

SOURCE : CWF

75. Claim Attending Physician Surname  
6 283 288

CHAR

Effective with Version H, the last name of the



attending physician (used for internal editing  
purpose in CMS' CWFMQA system.)

NOTE: Beginning with NCH weekly process date  
10/3/97 this field was populated with data.  
Claims processed prior to 10/3/97 will contain  
spaces in this field.

DB2 ALIAS : ATNDG SRNM  
SAS ALIAS : AT\_SRNM  
STANDARD ALIAS : CLM\_ATNDG\_PHYSN\_SRNM\_NAME  
TITLE ALIAS : ANDG\_PHYSN\_SURNAME

LENGTH : 6

SOURCE : CWF

76. Claim Attending Physician Given Name  
1 289 289

CHAR

Effective with Version H, the first name of the  
attending physician (used for internal editing  
purposes in CMS' CWFMQA system).

NOTE: Beginning with NCH weekly process date  
10/3/97 this field was populated with data.  
Claims processed prior to 10/3/97 will contain  
spaces in this field.

DB2 ALIAS : ATNDG\_GVN\_NAME  
SAS ALIAS : AT\_GVNNM  
STANDARD ALIAS : CLM\_ATNDG\_PHYSN\_GVN\_NAME  
TITLE ALIAS : ATNDG\_PHYSN\_FIRSTNAME

LENGTH : 1

SOURCE : CWF

77. Claim Attending Physician Middle Initial Name  
1 290 290

CHAR

Effective with Version H, the middle initial  
of the attending physician (used for internal  
editing purposes in CMS' CWFMQA system.)

NOTE: Beginning with NCH weekly process date  
10/3/97 this field was populated with data.  
Claims processed prior to 10/3/97 will contain  
spaces in this field.

DB2 ALIAS : ATNDG\_MI\_NAME  
SAS ALIAS : AT\_MDL  
STANDARD ALIAS : CLM\_ATNDG\_PHYSN\_MDL\_INITL\_NAME  
TITLE ALIAS : ATNDG\_PHYSN\_MI

LENGTH : 1

SOURCE : CWF

78. Operating Physician ID Group  
24 291 314

Name and identification numbers associated  
with the physician who performed the principal  
procedure.

STANDARD ALIAS : OPRTG\_PHYSN\_ID\_GRP

79. Claim Operating Physician UPIN Number  
6 291 296

CHAR

On an institutional claim, the unique physician  
identification number (UPIN) of the physician  
who performed the principal procedure. This  
element is used by the provider to identify the  
operating physician who performed the surgi-  
cal procedure.

DB2 ALIAS : OPRTG\_UPIN  
SAS ALIAS : OP\_UPIN  
STANDARD ALIAS : CLM\_OPRTG\_PHYSN\_UPIN\_NUM  
TITLE ALIAS : OPRTG\_UPIN

LENGTH : 6

COMMENTS :  
Prior to Version H this field was named:  
CLM\_PRNCPAL\_PRCDR\_PHYSN\_NUM and contained  
10 positions (6-position UPIN and 4-position  
physician surname.

NOTE: For HHA and Hospice formats beginning  
with NCH weekly process date 10/3/97 this field  
was populated with data. HHA and Hospice claims  
processed prior to 10/3/97 will contain spaces.

SOURCE : CWF

80. Claim Operating Physician NPI Number  
10 297 306

CHAR

On an institutional claim, the National Provider Identifier (NPI) number assigned to uniquely identify the physician with the primary responsibility for performing the surgical procedure(s).

NOTE: Effective May 2007, the NPI will become the national standard identifier for covered health care providers. NPIs will replace the current OSCAR provider number, UPINs, NSC numbers, and local contractor provider identification numbers (PINs) on standard HIPPA claim transactions. (During the NPI transition phase (4/3/06 - 5/23/07) the capability was there for the NCH to receive NPIs along with an existing legacy number (UPIN, PIN, OSCAR provider number, etc.)).

NOTE1: CMS has determined that dual provider identifiers (old legacy number and new NPI) must be available in the NCH. After the 5/07 NPI implementation, the standard system maintainers will add the legacy number to the claim when its adjudicated. We will continue to receive the OSCAR provider number and any currently issued UPINs. Effective May 2007, no NEW UPINs (legacy numbers) will be generated for NEW physicians (Part B and outpatient claims), so there will only be NPIs sent in to the NCH for those physicians.

DB2 ALIAS : OPRTG\_NPI  
SAS ALIAS : OP\_NPI  
STANDARD ALIAS : CLM\_OPRTG\_PHYSN\_NPI\_NUM  
TITLE ALIAS : OPRTG\_NPI

LENGTH : 10

SOURCE : CWF

81. Claim Operating Physician Surname  
6 307 312

CHAR

Effective with Version H, the last name of the operating physician (used for internal editing purposes in CMS' CWFMQA system.)

NOTE: Beginning with the NCH weekly process date 10/3/97 this field was populated with data.

Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : OPRTG\_SRNM  
SAS ALIAS : OP\_SRNM  
STANDARD ALIAS : CLM\_OPRTG\_PHYSN\_SRNM\_NAME  
TITLE ALIAS : OPRTG\_PHYSN\_SURNAME

LENGTH : 6

SOURCE : CWF

82. Claim Operating Physician Given Name

1 313 313 CHAR

Effective with Version H, the first name of the operating physician (used for internal editing purposes in CMS' CWFMQA system.)

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : OPRTG\_GVN\_NAME  
SAS ALIAS : OP\_GVN  
STANDARD ALIAS : CLM\_OPRTG\_PHYSN\_GVN\_NAME  
TITLE ALIAS : OPRTG\_PHYSN\_FIRSTNAME

LENGTH : 1

SOURCE : CWF

83. Claim Operating Physician Middle Initial Name

1 314 314 CHAR

Effective with Version H, the middle initial of the operating physician (used for internal editing purposes in CMS' CWFMQA system.)

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : OPRTG\_MI\_NAME  
SAS ALIAS : OP\_MDL  
STANDARD ALIAS : CLM\_OPRTG\_PHYSN\_MDL\_INITL\_NAME  
TITLE ALIAS : OPRTG\_PHYSN\_MI

			LENGTH	: 1
			SOURCE	: CWF
84.	Other Physician ID Group	24 315 338		
			Name and identification numbers associated with the other physician.	
			STANDARD ALIAS : OTHR_PHYSN_ID_GRP	
85.	Claim Other Physician UPIN Number	6 315 320	CHAR	
			On an institutional claim, the unique physician identification number (UPIN) of the other physician associated with the institutional claim.	
			DB2	ALIAS : OTHR_UPIN
			SAS	ALIAS : OT_UPIN
			STANDARD	ALIAS : CLM_OTHR_PHYSN_UPIN_NUM
			TITLE	ALIAS : OTH_PHYSN_UPIN
			LENGTH	: 6
			COMMENTS :	
			Prior to Version H this field was named:	
			CLM_OTHR_PHYSN_IDENT_NUM and contained	
			10 positions (6-position UPIN and 4-position other physician surname).	
			NOTE: For HHA and Hospice formats beginning with NCH weekly process date 10/3/97 this field was populated with data. HHA and Hospice claims processed prior to 10/3/97 will contain spaces.	
			SOURCE	: CWF
86.	Claim Other Physician NPI Number	10 321 330	CHAR	
			On an institutional claim, the National Provider Identifier (NPI) number assigned to uniquely identify the other physician associated with the institutiohal claim.	
			NOTE: Effective May 2007, the NPI will become the national standard identifier for	

covered health care providers. NPIs will replace current OSCAR provider number, UPINs, NSC numbers, and local contractor provider identification numbers (PINs) on standard HIPPA claim transactions. (During the NPI transition phase (4/3/06 - 5/23/07) the capability was there for the NCH to receive NPIs along with an existing legacy number (UPIN, PIN, OSCAR provider number, etc.)).

NOTE1: CMS has determined that dual provider identifiers (old legacy numbers and new NPI) must be available in the NCH. After the 5/07 NPI implementation, the standard system maintainers will add the legacy number to the claim when it is adjudicated. We will continue to receive the OSCAR provider number and any currently issued UPINs. Effective May 2007, no NEW UPINs (legacy number) will be generated for NEW physicians (Part B AND outpatient claims), so there will only be NPIs sent in to the NCH for those physicians.

DB2 ALIAS : OTHR\_NPI  
SAS ALIAS : OT\_NPI  
STANDARD ALIAS : CLM\_OTHR\_PHYSN\_NPI\_NUM

LENGTH : 10

SOURCE : CWF

87. Claim Other Physician Surname

6 331 336

CHAR

Effective with Version H, the last name of the other physician (used for internal editing purposes in CMS' CWFMQA system.)

NOTE: Beginning with the NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : OTHR\_SRNM  
SAS ALIAS : OT\_SRNM  
STANDARD ALIAS : CLM\_OTHR\_PHYSN\_SRNM\_NAME  
TITLE ALIAS : OTH\_PHYSN\_SURNAME

LENGTH : 6

SOURCE : CWF

88. Claim Other Physician Given Name  
1 337 337

CHAR

Effective with Version H, the first name of the other physician (used for internal editing purposes in CMS' CWFMQA system.)

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : OTHR\_GVN\_NAME  
SAS ALIAS : OT\_GVN  
STANDARD ALIAS : CLM\_OTHR\_PHYSN\_GVN\_NAME  
TITLE ALIAS : OTH\_PHYSN\_FIRSTNAME

LENGTH : 1

SOURCE : CWF

89. Claim Other Physician Middle Initial Name  
1 338 338

CHAR

Effective with Version H, the middle initial of the other physician (used for internal editing purposes in CMS' CWFMQA system.)

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : OTHR\_MI\_NAME  
SAS ALIAS : OT\_MDL  
STANDARD ALIAS : CLM\_OTHR\_PHYSN\_MDL\_INITL\_NAME  
TITLE ALIAS : OTH\_PHYSN\_MI

LENGTH : 1

SOURCE : CWF

90. Medicaid Provider Identification Number  
13 339 351

CHAR

A unique identification number assigned to each provider by the state Medicaid agency. This unique provider number is used to ensure proper payment of providers and to maintain

claims history on individual providers for surveillance and utilization review.

DB2 ALIAS : MDCD\_PRVDR\_NUM  
SAS ALIAS : MDCD\_PRV  
STANDARD ALIAS : MDCD\_PRVDR\_IDENT\_NUM  
TITLE ALIAS : MEDICAID\_PROVIDER

LENGTH : 13

COMMENTS :  
Prior to Version H the field size was X(12).

SOURCE : CWF

91. Claim Medicaid Information Code  
4 352 355

CHAR

Effective with Version G, code identifying Medicaid information supplied by the contractor to Medicaid.

DB2 ALIAS : CLM\_MDCD\_INFO\_CD  
SAS ALIAS : MDCDINFO  
STANDARD ALIAS : CLM\_MDCD\_INFO\_CD  
TITLE ALIAS : MEDICAID\_INFO

LENGTH : 4

SOURCE : CWF

92. Claim MCO Paid Switch  
1 356 356

CHAR

A switch indicating whether or not a Managed Care Organization (MCO) has paid the provider for an institutional claim.

COBOL ALIAS : MCO\_PD\_IND  
DB2 ALIAS : CLM\_MCO\_PD\_SW  
SAS ALIAS : MCO\_PDSW  
STANDARD ALIAS : CLM\_MCO\_PD\_SW  
TITLE ALIAS : MCO\_PAID\_SW

LENGTH : 1

COMMENTS :  
Prior to Version H this field was named:  
CLM\_GHO\_PD\_SW.

SOURCE : CWF



LIMITATIONS :

REFER TO :  
MCO\_PD\_SW\_LIM

CODE TABLE : CLM\_MCO\_PD\_TB

93. Claim Treatment Authorization Number  
18 357 374

CHAR

The number assigned by the medical reviewer and reported by the provider to identify the medical review (treatment authorization) action taken after review of the beneficiary's case. It designates that treatment covered by the bill has been authorized by the payer. This number is used by the intermediary and the Peer Review Organization.

NOTE: Under HH PPS this field will be used to link claims to the OASIS assessment used as the basis of payment. This eighteen character string consists of the start of care date, the OASIS assessment date and the two digit reason for assessment code.

COMMON ALIAS : TAN  
DB2 ALIAS : TRTMT\_AUTHRZTN\_NUM  
SAS ALIAS : AUTHRZTN  
STANDARD ALIAS : CLM\_TRTMT\_AUTHRZTN\_NUM  
TITLE ALIAS : TREATMENT\_AUTHORIZATION

LENGTH : 18

SOURCE : CWF

94. Patient Control Number  
20 375 394

CHAR

The unique alphanumeric identifier assigned by the provider to the institutional claim to facilitate retrieval of individual case records and posting of payments.

DB2 ALIAS : PTNT\_CNTL\_NUM  
SAS ALIAS : PTNTCNTL  
STANDARD ALIAS : PTNT\_CNTL\_NUM  
TITLE ALIAS : PATIENT\_CONTROL\_NUM

				LENGTH	: 20
				SOURCE	: CWF
95. Claim Medical Record Number	17	395	411	CHAR	
				The number assigned by the provider to the beneficiary's medical record to assist in record retrieval.	
				DB2	ALIAS : CLM_MDCL_REC_NUM
				SAS	ALIAS : MDCL_REC
				STANDARD	ALIAS : CLM_MDCL_REC_NUM
				TITLE	ALIAS : MEDICAL_RECORD_NUM
				LENGTH	: 17
				SOURCE	: CWF
96. Claim PRO Control Number	12	412	423	CHAR	
				Effective with Version G, the unique identifier assigned by the Peer Review Organization (PRO) for control purposes.	
				DB2	ALIAS : CLM_PRO_CNTL_NUM
				SAS	ALIAS : PRO_CNTL
				STANDARD	ALIAS : CLM_PRO_CNTL_NUM
				TITLE	ALIAS : PRO_CONTROL_NUM
				LENGTH	: 12
				SOURCE	: CWF
97. Claim PRO Process Date	8	424	431	NUM	
				Effective with Version H, the date the claim was used in the PRO review process.	
				NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.	
				DB2	ALIAS : CLM_PRO_PROC_DT
				SAS	ALIAS : PRO_DT
				STANDARD	ALIAS : CLM_PRO_PROC_DT

				TITLE      ALIAS : PRO_PROC_DT  LENGTH            : 8      SIGNED : N  SOURCE            : CWF  EDIT RULES : YYYYYMDD
98. Patient Discharge Status Code	2	432	433	CHAR  The code used to identify the status of the patient as of the CLM_THRU_DT.  DB2            ALIAS : PTNT_DSCHRG_STUS SAS            ALIAS : STUS_CD STANDARD ALIAS : PTNT_DSCHRG_STUS_CD TITLE          ALIAS : PTNT_DSCHRG_STUS_CD  LENGTH            : 2  COMMENTS : Prior to Version H this field was named: CLM_STUS_CD.  SOURCE            : CWF  CODE TABLE      : PTNT_DSCHRG_STUS_TB
99. Claim 1st Diagnosis E Code Group	8	434	441	GRP  Effective with Version 'J', the group used to identify the 1st diagnosis E code in the diagnosis E trailer. This group contains the 1st diagnosis E code and the 1st diagnosis E version code.  STANDARD ALIAS : CLM_1ST_DGNS_E_CD_GRP
100. Claim 1st Diagnosis E Version Code	1	434	434	CHAR  Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9 or ICD-10.  NOTE: With 5010, the diagnosis and procedure codes have been expanded to accomodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2013.

			DB2	ALIAS : UNDEFINED
			SAS	ALIAS : E1VRSNCD
			LENGTH	: 1
			CODE TABLE	: CLM_DGNS_VRSN_TB
101. Claim 1st Diagnosis E Code	7	435	441	CHAR
				The code used to identify the 1st external cause of injury, poisoning, or other adverse effect. This diagnosis E code is also stored as the 1st occurrence of the diagnosis E code trailer.
				NOTE: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10.
			DB2	ALIAS : CLM_1ST_DGNS_E_CD
			SAS	ALIAS : DGNS_E
			STANDARD	ALIAS : CLM_1ST_DGNS_E_CD
			LENGTH	: 7
			COMMENTS :	
				Prior to version 'J', this field was named: CLM_DGNS_E_CD.
			SOURCE	: CWF
			EDIT RULES :	
				ICD-9-CM
102. Claim PPS Indicator Code	1	442	442	CHAR
				Effective with Version H, the code indicating whether or not the (1) claim is PPS and/or (2) the beneficiary is a deemed insured Medicare Qualified Government Employee (MQGE).
				NOTE: Beginning with NCH weekly process date 10/3/97 through 5/29/98, this field was populated with only the PPS indicator. Beginning with NCH weekly process date 6/5/98, this field was additionally populated with the deemed MQGE indicator. Claims processed prior to 10/3/97 will contain spaces.

COBOL ALIAS : PPS\_IND  
DB2 ALIAS : CLM\_PPS\_IND\_CD  
SAS ALIAS : PPS\_IND  
STANDARD ALIAS : CLM\_PPS\_IND\_CD  
TITLE ALIAS : PPS\_IND

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM\_PPS\_IND\_TB

103. Claim Total Charge Amount

6 443 448

PACK

Effective with Version G, the total charges for all services included on the institutional claim. This field is redundant with revenue center code 0001/total charges.

DB2 ALIAS : CLM\_TOT\_CHRG\_AMT  
SAS ALIAS : TOT\_CHRG  
STANDARD ALIAS : CLM\_TOT\_CHRG\_AMT  
TITLE ALIAS : CLAIM\_TOTAL\_CHARGES

LENGTH : 9.2 SIGNED : Y

COMMENTS :  
Prior to Version H the size of this field was S9(7)V99.

SOURCE : CWF

LIMITATIONS :

REFER TO :  
TOT\_CHRG\_AMT\_LIM

104. Claim Pricer Return Code

2 449 450

CHAR

Effective 1/1/2004 with the implementation of NCH/NMUD CR#1, the code used to identify various PPS payment adjustment types. This code identifies the payment return code or the error return code for every claim type calculated by a PRICER (Inpatient, Outpatient, SNF, Inpatient Rehab Facility (IRF), Home Health and Hospice).

The payment return code identifies the type of payment calculated by the PRICER software.

The error return code identifies a condition in a claim that prevents the PRICER software from calculating a correct payment.

NOTE: Prior to 10/2005 (implementation of NCH/NMUD CR#2), this data was stored in positions 443-444 (FILLER) on all institutional claim types.

DB2 ALIAS : CLM\_PRCR\_RTRN\_CD  
SAS ALIAS : PRCRRTN  
STANDARD ALIAS : CLM\_PRCR\_RTRN\_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : CLM\_PRCR\_RTRN\_TB

105. Claim Business Segment Identifier Code

4 451 454

CHAR

Effective 10/1/2005 with the implementation of NCH/NMUD CR#2, the identifier that captures the 2-byte jurisdiction code (represents the USPS state/territory abbreviation (i.e. NY = New York) and the 2-byte modifier that identifies the type of Medicare FFS contract (intermediary, RHHI, carrier or DMERC). This 4-byte identifier along with the 5-byte FI/Carrier number comprises the Contractor Workload Identifier number. The business segment identifier (BSI) is intended to help sort workloads that may be redistributed with the implementation of contracting reform as required by MMA.

DB2 ALIAS : BUSNS\_SGMT\_ID\_CD  
SAS ALIAS : SGMT\_ID  
STANDARD ALIAS : CLM\_BUSNS\_SGMT\_ID\_CD

LENGTH : 4

SOURCE : CWF

106. Recovery Audit Contractor (RAC) Adjustment Indicator Code

1 455 455

CHAR

Effective January 5, 2009 with the implementation of CR#4, the code used to identify a Recovery Audit

				Contractor (RAC) requested adjustment. This occurs as a result of post-payment review activities done by the RAC.
				DB2 ALIAS : RAC_ADJSTMT_CD SAS ALIAS : RACINDCD STANDARD ALIAS : CLM_RAC_ADJSTMT_IND_CD
				LENGTH : 1
				CODE TABLE : CLM_RAC_ADJSTMT_TB
107. Worker's Compensation Indicator Code	1	456	456	CHAR
				This indicator is used to determine whether the diagnosis codes on the claims are related to the diagnosis codes on the MSP auxiliary file in CWF.
				DB2 ALIAS : CLM_WC_IND_CD SAS ALIAS : WCINDCD
				LENGTH : 1
				CODE TABLE : CLM_WC_IND_TB
				LANGUAGE : C
108. Claim Service Facility Zip Code	9	457	465	CHAR
				Effective with Version 'J', the zip code used to identify the location of the facility where the service was performed.
				DB2 ALIAS : SRVC_FAC_ZIP_CD SAS ALIAS : SRVCFAC STANDARD ALIAS : CLM_SRVC_FAC_ZIP_CD
				LENGTH : 9
109. FILLER	50	466	515	CHAR
				DB2 ALIAS : FILLER
				LENGTH : 50
110. HHA NCH Edit Code Count	2	516	517	NUM

The count of the number of edit codes annotated to the HHA claim during the HCFA's CWFMQA process. The purpose of this count is to indicate how many claim edit trailers are present.

DB2 ALIAS : HHA\_EDIT\_CD\_CNT  
SAS ALIAS : HHEDCNT  
STANDARD ALIAS : HHA\_NCH\_EDIT\_CD\_CNT

LENGTH : 2 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
CLM\_EDIT\_CD\_CNT.

SOURCE : NCH

111. HHA NCH Patch Code Count

2 518 519

NUM

Effective with Version H, the count of the number of HCFA patch codes annotated to the home health claim during the Nearline maintenance process. The purpose of this count is to indicate how many NCH patch trailers are present.

NOTE1: During the Version H conversion this field was populated with data throughout history (back to service year 1991).

NOTE2: Effective with Version 'I' the number of possible occurrences was reduced to 30. Prior to Version 'I' the number of possible occurrences was 99.

DB2 ALIAS : HHA\_PATCH\_CD\_CNT  
SAS ALIAS : HHPATCNT  
STANDARD ALIAS : HHA\_NCH\_PATCH\_CD\_I\_CNT

LENGTH : 2 SIGNED : N

SOURCE : NCH

112. HHA MCO Period Count

1 520 520

NUM

Effective with Version H, the count of the



number of Managed Care Organization (MCO)  
periods reported on an home health agency  
claim. The purpose of this count is to indicate  
how many MCO period trailers are present.

NOTE: Beginning with NCH weekly process date  
10/3/97 this field was populated with data.  
Claims processed prior to 10/3/97 will contain  
zeroes in this field.

DB2 ALIAS : HHA\_MCO\_PRD\_CNT  
SAS ALIAS : HHMCOCNT  
STANDARD ALIAS : HHA\_MCO\_PRD\_CNT

LENGTH : 1 SIGNED : N

SOURCE : NCH

EDIT RULES :  
RANGE: 0 TO 2

113. HHA Claim Demonstration ID Count  
1 521 521

NUM

Effective with Version H, the count of the number  
of claim demonstration IDs reported on an  
HHA claim. The purpose of this count is to  
indicate how many claim demonstration trailers  
are present.

NOTE: During the Version H conversion this field  
was populated with data where a demo was  
identifiable.

DB2 ALIAS : HHA\_DEMO\_ID\_CNT  
SAS ALIAS : HHDEMCNT  
STANDARD ALIAS : HHA\_CLM\_DEMO\_ID\_CNT

LENGTH : 1 SIGNED : N

SOURCE : NCH

EDIT RULES :  
RANGE: 0 TO 5

114. FILLER

2 522 523

NUM

DB2 ALIAS : FILLER

				LENGTH	: 2	SIGNED : N
115. FILLER	2	524	525	NUM		
				DB2	ALIAS : FILLER	
				LENGTH	: 2	SIGNED : N
116. HHA Claim Diagnosis Code Count	2	526	527	NUM		
				The count of the number of diagnosis codes (both principal and secondary) reported on a Home Health Agency (HHA) claim. The purpose of this count is to indicate how many claim diagnosis trailers are present.		
				NOTE: Effective with Version 'J', the count of the number of diagnosis code trailers was expanded from 10 to 25.		
				NOTE1: During the Version 'J' conversion, the diagnosis 'E' codes were removed from the diagnosis trailer and put in the newly created diagnosis 'E' code trailer. Effective with Version 'J', 'E' codes can be found in the diagnosis trailer as secondary diagnosis codes.		
				DB2	ALIAS : HHA_DGNS_CD_CNT	
				SAS	ALIAS : HHDGNCNT	
				LENGTH	: 2	SIGNED : N
				SOURCE	: NCH	
				EDIT RULES :		
				RANGE: 0 TO 25		
117. HHA Claim Diagnosis E Code Count	2	528	529	NUM		
				Effective with Version 'J', the count of the number of diagnosis E codes reported on the home health agency claim. The purpose of this count is to indicate how many diagnosis E trailers are present.		
				DB2	ALIAS : DGNS_E_TRLR_CNT	
				LENGTH	: 2	SIGNED : N
				SOURCE	: CWF	

EDIT RULES :  
RANGE: 0 TO 12

118. FILLER

2 530 531

NUM

DB2 ALIAS : FILLER

LENGTH : 2 SIGNED : N

119. HHA Claim Related Condition Code Count

2 532 533

NUM

The count of the number of condition codes reported on an HHA claim. The purpose of this count is to indicate how many condition code trailers are present.

DB2 ALIAS : HHA\_COND\_CD\_CNT

SAS ALIAS : HHCONCNT

STANDARD ALIAS : HHA\_CLM\_RLT\_COND\_CD\_CNT

LENGTH : 2 SIGNED : N

COMMENTS :

Prior to Version H this field was named:  
CLM\_RLT\_COND\_CD\_CNT.

SOURCE : NCH

EDIT RULES :  
RANGE: 0 TO 30

120. HHA Claim Related Occurrence Code Count

2 534 535

NUM

The count of the number of occurrence codes reported on an HHA claim. The purpose of this count is to indicate how many occurrence code trailers are present.

DB2 ALIAS : HHA\_RLT\_OCRNC\_CNT

SAS ALIAS : HHOCRCNT

STANDARD ALIAS : HHA\_CLM\_RLT\_OCRNC\_CD\_CNT

LENGTH : 2 SIGNED : N

COMMENTS :

Prior to Version H this field was named:  
CLM\_RLT\_OCRNC\_CD\_CNT.

SOURCE : NCH

EDIT RULES :  
RANGE: 0 TO 30

121. HHA Claim Occurrence Span Code Count  
2 536 537

NUM

The count of the number of occurrence span codes reported on an HHA claim. The purpose of the count is to indicate how many span code trailers are present.

DB2 ALIAS : HHA\_OCRNC\_SPAN\_CNT  
SAS ALIAS : HHSPNCNT  
STANDARD ALIAS : HHA\_CLM\_OCRNC\_SPAN\_CD\_CNT

LENGTH : 2 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
CLM\_OCRNC\_SPAN\_CD\_CNT.

SOURCE : NCH

122. HHA Claim Value Code Count  
2 538 539

NUM

The count of the number of value codes reported on an HHA claim. The purpose of the count is to indicate how many value code trailers are present.

DB2 ALIAS : HHA\_CLM\_VAL\_CD\_CNT  
SAS ALIAS : HHVALCNT  
STANDARD ALIAS : HHA\_CLM\_VAL\_CD\_CNT

LENGTH : 2 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
CLM\_VAL\_CD\_CNT.

SOURCE : NCH

EDIT RULES :  
RANGE: 0 TO 36

123. HHA Revenue Center Code Count

	2	540	541	NUM	
					The count of the number of revenue codes reported on an HHA claim. The purpose of the count is to indicate how many revenue center trailers are present.
				DB2	ALIAS : HHA_REV_CNTR_CNT
				SAS	ALIAS : HHREVCNT
				STANDARD	ALIAS : HHA_REV_CNTR_CD_I_CNT
				LENGTH	: 2 SIGNED : N
				COMMENTS :	
					Prior to Version H this field was named: CLM_REV_CNTR_CD_CNT.
					NOTE: During the Version 'I' conversion the number of occurrences changed to 45 (per segment - 450 total for claim). For claims prior to Version 'I' the number of occurrences was 58.
				SOURCE	: NCH
				EDIT RULES :	
					RANGE: 0 TO 45
124. FILLER					
	4	542	545	CHAR	
				DB2	ALIAS : FILLER
				LENGTH	: 4
125. FI HHA Claim Specific Group					
86		546	631	GRP	
					Data pertaining only to fiscal intermediary HHA claims.
				STANDARD	ALIAS : FI_HHA_CLM_SPECF_GRP
126. Claim HHA Low Utilization Payment Adjustment				(LUPA) Indicator Code	
1		546	546	CHAR	
					Effective with Version I, the code used to identify those Home Health PPS claims that have 4 visits or less in a 60-day episode. If an HHA provides 4 visits or less, they will be reimbursed based on a national standardized

per visit rate instead of HHRGs.

NOTE: Beginning 10/1/00, this field will be populated with data. Claims processed prior to 10/1/00 will contain spaces.

DB2 ALIAS : HHA\_LUPA\_IND\_CD  
SAS ALIAS : LUPAIND  
STANDARD ALIAS : CLM\_HHA\_LUPA\_IND\_CD  
TITLE ALIAS : HHA\_TOT\_VISITS

LENGTH : 1

SOURCE : CWF

LIMITATIONS :

REFER TO :  
HHA\_PPS\_LUPA\_IND\_CD\_LIM

CODE TABLE : CLM\_HHA\_LUPA\_IND\_TB

127. Claim HHA Referral Code

1 547 547

CHAR

Effective with Version 'I', the code used to identify the means by which the beneficiary was referred for Home Health services.

NOTE: Beginning 10/1/00, this field will be populated with data. Claims processed prior to 10/1/00 will contain spaces in this field.

DB2 ALIAS : CLM\_HHA\_RFRL\_CD  
SAS ALIAS : HHA\_RFRL  
STANDARD ALIAS : CLM\_HHA\_RFRL\_CD  
TITLE ALIAS : HHA\_REFERRAL\_CODE

LENGTH : 1

SOURCE : CWF

LIMITATIONS :

REFER TO :  
HHA\_RFRL\_CD\_LIM

CODE TABLE : CLM\_HHA\_RFRL\_TB

128. Claim HHA Total Visit Count

2 548 549 PACK

Effective with Version H, the count of the number of HHA visits as derived by CWF.

NOTE1: During the Version H conversion this field was populated with data throughout history (back to service year 1991) using the CWF derivation rule (units associated with revenue center codes 042X, 043X, 044X, 055X, 056X, 057X, 058X and 059X. Value '999' will be displayed if the sum of the revenue center unit count equals or exceeds '999'.

NOTE2: Effective 7/1/99, all HHA claims received with service from dates 7/1/99 and after will be processed as if the units field contains the 15 minute interval count; and each visit revenue code line item will be counted as ONE visit. This field is calculated correctly; but those users who derive the count themselves they will have to revise their routine. NO LONGER IS THE COUNT DERIVED BY ADDING UP THE UNITS FIELDS ASSOCIATED WITH THE HHA VISIT REVENUE CODES.

DB2 ALIAS : HHA\_TOT\_VISIT\_CNT  
SAS ALIAS : VISITCNT  
STANDARD ALIAS : CLM\_HHA\_TOT\_VISIT\_CNT  
TITLE ALIAS : HHA\_TOT\_VISITS

LENGTH : 3 SIGNED : Y

SOURCE : CWF

LIMITATIONS :

REFER TO :  
HHA\_TOT\_VISIT\_CNT\_LIM

129. NCH Qualified Stay From Date  
8

550 557

NUM

Effective with Version H, the beginning date of the beneficiary's qualifying stay (used for internal CWFMQA editing purposes). For inpatient claims, the date relates to the PPS portion of the inlier for which there is no utilization to benefits. For SNF claims, the date relates to a qualifying stay from a hospital that is at least two days in a row if the source of admission is an 'A', or at least three days in a row if the source of admission

is other than 'A'.

NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991).

DB2 ALIAS : QLFY\_STAY\_FROM\_DT  
SAS ALIAS : QLFYFROM  
STANDARD ALIAS : NCH\_QLFY\_STAY\_FROM\_DT  
TITLE ALIAS : QLFYG\_STAY\_FROM\_DT

LENGTH : 8 SIGNED : N

DERIVATIONS :  
DERIVED FROM:  
CLM\_OCRNC\_SPAN\_CD  
CLM\_OCRNC\_SPAN\_FROM\_DT

DERIVATION RULES:  
Based on the presence of occurrence code 70  
move the related occurrence from date to  
NCH\_QLFY\_STAY\_FROM\_DT.

SOURCE : NCH QA Process

EDIT RULES :  
YYYYMMDD

130. NCH Qualify Stay Through Date  
8 558 565

NUM

Effective with Version H, the ending date of the beneficiary's qualifying stay (used for internal CWFMQA editing purposes.) For inpatient claims, the date relates to the PPS portion of the inlier for which there is no utilization to benefits. For SNF claims, the date relates to a qualifying stay from a hospital that is at least two days in a row if the source of admission is an 'A', or at least three days in a row if the source of admission is other than 'A'.

NOTE: During the Version H, conversion this field was populated with data throughout history (back to service year 1991).

DB2 ALIAS : QLFY\_STAY\_THRU\_DT  
SAS ALIAS : QLFYTHRU  
STANDARD ALIAS : NCH\_QLFY\_STAY\_THRU\_DT  
TITLE ALIAS : QLFYG\_STAY\_THRU\_DT



LENGTH : 8 SIGNED : N

DERIVATIONS :  
DERIVED FROM:  
CLM\_OCRNC\_SPAN\_CD  
CLM\_OCRNC\_SPAN\_THRU\_DT

DERIVATION RULES:  
Based on the presence of occurrence code 70  
move the related occurrence thru date to  
NCH\_QLFY\_STAY\_THRU\_DT.

SOURCE : NCH QA Process

EDIT RULES :  
YYYYMMDD

131. NCH Beneficiary Discharge Date  
8 566 573

NUM

Effective with Version H, on an inpatient and  
HHA claim, the date the beneficiary was discharged  
from the facility or died (used for internal CWFMQA  
editing purposes.)

NOTE: During the Version H conversion this field  
was populated with data throughout history (back to  
service year 1991.)

DB2 ALIAS : NCH\_BENE\_DSCHRG\_DT  
SAS ALIAS : DSCHRGDT  
STANDARD ALIAS : NCH\_BENE\_DSCHRG\_DT  
TITLE ALIAS : DISCHARGE\_DT

LENGTH : 8 SIGNED : N

DERIVATIONS :  
DERIVED FROM:  
NCH\_PTNT\_STUS\_IND\_CD  
CLM\_THRU\_DT

DERIVATION RULES:  
Based on the presence of patient discharge status  
code not equal to 30 (still patient), move the claim  
thru date to the NCH\_BENE\_DSCHRG\_DT.

SOURCE : NCH QA Process

EDIT RULES :

YYYYMMDD

132. Claim HHA Care Start Date

8 574 581 NUM

Effective with Version H, the date care started for the HHA services reported on the institutional claim with a from date greater than 3/31/98. The Balanced Budget Act (BBA) required that this field be present on all HHA claims.

NOTE1: Beginning with NCH weekly process date 4/3/98, this field was populated with data. Claims processed prior to 4/3/98 will contain zeroes in this field.

NOTE2: Effective with Version 'I', the start of care date will be moved from the 1st eight positions of the Claim Treatment Authorization Number. Prior to Version 'I' this date was moved from Occurrence Code 27 date field.

DB2 ALIAS : HHA\_CARE\_STRT\_DT  
SAS ALIAS : HHSTRDT  
STANDARD ALIAS : CLM\_HHA\_CARE\_STRT\_DT  
TITLE ALIAS : HHA\_CARE\_START\_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

133. FILLER

50 582 631 CHAR

DB2 ALIAS : FILLER

LENGTH : 50

134. FI HHA Claim Variable Group

VAR 632 15825 GRP

STANDARD ALIAS : FI\_HHA\_CLM\_VAR\_GRP

135. NCH Edit Group

5 632 636 GRP

The number of claim edit trailers is determined by the claim edit code count.

STANDARD ALIAS : NCH\_EDIT\_GRP

OCCURS MIN: 0 OCCURS MAX: 13

DEPENDING ON : HHA\_NCH\_EDIT\_CD\_CNT

136. NCH Edit Trailer Indicator Code

1 632 632 CHAR

Effective with Version H, the code indicating the presence of an NCH edit trailer.

NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).

DB2 ALIAS : EDIT\_TRLR\_IND\_CD

SAS ALIAS : EDITIND

STANDARD ALIAS : NCH\_EDIT\_TRLR\_IND\_CD

LENGTH : 1

SOURCE : NCH QA Process

CODE TABLE : NCH\_EDIT\_TRLR\_IND\_TB

137. NCH Edit Code

4 633 636 CHAR

The code annotated to the claim indicating the CWFMQA editing results so users will be aware of data deficiencies.

NOTE: Prior to Version H only the highest priority code was stored. Beginning 11/98 up to 13 edit codes may be present.

COMMON ALIAS : QA\_ERROR\_CODE

DB2 ALIAS : NCH\_EDIT\_CD

SAS ALIAS : EDIT\_CD

STANDARD ALIAS : NCH\_EDIT\_CD

TITLE ALIAS : QA\_ERROR\_CD

LENGTH : 4

SOURCE : NCH QA EDIT PROCESS

				CODE TABLE	: NCH_EDIT_TB
138. NCH Patch Group	11	1	11	GRP	
				STANDARD ALIAS	: NCH_PATCH_GRP
				OCCURS MIN:	0 OCCURS MAX: 30
				DEPENDING ON	: HHA_NCH_PATCH_CD_I_CNT
139. NCH Patch Trailer Indicator Code	1	1	1	CHAR	
				Effective with Version H, the code indicating the presence of an NCH patch trailer.	
				NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).	
				DB2	ALIAS : PATCH_TRLR_IND_CD
				SAS	ALIAS : PATCHIND
				STANDARD ALIAS	: NCH_PATCH_TRLR_IND_CD
				LENGTH	: 1
				SOURCE	: NCH
				CODE TABLE	: NCH_PATCH_TRLR_IND_TB
140. NCH Patch Code	2	2	3	CHAR	
				Effective with Version H, the code annotated to the claim indicating a patch was applied to the record during an NCH Nearline record conversion and/or during current processing.	
				NOTE: Prior to Version H this field was located in the third and fourth occurrence of the CLM_EDIT_CD.	
				DB2	ALIAS : NCH_PATCH_CD
				SAS	ALIAS : PATCHCD
				STANDARD ALIAS	: NCH_PATCH_CD
				TITLE	ALIAS : NCH_PATCH

				LENGTH	: 2
				SOURCE	: NCH
				CODE TABLE	: NCH_PATCH_TB
141. NCH Patch Applied Date	8	4	11	NUM	
				Effective with Version H, the date the NCH patch was applied to the claim.	
				DB2	ALIAS : NCH_PATCH_APPLY_DT
				SAS	ALIAS : PATCHDT
				STANDARD	ALIAS : NCH_PATCH_APPLY_DT
				TITLE	ALIAS : NCH_PATCH_DT
				LENGTH	: 8 SIGNED : N
				SOURCE	: NCH
				EDIT RULES :	
					YYYYMMDD
142. MCO Period Group	37	1	37	GRP	
				The number of managed care organization (MCO) period data trailers present is determined by the claim MCO period trailer count. This field reflects the two most current MCO periods in the CWF beneficiary history record. It may have no connection to the services on the claim.	
				STANDARD ALIAS :	MCO_PRD_GRP
				OCCURS MIN:	0 OCCURS MAX: 2
				DEPENDING ON :	HHA_MCO_PRD_CNT
143. NCH MCO Trailer Indicator Code	1	1	1	CHAR	
				Effective with Version H, the code indicating the presence of a Managed Care Organization (MCO) trailer.	
				NOTE: Beginning with NCH weekly process date	

10/3/97 this field was populated with data.  
Claims processed prior to 10/3/97 will contain  
spaces in this field.

COBOL ALIAS : MCO\_IND  
DB2 ALIAS : MCO\_TRLR\_IND\_CD  
SAS ALIAS : MCOIND  
STANDARD ALIAS : NCH\_MCO\_TRLR\_IND\_CD  
TITLE ALIAS : MCO\_INDICATOR

LENGTH : 1

SOURCE : NCH QA Process

CODE TABLE : NCH\_MCO\_TRLR\_IND\_TB

144. MCO Contract Number

5 2 6

CHAR

Effective with Version H, this field represents  
the plan contract number of the Managed Care  
Organization (MCO).

NOTE: Beginning with NCH weekly process date  
10/3/97 this field was populated with data.  
Claims processed prior to 10/3/97 will contain  
spaces in this field.

DB2 ALIAS : MCO\_CNTRCT\_NUM  
SAS ALIAS : MCONUM  
STANDARD ALIAS : MCO\_CNTRCT\_NUM  
TITLE ALIAS : MCO\_NUM

LENGTH : 5

SOURCE : CWF

145. MCO Option Code

1 7 7

CHAR

Effective with Version H, the code indicating  
Managed Care Organization (MCO) lock-in  
enrollment status of the beneficiary.

NOTE: Beginning with NCH weekly process date  
10/3/97 this field was populated with data.  
Claims processed prior to 10/3/97 will contain  
spaces in this field.

DB2 ALIAS : MCO\_OPTN\_CD

SAS ALIAS : MCOOPTN  
STANDARD ALIAS : MCO\_OPTN\_CD  
TITLE ALIAS : MCO\_OPTION\_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : MCO\_OPTN\_TB

146. MCO Period Effective Date

8 8 15

NUM

Effective with Version H, the date the beneficiary's enrollment in the Managed Care Organization (MCO) became effective.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

DB2 ALIAS : MCO\_PRD\_EFCTV\_DT  
SAS ALIAS : MCOEFFDT  
STANDARD ALIAS : MCO\_PRD\_EFCTV\_DT  
TITLE ALIAS : MCO\_PERIOD\_EFF\_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

147. MCO Period Termination Date

8 16 23

NUM

Effective with Version H, the date the beneficiary's enrollment in the Managed Care Organization (MCO) was terminated.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

DB2 ALIAS : MCO\_PRD\_TRMNTN\_DT  
SAS ALIAS : MCOTRMDT  
STANDARD ALIAS : MCO\_PRD\_TRMNTN\_DT  
TITLE ALIAS : MCO\_PERIOD\_TERM\_DT

				LENGTH	: 8	SIGNED : N
				SOURCE	: CWF	
				EDIT RULES :	YYYYMMDD	
148. MCO Health PLANID Number	14	24	37	CHAR		
				A placeholder field (effective with Version H) for storing the Health PlanID associated with the Managed Care Organization (MCO). Prior to Version 'I' this field was named: MCO_PAYERID_NUM.		
				DB2	ALIAS :	MCO_PLANID_NUM
				SAS	ALIAS :	MCOPLNID
				STANDARD	ALIAS :	MCO_HLTH_PLANID_NUM
				TITLE	ALIAS :	MCO_PLANID
				LENGTH	: 14	
				COMMENTS :	Prior to Version I this field was named: MCO_PAYERID_NUM.	
				SOURCE	: CWF	
149. Claim Demonstration Identification Group	18	1	18	GRP		
				The number of demonstration identification trailers present is determined by the claim demonstration identification trailer count.		
				STANDARD	ALIAS :	CLM_DEMO_ID_GRP
				OCCURS MIN:	0	OCCURS MAX: 5
				DEPENDING ON :	HHA_CLM_DEMO_ID_CNT	
150. NCH Demonstration Trailer Indicator Code	1	1	1	CHAR		
				Effective with Version H, the code indicating the presence of a demo trailer.		



NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).

COBOL ALIAS : DEMO\_IND  
DB2 ALIAS : NCH\_DEMO\_TRLR\_IND\_  
SAS ALIAS : DEMOIND  
STANDARD ALIAS : NCH\_DEMO\_TRLR\_IND\_CD  
TITLE ALIAS : DEMO\_INDICATOR

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH\_DEMO\_TRLR\_IND\_TB

151. Claim Demonstration Identification Number  
2 2 3

CHAR

Effective with Version H, the number assigned to identify a demo. This field is also used to denote special processing (a.k.a. Special Processing Number, SPN).

NOTE: Prior to Version H, Demo ID was stored in the redefined Claim Edit Group, 4th occurrence, positions 3 and 4. During the H conversion, this field was populated with data throughout history (as appropriate either by moving ID on Version G or by deriving from specific demo criteria).

01 = Nursing Home Case-Mix and Quality: NHCMQ (RUGS) Demo -- testing PPS for SNFs in 6 states, using a case-mix classification system based on resident characteristics and actual resources used. The claims carry a RUGS indicator and one or more revenue center codes in the 9,000 series.

NOTE1: Effective for SNF claims with NCH weekly process date after 2/8/96 (and service date after 12/31/95) -- beginning 4/97, Demo ID '01' was derived in NCH based on presence of RUGS phase # '2','3' or '4' on incoming claim; since 7/97, CWF has been adding ID to claim.

NOTE2: During the Version H conversion, Demo ID '01' was populated back to NCH weekly process date 2/9/96 based on the RUGS phase indicator (stored in Claim Edit Group, 3rd occurrence, 4th position,

in Version G).

02 = National HHA Prospective Payment Demo -- testing PPS for HHAs in 5 states, using two alternate methods of paying HHAs: per visit by type of HHA visit and per episode of HH care.

NOTE1: Effective for HHA claims with NCH weekly process date after 5/31/95 -- beginning 4/97, Demo ID '02' was derived in NCH based on HCFA/CHPP-supplied listing of provider # and start/stop dates of participants.

NOTE2: During the Version H conversion, Demo ID '02' was populated back to NCH weekly process date 6/95 based on the CHPP criteria.

03 = Telemedicine Demo -- testing covering traditionally noncovered physician services for medical consultation furnished via two-way, interactive video systems (i.e. teleconsultation) in 4 states. The claims contain line items with 'QQ' HCPCS code.

NOTE1: Effective for physician/supplier (nonDMERC) claims with NCH weekly process date after 12/31/96 (and service date after 9/30/96) -- since 7/97, CWF has been adding Demo ID '03' to claim.

NOTE2: During Version H conversion, Demo ID '03' was populated back to NCH weekly process date 1/97 based on the presence of 'QQ' HCPCS on one or more line items.

04 = United Mine Workers of America (UMWA) Managed Care Demo -- testing risk sharing for Part A services, paying special capitation rates for all UMWA beneficiaries residing in 13 designated counties in 3 states. Under the demo, UMWA will waive the 3-day qualifying hospital stay for a SNF admission. The claims contain TOB '18X','21X','28X' and '51X'; condition code = W0; claim MCO paid switch = not '0'; and MCO contract # = '90091'.

NOTE: Initially scheduled to be implemented for all SNF claims for admission or services on 1/1/97 or later, CWF did not transmit any Demo ID '04' annotated claims until on or about 2/98.

05 = Medicare Choices (MCO encounter data) demo -- testing expanding the type of Managed Care plans available and different payment methods at 16 MCOs in 9 states. The claims contain one of the specific MCO Plan Contract # assigned to the Choices Demo site.

NOTE1: Effective for all claim types with NCH weekly process date after 7/31/97 -- CWF adds Demo ID '05' to claim based on the presence of the MCO Plan Contract #. \*\*\*Demonstration was terminated 12/31/2000.\*\*\*

NOTE2: During the Version H conversion, Demo ID '05' was populated back to NCH weekly process date 8/97 based on the presence of the Choices indicator (stored as an alpha character cross-walked from MCO plan contract # in the Claim Edit Group, 4th occurrence, 2nd position, in Version 'G').

06 = Coronary Artery Bypass Graft (CABG) Demo -- testing bundled payment (all-inclusive global pricing) for hospital + physician services related to CABG surgery in 7 hospitals in 7 states. The inpatient claims contain a DRG '106' or '107'.

NOTE1: Effective for Inpatient claims and physician/supplier claims with Claim Edit Date no earlier than 6/1/91 (not all CABG sites started at the same time) -- on 5/1/97, CWF started transmitting Demo ID '06' on the claim. The FI adds the ID to the claim based on the presence of DRG '106' or '107' from specific providers for specified time periods; the carrier adds the ID to the claim based on receiving 'Daily Census List' from participating hospitals. \*\*\*Demo terminated in 1998.\*\*\*

NOTE2: During the Version H conversion, any claims where Medicare is the primary payer that were not already identified as Demo ID '06' (stored in the redefined Claim Edit Group, 4th occurrence, positions 3 and 4, Version G) were annotated based on the following criteria: Inpatient - presence of DRG '106' or '107' and a provider number=220897, 150897,

380897,450897,110082,230156 or 360085 for specified service dates; noninstitutional - presence of HCPCS modifier (initial and/or second) = 'Q2' and a carrier number =00700/31143 00630,01380,00900,01040/00511,00710,00623, or 13630 for specified service dates.

07 = Virginia Cardiac Surgery Initiative (VCSI) (formerly referred to as Medicare Quality Partnerships Demo) -- this is a voluntary consortium of the cardiac surgery physician groups and the non-Veterans Administration hospitals providing open heart surgical services in the Commonwealth of Virginia. The goal of the demo is to share data on quality and process innovations in an attempt to improve the care for all cardiac patients. The demonstration only affects those FIs that process claims from hospitals in Virginia and the carriers that process claims from physicians providing inpatient services at those hospitals. The hospitals will be reimbursed on a global payment basis for selected cardiac surgical diagnosis related groups (DRGs). The inpatient claims will contain a DRG '104', '105', '106', '107', '109'; the related physician/supplier claims will contain the claim payment denial reason code = 'D'.

NOTE: The implementation date for this demo is 4/1/03. The FI will annotate the claim with the demo id add Demo ID '07' to claim. For carrier claims, the Standard Systems will annotate the claim with the '07' demo number.

08 = Provider Partnership Demo -- testing per-case payment approaches for acute inpatient hospitalizations, making a lump-sum payment (combining the normal Part A PPS payment with the Part B allowed charges into a single fee schedule) to a Physician/Hospital Organization for all Part A and Part B services associated with a hospital admission. From 3 to 6 hospitals in the Northeast and Mid-Atlantic regions may participate in the demo.

NOTE: The demo is on HOLD. The FI and carrier will add Demo ID '08' to claim.

15 = ESRD Managed Care (MCO encounter data) -- testing open enrollment of ESRD beneficiaries and capitation rates adjusted for patient

treatment needs at 3 MCOs in 3 States. The claims contain one of the specific MCO Plan Contract # assigned to the ESRD demo site.

NOTE: Effective 10/1/97 (but not actually implemented at a site until 1/1/98) for all claim types -- the FI and carrier add Demo ID '15' to claim based on the presence of the MCO plan contract #.

30 = Lung Volume Reduction Surgery (LVRS) or National Emphysema Treatment Trial (NETT) Clinical Study -- evaluating the effectiveness of LVRS and maximum medical therapy (including pulmonary rehab) for Medicare beneficiaries in last stages of emphysema at 18 hospitals nationally, in collaboration with NIH.

NOTE: Effective for all claim types (except DMERC) with NCH weekly process date after 2/27/98 (and service date after 10/31/97) -- the FI adds Demo ID '30' based on the presence of a condition code = EY; the participating physician (not the carrier) adds ID to the noninstitutional claim. DUE TO THE SENSITIVE NATURE OF THIS CLINICAL TRIAL AND UNDER THE TERMS OF THE INTERAGENCY AGREEMENT WITH NIH, THESE CLAIMS ARE PROCESSED BY CWF AND TRANSMITTED TO HCFA BUT NOT STORED IN THE NEARLINE FILE (access is restricted to study evaluators only).

31 = VA Pricing Special Processing (SPN) -- not really a demo but special request from VA due to court settlement; not Medicare services but VA inpatient and physician services submitted to FI 00400 and Carrier 00900 to obtain Medicare pricing -- CWF WILL PROCESS VA CLAIMS ANNOTATED WITH DEMO ID '31', BUT WILL NOT TRANSMIT TO HCFA (not in Nearline File).

37 = Medicare Coordinated Care Demonstration -- to test whether coordinated care services furnished to certain beneficiaries improves outcome of care and reduces Medicare expenditures under Part A and Part B. There will be at least 14 Coordinated Care Entities (CCEs). The selected entities will be assigned a provider number specifically for the demonstration services.

NOTE: All claims will be processed by carriers;

no FI processing (except for Georgetown site)

37 = Medicare Disease Management (DMD) -- the purpose of this demonstration is to study the impact on costs and health outcomes of applying disease management services supplemented with coverage for prescription drugs for certain Medicare beneficiaries with diagnosed, advanced-stage congestive heart failure, diabetes, or coronary heart disease. Three demonstration sites will be used for this demonstration and it will last for 3 years. (Effective 4/1/2003).

NOTE: All claims will be processed by NHIC-California (Carrier). FIs will only serve as a conduit for transmitting information to and from CWF about the NOEs.

38 = Physician Encounter Claims - the purpose of this demo id is to identify the physician encounter claims being processed at the HCFA Data Center (HDC). This number will help EDS in making the claim go through the appropriate processing logic, which differs from that for fee-for-service. \*\*NOT IN NCH.\*\*

NOTE: Effective October, 2000. Demo ids will not be assigned to Inpatient and Outpatient encounter claims.

39 = Centralized Billing of Flu and PPV Claims -- The purpose of this demo is to facilitate the processing carrier, Trailblazers, paying flu and PPV claims based on payment localities. Providers will be giving the shots throughout the country and transmitting the claims to Trailblazers for processing.

NOTE: Effective October, 2000 for carrier claims.

40 = Payment of Physician and Nonphysician Services in certain Indian Providers -- the purpose of this demo is to extend payment for services of physician and nonphysician practitioners furnished in hospitals and ambulatory care clinics. Prior to the legislation change in BIPA, reimbursement for Medicare services provided in IHS facilities was limited to services provided in hospitals and skilled nursing facilities. This change will allow payment for IHS, Tribe and Tribal Organization providers under the Medicare physician fee schedule.

NOTE: Effective July 1, 2001 for institutional and

carrier claims.

48 = Medical Adult Day-Care Services -- the purpose of this demonstration is to provide, as part of the episode of care for home health services, medical adult day care services to Medicare beneficiaries as a substitute for a portion of home health services that would otherwise be provided in the beneficiaries home. This demo would last approx. 3 years in not more than 5 sites. Payment for each home health service episode of care will be set at 95% of the amount that would otherwise be paid for home health services provided entirely in the home.

NOTE: Effective July 5, 2005 for HHA claims.

DB2 ALIAS : CLM\_DEMO\_ID\_NUM  
SAS ALIAS : DEMONUM  
STANDARD ALIAS : CLM\_DEMO\_ID\_NUM  
TITLE ALIAS : DEMO\_ID

LENGTH : 2

SOURCE : CWF

152. Claim Demonstration Information Text

15 4 18

CHAR

Effective with Version H, the text field that contains related demo information. For example, a claim involving a CHOICES demo id '05' would contain the MCO plan contract number in the first five positions of this text field.

NOTE: During the Version H conversion this field was populated with data throughout history.

DB2 ALIAS : CLM\_DEMO\_INFO\_TXT  
SAS ALIAS : DEMO\_TXT  
STANDARD ALIAS : CLM\_DEMO\_INFO\_TXT  
TITLE ALIAS : DEMO\_INFO

LENGTH : 15

DERIVATIONS :

DERIVATION RULES:

Demo ID = 01 (RUGS) -- the text field will contain a 2, 3 or 4 to denote the RUGS phase. If RUGS phase is blank or not one of the above the text field

will reflect 'INVALID'. NOTE: In Version 'G', RUGS phase was stored in redefined Claim Edit Group, 3rd occurrence, 4th position.

Demo ID = 02 (Home Health demo) -- the text field will contain PROV#. When demo number not equal to 02 then text will reflect 'INVALID'.

Demo ID = 03 (Telemedicine demo) -- text field will contain the HCPCS code. If the required HCPCS is not shown then the text field will reflect 'INVALID'.

Demo ID = 04 (UMWA) -- text field will contain W0 denoting that condition code W0 was present. If condition code W0 not present then the text field will reflect 'INVALID'.

Demo ID = 05 (CHOICES) -- the text field will contain the CHOICES plan number, if both of the following conditions are met: (1) CHOICES plan number present and PPS or Inpatient claim shows that 1st 3 positions of provider number as '210' and the admission date is within HMO effective/termination date; or non-PPS claim and the from date is within HMO effective/termination date and (2) CHOICES plan number matches the HMO plan number. If either condition is not met the text field will reflect 'INVALID CHOICES PLAN NUMBER'. When CHOICES plan number not present, text will reflect 'INVALID'.

NOTE: In Version 'G', a valid CHOICES plan ID is stored as alpha character in redefined Claim Edit Group, 4th occurrence, 2nd position. If invalid, CHOICES indicator 'ZZ' displayed.

Demo ID = 15 (ESRD Managed Care) -- text field will contain the ESRD/MCO plan number. If ESRD/MCO plan number not present the field will reflect 'INVALID'.

Demo ID = 38 (Physician Encounter Claims) -- text field will contain the MCO plan number. When MCO plan number not present the field will reflect 'INVALID'.

SOURCE : CWF



LIMITATIONS :

REFER TO :  
CHOICES\_DEMO\_LIM

153. Claim Diagnosis Group

9 1 9 GRP

The number of claim diagnosis trailers is determined by the claim diagnosis code count. The principal diagnosis is the first occurrence. The principal diagnosis is also stored (redundantly) in the fixed portion of the record.

NOTE:

Prior to Version H this group was named: CLM\_OTHR\_DGNS\_GRP and did not contain the CLM\_PRNCPAL\_DGNS\_CD.

STANDARD ALIAS : CLM\_DGNS\_GRP

OCCURS MIN: 0 OCCURS MAX: 25

DEPENDING ON : HHA\_CLM\_DGNS\_CD\_J\_CNT

154. NCH Diagnosis Trailer Indicator Code

1 1 1 CHAR

Effective with Version H, the code indicating the presence of a diagnosis trailer.

NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).

DB2 ALIAS : DGNS\_TRLR\_IND\_CD  
SAS ALIAS : DGNSIND  
STANDARD ALIAS : NCH\_DGNS\_TRLR\_IND\_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH\_DGNS\_TRLR\_IND\_TB

155. Claim Diagnosis Version Code

1 2 2 CHAR

Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9 or ICD-10.

NOTE: With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2013.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : DVRSNCD

LENGTH : 1

CODE TABLE : CLM\_DGNS\_VRSN\_TB

156. Claim Diagnosis Code

7 3 9

CHAR

The diagnosis code identifying the beneficiary's principal or other diagnosis (including E code).

NOTE:

Prior to Version H, the principal diagnosis code was not stored with the 'OTHER' diagnosis codes. During the Version H conversion the CLM\_PRNCPAL\_DGNS\_CD was added as the first occurrence.

NOTE1: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10.

NOTE2: Effective with Version 'J', the diagnosis E codes are stored in a separate trailer (CLM\_DGNS\_E\_GRP).

DB2 ALIAS : CLM\_DGNS\_CD  
SAS ALIAS : DGNS\_CD

LENGTH : 7

EDIT RULES :  
ICD-9-CM

157. Claim Diagnosis E Group

9 1 9

GRP

The number of claim diagnosis E trailers is determined by the claim diagnosis E code count.  
This group contains the diagnosis E codes and

the diagnosis E version code.

STANDARD ALIAS : CLM\_DGNS\_E\_GRP

OCCURS MIN: 0 OCCURS MAX: 12

DEPENDING ON : HHA\_CLM\_DGNS\_E\_CD\_CNT

158. NCH Diagnosis E Trailer Indicator Code

1 1 1

CHAR

Effective with Version 'J', the code indicating the presence of a diagnosis E trailer.

NOTE: During the Version 'J' conversion, this field was populated throughout history.

DB2 ALIAS : DGNS\_E\_TRLR\_IND\_CD

SAS ALIAS : ETRLRIND

LENGTH : 1

SOURCE :

CODE TABLE : NCH\_DGNS\_E\_TRLR\_IND\_TB

159. Claim Diagnosis Version Code

1 2 2

CHAR

Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9 or ICD-10.

NOTE: With 5010, the diagnosis and procedure codes have been expanded to accomodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2013.

DB2 ALIAS : UNDEFINED

SAS ALIAS : EVRSNCD

LENGTH : 1

CODE TABLE : CLM\_DGNS\_VRSN\_TB

160. Claim Diagnosis E Code

7 3 9

CHAR

Effective with Version J, the code used to identify the external cause of injury, poisoning, or other adverse affect.

NOTE: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accomodate the future implementation of ICD-10.

During the Version 'J' conversion, all 'E' codes in the diagnosis trailer were moved to the diagnosis 'E' trailer.

With the implementation of Version 'J', diagnosis 'E' codes can also be found in the regular diagnosis trailer.

DB2 ALIAS : CLM\_DGNS\_E\_CD  
SAS ALIAS : EDGNSCD

LENGTH : 7

SOURCE : CWF

EDIT RULES :  
ICD-9-CM

161. Claim Related Condition Group  
3 1 3

GRP

The number of claim related condition trailers is determined by the claim related condition code count. Effective 10/93, up to 30 occurrences can be reported on an institutional claim. Prior to 10/93, up to 10 occurrences could be reported.

STANDARD ALIAS : CLM\_RLT\_COND\_GRP

OCCURS MIN: 0 OCCURS MAX: 30

DEPENDING ON : HHA\_CLM\_RLT\_COND\_CD\_CNT

162. NCH Condition Trailer Indicator Code  
1 1 1

CHAR

Effective with Version H, the code indicating the presence of a condition code trailer.

NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).

DB2 ALIAS : COND\_TRLR\_IND\_CD  
SAS ALIAS : CONDIND  
STANDARD ALIAS : NCH\_COND\_TRLR\_IND\_CD

				LENGTH	: 1
				SOURCE	: NCH
				CODE TABLE	: NCH_COND_TRLR_IND_TB
163. Claim Related Condition Code	2	2	3	CHAR	
				The code that indicates a condition relating to an institutional claim that may affect payer processing.	
				DB2	ALIAS : CLM_RLT_COND_CD
				SAS	ALIAS : RLT_COND
				STANDARD	ALIAS : CLM_RLT_COND_CD
				TITLE	ALIAS : RELATED_CONDITION_CD
				LENGTH	: 2
				SOURCE	: CWF
				CODE TABLE	: CLM_RLT_COND_TB
164. Claim Related Occurrence Group	11	1	11	GRP	
				The number of claim related occurrence trailers is determined by the claim related occurrence code count. Effective 10/93, up to 30 occurrences can be reported on an institutional claim. Prior to 10/93, up to 10 occurrences could be reported.	
				STANDARD ALIAS : CLM_RLT_OCRNC_GRP	
				OCCURS MIN: 0 OCCURS MAX: 30	
				DEPENDING ON : HHA_CLM_RLT_OCRNC_CD_CNT	
165. NCH Occurrence Trailer Indicator Code	1	1	1	CHAR	
				Effective with Version H, the code indicating the presence of a occurrence code trailer.	
				NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).	

DB2 ALIAS : OCRNC\_TRLR\_IND\_CD  
SAS ALIAS : OCRNCIND  
STANDARD ALIAS : NCH\_OCRNC\_TRLR\_IND\_CD  
  
LENGTH : 1  
  
SOURCE : NCH  
  
CODE TABLE : NCH\_OCRNC\_TRLR\_IND\_TB

166. Claim Related Occurrence Code  
2 2 3

CHAR

The code that identifies a significant event relating to an institutional claim that may affect payer processing. These codes are claim-related occurrences that are related to a specific date.

DB2 ALIAS : CLM\_RLT\_OCRNC\_CD  
SAS ALIAS : OCRNC\_CD  
STANDARD ALIAS : CLM\_RLT\_OCRNC\_CD  
TITLE ALIAS : OCCURRENCE\_CD

LENGTH : 2  
  
SOURCE : CWF  
  
CODE TABLE : CLM\_RLT\_OCRNC\_TB

167. Claim Related Occurrence Date  
8 4 11

NUM

The date associated with a significant event related to an institutional claim that may affect payer processing.

DB2 ALIAS : CLM\_RLT\_OCRNC\_DT  
SAS ALIAS : OCRNCDT  
STANDARD ALIAS : CLM\_RLT\_OCRNC\_DT  
TITLE ALIAS : RLT\_OCRNC\_DT

LENGTH : 8 SIGNED : N  
  
SOURCE : CWF

EDIT RULES :  
YYYYMMDD

168. Claim Occurrence Span Group

19 1 19 GRP

The number of claim occurrence span trailers is determined by the claim occurrence span code count. Up to 10 occurrences may be reported on an institutional claim.

STANDARD ALIAS : CLM\_OCRNC\_SPAN\_GRP

OCCURS MIN: 0 OCCURS MAX: 10

DEPENDING ON : HHA\_CLM\_OCRNC\_SPAN\_CD\_CNT

169. NCH Span Trailer Indicator Code

1 1 1 CHAR

Effective with Version H, the code indicating the presence of a span code trailer.

NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).

DB2 ALIAS : SPAN\_TRLR\_IND\_CD

SAS ALIAS : SPANIND

STANDARD ALIAS : NCH\_SPAN\_TRLR\_IND\_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH\_SPAN\_TRLR\_IND\_TB

170. Claim Occurrence Span Code

2 2 3 CHAR

The code that identifies a significant event relating to an institutional claim that may affect payer processing. These codes are claim-related occurrences that are related to a time period (span of dates).

DB2 ALIAS : CLM\_OCRNC\_SPAN\_CD

SAS ALIAS : SPAN\_CD

STANDARD ALIAS : CLM\_OCRNC\_SPAN\_CD

TITLE ALIAS : SPAN\_CD

LENGTH : 2

				SOURCE	: CWF
				CODE TABLE	: CLM_OCRNC_SPAN_TB
171. Claim Occurrence Span From Date	8	4	11	NUM	
				The from date of a period associated with an occurrence of a specific event relating to an institutional claim that may affect payer processing.	
				DB2	ALIAS : OCRNC_SPAN_FROM_DT
				SAS	ALIAS : SPANFROM
				STANDARD	ALIAS : CLM_OCRNC_SPAN_FROM_DT
				TITLE	ALIAS : SPAN_FROM_DT
				LENGTH	: 8 SIGNED : N
				SOURCE	: CWF
				EDIT RULES :	YYYYMMDD
172. Claim Occurrence Span Through Date	8	12	19	NUM	
				The thru date of a period associated with an occurrence of a specific event relating to an institutional claim that may affect payer processing.	
				DB2	ALIAS : OCRNC_SPAN_THRU_DT
				SAS	ALIAS : SPANTHRU
				STANDARD	ALIAS : CLM_OCRNC_SPAN_THRU_DT
				TITLE	ALIAS : SPAN_THRU_DT
				LENGTH	: 8 SIGNED : N
				SOURCE	: CWF
				EDIT RULES :	YYYYMMDD
173. Claim Value Group	9	1	9	GRP	
				The number of claim value data trailers present is determined by the claim value code count. Effective	



10/93, up to 36 occurrences can be reported on an institutional claim. Prior to 10/93, up to 10 occurrences could be reported.

STANDARD ALIAS : CLM\_VAL\_GRP

OCCURS MIN: 0 OCCURS MAX: 36

DEPENDING ON : HHA\_CLM\_VAL\_CD\_CNT

174. NCH Value Trailer Indicator Code

1 1 1

CHAR

Effective with Version H, the code indicating the presence of a value code trailer.

NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).

DB2 ALIAS : VAL\_TRLR\_IND\_CD

SAS ALIAS : VALIND

STANDARD ALIAS : NCH\_VAL\_TRLR\_IND\_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH\_VAL\_TRLR\_IND\_TB

175. Claim Value Code

2 2 3

CHAR

The code indicating the value of a monetary condition which was used by the intermediary to process an institutional claim.

DB2 ALIAS : CLM\_VAL\_CD

SAS ALIAS : VAL\_CD

STANDARD ALIAS : CLM\_VAL\_CD

TITLE ALIAS : VALUE\_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : CLM\_VAL\_TB

176. Claim Value Amount

6 4 9

PACK

The amount related to the condition identified in the CLM\_VAL\_CD which was used by the intermediary to process the institutional claim.

DB2 ALIAS : CLM\_VAL\_AMT  
SAS ALIAS : VAL\_AMT  
STANDARD ALIAS : CLM\_VAL\_AMT  
TITLE ALIAS : VALUE\_AMOUNT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

EDIT RULES :  
\$\$\$\$\$\$\$CC

177. Claim Revenue Center Group  
297 1 297 GRP

The number of claim revenue center data trailers is determined by the claim revenue center code count. Effective 7/7/00, up to 450 occurrences may be reported on an institutional claim. The increase in the number of revenue center lines causes each claim to be broken out into records/segments (up to 10). Each record can have up to 45 occurrences of revenue center lines. Prior to 7/7/00, up to 58 occurrences may be reported on an institutional claim. Claims submitted prior to 10/93, contained up to 28 occurrences.

STANDARD ALIAS : CLM\_REV\_CNTR\_GRP

OCCURS MIN: 0 OCCURS MAX: 45

DEPENDING ON : HHA\_REV\_CNTR\_CD\_I\_CNT

178. NCH Revenue Center Trailer Indicator Code  
1 1 1 CHAR

Effective with Version H, the code identifying the revenue center trailer.

During the Version H conversion this field was populated with data throughout history (back to service year 1991).

DB2 ALIAS : REV\_CNTR\_TRLR\_CD

SAS ALIAS : REVIND  
 STANDARD ALIAS : NCH\_REV\_CNTR\_TRLR\_IND\_CD  
  
 LENGTH : 1  
  
 SOURCE : NCH  
  
 CODE TABLE : NCH\_REV\_TRLR\_IND\_TB

179. Revenue Center Code

4 2 5

CHAR

The provider-assigned revenue code for each cost center for which a separate charge is billed (type of accommodation or ancillary). A cost center is a division or unit within a hospital (e.g., radiology, emergency room, pathology).  
 EXCEPTION: Revenue center code 0001 represents the total of all revenue centers included on the claim.

COBOL ALIAS : REV\_CD  
 DB2 ALIAS : REV\_CNTR\_CD  
 SAS ALIAS : REV\_CNTR  
 STANDARD ALIAS : REV\_CNTR\_CD  
 TITLE ALIAS : REVENUE\_CENTER\_CD

LENGTH : 4  
  
 SOURCE : CWF  
  
 CODE TABLE : REV\_CNTR\_TB

180. Revenue Center Date

8 6 13

NUM

Effective with Version H, the date applicable to the service represented by the revenue center code. This field may be present on any of the institutional claim types. For home health claims the service date should be present on all bills with from date greater than 3/31/98. With the implementation of outpatient PPS, hospitals will be required to enter line item dates of service for all outpatient services which require a HCPCS.

NOTE1: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

NOTE2: When revenue center code equals '0022'

(SNF PPS) and revenue center HCPCS code not equal to 'AAA00' (default for no assessment), date represents the MDS RAI assessment reference date.

NOTE3: When revenue center code equals '0023' (HHPPS), the date on the initial claim (RAP) must represent the first date of service in the episode. The final claim will match the '0023' information submitted on the initial claim. The SCIC (significant change in condition) claims may show additional '0023' revenue lines in which the date represents the date of the first service under the revised plan of treatment.

DB2 ALIAS : REV\_CNTR\_DT  
STANDARD ALIAS : REV\_CNTR\_DT  
TITLE ALIAS : REV\_CNTR\_DATE

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

181. Revenue Center 1st ANSI Code  
5 14 18

CHAR

The first code used to identify the detailed reason an adjustment was made (e.g. reason for denial or reducing payment).

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: Beginning with NCH weekly process date

7/7/00, this field will be populated with data.  
Claims processed prior to 7/7/00 will contain  
spaces in this field.

DB2 ALIAS : REV\_CNTR\_ANSI1\_CD  
SAS ALIAS : REVANSI1  
STANDARD ALIAS : REV\_CNTR\_ANSI\_1\_CD  
TITLE ALIAS : ANSI\_CD

LENGTH : 5

SOURCE : CWF

CODE TABLE : REV\_CNTR\_ANSI\_TB

182. Revenue Center 2nd ANSI Code  
5

19

23

CHAR

The second code used to identify the  
detailed reason an adjustment was made  
(e.g. reason for denial or reducing payment).

NOTE1: This field is populated for those claims  
that are required to process through Outpatient  
PPS Pricer. The type of bills (TOB) required to  
process through are: 12X, 13X, 14X (except Maryland  
providers, Indian Health Providers, hospitals located  
in American Samoa, Guam and Saipan and Critical  
Access Hospitals (CAH)); 76X; 75X and 34X if  
certain HCPCS are on the bill; and any outpatient  
type of bill with a condition code '07' and certain  
HCPCS. These claim types could have lines that are  
not required to price under OPPS rules so those  
lines would not have data in this field.

Additional exception: Virgin Island hospitals and  
hospitals that furnish only inpatient Part B services  
with dates of service 1/1/02 and forward.

NOTE2: Beginning with NCH weekly process date  
7/7/00, this field will be populated with data.  
Claims processed prior to 7/7/00 will contain  
spaces in this field.

DB2 ALIAS : REV\_CNTR\_ANSI2\_CD  
SAS ALIAS : REVANSI2  
STANDARD ALIAS : REV\_CNTR\_ANSI\_2\_CD  
TITLE ALIAS : ANSI\_CD

LENGTH : 5

			SOURCE	: CWF
183. Revenue Center 3rd ANSI Code	24	28	CHAR	
5				
<p>The third code used to identify the detailed reason an adjustment was made (e.g. reason for denial or reducing payment).</p> <p>NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPFS rules so those lines would not have data in this field.</p> <p>Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.</p> <p>NOTE2: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.</p> <p>DB2 ALIAS : REV_CNTR_ANSI3_CD  SAS ALIAS : REVANSI3  STANDARD ALIAS : REV_CNTR_ANSI_3_CD  TITLE ALIAS : ANSI_CD</p> <p>LENGTH : 5</p> <p>SOURCE : CWF</p>				
184. Revenue Center 4th ANSI Code	29	33	CHAR	
5				
<p>The fourth code used to identify the detailed reason an adjustment was made (e.g. reason for denial or reducing payment).</p> <p>NOTE1: This field is populated for those claims that are required to process through Outpatient</p>				

PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.

DB2 ALIAS : REV\_CNTR\_ANSI4\_CD  
SAS ALIAS : REVANSI4  
STANDARD ALIAS : REV\_CNTR\_ANSI\_4\_CD  
TITLE ALIAS : ANSI\_CD

LENGTH : 5

SOURCE : CWF

185. Revenue Center APC/HIPPS Code

5 34 38

CHAR

Effective with Version 'I', this field was created to house two pieces of data. The Ambulatory Payment Classification (APC) code and the HIPPS code. The APC is used to identify groupings of outpatient services. APC codes are used to calculate payment for services under OPPS. The APC is a four byte field. The HIPPS codes are used to identify patient classifications for SNFPPS, HHPPS and IRFPPS that will be used to calculate payment. The HIPPS code is a five byte field.

NOTE1: The APC field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient

type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: Under SNFPPS, HHPPS & IRFPPS, HIPPS codes are stored in the HCPCS field. \*\*EXCEPTION: if a HHPPS HIPPS code is downcoded/upcoded the downcoded/upcoded HIPPS will be stored in this field.

NOTE3: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.

DB2 ALIAS : REV\_APC\_HIPPS\_CD S  
SAS ALIAS : APCHIPPS  
STANDARD ALIAS : REV\_CNTR\_APC\_HIPPS\_CD  
TITLE ALIAS : APC\_HIPPS

LENGTH : 5

SOURCE : CWF

CODE TABLE : REV\_CNTR\_APC\_TB

186. Revenue Center Healthcare Common Procedure Coding System Code  
5 39 43 CHAR

Healthcare Common Procedure Coding System (HCPCS) is a collection of codes that represent procedures, supplies, products and services which may be provided to Medicare beneficiaries and to individuals enrolled in private health insurance programs. The codes are divided into three levels, or groups, as described below:

DB2 ALIAS : REV\_CNTR\_HCPCS\_CD  
STANDARD ALIAS : REV\_CNTR\_HCPCS\_CD  
TITLE ALIAS : HCPCS\_CD

LENGTH : 5

COMMENTS :  
Prior to Version H this field was named:



HCPCS\_CD. With Version H, a prefix was added to denote the location of this field on each claim type (institutional: REV\_CNTR and non-institutional: LINE).

NOTE: When revenue center code = '0022' (SNF PPS), '0023' (HH PPS), or '0024' (IRF PPS); this field contains the Health Insurance PPS (HIPPS) code.

The HIPPS code for SNF PPS contains the rate code/assessment type that identifies (1) RUG-III group the beneficiary was classified into as of the RAI MDS assessment reference date and (2) the type of assessment for payment purposes.

The HIPPS code for Home Health PPS identifies (1) the three case-mix dimensions of the HHRG system, clinical, functional and utilization, from which a beneficiary is assigned to one of the 80 HHRG categories and (2) it identifies whether or not the elements of the code were computed or derived. The HHRGs, represented by the HIPPS coding, will be the basis of payment for each episode.

The HIPPS code (CMG Code) for IRF PPS identifies the clinical characteristics of the beneficiary. The HIPPS rate/CMG code (AXXXY - DXXYY) must contain five digits. The first position of the code is an A, B, C, or 'D'. The HIPPS code beginning with an 'A' in front of the CMG is defined as without comorbidity. The 'B' in front of the CMG is defined as with comorbidity for Tier 1. The 'C' is defined as comorbidity for Tier 2 and 'D' is defined as comorbidity for Tier 3. The 'XX' in the HIPPS rate code is the Rehabilitation Impairment Code (RIC). The 'YY' is the sequential number system within the RIC.

For SNF PPS, HH PPS & IRF PPS HIPPS values see CLM\_HIPPS\_TB.

Level I  
Codes and descriptors copyrighted by the American Medical Association's Current Procedural Terminology, Fourth Edition (CPT-4). These are 5 position numeric codes representing physician and nonphysician services.

\*\*\*\* Note: \*\*\*\*  
CPT-4 codes including both long and short

descriptions shall be used in accordance with the HCFA/AMA agreement. Any other use violates the AMA copyright.

#### Level II

Includes codes and descriptors copyrighted by the American Dental Association's Current Dental Terminology, Second Edition (CDT-2). These are 5 position alpha-numeric codes comprising the D series. All other level II codes and descriptors are approved and maintained jointly by the alpha-numeric editorial panel (consisting of HCFA, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association). These are 5 position alpha-numeric codes representing primarily items and nonphysician services that are not represented in the level I codes.

#### Level III

Codes and descriptors developed by Medicare carriers for use at the local (carrier) level. These are 5 position alpha-numeric codes in the W, X, Y or Z series representing physician and nonphysician services that are not represented in the level I or level II codes.

#### LIMITATIONS :

REFER TO :  
HHA\_HCPCS\_LIM

CODE TABLE : CLM\_HIPPS\_TB

187. Revenue Center HCPCS Initial Modifier Code  
2 44 45

CHAR

A first modifier to the procedure code to enable a more specific procedure identification for the claim.

DB2 ALIAS : REV\_HCPCS\_MDFR\_CD  
STANDARD ALIAS : REV\_CNTR\_HCPCS\_INITL\_MDFR\_CD  
TITLE ALIAS : INITIAL\_MODIFIER

LENGTH : 2

#### COMMENTS :

Prior to Version H this field was named:  
HCPCS\_INITL\_MDFR\_CD. With Version H, a prefix  
was added to denote the location of this field

on each claim type (institutional: REV\_CNTR and non-institutional: LINE).

SOURCE : CWF

EDIT RULES :  
Carrier Information File

188. Revenue Center HCPCS Second Modifier Code  
2 46 47

CHAR

A second modifier to the procedure code to make it more specific than the first modifier code to identify the procedures performed on the beneficiary for the claim.

DB2 ALIAS : REV\_HCPCS\_2ND\_CD  
STANDARD ALIAS : REV\_CNTR\_HCPCS\_2ND\_MDFR\_CD  
TITLE ALIAS : SECOND\_MODIFIER

LENGTH : 2

COMMENTS :  
Prior to Version H this field was named:  
HCPCS\_2ND\_MDFR\_CD. With Version H, a prefix  
was added to denote the location of this field  
on each claim type (institutional: REV\_CNTR and  
non-institutional: LINE).

SOURCE : CWF

EDIT RULES :  
CARRIER INFORMATION FILE

189. Revenue Center HCPCS Third Modifier Code  
2 48 49

CHAR

Effective with Version I, a third modifier to the procedure code to make it more specific than the second modifier code to identify the procedures performed on the beneficiary for the claim.

DB2 ALIAS : REV\_HCPCS\_3RD\_CD  
STANDARD ALIAS : REV\_CNTR\_HCPCS\_3RD\_MDFR\_CD  
TITLE ALIAS : THIRD\_MODIFIER

LENGTH : 2

COMMENTS :  
NOTE: Beginning with NCH weekly process date  
8/18/00, this field will be populated with data.

Claims processed prior to 8/18/00 will contain spaces in this field.

SOURCE : CWF

EDIT RULES :  
CARRIER INFORMATION FILE

190. Revenue Center HCPCS Fourth Modifier Code  
2 50 51

CHAR

Effective with Version I, a fourth modifier to the procedure code to make it more specific than the third modifier code to identify the procedures performed on the beneficiary for the claim.

DB2 ALIAS : REV\_HCPCS\_4TH\_CD  
STANDARD ALIAS : REV\_CNTR\_HCPCS\_4TH\_MDFR\_CD  
TITLE ALIAS : FOURTH\_MODIFIER

LENGTH : 2

COMMENTS :  
NOTE: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.

SOURCE : CWF

EDIT RULES :  
CARRIER INFORMATION FILE

191. Revenue Center HCPCS Fifth Modifier Code  
2 52 53

CHAR

Effective with Version I, a fifth modifier to the procedure code to make it more specific than the fourth modifier code to identify the procedures performed on the beneficiary for the claim.

DB2 ALIAS : REV\_HCPCS\_5TH\_CD  
SAS ALIAS : MDFR\_CD5  
STANDARD ALIAS : REV\_CNTR\_HCPCS\_5TH\_MDFR\_CD  
TITLE ALIAS : FIFTH\_MODIFIER

LENGTH : 2

COMMENTS :  
NOTE: Beginning with NCH weekly process date

8/18/00, this field will be populated with data.  
Claims processed prior to 8/18/00 will contain  
spaces in this field.

SOURCE : CWF

EDIT RULES :  
CARRIER INFORMATION FILE

192. Revenue Center Payment Method Indicator Code  
2 54 55 CHAR

Effective with Version 'I', the code used to  
identify how the service is priced for payment.  
This field is made up of two pieces of data,  
1st position being the service indicator and  
the 2nd position being the payment indicator.

NOTE1: This field is populated for those claims  
that are required to process through Outpatient  
PPS Pricer. The type of bills (TOB) required to  
process through are: 12X, 13X, 14X (except Maryland  
providers, Indian Health Providers, hospitals located  
in American Samoa, Guam and Saipan and Critical  
Access Hospitals (CAH)); 76X; 75X and 34X if  
certain HCPCS are on the bill; and any outpatient  
type of bill with a condition code '07' and certain  
HCPCS. These claim types could have lines that are  
not required to price under OPPS rules so those  
lines would not have data in this field.

Additional exception: Virgin Island hospitals and  
hospitals that furnish only inpatient Part B services  
with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be  
populated with data on claims with dates of service  
prior to 7/00 (implementation of Claim Line Expansion  
OPPS/HHPPS). The original understanding of the new  
revenue center fields was that data would be populated  
on claims with dates of service 7/00 and forward. Data  
has been found in claims with dates of service prior to  
7/00 because the Standard Systems have processed any  
claim coming in 7/00 and after, meeting the above criteria,  
through the Outpatient Code Editor (OCE) regardless of the  
dates of service.

NOTE3: Effective 10/2005, this field will no longer  
represent the service indicator and the payment  
indicator. This field will now house the 2-byte

payment indicator. The status indicator will be housed in a new field named: REV\_CNTR\_STUS\_IND\_CD.

DB2 ALIAS : REV\_PMT\_MTHD\_CD  
SAS ALIAS : PMTMTHD  
STANDARD ALIAS : REV\_CNTR\_PMT\_MTHD\_IND\_CD  
TITLE ALIAS : PMT\_MTHD

LENGTH : 2

SOURCE : CWF

CODE TABLE : REV\_CNTR\_PMT\_MTHD\_IND\_TB

193. Revenue Center Discount Indicator Code  
1 56 56

CHAR

Effective with Version 'I', this code represents a factor that specifies the amount of any APC discount. The discounting factor is applied to a line item with a service indicator (part of the REV\_CNTR\_PMT\_MTHD\_IND\_CD) of 'T'. The flag is applicable when more than one significant procedure is performed. \*\*If there is no discounting the factor will be 1.0.\*\*

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to

7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

NOTE3: VALUES D, U & T REPRESENT THE FOLLOWING:

D = Discounting fraction (currently 0.5)

U = Number of units

T = Terminated procedure discount (currently 0.5)

DB2 ALIAS : REV\_DSCNT\_IND\_CD

SAS ALIAS : DSCNTIND

STANDARD ALIAS : REV\_CNTR\_DSCNT\_IND\_CD

TITLE ALIAS : REV\_CNTR\_DSCNT\_IND\_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : REV\_CNTR\_DSCNT\_IND\_TB

#### 194. Revenue Center Packaging Indicator Code

1 57 57

CHAR

Effective with Version 'I', the code used to identify those services that are packaged/ bundled with another service.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HPPS). The original understanding of the new revenue center fields was that data would be populated

on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV\_PACKG\_IND\_CD  
SAS ALIAS : PACKGIND  
STANDARD ALIAS : REV\_CNTR\_PACKG\_IND\_CD  
TITLE ALIAS : REV\_CNTR\_PACKG\_IND

LENGTH : 1

SOURCE : CWF

CODE TABLE : REV\_CNTR\_PACKG\_IND\_TB

195. Revenue Center Pricing Indicator Code  
2 58 59

CHAR

Effective with Version 'I', the code used to identify if there was a deviation from the standard method of calculating payment amount.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to



7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV\_PRICNG\_IND\_CD  
SAS ALIAS : PRICNG  
STANDARD ALIAS : REV\_CNTR\_PRICNG\_IND\_CD  
TITLE ALIAS : REV\_CNTR\_PRICNG\_IND

LENGTH : 2

SOURCE : CWF

CODE TABLE : REV\_CNTR\_PRICNG\_IND\_TB

196. Revenue Center Obligation to Accept As Full (OTAF) Payment Code  
1 60 60 CHAR

Effective with Version 'j' the code used to indicate that the provider was obligated to accept as full payment the amount received from the primary (or secondary) payer.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria,

through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2        ALIAS : REV\_OTAF\_IND\_CD  
SAS        ALIAS : OTAF

LENGTH        : 1

SOURCE        : CWF

EDIT RULES :

Y = provider is obligated to accept the payment  
as payment in full for the service.  
N or blank = provider is not obligated to accept  
the payment, or there is no payment by a prior  
payer.

197. Revenue Center IDE, NDC, UPC Number  
24        61

84 CHAR

Effective with Version H, the exemption number assigned by the Food and Drug Administration (FDA) to an investigational device after a manufacturer has been approved by FDA to conduct a clinical trial on that device. HCFA established a new policy of covering certain IDE's which was implemented in claims processing on 10/1/96 (which is NCH weekly process 10/4/96) for service dates beginning 10/1/95. IDE's are always associated with revenue center code '0624'.

NOTE1: Prior to Version H a 'dummy' revenue center code '0624' trailer was created to store IDE's. The IDE number was housed in two fields: HCPCS code and HCPCS initial modifier; the second modifier contained the value 'ID'. There can be up to 7 distinct IDE numbers associated with an '0624' dummy trailer. During the Version H conversion IDE's were moved from the dummy '0624' trailer to this dedicated field.

NOTE2: Effective with Version 'I', this field was renamed to eventually accommodate the National Drug Code (NDC) and the Universal Product Code (UPC). This field could contain either of these 3 fields (there would never be an instance where more than one would come in on a claim). The size of this field was expanded to X(24) to accommodate either of the new fields (under Version 'H' it was X(7). DATA ANAMOLY/LIMITATION: During an CWFMQA review an edit revealed the IDE was missing.

The problem occurs in claim with an NCH weekly process dates of 6/9/00 through 9/8/00. During processing of the new format the program receives the IDE but then blanked out the data.

DB2 ALIAS : IDE\_NDC\_UPC\_NUM  
 SAS ALIAS : IDENDC  
 STANDARD ALIAS : REV\_CNTR\_IDE\_NDC\_UPC\_NUM  
 TITLE ALIAS : IDE\_NDC\_UPC

LENGTH : 24

SOURCE : CWF

LIMITATIONS :

REFER TO :  
 REV\_CNTR\_IDE\_NDC\_UPC\_LIM

198. Revenue Center NDC Quantity Qualifier Code  
                                   2      85      86

CHAR

Effective with Version 'J', the code used to indicate the unit of measurement for the drug that was administered.

DB2 ALIAS : NDC\_QTY\_QLFR\_CD  
 SAS ALIAS : QTYQLFR  
 STANDARD ALIAS : REV\_CNTR\_NDC\_QTY\_QLFR\_CD

LENGTH : 2

CODE TABLE : REV\_CNTR\_NDC\_QTY\_QLFR\_TB

199. Revenue Center NDC Quantity  
                                   6      87      92

PACK

Effective with Version 'J', the quantity dispensed for the drug reflected on the revenue center line item.

DB2 ALIAS : NDC\_QTY\_NUM  
 SAS ALIAS : NDCQTY

LENGTH : 7.3 SIGNED : Y

200. Revenue Center Unit Count  
                                   4      93      96

PACK

A quantitative measure (unit) of the number of times the service or procedure being reported was performed according to the revenue center/HCPCS code definition as described on

an institutional claim.

Depending on type of service, units are measured by number of covered days in a particular accommodation, pints of blood, emergency room visits, clinic visits, dialysis treatments (sessions or days), outpatient therapy visits, and outpatient clinical diagnostic laboratory tests.

NOTE1: When revenue center code = '0022' (SNF PPS) the unit count will reflect the number of covered days for each HIPPS code and, if applicable, the number of visits for each rehab therapy code.

DB2 ALIAS : REV\_CNTR\_UNIT\_CNT  
SAS ALIAS : REV\_UNIT  
STANDARD ALIAS : REV\_CNTR\_UNIT\_CNT  
TITLE ALIAS : UNITS

LENGTH : 7 SIGNED : Y

SOURCE : CWF

201. Revenue Center Rate Amount

6 97 102

PACK

Charges relating to unit cost associated with the revenue center code. Exception (encounter data only): If plan (e.g. MCO) does not know the actual rate for the accommodations, \$1 will be reported in the field.

NOTE1: For SNF PPS claims (when revenue center code equals '0022'), CMS has developed a SNF PRICER to compute the rate based on the provider supplied coding for the MDS RUGS III group and assessment type (HIPPS code, stored in revenue center HCPCS code field).

NOTE2: For OP PPS claims, CMS has developed a PRICER to compute the rate based on the Ambulatory Payment Classification (APC), discount factor, units of service and the wage index.

NOTE3: Under HH PPS (when revenue center code equals '0023'), CMS has developed a HHA PRICER to compute the rate. On the RAP, the rate is determined using the case mix weight associated with the HIPPS code, adjusting it for the wage index for the beneficiary's site of service, then multiplying the result by 60% or 50%, depending on

whether or not the RAP is for a first episode.

On the final claim, the HIPPS code could change the payment if the therapy threshold is not met, or partial episode payment (PEP) adjustment or a significant change in condition (SCIC) adjustment. In cases of SCICs, there will be more than one '0023' revenue center line, each representing the payment made at each case-mix level.

NOTE4: For IRF PPS claims (when revenue center code equals '0024'), CMS has developed a PRICER to compute the rate based on the HIPPS/CMG (HIPPS code, stored in revenue center HCPCS code field).

DB2 ALIAS : REV\_CNTR\_RATE\_AMT  
SAS ALIAS : REV\_RATE  
STANDARD ALIAS : REV\_CNTR\_RATE\_AMT  
TITLE ALIAS : CHARGE\_PER\_UNIT

LENGTH : 9.2 SIGNED : Y

COMMENTS :  
Prior to Version H the size of this field was:  
S9(7)V99.

SOURCE : CWF

202. Revenue Center Blood Deductible Amount  
6 103 108

PACK

Effective with Version 'I', the amount of money for which the intermediary determined the beneficiary is liable for the blood deductible for the line item service.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPFS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV\_BLOOD\_DDCTBL  
SAS ALIAS : REVBLOOD  
STANDARD ALIAS : REV\_CNTR\_BLOOD\_DDCTBL\_AMT  
TITLE ALIAS : BLOOD\_DDCTBL\_AMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

203. Revenue Center Cash Deductible Amount  
6 109 114

PACK

Effective with Version 'I' the amount of cash deductible the beneficiary paid for the line item service.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be

populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV\_CASH\_DDCTBL  
SAS ALIAS : REVDCTBL  
STANDARD ALIAS : REV\_CNTR\_CASH\_DDCTBL\_AMT  
TITLE ALIAS : CASH\_DDCTBL

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

204. Revenue Center Coinsurance/Wage Adjusted Coinsurance Amount  
6 115 120 PACK

Effective with Version 'I', the amount of coinsurance applicable to the line item service defined by the revenue center and HCPCS codes. For those services subject to Outpatient PPS, the applicable coinsurance is wage adjusted.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. The above claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

NOTE2: This field will have either a zero (for services for which coinsurance is not applicable), a regular coinsurance amount (calculated on either charges or a fee schedule) or if subject to OP PPS the national coinsurance amount will be wage adjusted. The wage adjusted coinsurance is based on the MSA where the provider is located or assigned

as a result of a reclassification.

NOTE3: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HPPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2        ALIAS : ADJSTD\_COINSRNC  
SAS        ALIAS : WAGEADJ  
STANDARD ALIAS : REV\_CNTR WAGE\_ADJSTD\_COINS\_AMT  
TITLE     ALIAS : WAGE\_ADJSTD\_COINS

LENGTH            : 9.2        SIGNED : Y

SOURCE            : CWF

205. Revenue Center Reduced Coinsurance Amount  
                                6    121    126

PACK

Effective with Version 'I', for all services subject to Outpatient PPS, the amount of coinsurance applicable to the line for a particular service (HCPCS) for which the provider has elected to reduce the coinsurance amount.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.



NOTE2: The reduced coinsurance amount cannot be lower than 20% of the payment rate for the APC line.

NOTE3: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : RDCD\_COINSRNC  
SAS ALIAS : RDCDCOIN  
STANDARD ALIAS : REV\_CNTR\_RDCD\_COINS\_AMT  
TITLE ALIAS : REDUCED\_COINS

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

206. Revenue Center 1st Medicare Secondary Payer Paid Amount  
6 127 132 PACK

Effective with Version 'I', the amount paid by the primary payer when the payer is primary to Medicare (Medicare is secondary).

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be

populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV\_MSP1\_PD\_AMT  
SAS ALIAS : REV\_MSP1  
STANDARD ALIAS : REV\_CNTR\_MSP1\_PD\_AMT  
TITLE ALIAS : MSP PAID AMOUNT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

207. Revenue Center 2nd Medicare Secondary Payer Paid Amount  
6 133 138 PACK

Effective with Version 'I', the amount paid by the secondary payer when two payers are primary to Medicare (Medicare is the tertiary payer).

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data

has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV\_MSP2\_PD\_AMT  
SAS ALIAS : REV\_MSP2  
STANDARD ALIAS : REV\_CNTR\_MSP2\_PD\_AMT  
TITLE ALIAS : MSP\_PAID\_AMOUNT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

208. Revenue Center Provider Payment Amount  
6 139 144

PACK

Effective with Version 'I', the amount paid to the provider for the services reported on the line item.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

ANAMOLY: For dates of service August 1, 2000 to the present, the OPPS revenue center fields are being processed differently by FISS and APASS (standard systems). For more information on OPPS data problems for this time period see Limitations Appendix. The following is how each system handles this field:

FISS: populated correctly with provider payment amount

APASS: provider payment amount plus interest on  
1st revenue center line (CMM will instruct  
APASS not to include interest)

Currently, the following FI numbers are under the APASS  
system and all other FI numbers are under FISS. See  
FI\_NUM table of codes for all FI numbers.

52280 -- Mutual of Omaha (until 6/1/2003)  
00430 -- Washington/Alaska (until 11/1/2003)  
00310 -- North Carolina BC (until 12/1/2003)  
00370 -- Rhode Island (until 2/1/2004)  
00270 -- New Hampshire/Vermont (until 3/1/2004)  
00181 -- Maine/Massachusetts (until 5/1/2004)

NOTE2: It has been discovered that this field may be  
populated with data on claims with dates of service  
prior to 7/00 (implementation of Claim Line Expansion  
OPPS/HHPPS). The original understanding of the new  
revenue center fields was that data would be populated  
on claims with dates of service 7/00 and forward. Data  
has been found in claims with dates of service prior to  
7/00 because the Standard Systems have processed any  
claim coming in 7/00 and after, meeting the above criteria,  
through the Outpatient Code Editor (OCE) regardless of the  
dates of service.

DB2 ALIAS : REV\_PRVDR\_PMT\_AMT  
SAS ALIAS : RPRVDPMT  
STANDARD ALIAS : REV\_CNTR\_PRVDR\_PMT\_AMT  
TITLE ALIAS : REV\_PRVDR\_PMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

209. Revenue Center Beneficiary Payment Amount  
6 145 150

PACK

Effective with Version I, the amount paid  
to the beneficiary for the services reported  
on the line item.

NOTE1: This field is populated for those claims  
that are required to process through Outpatient  
PPS Pricer. The type of bills (TOB) required to  
process through are: 12X, 13X, 14X (except Maryland  
providers, Indian Health Providers, hospitals located  
in American Samoa, Guam and Saipan and Critical  
Access Hospitals (CAH)); 76X; 75X and 34X if

certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV\_BENE\_PMT\_AMT  
SAS ALIAS : RBENEPMT  
STANDARD ALIAS : REV\_CNTR\_BENE\_PMT\_AMT  
TITLE ALIAS : REV\_BENE\_PMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

210. Revenue Center Patient Responsibility Payment Amount  
6 151 156 PACK

Effective with Version I, the amount paid by the beneficiary to the provider for the line item service.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

ANAMOLY: For dates of service August 1, 2000 to present, the OPPS revenue center fields are being processed differently by FISS and APASS (standard systems). For more information on OPPS data problems for this time period see the Limitations Appendix. The following is how each system is handling this field:

FISS: populating correctly (sum of coinsurance and deductible)

APASS: not populating this field

Currently, the following FI numbers are under the APASS system and all other FI numbers are under FISS. See FI\_NUM table of codes for all FI numbers.

52280 -- Mutual of Omaha (until 6/1/2003)  
00430 -- Washington/Alaska (until 11/1/2003)  
00310 -- North Carolina BC (until 12/1/2003)  
00370 -- Rhode Island (until 2/1/2004)  
00270 -- New Hampshire/Vermont (until 3/1/2004)  
00181 -- Maine/Massachusetts (until 5/1/2004)

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV\_PTNT\_RESP\_AMT  
SAS ALIAS : PTNTRESP  
STANDARD ALIAS : REV\_CNTR\_PTNT\_RESP\_PMT\_AMT  
TITLE ALIAS : REV\_PTNT\_RESP

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

Effective with Version 'I', the line item Medicare payment amount for the specific revenue center.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPSS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

ANAMOLY: For dates of service August 1, 2000 to present, the OPSS revenue center fields are being processed differently by FISS and APASS (standard systems). For more information on OPSS data problems for this time period see the Limitations Appendix. The following is how each system is handling this field:

FISS: this field contains provider reimbursement.

APASS: provider payment amount plus coinsurance and deductible (should not include coinsurance and deductible). Users should rely on provider payment amount field for the trust fund payment.

Currently, the following FI numbers are under the APASS system and all other FI numbers are under FISS. See FI\_NUM table of codes for all FI numbers.

52280 -- Mutual of Omaha (until 6/1/2003)  
00430 -- Washington/Alaska (until 11/1/2003)  
00310 -- North Carolina BC (until 12/1/2003)  
00370 -- Rhode Island (until 2/1/2004)  
00270 -- New Hampshire/Vermont (until 3/1/2004)  
00181 -- Maine/Massachusetts (until 5/1/2004)

NOTE2: It has been discovered that this field may be

populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2        ALIAS : REV\_CNTR\_PMT\_AMT  
SAS        ALIAS : REVPMT

LENGTH            : 9.2        SIGNED : Y

SOURCE            : CWF

EDIT RULES :  
             \$\$\$\$\$\$\$\$CC

212. Revenue Center Total Charge Amount  
                                6       163       168

PACK

The total charges (covered and non-covered) for all accommodations and services (related to the revenue code) for a billing period before reduction for the deductible and coinsurance amounts and before an adjustment for the cost of services provided. NOTE: For accommodation revenue center total charges must equal the rate times units (days).

EXCEPTIONS:

(1) For SNF RUGS demo claims only (9000 series revenue center codes), this field contains SNF customary accommodation charge, (ie., charges related to the accommodation revenue center code that would have been applicable if the provider had not been participating in the demo).

(2) For SNF PPS (non demo claims), when revenue center code = '0022', the total charges will be zero.

(3) For Home Health PPS (RAPs), when revenue center code = '0023', the total charges will equal the dollar amount for the '0023' line.

(4) For Home Health PPS (final claim), when revenue center code = '0023', the total charges will be the sum of the revenue center code lines (other than '0023').



(5) For Inpatient Rehabilitation Facility (IFR) PPS, when the revenue center code = '0024', the total charges will be zero. For accommodation revenue codes (010X - 021X), total charges must equal the rate times the units.

(6) For encounter data, if the plan (e.g. MCO) does not know the actual charges for the accommodations the total charges will be \$1 (rate) times units (days).

DB2 ALIAS : REV\_TOT\_CHRG\_AMT  
SAS ALIAS : REV\_CHRG  
STANDARD ALIAS : REV\_CNTR\_TOT\_CHRG\_AMT  
TITLE ALIAS : REVENUE\_CENTER\_CHARGES

LENGTH : 9.2 SIGNED : Y

COMMENTS :  
Prior to Version H the size of this field was:  
S9(7)V99.

SOURCE : CWF

LIMITATIONS :

REFER TO :  
MLTPL\_REV\_CNTR\_0001\_CD\_LIM  
REV\_CNTR\_TOT\_CHRG\_AMT\_LIM

EDIT RULES :  
\$\$\$\$\$\$\$\$CC

213. Revenue Center Non-Covered Charge Amount  
6 169 174

PACK

The charge amount related to a revenue center code for services that are not covered by Medicare.

NOTE: Prior to Version H the field size was S9(7)V99 and the element was only present on the Inpatient/SNF format. As of NCH weekly process date 10/3/97 this field was added to all institutional claim types.

DB2 ALIAS : REV\_NCVR\_CHRG\_AMT  
SAS ALIAS : REV\_NCVR  
STANDARD ALIAS : REV\_CNTR\_NCVR\_CHRG\_AMT  
TITLE ALIAS : REV\_CENTER\_NONCOVERED\_CHARGES

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

EDIT RULES :  
\$\$\$\$\$\$\$CC

214. Revenue Center Deductible Coinsurance Code  
1 175 175

CHAR

Code indicating whether the revenue center charges  
are subject to deductible and/or coinsurance.

DB2 ALIAS : DDCTBL\_COINSRNC\_CD  
SAS ALIAS : REVDED CD  
STANDARD ALIAS : REV\_CNTR\_DDCTBL\_COINSRNC\_CD  
TITLE ALIAS : REVENUE\_CENTER\_DEDUCTIBLE\_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : REV\_CNTR\_DDCTBL\_COINSRNC\_TB

215. Revenue Center Consolidated Billing Code  
1 176 176

CHAR

Effective 1/1/2004 with the implementation of NCH/NMUD  
CR#1, this code is reflected on outpatient claims only  
to identify those line item services (i.e. therapy  
and nonroutine supply services) that are subject  
to SNF and Home Health consolidated billing. If the  
line item service was paid by an intermediary prior  
to the submission of the SNF or home health claim  
an adjustment for the outpatient claim will be submitted  
identifying those services that are subject to  
consolidated billing.

NOTE1: Prior to 10/2005 (implementation of NCH/NMUD  
CR#2), this data was stored in position 175 (FILLER)  
in the revenue center trailer.

NOTE2: Effective July 2005, this data will no longer  
be coming into the NCH. This process is being handled  
in the new CWF override processing.

DB2 ALIAS : CNSLDTD\_BLG\_CD  
SAS ALIAS : RCNSLDTD  
STANDARD ALIAS : REV\_CNTR\_CNSLDTD\_BLG\_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : REV\_CNTR\_CNSLDTD\_BLG\_TB

216. Revenue Center Status Indicator Code  
2 177 178

CHAR

Effective 10/3/2005 with the implementation of NCH/NMUD CR#2, the code used to identify the status of the line item service. This field along with the payment method indicator field is used to identify how the service was priced for payment.

NOTE1: This 2-byte indicator is being added due to an expansion of a field that currently exist on the revenue center trailer. The status indicator is currently the 1st position of the Revenue Center Payment Method Indicator Code. The payment method indicator code is being split into two 2-byte fields (payment indicator and status indicator). The expanded payment indicator will continue to be stored in the existing payment method indicator field. The split of the current payment method indicator field is due to the expansion of both pieces of data from 1-byte to 2-bytes.

NOTE2: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services.

DB2 ALIAS : REV\_STUS\_IND\_CD  
SAS ALIAS : RSTUSIND  
STANDARD ALIAS : REV\_CNTR\_STUS\_IND\_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : REV\_CNTR\_STUS\_IND\_TB

217. Revenue Center Duplicate Claim Check Indicator Code

1 179 179 CHAR

Effective 1/1/2009 with the implementation of NCH/NMUD CR#4, the code used to identify an item or service that appeared to be a duuplicate but has been reviewed by an FI or MAC and appropriately approved for payment.

DB2 ALIAS : DUP\_CLM\_CHK\_IND\_CD  
SAS ALIAS : DUP-CHK  
STANDARD ALIAS : REV\_CNTR\_DUP\_CLM\_CHK\_IND\_CD

LENGTH : 1

CODE TABLE : REV\_CNTR\_DUP\_CLM\_CHK\_IND\_TB

218. Revenue Center APC Buffer Code

2 180 181 CHAR

APC - Ambulatory Payment Classification  
Effective 1/1/2009 with the implementation of CR#4, the code used to identify related line items that make up a composite APC group. This field is only applicable to outpatient PPS claims.

DB2 ALIAS : REV\_CNTR\_BUFR\_CD  
SAS ALIAS : APCBUFR  
STANDARD ALIAS : REV\_CNTR\_APC\_BUFR\_CD

LENGTH : 2

CODE TABLE : REV\_CNTR\_APC\_BUFR\_TB

219. Revenue Center Rendering Physician NPI Num

10 182 191 CHAR

Effective with Version 'J', the NPI of the rendering physician who performed the service.

DB2 ALIAS : RNDRNG\_NPI\_NUM  
SAS ALIAS : REVNPI

LENGTH : 10

220. Revenue Center Rendering Physician Surname

6 192 197 CHAR

Effective with Version 'J', the 6 position last name of the rendering physician who performed the service.

				DB2	ALIAS : RNRNG_SRM_NAME
				SAS	ALIAS : REVSARM
				LENGTH	: 6
221. FILLER	100	198	297	CHAR	
				DB2	ALIAS : FILLER
				LENGTH	: 100
222. End of Record Code	3	1	3	CHAR	
				Effective with Version 'I', the code used to identify the end of a record/segment or the end of the claim.	
				DB2	ALIAS : END_REC_CD
				SAS	ALIAS : EOR
				STANDARD	ALIAS : END_REC_CD
				TITLE	ALIAS : END_OF_REC
				LENGTH	: 3
				COMMENTS :	
				Prior to Version I this field was named: END_REC_CNSTNT.	
				SOURCE	: NCH
				CODE TABLE	: END_REC_TB

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H3PM.R\_RIF\_MAIN\_Q,Q1,F

1

LIMITATIONS APPENDIX FOR RECORD: FI\_HHA\_CLM\_REC  
AS OF: 06/30/2011

CHOICES\_DEMO\_LIM

FULL NAME: Choices Demonstration Limitation

DESCRIPTION :

A programming error created an 'INVALID' indication

in the demo text field for CHOICES claims.  
BACKGROUND :  
In 6/00, the CWFMOA front-end editing revealed that some CHOICES demo claims were coming in with a valid 'H' number in the fixed portion of the claims, but in the first occurrence MCO trailer a numeric packed field (value hex '0100000C') was moved to the MCO Contract Number/Option Code fields. This created an invalid period check of number/code to MCO effective date, resulting in an INVALID indication in the demo info text field.

CORRECTIVE ACTION :  
The problem was forwarded to the CWF BSOG staff for further investigation.

SOURCE:  
CONTACT : OIS/EDG/DMUDD

CLM\_TRANS\_CD\_LIM

FULL NAME: Claim Transaction Code Limitation

DESCRIPTION :  
Claim Transaction Code missing from 1999 inpatient records and there was also a problem identified in the May and June 2000 data.

BACKGROUND :  
Users of the data discovered that the claim transaction code was missing values 2 & 3 for service year 1999 and for the months of May and June, 2000. This information was confirmed and OIS/BSOG was notified.

CORRECTIVE ACTION :  
In July 2000 the problem was fixed and the claim transaction code contained the correct values.

SOURCE:  
CONTACT : OIS/EDG/DMUDD

HHA\_AB\_SHIFT\_LIM

FULL NAME: HHA A/B Shift Limitation

DESCRIPTION :  
There were several problems with the final HHA claims containing both Part A and Part B visits (RIC 'U'). The prorated amounts in value code 64/65 were not reliable and the claim-level total visit count did not always balance to the PTA & PTB visits.

BACKGROUND :  
Although the claim-level reimbursement is correct, the value code 64/65 amounts representing the prorated Part A and Part B trust fund payments are not reliable. The other problem with the HH PPS RIC 'U' data is that the claim-level HHA total visit count does not always balance to the total Part A and Part B visits, as reported in the value code 62/63 amount fields.

CORRECTIVE ACTION :  
CMM staff has been consulted and the problem will be

corrected at some future date, but in the interim users need to know how to derive the correct prorated amounts from the existing data. The following is the agreed-upon approach:

(1) Assume the claim-level reimbursement amount is correct on all final HHA claims, and properly includes any outlier payment. Nothing needs to be added to the field to derive the total Medicare trust fund payment.

(2) For those final HHA claims (RIC 'U') that report both Part A and Part B visits, drop whatever is reported in the value codes 64 and 65 (Part A/B reimbursement), and substitute the correct prorated amounts derived by:

(a) Adding up Part A and Part B visits, as reported in the value codes 62/63 amount fields (don't use the claim-level total visits because of the out-of-balance anomaly);

(b) Calculating percentage of total visits (from Step 1) attributable to Part A and Part B; and

(c) Applying the percentages to the claim-level reimbursement amount derive the correct Part A and Part B reimbursement (value code 64/65 amounts).

SOURCE:

CONTACT : OIS/EDG/DMUDD

HHA\_HCPCS\_LIM

FULL NAME: Home Health HCPCS Limitation

DESCRIPTION :

It was determined that providers were not complying with the 15-minute increment billing instructions for using the 'G' HCPCS codes.

BACKGROUND :

The instructions state that providers are to use the newly created 'G' codes to identify services of the six home health disciplines during an HH episode of care. These 'G' codes (G0151, G0152, G0153, G0154, G0155, G0156) are subject to 15-minute interval billing. As a result the user can not trust the 'G' codes for visit counting. For a more accurate accounting of services the user should rely on the revenue center codes rather than the HCPCS.

Currently there is a check that if the 15-minute increment 'G' codes appear, the revenue center code must be

the corresponding HH discipline; however, there is no check to see if the discipline revenue center code appears and that the HCPCS contains the corresponding 'G' code.

CORRECTIVE ACTION :

The Standard Systems has put a fix in to correct this problem.

SOURCE:

CONTACT : OIS/EDG/DMUDD

HHA\_MISG\_CLM\_LIM

FULL NAME: HHA Missing Claim Limitation

DESCRIPTION :

Incomplete HHA claims date beginning with service year 1998.

BACKGROUND :

The problem is related to the implementaion of the shift of payment for Medicare HHA visits between Part A and Part B trust funds. Claims with dates of service from 1/1/98, with visits that spanned A/B split, were auto canceled in a one time run at the end of June 1998. Although these claims were canceled (and therefore not in the NCH), these claims were paid.

There was a national total of 4,506,501 claims with service dates 1/1/98 and after; of which 63,029 (or 2%) were the missing cancel only claims which needed to be recovered.

All HHA files (NCH, SAF, HCIS) contained incomplete data until the problem was fixed.

CORRECTIVE ACTION :

A Two-Timer Utility was used to recalculate all Home Health benefit periods to determine the correct A or B benefits for claims in house.

A Three-Timer Utility was developed to create a file to identify all HHA claims that were auto-adjusted or auto-canceled in the June 1998 One-Timer and from current claims processing throught 5/21/99. The utility automatically processed the automatic adjustments/cancels and submitted the new claims to CWF for approval/posting and sent them to the NCH.

SOURCE:

ADMINISTRATIVE DATA:

START DATE : 1/1/98  
END DATE : 5/24/99  
CONTACT : OIS/EDG/DMUDD

HHA\_PPS\_LUPA\_IND\_CD\_LIM

FULL NAME: HHA PPS LUPA Indicator Code Limitation

DESCRIPTION :



LUPA indicator code blanked out.  
BACKGROUND :  
For Home Health PPS claims, the LUPA indicator was  
blanked out since the beginning of HHPPS (10/1/00).  
CORRECTIVE ACTION :  
CWFMQA put in a fix which was effective with claims  
with an NCH Weekly Process Date 3/16/01.  
SOURCE:  
ADMINISTRATIVE DATA:  
START DATE : 10/01/00  
END DATE : 03/16/01  
CONTACT : OIS/EDG/DMUDD

HHA\_PPS\_LUPA\_0023\_LINE\_LIM

FULL NAME: HHA PPS LUPA '0023' Revenue Center Line Limitation  
DESCRIPTION :

There are inconsistencies with the Home Health PPS  
LUPA claims with the '0023' revenue center line.

BACKGROUND :  
One of the Home Health PPS requirements for LUPA claims  
was that on a LUPA claim the '0023' revenue center  
line should show zero payment and the per visit amounts  
should be shown on the visit lines.

Prior to 4/1/02, noncovered revenue center lines were  
not being submitted to CWF. This should have meant that  
all LUPA claims in NCH should not have a '0023' revenue  
center line until after 4/1/02 implementation of  
noncovered revenue lines on OP, HHA & Hospice claims.

The problem was that one Standard System (APASS) did  
not implement the requirement correctly. APASS showed  
the total payment amount for the LUPA on the '0023'  
line and no payments on the visits. This caused the  
NCH to have both LUPA claims with no '0023' line and  
some with the '0023' line.

CORRECTIVE ACTION :  
Since APASS payments are accurate and there is no  
adverse provider impact from this variance, a  
resource decision was made not to pursue a fix  
to this issue in APASS. The RHHI (only one) currently  
on the APASS system will transition off of APASS onto  
FISS in 2004 and the variance should be resolved at  
that time.

SOURCE:  
ADMINISTRATIVE DATA:  
START DATE : 10/01/00  
END DATE : 04/01/02  
CONTACT : OIS/EDG/DMUDD

HHA\_PPS\_RIC\_CD\_ADJSTMT\_LIM

FULL NAME: Home Health PPS RIC Code Adjustment Limitation

DESCRIPTION :

The Record Identification Code (RIC) on Home Health PPS claims were not being adjusted properly.

BACKGROUND :

The value code on HHA claims that are auto-adjusted in CWF are not being changed to agree with the adjustment being made to the RIC code. For example, the HHA claims are initially received as a Part B (RIC 'W' with a value code '63'); then subsequently adjusted to Part A (RIC 'V'), but the value code is not changed to '62'.

CORRECTIVE ACTION :

A Change Request was written to correct this problem. The change was implemented March 2001.

SOURCE:

CONTACT : OIS/EDG/DMUDD

HHA\_PTA\_OVRD\_TRLR\_LIM

FULL NAME: HHA Part A Overlaid Trailer Limitation

DESCRIPTION :

Overlaid revenue center lines on HHA RIC 'V' claims

BACKGROUND :

During the Version 'I' conversion, it was decided that each segment of a claim would contain a maximum of 45 revenue center lines. During the month of June 2000 the CWFMQA began receiving the new format, but the NCH was not scheduled to receive the new format until July 2000. Since NCH was not ready, CWFMQA converted the 'I' claims back to the Version 'H' format. A typo in the code caused the additional revenue lines to overlay revenue lines on the base/initial record/segment.

The problem occurred in 2,627 HHA Part A (RIC 'V') claims with between 46-58 revenue center lines and NCH Weekly Process dates 6/16/00, 6/23/00, 6/30/00 and 7/7/00 (both Version 'H' and 'I' files). There were 2,277 claims for service year 2000; 324 claims for 1999 and 40 claims for 1998 and 1 claim for 1997.

NOTE: Instead of being the last line on the claim, revenue code '0001' was embedded within the other revenue lines on the base record.

CORRECTIVE ACTION :

In the NCH Version 'I' files, the annual service year 2000 files, service year 1999 and 1998 trickles were patched. The 18-month final service year 2000 SAF was created after the fix was applied. The 18-month service year 1999 was patched. A patch code '15' was created with a patch applied date of 06/29/2001.

SOURCE:

HHA\_RFRL\_CD\_LIM

CONTACT : OIS/EDG/DMUDD

FULL NAME: HHA Referral Code Limitation

DESCRIPTION :

HHA referral code was blanked out.

BACKGROUND :

For Home Health PPS claims, the HHA referral code was blanked out since the beginning of HHPPS (10/1/00).

CORRECTIVE ACTION :

CWFMQA put a fix in which will be effective with claims with an NCH Weekly Process Date 3/16/01.

SOURCE:

ADMINISTRATIVE DATA:

START DATE : 10/01/00

END DATE : 03/16/01

CONTACT : OIS/EDG/DMUDD

HHA\_TOT\_VISIT\_CNT\_LIM

FULL NAME: HHA Total Visit Count Limitation

DESCRIPTION :

NCH HHA recovered claims may be missing the claim-level total visit count.

BACKGROUND :

During the recovery of NCH dropped claims it was discovered that there is a possibility that some or all of the HHA claims may be missing the total visit count. There were 997,422 recovered HHA claims.

The field comes in from CWF but is also derivable from looking at revenue center trailer information, in combination with the Claim From Date. Beginning in 7/1/99, with HHA claims received with service dates 7/1/99 and after, the claims processing systems started counting visits based on the number of HHA visit revenue center lines. Prior to 7/1/99, the count was derived by adding up the units field associated with the HHA visit revenue centers.

To identify these claims, look for service year 1998 and 1999 HHA claims with revenue center codes 042X, 043X, 044X, 055X, 056X, 057X, 058X, 059X with missing total visit count. If the Claim From Date is less than 7/1/99, derive the total by adding up the Revenue Center Unit count for each of these visit revenue centers. If the Claim From Date is greater than 6/30/99, derive the total by counting each visit revenue code line item as 1 visit.

CORRECTIVE ACTION :

During the history conversion to Version 'I' the NCH and SAFs were patched to correct the problem. Any service year prior to 2000 could be involved. The patched record will be annotated with an NCH Patch Code = 12.

The patched claims will have an NCH Weekly Process Date of 12/10/99, 12/17/99, or 1/7/00.

SOURCE: NCH

CONTACT : OIS/EDG/DMUDD

MCO\_PD\_SW\_LIM

FULL NAME: Claim MCO Paid Switch Limitation

DESCRIPTION :

The MCO paid switch made consistent with criteria used to identify an inpatient encounter claim.

BACKGROUND :

During the NCH Version 'I' conversion, history was populated with an NCH Claim Type Code that will identify the record as an inpatient encounter claim. When applying the CWF logic to identify an inpatient encounter claim, it was discovered that when all the criteria was met the MCO paid switch was sometimes a blank or '0' (reflecting that the MCO did not pay the provider).

CORRECTIVE ACTION :

With the inception of the Version 'I' processing (7/00), if all the criteria for identifying an inpatient encounter claim is met but the MCO paid switch is a blank or '0' it is changed to a '1'.

A patch code = '13' was applied to all claims back to 7/1/97 service year thru date.

SOURCE:

CONTACT : OIS/EDG/DMUDD

MLTPL\_REV\_CNTR\_0001\_CD\_LIM

FULL NAME: Multiple Revenue Center '0001' Code Limitation

DESCRIPTION :

Multiple total charge '0001' revenue center codes appearing on outpatient, hospice and home health claim records.

BACKGROUND :

On outpatient, home health and hospice it appears that more than one '0001' revenue center code is showing up on the claims. The first total charge line adds the revenue center codes above it correctly; the problem exists below the first total charge line where garbage may be present due to the FI Standard System not clearing out fields before processing the next claim. We believe the error began with the change-over to a different claims processing contractor in 1/98.

CORRECTIVE ACTION :

CWF created an edit to reject multiple '0001' revenue center codes, effective 6/28/99. EDG's CWFMQA process implemented an edit to drop any revenue center line items below the first total charge line. The NCH Nearline File, as well as the 1998 Standard Analytic Files (SAFs), have been patched/corrected to delete the multiple '0001' codes where present on any of the institutional claim types. Also, HCIS will be correcting the revenue center summaries during the next refresh.

The NCH\_PATCH\_CD field will reflect a value '10'.

SOURCE:

CONTACT : OIS/EDG/DMUDD

PMT\_AMT\_EXCEDG\_CHRG\_AMT\_LIM

FULL NAME: Claim Payment Amount Exceeding Total Charge Amount Limitation

DESCRIPTION :

Approximately 75 Inpatient claims had a reimbursement amount exceed \$500,000 which was at least 25 times the total charge amount. There were also claims where the reimbursement was less than \$500,000 but greater than the total charges.

BACKGROUND :

In November of 1999, it was brought to the attention of the HDUG that large reimbursement amounts were being paid in Pennsylvania. There were 75 inpatient claims provided where the reimbursement amount was over \$500,000 and at least 25 times the total charge amount. These claims were processed between 9/29/98 and 10/1/98. There were also claims identified with reimbursement less than \$500,000 but greater than total charge. It was later discovered that the source of the problem was an error in entering an MSA; the decimal point was off by 2 positions.

Because there were no changes in utilization, the claims were corrected and the correct payments distributed, but the new payment amounts were never sent to CWF (not in NCH). There is currently no requirement that FIs and carriers update CWF with final payment information by submitting payment only adjustments. It was noted that there is no expectation that CWF will have final payment information for claims.

CORRECTIVE ACTION :

According to Veritus (FI), the problem was caught in their system using a pre-payment edit prior to sending out the payments. The erroneous MSA value was corrected and the claims were then sent to PRICER again and paid correctly.

The claims were corrected and correct payments were made but these new payment amounts were never sent to CWF and are not reflected in the NCH.

SOURCE:

CONTACT OIS/EDG/DMUDD

REV\_CNTR\_IDE\_NDC\_UPC\_LIM

FULL NAME: Revenue Center IDE, NDC, UPC Limitation

DESCRIPTION :

Missing data in the REV\_CNTR\_IDE\_NDC\_UPC\_NUM field.

BACKGROUND :

Prior to Version 'I', this field housed only the 7-position exemption number assigned by the FDA to an investigational device after a manufacturer has been approved to conduct a clinical trial on that device. With Version 'I', this field expanded to 24 positions to accommodate the future receipt of the National Drug Code and the Uniform Product Code. The CWFMQA editing process was moving the IDE to the expanded field, but then incorrectly blanked it out (positions 8-24 should be blank).

CORRECTIVE ACTION :

CWFMQA fixed the code and the problem was corrected with claims processed with NCH weekly process date 9/15/00.

SOURCE:

ADMINISTRATIVE DATA:

START DATE : 06/09/00  
END DATE : 09/08/00  
CONTACT : OIS/EDG/DMUDD

REV\_CNTR\_TOT\_CHRG\_AMT\_LIM

FULL NAME: Revenue Center Total Charge Amount Limitation

DESCRIPTION :

Revenue center total charge amount field being populated on segments 2-10 of the Version 'I' record.

BACKGROUND :

Under Version 'I', a decision was made that any amount, count and quantity field would be zeroed out to eliminate the risk of overstating values during an accumulation.

CORRECTIVE ACTION :

The CWFMQA front-end process was modified to zero out the total charge amount field in segments 2-10.

SOURCE:

ADMINISTRATIVE DATA:

START DATE : 07/01/00  
END DATE : 02/02/01  
CONTACT : OIS/EDG/DMUDD

TOT\_CHRG\_AMT\_LIM

FULL NAME: Claim Total Charge Amount Limitation

DESCRIPTION :

The total charge amount field in the fixed portion was truncated on outpatient, hospice and home health claims.

BACKGROUND :

For outpatient, hospice and home health claims, the total charge amount field in the fixed portion was truncated (the cents were dropped off; the decimal point was moved, making cents out of dollars) in the CWFMQA process beginning with data received from CWF 1/4/99 through 5/14/99. The problem occurred when CWF increased the size of the field.

CORRECTIVE ACTION :

The CWFMQA front-end was fixed. The Nearline was patched during the quarterly merge in 7/99 for service years 1998 and 1999. The NCH\_PACTCH\_CD field will be populated with a value '11'. The 1998 and 1999 SAFs were corrected when finalized in 7/99.

The patch involved moving the total charge amount in the revenue center trailer to the total charge amount field in the fixed portion, for records with NCH Daily Process Date 1/4/99 - 5/14/99.

SOURCE:

ADMINISTRATIVE DATA:

START DATE : 01/04/99  
END DATE : 05/14/99  
CONTACT : OIS/EDG/DMUDD

06/30/2011

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H3PM.R\_RIF\_LIM\_Q,F

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CMS RIF REPORT  
AS OF: 06/30/2011

NAME	LENGTH	BEG	END	CONTENTS
*** FI Hospice Claim Record (NCH)				
VAR	1	16242	REC	
				Fiscal intermediary hospice claim record for version J of the NCH.
				STANDARD ALIAS : FI_HOSPC_CLM_REC

SYSTEM ALIAS : UTLHOSPJ

LIMITATIONS :

REFER TO :  
CHOICES\_DEMO\_LIM  
CLM\_TRANS\_CD\_LIM  
HHA\_HCPCS\_LIM  
MCO\_PD\_SW\_LIM  
MLTFL\_REV\_CNTR\_0001\_CD\_LIM  
PMT\_AMT\_EXCEDG\_CHRG\_AMT\_LIM  
REV\_CNTR\_IDE\_NDC\_UPC\_LIM  
REV\_CNTR\_TOT\_CHRG\_AMT\_LIM  
TOT\_CHRG\_AMT\_LIM

1.	FI Hospice Claim Fixed Group				
	623	1	623	GRP	

Fixed portion of the fiscal intermediary hospice claim record for version J of the NCH.

STANDARD ALIAS : FI\_HOSPC\_CLM\_FIX\_GRP

2.	Claim Record Identification Group				
	8	1	8	GRP	

Effective with Version 'I' the record length, version code, record identification, code and NCH derived claim type code were moved to this group for internal NCH processing.

STANDARD ALIAS : CLM\_REC\_IDENT\_GRP

3.	Record Length Count				
	3	1	3	PACK	

Effective with Version H, the count (in bytes) of the length of the claim record.

NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991).

DB2 ALIAS : REC\_LNGTH\_CNT  
SAS ALIAS : REC\_LEN  
STANDARD ALIAS : REC\_LNGTH\_CNT

LENGTH : 5 SIGNED : Y



				SOURCE	: NCH
4.	NCH Near-Line Record Version Code	1	4	4	CHAR
					The code indicating the record version of the Nearline file where the institutional, carrier or DMERC claims data are stored.
				DB2	ALIAS : NCH_REC_VRSN_CD
				SAS	ALIAS : REC_LVL
				STANDARD	ALIAS : NCH_NEAR_LINE_REC_VRSN_CD
				TITLE	ALIAS : NCH_VERSION
				LENGTH	: 1
				COMMENTS :	
					Prior to Version H this field was named: CLM_NEAR_LINE_REC_VRSN_CD.
				SOURCE	: NCH
				CODE TABLE	: NCH_NEAR_LINE_REC_VRSN_TB
5.	NCH Near Line Record Identification Code	1	5	5	CHAR
					A code defining the type of claim record being processed.
				COMMON	ALIAS : RIC
				DB2	ALIAS : NEAR_LINE_RIC_CD
				SAS	ALIAS : RIC_CD
				STANDARD	ALIAS : NCH_NEAR_LINE_RIC_CD
				TITLE	ALIAS : RIC
				LENGTH	: 1
				COMMENTS :	
					Prior to Version H this field was named: RIC_CD.
				SOURCE	: NCH
				CODE TABLE	: NCH_NEAR_LINE_RIC_TB
6.	NCH MQA RIC Code	1	6	6	CHAR
					Effective with Version H, the code used (for internal

editing purposes) to identify the record being processed through CMS' CWFMQA system.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : NCH\_MQA\_RIC\_CD  
SAS ALIAS : MQA\_RIC  
STANDARD ALIAS : NCH\_MQA\_RIC\_CD  
TITLE ALIAS : MQA\_RIC

LENGTH : 1

SOURCE : NCH QA PROCESS

CODE TABLE : NCH\_MQA\_RIC\_TB

7. NCH Claim Type Code

2 7 8 CHAR

The code used to identify the type of claim record being processed in NCH.

NOTE1: During the Version H conversion this field was populated with data throughout history (back to service year 1991).

NOTE2: During the Version I conversion this field was expanded to include inpatient 'full' encounter claims (for service dates after 6/30/97).

NOTE3: Effective with Version 'J', 3 new code values have been added to include a type code for the Medicare Advantage claims (IME/GME, no-pay and paid as FFS). During the Version 'J' conversion, these type codes were populated throughout history. With Version 'J', these claims are also being stored in NMUD. Prior to Version 'J' they were only in the NCH. No history was converted in NMUD.

DB2 ALIAS : NCH\_CLM\_TYPE\_CD  
SAS ALIAS : CLM\_TYPE  
STANDARD ALIAS : NCH\_CLM\_TYPE\_CD  
TITLE ALIAS : CLAIM\_TYPE

LENGTH : 2

DERIVATIONS :  
FFS CLAIM TYPE CODES DERIVED FROM:  
NCH CLM\_NEAR\_LINE\_RIC\_CD

NCH PMT\_EDIT\_RIC\_CD  
NCH CLM\_TRANS\_CD  
NCH PRVDR\_NUM

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:

(Pre-HDC processing -- AVAILABLE IN NCH)

CLM\_MCO\_PD\_SW  
CLM\_RLT\_COND\_CD  
MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD  
MCO\_PRD\_EFCTV\_DT  
MCO\_PRD\_TRMNTN\_DT

DERIVATION RULES:

SET CLM\_TYPE\_CD TO 10 (HHA CLAIM) WHERE THE  
FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V', 'W' OR 'U'
2. PMT\_EDIT\_RIC\_CD EQUAL 'F'
3. CLM\_TRANS\_CD EQUAL '5'

SET CLM\_TYPE\_CD TO 20 (SNF NON-SWING BED CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'
3. CLM\_TRANS\_CD EQUAL '0' OR '4'
4. POSITION 3 OF PRVDR\_NUM IS NOT 'U', 'W', 'Y'  
OR 'Z'

SET CLM\_TYPE\_CD TO 30 (SNF SWING BED CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'
3. CLM\_TRANS\_CD EQUAL '0' OR '4'
4. POSITION 3 OF PRVDR\_NUM EQUAL 'U', 'W', 'Y'  
OR 'Z'

SET CLM\_TYPE\_CD TO 40 (OUTPATIENT CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'W'
2. PMT\_EDIT\_RIC\_CD EQUAL 'D'
3. CLM\_TRANS\_CD EQUAL '6'

SET CLM\_TYPE\_CD TO 50 (HOSPICE CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'
2. PMT\_EDIT\_RIC\_CD EQUAL 'I'
3. CLM\_TRANS\_CD EQUAL 'H'

SET CLM\_TYPE\_CD TO 60 (INPATIENT CLAIM)

WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'
3. CLM\_TRANS\_CD EQUAL '1' '2' OR '3'

SET CLM\_TYPE\_CD TO 61 (INPATIENT 'FULL' ENCOUNTER CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 - 12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_MCO\_PD\_SW = '1'
2. CLM\_RLT\_COND\_CD = '04'
3. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = 'C'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS

SET CLM\_TYPE\_CD TO 61 (INPATIENT 'FULL' ENCOUNTER CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'
3. CLM\_TRANS\_CD EQUAL '1' '2' OR '3'
4. FI\_NUM = 80881

SET CLM\_TYPE\_CD TO 62 (Medicare Advantage IME/GME CLAIMS - 10/1/05 - FORWARD)  
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_MCO\_PD\_SW = '0'
2. CLM\_RLT\_COND\_CD = '04' & '69'
3. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = 'C'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS

SET CLM\_TYPE\_CD TO 63 (HMO NO-PAY CLAIMS)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
CLAIMS PROCESSED ON OR AFTER 10/6/08

1. CLM\_THRU\_DT ON OR AFTER 10/1/06
2. CLM\_MCO\_PD\_SW = '1'
3. CLM\_RLT\_COND\_CD = '04'
4. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = 'A', 'B' OR 'C'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS
5. ZERO REIMBURSEMENT (CLM\_PMT\_AMT)

SET CLM\_TYPE\_CD TO 63 (HMO NO-PAY CLAIMS)  
WHERE THE FOLLOWING CONDITIONS ARE MET:

CLAIMS PROCESSED PRIOR to 10/6/08

1. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = 'A', 'B' OR 'C'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS
2. ZERO REIMBURSEMENT (CLM\_PMT\_AMT)

SET CLM\_TYPE\_CD TO 64 (HMO CLAIMS PAID AS FFS)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
CLAIMS PROCESSED PRIOR to 10/6/08

1. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = '1', '2' OR '4'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS

SET CLM\_TYPE\_CD TO 64 (HMO CLAIMS PAID AS FFS)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
CLAIMS PROCESSED on or after 10/6/08

1. CLM\_RLT\_COND\_CD = '04'
2. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = '1', '2' OR '4'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS

SET CLM\_TYPE\_CD TO 71 (RIC O non-DMEPOS CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'O'
2. HCPCS\_CD not on DMEPOS table

SET CLM\_TYPE\_CD TO 72 (RIC O DMEPOS CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'O'
2. HCPCS\_CD on DMEPOS table (NOTE: if one or  
more line item(s) match the HCPCS on the  
DMEPOS table).

SET CLM\_TYPE\_CD TO 81 (RIC M non-DMEPOS DMERC  
CLAIM)

WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'M'
2. HCPCS\_CD not on DMEPOS table

SET CLM\_TYPE\_CD TO 82 (RIC M DMEPOS DMERC CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'M'
2. HCPCS\_CD on DMEPOS table (NOTE: if one or

more line item(s) match the HCPCS on the  
DMEPOS table).

SOURCE : NCH

CODE TABLE : NCH\_CLM\_TYPE\_TB

8. Fiscal Intermediary Claim Link Group  
125 9 133

GRP

Effective with Version 'I', this group  
contains those fields necessary to keep  
segments together (a claim may have up to 10  
segments due to the increase in number of  
revenue center trailers (up to 450). It is  
also used to house fields necessary for sorting  
and the final action process.

STANDARD ALIAS : FI\_CLM\_LINK\_GRP

9. Claim Locator Number Group  
11 9 19

GRP

This number uniquely identifies the beneficiary in  
the NCH Nearline.

COMMON ALIAS : HIC

STANDARD ALIAS : CLM\_LCTR\_NUM\_GRP

TITLE ALIAS : HICAN

10. Beneficiary Claim Account Number  
9 9 17

CHAR

The number identifying the primary beneficiary  
under the SSA or RRB programs submitted.

COMMON ALIAS : CAN

DB2 ALIAS : BENE\_CLM\_ACNT\_NUM

SAS ALIAS : CAN

STANDARD ALIAS : BENE\_CLM\_ACNT\_NUM

TITLE ALIAS : CAN

LENGTH : 9

SOURCE : SSA,RRB

LIMITATIONS :

RRB-issued numbers contain an overpunch in

the first position that may appear as a plus  
zero or A-G. RRB-formatted numbers may  
cause matching problems on non-IBM machines.

11. NCH Category Equatable Beneficiary Identification Code

2 18 19 CHAR

The code categorizing groups of BICs  
representing similar relationships between  
the beneficiary and the primary wage earner.

The equatable BIC module electronically matches  
two records that contain different BICs where  
it is apparent that both are records for the  
same beneficiary. It validates the BIC and  
returns a base BIC under which to house the  
record in the National Claims History (NCH)  
databases. (All records for a beneficiary  
are stored under a single BIC.)

COMMON ALIAS : NCH\_BASE\_CATEGORY\_BIC  
DB2 ALIAS : CTGRY\_EQTBL\_BIC  
SAS ALIAS : EQ\_BIC  
STANDARD ALIAS : NCH\_CTGRY\_EQTBL\_BIC\_CD  
TITLE ALIAS : EQUATED\_BIC

LENGTH : 2

COMMENTS :  
Prior to Version H this field was named:  
CTGRY\_EQTBL\_BENE\_IDENT\_CD.

SOURCE : BIC EQUATE MODULE

CODE TABLE : CTGRY\_EQTBL\_BENE\_IDENT\_TB

12. Beneficiary Identification Code

2 20 21 CHAR

The code identifying the type of relationship between an  
individual and a primary Social Security Administration  
(SSA) beneficiary or a primary Railroad Board (RRB)  
beneficiary.

COMMON ALIAS : BIC  
DA3 ALIAS : BENE\_IDENT\_CODE  
DB2 ALIAS : BENE\_IDENT\_CD  
SAS ALIAS : BIC  
STANDARD ALIAS : BENE\_IDENT\_CD  
TITLE ALIAS : BIC

LENGTH : 2  
SOURCE : SSA/RRB  
EDIT RULES :  
EDB REQUIRED FIELD  
CODE TABLE : BENE\_IDENT\_TB

13. NCH State Segment Code

1 22 22 CHAR

The code identifying the segment of the NCH Nearline file containing the beneficiary's record for a specific service year. Effective 12/96, segmentation is by CLM\_LCTR\_NUM, then final action sequence within residence state. (Prior to 12/96, segmentation was by ranges of county codes within the residence state.)

DB2 ALIAS : NCH\_STATE\_SGMT\_CD  
SAS ALIAS : ST\_SGMT  
STANDARD ALIAS : NCH\_STATE\_SGMT\_CD  
TITLE ALIAS : NEAR\_LINE\_SEGMENT

LENGTH : 1

COMMENTS :  
Prior to Version H this field was named:  
BENE\_STATE\_SGMT\_NEAR\_LINE\_CD.

SOURCE : NCH

CODE TABLE : NCH\_STATE\_SGMT\_TB

14. Beneficiary Residence SSA Standard State Code

2 23 24 CHAR

The SSA standard state code of a beneficiary's residence.

DA3 ALIAS : SSA\_STANDARD\_STATE\_CODE  
DB2 ALIAS : BENE\_SSA\_STATE\_CD  
SAS ALIAS : STATE\_CD  
STANDARD ALIAS : BENE\_RSDNC\_SSA\_STD\_STATE\_CD  
TITLE ALIAS : BENE\_STATE\_CD

LENGTH : 2

COMMENTS :  
1. Used in conjunction with a county code, as



selection criteria for the determination of payment rates for HMO reimbursement.  
2. Concerning individuals directly billable for Part B and/or Part A premiums, this element is used to determine if the beneficiary will receive a bill in English or Spanish.  
3. Also used for special studies.

SOURCE : SSA/EDB

EDIT RULES :  
OPTIONAL: MAY BE BLANK

CODE TABLE : GEO\_SSA\_STATE\_TB

15. Claim From Date

8 25 32

NUM

The first day on the billing statement covering services rendered to the beneficiary (a.k.a. 'Statement Covers From Date').

NOTE: For Home Health PPS claims, the 'from' date and the 'thru' date on the RAP (initial claim) must always match.

DB2 ALIAS : CLM\_FROM\_DT  
SAS ALIAS : FROM\_DT  
STANDARD ALIAS : CLM\_FROM\_DT  
TITLE ALIAS : FROM\_DATE

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

16. Claim Through Date

8 33 40

NUM

The last day on the billing statement covering services rendered to the beneficiary (a.k.a. 'Statement Covers Thru Date').

NOTE: For Home Health PPS claims, the 'from' date and the 'thru' date on the RAP (initial claim) must always match.

DB2 ALIAS : CLM\_THRU\_DT

SAS ALIAS : THRU\_DT  
STANDARD ALIAS : CLM\_THRU\_DT  
TITLE ALIAS : THRU\_DATE

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

17. NCH Weekly Claim Processing Date  
8 41 48

NUM

The date the weekly NCH database load process cycle begins, during which the claim records are loaded into the Nearline file. This date will always be a Friday, although the claims will actually be appended to the database subsequent to the date.

DB2 ALIAS : NCH\_WKLY\_PROC\_DT  
SAS ALIAS : WKLY\_DT  
STANDARD ALIAS : NCH\_WKLY\_PROC\_DT  
TITLE ALIAS : NCH\_PROCESS\_DT

LENGTH : 8 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
HCFA\_CLM\_PROC\_DT.

SOURCE : NCH

EDIT RULES :  
YYYYMMDD

18. CWF Claim Accretion Date  
8 49 56

NUM

The date the claim record is accreted (posted/processed) to the beneficiary master record at the CWF host site and authorization for payment is returned to the fiscal intermediary or carrier.

DB2 ALIAS : CWF\_CLM\_ACRTN\_DT  
SAS ALIAS : ACRTN\_DT  
STANDARD ALIAS : CWF\_CLM\_ACRTN\_DT  
TITLE ALIAS : ACCRETION\_DT

				LENGTH	: 8	SIGNED : N
				SOURCE	: CWF	
				EDIT RULES :	YYYYMMDD	
19.	CWF Claim Accretion Number	2	57	58	PACK	
					The sequence number assigned to the claim record when accreted (posted/processed) to the beneficiary master record at the CWF host site on a given date. This element indicates the position of the claim within that day's processing at the CWF host. **(Exception: If the claim record is missing the accretion date CMS' CWFMQA system places a zero in the accretion number.	
				DB2	ALIAS : CWF_CLM_ACRTN_NUM	
				SAS	ALIAS : ACRTN_NM	
				STANDARD	ALIAS : CWF_CLM_ACRTN_NUM	
				TITLE	ALIAS : ACCRETION_NUMBER	
				LENGTH	: 3	SIGNED : Y
				SOURCE	: CWF	
20.	FI Document Claim Control Number	23	59	81	CHAR	
					Unique control number assigned by an intermediary to an institutional claim.	
				COMMON	ALIAS : ICN	
				DB2	ALIAS : DOC_CLM_CNTL_NUM	
				SAS	ALIAS : CLM_CNTL	
				STANDARD	ALIAS : FI_DOC_CLM_CNTL_NUM	
				TITLE	ALIAS : ICN	
				LENGTH	: 23	
				SOURCE	: CWF	
21.	FI Original Claim Control Number	23	82	104	CHAR	
					Effective with Version G, the original intermediary	

control number (ICN) which is present on adjustment claims, representing the ICN of the original transaction now being adjusted.

COMMON ALIAS : ORIGINAL\_ICN  
DB2 ALIAS : ORIG\_CLM\_CNTL\_NUM  
SAS ALIAS : ORIGCNTL  
STANDARD ALIAS : FI\_ORIG\_CLM\_CNTL\_NUM  
TITLE ALIAS : ORIGINAL\_ICN

LENGTH : 23

SOURCE : CWF

22. Claim Query Code

1 105 105

CHAR

Code indicating the type of claim record being processed with respect to payment (debit/credit indicator; interim/final indicator).

DB2 ALIAS : CLM\_QUERY\_CD  
SAS ALIAS : QUERY\_CD  
STANDARD ALIAS : CLM\_QUERY\_CD  
TITLE ALIAS : QUERY\_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM\_QUERY\_TB

23. Provider Number

6 106 111

CHAR

The identification number of the institutional provider certified by Medicare to provide services to the beneficiary.

NOTE: Effective October 1, 2007 the OSCAR Provider Number has been renamed the CMS Certification Number (CCN). The name was changed to avoid confusion with the National Provider Identifier (NPI). The CCN (OSCAR Provider Number) will continue to play a critical role in verifying that a provider has been Medicare certified and for what type of services.

DB2 ALIAS : PRVDR\_NUM  
SAS ALIAS : PROVIDER

STANDARD ALIAS : PRVDR\_NUM  
TITLE ALIAS : PROVIDER\_NUMBER

LENGTH : 6

CODE TABLE : PRVDR\_NUM\_TB

24. NCH Daily Process Date

8 112 119

NUM

Effective with Version H, the date the claim record was processed by CMS' CWFMQA system (used for internal editing purposes).

Effective with Version I, this date is used in conjunction with the NCH Segment Link Number to keep claims with multiple records/ segments together.

NOTE1: With Version 'H' this field was populated with data beginning with NCH weekly process date 10/3/97. Under Version 'I' claims prior to 10/3/97, that were blank under Version 'H', were populated with a date.

DB2 ALIAS : NCH\_DAILY\_PROC\_DT  
SAS ALIAS : DAILY\_DT  
STANDARD ALIAS : NCH\_DAILY\_PROC\_DT  
TITLE ALIAS : DAILY\_PROCESS\_DT

LENGTH : 8 SIGNED : N

SOURCE : NCH

EDIT RULES :  
YYYYMMDD

25. NCH Segment Link Number

5 120 124

PACK

Effective with Version 'I', the system generated number used in conjunction with the NCH daily process date to keep records/segments belonging to a specific claim together. This field was added to ensure that records/segments that come in on the same batch with the same identifying information in the link group are not mixed with each other.

NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991).

DB2 ALIAS : NCH\_SGMT\_LINK\_NUM  
SAS ALIAS : LINK\_NUM  
STANDARD ALIAS : NCH\_SGMT\_LINK\_NUM  
TITLE ALIAS : LINK\_NUM

LENGTH : 9 SIGNED : Y

SOURCE : NCH

26. Claim Total Segment Count

2 125 126 NUM

Effective with Version I, the count used to identify the total number of segments associated with a given claim. Each claim could have up to 10 segments.

NOTE: During the Version I conversion, this field was populated with data throughout history (back to service year 1991). For institutional claims, the count for claims prior to 7/00 will be 1 or 2 (1 if 45 or less revenue center lines on a claim and 2 if more than 45 revenue center lines on a claim). For noninstitutional claims, the count will always be 1.

DB2 ALIAS : TOT\_SGMT\_CNT  
SAS ALIAS : SGMT\_CNT  
STANDARD ALIAS : CLM\_TOT\_SGMT\_CNT  
TITLE ALIAS : SEGMENT\_COUNT

LENGTH : 2 SIGNED : N

SOURCE : CWF

27. Claim Segment Number

2 127 128 NUM

Effective with Version I, the number used to identify an actual record/segment (1 - 10) associated with a given claim.

NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991). For institutional claims prior to 7/00, this number will be either 1 or 2. For noninstitutional claims, the number will

always be 1.

DB2 ALIAS : CLM\_SGMT\_NUM  
SAS ALIAS : SGMT\_NUM  
STANDARD ALIAS : CLM\_SGMT\_NUM  
TITLE ALIAS : SEGMENT\_NUMBER

LENGTH : 2 SIGNED : N

SOURCE : CWF

28. Claim Total Line Count

3 129 131

NUM

Effective with Version I, the count used to identify the total number of revenue center lines associated with the claim.

NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991). Prior to Version 'I', the maximum line count will be no more than 58. Effective with Version 'I', the maximum line count could be 450.

DB2 ALIAS : TOT\_LINE\_CNT  
SAS ALIAS : LINECNT  
STANDARD ALIAS : CLM\_TOT\_LINE\_CNT  
TITLE ALIAS : TOTAL\_LINE\_COUNT

LENGTH : 3 SIGNED : N

SOURCE : CWF

29. Claim Segment Line Count

2 132 133

NUM

Effective with Version I, the count used to identify the number of lines on a record/segment.

NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991). The maximum line count per record/segment on the revenue center trailer is 45. The maximum number of lines on carrier and DMERC claims are 13.

DB2 ALIAS : SGMT\_LINE\_CNT

				SAS	ALIAS : SGMTLINE
				STANDARD	ALIAS : CLM_SGMT_LINE_CNT
				TITLE	ALIAS : SEGMENT_LINE_COUNT
				LENGTH	: 2 SIGNED : N
				SOURCE	: CWF
30.	FI Claim Common Group	382	134	515	GRP
					Information common to fiscal intermediary (FI) claims (inpatient/SNF, outpatient, HHA & hospice), for version J of NCH Nearline file.
					STANDARD ALIAS : FI_CLM_CMN_GRP
31.	NCH Payment and Edit Record Identification Code	1	134	134	CHAR
					The code used for payment and editing purposes that indicates the type of institutional claim record. Prior to Version H this field was named: PMT_EDIT_RIC_CD.
				DB2	ALIAS : PMT_EDIT_RIC_CD
				SAS	ALIAS : PE_RIC
				STANDARD	ALIAS : NCH_PMT_EDIT_RIC_CD
				TITLE	ALIAS : NCH_PAYMENT_EDIT_RIC
				LENGTH	: 1
				SOURCE	: NCH QA Process
				CODE TABLE	: PMT_EDIT_RIC_TB
32.	Claim Transaction Code	1	135	135	CHAR
					The code derived by CWF to indicate the type of claim submitted by an institutional provider.
				DB2	ALIAS : CLM_TRANS_CD
				SAS	ALIAS : TRANS_CD
				STANDARD	ALIAS : CLM_TRANS_CD
				TITLE	ALIAS : TRANSACTION_CODE
				LENGTH	: 1



				SOURCE	: CWF
				LIMITATIONS	:
				REFER TO	:
				CLM_TRANS_CD_LIM	
				CODE TABLE	: CLM_TRANS_TB
33.	Claim Bill Type Group	2	136	137	GRP
					Effective with Version H, the claim facility type code plus the claim service classification type code. (The first two positions of the ('type of bill')). During the Version H conversion, this grouping was created throughout history.
					NOTE: Effective 4/1/2002, TOB code 'XX0' was implemented to identify those claims that are totally non-covered.
					STANDARD ALIAS : CLM_BILL_TYPE_CD_GRP
					CODE TABLE : CLM_BILL_TYPE_TB
34.	Claim Facility Type Code	1	136	136	CHAR
					The first digit of the type of bill (TOB1) submitted on an institutional claim used to identify the type of facility that provided care to the beneficiary.
				COMMON	ALIAS : TOB1
				DB2	ALIAS : CLM_FAC_TYPE_CD
				SAS	ALIAS : FAC_TYPE
				STANDARD	ALIAS : CLM_FAC_TYPE_CD
				TITLE	ALIAS : TOB1
				LENGTH	: 1
				SOURCE	: CWF
				CODE TABLE	: CLM_FAC_TYPE_TB
35.	Claim Service Classification Type Code	1	137	137	CHAR
					The second digit of the type of bill (TOB2) submitted on an institutional claim record to indicate the classification of

the type of service provided to the beneficiary.

COMMON ALIAS : TOB2  
DB2 ALIAS : SRVC\_CLSFCTN\_CD  
SAS ALIAS : TYPESRVC  
STANDARD ALIAS : CLM\_SRVC\_CLSFCTN\_TYPE\_CD  
TITLE ALIAS : TOB2

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM\_SRVC\_CLSFCTN\_TYPE\_TB

36. Claim Frequency Code

1 138 138

CHAR

The third digit of the type of bill (TOB3) submitted on an institutional claim record to indicate the sequence of a claim in the beneficiary's current episode of care.

COMMON ALIAS : TOB3  
DB2 ALIAS : CLM\_FREQ\_CD  
SAS ALIAS : FREQ\_CD  
STANDARD ALIAS : CLM\_FREQ\_CD  
TITLE ALIAS : FREQUENCY\_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM\_FREQ\_TB

37. FILLER

1 139 139

CHAR

DB2 ALIAS : FILLER

LENGTH : 1

38. NCH MQA Query Patch Code

1 140 140

CHAR

Effective with Version H, a code used (for internal editing purposes) to indicate that the CWFMQA process changed the query code submitted on the claim record.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : MQA\_QUERY\_PATCH\_CD  
SAS ALIAS : MQAQUERY  
STANDARD ALIAS : NCH\_MQA\_QUERY\_PATCH\_CD  
TITLE ALIAS : MQA\_QUERY\_PATCH\_IND

LENGTH : 1

SOURCE : NCH QA Process

CODE TABLE : NCH\_MQA\_QUERY\_PATCH\_TB

39. Claim Disposition Code

2 141 142 CHAR

Code indicating the disposition or outcome of the processing of the claim record.

DB2 ALIAS : CLM\_DISP\_CD  
SAS ALIAS : DISP\_CD  
STANDARD ALIAS : CLM\_DISP\_CD  
TITLE ALIAS : DISPOSITION\_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : CLM\_DISP\_TB

40. NCH Edit Disposition Code

2 143 144 CHAR

Effective with Version H, a code used (for internal editing purposes) to indicate the disposition of the claim after editing in the CWFMQA process.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : NCH\_EDIT\_DISP\_CD  
SAS ALIAS : EDITDISP  
STANDARD ALIAS : NCH\_EDIT\_DISP\_CD  
TITLE ALIAS : NCH\_EDIT\_DISP

LENGTH : 2

SOURCE : NCH QA Process

CODE TABLE : NCH\_EDIT\_DISP\_TB

41. NCH Claim BIC Modify H Code

1 145 145

CHAR

Effective with Version H, the code used (for internal editing purposes) to identify a claim record that was submitted with an incorrect HA, HB, or HC BIC.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : NCH\_BIC\_MDFY\_CD  
SAS ALIAS : BIC\_MDFY  
STANDARD ALIAS : NCH\_CLM\_BIC\_MDFY\_CD  
TITLE ALIAS : BIC\_MODIFY\_CD

LENGTH : 1

SOURCE : NCH QA Process

CODE TABLE : NCH\_CLM\_BIC\_MDFY\_TB

42. Beneficiary Residence SSA Standard County Code

3 146 148

CHAR

The SSA standard county code of a beneficiary's residence.

DB2 ALIAS : BENE\_SSA\_CNTY\_CD  
SAS ALIAS : CNTY\_CD  
STANDARD ALIAS : BENE\_RSDNC\_SSA\_STD\_CNTY\_CD  
TITLE ALIAS : BENE\_COUNTY\_CD

LENGTH : 3

SOURCE : SSA/EDB

EDIT RULES :  
OPTIONAL: MAY BE BLANK

43. FI Claim Receipt Date

8 149 156

NUM

The date the fiscal intermediary received the institutional claim from the provider.

DB2 ALIAS : FI\_CLM\_RCPT\_DT  
SAS ALIAS : RCPT\_DT  
STANDARD ALIAS : FI\_CLM\_RCPT\_DT  
TITLE ALIAS : RECEIPT\_DT

LENGTH : 8 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
FICARR\_CLM\_RCPT\_DT.

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

44. FI Claim Scheduled Payment Date  
8 157 164

NUM

The scheduled date of payment to the institutional provider, as reflected on the claim record transmitted to the CWF host. Note: This date is considered to be the date paid since no additional information as to the actual payment date is available.

DB2 ALIAS : FI\_SCHLD\_PMT\_DT  
SAS ALIAS : SCHLD\_DT  
STANDARD ALIAS : FI\_CLM\_SCHLD\_PMT\_DT  
TITLE ALIAS : SCHEDULED\_PMT\_DT

LENGTH : 8 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
FICARR\_CLM\_PMT\_DT.

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

45. CWF Forwarded Date  
8 165 172

NUM

Effective with Version H, the date CWF forwarded the claim record to CMS (used for internal editing purposes).

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

DB2 ALIAS : CWF\_FRWRD\_DT  
SAS ALIAS : FRWRD\_DT

STANDARD ALIAS : CWF\_FRWRD\_DT  
TITLE ALIAS : FORWARD\_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

46. FI Number

5 173 177 CHAR

The identification number assigned by CMS to a fiscal intermediary authorized to process institutional claim records.

Effective October 2006, the Medicare Administrative Contractors (MACs) began replacing the existing fiscal intermediaries and started processing institutional claim records for states assigned to its jurisdiction.

NOTE: The 5-position MAC number will be housed in the existing FI\_NUM field. During the transition from an FI to a MAC the FI\_NUM field could contain either a FI number or a MAC number. See the FI\_NUM table of codes to identify the new MAC numbers and their effective dates.

DB2 ALIAS : FI\_NUM  
SAS ALIAS : FI\_NUM  
STANDARD ALIAS : FI\_NUM  
TITLE ALIAS : INTERMEDIARY

LENGTH : 5

COMMENTS :  
Prior to Version H this field was named:  
FICARR\_IDENT\_NUM.

SOURCE : CWF

CODE TABLE : FI\_NUM\_TB

47. CWF Claim Assigned Number

8 178 185 CHAR

Effective with Version H, the number assigned to an institutional claim record by CWF (used

for internal editing purposes).

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : CWF\_CLM\_ASGN\_NUM  
SAS ALIAS : ASGN\_NUM  
STANDARD ALIAS : CWF\_CLM\_ASGN\_NUM  
TITLE ALIAS : ASSIGNED\_NUM

LENGTH : 8

SOURCE : CWF

48. CWF Transmission Batch Number  
4 186 189

CHAR

Effective with Version H, the number assigned to each batch of claims transactions sent from CWF(used for internal editing purposes).

NOTE: Beginning 11/98, this field will be populated with data. Claims processed prior to 11/98 will contain spaces in this field.

DB2 ALIAS : TRNSMSN\_BATCH\_NUM  
SAS ALIAS : FIBATCH  
STANDARD ALIAS : CWF\_TRNSMSN\_BATCH\_NUM  
TITLE ALIAS : BATCH\_NUM

LENGTH : 4

SOURCE : CWF

49. Beneficiary Mailing Contact ZIP Code  
9 190 198

CHAR

The ZIP code of the mailing address where the beneficiary may be contacted.

DB2 ALIAS : BENE\_MLG\_ZIP\_CD  
SAS ALIAS : BENE\_ZIP  
STANDARD ALIAS : BENE\_MLG\_CNTCT\_ZIP\_CD  
TITLE ALIAS : BENE\_ZIP

LENGTH : 9

				SOURCE	: EDB
50.	Beneficiary Sex Identification Code	1	199	199	CHAR
					The sex of a beneficiary.
				COMMON	ALIAS : SEX_CD
				DA3	ALIAS : SEX_CODE
				DB2	ALIAS : BENE_SEX_IDENT_CD
				SAS	ALIAS : SEX
				STANDARD	ALIAS : BENE_SEX_IDENT_CD
				TITLE	ALIAS : SEX_CD
				LENGTH	: 1
				SOURCE	: SSA,RRB,EDB
				EDIT RULES :	
					REQUIRED FIELD
				CODE TABLE	: BENE_SEX_IDENT_TB
51.	Beneficiary Race Code	1	200	200	CHAR
					The race of a beneficiary.
				DA3	ALIAS : RACE_CODE
				DB2	ALIAS : BENE_RACE_CD
				SAS	ALIAS : RACE
				STANDARD	ALIAS : BENE_RACE_CD
				TITLE	ALIAS : RACE_CD
				LENGTH	: 1
				SOURCE	: SSA
				CODE TABLE	: BENE_RACE_TB
52.	Beneficiary Birth Date	8	201	208	NUM
					The beneficiary's date of birth.
				COMMON	ALIAS : DOB
				DA3	ALIAS : BIRTH_DATE
				DB2	ALIAS : BENE_BIRTH_DT
				SAS	ALIAS : BENE_DOB
				STANDARD	ALIAS : BENE_BIRTH_DT



TITLE ALIAS : BENE\_BIRTH\_DATE

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

53. CWF Beneficiary Medicare Status Code  
2 209 210

CHAR

The CWF-derived reason for a beneficiary's entitlement to Medicare benefits, as of the reference date (CLM\_THRU\_DT).

COBOL ALIAS : MSC  
COMMON ALIAS : MSC  
DB2 ALIAS : BENE\_MDCR\_STUS\_CD  
SAS ALIAS : MS\_CD  
STANDARD ALIAS : CWF\_BENE\_MDCR\_STUS\_CD  
TITLE ALIAS : MSC

LENGTH : 2

DERIVATIONS :  
CWF derives MSC from the following:

1. Date of Birth
2. Claim Through Date
3. Original/Current Reasons for entitlement
4. ESRD Indicator
5. Beneficiary Claim Number

Items 1,3,4,5 come from the CWF Beneficiary Master Record; item 2 comes from the FI/Carrier claim record. MSC is assigned as follows:

MSC	OASI	DIB	ESRD	AGE	BIC
10	YES	N/A	NO	65 and over	N/A
11	YES	N/A	YES	65 and over	N/A
20	NO	YES	NO	under 65	N/A
21	NO	YES	YES	under 65	N/A
31	NO	NO	YES	any age	T.

COMMENTS :  
Prior to Version H this field was named:  
BENE\_MDCR\_STUS\_CD. The name has been changed to distinguish this CWF-derived field from the EDB-derived MSC (BENE\_MDCR\_STUS\_CD).

SOURCE : CWF  
CODE TABLE : BENE\_MDCR\_STUS\_TB

54. Claim Patient 6 Position Surname  
6 211 216

CHAR

The first 6 positions of the Medicare patient's surname (last name) as reported by the provider on the claim.

NOTE1: Prior to Version H, this field was only present on the IP/SNF claim record. Effective with Version H, this field is present on all claim types.

NOTE2: For OP, HHA, Hospice and all Carrier claims, data was populated beginning with NCH weekly process 10/3/97. Claims processed prior to 10/3/97 will contain spaces in this field.

COMMON ALIAS : PATIENT\_SURNAME  
DB2 ALIAS : PTNT\_6\_PSTN\_SRNM  
SAS ALIAS : SURNAME  
STANDARD ALIAS : CLM\_PTNT\_6\_PSTN\_SRNM\_NAME  
TITLE ALIAS : PATIENT\_SURNAME

LENGTH : 6

SOURCE : CWF

55. Claim Patient 1st Initial Given Name  
1 217 217

CHAR

The first initial of the Medicare patient's given name (first name) as reported by the provider on the claim.

NOTE1: Prior to Version H, this field was only present on the IP/SNF claim record. Effective with Version H, this field is present on all claim types.

NOTE2: For OP, HHA, Hospice and all Carrier claims, data was populated beginning with NCH weekly process date 10/3/97. Claims processed prior to 10/3/97 will contain spaces in this field.

COMMON ALIAS : PATIENT GIVEN\_NAME  
DB2 ALIAS : 1ST\_INITL\_GVN\_NAME  
SAS ALIAS : FRSTINIT  
STANDARD ALIAS : CLM\_PTNT\_1ST\_INITL\_GVN\_NAME  
TITLE ALIAS : PATIENT\_FIRST\_INITIAL

LENGTH : 1

SOURCE : CWF

56. Claim Patient First Initial Middle Name  
1 218 218

CHAR

The first initial of the Medicare patient's middle name as reported by the provider on the claim.

NOTE1: Prior to Version H, this field was only present on the IP/SNF claim record. Effective with Version H, this field is present on all claim types.

NOTE2: For OP, HHA, Hospice and all Carrier claims, data was populated beginning with NCH weekly process date 10/3/97. Claims processed prior to 10/3/97 will contain spaces in this field.

COMMON ALIAS : PATIENT\_MIDDLE\_NAME  
DB2 ALIAS : 1ST\_INITL\_MDL\_NAME  
SAS ALIAS : MDL\_INIT  
STANDARD ALIAS : CLM\_PTNT\_1ST\_INITL\_MDL\_NAME  
TITLE ALIAS : PATIENT\_MIDDLE\_INITIAL

LENGTH : 1

SOURCE : CWF

57. Beneficiary CWF Location Code  
1 219 219

CHAR

The code that identifies the Common Working File (CWF) location (the host site) where a beneficiary's Medicare utilization records are maintained.

COMMON ALIAS : CWF\_HOST  
DB2 ALIAS : BENE\_CWF\_LOC\_CD  
SAS ALIAS : CWFLOCCD  
STANDARD ALIAS : BENE\_CWF\_LOC\_CD  
TITLE ALIAS : CWF\_HOST

				LENGTH	: 1
				SOURCE	: CWF
				CODE TABLE	: BENE_CWF_LOC_TB
58.	Claim Principal Diagnosis Group	8	220	227	GRP
					Effective with Version 'J', the group used to identify the principal diagnosis code. This group contains the principal diagnosis code and the principal diagnosis version code.
					STANDARD ALIAS : CLM_PRNCPAL_DGNS_GRP
59.	Claim Principal Diagnosis Version Code	1	220	220	CHAR
					Effective with Version 'J', the code used to indicate if the diagnosis is ICD-9 or ICD-10.
					NOTE: With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2013.
				DB2	ALIAS : UNDEFINED
				SAS	ALIAS : PDVRSNCD
				LENGTH	: 1
				CODE TABLE	: CLM_DGNS_VRSN_TB
60.	Claim Principal Diagnosis Code	7	221	227	CHAR
					The diagnosis code identifying the diagnosis, condition, problem or other reason for the admission/encounter/visit shown in the medical record to be chiefly responsible for the services provided.
					NOTE: Effective with Version H, this data is also redundantly stored as the first occurrence of the diagnosis trailer.
					NOTE1: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate

the future implementation of ICD-10.

DB2 ALIAS : PRNCPAL\_DGNS\_CD  
SAS ALIAS : PDGNS\_CD

LENGTH : 7

SOURCE : CWF

EDIT RULES :  
ICD-9-CM

61. FILLER

1 228 228 CHAR

DB2 ALIAS : FILLER

LENGTH : 1

62. Claim Medicare Non Payment Reason Code

2 229 230 CHAR

The reason that no Medicare payment is made for services on an institutional claim.

NOTE1: This field was put on all institutional claim types but data did not start coming in on OP/HHA/Hospice until 4/1/02. Prior to 4/1/02, data only came in Inpatient/SNF claims.

NOTE2: Effective 4/1/02, this field was also expanded to two bytes to accommodate new values. The NCH Nearline file did not expand the current 1-byte field but instituted a crosswalk of the 2-byte field to the 1-byte character value. See table of code for the crosswalk.

NOTE3: Effective with Version 'J', the field has been expanded on the NCH claim to 2 bytes. With this expansion the NCH will no longer use the character values to represent the official two byte values being sent in by CWF since 4/2002.

During the Version 'J' conversion, all character values were converted to the two byte values.

DB2 ALIAS : MDCR\_NPMT\_RSN\_CD  
SAS ALIAS : NOPAY\_CD

LENGTH : 2

CODE TABLE : CLM\_MDCR\_NPMT\_RSN\_TB

63. Claim Excepted/Nonexcepted Medical Treatment Code  
1 231 231 CHAR

Effective with Version I, the code used to identify whether or not the medical care or treatment received by a beneficiary, who has elected care from a Religious Nonmedical Health Care Institution (RNHCI), is excepted or nonexcepted. Excepted is medical care or treatment that is received involuntarily or is required under Federal, State or local law. Nonexcepted is defined as medical care or treatment other than excepted.

DB2 ALIAS : EXCPTD\_NEXCPTD\_CD  
SAS ALIAS : TRTMT\_CD  
STANDARD ALIAS : CLM\_EXCPTD\_NEXCPTD\_TRTMT\_CD  
TITLE ALIAS : EXCPTD\_NEXCPTD\_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM\_EXCPTD\_NEXCPTD\_TRTMT\_TB

64. Claim Payment Amount  
6 232 237 PACK

Amount of payment made from the Medicare trust fund for the services covered by the claim record. Generally, the amount is calculated by the FI or carrier; and represents what was paid to the institutional provider, physician, or supplier, with the exceptions noted below. \*\*NOTE: In some situations, a negative claim payment amount may be present; e.g., (1) when a beneficiary is charged the full deductible during a short stay and the deductible exceeded the amount Medicare pays; or (2) when a beneficiary is charged a coinsurance amount during a long stay and the coinsurance amount exceeds the amount Medicare pays (most prevalent situation involves psych hospitals who are paid a daily per diem rate no matter what the charges are.)

Under IP PPS, inpatient hospital services are paid based on a predetermined rate per discharge, using the DRG patient classification system and the PRICER program. On the IP PPS claim, the payment amount includes the DRG outlier approved payment amount, disproportionate share (since 5/1/86), indirect medical education (since 10/1/88), total PPS capital (since 10/1/91). After 4/1/03, the payment

amount could also include a "new technology" add-on amount. It does NOT include the pass-thru amounts (i.e., capital-related costs, direct medical education costs, kidney acquisition costs, bad debts); or any beneficiary-paid amounts (i.e., deductibles and coinsurance); or any other payer reimbursement.

Under IRFPPS, inpatient rehabilitation services are paid based on a predetermined rate per discharge, using the Case Mix Group (CMG) classification system and the PRICER program. From the CMG on the IRF PPS claim, payment is based on a standard payment amount for operating and capital cost for that facility (including routine and ancillary services). The payment is adjusted for wage, the % of low-income patients (LIP), locality, transfers, interrupted stays, short stay cases, deaths, and high cost outliers. Some or all of these adjustments could apply. The CMG payment does NOT include certain pass-through costs (i.e. bad debts, approved education activities); beneficiary-paid amounts, other payer reimbursement, and other services outside of the scope of PPS.

Under LTCH PPS, long term care hospital services are paid based on a predetermined rate per discharge based on the DRG and the PRICER program. Payments are based on a single standard Federal rate for both inpatient operating and capital-related costs (including routine and ancillary services), but do NOT include certain pass-through costs (i.e. bad debts, direct medical education, new technologies and blood clotting factors). Adjustments to the payment may occur due to short-stay outliers, interrupted stays, high cost outliers, wage index, and cost of living adjustments.

Under SNF PPS, SNFs will classify beneficiaries using the patient classification system known as RUGS III. For the SNF PPS claim, the SNF PRICER will calculate/return the rate for each revenue center line item with revenue center code = '0022'; multiply the rate times the units count; and then sum the amount payable for all lines with revenue center code '0022' to determine the total claim payment amount.

Under Outpatient PPS, the national ambulatory payment classification (APC) rate that is calculated for each APC group is the basis for determining the total claim payment. The payment amount also includes the outlier payment and interest.

Under Home Health PPS, beneficiaries will be classified into an appropriate case mix category known as the Home Health

Resource Group. A HIPPS code is then generated corresponding to the case mix category (HHRG).

For the RAP, the PRICER will determine the payment amount appropriate to the HIPPS code by computing 60% (for first episode) or 50% (for subsequent episodes) of the case mix episode payment. The payment is then wage index adjusted.

For the final claim, PRICER calculates 100% of the amount due, because the final claim is processed as an adjustment to the RAP, reversing the RAP payment in full. Although final claim will show 100% payment amount, the provider will actually receive the 40% or 50% payment. The payment may also include outlier payments.

Exceptions: For claims involving demos and BBA encounter data, the amount reported in this field may not just represent the actual provider payment.

For demo Ids '01','02','03','04' -- claims contain amount paid to the provider, except that special 'differentials' paid outside the normal payment system are not included.

For demo Ids '05','15' -- encounter data 'claims' contain amount Medicare would have paid under FFS, instead of the actual payment to the MCO.

For demo Ids '06','07','08' -- claims contain actual provider payment but represent a special negotiated bundled payment for both Part A and Part B services. To identify what the conventional provider Part A payment would have been, check value code = 'Y4'. The related noninstitutional (physician/supplier) claims contain what would have been paid had there been no demo.

For BBA encounter data (non-demo) -- 'claims' contain amount Medicare would have paid under FFS, instead of the actual payment to the BBA plan.

COMMON	ALIAS : REIMBURSEMENT
DB2	ALIAS : CLM_PMT_AMT
SAS	ALIAS : PMT_AMT
STANDARD	ALIAS : CLM_PMT_AMT
TITLE	ALIAS : REIMBURSEMENT

LENGTH : 9.2 SIGNED : Y



COMMENTS :  
Prior to Version H, the size of this field was S9(7)V99. Also,  
the noninstitutional claim records carried this field as  
a line item. Effective with Version H, this element is a  
claim level field across all claim types (and the line item  
field has been renamed.)

SOURCE : CWF

LIMITATIONS :  
Prior to 4/6/93, on inpatient, outpatient, and  
physician/supplier claims containing a  
CLM\_DISP\_CD of '02', the amount shown as the Medicare  
reimbursement does not take into consideration  
any CWF automatic adjustments (involving erroneous  
deductibles in most cases). In as many as 30% of  
the claims (30% IP, 15% OP, 5% PART B), the  
reimbursement reported on the claims may be over  
or under the actual Medicare payment amount.

REFER TO :  
PMT\_AMT\_EXCEDG\_CHRG\_AMT\_LIM

EDIT RULES :  
\$\$\$\$\$\$\$\$\$CC

65. NCH Primary Payer Claim Paid Amount  
6 238 243

PACK

The amount of a payment made on behalf of a Medicare  
beneficiary by a primary payer other than Medicare, that the  
provider is applying to covered Medicare charges on an  
institutional, carrier, or DMERC claim.

DB2 ALIAS : PRMRY\_PYR\_PD\_AMT  
STANDARD ALIAS : NCH\_PRMRY\_PYR\_CLM\_PD\_AMT  
TITLE ALIAS : PRIMARY\_PAYER\_AMOUNT

LENGTH : 9.2 SIGNED : Y

COMMENTS :  
Prior to Version H this field was named:  
BENE\_PRMRY\_PYR\_CLM\_PMT\_AMT and the field size  
was S9(7)V99.

SOURCE : NCH

EDIT RULES :  
\$\$\$\$\$\$\$\$\$CC

66. NCH Primary Payer Code

1 244 244

CHAR

The code, on an institutional claim, specifying a federal non-Medicare program or other source that has primary responsibility for the payment of the Medicare beneficiary's health insurance bills.

DB2 ALIAS : NCH\_PRMRY\_PYR\_CD  
SAS ALIAS : PRPAY\_CD  
STANDARD ALIAS : NCH\_PRMRY\_PYR\_CD  
TITLE ALIAS : PRIMARY\_PAYER\_CD

LENGTH : 1

DERIVATIONS :

DERIVED FROM:

CLM\_VAL\_CD  
CLM\_VAL\_AMT

DERIVATION RULES

SET NCH\_PRMRY\_PYR\_CD TO 'A' WHERE THE  
CLM\_VAL\_CD = '12'

SET NCH\_PRMRY\_PYR\_CD TO 'B' WHERE THE  
CLM\_VAL\_CD = '13'

SET NCH\_PRMRY\_PYR\_CD TO 'C' WHERE THE  
CLM\_VAL\_CD = '16' and CLM\_VAL\_AMT is zeroes

SET NCH\_PRMRY\_PYR\_CD TO 'D' WHERE THE  
CLM\_VAL\_CD = '14'

SET NCH\_PRMRY\_PYR\_CD TO 'E' WHERE THE  
CLM\_VAL\_CD = '15'

SET NCH\_PRMRY\_PYR\_CD TO 'F' WHERE THE  
CLM\_VAL\_CD = '16' (CLM\_VAL\_AMT not  
equal to zeroes)

SET NCH\_PRMRY\_PYR\_CD TO 'G' WHERE THE  
CLM\_VAL\_CD = '43'

SET NCH\_PRMRY\_PYR\_CD TO 'H' WHERE THE  
CLM\_VAL\_CD = '41'

SET NCH\_PRMRY\_PYR\_CD TO 'I' WHERE THE  
CLM\_VAL\_CD = '42'

SET NCH\_PRMRY\_PYR\_CD TO 'L' (or prior to 4/97  
set code to 'J') WHERE THE CLM\_VAL\_CD = '47'

COMMENTS :  
Prior to Version H this field was named:  
BENE\_PRMRY\_PYR\_CD.

SOURCE : NCH

CODE TABLE : BENE\_PRMRY\_PYR\_TB

67. FI Requested Claim Cancel Reason Code  
1 245 245

CHAR

The reason that an intermediary requested cancelling  
a previously submitted institutional claim.

DB2 ALIAS : RQST\_CNCL\_RSN\_CD  
SAS ALIAS : CANCELCD  
STANDARD ALIAS : FI\_RQST\_CLM\_CNCL\_RSN\_CD  
TITLE ALIAS : CANCEL\_CD

LENGTH : 1

COMMENTS :  
Prior to Version H this field was named:  
INTRMDRY\_RQST\_CLM\_CNCL\_RSN\_CD.

SOURCE : CWF

CODE TABLE : FI\_RQST\_CLM\_CNCL\_RSN\_TB

68. FI Claim Action Code  
1 246 246

CHAR

The type of action requested by the intermediary  
to be taken on an institutional claim.

DB2 ALIAS : FI\_CLM\_ACTN\_CD  
SAS ALIAS : ACTIONCD  
STANDARD ALIAS : FI\_CLM\_ACTN\_CD  
TITLE ALIAS : ACTION\_CD

LENGTH : 1

COMMENTS :  
Prior to Version H this field was named:  
INTRMDRY\_CLM\_ACTN\_CD.

SOURCE : CWF

CODE TABLE : FI\_CLM\_ACTN\_TB

69. FI Claim Process Date

8 247 254

NUM

The date the fiscal intermediary completes processing and releases the institutional claim to the CWF host.

DB2 ALIAS : FI\_CLM\_PROC\_DT  
SAS ALIAS : APRVL\_DT  
STANDARD ALIAS : FI\_CLM\_PROC\_DT  
TITLE ALIAS : FI\_PROCESS\_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

70. NCH Provider State Code

2 255 256

CHAR

Effective with Version H, the two position SSA state code where provider facility is located.

NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991).

DB2 ALIAS : NCH\_PRVDR\_STATE\_CD  
SAS ALIAS : PRSTATE  
STANDARD ALIAS : NCH\_PRVDR\_STATE\_CD  
TITLE ALIAS : PROVIDER\_STATE\_CD

LENGTH : 2

DERIVATIONS :  
DERIVED FROM:  
NCH\_PRVDR\_NUM

DERIVATION RULES:

SET NCH\_PRVDR\_STATE\_CD TO  
PRVDR\_NUM POS1-2.  
FOR PRVDR\_NUM POS1-2 EQUAL '55' OR '75'  
SET NCH\_PRVDR\_STATE\_CD TO '05'.  
FOR PRVDR\_NUM POS1-2 EQUAL '67' OR '74'

```

SET NCH_PRVDR_STATE_CD TO '45'.
FOR PRVDR_NUM POS1-2 EQUAL '68' OR '69'
SET NCH_PRVDR_STATE_CD TO '10'.
FOR PRVDR_NUM POS1-2 EQUAL '78'
SET NCH_PRVDR_STATE_CD TO '14'.
FOR PRVDR_NUM POS1-2 EQUAL TO '76'
SET NCH_PRVDR_STATE_CD TO '16'.
FOR PRVDR_NUM POS1-2 EQUAL '70'
SET NCH_PRVDR_STATE_CD TO '17'.
FOR PRVDR_NUM POS1-2 EQUAL '71'
SET NCH_PRVDR_STATE_CD TO '19'.
FOR PRVDR_NUMBER POS1-2 EQUAL '77'
SET NCH_PRVDR_STATE_CD TO '24'.
FOR PRVDR_NUM POS1-2 EQUAL TO '72'
SET NCH_PRVDR_STATE_CD TO '36'.
FOR PRVDR_NUM POS1-2 EQUAL TO '73'
SET NCH_PRVDR_STATE_CD TO '39'

```

SOURCE : NCH

CODE TABLE : GEO\_SSA\_STATE\_TB

71. Organization NPI Number

10 257 266

CHAR

On an institutional claim, the National Provider Identifier (NPI) number assigned to uniquely identify the institutional provider certified by Medicare to provide services to the beneficiary.

NOTE: Effective May 2007, the NPI will become the national standard identifier for covered health care providers. NPIs will replace current OSCAR provider number, UPINs, NSC numbers, and local contractor provider identification numbers (PINs) on standard HIPPA claim transactions. (During the NPI transition phase (4/3/06 - 5/23/07) the capability was there for the NCH to receive NPIs along with an existing legacy number (UPIN, PIN, OSCAR provider number, etc.)).

NOTE1: CMS has determined that dual provider identifiers (old legacy numbers and new NPI) must be available in the NCH. After the 5/07 NPI implementation, the standard system maintainers will add the legacy number to the claim when it is adjudicated. We will continue to receive the OSCAR provider number and any currently

issued UPINs. Effective May 2007, no NEW UPINs (legacy number) will be generated for NEW physicians (Part B and outpatient claims), so there will only be NPIs sent in to the NCH for those physicians.

DB2 ALIAS : ORG\_NPI\_NUM  
SAS ALIAS : ORGNPINM  
STANDARD ALIAS : ORG\_NPI\_NUM  
TITLE ALIAS : ORG\_NPI

LENGTH : 10

SOURCE : CWF

72. Attending Physician ID Group  
24 267 290

Name and identification numbers associated with the primary care physician.

STANDARD ALIAS : ATNDG\_PHYSN\_ID\_GRP

73. Claim Attending Physician UPIN Number  
6 267 272

CHAR

On an institutional claim, the unique physician identification number (UPIN) of the physician who would normally be expected to certify and recertify the medical necessity of the services rendered and/or who has primary responsibility for the beneficiary's medical care and treatment (attending physician).

COMMON ALIAS : ATTENDING\_PHYSICIAN\_UPIN  
DB2 ALIAS : ATNDG\_UPIN\_NUM  
SAS ALIAS : AT\_UPIN  
STANDARD ALIAS : CLM\_ATNDG\_PHYSN\_UPIN\_NUM  
TITLE ALIAS : ATTENDING\_PHYSICIAN

LENGTH : 6

COMMENTS :

Prior to Version H this field was named: CLM\_PRMRY\_CARE\_PHYSN\_IDENT\_NUM and contained 10 positions (6-position UPIN and 4-position physician surname).

SOURCE : CWF

74. Claim Attending Physician NPI Number

10 273 282

CHAR

On an institutional claim, the national provider identifier (NPI) number assigned to uniquely identify the physician who has overall responsibility for the beneficiary's care and treatment.

NOTE: Effective May 2007, the NPI will become the national standard identifier for covered health care providers. NPIs will replace current OSCAR provider number, UPINs, NSC numbers, and local contractor provider identification numbers (PINs) on standard HIPPA claim transactions. (During the NPI transition phase (4/3/06 - 5/23/07) the capability was there for the NCH to receive NPIs along with an existing legacy number (UPIN, PIN, OSCAR provider number, etc.)).

NOTE1: CMS has determined that dual provider identifiers (old legacy numbers and new NPI) must be available in the NCH. After the 5/07 NPI implementation, the standard system maintainers will add the legacy number to the claim when it is adjudicated. We will continue to receive the OSCAR provider number and any currently issued UPINs. Effective May 2007, no NEW UPINs (legacy number) will be generated for NEW physicians (Part B and Outpatient claims), so there will only be NPIs sent in to the NCH for those physicians.

COMMON ALIAS : ATTENDING\_PHYSICIAN\_NPI  
DB2 ALIAS : ATNDG\_NPI\_NUM  
SAS ALIAS : AT\_NPI  
STANDARD ALIAS : CLM\_ATNDG\_PHYSN\_NPI\_NUM  
TITLE ALIAS : ATNDG\_NPI

LENGTH : 10

SOURCE : CWF

75. Claim Attending Physician Surname

6 283 288

CHAR

Effective with Version H, the last name of the attending physician (used for internal editing purpose in CMS' CWFQA system.)

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : ATNDG\_SRNM  
SAS ALIAS : AT\_SRNM  
STANDARD ALIAS : CLM\_ATNDG\_PHYSN\_SRNM\_NAME  
TITLE ALIAS : ANDG\_PHYSN\_SURNAME

LENGTH : 6

SOURCE : CWF

76. Claim Attending Physician Given Name  
1 289 289

CHAR

Effective with Version H, the first name of the attending physician (used for internal editing purposes in CMS' CWFMQA system).

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : ATNDG\_GVN\_NAME  
SAS ALIAS : AT\_GVNNM  
STANDARD ALIAS : CLM\_ATNDG\_PHYSN\_GVN\_NAME  
TITLE ALIAS : ATNDG\_PHYSN\_FIRSTNAME

LENGTH : 1

SOURCE : CWF

77. Claim Attending Physician Middle Initial Name  
1 290 290

CHAR

Effective with Version H, the middle initial of the attending physician (used for internal editing purposes in CMS' CWFMQA system.)

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : ATNDG\_MI\_NAME  
SAS ALIAS : AT\_MDL



				STANDARD ALIAS : CLM_ATNDG_PHYSN_MDL_INITL_NAME
				TITLE ALIAS : ATNDG_PHYSN_MI
				LENGTH : 1
				SOURCE : CWF
78.	Operating Physician ID Group	24	291	314
				Name and identification numbers associated with the physician who performed the principal procedure.
				STANDARD ALIAS : OPRTG_PHYSN_ID_GRP
79.	Claim Operating Physician UPIN Number	6	291	296
				CHAR
				On an institutional claim, the unique physician identification number (UPIN) of the physician who performed the principal procedure. This element is used by the provider to identify the operating physician who performed the surgical procedure.
				DB2 ALIAS : OPRTG_UPIN
				SAS ALIAS : OP_UPIN
				STANDARD ALIAS : CLM_OPRTG_PHYSN_UPIN_NUM
				TITLE ALIAS : OPRTG_UPIN
				LENGTH : 6
				COMMENTS :
				Prior to Version H this field was named: CLM_PRNCPAL_PRCDR_PHYSN_NUM and contained 10 positions (6-position UPIN and 4-position physician surname.
				NOTE: For HHA and Hospice formats beginning with NCH weekly process date 10/3/97 this field was populated with data. HHA and Hospice claims processed prior to 10/3/97 will contain spaces.
				SOURCE : CWF
80.	Claim Operating Physician NPI Number	10	297	306
				CHAR
				On an institutional claim, the National Provider

Identifier (NPI) number assigned to uniquely identify the physician with the primary responsibility for performing the surgical procedure(s).

NOTE: Effective May 2007, the NPI will become the national standard identifier for covered health care providers. NPIs will replace the current OSCAR provider number, UPINs, NSC numbers, and local contractor provider identification numbers (PINs) on standard HIPPA claim transactions. (During the NPI transition phase (4/3/06 - 5/23/07) the capability was there for the NCH to receive NPIs along with an existing legacy number (UPIN, PIN, OSCAR provider number, etc.)).

NOTE1: CMS has determined that dual provider identifiers (old legacy number and new NPI) must be available in the NCH. After the 5/07 NPI implementation, the standard system maintainers will add the legacy number to the claim when its adjudicated. We will continue to receive the OSCAR provider number and any currently issued UPINs. Effective May 2007, no NEW UPINs (legacy numbers) will be generated for NEW physicians (Part B and outpatient claims), so there will only be NPIs sent in to the NCH for those physicians.

DB2 ALIAS : OPRTG\_NPI  
SAS ALIAS : OP\_NPI  
STANDARD ALIAS : CLM\_OPRTG\_PHYSN\_NPI\_NUM  
TITLE ALIAS : OPRTG\_NPI

LENGTH : 10

SOURCE : CWF

81. Claim Operating Physician Surname  
6 307 312

CHAR

Effective with Version H, the last name of the operating physician (used for internal editing purposes in CMS' CWFMQA system.)

NOTE: Beginning with the NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : OPRTG\_SRNM  
SAS ALIAS : OP\_SRNM  
STANDARD ALIAS : CLM\_OPRTG\_PHYSN\_SRNM\_NAME  
TITLE ALIAS : OPRTG\_PHYSN\_SURNAME  
  
LENGTH : 6  
  
SOURCE : CWF

82. Claim Operating Physician Given Name

1 313 313 CHAR

Effective with Version H, the first name  
of the operating physician (used for internal  
editing purposes in CMS' CWFMQA system.)

NOTE: Beginning with NCH weekly process date  
10/3/97 this field was populated with data.  
Claims processed prior to 10/3/97 will contain  
spaces in this field.

DB2 ALIAS : OPRTG\_GVN\_NAME  
SAS ALIAS : OP\_GVN  
STANDARD ALIAS : CLM\_OPRTG\_PHYSN\_GVN\_NAME  
TITLE ALIAS : OPRTG\_PHYSN\_FIRSTNAME  
  
LENGTH : 1  
  
SOURCE : CWF

83. Claim Operating Physician Middle Initial Name

1 314 314 CHAR

Effective with Version H, the middle initial  
of the operating physician (used for internal  
editing purposes in CMS' CWFMQA system.)

NOTE: Beginning with NCH weekly process date  
10/3/97 this field was populated with data.  
Claims processed prior to 10/3/97 will contain  
spaces in this field.

DB2 ALIAS : OPRTG\_MI\_NAME  
SAS ALIAS : OP\_MDL  
STANDARD ALIAS : CLM\_OPRTG\_PHYSN\_MDL\_INITL\_NAME  
TITLE ALIAS : OPRTG\_PHYSN\_MI  
  
LENGTH : 1

			SOURCE	: CWF
84.	Other Physician ID Group	24 315 338		
			Name and identification numbers associated with the other physician.	
			STANDARD ALIAS : OTHR_PHYSN_ID_GRP	
85.	Claim Other Physician UPIN Number	6 315 320	CHAR	
			On an institutional claim, the unique physician identification number (UPIN) of the other physician associated with the institutional claim.	
			DB2	ALIAS : OTHR_UPIN
			SAS	ALIAS : OT_UPIN
			STANDARD	ALIAS : CLM_OTHR_PHYSN_UPIN_NUM
			TITLE	ALIAS : OTH_PHYSN_UPIN
			LENGTH	: 6
			COMMENTS :	
			Prior to Version H this field was named:	
			CLM_OTHR_PHYSN_IDENT_NUM and contained	
			10 positions (6-position UPIN and 4-position other physician surname).	
			NOTE: For HHA and Hospice formats beginning with NCH weekly process date 10/3/97 this field was populated with data. HHA and Hospice claims processed prior to 10/3/97 will contain spaces.	
			SOURCE	: CWF
86.	Claim Other Physician NPI Number	10 321 330	CHAR	
			On an institutional claim, the National Provider Identifier (NPI) number assigned to uniquely identify the other physician associated with the institutiohal claim.	
			NOTE: Effective May 2007, the NPI will become the national standard identifier for covered health care providers. NPIs will replace current OSCAR provider number, UPINs,	

NSC numbers, and local contractor provider identification numbers (PINs) on standard HIPPA claim transactions. (During the NPI transition phase (4/3/06 - 5/23/07) the capability was there for the NCH to receive NPIs along with an existing legacy number (UPIN, PIN, OSCAR provider number, etc.)).

NOTE1: CMS has determined that dual provider identifiers (old legacy numbers and new NPI) must be available in the NCH. After the 5/07 NPI implementation, the standard system maintainers will add the legacy number to the claim when it is adjudicated. We will continue to receive the OSCAR provider number and any currently issued UPINs. Effective May 2007, no NEW UPINs (legacy number) will be generated for NEW physicians (Part B AND outpatient claims), so there will only be NPIs sent in to the NCH for those physicians.

DB2 ALIAS : OTHR\_NPI  
SAS ALIAS : OT\_NPI  
STANDARD ALIAS : CLM\_OTHR\_PHYSN\_NPI\_NUM

LENGTH : 10

SOURCE : CWF

87. Claim Other Physician Surname

6 331 336

CHAR

Effective with Version H, the last name of the other physician (used for internal editing purposes in CMS' CWFMQA system.)

NOTE: Beginning with the NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : OTHR\_SRNM  
SAS ALIAS : OT\_SRNM  
STANDARD ALIAS : CLM\_OTHR\_PHYSN\_SRNM\_NAME  
TITLE ALIAS : OTH\_PHYSN\_SURNAME

LENGTH : 6

SOURCE : CWF

88. Claim Other Physician Given Name

1 337 337

CHAR

Effective with Version H, the first name of the other physician (used for internal editing purposes in CMS' CWFMA system.)

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : OTHR\_GVN\_NAME  
SAS ALIAS : OT\_GVN  
STANDARD ALIAS : CLM\_OTHR\_PHYSN\_GVN\_NAME  
TITLE ALIAS : OTH\_PHYSN\_FIRSTNAME

LENGTH : 1

SOURCE : CWF

89. Claim Other Physician Middle Initial Name

1 338 338

CHAR

Effective with Version H, the middle initial of the other physician (used for internal editing purposes in CMS' CWFMA system.)

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : OTHR\_MI\_NAME  
SAS ALIAS : OT\_MDL  
STANDARD ALIAS : CLM\_OTHR\_PHYSN\_MDL\_INITL\_NAME  
TITLE ALIAS : OTH\_PHYSN\_MI

LENGTH : 1

SOURCE : CWF

90. Medicaid Provider Identification Number

13 339 351

CHAR

A unique identification number assigned to each provider by the state Medicaid agency. This unique provider number is used to ensure proper payment of providers and to maintain claims history on individual providers for surveillance and utilization review.

				DB2	ALIAS : MDCD_PRVDR_NUM
				SAS	ALIAS : MDCD_PRV
				STANDARD	ALIAS : MDCD_PRVDR_IDENT_NUM
				TITLE	ALIAS : MEDICAID_PROVIDER
				LENGTH	: 13
				COMMENTS :	
					Prior to Version H the field size was X(12).
				SOURCE	: CWF
91.	Claim Medicaid Information Code				
		4	352	355	CHAR
					Effective with Version G, code identifying Medicaid information supplied by the contractor to Medicaid.
				DB2	ALIAS : CLM_MDCD_INFO_CD
				SAS	ALIAS : MDCDINFO
				STANDARD	ALIAS : CLM_MDCD_INFO_CD
				TITLE	ALIAS : MEDICAID_INFO
				LENGTH	: 4
				SOURCE	: CWF
92.	Claim MCO Paid Switch				
		1	356	356	CHAR
					A switch indicating whether or not a Managed Care Organization (MCO) has paid the provider for an institutional claim.
				COBOL	ALIAS : MCO_PD_IND
				DB2	ALIAS : CLM_MCO_PD_SW
				SAS	ALIAS : MCO_PDSW
				STANDARD	ALIAS : CLM_MCO_PD_SW
				TITLE	ALIAS : MCO_PAID_SW
				LENGTH	: 1
				COMMENTS :	
					Prior to Version H this field was named: CLM_GHO_PD_SW.
				SOURCE	: CWF
				LIMITATIONS :	

REFER TO :  
MCO\_PD\_SW\_LIM

CODE TABLE : CLM\_MCO\_PD\_TB

93. Claim Treatment Authorization Number  
18 357 374

CHAR

The number assigned by the medical reviewer and reported by the provider to identify the medical review (treatment authorization) action taken after review of the beneficiary's case. It designates that treatment covered by the bill has been authorized by the payer. This number is used by the intermediary and the Peer Review Organization.

NOTE: Under HH PPS this field will be used to link claims to the OASIS assessment used as the basis of payment. This eighteen character string consists of the start of care date, the OASIS assessment date and the two digit reason for assessment code.

COMMON ALIAS : TAN  
DB2 ALIAS : TRTMT\_AUTHRZTN\_NUM  
SAS ALIAS : AUTHRZTN  
STANDARD ALIAS : CLM\_TRTMT\_AUTHRZTN\_NUM  
TITLE ALIAS : TREATMENT\_AUTHORIZATION

LENGTH : 18

SOURCE : CWF

94. Patient Control Number  
20 375 394

CHAR

The unique alphanumeric identifier assigned by the provider to the institutional claim to facilitate retrieval of individual case records and posting of payments.

DB2 ALIAS : PTNT\_CNTL\_NUM  
SAS ALIAS : PTNTCNTL  
STANDARD ALIAS : PTNT\_CNTL\_NUM  
TITLE ALIAS : PATIENT\_CONTROL\_NUM

LENGTH : 20



				SOURCE	: CWF
95.	Claim Medical Record Number				
	17	395	411	CHAR	
					The number assigned by the provider to the beneficiary's medical record to assist in record retrieval.
				DB2	ALIAS : CLM_MDCL_REC_NUM
				SAS	ALIAS : MDCL_REC
				STANDARD	ALIAS : CLM_MDCL_REC_NUM
				TITLE	ALIAS : MEDICAL_RECORD_NUM
				LENGTH	: 17
				SOURCE	: CWF
96.	Claim PRO Control Number				
	12	412	423	CHAR	
					Effective with Version G, the unique identifier assigned by the Peer Review Organization (PRO) for control purposes.
				DB2	ALIAS : CLM_PRO_CNTL_NUM
				SAS	ALIAS : PRO_CNTL
				STANDARD	ALIAS : CLM_PRO_CNTL_NUM
				TITLE	ALIAS : PRO_CONTROL_NUM
				LENGTH	: 12
				SOURCE	: CWF
97.	Claim PRO Process Date				
	8	424	431	NUM	
					Effective with Version H, the date the claim was used in the PRO review process.
					NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.
				DB2	ALIAS : CLM_PRO_PROC_DT
				SAS	ALIAS : PRO_DT
				STANDARD	ALIAS : CLM_PRO_PROC_DT
				TITLE	ALIAS : PRO_PROC_DT

				LENGTH	: 8	SIGNED : N
				SOURCE	: CWF	
				EDIT RULES :		
					YYYYMMDD	
98.	Patient Discharge Status Code					
	2	432	433	CHAR		
				The code used to identify the status of the patient as of the CLM_THRU_DT.		
				DB2	ALIAS :	PTNT_DSCHRG_STUS
				SAS	ALIAS :	STUS_CD
				STANDARD	ALIAS :	PTNT_DSCHRG_STUS_CD
				TITLE	ALIAS :	PTNT_DSCHRG_STUS_CD
				LENGTH	: 2	
				COMMENTS :		
				Prior to Version H this field was named: CLM_STUS_CD.		
				SOURCE	: CWF	
				CODE TABLE	: PTNT_DSCHRG_STUS_TB	
99.	Claim 1st Diagnosis E Code Group					
	8	434	441	GRP		
				Effective with Version 'J', the group used to identify the 1st diagnosis E code in the diagnosis E trailer. This group contains the 1st diagnosis E code and the 1st diagnosis E version code.		
				STANDARD ALIAS : CLM_1ST_DGNS_E_CD_GRP		
100.	Claim 1st Diagnosis E Version Code					
	1	434	434	CHAR		
				Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9 or ICD-10.		
				NOTE: With 5010, the diagnosis and procedure codes have been expanded to accomodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2013.		
				DB2	ALIAS :	UNDEFINED

			SAS	ALIAS : E1VRSNCD
			LENGTH	: 1
			CODE TABLE	: CLM_DGNS_VRSN_TB
101. Claim 1st Diagnosis E Code	7	435	441	CHAR
				The code used to identify the 1st external cause of injury, poisoning, or other adverse effect. This diagnosis E code is also stored as the 1st occurrence of the diagnosis E code trailer.
				NOTE: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10.
			DB2	ALIAS : CLM_1ST_DGNS_E_CD
			SAS	ALIAS : DGNS_E
			STANDARD	ALIAS : CLM_1ST_DGNS_E_CD
			LENGTH	: 7
			COMMENTS :	
				Prior to version 'J', this field was named: CLM_DGNS_E_CD.
			SOURCE	: CWF
			EDIT RULES :	
				ICD-9-CM
102. Claim PPS Indicator Code	1	442	442	CHAR
				Effective with Version H, the code indicating whether or not the (1) claim is PPS and/or (2) the beneficiary is a deemed insured Medicare Qualified Government Employee (MQGE).
				NOTE: Beginning with NCH weekly process date 10/3/97 through 5/29/98, this field was populated with only the PPS indicator. Beginning with NCH weekly process date 6/5/98, this field was additionally populated with the deemed MQGE indicator. Claims processed prior to 10/3/97 will contain spaces.
			COBOL	ALIAS : PPS_IND

DB2 ALIAS : CLM\_PPS\_IND\_CD  
SAS ALIAS : PPS\_IND  
STANDARD ALIAS : CLM\_PPS\_IND\_CD  
TITLE ALIAS : PPS\_IND

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM\_PPS\_IND\_TB

103. Claim Total Charge Amount

6 443 448

PACK

Effective with Version G, the total charges for all services included on the institutional claim. This field is redundant with revenue center code 0001/total charges.

DB2 ALIAS : CLM\_TOT\_CHRG\_AMT  
SAS ALIAS : TOT\_CHRG  
STANDARD ALIAS : CLM\_TOT\_CHRG\_AMT  
TITLE ALIAS : CLAIM\_TOTAL\_CHARGES

LENGTH : 9.2 SIGNED : Y

COMMENTS :

Prior to Version H the size of this field was S9(7)V99.

SOURCE : CWF

LIMITATIONS :

REFER TO :

TOT\_CHRG\_AMT\_LIM

104. Claim Pricer Return Code

2 449 450

CHAR

Effective 1/1/2004 with the implementation of NCH/NMUD CR#1, the code used to identify various PPS payment adjustment types. This code identifies the payment return code or the error return code for every claim type calculated by a PRICER (Inpatient, Outpatient, SNF, Inpatient Rehab Facility (IRF), Home Health and Hospice).

The payment return code identifies the type of payment calculated by the PRICER software.

The error return code identifies a condition in a claim that prevents the PRICER software from calculating a correct payment.

NOTE: Prior to 10/2005 (implementation of NCH/NMUD CR#2), this data was stored in positions 443-444 (FILLER) on all institutional claim types.

DB2 ALIAS : CLM\_PRCR\_RTRN\_CD  
SAS ALIAS : PRCRRTRN  
STANDARD ALIAS : CLM\_PRCR\_RTRN\_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : CLM\_PRCR\_RTRN\_TB

105. Claim Business Segment Identifier Code  
4 451 454

CHAR

Effective 10/1/2005 with the implementation of NCH/NMUD CR#2, the identifier that captures the 2-byte jurisdiction code (represents the USPS state/territory abbreviation (i.e. NY = New York) and the 2-byte modifier that identifies the type of Medicare FFS contract (intermediary, RHHI, carrier or DMERC). This 4-byte identifier along with the 5-byte FI/Carrier number comprises the Contractor Workload Identifier number. The business segment identifier (BSI) is intended to help sort workloads that may be redistributed with the implementation of contracting reform as required by MMA.

DB2 ALIAS : BUSNS\_SGMT\_ID\_CD  
SAS ALIAS : SGMT\_ID  
STANDARD ALIAS : CLM\_BUSNS\_SGMT\_ID\_CD

LENGTH : 4

SOURCE : CWF

106. Recovery Audit Contractor (RAC) Adjustment Indicator Code  
1 455 455

CHAR

Effective January 5, 2009 with the implementation of CR#4, the code used to identify a Recovery Audit Contractor (RAC) requested adjustment. This occurs as a result of post-payment review activities done by

				the RAC.
				DB2 ALIAS : RAC_ADJSTMT_CD
				SAS ALIAS : RACINDCD
				STANDARD ALIAS : CLM_RAC_ADJSTMT_IND_CD
				LENGTH : 1
				CODE TABLE : CLM_RAC_ADJSTMT_TB
107. Worker's Compensation Indicator Code	1	456	456	CHAR
				This indicator is used to determine whether the diagnosis codes on the claims are related to the diagnosis codes on the MSP auxiliary file in CWF.
				DB2 ALIAS : CLM_WC_IND_CD
				SAS ALIAS : WCINDCD
				LENGTH : 1
				CODE TABLE : CLM_WC_IND_TB
				LANGUAGE : C
108. Claim Service Facility Zip Code	9	457	465	CHAR
				Effective with Version 'J', the zip code used to identify the location of the facility where the service was performed.
				DB2 ALIAS : SRVC_FAC_ZIP_CD
				SAS ALIAS : SRVCFAC
				STANDARD ALIAS : CLM_SRVC_FAC_ZIP_CD
				LENGTH : 9
109. FILLER	50	466	515	CHAR
				DB2 ALIAS : FILLER
				LENGTH : 50
110. Hospice NCH Edit Code Count	2	516	517	NUM
				The count of the number of edit codes

annotated to the Hospice claim during the HCFA's CWFMA process. The purpose of this count is to indicate how many claim edit trailers are present.

DB2 ALIAS : HOSPC\_EDIT\_CD\_CNT  
SAS ALIAS : HSEDCNT  
STANDARD ALIAS : HOSPC\_NCH\_EDIT\_CD\_CNT

LENGTH : 2 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
CLM\_EDIT\_CD\_CNT.

SOURCE : NCH

111. Hospice NCH Patch Code Count

2 518 519

NUM

Effective with Version H, the count of the number of HCFA patch codes annotated to the hospice claim during the Nearline maintenance process. The purpose of this count is to indicate how many NCH patch trailers are present.

NOTE1: During the Version H conversion this field was populated with data throughout history (back to service year 1991).

NOTE2: Effective with Version 'I', the number of possible occurrences was reduced to 30. Prior to Version 'I' the number of possible occurrences was 99.

DB2 ALIAS : HOSPC\_PATCH\_CD\_CNT  
SAS ALIAS : HSPATCNT  
STANDARD ALIAS : HOSPC\_NCH\_PATCH\_CD\_I\_CNT

LENGTH : 2 SIGNED : N

SOURCE : NCH

112. Hospice MCO Period Count

1 520 520

NUM

Effective with Version H, the count of the number of Managed Care Organization (MCO) periods reported on an hospice claim.

The purpose of this count is to indicate  
how many MCO period trailers are present.

NOTE: Beginning with NCH weekly process date  
10/3/97 this field was populated with data.  
Claims processed prior to 10/3/97 will contain  
zeroes in this field.

DB2 ALIAS : HOSPC\_MCO\_PRD\_CNT  
SAS ALIAS : HSMCOCNT  
STANDARD ALIAS : HOSPC\_MCO\_PRD\_CNT

LENGTH : 1 SIGNED : N

SOURCE : NCH

EDIT RULES :  
RANGE: 0 TO 2

113. Hospice Claim Demonstration ID Count  
1 521 521

NUM

Effective with Version H, the count of the number  
of claim demonstration IDs reported on an  
hospice claim. The purpose of this count is to  
indicate how many claim demonstration trailers  
are present.

NOTE: During the Version H conversion this field  
was populated with data where a demo was  
identifiable.

DB2 ALIAS : HOSPC\_DEMO\_ID\_CNT  
SAS ALIAS : HSDEMCNT  
STANDARD ALIAS : HOSPC\_CLM\_DEMO\_ID\_CNT

LENGTH : 1 SIGNED : N

SOURCE : NCH

EDIT RULES :  
RANGE: 0 TO 5

114. FILLER

2 522 523

NUM

DB2 ALIAS : FILLER

LENGTH : 2 SIGNED : N



115. FILLER

2 524 525 NUM  
DB2 ALIAS : FILLER  
LENGTH : 2 SIGNED : N

116. Hospice Claim Diagnosis Code Count  
2 526

527 NUM  
The count of the number of diagnosis codes (both principal and secondary) reported on a Hospice claim. The purpose of this count is to indicate how many claim diagnosis code trailers are present.  
  
NOTE: Effective with Version 'J', the count of the number of diagnosis code trailers was expanded from 10 to 25.  
  
NOTE1: During the Version 'J' conversion, the diagnosis 'E' codes were removed from the diagnosis trailer and put in the newly created diagnosis 'E' trailer. Effective with Version 'J', 'E' codes can be found in the diagnosis trailer as secondary diagnosis codes.  
  
DB2 ALIAS : HOSPC\_DGNS\_CD\_CNT  
SAS ALIAS : HSDGNCNT  
STANDARD ALIAS : HOSPC\_CLM\_DGNS\_CD\_J\_CNT  
  
LENGTH : 2 SIGNED : N  
  
COMMENTS :  
Prior to Version H this field was named:  
CLM\_OTHR\_DGNS\_CD\_CNT and the principal was not included in the count.  
  
SOURCE : NCH  
  
EDIT RULES :  
RANGE: 0 TO 25

117. Hospice Claim Diagnosis E Code Count  
2 528

529 NUM  
Effective with Version 'J', the count of the number of diagnosis E codes (both principal and secondary) reported on a Hospice claim. The purpose of this count is to indicate how many claim diagnosis E code trailers are present.  
  
DB2 ALIAS : HOSPC\_CLM\_DGNS\_E\_C

			LENGTH	: 2	SIGNED : N
118. Hospice Claim Procedure Code Count	2	530	531	NUM	
					<p>The count of the number of procedure codes (both principal and secondary) reported on a Hospice claim. The purpose of this count is to indicate how many claim procedure trailers are present.</p> <p>NOTE: Effective with Version 'J', the count of the number of procedure code trailers was expanded from 6 to 25.</p> <p>DB2 ALIAS : HOSPC_PRCDR_CD_CNT  SAS ALIAS : HSPRCNT  STANDARD ALIAS : HOSPC_CLM_PRCDR_CD_J_CNT</p> <p>LENGTH : 2 SIGNED : N</p> <p>COMMENTS :  Prior to Version H this field was named:  CLM_PRCDR_CD_CNT.</p> <p>SOURCE : CWF</p> <p>EDIT RULES :  RANGE: 0 TO 25</p>
119. Hospice Claim Related Condition Code Count	2	532	533	NUM	
					<p>The count of the number of condition codes reported on an hospice claim. The purpose of this count is to indicate how many many condition code trailers are present.</p> <p>DB2 ALIAS : HOSPC_COND_CD_CNT  SAS ALIAS : HSCONCNT  STANDARD ALIAS : HOSPC_CLM_RLT_COND_CD_CNT</p> <p>LENGTH : 2 SIGNED : N</p> <p>COMMENTS :  Prior to Version H this field was named:  CLM_RLT_COND_CD_CNT.</p> <p>SOURCE : NCH</p>

EDIT RULES :  
RANGE: 0 TO 30

120. Hospice Claim Related Occurrence Code Count  
2 534 535

NUM

The count of the number of occurrence codes reported on an hospice claim. The purpose of this count is to indicate how many occurrence code trailers are present.

DB2 ALIAS : HOSPC\_OCRNC\_CD\_CNT  
SAS ALIAS : HSOCRCNT  
STANDARD ALIAS : HOSPC\_CLM\_RLT\_OCRNC\_CD\_CNT

LENGTH : 2 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
CLM\_RLT\_OCRNC\_CD\_CNT.

SOURCE : NCH

EDIT RULES :  
RANGE: 0 TO 30

121. Hospice Claim Occurrence Span Code Count  
2 536 537

NUM

The count of the number of occurrence span codes reported on an hospice claim. The purpose of the count is to indicate how many span code trailers are present.

DB2 ALIAS : HOSPC\_SPAN\_CNT  
SAS ALIAS : HSSPNCNT  
STANDARD ALIAS : HOSPC\_CLM\_OCRNC\_SPAN\_CD\_CNT

LENGTH : 2 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
CLM\_OCRNC\_SPAN\_CD\_CNT.

SOURCE : NCH

EDIT RULES :  
RANGE: 0 TO 10

122. Hospice Claim Value Code Count

2 538 539 NUM

The count of the number of value codes reported on an hospice claim. The purpose of the count is to indicate how many value code trailers are present.

DB2 ALIAS : HOSPC\_VAL\_CD\_CNT  
SAS ALIAS : HSVALCNT  
STANDARD ALIAS : HOSPC\_CLM\_VAL\_CD\_CNT

LENGTH : 2 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
CLM\_VAL\_CD\_CNT.

SOURCE : NCH

EDIT RULES :  
RANGE: 0 TO 36

123. Hospice Revenue Center Code Count

2 540 541 NUM

The count of the number of revenue codes reported on an hospice claim. The purpose of the count is to indicate how many revenue center trailers are present.

DB2 ALIAS : HOSPC\_REV\_CNTR\_CNT  
SAS ALIAS : HSREVCNT  
STANDARD ALIAS : HOSPC\_REV\_CNTR\_CD\_I\_CNT

LENGTH : 2 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
CLM\_REV\_CNTR\_CD\_CNT.

NOTE: Effective with Version 'I' the number of occurrences changed to 45 (per segment - 450 total for claim). For claims prior to Version 'I' the number of occurrences was 58.

SOURCE : NCH

EDIT RULES :  
RANGE: 0 TO 45

124. FILLER

	4	542	545	CHAR	
				DB2	ALIAS : FILLER
				LENGTH	: 4
125. FI Hospice Claim Specific Group	78	546	623	GRP	
					Data pertaining only to fiscal intermediary hospice claims.
					STANDARD ALIAS : FI_HOSPC_CLM_SPECF_GRP
126. NCH Patient Status Indicator Code	1	546	546	CHAR	
					Effective with Version H, the code on an inpatient/SNF and Hospice claim, indicating whether the beneficiary was discharged, died or still a patient (used for internal CWFMQA editing purposes.)
					NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).
				DB2	ALIAS : NCH_PTNT_STUS_IND
				SAS	ALIAS : PTNTSTUS
				STANDARD	ALIAS : NCH_PTNT_STUS_IND_CD
				TITLE	ALIAS : NCH_PATIENT_STUS
				LENGTH	: 1
				DERIVATIONS :	
				DERIVED FROM:	NCH_PTNT_DSCHRG_STUS_CD
				DERIVATION RULES:	
					SET NCH_PTNT_STUS_IND_CD TO 'A' WHERE THE PTNT_DSCHRG_STUS_CD NOT EQUAL TO '20'-'30' OR '40' - '42'.
					SET NCH_PTNT_STUS_IND_CD TO 'B' WHERE THE PTNT_DSCHRG_STUS_CD EQUAL TO '20'-'29' OR '40' - '42'.
					SET NCH_PTNT_STUS_IND_CD TO 'C' WHERE THE

PTNT\_DSCHRG\_STUS\_CD EQUAL TO '30'

SOURCE : NCH QA Process

CODE TABLE : NCH\_PTNT\_STUS\_IND\_TB

127. Claim Hospice Start Date

8 547 554 NUM

On an institutional claim, the date the beneficiary was admitted to the hospice.

DB2 ALIAS : CLM\_HOSPC\_STRT\_DT

SAS ALIAS : HSPCSTRT

STANDARD ALIAS : CLM\_HOSPC\_STRT\_DT

TITLE ALIAS : HOSPC\_START\_DT

LENGTH : 8 SIGNED : N

COMMENTS :

Prior to Version H, this field was named:  
CLM\_ADMSN\_DT.

SOURCE : CWF

EDIT RULES :

YYYYMMDD

128. NCH Beneficiary Medicare Benefits Exhausted Date

8 555 562 NUM

The last date for which the beneficiary has Medicare coverage. This is completed only where where benefits were exhausted before the date of discharge and during the billing period covered by this institutional claim.

DB2 ALIAS : MDCR\_BNFT\_EXHST\_DT

SAS ALIAS : EXHST\_DT

STANDARD ALIAS : NCH\_MDCR\_BNFT\_EXHST\_DT

TITLE ALIAS : BENEFIT\_EXHST\_DT

LENGTH : 8 SIGNED : N

DERIVATIONS :

DERIVED FROM:

CLM\_RLT\_OCRNC\_CD

CLM\_RLT\_OCRNC\_DT

DERIVATION RULES (Effective 10/93):

Based on the presence of occurrence code A3, B3 or C3 move the related occurrence date to NCH\_MDCR\_BNFT\_EXHST\_DT. \*NOTE: Prior to 10/93, the date associated with occurrence code 23 was moved to this field.

COMMENTS :  
Prior to Version H this field was named:  
CLM\_MDCR\_BNFT\_EXHST\_DT.

SOURCE : NCH QA Process

EDIT RULES :  
YYYYMMDD

129. NCH Beneficiary Discharge Date  
8 563 570

NUM

Effective with Version H, on an inpatient and HHA claim, the date the beneficiary was discharged from the facility or died (used for internal CWFMQA editing purposes.)

NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991.)

DB2 ALIAS : NCH\_BENE\_DSCHRG\_DT  
SAS ALIAS : DSCHRGDT  
STANDARD ALIAS : NCH\_BENE\_DSCHRG\_DT  
TITLE ALIAS : DISCHARGE\_DT

LENGTH : 8 SIGNED : N

DERIVATIONS :  
DERIVED FROM:  
NCH\_PTNT\_STUS\_IND\_CD  
CLM\_THRU\_DT

DERIVATION RULES:  
Based on the presence of patient discharge status code not equal to 30 (still patient), move the claim thru date to the NCH\_BENE\_DSCHRG\_DT.

SOURCE : NCH QA Process

EDIT RULES :  
YYYYMMDD

130. Claim Utilization Day Count

2 571 572 PACK

On an institutional claim, the number of covered days of care that are chargeable to Medicare facility utilization that includes full days, coinsurance days, and lifetime reserve days. It excludes any days classified as non-covered, leave of absence days, and the day of discharge or death.

DB2 ALIAS : CLM\_UTLZTN\_DAY\_CNT  
SAS ALIAS : UTIL\_DAY  
STANDARD ALIAS : CLM\_UTLZTN\_DAY\_CNT  
TITLE ALIAS : UTILIZATION\_DAYS

LENGTH : 3 SIGNED : Y

131. Beneficiary's Hospice Period Count

1 573 573

NUM

The count of the number of hospice period trailers present for the beneficiary's record. Prior to BBA a beneficiary was entitled to a maximum of 4 hospice benefit periods that may be elected in lieu of standard Part A hospital benefits. The BBA changed the hospice benefit to the following: 2 initial 90 day periods followed by an unlimited number of 60 day periods (effective 8/5/97).

DB2 ALIAS : BENE\_HOSPC\_PRD\_CNT  
SAS ALIAS : HOSPCPRD  
STANDARD ALIAS : BENE\_HOSPC\_PRD\_CNT  
TITLE ALIAS : HOSPICE\_PERIOD\_COUNT

LENGTH : 1 SIGNED : N

SOURCE : CWF

EDIT RULES :

RANGE: 1 THRU 3: 1 = 1st 90-day period; 2 = 2nd 90 day period and 3 = 60-day period (3 or greater periods)

132. FILLER

50 574 623

CHAR

DB2 ALIAS : FILLER

LENGTH : 50



133. FI Hospice Claim Variable Group	VAR	624	16242	GRP	
					Variable portion of the fiscal intermediary hospice claim record for version J of the NCH.
					STANDARD ALIAS : FI_HOSPC_CLM_VAR_GRP
134. NCH Edit Group	5	624	628	GRP	
					The number of claim edit trailers is determined by the claim edit code count.
					STANDARD ALIAS : NCH_EDIT_GRP
					OCCURS MIN: 0 OCCURS MAX: 13
					DEPENDING ON : HOSPC_NCH_EDIT_CD_CNT
135. NCH Edit Trailer Indicator Code	1	624	624	CHAR	
					Effective with Version H, the code indicating the presence of an NCH edit trailer.
					NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).
					DB2 ALIAS : EDIT_TRLR_IND_CD
					SAS ALIAS : EDITIND
					STANDARD ALIAS : NCH_EDIT_TRLR_IND_CD
					LENGTH : 1
					SOURCE : NCH QA Process
					CODE TABLE : NCH_EDIT_TRLR_IND_TB
136. NCH Edit Code	4	625	628	CHAR	
					The code annotated to the claim indicating the CWFMQA editing results so users will be aware of data deficiencies.
					NOTE: Prior to Version H only the highest

priority code was stored. Beginning 11/98  
up to 13 edit codes may be present.

COMMON ALIAS : QA\_ERROR\_CODE  
DB2 ALIAS : NCH\_EDIT\_CD  
SAS ALIAS : EDIT\_CD  
STANDARD ALIAS : NCH\_EDIT\_CD  
TITLE ALIAS : QA\_ERROR\_CD

LENGTH : 4

SOURCE : NCH QA EDIT PROCESS

CODE TABLE : NCH\_EDIT\_TB

137. NCH Patch Group

11 1 11

GRP

STANDARD ALIAS : NCH\_PATCH\_GRP

OCCURS MIN: 0 OCCURS MAX: 30

DEPENDING ON : HOSPC\_NCH\_PATCH\_CD\_I\_CNT

138. NCH Patch Trailer Indicator Code

1 1 1

CHAR

Effective with Version H, the code indicating  
the presence of an NCH patch trailer.

NOTE: During the Version H conversion this field  
was populated throughout history (back to service  
year 1991).

DB2 ALIAS : PATCH\_TRLR\_IND\_CD  
SAS ALIAS : PATCHIND  
STANDARD ALIAS : NCH\_PATCH\_TRLR\_IND\_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH\_PATCH\_TRLR\_IND\_TB

139. NCH Patch Code

2 2 3

CHAR

Effective with Version H, the code annotated  
to the claim indicating a patch was applied

to the record during an NCH Nearline record conversion and/or during current processing.

NOTE: Prior to Version H this field was located in the third and fourth occurrence of the CLM\_EDIT\_CD.

DB2 ALIAS : NCH\_PATCH\_CD  
SAS ALIAS : PATCHCD  
STANDARD ALIAS : NCH\_PATCH\_CD  
TITLE ALIAS : NCH\_PATCH

LENGTH : 2

SOURCE : NCH

CODE TABLE : NCH\_PATCH\_TB

140. NCH Patch Applied Date

8 4 11

NUM

Effective with Version H, the date the NCH patch was applied to the claim.

DB2 ALIAS : NCH\_PATCH\_APPLY\_DT  
SAS ALIAS : PATCHDT  
STANDARD ALIAS : NCH\_PATCH\_APPLY\_DT  
TITLE ALIAS : NCH\_PATCH\_DT

LENGTH : 8 SIGNED : N

SOURCE : NCH

EDIT RULES :  
YYYYMMDD

141. MCO Period Group

37 1 37

GRP

The number of managed care organization (MCO) period data trailers present is determined by the claim MCO period trailer count. This field reflects the two most current MCO periods in the CWF beneficiary history record. It may have no connection to the services on the claim.

STANDARD ALIAS : MCO\_PRD\_GRP

OCCURS MIN: 0 OCCURS MAX: 2

DEPENDING ON : HOSPC\_MCO\_PRD\_CNT

142. NCH MCO Trailer Indicator Code

1 1 1

CHAR

Effective with Version H, the code indicating the presence of a Managed Care Organization (MCO) trailer.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

COBOL ALIAS : MCO\_IND  
DB2 ALIAS : MCO\_TRLR\_IND\_CD  
SAS ALIAS : MCOIND  
STANDARD ALIAS : NCH\_MCO\_TRLR\_IND\_CD  
TITLE ALIAS : MCO\_INDICATOR

LENGTH : 1

SOURCE : NCH QA Process

CODE TABLE : NCH\_MCO\_TRLR\_IND\_TB

143. MCO Contract Number

5 2 6

CHAR

Effective with Version H, this field represents the plan contract number of the Managed Care Organization (MCO).

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : MCO\_CNTRCT\_NUM  
SAS ALIAS : MCONUM  
STANDARD ALIAS : MCO\_CNTRCT\_NUM  
TITLE ALIAS : MCO\_NUM

LENGTH : 5

SOURCE : CWF

144. MCO Option Code

1 7 7 CHAR

Effective with Version H, the code indicating  
Managed Care Organization (MCO) lock-in  
enrollment status of the beneficiary.

NOTE: Beginning with NCH weekly process date  
10/3/97 this field was populated with data.  
Claims processed prior to 10/3/97 will contain  
spaces in this field.

DB2 ALIAS : MCO\_OPTN\_CD  
SAS ALIAS : MCOOPTN  
STANDARD ALIAS : MCO\_OPTN\_CD  
TITLE ALIAS : MCO\_OPTION\_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : MCO\_OPTN\_TB

145. MCO Period Effective Date

8 8 15 NUM

Effective with Version H, the date the bene-  
ficiary's enrollment in the Managed Care  
Organization (MCO) became effective.

NOTE: Beginning with NCH weekly process date  
10/3/97 this field was populated with data.  
Claims processed prior to 10/3/97 will contain  
zeroes in this field.

DB2 ALIAS : MCO\_PRD\_EFCTV\_DT  
SAS ALIAS : MCOEFFDT  
STANDARD ALIAS : MCO\_PRD\_EFCTV\_DT  
TITLE ALIAS : MCO\_PERIOD\_EFF\_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

146. MCO Period Termination Date

8 16 23 NUM

Effective with Version H, the date the bene-

ficiary's enrollment in the Managed Care Organization (MCO) was terminated.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

DB2 ALIAS : MCO\_PRD TRMNTN\_DT  
SAS ALIAS : MCOTRMDT  
STANDARD ALIAS : MCO\_PRD TRMNTN\_DT  
TITLE ALIAS : MCO\_PERIOD\_TERM\_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

147. MCO Health PLANID Number

14 24 37

CHAR

A placeholder field (effective with Version H) for storing the Health PlanID associated with the Managed Care Organization (MCO). Prior to Version 'I' this field was named: MCO\_PAYERID\_NUM.

DB2 ALIAS : MCO\_PLANID\_NUM  
SAS ALIAS : MCOPLNID  
STANDARD ALIAS : MCO\_HLTH\_PLANID\_NUM  
TITLE ALIAS : MCO\_PLANID

LENGTH : 14

COMMENTS :  
Prior to Version I this field was named: MCO\_PAYERID\_NUM.

SOURCE : CWF

148. Claim Demonstration Identification Group

18 1 18

GRP

The number of demonstration identification trailers present is determined by the claim demonstration identification trailer count.

STANDARD ALIAS : CLM\_DEMO\_ID\_GRP

OCCURS MIN: 0 OCCURS MAX: 5

DEPENDING ON : HOSPC\_CLM\_DEMO\_ID\_CNT

149. NCH Demonstration Trailer Indicator Code  
1 1 1

CHAR

Effective with Version H, the code indicating the presence of a demo trailer.

NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).

COBOL ALIAS : DEMO\_IND

DB2 ALIAS : NCH\_DEMO\_TRLR\_IND\_

SAS ALIAS : DEMOIND

STANDARD ALIAS : NCH\_DEMO\_TRLR\_IND\_CD

TITLE ALIAS : DEMO\_INDICATOR

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH\_DEMO\_TRLR\_IND\_TB

150. Claim Demonstration Identification Number  
2 2 3

CHAR

Effective with Version H, the number assigned to identify a demo. This field is also used to denote special processing (a.k.a. Special Processing Number, SPN).

NOTE: Prior to Version H, Demo ID was stored in the redefined Claim Edit Group, 4th occurrence, positions 3 and 4. During the H conversion, this field was populated with data throughout history (as appropriate either by moving ID on Version G or by deriving from specific demo criteria).

01 = Nursing Home Case-Mix and Quality: NHCMQ (RUGS) Demo -- testing PPS for SNFs in 6 states, using a case-mix classification system based on resident characteristics and actual resources used. The claims carry a RUGS indicator and one or more revenue center codes in the 9,000 series.

NOTE1: Effective for SNF claims with NCH weekly process date after 2/8/96 (and service date after 12/31/95) -- beginning 4/97, Demo ID '01' was derived in NCH based on presence of RUGS phase # '2','3' or '4' on incoming claim; since 7/97, CWF has been adding ID to claim.

NOTE2: During the Version H conversion, Demo ID '01' was populated back to NCH weekly process date 2/9/96 based on the RUGS phase indicator (stored in Claim Edit Group, 3rd occurrence, 4th position, in Version G).

02 = National HHA Prospective Payment Demo -- testing PPS for HHAs in 5 states, using two alternate methods of paying HHAs: per visit by type of HHA visit and per episode of HH care.

NOTE1: Effective for HHA claims with NCH weekly process date after 5/31/95 -- beginning 4/97, Demo ID '02' was derived in NCH based on HCFA/CHPP-supplied listing of provider # and start/stop dates of participants.

NOTE2: During the Version H conversion, Demo ID '02' was populated back to NCH weekly process date 6/95 based on the CHPP criteria.

03 = Telemedicine Demo -- testing covering traditionally noncovered physician services for medical consultation furnished via two-way, interactive video systems (i.e. teleconsultation) in 4 states. The claims contain line items with 'QQ' HCPCS code.

NOTE1: Effective for physician/supplier (nonDMERC) claims with NCH weekly process date after 12/31/96 (and service date after 9/30/96) -- since 7/97, CWF has been adding Demo ID '03' to claim.

NOTE2: During Version H conversion, Demo ID '03' was populated back to NCH weekly process date 1/97 based on the presence of 'QQ' HCPCS on one or more line items.

04 = United Mine Workers of America (UMWA) Managed Care Demo -- testing risk sharing for Part A services, paying special capitation rates for



all UMWA beneficiaries residing in 13 designated counties in 3 states. Under the demo, UMWA will waive the 3-day qualifying hospital stay for a SNF admission. The claims contain TOB '18X','21X','28X' and '51X'; condition code = W0; claim MCO paid switch = not '0'; and MCO contract # = '90091'.

NOTE: Initially scheduled to be implemented for all SNF claims for admission or services on 1/1/97 or later, CWF did not transmit any Demo ID '04' annotated claims until on or about 2/98.

05 = Medicare Choices (MCO encounter data) demo -- testing expanding the type of Managed Care plans available and different payment methods at 16 MCOs in 9 states. The claims contain one of the specific MCO Plan Contract # assigned to the Choices Demo site.

NOTE1: Effective for all claim types with NCH weekly process date after 7/31/97 -- CWF adds Demo ID '05' to claim based on the presence of the MCO Plan Contract #. \*\*\*Demonstration was terminated 12/31/2000.\*\*\*

NOTE2: During the Version H conversion, Demo ID '05' was populated back to NCH weekly process date 8/97 based on the presence of the Choices indicator (stored as an alpha character cross-walked from MCO plan contract # in the Claim Edit Group, 4th occurrence, 2nd position, in Version 'G').

06 = Coronary Artery Bypass Graft (CABG) Demo -- testing bundled payment (all-inclusive global pricing) for hospital + physician services related to CABG surgery in 7 hospitals in 7 states. The inpatient claims contain a DRG '106' or '107'.

NOTE1: Effective for Inpatient claims and physician/supplier claims with Claim Edit Date no earlier than 6/1/91 (not all CABG sites started at the same time) -- on 5/1/97, CWF started transmitting Demo ID '06' on the claim. The FI adds the ID to the claim based on the presence of DRG '106' or '107' from specific providers for specified time periods; the carrier adds the ID to the claim based on

receiving 'Daily Census List' from participating hospitals. \*\*\*Demo terminated in 1998.\*\*\*

NOTE2: During the Version H conversion, any claims where Medicare is the primary payer that were not already identified as Demo ID '06' (stored in the redefined Claim Edit Group, 4th occurrence, positions 3 and 4, Version G) were annotated based on the following criteria: Inpatient - presence of DRG '106' or '107' and a provider number=220897, 150897, 380897,450897,110082,230156 or 360085 for specified service dates; noninstitutional - presence of HCPCS modifier (initial and/or second) = 'Q2' and a carrier number =00700/31143 00630,01380,00900,01040/00511,00710,00623, or 13630 for specified service dates.

07 = Virginia Cardiac Surgery Initiative (VCSI) (formerly referred to as Medicare Quality Partnerships Demo) -- this is a voluntary consortium of the cardiac surgery physician groups and the non-Veterans Administration hospitals providing open heart surgical services in the Commonwealth of Virginia. The goal of the demo is to share data on quality and process innovations in an attempt to improve the care for all cardiac patients. The demonstration only affects those FIs that process claims from hospitals in Virginia and the carriers that process claims from physicians providing inpatient services at those hospitals. The hospitals will be reimbursed on a global payment basis for selected cardiac surgical diagnosis related groups (DRGs). The inpatient claims will contain a DRG '104', '105', '106', '107', '109'; the related physician/supplier claims will contain the claim payment denial reason code = 'D'.

NOTE: The implementation date for this demo is 4/1/03. The FI will annotate the claim with the demo id add Demo ID '07' to claim. For carrier claims, the Standard Systems will annotate the claim with the '07' demo number.

08 = Provider Partnership Demo -- testing per-case payment approaches for acute inpatient hospitalizations, making a lump-sum payment (combining the normal Part A PPS payment with the Part B allowed charges into a single fee

schedule) to a Physician/Hospital Organization for all Part A and Part B services associated with a hospital admission. From 3 to 6 hospitals in the Northeast and Mid-Atlantic regions may participate in the demo.

NOTE: The demo is on HOLD. The FI and carrier will add Demo ID '08' to claim.

15 = ESRD Managed Care (MCO encounter data) -- testing open enrollment of ESRD beneficiaries and capitation rates adjusted for patient treatment needs at 3 MCOs in 3 States. The claims contain one of the specific MCO Plan Contract # assigned to the ESRD demo site.

NOTE: Effective 10/1/97 (but not actually implemented at a site until 1/1/98) for all claim types -- the FI and carrier add Demo ID '15' to claim based on the presence of the MCO plan contract #.

30 = Lung Volume Reduction Surgery (LVRS) or National Emphysema Treatment Trial (NETT) Clinical Study -- evaluating the effectiveness of LVRS and maximum medical therapy (including pulmonary rehab) for Medicare beneficiaries in last stages of emphysema at 18 hospitals nationally, in collaboration with NIH.

NOTE: Effective for all claim types (except DMERC) with NCH weekly process date after 2/27/98 (and service date after 10/31/97) -- the FI adds Demo ID '30' based on the presence of a condition code = EY; the participating physician (not the carrier) adds ID to the noninstitutional claim. DUE TO THE SENSITIVE NATURE OF THIS CLINICAL TRIAL AND UNDER THE TERMS OF THE INTERAGENCY AGREEMENT WITH NIH, THESE CLAIMS ARE PROCESSED BY CWF AND TRANSMITTED TO HCFA BUT NOT STORED IN THE NEARLINE FILE (access is restricted to study evaluators only).

31 = VA Pricing Special Processing (SPN) -- not really a demo but special request from VA due to court settlement; not Medicare services but VA inpatient and physician services submitted to FI 00400 and Carrier 00900 to obtain Medicare pricing -- CWF WILL PROCESS VA CLAIMS ANNOTATED WITH DEMO ID '31', BUT WILL

NOT TRANSMIT TO HCFA (not in Nearline File).

37 = Medicare Coordinated Care Demonstration -- to test whether coordinated care services furnished to certain beneficiaries improves outcome of care and reduces Medicare expenditures under Part A and Part B. There will be at least 14 Coordinated Care Entities (CCEs). The selected entities will be assigned a provider number specifically for the demonstration services.

NOTE: All claims will be processed by carriers;  
no FI processing (except for Georgetown site)

37 = Medicare Disease Management (DMD) -- the purpose of this demonstration is to study the impact on costs and health outcomes of applying disease management services supplemented with coverage for prescription drugs for certain Medicare beneficiaries with diagnosed, advanced-stage congestive heart failure, diabetes, or coronary heart disease. Three demonstration sites will be used for this demonstration and it will last for 3 years. (Effective 4/1/2003).

NOTE: All claims will be processed by NHIC-California (Carrier). FIs will only serve as a conduit for transmitting information to and from CWF about the NOEs.

38 = Physician Encounter Claims - the purpose of this demo id is to identify the physician encounter claims being processed at the HCFA Data Center (HDC). This number will help EDS in making the claim go through the appropriate processing logic, which differs from that for fee-for-service. \*\*NOT IN NCH.\*\*

NOTE: Effective October, 2000. Demo ids will not be assigned to Inpatient and Outpatient encounter claims.

39 = Centralized Billing of Flu and PPV Claims -- The purpose of this demo is to facilitate the processing carrier, Trailblazers, paying flu and PPV claims based on payment localities. Providers will be giving the shots throughout the country and transmitting the claims to Trailblazers for processing.

NOTE: Effective October, 2000 for carrier claims.

40 = Payment of Physician and Nonphysician Services in certain Indian Providers -- the purpose of

this demo is to extend payment for services of physician and nonphysician practitioners furnished in hospitals and ambulatory care clinics. Prior to the legislation change in BIPA, reimbursement for Medicare services provided in IHS facilities was limited to services provided in hospitals and skilled nursing facilities. This change will allow payment for IHS, Tribe and Tribal Organization providers under the Medicare physician fee schedule.

NOTE: Effective July 1, 2001 for institutional and carrier claims.

48 = Medical Adult Day-Care Services -- the purpose of this demonstration is to provide, as part of the episode of care for home health services, medical adult day care services to Medicare beneficiaries as a substitute for a portion of home health services that would otherwise be provided in the beneficiaries home. This demo would last approx. 3 years in not more than 5 sites. Payment for each home health service episode of care will be set at 95% of the amount that would otherwise be paid for home health services provided entirely in the home.

NOTE: Effective July 5, 2005 for HHA claims.

DB2 ALIAS : CLM\_DEMO\_ID\_NUM  
SAS ALIAS : DEMONUM  
STANDARD ALIAS : CLM\_DEMO\_ID\_NUM  
TITLE ALIAS : DEMO\_ID

LENGTH : 2

SOURCE : CWF

151. Claim Demonstration Information Text

15 4 18

CHAR

Effective with Version H, the text field that contains related demo information. For example, a claim involving a CHOICES demo id '05' would contain the MCO plan contract number in the first five positions of this text field.

NOTE: During the Version H conversion this field was populated with data throughout history.

DB2        ALIAS : CLM\_DEMO\_INFO\_TXT  
SAS        ALIAS : DEMOTXT  
STANDARD ALIAS : CLM\_DEMO\_INFO\_TXT  
TITLE      ALIAS : DEMO\_INFO

LENGTH        : 15

DERIVATIONS :

DERIVATION RULES:

Demo ID = 01 (RUGS) -- the text field will contain a 2, 3 or 4 to denote the RUGS phase. If RUGS phase is blank or not one of the above the text field will reflect 'INVALID'. NOTE: In Version 'G', RUGS phase was stored in redefined Claim Edit Group, 3rd occurrence, 4th position.

Demo ID = 02 (Home Health demo) -- the text field will contain PROV#. When demo number not equal to 02 then text will reflect 'INVALID'.

Demo ID = 03 (Telemedicine demo) -- text field will contain the HCPCS code. If the required HCPCS is not shown then the text field will reflect 'INVALID'.

Demo ID = 04 (UMWA) -- text field will contain W0 denoting that condition code W0 was present. If condition code W0 not present then the text field will reflect 'INVALID'.

Demo ID = 05 (CHOICES) -- the text field will contain the CHOICES plan number, if both of the following conditions are met: (1) CHOICES plan number present and PPS or Inpatient claim shows that 1st 3 positions of provider number as '210' and the admission date is within HMO effective/termination date; or non-PPS claim and the from date is within HMO effective/termination date and (2) CHOICES plan number matches the HMO plan number. If either condition is not met the text field will reflect 'INVALID CHOICES PLAN NUMBER'. When CHOICES plan number not present, text will reflect 'INVALID'.

NOTE: In Version 'G', a valid CHOICES plan ID is stored as alpha character in redefined Claim Edit Group, 4th occurrence, 2nd position. If invalid, CHOICES indicator 'ZZ' displayed.

Demo ID = 15 (ESRD Managed Care) -- text field

will contain the ESRD/MCO plan number. If ESRD/  
MCO plan number not present the field will  
reflect 'INVALID'.

Demo ID = 38 (Physician Encounter Claims) --  
text field will contain the MCO plan number.  
When MCO plan number not present the field will  
reflect 'INVALID'.

SOURCE : CWF

LIMITATIONS :

REFER TO :  
CHOICES\_DEMO\_LIM

152. Claim Diagnosis Group

9 1 9 GRP

The number of claim diagnosis trailers is  
determined by the claim diagnosis code  
count. The principal diagnosis is the first occurrence.  
The principal diagnosis is also  
stored (redundantly) in the fixed portion  
of the record.

NOTE:  
Prior to Version H this group was named:  
CLM\_OTHR\_DGNS\_GRP and did not contain the  
CLM\_PRNCPAL\_DGNS\_CD.

STANDARD ALIAS : CLM\_DGNS\_GRP

OCCURS MIN: 0 OCCURS MAX: 25

DEPENDING ON : HOSPC\_CLM\_DGNS\_CD\_J\_CNT

153. NCH Diagnosis Trailer Indicator Code

1 1 1 CHAR

Effective with Version H, the code indicating  
the presence of a diagnosis trailer.

NOTE: During the Version H conversion this field  
was populated throughout history (back to service  
year 1991).

DB2 ALIAS : DGNS\_TRLR\_IND\_CD

				SAS        ALIAS : DGNSIND STANDARD ALIAS : NCH_DGNS_TRLR_IND_CD  LENGTH        : 1  SOURCE        : NCH  CODE TABLE   : NCH_DGNS_TRLR_IND_TB
154. Claim Diagnosis Version Code	1	2	2	CHAR  Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9 or ICD-10.  NOTE: With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2013.  DB2        ALIAS : UNDEFINED SAS        ALIAS : DVRSNCD  LENGTH        : 1  CODE TABLE   : CLM_DGNS_VRSN_TB
155. Claim Diagnosis Code	7	3	9	CHAR  The diagnosis code identifying the beneficiary's principal or other diagnosis (including E code).  NOTE: Prior to Version H, the principal diagnosis code was not stored with the 'OTHER' diagnosis codes. During the Version H conversion the CLM_PRNCPAL_DGNS_CD was added as the first occurrence.  NOTE1: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10.  NOTE2: Effective with Version 'J', the diagnosis E codes are stored in a separate trailer (CLM_DGNS_E_GRP).  DB2        ALIAS : CLM_DGNS_CD SAS        ALIAS : DGNS_CD



				LENGTH	: 7
				EDIT RULES :	
				ICD-9-CM	
156. Claim Diagnosis E Group	9	1	9	GRP	
				<p>The number of claim diagnosis E trailers is determined by the claim diagnosis E code count. This group contains the diagnosis E codes and the diagnosis E version code.</p> <p>STANDARD ALIAS : CLM_DGNS_E_GRP</p> <p>OCCURS MIN: 0 OCCURS MAX: 12</p> <p>DEPENDING ON : HOSPC_CLM_DGNS_E_CD_CNT</p>	
157. NCH Diagnosis E Trailer Indicator Code	1	1	1	CHAR	
				<p>Effective with Version 'J', the code indicating the presence of a diagnosis E trailer.</p> <p>NOTE: During the Version 'J' conversion, this field was populated throughout history.</p> <p>DB2 ALIAS : DGNS_E_TRLR_IND_CD</p> <p>SAS ALIAS : ETRLRIND</p> <p>LENGTH : 1</p> <p>SOURCE :</p> <p>CODE TABLE : NCH_DGNS_E_TRLR_IND_TB</p>	
158. Claim Diagnosis Version Code	1	2	2	CHAR	
				<p>Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9 or ICD-10.</p> <p>NOTE: With 5010, the diagnosis and procedure codes have been expanded to accomodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2013.</p> <p>DB2 ALIAS : UNDEFINED</p> <p>SAS ALIAS : EVRSNCD</p>	

				LENGTH	: 1
				CODE TABLE	: CLM_DGNS_VRSN_TB
159. Claim Diagnosis E Code	7	3	9	CHAR	
					Effective with Version J, the code used to identify the external cause of injury, poisoning, or other adverse affect.
					NOTE: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accomodate the future implementation of ICD-10.
					During the Version 'J' conversion, all 'E' codes in the diagnosis trailer were moved to the diagnosis 'E' trailer.
					With the implementation of Version 'J', diagnosis 'E' codes can also be found in the regular diagnosis trailer.
				DB2	ALIAS : CLM_DGNS_E_CD
				SAS	ALIAS : EDGNSCD
				LENGTH	: 7
				SOURCE	: CWF
				EDIT RULES :	ICD-9-CM
160. Claim Procedure Group	17	1	17	GRP	
					The number of claim procedure trailers is determined by the claim procedure code count.
					Effective with Version 'J', up to 25 occurrences may be reported on a claim.
					Beginning 10/93, up to six occurrences (one principal; five others) may be reported.
					OCCURS MIN: 0 OCCURS MAX: 25
					DEPENDING ON : HOSPC_CLM_PRCDR_CD_J_CNT
161. NCH Procedure Trailer Indicator Code	1	1	1	CHAR	

Effective with Version H, the code indicating the presence of a procedure trailer.

NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).

DB2 ALIAS : NCH\_PRCDR\_TRLR\_IND  
SAS ALIAS : PRCDRIND  
STANDARD ALIAS : NCH\_PRCDR\_TRLR\_IND\_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH\_PRCDR\_TRLR\_IND\_TB

162. Claim Procedure Version Code

1 2 2

CHAR

Effective with Version 'J', the code used to indicate if the surgical procedure code is ICD-9 or ICD-10.

NOTE: With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2013.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : PVRSNCD

LENGTH : 1

CODE TABLE : CLM\_PRCDR\_VRSN\_TB

163. Claim Procedure Code

7 3 9

CHAR

The code that indicates the principal or other procedure performed during the period covered by the institutional claim.

NOTE:  
Effective July 2004, ICD-9-CM procedure codes are no longer being accepted on Outpatient claims. The ICD-9-CM codes were named as the HIPPA standard code set for inpatient hospital procedures. HCPCS/CPT codes were named as the standard code set for physician services and other health care services.

NOTE1: Effective with Version 'J', the number of procedure

code occurrences has expanded from 6 to 25.

DB2 ALIAS : CLM\_PRCDR\_CD  
SAS ALIAS : PRCDR\_CD

LENGTH : 7

DERIVATIONS :  
DERIVED FROM:  
NCH CLM\_PRCDR\_CD

IF FIELD CONTAINS 4 ALPHA-NUMERIC CHARACTERS OR  
OR 3 ALPHA-NUMERIC CHARACTERS FOLLOWED BY A  
SPACE, ASSUME CODE IS VALID  
OTHERWISE  
MOVE SPACES TO CLM\_PRCDR\_CD.

SOURCE : CWF

EDIT RULES :  
ICD-9-CM

164. Claim Procedure Performed Date  
8 10 17

NUM

On an institutional claim, the date on which  
the principal or other procedure was performed.

DB2 ALIAS : CLM\_PRCDR\_PRFRM\_DT  
SAS ALIAS : PRCDR\_DT  
STANDARD ALIAS : CLM\_PRCDR\_PRFRM\_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

165. Claim Related Condition Group  
3 1 3

GRP

The number of claim related condition trailers is  
determined by the claim related condition code count.  
Effective 10/93, up to 30 occurrences can be reported  
on an institutional claim. Prior to 10/93, up to  
10 occurrences could be reported.

STANDARD ALIAS : CLM\_RLT\_COND\_GRP

OCCURS MIN: 0 OCCURS MAX: 30

DEPENDING ON : HOSPC\_CLM\_RLT\_COND\_CD\_CNT

166. NCH Condition Trailer Indicator Code

1 1 1

CHAR

Effective with Version H, the code indicating the presence of a condition code trailer.

NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).

DB2 ALIAS : COND\_TRLR\_IND\_CD  
SAS ALIAS : CONDIND  
STANDARD ALIAS : NCH\_COND\_TRLR\_IND\_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH\_COND\_TRLR\_IND\_TB

167. Claim Related Condition Code

2 2 3

CHAR

The code that indicates a condition relating to an institutional claim that may affect payer processing.

DB2 ALIAS : CLM\_RLT\_COND\_CD  
SAS ALIAS : RLT\_COND  
STANDARD ALIAS : CLM\_RLT\_COND\_CD  
TITLE ALIAS : RELATED\_CONDITION\_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : CLM\_RLT\_COND\_TB

168. Claim Related Occurrence Group

11 1 11

GRP

The number of claim related occurrence trailers is determined by the claim related occurrence code count. Effective 10/93, up to 30 occurrences can be reported

on an institutional claim. Prior to 10/93, up to 10 occurrences could be reported.

STANDARD ALIAS : CLM\_RLT\_OCRNC\_GRP

OCCURS MIN: 0 OCCURS MAX: 30

DEPENDING ON : HOSPC\_CLM\_RLT\_OCRNC\_CD\_CNT

169. NCH Occurrence Trailer Indicator Code  
1 1 1

CHAR

Effective with Version H, the code indicating the presence of a occurrence code trailer.

NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).

DB2 ALIAS : OCRNC\_TRLR\_IND\_CD

SAS ALIAS : OCRNCIND

STANDARD ALIAS : NCH\_OCRNC\_TRLR\_IND\_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH\_OCRNC\_TRLR\_IND\_TB

170. Claim Related Occurrence Code  
2 2 3

CHAR

The code that identifies a significant event relating to an institutional claim that may affect payer processing. These codes are claim-related occurrences that are related to a specific date.

DB2 ALIAS : CLM\_RLT\_OCRNC\_CD

SAS ALIAS : OCRNC\_CD

STANDARD ALIAS : CLM\_RLT\_OCRNC\_CD

TITLE ALIAS : OCCURRENCE\_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : CLM\_RLT\_OCRNC\_TB

171. Claim Related Occurrence Date

8 4 11 NUM

The date associated with a significant event related to an institutional claim that may affect payer processing.

DB2 ALIAS : CLM\_RLT\_OCRNC\_DT  
SAS ALIAS : OCRNCDT  
STANDARD ALIAS : CLM\_RLT\_OCRNC\_DT  
TITLE ALIAS : RLT\_OCRNC\_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

172. Claim Occurrence Span Group  
19 1 19 GRP

The number of claim occurrence span trailers is determined by the claim occurrence span code count. Up to 10 occurrences may be reported on an institutional claim.

STANDARD ALIAS : CLM\_OCRNC\_SPAN\_GRP

OCCURS MIN: 0 OCCURS MAX: 10

DEPENDING ON : HOSPC\_CLM\_OCRNC\_SPAN\_CD\_CNT

173. NCH Span Trailer Indicator Code  
1 1 1 CHAR

Effective with Version H, the code indicating the presence of a span code trailer.

NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).

DB2 ALIAS : SPAN\_TRLR\_IND\_CD  
SAS ALIAS : SPANIND  
STANDARD ALIAS : NCH\_SPAN\_TRLR\_IND\_CD

LENGTH : 1

SOURCE : NCH

				CODE TABLE	: NCH_SPAN_TRLR_IND_TB
174. Claim Occurrence Span Code	2	2	3	CHAR	
				The code that identifies a significant event relating to an institutional claim that may affect payer processing. These codes are claim-related occurrences that are related to a time period (span of dates).	
				DB2	ALIAS : CLM_OCRNC_SPAN_CD
				SAS	ALIAS : SPAN_CD
				STANDARD	ALIAS : CLM_OCRNC_SPAN_CD
				TITLE	ALIAS : SPAN_CD
				LENGTH	: 2
				SOURCE	: CWF
				CODE TABLE	: CLM_OCRNC_SPAN_TB
175. Claim Occurrence Span From Date	8	4	11	NUM	
				The from date of a period associated with an occurrence of a specific event relating to an institutional claim that may affect payer processing.	
				DB2	ALIAS : OCRNC_SPAN_FROM_DT
				SAS	ALIAS : SPANFROM
				STANDARD	ALIAS : CLM_OCRNC_SPAN_FROM_DT
				TITLE	ALIAS : SPAN_FROM_DT
				LENGTH	: 8      SIGNED : N
				SOURCE	: CWF
				EDIT RULES : YYYYMMDD	
176. Claim Occurrence Span Through Date	8	12	19	NUM	
				The thru date of a period associated with an occurrence of a specific event relating to an institutional claim that may affect payer processing.	



DB2 ALIAS : OCRNC\_SPAN\_THRU\_DT  
SAS ALIAS : SPANTHRU  
STANDARD ALIAS : CLM\_OCRNC\_SPAN\_THRU\_DT  
TITLE ALIAS : SPAN\_THRU\_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

177. Claim Value Group

9 1 9 GRP

The number of claim value data trailers present is determined by the claim value code count. Effective 10/93, up to 36 occurrences can be reported on an institutional claim. Prior to 10/93, up to 10 occurrences could be reported.

STANDARD ALIAS : CLM\_VAL\_GRP

OCCURS MIN: 0 OCCURS MAX: 36

DEPENDING ON : HOSPC\_CLM\_VAL\_CD\_CNT

178. NCH Value Trailer Indicator Code

1 1 1 CHAR

Effective with Version H, the code indicating the presence of a value code trailer.

NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).

DB2 ALIAS : VAL\_TRLR\_IND\_CD  
SAS ALIAS : VALIND  
STANDARD ALIAS : NCH\_VAL\_TRLR\_IND\_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH\_VAL\_TRLR\_IND\_TB

179. Claim Value Code

	2	2	3	CHAR	
				The code indicating the value of a monetary condition which was used by the intermediary to process an institutional claim.	
				DB2 ALIAS : CLM_VAL_CD	
				SAS ALIAS : VAL_CD	
				STANDARD ALIAS : CLM_VAL_CD	
				TITLE ALIAS : VALUE_CD	
				LENGTH : 2	
				SOURCE : CWF	
				CODE TABLE : CLM_VAL_TB	
180. Claim Value Amount	6	4	9	PACK	
				The amount related to the condition identified in the CLM_VAL_CD which was used by the intermediary to process the institutional claim.	
				DB2 ALIAS : CLM_VAL_AMT	
				SAS ALIAS : VAL_AMT	
				STANDARD ALIAS : CLM_VAL_AMT	
				TITLE ALIAS : VALUE_AMOUNT	
				LENGTH : 9.2 SIGNED : Y	
				SOURCE : CWF	
				EDIT RULES : \$\$\$\$\$\$\$\$CC	
181. Claim Revenue Center Group	297	1	297	GRP	
				The number of claim revenue center data trailers is determined by the claim revenue center code count. Effective 7/7/00, up to 450 occurrences may be reported on an institutional claim. The increase in the number of revenue center lines causes each claim to be broken out into records/segments (up to 10). Each record can have up to 45 occurrences of revenue center lines. Prior to 7/7/00, up to 58 occurrences may be reported on an institutional claim. Claims submitted	

prior to 10/93, contained up to 28 occurrences.

STANDARD ALIAS : CLM\_REV\_CNTR\_GRP

OCCURS MIN: 0 OCCURS MAX: 45

DEPENDING ON : HOSPC\_REV\_CNTR\_CD\_I\_CNT

182. NCH Revenue Center Trailer Indicator Code

1 1 1

CHAR

Effective with Version H, the code identifying the revenue center trailer.

During the Version H conversion this field was populated with data throughout history (back to service year 1991).

DB2 ALIAS : REV\_CNTR\_TRLR\_CD

SAS ALIAS : REVIND

STANDARD ALIAS : NCH\_REV\_CNTR\_TRLR\_IND\_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH\_REV\_TRLR\_IND\_TB

183. Revenue Center Code

4 2 5

CHAR

The provider-assigned revenue code for each cost center for which a separate charge is billed (type of accommodation or ancillary). A cost center is a division or unit within a hospital (e.g., radiology, emergency room, pathology). EXCEPTION: Revenue center code 0001 represents the total of all revenue centers included on the claim.

COBOL ALIAS : REV\_CD

DB2 ALIAS : REV\_CNTR\_CD

SAS ALIAS : REV\_CNTR

STANDARD ALIAS : REV\_CNTR\_CD

TITLE ALIAS : REVENUE\_CENTER\_CD

LENGTH : 4

SOURCE : CWF

CODE TABLE : REV\_CNTR\_TB

184. Revenue Center Date

8 6 13 NUM

Effective with Version H, the date applicable to the service represented by the revenue center code. This field may be present on any of the institutional claim types. For home health claims the service date should be present on all bills with from date greater than 3/31/98. With the implementation of outpatient PPS, hospitals will be required to enter line item dates of service for all outpatient services which require a HCPCS.

NOTE1: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

NOTE2: When revenue center code equals '0022' (SNF PPS) and revenue center HCPCS code not equal to 'AAA00' (default for no assessment), date represents the MDS RAI assessment reference date.

NOTE3: When revenue center code equals '0023' (HHPPS), the date on the initial claim (RAP) must represent the first date of service in the episode. The final claim will match the '0023' information submitted on the initial claim. The SCIC (significant change in condition) claims may show additional '0023' revenue lines in which the date represents the date of the first service under the revised plan of treatment.

DB2 ALIAS : REV\_CNTR\_DT  
STANDARD ALIAS : REV\_CNTR\_DT  
TITLE ALIAS : REV\_CNTR\_DATE

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

185. Revenue Center 1st ANSI Code  
5

14 18 CHAR

The first code used to identify the detailed reason an adjustment was made (e.g. reason for denial or reducing payment).

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.

DB2 ALIAS : REV\_CNTR\_ANSI1\_CD  
SAS ALIAS : REVANSI1  
STANDARD ALIAS : REV\_CNTR\_ANSI\_1\_CD  
TITLE ALIAS : ANSI\_CD

LENGTH : 5

SOURCE : CWF

CODE TABLE : REV\_CNTR\_ANSI\_TB

186. Revenue Center 2nd ANSI Code  
5

19

23

CHAR

The second code used to identify the detailed reason an adjustment was made (e.g. reason for denial or reducing payment).

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain

HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.

DB2 ALIAS : REV\_CNTR\_ANSI2\_CD  
SAS ALIAS : REVANSI2  
STANDARD ALIAS : REV\_CNTR\_ANSI\_2\_CD  
TITLE ALIAS : ANSI\_CD

LENGTH : 5

SOURCE : CWF

187. Revenue Center 3rd ANSI Code

5 24 28

CHAR

The third code used to identify the detailed reason an adjustment was made (e.g. reason for denial or reducing payment).

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.

DB2 ALIAS : REV\_CNTR\_ANSI3\_CD  
SAS ALIAS : REVANSI3  
STANDARD ALIAS : REV\_CNTR\_ANSI\_3\_CD  
TITLE ALIAS : ANSI\_CD

LENGTH : 5

SOURCE : CWF

188. Revenue Center 4th ANSI Code

5 29 33

CHAR

The fourth code used to identify the detailed reason an adjustment was made (e.g. reason for denial or reducing payment).

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPSS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: Beginning with NCH weekly process date 7/7/00, this field will be populated with data. Claims processed prior to 7/7/00 will contain spaces in this field.

DB2 ALIAS : REV\_CNTR\_ANSI4\_CD  
SAS ALIAS : REVANSI4  
STANDARD ALIAS : REV\_CNTR\_ANSI\_4\_CD  
TITLE ALIAS : ANSI\_CD

LENGTH : 5

SOURCE : CWF

189. Revenue Center APC/HIPPS Code

5 34 38

CHAR

Effective with Version 'I', this field was created to house two pieces of data. The Ambulatory Payment Classification (APC) code and the HIPPS code. The APC is used to identify groupings of outpatient services. APC codes are used to calculate payment for services under OPPS. The APC is a four byte field. The HIPPS codes are used to identify patient classifications for SNFPPS, HHPPS and IRFPPS that will be used to calculate payment. The HIPPS code is a five byte field.

NOTE1: The APC field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: Under SNFPPS, HHPPS & IRFPPS, HIPPS codes are stored in the HCPCS field. \*\*EXCEPTION: if a HHPPS HIPPS code is downcoded/upcoded the downcoded/upcoded HIPPS will be stored in this field.

NOTE3: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.

DB2        ALIAS : REV\_APC\_HIPPS\_CD S  
SAS        ALIAS : APCHIPPS  
STANDARD ALIAS : REV\_CNTR\_APC\_HIPPS\_CD  
TITLE      ALIAS : APC\_HIPPS

LENGTH        : 5

SOURCE        : CWF

CODE TABLE    : REV\_CNTR\_APC\_TB



5        39        43        CHAR

Healthcare Common Procedure Coding System (HCPCS) is a collection of codes that represent procedures, supplies, products and services which may be provided to Medicare beneficiaries and to individuals enrolled in private health insurance programs. The codes are divided into three levels, or groups, as described below:

DB2        ALIAS : REV\_CNTR\_HCPCS\_CD  
STANDARD ALIAS : REV\_CNTR\_HCPCS\_CD  
TITLE      ALIAS : HCPCS\_CD

LENGTH        : 5

COMMENTS :

Prior to Version H this field was named: HCPCS\_CD. With Version H, a prefix was added to denote the location of this field on each claim type (institutional: REV\_CNTR and non-institutional: LINE).

NOTE: When revenue center code = '0022' (SNF PPS), '0023' (HH PPS), or '0024' (IRF PPS); this field contains the Health Insurance PPS (HIPPS) code.

The HIPPS code for SNF PPS contains the rate code/assessment type that identifies (1) RUG-III group the beneficiary was classified into as of the RAI MDS assessment reference date and (2) the type of assessment for payment purposes.

The HIPPS code for Home Health PPS identifies (1) the three case-mix dimensions of the HHRG system, clinical, functional and utilization, from which a beneficiary is assigned to one of the 80 HHRG categories and (2) it identifies whether or not the elements of the code were computed or derived. The HHRGs, represented by the HIPPS coding, will be the basis of payment for each episode.

The HIPPS code (CMG Code) for IRF PPS identifies the clinical characteristics of the beneficiary. The HIPPS rate/CMG code (AXXY - DXXY) must contain five digits. The first position of the code is an A, B, C, or 'D'. The HIPPS code beginning with an 'A' in front of the CMG is defined as without comorbidity. The 'B' in front of the CMG is defined as

with comorbidity for Tier 1. The 'C' is defined as comorbidity for Tier 2 and 'D' is defined as comorbidity for Tier 3. The 'XX' in the HIPPS rate code is the Rehabilitation Impairment Code (RIC). The 'YY' is the sequential number system within the RIC.

For SNF PPS, HH PPS & IRF PPS HIPPS values see CLM\_HIPPS\_TB.

#### Level I

Codes and descriptors copyrighted by the American Medical Association's Current Procedural Terminology, Fourth Edition (CPT-4). These are 5 position numeric codes representing physician and nonphysician services.

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

CPT-4 codes including both long and short descriptions shall be used in accordance with the HCFA/AMA agreement. Any other use violates the AMA copyright.

#### Level II

Includes codes and descriptors copyrighted by the American Dental Association's Current Dental Terminology, Second Edition (CDT-2). These are 5 position alpha-numeric codes comprising the D series. All other level II codes and descriptors are approved and maintained jointly by the alpha-numeric editorial panel (consisting of HCFA, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association). These are 5 position alpha-numeric codes representing primarily items and nonphysician services that are not represented in the level I codes.

#### Level III

Codes and descriptors developed by Medicare carriers for use at the local (carrier) level. These are 5 position alpha-numeric codes in the W, X, Y or Z series representing physician and nonphysician services that are not represented in the level I or level II codes.

#### LIMITATIONS :

REFER TO :  
HHA\_HCPCS\_LIM

CODE TABLE : CLM\_HIPPS\_TB

191. Revenue Center HCPCS Initial Modifier Code  
2 44 45

CHAR

A first modifier to the procedure code to enable a more specific procedure identification for the claim.

DB2 ALIAS : REV\_HCPCS\_MDFR\_CD  
STANDARD ALIAS : REV\_CNTR\_HCPCS\_INITL\_MDFR\_CD  
TITLE ALIAS : INITIAL\_MODIFIER

LENGTH : 2

COMMENTS :  
Prior to Version H this field was named:  
HCPCS\_INITL\_MDFR\_CD. With Version H, a prefix  
was added to denote the location of this field  
on each claim type (institutional: REV\_CNTR and  
non-institutional: LINE).

SOURCE : CWF

EDIT RULES :  
Carrier Information File

192. Revenue Center HCPCS Second Modifier Code  
2 46 47

CHAR

A second modifier to the procedure code to make it more specific than the first modifier code to identify the procedures performed on the beneficiary for the claim.

DB2 ALIAS : REV\_HCPCS\_2ND\_CD  
STANDARD ALIAS : REV\_CNTR\_HCPCS\_2ND\_MDFR\_CD  
TITLE ALIAS : SECOND\_MODIFIER

LENGTH : 2

COMMENTS :  
Prior to Version H this field was named:  
HCPCS\_2ND\_MDFR\_CD. With Version H, a prefix  
was added to denote the location of this field  
on each claim type (institutional: REV\_CNTR and  
non-institutional: LINE).

SOURCE : CWF

EDIT RULES :

CARRIER INFORMATION FILE

193. Revenue Center HCPCS Third Modifier Code  
2 48 49

CHAR

Effective with Version I, a third modifier to the procedure code to make it more specific than the second modifier code to identify the procedures performed on the beneficiary for the claim.

DB2 ALIAS : REV\_HCPCS\_3RD\_CD  
STANDARD ALIAS : REV\_CNTR\_HCPCS\_3RD\_MDFR\_CD  
TITLE ALIAS : THIRD\_MODIFIER

LENGTH : 2

COMMENTS :

NOTE: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.

SOURCE : CWF

EDIT RULES :

CARRIER INFORMATION FILE

194. Revenue Center HCPCS Fourth Modifier Code  
2 50 51

CHAR

Effective with Version I, a fourth modifier to the procedure code to make it more specific than the third modifier code to identify the procedures performed on the beneficiary for the claim.

DB2 ALIAS : REV\_HCPCS\_4TH\_CD  
STANDARD ALIAS : REV\_CNTR\_HCPCS\_4TH\_MDFR\_CD  
TITLE ALIAS : FOURTH\_MODIFIER

LENGTH : 2

COMMENTS :

NOTE: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.

SOURCE : CWF

EDIT RULES :

CARRIER INFORMATION FILE

195. Revenue Center HCPCS Fifth Modifier Code  
2 52 53

CHAR

Effective with Version I, a fifth modifier to the procedure code to make it more specific than the fourth modifier code to identify the procedures performed on the beneficiary for the claim.

DB2 ALIAS : REV\_HCPCS\_5TH\_CD  
SAS ALIAS : MDFR\_CD5  
STANDARD ALIAS : REV\_CNTR\_HCPCS\_5TH\_MDFR\_CD  
TITLE ALIAS : FIFTH\_MODIFIER

LENGTH : 2

COMMENTS :

NOTE: Beginning with NCH weekly process date 8/18/00, this field will be populated with data. Claims processed prior to 8/18/00 will contain spaces in this field.

SOURCE : CWF

EDIT RULES :

CARRIER INFORMATION FILE

196. Revenue Center Payment Method Indicator Code  
2 54 55

CHAR

Effective with Version 'I', the code used to identify how the service is priced for payment. This field is made up of two pieces of data, 1st position being the service indicator and the 2nd position being the payment indicator.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPFS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

NOTE3: Effective 10/2005, this field will no longer represent the service indicator and the payment indicator. This field will now house the 2-byte payment indicator. The status indicator will be housed in a new field named: REV\_CNTR\_STUS\_IND\_CD.

DB2 ALIAS : REV\_PMT\_MTHD\_CD  
SAS ALIAS : PMTMTHD  
STANDARD ALIAS : REV\_CNTR\_PMT\_MTHD\_IND\_CD  
TITLE ALIAS : PMT\_MTHD

LENGTH : 2

SOURCE : CWF

CODE TABLE : REV\_CNTR\_PMT\_MTHD\_IND\_TB

197. Revenue Center Discount Indicator Code

1 56 56

CHAR

Effective with Version 'I', this code represents a factor that specifies the amount of any APC discount. The discounting factor is applied to a line item with a service indicator (part of the REV\_CNTR\_PMT\_MTHD\_IND\_CD) of 'T'. The flag is applicable when more than one significant procedure is performed. \*\*If there is no discounting the factor will be 1.0.\*\*

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located

in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

NOTE3: VALUES D, U & T REPRESENT THE FOLLOWING:  
D = Discounting fraction (currently 0.5)  
U = Number of units  
T = Terminated procedure discount (currently 0.5)

DB2 ALIAS : REV\_DSCNT\_IND\_CD  
SAS ALIAS : DSCNTIND  
STANDARD ALIAS : REV\_CNTR\_DSCNT\_IND\_CD  
TITLE ALIAS : REV\_CNTR\_DSCNT\_IND\_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : REV\_CNTR\_DSCNT\_IND\_TB

198. Revenue Center Packaging Indicator Code  
1 57 57

CHAR

Effective with Version 'I', the code used to identify those services that are packaged/ bundled with another service.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to

process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV\_PACKG\_IND\_CD  
SAS ALIAS : PACKGIND  
STANDARD ALIAS : REV\_CNTR\_PACKG\_IND\_CD  
TITLE ALIAS : REV\_CNTR\_PACKG\_IND

LENGTH : 1

SOURCE : CWF

CODE TABLE : REV\_CNTR\_PACKG\_IND\_TB

199. Revenue Center Pricing Indicator Code  
2 58 59

CHAR

Effective with Version 'I', the code used to identify if there was a deviation from the standard method of calculating payment amount.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located



in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV\_PRICNG\_IND\_CD  
SAS ALIAS : PRICNG  
STANDARD ALIAS : REV\_CNTR\_PRICNG\_IND\_CD  
TITLE ALIAS : REV\_CNTR\_PRICNG\_IND

LENGTH : 2

SOURCE : CWF

CODE TABLE : REV\_CNTR\_PRICNG\_IND\_TB

200. Revenue Center Obligation to Accept As Full (OTAF) Payment Code  
1 60 60 CHAR

Effective with Version 'j' the code used to indicate that the provider was obligated to accept as full payment the amount received from the primary (or secondary) payer.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if

certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV\_OTAF\_IND\_CD  
SAS ALIAS : OTAF

LENGTH : 1

SOURCE : CWF

EDIT RULES :

Y = provider is obligated to accept the payment as payment in full for the service.  
N or blank = provider is not obligated to accept the payment, or there is no payment by a prior payer.

201. Revenue Center IDE, NDC, UPC Number  
24 61

84 CHAR

Effective with Version H, the exemption number assigned by the Food and Drug Administration (FDA) to an investigational device after a manufacturer has been approved by FDA to conduct a clinical trial on that device. HCFA established a new policy of covering certain IDE's which was implemented in claims processing on 10/1/96 (which is NCH weekly process 10/4/96) for service dates beginning 10/1/95. IDE's are always associated with revenue center code '0624'.

NOTE1: Prior to Version H a 'dummy' revenue center code '0624' trailer was created to store IDE's. The IDE number was housed in two fields: HCPCS code and HCPCS initial modifier; the second modifier contained the value 'ID'. There can be up to 7 distinct IDE numbers associated with an '0624' dummy trailer. During the Version H conversion IDE's were moved from the dummy '0624' trailer to this dedicated field.

NOTE2: Effective with Version 'I', this field was renamed to eventually accommodate the National Drug Code (NDC) and the Universal Product Code (UPC). This field could contain either of these 3 fields (there would never be an instance where more than one would come in on a claim). The size of this field was expanded to X(24) to accommodate either of the new fields (under Version 'H' it was X(7)). DATA ANAMOLY/LIMITATION: During an CWFMQA review an edit revealed the IDE was missing. The problem occurs in claim with an NCH weekly process dates of 6/9/00 through 9/8/00. During processing of the new format the program receives the IDE but then blanked out the data.

DB2 ALIAS : IDE\_NDC\_UPC\_NUM  
SAS ALIAS : IDENDC  
STANDARD ALIAS : REV\_CNTR\_IDE\_NDC\_UPC\_NUM  
TITLE ALIAS : IDE\_NDC\_UPC

LENGTH : 24

SOURCE : CWF

LIMITATIONS :

REFER TO :  
REV\_CNTR\_IDE\_NDC\_UPC\_LIM

202. Revenue Center NDC Quantity Qualifier Code  
2 85 86

CHAR

Effective with Version 'J', the code used to indicate the unit of measurement for the drug that was administered.

DB2 ALIAS : NDC\_QTY\_QLFR\_CD  
SAS ALIAS : QTYQLFR  
STANDARD ALIAS : REV\_CNTR\_NDC\_QTY\_QLFR\_CD

LENGTH : 2

				CODE TABLE	: REV_CNTR_NDC_QTY_QLFR_TB
203. Revenue Center NDC Quantity	6	87	92	PACK	
					Effective with Version 'J', the quantity dispensed for the drug reflected on the revenue center line item.
				DB2	ALIAS : NDC_QTY_NUM
				SAS	ALIAS : NDCQTY
				LENGTH	: 7.3 SIGNED : Y
204. Revenue Center Unit Count	4	93	96	PACK	
					A quantitative measure (unit) of the number of times the service or procedure being reported was performed according to the revenue center/HCPSC code definition as described on an institutional claim.
					Depending on type of service, units are measured by number of covered days in a particular accommodation, pints of blood, emergency room visits, clinic visits, dialysis treatments (sessions or days), outpatient therapy visits, and outpatient clinical diagnostic laboratory tests.
					NOTE1: When revenue center code = '0022' (SNF PPS) the unit count will reflect the number of covered days for each HIPPS code and, if applicable, the number of visits for each rehab therapy code.
				DB2	ALIAS : REV_CNTR_UNIT_CNT
				SAS	ALIAS : REV_UNIT
				STANDARD	ALIAS : REV_CNTR_UNIT_CNT
				TITLE	ALIAS : UNITS
				LENGTH	: 7 SIGNED : Y
				SOURCE	: CWF
205. Revenue Center Rate Amount	6	97	102	PACK	
					Charges relating to unit cost associated with the revenue center code. Exception (encounter data only): If plan (e.g. MCO) does not know the actual rate for the accommodations, \$1 will be reported in the field.

NOTE1: For SNF PPS claims (when revenue center code equals '0022'), CMS has developed a SNF PRICER to compute the rate based on the provider supplied coding for the MDS RUGS III group and assessment type (HIPPS code, stored in revenue center HCPCS code field).

NOTE2: For OP PPS claims, CMS has developed a PRICER to compute the rate based on the Ambulatory Payment Classification (APC), discount factor, units of service and the wage index.

NOTE3: Under HH PPS (when revenue center code equals '0023'), CMS has developed a HHA PRICER to compute the rate. On the RAP, the rate is determined using the case mix weight associated with the HIPPS code, adjusting it for the wage index for the beneficiary's site of service, then multiplying the result by 60% or 50%, depending on whether or not the RAP is for a first episode.

On the final claim, the HIPPS code could change the payment if the therapy threshold is not met, or partial episode payment (PEP) adjustment or a significant change in condition (SCIC) adjustment. In cases of SCICs, there will be more than one '0023' revenue center line, each representing the payment made at each case-mix level.

NOTE4: For IRF PPS claims (when revenue center code equals '0024'), CMS has developed a PRICER to compute the rate based on the HIPPS/CMG (HIPPS code, stored in revenue center HCPCS code field).

DB2 ALIAS : REV\_CNTR\_RATE\_AMT  
SAS ALIAS : REV\_RATE  
STANDARD ALIAS : REV\_CNTR\_RATE\_AMT  
TITLE ALIAS : CHARGE\_PER\_UNIT

LENGTH : 9.2 SIGNED : Y

COMMENTS :  
Prior to Version H the size of this field was:  
S9(7)V99.

SOURCE : CWF

206. Revenue Center Blood Deductible Amount  
6 103 108

PACK

Effective with Version 'I', the amount of money for which the intermediary determined the beneficiary is liable for the blood deductible for the line item service.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV\_BLOOD\_DDCTBL  
SAS ALIAS : REVBLOOD  
STANDARD ALIAS : REV\_CNTR\_BLOOD\_DDCTBL\_AMT  
TITLE ALIAS : BLOOD\_DDCTBL\_AMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

207. Revenue Center Cash Deductible Amount  
6 109 114

PACK

Effective with Version 'I' the amount of cash deductible the beneficiary paid for the line item service.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV\_CASH\_DDCTBL  
SAS ALIAS : REVDDCTBL  
STANDARD ALIAS : REV\_CNTR\_CASH\_DDCTBL\_AMT  
TITLE ALIAS : CASH\_DDCTBL

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

208. Revenue Center Coinsurance/Wage Adjusted Coinsurance Amount

6 115 120 PACK

Effective with Version 'I', the amount of coinsurance applicable to the line item service defined by the revenue center and HCPCS codes. For those services subject to Outpatient PPS, the applicable coinsurance is wage adjusted.

NOTE1: This field is populated for those claims

that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. The above claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

NOTE2: This field will have either a zero (for services for which coinsurance is not applicable), a regular coinsurance amount (calculated on either charges or a fee schedule) or if subject to OP PPS the national coinsurance amount will be wage adjusted. The wage adjusted coinsurance is based on the MSA where the provider is located or assigned as a result of a reclassification.

NOTE3: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : ADJSTD\_COINSRNC  
SAS ALIAS : WAGEADJ  
STANDARD ALIAS : REV\_CNTR\_WAGE\_ADJSTD\_COINS\_AMT  
TITLE ALIAS : WAGE\_ADJSTD\_COINS

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

209. Revenue Center Reduced Coinsurance Amount  
6 121 126

PACK

Effective with Version 'I', for all services subject to Outpatient PPS, the amount of coinsurance applicable to the line for a particular service (HCPCS) for which the provider has elected to reduce the coinsurance



amount.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPFS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: The reduced coinsurance amount cannot be lower than 20% of the payment rate for the APC line.

NOTE3: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPFS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : RDCD\_COINSRNC  
SAS ALIAS : RDCDCOIN  
STANDARD ALIAS : REV\_CNTR\_RDCD\_COINS\_AMT  
TITLE ALIAS : REDUCED\_COINS

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

210. Revenue Center 1st Medicare Secondary Payer Paid Amount  
6 127 132 PACK

Effective with Version 'I', the amount paid by the primary payer when the payer is primary to Medicare (Medicare is secondary).

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV\_MSP1\_PD\_AMT  
SAS ALIAS : REV\_MSP1  
STANDARD ALIAS : REV\_CNTR\_MSP1\_PD\_AMT  
TITLE ALIAS : MSP\_PAID\_AMOUNT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

211. Revenue Center 2nd Medicare Secondary Payer Paid Amount  
6 133 138 PACK

Effective with Version 'I', the amount paid by the secondary payer when two payers are primary to Medicare (Medicare is the tertiary payer).

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland

providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV\_MSP2\_PD\_AMT  
SAS ALIAS : REV\_MSP2  
STANDARD ALIAS : REV\_CNTR\_MSP2\_PD\_AMT  
TITLE ALIAS : MSP PAID AMOUNT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

212. Revenue Center Provider Payment Amount  
6 139 144

PACK

Effective with Version 'I', the amount paid to the provider for the services reported on the line item.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain

HPCPS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

ANAMOLY: For dates of service August 1, 2000 to the present, the OPPS revenue center fields are being processed differently by FISS and APASS (standard systems). For more information on OPPS data problems for this time period see Limitations Appendix. The following is how each system handles this field:

FISS: populated correctly with provider payment amount

APASS: provider payment amount plus interest on 1st revenue center line (CMM will instruct APASS not to include interest)

Currently, the following FI numbers are under the APASS system and all other FI numbers are under FISS. See FI\_NUM table of codes for all FI numbers.

52280 -- Mutual of Omaha (until 6/1/2003)  
00430 -- Washington/Alaska (until 11/1/2003)  
00310 -- North Carolina BC (until 12/1/2003)  
00370 -- Rhode Island (until 2/1/2004)  
00270 -- New Hampshire/Vermont (until 3/1/2004)  
00181 -- Maine/Massachusetts (until 5/1/2004)

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2        ALIAS : REV\_PRVDR\_PMT\_AMT  
SAS        ALIAS : RPRVDPMT  
STANDARD ALIAS : REV\_CNTR\_PRVDR\_PMT\_AMT  
TITLE     ALIAS : REV\_PRVDR\_PMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

213. Revenue Center Beneficiary Payment Amount  
6 145 150

PACK

Effective with Version I, the amount paid  
to the beneficiary for the services reported  
on the line item.

NOTE1: This field is populated for those claims  
that are required to process through Outpatient  
PPS Pricer. The type of bills (TOB) required to  
process through are: 12X, 13X, 14X (except Maryland  
providers, Indian Health Providers, hospitals located  
in American Samoa, Guam and Saipan and Critical  
Access Hospitals (CAH)); 76X; 75X and 34X if  
certain HCPCS are on the bill; and any outpatient  
type of bill with a condition code '07' and certain  
HCPCS. These claim types could have lines that are  
not required to price under OPPS rules so those  
lines would not have data in this field.

Additional exception: Virgin Island hospitals and  
hospitals that furnish only inpatient Part B services  
with dates of service 1/1/02 and forward.

NOTE2: It has been discovered that this field may be  
populated with data on claims with dates of service  
prior to 7/00 (implementation of Claim Line Expansion  
OPPS/HHPPS). The original understanding of the new  
revenue center fields was that data would be populated  
on claims with dates of service 7/00 and forward. Data  
has been found in claims with dates of service prior to  
7/00 because the Standard Systems have processed any  
claim coming in 7/00 and after, meeting the above criteria,  
through the Outpatient Code Editor (OCE) regardless of the  
dates of service.

DB2 ALIAS : REV\_BENE\_PMT\_AMT  
SAS ALIAS : RBENEPMT  
STANDARD ALIAS : REV\_CNTR\_BENE\_PMT\_AMT  
TITLE ALIAS : REV\_BENE\_PMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

214. Revenue Center Patient Responsibility Payment Amount

6 151 156 PACK

Effective with Version I, the amount paid by the beneficiary to the provider for the line item service.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

ANAMOLY: For dates of service August 1, 2000 to present, the OPPS revenue center fields are being processed differently by FISS and APASS (standard systems). For more information on OPPS data problems for this time period see the Limitations Appendix. The following is how each system is handling this field:

FISS: populating correctly (sum of coinsurance and deductible)

APASS: not populating this field

Currently, the following FI numbers are under the APASS system and all other FI numbers are under FISS. See FI\_NUM table of codes for all FI numbers.

52280 -- Mutual of Omaha (until 6/1/2003)  
00430 -- Washington/Alaska (until 11/1/2003)  
00310 -- North Carolina BC (until 12/1/2003)  
00370 -- Rhode Island (until 2/1/2004)  
00270 -- New Hampshire/Vermont (until 3/1/2004)  
00181 -- Maine/Massachusetts (until 5/1/2004)

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion

OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV\_PTNT\_RESP\_AMT  
SAS ALIAS : PTNTRESP  
STANDARD ALIAS : REV\_CNTR\_PTNT\_RESP\_PMT\_AMT  
TITLE ALIAS : REV\_PTNT\_RESP

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

215. Revenue Center Payment Amount

6 157 162

PACK

Effective with Version 'I', the line item Medicare payment amount for the specific revenue center.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.

ANAMOLY: For dates of service August 1, 2000 to present, the OPPS revenue center fields are being processed differently by FISS and APASS (standard systems). For more information on OPPS data problems for this time period see the Limitations Appendix. The following is how each system is handling this field:

FISS: this field contains provider reimbursement.

APASS: provider payment amount plus coinsurance and deductible (should not include coinsurance and deductible). Users should rely on provider payment amount field for the trust fund payment.

Currently, the following FI numbers are under the APASS system and all other FI numbers are under FISS. See FI\_NUM table of codes for all FI numbers.

52280 -- Mutual of Omaha (until 6/1/2003)  
00430 -- Washington/Alaska (until 11/1/2003)  
00310 -- North Carolina BC (until 12/1/2003)  
00370 -- Rhode Island (until 2/1/2004)  
00270 -- New Hampshire/Vermont (until 3/1/2004)  
00181 -- Maine/Massachusetts (until 5/1/2004)

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV\_CNTR\_PMT\_AMT  
SAS ALIAS : REVPMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

EDIT RULES :  
\$\$\$\$\$\$\$\$\$CC

216. Revenue Center Total Charge Amount  
6 163 168

PACK

The total charges (covered and non-covered) for all accommodations and services (related to the revenue code) for a billing period before reduction for the deductible and coinsurance amounts and before an adjustment for the cost of services provided. NOTE: For accommodation revenue center total charges must equal the rate times units (days).



EXCEPTIONS:

(1) For SNF RUGS demo claims only (9000 series revenue center codes), this field contains SNF customary accommodation charge, (ie., charges related to the accommodation revenue center code that would have been applicable if the provider had not been participating in the demo).

(2) For SNF PPS (non demo claims), when revenue center code = '0022', the total charges will be zero.

(3) For Home Health PPS (RAPs), when revenue center code = '0023', the total charges will equal the dollar amount for the '0023' line.

(4) For Home Health PPS (final claim), when revenue center code = '0023', the total charges will be the sum of the revenue center code lines (other than '0023').

(5) For Inpatient Rehabilitation Facility (IFR) PPS, when the revenue center code = '0024', the total charges will be zero. For accommodation revenue codes (010X - 021X), total charges must equal the rate times the units.

(6) For encounter data, if the plan (e.g. MCO) does not know the actual charges for the accommodations the total charges will be \$1 (rate) times units (days).

DB2 ALIAS : REV\_TOT\_CHRG\_AMT  
SAS ALIAS : REV\_CHRG  
STANDARD ALIAS : REV\_CNTR\_TOT\_CHRG\_AMT  
TITLE ALIAS : REVENUE\_CENTER\_CHARGES

LENGTH : 9.2 SIGNED : Y

COMMENTS :

Prior to Version H the size of this field was:  
S9(7)V99.

SOURCE : CWF

LIMITATIONS :

REFER TO :

MLTPL\_REV\_CNTR\_0001\_CD\_LIM  
REV\_CNTR\_TOT\_CHRG\_AMT\_LIM

EDIT RULES :

\$\$\$\$\$\$CC

217. Revenue Center Non-Covered Charge Amount  
6 169 174

PACK

The charge amount related to a revenue center code for services that are not covered by Medicare.

NOTE: Prior to Version H the field size was S9(7)V99 and the element was only present on the Inpatient/SNF format. As of NCH weekly process date 10/3/97 this field was added to all institutional claim types.

DB2 ALIAS : REV\_NCVR\_CHRG\_AMT  
SAS ALIAS : REV\_NCVR  
STANDARD ALIAS : REV\_CNTR\_NCVR\_CHRG\_AMT  
TITLE ALIAS : REV\_CENTER\_NONCOVERED\_CHARGES

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

EDIT RULES :  
\$\$\$\$\$\$\$\$\$CC

218. Revenue Center Deductible Coinsurance Code  
1 175 175

CHAR

Code indicating whether the revenue center charges are subject to deductible and/or coinsurance.

DB2 ALIAS : DDCTBL\_COINSRNC\_CD  
SAS ALIAS : REVDEDCD  
STANDARD ALIAS : REV\_CNTR\_DDCTBL\_COINSRNC\_CD  
TITLE ALIAS : REVENUE\_CENTER\_DEDUCTIBLE\_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : REV\_CNTR\_DDCTBL\_COINSRNC\_TB

219. Revenue Center Consolidated Billing Code  
1 176 176

CHAR

Effective 1/1/2004 with the implementation of NCH/NMUD CR#1, this code is reflected on outpatient claims only to identify those line item services (i.e. therapy and nonroutine supply services) that are subject to SNF and Home Health consolidated billing. If the line item service was paid by an intermediary prior to the submission of the SNF or home health claim

an adjustment for the outpatient claim will be submitted identifying those services that are subject to consolidated billing.

NOTE1: Prior to 10/2005 (implementation of NCH/NMUD CR#2), this data was stored in position 175 (FILLER) in the revenue center trailer.

NOTE2: Effective July 2005, this data will no longer be coming into the NCH. This process is being handled in the new CWF override processing.

DB2 ALIAS : CNSLDTD\_BLG\_CD  
SAS ALIAS : RCNSLDTD  
STANDARD ALIAS : REV\_CNTR\_CNSLDTD\_BLG\_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : REV\_CNTR\_CNSLDTD\_BLG\_TB

## 220. Revenue Center Status Indicator Code

2 177 178

CHAR

Effective 10/3/2005 with the implementation of NCH/NMUD CR#2, the code used to identify the status of the line item service. This field along with the payment method indicator field is used to identify how the service was priced for payment.

NOTE1: This 2-byte indicator is being added due to an expansion of a field that currently exist on the revenue center trailer. The status indicator is currently the 1st position of the Revenue Center Payment Method Indicator Code. The payment method indicator code is being split into two 2-byte fields (payment indicator and status indicator). The expanded payment indicator will continue to be stored in the existing payment method indicator field. The split of the current payment method indicator field is due to the expansion of both pieces of data from 1-byte to 2-bytes.

NOTE2: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical

Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services.

DB2 ALIAS : REV\_STUS\_IND\_CD  
SAS ALIAS : RSTUSIND  
STANDARD ALIAS : REV\_CNTR\_STUS\_IND\_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : REV\_CNTR\_STUS\_IND\_TB

221. Revenue Center Duplicate Claim Check Indicator Code

1 179 179 CHAR

Effective 1/1/2009 with the implementation of NCH/NMUD CR#4, the code used to identify an item or service that appeared to be a duuplicate but has been reviewed by an FI or MAC and appropriately approved for payment.

DB2 ALIAS : DUP\_CLM\_CHK\_IND\_CD  
SAS ALIAS : DUP-CHK  
STANDARD ALIAS : REV\_CNTR\_DUP\_CLM\_CHK\_IND\_CD

LENGTH : 1

CODE TABLE : REV\_CNTR\_DUP\_CLM\_CHK\_IND\_TB

222. Revenue Center APC Buffer Code

2 180 181 CHAR

APC - Ambulatory Payment Classification  
Effective 1/1/2009 with the implementation of CR#4, the code used to identify related line items that make up a composite APC group. This field is only applicable to outpatient PPS claims.

DB2 ALIAS : REV\_CNTR\_BUFR\_CD  
SAS ALIAS : APCBUFR  
STANDARD ALIAS : REV\_CNTR\_APC\_BUFR\_CD

LENGTH : 2

				CODE TABLE	: REV_CNTR_APC_BUFR_TB
223. Revenue Center Rendering Physician NPI Num	10	182	191	CHAR	
					Effective with Version 'J', the NPI of the rendering physician who performed the service.
				DB2	ALIAS : RNRNG_NPI_NUM
				SAS	ALIAS : REVNPI
				LENGTH	: 10
224. Revenue Center Rendering Physician Surname	6	192	197	CHAR	
					Effective with Version 'J', the 6 position last name of the rendering physician who performed the service.
				DB2	ALIAS : RNRNG_SRNM_NAME
				SAS	ALIAS : REVSERNM
				LENGTH	: 6
225. FILLER	100	198	297	CHAR	
				DB2	ALIAS : FILLER
				LENGTH	: 100
226. End of Record Code	3	1	3	CHAR	
					Effective with Version 'I', the code used to identify the end of a record/segment or the end of the claim.
				DB2	ALIAS : END_REC_CD
				SAS	ALIAS : EOR
				STANDARD	ALIAS : END_REC_CD
				TITLE	ALIAS : END_OF_REC
				LENGTH	: 3
				COMMENTS :	
					Prior to Version I this field was named: END_REC_CNSTNT.

SOURCE : NCH  
CODE TABLE : END\_REC\_TB

\*\*\*\*\*

H3PM.R\_RIF\_MAIN\_Q,Q1,F

1

LIMITATIONS APPENDIX FOR RECORD: FI\_HOSPC\_CLM\_REC  
AS OF: 06/30/2011

CHOICES\_DEMO\_LIM

FULL NAME: Choices Demonstration Limitation

DESCRIPTION :

A programming error created an 'INVALID' indication  
in the demo text field for CHOICES claims.

BACKGROUND :

In 6/00, the CWFMQA front-end editing revealed that some  
CHOICES demo claims were coming in with a valid 'H'  
number in the fixed portion of the claims, but in the  
first occurrence MCO trailer a numeric packed field  
(value hex '0100000C') was moved to the MCO Contract  
Number/Option Code fields. This created an invalid  
period check of number/code to MCO effective date,  
resulting in an INVALID indication in the demo info  
text field.

CORRECTIVE ACTION :

The problem was forwarded to the CWF BSOG staff  
for further investigation.

SOURCE:

CONTACT : OIS/EDG/DMUDD

CLM\_TRANS\_CD\_LIM

FULL NAME: Claim Transaction Code Limitation

DESCRIPTION :

Claim Transaction Code missing from 1999 inpatient  
records and there was also a problem identified  
in the May and June 2000 data.

BACKGROUND :

Users of the data discovered taht the claim trans-  
action code was missing values 2 & 3 for service year  
1999 and for the months of May and June, 2000. This  
information was confirmed and OIS/BSOG was notified.

CORRECTIVE ACTION :

In July 2000 the problem was fixed and the claim  
transaction code contained the correct values.

SOURCE:

HHA\_HCPCS\_LIM

CONTACT : OIS/EDG/DMUDD

FULL NAME: Home Health HCPCS Limitation

DESCRIPTION :

It was determined that providers were not complying with the 15-minute increment billing instructions for using the 'G' HCPCS codes.

BACKGROUND :

The instructions state that providers are to use the newly created 'G' codes to identify services of the six home health disciplines during an HH episode of care. These 'G' codes (G0151, G0152, G0153, G0154, G0155, G0156) are subject to 15-minute interval billing. As a result the user can not trust the 'G' codes for visit counting. For a more accurate accounting of services the user should rely on the revenue center codes rather than the HCPCS.

Currently there is a check that if the 15-minute increment 'G' codes appear, the revenue center code must be the corresponding HH discipline; however, there is no check to see if the discipline revenue center code appears and that the HCPCS contains the corresponding 'G' code.

CORRECTIVE ACTION :

The Standard Systems has put a fix in to correct this problem.

SOURCE:

CONTACT : OIS/EDG/DMUDD

MCO\_PD\_SW\_LIM

FULL NAME: Claim MCO Paid Switch Limitation

DESCRIPTION :

The MCO paid switch made consistent with criteria used to identify an inpatient encounter claim.

BACKGROUND :

During the NCH Version 'I' conversion, history was populated with an NCH Claim Type Code that will identify the record as an inpatient encounter claim. When applying the CWF logic to identify an inpatient encounter claim, it was discovered that when all the criteria was met the MCO paid switch was sometimes a blank or '0' (reflecting that the MCO did not pay the provider).

CORRECTIVE ACTION :

With the inception of the Version 'I' processing (7/00), if all the criteria for identifying an inpatient encounter claim is met but the MCO paid switch is a blank or '0' it is changed to a '1'.

A patch code = '13' was applied to all claims back

to 7/1/97 service year thru date.

SOURCE:

CONTACT : OIS/EDG/DMUDD

MLTPL\_REV\_CNTR\_0001\_CD\_LIM

FULL NAME: Multiple Revenue Center '0001' Code Limitation

DESCRIPTION :

Multiple total charge '0001' revenue center codes appearing on outpatient, hospice and home health claim records.

BACKGROUND :

On outpatient, home health and hospice it appears that more than one '0001' revenue center code is showing up on the claims. The first total charge line adds the revenue center codes above it correctly; the problem exists below the first total charge line where garbage may be present due to the FI Standard System not clearing out fields before processing the next claim. We believe the error began with the change-over to a different claims processing contractor in 1/98.

CORRECTIVE ACTION :

CWF created an edit to reject multiple '0001' revenue center codes, effective 6/28/99. EDG's CWFMQA process implemented an edit to drop any revenue center line items below the first total charge line. The NCH Nearline File, as well as the 1998 Standard Analytic Files (SAFs), have been patched/corrected to delete the multiple '0001' codes where present on any of the institutional claim types. Also, HCIS will be correcting the revenue center summaries during the next refresh.

The NCH\_PATCH\_CD field will reflect a value '10'.

SOURCE:

CONTACT : OIS/EDG/DMUDD

PMT\_AMT\_EXCEDG\_CHRG\_AMT\_LIM

FULL NAME: Claim Payment Amount Exceeding Total Charge Amount Limitation

DESCRIPTION :

Approximately 75 Inpatient claims had a reimbursement amount exceed \$500,000 which was at least 25 times the total charge amount. There were also claims where the reimbursement was less than \$500,000 but greater than the total charges.

BACKGROUND :

In November of 1999, it was brought to the attention of the HDUG that large reimbursement amounts were being paid in Pennsylvania. There were 75 inpatient claims provided where the reimbursement amount was over \$500,000 and at least 25 times the total charge amount. These claims were processed between 9/29/98 and 10/1/98. There were also claims identified with



reimbursement less than \$500,000 but greater than total charge. It was later discovered that the source of the problem was an error in entering an MSA; the decimal point was off by 2 positions.

Because there were no changes in utilization, the claims were corrected and the correct payments distributed, but the new payment amounts were never sent to CWF (not in NCH). There is currently no requirement that FIs and carriers update CWF with final payment information by submitting payment only adjustments. It was noted that there is no expectation that CWF will have final payment information for claims.

CORRECTIVE ACTION :

According to Veritus (FI), the problem was caught in their system using a pre-payment edit prior to sending out the payments. The erroneous MSA value was corrected and the claims were then sent to PRICER again and paid correctly.

The claims were corrected and correct payments were made but these new payment amounts were never sent to CWF and are not reflected in the NCH.

SOURCE:

CONTACT OIS/EDG/DMUDD

REV\_CNTR\_IDE\_NDC\_UPC\_LIM

FULL NAME: Revenue Center IDE, NDC, UPC Limitation

DESCRIPTION :

Missing data in the REV\_CNTR\_IDE\_NDC\_UPC\_NUM field.

BACKGROUND :

Prior to Version 'I', this field housed only the 7-position exemption number assigned by the FDA to an investigational device after a manufacturer has been approved to conduct a clinical trial on that device. With Version 'I', this field expanded to 24 positions to accommodate the future receipt of the National Drug Code and the Uniform Product Code. The CWFMQA editing process was moving the IDE to the expanded field, but then incorrectly blanked it out (positions 8-24 should be blank).

CORRECTIVE ACTION :

CWFMQA fixed the code and the problem was corrected with claims processed with NCH weekly process date 9/15/00.

SOURCE:

ADMINISTRATIVE DATA:

START DATE : 06/09/00  
END DATE : 09/08/00  
CONTACT : OIS/EDG/DMUDD

REV\_CNTR\_TOT\_CHRG\_AMT\_LIM

FULL NAME: Revenue Center Total Charge Amount Limitation

DESCRIPTION :

Revenue center total charge amount field being populated on segments 2-10 of the Version 'I' record.

BACKGROUND :

Under Version 'I', a decision was made that any amount, count and quantity field would be zeroed out to eliminate the risk of overstating values during an accumulation.

CORRECTIVE ACTION :

The CWFMQA front-end process was modified to zero out the total charge amount field in segments 2-10.

SOURCE:

ADMINISTRATIVE DATA:

START DATE : 07/01/00  
END DATE : 02/02/01  
CONTACT : OIS/EDG/DMUDD

TOT\_CHRG\_AMT\_LIM

FULL NAME: Claim Total Charge Amount Limitation

DESCRIPTION :

The total charge amount field in the fixed portion was truncated on outpatient, hospice and home health claims.

BACKGROUND :

For outpatient, hospice and home health claims, the total charge amount field in the fixed portion was truncated (the cents were dropped off; the decimal point was moved, making cents out of dollars) in the CWFMQA process beginning with data received from CWF 1/4/99 through 5/14/99. The problem occurred when CWF increased the size of the field.

CORRECTIVE ACTION :

The CWFMQA front-end was fixed. The Nearline was patched during the quarterly merge in 7/99 for service years 1998 and 1999. The NCH\_PACTCH\_CD field will be populated with a value '11'. The 1998 and 1999 SAFs were corrected when finalized in 7/99.

The patch involved moving the total charge amount in the revenue center trailer to the total charge amount field in the fixed portion, for records with NCH Daily Process Date 1/4/99 - 5/14/99.

SOURCE:

ADMINISTRATIVE DATA:

START DATE : 01/04/99  
END DATE : 05/14/99  
CONTACT : OIS/EDG/DMUDD

06/30/2011

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H3PM.R\_RIF\_LIM\_Q,F  
1  
CMS RIF REPORT  
AS OF: 06/29/2011

NAME	LENGTH	BEG	END	CONTENTS
*** Carrier Claim Record (NCH)				
VAR	1	6591	REC	
				Carrier claim record (other than DMERC) for version J of the NCH.
				STANDARD ALIAS : CARR_CLM_REC
				SYSTEM ALIAS : UTLCARRJ
				LIMITATIONS :
				REFER TO :
				CARR_LINE_MTUS_CNT_LIM
				CARR_LINE_PRFRMG_UPIN_LIM
				CARR_LINE_RX_NUM_LIM
				CHOICES_DEMO_LIM
				PMT_AMT_EXCEDG_CHRG_AMT_LIM
1. Carrier Claim Fixed Group				
461	1	461	GRP	
				Fixed portion of the carrier claim record for version J of the NCH.
				STANDARD ALIAS : CARR_CLM_FIX_GRP
2. Claim Record Identification Group				
8	1	8	GRP	
				Effective with Version 'I' the record length, version code, record identification, code and NCH derived claim type code were moved to this group for internal NCH processing.
				STANDARD ALIAS : CLM_REC_IDENT_GRP

3. Record Length Count

3 1 3

PACK

Effective with Version H, the count (in bytes)  
of the length of the claim record.

NOTE: During the Version H conversion this field  
was populated with data throughout history  
(back to service year 1991).

DB2 ALIAS : REC\_LNGTH\_CNT  
SAS ALIAS : REC\_LEN  
STANDARD ALIAS : REC\_LNGTH\_CNT

LENGTH : 5 SIGNED : Y

SOURCE : NCH

4. NCH Near-Line Record Version Code

1 4 4

CHAR

The code indicating the record version of the Nearline file  
where the institutional, carrier or DMERC claims data are  
stored.

DB2 ALIAS : NCH\_REC\_VRSN\_CD  
SAS ALIAS : REC\_LVL  
STANDARD ALIAS : NCH\_NEAR\_LINE\_REC\_VRSN\_CD  
TITLE ALIAS : NCH\_VERSION

LENGTH : 1

COMMENTS :  
Prior to Version H this field was named:  
CLM\_NEAR\_LINE\_REC\_VRSN\_CD.

SOURCE : NCH

CODE TABLE : NCH\_NEAR\_LINE\_REC\_VRSN\_TB

5. NCH Near Line Record Identification Code

1 5 5

CHAR

A code defining the type of claim record being processed.

COMMON ALIAS : RIC  
DB2 ALIAS : NEAR\_LINE\_RIC\_CD  
SAS ALIAS : RIC\_CD  
STANDARD ALIAS : NCH\_NEAR\_LINE\_RIC\_CD  
TITLE ALIAS : RIC

LENGTH : 1

COMMENTS :  
Prior to Version H this field was named:  
RIC\_CD.

SOURCE : NCH

CODE TABLE : NCH\_NEAR\_LINE\_RIC\_TB

6. NCH MQA RIC Code

1 6 6

CHAR

Effective with Version H, the code used (for internal editing purposes) to identify the record being processed through CMS' CWFMQA system.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : NCH\_MQA\_RIC\_CD  
SAS ALIAS : MQA\_RIC  
STANDARD ALIAS : NCH\_MQA\_RIC\_CD  
TITLE ALIAS : MQA\_RIC

LENGTH : 1

SOURCE : NCH QA PROCESS

CODE TABLE : NCH\_MQA\_RIC\_TB

7. NCH Claim Type Code

2 7 8

CHAR

The code used to identify the type of claim record being processed in NCH.

NOTE1: During the Version H conversion this field was populated with data throughout history (back to service year 1991).

NOTE2: During the Version I conversion this field was expanded to include inpatient 'full' encounter claims (for service dates after 6/30/97).

NOTE3: Effective with Version 'J', 3 new code values have been added to include a type code for the Medicare Advantage claims (IME/GME, no-pay and paid as FFS).

During the Version 'J' conversion, these type codes were populated throughout history. With Version 'J', these claims are also being stored in NMUD. Prior to Version 'J' they were only in the NCH. No history was converted in NMUD.

DB2        ALIAS : NCH\_CLM\_TYPE\_CD  
SAS        ALIAS : CLM\_TYPE  
STANDARD ALIAS : NCH\_CLM\_TYPE\_CD  
TITLE     ALIAS : CLAIM\_TYPE

LENGTH        : 2

DERIVATIONS :

FFS CLAIM TYPE CODES DERIVED FROM:

NCH CLM\_NEAR\_LINE\_RIC\_CD  
NCH PMT\_EDIT\_RIC\_CD  
NCH CLM\_TRANS\_CD  
NCH PRVDR\_NUM

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:

(Pre-HDC processing -- AVAILABLE IN NCH)  
CLM\_MCO\_PD\_SW  
CLM\_RLT\_COND\_CD  
MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD  
MCO\_PRD\_EFCTV\_DT  
MCO\_PRD\_TRMNTN\_DT

DERIVATION RULES:

SET CLM\_TYPE\_CD TO 10 (HHA CLAIM) WHERE THE  
FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V','W' OR 'U'  
2. PMT\_EDIT\_RIC\_CD EQUAL 'F'  
3. CLM\_TRANS\_CD EQUAL '5'

SET CLM\_TYPE\_CD TO 20 (SNF NON-SWING BED CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'  
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'  
3. CLM\_TRANS\_CD EQUAL '0' OR '4'  
4. POSITION 3 OF PRVDR\_NUM IS NOT 'U', 'W', 'Y'  
OR 'Z'

SET CLM\_TYPE\_CD TO 30 (SNF SWING BED CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'  
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'  
3. CLM\_TRANS\_CD EQUAL '0' OR '4'  
4. POSITION 3 OF PRVDR\_NUM EQUAL 'U', 'W', 'Y'

OR 'Z'

SET CLM\_TYPE\_CD TO 40 (OUTPATIENT CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'W'
2. PMT\_EDIT\_RIC\_CD EQUAL 'D'
3. CLM\_TRANS\_CD EQUAL '6'

SET CLM\_TYPE\_CD TO 50 (HOSPICE CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'
2. PMT\_EDIT\_RIC\_CD EQUAL 'I'
3. CLM\_TRANS\_CD EQUAL 'H'

SET CLM\_TYPE\_CD TO 60 (INPATIENT CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'
3. CLM\_TRANS\_CD EQUAL '1' '2' OR '3'

SET CLM\_TYPE\_CD TO 61 (INPATIENT 'FULL' ENCOUNTER  
CLAIM -- PRIOR TO HDC PROCESSING -- AFTER 6/30/97 -  
12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_MCO\_PD\_SW = '1'
2. CLM\_RLT\_COND\_CD = '04'
3. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = 'C'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS

SET CLM\_TYPE\_CD TO 61 (INPATIENT 'FULL' ENCOUNTER  
CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE  
FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'
3. CLM\_TRANS\_CD EQUAL '1' '2' OR '3'
4. FI\_NUM = 80881

SET CLM\_TYPE\_CD TO 62 (Medicare Advantage IME/GME  
CLAIMS -- 10/1/05 -- FORWARD)  
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_MCO\_PD\_SW = '0'
2. CLM\_RLT\_COND\_CD = '04' & '69'
3. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = 'C'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS

SET CLM\_TYPE\_CD TO 63 (HMO NO-PAY CLAIMS)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
CLAIMS PROCESSED ON OR AFTER 10/6/08  
1. CLM\_THRU\_DT ON OR AFTER 10/1/06  
2. CLM\_MCO\_PD\_SW = '1'  
3. CLM\_RLT\_COND\_CD = '04'  
4. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = 'A', 'B' OR 'C'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS  
5. ZERO REIMBURSEMENT (CLM\_PMT\_AMT)

SET CLM\_TYPE\_CD TO 63 (HMO NO-PAY CLAIMS)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
CLAIMS PROCESSED PRIOR to 10/6/08  
1. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = 'A', 'B' OR 'C'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS  
2. ZERO REIMBURSEMENT (CLM\_PMT\_AMT)

SET CLM\_TYPE\_CD TO 64 (HMO CLAIMS PAID AS FFS)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
CLAIMS PROCESSED PRIOR to 10/6/08  
1. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = '1', '2' OR '4'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS

SET CLM\_TYPE\_CD TO 64 (HMO CLAIMS PAID AS FFS)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
CLAIMS PROCESSED on or after 10/6/08  
1. CLM\_RLT\_COND\_CD = '04'  
2. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = '1', '2' OR '4'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS

SET CLM\_TYPE\_CD TO 71 (RIC O non-DMEPOS CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'O'  
2. HCPCS\_CD not on DMEPOS table

SET CLM\_TYPE\_CD TO 72 (RIC O DMEPOS CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:



1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'O'
2. HCPCS\_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).

SET CLM\_TYPE\_CD TO 81 (RIC M non-DMEPOS DMERC CLAIM)

WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'M'
2. HCPCS\_CD not on DMEPOS table

SET CLM\_TYPE\_CD TO 82 (RIC M DMEPOS DMERC CLAIM)

WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'M'
2. HCPCS\_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).

SOURCE : NCH

CODE TABLE : NCH\_CLM\_TYPE\_TB

8. Carrier/DMERC Claim Link Group  
125 9 133 GRP

Effective with Version 'I', this group was added to the carrier and DMERC records to keep fields common across all record types in the same position. Due to OP PPS, several fields on the Institutional record had to be moved to a link group so those same fields had to be moved on the carrier records eventhough OP PPS only affects institutional claims.

STANDARD ALIAS : CARR\_DMERC\_CLM\_LINK\_GRP

9. Claim Locator Number Group  
11 9 19 GRP

This number uniquely identifies the beneficiary in the NCH Nearline.

COMMON ALIAS : HIC  
STANDARD ALIAS : CLM\_LCTR\_NUM\_GRP  
TITLE ALIAS : HICAN

10. Beneficiary Claim Account Number  
9 9 17 CHAR

The number identifying the primary beneficiary under the SSA or RRB programs submitted.

COMMON ALIAS : CAN  
DB2 ALIAS : BENE\_CLM\_ACNT\_NUM  
SAS ALIAS : CAN  
STANDARD ALIAS : BENE\_CLM\_ACNT\_NUM  
TITLE ALIAS : CAN

LENGTH : 9

SOURCE : SSA,RRB

LIMITATIONS :  
RRB-issued numbers contain an overpunch in the first position that may appear as a plus zero or A-G. RRB-formatted numbers may cause matching problems on non-IBM machines.

11. NCH Category Equatable Beneficiary Identification Code  
2 18 19 CHAR

The code categorizing groups of BICs representing similar relationships between the beneficiary and the primary wage earner.

The equatable BIC module electronically matches two records that contain different BICs where it is apparent that both are records for the same beneficiary. It validates the BIC and returns a base BIC under which to house the record in the National Claims History (NCH) databases. (All records for a beneficiary are stored under a single BIC.)

COMMON ALIAS : NCH\_BASE\_CATEGORY\_BIC  
DB2 ALIAS : CTGRY\_EQTBL\_BIC  
SAS ALIAS : EQ\_BIC  
STANDARD ALIAS : NCH\_CTGRY\_EQTBL\_BIC\_CD  
TITLE ALIAS : EQUATED\_BIC

LENGTH : 2

COMMENTS :  
Prior to Version H this field was named:  
CTGRY\_EQTBL\_BENE\_IDENT\_CD.

SOURCE : BIC EQUATE MODULE

				CODE TABLE	: CTGRY_EQTBL_BENE_IDENT_TB
12.	Beneficiary Identification Code	2	20	21	CHAR
					The code identifying the type of relationship between an individual and a primary Social Security Administration (SSA) beneficiary or a primary Railroad Board (RRB) beneficiary.
				COMMON	ALIAS : BIC
				DA3	ALIAS : BENE_IDENT_CODE
				DB2	ALIAS : BENE_IDENT_CD
				SAS	ALIAS : BIC
				STANDARD	ALIAS : BENE_IDENT_CD
				TITLE	ALIAS : BIC
				LENGTH	: 2
				SOURCE	: SSA/RRB
				EDIT RULES :	
					EDB REQUIRED FIELD
				CODE TABLE	: BENE_IDENT_TB
13.	NCH State Segment Code	1	22	22	CHAR
					The code identifying the segment of the NCH Nearline file containing the beneficiary's record for a specific service year. Effective 12/96, segmentation is by CLM_LCTR_NUM, then final action sequence within residence state. (Prior to 12/96, segmentation was by ranges of county codes within the residence state.)
				DB2	ALIAS : NCH_STATE_SGMT_CD
				SAS	ALIAS : ST_SGMT
				STANDARD	ALIAS : NCH_STATE_SGMT_CD
				TITLE	ALIAS : NEAR_LINE_SEGMENT
				LENGTH	: 1
				COMMENTS :	
					Prior to Version H this field was named: BENE_STATE_SGMT_NEAR_LINE_CD.
				SOURCE	: NCH
				CODE TABLE	: NCH_STATE_SGMT_TB

14. Beneficiary Residence SSA Standard State Code  
2 23 24 CHAR

The SSA standard state code of a beneficiary's residence.

DA3 ALIAS : SSA\_STANDARD\_STATE\_CODE  
DB2 ALIAS : BENE\_SSA\_STATE\_CD  
SAS ALIAS : STATE\_CD  
STANDARD ALIAS : BENE\_RSDNC\_SSA\_STD\_STATE\_CD  
TITLE ALIAS : BENE\_STATE\_CD

LENGTH : 2

COMMENTS :

1. Used in conjunction with a county code, as selection criteria for the determination of payment rates for HMO reimbursement.  
2. Concerning individuals directly billable for Part B and/or Part A premiums, this element is used to determine if the beneficiary will receive a bill in English or Spanish.  
3. Also used for special studies.

SOURCE : SSA/EDB

EDIT RULES :

OPTIONAL: MAY BE BLANK

CODE TABLE : GEO\_SSA\_STATE\_TB

15. Claim From Date  
8 25 32 NUM

The first day on the billing statement covering services rendered to the beneficiary (a.k.a. 'Statement Covers From Date').

NOTE: For Home Health PPS claims, the 'from' date and the 'thru' date on the RAP (initial claim) must always match.

DB2 ALIAS : CLM\_FROM\_DT  
SAS ALIAS : FROM\_DT  
STANDARD ALIAS : CLM\_FROM\_DT  
TITLE ALIAS : FROM\_DATE

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

16. Claim Through Date

8 33 40 NUM

The last day on the billing statement covering services rendered to the beneficiary (a.k.a 'Statement Covers Thru Date').

NOTE: For Home Health PPS claims, the 'from' date and the 'thru' date on the RAP (initial claim) must always match.

DB2 ALIAS : CLM\_THRU\_DT  
SAS ALIAS : THRU\_DT  
STANDARD ALIAS : CLM\_THRU\_DT  
TITLE ALIAS : THRU\_DATE

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

17. NCH Weekly Claim Processing Date

8 41 48 NUM

The date the weekly NCH database load process cycle begins, during which the claim records are loaded into the Nearline file. This date will always be a Friday, although the claims will actually be appended to the database subsequent to the date.

DB2 ALIAS : NCH\_WKLY\_PROC\_DT  
SAS ALIAS : WKLY\_DT  
STANDARD ALIAS : NCH\_WKLY\_PROC\_DT  
TITLE ALIAS : NCH\_PROCESS\_DT

LENGTH : 8 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
HCFA\_CLM\_PROC\_DT.

SOURCE : NCH

EDIT RULES :  
YYYYMMDD

18. CWF Claim Accretion Date

8 49 56 NUM

The date the claim record is accreted (posted/processed) to the beneficiary master record at the CWF host site and authorization for payment is returned to the fiscal intermediary or carrier.

DB2 ALIAS : CWF\_CLM\_ACRTN\_DT  
SAS ALIAS : ACRTN\_DT  
STANDARD ALIAS : CWF\_CLM\_ACRTN\_DT  
TITLE ALIAS : ACCRETION\_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

19. CWF Claim Accretion Number

2 57 58 PACK

The sequence number assigned to the claim record when accreted (posted/processed) to the beneficiary master record at the CWF host site on a given date. This element indicates the position of the claim within that day's processing at the CWF host. \*\*(Exception: If the claim record is missing the accretion date CMS' CWFMQA system places a zero in the accretion number.

DB2 ALIAS : CWF\_CLM\_ACRTN\_NUM  
SAS ALIAS : ACRTN\_NM  
STANDARD ALIAS : CWF\_CLM\_ACRTN\_NUM  
TITLE ALIAS : ACCRETION\_NUMBER

LENGTH : 3 SIGNED : Y

SOURCE : CWF

20. Carrier Claim Control Number

15 59 73 CHAR

Unique control number assigned by a carrier

to a non-institutional claim.

COMMON ALIAS : CCN  
DB2 ALIAS : CARR\_CLM\_CNTL\_NUM  
SAS ALIAS : CARRCNTL  
STANDARD ALIAS : CARR\_CLM\_CNTL\_NUM  
TITLE ALIAS : CCN

LENGTH : 15

COMMENTS :  
For the physician/supplier or DMERC claim, this  
field allows CMS to associate each line item  
with its respective claim.

SOURCE : CWF

EDIT RULES :  
LEFT JUSTIFY

21. FILLER

38 74 111

CHAR

DB2 ALIAS : FILLER

LENGTH : 38

22. NCH Daily Process Date

8 112 119

NUM

Effective with Version H, the date the claim record was  
processed by CMS' CWFMQA system (used for internal editing  
purposes).

Effective with Version I, this date is used in conjunction  
with the NCH Segment Link Number to keep claims with  
multiple records/ segments together.

NOTE1: With Version 'H' this field was populated with  
data beginning with NCH weekly process date 10/3/97.  
Under Version 'I' claims prior to 10/3/97, that were  
blank under Version 'H', were populated with a date.

DB2 ALIAS : NCH\_DAILY\_PROC\_DT  
SAS ALIAS : DAILY\_DT  
STANDARD ALIAS : NCH\_DAILY\_PROC\_DT  
TITLE ALIAS : DAILY\_PROCESS\_DT

LENGTH : 8 SIGNED : N

SOURCE : NCH

EDIT RULES :  
YYYYMMDD

23. NCH Segment Link Number

5 120 124

PACK

Effective with Version 'I', the system generated number used in conjunction with the NCH daily process date to keep records/segments belonging to a specific claim together. This field was added to ensure that records/segments that come in on the same batch with the same identifying information in the link group are not mixed with each other.

NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991).

DB2 ALIAS : NCH\_SGMT\_LINK\_NUM  
SAS ALIAS : LINK\_NUM  
STANDARD ALIAS : NCH\_SGMT\_LINK\_NUM  
TITLE ALIAS : LINK\_NUM

LENGTH : 9 SIGNED : Y

SOURCE : NCH

24. Claim Total Segment Count

2 125 126

NUM

Effective with Version I, the count used to identify the total number of segments associated with a given claim. Each claim could have up to 10 segments.

NOTE: During the Version I conversion, this field was populated with data throughout history (back to service year 1991). For institutional claims, the count for claims prior to 7/00 will be 1 or 2 (1 if 45 or less revenue center lines on a claim and 2 if more than 45 revenue center lines on a claim). For noninstitutional claims, the count will always be 1.

DB2 ALIAS : TOT\_SGMT\_CNT  
SAS ALIAS : SGMT\_CNT



STANDARD ALIAS : CLM TOT\_SGMT\_CNT  
TITLE ALIAS : SEGMENT\_COUNT

LENGTH : 2 SIGNED : N

SOURCE : CWF

25. Claim Segment Number

2 127 128

NUM

Effective with Version I, the number used to identify an actual record/segment (1 - 10) associated with a given claim.

NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991). For institutional claims prior to 7/00, this number will be either 1 or 2. For noninstitutional claims, the number will always be 1.

DB2 ALIAS : CLM\_SGMT\_NUM  
SAS ALIAS : SGMT\_NUM  
STANDARD ALIAS : CLM\_SGMT\_NUM  
TITLE ALIAS : SEGMENT\_NUMBER

LENGTH : 2 SIGNED : N

SOURCE : CWF

26. Claim Total Line Count

3 129 131

NUM

Effective with Version I, the count used to identify the total number of revenue center lines associated with the claim.

NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991). Prior to Version 'I', the maximum line count will be no more than 58. Effective with Version 'I', the maximum line count could be 450.

DB2 ALIAS : TOT\_LINE\_CNT  
SAS ALIAS : LINECNT  
STANDARD ALIAS : CLM TOT\_LINE\_CNT  
TITLE ALIAS : TOTAL\_LINE\_COUNT

				LENGTH	: 3	SIGNED : N
				SOURCE	: CWF	
27. Claim Segment Line Count	2	132	133	NUM		
				Effective with Version I, the count used to identify the number of lines on a record/segment.		
				NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991). The maximum line count per record/segment on the revenue center trailer is 45. The maximum number of lines on carrier and DMERC claims are 13.		
				DB2	ALIAS : SGMT_LINE_CNT	
				SAS	ALIAS : SGMTLINE	
				STANDARD	ALIAS : CLM_SGMT_LINE_CNT	
				TITLE	ALIAS : SEGMENT_LINE_COUNT	
				LENGTH	: 2	SIGNED : N
				SOURCE	: CWF	
28. Carrier/DMERC Claim Common 1 Group	230	134	363	GRP		
				Information common to both carrier and DMERC claims for version I of NCH.		
				STANDARD ALIAS : CARR_DMERC_CLM_CMN_1_GRP		
29. FILLER	5	134	138	CHAR		
				DB2	ALIAS : FILLER	
				LENGTH	: 5	
30. Carrier Claim Entry Code	1	139	139	CHAR		
				Carrier-generated code describing whether the Part B claim is an original debit, full credit, or replacement debit.		

				DB2	ALIAS : CARR_CLM_ENTRY_CD
				SAS	ALIAS : ENTRY_CD
				STANDARD	ALIAS : CARR_CLM_ENTRY_CD
				TITLE	ALIAS : ENTRY_CD
				LENGTH	: 1
				COMMENTS :	
					Prior to Version H this field was named: CWFB_CLM_ENTRY_CD.
				SOURCE	: CWF
31.	FILLER	1	140	140	CHAR
				DB2	ALIAS : FILLER
				LENGTH	: 1
32.	Claim Disposition Code	2	141	142	CHAR
					Code indicating the disposition or outcome of the processing of the claim record.
				DB2	ALIAS : CLM_DISP_CD
				SAS	ALIAS : DISP_CD
				STANDARD	ALIAS : CLM_DISP_CD
				TITLE	ALIAS : DISPOSITION_CD
				LENGTH	: 2
				SOURCE	: CWF
				CODE TABLE	: CLM_DISP_TB
33.	NCH Edit Disposition Code	2	143	144	CHAR
					Effective with Version H, a code used (for internal editing purposes) to indicate the disposition of the claim after editing in the CWFMQA process.
					NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.
				DB2	ALIAS : NCH_EDIT_DISP_CD

SAS ALIAS : EDITDISP  
STANDARD ALIAS : NCH\_EDIT\_DISP\_CD  
TITLE ALIAS : NCH\_EDIT\_DISP

LENGTH : 2

SOURCE : NCH QA Process

CODE TABLE : NCH\_EDIT\_DISP\_TB

34. NCH Claim BIC Modify H Code  
1 145 145

CHAR

Effective with Version H, the code used (for internal editing purposes) to identify a claim record that was submitted with an incorrect HA, HB, or HC BIC.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : NCH\_BIC\_MDFY\_CD  
SAS ALIAS : BIC\_MDFY  
STANDARD ALIAS : NCH\_CLM\_BIC\_MDFY\_CD  
TITLE ALIAS : BIC\_MODIFY\_CD

LENGTH : 1

SOURCE : NCH QA Process

CODE TABLE : NCH\_CLM\_BIC\_MDFY\_TB

35. Beneficiary Residence SSA Standard County Code  
3 146 148

CHAR

The SSA standard county code of a beneficiary's residence.

DB2 ALIAS : BENE\_SSA\_CNTY\_CD  
SAS ALIAS : CNTY\_CD  
STANDARD ALIAS : BENE\_RSDNC\_SSA\_STD\_CNTY\_CD  
TITLE ALIAS : BENE\_COUNTY\_CD

LENGTH : 3

SOURCE : SSA/EDB

EDIT RULES :  
OPTIONAL: MAY BE BLANK

36. Carrier Claim Receipt Date

8 149 156

NUM

The date the carrier receives the non-institutional claim.

DB2 ALIAS : CLM\_RCPT\_DT  
SAS ALIAS : RCPT\_DT

LENGTH : 8 SIGNED : N

COMMENTS :  
Prior to Version 'H' this field was named:  
FICARR\_CLM\_RCPT\_DT.

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

37. Carrier Claim Scheduled Payment Date

8 157 164

NUM

The scheduled date of payment to the physician or supplier, as appearing on the original non-institutional claim sent to the CWF host.  
\*\*Note: This date is considered to be the date paid since no additional information as to the actual payment date is available.

DB2 ALIAS : CARR\_SCHLD\_PMT\_DT  
SAS ALIAS : SCHLD\_DT  
STANDARD ALIAS : CARR\_CLM\_SCHLD\_PMT\_DT  
TITLE ALIAS : SCHLD\_PMT\_DT

LENGTH : 8 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
FICARR\_CLM\_PMT\_DT.

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

38. CWF Forwarded Date

8 165 172

NUM

Effective with Version H, the date CWF forwarded the claim record to CMS (used for internal editing purposes).

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

DB2 ALIAS : CWF\_FRWRD\_DT  
SAS ALIAS : FRWRD\_DT  
STANDARD ALIAS : CWF\_FRWRD\_DT  
TITLE ALIAS : FORWARD\_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

39. Carrier Number

5 173 177 CHAR

The identification number assigned by CMS to a carrier authorized to process claims from a physician or supplier.

Effective July 2006, the Medicare Administrative Contractors (MACs) began replacing the existing carriers and started processing physician or supplier claim records for states assigned to its jurisdiction.

NOTE: The 5-position MAC number will be housed in the existing CARR\_NUM field. During the transition from a carrier to a MAC the CARR\_NUM field could contain either a Carrier number or a MAC number. See the CARR\_NUM table of codes to identify the new MAC numbers and their effective dates.

DB2 ALIAS : CARR\_NUM  
SAS ALIAS : CARR\_NUM  
STANDARD ALIAS : CARR\_NUM  
TITLE ALIAS : CARRIER

LENGTH : 5

COMMENTS :  
Prior to Version H this field was named:  
FICARR\_IDENT\_NUM.

SOURCE : CWF

				CODE TABLE	: CARR_NUM_TB
40.	FILLER	8	178	185	CHAR
				DB2	ALIAS : FILLER
				LENGTH	: 8
41.	CWF Transmission Batch Number	4	186	189	CHAR
					Effective with Version H, the number assigned to each batch of claims transactions sent from CWF(used for internal editing purposes).
					NOTE: Beginning 11/98, this field will be populated with data. Claims processed prior to 11/98 will contain spaces in this field.
				DB2	ALIAS : TRNSMSN_BATCH_NUM
				SAS	ALIAS : FIBATCH
				STANDARD	ALIAS : CWF_TRNSMSN_BATCH_NUM
				TITLE	ALIAS : BATCH_NUM
				LENGTH	: 4
				SOURCE	: CWF
42.	Beneficiary Mailing Contact ZIP Code	9	190	198	CHAR
					The ZIP code of the mailing address where the beneficiary may be contacted.
				DB2	ALIAS : BENE_MLG_ZIP_CD
				SAS	ALIAS : BENE_ZIP
				STANDARD	ALIAS : BENE_MLG_CNTCT_ZIP_CD
				TITLE	ALIAS : BENE_ZIP
				LENGTH	: 9
				SOURCE	: EDB
43.	Beneficiary Sex Identification Code	1	199	199	CHAR
					The sex of a beneficiary.

				COMMON	ALIAS : SEX_CD
				DA3	ALIAS : SEX_CODE
				DB2	ALIAS : BENE_SEX_IDENT_CD
				SAS	ALIAS : SEX
				STANDARD	ALIAS : BENE_SEX_IDENT_CD
				TITLE	ALIAS : SEX_CD
				LENGTH	: 1
				SOURCE	: SSA,RRB,EDB
				EDIT RULES :	
					REQUIRED FIELD
				CODE TABLE	: BENE_SEX_IDENT_TB
44. Beneficiary Race Code	1	200	200	CHAR	
					The race of a beneficiary.
				DA3	ALIAS : RACE_CODE
				DB2	ALIAS : BENE_RACE_CD
				SAS	ALIAS : RACE
				STANDARD	ALIAS : BENE_RACE_CD
				TITLE	ALIAS : RACE_CD
				LENGTH	: 1
				SOURCE	: SSA
				CODE TABLE	: BENE_RACE_TB
45. Beneficiary Birth Date	8	201	208	NUM	
					The beneficiary's date of birth.
				COMMON	ALIAS : DOB
				DA3	ALIAS : BIRTH_DATE
				DB2	ALIAS : BENE_BIRTH_DT
				SAS	ALIAS : BENE_DOB
				STANDARD	ALIAS : BENE_BIRTH_DT
				TITLE	ALIAS : BENE_BIRTH_DATE
				LENGTH	: 8      SIGNED : N
				SOURCE	: CWF



EDIT RULES :  
YYYYMMDD

46. CWF Beneficiary Medicare Status Code  
2 209 210

CHAR

The CWF-derived reason for a beneficiary's entitlement to Medicare benefits, as of the reference date (CLM\_THRU\_DT).

COBOL ALIAS : MSC  
COMMON ALIAS : MSC  
DB2 ALIAS : BENE\_MDCR\_STUS\_CD  
SAS ALIAS : MS\_CD  
STANDARD ALIAS : CWF\_BENE\_MDCR\_STUS\_CD  
TITLE ALIAS : MSC

LENGTH : 2

DERIVATIONS :

CWF derives MSC from the following:

1. Date of Birth
2. Claim Through Date
3. Original/Current Reasons for entitlement
4. ESRD Indicator
5. Beneficiary Claim Number

Items 1,3,4,5 come from the CWF Beneficiary Master Record; item 2 comes from the FI/Carrier claim record. MSC is assigned as follows:

MSC	OASI	DIB	ESRD	AGE	BIC
10	YES	N/A	NO	65 and over	N/A
11	YES	N/A	YES	65 and over	N/A
20	NO	YES	NO	under 65	N/A
21	NO	YES	YES	under 65	N/A
31	NO	NO	YES	any age	T.

COMMENTS :

Prior to Version H this field was named: BENE\_MDCR\_STUS\_CD. The name has been changed to distinguish this CWF-derived field from the EDB-derived MSC (BENE\_MDCR\_STUS\_CD).

SOURCE : CWF

CODE TABLE : BENE\_MDCR\_STUS\_TB

47. Claim Patient 6 Position Surname  
6 211 216

CHAR

The first 6 positions of the Medicare patient's surname (last name) as reported by the provider on the claim.

NOTE1: Prior to Version H, this field was only present on the IP/SNF claim record. Effective with Version H, this field is present on all claim types.

NOTE2: For OP, HHA, Hospice and all Carrier claims, data was populated beginning with NCH weekly process 10/3/97. Claims processed prior to 10/3/97 will contain spaces in this field.

COMMON ALIAS : PATIENT\_SURNAME  
DB2 ALIAS : PTNT\_6\_PSTN\_SRNM  
SAS ALIAS : SURNAME  
STANDARD ALIAS : CLM\_PTNT\_6\_PSTN\_SRNM\_NAME  
TITLE ALIAS : PATIENT\_SURNAME

LENGTH : 6

SOURCE : CWF

48. Claim Patient 1st Initial Given Name  
1 217 217

CHAR

The first initial of the Medicare patient's given name (first name) as reported by the provider on the claim.

NOTE1: Prior to Version H, this field was only present on the IP/SNF claim record. Effective with Version H, this field is present on all claim types.

NOTE2: For OP, HHA, Hospice and all Carrier claims, data was populated beginning with NCH weekly process date 10/3/97. Claims processed prior to 10/3/97 will contain spaces in this field.

COMMON ALIAS : PATIENT\_GIVEN\_NAME  
DB2 ALIAS : 1ST\_INITL\_GVN\_NAME  
SAS ALIAS : FRSTINIT  
STANDARD ALIAS : CLM\_PTNT\_1ST\_INITL\_GVN\_NAME  
TITLE ALIAS : PATIENT\_FIRST\_INITIAL

			LENGTH	: 1
			SOURCE	: CWF
49.	Claim Patient First Initial Middle Name			
	1	218	218	CHAR
				The first initial of the Medicare patient's middle name as reported by the provider on the claim.
				NOTE1: Prior to Version H, this field was only present on the IP/SNF claim record. Effective with Version H, this field is present on all claim types.
				NOTE2: For OP, HHA, Hospice and all Carrier claims, data was populated beginning with NCH weekly process date 10/3/97. Claims processed prior to 10/3/97 will contain spaces in this field.
			COMMON	ALIAS : PATIENT_MIDDLE_NAME
			DB2	ALIAS : 1ST_INITL_MDL_NAME
			SAS	ALIAS : MDL_INIT
			STANDARD	ALIAS : CLM_PTNT_1ST_INITL_MDL_NAME
			TITLE	ALIAS : PATIENT_MIDDLE_INITIAL
			LENGTH	: 1
			SOURCE	: CWF
50.	Beneficiary CWF Location Code			
	1	219	219	CHAR
				The code that identifies the Common Working File (CWF) location (the host site) where a beneficiary's Medicare utilization records are maintained.
			COMMON	ALIAS : CWF_HOST
			DB2	ALIAS : BENE_CWF_LOC_CD
			SAS	ALIAS : CWFLOC_CD
			STANDARD	ALIAS : BENE_CWF_LOC_CD
			TITLE	ALIAS : CWF_HOST
			LENGTH	: 1
			SOURCE	: CWF
			CODE TABLE	: BENE_CWF_LOC_TB

51. Claim Principal Diagnosis Group  
8 220 227

GRP

Effective with Version 'J', the group used to identify the principal diagnosis code. This group contains the principal diagnosis code and the principal diagnosis version code.

STANDARD ALIAS : CLM\_PRNCPAL\_DGNS\_GRP

52. Claim Principal Diagnosis Version Code  
1 220 220

CHAR

Effective with Version 'J', the code used to indicate if the diagnosis is ICD-9 or ICD-10.

NOTE: With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2013.

DB2 ALIAS : UNDEFINED

SAS ALIAS : PDVRSNCD

LENGTH : 1

CODE TABLE : CLM\_DGNS\_VRSN\_TB

53. Claim Principal Diagnosis Code  
7 221 227

CHAR

The diagnosis code identifying the diagnosis, condition, problem or other reason for the admission/encounter/visit shown in the medical record to be chiefly responsible for the services provided.

NOTE: Effective with Version H, this data is also redundantly stored as the first occurrence of the diagnosis trailer.

NOTE1: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10.

DB2 ALIAS : PRNCPAL\_DGNS\_CD

SAS ALIAS : PDGNS\_CD

LENGTH : 7

SOURCE : CWF

EDIT RULES :  
ICD-9-CM

54. FILLER

1 228 228 CHAR  
DB2 ALIAS : FILLER  
LENGTH : 1

55. Carrier Claim Payment Denial Code

2 229 230 CHAR

The code on a noninstitutional claim indicating to whom payment was made or if the claim was denied.

NOTE1: Effective 4/1/02, this field was expanded to two bytes to accommodate new values. The NCH Nearline file did not expand the current 1-byte field but instituted a crosswalk of the 2-byte field to the 1-byte character value. See table of code for the crosswalk.

NOTE2: Effective with Version 'J', the field has been expanded on the NCH record to 2 bytes, With this expansion, the NCH will no longer use the character values to represent the official two byte values sent in by CWF since 4/2002. During the Version J conversion, all character values were converted to the two byte values throughout history..

DB2 ALIAS : CARR\_PMT\_DNL\_CD  
SAS ALIAS : PMTDNLCD

LENGTH : 2

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_CLM\_PMT\_DNL\_CD.

CODE TABLE : CARR\_CLM\_PMT\_DNL\_TB

56. Claim Excepted/Nonexcepted Medical Treatment Code

1 231 231 CHAR

Effective with Version I, the code used to identify whether or not the medical care or treatment received

by a beneficiary, who has elected care from a Religious Nonmedical Health Care Institution (RNHCI), is excepted or nonexcepted. Excepted is medical care or treatment that is received involuntarily or is required under Federal, State or local law. Nonexcepted is defined as medical care or treatment other than excepted.

DB2 ALIAS : EXCPTD\_NEXCPTD\_CD  
SAS ALIAS : TRTMT\_CD  
STANDARD ALIAS : CLM\_EXCPTD\_NEXCPTD\_TRTMT\_CD  
TITLE ALIAS : EXCPTD\_NEXCPTD\_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM\_EXCPTD\_NEXCPTD\_TRTMT\_TB

57. Claim Payment Amount

6 232 237

PACK

Amount of payment made from the Medicare trust fund for the services covered by the claim record. Generally, the amount is calculated by the FI or carrier; and represents what was paid to the institutional provider, physician, or supplier, with the exceptions noted below. \*\*NOTE: In some situations, a negative claim payment amount may be present; e.g., (1) when a beneficiary is charged the full deductible during a short stay and the deductible exceeded the amount Medicare pays; or (2) when a beneficiary is charged a coinsurance amount during a long stay and the coinsurance amount exceeds the amount Medicare pays (most prevalent situation involves psych hospitals who are paid a daily per diem rate no matter what the charges are.)

Under IP PPS, inpatient hospital services are paid based on a predetermined rate per discharge, using the DRG patient classification system and the PRICER program. On the IP PPS claim, the payment amount includes the DRG outlier approved payment amount, disproportionate share (since 5/1/86), indirect medical education (since 10/1/88), total PPS capital (since 10/1/91). After 4/1/03, the payment amount could also include a "new technology" add-on amount. It does NOT include the pass-thru amounts (i.e., capital-related costs, direct medical education costs, kidney acquisition costs, bad debts); or any beneficiary-paid amounts (i.e., deductibles and coinsurance); or any other payer reimbursement.

Under IRFPPS, inpatient rehabilitation services are paid

based on a predetermined rate per discharge, using the Case Mix Group (CMG) classification system and the PRICER program. From the CMG on the IRF PPS claim, payment is based on a standard payment amount for operating and capital cost for that facility (including routine and ancillary services). The payment is adjusted for wage, the % of low-income patients (LIP), locality, transfers, interrupted stays, short stay cases, deaths, and high cost outliers. Some or all of these adjustments could apply. The CMG payment does NOT include certain pass-through costs (i.e. bad debts, approved education activities); beneficiary-paid amounts, other payer reimbursement, and other services outside of the scope of PPS.

Under LTCH PPS, long term care hospital services are paid based on a predetermined rate per discharge based on the DRG and the PRICER program. Payments are based on a single standard Federal rate for both inpatient operating and capital-related costs (including routine and ancillary services), but do NOT include certain pass-through costs (i.e. bad debts, direct medical education, new technologies and blood clotting factors). Adjustments to the payment may occur due to short-stay outliers, interrupted stays, high cost outliers, wage index, and cost of living adjustments.

Under SNF PPS, SNFs will classify beneficiaries using the patient classification system known as RUGS III. For the SNF PPS claim, the SNF PRICER will calculate/return the rate for each revenue center line item with revenue center code = '0022'; multiply the rate times the units count; and then sum the amount payable for all lines with revenue center code '0022' to determine the total claim payment amount.

Under Outpatient PPS, the national ambulatory payment classification (APC) rate that is calculated for each APC group is the basis for determining the total claim payment. The payment amount also includes the outlier payment and interest.

Under Home Health PPS, beneficiaries will be classified into an appropriate case mix category known as the Home Health Resource Group. A HIPPS code is then generated corresponding to the case mix category (HHRG).

For the RAP, the PRICER will determine the payment amount appropriate to the HIPPS code by computing 60% (for first episode) or 50% (for subsequent episodes) of the case mix episode payment. The payment is then wage index adjusted.

For the final claim, PRICER calculates 100% of the amount due, because the final claim is processed as an adjustment to the RAP, reversing the RAP payment in full. Although final claim will show 100% payment amount, the provider will actually receive the 40% or 50% payment. The payment may also include outlier payments.

Exceptions: For claims involving demos and BBA encounter data, the amount reported in this field may not just represent the actual provider payment.

For demo Ids '01','02','03','04' -- claims contain amount paid to the provider, except that special 'differentials' paid outside the normal payment system are not included.

For demo Ids '05','15' -- encounter data 'claims' contain amount Medicare would have paid under FFS, instead of the actual payment to the MCO.

For demo Ids '06','07','08' -- claims contain actual provider payment but represent a special negotiated bundled payment for both Part A and Part B services. To identify what the conventional provider Part A payment would have been, check value code = 'Y4'. The related noninstitutional (physician/supplier) claims contain what would have been paid had there been no demo.

For BBA encounter data (non-demo) -- 'claims' contain amount Medicare would have paid under FFS, instead of the actual payment to the BBA plan.

COMMON ALIAS : REIMBURSEMENT  
DB2 ALIAS : CLM\_PMT\_AMT  
SAS ALIAS : PMT\_AMT  
STANDARD ALIAS : CLM\_PMT\_AMT  
TITLE ALIAS : REIMBURSEMENT

LENGTH : 9.2 SIGNED : Y

COMMENTS :

Prior to Version H, the size of this field was S9(7)V99. Also, the noninstitutional claim records carried this field as a line item. Effective with Version H, this element is a claim level field across all claim types (and the line item field has been renamed.)

SOURCE : CWF



LIMITATIONS :  
Prior to 4/6/93, on inpatient, outpatient, and  
physician/supplier claims containing a  
CLM\_DISP\_CD of '02', the amount shown as the Medicare  
reimbursement does not take into consideration  
any CWF automatic adjustments (involving erroneous  
deductibles in most cases). In as many as 30% of  
the claims (30% IP, 15% OP, 5% PART B), the  
reimbursement reported on the claims may be over  
or under the actual Medicare payment amount.

REFER TO :  
PMT\_AMT\_EXCEDG\_CHRG\_AMT\_LIM

EDIT RULES :  
\$\$\$\$\$\$\$\$\$CC

58. Carrier Claim Primary Payer Paid Amount  
6 238 243

PACK

Effective with Version H, the amount of a  
payment made on behalf of a Medicare bene-  
ficiary by a primary payer other than Medicare,  
that the provider is applying to covered  
Medicare charges on a non-institutional claim.

NOTE: During the Version H conversion, this field  
was populated with data throughout history (back to  
service year 1991) by summing up the line item primary  
payer amounts.

DB2 ALIAS : CARR\_PRMRY\_PYR\_AMT  
SAS ALIAS : PRPAYAMT  
STANDARD ALIAS : CARR\_CLM\_PRMRY\_PYR\_PD\_AMT  
TITLE ALIAS : PRIMARY\_PAYER\_AMOUNT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

EDIT RULES :  
\$\$\$\$\$\$\$\$\$CC

59. FILLER

1 244 244

CHAR

DB2 ALIAS : FILLER

LENGTH : 1

60. Carrier Claim Referring UPIN Number  
6 245 250

CHAR

The unique physician identification number (UPIN) of the physician who referred the beneficiary to the physician who performed the Part B services.

COMMON ALIAS : REFERRING\_PHYSICIAN\_UPIN  
DB2 ALIAS : RFRG\_UPIN\_NUM  
SAS ALIAS : RFR\_UPIN  
STANDARD ALIAS : CARR\_CLM\_RFRG\_UPIN\_NUM  
TITLE ALIAS : REFERRING\_PHYSICIAN\_UPIN

LENGTH : 6

COMMENTS :

Prior to Version H this field was named:  
CWFB\_CLM\_RFRG\_UPIN\_NUM.

SOURCE : CWF

61. Carrier Claim Referring Physician NPI Number  
10 251 260

CHAR

The national provider identifier (NPI) number of the physician who referred the beneficiary to the physician who performed the Part B services.

NOTE: Effective May 2007, the NPI will become the national standard identifier for covered health care providers. NPIs will replace current OSCAR provider number, UPINs, NSC numbers, and local contractor provider identification numbers (PINs) on standard HIPPA claim transactions. (During the NPI transition phase (4/3/06 - 5/23/07) the capability was there for the NCH to receive NPIs along with an existing legacy number (UPIN, PIN, OSCAR provider number, etc.)).

NOTE1: CMS has determined that dual provider identifiers (old legacy numbers and new NPI) must be available on the NCH. After the 5/07 NPI implementation, the standard system maintainers will add the legacy number to the claim when it is adjudicated. We will continue to receive any currently issued UPINs. Effective May

2007, no new UPINs (legacy number) will be generated for new physicians (Part B and Outpatient claims) so there will only be NPIs sent in to the NCH for those physicians.

DB2 ALIAS : RFRG\_PHYSN\_NPI\_NUM  
SAS ALIAS : RFR\_NPI

LENGTH : 10

SOURCE : CWF

62. Carrier Claim Provider Assignment Indicator Switch  
1 261 261 CHAR

A switch indicating whether or not the provider accepts assignment for the noninstitutional claim.

DB2 ALIAS : PRVDR\_ASGNMT\_SW  
SAS ALIAS : ASGMNTCD  
STANDARD ALIAS : CARR\_CLM\_PRVDR\_ASGNMT\_IND\_SW  
TITLE ALIAS : ASSIGNMENT\_SW

LENGTH : 1

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_CLM\_PRVDR\_ASGNMT\_IND\_SW.

SOURCE : CWF

CODE TABLE : CARR\_CLM\_PRVDR\_ASGNMT\_IND\_TB

63. NCH Claim Provider Payment Amount  
6 262 267 PACK

Effective with Version H, the total payments made to the provider for this claim (sum of line item provider payment amounts.)

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

DB2 ALIAS : NCH\_PRVDR\_PMT\_AMT  
SAS ALIAS : PROV\_PMT  
STANDARD ALIAS : NCH\_CLM\_PRVDR\_PMT\_AMT  
TITLE ALIAS : PRVDR\_PMT

			LENGTH	: 9.2	SIGNED : Y
			SOURCE	: NCH QA Process	
64.	NCH Claim Beneficiary Payment Amount				
		6	268	273	PACK
					Effective with Version H, the total payments made to the beneficiary for this claim (sum of line payment amounts to the beneficiary.)
					NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.
			DB2	ALIAS : NCH_BENE_PMT_AMT	
			SAS	ALIAS : BENE_PMT	
			STANDARD	ALIAS : NCH_CLM_BENE_PMT_AMT	
			TITLE	ALIAS : BENE_PMT	
			LENGTH	: 9.2	SIGNED : Y
			SOURCE	: NCH QA Process	
65.	Carrier Claim Beneficiary Paid Amount				
		6	274	279	PACK
					Effective with Version H, the amount paid by the beneficiary for the non-institutional Part B services.
					NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.
			DB2	ALIAS : CARR_BENE_PD_AMT	
			SAS	ALIAS : BENEPAID	
			STANDARD	ALIAS : CARR_CLM_BENE_PD_AMT	
			TITLE	ALIAS : BENE_PD_AMT	
			LENGTH	: 9.2	SIGNED : Y
			SOURCE	: CWF	
66.	NCH Carrier Claim Submitted Charge Amount				
		6	280	285	PACK
					Effective with Version H, the total submitted

charges on the claim (the sum of line item submitted charges).

NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991).

DB2 ALIAS : CARR\_SBMT\_CHRG\_AMT  
SAS ALIAS : SBMTCHRG  
STANDARD ALIAS : NCH\_CARR\_SBMT\_CHRG\_AMT  
TITLE ALIAS : SBMT\_CHRG

LENGTH : 9.2 SIGNED : Y

SOURCE : NCH QA Process

EDIT RULES :  
\$\$\$\$\$\$\$\$CC

67. NCH Carrier Claim Allowed Charge Amount  
6 286 291

PACK

Effective with Version H, the total allowed charges on the claim (the sum of line item allowed charges).

NOTE1: The amount includes beneficiary-paid amounts (i.e., deductible and coinsurance).

NOTE2: During the Version H conversion this field was populated with data throughout history (back to service year 1991).

DB2 ALIAS : CARR\_ALOW\_CHRG\_AMT  
SAS ALIAS : ALOWCHRG  
STANDARD ALIAS : NCH\_CARR\_ALOW\_CHRG\_AMT  
TITLE ALIAS : ALOW\_CHRG

LENGTH : 9.2 SIGNED : Y

SOURCE : NCH QA Process

EDIT RULES :  
\$\$\$\$\$\$\$\$CC

68. Carrier Claim Cash Deductible Applied Amount  
6 292 297

PACK

Effective with Version H, the amount of the cash deductible as submitted on the claim.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

DB2 ALIAS : CASH\_DDCTBL\_AMT  
SAS ALIAS : DEDAPPLY  
STANDARD ALIAS : CARR\_CLM\_CASH\_DDCTBL\_APPLY\_AMT  
TITLE ALIAS : CASH\_DDCTBL

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

69. Carrier Claim HCPCS Year Code  
1 298 298

NUM

Effective with Version H, the terminal digit of HCPCS version used to code the claim.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

DB2 ALIAS : CARR\_HCPCS\_YR\_CD  
SAS ALIAS : HCPCS\_YR  
STANDARD ALIAS : CARR\_CLM\_HCPCS\_YR\_CD  
TITLE ALIAS : HCPCS\_YR

LENGTH : 1 SIGNED : N

SOURCE : CWF

70. Carrier Claim MCO Override Indicator Code  
1 299 299

CHAR

Effective with Version H, the code used to indicate whether or not an MCO investigation applies to the claim (used for internal CWFMQA editing purposes).

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : MCO\_OVRD\_IND\_CD  
SAS ALIAS : MCOOVRD

STANDARD ALIAS : CARR\_CLM\_MCO\_OVRRD\_IND\_CD  
TITLE ALIAS : MCO\_OVERRIDE  
  
LENGTH : 1  
  
SOURCE : CWF  
  
CODE TABLE : CARR\_CLM\_MCO\_OVRRD\_IND\_TB

71. Carrier Claim Hospice Override Indicator Code

1 300 300 CHAR

Effective with Version H, the code used to indicate whether or not an Hospice investigation applies to the claim (used for internal CWFMQA editing purposes).

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : HOSPC\_OVRRD\_IND\_CD  
SAS ALIAS : HOSPOVRD  
STANDARD ALIAS : CARR\_CLM\_HOSPC\_OVRRD\_IND\_CD  
TITLE ALIAS : HOSPC\_OVERRIDE  
  
LENGTH : 1  
  
SOURCE : CWF  
  
CODE TABLE : CARR\_CLM\_HOSPC\_OVRRD\_IND\_TB

72. Claim Business Segment Identifier Code

4 301 304 CHAR

Effective 10/1/2005 with the implementation of NCH/NMUD CR#2, the identifier that captures the 2-byte jurisdiction code (represents the USPS state/territory abbreviation (i.e. NY = New York) and the 2-byte modifier that identifies the type of Medicare FFS contract (intermediary, RHHI, carrier or DMERC). This 4-byte identifier along with the 5-byte FI/Carrier number comprises the Contractor Workload Identifier number. The business segment identifier (BSI) is intended to help sort workloads that may be redistributed with the implementation of contracting reform as required by MMA.

DB2 ALIAS : BUSNS\_SGMT\_ID\_CD

				SAS	ALIAS : SGMT_ID
				STANDARD	ALIAS : CLM_BUSNS_SGMT_ID_CD
				LENGTH	: 4
				SOURCE	: CWF
73.	Claim Clinical Trial Number	8	305	312	CHAR
					Effective September 1, 2008 with the implementation of CR#3, the number used to identify all items and services provided to a beneficiary during their participation in a clinical trial.
					NOTE: CMS is requesting the clinical trial number be voluntarily reported. The number is assigned by the National Library of Medicine (NLM) Clinical Trials Data Bank when a new study is registered.
				DB2	ALIAS : CLM_CLNCL_TRIL_NUM
				SAS	ALIAS : CTRILNUM
				LENGTH	: 8
74.	Recovery Audit Contractor (RAC) Adjustment Indicator Code	1	313	313	CHAR
					Effective January 5, 2009 with the implementation of CR#4, the code used to identify a Recovery Audit Contractor (RAC) requested adjustment. This occurs as a result of post-payment review activities done by the RAC.
				DB2	ALIAS : RAC_ADJSTMT_CD
				SAS	ALIAS : RACINDCD
				STANDARD	ALIAS : CLM_RAC_ADJSTMT_IND_CD
				LENGTH	: 1
				CODE TABLE	: CLM_RAC_ADJSTMT_TB
75.	FILLER	50	314	363	CHAR
				DB2	ALIAS : FILLER
				LENGTH	: 50



76. Carrier Specific Group

84 364 447 GRP

This group identifies those fields specific to the carrier claim record.

STANDARD ALIAS : CARR\_SPECFC\_GRP

77. Carrier Claim Referring PIN Number

14 364 377 CHAR

Carrier-assigned identification (profiling) number of the physician who referred the beneficiary to the physician that performed the Part B services.

COMMON ALIAS : REFERRING\_PHYSICIAN\_PIN  
DB2 ALIAS : RFRG\_PIN\_NUM  
SAS ALIAS : RFR\_PRFL  
STANDARD ALIAS : CARR\_CLM\_RFRG\_PIN\_NUM  
TITLE ALIAS : RFRG\_PIN

LENGTH : 14

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_CLM\_RFRG\_PHYSN\_PRFLG\_NUM.

SOURCE : CWF

78. Care Plan Oversight (CPO) Provider Number

6 378 383 CHAR

Effective with NCH weekly process date 3/7/97, the Medicare provider number of the HHA or Hospice rendering Medicare covered services during period the physician is providing care plan oversight. The purpose of this field is to ensure compliance with the CPO requirement that the beneficiary must be receiving covered HHA or Hospice services during the billing period. There can be only one CPO provider number per claim, and no other services but CPO physician services are to be reported on the claim. This field is only present on the non-DMERC processed carrier claim.

NOTE: On the Version G format, this field is stored as a redefinition of the NEAR\_LINE\_ORGNL\_BENE\_CAN\_NUM (the first 3 positions contain 'CPO', followed by

the 6-position provider number). During the Version H conversion the data was moved to this dedicated field.

DB2 ALIAS : CPO\_PRVDR\_NUM  
SAS ALIAS : CPO\_PROV  
STANDARD ALIAS : CPO\_PRVDR\_NUM

LENGTH : 6

SOURCE : CWF

79. CPO Organization NPI Number  
10 384 393

CHAR

The National Provider Identifier (NPI) number of the HHA or Hospice rendering Medicare services during the period the physician is providing care plan oversight. The purpose of this field is to ensure compliance with the CPO requirement that the beneficiary must be receiving covered HHA or Hospice services during the billing period. There can be only one CPO provider number per claim, and no other services but CPO physician services are to be reported on the claim. This field is only present on the non-DMERC processed carrier claim.

NOTE: Effective May 2008, the NPI will become the national standard identifier for covered health care providers. NPIs will replace the current legacy provider numbers (UPINs, PINs, OSCAR provider numbers, etc.) on the standard HIPPA claim transactions. (During the NPI transition phase the capability was there for the NCH to receive NPIs along with an existing legacy number (UPIN, NPIs, OSCAR provider numbers, etc.)).

NOTE1: CMS has determined that dual provider identifiers (legacy numbers and NPIs) must be available on the NCH. After the 5/08 NPI implementation, the standard system maintainers will add the legacy number to the claim when it is adjudicated. Effective May 2008, no NEW UPINs (legacy number) will be generated for NEW physicians (Part B and Outpatient claims) so there will only be NPIs sent in to the NCH for those physicians.

DB2 ALIAS : CPO\_ORG\_NPI\_NUM  
SAS ALIAS : CPO\_NPI

			LENGTH	:	10
			SOURCE	:	CWF
80.	Claim Blood Pints Furnished Quantity				
		2	394	395	
			PACK		
			Number of whole pints of blood furnished to the beneficiary, as reported on the carrier claim (non-DMERC).		
			DB2	ALIAS :	BLOOD_PT_FRNSH_QTY
			SAS	ALIAS :	BLDFRNSH
			STANDARD	ALIAS :	CLM_BLOOD_PT_FRNSH_QTY
			TITLE	ALIAS :	BLOOD_PINTS_FURNISHED
			LENGTH	:	3 SIGNED : Y
			COMMENTS :		
			Prior to Version H this field was stored in a blood trailer. Version H eliminated the blood trailer.		
			SOURCE	:	CWF
			EDIT RULES :		
			NUMERIC		
81.	Claim Blood Deductible Pints Quantity				
		2	396	397	
			PACK		
			The quantity of blood pints applied (blood deductible) as reported on the carrier claim (non-DMERC).		
			DB2	ALIAS :	BLOOD_DDCTBL_PT
			SAS	ALIAS :	BLD_DED
			STANDARD	ALIAS :	CLM_BLOOD_DDCTBL_PT_QTY
			TITLE	ALIAS :	BLOOD_PINTS_DEDUCTIBLE
			LENGTH	:	3 SIGNED : Y
			COMMENTS :		
			Prior to Version H this field was stored in a blood trailer. Version H eliminated the blood trailer.		
			SOURCE	:	CWF

				EDIT RULES :	
				NUMERIC	
82.	FILLER	50	398	447	CHAR
				DB2 ALIAS : FILLER	
				LENGTH : 50	
83.	Carrier NCH Edit Code Count	2	448	449	NUM
The count of the number of edit codes annotated to the carrier claim during HCFA's CWFMQA process. The purpose of this count is to indicate how many claim edit trailers are present.					
				DB2 ALIAS : EDIT_TRLR_CNT	
				SAS ALIAS : CEDCNT	
				STANDARD ALIAS : CARR_NCH_EDIT_CD_CNT	
				LENGTH : 2 SIGNED : N	
COMMENTS :					
Prior to Version H this field was named: CLM_EDIT_CD_CNT.					
				SOURCE : NCH	
84.	Carrier NCH Patch Code Count	2	450	451	NUM
Effective with Version H, the count of the number of HCFA patch codes annotated to the carrier claim during the Nearline maintenance process. The purpose of this count is to indicate how many NCH patch trailers are present.					
NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991).					
				DB2 ALIAS : PATCH_TRLR_CNT	
				SAS ALIAS : CPATCNT	
				STANDARD ALIAS : CARR_NCH_PATCH_CD_I_CNT	
				LENGTH : 2 SIGNED : N	

SOURCE : NCH

85. Carrier MCO Period Count

1 452 452

NUM

Effective with Version H, the count of the number of Managed Care Organization (MCO) periods reported on a carrier claim. The purpose of this count is to indicate how many MCO period trailers are present.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

DB2 ALIAS : CARR\_MCO\_PRD\_CNT  
SAS ALIAS : CMCOCNT  
STANDARD ALIAS : CARR\_MCO\_PRD\_CNT

LENGTH : 1 SIGNED : N

SOURCE : NCH

EDIT RULES :  
RANGE: 0 TO 2

86. Carrier Claim Demonstration ID Count

1 453 453

NUM

Effective with Version H, the count of the number of claim demonstration IDs reported on an carrier claim. The purpose of this count is to indicate how many claim demonstration trailers are present.

NOTE: During the Version H conversion this field was populated with data where a demo was identifiable.

DB2 ALIAS : DEMO\_TRLR\_CNT  
SAS ALIAS : CDEMCNT  
STANDARD ALIAS : CARR\_CLM\_DEMO\_ID\_CNT

LENGTH : 1 SIGNED : N

SOURCE : NCH

EDIT RULES :

RANGE: 0 TO 5

87. Carrier Claim Diagnosis Code J Count

2 454 455 NUM

The count of the number of diagnosis codes (both principal and other) reported on a carrier claim. The purpose of this count is to indicate how many claim diagnosis code trailers are present.

NOTE: Effective with Version 'J', the count of diagnosis code trailers was expanded from 8 to 12.

DB2 ALIAS : DGNS\_TRLR\_CNT  
SAS ALIAS : CDGNCNT

LENGTH : 2 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
CLM\_DGNS\_CD\_CNT.

SOURCE : NCH

EDIT RULES :  
RANGE: 0 TO 12

88. Carrier Claim Line Count

2 456 457 NUM

The count of the number of line items reported on the carrier claim. The purpose of this count is to indicate how many line item trailers are present.

DB2 ALIAS : LINE\_ITM\_TRLR\_CNT  
SAS ALIAS : CLINECNT  
STANDARD ALIAS : CARR\_CLM\_LINE\_CNT

LENGTH : 2 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_CLM\_NUM\_LINE\_ITM\_CNT.

SOURCE : CWFB CLAIMS

EDIT RULES :  
RANGE: 1 TO 13

89.	FILLER	4	458	461	CHAR	
					DB2	ALIAS : FILLER
					LENGTH	: 4
90.	Carrier Claim Variable Group					
	VAR	462	6591		GRP	
						Variable portion of the carrier claim record for version J of the NCH.
						STANDARD ALIAS : CARR_CLM_VAR_GRP
91.	NCH Edit Group	5	462	466	GRP	
						The number of claim edit trailers is determined by the claim edit code count.
						STANDARD ALIAS : NCH_EDIT_GRP
						OCCURS MIN: 0 OCCURS MAX: 13
						DEPENDING ON : CARR_NCH_EDIT_CD_CNT
92.	NCH Edit Trailer Indicator Code	1	462	462	CHAR	
						Effective with Version H, the code indicating the presence of an NCH edit trailer.
						NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).
					DB2	ALIAS : EDIT_TRLR_IND_CD
					SAS	ALIAS : EDITIND
					STANDARD ALIAS	: NCH_EDIT_TRLR_IND_CD
					LENGTH	: 1
					SOURCE	: NCH QA Process
					CODE TABLE	: NCH_EDIT_TRLR_IND_TB
93.	NCH Edit Code					

4	463	466	CHAR
---	-----	-----	------

The code annotated to the claim indicating the CWFMQA editing results so users will be aware of data deficiencies.

NOTE: Prior to Version H only the highest priority code was stored. Beginning 11/98 up to 13 edit codes may be present.

COMMON ALIAS : QA\_ERROR\_CODE  
 DB2 ALIAS : NCH\_EDIT\_CD  
 SAS ALIAS : EDIT\_CD  
 STANDARD ALIAS : NCH\_EDIT\_CD  
 TITLE ALIAS : QA\_ERROR\_CD

LENGTH : 4

SOURCE : NCH QA EDIT PROCESS

CODE TABLE : NCH\_EDIT\_TB

94. NCH Patch Group

11	1	11	GRP
----	---	----	-----

STANDARD ALIAS : NCH\_PATCH\_GRP

OCCURS MIN: 0 OCCURS MAX: 30

DEPENDING ON : CARR\_NCH\_PATCH\_CD\_I\_CNT

95. NCH Patch Trailer Indicator Code

1	1	1	CHAR
---	---	---	------

Effective with Version H, the code indicating the presence of an NCH patch trailer.

NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).

DB2 ALIAS : PATCH\_TRLR\_IND\_CD  
 SAS ALIAS : PATCHIND  
 STANDARD ALIAS : NCH\_PATCH\_TRLR\_IND\_CD

LENGTH : 1

SOURCE : NCH



				CODE TABLE : NCH_PATCH_TRLR_IND_TB
96. NCH Patch Code	2	2	3	CHAR
				Effective with Version H, the code annotated to the claim indicating a patch was applied to the record during an NCH Nearline record conversion and/or during current processing.
				NOTE: Prior to Version H this field was located in the third and fourth occurrence of the CLM_EDIT_CD.
				DB2 ALIAS : NCH_PATCH_CD
				SAS ALIAS : PATCHCD
				STANDARD ALIAS : NCH_PATCH_CD
				TITLE ALIAS : NCH_PATCH
				LENGTH : 2
				SOURCE : NCH
				CODE TABLE : NCH_PATCH_TB
97. NCH Patch Applied Date	8	4	11	NUM
				Effective with Version H, the date the NCH patch was applied to the claim.
				DB2 ALIAS : NCH_PATCH_APPLY_DT
				SAS ALIAS : PATCHDT
				STANDARD ALIAS : NCH_PATCH_APPLY_DT
				TITLE ALIAS : NCH_PATCH_DT
				LENGTH : 8 SIGNED : N
				SOURCE : NCH
				EDIT RULES : YYYYMMDD
98. MCO Period Group	37	1	37	GRP
				The number of managed care organization (MCO) period data trailers present is determined by

the claim MCO period trailer count. This field reflects the two most current MCO periods in the CWF beneficiary history record. It may have no connection to the services on the claim.

STANDARD ALIAS : MCO\_PRD\_GRP

OCCURS MIN: 0 OCCURS MAX: 2

DEPENDING ON : CARR\_MCO\_PRD\_CNT

99. NCH MCO Trailer Indicator Code  
1 1 1

CHAR

Effective with Version H, the code indicating the presence of a Managed Care Organization (MCO) trailer.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

COBOL ALIAS : MCO\_IND

DB2 ALIAS : MCO\_TRLR\_IND\_CD

SAS ALIAS : MCOIND

STANDARD ALIAS : NCH\_MCO\_TRLR\_IND\_CD

TITLE ALIAS : MCO\_INDICATOR

LENGTH : 1

SOURCE : NCH QA Process

CODE TABLE : NCH\_MCO\_TRLR\_IND\_TB

100. MCO Contract Number

5 2 6

CHAR

Effective with Version H, this field represents the plan contract number of the Managed Care Organization (MCO).

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : MCO\_CNTRCT\_NUM

SAS ALIAS : MCONUM

STANDARD ALIAS : MCO\_CNTRCT\_NUM

				TITLE	ALIAS : MCO_NUM
				LENGTH	: 5
				SOURCE	: CWF
101. MCO Option Code	1	7	7	CHAR	
					Effective with Version H, the code indicating Managed Care Organization (MCO) lock-in enrollment status of the beneficiary.
					NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.
				DB2	ALIAS : MCO_OPTN_CD
				SAS	ALIAS : MCOOPTN
				STANDARD	ALIAS : MCO_OPTN_CD
				TITLE	ALIAS : MCO_OPTION_CD
				LENGTH	: 1
				SOURCE	: CWF
				CODE TABLE	: MCO_OPTN_TB
102. MCO Period Effective Date	8	8	15	NUM	
					Effective with Version H, the date the beneficiary's enrollment in the Managed Care Organization (MCO) became effective.
					NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.
				DB2	ALIAS : MCO_PRD_EFCTV_DT
				SAS	ALIAS : MCOEFFDT
				STANDARD	ALIAS : MCO_PRD_EFCTV_DT
				TITLE	ALIAS : MCO_PERIOD_EFF_DT
				LENGTH	: 8 SIGNED : N
				SOURCE	: CWF

EDIT RULES :  
YYYYMMDD

103. MCO Period Termination Date  
8 16 23

NUM

Effective with Version H, the date the beneficiary's enrollment in the Managed Care Organization (MCO) was terminated.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

DB2 ALIAS : MCO\_PRD\_TRMNTN\_DT  
SAS ALIAS : MCOTRMDT  
STANDARD ALIAS : MCO\_PRD\_TRMNTN\_DT  
TITLE ALIAS : MCO\_PERIOD\_TERM\_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

104. MCO Health PLANID Number  
14 24 37

CHAR

A placeholder field (effective with Version H) for storing the Health PlanID associated with the Managed Care Organization (MCO). Prior to Version 'I' this field was named: MCO\_PAYERID\_NUM.

DB2 ALIAS : MCO\_PLANID\_NUM  
SAS ALIAS : MCOPLNID  
STANDARD ALIAS : MCO\_HLTH\_PLANID\_NUM  
TITLE ALIAS : MCO\_PLANID

LENGTH : 14

COMMENTS :  
Prior to Version I this field was named: MCO\_PAYERID\_NUM.

SOURCE : CWF

105. Claim Demonstration Identification Group

18            1            18    GRP

The number of demonstration identification trailers present is determined by the claim demonstration identification trailer count.

STANDARD ALIAS : CLM\_DEMO\_ID\_GRP

OCCURS MIN: 0 OCCURS MAX: 5

DEPENDING ON : CARR\_CLM\_DEMO\_ID\_CNT

106. NCH Demonstration Trailer Indicator Code  
                  1            1            1

CHAR

Effective with Version H, the code indicating the presence of a demo trailer.

NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).

COBOL        ALIAS : DEMO\_IND  
DB2          ALIAS : NCH\_DEMO\_TRLR\_IND\_  
SAS          ALIAS : DEMOIND  
STANDARD ALIAS : NCH\_DEMO\_TRLR\_IND\_CD  
TITLE        ALIAS : DEMO\_INDICATOR

LENGTH            : 1

SOURCE            : NCH

CODE TABLE        : NCH\_DEMO\_TRLR\_IND\_TB

107. Claim Demonstration Identification Number  
                  2            2            3

CHAR

Effective with Version H, the number assigned to identify a demo. This field is also used to denote special processing (a.k.a. Special Processing Number, SPN).

NOTE: Prior to Version H, Demo ID was stored in the redefined Claim Edit Group, 4th occurrence, positions 3 and 4. During the H conversion, this field was populated with data throughout history (as appropriate either by moving ID on Version G or by deriving from specific demo criteria).

01 = Nursing Home Case-Mix and Quality: NHCMQ (RUGS) Demo -- testing PPS for SNFs in 6 states, using a case-mix classification system based on resident characteristics and actual resources used. The claims carry a RUGS indicator and one or more revenue center codes in the 9,000 series.

NOTE1: Effective for SNF claims with NCH weekly process date after 2/8/96 (and service date after 12/31/95) -- beginning 4/97, Demo ID '01' was derived in NCH based on presence of RUGS phase # '2','3' or '4' on incoming claim; since 7/97, CWF has been adding ID to claim.

NOTE2: During the Version H conversion, Demo ID '01' was populated back to NCH weekly process date 2/9/96 based on the RUGS phase indicator (stored in Claim Edit Group, 3rd occurrence, 4th position, in Version G).

02 = National HHA Prospective Payment Demo -- testing PPS for HHAs in 5 states, using two alternate methods of paying HHAs: per visit by type of HHA visit and per episode of HH care.

NOTE1: Effective for HHA claims with NCH weekly process date after 5/31/95 -- beginning 4/97, Demo ID '02' was derived in NCH based on HCFA/CHPP-supplied listing of provider # and start/stop dates of participants.

NOTE2: During the Version H conversion, Demo ID '02' was populated back to NCH weekly process date 6/95 based on the CHPP criteria.

03 = Telemedicine Demo -- testing covering traditionally noncovered physician services for medical consultation furnished via two-way, interactive video systems (i.e. teleconsultation) in 4 states. The claims contain line items with 'QQ' HCPCS code.

NOTE1: Effective for physician/supplier (nonDMERC) claims with NCH weekly process date after 12/31/96 (and service date after 9/30/96) -- since 7/97, CWF has been adding Demo ID '03' to claim.

NOTE2: During Version H conversion, Demo ID '03'

was populated back to NCH weekly process date 1/97 based on the presence of 'QQ' HCPCS on one or more line items.

04 = United Mine Workers of America (UMWA) Managed Care Demo -- testing risk sharing for Part A services, paying special capitation rates for all UMWA beneficiaries residing in 13 designated counties in 3 states. Under the demo, UMWA will waive the 3-day qualifying hospital stay for a SNF admission. The claims contain TOB '18X','21X','28X' and '51X'; condition code = W0; claim MCO paid switch = not '0'; and MCO contract # = '90091'.

NOTE: Initially scheduled to be implemented for all SNF claims for admission or services on 1/1/97 or later, CWF did not transmit any Demo ID '04' annotated claims until on or about 2/98.

05 = Medicare Choices (MCO encounter data) demo -- testing expanding the type of Managed Care plans available and different payment methods at 16 MCOs in 9 states. The claims contain one of the specific MCO Plan Contract # assigned to the Choices Demo site.

NOTE1: Effective for all claim types with NCH weekly process date after 7/31/97 -- CWF adds Demo ID '05' to claim based on the presence of the MCO Plan Contract #. \*\*\*Demonstration was terminated 12/31/2000.\*\*\*

NOTE2: During the Version H conversion, Demo ID '05' was populated back to NCH weekly process date 8/97 based on the presence of the Choices indicator (stored as an alpha character cross-walked from MCO plan contract # in the Claim Edit Group, 4th occurrence, 2nd position, in Version 'G').

06 = Coronary Artery Bypass Graft (CABG) Demo -- testing bundled payment (all-inclusive global pricing) for hospital + physician services related to CABG surgery in 7 hospitals in 7 states. The inpatient claims contain a DRG '106' or '107'.

NOTE1: Effective for Inpatient claims and physician/supplier claims with Claim Edit Date

no earlier than 6/1/91 (not all CABG sites started at the same time) -- on 5/1/97, CWF started transmitting Demo ID '06' on the claim. The FI adds the ID to the claim based on the presence of DRG '106' or '107' from specific providers for specified time periods; the carrier adds the ID to the claim based on receiving 'Daily Census List' from participating hospitals. \*\*\*Demo terminated in 1998.\*\*\*

NOTE2: During the Version H conversion, any claims where Medicare is the primary payer that were not already identified as Demo ID '06' (stored in the redefined Claim Edit Group, 4th occurrence, positions 3 and 4, Version G) were annotated based on the following criteria: Inpatient - presence of DRG '106' or '107' and a provider number=220897, 150897, 380897, 450897, 110082, 230156 or 360085 for specified service dates; noninstitutional - presence of HCPCS modifier (initial and/or second) = 'Q2' and a carrier number =00700/31143 00630, 01380, 00900, 01040/00511, 00710, 00623, or 13630 for specified service dates.

07 = Virginia Cardiac Surgery Initiative (VCSI) (formerly referred to as Medicare Quality Partnerships Demo) -- this is a voluntary consortium of the cardiac surgery physician groups and the non-Veterans Administration hospitals providing open heart surgical services in the Commonwealth of Virginia. The goal of the demo is to share data on quality and process innovations in an attempt to improve the care for all cardiac patients. The demonstration only affects those FIs that process claims from hospitals in Virginia and the carriers that process claims from physicians providing inpatient services at those hospitals. The hospitals will be reimbursed on a global payment basis for selected cardiac surgical diagnosis related groups (DRGs). The inpatient claims will contain a DRG '104', '105', '106', '107', '109'; the related physician/supplier claims will contain the claim payment denial reason code = 'D'.

NOTE: The implementation date for this demo is 4/1/03. The FI will annotate the claim with the demo id add Demo ID '07' to claim. For carrier claims, the Standard Systems will annotate the claim with the



'07' demo number.

08 = Provider Partnership Demo -- testing per-case payment approaches for acute inpatient hospitalizations, making a lump-sum payment (combining the normal Part A PPS payment with the Part B allowed charges into a single fee schedule) to a Physician/Hospital Organization for all Part A and Part B services associated with a hospital admission. From 3 to 6 hospitals in the Northeast and Mid-Atlantic regions may participate in the demo.

NOTE: The demo is on HOLD. The FI and carrier will add Demo ID '08' to claim.

15 = ESRD Managed Care (MCO encounter data) -- testing open enrollment of ESRD beneficiaries and capitation rates adjusted for patient treatment needs at 3 MCOs in 3 States. The claims contain one of the specific MCO Plan Contract # assigned to the ESRD demo site.

NOTE: Effective 10/1/97 (but not actually implemented at a site until 1/1/98) for all claim types -- the FI and carrier add Demo ID '15' to claim based on the presence of the MCO plan contract #.

30 = Lung Volume Reduction Surgery (LVRS) or National Emphysema Treatment Trial (NETT) Clinical Study -- evaluating the effectiveness of LVRS and maximum medical therapy (including pulmonary rehab) for Medicare beneficiaries in last stages of emphysema at 18 hospitals nationally, in collaboration with NIH.

NOTE: Effective for all claim types (except DMERC) with NCH weekly process date after 2/27/98 (and service date after 10/31/97) -- the FI adds Demo ID '30' based on the presence of a condition code = EY; the participating physician (not the carrier) adds ID to the noninstitutional claim. DUE TO THE SENSITIVE NATURE OF THIS CLINICAL TRIAL AND UNDER THE TERMS OF THE INTERAGENCY AGREEMENT WITH NIH, THESE CLAIMS ARE PROCESSED BY CWF AND TRANSMITTED TO HCFA BUT NOT STORED IN THE NEARLINE FILE (access is restricted to study evaluators only).

31 = VA Pricing Special Processing (SPN) -- not really a demo but special request from VA due to court settlement; not Medicare services but VA inpatient and physician services submitted to FI 00400 and Carrier 00900 to obtain Medicare pricing -- CWF WILL PROCESS VA CLAIMS ANNOTATED WITH DEMO ID '31', BUT WILL NOT TRANSMIT TO HCFA (not in Nearline File).

37 = Medicare Coordinated Care Demonstration -- to test whether coordinated care services furnished to certain beneficiaries improves outcome of care and reduces Medicare expenditures under Part A and Part B. There will be at least 14 Coordinated Care Entities (CCEs). The selected entities will be assigned a provider number specifically for the demonstration services.

NOTE: All claims will be processed by carriers; no FI processing (except for Georgetown site)

37 = Medicare Disease Management (DMD) -- the purpose of this demonstration is to study the impact on costs and health outcomes of applying disease management services supplemented with coverage for prescription drugs for certain Medicare beneficiaries with diagnosed, advanced-stage congestive heart failure, diabetes, or coronary heart disease. Three demonstration sites will be used for this demonstration and it will last for 3 years. (Effective 4/1/2003).

NOTE: All claims will be processed by NHIC-California (Carrier). FIs will only serve as a conduit for transmitting information to and from CWF about the NOEs.

38 = Physician Encounter Claims - the purpose of this demo id is to identify the physician encounter claims being processed at the HCFA Data Center (HDC). This number will help EDS in making the claim go through the appropriate processing logic, which differs from that for fee-for-service. \*\*NOT IN NCH.\*\*

NOTE: Effective October, 2000. Demo ids will not be assigned to Inpatient and Outpatient encounter claims.

39 = Centralized Billing of Flu and PPV Claims -- The purpose of this demo is to facilitate the processing carrier, Trailblazers, paying flu and PPV claims based on payment localities. Providers will be

giving the shots throughout the country and transmitting the claims to Trailblazers for processing.

NOTE: Effective October, 2000 for carrier claims.

40 = Payment of Physician and Nonphysician Services in certain Indian Providers -- the purpose of this demo is to extend payment for services of physician and nonphysician practitioners furnished in hospitals and ambulatory care clinics. Prior to the legislation change in BIPA, reimbursement for Medicare services provided in IHS facilities was limited to services provided in hospitals and skilled nursing facilities. This change will allow payment for IHS, Tribe and Tribal Organization providers under the Medicare physician fee schedule.

NOTE: Effective July 1, 2001 for institutional and carrier claims.

48 = Medical Adult Day-Care Services -- the purpose of this demonstration is to provide, as part of the episode of care for home health services, medical adult day care services to Medicare beneficiaries as a substitute for a portion of home health services that would otherwise be provided in the beneficiaries home. This demo would last approx. 3 years in not more than 5 sites. Payment for each home health service episode of care will be set at 95% of the amount that would otherwise be paid for home health services provided entirely in the home.

NOTE: Effective July 5, 2005 for HHA claims.

DB2 ALIAS : CLM\_DEMO\_ID\_NUM  
SAS ALIAS : DEMONUM  
STANDARD ALIAS : CLM\_DEMO\_ID\_NUM  
TITLE ALIAS : DEMO\_ID

LENGTH : 2

SOURCE : CWF

108. Claim Demonstration Information Text

15 4

18

CHAR

Effective with Version H, the text field that contains related demo information. For example, a claim involving a CHOICES demo id '05' would

contain the MCO plan contract number in the first five positions of this text field.

NOTE: During the Version H conversion this field was populated with data throughout history.

DB2        ALIAS : CLM\_DEMO\_INFO\_TXT  
SAS        ALIAS : DEMOTXT  
STANDARD ALIAS : CLM\_DEMO\_INFO\_TXT  
TITLE     ALIAS : DEMO\_INFO

LENGTH        : 15

DERIVATIONS :

DERIVATION RULES:

Demo ID = 01 (RUGS) -- the text field will contain a 2, 3 or 4 to denote the RUGS phase. If RUGS phase is blank or not one of the above the text field will reflect 'INVALID'. NOTE: In Version 'G', RUGS phase was stored in redefined Claim Edit Group, 3rd occurrence, 4th position.

Demo ID = 02 (Home Health demo) -- the text field will contain PROV#. When demo number not equal to 02 then text will reflect 'INVALID'.

Demo ID = 03 (Telemedicine demo) -- text field will contain the HCPCS code. If the required HCPCS is not shown then the text field will reflect 'INVALID'.

Demo ID = 04 (UMWA) -- text field will contain W0 denoting that condition code W0 was present. If condition code W0 not present then the text field will reflect 'INVALID'.

Demo ID = 05 (CHOICES) -- the text field will contain the CHOICES plan number, if both of the following conditions are met: (1) CHOICES plan number present and PPS or Inpatient claim shows that 1st 3 positions of provider number as '210' and the admission date is within HMO effective/termination date; or non-PPS claim and the from date is within HMO effective/termination date and (2) CHOICES plan number matches the HMO plan number. If either condition is not met the text field will reflect 'INVALID CHOICES PLAN NUMBER'. When CHOICES plan number not present, text will reflect 'INVALID'.

NOTE: In Version 'G', a valid CHOICES plan ID is stored as alpha character in redefined Claim Edit Group, 4th occurrence, 2nd position. If invalid, CHOICES indicator 'ZZ' displayed.

Demo ID = 15 (ESRD Managed Care) -- text field will contain the ESRD/MCO plan number. If ESRD/MCO plan number not present the field will reflect 'INVALID'.

Demo ID = 38 (Physician Encounter Claims) -- text field will contain the MCO plan number. When MCO plan number not present the field will reflect 'INVALID'.

SOURCE : CWF

LIMITATIONS :

REFER TO :  
CHOICES\_DEMO\_LIM

109. Carrier Claim Diagnosis Group  
9 1 9

GRP

The number of claim diagnosis trailers is determined by the carrier claim diagnosis code count.

STANDARD ALIAS : CARR\_CLM\_DGNS\_GRP

OCCURS MIN: 0 OCCURS MAX: 12

DEPENDING ON : CARR\_CLM\_DGNS\_CD\_J\_CNT

110. NCH Diagnosis Trailer Indicator Code  
1 1 1

CHAR

Effective with Version H, the code indicating the presence of a diagnosis trailer.

NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).

DB2 ALIAS : DGNS\_TRLR\_IND\_CD  
SAS ALIAS : DGNSIND  
STANDARD ALIAS : NCH\_DGNS\_TRLR\_IND\_CD

				LENGTH	: 1
				SOURCE	: NCH
				CODE TABLE	: NCH_DGNS_TRLR_IND_TB
111. Claim Diagnosis Version Code	1	2	2	CHAR	
					Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9 or ICD-10.
					NOTE: With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2013.
				DB2	ALIAS : UNDEFINED
				SAS	ALIAS : DVRSNCD
				LENGTH	: 1
				CODE TABLE	: CLM_DGNS_VRSN_TB
112. Claim Diagnosis Code	7	3	9	CHAR	
					The diagnosis code identifying the beneficiary's principal or other diagnosis (including E code).
					NOTE:
					Prior to Version H, the principal diagnosis code was not stored with the 'OTHER' diagnosis codes. During the Version H conversion the CLM_PRNCPAL_DGNS_CD was added as the first occurrence.
					NOTE1: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10.
					NOTE2: Effective with Version 'J', the diagnosis E codes are stored in a separate trailer (CLM_DGNS_E_GRP).
				DB2	ALIAS : CLM_DGNS_CD
				SAS	ALIAS : DGNS_CD
				LENGTH	: 7

EDIT RULES :  
ICD-9-CM

113.

420 1 420

OCCURS MIN: 1OCCURS MAX: 13

DEPENDING ON : CARR\_CLM\_LINE\_CNT

114. NCH Line Item Trailer Indicator Code

1 1 1

CHAR

Effective with Version H, the code indicating the presence of a line item trailer on the non-institutional claim.

NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).

DB2 ALIAS : LINE\_TRLR\_IND\_CD  
SAS ALIAS : LINEIND  
STANDARD ALIAS : NCH\_LINE\_TRLR\_IND\_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH\_LINE\_TRLR\_IND\_TB

115. Carrier Line Performing PIN Number

10 2 11

CHAR

The profiling identification number (PIN) of the physician\supplier (assigned by the carrier) who performed the service for this line item on the carrier claim (non-DMERC).

COMMON ALIAS : PHYSICIAN/SUPPLIER\_PROVIDER\_NUM  
DB2 ALIAS : LINE\_PRFRMG\_PIN  
SAS ALIAS : PRF\_PRFL  
STANDARD ALIAS : CARR\_LINE\_PRFRMG\_PIN\_NUM  
TITLE ALIAS : PRFRMG\_PIN

LENGTH : 10

COMMENTS :

Prior to Version H this field was named:  
CWFB\_PRFRMG\_PRVDR\_PRFLG\_NUM.

			SOURCE	: CWF
116. Carrier Line Performing UPIN Number	6	12	17	CHAR
				The unique physician identification number (UPIN) of the physician who performed the service for this line item on the carrier claim (non-DMERC).
			DB2	ALIAS : LINE_PRFRMG_UPIN
			SAS	ALIAS : PRF_UPIN
			STANDARD	ALIAS : CARR_LINE_PRFRMG_UPIN_NUM
			TITLE	ALIAS : PRFRMG_UPIN
			LENGTH	: 6
			COMMENTS :	
				Prior to Version H this field was named: CWFB_PRFRMG_PRVDR_UPIN_NUM.
			SOURCE	: CWF
			LIMITATIONS :	
			REFER TO :	
				CARR_LINE_PRFRMG_UPIN_LIM
117. Carrier Line Performing NPI Number	10	18	27	CHAR
				A placeholder field (effective with Version H) for storing the NPI assigned to the performing provider.
			DB2	ALIAS : LINE_PRFRMG_NPI
			SAS	ALIAS : PRFNPI
			LENGTH	: 10
			SOURCE	: CWF
118. Carrier Line Performing Group NPI Number	10	28	37	CHAR
				The National Provider Identifier (NPI) of the group practice, where the performing physician is part of that group.



NOTE: Effective May 2007, the NPI will become the national standard identifier for covered health care providers. NPIs will replace the current legacy numbers (UPINs, PINs, etc.) on the standard HIPPA claim transactions. (During the NPI transition phase (4/3/06 - 5/23/07) the capability was there for the NCH to receive NPIs along with an existing legacy number.

CMS has determined that dual provider identifiers (old legacy numbers and new NPI) must be available in the NCH. After the 5/07 NPI implementation, the standard system maintainers will add the legacy number to the claim when it is adjudicated. We will continue to receive the OSCAR provider number and any currently issued UPINs. Effective May 2007, no NEW UPINs (legacy number) will be generated for NEW physicians (Part B and Outpatient claims), so there will only be NPIs sent in to the NCH for those physicians.

DB2 ALIAS : PRFRMG\_GRP\_NPI  
SAS ALIAS : PRGRPNPI  
STANDARD ALIAS : CARR\_LINE\_PRFRMG\_GRP\_NPI\_NUM

LENGTH : 10

SOURCE : CWF

119. Carrier Line Provider Type Code

1 38 38

CHAR

Code identifying the type of provider  
furnishing the service for this line item  
on the carrier claim (non-DMERC).

DB2 ALIAS : LINE\_PRVDR\_TYPE\_CD  
SAS ALIAS : PRV\_TYPE  
STANDARD ALIAS : CARR\_LINE\_PRVDR\_TYPE\_CD  
TITLE ALIAS : PRVDR\_TYPE

LENGTH : 1

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_PRVDR\_TYPE\_CD.

SOURCE : CWF

CODE TABLE : CARR\_LINE\_PRVDR\_TYPE\_TB

120. Line Provider Tax Number

10

39

48

CHAR

Social security number or employee identification number of physician/supplier used to identify to whom payment is made for the line item service on the noninstitutional claim.

DB2 ALIAS : LINE\_PRVDR\_TAX\_NUM  
SAS ALIAS : TAX\_NUM  
STANDARD ALIAS : LINE\_PRVDR\_TAX\_NUM  
TITLE ALIAS : PRVDR\_TAX\_NUM

LENGTH : 10

COMMENTS :

Prior to Version H this field was named:  
CWFB\_PRVDR\_TAX\_NUM.

SOURCE : NCH

121. Line NCH Provider State Code

2

49

50

CHAR

Effective with Version H, the two position SSA state code where provider facility is located.

NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991).

DB2 ALIAS : LINE\_PRVDR\_STATE  
SAS ALIAS : PRVSTATE  
STANDARD ALIAS : LINE\_NCH\_PRVDR\_STATE\_CD  
TITLE ALIAS : PRVDR\_STATE

LENGTH : 2

DERIVATIONS :

DERIVED FROM:

CARR\_LINE\_PRFRMG\_PRVDR\_ZIP\_CD

DERIVATION RULES:

Use the first three positions of the provider zip code to derive the LINE\_NCH\_PRVDR\_STATE\_CD from a crosswalk file. Where a match is not

achieved this field will be blank.

SOURCE : NCH

CODE TABLE : GEO\_SSA\_STATE\_TB

122. Carrier Line Performing Provider ZIP Code  
9 51 59

CHAR

The ZIP code of the physician/supplier who performed the Part B service for this line item on the carrier claim (non-DMERC).

DB2 ALIAS : LINE\_PRVDR\_ZIP\_CD

SAS ALIAS : PROVZIP

STANDARD ALIAS : CARR\_LINE\_PRFRMG\_PRVDR\_ZIP\_CD

TITLE ALIAS : PRVDR\_ZIP\_CD

LENGTH : 9

COMMENTS :

Prior to Version H this field was named:

CWFB\_PRFRMG\_PRVDR\_ZIP\_CD and the field size was S9(9).

SOURCE : CWF

123. Line HCFA Provider Specialty Code  
2 60 61

CHAR

CMS specialty code used for pricing the line item service on the noninstitutional claim.

DB2 ALIAS : HCFA\_SPCLTY\_CD

SAS ALIAS : HCFASPCCL

STANDARD ALIAS : LINE\_HCFA\_PRVDR\_SPCLTY\_CD

TITLE ALIAS : HCFA\_PRVDR\_SPCLTY

LENGTH : 2

COMMENTS :

Prior to Version H this field was named:

CWFB\_HCFA\_PRVDR\_SPCLTY\_CD.

SOURCE : CWF

CODE TABLE : HCFA\_PRVDR\_SPCLTY\_TB

124. Carrier Line Provider Specialty Code

2        62        63        CHAR

The carrier's specialty code for the provider (usually different from HCFA's) used for pricing the service for this line item on the carrier claim (non-DMERC).

NOTE: The LINE\_HCFA\_PRVDR\_SPCLTY\_CD is the code to use, This code is an hold over field from the days before the Physician Fee Schedule was implemented. CMS allowed carriers to have their own set of codes for developing local pricing profiles, i.e. prevailing charge, customary charge, or reasonable charge systems. Physician services are no longer priced using this method. Some carriers still maintain these local specialties but they are NOT recognized by CMS.

It has been determined that this field is useless for national pricing or statistics. CWF systems still allows this field and passes the data (if submitted) on to the NCH.

DB2        ALIAS : PRVDR\_SPCLTY\_CD  
SAS        ALIAS : CARRSPCL  
STANDARD ALIAS : CARR\_LINE\_PRVDR\_SPCLTY\_CD  
TITLE      ALIAS : CARR\_PRVDR\_SPCLTY

LENGTH        : 2

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_CARR\_PRVDR\_SPCLTY\_CD.

SOURCE        : CWF

EDIT RULES :  
CARRIER INFORMATION FILE

125. Line Provider Participating Indicator Code  
1        64        64

CHAR

Code indicating whether or not a provider is participating or accepting assignment for this line item service on the noninstitutional claim.

DB2        ALIAS : PRVDR\_PRTCPTG\_CD  
SAS        ALIAS : PRTCPTG  
STANDARD ALIAS : LINE\_PRVDR\_PRTCPTG\_IND\_CD  
TITLE      ALIAS : PRVDR\_PRTCPTG\_IND

LENGTH : 1

COMMENTS :

Prior to Version H this field was named:  
CWFB\_PRVDR\_PRTCPTG\_IND\_CD.

SOURCE : CWF

CODE TABLE : LINE\_PRVDR\_PRTCPTG\_IND\_TB

126. Carrier Line Reduced Payment Physician Assistant Code

1 65 65 CHAR

Effective 1/92, the code on the carrier (non-DMERC)  
line item that identifies claims that have been  
paid a reduced fee schedule amount (65%, 75% or 85%)  
because a physician's assistant performed the  
services.

COMMON ALIAS : PA\_65/75/85%\_FEE  
DB2 ALIAS : PHYSN\_ASTNT\_CD  
SAS ALIAS : ASTNT\_CD  
STANDARD ALIAS : CARR\_LINE\_RDCD\_PHYSN\_ASTNT\_CD  
TITLE ALIAS : PHYSN\_ASTNT\_CD

LENGTH : 1

COMMENTS :

Prior to Version H this field was named:  
CWFB\_RDCD\_PMT\_PHYSN\_ASTNT\_CD.

SOURCE : CWF

CODE TABLE : CARR\_LINE\_RDCD\_PHYSN\_ASTNT\_TB

127. Line Service Count

6 66 71 PACK

The count of the total number of services  
processed for the line item on the non-institutional  
claim.

DB2 ALIAS : SRVC\_CNT  
SAS ALIAS : SRVC\_CNT  
STANDARD ALIAS : LINE\_SRVC\_CNT

LENGTH : 7.3 SIGNED : Y

COMMENTS :

Prior to Version H this field was named:

CWFB\_SRVC\_CNT.

Prior to Version 'J', this field was S9(3)  
Length: 7.3

SOURCE : CWF

128. Line HCFA Type Service Code  
1 72 72

CHAR

Code indicating the type of service, as defined  
in the CMS Medicare Carrier Manual, for this  
line item on the non-institutional claim.

DB2 ALIAS : HCFA\_TYPE\_SRVC\_CD  
SAS ALIAS : TYPESRVCB  
STANDARD ALIAS : LINE\_HCFA\_TYPE\_SRVC\_CD  
TITLE ALIAS : HCFA\_TYPE\_SRVC

LENGTH : 1

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_HCFA\_TYPE\_SRVC\_CD.

SOURCE : CWF

EDIT RULES :  
The only type of service codes applicable to DMERC  
claims are: 1, 9, A, E, G, H, J, K, L, M, P,  
R, and S.

CODE TABLE : CMS\_TYPE\_SRVC\_TB

129. Carrier Line Type Service Code  
2 73 74

CHAR

Carrier's type of service code (usually  
different from HCFA's) used for pricing the  
service reported on the line item on the  
carrier claim (non-DMERC).

DB2 ALIAS : LINE\_TYPE\_SRVC\_CD  
SAS ALIAS : PTYPESRV  
STANDARD ALIAS : CARR\_LINE\_TYPE\_SRVC\_CD  
TITLE ALIAS : CARR\_TYPE\_SRVC

LENGTH : 2

COMMENTS :

Prior to Version H this field was named:  
CWFB\_CARR\_TYPE\_SRVC\_CD.

SOURCE : CWF

130. Line Place of Service Code  
2 75 76

CHAR

The code indicating the place of service, as  
defined in the Medicare Carrier Manual, for  
this line item on the noninstitutional claim.

COMMON ALIAS : POS  
DB2 ALIAS : LINE\_PLC\_SRVC\_CD  
SAS ALIAS : PLCSRVC  
STANDARD ALIAS : LINE\_PLC\_SRVC\_CD  
TITLE ALIAS : PLC\_SRVC

LENGTH : 2

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_PLC\_SRVC\_CD.

SOURCE : CWF

131. Carrier Line Pricing Locality Code  
2 77 78

CHAR

Code denoting the carrier-specific locality  
used for pricing the service for this line  
item on the carrier claim (non-DMERC).

DB2 ALIAS : PRCNG\_LCLTY\_CD  
SAS ALIAS : LCLTY\_CD  
STANDARD ALIAS : CARR\_LINE\_PRCNG\_LCLTY\_CD  
TITLE ALIAS : PRICING\_LOCALITY

LENGTH : 2

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_CARR\_PRCNG\_LCLTY\_CD.

SOURCE : CWF

EDIT RULES :  
CARRIER INFORMATION FILE

132. Line First Expense Date

8	79	86	NUM
Beginning date (1st expense) for this line item service on the noninstitutional claim.			
DB2 ALIAS : LINE_1ST_EXPNS_DT			
SAS ALIAS : EXPNSDT1			
STANDARD ALIAS : LINE_1ST_EXPNS_DT			
TITLE ALIAS : 1ST_EXPNS_DT			
LENGTH : 8 SIGNED : N			
COMMENTS :			
Prior to Version H this field was named: CWFB_1ST_EXPNS_DT.			
SOURCE : CWF			
EDIT RULES :			
YYYYMMDD			

133. Line Last Expense Date

8	87	94	NUM
The ending date (last expense) for the line item service on the noninstitutional claim.			
COBOL ALIAS : LST_EXP_DT			
DB2 ALIAS : LINE_LAST_EXPNS_DT			
SAS ALIAS : EXPNSDT2			
STANDARD ALIAS : LINE_LAST_EXPNS_DT			
TITLE ALIAS : LAST_EXPNS_DT			
LENGTH : 8 SIGNED : N			
COMMENTS :			
Prior to Version H this field was named: CWFB_LAST_EXPNS_DT.			
SOURCE : CWF			
EDIT RULES :			
YYYYMMDD			

134. Line HCPCS Code

5	95	99	CHAR
The Health Care Common Procedure Coding System (HCPCS) is a collection of codes that			



represent procedures, supplies, products and services which may be provided to Medicare beneficiaries and to individuals enrolled in private health insurance programs. The codes are divided into three levels, or groups as described below:

DB2        ALIAS : LINE\_HCPCS\_CD  
SAS        ALIAS : HCPCS\_CD  
STANDARD ALIAS : LINE\_HCPCS\_CD  
TITLE      ALIAS : HCPCS\_CD

LENGTH        : 5

COMMENTS :

Prior to Version H this line item field was named: HCPCS\_CD. With Version H, a prefix was added to denote the location of this field on each claim type (institutional: REV\_CNTR and noninstitutional: LINE).

Level I

Codes and descriptors copyrighted by the American Medical Association's Current Procedural Terminology, Fourth Edition (CPT-4). These are 5 position numeric codes representing physician and nonphysician services.

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

CPT-4 codes including both long and short descriptions shall be used in accordance with the CMS/AMA agreement. Any other use violates the AMA copyright.

Level II

Includes codes and descriptors copyrighted by the American Dental Association's Current Dental Terminology, Fifth Edition (CDT-5). These are 5 position alpha-numeric codes comprising the D series. All other level II codes and descriptors are approved and maintained jointly by the alpha-numeric editorial panel (consisting of CMS, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association). These are 5 position alpha-numeric codes representing primarily items and nonphysician services that are not represented in the level I codes.

Level III  
Codes and descriptors developed by Medicare  
carriers for use at the local (carrier) level.  
These are 5 position alpha-numeric codes in the  
W, X, Y or Z series representing physician  
and nonphysician services that are not  
represented in the level I or level II codes.

135. Line HCPCS Initial Modifier Code  
2 100 101

CHAR

A first modifier to the HCPCS procedure code  
to enable a more specific procedure  
identification for the line item service  
on the noninstitutional claim.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : MDFR\_CD1  
STANDARD ALIAS : LINE\_HCPCS\_INITL\_MDFR\_CD  
TITLE ALIAS : INITIAL\_MODIFIER

LENGTH : 2

COMMENTS :  
Prior to Version H this field was named:  
HCPCS\_INITL\_MDFR\_CD. With Version H, a prefix  
was added to denote the location of this field  
on each claim type (institutional: REV\_CNTR and  
noninstitutional: LINE).

SOURCE : CWF

EDIT RULES :  
CARRIER INFORMATION FILE

136. Line HCPCS Second Modifier Code  
2 102 103

CHAR

A second modifier to the HCPCS procedure code to  
make it more specific than the first modifier  
code to identify the line item procedures for  
this claim.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : MDFR\_CD2  
STANDARD ALIAS : LINE\_HCPCS\_2ND\_MDFR\_CD  
TITLE ALIAS : SECOND\_MODIFIER

LENGTH : 2

COMMENTS :

Prior to Version H this field was named:  
HCPCS\_2ND\_MDFR\_CD. With Version H, a prefix  
was added to denote the location of this field  
on each claim type (institutional: REV\_CNTR and  
noninstitutional: LINE).

SOURCE : CWF

EDIT RULES :

CARRIER INFORMATION FILE

137. Line HCPCS Third Modifier Code

2 104 105

CHAR

Prior to Version H this field was named:  
HCPCS\_3RD\_MDFR\_CD.

DB2 ALIAS : HCPCS\_3RD\_MDFR\_CD

SAS ALIAS : MDFR\_CD3

STANDARD ALIAS : LINE\_HCPCS\_3RD\_MDFR\_CD

LENGTH : 2

SOURCE : CWF

138. Line HCPCS Fourth Modifier Code

2 106 107

CHAR

Prior to Version H this field was named:  
HCPCS\_4TH\_MDFR\_CD.

DB2 ALIAS : HCPCS\_4TH\_MDFR\_CD

SAS ALIAS : MDFR\_CD4

STANDARD ALIAS : LINE\_HCPCS\_4TH\_MDFR\_CD

LENGTH : 2

SOURCE : CWF

139. Line NCH BETOS Code

3 108 110

CHAR

Effective with Version H, the Berenson-Eggers  
type of service (BETOS) for the procedure code  
based on generally agreed upon clinically  
meaningful groupings of procedures and services.  
This field is included as a line item on the

noninstitutional claim.

NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991).

DB2 ALIAS : LINE\_NCH\_BETOS\_CD  
SAS ALIAS : BETOS  
STANDARD ALIAS : LINE\_NCH\_BETOS\_CD  
TITLE ALIAS : BETOS

LENGTH : 3

DERIVATIONS :  
DERIVED FROM:  
LINE\_HCPCS\_CD  
LINE\_HCPCS\_INITL\_MDFR\_CD  
LINE\_HCPCS\_2ND\_MDFR\_CD  
HCPCS MASTER FILE

DERIVATION RULES:  
Match the HCPCS on the claim to the HCPCS on the HCPCS Master File to obtain the BETOS code.

SOURCE : NCH

CODE TABLE : BETOS\_TB

140. Line IDE Number

7 111 117

CHAR

Effective with Version H, the exemption number assigned by the Food and Drug Administration (FDA) to an investigational device after a manufacturer has been approved by FDA to conduct a clinical trial on that device. HCFA established a new policy of covering certain IDE's which was implemented in claims processing on 10/1/96 (which is NCH weekly process 10/4/96) for service dates beginning 10/1/95.

NOTE: Prior to Version H a dummy line item was created in the last occurrence of line item group to store IDE. The IDE number was housed in two fields: HCPCS code and HCPCS initial modifier; the second modifier contained the value 'ID'. There will be only one distinct IDE number reported on the non-institutional claim. During the Version H conversion, the IDE was moved from the dummy line item to its own dedicated field

for each line item (i.e., the IDE was repeated  
on all line items on the claim.)

DB2 ALIAS : LINE\_IDE\_NUM  
SAS ALIAS : LINE\_IDE  
STANDARD ALIAS : LINE\_IDE\_NUM  
TITLE ALIAS : IDE\_NUMBER

LENGTH : 7

SOURCE : CWF

141. Line National Drug Code

11 118 128

CHAR

Effective 1/1/94 on the DMERC claim, the National  
Drug Code identifying the oral anti-cancer drugs.  
Effective with Version H, this line item field was  
added as a placeholder on the carrier claim.

DB2 ALIAS : LINE\_NATL\_DRUG\_CD  
SAS ALIAS : NDC\_CD  
STANDARD ALIAS : LINE\_NATL\_DRUG\_CD  
TITLE ALIAS : NDC\_CD

LENGTH : 11

SOURCE : CWF

142. Line NCH Payment Amount

6 129 134

PACK

Amount of payment made from the trust funds (after  
deductible and coinsurance amounts have been  
paid) for the line item service on the non-  
institutional claim.

COMMON ALIAS : REIMBURSEMENT  
DB2 ALIAS : LINE\_NCH\_PMT\_AMT  
SAS ALIAS : LINEPMT  
STANDARD ALIAS : LINE\_NCH\_PMT\_AMT  
TITLE ALIAS : REIMBURSEMENT

LENGTH : 9.2 SIGNED : Y

COMMENTS :

Prior to Version H this line item field was named:  
CLM\_PMT\_AMT and the size of this field was  
S9(7)V99.

SOURCE : NCH

EDIT RULES :  
\$\$\$\$\$\$\$\$\$CC

143. Line Beneficiary Payment Amount

6 135 140

PACK

Effective with Version H, the payment (reimbursement) made to the beneficiary related to the line item service on the noninstitutional claim.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

DB2 ALIAS : LINE\_BENE\_PMT\_AMT  
SAS ALIAS : LBENPMT  
STANDARD ALIAS : LINE\_BENE\_PMT\_AMT  
TITLE ALIAS : BENE\_PMT\_AMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

144. Line Provider Payment Amount

6 141 146

PACK

Effective with Version H, the payment made to the provider for the line item service on the noninstitutional claim.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

DB2 ALIAS : LINE\_PRVDR\_PMT\_AMT  
SAS ALIAS : LPRVPMT  
STANDARD ALIAS : LINE\_PRVDR\_PMT\_AMT  
TITLE ALIAS : PRVDR\_PMT\_AMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

145. Line Beneficiary Part B Deductible Amount

6 147 152

PACK

The amount of money for which the carrier has determined that the beneficiary is liable for the Part B cash deductible for the line item service on the noninstitutional claim.

DB2 ALIAS : LINE\_DDCTBL\_AMT  
SAS ALIAS : LDEDAMT  
STANDARD ALIAS : LINE\_BENE\_PTB\_DDCTBL\_AMT  
TITLE ALIAS : PTB\_DED\_AMT

LENGTH : 9.2 SIGNED : Y

COMMENTS :  
Prior to Version H this field was named:  
BENE\_PTB\_DDCTBL\_LBLTY\_AMT and the size of the  
field was S9(3)V99.

SOURCE : CWF

EDIT RULES :  
\$\$\$\$\$\$\$\$\$CC

146. Line Beneficiary Primary Payer Code  
1 153 153

CHAR

The code specifying a federal non-Medicare program or other source that has primary responsibility for the payment of the Medicare beneficiary's medical bills relating to the line item service on the noninstitutional claim.

DB2 ALIAS : LINE\_PRMRY\_PYR\_CD  
SAS ALIAS : LPRPAYCD  
STANDARD ALIAS : LINE\_BENE\_PRMRY\_PYR\_CD  
TITLE ALIAS : PRIMARY\_PAYER\_CD

LENGTH : 1

COMMENTS :  
Prior to Version H this field was named:  
BENE\_PRMRY\_PYR\_CD.

SOURCE : CWF,VA,DOL,SSA

CODE TABLE : BENE\_PRMRY\_PYR\_TB

147. Line Beneficiary Primary Payer Paid Amount  
6 154 159

PACK

The amount of a payment made on behalf of a Medicare beneficiary by a primary payer other than Medicare, that the provider is applying to covered Medicare charges for to the line ITEM SERVICE ON THE NONINSTITUTIONAL.

DB2 ALIAS : LINE\_PRMRY\_PYR\_PD  
SAS ALIAS : LPRPDAMT  
STANDARD ALIAS : LINE\_BENE\_PRMRY\_PYR\_PD\_AMT  
TITLE ALIAS : PRMRY\_PYR\_PD

LENGTH : 9.2 SIGNED : Y

COMMENTS :  
Prior to Version H this field was named:  
BENE\_PRMRY\_PYR\_PMY\_AMT and the field size  
was S9(5)V99.

SOURCE : CWF

EDIT RULES :  
\$\$\$\$\$\$\$\$\$CC

148. Line Coinsurance Amount

6 160 165

PACK

Effective with Version H, the beneficiary coinsurance liability amount for this line item service on the noninstitutional claim.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

DB2 ALIAS : LINE\_COINSRNC\_AMT  
SAS ALIAS : COINAMT  
STANDARD ALIAS : LINE\_COINSRNC\_AMT  
TITLE ALIAS : COINSRNC\_AMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

149. Carrier Line Psychiatric, Occupational Therapy, Physical Therapy Limit Amount

6 166 171

PACK

For type of service psychiatric, occupational therapy or physical therapy, the amount of



allowed charges applied toward the limit cap  
for this line item service on the noninstitutional  
claim.

DB2 ALIAS : PSYCH\_OT\_PT\_LMT  
SAS ALIAS : LLMTAMT  
STANDARD ALIAS : CARR LINE PSYCH\_OT\_PT\_LMT\_AMT  
TITLE ALIAS : PSYCH\_OT\_PT\_LIMIT

LENGTH : 9.2 SIGNED : Y

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_PSYCH\_OT\_PT\_LMT\_AMT and the field size  
was S9(5)V99.

SOURCE : CWF

150. Line Interest Amount

6 172 177

PACK

Amount of interest to be paid for this line  
item service on the noninstitutional claim.  
\*\*NOTE: This is not included in the line item  
NCH payment (reimbursement) amount.

DB2 ALIAS : LINE\_INTRST\_AMT  
SAS ALIAS : LINT\_AMT  
STANDARD ALIAS : LINE\_INTRST\_AMT  
TITLE ALIAS : INTRST\_AMT

LENGTH : 9.2 SIGNED : Y

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_INTRST\_AMT and the field size was  
S9(5)V99.

SOURCE : CWF

EDIT RULES :  
\$\$\$\$\$\$\$\$\$CC

151. Line Primary Payer Allowed Charge Amount

6 178 183

PACK

Effective with Version H, the primary payer  
allowed charge amount for the line item  
service on the noninstitutional claim.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

DB2 ALIAS : PRMRY\_PYR\_ALLOW\_AMT  
SAS ALIAS : PRPYALLOW  
STANDARD ALIAS : LINE\_PRMRY\_PYR\_ALLOW\_CHRG\_AMT  
TITLE ALIAS : PRMRY\_PYR\_ALLOW\_CHRG

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

152. Line 10% Penalty Reduction Amount  
6 184 189

PACK

Effective with Version H, the 10% payment reduction amount (applicable to a late filing claim) for the line item service. on the noninstitutional claim.

DB2 ALIAS : TENPCT\_PNLTY\_AMT  
SAS ALIAS : PNLTYAMT  
STANDARD ALIAS : LINE\_10PCT\_PNLTY\_RDCTN\_AMT  
TITLE ALIAS : TENPCT\_PNLTY

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

153. Carrier Line Blood Deductible Pints Quantity  
2 190 191

PACK

The blood pints quantity (deductible) for the line item on the carrier claim (non-DMERC).

DB2 ALIAS : LINE\_BLOOD\_DDCTBL  
SAS ALIAS : LBLD\_DED  
STANDARD ALIAS : CARR\_LINE\_BLOOD\_DDCTBL\_QTY  
TITLE ALIAS : BLOOD\_DDCTBL

LENGTH : 3 SIGNED : Y

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_LINE\_BLOOD\_DDCTBL\_QTY.

SOURCE : CWF

EDIT RULES :  
NUMERIC

154. Line Submitted Charge Amount  
6

192 197

PACK

The amount of submitted charges for the line item service on the noninstitutional claim.

DB2 ALIAS : LINE\_SBMT\_CHRG\_AMT  
SAS ALIAS : LSBMTCHG  
STANDARD ALIAS : LINE\_SBMT\_CHRG\_AMT  
TITLE ALIAS : SBMT\_CHRG

LENGTH : 9.2 SIGNED : Y

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_SBMT\_CHRG\_AMT and the field size was  
S9(5)V99.

SOURCE : CWF

EDIT RULES :  
\$\$\$\$\$\$\$\$\$CC

155. Line Allowed Charge Amount  
6

198 203

PACK

The amount of allowed charges for the line item service on the noninstitutional claim. This charge is used to compute pay to providers or reimbursement to beneficiaries. \*\*NOTE: The

Note1: The amount includes beneficiary-paid amounts (i.e., deductible and coinsurance).

Note2: The allowed charge is determined by the lower of three charges: prevailing, customary or actual.

DB2 ALIAS : LINE\_ALOW\_CHRG\_AMT  
SAS ALIAS : LALOWCHG  
STANDARD ALIAS : LINE\_ALOW\_CHRG\_AMT  
TITLE ALIAS : ALOW\_CHRG

LENGTH : 9.2 SIGNED : Y

COMMENTS :  
Prior to Version H this field was named:

CWFB\_ALOW\_CHRG\_AMT and the field size was  
S9(5)V99.

SOURCE : CWF

EDIT RULES :  
\$\$\$\$\$\$CC

156. Carrier Line Clinical Lab Number  
10 204 213

CHAR

The identification number assigned to the  
clinical laboratory providing services for  
the line item on the carrier claim (non-DMERC).

DB2 ALIAS : CLNCL\_LAB\_NUM  
SAS ALIAS : LAB\_NUM  
STANDARD ALIAS : CARR\_LINE\_CLNCL\_LAB\_NUM  
TITLE ALIAS : LAB\_NUM

LENGTH : 10

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_CLNCL\_LAB\_NUM.

SOURCE : CWF

157. Carrier Line Clinical Lab Charge Amount  
6 214 219

PACK

Fee schedule charge amount applied for the line  
item clinical laboratory service on the carrier  
claim (non-DMERC).

DB2 ALIAS : CLNCL\_LAB\_CHRG\_AMT  
SAS ALIAS : LAB\_AMT  
STANDARD ALIAS : CARR\_LINE\_CLNCL\_LAB\_CHRG\_AMT  
TITLE ALIAS : LAB\_CHRG

LENGTH : 9.2 SIGNED : Y

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_CLNCL\_LAB\_CHRG\_AMT and the field size was  
S9(5)V99.

SOURCE : CWF

EDIT RULES :

\$\$\$\$\$\$C

158. Line Processing Indicator Code

2 220 221 CHAR

The code on a noninstitutional claim indicating to whom payment was made or if the claim was denied.

NOTE1: Effective 4/1/02, this field was expanded to two bytes to accommodate new values. The NCH Nearline file did not expand the current 1-byte field but instituted a crosswalk of the 2-byte field to the 1-byte character value. See table of code for the crosswalk.

NOTE2: Effective with Version 'J', the field has been expanded on the NCH record to 2 bytes, With this expansion, the NCH will no longer use the character values to represent the official two byte values sent in by CWF since 4/2002. During the Version J conversion, all character values were converted to the two byte values.

DB2 ALIAS : LINE\_PRCSG\_IND\_CD  
SAS ALIAS : PRCNGIND  
STANDARD ALIAS : LINE\_PRCSG\_IND\_CD

LENGTH : 2

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_PRCSG\_IND\_CD.

SOURCE : CWF

CODE TABLE : LINE\_PRCSG\_IND\_TB

159. Line Payment 80%/100% Code

1 222 222 CHAR

The code indicating that the amount shown in the payment field on the noninstitutional line item represents either 80% or 100% of the allowed charges less any deductible, or 100% limitation of liability only.

COMMON ALIAS : REIMBURSEMENT\_IND  
DB2 ALIAS : LINE\_PMT\_80\_100\_CD  
SAS ALIAS : PMTINDSW  
STANDARD ALIAS : LINE\_PMT\_80\_100\_CD

TITLE ALIAS : REINBURSEMENT\_IND

LENGTH : 1

COMMENTS :

Prior to Version H this field was named:

CWFB\_PMT\_80\_100\_CD.

SOURCE : CWF

160. Line Service Deductible Indicator Switch

1 223 223

CHAR

Switch indicating whether or not the line item service on the noninstitutional claim is subject to a deductible.

DB2 ALIAS : SRVC\_DDCTBL\_SW

SAS ALIAS : DED\_SW

STANDARD ALIAS : LINE\_SRVC\_DDCTBL\_IND\_SW

TITLE ALIAS : SRVC\_DED\_IND

LENGTH : 1

COMMENTS :

Prior to Version H this field was named:

CWFB\_SRVC\_DDCTBL\_IND\_SW.

SOURCE : CWF

CODE TABLE : LINE\_SRVC\_DDCTBL\_IND\_TB

161. Line Payment Indicator Code

1 224 224

CHAR

Code that indicates the payment screen used to determine the allowed charge for the line item service on the noninstitutional claim.

DB2 ALIAS : LINE\_PMT\_IND\_CD

SAS ALIAS : PMTINDCD

STANDARD ALIAS : LINE\_PMT\_IND\_CD

TITLE ALIAS : PMT\_IND

LENGTH : 1

COMMENTS :

Prior to Version H this field was named:

CWFB\_PMT\_IND\_CD.

SOURCE : CWF

162. Carrier Line Miles/Time/Units/Services Count

6 225 230 PACK

The count of the total units associated with services needing unit reporting such as transportation, miles, anesthesia time units, number of services, volume of oxygen or blood units. This is a line item field on the carrier claim (non-DMERC) and is used for both allowed and denied services.

NOTE: For anesthesia (MTUS Indicator = 2) this field should be reported in time unit intervals, i.e. 15 minute intervals or fraction thereof. It appears that some carriers are reporting minutes instead of time units.

DB2 ALIAS : LINE\_MTUS\_CNT  
SAS ALIAS : MTUS\_CNT  
STANDARD ALIAS : CARR\_LINE\_MTUS\_CNT  
TITLE ALIAS : MTUS\_CNT

LENGTH : 7.3 SIGNED : Y

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_MTUS\_CNT.

Prior to Version 'J', this field was S9(3)  
Length: 7.3

SOURCE : CWF

LIMITATIONS :

REFER TO :  
CARR\_LINE\_MTUS\_CNT\_LIM

EDIT RULES :  
For CARR\_LINE\_MTUS\_IND\_CD equal to 2 (anesthesia time units) there is one implied decimal point.

163. Carrier Line Miles/Time/Units/Services Indicator Code

1 231 231 CHAR

Code indicating the units associated with services needing unit reporting on the line item for the carrier claim (non-DMERC).

				DB2	ALIAS : LINE_MTUS_IND_CD
				SAS	ALIAS : MTUS_IND
				STANDARD	ALIAS : CARR_LINE_MTUS_IND_CD
				TITLE	ALIAS : MTUS_IND
				LENGTH	: 1
				COMMENTS :	
					Prior to Version H this field was named: CWFB_MTUS_IND_CD.
				SOURCE	: CWF
				CODE TABLE	: CARR_LINE_MTUS_IND_TB
164. Claim Principal Diagnosis Group	8	232	239	GRP	
					Effective with Version 'J', the group used to identify the diagnosis codes at the time level. This group contains the diagnosis code and the diagnosis version code.
					STANDARD ALIAS : LINE_DGNS_GRP
165. Line Diagnosis Version Code	1	232	232	CHAR	
					Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9 or ICD-10.
					NOTE: With 5010, the diagnosis and procedure codes have been expanded to accomodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2013.
				DB2	ALIAS : UNDEFINED
				SAS	ALIAS : LDVRSNCD
				LENGTH	: 1
				CODE TABLE	: LINE_DGNS_VRSN_TB
166. Line Diagnosis Code	7	233	239	CHAR	
					The code indicating the diagnosis supporting this line item procedure/service on the noninstitutional claim.



DB2 ALIAS : LINE\_DGNS\_CD  
SAS ALIAS : LINEDGNS  
STANDARD ALIAS : LINE\_DGNS\_CD  
TITLE ALIAS : DGNS\_CD

LENGTH : 7

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_LINE\_DGNS\_CD.

SOURCE : CWF

167. Carrier Line Anesthesia Base Unit Count  
6 240 245

PACK

The base number of units assigned to the line  
item anesthesia procedure on the carrier claim  
(non-DMERC).

DB2 ALIAS : ANSTHSA\_UNIT\_CNT  
SAS ALIAS : ANSTHUNT  
STANDARD ALIAS : CARR\_LINE\_ANSTHSA\_UNIT\_CNT  
TITLE ALIAS : ANSTHSA\_UNITS

LENGTH : 7.3 SIGNED : Y

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_ANSTHSA\_BASE\_UNIT\_CNT.

Prior to Version 'J', this field was  
S9(3), Length 7.3.

SOURCE : CWF

168. Carrier Line CLIA Alert Indicator Code  
1 246 246

CHAR

Effective with Version G, the alert code (resulting  
from CLIA editing) added by CWF as a line item  
on the carrier claim (non-DMERC).

DB2 ALIAS : CLIA\_ALERT\_IND\_CD  
SAS ALIAS : CLIAALRT  
STANDARD ALIAS : CARR\_LINE\_CLIA\_ALERT\_IND\_CD  
TITLE ALIAS : CLIA\_ALERT

LENGTH : 1

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_CLIA\_ALERT\_IND\_CD.

SOURCE : CWF

CODE TABLE : CARR\_LINE\_CLIA\_ALERT\_IND\_TB

169. Line Additional Claim Documentation Indicator Code  
1 247 247 CHAR

Effective 5/92, the code indicating additional  
claim documentation was submitted for this line  
item service on the noninstitutional claim.

COMMON ALIAS : DOCUMENT\_IND  
DB2 ALIAS : ADDTNL\_DCMTN\_CD  
SAS ALIAS : DCMTN\_CD  
STANDARD ALIAS : LINE\_ADDTNL\_CLM\_DCMTN\_IND\_CD  
TITLE ALIAS : ADDTNL\_DCMTN\_IND

LENGTH : 1

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_ADDTNL\_CLM\_DCMTN\_IND\_CD.

SOURCE : CWF

EDIT RULES :  
In any case where more than one value is  
applicable, highest number is shown.

CODE TABLE : LINE\_ADDTNL\_CLM\_DCMTN\_IND\_TB

170. Carrier Line DME Coverage Period Start Date  
8 248 255 NUM

Effective 5/92 through 6/94, as line item on the  
carrier claim (non-DMERC), the date durable medical  
equipment (DME) coverage period started per certi-  
ficate of medical necessity, prescription, other  
documentation or carrier determination. This field  
is applicable to line items involving DME,  
prosthetic, orthotic and supply items, immuno-  
suppressive drugs, pen, ESRD and oxygen items  
referred to as DMEPOS).

DB2 ALIAS : DME\_CVRG\_STRT\_DT

SAS ALIAS : DMEST\_DT  
STANDARD ALIAS : CARR\_LINE\_DME\_CVRG\_PRD\_STRT\_DT  
TITLE ALIAS : DME\_CVRG\_START\_DT

LENGTH : 8 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_DME\_CVRG\_PRD\_STRT\_DT.

SOURCE : CWF

LIMITATIONS :  
When the revised DME processing was implemented  
(phased in between 10/93-6/94), this field was not  
included on the new DMERC claim; it is being  
reported on the certificate of medical necessity  
(CMN) transaction. HCFA does not receivee CMN  
transaction from CWF.

EDIT RULES :  
YYYYMMDD

171. Line DME Purchase Price Amount  
6 256 261

PACK

Effective 5/92, the amount representing the  
lower of fee schedule for purchase of new or  
used DME, or actual charge. In case of rental  
DME, this amount represents the purchase cap;  
rental payments can only be made until the  
cap is met. This line item field is applicable  
to non-institutional claims involving DME,  
prosthetic, orthotic and supply items,  
immunosuppressive drugs, pen, ESRD and oxygen  
items referred to as DMEPOS.

DB2 ALIAS : DME\_PURC\_PRICE\_AMT  
SAS ALIAS : DME\_PURC  
STANDARD ALIAS : LINE\_DME\_PURC\_PRICE\_AMT  
TITLE ALIAS : DME\_PURC\_PRICE

LENGTH : 9.2 SIGNED : Y

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_DME\_PURC\_PRICE\_AMT and the field size  
was S9(5)V99.

SOURCE : CWF

EDIT RULES :  
\$\$\$\$\$\$\$\$CC

172. Carrier Line DME Medical Necessity Month Count

2 262 263 PACK

Effective 5/92 through 6/94, as line item on the carrier claim (non-DMERC), the count determined by the carrier showing the length of need (medical necessity for DME in months from the start date through the determined period of need. This field is applicable to line items involving DME, prosthetic, orthotic and supply items, immuno-suppressive drugs, pen, ESRD and oxygen items referred to as DMEPOS).

Exception: If the DME is determined to be medically necessary for the life of the beneficiary, 99 is placed in this field, rather than a month count.

DB2 ALIAS : DME\_NCSTY\_MO\_CNT  
SAS ALIAS : NCSTY\_MO  
STANDARD ALIAS : CARR\_LINE\_DME\_NCSTY\_MO\_CNT  
TITLE ALIAS : DME\_NCSTY\_MONTHS

LENGTH : 3 SIGNED : Y

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_DME\_MDCL\_NCSTY\_MO\_CNT.

SOURCE : CWF

LIMITATIONS :  
When the revised DME processing was implemented (phased in between 10/93-6/94), this field was not included on the new DMERC claim; it is being reported on the certificate of medical necessity (CMN) transaction. HCFA does not receive CMN transaction from CWF.

173. Line Consolidated Billing Indicator Code

1 264 264 CHAR

Effective 1/1/2004 with implementation of NCH/NMUD CR#1, this code is reflected on carrier & DMERC claims

to identify those line item services (i.e. therapy and nonroutine supply services) that are subject to SNF and Home Health consolidated billing. If the line item service was paid by a carrier prior to the submission of the SNF or home health claim an adjustment for the carrier or DMERC claim will be submitted identifying those services that are subject to consolidated billing.

NOTE1: Prior to 10/2005 (implementation of NCH/NMUD CR#2), this data was stored in position 245 (FILLER) of the line item trailer.

Effective July 2005, this data will no longer be coming into the NCH.

DB2 ALIAS : CNSLDTD\_BLG\_CD  
SAS ALIAS : LCNSLDTD  
STANDARD ALIAS : LINE\_CNSLDTD\_BLG\_CD

LENGTH : 1

CODE TABLE : LINE\_CNSLDTD\_BLG\_TB

174. Line Duplicate Claim Check Indicator Code  
1 265 265

CHAR

Effective 1/1/2004 with the implementation of NCH/NMUD CR#1, the code used to identify an item or service that appeared to be a duplicate but has been reviewed by a carrier and appropriately approved for payment.

NOTE1: Prior to 10/2005 (implementation of NCH/NMUD CR#2), this data was stored in position 246 (FILLER) on the line item trailer.

DB2 ALIAS : DUP\_CLM\_CHK\_IND\_CD  
SAS ALIAS : DUP\_CHK  
STANDARD ALIAS : LINE\_DUP\_CLM\_CHK\_IND\_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : LINE\_DUP\_CLM\_CHK\_IND\_TB

175. Carrier Line Point of Pickup Zip Code  
9 266 274

CHAR

Effective 1/1/2004 with the implementation of NCH/NMUD

CR#1, the code identifying the point of pickup  
zip code on carrier claims. The point of pickup  
zip code is used for pricing ambulance services.

NOTE: Prior to 10/2005 (implementation of NCH/NMUD  
CR#2), this data was stored in positions 247-251 on  
the carrier line item trailer.

DB2 ALIAS : PNT\_PCKP\_ZIP\_CD  
SAS ALIAS : PNT\_PCKP  
STANDARD ALIAS : CARR\_LINE\_PNT\_PCKP\_ZIP\_CD

LENGTH : 9

SOURCE : CWF

176. Carrier Line Drop Off Zip Code  
9 275 283

CHAR

Effective with Version 'J', the code used to identify the drop  
off zip code on carrier claims. The drop off zip code is used  
for pricing ambulance services.

DB2 ALIAS : DROP\_OFF\_ZIP\_CD  
SAS ALIAS : DROP\_OFF

LENGTH : 9

177. Carrier Line HPSA/Scarcity Indicator Code  
1 284 284

CHAR

Effective 10/3/2005 with the implementation of NCH/  
NMUD CR#2, the code used to track health professional  
shortage area (HPSA) and physician scarcity bonus  
payments on carrier claims.

NOTE: Prior to 10/3/2005, claims contained a  
modifier code to indicate the bonus payment. A  
'QU' represented a HPSA bonus payment and an 'AR'  
represented a scarcity bonus payment. As of 1/1/2005,  
the modifiers were no longer being reported by the  
provider. NCH & NMUD were not ready to accept the  
new field until 10/3/2005.

DB2 ALIAS : HPSA\_SCRCTY\_IND\_CD  
SAS ALIAS : HSCRCTY  
STANDARD ALIAS : CARR\_LINE\_HPSA\_SCRCTY\_IND\_CD

LENGTH : 1

				SOURCE	: CWF
				CODE TABLE	: CARR_LINE_HPSA_SCRCTY_IND_TB
178. Carrier Line RX Number	30	285	314	CHAR	
				<p>The number used to identify the prescription order number for drugs and biologicals purchased through the competitive acquisition program (CAP).</p> <p>NOTE1: MMA required the implementation of a competitive acquisition program (CAP) for Part B drugs and biologicals not paid on a cost or PPS basis. Physicians will be given a choice between buying and billing these drugs under the average sales price (ASP) or obtaining these drugs from an approved CAP vendor. The prescription number is needed to identify which claims were submitted for CAP drugs and their administration.</p> <p>NOTE2: Eventhough this field was implemented with NCH/NMUD CR#2, data will not be coming in until 1/1/2006.</p> <p>DB2 ALIAS : CARR_LINE_RX_NUM  SAS ALIAS : RX_NUM  STANDARD ALIAS : CARR_LINE_RX_NUM</p> <p>LENGTH : 30</p> <p>COMMENTS :  The prescription order number consist of:  --Vendor ID Number (positions 1 - 4)  --HCPCS Code (positions 5 - 9)  --Vendor Controlled Prescription Number (positions 10 - 30)</p> <p>SOURCE : CWF</p> <p>LIMITATIONS :</p> <p>REFER TO :  CARR_LINE_RX_NUM_LIM</p>	
179. Line Hematocrit/Hemoglobin Test Type Code	2	315	316	CHAR	

Effective September 1, 2008 with the implementation of CR#3, the code used to identify which reading is reflected in the hematocrit/hemoglobin result number field on the noninstitutional claim.

DB2 ALIAS : HCT\_HGB\_TYPE\_CD  
SAS ALIAS : HTYPECD  
STANDARD ALIAS : LINE\_HCT\_HGB\_TYPE\_CD

LENGTH : 2

CODE TABLE : LINE\_HCT\_HGB\_TYPE\_TB

180. Line Hematocrit/Hemoglobin Result Number  
3 317 319

CHAR

Effective September 1, 2008, with the implementation of CR#3, the number used to identify the most recent hematocrit or hemoglobin reading on the noninstitutional claim.

NOTE: The hematocrit/hemoglobin test result field is a redefined field. The field is being defined as X(3) and redefined as numeric (99V9). A numeric test on the alphanumeric field is needed. Whenever a user wants to use the field they must test the alphanumeric field for numerics and if it is numeric then the 99V9 definition would be used. The older data will cause an abend if trying to process numeric data with characters.

DB2 ALIAS : HCT\_HGB\_RSLT\_NUM  
SAS ALIAS : HRSLTNUM  
STANDARD ALIAS : LINE\_HCT\_HGB\_RSLT\_NUM

LENGTH : 3

181. Line Hematocrit/Hemoglobin Result Number -- Redefined  
3 317 319 NUM

Effective September 1, 2008, with the implementation of CR#3, the number used to identify the most recent hematocrit or hemoglobin reading on the noninstitutional claim.

NOTE: The hematocrit/hemoglobin test result field is a redefined field. The field is being defined as X(3) and redefined as numeric (99V9). A numeric test on the alphanumeric field is needed. Whenever a user wants to use the field they must test the alphanumeric field for numerics and if it is numeric then the 99V9 definition



would be used. The older data will cause an abend if trying to process numeric data with characters.

DB2 ALIAS : HCT\_HGB\_RSLT\_NUM  
SAS ALIAS : HRLSTNUM  
STANDARD ALIAS : LINE\_HCT\_HGB\_RSLT\_NUM\_R

LENGTH : 2.1 SIGNED : N

REDEFINE : LINE\_HCT\_HGB\_RSLT\_NUM

182. Worker's Compensation Indicator Code

1 320 320

CHAR

This indicator is used to determine whether the diagnosis codes on the claims are related to the diagnosis codes on the MSP auxiliary file in CWF.

DB2 ALIAS : LINE\_WC\_IND\_CD  
SAS ALIAS : WCINDCD

LENGTH : 1

CODE TABLE : LINE\_WC\_IND\_TB

LANGUAGE : C

183. FILLER

100 321 420

CHAR

DB2 ALIAS : FILLER

LENGTH : 100

184. End of Record Code

3 1 3

CHAR

Effective with Version 'I', the code used to identify the end of a record/segment or the end of the claim.

DB2 ALIAS : END\_REC\_CD  
SAS ALIAS : EOR  
STANDARD ALIAS : END\_REC\_CD  
TITLE ALIAS : END\_OF\_REC

LENGTH : 3

COMMENTS :

Prior to Version I this field was named:

END\_REC\_CNSTNT.  
SOURCE : NCH  
CODE TABLE : END\_REC\_TB

\*\*\*\*\*

H3PM.R\_RIF\_MAIN\_Q,Q1,F

1

LIMITATIONS APPENDIX FOR RECORD: CARR\_CLM\_REC  
AS OF: 06/29/2011

CARR\_LINE\_PRFRMG\_UPIN\_LIM

FULL NAME: Carrier Line Performing UPIN Limitation  
DESCRIPTION :  
Missing performing provider UPINS on denied carrier  
claims.  
BACKGROUND :  
In 1996 it was discovered that the performing provider  
UPINS were missing on denied carrier claims.  
CORRECTIVE ACTION :  
A change release was added in CWF in 7/00. A remedy  
had been worked out prior to 7/00 but other activities  
precluded its resolution.  
SOURCE:  
ADMINISTRATIVE DATA:  
START DATE : 1996  
END DATE : 07/00  
CONTACT : OIS/EDG/DMUDD

CHOICES\_DEMO\_LIM

FULL NAME: Choices Demonstration Limitation  
DESCRIPTION :  
A programming error created an 'INVALID' indication  
in the demo text field for CHOICES claims.  
BACKGROUND :  
In 6/00, the CWFMQA front-end editing revealed that some  
CHOICES demo claims were coming in with a valid 'H'  
number in the fixed portion of the claims, but in the  
first occurrence MCO trailer a numeric packed field  
(value hex '0100000C') was moved to the MCO Contract  
Number/Option Code fields. This created an invalid  
period check of number/code to MCO effective date,  
resulting in an INVALID indication in the demo info  
text field.  
CORRECTIVE ACTION :

The problem was forwarded to the CWF BSOG staff  
for further investigation.

SOURCE:

CONTACT : OIS/EDG/DMUDD

PMT\_AMT\_EXCEDG\_CHRG\_AMT\_LIM

FULL NAME: Claim Payment Amount Exceeding Total Charge Amount Limitation

DESCRIPTION :

Approximately 75 Inpatient claims had a reimbursement amount exceed \$500,000 which was at least 25 times the total charge amount. There were also claims where the reimbursement was less than \$500,000 but greater than the total charges.

BACKGROUND :

In November of 1999, it was brought to the attention of the HDUG that large reimbursement amounts were being paid in Pennsylvania. There were 75 inpatient claims provided where the reimbursement amount was over \$500,000 and at least 25 times the total charge amount. These claims were processed between 9/29/98 and 10/1/98. There were also claims identified with reimbursement less than \$500,000 but greater than total charge. It was later discovered that the source of the problem was an error in entering an MSA; the decimal point was off by 2 positions.

Because there were no changes in utilization, the claims were corrected and the correct payments distributed, but the new payment amounts were never sent to CWF (not in NCH). There is currently no requirement that FIs and carriers update CWF with final payment information by submitting payment only adjustments. It was noted that there is no expectation that CWF will have final payment information for claims.

CORRECTIVE ACTION :

According to Veritus (FI), the problem was caught in their system using a pre-payment edit prior to sending out the payments. The erroneous MSA value was corrected and the claims were then sent to PRICER again and paid correctly.

The claims were corrected and correct payments were made but these new payment amounts were never sent to CWF and are not reflected in the NCH.

SOURCE:

CONTACT OIS/EDG/DMUDD

CARR\_LINE\_RX\_NUM\_LIM

FULL NAME: Carrier Line Prescription (RX) Number

DESCRIPTION :

Invalid data found in the prescription number (RX) field on the carrier claim.

BACKGROUND :

MMA required the implementation of a Competitive Acquisition Program (CAP) for Part B drugs and biologicals not paid on a cost or prospective payment system basis. Under this program, physicians are given the choice between buying and billing these drugs under the average sales price (ASP) system, or obtaining these drugs from the CAP if competitive pricing will not result in significant savings or have an adverse impact on access to these drugs.

During an analysis of carrier claims to review CAP physician and vendor claims it was discovered that these claims contained invalid data.

In both the NCH and NMUD claims from 7/1/2006 - 12/12/2006 will contain invalid data in the CARR\_LINE\_RX\_NUM field. The problem was caused by a coding error in the CWFMQA front-end process. Due to the coding error the prescription (RX) number was never passed to the NCH or NMUD.

CORRECTIVE ACTION :

A fix was put into the CWFMQA code to move the RX number on the host files into the appropriate field on the CWFMQA file that is used in the NCH process. The fix was implemented 12/12/2006.

SOURCE:

ADMINISTRATIVE DATA:

START DATE : 07/01/06  
END DATE : 12/12/06  
CONTACT : OIS/EDG/DIDPM

CARR\_LINE\_MTUS\_CNT\_LIM

FULL NAME: Carrier Line Miles/Time/Units/Services Count Limitation

DESCRIPTION :

DESCRIPTION:

Inaccurate data reflected in the MTUS field for anesthesia claims.

BACKGROUND :

BACKGROUND:

A problem was found with the CARR-LINE-MTUS-CNT field on the NCH carrier claims when an anesthesia claim (CARR-LINE-MTUS-IND-CD = '2') is submitted with minutes. The problem is happening now because as of July 6, 2009, the shared system maintainers (SSM) and CWF maintainers began using the 5010 claim format (will be NCH Version 'J' format) which has expanded this field from S999 to S9(7)V999.

When anesthesia claims are being received with minutes, MCS (SSM) converts them to units, which is causing the field to the right of the decimal to be utilized when the claims are transmitted to CWF.

For example, 14 minutes converted to units (15 minutes = 1 unit) converts to 0.9 units. CWF maps 0.900 to the MTUS field and sends that on to the NCH. Since the NCH has not implemented Version 'J', the data in the NCH will reflect '0'.

The NCH and other downstream systems are still using the Version 'I' format (4010 data) and will be until January 3, 2011. It was our understanding since the implementation of the HIPAA 5010 project that no 5010 data would be coming in to NCH until January 3, 2011.

CORRECTIVE ACTION :

CORRECTIVE ACTION:

The problem has been forwarded to the CWF BAMG staff for further investigation.

SOURCE:

ADMINISTRATIVE DATA:

START DATE : 07/05/2009

END DATE : UNKNOWN

CONTACT

CONTACT ACT: OIS/DG/DIDPM

06/29/2011

\*\*\*\*\*

H3PM.R\_RIF\_LIM\_Q,F

1

CMS RIF REPORT

AS OF: 06/29/2011

NAME	LENGTH	BEG	END	CONTENTS
*** DMERC Claim Record (NCH)				
	VAR	1	5441	REC
				Durable medical equipment (DME) regional carrier (DMERC) claim record for version J of the NCH.
				STANDARD ALIAS : DMERC_CLM_REC
				SYSTEM ALIAS : UTLDMERJ
				LIMITATIONS :
				REFER TO :
				CHOICES_DEMO_LIM
				PMT_AMT_EXCEDG_CHRG_AMT_LIM

1.	DMERC Claim Fixed Group	377	1	377	GRP
					Fixed portion of the durable medical equipment regional carrier (DMERC) claim record for version J of the NCH.
					STANDARD ALIAS : DMERC_CLM_FIX_GRP
2.	Claim Record Identification Group	8	1	8	GRP
					Effective with Version 'I' the record length, version code, record identification, code and NCH derived claim type code were moved to this group for internal NCH processing.
					STANDARD ALIAS : CLM_REC_IDENT_GRP
3.	Record Length Count	3	1	3	PACK
					Effective with Version H, the count (in bytes) of the length of the claim record.
					NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991).
					DB2 ALIAS : REC_LNGTH_CNT
					SAS ALIAS : REC_LEN
					STANDARD ALIAS : REC_LNGTH_CNT
					LENGTH : 5 SIGNED : Y
					SOURCE : NCH
4.	NCH Near-Line Record Version Code	1	4	4	CHAR
					The code indicating the record version of the Nearline file where the institutional, carrier or DMERC claims data are stored.
					DB2 ALIAS : NCH_REC_VRSN_CD
					SAS ALIAS : REC_LVL
					STANDARD ALIAS : NCH_NEAR_LINE_REC_VRSN_CD
					TITLE ALIAS : NCH_VERSION

LENGTH : 1

COMMENTS :  
Prior to Version H this field was named:  
CLM\_NEAR\_LINE\_REC\_VRSN\_CD.

SOURCE : NCH

CODE TABLE : NCH\_NEAR\_LINE\_REC\_VRSN\_TB

5. NCH Near Line Record Identification Code  
1 5 5

CHAR

A code defining the type of claim record being processed.

COMMON ALIAS : RIC  
DB2 ALIAS : NEAR\_LINE\_RIC\_CD  
SAS ALIAS : RIC\_CD  
STANDARD ALIAS : NCH\_NEAR\_LINE\_RIC\_CD  
TITLE ALIAS : RIC

LENGTH : 1

COMMENTS :  
Prior to Version H this field was named:  
RIC\_CD.

SOURCE : NCH

CODE TABLE : NCH\_NEAR\_LINE\_RIC\_TB

6. NCH MQA RIC Code  
1 6 6

CHAR

Effective with Version H, the code used (for internal editing purposes) to identify the record being processed through CMS' CWFMQA system.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : NCH\_MQA\_RIC\_CD  
SAS ALIAS : MQA\_RIC  
STANDARD ALIAS : NCH\_MQA\_RIC\_CD  
TITLE ALIAS : MQA\_RIC

LENGTH : 1

SOURCE : NCH QA PROCESS

CODE TABLE : NCH\_MQA\_RIC\_TB

7. NCH Claim Type Code

2

7

8

CHAR

The code used to identify the type of claim record being processed in NCH.

NOTE1: During the Version H conversion this field was populated with data throughout history (back to service year 1991).

NOTE2: During the Version I conversion this field was expanded to include inpatient 'full' encounter claims (for service dates after 6/30/97).

NOTE3: Effective with Version 'J', 3 new code values have been added to include a type code for the Medicare Advantage claims (IME/GME, no-pay and paid as FFS). During the Version 'J' conversion, these type codes were populated throughout history. With Version 'J', these claims are also being stored in NMUD. Prior to Version 'J' they were only in the NCH. No history was converted in NMUD.

DB2 ALIAS : NCH\_CLM\_TYPE\_CD

SAS ALIAS : CLM\_TYPE

STANDARD ALIAS : NCH\_CLM\_TYPE\_CD

TITLE ALIAS : CLAIM\_TYPE

LENGTH : 2

DERIVATIONS :

FFS CLAIM TYPE CODES DERIVED FROM:

NCH\_CLM\_NEAR\_LINE\_RIC\_CD

NCH\_PMT\_EDIT\_RIC\_CD

NCH\_CLM\_TRANS\_CD

NCH\_PRVDR\_NUM

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:

(Pre-HDC processing -- AVAILABLE IN NCH)

CLM\_MCO\_PD\_SW

CLM\_RLT\_COND\_CD

MCO\_CNTRCT\_NUM

MCO\_OPTN\_CD

MCO\_PRD\_EFCTV\_DT

MCO\_PRD\_TRMNTN\_DT

DERIVATION RULES:



SET CLM\_TYPE\_CD TO 10 (HHA CLAIM) WHERE THE  
FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V', 'W' OR 'U'
2. PMT\_EDIT\_RIC\_CD EQUAL 'F'
3. CLM\_TRANS\_CD EQUAL '5'

SET CLM\_TYPE\_CD TO 20 (SNF NON-SWING BED CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'
3. CLM\_TRANS\_CD EQUAL '0' OR '4'
4. POSITION 3 OF PRVDR\_NUM IS NOT 'U', 'W', 'Y'  
OR 'Z'

SET CLM\_TYPE\_CD TO 30 (SNF SWING BED CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'
3. CLM\_TRANS\_CD EQUAL '0' OR '4'
4. POSITION 3 OF PRVDR\_NUM EQUAL 'U', 'W', 'Y'  
OR 'Z'

SET CLM\_TYPE\_CD TO 40 (OUTPATIENT CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'W'
2. PMT\_EDIT\_RIC\_CD EQUAL 'D'
3. CLM\_TRANS\_CD EQUAL '6'

SET CLM\_TYPE\_CD TO 50 (HOSPICE CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'
2. PMT\_EDIT\_RIC\_CD EQUAL 'I'
3. CLM\_TRANS\_CD EQUAL 'H'

SET CLM\_TYPE\_CD TO 60 (INPATIENT CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'
3. CLM\_TRANS\_CD EQUAL '1' '2' OR '3'

SET CLM\_TYPE\_CD TO 61 (INPATIENT 'FULL' ENCOUNTER  
CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 -  
12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_MCO\_PD\_SW = '1'
2. CLM\_RLT\_COND\_CD = '04'
3. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = 'C'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT

ENROLLMENT PERIODS

SET CLM\_TYPE\_CD TO 61 (INPATIENT 'FULL' ENCOUNTER  
CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE  
FOLLOWING CONDITIONS ARE MET:

1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'V'
2. PMT\_EDIT\_RIC\_CD EQUAL 'C' OR 'E'
3. CLM\_TRANS\_CD EQUAL '1' '2' OR '3'
4. FI\_NUM = 80881

SET CLM\_TYPE\_CD TO 62 (Medicare Advantage IME/GME  
CLAIMS - 10/1/05 - FORWARD)  
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM\_MCO\_PD\_SW = '0'
2. CLM\_RLT\_COND\_CD = '04' & '69'
3. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = 'C'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS

SET CLM\_TYPE\_CD TO 63 (HMO NO-PAY CLAIMS)  
WHERE THE FOLLOWING CONDITIONS ARE MET:

CLAIMS PROCESSED ON OR AFTER 10/6/08

1. CLM\_THRU\_DT ON OR AFTER 10/1/06
2. CLM\_MCO\_PD\_SW = '1'
3. CLM\_RLT\_COND\_CD = '04'
4. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = 'A', 'B' OR 'C'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS
5. ZERO REIMBURSEMENT (CLM\_PMT\_AMT)

SET CLM\_TYPE\_CD TO 63 (HMO NO-PAY CLAIMS)  
WHERE THE FOLLOWING CONDITIONS ARE MET:

CLAIMS PROCESSED PRIOR to 10/6/08

1. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = 'A', 'B' OR 'C'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS
2. ZERO REIMBURSEMENT (CLM\_PMT\_AMT)

SET CLM\_TYPE\_CD TO 64 (HMO CLAIMS PAID AS FFS)  
WHERE THE FOLLOWING CONDITIONS ARE MET:

CLAIMS PROCESSED PRIOR to 10/6/08

1. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = '1', '2' OR '4'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE

MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS

SET CLM\_TYPE\_CD TO 64 (HMO CLAIMS PAID AS FFS)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
CLAIMS PROCESSED on or after 10/6/08  
1. CLM\_RLT\_COND\_CD = '04'  
2. MCO\_CNTRCT\_NUM  
MCO\_OPTN\_CD = '1', '2' OR '4'  
CLM\_FROM\_DT & CLM\_THRU\_DT ARE WITHIN THE  
MCO\_PRD\_EFCTV\_DT & MCO\_PRD\_TRMNTN\_DT  
ENROLLMENT PERIODS

SET CLM\_TYPE\_CD TO 71 (RIC O non-DMEPOS CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'O'  
2. HCPCS\_CD not on DMEPOS table

SET CLM\_TYPE\_CD TO 72 (RIC O DMEPOS CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'O'  
2. HCPCS\_CD on DMEPOS table (NOTE: if one or  
more line item(s) match the HCPCS on the  
DMEPOS table).

SET CLM\_TYPE\_CD TO 81 (RIC M non-DMEPOS DMERC  
CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'M'  
2. HCPCS\_CD not on DMEPOS table

SET CLM\_TYPE\_CD TO 82 (RIC M DMEPOS DMERC CLAIM)  
WHERE THE FOLLOWING CONDITIONS ARE MET:  
1. CLM\_NEAR\_LINE\_RIC\_CD EQUAL 'M'  
2. HCPCS\_CD on DMEPOS table (NOTE: if one or  
more line item(s) match the HCPCS on the  
DMEPOS table).

SOURCE : NCH

CODE TABLE : NCH\_CLM\_TYPE\_TB

8. Carrier/DMERC Claim Link Group  
125 9 133 GRP

Effective with Version 'I', this group  
was added to the carrier and DMERC records  
to keep fields common across all record types

in the same position. Due to OP PPS, several fields on the Institutional record had to be moved to a link group so those same fields had to be moved on the carrier records eventhough OP PPS only affects institutional claims.

STANDARD ALIAS : CARR\_DMERC\_CLM\_LINK\_GRP

9. Claim Locator Number Group  
11 9 19 GRP

This number uniquely identifies the beneficiary in the NCH Nearline.

COMMON ALIAS : HIC  
STANDARD ALIAS : CLM\_LCTR\_NUM\_GRP  
TITLE ALIAS : HICAN

10. Beneficiary Claim Account Number  
9 9 17 CHAR

The number identifying the primary beneficiary under the SSA or RRB programs submitted.

COMMON ALIAS : CAN  
DB2 ALIAS : BENE\_CLM\_ACNT\_NUM  
SAS ALIAS : CAN  
STANDARD ALIAS : BENE\_CLM\_ACNT\_NUM  
TITLE ALIAS : CAN

LENGTH : 9

SOURCE : SSA,RRB

LIMITATIONS :  
RRB-issued numbers contain an overpunch in the first position that may appear as a plus zero or A-G. RRB-formatted numbers may cause matching problems on non-IBM machines.

11. NCH Category Equatable Beneficiary Identification Code  
2 18 19 CHAR

The code categorizing groups of BICs representing similar relationships between the beneficiary and the primary wage earner.

The equatable BIC module electronically matches two records that contain different BICs where

it is apparent that both are records for the same beneficiary. It validates the BIC and returns a base BIC under which to house the record in the National Claims History (NCH) databases. (All records for a beneficiary are stored under a single BIC.)

COMMON ALIAS : NCH\_BASE\_CATEGORY\_BIC  
DB2 ALIAS : CTGRY\_EQTBL\_BIC  
SAS ALIAS : EQ\_BIC  
STANDARD ALIAS : NCH\_CTGRY\_EQTBL\_BIC\_CD  
TITLE ALIAS : EQUATED\_BIC

LENGTH : 2

COMMENTS :  
Prior to Version H this field was named:  
CTGRY\_EQTBL\_BENE\_IDENT\_CD.

SOURCE : BIC EQUATE MODULE

CODE TABLE : CTGRY\_EQTBL\_BENE\_IDENT\_TB

12. Beneficiary Identification Code

2 20 21

CHAR

The code identifying the type of relationship between an individual and a primary Social Security Administration (SSA) beneficiary or a primary Railroad Board (RRB) beneficiary.

COMMON ALIAS : BIC  
DA3 ALIAS : BENE\_IDENT\_CODE  
DB2 ALIAS : BENE\_IDENT\_CD  
SAS ALIAS : BIC  
STANDARD ALIAS : BENE\_IDENT\_CD  
TITLE ALIAS : BIC

LENGTH : 2

SOURCE : SSA/RRB

EDIT RULES :  
EDB REQUIRED FIELD

CODE TABLE : BENE\_IDENT\_TB

13. NCH State Segment Code

1 22 22

CHAR

The code identifying the segment of the NCH Nearline file containing the beneficiary's record for a specific service year. Effective 12/96, segmentation is by CLM\_LCTR\_NUM, then final action sequence within residence state. (Prior to 12/96, segmentation was by ranges of county codes within the residence state.)

DB2 ALIAS : NCH\_STATE\_SGMT\_CD  
SAS ALIAS : ST\_SGMT  
STANDARD ALIAS : NCH\_STATE\_SGMT\_CD  
TITLE ALIAS : NEAR\_LINE\_SEGMENT

LENGTH : 1

COMMENTS :  
Prior to Version H this field was named:  
BENE\_STATE\_SGMT\_NEAR\_LINE\_CD.

SOURCE : NCH

CODE TABLE : NCH\_STATE\_SGMT\_TB

14. Beneficiary Residence SSA Standard State Code

2 23 24 CHAR

The SSA standard state code of a beneficiary's residence.

DA3 ALIAS : SSA\_STANDARD\_STATE\_CODE  
DB2 ALIAS : BENE\_SSA\_STATE\_CD  
SAS ALIAS : STATE\_CD  
STANDARD ALIAS : BENE\_RSDNC\_SSA\_STD\_STATE\_CD  
TITLE ALIAS : BENE\_STATE\_CD

LENGTH : 2

COMMENTS :  
1. Used in conjunction with a county code, as selection criteria for the determination of payment rates for HMO reimbursement.  
2. Concerning individuals directly billable for Part B and/or Part A premiums, this element is used to determine if the beneficiary will receive a bill in English or Spanish.  
3. Also used for special studies.

SOURCE : SSA/EDB

EDIT RULES :  
OPTIONAL: MAY BE BLANK

CODE TABLE : GEO\_SSA\_STATE\_TB

15. Claim From Date

8 25 32

NUM

The first day on the billing statement covering services rendered to the beneficiary (a.k.a. 'Statement Covers From Date').

NOTE: For Home Health PPS claims, the 'from' date and the 'thru' date on the RAP (initial claim) must always match.

DB2 ALIAS : CLM\_FROM\_DT  
SAS ALIAS : FROM\_DT  
STANDARD ALIAS : CLM\_FROM\_DT  
TITLE ALIAS : FROM\_DATE

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

16. Claim Through Date

8 33 40

NUM

The last day on the billing statement covering services rendered to the beneficiary (a.k.a. 'Statement Covers Thru Date').

NOTE: For Home Health PPS claims, the 'from' date and the 'thru' date on the RAP (initial claim) must always match.

DB2 ALIAS : CLM\_THRU\_DT  
SAS ALIAS : THRU\_DT  
STANDARD ALIAS : CLM\_THRU\_DT  
TITLE ALIAS : THRU\_DATE

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

17. NCH Weekly Claim Processing Date

8 41 48

NUM

The date the weekly NCH database load process cycle begins, during which the claim records are loaded into the Nearline file. This date will always be a Friday, although the claims will actually be appended to the database subsequent to the date.

DB2 ALIAS : NCH\_WKLY\_PROC\_DT  
SAS ALIAS : WKLY\_DT  
STANDARD ALIAS : NCH\_WKLY\_PROC\_DT  
TITLE ALIAS : NCH\_PROCESS\_DT

LENGTH : 8 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
HCFA\_CLM\_PROC\_DT.

SOURCE : NCH

EDIT RULES :  
YYYYMMDD

18. CWF Claim Accretion Date

8 49 56

NUM

The date the claim record is accreted (posted/processed) to the beneficiary master record at the CWF host site and authorization for payment is returned to the fiscal intermediary or carrier.

DB2 ALIAS : CWF\_CLM\_ACRTN\_DT  
SAS ALIAS : ACRTN\_DT  
STANDARD ALIAS : CWF\_CLM\_ACRTN\_DT  
TITLE ALIAS : ACCRETION\_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

19. CWF Claim Accretion Number

2 57 58

PACK

The sequence number assigned to the claim record when accreted (posted/processed) to



the beneficiary master record at the CWF host site on a given date. This element indicates the position of the claim within that day's processing at the CWF host. \*\*(Exception: If the claim record is missing the accretion date CMS' CWFMQA system places a zero in the accretion number.

DB2 ALIAS : CWF\_CLM\_ACRTN\_NUM  
SAS ALIAS : ACRTN\_NM  
STANDARD ALIAS : CWF\_CLM\_ACRTN\_NUM  
TITLE ALIAS : ACCRETION\_NUMBER

LENGTH : 3 SIGNED : Y

SOURCE : CWF

20. Carrier Claim Control Number  
15 59 73

CHAR

Unique control number assigned by a carrier to a non-institutional claim.

COMMON ALIAS : CCN  
DB2 ALIAS : CARR\_CLM\_CNTL\_NUM  
SAS ALIAS : CARRCNTL  
STANDARD ALIAS : CARR\_CLM\_CNTL\_NUM  
TITLE ALIAS : CCN

LENGTH : 15

COMMENTS :  
For the physician/supplier or DMERC claim, this field allows CMS to associate each line item with its respective claim.

SOURCE : CWF

EDIT RULES :  
LEFT JUSTIFY

21. FILLER

38 74 111

CHAR

DB2 ALIAS : FILLER

LENGTH : 38

22. NCH Daily Process Date

8 112 119

NUM

Effective with Version H, the date the claim record was processed by CMS' CWFMQA system (used for internal editing purposes).

Effective with Version I, this date is used in conjunction with the NCH Segment Link Number to keep claims with multiple records/ segments together.

NOTE1: With Version 'H' this field was populated with data beginning with NCH weekly process date 10/3/97. Under Version 'I' claims prior to 10/3/97, that were blank under Version 'H', were populated with a date.

DB2 ALIAS : NCH\_DAILY\_PROC\_DT  
SAS ALIAS : DAILY\_DT  
STANDARD ALIAS : NCH\_DAILY\_PROC\_DT  
TITLE ALIAS : DAILY\_PROCESS\_DT

LENGTH : 8 SIGNED : N

SOURCE : NCH

EDIT RULES :  
YYYYMMDD

23. NCH Segment Link Number

5 120 124

PACK

Effective with Version 'I', the system generated number used in conjunction with the NCH daily process date to keep records/segments belonging to a specific claim together. This field was added to ensure that records/segments that come in on the same batch with the same identifying information in the link group are not mixed with each other.

NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991).

DB2 ALIAS : NCH\_SGMT\_LINK\_NUM  
SAS ALIAS : LINK\_NUM  
STANDARD ALIAS : NCH\_SGMT\_LINK\_NUM  
TITLE ALIAS : LINK\_NUM

LENGTH : 9 SIGNED : Y

SOURCE : NCH

24. Claim Total Segment Count

2 125 126 NUM

Effective with Version I, the count used to identify the total number of segments associated with a given claim. Each claim could have up to 10 segments.

NOTE: During the Version I conversion, this field was populated with data throughout history (back to service year 1991). For institutional claims, the count for claims prior to 7/00 will be 1 or 2 (1 if 45 or less revenue center lines on a claim and 2 if more than 45 revenue center lines on a claim). For noninstitutional claims, the count will always be 1.

DB2 ALIAS : TOT\_SGMT\_CNT  
SAS ALIAS : SGMT\_CNT  
STANDARD ALIAS : CLM\_TOT\_SGMT\_CNT  
TITLE ALIAS : SEGMENT\_COUNT

LENGTH : 2 SIGNED : N

SOURCE : CWF

25. Claim Segment Number

2 127 128 NUM

Effective with Version I, the number used to identify an actual record/segment (1 - 10) associated with a given claim.

NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991). For institutional claims prior to 7/00, this number will be either 1 or 2. For noninstitutional claims, the number will always be 1.

DB2 ALIAS : CLM\_SGMT\_NUM  
SAS ALIAS : SGMT\_NUM  
STANDARD ALIAS : CLM\_SGMT\_NUM  
TITLE ALIAS : SEGMENT\_NUMBER

LENGTH : 2 SIGNED : N

				SOURCE	: CWF
26. Claim Total Line Count	3	129	131	NUM	
				Effective with Version I, the count used to identify the total number of revenue center lines associated with the claim.	
				NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991). Prior to Version 'I', the maximum line count will be no more than 58. Effective with Version 'I', the maximum line count could be 450.	
				DB2	ALIAS : TOT_LINE_CNT
				SAS	ALIAS : LINECNT
				STANDARD	ALIAS : CLM_TOT_LINE_CNT
				TITLE	ALIAS : TOTAL_LINE_COUNT
				LENGTH	: 3 SIGNED : N
				SOURCE	: CWF
27. Claim Segment Line Count	2	132	133	NUM	
				Effective with Version I, the count used to identify the number of lines on a record/segment.	
				NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991). The maximum line count per record/segment on the revenue center trailer is 45. The maximum number of lines on carrier and DMERC claims are 13.	
				DB2	ALIAS : SGMT_LINE_CNT
				SAS	ALIAS : SGMTLINE
				STANDARD	ALIAS : CLM_SGMT_LINE_CNT
				TITLE	ALIAS : SEGMENT_LINE_COUNT
				LENGTH	: 2 SIGNED : N
				SOURCE	: CWF
28. Carrier/DMERC Claim Common 2 Group					

Field Number	Field Name	Start	End	Length	Data Type	Comments
230		134	363		GRP	Information common to both carrier and DMERC claims for version J of NCH.  STANDARD ALIAS : CARR_DMERC_CLM_CMN_2_GRP
29.	FILLER	5	134	138	CHAR	DB2 ALIAS : FILLER  LENGTH : 5
30.	Carrier Claim Entry Code	1	139	139	CHAR	Carrier-generated code describing whether the Part B claim is an original debit, full credit, or replacement debit.  DB2 ALIAS : CARR_CLM_ENTRY_CD SAS ALIAS : ENTRY_CD STANDARD ALIAS : CARR_CLM_ENTRY_CD TITLE ALIAS : ENTRY_CD  LENGTH : 1  COMMENTS : Prior to Version H this field was named: CWFB_CLM_ENTRY_CD.  SOURCE : CWF
31.	FILLER	1	140	140	CHAR	DB2 ALIAS : FILLER  LENGTH : 1
32.	Claim Disposition Code	2	141	142	CHAR	Code indicating the disposition or outcome of the processing of the claim record.  DB2 ALIAS : CLM_DISP_CD SAS ALIAS : DISP_CD

STANDARD ALIAS : CLM\_DISP\_CD  
TITLE ALIAS : DISPOSITION\_CD  
  
LENGTH : 2  
  
SOURCE : CWF  
  
CODE TABLE : CLM\_DISP\_TB

33. NCH Edit Disposition Code

2 143 144

CHAR

Effective with Version H, a code used (for internal editing purposes) to indicate the disposition of the claim after editing in the CWFMQA process.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : NCH\_EDIT\_DISP\_CD  
SAS ALIAS : EDITDISP  
STANDARD ALIAS : NCH\_EDIT\_DISP\_CD  
TITLE ALIAS : NCH\_EDIT\_DISP  
  
LENGTH : 2  
  
SOURCE : NCH QA Process  
  
CODE TABLE : NCH\_EDIT\_DISP\_TB

34. NCH Claim BIC Modify H Code

1 145 145

CHAR

Effective with Version H, the code used (for internal editing purposes) to identify a claim record that was submitted with an incorrect HA, HB, or HC BIC.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : NCH\_BIC\_MDFY\_CD  
SAS ALIAS : BIC\_MDFY  
STANDARD ALIAS : NCH\_CLM\_BIC\_MDFY\_CD  
TITLE ALIAS : BIC\_MODIFY\_CD  
  
LENGTH : 1  
  
SOURCE : NCH QA Process

CODE TABLE : NCH\_CLM\_BIC\_MDFY\_TB

35. Beneficiary Residence SSA Standard County Code

3 146 148 CHAR

The SSA standard county code of a beneficiary's residence.

DB2 ALIAS : BENE\_SSA\_CNTY\_CD  
SAS ALIAS : CNTY\_CD  
STANDARD ALIAS : BENE\_RSDNC\_SSA\_STD\_CNTY\_CD  
TITLE ALIAS : BENE\_COUNTY\_CD

LENGTH : 3

SOURCE : SSA/EDB

EDIT RULES :  
OPTIONAL: MAY BE BLANK

36. Carrier Claim Receipt Date

8 149 156 NUM

The date the carrier receives the non-institutional claim.

DB2 ALIAS : CLM\_RCPT\_DT  
SAS ALIAS : RCPT\_DT

LENGTH : 8 SIGNED : N

COMMENTS :  
Prior to Version 'H' this field was named:  
FICARR\_CLM\_RCPT\_DT.

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

37. Carrier Claim Scheduled Payment Date

8 157 164 NUM

The scheduled date of payment to the physician or supplier, as appearing on the original non-institutional claim sent to the CWF host.  
\*\*Note: This date is considered to be the date paid since no additional information as to the actual payment date is available.

DB2 ALIAS : CARR\_SCHLD\_PMT\_DT  
SAS ALIAS : SCHLD\_DT  
STANDARD ALIAS : CARR\_CLM\_SCHLD\_PMT\_DT  
TITLE ALIAS : SCHLD\_PMT\_DT

LENGTH : 8 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
FICARR\_CLM\_PMT\_DT.

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

38. CWF Forwarded Date

8 165 172 NUM

Effective with Version H, the date CWF forwarded the claim record to CMS (used for internal editing purposes).

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

DB2 ALIAS : CWF\_FRWRD\_DT  
SAS ALIAS : FRWRD\_DT  
STANDARD ALIAS : CWF\_FRWRD\_DT  
TITLE ALIAS : FORWARD\_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

39. Carrier Number

5 173 177 CHAR

The identification number assigned by CMS to a carrier authorized to process claims from a physician or supplier.

Effective July 2006, the Medicare Administrative Contractors (MACs) began replacing the existing carriers and started processing physician or supplier claim records for states assigned to its jurisdiction.



NOTE: The 5-position MAC number will be housed in the existing CARR\_NUM field. During the transition from a carrier to a MAC the CARR\_NUM field could contain either a Carrier number or a MAC number. See the CARR\_NUM table of codes to identify the new MAC numbers and their effective dates.

DB2 ALIAS : CARR\_NUM  
 SAS ALIAS : CARR\_NUM  
 STANDARD ALIAS : CARR\_NUM  
 TITLE ALIAS : CARRIER

LENGTH : 5

COMMENTS :  
 Prior to Version H this field was named:  
 FICARR\_IDENT\_NUM.

SOURCE : CWF

CODE TABLE : CARR\_NUM\_TB

40. FILLER 8 178 185

CHAR

DB2 ALIAS : FILLER

LENGTH : 8

41. CWF Transmission Batch Number 4 186 189

CHAR

Effective with Version H, the number assigned to each batch of claims transactions sent from CWF(used for internal editing purposes).

NOTE: Beginning 11/98, this field will be populated with data. Claims processed prior to 11/98 will contain spaces in this field.

DB2 ALIAS : TRNSMSN\_BATCH\_NUM  
 SAS ALIAS : FIBATCH  
 STANDARD ALIAS : CWF\_TRNSMSN\_BATCH\_NUM  
 TITLE ALIAS : BATCH\_NUM

LENGTH : 4

				SOURCE	: CWF
42.	Beneficiary Mailing Contact ZIP Code	9	190	198	CHAR
					The ZIP code of the mailing address where the beneficiary may be contacted.
				DB2	ALIAS : BENE_MLG_ZIP_CD
				SAS	ALIAS : BENE_ZIP
				STANDARD	ALIAS : BENE_MLG_CNTCT_ZIP_CD
				TITLE	ALIAS : BENE_ZIP
				LENGTH	: 9
				SOURCE	: EDB
43.	Beneficiary Sex Identification Code	1	199	199	CHAR
					The sex of a beneficiary.
				COMMON	ALIAS : SEX_CD
				DA3	ALIAS : SEX_CODE
				DB2	ALIAS : BENE_SEX_IDENT_CD
				SAS	ALIAS : SEX
				STANDARD	ALIAS : BENE_SEX_IDENT_CD
				TITLE	ALIAS : SEX_CD
				LENGTH	: 1
				SOURCE	: SSA,RRB,EDB
				EDIT RULES :	
					REQUIRED FIELD
				CODE TABLE	: BENE_SEX_IDENT_TB
44.	Beneficiary Race Code	1	200	200	CHAR
					The race of a beneficiary.
				DA3	ALIAS : RACE_CODE
				DB2	ALIAS : BENE_RACE_CD
				SAS	ALIAS : RACE
				STANDARD	ALIAS : BENE_RACE_CD
				TITLE	ALIAS : RACE_CD
				LENGTH	: 1

				SOURCE	: SSA
				CODE TABLE	: BENE_RACE_TB
45.	Beneficiary Birth Date	8	201	208	NUM
					The beneficiary's date of birth.
				COMMON	ALIAS : DOB
				DA3	ALIAS : BIRTH_DATE
				DB2	ALIAS : BENE_BIRTH_DT
				SAS	ALIAS : BENE_DOB
				STANDARD	ALIAS : BENE_BIRTH_DT
				TITLE	ALIAS : BENE_BIRTH_DATE
				LENGTH	: 8 SIGNED : N
				SOURCE	: CWF
				EDIT RULES :	
					YYYYMMDD
46.	CWF Beneficiary Medicare Status Code	2	209	210	CHAR
					The CWF-derived reason for a beneficiary's entitlement to Medicare benefits, as of the reference date (CLM_THRU_DT).
				COBOL	ALIAS : MSC
				COMMON	ALIAS : MSC
				DB2	ALIAS : BENE_MDCR_STUS_CD
				SAS	ALIAS : MS_CD
				STANDARD	ALIAS : CWF_BENE_MDCR_STUS_CD
				TITLE	ALIAS : MSC
				LENGTH	: 2
				DERIVATIONS :	
					CWF derives MSC from the following:
					1. Date of Birth
					2. Claim Through Date
					3. Original/Current Reasons for entitlement
					4. ESRD Indicator
					5. Beneficiary Claim Number
					Items 1,3,4,5 come from the CWF Beneficiary Master Record; item 2 comes from the FI/Carrier claim record. MSC is assigned as follows:

MSC	OASI	DIB	ESRD	AGE	BIC
10	YES	N/A	NO	65 and over	N/A
11	YES	N/A	YES	65 and over	N/A
20	NO	YES	NO	under 65	N/A
21	NO	YES	YES	under 65	N/A
31	NO	NO	YES	any age	T.

COMMENTS :

Prior to Version H this field was named:  
BENE\_MDCR\_STUS\_CD. The name has been changed  
to distinguish this CWF-derived field from the  
EDB-derived MSC (BENE\_MDCR\_STUS\_CD).

SOURCE : CWF

CODE TABLE : BENE\_MDCR\_STUS\_TB

47. Claim Patient 6 Position Surname  
6 211 216

CHAR

The first 6 positions of the Medicare patient's  
surname (last name) as reported by the provider  
on the claim.

NOTE1: Prior to Version H, this field was only  
present on the IP/SNF claim record.  
Effective with Version H, this field is  
present on all claim types.

NOTE2: For OP, HHA, Hospice and all Carrier  
claims, data was populated beginning  
with NCH weekly process 10/3/97. Claims  
processed prior to 10/3/97 will contain  
spaces in this field.

COMMON ALIAS : PATIENT\_SURNAME  
DB2 ALIAS : PTNT\_6\_PSTN\_SRNM  
SAS ALIAS : SURNAME  
STANDARD ALIAS : CLM\_PTNT\_6\_PSTN\_SRNM\_NAME  
TITLE ALIAS : PATIENT\_SURNAME

LENGTH : 6

SOURCE : CWF

48. Claim Patient 1st Initial Given Name  
1 217 217

CHAR

The first initial of the Medicare patient's given name (first name) as reported by the provider on the claim.

NOTE1: Prior to Version H, this field was only present on the IP/SNF claim record. Effective with Version H, this field is present on all claim types.

NOTE2: For OP, HHA, Hospice and all Carrier claims, data was populated beginning with NCH weekly process date 10/3/97. Claims processed prior to 10/3/97 will contain spaces in this field.

COMMON ALIAS : PATIENT\_GIVEN\_NAME  
DB2 ALIAS : 1ST\_INITL\_GVN\_NAME  
SAS ALIAS : FRSTINIT  
STANDARD ALIAS : CLM\_PTNT\_1ST\_INITL\_GVN\_NAME  
TITLE ALIAS : PATIENT\_FIRST\_INITIAL

LENGTH : 1

SOURCE : CWF

49. Claim Patient First Initial Middle Name  
1 218 218

CHAR

The first initial of the Medicare patient's middle name as reported by the provider on the claim.

NOTE1: Prior to Version H, this field was only present on the IP/SNF claim record. Effective with Version H, this field is present on all claim types.

NOTE2: For OP, HHA, Hospice and all Carrier claims, data was populated beginning with NCH weekly process date 10/3/97. Claims processed prior to 10/3/97 will contain spaces in this field.

COMMON ALIAS : PATIENT\_MIDDLE\_NAME  
DB2 ALIAS : 1ST\_INITL\_MDL\_NAME  
SAS ALIAS : MDL\_INIT  
STANDARD ALIAS : CLM\_PTNT\_1ST\_INITL\_MDL\_NAME  
TITLE ALIAS : PATIENT\_MIDDLE\_INITIAL

LENGTH : 1

				SOURCE	: CWF
50.	Beneficiary CWF Location Code				
	1	219	219	CHAR	
					The code that identifies the Common Working File (CWF) location (the host site) where a beneficiary's Medicare utilization records are maintained.
				COMMON	ALIAS : CWF_HOST
				DB2	ALIAS : BENE_CWF_LOC_CD
				SAS	ALIAS : CWFLOCCD
				STANDARD	ALIAS : BENE_CWF_LOC_CD
				TITLE	ALIAS : CWF_HOST
				LENGTH	: 1
				SOURCE	: CWF
				CODE TABLE	: BENE_CWF_LOC_TB
51.	Claim Principal Diagnosis Group				
	8	220	227	GRP	
					Effective with Version 'J', the group used to identify the principal diagnosis code. This group contains the principal diagnosis code and the principal diagnosis version code.
				STANDARD	ALIAS : CLM_PRNCPAL_DGNS_GRP
52.	Claim Principal Diagnosis Version Code				
	1	220	220	CHAR	
					Effective with Version 'J', the code used to indicate if the diagnosis is ICD-9 or ICD-10.
					NOTE: With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2013.
				DB2	ALIAS : UNDEFINED
				SAS	ALIAS : PDVRSNCD
				LENGTH	: 1
				CODE TABLE	: CLM_DGNS_VRSN_TB

53. Claim Principal Diagnosis Code

7 221 227

CHAR

The diagnosis code identifying the diagnosis, condition, problem or other reason for the admission/encounter/visit shown in the medical record to be chiefly responsible for the services provided.

NOTE: Effective with Version H, this data is also redundantly stored as the first occurrence of the diagnosis trailer.

NOTE1: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10.

DB2 ALIAS : PRNCPAL\_DGNS\_CD  
SAS ALIAS : PDGNS\_CD

LENGTH : 7

SOURCE : CWF

EDIT RULES :  
ICD-9-CM

54. FILLER

1 228 228

CHAR

DB2 ALIAS : FILLER

LENGTH : 1

55. Carrier Claim Payment Denial Code

2 229 230

CHAR

The code on a noninstitutional claim indicating to whom payment was made or if the claim was denied.

NOTE1: Effective 4/1/02, this field was expanded to two bytes to accommodate new values. The NCH Nearline file did not expand the current 1-byte field but instituted a crosswalk of the 2-byte field to the 1-byte character value. See table of code for the crosswalk.

NOTE2: Effective with Version 'J', the field has been expanded on the NCH record to 2 bytes, With this expansion, the NCH will no longer use the character

values to represent the official two byte values sent in by CWF since 4/2002. During the Version J conversion, all character values were converted to the two byte values throughout history..

DB2 ALIAS : CARR\_PMT\_DNL\_CD  
SAS ALIAS : PMTDNLC

LENGTH : 2

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_CLM\_PMT\_DNL\_CD.

CODE TABLE : CARR\_CLM\_PMT\_DNL\_TB

56. Claim Excepted/Nonexcepted Medical Treatment Code  
1 231 231 CHAR

Effective with Version I, the code used to identify whether or not the medical care or treatment received by a beneficiary, who has elected care from a Religious Nonmedical Health Care Institution (RNHCI), is excepted or nonexcepted. Excepted is medical care or treatment that is received involuntarily or is required under Federal, State or local law. Nonexcepted is defined as medical care or treatment other than excepted.

DB2 ALIAS : EXCPTD\_NEXCPTD\_CD  
SAS ALIAS : TRTMT\_CD  
STANDARD ALIAS : CLM\_EXCPTD\_NEXCPTD\_TRTMT\_CD  
TITLE ALIAS : EXCPTD\_NEXCPTD\_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM\_EXCPTD\_NEXCPTD\_TRTMT\_TB

57. Claim Payment Amount  
6 232 237 PACK

Amount of payment made from the Medicare trust fund for the services covered by the claim record. Generally, the amount is calculated by the FI or carrier; and represents what was paid to the institutional provider, physician, or supplier, with the exceptions noted below. \*\*NOTE: In some situations, a negative claim payment amount may be present; e.g., (1) when a beneficiary is charged the full deductible during a short stay and the deductible exceeded



the amount Medicare pays; or (2) when a beneficiary is charged a coinsurance amount during a long stay and the coinsurance amount exceeds the amount Medicare pays (most prevalent situation involves psych hospitals who are paid a daily per diem rate no matter what the charges are.)

Under IP PPS, inpatient hospital services are paid based on a predetermined rate per discharge, using the DRG patient classification system and the PRICER program. On the IP PPS claim, the payment amount includes the DRG outlier approved payment amount, disproportionate share (since 5/1/86), indirect medical education (since 10/1/88), total PPS capital (since 10/1/91). After 4/1/03, the payment amount could also include a "new technology" add-on amount. It does NOT include the pass-thru amounts (i.e., capital-related costs, direct medical education costs, kidney acquisition costs, bad debts); or any beneficiary-paid amounts (i.e., deductibles and coinsurance); or any other payer reimbursement.

Under IRFPPS, inpatient rehabilitation services are paid based on a predetermined rate per discharge, using the Case Mix Group (CMG) classification system and the PRICER program. From the CMG on the IRF PPS claim, payment is based on a standard payment amount for operating and capital cost for that facility (including routine and ancillary services). The payment is adjusted for wage, the % of low-income patients (LIP), locality, transfers, interrupted stays, short stay cases, deaths, and high cost outliers. Some or all of these adjustments could apply. The CMG payment does NOT include certain pass-through costs (i.e. bad debts, approved education activities); beneficiary-paid amounts, other payer reimbursement, and other services outside of the scope of PPS.

Under LTCH PPS, long term care hospital services are paid based on a predetermined rate per discharge based on the DRG and the PRICER program. Payments are based on a single standard Federal rate for both inpatient operating and capital-related costs (including routine and ancillary services), but do NOT include certain pass-through costs (i.e. bad debts, direct medical education, new technologies and blood clotting factors). Adjustments to the payment may occur due to short-stay outliers, interrupted stays, high cost outliers, wage index, and cost of living adjustments.

Under SNF PPS, SNFs will classify beneficiaries using the patient classification system known as RUGS III. For the SNF PPS claim, the SNF PRICER will calculate/return the rate

for each revenue center line item with revenue center code = '0022'; multiply the rate times the units count; and then sum the amount payable for all lines with revenue center code '0022' to determine the total claim payment amount.

Under Outpatient PPS, the national ambulatory payment classification (APC) rate that is calculated for each APC group is the basis for determining the total claim payment. The payment amount also includes the outlier payment and interest.

Under Home Health PPS, beneficiaries will be classified into an appropriate case mix category known as the Home Health Resource Group. A HIPPS code is then generated corresponding to the case mix category (HHRG).

For the RAP, the PRICER will determine the payment amount appropriate to the HIPPS code by computing 60% (for first episode) or 50% (for subsequent episodes) of the case mix episode payment. The payment is then wage index adjusted.

For the final claim, PRICER calculates 100% of the amount due, because the final claim is processed as an adjustment to the RAP, reversing the RAP payment in full. Although final claim will show 100% payment amount, the provider will actually receive the 40% or 50% payment. The payment may also include outlier payments.

Exceptions: For claims involving demos and BBA encounter data, the amount reported in this field may not just represent the actual provider payment.

For demo Ids '01','02','03','04' -- claims contain amount paid to the provider, except that special 'differentials' paid outside the normal payment system are not included.

For demo Ids '05','15' -- encounter data 'claims' contain amount Medicare would have paid under FFS, instead of the actual payment to the MCO.

For demo Ids '06','07','08' -- claims contain actual provider payment but represent a special negotiated bundled payment for both Part A and Part B services. To identify what the conventional provider Part A payment would have been, check value code = 'Y4'. The related noninstitutional (physician/supplier) claims contain what would have been paid had there been no demo.

For BBA encounter data (non-demo) -- 'claims' contain amount Medicare would have paid under FFS, instead of the actual payment to the BBA plan.

COMMON ALIAS : REIMBURSEMENT  
DB2 ALIAS : CLM\_PMT\_AMT  
SAS ALIAS : PMT\_AMT  
STANDARD ALIAS : CLM\_PMT\_AMT  
TITLE ALIAS : REIMBURSEMENT

LENGTH : 9.2 SIGNED : Y

COMMENTS :

Prior to Version H, the size of this field was S9(7)V99. Also, the noninstitutional claim records carried this field as a line item. Effective with Version H, this element is a claim level field across all claim types (and the line item field has been renamed.)

SOURCE : CWF

LIMITATIONS :

Prior to 4/6/93, on inpatient, outpatient, and physician/supplier claims containing a CLM\_DISP\_CD of '02', the amount shown as the Medicare reimbursement does not take into consideration any CWF automatic adjustments (involving erroneous deductibles in most cases). In as many as 30% of the claims (30% IP, 15% OP, 5% PART B), the reimbursement reported on the claims may be over or under the actual Medicare payment amount.

REFER TO :

PMT\_AMT\_EXCEDG\_CHRG\_AMT\_LIM

EDIT RULES :

\$\$\$\$\$\$\$\$CC

58. Carrier Claim Primary Payer Paid Amount  
6 238 243

PACK

Effective with Version H, the amount of a payment made on behalf of a Medicare beneficiary by a primary payer other than Medicare, that the provider is applying to covered Medicare charges on a non-institutional claim.

NOTE: During the Version H conversion, this field was populated with data throughout history (back to

service year 1991) by summing up the line item primary payer amounts.

DB2 ALIAS : CARR\_PRMRY\_PYR\_AMT  
SAS ALIAS : PRPAYAMT  
STANDARD ALIAS : CARR\_CLM\_PRMRY\_PYR\_PD\_AMT  
TITLE ALIAS : PRIMARY\_PAYER\_AMOUNT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

EDIT RULES :  
\$\$\$\$\$\$\$\$\$CC

59. FILLER

1 244 244 CHAR

DB2 ALIAS : FILLER

LENGTH : 1

60. DMERC Claim Ordering Physician UPIN Number

6 245 250 CHAR

Effective with Version G, the unique physician identification number (UPIN) of the physician ordering the Part B services/DMEPOS item.

DB2 ALIAS : ORDRG\_PHYSN\_UPIN  
SAS ALIAS : ORD\_UPIN  
STANDARD ALIAS : DMERC\_CLM\_ORDRG\_PHYSN\_UPIN\_NUM  
TITLE ALIAS : ORDRG\_UPIN

LENGTH : 6

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_CLM\_ORDRG\_PHYSN\_UPIN\_NUM.

SOURCE : CWF

61. DMERC Claim Ordering Physician NPI Number

10 251 260 CHAR

The National Provider Identifier (NPI) assigned to the physician ordering the Part B/DMEPOS line item.

NOTE: Effective May 2007, the NPI will become

the national standard identifier for covered health care providers. NPIs will replace the current legacy provider numbers (UPINs, NPIs, OSCAR provider numbers, etc.) on the standard HIPAA claim transactions. (During the NPI transition phase (4/3/06 - 5/23/07) the capability was there for the NCH to receive NPIs along with an existing legacy number.

NOTE1: CMS has determined that dual provider identifiers (legacy numbers and NPIs) must be available on the NCH. After the 5/07 NPI implementation, the standard system maintainers will add the legacy number to the claim when it is adjudicated. Effective May 2007, no NEW UPINs (legacy number) will be generated for NEW physicians (Part B and Outpatient claims) so there will only be NPIs sent in to the NCH for those physicians.

COMMON ALIAS : ORDERING\_PHYSICIAN\_NPI  
DB2 ALIAS : ORDRG\_PHYSN\_NPI  
SAS ALIAS : ORD\_NPI  
TITLE ALIAS : ORDRG\_NPI

LENGTH : 10

SOURCE : CWF

62. Carrier Claim Provider Assignment Indicator Switch  
1 261 261 CHAR

A switch indicating whether or not the provider accepts assignment for the noninstitutional claim.

DB2 ALIAS : PRVDR\_ASGNMT\_SW  
SAS ALIAS : ASGMNTCD  
STANDARD ALIAS : CARR\_CLM\_PRVDR\_ASGNMT\_IND\_SW  
TITLE ALIAS : ASSIGNMENT\_SW

LENGTH : 1

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_CLM\_PRVDR\_ASGNMT\_IND\_SW.

SOURCE : CWF

CODE TABLE : CARR\_CLM\_PRVDR\_ASGNMT\_IND\_TB

63. NCH Claim Provider Payment Amount

6 262 267

PACK

Effective with Version H, the total payments made to the provider for this claim (sum of line item provider payment amounts.)

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

DB2 ALIAS : NCH\_PRVDR\_PMT\_AMT  
SAS ALIAS : PROV\_PMT  
STANDARD ALIAS : NCH\_CLM\_PRVDR\_PMT\_AMT  
TITLE ALIAS : PRVDR\_PMT

LENGTH : 9.2 SIGNED : Y

SOURCE : NCH QA Process

64. NCH Claim Beneficiary Payment Amount

6 268 273

PACK

Effective with Version H, the total payments made to the beneficiary for this claim (sum of line payment amounts to the beneficiary.)

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

DB2 ALIAS : NCH\_BENE\_PMT\_AMT  
SAS ALIAS : BENE\_PMT  
STANDARD ALIAS : NCH\_CLM\_BENE\_PMT\_AMT  
TITLE ALIAS : BENE\_PMT

LENGTH : 9.2 SIGNED : Y

SOURCE : NCH QA Process

65. Carrier Claim Beneficiary Paid Amount

6 274 279

PACK

Effective with Version H, the amount paid by the beneficiary for the non-institutional Part B services.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data.

Claims processed prior to 10/3/97 will contain zeroes in this field.

DB2 ALIAS : CARR\_BENE\_PD\_AMT  
SAS ALIAS : BENEPAID  
STANDARD ALIAS : CARR\_CLM\_BENE\_PD\_AMT  
TITLE ALIAS : BENE\_PD\_AMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

66. NCH Carrier Claim Submitted Charge Amount  
6 280 285

PACK

Effective with Version H, the total submitted charges on the claim (the sum of line item submitted charges).

NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991).

DB2 ALIAS : CARR\_SBMT\_CHRG\_AMT  
SAS ALIAS : SBMTCHRG  
STANDARD ALIAS : NCH\_CARR\_SBMT\_CHRG\_AMT  
TITLE ALIAS : SBMT\_CHRG

LENGTH : 9.2 SIGNED : Y

SOURCE : NCH QA Process

EDIT RULES :  
\$\$\$\$\$\$\$\$\$CC

67. NCH Carrier Claim Allowed Charge Amount  
6 286 291

PACK

Effective with Version H, the total allowed charges on the claim (the sum of line item allowed charges).

NOTE1: The amount includes beneficiary-paid amounts (i.e., deductible and coinsurance).

NOTE2: During the Version H conversion this field was populated with data throughout history (back to service year 1991).

DB2 ALIAS : CARR\_ALOW\_CHRG\_AMT

SAS ALIAS : ALOWCHRG  
STANDARD ALIAS : NCH\_CARR\_ALOW\_CHRG\_AMT  
TITLE ALIAS : ALOW\_CHRG

LENGTH : 9.2 SIGNED : Y

SOURCE : NCH QA Process

EDIT RULES :  
\$\$\$\$\$\$CC

68. Carrier Claim Cash Deductible Applied Amount  
6 292 297 PACK

Effective with Version H, the amount of the cash deductible as submitted on the claim.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

DB2 ALIAS : CASH\_DDCTBL\_AMT  
SAS ALIAS : DEDAPPLY  
STANDARD ALIAS : CARR\_CLM\_CASH\_DDCTBL\_APPLY\_AMT  
TITLE ALIAS : CASH\_DDCTBL

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

69. Carrier Claim HCPCS Year Code  
1 298 298 NUM

Effective with Version H, the terminal digit of HCPCS version used to code the claim.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

DB2 ALIAS : CARR\_HCPCS\_YR\_CD  
SAS ALIAS : HCPCS\_YR  
STANDARD ALIAS : CARR\_CLM\_HCPCS\_YR\_CD  
TITLE ALIAS : HCPCS\_YR

LENGTH : 1 SIGNED : N

SOURCE : CWF



70. Carrier Claim MCO Override Indicator Code  
1 299 299

CHAR

Effective with Version H, the code used to indicate whether or not an MCO investigation applies to the claim (used for internal CWFMQA editing purposes).

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : MCO\_OVRRD\_IND\_CD  
SAS ALIAS : MCOOVRRD  
STANDARD ALIAS : CARR\_CLM\_MCO\_OVRRD\_IND\_CD  
TITLE ALIAS : MCO\_OVERRIDE

LENGTH : 1

SOURCE : CWF

CODE TABLE : CARR\_CLM\_MCO\_OVRRD\_IND\_TB

71. Carrier Claim Hospice Override Indicator Code  
1 300 300

CHAR

Effective with Version H, the code used to indicate whether or not an Hospice investigation applies to the claim (used for internal CWFMQA editing purposes).

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : HOSPC\_OVRRD\_IND\_CD  
SAS ALIAS : HOSPOVRD  
STANDARD ALIAS : CARR\_CLM\_HOSPC\_OVRRD\_IND\_CD  
TITLE ALIAS : HOSPC\_OVERRIDE

LENGTH : 1

SOURCE : CWF

CODE TABLE : CARR\_CLM\_HOSPC\_OVRRD\_IND\_TB

72. Claim Business Segment Identifier Code

4 301 304 CHAR

Effective 10/1/2005 with the implementation of NCH/NMUD CR#2, the identifier that captures the 2-byte jurisdiction code (represents the USPS state/territory abbreviation (i.e. NY = New York) and the 2-byte modifier that identifies the type of Medicare FFS contract (intermediary, RHHI, carrier or DMERC). This 4-byte identifier along with the 5-byte FI/Carrier number comprises the Contractor Workload Identifier number. The business segment identifier (BSI) is intended to help sort workloads that may be redistributed with the implementation of contracting reform as required by MMA.

DB2 ALIAS : BUSNS\_SGMT\_ID\_CD  
SAS ALIAS : SGMT\_ID  
STANDARD ALIAS : CLM\_BUSNS\_SGMT\_ID\_CD

LENGTH : 4

SOURCE : CWF

73. Claim Clinical Trial Number  
8

305 312 CHAR

Effective September 1, 2008 with the implementation of CR#3, the number used to identify all items and services provided to a beneficiary during their participation in a clinical trial.

NOTE:

CMS is requesting the clinical trial number be voluntarily reported. The number is assigned by the National Library of Medicine (NLM) Clinical Trials Data Bank when a new study is registered.

DB2 ALIAS : CLM\_CLNCL\_TRIL\_NUM  
SAS ALIAS : CTRLNUM

LENGTH : 8

74. Recovery Audit Contractor (RAC) Adjustment Indicator Code  
1 313 313 CHAR

Effective January 5, 2009 with the implementation of CR#4, the code used to identify a Recovery Audit Contractor (RAC) requested adjustment. This occurs as a result of post-payment review activities done by the RAC.

				DB2	ALIAS : RAC_ADJSTMT_CD
				SAS	ALIAS : RACINDCD
				STANDARD	ALIAS : CLM_RAC_ADJSTMT_IND_CD
				LENGTH	: 1
				CODE TABLE	: CLM_RAC_ADJSTMT_TB
75.	FILLER	50	314	363	CHAR
				DB2	ALIAS : FILLER
				LENGTH	: 50
76.	DMERC NCH Edit Code Count	2	364	365	NUM
					The count of the number of edit codes annotated to the DMERC claim during HCFA's CWFMQA process. The purpose of this count is to indicate how many claim edit trailers are present. Prior to Version H this field was named: CLM_EDIT_CD_CNT.
				DB2	ALIAS : EDIT_TRLR_CNT
				SAS	ALIAS : DEDCNT
				STANDARD	ALIAS : DMERC_NCH_EDIT_CD_CNT
				LENGTH	: 2 SIGNED : N
				COMMENTS :	Prior to Version H this field was named: CLM_EDIT_CD_CNT.
				SOURCE	: NCH
77.	DMERC NCH Patch Code Count	2	366	367	NUM
					Effective with Version H, the count of the number of HCFA patch codes annotated to the DMERC claim during the Nearline maintenance process. The purpose of this count is to indicate how many NCH patch trailers are present. NOTE: During the Version H conversion this field was populated with data throughout

history (back to service year 1991).

DB2 ALIAS : DMERC\_PATCH\_CD\_CNT  
SAS ALIAS : DPATCNT  
STANDARD ALIAS : DMERC\_NCH\_PATCH\_CD\_I\_CNT

LENGTH : 2 SIGNED : N

SOURCE : NCH

78. DMERC MCO Period Count

1 368 368 NUM

Effective with Version H, the count of the number of Managed Care Organization (MCO) periods reported on a DMERC claim. The purpose of this count is to indicate how many MCO period trailers are present.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

DB2 ALIAS : DMERC\_MCO\_PRD\_CNT  
SAS ALIAS : DMCOCNT  
STANDARD ALIAS : DMERC\_MCO\_PRD\_CNT

LENGTH : 1 SIGNED : N

SOURCE : NCH

EDIT RULES :  
RANGE: 0 TO 2

79. DMERC Claim Demonstration ID Count

1 369 369 NUM

Effective with Version H, the count of the number of claim demonstration IDs reported on an DMERC claim. The purpose of this count is to indicate how many claim demonstration trailers are present.

NOTE: During the Version H conversion this field was populated with data where a demo was identifiable.

DB2 ALIAS : DEMO\_TRLR\_CNT  
SAS ALIAS : DDEMCNT

STANDARD ALIAS : DMERC\_CLM\_DEMO\_ID\_CNT

LENGTH : 1 SIGNED : N

SOURCE : NCH

EDIT RULES :  
RANGE: 0 TO 5

80. DMERC Claim Diagnosis Code Count  
2 370 371

NUM

The count of the number of diagnosis codes (both principal and secondary) reported on a DMERC claim. The purpose of this count is to indicate how many claim diagnosis code trailers are present.

NOTE: Effective with Version 'J', the count of the number of diagnosis code trailers was expanded from 8 to 12.

DB2 ALIAS : DGNS\_TRLR\_CNT

SAS ALIAS : DDGNCNT

STANDARD ALIAS : DMERC\_CLM\_DGNS\_CD\_J\_CNT

LENGTH : 2 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
CLM\_DGNS\_CD\_CNT.

SOURCE : NCH

EDIT RULES :  
RANGE: 0 TO 12

81. DMERC Claim Line Count  
2 372 373

NUM

The count of the number of line items reported on the DMERC claim. The purpose of this count is to indicate how many line item trailers are present.

DB2 ALIAS : LINE\_ITM\_TRLR\_CNT

SAS ALIAS : DLINECNT

STANDARD ALIAS : DMERC\_CLM\_LINE\_CNT

LENGTH : 2 SIGNED : N

				COMMENTS :
				Prior to Version H this field was named:
				CWFB_CLM_NUM_LINE_ITM_CNT.
				SOURCE : CWFB CLAIMS
				EDIT RULES :
				RANGE: 1 TO 13
82.	FILLER	4	374 377	CHAR
				DB2 ALIAS : FILLER
				LENGTH : 4
83.	DMERC Claim Variable Group			
	VAR	378	5441	GRP
				Variable portion of the durable medical equipment (DME) regional carrier (DMERC) claim record For Version J of the NCH.
				STANDARD ALIAS : DMERC_CLM_VAR_GRP
84.	NCH Edit Group	5	378 382	GRP
				The number of claim edit trailers is determined by the claim edit code count.
				STANDARD ALIAS : NCH_EDIT_GRP
				OCCURS MIN: 0 OCCURS MAX: 13
				DEPENDING ON : DMERC_NCH_EDIT_CD_CNT
85.	NCH Edit Trailer Indicator Code	1	378 378	CHAR
				Effective with Version H, the code indicating the presence of an NCH edit trailer.
				NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).
				DB2 ALIAS : EDIT_TRLR_IND_CD

				SAS ALIAS : EDITIND STANDARD ALIAS : NCH_EDIT_TRLR_IND_CD  LENGTH : 1  SOURCE : NCH QA Process  CODE TABLE : NCH_EDIT_TRLR_IND_TB
86. NCH Edit Code	4	379	382	CHAR  The code annotated to the claim indicating the CWFMQA editing results so users will be aware of data deficiencies.  NOTE: Prior to Version H only the highest priority code was stored. Beginning 11/98 up to 13 edit codes may be present.  COMMON ALIAS : QA_ERROR_CODE DB2 ALIAS : NCH_EDIT_CD SAS ALIAS : EDIT_CD STANDARD ALIAS : NCH_EDIT_CD TITLE ALIAS : QA_ERROR_CD  LENGTH : 4  SOURCE : NCH QA EDIT PROCESS  CODE TABLE : NCH_EDIT_TB
87. NCH Patch Group	11	1	11	GRP  STANDARD ALIAS : NCH_PATCH_GRP  OCCURS MIN: 0 OCCURS MAX: 30  DEPENDING ON : DMERC_NCH_PATCH_CD_I_CNT
88. NCH Patch Trailer Indicator Code	1	1	1	CHAR  Effective with Version H, the code indicating the presence of an NCH patch trailer.  NOTE: During the Version H conversion this field was populated throughout history (back to service

year 1991).

DB2 ALIAS : PATCH\_TRLR\_IND\_CD  
SAS ALIAS : PATCHIND  
STANDARD ALIAS : NCH\_PATCH\_TRLR\_IND\_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH\_PATCH\_TRLR\_IND\_TB

89. NCH Patch Code

2 2 3 CHAR

Effective with Version H, the code annotated to the claim indicating a patch was applied to the record during an NCH Nearline record conversion and/or during current processing.

NOTE: Prior to Version H this field was located in the third and fourth occurrence of the CLM\_EDIT\_CD.

DB2 ALIAS : NCH\_PATCH\_CD  
SAS ALIAS : PATCHCD  
STANDARD ALIAS : NCH\_PATCH\_CD  
TITLE ALIAS : NCH\_PATCH

LENGTH : 2

SOURCE : NCH

CODE TABLE : NCH\_PATCH\_TB

90. NCH Patch Applied Date

8 4 11 NUM

Effective with Version H, the date the NCH patch was applied to the claim.

DB2 ALIAS : NCH\_PATCH\_APPLY\_DT  
SAS ALIAS : PATCHDT  
STANDARD ALIAS : NCH\_PATCH\_APPLY\_DT  
TITLE ALIAS : NCH\_PATCH\_DT

LENGTH : 8 SIGNED : N

SOURCE : NCH



EDIT RULES :  
YYYYMMDD

91. MCO Period Group

37 1 37 GRP

The number of managed care organization (MCO) period data trailers present is determined by the claim MCO period trailer count. This field reflects the two most current MCO periods in the CWF beneficiary history record. It may have no connection to the services on the claim.

STANDARD ALIAS : MCO\_PRD\_GRP

OCCURS MIN: 0 OCCURS MAX: 2

DEPENDING ON : DMERC\_MCO\_PRD\_CNT

92. NCH MCO Trailer Indicator Code

1 1 1 CHAR

Effective with Version H, the code indicating the presence of a Managed Care Organization (MCO) trailer.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

COBOL ALIAS : MCO\_IND  
DB2 ALIAS : MCO\_TRLR\_IND\_CD  
SAS ALIAS : MCOIND  
STANDARD ALIAS : NCH\_MCO\_TRLR\_IND\_CD  
TITLE ALIAS : MCO\_INDICATOR

LENGTH : 1

SOURCE : NCH QA Process

CODE TABLE : NCH\_MCO\_TRLR\_IND\_TB

93. MCO Contract Number

5 2 6 CHAR

Effective with Version H, this field represents the plan contract number of the Managed Care

Organization (MCO).

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : MCO\_CNTRCT\_NUM  
SAS ALIAS : MCONUM  
STANDARD ALIAS : MCO\_CNTRCT\_NUM  
TITLE ALIAS : MCO\_NUM

LENGTH : 5

SOURCE : CWF

94. MCO Option Code

1 7 7 CHAR

Effective with Version H, the code indicating Managed Care Organization (MCO) lock-in enrollment status of the beneficiary.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.

DB2 ALIAS : MCO\_OPTN\_CD  
SAS ALIAS : MCOOPTN  
STANDARD ALIAS : MCO\_OPTN\_CD  
TITLE ALIAS : MCO\_OPTION\_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : MCO\_OPTN\_TB

95. MCO Period Effective Date

8 8 15 NUM

Effective with Version H, the date the beneficiary's enrollment in the Managed Care Organization (MCO) became effective.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

DB2 ALIAS : MCO\_PRD\_EFCTV\_DT  
SAS ALIAS : MCOEFFDT  
STANDARD ALIAS : MCO\_PRD\_EFCTV\_DT  
TITLE ALIAS : MCO\_PERIOD\_EFF\_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

96. MCO Period Termination Date  
8 16 23

NUM

Effective with Version H, the date the beneficiary's enrollment in the Managed Care Organization (MCO) was terminated.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

DB2 ALIAS : MCO\_PRD\_TRMNTN\_DT  
SAS ALIAS : MCOTRMDT  
STANDARD ALIAS : MCO\_PRD\_TRMNTN\_DT  
TITLE ALIAS : MCO\_PERIOD\_TERM\_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

97. MCO Health PLANID Number  
14 24 37

CHAR

A placeholder field (effective with Version H) for storing the Health PlanID associated with the Managed Care Organization (MCO). Prior to Version 'I' this field was named: MCO\_PAYERID\_NUM.

DB2 ALIAS : MCO\_PLANID\_NUM  
SAS ALIAS : MCOPLNID  
STANDARD ALIAS : MCO\_HLTH\_PLANID\_NUM  
TITLE ALIAS : MCO\_PLANID

			LENGTH	: 14
			COMMENTS :	
				Prior to Version I this field was named:
				MCO_PAYERID_NUM.
			SOURCE	: CWF
98.	Claim Demonstration Identification Group			
	18	1	18	GRP
				The number of demonstration identification
				trailers present is determined by the claim
				demonstration identification trailer count.
			STANDARD ALIAS	: CLM_DEMO_ID_GRP
			OCCURS MIN:	0 OCCURS MAX: 5
			DEPENDING ON	: DMERC_CLM_DEMO_ID_CNT
99.	NCH Demonstration Trailer Indicator Code			
	1	1	1	CHAR
				Effective with Version H, the code indicating
				the presence of a demo trailer.
				NOTE: During the Version H conversion this field
				was populated throughout history (back to service
				year 1991).
			COBOL	ALIAS : DEMO_IND
			DB2	ALIAS : NCH_DEMO_TRLR_IND_
			SAS	ALIAS : DEMOIND
			STANDARD	ALIAS : NCH_DEMO_TRLR_IND_CD
			TITLE	ALIAS : DEMO_INDICATOR
			LENGTH	: 1
			SOURCE	: NCH
			CODE TABLE	: NCH_DEMO_TRLR_IND_TB
100.	Claim Demonstration Identification Number			
	2	2	3	CHAR
				Effective with Version H, the number assigned
				to identify a demo. This field is also used to

denote special processing (a.k.a. Special Processing Number, SPN).

NOTE: Prior to Version H, Demo ID was stored in the redefined Claim Edit Group, 4th occurrence, positions 3 and 4. During the H conversion, this field was populated with data throughout history (as appropriate either by moving ID on Version G or by deriving from specific demo criteria).

01 = Nursing Home Case-Mix and Quality: NHCMQ (RUGS) Demo -- testing PPS for SNFs in 6 states, using a case-mix classification system based on resident characteristics and actual resources used. The claims carry a RUGS indicator and one or more revenue center codes in the 9,000 series.

NOTE1: Effective for SNF claims with NCH weekly process date after 2/8/96 (and service date after 12/31/95) -- beginning 4/97, Demo ID '01' was derived in NCH based on presence of RUGS phase # '2','3' or '4' on incoming claim; since 7/97, CWF has been adding ID to claim.

NOTE2: During the Version H conversion, Demo ID '01' was populated back to NCH weekly process date 2/9/96 based on the RUGS phase indicator (stored in Claim Edit Group, 3rd occurrence, 4th position, in Version G).

02 = National HHA Prospective Payment Demo -- testing PPS for HHAs in 5 states, using two alternate methods of paying HHAs: per visit by type of HHA visit and per episode of HH care.

NOTE1: Effective for HHA claims with NCH weekly process date after 5/31/95 -- beginning 4/97, Demo ID '02' was derived in NCH based on HCFA/CHPP-supplied listing of provider # and start/stop dates of participants.

NOTE2: During the Version H conversion, Demo ID '02' was populated back to NCH weekly process date 6/95 based on the CHPP criteria.

03 = Telemedicine Demo -- testing covering traditionally noncovered physician services for medical consultation furnished via two-way, inter-

active video systems (i.e. teleconsultation)  
in 4 states. The claims contain line items  
with 'QQ' HCPCS code.

NOTE1: Effective for physician/supplier (nonDMERC)  
claims with NCH weekly process date after 12/31/96  
(and service date after 9/30/96) -- since 7/97,  
CWF has been adding Demo ID '03' to claim.

NOTE2: During Version H conversion, Demo ID '03'  
was populated back to NCH weekly process date 1/97  
based on the presence of 'QQ' HCPCS on one or more  
line items.

04 = United Mine Workers of America (UMWA) Managed  
Care Demo -- testing risk sharing for Part A  
services, paying special capitation rates for  
all UMWA beneficiaries residing in 13 design-  
ated counties in 3 states. Under the demo,  
UMWA will waive the 3-day qualifying hospital  
stay for a SNF admission. The claims contain  
TOB '18X', '21X', '28X' and '51X'; condition  
code = W0; claim MCO paid switch = not '0';  
and MCO contract # = '90091'.

NOTE: Initially scheduled to be implemented for  
all SNF claims for admission or services on  
1/1/97 or later, CWF did not transmit any Demo  
ID '04' annotated claims until on or about 2/98.

05 = Medicare Choices (MCO encounter data) demo --  
testing expanding the type of Managed Care  
plans available and different payment methods  
at 16 MCOs in 9 states. The claims contain  
one of the specific MCO Plan Contract #  
assigned to the Choices Demo site.

NOTE1: Effective for all claim types with NCH  
weekly process date after 7/31/97 -- CWF adds  
Demo ID '05' to claim based on the presence of  
the MCO Plan Contract #. \*\*\*Demonstration was  
terminated 12/31/2000.\*\*\*

NOTE2: During the Version H conversion, Demo ID  
'05' was populated back to NCH weekly process  
date 8/97 based on the presence of the Choices  
indicator (stored as an alpha character cross-  
walked from MCO plan contract # in the Claim  
Edit Group, 4th occurrence, 2nd position, in  
Version 'G').

06 = Coronary Artery Bypass Graft (CABG) Demo -- testing bundled payment (all-inclusive global pricing) for hospital + physician services related to CABG surgery in 7 hospitals in 7 states. The inpatient claims contain a DRG '106' or '107'.

NOTE1: Effective for Inpatient claims and physician/supplier claims with Claim Edit Date no earlier than 6/1/91 (not all CABG sites started at the same time) -- on 5/1/97, CWF started transmitting Demo ID '06' on the claim. The FI adds the ID to the claim based on the presence of DRG '106' or '107' from specific providers for specified time periods; the carrier adds the ID to the claim based on receiving 'Daily Census List' from participating hospitals. \*\*\*Demo terminated in 1998.\*\*\*

NOTE2: During the Version H conversion, any claims where Medicare is the primary payer that were not already identified as Demo ID '06' (stored in the redefined Claim Edit Group, 4th occurrence, positions 3 and 4, Version G) were annotated based on the following criteria: Inpatient - presence of DRG '106' or '107' and a provider number=220897, 150897, 380897,450897,110082,230156 or 360085 for specified service dates; noninstitutional - presence of HCPCS modifier (initial and/or second) = 'Q2' and a carrier number =00700/31143 00630,01380,00900,01040/00511,00710,00623, or 13630 for specified service dates.

07 = Virginia Cardiac Surgery Initiative (VCSI) (formerly referred to as Medicare Quality Partnerships Demo) -- this is a voluntary consortium of the cardiac surgery physician groups and the non-Veterans Administration hospitals providing open heart surgical services in the Commonwealth of Virginia. The goal of the demo is to share data on quality and process innovations in an attempt to improve the care for all cardiac patients. The demonstration only affects those FIs that process claims from hospitals in Virginia and the carriers that process claims from physicians providing inpatient services at those hospitals. The hospitals will be reimbursed on a global payment

basis for selected cardiac surgical diagnosis related groups (DRGs). The inpatient claims will contain a DRG '104', '105', '106', '107', '109'; the related physician/supplier claims will contain the claim payment denial reason code = 'D'.

NOTE: The implementation date for this demo is 4/1/03. The FI will annotate the claim with the demo id add Demo ID '07' to claim. For carrier claims, the Standard Systems will annotate the claim with the '07' demo number.

08 = Provider Partnership Demo -- testing per-case payment approaches for acute inpatient hospitalizations, making a lump-sum payment (combining the normal Part A PPS payment with the Part B allowed charges into a single fee schedule) to a Physician/Hospital Organization for all Part A and Part B services associated with a hospital admission. From 3 to 6 hospitals in the Northeast and Mid-Atlantic regions may participate in the demo.

NOTE: The demo is on HOLD. The FI and carrier will add Demo ID '08' to claim.

15 = ESRD Managed Care (MCO encounter data) -- testing open enrollment of ESRD beneficiaries and capitation rates adjusted for patient treatment needs at 3 MCOs in 3 States. The claims contain one of the specific MCO Plan Contract # assigned to the ESRD demo site.

NOTE: Effective 10/1/97 (but not actually implemented at a site until 1/1/98) for all claim types -- the FI and carrier add Demo ID '15' to claim based on the presence of the MCO plan contract #.

30 = Lung Volume Reduction Surgery (LVRS) or National Emphysema Treatment Trial (NETT) Clinical Study -- evaluating the effectiveness of LVRS and maximum medical therapy (including pulmonary rehab) for Medicare beneficiaries in last stages of emphysema at 18 hospitals nationally, in collaboration with NIH.

NOTE: Effective for all claim types (except DMERC) with NCH weekly process date after 2/27/98 (and



service date after 10/31/97) -- the FI adds Demo ID '30' based on the presence of a condition code = EY; the participating physician (not the carrier) adds ID to the noninstitutional claim. DUE TO THE SENSITIVE NATURE OF THIS CLINICAL TRIAL AND UNDER THE TERMS OF THE INTERAGENCY AGREEMENT WITH NIH, THESE CLAIMS ARE PROCESSED BY CWF AND TRANSMITTED TO HCFA BUT NOT STORED IN THE NEARLINE FILE (access is restricted to study evaluators only).

31 = VA Pricing Special Processing (SPN) -- not really a demo but special request from VA due to court settlement; not Medicare services but VA inpatient and physician services submitted to FI 00400 and Carrier 00900 to obtain Medicare pricing -- CWF WILL PROCESS VA CLAIMS ANNOTATED WITH DEMO ID '31', BUT WILL NOT TRANSMIT TO HCFA (not in Nearline File).

37 = Medicare Coordinated Care Demonstration -- to test whether coordinated care services furnished to certain beneficiaries improves outcome of care and reduces Medicare expenditures under Part A and Part B. There will be at least 14 Coordinated Care Entities (CCEs). The selected entities will be assigned a provider number specifically for the demonstration services.

NOTE: All claims will be processed by carriers; no FI processing (except for Georgetown site)

37 = Medicare Disease Management (DMD) -- the purpose of this demonstration is to study the impact on costs and health outcomes of applying disease management services supplemented with coverage for prescription drugs for certain Medicare beneficiaries with diagnosed, advanced-stage congestive heart failure, diabetes, or coronary heart disease. Three demonstration sites will be used for this demonstration and it will last for 3 years. (Effective 4/1/2003).

NOTE: All claims will be processed by NHIC-California (Carrier). FIs will only serve as a conduit for transmitting information to and from CWF about the NOEs.

38 = Physician Encounter Claims - the purpose of this demo id is to identify the physician encounter claims being processed at the HCFA Data Center (HDC). This number will help EDS in making the claim go through the appropriate processing logic, which

differs from that for fee-for-service. \*\*NOT  
IN NCH.\*\*

NOTE: Effective October, 2000. Demo ids will not be  
assigned to Inpatient and Outpatient encounter claims.

39 = Centralized Billing of Flu and PPV Claims -- The  
purpose of this demo is to facilitate the processing  
carrier, Trailblazers, paying flu and PPV claims  
based on payment localities. Providers will be  
giving the shots throughout the country and trans-  
mitting the claims to Trailblazers for processing.

NOTE: Effective October, 2000 for carrier claims.

40 = Payment of Physician and Nonphysician Services  
in certain Indian Providers -- the purpose of  
this demo is to extend payment for services of  
physician and nonphysician practitioners  
furnished in hospitals and ambulatory care clinics.  
Prior to the legislation change in BIPA, reim-  
bursement for Medicare services provided in IHS  
facilities was limited to services provided in  
hospitals and skilled nursing facilities. This  
change will allow payment for IHS, Tribe and  
Tribal Organization providers under the Medicare  
physician fee schedule.

NOTE: Effective July 1, 2001 for institutional and  
carrier claims.

48 = Medical Adult Day-Care Services -- the purpose  
of this demonstration is to provide, as part of the  
episode of care for home health services, medical  
adult day care services to Medicare beneficiaries as  
a substitute for a portion of home health services  
that would otherwise be provided in the beneficiaries  
home. This demo would last approx. 3 years in not  
more than 5 sites. Payment for each home health ser-  
vice episode of care will be set at 95% of the amount  
that would otherwise be paid for home health services  
provided entirely in the home.

NOTE: Effective July 5, 2005 for HHA claims.

DB2        ALIAS : CLM\_DEMO\_ID\_NUM  
SAS        ALIAS : DEMONUM  
STANDARD ALIAS : CLM\_DEMO\_ID\_NUM  
TITLE      ALIAS : DEMO\_ID

			LENGTH	:	2
			SOURCE	:	CWF
101. Claim Demonstration Information Text	15	4	18	CHAR	

Effective with Version H, the text field that contains related demo information. For example, a claim involving a CHOICES demo id '05' would contain the MCO plan contract number in the first five positions of this text field.

NOTE: During the Version H conversion this field was populated with data throughout history.

DB2 ALIAS : CLM\_DEMO\_INFO\_TXT  
SAS ALIAS : DEMOTXT  
STANDARD ALIAS : CLM\_DEMO\_INFO\_TXT  
TITLE ALIAS : DEMO\_INFO

LENGTH : 15

DERIVATIONS :  
DERIVATION RULES:  
Demo ID = 01 (RUGS) -- the text field will contain a 2, 3 or 4 to denote the RUGS phase. If RUGS phase is blank or not one of the above the text field will reflect 'INVALID'. NOTE: In Version 'G', RUGS phase was stored in redefined Claim Edit Group, 3rd occurrence, 4th position.

Demo ID = 02 (Home Health demo) -- the text field will contain PROV#. When demo number not equal to 02 then text will reflect 'INVALID'.

Demo ID = 03 (Telemedicine demo) -- text field will contain the HCPCS code. If the required HCPCS is not shown then the text field will reflect 'INVALID'.

Demo ID = 04 (UMWA) -- text field will contain W0 denoting that condition code W0 was present. If condition code W0 not present then the text field will reflect 'INVALID'.

Demo ID = 05 (CHOICES) -- the text field will contain the CHOICES plan number, if both of the following conditions are met: (1) CHOICES plan number

present and PPS or Inpatient claim shows that 1st 3 positions of provider number as '210' and the admission date is within HMO effective/termination date; or non-PPS claim and the from date is within HMO effective/termination date and (2) CHOICES plan number matches the HMO plan number. If either condition is not met the text field will reflect 'INVALID CHOICES PLAN NUMBER'. When CHOICES plan number not present, text will reflect 'INVALID'.

NOTE: In Version 'G', a valid CHOICES plan ID is stored as alpha character in redefined Claim Edit Group, 4th occurrence, 2nd position. If invalid, CHOICES indicator 'ZZ' displayed.

Demo ID = 15 (ESRD Managed Care) -- text field will contain the ESRD/MCO plan number. If ESRD/MCO plan number not present the field will reflect 'INVALID'.

Demo ID = 38 (Physician Encounter Claims) -- text field will contain the MCO plan number. When MCO plan number not present the field will reflect 'INVALID'.

SOURCE : CWF

LIMITATIONS :

REFER TO :  
CHOICES\_DEMO\_LIM

102. Carrier Claim Diagnosis Group  
9 1

9 GRP

The number of claim diagnosis trailers is determined by the carrier claim diagnosis code count.

STANDARD ALIAS : CARR\_CLM\_DGNS\_GRP

OCCURS MIN: 0 OCCURS MAX: 12

DEPENDING ON : DMERC\_CLM\_DGNS\_CD\_J\_CNT

103. NCH Diagnosis Trailer Indicator Code  
1 1

1 CHAR

Effective with Version H, the code indicating the presence of a diagnosis trailer.

NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).

DB2 ALIAS : DGNS\_TRLR\_IND\_CD  
SAS ALIAS : DGNSIND  
STANDARD ALIAS : NCH\_DGNS\_TRLR\_IND\_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH\_DGNS\_TRLR\_IND\_TB

104. Claim Diagnosis Version Code

1 2 2

CHAR

Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9 or ICD-10.

NOTE: With 5010, the diagnosis and procedure codes have been expanded to accommodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2013.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : DVRSNCD

LENGTH : 1

CODE TABLE : CLM\_DGNS\_VRSN\_TB

105. Claim Diagnosis Code

7 3 9

CHAR

The diagnosis code identifying the beneficiary's principal or other diagnosis (including E code).

NOTE:

Prior to Version H, the principal diagnosis code was not stored with the 'OTHER' diagnosis codes. During the Version H conversion the CLM\_PRNCPAL\_DGNS\_CD was added as the first occurrence.

NOTE1: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the

future implementation of ICD-10.

NOTE2: Effective with Version 'J', the diagnosis E codes are stored in a separate trailer (CLM\_DGNS\_E\_GRP).

DB2 ALIAS : CLM\_DGNS\_CD  
SAS ALIAS : DGNS\_CD

LENGTH : 7

EDIT RULES :  
ICD-9-CM

106. DMERC Line Item Group

338 1 338 GRP

The DMERC line item trailer group may occur multiple times in one DMERC claim.

OCCURS MIN: 0 OCCURS MAX: 13

DEPENDING ON : DMERC\_CLM\_LINE\_CNT

107. NCH Line Item Trailer Indicator Code

1 1 1 CHAR

Effective with Version H, the code indicating the presence of a line item trailer on the non-institutional claim.

NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).

DB2 ALIAS : LINE\_TRLR\_IND\_CD  
SAS ALIAS : LINEIND  
STANDARD ALIAS : NCH\_LINE\_TRLR\_IND\_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH\_LINE\_TRLR\_IND\_TB

108. DMERC Line Supplier Provider Number

10 2 11 CHAR

Effective with Version 'G', billing number assigned to the supplier of the Part B service/DMEPOS by

the National Supplier Clearinghouse, as reported on the line item for the DMERC claim.

DB2 ALIAS : SUPLR\_PRVDR\_NUM  
SAS ALIAS : SUPLRNUM  
STANDARD ALIAS : DMERC\_LINE\_SUPLR\_PRVDR\_NUM  
TITLE ALIAS : SUPLR\_NUM

LENGTH : 10

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_SUPLR\_PRVDR\_NUM.

SOURCE : CWF

109. DMERC Line Item Supplier NPI Number  
10 12 21

CHAR

The National Provider Identifier (NPI) assigned to the supplier of the Part B service/DMEPOS line item.

NOTE: Effective May 2007, the NPI will become the national standard identifier for covered health care providers. NPIs will replace the current legacy provider numbers (UPINs, PINs, OSCAR provider numbers, etc.) on the standard HIPPA claim transactions. (During the NPI transition phase (4/3/06 - 5/23/07) the capability was there for the NCH to receive NPIs along with an existing legacy number (UPIN, NPIs OSCAR provider numbers, etc.).

NOTE1: CMS has determined that dual provider identifiers (legacy numbers and NPIs) must be available on the NCH. After the 5/07 NPI implementation, the standard system maintainers will add the legacy number to the claim when it is adjudicated. Effective May 2007, no NEW UPINs will be generated for NEW physicians (Part B and Outpatient claims) so there will only be NPIs sent in to the NCH for those physicians.

COMMON ALIAS : SUPPLIER\_NPI  
DB2 ALIAS : SUPLR\_NPI\_NUM  
SAS ALIAS : SUP\_NPI  
STANDARD ALIAS : DMERC\_LINE\_SUPLR\_NPI\_NUM  
TITLE ALIAS : SUPLR\_NPI

				LENGTH	: 10
				SOURCE	: CWF
110. DMERC Line Pricing State Code	2	22	23	CHAR	
				Prior to Version H this field was named: CWFB_DME_PRCNG_STATE_CD.	
				DB2	ALIAS : DMERC_PRCNG_STATE
				SAS	ALIAS : PRCNG_ST
				STANDARD	ALIAS : DMERC_LINE_PRCNG_STATE_CD
				TITLE	ALIAS : DMERC_PRCNG_STATE_CD
				LENGTH	: 2
				COMMENTS :	
				Prior to Version H this field was named: CWFB_DME_PRCNG_STATE_CD.	
				SOURCE	: CWF/NCH
				CODE TABLE	: GEO_SSA_STATE_TB
111. DMERC Line Pricing Zip Code	9	24	32	CHAR	
				The zip code used to identify where the supply/item was rendered. The pricing state code and the pricing zip code will be used in pricing DMEPOS claims.	
				NOTE: Due to a change in the CWF release schedule, we will not see data in this field until April 2010.	
				DB2	ALIAS : DMERC_PRCNG_ZIP_CD
				SAS	ALIAS : PRCNGZIP
				LENGTH	: 9
				LANGUAGE	: C
112. DMERC Line Beneficiary Mailing State Code	2	33	34	CHAR	
				The state code used to identify the beneficiary's mailing address. This state code may be the same as the pricing state code, but it could be different (e.g. representative payee, temporary address, etc.).	



NOTE1: The pricing state code (existing field) will contain the state code where the supply/item was rendered. The mailing state code (new field) will represent where the beneficiary's MSN is sent.

NOTE2: NOTE: Due to a change in the CWF release schedule, we will not see data in this field until April 2010.

DB2 ALIAS : DMERC\_MLG\_STATE\_CD  
SAS ALIAS : MLGSTATE

LENGTH : 2

LANGUAGE : C

113. DMERC Line Provider State Code  
2 35 36

CHAR

Prior to Version H this field was named:  
CWFB\_DME\_PRVDR\_STATE\_CD.

DB2 ALIAS : DMERC\_PRVDR\_STATE  
SAS ALIAS : PRVSTATE  
STANDARD ALIAS : DMERC\_LINE\_PRVDR\_STATE\_CD  
TITLE ALIAS : DMERC\_PRVDR\_STATE\_CD

LENGTH : 2

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_DME\_PRVDR\_STATE\_CD.

SOURCE : CWF/NCH

CODE TABLE : GEO\_SSA\_STATE\_TB

114. DMERC Line Supplier Type Code  
1 37 37

CHAR

Prior to Version H this field on the DMERC claim was named: CWFB\_PRVDR\_TYPE\_CD.

DB2 ALIAS : SUPLR\_TYPE\_CD  
SAS ALIAS : SUP\_TYPE  
STANDARD ALIAS : DMERC\_LINE\_SUPLR\_TYPE\_CD  
TITLE ALIAS : SUPLR\_TYPE

LENGTH : 1

COMMENTS :  
Prior to Version H this field on the DMERC claim  
was named: CWFB\_PRVDR\_TYPE\_CD.

SOURCE : CWF

CODE TABLE : DMERC\_LINE\_SUPLR\_TYPE\_TB

115. Line Provider Tax Number

10 38 47

CHAR

Social security number or employee  
identification number of physician/supplier  
used to identify to whom payment is made for  
the line item service on the noninstitutional  
claim.

DB2 ALIAS : LINE\_PRVDR\_TAX\_NUM  
SAS ALIAS : TAX\_NUM  
STANDARD ALIAS : LINE\_PRVDR\_TAX\_NUM  
TITLE ALIAS : PRVDR\_TAX\_NUM

LENGTH : 10

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_PRVDR\_TAX\_NUM.

SOURCE : NCH

116. Line HCFA Provider Specialty Code

2 48 49

CHAR

CMS specialty code used for pricing the  
line item service on the noninstitutional  
claim.

DB2 ALIAS : HCFA\_SPCLTY\_CD  
SAS ALIAS : HCFASPCL  
STANDARD ALIAS : LINE\_HCFA\_PRVDR\_SPCLTY\_CD  
TITLE ALIAS : HCFA\_PRVDR\_SPCLTY

LENGTH : 2

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_HCFA\_PRVDR\_SPCLTY\_CD.

SOURCE : CWF

				CODE TABLE	: HCFA_PRVDR_SPCLTY_TB
117. Line Provider Participating Indicator Code	1	50	50	CHAR	
					Code indicating whether or not a provider is participating or accepting assignment for this line item service on the noninstitutional claim.
				DB2	ALIAS : PRVDR_PRTCPTG_CD
				SAS	ALIAS : PRTCPTG
				STANDARD	ALIAS : LINE_PRVDR_PRTCPTG_IND_CD
				TITLE	ALIAS : PRVDR_PRTCPTG_IND
				LENGTH	: 1
				COMMENTS :	
					Prior to Version H this field was named: CWFB_PRVDR_PRTCPTG_IND_CD.
				SOURCE	: CWF
				CODE TABLE	: LINE_PRVDR_PRTCPTG_IND_TB
118. Line Service Count	6	51	56	PACK	
					The count of the total number of services processed for the line item on the non-institutional claim.
				DB2	ALIAS : SRVC_CNT
				SAS	ALIAS : SRVC_CNT
				STANDARD	ALIAS : LINE_SRVC_CNT
				LENGTH	: 7.3 SIGNED : Y
				COMMENTS :	
					Prior to Version H this field was named: CWFB_SRVC_CNT.
					Prior to Version 'J', this field was S9(3) Length: 7.3
				SOURCE	: CWF
119. Line HCFA Type Service Code	1	57	57	CHAR	
					Code indicating the type of service, as defined

in the CMS Medicare Carrier Manual, for this  
line item on the non-institutional claim.

DB2 ALIAS : HCFA\_TYPE\_SRVC\_CD  
SAS ALIAS : TYPESRVCB  
STANDARD ALIAS : LINE\_HCFA\_TYPE\_SRVC\_CD  
TITLE ALIAS : HCFA\_TYPE\_SRVC

LENGTH : 1

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_HCFA\_TYPE\_SRVC\_CD.

SOURCE : CWF

EDIT RULES :  
The only type of service codes applicable to DMERC  
claims are: 1, 9, A, E, G, H, J, K, L, M, P,  
R, and S.

CODE TABLE : CMS\_TYPE\_SRVC\_TB

120. Line Place of Service Code

2 58 59

CHAR

The code indicating the place of service, as  
defined in the Medicare Carrier Manual, for  
this line item on the noninstitutional claim.

COMMON ALIAS : POS  
DB2 ALIAS : LINE\_PLC\_SRVC\_CD  
SAS ALIAS : PLCSRVC  
STANDARD ALIAS : LINE\_PLC\_SRVC\_CD  
TITLE ALIAS : PLC\_SRVC

LENGTH : 2

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_PLC\_SRVC\_CD.

SOURCE : CWF

121. Line First Expense Date

8 60 67

NUM

Beginning date (1st expense) for this line item  
service on the noninstitutional  
claim.

DB2 ALIAS : LINE\_1ST\_EXPNS\_DT  
SAS ALIAS : EXPNSDT1  
STANDARD ALIAS : LINE\_1ST\_EXPNS\_DT  
TITLE ALIAS : 1ST\_EXPNS\_DT

LENGTH : 8 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_1ST\_EXPNS\_DT.

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

122. Line Last Expense Date

8 68 75 NUM

The ending date (last expense) for the line  
item service on the noninstitutional claim.

COBOL ALIAS : LST\_EXP\_DT  
DB2 ALIAS : LINE\_LAST\_EXPNS\_DT  
SAS ALIAS : EXPNSDT2  
STANDARD ALIAS : LINE\_LAST\_EXPNS\_DT  
TITLE ALIAS : LAST\_EXPNS\_DT

LENGTH : 8 SIGNED : N

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_LAST\_EXPNS\_DT.

SOURCE : CWF

EDIT RULES :  
YYYYMMDD

123. Line HCPCS Code

5 76 80 CHAR

The Health Care Common Procedure Coding  
System (HCPCS) is a collection of codes that  
represent procedures, supplies, products and  
services which may be provided to Medicare  
beneficiaries and to individuals enrolled in  
private health insurance programs. The codes  
are divided into three levels, or groups as

described below:

DB2        ALIAS : LINE\_HCPCS\_CD  
SAS        ALIAS : HCPCS\_CD  
STANDARD ALIAS : LINE\_HCPCS\_CD  
TITLE     ALIAS : HCPCS\_CD

LENGTH        : 5

COMMENTS :

Prior to Version H this line item field was named: HCPCS\_CD. With Version H, a prefix was added to denote the location of this field on each claim type (institutional: REV\_CNTR and noninstitutional: LINE).

Level I

Codes and descriptors copyrighted by the American Medical Association's Current Procedural Terminology, Fourth Edition (CPT-4). These are 5 position numeric codes representing physician and nonphysician services.

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

CPT-4 codes including both long and short descriptions shall be used in accordance with the CMS/AMA agreement. Any other use violates the AMA copyright.

Level II

Includes codes and descriptors copyrighted by the American Dental Association's Current Dental Terminology, Fifth Edition (CDT-5). These are 5 position alpha-numeric codes comprising the D series. All other level II codes and descriptors are approved and maintained jointly by the alpha-numeric editorial panel (consisting of CMS, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association). These are 5 position alpha-numeric codes representing primarily items and nonphysician services that are not represented in the level I codes.

Level III

Codes and descriptors developed by Medicare carriers for use at the local (carrier) level. These are 5 position alpha-numeric codes in the W, X, Y or Z series representing physician

and nonphysician services that are not  
represented in the level I or level II codes.

124. Line HCPCS Initial Modifier Code  
2 81

82 CHAR

A first modifier to the HCPCS procedure code  
to enable a more specific procedure  
identification for the line item service  
on the noninstitutional claim.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : MDFR\_CD1  
STANDARD ALIAS : LINE\_HCPCS\_INITL\_MDFR\_CD  
TITLE ALIAS : INITIAL\_MODIFIER

LENGTH : 2

COMMENTS :  
Prior to Version H this field was named:  
HCPCS\_INITL\_MDFR\_CD. With Version H, a prefix  
was added to denote the location of this field  
on each claim type (institutional: REV\_CNTR and  
noninstitutional: LINE).

SOURCE : CWF

EDIT RULES :  
CARRIER INFORMATION FILE

125. Line HCPCS Second Modifier Code  
2 83

84 CHAR

A second modifier to the HCPCS procedure code to  
make it more specific than the first modifier  
code to identify the line item procedures for  
this claim.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : MDFR\_CD2  
STANDARD ALIAS : LINE\_HCPCS\_2ND\_MDFR\_CD  
TITLE ALIAS : SECOND\_MODIFIER

LENGTH : 2

COMMENTS :  
Prior to Version H this field was named:  
HCPCS\_2ND\_MDFR\_CD. With Version H, a prefix

was added to denote the location of this field  
on each claim type (institutional: REV\_CNTR and  
noninstitutional: LINE).

SOURCE : CWF

EDIT RULES :  
CARRIER INFORMATION FILE

126. DMERC Line HCPCS Third Modifier Code  
2 85 86

CHAR

Prior to Version H this field was named:  
HCPCS\_3RD\_MDFR\_CD.

DB2 ALIAS : HCPCS\_3RD\_MDFR\_CD  
SAS ALIAS : MDFR\_CD3  
STANDARD ALIAS : DMERC\_LINE\_HCPCS\_3RD\_MDFR\_CD  
TITLE ALIAS : HCPCS\_3RD\_MDFR

LENGTH : 2

COMMENTS :  
Prior to Version H this field was named:  
HCPCS\_3RD\_MDFR\_CD.

SOURCE : CWF

127. DMERC Line HCPCS Fourth Modifier Code  
2 87 88

CHAR

Prior to Version H this field was named:  
HCPCS\_4TH\_MDFR\_CD.

DB2 ALIAS : HCPCS\_4TH\_MDFR\_CD  
SAS ALIAS : MDFR\_CD4  
STANDARD ALIAS : DMERC\_LINE\_HCPCS\_4TH\_MDFR\_CD  
TITLE ALIAS : HCPCS\_4TH\_MDFR

LENGTH : 2

COMMENTS :  
Prior to Version H this field was named:  
HCPCS\_4TH\_MDFR\_CD.

SOURCE : CWF

128. Line NCH BETOS Code  
3 89 91

CHAR



Effective with Version H, the Berenson-Eggers type of service (BETOS) for the procedure code based on generally agreed upon clinically meaningful groupings of procedures and services. This field is included as a line item on the noninstitutional claim.

NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991).

DB2 ALIAS : LINE\_NCH\_BETOS\_CD  
SAS ALIAS : BETOS  
STANDARD ALIAS : LINE\_NCH\_BETOS\_CD  
TITLE ALIAS : BETOS

LENGTH : 3

DERIVATIONS :  
DERIVED FROM:  
LINE\_HCPCS\_CD  
LINE\_HCPCS\_INITL\_MDFR\_CD  
LINE\_HCPCS\_2ND\_MDFR\_CD  
HCPCS MASTER FILE

DERIVATION RULES:  
Match the HCPCS on the claim to the HCPCS on the HCPCS Master File to obtain the BETOS code.

SOURCE : NCH

CODE TABLE : BETOS\_TB

129. Line IDE Number

7 92 98

CHAR

Effective with Version H, the exemption number assigned by the Food and Drug Administration (FDA) to an investigational device after a manufacturer has been approved by FDA to conduct a clinical trial on that device. HCFA established a new policy of covering certain IDE's which was implemented in claims processing on 10/1/96 (which is NCH weekly process 10/4/96) for service dates beginning 10/1/95.

NOTE: Prior to Version H a dummy line item was created in the last occurrence of line item group to store IDE. The IDE number was housed in two fields: HCPCS code and HCPCS initial modifier;

the second modifier contained the value 'ID'.  
There will be only one distinct IDE number  
reported on the non-institutional claim. During  
the Version H conversion, the IDE was moved from  
the dummy line item to its own dedicated field  
for each line item (i.e., the IDE was repeated  
on all line items on the claim.)

DB2 ALIAS : LINE\_IDE\_NUM  
SAS ALIAS : LINE\_IDE  
STANDARD ALIAS : LINE\_IDE\_NUM  
TITLE ALIAS : IDE\_NUMBER

LENGTH : 7

SOURCE : CWF

130. DMERC Line Not Otherwise Classified HCPCS Code Text

14 99 112 CHAR

Prior to Version H this field was named:  
CWFB\_DME\_ITM\_NOC\_HCPCS\_CD\_TXT.

DB2 ALIAS : NOC\_HCPCS\_CD\_TXT  
SAS ALIAS : NOC\_TXT  
STANDARD ALIAS : DMERC\_LINE\_NOC\_HCPCS\_CD\_TXT  
TITLE ALIAS : NOC\_HCPCS\_TXT

LENGTH : 14

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_DME\_ITM\_NOC\_HCPCS\_CD\_TXT.

SOURCE : CWF

131. Line National Drug Code

11 113 123 CHAR

Effective 1/1/94 on the DMERC claim, the National  
Drug Code identifying the oral anti-cancer drugs.  
Effective with Version H, this line item field was  
added as a placeholder on the carrier claim.

DB2 ALIAS : LINE\_NATL\_DRUG\_CD  
SAS ALIAS : NDC\_CD  
STANDARD ALIAS : LINE\_NATL\_DRUG\_CD  
TITLE ALIAS : NDC\_CD

LENGTH : 11

SOURCE : CWF

132. Line NCH Payment Amount

6 124 129

PACK

Amount of payment made from the trust funds (after deductible and coinsurance amounts have been paid) for the line item service on the non-institutional claim.

COMMON ALIAS : REIMBURSEMENT  
DB2 ALIAS : LINE\_NCH\_PMT\_AMT  
SAS ALIAS : LINEPMT  
STANDARD ALIAS : LINE\_NCH\_PMT\_AMT  
TITLE ALIAS : REIMBURSEMENT

LENGTH : 9.2 SIGNED : Y

COMMENTS :

Prior to Version H this line item field was named: CLM\_PMT\_AMT and the size of this field was S9(7)V99.

SOURCE : NCH

EDIT RULES :

\$\$\$\$\$\$\$\$CC

133. Line Beneficiary Payment Amount

6 130 135

PACK

Effective with Version H, the payment (reimbursement) made to the beneficiary related to the line item service on the noninstitutional claim.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

DB2 ALIAS : LINE\_BENE\_PMT\_AMT  
SAS ALIAS : LBENPMT  
STANDARD ALIAS : LINE\_BENE\_PMT\_AMT  
TITLE ALIAS : BENE\_PMT\_AMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

## 134. Line Provider Payment Amount

6 136 141

PACK

Effective with Version H, the payment made to the provider for the line item service on the noninstitutional claim.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

DB2 ALIAS : LINE\_PRVDR\_PMT\_AMT  
SAS ALIAS : LPRVPMT  
STANDARD ALIAS : LINE\_PRVDR\_PMT\_AMT  
TITLE ALIAS : PRVDR\_PMT\_AMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

## 135. Line Beneficiary Part B Deductible Amount

6 142 147

PACK

The amount of money for which the carrier has determined that the beneficiary is liable for the Part B cash deductible for the line item service on the noninstitutional claim.

DB2 ALIAS : LINE\_DDCTBL\_AMT  
SAS ALIAS : LDEDAMT  
STANDARD ALIAS : LINE\_BENE\_PTB\_DDCTBL\_AMT  
TITLE ALIAS : PTB\_DED\_AMT

LENGTH : 9.2 SIGNED : Y

## COMMENTS :

Prior to Version H this field was named: BENE\_PTB\_DDCTBL\_LBLTY\_AMT and the size of the field was S9(3)V99.

SOURCE : CWF

## EDIT RULES :

\$\$\$\$\$\$\$\$\$CC

## 136. Line Beneficiary Primary Payer Code

1 148 148

CHAR

The code specifying a federal non-Medicare program or other source that has primary responsibility for the payment of the Medicare beneficiary's medical bills relating to the line item service on the noninstitutional claim.

DB2 ALIAS : LINE\_PRMRY\_PYR\_CD  
SAS ALIAS : LPRPAYCD  
STANDARD ALIAS : LINE\_BENE\_PRMRY\_PYR\_CD  
TITLE ALIAS : PRIMARY\_PAYER\_CD

LENGTH : 1

COMMENTS :  
Prior to Version H this field was named:  
BENE\_PRMRY\_PYR\_CD.

SOURCE : CWF,VA,DOL,SSA

CODE TABLE : BENE\_PRMRY\_PYR\_TB

137. Line Beneficiary Primary Payer Paid Amount  
6 149 154

PACK

The amount of a payment made on behalf of a Medicare beneficiary by a primary payer other than Medicare, that the provider is applying to covered Medicare charges for to the line ITEM SERVICE ON THE NONINSTITUTIONAL.

DB2 ALIAS : LINE\_PRMRY\_PYR\_PD  
SAS ALIAS : LPRPDAMT  
STANDARD ALIAS : LINE\_BENE\_PRMRY\_PYR\_PD\_AMT  
TITLE ALIAS : PRMRY\_PYR\_PD

LENGTH : 9.2 SIGNED : Y

COMMENTS :  
Prior to Version H this field was named:  
BENE\_PRMRY\_PYR\_PMY\_AMT and the field size was S9(5)V99.

SOURCE : CWF

EDIT RULES :  
\$\$\$\$\$\$\$\$\$CC

138. Line Coinsurance Amount

6 155 160

PACK

Effective with Version H, the beneficiary coinsurance liability amount for this line item service on the noninstitutional claim.

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

DB2 ALIAS : LINE\_COINSRNC\_AMT  
SAS ALIAS : COINAMT  
STANDARD ALIAS : LINE\_COINSRNC\_AMT  
TITLE ALIAS : COINSRNC\_AMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

139. Line Interest Amount

6 161 166

PACK

Amount of interest to be paid for this line item service on the noninstitutional claim.  
\*\*NOTE: This is not included in the line item NCH payment (reimbursement) amount.

DB2 ALIAS : LINE\_INTRST\_AMT  
SAS ALIAS : LINT\_AMT  
STANDARD ALIAS : LINE\_INTRST\_AMT  
TITLE ALIAS : INTRST\_AMT

LENGTH : 9.2 SIGNED : Y

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_INTRST\_AMT and the field size was  
S9(5)V99.

SOURCE : CWF

EDIT RULES :  
\$\$\$\$\$\$\$\$\$CC

140. Line Primary Payer Allowed Charge Amount

6 167 172

PACK

Effective with Version H, the primary payer allowed charge amount for the line item service on the noninstitutional claim.

NOTE: Beginning with NCH weekly process date  
10/3/97 this field was populated with data.  
Claims processed prior to 10/3/97 will contain  
zeroes in this field.

DB2 ALIAS : PRMRY\_PYR\_ALOW\_AMT  
SAS ALIAS : PRPYALOW  
STANDARD ALIAS : LINE\_PRMRY\_PYR\_ALOW\_CHRG\_AMT  
TITLE ALIAS : PRMRY\_PYR\_ALOW\_CHRG

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

141. Line 10% Penalty Reduction Amount  
6 173 178

PACK

Effective with Version H, the 10% payment  
reduction amount (applicable to a late  
filing claim) for the line item service.  
on the noninstitutional claim.

DB2 ALIAS : TENPCT\_PNLTY\_AMT  
SAS ALIAS : PNLTYAMT  
STANDARD ALIAS : LINE\_10PCT\_PNLTY\_RDCTN\_AMT  
TITLE ALIAS : TENPCT\_PNLTY

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

142. Line Submitted Charge Amount  
6 179 184

PACK

The amount of submitted charges for the line  
item service on the noninstitutional claim.

DB2 ALIAS : LINE\_SBM\_T\_CHRG\_AMT  
SAS ALIAS : LSBMTCHG  
STANDARD ALIAS : LINE\_SBM\_T\_CHRG\_AMT  
TITLE ALIAS : SBMT\_CHRG

LENGTH : 9.2 SIGNED : Y

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_SBM\_T\_CHRG\_AMT and the field size was  
S9(5)V99.

SOURCE : CWF

EDIT RULES :  
\$\$\$\$\$\$\$\$CC

143. Line Allowed Charge Amount

6 185 190

PACK

The amount of allowed charges for the line item service on the noninstitutional claim. This charge is used to compute pay to providers or reimbursement to beneficiaries. \*\*NOTE: The

Note1: The amount includes beneficiary-paid amounts (i.e., deductible and coinsurance).

Note2: The allowed charge is determined by the lower of three charges: prevailing, customary or actual.

DB2 ALIAS : LINE\_ALLOW\_CHRG\_AMT  
SAS ALIAS : LALOWCHG  
STANDARD ALIAS : LINE\_ALLOW\_CHRG\_AMT  
TITLE ALIAS : ALLOW\_CHRG

LENGTH : 9.2 SIGNED : Y

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_ALLOW\_CHRG\_AMT and the field size was  
S9(5)V99.

SOURCE : CWF

EDIT RULES :  
\$\$\$\$\$\$\$\$CC

144. DMERC Line Screen Savings Amount

6 191 196

PACK

Prior to Version H this field was named:  
CWFB\_DME\_SCRN\_SVGS\_AMT and the field size was  
S9(5)V99.

DB2 ALIAS : LINE\_SCRN\_SVGS\_AMT  
SAS ALIAS : SCRNSVGS  
STANDARD ALIAS : DMERC\_LINE\_SCRN\_SVGS\_AMT  
TITLE ALIAS : SCRN\_SVGS

LENGTH : 9.2 SIGNED : Y



COMMENTS :  
Prior to Version H this field was named:  
CWFB\_DME\_SCRN\_SVGS\_AMT and the field size was  
S9(5)V99.

SOURCE : CWF

145. Line DME Purchase Price Amount  
6 197 202

PACK

Effective 5/92, the amount representing the  
lower of fee schedule for purchase of new or  
used DME, or actual charge. In case of rental  
DME, this amount represents the purchase cap;  
rental payments can only be made until the  
cap is met. This line item field is applicable  
to non-institutional claims involving DME,  
prosthetic, orthotic and supply items,  
immunosuppressive drugs, pen, ESRD and oxygen  
items referred to as DMEPOS.

DB2 ALIAS : DME\_PURC\_PRICE\_AMT  
SAS ALIAS : DME\_PURC  
STANDARD ALIAS : LINE\_DME\_PURC\_PRICE\_AMT  
TITLE ALIAS : DME\_PURC\_PRICE

LENGTH : 9.2 SIGNED : Y

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_DME\_PURC\_PRICE\_AMT and the field size  
was S9(5)V99.

SOURCE : CWF

EDIT RULES :  
\$\$\$\$\$\$\$\$\$CC

146. Line Processing Indicator Code  
2 203 204

CHAR

The code on a noninstitutional claim indicating to  
whom payment was made or if the claim was denied.

NOTE1: Effective 4/1/02, this field was expanded  
to two bytes to accommodate new values. The  
NCH Nearline file did not expand the current  
1-byte field but instituted a crosswalk of the  
2-byte field to the 1-byte character value.

See table of code for the crosswalk.

NOTE2: Effective with Version 'J', the field has been expanded on the NCH record to 2 bytes, With this expansion, the NCH will no longer use the character values to represent the official two byte values sent in by CWF since 4/2002. During the Version J conversion, all character values were converted to the two byte values.

DB2 ALIAS : LINE\_PRCSG\_IND\_CD  
SAS ALIAS : PRCNGIND  
STANDARD ALIAS : LINE\_PRCSG\_IND\_CD

LENGTH : 2

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_PRCSG\_IND\_CD.

SOURCE : CWF

CODE TABLE : LINE\_PRCSG\_IND\_TB

147. Line Payment 80%/100% Code  
1 205 205

CHAR

The code indicating that the amount shown in the payment field on the noninstitutional line item represents either 80% or 100% of the allowed charges less any deductible, or 100% limitation of liability only.

COMMON ALIAS : REIMBURSEMENT\_IND  
DB2 ALIAS : LINE\_PMT\_80\_100\_CD  
SAS ALIAS : PMTINDSW  
STANDARD ALIAS : LINE\_PMT\_80\_100\_CD  
TITLE ALIAS : REINBURSEMENT\_IND

LENGTH : 1

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_PMT\_80\_100\_CD.

SOURCE : CWF

148. Line Service Deductible Indicator Switch  
1 206 206

CHAR

Switch indicating whether or not the line item service on the noninstitutional claim is subject to a deductible.

DB2 ALIAS : SRVC\_DDCTBL\_SW  
SAS ALIAS : DED\_SW  
STANDARD ALIAS : LINE\_SRVC\_DDCTBL\_IND\_SW  
TITLE ALIAS : SRVC\_DED\_IND

LENGTH : 1

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_SRVC\_DDCTBL\_IND\_SW.

SOURCE : CWF

CODE TABLE : LINE\_SRVC\_DDCTBL\_IND\_TB

149. Line Payment Indicator Code  
1 207 207

CHAR

Code that indicates the payment screen used to determine the allowed charge for the line item service on the noninstitutional claim.

DB2 ALIAS : LINE\_PMT\_IND\_CD  
SAS ALIAS : PMTINDCD  
STANDARD ALIAS : LINE\_PMT\_IND\_CD  
TITLE ALIAS : PMT\_IND

LENGTH : 1

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_PMT\_IND\_CD.

SOURCE : CWF

150. DMERC Line Miles/Time/Units/Services Count  
6 208 213

PACK

The count of the total units associated with the DMERC line item service needing unit reporting, including number of services, volume of oxygen and drug dose.

DB2 ALIAS : DMERC\_MTUS\_CNT  
SAS ALIAS : DME\_UNIT  
STANDARD ALIAS : DMERC\_LINE\_MTUS\_CNT

TITLE ALIAS : MTUS\_CNT  
LENGTH : 7.3 SIGNED : Y  
COMMENTS :  
Prior to Version H this field was named:  
CWFB\_MTUS\_CNT.  
Prior to Version 'J', this field was S9(3)  
Length: 7.3

151. DMERC Line Miles/Time/Units/Services Indicator Code  
1 214 214 CHAR

Prior to Version H this field was named:  
CWFB\_DME\_MTUS\_IND\_CD.  
DB2 ALIAS : DMERC\_MTUS\_IND\_CD  
SAS ALIAS : UNIT\_IND  
STANDARD ALIAS : DMERC\_LINE\_MTUS\_IND\_CD  
TITLE ALIAS : MTUS\_IND  
LENGTH : 1  
COMMENTS :  
Prior to Version H this field was named:  
CWFB\_DME\_MTUS\_IND\_CD.  
SOURCE : CWF  
CODE TABLE : DMERC\_LINE\_MTUS\_IND\_TB

152. Line Diagnosis Code Group  
8 215 222 GRP

Effective with Version 'J', the group used to  
identify the diagnosis codes at the line level.  
This group contains the diagnosis code and the  
diagnosis version code.  
STANDARD ALIAS : LINE\_DGNS\_CD\_GRP

153. Line Diagnosis Version Code  
1 215 215 CHAR

Effective with Version 'J', the code used to indicate if the  
diagnosis code is ICD-9 or ICD-10.  
NOTE: With 5010, the diagnosis and procedure codes have

been expanded to accomodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2013.

DB2 ALIAS : UNDEFINED  
SAS ALIAS : LDVRSNCD

LENGTH : 1

CODE TABLE : LINE\_DGNS\_VRSN\_TB

154. Line Diagnosis Code

7 216 222 CHAR

The code indicating the diagnosis supporting this line item procedure/service on the noninstitutional claim.

DB2 ALIAS : LINE\_DGNS\_CD  
SAS ALIAS : LINEDGNS  
STANDARD ALIAS : LINE\_DGNS\_CD  
TITLE ALIAS : DGNS\_CD

LENGTH : 7

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_LINE\_DGNS\_CD.

SOURCE : CWF

155. Line Additional Claim Documentation Indicator Code

1 223 223 CHAR

Effective 5/92, the code indicating additional claim documentation was submitted for this line item service on the noninstitutional claim.

COMMON ALIAS : DOCUMENT\_IND  
DB2 ALIAS : ADDTNL\_DCMTN\_CD  
SAS ALIAS : DCMTN\_CD  
STANDARD ALIAS : LINE\_ADDTNL\_CLM\_DCMTN\_IND\_CD  
TITLE ALIAS : ADDTNL\_DCMTN\_IND

LENGTH : 1

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_ADDTNL\_CLM\_DCMTN\_IND\_CD.

SOURCE : CWF

EDIT RULES :  
In any case where more than one value is  
applicable, highest number is shown.

CODE TABLE : LINE\_ADDTNL\_CLM\_DCMTN\_IND\_TB

156. DMERC Line Screen Suspension Indicator Code  
4 224 227

CHAR

Effective with Version G, the code identifying  
the medical review (MR) screen that caused DMERC  
line item to suspend.

DB2 ALIAS : SCR\_N\_SUSPNSN\_CD  
SAS ALIAS : SUSP\_IND  
STANDARD ALIAS : DMERC\_LINE\_SCRN\_SUSPNSN\_IND\_CD  
TITLE ALIAS : SCR\_N\_SUSPNSN\_IND

LENGTH : 4

SOURCE : CWF

CODE TABLE : DMERC\_LINE\_SCRN\_SUSPNSN\_IND\_TB

157. DMERC Line Screen Result Indicator Code  
1 228 228

CHAR

Effective with Version G, code indicating the  
outcome of the medical review (MR) unit's evaluation  
of the DMERC line item.

DB2 ALIAS : SCR\_N\_RSLT\_IND\_CD  
SAS ALIAS : RSLT\_IND  
STANDARD ALIAS : DMERC\_LINE\_SCRN\_RSLT\_IND\_CD  
TITLE ALIAS : SCR\_N\_RSLT\_IND

LENGTH : 1

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_DME\_SCRN\_RSLT\_IND\_CD.

SOURCE : CWF

CODE TABLE : DMERC\_LINE\_SCRN\_RSLT\_IND\_TB

158. DMERC Line Waiver Of Provider Liability Switch  
1 229 229

CHAR

Effective with Version G, the switch indicating the beneficiary was notified that the item, reported as a DMERC line item, may not be considered medically necessary and has agreed in writing to pay for the item.

DB2 ALIAS : WVR\_PRVDR\_LBLTY\_SW  
SAS ALIAS : WAIVERSW  
STANDARD ALIAS : DMERC\_LINE\_WVR\_PRVDR\_LBLTY\_SW  
TITLE ALIAS : WAIVER\_LBLTY\_SW

LENGTH : 1

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_DME\_WVR\_PRVDR\_LBLTY\_SW.

SOURCE : CWF

CODE TABLE : YES\_NO\_TB

159. DMERC Line Decision Indicator Switch  
1 230 230

CHAR

Effective with Version G, the switch identifying whether the DMERC claim represents an original decision or a reversal of an earlier decision on the original claim.

DB2 ALIAS : DMERC\_DCSN\_IND\_SW  
SAS ALIAS : DCSN\_IND  
STANDARD ALIAS : DMERC\_LINE\_DCSN\_IND\_SW  
TITLE ALIAS : DCSN\_IND

LENGTH : 1

COMMENTS :  
Prior to Version H this field was named:  
CWFB\_DME\_DCSN\_IND\_SW.

SOURCE : CWF

CODE TABLE : DMERC\_LINE\_DCSN\_IND\_TB

160. Line Consolidated Billing Indicator Code  
1 231 231

CHAR

Effective 1/1/2004 with implementation of NCH/NMUD CR#1, this code is reflected on carrier & DMERC claims to identify those line item services (i.e. therapy

and nonroutine supply services) that are subject to SNF and Home Health consolidated billing. If the line item service was paid by a carrier prior to the submission of the SNF or home health claim an adjustment for the carrier or DMERC claim will be submitted identifying those services that are subject to consolidated billing.

NOTE1: Prior to 10/2005 (implementation of NCH/NMUD CR#2), this data was stored in position 245 (FILLER) of the line item trailer.

Effective July 2005, this data will no longer be coming into the NCH.

DB2 ALIAS : CNSLDTD\_BLG\_CD  
SAS ALIAS : LCNSLDTD  
STANDARD ALIAS : LINE\_CNSLDTD\_BLG\_CD

LENGTH : 1

CODE TABLE : LINE\_CNSLDTD\_BLG\_TB

161. Line Duplicate Claim Check Indicator Code  
1 232 232

CHAR

Effective 1/1/2004 with the implementation of NCH/NMUD CR#1, the code used to identify an item or service that appeared to be a duplicate but has been reviewed by a carrier and appropriately approved for payment.

NOTE1: Prior to 10/2005 (implementation of NCH/NMUD CR#2), this data was stored in position 246 (FILLER) on the line item trailer.

DB2 ALIAS : DUP\_CLM\_CHK\_IND\_CD  
SAS ALIAS : DUP\_CHK  
STANDARD ALIAS : LINE\_DUP\_CLM\_CHK\_IND\_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : LINE\_DUP\_CLM\_CHK\_IND\_TB

162. Line Hematocrit/Hemoglobin Test Type Code  
2 233 234

CHAR

Effective September 1, 2008 with the implementation of CR#3, the code used to identify which reading is



reflected in the hematocrit/hemoglobin result number field on the noninstitutional claim.

DB2 ALIAS : HCT\_HGB\_TYPE\_CD  
SAS ALIAS : HTYPECD  
STANDARD ALIAS : LINE\_HCT\_HGB\_TYPE\_CD

LENGTH : 2

CODE TABLE : LINE\_HCT\_HGB\_TYPE\_TB

163. Line Hematocrit/Hemoglobin Result Number  
3 235 237

CHAR

Effective September 1, 2008, with the implementation of CR#3, the number used to identify the most recent hematocrit or hemoglobin reading on the noninstitutional claim.

NOTE: The hematocrit/hemoglobin test result field is a redefined field. The field is being defined as X(3) and redefined as numeric (99V9). A numeric test on the alphanumeric field is needed. Whenever a user wants to use the field they must test the alphanumeric field for numerics and if it is numeric then the 99V9 definition would be used. The older data will cause an abend if trying to process numeric data with characters.

DB2 ALIAS : HCT\_HGB\_RSLT\_NUM  
SAS ALIAS : HRSLTNUM  
STANDARD ALIAS : LINE\_HCT\_HGB\_RSLT\_NUM

LENGTH : 3

164. Line Hematocrit/Hemoglobin Result Number -- Redefined  
3 235 237 NUM

Effective September 1, 2008, with the implementation of CR#3, the number used to identify the most recent hematocrit or hemoglobin reading on the noninstitutional claim.

NOTE: The hematocrit/hemoglobin test result field is a redefined field. The field is being defined as X(3) and redefined as numeric (99V9). A numeric test on the alphanumeric field is needed. Whenever a user wants to use the field they must test the alphanumeric field for numerics and if it is numeric then the 99V9 definition would be used. The older data will cause an abend if trying to process numeric data with characters.

				DB2	ALIAS : HCT_HGB_RSLT_NUM
				SAS	ALIAS : HRLSTNUM
				STANDARD	ALIAS : LINE_HCT_HGB_RSLT_NUM_R
				LENGTH	: 2.1 SIGNED : N
				REDEFINE	: LINE_HCT_HGB_RSLT_NUM
165. Worker's Compensation Indicator Code	1	238	238	CHAR	
					This indicator is used to determine whether the diagnosis codes on the claims are related to the diagnosis codes on the MSP auxiliary file in CWF.
				DB2	ALIAS : LINE_WC_IND_CD
				SAS	ALIAS : WCINDCD
				LENGTH	: 1
				CODE TABLE	: LINE_WC_IND_TB
				LANGUAGE	: C
166. FILLER	100	239	338	CHAR	
				DB2	ALIAS : FILLER
				LENGTH	: 100
167. End of Record Code	3	1	3	CHAR	
					Effective with Version 'I', the code used to identify the end of a record/segment or the end of the claim.
				DB2	ALIAS : END_REC_CD
				SAS	ALIAS : EOR
				STANDARD	ALIAS : END_REC_CD
				TITLE	ALIAS : END_OF_REC
				LENGTH	: 3
				COMMENTS	:
					Prior to Version I this field was named: END_REC_CNSTNT.

SOURCE : NCH  
CODE TABLE : END\_REC\_TB

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H3PM.R\_RIF\_MAIN\_Q,Q1,F

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LIMITATIONS APPENDIX FOR RECORD: DMERC\_CLM\_REC  
AS OF: 06/29/2011

CHOICES\_DEMO\_LIM

FULL NAME: Choices Demonstration Limitation

DESCRIPTION :

A programming error created an 'INVALID' indication  
in the demo text field for CHOICES claims.

BACKGROUND :

In 6/00, the CWFMQA front-end editing revealed that some  
CHOICES demo claims were coming in with a valid 'H'  
number in the fixed portion of the claims, but in the  
first occurrence MCO trailer a numeric packed field  
(value hex '0100000C') was moved to the MCO Contract  
Number/Option Code fields. This created an invalid  
period check of number/code to MCO effective date,  
resulting in an INVALID indication in the demo info  
text field.

CORRECTIVE ACTION :

The problem was forwarded to the CWF BSOG staff  
for further investigation.

SOURCE:

CONTACT : OIS/EDG/DMUDD

PMT\_AMT\_EXCEDG\_CHRG\_AMT\_LIM

FULL NAME: Claim Payment Amount Exceeding Total Charge Amount Limitation

DESCRIPTION :

Approximately 75 Inpatient claims had a reimbursement  
amount exceed \$500,000 which was at least 25 times  
the total charge amount. There were also claims where  
the reimbursement was less than \$500,000 but greater  
than the total charges.

BACKGROUND :

In November of 1999, it was brought to the attention  
of the HDUG that large reimbursement amounts were  
being paid in Pennsylvania. There were 75 inpatient  
claims provided where the reimbursement amount was  
over \$500,000 and at least 25 times the total charge  
amount. These claims were processed between 9/29/98

and 10/1/98. There were also claims identified with reimbursement less than \$500,000 but greater than total charge. It was later discovered that the source of the problem was an error in entering an MSA; the decimal point was off by 2 positions.

Because there were no changes in utilization, the claims were corrected and the correct payments distributed, but the new payment amounts were never sent to CWF (not in NCH). There is currently no requirement that FIs and carriers update CWF with final payment information by submitting payment only adjustments. It was noted that there is no expectation that CWF will have final payment information for claims.

CORRECTIVE ACTION :

According to Veritus (FI), the problem was caught in their system using a pre-payment edit prior to sending out the payments. The erroneous MSA value was corrected and the claims were then sent to PRICER again and paid correctly.

The claims were corrected and correct payments were made but these new payment amounts were never sent to CWF and are not reflected in the NCH.

SOURCE:

CONTACT                      OIS/EDG/DMUDD

06/29/2011

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H3PM.R\_RIF\_LIM\_Q,F