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CMS RIF REPORT  
AS OF: 08/01/2011

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 : UTLCARRI
				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	
				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

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
				CODE TABLE	: CARR_CLM_ENTRY_TB
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 : 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\_OVRRD\_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. Claim Paperwork (PWK) Code

2 314 315 CHAR

Effective with CR#6, the code used to indicate a provider has submitted an electronic claim that requires additional documentation.

DB2 ALIAS : CLM\_PWK\_CD

STANDARD ALIAS : CLM\_PWK\_CD

LENGTH : 2

CODE TABLE : CLM\_PWK\_TB

76. FILLER

48 316 363 CHAR

				DB2	ALIAS : FILLER
				LENGTH	: 48
77.	Carrier Specific Group	84	364	447	GRP
					This group identifies those fields specific to the carrier claim record.
					STANDARD ALIAS : CARR_SPECFC_GRP
78.	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
79.	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

80. 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

81. 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

82. 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

83. FILLER

50 398 447

CHAR

DB2 ALIAS : FILLER

LENGTH : 50

84. 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

85. 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

86. 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

87. 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	
88.	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	
89.	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
90.	FILLER	4	458	461	CHAR
				DB2	ALIAS : FILLER
				LENGTH	: 4
91.	Carrier Claim Variable Group				
	VAR	462	6591		GRP
				STANDARD ALIAS :	CARR_CLM_VAR_GRP
92.	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
93.	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

94. 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

95. 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

96. 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
97. 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
98. 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	
99. 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

100. 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

101. 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
102. 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
103. 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	
104. 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				
105. 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				

106. 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

107. 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

108. 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

109. 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

110. 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

111. 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
112. 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
113. 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	
114. Carrier Line Item Group	420	1	420	GRP	
				STANDARD ALIAS :	CARR_LINE_GRP
				OCCURS MIN:	1OCCURS MAX: 13
				DEPENDING ON :	CARR_CLM_LINE_CNT
115. 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
116. 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
117. 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
118. 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
119. 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

120. 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

121. 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

122. 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

123. 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

124. 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 : 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 : CMS\_PRVDR\_SPCLTY\_TB

125. 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

126. 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

127. 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

128. 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

129. 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 : TYPSTRVCB  
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

130. 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 : PTYPE\_SRV  
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

131. 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

132. 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

133. 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

134. 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

135. 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.

136. 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

137. 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

138. 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

139. 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

140. 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

141. 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

142. 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

143. 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

144. Line Beneficiary Payment Amount  
6 135 140

PACK

Effective with Version H, the payment (reim-  
bursement) made to the beneficiary related  
to the line item service on the noninstitu-  
tional 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

145. 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

146. 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

147. 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

148. 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

149. 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

150. 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

151. 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

152. 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\_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

153. 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

154. 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

155. 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

156. 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

157. 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

158. 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

159. 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

160. 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

CODE TABLE : LINE\_PMT\_80\_100\_TB

161. 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

162. 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

163. 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.

164. 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

165. 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

166. 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

## 167. 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

## 168. 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

## 169. 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

170. 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

171. 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 receive CMN transaction from CWF.

EDIT RULES :  
YYYYMMDD

172. 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

173. 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.

174. 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

175. 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

176. 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

177. 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

178. 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

179. Carrier Line RX Number

30 285 314

CHAR

The number used to identify the prescription order number for drugs and biologicals purchased through the competitive acquisition program (CAP).

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.

NOTE2: Eventhough this field was implemented with NCH/NMUD CR#2, data will not be coming in until 1/1/2006.

DB2 ALIAS : CARR\_LINE\_RX\_NUM  
SAS ALIAS : RX\_NUM  
STANDARD ALIAS : CARR\_LINE\_RX\_NUM

LENGTH : 30

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)

SOURCE : CWF

LIMITATIONS :

REFER TO :  
CARR\_LINE\_RX\_NUM\_LIM

180. 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

181. 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

182. 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

183. 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

184. Line Paperwork (PWK) Code

2 321 322

CHAR

Effective with CR#6, the code used to indicate a provider has submitted an electronic claim that requires additional documentation.

DB2 ALIAS : LINE\_PWK\_CD  
STANDARD ALIAS : LINE\_PWK\_CD

LENGTH : 2

CODE TABLE : LINE\_PWK\_TB

185. FILLER

98 323 420

CHAR

DB2 ALIAS : FILLER

LENGTH : 98

186. 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

TABLE OF CODES APPENDIX  
FROM CA REPOSITORY RIF REPORT

CARR\_CLM\_REC

BENE\_CWF\_LOC\_TB

Beneficiary Common Working File Location Table

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



J = Pacific

BENE\_IDENT\_TB

Beneficiary Identification Code (BIC) Table

Social Security Administration:

A = Primary claimant  
B = Aged wife, age 62 or over (1st claimant)  
B1 = Aged husband, age 62 or over (1st claimant)  
B2 = Young wife, with a child in her care (1st claimant)  
B3 = Aged wife (2nd claimant)  
B4 = Aged husband (2nd claimant)  
B5 = Young wife (2nd claimant)  
B6 = Divorced wife, age 62 or over (1st claimant)  
B7 = Young wife (3rd claimant)  
B8 = Aged wife (3rd claimant)  
B9 = Divorced wife (2nd claimant)  
BA = Aged wife (4th claimant)  
BD = Aged wife (5th claimant)  
BG = Aged husband (3rd claimant)  
BH = Aged husband (4th claimant)  
BJ = Aged husband (5th claimant)  
BK = Young wife (4th claimant)  
BL = Young wife (5th claimant)  
BN = Divorced wife (3rd claimant)  
BP = Divorced wife (4th claimant)  
BQ = Divorced wife (5th claimant)  
BR = Divorced husband (1st claimant)  
BT = Divorced husband (2nd claimant)  
BW = Young husband (2nd claimant)  
BY = Young husband (1st claimant)  
C1-C9,CA-CZ = Child (includes minor, student or disabled child)  
D = Aged widow, 60 or over (1st claimant)  
D1 = Aged widower, age 60 or over (1st claimant)  
D2 = Aged widow (2nd claimant)  
D3 = Aged widower (2nd claimant)  
D4 = Widow (remarried after attainment of age 60) (1st claimant)  
D5 = Widower (remarried after attainment of age 60) (1st claimant)  
D6 = Surviving divorced wife, age 60 or over (1st claimant)

D7 = Surviving divorced wife (2nd claimant)  
D8 = Aged widow (3rd claimant)  
D9 = Remarried widow (2nd claimant)  
DA = Remarried widow (3rd claimant)  
DD = Aged widow (4th claimant)  
DG = Aged widow (5th claimant)  
DH = Aged widower (3rd claimant)  
DJ = Aged widower (4th claimant)  
DK = Aged widower (5th claimant)  
DL = Remarried widow (4th claimant)  
DM = Surviving divorced husband (2nd  
claimant)  
DN = Remarried widow (5th claimant)  
DP = Remarried widower (2nd claimant)  
DQ = Remarried widower (3rd claimant)  
DR = Remarried widower (4th claimant)  
DS = Surviving divorced husband (3rd  
claimant)  
DT = Remarried widower (5th claimant)  
DV = Surviving divorced wife (3rd claimant)  
DW = Surviving divorced wife (4th claimant)  
DX = Surviving divorced husband (4th  
claimant)  
DY = Surviving divorced wife (5th claimant)  
DZ = Surviving divorced husband (5th  
claimant)  
E = Mother (widow) (1st claimant)  
E1 = Surviving divorced mother (1st  
claimant)  
E2 = Mother (widow) (2nd claimant)  
E3 = Surviving divorced mother (2nd  
claimant)  
E4 = Father (widower) (1st claimant)  
E5 = Surviving divorced father (widower)  
(1st claimant)  
E6 = Father (widower) (2nd claimant)  
E7 = Mother (widow) (3rd claimant)  
E8 = Mother (widow) (4th claimant)  
E9 = Surviving divorced father (widower)  
(2nd claimant)  
EA = Mother (widow) (5th claimant)  
EB = Surviving divorced mother (3rd  
claimant)  
EC = Surviving divorced mother (4th  
claimant)  
ED = Surviving divorced mother (5th  
claimant)  
EF = Father (widower) (3rd claimant)  
EG = Father (widower) (4th claimant)  
EH = Father (widower) (5th claimant)

EJ = Surviving divorced father (3rd claimant)  
EK = Surviving divorced father (4th claimant)  
EM = Surviving divorced father (5th claimant)  
F1 = Father  
F2 = Mother  
F3 = Stepfather  
F4 = Stepmother  
F5 = Adopting father  
F6 = Adopting mother  
F7 = Second alleged father  
F8 = Second alleged mother  
J1 = Primary prouty entitled to HIB (less than 3 Q.C.) (general fund)  
J2 = Primary prouty entitled to HIB (over 2 Q.C.) (RSI trust fund)  
J3 = Primary prouty not entitled to HIB (less than 3 Q.C.) (general fund)  
J4 = Primary prouty not entitled to HIB (over 2 Q.C.) (RSI trust fund)  
K1 = Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (1st claimant)  
K2 = Prouty wife entitled to HIB (over 2 Q.C.) (RSI trust fund) (1st claimant)  
K3 = Prouty wife not entitled to HIB (less than 3 Q.C.) (general fund) (1st claimant)  
K4 = Prouty wife not entitled to HIB (over 2 Q.C.) (RSI trust fund) (1st claimant)  
K5 = Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (2nd claimant)  
K6 = Prouty wife entitled to HIB (over 2 Q.C.) (RSI trust fund) (2nd claimant)  
K7 = Prouty wife not entitled to HIB (less than 3 Q.C.) (general fund) (2nd claimant)  
K8 = Prouty wife not entitled to HIB (over 2 Q.C.) (RSI trust fund) (2nd claimant)  
K9 = Prouty wife entitled to HIB (less than 3 Q.C.) (general fund) (3rd claimant)  
KA = Prouty wife entitled to HIB (over 2 Q.C.) (RSI trust fund) (3rd claimant)  
KB = Prouty wife not entitled to HIB (less than 3 Q.C.) (general fund) (3rd claimant)  
KC = Prouty wife not entitled to HIB (over

2 Q.C.) (RSI trust fund) (3rd  
 claimant)  
 KD = Prouty wife entitled to HIB (less than  
 3 Q.C.) (general fund) (4th claimant)  
 KE = Prouty wife entitled to HIB (over 2 Q.C.  
 (4th claimant)  
 KF = Prouty wife not entitled to HIB (less  
 than 3 Q.C.) (4th claimant)  
 KG = Prouty wife not entitled to HIB (over  
 2 Q.C.) (4th claimant)  
 KH = Prouty wife entitled to HIB (less than  
 3 Q.C.) (5th claimant)  
 KJ = Prouty wife entitled to HIB (over 2  
 Q.C.) (5th claimant)  
 KL = Prouty wife not entitled to HIB (less  
 than 3 Q.C.) (5th claimant)  
 KM = Prouty wife not entitled to HIB (over  
 2 Q.C.) (5th claimant)  
 M = Uninsured-not qualified for deemed HIB  
 M1 = Uninsured-qualified but refused HIB  
 T = Uninsured-entitled to HIB under deemed  
 or renal provisions  
 TA = MQGE (primary claimant)  
 TB = MQGE aged spouse (first claimant)  
 TC = MQGE disabled adult child (first claimant)  
 TD = MQGE aged widow(er) (first claimant)  
 TE = MQGE young widow(er) (first claimant)  
 TF = MQGE parent (male)  
 TG = MQGE aged spouse (second claimant)  
 TH = MQGE aged spouse (third claimant)  
 TJ = MQGE aged spouse (fourth claimant)  
 TK = MQGE aged spouse (fifth claimant)  
 TL = MQGE aged widow(er) (second claimant)  
 TM = MQGE aged widow(er) (third claimant)  
 TN = MQGE aged widow(er) (fourth claimant)  
 TP = MQGE aged widow(er) (fifth claimant)  
 TQ = MQGE parent (female)  
 TR = MQGE young widow(er) (second claimant)  
 TS = MQGE young widow(er) (third claimant)  
 TT = MQGE young widow(er) (fourth claimant)  
 TU = MQGE young widow(er) (fifth claimant)  
 TV = MQGE disabled widow(er) fifth claimant  
 TW = MQGE disabled widow(er) first claimant  
 TX = MQGE disabled widow(er) second claimant  
 TY = MQGE disabled widow(er) third claimant  
 TZ = MQGE disabled widow(er) fourth claimant  
 T2-T9 = Disabled child (second to ninth  
 claimant)  
 W = Disabled widow, age 50 or over (1st  
 claimant)

W1 = Disabled widower, age 50 or over (1st claimant)  
W2 = Disabled widow (2nd claimant)  
W3 = Disabled widower (2nd claimant)  
W4 = Disabled widow (3rd claimant)  
W5 = Disabled widower (3rd claimant)  
W6 = Disabled surviving divorced wife (1st claimant)  
W7 = Disabled surviving divorced wife (2nd claimant)  
W8 = Disabled surviving divorced wife (3rd claimant)  
W9 = Disabled widow (4th claimant)  
WB = Disabled widower (4th claimant)  
WC = Disabled surviving divorced wife (4th claimant)  
WF = Disabled widow (5th claimant)  
WG = Disabled widower (5th claimant)  
WJ = Disabled surviving divorced wife (5th claimant)  
WR = Disabled surviving divorced husband (1st claimant)  
WT = Disabled surviving divorced husband (2nd claimant)

Railroad Retirement Board:

NOTE:

Employee: a Medicare beneficiary who is still working or a worker who died before retirement

Annuitant: a person who retired under the railroad retirement act on or after 03/01/37

Pensioner: a person who retired prior to 03/01/37 and was included in the railroad retirement act

10 = Retirement - employee or annuitant  
80 = RR pensioner (age or disability)  
14 = Spouse of RR employee or annuitant (husband or wife)  
84 = Spouse of RR pensioner  
43 = Child of RR employee  
13 = Child of RR annuitant  
17 = Disabled adult child of RR annuitant  
46 = Widow/widower of RR employee  
16 = Widow/widower of RR annuitant  
86 = Widow/widower of RR pensioner  
43 = Widow of employee with a child in her care

13 = Widow of annuitant with a child in her care  
83 = Widow of pensioner with a child in her care  
45 = Parent of employee  
15 = Parent of annuitant  
85 = Parent of pensioner  
11 = Survivor joint annuitant  
(reduced benefits taken to insure benefits  
for surviving spouse)

BENE\_MDCR\_STUS\_TB

CWF Beneficiary Medicare Status Table

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

BENE\_PRMRY\_PYR\_TB

Beneficiary Primary Payer Table

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

for FI claims; obsoleted for all claim  
types 7/1/96)

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

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

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

Y = Other secondary payer investigation  
shows Medicare as primary payer  
Z = Medicare is primary payer

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

BENE\_RACE\_TB

Beneficiary Race Table

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

BENE\_SEX\_IDENT\_TB

Beneficiary Sex Identification Table

1 = Male  
2 = Female  
0 = Unknown

BETOS\_TB

BETOS Table

M1A = Office visits - new

M1B = Office visits - established  
M2A = Hospital visit - initial  
M2B = Hospital visit - subsequent  
M2C = Hospital visit - critical care  
M3 = Emergency room visit  
M4A = Home visit  
M4B = Nursing home visit  
M5A = Specialist - pathology  
M5B = Specialist - psychiatry  
M5C = Specialist - opthamology  
M5D = Specialist - other  
M6 = Consultations  
P0 = Anesthesia  
P1A = Major procedure - breast  
P1B = Major procedure - colectomy  
P1C = Major procedure - cholecystectomy  
P1D = Major procedure - turp  
P1E = Major procedure - hysterectomy  
P1F = Major procedure - explor/decompr/excisdisc  
P1G = Major procedure - Other  
P2A = Major procedure, cardiovascular-CABG  
P2B = Major procedure, cardiovascular-Aneurysm repair  
P2C = Major Procedure, cardiovascular-Thromboendarterectomy  
P2D = Major procedure, cardiovascular-Coronary angioplasty (PTCA)  
P2E = Major procedure, cardiovascular-Pacemaker insertion  
P2F = Major procedure, cardiovascular-Other  
P3A = Major procedure, orthopedic - Hip fracture repair  
P3B = Major procedure, orthopedic - Hip replacement  
P3C = Major procedure, orthopedic - Knee replacement  
P3D = Major procedure, orthopedic - other  
P4A = Eye procedure - corneal transplant  
P4B = Eye procedure - cataract removal/lens insertion  
P4C = Eye procedure - retinal detachment  
P4D = Eye procedure - treatment of retinal lesions  
P4E = Eye procedure - other  
P5A = Ambulatory procedures - skin  
P5B = Ambulatory procedures - musculoskeletal  
P5C = Ambulatory procedures - inguinal hernia repair  
P5D = Ambulatory procedures - lithotripsy  
P5E = Ambulatory procedures - other  
P6A = Minor procedures - skin  
P6B = Minor procedures - musculoskeletal  
P6C = Minor procedures - other (Medicare fee schedule)  
P6D = Minor procedures - other (non-Medicare fee schedule)  
P7A = Oncology - radiation therapy  
P7B = Oncology - other  
P8A = Endoscopy - arthroscopy  
P8B = Endoscopy - upper gastrointestinal  
P8C = Endoscopy - sigmoidoscopy  
P8D = Endoscopy - colonoscopy



P8E = Endoscopy - cystoscopy  
P8F = Endoscopy - bronchoscopy  
P8G = Endoscopy - laparoscopic cholecystectomy  
P8H = Endoscopy - laryngoscopy  
P8I = Endoscopy - other  
P9A = Dialysis services (medicare fee schedule)  
P9B = Dialysis services (non-medicare fee schedule)  
I1A = Standard imaging - chest  
I1B = Standard imaging - musculoskeletal  
I1C = Standard imaging - breast  
I1D = Standard imaging - contrast gastrointestinal  
I1E = Standard imaging - nuclear medicine  
I1F = Standard imaging - other  
I2A = Advanced imaging - CAT/CT/CTA: brain/head/neck  
I2B = Advanced imaging - CAT/CT/CTA: other  
I2C = Advanced imaging - MRI/MRA: brain/head/neck  
I2D = Advanced imaging - MRI/MRA: other  
I3A = Echography/ultrasonography - eye  
I3B = Echography/ultrasonography - abdomen/pelvis  
I3C = Echography/ultrasonography - heart  
I3D = Echography/ultrasonography - carotid arteries  
I3E = Echography/ultrasonography - prostate, transrectal  
I3F = Echography/ultrasonography - other  
I4A = Imaging/procedure - heart including cardiac  
catheterization  
I4B = Imaging/procedure - other  
T1A = Lab tests - routine venipuncture (non Medicare  
fee schedule)  
T1B = Lab tests - automated general profiles  
T1C = Lab tests - urinalysis  
T1D = Lab tests - blood counts  
T1E = Lab tests - glucose  
T1F = Lab tests - bacterial cultures  
T1G = Lab tests - other (Medicare fee schedule)  
T1H = Lab tests - other (non-Medicare fee schedule)  
T2A = Other tests - electrocardiograms  
T2B = Other tests - cardiovascular stress tests  
T2C = Other tests - EKG monitoring  
T2D = Other tests - other  
D1A = Medical/surgical supplies  
D1B = Hospital beds  
D1C = Oxygen and supplies  
D1D = Wheelchairs  
D1E = Other DME  
D1F = Prosthetic/Orthotic devices  
D1G = Drugs Administered through DME  
O1A = Ambulance  
O1B = Chiropractic  
O1C = Enteral and parenteral  
O1D = Chemotherapy

01E = Other drugs  
01F = Hearing and speech services  
01G = Immunizations/Vaccinations  
Y1 = Other - Medicare fee schedule  
Y2 = Other - non-Medicare fee schedule  
Z1 = Local codes  
Z2 = Undefined codes

CARR\_CLM\_ENTRY\_TB

Carrier Claim Entry Table

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

CARR\_CLM\_HOSPC\_OVRD\_IND\_TB

Carrier Claim Hospice Override Indicator Table

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

CARR\_CLM\_MCO\_OVRD\_IND\_TB

Carrier Claim MCO Override Indicator Table

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

CARR\_CLM\_PMT\_DNL\_TB

Carrier Claim Payment Denial Table

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

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

8 = Federally funded  
 9 = PA service  
 A = Beneficiary under limitation of liability  
 B = Physician/supplier under limitation of liability  
 D = Denied due to demonstration involvement (eff. 5/97)  
 E = MSP cost avoided IRS/SSA/HCFA Data Match (eff. 7/3/00)  
 F = MSP cost avoided HMO Rate Cell (eff. 7/3/00)  
 G = MSP cost avoided Litigation Settlement (eff. 7/3/00)  
 H = MSP cost avoided Employer Voluntary Reporting (eff. 7/3/00)  
 J = MSP cost avoided Insurer Voluntary Reporting (eff. 7/3/00)  
 K = MSP cost avoided Initial Enrollment Questionnaire (eff. 7/3/00)  
 P = Physician ownership denial (eff 3/92)  
 Q = MSP cost avoided - (Contractor #88888) voluntary agreement (eff. 1/98)  
 T = MSP cost avoided - IEQ contractor (eff. 7/96) (obsolete 6/30/00)  
 U = MSP cost avoided - HMO rate cell adjustment (eff. 7/96) (obsolete 6/30/00)  
 V = MSP cost avoided - litigation settlement (eff. 7/96) (obsolete 6/30/00)  
 X = MSP cost avoided - generic  
 Y = MSP cost avoided - IRS/SSA data match project (obsolete 6/30/00)  
 00= MSP cost avoided - COB Contractor  
 12= MSP cost avoided - BC/BS Voluntary Agreements  
 13= MSP cost avoided - Office of Personnel Management  
 14= MSP cost avoided - Workman's Compensation (WC) Datamatch  
 15= MSP cost avoided - Workman's Compensation Insurer Voluntary Data Sharing Agreements (WC VDSA) (eff. 4/2006)  
 16= MSP cost avoided - Liability Insurer VDSA (eff.4/2006)  
 17= MSP cost avoided - No-Fault Insurer VDSA (eff.4/2006)  
 18= MSP cost avoided - Pharmacy Benefit Manager Data Sharing Agreement (eff.4/2006)  
 21= MSP cost avoided - MIR Group Health Plan (eff.1/2009)  
 22= MSP cost avoided - MIR non-Group Health Plan (eff.1/2009)  
 25= MSP cost avoided - Recovery Audit Contractor - California (eff.10/2005)  
 26= MSP cost avoided - Recovery Audit Contractor - Florida (eff.10/2005)  
 NOTE: Effective 4/1/02, the Carrier claim payment denial code was expanded to a 2-byte field. The NCH instituted

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

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

CARR\_CLM\_PRVDR\_ASGNMT\_IND\_TB

Carrier Claim Provider Assignment Code Table

A = Assigned claim  
N = Non-assigned claim

CARR\_LINE\_CLIA\_ALERT\_IND\_TB

Carrier Line CLIA Alert Indicator Code Table

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

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

7 = 77XB

CARR\_LINE\_HPSA\_SCRCTY\_IND\_TB

Carrier Line HPSA/Scarcity Indicator Code Table

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

CARR\_LINE\_MTUS\_IND\_TB

Carrier Line Miles/Time/Units Indicator Table

0 = Values reported as zero (no allowed activities)  
1 = Transportation (ambulance) miles  
2 = Anesthesia time units  
3 = Services  
4 = Oxygen units  
5 = Units of blood  
6 = Anesthesia base and time units (prior to 1991; from BMAD)

CARR\_LINE\_PRVDR\_TYPE\_TB

Carrier Line Provider Type Table

For Physician/Supplier (RIC O) Claims:

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

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

0 = Clinics, groups, associations, partnerships, or other entities

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

CARR\_LINE\_RDCD\_PHYSN\_ASTNT\_TB

Carrier Line Part B Reduced Physician Assistant Table

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

0 = N/A

1 = 65%

A) Physician assistants assisting in surgery

B) Nurse midwives

2 = 75%

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

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

C) Clinical social worker services

3 = 85%

A) Physician assistant services for other than assisting surgery

B) Nurse practitioners services

CARR\_NUM\_TB

Carrier Number/MAC Table

00510 = Alabama - CAHABA (eff. 1983)  
(replaced by MAC #10102 -- see below)  
00511 = Georgia - CAHABA (eff. 1998)  
(replaced by MAC #10202 -- see below)  
00512 = Mississippi - CAHABA (eff. 2000)  
00520 = Arkansas BC/BS (eff. 1983)  
00521 = New Mexico - Arkansas BC/BS (eff. 1998; term. 2008)  
(replaced by MAC #04202 -- see below)  
00522 = Oklahoma - Arkansas BC/BS (eff. 1998; term. 2008)  
(replaced by MAC #04302 -- see below)  
00523 = Missouri East - Arkansas BC/BS (eff. 1999; term. 2008)  
(replaced by MAC #05392 -- see below)  
00524 = Rhode Island - Arkansas BC/BS (eff. 2004)  
(replaced by MAC #14402 -- see below)  
00528 = Louisiana - Arkansas BS (eff. 1984)  
00542 = California BS (eff. 1983; term. 1996)  
00550 = Colorado BS (eff. 1983; term. 1994)  
00570 = Delaware - Pennsylvania BS (eff. 1983;  
term. 1997)  
00580 = District of Columbia - Pennsylvania BS  
(eff. 1983; term. 1997)  
00590 = Florida - First Coast (eff. 1983)  
(replaced by MAC #09102 -- see below)  
00591 = Connecticut - First Coast (eff. 2000)  
(replaced by MAC #13102 -- see below)  
00621 = Illinois BS - HCSC (eff. 1983; term. 1998)  
00623 = Michigan - Illinois Blue Shield (eff. 1995)  
(term. 1998)  
00630 = Indiana - Administar (eff. 1983)  
00635 = DMERC-B - Administar (eff. 1993)  
(replaced by MAC #17003 -- see below)  
00640 = Iowa - Wellmark, Inc. (eff. 1983; term. 1998)  
00645 = Nebraska - Iowa BS (eff. 1985; term. 1987)  
00650 = Kansas BCBS (eff. 1983) (term. 2008)  
(replaced by MAC #05202 -- see below)  
00655 = Nebraska - Kansas BC/BS (eff. 1988; term. 2008)  
(replaced by MAC #05402 -- see below)  
00660 = Kentucky - Administar (eff. 1983)  
00690 = Maryland BS (eff. 1983; term. 1994)  
00700 = Massachusetts BS (eff. 1983; term. 1997)  
00710 = Michigan BS (eff. 1983; term. 1994)  
00720 = Minnesota BS (eff. 1983; term. 1995)  
00740 = Western Missouri - Kansas BS (eff. 1983; term. 2008)  
(replaced by MAC #05302 -- see below)

00751 = Montana BC/BS (eff. 1983)  
(replaced by MAC # 03202 -- see below)  
00770 = New Hampshire/Vermont Physician Services  
(eff. 1983; term. 1984)  
00780 = New Hampshire/Vermont - Massachusetts BS  
(eff. 1985; term. 1997)  
00801 = New York - Healthnow (eff. 1983)  
(replaced by MAC #13282 -- see below)  
00803 = New York - Empire BS (eff. 1983)  
(replaced by MAC #13202 -- see below)  
00805 = New Jersey - Empire BS (eff. 3/99)  
(replaced by MAC # 12402 -- see below)  
00811 = DMERC (A) - Healthnow (eff. 2000)  
(replaced by MAC #16003 -- see below)  
00820 = North Dakota - Noridian (eff. 1983)  
(replaced by MAC #03302 -- see below)  
00823 = Utah - Noridian (eff. 12/1/2005)  
(replaced by MAC #03502 -- see below)  
00824 = Colorado - Noridian (eff. 1995)  
(term. 2008)  
(replaced by MAC #04102 -- see below)  
00825 = Wyoming - Noridian (eff. 1990)  
(replaced by MAC #03602 -- see below)  
00826 = Iowa - Noridian (eff. 1999) (term. 2008)  
(replaced by MAC #05102 -- see below)  
00831 = Alaska - Noridian (eff. 1998)  
00832 = Arizona - Noridian (eff. 1998)  
(replaced by MAC # 03102 -- see below)  
00833 = Hawaii - Noridian (eff. 1998)  
(replaced by MAC # 01202 -- see below)  
00834 = Nevada - Noridian (eff. 1998)  
(replaced by MAC # 01302 -- see below)  
00835 = Oregon - Noridian (eff. 1998)  
00836 = Washington - Noridian (eff. 1998)  
00860 = New Jersey - Pennsylvania BS (eff. 1988;  
term. 1999)  
00865 = Pennsylvania - Highmark (eff. 1983)  
(replaced by MAC # 12502 -- see below)  
00870 = Rhode Island BS (eff. 1983; term. 2004)  
00880 = South Carolina - Palmetto (eff. 1983)  
00882 = RRB - South Carolina PGBA (eff. 2000)  
00883 = Ohio - Palmetto (eff. 2002)  
00884 = West Virginia - Palmetto (eff. 2002)  
00885 = DMERC C - Palmetto (eff. 1993)  
(replaced by MAC #18003 -- see below)  
00889 = South Dakota - Noridian (eff. 4/1/2006)  
(replaced by MAC # 03402 -- see below)  
00900 = Texas - Trailblazer (eff. 1983; term. 2008)  
(replaced by MAC # 04402 -- see below)  
00901 = Maryland - Trailblazer (eff. 1995)



(replaced by MAC # 12302 -- see below)  
 00902 = Delaware - Trailblazer (eff. 1998)  
 (replaced by MAC # 12102 -- see below)  
 00903 = District of Columbia - Trailblazer (eff. 1998)  
 (replaced by MAC # 12202 -- see below)  
 00904 = Virginia - Trailblazer (eff. 2000)  
 (replaced by MAC # 11302 -- see below)  
 00910 = Utah BS (eff. 1983)  
 00951 = Wisconsin - Wisconsin Phy Svc (eff. 1983)  
 00952 = Illinois - Wisconsin Phy Svc (eff. 1999)  
 00953 = Michigan - Wisconsin Phy Svc (eff. 1999)  
 00954 = Minnesota - Wisconsin Phy Svc (eff. 2000)  
 00973 = Puerto Rico - Triple S, Inc. (eff. 1983)  
 (replaced by MAC # 09202 -- see below)  
 00974 = Triple-S, Inc. - Virgin Islands  
 01020 = Alaska - AETNA (eff. 1983; term. 1997)  
 01030 = Arizona - AETNA (eff. 1983; term. 1997)  
 01040 = Georgia - AETNA (eff. 1988; term. 1997)  
 01120 = Hawaii - AETNA (eff. 1983; term. 1997)  
 01290 = Nevada - AETNA (eff. 1983; term. 1997)  
 01360 = New Mexico - AETNA (eff. 1986; term. 1997)  
 01370 = Oklahoma - AETNA (eff. 1983; term. 1997)  
 01380 = Oregon - AETNA (eff. 1983; term. 1997)  
 01390 = Washington - AETNA (eff. 1994; term. 1997)  
 02050 = California - TOLIC (eff. 1983; term. 2000)  
 03070 = Connecticut General Life Insurance Co.  
 (eff. 1983; term. 1985)  
 05130 = Idaho - CIGNA (eff. 1983)  
 05302 = Western Missouri (eff. 3/2008)  
 05320 = New Mexico - Equitable Insurance  
 (eff. 1983; term. 1985)  
 05440 = Tennessee - CIGNA (eff. 1983)  
 (replaced by MAC #10302 - see below)  
 05530 = Wyoming - Equitable Insurance (eff. 1983)  
 (term. 1989)  
 05535 = North Carolina - CIGNA (eff. 1988)  
 05655 = DMERC-D Alaska - CIGNA (eff. 1993)  
 (replaced by MAC #19003 -- see below)  
 10071 = Railroad Board Travelers (eff. 1983)  
 (term. 2000)  
 10230 = Connecticut - Metra Health (eff. 1986)  
 (term. 2000)  
 10240 = Minnesota - Metra Health (eff. 1983)  
 (term. 2000)  
 10250 = Mississippi - Metra Health (eff. 1983)  
 (term. 2000)  
 10490 = Virginia - Metra Health (eff. 1983)  
 (term. 2000)  
 10555 = DMERC A - Travelers Insurance Co.  
 (eff. 1993) (term. 2000)

11260 = General American Life of Missouri  
(eff. 1983; term. 1998)  
14330 = New York - GHI (eff. 1983)  
(replaced by MAC #13292 -- see below)  
16360 = Ohio - Nationwide Insurance Co. (eff. 1983)  
(term. 2002)  
16510 = West Virginia - Nationwide Insurance Co.  
(eff. 1983) (term. 2002)  
21200 = Maine - Massachusetts BS  
(eff. 1983) (term. 1998)  
31140 = N. California - National Heritage Ins.  
(eff. 1997) (replaced by MAC #01102 -- see below)  
31142 = Maine - National Heritage Ins.  
(eff. 1998) (replaced with MAC # 14102 - see below)  
31143 = Massachusetts - National Heritage Ins.  
(eff. 1998) (replaced with MAC # 14202 - see below)  
31144 = New Hampshire - National Heritage Ins.  
(eff. 1998) (replaced with MAC # 14302 - see below)  
31145 = Vermont - National Heritage Ins.  
(eff. 1998)  
31146 = So. California - NHIC (eff. 2000)  
80884 = Contractor ID for Physician Risk Adjust-  
ment Data (data not sent through CWF;  
but through Palmetto)

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Medicare Administrative Contractors (MACs)

JURISDICTION 1 -- Part B MACs

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

JURISDICTION 3 -- Part B MACs

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

(replaces carrier #00825)

JURISDICTION 4 -- Part B MACs

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

JURISDICTION 5 -- Part B MACs

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

JURISDICTION 9 -- Part B MACs

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

JURISDICTION 10 -- Part B MACs

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

JURISDICTION 11 -- Part B MACs

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

JURISDICTION 12 -- Part B MACs

12102 = New Jersey (eff. 7/11/2008)

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

JURISDICTION 13 -- Part B MACs

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

JURISDICTION 14 -- Part B MACs

14102 = Maine (eff. 6/1/2009)  
(replaces carrier # 31142)  
14202 = Massachusetts (eff. 6/1/2009)  
(replaces carrier # 31143)  
14302 = N. Hampshire (eff. 6/1/2009)  
(replaces carrier # 31144)  
14402 = Rhode Island (eff. 5/1/2009)  
(replaces carrier # 00524)  
14502 = Vermont (eff. 6/1/2009)  
(replaces carrier # 31145)

Durable Medical Equipment (DME) MACs

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

19003 = Noridan Administrative Services  
(eff. 10/1/06) (replaces carrier  
#05655)

CLM\_DGNS\_VRSN\_TB

Claim Diagnosis Version Code Table

Valid Values:

9 = ICD-9  
0 = ICD-10

CLM\_DISP\_TB

Claim Disposition Table

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

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

CLM\_EXCPTD\_NEXCPTD\_TRTMT\_TB

Claim Excepted/Nonexcepted Treatment Table

0 = No Entry  
1 = Excepted  
2 = Nonexcepted

CLM\_PWK\_TB

Claim Paperwork Code Table

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

CLM\_RAC\_ADJSTMT\_TB

Recovery Audit Contractor (RAC) Adjustment Indicator Table

R = RAC adjusted claim  
Spaces

CMS\_PRVDR\_SPCLTY\_TB

CMS Provider Specialty Table

00 = Carrier wide  
01 = General practice  
02 = General surgery  
03 = Allergy/immunology  
04 = Otolaryngology  
05 = Anesthesiology  
06 = Cardiology  
07 = Dermatology  
08 = Family practice  
09 = Interventional Pain Management (IPM) (eff. 4/1/03)  
09 = Gynecology (osteopaths only)  
    (discontinued 5/92 use code 16)  
10 = Gastroenterology  
11 = Internal medicine  
12 = Osteopathic manipulative therapy  
13 = Neurology  
14 = Neurosurgery  
15 = Obstetrics (osteopaths only)  
    (discontinued 5/92 use code 16)  
16 = Obstetrics/gynecology  
17 = Ophthalmology, otology, laryngology,  
    rhinology (osteopaths only)  
    (discontinued 5/92 use codes 18 or 04  
    depending on percentage of practice)  
18 = Ophthalmology  
19 = Oral surgery (dentists only)  
20 = Orthopedic surgery  
21 = Pathologic anatomy, clinical  
    pathology (osteopaths only)  
    (discontinued 5/92 use code 22)  
22 = Pathology  
23 = Peripheral vascular disease, medical  
    or surgical (osteopaths only)  
    (discontinued 5/92 use code 76)  
24 = Plastic and reconstructive surgery  
25 = Physical medicine and rehabilitation  
26 = Psychiatry

27 = Psychiatry, neurology (osteopaths only) (discontinued 5/92 use code 86)  
28 = Colorectal surgery (formerly proctology)  
29 = Pulmonary disease  
30 = Diagnostic radiology  
31 = Roentgenology, radiology (osteopaths only) (discontinued 5/92 use code 30)  
32 = Anesthesiologist Assistants (eff. 4/1/03--previously grouped with Certified Registered Nurse Anesthetists (CRNA))  
32 = Radiation therapy (osteopaths only) (discontinued 5/92 use code 92)  
33 = Thoracic surgery  
34 = Urology  
35 = Chiropractic  
36 = Nuclear medicine  
37 = Pediatric medicine  
38 = Geriatric medicine  
39 = Nephrology  
40 = Hand surgery  
41 = Optometry (revised 10/93 to mean optometrist)  
42 = Certified nurse midwife (eff 1/87)  
43 = CRNA (eff. 1/87) (Anesthesiologist Assistants were removed from this specialty 4/1/03)  
44 = Infectious disease  
45 = Mammography screening center  
46 = Endocrinology (eff 5/92)  
47 = Independent Diagnostic Testing Facility (IDTF) (eff. 6/98)  
48 = Podiatry  
49 = Ambulatory surgical center (formerly miscellaneous)  
50 = Nurse practitioner  
51 = Medical supply company with certified orthotist (certified by American Board for Certification in Prosthetics And Orthotics)  
52 = Medical supply company with certified prosthetist (certified by American Board for Certification In Prosthetics And Orthotics)  
53 = Medical supply company with certified prosthetist-orthotist (certified by American Board for Certification in Prosthetics and Orthotics)  
54 = Medical supply company not included

in 51, 52, or 53. (Revised 10/93  
to mean medical supply company for DMERC)

55 = Individual certified orthotist  
56 = Individual certified prosthetist  
57 = Individual certified prosthetist-orthotist  
58 = Individuals not included in 55, 56, or 57,  
(revised 10/93 to mean medical supply company  
with registered pharmacist)  
59 = Ambulance service supplier, e.g.,  
private ambulance companies, funeral homes, etc.

60 = Public health or welfare agencies  
(federal, state, and local)  
61 = Voluntary health or charitable agencies (e.g.  
National Cancer Society, National Heart  
Association, Catholic Charities)  
62 = Psychologist (billing independently)  
63 = Portable X-ray supplier  
64 = Audiologist (billing independently)  
65 = Physical therapist (private practice added 4/1/03)  
(independently practicing removed 4/1/03)  
66 = Rheumatology (eff 5/92)  
Note: during 93/94 DMERC also used this to mean  
medical supply company with  
respiratory therapist  
67 = Occupational therapist (private practice added 4/1/03)  
(independently practicing removed 4/1/03)  
68 = Clinical psychologist  
69 = Clinical laboratory (billing independently)  
70 = Multispecialty clinic or group practice  
71 = Registered Dietician/Nutrition Professional (eff. 1/1/02)  
72 = Pain Management (eff. 1/1/02)  
73 = Mass Immunization Roster Biller (eff. 4/1/03)  
74 = Radiation Therapy Centers (added to differentiate  
them from Independent Diagnostic Testing Facilities  
(IDTF --eff. 4/1/03)  
74 = Occupational therapy (GPPP)  
(not to be assigned after 5/92)  
75 = Slide Preparation Facilities (added to differentiate  
them from Independent Diagnostic Testing Facilities  
(IDTFs -- eff. 4/1/03)  
75 = Other medical care (GPPP) (not to  
assigned after 5/92)  
76 = Peripheral vascular disease  
(eff 5/92)  
77 = Vascular surgery (eff 5/92)  
78 = Cardiac surgery (eff 5/92)  
79 = Addiction medicine (eff 5/92)  
80 = Licensed clinical social worker  
81 = Critical care (intensivists)



(eff 5/92)

82 = Hematology (eff 5/92)

83 = Hematology/oncology (eff 5/92)

84 = Preventive medicine (eff 5/92)

85 = Maxillofacial surgery (eff 5/92)

86 = Neuropsychiatry (eff 5/92)

87 = All other suppliers (e.g. drug and department stores) (note: DMERC used 87 to mean department store from 10/93 through 9/94; recoded eff 10/94 to A7; NCH cross-walked DMERC reported 87 to A7.

88 = Unknown supplier/provider specialty (note: DMERC used 87 to mean grocery store from 10/93 - 9/94; recoded eff 10/94 to A8; NCH cross-walked DMERC reported 88 to A8.

89 = Certified clinical nurse specialist

90 = Medical oncology (eff 5/92)

91 = Surgical oncology (eff 5/92)

92 = Radiation oncology (eff 5/92)

93 = Emergency medicine (eff 5/92)

94 = Interventional radiology (eff 5/92)

95 = Competative Acquisition Program (CAP) Vendor (eff. 07/01/06). Prior to 07/01/06, known as Independent physiological laboratory (eff. 5/92)

96 = Optician (eff 10/93)

97 = Physician assistant (eff 5/92)

98 = Gynecologist/oncologist (eff 10/94)

99 = Unknown physician specialty

A0 = Hospital (eff 10/93) (DMERCs only)

A1 = SNF (eff 10/93) (DMERCs only)

A2 = Intermediate care nursing facility (eff 10/93) (DMERCs only)

A3 = Nursing facility, other (eff 10/93) (DMERCs only)

A4 = HHA (eff 10/93) (DMERCs only)

A5 = Pharmacy (eff 10/93) (DMERCs only)

A6 = Medical supply company with respiratory therapist (eff 10/93) (DMERCs only)

A7 = Department store (for DMERC use: eff 10/94, but cross-walked from code 87 eff 10/93)

A8 = Grocery store (for DMERC use: eff 10/94, but cross-walked from code 88 eff 10/93)

A9 = Indian Health Service (IHS), tribe and tribal organizations (non-hospital or non-hospital based facilities. DMERCs shall process claims submitted by IHS, tribe and

non-tribal organizations for DMEPOS and drugs  
covered by the DMERCs. (eff. 1/2005)  
B1 = Supplier of oxygen and/or oxygen related  
equipment (eff. 10/2/07)  
B2 = Pedorthic Personnel (eff. 10/2/07)  
B3 = Medical Supply Company with Pedorthic Personnel  
(eff. 10/2/07)  
B4 = Rehabilitation Agency (eff. 10/2/07)

CMS\_TYPE\_SRVCTB

CMS Type of Service Table

1 = Medical care  
2 = Surgery  
3 = Consultation  
4 = Diagnostic radiology  
5 = Diagnostic laboratory  
6 = Therapeutic radiology  
7 = Anesthesia  
8 = Assistant at surgery  
9 = Other medical items or services  
0 = Whole blood only eff 01/96,  
whole blood or packed red cells before 01/96  
A = Used durable medical equipment (DME)  
B = High risk screening mammography  
(obsolete 1/1/98)  
C = Low risk screening mammography  
(obsolete 1/1/98)  
D = Ambulance (eff 04/95)  
E = Enteral/parenteral nutrients/supplies  
(eff 04/95)  
F = Ambulatory surgical center (facility  
usage for surgical services)  
G = Immunosuppressive drugs  
H = Hospice services (discontinued 01/95)  
I = Purchase of DME (installment basis)  
(discontinued 04/95)  
J = Diabetic shoes (eff 04/95)  
K = Hearing items and services (eff 04/95)  
L = ESRD supplies (eff 04/95)  
(renal supplier in the home before 04/95)  
M = Monthly capitation payment for dialysis  
N = Kidney donor  
P = Lump sum purchase of DME, prosthetics,  
orthotics  
Q = Vision items or services  
R = Rental of DME  
S = Surgical dressings or other medical supplies  
(eff 04/95)

T = Psychological therapy (term. 12/31/97)  
 outpatient mental health limitation (eff. 1/1/98)  
 U = Occupational therapy  
 V = Pneumococcal/flu vaccine (eff 01/96),  
 Pneumococcal/flu/hepatitis B vaccine (eff 04/95-12/95),  
 Pneumococcal only before 04/95  
 W = Physical therapy  
 Y = Second opinion on elective surgery  
 (obsoleted 1/97)  
 Z = Third opinion on elective surgery  
 (obsoleted 1/97)

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

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

F2 = F2;TQ  
F3-F8 = Equatable only to itself (e.g., F3 IS  
equatable to F3)  
CA-CZ = Equatable only to itself. (e.g., CA is  
only equatable to CA)

-----  
RRB Categories

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

END\_REC\_TB

End of Record Code Table

EOR = End of record/segment  
EOC = End of claim

GEO\_SSA\_STATE\_TB

State Table

01 = Alabama  
02 = Alaska  
03 = Arizona  
04 = Arkansas  
05 = California  
06 = Colorado  
07 = Connecticut  
08 = Delaware  
09 = District of Columbia  
10 = Florida  
11 = Georgia  
12 = Hawaii  
13 = Idaho  
14 = Illinois  
15 = Indiana  
16 = Iowa  
17 = Kansas

18 = Kentucky  
19 = Louisiana  
20 = Maine  
21 = Maryland  
22 = Massachusetts  
23 = Michigan  
24 = Minnesota  
25 = Mississippi  
26 = Missouri  
27 = Montana  
28 = Nebraska  
29 = Nevada  
30 = New Hampshire  
31 = New Jersey  
32 = New Mexico  
33 = New York  
34 = North Carolina  
35 = North Dakota  
36 = Ohio  
37 = Oklahoma  
38 = Oregon  
39 = Pennsylvania  
40 = Puerto Rico  
41 = Rhode Island  
42 = South Carolina  
43 = South Dakota  
44 = Tennessee  
45 = Texas  
46 = Utah  
47 = Vermont  
48 = Virgin Islands  
49 = Virginia  
50 = Washington  
51 = West Virginia  
52 = Wisconsin  
53 = Wyoming  
54 = Africa  
55 = California  
56 = Canada & Islands  
57 = Central America and West Indies  
58 = Europe  
59 = Mexico  
60 = Oceania  
61 = Philippines  
62 = South America  
63 = U.S. Possessions  
64 = American Samoa  
65 = Guam  
66 = Commonwealth of the Northern Marianas Islands  
67 = Texas

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

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

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

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

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

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

Valid Values:  
9 = ICD-9  
0 = ICD-10

LINE\_DUP\_CLM\_CHK\_IND\_TB                              Line Duplicate Claim Check Indicator Table

1 = Exact duplicate review performed-service  
determined not to be a duplicate and is  
approved for payment  
2 = Suspected duplicate review performed-service  
determined not to be a duplicate and is  
approved for payment  
Blank = not applicable or the line item or service  
is being denied as a duplicate

LINE\_HCT\_HGB\_TYPE\_TB                      Line Hematocrit/Hemoglobin Test Type      Code

R1 = Hemoglobin Test  
R2 = Hematocrit Test

LINE\_PMT\_80\_100\_TB                      Line Payment 80%/100% Table

0 = 80%  
1 = 100%  
3 = 100% Limitation of liability only  
4 = 75% Reimbursement

LINE\_PRCSG\_IND\_TB                      Line Processing Indicator Table

A = Allowed  
B = Benefits exhausted  
C = Noncovered care  
D = Denied (existed prior to 1991; from  
BMAD)  
I = Invalid data  
L = CLIA (eff 9/92)  
M = Multiple submittal--duplicate line item  
N = Medically unnecessary  
O = Other  
P = Physician ownership denial (eff 3/92)  
Q = MSP cost avoided (contractor #88888) -  
voluntary agreement (eff. 1/98)  
R = Reprocessed--adjustments based on  
subsequent reprocessing of claim  
S = Secondary payer  
T = MSP cost avoided - IEQ contractor  
(eff. 7/76)  
U = MSP cost avoided - HMO rate cell  
adjustment (eff. 7/96)  
V = MSP cost avoided - litigation

settlement (eff. 7/96)  
 X = MSP cost avoided - generic  
 Y = MSP cost avoided - IRS/SSA data  
 match project  
 Z = Bundled test, no payment  
 (eff. 1/1/98)  
 00= MSP cost avoided - COB Contractor  
 12= MSP cost avoided - BC/BS Voluntary Agreements  
 13= MSP cost avoided - Office of Personnel Management  
 14= MSP cost avoided - Workman's Compensation (WC) Datamatch  
 15= MSP cost avoided - Workman's Compensation Insurer Voluntary  
 Data Sharing Agreements (WC VDSA) (eff. 4/2006)  
 16= MSP cost avoided - Liability Insurer VDSA (eff.4/2006)  
 17= MSP cost avoided - No-Fault Insurer VDSA (eff.4/2006)  
 18= MSP cost avoided - Pharmacy Benefit Manager Data Sharing  
 Agreement (eff.4/2006)  
 21= MSP cost avoided - MIR Group Health Plan (eff.1/2009)  
 22= MSP cost avoided - MIR non-Group Health Plan (eff.1/2009)  
 25= MSP cost avoided - Recovery Audit Contractor - California  
 (eff.10/2005)  
 26= MSP cost avoided - Recovery Audit Contractor - Florida  
 (eff.10/2005)

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

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



('22' 2-byte code) (eff. 1/2009)  
% = MSP cost avoided - Recovery Audit Contractor -  
- California ('25' 2-byte code) (eff. 10/2005)  
& = MSP cost avoided - Recovery Audit Contractor -  
Florida ('26' 2-byte code) (eff. 10/2005)

LINE\_PRVDR\_PRTCPTG\_IND\_TB                      Line Provider Participating Indicator Table

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

LINE\_SRVC\_DDCTBL\_IND\_TB                      Line Service Deductible Indicator Switch Code Table

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

MCO\_OPTN\_TB                                      MCO Option Table

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

NCH\_CLM\_BIC\_MDFY\_TB                      NCH Claim BIC Modify H Code Table

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

NCH\_CLM\_TYPE\_TB

NCH Claim Type Table

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

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

NCH\_DEMO\_TRLR\_IND\_TB

NCH Demonstration Trailer Indicator Table

D = Demo trailer present

NCH\_DGNS\_TRLR\_IND\_TB

NCH Diagnosis Trailer Indicator Table

Y = Diagnosis code trailer present

NCH\_EDIT\_DISP\_TB

NCH Edit Disposition Table

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

70 = Systems duplicate

NCH\_EDIT\_TB

NCH EDIT TABLE

A0X1 = (C) PHYSICIAN-SUPPLIER ZIP CODE  
A000 = (C) REIMB > \$100,000 OR UNITS > 150  
A002 = (C) CLAIM IDENTIFIER (CAN)  
A003 = (C) BENEFICIARY IDENTIFICATION (BIC)  
A004 = (C) PATIENT SURNAME BLANK  
A005 = (C) PATIENT 1ST INITIAL NOT-ALPHABETIC  
A006 = (C) DATE OF BIRTH IS NOT NUMERIC  
A007 = (C) INVALID GENDER (0, 1, 2)  
A008 = (C) INVALID QUERY-CODE (WAS CORRECTED)  
A009 = (C) TYPE OF BILL RECEIVED IS 41A, 41B, OR 41D  
A010 = (C) DISPOSITION CODE VS. ACTION/ENTRY CODE  
A023 = (C) PORTABLE X-RAY WITHOUT MODIFIER  
A025 = (C) FOR OV 4, TOB MUST = 13,83,85,73  
A031 = (C) HOSPITAL CLAIMS--CLAIM SHOWS SERVICES WERE PAID  
BY AN HMO AND CODITION CODE '04' IS NOT PRESENT.  
(TOB '11' & '12')  
A041 = (C) HHA CLAIMS--TOB 32X OR 33X WITH >4 VISITS; DATE  
OF SERVICE > 9/30/00 AND LUPA IND IS PRESENT.  
BYPASS FOR NON-PAYMENT CODE B, C, Q, T-Y.  
A1X1 = (C) PERCENT ALLOWED INDICATOR  
A1X2 = (C) DT>97273,DG1=7611,DG<>103,163,1589  
A1X3 = (C) DT>96365,DIAG=V725  
A1X4 = (C) INVALID DIAGNOSTIC CODES  
C050 = (U) HOSPICE - SPELL VALUE INVALID  
D102 = (C) DME DATE OF BIRTH INVALID  
D2X2 = (C) DME SCREEN SAVINGS INVALID  
D2X3 = (C) DME SCREEN RESULT INVALID  
D2X4 = (C) DME DECISION IND INVALID  
D2X5 = (C) DME WAIVER OF PROV LIAB INVALID  
D3X1 = (C) DME NATIONAL DRUG CODE INVALID  
D4X1 = (C) DME BENE RESIDNC STATE CODE INVALID  
D4X2 = (C) DME OUT OF DMERC SERVICE AREA  
D4X3 = (C) DME STATE CODE INVALID  
D5X1 = (C) TOS INVALID FOR DME HCPCS  
D5X2 = (C) DME HCPCS NOC & NOC DESCRIP MISSING  
D5X3 = (C) DME INVALID USE OF MS MODIFIER  
D5X4 = (C) TOS9 NDC REQD WHEN HCPCS OMITTED  
D5X5 = (C) TOS9 NDC REQD FOR Q0127-130 HCPCS  
D5X6 = (C) TOS9 NDC/DIAGNOSIS CODE INVALID  
D5X7 = (C) ANTI-EMETIC/ANTI-CANCER DRUG W/0 CANCER  
DIAGNOSIS  
D5X8 = (C) TWO ANTI-EMETIC DRUGS PRESENT ON SAME CLAIM  
WITH IDENTICAL DATES OF SERVICE.  
D6X1 = (C) DME SUPPLIER NUMBER MISSING

D7X1 = (C) DME PURCHASE ALLOWABLE INVALID  
D919 = (C) CAPPED/PEN PUMPS,NUM OF SRVCS > 1  
D921 = (C) SHOE HCPC W/O MOD RT,LT REQ U=2/4/6  
D922 = (C) THERAPEUTIC SHOE CODES 'A5505-A5501'  
W/MODIFIER 'LT' OR 'RT' MUST HAVE  
UNITS = '001'  
XXXX = (D) SYS DUPL: HOST/BATCH/QUERY-CODE  
Y001 = (C) HCPCS R0075/UNITS>1/SERVICES=1  
Y002 = (C) HCPCS R0075/UNITS=1/SERVICES>1  
Y003 = (C) HCPCS R0075/UNITS=SERVICES  
Y010 = (C) TOB=13X/14X AND T.C.>\$7,500  
Y011 = (C) INP CLAIM/REIM > \$350,000  
Z001 = (C) RVNU 820-859 REQ COND CODE 71-76  
Z002 = (C) CC M2 PRESENT/REIMB > \$150,000  
Z003 = (C) CC M2 PRESENT/UNITS > 150  
Z004 = (C) CC M2 PRESENT/UNITS & REIM < MAX  
Z005 = (C) REIMB>99999 AND REIMB<150000  
Z006 = (C) UNITS>99 AND UNITS<150  
Z007 = (C) TOB VS TOTAL CHARGE  
Z008 = (C) TOB VS TOTAL CHARGE W/O 20/21  
CONDITION CODE  
Z237 = (E) HOSPICE OVERLAP - DATE ZERO  
0011 = (C) ACTION CODE INVALID  
0012 = (C) IME/GME CLAIM -- '04' OR '69'  
CONDITION CODE  
0013 = (C) CABG/PCOE/MPPD AND INVALID ADMIT DATE  
0014 = (C) DEMO NUM INVALID  
0015 = (C) ESRD PLAN VS DEMO NUM  
0016 = (C) INVALID VA CLAIM  
0017 = (C) DEMO=38 W/O CONTRACTOR #80881/80882  
0018 = (C) DEMO=31,ACT CD<>1/5 OR ENT CD<>1/5  
0019 = (C) DEMO 07/08 WITH CONDITION CODE B1  
0020 = (C) CANCEL ONLY CODE INVALID  
0021 = (C) DEMO COUNT > 1  
0022 = (C) TOB '32X' OR '33X' W/DATES OF SERVICE >9/30/00  
AND HAS CANCEL ONLY CODE OTHER THAN A,B,E,F  
0023 = (C) DEMO '46' AND HCPCS INCONSISTENT  
0301 = (C) INVALID HI CLAIM NUMBER  
0302 = (C) BENE IDEN CDE (BIC) INVAL OR BLK  
04A1 = (C) PATIENT SURNAME BLANK (PHYS/SUP)  
04B1 = (C) PATIENT 1ST INITIAL NOT-ALPHABETIC  
0401 = (C) BILL TYPE/PROVIDER INVALID  
0402 = (C) BILL TYPE/REV CODE/PROVR RANGE  
0403 = (C) TOB '41X'/PRVDR # 1990-1999) OR TOB '51X'/  
PRVDR #6990-6999, TRANS CODE SHOULD BE  
'0' OR '3'  
0406 = (C) MAMMOGRAPHY WITH NO HCPCS 76092 OR SEX NOT F  
0407 = (C) RESPITE CARE BILL TYPE NOT 34X,NO REV 66  
0408 = (C) REV CODE 403 /TYPE 71X/ PROV3800-974  
041A = (C) TOB '11A' OR '11D' AND DEMO #'07' OR '08'

NOT PRESENT

0410 = (C) IMMUNO DRUG OCCR-36,NO REV-25 OR 636  
0412 = (C) BILL TYPE XX5 HAS ACCOM. REV. CODES  
0413 = (C) CABG/PCOE BUT TOB = HHA,OUT,HOS  
0414 = (C) VALU CD 61,MSA AMOUNT MISSING  
0415 = (C) HOME HEALTH INCORRECT ALPHA RIC  
0416 = (C) REVENUE CENTER '0022', TOB MUST BE  
          '18X' OR '21X'  
0417 = (C) REVENUE CENTER '0023', TOB MUST BE '32X'  
          OR '33X'  
0418 = (C) HHA--TOB '3X5' AND DATES OF SERVICE  
          >9/30/00  
0419 = (C) HHA--RIC 'W' MUST HAVE VALUE CODE '63'/  
          RIC 'V' MUST HAVE VALUE CODE '62' AND  
          RIC 'U' MUST HAVE VALUE CODES '62' AND  
          '63' PRESENT FOR DATES OF SERVICE >  
          9/30/00.  
0420 = (C) HHA W/O REVENUE CODE '0023'  
0421 = (C) START DATE MISSING  
0422 = (C) COB VS. OVERRIDE CODE  
05X4 = (C) UPIN REQUIRED FOR TYPE-OF-SERVICE  
05X5 = (C) UPIN REQUIRED FOR DME  
0501 = (C) REFFERING UPIN REQUIRED FOR CLINICAL LAB  
0502 = (C) REFERRING UPIN INVALID  
0601 = (C) GENDER INVALID  
0701 = (C) CONTRACTOR/POS 1-2 PROVIDER NUM INVALID  
0702 = (C) PROVIDER NUMBER VS. TOB  
0703 = (C) MAMMOGRAPHY FOR NOT FEMALE  
0704 = (C) INVALID CONT FOR CABG DEMO  
0705 = (C) INVALID CONT FOR PCOE DEMO  
0706 = (C) REVENUE CENTER CODE MAMMOGRAPHY AND  
          BENEFICIARY <35  
0901 = (C) INVALID DISP CODE OF 02  
0902 = (C) INVALID DISP CODE OF SPACES  
0903 = (C) INVALID DISP CODE  
1001 = (C) PROF REVIEW/ACT CODE/BILL TYPE  
13X2 = (C) MULTIPLE ITEMS FOR SAME SERVICE  
1301 = (C) LINE COUNT NOT NUMERIC OR > 13  
1302 = (C) RECORD LENGTH INVALID  
1401 = (C) INVALID MEDICARE STATUS CODE  
1501 = (C) ADMIT DATE/START DATE/ENTRY CODE INVALID  
1502 = (C) ADMIT DATE/START CARE DATE > STAY FROM DATE  
1503 = (C) ADMIT DATE INVALID WITH THRU DATE  
1504 = (C) ADM/FROM/THRU DATE > TODAYS DATE  
1505 = (C) HCPCS W SERVICE DATES > 09-30-94  
1601 = (C) INVESTIGATION IND INVALID  
1701 = (C) SPLIT IND INVALID  
1801 = (C) PAY-DENY CODE INVALID  
1802 = (C) HEADER AMT/LINE ITEMS DENIED  
1803 = (C) MSP COST AVD/ALL MSP LI NOT SAME

1901 = (C) AB CROSSOVER IND INVALID  
2001 = (C) HOSPICE OVERRIDE INVALID  
2101 = (C) HMO-OVERRIDE/PATIENT-STAT INVALID  
2102 = (C) PATIENT STATUS VS. TOB  
2103 = (C) HIPPS RATE/CMG CODE VS. PATIENT STATUS  
2201 = (C) FROM DATE/HCPDS YR INVALID  
2202 = (C) STAY-FROM DATE > THRU-DATE  
2203 = (C) THRU DATE INVALID  
2204 = (C) FROM DATE BEFORE EFFECTIVE DATE  
2205 = (C) DATE YEARS DIFFERENT ON OUTPAT  
2207 = (C) MAMMOGRAPHY BEFORE 1991  
2208 = (C) TOB '21X', REV CODE 0022 FROM DATE  
          < 06-03-98  
2209 = (C) HHA WITH OVERLAPPING DATES JUNE/JULY,  
          SEPT/OCT  
2210 = (C) TOB 41X, SERVICE DATES 6/30/00,  
          EXCEP/NONEXCEP IND = 1,2  
2212 = (C) TOB 51X WITH SERVICE DATES >6/30/00  
2213 = (C) TOB 32X OR 33X, SERVICE >9/30/00 DAYS  
          CAN NOT = 60  
2215 = (C) DEMO 37 WITH VALUE CODES 'A2', 'B2', 'C2'  
2216 = (C) DEMO 37 OR CONDITION CODE 78 AND CHARGES  
          SUB TO DED > 0  
2301 = (C) DOCUMENT CNTL OR UTIL DYS INVALID  
2302 = (C) COVERED DAYS INVALID OR INCONSIST  
2303 = (C) COST REPORT DAYS > ACCOMIDATION  
2304 = (C) UTIL DAYS = ZERO ON PATIENT BILL  
2305 = (C) LATE CHARGE BILL WITH DATA FIELD PRESENT  
2306 = (C) UTIL DYS/NOPAY/REIMB INCONSISTENT  
2307 = (C) COND=40,UTL DYS >0/VAL CDE A1,08,09  
2308 = (C) NOPAY = R WHEN UTIL DAYS = ZERO  
2401 = (C) NON-UTIL DAYS INVALID  
2501 = (C) CLAIM RCV DT OR COINSURANCE INVAL  
2502 = (C) COIN+LR>UTIL DAYS/RCPT DTE>CUR DTE  
2503 = (C) COIN/TR TYP/UTIL DYS/RCPT DTE>PD/DEN  
2504 = (C) COINSURANCE AMOUNT EXCESSIVE  
2505 = (C) COINSURANCE RATE > ALLOWED AMOUNT  
2506 = (C) COINSURANCE DAYS/AMOUNT INCONSIST  
2507 = (C) COIN+LR DAYS > TOTAL DAYS FOR YR  
2508 = (C) COINSURANCE DAYS INVALID FOR TRAN  
2601 = (C) CLAIM PAID DT INVALID OR LIFE RES  
2602 = (C) LR-DAYS, NO VAL 08,10/PD/DEN>CUR+27  
2603 = (C) LIFE RESERVE > RATE FOR CAL YEAR  
2604 = (C) PPS BILL, NO DAY OUTLIER  
2605 = (C) LIFE RESERVE RATE > DAILY RATE AVR.  
28XA = (C) UTIL DAYS > FROM TO BENEF EXH  
28XB = (C) BENEFITS EXH DATE > FROM DATE  
28XC = (C) BENEFITS EXH DATE/INVALID TRANS TYPE  
28XD = (C) OCCUR 23 WITH SPAN 70 ON INPAT HOSP  
28XE = (C) MULTI BENE EXH DATE (OCCR A3,B3,C3)

28XF = (C) ACE DATE ON SNF (NOPAY =B, C, N, W)  
 28XG = (C) SPAN CD 70+4+6+9 NOT = NONUTIL DAYS  
 28XM = (C) OCC CD 42 DATE NOT = SRVCE THRU DTE  
 28XN = (C) INVALID OCC CODE  
 28XO = (C) AN 'N' NO-PAY CODE IS PRESENT AND OCCURRENCE  
 CODE '23' OR '42' IS NOT PRESENT AND THE  
 DATE ASSOCIATED WITH CODE IS MISSING OR NOT  
 EQUAL TO THRU DATE.  
 28XP = (C) THE OCCURRENCE CODE 23 DATE DOES NOT EQUAL THE  
 THRU DATE  
 28X0 = (C) BENE EXH DATE OUTSIDE SERVICE DATES  
 28X1 = (C) OCCUR DATE INVALID  
 28X2 = (C) OCCUR = 20 AND TRANS = 4  
 28X3 = (C) OCCUR 20 DATE < ADMIT DATE  
 28X4 = (C) OCCUR 20 DATE > ADMIT + 12  
 28X5 = (C) OCCUR 20 AND ADMIT NOT = FROM  
 28X6 = (C) OCCUR 20 DATE < BENE EXH DATE  
 28X7 = (C) OCCUR 20 DATE+UTIL-COIN>COVERAGE  
 28X8 = (C) OCCUR 22 DATE < FROM OR > THRU  
 28X9 = (C) UTIL > FROM - THRU LESS NCOV  
 33X1 = (C) QUAL STAY DATES INVALID (SPAN=70)  
 33X2 = (C) QS FROM DATE NOT < THRU (SPAN=70)  
 33X3 = (C) QS DAYS/ADMISSION ARE INVALID  
 33X4 = (C) QS THRU DATE > ADMIT DATE (SPAN=70)  
 33X5 = (C) SPAN 70 INVALID FOR DATE OF SERVICE  
 33X6 = (C) TOB=18/21/28/51,COND=WO,HMO<>90091  
 33X7 = (C) TOB<>18/21/28/51,COND=WO  
 33X8 = (C) TOB=18/21/28/51,CO=WO,ADM DT<97001  
 33X9 = (C) TOB=32X SPAN 70 OR OCCR BO PRESENT  
 33#A = (C) MULTIPLE PET SCANS  
 33#B = (C) MULTIPLE PET SCANS W/O MODIFIER 26  
 OR TC  
 3401 = (C) DEMO ID = 04 AND RIC NOT = 1 OR 2  
 34X2 = (C) DEMO ID = 04 AND COND WO NOT SHOWN  
 34#3 = (C) CONDITION CODE = W0 AND DEMO NOT = 04  
 35X1 = (C) 60, 61, 66 & NON-PPS / 65 & PPS  
 35X2 = (C) COND = 60 OR 61 AND NO VALU 17  
 35X3 = (C) PRO APPROVAL COND C3,C7 REQ SPAN M0  
 35#3 = (C) (SECOND CONDITION) CONDITION CODE = C3  
 REQUIRES SPAN CODE 76 OR 77  
 35#4 = (C) CONDITION CODE = 69 AND TOB NOT 11X  
 36X1 = (C) SURG DATE < STAY FROM/ > STAY THRU  
 36#1 = (C) SURGICAL DATE = ZEROES OR < FROM OR >  
 THRU DATES  
 3701 = (C) ASSIGN CODE INVALID  
 3705 = (C) 1ST CHAR OF IDE# IS NOT ALPHA  
 3706 = (C) INVALID IDE NUMBER-NOT IN FILE  
 3710 = (C) NUM OF IDE# > REV 0624  
 3715 = (C) NUM OF IDE# < REV 0624  
 3720 = (C) IDE AND LINE ITEM NUMBER > 2

3801 = (C) AMT BENE PD INVALID  
 3XA/ = (C) COLORECTAL/PROSTATE SCREENING BILLED  
 MULTIPLE TIMES  
 4001 = (C) BLOOD PINTS FURNISHED INVALID  
 4002 = (C) BLOOD FURNISHED/REPLACED INVALID  
 4003 = (C) BLOOD FURNISHED/VERIFIED/DEDUCT  
 4201 = (C) BLOOD PINTS UNREPLACED INVALID  
 4202 = (C) BLOOD PINTS UNREPLACED/BLOOD DED  
 4203 = (C) INVALID CPO PROVIDER NUMBER  
 4301 = (C) BLOOD DEDUCTABLE INVALID  
 4302 = (C) BLOOD DEDUCT/FURNISHED PINTS  
 4303 = (C) BLOOD DEDUCT > UNREPLACED BLOOD  
 4304 = (C) BLOOD DEDUCT > 3 - REPLACED  
 4501 = (C) PRIMARY DIAGNOSIS INVALID  
 4502 = (C) SERVICE DATES > CURRENT DATE  
 46#A = (C) MSP VET AND VET AT MEDICARE  
 46#B = (C) MULTIPLE COIN VALU CODES (A2,B2,C2)  
 46#C = (C) COIN VALUE (A2,B2,C2) ON INP/SNF  
 46#G = (C) VALU CODE 20 INVALID  
 46#L = (C) BLOOD FURNISHED < BLOOD REPLACED  
 46#N = (C) VALUE CODE 37,38,39 INVALID  
 46#O = (C) VALUE CDE 37,38,39 AMOUNT NOT > 00  
 46#P = (C) BLD UNREP VS REV CDS AND/OR UNITS  
 46#Q = (C) VALUE CDE 37=39 AND 38 IS PRESENT  
 46#R = (C) BLD FIELDS VS REV CDE 380,381,382  
 46#S = (C) VALU CODE 39, AND 37 IS NOT PRESENT  
 46#T = (C) CABG/PCOE/MPPD,VC<>Y1,Y2,Y3,Y4,VA NOT>0  
 46#U = (C) MSP VALUES ON CABG/PCOE/MPPD (INP)  
 TOB '32X'/'33X' MUST HAVE VALUE 62/64  
 OR 63/65 (HHA)  
 46#V = (C) TOB '32X'/'33X' VISITS IN 62/63 NOT =  
 REVENUE CODE 42X-44X, 55X-57X  
 46#W = (C) CONDITION CODE =30/78 AND WITH VALUE  
 CODE = A1, B1, C1  
 46#1 = (C) VALUE AMOUNT INVALID  
 46#2 = (C) VALU 06 AND BLD-DED-PTS IS ZERO  
 46#3 = (C) VALU 06 AND TTL-CHGS=NC-CHGS(001)  
 46#4 = (C) VALU (A1,B1,C1): AMT > DEDUCT  
 46#5 = (C) DEDUCT VALUE (A1,B1,C1) ON SNF BILL  
 46#6 = (C) VALU 17 AND NO COND CODE 60 OR 61  
 46#7 = (C) OUTLIER(VAL 17) > REIMB + VAL6-16  
 46#8 = (C) MULTI CASH DED VALU CODES (A1,B1,C1)  
 46X9 = (C) DEMO ID=03,REQUIRED HCPCS NOT SHOWN  
 4600 = (C) CAPITAL TOTAL NOT = CAP VALUES  
 4601 = (C) CABG/PCOE, MSP CODE PRESENT  
 4603 = (C) DEMO ID = 03 AND RIC NOT=6,7  
 4604 = (C) DEMO = 03 WITH DATES OF SERVICE  
 > 09/31/01  
 4901 = (C) PCOE/CABG,DEN CD NOT D  
 4902 = (C) PCOE/CABG BUT DME



50#1 = (C) RVCD=54,TOB<>13,23,32,33,34,83,85  
 50#2 = (C) REV CD=054X,MOD NOT = QM,QN  
 5051 = (E) EDB: NOMATCH ON 3 CHARACTERISTICS  
 5052 = (E) EDB: NOMATCH ON MASTER-ID RECORD  
 5053 = (E) EDB: NOMATCH ON CLAIM-NUMBER  
 51#A = (C) HCPCS EYEWARE & REV CODE NOT 274  
 51#C = (C) HCPCS REQUIRES DIAG CODE OF CANCER  
 51#D = (C) HCPCS REQUIRES UNITS > ZERO  
 51#E = (C) HCPCS REQUIRES REVENUE CODE 636/294  
 51#F = (C) INV BILL TYP/ANTI-CAN DRUG HCPCS  
 51#G = (C) HCPCS REQUIRES DIAG OF HEMOPHILL1A  
 51#H = (C) TOB 21X/P82=2/3/4;REV CD<9001,>9044  
 51#I = (C) TOB 21X/P82<>2/3/4:REV CD>8999<9045  
 51#J = (C) TOB 21X/REV CD: SVC-FROM DT INVALID  
 51#K = (C) TOB 21X/P82=2/3/4,REV CD = NNX  
 51#L = (C) REV 0762/UNT>48,TOB NOT=12,13,85,83  
 51#M = (C) 21X,RC>9041/<9045,RC<>4/234  
 51#N = (C) 21X,RC>9032/<9042,RC<>4/234  
 51#O = (C) TWO ANTI-EMETIC/ANTI-CANCER DRUGS  
 ON SAME CLAIM  
 51#P = (C) HHA/OUTPATIENT RC DATE OF SRVC MISSING  
 51#Q = (C) NO RC 0636 OR DTE INVALID  
 51#R = (C) DEMO ID=01,RIC NOT=2  
 51#S = (C) DEMO ID=01,RUGS<>2,3,4 OR BILL<>21  
 51#V = (C) TOB 72X W HCPCS 'J1955' MISSING REVENUE  
 CENTER 636  
 51#W = (C) TOB 12X, 13X, 22X, 23X, 34X, 74X, 75X,  
 83X, HCPCS '97504', '97116', PRESENT  
 ON SAME DAY  
 51#X = (C) TOB '32X-34X' REQUIRE HCPCS FOR REVENUE  
 CODE '29X', '60X', '636'  
 51X0 = (C) REV CENTER CODE INVALID  
 51X1 = (C) REV CODE CHECK  
 51X2 = (C) REV CODE INCOMPATIBLE BILL TYPE  
 51X3 = (C) UNITS MUST BE > 0  
 51X4 = (C) INP:CHGS/YR-RATE,ETC; OUTP:PSYCH>YR  
 51X5 = (C) REVENUE NON-COVERED > TOTAL CHRGE  
 51X6 = (C) REV TOTAL CHARGES EQUAL ZERO  
 51X7 = (C) REV CDE 403 WTH NO BILL 14 23 71 85  
 51X8 = (C) MAMMOGRAPHY SUBMISSION INVALID  
 51X9 = (C) HCPCS/REV CODE/BILL TYPE  
 5100 = (U) TRANSITION SPELL / SNF  
 5160 = (U) LATE CHG HSP BILL STAY DAYS > 0  
 5166 = (U) PROVIDER NE TO 1ST WORK PRVDR  
 5167 = (U) PROVIDER 1 NE 2: FROM DT < START DT  
 5168 = (E) CLAIM IN HOSPICE WITH 2ND START DATE  
 PRESENT  
 5169 = (U) PROVIDER NE TO WORK PROVIDER  
 5170 = (E) OCCURRENCE CODE = 42 AND < DOLBA  
 5177 = (U) PROVIDER NE TO WORK PROVIDER

5178 = (U) HOSPICE BILL THRU < DOLBA  
5181 = (U) HOSP BILL OCCR 27 DISCREPANCY  
5200 = (E) ENTITLEMENT EFFECTIVE DATE  
5201 = (U) HOSP DATE DIFFERENCE NE 60 OR 90  
5202 = (E) ENTITLEMENT HOSPICE EFFECTIVE DATE  
5202 = (U) HOSPICE TRAILER ERROR  
5203 = (E) ENTITLEMENT HOSPICE PERIODS  
5203 = (U) HOSPICE START DATE ERROR  
5204 = (U) HOSPICE DATE DIFFERENCE NE 90  
5205 = (U) HOSPICE DATE DISCREPANCY  
5206 = (U) HOSPICE DATE DISCREPANCY  
5207 = (U) HOSPICE THRU > TERM DATE 2ND  
5208 = (U) HOSPICE PERIOD NUMBER BLANK  
5209 = (U) HOSPICE DATE DISCREPANCY  
5210 = (E) ENTITLEMENT FRM/TRU/END DATES  
5211 = (E) ENTITLEMENT DATE DEATH/THRU  
5212 = (E) ENTITLEMENT DATE DEATH/THRU  
5213 = (E) ENTITLEMENT DATE DEATH MBR  
5220 = (E) ENTITLEMENT FROM/EFF DATES  
5225 = (E) ENT INP PPS SPAN 70 DATES  
5232 = (E) ENTL HMO NO HMO OVERRIDE CDE  
5233 = (E) ENTITLEMENT HMO PERIODS  
5234 = (E) ENTITLEMENT HMO NUMBER NEEDED  
5235 = (E) ENTITLEMENT HMO HOSP+NO CC07  
5236 = (E) ENTITLEMENT HMO HOSP + CC07  
5237 = (E) ENTITLEMENT HOSP OVERLAP  
5238 = (U) HOSPICE CLAIM OVERLAP > 90  
5239 = (U) HOSPICE CLAIM OVERLAP > 60  
524Z = (E) HOSP OVERLAP NO OVD NO DEMO  
5240 = (U) HOSPICE DAYS STAY+USED > 90  
5241 = (U) HOSPICE DAYS STAY+USED > 60  
5242 = (C) INVALID CARRIER FOR RRB  
5243 = (C) HMO=90091,INVALID SERVICE DTE  
5244 = (E) DEMO CABG/PCOE MISSING ENTL  
5245 = (C) INVALID CARRIER FOR NON RRB  
525Z = (E) HMO/HOSP 6/7 NO OVD NO DEMO  
5250 = (U) HOSPICE DOEBA/DOLBA  
5255 = (U) HOSPICE DAYS USED  
5256 = (U) HOSPICE DAYS USED > 999  
526Y = (E) HMO/HOSP DEMO 5/15 REIMB > 0  
526Z = (E) HMO/HOSP DEMO 5/15 REIMB = 0  
5270 = (C) CONDITION CODE = 30 AND HMO REQUIRES  
MODIFIER = 'QV' OR 'KZ'/DED IND  
5271 = (C) RISK HMO NOT PRESENT AND MOD 'KZ'/  
OR CONDITION CODE 78 PRESENT  
527Y = (E) HMO/HOSP DEMO OVD=1 REIMB > 0  
527Z = (E) HMO/HOSP DEMO OVD=1 REIMB = 0  
5299 = (U) HOSPICE PERIOD NUMBER ERROR  
52#K = (C) HCPCS VS DIAGNOSIS  
52#L = (C) HCPCS VS MODIFIER

52#M = (C) HCPCS VS DATES OF SERVICE  
52#N = (C) TOB '71X' OR '73X' WITH REVENUE  
CENTER CODE 0403 MISSING REVENUE  
CENTER CODE 0521  
52#O = (C) REVENUE CENTER CODE 0022/0024 WITH  
CHARGES >0  
52#P = (C) REVENUE CENTER CODE 010X-021X MINUS  
18X <> 0022  
52#Q = (C) REVENUE CENTER CODE 0022 AND HIPPS  
MISSING  
52#R = (C) REVENUE CENTER CODE 0022 MISSING DATE  
OF SERVICE  
52#T = (C) REVENUE CENTER CODE 0022 MISSING REVENUE  
CENTER CODE 042X-044X  
5320 = (U) BILL > DOEBA AND IND-1 = 2  
5350 = (U) HOSPICE DOEBA/DOLBA SECONDARY  
5355 = (U) HOSPICE DAYS USED SECONDARY  
5362 = (C) MAMMOGRAPHY AND BENE <35  
5378 = (C) SERVICE DATE < AGE 50  
5379 = (C) HCPCS 'G0160' PRESENT MORE THAN  
ONCE  
5381 = (C) HCPCS 'G0161' PRESENT MORE THAN  
ONCE  
5382 = (C) HCPCS 'G0102-03' AND BENE <50  
538Q = (C) SERVICE DATES WITHIN ALIEN RECORD  
5397 = (C) DEMO '37' AND NOT CAT 74  
5398 = (C) HCPCS 'G9001-G9005 & G9009-G9011 >1  
OR 2 ARE PRESENT  
5399 = (U) HOSPICE PERIOD NUM MATCH  
539A = (C) HCPCS 'G9008' PRESENT MORE THAN ONCE  
539C = (C) HCPCS 'G9013-G9015' PRESENT MORE THAN  
ONCE OR 2 PRESENT  
5410 = (U) INPAT DEDUCTABLE  
5425 = (U) PART B DEDUCTABLE CHECK  
5430 = (U) PART B DEDUCTABLE CHECK  
5450 = (U) PART B COMPARE MED EXPENSE  
5460 = (U) PART B COMPARE MED EXPENSE  
5499 = (U) MED EXPENSE TRAILER MISSING  
5500 = (U) FULL DAYS/SNF-HOSP FULL DAYS  
5510 = (U) COIN DAYS/SNF COIN DAYS  
5515 = (U) FULL DAYS/COIN DAYS  
5516 = (U) SNF FULL DAYS/SNF COIN DAYS  
5520 = (U) LIFE RESERVE DAYS  
5530 = (U) UTIL DAYS/LIFE PSYCH DAYS  
5540 = (U) HH VISITS NE AFT PT B TRLR  
5550 = (E) SNF LESS THAN PT A EFF DATE  
5600 = (D) LOGICAL DUPE, COVERED  
5601 = (D) LOGICAL DUPE, QRY-CDE, RIC 123  
5602 = (D) LOGICAL DUPE, PANDE C, E OR I  
5603 = (D) LOGICAL DUPE, COVERED

5604 = (D) LOGICAL DUPE, DATES  
 5605 = (D) POSS DUPE, OUTPAT REIMB  
 5606 = (D) POSS DUPE, HOME HEALTH COVERED U  
 5623 = (U) NON-PAY CODE IS P  
 57X1 = (C) PROVIDER SPECIALITY CODE INVALID  
 57X2 = (C) PHYS THERAPY/PROVIDER SPEC INVAL  
 57X3 = (C) PLACE/TYPE/SPECIALTY/REIMB IND  
 57X4 = (C) SPECIALTY CODE VS. HCPCS INVALID  
 57X5 = (C) HCPCS 98940-2 MODIFIER NOT = 'AT'  
 5700 = (U) LINKED TO THREE SPELLS  
 5701 = (C) DEMO ID=02,RIC NOT = 5  
 5702 = (C) DEMO ID=02,INVALID PROVIDER NUM  
 58X1 = (C) PROVIDER TYPE INVALID  
 58X9 = (C) TYPE OF SERVICE INVALID  
 5802 = (C) REIMB > \$150,000  
 5803 = (C) UNITS/VISITS > 150  
 5804 = (C) UNITS/VISITS > 99  
 5805 = (C) OUTPATIENT CHARGE > \$150,000  
 5806 = (C) REVENUE CENTER CODE '042X-044X'  
 WITHOUT MODIFIER 'GN-GP'  
 58#4 = (C) REVENUE CENTER CODE MISSING REQUIRED  
 HCPCS OR MODIFIER  
 59XA = (C) PROST ORTH HCPCS/FROM DATE  
 59XB = (C) HCPCS/FROM DATE/TYPE P OR I  
 59XC = (C) HCPCS Q0036,37,42,43,46/FROM DATE  
 59XD = (C) HCPCS Q0038-41/FROM DATE/TYPE  
 59XE = (C) HCPCS/MAMMOGRAPHY-RISK/ DIAGNOSIS  
 59XG = (C) INVALID TOS FOR DME  
 59XH = (C) HCPCS E0620/TYPE/DATE  
 59XI = (C) HCPCS E0627-9/ DATE < 1991  
 59XJ = (C) GLOBAL HCPCS TOS MUST = 2  
 59XK = (C) HCPCS PEN PUMP AND TOS <>9  
 59XL = (C) HCPCS 00104 - TOS/POS  
 59X1 = (C) INVALID HCPCS/TOS COMBINATION  
 59X2 = (C) ASC IND/TYPE OF SERVICE INVALID  
 59X3 = (C) TOS INVALID TO MODIFIER  
 59X4 = (C) KIDNEY DONOR/TYPE/PLACE/REIMB  
 59X5 = (C) MAMMOGRAPHY FOR MALE  
 59X6 = (C) DRUG AND NON DRUG BILL LINE ITEMS  
 59X7 = (C) CAPPED-HCPCS/FROM DATE  
 59X8 = (C) FREQUENTLY MAINTAINED HCPCS  
 59X9 = (C) HCPCS E1220/FROM DATE/TYPE IS R  
 5901 = (U) ERROR CODE OF Q  
 5A#1 = (C) DEMO=37, UNITS >1 FOR 'G9001-05'  
 'G9007-11', G9013-G9015'  
 60X1 = (C) ASSIGN IND INVALID  
 6000 = (U) ADJUSTMENT BILL SPELL DATA  
 6020 = (U) CURRENT SPELL DOEBA < 1990  
 6030 = (U) ADJUSTMENT BILL SPELL DATA  
 6035 = (U) ADJUSTMENT BILL THRU DTE/DOLBA

61X1 = (C) PAY PROCESS IND INVALID  
 61X2 = (C) DENIED CLAIM/NO DENIED LINE  
 61X3 = (C) PAY PROCESS IND/ALLOWED CHARGES  
 61X4 = (C) RATE MISSING OR NON-NUMERIC  
 61#E = (C) PROVIDER PAYMENT INCONSISTENCIES  
 61#F = (C) BENEFICIARY PAYMENT INCONSISTENCIES  
 61#G = (C) PATIENT RESPONSIBILITY INCONSISTENCIES  
 61#H = (C) MEDICARE PAYMENT INCONSISTENCIES  
 61#I = (C) LINE DATE OF SERVICE < FROM DATE  
           > THRU DATE  
 61#J = (C) DUPLICATE HCPCS CODE '55873'  
 61#K = (C) HCPCS 'G0117-8' >2 OR BOTH PRESENT  
 61#L = (C) REVENUE CENTER CODE 0024 > 2  
 61#M = (C) REVENUE CENTER CODE 0024 VS PROVIDER  
           NUMBER  
 61#N = (C) REVENUE CENTER CODE 0024 REQUIRES  
           VALID HIPPS RATE CMG CODE  
 61#R = (C) HCPCS/TOB/REVENUE CENTER CODE  
 61#S = (C) HCPCS 'G0247' REQUIRES 'G0245-6' TO  
           BE COVERED  
 61#T = (C) HCPCS CODE '0245-0246' PRESENT MULTIPLE  
           TIMES  
 61#0 = (C) REVENUE CENTER CODE VS SPAN CODE '74'  
 61#6 = (C) PAYMENT METHOD INVALID  
 61#7 = (C) ANSI CODE MISSING  
 61#8 = (C) BLOOD CASH DEDUCTIBLE INCONSISTENCIES  
 61#9 = (C) CASH DEDUCTIBLE INCONSISTENCIES  
 6100 = (C) REV 0001 NOT PRESENT ON CLAIM  
 6101 = (C) REV COMPUTED CHARGES NOT=TOTAL  
 6102 = (C) REV COMPUTED NON-COVERED/NON-COV  
 6103 = (C) REV TOTAL CHARGES < PRIMARY PAYER  
 6105 = (C) REVE CODE 0001 > 1  
 6106 = TOB 3X2 REVENUE CENTER CODE 0023 NOT =  
           TOTAL CHARGE  
 6109 = (C) REIMBURSEMENT > 4 OR 6 TIMES  
 62XA = (C) PSYC OT PT/REIM/TYPE  
 62XC = (C) DEMO 37 WITH REIMBURSEMENT/DED IND  
           <>1  
 62X1 = (C) DME/DATE/100% OR INVAL REIMB IND  
 62X6 = (C) RAD PATH/PLACE/TYPE/DATE/DED  
 62X8 = (C) KIDNEY DONO/TYPE/100%  
 62X9 = (C) PNEUM VACCINE/TYPE/100%  
 6201 = (C) TOTAL DEDUCT > CHARGES/NON-COV  
 6203 = (U) HOSPICE ADJUSTMENT PERIOD/DATE  
 6204 = (U) HOSPICE ADJUSTMENT THRU>DOLBA  
 6260 = (U) HOSPICE ADJUSTMENT STAY DAYS  
 6261 = (U) HOSPICE ADJUSTMENT DAYS USED  
 6265 = (U) HOSPICE ADJUSTMENT DAYS USED  
 6269 = (U) HOSPICE ADJUSTMENT PERIOD# (MAIN)  
 63X1 = (C) DEDUCT IND INVALID

63X2 = (C) DED/HCFA COINS IN PCOE/CABG  
6365 = (U) HOSPICE ADJUSTMENT SECONDARY DAYS  
6369 = (U) HOSPICE ADJUSTMENT PERIOD# (SECOND)  
64X1 = (C) PROVIDER IND INVALID  
6430 = (U) PART B DEDUCTABLE CHECK  
65X1 = (C) PAYSCREEN IND INVALID  
66?? = (D) POSS DUPE, CR/DB, DOC-ID  
66XX = (D) POSS DUPE, CR/DB, DOC-ID  
66X1 = (C) UNITS AMOUNT INVALID  
66X2 = (C) UNITS IND > 0; AMT NOT VALID  
66X3 = (C) UNITS IND = 0; AMT > 0  
66X4 = (C) MT INDICATOR/AMOUNT  
66X7 = (C) DEMO 37/HCPCS/UNITS  
6600 = (U) ADJUSTMENT BILL FULL DAYS  
6610 = (U) ADJUSTMENT BILL COIN DAYS  
6620 = (U) ADJUSTMENT BILL LIFE RESERVE  
6630 = (U) ADJUSTMENT BILL LIFE PSYCH DYS  
67X1 = (C) UNITS INDICATOR INVALID  
67X2 = (C) CHG ALLOWED > 0; UNITS IND = 0  
67X3 = (C) TOS/HCPCS=ANEST, MTU IND NOT = 2  
67X4 = (C) HCPCS = AMBULANCE, MTU IND NOT = 1  
67X6 = (C) INVALID PROC FOR MT IND 2, ANEST  
67X7 = (C) INVALID UNITS IND WITH TOS OF BLOOD  
67X8 = (C) INVALID PROC FOR MT IND 4, OXYGEN  
6700 = (U) ADJUSTMENT BILL FULL/SNF DAYS  
6710 = (U) ADJUSTMENT BILL COIN/SNF DAYS  
68XA = (C) HCPCS G0117-8 >1 OR BOTH PRESENT  
68XB = (C) HCPCS CODE G0245-46 > 1  
68X1 = (C) INVALID HCPCS CODE  
68X2 = (C) MAMMOGRAPY/DATE/PROC NOT 76092  
68X3 = (C) TYPE OF SERVICE = G /PROC CODE  
68X4 = (C) HCPCS NOT VALID FOR SERVICE DATE  
68X5 = (C) MODIFIER NOT VALID FOR HCPCS, ETC  
68X6 = (C) TYPE SERVICE INVALID FOR HCPCS, ETC  
68X7 = (C) ZX MOD REQ FOR THER SHOES/INS/MOD.  
68X8 = (C) ANTI-EMETIC WITHOUT ANTI-CANCER DRUG  
6812 = (C) DEMO 37 WITH PRIMARY PAYER CODE  
69XA = (C) MODIFIER NOT VALID FOR HCPCS/GLOBAL  
69XB = (C) HCPCS CODE 97504/97116 PRESENT ON  
SAME DAY  
69XC = (C) HCPCS CODE VS PAY PROCESS INDICATOR  
69X3 = (C) PROC CODE MOD = LL / TYPE = R  
69X6 = (C) PROC CODE MOD/NOT CAPPED  
69X8 = (C) SPEC CODE NURSE PRACT, MOD INVAL  
69X9 = (C) NURSE PRACTITIONER, MOD INVALID  
6901 = (C) KRON IND AND UTIL DYS EQUALS ZERO  
6902 = (C) KRON IND AND NO-PAY CODE B OR N  
6903 = (C) KRON IND AND INPATIENT DEDUCT = 0  
6904 = (C) KRON IND AND TRANS CODE IS 4  
6910 = (C) REV CODES ON HOME HEALTH

6911 = (C) REV CODE 274 ON OUTPAT AND HH ONLY  
6912 = (C) REV CODE INVAL FOR PROSTH AND ORTHO  
6913 = (C) REV CODE INVAL FOR OXYGEN  
6914 = (C) REV CODE INVAL FOR DME  
6915 = (C) PURCHASE OF RENT DME INVAL ON DATES  
6916 = (C) PURCHASE OF RENT DME INVAL ON DATES  
6917 = (C) PURCHASE OF LIFT CHAIR INVAL > 91000  
6918 = (C) HCPCS INVALID ON DATE RANGES  
6919 = (C) DME OXYGEN ON HH INVAL BEFORE 7/1/89  
6920 = (C) HCPCS INVAL ON REV 270/BILL 32-33  
6921 = (C) HCPCS ON REV CODE 272 BILL TYPE 83X  
6922 = (C) HCPCS ON BILL TYPE 83X -NOT REV 274  
6923 = (C) RENTAL OF DME CUSTOMIZE AND REV 291  
6924 = (C) INVAL MODIFIER FOR CAPPED RENTAL  
6925 = (C) HCPCS ALLOWED ON BILL TYPES 32X-34X  
6929 = (U) ADJUSTMENT BILL LIFE RESERVE  
6930 = (U) ADJUSTMENT BILL LIFE PSYCH DYS  
7000 = (U) INVALID DOEBA/DOLBA  
7002 = (U) LESS THAN 60/61 BETWEEN SPELLS  
7010 = (E) TOB 85X/ELECTN PRD: COND CD 07 REQD  
71X1 = (C) SUBMITTED CHARGES INVALID  
71X2 = (C) MAMMOGRPY/PROC CODE MOD TC,26/CHG  
71X3 = (C) HCPCS 76092 PAY INDICATOR <> A,R,S  
& 76085 PAY INDICATOR A,R,S  
72X1 = (C) ALLOWED CHGS INVALID  
72X2 = (C) ALLOWED/SUBMITTED CHARGES/TYPE  
72X3 = (C) DENIED LINE/ALLOWED CHARGES  
7230 = (C) FRAMES >1, LENSES >2  
73X1 = (C) SS NUMBER INVALID  
73X2 = (C) CARRIER ASSIGNED PROV NUM MISSING  
74X1 = (C) LOCALITY CODE INVAL FOR CONTRACT  
76X1 = (C) PL OF SER INVAL ON MAMMOGRAPHY BILL  
77X1 = (C) PLACE OF SERVICE INVALID  
77X2 = (C) PHYS THERAPY/PLACE  
77X3 = (C) PHYS THERAPY/SPECIALTY/TYPE  
77X4 = (C) ASC/TYPE/PLACE/REIMB IND/DED IND  
77X6 = (C) TOS=F, PL OF SER NOT = 24  
7701 = (C) INCORRECT MODIFIER  
7777 = (D) POSS DUPE, PART B DOC-ID  
78XA = (C) MAMMOGRAPHY BEFORE 1991  
78XB = (C) ANTI-CANCER BEFORE 01/01/1998  
78X1 = (C) FROM DATE IMPOSSIBLE  
78X2 = (C) FROM DATE > CURRENT DATE OR  
< 07/01/1966  
78X3 = (C) FROM DATE GREATER THAN THRU DATE  
78X4 = (C) FROM DATE > RCVD DATE/PAY-DENY  
78X5 = (C) FROM DATE > PAID DATE/TYPE/100%  
78X7 = (C) LAB EDIT/TYPE/100%/FROM DATE  
79X1 = (C) THRU DATE IMPOSSIBLE  
79X2 = (C) THRU DATE > CURRENT DATE

79X3 = (C) THRU DATE>RECD DATE/NOT DENIED  
79X4 = (C) THRU DATE>PAID DATE/NOT DENIED  
8000 = (U) MAIN & 2NDARY DOEBA < 01/01/90  
8028 = (E) NO ENTITLEMENT  
8029 = (U) HH BEFORE PERIOD NOT PRESENT  
8030 = (U) HH BILL VISITS > PT A REMAINING  
8031 = (U) HH PT A REMAINING > 0  
8032 = (U) HH DOLBA+59 NOT GT FROM-DATE  
8050 = (U) HH QUALIFYING INDICATOR = 1  
8051 = (U) HH # VISITS NE AFT PT B APPLIED  
8052 = (U) HH # VISITS NE AFT TRAILER  
8053 = (U) HH BENEFIT PERIOD NOT PRESENT  
8054 = (U) HH DOEBA/DOLBA NOT > 0  
8060 = (U) HH QUALIFYING INDICATOR NE 1  
8061 = (U) HH DATE NE DOLBA IN AFT TRLR  
8062 = (U) HH NE PT-A VISITS REMAINING  
81X1 = (C) NUM OF SERVICES INVALID  
83X1 = (C) DIAGNOSIS INVALID  
8301 = (C) HCPCS/GENDER DIAGNOSIS  
8302 = (C) HCPCS G0101 V-CODE/SEX CODE  
8303 = (C) HCPCS/GENDER  
8304 = (C) BILL TYPE INVALID FOR G0123/4  
8305 = (C) HCPCS/SERVICE DATES/GENDER  
84X1 = (C) PAP SMEAR/DIAGNOSIS/GENDER/PROC  
84X2 = (C) INVALID DME START DATE  
84X3 = (C) INVALID DME START DATE W/HCPCS  
84X4 = (C) HCPCS G0101 V-CODE/SEX CODE  
84X5 = (C) HCPCS CODE WITH INV DIAG CODE  
84X6 = (C) HCPCS/GENDER  
84X7 = (C) HCPCS/SERVICE DATES/GENDER  
84X8 = (C) DUPLICATE HCPCS  
86X1 = (C) CLINICAL LAB HCPCS W/O CLINICAL  
LAB ID  
86X2 = (C) NON-WAIVER HCPCS/PAY DENIAL CODE/  
MODIFIER  
86X8 = (C) CLIA REQUIRES NON-WAIVER HCPCS  
88XX = (D) POSS DUPE, DOC-ID,UNITS,ENT,ALWD  
9000 = (U) DOEBA/DOLBA CALC  
9005 = (U) FULL/COINS HOSP DAYS CALC  
9010 = (U) FULL/COINS SNF DAYS CALC  
9015 = (U) LIFE RESERVE DAYS CALC  
9020 = (U) LIFE PSYCH DAYS CALC  
9030 = (U) INPAT DEDUCTABLE CALC  
9040 = (U) DATA INDICATOR 1 SET  
9050 = (U) DATA INDICATOR 2 SET  
91X1 = (C) PATIENT REIMB/PAY-DENY CODE  
92X1 = (C) PATIENT REIMB INVALID  
92X2 = (C) PROVIDER REIMB INVALID  
92X3 = (C) LINE DENIED/PATIENT-PROV REIMB  
92X4 = (C) MSP CODE/AMT/DATE/ALLOWED CHARGES



92X5 = (C) CHARGES/REIMB AMT NOT CONSISTANT  
92X7 = (C) REIMB/PAY-DENY INCONSISTANT  
9201 = (C) UPIN REF NAME OR INITIAL MISSING  
9202 = (C) UPIN REF FIRST 3 CHAR INVALID  
9203 = (C) UPIN REF LAST 3 CHAR NOT NUMERIC  
93X1 = (C) CASH DEDUCTABLE INVALID  
93X2 = (C) DEDUCT INDICATOR/CASH DEDUCTIBLE  
93X3 = (C) DENIED LINE/CASH DEDUCTIBLE  
93X4 = (C) FROM DATE/CASH DEDUCTIBLE  
93X5 = (C) TYPE/CASH DEDUCTIBLE/ALLOWED CHGS  
9300 = (C) UPIN OTHER, NOT PRESENT  
9301 = (C) UPIN NME MIS/DED TOT LI>0 FR DEN CLM  
9302 = (C) UPIN OPERATING, FIRST 3 NOT NUMERIC  
9303 = (C) UPIN L 3 CH NT NUM/DED TOT LI>YR DED  
9351 = (C) OTHER UPIN PRESENT/MISSING OTHER FIELDS  
9352 = (C) OTHER UPIN INVALID  
9353 = (C) OTHER UPIN INVALID  
94A1 = (C) NON-COVERED FROM DATE INVALID  
94A2 = (C) NON-COVERED FROM > THRU DATE  
94A3 = (C) NON-COVERED THRU DATE INVALID  
94A4 = (C) NON-COVERED THRU DATE > ADMIT  
94A5 = (C) NON-COVERED THRU DATE/ADMIT DATE  
94C1 = (C) PR-PSYCH DAYS INVALID  
94C3 = (C) PR-PSYCH DAYS > PROVIDER LIMIT  
94F1 = (C) REIMBURSEMENT AMOUNT INVALID  
94F2 = (C) REIMBURSE AMT NOT 0 FOR HMO PAID  
94G1 = (C) NO-PAY CODE INVALID  
94G2 = (C) NO-PAY CODE SPACE/NON-COVERD=TOTL  
94G3 = (C) NO-PAY/PROVIDER INCONSISTANT  
94G4 = (C) NO PAY CODE = R & REIMB PRESENT  
94X1 = (C) BLOOD LIMIT INVALID  
94X2 = (C) TYPE/BLOOD DEDUCTIBLE  
94X3 = (C) TYPE/DATE/LIMIT AMOUNT  
94X4 = (C) BLOOD DED/TYPE/NUMBER OF SERVICES  
94X5 = (C) BLOOD/MSP CODE/COMPUTED LINE MAX  
9401 = (C) BLOOD DEDUCTIBLE AMT > 3  
9402 = (C) BLOOD FURNISHED > DEDUCTIBLE  
9403 = (C) DATE OF BIRTH MISSING ON PRO-PAY  
9404 = (C) INVALID GENDER CODE ON PRO-PAY  
9407 = (C) INVALID DIAGNOSIS  
9408 = (C) INVALID DRG NUMBER (GLOBAL)  
9409 = (C) HCFA DRG<>DRG ON BILL  
940X = (C) INVALID DRG  
9410 = (C) CABG/PCOE,INVALID DRG  
95X1 = (C) MSP CODE G/DATE BEFORE 1/1/87  
95X2 = (C) MSP AMOUNT APPLIED INVALID  
95X3 = (C) MSP AMOUNT APPLIED > SUB CHARGES  
95X4 = (C) MSP PRIMARY PAY/AMOUNT/CODE/DATE  
95X5 = (C) MSP CODE = G/DATE BEFORE 1987  
95X6 = (C) MSP CODE = X AND NOT AVOIDED

95X7 = (C) MSP CODE VALID, CABG/PCOE  
 96X1 = (C) OTHER AMOUNTS INVALID  
 96X2 = (C) OTHER AMOUNTS > PAT-PROV REIMB  
 97X1 = (C) OTHER AMOUNTS INDICATOR INVALID  
 97X2 = (C) GRUDMAN SW/GRUDMAN AMT NOT > 0  
 98X1 = (C) COINSURANCE INVALID  
 98X3 = (C) MSP CODE/TYPE/COIN AMT/ALLOW/CSH  
 98X4 = (C) DATE/MSP/TYPE/CASH DED/ALLOW/COI  
 98X5 = (C) DATE/ALLOW/CASH DED/REIMB/MSP/TYP  
 9801 = (C) REV CENTER CODE 0910 WITH SERVICE  
 DATE > 10/15/2004  
 99XX = (D) POSS DUPE, PART B DOC-ID  
 9901 = (C) REV CODE INVALID OR TRAILER CNT=0  
 9902 = (C) ACCOMMODATION DAYS/FROM/THRU DATE  
 9903 = (C) NO CLINIC VISITS FOR RHC  
 9904 = (C) INCOMPATIBLE DATES/CLAIM TYPE  
 991X = (C) NO DATE OF SERVICE  
 9910 = (C) BLOOD DEDUCTIBLE NON NUMERIC  
 9911 = (C) BLOOD DEDUCTIBLE PRESENT WITHOUT  
 BLOOD FURNISHED  
 9920 = (C) CASH DEDUCTIBLE INVALID  
 9930 = (C) COINSURANCE INVALID  
 9931 = (C) OUTPAT COINSURANCE VALUES  
 9933 = (C) RATE EXCEDES MAMMOGRAPHY LIMIT  
 9934 = (C) HCPCS 76092 NON COVERED/76085 COVERED  
 9940 = (C) PROVIDER PAYMENT INVALID  
 9941 = (C) REIMBURSEMENT AMOUNT/COND/NON-PAYMENT/  
 PRIMARY PAYER  
 9942 = (C) PATIENT DISTRIBUTION INVALID  
 9944 = (C) STAY FROM>97273,DIAG<>V103,163,7612  
 9945 = (C) HCPCS INVALID FOR SERVICE DATES  
 9946 = (C) TOB INVALID FOR HCPCS  
 9947 = (C) INVALID DATE FOR HCPCS  
 9948 = (C) STAY FROM>96365,DIAG=V725  
 9960 = (C) MED CHOICE BUT HMO DATA MISSING  
 9965 = (C) HMO PRESENT BUT MED CHOICE MISSING  
 9968 = (C) MED CHOICE NOT= HMO PLAN NUMBER  
 9999 = (U) MAIN SPELL TRAILER NUMBER DOES NOT MATCH SPELL

NCH\_EDIT\_TRLR\_IND\_TB

NCH Edit Trailer Indicator Table

E = Edit code trailer present

NCH\_LINE\_TRLR\_IND\_TB

NCH Line Item Trailer Indicator Table

L = Line Item trailer present

Blank = No trailer present

NCH\_MCO\_TRLR\_IND\_TB

NCH Managed Care Organization (MCO) Trailer Indicator Table

M = MCO trailer present

NCH\_MQA\_RIC\_TB

NCH MQA Record Identification Code Table

- 1 = Inpatient
- 2 = SNF
- 3 = Hospice
- 4 = Outpatient
- 5 = Home Health Agency
- 6 = Physician/Supplier
- 7 = Durable Medical Equipment

NCH\_NEAR\_LINE\_REC\_VRSN\_TB

NCH Near Line Record Version Table

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

NCH\_NEAR\_LINE\_RIC\_TB

NCH Near-Line Record Identification Code Table

- O = Part B physician/supplier claim record (processed by local carriers; can include DMEPOS services)
- V = Part A institutional claim record (inpatient (IP), skilled nursing facility (SNF), christian science (CS), home health agency (HHA), or hospice)
- W = Part B institutional claim record (outpatient (OP), HHA)
- U = Both Part A and B institutional home

health agency (HHA) claim records --  
due to HHPPS and HHA A/B split.  
(effective 10/00)  
M = Part B DMEPOS claim record (processed  
by DME Regional Carrier) (effective 10/93)

NCH\_PATCH\_TB

NCH Patch Table

- 01 = RRB Category Equatable BIC - changed (all claim types) -- applied during the Nearline 'G' conversion to claims with NCH weekly process date before 3/91. Prior to Version 'H', patch indicator stored in redefined Claim Edit Group, 3rd occurrence, position 2.
- 02 = Claim Transaction Code made consistent with NCH payment/edit RIC code (OP and HHA) -- effective 3/94, CWFMQA began patch. During 'H' conversion, patch applied to claims with NCH weekly process date prior to 3/94. Prior to version 'H', patch indicator stored in redefined Claim Edit Group, 4th occurrence, position 1.
- 03 = Garbage/nonnumeric Claim Total Charge Amount set to zeroes (Instnl) -- during the Version 'G' conversion, error occurred in the derivation of this field where the claim was missing revenue center code = '0001'. In 1994, patch was applied to the OP and HHA SAFs only. (This SAF patch indicator was stored in the redefined Claim Edit Group, 4th occurrence, position 2). During the 'H' conversion, patch applied to Nearline claims where garbage or nonnumeric values.
- 04 = Incorrect bene residence SSA standard county code '999' changed (all claim types) -- applied during the Nearline 'G' conversion and ongoing through 4/21/94, calling EQSTZIP routine to claims with NCH weekly process date prior to 4/22/94. Prior to Version 'H' patch indicator stored in redefined Claim Edit Group, 3rd occurrence, position 4.
- 05 = Wrong century bene birth date corrected (all claim types) -- applied during Nearline 'H' conversion to all history where century greater than 1700 and less than 1850; if century less than 1700, zeroes moved.
- 06 = Inconsistent CWF bene medicare status code made consistent with age (all claim types) --

- applied during Nearline 'H' conversion to all history and patched ongoing. Bene age is calculated to determine the correct value; if greater than 64, 1st position MSC = '1'; if less than 65, 1st position MSC = '2'.
- 07 = Missing CWF bene medicare status code derived (all claim types) -- applied during Nearline 'H' conversion to all history and patched ongoing, except claims with unknown DOB and/or Claim From Date='0' (left blank). Bene age is calculated to determine missing value; if greater than 64, MSC='10'; if less than 65, MSC = '20'.
- 08 = Invalid NCH primary payer code set to blanks (Instnl) -- applied during Version 'H' conversion to claims with NCH weekly process date 10/1/93-10/30/95, where MSP values = invalid '0', '1', '2', '3' or '4' (caused by erroneous logic in HCFA program code, which was corrected on 11/1/95).
- 09 = Zero CWF claim accretion date replaced with NCH weekly process date (all claim types) -- applied during Version 'H' conversion to Instnl and DMERC claims; applied during Version 'G' conversion to non-institutional (non-DMERC) claims. Prior to Version 'H', patch indicator stored in redefined claim edit group, 3rd occurrence, position 1.
- 10 = Multiple Revenue Center 0001 (Outpatient, HHA and Hospice) -- patch applied to 1998 & 1999 Nearline and SAFs to delete any revenue codes that followed the first '0001' revenue center code. The edit was applied across all institutional claim types, including Inpatient/SNF (the problem was only found with OP/HHA/Hospice claims). The problem was corrected 6/25/99.
- 11 = Truncated claim total charge amount in the fixed portion replaced with the total charge amount in the revenue center 0001 amount field -- service years 1998 & 1999 patched during quarterly merge. The 1998 & 1999 SAFs were corrected when finalized in 7/99. The patch was done for records with NCH Daily Process Date 1/4/99 - 5/14/99.
- 12 = Missing claim-level HHA Total Visit Count -- service years 1998, 1999 & 2000 patch applied during Version 'I' conversion of both the Nearline and SAFs. Problem occurs in those claims recovered during the missing claims

effort.

- 13 = Inconsistent Claim MCO Paid Switch made consistent with criteria used to identify an inpatient encounter claim -- if MCO paid switch equal to blank or '0' and ALL conditions are met to indicate an inpatient encounter claim (bene enrolled in a risk MCO during the service period), change the switch to a '1'. The patch was applied during the Version 'I' conversion, for claims back to 7/1/97 service thru date.
- 14 = SNF claims incorrectly identified as Inpatient Encounter claims -- SNF claims matching the Inpatient encounter data criteria were incorrectly identified as Inpatient encounter claims (claim type code = '61' instead of '20' or '30'). NOTE: if the SNF claims were identified the MCO paid switch was set to '1'. The patch was applied to correctly identify these claims as a '20' or '30'. The MCO paid switch will be set to '0' as there is no way to recover the original value. The problem occurred in claims with an NCH Weekly Process Date ranging from 7/7/2000 - 1/26/2001. The patch applied date is 03/30/2001.
- 15 = HHA Part A claims with overlaid revenue center lines - During the Version 'I' conversion, NCH made each segment of a claim contains a maximum of 45 revenue lines. During the month of June 2000 our CWFMQA had to be ready to except the new expanded format, but the NCH was not ready. CWFMQA converted these 'I' claims back to Version 'H', a typo in the code caused the additional revenue lines to overlay some of the revenue lines on the base/initial record/segment. The problem occurred in claims with NCH Weekly Process dates from 6/16/00, 6/23/00, 6/30/00 and 7/7/00 (both Version 'H' & 'I' files).

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

The patch applied date is 06/29/2001.

NCH\_PATCH\_TRLR\_IND\_TB

NCH Patch Trailer Indicator Table

P = Patch code trailer present

NCH\_STATE\_SGMT\_TB

NCH State Segment Table

| NCH State Segment | State Codes                                                                                                                 |
|-------------------|-----------------------------------------------------------------------------------------------------------------------------|
| B =               | 01;02;03;04;06;07;08;09;<br>12;13;16;17;19;20;21;25;<br>27;28;29;30;32;35;37;38;<br>40;41;42;43;44;46;47;48;<br>50;51;53-99 |
| C =               | 11;14;15;18;24;26;49;52                                                                                                     |
| D =               | 11;14;15;18;24;26;31;34;<br>45;49;52                                                                                        |
| E =               | 22;23;31;34;36;45                                                                                                           |
| F =               | 10;22;23;31;34;36;45                                                                                                        |
| G =               | 10;22;23;36;39                                                                                                              |
| H =               | 05;10;22;23;39                                                                                                              |
| I =               | 05;10;39                                                                                                                    |
| J =               | 05;10;33;39                                                                                                                 |
| K =               | 05;33;39                                                                                                                    |
| L =               | 05;33;39                                                                                                                    |
| M =               | 05;33                                                                                                                       |
| N =               | 05;33                                                                                                                       |
| O =               | 33                                                                                                                          |
| P =               | 33                                                                                                                          |
| Q =               | 33                                                                                                                          |
| R =               | 33                                                                                                                          |

08/01/2011

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LIMITATIONS APPENDIX FOR RECORD: CARR\_CLM\_REC  
AS OF: 08/01/2011

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

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

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

CHOICES\_DEMO\_LIM

END DATE : 12/12/06  
CONTACT : OIS/EDG/DIDPM

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

08/01/2011

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H3PM.R\_RIF\_LIM\_Q,F