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CMS RIF REPORT
AS OF: 08/01/2011

NAME	LENGTH	BEG	END	CONTENTS
*** FI Hospice Claim Record (NCH) VAR	1	16242	REC	Fiscal intermediary hospice claim record for version J of the NCH. STANDARD ALIAS : FI_HOSPC_CLM_REC SYSTEM ALIAS : UTLHOSPI LIMITATIONS : REFER TO : CHOICES_DEMO_LIM CLM_TRANS_CD_LIM HHA_HCPCS_LIM MCO_PD_SW_LIM MLTPL_REV_CNTR_0001_CD_LIM PMT_AMT_EXCEDG_CHRG_AMT_LIM REV_CNTR_IDE_NDC_UPC_LIM REV_CNTR_TOT_CHRG_AMT_LIM TOT_CHRG_AMT_LIM
1. FI Hospice Claim Fixed Group 623	1	623	GRP	STANDARD ALIAS : FI_HOSPC_CLM_FIX_GRP
2. Claim Record Identification Group 8	1	8	GRP	Effective with Version 'I' the record length, version code, record identification, code and NCH derived claim type code were moved to this group for internal NCH processing. STANDARD ALIAS : CLM_REC_IDENT_GRP
3. Record Length Count 3	1	3	PACK	Effective with Version H, the count (in bytes)

of the length of the claim record.

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

DB2 ALIAS : REC_LNGTH_CNT
SAS ALIAS : REC_LEN
STANDARD ALIAS : REC_LNGTH_CNT

LENGTH : 5 SIGNED : Y

SOURCE : NCH

4. NCH Near-Line Record Version Code
1 4 4

CHAR

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

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

LENGTH : 1

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

SOURCE : NCH

CODE TABLE : NCH_NEAR_LINE_REC_VRSN_TB

5. NCH Near Line Record Identification Code
1 5 5

CHAR

A code defining the type of claim record being processed.

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

LENGTH : 1

COMMENTS :

Prior to Version H this field was named:
RIC_CD.

SOURCE : NCH

CODE TABLE : NCH_NEAR_LINE_RIC_TB

6. NCH MQA RIC Code

1 6 6

CHAR

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

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

DB2 ALIAS : NCH_MQA_RIC_CD

SAS ALIAS : MQA_RIC

STANDARD ALIAS : NCH_MQA_RIC_CD

TITLE ALIAS : MQA_RIC

LENGTH : 1

SOURCE : NCH QA PROCESS

CODE TABLE : NCH_MQA_RIC_TB

7. NCH Claim Type Code

2 7 8

CHAR

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

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

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

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

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

LENGTH : 2

DERIVATIONS :

FFS CLAIM TYPE CODES DERIVED FROM:

NCH CLM_NEAR_LINE_RIC_CD
NCH PMT_EDIT_RIC_CD
NCH CLM_TRANS_CD
NCH PRVDR_NUM

INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:

(Pre-HDC processing -- AVAILABLE IN NCH)

CLM_MCO_PD_SW
CLM_RLT_COND_CD
MCO_CNTRCT_NUM
MCO_OPTN_CD
MCO_PRD_EFCTV_DT
MCO_PRD_TRMNTN_DT

DERIVATION RULES:

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

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

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

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

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

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

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

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

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

1. CLM_NEAR_LINE_RIC_CD EQUAL 'V'
2. PMT_EDIT_RIC_CD EQUAL 'I'
3. CLM_TRANS_CD EQUAL 'H'

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

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

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

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

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

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

SET CLM_TYPE_CD TO 62 (Medicare Advantage IME/GME
CLAIMS - 10/1/05 - FORWARD)

WHERE THE FOLLOWING CONDITIONS ARE MET:

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

SET CLM_TYPE_CD TO 63 (HMO NO-PAY CLAIMS)
WHERE THE FOLLOWING CONDITIONS ARE MET:

1. CLM_THRU_DT ON OR AFTER 10/6/08

2. CLM_MCO_PD_SW = '1'
3. CLM_RLT_COND_CD = '04'
4. MCO_CNTRCT_NUM
MCO_OPTN_CD = 'A', 'B' OR 'C'
CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
ENROLLMENT PERIODS
5. ZERO REIMBURSEMENT (CLM_PMT_AMT)

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

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

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

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

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

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

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

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

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

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

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

WHERE THE FOLLOWING CONDITIONS ARE MET:

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

SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM)

WHERE THE FOLLOWING CONDITIONS ARE MET:

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

SOURCE : NCH

CODE TABLE : NCH_CLM_TYPE_TB

8. Fiscal Intermediary Claim Link Group
125 9 133

GRP

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

STANDARD ALIAS : FI_CLM_LINK_GRP

9. Claim Locator Number Group
11 9 19

GRP

This number uniquely identifies the beneficiary in the NCH Nearline.

COMMON ALIAS : HIC

STANDARD ALIAS : CLM_LCTR_NUM_GRP

TITLE ALIAS : HICAN

10. Beneficiary Claim Account Number
9 9 17

CHAR

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

COMMON ALIAS : CAN

DB2 ALIAS : BENE_CLM_ACNT_NUM
SAS ALIAS : CAN
STANDARD ALIAS : BENE_CLM_ACNT_NUM
TITLE ALIAS : CAN

LENGTH : 9

SOURCE : SSA,RRB

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

11. NCH Category Equatable Beneficiary Identification Code
2 18 19 CHAR

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

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

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

LENGTH : 2

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

SOURCE : BIC EQUATE MODULE

CODE TABLE : CTGRY_EQTBL_BENE_IDENT_TB

12. Beneficiary Identification Code
2 20 21 CHAR

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

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

LENGTH : 2

SOURCE : SSA/RRB

EDIT RULES :
EDB REQUIRED FIELD

CODE TABLE : BENE_IDENT_TB

13. NCH State Segment Code

1 22 22 CHAR

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

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

LENGTH : 1

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

SOURCE : NCH

CODE TABLE : NCH_STATE_SGMT_TB

14. Beneficiary Residence SSA Standard State Code

2 23 24 CHAR

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

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

LENGTH : 2

COMMENTS :

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

SOURCE : SSA/EDB

EDIT RULES :

OPTIONAL: MAY BE BLANK

CODE TABLE : GEO_SSA_STATE_TB

15. Claim From Date

8 25 32 NUM

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

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

DB2 ALIAS : CLM_FROM_DT
SAS ALIAS : FROM_DT
STANDARD ALIAS : CLM_FROM_DT
TITLE ALIAS : FROM_DATE

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :

YYYYMMDD

16. Claim Through Date

8 33 40 NUM

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

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

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

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

17. NCH Weekly Claim Processing Date

8 41

48 NUM

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

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

LENGTH : 8 SIGNED : N

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

SOURCE : NCH

EDIT RULES :
YYYYMMDD

18. CWF Claim Accretion Date

8 49

56 NUM

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

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

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

19. CWF Claim Accretion Number
2 57 58

PACK

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

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

LENGTH : 3 SIGNED : Y

SOURCE : CWF

20. FI Document Claim Control Number
23 59 81

CHAR

Unique control number assigned by an intermediary to an institutional claim.

COMMON ALIAS : ICN
DB2 ALIAS : DOC_CLM_CNTL_NUM
SAS ALIAS : CLM_CNTL

				STANDARD ALIAS : FI_DOC_CLM_CNTL_NUM
				TITLE ALIAS : ICN
				LENGTH : 23
				SOURCE : CWF
21. FI Original Claim Control Number	23	82	104	CHAR
				Effective with Version G, the original intermediary control number (ICN) which is present on adjustment claims, representing the ICN of the original transaction now being adjusted.
				COMMON ALIAS : ORIGINAL_ICN
				DB2 ALIAS : ORIG_CLM_CNTL_NUM
				SAS ALIAS : ORIGCNTL
				STANDARD ALIAS : FI_ORIG_CLM_CNTL_NUM
				TITLE ALIAS : ORIGINAL_ICN
				LENGTH : 23
				SOURCE : CWF
22. Claim Query Code	1	105	105	CHAR
				Code indicating the type of claim record being processed with respect to payment (debit/credit indicator; interim/final indicator).
				DB2 ALIAS : CLM_QUERY_CD
				SAS ALIAS : QUERY_CD
				STANDARD ALIAS : CLM_QUERY_CD
				TITLE ALIAS : QUERY_CD
				LENGTH : 1
				SOURCE : CWF
				CODE TABLE : CLM_QUERY_TB
23. Provider Number	6	106	111	CHAR
				The identification number of the institutional provider certified by Medicare to provide services to the beneficiary.

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

DB2 ALIAS : PRVDR_NUM
SAS ALIAS : PROVIDER
STANDARD ALIAS : PRVDR_NUM
TITLE ALIAS : PROVIDER_NUMBER

LENGTH : 6

CODE TABLE : PRVDR_NUM_TB

24. NCH Daily Process Date

8 112 119

NUM

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

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

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

DB2 ALIAS : NCH_DAILY_PROC_DT
SAS ALIAS : DAILY_DT
STANDARD ALIAS : NCH_DAILY_PROC_DT
TITLE ALIAS : DAILY_PROCESS_DT

LENGTH : 8 SIGNED : N

SOURCE : NCH

EDIT RULES :
YYYYMMDD

25. NCH Segment Link Number

5 120 124

PACK

Effective with Version 'I', the system gen-

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

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

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

LENGTH : 9 SIGNED : Y

SOURCE : NCH

26. Claim Total Segment Count

2 125 126 NUM

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

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

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

LENGTH : 2 SIGNED : N

SOURCE : CWF

27. Claim Segment Number

2 127 128 NUM

Effective with Version I, the number used to identify an actual record/segment (1 - 10) associated with a given claim.

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

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

LENGTH : 2 SIGNED : N

SOURCE : CWF

28. Claim Total Line Count

3 129 131 NUM

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

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

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

LENGTH : 3 SIGNED : N

SOURCE : CWF

29. Claim Segment Line Count

2 132 133 NUM

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

segment.

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

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

LENGTH : 2 SIGNED : N

SOURCE : CWF

30. FI Claim Common Group

382 134 515 GRP

STANDARD ALIAS : FI_CLM_CMN_GRP

31. NCH Payment and Edit Record Identification Code

1 134 134 CHAR

The code used for payment and editing purposes that indicates the type of institutional claim record. Prior to Version H this field was named: PMT_EDIT_RIC_CD.

DB2 ALIAS : PMT_EDIT_RIC_CD
SAS ALIAS : PE_RIC
STANDARD ALIAS : NCH_PMT_EDIT_RIC_CD
TITLE ALIAS : NCH_PAYMENT_EDIT_RIC

LENGTH : 1

SOURCE : NCH QA Process

CODE TABLE : PMT_EDIT_RIC_TB

32. Claim Transaction Code

1 135 135 CHAR

The code derived by CWF to indicate the type of claim submitted by an institutional provider.

DB2 ALIAS : CLM_TRANS_CD
SAS ALIAS : TRANS_CD
STANDARD ALIAS : CLM_TRANS_CD
TITLE ALIAS : TRANSACTION_CODE

LENGTH : 1

SOURCE : CWF

LIMITATIONS :

REFER TO :
CLM_TRANS_CD_LIM

CODE TABLE : CLM_TRANS_TB

33. Claim Bill Type Group

2 136 137 GRP

Effective with Version H, the claim facility type code plus the claim service classification type code. (The first two positions of the ('type of bill')). During the Version H conversion, this grouping was created throughout history.

NOTE: Effective 4/1/2002, TOB code 'XX0' was implemented to identify those claims that are totally non-covered.

STANDARD ALIAS : CLM_BILL_TYPE_CD_GRP

CODE TABLE : CLM_BILL_TYPE_TB

34. Claim Facility Type Code

1 136 136 CHAR

The first digit of the type of bill (TOB1) submitted on an institutional claim used to identify the type of facility that provided care to the beneficiary.

COMMON ALIAS : TOB1
DB2 ALIAS : CLM_FAC_TYPE_CD
SAS ALIAS : FAC_TYPE
STANDARD ALIAS : CLM_FAC_TYPE_CD
TITLE ALIAS : TOB1

LENGTH : 1

SOURCE : CWF

				CODE TABLE	: CLM_FAC_TYPE_TB
35.	Claim Service Classification Type Code	1	137	137	CHAR
					The second digit of the type of bill (TOB2) submitted on an institutional claim record to indicate the classification of the type of service provided to the beneficiary.
				COMMON	ALIAS : TOB2
				DB2	ALIAS : SRVC_CLSFCTN_CD
				SAS	ALIAS : TYPESRVC
				STANDARD	ALIAS : CLM_SRVC_CLSFCTN_TYPE_CD
				TITLE	ALIAS : TOB2
				LENGTH	: 1
				SOURCE	: CWF
				CODE TABLE	: CLM_SRVC_CLSFCTN_TYPE_TB
36.	Claim Frequency Code	1	138	138	CHAR
					The third digit of the type of bill (TOB3) submitted on an institutional claim record to indicate the sequence of a claim in the beneficiary's current episode of care.
				COMMON	ALIAS : TOB3
				DB2	ALIAS : CLM_FREQ_CD
				SAS	ALIAS : FREQ_CD
				STANDARD	ALIAS : CLM_FREQ_CD
				TITLE	ALIAS : FREQUENCY_CD
				LENGTH	: 1
				SOURCE	: CWF
				CODE TABLE	: CLM_FREQ_TB
37.	FILLER	1	139	139	CHAR
				DB2	ALIAS : FILLER
				LENGTH	: 1
38.	NCH MQA Query Patch Code	1	140	140	CHAR

Effective with Version H, a code used (for internal editing purposes) to indicate that the CWFMQA process changed the query code submitted on the claim record.

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

DB2 ALIAS : MQA_QUERY_PATCH_CD
SAS ALIAS : MQAQUERY
STANDARD ALIAS : NCH_MQA_QUERY_PATCH_CD
TITLE ALIAS : MQA_QUERY_PATCH_IND

LENGTH : 1

SOURCE : NCH QA Process

CODE TABLE : NCH_MQA_QUERY_PATCH_TB

39. Claim Disposition Code

2 141 142

CHAR

Code indicating the disposition or outcome of the processing of the claim record.

DB2 ALIAS : CLM_DISP_CD
SAS ALIAS : DISP_CD
STANDARD ALIAS : CLM_DISP_CD
TITLE ALIAS : DISPOSITION_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : CLM_DISP_TB

40. NCH Edit Disposition Code

2 143 144

CHAR

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

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

DB2 ALIAS : NCH_EDIT_DISP_CD
SAS ALIAS : EDITDISP
STANDARD ALIAS : NCH_EDIT_DISP_CD

				TITLE	ALIAS : NCH_EDIT_DISP
				LENGTH	: 2
				SOURCE	: NCH QA Process
				CODE TABLE	: NCH_EDIT_DISP_TB
41.	NCH Claim BIC Modify H Code	1	145	145	CHAR
					Effective with Version H, the code used (for internal editing purposes) to identify a claim record that was submitted with an incorrect HA, HB, or HC BIC.
					NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain spaces in this field.
				DB2	ALIAS : NCH_BIC_MDFY_CD
				SAS	ALIAS : BIC_MDFY
				STANDARD	ALIAS : NCH_CLM_BIC_MDFY_CD
				TITLE	ALIAS : BIC_MODIFY_CD
				LENGTH	: 1
				SOURCE	: NCH QA Process
				CODE TABLE	: NCH_CLM_BIC_MDFY_TB
42.	Beneficiary Residence SSA Standard County Code	3	146	148	CHAR
					The SSA standard county code of a beneficiary's residence.
				DB2	ALIAS : BENE_SSA_CNTY_CD
				SAS	ALIAS : CNTY_CD
				STANDARD	ALIAS : BENE_RSDNC_SSA_STD_CNTY_CD
				TITLE	ALIAS : BENE_COUNTY_CD
				LENGTH	: 3
				SOURCE	: SSA/EDB
				EDIT RULES :	
					OPTIONAL: MAY BE BLANK
43.	FI Claim Receipt Date	8	149	156	NUM

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

DB2 ALIAS : FI_CLM_RCPT_DT
SAS ALIAS : RCPT_DT
STANDARD ALIAS : FI_CLM_RCPT_DT
TITLE ALIAS : RECEIPT_DT

LENGTH : 8 SIGNED : N

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

SOURCE : CWF

EDIT RULES :
YYYYMMDD

44. FI Claim Scheduled Payment Date
8 157 164

NUM

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

DB2 ALIAS : FI_SCHLD_PMT_DT
SAS ALIAS : SCHLD_DT
STANDARD ALIAS : FI_CLM_SCHLD_PMT_DT
TITLE ALIAS : SCHEDULED_PMT_DT

LENGTH : 8 SIGNED : N

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

SOURCE : CWF

EDIT RULES :
YYYYMMDD

45. CWF Forwarded Date
8 165 172

NUM

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

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

DB2 ALIAS : CWF_FRWRD_DT
SAS ALIAS : FRWRD_DT
STANDARD ALIAS : CWF_FRWRD_DT
TITLE ALIAS : FORWARD_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

46. FI Number

5 173 177 CHAR

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

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

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

DB2 ALIAS : FI_NUM
SAS ALIAS : FI_NUM
STANDARD ALIAS : FI_NUM
TITLE ALIAS : INTERMEDIARY

LENGTH : 5

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

SOURCE : CWF

CODE TABLE : FI_NUM_TB

47. CWF Claim Assigned Number

8 178 185

CHAR

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

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

DB2 ALIAS : CWF_CLM_ASGN_NUM
SAS ALIAS : ASGN_NUM
STANDARD ALIAS : CWF_CLM_ASGN_NUM
TITLE ALIAS : ASSIGNED_NUM

LENGTH : 8

SOURCE : CWF

48. CWF Transmission Batch Number

4 186 189

CHAR

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

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

DB2 ALIAS : TRNSMSN_BATCH_NUM
SAS ALIAS : FIBATCH
STANDARD ALIAS : CWF_TRNSMSN_BATCH_NUM
TITLE ALIAS : BATCH_NUM

LENGTH : 4

SOURCE : CWF

49. Beneficiary Mailing Contact ZIP Code

9 190 198

CHAR

The ZIP code of the mailing address where the beneficiary may be contacted.

				DB2	ALIAS : BENE_MLG_ZIP_CD
				SAS	ALIAS : BENE_ZIP
				STANDARD	ALIAS : BENE_MLG_CNTCT_ZIP_CD
				TITLE	ALIAS : BENE_ZIP
				LENGTH	: 9
				SOURCE	: EDB
50.	Beneficiary Sex Identification Code	1	199	199	CHAR
					The sex of a beneficiary.
				COMMON	ALIAS : SEX_CD
				DA3	ALIAS : SEX_CODE
				DB2	ALIAS : BENE_SEX_IDENT_CD
				SAS	ALIAS : SEX
				STANDARD	ALIAS : BENE_SEX_IDENT_CD
				TITLE	ALIAS : SEX_CD
				LENGTH	: 1
				SOURCE	: SSA,RRB,EDB
				EDIT RULES :	REQUIRED FIELD
				CODE TABLE	: BENE_SEX_IDENT_TB
51.	Beneficiary Race Code	1	200	200	CHAR
					The race of a beneficiary.
				DA3	ALIAS : RACE_CODE
				DB2	ALIAS : BENE_RACE_CD
				SAS	ALIAS : RACE
				STANDARD	ALIAS : BENE_RACE_CD
				TITLE	ALIAS : RACE_CD
				LENGTH	: 1
				SOURCE	: SSA
				CODE TABLE	: BENE_RACE_TB
52.	Beneficiary Birth Date	8	201	208	NUM

The beneficiary's date of birth.

COMMON ALIAS : DOB
DA3 ALIAS : BIRTH_DATE
DB2 ALIAS : BENE_BIRTH_DT
SAS ALIAS : BENE_DOB
STANDARD ALIAS : BENE_BIRTH_DT
TITLE ALIAS : BENE_BIRTH_DATE

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

53. CWF Beneficiary Medicare Status Code
2 209 210

CHAR

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

COBOL ALIAS : MSC
COMMON ALIAS : MSC
DB2 ALIAS : BENE_MDCR_STUS_CD
SAS ALIAS : MS_CD
STANDARD ALIAS : CWF_BENE_MDCR_STUS_CD
TITLE ALIAS : MSC

LENGTH : 2

DERIVATIONS :
CWF derives MSC from the following:

1. Date of Birth
2. Claim Through Date
3. Original/Current Reasons for entitlement
4. ESRD Indicator
5. Beneficiary Claim Number

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

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

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

SOURCE : CWF

CODE TABLE : BENE_MDCR_STUS_TB

54. Claim Patient 6 Position Surname
6 211 216

CHAR

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

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

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

COMMON ALIAS : PATIENT_SURNAME
DB2 ALIAS : PTNT_6_PSTN_SRNM
SAS ALIAS : SURNAME
STANDARD ALIAS : CLM_PTNT_6_PSTN_SRNM_NAME
TITLE ALIAS : PATIENT_SURNAME

LENGTH : 6

SOURCE : CWF

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

CHAR

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

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

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

COMMON ALIAS : PATIENT_GIVEN_NAME
DB2 ALIAS : 1ST_INITL_GVN_NAME
SAS ALIAS : FRSTINIT
STANDARD ALIAS : CLM_PTNT_1ST_INITL_GVN_NAME
TITLE ALIAS : PATIENT_FIRST_INITIAL

LENGTH : 1

SOURCE : CWF

56. Claim Patient First Initial Middle Name
1 218 218

CHAR

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

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

NOTE2: For OP, HHA, Hospice and all Carrier claims,
data was populated beginning with NCH
weekly process date 10/3/97. Claims 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

57. Beneficiary CWF Location Code
1 219 219

CHAR

The code that identifies the Common Working File
(CWF) location (the host site) where a beneficiary's

Medicare utilization records are maintained.

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

LENGTH : 1

SOURCE : CWF

CODE TABLE : BENE_CWF_LOC_TB

58. Claim Principal Diagnosis Group
8 220 227

GRP

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

STANDARD ALIAS : CLM_PRNCPAL_DGNS_GRP

59. Claim Principal Diagnosis Version Code
1 220 220

CHAR

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

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

DB2 ALIAS : UNDEFINED
SAS ALIAS : PDVRSNCD

LENGTH : 1

CODE TABLE : CLM_DGNS_VRSN_TB

60. Claim Principal Diagnosis Code
7 221 227

CHAR

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

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

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

DB2 ALIAS : PRNCPAL_DGNS_CD
SAS ALIAS : PDGNS_CD

LENGTH : 7

SOURCE : CWF

EDIT RULES :
ICD-9-CM

61. FILLER

1 228 228

CHAR

DB2 ALIAS : FILLER

LENGTH : 1

62. Claim Medicare Non Payment Reason Code

2 229 230

CHAR

The reason that no Medicare payment is made for services on an institutional claim.

NOTE1: This field was put on all institutional claim types but data did not start coming in on OP/HHA/Hospice until 4/1/02. Prior to 4/1/02, data only came in Inpatient/SNF claims.

NOTE2: Effective 4/1/02, this field was also expanded to two bytes to accommodate new values. The NCH Nearline file did not expand the current 1-byte field but instituted a crosswalk of the 2-byte field to the 1-byte character value. See table of code for the crosswalk.

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

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

DB2 ALIAS : MDCR_NPMT_RSN_CD
SAS ALIAS : NOPAY_CD

LENGTH : 2

CODE TABLE : CLM_MDCR_NPMT_RSN_TB

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

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

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

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM_EXCPTD_NEXCPTD_TRTMT_TB

64. Claim Payment Amount
6 232 237 PACK

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

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

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

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

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

Under Outpatient PPS, the national ambulatory payment

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

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

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

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

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

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

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

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

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

COMMON ALIAS : REIMBURSEMENT

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

LENGTH : 9.2 SIGNED : Y

COMMENTS :

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

SOURCE : CWF

LIMITATIONS :

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

REFER TO :

PMT_AMT_EXCEDG_CHRG_AMT_LIM

EDIT RULES :

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

65. NCH Primary Payer Claim Paid Amount

6 238 243

PACK

The amount of a payment made on behalf of a Medicare beneficiary by a primary payer other than Medicare, that the provider is applying to covered Medicare charges on an institutional, carrier, or DMERC claim.

DB2 ALIAS : PRMRY_PYR_PD_AMT
STANDARD ALIAS : NCH_PRMRY_PYR_CLM_PD_AMT
TITLE ALIAS : PRIMARY_PAYER_AMOUNT

LENGTH : 9.2 SIGNED : Y

COMMENTS :

Prior to Version H this field was named:
BENE_PRMRY_PYR_CLM_PMT_AMT and the field size

was S9(7)V99.

SOURCE : NCH

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

66. NCH Primary Payer Code

1 244 244

CHAR

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

DB2 ALIAS : NCH_PRMRY_PYR_CD
SAS ALIAS : PRPAY_CD
STANDARD ALIAS : NCH_PRMRY_PYR_CD
TITLE ALIAS : PRIMARY_PAYER_CD

LENGTH : 1

DERIVATIONS :

DERIVED FROM:
CLM_VAL_CD
CLM_VAL_AMT

DERIVATION RULES

SET NCH_PRMRY_PYR_CD TO 'A' WHERE THE
CLM_VAL_CD = '12'

SET NCH_PRMRY_PYR_CD TO 'B' WHERE THE
CLM_VAL_CD = '13'

SET NCH_PRMRY_PYR_CD TO 'C' WHERE THE
CLM_VAL_CD = '16' and CLM_VAL_AMT is zeroes

SET NCH_PRMRY_PYR_CD TO 'D' WHERE THE
CLM_VAL_CD = '14'

SET NCH_PRMRY_PYR_CD TO 'E' WHERE THE
CLM_VAL_CD = '15'

SET NCH_PRMRY_PYR_CD TO 'F' WHERE THE
CLM_VAL_CD = '16' (CLM_VAL_AMT not
equal to zeroes)

SET NCH_PRMRY_PYR_CD TO 'G' WHERE THE
CLM_VAL_CD = '43'

SET NCH_PRMRY_PYR_CD TO 'H' WHERE THE
CLM_VAL_CD = '41'

SET NCH_PRMRY_PYR_CD TO 'I' WHERE THE
CLM_VAL_CD = '42'

SET NCH_PRMRY_PYR_CD TO 'L' (or prior to 4/97
set code to 'J') WHERE THE CLM_VAL_CD = '47'

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

SOURCE : NCH

CODE TABLE : BENE_PRMRY_PYR_TB

67. FI Requested Claim Cancel Reason Code
1 245 245

CHAR

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

DB2 ALIAS : RQST_CNCL_RSN_CD
SAS ALIAS : CANCELCD
STANDARD ALIAS : FI_RQST_CLM_CNCL_RSN_CD
TITLE ALIAS : CANCEL_CD

LENGTH : 1

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

SOURCE : CWF

CODE TABLE : FI_RQST_CLM_CNCL_RSN_TB

68. FI Claim Action Code
1 246 246

CHAR

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

DB2 ALIAS : FI_CLM_ACTN_CD
SAS ALIAS : ACTIONCD
STANDARD ALIAS : FI_CLM_ACTN_CD
TITLE ALIAS : ACTION_CD

				LENGTH	: 1
				COMMENTS :	
					Prior to Version H this field was named: INTRMDRY_CLM_ACTN_CD.
				SOURCE	: CWF
				CODE TABLE	: FI_CLM_ACTN_TB
69.	FI Claim Process Date	8	247	254	NUM
					The date the fiscal intermediary completes processing and releases the institutional claim to the CWF host.
				DB2	ALIAS : FI_CLM_PROC_DT
				SAS	ALIAS : APRVL_DT
				STANDARD	ALIAS : FI_CLM_PROC_DT
				TITLE	ALIAS : FI_PROCESS_DT
				LENGTH	: 8 SIGNED : N
				SOURCE	: CWF
				EDIT RULES :	
					YYYYMMDD
70.	NCH Provider State Code	2	255	256	CHAR
					Effective with Version H, the two position SSA state code where provider facility is located.
					NOTE: During the Version H conversion this field was populated with data throughout history (back to service year 1991).
				DB2	ALIAS : NCH_PRVDR_STATE_CD
				SAS	ALIAS : PRSTATE
				STANDARD	ALIAS : NCH_PRVDR_STATE_CD
				TITLE	ALIAS : PROVIDER_STATE_CD
				LENGTH	: 2
				DERIVATIONS :	
				DERIVED FROM:	
					NCH PRVDR_NUM

DERIVATION RULES:

```

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

```

SOURCE : NCH

CODE TABLE : GEO_SSA_STATE_TB

71. Organization NPI Number

10 257 266

CHAR

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

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

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

DB2 ALIAS : ORG_NPI_NUM
SAS ALIAS : ORGNPINM
STANDARD ALIAS : ORG_NPI_NUM
TITLE ALIAS : ORG_NPI

LENGTH : 10

SOURCE : CWF

72. Attending Physician ID Group
24 267 290

Name and identification numbers associated with the primary care physician.

STANDARD ALIAS : ATNDG_PHYSN_ID_GRP

73. Claim Attending Physician UPIN Number
6 267 272

CHAR

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

COMMON ALIAS : ATTENDING_PHYSICIAN_UPIN
DB2 ALIAS : ATNDG_UPIN_NUM
SAS ALIAS : AT_UPIN
STANDARD ALIAS : CLM_ATNDG_PHYSN_UPIN_NUM
TITLE ALIAS : ATTENDING_PHYSICIAN

LENGTH : 6

COMMENTS :

Prior to Version H this field was named:
CLM_PRMRY_CARE_PHYSN_IDENT_NUM and contained
10 positions (6-position UPIN and 4-position
physician surname).

SOURCE : CWF

74. Claim Attending Physician NPI Number
10 273 282

CHAR

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

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

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

COMMON ALIAS : ATTENDING_PHYSICIAN_NPI
DB2 ALIAS : ATNDG_NPI_NUM
SAS ALIAS : AT_NPI
STANDARD ALIAS : CLM_ATNDG_PHYSN_NPI_NUM
TITLE ALIAS : ATNDG_NPI

LENGTH : 10

SOURCE : CWF

75. Claim Attending Physician Surname
6 283 288

CHAR

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

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

DB2 ALIAS : ATNDG_SRNM
SAS ALIAS : AT_SRNM
STANDARD ALIAS : CLM_ATNDG_PHYSN_SRNM_NAME
TITLE ALIAS : ANDG_PHYSN_SURNAME

LENGTH : 6

SOURCE : CWF

76. Claim Attending Physician Given Name
1 289 289

CHAR

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

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

DB2 ALIAS : ATNDG_GVN_NAME
SAS ALIAS : AT_GVNNM
STANDARD ALIAS : CLM_ATNDG_PHYSN_GVN_NAME
TITLE ALIAS : ATNDG_PHYSN_FIRSTNAME

LENGTH : 1

SOURCE : CWF

77. Claim Attending Physician Middle Initial Name
1 290 290

CHAR

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

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

DB2 ALIAS : ATNDG_MI_NAME
SAS ALIAS : AT MDL
STANDARD ALIAS : CLM_ATNDG_PHYSN_MDL_INITL_NAME
TITLE ALIAS : ATNDG_PHYSN_MI

LENGTH : 1

SOURCE : CWF

78. Operating Physician ID Group
24 291 314

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

STANDARD ALIAS : OPRTG_PHYSN_ID_GRP

79. Claim Operating Physician UPIN Number
6 291 296

CHAR

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

DB2 ALIAS : OPRTG_UPIN
SAS ALIAS : OP_UPIN
STANDARD ALIAS : CLM_OPRTG_PHYSN_UPIN_NUM
TITLE ALIAS : OPRTG_UPIN

LENGTH : 6

COMMENTS :

Prior to Version H this field was named: CLM_PRNCPAL_PRCDR_PHYSN_NUM and contained 10 positions (6-position UPIN and 4-position physician surname.

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

SOURCE : CWF

80. Claim Operating Physician NPI Number
10 297 306

CHAR

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

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

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

DB2 ALIAS : OPRTG_NPI
SAS ALIAS : OP_NPI
STANDARD ALIAS : CLM_OPRTG_PHYSN_NPI_NUM
TITLE ALIAS : OPRTG_NPI

LENGTH : 10

SOURCE : CWF

81. Claim Operating Physician Surname
6 307 312

CHAR

Effective with Version H, the last name of the

operating physician (used for internal editing purposes in CMS' CWFMQA system.)

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

DB2 ALIAS : OPRTG SRNM
SAS ALIAS : OP_SRNM
STANDARD ALIAS : CLM_OPRTG_PHYSN_SRNM_NAME
TITLE ALIAS : OPRTG_PHYSN_SURNAME

LENGTH : 6

SOURCE : CWF

82. Claim Operating Physician Given Name
1 313 313

CHAR

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

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

DB2 ALIAS : OPRTG_GVN_NAME
SAS ALIAS : OP_GVN
STANDARD ALIAS : CLM_OPRTG_PHYSN_GVN_NAME
TITLE ALIAS : OPRTG_PHYSN_FIRSTNAME

LENGTH : 1

SOURCE : CWF

83. Claim Operating Physician Middle Initial Name
1 314 314

CHAR

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

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

				DB2	ALIAS : OPRTG_MI_NAME
				SAS	ALIAS : OP_MDL
				STANDARD	ALIAS : CLM_OPRTG_PHYSN_MDL_INITL_NAME
				TITLE	ALIAS : OPRTG_PHYSN_MI
				LENGTH	: 1
				SOURCE	: CWF
84.	Other Physician ID Group	24	315	338	
					Name and identification numbers associated with the other physician.
					STANDARD ALIAS : OTHR_PHYSN_ID_GRP
85.	Claim Other Physician UPIN Number	6	315	320	CHAR
					On an institutional claim, the unique physician identification number (UPIN) of the other physician associated with the institutional claim.
				DB2	ALIAS : OTHR_UPIN
				SAS	ALIAS : OT_UPIN
				STANDARD	ALIAS : CLM_OTHR_PHYSN_UPIN_NUM
				TITLE	ALIAS : OTH_PHYSN_UPIN
				LENGTH	: 6
				COMMENTS :	
					Prior to Version H this field was named: CLM_OTHR_PHYSN_IDENT_NUM and contained 10 positions (6-position UPIN and 4-position other physician surname).
					NOTE: For HHA and Hospice formats beginning with NCH weekly process date 10/3/97 this field was populated with data. HHA and Hospice claims processed prior to 10/3/97 will contain spaces.
				SOURCE	: CWF
86.	Claim Other Physician NPI Number	10	321	330	CHAR
					On an institutional claim, the National Provider Identifier (NPI) number assigned

to uniquely identify the other physician associated with the institutional claim.

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

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

DB2 ALIAS : OTHR_NPI
SAS ALIAS : OT_NPI
STANDARD ALIAS : CLM_OTHR_PHYSN_NPI_NUM

LENGTH : 10

SOURCE : CWF

87. Claim Other Physician Surname
6 331 336

CHAR

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

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

DB2 ALIAS : OTHR_SRN
SAS ALIAS : OT_SRN

STANDARD ALIAS : CLM_OTHR_PHYSN_SRNM_NAME
TITLE ALIAS : OTH_PHYSN_SURNAME

LENGTH : 6

SOURCE : CWF

88. Claim Other Physician Given Name
1 337 337

CHAR

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

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

DB2 ALIAS : OTHR_GVN_NAME
SAS ALIAS : OT_GVN
STANDARD ALIAS : CLM_OTHR_PHYSN_GVN_NAME
TITLE ALIAS : OTH_PHYSN_FIRSTNAME

LENGTH : 1

SOURCE : CWF

89. Claim Other Physician Middle Initial Name
1 338 338

CHAR

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

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

DB2 ALIAS : OTHR_MI_NAME
SAS ALIAS : OT_MDL
STANDARD ALIAS : CLM_OTHR_PHYSN_MDL_INITL_NAME
TITLE ALIAS : OTH_PHYSN_MI

LENGTH : 1

SOURCE : CWF

90. Medicaid Provider Identification Number

13 339 351 CHAR

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

DB2 ALIAS : MDCD_PRVDR_NUM
SAS ALIAS : MDCD_PRV
STANDARD ALIAS : MDCD_PRVDR_IDENT_NUM
TITLE ALIAS : MEDICAID_PROVIDER

LENGTH : 13

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

SOURCE : CWF

91. Claim Medicaid Information Code

4 352 355 CHAR

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

DB2 ALIAS : CLM_MDCD_INFO_CD
SAS ALIAS : MDCDINFO
STANDARD ALIAS : CLM_MDCD_INFO_CD
TITLE ALIAS : MEDICAID_INFO

LENGTH : 4

SOURCE : CWF

CODE TABLE : CLM_MDCD_INFO_TB

92. Claim MCO Paid Switch

1 356 356 CHAR

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

COBOL ALIAS : MCO_PD_IND
DB2 ALIAS : CLM_MCO_PD_SW
SAS ALIAS : MCOPDSW
STANDARD ALIAS : CLM_MCO_PD_SW
TITLE ALIAS : MCO_PAID_SW

LENGTH : 1

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

SOURCE : CWF

LIMITATIONS :

REFER TO :
MCO_PD_SW_LIM

CODE TABLE : CLM_MCO_PD_TB

93. Claim Treatment Authorization Number
18 357 374

CHAR

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

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

COMMON ALIAS : TAN
DB2 ALIAS : TRTMT_AUTHRZTN_NUM
SAS ALIAS : AUTHRZTN
STANDARD ALIAS : CLM_TRTMT_AUTHRZTN_NUM
TITLE ALIAS : TREATMENT_AUTHORIZATION

LENGTH : 18

SOURCE : CWF

94. Patient Control Number
20 375 394

CHAR

The unique alphanumeric identifier assigned by the provider to the institutional claim to facilitate retrieval of individual case records and posting

of payments.

DB2 ALIAS : PTNT_CNTL_NUM
SAS ALIAS : PTNTCNTL_
STANDARD ALIAS : PTNT_CNTL_NUM
TITLE ALIAS : PATIENT_CONTROL_NUM

LENGTH : 20

SOURCE : CWF

95. Claim Medical Record Number
17 395 411

CHAR

The number assigned by the provider to the beneficiary's medical record to assist in record retrieval.

DB2 ALIAS : CLM_MDCL_REC_NUM
SAS ALIAS : MDCL_REC_
STANDARD ALIAS : CLM_MDCL_REC_NUM
TITLE ALIAS : MEDICAL_RECORD_NUM

LENGTH : 17

SOURCE : CWF

96. Claim PRO Control Number
12 412 423

CHAR

Effective with Version G, the unique identifier assigned by the Peer Review Organization (PRO) for control purposes.

DB2 ALIAS : CLM_PRO_CNTL_NUM
SAS ALIAS : PRO_CNTL_
STANDARD ALIAS : CLM_PRO_CNTL_NUM
TITLE ALIAS : PRO_CONTROL_NUM

LENGTH : 12

SOURCE : CWF

97. Claim PRO Process Date
8 424 431

NUM

Effective with Version H, the date the claim was used in the PRO review process.

NOTE: Beginning with NCH weekly process date

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

DB2 ALIAS : CLM_PRO_PROC_DT
SAS ALIAS : PRO_DT
STANDARD ALIAS : CLM_PRO_PROC_DT
TITLE ALIAS : PRO_PROC_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

98. Patient Discharge Status Code
2 432 433

CHAR

The code used to identify the status of the
patient as of the CLM_THRU_DT.

DB2 ALIAS : PTNT_DSCHRG_STUS
SAS ALIAS : STUS_CD
STANDARD ALIAS : PTNT_DSCHRG_STUS_CD
TITLE ALIAS : PTNT_DSCHRG_STUS_CD

LENGTH : 2

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

SOURCE : CWF

CODE TABLE : PTNT_DSCHRG_STUS_TB

99. Claim 1st Diagnosis E Code Group
8 434 441

GRP

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

STANDARD ALIAS : CLM_1ST_DGNS_E_CD_GRP

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

CHAR

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

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

DB2 ALIAS : UNDEFINED
SAS ALIAS : E1VRSNCD

LENGTH : 1

CODE TABLE : CLM_DGNS_VRSN_TB

101. Claim 1st Diagnosis E Code

7 435 441

CHAR

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

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

DB2 ALIAS : CLM_1ST_DGNS_E_CD
SAS ALIAS : DGNS_E
STANDARD ALIAS : CLM_1ST_DGNS_E_CD

LENGTH : 7

COMMENTS :
Prior to version 'J', this field was named:
CLM_DGNS_E_CD.

SOURCE : CWF

EDIT RULES :
ICD-9-CM

102. Claim PPS Indicator Code

1 442 442

CHAR

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

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

COBOL ALIAS : PPS_IND
DB2 ALIAS : CLM_PPS_IND_CD
SAS ALIAS : PPS_IND
STANDARD ALIAS : CLM_PPS_IND_CD
TITLE ALIAS : PPS_IND

LENGTH : 1

SOURCE : CWF

CODE TABLE : CLM_PPS_IND_TB

103. Claim Total Charge Amount

6 443 448

PACK

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

DB2 ALIAS : CLM_TOT_CHRG_AMT
SAS ALIAS : TOT_CHRG
STANDARD ALIAS : CLM_TOT_CHRG_AMT
TITLE ALIAS : CLAIM_TOTAL_CHARGES

LENGTH : 9.2 SIGNED : Y

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

SOURCE : CWF

LIMITATIONS :

REFER TO :
TOT_CHRG_AMT_LIM

104. Claim Pricer Return Code

2 449 450

CHAR

Effective 1/1/2004 with the implementation of NCH/NMUD

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

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

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

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

DB2 ALIAS : CLM_PRCR_RTRN_CD
SAS ALIAS : PRCRTRN
STANDARD ALIAS : CLM_PRCR_RTRN_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : CLM_PRCR_RTRN_TB

105. Claim Business Segment Identifier Code
4 451 454

CHAR

Effective 10/1/2005 with the implementation of NCH/NMUD CR#2, the identifier that captures the 2-byte jurisdiction code (represents the USPS state/territory abbreviation (i.e. NY = New York) and the 2-byte modifier that identifies the type of Medicare FFS contract (intermediary, RHHI, carrier or DMERC). This 4-byte identifier along with the 5-byte FI/Carrier number comprises the Contractor Workload Identifier number. The business segment identifier (BSI) is intended to help sort workloads that may be redistributed with the implementation of contracting reform as required by MMA.

DB2 ALIAS : BUSNS_SGMT_ID_CD
SAS ALIAS : SGMT_ID
STANDARD ALIAS : CLM_BUSNS_SGMT_ID_CD

LENGTH : 4

SOURCE : CWF

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

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

DB2 ALIAS : RAC_ADJSTMT_CD
SAS ALIAS : RACINDCD
STANDARD ALIAS : CLM_RAC_ADJSTMT_IND_CD

LENGTH : 1

CODE TABLE : CLM_RAC_ADJSTMT_TB

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

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

DB2 ALIAS : CLM_WC_IND_CD
SAS ALIAS : WCINDCD

LENGTH : 1

CODE TABLE : CLM_WC_IND_TB

LANGUAGE : C

108. Claim Service Facility Zip Code
9 457 465 CHAR

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

DB2 ALIAS : SRVC_FAC_ZIP_CD
SAS ALIAS : SRVCFAC
STANDARD ALIAS : CLM_SRVC_FAC_ZIP_CD

LENGTH : 9

109. Claim Paperwork (PWK) Code
2 466 467 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

110. FILLER

48 468 515

CHAR

DB2 ALIAS : FILLER

LENGTH : 48

111. Hospice NCH Edit Code Count
2

516 517

NUM

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

DB2 ALIAS : HOSPC_EDIT_CD_CNT
SAS ALIAS : HSEDCNT
STANDARD ALIAS : HOSPC_NCH_EDIT_CD_CNT

LENGTH : 2 SIGNED : N

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

SOURCE : NCH

112. Hospice NCH Patch Code Count
2

518 519

NUM

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

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

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

DB2 ALIAS : HOSPC_PATCH_CD_CNT
SAS ALIAS : HSPATCNT
STANDARD ALIAS : HOSPC_NCH_PATCH_CD_I_CNT

LENGTH : 2 SIGNED : N

SOURCE : NCH

113. Hospice MCO Period Count

1 520 520

NUM

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

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

DB2 ALIAS : HOSPC_MCO_PRD_CNT
SAS ALIAS : HSMCOCNT
STANDARD ALIAS : HOSPC_MCO_PRD_CNT

LENGTH : 1 SIGNED : N

SOURCE : NCH

EDIT RULES :
RANGE: 0 TO 2

114. Hospice Claim Demonstration ID Count

1 521 521

NUM

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

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

DB2 ALIAS : HOSPC_DEMO_ID_CNT
SAS ALIAS : HSDEMCNT
STANDARD ALIAS : HOSPC_CLM_DEMO_ID_CNT

LENGTH : 1 SIGNED : N

SOURCE : NCH

EDIT RULES :
RANGE: 0 TO 5

115. FILLER

2 522 523

NUM

DB2 ALIAS : FILLER

LENGTH : 2 SIGNED : N

116. FILLER

2 524 525

NUM

DB2 ALIAS : FILLER

LENGTH : 2 SIGNED : N

117. Hospice Claim Diagnosis Code Count

2 526 527

NUM

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

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

NOTE1: During the Version 'J' conversion, the diagnosis 'E' codes were removed from the diagnosis trailer and put in the newly created diagnosis 'E' trailer. Effective with Version 'J', 'E' codes can be found in the diagnosis trailer as secondary diagnosis codes.

DB2 ALIAS : HOSPC_DGNS_CD_CNT
SAS ALIAS : HSDGNCNT
STANDARD ALIAS : HOSPC_CLM_DGNS_CD_J_CNT

LENGTH : 2 SIGNED : N

COMMENTS :
Prior to Version H this field was named:
CLM_OTHR_DGNS_CD_CNT and the principal was
not included in the count.

SOURCE : NCH

EDIT RULES :
RANGE: 0 TO 25

118. Hospice Claim Diagnosis E Code Count
2 528 529

NUM

Effective with Version 'J', the count of the number of
diagnosis E codes (both principal and secondary)
reported on a Hospice claim.
The purpose of this count is to indicate
how many claim diagnosis E code trailers are present.

DB2 ALIAS : HOSPC_CLM_DGNS_E_C

LENGTH : 2 SIGNED : N

119. Hospice Claim Procedure Code Count
2 530 531

NUM

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

NOTE: Effective with Version 'J', the count of the
number of procedure code trailers was expanded
from 6 to 25.

DB2 ALIAS : HOSPC_PRCDR_CD_CNT
SAS ALIAS : HSPRCNT
STANDARD ALIAS : HOSPC_CLM_PRCDR_CD_J_CNT

LENGTH : 2 SIGNED : N

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

SOURCE : CWF

EDIT RULES :
RANGE: 0 TO 25

120. Hospice Claim Related Condition Code Count
2 532 533

NUM

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

DB2 ALIAS : HOSPC_COND_CD_CNT
SAS ALIAS : HSCONCNT
STANDARD ALIAS : HOSPC_CLM_RLT_COND_CD_CNT

LENGTH : 2 SIGNED : N

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

SOURCE : NCH

EDIT RULES :
RANGE: 0 TO 30

121. Hospice Claim Related Occurrence Code Count
2 534 535

NUM

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

DB2 ALIAS : HOSPC_OCRNC_CD_CNT
SAS ALIAS : HSOCRCNT
STANDARD ALIAS : HOSPC_CLM_RLT_OCRNC_CD_CNT

LENGTH : 2 SIGNED : N

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

SOURCE : NCH

EDIT RULES :
RANGE: 0 TO 30

122. Hospice Claim Occurrence Span Code Count

2 536 537 NUM

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

DB2 ALIAS : HOSPC_SPAN_CNT
SAS ALIAS : HSSPNCNT
STANDARD ALIAS : HOSPC_CLM_OCRNC_SPAN_CD_CNT

LENGTH : 2 SIGNED : N

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

SOURCE : NCH

EDIT RULES :
RANGE: 0 TO 10

123. Hospice Claim Value Code Count

2 538 539 NUM

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

DB2 ALIAS : HOSPC_VAL_CD_CNT
SAS ALIAS : HSVALCNT
STANDARD ALIAS : HOSPC_CLM_VAL_CD_CNT

LENGTH : 2 SIGNED : N

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

SOURCE : NCH

EDIT RULES :
RANGE: 0 TO 36

124. Hospice Revenue Center Code Count

2 540 541 NUM

The count of the number of revenue codes reported on an hospice claim. The purpose of the count is to indicate how

many revenue center trailers are present.

DB2 ALIAS : HOSPC_REV_CNTR_CNT
SAS ALIAS : HSREVCNT
STANDARD ALIAS : HOSPC_REV_CNTR_CD_I_CNT

LENGTH : 2 SIGNED : N

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

NOTE: Effective with Version 'I' the number
of occurrences changed to 45 (per segment -
450 total for claim). For claims prior to
Version 'I' the number of occurrences was 58.

SOURCE : NCH

EDIT RULES :
RANGE: 0 TO 45

125. FILLER

4 542 545 CHAR

DB2 ALIAS : FILLER

LENGTH : 4

126. FI Hospice Claim Specific Group

78 546 623 GRP

STANDARD ALIAS : FI_HOSPC_CLM_SPECF_GRP

127. NCH Patient Status Indicator Code

1 546 546 CHAR

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

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

DB2 ALIAS : NCH_PTNT_STUS_IND
SAS ALIAS : PTNTSTUS

STANDARD ALIAS : NCH_PTNT_STUS_IND_CD
TITLE ALIAS : NCH_PATIENT_STUS

LENGTH : 1

DERIVATIONS :
DERIVED FROM:
NCH_PTNT_DSCHRG_STUS_CD

DERIVATION RULES:

SET NCH_PTNT_STUS_IND_CD TO 'A' WHERE THE
PTNT_DSCHRG_STUS_CD NOT EQUAL TO '20' - '30'
OR '40' - '42'.

SET NCH_PTNT_STUS_IND_CD TO 'B' WHERE THE
PTNT_DSCHRG_STUS_CD EQUAL TO '20' - '29'
OR '40' - '42'.

SET NCH_PTNT_STUS_IND_CD TO 'C' WHERE THE
PTNT_DSCHRG_STUS_CD EQUAL TO '30'

SOURCE : NCH_QA_Process

CODE TABLE : NCH_PTNT_STUS_IND_TB

128. Claim Hospice Start Date

8 547 554

NUM

On an institutional claim, the date the beneficiary
was admitted to the hospice.

DB2 ALIAS : CLM_HOSPC_STRT_DT
SAS ALIAS : HSPCSTRT
STANDARD ALIAS : CLM_HOSPC_STRT_DT
TITLE ALIAS : HOSPC_START_DT

LENGTH : 8 SIGNED : N

COMMENTS :
Prior to Version H, this field was named:
CLM_ADMSN_DT.

SOURCE : CWF

EDIT RULES :
YYYYMMDD

129. NCH Beneficiary Medicare Benefits Exhausted Date

8 555 562 NUM

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

DB2 ALIAS : MDCR_BNFT_EXHST_DT
SAS ALIAS : EXHST_DT
STANDARD ALIAS : NCH_MDCR_BNFT_EXHST_DT
TITLE ALIAS : BENEFIT_EXHST_DT

LENGTH : 8 SIGNED : N

DERIVATIONS :
DERIVED FROM:
CLM_RLT_OCRNC_CD
CLM_RLT_OCRNC_DT

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

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

SOURCE : NCH QA Process

EDIT RULES :
YYYYMMDD

130. NCH Beneficiary Discharge Date
8 563 570

NUM

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

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

DB2 ALIAS : NCH_BENE_DSCHRG_DT
SAS ALIAS : DSCHRGDT
STANDARD ALIAS : NCH_BENE_DSCHRG_DT

TITLE ALIAS : DISCHARGE_DT

LENGTH : 8 SIGNED : N

DERIVATIONS :

DERIVED FROM:

NCH_PTNT_STUS_IND_CD

CLM_THRU_DT

DERIVATION RULES:

Based on the presence of patient discharge status code not equal to 30 (still patient), move the claim thru date to the NCH_BENE_DSCHRG_DT.

SOURCE : NCH QA Process

EDIT RULES :

YYYYMMDD

131. Claim Utilization Day Count

2 571 572

PACK

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

DB2 ALIAS : CLM_UTLZTN_DAY_CNT

SAS ALIAS : UTIL_DAY

STANDARD ALIAS : CLM_UTLZTN_DAY_CNT

TITLE ALIAS : UTILIZATION_DAYS

LENGTH : 3 SIGNED : Y

132. Beneficiary's Hospice Period Count

1 573 573

NUM

The count of the number of hospice period trailers present for the beneficiary's record. Prior to BBA a beneficiary was entitled to a maximum of 4 hospice benefit periods that may be elected in lieu of standard Part A hospital benefits. The BBA changed the hospice benefit to the following: 2 initial 90 day periods followed by an unlimited number of 60 day periods (effective 8/5/97).

DB2 ALIAS : BENE_HOSPC_PRD_CNT

SAS ALIAS : HOSPCPRD
STANDARD ALIAS : BENE_HOSPC_PRD_CNT
TITLE ALIAS : HOSPICE_PERIOD_COUNT

LENGTH : 1 SIGNED : N

SOURCE : CWF

EDIT RULES :

RANGE: 1 THRU 3: 1 = 1st 90-day period; 2 = 2nd 90
day period and 3 = 60-day period (3 or greater
periods)

133. Claim Attending Physician Specialty Code
2 574 575

CHAR

Effective with CR#6, the code used to identify the CMS
specialty code corresponding to the attending physician.
The Affordable Care Act (ACA) provides for incentive
payments for attending physicians and non-physician
practitioners with specific primary specialty designations.
In order to determine if the physician or non-physician is
eligible for the incentive payment, the specialty code,
NPI and name must be carried on the claims.

DB2 ALIAS : CLM_ATNDG_SPCLTY_CD
STANDARD ALIAS : CLM_ATNDG_PHYSN_SPCLTY_CD

LENGTH : 2

CODE TABLE : CMS_PRVDR_SPCLTY_TB

134. Claim Operating Physician Specialty Code
2 576 577

CHAR

Effective with CR#6, the code used to identify the CMS
specialty code corresponding to the operating physician.
The Affordable Care Act (ACA) provides for incentive
payments for physicians and non-physician practitioners
with specific primary specialty designations. In order
to determine if the physician or non-physicians is
eligible for the incentive payment, the specialty code,
NPI and name must be carried on the claims.

DB2 ALIAS : CLM_OPRTG_SPCLTY_CD
STANDARD ALIAS : CLM_OPRTG_PHYSN_SPCLTY_CD

LENGTH : 2

CODE TABLE : CMS_PRVDR_SPCLTY_TB

135. Claim Other Physician Specialty Code	2	578	579	CHAR	
					Effective with CR#6, the code used to identify the CMS specialty code corresponding to the other physician. The Affordable Care Act (ACA) provides for incentive payments for physicians and non-physician practitioners with specific primary specialty designations. In order to determine if the physician or non-physicians is eligible for the incentive payment, the specialty code, NPI and name must be carried on the claims.
				DB2	ALIAS : CLM_OTHR_SPCLTY_CD
				STANDARD	ALIAS : CLM_OTHR_PHYSN_SPCLTY_CD
				LENGTH	: 2
				CODE TABLE	: CMS_PRVDR_SPCLTY_TB
136. FILLER	44	580	623	CHAR	
				DB2	ALIAS : FILLER
				LENGTH	: 44
137. FI Hospice Claim Variable Group					
	VAR	624	16242	GRP	
				STANDARD	ALIAS : FI_HOSPC_CLM_VAR_GRP
138. NCH Edit Group	5	624	628	GRP	
					The number of claim edit trailers is determined by the claim edit code count.
				STANDARD	ALIAS : NCH_EDIT_GRP
				OCCURS MIN:	0 OCCURS MAX: 13
				DEPENDING ON	: HOSPC_NCH_EDIT_CD_CNT
139. NCH Edit Trailer Indicator Code	1	624	624	CHAR	
					Effective with Version H, the code indicating

the presence of an NCH edit trailer.

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

DB2 ALIAS : EDIT_TRLR_IND_CD
SAS ALIAS : EDITIND
STANDARD ALIAS : NCH_EDIT_TRLR_IND_CD

LENGTH : 1

SOURCE : NCH QA Process

CODE TABLE : NCH_EDIT_TRLR_IND_TB

140. NCH Edit Code

4 625 628 CHAR

The code annotated to the claim indicating the CWFMQA editing results so users will be aware of data deficiencies.

NOTE: Prior to Version H only the highest priority code was stored. Beginning 11/98 up to 13 edit codes may be present.

COMMON ALIAS : QA_ERROR_CODE
DB2 ALIAS : NCH_EDIT_CD
SAS ALIAS : EDIT_CD
STANDARD ALIAS : NCH_EDIT_CD
TITLE ALIAS : QA_ERROR_CD

LENGTH : 4

SOURCE : NCH QA EDIT PROCESS

CODE TABLE : NCH_EDIT_TB

141. NCH Patch Group

11 1 11 GRP

STANDARD ALIAS : NCH_PATCH_GRP

OCCURS MIN: 0 OCCURS MAX: 30

DEPENDING ON : HOSPC_NCH_PATCH_CD_I_CNT

142. NCH Patch Trailer Indicator Code

	1	1	1	CHAR	<p>Effective with Version H, the code indicating the presence of an NCH patch trailer.</p> <p>NOTE: During the Version H conversion this field was populated throughout history (back to service year 1991).</p> <p>DB2 ALIAS : PATCH_TRLR_IND_CD SAS ALIAS : PATCHIND STANDARD ALIAS : NCH_PATCH_TRLR_IND_CD</p> <p>LENGTH : 1</p> <p>SOURCE : NCH</p> <p>CODE TABLE : NCH_PATCH_TRLR_IND_TB</p>
143. NCH Patch Code	2	2	3	CHAR	<p>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.</p> <p>NOTE: Prior to Version H this field was located in the third and fourth occurrence of the CLM_EDIT_CD.</p> <p>DB2 ALIAS : NCH_PATCH_CD SAS ALIAS : PATCHCD STANDARD ALIAS : NCH_PATCH_CD TITLE ALIAS : NCH_PATCH</p> <p>LENGTH : 2</p> <p>SOURCE : NCH</p> <p>CODE TABLE : NCH_PATCH_TB</p>
144. NCH Patch Applied Date	8	4	11	NUM	<p>Effective with Version H, the date the NCH patch was applied to the claim.</p> <p>DB2 ALIAS : NCH_PATCH_APPLY_DT</p>

SAS ALIAS : PATCHDT
STANDARD ALIAS : NCH_PATCH_APPLY_DT
TITLE ALIAS : NCH_PATCH_DT

LENGTH : 8 SIGNED : N

SOURCE : NCH

EDIT RULES :
YYYYMMDD

145. MCO Period Group

37 1 37 GRP

The number of managed care organization (MCO) period data trailers present is determined by the claim MCO period trailer count. This field reflects the two most current MCO periods in the CWF beneficiary history record. It may have no connection to the services on the claim.

STANDARD ALIAS : MCO_PRD_GRP

OCCURS MIN: 0 OCCURS MAX: 2

DEPENDING ON : HOSPC_MCO_PRD_CNT

146. 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
147. 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
148. 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
149. MCO Period Effective Date	8	8	15	NUM
				Effective with Version H, the date the bene-

ficiary's enrollment in the Managed Care Organization (MCO) became effective.

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

DB2 ALIAS : MCO_PRD_EFCTV_DT
SAS ALIAS : MCOEFFDT
STANDARD ALIAS : MCO_PRD_EFCTV_DT
TITLE ALIAS : MCO_PERIOD_EFF_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

150. 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

151. 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

152. Claim Demonstration Identification Group
18 1 18

GRP

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

STANDARD ALIAS : CLM_DEMO_ID_GRP

OCCURS MIN: 0 OCCURS MAX: 5

DEPENDING ON : HOSPC_CLM_DEMO_ID_CNT

153. 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

154. 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 (in-

cluding 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 trans-

mitting 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

155. 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

156. Claim Diagnosis Group

9 1 9 GRP

The number of claim diagnosis trailers is determined by the claim diagnosis code count. The principal diagnosis is the first occurrence. The principal diagnosis is also stored (redundantly) in the fixed portion

of the record.

NOTE:

Prior to Version H this group was named:
CLM_OTHR_DGNS_GRP and did not contain the
CLM_PRNCPAL_DGNS_CD.

STANDARD ALIAS : CLM_DGNS_GRP

OCCURS MIN: 0 OCCURS MAX: 25

DEPENDING ON : HOSPC_CLM_DGNS_CD_J_CNT

157. 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

158. 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

159. 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

160. Claim Diagnosis E Group

9 1 9 GRP

The number of claim diagnosis E trailers is determined by the claim diagnosis E code count. This group contains the diagnosis E codes and the diagnosis E version code.

STANDARD ALIAS : CLM_DGNS_E_GRP

OCCURS MIN: 0 OCCURS MAX: 12

DEPENDING ON : HOSPC_CLM_DGNS_E_CD_CNT

161. NCH Diagnosis E Trailer Indicator Code

1 1 1 CHAR

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

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

DB2 ALIAS : DGNS_E_TRLR_IND_CD
SAS ALIAS : ETRLRIND

LENGTH : 1

SOURCE :

CODE TABLE : NCH_DGNS_E_TRLR_IND_TB

162. Claim Diagnosis Version Code

1 2 2

CHAR

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

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

DB2 ALIAS : UNDEFINED
SAS ALIAS : EVRSNCD

LENGTH : 1

CODE TABLE : CLM_DGNS_VRSN_TB

163. Claim Diagnosis E Code

7 3 9

CHAR

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

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

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

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

DB2 ALIAS : CLM_DGNS_E_CD
SAS ALIAS : EDGNSCD

LENGTH : 7

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

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

DB2 ALIAS : UNDEFINED
SAS ALIAS : PVRSNCD

LENGTH : 1

CODE TABLE : CLM_PRCDR_VRSN_TB

167. Claim Procedure Code

7 3 9

CHAR

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

NOTE:

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

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

DB2 ALIAS : CLM_PRCDR_CD
SAS ALIAS : PRCDR_CD

LENGTH : 7

DERIVATIONS :

DERIVED FROM:

NCH CLM_PRCDR_CD

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

SOURCE : CWF

EDIT RULES :

ICD-9-CM

168. Claim Procedure Performed Date

8 10 17

NUM

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

DB2 ALIAS : CLM_PRCDR_PRFRM_DT
SAS ALIAS : PRCDR_DT
STANDARD ALIAS : CLM_PRCDR_PRFRM_DT

LENGTH : 8 SIGNED : N

SOURCE : CWF

EDIT RULES :
YYYYMMDD

169. Claim Related Condition Group
3 1 3

GRP

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

STANDARD ALIAS : CLM_RLT_COND_GRP

OCCURS MIN: 0 OCCURS MAX: 30

DEPENDING ON : HOSPC_CLM_RLT_COND_CD_CNT

170. NCH Condition Trailer Indicator Code
1 1 1

CHAR

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

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

DB2 ALIAS : COND_TRLR_IND_CD
SAS ALIAS : CONDIND
STANDARD ALIAS : NCH_COND_TRLR_IND_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH_COND_TRLR_IND_TB

171. Claim Related Condition Code
2 2 3

CHAR

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

DB2 ALIAS : CLM_RLT_COND_CD
SAS ALIAS : RLT_COND
STANDARD ALIAS : CLM_RLT_COND_CD
TITLE ALIAS : RELATED_CONDITION_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : CLM_RLT_COND_TB

172. Claim Related Occurrence Group
11 1 11

GRP

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

STANDARD ALIAS : CLM_RLT_OCRNC_GRP

OCCURS MIN: 0 OCCURS MAX: 30

DEPENDING ON : HOSPC_CLM_RLT_OCRNC_CD_CNT

173. NCH Occurrence Trailer Indicator Code
1 1 1

CHAR

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

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

DB2 ALIAS : OCRNC_TRLR_IND_CD
SAS ALIAS : OCRNCIND
STANDARD ALIAS : NCH_OCRNC_TRLR_IND_CD

LENGTH : 1

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

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

STANDARD ALIAS : CLM_OCRNC_SPAN_GRP

OCCURS MIN: 0 OCCURS MAX: 10

DEPENDING ON : HOSPC_CLM_OCRNC_SPAN_CD_CNT

177. NCH Span Trailer Indicator Code

1 1 1

CHAR

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

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

DB2 ALIAS : SPAN_TRLR_IND_CD

SAS ALIAS : SPANIND

STANDARD ALIAS : NCH_SPAN_TRLR_IND_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH_SPAN_TRLR_IND_TB

178. Claim Occurrence Span Code

2 2 3

CHAR

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

DB2 ALIAS : CLM_OCRNC_SPAN_CD

SAS ALIAS : SPAN_CD

STANDARD ALIAS : CLM_OCRNC_SPAN_CD

TITLE ALIAS : SPAN_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : CLM_OCRNC_SPAN_TB

179. Claim Occurrence Span From Date

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

OCCURS MIN: 0 OCCURS MAX: 36

DEPENDING ON : HOSPC_CLM_VAL_CD_CNT

182. NCH Value Trailer Indicator Code

1 1 1

CHAR

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

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

DB2 ALIAS : VAL_TRLR_IND_CD

SAS ALIAS : VALIND

STANDARD ALIAS : NCH_VAL_TRLR_IND_CD

LENGTH : 1

SOURCE : NCH

CODE TABLE : NCH_VAL_TRLR_IND_TB

183. Claim Value Code

2 2 3

CHAR

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

DB2 ALIAS : CLM_VAL_CD

SAS ALIAS : VAL_CD

STANDARD ALIAS : CLM_VAL_CD

TITLE ALIAS : VALUE_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : CLM_VAL_TB

184. Claim Value Amount

6 4 9

PACK

The amount related to the condition identified in the CLM_VAL_CD which was used by the intermediary to process the institutional claim.

				DB2	ALIAS : CLM_VAL_AMT
				SAS	ALIAS : VAL_AMT
				STANDARD	ALIAS : CLM_VAL_AMT
				TITLE	ALIAS : VALUE_AMOUNT
				LENGTH	: 9.2 SIGNED : Y
				SOURCE	: CWF
				EDIT RULES :	
					\$\$\$\$\$\$\$CC
185. Claim Revenue Center Group	297	1	297	GRP	
				STANDARD ALIAS :	CLM_REV_CNTR_GRP
				OCCURS MIN:	0 OCCURS MAX: 45
				DEPENDING ON :	HOSPC_REV_CNTR_CD_I_CNT
186. NCH Revenue Center Trailer Indicator Code	1	1	1	CHAR	
				Effective with Version H, the code identifying the revenue center trailer.	
				During the Version H conversion this field was populated with data throughout history (back to service year 1991).	
				DB2	ALIAS : REV_CNTR_TRLR_CD
				SAS	ALIAS : REVIND
				STANDARD	ALIAS : NCH_REV_CNTR_TRLR_IND_CD
				LENGTH	: 1
				SOURCE	: NCH
				CODE TABLE	: NCH_REV_TRLR_IND_TB
187. Revenue Center Code	4	2	5	CHAR	
				The provider-assigned revenue code for each cost center for which a separate charge is billed (type of accommodation or ancillary). A cost center is a division or unit within a hospital (e.g., radiology, emergency room, pathology).	

EXCEPTION: Revenue center code 0001 represents the total of all revenue centers included on the claim.

COBOL ALIAS : REV_CD
DB2 ALIAS : REV_CNTR_CD
SAS ALIAS : REV_CNTR
STANDARD ALIAS : REV_CNTR_CD
TITLE ALIAS : REVENUE_CENTER_CD

LENGTH : 4

SOURCE : CWF

CODE TABLE : REV_CNTR_TB

188. Revenue Center Date

8 6 13

NUM

Effective with Version H, the date applicable to the service represented by the revenue center code. This field may be present on any of the institutional claim types. For home health claims the service date should be present on all bills with from date greater than 3/31/98. With the implementation of outpatient PPS, hospitals will be required to enter line item dates of service for all outpatient services which require a HCPCS.

NOTE1: Beginning with NCH weekly process date 10/3/97 this field was populated with data. Claims processed prior to 10/3/97 will contain zeroes in this field.

NOTE2: When revenue center code equals '0022' (SNF PPS) and revenue center HCPCS code not equal to 'AAA00' (default for no assessment), date represents the MDS RAI assessment reference date.

NOTE3: When revenue center code equals '0023' (HHPPS), the date on the initial claim (RAP) must represent the first date of service in the episode. The final claim will match the '0023' information submitted on the initial claim. The SCIC (significant change in condition) claims may show additional '0023' revenue lines in which the date represents the date of the first service under the revised plan of treatment.

DB2 ALIAS : REV_CNTR_DT
STANDARD ALIAS : REV_CNTR_DT

TITLE ALIAS : REV_CNTR_DATE
LENGTH : 8 SIGNED : N
SOURCE : CWF
EDIT RULES :
YYYYMMDD

189. Revenue Center 1st ANSI Code
5

14

18

CHAR

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

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

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

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

DB2 ALIAS : REV_CNTR_ANSI1_CD
SAS ALIAS : REVANSI1
STANDARD ALIAS : REV_CNTR_ANSI_1_CD
TITLE ALIAS : ANSI_CD

LENGTH : 5

SOURCE : CWF

CODE TABLE : REV_CNTR_ANSI_TB

190. Revenue Center 2nd ANSI Code

5 19 23 CHAR

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

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

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

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

DB2 ALIAS : REV_CNTR_ANSI2_CD
SAS ALIAS : REVANSI2
STANDARD ALIAS : REV_CNTR_ANSI_2_CD
TITLE ALIAS : ANSI_CD

LENGTH : 5

SOURCE : CWF

191. Revenue Center 3rd ANSI Code

5 24 28 CHAR

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

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

Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

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

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

DB2 ALIAS : REV_CNTR_ANSI3_CD
SAS ALIAS : REVANSI3
STANDARD ALIAS : REV_CNTR_ANSI_3_CD
TITLE ALIAS : ANSI_CD

LENGTH : 5

SOURCE : CWF

192. Revenue Center 4th ANSI Code
5

29

33

CHAR

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

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

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

NOTE2: Beginning with NCH weekly process date

7/7/00, this field will be populated with data.
Claims processed prior to 7/7/00 will contain
spaces in this field.

DB2 ALIAS : REV_CNTR_ANSI4_CD
SAS ALIAS : REVANSI4
STANDARD ALIAS : REV_CNTR_ANSI_4_CD
TITLE ALIAS : ANSI_CD

LENGTH : 5

SOURCE : CWF

193. Revenue Center APC/HIPPS Code

5 34 38

CHAR

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

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

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

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

NOTE3: Beginning with NCH weekly process date 8/18/00, this field will be populated with data.

Claims processed prior to 8/18/00 will contain spaces in this field.

DB2 ALIAS : REV_APC_HIPPS_CD S
SAS ALIAS : APCHIPPS
STANDARD ALIAS : REV_CNTR_APC_HIPPS_CD
TITLE ALIAS : APC_HIPPS

LENGTH : 5

SOURCE : CWF

CODE TABLE : REV_CNTR_APC_TB

194. Revenue Center Healthcare Common Procedure Coding System Code

5 39 43 CHAR

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

DB2 ALIAS : REV_CNTR_HCPCS_CD
STANDARD ALIAS : REV_CNTR_HCPCS_CD
TITLE ALIAS : HCPCS_CD

LENGTH : 5

COMMENTS :

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

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

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

The HIPPS code for Home Health PPS identifies

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

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

For SNF PPS, HH PPS & IRF PPS HIPPS values see CLM_HIPPS_TB.

Level I

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

**** Note: ****

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

Level II

Includes codes and descriptors copyrighted by the American Dental Association's Current Dental Terminology, Second Edition (CDT-2). These are 5 position alpha-numeric codes comprising the D series. All other level II codes and descriptors are approved and maintained jointly by the alpha-numeric editorial panel (consisting of HCFA, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association). These are 5 position alpha-numeric codes representing primarily items and

nonphysician services that are not
represented in the level I codes.

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

LIMITATIONS :

REFER TO :
HHA_HCPCS_LIM

CODE TABLE : CLM_HIPPS_TB

195. Revenue Center HCPCS Initial Modifier Code
2 44 45

CHAR

A first modifier to the procedure code to enable a more
specific procedure identification for the claim.

DB2 ALIAS : REV_HCPCS_MDFR_CD
STANDARD ALIAS : REV_CNTR_HCPCS_INITL_MDFR_CD
TITLE ALIAS : INITIAL_MODIFIER

LENGTH : 2

COMMENTS :

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

SOURCE : CWF

EDIT RULES :
Carrier Information File

196. Revenue Center HCPCS Second Modifier Code
2 46 47

CHAR

A second modifier to the procedure code to make it more
specific than the first modifier code to identify the
procedures performed on the beneficiary for the claim.

DB2 ALIAS : REV_HCPCS_2ND_CD

STANDARD ALIAS : REV_CNTR_HCPCS_2ND_MDFR_CD
TITLE ALIAS : SECOND_MODIFIER

LENGTH : 2

COMMENTS :

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

SOURCE : CWF

EDIT RULES :

CARRIER INFORMATION FILE

197. Revenue Center HCPCS Third Modifier Code
2 48 49

CHAR

Effective with Version I, a third modifier to the
procedure code to make it more specific than the
second modifier code to identify the procedures
performed on the beneficiary for the claim.

DB2 ALIAS : REV_HCPCS_3RD_CD
STANDARD ALIAS : REV_CNTR_HCPCS_3RD_MDFR_CD
TITLE ALIAS : THIRD_MODIFIER

LENGTH : 2

COMMENTS :

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

SOURCE : CWF

EDIT RULES :

CARRIER INFORMATION FILE

198. Revenue Center HCPCS Fourth Modifier Code
2 50 51

CHAR

Effective with Version I, a fourth modifier to the
procedure code to make it more specific than the
third modifier code to identify the procedures
performed on the beneficiary for the claim.

DB2 ALIAS : REV_HCPCS_4TH_CD
STANDARD ALIAS : REV_CNTR_HCPCS_4TH_MDFR_CD
TITLE ALIAS : FOURTH_MODIFIER

LENGTH : 2

COMMENTS :

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

SOURCE : CWF

EDIT RULES :

CARRIER INFORMATION FILE

199. Revenue Center HCPCS Fifth Modifier Code
2 52 53

CHAR

Effective with Version I, a fifth modifier to the
procedure code to make it more specific than the
fourth modifier code to identify the procedures
performed on the beneficiary for the claim.

DB2 ALIAS : REV_HCPCS_5TH_CD
SAS ALIAS : MDFR_CD5
STANDARD ALIAS : REV_CNTR_HCPCS_5TH_MDFR_CD
TITLE ALIAS : FIFTH_MODIFIER

LENGTH : 2

COMMENTS :

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

SOURCE : CWF

EDIT RULES :

CARRIER INFORMATION FILE

200. Revenue Center Payment Method Indicator Code
2 54 55

CHAR

Effective with Version 'I', the code used to
identify how the service is priced for payment.
This field is made up of two pieces of data,
1st position being the service indicator and

the 2nd position being the payment indicator.

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

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

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

NOTE3: Effective 10/2005, this field will no longer represent the service indicator and the payment indicator. This field will now house the 2-byte payment indicator. The status indicator will be housed in a new field named: REV_CNTR_STUS_IND_CD.

DB2 ALIAS : REV_PMT_MTHD_CD
SAS ALIAS : PMTMTHD
STANDARD ALIAS : REV_CNTR_PMT_MTHD_IND_CD
TITLE ALIAS : PMT_MTHD

LENGTH : 2

SOURCE : CWF

CODE TABLE : REV_CNTR_PMT_MTHD_IND_TB

201. Revenue Center Discount Indicator Code

1 56 56

CHAR

Effective with Version 'I', this code represents a factor that specifies the amount of any APC discount. The discounting factor is applied to a line item with a service indicator (part of the REV_CNTR_PMT_MTHD_IND_CD) of 'T'. The flag is applicable when more than one significant procedure is performed. **If there is no discounting the factor will be 1.0.**

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

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

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

NOTE3: VALUES D, U & T REPRESENT THE FOLLOWING:

D = Discounting fraction (currently 0.5)

U = Number of units

T = Terminated procedure discount (currently 0.5)

DB2 ALIAS : REV_DSCNT_IND_CD

SAS ALIAS : DSCNTIND

STANDARD ALIAS : REV_CNTR_DSCNT_IND_CD

TITLE ALIAS : REV_CNTR_DSCNT_IND_CD

LENGTH : 1

	SOURCE	: CWF
	CODE TABLE	: REV_CNTR_DSCNT_IND_TB
202. Revenue Center Packaging Indicator Code		
1 57 57	CHAR	
	Effective with Version 'I', the code used to identify those services that are packaged/ bundled with another service.	
	NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPBS rules so those lines would not have data in this field.	
	Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and forward.	
	NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPBS/HPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.	
	DB2	ALIAS : REV_PACKG_IND_CD
	SAS	ALIAS : PACKGIND
	STANDARD	ALIAS : REV_CNTR_PACKG_IND_CD
	TITLE	ALIAS : REV_CNTR_PACKG_IND
	LENGTH	: 1
	SOURCE	: CWF

203. Revenue Center Pricing Indicator Code
2 58 59

CODE TABLE : REV_CNTR_PACKG_IND_TB

CHAR

Effective with Version 'I', the code used to identify if there was a deviation from the standard method of calculating payment amount.

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

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

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV_PRICNG_IND_CD
SAS ALIAS : PRICNG
STANDARD ALIAS : REV_CNTR_PRICNG_IND_CD
TITLE ALIAS : REV_CNTR_PRICNG_IND

LENGTH : 2

SOURCE : CWF

CODE TABLE : REV_CNTR_PRICNG_IND_TB

204. Revenue Center Obligation to Accept As Full (OTAF) Payment Code
1 60 60 CHAR

Effective with Version 'j' the code used to indicate that the provider was obligated to accept as full payment the amount received from the primary (or secondary) payer.

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

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

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPBS/HPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV_OTAF_IND_CD
SAS ALIAS : OTAF

LENGTH : 1

SOURCE : CWF

EDIT RULES :

Y = provider is obligated to accept the payment as payment in full for the service.
N or blank = provider is not obligated to accept the payment, or there is no payment by a prior payer.

205. Revenue Center IDE, NDC, UPC Number
24 61

84 CHAR

Effective with Version H, the exemption number assigned by the Food and Drug Administration (FDA) to an investigational device after a manufacturer has been approved by FDA to conduct a clinical trial on that device. HCFA established a new policy of covering certain IDE's which was implemented in claims processing on 10/1/96 (which is NCH weekly process 10/4/96) for service dates beginning 10/1/95. IDE's are always associated with revenue center code '0624'.

NOTE1: Prior to Version H a 'dummy' revenue center code '0624' trailer was created to store IDE's. The IDE number was housed in two fields: HCPCS code and HCPCS initial modifier; the second modifier contained the value 'ID'. There can be up to 7 distinct IDE numbers associated with an '0624' dummy trailer. During the Version H conversion IDE's were moved from the dummy '0624' trailer to this dedicated field.

NOTE2: Effective with Version 'I', this field was renamed to eventually accommodate the National Drug Code (NDC) and the Universal Product Code (UPC). This field could contain either of these 3 fields (there would never be an instance where more than one would come in on a claim). The size of this field was expanded to X(24) to accommodate either of the new fields (under Version 'H' it was X(7)). DATA ANAMOLY/LIMITATION: During an CWFMQA review an edit revealed the IDE was missing. The problem occurs in claim with an NCH weekly process dates of 6/9/00 through 9/8/00. During processing of the new format the program receives the IDE but then blanked out the data.

DB2 ALIAS : IDE_NDC_UPC_NUM
SAS ALIAS : IDENDC
STANDARD ALIAS : REV_CNTR IDE_NDC_UPC_NUM
TITLE ALIAS : IDE_NDC_UPC

LENGTH : 24

SOURCE : CWF

LIMITATIONS :

REFER TO :
REV_CNTR_IDE_NDC_UPC_LIM

206. Revenue Center NDC Quantity Qualifier Code
2 85 86

CHAR

Effective with Version 'J', the code used to indicate the unit of measurement for the drug that was administered.

DB2 ALIAS : NDC_QTY_QLFR_CD
SAS ALIAS : QTYQLFR
STANDARD ALIAS : REV_CNTR_NDC_QTY_QLFR_CD

LENGTH : 2

CODE TABLE : REV_CNTR_NDC_QTY_QLFR_TB

207. Revenue Center NDC Quantity
6 87 92

PACK

Effective with Version 'J', the quantity dispensed for the drug reflected on the revenue center line item.

DB2 ALIAS : NDC_QTY_NUM
SAS ALIAS : NDCQTY

LENGTH : 7.3 SIGNED : Y

208. Revenue Center Unit Count
4 93 96

PACK

A quantitative measure (unit) of the number of times the service or procedure being reported was performed according to the revenue center/HCPSC code definition as described on an institutional claim.

Depending on type of service, units are measured by number of covered days in a particular accommodation, pints of blood, emergency room visits, clinic visits, dialysis treatments (sessions or days), outpatient therapy visits, and outpatient clinical diagnostic laboratory tests.

NOTE1: When revenue center code = '0022' (SNF PPS) the unit count will reflect the number of covered days for each HIPPS code and, if applicable, the number of visits for each rehab therapy code.

DB2 ALIAS : REV_CNTR_UNIT_CNT
SAS ALIAS : REV_UNIT
STANDARD ALIAS : REV_CNTR_UNIT_CNT

TITLE ALIAS : UNITS

LENGTH : 7 SIGNED : Y

SOURCE : CWF

209. Revenue Center Rate Amount

6 97 102

PACK

Charges relating to unit cost associated with the revenue center code. Exception (encounter data only): If plan (e.g. MCO) does not know the actual rate for the accommodations, \$1 will be reported in the field.

NOTE1: For SNF PPS claims (when revenue center code equals '0022'), CMS has developed a SNF PRICER to compute the rate based on the provider supplied coding for the MDS RUGS III group and assessment type (HIPPS code, stored in revenue center HCPCS code field).

NOTE2: For OP PPS claims, CMS has developed a PRICER to compute the rate based on the Ambulatory Payment Classification (APC), discount factor, units of service and the wage index.

NOTE3: Under HH PPS (when revenue center code equals '0023'), CMS has developed a HHA PRICER to compute the rate. On the RAP, the rate is determined using the case mix weight associated with the HIPPS code, adjusting it for the wage index for the beneficiary's site of service, then multiplying the result by 60% or 50%, depending on whether or not the RAP is for a first episode.

On the final claim, the HIPPS code could change the payment if the therapy threshold is not met, or partial episode payment (PEP) adjustment or a significant change in condition (SCIC) adjustment. In cases of SCICs, there will be more than one '0023' revenue center line, each representing the payment made at each case-mix level.

NOTE4: For IRF PPS claims (when revenue center code equals '0024'), CMS has developed a PRICER to compute the rate based on the HIPPS/CMG (HIPPS code, stored in revenue center HCPCS code field).

DB2 ALIAS : REV_CNTR_RATE_AMT
SAS ALIAS : REV_RATE
STANDARD ALIAS : REV_CNTR_RATE_AMT
TITLE ALIAS : CHARGE_PER_UNIT

LENGTH : 9.2 SIGNED : Y

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

SOURCE : CWF

210. Revenue Center Blood Deductible Amount
6 103 108

PACK

Effective with Version 'I', the amount of money for which the intermediary determined the beneficiary is liable for the blood deductible for the line item service.

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

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

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV_BLOOD_DDCTBL
SAS ALIAS : REVBLOOD
STANDARD ALIAS : REV_CNTR_BLOOD_DDCTBL_AMT
TITLE ALIAS : BLOOD_DDCTBL_AMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

211. Revenue Center Cash Deductible Amount
6 109 114

PACK

Effective with Version 'I' the amount of cash deductible the beneficiary paid for the line item service.

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

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

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV_CASH_DDCTBL
SAS ALIAS : REVDCTBL
STANDARD ALIAS : REV_CNTR_CASH_DDCTBL_AMT
TITLE ALIAS : CASH_DDCTBL

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

212. Revenue Center Coinsurance/Wage Adjusted Coinsurance Amount

6 115 120 PACK

Effective with Version 'I', the amount of coinsurance applicable to the line item service defined by the revenue center and HCPCS codes. For those services subject to Outpatient PPS, the applicable coinsurance is wage adjusted.

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

NOTE2: This field will have either a zero (for services for which coinsurance is not applicable), a regular coinsurance amount (calculated on either charges or a fee schedule) or if subject to OP PPS the national coinsurance amount will be wage adjusted. The wage adjusted coinsurance is based on the MSA where the provider is located or assigned as a result of a reclassification.

NOTE3: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : ADJSTD_COINSRNC
SAS ALIAS : WAGEADJ

STANDARD ALIAS : REV_CNTR_WAGE_ADJSTD_COINS_AMT
TITLE ALIAS : WAGE_ADJSTD_COINS

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

213. Revenue Center Reduced Coinsurance Amount
6 121 126

PACK

Effective with Version 'I', for all services subject to Outpatient PPS, the amount of coinsurance applicable to the line for a particular service (HCPCS) for which the provider has elected to reduce the coinsurance amount.

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

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

NOTE2: The reduced coinsurance amount cannot be lower than 20% of the payment rate for the APC line.

NOTE3: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : RDCD_COINSRNC
SAS ALIAS : RDCDCOIN
STANDARD ALIAS : REV_CNTR_RDCD_COINS_AMT
TITLE ALIAS : REDUCED_COINS

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

214. Revenue Center 1st Medicare Secondary Payer Paid Amount
6 127 132 PACK

Effective with Version 'I', the amount paid by the primary payer when the payer is primary to Medicare (Medicare is secondary).

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

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

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV_MSP1_PD_AMT
SAS ALIAS : REV_MSP1
STANDARD ALIAS : REV_CNTR_MSP1_PD_AMT
TITLE ALIAS : MSP PAID AMOUNT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

215. Revenue Center 2nd Medicare Secondary Payer Paid Amount
6 133 138 PACK

Effective with Version 'I', the amount paid by the secondary payer when two payers are primary to Medicare (Medicare is the tertiary payer).

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

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

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV_MSP2_PD_AMT
SAS ALIAS : REV_MSP2
STANDARD ALIAS : REV_CNTR_MSP2_PD_AMT
TITLE ALIAS : MSP PAID AMOUNT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

216. Revenue Center Provider Payment Amount

Effective with Version 'I', the amount paid to the provider for the services reported on the line item.

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

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

ANAMOLY: For dates of service August 1, 2000 to the present, the OPPS revenue center fields are being processed differently by FISS and APASS (standard systems). For more information on OPPS data problems for this time period see Limitations Appendix. The following is how each system handles this field:

FISS: populated correctly with provider payment amount

APASS: provider payment amount plus interest on 1st revenue center line (CMM will instruct APASS not to include interest)

Currently, the following FI numbers are under the APASS system and all other FI numbers are under FISS. See FI_NUM table of codes for all FI numbers.

52280 -- Mutual of Omaha (until 6/1/2003)
00430 -- Washington/Alaska (until 11/1/2003)
00310 -- North Carolina BC (until 12/1/2003)
00370 -- Rhode Island (until 2/1/2004)
00270 -- New Hampshire/Vermont (until 3/1/2004)
00181 -- Maine/Massachusetts (until 5/1/2004)

NOTE2: It has been discovered that this field may be

populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV_PRVDR_PMT_AMT
SAS ALIAS : RPRVDPMT
STANDARD ALIAS : REV_CNTR_PRVDR_PMT_AMT
TITLE ALIAS : REV_PRVDR_PMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

217. Revenue Center Beneficiary Payment Amount
6 145 150

PACK

Effective with Version I, the amount paid to the beneficiary for the services reported on the line item.

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

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

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data

has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV_BENE_PMT_AMT
SAS ALIAS : RBENEPMT
STANDARD ALIAS : REV_CNTR_BENE_PMT_AMT
TITLE ALIAS : REV_BENE_PMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

218. Revenue Center Patient Responsibility Payment Amount
6 151 156 PACK

Effective with Version I, the amount paid by the beneficiary to the provider for the line item service.

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

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

ANAMOLY: For dates of service August 1, 2000 to present, the OPPS revenue center fields are being processed differently by FISS and APASS (standard systems). For more information on OPPS data problems for this time period see the Limitations Appendix. The following is how each system is handling this field:

FISS: populating correctly (sum of coinsurance and deductible)

APASS: not populating this field

Currently, the following FI numbers are under the APASS system and all other FI numbers are under FISS. See FI_NUM table of codes for all FI numbers.

52280 -- Mutual of Omaha (until 6/1/2003)
00430 -- Washington/Alaska (until 11/1/2003)
00310 -- North Carolina BC (until 12/1/2003)
00370 -- Rhode Island (until 2/1/2004)
00270 -- New Hampshire/Vermont (until 3/1/2004)
00181 -- Maine/Massachusetts (until 5/1/2004)

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV_PTNT_RESP_AMT
SAS ALIAS : PTNTRESP
STANDARD ALIAS : REV_CNTR_PTNT_RESP_PMT_AMT
TITLE ALIAS : REV_PTNT_RESP

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

219. Revenue Center Payment Amount

6 157 162

PACK

Effective with Version 'I', the line item Medicare payment amount for the specific revenue center.

NOTE1: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are

not required to price under OPPS rules so those lines would not have data in this field.

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

ANAMOLY: For dates of service August 1, 2000 to present, the OPPS revenue center fields are being processed differently by FISS and APASS (standard systems). For more information on OPPS data problems for this time period see the Limitations Appendix. The following is how each system is handling this field:

FISS: this field contains provider reimbursement.

APASS: provider payment amount plus coinsurance and deductible (should not include coinsurance and deductible). Users should rely on provider payment amount field for the trust fund payment.

Currently, the following FI numbers are under the APASS system and all other FI numbers are under FISS. See FI_NUM table of codes for all FI numbers.

52280 -- Mutual of Omaha (until 6/1/2003)
00430 -- Washington/Alaska (until 11/1/2003)
00310 -- North Carolina BC (until 12/1/2003)
00370 -- Rhode Island (until 2/1/2004)
00270 -- New Hampshire/Vermont (until 3/1/2004)
00181 -- Maine/Massachusetts (until 5/1/2004)

NOTE2: It has been discovered that this field may be populated with data on claims with dates of service prior to 7/00 (implementation of Claim Line Expansion OPPS/HHPPS). The original understanding of the new revenue center fields was that data would be populated on claims with dates of service 7/00 and forward. Data has been found in claims with dates of service prior to 7/00 because the Standard Systems have processed any claim coming in 7/00 and after, meeting the above criteria, through the Outpatient Code Editor (OCE) regardless of the dates of service.

DB2 ALIAS : REV_CNTR_PMT_AMT
SAS ALIAS : REVPMT

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

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

220. Revenue Center Total Charge Amount
6 163 168

PACK

The total charges (covered and non-covered) for all accommodations and services (related to the revenue code) for a billing period before reduction for the deductible and coinsurance amounts and before an adjustment for the cost of services provided. NOTE: For accommodation revenue center total charges must equal the rate times units (days).

EXCEPTIONS:

(1) For SNF RUGS demo claims only (9000 series revenue center codes), this field contains SNF customary accommodation charge, (ie., charges related to the accommodation revenue center code that would have been applicable if the provider had not been participating in the demo).

(2) For SNF PPS (non demo claims), when revenue center code = '0022', the total charges will be zero.

(3) For Home Health PPS (RAPs), when revenue center code = '0023', the total charges will equal the dollar amount for the '0023' line.

(4) For Home Health PPS (final claim), when revenue center code = '0023', the total charges will be the sum of the revenue center code lines (other than '0023').

(5) For Inpatient Rehabilitation Facility (IFR) PPS, when the revenue center code = '0024', the total charges will be zero. For accommodation revenue codes (010X - 021X), total charges must equal the rate times the units.

(6) For encounter data, if the plan (e.g. MCO) does not know the actual charges for the accommodations the total charges will be \$1 (rate) times units (days).

DB2 ALIAS : REV_TOT_CHRG_AMT
SAS ALIAS : REV_CHRG
STANDARD ALIAS : REV_CNTR_TOT_CHRG_AMT
TITLE ALIAS : REVENUE_CENTER_CHARGES

LENGTH : 9.2 SIGNED : Y

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

SOURCE : CWF

LIMITATIONS :

REFER TO :
MLTPL_REV_CNTR_0001_CD_LIM
REV_CNTR_TOT_CHRG_AMT_LIM

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

221. Revenue Center Non-Covered Charge Amount
6 169 174

PACK

The charge amount related to a revenue center code for
services that are not covered by Medicare.

NOTE: Prior to Version H the field size was S9(7)V99 and
the element was only present on the Inpatient/SNF format.
As of NCH weekly process date 10/3/97 this field was added
to all institutional claim types.

DB2 ALIAS : REV_NCVR_CHRG_AMT
SAS ALIAS : REV_NCVR
STANDARD ALIAS : REV_CNTR_NCVR_CHRG_AMT
TITLE ALIAS : REV_CENTER_NONCOVERED_CHARGES

LENGTH : 9.2 SIGNED : Y

SOURCE : CWF

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

222. Revenue Center Deductible Coinsurance Code
1 175 175

CHAR

Code indicating whether the revenue center charges
are subject to deductible and/or coinsurance.

DB2 ALIAS : DDCTBL_COINSRNC_CD
SAS ALIAS : REVDEDCD
STANDARD ALIAS : REV_CNTR_DDCTBL_COINSRNC_CD
TITLE ALIAS : REVENUE_CENTER_DEDUCTIBLE_CD

LENGTH : 1

			SOURCE	: CWF
			CODE TABLE	: REV_CNTR_DDCTBL_COINSRNC_TB
223. Revenue Center Consolidated Billing Code	1	176	176	
			CHAR	
				Effective 1/1/2004 with the implementation of NCH/NMUD CR#1, this code is reflected on outpatient claims only to identify those line item services (i.e. therapy and nonroutine supply services) that are subject to SNF and Home Health consolidated billing. If the line item service was paid by an intermediary prior to the submission of the SNF or home health claim an adjustment for the outpatient claim will be submitted identifying those services that are subject to consolidated billing.
				NOTE1: Prior to 10/2005 (implementation of NCH/NMUD CR#2), this data was stored in position 175 (FILLER) in the revenue center trailer.
				NOTE2: Effective July 2005, this data will no longer be coming into the NCH. This process is being handled in the new CWF override processing.
			DB2	ALIAS : CNSLDTD_BLG_CD
			SAS	ALIAS : RCNSLDTD
			STANDARD	ALIAS : REV_CNTR_CNSLDTD_BLG_CD
			LENGTH	: 1
			SOURCE	: CWF
			CODE TABLE	: REV_CNTR_CNSLDTD_BLG_TB
224. Revenue Center Status Indicator Code	2	177	178	
			CHAR	
				Effective 10/3/2005 with the implementation of NCH/NMUD CR#2, the code used to identify the status of the line item service. This field along with the payment method indicator field is used to identify how the service was priced for payment.
				NOTE1: This 2-byte indicator is being added due to an expansion of a field that currently exist on the revenue center trailer. The status indicator is currently the 1st position of the Revenue Center

Payment Method Indicator Code. The payment method indicator code is being split into two 2-byte fields (payment indicator and status indicator). The expanded payment indicator will continue to be stored in the existing payment method indicator field. The split of the current payment method indicator field is due to the expansion of both pieces of data from 1-byte to 2-bytes.

NOTE2: This field is populated for those claims that are required to process through Outpatient PPS Pricer. The type of bills (TOB) required to process through are: 12X, 13X, 14X (except Maryland providers, Indian Health Providers, hospitals located in American Samoa, Guam and Saipan and Critical Access Hospitals (CAH)); 76X; 75X and 34X if certain HCPCS are on the bill; and any outpatient type of bill with a condition code '07' and certain HCPCS. These claim types could have lines that are not required to price under OPPS rules so those lines would not have data in this field.

Additional exception: Virgin Island hospitals and hospitals that furnish only inpatient Part B services.

DB2 ALIAS : REV_STUS_IND_CD
SAS ALIAS : RSTUSIND
STANDARD ALIAS : REV_CNTR_STUS_IND_CD

LENGTH : 2

SOURCE : CWF

CODE TABLE : REV_CNTR_STUS_IND_TB

225. Revenue Center Duplicate Claim Check Indicator Code

1 179 179 CHAR

Effective 1/1/2009 with the implementation of NCH/NMUD CR#4, the code used to identify an item or service that appeared to be a duplicate but has been reviewed by an FI or MAC and appropriately approved for payment.

DB2 ALIAS : DUP_CLM_CHK_IND_CD
SAS ALIAS : DUP-CHK
STANDARD ALIAS : REV_CNTR_DUP_CLM_CHK_IND_CD

LENGTH : 1

CODE TABLE : REV_CNTR_DUP_CLM_CHK_IND_TB

226. Revenue Center APC Buffer Code	2	180	181	CHAR
<p>APC - Ambulatory Payment Classification Effective 1/1/2009 with the implementation of CR#4, the code used to identify related line items that make up a composite APC group. This field is only applicable to outpatient PPS claims.</p>				
<p>DB2 ALIAS : REV_CNTR_BUFR_CD SAS ALIAS : APCBUFR STANDARD ALIAS : REV_CNTR_APC_BUFR_CD</p>				
<p>LENGTH : 2</p>				
<p>CODE TABLE : REV_CNTR_APC_BUFR_TB</p>				
227. Revenue Center Rendering Physician NPI Num	10	182	191	CHAR
<p>Effective with Version 'J', the NPI of the rendering physician who performed the service.</p>				
<p>DB2 ALIAS : RNDRNG_NPI_NUM SAS ALIAS : REVNPI</p>				
<p>LENGTH : 10</p>				
228. Revenue Center Rendering Physician Surname	6	192	197	CHAR
<p>Effective with Version 'J', the 6 position last name of the rendering physician who performed the service.</p>				
<p>DB2 ALIAS : RNDRNG_SRNM_NAME SAS ALIAS : REVSERNM</p>				
<p>LENGTH : 6</p>				
229. Revenue Center Paperwork (PWK) Code	2	198	199	CHAR
<p>Effective with CR#6, the code used to indicate a provider submitted an electronic claim that requires additional documentation.</p>				
<p>DB2 ALIAS : REV_CNTR_PWK_CD</p>				
<p>LENGTH : 2</p>				

				CODE TABLE	: REV_CNTR_PWK_TB
230. FILLER	98	200	297	CHAR	
				DB2	ALIAS : FILLER
				LENGTH	: 98
231. 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

FI_HOSPC_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

11 = Hospital-inpatient (Part A)
12 = Hospital-inpatient or home health visits (Part B only)
13 = Hospital-outpatient (HHA-A also) (under OPPTS 13X
must be used for ASC claims submitted for OPPTS
payment -- eff. 7/00)
14 = Hospital-Laboratory Services Provided to
Non-patients
15 = Hospital-intermediate care - level I (obsolete)
16 = Hospital-intermediate care - level II (obsolete)
17 = Hospital-intermediate care - level III (obsolete)
18 = Hospital-swing beds
19 = Reserved for national assignment
21 = SNF-inpatient (including Part A)
22 = SNF-inpatient or home health visits (Part B only)
23 = SNF-outpatient (HHA-A also)
24 = SNF-other (Part B) - (obsolete)
25 = SNF-intermediate care - level I (obsolete)
26 = SNF-intermediate care - level II (obsolete)
27 = SNF-intermediate care - level III (obsolete)
28 = SNF-swing beds
29 = SNF-reserved for national assignment
31 = HHA-inpatient (including Part A) (obsolete)
32 = HHA-inpatient (plan of treatment under Part B only)
33 = HHA-outpatient (plan of treatment under Part A,
including DME under Part A)
34 = HHA-other (for medical and surgical services not
under a plan of treatment)
35 = HHA-intermediate care - level I (obsolete)
36 = HHA-intermediate care - level II (obsolete)
37 = HHA-intermediate care - level III (obsolete)
38 = HHA-swing beds (obsolete)
39 = HHA-reserved for national assignment
41 = Religious Nonmedical Health Care Institution (RNHCI)
hospital-inpatient (including Part A) (all references
to Christian Science (CS) is obsolete eff. 8/00 and
replaced with RNHCI)
42 = RNHCI hospital-inpatient or home health visits (Part B only)
43 = RNHCI hospital-outpatient (HHA-A also)
44 = RNHCI hospital-other (Part B) - (obsolete)
45 = RNHCI hospital-intermediate care - level I (obsolete)
46 = RNHCI hospital-intermediate care - level II (obsolete)
47 = RNHCI hospital-intermediate care - level III (obsolete)
48 = RNHCI hospital-swing beds (obsolete)
49 = RNHCI hospital-reserved for national assignment
51 = CS extended care-inpatient (including Part A) OBSOLETE
eff. 7/00 - implementation of Religious Nonmedical

Health Care Institutions (RNHCI)

52 = RNHCI extended care-inpatient or home health visits
(Part B only) (eff. 7/00) - OBSOLETE; prior to 7/00
Christian Science (CS)

53 = RNHCI extended care-outpatient (HHA-A also) (eff. 7/00);
OBSOLETE - prior to 7/00 referenced CS

54 = RNHCI extended care-other (Part B) (eff. 7/00)- OBSOLETE;
prior to 7/00 referenced CS

55 = RNHCI extended care-intermediate care - level I (eff. 7/00)
OBSOLETE - prior to 7/00 referenced CS

56 = RNHCI extended care-intermediate care - level II (eff. 7/00)
OBSOLETE - prior to 7/00 referenced CS

57 = RNHCI extended care-intermediate care - level III (eff. 7/00)
OBSOLETE - prior to 7/00 referenced CS

58 = RNHCI extended care-swing beds (eff. 7/00)- OBSOLETE
prior to 7/00 referenced CS

59 = RNHCI extended care-reserved for national assignment
(eff. 7/00) - OBSOLETE; prior to 7/00 referenced CS

61 = Intermediate care-inpatient (including Part A)
OBSOLETE

62 = Intermediate care-inpatient or home health visits (Part B only)
OBSOLETE

63 = Intermediate care-outpatient (HHA-A also) - OBSOLETE

64 = Intermediate care-other (Part B)- OBSOLETE

65 = Intermediate care-intermediate care - level I

66 = Intermediate care-intermediate care - level II

67 = Intermediate care-intermediate care - level III - OBSOLETE

68 = Intermediate care-swing beds - OBSOLETE

69 = Reserved for national assignment

71 = Clinic-rural health

72 = Clinic-hospital based or independent renal dialysis facility

73 = Clinic-Freestanding

74 = Clinic-ORF only (eff 4/97);
ORF and CMHC (10/91 - 3/97)

75 = Clinic-CORF

76 = Clinic-CMHC (eff 4/97)

77 = Clinic-Federally Qualified Health Center (FQHC)
eff. 4/2010

78 = Clinic-reserved for national assignment

79 = Clinic-other

81 = Hospice (non-hospital based)

82 = Hospice (hospital based)

83 = Ambulatory Aurgical Center
(Discontinued for Hospitals Subject to Outpatient PPS;
hospitals must use 13X for ASC claims submitted for OPPS
payment -- eff. 7/00)

84 = Freestanding Birthing Center

85 = Critical Access Hospital

86 = Residential Facility (eff. 4/1/2010)

87 = Reserved for national assignment

88 = Reserved for national assignment
89 = Special facility or ASC surgery-other
91 = Reserved for national assignment
92 = Reserved for national assignment
93 = Reserved for national assignment
94 = Reserved for national assignment
95 = Reserved for national assignment
96 = Reserved for national assignment
97 = Reserved for national assignment
98 = Reserved for national assignment
99 = Reserved for national assignment

CLM_DGNS_VRSN_TB

Claim Diagnosis Version Code Table

Valid Values:

9 = ICD-9
0 = ICD-10

CLM_DISP_TB

Claim Disposition Table

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

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

CLM_EXCPTD_NEXCPTD_TRTMT_TB

Claim Excepted/Nonexcepted Treatment Table

0 = No Entry
1 = Excepted
2 = Nonexcepted

CLM_FAC_TYPE_TB

Claim Facility Type Table

1 = Hospital
2 = Skilled nursing facility (SNF)

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

CLM_FREQ_TB

Claim Frequency Table

- 0 = Non-payment/zero claims
- 1 = Admit thru discharge claim
- 2 = Interim - first claim
- 3 = Interim - continuing claim (not valid for
PPS claims)
- 4 = Interim - last claim (not valid for PPS claims)
- 5 = Late charge(s) only claim
- 6 = Reserved for national assignment; Adjustment of prior claim. Obsolete
- 7 = Replacement of prior claim;
eff 10/93, provider debit
- 8 = Void/cancel prior claim
eff 10/93, provider cancel
- 9 = Final claim -- used in an HH PPS
episode to indicate the claim
should be processed like debit/
credit adjustment to RAP (initial
claim) (eff. 10/00)
- A = Admission election notice - used when hospice
or Religious Nonmedical Health Care Institution
is submitting the HCFA-1450 as an
admission notice - hospice NOE only
- B = Hospice/Medicare Coordinated Care Demonstration/
RNCHI - Termination/Revocation Notice - hospice
NOE only (eff 9/93)
- C = Hospice change of provider notice
- hospice NOE only (eff 9/93)
- D = Hospice/Medicare Coordinated Care Demonstration/
RNHCI - void/cancel
- hospice NOE only (eff 9/93)
- E = Hospice change of ownership
- hospice NOE only (eff 1/97)
- F = Beneficiary initiated adjustment claim
(eff 10/93)
- G = CWF initiated adjustment claim (eff 10/93)

H = CMS initiated adjustment claim (eff 10/93)
 I = Intermediary adjustment claim (other than PRO
 or provider) - used to identify a
 debit adjustment initiated by CMS or
 an intermediary (other than QIO or Provider)
 - eff 10/93, used to identify intermediary
 initiated adjustment only
 J = Other adjustment request (eff 10/93)
 K = OIG initiated adjustment (eff 10/93)
 M = MSP initiated adjustment (eff 10/93)
 N = Reserved for national assignment
 O = Nonpayment/Zero claims
 P = Adjustment required by Quality Improvement
 Organization (QIO) -- formerly Peer Review
 Organization (PRO)
 Q = Claim Submitted for Reconsideration Outside of
 Timely Limits
 X = Replacement of Prior Abbreviated Encounter Submission
 (used by Medicare Advantage contractor or other plan
 required to submit encounter data);
 Special adjustment processing - used for QA editing (eff 8/92)
 Obsolete
 Z = New Abbreviated Encounter Submission (TOB '11Z') used
 for MCO enrollee hospital discharges 7/1/97 - 12/31/98;
 not stored in the NCH. Exception: Problem in
 startup months may have resulted in this abbreviated
 UB-92 being erroneously stored in the NCH.

CLM_HIPPS_TB

Claim SNF, HHA & IRF Health Insurance PPS Table

***** SNF PPS HIPPS *****
 *****1st 3 positions (RUGS-III group)*****
 AAA = Default: No assessment

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

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

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

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

RHA,RHB,RHC,RHL,RHX, RLA = Low/medium/high rehabilitation

RLB,RLX,RMA,RMB,RMC,RML,RMX

NOTE: (Codes RHL, RHX, RLX, RML, RMX are effective 1/3/06)

RUA,RUB,RUC,RUL,RUX,RVA = Very high/ultra high rehabilita-
RVB,RVC,RVL,RVX tion: highest level

NOTE: (Codes RUL, RUX, RVL, RVx are effective 1/3/06)

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

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

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

00 = No assessment completed
01 = Medicare 5-day full required assessment/not an
initial admission assessment
02 = Medicare 30-day full required assessment
03 = Medicare 60-day full required assessment
04 = Medicare 90-day full required assessment
05 = Medicare Readmission/Return required assessment
(eff. 10/2000)
07 = Medicare 14-day full or comprehensive assessment/
not an initial admission assessment
08 = Off-cycle Other Medicare Required Assessment (OMRA)
11 = Admission assessment AND Medicare 5-day (or readmission/
return) assessment
17 = Medicare 14-day required assessment AND initial
admission assessment (eff. 10/2000)
18 = OMRA replacing Medicare 5-day required assessment
(eff. 10/2000)
19 = Special payment situation - 5 day assessment
(eff. 7/1/2002)
28 = OMRA replacing Medicare 30-day required assessment
(eff. 10/2000)
29 = Special payment situation - 30 day assessment
(eff. 7/1/2002)
30 = Off-cycle significant change assessment (outside
assessment window) (eff. 10/2000)
31 = Significant change assessment replaces Medicare
5-day assessment (eff. 10/2000)
32 = Significant change assessment replaces Medicare
30-day assessment
33 = Significant change assessment replaces Medicare
6--day assessment
34 = Significant change assessment replaces Medicare
90-day assessment
35 = Significant change assessment replaces a Medicare
readmission/return assessment

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

*****Claim Home Health PPS HIPPS Table*****
***** KEY *****

Position 1 = 'H'
Position 2 = Clinical (A, B, C, D)
Position 3 = Functional (E, F, G, H, I)
Position 4 = Service (J, K, L, M)
Position 5 = identifies which elements of the code were
computed or derived:
1 = 2nd, 3rd, 4th positions computed
2 = 2nd position derived
3 = 3rd position derived
4 = 4th position derived
5 = 2nd & 3rd positions derived
6 = 3rd & 4th positions derived

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7 = 2nd & 4th positions derived
8 = 2nd, 3rd, 4th positions derived
*****

**HHRG = C0F0S0/Clinical = Min, Functional = Min, Service = Min**
HAEJ1
HAEJ2
HAEJ3
HAEJ4
HAEJ5
HAEJ6
HAEJ7
HAEJ8
**HHRG = C0F0S1/Clinical = Min, Functional = Min, Service = Low**
HAEK1
HAEK2
HAEK3
HAEK4
HAEK5
HAEK6
HAEK7
HAEK8
**HHRG = C0F0S2/Clinical = Min, Functional = Min, Service = Mod**
HAEL1
HAEL2
HAEL3
HAEL4
HAEL5
HAEL6
HAEL7
HAEL8
**HHRG = C0F0S3/Clinical = Min, Functional = Min, Service = High**
HAEM1
HAEM2
HAEM3
HAEM4
HAEM5
HAEM6
HAEM7
HAEM8
**HHRG = C0F1S0/Clinical = Min, Functional = Low, Service = Min**
HAFJ1
HAFJ2
HAFJ3
HAFJ4
HAFJ5
HAFJ6
HAFJ7
HAFJ8
**HHRG = C0F1S1/Clinical = Min, Functional = Low, Service = Low**

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HAFK1
HAFK2
HAFK3
HAFK4
HAFK5
HAFK6
HAFK7
HAFK8
HHRG = C0F1S2/Clinical = Min, Functional = Low, Service = Mod
HAFL1
HAFL2
HAFL3
HAFL4
HAFL5
HAFL6
HAFL7
HAFL8
HHRG = C0F1S3/Clinical = Min, Functional = Low, Service = High
HAFM1
HAFM2
HAFM3
HAFM4
HAFM5
HAFM6
HAFM7
HAFM8
HHRG = C0F2S0/Clinical = Min, Functional = Mod, Service = Min
HAGJ1
HAGJ2
HAGJ3
HAGJ4
HAGJ5
HAGJ6
HAGJ7
HAGJ8
HHRG = C0F2S1/Clinical = Min, Functional = Mod, Service = Low
HAGK1
HAGK2
HAGK3
HAGK4
HAGK5
HAGK6
HAGK7
HAGK8
HHRG = C0F2S2/Clinical = Min, Functional = Mod, Service = Mod
HAGL1
HAGL2
HAGL3
HAGL4
HAGL5

HAGL6
HAGL7
HAGL8
HHRG = C0F2S3/Clinical = Min, Functional = Mod, Service = High
HAGM1
HAGM2
HAGM3
HAGM4
HAGM5
HAGM6
HAGM7
HAGM8
HHRG = C0F3S0/Clinical = Min, Functional = High, Service = Min
HAHJ1
HAHJ2
HAHJ3
HAHJ4
HAHJ5
HAHJ6
HAHJ7
HAHJ8
HHRG = C0F3S1/Clinical = Min, Functional = High, Service = Low
HAHK1
HAHK2
HAHK3
HAHK4
HAHK5
HAHK6
HAHK7
HAHK8
HHRG = C0F3S2/Clinical = Min, Functional = High, Service = Mod
HAHL1
HAHL2
HAHL3
HAHL4
HAHL5
HAHL6
HAHL7
HAHL8
HHRG = C0F3S3/Clinical = Min, Functional = High, Service = High
HAHM1
HAHM2
HAHM3
HAHM4
HAHM5
HAHM6
HAHM7
HAHM8
HHRG = C0F4S0/Clinical = Min, Functional = Max, Service = Min
HAIJ1

HAIJ2
HAIJ3
HAIJ4
HAIJ5
HAIJ6
HAIJ7
HAIJ8
HHRG = C0F4S1/Clinical = Min, Functional = Max, Service = Low
HAIK1
HAIK2
HAIK3
HAIK4
HAIK5
HAIK6
HAIK7
HAIK8
HHRG = C0F4S2/Clinical = Min, Functional = Max, Service = Mod
HAIL1
HAIL2
HAIL3
HAIL4
HAIL5
HAIL6
HAIL7
HAIL8
HHRG = C0F4S3/Clinical = Min, Functional = Max, Service = High
HAIM1
HAIM2
HAIM3
HAIM4
HAIM5
HAIM6
HAIM7
HAIM8
HHRG = C1F0S0/Clinical = Low, Functional = Min, Service = Min
HBEJ1
HBEJ2
HBEJ3
HBEJ4
HBEJ5
HBEJ6
HBEJ7
HBEJ8
HHRG = C1F0S1/Clinical = Low, Functional = Min, Service = Low
HBEK1
HBEK2
HBEK3
HBEK4
HBEK5
HBEK6

HBEK7
HBEK8
HHRG = C1F0S2/Clinical = Low, Functional = Min, Service = Mod
HBEL1
HBEL2
HBEL3
HBEL4
HBEL5
HBEL6
HBEL7
HBEL8
HHRG = C1F0S3/Clinical = Low, Functional = Min, Service = High
HBEM1
HBEM2
HBEM3
HBEM4
HBEM5
HBEM6
HBEM7
HBEM8
HHRG = C1F1S0/Clinical = Low, Functional = Low, Service = Min
HBFJ1
HBFJ2
HBFJ3
HBFJ4
HBFJ5
HBFJ6
HBFJ7
HBFJ8
HHRG = C1F1S1/Clinical = Low, Functional = Low, Service = Low
HBFK1
HBFK2
HBFK3
HBFK4
HBFK5
HBFK6
HBFK7
HBFK8
HHRG = C1F1S2/Clinical = Low, Functional = Low, Service = Mod
HBFL1
HBFL2
HBFL3
HBFL4
HBFL5
HBFL6
HBFL7
HBFL8
HHRG = C1F1S3/Clinical = Low, Functional = Low, Service = High
HBFM1
HBFM2

HBFM3
HBFM4
HBFM5
HBFM6
HBFM7
HBFM8
HHRG = C1F2S0/Clinical = Low, Functional = Mod, Service = Min
HBGJ1
HBGJ2
HBGJ3
HBGJ4
HBGJ5
HBGJ6
HBGJ7
HBGJ8
HHRG = C1F2S1/Clinical = Low, Functional = Mod, Service = Low
HBGK1
HBGK2
HBGK3
HBGK4
HBGK5
HBGK6
HBGK7
HBGK8
HHRG = C1F2S2/Clinical = Low, Functional = Mod, Service = Mod
HBGL1
HBGL2
HBGL3
HBGL4
HBGL5
HBGL6
HBGL7
HBGL8
HHRG = C1F2S3/Clinical = Low, Functional = Mod, Service = High
HBGM1
HBGM2
HBGM3
HBGM4
HBGM5
HBGM6
HBGM7
HBGM8
HHRG = C1F3S0/Clinical = Low, Functional = High, Service = Min
HBHJ1
HBHJ2
HBHJ3
HBHJ4
HBHJ5
HBHJ6
HBHJ7

HBHJ8
HHRG = C1F3S1/Clinical = Low, Functional = High, Service = Low
HBHK1
HBHK2
HBHK3
HBHK4
HBHK5
HBHK6
HBHK7
HBHK8
HHRG = C1F3S2/Clinical = Low, Functional = High, Service = Mod
HBHL1
HBHL2
HBHL3
HBHL4
HBHL5
HBHL6
HBHL7
HBHL8
HHRG = C1F3S3/Clinical = Low, Functional = High, Service = High
HBHM1
HBHM2
HBHM3
HBHM4
HBHM5
HBHM6
HBHM7
HBHM8
HHRG = C1F4S0/Clinical = Low, Functional = Max, Service = Min
HBIJ1
HBIJ2
HBIJ3
HBIJ4
HBIJ5
HBIJ6
HBIJ7
HBIJ8
HHRG = C1F4S1/Clinical = Low, Functional = Max, Service = Low
HBIK1
HBIK2
HBIK3
HBIK4
HBIK5
HBIK6
HBIK7
HBIK8
HHRG = C1F4S2/Clinical = Low, Functional = Max, Service = Mod
HBIL1
HBIL2
HBIL3

HBIL4
HBIL5
HBIL6
HBIL7
HBIL8
HHRG = C1F4S3/Clinical = Low, Functional = Max, Service = High
HBIM1
HBIM2
HBIM3
HBIM4
HBIM5
HBIM6
HBIM7
HBIM8
HHRG = C2F0S0/Clinical = Mod, Functional = Min, Service = Min
HCEJ1
HCEJ2
HCEJ3
HCEJ4
HCEJ5
HCEJ6
HCEJ7
HCEJ8
HHRG = C2F0S1/Clinical = Mod, Functional = Min, Service = Low
HCEK1
HCEK2
HCEK3
HCEK4
HCEK5
HCEK6
HCEK7
HCEK8
HHRG = C2F0S2/Clinical = Mod, Functional = Min, Service = Mod
HCEL1
HCEL2
HCEL3
HCEL4
HCEL5
HCEL6
HCEL7
HCEL8
HHRG = C2F0S3/Clinical = Mod, Functional = Min, Service = High
HCEM1
HCEM2
HCEM3
HCEM4
HCEM5
HCEM6
HCEM7
HCEM8

HHRG = C2F1S0/Clinical = Mod, Functional = Low, Service = Min
HCFJ1
HCFJ2
HCFJ3
HCFJ4
HCFJ5
HCFJ6
HCFJ7
HCFJ8
HHRG = C2F1S1/Clinical = Mod, Functional = Low, Service = Low
HCFK1
HCFK2
HCFK3
HCFK4
HCFK5
HCFK6
HCFK7
HCFK8
HHRG = C2F1S2/Clinical = Mod, Functional = Low, Service = Mod
HCFL1
HCFL2
HCFL3
HCFL4
HCFL5
HCFL6
HCFL7
HCFL8
HHRG = C2F1S3/Clinical = Mod, Functional = Low, Service = High
HCFM1
HCFM2
HCFM3
HCFM4
HCFM5
HCFM6
HCFM7
HCFM8
HHRG = C2F2S0/Clinical = Mod, Functional = Mod, Service = Min
HCGJ1
HCGJ2
HCGJ3
HCGJ4
HCGJ5
HCGJ6
HCGJ7
HCGJ8
HHRG = C2F2S1/Clinical = Mod, Functional = Mod, Service = Low
HCGK1
HCGK2
HCGK3
HCGK4

HCGK5
HCGK6
HCGK7
HCGK8
HHRG = C2F2S2/Clinical = Mod, Functional = Mod, Service = Mod
HCGL1
HCGL2
HCGL3
HCGL4
HCGL5
HCGL6
HCGL7
HCGL8
HHRG = C2F2S3/Clinical = Mod, Functional = Mod, Service = High
HCGM1
HCGM2
HCGM3
HCGM4
HCGM5
HCGM6
HCGM7
HCGM8
HHRG = C2F3S0/Clinical = Mod, Functional = High, Service = Min
HCHJ1
HCHJ2
HCHJ3
HCHJ4
HCHJ5
HCHJ6
HCHJ7
HCHJ8
HHRG = C2F3S1/Clinical = Mod, Functional = High, Service = Low
HCHK1
HCHK2
HCHK3
HCHK4
HCHK5
HCHK6
HCHK7
HCHK8
HHRG = C2F3S2/Clinical = Mod, Functional = High, Service = Mod
HCHL1
HCHL2
HCHL3
HCHL4
HCHL5
HCHL6
HCHL7
HCHL8
HHRG = C2F3S3/Clinical = Mod, Functional = High, Service = High

HCHM1
HCHM2
HCHM3
HCHM4
HCHM5
HCHM6
HCHM7
HCHM8
HHRG = C2F4S0/Clinical = Mod, Functional = Max, Service = Min
HCIJ1
HCIJ2
HCIJ3
HCIJ4
HCIJ5
HCIJ6
HCIJ7
HCIJ8
HHRG = C2F4S1/Clinical = Mod, Functional = Max, Service = Low
HCIK1
HCIK2
HCIK3
HCIK4
HCIK5
HCIK6
HCIK7
HCIK8
HHRG = C2F4S2/Clinical = Mod, Functional = Max, Service = Mod
HCIL1
HCIL2
HCIL3
HCIL4
HCIL5
HCIL6
HCIL7
HCIL8
HHRG = C2F4S3/Clinical = Mod, Functional = Max, Service = High
HCIM1
HCIM2
HCIM3
HCIM4
HCIM5
HCIM6
HCIM7
HCIM8
HHRG = C3F0S0/Clinical = High, Functional = Min, Service = Min
HDEJ1
HDEJ2
HDEJ3
HDEJ4
HDEJ5

HDEJ6
HDEJ7
HDEJ8
HHRG = C3F0S1/Clinical = High, Functional = Min, Service = Low
HDEK1
HDEK2
HDEK3
HDEK4
HDEK5
HDEK6
HDEK7
HDEK8
HHRG = C3F0S2/Clinical = High, Functional = Min, Service = Mod
HDEL1
HDEL2
HDEL3
HDEL4
HDEL5
HDEL6
HDEL7
HDEL8
HHRG = C3F0S3/Clinical = High, Functional = Min, Service = High
HDEM1
HDEM2
HDEM3
HDEM4
HDEM5
HDEM6
HDEM7
HDEM8
HHRG = C3F1S0/Clinical = High, Functional = Low, Service = Min
HDFJ1
HDFJ2
HDFJ3
HDFJ4
HDFJ5
HDFJ6
HDFJ7
HDFJ8
HHRG = C3F1S1/Clinical = High, Functional = Low, Service = Low
HDFK1
HDFK2
HDFK3
HDFK4
HDFK5
HDFK6
HDFK7
HDFK8
HHRG = C3F1S2/Clinical = High, Functional = Low, Service = Mod
HDFL1

HDFL2
HDFL3
HDFL4
HDFL5
HDFL6
HDFL7
HDFL8
HHRG = C3F1S3/Clinical = High, Functional = Low, Service = High
HDFM1
HDFM2
HDFM3
HDFM4
HDFM5
HDFM6
HDFM7
HDFM8
HHRG = C3F2S0/Clinical = High, Functional = Mod, Service = Min
HDGJ1
HDGJ2
HDGJ3
HDGJ4
HDGJ5
HDGJ6
HDGJ7
HDGJ8
HHRG = C3F2S1/Clinical = High, Functional = Mod, Service = Low
HDGK1
HDGK2
HDGK3
HDGK4
HDGK5
HDGK6
HDGK7
HDGK8
HHRG = C3F2S2/Clinical = High, Functional = Mod, Service = Mod
HDGL1
HDGL2
HDGL3
HDGL4
HDGL5
HDGL6
HDGL7
HDGL8
HHRG = C3F2S3/Clinical = High, Functional = Mod, Service = High
HDGM1
HDGM2
HDGM3
HDGM4
HDGM5
HDGM6

HDGM7
HDGM8
HHRG = C3F3S0/Clinical = High, Functional = High, Service = Min
HDHJ1
HDHJ2
HDHJ3
HDHJ4
HDHJ5
HDHJ6
HDHJ7
HDHJ8
HHRG = C3F3S1/Clinical = High, Functional = High, Service = Low
HDHK1
HDHK2
HDHK3
HDHK4
HDHK5
HDHK6
HDHK7
HDHK8
HHRG = C3F3S2/Clinical = High, Functional = High, Service = Mod
HDHL1
HDHL2
HDHL3
HDHL4
HDHL5
HDHL6
HDHL7
HDHL8
HHRG = C3F3S3/Clinical = High, Functional = High, Service = High
HDHM1
HDHM2
HDHM3
HDHM4
HDHM5
HDHM6
HDHM7
HDHM8
HHRG = C3F4S0/Clinical = High, Functional = Max, Service = Min
HDIJ1
HDIJ2
HDIJ3
HDIJ4
HDIJ5
HDIJ6
HDIJ7
HDIJ8
HHRG = C3F4S1/Clinical = High, Functional = Max, Service = Low
HDIK1
HDIK2

HDIK3
 HDIK4
 HDIK5
 HDIK6
 HDIK7
 HDIK8
 HHRG = C3F4S2/Clinical = High, Functional = Max, Service = Mod
 HDIL1
 HDIL2
 HDIL3
 HDIL4
 HDIL5
 HDIL6
 HDIL7
 HDIL8
 HHRG = C3F4S3/Clinical = High, Functional = Max, Service = High
 HDIM1
 HDIM2
 HDIM3
 HDIM4
 HDIM5
 HDIM6
 HDIM7
 HDIM8

 *****Claim IRF PPS HIPPS Table*****
 *****1st position*****
 A = CMG is defined as without comorbidity
 B = CMG is defined as with comorbidity for Tier 1
 C = CMG is defined as with comorbidity for Tier 2
 D = CMG is defined as with comorbidity for Tier 3
 *****2nd/3rd & 4th/5th positions*****
 The 2nd & 3rd positions represent the Rehabilitation Impairment Code (RIC).
 The 3rd & 4th positions represent the sequential number system within the RIC.
 0101 = Stroke with motor score from 69-84 and cognitive score from 23-35
 0102 = Stroke with motor score from 59-68 and cognitive score from 23-35
 0103 = Stroke with motor score from 59-64 and cognitive score from 5-22

0104 = Stroke with motor score from 53-58

0105 = Stroke with motor score from 47-52

0106 = Stroke with motor score from 42-46

0107 = Stroke with motor score from 39-41

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

0504 = Non-traumatic spinal cord injury with motor score
34-40

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

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

0601 = Neurological with motor score from 56-84

0602 = Neurological with motor score from 47-55

0603 = Neurological with motor score from 36-46

0604 = Neurological with motor score from 12-35

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

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

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

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

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

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

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

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

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

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

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

0901 = Other orthopedic with motor score from 54-84

0902 = Other orthopedic with motor score from 47-53

0903 = Other orthopedic with motor score from 38-46

0904 = Other orthopedic with motor score from 12-37

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

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

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

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

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

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

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

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

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

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

1203 = Osteoarthritis with motor score from 48-54

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

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

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

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

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

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

1401 = Cardiac with motor score from 56-84

1402 = Cardiac with motor score from 48-55

1403 = Cardiac with motor score from 38-47

1404 = Cardiac with motor score from 12-37

1501 = Pulmonary with motor score from 61-84

1502 = Pulmonary with motor score from 48-60

1503 = Pulmonary with motor score from 36-47

1504 = Pulmonary with motor score from 12-35

1601 = Pain syndrome with motor score from 45-84

1602 = Pain syndrome with motor score from 12-44

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

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

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

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

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

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

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

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

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

1901 = Guillian Barre with motor score from 47-84

1902 = Guillian Barre with motor score from 31-46

1903 = Guillian Barre with motor score from 12-30

2001 = Miscellaneous with motor score from 54-84

2002 = Miscellaneous with motor score from 45-53

2003 = Miscellaneous with motor score from 33-44

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

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

2101 = Burns with motor score from 46-84

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

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

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

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

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

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

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

CLM_MCO_PD_TB

Claim MCO Paid Switch Code Table

1 = MCO has paid the provider for a claim

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

CLM_MDCR_NPMT_RSN_TB

Claim Medicare Non-Payment Reason Table

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

A = Covered worker's compensation (Obsolete)
B = Benefit exhausted
C = Custodial care - noncovered care
(includes all 'beneficiary at fault'
waiver cases) (Obsolete)
E = HMO out-of-plan services not emergency
or urgently needed (Obsolete)
E = MSP cost avoided - IRS/SSA/HCFA Data
Match (eff. 7/00)
F = MSP cost avoid HMO Rate Cell (eff. 7/00)
G = MSP cost avoided Litigation Settlement
(eff. 7/00)
H = MSP cost avoided Employer Voluntary
Reporting (eff. 7/00)
J = MSP cost avoid Insurer Voluntary
Reporting (eff. 7/00)
K = MSP cost avoid Initial Enrollment
Questionnaire (eff. 7/00)
N = All other reasons for nonpayment
P = Payment requested
Q = MSP cost avoided Voluntary Agreement
(eff. 7/00)
R = Benefits refused, or evidence not
submitted
T = MSP cost avoided - IEQ contractor
(eff. 9/76) (obsolete 6/30/00)
U = MSP cost avoided - HMO rate cell
adjustment (eff. 9/76) (Obsolete 6/30/00)
V = MSP cost avoided - litigation
settlement (eff. 9/76) (Obsolete 6/30/00)
W = Worker's compensation (Obsolete)
X = MSP cost avoided - generic
Y = MSP cost avoided - IRS/SSA data
match project (obsolete 6/30/00)
Z = Zero reimbursement RAPs -- zero reimbursement
made due to medical review intervention or
where provider specific zero payment has been
determined. (effective with HHPPS - 10/00)
00 = MSP cost avoided - COB Contractor
12 = MSP cost avoided - BCBS Voluntary Agreements
13 = MSP cost avoided - Office of Personnel Management
14 = MSP cost avoided - Workman's Compensation (WC) Datamatch
15 = MSP cost avoided - Workman's Compensation Insurer Voluntary
Data Sharing Agreements (WC VDSA) (eff. 4/2006)
16 = MSP cost avoided - Liability Insurer VDSA (eff. 4/2006)
17 = MSP cost avoided - No-Fault Insurer VDSA (eff. 4/2006)
18 = MSP cost avoided - Pharmacy Benefit Manager Data
Sharing Agreement (eff. 4/2006)
21 = MSP cost avoided - MIR Group Health Plan (eff. 1/2009)
22 = MSP cost avoided - MIR non-Group Health Plan (eff. 1/2009)

25 = MSP cost avoided - Recovery Audit Contractor - California
(eff. 10/2005)
26 = MSP cost avoided - Recovery Audit Contractor - Florida
(eff. 10/2005)

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

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

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

CLM_OCRNC_SPAN_TB

Claim Occurrence Span Table

70 = Qualifying Stay Dates for SNF Use
Only - the from/through dates of at
least a 3-day inpatient hospital stay
that qualifies the resident for Medicare
payment of SNF services billed. Code

- can only be used by SNF for billing.
- 71 = Hospital prior stay dates - the from/
thru dates of any hospital stay that
ended within 60 days of this hospital
or SNF admission.
- 72 = First/last visit - the dates of the
first and last visits occurring in this
billing period if the dates are different
from those in the statement covers period.
- 73 = Benefit eligibility period - the
inclusive dates during which CHAMPUS
medical benefits are available to a
sponsor's bene as shown on the
bene's ID card.
- 74 = Non-covered level of care - The from/
thru dates of a period at a noncovered
level of care in an otherwise
covered stay, excluding any period
reported with occurrence span code 76,
77, or 79.
- 75 = The from/thru dates of SNF level of care
during IP hospital stay. Shows PRO approval
of patient remaining in hospital
because SNF bed not available.
not applicable to swing bed
cases. PPS hospitals use in day
outlier cases only.
- 76 = Patient liability - From/thru
dates of period of noncovered care
for which hospital may charge
bene. The FI or PRO must have
approved such charges in advance.
patient must be notified in writing
3 days prior to noncovered period
- 77 = Provider liability (utilization charged) -
The from/thru dates of period of noncovered
care for which the provider is liable.
Eff 3/92, applies to provider liability
where bene is charged with utilization
and is liable for deductible/coinsurance
- 78 = SNF prior stay dates - The from/
thru dates of any SNF stay that
ended within 60 days of this hospital
or SNF admission.
- 79 = Provider Liability (non-utilization) (Payer code) -
Eff 3/92, from/thru dates of
period of noncovered care where
bene is not charged with utilization,
deductible, or coinsurance.
and provider is liable.

Eff 9/93, noncovered period of care due to lack of medical necessity.

80 = Prior Same-SNF Stay Dates for Payment Ban Purposes - the from/thru dates of a prior same-SNF stay indicating a patient resided in the SNF prior to, and if applicable, during a payment ban period up until their discharge to a hospital.

81 - 99 = Reserved for state assignment

M0 = QIO/UR approved stay dates - Eff 10/93, the first and last days that were approved where not all of the stay was approved.

M1 = Provider Liability-No Utilization -- from/thru dates of a period of noncovered care that is denied due to lack of medical necessity or custodial care for which the provider is liable. (eff. 10/01)

M2 = Dates of Inpatient Respite Care -- from/thru dates of a period of inpatient respite care for hospice patients. (eff. 10/00)

M3 = ICF Level of Care -- the from/through dates of a period of intermediate level of care during an inpatient hospital stay.

M4 = Residential Level of Care - The from/through dates of a period of residential level of care during an inpatient hospital stay.

CLM_PPS_IND_TB

Claim PPS Indicator Table

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

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

Effective NCH weekly process date 6/5/98

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

CLM_PRCDR_VRSN_TB

Claim Procedure Version Code Table

Valid Values:

9 = ICD-9

0 = ICD-10

CLM_PRCR_RTRN_TB

Claim Pricer Return Code Table

*****Home Health Pricer Return Codes*****

*****TOB 32X or 33X, DOS 10/1/2000 and after*****

Home Health Payment Return Codes:

00 = Final payment where no outlier applies

01 = Final payment where outlier applies

03 = Initial percentage payment, 0%

04 = Initial percentage payment, 50%

05 = Initial percentage payment, 60%

06 = LUPA payment only

07 = Final payment, SCIC

08 = Final payment, SCIC with outlier

09 = Final payment, PEP

11 = Final payment, PEP with outlier

12 = Final payment, SCIC within PEP

13 = Final payment, SCIS within PEP with outlier

Home Health Error Return Codes:

10 = Invalid TOB

15 = Invalid PEP Days

16 = Invalid HRG Days, >60

20 = PEP indicator invalid

25 = Med review indicator invalid

30 = Invalid MSA code

35 = Invalid Initial Payment Indicator

40 = Dates < October 1, 2000 or invalid

70 = Invalid HRG Code

75 = No HRG present in 1st occurrence

80 = Invalid Revenue code

85 = No revenue code present on HH final claim/
adjustment

*****Hospice Pricer Return Codes*****

*****TOB 81X or 82X*****

Hospice Payment Return Codes:

00 = Home rate returned

Hospice Error Return Codes:

10 = Bad units

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

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

SNF Payment return codes:

00 = RUG III group rate returned

SNF Error return codes:

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

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

Inpatient Hospital Payment return codes:

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

Inpatient Hospital Error return codes:

51 = No provider specific information found
52 = Invalid MSA# in provider file
53 = Waiver state - not calculated by PPS
54 = DRG < 001 or > 511, or = 214, 215, 221, 222, 438,
456, 457, 458

55 = Discharge date < provider effective start date or
discharge date < MSA effective start date for PPS
56 = Invalid length of stay
57 = Review code invalid (Not 00, 03, 06, 07, 09)
58 = Total charges not numeric
61 = Lifetime reserve days not numeric or BILL-LTR-DAYS
> 60
62 = Invalid number of covered days
65 = PAY-CODE not = A, B or C on provider specific file
for capital
67 = Cost outlier with LOS > covered days

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

Outpatient PPS Payment return codes:

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

Outpatient PPS Error return codes:

30 = Missing, deleted or invalid APC
38 = Missing or invalid discount factor
40 = Invalid service indicator passed by the OCE
41 = Service indicator invalid for OPPTS PRICER
42 = APC = '00000' or (packaging flag = 1 or 2)
43 = Payment indicator not = to 1 or 5 thru 9
44 = Service indicator = 'H' but payment indicator
not = to 6
45 = Packaging flag not = to 0
46 = Line item denial/reject flag not = to 0
or line item denial/reject flag = to 1 and (APC
not = 0033 or 0034 or 0322 or 0323 or 0324 or 0325
or 0373 or 0374) or line item action flag not = to
1
47 = Line item action flag = 2 or 3
48 = Payment adjustment flag not valid
49 = Site of service flag not = to 0 or (APC 0033 is not
on the claim and service indicator = 'P' or APC =
0322, 0325, 0373, 0374)
50 = Wage index not located
51 = Wage index equals zero
52 = Provider specific file wage index reclassification
code invalid or missing
53 = Service from date not numeric or < 20000801
54 = Service from date < provider effective date
or service from date > provider termination date

Inpatient Rehab Facility (IRF) Pricer Return Codes

IRF Payment return codes:

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

IRF Error return codes:

50 = Provider specific rate not numeric
51 = Provider record terminated
52 = Invalid wage index
53 = Waiver state - not calculated by PPS
54 = CMG on claim not found in table
55 = Discharge date < provider effective start
date or discharge date < MSA effective start
date for PPS
56 = Invalid length of stay
57 = Provider specific rate zero when blended payment
requested
58 = Total covered charges not numeric
59 = Provider specific record not found
60 = MSA wage index record not found

61 = Lifetime reserve days not numeric or
BILL-LTR-DAYS > 60
62 = Invalid number of covered days
65 = Operating cost-to-charge ratio not numeric
67 = Cost outlier with LOS > covered days or cost
outlier threshold calculation
72 = Invalid blend indicator (not 3 or 4)
73 = Discharged before provider FY begin date
74 = Provider FY begin date not in 2002

Long Term Care Hospital (LTCH) Pricer Return Codes

LTCH Payment return codes:

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

LTCH Error return codes:

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

End Stage Renal Disease (ESRD) Pricer Return Codes

ESRD Payment return codes:

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

ESRD Error return codes:

50 = ESRD facility rate not numeric
52 = Provider type not = '40' or '41'
53 = Special payment indicator not = '1'
or blank
54 = Date of birth not numeric or = zero
55 = Patient weight not numeric or = zero
56 = Patient height not numeric or = zero
57 = Revenue center code not in range
58 = Condition code not = '73' or '74' or blank
60 = MSA wage adjusted rate record not found
98 = Claim through date before 4/1/2005 or not numeric

CLM_PWK_TB

Claim Paperwork Code Table

P1 = one iteration is present
P2 = two iterations are present

P3 = three iterations are present
P4 = four iterations are present
P5 = five iterations are present
P6 = six iterations are present
P7 = seven iterations are present
P8 = eight iterations are present
P9 = nine iterations are present
P0 = ten iterations are present

CLM_QUERY_TB

Claim Query Table

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

CLM_RAC_ADJSTMT_TB

Recovery Audit Contractor (RAC) Adjustment Indicator Table

R = RAC adjusted claim
Spaces

CLM_RLT_COND_TB

Claim Related Condition Table

01 = Military service related - Medical
condition incurred during military
service.
02 = Employment related - Patient alleged
that the medical condition causing this
episode of care was due to environment/
events resulting from employment.
03 = Patient covered by insurance not
reflected here - Indicates that patient
or patient representative has stated
that coverage may exist beyond that
reflected on this bill.
04 = Information Only Bill - Health Maintenance
Organization (HMO) enrollee - Medicare bene-
ficiary is enrolled in an HMO. Eff 9/93, hospital
must also expect to receive payment from HMO.
05 = Lien has been filed - Provider has
filed legal claim for recovery of funds

potentially due a patient as a result
of legal action initiated by or on
behalf of the patient.

- 06 = ESRD patient in 1st 30 months of entitlement
covered by employer group health insurance -
indicates Medicare may be secondary
insurer. Eff 3/1/96, ESRD patient in 1st
30 months of entitlement covered by employer
group health insurance.
- 07 = Treatment of nonterminal condition for
hospice patient - The patient is a
hospice enrollee, but the provider is
not treating a terminal condition and
is requesting Medicare reimbursement.
- 08 = Beneficiary would not provide information
concerning other insurance coverage.
- 09 = Neither patient nor spouse is employed
- Code indicates that in response to
development questions, the patient and
spouse have denied employment.
- 10 = Patient and/or spouse is employed but
no EGHP coverage exists or (eff 9/93)
other employer sponsored/provided
health insurance covering patient.
- 11 = The disabled beneficiary and/or family
member has no group coverage from a LGHP
or (eff 9/93) other employer
sponsored/provided health insurance
covering patient.
- 12 = Payer code - Reserved for internal
use only by third party payers. CMS
will assign as needed. Providers will
not report them.
- 13 = Payer code - Reserved for internal
use only by third party payers. CMS
will assign as needed. Providers will
not report them.
- 14 = Payer code - Reserved for internal
use only by third party payers. CMS
will assign as needed. Providers will
not report them.
- 15 = Payer code - reserved for internal
use only by third party payers. CMS
will assign as needed. Providers will
not report them. Prior to 3/07, clean
claim (eff 10/92) OBSOLETE
- 16 = Payer code - reserved for internal
use only by third party payers. CMS
will assign as needed. Providers will
not report them. Prior to 3/07. SNF

transition exemption - An exemption from the post-hospital requirement applies for this SNF stay for the qualifying stay dates are more than 30 days prior to the admission date. OBSOLETE

- 17 = Patient is homeless (eff. 3/07). Prior to 3/07, code indicated Patient is over 100 years old - patient was over 100 years old at the date of admission.
- 18 = Maiden name retained - A dependent spouse entitled to benefits who does not use her husband's last name.
- 19 = Child retains mother's name - A patient who is a dependent child entitled to CHAMPVA benefits that does not have father's last name.
- 20 = Bene requested billing - Provider realizes the services on this bill are at a noncovered level of care or otherwise excluded from coverage, but the bene has requested formal determination
- 21 = Billing for denial notice - The SNF or HHA realizes services are at a noncovered level of care or excluded, but requests a Medicare denial in order to bill medicaid or other insurer
- 22 = Patient on multiple drug regimen - A patient who is receiving multiple intravenous drugs while on home IV therapy
- 23 = Homecaregiver available - The patient has a caregiver available to assist him or her during self-administration of an intravenous drug
- 24 = Home IV patient also receiving HHA services - the patient is under care of HHA while receiving home IV drug therapy services
- 25 = Patient is Non-U.S. resident
- 26 = VA eligible patient chooses to receive services in Medicare certified facility rather than a VA facility (eff 3/92)
- 27 = Patient referred to a sole community hospital for a diagnostic laboratory test - (sole community hospital only). (eff 9/93)
- 28 = Patient and/or spouse's EGHP is secondary to Medicare - Qualifying EGHP for employers who have fewer than 20 employees. (eff 9/93)

- 29 = Disabled beneficiary and/or family member's LGHP is secondary to Medicare - Qualifying LGHP for employer having fewer than 100 full and part-time employees
- 30 = Qualifying Clinical Trials - Non-research services provided to all patients, including managed care enrollees, enrolled in a Qualified Clinical Trial.
- 31 = Patient is student (full time - day) - Patient declares that he or she is enrolled as a full time day student.
- 32 = Patient is student (cooperative/work study program)
- 33 = Patient is student (full time - night) - Patient declares that he or she is enrolled as a full time night student.
- 34 = Patient is student (part time) - Patient declares that he or she is enrolled as a part time student.
- 36 = General care patient in a special unit - Patient is temporarily placed in special care unit bed because no general care beds were available.
- 37 = Ward accommodation is patient's request - Patient is assigned to ward accommodations at patient's request.
- 38 = Semi-private room not available - Indicates that either private or ward accommodations were assigned because semi-private accommodations were not available.
- 39 = Private room medically necessary - Patient needed a private room for medical reasons.
- 40 = Same day transfer - Patient transferred to another facility before midnight of the day of admission.
- 41 = Partial hospitalization - Eff 3/92, indicates claim is for partial hospitalization services. For OP services, this includes a variety of psych programs.
- 42 = Continuing Care Not Related to Inpatient Admission - continuing care not related to the condition or diagnosis for which the beneficiary received inpatient hospital services. (eff. 10/01)
- 43 = Continuing Care Not Provided Within Prescribed Postdischarge Window -

continuing care was related to the inpatient admission but the prescribed care was not provided within the post-discharge window. (eff. 10/01)

- 44 = Inpatient Admission Changed to Outpatient - For use on outpatient claims only, when the physician ordered inpatient services, but upon internal review performed before the claim was initially submitted, the hospital determined the services did not meet its inpatient criteria. (eff. 4/1/04)
- 45 = Ambiguous Gender Category - claim indicates patient has ambiguous gender characteristics (e.g. transgendered or hermaphrodite).
- 46 = Nonavailability statement on file for CHAMPUS claim for nonemergency IP care for CHAMPUS bene residing within the catchment area (usually a 40 mile radius) of a uniform services hospital.
- 47 = Transfer from another Home Health Agency. (eff. 7/1/10)
- 48 = Psychiatric Residential Treatment Centers for Children and Adolescents (RTCs)
- 49 = Product Replacement within Product Lifecycle- replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly (eff. 4/2006)
- 50 = Product Replacement for Known Recall of a Product - Manufacturer or FDA has identified the product for recall and therefore replacement. (eff. 4/2006)
- 51 = Reserved for national assignment.
- 52 = Reserved for national assignment.
- 53 = Reserved for national assignment.
- 54 = Reserved for national assignment.
- 55 = SNF bed not available - The patient's SNF admission was delayed more than 30 days after hospital discharge because a SNF bed was not available.
- 56 = Medical appropriateness - Patient's SNF admission was delayed more than 30 days after hospital discharge because physical condition made it inappropriate to begin active care within that period
- 57 = SNF readmission - Patient previously received Medicare covered SNF care within 30 days of the current SNF admission.
- 58 = Payment of SNF claims for beneficiaries

- disenrolling from terminating M+C plans
plans who have not met the 3-day hospital
stay requirement (eff. 10/1/00)
- 59 = Non-primary ESRD facility - code indicates
that ESRD beneficiary received non-scheduled
or emergency dialysis services at a facility
other than his/her primary ESRD dialysis
facility.
- 60 = Operating cost day outlier - A hospital
being paid under a prospective payment
system (PPS) is reporting this stay as a
day outlier.
- 61 = Operating cost cost outlier - A hospital
is being paid under a prospective payment
system (PPS) is requesting additional payment
for this stay as a cost outlier.
- 62 = Payer Code - providers do not report this code.
PIP bill - This bill is a periodic interim
payment bill. Obsolete
- 63 = Payer Code - providers do not report this code.
PRO denial received before batch
clearance report - The HCSSACL receipt date
is used on PRO adjustment if the PRO's
notification is before orig bill's acceptance
report. (Payer only code eff 9/93)
- 64 = Payer Code - providers do not report this code.
Other than clean claim - the claim is not a
'clean claim'. Obsolete
- 65 = Payer Code - Providers do not report this code.
Non-PPS code - The bill is not a prospective
payment system bill. Obsolete
- 66 = Outlier not claimed - Bill may meet
the criteria for cost outlier, but the
hospital did not claim the cost outlier
(PPS)
- 67 = Beneficiary elects not to use LTR days
- 68 = Beneficiary elects to use LTR days
- 69 = IME/DGME/N&AH Payment Only - providers
request for supplemental IME/DGME/N&AH payment for
each discharge of MCO enrollee, beginning 1/1/98,
from teaching hospitals (facilities with approved
medical residency training program); not
stored in NCH. Exception: problem in
startup year may have resulted in this
special IME payment request being erroneously
stored in NCH. If present, disregard claim
as condition code '69' is not valid NCH
claim.
- 70 = Self-administered EPO - Billing is
for a home dialysis patient who self

- administers EPO.
- 71 = Full care in unit - Billing is for a patient who received staff assisted dialysis services in a hospital or renal dialysis facility.
 - 72 = Self care in unit - Billing is for a patient who managed his own dialysis services without staff assistance in a hospital or renal dialysis facility.
 - 73 = Self care training - Billing is for special dialysis services where the patient and helper (if necessary) were learning to perform dialysis.
 - 74 = Home - Billing is for a patient who received dialysis services at home.
 - 75 = Home 100% reimbursement -
(not to be used for services after 4/15/90)
The billing is for home dialysis patient using a dialysis machine that was purchased under the 100% program.
 - 76 = Back-up facility - Billing is for a patient who received dialysis services in a back-up facility.
 - 77 = Provider accepts or is obligated/required due to contractual agreement or law to accept payment by a primary payer as payment in full - Medicare pays nothing.
 - 78 = New coverage not implemented by HMO - eff 3/92, indicates newly covered service under Medicare for which HMO does not pay.
 - 79 = CORF services provided off site - Code indicates that physical therapy, occupational therapy, or speech pathology services were provided off site.
 - 80 = Home Dialysis - Nursing Facility - Home dialysis furnished in a SNF or nursing facility. (eff. 4/4/05)
 - 81 - 99 = Reserved for state assignment.
 - A0 = TRICARE External Partnership Program - This code identifies TRICARE claims submitted under the External Partnership Program.
 - A0 = Special Zip Code Reporting - five digit zip code of the location from which the beneficiary is initially placed on board the ambulance. (eff. 9/01) Obsolete
 - A0 = CHAMPUS external partnership program special program indicator code. (eff 10/93) (obsolete)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

AF = Abortion Performed due to emotional/

psychological health of mother (eff. 10/1/02)

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

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

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

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

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

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

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

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

B0 = Medicare Coordinated Care Demonstration Program - patient is a participant in a Medicare Coordinated Care Demonstration (eff. 10/01)

B1 = Beneficiary ineligible for demonstration program (eff. 1/02).

B2 = Critical Access Hospital Ambulance Attestation - Attestation by CAH that it meets the criteria for exemption from the Ambulance Fee Schedule

B3 = Pregnancy Indicator - Indicates the patient is pregnant. Required when mandated by law. (eff. 10/16/03)

B4 = Admission Unrelated to Discharge - Admission unrelated to discharge on same day. This code is for discharges starting on January 1, 2004.

B5 = Special program indicator
Reserved for national assignment.

B6 = Special program indicator
Reserved for national assignment.

B7 = Special program indicator
Reserved for national assignment.

B8 = Special program indicator
Reserved for national assignment.

B9 = Special program indicator
Reserved for national assignment.

BP = Gulf Oil Spill of 2010 - The code identifies claims where the provision of all services on the claim are related, in whole or in part, to an illness, injury, or condition

that was caused by or exacerbated by the effects, direct or indirect, of the 2010 oil spill in the Gulf of Mexico and/or circumstances related to such spill, including but not limited to subsequent clean-up activities.

- C0 = Reserved for national assignment.
- C1 = Approved as billed - The services provided for this billing period have been reviewed by the QIO/UR or intermediary and are fully approved including any day or cost outlier. (eff 10/93)
NOTE: Beginning July 2005, this code is relevant to type of bills other than inpatient (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).
- C2 = Automatic approval as billed based on focused review. (No longer used for Medicare)
QIO approval indicator services (eff 10/93)
NOTE: Beginning July 2005, this code is relevant to type of bills other than inpatient (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).
- C3 = Partial approval - The services provided for this billing period have been reviewed by the QIO/UR or intermediary and some portion has been denied (days or services). (eff 10/93)
NOTE: Beginning July 2005, this code is relevant to type of bills other than inpatient (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).
- C4 = Admission/services denied - Indicates that all of the services were denied by the QIO/UR.
QIO approval indicator services (eff 10/93)
NOTE: Beginning July 2005, this code is relevant to types of bill other than inpatient (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).
- C5 = Postpayment review applicable - QIO/UR review to take place after payment.
QIO approval indicator services (eff 10/93)
NOTE: Beginning July 2005, this code is relevant to types of bill other than inpatient (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).
- C6 = Admission preauthorization - The QIO/UR authorized this admission/service but has not reviewed the services provided.
QIO approval indicator services (eff 10/93)
NOTE: Beginning July 2005, this code is relevant to types of bill other than inpatient (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).

C7 = Extended authorization - the QIO has authorized these services for an extended length of time but has not reviewed the services provided.
QIO approval indicator services (eff 10/93)
NOTE: Beginning July 2005, this code is relevant to types of bill other than inpatient (18X, 21X, 22X, 32X, 33X, 34X, 75X, 81X, 82X).

C8 = Reserved for national assignment.
QIO approval indicator services (eff 10/93)

C9 = Reserved for national assignment.
QIO approval indicator services (eff 10/93)

D0 = Changes to service dates.
Change condition (eff 10/93)

D1 = Changes in charges.
Change condition (eff 10/93)

D2 = Changes in revenue codes/HCPCS/HIPPS
Rate Code
Change condition (eff 10/93)

D3 = Second or subsequent interim
PPS bill.
Change condition (eff 10/93)

D4 = Change in ICD-9-CM diagnosis and/or
procedure code
Change condition (eff 10/93)

D5 = Cancel only to correct a beneficiary
claim account number or provider
identification number.
change condition (eff 10/93)

D6 = Cancel only to repay a duplicate
payment or OIG overpayment (includes
cancellation of an OP bill containing
services required to be included on the
IP bill). Change condition eff 10/93.

D7 = Change to make Medicare the secondary
payer.
Change condition (eff 10/93)

D8 = Change to make Medicare the primary
payer.
Change condition (eff 10/93)

D9 = Any other change.
Change condition (eff 10/93)

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

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

EY = National Emphysema Treatment Trial (NETT)
or Lung Volume Reduction Surgery (LVRS)

clinical study (eff. 11/97) Obsolete

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

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

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

M0 = Reserved for national assignment.

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

M1 = Reserved for national assignment.

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

M2 = Reserved for national assignment.

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

P1 = Do Not Resuscitate Order (DNR) - for public health reporting only - code indicates that a DNR order was written at the time of or within the first 24 hours of the patient's admission to the hospital and is clearly documented in the patient's medical record.

P7 = Direct Inpatient Admission from Emergency Room - for public health reporting only when required by state or federal law or regulations. Code indicates that patient was admitted directly from this facility's emergency room department. (eff. 7/1/10)

W0 = United Mine Workers of America (UMWA) SNF demonstration indicator (eff 1/97); but no claims transmitted until 2/98)

W2 = Duplicate of Original Bill - code indicates bill is exact duplicate of the original bill submitted. (eff. 10/1/08)

W3 = Level I Appeal - code indicates bill is submitted for reconsideration; the Level of appeal/reconsideration (I) is specified/

defined by the payer. (eff. 10/1/08)
W4 = Level II Appeal - Code indicates bill is submitted for reconsideration; the Level of appeal/reconsideration (II) is specified/defined by the payer. (eff. 10/1/08)
W5 = Level III Appeal - Code indicates bill is submitted for reconsideration; the Level of appeal/reconsideration (III) is specified/defined by the payer. (eff. 10/1/08)
XX = Transgender/Hermaphrodite Beneficiaries (eff. 1/2/07) Obsolete

CLM_RLT_OCRNC_TB

Claim Related Occurrence Table

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

01 = Auto accident - The date of an auto accident.
02 = No-fault insurance involved, including auto accident/other - The date of an accident where the state has applicable no-fault liability laws, (i.e., legal basis for settlement without admission or proof of guilt).
03 = Accident/tort liability - The date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no-fault liability.
04 = Accident/employment related - The date of an accident relating to the patient's employment.
05 = Accident/No medical liability coverage - code indicating accident related injury for which there is no medical payment or third party liability coverage. Provide the date of accident/injury.
05 = Other accident - The date of an accident not described by the codes 01 thru 04. (obsolete)
06 = Crime victim - Code indicating the date on which a medical condition resulted from alleged criminal action

- committed by one or more parties.
- 07 = Reserved for national assignment.
 - 08 = Reserved for national assignment.
 - 09 = Start of Infertility Treatment Cycle - code indicating the start date of infertility treatment cycle.
 - 10 = Last Menstrual Period - code indicating the date of the last menstrual period; ONLY applies when patient is being treated for maternity related conditions.
 - 11 = Onset of symptoms/illness - The date the patient first became aware of symptoms/illness.
 - 12 = Date of onset for a chronically dependent individual - Code indicates the date the patient/bene became a chronically dependent individual.
 - 13 = Reserved for national assignment.
 - 14 = Reserved for national assignment.
 - 15 = Reserved for national assignment.
 - 16 = Date of Last Therapy - code denotes last day of therapy services (e.g., physical therapy, occupational therapy, speech therapy).
 - 17 = Date outpatient occupational therapy plan established or last reviewed - Code indicating the date an occupational therapy plan was established or last reviewed (eff 3/93)
 - 18 = Date of retirement (patient/bene) - Code indicates the date of retirement for the patient/bene.
 - 19 = Date of retirement spouse - Code indicates the date of retirement for the patient's spouse.
 - 20 = Guarantee of payment began - The date on which the provider began claiming Medicare payment under the guarantee of payment provision.
 - 21 = UR notice received - Code indicating the date of receipt by the hospital & SNF of the UR committee's finding that the admission or future stay was not medically necessary.
 - 22 = Active care ended - The date on which a covered level of care ended in a SNF or general hospital, or date active care ended in a psychiatric or tuberculosis hospital or date on which patient was

released on a trial basis from a residential facility. Code is not required if code "21" is used.

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

was established or last reviewed.

Not used by hospital unless owner of facility

- 31 = Date bene notified of intent to bill (accommodations) - The date of the notice provided to the patient by the hospital stating that he no longer required a covered level of IP care.
- 32 = Date bene notified of intent to bill (procedures or treatment) - The date of the notice provided to the patient by the hospital stating requested care (diagnostic procedures or treatments) is not considered reasonable or necessary.
- 33 = First day of the Medicare coordination period for ESRD bene - During which Medicare benefits are secondary to benefits payable under an EGHP. Required only for ESRD beneficiaries.
- 34 = Date of election of extended care facilities - The date the guest elected to receive extended care services (used by Religious Nonmedical Health Care Institutions only).
- 35 = Date treatment started for physical therapy - Code indicates the date services were initiated by the billing provider for physical therapy.
- 36 = Date of discharge for the IP hospital stay when patient received a transplant procedure - Hospital is billing for immunosuppressive drugs.
- 37 = The date of discharge for the IP hospital stay when patient received a noncovered transplant procedure - Hospital is billing for immunosuppressive drugs.
- 38 = Date treatment started for home IV therapy - Date the patient was first treated in his home for IV therapy.
- 39 = Date discharged on a continuous course of IV therapy - Date the patient was discharged from the hospital on a continuous course of IV therapy.
- 40 = Scheduled date of admission - The date on which a patient will be admitted as an inpatient to the hospital. (This code may only be used on an outpatient claim.)
- 41 = Date of First Test for Pre-admission

Testing - The date on which the first outpatient diagnostic test was performed as part of a pre-admission testing (PAT) program. This code may only be used if a date of admission was scheduled prior to the administration of the test(s). (eff. 10/01)

- 42 = Date of discharge/termination of hospice care - for the final bill for hospice care. Eff 5/93, definition revised to apply only to date patient revoked hospice election.
- 43 = Scheduled Date of Canceled Surgery - date which ambulatory surgery was scheduled. (eff. 9/01)
- 44 = Date treatment started for occupational therapy - Code indicates the date services were initiated by the billing provider for occupational therapy.
- 45 = Date treatment started for speech therapy - Code indicates the date services were initiated by the billing provider for speech therapy.
- 46 = Date treatment started for cardiac rehabilitation - Code indicates the date services were initiated by the billing provider for cardiac rehabilitation.
- 47 = Date Cost Outlier Status Begins - code indicates that this is the first day the cost outlier threshold is reached. For Medicare purposes, a bene must have regular coinsurance and/or lifetime reserve days available beginning on this date to allow coverage of additional daily charges for the purpose of making cost outlier payments. (eff. 9/01)
- 48 = Payer code - Code reserved for internal use only by third party payers. HCFA assigns as needed for your use. Providers will not report it.
- 49 = Payer code - Code reserved for internal use only by third party payers. HCFA assigns as needed for your use. Providers will not report it.
- 50 = Assessment Date - code indicating an assessment date as defined by the assessment instrument applicable to this provider type (e.g. Minimum Data Set (MDS) for skilled nursing). eff. 1/1/11

- 51 = Date of Last Kt/V Reading - for in-center hemodialysis patients, this is the date of the last reading taken during the billing period. For peritoneal dialysis patients (and home hemodialysis patients), this date may be before the current billing period but should be within 4 months of the date of service. eff. 7/1/10
- 52 = Medical Certification/recertification date - the date of the most recent non-hospice medical certification or recertification of the patient. Use occurrence code 27 for Date of Hospice Certification or Recertification. eff. 1/1/11
- 54 = Physician Follow-up Date - Last date of a physician follow-up with the patient. eff. 1/1/11
- A1 = Birthdate, Insured A - The birthdate of the individual in whose name the insurance is carried. (Eff 10/93)
- A2 = Effective date, Insured A policy - A code indicating the first date insurance is in force. (eff 10/93)
- A3 = Benefits exhausted - Code indicating the last date for which benefits are available and after which no payment can be made to payer A. (eff 10/93)
- A4 = Split Bill Date - date patient became eligible due to medically needy spend down (sometimes referred to as "Split Bill Date").
- B1 = Birthdate, Insured B - The birthdate of the individual in whose name the insurance is carried. (eff 10/93)
- B2 = Effective date, Insured B policy - A code indicating the first date insurance is in force. (eff 10/93)
- B3 = Benefits exhausted - code indicating the last date for which benefits are available and after which no payment can be made to payer B. (eff 10/93)
- C1 = Birthdate, Insured C - The birthdate of the individual in whose name the insurance is carried. (eff 10/93)
- C2 = Effective date, Insured C policy - A code indicating the first date insurance is in force. (eff 10/93) Obsolete
- C3 = Benefits exhausted - Code indicating the last date for which benefits are available and after which no payment

can be made to payer C. (eff 10/93)
Obsolete

CLM_SRVC_CLSFCTN_TYPE_TB

Claim Service Classification Type Table

For facility type code 1 thru 6, and 9

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

For facility type code 7

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

For facility type code 8

- 1 = Hospice (non-hospital based)
- 2 = Hospice (hospital based)

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

CLM_TRANS_TB

Claim Transaction Table

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

CLM_VAL_TB

Claim Value Table

- 01 = Most Common Semi-Private Rate - to provide for the recording of hospital's most common semi-private rate.
- 02 = Hospital Has No Semi-Private Rooms - Entering this code requires \$0.00 amount.
- 03 = Reserved for national assignment.
- 04 = Inpatient professional component charges which are combined billed - For use only by some all inclusive rate hospitals. (Eff 9/93)
- 05 = Professional component included in charges and also billed separately to carrier - For use on Medicare and Medicaid bills if the state requests this information.
- 06 = Medicare blood deductible - Total cash blood deductible (Part A blood deductible).
- 07 = Medicare cash deductible (term 9/30/93)

Reserved for national assignment.

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

to Medicare covered services on this bill. Six zeroes indicate provider claimed conditional Medicare payment.

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

- ment Covers Period).
- 26 - Prescription Drugs Offset to Patient
(Payment Amount - Hearing and Ear Services)
Hearing and ear services paid for out of
a long term care facility resident/patient's
funds in the billing period submitted
(Statement covers period).
 - 27 = Offset to the Patient (Payment Amount - Vision
and Eye Services) - Vision and eye services paid
for out of a long term care facility resident/
patient's funds in the billing period submitted
(Statement Covers Period).
 - 28 = Offset to the Patient (Payment Amount - Dental
Services) - Dental services paid for out of a
long term care facility resident/patient's funds
in the billing period submitted (Statement
Covers Period).
 - 29 = Offset to the Patient (Payment Amount - Chiro-
practic Services) - Chiropractic services paid
for out of a long term care facility resident/
patient's funds in the billing period submitted
(Statement Covers Period).
 - 30 = Preadmission Testing - the code used to reflect
the charges for preadmission outpatient diag-
nostic services in preparation for a previously
scheduled admission.
 - 31 = Patient liability amount - Amount
shown is that which you or the PRO
approved to charge the bene for
noncovered accommodations, diagnostic
procedures or treatments.
 - 32 = Multiple patient ambulance transport -
The number of patients transported during
one ambulance ride to the same destination.
(eff. 4/1/2003)
 - 33 = Offset to the Patient Payment Amount (Podiatric
Services) -- Podiatric services paid out of
a long-term care facility resident/patient's
funds in the billing period submitted.
 - 34 = Offset to the Patient Payment Amount (Medical
Services) -- Other medical services paid out of
a long-term care facility resident/patient's
funds in the billing period submitted.
 - 35 = Offset to the Patient Payment Amount (Health
Insurance Premiums) -- Other medical services
paid out of a long-term care facility resident/
patient's funds in the billing period submitted.
 - 37 = Pints of blood furnished - Total
number of pints of whole blood or units
of packed red cells furnished to the

- patient. (eff 10/93)
- 38 = Blood deductible pints - The number of unreplaced pints of whole blood or units of packed red cells furnished for which the patient is responsible. (eff 10/93)
- 39 = Pints of blood replaced - The total number of pints of whole blood or units of packed red cells furnished to the patient that have been replaced by or on behalf of the patient. (eff 10/93)
- 40 = New coverage not implemented by HMO - amount shown is for inpatient charges covered by HMO (eff 3/92). (use this code when the bill includes inpatient charges for newly covered services which are not paid by HMO.)
- 41 = Amount is that portion of a payment from higher priority Black Lung federal program made on behalf of bene the provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional Medicare payment.
- 42 = Amount is that portion of a payment from higher priority VA made on behalf of bene the provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional Medicare payment.
- 43 = Disabled bene under age 65 with LGHP - Amount is that portion of a payment from a higher priority LGHP made on behalf of a disabled Medicare bene the provider applied to Medicare covered services on this bill.
- 44 = Amount provider agreed to accept from primary payer when amount less than charges but more than payment received - When a lesser amount is received and the received amount is less than charges, a Medicare secondary payment is due.
- 45 = Accident Hour - The hour the accident occurred that necessitated medical treatment.
- 46 = Number of grace days - Following the date of the PRO/UR determination, this is the number of days determined by the PRO/UR to be necessary to arrange for

the patient's post-discharge care.
(eff 10/93)

- 47 = Any liability insurance - Amount
is that portion from a higher priority
liability insurance made on behalf of
Medicare bene the provider
is applying to Medicare covered
services on this bill. (Eff 9/93)
- 48 = Hemoglobin reading - The patient's most
recent hemoglobin reading taken before
the start of the billing period (eff.
1/3/2006). Prior to 1/3/2006 defined as
the latest hemoglobin reading taken during
the billing cycle.
- 49 = Hematocrit reading - The patient's most
recent hematocrit reading taken before the
start of the billing period (eff. 1/3/2006).
Prior to 1/3/2006 defined as hematocrit
reading taken during the billing cycle.
- 50 = Physical therapy visits - Indicates
the number of physical therapy
visits from onset (at billing provider)
through this billing period.
- 51 = Occupational therapy visits - Indicates
the number of occupational therapy
visits from onset (at the billing
provider) through this billing period.
- 52 = Speech therapy visits - Indicates
the number of speech therapy
visits from onset (at billing provider)
through this billing period.
- 53 = Cardiac rehabilitation - Indicates
the number of cardiac rehabilitation
visits from onset (at billing
provider) through this billing period.
- 54 = New birth weight in grams - Actual birth
weight or weight at time of admission for
an extramural birth. Required on all claims
with type of admission of '4' and on other
claims as required by law.
- 55 = Eligibility Threshold for Charity Care - code
identifies the corresponding value amount at
which a health care facility determines the
eligibility threshold of charity care.
- 56 = Hours skilled nursing provided - The
number of hours skilled nursing
provided during the billing period. Count
only hours spent in the home.
- 57 = Home health visit hours - The number
of home health aide services provided

- during the billing period. Count only the hours spent in the home.
- 58 = Arterial blood gas - Arterial blood gas value at beginning of each reporting period for oxygen therapy. This value or value 59 will be required on the initial bill for oxygen therapy and on the fourth month's bill.
- 59 = Oxygen saturation - Oxygen saturation at the beginning of each reporting period for oxygen therapy. This value or value 58 will be required on the initial bill for oxygen therapy and on the fourth month's bill.
- 60 = HHA branch MSA - MSA in which HHA branch is located.
- 61 = Location of HHA service or hospice service - the balanced budget act (BBA) requires that the geographic location of where the service was provided be furnished instead of the geographic location of the provider.

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

- 62 = Number of Part A home health visits accrued during a period of continuous care - necessitated by the change in payment basis under HH PPS (eff. 10/00)
- 63 = Number of Part B home health visits accrued during a period of continuous care - necessitated by the change in payment basis under HH PPS (eff. 10/00)
- 64 = Amount of home health payments attributed to the Part A trust fund in a period of continuous care - necessitated by the change in payment basis under HH PPS (eff. 10/00)
- 65 = Amount of home health payments attributed to the Part B trust fund in a period of continuous care - necessitated by the change in payment basis under HH PPS (eff. 10/00)
- 66 = Medicare Spend-down Amount -- The dollar amount that was used to meet the recipient's

- spend-down liability for this claim.
- 67 = Peritoneal dialysis - The number of hours of peritoneal dialysis provided during the billing period (only the hours spent in the home).
(eff. 10/97)
- 68 = EPO drug - Number of units of EPO administered relating to the billing period.
- 69 = State Charity Care Percent - code indicates the percentage of charity care eligibility for the patient.
- 70 = Interest amount - (Providers do not report this.) Report the amount applied to this bill.
- 71 = Funding of ESRD networks - (Providers do not report this.) Report the amount the Medicare payment was reduced to help fund the ESRD networks.
- 72 = Flat rate surgery charge - Code indicates the amount of the charge for outpatient surgery where the hospital has such a charging structure.
- 73 = Drug deductible - (For internal use by third party payers only). Report the amount of the drug deductible to be applied to the claim.
- 74 = Drug coinsurance - (For internal use by third party payers only). Report the amount of drug coinsurance to be applied to the claim.
- 75 = Gramm/Rudman/Hollings - (Providers do not report this.) Report the amount of the sequestration applied to this bill.
- 76 = Report provider's percentage of billed charges interim rate during billing period. Applies to OP hospital, SNF and HHA claims where interim rate is applicable. Report to left of dollar/cents delimiter.
(TP payers internal use only)
- 77 = New Technology Add-on Payment Amount - Amount of payments made for discharges involving approved new technologies. If the total covered costs of the discharge exceed the DRG payment for the case (including adjustments for IME and disproportionate share hospitals (DSH) but excluding outlier payments) an add-on amount is made indicating a new technology

was used in the treatment of the beneficiary.
(eff. 4/1/03, under Inpatient PPS)

78 = Payer code - This code is set aside for payer use only. Providers do not report these codes.

79 = Payer code - This code is set aside for payer use only. Providers do not report these codes.

80 = Covered days - the number of days covered by the primary payer as qualified by the payer.

81 = Non-covered Days - days of care not covered by the primary payer.

82 = Co-insurance Days - The inpatient Medicare days occurring after the 60th day and before the 91st day or inpatient SNF/Swing bed days occurring after the 20th and before the 101st day in a single spell of illness.

83 = Lifetime Reserve Days - Under Medicare, each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days of inpatient hospital services during a spell of illness.

84 - 99 = Reserved for national assignment.

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

A1 = Deductible Payer A - The amount assumed by the provider to be applied to the patient's deductible amount to the involving the indicated payer. (eff. 10/93)
- Prior value 07

A2 = Coinsurance Payer A - The amount assumed by the provider to be applied to the patient's Part B coinsurance amount involving the indicated payer. (eff 10/93)

A3 = Estimated Responsibility Payer A - The amount estimated by the provider to be paid by the indicated payer.

A4 = Self-administered drugs administered in an emergency situation - Ordinarily the only noncovered self-administered drug paid for under Medicare in an emergency situation is insulin administered to a patient in a diabetic coma. (eff 7/97)

A5 = Covered self-administered drugs -- The amount included in covered charges for self-administerable drugs administered to the patient because the drug was not self-administered in the form and situation in which it was furnished to

the patient.

- A6 = Covered self-administered drugs -Diagnostic study and Other --- the amount included in covered charges for self-administrable drugs administered to the patient because the drug was necessary for diagnostic study or other reasons. For use with Revenue Center 0637.
- A7 = Copayment A -- The amount assumed by the provider to be applied toward the patient's copayment amount involving the indicated payer.
- A8 = Patient Weight -- Weight of patient in kilograms. Report this data only when the health plan has a predefined change in reimbursement that is affected by weight.
- A9 = Patient Height - Height of patient in centimeters. Report this data only when the health plan has a predefined change in reimbursement that is affected by height.
- AA = Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes (Payer A) -- The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer (eff. 10/2003).
- AB = Other Assessments or Allowances (Payer A) -- The amount of other assessments or allowances pertaining to the indicated payer. (eff. 10/2003).
- B1 = Deductible Payer B - The amount assumed by the provider to be applied to the patient's deductible amount involving the indicated payer. (eff 10/93)
- Prior value 07
- B2 = Coinsurance Payer B - the amount assumed by the provider to be applied to the patient's Part B coinsurance amount involving the indicated payer. (eff 10/93)
- B3 = Estimated Responsibility Payer B - The amount estimated by the provider to be paid by the indicated payer.
- B7 = Copayment B -- The amount assumed by the provider to be applied toward the patient's copayment amount involving the indicated payer.
- BA = Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes (Payer B) -- The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer (eff. 10/2003).
- BB = Other Assessments or Allowances (Payer B) -- The amount of other assessments or allowances pertaining to the indicated payer. (eff. 10/2003).
- C1 = Deductible Payer C - The amount

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

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

C3 = Estimated Responsibility Payer C - The

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

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

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

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

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

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

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

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

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

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

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

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

Y3 = Part B coinsurance - Amount of Part B coinsurance applied by the intermediary to this demo claim. For demonstration claims this will be a fixed copayment unique to each hospital and DRG (or DRG/procedure group).

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

operating IME and DSH.

CLM_WC_IND_TB

Workers' Compensation Indicator Table

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

Spaces

CMS_PRVDR_SPCLTY_TB

CMS Provider Specialty Table

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

24 = Plastic and reconstructive surgery
25 = Physical medicine and rehabilitation
26 = Psychiatry
27 = Psychiatry, neurology (osteopaths
only) (discontinued 5/92 use code 86)
28 = Colorectal surgery (formerly
proctology)
29 = Pulmonary disease
30 = Diagnostic radiology
31 = Roentgenology, radiology (osteopaths
only) (discontinued 5/92 use code 30)
32 = Anesthesiologist Assistants (eff. 4/1/03--previously
grouped with Certified Registered Nurse Anesthetists
(CRNA))
32 = Radiation therapy (osteopaths only)
(discontinued 5/92 use code 92)
33 = Thoracic surgery
34 = Urology
35 = Chiropractic
36 = Nuclear medicine
37 = Pediatric medicine
38 = Geriatric medicine
39 = Nephrology
40 = Hand surgery
41 = Optometry (revised 10/93 to
mean optometrist)
42 = Certified nurse midwife (eff 1/87)
43 = CRNA (eff. 1/87) (Anesthesiologist Assistants
were removed from this specialty 4/1/03)
44 = Infectious disease
45 = Mammography screening center
46 = Endocrinology (eff 5/92)
47 = Independent Diagnostic Testing Facility
(IDTF) (eff. 6/98)
48 = Podiatry
49 = Ambulatory surgical center
(formerly miscellaneous)
50 = Nurse practitioner
51 = Medical supply company with
certified orthotist (certified by
American Board for Certification in
Prosthetics And Orthotics)
52 = Medical supply company with
certified prosthetist
(certified by American Board for
Certification In Prosthetics And
Orthotics)
53 = Medical supply company with
certified prosthetist-orthotist
(certified by American Board for

Certification in Prosthetics
and Orthotics)

- 54 = Medical supply company not included
in 51, 52, or 53. (Revised 10/93
to mean medical supply company for DMERC)
- 55 = Individual certified orthotist
- 56 = Individual certified prosthetist
- 57 = Individual certified prosthetist-orthotist
- 58 = Individuals not included in 55, 56, or 57,
(revised 10/93 to mean medical supply company
with registered pharmacist)
- 59 = Ambulance service supplier, e.g.,
private ambulance companies, funeral homes, etc.

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

79 = Addiction medicine (eff 5/92)
80 = Licensed clinical social worker
81 = Critical care (intensivists)
 (eff 5/92)
82 = Hematology (eff 5/92)
83 = Hematology/oncology (eff 5/92)
84 = Preventive medicine (eff 5/92)
85 = Maxillofacial surgery (eff 5/92)
86 = Neuropsychiatry (eff 5/92)
87 = All other suppliers (e.g. drug and
 department stores) (note: DMERC used
 87 to mean department store from 10/93
 through 9/94; recoded eff 10/94 to A7;
 NCH cross-walked DMERC reported 87 to A7.
88 = Unknown supplier/provider specialty
 (note: DMERC used 87 to mean grocery
 store from 10/93 - 9/94; recoded eff
 10/94 to A8; NCH cross-walked DMERC
 reported 88 to A8.
89 = Certified clinical nurse specialist
90 = Medical oncology (eff 5/92)
91 = Surgical oncology (eff 5/92)
92 = Radiation oncology (eff 5/92)
93 = Emergency medicine (eff 5/92)
94 = Interventional radiology (eff 5/92)
95 = Competative Acquisition Program (CAP)
 Vendor (eff. 07/01/06). Prior to
 07/01/06, known as Independent
 physiological laboratory (eff. 5/92)
96 = Optician (eff 10/93)
97 = Physician assistant (eff 5/92)
98 = Gynecologist/oncologist (eff 10/94)
99 = Unknown physician specialty
A0 = Hospital (eff 10/93) (DMERCs only)
A1 = SNF (eff 10/93) (DMERCs only)
A2 = Intermediate care nursing facility
 (eff 10/93) (DMERCs only)
A3 = Nursing facility, other (eff 10/93)
 (DMERCs only)
A4 = HHA (eff 10/93) (DMERCs only)
A5 = Pharmacy (eff 10/93) (DMERCs only)
A6 = Medical supply company with respiratory
 therapist (eff 10/93) (DMERCs only)
A7 = Department store (for DMERC use:
 eff 10/94, but cross-walked from
 code 87 eff 10/93)
A8 = Grocery store (for DMERC use:
 eff 10/94, but cross-walked from
 code 88 eff 10/93)
A9 = Indian Health Service (IHS), tribe and

tribal organizations (non-hospital or non-hospital based facilities. DMERCs shall process claims submitted by IHS, tribe and non-tribal organizations for DMEPOS and drugs covered by the DMERCs. (eff. 1/2005)

B1 = Supplier of oxygen and/or oxygen related equipment (eff. 10/2/07)

B2 = Pedorthic Personnel (eff. 10/2/07)

B3 = Medical Supply Company with Pedorthic Personnel (eff. 10/2/07)

B4 = Rehabilitation Agency (eff. 10/2/07)

CTGRY_EQTBL_BENE_IDENT_TB Category Equatable Beneficiary Identification Code (BIC) Table

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

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

RRB Categories

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

END_REC_TB

End of Record Code Table

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

FI_CLM_ACTN_TB

Fiscal Intermediary Claim Action Table

1 = Original debit action (includes non-
adjustment RTI correction items) - it
will always be a 1 in regular bills.
2 = Cancel by credit adjustment - used
only in credit/debit pairs (under HHPPS,
updates the RAP).
3 = Secondary debit adjustment - used only
in credit/debit pairs (under HHPPS, would
be the final claim or an adjustment on
a LUPA).
4 = Cancel only adjustment (under HHPPS,
RAP/final claim/LUPA).
5 = Force action code 3
6 = Force action code 2
8 = Benefits refused (for inpatient bills,
an 'R' nonpayment code must also be
present

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

FI_NUM_TB	Fiscal Intermediary Number /	Medicare Administrative Contractor Table
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00010	= Alabama BC - Alabama (replaced with MAC #10101 -- see below)	
00011	= Alabama BC - Iowa replaced by MAC # 03401 -- see below)	
00012	= Iowa replaced by MAC # 05101 -- see below)	
00020	= Arkansas BC - Arkansas	
00021	= Arkansas BC - Rhode Island	
00030	= Arizona BC (replaced by MAC # 03101 -- see below)	
00040	= California BC (term. 12/00)	
00050	= New Mexico BC/CO (term. 06/89)	
00060	= Connecticut BC (term. 06/99)	
00070	= Delaware BC - terminated 2/98	
00080	= Florida BC (term. 03/88)	
00090	= Florida BC (replaced with MAC #09101 -- see below)	
00101	= Georgia BC (replaced with MAC #10201 -- see below)	
00121	= Illinois - HCSC (term. 08/98)	
00123	= Michigan - HCSC (term. 08/98)	
00130	= Indiana BC/Administar Federal	
00131	= Illinois - Administar	
00140	= Iowa - Wellmark (term. 6/2000)	
00150	= Kansas BC (term. 2008) (replaced with MAC # 05201 -- see below)	
00160	= Kentucky/Administar (replaced with MAC # 15101 -- see below)	
00180	= Maine BC (replaced with MAC #14004 & 14101 -- see below)	
00181	= Maine BC - Massachusetts	
00190	= Maryland BC (term. 9/2005)	
00200	= Massachusetts BC (term. 7/97)	
00210	= Michigan BC (term. 9/94)	
00220	= Minnesota BC (term. 07/99)	
00230	= Mississippi BC	
00231	= Mississippi BC/LA (term. 09/92)	
00232	= Mississippi BC	

00241 = Missouri BC (term. 9/92)
00242 = Missouri
(replaced with MAC # 05301 --see below)
00250 = Montana BC (replaced by MAC #
03201 -- see below)
00260 = Nebraska BC (term. 2007)
(replaced with MAC # 05401 --see below)
00270 = New Hampshire BC
(replaced with MAC #14501 -- see below)
00280 = New Jersey BC (term. 8/2000)
00290 = New Mexico BC - terminated 11/95
00308 = New York - Empire BC
(replaced with MAC # 12101, 13201 & 13101 -- see below)
00310 = North Carolina BC (term. 01/02)
00320 = North Dakota BC - North Dakota
(replaced with MAC # 03301 -- see
below)
00322 = North Dakota BC - Washington & Alaska
00323 = North Dakota BC - Idaho, Oregon & Utah
(replaced with MAC # 03501 --see below)
00332 = Ohio-Administar
00340 = Oklahoma BC (term. 2008)
(replaced with MAC # 04301 -- see below)
00350 = Oregon BC
00351 = Oregon BC/ID. (term. 09/88)
00355 = Oregon-CWF
00362 = Independence BC - terminated 8/97
00363 = Pennsylvania/Highmark - Veritus
00366 = Highmark (MD & DC) - Part A (eff. 10/2005)
00370 = Rhode Island BC
(replaced with MAC #14401 - see below)
00380 = South Carolina BC - South Carolina
(replaced with MAC #11004 & 11201 - see below)
00382 = South Carolina BC - North Carolina
(replaced with MAC #11501 - see below)
00390 = Tennessee BC/Riverbend
(replaced with MAC # 12001 & 10301 -- see below)
00400 = Texas BC
(replaced with MAC #04101, 04201, 04401 -- see below)
00410 = Utah BC (term. 09/00)
00423 = Virginia BC; Trigon (term. 08/99)
00430 = Washington/Alaska BC
00450 = Wisconsin BC - Wisconsin
00452 = Wisconsin BC - Michigan
00453 = Wisconsin BC - Virginia & West Virginia
(replaced with MAC #11301 & 11401 - see below)
00454 = Wisconsin BC - California
(replaced by MAC #01101, 01201 & 01301 -- see below)
00460 = Wyoming BC
(replaced by MAC # 03601 -- see below)

00468 = N Carolina BC/CPRTIVA
00993 = BC/BS Assoc.
17120 = Hawaii Medical Service (term. 06/99)
50333 = Travelers; Connecticut United Healthcare
(terminated - date unknown)
51051 = Aetna California - terminated 6/97
51070 = Aetna Connecticut - terminated 6/97
51100 = Aetna Florida - terminated 6/97
51140 = Aetna Illinois - terminated 6/97
51390 = Aetna Pennsylvania - terminated 6/97
52280 = NE - Mutual of Omaha
57400 = Puerto Rico - Cooperativa
(replaced with MAC # 09201)
61000 = Aetna (term. 06/97)
80883 = Contractor ID for Inpatient & Outpatient
Risk Adjustment Data (data not sent through
CWF; but through Palmetto)

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#### Medicare Administrative Contractor Numbers

##### JURISDICTION 1 - PART A MACs

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

##### JURISDICTION 3 - Part A MACs

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

##### JURISDICTION 4 - Part A MACs

04101 = Colorado (eff. 6/16/2008)  
(replaces FI #00400)  
04201 = New Mexico (eff. 6/16/2008)

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

JURISDICTION 5 - Part A MACs

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

JURISDICTION 9 - PART A MACs

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

JURISDICTION 10 - PART A MACs

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

JURISDICTION 11 - PART A MACs

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

JURISDICTION 12 - PART A MACs

12001 = New Jersey (eff. 9/1/2008)  
(replaces FI # 00390)

12101 = Delaware (eff. 11/14/2008)  
(replaces FI # 00308)

JURISDICTION 13 - PART A MACs

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

JURISDICTION 14 - PART A MACs

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

JURISDICTION 15 - PART A MACs

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

FI\_RQST\_CLM\_CNCL\_RSN\_TB

Claim Cancel Reason Code Table

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

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

GEO\_SSA\_STATE\_TB

State Table

01 = Alabama  
02 = Alaska  
03 = Arizona  
04 = Arkansas  
05 = California  
06 = Colorado  
07 = Connecticut  
08 = Delaware  
09 = District of Columbia  
10 = Florida  
11 = Georgia  
12 = Hawaii  
13 = Idaho  
14 = Illinois  
15 = Indiana  
16 = Iowa  
17 = Kansas  
18 = Kentucky  
19 = Louisiana  
20 = Maine  
21 = Maryland  
22 = Massachusetts  
23 = Michigan  
24 = Minnesota  
25 = Mississippi  
26 = Missouri  
27 = Montana  
28 = Nebraska  
29 = Nevada  
30 = New Hampshire  
31 = New Jersey  
32 = New Mexico  
33 = New York  
34 = North Carolina  
35 = North Dakota  
36 = Ohio  
37 = Oklahoma  
38 = Oregon  
39 = Pennsylvania  
40 = Puerto Rico  
41 = Rhode Island  
42 = South Carolina  
43 = South Dakota



44 = Tennessee  
 45 = Texas  
 46 = Utah  
 47 = Vermont  
 48 = Virgin Islands  
 49 = Virginia  
 50 = Washington  
 51 = West Virginia  
 52 = Wisconsin  
 53 = Wyoming  
 54 = Africa  
 55 = California  
 56 = Canada & Islands  
 57 = Central America and West Indies  
 58 = Europe  
 59 = Mexico  
 60 = Oceania  
 61 = Philippines  
 62 = South America  
 63 = U.S. Possessions  
 64 = American Samoa  
 65 = Guam  
 66 = Commonwealth of the Northern Marianas Islands  
 67 = Texas  
 68 = Florida (eff. 10/2005)  
 69 = Florida (eff. 10/2005)  
 70 = Kansas (eff. 10/2005)  
 71 = Louisiana (eff. 10/2005)  
 72 = Ohio (eff. 10/2005)  
 73 = Pennsylvania (eff. 10/2005)  
 74 = Texas (eff. 10/2005)  
 80 = Maryland (eff. 8/2000)  
 97 = Northern Marianas  
 98 = Guam  
 99 = With 000 county code is American Samoa;  
 otherwise unknown

MCO\_OPTN\_TB

MCO Option Table

\*\*\*\*\*For lock-in beneficiaries\*\*\*\*\*  
 A = HCFA to process all provider bills  
 B = MCO to process only in-plan  
 C = MCO to process all Part A and Part B bills

\*\*\*\*\* For non-lock-in beneficiaries\*\*\*\*\*  
 1 = HCFA to process all provider bills  
 2 = MCO to process only in-plan Part A and  
 Part B bills

4 = Cost Plan-Chronic Care Organizations (eff. 10/2005)

NCH\_CLM\_BIC\_MDFY\_TB

NCH Claim BIC Modify H Code Table

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

NCH\_CLM\_TYPE\_TB

NCH Claim Type Table

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

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

NCH\_COND\_TRLR\_IND\_TB

NCH Condition Trailer Indicator Table

C = Condition code trailer present

NCH\_DEMO\_TRLR\_IND\_TB

NCH Demonstration Trailer Indicator Table

D = Demo trailer present

NCH\_DGNS\_E\_TRLR\_IND\_TB

NCH Diagnosis E Trailer Indicator Code Table

Valid Value:

W = NCH Diagnosis E Code trailer

NCH\_DGNS\_TRLR\_IND\_TB

NCH Diagnosis Trailer Indicator Table

Y = Diagnosis code trailer present

NCH\_EDIT\_DISP\_TB

NCH Edit Disposition Table

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

NCH\_EDIT\_TB

NCH EDIT TABLE

A0X1 = (C) PHYSICIAN-SUPPLIER ZIP CODE  
A000 = (C) REIMB > \$100,000 OR UNITS > 150  
A002 = (C) CLAIM IDENTIFIER (CAN)  
A003 = (C) BENEFICIARY IDENTIFICATION (BIC)  
A004 = (C) PATIENT SURNAME BLANK  
A005 = (C) PATIENT 1ST INITIAL NOT-ALPHABETIC  
A006 = (C) DATE OF BIRTH IS NOT NUMERIC  
A007 = (C) INVALID GENDER (0, 1, 2)  
A008 = (C) INVALID QUERY-CODE (WAS CORRECTED)  
A009 = (C) TYPE OF BILL RECEIVED IS 41A, 41B, OR 41D  
A010 = (C) DISPOSITION CODE VS. ACTION/ENTRY CODE  
A023 = (C) PORTABLE X-RAY WITHOUT MODIFIER  
A025 = (C) FOR OV 4, TOB MUST = 13,83,85,73  
A031 = (C) HOSPITAL CLAIMS--CLAIM SHOWS SERVICES WERE PAID  
BY AN HMO AND CODITION CODE '04' IS NOT PRESENT.  
(TOB '11' & '12')  
A041 = (C) HHA CLAIMS--TOB 32X OR 33X WITH >4 VISITS; DATE  
OF SERVICE > 9/30/00 AND LUPA IND IS PRESENT.  
BYPASS FOR NON-PAYMENT CODE B, C, Q, T-Y.  
A1X1 = (C) PERCENT ALLOWED INDICATOR  
A1X2 = (C) DT>97273,DG1=7611,DG<>103,163,1589  
A1X3 = (C) DT>96365,DIAG=V725  
A1X4 = (C) INVALID DIAGNOSTIC CODES  
C050 = (U) HOSPICE - SPELL VALUE INVALID  
D102 = (C) DME DATE OF BIRTH INVALID

D2X2 = (C) DME SCREEN SAVINGS INVALID  
D2X3 = (C) DME SCREEN RESULT INVALID  
D2X4 = (C) DME DECISION IND INVALID  
D2X5 = (C) DME WAIVER OF PROV LIAB INVALID  
D3X1 = (C) DME NATIONAL DRUG CODE INVALID  
D4X1 = (C) DME BENE RESIDNC STATE CODE INVALID  
D4X2 = (C) DME OUT OF DMERC SERVICE AREA  
D4X3 = (C) DME STATE CODE INVALID  
D5X1 = (C) TOS INVALID FOR DME HCPCS  
D5X2 = (C) DME HCPCS NOC & NOC DESCRIP MISSING  
D5X3 = (C) DME INVALID USE OF MS MODIFIER  
D5X4 = (C) TOS9 NDC REQD WHEN HCPCS OMITTED  
D5X5 = (C) TOS9 NDC REQD FOR Q0127-130 HCPCS  
D5X6 = (C) TOS9 NDC/DIAGNOSIS CODE INVALID  
D5X7 = (C) ANTI-EMETIC/ANTI-CANCER DRUG W/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) INVAL OR BLK  
04A1 = (C) PATIENT SURNAME BLANK (PHYS/SUP)  
04B1 = (C) PATIENT 1ST INITIAL NOT-ALPHABETIC  
0401 = (C) BILL TYPE/PROVIDER INVALID  
0402 = (C) BILL TYPE/REV CODE/PROVR RANGE  
0403 = (C) TOB '41X'/PRVDR # 1990-1999) OR TOB '51X'/  
PRVDR #6990-6999, TRANS CODE SHOULD BE  
'0' OR '3'  
0406 = (C) MAMMOGRAPHY WITH NO HCPCS 76092 OR SEX NOT F  
0407 = (C) RESPIRE CARE BILL TYPE NOT 34X,NO REV 66  
0408 = (C) REV CODE 403 /TYPE 71X/ PROV3800-974  
041A = (C) TOB '11A' OR '11D' AND DEMO #'07' OR '08'  
NOT PRESENT  
0410 = (C) IMMUNO DRUG OCCR-36,NO REV-25 OR 636  
0412 = (C) BILL TYPE XX5 HAS ACCOM. REV. CODES  
0413 = (C) CABG/PCOE BUT TOB = HHA,OUT,HOS  
0414 = (C) VALU CD 61,MSA AMOUNT MISSING  
0415 = (C) HOME HEALTH INCORRECT ALPHA RIC  
0416 = (C) REVENUE CENTER '0022', TOB MUST BE  
'18X' OR '21X'  
0417 = (C) REVENUE CENTER '0023', TOB MUST BE '32X'  
OR '33X'  
0418 = (C) HHA--TOB '3X5' AND DATES OF SERVICE  
>9/30/00  
0419 = (C) HHA--RIC 'W' MUST HAVE VALUE CODE '63'/  
RIC 'V' MUST HAVE VALUE CODE '62' AND  
RIC 'U' MUST HAVE VALUE CODES '62' AND  
'63' PRESENT FOR DATES OF SERVICE >  
9/30/00.  
0420 = (C) HHA W/O REVENUE CODE '0023'  
0421 = (C) START DATE MISSING  
0422 = (C) COB VS. OVERRIDE CODE  
05X4 = (C) UPIN REQUIRED FOR TYPE-OF-SERVICE  
05X5 = (C) UPIN REQUIRED FOR DME  
0501 = (C) REFFERING UPIN REQUIRED FOR CLINICAL LAB  
0502 = (C) REFERRING UPIN INVALID  
0601 = (C) GENDER INVALID  
0701 = (C) CONTRACTOR/POS 1-2 PROVIDER NUM INVALID  
0702 = (C) PROVIDER NUMBER VS. TOB  
0703 = (C) MAMMOGRAPHY FOR NOT FEMALE  
0704 = (C) INVALID CONT FOR CABG DEMO  
0705 = (C) INVALID CONT FOR PCOE DEMO  
0706 = (C) REVENUE CENTER CODE MAMMOGRAPHY AND

BENEFICIARY <35  
 0901 = (C) INVALID DISP CODE OF 02  
 0902 = (C) INVALID DISP CODE OF SPACES  
 0903 = (C) INVALID DISP CODE  
 1001 = (C) PROF REVIEW/ACT CODE/BILL TYPE  
 13X2 = (C) MULTIPLE ITEMS FOR SAME SERVICE  
 1301 = (C) LINE COUNT NOT NUMERIC OR > 13  
 1302 = (C) RECORD LENGTH INVALID  
 1401 = (C) INVALID MEDICARE STATUS CODE  
 1501 = (C) ADMIT DATE/START DATE/ENTRY CODE INVALID  
 1502 = (C) ADMIT DATE/START CARE DATE > STAY FROM DATE  
 1503 = (C) ADMIT DATE INVALID WITH THRU DATE  
 1504 = (C) ADM/FROM/THRU DATE > TODAYS DATE  
 1505 = (C) HCPCS W SERVICE DATES > 09-30-94  
 1601 = (C) INVESTIGATION IND INVALID  
 1701 = (C) SPLIT IND INVALID  
 1801 = (C) PAY-DENY CODE INVALID  
 1802 = (C) HEADER AMT/LINE ITEMS DENIED  
 1803 = (C) MSP COST AVD/ALL MSP LI NOT SAME  
 1901 = (C) AB CROSSOVER IND INVALID  
 2001 = (C) HOSPICE OVERRIDE INVALID  
 2101 = (C) HMO-OVERRIDE/PATIENT-STAT INVALID  
 2102 = (C) PATIENT STATUS VS. TOB  
 2103 = (C) HIPPS RATE/CMG CODE VS. PATIENT STATUS  
 2201 = (C) FROM DATE/HCPCS YR INVALID  
 2202 = (C) STAY-FROM DATE > THRU-DATE  
 2203 = (C) THRU DATE INVALID  
 2204 = (C) FROM DATE BEFORE EFFECTIVE DATE  
 2205 = (C) DATE YEARS DIFFERENT ON OUTPAT  
 2207 = (C) MAMMOGRAPHY BEFORE 1991  
 2208 = (C) TOB '21X', REV CODE 0022 FROM DATE  
 < 06-03-98  
 2209 = (C) HHA WITH OVERLAPPING DATES JUNE/JULY,  
 SEPT/OCT  
 2210 = (C) TOB 41X, SERVICE DATES 6/30/00,  
 EXCEP/NONEXCEP IND = 1,2  
 2212 = (C) TOB 51X WITH SERVICE DATES >6/30/00  
 2213 = (C) TOB 32X OR 33X, SERVICE >9/30/00 DAYS  
 CAN NOT = 60  
 2215 = (C) DEMO 37 WITH VALUE CODES 'A2', 'B2', 'C2'  
 2216 = (C) DEMO 37 OR CONDITION CODE 78 AND CHARGES  
 SUB TO DED > 0  
 2301 = (C) DOCUMENT CNTL OR UTIL DYS INVALID  
 2302 = (C) COVERED DAYS INVALID OR INCONSIST  
 2303 = (C) COST REPORT DAYS > ACCOMIDATION  
 2304 = (C) UTIL DAYS = ZERO ON PATIENT BILL  
 2305 = (C) LATE CHARGE BILL WITH DATA FIELD PRESENT  
 2306 = (C) UTIL DYS/NOPAY/REIMB INCONSISTENT  
 2307 = (C) COND=40,UTL DYS >0/VAL CDE A1,08,09  
 2308 = (C) NOPAY = R WHEN UTIL DAYS = ZERO

2401 = (C) NON-UTIL DAYS INVALID  
 2501 = (C) CLAIM RCV DT OR COINSURANCE INVAL  
 2502 = (C) COIN+LR>UTIL DAYS/RCPT DTE>CUR DTE  
 2503 = (C) COIN/TR TYP/UTIL DYS/RCPT DTE>PD/DEN  
 2504 = (C) COINSURANCE AMOUNT EXCESSIVE  
 2505 = (C) COINSURANCE RATE > ALLOWED AMOUNT  
 2506 = (C) COINSURANCE DAYS/AMOUNT INCONSIST  
 2507 = (C) COIN+LR DAYS > TOTAL DAYS FOR YR  
 2508 = (C) COINSURANCE DAYS INVALID FOR TRAN  
 2601 = (C) CLAIM PAID DT INVALID OR LIFE RES  
 2602 = (C) LR-DAYS, NO VAL 08,10/PD/DEN>CUR+27  
 2603 = (C) LIFE RESERVE > RATE FOR CAL YEAR  
 2604 = (C) PPS BILL, NO DAY OUTLIER  
 2605 = (C) LIFE RESERVE RATE > DAILY RATE AVR.  
 28XA = (C) UTIL DAYS > FROM TO BENEF EXH  
 28XB = (C) BENEFITS EXH DATE > FROM DATE  
 28XC = (C) BENEFITS EXH DATE/INVALID TRANS TYPE  
 28XD = (C) OCCUR 23 WITH SPAN 70 ON INPAT HOSP  
 28XE = (C) MULTI BENE EXH DATE (OCCR A3,B3,C3)  
 28XF = (C) ACE DATE ON SNF (NOPAY =B, C, N, W)  
 28XG = (C) SPAN CD 70+4+6+9 NOT = NONUTIL DAYS  
 28XM = (C) OCC CD 42 DATE NOT = SRVCE THRU DTE  
 28XN = (C) INVALID OCC CODE  
 28XO = (C) AN 'N' NO-PAY CODE IS PRESENT AND OCCURRENCE  
 CODE '23' OR '42' IS NOT PRESENT AND THE  
 DATE ASSOCIATED WITH CODE IS MISSING OR NOT  
 EQUAL TO THRU DATE.  
 28XP = (C) THE OCCURRENCE CODE 23 DATE DOES NOT EQUAL THE  
 THRU DATE  
 28X0 = (C) BENE EXH DATE OUTSIDE SERVICE DATES  
 28X1 = (C) OCCUR DATE INVALID  
 28X2 = (C) OCCUR = 20 AND TRANS = 4  
 28X3 = (C) OCCUR 20 DATE < ADMIT DATE  
 28X4 = (C) OCCUR 20 DATE > ADMIT + 12  
 28X5 = (C) OCCUR 20 AND ADMIT NOT = FROM  
 28X6 = (C) OCCUR 20 DATE < BENE EXH DATE  
 28X7 = (C) OCCUR 20 DATE+UTIL-COIN>COVERAGE  
 28X8 = (C) OCCUR 22 DATE < FROM OR > THRU  
 28X9 = (C) UTIL > FROM - THRU LESS NCOV  
 33X1 = (C) QUAL STAY DATES INVALID (SPAN=70)  
 33X2 = (C) QS FROM DATE NOT < THRU (SPAN=70)  
 33X3 = (C) QS DAYS/ADMISSION ARE INVALID  
 33X4 = (C) QS THRU DATE > ADMIT DATE (SPAN=70)  
 33X5 = (C) SPAN 70 INVALID FOR DATE OF SERVICE  
 33X6 = (C) TOB=18/21/28/51,COND=WO,HMO<>90091  
 33X7 = (C) TOB<>18/21/28/51,COND=WO  
 33X8 = (C) TOB=18/21/28/51,CO=WO,ADM DT<97001  
 33X9 = (C) TOB=32X SPAN 70 OR OCCR BO PRESENT  
 33#A = (C) MULTIPLE PET SCANS  
 33#B = (C) MULTIPLE PET SCANS W/O MODIFIER 26

OR TC  
 3401 = (C) DEMO ID = 04 AND RIC NOT = 1 OR 2  
 34X2 = (C) DEMO ID = 04 AND COND WO NOT SHOWN  
 34#3 = (C) CONDITION CODE = W0 AND DEMO NOT = 04  
 35X1 = (C) 60, 61, 66 & NON-PPS / 65 & PPS  
 35X2 = (C) COND = 60 OR 61 AND NO VALU 17  
 35X3 = (C) PRO APPROVAL COND C3,C7 REQ SPAN M0  
 35#3 = (C) (SECOND CONDITION) CONDITION CODE = C3  
 REQUIRES SPAN CODE 76 OR 77  
 35#4 = (C) CONDITION CODE = 69 AND TOB NOT 11X  
 36X1 = (C) SURG DATE < STAY FROM/ > STAY THRU  
 36#1 = (C) SURGICAL DATE = ZEROES OR < FROM OR >  
 THRU DATES  
 3701 = (C) ASSIGN CODE INVALID  
 3705 = (C) 1ST CHAR OF IDE# IS NOT ALPHA  
 3706 = (C) INVALID IDE NUMBER-NOT IN FILE  
 3710 = (C) NUM OF IDE# > REV 0624  
 3715 = (C) NUM OF IDE# < REV 0624  
 3720 = (C) IDE AND LINE ITEM NUMBER > 2  
 3801 = (C) AMT BENE PD INVALID  
 3XA/ = (C) COLORECTAL/PROSTATE SCREENING BILLED  
 MULTIPLE TIMES  
 4001 = (C) BLOOD PINTS FURNISHED INVALID  
 4002 = (C) BLOOD FURNISHED/REPLACED INVALID  
 4003 = (C) BLOOD FURNISHED/VERIFIED/DEDUCT  
 4201 = (C) BLOOD PINTS UNREPLACED INVALID  
 4202 = (C) BLOOD PINTS UNREPLACED/BLOOD DED  
 4203 = (C) INVALID CPO PROVIDER NUMBER  
 4301 = (C) BLOOD DEDUCTABLE INVALID  
 4302 = (C) BLOOD DEDUCT/FURNISHED PINTS  
 4303 = (C) BLOOD DEDUCT > UNREPLACED BLOOD  
 4304 = (C) BLOOD DEDUCT > 3 - REPLACED  
 4501 = (C) PRIMARY DIAGNOSIS INVALID  
 4502 = (C) SERVICE DATES > CURRENT DATE  
 46#A = (C) MSP VET AND VET AT MEDICARE  
 46#B = (C) MULTIPLE COIN VALU CODES (A2,B2,C2)  
 46#C = (C) COIN VALUE (A2,B2,C2) ON INP/SNF  
 46#G = (C) VALU CODE 20 INVALID  
 46#L = (C) BLOOD FURNISHED < BLOOD REPLACED  
 46#N = (C) VALUE CODE 37,38,39 INVALID  
 46#O = (C) VALUE CDE 37,38,39 AMOUNT NOT > 00  
 46#P = (C) BLD UNREP VS REV CDS AND/OR UNITS  
 46#Q = (C) VALUE CDE 37=39 AND 38 IS PRESENT  
 46#R = (C) BLD FIELDS VS REV CDE 380,381,382  
 46#S = (C) VALU CODE 39, AND 37 IS NOT PRESENT  
 46#T = (C) CABG/PCOE/MPPD,VC<>Y1,Y2,Y3,Y4,VA NOT>0  
 46#U = (C) MSP VALUES ON CABG/PCOE/MPPD (INP)  
 TOB '32X'/'33X' MUST HAVE VALUE 62/64  
 OR 63/65 (HHA)  
 46#V = (C) TOB '32X'/'33X' VISITS IN 62/63 NOT =



REVENUE CODE 42X-44X, 55X-57X  
 46#W = (C) CONDITION CODE =30/78 AND WITH VALUE  
 CODE = A1, B1, C1  
 46#1 = (C) VALUE AMOUNT INVALID  
 46#2 = (C) VALU 06 AND BLD-DED-PTS IS ZERO  
 46#3 = (C) VALU 06 AND TTL-CHGS=NC-CHGS(001)  
 46#4 = (C) VALU (A1,B1,C1): AMT > DEDUCT  
 46#5 = (C) DEDUCT VALUE (A1,B1,C1) ON SNF BILL  
 46#6 = (C) VALU 17 AND NO COND CODE 60 OR 61  
 46#7 = (C) OUTLIER(VAL 17) > REIMB + VAL6-16  
 46#8 = (C) MULTI CASH DED VALU CODES (A1,B1,C1)  
 46X9 = (C) DEMO ID=03,REQUIRED HCPCS NOT SHOWN  
 4600 = (C) CAPITAL TOTAL NOT = CAP VALUES  
 4601 = (C) CABG/PCOE, MSP CODE PRESENT  
 4603 = (C) DEMO ID = 03 AND RIC NOT=6,7  
 4604 = (C) DEMO = 03 WITH DATES OF SERVICE  
 > 09/31/01  
 4901 = (C) PCOE/CABG,DEN CD NOT D  
 4902 = (C) PCOE/CABG BUT DME  
 50#1 = (C) RVCD=54,TOB<>13,23,32,33,34,83,85  
 50#2 = (C) REV CD=054X,MOD NOT = QM,QN  
 5051 = (E) EDB: NOMATCH ON 3 CHARACTERISTICS  
 5052 = (E) EDB: NOMATCH ON MASTER-ID RECORD  
 5053 = (E) EDB: NOMATCH ON CLAIM-NUMBER  
 51#A = (C) HCPCS EYEWARE & REV CODE NOT 274  
 51#C = (C) HCPCS REQUIRES DIAG CODE OF CANCER  
 51#D = (C) HCPCS REQUIRES UNITS > ZERO  
 51#E = (C) HCPCS REQUIRES REVENUE CODE 636/294  
 51#F = (C) INV BILL TYP/ANTI-CAN DRUG HCPCS  
 51#G = (C) HCPCS REQUIRES DIAG OF HEMOPHILL1A  
 51#H = (C) TOB 21X/P82=2/3/4;REV CD<9001,>9044  
 51#I = (C) TOB 21X/P82<>2/3/4;REV CD>8999<9045  
 51#J = (C) TOB 21X/REV CD: SVC-FROM DT INVALID  
 51#K = (C) TOB 21X/P82=2/3/4,REV CD = NNX  
 51#L = (C) REV 0762/UNT>48,TOB NOT=12,13,85,83  
 51#M = (C) 21X,RC>9041/<9045,RC<>4/234  
 51#N = (C) 21X,RC>9032/<9042,RC<>4/234  
 51#O = (C) TWO ANTI-EMETIC/ANTI-CANCER DRUGS  
 ON SAME CLAIM  
 51#P = (C) HHA/OUTPATIENT RC DATE OF SRVC MISSING  
 51#Q = (C) NO RC 0636 OR DTE INVALID  
 51#R = (C) DEMO ID=01,RIC NOT=2  
 51#S = (C) DEMO ID=01,RUGS<>2,3,4 OR BILL<>21  
 51#V = (C) TOB 72X W HCPCS 'J1955' MISSING REVENUE  
 CENTER 636  
 51#W = (C) TOB 12X, 13X, 22X, 23X, 34X, 74X, 75X,  
 83X, HCPCS '97504', '97116', PRESENT  
 ON SAME DAY  
 51#X = (C) TOB '32X-34X' REQUIRE HCPCS FOR REVENUE  
 CODE '29X', '60X', '636'

51X0 = (C) REV CENTER CODE INVALID  
51X1 = (C) REV CODE CHECK  
51X2 = (C) REV CODE INCOMPATIBLE BILL TYPE  
51X3 = (C) UNITS MUST BE > 0  
51X4 = (C) INP:CHGS/YR-RATE,ETC; OUTP:PSYCH>YR  
51X5 = (C) REVENUE NON-COVERED > TOTAL CHRGE  
51X6 = (C) REV TOTAL CHARGES EQUAL ZERO  
51X7 = (C) REV CDE 403 WTH NO BILL 14 23 71 85  
51X8 = (C) MAMMOGRAPHY SUBMISSION INVALID  
51X9 = (C) HCPCS/REV CODE/BILL TYPE  
5100 = (U) TRANSITION SPELL / SNF  
5160 = (U) LATE CHG HSP BILL STAY DAYS > 0  
5166 = (U) PROVIDER NE TO 1ST WORK PRVDR  
5167 = (U) PROVIDER 1 NE 2: FROM DT < START DT  
5168 = (E) CLAIM IN HOSPICE WITH 2ND START DATE  
PRESENT  
5169 = (U) PROVIDER NE TO WORK PROVIDER  
5170 = (E) OCCURRENCE CODE = 42 AND < DOLBA  
5177 = (U) PROVIDER NE TO WORK PROVIDER  
5178 = (U) HOSPICE BILL THRU < DOLBA  
5181 = (U) HOSP BILL OCCR 27 DISCREPANCY  
5200 = (E) ENTITLEMENT EFFECTIVE DATE  
5201 = (U) HOSP DATE DIFFERENCE NE 60 OR 90  
5202 = (E) ENTITLEMENT HOSPICE EFFECTIVE DATE  
5202 = (U) HOSPICE TRAILER ERROR  
5203 = (E) ENTITLEMENT HOSPICE PERIODS  
5203 = (U) HOSPICE START DATE ERROR  
5204 = (U) HOSPICE DATE DIFFERENCE NE 90  
5205 = (U) HOSPICE DATE DISCREPANCY  
5206 = (U) HOSPICE DATE DISCREPANCY  
5207 = (U) HOSPICE THRU > TERM DATE 2ND  
5208 = (U) HOSPICE PERIOD NUMBER BLANK  
5209 = (U) HOSPICE DATE DISCREPANCY  
5210 = (E) ENTITLEMENT FRM/TRU/END DATES  
5211 = (E) ENTITLEMENT DATE DEATH/THRU  
5212 = (E) ENTITLEMENT DATE DEATH/THRU  
5213 = (E) ENTITLEMENT DATE DEATH MBR  
5220 = (E) ENTITLEMENT FROM/EFF DATES  
5225 = (E) ENT INP PPS SPAN 70 DATES  
5232 = (E) ENTL HMO NO HMO OVERRIDE CDE  
5233 = (E) ENTITLEMENT HMO PERIODS  
5234 = (E) ENTITLEMENT HMO NUMBER NEEDED  
5235 = (E) ENTITLEMENT HMO HOSP+NO CC07  
5236 = (E) ENTITLEMENT HMO HOSP + CC07  
5237 = (E) ENTITLEMENT HOSP OVERLAP  
5238 = (U) HOSPICE CLAIM OVERLAP > 90  
5239 = (U) HOSPICE CLAIM OVERLAP > 60  
524Z = (E) HOSP OVERLAP NO OVD NO DEMO  
5240 = (U) HOSPICE DAYS STAY+USED > 90  
5241 = (U) HOSPICE DAYS STAY+USED > 60

5242 = (C) INVALID CARRIER FOR RRB  
 5243 = (C) HMO=90091,INVALID SERVICE DTE  
 5244 = (E) DEMO CABG/PCOE MISSING ENTL  
 5245 = (C) INVALID CARRIER FOR NON RRB  
 525Z = (E) HMO/HOSP 6/7 NO OVD NO DEMO  
 5250 = (U) HOSPICE DOEBA/DOLBA  
 5255 = (U) HOSPICE DAYS USED  
 5256 = (U) HOSPICE DAYS USED > 999  
 526Y = (E) HMO/HOSP DEMO 5/15 REIMB > 0  
 526Z = (E) HMO/HOSP DEMO 5/15 REIMB = 0  
 5270 = (C) CONDITION CODE = 30 AND HMO REQUIRES  
 MODIFIER = 'QV' OR 'KZ'/DED IND  
 5271 = (C) RISK HMO NOT PRESENT AND MOD 'KZ'/  
 OR CONDITION CODE 78 PRESENT  
 527Y = (E) HMO/HOSP DEMO OVD=1 REIMB > 0  
 527Z = (E) HMO/HOSP DEMO OVD=1 REIMB = 0  
 5299 = (U) HOSPICE PERIOD NUMBER ERROR  
 52#K = (C) HCPCS VS DIAGNOSIS  
 52#L = (C) HCPCS VS MODIFIER  
 52#M = (C) HCPCS VS DATES OF SERVICE  
 52#N = (C) TOB '71X' OR '73X' WITH REVENUE  
 CENTER CODE 0403 MISSING REVENUE  
 CENTER CODE 0521  
 52#O = (C) REVENUE CENTER CODE 0022/0024 WITH  
 CHARGES >0  
 52#P = (C) REVENUE CENTER CODE 010X-021X MINUS  
 18X <> 0022  
 52#Q = (C) REVENUE CENTER CODE 0022 AND HIPPS  
 MISSING  
 52#R = (C) REVENUE CENTER CODE 0022 MISSING DATE  
 OF SERVICE  
 52#T = (C) REVENUE CENTER CODE 0022 MISSING REVENUE  
 CENTER CODE 042X-044X  
 5320 = (U) BILL > DOEBA AND IND-1 = 2  
 5350 = (U) HOSPICE DOEBA/DOLBA SECONDARY  
 5355 = (U) HOSPICE DAYS USED SECONDARY  
 5362 = (C) MAMMOGRAPHY AND BENE <35  
 5378 = (C) SERVICE DATE < AGE 50  
 5379 = (C) HCPCS 'G0160' PRESENT MORE THAN  
 ONCE  
 5381 = (C) HCPCS 'G0161' PRESENT MORE THAN  
 ONCE  
 5382 = (C) HCPCS 'G0102-03' AND BENE <50  
 538Q = (C) SERVICE DATES WITHIN ALIEN RECORD  
 5397 = (C) DEMO '37' AND NOT CAT 74  
 5398 = (C) HCPCS 'G9001-G9005 & G9009-G9011 >1  
 OR 2 ARE PRESENT  
 5399 = (U) HOSPICE PERIOD NUM MATCH  
 539A = (C) HCPCS 'G9008' PRESENT MORE THAN ONCE  
 539C = (C) HCPCS 'G9013-G9015' PRESENT MORE THAN

ONCE OR 2 PRESENT  
 5410 = (U) INPAT DEDUCTABLE  
 5425 = (U) PART B DEDUCTABLE CHECK  
 5430 = (U) PART B DEDUCTABLE CHECK  
 5450 = (U) PART B COMPARE MED EXPENSE  
 5460 = (U) PART B COMPARE MED EXPENSE  
 5499 = (U) MED EXPENSE TRAILER MISSING  
 5500 = (U) FULL DAYS/SNF-HOSP FULL DAYS  
 5510 = (U) COIN DAYS/SNF COIN DAYS  
 5515 = (U) FULL DAYS/COIN DAYS  
 5516 = (U) SNF FULL DAYS/SNF COIN DAYS  
 5520 = (U) LIFE RESERVE DAYS  
 5530 = (U) UTIL DAYS/LIFE PSYCH DAYS  
 5540 = (U) HH VISITS NE AFT PT B TRLR  
 5550 = (E) SNF LESS THAN PT A EFF DATE  
 5600 = (D) LOGICAL DUPE, COVERED  
 5601 = (D) LOGICAL DUPE, QRY-CDE, RIC 123  
 5602 = (D) LOGICAL DUPE, PANDE C, E OR I  
 5603 = (D) LOGICAL DUPE, COVERED  
 5604 = (D) LOGICAL DUPE, DATES  
 5605 = (D) POSS DUPE, OUTPAT REIMB  
 5606 = (D) POSS DUPE, HOME HEALTH COVERED U  
 5623 = (U) NON-PAY CODE IS P  
 57X1 = (C) PROVIDER SPECIALITY CODE INVALID  
 57X2 = (C) PHYS THERAPY/PROVIDER SPEC INVAL  
 57X3 = (C) PLACE/TYPE/SPECIALTY/REIMB IND  
 57X4 = (C) SPECIALTY CODE VS. HCPCS INVALID  
 57X5 = (C) HCPCS 98940-2 MODIFIER NOT = 'AT'  
 5700 = (U) LINKED TO THREE SPELLS  
 5701 = (C) DEMO ID=02,RIC NOT = 5  
 5702 = (C) DEMO ID=02,INVALID PROVIDER NUM  
 58X1 = (C) PROVIDER TYPE INVALID  
 58X9 = (C) TYPE OF SERVICE INVALID  
 5802 = (C) REIMB > \$150,000  
 5803 = (C) UNITS/VISITS > 150  
 5804 = (C) UNITS/VISITS > 99  
 5805 = (C) OUTPATIENT CHARGE > \$150,000  
 5806 = (C) REVENUE CENTER CODE '042X-044X'  
 WITHOUT MODIFIER 'GN-GP'  
 58#4 = (C) REVENUE CENTER CODE MISSING REQUIRED  
 HCPCS OR MODIFIER  
 59XA = (C) PROST ORTH HCPCS/FROM DATE  
 59XB = (C) HCPCS/FROM DATE/TYPE P OR I  
 59XC = (C) HCPCS Q0036,37,42,43,46/FROM DATE  
 59XD = (C) HCPCS Q0038-41/FROM DATE/TYPE  
 59XE = (C) HCPCS/MAMMOGRAPHY-RISK/ DIAGNOSIS  
 59XG = (C) INVALID TOS FOR DME  
 59XH = (C) HCPCS E0620/TYPE/DATE  
 59XI = (C) HCPCS E0627-9/ DATE < 1991  
 59XJ = (C) GLOBAL HCPCS TOS MUST = 2

59XK = (C) HCPCS PEN PUMP AND TOS <>9  
 59XL = (C) HCPCS 00104 - TOS/POS  
 59X1 = (C) INVALID HCPCS/TOS COMBINATION  
 59X2 = (C) ASC IND/TYPE OF SERVICE INVALID  
 59X3 = (C) TOS INVALID TO MODIFIER  
 59X4 = (C) KIDNEY DONOR/TYPE/PLACE/REIMB  
 59X5 = (C) MAMMOGRAPHY FOR MALE  
 59X6 = (C) DRUG AND NON DRUG BILL LINE ITEMS  
 59X7 = (C) CAPPED-HCPCS/FROM DATE  
 59X8 = (C) FREQUENTLY MAINTAINED HCPCS  
 59X9 = (C) HCPCS E1220/FROM DATE/TYPE IS R  
 5901 = (U) ERROR CODE OF Q  
 5A#1 = (C) DEMO=37, UNITS >1 FOR 'G9001-05'  
           'G9007-11', G9013-G9015'  
 60X1 = (C) ASSIGN IND INVALID  
 6000 = (U) ADJUSTMENT BILL SPELL DATA  
 6020 = (U) CURRENT SPELL DOEBA < 1990  
 6030 = (U) ADJUSTMENT BILL SPELL DATA  
 6035 = (U) ADJUSTMENT BILL THRU DTE/DOLBA  
 61X1 = (C) PAY PROCESS IND INVALID  
 61X2 = (C) DENIED CLAIM/NO DENIED LINE  
 61X3 = (C) PAY PROCESS IND/ALLOWED CHARGES  
 61X4 = (C) RATE MISSING OR NON-NUMERIC  
 61#E = (C) PROVIDER PAYMENT INCONSISTENCIES  
 61#F = (C) BENEFICIARY PAYMENT INCONSISTENCIES  
 61#G = (C) PATIENT RESPONSIBILITY INCONSISTENCIES  
 61#H = (C) MEDICARE PAYMENT INCONSISTENCIES  
 61#I = (C) LINE DATE OF SERVICE < FROM DATE  
           > THRU DATE  
 61#J = (C) DUPLICATE HCPCS CODE '55873'  
 61#K = (C) HCPCS 'G0117-8' >2 OR BOTH PRESENT  
 61#L = (C) REVENUE CENTER CODE 0024 > 2  
 61#M = (C) REVENUE CENTER CODE 0024 VS PROVIDER  
           NUMBER  
 61#N = (C) REVENUE CENTER CODE 0024 REQUIRES  
           VALID HIPPS RATE CMG CODE  
 61#R = (C) HCPCS/TOB/REVENUE CENTER CODE  
 61#S = (C) HCPCS 'G0247' REQUIRES 'G0245-6' TO  
           BE COVERED  
 61#T = (C) HCPCS CODE '0245-0246' PRESENT MULTIPLE  
           TIMES  
 61#0 = (C) REVENUE CENTER CODE VS SPAN CODE '74'  
 61#6 = (C) PAYMENT METHOD INVALID  
 61#7 = (C) ANSI CODE MISSING  
 61#8 = (C) BLOOD CASH DEDUCTIBLE INCONSISTENCIES  
 61#9 = (C) CASH DEDUCTIBLE INCONSISTENCIES  
 6100 = (C) REV 0001 NOT PRESENT ON CLAIM  
 6101 = (C) REV COMPUTED CHARGES NOT=TOTAL  
 6102 = (C) REV COMPUTED NON-COVERED/NON-COV  
 6103 = (C) REV TOTAL CHARGES < PRIMARY PAYER

6105 = (C) REVE CODE 0001 > 1  
6106 = TOB 3X2 REVENUE CENTER CODE 0023 NOT =  
TOTAL CHARGE  
6109 = (C) REIMBURSEMENT > 4 OR 6 TIMES  
62XA = (C) PSYC OT PT/REIM/TYPE  
62XC = (C) DEMO 37 WITH REIMBURSEMENT/DED IND  
<>1  
62X1 = (C) DME/DATE/100% OR INVAL REIMB IND  
62X6 = (C) RAD PATH/PLACE/TYPE/DATE/DED  
62X8 = (C) KIDNEY DONO/TYPE/100%  
62X9 = (C) PNEUM VACCINE/TYPE/100%  
6201 = (C) TOTAL DEDUCT > CHARGES/NON-COV  
6203 = (U) HOSPICE ADJUSTMENT PERIOD/DATE  
6204 = (U) HOSPICE ADJUSTMENT THRU>DOLBA  
6260 = (U) HOSPICE ADJUSTMENT STAY DAYS  
6261 = (U) HOSPICE ADJUSTMENT DAYS USED  
6265 = (U) HOSPICE ADJUSTMENT DAYS USED  
6269 = (U) HOSPICE ADJUSTMENT PERIOD# (MAIN)  
63X1 = (C) DEDUCT IND INVALID  
63X2 = (C) DED/HCFA COINS IN PCOE/CABG  
6365 = (U) HOSPICE ADJUSTMENT SECONDARY DAYS  
6369 = (U) HOSPICE ADJUSTMENT PERIOD# (SECOND)  
64X1 = (C) PROVIDER IND INVALID  
6430 = (U) PART B DEDUCTABLE CHECK  
65X1 = (C) PAYSCREEN IND INVALID  
66?? = (D) POSS DUPE, CR/DB, DOC-ID  
66XX = (D) POSS DUPE, CR/DB, DOC-ID  
66X1 = (C) UNITS AMOUNT INVALID  
66X2 = (C) UNITS IND > 0; AMT NOT VALID  
66X3 = (C) UNITS IND = 0; AMT > 0  
66X4 = (C) MT INDICATOR/AMOUNT  
66X7 = (C) DEMO 37/HCPCS/UNITS  
6600 = (U) ADJUSTMENT BILL FULL DAYS  
6610 = (U) ADJUSTMENT BILL COIN DAYS  
6620 = (U) ADJUSTMENT BILL LIFE RESERVE  
6630 = (U) ADJUSTMENT BILL LIFE PSYCH DYS  
67X1 = (C) UNITS INDICATOR INVALID  
67X2 = (C) CHG ALLOWED > 0; UNITS IND = 0  
67X3 = (C) TOS/HCPCS=ANEST, MTU IND NOT = 2  
67X4 = (C) HCPCS = AMBULANCE, MTU IND NOT = 1  
67X6 = (C) INVALID PROC FOR MT IND 2, ANEST  
67X7 = (C) INVALID UNITS IND WITH TOS OF BLOOD  
67X8 = (C) INVALID PROC FOR MT IND 4, OXYGEN  
6700 = (U) ADJUSTMENT BILL FULL/SNF DAYS  
6710 = (U) ADJUSTMENT BILL COIN/SNF DAYS  
68XA = (C) HCPCS G0117-8 >1 OR BOTH PRESENT  
68XB = (C) HCPCS CODE G0245-46 > 1  
68X1 = (C) INVALID HCPCS CODE  
68X2 = (C) MAMMOGRAPY/DATE/PROC NOT 76092  
68X3 = (C) TYPE OF SERVICE = G /PROC CODE

68X4 = (C) HCPCS NOT VALID FOR SERVICE DATE  
 68X5 = (C) MODIFIER NOT VALID FOR HCPCS, ETC  
 68X6 = (C) TYPE SERVICE INVALID FOR HCPCS, ETC  
 68X7 = (C) ZX MOD REQ FOR THER SHOES/INS/MOD.  
 68X8 = (C) ANTI-EMETIC WITHOUT ANTI-CANCER DRUG  
 6812 = (C) DEMO 37 WITH PRIMARY PAYER CODE  
 69XA = (C) MODIFIER NOT VALID FOR HCPCS/GLOBAL  
 69XB = (C) HCPCS CODE 97504/97116 PRESENT ON  
 SAME DAY  
 69XC = (C) HCPCS CODE VS PAY PROCESS INDICATOR  
 69X3 = (C) PROC CODE MOD = LL / TYPE = R  
 69X6 = (C) PROC CODE MOD/NOT CAPPED  
 69X8 = (C) SPEC CODE NURSE PRACT, MOD INVAL  
 69X9 = (C) NURSE PRACTITIONER, MOD INVALID  
 6901 = (C) KRON IND AND UTIL DYS EQUALS ZERO  
 6902 = (C) KRON IND AND NO-PAY CODE B OR N  
 6903 = (C) KRON IND AND INPATIENT DEDUCT = 0  
 6904 = (C) KRON IND AND TRANS CODE IS 4  
 6910 = (C) REV CODES ON HOME HEALTH  
 6911 = (C) REV CODE 274 ON OUTPAT AND HH ONLY  
 6912 = (C) REV CODE INVAL FOR PROSTH AND ORTHO  
 6913 = (C) REV CODE INVAL FOR OXYGEN  
 6914 = (C) REV CODE INVAL FOR DME  
 6915 = (C) PURCHASE OF RENT DME INVAL ON DATES  
 6916 = (C) PURCHASE OF RENT DME INVAL ON DATES  
 6917 = (C) PURCHASE OF LIFT CHAIR INVAL > 91000  
 6918 = (C) HCPCS INVALID ON DATE RANGES  
 6919 = (C) DME OXYGEN ON HH INVAL BEFORE 7/1/89  
 6920 = (C) HCPCS INVAL ON REV 270/BILL 32-33  
 6921 = (C) HCPCS ON REV CODE 272 BILL TYPE 83X  
 6922 = (C) HCPCS ON BILL TYPE 83X -NOT REV 274  
 6923 = (C) RENTAL OF DME CUSTOMIZE AND REV 291  
 6924 = (C) INVAL MODIFIER FOR CAPPED RENTAL  
 6925 = (C) HCPCS ALLOWED ON BILL TYPES 32X-34X  
 6929 = (U) ADJUSTMENT BILL LIFE RESERVE  
 6930 = (U) ADJUSTMENT BILL LIFE PSYCH DYS  
 7000 = (U) INVALID DOEBA/DOLBA  
 7002 = (U) LESS THAN 60/61 BETWEEN SPELLS  
 7010 = (E) TOB 85X/ELECTN PRD: COND CD 07 REQD  
 71X1 = (C) SUBMITTED CHARGES INVALID  
 71X2 = (C) MAMMOGRPY/PROC CODE MOD TC,26/CHG  
 71X3 = (C) HCPCS 76092 PAY INDICATOR <> A,R,S  
 & 76085 PAY INDICATOR A,R,S  
 72X1 = (C) ALLOWED CHGS INVALID  
 72X2 = (C) ALLOWED/SUBMITTED CHARGES/TYPE  
 72X3 = (C) DENIED LINE/ALLOWED CHARGES  
 7230 = (C) FRAMES >1, LENSES >2  
 73X1 = (C) SS NUMBER INVALID  
 73X2 = (C) CARRIER ASSIGNED PROV NUM MISSING  
 74X1 = (C) LOCALITY CODE INVAL FOR CONTRACT

76X1 = (C) PL OF SER INVAL ON MAMMOGRAPHY BILL  
77X1 = (C) PLACE OF SERVICE INVALID  
77X2 = (C) PHYS THERAPY/PLACE  
77X3 = (C) PHYS THERAPY/SPECIALTY/TYPE  
77X4 = (C) ASC/TYPE/PLACE/REIMB IND/DED IND  
77X6 = (C) TOS=F, PL OF SER NOT = 24  
7701 = (C) INCORRECT MODIFIER  
7777 = (D) POSS DUPE, PART B DOC-ID  
78XA = (C) MAMMOGRAPHY BEFORE 1991  
78XB = (C) ANTI-CANCER BEFORE 01/01/1998  
78X1 = (C) FROM DATE IMPOSSIBLE  
78X2 = (C) FROM DATE > CURRENT DATE OR  
    < 07/01/1966  
78X3 = (C) FROM DATE GREATER THAN THRU DATE  
78X4 = (C) FROM DATE > RCVD DATE/PAY-DENY  
78X5 = (C) FROM DATE > PAID DATE/TYPE/100%  
78X7 = (C) LAB EDIT/TYPE/100%/FROM DATE  
79X1 = (C) THRU DATE IMPOSSIBLE  
79X2 = (C) THRU DATE > CURRENT DATE  
79X3 = (C) THRU DATE>RECD DATE/NOT DENIED  
79X4 = (C) THRU DATE>PAID DATE/NOT DENIED  
8000 = (U) MAIN & 2NDARY DOEBA < 01/01/90  
8028 = (E) NO ENTITLEMENT  
8029 = (U) HH BEFORE PERIOD NOT PRESENT  
8030 = (U) HH BILL VISITS > PT A REMAINING  
8031 = (U) HH PT A REMAINING > 0  
8032 = (U) HH DOLBA+59 NOT GT FROM-DATE  
8050 = (U) HH QUALIFYING INDICATOR = 1  
8051 = (U) HH # VISITS NE AFT PT B APPLIED  
8052 = (U) HH # VISITS NE AFT TRAILER  
8053 = (U) HH BENEFIT PERIOD NOT PRESENT  
8054 = (U) HH DOEBA/DOLBA NOT > 0  
8060 = (U) HH QUALIFYING INDICATOR NE 1  
8061 = (U) HH DATE NE DOLBA IN AFT TRLR  
8062 = (U) HH NE PT-A VISITS REMAINING  
81X1 = (C) NUM OF SERVICES INVALID  
83X1 = (C) DIAGNOSIS INVALID  
8301 = (C) HCPCS/GENDER DIAGNOSIS  
8302 = (C) HCPCS G0101 V-CODE/SEX CODE  
8303 = (C) HCPCS/GENDER  
8304 = (C) BILL TYPE INVALID FOR G0123/4  
8305 = (C) HCPCS/SERVICE DATES/GENDER  
84X1 = (C) PAP SMEAR/DIAGNOSIS/GENDER/PROC  
84X2 = (C) INVALID DME START DATE  
84X3 = (C) INVALID DME START DATE W/HCPCS  
84X4 = (C) HCPCS G0101 V-CODE/SEX CODE  
84X5 = (C) HCPCS CODE WITH INV DIAG CODE  
84X6 = (C) HCPCS/GENDER  
84X7 = (C) HCPCS/SERVICE DATES/GENDER  
84X8 = (C) DUPLICATE HCPCS



86X1 = (C) CLINICAL LAB HCPCS W/O CLINICAL  
LAB ID  
86X2 = (C) NON-WAIVER HCPCS/PAY DENIAL CODE/  
MODIFIER  
86X8 = (C) CLIA REQUIRES NON-WAIVER HCPCS  
88XX = (D) POSS DUPE, DOC-ID,UNITS,ENT,ALWD  
9000 = (U) DOEBA/DOLBA CALC  
9005 = (U) FULL/COINS HOSP DAYS CALC  
9010 = (U) FULL/COINS SNF DAYS CALC  
9015 = (U) LIFE RESERVE DAYS CALC  
9020 = (U) LIFE PSYCH DAYS CALC  
9030 = (U) INPAT DEDUCTABLE CALC  
9040 = (U) DATA INDICATOR 1 SET  
9050 = (U) DATA INDICATOR 2 SET  
91X1 = (C) PATIENT REIMB/PAY-DENY CODE  
92X1 = (C) PATIENT REIMB INVALID  
92X2 = (C) PROVIDER REIMB INVALID  
92X3 = (C) LINE DENIED/PATIENT-PROV REIMB  
92X4 = (C) MSP CODE/AMT/DATE/ALLOWED CHARGES  
92X5 = (C) CHARGES/REIMB AMT NOT CONSISTANT  
92X7 = (C) REIMB/PAY-DENY INCONSISTANT  
9201 = (C) UPIN REF NAME OR INITIAL MISSING  
9202 = (C) UPIN REF FIRST 3 CHAR INVALID  
9203 = (C) UPIN REF LAST 3 CHAR NOT NUMERIC  
93X1 = (C) CASH DEDUCTABLE INVALID  
93X2 = (C) DEDUCT INDICATOR/CASH DEDUCTIBLE  
93X3 = (C) DENIED LINE/CASH DEDUCTIBLE  
93X4 = (C) FROM DATE/CASH DEDUCTIBLE  
93X5 = (C) TYPE/CASH DEDUCTIBLE/ALLOWED CHGS  
9300 = (C) UPIN OTHER, NOT PRESENT  
9301 = (C) UPIN NME MIS/DED TOT LI>0 FR DEN CLM  
9302 = (C) UPIN OPERATING, FIRST 3 NOT NUMERIC  
9303 = (C) UPIN L 3 CH NT NUM/DED TOT LI>YR DED  
9351 = (C) OTHER UPIN PRESENT/MISSING OTHER FIELDS  
9352 = (C) OTHER UPIN INVALID  
9353 = (C) OTHER UPIN INVALID  
94A1 = (C) NON-COVERED FROM DATE INVALID  
94A2 = (C) NON-COVERED FROM > THRU DATE  
94A3 = (C) NON-COVERED THRU DATE INVALID  
94A4 = (C) NON-COVERED THRU DATE > ADMIT  
94A5 = (C) NON-COVERED THRU DATE/ADMIT DATE  
94C1 = (C) PR-PSYCH DAYS INVALID  
94C3 = (C) PR-PSYCH DAYS > PROVIDER LIMIT  
94F1 = (C) REIMBURSEMENT AMOUNT INVALID  
94F2 = (C) REIMBURSE AMT NOT 0 FOR HMO PAID  
94G1 = (C) NO-PAY CODE INVALID  
94G2 = (C) NO-PAY CODE SPACE/NON-COVERD=TOTL  
94G3 = (C) NO-PAY/PROVIDER INCONSISTANT  
94G4 = (C) NO PAY CODE = R & REIMB PRESENT  
94X1 = (C) BLOOD LIMIT INVALID

94X2 = (C) TYPE/BLOOD DEDUCTIBLE  
94X3 = (C) TYPE/DATE/LIMIT AMOUNT  
94X4 = (C) BLOOD DED/TYPE/NUMBER OF SERVICES  
94X5 = (C) BLOOD/MSP CODE/COMPUTED LINE MAX  
9401 = (C) BLOOD DEDUCTIBLE AMT > 3  
9402 = (C) BLOOD FURNISHED > DEDUCTIBLE  
9403 = (C) DATE OF BIRTH MISSING ON PRO-PAY  
9404 = (C) INVALID GENDER CODE ON PRO-PAY  
9407 = (C) INVALID DIAGNOSIS  
9408 = (C) INVALID DRG NUMBER (GLOBAL)  
9409 = (C) HCFA DRG<>DRG ON BILL  
940X = (C) INVALID DRG  
9410 = (C) CABG/PCOE,INVALID DRG  
95X1 = (C) MSP CODE G/DATE BEFORE 1/1/87  
95X2 = (C) MSP AMOUNT APPLIED INVALID  
95X3 = (C) MSP AMOUNT APPLIED > SUB CHARGES  
95X4 = (C) MSP PRIMARY PAY/AMOUNT/CODE/DATE  
95X5 = (C) MSP CODE = G/DATE BEFORE 1987  
95X6 = (C) MSP CODE = X AND NOT AVOIDED  
95X7 = (C) MSP CODE VALID, CABG/PCOE  
96X1 = (C) OTHER AMOUNTS INVALID  
96X2 = (C) OTHER AMOUNTS > PAT-PROV REIMB  
97X1 = (C) OTHER AMOUNTS INDICATOR INVALID  
97X2 = (C) GRUDMAN SW/GRUDMAN AMT NOT > 0  
98X1 = (C) COINSURANCE INVALID  
98X3 = (C) MSP CODE/TYPE/COIN AMT/ALLOW/CSH  
98X4 = (C) DATE/MSP/TYPE/CASH DED/ALLOW/COI  
98X5 = (C) DATE/ALLOW/CASH DED/REIMB/MSP/TYP  
9801 = (C) REV CENTER CODE 0910 WITH SERVICE  
DATE > 10/15/2004  
99XX = (D) POSS DUPE, PART B DOC-ID  
9901 = (C) REV CODE INVALID OR TRAILER CNT=0  
9902 = (C) ACCOMMODATION DAYS/FROM/THRU DATE  
9903 = (C) NO CLINIC VISITS FOR RHC  
9904 = (C) INCOMPATIBLE DATES/CLAIM TYPE  
991X = (C) NO DATE OF SERVICE  
9910 = (C) BLOOD DEDUCTIBLE NON NUMERIC  
9911 = (C) BLOOD DEDUCTIBLE PRESENT WITHOUT  
BLOOD FURNISHED  
9920 = (C) CASH DEDUCTIBLE INVALID  
9930 = (C) COINSURANCE INVALID  
9931 = (C) OUTPAT COINSURANCE VALUES  
9933 = (C) RATE 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



D = Record format as of January 1992  
E = Record format as of March 1992  
F = Record format as of May 1992  
G = Record format as of October 1993  
H = Record format as of September 1998  
I = Record format as of July 2000  
J = Record format as of January 2011

NCH\_NEAR\_LINE\_RIC\_TB

NCH Near-Line Record Identification Code Table

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

NCH\_OCRNC\_TRLR\_IND\_TB

NCH Occurrence Trailer Indicator Table

O = Occurrence code trailer present

NCH\_PATCH\_TB

NCH Patch Table

01 = RRB Category Equatable BIC - changed (all  
claim types) -- applied during the Nearline  
'G' conversion to claims with NCH weekly  
process date before 3/91. Prior to Version  
'H', patch indicator stored in redefined Claim  
Edit Group, 3rd occurrence, position 2.  
02 = Claim Transaction Code made consistent with  
NCH payment/edit RIC code (OP and HHA) --  
effective 3/94, CWFMQA began patch. During  
'H' conversion, patch applied to claims with  
NCH weekly process date prior to 3/94. Prior

to version 'H', patch indicator stored in redefined Claim Edit Group, 4th occurrence, position 1.

- 03 = Garbage/nonnumeric Claim Total Charge Amount set to zeroes (Instnl) -- during the Version 'G' conversion, error occurred in the derivation of this field where the claim was missing revenue center code = '0001'. In 1994, patch was applied to the OP and HHA SAFs only. (This SAF patch indicator was stored in the redefined Claim Edit Group, 4th occurrence, position 2). During the 'H' conversion, patch applied to Nearline claims where garbage or nonnumeric values.
- 04 = Incorrect bene residence SSA standard county code '999' changed (all claim types) -- applied during the Nearline 'G' conversion and ongoing through 4/21/94, calling EQSTZIP routine to claims with NCH weekly process date prior to 4/22/94. Prior to Version 'H' patch indicator stored in redefined Claim Edit Group, 3rd occurrence, position 4.
- 05 = Wrong century bene birth date corrected (all claim types) -- applied during Nearline 'H' conversion to all history where century greater than 1700 and less than 1850; if century less than 1700, zeroes moved.
- 06 = Inconsistent CWF bene medicare status code made consistent with age (all claim types) -- applied during Nearline 'H' conversion to all history and patched ongoing. Bene age is calculated to determine the correct value; if greater than 64, 1st position MSC = '1'; if less than 65, 1st position MSC = '2'.
- 07 = Missing CWF bene medicare status code derived (all claim types) -- applied during Nearline 'H' conversion to all history and patched ongoing, except claims with unknown DOB and/or Claim From Date='0' (left blank). Bene age is calculated to determine missing value; if greater than 64, MSC='10'; if less than 65, MSC = '20'.
- 08 = Invalid NCH primary payer code set to blanks (Instnl) -- applied during Version 'H' conversion to claims with NCH weekly process date 10/1/93-10/30/95, where MSP values = invalid '0', '1', '2', '3' or '4' (caused by erroneous logic in HCFA program code, which was corrected on 11/1/95).
- 09 = Zero CWF claim accretion date replaced with

- NCH weekly process date (all claim types)  
-- applied during Version 'H' conversion to  
Instnl and DMERC claims; applied during  
Version 'G' conversion to non-institutional  
(non-DMERC) claims. Prior to Version 'H',  
patch indicator stored in redefined claim  
edit group, 3rd occurrence, position 1.
- 10 = Multiple Revenue Center 0001 (Outpatient,  
HHA and Hospice) -- patch applied to 1998 &  
1999 Nearline and SAFs to delete any revenue  
codes that followed the first '0001' revenue  
center code. The edit was applied across all  
institutional claim types, including Inpatient/  
SNF (the problem was only found with OP/HHA/  
Hospice claims). The problem was corrected  
6/25/99.
- 11 = Truncated claim total charge amount in the  
fixed portion replaced with the total charge  
amount in the revenue center 0001 amount field  
-- service years 1998 & 1999 patched during  
quarterly merge. The 1998 & 1999 SAFs were  
corrected when finalized in 7/99. The patch  
was done for records with NCH Daily Process  
Date 1/4/99 - 5/14/99.
- 12 = Missing claim-level HHA Total Visit Count --  
service years 1998, 1999 & 2000 patch applied  
during Version 'I' conversion of both the  
Nearline and SAFs. Problem occurs in those  
claims recovered during the missing claims  
effort.
- 13 = Inconsistent Claim MCO Paid Switch made consistent  
with criteria used to identify an inpatient  
encounter claim -- if MCO paid switch equal to blank  
or '0' and ALL conditions are met to indicate an  
inpatient encounter claim (bene enrolled in a risk  
MCO during the service period), change the switch to  
a '1'. The patch was applied during the Version 'I'  
conversion, for claims back to 7/1/97 service thru date.
- 14 = SNF claims incorrectly identified as Inpatient  
Encounter claims -- SNF claims matching the Inpatient  
encounter data criteria were incorrectly identified  
as Inpatient encounter claims (claim type code = '61'  
instead of '20' or '30'). NOTE: if the SNF claims  
were identified the MCO paid switch was set to '1'.  
The patch was applied to correctly identify these  
claims as a '20' or '30'. The MCO paid switch will  
be set to '0' as there is no way to recover the original  
value. The problem occurred in claims with an NCH  
Weekly Process Date ranging from 7/7/2000 - 1/26/2001.

The patch applied date is 03/30/2001.

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

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

The patch applied date is 06/29/2001.

NCH\_PATCH\_TRLR\_IND\_TB

NCH Patch Trailer Indicator Table

P = Patch code trailer present

NCH\_PRCDR\_TRLR\_IND\_TB

NCH Procedure Trailer Indicator Table

Z = Procedure code trailer present

NCH\_PTNT\_STUS\_IND\_TB

NCH Patient Status Indicator Table

A = Discharged

B = Died

C = Still patient

NCH\_REV\_TRLR\_IND\_TB

NCH Revenue Center Trailer Indicator Table

R = Revenue code trailer present

NCH\_SPAN\_TRLR\_IND\_TB

NCH Span Trailer Indicator Table

S = Span code trailer present

NCH\_STATE\_SGMT\_TB

NCH State Segment Table

| NCH State Segment | State Codes                                                                                                                 |
|-------------------|-----------------------------------------------------------------------------------------------------------------------------|
| B =               | 01;02;03;04;06;07;08;09;<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                                                                                                                          |



NCH\_VAL\_TRLR\_IND\_TB

NCH Value Trailer Indicator Table

V = Value code trailer present

PMT\_EDIT\_RIC\_TB

Payment And Edit Record Identification Code Table

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

PRVDR\_NUM\_TB

Provider Number Table

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

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

TOB = 72X  
 1300-1399 Rural Primary Care Hospital (RCPH) -  
 eff. 10/97 changed to Critical Access  
 Hospitals (CAH)  
 1400-1499 Continuation of 4900-4999 series (CMHC)  
 1500-1799 Hospices  
 1800-1989 Federally Qualified Health Centers  
 (FQHC) where TOB = 73X; SNF (IP PTB)  
 where TOB = 22X; HHA where TOB = 32X,  
 33X, 34X  
 1990-1999 Christian Science Sanatoria  
 (hospital services) - eff. 7/00 changed  
 to Religious Nonmedical Health Care  
 Institutions (RNHCI)  
 2000-2299 Long-term hospitals  
 2300-2499 Chronic renal disease facilities  
 (hospital based)  
 2500-2899 Non-hospital renal disease  
 treatment centers  
 2900-2999 Independent special purpose renal  
 dialysis facility (1)  
 3000-3024 Formerly tuberculosis hospitals  
 (numbers retired)  
 3025-3099 Rehabilitation hospitals  
 3100-3199 Continuation of Subunits of Nonprofit  
 and Proprietary Home Health Agencies  
 (7300-7399) Series (3) (eff. 4/96)  
 3200-3299 Continuation of 4800-4899 series (CORF)  
 3300-3399 Children's hospitals (excluded from PPS)  
 where TOB = 11X; ESRD clinic where TOB =  
 72X  
 3400-3499 Continuation of rural health clinics  
 (provider-based) (3975-3999)  
 3500-3699 Renal disease treatment centers  
 (hospital satellites)  
 3700-3799 Hospital based special purpose renal  
 dialysis facility (1)  
 3800-3974 Rural health clinics (free-standing)  
 3975-3999 Rural health clinics (provider-based)  
 4000-4499 Psychiatric hospitals  
 4500-4599 Comprehensive Outpatient  
 Rehabilitation Facilities (CORF)  
 4600-4799 Community Mental Health Centers (CMHC);  
 9/30/91 - 3/31/97 used for clinic OPT  
 where TOB = 74X  
 4800-4899 Continuation of 4500-4599 series (CORF)  
 (eff. 10/95)  
 4900-4999 Continuation of 4600-4799 series (CMHC)  
 (eff. 10/95); 9/30/91 - 3/31/97 used for  
 clinic OPT where TOB = 74X

5000-6499 Skilled Nursing Facilities  
 6500-6989 CMHC / Outpatient physical therapy services  
 where TOB = 74X; CORF where TOB =  
 75X  
 6990-6999 Christian Science Sanatoria (skilled  
 nursing services) - eff. 7/00 Numbers  
 Reserved (formerly CS)  
 7000-7299 Home Health Agencies (HHA) (2)  
 7300-7399 Subunits of 'nonprofit' and  
 'proprietary' Home Health Agencies (3)  
 7400-7799 Continuation of 7000-7299 series  
 7800-7999 Subunits of state and local governmental  
 Home Health Agencies (3)  
 8000-8499 Continuation of 7400-7799 series (HHA)  
 8500-8899 Continuation of rural health  
 center (provider based) (3400-3499)  
 8900-8999 Continuation of rural health  
 center (free-standing) (3800-3974)  
 9000-9799 Continuation of 8000-8499 series (HHA)  
 (eff. 10/95)  
 9800-9899 Transplant Centers (eff. 10/1/07)  
 9900-9999 Reserved for future use (eff. 8/1/98)  
 NOTE: 10/95-7/98 this series was  
 assigned to HHA's but rescinded - no  
 HHA's were ever assigned a number  
 from this series.

Exception:

P001-P999 Organ procurement organization

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

NOTE:

There is a special numbering system for units of hospitals that are excluded from prospective

payment system (PPS) and hospitals with SNF swing-bed designation. An alpha character in the third position of the provider number identifies the type of unit or swing-bed designation as follows:

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

There is also a special numbering system for assigning emergency hospital identification numbers (non participating hospitals). The sixth position of the provider number is as follows:

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

PTNT\_DSCHRG\_STUS\_TB

Patient Discharge Status Table

- 01 = Discharged to home/self care (routine charge).
- 02 = Discharged/transferred to other short term general hospital for inpatient care.
- 03 = Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care -- (For hospitals with an approved swing bed arrangement, use Code 61 - swing bed. For reporting discharges/transfers to a non-certified SNF, the hospital must use Code 04 - ICF.
- 04 = Discharged/transferred to a facility that provides custodial or supportive care (includes intermediate care facilities (ICF)). Also used to designate patients that are discharged/transferred to a nursing facility with neither

- Medicare nor Medicaid certification and for discharges/transfers to Assisted Living Facilities.
- 05 = Discharged/transferred to a designated cancer center or children's hospital (eff. 10/09). Prior to 10/1/09, discharged/transferred to another type of institution for inpatient care (including distinct parts). NOTE: Effective 1/2005, psychiatric hospital or psychiatric distinct part unit of a hospital will no longer be identified by this code. New code is '65'.
  - 06 = Discharged/transferred to home care of organized home health service organization in anticipation of covered skilled care.
  - 07 = Left against medical advice or discontinued care.
  - 08 = Discharged/transferred to home under care of a home IV drug therapy provider. (discontinued effective 10/1/05)
  - 09 = Admitted as an inpatient to this hospital (effective 3/1/91). In situations where a patient is admitted before midnight of the third day following the day of an outpatient service, the outpatient services are considered inpatient.
  - 20 = Expired
  - 21 = Discharged/transferred to Court/Law Enforcement.
  - 30 = Still patient.
  - 40 = Expired at home (Hospice claims only).
  - 41 = Expired in a medical facility such as hospital, SNF, ICF, or freestanding hospice. (Hospice claims only)
  - 42 = Expired - place unknown (Hospice claims only)
  - 43 = Discharged/transferred to a federal hospital (eff. 10/1/03). Discharges and transfers to a government operated health facility such as a Department of Defense hospital, a Veteran's Administration hospital or a Veteran's Administration nursing facility. To be used whenever the destination at discharge is a federal health care facility, whether the patient lives there or not.
  - 50 = Hospice - home (eff. 10/96)
  - 51 = Hospice - medical facility (certified) providing hospice level of care
  - 61 = Discharged/transferred within this institution to a hospital-based Medicare approved swing bed (eff. 9/01)
  - 62 = Discharged/transferred to an inpatient rehabilitation facility including distinct

parts units of a hospital.  
(eff. 1/2002)

63 = Discharged/transferred to a Medicare certified  
long term care hospital. (eff. 1/2002)

64 = Discharged/transferred to a nursing facility  
certified under Medicaid but not certified under  
Medicare (eff. 10/2002)

65 = Discharged/Transferred to a psychiatric  
hospital or psychiatric distinct unit of a  
hospital (these types of hospitals were  
pulled from patient/discharge status code  
'05' and given their own code). (eff. 1/2005).

66 = Discharged/transferred to a Critical Access  
Hospital (CAH) (eff. 1/1/06)

70 = Discharged/transferred to another type of health  
care institution not defined elsewhere in code  
list.

71 = Discharged/transferred/referred to another  
institution for outpatient services as  
specified by the discharge plan of care  
(eff. 9/01) (discontinued effective 10/1/05)

72 = Discharged/transferred/referred to this  
institution for outpatient services as  
specified by the discharge plan of care  
(eff. 9/01) (discontinued effective 10/1/05)

REV\_CNTR\_ANSI\_TB

Revenue Center ANSI Code Table

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

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

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

CR = Corrections and Reversals -- this group code should  
be used for correcting a prior claim. It applies  
when there is a change to a previously adjudicated  
claim.

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

PI = Payer Initiated Reductions -- this group code should  
be used when, in the opinion of the payer, the adjust-  
ment is not the responsibility of the patient, but

there is no supporting contract between the provider and the payer (i.e., medical review or professional review organization adjustments).

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

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

1 = Deductible Amount  
2 = Coinsurance Amount  
3 = Co-pay Amount  
4 = The procedure code is inconsistent with the modifier used or a required modifier is missing.  
5 = The procedure code/bill type is inconsistent with the place of service.  
6 = The procedure code is inconsistent with the patient's age.  
7 = The procedure code is inconsistent with the patient's gender.  
8 = The procedure code is inconsistent with the provider type.  
9 = The diagnosis is inconsistent with the patient's age.  
10 = The diagnosis is inconsistent with the patient's gender.  
11 = The diagnosis is inconsistent with the procedure.  
12 = The diagnosis is inconsistent with the provider type.  
13 = the date of death precedes the date of service.  
14 = The date of birth follows the date of service.  
15 = Claim/service adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.  
16 = Claim/service lacks information which is needed for adjudication.  
17 = Claim/service adjusted because requested information was not provided or was insufficient/incomplete.  
18 = Duplicate claim/service.  
19 = Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.  
20 = Claim denied because this injury/illness is covered by the liability carrier.  
21 = Claim denied because this injury/illness is the liability of the no-fault carrier.  
22 = Claim adjusted because this care may be covered by another payer per coordination of benefits.

23 = Claim adjusted because charges have been paid by another payer.  
24 = Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.  
25 = Payment denied. Your Stop loss deductible has not been met.  
26 = Expenses incurred prior to coverage.  
27 = Expenses incurred after coverage terminated.  
28 = Coverage not in effect at the time the service was provided.  
29 = The time limit for filing has expired.  
30 = Claim/service adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.  
31 = Claim denied as patient cannot be identified as our insured.  
32 = Our records indicate that this dependent is not an eligible dependent as defined.  
33 = Claim denied. Insured has no dependent coverage.  
34 = Claim denied. Insured has no coverage for newborns.  
35 = Benefit maximum has been reached.  
36 = Balance does not exceed copayment amount.  
37 = Balance does not exceed deductible amount.  
38 = Services not provided or authorized by designated (network) providers.  
39 = Services denied at the time authorization/pre-certification was requested.  
40 = Charges do not meet qualifications for emergency/urgent care.  
41 = Discount agreed to in Preferred Provider contract.  
42 = Charges exceed our fee schedule or maximum allowable amount.  
43 = Gramm-Rudman reduction.  
44 = Prompt-pay discount.  
45 = Charges exceed your contracted/legislated fee arrangement.  
46 = This (these) service(s) is(are) not covered.  
47 = This (these) diagnosis(es) is(are) not covered, missing, or are invalid.  
48 = This (these) procedure(s) is(are) not covered.  
49 = These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.  
50 = These are non-covered services because this is not deemed a 'medical necessity' by the payer.  
51 = These are non-covered services because this a pre-existing condition.  
52 = The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.



53 = Services by an immediate relative or a member of the same household are not covered.  
54 = Multiple physicians/assistants are not covered in this case.  
55 = Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.  
56 = Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by payer.  
57 = Claim/service adjusted because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage.  
58 = Claim/service adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.  
59 = Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.  
60 = Charges for outpatient services with the proximity to inpatient services are not covered.  
61 = Charges adjusted as penalty for failure to obtain second surgical opinion.  
62 = Claim/service denied/reduced for absence of, or exceeded, precertification/authorization.  
63 = Correction to a prior claim. INACTIVE  
64 = Denial reversed per Medical Review. INACTIVE  
65 = Procedure code was incorrect. This payment reflects the correct code. INACTIVE  
66 = Blood Deductible.  
67 = Lifetime reserve days. INACTIVE  
68 = DRG weight. INACTIVE  
69 = Day outlier amount.  
70 = Cost outlier amount.  
71 = Primary Payer amount.  
72 = Coinsurance day. INACTIVE  
73 = Administrative days. INACTIVE  
74 = Indirect Medical Education Adjustment.  
75 = Direct Medical Education Adjustment.  
76 = Disproportionate Share Adjustment.  
77 = Covered days. INACTIVE  
78 = Non-covered days/room charge adjustment.  
79 = Cost report days. INACTIVE  
80 = Outlier days. INACTIVE  
81 = Discharges. INACTIVE  
82 = PIP days. INACTIVE  
83 = Total visits. INACTIVE  
84 = Capital adjustments. INACTIVE  
85 = Interest amount. INACTIVE  
86 = Statutory adjustment. INACTIVE  
87 = Transfer amounts.  
88 = Adjustment amount represents collection against

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

123 = Payer refund due to overpayment. INACTIVE  
124 = Payer refund amount - not our patient. INACTIVE  
125 = Claim/service adjusted due to a submission/billing error(s).  
126 = Deductible - Major Medical.  
127 = Coinsurance - Major Medical.  
128 = Newborn's services are covered in the mother's allowance.  
129 = Claim denied - prior processing information appears incorrect.  
130 = Paper claim submission fee.  
131 = Claim specific negotiated discount.  
132 = Prearranged demonstration project adjustment.  
133 = The disposition of this claim/service is pending further review.  
134 = Technical fees removed from charges.  
135 = Claim denied. Interim bills cannot be processed.  
136 = Claim adjusted. Plan procedures of a prior payer were not followed.  
137 = Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.  
138 = Claim/service denied. Appeal procedures not followed or time limits not met.  
139 = Contracted funding agreement - subscriber is employed by the provider of services.  
140 = Patient/Insured health identification number and name do not match.  
141 = Claim adjustment because the claim spans eligible and ineligible periods of coverage.  
142 = Claim adjusted by the monthly Medicaid patient liability amount.  
A0 = Patient refund amount  
A1 = Claim denied charges.  
A2 = Contractual adjustment.  
A3 = Medicare Secondary Payer liability met. INACTIVE  
A4 = Medicare Claim PPS Capital Day Outlier Amount.  
A5 = Medicare Claim PPS Capital Cost Outlier Amount.  
A6 = Prior hospitalization or 30 day transfer requirement not met.  
A7 = Presumptive Payment Adjustment.  
A8 = Claim denied; ungroupable DRG.  
B1 = Non-covered visits.  
B2 = Covered visits. INACTIVE  
B3 = Covered charges. INACTIVE  
B4 = Late filing penalty.  
B5 = Claim/service adjusted because coverage/program guidelines were not met or were exceeded.  
B6 = This service/procedure is adjusted when performed/billed by this type of provider, by this type of facility, or by a provider of this specialty.

B7 = This provider was not certified/eligible to be paid for this procedure/service on this date of service.  
 B8 = Claim/service not covered/reduced because alternative services were available, and should have been utilized.  
 B9 = Services not covered because the patient is enrolled in a Hospice.  
 B10 = Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.  
 B11 = The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.  
 B12 = Services not documented in patients' medical records.  
 B13 = Previously paid. Payment for this claim/service may have been provided in a previous payment.  
 B14 = Claim/service denied because only one visit or consultation per physician per day is covered.  
 B15 = Claim/service adjusted because this procedure/service is not paid separately.  
 B16 = Claim/service adjusted because 'New Patient' qualifications were not met.  
 B17 = Claim/service adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.  
 B18 = Claim/service denied because this procedure code/modifier was invalid on the date of service or claim submission.  
 B19 = Claim/service adjusted because of the finding of a Review Organization. INACTIVE  
 B20 = Charges adjusted because procedure/service was partially or fully furnished by another provider.  
 B21 = The charges were reduced because the service/care was partially furnished by another physician.  
 INACTIVE  
 B22 = This claim/service is adjusted based on the diagnosis.  
 B23 = Claim/service denied because this provider has failed an aspect of a proficiency testing program.  
 W1 = Workers Compensation State Fee Schedule Adjustment.

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

00        =        N/A in this case

01-99 = 1st composite - 99th composite  
A1-A9 = 100th composite - 108th composite  
B1-B9 = 109th composite - 117th composite  
C1-C9 = 118th composite - 126th composite  
D1-D9 = 127th composite - 135th composite  
E1-E9 = 136th composite - 144th composite  
F1-F9 = 145th composite - 153rd composite  
G1-G9 = 154th composite - 162nd composite  
H1-H9 = 163rd composite - 171st composite  
I1-I9 = 172nd composite - 180th composite  
J1-J9 = 181st composite - 189th composite  
K1-K9 = 190th composite - 198th composite  
L1-L9 = 199th composite - 207th composite  
M1-M9 = 208th composite - 216th composite  
N1-N9 = 217th composite - 225th composite  
O1-O9 = 226th composite - 234th composite  
P1-P9 = 235th composite - 243rd composite  
Q1-Q9 = 244th composite - 252nd composite  
R1-R9 = 253rd composite - 261st composite  
S1-S9 = 262nd composite - 270th composite  
T1-T9 = 271st composite - 279th composite  
U1-U9 = 280th composite - 288th composite  
V1-V9 = 289th composite - 297th composite  
W1-W9 = 298th composite - 306th composite  
X1-X9 = 307th composite - 315th composite  
Y1-Y9 = 316th composite - 324th composite  
Z1-Z9 = 325th composite - 333rd composite

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

WA-WZ = 906th composite - 931st composite  
XA-XZ = 932nd composite - 957th composite  
ZA-ZZ = 958th composite - 983rd composite

REV\_CNTR\_APC\_TB

Revenue Center Ambulatory Payment Classification (APC)

0000 = Code used when Payment Method Indicator  
equals 'N9'  
0001 = Photochemotherapy  
0002 = Fine needle Biopsy/Aspiration  
0003 = Bone Marrow Biopsy/Aspiration  
0004 = Level I Needle Biopsy/ Aspiration Except  
Bone Marrow  
0005 = Level II Needle Biopsy /Aspiration Except  
Bone Marrow  
0006 = Level I Incision & Drainage  
0007 = Level II Incision & Drainage  
0008 = Level III Incision & Drainage  
0009 = Nail Procedures  
0010 = Level I Destruction of Lesion  
0011 = Level II Destruction of Lesion  
0012 = Level I Debridement & Destruction  
0013 = Level II Debridement & Destruction  
0014 = Level III Debridement & Destruction  
0015 = Level IV Debridement & Destruction  
0016 = Level V Debridement & Destruction  
0017 = Level VI Debridement & Destruction  
0018 = Biopsy Skin, Subcutaneous Tissue or Mucous Membrane  
0019 = Level I Excision/ Biopsy  
0020 = Level II Excision/ Biopsy  
0021 = Level III Excision/ Biopsy  
0022 = Level IV Excision/ Biopsy  
0023 = Exploration Penetrating Wound  
0024 = Level I Skin Repair  
0025 = Level II Skin Repair  
0026 = Level III Skin Repair  
0027 = Level IV Skin Repair  
0028 = Level I Incision/Excision Breast  
0029 = Incision/Excision Breast (obsolete 12/00);  
Level II Incision/Excision Breast (effective 1/01)  
0030 = Breast Reconstruction/Mastectomy  
0031 = Hyperbaric Oxygen (obsolete 1/01)  
0032 = Placement Transvenous Catheters/Arterial Cutdown  
0033 = Partial Hospitalization  
0040 = Arthrocentesis & Ligament/Tendon Injection  
0041 = Arthroscopy  
0042 = Arthroscopically-Aided Procedures  
0043 = Closed Treatment Fracture Finger/Toe/Trunk

0044 = Closed Treatment Fracture/Dislocation Except  
Finger/Toe/Trunk  
0045 = Bone/Joint Manipulation Under Anesthesia  
0046 = Open/Percutaneous Treatment Fracture or Dislocation  
0047 = Arthroplasty without Prosthesis  
0048 = Arthroplasty with Prosthesis  
0049 = Level I Musculoskeletal Procedures Except Hand  
and Foot  
0050 = Level II Musculoskeletal Procedures Except Hand  
and Foot  
0051 = Level III Musculoskeletal Procedures Except Hand  
and Foot  
0052 = Level IV Musculoskeletal Procedures Except Hand  
and Foot  
0053 = Level I Hand Musculoskeletal Procedures  
0054 = Level II Hand Musculoskeletal Procedures  
0055 = Level I Foot Musculoskeletal Procedures  
0056 = Level II Foot Musculoskeletal Procedures  
0057 = Bunion Procedures  
0058 = Level I Strapping and Cast Application  
0059 = Level II Strapping and Cast Application  
0060 = Manipulation Therapy  
0070 = Thoracentesis/Lavage Procedures  
0071 = Level I Endoscopy Upper Airway  
0072 = Level II Endoscopy Upper Airway  
0073 = Level III Endoscopy Upper Airway  
0074 = Level IV Endoscopy Upper Airway  
0075 = Level V Endoscopy Upper Airway  
0076 = Endoscopy Lower Airway  
0077 = Level I Pulmonary Treatment  
0078 = Level II Pulmonary Treatment  
0079 = Ventilation Initiation and Management  
0080 = Diagnostic Cardiac Catheterization  
0081 = Non-Coronary Angioplasty or Atherectomy  
0082 = Coronary Atherectomy  
0083 = Coronary Angiosplasty  
0084 = Level I Electrophysiologic Evaluation  
0085 = Level II Electrophysiologic Evaluation  
0086 = Ablate Heart Dysrhythm Focus  
0087 = Cardiac Electrophysiologic Recording/Mapping  
0088 = Thrombectomy  
0089 = Level I Implantation/Removal/Revision of  
Pacemaker, AICD Vascular Device (obsolete 12/00);  
Insertion/Replacement of Permanent Pacemaker and  
Electrodes (eff. 1/01)  
0090 = Level II Implantation/Removal/Revision of  
Pacemaker AICD Vascular Device (obsolete 12/00);  
Insertion/Replacement of Permanent Pacemaker  
and Pulse Generator  
0091 = Level I Vascular Ligation

0092 = Level II Vascular Ligation  
0093 = Vascular Repair/Fistula Construction  
0094 = Resuscitation and Cardioversion  
0095 = Cardiac Rehabilitation  
0096 = Non-Invasive Vascular Studies  
0097 = Cardiovascular Stress Test (obsolete 12/00);  
Cardiac Monitoring for 30 days (eff. 1/01)  
0098 = Injection of Sclerosing Solution  
0099 = Continuous Cardiac Monitoring (obsolete 12/00);  
Electrocardiograms (eff. 1/01)  
0100 = Stress test and continuous ECG  
0101 = Tilt Table Evaluation  
0102 = Electronic Analysis of Pacemakers/other Devices  
0103 = Miscellaneous Vascular Procedures (eff. 1/01)  
0104 = Transcatheter Placement of Intracoronary Stents  
(eff. 1/01)  
0105 = Revision/Removal of Pacemakers, AICD or Vascular  
(eff. 1/01)  
0106 = Insertion/Replacement/Repair of Pacemaker  
Electrode (eff. 1/01)  
0107 = Insertion of Cardioverter-Defibrillator  
(eff. 1/01)  
0108 = Insertion/Replacement/Repair of Cardioverter-  
Defibrillator Leads (eff. 1/01)  
0109 = Bone Marrow Harvesting and Bone Marrow/Stem Cell  
Transplant (obsolete 12/00); Removal of Implanted  
Devices (eff. 1/01)  
0110 = Transfusion  
0111 = Blood PRODUct Exchange  
0112 = Extracorporeal Photopheresis  
0113 = Excision Lymphatic System  
0114 = Thyroid/Lymphadenectomy Procedures  
0115 = Cannula/Access Device Procedures  
(eff. 1/01)  
0116 = Chemotherapy Administration by Other Technique  
Except Infusion  
0117 = Chemotherapy Administration by Infusion Only  
0118 = Chemotherapy Administration by Both Infusion and  
Other Technique  
0119 = Implantation of Devices (eff. 1/01)  
0120 = Infusion Therapy Except Chemotherapy  
0121 = Level I Tube changes and Repositioning  
0122 = Level II Tube changes and Repositioning  
0123 = Bone Marrow Harvesting and Bone Marrow/Stem  
Cell Transplant  
0124 = Revision of Implanted Infusion Pump  
(eff. 1/01)  
0130 = Level I Laparoscopy  
0131 = Level II Laparoscopy  
0132 = Level III Laparoscopy



0140 = Esophageal Dilation without Endoscopy  
0141 = Upper GI Procedures  
0142 = Small Intestine Endoscopy  
0143 = Lower GI Endoscopy  
0144 = Diagnostic Anoscopy  
0145 = Therapeutic Anoscopy  
0146 = Level I Sigmoidoscopy  
0147 = Level II Sigmoidoscopy  
0148 = Level I Anal/Rectal Procedure  
0149 = Level II Anal/Rectal Procedure  
0150 = Level III Anal/Rectal Procedure  
0151 = Endoscopic Retrograde Cholangio-Pancreatography (ERCP)  
0152 = Percutaneous Biliary Endoscopic Procedures  
0153 = Peritoneal and Abdominal Procedures  
0154 = Hernia/Hydrocele Procedures  
0157 = Colorectal Cancer Screening: Barium Enema  
(Not subject to National coinsurance)  
0158 = Colorectal Cancer Screening: Colonoscopy  
Not subject to National coinsurance. Minimum  
unadjusted coinsurance is 25% of the payment rate.  
Payment rate is lower of the HOPD payment rate or  
the Ambulatory Surgical Center payment.  
0159 = Colorectal Cancer Screening: Flexible Sigmoidoscopy  
Not subject to National coinsurance. Minimum  
unadjusted coinsurance is 25% of the payment rate.  
Payment rate is lower of the HOPD payment rate or  
the Ambulatory Surgical Center payment.  
0160 = Level I Cystourethroscopy and other Genitourinary  
Procedures  
0161 = Level II Cystourethroscopy and other Genitourinary  
Procedures  
0162 = Level III Cystourethroscopy and other Genitourinary  
Procedures  
0163 = Level IV Cystourethroscopy and other Genitourinary  
Procedures  
0164 = Level I Urinary and Anal Procedures  
0165 = Level II Urinary and Anal Procedures  
0166 = Level I Urethral Procedures  
0167 = Level II Urethral Procedures  
0168 = Level III Urethral Procedures  
0169 = Lithotripsy  
0170 = Dialysis for Other Than ESRD Patients  
0180 = Circumcision  
0181 = Penile Procedures  
0182 = Insertion of Penile Prosthesis  
0183 = Testes/Epididymis Procedures  
0184 = Prostate Biopsy  
0190 = Surgical Hysteroscopy  
0191 = Level I Female RePROductive Procedures  
0192 = Level II Female RePROductive Procedures

0193 = Level III Female RePRODuctive Procedures  
0194 = Level IV Female RePRODuctive Procedures  
0195 = Level V Female RePRODuctive Procedures  
0196 = Dilatation & Curettage  
0197 = Infertility Procedures  
0198 = Pregnancy and Neonatal Care Procedures  
0199 = Vaginal Delivery  
0200 = Therapeutic Abortion  
0201 = Spontaneous Abortion  
0210 = Spinal Tap  
0211 = Level I Nervous System Injections  
0212 = Level II Nervous System Injections  
0213 = Extended EEG Studies and Sleep Studies  
0214 = Electroencephalogram  
0215 = Level I Nerve and Muscle Tests  
0216 = Level II Nerve and Muscle Tests  
0217 = Level III Nerve and Muscle Tests  
0220 = Level I Nerve Procedures  
0221 = Level II Nerve Procedures  
0222 = Implantation of Neurological Device  
0223 = Level I Revision/Removal Neurological Device  
(obsolete 12/00); Implantation of Pain  
Management Device (eff. 1/01)  
0224 = Level II Revision/Removal Neurological Device  
(obsolete 12/00); Implantation of Reservoir/  
Pump/Shunt (eff. 1/01)  
0225 = Implantation of Neurostimulator Electrodes  
0226 = Implantation of Drug Infusion Reservoir  
(eff. 1/01)  
0227 = Implantation of Drug Infusion Device  
(eff. 1/01)  
0228 = Creation of Lumbar Subarachnoid Shunt  
(eff. 1/01)  
0229 = Transcatherter Placement of Intravascular Shunts  
(eff. 1/01)  
0230 = Level I Eye Tests  
0231 = Level II Eye Tests  
0232 = Level I Anterior Segment Eye  
0233 = Level II Anterior Segment Eye  
0234 = Level III Anterior Segment Eye Procedures  
0235 = Level I Posterior Segment Eye Procedures  
0236 = Level II Posterior Segment Eye Procedures  
0237 = Level III Posterior Segment Eye Procedures  
0238 = Level I Repair and Plastic Eye Procedures  
0239 = Level II Repair and Plastic Eye Procedures  
0240 = Level III Repair and Plastic Eye Procedures  
0241 = Level IV Repair and Plastic Eye Procedures  
0242 = Level V Repair and Plastic Eye Procedures  
0243 = Strabismus/Muscle Procedures  
0244 = Corneal Transplant

0245 = Cataract Procedures without IOL Insert  
0246 = Cataract Procedures with IOL Insert  
0247 = Laser Eye Procedures Except Retinal  
0248 = Laser Retinal Procedures  
0250 = Nasal Cauterization/Packing  
0251 = Level I ENT Procedures  
0252 = Level II ENT Procedures  
0253 = Level III ENT Procedures  
0254 = Level IV ENT Procedures  
0256 = Level V ENT Procedures  
0257 = Implantation of Cochlear Device (obsolete 1/01)  
0258 = Tonsil and Adenoid Procedures  
0260 = Level I Plain Film Except Teeth  
0261 = Level II Plain Film Except Teeth Including Bone  
Density Measurement  
0262 = Plain Film of Teeth  
0263 = Level I Miscellaneous Radiology Procedures  
0264 = Level II Miscellaneous Radiology Procedures  
0265 = Level I Diagnostic Ultrasound Except Vascular  
0266 = Level II Diagnostic Ultrasound Except Vascular  
0267 = Vascular Ultrasound  
0268 = Guidance Under Ultrasound  
0269 = Echocardiogram Except Transesophageal  
0270 = Transesophageal Echocardiogram  
0271 = Mammography  
0272 = Level I Fluoroscopy  
0273 = Level II Fluoroscopy  
0274 = Myelography  
0275 = Arthrography  
0276 = Level I Digestive Radiology  
0277 = Level II Digestive Radiology  
0278 = Diagnostic Urography  
0279 = Level I Diagnostic Angiography and Venography  
Except Extremity  
0280 = Level II Diagnostic Angiography and Venography  
Except Extremity  
0281 = Venography of Extremity  
0282 = Level I Computerized Axial Tomography  
0283 = Level II Computerized Axial Tomography  
0284 = Magnetic Resonance Imaging  
0285 = Positron Emission Tomography (PET)  
0286 = Myocardial Scans  
0290 = Standard Non-Imaging Nuclear Medicine  
0291 = Level I Diagnostic Nuclear Medicine Excluding  
Myocardial Scans  
0292 = Level II Diagnostic Nuclear Medicine Excluding  
Myocardial Scans  
0294 = Level I Therapeutic Nuclear Medicine  
0295 = Level II Therapeutic Nuclear Medicine  
0296 = Level I Therapeutic Radiologic Procedures

0297 = Level II Therapeutic Radiologic Procedures  
0300 = Level I Radiation Therapy  
0301 = Level II Radiation Therapy  
0302 = Level III Radiation Therapy  
0303 = Treatment Device Construction  
0304 = Level I Therapeutic Radiation Treatment  
Preparation  
0305 = Level II Therapeutic Radiation Treatment  
Preparation  
0310 = Level III Therapeutic Radiation Treatment  
Preparation  
0311 = Radiation Physics Services  
0312 = Radioelement Applications  
0313 = Brachytherapy  
0314 = Hyperthermic Therapies  
0320 = Electroconvulsive Therapy  
0321 = Biofeedback and Other Training  
0322 = Brief Individual Psychotherapy  
0323 = Extended Individual Psychotherapy  
0324 = Family Psychotherapy  
0325 = Group Psychotherapy  
0330 = Dental Procedures  
0340 = Minor Ancillary Procedures  
0341 = Immunology Tests  
0342 = Level I Pathology  
0343 = Level II Pathology  
0344 = Level III Pathology  
0345 = Transfusion Laboratory Procedures Level I  
(eff. 1/01)  
0346 = Transfusion Laboratory Procedures Level II  
(eff. 1/01)  
0347 = Transfusion Laboratory Procedures Level III  
(eff. 1/01)  
0348 = Fertility Laboratory Procedures  
(eff. 1/01)  
0349 = Miscellaneous Laboratory Procedures  
(eff. 1/01)  
0354 = Administration of Influenza Vaccine (Not  
subject to national coinsurance)  
0355 = Level I Immunizations  
0356 = Level II Immunizations  
0357 = Level III Immunizations (obsolete 1/01)  
0358 = Level IV Immunizations (obsolete 1/01)  
0359 = Injections  
0360 = Level I Alimentary Tests  
0361 = Level II Alimentary Tests  
0362 = Fitting of Vision Aids  
0363 = Otorhinolaryngologic Function Tests  
0364 = Level I Audiometry  
0365 = Level II Audiometry

0366 = Electrocardiogram (ECG) (obsolete 1/01)  
0367 = Level I Pulmonary Test  
0368 = Level II Pulmonary Test  
0369 = Level III Pulmonary Test  
0370 = Allergy Tests  
0371 = Allergy Injections  
0372 = Therapeutic Phlebotomy  
0373 = Neuropsychological Testing  
0374 = Monitoring Psychiatric Drugs  
0600 = Low Level Clinic Visits  
0601 = Mid Level Clinic Visits  
0602 = High Level Clinic Visits  
0603 = Interdisciplinary Team Conference (obsolete 1/01)  
0610 = Low Level Emergency Visits  
0611 = Mid Level Emergency Visits  
0612 = High Level Emergency Visits  
0620 = Critical Care  
0701 = Strontium (eligible for pass-through payments)  
(obsolete 12/00); SR 89 chloride, per mCi  
(eff. 1/01)  
0702 = Samarium (eligible for pass-through payments)  
(obsolete 12/00); SM 153 lexidronam, 50 mCi  
(eff. 1/01)  
0704 = IN 111 Satumomab Pendetide (eligible for pass-through payments)  
0705 = Tc99 Tetrofosmin (eligible for pass-through payments)  
0725 = Leucovorin Calcium (eligible for pass-through payments)  
0726 = Dexrazoxane Hydrochloride (eligible for pass-through payments)  
0727 = Injection, Etidronate Disodium (eligible for pass-through payments)  
0728 = Filgrastim (G-CSF) (eligible for pass-through payments)  
0730 = Pamidronate Disodium (eligible for pass-through payments)  
0731 = Sargramostim (GM-CSF) (eligible for pass-through payments)  
0732 = Mesna (eligible for pass-through payments)  
0733 = Non-ESRD Epoetin Alpha (eligible for pass-through payments)  
0750 = Dolasetron Mesylate 10 mg (eligible for pass-through payments)  
0754 = Metoclopramide HCL (eligible for pass-through payments)  
0755 = Thiethylperazine Maleate (eligible for pass-through payments)  
0761 = Oral Substitute for IV Antiemetic (eligible for pass-through payments)

0762 = Dronabinol (eligible for pass-through payments)  
0763 = Dolasetron Mesylate 100 mg Oral (eligible for pass-through payments)  
0764 = Granisetron HCL, 100 mcg (eligible for pass-through payments)  
0765 = Granisetron HCL, 1mg Oral (eligible for pass-through payments)  
0768 = Ondansetron Hydrochloride per 1 mg Injection (eligible for pass-through payments)  
0769 = Ondansetron Hydrochloride 8 mg oral (eligible for pass-through payments)  
0800 = Leuprolide Acetate per 3.75 mg (eligible for pass-through payments)  
0801 = Cyclophosphamide (eligible for pass-through payments)  
0802 = Etoposide (eligible for pass-through payments)  
0803 = Melphalan (eligible for pass-through payments)  
0807 = Aldesleukin single use vial (eligible for pass-through payments)  
0809 = BCG (Intravesical) one vial (eligible for pass-through payments)  
0810 = Goserelin Acetate Implant, per 3.6 mg (eligible for pass-through payments)  
0811 = Carboplatin 50 mg (eligible for pass-through payments)  
0812 = Carmustine 100 mg (eligible for pass-through payments)  
0813 = Cisplatin 10 mg (eligible for pass-through payments)  
0814 = Asparaginase, 10,000 units (eligible for pass-through payments)  
0815 = Cyclophosphamide 100 mg (eligible for pass-through payments)  
0816 = Cyclophosphamide, Lyophilized 100 mg (eligible for pass-through payments)  
0817 = Cytrabine 100 mg (eligible for pass-through payments)  
0818 = Dactinomycin 0.5 mg (eligible for pass-through payments)  
0819 = Dacarbazine 100 mg (eligible for pass-through payments)  
0820 = Daunorubicin HCl 10 mg (eligible for pass-through payments)  
0821 = Daunorubicin Citrate, Liposomal Formulation, 10 mg (eligible for pass-through payments)  
0822 = Diethylstilbestrol Diphosphate 250 mg (eligible for pass-through payments)  
0823 = Docetaxel 20 mg (eligible for pass-through payments)  
0824 = Etoposide 10 mg (eligible for pass-through payments)

payments)  
0826 = Methotrexate Oral 2.5 mg (eligible for pass-through payments)  
0827 = Floxuridine injection 500mg  
0828 = Gemcitabine HCL 200 mg (eligible for pass-through payments)  
0830 = Irinotecan 20 mg (eligible for pass-through payments)  
0831 = Ifosfamide injection 1 gm (eligible for pass-through payments)  
0832 = Idarubicin HCL injection 5 mg (eligible for pass-through payments)  
0833 = Interferon Alfacon-1, 1 mcg (eligible for pass-through payments)  
0834 = Interferon, Alfa-2A, Recombinant 3 million units (eligible for pass-through payments)  
0836 = Interferon, Alfa-2B, Recombinant, 1 million units (eligible for pass-through payments)  
0838 = Interferon, Gamma 1-B injection, 3 million units (eligible for pass-through payments)  
0839 = Mechlorethamine HCL injection 10 mg (eligible for pass-through payments)  
0840 = Melphalan HCL 50 mg (eligible for pass-through payments)  
0841 = Methotrexate sodium injection 5 mg (eligible for pass-through payments)  
0842 = Fludarabine Phosphate injection 50 mg (eligible for pass-through payments)  
0843 = Pegaspargase, single dose vial (eligible for pass-through payments)  
0844 = Pentostatin injection, 10 mg (eligible for pass-through payments)  
0847 = Doxorubicin HCL 10 mg (eligible for pass-through payments)  
0849 = Rituximab, 100 mg (eligible for pass-through payments)  
0850 = Streptozocin injection, 1 gm (eligible for pass-through payments)  
0851 = Thiotepa injection, 15 mg (eligible for pass-through payments)  
0852 = Topotecan 4 mg (eligible for pass-through payments)  
0853 = Vinblastine Sulfate injection, 1 mg (eligible for pass-through payments)  
0854 = Vincristine Sulfate 1 mg (eligible for pass-through payments)  
0855 = Vinorelbine Tartrate per 10 mg (eligible for pass-through payments)  
0856 = Porfimer Sodium 75 mg (eligible for pass-through payments)  
0857 = Bleomycin Sulfate injection 15 units (eligible for

pass-through payments)  
0858 = Cladribine, 1mg (eligible for pass-through payments)  
0859 = Fluorouracil injection 500 mg  
0860 = Plicamycin (mithramycin) injection, 2.5 mg  
0861 = Leuprolide Acetate 1 mg (eligible for pass-through payments)  
0862 = Mitomycin, 5mg (eligible for pass-through payments)  
0863 = Paclitaxel, 30mg (eligible for pass-through payments)  
0864 = Mitoxantrone HCl, per 5mg (eligible for pass-through payments)  
0865 = Interferon alfa-N3, 250,000 IU (eligible for pass-through payments)  
0884 = Rho (D) Immune Globulin, Human one dose pack (eligible for pass-through payments)  
0886 = Azathioprine, 50 mg oral  
(Not subject to national coinsurance)  
0887 = Azathioprine, Parenteral 100 mg, 20 ml each injection  
(Not subject to national coinsurance)  
0888 = Cyclosporine, Oral 100 mg  
(Not subject to national coinsurance)  
0889 = Cyclosporine, Parenteral  
(Not subject to national coinsurance)  
0890 = Lymphocyte Immune Globulin 250 mg  
(Not subject to national coinsurance)  
0891 = Tacrolimus per 1 mg oral  
(Not subject to national coinsurance)  
0892 = Daclizumab, Parenteral, 25 mg (obsolete 1/01)  
(eligible for pass-through payments)  
0900 = Injection, Alglucerase per 10 units  
(eligible for pass-through payments)  
0901 = Alpha I, Proteinase Inhibitor, Human per 10mg  
(eligible for pass-through payments)  
0902 = Botulinum Toxin, Type A per unit  
(eligible for pass-through payments)  
0903 = CMV Immune Globulin (obsolete 12/00);  
Cytomegalovirus imm IV, vial  
(eligible for pass-through payments) (eff. 1/01)  
0905 = Immune Globulin per 500 mg  
(eligible for pass-through payments)  
0906 = RSV-ivig 50 mg  
(eligible for pass-through payments)  
0907 = Ganciclovir Sodium 500 mg injection  
(Not subject to national coinsurance)  
0908 = Tetanus Immune Globulin, injection up to 250 units  
(Not subject to national coinsurance)  
0909 = Interferon Beta - 1a 33 mcg (eligible for pass-through payments)  
0910 = Interferon Beta - 1b 0.25 mg (eligible for pass-through payments)  
0911 = Streptokinase per 250,000 iu



(Not subject to national coinsurance)  
0913 = Ganciclovir long act implant 4.5 mg (eligible for pass-through payments)  
0914 = Reteplase, 37.6 mg  
(Not subject to national coinsurance)  
0915 = Alteplase injection, recombinant, 10mg  
(Not subject to national coinsurance)  
0916 = Imiglucerase per unit (eligible for pass-through payments)  
0917 = Dipyridamole, 10mg / Adenosine 6MG  
(Not subject to national coinsurance) (obsolete 1/01)  
Pharmacologic stresses (eff. 1/01)  
0918 = Brachytherapy Seeds, Any type, Each (eligible for pass-through payments) (obsolete 4/01)  
0925 = Factor VIII (Antihemophilic Factor, Human) per iu (eligible for pass-through payments)  
0926 = Factor VIII (Antihemophilic Factor, Porcine) per iu (eligible for pass-through payments)  
0927 = Factor VIII (Antihemophilic Factor, Recombinant) per iu (eligible for pass-through payments)  
0928 = Factor IX, Complex (eligible for pass-through payments)  
0929 = Other Hemophilia Clotting Factors per iu (eligible for pass-through payments) (obsolete 1/01)  
Anti-inhibitor per iu (eff. 1/01)  
0930 = Antithrombin III (Human) per iu (eligible for pass-through payments)  
0931 = Factor IX (Antihemophilic Factor, Purified, Non-Recombinant) (eligible for pass-through payments)  
0932 = Factor IX (Antihemophilic Factor, Recombinant) (eligible for pass-through payments)  
0949 = Plasma, Pooled Multiple Donor, Solvent/Detergent Treated, Frozen (not subject to national coinsurance)  
0950 = Blood (Whole) For Transfusion (not subject to national coinsurance)  
0952 = Cryoprecipitate (not subject to national coinsurance)  
0953 = Fibrinogen Unit (not subject to national coinsurance)  
0954 = Leukocyte Poor Blood (not subject to national coinsurance)  
0955 = Plasma, Fresh Frozen (not subject to national coinsurance)  
0956 = Plasma Protein Fraction (not subject to national coinsurance)  
0957 = Platelet Concentrate (not subject to national coinsurance)  
0958 = Platelet Rich Plasma (not subject to national coinsurance)  
0959 = Red Blood Cells (not subject to national coinsurance)  
0960 = Washed Red Blood Cells (not subject to national coinsurance)

0961 = Infusion, Albumin (Human) 5%, 500 ml  
(not subject to national coinsurance)  
0962 = Infusion, Albumin (Human) 25%, 50 ml  
(not subject to national coinsurance)  
0970 = New Technology - Level I (\$0 - \$50)  
(not subject to national coinsurance)  
0971 = New Technology - Level II (\$50 - \$100)  
(not subject to national coinsurance)  
0972 = New Technology - Level III (\$100 - \$200)  
(not subject to national coinsurance)  
0973 = New Technology - Level IV (\$200 - \$300)  
(not subject to national coinsurance)  
0974 = New Technology - Level V (\$300 - \$500)  
(not subject to national coinsurance)  
0975 = New Technology - Level VI (\$500 - \$750)  
(not subject to national coinsurance)  
0976 = New Technology - Level VII (\$750 - \$1000)  
(not subject to national coinsurance)  
0977 = New Technology - Level VIII (\$1000 - \$1250)  
(not subject to national coinsurance)  
0978 = New Technology - Level IX (\$1250 - \$1500)  
(not subject to national coinsurance)  
0979 = New Technology - Level X (\$1500 - \$1750)  
(not subject to national coinsurance)  
0980 = New Technology - Level XI (\$1750 - \$2000)  
(not subject to national coinsurance)  
0981 = New Technology - Level XII (\$2000 - \$2500)  
(not subject to national coinsurance)  
0982 = New Technology - Level XIII (\$2500 - \$3500)  
(not subject to national coinsurance)  
0983 = New Technology - Level XIV (\$3500 - \$5000)  
(not subject to national coinsurance)  
0984 = New Technology - Level XV (\$5000 - \$6000)  
(not subject to national coinsurance)  
0987 = New Device Technology - Level I (\$0 - \$250)  
(eff. 1/01)  
0988 = New Device Technology - Level II (\$250 - \$500)  
(eff. 1/01)  
0989 = New Device Technology - Level III (\$500 - \$750)  
(eff. 1/01)  
0990 = New Device Technology - Level IV (\$750 - \$1000)  
(eff. 1/01)  
0991 = New Device Technology - Level V (\$1000 - \$1500)  
(eff. 1/01)  
0992 = New Device Technology - Level VI (\$1500 - \$2000)  
(eff. 1/01)  
0993 = New Device Technology - Level VII (\$2000 - \$3000)  
(eff. 1/01)  
0994 = New Device Technology - Level VIII (\$3000 - \$4000)  
(eff. 1/01)

0995 = New Device Technology - Level IX (\$4000 - \$5000)  
(eff. 1/01)  
0996 = New Device Technology - Level X (\$5000 - \$7000)  
(eff. 1/01)  
0997 = New Device Technology - Level XI (\$7000 - \$9000)  
(eff. 1/01)  
1000 = Perclose Closer Prostar Arterial Vascular  
Closure (eff. 1/01)  
1001 = AcuNav-diagnostic ultrasound ca (eff. 1/01)  
1002 = Cochlear Implant System (eff. 1/01)  
1003 = Cath, ablation, livewire TC (eff. 1/01)  
1004 = Fast-Cath, Swartz, SAFL, CSTA (eff. 1/01)  
1006 = ARRAY post chamb IOL (eff. 1/01)  
1007 = Ams 700 penile prosthesis (eff. 1/01)  
1008 = Urolume-implant urethral stent (eff. 1/01)  
1009 = Plasma, cryoprecipitate-reduced, unit  
(eff. 1/01)  
1010 = Blood, L/R CMV-neg (eff. 1/01)  
1011 = Platelets, L/R, CMV-neg (eff. 1/01)  
1012 = Platelet concentrate, L/R, irradiated, unit  
(eff. 1/01)  
1013 = Platelet concentrate, L/R, unit (eff. 1/01)  
1014 = Platelets, aph/pher, L/R, unit (eff. 1/01)  
1016 = Blood, L/R, froz/deglycerol/washed (eff. 1/01)  
1017 = Platelets, aph/pher, L/R CMV-neg, unit  
(eff. 1/01)  
1018 = Blood, L/R, irradiated (eff. 1/01)  
1019 = Platelets, aph/pher, L/R, irradiated, unit  
(eff. 1/01)  
1024 = Quinupristin 150 mg/dalfopriston 350 mg  
(eff. 1/01)  
1025 = Marinr CS catheter (eff. 1/01)  
1026 = RF Perfrmr cath 5F RF Marinr (eff. 1/01)  
1027 = Magic x/short, radius 14m (eff. 1/01)  
1028 = Prcis Twst trnsvg anch sys (eff. 1/01)  
1029 = CRE guided balloon dil cath (eff. 1/01)  
1030 = Cthtr:Mrshal, Blu Max Utr Dmnd (eff. 1/01)  
1033 = Sonicath mdl 37-410 (eff. 1/01)  
1034 = SURPASS, Long30 SURPASS-cath (eff. 1/01)  
1035 = Cath, Ultra ICE (eff. 1/01)  
1036 = R port/reservior impl dev (eff. 1/01)  
1037 = Vaxcelchronic dialysis cath (eff. 1/01)  
1038 = UltraCross Imaging Cath (eff. 1/01)  
1039 = Wallstent/RP:Trach (eff. 1/01)  
1040 = Wallstent/RP TIPS -- 20/40/60 (eff. 1/01)  
1042 = Wallstent, UltraFlex: Bil (eff. 1/01)  
1045 = I-131 MIBG (ioben-sulfate) 0.5mCi  
(eff. 1/01)  
1047 = Navi-Star, Noga-Star cath (eff. 1/01)  
1048 = NeuroCyberneticPros: gen (eff. 1/01)

1051 = Oasis Thrombectomy Cath (eff. 1/01)  
1053 = EnSite 3000 catheter (eff. 1/01)  
1054 = Hydrolyser Thromb Cath 6/7F (eff. 1/01)  
1055 = Transesoph 210, 210-S Cath (eff. 1/01)  
1056 = Thermachoice II Cath (eff. 1/01)  
1057 = Micromark Tissue Marker (eff. 1/01)  
1059 = Carticel, auto cult-chnr cyte (eff. 1/01)  
1060 = ACS multi-link tristor stent (eff. 1/01)  
1061 = ACS Viking Guiding cath (eff. 1/01)  
1063 = EndoTak Endurance EZ,RX leads (eff. 1/01)  
1067 = Megalink biliary stent (eff. 1/01)  
1068 = Pulsar DDD pmkr (eff. 1/01)  
1069 = Discovery DR, pmaker  
1071 = Pulsar Max, Pulsar SR pmkr (eff. 1/01)  
1072 = Guidant: blln dil cath (eff. 1/01)  
1073 = Gynecare Morcellator (eff. 1/01)  
1074 = RX/OTW Viatrac-peri dil cath (eff. 1/01)  
1075 = Guidant: lead (eff. 1/01)  
1076 = Ventak minisc defib (eff. 1/01)  
1077 = Ventak VR Prizm VR, sc defib (eff. 1/01)  
1078 = Ventak: Prizm, AVIIIDR defib  
1079 = CO 57/58 0.5 mCi (eff. 1/01)  
1084 = Denileukin diftitox, 300 mcg (eff. 1/01)  
1086 = Temozolomide, 5 mg (eff. 1/01)  
1087 = I-123 per uCi capsule (eff. 1/01)  
1089 = CO 57, 0.5 mCi (eff. 1/01)  
1090 = IN 111 Chloride, per mCi (eff. 1/01)  
1091 = IN 111 Oxyquinoline, per 5 mCi (eff. 1/01)  
1092 = IN 111 Pentetate, per 1.5 mCi (eff. 1/01)  
1094 = TC 99M Albumin aggr, per vial  
1095 = TC 99M Depreotide, per vial (eff. 1/01)  
1096 = TC 99M Exametazime, per dose (eff. 1/01)  
1097 = TC 99M Mebrofenin, per vial (eff. 1/01)  
1098 = TC 99M Pentetate, per vial (eff. 1/01)  
1099 = TC 99M Pyrophosphate, per vial (eff. 1/01)  
1100 = Medtronic AVE GT1 guidewire (eff. 1/01)  
1101 = Medtronic AVE, AVE Z2 cath (eff. 1/01)  
1102 = Synergy Neurostim Genrtr (eff. 1/01)  
1103 = Micro Jewell Defibrillator (eff. 1/01)  
1104 = RF ConductorAblative Cath (eff. 1/01)  
1105 = Sigman 300VDD pacmkr (eff. 1/01)  
1106 = SynergyEZ Pt Progmr (eff. 1/01)  
1107 = Torqr, Solist cath (eff. 1/01)  
1108 = Reveal Cardiac Recorder (eff. 1/01)  
1109 = Implantable anchor: Ethicon (eff. 1/01)  
1110 = Stable Mapper, cath electrd (eff. 1/01)  
1111 = AneuRx Aort-Uni-llicstnt & cath (eff. 1/01)  
1112 = AneuRx Stent graft/del cath (eff. 1/01)  
1113 = Tlnt Endo Sprng Stnt Grft Sys (eff. 1/01)  
1114 = TalntSprgStnt + Graf endo pros (eff. 1/01)

1115 = 5038S, 5038, 5038L pace lead (eff. 1/01)  
1116 = CapSureSP pacing lead (eff. 1/01)  
1117 = Ancure Endograft Del Sys (eff. 1/01)  
1118 = Sigma300DR LegIIDR, pacemkr (eff. 1/01)  
1119 = Sprint6932, 6943 defib lead (eff. 1/01)  
1120 = Sprint6942, 6945 defi lead (eff. 1/01)  
1121 = Gem defibrillator (eff. 1/01)  
1122 = TC 99M arcitumomab per dose (eff. 1/01)  
1123 = Gem II VR defibrillator (eff. 1/01)  
1124 = InterStim Test Stim Kit (eff. 1/01)  
1125 = Kappa 400SR, Ttopaz II SR pmkr (eff. 1/01)  
1126 = Kappa 700 DR pacemkr (eff. 1/01)  
1127 = Kappa 700SR, pmkr sgl chamber (eff. 1/01)  
1128 = Kappa 700D, Ruby IID pmkr (eff. 1/01)  
1129 = Kappa 700VDD, pacmkr (eff. 1/01)  
1130 = Sigma 200D, LGCY IID sc pmkr (eff. 1/01)  
1131 = Sigma 200DR pmker (eff. 1/01)  
1132 = Sigma 200SR Leg II:sc pac (eff. 1/01)  
1133 = Sigma SR, Vita SR, pmaker (eff. 1/01)  
1134 = Sigma 300D pmker (eff. 1/01)  
1135 = Entity DR 5326L/R, DC, pmkr (eff. 1/01)  
1136 = Affinity DR 5330L/R, DC, pmkr (eff. 1/01)  
1137 = CardioSEAL implant syst (eff. 1/01)  
1143 = AddVent mod 2060BL, VDD (eff. 1/01)  
1144 = Afnty SP 5130, Integrity SR, pmkr (eff. 1/01)  
1145 = Angio-Seal 6fr, 8fr (eff. 1/01)  
1147 = AV Plus DX 1368: lead (eff. 1/01)  
1148 = Contour MD sc defib (eff. 1/01)  
1149 = Entity DC 5226R-pmker (eff. 1/01)  
1151 = Passiveplus DXlead, 10mdls (eff. 1/01)  
1152 = LifeSite Access System (eff. 1/01)  
1153 = Regency SC+ 2402L pmkr (eff. 1/01)  
1154 = SPL:SPOI, 0204- defib lead (eff. 1/01)  
1155 = Repliform 8 sq cm (eff. 1/01)  
1156 = Tr 1102TrSR+ 2260L, 2264L, 5131 (eff. 1/01)  
1157 = Trilogy DCT 23/8L pmkr (eff. 1/01)  
1158 = TVL lead SV01, SV02, SV04 (eff. 1/01)  
1159 = TVL RV02, RV06, RV07: lead (eff. 1/01)  
1160 = TVL-ADX 1559: lead (eff. 1/01)  
1161 = Tendril DX, 1338 pacing lead (eff. 1/01)  
1162 = TempoDr, TrilogyDR+ DC pmkr (eff. 1/01)  
1163 = Tendril SDX, 1488T pacing lead (eff. 1/01)  
1164 = Iodine-125 brachytx seed (eff. 1/01)  
1166 = Cytarabine liposomal, 10 mg (eff. 1/01)  
1167 = Epirubicin hcl, 2 mg (eff. 1/01)  
1171 = Autosuture site marker stple (eff. 1/01)  
1172 = Spacemaker dissect ballon (eff. 1/01)  
1173 = Cor stntS540, S670, o-wire stn (eff. 1/01)  
1174 = Bard brachytx needle (eff. 1/01)  
1178 = Busulfan IV, 6 mg (eff. 1/01)

1180 = Vigor SR, SC, pmkr (eff. 1/01)  
1181 = Meridian SSI, SC pmkr (eff. 1/01)  
1182 = Pulsar SSI, SC, pmkr (eff. 1/01)  
1183 = Jade IIS, Sigma 300S, SC, pmkr (eff. 1/01)  
1184 = Sigma 200S, SC, pmkr (eff. 1/01)  
1188 = I 131, per mCi (eff. 1/01)  
1200 = TC 99M Sodium Clucoheptonate, per vial  
(eff. 1/01)  
1201 = TC 99M succimer, per vial (eff. 1/01)  
1202 = TC 99M Sulfur Colloid, per dose (eff. 1/01)  
1203 = Verteporfin for Injection (eff. 1/01)  
1205 = TC 99M Disofenin, per vial (eff. 1/01)  
1207 = Octreotide acetate depot 1 mg (eff. 1/01)  
1302 = SQ01:lead (eff. 1/01)  
1303 = CapSure Fix 6940/4068-110, lead (eff. 1/01)  
1304 = Sonicath mdl 37-416,-418 (eff. 1/01)  
1305 = Apligraf (eff. 1/01)  
1306 = NeuroCyberneticsPros: lead (eff. 1/01)  
1311 = Trilogy DR + DAO pmkr (eff. 1/01)  
1312 = Magic WALLSTENT stent-mini (eff. 1/01)  
1313 = Magic medium, radius 31mm (eff. 1/01)  
1314 = Magic WALLSTENT stent-Long (eff. 1/01)  
1315 = Vigor DR, Meridian DR pmkr (eff. 1/01)  
1316 = Meridian DDD pmkr (eff. 1/01)  
1317 = Discovery SR, pmkr (eff. 1/01)  
1318 = Meridian SR pmkr (eff. 1/01)  
1319 = Wallstent/RP Enteral--60mm (eff. 1/01)  
1320 = Wallstent/RP lliac Del Sys (eff. 1/01)  
1325 = Pallidium - 103 seed (eff. 1/01)  
1326 = Angio-jet rheolytic thromb cath (eff. 1/01)  
1328 = ANS Renew NS trnsmt (eff. 1/01)  
1333 = PALMZA Corinthian bill stent (eff. 1/01)  
1334 = Crown, Mini-crown,CrossLC (eff. 1/01)  
1335 = Mesh, Prolene (eff. 1/01)  
1336 = Constant Flow Imp Pump (eff. 1/01)  
1337 = IsoMed 8472-20/35/60 (eff. 1/01)  
1348 = I 131 per mCi solution (eff. 1/01)  
1350 = Prosta/OncoSeed, RAPID strand, I-125 (eff. 1/01)  
1351 = CapSure (Fix) pacing lead (eff. 1/01)  
1352 = Gem II defib (eff. 1/01)  
1353 = Itrel Interstm neurostim + ext (eff. 1/01)  
1354 = Kappa 400DR, Diamond II 820 DR (eff. 1/01)  
1355 = Kappa 600 DR, Vita DR (eff. 1/01)  
1356 = Profile MD V-186HV3 sc defib (eff. 1/01)  
1357 = Angstrom MD V-190HV3 sc defib (eff. 1/01)  
1358 = Affinity DC 5230R-Pacemaker (eff. 1/01)  
1359 = Pulsar, Pulsar Max DR, pmkr (eff. 1/01)  
1363 = Gem DR, DC, defib (eff. 1/01)  
1364 = Photon DR V-230HV3 DC defib (eff. 1/01)  
1365 = Guidewire, Hi-Torque 14/18/35 (eff. 1/01)

1366 = Guidewire, PTCA, Hi-Torque (eff. 1/01)  
1367 = Guidewire, Hi-Torque Crosslt (eff. 1/01)  
1369 = ANS Renew Stim Sys recvr (eff. 1/01)  
1370 = Tension-Free Vaginal Tape (eff. 1/01)  
1371 = Symp Nitinol Transhep Bil Sys (eff. 1/01)  
1372 = Cordis Nitinol bil Stent (eff. 1/01)  
1375 = Stent, corornary, NIR (eff. 1/01)  
1376 = ANS Renew Stim Sys lead (eff. 1/01)  
1377 = Specify 3988 neuro lead (eff. 1/01)  
1378 = InterStim Tx 3080/3886 lead (eff. 1/01)  
1379 = Pisces-Quad 3887 lead (eff. 1/01)  
1400 = Diphenhydramine hcl 50 mg (eff. 1/01)  
1401 = Prochlorperazine maleate 5 mg (eff. 1/01)  
1402 = Promethazine hcl 12.5 mg oral (eff. 1/01)  
1403 = Chlorpromazine hcl 10mg oral (eff. 1/01)  
1404 = Trimethobenzamide hcl 250mg (eff. 1/01)  
1405 = Thiethylperazine maleate 10 mg (eff. 1/01)  
1406 = Perphenazine 4 mg oral (eff. 1/01)  
1407 = Hydroxyzine pamoate 25 mg (eff. 1/01)  
1409 = Factor via recombinant, per 1.2 mg (eff. 1/01)  
1410 = Prosorba column (eff. 1/01)  
1411 = Herculink, OTW SDS bil stent (eff. 1/01)  
1420 = StapleTac2 Bone w/Dermis (eff. 1/01)  
1421 = StapleTac2 Bone w/o Dermis (eff. 1/01)  
1450 = Orthosphere Arthroplasty (eff. 1/01)  
1451 = Orthosphere Arthroplasty Kity (eff. 1/01)  
1500 = Atherectomy sys, peripheral (eff. 1/01)  
1600 = TC 99M sestamibi, per syringe (eff. 1/01)  
1601 = TC 99M medronate, per dose (eff. 1/01)  
1602 = TC 99M apcitide, per vial (eff. 1/01)  
1603 = TL 201, mCi (eff. 1/01)  
1604 = IN 111 capromab pendetide, per dose (eff. 1/01)  
1605 = Abciximab injection, 10 mg (eff. 1/01)  
1606 = Anistreplase, 30 u (eff. 1/01)  
1607 = Eptifibatide injection, 5 mg (eff. 1/01)  
1608 = Etanercept injection, 25 mg (eff. 1/01)  
1609 = Rho(D) Immune globulin h, sd 100 iu (eff. 1/01)  
1611 = Hylan G-F 20 injection, 16 mg (eff. 1/01)  
1612 = Daclizumab, parenteral, 25 mg (eff. 1/01)  
1613 = Trastuzumab, 10 mg (eff. 1/01)  
1614 = Valrubicin, 200 mg (eff. 1/01)  
1615 = Basiliximab, 20 mg (eff. 1/01)  
1616 = Histrelin Acetate, 0.5 mg (eff. 1/01)  
1617 = Lepirdin, 50 mg (eff. 1/01)  
1618 = Von Willebrand factor, per iu (eff. 1/01)  
1619 = Ga 67, per mCi (eff. 1/01)  
1620 = TC 99M Bicisate, per vial (eff. 1/01)  
1621 = Xe 133, per mCi (eff. 1/01)  
1622 = TC 99M Mertiatide, per vial (eff. 1/01)  
1623 = TC 99M Gluceptate (eff. 1/01)

1624 = P32 sodium, per mCi (eff. 1/01)  
1625 = IN 111 Pentetreotide, per mCi (eff. 1/01)  
1626 = TC 99M Oxidronate, per vial (eff. 1/01)  
1627 = TC-99 labeled red blood cell, per test (eff. 1/01)  
1628 = P32 phosphate chromic, per mCi (eff. 1/01)  
1700 = Authen Mick TP brachy needle (eff. 1/01)  
(obsolete 4/01)  
1701 = Medtec MT-BT-5201-25 ndl (eff. 1/01)  
(obsolete 4/01)  
1702 = WWMT brachytx needle (eff. 1/01)  
(obsolete 4/01)  
1703 = Mentor Prostate Brachy (eff. 1/01)  
(obsolete 4/01)  
1704 = MT-BT-5001-25/5051-25 (eff. 1/01)  
(obsolete 4/01)  
1705 = Best Flexi Brachy Needle (eff. 1/01)  
(obsolete 4/01)  
1706 = Indigo Prostate Seeding Ndl (eff. 1/01)  
(obsolete 4/01)  
1707 = Varisource Implt Ndl (eff. 1/01)  
(obsolete 4/01)  
1708 = UroMed Prostate Seed Ndl (eff. 1/01)  
(obsolete 4/01)  
1709 = Remington Brachytx Needle (eff. 1/01)  
(obsolete 4/01)  
1710 = US Biopsy Prostate Needle (eff. 1/01)  
(obsolete 4/01)  
1711 = MD Tech brachytx needle (eff. 1/01)  
(obsolete 4/01)  
1712 = Imagyn brachytx needle (eff. 1/01)  
(obsolete 4/01)  
1713 = Anchor/screw bn/bn,tis/bn (eff. 4/01)  
1714 = Cath, trans atherectomy, dir (eff. 4/01)  
1715 = Brachytherapy needle (eff. 4/01)  
1716 = Brachytx seed, Gold 198 (eff. 4/01)  
1717 = Brachytx seed, HDR Ir-192 (eff. 4/01)  
1718 = Brachytx seed, Iodine 125 (eff. 4/01)  
1719 = Brachytx seed, Non-HDR Ir-192 (eff. 4/01)  
1720 = Brachytx, Palladium 103 (eff. 4/01)  
1721 = AICD, dual chamber (eff. 4/01)  
1722 = AICD, single chamber (eff. 4/01)  
1723 = Cath, ablation, non-cardiac (eff. 4/01)  
1724 = Cath, trans atherec, rotation (eff. 4/01)  
1725 = Cath, translumin non-laser (eff. 4/01)  
1726 = Cath, bal dil, non-vascular (eff. 4/01)  
1727 = Cath, bal tis, dis, nonvas (eff. 4/01)  
1728 = Cath, brachytx seed adm (eff. 4/01)  
1729 = Cath, drainage, biliary (eff. 4/01)  
1730 = Cath, EP, 19 or fewer elect (eff. 4/01)  
1731 = Cath, EP, 20 or more elect (eff. 4/01)



1732 = Cath, EP, diag/abl, 3D/vect (eff. 4/01)  
1733 = Cath, EP, other than temp (eff. 4/01)  
1750 = Cath, hemodialysis, long-term (eff. 4/01)  
1751 = Cath, inf pr/cent/midline (eff. 4/01)  
1752 = Cath, hemodialysis, short-term (eff. 4/01)  
1753 = Cath, intravas ultrasound (eff. 4/01)  
1754 = Catheter, intradiscal (eff. 4/01)  
1755 = Catheter, intraspinal (eff. 4/01)  
1756 = Cath, pacing, transesoph (eff. 4/01)  
1757 = Cath, thrombectomy/embolect (eff. 4/01)  
1758 = Cath, ureteral (eff. 4/01)  
1759 = Cath, intra echocardiography (eff. 4/01)  
1760 = Closure dev, vasc, imp/insert (eff. 4/01)  
1762 = Conn tiss, human (inc fascia) (eff. 4/01)  
1763 = Conn tiss, non-human (eff. 4/01)  
1764 = Event recorder, cardiac (eff. 4/01)  
1767 = Generator, neurostim, imp (eff. 4/01)  
1768 = Graft, vascular (eff. 4/01)  
1769 = Guide wire (eff. 4/01)  
1770 = Imaging coil, MR insertable (eff. 4/01)  
1771 = Rep dev, urinary , w/sling (eff. 4/01)  
1772 = Infusion pump, programmable (eff. 4/01)  
1773 = Retrieval dev, insert (eff. 4/01)  
1776 = Joint device (implantable) (eff. 4/01)  
1777 = Lead, AICD, endo single coil (eff. 4/01)  
1778 = Lead, neurostimulator (eff. 4/01)  
1779 = Lead, pmkr, transvenous VDD (eff. 4/01)  
1780 = Lens, intraocular (eff. 4/01)  
1781 = Mesh (implantable) (eff. 4/01)  
1782 = Morcellator (eff. 4/01)  
1784 = Ocular dev, intraop, det ret (eff. 4/01)  
1785 = Pmkr, dual, rate-resp (eff. 4/01)  
1786 = Pmkr, single, rate-resp (eff. 4/01)  
1787 = Patient progr, neurostim (eff. 4/01)  
1788 = Port, indwelling, imp (eff. 4/01)  
1789 = Prosthesis, breast, imp. (eff. 4/01)  
1790 = Iridium 192 HDR (eff. 1/01)  
(obsolete 4/01)  
1791 = OncoSeed, Rapid Strand I-125 (eff. 1/01)  
(obsolete 4/01)  
1792 = UroMed I-125 Brachy seed (eff. 1/01)  
(obsolete 4/01)  
1793 = Bard InterSource P-103 seed (eff. 1/01)  
(obsolete 4/01)  
1794 = Bard IsoSeed P-103 seed (eff. 1/01)  
(obsolete 4/01)  
1795 = Bard BrachySource I-125 (eff. 1/01)  
(obsolete 4/01)  
1796 = Source Tech Med I-125 (eff. 1/01)  
(obsolete 4/01)

1797 = Draximage I-125 seed (eff. 1/01)  
(obsolete 4/01)  
1798 = Syncor I-125 PharmaSeed (eff. 1/01)  
(obsolete 4/01)  
1799 = I-Plant I-125 Brachytx seed (eff. 1/01)  
(obsolete 4/01)  
1800 = Pd-103 brachytx seed (eff. 1/01)  
(obsolete 4/01)  
1801 = IoGold I-125 brachytx seed (eff. 1/01)  
(obsolete 4/01)  
1802 = Iridium 192 brachytx seed (eff. 1/01)  
(obsolete 4/01)  
1803 = Best Iodine 125 brachytx seeds (eff. 1/01)  
(obsolete 4/01)  
1804 = Best Palladium 103 seeds (eff. 1/01)  
(obsolete 4/01)  
1805 = IsoStar Iodine-125 seeds (eff. 1/01)  
(obsolete 4/01)  
1806 = Gold 198 (eff. 1/01)  
(obsolete 4/01)  
1810 = D114S Dilatation Cath (eff. 1/01)  
(obsolete 4/01)  
1811 = Surgical Dynamics Anchors (eff. 1/01)  
(obsolete 4/01)  
1812 = OBL Anchors (eff. 1/01)  
(obsolete 4/01)  
1813 = Prosthesis, penile, inflatab (eff. 4/01)  
1815 = Pros, urinary sph, imp (eff. 4/01)  
1816 = Receiver/transmitter, neuro (eff. 4/01)  
1817 = Septal defect imp sys (eff. 4/01)  
1850 = Repliform 14/21 sq cm (eff. 1/01)  
(obsolete 4/01)  
1851 = Repliform 24/28 sq cm (eff. 1/01)  
(obsolete 4/01)  
1852 = TransCyte, per 247 sq cm (eff. 1/01)  
(obsolete 4/01)  
1853 = Suspend, per 8/14 sq cm (eff. 1/01)  
(obsolete 4/01)  
1854 = Suspend, per 24/28 sq cm (eff. 1/01)  
(obsolete 4/01)  
1855 = Suspend, per 36 sq cm (eff. 1/01)  
(obsolete 4/01)  
1856 = Suspend, per 48 sq cm (eff. 1/01)  
(obsolete 4/01)  
1857 = Suspend, per 84 sq cm (eff. 1/01)  
(obsolete 4/01)  
1858 = DuraDerm, per 8/14 sq cm (eff. 1/01)  
(obsolete 4/01)  
1859 = DuraDerm, per 21/24 sq cm (eff. 1/01)  
(obsolete 4/01)

1860 = DuraDerm, per 48 sq cm (eff. 1/01)  
(obsolete 4/01)  
1861 = DuraDerm, per 36 sq cm (eff. 1/01)  
(obsolete 4/01)  
1862 = DuraDerm, per 72 sq cm (eff. 1/01)  
(obsolete 4/01)  
1863 = DuraDerm, per 84 sq cm (eff. 1/01)  
(obsolete 4/01)  
1864 = SpermaTex, per 13/44 sq cm (eff. 1/01)  
(obsolete 4/01)  
1865 = FasLata, per 8/14 sq cm (eff. 1/01)  
(obsolete 4/01)  
1866 = FasLata, per 24/28 sq cm (eff. 1/01)  
(obsolete 4/01)  
1867 = FasLata, per 36/48 sq cm (eff. 1/01)  
(obsolete 4/01)  
1868 = FasLata, per 96 sq cm (eff. 1/01)  
(obsolete 4/01)  
1869 = Gore Thyroplasty Dev (eff. 1/01)  
(obsolete 4/01)  
1870 = DermMatrix, per 16 sq cm (eff. 1/01)  
(obsolete 4/01)  
1871 = DermMatrix, 32 or 64 sq cm (eff. 1/01)  
(obsolete 4/01)  
1872 = Dermagraft, per 37.5 sq cm (eff. 1/01)  
(obsolete 4/01)  
1873 = Bard 3DMax Mesh (eff. 1/01)  
(obsolete 4/01)  
1874 = Stent, coated/cov w/del sys (eff. 4/01)  
1875 = Stent, coated/cov w/o del sys (eff. 4/01)  
1876 = Stent, non-coated/no-cov w/del (eff. 4/01)  
1877 = Stent, non-coated/cov w/o del (eff. 4/01)  
1878 = Martl for vocal cord (eff. 4/01)  
1879 = Tissue marker, imp (eff. 4/01)  
1880 = Vena cava filter (eff. 4/01)  
1881 = Dialysis access system (eff. 4/01)  
1882 = AICD, other than sing/dual (eff. 4/01)  
1883 = Adapt/ext, pacing/neuro lead (eff. 4/01)  
1885 = Cath, translumin angio laser (eff. 4/01)  
1887 = Catheter, guiding (eff. 4/01)  
1891 = Infusion pump, non-prog, perm (eff. 4/01)  
1892 = Intro/sheath , fixed, peel-away (eff. 4/01)  
1893 = Intro/sheath, fixed, non-peel (eff. 4/01)  
1894 = Intro/sheath, non-laser (eff. 4/01)  
1895 = Lead, AICD, endo dual coil (eff. 4/01)  
1896 = Lead, AICD, non sing/dual (eff. 4/01)  
1897 = Lead, neurostim test kit (eff. 4/01)  
1898 = Lead, pmkr, other than trans (eff. 4/01)  
1899 = Lead, pmkr/AICD combination (eff. 4/01)  
1929 = Maverick PTCA Cath (eff. 1/01) (obsolete 4/01)

1930 = Coyote Dil Cath, 20/30/40mm (eff. 1/01)  
(obsolete 4/01)  
1931 = Talon Dil Cath (eff. 1/01) (obsolete 4/01)  
1932 = Scimed remedy Dil Cath (eff. 1/01)  
(obsolete 4/01)  
1933 = Opti-Plast XL/Centurion Cath (eff. 1/01)  
(obsolete 4/01)  
1934 = Ultraverse 3.5F Bal Dil Cath (eff. 1/01)  
(obsolete 4/01)  
1935 = Workhorse PTA Bal Cath (eff. 1/01)  
(obsolete 4/01)  
1936 = Uromax Ultra Bal Dil Cath (eff. 1/01)  
(obsolete 4/01)  
1937 = Synergy Balloon Dil Cath (eff. 1/01)  
(obsolete 4/01)  
1938 = Uroforce Bal Dil Cath (eff. 1/01) (obsolete 4/01)  
1939 = Raptur, Ninja PTCA Dil Cath (eff. 1/01)  
(obsolete 4/01)  
1940 = PowerFlex, OPTA 5/LP Bal Cath (eff. 1/01)  
(obsolete 4/01)  
1941 = Jupiter PTA Dil Cath (eff. 1/01)  
(obsolete 4/01)  
1942 = Cordis Maxi LD PTA Bal Cath (eff. 1/01)  
(obsolete 4/01)  
1943 = RXCrossSail OTW OpenSail (eff. 1/01)  
(obsolete 4/01)  
1944 = Rapid Exchange Bil Dil Cath (eff. 1/01)  
(obsolete 4/01)  
1945 = Savvy PTA Dil Cath (eff. 1/01)  
(obsolete 4/01)  
1946 = Rls Rapid Dil Cath (eff. 1/01)  
(obsolete 4/01)  
1947 = Gazelle Bal Dil Cath (eff. 1/01)  
(obsolete 4/01)  
1948 = Pursuit Balloon Cath (eff. 1/01)  
(obsolete 4/01)  
1949 = Oracle Megasonics Cath (eff. 1/01)  
(obsolete 4/01)  
1979 = Visions PV/Avanar US Cath (eff. 1/01)  
(obsolete 4/01)  
1980 = Atlantis SR Coronary Cath (eff. 1/01)  
(obsolete 4/01)  
1981 = PTCA Catheters (eff. 1/01)  
(obsolete 4/01)  
2000 = Orbiter ST Steerable Cath (eff. 1/01)  
(obsolete 4/01)  
2001 = Constellation Diag Cath (eff. 1/01)  
(obsolete 4/01)  
2002 = Irvine 5F Inquiry Diag EP Cath (eff. 1/01)  
(obsolete 4/01)

2003 = Irvine 6F Inquiry Diag EP Cath (eff. 1/01)  
(obsolete 4/01)  
2004 = Biosense EP Cath -- Octapolar (eff. 1/01)  
(obsolete 4/01)  
2005 = Biosense EP Cath -- Hexapolar (eff. 1/01)  
(obsolete 4/01)  
2006 = Biosense EP Cath -- Decapolar (eff. 1/01)  
(obsolete 4/01)  
2007 = Irvine 6F Luma-Cath EP Cath (eff. 1/01)  
(obsolete 4/01)  
2008 = 7F Luma-Cath EP Cath 81910-15 (eff. 1/01)  
(obsolete 4/01)  
2009 = Irvine 7F Luma-Cath EP Cath (eff. 1/01)  
(obsolete 4/01)  
2010 = Fixed Curve EP Cath (eff. 1/01)  
(obsolete 4/01)  
2011 = Deflectable Tip Cath--Quad (eff. 1/01)  
(obsolete 4/01)  
2012 = Celsius Abln Cath (eff. 1/01)  
(obsolete 4/01)  
2013 = Celsius Large Abln Cath (eff. 1/01)  
(obsolete 4/01)  
2014 = Celsius II Asym Abln Cath (eff. 1/01)  
(obsolete 4/01)  
2015 = Celsius II Sym Abln Cath (eff. 1/01)  
(obsolete 4/01)  
2016 = Navi-Star DS, Navi-Star Ther (eff. 1/01)  
(obsolete 4/01)  
2017 = Navi-Star Abln Cath (eff. 1/01)  
(obsolete 4/01)  
2018 = Polaris T Ablation Cath (eff. 1/01)  
(obsolete 4/01)  
2019 = EP Deflectable Cath (eff. 1/01)  
(obsolete 4/01)  
2020 = Blazer II XP Abln Cath (eff. 1/01)  
(obsolete 4/01)  
2021 = SilverFlex EP Cath (eff. 1/01)  
(obsolete 4/01)  
2022 = CP Chillli Cooled Abln Cath (eff. 1/01)  
(obsolete 4/01)  
2023 = Chillli Cld AblnCath-std, lg (eff. 1/01)  
(obsolete 4/01)  
2100 = CP CS Reference Cath (eff. 1/01)  
(obsolete 4/01)  
2102 = CP Radii 7F EP Cath (eff. 1/01)  
(obsolete 4/01)  
2103 = CP Radii 7F EP Cath w/Track (eff. 1/01)  
(obsolete 4/01)  
2104 = Lasso Deflectable Cath (eff. 1/01)  
(obsolete 4/01)

2151 = Veripath Guiding Cath (eff. 1/01)  
(obsolete 4/01)  
2152 = Cordis Vista Brite Tip Cath (eff. 1/01)  
(obsolete 4/01)  
2153 = Bard Viking Cath (eff. 1/01)  
(obsolete 4/01)  
2200 = Arrow-Trerotola PTD Cath (eff. 1/01)  
(obsolete 4/01)  
2300 = Varisource Stnd Catheters (eff. 1/01)  
(obsolete 4/01)  
2597 = Clinicath/kit 16/18 sgl/dbl (eff. 1/01)  
(obsolete 4/01)  
2598 = Clinicath 18/20/24-G single (eff. 1/01)  
(obsolete 4/01)  
2599 = Clinicath 16/18-G-double (eff. 1/01)  
(obsolete 4/01)  
2601 = Bard DL Ureteral Cath (eff. 1/01)  
(obsolete 4/01)  
2602 = Vitesse Laser Cath 1.4/1.7mm (eff. 1/01)  
(obsolete 4/01)  
2603 = Vitesse Laser Cath 2.0mm (eff. 1/01)  
(obsolete 4/01)  
2604 = Vitesse E Laser Cath 2.0mm (eff. 1/01)  
(obsolete 4/01)  
2605 = Extreme Laser Catheter (eff. 1/01)  
(obsolete 4/01)  
2606 = SpineCath XL Catheter (eff. 1/01)  
(obsolete 4/01)  
2607 = SpineCath Intradiscal Cath (eff. 1/01)  
(obsolete 4/01)  
2608 = Scimed 6F Wiseguide Cath (eff. 1/01)  
(obsolete 4/01)  
2609 = Flexima Bil Draingage Cath (eff. 1/01)  
(obsolete 4/01)  
2610 = FlexTipPlus Intraspinal Cath (eff. 1/01)  
(obsolete 4/01)  
2611 = AlgoLine Intraspinal Cath (eff. 1/01)  
(obsolete 4/01)  
2612 = InDura Catheter (eff. 1/01)  
(obsolete 4/01)  
2615 = Sealant, pulmonary, liquid (eff. 4/01)  
2616 = Brachytx seed, Yttrium-90 (eff. 4/01)  
2617 = Stent, non-cor, tem w/o del (eff. 4/01)  
2618 = Probe, cryoablation (eff. 4/01)  
2619 = Pmkr, dual, non rate-resp (eff. 4/01)  
2620 = Pmkr, single, non rate-resp (eff. 4/01)  
2621 = Pmkr, other than single/dual (eff. 4/01)  
2622 = Prosthesis, penile, non-inf (eff. 4/01)  
2625 = Stent, non-cor , tem w/del sys (eff. 4/01)  
2626 = Infusion pump, non-prog, temp (eff. 4/01)

2627 = Cath, suprapubic/cystoscopic (eff. 4/01)  
2628 = Catheter, occlusion (eff. 4/01)  
2629 = Intro/sheath, laser (eff. 4/01)  
2630 = Cath, EP, temp-controlled (eff. 4/01)  
2631 = Rep dev, urinary, w/o sling (eff. 4/01)  
2700 = MycroPhylax Plus CS defib (eff. 1/01)  
(obsolete 4/01)  
2701 = Phylax XM SC defib (eff. 1/01)  
(obsolete 4/01)  
2702 = Ventak Prizm 2VR Defib (eff. 1/01)  
(obsolete 4/01)  
2703 = Ventak Prizm VR HE Defib (eff. 1/01)  
(obsolete 4/01)  
2704 = Ventak Mini IV + Defib (eff. 1/01)  
(obsolete 4/01)  
2801 = Defender IV DR 612 DC defib (eff. 1/01)  
(obsolete 4/01)  
2802 = Phylax AV DC defib (eff. 1/01)  
(obsolete 4/01)  
2803 = Ventak Prizm DR HE Defib (eff. 1/01)  
(obsolete 4/01)  
2804 = Ventak Prizm 2 DR Defib (eff. 1/01)  
(obsolete 4/01)  
2805 = Jewel AF 7250 Defib (eff. 1/01)  
(obsolete 4/01)  
2806 = GEM VR 7227 Defib (eff. 1/01)  
(obsolete 4/01)  
2807 = Contak CD 1823 (eff. 1/01)  
(obsolete 4/01)  
2808 = Contak TR 1241 (eff. 1/01)  
(obsolete 4/01)  
3001 = Kainox SL/RV defib lead (eff. 1/01)  
(obsolete 4/01)  
3002 = EasyTrak Defib Lead (eff. 1/01)  
(obsolete 4/01)  
3003 = Endotak SQ Array XP lead (eff. 1/01)  
(obsolete 4/01)  
3004 = Intervene Defib lead (eff. 1/01)  
(obsolete 4/01)  
3400 = Siltex Spectrum, Contour Prof (eff. 1/01)  
(obsolete 4/01)  
3401 = Saline-Filled Spectrum (eff. 1/01)  
(obsolete 4/01)  
3500 = Mentor alpha I Inf Penile Pros (eff. 1/01)  
(obsolete 4/01)  
3510 = AMS 800 Urinary Pros (eff. 1/01)  
(obsolete 4/01)  
3551 = Choice/PT Graphix/Luge/Trooper (eff. 1/01)  
(obsolete 4/01)  
3552 = Hi-Torque Whisper (eff. 1/01)

(obsolete 4/01)  
3553 = Cordis guidewires (eff. 1/01)  
(obsolete 4/01)  
3554 = Jindo guidewire (eff. 1/01)  
(obsolete 4/01)  
3555 = Wholey Hi-Torque Plus GW (eff. 1/01)  
(obsolete 4/01)  
3556 = Wave/FlowWire Guidewire (eff. 1/01)  
(obsolete 4/01)  
3557 = HyTek guidewire (eff. 1/01)  
(obsolete 4/01)  
3800 = SynchroMed EL infusion pump (eff. 1/01)  
(obsolete 4/01)  
3801 = Arrow/Microject PCAQ Sys (eff. 1/01)  
(obsolete 4/01)  
3851 = Elastic UV IOL AA-4203T/TF/TL (eff. 1/01)  
(obsolete 4/01)  
4000 = Opus G 4621, 4624 SC pmkr (eff. 1/01)  
(obsolete 4/01)  
4001 = Opus S 4121/4124 SC pmkr (eff. 1/01)  
(obsolete 4/01)  
4002 = Talent 113 SC pmkr (eff. 1/01)  
(obsolete 4/01)  
4003 = Kairos SR SC pmkr (eff. 1/01)  
(obsolete 4/01)  
4004 = Actros SR, Actros SLR SC pmkr (eff. 1/01)  
(obsolete 4/01)  
4005 = Philos SR/SR-B SC pmkr (eff. 1/01)  
(obsolete 4/01)  
4006 = Pulsar Max II SR pmkr (eff. 1/01)  
(obsolete 4/01)  
4007 = Marathon SR pmkr (eff. 1/01)  
(obsolete 4/01)  
4008 = Discovery II SSI pmkr (eff. 1/01)  
(obsolete 4/01)  
4009 = Discovery II SR pmkr (eff. 1/01)  
(obsolete 4/01)  
4300 = Integrity AFx DR 5342 pmkr (eff. 1/01)  
(obsolete 4/01)  
4301 = Integrity AFx DR 5346 pmkr (eff. 1/01)  
(obsolete 4/01)  
4302 = Affinity VDR 5430 DR (eff. 1/01)  
(obsolete 4/01)  
4303 = Brio 112 DC pmkr (eff. 1/01)  
(obsolete 4/01)  
4304 = Brio 212, Talent 213/223 DC pmkr (eff. 1/01)  
(obsolete 4/01)  
4305 = Brio 222 DC pmkr (eff. 1/01)  
(obsolete 4/01)  
4306 = Brio 220 DC pmkr (eff. 1/01)



(obsolete 4/01)  
4307 = Kairos DR DC pmkr (eff. 1/01)  
(obsolete 4/01)  
4308 = Inos2, Inos2+ DC pmkr (eff. 1/01)  
(obsolete 4/01)  
4309 = Actros DR,D,DR-A, SLR DC pmkr (eff. 1/01)  
(obsolete 4/01)  
4310 = Actros DR-B DC pmkr (eff. 1/01)  
(obsolete 4/01)  
4311 = Philos DR/DR-B/SLR DC (eff. 1/01)  
(obsolete 4/01)  
4312 = Pulsar Max II DR pmkr (eff. 1/01)  
(obsolete 4/01)  
4313 = Marathon DR pmkr (eff. 1/01)  
(obsolete 4/01)  
4314 = Momentum DR pmkr (eff. 1/01)  
(obsolete 4/01)  
4315 = Selection AFm pmkr (eff. 1/01)  
(obsolete 4/01)  
4316 = Discovery II DR (eff. 1/01)  
(obsolete 4/01)  
4317 = Discovery II DDD (eff. 1/01)  
(obsolete 4/01)  
4600 = Snynox, Polyrox, Elox, Retrox (eff. 1/01)  
(obsolete 4/01)  
4602 = Tendril SDX, 1488K pmkr lead (eff. 1/01)  
(obsolete 4/01)  
4603 = Oscan/Flexion pmkr lead (eff. 1/01)  
(obsolete 4/01)  
4604 = CrystallineActFix, CapsureFix (eff. 1/01)  
(obsolete 4/01)  
4605 = CapSure Epi pmkr lead (eff. 1/01)  
(obsolete 4/01)  
4606 = Flexextend pmkr lead (eff. 1/01)  
(obsolete 4/01)  
4607 = FinelineII/EZ, ThinlineII/EZ (eff. 1/01)  
(obsolete 4/01)  
5000 = BX Velocity w/Hepacoat (eff. 1/01)  
(obsolete 4/01)  
5001 = Memotherm Bil Stent, sm, med (eff. 1/01)  
(obsolete 4/01)  
5002 = Memotherm Bil Stent, large (eff. 1/01)  
(obsolete 4/01)  
5003 = Memotherm Bil Stent, x-large (eff. 1/01)  
(obsolete 4/01)  
5004 = PalmazCorinthian IQ Bil Stent (eff. 1/01)  
(obsolete 4/01)  
5005 = PalmazCorinthian IQ Trans/Bil (eff. 1/01)  
(obsolete 4/01)  
5006 = PalmazTran Bil Stent Sys-Med (eff. 1/01)

(obsolete 4/01)  
5007 = PalmazTran XL Bil Stent--40mm (eff. 1/01)  
(obsolete 4/01)  
5008 = PalmazTran XL Bil Stent--50mm (eff. 1/01)  
(obsolete 4/01)  
5009 = VistaFlex Biliary Stent (eff. 1/01)  
(obsolete 4/01)  
5010 = Rapid Exchange Bil Stent Sys (eff. 1/01)  
(obsolete 4/01)  
5011 = IntraStent, IntraStent LP (eff. 1/01)  
(obsolete 4/01)  
5012 = IntraStent DoubleStrut LD (eff. 1/01)  
(obsolete 4/01)  
5013 = IntraStent DoubleStrut XS (eff. 1/01)  
(obsolete 4/01)  
5014 = AVE Bridge Stent Sys-10/17/28 (eff. 1/01)  
(obsolete 4/01)  
5015 = AVE/X3 Bridge Sys, 40-100 (eff. 1/01)  
(obsolete 4/01)  
5016 = Biliary stent single use cov (eff. 1/01)  
(obsolete 4/01)  
5017 = WallstentRP Bil--20/40/60/68mm (eff. 1/01)  
(obsolete 4/01)  
5018 = WallstentRP Bil--80/94mm (eff. 1/01)  
(obsolete 4/01)  
5019 = Flexima Bil Stent Sys (eff. 1/01)  
(obsolete 4/01)  
5020 = Smart Nitinol Stent--20mm (eff. 1/01)  
(obsolete 4/01)  
5021 = Smart Nitinol Stent--40/60mm (eff. 1/01)  
(obsolete 4/01)  
5022 = Smart Nitinol Stent--80mm (eff. 1/01)  
(obsolete 4/01)  
5023 = BX Velocity Stent--8/13mm (eff. 1/01)  
(obsolete 4/01)  
5024 = BX Velocity Stent 18mm (eff. 1/01)  
(obsolete 4/01)  
5025 = BX Velocity Stent 23 mm (eff. 1/01)  
(obsolete 4/01)  
5026 = BX Velocity Stent 28/33mm (eff. 1/01)  
(obsolete 4/01)  
5027 = BX Velocity Stent w/Hep--8/13mm (eff. 1/01)  
(obsolete 4/01)  
5028 = BX Velocity Stent w/Hep--18mm (eff. 1/01)  
(obsolete 4/01)  
5029 = BX Velocity Stent w/Hep--23mm (eff. 1/01)  
(obsolete 4/01)  
5030 = Stent, coronary, S660 9/12mm (eff. 1/01)  
(obsolete 4/01)  
5031 = Stent, coronary, S660 15/18mm (eff. 1/01)

(obsolete 4/01)  
5032 = Stent, coronary, S660 24/30mm (eff. 1/01)  
(obsolete 4/01)  
5033 = Nitroal Stent Sys, 9mm (eff. 1/01)  
(obsolete 4/01)  
5034 = Nitroal Stent Sys, 12/15mm (eff. 1/01)  
(obsolete 4/01)  
5035 = Nitroal Stent Sys, 18mm (eff. 1/01)  
(obsolete 4/01)  
5036 = Nitroal Stent Sys, 25mm (eff. 1/01)  
(obsolete 4/01)  
5037 = Nitroal Stent Sys, 31mm (eff. 1/01)  
(obsolete 4/01)  
5038 = BX Velocity Stent w/Raptor (eff. 1/01)  
(obsolete 4/01)  
5039 = IntraCoil Periph Stent--40mm (eff. 1/01)  
(obsolete 4/01)  
5040 = IntraCoil Periph Stent--60mm (eff. 1/01)  
(obsolete 4/01)  
5041 = BeStent Over-the-Wire 24/30mm (eff. 1/01)  
(obsolete 4/01)  
5042 = BeStent Over-the-Wire 18mm (eff. 1/01)  
(obsolete 4/01)  
5043 = BeStent Over-the-Wire 15mm (eff. 1/01)  
(obsolete 4/01)  
5044 = BeStent Over-the-Wire 9/12mm (eff. 1/01)  
(obsolete 4/01)  
5045 = Multilink Tetra Cor Stent Sys (eff. 1/01)  
(obsolete 4/01)  
5046 = Radius 20mm cor stent (eff. 1/01)  
(obsolete 4/01)  
5047 = Nitroal Elite Cor Stent Sys (eff. 1/01)  
(obsolete 4/01)  
5048 = GR II Coronary Stent (eff. 1/01)  
(obsolete 4/01)  
5130 = Wilson-Cook Colonic Z-Stent (eff. 1/01)  
(obsolete 4/01)  
5131 = Bard Colorectal Stent-60mm (eff. 1/01)  
(obsolete 4/01)  
5132 = Bard Colorectal Stent-80mm (eff. 1/01)  
(obsolete 4/01)  
5133 = Bard Colorectal Stent-100mm (eff. 1/01)  
(obsolete 4/01)  
5134 = Enteral Wallstent-90mm (eff. 1/01)  
(obsolete 4/01)  
5279 = Contour/Percuflex Stent (eff. 1/01)  
(obsolete 4/01)  
5280 = Inlay Dbl Ureteral Stent (eff. 1/01)  
(obsolete 4/01)  
5281 = Wallgraft Trach Sys 70mm (eff. 1/01)

(obsolete 4/01)  
5282 = Wallgraft Trach Sys 20/30/50 (eff. 1/01)  
(obsolete 4/01)  
5283 = Wallstent/RP TIPS--80mm (eff. 1/01)  
(obsolete 4/01)  
5284 = Wallstent TrachUltraFlex (eff. 1/01)  
(obsolete 4/01)  
5600 = Closure dev, VasoSeal ES (eff. 1/01)  
(obsolete 4/01)  
5601 = VasoSeal Model 1000 (eff. 1/01)  
(obsolete 4/01)  
6001 = Composix Mesh 8/21 in (eff. 1/01)  
(obsolete 4/01)  
6002 = Composix Mesh 32 in (eff. 1/01)  
(obsolete 4/01)  
6003 = Composix Mesh 48 in (eff. 1/01)  
(obsolete 4/01)  
6004 = Composix Mesh 80 in (eff. 1/01)  
(obsolete 4/01)  
6005 = Composix Mesh 140 in (eff. 1/01)  
(obsolete 4/01)  
6006 = Composix Mesh 144 in (eff. 1/01)  
(obsolete 4/01)  
6012 = Pelvicol Collagen 8/14 sq cm (eff. 1/01)  
(obsolete 4/01)  
6013 = Pelvicol Collagen 21/24/28 sq cm (eff. 1/01)  
(obsolete 4/01)  
6014 = Pelvicol Collagen 36 sq cm (eff. 1/01)  
(obsolete 4/01)  
6015 = Pelvicol Collagen 48 sq cm (eff. 1/01)  
(obsolete 4/01)  
6016 = Pelvicol Collagen 96 sq cm (eff. 1/01)  
(obsolete 4/01)  
6017 = Gore-Tex DualMesh 75/96 sq cm (eff. 1/01)  
(obsolete 4/01)  
6018 = Gore-Tex DualMesh 150 sq cm (eff. 1/01)  
(obsolete 4/01)  
6019 = Gore-Tex DualMesh 285 sq cm (eff. 1/01)  
(obsolete 4/01)  
6020 = Gore-Tex DualMesh 432 sq cm (eff. 1/01)  
(obsolete 4/01)  
6021 = Gore-Tex DualMesh 600 sq cm (eff. 1/01)  
(obsolete 4/01)  
6022 = Gore-Tex DualMesh 884 sq cm (eff. 1/01)  
(obsolete 4/01)  
6023 = Gore-TexPlus 1mm, 75/96 sq cm (eff. 1/01)  
(obsolete 4/01)  
6024 = Gore-TexPlus 1mm, 150 sq cm (eff. 1/01)  
(obsolete 4/01)  
6025 = Gore-TexPlus 1mm, 285 sq cm (eff. 1/01)

(obsolete 4/01)  
6026 = Gore-TexPlus 1mm, 432 sq cm (eff. 1/01)  
(obsolete 4/01)  
6027 = Gore-TexPlus 1mm, 600 sq cm (eff. 1/01)  
(obsolete 4/01)  
6028 = Gore-TexPlus 1mm, 884 sq cm (eff. 1/01)  
(obsolete 4/01)  
6029 = Gore-TexPlus 2mm, 150 sq cm (eff. 1/01)  
(obsolete 4/01)  
6030 = Gore-TexPlus 2mm, 285 sq cm (eff. 1/01)  
(obsolete 4/01)  
6031 = Gore-TexPlus 2mm, 432 sq cm (eff. 1/01)  
(obsolete 4/01)  
6032 = Gore-TexPlus 2mm, 600 sq cm (eff. 1/01)  
(obsolete 4/01)  
6033 = Gore-TexPlus 2mm, 884 sq cm (eff. 1/01)  
(obsolete 4/01)  
6034 = Bard ePTFE: 150 sq cm-2mm  
(obsolete 4/01)  
6035 = Bard ePTFE: 150sqcm-1mm,75-2mm (eff. 1/01)  
(obsolete 4/01)  
6036 = Bard ePTFE: 50/75sqcm-1,2mm (eff. 1/01)  
(obsolete 4/01)  
6037 = Bard ePTFE: 300 sq cm-1,2mm (eff. 1/01)  
(obsolete 4/01)  
6038 = Bard ePTFE: 600 sq cm-1mm (eff. 1/01)  
(obsolete 4/01)  
6039 = Bard ePTFE: 884sq cm-1mm (eff. 1/01)  
(obsolete 4/01)  
6040 = Bard ePTFE: 600sq cm-2mm (eff. 1/01)  
(obsolete 4/01)  
6041 = Bard ePTFE: 884sq cm -2mm (eff. 1/01)  
(obsolete 4/01)  
6050 = Female Sling Sys w/wo Matrl (eff. 1/01)  
(obsolete 4/01)  
6051 = Stratasis Sling, 20/40 cm (eff. 1/01)  
(obsolete 4/01)  
6052 = Stratasis Sling, 60 cm (eff. 1/01)  
(obsolete 4/01)  
6053 = Surgisis Soft Graft (eff. 1/01)  
(obsolete 4/01)  
6054 = Surgisis Enhanced Graft (eff. 1/01)  
(obsolete 4/01)  
6055 = Surgisis Enhanced Tissue (eff. 1/01)  
(obsolete 4/01)  
6056 = Surgisis Soft Tissue Graft (eff. 1/01)  
(obsolete 4/01)  
6057 = Surgisis Hernia Graft (eff. 1/01)  
(obsolete 4/01)  
6058 = SurgiPro Hernia Plug, med/lg (eff. 1/01)

(obsolete 4/01)  
6080 = Male Sling Sys w/wo Matrial (eff. 1/01)  
(obsolete 4/01)  
6200 = Exxcel Soft ePTFE vas graft (ef. 1/01)  
(obsolete 4/01)  
6201 = Impra Venaflo--10/20cm (eff. 1/01)  
(obsolete 4/01)  
6202 = Impra Venaflo--30/40 cm (eff. 1/01)  
(obsolete 4/01)  
6203 = Impra Venaflo--50 cm, vt45 (eff. 1/01)  
(obsolete 4/01)  
6204 = Impra Venaflo--stepped (eff. 1/01)  
(obsolete 4/01)  
6205 = Impra Carboflo--10cm (eff. 1/01)  
(obsolete 4/01)  
6206 = Impra Carboflo--20 cm (eff. 1/01)  
(obsolete 4/01)  
6207 = Impra Carboflo--30/35/40cm (eff. 1/01)  
(obsolete 4/01)  
6208 = Impra Carboflo--40/50cm (eff. 1/01)  
(obsolete 4/01)  
6209 = Impra Carboflo--ctrflex (eff. 1/01)  
(obsolete 4/01)  
6210 = Exxcel ePTFE vas graft (eff. 1/01)  
(obsolete 4/01)  
6300 = Vanguard III Endovas Graft (eff. 1/01)  
(obsolete 4/01)  
6500 = Preface Guiding Sheath (eff. 1/01)  
(obsolete 4/01)  
6501 = Soft Tip Sheaths (eff. 1/01)  
(obsolete 4/01)  
6502 = Perry Exchange Dilator (eff. 1/01)  
(obsolete 4/01)  
6525 = Spectranetics Laser Sheath (eff. 1/01)  
(obsolete 4/01)  
6600 = Micro Litho Flex Probes (eff. 1/01)  
(obsolete 4/01)  
6650 = Fast-Cath Guiding Introducer (eff. 1/01)  
(obsolete 4/01)  
6651 = Seal-Away Guding Introducer (eff. 1/01)  
(obsolete 4/01)  
6652 = Bard Excalibur Introducer (eff. 1/01)  
(obsolete 4/01)  
6700 = Focal Seal-L (eff. 1/01)  
(obsolete 4/01)  
7000 = Amifostine, 500 mg (eligible for pass-through  
payments)  
7001 = Amphotericin B lipid complex, 50 mg, Inj  
(eligible for pass-through payments)  
7002 = Clonidine, HCl, 1 MG (eligible for pass-

through payments) (obsolete 1/01)  
7003 = Epoprostenol, 0.5 MG, inj (eligible for pass-through payments)  
7004 = Immune globulin intravenous human 5g, inj (eligible for pass-through payments)  
7005 = Gonadorelin hcI, 100 mcg (eligible for pass-through payments)  
7007 = Milrinone lactate, per 5 ml, inj (not subject to national coinsurance)  
7010 = Morphine sulfate concentrate (preservative free) per 10 mg (eligible for pass-through payments)  
7011 = Oprelevakin, inj, 5 mg (eligible for pass-through payments)  
7012 = Pentamidine isethionate, 300 mg (eligible for pass-through payments) (obsolete 1/01)  
7014 = Fentanyl citrate, inj, up to 2 ml (eligible for pass-through payments)  
7015 = Busulfan, oral 2 mg (eligible for pass-through payments)  
7019 = Aprotinin, 10,000 kiu (eligible for pass-through payments)  
7021 = Baclofen, intrathecal, 50 mcg (eligible for pass-through payments) (obsolete 1/01)  
7022 = Elliotts B Solution, per ml (eligible for pass-through payments)  
7023 = Treatment for bladder calculi, I.e. Renacidin per 500 ml (eligible for pass-through payments)  
7024 = Corticorelin ovine triflutate, 0.1 mg (eligible for pass-through payments)  
7025 = Digoxin immune FAB (Ovine), 10 mg (eligible for pass-through payments)  
7026 = Ethanolamine oleate, 1000 ml (eligible for pass-through payments)  
7027 = Fomepizole, 1.5 G (eligible for pass-through payments)  
7028 = Fosphenytoin, 50 mg (eligible for pass-through payments)  
7029 = Glatiramer acetate, 25 mg (eligible for pass-through payments)  
7030 = Hemin, 1 mg (eligible for pass-through payments)  
7031 = Octreotide Acetate, 500 mcg (eligible for pass-through payments)  
7032 = Sermorelin acetate, 0.5 mg (eligible for pass-through payments)  
7033 = Somatrem, 5 mg (eligible for pass-through payments)  
7034 = Somatropin, 1 mg (eligible for pass-through payments)  
7035 = Teniposide, 50 mg

(eligible for pass-through payments)  
7036 = Urokinase, inj, IV, 250,000 I.U.  
(not subject to national coinsurance)  
7037 = Urofollitropin, 75 I.U.  
(eligible for pass-through payments)  
7038 = Muromonab-CD3, 5 mg  
(eligible for pass-through payments)  
7039 = Pegademase bovine inj 25 I.U.  
(eligible for pass-through payments)  
7040 = Pentastarch 10% inj, 100 ml  
(eligible for pass-through payments)  
7041 = Tirofiban HCL, 0.5 mg  
(not subject to national coinsurance)  
7042 = Capecitabine, oral 150 mg  
(eligible for pass-through payments)  
7043 = Infliximab, 10 MG (eligible for pass-through  
payments)  
7045 = Trimetrexate Glucoronate (eligible for pass-  
through payments)  
7046 = Doxorubicin Hcl Liposome (eligible for pass-  
through payments)  
7047 = Droperidol/fentanyl inj (eff. 1/01)  
7048 = Alteplase, 1 mg (eff. 1/01)  
7049 = Filgrastim 480 mcg injection (eff. 1/01)  
7315 = Sodium hyaluronate, 20 mg (eff. 1/01)  
8099 = Spectranetics Lead Lock Dev (eff. 1/01)  
(obsolete 4/01)  
8100 = Adhesion barrier, ADCON-L (eff. 1/01)  
(obsolete 4/01)  
8102 = SurgiVision Esoph Coil (eff. 1/01)  
(obsolete 4/01)  
9000 = Na chromate Cr51, per 0.25mCi (eff. 1/01)  
9001 = Linezolid inj, 200mg (eff. 1/01)  
9002 = Tenecteplase, 50mg/vial (eff. 1/01)  
9003 = Palivizumab, per 50 mg (eff. 1/01)  
9004 = Gemtuzumab ozogamicin inj, 5mg (eff. 1/01)  
9005 = Reteplase inj, half-kit, 18.8 mg/vial (eff. 1/01)  
9006 = Tacrolimus inj, per 5 mg (1 amp) (eff. 1/01)  
9007 = Baclofen Intrathecal kit-1amp (eff. 1/01)  
9008 = Baclofen Refill Kit--500mcg (eff. 1/01)  
9009 = Baclofen Refill Kit--2000mcg (eff. 1/01)  
9010 = Baclofen Refill Kit--4000mcg (eff. 1/01)  
9011 = Caffeine Citrate, inj, 1ml (eff. 1/01)  
9012 = Arsenic Trioxide, 1mg/kg (eff. 4/01)  
9013 = Co 57 Cobaltous Cl, 1 ml (eff. 4/01)  
9100 = Iodinated I-131 Albumin (eff. 1/01)  
9102 = 51 Na chromate, 50mCi (eff. 1/01)  
9103 = Na lothalamate I-125, 10uCi (eff. 1/01)  
9104 = Anti-thymocyte globin, 25 mg (eff. 1/01)  
9105 = Hep B immun glob, per 1 ml (eff. 1/01)



9106 = Sirolimus 1 mg/ml (eff. 1/01)  
9107 = Tinzaparin sodium, 2ml vial (eff. 1/01)  
9108 = Thyrotropin Alfa, 1.1 mg (eff. 1/01)  
9109 = Tirofiban hydrachloride 6.25 mg (eff. 1/01)  
9217 = Leuprolide acetate for depot suspension,  
7.5 mg (eff. 1/01)  
9500 = Platelets, irradiated, ea unit (eff. 1/01)  
9501 = Platelets, pheresis, ea unit (eff. 1/01)  
9502 = Platelets, pher/irradiated, ea unit (eff. 1/01)  
9503 = Fresh frozen plasma, ea unit (eff. 1/01)  
9504 = RBC, deglycerolized, ea unit (eff. 1/01)  
9505 = RBC, irradiated, ea unit (eff. 1/01)  
9998 = Enoxaparin (eff. 1/01)

REV\_CNTR\_CNSLDTD\_BLG\_TB

Revenue Center Consolidated Billing Table

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

REV\_CNTR\_DDCTBL\_COINSRNC\_TB

Revenue Center Deductible Coinsurance Code

0 = Charges are subject to deductible  
and coinsurance  
1 = Charges are not subject to deductible  
2 = Charges are not subject to coinsurance  
3 = Charges are not subject to deductible  
or coinsurance  
4 = No charge or units associated with this  
revenue center code. (For multiple  
HCPCS per single revenue center code)

For revenue center code 0001, the following  
MSP override values may be present:

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

REV\_CNTR\_DSCNT\_IND\_TB

Revenue Center Discount Indicator Table

\*DISCOUNTING FORMULAS\*

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

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

D = Discounting fraction (currently 0.5)

U = Number of units

T = Terminated procedure discount (currently 0.5)

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

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

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

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

2 =

Blank =  
denied

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

Valid Values:

F2 = International Unit

GR = Gram

ML = Milliliter

UN = Unit

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

0 = Not packaged

1 = Packaged service (service indicator N)

2 = Packaged as part of partial hospitalization  
per diem or daily mental health service  
per diem

3 = Artificial charges for surgical procedure

(eff. 7/2004)

REV\_CNTR\_PMT\_MTHD\_IND\_TB

Revenue Center Payment Method Indicator Table

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

- 1 = Paid standard hospital OPPS amount  
(status indicators K, S,T,V,X)
- 2 = Services not paid under OPPS (status indicator A, or no HCPCS code and not certain revenue center codes)
- 3 = Not paid (status indicator M,W,Y,E) or not paid under OPPS (status indicator B,C & Z)
- 4 = Paid at reasonable cost (status indicator F,L)
- 5 = Additional payment for drug or biological (status indicator G)
- 6 = Additional payment for device (status indicator H)
- 7 = Additional payment for new drug or new biological (status indicator J)
- 8 = Paid partial hospitalization per diem (status indicator P)
- 9 = No additional payment, payment included in line items with APCs (status indicator N, or no HCPCS code and certain revenue center codes, or HCPCS codes G0176 (activity therapy), G0129 (occupational therapy) or G0177 (partial hospitalization program services))

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

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

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

- A = Services not paid under OPPS
- C = Inpatient procedure
- E = Noncovered items or services
- F = Corneal tissue acquisition
- G = Current drug or biological pass-through
- H = Device pass-through

J = New drug or new biological pass-through  
N = Packaged incidental service  
P = Partial hospitalization services  
S = Significant procedure not subject to  
multiple procedure discounting  
T = Significant procedure subject to multiple  
procedure discounting  
V = Medical visit to clinic or emergency  
department  
X = Ancillary service

\*\*\*\*\*Payment Indicator\*\*\*\*\*  
\*\*\*\*\* 2nd position \*\*\*\*\*  
1 = Paid standard hospital OPPS amount  
(service indicators S,T,V,X)  
2 = Services not paid under OPPS (service  
indicator A, or no HCPCS code and not  
certain revenue center codes)  
3 = Not paid (service indicators C & E)  
4 = Acquisition cost paid (service indica-  
tor F)  
5 = Additional payment for current drug or  
biological (service indicator G)  
6 = Additional payment for device (service  
indicator H)  
7 = Additional payment for new drug or new  
biological (service indicator J)  
8 = Paid partial hospitalization per diem  
(service indicator P)  
9 = No additional payment, payment included  
in line items with APCs (service  
indicator N, or no HCPCS code and certain  
revenue center codes, or HCPCS codes Q0082  
(activity therapy), G0129 (occupational  
therapy) or G0172 (partial hospitalization  
training)

REV\_CNTR\_PRICNG\_IND\_TB

Revenue Center Pricing Indicator Table

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

B = A valid HCPCS code subject to the fee schedule payment.  
for the provider billed charges. NOTE: There is an excep-  
tion for Critical Access Hospitals (provider numbers  
XX1300-XX1399) with reimbursement method 'J' (all-  
inclusive method) and dates of service on or after

7/1/01. In these situations, reimbursement for professional services (revenue codes 96X, 97X, 98X) is always at the fee schedule amount of logic is not applicable.

C = Unlisted Rehabilitation Carrier Priced HCPCS

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

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

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

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

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

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

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

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

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

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

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

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

Q = Manual pricing

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

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

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

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

X = Unclassified drug as subject to manual pricing.

REV\_CNTR\_STUS\_IND\_TB

Revenue Center Status Indicator Table

A = Services not paid under OPPS

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

REV\_CNTR\_TB

Revenue Center Table

0001 = Total charge  
 0022 = SNF claim paid under PPS submitted as TOB 21X, effective for cost reporting periods beginning on or after 7/1/98 (dates of service after 6/30/98). NOTE: This code may appear multiple times on a claim to identify different HIPPS Rate Code/assessment periods.  
 0023 = Home Health services paid under PPS submitted as TOB 32X and 33X, effective 10/00. This code may appear multiple times on a claim to identify different HIPPS/Home Health Resource Groups (HRG).  
 0024 = Inpatient Rehabilitation Facility services paid under PPS submitted as TOB 11X, effective for cost reporting periods beginning on or after 1/1/2002 (dates of service after 12/31/01). This code may appear only once on a claim.  
 0100 = All inclusive rate-room and board plus ancillary  
 0101 = All inclusive rate-room and board  
 0110 = Private medical or general-general classification  
 0111 = Private medical or general-medical/surgical/GYN

0112 = Private medical or general-OB  
0113 = Private medical or general-pediatric  
0114 = Private medical or general-psychiatric  
0115 = Private medical or general-hospice  
0116 = Private medical or general-detoxification  
0117 = Private medical or general-oncology  
0118 = Private medical or general-rehabilitation  
0119 = Private medical or general-other  
0120 = Semi-private 2 bed (medical or general)  
general classification  
0121 = Semi-private 2 bed (medical or general)  
medical/surgical/GYN  
0122 = Semi-private 2 bed (medical or general)-OB  
0123 = Semi-private 2 bed (medical or general)-pediatric  
0124 = Semi-private 2 bed (medical or general)-psychiatric  
0125 = Semi-private 2 bed (medical or general)-hospice  
0126 = Semi-private 2 bed (medical or general)  
detoxification  
0127 = Semi-private 2 bed (medical or general)-oncology  
0128 = Semi-private 2 bed (medical or general)  
rehabilitation  
0129 = Semi-private 2 bed (medical or general)-other  
0130 = Semi-private 3 and 4 beds-general classification  
0131 = Semi-private 3 and 4 beds-medical/surgical/GYN  
0132 = Semi-private 3 and 4 beds-OB  
0133 = Semi-private 3 and 4 beds-pediatric  
0134 = Semi-private 3 and 4 beds-psychiatric  
0135 = Semi-private 3 and 4 beds-hospice  
0136 = Semi-private 3 and 4 beds-detoxification  
0137 = Semi-private 3 and 4 beds-oncology  
0138 = Semi-private 3 and 4 beds-rehabilitation  
0139 = Semi-private 3 and 4 beds-other  
0140 = Private (deluxe)-general classification  
0141 = Private (deluxe)-medical/surgical/GYN  
0142 = Private (deluxe)-OB  
0143 = Private (deluxe)-pediatric  
0144 = Private (deluxe)-psychiatric  
0145 = Private (deluxe)-hospice  
0146 = Private (deluxe)-detoxification  
0147 = Private (deluxe)-oncology  
0148 = Private (deluxe)-rehabilitation  
0149 = Private (deluxe)-other  
0150 = Room&Board ward (medical or general)  
general classification  
0151 = Room&Board ward (medical or general)  
medical/surgical/GYN  
0152 = Room&Board ward (medical or general)-OB  
0153 = Room&Board ward (medical or general)-pediatric  
0154 = Room&Board ward (medical or general)-psychiatric  
0155 = Room&Board ward (medical or general)-hospice



0156 = Room&Board ward (medical or general)-detoxification  
0157 = Room&Board ward (medical or general)-oncology  
0158 = Room&Board ward (medical or general)-rehabilitation  
0159 = Room&Board ward (medical or general)-other  
0160 = Other Room&Board-general classification  
0164 = Other Room&Board-sterile environment  
0167 = Other Room&Board-self care  
0169 = Other Room&Board-other  
0170 = Nursery-general classification  
0171 = Nursery-newborn  
    level I (routine)  
0172 = Nursery-premature  
    newborn-level II (continuing care)  
0173 = Nursery-newborn-level III (intermediate care)  
    (eff 10/96)  
0174 = Nursery-newborn-level IV (intensive care)  
    (eff 10/96)  
0175 = Nursery-neonatal ICU (obsolete eff 10/96)  
0179 = Nursery-other  
0180 = Leave of absence-general classification  
0182 = Leave of absence-patient convenience charges  
    billable  
0183 = Leave of absence-therapeutic leave  
0184 = Leave of absence-ICF mentally retarded-any reason  
0185 = Leave of absence-nursing home (hospitalization)  
0189 = Leave of absence-other leave of absence  
0190 = Subacute care - general classification  
    (eff. 10/97)  
0191 = Subacute care - level I (eff. 10/97)  
0192 = Subacute care - level II (eff. 10/97)  
0193 = Subacute care - level III (eff. 10/97)  
0194 = Subacute care - level IV (eff. 10/97)  
0199 = Subacute care - other (eff 10/97)  
0200 = Intensive care-general classification  
0201 = Intensive care-surgical  
0202 = Intensive care-medical  
0203 = Intensive care-pediatric  
0204 = Intensive care-psychiatric  
0206 = Intensive care-post ICU; redefined as  
    intermediate ICU (eff 10/96)  
0207 = Intensive care-burn care  
0208 = Intensive care-trauma  
0209 = Intensive care-other intensive care  
0210 = Coronary care-general classification  
0211 = Coronary care-myocardial infraction  
0212 = Coronary care-pulmonary care  
0213 = Coronary care-heart transplant  
0214 = Coronary care-post CCU; redefined as  
    intermediate CCU (eff 10/96)  
0219 = Coronary care-other coronary care

0220 = Special charges-general classification  
0221 = Special charges-admission charge  
0222 = Special charges-technical support charge  
0223 = Special charges-UR service charge  
0224 = Special charges-late discharge, medically  
necessary  
0229 = Special charges-other special charges  
0230 = Incremental nursing charge rate-general  
classification  
0231 = Incremental nursing charge rate-nursery  
0232 = Incremental nursing charge rate-OB  
0233 = Incremental nursing charge rate-ICU (include  
transitional care)  
0234 = Incremental nursing charge rate-CCU (include  
transitional care)  
0235 = Incremental nursing charge rate-hospice  
0239 = Incremental nursing charge rate-other  
0240 = All inclusive ancillary-general classification  
0241 = All inclusive ancillary-basic  
0242 = All inclusive ancillary-comprehensive  
0243 = All inclusive ancillary-specialty  
0249 = All inclusive ancillary-other inclusive ancillary  
0250 = Pharmacy-general classification  
0251 = Pharmacy-generic drugs  
0252 = Pharmacy-nongeneric drugs  
0253 = Pharmacy-take home drugs  
0254 = Pharmacy-drugs incident to other diagnostic service-  
subject to payment limit  
0255 = Pharmacy-drugs incident to radiology-  
subject to payment limit  
0256 = Pharmacy-experimental drugs  
0257 = Pharmacy-non-prescription  
0258 = Pharmacy-IV solutions  
0259 = Pharmacy-other pharmacy  
0260 = IV therapy-general classification  
0261 = IV therapy-infusion pump  
0262 = IV therapy-pharmacy services (eff 10/94)  
0263 = IV therapy-drug supply/delivery (eff 10/94)  
0264 = IV therapy-supplies (eff 10/94)  
0269 = IV therapy-other IV therapy  
0270 = Medical/surgical supplies-general classification  
(also see 062X)  
0271 = Medical/surgical supplies-nonsterile supply  
0272 = Medical/surgical supplies-sterile supply  
0273 = Medical/surgical supplies-take home supplies  
0274 = Medical/surgical supplies-prosthetic/orthotic  
devices  
0275 = Medical/surgical supplies-pace maker  
0276 = Medical/surgical supplies-intraocular lens  
0277 = Medical/surgical supplies-oxygen-take home

0278 = Medical/surgical supplies-other implants  
0279 = Medical/surgical supplies-other devices  
0280 = Oncology-general classification  
0289 = Oncology-other oncology  
0290 = DME (other than renal)-general classification  
0291 = DME (other than renal)-rental  
0292 = DME (other than renal)-purchase of new DME  
0293 = DME (other than renal)-purchase of used DME  
0294 = DME (other than renal)-related to and listed as DME  
0299 = DME (other than renal)-other  
0300 = Laboratory-general classification  
0301 = Laboratory-chemistry  
0302 = Laboratory-immunology  
0303 = Laboratory-renal patient (home)  
0304 = Laboratory-non-routine dialysis  
0305 = Laboratory-hematology  
0306 = Laboratory-bacteriology & microbiology  
0307 = Laboratory-urology  
0309 = Laboratory-other laboratory  
0310 = Laboratory pathological-general classification  
0311 = Laboratory pathological-cytology  
0312 = Laboratory pathological-histology  
0314 = Laboratory pathological-biopsy  
0319 = Laboratory pathological-other  
0320 = Radiology diagnostic-general classification  
0321 = Radiology diagnostic-angiocardiology  
0322 = Radiology diagnostic-arthrography  
0323 = Radiology diagnostic-arteriography  
0324 = Radiology diagnostic-chest X-ray  
0329 = Radiology diagnostic-other  
0330 = Radiology therapeutic-general classification  
0331 = Radiology therapeutic-chemotherapy injected  
0332 = Radiology therapeutic-chemotherapy oral  
0333 = Radiology therapeutic-radiation therapy  
0335 = Radiology therapeutic-chemotherapy IV  
0339 = Radiology therapeutic-other  
0340 = Nuclear medicine-general classification  
0341 = Nuclear medicine-diagnostic  
0342 = Nuclear medicine-therapeutic  
0343 = Nuclear medicine-diagnostic radiopharmaceuticals  
0344 = Nuclear medicine-therapeutic radiopharmaceuticals  
0349 = Nuclear medicine-other  
0350 = Computed tomographic (CT) scan-general  
classification  
0351 = CT scan-head scan  
0352 = CT scan-body scan  
0359 = CT scan-other CT scans  
0360 = Operating room services-general classification  
0361 = Operating room services-minor surgery  
0362 = Operating room services-organ transplant,

other than kidney  
0367 = Operating room services-kidney transplant  
0369 = Operating room services-other operating room  
services  
0370 = Anesthesia-general classification  
0371 = Anesthesia-incident to RAD and  
subject to the payment limit  
0372 = Anesthesia-incident to other diagnostic service  
and subject to the payment limit  
0374 = Anesthesia-acupuncture  
0379 = Anesthesia-other anesthesia  
0380 = Blood-general classification  
0381 = Blood-packed red cells  
0382 = Blood-whole blood  
0383 = Blood-plasma  
0384 = Blood-platelets  
0385 = Blood-leukocytes  
0386 = Blood-other components  
0387 = Blood-other derivatives (cryoprecipitates)  
0389 = Blood-other blood  
0390 = Blood storage and processing-general  
classification  
0391 = Blood storage and processing-blood  
administration  
0399 = Blood storage and processing-other  
0400 = Other imaging services-general classification  
0401 = Other imaging services-diagnostic mammography  
0402 = Other imaging services-ultrasound  
0403 = Other imaging services-screening mammography  
(eff 1/1/91)  
0404 = Other imaging services-positron emission  
tomography (eff 10/94)  
0409 = Other imaging services-other  
0410 = Respiratory services-general classification  
0412 = Respiratory services-inhalation services  
0413 = Respiratory services-hyperbaric oxygen therapy  
0419 = Respiratory services-other  
0420 = Physical therapy-general classification  
0421 = Physical therapy-visit charge  
0422 = Physical therapy-hourly charge  
0423 = Physical therapy-group rate  
0424 = Physical therapy-evaluation or re-evaluation  
0429 = Physical therapy-other  
0430 = Occupational therapy-general classification  
0431 = Occupational therapy-visit charge  
0432 = Occupational therapy-hourly charge  
0433 = Occupational therapy-group rate  
0434 = Occupational therapy-evaluation or re-evaluation  
0439 = Occupational therapy-other (may include  
restorative therapy)

0440 = Speech language pathology-general classification  
0441 = Speech language pathology-visit charge  
0442 = Speech language pathology-hourly charge  
0443 = Speech language pathology-group rate  
0444 = Speech language pathology-evaluation or  
re-evaluation  
0449 = Speech language pathology-other  
0450 = Emergency room-general classification  
0451 = Emergency room-emtala emergency medical screening  
services (eff 10/96)  
0452 = Emergency room-ER beyond emtala screening  
(eff 10/96)  
0456 = Emergency room-urgent care (eff 10/96)  
0459 = Emergency room-other  
0460 = Pulmonary function-general classification  
0469 = Pulmonary function-other  
0470 = Audiology-general classification  
0471 = Audiology-diagnostic  
0472 = Audiology-treatment  
0479 = Audiology-other  
0480 = Cardiology-general classification  
0481 = Cardiology-cardiac cath lab  
0482 = Cardiology-stress test  
0483 = Cardiology-Echocardiology  
0489 = Cardiology-other  
0490 = Ambulatory surgical care-general classification  
0499 = Ambulatory surgical care-other  
0500 = Outpatient services-general classification  
(deleted 9/93)  
0509 = Outpatient services-other  
0510 = Clinic-general classification  
0511 = Clinic-chronic pain center  
0512 = Clinic-dental center  
0513 = Clinic-psychiatric  
0514 = Clinic-OB-GYN  
0515 = Clinic-pediatric  
0516 = Clinic-urgent care clinic (eff 10/96)  
0517 = Clinic-family practice clinic (eff 10/96)  
0519 = Clinic-other  
0520 = Free-standing clinic-general classification  
0521 = Free-standing clinic-Clinic visit by a  
member to RHC/FQHC (eff. 7/1/06). Prior to  
7/1/06 - Rural Health-Clinic  
0522 = Free-standing clinic-Home visit by RHC/FQHC  
practitioner (eff. 7/1/06). Prior to  
7/1/06 - Rural Health-Home  
0523 = Free-standing clinic-family practice  
0524 = Free-standing clinic - visit by RHC/FQHC  
practitioner to a member in a covered Part  
A stay at the SNF. (eff. 7/1/06)

0525 = Free-standing clinic - visit by RHC/FQHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility. (eff. 7/1/06)  
0526 = Free-standing clinic-urgent care (eff 10/96)  
0527 = Free-standing clinic-RHC/FQHC visiting nurse service(s) to a member's home when in a home health shortage area. (eff. 7/1/06)  
0528 = Free-standing clinic-visit by RHC/FQHC practitioner to other non RHC/FQHC site (e.g. scene of accident). (eff. 7/1/06)  
0529 = Free-standing clinic-other  
0530 = Osteopathic services-general classification  
0531 = Osteopathic services-osteopathic therapy  
0539 = Osteopathic services-other  
0540 = Ambulance-general classification  
0541 = Ambulance-supplies  
0542 = Ambulance-medical transport  
0543 = Ambulance-heart mobile  
0544 = Ambulance-oxygen  
0545 = Ambulance-air ambulance  
0546 = Ambulance-neo-natal ambulance  
0547 = Ambulance-pharmacy  
0548 = Ambulance-telephone transmission EKG  
0549 = Ambulance-other  
0550 = Skilled nursing-general classification  
0551 = Skilled nursing-visit charge  
0552 = Skilled nursing-hourly charge  
0559 = Skilled nursing-other  
0560 = Medical social services-general classification  
0561 = Medical social services-visit charge  
0562 = Medical social services-hourly charges  
0569 = Medical social services-other  
0570 = Home health aid (home health)-general classification  
0571 = Home health aid (home health)-visit charge  
0572 = Home health aid (home health)-hourly charge  
0579 = Home health aid (home health)-other  
0580 = Other visits (home health)-general classification (under HHPPS, not allowed as covered charges)  
0581 = Other visits (home health)-visit charge (under HHPPS, not allowed as covered charges)  
0582 = Other visits (home health)-hourly charge (under HHPPS, not allowed as covered charges)  
0589 = Other visits (home health)-other (under HHPPS, not allowed as covered charges)  
0590 = Units of service (home health)-general classification (under HHPPS, not allowed as covered charges)

0599 = Units of service (home health)-other  
(under HHPPS, not allowed as covered charges)  
0600 = Oxygen/Home Health-general classification  
0601 = Oxygen/Home Health-stat or port equip/supply  
or count  
0602 = Oxygen/Home Health-stat/equip/under 1 LPM  
0603 = Oxygen/Home Health-stat/equip/over 4 LPM  
0604 = Oxygen/Home Health-stat/equip/portable add-on  
0609 = Oxygen/Home Health - Other  
0610 = Magnetic resonance technology (MRT)-general  
classification  
0611 = MRT/MRI-brain (including brainstem)  
0612 = MRT/MRI-spinal cord (including spine)  
0614 = MRT/MRI-other  
0615 = MRT/MRA-Head and Neck  
0616 = MRT/MRA-Lower Extremities  
0618 = MRT/MRA-other  
0619 = MRT/Other MRT  
0620 = Reserved (Use 0270 for general classification)  
0621 = Medical/surgical supplies-incident to radiology-  
subject to the payment limit - extension of 027X  
0622 = Medical/surgical supplies-incident to other  
diagnostic service-subject to the payment limit -  
extension of 027X  
0623 = Medical/surgical supplies-surgical dressings  
(eff 1/95) - extension of 027X  
0624 = Medical/surgical supplies-medical investigational  
devices and procedures with FDA approved IDE's  
(eff 10/96) - extension of 027X  
0630 = Reserved (eff. 1/98)  
0631 = Drugs requiring specific identification-single drug  
source (eff 9/93)  
0632 = Drugs requiring specific identification-multiple drug  
source (eff 9/93)  
0633 = Drugs requiring specific identification-restrictive  
prescription (eff 9/93)  
0634 = Drugs requiring specific identification-EPO under  
10,000 units  
0635 = Drugs requiring specific identification-EPO 10,000  
units or more  
0636 = Drugs requiring specific identification-detailed  
coding (eff 3/92)  
0637 = Self-administered drugs administered in an  
emergency situation - not requiring detailed  
coding  
0640 = Home IV therapy-general classification  
(eff 10/94)  
0641 = Home IV therapy-nonroutine nursing  
(eff 10/94)  
0642 = Home IV therapy-IV site care, central line

(eff 10/94)  
0643 = Home IV therapy-IV start/change peripheral line  
(eff 10/94)  
0644 = Home IV therapy-nonroutine nursing, peripheral line  
(eff 10/94)  
0645 = Home IV therapy-train patient/caregiver, central  
line (eff 10/94)  
0646 = Home IV therapy-train disabled patient, central  
line (eff 10/94)  
0647 = Home IV therapy-train patient/caregiver, peripheral  
line (eff 10/94)  
0648 = Home IV therapy-train disabled patient, peripheral  
line (eff 10/94)  
0649 = Home IV therapy-other IV therapy services  
(eff 10/94)  
0650 = Hospice services-general classification  
0651 = Hospice services-routine home care  
0652 = Hospice services-continuous home care-1/2  
  
0655 = Hospice services-inpatient care  
0656 = Hospice services-general inpatient care  
(non-respite)  
0657 = Hospice services-physician services  
0658 = Hospice services-Hospice Room & Board -  
Nursing Facility  
0659 = Hospice services-other  
0660 = Respite care (HHA)-general classification  
(eff 9/93)  
0661 = Respite care (HHA)-hourly charge/skilled nursing  
(eff 9/93)  
0662 = Respite care (HHA)-hourly charge/home health aide/  
homemaker (eff 9/93)  
0663 = Respite care-daily respite care  
0669 = Respite care-other respite care  
0670 = OP special residence charges - general  
classification  
0671 = OP special residence charges - hospital based  
0672 = OP special residence charges - contracted  
0679 = OP special residence charges - other special  
residence charges  
0680 = Trauma Response-not used  
0681 = Trauma response-Level I Trauma  
0682 = Trauma response-Level II Trauma  
0683 = Trauma response-Level III Trauma  
0684 = Trauma response-Level IV Trauma  
0689 = Trauma response-Other trauma response  
0700 = Cast room-general classification  
0709 = Cast room-other  
0710 = Recovery room-general classification  
0719 = Recovery room-other



0720 = Labor room/delivery-general classification  
0721 = Labor room/delivery-labor  
0722 = Labor room/delivery-delivery  
0723 = Labor room/delivery-circumcision  
0724 = Labor room/delivery-birthing center  
0729 = Labor room/delivery-other  
0730 = EKG/ECG-general classification  
0731 = EKG/ECG-Holter monitor  
0732 = EKG/ECG-telemetry (include fetal monitoring until  
9/93)  
0739 = EKG/ECG-other  
0740 = EEG-general classification  
0749 = EEG (electroencephalogram)-other  
0750 = Gastro-intestinal services-general classification  
0759 = Gastro-intestinal services-other  
0760 = Treatment or observation room-general  
classification  
0761 = Treatment or observation room-treatment room  
(eff 9/93)  
0762 = Treatment or observation room-observation room  
(eff 9/93)  
0769 = Treatment or observation room-other  
0770 = Preventative care services-general classification  
(eff 10/94)  
0771 = Preventative care services-vaccine administration  
(eff 10/94)  
0779 = Preventative care services-other (eff 10/94)  
0780 = Telemedicine - general classification  
(eff 10/97)  
0789 = Telemedicine - telemedicine (eff 10/97)  
0790 = Lithotripsy-general classification  
0799 = Lithotripsy-other  
0800 = Inpatient renal dialysis-general classification  
0801 = Inpatient renal dialysis-inpatient hemodialysis  
0802 = Inpatient renal dialysis-inpatient peritoneal  
(non-CAPD)  
0803 = Inpatient renal dialysis-inpatient CAPD  
0804 = Inpatient renal dialysis-inpatient CCPD  
0809 = Inpatient renal dialysis-other inpatient dialysis  
0810 = Organ acquisition-general classification  
0811 = Organ acquisition-living donor (eff 10/94);  
prior to 10/94, defined as living donor kidney  
0812 = Organ acquisition-cadaver donor (eff 10/94);  
prior to 10/94, defined as cadaver donor kidney  
0813 = Organ acquisition-unknown donor (eff 10/94)  
prior to 10/94, defined as unknown donor kidney  
0814 = Organ acquisition - unsuccessful organ search-  
donor bank charges (eff 10/94); prior to 10/94,  
defined as other kidney acquisition  
0815 = Organ acquisition-cadaver donor-heart

(obsolete, eff 10/94)  
 0816 = Organ acquisition-other heart acquisition  
 (obsolete, eff 10/94)  
 0817 = Organ acquisition-donor-liver  
 (obsolete, eff 10/94)  
 0819 = Organ acquisition-other donor (eff 10/94);  
 prior to 10/94, defined as other  
 0820 = Hemodialysis OP or home dialysis-general  
 classification  
 0821 = Hemodialysis OP or home dialysis-hemodialysis-  
 composite or other rate  
 0822 = Hemodialysis OP or home dialysis-home supplies  
 0823 = Hemodialysis OP or home dialysis-home equipment  
 0824 = Hemodialysis OP or home dialysis-maintenance/100%  
 0825 = Hemodialysis OP or home dialysis-support services  
 0829 = Hemodialysis OP or home dialysis-other  
 0830 = Peritoneal dialysis OP or home-general  
 classification  
 0831 = Peritoneal dialysis OP or home-peritoneal-  
 composite or other rate  
 0832 = Peritoneal dialysis OP or home-home supplies  
 0833 = Peritoneal dialysis OP or home-home equipment  
 0834 = Peritoneal dialysis OP or home-maintenance/100%  
 0835 = Peritoneal dialysis OP or home-support services  
 0839 = Peritoneal dialysis OP or home-other  
 0840 = CAPD outpatient-general classification  
 0841 = CAPD outpatient-CAPD/composite or other rate  
 0842 = CAPD outpatient-home supplies  
 0843 = CAPD outpatient-home equipment  
 0844 = CAPD outpatient-maintenance/100%  
 0845 = CAPD outpatient-support services  
 0849 = CAPD outpatient-other  
 0850 = CCPD outpatient-general classification  
 0851 = CCPD outpatient-CCPD/composite or other rate  
 0852 = CCPD outpatient-home supplies  
 0853 = CCPD outpatient-home equipment  
 0854 = CCPD outpatient-maintenance/100%  
 0855 = CCPD outpatient-support services  
 0859 = CCPD outpatient-other  
 0860 = Magnetoencephalography (MEG) - general  
 classification  
 0861 = Magnetoencephalography (MEG) - MEG  
 0880 = Miscellaneous dialysis-general classification  
 0881 = Miscellaneous dialysis-ultrafiltration  
 0882 = Miscellaneous dialysis-home dialysis aide visit  
 (eff 9/93)  
 0889 = Miscellaneous dialysis-other  
 0890 = Other donor bank-general classification; changed to  
 reserved for national assignment (eff 4/94)  
 0891 = Other donor bank-bone; changed to

reserved for national assignment (eff 4/94)  
0892 = Other donor bank-organ (other than kidney); changed  
to reserved for national assignment (eff 4/94)  
0893 = Other donor bank-skin; changed to  
reserved for national assignment (eff 4/94)  
0899 = Other donor bank-other; changed to  
reserved for national assignment (eff 4/94)  
0900 = Behavior Health Treatment/Services - general  
classification (eff. 10/2004); prior to  
10/2004 defined as Psychiatric/psychological  
treatments-general classification  
0901 = Behavior Health Treatment/Services - electroshock  
treatment (eff. 10/2004); prior to 10/2004  
defined as Psychiatric/psychological  
treatments-electroshock treatment  
0902 = Behavior Health Treatment/Services - milieu  
therapy (eff. 10/2004); prior to 10/2004  
defined as Psychiatric/psychological  
treatments-milieu therapy  
0903 = Behavior Health Treatment/Services - play  
therapy (eff. 10/2004); prior to 10/2004  
defined as Psychiatric/psychological  
treatments-play therapy  
0904 = Behavior Health Treatment/Services - activity  
therapy (eff. 10/2004); prior to 10/2004  
defined as Psychiatric/psychological  
treatments-activity therapy  
0905 = Behavior Health Treatment/Services - intensive  
outpatient services-psychiatric (eff. 10/2004)  
0906 = Behavior Health Treatment/Services - intensive  
outpatient services-chemical dependency  
(eff. 10/2004)  
0907 = Behavior Health Treatment/Services - community  
behavioral health program-day treatment  
(eff. 10/2004)  
0909 = Reserved for National Use (eff. 10/2004); prior  
to 10/2004 defined as Psychiatric/psychological  
treatments-other  
0910 = Behavioral Health Treatment/Services-Reserved for  
National Assignment (eff. 10/2004); prior to  
10/2004 defined as Psychiatric/psychological  
services-general classification  
0911 = Behavioral Health Treatment/Services-rehabilitation  
(eff. 10/2004); prior to 10/2004 defined as  
Psychiatric/psychological services-rehabilitation  
0912 = Behavioral Health Treatment/Services-partial  
hospitalization-less intensive (eff. 10/2004);  
prior to 10/2004 defined as Psychiatric/  
psychological services-less intensive  
0913 = Behavioral Health Treatment/Services-partial

hospitalization-intensive (eff. 10/2004);  
 prior to 10/2004 defined as Psychiatric/  
 psychological services-intensive  
 0914 = Behavioral Health Treatment/Services-indivi-  
 dual therapy (eff. 10/2004); prior to  
 10/2004 defined as Psychiatric/psychological  
 services-individual therapy  
 0915 = Behavioral Health Treatment/Services-group  
 therapy (eff. 10/2004); prior to 10/2004  
 defined as Psychiatric/psychological services-  
 group therapy  
 0916 = Behavioral Health Treatment/Services-family  
 therapy (eff. 10/2004); prior to 10/2004  
 defined as Psychiatric/psychological services-  
 family therapy  
 0917 = Behavioral Health Treatment/Services-bio  
 feedback (eff. 10/2004); prior to 10/2004  
 defined as Psychiatric/psychological services-  
 bio feedback  
 0918 = Behavioral Health Treatment/Services-testing  
 (eff. 10/2004); prior to 10/2004 defined as  
 Psychiatric/psychological services-testing  
 0919 = Behavioral Health Treatment/Services-other  
 (eff. 10/2004); prior to 10/2004 defined as  
 Psychiatric/psychological services-other  
 0920 = Other diagnostic services-general classification  
 0921 = Other diagnostic services-peripheral vascular lab  
 0922 = Other diagnostic services-electromyogram  
 0923 = Other diagnostic services-pap smear  
 0924 = Other diagnostic services-allergy test  
 0925 = Other diagnostic services-pregnancy test  
 0929 = Other diagnostic services-other  
 0931 = Medical Rehabilitation Day Program - Half Day  
 0932 = Medical Rehabilitation Day Program - Full Day  
 0940 = Other therapeutic services-general classification  
 0941 = Other therapeutic services-recreational therapy  
 0942 = Other therapeutic services-education/training  
 (include diabetes diet training)  
 0943 = Other therapeutic services-cardiac rehabilitation  
 0944 = Other therapeutic services-drug rehabilitation  
 0945 = Other therapeutic services-alcohol  
 rehabilitation  
 0946 = Other therapeutic services-routine complex  
 medical equipment  
 0947 = Other therapeutic services-ancillary complex  
 medical equipment (eff 3/92)  
 0949 = Other therapeutic services-other  
 0951 = Professional Fees-athletic training (extension  
 of 094X)  
 0952 = Professional Fees-kinesiotherapy (extension

of 094X)

0960 = Professional fees-general classification  
 0961 = Professional fees-psychiatric  
 0962 = Professional fees-ophthalmology  
 0963 = Professional fees-anesthesiologist (MD)  
 0964 = Professional fees-anesthetist (CRNA)  
 0969 = Professional fees-other  
 NOTE: 097X is an extension of 096X  
 0971 = Professional fees-laboratory  
 0972 = Professional fees-radiology diagnostic  
 0973 = Professional fees-radiology therapeutic  
 0974 = Professional fees-nuclear medicine  
 0975 = Professional fees-operating room  
 0976 = Professional fees-respiratory therapy  
 0977 = Professional fees-physical therapy  
 0978 = Professional fees-occupational therapy  
 0979 = Professional fees-speech pathology  
 NOTE: 098X is an extension of 096X & 097X  
 0981 = Professional fees-emergency room  
 0982 = Professional fees-outpatient services  
 0983 = Professional fees-clinic  
 0984 = Professional fees-medical social services  
 0985 = Professional fees-EKG  
 0986 = Professional fees-EEG  
 0987 = Professional fees-hospital visit  
 0988 = Professional fees-consultation  
 0989 = Professional fees-private duty nurse  
 0990 = Patient convenience items-general classification  
 0991 = Patient convenience items-cafeteria/guest tray  
 0992 = Patient convenience items-private linen service  
 0993 = Patient convenience items-telephone/telecom  
 0994 = Patient convenience items-tv/radio  
 0995 = Patient convenience items-nonpatient room rentals  
 0996 = Patient convenience items-late discharge charge  
 0997 = Patient convenience items-admission kits  
 0998 = Patient convenience items-beauty shop/barber  
 0999 = Patient convenience items-other  
 1000 = Behavioral Health Accommodations -  
 general classification  
 1001 = Behavioral Health Accommodations -  
 residential treatment -Psychiatric  
 1002 = Behavioral Health Accommodations -  
 residential treatment - chemical  
 dependency  
 1003 = Behavioral Health Accommodations -  
 supervised living  
 1004 = Behavioral Health Accommodations -  
 halfway house  
 1005 = Behavioral Health Accommodations -  
 group home

2100 = Alternative Therapy Services - general  
classification  
2101 = Alternative Therapy Services -  
Acupuncture  
2102 = Alternative Therapy Services -  
Acupressure  
2103 = Alternative Therapy Services -  
massage  
2104 = Alternative Therapy Services -  
reflexology  
2105 = Alternative Therapy Services -  
biofeedback  
2106 = Alternative Therapy Services -  
hypnosis  
2109 = Alternative Therapy Services -  
other alternative therapy service  
3100 = Adult Care - Reserved  
3101 = Adult Care - adult day care, medical  
and social hourly  
3102 = Adult Care - adult day care, social-  
hourly  
3103 = Adult Care - adult day care, medical  
and social - daily  
3104 = Adult Care - adult day care, social -  
daily  
3105 = Adult Care - adult foster care daily  
3109 = Adult Care - other adult care

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

9000 = RUGS-no MDS assessment available  
9001 = Reduced physical functions-  
RUGS PA1/ADL index of 4-5  
9002 = Reduced physical functions-  
RUGS PA2/ADL index of 4-5  
9003 = Reduced physical functions-  
RUGS PB1/ADL index of 6-8  
9004 = Reduced physical functions-  
RUGS PB2/ADL index of 6-8  
9005 = Reduced physical functions-  
RUGS PC1/ADL index of 9-10  
9006 = Reduced physical functions-  
RUGS PC2/ADL index of 9-10  
9007 = Reduced physical functions-  
RUGS PD1/ADL index of 11-15  
9008 = Reduced physical functions-  
RUGS PD2/ADL index of 11-15  
9009 = Reduced physical functions-

RUGS PE1/ADL index of 16-18  
9010 = Reduced physical functions-  
RUGS PE2/ADL index of 16-18  
9011 = Behavior only problems-  
RUGS BA1/ADL index of 4-5  
9012 = Behavior only problems-  
RUGS BA2/ADL index of 4-5  
9013 = Behavior only problems-  
RUGS BB1/ADL index of 6-10  
9014 = Behavior only problems-  
RUGS BB2/ADL index of 6-10  
9015 = Impaired cognition-  
RUGS IA1/ADL index of 4-5  
9016 = Impaired cognition-  
RUGS IA2/ADL index of 4-5  
9017 = Impaired cognition-  
RUGS IB1/ADL index of 6-10  
9018 = Impaired cognition-  
RUGS IB2/ADL index of 6-10  
9019 = Clinically complex-  
RUGS CA1/ADL index of 4-5  
9020 = Clinically complex-  
RUGS CA2/ADL index of 4-5d  
9021 = Clinically complex-  
RUGS CB1/ADL index of 6-10  
9022 = Clinically complex-  
RUGS CB2/ADL index of 6-10d  
9023 = Clinically complex-  
RUGS CC1/ADL index of 11-16  
9024 = Clinically complex-  
RUGS CC2/ADL index of 11-16d  
9025 = Clinically complex-  
RUGS CD1/ADL index of 17-18  
9026 = Clinically complex-  
RUGS CD2/ADL index of 17-18d  
9027 = Special care-  
RUGS SSA/ADL index of 7-13  
9028 = Special care-  
RUGS SSB/ADL index of 14-16  
9029 = Special care-  
RUGS SSC/ADL index of 17-18  
9030 = Extensive services-  
RUGS SE1/1 procedure  
9031 = Extensive services-  
RUGS SE2/2 procedures  
9032 = Extensive services-  
RUGS SE3/3 procedures  
9033 = Low rehabilitation-  
RUGS RLA/ADL index of 4-11  
9034 = Low rehabilitation-

RUGS RLB/ADL index of 12-18  
9035 = Medium rehabilitation-  
RUGS RMA/ADL index of 4-7  
9036 = Medium rehabilitation-  
RUGS RMB/ADL index of 8-15  
9037 = Medium rehabilitation-  
RUGS RMC/ADL index of 16-18  
9038 = High rehabilitation-  
RUGS RHA/ADL index of 4-7  
9039 = High rehabilitation-  
RUGS RHB/ADL index of 8-11  
9040 = High rehabilitation-  
RUGS RHC/ADL index of 12-14  
9041 = High rehabilitation-  
RUGS RHD/ADL index of 15-18  
9042 = Very high rehabilitation-  
RUGS RVA/ADL index of 4-7  
9043 = Very high rehabilitation-  
RUGS RVB/ADL index of 8-13  
9044 = Very high rehabilitation-  
RUGS RVC/ADL index of 14-18

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

9019 = Clinically complex-  
RUGS CA1/ADL index of 11  
9020 = Clinically complex-  
RUGS CA2/ADL index of 11D  
9021 = Clinically complex-  
RUGS CB1/ADL index of 12-16  
9022 = Clinically complex-  
RUGS CB2/ADL index of 12-16D  
9023 = Clinically complex-  
RUGS CC1/ADL index of 17-18  
9024 = Clinically complex-  
RUGS CC2/ADL index of 17-18D  
9025 = Special care-  
RUGS SSA/ADL index of 14  
9026 = Special care-  
RUGS SSB/ADL index of 15-16  
9027 = Special care-  
RUGS SSC/ADL index of 17-18  
9028 = Extensive services-  
RUGS SE1/ADL index 7-18/1 procedure  
9029 = Extensive services-  
RUGS SE2/ADL index 7-18/2 procedures  
9030 = Extensive services-  
RUGS SE3/ADL index 7-18/3 procedures  
9031 = Low rehabilitation-



RUGS RLA/ADL index of 4-13  
9032 = Low rehabilitation-  
RUGS RLB/ADL index of 14-18  
9033 = Medium rehabilitation-  
RUGS RMA/ADL index of 4-7  
9034 = Medium rehabilitation-  
RUGS RMB/ADL index of 8-14  
9035 = Medium rehabilitation-  
RUGS RMC/ADL index of 15-18  
9036 = High rehabilitation-  
RUGS RHA/ADL index of 4-7  
9037 = High rehabilitation-  
RUGS RHB/ADL index of 8-12  
9038 = High rehabilitation-  
RUGS RHC/ADL index of 13-18  
9039 = Very High rehabilitation-  
RUGS RVA/ADL index of 4-8  
9040 = Very high rehabilitation-  
RUGS RVB/ADL index of 9-15  
9041 = Very high rehabilitation-  
RUGS RVC/ADL index of 16  
9042 = Very high rehabilitation-  
RUGS RUA/ADL index of 4-8  
9043 = Very high rehabilitation-  
RUGS RUB/ADL index of 9-15  
9044 = Ultra high rehabilitation-  
RUGS RUC/ADL index of 16-18

08/01/2011

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LIMITATIONS APPENDIX FOR RECORD: FI\_HOSPC\_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 CWFMQA front-end editing revealed that some

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

CORRECTIVE ACTION :

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

SOURCE:

CONTACT : OIS/EDG/DMUDD

CLM\_TRANS\_CD\_LIM

FULL NAME: Claim Transaction Code Limitation

DESCRIPTION :

Claim Transaction Code missing from 1999 inpatient records and there was also a problem identified in the May and June 2000 data.

BACKGROUND :

Users of the data discovered taht the claim transaction code was missing values 2 & 3 for service year 1999 and for the months of May and June, 2000. This information was confirmed and OIS/BSOG was notified.

CORRECTIVE ACTION :

In July 2000 the problem was fixed and the claim transaction code contained the correct values.

SOURCE:

CONTACT : OIS/EDG/DMUDD

HHA\_HCPCS\_LIM

FULL NAME: Home Health HCPCS Limitation

DESCRIPTION :

It was determined that providers were not complying with the 15-minute increment billing instructions for using the 'G' HCPCS codes.

BACKGROUND :

The instructions state that providers are to use the newly created 'G' codes to identify services of the six home health disciplines during an HH episode of care. These 'G' codes (G0151, G0152, G0153, G0154, G0155, G0156) are subject to 15-minute interval billing. As a result the user can not trust the 'G' codes for visit counting. For a more accurate accounting of services the user should rely on the revenue center codes rather than the HCPCS.

Currently there is a check that if the 15-minute increment 'G' codes appear, the revenue center code must be the corresponding HH discipline; however, there is no check to see if the discipline revenue center code

appears and that the HCPCS contains the corresponding 'G' code.

CORRECTIVE ACTION :

The Standard Systems has put a fix in to correct this problem.

SOURCE:

CONTACT : OIS/EDG/DMUDD

MCO\_PD\_SW\_LIM

FULL NAME: Claim MCO Paid Switch Limitation

DESCRIPTION :

The MCO paid switch made consistent with criteria used to identify an inpatient encounter claim.

BACKGROUND :

During the NCH Version 'I' conversion, history was populated with an NCH Claim Type Code that will identify the record as an inpatient encounter claim. When applying the CWF logic to identify an inpatient encounter claim, it was discovered that when all the criteria was met the MCO paid switch was sometimes a blank or '0' (reflecting that the MCO did not pay the provider).

CORRECTIVE ACTION :

With the inception of the Version 'I' processing (7/00), if all the criteria for identifying an inpatient encounter claim is met but the MCO paid switch is a blank or '0' it is changed to a '1'.

A patch code = '13' was applied to all claims back to 7/1/97 service year thru date.

SOURCE:

CONTACT : OIS/EDG/DMUDD

MLTPL\_REV\_CNTR\_0001\_CD\_LIM

FULL NAME: Multiple Revenue Center '0001' Code Limitation

DESCRIPTION :

Multiple total charge '0001' revenue center codes appearing on outpatient, hospice and home health claim records.

BACKGROUND :

On outpatient, home health and hospice it appears that more than one '0001' revenue center code is showing up on the claims. The first total charge line adds the revenue center codes above it correctly; the problem exists below the first total charge line where garbage may be present due to the FI Standard System not clearing out fields before processing the next claim. We believe the error began with the change-over to a different claims processing contractor in 1/98.

CORRECTIVE ACTION :

CWF created an edit to reject multiple '0001' revenue center codes, effective 6/28/99. EDG's CWFMQA process

implemented an edit to drop any revenue center line items below the first total charge line. The NCH Nearline File, as well as the 1998 Standard Analytic Files (SAFs), have been patched/corrected to delete the multiple '0001' codes where present on any of the institutional claim types. Also, HCIS will be correcting the revenue center summaries during the next refresh.

The NCH\_PATCH\_CD field will reflect a value '10'.

SOURCE:

CONTACT : OIS/EDG/DMUDD

PMT\_AMT\_EXCEDG\_CHRG\_AMT\_LIM

FULL NAME: Claim Payment Amount Exceeding Total Charge Amount Limitation

DESCRIPTION :

Approximately 75 Inpatient claims had a reimbursement amount exceed \$500,000 which was at least 25 times the total charge amount. There were also claims where the reimbursement was less than \$500,000 but greater than the total charges.

BACKGROUND :

In November of 1999, it was brought to the attention of the HDUG that large reimbursement amounts were being paid in Pennsylvania. There were 75 inpatient claims provided where the reimbursement amount was over \$500,000 and at least 25 times the total charge amount. These claims were processed between 9/29/98 and 10/1/98. There were also claims identified with reimbursement less than \$500,000 but greater than total charge. It was later discovered that the source of the problem was an error in entering an MSA; the decimal point was off by 2 positions.

Because there were no changes in utilization, the claims were corrected and the correct payments distributed, but the new payment amounts were never sent to CWF (not in NCH). There is currently no requirement that FIs and carriers update CWF with final payment information by submitting payment only adjustments. It was noted that there is no expectation that CWF will have final payment information for claims.

CORRECTIVE ACTION :

According to Veritus (FI), the problem was caught in their system using a pre-payment edit prior to sending out the payments. The erroneous MSA value was corrected and the claims were then sent to PRICER again and paid correctly.

The claims were corrected and correct payments were made but these new payment amounts were never sent

to CWF and are not reflected in the NCH.

SOURCE:  
 CONTACT                    OIS/EDG/DMUDD

REV\_CNTR\_IDE\_NDC\_UPC\_LIM

FULL NAME: Revenue Center IDE, NDC, UPC Limitation  
 DESCRIPTION :  
   Missing data in the REV\_CNTR\_IDE\_NDC\_UPC\_NUM  
   field.  
 BACKGROUND       :  
   Prior to Version 'I', this field housed only the 7-position  
   exemption number assigned by the FDA to an investigational  
   device after a manufacturer has been approved to conduct  
   a clinical trial on that device. With Version 'I', this  
   field expanded to 24 positions to accommodate the future  
   receipt of the National Drug Code and the Uniform Product  
   Code. The CWFMQA editing process was moving the IDE to  
   the expanded field, but then incorrectly blanked it out  
   (positions 8-24 should be blank).  
 CORRECTIVE ACTION :  
   CWFMQA fixed the code and the problem was corrected with  
   claims processed with NCH weekly process date 9/15/00.  
 SOURCE:  
 ADMINISTRATIVE DATA:  
   START DATE           : 06/09/00  
   END DATE             : 09/08/00  
   CONTACT              : OIS/EDG/DMUDD

REV\_CNTR\_TOT\_CHRG\_AMT\_LIM

FULL NAME: Revenue Center Total Charge Amount Limitation  
 DESCRIPTION :  
   Revenue center total charge amount field being  
   populated on segments 2-10 of the Version 'I'  
   record.  
 BACKGROUND       :  
   Under Version 'I', a decision was made that any  
   amount, count and quantity field would be zeroed  
   out to eliminate the risk of overstating values  
   during an accumulation.  
 CORRECTIVE ACTION :  
   The CWFMQA front-end process was modified to zero  
   out the total charge amount field in segments 2-10.  
 SOURCE:  
 ADMINISTRATIVE DATA:  
   START DATE           : 07/01/00  
   END DATE             : 02/02/01  
   CONTACT              : OIS/EDG/DMUDD

TOT\_CHRG\_AMT\_LIM

FULL NAME: Claim Total Charge Amount Limitation  
 DESCRIPTION :  
   The total charge amount field in the fixed portion was  
   truncated on outpatient, hospice and home health claims.

BACKGROUND :

For outpatient, hospice and home health claims, the total charge amount field in the fixed portion was truncated (the cents were dropped off; the decimal point was moved, making cents out of dollars) in the CWFMQA process beginning with data received from CWF 1/4/99 through 5/14/99. The problem occurred when CWF increased the size of the field.

CORRECTIVE ACTION :

The CWFMQA front-end was fixed. The Nearline was patched during the quarterly merge in 7/99 for service years 1998 and 1999. The NCH\_PACTCH\_CD field will be populated with a value '11'. The 1998 and 1999 SAFs were corrected when finalized in 7/99.

The patch involved moving the total charge amount in the revenue center trailer to the total charge amount field in the fixed portion, for records with NCH Daily Process Date 1/4/99 - 5/14/99.

SOURCE:

ADMINISTRATIVE DATA:

START DATE : 01/04/99  
END DATE : 05/14/99  
CONTACT : OIS/EDG/DMUDD

08/01/2011

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