

1
CMS RIF REPORT
AS OF: 08/01/2011

NAME	LENGTH	BEG	END	CONTENTS
*** DMERC Claim Record (NCH)	VAR	1	5441	REC
				Durable medical equipment (DME) regional carrier (DMERC) claim record for version J of the NCH.
				STANDARD ALIAS : DMERC_CLM_REC
				SYSTEM ALIAS : UTLDMERI
				LIMITATIONS :
				REFER TO :
				CHOICES_DEMO_LIM
				PMT_AMT_EXCEDG_CHRG_AMT_LIM
1. DMERC Claim Fixed Group	377	1	377	GRP
				STANDARD ALIAS : DMERC_CLM_FIX_GRP
2. Claim Record Identification Group	8	1	8	GRP
				Effective with Version 'I' the record length, version code, record identification, code and NCH derived claim type code were moved to this group for internal NCH processing.
				STANDARD ALIAS : CLM_REC_IDENT_GRP
3. Record Length Count	3	1	3	PACK
				Effective with Version H, the count (in bytes) of the length of the claim record.
				NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991).
				DB2 ALIAS : REC_LNGTH_CNT

SAS ALIAS : REC_LEN
STANDARD ALIAS : REC_LENGTH_CNT

LENGTH : 5 SIGNED : Y

SOURCE : NCH

4. NCH Near-Line Record Version Code
1 4

4 CHAR

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

DB2 ALIAS : NCH_REC_VRSN_CD
SAS ALIAS : REC_LVL
STANDARD ALIAS : NCH_NEAR_LINE_REC_VRSN_CD
TITLE ALIAS : NCH_VERSION

LENGTH : 1

COMMENTS :
Prior to Version H this field was named:
CLM_NEAR_LINE_REC_VRSN_CD.

SOURCE : NCH

CODE TABLE : NCH_NEAR_LINE_REC_VRSN_TB

5. NCH Near Line Record Identification Code
1 5 5

CHAR

A code defining the type of claim record being processed.

COMMON ALIAS : RIC
DB2 ALIAS : NEAR_LINE_RIC_CD
SAS ALIAS : RIC_CD
STANDARD ALIAS : NCH_NEAR_LINE_RIC_CD
TITLE ALIAS : RIC

LENGTH : 1

COMMENTS :
Prior to Version H this field was named:
RIC_CD.

SOURCE : NCH

CODE TABLE : NCH_NEAR_LINE_RIC_TB

6. NCH MQA RIC Code

1 6 6

CHAR

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

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

DB2 ALIAS : NCH_MQA_RIC_CD
SAS ALIAS : MQA_RIC
STANDARD ALIAS : NCH_MQA_RIC_CD
TITLE ALIAS : MQA_RIC

LENGTH : 1

SOURCE : NCH QA PROCESS

CODE TABLE : NCH_MQA_RIC_TB

7. NCH Claim Type Code

2 7 8

CHAR

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

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

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

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

DB2 ALIAS : NCH_CLM_TYPE_CD
SAS ALIAS : CLM_TYPE
STANDARD ALIAS : NCH_CLM_TYPE_CD
TITLE ALIAS : CLAIM_TYPE

LENGTH : 2

DERIVATIONS :

FFS CLAIM TYPE CODES DERIVED FROM:

NCH CLM_NEAR_LINE_RIC_CD
NCH PMT_EDIT_RIC_CD
NCH CLM_TRANS_CD
NCH PRVDR_NUM

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:

(Pre-HDC processing -- AVAILABLE IN NCH)
CLM_MCO_PD_SW
CLM_RLT_COND_CD
MCO_CNTRCT_NUM
MCO_OPTN_CD
MCO_PRD_EFCTV_DT
MCO_PRD_TRMNTN_DT

DERIVATION RULES:

SET CLM_TYPE_CD TO 10 (HHA CLAIM) WHERE THE
FOLLOWING CONDITIONS ARE MET:

1. CLM_NEAR_LINE_RIC_CD EQUAL 'V', 'W' OR 'U'
2. PMT_EDIT_RIC_CD EQUAL 'F'
3. CLM_TRANS_CD EQUAL '5'

SET CLM_TYPE_CD TO 20 (SNF NON-SWING BED CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '0' OR '4'
4. POSITION 3 OF PRVDR_NUM IS NOT 'U', 'W', 'Y'
OR 'Z'

SET CLM_TYPE_CD TO 30 (SNF SWING BED CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '0' OR '4'
4. POSITION 3 OF PRVDR_NUM EQUAL 'U', 'W', 'Y'
OR 'Z'

SET CLM_TYPE_CD TO 40 (OUTPATIENT CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM_NEAR_LINE_RIC_CD EQUAL 'W'
2. PMT_EDIT_RIC_CD EQUAL 'D'
3. CLM_TRANS_CD EQUAL '6'

SET CLM_TYPE_CD TO 50 (HOSPICE CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'

2. PMT_EDIT_RIC_CD EQUAL 'I'
3. CLM_TRANS_CD EQUAL 'H'

SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '1' '2' OR '3'

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

1. CLM_MCO_PD_SW = '1'
2. CLM_RLT_COND_CD = '04'
3. MCO_CNTRCT_NUM
MCO_OPTN_CD = 'C'
CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
ENROLLMENT PERIODS

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

1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
3. CLM_TRANS_CD EQUAL '1' '2' OR '3'
4. FI_NUM = 80881

SET CLM_TYPE_CD TO 62 (Medicare Advantage IME/GME
CLAIMS - 10/1/05 - FORWARD)
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM_MCO_PD_SW = '0'
2. CLM_RLT_COND_CD = '04' & '69'
3. MCO_CNTRCT_NUM
MCO_OPTN_CD = 'C'
CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
ENROLLMENT PERIODS

SET CLM_TYPE_CD TO 63 (HMO NO-PAY CLAIMS)
WHERE THE FOLLOWING CONDITIONS ARE MET:
CLAIMS PROCESSED ON OR AFTER 10/6/08

1. CLM_THRU_DT ON OR AFTER 10/1/06
2. CLM_MCO_PD_SW = '1'
3. CLM_RLT_COND_CD = '04'
4. MCO_CNTRCT_NUM
MCO_OPTN_CD = 'A', 'B' OR 'C'
CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
ENROLLMENT PERIODS

5. ZERO REIMBURSEMENT (CLM_PMT_AMT)

SET CLM_TYPE_CD TO 63 (HMO NO-PAY CLAIMS)
WHERE THE FOLLOWING CONDITIONS ARE MET:
CLAIMS PROCESSED PRIOR to 10/6/08

1. MCO_CNTRCT_NUM
MCO_OPTN_CD = 'A', 'B' OR 'C'
CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
ENROLLMENT PERIODS
2. ZERO REIMBURSEMENT (CLM_PMT_AMT)

SET CLM_TYPE_CD TO 64 (HMO CLAIMS PAID AS FFS)
WHERE THE FOLLOWING CONDITIONS ARE MET:
CLAIMS PROCESSED PRIOR to 10/6/08

1. MCO_CNTRCT_NUM
MCO_OPTN_CD = '1', '2' OR '4'
CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
ENROLLMENT PERIODS

SET CLM_TYPE_CD TO 64 (HMO CLAIMS PAID AS FFS)
WHERE THE FOLLOWING CONDITIONS ARE MET:
CLAIMS PROCESSED on or after 10/6/08

1. CLM_RLT_COND_CD = '04'
2. MCO_CNTRCT_NUM
MCO_OPTN_CD = '1', '2' OR '4'
CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
ENROLLMENT PERIODS

SET CLM_TYPE_CD TO 71 (RIC O non-DMEPOS CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2. HCPCS_CD not on DMEPOS table

SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM)
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM_NEAR_LINE_RIC_CD EQUAL 'O'
2. HCPCS_CD on DMEPOS table (NOTE: if one or more line item(s) match the HCPCS on the DMEPOS table).

SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS DMERC CLAIM)

WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM_NEAR_LINE_RIC_CD EQUAL 'M'
2. HCPCS_CD not on DMEPOS table

SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM)
 WHERE THE FOLLOWING CONDITIONS ARE MET:
 1. CLM_NEAR_LINE_RIC_CD EQUAL 'M'
 2. HCPCS_CD on DMEPOS table (NOTE: if one or
 more line item(s) match the HCPCS on the
 DMEPOS table).

SOURCE : NCH

CODE TABLE : NCH_CLM_TYPE_TB

8. Carrier/DMERC Claim Link Group
 125 9 133 GRP

Effective with Version 'I', this group
 was added to the carrier and DMERC records
 to keep fields common across all record types
 in the same position. Due to OP PPS, several
 fields on the Institutional record had to be
 moved to a link group so those same fields had
 to be moved on the carrier records eventhough
 OP PPS only affects institutional claims.

STANDARD ALIAS : CARR_DMERC_CLM_LINK_GRP

9. Claim Locator Number Group
 11 9 19 GRP

This number uniquely identifies the beneficiary in
 the NCH Nearline.

COMMON ALIAS : HIC

STANDARD ALIAS : CLM_LCTR_NUM_GRP

TITLE ALIAS : HICAN

10. Beneficiary Claim Account Number
 9 9 17 CHAR

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

COMMON ALIAS : CAN

DB2 ALIAS : BENE_CLM_ACNT_NUM

SAS ALIAS : CAN

STANDARD ALIAS : BENE_CLM_ACNT_NUM

TITLE ALIAS : CAN

LENGTH : 9

SOURCE : SSA,RRB

LIMITATIONS :

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

11. NCH Category Equatable Beneficiary Identification Code

2 18 19 CHAR

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

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

COMMON ALIAS : NCH_BASE_CATEGORY_BIC
DB2 ALIAS : CTGRY_EQTBL_BIC
SAS ALIAS : EQ_BIC
STANDARD ALIAS : NCH_CTGRY_EQTBL_BIC_CD
TITLE ALIAS : EQUATED_BIC

LENGTH : 2

COMMENTS :

Prior to Version H this field was named:
CTGRY_EQTBL_BENE_IDENT_CD.

SOURCE : BIC EQUATE MODULE

CODE TABLE : CTGRY_EQTBL_BENE_IDENT_TB

12. Beneficiary Identification Code

2 20 21 CHAR

The code identifying the type of relationship between an individual and a primary Social Security Administration (SSA) beneficiary or a primary Railroad Board (RRB) beneficiary.

COMMON ALIAS : BIC

DA3 ALIAS : BENE_IDENT_CODE
DB2 ALIAS : BENE_IDENT_CD
SAS ALIAS : BIC
STANDARD ALIAS : BENE_IDENT_CD
TITLE ALIAS : BIC

LENGTH : 2

SOURCE : SSA/RRB

EDIT RULES :
EDB REQUIRED FIELD

CODE TABLE : BENE_IDENT_TB

13. NCH State Segment Code

1 22 22 CHAR

The code identifying the segment of the NCH Nearline file containing the beneficiary's record for a specific service year. Effective 12/96, segmentation is by CLM_LCTR_NUM, then final action sequence within residence state. (Prior to 12/96, segmentation was by ranges of county codes within the residence state.)

DB2 ALIAS : NCH_STATE_SGMT_CD
SAS ALIAS : ST_SGMT
STANDARD ALIAS : NCH_STATE_SGMT_CD
TITLE ALIAS : NEAR_LINE_SEGMENT

LENGTH : 1

COMMENTS :
Prior to Version H this field was named:
BENE_STATE_SGMT_NEAR_LINE_CD.

SOURCE : NCH

CODE TABLE : NCH_STATE_SGMT_TB

14. Beneficiary Residence SSA Standard State Code

2 23 24 CHAR

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

DA3 ALIAS : SSA_STANDARD_STATE_CODE
DB2 ALIAS : BENE_SSA_STATE_CD
SAS ALIAS : STATE_CD
STANDARD ALIAS : BENE_RSDNC_SSA_STD_STATE_CD
TITLE ALIAS : BENE_STATE_CD

LENGTH : 2

COMMENTS :

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

SOURCE : SSA/EDB

EDIT RULES :

OPTIONAL: MAY BE BLANK

CODE TABLE : GEO_SSA_STATE_TB

15. Claim From Date

8 25 32 NUM

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

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

DB2 ALIAS : CLM_FROM_DT

SAS ALIAS : FROM_DT

STANDARD ALIAS : CLM_FROM_DT

TITLE ALIAS : FROM_DATE

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :

YYYYMMDD

16. Claim Through Date

8 33 40 NUM

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

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

DB2 ALIAS : CLM_THRU_DT
SAS ALIAS : THRU_DT
STANDARD ALIAS : CLM_THRU_DT
TITLE ALIAS : THRU_DATE

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

17. NCH Weekly Claim Processing Date
8 41 48

NUM

The date the weekly NCH database load process cycle begins, during which the claim records are loaded into the Nearline file. This date will always be a Friday, although the claims will actually be appended to the database subsequent to the date.

DB2 ALIAS : NCH_WKLY_PROC_DT
SAS ALIAS : WKLY_DT
STANDARD ALIAS : NCH_WKLY_PROC_DT
TITLE ALIAS : NCH_PROCESS_DT

LENGTH : 8 SIGNED : N

COMMENTS :
Prior to Version H this field was named:
HCFA_CLM_PROC_DT.

SOURCE : NCH

EDIT RULES :
YYYYMMDD

18. CWF Claim Accretion Date
8 49 56

NUM

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

DB2 ALIAS : CWF_CLM_ACRTN_DT
SAS ALIAS : ACRTN_DT
STANDARD ALIAS : CWF_CLM_ACRTN_DT
TITLE ALIAS : ACCRETION_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

19. CWF Claim Accretion Number
2 57 58

PACK

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

DB2 ALIAS : CWF_CLM_ACRTN_NUM
SAS ALIAS : ACRTN_NM
STANDARD ALIAS : CWF_CLM_ACRTN_NUM
TITLE ALIAS : ACCRETION_NUMBER

LENGTH : 3 SIGNED : Y

SOURCE : CWF

20. Carrier Claim Control Number
15 59 73

CHAR

Unique control number assigned by a carrier to a non-institutional claim.

COMMON ALIAS : CCN
DB2 ALIAS : CARR_CLM_CNTL_NUM
SAS ALIAS : CARRCNTL
STANDARD ALIAS : CARR_CLM_CNTL_NUM
TITLE ALIAS : CCN

LENGTH : 15

COMMENTS :

For the physician/supplier or DMERC claim, this field allows CMS to associate each line item with its respective claim.

SOURCE : CWF

EDIT RULES :
LEFT JUSTIFY

21. FILLER

38 74 111

CHAR

DB2 ALIAS : FILLER

LENGTH : 38

22. NCH Daily Process Date

8 112 119

NUM

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

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

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

DB2 ALIAS : NCH_DAILY_PROC_DT

SAS ALIAS : DAILY_DT

STANDARD ALIAS : NCH_DAILY_PROC_DT

TITLE ALIAS : DAILY_PROCESS_DT

LENGTH : 8 SIGNED : N

SOURCE : NCH

EDIT RULES :
YYYYMMDD

23. NCH Segment Link Number

5 120 124

PACK

Effective with Version 'I', the system generated number used in conjunction with the NCH daily process date to keep records/segments

belonging to a specific claim together.
This field was added to ensure that records/
segments that come in on the same batch with
the same identifying information in the link
group are not mixed with each other.

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

DB2 ALIAS : NCH_SGMT_LINK_NUM
SAS ALIAS : LINK_NUM
STANDARD ALIAS : NCH_SGMT_LINK_NUM
TITLE ALIAS : LINK_NUM

LENGTH : 9 SIGNED : Y

SOURCE : NCH

24. Claim Total Segment Count
2 125 126

NUM

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

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

DB2 ALIAS : TOT_SGMT_CNT
SAS ALIAS : SGMT_CNT
STANDARD ALIAS : CLM_TOT_SGMT_CNT
TITLE ALIAS : SEGMENT_COUNT

LENGTH : 2 SIGNED : N

SOURCE : CWF

25. Claim Segment Number
2 127 128

NUM

Effective with Version I, the number used

to identify an actual record/segment (1 - 10)
associated with a given claim.

NOTE: During the Version I conversion this
field was populated with data throughout
history (back to service year 1991).
For institutional claims prior to 7/00,
this number will be either 1 or 2. For
noninstitutional claims, the number will
always be 1.

DB2 ALIAS : CLM_SGMT_NUM
SAS ALIAS : SGMT_NUM
STANDARD ALIAS : CLM_SGMT_NUM
TITLE ALIAS : SEGMENT_NUMBER

LENGTH : 2 SIGNED : N

SOURCE : CWF

26. Claim Total Line Count

3 129 131

NUM

Effective with Version I, the count used to
identify the total number of revenue center
lines associated with the claim.

NOTE: During the Version I conversion this
field was populated with data throughout
history (back to service year 1991).
Prior to Version 'I', the maximum line count
will be no more than 58. Effective with Version
'I', the maximum line count could be 450.

DB2 ALIAS : TOT_LINE_CNT
SAS ALIAS : LINECNT
STANDARD ALIAS : CLM_TOT_LINE_CNT
TITLE ALIAS : TOTAL_LINE_COUNT

LENGTH : 3 SIGNED : N

SOURCE : CWF

27. Claim Segment Line Count

2 132 133

NUM

Effective with Version I, the count used
to identify the number of lines on a record/
segment.

NOTE: During the Version I conversion this field was populated with data throughout history (back to service year 1991). The maximum line count per record/segment on the revenue center trailer is 45. The maximum number of lines on carrier and DMERC claims are 13.

DB2 ALIAS : SGMT_LINE_CNT
SAS ALIAS : SGMTLINE
STANDARD ALIAS : CLM_SGMT_LINE_CNT
TITLE ALIAS : SEGMENT_LINE_COUNT

LENGTH : 2 SIGNED : N

SOURCE : CWF

28. Carrier/DMERC Claim Common 2 Group
230 134 363

GRP

STANDARD ALIAS : CARR_DMERC_CLM_CMN_2_GRP

29. FILLER
5 134 138

CHAR

DB2 ALIAS : FILLER

LENGTH : 5

30. Carrier Claim Entry Code
1 139 139

CHAR

Carrier-generated code describing whether the Part B claim is an original debit, full credit, or replacement debit.

DB2 ALIAS : CARR_CLM_ENTRY_CD
SAS ALIAS : ENTRY_CD
STANDARD ALIAS : CARR_CLM_ENTRY_CD
TITLE ALIAS : ENTRY_CD

LENGTH : 1

COMMENTS :
Prior to Version H this field was named:
CWFB_CLM_ENTRY_CD.

SOURCE : CWF

				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 pro-
cessed prior to 10/3/97 will contain
spaces in this field.

COMMON ALIAS : PATIENT_MIDDLE_NAME
DB2 ALIAS : 1ST_INITL_MDL_NAME
SAS ALIAS : MDL_INIT
STANDARD ALIAS : CLM_PTNT_1ST_INITL_MDL_NAME
TITLE ALIAS : PATIENT_MIDDLE_INITIAL

LENGTH : 1

SOURCE : CWF

50. Beneficiary CWF Location Code
1 219 219

CHAR

The code that identifies the Common Working File
(CWF) location (the host site) where a beneficiary's
Medicare utilization records are maintained.

COMMON ALIAS : CWF_HOST
DB2 ALIAS : BENE_CWF_LOC_CD
SAS ALIAS : CWFLOCCD
STANDARD ALIAS : BENE_CWF_LOC_CD
TITLE ALIAS : CWF_HOST

LENGTH : 1

SOURCE : CWF

CODE TABLE : BENE_CWF_LOC_TB

51. Claim Principal Diagnosis Group
8 220 227

GRP

Effective with Version 'J', the group used to identify
the principal diagnosis code.
This group contains the principal diagnosis code
and the principal diagnosis version code.

STANDARD ALIAS : CLM_PRNCPAL_DGNS_GRP

52. Claim Principal Diagnosis Version Code
1 220 220

CHAR

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

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

DB2 ALIAS : UNDEFINED

SAS ALIAS : PDVRSNCD

LENGTH : 1

CODE TABLE : CLM_DGNS_VRSN_TB

53. Claim Principal Diagnosis Code
7 221 227

CHAR

The diagnosis code identifying the diagnosis, condition, problem or other reason for the admission/encounter/visit shown in the medical record to be chiefly responsible for the services provided.

NOTE: Effective with Version H, this data is also redundantly stored as the first occurrence of the diagnosis trailer.

NOTE1: Effective with Version 'J', this field has been expanded from 5 bytes to 7 bytes to accommodate the future implementation of ICD-10.

DB2 ALIAS : PRNCPAL_DGNS_CD

SAS ALIAS : PDGNS_CD

LENGTH : 7

SOURCE : CWF

EDIT RULES :
ICD-9-CM

54. FILLER
1 228 228

CHAR

DB2 ALIAS : FILLER

LENGTH : 1

55. Carrier Claim Payment Denial Code
2 229 230

CHAR

The code on a noninstitutional claim indicating to whom payment was made or if the claim was denied.

NOTE1: Effective 4/1/02, this field was expanded to two bytes to accommodate new values. The NCH Nearline file did not expand the current 1-byte field but instituted a crosswalk of the 2-byte field to the 1-byte character value. See table of code for the crosswalk.

NOTE2: Effective with Version 'J', the field has been expanded on the NCH record to 2 bytes, With this expansion, the NCH will no longer use the character values to represent the official two byte values sent in by CWF since 4/2002. During the Version J conversion, all character values were converted to the two byte values throughout history..

DB2 ALIAS : CARR_PMT_DNL_CD
SAS ALIAS : PMTDNLC

LENGTH : 2

COMMENTS :
Prior to Version H this field was named:
CWFB_CLM_PMT_DNL_CD.

CODE TABLE : CARR_CLM_PMT_DNL_TB

56. Claim Excepted/Nonexcepted Medical Treatment Code
1 231 231

CHAR

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

DB2 ALIAS : EXCPTD_NEXCPTD_CD
SAS ALIAS : TRTMT_CD
STANDARD ALIAS : CLM_EXCPTD_NEXCPTD_TRTMT_CD
TITLE ALIAS : EXCPTD_NEXCPTD_CD

LENGTH : 1
SOURCE : CWF
CODE TABLE : CLM_EXCPTD_NEXCPTD_TRTMT_TB

57. Claim Payment Amount

6 232 237 PACK

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

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

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

bursement, and other services outside of the scope of PPS.

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

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

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

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

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

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

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

For demo Ids '01','02','03','04' -- claims contain

amount paid to the provider, except that special 'differentials' paid outside the normal payment system are not included.

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

For demo Ids '06','07','08' -- claims contain actual provider payment but represent a special negotiated bundled payment for both Part A and Part B services. To identify what the conventional provider Part A payment would have been, check value code = 'Y4'. The related noninstitutional (physician/supplier) claims contain what would have been paid had there been no demo.

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

COMMON	ALIAS : REIMBURSEMENT
DB2	ALIAS : CLM_PMT_AMT
SAS	ALIAS : PMT_AMT
STANDARD	ALIAS : CLM_PMT_AMT
TITLE	ALIAS : REIMBURSEMENT

LENGTH : 9.2 SIGNED : Y

COMMENTS :

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

SOURCE : CWF

LIMITATIONS :

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

REFER TO :
PMT_AMT_EXCEDG_CHRG_AMT_LIM

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

58. Carrier Claim Primary Payer Paid Amount
6 238 243

PACK

Effective with Version H, the amount of a payment made on behalf of a Medicare beneficiary by a primary payer other than Medicare, that the provider is applying to covered Medicare charges on a non-institutional claim.

NOTE: During the Version H conversion, this field was populated with data throughout history (back to service year 1991) by summing up the line item primary payer amounts.

DB2 ALIAS : CARR_PRMRY_PYR_AMT
SAS ALIAS : PRPAYAMT
STANDARD ALIAS : CARR_CLM_PRMRY_PYR_PD_AMT
TITLE ALIAS : PRIMARY_PAYER_AMOUNT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

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

59. FILLER
1 244 244

CHAR

DB2 ALIAS : FILLER

LENGTH : 1

60. DMERC Claim Ordering Physician UPIN Number
6 245 250

CHAR

Effective with Version G, the unique physician identification number (UPIN) of the physician ordering the Part B services/DMEPOS item.

DB2 ALIAS : ORDRG_PHYSN_UPIN
SAS ALIAS : ORD_UPIN
STANDARD ALIAS : DMERC_CLM_ORDRG_PHYSN_UPIN_NUM
TITLE ALIAS : ORDRG_UPIN

LENGTH : 6

COMMENTS :

Prior to Version H this field was named:
CWFB_CLM_ORDRG_PHYSN_UPIN_NUM.

SOURCE : CWF

61. DMERC Claim Ordering Physician NPI Number
10 251 260

CHAR

The National Provider Identifier (NPI) assigned to the physician ordering the Part B/DMEPOS line item.

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

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

COMMON ALIAS : ORDERING_PHYSICIAN_NPI
DB2 ALIAS : ORDRG_PHYSN_NPI
SAS ALIAS : ORD_NPI
TITLE ALIAS : ORDRG_NPI

LENGTH : 10

SOURCE : CWF

62. Carrier Claim Provider Assignment Indicator Switch
1 261 261

CHAR

A switch indicating whether or not the provider accepts assignment for the noninstitutional claim.

DB2 ALIAS : PRVDR_ASGNMT_SW
SAS ALIAS : ASGMNTCD
STANDARD ALIAS : CARR_CLM_PRVDR_ASGNMT_IND_SW
TITLE ALIAS : ASSIGNMENT_SW

LENGTH : 1

COMMENTS :
Prior to Version H this field was named:
CWFB_CLM_PRVDR_ASGNMT_IND_SW.

SOURCE : CWF

CODE TABLE : CARR_CLM_PRVDR_ASGNMT_IND_TB

63. NCH Claim Provider Payment Amount
6 262 267

PACK

Effective with Version H, the total payments
made to the provider for this claim (sum of
line item provider payment amounts.)

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

DB2 ALIAS : NCH_PRVDR_PMT_AMT
SAS ALIAS : PROV_PMT
STANDARD ALIAS : NCH_CLM_PRVDR_PMT_AMT
TITLE ALIAS : PRVDR_PMT

LENGTH : 9.2 SIGNED : Y

SOURCE : NCH QA Process

64. NCH Claim Beneficiary Payment Amount
6 268 273

PACK

Effective with Version H, the total payments
made to the beneficiary for this claim (sum of
line payment amounts to the beneficiary.)

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

DB2 ALIAS : NCH_BENE_PMT_AMT

SAS ALIAS : BENE_PMT
STANDARD ALIAS : NCH_CLM_BENE_PMT_AMT
TITLE ALIAS : BENE_PMT

LENGTH : 9.2 SIGNED : Y

SOURCE : NCH QA Process

65. Carrier Claim Beneficiary Paid Amount
6 274 279

PACK

Effective with Version H, the amount paid by the beneficiary for the non-institutional Part B services.

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

DB2 ALIAS : CARR_BENE_PD_AMT
SAS ALIAS : BENEFPAID
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_ALLOW_CHRG_AMT
SAS ALIAS : ALLOWCHRG
STANDARD ALIAS : NCH_CARR_ALLOW_CHRG_AMT
TITLE ALIAS : ALLOW_CHRG

LENGTH : 9.2 SIGNED : Y

SOURCE : NCH QA Process

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

68. Carrier Claim Cash Deductible Applied Amount
6 292 297

PACK

Effective with Version H, the amount of the cash deductible as submitted on the claim.

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

DB2 ALIAS : CASH_DDCTBL_AMT
SAS ALIAS : DEDAPPLY
STANDARD ALIAS : CARR_CLM_CASH_DDCTBL_APPLY_AMT
TITLE ALIAS : CASH_DDCTBL

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

69. Carrier Claim HCPCS Year Code
1 298 298

NUM

Effective with Version H, the terminal digit
of HCPCS version used to code the claim.

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

DB2 ALIAS : CARR_HCPCS_YR_CD
SAS ALIAS : HCPCS_YR
STANDARD ALIAS : CARR_CLM_HCPCS_YR_CD
TITLE ALIAS : HCPCS_YR

LENGTH : 1 SIGNED : N

SOURCE : CWF

70. Carrier Claim MCO Override Indicator Code
1 299 299

CHAR

Effective with Version H, the code used to
indicate whether or not an MCO investigation
applies to the claim (used for internal CWFMQA
editing purposes).

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

DB2 ALIAS : MCO_OVRRD_IND_CD
SAS ALIAS : MCOOVRRD
STANDARD ALIAS : CARR_CLM_MCO_OVRRD_IND_CD
TITLE ALIAS : MCO_OVERRIDE

LENGTH : 1

SOURCE : CWF

CODE TABLE : CARR_CLM_MCO_OVRRD_IND_TB

71. Carrier Claim Hospice Override Indicator Code
1 300 300

CHAR

Effective with Version H, the code used to
indicate whether or not an Hospice investigation
applies to the claim (used for internal CWFMQA
editing purposes).

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

DB2 ALIAS : HOSPC_OVRD_IND_CD
SAS ALIAS : HOSPOVRD
STANDARD ALIAS : CARR_CLM_HOSPC_OVRD_IND_CD
TITLE ALIAS : HOSPC_OVERRIDE

LENGTH : 1

SOURCE : CWF

CODE TABLE : CARR_CLM_HOSPC_OVRD_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. DMERC NCH Edit Code Count
2 364 365 NUM

The count of the number of edit codes annotated to the DMERC claim during HCFA's CWFMQA process. The purpose of this count is to indicate how many claim edit trailers are present. Prior to Version H this field was named: CLM_EDIT_CD_CNT.

DB2 ALIAS : EDIT_TRLR_CNT
SAS ALIAS : DEDCNT
STANDARD ALIAS : DMERC_NCH_EDIT_CD_CNT

LENGTH : 2 SIGNED : N

COMMENTS :
Prior to Version H this field was named: CLM_EDIT_CD_CNT.

SOURCE : NCH

78. DMERC NCH Patch Code Count
2 366 367

NUM

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

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

DB2 ALIAS : DMERC_PATCH_CD_CNT
SAS ALIAS : DPATCNT
STANDARD ALIAS : DMERC_NCH_PATCH_CD_I_CNT

LENGTH : 2 SIGNED : N

SOURCE : NCH

79. DMERC MCO Period Count
1 368 368

NUM

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

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

DB2 ALIAS : DMERC_MCO_PRD_CNT
SAS ALIAS : DMCOCNT
STANDARD ALIAS : DMERC_MCO_PRD_CNT

LENGTH : 1 SIGNED : N

SOURCE : NCH

EDIT RULES :
RANGE: 0 TO 2

80. DMERC Claim Demonstration ID Count
1 369 369

NUM

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

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

DB2 ALIAS : DEMO_TRLR_CNT
SAS ALIAS : DDEMCNT
STANDARD ALIAS : DMERC_CLM_DEMO_ID_CNT

LENGTH : 1 SIGNED : N

SOURCE : NCH

EDIT RULES :
RANGE: 0 TO 5

81. DMERC Claim Diagnosis Code Count
2 370 371

NUM

The count of the number of diagnosis codes (both principal and secondary) reported on a DMERC claim. The purpose of this count is to indicate how many claim diagnosis code trailers are present.

NOTE: Effective with Version 'J', the count of the number of diagnosis code trailers was expanded

from 8 to 12.

DB2 ALIAS : DGNS_TRLR_CNT
SAS ALIAS : DDGNCNT
STANDARD ALIAS : DMERC_CLM_DGNS_CD_J_CNT

LENGTH : 2 SIGNED : N

COMMENTS :
Prior to Version H this field was named:
CLM_DGNS_CD_CNT.

SOURCE : NCH

EDIT RULES :
RANGE: 0 TO 12

82. DMERC Claim Line Count

2 372 373

NUM

The count of the number of line items reported
on the DMERC claim. The purpose of this count
is to indicate how many line item trailers are
present.

DB2 ALIAS : LINE_ITM_TRLR_CNT
SAS ALIAS : DLINECNT
STANDARD ALIAS : DMERC_CLM_LINE_CNT

LENGTH : 2 SIGNED : N

COMMENTS :
Prior to Version H this field was named:
CWFB_CLM_NUM_LINE_ITM_CNT.

SOURCE : CWFB CLAIMS

EDIT RULES :
RANGE: 1 TO 13

83. FILLER

4 374 377

CHAR

DB2 ALIAS : FILLER

LENGTH : 4

84. DMERC Claim Variable Group

VAR 378 5441

GRP

				STANDARD ALIAS : DMERC_CLM_VAR_GRP
85. NCH Edit Group	5	378	382	GRP
				The number of claim edit trailers is determined by the claim edit code count.
				STANDARD ALIAS : NCH_EDIT_GRP
				OCCURS MIN: 0 OCCURS MAX: 13
				DEPENDING ON : DMERC_NCH_EDIT_CD_CNT
86. NCH Edit Trailer Indicator Code	1	378	378	CHAR
				Effective with Version H, the code indicating the presence of an NCH edit trailer.
				NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).
				DB2 ALIAS : EDIT_TRLR_IND_CD
				SAS ALIAS : EDITIND
				STANDARD ALIAS : NCH_EDIT_TRLR_IND_CD
				LENGTH : 1
				SOURCE : NCH QA Process
				CODE TABLE : NCH_EDIT_TRLR_IND_TB
87. NCH Edit Code	4	379	382	CHAR
				The code annotated to the claim indicating the CWFMQA editing results so users will be aware of data deficiencies.
				NOTE: Prior to Version H only the highest priority code was stored. Beginning 11/98 up to 13 edit codes may be present.
				COMMON ALIAS : QA_ERROR_CODE
				DB2 ALIAS : NCH_EDIT_CD
				SAS ALIAS : EDIT_CD

				STANDARD ALIAS : NCH_EDIT_CD
				TITLE ALIAS : QA_ERROR_CD
				LENGTH : 4
				SOURCE : NCH QA EDIT PROCESS
				CODE TABLE : NCH_EDIT_TB
88. NCH Patch Group	11	1	11	GRP
				STANDARD ALIAS : NCH_PATCH_GRP
				OCCURS MIN: 0 OCCURS MAX: 30
				DEPENDING ON : DMERC_NCH_PATCH_CD_I_CNT
89. 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
90. 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
91.	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
92.	MCO Period Group	37	1	37	GRP
					The number of managed care organization (MCO) period data trailers present is determined by the claim MCO period trailer count. This field reflects the two most current MCO periods in the CWF beneficiary history record. It may have no connection to the services on the claim.
				STANDARD	ALIAS : MCO_PRD_GRP
				OCCURS MIN:	0 OCCURS MAX: 2
				DEPENDING ON :	DMERC_MCO_PRD_CNT
93.	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

94. 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

95. 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

96. 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

97. 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

98. 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

99. Claim Demonstration Identification Group

18 1 18

GRP

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

STANDARD ALIAS : CLM_DEMO_ID_GRP

OCCURS MIN: 0 OCCURS MAX: 5

DEPENDING ON : DMERC_CLM_DEMO_ID_CNT

100. 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

101. 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

102. Claim Demonstration Information Text

15 4 18

CHAR

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

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

DB2 ALIAS : CLM_DEMO_INFO_TXT
SAS ALIAS : DEMO_TXT
STANDARD ALIAS : CLM_DEMO_INFO_TXT
TITLE ALIAS : DEMO_INFO

LENGTH : 15

DERIVATIONS :

DERIVATION RULES:

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

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

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

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

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

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

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

Demo ID = 38 (Physician Encounter Claims) -- text field will contain the MCO plan number.

When MCO plan number not present the field will reflect 'INVALID'.

SOURCE : CWF

LIMITATIONS :

REFER TO :
CHOICES_DEMO_LIM

103. Carrier Claim Diagnosis Group
9 1 9

GRP

The number of claim diagnosis trailers is determined by the carrier claim diagnosis code count.

STANDARD ALIAS : CARR_CLM_DGNS_GRP

OCCURS MIN: 0 OCCURS MAX: 12

DEPENDING ON : DMERC_CLM_DGNS_CD_J_CNT

104. 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

105. 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

106. 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

107. DMERC Line Item Group

338 1 338

GRP

STANDARD ALIAS : DMERC_LINE_GRP

OCCURS MIN: 0 OCCURS MAX: 13

DEPENDING ON : DMERC_CLM_LINE_CNT

108. 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

109. DMERC Line Supplier Provider Number

10 2 11

CHAR

Effective with Version 'G', billing number assigned to the supplier of the Part B service/DMEPOS by the National Supplier Clearinghouse, as reported on the line item for the DMERC claim.

DB2 ALIAS : SUPLR_PRVDR_NUM
SAS ALIAS : SUPLRNUM
STANDARD ALIAS : DMERC_LINE_SUPLR_PRVDR_NUM
TITLE ALIAS : SUPLR_NUM

LENGTH : 10

COMMENTS :
Prior to Version H this field was named:
CWFB_SUPLR_PRVDR_NUM.

SOURCE : CWF

110. DMERC Line Item Supplier NPI Number

10 12 21

CHAR

The National Provider Identifier (NPI) assigned to the supplier of the Part B service/DMEPOS line item.

NOTE: Effective May 2007, the NPI will become

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

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

COMMON ALIAS : SUPPLIER_NPI
DB2 ALIAS : SUPLR_NPI_NUM
SAS ALIAS : SUP_NPI
STANDARD ALIAS : DMERC_LINE_SUPLR_NPI_NUM
TITLE ALIAS : SUPLR_NPI

LENGTH : 10

SOURCE : CWF

111. DMERC Line Pricing State Code

2 22 23

CHAR

Prior to Version H this field was named:
CWFB_DME_PRCNG_STATE_CD.

DB2 ALIAS : DMERC_PRCNG_STATE
SAS ALIAS : PRCNG_ST
STANDARD ALIAS : DMERC_LINE_PRCNG_STATE_CD
TITLE ALIAS : DMERC_PRCNG_STATE_CD

LENGTH : 2

COMMENTS :
Prior to Version H this field was named:
CWFB_DME_PRCNG_STATE_CD.

SOURCE : CWF/NCH

CODE TABLE : GEO_SSA_STATE_TB

112. DMERC Line Pricing Zip Code
9 24 32

CHAR

The zip code used to identify where the supply/item was rendered. The pricing state code and the pricing zip code will be used in pricing DMEPOS claims.

NOTE: Due to a change in the CWF release schedule, we will not see data in this field until April 2010.

DB2 ALIAS : DMERC_PRCNG_ZIP_CD

SAS ALIAS : PRCNGZIP

LENGTH : 9

LANGUAGE : C

113. DMERC Line Beneficiary Mailing State Code
2 33 34

CHAR

The state code used to identify the beneficiary's mailing address. This state code may be the same as the pricing state code, but it could be different(e.g. representative payee, temporary address, etc.).

NOTE1: The pricing state code (existing field) will contain the state code where the supply/item was rendered. The mailing state code (new field) will represent where the beneficiary's MSN is sent.

NOTE2: NOTE: Due to a change in the CWF release schedule, we will not see data in this field until April 2010.

DB2 ALIAS : DMERC_MLG_STATE_CD

SAS ALIAS : MLGSTATE

LENGTH : 2

LANGUAGE : C

114. DMERC Line Provider State Code
2 35 36

CHAR

Prior to Version H this field was named:
CWFB_DME_PRVDR_STATE_CD.

DB2 ALIAS : DMERC_PRVDR_STATE

SAS ALIAS : PRVSTATE

STANDARD ALIAS : DMERC_LINE_PRVDR_STATE_CD
TITLE ALIAS : DMERC_PRVDR_STATE_CD

LENGTH : 2

COMMENTS :
Prior to Version H this field was named:
CWFB_DME_PRVDR_STATE_CD.

SOURCE : CWF/NCH

CODE TABLE : GEO_SSA_STATE_TB

115. DMERC Line Supplier Type Code

1 37 37

CHAR

Prior to Version H this field on the DMERC claim
was named: CWFB_PRVDR_TYPE_CD.

DB2 ALIAS : SUPLR_TYPE_CD
SAS ALIAS : SUP_TYPE
STANDARD ALIAS : DMERC_LINE_SUPLR_TYPE_CD
TITLE ALIAS : SUPLR_TYPE

LENGTH : 1

COMMENTS :
Prior to Version H this field on the DMERC claim
was named: CWFB_PRVDR_TYPE_CD.

SOURCE : CWF

CODE TABLE : DMERC_LINE_SUPLR_TYPE_TB

116. Line Provider Tax Number

10 38 47

CHAR

Social security number or employee
identification number of physician/supplier
used to identify to whom payment is made for
the line item service on the noninstitutional
claim.

DB2 ALIAS : LINE_PRVDR_TAX_NUM
SAS ALIAS : TAX_NUM
STANDARD ALIAS : LINE_PRVDR_TAX_NUM
TITLE ALIAS : PRVDR_TAX_NUM

LENGTH : 10

COMMENTS :
Prior to Version H this field was named:
CWFB_PRVDR_TAX_NUM.

SOURCE : NCH

117. Line HCFA Provider Specialty Code
2 48 49

CHAR

CMS specialty code used for pricing the
line item service on the noninstitutional
claim.

DB2 ALIAS : HCFA_SPCLTY_CD
SAS ALIAS : HCFASPCL
STANDARD ALIAS : LINE_HCFA_PRVDR_SPCLTY_CD
TITLE ALIAS : HCFA_PRVDR_SPCLTY

LENGTH : 2

COMMENTS :
Prior to Version H this field was named:
CWFB_HCFA_PRVDR_SPCLTY_CD.

SOURCE : CWF

CODE TABLE : CMS_PRVDR_SPCLTY_TB

118. Line Provider Participating Indicator Code
1 50 50

CHAR

Code indicating whether or not a provider is
participating or accepting assignment for this
line item service on the noninstitutional claim.

DB2 ALIAS : PRVDR_PRTCPTG_CD
SAS ALIAS : PRTCPTG
STANDARD ALIAS : LINE_PRVDR_PRTCPTG_IND_CD
TITLE ALIAS : PRVDR_PRTCPTG_IND

LENGTH : 1

COMMENTS :
Prior to Version H this field was named:
CWFB_PRVDR_PRTCPTG_IND_CD.

SOURCE : CWF

CODE TABLE : LINE_PRVDR_PRTCPTG_IND_TB

119. Line Service Count

6 51 56

PACK

The count of the total number of services
processed for the line item on the non-institutional
claim.

DB2 ALIAS : SRVC_CNT
SAS ALIAS : SRVC_CNT
STANDARD ALIAS : LINE_SRVC_CNT

LENGTH : 7.3 SIGNED : Y

COMMENTS :

Prior to Version H this field was named:
CWFB_SRVC_CNT.

Prior to Version 'J', this field was S9(3)
Length: 7.3

SOURCE : CWF

120. Line HCFA Type Service Code

1 57 57

CHAR

Code indicating the type of service, as defined
in the CMS Medicare Carrier Manual, for this
line item on the non-institutional claim.

DB2 ALIAS : HCFA_TYPE_SRVC_CD
SAS ALIAS : TYPESRVCB
STANDARD ALIAS : LINE_HCFA_TYPE_SRVC_CD
TITLE ALIAS : HCFA_TYPE_SRVC

LENGTH : 1

COMMENTS :

Prior to Version H this field was named:
CWFB_HCFA_TYPE_SRVC_CD.

SOURCE : CWF

EDIT RULES :

The only type of service codes applicable to DMERC
claims are: 1, 9, A, E, G, H, J, K, L, M, P,
R, and S.

CODE TABLE : CMS_TYPE_SRVC_TB

121. Line Place of Service Code

2	58	59	CHAR
The code indicating the place of service, as defined in the Medicare Carrier Manual, for this line item on the noninstitutional claim.			
COMMON ALIAS : POS			
DB2 ALIAS : LINE_PLC_SRVC_CD			
SAS ALIAS : PLCSRVC			
STANDARD ALIAS : LINE_PLC_SRVC_CD			
TITLE ALIAS : PLC_SRVC			
LENGTH : 2			
COMMENTS :			
Prior to Version H this field was named: CWFB_PLC_SRVC_CD.			
SOURCE : CWF			

122. Line First Expense Date

8	60	67	NUM
Beginning date (1st expense) for this line item service on the noninstitutional claim.			
DB2 ALIAS : LINE_1ST_EXPNS_DT			
SAS ALIAS : EXPNSDT1			
STANDARD ALIAS : LINE_1ST_EXPNS_DT			
TITLE ALIAS : 1ST_EXPNS_DT			
LENGTH : 8 SIGNED : N			
COMMENTS :			
Prior to Version H this field was named: CWFB_1ST_EXPNS_DT.			
SOURCE : CWF			
EDIT RULES :			
YYYYMMDD			

123. Line Last Expense Date

8	68	75	NUM
The ending date (last expense) for the line item service on the noninstitutional claim.			
COBOL ALIAS : LST_EXP_DT			

DB2 ALIAS : LINE_LAST_EXPNS_DT
SAS ALIAS : EXPNSDT2
STANDARD ALIAS : LINE_LAST_EXPNS_DT
TITLE ALIAS : LAST_EXPNS_DT

LENGTH : 8 SIGNED : N

COMMENTS :
Prior to Version H this field was named:
CWFB_LAST_EXPNS_DT.

SOURCE : CWF

EDIT RULES :
YYYYMMDD

124. Line HCPCS Code

5 76 80 CHAR

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

DB2 ALIAS : LINE_HCPCS_CD
SAS ALIAS : HCPCS_CD
STANDARD ALIAS : LINE_HCPCS_CD
TITLE ALIAS : HCPCS_CD

LENGTH : 5

COMMENTS :
Prior to Version H this line item field was named: HCPCS_CD. With Version H, a prefix was added to denote the location of this field on each claim type (institutional: REV_CNTR and noninstitutional: LINE).

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

**** Note: ****
CPT-4 codes including both long and short descriptions shall be used in accordance with the CMS/AMA agreement. Any other use violates the AMA copyright.

Level II
Includes codes and descriptors copyrighted by the American Dental Association's Current Dental Terminology, Fifth Edition (CDT-5). These are 5 position alpha-numeric codes comprising the D series. All other level II codes and descriptors are approved and maintained jointly by the alpha-numeric editorial panel (consisting of CMS, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association). These are 5 position alpha-numeric codes representing primarily items and nonphysician services that are not represented in the level I codes.

Level III
Codes and descriptors developed by Medicare carriers for use at the local (carrier) level. These are 5 position alpha-numeric codes in the W, X, Y or Z series representing physician and nonphysician services that are not represented in the level I or level II codes.

125. Line HCPCS Initial Modifier Code
2 81 82

CHAR

A first modifier to the HCPCS procedure code to enable a more specific procedure identification for the line item service on the noninstitutional claim.

DB2 ALIAS : UNDEFINED
SAS ALIAS : MDFR_CD1
STANDARD ALIAS : LINE_HCPCS_INITL_MDFR_CD
TITLE ALIAS : INITIAL_MODIFIER

LENGTH : 2

COMMENTS :
Prior to Version H this field was named:
HCPCS_INITL_MDFR_CD. With Version H, a prefix was added to denote the location of this field

on each claim type (institutional: REV_CNTR and noninstitutional: LINE).

SOURCE : CWF

EDIT RULES :
CARRIER INFORMATION FILE

126. Line HCPCS Second Modifier Code

2 83 84

CHAR

A second modifier to the HCPCS procedure code to make it more specific than the first modifier code to identify the line item procedures for this claim.

DB2 ALIAS : UNDEFINED
SAS ALIAS : MDFR_CD2
STANDARD ALIAS : LINE_HCPCS_2ND_MDFR_CD
TITLE ALIAS : SECOND_MODIFIER

LENGTH : 2

COMMENTS :
Prior to Version H this field was named: HCPCS_2ND_MDFR_CD. With Version H, a prefix was added to denote the location of this field on each claim type (institutional: REV_CNTR and noninstitutional: LINE).

SOURCE : CWF

EDIT RULES :
CARRIER INFORMATION FILE

127. DMERC Line HCPCS Third Modifier Code

2 85 86

CHAR

Prior to Version H this field was named: HCPCS_3RD_MDFR_CD.

DB2 ALIAS : HCPCS_3RD_MDFR_CD
SAS ALIAS : MDFR_CD3
STANDARD ALIAS : DMERC_LINE_HCPCS_3RD_MDFR_CD
TITLE ALIAS : HCPCS_3RD_MDFR

LENGTH : 2

COMMENTS :
Prior to Version H this field was named:

```

HCPCS_3RD_MDFR_CD.

SOURCE          : CWF

128. DMERC Line HCPCS Fourth Modifier Code
      2      87      88 CHAR

Prior to Version H this field was named:
HCPCS_4TH_MDFR_CD.

DB2      ALIAS : HCPCS_4TH_MDFR_CD
SAS      ALIAS : MDFR_CD4
STANDARD ALIAS : DMERC_LINE_HCPCS_4TH_MDFR_CD
TITLE    ALIAS : HCPCS_4TH_MDFR

LENGTH          : 2

COMMENTS :
Prior to Version H this field was named:
HCPCS_4TH_MDFR_CD.

SOURCE          : CWF

129. Line NCH BETOS Code
      3      89      91 CHAR

Effective with Version H, the Berenson-Eggers
type of service (BETOS) for the procedure code
based on generally agreed upon clinically
meaningful groupings of procedures and services.
This field is included as a line item on the
noninstitutional claim.

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

DB2      ALIAS : LINE_NCH_BETOS_CD
SAS      ALIAS : BETOS
STANDARD ALIAS : LINE_NCH_BETOS_CD
TITLE    ALIAS : BETOS

LENGTH          : 3

DERIVATIONS :
DERIVED FROM:
  LINE_HCPCS_CD
  LINE_HCPCS_INITL_MDFR_CD
  LINE_HCPCS_2ND_MDFR_CD
  HCPCS MASTER FILE

```

DERIVATION RULES:

Match the HCPCS on the claim to the HCPCS on the HCPCS Master File to obtain the BETOS code.

SOURCE : NCH

CODE TABLE : BETOS_TB

130. Line IDE Number

7 92 98

CHAR

Effective with Version H, the exemption number assigned by the Food and Drug Administration (FDA) to an investigational device after a manufacturer has been approved by FDA to conduct a clinical trial on that device. HCFA established a new policy of covering certain IDE's which was implemented in claims processing on 10/1/96 (which is NCH weekly process 10/4/96) for service dates beginning 10/1/95.

NOTE: Prior to Version H a dummy line item was created in the last occurrence of line item group to store IDE. The IDE number was housed in two fields: HCPCS code and HCPCS initial modifier; the second modifier contained the value 'ID'. There will be only one distinct IDE number reported on the non-institutional claim. During the Version H conversion, the IDE was moved from the dummy line item to its own dedicated field for each line item (i.e., the IDE was repeated on all line items on the claim.)

DB2 ALIAS : LINE_IDE_NUM
SAS ALIAS : LINE_IDE
STANDARD ALIAS : LINE_IDE_NUM
TITLE ALIAS : IDE_NUMBER

LENGTH : 7

SOURCE : CWF

131. DMERC Line Not Otherwise Classified HCPCS Code Text

14 99 112

CHAR

Prior to Version H this field was named:
CWFB_DME_ITM_NOC_HCPCS_CD_TXT.

DB2 ALIAS : NOC_HCPCS_CD_TXT

SAS ALIAS : NOC_TXT
STANDARD ALIAS : DMERC_LINE_NOC_HCPCS_CD_TXT
TITLE ALIAS : NOC_HCPCS_TXT

LENGTH : 14

COMMENTS :
Prior to Version H this field was named:
CWFB_DME_ITM_NOC_HCPCS_CD_TXT.

SOURCE : CWF

132. Line National Drug Code

11 113 123

CHAR

Effective 1/1/94 on the DMERC claim, the National Drug Code identifying the oral anti-cancer drugs. Effective with Version H, this line item field was added as a placeholder on the carrier claim.

DB2 ALIAS : LINE_NATL_DRUG_CD
SAS ALIAS : NDC_CD
STANDARD ALIAS : LINE_NATL_DRUG_CD
TITLE ALIAS : NDC_CD

LENGTH : 11

SOURCE : CWF

133. Line NCH Payment Amount

6 124 129

PACK

Amount of payment made from the trust funds (after deductible and coinsurance amounts have been paid) for the line item service on the non-institutional claim.

COMMON ALIAS : REIMBURSEMENT
DB2 ALIAS : LINE_NCH_PMT_AMT
SAS ALIAS : LINEPMT
STANDARD ALIAS : LINE_NCH_PMT_AMT
TITLE ALIAS : REIMBURSEMENT

LENGTH : 9.2 SIGNED : Y

COMMENTS :
Prior to Version H this line item field was named:
CLM_PMT_AMT and the size of this field was
S9(7)V99.

SOURCE : NCH

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

134. Line Beneficiary Payment Amount

6 130 135

PACK

Effective with Version H, the payment (reimbursement) made to the beneficiary related to the line item service on the noninstitutional claim.

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

DB2 ALIAS : LINE_BENE_PMT_AMT
SAS ALIAS : LBENPMT
STANDARD ALIAS : LINE_BENE_PMT_AMT
TITLE ALIAS : BENE_PMT_AMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

135. Line Provider Payment Amount

6 136 141

PACK

Effective with Version H, the payment made to the provider for the line item service on the noninstitutional claim.

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

DB2 ALIAS : LINE_PRVDR_PMT_AMT
SAS ALIAS : LPRVPMT
STANDARD ALIAS : LINE_PRVDR_PMT_AMT
TITLE ALIAS : PRVDR_PMT_AMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

136. Line Beneficiary Part B Deductible Amount

6 142 147

PACK

The amount of money for which the carrier has determined that the beneficiary is liable for the Part B cash deductible for the line item service on the noninstitutional claim.

DB2 ALIAS : LINE_DDCTBL_AMT
SAS ALIAS : LDEDAMT
STANDARD ALIAS : LINE_BENE_PTB_DDCTBL_AMT
TITLE ALIAS : PTB_DED_AMT

LENGTH : 9.2 SIGNED : Y

COMMENTS :
Prior to Version H this field was named:
BENE_PTB_DDCTBL_LBLTY_AMT and the size of the
field was S9(3)V99.

SOURCE : CWF

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

137. Line Beneficiary Primary Payer Code
1 148 148

CHAR

The code specifying a federal non-Medicare program or other source that has primary responsibility for the payment of the Medicare beneficiary's medical bills relating to the line item service on the noninstitutional claim.

DB2 ALIAS : LINE_PRMRY_PYR_CD
SAS ALIAS : LPRPAYCD
STANDARD ALIAS : LINE_BENE_PRMRY_PYR_CD
TITLE ALIAS : PRIMARY_PAYER_CD

LENGTH : 1

COMMENTS :
Prior to Version H this field was named:
BENE_PRMRY_PYR_CD.

SOURCE : CWF,VA,DOL,SSA

CODE TABLE : BENE_PRMRY_PYR_TB

138. Line Beneficiary Primary Payer Paid Amount
6 149 154

PACK

The amount of a payment made on behalf of a Medicare beneficiary by a primary payer other than Medicare, that the provider is applying to covered Medicare charges for to the line ITEM SERVICE ON THE NONINSTITUTIONAL.

DB2 ALIAS : LINE_PRMRY_PYR_PD
SAS ALIAS : LPRPDAMT
STANDARD ALIAS : LINE_BENE_PRMRY_PYR_PD_AMT
TITLE ALIAS : PRMRY_PYR_PD

LENGTH : 9.2 SIGNED : Y

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

SOURCE : CWF

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

139. Line Coinsurance Amount

6 155 160

PACK

Effective with Version H, the beneficiary coinsurance liability amount for this line item service on the noninstitutional claim.

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

DB2 ALIAS : LINE_COINSRNC_AMT
SAS ALIAS : COINAMT
STANDARD ALIAS : LINE_COINSRNC_AMT
TITLE ALIAS : COINSRNC_AMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

140. Line Interest Amount

6 161 166

PACK

Amount of interest to be paid for this line item service on the noninstitutional claim.

**NOTE: This is not included in the line item
NCH payment (reimbursement) amount.

DB2 ALIAS : LINE_INTRST_AMT
SAS ALIAS : LINT_AMT
STANDARD ALIAS : LINE_INTRST_AMT
TITLE ALIAS : INTRST_AMT

LENGTH : 9.2 SIGNED : Y

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

SOURCE : CWF

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

141. Line Primary Payer Allowed Charge Amount
6 167 172

PACK

Effective with Version H, the primary payer
allowed charge amount for the line item
service on the noninstitutional claim.

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

DB2 ALIAS : PRMRY_PYR_ALOW_AMT
SAS ALIAS : PRPYALOW
STANDARD ALIAS : LINE_PRMRY_PYR_ALOW_CHRG_AMT
TITLE ALIAS : PRMRY_PYR_ALOW_CHRG

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

142. Line 10% Penalty Reduction Amount
6 173 178

PACK

Effective with Version H, the 10% payment
reduction amount (applicable to a late
filing claim) for the line item service.
on the noninstitutional claim.

DB2 ALIAS : TENPCT_PNLTY_AMT

SAS ALIAS : PNLTYAMT
STANDARD ALIAS : LINE_10PCT_PNLTY_RDCTN_AMT
TITLE ALIAS : TENPCT_PNLTY

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

143. Line Submitted Charge Amount

6 179 184

PACK

The amount of submitted charges for the line
item service on the noninstitutional claim.

DB2 ALIAS : LINE_SBM_T_CHRG_AMT
SAS ALIAS : LSBMTCHG
STANDARD ALIAS : LINE_SBM_T_CHRG_AMT
TITLE ALIAS : SBMT_CHRG

LENGTH : 9.2 SIGNED : Y

COMMENTS :

Prior to Version H this field was named:
CWFB_SBM_T_CHRG_AMT and the field size was
S9(5)V99.

SOURCE : CWF

EDIT RULES :

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

144. Line Allowed Charge Amount

6 185 190

PACK

The amount of allowed charges for the line item
service on the noninstitutional claim. This
charge is used to compute pay to providers or
reimbursement to beneficiaries. **NOTE: The

Note1: The amount includes beneficiary-paid
amounts (i.e., deductible and coinsurance).

Note2: The allowed charge is determined by the
lower of three charges: prevailing, customary or
actual.

DB2 ALIAS : LINE_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_ALLOW_CHRG_AMT and the field size was
S9(5)V99.

SOURCE : CWF

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

145. DMERC Line Screen Savings Amount
6 191 196

PACK

Prior to Version H this field was named:
CWFB_DME_SCRN_SVGS_AMT and the field size was
S9(5)V99.

DB2 ALIAS : LINE_SCRN_SVGS_AMT
SAS ALIAS : SCRNSVGS
STANDARD ALIAS : DMERC_LINE_SCRN_SVGS_AMT
TITLE ALIAS : SCRN_SVGS

LENGTH : 9.2 SIGNED : Y

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

SOURCE : CWF

146. Line DME Purchase Price Amount
6 197 202

PACK

Effective 5/92, the amount representing the
lower of fee schedule for purchase of new or
used DME, or actual charge. In case of rental
DME, this amount represents the purchase cap;
rental payments can only be made until the
cap is met. This line item field is applicable
to non-institutional claims involving DME,
prosthetic, orthotic and supply items,
immunosuppressive drugs, pen, ESRD and oxygen
items referred to as DMEPOS.

DB2 ALIAS : DME_PURC_PRICE_AMT
SAS ALIAS : DME_PURC

STANDARD ALIAS : LINE_DME_PURC_PRICE_AMT
TITLE ALIAS : DME_PURC_PRICE

LENGTH : 9.2 SIGNED : Y

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

SOURCE : CWF

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

147. Line Processing Indicator Code
2 203 204

CHAR

The code on a noninstitutional claim indicating to
whom payment was made or if the claim was denied.

NOTE1: Effective 4/1/02, this field was expanded
to two bytes to accommodate new values. The
NCH Nearline file did not expand the current
1-byte field but instituted a crosswalk of the
2-byte field to the 1-byte character value.
See table of code for the crosswalk.

NOTE2: Effective with Version 'J', the field has been
expanded on the NCH record to 2 bytes, With this
expansion, the NCH will no longer use the character
values to represent the official two byte values sent in
by CWF since 4/2002. During the Version J conversion,
all character values were converted to the two byte
values.

DB2 ALIAS : LINE_PRC SG_IND_CD
SAS ALIAS : PRCNGIND
STANDARD ALIAS : LINE_PRC SG_IND_CD

LENGTH : 2

COMMENTS :
Prior to Version H this field was named:
CWFB_PRC SG_IND_CD.

SOURCE : CWF

CODE TABLE : LINE_PRC SG_IND_TB

148. Line Payment 80%/100% Code

1 205 205

CHAR

The code indicating that the amount shown in the payment field on the noninstitutional line item represents either 80% or 100% of the allowed charges less any deductible, or 100% limitation of liability only.

COMMON ALIAS : REIMBURSEMENT_IND
DB2 ALIAS : LINE_PMT_80_100_CD
SAS ALIAS : PMTINDSW
STANDARD ALIAS : LINE_PMT_80_100_CD
TITLE ALIAS : REINBURSEMENT_IND

LENGTH : 1

COMMENTS :

Prior to Version H this field was named:
CWFB_PMT_80_100_CD.

SOURCE : CWF

CODE TABLE : LINE_PMT_80_100_TB

149. Line Service Deductible Indicator Switch

1 206 206

CHAR

Switch indicating whether or not the line item service on the noninstitutional claim is subject to a deductible.

DB2 ALIAS : SRVC_DDCTBL_SW
SAS ALIAS : DED_SW
STANDARD ALIAS : LINE_SRVC_DDCTBL_IND_SW
TITLE ALIAS : SRVC_DED_IND

LENGTH : 1

COMMENTS :

Prior to Version H this field was named:
CWFB_SRVC_DDCTBL_IND_SW.

SOURCE : CWF

CODE TABLE : LINE_SRVC_DDCTBL_IND_TB

150. Line Payment Indicator Code

1 207 207

CHAR

Code that indicates the payment screen used to determine the allowed charge for the line item service on the noninstitutional claim.

DB2 ALIAS : LINE_PMT_IND_CD
SAS ALIAS : PMTINDCD
STANDARD ALIAS : LINE_PMT_IND_CD
TITLE ALIAS : PMT_IND

LENGTH : 1

COMMENTS :
Prior to Version H this field was named:
CWFB_PMT_IND_CD.

SOURCE : CWF

151. DMERC Line Miles/Time/Units/Services Count
6 208 213

PACK

The count of the total units associated with the DMERC line item service needing unit reporting, including number of services, volume of oxygen and drug dose.

DB2 ALIAS : DMERC_MTUS_CNT
SAS ALIAS : DME_UNIT
STANDARD ALIAS : DMERC_LINE_MTUS_CNT
TITLE ALIAS : MTUS_CNT

LENGTH : 7.3 SIGNED : Y

COMMENTS :
Prior to Version H this field was named:
CWFB_MTUS_CNT.

Prior to Version 'J', this field was S9(3)
Length: 7.3

152. DMERC Line Miles/Time/Units/Services Indicator Code
1 214 214 CHAR

Prior to Version H this field was named:
CWFB_DME_MTUS_IND_CD.

DB2 ALIAS : DMERC_MTUS_IND_CD
SAS ALIAS : UNIT_IND
STANDARD ALIAS : DMERC_LINE_MTUS_IND_CD
TITLE ALIAS : MTUS_IND

				LENGTH	: 1
				COMMENTS :	
					Prior to Version H this field was named: CWFB_DME_MTUS_IND_CD.
				SOURCE	: CWF
				CODE TABLE	: DMERC_LINE_MTUS_IND_TB
153. Line Diagnosis Code Group	8	215	222	GRP	
					Effective with Version 'J', the group used to identify the diagnosis codes at the line level. This group contains the diagnosis code and the diagnosis version code.
					STANDARD ALIAS : LINE_DGNS_CD_GRP
154. Line Diagnosis Version Code	1	215	215	CHAR	
					Effective with Version 'J', the code used to indicate if the diagnosis code is ICD-9 or ICD-10.
					NOTE: With 5010, the diagnosis and procedure codes have been expanded to accomodate ICD-10, even though ICD-10 is not scheduled for implementation until 10/2013.
				DB2	ALIAS : UNDEFINED
				SAS	ALIAS : LDVRSNCD
				LENGTH	: 1
				CODE TABLE	: LINE_DGNS_VRSN_TB
155. Line Diagnosis Code	7	216	222	CHAR	
					The code indicating the diagnosis supporting this line item procedure/service on the noninstitutional claim.
				DB2	ALIAS : LINE_DGNS_CD
				SAS	ALIAS : LINEDGNS
				STANDARD	ALIAS : LINE_DGNS_CD
				TITLE	ALIAS : DGNS_CD

LENGTH : 7

COMMENTS :
Prior to Version H this field was named:
CWFB_LINE_DGNS_CD.

SOURCE : CWF

156. Line Additional Claim Documentation Indicator Code

1 223 223 CHAR

Effective 5/92, the code indicating additional
claim documentation was submitted for this line
item service on the noninstitutional claim.

COMMON ALIAS : DOCUMENT_IND
DB2 ALIAS : ADDTNL_DCMTN_CD
SAS ALIAS : DCMTN_CD
STANDARD ALIAS : LINE_ADDTNL_CLM_DCMTN_IND_CD
TITLE ALIAS : ADDTNL_DCMTN_IND

LENGTH : 1

COMMENTS :
Prior to Version H this field was named:
CWFB_ADDTNL_CLM_DCMTN_IND_CD.

SOURCE : CWF

EDIT RULES :
In any case where more than one value is
applicable, highest number is shown.

CODE TABLE : LINE_ADDTNL_CLM_DCMTN_IND_TB

157. DMERC Line Screen Suspension Indicator Code

4 224 227 CHAR

Effective with Version G, the code identifying
the medical review (MR) screen that caused DMERC
line item to suspend.

DB2 ALIAS : SCR_N_SUSPNSN_CD
SAS ALIAS : SUSP_IND
STANDARD ALIAS : DMERC_LINE_SCRN_SUSPNSN_IND_CD
TITLE ALIAS : SCR_N_SUSPNSN_IND

LENGTH : 4

SOURCE : CWF

			CODE TABLE	: DMERC_LINE_SCRN_SUSPNSN_IND_TB
158. DMERC Line Screen Result Indicator Code	1	228	228	CHAR
				Effective with Version G, code indicating the outcome of the medical review (MR) unit's evaluation of the DMERC line item.
	DB2		ALIAS	: SCR_N_RSLT_IND_CD
	SAS		ALIAS	: RSLT_IND
	STANDARD		ALIAS	: DMERC_LINE_SCRN_RSLT_IND_CD
	TITLE		ALIAS	: SCR_N_RSLT_IND
	LENGTH		:	1
	COMMENTS		:	
				Prior to Version H this field was named: CWFB_DME_SCRN_RSLT_IND_CD.
	SOURCE		:	CWF
	CODE TABLE		:	DMERC_LINE_SCRN_RSLT_IND_TB
159. DMERC Line Waiver Of Provider Liability Switch	1	229	229	CHAR
				Effective with Version G, the switch indicating the beneficiary was notified that the item, reported as a DMERC line item, may not be considered medically necessary and has agreed in writing to pay for the item.
	DB2		ALIAS	: WVR_PRVDR_LBLTY_SW
	SAS		ALIAS	: WAIVERSW
	STANDARD		ALIAS	: DMERC_LINE_WVR_PRVDR_LBLTY_SW
	TITLE		ALIAS	: WAIVER_LBLTY_SW
	LENGTH		:	1
	COMMENTS		:	
				Prior to Version H this field was named: CWFB_DME_WVR_PRVDR_LBLTY_SW.
	SOURCE		:	CWF
	CODE TABLE		:	YES_NO_TB
160. DMERC Line Decision Indicator Switch				

1 230 230 CHAR

Effective with Version G, the switch identifying whether the DMERC claim represents an original decision or a reversal of an earlier decision on the original claim.

DB2 ALIAS : DMERC_DCSN_IND_SW
SAS ALIAS : DCSN_IND
STANDARD ALIAS : DMERC_LINE_DCSN_IND_SW
TITLE ALIAS : DCSN_IND

LENGTH : 1

COMMENTS :
Prior to Version H this field was named:
CWFB_DME_DCSN_IND_SW.

SOURCE : CWF

CODE TABLE : DMERC_LINE_DCSN_IND_TB

161. Line Consolidated Billing Indicator Code
1 231 231

CHAR

Effective 1/1/2004 with implementation of NCH/NMUD CR#1, this code is reflected on carrier & DMERC claims to identify those line item services (i.e. therapy and nonroutine supply services) that are subject to SNF and Home Health consolidated billing. If the line item service was paid by a carrier prior to the submission of the SNF or home health claim an adjustment for the carrier or DMERC claim will be submitted identifying those services that are subject to consolidated billing.

NOTE1: Prior to 10/2005 (implementation of NCH/NMUD CR#2), this data was stored in position 245 (FILLER) of the line item trailer.

Effective July 2005, this data will no longer be coming into the NCH.

DB2 ALIAS : CNSLDTD_BLG_CD
SAS ALIAS : LCNSLDTD
STANDARD ALIAS : LINE_CNSLDTD_BLG_CD

LENGTH : 1

CODE TABLE : LINE_CNSLDTD_BLG_TB

162. Line Duplicate Claim Check Indicator Code
1 232 232

CHAR

Effective 1/1/2004 with the implementation of NCH/NMUD CR#1, the code used to identify an item or service that appeared to be a duplicate but has been reviewed by a carrier and appropriately approved for payment.

NOTE1: Prior to 10/2005 (implementation of NCH/NMUD CR#2), this data was stored in position 246 (FILLER) on the line item trailer.

DB2 ALIAS : DUP_CLM_CHK_IND_CD
SAS ALIAS : DUP_CHK
STANDARD ALIAS : LINE_DUP_CLM_CHK_IND_CD

LENGTH : 1

SOURCE : CWF

CODE TABLE : LINE_DUP_CLM_CHK_IND_TB

163. Line Hematocrit/Hemoglobin Test Type Code
2 233 234

CHAR

Effective September 1, 2008 with the implementation of CR#3, the code used to identify which reading is reflected in the hematocrit/hemoglobin result number field on the noninstitutional claim.

DB2 ALIAS : HCT_HGB_TYPE_CD
SAS ALIAS : HTYPECD
STANDARD ALIAS : LINE_HCT_HGB_TYPE_CD

LENGTH : 2

CODE TABLE : LINE_HCT_HGB_TYPE_TB

164. Line Hematocrit/Hemoglobin Result Number
3 235 237

CHAR

Effective September 1, 2008, with the implementation of CR#3, the number used to identify the most recent hematocrit or hemoglobin reading on the noninstitutional claim.

NOTE: The hematocrit/hemoglobin test result field is a redefined field. The field is being defined as X(3) and redefined as numeric (99V9). A numeric test on the

alphanumeric field is needed. Whenever a user wants to use the field they must test the alphanumeric field for numerics and if it is numeric then the 99V9 definition would be used. The older data will cause an abend if trying to process numeric data with characters.

DB2 ALIAS : HCT_HGB_RSLT_NUM
SAS ALIAS : HRSLTNUM
STANDARD ALIAS : LINE_HCT_HGB_RSLT_NUM

LENGTH : 3

165. Line Hematocrit/Hemoglobin Result Number -- Redefined
3 235 237 NUM

Effective September 1, 2008, with the implementation of CR#3, the number used to identify the most recent hematocrit or hemoglobin reading on the noninstitutional claim.

NOTE: The hematocrit/hemoglobin test result field is a redefined field. The field is being defined as X(3) and redefined as numeric (99V9). A numeric test on the alphanumeric field is needed. Whenever a user wants to use the field they must test the alphanumeric field for numerics and if it is numeric then the 99V9 definition would be used. The older data will cause an abend if trying to process numeric data with characters.

DB2 ALIAS : HCT_HGB_RSLT_NUM
SAS ALIAS : HRLSTNUM
STANDARD ALIAS : LINE_HCT_HGB_RSLT_NUM_R

LENGTH : 2.1 SIGNED : N

REDEFINE : LINE_HCT_HGB_RSLT_NUM

166. Worker's Compensation Indicator Code
1 238 238 CHAR

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

DB2 ALIAS : LINE_WC_IND_CD
SAS ALIAS : WCINDCD

LENGTH : 1

CODE TABLE : LINE_WC_IND_TB

LANGUAGE : C

167. Line Paperwork (PWK) Code

2 239 240

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

168. FILLER

98 241 338

CHAR

DB2 ALIAS : FILLER

LENGTH : 98

169. 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

DMERC_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 - ophthalmology
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/decomp/excisedisc
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
 O1E = Other drugs
 O1F = Hearing and speech services
 O1G = Immunizations/Vaccinations
 Y1 = Other - Medicare fee schedule
 Y2 = Other - non-Medicare fee schedule
 Z1 = Local codes
 Z2 = Undefined codes

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_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)

~~~~~  
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\_SRVC\_TB

CMS Type of Service Table

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

orthotics  
 Q = Vision items or services  
 R = Rental of DME  
 S = Surgical dressings or other medical supplies  
 (eff 04/95)  
 T = Psychological therapy (term. 12/31/97)  
 outpatient mental health limitation (eff. 1/1/98)  
 U = Occupational therapy  
 V = Pneumococcal/flu vaccine (eff 01/96),  
 Pneumococcal/flu/hepatitis B vaccine (eff 04/95-12/95),  
 Pneumococcal only before 04/95  
 W = Physical therapy  
 Y = Second opinion on elective surgery  
 (obsoleted 1/97)  
 Z = Third opinion on elective surgery  
 (obsoleted 1/97)

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

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

C6 = C6;T6  
C7 = C7;T7  
C8 = C8;T8  
C9 = C9;T9  
F1 = F1;TF  
F2 = F2;TQ  
F3-F8 = Equatable only to itself (e.g., F3 IS  
equatable to F3)  
CA-CZ = Equatable only to itself. (e.g., CA is  
only equatable to CA)

-----  
RRB Categories

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

DMERC\_LINE\_DCSN\_IND\_TB

DMERC Line Decision Indicator Table

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

DMERC\_LINE\_MTUS\_IND\_TB

DMERC Line Miles/Time/Units Indicator Table

0 = Values reported as zero  
3 = Number of services  
4 = Oxygen volume units  
6 = Drug dosage -- since early 1994 this value has  
incorrectly been placed on DMERC claims. The DMERCs  
were overriding the MTUS indicator with a '6' if the  
claim was submitted with an NDC code.  
NOTE: It was recently discovered that this problem  
has been corrected -- no date on when the correction  
became effective.



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

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

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

D = Reserved for future use

E = Paid after automated level I review

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

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

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

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

J = Paid after manual level I review

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

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

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

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

O = Paid after manual level II review

P = Denied for lack of medical necessity;  
highest level of review was manual  
level III review

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

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

S = Denied for coding/unbundling reasons;  
highest level of review was manual  
level III review  
T = Paid after manual level III review

DMERC\_LINE\_SCRN\_SUSPNSN\_IND\_TB

DMERC Line Screen Suspension Indicator Table

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

DMERC\_LINE\_SUPLR\_TYPE\_TB

DMERC Line Supplier Type Table

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

proprietorship for whom EI numbers are  
used in coding the ID field.

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

```

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/O 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) INVALID 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) REFERRING UPIN REQUIRED FOR CLINICAL LAB  
0502 = (C) REFERRING UPIN INVALID  
0601 = (C) GENDER INVALID  
0701 = (C) CONTRACTOR/POS 1-2 PROVIDER NUM INVALID  
0702 = (C) PROVIDER NUMBER VS. TOB  
0703 = (C) MAMMOGRAPHY FOR NOT FEMALE  
0704 = (C) INVALID CONT FOR CABG DEMO  
0705 = (C) INVALID CONT FOR PCOE DEMO  
0706 = (C) REVENUE CENTER CODE MAMMOGRAPHY AND  
BENEFICIARY <35  
0901 = (C) INVALID DISP CODE OF 02  
0902 = (C) INVALID DISP CODE OF SPACES  
0903 = (C) INVALID DISP CODE  
1001 = (C) PROF REVIEW/ACT CODE/BILL TYPE  
13X2 = (C) MULTIPLE ITEMS FOR SAME SERVICE  
1301 = (C) LINE COUNT NOT NUMERIC OR > 13  
1302 = (C) RECORD LENGTH INVALID  
1401 = (C) INVALID MEDICARE STATUS CODE  
1501 = (C) ADMIT DATE/START DATE/ENTRY CODE INVALID  
1502 = (C) ADMIT DATE/START CARE DATE > STAY FROM DATE  
1503 = (C) ADMIT DATE INVALID WITH THRU DATE  
1504 = (C) ADM/FROM/THRU DATE > TODAYS DATE  
1505 = (C) HCPCS W SERVICE DATES > 09-30-94  
1601 = (C) INVESTIGATION IND INVALID  
1701 = (C) SPLIT IND INVALID  
1801 = (C) PAY-DENY CODE INVALID  
1802 = (C) HEADER AMT/LINE ITEMS DENIED  
1803 = (C) MSP COST AVD/ALL MSP LI NOT SAME  
1901 = (C) AB CROSSOVER IND INVALID  
2001 = (C) HOSPICE OVERRIDE INVALID  
2101 = (C) HMO-OVERRIDE/PATIENT-STAT INVALID  
2102 = (C) PATIENT STATUS VS. TOB  
2103 = (C) HIPPS RATE/CMG CODE VS. PATIENT STATUS  
2201 = (C) FROM DATE/HCPCS YR INVALID  
2202 = (C) STAY-FROM DATE > THRU-DATE  
2203 = (C) THRU DATE INVALID  
2204 = (C) FROM DATE BEFORE EFFECTIVE DATE  
2205 = (C) DATE YEARS DIFFERENT ON OUTPAT  
2207 = (C) MAMMOGRAPHY BEFORE 1991  
2208 = (C) TOB '21X', REV CODE 0022 FROM DATE  
< 06-03-98  
2209 = (C) HHA WITH OVERLAPPING DATES JUNE/JULY,  
SEPT/OCT  
2210 = (C) TOB 41X, SERVICE DATES 6/30/00,  
EXCEP/NONEXCEP IND = 1,2  
2212 = (C) TOB 51X WITH SERVICE DATES >6/30/00  
2213 = (C) TOB 32X OR 33X, SERVICE >9/30/00 DAYS

CAN NOT = 60  
 2215 = (C) DEMO 37 WITH VALUE CODES 'A2', 'B2', 'C2'  
 2216 = (C) DEMO 37 OR CONDITION CODE 78 AND CHARGES  
 SUB TO DED > 0  
 2301 = (C) DOCUMENT CNTL OR UTIL DYS INVALID  
 2302 = (C) COVERED DAYS INVALID OR INCONSIST  
 2303 = (C) COST REPORT DAYS > ACCOMIDATION  
 2304 = (C) UTIL DAYS = ZERO ON PATIENT BILL  
 2305 = (C) LATE CHARGE BILL WITH DATA FIELD PRESENT  
 2306 = (C) UTIL DYS/NOPAY/REIMB INCONSISTENT  
 2307 = (C) COND=40,UTL DYS >0/VAL CDE A1,08,09  
 2308 = (C) NOPAY = R WHEN UTIL DAYS = ZERO  
 2401 = (C) NON-UTIL DAYS INVALID  
 2501 = (C) CLAIM RCV DT OR COINSURANCE INVAL  
 2502 = (C) COIN+LR>UTIL DAYS/RCPT DTE>CUR DTE  
 2503 = (C) COIN/TR TYP/UTIL DYS/RCPT DTE>PD/DEN  
 2504 = (C) COINSURANCE AMOUNT EXCESSIVE  
 2505 = (C) COINSURANCE RATE > ALLOWED AMOUNT  
 2506 = (C) COINSURANCE DAYS/AMOUNT INCONSIST  
 2507 = (C) COIN+LR DAYS > TOTAL DAYS FOR YR  
 2508 = (C) COINSURANCE DAYS INVALID FOR TRAN  
 2601 = (C) CLAIM PAID DT INVALID OR LIFE RES  
 2602 = (C) LR-DAYS, NO VAL 08,10/PD/DEN>CUR+27  
 2603 = (C) LIFE RESERVE > RATE FOR CAL YEAR  
 2604 = (C) PPS BILL, NO DAY OUTLIER  
 2605 = (C) LIFE RESERVE RATE > DAILY RATE AVR.  
 28XA = (C) UTIL DAYS > FROM TO BENEF EXH  
 28XB = (C) BENEFITS EXH DATE > FROM DATE  
 28XC = (C) BENEFITS EXH DATE/INVALID TRANS TYPE  
 28XD = (C) OCCUR 23 WITH SPAN 70 ON INPAT HOSP  
 28XE = (C) MULTI BENE EXH DATE (OCCR A3,B3,C3)  
 28XF = (C) ACE DATE ON SNF (NOPAY =B, C, N, W)  
 28XG = (C) SPAN CD 70+4+6+9 NOT = NONUTIL DAYS  
 28XM = (C) OCC CD 42 DATE NOT = SRVCE THRU DTE  
 28XN = (C) INVALID OCC CODE  
 28XO = (C) AN 'N' NO-PAY CODE IS PRESENT AND OCCURRENCE  
 CODE '23' OR '42' IS NOT PRESENT AND THE  
 DATE ASSOCIATED WITH CODE IS MISSING OR NOT  
 EQUAL TO THRU DATE.  
 28XP = (C) THE OCCURRENCE CODE 23 DATE DOES NOT EQUAL THE  
 THRU DATE  
 28X0 = (C) BENE EXH DATE OUTSIDE SERVICE DATES  
 28X1 = (C) OCCUR DATE INVALID  
 28X2 = (C) OCCUR = 20 AND TRANS = 4  
 28X3 = (C) OCCUR 20 DATE < ADMIT DATE  
 28X4 = (C) OCCUR 20 DATE > ADMIT + 12  
 28X5 = (C) OCCUR 20 AND ADMIT NOT = FROM  
 28X6 = (C) OCCUR 20 DATE < BENE EXH DATE  
 28X7 = (C) OCCUR 20 DATE+UTIL-COIN>COVERAGE  
 28X8 = (C) OCCUR 22 DATE < FROM OR > THRU

28X9 = (C) UTIL > FROM - THRU LESS NCOV  
 33X1 = (C) QUAL STAY DATES INVALID (SPAN=70)  
 33X2 = (C) QS FROM DATE NOT < THRU (SPAN=70)  
 33X3 = (C) QS DAYS/ADMISSION ARE INVALID  
 33X4 = (C) QS THRU DATE > ADMIT DATE (SPAN=70)  
 33X5 = (C) SPAN 70 INVALID FOR DATE OF SERVICE  
 33X6 = (C) TOB=18/21/28/51,COND=WO,HMO<>90091  
 33X7 = (C) TOB<>18/21/28/51,COND=WO  
 33X8 = (C) TOB=18/21/28/51,CO=WO,ADM DT<97001  
 33X9 = (C) TOB=32X SPAN 70 OR OCCR BO PRESENT  
 33#A = (C) MULTIPLE PET SCANS  
 33#B = (C) MULTIPLE PET SCANS W/O MODIFIER 26  
 OR TC  
 3401 = (C) DEMO ID = 04 AND RIC NOT = 1 OR 2  
 34X2 = (C) DEMO ID = 04 AND COND WO NOT SHOWN  
 34#3 = (C) CONDITION CODE = W0 AND DEMO NOT = 04  
 35X1 = (C) 60, 61, 66 & NON-PPS / 65 & PPS  
 35X2 = (C) COND = 60 OR 61 AND NO VALU 17  
 35X3 = (C) PRO APPROVAL COND C3,C7 REQ SPAN M0  
 35#3 = (C) (SECOND CONDITION) CONDITION CODE = C3  
 REQUIRES SPAN CODE 76 OR 77  
 35#4 = (C) CONDITION CODE = 69 AND TOB NOT 11X  
 36X1 = (C) SURG DATE < STAY FROM/ > STAY THRU  
 36#1 = (C) SURGICAL DATE = ZEROES OR < FROM OR >  
 THRU DATES  
 3701 = (C) ASSIGN CODE INVALID  
 3705 = (C) 1ST CHAR OF IDE# IS NOT ALPHA  
 3706 = (C) INVALID IDE NUMBER-NOT IN FILE  
 3710 = (C) NUM OF IDE# > REV 0624  
 3715 = (C) NUM OF IDE# < REV 0624  
 3720 = (C) IDE AND LINE ITEM NUMBER > 2  
 3801 = (C) AMT BENE PD INVALID  
 3XA/ = (C) COLORECTAL/PROSTATE SCREENING BILLED  
 MULTIPLE TIMES  
 4001 = (C) BLOOD PINTS FURNISHED INVALID  
 4002 = (C) BLOOD FURNISHED/REPLACED INVALID  
 4003 = (C) BLOOD FURNISHED/VERIFIED/DEDUCT  
 4201 = (C) BLOOD PINTS UNREPLACED INVALID  
 4202 = (C) BLOOD PINTS UNREPLACED/BLOOD DED  
 4203 = (C) INVALID CPO PROVIDER NUMBER  
 4301 = (C) BLOOD DEDUCTABLE INVALID  
 4302 = (C) BLOOD DEDUCT/FURNISHED PINTS  
 4303 = (C) BLOOD DEDUCT > UNREPLACED BLOOD  
 4304 = (C) BLOOD DEDUCT > 3 - REPLACED  
 4501 = (C) PRIMARY DIAGNOSIS INVALID  
 4502 = (C) SERVICE DATES > CURRENT DATE  
 46#A = (C) MSP VET AND VET AT MEDICARE  
 46#B = (C) MULTIPLE COIN VALU CODES (A2,B2,C2)  
 46#C = (C) COIN VALUE (A2,B2,C2) ON INP/SNF  
 46#G = (C) VALU CODE 20 INVALID

46#L = (C) BLOOD FURNISHED < BLOOD REPLACED  
 46#N = (C) VALUE CODE 37,38,39 INVALID  
 46#O = (C) VALUE CDE 37,38,39 AMOUNT NOT > 00  
 46#P = (C) BLD UNREP VS REV CDS AND/OR UNITS  
 46#Q = (C) VALUE CDE 37=39 AND 38 IS PRESENT  
 46#R = (C) BLD FIELDS VS REV CDE 380,381,382  
 46#S = (C) VALU CODE 39, AND 37 IS NOT PRESENT  
 46#T = (C) CABG/PCOE/MPPD,VC<>Y1,Y2,Y3,Y4,VA NOT>0  
 46#U = (C) MSP VALUES ON CABG/PCOE/MPPD (INP)  
     TOB '32X'/'33X' MUST HAVE VALUE 62/64  
     OR 63/65 (HHA)  
 46#V = (C) TOB '32X'/'33X' VISITS IN 62/63 NOT =  
     REVENUE CODE 42X-44X, 55X-57X  
 46#W = (C) CONDITION CODE =30/78 AND WITH VALUE  
     CODE = A1, B1, C1  
 46#1 = (C) VALUE AMOUNT INVALID  
 46#2 = (C) VALU 06 AND BLD-DED-PTS IS ZERO  
 46#3 = (C) VALU 06 AND TTL-CHGS=NC-CHGS(001)  
 46#4 = (C) VALU (A1,B1,C1): AMT > DEDUCT  
 46#5 = (C) DEDUCT VALUE (A1,B1,C1) ON SNF BILL  
 46#6 = (C) VALU 17 AND NO COND CODE 60 OR 61  
 46#7 = (C) OUTLIER(VAL 17) > REIMB + VAL6-16  
 46#8 = (C) MULTI CASH DED VALU CODES (A1,B1,C1)  
 46X9 = (C) DEMO ID=03,REQUIRED HCPCS NOT SHOWN  
 4600 = (C) CAPITAL TOTAL NOT = CAP VALUES  
 4601 = (C) CABG/PCOE, MSP CODE PRESENT  
 4603 = (C) DEMO ID = 03 AND RIC NOT=6,7  
 4604 = (C) DEMO = 03 WITH DATES OF SERVICE  
     > 09/31/01  
 4901 = (C) PCOE/CABG,DEN CD NOT D  
 4902 = (C) PCOE/CABG BUT DME  
 50#1 = (C) RVCD=54,TOB<>13,23,32,33,34,83,85  
 50#2 = (C) REV CD=054X,MOD NOT = QM,QN  
 5051 = (E) EDB: NOMATCH ON 3 CHARACTERISTICS  
 5052 = (E) EDB: NOMATCH ON MASTER-ID RECORD  
 5053 = (E) EDB: NOMATCH ON CLAIM-NUMBER  
 51#A = (C) HCPCS EYEWARE & REV CODE NOT 274  
 51#C = (C) HCPCS REQUIRES DIAG CODE OF CANCER  
 51#D = (C) HCPCS REQUIRES UNITS > ZERO  
 51#E = (C) HCPCS REQUIRES REVENUE CODE 636/294  
 51#F = (C) INV BILL TYP/ANTI-CAN DRUG HCPCS  
 51#G = (C) HCPCS REQUIRES DIAG OF HEMOPHILL1A  
 51#H = (C) TOB 21X/P82=2/3/4;REV CD<9001,>9044  
 51#I = (C) TOB 21X/P82<>2/3/4;REV CD>8999<9045  
 51#J = (C) TOB 21X/REV CD: SVC-FROM DT INVALID  
 51#K = (C) TOB 21X/P82=2/3/4,REV CD = NNX  
 51#L = (C) REV 0762/UNT>48,TOB NOT=12,13,85,83  
 51#M = (C) 21X,RC>9041/<9045,RC<>4/234  
 51#N = (C) 21X,RC>9032/<9042,RC<>4/234  
 51#O = (C) TWO ANTI-EMETIC/ANTI-CANCER DRUGS

ON SAME CLAIM  
 51#P = (C) HHA/OUTPATIENT RC DATE OF SRVC MISSING  
 51#Q = (C) NO RC 0636 OR DTE INVALID  
 51#R = (C) DEMO ID=01,RIC NOT=2  
 51#S = (C) DEMO ID=01,RUGS<>2,3,4 OR BILL<>21  
 51#V = (C) TOB 72X W HCPCS 'J1955' MISSING REVENUE  
 CENTER 636  
 51#W = (C) TOB 12X, 13X, 22X, 23X, 34X, 74X, 75X,  
 83X, HCPCS '97504', '97116', PRESENT  
 ON SAME DAY  
 51#X = (C) TOB '32X-34X' REQUIRE HCPCS FOR REVENUE  
 CODE '29X', '60X', '636'  
 51X0 = (C) REV CENTER CODE INVALID  
 51X1 = (C) REV CODE CHECK  
 51X2 = (C) REV CODE INCOMPATIBLE BILL TYPE  
 51X3 = (C) UNITS MUST BE > 0  
 51X4 = (C) INP:CHGS/YR-RATE,ETC; OUTP:PSYCH>YR  
 51X5 = (C) REVENUE NON-COVERED > TOTAL CHRGE  
 51X6 = (C) REV TOTAL CHARGES EQUAL ZERO  
 51X7 = (C) REV CDE 403 WTH NO BILL 14 23 71 85  
 51X8 = (C) MAMMOGRAPHY SUBMISSION INVALID  
 51X9 = (C) HCPCS/REV CODE/BILL TYPE  
 5100 = (U) TRANSITION SPELL / SNF  
 5160 = (U) LATE CHG HSP BILL STAY DAYS > 0  
 5166 = (U) PROVIDER NE TO 1ST WORK PRVDR  
 5167 = (U) PROVIDER 1 NE 2: FROM DT < START DT  
 5168 = (E) CLAIM IN HOSPICE WITH 2ND START DATE  
 PRESENT  
 5169 = (U) PROVIDER NE TO WORK PROVIDER  
 5170 = (E) OCCURRENCE CODE = 42 AND < DOLBA  
 5177 = (U) PROVIDER NE TO WORK PROVIDER  
 5178 = (U) HOSPICE BILL THRU < DOLBA  
 5181 = (U) HOSP BILL OCCR 27 DISCREPANCY  
 5200 = (E) ENTITLEMENT EFFECTIVE DATE  
 5201 = (U) HOSP DATE DIFFERENCE NE 60 OR 90  
 5202 = (E) ENTITLEMENT HOSPICE EFFECTIVE DATE  
 5202 = (U) HOSPICE TRAILER ERROR  
 5203 = (E) ENTITLEMENT HOSPICE PERIODS  
 5203 = (U) HOSPICE START DATE ERROR  
 5204 = (U) HOSPICE DATE DIFFERENCE NE 90  
 5205 = (U) HOSPICE DATE DISCREPANCY  
 5206 = (U) HOSPICE DATE DISCREPANCY  
 5207 = (U) HOSPICE THRU > TERM DATE 2ND  
 5208 = (U) HOSPICE PERIOD NUMBER BLANK  
 5209 = (U) HOSPICE DATE DISCREPANCY  
 5210 = (E) ENTITLEMENT FRM/TRU/END DATES  
 5211 = (E) ENTITLEMENT DATE DEATH/THRU  
 5212 = (E) ENTITLEMENT DATE DEATH/THRU  
 5213 = (E) ENTITLEMENT DATE DEATH MBR  
 5220 = (E) ENTITLEMENT FROM/EFF DATES



5225 = (E) ENT INP PPS SPAN 70 DATES  
 5232 = (E) ENTL HMO NO HMO OVERRIDE CDE  
 5233 = (E) ENTITLEMENT HMO PERIODS  
 5234 = (E) ENTITLEMENT HMO NUMBER NEEDED  
 5235 = (E) ENTITLEMENT HMO HOSP+NO CC07  
 5236 = (E) ENTITLEMENT HMO HOSP + CC07  
 5237 = (E) ENTITLEMENT HOSP OVERLAP  
 5238 = (U) HOSPICE CLAIM OVERLAP > 90  
 5239 = (U) HOSPICE CLAIM OVERLAP > 60  
 524Z = (E) HOSP OVERLAP NO OVD NO DEMO  
 5240 = (U) HOSPICE DAYS STAY+USED > 90  
 5241 = (U) HOSPICE DAYS STAY+USED > 60  
 5242 = (C) INVALID CARRIER FOR RRB  
 5243 = (C) HMO=90091,INVALID SERVICE DTE  
 5244 = (E) DEMO CABG/PCOE MISSING ENTL  
 5245 = (C) INVALID CARRIER FOR NON RRB  
 525Z = (E) HMO/HOSP 6/7 NO OVD NO DEMO  
 5250 = (U) HOSPICE DOEBA/DOLBA  
 5255 = (U) HOSPICE DAYS USED  
 5256 = (U) HOSPICE DAYS USED > 999  
 526Y = (E) HMO/HOSP DEMO 5/15 REIMB > 0  
 526Z = (E) HMO/HOSP DEMO 5/15 REIMB = 0  
 5270 = (C) CONDITION CODE = 30 AND HMO REQUIRES  
 MODIFIER = 'QV' OR 'KZ'/DED IND  
 5271 = (C) RISK HMO NOT PRESENT AND MOD 'KZ'/  
 OR CONDITION CODE 78 PRESENT  
 527Y = (E) HMO/HOSP DEMO OVD=1 REIMB > 0  
 527Z = (E) HMO/HOSP DEMO OVD=1 REIMB = 0  
 5299 = (U) HOSPICE PERIOD NUMBER ERROR  
 52#K = (C) HCPCS VS DIAGNOSIS  
 52#L = (C) HCPCS VS MODIFIER  
 52#M = (C) HCPCS VS DATES OF SERVICE  
 52#N = (C) TOB '71X' OR '73X' WITH REVENUE  
 CENTER CODE 0403 MISSING REVENUE  
 CENTER CODE 0521  
 52#O = (C) REVENUE CENTER CODE 0022/0024 WITH  
 CHARGES >0  
 52#P = (C) REVENUE CENTER CODE 010X-021X MINUS  
 18X <> 0022  
 52#Q = (C) REVENUE CENTER CODE 0022 AND HIPPS  
 MISSING  
 52#R = (C) REVENUE CENTER CODE 0022 MISSING DATE  
 OF SERVICE  
 52#T = (C) REVENUE CENTER CODE 0022 MISSING REVENUE  
 CENTER CODE 042X-044X  
 5320 = (U) BILL > DOEBA AND IND-1 = 2  
 5350 = (U) HOSPICE DOEBA/DOLBA SECONDARY  
 5355 = (U) HOSPICE DAYS USED SECONDARY  
 5362 = (C) MAMMOGRAPHY AND BENE <35  
 5378 = (C) SERVICE DATE < AGE 50

5379 = (C) HCPCS 'G0160' PRESENT MORE THAN  
ONCE  
5381 = (C) HCPCS 'G0161' PRESENT MORE THAN  
ONCE  
5382 = (C) HCPCS 'G0102-03' AND BENE <50  
538Q = (C) SERVICE DATES WITHIN ALIEN RECORD  
5397 = (C) DEMO '37' AND NOT CAT 74  
5398 = (C) HCPCS 'G9001-G9005 & G9009-G9011 >1  
OR 2 ARE PRESENT  
5399 = (U) HOSPICE PERIOD NUM MATCH  
539A = (C) HCPCS 'G9008' PRESENT MORE THAN ONCE  
539C = (C) HCPCS 'G9013-G9015' PRESENT MORE THAN  
ONCE OR 2 PRESENT  
5410 = (U) INPAT DEDUCTABLE  
5425 = (U) PART B DEDUCTABLE CHECK  
5430 = (U) PART B DEDUCTABLE CHECK  
5450 = (U) PART B COMPARE MED EXPENSE  
5460 = (U) PART B COMPARE MED EXPENSE  
5499 = (U) MED EXPENSE TRAILER MISSING  
5500 = (U) FULL DAYS/SNF-HOSP FULL DAYS  
5510 = (U) COIN DAYS/SNF COIN DAYS  
5515 = (U) FULL DAYS/COIN DAYS  
5516 = (U) SNF FULL DAYS/SNF COIN DAYS  
5520 = (U) LIFE RESERVE DAYS  
5530 = (U) UTIL DAYS/LIFE PSYCH DAYS  
5540 = (U) HH VISITS NE AFT PT B TRLR  
5550 = (E) SNF LESS THAN PT A EFF DATE  
5600 = (D) LOGICAL DUPE, COVERED  
5601 = (D) LOGICAL DUPE, QRY-CDE, RIC 123  
5602 = (D) LOGICAL DUPE, PANDE C, E OR I  
5603 = (D) LOGICAL DUPE, COVERED  
5604 = (D) LOGICAL DUPE, DATES  
5605 = (D) POSS DUPE, OUTPAT REIMB  
5606 = (D) POSS DUPE, HOME HEALTH COVERED U  
5623 = (U) NON-PAY CODE IS P  
57X1 = (C) PROVIDER SPECIALITY CODE INVALID  
57X2 = (C) PHYS THERAPY/PROVIDER SPEC INVAL  
57X3 = (C) PLACE/TYPE/SPECIALTY/REIMB IND  
57X4 = (C) SPECIALTY CODE VS. HCPCS INVALID  
57X5 = (C) HCPCS 98940-2 MODIFIER NOT = 'AT'  
5700 = (U) LINKED TO THREE SPELLS  
5701 = (C) DEMO ID=02,RIC NOT = 5  
5702 = (C) DEMO ID=02,INVALID PROVIDER NUM  
58X1 = (C) PROVIDER TYPE INVALID  
58X9 = (C) TYPE OF SERVICE INVALID  
5802 = (C) REIMB > \$150,000  
5803 = (C) UNITS/VISITS > 150  
5804 = (C) UNITS/VISITS > 99  
5805 = (C) OUTPATIENT CHARGE > \$150,000  
5806 = (C) REVENUE CENTER CODE '042X-044X'

WITHOUT MODIFIER 'GN-GP'  
 58#4 = (C) REVENUE CENTER CODE MISSING REQUIRED  
 HCPCS OR MODIFIER  
 59XA = (C) PROST ORTH HCPCS/FROM DATE  
 59XB = (C) HCPCS/FROM DATE/TYPE P OR I  
 59XC = (C) HCPCS Q0036,37,42,43,46/FROM DATE  
 59XD = (C) HCPCS Q0038-41/FROM DATE/TYPE  
 59XE = (C) HCPCS/MAMMOGRAPHY-RISK/ DIAGNOSIS  
 59XG = (C) INVALID TOS FOR DME  
 59XH = (C) HCPCS E0620/TYPE/DATE  
 59XI = (C) HCPCS E0627-9/ DATE < 1991  
 59XJ = (C) GLOBAL HCPCS TOS MUST = 2  
 59XK = (C) HCPCS PEN PUMP AND TOS <>9  
 59XL = (C) HCPCS 00104 - TOS/POS  
 59X1 = (C) INVALID HCPCS/TOS COMBINATION  
 59X2 = (C) ASC IND/TYPE OF SERVICE INVALID  
 59X3 = (C) TOS INVALID TO MODIFIER  
 59X4 = (C) KIDNEY DONOR/TYPE/PLACE/REIMB  
 59X5 = (C) MAMMOGRAPHY FOR MALE  
 59X6 = (C) DRUG AND NON DRUG BILL LINE ITEMS  
 59X7 = (C) CAPPED-HCPCS/FROM DATE  
 59X8 = (C) FREQUENTLY MAINTAINED HCPCS  
 59X9 = (C) HCPCS E1220/FROM DATE/TYPE IS R  
 5901 = (U) ERROR CODE OF Q  
 5A#1 = (C) DEMO=37, UNITS >1 FOR 'G9001-05'  
 'G9007-11', G9013-G9015'  
 60X1 = (C) ASSIGN IND INVALID  
 6000 = (U) ADJUSTMENT BILL SPELL DATA  
 6020 = (U) CURRENT SPELL DOEBA < 1990  
 6030 = (U) ADJUSTMENT BILL SPELL DATA  
 6035 = (U) ADJUSTMENT BILL THRU DTE/DOLBA  
 61X1 = (C) PAY PROCESS IND INVALID  
 61X2 = (C) DENIED CLAIM/NO DENIED LINE  
 61X3 = (C) PAY PROCESS IND/ALLOWED CHARGES  
 61X4 = (C) RATE MISSING OR NON-NUMERIC  
 61#E = (C) PROVIDER PAYMENT INCONSISTENCIES  
 61#F = (C) BENEFICIARY PAYMENT INCONSISTENCIES  
 61#G = (C) PATIENT RESPONSIBILITY INCONSISTENCIES  
 61#H = (C) MEDICARE PAYMENT INCONSISTENCIES  
 61#I = (C) LINE DATE OF SERVICE < FROM DATE  
 > THRU DATE  
 61#J = (C) DUPLICATE HCPCS CODE '55873'  
 61#K = (C) HCPCS 'G0117-8' >2 OR BOTH PRESENT  
 61#L = (C) REVENUE CENTER CODE 0024 > 2  
 61#M = (C) REVENUE CENTER CODE 0024 VS PROVIDER  
 NUMBER  
 61#N = (C) REVENUE CENTER CODE 0024 REQUIRES  
 VALID HIPPS RATE CMG CODE  
 61#R = (C) HCPCS/TOB/REVENUE CENTER CODE  
 61#S = (C) HCPCS 'G0247' REQUIRES 'G0245-6' TO

BE COVERED  
 61#T = (C) HCPCS CODE '0245-0246' PRESENT MULTIPLE  
 TIMES  
 61#0 = (C) REVENUE CENTER CODE VS SPAN CODE '74'  
 61#6 = (C) PAYMENT METHOD INVALID  
 61#7 = (C) ANSI CODE MISSING  
 61#8 = (C) BLOOD CASH DEDUCTIBLE INCONSISTENCIES  
 61#9 = (C) CASH DEDUCTIBLE INCONSISTENCIES  
 6100 = (C) REV 0001 NOT PRESENT ON CLAIM  
 6101 = (C) REV COMPUTED CHARGES NOT=TOTAL  
 6102 = (C) REV COMPUTED NON-COVERED/NON-COV  
 6103 = (C) REV TOTAL CHARGES < PRIMARY PAYER  
 6105 = (C) REVE CODE 0001 > 1  
 6106 = TOB 3X2 REVENUE CENTER CODE 0023 NOT =  
 TOTAL CHARGE  
 6109 = (C) REIMBURSEMENT > 4 OR 6 TIMES  
 62XA = (C) PSYC OT PT/REIM/TYPE  
 62XC = (C) DEMO 37 WITH REIMBURSEMENT/DED IND  
 <>1  
 62X1 = (C) DME/DATE/100% OR INVAL REIMB IND  
 62X6 = (C) RAD PATH/PLACE/TYPE/DATE/DED  
 62X8 = (C) KIDNEY DONO/TYPE/100%  
 62X9 = (C) PNEUM VACCINE/TYPE/100%  
 6201 = (C) TOTAL DEDUCT > CHARGES/NON-COV  
 6203 = (U) HOSPICE ADJUSTMENT PERIOD/DATE  
 6204 = (U) HOSPICE ADJUSTMENT THRU>DOLBA  
 6260 = (U) HOSPICE ADJUSTMENT STAY DAYS  
 6261 = (U) HOSPICE ADJUSTMENT DAYS USED  
 6265 = (U) HOSPICE ADJUSTMENT DAYS USED  
 6269 = (U) HOSPICE ADJUSTMENT PERIOD# (MAIN)  
 63X1 = (C) DEDUCT IND INVALID  
 63X2 = (C) DED/HCFA COINS IN PCOE/CABG  
 6365 = (U) HOSPICE ADJUSTMENT SECONDARY DAYS  
 6369 = (U) HOSPICE ADJUSTMENT PERIOD# (SECOND)  
 64X1 = (C) PROVIDER IND INVALID  
 6430 = (U) PART B DEDUCTABLE CHECK  
 65X1 = (C) PAYSCREEN IND INVALID  
 66?? = (D) POSS DUPE, CR/DB, DOC-ID  
 66XX = (D) POSS DUPE, CR/DB, DOC-ID  
 66X1 = (C) UNITS AMOUNT INVALID  
 66X2 = (C) UNITS IND > 0; AMT NOT VALID  
 66X3 = (C) UNITS IND = 0; AMT > 0  
 66X4 = (C) MT INDICATOR/AMOUNT  
 66X7 = (C) DEMO 37/HCPCS/UNITS  
 6600 = (U) ADJUSTMENT BILL FULL DAYS  
 6610 = (U) ADJUSTMENT BILL COIN DAYS  
 6620 = (U) ADJUSTMENT BILL LIFE RESERVE  
 6630 = (U) ADJUSTMENT BILL LIFE PSYCH DYS  
 67X1 = (C) UNITS INDICATOR INVALID  
 67X2 = (C) CHG ALLOWED > 0; UNITS IND = 0

67X3 = (C) TOS/HCPCS=ANEST, MTU IND NOT = 2  
67X4 = (C) HCPCS = AMBULANCE, MTU IND NOT = 1  
67X6 = (C) INVALID PROC FOR MT IND 2, ANEST  
67X7 = (C) INVALID UNITS IND WITH TOS OF BLOOD  
67X8 = (C) INVALID PROC FOR MT IND 4, OXYGEN  
6700 = (U) ADJUSTMENT BILL FULL/SNF DAYS  
6710 = (U) ADJUSTMENT BILL COIN/SNF DAYS  
68XA = (C) HCPCS G0117-8 >1 OR BOTH PRESENT  
68XB = (C) HCPCS CODE G0245-46 > 1  
68X1 = (C) INVALID HCPCS CODE  
68X2 = (C) MAMMOGRAPY/DATE/PROC NOT 76092  
68X3 = (C) TYPE OF SERVICE = G /PROC CODE  
68X4 = (C) HCPCS NOT VALID FOR SERVICE DATE  
68X5 = (C) MODIFIER NOT VALID FOR HCPCS, ETC  
68X6 = (C) TYPE SERVICE INVALID FOR HCPCS, ETC  
68X7 = (C) ZX MOD REQ FOR THER SHOES/INS/MOD.  
68X8 = (C) ANTI-EMETIC WITHOUT ANTI-CANCER DRUG  
6812 = (C) DEMO 37 WITH PRIMARY PAYER CODE  
69XA = (C) MODIFIER NOT VALID FOR HCPCS/GLOBAL  
69XB = (C) HCPCS CODE 97504/97116 PRESENT ON  
SAME DAY  
69XC = (C) HCPCS CODE VS PAY PROCESS INDICATOR  
69X3 = (C) PROC CODE MOD = LL / TYPE = R  
69X6 = (C) PROC CODE MOD/NOT CAPPED  
69X8 = (C) SPEC CODE NURSE PRACT, MOD INVAL  
69X9 = (C) NURSE PRACTITIONER, MOD INVALID  
6901 = (C) KRON IND AND UTIL DYS EQUALS ZERO  
6902 = (C) KRON IND AND NO-PAY CODE B OR N  
6903 = (C) KRON IND AND INPATIENT DEDUCT = 0  
6904 = (C) KRON IND AND TRANS CODE IS 4  
6910 = (C) REV CODES ON HOME HEALTH  
6911 = (C) REV CODE 274 ON OUTPAT AND HH ONLY  
6912 = (C) REV CODE INVAL FOR PROSTH AND ORTHO  
6913 = (C) REV CODE INVAL FOR OXYGEN  
6914 = (C) REV CODE INVAL FOR DME  
6915 = (C) PURCHASE OF RENT DME INVAL ON DATES  
6916 = (C) PURCHASE OF RENT DME INVAL ON DATES  
6917 = (C) PURCHASE OF LIFT CHAIR INVAL > 91000  
6918 = (C) HCPCS INVALID ON DATE RANGES  
6919 = (C) DME OXYGEN ON HH INVAL BEFORE 7/1/89  
6920 = (C) HCPCS INVAL ON REV 270/BILL 32-33  
6921 = (C) HCPCS ON REV CODE 272 BILL TYPE 83X  
6922 = (C) HCPCS ON BILL TYPE 83X -NOT REV 274  
6923 = (C) RENTAL OF DME CUSTOMIZE AND REV 291  
6924 = (C) INVAL MODIFIER FOR CAPPED RENTAL  
6925 = (C) HCPCS ALLOWED ON BILL TYPES 32X-34X  
6929 = (U) ADJUSTMENT BILL LIFE RESERVE  
6930 = (U) ADJUSTMENT BILL LIFE PSYCH DYS  
7000 = (U) INVALID DOEBA/DOLBA  
7002 = (U) LESS THAN 60/61 BETWEEN SPELLS

7010 = (E) TOB 85X/ELECTN PRD: COND CD 07 REQD  
71X1 = (C) SUBMITTED CHARGES INVALID  
71X2 = (C) MAMMOGRPY/PROC CODE MOD TC,26/CHG  
71X3 = (C) HCPCS 76092 PAY INDICATOR <> A,R,S  
& 76085 PAY INDICATOR A,R,S  
72X1 = (C) ALLOWED CHGS INVALID  
72X2 = (C) ALLOWED/SUBMITTED CHARGES/TYPE  
72X3 = (C) DENIED LINE/ALLOWED CHARGES  
7230 = (C) FRAMES >1, LENSES >2  
73X1 = (C) SS NUMBER INVALID  
73X2 = (C) CARRIER ASSIGNED PROV NUM MISSING  
74X1 = (C) LOCALITY CODE INVAL FOR CONTRACT  
76X1 = (C) PL OF SER INVAL ON MAMMOGRAPHY BILL  
77X1 = (C) PLACE OF SERVICE INVALID  
77X2 = (C) PHYS THERAPY/PLACE  
77X3 = (C) PHYS THERAPY/SPECIALTY/TYPE  
77X4 = (C) ASC/TYPE/PLACE/REIMB IND/DED IND  
77X6 = (C) TOS=F, PL OF SER NOT = 24  
7701 = (C) INCORRECT MODIFIER  
7777 = (D) POSS DUPE, PART B DOC-ID  
78XA = (C) MAMMOGRAPHY BEFORE 1991  
78XB = (C) ANTI-CANCER BEFORE 01/01/1998  
78X1 = (C) FROM DATE IMPOSSIBLE  
78X2 = (C) FROM DATE > CURRENT DATE OR  
< 07/01/1966  
78X3 = (C) FROM DATE GREATER THAN THRU DATE  
78X4 = (C) FROM DATE > RCVD DATE/PAY-DENY  
78X5 = (C) FROM DATE > PAID DATE/TYPE/100%  
78X7 = (C) LAB EDIT/TYPE/100%/FROM DATE  
79X1 = (C) THRU DATE IMPOSSIBLE  
79X2 = (C) THRU DATE > CURRENT DATE  
79X3 = (C) THRU DATE>RECD DATE/NOT DENIED  
79X4 = (C) THRU DATE>PAID DATE/NOT DENIED  
8000 = (U) MAIN & 2NDARY DOEBA < 01/01/90  
8028 = (E) NO ENTITLEMENT  
8029 = (U) HH BEFORE PERIOD NOT PRESENT  
8030 = (U) HH BILL VISITS > PT A REMAINING  
8031 = (U) HH PT A REMAINING > 0  
8032 = (U) HH DOLBA+59 NOT GT FROM-DATE  
8050 = (U) HH QUALIFYING INDICATOR = 1  
8051 = (U) HH # VISITS NE AFT PT B APPLIED  
8052 = (U) HH # VISITS NE AFT TRAILER  
8053 = (U) HH BENEFIT PERIOD NOT PRESENT  
8054 = (U) HH DOEBA/DOLBA NOT > 0  
8060 = (U) HH QUALIFYING INDICATOR NE 1  
8061 = (U) HH DATE NE DOLBA IN AFT TRLR  
8062 = (U) HH NE PT-A VISITS REMAINING  
81X1 = (C) NUM OF SERVICES INVALID  
83X1 = (C) DIAGNOSIS INVALID  
8301 = (C) HCPCS/GENDER DIAGNOSIS

8302 = (C) HCPCS G0101 V-CODE/SEX CODE  
8303 = (C) HCPCS/GENDER  
8304 = (C) BILL TYPE INVALID FOR G0123/4  
8305 = (C) HCPCS/SERVICE DATES/GENDER  
84X1 = (C) PAP SMEAR/DIAGNOSIS/GENDER/PROC  
84X2 = (C) INVALID DME START DATE  
84X3 = (C) INVALID DME START DATE W/HCPCS  
84X4 = (C) HCPCS G0101 V-CODE/SEX CODE  
84X5 = (C) HCPCS CODE WITH INV DIAG CODE  
84X6 = (C) HCPCS/GENDER  
84X7 = (C) HCPCS/SERVICE DATES/GENDER  
84X8 = (C) DUPLICATE HCPCS  
86X1 = (C) CLINICAL LAB HCPCS W/O CLINICAL  
LAB ID  
86X2 = (C) NON-WAIVER HCPCS/PAY DENIAL CODE/  
MODIFIER  
86X8 = (C) CLIA REQUIRES NON-WAIVER HCPCS  
88XX = (D) POSS DUPE, DOC-ID,UNITS,ENT,ALWD  
9000 = (U) DOEBA/DOLBA CALC  
9005 = (U) FULL/COINS HOSP DAYS CALC  
9010 = (U) FULL/COINS SNF DAYS CALC  
9015 = (U) LIFE RESERVE DAYS CALC  
9020 = (U) LIFE PSYCH DAYS CALC  
9030 = (U) INPAT DEDUCTABLE CALC  
9040 = (U) DATA INDICATOR 1 SET  
9050 = (U) DATA INDICATOR 2 SET  
91X1 = (C) PATIENT REIMB/PAY-DENY CODE  
92X1 = (C) PATIENT REIMB INVALID  
92X2 = (C) PROVIDER REIMB INVALID  
92X3 = (C) LINE DENIED/PATIENT-PROV REIMB  
92X4 = (C) MSP CODE/AMT/DATE/ALLOWED CHARGES  
92X5 = (C) CHARGES/REIMB AMT NOT CONSISTANT  
92X7 = (C) REIMB/PAY-DENY INCONSISTANT  
9201 = (C) UPIN REF NAME OR INITIAL MISSING  
9202 = (C) UPIN REF FIRST 3 CHAR INVALID  
9203 = (C) UPIN REF LAST 3 CHAR NOT NUMERIC  
93X1 = (C) CASH DEDUCTABLE INVALID  
93X2 = (C) DEDUCT INDICATOR/CASH DEDUCTIBLE  
93X3 = (C) DENIED LINE/CASH DEDUCTIBLE  
93X4 = (C) FROM DATE/CASH DEDUCTIBLE  
93X5 = (C) TYPE/CASH DEDUCTIBLE/ALLOWED CHGS  
9300 = (C) UPIN OTHER, NOT PRESENT  
9301 = (C) UPIN NME MIS/DED TOT LI>0 FR DEN CLM  
9302 = (C) UPIN OPERATING, FIRST 3 NOT NUMERIC  
9303 = (C) UPIN L 3 CH NT NUM/DED TOT LI>YR DED  
9351 = (C) OTHER UPIN PRESENT/MISSING OTHER FIELDS  
9352 = (C) OTHER UPIN INVALID  
9353 = (C) OTHER UPIN INVALID  
94A1 = (C) NON-COVERED FROM DATE INVALID  
94A2 = (C) NON-COVERED FROM > THRU DATE

94A3 = (C) NON-COVERED THRU DATE INVALID  
94A4 = (C) NON-COVERED THRU DATE > ADMIT  
94A5 = (C) NON-COVERED THRU DATE/ADMIT DATE  
94C1 = (C) PR-PSYCH DAYS INVALID  
94C3 = (C) PR-PSYCH DAYS > PROVIDER LIMIT  
94F1 = (C) REIMBURSEMENT AMOUNT INVALID  
94F2 = (C) REIMBURSE AMT NOT 0 FOR HMO PAID  
94G1 = (C) NO-PAY CODE INVALID  
94G2 = (C) NO-PAY CODE SPACE/NON-COVERD=TOTL  
94G3 = (C) NO-PAY/PROVIDER INCONSISTANT  
94G4 = (C) NO PAY CODE = R & REIMB PRESENT  
94X1 = (C) BLOOD LIMIT INVALID  
94X2 = (C) TYPE/BLOOD DEDUCTIBLE  
94X3 = (C) TYPE/DATE/LIMIT AMOUNT  
94X4 = (C) BLOOD DED/TYPE/NUMBER OF SERVICES  
94X5 = (C) BLOOD/MSP CODE/COMPUTED LINE MAX  
9401 = (C) BLOOD DEDUCTIBLE AMT > 3  
9402 = (C) BLOOD FURNISHED > DEDUCTIBLE  
9403 = (C) DATE OF BIRTH MISSING ON PRO-PAY  
9404 = (C) INVALID GENDER CODE ON PRO-PAY  
9407 = (C) INVALID DIAGNOSIS  
9408 = (C) INVALID DRG NUMBER (GLOBAL)  
9409 = (C) HCFA DRG<>DRG ON BILL  
940X = (C) INVALID DRG  
9410 = (C) CABG/PCOE,INVALID DRG  
95X1 = (C) MSP CODE G/DATE BEFORE 1/1/87  
95X2 = (C) MSP AMOUNT APPLIED INVALID  
95X3 = (C) MSP AMOUNT APPLIED > SUB CHARGES  
95X4 = (C) MSP PRIMARY PAY/AMOUNT/CODE/DATE  
95X5 = (C) MSP CODE = G/DATE BEFORE 1987  
95X6 = (C) MSP CODE = X AND NOT AVOIDED  
95X7 = (C) MSP CODE VALID, CABG/PCOE  
96X1 = (C) OTHER AMOUNTS INVALID  
96X2 = (C) OTHER AMOUNTS > PAT-PROV REIMB  
97X1 = (C) OTHER AMOUNTS INDICATOR INVALID  
97X2 = (C) GRUDMAN SW/GRUDMAN AMT NOT > 0  
98X1 = (C) COINSURANCE INVALID  
98X3 = (C) MSP CODE/TYPE/COIN AMT/ALLOW/CSH  
98X4 = (C) DATE/MSP/TYPE/CASH DED/ALLOW/COI  
98X5 = (C) DATE/ALLOW/CASH DED/REIMB/MSP/TYP  
9801 = (C) REV CENTER CODE 0910 WITH SERVICE  
DATE > 10/15/2004  
99XX = (D) POSS DUPE, PART B DOC-ID  
9901 = (C) REV CODE INVALID OR TRAILER CNT=0  
9902 = (C) ACCOMMODATION DAYS/FROM/THRU DATE  
9903 = (C) NO CLINIC VISITS FOR RHC  
9904 = (C) INCOMPATIBLE DATES/CLAIM TYPE  
991X = (C) NO DATE OF SERVICE  
9910 = (C) BLOOD DEDUCTIBLE NON NUMERIC  
9911 = (C) BLOOD DEDUCTIBLE PRESENT WITHOUT



BLOOD FURNISHED  
9920 = (C) CASH DEDUCTIBLE INVALID  
9930 = (C) COINSURANCE INVALID  
9931 = (C) OUTPAT COINSURANCE VALUES  
9933 = (C) RATE EXCEEDS 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, CWFQA 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

YES\_NO\_TB

Yes/No Table

Y = Yes  
N = No

08/01/2011

\*\*\*\*\*

H3PM.R\_RIF\_TOC\_RPT\_Q,F

1

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

CHOICES\_DEMO\_LIM

FULL NAME: Choices Demonstration Limitation

DESCRIPTION :

A programming error created an 'INVALID' indication in the demo text field for CHOICES claims.

BACKGROUND :

In 6/00, the CWFMOA front-end editing revealed that some CHOICES demo claims were coming in with a valid 'H' number in the fixed portion of the claims, but in the first occurrence MCO trailer a numeric packed field (value hex '0100000C') was moved to the MCO Contract Number/Option Code fields. This created an invalid period check of number/code to MCO effective date, resulting in an INVALID indication in the demo info text field.

CORRECTIVE ACTION :

The problem was forwarded to the CWF BSOG staff for further investigation.

SOURCE:

CONTACT : OIS/EDG/DMUDD

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

\*\*\*\*\*

H3PM.R\_RIF\_LIM\_Q,F